GAA/RUR 76

equality
TASMANIA
formerly known as Tasmanian Gay and Lesbian Rights Group

Rodney Croome
President, Equality Tasmania
0409 010 668

Rural Health Services Inquiry
Legislative Council Committee A
C/o Hon Sarah Lovell MLC & Hon Ruth Forrest MLC

re: Legislative Council rural health inquiry

Dear Sarah and Ruth,

Please accept this late submission to the Legislative Council inquiry into rural health services. We hope it may still be accepted.

Equality Tasmania is Australia's oldest LGBTIQ+ advocacy and lobbying organisation. We have been at the forefront of campaigns to decriminalise homosexuality, enact anti-discrimination legislation, recognise same-gender couples and their families, pass marriage equality and enact gender recognition. We are also intimately involved in improving Tasmanian Government policy responses across a range of areas including health and mental health.

Terms of reference

We are disappointed that the inquiry's terms of reference do not include any reference to the LGBTIQ+ community, alongside other communities such as the Indigenous, and culturally and linguistically diverse (CALD) communities.

There has been a relatively large amount of research into the health and related outcomes of LGBTIQ+ Tasmanians in the past two or three years, including Covid-related research and a survey conducted by the Tasmanian Government (yet to be publicly released). We have attached a number of studies that show

a) the relatively poor health and mental health outcomes of LGBTIQ+ Tasmanians,
b) the disproportionate impact on Covid on LGBTIQ+ Tasmanians, and
c) the lower standard of living experienced by LGBTIQ+ Tasmanians, and

d) all of which is due in large part to stigma and discrimination including in health care

We have included these studies to make it clear that any future parliamentary inquiry into health and related matters should include an explicit focus on the health of LGBTIQ+ people. Failure to take our health outcomes into account will result in an incomplete picture of health outcomes in Tasmania.

LGBTIQ+ rural health

In relation to the health of LGBTIQ+ people in rural areas, we draw the inquiry's attention to the three national studies we have attached.

These are the 2020 Private Lives 3 survey of LGBTIQ+ Australians, the 2019 Writing Themselves In 4 survey of young LGBTIQ+ Australians and the 2013 Australian Transgender Mental Health survey.

These three studies carefully analyse the health and mental health outcomes of LGBTIQ+ people living in rural areas, as well as the level of support they have and their access to inclusive health services.

The PL3 report shows rural and remote LGBTIQ+ people experiencing lower levels of support, higher levels of health and mental health distress and greater difficulties in accessing inclusive services (p113-117). The WTI4 report shows the same problems for young LGBTIQ+ people in rural and remote areas (p167-173). The TMH report showed significant problems accessing inclusive health care in rural and remote areas (p50).

There is no reason to believe these results would be any better in Tasmania. Indeed, given the lower health and mental health outcomes for LGBTIQ+ Tasmanians compared to our counterparts on the continent, we believe the reality is probably worse for LGBTIQ+ people in rural and remote Tasmania than it is in other rural areas of Australia.

We recommend

1. The commitment of greater resources to improving access for LGBTIQ+ people to existing health and mental health services in rural and remote Tasmania, including training for staff and promotion of inclusive services

2. The establishment of a statewide LGBTIQ+ health and mental health service with services targeted specifically at LGBTIQ+ people in rural and remote areas

Best wishes,
Rodney Croome
for Equality Tasmania

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The Spatial Impacts of COVID-19 Restrictions on LGBTIQ Wellbeing, Visibility, and Belonging in Tasmania, Australia

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ABSTRACT

International emergency management and disaster risk reduction policies and planning have rarely included lesbian, gay, bisexual, transgender, intersex, and queer (LGBTIQ) people's specific health and wellbeing concerns, despite increasing research showing that these groups face some specific vulnerabilities and additional challenges. Emerging studies in the US and UK noted increased feelings of loneliness, minority stress, and vulnerability to family violence since the outbreak of COVID-19. However, little is known about LGBTIQ people's experiences of COVID-19 in Australia. This article explores the effects of COVID-19 on LGBTIQ mental health and wellbeing in Tasmania, Australia. Drawing on a survey of 231 LGBTIQ respondents aged 14–78, we use the spaces of wellbeing framework to examine the impacts of COVID-19 restrictions on LGBTIQ (in)visibility in relation to the public, private, and online spaces, arguing that COVID-19 restrictions affected LGBTIQ Tasmanians' experiences and use of spaces in ways that detracted from wellbeing, visibility, and belonging.

KEYWORDS
Australia; COVID-19; LGBTIQ; mental health; wellbeing

Since its outbreak in December 2019, the coronavirus (COVID-19) pandemic has caused the international social and economic disruption, including recession, the postponement of events, closure of schools and businesses, travel restrictions, food shortages, and a range of region-specific public health emergency responses. Interventions introduced in Australia, such as home isolation, physical distancing, and travel restrictions have prevented the devastating growth seen in other COVID-19 affected nations, although there have been some resurgences of cases at the time of writing. Tasmania, Australia's southern "island state" (pop. 534,000), was one of the first states to initiate interstate border closure and has since enforced strict quarantine procedures for travelers, closure of non-essential public spaces and businesses, physical distancing measures, and home isolation (MacDonald, 2020). While such measures have been effective in reducing the spread of COVID-19, little is

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known about the impact these spatial restrictions have on the mental health and wellbeing of the community. As a group with poorer mental health than the wider population (Whitehead, Shaver, & Stephenson, 2016), lesbian, gay, bisexual, transgender, intersex, and queer (LGBTIQ) people may be especially affected by COVID-19 restrictions. Given these circumstances, in this article, we aim to explore how these measures influence LGBTIQ people's experiences and use of space and the effect on LGBTIQ wellbeing.

For the purposes of this article, a disaster refers to "a sudden, calamitous event that seriously disrupts the functioning of a community or society and causes human, material, and economic or environmental losses that exceed the community's or society's ability to cope" (World Health Organization, 2020). In contrast, an emergency, such as a public health emergency, describes a combination of circumstances or the resulting state that calls for an immediate response (World Health Organization, 2020). COVID-19 constitutes both a disaster and an emergency, requiring rapid response. Disasters are often framed as neutral events that affect everyone. For example, in Australia much of the COVID-19 public health messaging and relief efforts emphasized that "we are all in this together" (e.g. North Western Melbourne Primary Health Network, 2020). However, disasters are social phenomena (Brun, 2009), and as Gorman-Murray, McKinnon, Dominey-Howes, Nash, and Bolton (2018) argued, "the detrimental impacts [of disasters] are unevenly distributed across local communities and social groups" (p. 169). Previous research indicated that marginalized groups are especially vulnerable during disasters and emergencies because they already face reduced access to resources (Gaillard, 2010), and a growing body of work highlights how LGBTIQ people are particularly impacted in disasters and emergencies.

Gender and sexuality are often disregarded in emergency situations, seen as factors to be "controlled and contained" rather than central to the human experience (McSherry, Manalastas, Gaillard, & Dalisay, 2015, p. 27). Yet experiences of disasters and emergencies are highly gendered (Enarson & Pease, 2016; True, 2013) and sexualized (McKinnon, 2017), with existing inequalities being further exacerbated in times of crisis. Mental-health conditions and barriers to LGBTIQ-inclusive health and social care are often amplified in emergency situations, deterring LGBTIQ people from seeking necessary and life-saving care (Gorman-Murray et al., 2018; Gorman-Murray, Morris, Keppel, McKinnon, & Dominey-Howes, 2017). For example, transgender and gender non-conforming people have been refused entry to emergency shelters or experienced abuse when accessing these services (D'Ooge, 2008; Gaillard, 2010; Yamashita, Gomez, & Dombroski, 2017). This literature provides some insight into how COVID-19 may be impacting LGBTIQ people's mental health; however, further research is required to capture the specificities and inform policy, relief, and ongoing service provision.

Spaces of wellbeing

In this analysis, we are interested in understanding LGBTIQ experiences of wellbeing, visibility, and belonging, which are inherently bound up with LGBTIQ experiences of space and place. A theoretical framework drawn from the discipline of geography is most useful for our purposes. Within geography, there is growing interest in the relationship between wellbeing and place (Atkinson, Fuller, & Painter, 2012; Schwanen & Atkinson, 2015). This work fundamentally argues that "space is an active agent in shaping wellbeing" (Fleuret & Prugneau, 2015, p. 111): where people are located and the characteristics and relationships that shape that place thoroughly affects wellbeing (Nordbakke & Schwanen, 2014). While some research and policy work conflates wellbeing with health or economic indicators, more holistic approaches define it as living a good or flourishing life. Here, health and economic indicators are understood as part of the means to human flourishing, but not ends in themselves (Atkinson, 2013; Schwanen & Wang, 2014).

To connect broad perspectives on wellbeing in a geographical approach, Fleuret and Atkinson (2007) developed the "spaces of wellbeing" framework, which we use in our analysis. Fleuret & Prugneau (2015, p. 112) argue that wellbeing can be evaluated not only from an individual or social perspective but also from an assessment of the potentialities of space: "the framework … offers a tool to understand the ways in which spatial contexts mediate and shape individuals' wellbeing because space is studied for its virtues which are conducive or unconducive to wellbeing." In this framework, wellbeing is contextual: it emerges within spaces and places from the interactions between humans and their environments (Nordbakke & Schwanen, 2014). Drawing together ideas that bridge hedonic (pleasure experienced, displeasure avoided) and eudaimonic (realizing one's potential, leading a meaningful life) understandings of wellbeing – from Abraham Maslow's (1954) hierarchy of needs to Amartya Sen's (1992) theory of capability—in a contextualist framing, a space of wellbeing inheres "four interrelated spaces of resource mobilization" (Atkinson, 2013, p. 142): spaces of security, capabilities, social integration, and therapeutic processes (see Figure 1).

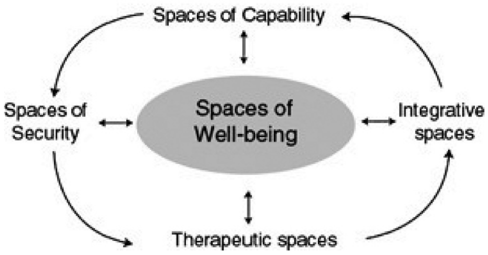

Figure 1. Spaces of well-being (Fleuret & Atkinson, 2007).

"Spaces of security" are related to physical security and material support, and whether threat and risk are mitigated and contained. These risks might be environmental, housing, food, conflict, or access to "safe spaces" broadly. "Spaces of capability" are capacities for self-fulfillment, to reach one's potential, to achieve one's purpose and goals such as access to educational and employment opportunities, health services, spiritual facilities, and the like, as well as other opportunities for self-development and growth. "Integrative spaces" refer to whether there are social networks and interpersonal support at the local scale. Social supports may be broad, from family to friends to community networks. They reduce isolation and related mental-health issues, and also offer connection through which people become valued, which seems particularly important to consider in the current pandemic. "Therapeutic spaces" offer physiological, mental, and emotional health and healing (a common example is urban green space).

The spaces of the wellbeing framework has been applied to a range of specific communities to understand how daily spaces enable different resources (security, capability, integration, therapy) for wellbeing. Applications include students (Beasy et al., 2020; Fleuret & Prugneau, 2015), mobile workers (Gorman-Murray & Bissell, 2018), people with physical disabilities (Lindsay, 2018), people with learning disabilities (Hall, 2010; Rotheram, McGarrol, & Watkins, 2017), people with regional disadvantage (Farmer et al., 2020; Kilpatrick, Emery, Adler, & Farmer, 2019) and public housing tenants (Waitt & Harada, 2019). The present study aims to use this framework to better understand how the spatial restrictions during COVID-19 have impacted LGBTIQ people's wellbeing in Tasmania, Australia.

Materials and methods

Study design

This article draws on findings from a questionnaire administered to a convenience sample of 231 LGBTIQ people aged 14 and over from Tasmania, Australia, exploring their health and wellbeing during COVID-19. The study received approval from the University of Tasmania Social Sciences Human Research Ethics Committee.

Participants

Participants were recruited using purposive self-selected sampling methods. In late April 2020, the survey link was distributed through social media, newspapers, local radio, and word of mouth, assisted by a range of Tasmanian LGBTIQ community organizations and social networks. Participants were directed via weblink to an information sheet that provided detail on the background, rationale, and anticipated outcomes of the project. The survey was open for 2 weeks. To ensure all participants could provide informed consent prior to participation, an electronic consent form was positioned at the start of the survey. A skip logic was used to ensure that any participant who did not provide informed consent could not complete the survey. No, compensation or reimbursement were provided as part of this study. In total, 325 people commenced the survey. Of those, 94 people started the survey but did not respond to any items. The final sample of 231 people spent an average of 9 min completing the questionnaire.

Measures

Participants were invited to complete an online questionnaire developed by Author 1, hosted on Survey Monkey (San Mateo, CA, USA). The first page of the survey included background information to the research and a list of support resources. The questionnaire included demographic questions on age, gender, sexuality, nationality, language spoken at home, education, and type of employment. Participants selected responses from specific options, with some opportunities for write-in responses (e.g. "other, please specify"). Five-point Likert-type scales were used to gauge participants' level of concern about a range of predetermined issues during COVID-19 (ranging from 1 = not at all concerned, 3 = neutral, and 5 = very concerned). Following this, one open-ended question asked "do you have any other concerns/worries not listed above?" To gather any additional information not captured by the predetermined list. Forty-nine participants responded to this question. Five-point Likert-type scales were used to gauge participants' levels of agreement (1 = strongly disagree, 3 = neither agree nor disagree, 5 = strongly agree) with a series of statements about their safety and wellbeing before and since COVID-19. The questionnaire concluded with another open-ended question-inviting participants to share "anything else about [their] experiences or concerns during COVID-19." Twenty-nine participants responded to this question.

Analysis

Following data collection, survey responses were analyzed using descriptive statistics. Quantitative results were tabulated and graphed by Author 1 using IBM SPSS Statistics 24. Likert-type responses were dichotomized (e.g. agree/disagree, concerned/not concerned) for analysis, with neutral responses (e.g. neither agree nor disagree) excluded. Qualitative responses to open-ended questions were analyzed thematically using QSR NVivo by Author 1 first by open coding or surface reading responses, taking note of any striking words or phrases arising from the data using the NVivo's annotate function (Braun & Clarke, 2014). Once common themes were identified, thematic categories, or "nodes," were created in NVivo and relevant data were coded to those nodes.

To ensure the validity of this thematic analysis and intercoder reliability of the coding system, Authors 2 and 3 conducted additional analyses and provided critical feedback on the initial interpretation of the data. Author 2 provided further analysis of qualitative data using the Fleuret–Atkinson Spaces of Wellbeing framework. Through this process, three key themes in the qualitative responses relating to experiences of space during COVID-19 were developed, as described in our analysis below.

Results

Participant demographics

We received 231 complete survey responses. Participants ranged in age from 14 to 78 with an average age of 33.5. The majority of participants (32% n = 74) identified as cisgender women, with smaller proportions of cisgender men (20.3% n = 47), non-binary people (11.2% n = 26) and transgender men (5.6% n = 13) and women (6.9% n = 16). Of the 7.7% of the participants who preferred to describe their own gender, the most common responses were genderfluid, agender, and combinations such as transgender/non-binary. We garnered the most responses from bisexual people (29.8% n = 69), with other commonly selected sexualities including gay (26.8% n = 62), queer (25% n = 59), lesbian (22% n = 51), and pansexual (19.9% n = 46). Of the 6.4% of the participants who identified with sexualities not listed, the most common write-in responses were demisexual and panromantic. According to Intersex Human Rights Australia (2020), approximately 1.7% of the wider Australian population are intersex, although this is difficult to capture and define for a number of reasons. In line with these figures, 1.8% of the participants in our study described themselves as intersex.

At the last census the Australian Bureau of Statistics (2016) found that 88.3% of the Tasmanian population spoke only English at home. Similarly, 80.7% of the Tasmanians were born in Australia with 69.3% born to Australian-born parents and 80.8% reported having Australian, English, Irish, and Scottish ancestry. Aboriginal and Torres Strait Islanders made up 4.6% of the Tasmanian population. In 2016, the most common places of birth outside of Australia for Tasmanian residents were England, New Zealand, and China. The most common languages spoken in Tasmania other than English were Mandarin, Nepali, and German.

Echoing these population-level statistics, 98% of our participants spoke only English at home and 88.7% were born in Australia, with 4.3% identifying as Aboriginal and/or Torres Strait Islanders. Languages spoken other than English included Tamil, Dutch, and Spanish. Of the 9.9% of the participants who were born outside of Australia, most were born in the United Kingdom, New Zealand, and the United States.

At last census, 52.3% of the Tasmanians over the age of 15 were working full time and just 17.4% had completed high school (ABS 2016). In contrast, at the time of our survey, 62% of our participants were in some form of paid employment and 52% had completed a university degree. Although the majority of participants' (59%) jobs had not been impacted by COVID-19, 20% reported having their hours and/or income reduced and 13% were unemployed or unable to earn an income as a result of the pandemic.

Impact of COVID-19 on safety and belonging

Figure 2 demonstrates that COVID-19 has had a moderate impact on LGBTIQ Tasmanians' feelings of safety and connection in local communities and their spaces, where 41.5% of the participants strongly agreed to feel at home in their local communities and 40.5% agreed that they felt part of those communities prior to the outbreak of COVID-19. However, during COVID-19 the percentage of those who strongly agreed to feel at home in their communities dropped to 34.7%. COVID-19 had a significant effect on community connection, with just 9.8% strongly agreeing to feel part of their local community since COVID-19, down from 18% prior to COVID-19. While 6% of the participants felt that people in their community were not accepting of their gender identity/expression and/or sexuality prior to COVID-19, this increased to 9.8% since COVID-19. Similarly, the percentage of those who strongly felt that their community did accept their gender and/or sexuality dropped from 22.3% before COVID-19, to 19.6% since the outbreak.

LGBTIQ Tasmanians' concerns during COVID-19

As outlined in Figure 3, the issues of highest concern to our participants were the safety of family and friends and those relating to mental health and

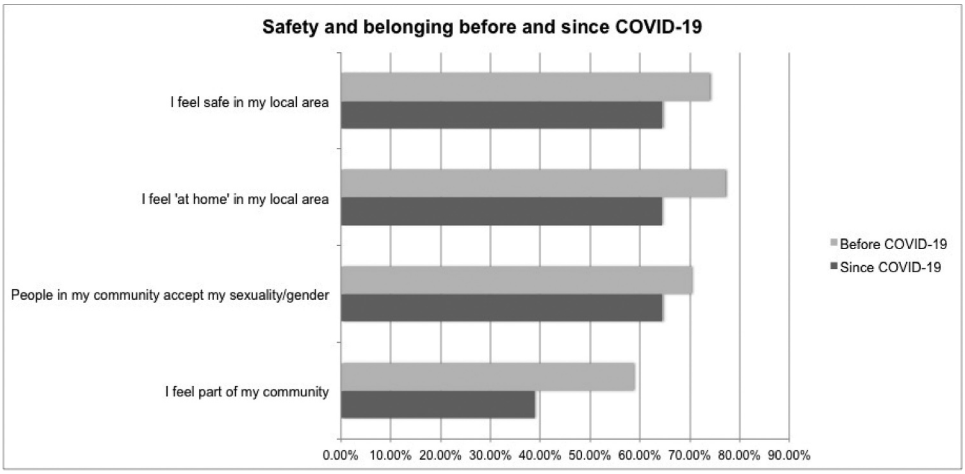

Figure 2. Safety and belonging before and since COVID-19.

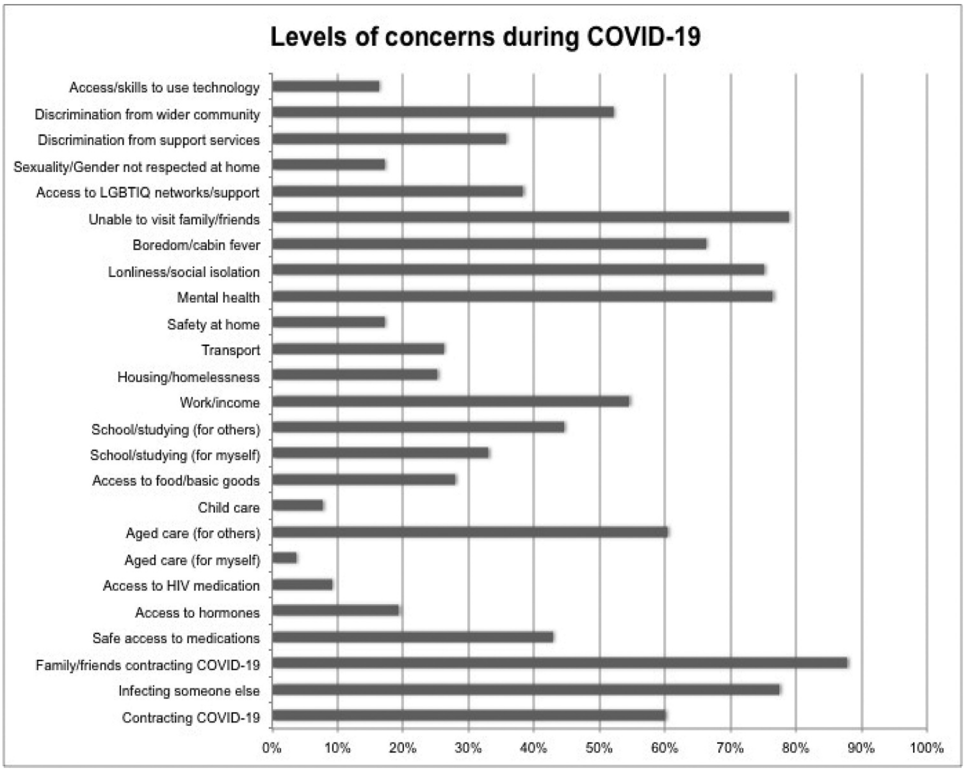

Figure 3. Levels of concerns during COVID-19.

wellbeing. Most (75%) reported that they felt lonely or isolated during COVID-19, 78% were concerned they were not able to visit their family and friends, and 66%-experienced boredom or "cabin fever" during home isolation. These concerns notably outweighed the fear of contracting the virus itself. Issues of least concern for our participants were aged care, child care, access to HIV medication, and safety at home.

In addition to the concerns listed in Figure 3, 49 participants chose to elaborate further. Building on the theme of the mental-health impacts of COVID-19 on LGBTIQ people, participants were especially concerned about the loss of community spaces and place-based events. For example, one pansexual transgender/non-binary man described feeling "grief due to losing access to my community." This participant was also experiencing "misgendering by workmates and the wider community due to working by phone/internet." In this participant's view, COVID-19 restrictions had caused a "loss of visibility of trans folk with social distancing." Similarly, one lesbian also described feeling concerned "that many friends in the community [were] restricted from the sense of belonging and mental-health affirming visibility and safety that social interaction with the LGBTIQ community offers in LGBTIQ specific social events."

As social interaction and events have been increasingly conducted through social media or online video call applications (e.g. Zoom, Skype), several participants in their late forties and fifties expressed frustration with the perceived inadequacy of virtual environments for fostering community connections. This was notably a concern for those in the LGBTIQ community who had relied on public events for vital social connections. For instance, one 40-year-old gay man noted that "being physically disabled and gay, isolation has just worsened since COVID-19. Even though I can use technology, I still struggle with loneliness, not being able to physically see people." One 51-year-old lesbian also felt that online events were inadequate in addressing loneliness, explaining: "it is hard to get past the idea for me that online connection is not a real connection. It feels forced and actually feels counterproductive in exacerbating loneliness in many regards." Another 50-year-old lesbian shared this view and elaborated that:

> Reaching out online seems so 'intentional.' But turning up to an event, enjoying the swirl, the safety, and the acceptance to be there as short or long a time as you need … It's really hard to feel that 'come as you are'/no pressure/joy in community energy in an online way. I feel it may be limiting people's capacity to reach out when they need to. Because it might not be talk they need, but just presence.

As well as general concerns about COVID-safety in public, several participants highlighted concerns specific to being LGBTIQ. For example, one 19-year-old pansexual agender participant felt that being "outwardly" gender non-conforming made others in public less likely to respect their requests for them to adhere to physical distancing rules:

> As an essential worker (retail), I am in a situation where people do not respect social distancing because they don't believe that my imuno-compromised condition is that serious, especially because I am outwardly [gender non-conforming] and they see this as rebelling and therefore I am a hipster who is overreacting and doesn't deserve their time.

In contrast, for one 28-year-old lesbian, her visibility as a lesbian became a concern in light of physical distancing, as she explained that "I [was] worried about lesbian invisibility when out with my partner, I worry that people will not assume we are 'in the same household' and that they/police will think we are not practicing social distancing."

Other participants raised concerns about how being in home isolation was impacting their relationships with others. For example, several respondents noted that they were concerned about their relationships with partners becoming strained:

> "[I'm worried about the] strain on my relationship with my significant other" (25, asexual, non-binary)
>
> "Being quarantined inside with my fiancé with no space of my own, having my personal space boundaries violated because of being inside 24/7." (24, lesbian/queer woman)

> "I'm worried my relationship with my partner will be strained. I'm not feeling a sexual connection right now (not unusual for me to spend long periods of time like this) but he's home more often and our sexual needs aren't matching up." (24, lesbian woman)

Some participants described feeling especially vulnerable in home isolation with family members who were not supportive. For example, one 17-year-old bisexual, transgender/non-binary participant described a more extreme example of potential abuse at home during COVID-19:

> I'm altogether finding it really difficult to not only take care of myself, but also my family as my parents kinda 'quit' at being parents through this whole thing. I'm also acutely aware of where my family members are at all times so that I can avoid getting abused [as] best I can which hasn't been great on my mental health.

This participant's experience raises significant issues around the potential impact of home isolation on members of LGBTIQ communities isolating with unsupportive or abusive family members.

Discussion

Drawing on the spaces of wellbeing framework, our analysis explored how COVID-19 restrictions have impacted LGBTIQ Tasmanians' experiences of three key sites: 1) public spaces, (2) private spaces, and (3) online spaces.

Public spaces

Our results indicated that the loss of public space during the COVID-19 lockdown had some specific effects on LGBTIQ wellbeing. For example, participants indicated that home isolation was limiting their visibility as LGBTIQ people and reducing their sense of connections within their local communities. LGBTIQ communities have long been spatially constituted through public places such as bars, clubs, community spaces, and other sites where gender and sexuality can be safely embodied and expressed (Oswin, 2008). While previous disaster study literature has highlighted LGBTIQ people's specific vulnerabilities when losing their homes (Gorman-Murray, McKinnon, & Dominey-Howes, 2014, 2018), COVID-19 has uniquely affected access to public spaces, events, and community spaces that can be vital for LGBTIQ people's sense of self and belonging, and hence wellbeing. Participants' accounts emphasized the extent to which sexuality and gender identities are often given meaning through interactions in public space. Some participants expressed a desire not just to be seen, but to be seen *affirmatively*; that is, participants wanted to be seen *as* LGBTIQ by people who both recognize and support their sexual orientation and/or gender. This suggests that public spaces that promote "affirming visibility" —such as spaces supporting LGBTIQ specific social events—can be important spaces of wellbeing.

By providing opportunities for affirmative visibility, LGBTIQ-centered public spaces allow not only security from prejudice and opportunities for the formation of integrative social support but provides capability-building and therapeutic resources, bolstering mental health and a sense of belonging. All four spaces of resource mobilization offered by LGBTIQ-affirming public and community spaces were hindered by COVID-19 restrictions. Without these place-based resources during COVID-19, LGBTIQ Tasmanians' senses of belonging and connection with local communities significantly reduced, inhibiting their wellbeing.

When LGBTIQ Tasmanians did access wider public spaces during COVID-19, their experiences were not positive. Although feelings of unsafety during COVID-19 are likely in the wider population (e.g., Usher, Durkin, & Bhullar, 2020), our findings suggest that public spaces hindered LGBTIQ wellbeing specifically by detracting from security and self-fulfillment. Participants expressed concern that being visible as LGBTIQ would expose them to prejudice and risk in public spaces during COVID-19, yet being *in*visible was also seen as potentially dangerous, posing specific safety concerns in light of physical distancing regulations, as one participant highlighted. Disaster and emergency situations are often discursively framed by heteronormativity (McKinnon, 2017; McSherry et al., 2015). Public health advice and messaging around COVID-19 restrictions in Australia have largely centered on heteronormative family and household structures. Our participants' anxieties demonstrate how same-sex couples can be further marginalized during disasters and emergencies. This may account for why participants perceived a reduction in acceptance of sexuality and gender diversity in their local communities since COVID-19. In this context, wider public spaces did not support LGBTIQ people's wellbeing during COVID-19 because they offered neither security nor capability (Fleuret & Atkinson, 2007).

Private space

Given the emphasis on home isolation as a means of mitigating the spread of COVID-19, relationships within the private space of the home were prominent in participants' experiences. While the literature on the queer home has acknowledged the frequent association of the family home with rejection and displacement for LGBTIQ people (Elwood, 2000), others suggest that queer home-making has radical potential to destabilize the heteronormativity of domestic space and affirm a sense of self (Gorman-Murray, 2017; Kentlyn, 2008). In the context of COVID-19, we found that the space of the home detracted from wellbeing in a number of complex ways. While loneliness and boredom were significant concerns for participants, those who were isolating with partners and family also expressed concerns about the impact home isolation was having on their relationships such as tension with partners and family. We also noted a moderate decline in participants feeling safe at home during COVID-19. Here, the private space of the home detracted from some LGBTIQ people's wellbeing because homes failed to be secure, therapeutic, and integrative resources. Much like the loss of public space, loss of personal space in home isolation reduced LGBTIQ people's capability and self-fulfillment, as participants noted strained relationships and in some case abuse from family members. In contrast, with the Australian Government messaging emphasizing that people "stay home, stay safe," for many LGBTIQ people the space of the home was not safe, capacitating, integrative, or therapeutic during COVID-19, and thus diminished their wellbeing.

Online spaces

Given the reduction of access to public spaces during lockdowns and physical distancing restrictions, the expanded use of the internet and social media for work, study, and socializing has been a defining feature of social life for many during COVID-19. LGBTIQ communities have a long history of forming strong social networks using social media (Hanckel, Vivienne, Byron, Robards, & Churchill, 2019; Robards, Churchill, Vivienne, Hanckel, & Byron, 2018). Online spaces have often been a site for the safe expression of non-normative genders and sexualities prior to doing so in life offline (Craig & McInroy, 2014). While many LGBTIQ communities may be well acquainted with online spaces, this did not mean the shift to online forms of socializing during COVID-19 was seamless. While online spaces were arguably secure (from COVID-19) and capacitating (allowing work and study to continue), their use as integrative and therapeutic resources was less certain. For some participants, the online spaces they engaged with were not experienced as integrative because they felt "intentional" and "forced" compared to socialize in person. Participants noted how socializing online during COVID-19 paradoxically made them feel more lonely due to the lack of physical presence and community. In this way, online spaces could be seen as failing to be therapeutic for some LGBTIQ people, particularly those who were already socially isolated prior to COVID-19. Online spaces were thus uneven spaces of wellbeing, offering safety and capability but not necessarily sustained social integration and therapeutic healing.

This article has innovatively deployed the spaces of wellbeing framework to identify key spatial factors that can influence LGBTIQ wellbeing during a public health emergency requiring physical distancing and home isolation. For example, we identified the particular impact loss of public community space can have on LGBTIQ people and the importance of finding alternative ways to build online spaces that are capacitating, integrative, and therapeutic. However, this work is not without limitations. Data have been drawn from a small, convenience sample of LGBTIQ people in a very specific sociogeographical context in a particular time during the COVID-19 pandemic when events and responses have been changing rapidly. For this reason, it is difficult to ascertain whether and how these results may be generalizable to broader populations, although this was not necessarily the goal of this study. Furthermore, our results were likely influenced by certain demographic factors that may not be more broadly generalizable. For instance, the survey sample included limited racial/ethnic diversity, with the majority of participants being white Australians with disproportionately high levels of education and employment compared with the broader Tasmanian population. While our sample does reflect some demographics of the broader Tasmanian population (of which 80.7% were born in Australia with English/Irish/Scottish ancestry [ABS 2016]), lacking diversity was also a likely result of the particular recruitment measures taken. Similarly, response rates were highest among cisgender women and those between the ages of 14–23. Again, the overrepresentation of these groups was likely due to sampling techniques. Despite these limitations, our results provide important new insights into LGBTIQ people's experiences during COVID-19 and we welcome further research exploring the spatial aspects of COVID-19 on LGBTIQ communities globally, and how spaces can be used to promote LGBTIQ wellbeing into the future.

In conclusion, we investigated the spatial impacts of COVID-19 restrictions on LGBTIQ mental health and wellbeing in Tasmania, Australia. Our analysis extends work on LGBTIQ vulnerabilities and adaptive capacities during disasters and emergencies (Gorman-Murray et al., 2018, 2017). COVID-19 restrictions provide a novel context for understanding LGBTIQ wellbeing, including mental health, which previous disaster research has shown to be affected by locational displacement, spatial isolation, and community disruption. We analyzed qualitative survey data using the Fleuret–Atkinson Spaces of Wellbeing framework to understand LGBTIQ Tasmanians' experiences of three key sites: public, private, and online spaces. Notably, the issues of the highest concern for LGBTIQ Tasmanians were not contracting the virus itself, but the social impacts caused by spatial restrictions. We found that COVID-19 has had a significant impact on LGBTIQ people's feelings of safety and belonging in their local communities.

By expanding our understanding of LGBTIQ wellbeing during COVID-19, our results can contribute to better disaster and emergency responses for LGBTIQ communities. Our findings suggest that mental-health support is critical, especially for vulnerable people in the LGBTIQ community whose spaces of wellbeing have been affected by COVID-19 restrictions, such as older people, younger people, and trans people. While there has been an emphasis on online support, perhaps dedicated telephone assistance could be beneficial for reaching these vulnerable groups. Beyond immediate assistance, ongoing peer-support would be helpful for LGBTIQ people, providing therapeutic and integrative resources, which might involve telephone or online support in the first instance but, if safe (in terms of COVID-19 distancing), move to face-to-face visits at home or in public spaces. This could also be used to address the at-home family violence some have reported during the lockdown. To sustain wider existing relationships beyond the household for therapeutic and integrative goals, "social bubbles" could be allowed where limited numbers of people might physically meet with each other in their homes or selected public spaces. Efforts could be made to maintain LGBTIQ community spaces, which are important for security and capability, as well as integration but face permanent closure due to the financial impacts of public restrictions and home isolation. This might involve financial concessions or grants to keep community spaces "operational" even at reduced patronage. Wider public visibility is also important for security and capability, and authorities charged with enforcing physical distancing should be made aware of diverse (not just heternormative) relationships within the community. In these ways, more might be done to enhance security, capability, integration, and therapy to bolster public, private, and online spaces as spaces of wellbeing for LGBTIQ people.

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LGBTIQ+ COMMUNITIES AND COVID-19:

A REPORT ON THE IMPACTS OF COVID-19 ON AUSTRALIAN LGBTIQ+ COMMUNITIES AND BUILDING A STRONG RESPONSE

INTRODUCTION

We are strong. We have weathered health crises before and emerged stronger together on the other side. We have also helped to build a more equal Australia in the face of adversity and discrimination against us, both in the past and present.

But the coronavirus pandemic (**COVID-19**) presents us with a new challenge. Recognising that challenge, Equality Australia assembled a roundtable of LGBTIQ+ and allied organisations to open the conversation about the specific issues facing LGBTIQ+ people in Australia due to COVID-19 and its impacts. This conversation is not over. We need the voices of other members of our communities to provide their input into this conversation. If your organisation wishes to join this conversation, please contact us at info@equalityaustralia.org.au. We especially encourage organisations representing the diversity of people in our communities to join this conversation, as we recognise the differing needs of LGBTIQ+ people with intersectional experiences and identities.

This report summarises our analysis of the current needs and vulnerabilities of LGBTIQ+ communities based on issues raised at the national online roundtable of 42 LGBTIQ+ and allied organisations held on 26 March 2020 and discussions and input received since that time.[1] This report is also informed by ongoing conversations with key agencies responding to the COVID-19 crisis. We recognise the current social and regulatory environment is rapidly changing in response to the threat posed by COVID-19. The analysis and recommendations in this report represent our current thinking, informed by the available evidence and information as at 31 March 2020.

While LGBTIQ+ people face many challenges from COVID-19 which are similar to others in the community, we are also likely to experience some unique and more acute impacts from COVID-19 as a result of discrimination, disparities and differences connected to our LGBTIQ+ status.

These include:

- health disparities which put some LGBTIQ+ people at greater risk of severe health consequences from contracting COVID-19;
- mental health disparities, particularly in rates of depression and suicide, which place LGBTIQ+ people at significant risk when faced with physical distancing measures and greater isolation, a sudden loss of community support and cultural spaces, barriers to finding comfort and connection with our chosen families, and the possibility for some of living in unsafe or unsupportive environments;
- historical and continuing experiences of discrimination which make accessing inclusive healthcare, support, services and information, and interacting with law enforcement, more challenging, while LGBTIQ+ organisations are themselves insufficiently supported to meet increased demand for their services.

This potentially devastating combination of impacts and consequences may be further compounded and magnified for those with additional needs based on other attributes, such as disability or age.

While LGBTIQ+ people have demonstrated their resilience, resourcefulness and creativity in the face of adversity before, there is an urgent need for government and mainstream services providers and agencies to stand with us and act swiftly in supporting our efforts by implementing substantive and practical measures to ensure no-one is left behind in Australia's response to COVID-19.

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[1] The organisations represented in the online roundtable are listed at the back of this document.

GUIDING PRINCIPLES

Having regard to the issues raised by the LGBTIQ+ and allied organisations who shared their expertise and perspectives with us, we seek that government, policy and community responses to the COVID-19 crisis adopt and follow these guiding principles and recommendations.

PRINCIPLE 1

The response to COVID-19 must comply with Australia's human rights obligations, including with respect to LGBTIQ+ people in Australia or within our care and control.

At a minimum, this means that:

- public policy and health responses must not, whether directly or in practice, discriminate on the grounds of sexual orientation, gender identity or sex characteristics, or any other ground such as age, disability, cultural or linguistic diversity, marital or relationship status, citizenship status, line of work or socio-economic status;
- LGBTIQ+ people in Australia or within our care and control must have equal and ready access to the essential healthcare they need without discrimination, whether or not those health needs are related to COVID-19; and
- any incursions to civil liberties must be strictly necessary and proportionate to the legitimate purpose of responding to the COVID-19 crisis, and must not discriminate whether directly or in practice against LGBTIQ+ people in Australia or within our care and control.

PRINCIPLE 2

The response to COVID-19 must meaningfully take into account the specific needs and circumstances of LGBTIQ+ people and communities, especially people who may be socially or economically marginalised or at greater risk from COVID-19 or its impacts.

At a minimum, this means ensuring that:

- LGBTIQ+ communities and organisations are, directly and to the extent possible, engaged with when formulating policy responses, so that no-one is left behind;
- information and services are inclusive and accessible to LGBTIQ+ people, regardless of disability, age, socio-economic status, cultural or linguistic background, citizenship status, line of work or personal circumstances;
- safeguards and alternatives are available for LGBTIQ+ people living in vulnerable situations, such as those who are homeless, in aged care facilities, in supported accommodation, in prisons, in immigration detention, who rely on receiving care or support at home (such as older people or people with disability), or people who are living in unsafe domestic arrangements (whether because of actual or threatened violence, or a lack of familial acceptance regarding sexual orientation, gender identity or sex characteristics);
- LGBTIQ+ families (including parents and caregivers who are not resident with their children) and LGBTIQ+ families of choice are given meaningful opportunities to maintain appropriate face-to-face contact and connection despite any domestic lock-down;

- any regressive measures that diminish existing protections or harm our community, such as the Religious Discrimination Bill, are not progressed; and
- the continuity of existing government programs and policies that support LGBTIQ+ communities is guaranteed and boosted to accommodate increased need for those support services.

PRINCIPLE 3

Economic stimulus must recognise the impact of COVID-19 on LGBTIQ+ people and communities in Australia, including our unique and few-in-number organisations, businesses and venues.

At a minimum, this means ensuring that:

- LGBTIQ+ people who are unable to rely on employment or other financial support are given adequate financial support and assistance to guarantee the necessities, such as food, shelter and healthcare, without discrimination and without moral judgement regarding their line of work;
- financial support measures take into account additional costs borne out of physical distancing measures, such as for people with disability or for organisations who need to adapt their ways of working to continue providing support;
- financial support and assistance is available and given to sustain our unique and few-in-number LGBTIQ+ organisations, businesses and venues into the future, so that there is a vibrant LGBTIQ+ community on the other side.

PRINCIPLE 4

Responses must work with us, and where possible, should be led by us.

At a minimum, this means:

- ensuring LGBTIQ+ voices are at the table and genuinely consulted in government-led COVID-19 policy and program development and delivery;
- supporting LGBTIQ+ and allied organisations to deliver services to our communities in a culturally appropriate and accessible way, and boosting funding and support where an increased need for services now demands it;
- ensuring meaningful and effective LGBTIQ+ inclusion as a mandatory requirement when distributing funding to mainstream service providers, such as those providing mental health services, aged care services, youth services, drug and alcohol services and disability services;
- collecting appropriate and inclusive data on LGBTIQ+ people, including specific groups within this cohort, in service delivery and health and wellbeing metrics so that the impacts of COVID-19 on all our communities are properly counted.

ISSUES FACING THE LGBTIQ+ COMMUNITIES DUE TO THE COVID-19 CRISIS

LGBTIQ+ people will face many of the same COVID-19-related issues which impact on all Australians, including health issues, economic hardship and social isolation. However, there are also some important differences.

Some LGBTIQ+ people will experience the impacts of the COVID-19 crisis in more acute ways because of circumstances associated with their LGBTIQ+ status and discrimination they face as a result of that status. Some LGBTIQ+ people will also experience unique issues because of their LGBTIQ+ status.

Insights from a new weekly survey conducted by Newgate Research suggest that LGBTIQ+ people are more likely than other Australians to have experienced a reduction in income or work hours, and to have been laid off from their job. They are also more likely than others to have experienced more mental health issues or tension at home compared to usual. In addition, LGBTIQ+ participants in the survey were more likely to find it hard to meet the costs of daily living, to be living with at least one physical or mental disability, to have or be living with someone with an immunodeficiency, and to be a carer for someone with a disability.[2]

IMMEDIATE ISSUES

Looking at the current public health and policy response to COVID-19, there are a number of immediate issues which arise from COVID-19 and its associated restrictions for LGBTIQ+ people.

PUBLIC HEALTH

Everyone is susceptible to contracting COVID-19. Certain groups of people, such as people who are older and/or with certain chronic conditions, are at increased risk of serious illness from COVID-19.[3]

While our understanding of COVID-19 develops with further scientific research, we should remain mindful of the existing health disparities experienced by LGBTIQ+ people (such as in connection with certain cancers, asthma, obesity and smoking rates), and that this creates a disproportionate risk for LGBTIQ+ people who contract COVID-19.

Members of our communities also face **increased or specific barriers to accessing essential needs and medical treatment.** This can include barriers to accessing food, shelter and treatment (such as antiretrovirals, hormone treatment and gender-affirming procedures, STI and blood borne virus testing, delays in surgeries or absence of support post-surgery) while there are restrictions on movement or mobility, requirements for face-to-face consultations that cannot be met, or due to overrun health and other essential care systems.

Access to medical treatment and screening for all health issues will remain essential to ensure meeting one public health priority does not compromise other public health priorities.

LGBTIQ+ people already face challenges and disadvantages in our health system and are often less able to access culturally appropriate and inclusive healthcare.[4] These barriers can also be

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[2] For more information on this COVID-19 tracking research, please contact Newgate's Research Director Philip Partalis at philip.partalis@newgateresearch.com.au.

[3] Australian Department of Health, *Advice for people at risk of coronavirus (COVID-19)*.

[4] See e.g. Australian Human Rights Commission (2015) *Resilient Individuals: Sexual orientation, gender identity & intersex rights – national consultation report*, Sydney: Australian Human Rights Commission, p.33; M Kang et al (2018) *Access 3: Young people and the health system in the digital age – final research report*, Department of General Practice Westmead, The University of Sydney and the Australian Centre for Public and Population Health Research, The University of Technology Sydney, Australia, pp.54, 64; E Smith et al (2014) *From Blues to Rainbows: Mental health and wellbeing of*

compounded by other factors, such as disability, age or geographic location. **Existing barriers to and problems with accessing healthcare are likely to be exacerbated in a COVID-19 environment.**

There is also a concern that an overrun health system may deny care based on discriminatory criteria, such as age, disability or physicality. Care needs to be taken in ensuring ethical treatment guidelines do not discriminate.

Health care workers may, either consciously or unconsciously, make decisions to deny or delay treatment which in practice discriminates against persons on the basis of their LGBTIQ+ status, including because of prejudiced attitudes, unconscious bias or a failure to consider the specific health needs of particular LGBTIQ+ populations.

MENTAL HEALTH

LGBTIQ+ people experience disproportionately high rates of anxiety, depression, suicide and self-harm when compared to the rest of the population.

For a population already under stress, the response to COVID-19 prevents access to community and cultural spaces which provide a level of protection and connection for people seeking support.[5] Coupled with this, many in our communities will face additional stress as a result of job losses, financial stress, or because of the situation they face at home.

Accessible and inclusive mental health services will be increasingly critical in connecting LGBTIQ+ people with the mental health support they need to stay healthy and safe.

ACCESS TO INFORMATION

Public health information needs to be accessible and relevant to members of the LGBTIQ+ communities.

There is **no one 'source of truth' for information** relevant to LGBTIQ+ people, including about public health, connection and available economic and social assistance.

Social distancing guidance that refers to 'families' and 'households' are unclear in their application to non-nuclear households, partners who do not live together, or 'chosen' families split across multiple households. **The degree to which unrelated persons can connect with one another is unclear.** Materials must use inclusive language which speaks to our families and communities.

LGBTIQ+ communities include people who are D/deaf, Deafblind, blind or have low vision, or who need access to Easy Read resources. Information tailored for LGBTIQ+ communities must also be accessible for these people. Vital information should be available in Easy Read English and other languages.

DISCRIMINATION

As we face the prospect of people having to make medical and crucial end-of-life decisions for themselves and their loved ones, this is where discrimination against our partners and families has surfaced in the past.

LGBTIQ+ people need to know that they have strong protections and rights as partners and parents in medical settings, in next-of-kin decisions, and when dealing with service providers (e.g. funeral providers, counsellors etc.) and inheritance issues, whether or not they are married. **Service providers must be made aware of their legal obligations** to treat LGBTIQ+ people without discrimination and recognise our relationships and families.

LGBTIQ+ people who rely on services provided by faith-based providers are not adequately protected against discrimination in many states and territories. LGBTIQ+ people may face discrimination or fear it, presenting additional barriers to accessing support services such as housing, food and financial relief services.

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gender diverse and transgender young people in Australia, Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University, p.73.

[5] M Carman et al (2020) *COVID-19: Impacts for LGBTIQ communications and implication for services*, Australian Research Centre in Sex, Health and Society, La Trobe University, p. 2.

Experiences of discrimination may also be compounded by a range of attributes held by LGBTIQ+ people, such as ethnicity, gender, disability, age, socio-economic status, employment, citizenship status and the ability to speak English.

SOCIAL ISOLATION AND DISLOCATION

Physical separation is going to be difficult for everyone, but these **difficulties will be exacerbated for people in particular groups**, such as those:

- living on their own, or in self-isolation,
- living with families or in households which do not accept them for who they are or who they love,
- living with or at risk of violence or fear,
- who are homeless or at risk of homelessness,
- who have lost their income, or are poor,
- living under state control or care,
- who are disabled or have chronic illnesses,
- who are socially isolated or lacking in capacity to connect with others online,
- without broader support or familial networks, or who have lost access to regular disability and psychosocial services and supports,
- who have lost access or connection to community, culture or country,
- who use or are dependent on drugs and alcohol, and
- with mental health concerns such as depression or at risk of suicide, among others.

We know LGBTIQ+ people are represented in each of these populations, and may be overrepresented in some. For example, LGBTIQ+ young people face higher risk of homelessness due to rejection and violence within the family home.

Due to discrimination or a lack of acceptance, LGBTIQ+ people may be unwilling or unable to rely on channels of support that are available to others for the care and connection they need to stay healthy and safe. **This impact is further magnified for LGBTIQ+ people because of the disappearance of community and cultural gathering spaces, whether that be community centres, clubs or licensed venues.**

LGBTIQ+ FAMILY VIOLENCE

The current pandemic will place increased pressure on strained familial relationships and will disproportionately impact on some LGBTIQ+ people in unsafe family situations.

The family home can be a hostile and unsafe place for same-sex attracted or gender questioning young people. **Without the ability to escape to a school environment, or to welcoming friends or other family members, LGBTIQ+ young people and others will be at increased risk** during this time of physical distancing.

Violence in LGBTIQ+ intimate partner relationships is generally thought to be as prevalent as in other intimate partner relationships (if not higher for some sections of our communities).[6] These levels of violence, as with all forms of family violence, can only be expected to worsen over the coming months.

LGBTIQ+ people face significant barriers to accessing family violence services. For example, gay and bisexual men, and trans and gender diverse people, who are victims of family violence may not be accommodated in services. **Gaps in service delivery for LGBTIQ+ people will be further exposed as the strain on the family violence system increases.**

Action must be taken to ensure LGBTIQ+ victims (and perpetrators) can access timely services that meet their distinct needs, and specific strategies developed for particular at-risk cohorts such as LGBTIQ+ youth, people with disability and people who are homeless or at risk of homelessness.

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[6] Royal Commission into Family Violence (2016) *Final Report*, p.35.

CARING FOR LGBTIQ+ OLDER PEOPLE

LGBTIQ+ elders grew up in particularly oppressive times, and continue to be impacted by stigma, discrimination and the trauma of losing loved ones during the HIV/AIDS epidemic. Many LGBTIQ+ people live alone and do not have family to care for them.

LGBTIQ+ older people, particularly those who live alone, who do not have children, or who have mobility or other restrictions on their movement, may be particularly isolated in the coming months.

Channels of support available to others may not be available in equal measure to LGBTIQ+ older people, who may be averse to or avoid accessing services, due to the risk of discrimination or the fear of it. For example, LGBTIQ+ older people may be reluctant for workers from faith-based charities to enter their home or fail to disclose crucial information for fear of discrimination.

Overall, LGBTIQ+ older people may have a greater need for support services during this time and also experience greater barriers to accessing these services from mainstream services providers.

LGBTIQ+ PEOPLE WITH DISABILITY

LGBTIQ+ people with disability may experience a range of compounding disadvantages associated with the impacts of COVID-19 in their lives.

Challenges in accessing equipment, technology, information, necessities, transport and/or a range of support are further compounded by a loss of work, further isolation, insufficient financial and social support and a lack of access to alternative options.

The physical and mental impacts of social isolation are likely to be more heavily felt by people with particular disabilities, while informal LGBTIQ+ disabled peer support networks are reporting a rising demand for help in people seeking access to basic needs, such as food, support and information.

LGBTIQ+ COMMUNITY ORGANISATIONS

The LGBTIQ+ sector is fragile, fragmented and underfunded.[7] Many LGBTIQ+ organisations, offering services such as peer support, counselling and advocacy, rely on short term grants and volunteers to operate, if they have funding at all.

In the immediate term, LGBTIQ+ community organisations with capacity to do so (such as AIDS Councils in each state and territory) are moving towards the online delivery of services, but not all services can be delivered online (such as access to health services). **Some LGBTIQ+ community organisations may not have access to the funds and technology necessary to adapt to the COVID-19 environment.**

As with all organisations, LGBTIQ+ community organisations are also adjusting their service delivery while contending with the challenges of **maintaining productivity, staff engagement and morale**.

Funding arrangements have not taken account the possibility of such wide-scale disruption, nor the costs of dealing with it.

ESSENTIAL REFORMS ON HOLD, THREATS REMAIN

Members of our communities continue to need essential legal reforms, such as removing legal barriers to accessing gender congruent identification, and stopping forced or coercive medical practices towards intersex people.

While there is understandably less public and political bandwidth to progress essential reforms during the current crisis, the **adverse effect of these laws continue to be felt**. For example, trans and gender diverse people will still need to rely on identification documents that are difficult to change in order to access economic and social support from service providers, financial institutions and governments.

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[7] K Bradshaw and I Seal (2018) *National LGBTIQ+ Community Impact Project: Down the slippery slope to full equality for all*, Collective Impact and Three for All Foundation.

Meanwhile, as our community confronts the daily challenge of living with the impacts of COVID-19, **threats to our human rights remain on the table.** These include the Religious Discrimination Bill, which undermines access to healthcare and threatens to roll back existing discrimination protections for LGBTIQ+ people and others, and concerted attempts and campaigns to undermine gender-affirming care models for trans and gender diverse people.

RELATIONSHIP WITH LAW ENFORCEMENT

As police and other law enforcement officers enforce social distancing, we will see greater interaction between members of our LGBTIQ+ communities and law enforcement. **The historical legacy of violence at the hands of police looms large for many LGBTIQ+ people and is still a daily reality for some.**

Members of our communities who experience poor relationships with law enforcement, such as queer youth, trans people, people with cognitive and intellectual disabilities, First Nations peoples, sex workers, and illicit drug users among others, are concerned about how they will be treated by law enforcement who have strong powers to search, arrest and detain. **Uncertainty about the operation of new laws and police powers, and fear of unfair treatment, will add to the stress and anxiety experienced by LGBTIQ+ people during this time.**

MEDIUM AND LONG-TERM ISSUES

Looking beyond the current public health and policy response to COVID-19, there are a number of medium and longer-term issues which will arise in the aftermath of the immediate response to COVID-19.

LONGER TERM DIRECT IMPACTS

While distancing measures may be wound back over time, those at higher risk of infection may be required to continue physical distancing for a longer period or until a vaccine is available, compounding the effects of social isolation.

For those who lose loved ones due to COVID-19, the experience of grief and loss may well continue beyond the immediate aftermath of a person's death. LGBTIQ+ people will need culturally appropriate support avenues to deal with their grief and loss. So too will LGBTIQ+ first responders and healthcare workers who have been on the frontline of the public health response.

FINANCIAL DISADVANTAGE

Some cohorts of LGBTIQ+ people, particularly trans and gender diverse people, are already more likely to live in poverty or experience unemployment than others.[8] It is likely that the impacts of the COVID-19 related economic downturn will be felt by these disadvantaged cohorts sooner and more acutely than other population groups.

We suspect that there are **large numbers of LGBTIQ+ people working in the creative arts, tourism, retail and hospitality, some of the industries hardest hit by COVID-19.** Unemployment and financial disadvantage will place even greater strain on people who are already at risk.

ABSENCE OF RELIABLE DATA

With the absence of Census data on the LGBTIQ+ population, we **do not have reliable and comprehensive national data** on LGBTIQ+ people: where the live, what they do for work and their care needs. The particular impact of the COVID-19 crisis on LGBTIQ+ people economically and socially is hard to predict, plan for and respond to.

We know there will be large scale job losses in the tourism, hospitality, retail and creative sectors, but **we cannot confirm that LGBTIQ+ people are**

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[8] Leonard, W., Lyons, A. & Bariola, E. (2015) *A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual, and transgender (LGBT) Australians.* Monograph series No. 103, La Trobe University (2015), p 24.

overrepresented in industries facing this economic downturn.

VIABILITY OF LGBTIQ+ INSTITUTIONS

There are very few LGBTIQ+ organisations, businesses and venues in Australia. These are important cultural and commercial institutions that provide a place for connection, support, pride and community. They are also sites for spreading important community information, such as safe sex information. Many of these institutions rely on events income or opening their doors to patrons, and give LGBTIQ+ organisations platforms to meet, fundraise and host events. They are our community's town halls and squares, our places of congregation, and our cultural and sporting gathering grounds.

Additionally, many **LGBTIQ+ community organisations rely on income from events and gatherings** to fundraise and support their work. While COVID-19 shuts down these income streams, community organisations face uncertain economic futures during the COVID-19 'fundraising freeze'.

The ongoing financial viability of these institutions, and whether they will make it through to a post-COVID-19 world, is unclear.

ABOUT US

Equality Australia is a national LGBTIQ+ organisation dedicated to achieving equality for LGBTIQ+ people. Equality Australia has been built from the Equality Campaign, which ran the successful campaign for marriage equality, and was established with support from the Human Rights Law Centre.

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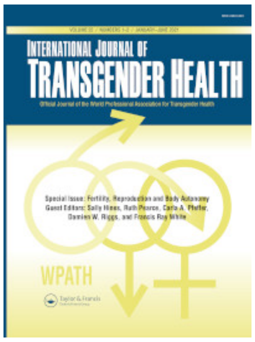
We acknowledge that our offices are on the land of the Kulin Nation and the land of the Eora Nation and we pay our respects to their traditional owners.

Cover image: C. Moore Hardy, Equality Green, Prince Alfred Park, Sydney, 15 November 2017.

APPENDIX: ROUNDTABLE ATTENDEES

A national online roundtable of LGBTIQ+ and allied community organisations was hosted by Equality Australia on 25 March 2020. The following organisations attended or have since provided input to this paper.

1. ACON
2. ACT LGBTIQ Ministerial Advisory Council
3. Advocacy Tasmania
4. AIDS Action Council of the ACT
5. Aleph Melbourne
6. Amnesty International, NSW LGBTQI Network (GLYN)
7. Australian Federation of AIDS Organisations (AFAO)
8. Australian GLBTIQ Multicultural Council (AGMC)
9. BFriend
10. Bisexual Alliance
11. Council of the Ageing (COTA)
12. Equal Voices
13. Equality Australia
14. Equality Project
15. Gender and Sexuality Commissioner, Victorian Department of Premier and Cabinet
16. GLOBE Melbourne
17. GLTBI Rights in Ageing Inc (GRAI)
18. Intersex Human Rights Australia (IHRA)
19. Intersex Peer Support Australia (IPSA)
20. Liberty Victoria
21. LGBTIQ Legal Service (St Kilda Legal Service)
22. LGBTI Rights Australia (Facebook community)
23. Midsumma
24. Queerspace, Drummond Street Services
25. National LGBTI Health Alliance
26. NSW Gay & Lesbian Rights Lobby
27. Northern Territory AIDS & Hepatitis Council (NTAHC)
28. Public Interest Advocacy Centre (PIAC)
29. Queensland Council for LGBTQI Health (formerly Queensland AIDS Council)
30. Rainbow Families Victoria
31. Rainbow Health Victoria
32. Rainbow Territory
33. South Australian Rainbow Advocacy Alliance
34. Sydney Gay and Lesbian Mardi Gras
35. Thorne Harbour Health
36. Transfamily Inc
37. Transforming Tasmania
38. Transgender Victoria
39. Uniting NSW
40. Victorian Gay and Lesbian Rights Lobby
41. Victorian Pride Centre
42. WA AIDS Council



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The impact of the first three months of the COVID-19 pandemic on the Australian trans community

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ABSTRACT

Background: Trans and gender diverse individuals (people who identify with a gender different to what was presumed for them at birth) are one of the most medically and socially marginalized groups in our community. The COVID-19 pandemic may compound preexisting depression and thoughts of self-harm or suicide.

Aim: We aimed to explore the impact of the COVID-19 pandemic on the Australian trans community.

Methods: An online cross-sectional survey was conducted between 1st May 2020 and 30th June 2020, amidst strict Australia-wide social restrictions. Australian trans people aged ≥16 years were eligible to participate. Survey questions explored the impact of the COVID-19 pandemic on living situation, employment, financial situation, and healthcare. Logistic regression to assess negative impacts due to COVID-19 on depression and thoughts of self-harm or suicide (measured by Patient Health Questionnaire-9 (PHQ-9) are presented as odds ratios (95% confidence interval)).

Results: Of 1019 participants, 49.6% reported experiencing financial strain, 22% had reduced working hours, and 22.4% were unemployed (three times the national rate). Concerningly, 61.1% experienced clinically significant symptoms of depression (Patient Health Questionnaire-9 score ≥10), considerably higher than pre-COVID rates for the trans community and over twice the national rate. Moreover, 49% reported thoughts of self-harm or suicide (over three times the national rate) which was more likely if a person experienced cancelation or postponement of gender-affirming surgery (OR 1.56 (1.04, 2.35)), financial strain (OR 1.80 (1.36, 2.38)), or felt unsafe or afraid in their household (OR 1.96 (1.23, 3.08)).

Discussion: Given rates of clinically significant depression and thoughts of self-harm or suicide are far higher in trans people than the general population, specific strategies to improve mental health in the trans community during the COVID-19 pandemic must be made a priority for policymakers, researchers, and health service providers to prevent suicide.

KEYWORDS
Coronavirus; COVID-19; depression; suicidality; transgender

Introduction

Transgender and gender diverse (referred to herein as *trans*) refers to people who have a gender that is different to what was presumed for them at birth and includes binary (male or female) and non-binary gender identities. Trans individuals comprise an estimated 0.5–4.5% of the adult population (Åhs et al., 2018; Crissman et al., 2017; Lai et al., 2010) but face numerous health disparities and are one of the most medically and socially marginalized groups in our community (Bockting et al., 2013; Bretherton et al., 2021).

Prior to the COVID-19 pandemic, trans people in Australia faced high rates of discrimination, sexual assault, physical and verbal abuse, homelessness, and multiple barriers to healthcare access (Bretherton et al., 2021; Strauss et al., 2020). Few Australian studies have used a validated diagnostic measure to estimate the rate of depression and thoughts of self-harm or suicide in the trans community. Pitts et al. (2009) reported 36.2% of trans adults in Australia met the criteria for a current major depressive episode and 25% reported thoughts of self-harm or suicide in the prior two weeks, as assessed by the Primary Care

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Evaluation of Mental Disorders Patient Questionnaire. More recently, Hyde et al. (2013) reported that 43.7% of trans adults experienced clinically significant depression and 53.6% reported thoughts of self-harm or suicide in the preceding two weeks, as assessed by the Patient Health Questionnaire-9 (PHQ-9). Comparatively, only 3.7% of a random sample of the Australian population in 2015 met criteria for clinically significant depression based on the PHQ-9 (Kiely & Butterworth, 2015). Over 40% of trans adults (Bretherton et al., 2021) and young people (Strauss et al., 2020) have attempted suicide, and deaths by suicide in trans people have been reported to be significantly higher than the general population (Wiepjes et al., 2020). Similar high rates of depression and suicidality in trans communities have been reported internationally (Adams et al., 2017; Bockting et al., 2013).

As many as one in five have experienced discrimination from healthcare providers and consequently, many trans people struggled to access health services even before the COVID-19 pandemic (Bretherton et al., 2021; Jaffee et al., 2016). Social disadvantage is likely to increase the risk of illness and mortality during the COVID-19 pandemic, increasing fear and anxiety experienced by marginalized groups.

Recent research has also begun to explore resilience and protective factors against depression, suicidality, and other mental health comorbidities in the trans community. For example, access to gender-affirming hormones and surgery (Riggs et al., 2014; White Hughto & Reisner, 2016) and social support and connection with the trans community (Moody & Smith, 2013; Sherman et al., 2020) have been shown to improve mental health and improve quality of life.

In Australia, the early months of the COVID-19 pandemic were characterized by relatively low positive cases and deaths due to strict social restrictions. International borders were closed and non-essential travel within and between states and territories was limited. Schools and universities transitioned to home-based online learning, and employees were instructed to work from home where possible. Many allied health services, including psychology and non-essential businesses were closed or changed to an online model for service delivery (i.e., telehealth). All elective surgery, including gender-affirming surgery was canceled or postponed to conserve healthcare resources. Rates of domestic violence were reported to have exponentially increased during extended periods of "lockdown" restrictions worldwide (Bradbury-Jones & Isham, 2020). With government orders to stay at home, trans people were potentially isolated with family or household members who may not have accepted their gender identity.

The COVID-19 pandemic has brought significant psychological distress on a global scale to many populations (Fisher et al., 2020; Pierce et al., 2020). Suicidal behavior is likely to be present for longer and peak later than the pandemic (Gunnell et al., 2020), and concern for the trans community has been raised as a priority (Wang et al., 2020). As such, we aimed to explore and understand the impact of the COVID-19 pandemic on the living situation, employment, financial status, depression, and thoughts of self-harm or suicide of the trans community in Australia. We hypothesized that the trans community would experience higher rates depression and thoughts of self-harm or suicide during the COVID-19 pandemic, as COVID-19-related stressors were likely to compound the impacts of preexisting social marginalization, discrimination and abuse.

Materials and methods

We conducted an online cross-sectional survey of trans Australians utilizing a non-probability snowball sampling approach. The survey was open to Australian residents ≥16 years of age who identified as trans between 1st May 2020 and 30th June 2020. The survey was designed collaboratively by our core team of researchers who are members of the Australian trans community (SZ, AWFQ, AG, TC, KE, ED), with support from clinicians experienced in trans healthcare (LMA, ASC). Survey data were collected and managed using REDCap electronic data capture tools hosted at The University of Melbourne. The study received ethical and governance approval by the Austin Health Human Research Ethics Committee (Reference Number HREC/57155/Austin-2019), ACON Research Ethics Review Committee

(Reference Number 2020/03), and the Thorne Harbour Health Community Research Endorsement Panel (Reference Number THH/CREP 20-006).

The survey preamble outlined that completing the survey implied consent. Inclusion criteria were assessed *via* three screening questions: (a) currently living in Australia; (b) identification as trans ("is your gender different to what was presumed for you at birth?"); and (c) aged 16 years or older. Participants were asked to first complete an enrollment survey (as part of a larger longitudinal project) with demographic questions. An individualized link to the "COVID-19 survey" was subsequently sent by email. Duplicate responses or incomplete responses were excluded. All survey questions were optional. Reimbursement (AUD$5 gift card) was provided to participants following completion of the survey.

The survey was posted on social media (Facebook and Instagram). Furthermore, over 100 trans community support groups and organizations in Australia were directly contacted to share the survey within their networks.

Demographic data, including state of residence, age, presumed gender at birth, and gender identity were ascertained. To facilitate data analysis, participants were then asked to self-select the most appropriate gender category of three: trans man, trans woman, or non-binary (see Table 1).

Participants were asked "Has your living situation changed in response to COVID-19?" with Yes or No response options; as well as "What statement best describes your current living situation at the moment?" with fixed-response and open-ended options, as outlined in Table 2. To explore safety during social isolation, participants

Table 1. Demographic characteristics of the study sample.

Demographic variable	*N*	%	National data (%)
Age (N = 1017)			
16–25	368	36.2	12.8
26–35	344	33.9	14.4
36–45	121	12.0	13.5
46–55	95	9.4	13.3
56 – 65	61	6.0	11.8
66–75	24	2.4	8.9
76–85	3	0.3	4.8
Sex presumed at birth (N = 1019)			
Male	469	46.0	49.1
Female	532	52.2	50.9
Unsure/prefer not to say	18	1.8	NA
Variation of sex characteristics (Intersex) (N = 1019)			
No	827	81.2	NA
Yes	88	8.6	NA
Unknown	100	9.8	NA
Prefer not to say	4	0.4	NA
Gender category (N = 1019)			
Trans woman	396	38.9	NA
Trans man	362	35.5	NA
Non-binary	261	25.6	NA
Aboriginal or Torres Strait Islander (N = 1019)			
Aboriginal	89	8.7	3.0
Torres Strait Islander	21	2.1	0.2
Both Aboriginal and Torres Strait Islander	12	1.2	0.1
Non-Indigenous	885	86.9	96.7
Prefer not to say	12	1.2	NA
Country of birth (N = 1019)			
Australia	859	84.3	70.3
Other	160	15.7	29.7
State/territory of residence (N = 1019)			
Australian Capital Territory	53	5.2	1.7
New South Wales	255	25.0	32.1
Northern Territory	11	1.1	0.9
South Australia	132	13.0	7.0
Queensland	66	6.5	19.8
Tasmania	25	2.5	2.1
Victoria	375	36.8	26.2
Western Australia	102	10.0	10.2

NA equals not applicable. Source of National Data: Australian Bureau of Statistics 2020, and Australian Institute of Health and Welfare 2019 Profile of Indigenous Australians.

Table 2. Living situation, employment, and finances.

Living situation, employment and financial variable	*N*	%	National data (%) (Fisher et al., 2020; Morgan et al., 2020)
Change of living situation during COVID-19 (N = 1013)			
Yes	273	27.0	NA
No	740	73.1	NA
Current household composition (N = 1017)			
With family (logical or chosen)	300	29.5	NA
With partner(s)	288	28.3	NA
Alone	187	18.4	19.2
With friends or housemates	185	18.2	6.9
With some but not all partners	30	3.0	NA
Mixed household (e.g. parent and housemates)	11	1.1	NA
No regular place of residence	4	0.4	NA
Assisted living/care facility	4	0.4	NA
Boarding school or residential college	4	0.4	NA
Shared custody arrangement	3	0.3	NA
Foster care	1	0.1	NA
Feeling unsafe or afraid in household (N = 1016)			
Yes	119	11.7	11.6
No	897	88.3	88.4
Change in employment status due to COVID-19 (N = 909)			
No change in employment	289	31.8	NA
Contact with work colleagues greatly reduced	217	23.9	NA
Working reduced hours	200	22.0	NA
Unemployed prior to the pandemic	142	15.6	NA
Lost employment	106	11.7	11.2
Other (e.g. increase in work hours)	146	16.1	NA
Current employment status (N = 1015)			
Full time employment	309	30.4	NA
Student	237	23.4	NA
Unemployment	227	22.4	7·4
Part time employment	185	18.2	NA
Casual employment	156	15.4	NA
Pension	97	9.6	NA
Volunteer	50	4.9	NA
House duties	44	4.3	NA
Retired	21	2.1	NA
COVID-19 related financial strain (N = 1019)			
Rent/mortgage	240	23.6	NA
Utilities (e.g. electricity, gas, water, internet)	260	25.5	NA
Food/groceries	318	31.2	NA
Financially supporting others	145	14.2	NA
Other (e.g. medication, healthcare)	106	10.4	NA

NA – not applicable. National data are for the same time period. Source of National Data: Fisher et al. (2020) and Morgan et al. (2020). Canberra: Australian Institute of Criminology, 2020, and Employment, hours worked and unemployment rise in June. Australian Bureau of Statistics 2020.

were asked "Does anyone in your household make you feel unsafe or afraid?" with Yes or No response options. Changes in employment as a result of the COVID-19 pandemic were assessed with fixed-responses to "What best describes your current employment status?" and "How has your employment status changed because of the COVID-19 pandemic?" specifically with the option to select all that applied from (a) I lost my job; (b) I am working reduced hours; (c) Contact with work colleagues reduced; (d) I was unemployed prior to the COVID-19 pandemic; (e) it has not been affected; and (f) other. For the purposes of statistical analysis, "job loss" was categorized as any participant who selected "I lost my job".

Participants were asked "Has the COVID-19 pandemic put financial strain on any of the following?" with the option to select all that applied from; (a) rent/mortgage; (b) utilities (e.g. electricity, gas, water, internet); (c) food/groceries; (d) provision of financial support to others; (e) other (open-text response). For purposes of analysis, "financial strain" was categorized as any participant who had indicated one or more of the forms of financial strain.

Depression and thoughts of self-harm or suicide were assessed using the PHQ-9 (Arroll et al., 2010; Kroenke et al., 2001). The PHQ-9 was chosen given the availability of Australian normative data (Fisher et al., 2020), and validation against formal diagnostic psychiatric interviews (Arroll et al., 2010; Staples et al., 2019). PHQ-9 is an easy to understand, self-reported 9-item scale, whereby respondents select the severity of nine depressive symptoms as “0” (not experienced) to “3” (experienced nearly every day). The sum of all nine responses provide a total score. PHQ-9 scores ≥10 are 88% sensitive and 85% specific for detecting clinically significant major depression (Levis et al., 2019). PHQ-9 scores of 5–9 represent mild, 10–14 moderate, 15–19 moderately severe, and ≥20 severe depressive symptoms. Specifically, PHQ-9 Item 9 assessed thoughts of self-harm or suicide (“thoughts that you would be better off dead or of hurting yourself in some way”).

Descriptive frequencies were reported, and median (interquartile range) values were included for not normally distributed data. Statistical analysis was performed using R version 4.0.2 (R Foundation for Statistical Computing, Vienna, Austria). Logistic regression was performed to explore associations between experiences of COVID-19-related stressors and depression and thoughts of self-harm or suicide. Models for depression and responses to item-9 (thoughts that one would be better off dead or of hurting themselves) were analyzed separately with four types of experiences of COVID-19 – job loss (participants who indicated “I lost my job”), feeling unsafe or afraid in household, financial strain (participants who indicated financial strain in relation to at least one of housing, utilities, groceries, financial supporting others, or “other”), and surgery canceled or postponed. All models were adjusted for age, being born overseas, gender category, and living situation to allow for similar comparisons with a national survey (Fisher et al., 2020).

Results

A total of 1162 responses were received. After removing duplicates, ineligible responses and incomplete surveys, 1019 participants remained.

Demographic data

Demographic data are summarized in Table 1. The median age of participants was 29 years (range 16–80). Responses were received from participants living in all Australian states and territories, though were not represented proportionately to the population. There was a greater number of younger individuals, and a higher proportion of First Nations Aboriginal or Torres Strait Islander people in our sample than national averages (Table 1). The proportion of individuals identifying as trans women, trans men, and non-binary in this sample were similar to another trans adult community survey in Australia (Zwickl et al., 2019).

Living situation

Since the onset of the COVID-19 pandemic, 27% ($n = 273$) of participants reported that their living situation had changed. Reasons for a change in living situation included job loss, financial strain, and attempts to ensure ongoing access to informal supports during social restrictions by combining formerly separate households. Household composition is outlined in Table 2. A total of 11.7% reported that they were living with someone that made them feel unsafe or afraid, which is comparable to Australian general population reports of 11.6% during the early stages of the COVID-19 pandemic (Morgan et al., 2020).

Employment and financial situation

The majority of the participants experienced some negative change in employment status as outlined in Table 2. Over a third had reduced working hours or had become unemployed. Approximately, one in four experienced social impacts, such as reduction in contact with work colleagues. Almost half of participants ($n = 550$) reported experiencing financial strain related to the COVID-19 pandemic.

Patient health questionnaire-9 (PHQ-9)

The PHQ-9 was completed by 985 participants (Table 3). Of note, 61.1% ($n = 602$) of participants experienced clinically significant symptoms of depression (PHQ-9 score ≥10). This is significantly higher than 27.6% reported in the general

Table 3. Depression and thoughts of self-harm or suicide (PHQ-9).

Mental health variable	Trans men *N* (%)	Trans women *N* (%)	Non-binary *N* (%)	Total *N* (%)	National data (%) (Fisher et al., 2020)
*PHQ-9 score and depression severity (N = 985)**					
0–4 (minimal or none)	46 (13.3)	72 (18.9)	22 (8.6)	140 (14.2)	NA
5–9 (mild)	95 (27.4)	104 (27.3)	44 (17.1)	243 (24.7)	26.5
10–14 (moderate)	77 (22.2)	77 (20.2)	64 (24.9)	218 (22.1)	A total of 27.6
15–19 (moderately severe)	66 (19.0)	66 (17.3)	57 (22.2)	189 (19.2)	(score ≥ 10)
20–27 (severe)	65 (18.7)	62 (16.3)	70 (27.2)	195 (19.8)	
*PHQ-9 – item 9 Thoughts that you would be better off dead or of hurting yourself in some way (last two weeks) (N = 985)***					
Not at all	189 (54.5)	205 (53.8)	108 (42.0)	502 (51.0)	85.4
Several days	73 (21.0)	91 (23.9)	71 (27.6)	235 (23.9)	8.9
More than half the days	51 (14.7)	49 (12.9)	31 (12.1)	131 (13.3)	3.0
Nearly every day	34 (9.8)	36 (9.5)	47 (18.3)	117 (11.9)	2.7

NA equals not applicable. Source of National Data: Fisher et al. (2020).

*Overall p value from Chi-squared test comparing between non-binary and binary (trans men $p = 0.004$ and trans women $p < 0.0001$).

**Overall p value from Chi-squared test comparing between non-binary and binary (trans men $p = 0.001$ and trans women $p = 0.002$).

Australian population in response to COVID-19 during May 2020 (Fisher et al., 2020), and higher than in trans Australians prior to the pandemic (36% and 44% reported to have PHQ-9 score ≥10 in 2009 by Pitts et al. and in 2013 by Hyde et al. respectively). In a subgroup analysis by gender (trans men, trans women, or non-binary shown in Table 3), the non-binary group was more likely to experience clinically significant symptoms of depression compared to binary groups (74.3% in non-binary group compared to 59.9% in trans men and 53.8% in trans women, all overall p values <0.01).

Notably, 49% ($n = 483$) of participants reported that they had thought that they would be better off dead or of hurting themselves in the two preceding weeks, which is almost double the rate reported by Pitts et al. (2009), though similar to Hyde et al. (2013). A total of 11.9% ($n = 117$) reported that they experienced these thoughts nearly every day. The occurrence of such thoughts during the COVID-19 pandemic in 49% of trans Australian adults was significantly higher than 14.9% of the general Australian population (Fisher et al., 2020). Individuals with non-binary identities reported a higher prevalence of having thoughts that they would be better off dead or of hurting themselves in the prior two weeks compared to individuals with binary identities (Table 3). A descriptive table of the PHQ-9 and Item 9 scores by state and territory has been included as a Supplementary Table.

Predictors of clinically significant depression or a participant selecting that they had experienced "thoughts that you would be better off dead or of hurting yourself in some way" are outlined in Table 4. Contrary to national data, job loss due to COVID-19 restrictions was not statistically associated with a higher risk of depression or thoughts that they would be better off dead or of hurting themselves in Australian trans individuals. Notably, the unemployment rate was 22.4% which is three times higher than the national rate (Table 2). Feeling unsafe or afraid in the household and financial strain posed a higher risk for both depression and having thoughts that they would be better off dead or of hurting themselves. Cancelation or postponement of gender-affirming surgery due to COVID-19 was associated with a 56% increase in the risk of having thoughts that they would be better off dead or of hurting themselves (Table 4).

Discussion

This large community survey involving 1019 participants is one of the first studies describing the impact of the COVID-19 pandemic on the trans community in Australia. These data quantify the magnitude and severity of depression and thoughts of self-harm or suicide in the first three months of the COVID-19 pandemic. Concerningly, 61% of trans Australians met criteria based on PHQ-9 for clinically significant depression, considerably higher than prior to the pandemic (rates of 36% reported in 2009 by Pitts et al. and 44% in 2013 by Hyde et al.) and more than twice the rate seen in the Australian general population during the pandemic (Fisher

Table 4. Associations between experiences of COVID-19 and depression and thoughts of self-harm or suicide.

	Mental health outcome (last two weeks)			
	Clinically significant symptoms of depression (PHQ9 score >10)		Thoughts that you would be better off dead or of hurting yourself in some way	
(*N* = 985)	Trans sample OR (95% CI)*	National data (Fisher et al., 2020)	Trans Sample OR (95% CI)*	National data (Fisher et al., 2020)
Job loss due to COVID-19 restrictions	0.70 (0.44, 1.11)	**1.50 (1.31, 1.72)**	1.11 (0.71, 1.73)	**1.31 (1.11, 1.55)**
Feeling unsafe or afraid in household	**1.75 (1.06, 2.89)**	NA	**1.96 (1.23, 3.08)**	NA
Financial strain	**1.85 (1.69, 2.47)**	NA	**1.80 (1.36, 2.38)**	NA
Gender-affirming surgery canceled or postponed	1.35 (0.88, 2.07)	NA	**1.56 (1.04, 2.35)**	NA

NA equals not applicable. Bold values indicate odds ratios where its corresponding 95% confidence interval does not cross 1.

*Odds ratio (95% CI) for all four types of experiences of COVID-19 are mutually adjusted for each other with age, being born overseas, gender, and living situation also included as covariates. National data from Fisher et al. (2022).

et al., 2020). Additionally, almost half the participants (49%) reported thoughts of self-harm or suicide in the preceding two weeks, which was significantly more likely in people who reported feeling unsafe or afraid in their household, experienced financial strain, or had cancelation or postponement of planned gender-affirming surgery. Rates of experiencing thoughts of self-harm or suicide are higher than the general Australian population (Fisher et al., 2020) but are similar to previous reports in trans Australians (Hyde et al., 2013).

Trans Australians with non-binary identities reported higher rates of both depression and thoughts of self-harm or suicide compared to those with binary identities which is consistent with findings from prior to the pandemic (Cheung et al., 2020; James et al., 2016). This may be related to a lack of social and legal recognition of non-binary genders (McLemore, 2015; Valentine, 2016) and is unlikely to be attributed to the COVID-19 pandemic.

The overall high rates of clinically significant depression and thoughts of self-harm or suicide are likely the result of the preexisting effects of social marginalization, discrimination, and high rates of physical and verbal abuse and associated high rates of depression and suicidality experienced by the trans community (Bretherton et al., 2021; Strauss et al., 2020), *compounded by* COVID-19 pandemic-related stressors. In addition to ongoing challenges faced by the trans community, trans Australians may have faced isolation from trans community and wider support networks and some have experienced disruptions to their gender-affirming healthcare through cancelation of surgeries.

Feeling unsafe or afraid in the household posed a higher risk for both depression and thoughts of self-harm or suicide. Rates of feelings unsafe or unafraid in the household were comparable with the general population (Fisher et al., 2020), and therefore it cannot be presumed that such experiences are related to one's trans status. There is, however, some evidence that many trans people face discrimination and violence within the home (James et al., 2016; Riggs et al., 2015; Smith et al., 2014) and that this is associated with poorer mental health (Riggs et al., 2015).

There were significantly greater odds of thoughts of self-harm or suicide in trans people experiencing cancelation or postponement of their gender-affirming surgery. Gender-affirming surgery can be a critical part of transition and affirmation for many trans people, with previous data demonstrating that access to gender-affirming surgery is protective against suicidal ideation and suicide risk (Bauer et al., 2015; Tucker et al., 2018). Despite the 95% confidence interval crossing 1 for reporting depression, the point estimate indicates an increased odds ratio of 1.35 for cancelation of surgery. Statistically, whilst the concordance rate between depression and suicide is high (76%), there is a group of individuals (18%) who met criteria for clinically significant depression but did not have thoughts of self-harm or suicide. Amongst those who had thoughts of self-harm or suicide and had surgery canceled, the majority (93%) also had depression. In contrast, amongst those who had surgery canceled and no thoughts of self-harm or suicide, only 29% had depression. This may suggest that cancelation of surgery may not be a primary risk factor for some individuals with depression but no thoughts of self-harm or suicide. This is likely contributing to the (relatively) smaller effect size between surgery canceled and depression, in contrast to the effect size for thoughts of self-harm or suicide. With resumption of elective surgery, prioritization of gender-affirming surgery may help alleviate symptoms of depression and thoughts of self-harm or suicide in the trans community which are clearly higher than the general population.

The increased financial strain resulting from the COVID-19 pandemic is associated with 80% higher odds of experiencing depression or thoughts of self-harm or suicide, which disproportionately impacted an already economically marginalized community. Contrary to general population data, job loss itself during the COVID-19 pandemic was not statistically associated with a higher risk of depression or thoughts of self-harm or suicide in trans Australians. Notably, the national data (Fisher et al., 2020) was collected in the first month of COVID-19 restrictions in Australia (3rd April–2nd May 2020) and found an increased odds of reporting depression or thoughts of self-harm/suicide with job loss at a time prior to any tangible government assistance. This survey was conducted between the 1st May and 30th June 2020. From the first week of May 2020, the Australian Government began paying businesses who were adversely affected by the COVID-19 pandemic a wage subsidy (known as JobKeeper) to enable them to keep employees in jobs. This flat payment of AUD$1500 per fortnight was the equivalent of 70% of the national median wage. This likely provided financial relief and job certainty for at least six months for many individuals and for some, JobKeeper payments were higher than their usual income, providing positive financial benefits. This complexity likely explained the lack of associations with job loss in our survey. There are also potential confounding effects with financial strain, in which despite evidence of an association in univariate analysis, there is a considerable change in the estimated odds ratio of job loss (>10%) when financial strain was included in the model.

With ongoing uncertainty surrounding the pandemic and intermittent implementation of social restrictions, there is likely to be ongoing issues of unemployment, financial strain, and unsafe living situations, coupled with fear and social isolation. These are all likely to have a long-term adverse impact on mental health. Suicidality is likely to present for longer and peak later than the pandemic (Gunnell et al., 2020), with great fears for a suicide epidemic in the trans community (Wang et al., 2020).

Overall, mental health services and support are critical to addressing the high rates of depression and thoughts of self-harm or suicide in the Australian trans community during and after the COVID-19 pandemic. Whilst Australia's mental health sector has been agile in responding to the needs exposed by the COVID-19 pandemic, including expanding telehealth, mainstream services are often inept in their understanding of the trans experience and therefore the complex mental health needs of many trans people (Strauss et al., 2020; Zwickl et al., 2019). Certainly, previous research has found that LGBTIQA + individuals avoid mainstream telephone crisis counseling because they anticipate discrimination (Waling et al., 2020). Given the unique and complex challenges that trans people often face, mainstream mental health services should be provided with additional trans competency training, and specialized LGBTIQA + and trans-specific services require additional funding and resources to increase their capacity to meet the increase in demand. Safe and affirming mental health support strategies that can be delivered safely within COVID-19 social restrictions need to be explored, and potentially online-based peer support programs, smartphone-based applications, or text messaging may be useful options. The financial accessibility of mental health support should also be considered, given the high rates of unemployment and financial strain experienced by the trans community. In addition, given that loss of employment and financial strain are well-recognized risk factors for suicide in the general population (Blakely et al., 2003; Classen & Dunn, 2012; Nordt et al., 2015), both issues require urgent government attention.

Limitations

There are multiple limitations to this cross-sectional study and based upon a non-probability snowball sampling approach. This study identified associations but not causal relationships. The online-based recruitment may explain why a greater proportion of responders were younger individuals and hence may not accurately reflect the views of the older trans community, those who are less computer proficient or in people who may have difficulty with English fluency. Not all areas of Australia were represented equally, as recruitment was not targeted. However, the predominance of respondents in south eastern states is in line with previous Australian trans community surveys (Bretherton et al., 2021; Strauss et al., 2020). The lack of an objective measure of anxiety is also a significant limitation of this study, given that there has been a noted increase in anxiety in the general population during the pandemic (Fisher et al., 2020). Additionally, the survey did not clarify whether feeling unsafe or afraid in one's household was related to being trans.

Nonetheless, this survey provided a platform for participants to express their views at a time when in-person interviews are not feasible during COVID-19 social restrictions. This is one of few studies describing the impact of the COVID-19 pandemic on trans people who are traditionally marginalized and underrepresented in research. Our use of the standardized PHQ-9 additionally allows comparisons with the general population during COVID-19 social restrictions and outside of COVID-19.

Conclusion

An urgent, targeted public health response co-created with trans individuals is needed to address the alarming rates of depression and thoughts of self-harm and suicide in trans Australians. COVID-19 pandemic-related stressors appear to have further exacerbated preexisting high rates of depression. Strategies to ensure the safety of trans people to live without discrimination, abuse or violence are needed, particularly in home environments during social restrictions. Moreover, our findings highlight the importance of gender-affirming surgery for trans people and reinstating access may aid in preventing suicide.

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Authors' contributions

Conceptualization: SZ, LMA, AWFQ, AG, KE, TC, ED, JDZ, and ASC; Methodology: SZ, LMA, AWFQ, AG, KE, TC, ED, and ASC; Data Curation: LMA; Investigation: SZ, LMA, AWFQ, AG, KE, TC, and ASC; Formal analysis: SZ, SYL, AWFQ, AG, and KE; Writing – Original Draft Preparation: SZ and ASC; Writing – Review & Editing SZ, LMA, AWFQ, AG, KE, TC, ED, SYL, JDZ, and ASC; Funding Acquisition: ASC; Supervision: JDZ and ASC. All authors had full access to all of the data (including statistical reports and tables) in the study, approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

Data sharing statement

Deidentified participate data are available upon reasonable request from the corresponding author via email (adac@unimelb.edu.au), provided that the related research is deemed to be of benefit to the trans and gender diverse community and has undergone Austin Health Human Research Ethics Committee approval in the form of an amendment.

Declaration of interests

The authors have nothing to disclose.

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Gay Community Periodic Survey: Tasmania 2018

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Survey participants

the 232 men who participated in the survey

Contents

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Glossary

AIDS acquired immune deficiency syndrome

ART antiretroviral treatment

CAIC condomless anal intercourse with casual partners

CAIR condomless anal intercourse with regular partners

Cisgender a term used to describe people whose gender identity matches the sex they were assigned at birth

HIV human immunodeficiency virus

HIV-seroconcordant relationship a relationship in which both partners are of the same HIV status, either HIV-positive or HIV-negative

HIV-serodiscordant relationship a relationship in which both partners are known (as a result of testing) to be of different HIV status, e.g. HIV-positive and HIV-negative

HIV-serononconcordant relationship a relationship in which the HIV status of at least one partner is not known, e.g. HIV-positive and untested, HIV-negative and untested, or both untested

HIV status a person's antibody status established by HIV testing, e.g. HIV-negative, HIV-positive, or unknown (untested)

PEP post-exposure prophylaxis, a course of antiretroviral drugs used to reduce the risk of HIV infection after potential exposure has occurred

PrEP pre-exposure prophylaxis, antiretroviral drugs used to reduce the risk of HIV infection before a potential exposure

STI sexually transmissible infection

Executive summary

The Tasmania Gay Community Periodic Survey is a cross-sectional survey of gay and homosexually active men recruited online throughout Tasmania. The major aim of the survey is to provide data on sexual, drug use and testing practices related to the transmission of HIV and other sexually transmissible infections (STIs) among gay men. The most recent survey, the third to be conducted in Tasmania, was conducted in November 2018.

The project has been funded by the Tasmanian Department of Health since 2014. The Centre for Social Research in Health coordinates the survey, with support from the Kirby Institute. The Tasmanian Council on AIDS, Hepatitis & Related Diseases (TasCAHRD) provides advice on recruitment and promotes the survey.

In total, 232 men completed the 2018 survey, and all participants were recruited online. As 321 eligible participants commenced the online questionnaire, this represents a 72% completion rate. Recruitment in Tasmania for the Gay Community Periodic Survey is unlike other jurisdictions where the bulk of recruitment is conducted face-to-face, by trained staff, at gay social events and venues, sex-on-premises venues and clinics. Online recruitment has, however, been conducted in all participating jurisdictions since 2014, and is done via paid advertisements on the social networking site Facebook. For the 2018 Tasmanian survey, advertisements were targeted to men aged 16 and above who were resident in Tasmania and whose Facebook profiles included any LGBTI related interests, such as ‘same sex relationship’, ‘gay friendly’, ‘LGBT social movements’, or ‘LGBT culture’. Potential participants were directed to the study website with links to the online version of the questionnaire (http://gcpsonline.net).

Key points

- The proportion of men who had ever tested for HIV remained stable at 79% in 2018.
- The proportion of men who reported that they were HIV-positive was 7% in 2018, and all but one of these participants was on antiretroviral treatment.
- The use of mobile phone apps continued to be the most common way that men met male sex partners (45% in 2018).
- The proportion of men who reported being in a monogamous relationship has declined since 2014, to 32% in 2018.
- The proportion of men with regular partners who reported condomless anal intercourse with those partners remained stable at 73% in 2018.
- There was an increase in the proportion of men who reported any condomless anal intercourse with casual partners, from 38% in 2016 to 61% in 2018. This increase was amongst HIV-negative and untested men (both users and non-users of pre-exposure prophylaxis [PrEP]).
- Rates of recreational drug use remained stable but high, with 50% of men reporting any recreational drug use in the six months prior to the survey.
- The proportion of men who believed that PrEP was available increased significantly from 51% in 2016 to 70% in 2018.
- The proportion of non-HIV-positive men taking prescribed PrEP increased from 3% in 2016 to 15% in 2018.

Demographic profile

As in previous surveys, the men surveyed mostly lived in or close to Hobart (49.6%), had an Anglo-Australian background (78.0%), had completed a university degree or other tertiary qualification (61.6%), and were in paid employment (62.1%). The majority of the sample identified as gay (75.4%), though this was a smaller proportion than in 2016 (91.5%). The proportion of men who identified as bisexual in 2018 increased substantially from 2016 (19.8% vs. 4.0%). Younger men were most likely to identify as bisexual; in 2018, nearly 1 in 4 men aged under 30 years identified as bisexual (22.9%). Most of the sample was born in Australia (86.2%). A minority of participants identified as Aboriginal and/or Torres Strait Islander (6.0%).

The majority of participants identified as cisgender men (97.8%), with a small number of men identifying as non-binary (n=2, 0.9%) or 'other' (n=3, 1.3%).

The mean age of the sample was 35.1 years (standard deviation = 14.7 years). Since 2014, there has been an increase in the proportion of men aged 50 and above in the survey and a decrease in the proportion of men aged 25-29 years (see Table 1).

HIV status and testing

In 2018, 4 in 5 men reported having ever been tested for HIV (78.9%; see Table 2). The proportion of men who reported ever having tested for HIV has remained stable since 2014. Being untested was concentrated among younger men in the sample; in 2018, 2 in 5 men aged under 25 years reported that they had never had a HIV test (39.7%). The proportion of non-HIV-positive men who reported testing for HIV in the previous 12 months remained stable in 2018 (64.9%).

The most common locations where non-HIV-positive participants said they had had their last HIV test were at a general practice (45.6%) or a sexual health clinic or hospital (45.6%; see Table 3).

Among non-HIV-positive men in the 2018 survey, more participants reported three or more HIV tests in the previous 12 months than reported one or two tests. Since 2014, there has been a significant increase in the proportion of men reporting three or more tests within the previous 12 months. Regular HIV testing was concentrated amongst PrEP users, 90.6% of whom reported three or more tests within the previous 12 months.

Among men who had been tested for HIV, in 2018 the majority reported that they were HIV-negative (92.4%; see Table 5). A small proportion of men reported that they were HIV-positive (n=12, 6.6%) and two men reported that they did not know their HIV status. There has been no significant change in the proportion of men who reported being HIV-negative since 2014. The number of HIV-positive men recruited into the survey has varied between 11 and 19 since 2014, indicating that it is relatively difficult to recruit HIV-positive men into the survey. Other methods may need to be considered (e.g. clinic-based recruitment) if better capturing the experiences of HIV-positive men in Tasmania is important.

In 2018, all but one of the HIV-positive men reported taking combination antiretroviral treatment at the time of the survey (90.9%; see Table 6), and all but one of the men on treatment reported having an undetectable viral load (90.0%; see Table 7). In 2018, 2 in 3 HIV-positive men reported having attended at least three clinical appointments in the previous 12 months to manage their HIV.

Sexual relationships with men

At the time of the 2018 survey, there were equal proportions of men who reported having no sexual relationships with men (25.5%) or having both regular and casual male partners (25.5%; see Table 8). A higher proportion of participants reported being in a monogamous relationship (32.0%), while fewer reported having casual partners only (16.9%). Since 2014, there has been a decline in the proportion of men who reported being in monogamous relationships.

In 2018, just under 1 in 2 men (45.3%) reported meeting male sex partners via mobile apps such as Grindr in the six months prior to the survey (see Table 9). The next most common ways of meeting sex partners included the Internet (27.6%) and meeting men while travelling in Australia (21.1%). There were no significant changes between 2016 and 2018 in the ways that men reported meeting male sex partners.

Regular male partners

Among men with regular male partners in the six months prior to the survey, the majority reported having an agreement with their regular partner about sex within the relationship (62.1%; see Table 10), and a similar proportion reported having an agreement about sex outside of the relationship (65.1%; see Table 11). The most common agreement about sex within the relationship was that anal intercourse could occur without a condom (43.9%; see Table 10). There was no significant change between 2016 and 2018 in the proportion of men who reported an agreement about sex within the relationship.

The most common agreements about sex outside of the relationship were that sex with casual partners could not occur (33.3%), or that condoms must be used for anal intercourse with casual partners (18.9%; see Table 11). There was no significant change between 2016 and 2018 in the proportion of men who reported an agreement about sex outside the relationship.

Men with regular partners were asked if they knew the HIV status of their partner. Based on their response to this question and their self-reported HIV status, men were categorised as being in a seroconcordant, serodiscordant or serononconcordant relationship. In 2018, among the eight HIV-positive men with regular partners in the six months prior to the survey, three were in seroconcordant relationships, two were in serodiscordant relationships and three were in serononconcordant relationships (see Table 12). Among HIV-negative men with regular partners, most were in seroconcordant relationships (70.2%) or serononconcordant relationships (25.0%; see Table 12). There were no significant changes in the proportions of HIV-negative men reporting these different relationship types between 2016 and 2018.

The majority of men with regular partners in the six months prior to the survey reported at least some condomless anal intercourse with their partners (CAIR) during this time (73.4%), while nearly 1 in 10 men reported consistently using condoms with their partner (9.1%; see Table 13). Rates of CAIR did not significantly change between 2016 and 2018.

Among the eight HIV-positive participants with regular partners in the six months prior to the survey, three reported CAIR that was not concordant, three reported seroconcordant CAIR and two reported no CAIR (see Table 14). Among HIV-negative men with regular partners, more than half reported seroconcordant CAIR (58.1%), nearly 1 in 6 reported CAIR that was not concordant (15.3%) and over a quarter reported no CAIR (26.6%; see Table 14).

Casual male partners

As is typically found in samples of Australian gay men, the use of condoms for anal intercourse was more commonly reported with casual male partners than with regular partners. Among men who had casual partners, just under 1 in 6 men reported no anal intercourse with those partners (14.6%), a quarter of men reported consistent condom use (24.6%), and 3 in 5 men reported any condomless anal intercourse with casual partners (CAIC; 60.9%) in the six months prior to the survey (see Table 15). Between 2016 and 2018, there was an increase in the proportion of men who reported CAIC and a reduction in the proportion of men who reported consistent condom use. The increase in CAIC between 2016 and 2018 was largely attributable to an increase in the proportion of HIV-negative men on PrEP reporting CAIC (from 3.7% in 2016 to 20.9% in 2018), and an increase in the proportion of HIV-negative and untested men not on PrEP who reported any receptive CAIC (from 15.9% of men with casual partners in 2016 to 25.5% in 2018; see Table 15).

Among men with casual partners in 2018, HIV-positive participants were more likely to report CAIC (71.4%) compared with HIV-negative participants (60.5%) and HIV untested and unknown status participants (58.8%; see Table 16). Between 2016 and 2018, there was an increase in the proportion of HIV-negative men who reported CAIC. There was also an increase in the proportion of HIV untested and unknown status men who reported CAIC, though the number of HIV untested and unknown status men was too small to determine whether this was a meaningful change (and thus should be interpreted with caution). Rates of CAIC reported by HIV-positive men remained stable.

Among the five HIV-positive men who reported CAIC in the six months prior to the 2018 survey, the most frequently used risk reduction strategies were having an undetectable viral load and knowing their partner was on PrEP before sex (n=3; see Table 19). Among HIV-negative men who reported CAIC in the six months prior to the survey, the most commonly reported risk reduction strategies were serosorting (55.8%), knowing their partner was on PrEP before sex (51.9%), and taking PrEP themselves (40.4%; see Table 19).

Sexual health

In 2018, a larger proportion of HIV-positive men reported having had any sexual health test (including a blood test for syphilis) in the 12 months prior to the survey compared to HIV-negative men (84.6% vs. 70.6%; see Tables 20 and 21). Rates of any sexual health testing (including a blood test for syphilis) in the 12 months prior to the survey were considerably lower among men who reported that their HIV status was untested or unknown (14.3%) than among HIV-positive and HIV-negative men. Rates of sexual health testing remained stable between 2016 and 2018, irrespective of the HIV status of participants, though the small number of HIV-positive men means that these findings should be interpreted cautiously. The only exception to this was an increase in anal swabs reported by HIV-negative men since 2014 (see Table 21).

In 2018, fewer than 1 in 10 participants (8.2%) reported having been diagnosed with an STI (other than HIV) in the 12 months prior to the survey. Rates of STI diagnoses have remained stable since 2014.

In 2018, two thirds of participants reported having been vaccinated for hepatitis A (66.4%). Slightly more participants (70.3%) had been vaccinated for hepatitis B (an increase from 48.0% in 2016). Being vaccinated for hepatitis A and/or B was more commonly reported by HIV-positive men (84.6%) and HIV-negative men (82.4%) than by HIV untested and unknown status men (61.2%).

In 2018, almost 2 in 3 men (64.2%) reported having ever been tested for hepatitis C, while 1 in 10 men (11.1%) did not know whether or not they had been tested. Among men who had been tested, three participants reported having hepatitis C (2.0%). There have been no significant changes in rates of hepatitis C testing since 2014.

Drug use

In 2018, recreational drug use was commonly reported by participants, with half of men (50.4%) reporting the use of any drug in the six months preceding the survey (see Table 22). The most commonly used drugs were amyl (28.0%), cannabis (26.3%), and Viagra (21.6%). Between 2016 and 2018, there was no significant change in the use of any drug, though there has been an increase in amyl and Viagra use since 2014 (see Table 22).

Injecting drug use was not commonly reported by participants, with only five men (2.2%) reporting any injecting in the six months prior to the 2018 survey (see Table 23).

In 2018, almost 1 in 10 men (9.9%) reported the use of party drugs for sex in the six months prior to the survey, and 15 men (6.5%) reported that they had engaged in group sex during or after drug use (see Table 24).

In 2018, a quarter of men reported drinking more than four drinks on one occasion at least weekly (24.7%), another quarter reporting doing so at least monthly (26.0%), and another quarter reported doing this once or twice in the six months prior to the survey (26.9%).

Knowledge and use of PEP and PrEP

In 2018, more than half of all participants reported knowing that post-exposure prophylaxis (PEP) was available (55.6%; see Table 25). Since 2014, there has been a significant increase in the proportion who reported knowing that PEP was available (from 32.9%).

In 2018, more than two thirds of men (69.8%) reported that they believed that pre-exposure prophylaxis (PrEP) was available (see Table 25). Between 2016 and 2018, there was a large increase in the proportion who believed that PrEP was available (from 50.5%).

Among non-HIV-positive participants, eight men (3.7%) reported taking a prescribed course of PEP during the six months prior to the survey, while 32 men (14.6%) reported taking PrEP in the previous six months. There has been a large increase in the proportion of non-HIV-positive participants taking PrEP since 2016 (from 3.3%).

Reporting

Data are shown for the period 2014 to 2018. Each table includes the statistical significance (p-value), if any, of the change between 2016 and 2018 and the trend over time (2014-2018). An alpha level of .05 was used for all statistical tests. Changes between 2016 and 2018 were assessed with logistic regression. The p-value of the logistic regression test (if shown) indicates a statistically significant change within that category. Where there is no significant change, ns (non-significant) is shown. Where there are low frequencies (i.e. n<30 for most cells) or data are not comparable over time, tests have not been performed and are marked NA (not applicable). Please exercise caution when interpreting results where there are low frequencies, particularly for results that are analysed separately by HIV status, due to the small number of HIV-positive participants in the survey. When data are missing or were not collected in a given year, this is indicated in the table by a dash (–).

Table 1: Age

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
Under 25	79 (37.6)	57 (28.6)	68 (29.3)	ns	ns
25–29	30 (14.3)	22 (11.1)	15 (6.5)	ns	Decrease $p<.01$
30–39	57 (27.1)	43 (21.6)	52 (22.4)	ns	ns
40–49	22 (10.5)	35 (17.6)	39 (16.8)	ns	ns
50 and over	22 (10.5)	42 (21.1)	58 (25.0)	ns	Increase $p<.001$
Total	**210 (100)**	**199 (100)**	**232 (100)**		

Table 2: HIV testing

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
All participants					
Ever tested	162 (77.1)	162 (81.0)	182 (78.9)	ns	ns
Total	**210 (100)**	**200 (100)**	**232 (100)**		
Non-HIV-positive participants					
Tested in previous 12 months	94 (62.3)	86 (60.1)	111 (64.9)	ns	ns
Total[a]	**151 (100)**	**143 (100)**	**171 (100)**		

a This total only includes non-HIV-positive participants who had ever tested for HIV.

Table 3: Where non-HIV-positive men were last tested for HIV

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
General practice	71 (47.3)	67 (47.2)	78 (45.6)	ns	ns
Sexual health clinic/hospital	52 (34.7)	66 (46.5)	78 (45.6)	ns	ns
At home	1 (0.7)	2 (1.4)	0	NA	NA
Community-based service	23 (15.3)	4 (2.8)	11 (6.4)	NA	NA
Somewhere else (including gay bar)	3 (2.0)	3 (2.1)	4 (2.3)	NA	NA
Total	**150 (100)**	**142 (100)**	**171 (100)**		

Note: This table only includes men who have ever been tested for HIV.

Table 4: Number of HIV tests in the previous 12 months

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
None	107 (54.0)	95 (52.5)	109 (49.8)	ns	ns
One	45 (22.7)	41 (22.7)	39 (17.8)	ns	ns
Two	30 (15.2)	28 (15.5)	23 (10.5)	ns	ns
3 or more	16 (8.1)	17 (9.4)	48 (21.9)	Increase $p<.001$	Increase $p<.001$
Total	**198 (100)**	**181 (100)**	**219 (100)**		

Note: This table only contains data from non-HIV-positive men.

Table 5: HIV test results

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
HIV-positive	11 (6.8)	19 (11.7)	12 (6.6)	NA	NA
HIV-negative	149 (92.0)	142 (87.7)	169 (92.4)	ns	ns
Unknown status	2 (1.2)	1 (0.6)	2 (1.1)	NA	NA
Total	**162 (100)**	**162 (100)**	**183 (100)**		

Note: This table only includes data from men who have been tested for HIV.

Table 6: Use of combination antiretroviral treatment among HIV-positive men

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
On treatment	11 (100)	17 (94.4)	10 (90.9)	NA	NA
Total	**11 (100)**	**18 (100)**	**11 (100)**		

Table 7: Undetectable viral load and CD4 count among HIV-positive men using ART

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
Men using ART					
Undetectable viral load	11 (100)	16 (94.1)	9 (90.0)	NA	NA
CD4 count > 500	8 (72.7)	13 (76.5)	2 (20.0)	NA	NA
Total	**11 (100)**	**17 (100)**	**10 (100)**		

Note: In 2014, all HIV-positive participants reported being on ART. In both 2016 and 2018, only one HIV-positive participant was not on ART.

Table 8: Current relationships with men

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
None	46 (21.9)	49 (24.5)	59 (25.5)	ns	ns
Casual only	35 (16.7)	38 (19.0)	39 (16.9)	ns	ns
Regular plus casual	42 (20.0)	49 (24.5)	59 (25.5)	ns	ns
Regular only (monogamous)	87 (41.4)	64 (32.0)	74 (32.0)	ns	Decrease $p<.05$
Total	**210 (100)**	**200 (100)**	**231 (100)**		

Table 9: Where men met their male sex partners in the six months prior to the survey

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
Mobile app, e.g. Grindr	77 (36.7)	79 (39.5)	105 (45.3)	ns	ns
Internet	76 (36.2)	58 (29.0)	64 (27.6)	ns	ns
Gay saunas/Sex venues[1]	18 (8.6)	18 (9.0)	31 (13.4)	NA	NA
Gay bar	33 (15.7)	26 (13.0)	23 (9.9)	NA	NA
Overseas	20 (9.5)	18 (9.0)	28 (12.1)	NA	NA
Travelling in Australia[2]	50 (23.8)	59 (29.5)	49 (21.1)	NA	NA
Dance party	18 (8.6)	8 (4.0)	19 (8.2)	NA	NA
Beat	19 (9.0)	20 (10.0)	32 (13.8)	NA	NA
Private sex parties	8 (3.8)	2 (1.0)	14 (6.0)	NA	NA
Sex workers	9 (4.3)	4 (2.0)	4 (1.7)	NA	NA
Total (not mutually exclusive)	**210**	**200**	**232**		

1 Prior to 2018, the questionnaire listed ‘gay saunas’ and ‘sex venues’ as separate items. They have been combined here.

2 Prior to 2018, the questionnaire listed meeting men ‘In other Australian cities’ and ‘Elsewhere in Australia’ as separate items. They have been combined here.

Table 10: Agreements with regular male partners about sex within the relationship

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
No agreement about sex within the relationship	52 (40.0)	33 (29.5)	50 (37.9)	ns	ns
No sex within the relationship permitted	1 (0.8)	3 (2.7)	4 (3.0)	NA	NA
No anal intercourse permitted	4 (3.1)	5 (4.5)	3 (2.3)	NA	NA
Anal intercourse permitted only with a condom	22 (16.9)	17 (15.2)	17 (12.9)	NA	NA
Anal intercourse permitted without a condom	51 (39.2)	54 (48.2)	58 (43.9)	ns	ns
Total	**130 (100)**	**112 (100)**	**132 (100)**		

Note: This table only includes data from men who reported that they had a regular male partner in the six months prior to the survey.

Table 11: Agreements with regular male partners about sex outside the relationship

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
No agreement about casual sex	48 (36.9)	39 (34.8)	46 (34.9)	Ns	Ns
No sex with casual partners permitted	61 (46.9)	40 (35.7)	44 (33.3)	ns	Decrease $p<.05$
No anal intercourse with casual partners permitted	1 (0.8)	7 (6.3)	7 (5.3)	NA	NA
Anal intercourse with casual partners permitted only with a condom	17 (13.1)	20 (17.9)	25 (18.9)	NA	NA
Anal intercourse with casual partners permitted without a condom	3 (2.3)	6 (5.4)	10 (7.6)	NA	NA
Total	**130 (100)**	**112 (100)**	**132 (100)**		

Note: This table only includes data from men who reported that they had a regular male partner in the six months prior to the survey.

Table 12: Match of HIV status between regular partners

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
HIV-positive men					
Seroconcordant	2 (40.0)	4 (36.4)	3 (37.5)	NA	NA
Serodiscordant	0	2 (18.2)	2 (25.0)	NA	NA
Serononconcordant	3 (60.0)	5 (45.5)	3 (37.5)	NA	NA
Total	**5 (100)**	**11 (100)**	**8 (100)**		
HIV-negative men					
Seroconcordant	79 (68.1)	68 (62.4)	87 (70.2)	ns	ns
Serodiscordant	4 (3.4)	3 (2.8)	6 (4.8)	NA	NA
Serononconcordant	33 (28.4)	38 (34.9)	31 (25.0)	ns	ns
Total	**116 (100)**	**109 (100)**	**124 (100)**		

Note: This table only includes data from men who reported that they had a regular male partner in the six months prior to the survey.

Table 13: Anal intercourse and condom use with regular partners

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
No anal intercourse	18 (11.8)	22 (16.4)	27 (17.5)	NA	NA
Always uses a condom	30 (19.7)	17 (12.7)	14 (9.1)	NA	NA
Sometimes does not use a condom	104 (68.4)	95 (70.9)	113 (73.4)	ns	ns
Total	**152 (100)**	**134 (100)**	**154 (100)**		

Note: This table only includes data from men who reported that they had a regular male partner in the six months prior to the survey.

Table 14: Condomless anal intercourse with regular partners, by match of HIV status

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
HIV-positive men					
Seroconcordant CAIR	1 (20.0)	2 (18.2)	3 (37.5)	NA	NA
Not concordant CAIR	0	6 (54.5)	3 (37.5)	NA	NA
No CAIR	4 (80.0)	3 (27.3)	2 (25.0)	NA	NA
Total	**5 (100)**	**11 (100)**	**8 (100)**		
HIV-negative men					
Seroconcordant CAIR	55 (47.4)	53 (48.6)	72 (58.1)	ns	ns
Not concordant CAIR	24 (20.7)	24 (22.0)	9 (15.3)	NA	NA
No CAIR	37 (31.9)	32 (29.4)	33 (26.6)	ns	ns
Total	**116 (100)**	**109 (100)**	**124 (100)**		

Note: This table only includes data from men who reported that they had a regular male partner in the six months prior to the survey.

Table 15: Anal intercourse and condom use with casual partners

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
No anal intercourse	11 (11.6)	26 (24.3)	16 (14.6)	ns	ns
Always uses a condom	34 (35.8)	40 (37.4)	27 (24.6)	Decrease $p<.05$	ns
Sometimes does not use a condom	50 (52.6)	41 (38.3)	67 (60.9)	Increase $p<.001$	ns
Subcategories of men who did not always use condoms:					
HIV-positive on treatment with undetectable viral load	3 (3.2)	6 (5.6)	4 (3.6)	NA	NA
HIV-negative on PrEP	0	4 (3.7)	23 (20.9)	NA	NA
HIV-positive not on treatment or detectable viral load	0	1 (0.9)	1 (0.9)	NA	NA
HIV-negative/untested not on PrEP (only insertive anal intercourse)	11 (11.6)	13 (12.1)	11 (10.0)	NA	NA
HIV-negative/untested not on PrEP (any receptive anal intercourse)	36 (37.9)	17 (15.9)	28 (25.5)	NA	NA
Total	**95 (100)**	**107 (100)**	**110 (100)**		

Note: This table only includes data from men who reported that they had any casual male partners in the six months prior to the survey.

Table 16: Any condomless anal intercourse with casual partners, by HIV status of participants

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
HIV-positive men	3 (42.9)	7 (70.0)	5 (71.4)	NA	NA
Total	**7 (100)**	**10 (100)**	**7 (100)**		
HIV-negative men	35 (50.7)	31 (38.3)	52 (60.5)	Increase $p<.01$	ns
Total	**69 (100)**	**81 (100)**	**86 (100)**		
Untested/unknown status men	12 (63.2)	3 (18.8)	10 (58.8)	NA	NA
Total	**19 (100)**	**16 (100)**	**17 (100)**		

Note: This table only includes data from men who reported that they had any casual male partners in the six months prior to the survey. Untested and unknown status includes men who have never been tested for HIV and men who have been tested but do not know their results.

Table 17: Disclosure of HIV status to or from casual partners, by HIV status of participants

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
HIV-positive men					
Told casual partners	5 (83.3)	6 (66.7)	4 (66.7)	NA	NA
Told by casual partners	5 (83.3)	4 (44.4)	3 (50.0)	NA	NA
Total (not mutually exclusive)	**6**	**9**	**6**		
HIV-negative men					
Told casual partners	48 (70.6)	53 (67.9)	63 (77.8)	ns	ns
Told by casual partners	48 (70.6)	53 (67.9)	61 (75.3)	ns	ns
Total (not mutually exclusive)	**68**	**78**	**81**		

Note: This table only includes data from men who reported that they had any casual male partners in the six months prior to the survey.

Table 18: Consistent disclosure of HIV status to casual partners among men who engaged in condomless anal intercourse, by HIV status of participants

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
HIV-positive men who disclosed to all	1 (33.3)	2 (28.6)	3 (60.0)	NA	NA
Total	**3 (100)**	**7 (100)**	**5 (100)**		
HIV-negative men who disclosed to all	15 (42.9)	14 (45.2)	31 (59.6)	NA	NA
Total	**35 (100)**	**31 (100)**	**52 (100)**		

Note: This table only includes data from men who reported that they had any CAIC in the six months prior to the survey.

Table 19: Men who frequently used risk reduction strategies when engaging in condomless anal intercourse with casual partners, by HIV status of participants

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
HIV-positive men					
Ensured partners were seroconcordant before CAIC (serosorting)	2 (66.7)	2 (28.6)	1 (20.0)	NA	NA
Took receptive position during CAIC when partners were not concordant	0	1 (14.3)	2 (40.0)	NA	NA
Participant withdrew before ejaculation when he was insertive	0	1 (14.3)	1 (20.0)	NA	NA
Participant knew he had an undetectable viral load before having sex	2 (66.7)	6 (85.7)	3 (60.0)	NA	NA
Participant knew partner was on PrEP before sex	-	-	3 (60.0)	NA	NA
Total (not mutually exclusive)	**3**	**7**	**5**		
HIV-negative men					
Ensured partners were seroconcordant before CAIC (serosorting)	19 (54.3)	15 (48.4)	29 (55.8)	NA	NA
Took insertive position during CAIC when partners were not concordant	2 (5.7)	4 (12.9)	4 (7.7)	NA	NA
Partner withdrew before ejaculation when participant was receptive	3 (8.6)	3 (9.7)	1 (1.9)	NA	NA
Ensured HIV-positive partner had an undetectable viral load before having sex	2 (5.7)	3 (9.7)	7 (13.5)	NA	NA
Participant took PrEP before sex	1 (2.9)	5 (16.1)	21 (40.4)	NA	NA
Participant knew partner was on PrEP before sex	-	-	27 (51.9)	NA	NA
Total (not mutually exclusive)	**35**	**31**	**52**		

Note: This table only includes data from men who reported having CAIC in the six months prior to the survey.

Table 20: STI testing among HIV-positive men in the 12 months prior to the survey

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
Anal swab	7 (63.6)	6 (31.6)	8 (61.5)	NA	NA
Throat swab	8 (72.3)	5 (26.3)	8 (61.5)	NA	NA
Penile swab	4 (36.4)	2 (10.5)	4 (30.8)	NA	NA
Urine sample	10 (90.9)	12 (63.2)	11 (84.6)	NA	NA
Blood test other than for HIV	9 (81.8)	11 (57.9)	10 (76.9)	NA	NA
Blood test for syphilis	9 (81.8)	10 (52.6)	9 (69.2)	NA	NA
Any STI test (not including blood tests)	10 (90.9)	12 (63.2)	11 (84.6)	NA	NA
Any STI test (including blood tests)	11 (100)	13 (68.4)	11 (84.6)	NA	NA
Total (not mutually exclusive)	**11**	**19**	**13**		

Table 21: STI testing among HIV-negative men in the 12 months prior to the survey

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
Anal swab	51 (34.2)	50 (35.0)	76 (44.7)	ns	Increase *p*<.05
Throat swab	56 (37.6)	53 (37.1)	81 (47.7)	ns	ns
Penile swab	37 (24.8)	24 (16.8)	39 (22.9)	ns	ns
Urine sample	75 (50.3)	77 (53.8)	95 (55.9)	ns	ns
Blood test other than for HIV	79 (53.0)	82 (57.3)	95 (55.9)	ns	ns
Blood test for syphilis	74 (49.7)	77 (53.8)	93 (54.7)	ns	ns
Any STI test (not including blood test)	79 (53.0)	79 (55.2)	101 (59.4)	ns	ns
Any STI test (including blood tests)	97 (65.1)	98 (68.5)	120 (70.6)	ns	ns
Total (not mutually exclusive)	**149**	**143**	**170**		

Table 22: Recreational drug use among all men in the six months prior to the survey

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
Cannabis	65 (31.0)	56 (28.0)	61 (26.3)	ns	ns
Amyl	39 (18.6)	50 (25.0)	65 (28.0)	ns	Increase *p*<.05
Ecstasy	14 (6.7)	20 (10.0)	23 (9.9)	NA	NA
Amphetamine (speed)	12 (5.7)	6 (3.0)	19 (8.2)	NA	NA
Crystal methamphetamine	8 (3.8)	10 (5.0)	7 (3.0)	NA	NA
Viagra	23 (11.0)	30 (15.0)	50 (21.6)	ns	Increase *p*<.01
Cocaine	6 (2.9)	9 (4.5)	21 (9.1)	NA	NA
Ketamine (special K)	4 (1.9)	1 (0.5)	7 (3.0)	NA	NA
GHB	5 (2.4)	3 (1.5)	4 (1.7)	NA	NA
Heroin	4 (1.9)	0	1 (0.4)	NA	NA
Steroids	6 (2.9)	0	3 (1.3)	NA	NA
Other drugs	14 (6.7)	14 (7.0)	22 (9.5)	NA	NA
Total (not mutually exclusive)	**210**	**200**	**232**		
Number of drugs used					
None	114 (54.3)	98 (49.0)	115 (49.6)	ns	ns
One or two drugs	72 (34.3)	74 (37.0)	74 (31.9)	ns	ns
More than two drugs	24 (11.4)	28 (14.0)	43 (18.5)	ns	Increase *p*<.05
Total	**210 (100)**	**200 (100)**	**232 (100)**		

Table 23: Injecting drug use in the six months prior to the survey, by HIV status of participants

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
All men	8 (3.8)	3 (1.5)	5 (2.2)	NA	NA
Total	**210 (100)**	**200 (100)**	**232 (100)**		
HIV-positive men	1 (9.1)	3 (15.8)	2 (15.4)	NA	NA
Total	**11 (100)**	**19 (100)**	**13 (100)**		
HIV-negative men	6 (4.0)	0	3 (1.8)	NA	NA
Total	**149 (100)**	**143 (100)**	**170 (100)**		

Table 24: Party drug use and group sex in the six months prior to the survey

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
Used party drugs for sex	18 (8.6)	16 (8.0)	23 (9.9)	NA	NA
Engaged in group sex during or after drug use	13 (6.2)	4 (2.0)	15 (6.5)	NA	NA
Total (not mutually exclusive)	**210**	**200**	**232**		

Table 25: Knowledge and use of pre- and post-exposure prophylaxis

	2014 *n* (%)	2016 *n* (%)	2018 *n* (%)	Change from 2016 (*p*-value)	Trend over time (*p*-value)
Belief that PEP is available now (all men)	69 (32.9)	97 (48.5)	129 (55.6)	ns	Increase $p<.001$
Total	**210 (100)**	**200 (100)**	**232 (100)**		
Belief that PrEP is available now (all men)	33 (15.7)	101 (50.5)	162 (69.8)	Increase $p<.001$	Increase $p<.001$
Total	**210 (100)**	**200 (100)**	**232 (100)**		
Use of PEP by non-HIV-positive men in the six months prior to the survey	1 (0.5)	4 (2.2)	8 (3.7)	NA	NA
Total	**199 (100)**	**181 (100)**	**219 (100)**		
Use of PrEP by non-HIV-positive men in the six months prior to the survey	1 (0.5)	6 (3.3)	32 (14.6)	NA	NA
Total	**199 (100)**	**181 (100)**	**219 (100)**		

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ORIGINAL ARTICLE

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Tasmanian healthcare professionals' & students' capacity for LGBTI + inclusive care: A qualitative inquiry

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Abstract

The health disparities and care needs of lesbian, gay, bisexual, transgender and intersex (LGBTI+) patients are becoming well known. However, healthcare practitioners (HCPs) and medical students across the Global North report limited understanding of this population and express concern about their capacity to meet the needs of LGBTI + patients. To address these gaps in literature and practice, this study draws on qualitative interviews with 12 clinicians and five health professional students exploring their understandings and approaches to LGBTI + inclusive practice in Tasmania, Australia. Through a reflexive thematic analysis, we identified that both practicing clinicians and students did not believe that their training adequately prepared them to treat LGBTI + patients. Other key *barriers* included reduced awareness of LGBTI + community needs due to the lack of exposure to LGBTI + patients and unfamiliarity with appropriate referral pathways in the regional Tasmanian context. Conversely, factors *enabling* provision of LGBTI + inclusive care included prior experience working with LGBTI + patients and establishing a network of supportive colleagues and local services. Participants who identified as LGBTI + themselves saw their personal experiences as a strength in supporting LGBTI + patients. While awareness of LGBTI + inclusive health practice is increasing, Tasmanian practitioners report insufficient training and practical difficulties with referral as key challenges.

KEYWORDS
Australia, gender, inclusive practice, LGBTI health, sexuality

1 | INTRODUCTION

As the rights of lesbian, gay, bisexual, transgender and intersex (LGBTI+) people have variously improved in the Global North, albeit with many disparities and with differences across spaces, research has increasingly focused on the capacity of healthcare practitioners (HCPs) to provide healthcare that is either culturally competent or inclusive. We use the term 'LGBTI + inclusive healthcare' in this article, although cultural competence is frequently used in the US and Canadian literature. Numerous studies have concluded that LGBTI + inclusive healthcare is important in delivering optimised healthcare, including alcohol treatment and mental health (McNair et al., 2018), HIV prevention, including pre-exposure prophylaxis (Maloney et al., 2017; Smith, Holt, Hughes, Truong, & Newman, 2019), sexual and reproductive health (Grant & Nash, 2019; Logie et al., 2019; Malmquist & Nelson, 2014), cancer treatment (Quinn et al., 2015), dementia care (Price, 2010) and aged care (Waling et al., 2019). Access to and provision of high-quality healthcare, free from discrimination, pertaining to diverse sexual orientation, gender identity, gender expression and sex characteristics is an explicit right in the Yogyakarta Principles plus 10, the highest level international human rights instrument pertaining to LGBTI + people (Yogyakarta Principles plus10, 2017; Zeeman et al., 2019).

Qualitative research on LGBTI + inclusive healthcare presents numerous issues regarding the interactions between HCPs and LGBTI + patients. Lesbian, bisexual and queer women in multiple Canadian studies held low expectations of their HCPs' capacity to provide culturally competent care, and instead hoped that, at the very least, HCPs would not be discriminatory (Baker & Beagan, 2014; Heyes, Dean, & Goldberg, 2016). Although HCPs may feel that it is medically appropriate to approach every patient in an equal way, this frequently translated to a neutralising stance that ignored the diverse needs of LGBTI + patients by maintaining cisgender heterosexuality as the assumed norm (Baker & Beagan, 2014). It is common for HCPs to assume that patients are not diverse in their sexuality and/or gender unless otherwise disclosed by the patient (McGlynn et al., 2020). However, young LGBTI + Australians have reported feeling uncomfortable disclosing their identity to HCPs due to fears of experiencing homophobia or transphobia (Robinson, Bansel, Denson, Ovenden, & Davies, 2014). LGBTI + people often look for cues or signs from their HCP that disclosing is safe and will be met positively, such as their HCPs' use of gender-neutral terms such as ‘partner’ rather than assuming ‘boy/girlfriend’, and the presence of LGBTI-friendly posters, badges, stickers and declarations in waiting rooms that diversity is welcome (Grant, Nash, & Hansen, 2020; Wilkerson, Rybicki, Barber, & Smolenski, 2011). LGBTI + inclusive healthcare therefore involves not just an openness to the LGBTI + patient who discloses their identity and experience, but also facilitating a clinical encounter in which LGBTI + people know that they are safe to bring their whole identity into the space (Utamsingh, Richman, Martin, Lattanner, & Chaikind, 2016).

Despite the well-documented need for LGBTI + inclusive healthcare internationally, clinicians report various difficulties treating LGBTI + patients including personal discomfort, unconscious bias or insufficient education and training (Hinchliff, Gott, & Galena, 2005; McNair, Hegarty, & Taft, 2015; Moe & Sparkman, 2015). A comprehensive understanding of LGBTI + medical curricula in Australia and New Zealand is lacking. One survey in Australia and New Zealand found an average of 0–5 teaching hours throughout an average medical course, which typically only addressed sexuality or sexual health, and usually focused on men who have sex with men (Sanchez, Southgate, Rogers, & Duvivier, 2017). Evidence suggests that inadequate curriculum development and learning activities shape medical students' attitudes towards LGBTI + patients. For example, Burke et al.'s (2015) study of the US medical undergraduates shows that nearly half of those surveyed held explicit bias against LGBTI + people, while the majority held some implicit or unconscious bias. Stroumsa, Shires, Richardson, Jaffee, and Woodford (2019) importantly noted that medical students may hold homophobic or transphobic views that must be challenged through medical education in order for key information about LGBTI + health and care provision to be learned. Although most HCPs are required to engage in continuous professional development as part of their ongoing professional registration, it is not clear what proportion of ongoing training addresses LGBTI + inclusive healthcare or LGBTI + topics. Furthermore, when this training exists, it is optional.

What is known about this topic

- Lesbian, gay, bisexual, transgender and intersex (LGBTI+) people experience a range of health disparities and barriers to quality health and community care.
- Healthcare practitioners (HCPs) frequently report limited knowledge and awareness of LGBTI + health and care needs.
- LGBTI + health and inclusive practice are often poorly integrated into medical curricula and training.

What this paper adds

- Rich insight into HCPs' and students' understandings and attitudes to LGBTI + inclusion in Tasmania, Australia.
- A qualitative consideration of the barriers and enablers for LGBTI + inclusive care among Tasmanian HCPs and students.
- An improved understanding of these issues, which may assist service providers, medical educators and the development of interventions to more effectively support and meet the needs of this population.

In the Australian Trans Pathways study—the largest survey of young Australian trans and gender diverse people—participants reported significant negative experiences with HCPs, including invalidation of identity, misgendering and refusal of services (Strauss et al., 2017). Although there were some positive stories in Trans Pathways, even stories of respectful HCPs reflected a lack of training and expertise, in which many trans people needed to educate their clinician about the kind of specialist care they needed. Australian trans people experience difficulties finding trans-inclusive services and HCPs, and this is amplified outside of major cities and in rural and remote areas (Heng, Heal, Banks, & Preston, 2019; Kerry, 2017).

It should be noted that in many parts of the world, movements championing intersex rights exist separately to LGBTI + movements. In Australia, intersex people are included as part of many LGBTI + organisations. However, the violations of the human rights of intersex people occurring through healthcare in Australia (Australian Senate. Community Affairs References Committee, 2013) are not always well understood or effectively advocated for outside of specific intersex organisations (Carpenter, 2016; Jones, 2018). Australian peer-based intersex organisations have compared historic and ongoing non-consensual surgery performed on intersex infants and children as analogous to female genital mutilation, which is legally prohibited as a human rights violation (Senate, 2013). Intersex-inclusive healthcare involves understanding that intersex people variously identify as cisgender, heterosexual, trans and/or non-heterosexual (Jones et al., 2016), but also that intersex people may have specific healthcare needs related to their intersex variation, and/or as a result of the non-consensual healthcare abuses enacted upon some intersex people in infancy or childhood (Carpenter, 2018).

Understanding and practice of LGBTI + inclusive healthcare are increasing in Australia. For example, the Royal Australian College of General Practitioners has produced guidelines for sensitive care for lesbian, gay and bisexual patients (see McNair, 2012). However, previous research highlights the need for further consideration of LGBTI + health in regional and rural areas (Staunton Smith & Haigh, 2019). The Australian state of Tasmania falls behind the nation on many key health indicators. For instance, compared with national averages, Tasmanians exhibit higher rates of obesity, smoking, disability, chronic illness and increased difficulty accessing health services (Australian Bureau of Statistics [ABS], 2014a; 2014b). In addition to this unique health profile, as the last Australian state to decriminalise homosexuality in 1997, Tasmania has a particular LGBTI + social history that arguably shapes contemporary LGBTI + health and well-being. While there is limited research examining LGBTI + health in the state of Tasmania, previous studies highlight barriers to inclusive services (Grant & Nash, 2019; Grant et al., 2020). For this reason, Tasmania is a compelling site to examine healthcare students' and clinicians' understandings and approaches to LGBTI + inclusive practice.

2 | METHODS

This article reports on interpretive qualitative interview data that were collected as a part of a broader mixed-methods study investigating HCPs' and students' understandings of LGBTI + inclusive practices in Tasmania, Australia from May to September 2019. Key research questions were: (a) How do Tasmanian HCPs and students understand and approach LGBTI + health? and (b) What are the challenges Tasmanian HCPs and students face in providing optimum care to LGBTI + patients? In addressing these questions, the project aimed to explore the knowledge and practices of both clinicians and students with a view to informing health policy, training and curriculum development.

The first phase of the broader study included an exploratory online survey using a validated questionnaire based in Sanchez et al.'s (2017) model, garnering 219 individual responses (207 valid at 75% complete). Inclusion criteria for the study were: >18 years of age, currently studying or working in a health-related field (e.g. medicine, nursing, paramedics and psychology) in Tasmania. Survey respondents were recruited via social media advertisements, a University staff newsletter and medical professional association newsletters and listservs. Following completion of the survey, respondents were then invited to express interest in being interviewed. This study only reports the data gathered from the qualitative interview stage of this study.

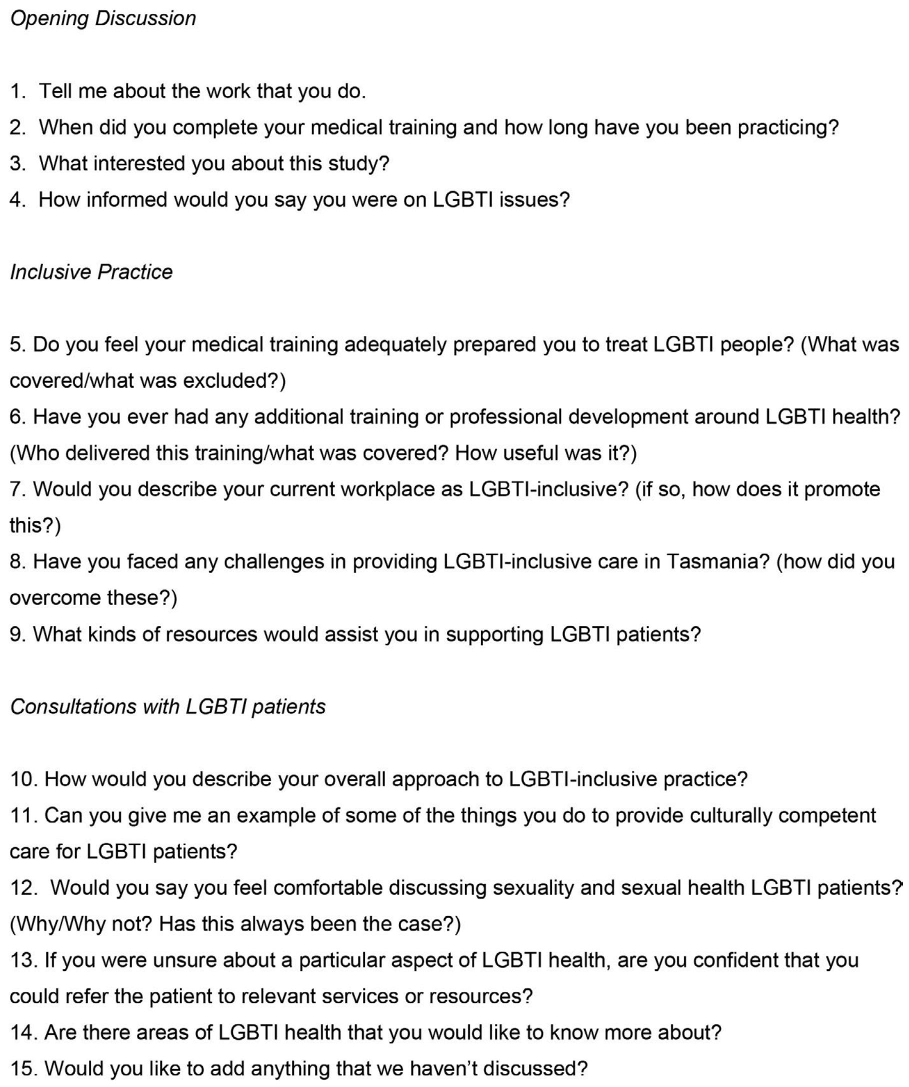
Seventeen participants were purposively selected from a larger pool of expressions of interest ($n = 42$). These specific participants were chosen to represent a range of professions and areas of study and to ensure representation of men and participants from diverse cultural backgrounds. Although this is a small sample, it meets the criteria for sample size outlined in Malterud, Siersma, and Guassora (2015) and Morse (2000) in relation to aims and scope of the study, study design, analysis strategy and quality of the data.

On obtaining participants' informed consent, semi-structured interviews were conducted by Author 3. The interviews lasted up to 1 hr and were conducted via telephone, Skype or in person at a University or participants' workplace. All interviews were conducted using an interview guide (see Figure 1) developed by Authors 1 and 4 building on the initial survey model and its emerging findings. This guide included a range of open-ended questions about participants' health professional training, professional development opportunities, clinical experiences and understandings of LGBTI + inclusive practice. Participants were also encouraged to reflect on any challenges they had faced (or anticipated) in providing LGBTI + inclusive care in their professional contexts in Tasmania. Some improvised follow-up questions were also deployed during interviews to build rapport and expand on individual participants' particular experiences. Interviews were audio-recorded with consent and transcribed verbatim. No compensation or reimbursement was provided as part of this study. The study received ethical approval from the University of Tasmania Social Science Human Research Ethics Committee (Ref: H0018092). In line with the committee's recommendations, data have been deidentified to ensure participant anonymity and confidentiality. Participants have been assigned numerical pseudonyms, and some general descriptors of their role are used to provide context in the reporting of data.

Interview transcripts were analysed using reflexive thematic analysis, with a focus on developing inductive codes that are identified during analysis, but also deductive codes that reflected our research questions (Braun & Clarke, 2006). QSR NVivo (v.11.2.2 Mac) was used as a software to organise data and codes. Author 2 immersed himself with the data, generated initial codes and then developed draft themes to collate patterns of meaning across the data (Braun & Clarke, 2006). Author 2 conferred twice with Author 1 to critically discuss coding and to workshop and refine themes. In developing the analysis and linking to broader literature, Author 2 went back to the data to ensure that the patterns of meaning described in this article reflected the data. All authors contributed to writing the manuscript.

3 | FINDINGS

This section explores qualitative data from the interview stage of the broader mixed-methods study. As outlined above, data have been analysed thematically using an interpretive qualitative methodology. Through this process, key themes relating to barriers and enablers for LGBTI + inclusive practice were developed. Specifically, key barriers included: insufficient training, lack of exposure to LGBTI + communities and difficulties referring LGBTI + patients. Conversely,



Opening Discussion

1. Tell me about the work that you do.
2. When did you complete your medical training and how long have you been practicing?
3. What interested you about this study?
4. How informed would you say you were on LGBTI issues?

Inclusive Practice

5. Do you feel your medical training adequately prepared you to treat LGBTI people? (What was covered/what was excluded?)
6. Have you ever had any additional training or professional development around LGBTI health? (Who delivered this training/what was covered? How useful was it?)
7. Would you describe your current workplace as LGBTI-inclusive? (if so, how does it promote this?)
8. Have you faced any challenges in providing LGBTI-inclusive care in Tasmania? (how did you overcome these?)
9. What kinds of resources would assist you in supporting LGBTI patients?

Consultations with LGBTI patients

10. How would you describe your overall approach to LGBTI-inclusive practice?
11. Can you give me an example of some of the things you do to provide culturally competent care for LGBTI patients?
12. Would you say you feel comfortable discussing sexuality and sexual health LGBTI patients? (Why/Why not? Has this always been the case?)
13. If you were unsure about a particular aspect of LGBTI health, are you confident that you could refer the patient to relevant services or resources?
14. Are there areas of LGBTI health that you would like to know more about?
15. Would you like to add anything that we haven't discussed?

FIGURE 1 Example interview guide for healthcare practitioners. LGBTI, lesbian, gay, bisexual, transgender and intersex

common enablers were identifying as LGBTI+, experience with LGBTI + patients and building inclusive practitioner networks.

3.1 | Participants

While information about age, gender, language spoken at home and professional role were gathered during interviews, 11 participants identified themselves as members of the LGBTI + community without prompting from the interviewer (although none of these participants identified as intersex; Table 1).

3.2 | Barriers to LGBTI + inclusive practice

3.2.1 | Insufficient training

The most common barrier reported by health students and clinicians was a lack of knowledge about LGBTI + health issues and inclusive practices resulting from insufficient training on the topic. When participants were asked if they had received any training regarding LGBTI + inclusive healthcare in their education, they explained:

> Not as of yet, no. Like, I don't know if there's going to be more content in the future, but as of now, no
>
> [P19 – student – medicine].

> I don't think I learnt anything about LGB – like treating LGBTI+ people in my university at all
>
> [P14 – clinician – naturopath].

> Not at all, not in the slightest. I mean I graduated quite a long time ago and we weren't even encouraged to ask about gender preferences and orientation and we were completely ignorant
>
> [P11 – clinician – GP].

TABLE 1 Participant demographics (*n* = 17)

Demographic characteristics	*N*
Age	
18–24	6
25–34	3
35–44	2
45–54	3
55+	3
Gender	
Women	10
Men	5
Non-binary	2
Identifies as member of the LGBTI + Community	11
Language spoken at home	
English	14
Mandarin	1
Cantonese	1
Arabic	1
Healthcare practitioners	12
Medical doctor/GP	4
Nurse	4
Psychologist/counsellor	3
Naturopath	1
Students	5
Medicine	2
Nursing	2
Pharmacy	1

Abbreviation: LGBTI, lesbian, gay, bisexual, transgender and intersex.

Echoing previous US research (see Burke et al., 2015), both clinicians and students reported little formal training on these topics. While older clinicians like P11 saw this as characteristic of the era when they were studying, current students also report limited coverage of LGBTI + health in their degrees. In line with Sanchez et al.'s similar findings in Australia and New Zealand (2017), this is concerning as it suggests that little has changed despite the growing awareness of the need for LGBTI + inclusive practice.

When LGBTI + health was included in medical curricula it was described as brief and with little detail or practical application:

> Well, the only time they've ever mentioned it is when we were looking at special patient groups, so elderly, babies, international people and they just mentioned that people in the LGBT community are special patient groups which you have to treat differently and be careful, but it was never anything specific … It was just like one dot point on a slide
>
> [P5 – student – pharmacy].

> Each week we have to practice history taking, because that is a skill we have to develop, so you get a hypothetical case with a hypothetical patient, and once we got a hypothetical patient that had – he was a male and he had a male partner and that kind of thing. So, they're kind of exposing us to that, but I wouldn't say we've had any overt education about it
>
> [P19 – student – medicine].

These students highlight that while some progress has perhaps been made, LGBTI + health remains a peripheral issue in their broader medical training and is not taught in depth or as a focused topic. Further, as previous studies have identified, when LGBTI + issues are taught these tend to focus on the sexual health of men who have sex with men (Sanchez et al., 2017).

3.2.2 | Lack of exposure

In addition to experiencing limited formal education or training about LGBTI + health, participants believed that a lack of social and professional exposure to LGBTI + individuals and communities was another barrier to providing LGBTI + inclusive care:

> A lot of people just don't think they've ever met someone [in the LGBTI+ community], and the ignorance comes from just lack of exposure
>
> [P9 – clinician – emergency medicine specialist].

> I guess I face LGBTI+ issues so rarely that I think the biggest challenge is just not experiencing it or having that ongoing practice, if that makes any sense
>
> [P14 – clinician – naturopath].

For these participants, limited social experience, such as having never met someone who publicly identifies as LGBTI+, compounded with a lack of formal education on LGBTI + health led to a feeling of unpreparedness to work with LGBTI + patients. While awareness of LGBTI + population needs was low in general, our participants highlighted transgender and intersex patients as groups that were especially misunderstood:

> Transgender; I think this one is quite tricky because I haven't experienced anyone or have any experience working with them. And so, I can't say, whether I have, or I haven't had any sort of challenges because I haven't experienced them
>
> [P3 – clinician – psychology].

> … intersex people, because I feel like my knowledge is lacking in that area and they're a minority – from my

> understanding, intersex people are a minority even within the LGBTI community. So, yeah
>
> [P19 – student – medicine].

Here, in line with Grant et al. (2020) findings, LGBTI + inclusive practice is seen as a niche issue requiring specific expertise that can only be gained through familiarity with the community and experience treating this population group regularly. Like P3, several participants identified transgender and intersex people as particular patient groups within the broader LGBTI + community that pose challenges, as many were unfamiliar with their specific health needs. P19 importantly identifies intersex people as a minority within the LGBTI + community, echoing the limited scholarly literature on the topic of intersex inclusive care. In addition to a lack of exposure to LGBTI + patients in a professional context, P9 also highlights that many HCPs and students do not have social exposure to LGBTI + individuals or communities. Following Stroumsa et al.'s (2019) recommendations for more reflective and community-based learning opportunities in medical school, our findings also suggest the need for greater awareness and engagement with local LGBTI + communities.

3.2.3 | Difficulty referring LGBTI + patients

Perhaps as a result of their limited training and reduced awareness of LGBTI + communities, participants were not aware of relevant referral pathways for LGBTI + patients:

> But in terms of resources about where do I refer somebody I wouldn't even know. And I'm a leader, I should know this stuff but if I don't know... it makes me think that other people wouldn't have a clue
>
> [P9 – clinician – emergency specialist doctor.

> I think that if I was caring for somebody that was transgender or anything really and I didn't know how to get them the support that they needed I'd think I'd find that quite stressful
>
> [P6 – clinician – nurse].

Participants' lack of awareness of existing referral pathways was also compounded by the scarcity of such services available in Tasmania, especially in rural areas:

> Particularly one of the hardest things in Tasmania is there's only one service
>
> [P16 – clinician – counsellor].

> ... there's not many services at all. There's a couple of sexual health services but I'm not really aware of any that are particularly LGBTI focused. So I think that makes it really hard. And Tassie's [Tasmania] such a small place that it's – again harder just to have all the services around that they might have on the mainland
>
> [P13 – student – medicine.

In rural areas with limited health services, greater pressure is placed on primary care to address a range of complex concerns. For this reason, it is important that LGBTI + inclusive principles are incorporated in generalist health settings, and that rural clinicians are familiar with referral pathways, including other local services and community resources. As the quotes above suggest, a dearth of services and unfamiliarity with appropriate referral pathways reduce clinicians' capacity to provide inclusive whole-patient care.

3.3 | Enablers for LGBTI + inclusive care

While participants noted several barriers or challenges they faced in providing LGBTI + inclusive care in Tasmania, in this section, we explore positive factors that enabled inclusive practices.

3.3.1 | LGBTI + identifying practitioners

As nearly 65% of the sample identified as LGBTI + themselves, sharing a LGBTI + identity with patients was a common strength noted by these participants:

> I feel like a lot of the stuff I know about LGBTI+ health I know from being a member of the community, not from medical school
>
> [P9 – clinician – emergency medicine specialist].

> I am a queer person myself and that's probably one of the biggest factors [helping understand LGBTI+ inclusive practice]. General media coverage and friends who are also queer have all helped as well
>
> [P7 – student – medicine].

> Just being gay myself, I know – I've educated myself a lot about transgender issues and things like that, so I feel like I would have some knowledge, something to go off whereas others may have no basic knowledge at all
>
> [P5 – student – pharmacy].

> I would say [I'm] well informed but there are still areas where I am learning and one of those things is in supporting people who identify as trans, which is kind of strange because that's a fairly recent thing for me that

> I identify as non-binary. The reason it's recent is there weren't words for that when I grew up
>
> [P15 – clinician – counsellor].

Here, participants suggest that being members of LGBTI + communities themselves, they are more aware of the issues faced this patient group. In contrast to participants who felt they had not been exposed to LGBTI + individuals, LGBTI + identifying participants note that community membership had been a key source of knowledge about LGBTI + health issues, contributing to their professional practice. However, P5 notes that identifying as gay did not automatically result in understanding all issues related to LGBTI + health, with transgender issues being something they had to learn about. Furthermore, as P15 demonstrates, LGBTI + identifying HCPs may also be in an ongoing process of learning about their own identities and how these relate to the broader LGBTI + community. Thus, while sharing an identity with a patient group is not a prerequisite for quality care, these participants felt it made them more empathetic towards minority patients and willing to self-educate on aspects of inclusive practice they were not familiar with.

3.3.2 | Experience working with LGBTI + patients

For participants who did not identify as LGBTI + themselves, approaches to LGBTI + inclusion developed with time and experience. Just as lack of exposure to LGBTI + individuals and communities was seen as a barrier to inclusive care, having clinical experience working with LGBTI + patients was a key factor contributing to confidence in this area:

> Initially the first few [transgender patients] had to inform me. I asked lots of questions and learnt from what they had to say, so I think over the years I've – again, nothing formal, but acquired a bit of knowledge just from the people I've looked after and the first few times, 'well I know nothing, tell me,' and they were kind enough to help me
>
> [P11 – clinician – GP].

Participants who did identify as LGBTI + still stressed the importance of learning from their patients:

> I actually work with transparency in so far as my clients are concerned so I encourage open communications whereby we regularly check in: where I'm going wrong, where I'm going right, ways they think I should improve. So taking it from the people themselves
>
> [P15 – clinician – counsellor].

Baker and Beagan (2014, p. 594) emphasise how health practitioners can promote inclusive clinical encounters by 'learning with' patients rather than 'learning about' them. In the present study, clinicians similarly note that their understandings and abilities to provide inclusive care developed through actively learning with LGBTI + patients rather than adopting the stance of an 'expert'. Participants also routinely drew upon the notions of patient/person-centred care and holistic care as important to approaching all of their patients.

3.3.3 | Building and accessing LGBTI + inclusive practitioner networks

In rural and regional Tasmanian contexts where participants noted limited awareness of LGBTI + community needs and fewer services, strength in LGBTI + inclusive practice was gained by making use of knowledgeable colleagues, referral networks and LGBTI + organisations:

> Yeah, we've got a really good relationship with the local sexual health people, so I'd – for instance, when I first had to break the news of HIV diagnosis, I just rang up the sexual health nurse who knows everything there is to know and said, "I don't know how to do this, I don't know what to say, what should I do?" And she was fantastic, sent me resources, told me what to say and how to say it and what to do next, and all that sort of stuff. Not only referring but helping me to deal with my issues with communicating that sort of news and treatment and all that sort of stuff and if I didn't know quite where to send people, I'd ask her as well
>
> [P11 – clinician – GP].

> I just have a disposition to try to keep myself up to date with [LGBTI knowledge]. If I think that I don't understand something, I'll go and ask. So, I'll go and ask TasCAHRD in Hobart if I need to understand the changes to things like PrEP or something like that. That sort of thing
>
> [P12 – clinician – nurse].

As participant accounts reveal, knowing where to refer patients or who to ask for advice or assistance empowered clinicians to support LGBTI + patients. However, while some participants highlighted networks that were important to maintaining LGBTI + inclusive practice, expertise was typically located in one or two organisations and participants worried about where else they could find locally relevant information, similar to the difficulties reported earlier in referring LGBTI + patients. In rural areas, LGBTI + inclusion is often left to singular 'change champions' in health services, making the delivery of holistic LGBTI-inclusive care fragile and conditional on individual clinicians (see Barrett & Stephens, 2012). As Barrett and Stephens (2012) note, this is an unsustainable model for rural communities, and more whole-clinic approaches to LGBTI + inclusion are needed. Although participants in this study emphasised the limited number of services available in Tasmania, they highlighted the importance of accessing or building networks with colleagues, services and local organisations.

Furthermore, while geographical location and limited available services were barriers both for LGBTI + health and for clinicians to provide inclusive care in rural areas, participants identified telehealth initiatives as helping to overcome these challenges. For example, one general practitioner described how teleconferencing had improved their ability to refer patients in isolated areas to specialist mental health services:

> Good access to things like telehealth, telemedicine, telepsych; in fact since we've been using telepsych, like Psych2U, that's made this process an awful lot easier because before we would have to try and find a psychiatrist who had some sort of experience or a psychologist. They're pretty thin on the ground, they're usually in Hobart, travel's an issue and people don't have great incomes so there's lots of barriers and removing as many barriers including distance and cost, those sorts of resources would be good
>
> [P11 – clinician – GP].

This participant highlights how initiatives like telehealth make specialist care more accessible for rural patients and enable practitioners to establish referral networks beyond their local area, where these services may not be available. However, practitioners were not always sure if these services would be LGBTI + inclusive, and identified the need for further resources to assist these services in providing LGBTI + inclusive care.

4 | DISCUSSION

Our study provides a unique and timely opportunity to identify key issues shaping clinicians' and students' approaches to LGBTI + inclusive healthcare provision in rural Australia, focusing on Tasmania. Based on the data, we identified various barriers and enablers for LGBTI + inclusion. In line with the existing literature, we found that HCPs were unlikely to learn about LGBTI + health and inclusive practice principles during their medical education. Current students also reported receiving limited information about LGBTI + health in their degrees so far. However, students reported higher levels of confidence and awareness of LGBTI + issues compared to HCPs. Students highlighted that specific areas of LGBTI + inclusion were especially lacking, particularly transgender and intersex health. Therefore, more understanding of what is currently taught in Australian medical schools is required to inform future development in this area.

A lack of formal training combined with limited social awareness of LGBTI + people can result in 'inappropriate curiosity' among HCPs, especially regarding trans and gender diverse patients (see also Shepherd, Hacknel, & Guise, 2019; Stroumsa et al., 2019), detracting from the quality of care these patients receive. In contrast, participants who identified as LGBTI + themselves believed that they had a greater understanding of LGBTI + inclusion and were more likely than cisgender/heterosexual colleagues to self-educate on LGBTI + health issues. However, given that there are important differences between various LGBTI + identities and people, belonging to one aspect of the LGBTI + spectrum does not necessarily translate to interest and expertise with others, and this was reflected by some cisgender gay participants who were not familiar or confident with transgender or intersex topics.

Although reduced awareness due to limited training and exposure was seen as a barrier to inclusive care, clinicians emphasised that gaining experience treating LGBTI + patients helped to address their gaps in knowledge. Echoing previous research, practitioners reported being educated on LGBTI + inclusion by patients themselves, which they saw as a positive experience. Although some scholars argue that this approach places undue burden on marginalised groups to educate their HCPs, some empirical studies suggest that patients prefer clinicians who are willing to educate themselves with an open mind (Heng et al., 2019; Heyes et al., 2016; Strauss et al., 2017). In light of this, Baker and Beagan (2014) stress the difference between 'learning about' minority patient groups and 'learning with' patients themselves. We argue that healthcare providers and medical students require additional support in building foundational skills to learn *with* LGBTI + patients, both through formal education and workplace training.

Clinicians and students reported a lack of awareness of referral pathways for LGBTI + patients. This was noted as an issue specific to their context, given the statewide socioeconomic and health service disparities experienced in comparison to more populous cities in mainland Australian states. To address this, participants stressed the importance of building local networks with other LGBTI + inclusive colleagues, services and organisations to draw on the strength of their collective expertise and networks. Some participants also mentioned that telehealth and other flexible healthcare services and support were especially important but were unsure if these were LGBTI + inclusive. We suggest that information about such networks, or how to establish them, be further incorporated in formal education and workplace training, particularly in rural and regional areas.

Given the study's small sample size and the self-selected method, this research can only provide a 'snapshot' into a particular group of clinicians and students. Although this study aimed to investigate the understandings and experiences of a specific group, and therefore did not aim to be generalisable, it is notable that the self-selected sampling method produced a sample biased towards younger women, many of whom were nurses or medical students. While it was useful to explore the understandings and experiences of professionals from different healthcare disciplines, the small sample means that participant accounts should not necessarily be interpreted as generalisable to their fields more broadly. The self-selected sampling approach was also unlikely to capture those with anti-LGBTI + views or those with less interest or experience with LGBTI + patient groups, suggesting that the higher levels of confidence/comfort treating these populations reported in this study may be biased. These results are also somewhat limited by their focus on clinicians' and students' self-assessed competence in providing LGBTI + inclusive care rather than more objective measures of knowledge and practice.

Despite these limitations, we argue that our results make an important empirical contribution to literature and practice, with the key findings being conceptually transferable in a range of contexts (see Kitto, Chesters, & Grbich, 2008). Although awareness of LGBTI + health issues is arguably increasing in Australian healthcare, few Australian studies have qualitatively examined clinicians' and students' lived experiences and challenges in providing LGBTI + inclusive care. In doing so, this article contributes new insight into the barriers and enablers students and HCPs face in LGBTI + inclusive healthcare provision. By focusing on Tasmania specifically, this research also contributes to further understanding of LGBTI + healthcare provision in regional and rural areas. Unlike previous Australian research, the high proportion of clinician and student participants identifying as LGBTI + themselves provides a new perspective on inclusive healthcare that warrants further exploration in future research.

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Women's Health Tasmania

Talking to LGBTIQ+ women about health, Tasmania 2020

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Background

A word about definitions and language

The letters LGBTIQ+ stand for Lesbian, Gay, Bisexual, Transgender, Intersex and Queer. The plus symbol (+) at the end acknowledges and includes the myriad of identities that exist beyond those six labels.[1]

Sexuality, gender identity and bodies are diverse. The words we use to talk about ourselves, our relationships and our bodies are important. Words and their meanings can change over time. We have included an appendix with definitions of some words used in this report (Appendix 2).

Our discussions with women who identified with one or more identity captured in the LGBTIQ+ definition provoked much reflection on how health systems struggle to take a holistic view of a person, instead understanding people only as their "presenting issue."

Our health systems often maintain a rigid distinction between male and female bodies and the ways in which gender maps onto these. Our conversations were open to anyone who identified as a woman. We also talked to people who were assigned female at birth but now identified as non-binary. These people elected to be involved because of their life experiences navigating women's health systems.

We acknowledge there are both distinct and overlapping issues for trans men and non-binary people assigned female at birth in accessing health services. More consultation and research are required to understand how trans men and non-binary people navigate health systems.

Who did we talk to?

We talked with 15 women across two focus groups and conducted several one-on-one interviews. We also spoke with one person who identified as non-binary and was assigned female at birth.

The women and people we spoke to range in age from their 20s to 70s, but the majority were under 40 years old (20-29 year olds making up 40% and 30-39 year olds making up 20%).

They lived in seven different postcodes and we held interviews and consultation groups in Burnie and Hobart.

While everyone's main language at home was English, 20% of them were born overseas, including non-English speaking Asian and European countries.

More than half of those we spoke to had been diagnosed with a mental health illness (53.22%).

A third of the people we spoke to were living on low incomes; 33% held a health care card or pensioner concession card.

This report also includes data from our statewide online survey on women's health, conducted in 2019. The survey received 462 responses and 79 respondents (17%) identified as lesbian, gay, bisexual, transgender, intersex, queer or another identity around gender/sexuality.

How did we reach them?

To reach women for these consultations we used the Women's Health Tasmania networks through our social media, enews and newsletter.

We also received promotional support from Working It Out, Tasmania's gender, sexuality and intersex status support and education service. Working It Out is a non-government organisation working with the LGBTIQ+ community in Tasmania for over 20 years. Working It Out maintain networks with the LGBTIQ+ community around Tasmania. We also reached out to health services in North West Tasmania listed in the LGBTIQ+ service directory, Signpost, to promote the project.

We are very grateful to Connect4Life LGBTIQ+ social group in the North West for their assistance in promoting the consultation in Burnie, Working It Out's support across the state and the Queering Health Reading Group in the South.

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[1] We use this abbreviation throughout this paper. However, when discussing other people's research, we use the language and abbreviations that they have used.

What did we hear?

What's working well?

Place, home and relationships

Women told us how environments and having a safe home kept them well.

Home

Women told us having a safe home was essential part of their health and wellbeing. Homes allowed women to engage with supportive partnerships and families of choice.

Home was also a place where personal mental health strategies could be implemented. Women discussed how they implemented personal strategies that they have learnt in response to discrimination as a way of managing mental health problems. These included adopting resilient attitudes, making time for sadness, personal hobbies and relaxing activities. These were all seen as ways of combating depression and anxiety.

Geography/place

Women placed a high value on where they lived and access to outdoor spaces. The bush and beautiful natural places were important to mental health and were recognised as places of sanctuary from discrimination.[2] For the participants living in the bush and being in nature provided a safe boundary between work and home life.

The women consulted in Hobart said that there was a relative feeling of safety on the streets and using public transport. However, these women also recalled firsthand experiences of verbal assault on the street directly related to their gender identity or sexuality. These past experiences of harassment and assault continued to impact on the women and the way they understood safety. Being able to get around towns and cities safely was valuable and not taken for granted.

Access to amenities

Women talked about places near them where it was possible to access cheap or free vegetables and fruit and this resource allowed them to maintain their health. The importance of being able to access shops, entertainment and to have things happening in their area was also important to the women.

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[2] The importance of place is discussed in research with older lesbian women living in regional Tasmania. See *Visual Herstories: Older Lesbian's Health, Wellbeing and Community Connection in Rural Tasmania Progress Report.* (2020). Dr Ruby Grant and Briohny Walker. (copy on file).

Social connection and LGBTIQ+ specific community groups

Social connection through activities organised for the LGBTIQ+ community were cited as important spaces. Where funded support services were insufficient, community organised activities could become the main or only source of support for LGBTIQ+ women.

Women living in regional areas noted LGBTIQ+ community organised events provided a lifeline and 'third space' for LGBTIQ+ women and people. The LGBTIQ+ community was also active in educating the broader community and changing discriminatory attitudes.

Although these social connection opportunities were highly prized, the women also acknowledged the work, time and emotional labour that went into organising these activities and networks.

" ...I get a lot personally out of educating and seeing other people grow... if I hadn't had those sort of supports myself I wouldn't be here. But it's also brought me a lot of stress, it's one of the reasons I am now doing [other things] because I need some time out."

Inclusion at work and in the community

Women told us about the positive mental health impacts of being included both at work and in the community. Women told us arts events were often inclusive spaces and some had positive experiences of inclusion at work.

The women defined inclusion as a sense that diversity was the norm. Women said inclusion came about when differences in sexuality, gender and bodies are considered valid and an everyday part of life.

Actions that signalled inclusion were things such as smiling, positive body language, having a welcoming attitude and including people in everyday conversations. Women found this gave them a sense of shared values and the sense their lives were respected and valid.

"I don't feel I have to closet myself [at work]. They care less about sexuality, and what you're doing outside of work so long as it sounds fun and interesting.... [it's] been really wonderful from a mental health perspective because you're not stifled at work ... which I am sure every queer woman has experienced in her life."

What’s *not* working well?

Access and cost of mental health support

Women told us their experience of accessing mental health support was expensive, limited and involved having to wait a long time to gain access. There was a perception that people with independent funds accessed a less complex and more timely pathway to ongoing, needs-based mental health support.

Women told us about waiting months to get psychology appointments and that the 10 sessions allocated through mental health plans were not enough in their experience. Women said the gap fees for many psychologists were a financial burden. For women with acute needs for mental health support, the 10 sessions were not enough, and they used savings to pay psychology fees, or went without.

Women described how ‘good’ psychologists have longer waiting lists and for LGBTIQ+ women the pool of inclusive mental health practitioners was quite small, exacerbating the length of waits.

Women also described how the circumstances of daily life such as socio-economic disadvantage, living with chronic health conditions and the inaccessibility of health services came together to make getting help difficult.

Work pressure, insecure work, the inability to find time and space for self-care and societal expectations around how people ‘should’ function (despite living with a chronic condition) were barriers to pursing health care. Women were also critical of the ‘mutual obligations’ placed on those on Centrelink payments, especially when managing poor health.

“[taking time out to work on my mental health] meant going onto a single income. Because I get nothing from the government because [my wife’s] income is just a little bit too high. So [she] has been supporting me… [it’s] put a lot of strain on us because I have a lot of health issues, a lot of medical costs and no concession card. But you know, when she realised it was like ‘I need to stop working or I’m going to not be here in 6 months’ time’ it was just, do whatever you need to do.”

A lack of community services and face to face contact

Women from Burnie told us how a lack of community services on the ground presents difficulties for LGBTIQ+ women.

The women said community social groups took the lead in providing safe spaces and support for LGBTIQ+ people. Although they recognised this was a sign of a healthy community, it was also acknowledged this could and did have mental health impacts for community members.

Not having the depth of health services on the ground in the North West also meant travelling to a different part of the state to access medical specialists. Transgender women told us endocrinology appointments for support around hormone therapy were hard to get in Burnie. The women travelled to Launceston as there were generally more appointments available. This travel added cost, time and presented issues for trans women who did not have access to a car or were on low incomes.

Women had mixed responses to telehealth as an option for accessing health care. Some women reported positive experiences, but this came with an understanding that telehealth was not appropriate for every kind of appointment. Other women told us that accessing psychiatric support via telehealth was inadequate. Across both groups there was a desire for face to face contact, especially when tackling complex or sensitive health issues.

Health care for trans and gender diverse women

“There is one transgender friendly doctor [that I know of] but she’s really hard to get into.”

“I asked my GP how many trans patients do you have? They said, ‘you’re the first’ and I said ‘no I’m not, I am just the first you know about.’”

The women said lack of knowledge and options for trans-informed health care was a barrier for transgender women’s health and wellbeing.

Trans women we spoke to said it was rare to access a doctor who understood important elements of gender affirmation – either medically or socially. In other cases, medical professionals had outdated and harmful views about transgender people, believing that being transgender was a mental illness.[3] The women described these experiences as intensely negative and invalidating. Women we spoke to avoided interacting with these health professionals if they could – shrinking the pool of doctors who these women felt confident accessing.

Some transgender women we spoke to highly valued the Sexual Health Service[4] – the main publicly funded access point for transgender people who want to explore medical gender affirmation. Through this service the women said they could access endocrinology specialists, psychiatry, and other support.

"I've had countless experiences with doctors who just have no clue... I've had doctors try and use my being trans as a symptom of a ...personality disorder."

"There's no GPs who identify themselves as practitioners who know what they are doing with the trans community and a trans patients which … requires different skills and requires a different breadth of knowledge and most doctors just haven't been exposed to it and you end up having to teach your doctor and that's horrible. Having to teach your doctor 'what you are', and what you need and how to get it – that's exhausting! Like why would you go and get hormone therapy if you have to tell your doctor all of this other stuff about yourself and go through all of the history of what it means to be a trans person?"

"[There are] improved legal aspects around trans people and trans communities but I don't think that's necessarily translates to medicine."

Access to inclusive GPs

"It's difficult to have a worthwhile exchange with a doctor if you're not able to feel comfortable with them."

Women told us the lack of access to GPs they could trust to be inclusive was a barrier to health care. When GPs made assumptions regarding identity and health needs this reduced the ability for women to be open with their doctor. Examples included assuming the gender of someone's partner or the need for hormones or contraceptives. Women spoke about the burden of having to decide whether to 'correct' the assumptions their doctor made by disclosing their relationships, identity and needs.

Access to doctors with whom relationships were already formed or who were known to be inclusive were highly valued, but often these doctors had waiting lists. This meant women often had to access another GP who might not be an ally or wait weeks for an appointment.

Lack of access to inclusive GPs was also linked to a perceived high number of LGBTIQ+ women presenting at emergency for issues that could be dealt with by a GP.

The women told us in their experience, the health system had a low knowledge of LGBTIQ+ people's existence and health needs. General Practitioners were cited as needing more comprehensive training around health needs of LGBTIQ+ people and women.

"If you're LGBTIQ that difficulty is compounded. A small pool of GPs means there's less diversity among GPs, and so less options for inclusive or queer friendly doctors...so when your health system is under enormous strain as ours is, it's another level of difficulty for queer women."

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[3] Transgender health categories were reclassified from mental health disorders to sexual health issues by the World Health Organisation in 2018: World Health Organisation, *WHO: Revision of ICD-11 (gender incongruence/transgender) – questions and answers (Q&A)*, 2018. https://www.youtube.com/watch?v=kyCgz0z05Ik

[4] The Sexual Health Service operates Clinic 60 (Hobart) and Clinic 34 (Launceston) and an outreach service to the north west.

Affordability of primary health care

Women told us the cost of going to the GP was an issue and could sometimes deter them from attending to their health care.

Women who had moved to Tasmania from interstate noted the differences between health services here and on the mainland. The women said interstate, there were free health clinics and that it was easy to get an appointment on the same day of request. They also described bulk billing student health services which exist on the mainland. Women who had come from interstate said free and available services helped them access what they needed in a timely way.

Discrimination in health settings

Women told us discriminatory behaviour and attitudes presented clear barriers both in primary health and preventative health.

Women said the historical legacy of discrimination in medical and mental health settings continued to have negative impacts on LGBTIQ+ women.

Women discussed how gender and sexual diversity were considered mental disorders in the past. Medical systems and institutions had also had a history of not listening to women's knowledge about their bodies and needs. The women also spoke about their distrust of church-based medical and other institutions. Women provided examples of recent refusals of service by GPs because they "did not agree" with transgender identities.

Women told us they did not want to access health workers who held discriminatory views based on religious or other grounds. Some women living in rural Tasmania expressed concerns about the proposed Federal Religious Discrimination laws and what this would mean in regional areas where there were already limited options for primary health care.

The women said discrimination made it hard to access preventative health spaces and activities. For example, transgender women cited their concerns about changing facilities, bathrooms and the role of workers in these places to single out trans and gender diverse people in ways that were unfair and unwelcoming. Other women talked about exclusive cultures of some gyms and exercise spaces and implicit ideas that only certain kinds of bodies were allowed.

Siloed health services

The women told us maintaining health when living with chronic health conditions was burdensome. Women said a siloed approach to health care meant there was no 'one place' people could go to get their health care sorted. This put women in the position of needing to retell their story to multiple health professionals who were often scattered across the town or region. Women felt they essentially needed to be their own case managers – an overwhelming task especially if the person was also living on a low income.

Some of the women we spoke to also worked in health settings and they believed funding arrangements were rarely flexible or long-term enough for services to create innovative or holistic approaches.

A health system lacking in humanity

The women discussed what they saw as a lack of humanity and empathy in acute mental health care. The women related this to under-resourcing in mental health care. The use of restrictive practices in mental health settings were criticised as inhumane.

In this part of the conversation, the women described how health systems often reduced people to their behaviours or their illness rather than seeing the whole person. There was concern this narrow approach to health was bad for patients and an increase of resources would be needed to fix it.

What hasn't begun but needs to start?

Free, universal health care

Women told us cost continued to be an issue in all aspects of health including preventative health, mental health and medical care. Women said free health care available to everyone was vital.

The women told us free healthcare needed to include gender affirming medical care for transgender women and reproductive and gynaecological care for all women.

Holistic health spaces putting diversity at their core

The women wanted a shift in health systems towards holistic understandings of health and wellbeing. Women believed building systems with a focus on the different needs and diversity of service users would have immense benefits – for LGBTIQ+ women and the wider community.

Women said in order to change people's experiences of their health, the system needed to be changed to accommodate the diverse experiences, identities and needs of the people using the system. Multidisciplinary approaches were seen as giving people better access to a range of health professionals, information and activities.

Bringing sexuality, gender and body diversity into focus could mean new approaches to drug and alcohol programs and services around family violence in the LGBTIQ+ community. For preventative health spaces, this meant this meant designing environments where lots of different bodies and genders could fit in and find positive acceptance.

Women wanted "just to be able to go in and enjoy your body" without feeling body shame. The women placed emphasis on the need for public spaces where people of diverse genders, bodies and sexualities can exercise and do preventative health activities comfortably.

Mandatory, systemic training and education for health workers

The women wanted mandatory training in gender, sexuality and body diversity for everyone who worked in the health system. The women believed non-compulsory training already on offer was not valued or understood to be a core part of health worker practice and that as a result, the health workers who would benefit from such training rarely participate. Mandatory training was seen to be needed to ensure all workers understood they had a responsibility to be informed and up to date.

Further, women suggested specific training around transgender health and medical affirmation was needed and should be encouraged for all general practitioners. Transgender health and medical affirmation are developing areas of medical practice. General practitioners play a key role in supporting transgender people access medical gender affirmation.

Normalising transgender identities and experiences

Women believed the health system should work in ways to normalise transgender identities and experiences. They said work needs to be done within the health system to change the idea that being transgender is a mental illness. The women believed gender transition shouldn't be considered something outside of the ordinary, but rather something some people experience.

Visibility: Health services need to make it clear LGBTIQ+ people are a focus

LGBTIQ+ women wanted to know whom they can trust to provide a friendly, inclusive service. For the women this involved organisations and individuals taking action to become visible as having expertise and an inclusive approach.

There were two issues involved in this idea.

First, women told us they wanted to feel their identity was valued, recognised and respected from the very beginning of their contact with the service until its conclusion. From walking through the door, the words and options presented in paperwork as well as the interactions with workers and professionals in the health system – all were important in creating spaces where women felt safe. The attitudes, assumptions and visibility of workers played a significant role in feeling the service was inclusive.

Secondly, women felt there was much to be gained from health services taking a stronger stand on inclusion and being loud, visible and clearly in this space. Women suggested practical solutions to help LGBTIQ+ communities know who they could trust such as a list of inclusive health care providers.[5]

Documentation and access to notes and medical information

The women had concerns about what information about them was recorded and how to access to their own medical information. Some women described times when they felt things being written about them may have been incorrect or discriminatory. There were concerns that workers were not always accountable for the things they wrote. Women found accessing their own medical information and notes was difficult. They wanted systems that would enable them to have more access to their medical information.

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[5] Working It Out hosts an online Tasmanian service directory of LGBTIQ+ inclusive services called Signpost. Services opt into this list and create their own listing. Notably, Burnie has one listing on Signpost for a psychologist and no listings for General Practitioners.

Postscript: impacts of COVID-19

The consultations that inform this research project were conducted prior to the COVID-19 pandemic.

During the Tasmanian COVID-19 isolation period we made contact via email with some of our participants to hear how the isolation period was affecting them.

The shutdown of community spaces and events meant a sudden end to face to face LGBTIQ+ specific events, local sport events and community spaces. The women told us that isolation had brought immense challenges and these challenges were accentuated by existing vulnerabilities.

LGBTIQ+ community run events were a key place to socialise and be supported in their identities. Some women told us they felt cut off from LGBTIQ+ community and the support, recognition and celebration of their identities they found there. Without these events, women found themselves socially isolated at home or with families who could not provide the social and emotional support they got through peers. Online support via video calls, video meetings and phone support became the only way to access LGBTIQ+ community peer support. Those who accessed these supports described them as essential and valued them very highly.

Prior to recontacting the participants there had been media discussion of a possible presentation of the Religious Discrimination Bill in 2021. Women also felt a renewed worry concerning the proposed Bill and whether they were more vulnerable to adverse legislative changes during the crisis. Women reported anxiety about fronting up to unfamiliar health services as an LGBTIQ+ person if acute medical care was needed.

Appendix 1

General health

Our understanding of the health and wellbeing of LGBTIQ+ people in Australia is limited by a lack of a standardised data collection,[6] however the evidence that exists shows that LGBTIQ+ people have poorer health outcomes than the general population, particularly when we look at mental health.[7]

LGBT Australians report lower levels of general wellbeing than the overall population.[8] When we look at these statistics in terms of gender, young women (16-24 years old) rate their overall health as being much poorer than heterosexual young women.[9] LGBT people are also more likely to engage in risk behaviours such as alcohol consumption and drug use than the general population.[10]

Mental health

LGBTIQ+ people in Australia show higher levels of psychological distress[11] and are more likely to be diagnosed with depression or anxiety than the general population.[12]

Evidence also tells us that LGBTIQ+ people are more at risk of suicide and self-harm than the general population.[13]

Within the LGBTIQ+ community there are considerable differences in mental health across age and identity groups.

Young people

LGBT young people (16-19 years old) show the biggest disparities in terms of mental wellbeing when compared to the general population.[14] A 2017 study found 74.6% of transgender people aged 14 to 25 years old had been diagnosed with depression and 72.2% had been diagnosed with anxiety.[15]

People with an intersex variation

A recent Australian study with people who have an intersex variation showed the most commonly reported mental health diagnoses were depression, anxiety and PTSD.[16]

60% of the participants in this study had thought about suicide and 19% had attempted suicide because of issues around their congenital sex variation.[17] The respondents largely attributed their mental health issues to social responses to their differences, medical interventions or issues around sexuality or gender identity.[18]

Lesbians

Lesbians are twice as likely to experience depression and anxiety as heterosexual women.[19] Data from 2014 showed that 44% of lesbian women aged 16 to 27 experienced thoughts of suicide and 20% have attempted suicide.[20]

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[6] Australian Institute of Health and Welfare, *Australia's health 2018. Australia's health series no. 16. AUS 221*, 2018; National LGBTI Health Alliance, *The Statistics at a Glance: Mental Health of Lesbian, Gay, Bisexual, Transgender and Intersex People in Australia*, 2020. https://lgbtihealth.org.au/statistics/

[7] Most of the data used in this section of the report is from *Private Lives 2* (2012) a report of a national survey for Gay, Lesbian, Bisexual and Transgender people. The third iteration of this survey closed in 2019 and the *Private Lives 3 Report* is forthcoming.

[8] Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., & Couch, M. *Private lives 2: The second national survey on the health and wellbeing of gay, lesbian, bisexual, transgender (GLBT) Australians, 2012*, Melbourne: The Australian Research Centre in Sex Health and Society, La Trobe University. Page 27.

[9] Leonard et al (2012). Page 28.

[10] Leonard, W., Lyons, A., & Bariola, E. *A closer look at private lives 2: addressing the mental health and wellbeing of lesbian, gay, bisexual, and transgender (LGBT) Australians*, 2015. Melbourne: The Australian Research Centre in Sex Health and Society, La Trobe University. Page 3.

[11] Leonard et al (2012). Page 15.

[12] National LGBTI Health Alliance, *Snapshot of Mental Health and Suicide Prevention for LGBTI people*, February 2020, Sydney. https://lgbtihealth.org.au/wp-content/uploads/2020/02/2020-Snapshot-of-Mental-Health-and-Suicide-Prevention-Statistics-for-LGBTI-People-LGBTI-Health-Alliance.pdf

[13] National LGBTI Health Alliance, 2020. Page 2.

[14] Leonard et al, 2012. Page 38.

[15] Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., Lin, A. *Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results*, 2017, Telethon Kids Institute, Perth, Australia. Page 10.

[16] Jones, T., Carpenter, M., Hart, B., Ansara, G., Leonard, W. and Lucke, J., 2016, *Intersex: Stories and Statistics from Australia*. Open Book Publishers: London. Page 3.

[17] Jones et al, 2016. Page 120.

[18] Jones et al, 2016. Page 3.

[19] Victorian Department of Health, 2020, *Lesbian Health*. https://www2.health.vic.gov.au/about/populations/lgbti-health/rainbow-equality/lgbti-populations/lesbian-health

[20] Robinson, KH, Bansel, P, Denson, N, Ovenden, G & Davies, C, 2014, *Growing Up Queer: Issues Facing Young Australians Who Are Gender Variant and Sexuality Diverse*, Young and Well Cooperative Research Centre, Melbourne. Page 24.

Bisexual People

Bisexual people experience worse mental health than heterosexual, gay and lesbian people. A recent study found that 58.5% of bisexual people reported high or very high psychological distress, in comparison to 11.7% of the general population.[21]

While the rate of psychological distress decreases with age for lesbian and gay people, for bisexual women the rate of psychological distress remains largely the same across the age groups.[22]

Suicidality among bisexual people is higher than the general population. A recent study shows that 77.6% of bisexual people had experienced thoughts of suicide, markedly higher than the general population (13.3%.)[23]

Transgender people

Transgender people report poorer mental health than lesbian, gay and bisexual people.[24] In a 2013 study of adult transgender and gender diverse people, 57% had been diagnosed with depression and 39.9% with an anxiety disorder at some point during their lives.[25]

Comparing these numbers against the general population shows that transgender people are "four times more likely to have ever been diagnosed with depression… and approximately 1.5 times more likely to have ever been diagnosed with an anxiety disorder."[26]

The risk of suicide and self-harm is far greater for transgender people than the general population, and for LGB people.[27] Transgender people are "nearly eleven times more likely to attempt suicide than the general population."[28]

Importantly, access to gender affirmation makes a difference to the mental health of transgender and gender diverse people. Evidence suggests that being able to access hormone therapy and gender affirming surgeries is associated with improved mental wellbeing.[29]

Transgender and gender diverse people also report that 'transition' can have a huge personal impact on mental wellbeing, especially when there is support and acceptance from family, friends and the community.[30]

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[21] Taylor, J., Power, J., Smith, E., & Rathbone, M, 2019, Bisexual mental health: Findings from the 'who I am study'. *Australian journal of general practice, 48*(3), 138. doi: 10.31128/AJGP-06-18-4615.

[22] Leonard et al, 2015. Page 2.

[23] National LGBTI Health Alliance, ibid.

[24] Leonard et al, 2012. Page 37.

[25] Hyde Z, Doherty M, Tilley PJM, McCaul KA, Rooney R, Jancey J, *The First Australian National Trans Mental Health Study: Summary of Results. School of Public Health*, 2014, Curtin University, Perth, Australia. Page iv.

[26] Hyde et al, 2014. Page iv.

[27] National LGBTI Health Alliance, 2020. Page 7.

[28] National LGBTI Health Alliance, ibid.

[29] Hyde et al, 2014. Page 23.

[30] Hyde et al, 2014. Page 26-7.

Discrimination, health and accessing health services

Poor mental health outcomes for LGBTIQ+ people are directly related to social exclusion and discrimination.[31]

For example, research found an increase in mental distress for LGBTIQ+ people during the 2017 same sex marriage equality debate.[32] Negative messages about gender identity and sexuality that were circulated during the debate led to adverse mental health for LGBTIQ+ people, except where there were protective factors such as supportive family and friends or positive community messaging.[33]

A survey undertaken during the debate on the first draft of the 2019 Religious Discrimination Bill debate found that the vast majority of LGBTIQ+ Australians (81%) felt the same negative feelings or worse than they had done during the same sex marriage debate.[34] The debate around religious freedom and proposition that there be a legal right to discriminate against LGBTIQ+ people had respondents feeling not respected (78.4%), tired (70.6%), angry (67.2%) and targeted (63.3%).[35]

LGBTIQ+ Australians have spoken about the impacts of discrimination and unconscious bias in health settings and the reluctance and worry this can bring when accessing services.[36] 33.6% LGBT people report they occasionally or usually hide their gender identity or sexuality when accessing a service.[37]

In terms of primary health, three quarters of the LGBT people surveyed in *Private Lives 2* study had a regular GP, however 18.5% of respondents said that their regular GP did not know their sexuality and 12.8% of respondents did not know if their GP knew their sexuality.

The majority of transgender people have a regular GP,[38] however factors such as past discrimination or dissatisfaction with their doctor's level of expertise will stop some from finding and maintaining a GP.[39] This is can have particular impacts because transgender people who wish to undertake medical gender affirmation need the support of a GP.[40]

While it should be a matter of individual choice to 'come out' or not, not being able to disclose sexuality or gender identity in health settings can have implications for clinical outcomes and quality of care.[41]

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[31] Beyond Blue, *In My Shoes: Experiences of discrimination, depression and anxiety among gay, lesbian, bisexual, trans and intersex people*, 2012. https://humanrights.gov.au/sites/default/files/FTFLGBTI.pdf

[32] Ecker, S., Riggle, E. D., Rostosky, S. S., & Byrnes, J. M. , 2019, Impact of the Australian marriage equality postal survey and debate on psychological distress among lesbian, gay, bisexual, transgender, intersex and queer/questioning people and allies. *Australian Journal of Psychology*, 71(3), 285-295. DOI: https://doi.org/10.1111/ajpy.12245

[33] Verrelli, S., White, F. A., Harvey, L. J., & Pulciani, M. R., 2019, Minority stress, social support, and the mental health of lesbian, gay, and bisexual Australians during the Australian Marriage Law Postal Survey. *Australian Psychologist, 54*(4), 336-346. DOI: https://doi.org/10.1111/ap.12380

[34] Just Equal, *Religious Freedom and Transgender Debates: Survey Report*, 2019. https://drive.google.com/file/d/1GgGusJV7K10EdUWxDPyus_VuB_bwuEwE/view. Page 4.

[35] Ibid.

[36] Australian Human Rights Commission, *Resilient Individuals: Sexual Orientation, Gender Identity and Intersex Rights National Consultation Report*, 2015. Chapter 7.

[37] Leonard et al, 2012. Page 46.

[38] Hyde et al. Page 50; Leonard et al, page 42.

[39] Hyde et al, 2014. Page 49-50.

[40] Hyde et al, 2014. Page 49.

[41] Australian Human Rights Commission, 2015. Page 37.

Appendix 2

Language and definitions

Bisexual

"A bisexual person is a person of any gender who has romantic and/or sexual relationships with and/or is attracted to people from more than one gender. Some people who fit this description prefer the terms 'queer' or 'pansexual', in recognition of more than two genders. Although 'bi' technically refers to two, it is often used by people who have relationships with and/or attractions for people of more genders than just women or men."[42]

Cisgender

"A term used to describe people who identify their gender as the same as what was assigned to them at birth (male or female). 'Cis' is a Latin term meaning 'on the same side as'."[43]

Family of Choice

"LGBTI people may establish 'families of choice', who are supportive and loving of each other and are not necessarily biologically related. There are many reasons why a person may create a family of choice including; discrimination and rejection from their family of origin; finding more in common with people who know what it's like to be part of a marginalised group; and simply because they wish to. These families of choice may not be modelled on traditional family structures but are the place for support, connection and love for that person."[44]

Gay

"A gay man is a person who self-describes as a man and who has experiences of romantic, sexual and/or affectional attraction solely or primarily to other people who self-describe as men."[45] The term can also be used by women who are primarily attracted to other women.[46]

Heteronormativity

The idea that heterosexuality is the standard way to define normal sexual behaviour. Gender stereotypes about how men and women should be and behave are seen as natural and unchanging parts of human relations.[47] Heteronormativity can have the effect of making LGBTIQ people and relationships seem 'different', 'other' or out of the ordinary.

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[42] National LGBTI Health Alliance, *LGBTI People and Communities*, 2020, Sydney Australia. https://lgbtihealth.org.au/communities/

[43] ACON, *A Language Guide: Trans and Gender Diverse Inclusion*, 2017, Sydney. https://www.acon.org.au/wp-content/uploads/2017/11/External_Language-Guide-17396_print_V12A.pdf

[44] Qlife, *Families: Qlife Guide for Health Professionals*, 2016. https://qlife.org.au/uploads/5-Families.pdf

[45] National LGBTI Health Alliance, *LGBTI People and Communities*, 2020, Sydney Australia. https://lgbtihealth.org.au/communities/

[46] Australian Institute of Family Studies, *LGBTIQA+ Communities: Glossary of Common Terms*, 2019 https://aifs.gov.au/cfca/sites/default/files/publication-documents/1911_lgbtiqa_communities_0.pdf

[47] American Psychological Association, *Heteronormativity*, 2020. https://dictionary.apa.org/heteronormativity

Intersex

People with intersex variations are "born with physical sex characteristics that don't fit medical and social norms for female or male bodies."[48] The word intersex is an umbrella term that captures a range of "physical, hormonal or genetic features that are neither wholly female nor wholly male; or a combination of female and male; or neither female nor male."[49] Intersex variations occur in up to 1.7% of all births.[50] "Intersex bodies are a normal part of human biological diversity."[51]

Lesbian

"A lesbian is a person who self-describes as a woman and who has experiences of romantic, sexual, and/or affectional attraction solely or primarily to other people who self-describe as women."[52]

Non-binary

"This is an umbrella term for any number of gender identities that sit within, outside of, across or between the spectrum of the male and female binary. A non-binary person might identify as gender fluid, trans masculine, trans feminine, agender, bigender etc."[53]

Queer

"A term used to describe a range of sexual orientations and gender identities. Although once used as a derogatory term, the term queer now encapsulates political ideas of resistance to heteronormativity and homonormativity and is often used as an umbrella term to describe the full range of LGBTIQA+ identities."[54]

Transgender

"Trans and Transgender are umbrella terms often used to describe people who were assigned a sex at birth that they do not feel reflects how they understand their gender identity, expression, or behaviour. Most people of trans experience live and identify simply as women or men; most do not have 'a trans identity'. In addition to women and men of trans experience, some people do identify their gender as trans or as a gender other than woman or man."[55]

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[48] Intersex Human Rights Australia, *What is Intersex?*, 2013. https://ihra.org.au/18106/what-is-intersex/

[49] Victorian Department of Health and Human Services, *Health of People with Intersex Variations*, 2020. https://www2.health.vic.gov.au/about/populations/lgbti-health/health-of-people-with-intersex-variations

[50] Ibid.

[51] Head to Health, *Intersex*, 2020. https://headtohealth.gov.au/supporting-yourself/support-for/intersex

[52] National LGBTI Health Alliance, *LGBTI People and Communities*, 2020, Sydney Australia. https://lgbtihealth.org.au/communities/

[53] ACON, *A Language Guide: Trans and Gender Diverse Inclusion*, 2017, Sydney. https://www.acon.org.au/wp-content/uploads/2017/11/External_Language-Guide-17396_print_V12A.pdf

[54] Australian Institute of Family Studies, *LGBTIQA+ Communities: Glossary of Common Terms*, 2019 https://aifs.gov.au/cfca/sites/default/files/publication-documents/1911_lgbtiqa_communities_0.pdf

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Talking to LGBTIQ+ women about health, Tasmania 2020

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Background

A word about definitions and language

The letters LGBTIQ+ stand for Lesbian, Gay, Bisexual, Transgender, Intersex and Queer. The plus symbol (+) at the end acknowledges and includes the myriad of identities that exist beyond those six labels.[1]

Sexuality, gender identity and bodies are diverse. The words we use to talk about ourselves, our relationships and our bodies are important. Words and their meanings can change over time. We have included an appendix with definitions of some words used in this report (Appendix 2).

Our discussions with women who identified with one or more identity captured in the LGBTIQ+ definition provoked much reflection on how health systems struggle to take a holistic view of a person, instead understanding people only as their "presenting issue."

Our health systems often maintain a rigid distinction between male and female bodies and the ways in which gender maps onto these. Our conversations were open to anyone who identified as a woman. We also talked to people who were assigned female at birth but now identified as non-binary. These people elected to be involved because of their life experiences navigating women's health systems.

We acknowledge there are both distinct and overlapping issues for trans men and non-binary people assigned female at birth in accessing health services. More consultation and research are required to understand how trans men and non-binary people navigate health systems.

Who did we talk to?

We talked with 15 women across two focus groups and conducted several one-on-one interviews. We also spoke with one person who identified as non-binary and was assigned female at birth.

The women and people we spoke to range in age from their 20s to 70s, but the majority were under 40 years old (20-29 year olds making up 40% and 30-39 year olds making up 20%).

They lived in seven different postcodes and we held interviews and consultation groups in Burnie and Hobart.

While everyone's main language at home was English, 20% of them were born overseas, including non-English speaking Asian and European countries.

More than half of those we spoke to had been diagnosed with a mental health illness (53.22%).

A third of the people we spoke to were living on low incomes; 33% held a health care card or pensioner concession card.

This report also includes data from our statewide online survey on women's health, conducted in 2019. The survey received 462 responses and 79 respondents (17%) identified as lesbian, gay, bisexual, transgender, intersex, queer or another identity around gender/sexuality.

How did we reach them?

To reach women for these consultations we used the Women's Health Tasmania networks through our social media, enews and newsletter.

We also received promotional support from Working It Out, Tasmania's gender, sexuality and intersex status support and education service. Working It Out is a non-government organisation working with the LGBTIQ+ community in Tasmania for over 20 years. Working It Out maintain networks with the LGBTIQ+ community around Tasmania. We also reached out to health services in North West Tasmania listed in the LGBTIQ+ service directory, Signpost, to promote the project.

We are very grateful to Connect4Life LGBTIQ+ social group in the North West for their assistance in promoting the consultation in Burnie, Working It Out's support across the state and the Queering Health Reading Group in the South.

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[1] We use this abbreviation throughout this paper. However, when discussing other people's research, we use the language and abbreviations that they have used.

What did we hear?

What's working well?

Place, home and relationships

Women told us how environments and having a safe home kept them well.

Home

Women told us having a safe home was essential part of their health and wellbeing. Homes allowed women to engage with supportive partnerships and families of choice.

Home was also a place where personal mental health strategies could be implemented. Women discussed how they implemented personal strategies that they have learnt in response to discrimination as a way of managing mental health problems. These included adopting resilient attitudes, making time for sadness, personal hobbies and relaxing activities. These were all seen as ways of combating depression and anxiety.

Geography/place

Women placed a high value on where they lived and access to outdoor spaces. The bush and beautiful natural places were important to mental health and were recognised as places of sanctuary from discrimination.[2] For the participants living in the bush and being in nature provided a safe boundary between work and home life.

The women consulted in Hobart said that there was a relative feeling of safety on the streets and using public transport. However, these women also recalled firsthand experiences of verbal assault on the street directly related to their gender identity or sexuality. These past experiences of harassment and assault continued to impact on the women and the way they understood safety. Being able to get around towns and cities safely was valuable and not taken for granted.

Access to amenities

Women talked about places near them where it was possible to access cheap or free vegetables and fruit and this resource allowed them to maintain their health. The importance of being able to access shops, entertainment and to have things happening in their area was also important to the women.

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[2] The importance of place is discussed in research with older lesbian women living in regional Tasmania. See *Visual Herstories: Older Lesbian's Health, Wellbeing and Community Connection in Rural Tasmania Progress Report.* (2020). Dr Ruby Grant and Briohny Walker. (copy on file).

Social connection and LGBTIQ+ specific community groups

Social connection through activities organised for the LGBTIQ+ community were cited as important spaces. Where funded support services were insufficient, community organised activities could become the main or only source of support for LGBTIQ+ women.

Women living in regional areas noted LGBTIQ+ community organised events provided a lifeline and 'third space' for LGBTIQ+ women and people. The LGBTIQ+ community was also active in educating the broader community and changing discriminatory attitudes.

Although these social connection opportunities were highly prized, the women also acknowledged the work, time and emotional labour that went into organising these activities and networks.

" ...I get a lot personally out of educating and seeing other people grow... if I hadn't had those sort of supports myself I wouldn't be here. But it's also brought me a lot of stress, it's one of the reasons I am now doing [other things] because I need some time out."

Inclusion at work and in the community

Women told us about the positive mental health impacts of being included both at work and in the community. Women told us arts events were often inclusive spaces and some had positive experiences of inclusion at work.

The women defined inclusion as a sense that diversity was the norm. Women said inclusion came about when differences in sexuality, gender and bodies are considered valid and an everyday part of life.

Actions that signalled inclusion were things such as smiling, positive body language, having a welcoming attitude and including people in everyday conversations. Women found this gave them a sense of shared values and the sense their lives were respected and valid.

"I don't feel I have to closet myself [at work]. They care less about sexuality, and what you're doing outside of work so long as it sounds fun and interesting.... [it's] been really wonderful from a mental health perspective because you're not stifled at work ... which I am sure every queer woman has experienced in her life."

What's *not* working well?

Access and cost of mental health support

Women told us their experience of accessing mental health support was expensive, limited and involved having to wait a long time to gain access. There was a perception that people with independent funds accessed a less complex and more timely pathway to ongoing, needs-based mental health support.

Women told us about waiting months to get psychology appointments and that the 10 sessions allocated through mental health plans were not enough in their experience. Women said the gap fees for many psychologists were a financial burden. For women with acute needs for mental health support, the 10 sessions were not enough, and they used savings to pay psychology fees, or went without.

Women described how 'good' psychologists have longer waiting lists and for LGBTIQ+ women the pool of inclusive mental health practitioners was quite small, exacerbating the length of waits.

Women also described how the circumstances of daily life such as socio-economic disadvantage, living with chronic health conditions and the inaccessibility of health services came together to make getting help difficult.

Work pressure, insecure work, the inability to find time and space for self-care and societal expectations around how people 'should' function (despite living with a chronic condition) were barriers to pursing health care. Women were also critical of the 'mutual obligations' placed on those on Centrelink payments, especially when managing poor health.

"[taking time out to work on my mental health] meant going onto a single income. Because I get nothing from the government because [my wife's] income is just a little bit too high. So [she] has been supporting me… [it's] put a lot of strain on us because I have a lot of health issues, a lot of medical costs and no concession card. But you know, when she realised it was like 'I need to stop working or I'm going to not be here in 6 months' time' it was just, do whatever you need to do."

A lack of community services and face to face contact

Women from Burnie told us how a lack of community services on the ground presents difficulties for LGBTIQ+ women.

The women said community social groups took the lead in providing safe spaces and support for LGBTIQ+ people. Although they recognised this was a sign of a healthy community, it was also acknowledged this could and did have mental health impacts for community members.

Not having the depth of health services on the ground in the North West also meant travelling to a different part of the state to access medical specialists. Transgender women told us endocrinology appointments for support around hormone therapy were hard to get in Burnie. The women travelled to Launceston as there were generally more appointments available. This travel added cost, time and presented issues for trans women who did not have access to a car or were on low incomes.

Women had mixed responses to telehealth as an option for accessing health care. Some women reported positive experiences, but this came with an understanding that telehealth was not appropriate for every kind of appointment. Other women told us that accessing psychiatric support via telehealth was inadequate. Across both groups there was a desire for face to face contact, especially when tackling complex or sensitive health issues.

Health care for trans and gender diverse women

"There is one transgender friendly doctor [that I know of] but she's really hard to get into."

"I asked my GP how many trans patients do you have? They said, 'you're the first' and I said 'no I'm not, I am just the first you know about.'"

The women said lack of knowledge and options for trans-informed health care was a barrier for transgender women's health and wellbeing.

Trans women we spoke to said it was rare to access a doctor who understood important elements of gender affirmation – either medically or socially. In other cases, medical professionals had outdated and harmful views about transgender people, believing that being transgender was a mental illness.[3] The women described these experiences as intensely negative and invalidating. Women we spoke to avoided interacting with these health professionals if they could – shrinking the pool of doctors who these women felt confident accessing.

Some transgender women we spoke to highly valued the Sexual Health Service[4] – the main publicly funded access point for transgender people who want to explore medical gender affirmation. Through this service the women said they could access endocrinology specialists, psychiatry, and other support.

"I've had countless experiences with doctors who just have no clue… I've had doctors try and use my being trans as a symptom of a …personality disorder."

"There's no GPs who identify themselves as practitioners who know what they are doing with the trans community and a trans patients which … requires different skills and requires a different breadth of knowledge and most doctors just haven't been exposed to it and you end up having to teach your doctor and that's horrible. Having to teach your doctor 'what you are', and what you need and how to get it – that's exhausting! Like why would you go and get hormone therapy if you have to tell your doctor all of this other stuff about yourself and go through all of the history of what it means to be a trans person?"

"[There are] improved legal aspects around trans people and trans communities but I don't think that's necessarily translates to medicine."

Access to inclusive GPs

"It's difficult to have a worthwhile exchange with a doctor if you're not able to feel comfortable with them."

Women told us the lack of access to GPs they could trust to be inclusive was a barrier to health care. When GPs made assumptions regarding identity and health needs this reduced the ability for women to be open with their doctor. Examples included assuming the gender of someone's partner or the need for hormones or contraceptives. Women spoke about the burden of having to decide whether to 'correct' the assumptions their doctor made by disclosing their relationships, identity and needs.

Access to doctors with whom relationships were already formed or who were known to be inclusive were highly valued, but often these doctors had waiting lists. This meant women often had to access another GP who might not be an ally or wait weeks for an appointment.

Lack of access to inclusive GPs was also linked to a perceived high number of LGBTIQ+ women presenting at emergency for issues that could be dealt with by a GP.

The women told us in their experience, the health system had a low knowledge of LGBTIQ+ people's existence and health needs. General Practitioners were cited as needing more comprehensive training around health needs of LGBTIQ+ people and women.

"If you're LGBTIQ that difficulty is compounded. A small pool of GPs means there's less diversity among GPs, and so less options for inclusive or queer friendly doctors…so when your health system is under enormous strain as ours is, it's another level of difficulty for queer women."

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[3] Transgender health categories were reclassified from mental health disorders to sexual health issues by the World Health Organisation in 2018: World Health Organisation, *WHO: Revision of ICD-11 (gender incongruence/transgender) – questions and answers (Q&A)*, 2018. https://www.youtube.com/watch?v=kyCgz0z05Ik

[4] The Sexual Health Service operates Clinic 60 (Hobart) and Clinic 34 (Launceston) and an outreach service to the north west.

Affordability of primary health care

Women told us the cost of going to the GP was an issue and could sometimes deter them from attending to their health care.

Women who had moved to Tasmania from interstate noted the differences between health services here and on the mainland. The women said interstate, there were free health clinics and that it was easy to get an appointment on the same day of request. They also described bulk billing student health services which exist on the mainland. Women who had come from interstate said free and available services helped them access what they needed in a timely way.

Discrimination in health settings

Women told us discriminatory behaviour and attitudes presented clear barriers both in primary health and preventative health.

Women said the historical legacy of discrimination in medical and mental health settings continued to have negative impacts on LGBTIQ+ women.

Women discussed how gender and sexual diversity were considered mental disorders in the past. Medical systems and institutions had also had a history of not listening to women's knowledge about their bodies and needs. The women also spoke about their distrust of church-based medical and other institutions. Women provided examples of recent refusals of service by GPs because they "did not agree" with transgender identities.

Women told us they did not want to access health workers who held discriminatory views based on religious or other grounds. Some women living in rural Tasmania expressed concerns about the proposed Federal Religious Discrimination laws and what this would mean in regional areas where there were already limited options for primary health care.

The women said discrimination made it hard to access preventative health spaces and activities. For example, transgender women cited their concerns about changing facilities, bathrooms and the role of workers in these places to single out trans and gender diverse people in ways that were unfair and unwelcoming. Other women talked about exclusive cultures of some gyms and exercise spaces and implicit ideas that only certain kinds of bodies were allowed.

Siloed health services

The women told us maintaining health when living with chronic health conditions was burdensome. Women said a siloed approach to health care meant there was no 'one place' people could go to get their health care sorted. This put women in the position of needing to retell their story to multiple health professionals who were often scattered across the town or region. Women felt they essentially needed to be their own case managers – an overwhelming task especially if the person was also living on a low income.

Some of the women we spoke to also worked in health settings and they believed funding arrangements were rarely flexible or long-term enough for services to create innovative or holistic approaches.

A health system lacking in humanity

The women discussed what they saw as a lack of humanity and empathy in acute mental health care. The women related this to under-resourcing in mental health care. The use of restrictive practices in mental health settings were criticised as inhumane.

In this part of the conversation, the women described how health systems often reduced people to their behaviours or their illness rather than seeing the whole person. There was concern this narrow approach to health was bad for patients and an increase of resources would be needed to fix it.

What hasn't begun but needs to start?

Free, universal health care

Women told us cost continued to be an issue in all aspects of health including preventative health, mental health and medical care. Women said free health care available to everyone was vital.

The women told us free healthcare needed to include gender affirming medical care for transgender women and reproductive and gynaecological care for all women.

Holistic health spaces putting diversity at their core

The women wanted a shift in health systems towards holistic understandings of health and wellbeing. Women believed building systems with a focus on the different needs and diversity of service users would have immense benefits – for LGBTIQ+ women and the wider community.

Women said in order to change people's experiences of their health, the system needed to be changed to accommodate the diverse experiences, identities and needs of the people using the system. Multidisciplinary approaches were seen as giving people better access to a range of health professionals, information and activities.

Bringing sexuality, gender and body diversity into focus could mean new approaches to drug and alcohol programs and services around family violence in the LGBTIQ+ community. For preventative health spaces, this meant this meant designing environments where lots of different bodies and genders could fit in and find positive acceptance.

Women wanted "just to be able to go in and enjoy your body" without feeling body shame. The women placed emphasis on the need for public spaces where people of diverse genders, bodies and sexualities can exercise and do preventative health activities comfortably.

Mandatory, systemic training and education for health workers

The women wanted mandatory training in gender, sexuality and body diversity for everyone who worked in the health system. The women believed non-compulsory training already on offer was not valued or understood to be a core part of health worker practice and that as a result, the health workers who would benefit from such training rarely participate. Mandatory training was seen to be needed to ensure all workers understood they had a responsibility to be informed and up to date.

Further, women suggested specific training around transgender health and medical affirmation was needed and should be encouraged for all general practitioners. Transgender health and medical affirmation are developing areas of medical practice. General practitioners play a key role in supporting transgender people access medical gender affirmation.

Normalising transgender identities and experiences

Women believed the health system should work in ways to normalise transgender identities and experiences. They said work needs to be done within the health system to change the idea that being transgender is a mental illness. The women believed gender transition shouldn't be considered something outside of the ordinary, but rather something some people experience.

Visibility: Health services need to make it clear LGBTIQ+ people are a focus

LGBTIQ+ women wanted to know whom they can trust to provide a friendly, inclusive service. For the women this involved organisations and individuals taking action to become visible as having expertise and an inclusive approach.

There were two issues involved in this idea.

First, women told us they wanted to feel their identity was valued, recognised and respected from the very beginning of their contact with the service until its conclusion. From walking through the door, the words and options presented in paperwork as well as the interactions with workers and professionals in the health system – all were important in creating spaces where women felt safe. The attitudes, assumptions and visibility of workers played a significant role in feeling the service was inclusive.

Secondly, women felt there was much to be gained from health services taking a stronger stand on inclusion and being loud, visible and clearly in this space. Women suggested practical solutions to help LGBTIQ+ communities know who they could trust such as a list of inclusive health care providers.[5]

Documentation and access to notes and medical information

The women had concerns about what information about them was recorded and how to access to their own medical information. Some women described times when they felt things being written about them may have been incorrect or discriminatory. There were concerns that workers were not always accountable for the things they wrote. Women found accessing their own medical information and notes was difficult. They wanted systems that would enable them to have more access to their medical information.

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[5] Working It Out hosts an online Tasmanian service directory of LGBTIQ+ inclusive services called Signpost. Services opt into this list and create their own listing. Notably, Burnie has one listing on Signpost for a psychologist and no listings for General Practitioners.

Postscript: impacts of COVID-19

The consultations that inform this research project were conducted prior to the COVID-19 pandemic.

During the Tasmanian COVID-19 isolation period we made contact via email with some of our participants to hear how the isolation period was affecting them.

The shutdown of community spaces and events meant a sudden end to face to face LGBTIQ+ specific events, local sport events and community spaces. The women told us that isolation had brought immense challenges and these challenges were accentuated by existing vulnerabilities.

LGBTIQ+ community run events were a key place to socialise and be supported in their identities. Some women told us they felt cut off from LGBTIQ+ community and the support, recognition and celebration of their identities they found there. Without these events, women found themselves socially isolated at home or with families who could not provide the social and emotional support they got through peers. Online support via video calls, video meetings and phone support became the only way to access LGBTIQ+ community peer support. Those who accessed these supports described them as essential and valued them very highly.

Prior to recontacting the participants there had been media discussion of a possible presentation of the Religious Discrimination Bill in 2021. Women also felt a renewed worry concerning the proposed Bill and whether they were more vulnerable to adverse legislative changes during the crisis. Women reported anxiety about fronting up to unfamiliar health services as an LGBTIQ+ person if acute medical care was needed.

Appendix 1

General health

Our understanding of the health and wellbeing of LGBTIQ+ people in Australia is limited by a lack of a standardised data collection,[6] however the evidence that exists shows that LGBTIQ+ people have poorer health outcomes than the general population, particularly when we look at mental health.[7]

LGBT Australians report lower levels of general wellbeing than the overall population.[8] When we look at these statistics in terms of gender, young women (16-24 years old) rate their overall health as being much poorer than heterosexual young women.[9] LGBT people are also more likely to engage in risk behaviours such as alcohol consumption and drug use than the general population.[10]

Mental health

LGBTIQ+ people in Australia show higher levels of psychological distress[11] and are more likely to be diagnosed with depression or anxiety than the general population.[12]

Evidence also tells us that LGBTIQ+ people are more at risk of suicide and self-harm than the general population.[13]

Within the LGBTIQ+ community there are considerable differences in mental health across age and identity groups.

Young people

LGBT young people (16-19 years old) show the biggest disparities in terms of mental wellbeing when compared to the general population.[14] A 2017 study found 74.6% of transgender people aged 14 to 25 years old had been diagnosed with depression and 72.2% had been diagnosed with anxiety.[15]

People with an intersex variation

A recent Australian study with people who have an intersex variation showed the most commonly reported mental health diagnoses were depression, anxiety and PTSD.[16]

60% of the participants in this study had thought about suicide and 19% had attempted suicide because of issues around their congenital sex variation.[17] The respondents largely attributed their mental health issues to social responses to their differences, medical interventions or issues around sexuality or gender identity.[18]

Lesbians

Lesbians are twice as likely to experience depression and anxiety as heterosexual women.[19] Data from 2014 showed that 44% of lesbian women aged 16 to 27 experienced thoughts of suicide and 20% have attempted suicide.[20]

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[6] Australian Institute of Health and Welfare, *Australia's health 2018. Australia's health series no. 16. AUS 221*, 2018; National LGBTI Health Alliance, *The Statistics at a Glance: Mental Health of Lesbian, Gay, Bisexual, Transgender and Intersex People in Australia*, 2020. https://lgbtihealth.org.au/statistics/

[7] Most of the data used in this section of the report is from *Private Lives 2* (2012) a report of a national survey for Gay, Lesbian, Bisexual and Transgender people. The third iteration of this survey closed in 2019 and the *Private Lives 3 Report* is forthcoming.

[8] Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., & Couch, M. *Private lives 2: The second national survey on the health and wellbeing of gay, lesbian, bisexual, transgender (GLBT) Australians, 2012*, Melbourne: The Australian Research Centre in Sex Health and Society, La Trobe University. Page 27.

[9] Leonard et al (2012). Page 28.

[10] Leonard, W., Lyons, A., & Bariola, E. *A closer look at private lives 2: addressing the mental health and wellbeing of lesbian, gay, bisexual, and transgender (LGBT) Australians*, 2015. Melbourne: The Australian Research Centre in Sex Health and Society, La Trobe University. Page 3.

[11] Leonard et al (2012). Page 15.

[12] National LGBTI Health Alliance, *Snapshot of Mental Health and Suicide Prevention for LGBTI people,* February 2020, Sydney. https://lgbtihealth.org.au/wp-content/uploads/2020/02/2020-Snapshot-of-Mental-Health-and-Suicide-Prevention-Statistics-for-LGBTI-People-LGBTI-Health-Alliance.pdf

[13] National LGBTI Health Alliance, 2020. Page 2.

[14] Leonard et al, 2012. Page 38.

[15] Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., Lin, A. *Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results*, 2017, Telethon Kids Institute, Perth, Australia. Page 10.

[16] Jones, T., Carpenter, M., Hart, B., Ansara, G., Leonard, W. and Lucke, J., 2016, *Intersex: Stories and Statistics from Australia*. Open Book Publishers: London. Page 3.

[17] Jones et al, 2016. Page 120.

[18] Jones et al, 2016. Page 3.

[19] Victorian Department of Health, 2020, *Lesbian Health*. https://www2.health.vic.gov.au/about/populations/lgbti-health/rainbow-equality/lgbti-populations/lesbian-health

[20] Robinson, KH, Bansel, P, Denson, N, Ovenden, G & Davies, C, 2014, *Growing Up Queer: Issues Facing Young Australians Who Are Gender Variant and Sexuality Diverse*, Young and Well Cooperative Research Centre, Melbourne. Page 24.

Bisexual People

Bisexual people experience worse mental health than heterosexual, gay and lesbian people. A recent study found that 58.5% of bisexual people reported high or very high psychological distress, in comparison to 11.7% of the general population.[21]

While the rate of psychological distress decreases with age for lesbian and gay people, for bisexual women the rate of psychological distress remains largely the same across the age groups.[22]

Suicidality among bisexual people is higher than the general population. A recent study shows that 77.6% of bisexual people had experienced thoughts of suicide, markedly higher than the general population (13.3%.)[23]

Transgender people

Transgender people report poorer mental health than lesbian, gay and bisexual people.[24] In a 2013 study of adult transgender and gender diverse people, 57% had been diagnosed with depression and 39.9% with an anxiety disorder at some point during their lives.[25]

Comparing these numbers against the general population shows that transgender people are "four times more likely to have ever been diagnosed with depression… and approximately 1.5 times more likely to have ever been diagnosed with an anxiety disorder."[26]

The risk of suicide and self-harm is far greater for transgender people than the general population, and for LGB people.[27] Transgender people are "nearly eleven times more likely to attempt suicide than the general population."[28]

Importantly, access to gender affirmation makes a difference to the mental health of transgender and gender diverse people. Evidence suggests that being able to access hormone therapy and gender affirming surgeries is associated with improved mental wellbeing.[29]

Transgender and gender diverse people also report that 'transition' can have a huge personal impact on mental wellbeing, especially when there is support and acceptance from family, friends and the community.[30]

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[21] Taylor, J., Power, J., Smith, E., & Rathbone, M, 2019, Bisexual mental health: Findings from the 'who I am study'. *Australian journal of general practice, 48*(3), 138. doi: 10.31128/AJGP-06-18-4615.

[22] Leonard et al, 2015. Page 2.

[23] National LGBTI Health Alliance, ibid.

[24] Leonard et al, 2012. Page 37.

[25] Hyde Z, Doherty M, Tilley PJM, McCaul KA, Rooney R, Jancey J, *The First Australian National Trans Mental Health Study: Summary of Results. School of Public Health*, 2014, Curtin University, Perth, Australia. Page iv.

[26] Hyde et al, 2014. Page iv.

[27] National LGBTI Health Alliance, 2020. Page 7.

[28] National LGBTI Health Alliance, ibid.

[29] Hyde et al, 2014. Page 23.

[30] Hyde et al, 2014. Page 26-7.

Discrimination, health and accessing health services

Poor mental health outcomes for LGBTIQ+ people are directly related to social exclusion and discrimination.[31]

For example, research found an increase in mental distress for LGBTIQ+ people during the 2017 same sex marriage equality debate.[32] Negative messages about gender identity and sexuality that were circulated during the debate led to adverse mental health for LGBTIQ+ people, except where there were protective factors such as supportive family and friends or positive community messaging.[33]

A survey undertaken during the debate on the first draft of the 2019 Religious Discrimination Bill debate found that the vast majority of LGBTIQ+ Australians (81%) felt the same negative feelings or worse than they had done during the same sex marriage debate.[34] The debate around religious freedom and proposition that there be a legal right to discriminate against LGBTIQ+ people had respondents feeling not respected (78.4%), tired (70.6%), angry (67.2%) and targeted (63.3%).[35]

LGBTIQ+ Australians have spoken about the impacts of discrimination and unconscious bias in health settings and the reluctance and worry this can bring when accessing services.[36] 33.6% LGBT people report they occasionally or usually hide their gender identity or sexuality when accessing a service.[37]

In terms of primary health, three quarters of the LGBT people surveyed in *Private Lives 2* study had a regular GP, however 18.5% of respondents said that their regular GP did not know their sexuality and 12.8% of respondents did not know if their GP knew their sexuality.

The majority of transgender people have a regular GP,[38] however factors such as past discrimination or dissatisfaction with their doctor's level of expertise will stop some from finding and maintaining a GP.[39] This is can have particular impacts because transgender people who wish to undertake medical gender affirmation need the support of a GP.[40]

While it should be a matter of individual choice to 'come out' or not, not being able to disclose sexuality or gender identity in health settings can have implications for clinical outcomes and quality of care.[41]

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[31] Beyond Blue, *In My Shoes: Experiences of discrimination, depression and anxiety among gay, lesbian, bisexual, trans and intersex people*, 2012. https://humanrights.gov.au/sites/default/files/FTFLGBTI.pdf

[32] Ecker, S., Riggle, E. D., Rostosky, S. S., & Byrnes, J. M. , 2019, Impact of the Australian marriage equality postal survey and debate on psychological distress among lesbian, gay, bisexual, transgender, intersex and queer/questioning people and allies. *Australian Journal of Psychology*, 71(3), 285-295. DOI: https://doi.org/10.1111/ajpy.12245

[33] Verrelli, S., White, F. A., Harvey, L. J., & Pulciani, M. R., 2019, Minority stress, social support, and the mental health of lesbian, gay, and bisexual Australians during the Australian Marriage Law Postal Survey. *Australian Psychologist, 54*(4), 336-346. DOI: https://doi.org/10.1111/ap.12380

[34] Just Equal, *Religious Freedom and Transgender Debates: Survey Report*, 2019. https://drive.google.com/file/d/1GgGusJV7K10EdUWxDPyus_VuB_bwuEwE/view. Page 4.

[35] Ibid.

[36] Australian Human Rights Commission, *Resilient Individuals: Sexual Orientation, Gender Identity and Intersex Rights National Consultation Report*, 2015. Chapter 7.

[37] Leonard et al, 2012. Page 46.

[38] Hyde et al. Page 50; Leonard et al, page 42.

[39] Hyde et al, 2014. Page 49-50.

[40] Hyde et al, 2014. Page 49.

[41] Australian Human Rights Commission, 2015. Page 37.

Appendix 2

Language and definitions

Bisexual

"A bisexual person is a person of any gender who has romantic and/or sexual relationships with and/or is attracted to people from more than one gender. Some people who fit this description prefer the terms 'queer' or 'pansexual', in recognition of more than two genders. Although 'bi' technically refers to two, it is often used by people who have relationships with and/or attractions for people of more genders than just women or men."[42]

Cisgender

"A term used to describe people who identify their gender as the same as what was assigned to them at birth (male or female). 'Cis' is a Latin term meaning 'on the same side as'."[43]

Family of Choice

"LGBTI people may establish 'families of choice', who are supportive and loving of each other and are not necessarily biologically related. There are many reasons why a person may create a family of choice including; discrimination and rejection from their family of origin; finding more in common with people who know what it's like to be part of a marginalised group; and simply because they wish to. These families of choice may not be modelled on traditional family structures but are the place for support, connection and love for that person."[44]

Gay

"A gay man is a person who self-describes as a man and who has experiences of romantic, sexual and/or affectional attraction solely or primarily to other people who self-describe as men."[45] The term can also be used by women who are primarily attracted to other women.[46]

Heteronormativity

The idea that heterosexuality is the standard way to define normal sexual behaviour. Gender stereotypes about how men and women should be and behave are seen as natural and unchanging parts of human relations.[47] Heteronormativity can have the effect of making LGBTIQ people and relationships seem 'different', 'other' or out of the ordinary.

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[42] National LGBTI Health Alliance, *LGBTI People and Communities*, 2020, Sydney Australia. https://lgbtihealth.org.au/communities/

[43] ACON, *A Language Guide: Trans and Gender Diverse Inclusion*, 2017, Sydney. https://www.acon.org.au/wp-content/uploads/2017/11/External_Language-Guide-17396_print_V12A.pdf

[44] Qlife, *Families: Qlife Guide for Health Professionals*, 2016. https://qlife.org.au/uploads/5-Families.pdf

[45] National LGBTI Health Alliance, *LGBTI People and Communities*, 2020, Sydney Australia. https://lgbtihealth.org.au/communities/

[46] Australian Institute of Family Studies, *LGBTIQA+ Communities: Glossary of Common Terms*, 2019 https://aifs.gov.au/cfca/sites/default/files/publication-documents/1911_lgbtiqa_communities_0.pdf

[47] American Psychological Association, *Heteronormativity*, 2020. https://dictionary.apa.org/heteronormativity

Intersex

People with intersex variations are "born with physical sex characteristics that don't fit medical and social norms for female or male bodies."[48] The word intersex is an umbrella term that captures a range of "physical, hormonal or genetic features that are neither wholly female nor wholly male; or a combination of female and male; or neither female nor male."[49] Intersex variations occur in up to 1.7% of all births.[50] "Intersex bodies are a normal part of human biological diversity."[51]

Lesbian

"A lesbian is a person who self-describes as a woman and who has experiences of romantic, sexual, and/or affectional attraction solely or primarily to other people who self-describe as women."[52]

Non-binary

"This is an umbrella term for any number of gender identities that sit within, outside of, across or between the spectrum of the male and female binary. A non-binary person might identify as gender fluid, trans masculine, trans feminine, agender, bigender etc."[53]

Queer

"A term used to describe a range of sexual orientations and gender identities. Although once used as a derogatory term, the term queer now encapsulates political ideas of resistance to heteronormativity and homonormativity and is often used as an umbrella term to describe the full range of LGBTIQA+ identities."[54]

Transgender

"Trans and Transgender are umbrella terms often used to describe people who were assigned a sex at birth that they do not feel reflects how they understand their gender identity, expression, or behaviour. Most people of trans experience live and identify simply as women or men; most do not have 'a trans identity'. In addition to women and men of trans experience, some people do identify their gender as trans or as a gender other than woman or man."[55]

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[48] Intersex Human Rights Australia, *What is Intersex?*, 2013. https://ihra.org.au/18106/what-is-intersex/

[49] Victorian Department of Health and Human Services, *Health of People with Intersex Variations*, 2020. https://www2.health.vic.gov.au/about/populations/lgbti-health/health-of-people-with-intersex-variations

[50] Ibid.

[51] Head to Health, *Intersex*, 2020. https://headtohealth.gov.au/supporting-yourself/support-for/intersex

[52] National LGBTI Health Alliance, *LGBTI People and Communities*, 2020, Sydney Australia. https://lgbtihealth.org.au/communities/

[53] ACON, *A Language Guide: Trans and Gender Diverse Inclusion*, 2017, Sydney. https://www.acon.org.au/wp-content/uploads/2017/11/External_Language-Guide-17396_print_V12A.pdf

[54] Australian Institute of Family Studies, *LGBTIQA+ Communities: Glossary of Common Terms*, 2019 https://aifs.gov.au/cfca/sites/default/files/publication-documents/1911_lgbtiqa_communities_0.pdf

[55] National LGBTI Health Alliance, *LGBTI People and Communities*, 2020, Sydney Australia. https://lgbtihealth.org.au/communities/

Women's Health Tasmania
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North Hobart, Tasmania 7002
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Women's Health Information Line: **1800 675 028**

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LGBTI
National LGBTI
Health Alliance

SNAPSHOT OF MENTAL HEALTH AND SUICIDE PREVENTION STATISTICS FOR LGBTI PEOPLE

February 2020

SNAPSHOT OF MENTAL HEALTH AND SUICIDE PREVENTION STATISTICS FOR LGBTI PEOPLE

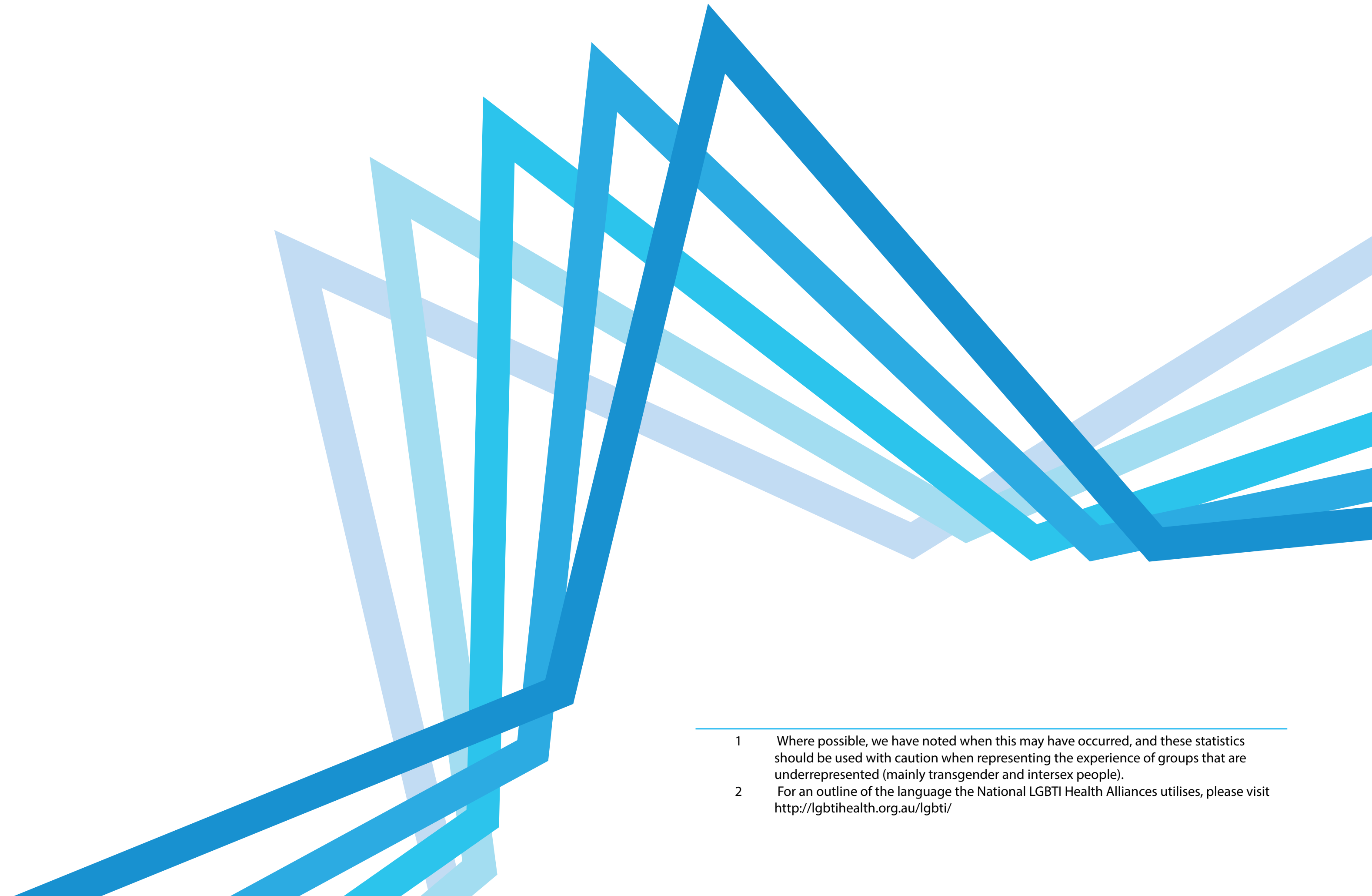
February 2020

Although many lesbian, gay, bisexual, transgender and intersex (LGBTI) Australians live healthy and happy lives, research has demonstrated that a disproportionate number experience poorer mental health outcomes and have higher risk of suicidal behaviours than their peers. These health outcomes are directly related to experiences of stigma, prejudice, discrimination and abuse on the basis of being LGBTI. This document aims to provide a snapshot of what is known of the current mental health and wellbeing outcomes of LGBTI people in Australia.

While Australian and international research provide evidence that demonstrate significant concern regarding mental health outcomes and suicidal behaviours among LGBTI people, significant knowledge gaps remain. This is due to lack of inclusion of sexual orientation, gender identity and intersex status in population research[i] and data collection in mental health services[ii]. As data informs evidence-based policy, this exclusion has lead to inaccuracy in reporting and significant underestimates, which in turn impacts on LGBTI inclusion in mental health and suicide prevention policies, strategies and programmes.

Consequently, Australian national evidence on the health and wellbeing of LGBTI populations relies upon a growing but limited number of smaller scale studies that target LGBTI populations, or part thereof. While uniquely valuable, these can have methodological issues relating to representative data collection and data analysis, and therefore may not represent a holistic picture of LGBTI people[iii]. Additionally, research that groups LGBTI people into a single group for analysis risks conflation and reaching conclusions that are not representative[1].

This document includes a range of language beyond that typically used by the National LGBTI Health Alliance[2]. This is to directly reflect the terminology and classifications used by the various research papers used as source data in this document. Across this research, there is often little uniformity of demographic information or definitions of mental health concerns that supports direct comparison between LGBTI populations and the general population. We urge the reader to consider this broader context in which adequately estimating the mental health outcomes and suicidal behaviours for LGBTI populations remains highly challenging.



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[1] Where possible, we have noted when this may have occurred, and these statistics should be used with caution when representing the experience of groups that are underrepresented (mainly transgender and intersex people).

[2] For an outline of the language the National LGBTI Health Alliances utilises, please visit http://lgbtihealth.org.au/lgbti/

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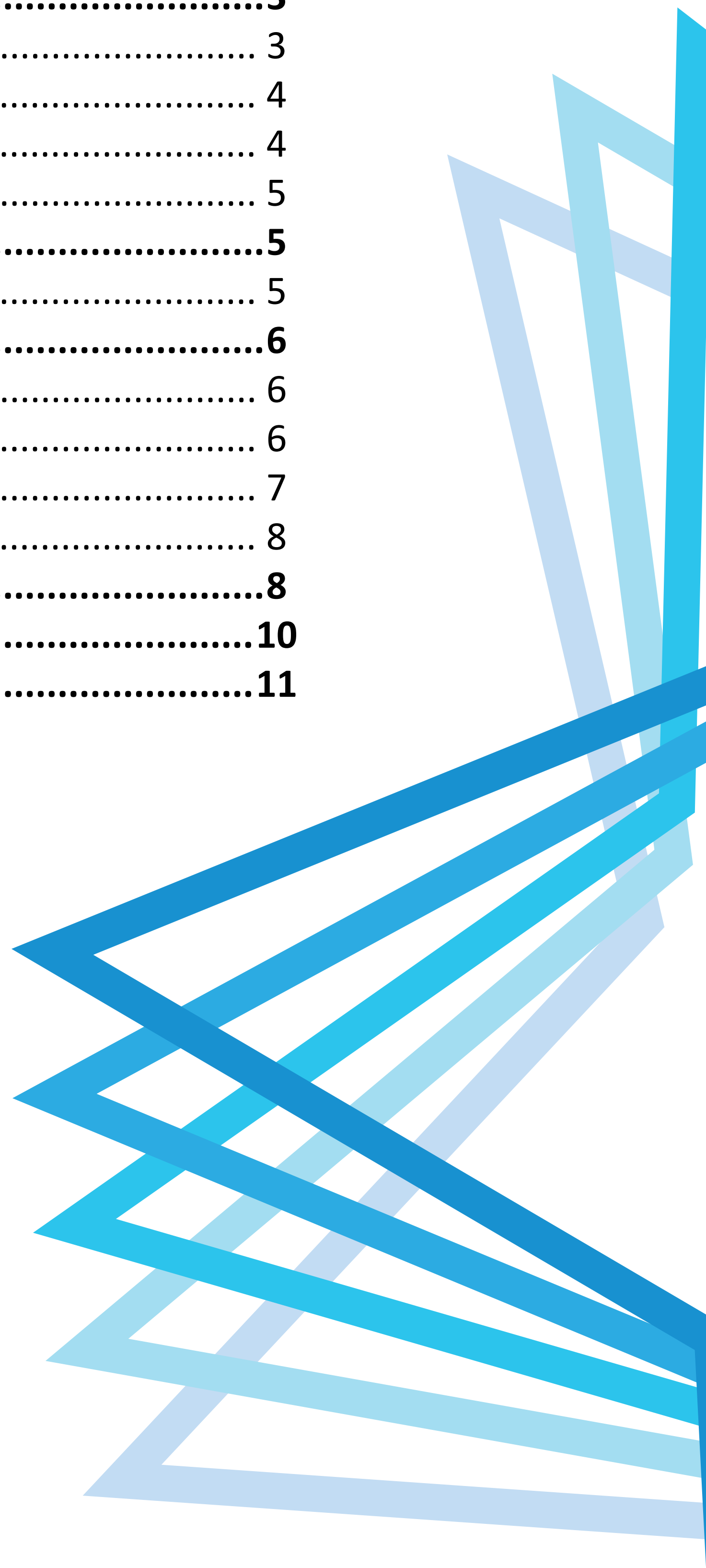

SUICIDIALITY

Suicide Attempts[3]

Compared to the general population, LGBTI people are more likely to attempt suicide in their lifetime, specifically:

- LGBTI young people aged 16 to 27 are five times more likely
- Transgender people aged 18 and over are nearly eleven times more likely
- People with an intersex variation aged 16 and over are nearly six times more likely
- LGBT young people who experience abuse and harassment are more likely to attempt suicide

Statistics for LGBTI populations

- 16% of LGBTI[4] young people aged 16 to 27 reported that they had attempted suicide[iv]
- 27.8% of bisexual[5] people aged 18 and over reported having attempted suicide[v]
- 48.1% of transgender and gender diverse[6] people aged 14 to 25 have attempted suicide in their lifetime[vi]
- 19% of people with an intersex variation aged 16 and over had attempted suicide on the basis of issues related to their intersex status[vii]
- 8% of Same-Gender Attracted and Gender Diverse young people between 14 and 21 years had attempted suicide, 18% had experienced verbal abuse, and 37% of those who experienced physical abuse[viii]

Statistics for the General Population

- 3.2% of people (4.4% females; 2.1% males) aged 16 and over have attempted suicide in their lifetime; 0.4% of general population (0.5% females; 0.3% males) in the last 12 months[ix]
- 1.1% of people (1.7% females; 0.5% males) aged 16 to 24 have attempted suicide in the past 12 months[x]
- 2.4% of people (3.4% females; 1.5% males) aged 12 to 17 have attempted suicide in the past 12 months[xi]

Suicide Ideation

Compared to the general population, LGBTI people are more likely to have thoughts of suicide, specifically:

- Lesbian, gay and bisexual people aged 16 and over are over six times more likely
- Transgender people aged 18 and over are nearly eighteen times more likely
- People with an intersex variation aged 16 and over are nearly five times more likely
- LGBT young people who experience abuse and harassment are even more likely to have thoughts of suicide

Statistics for LGBTI Populations

- 15.15% of LGBTI[7] people aged 16 and over reported current thoughts of suicide in the past two weeks[xii]
- 77.6% of bisexual[8] people aged 18 and over reported having thoughts of suicide in their lifetime[xiii]
- 41% of transgender people and non-binary people aged 18 years and over reported thoughts of suicide or self-harm in the last two weeks[xiv]
- 60% of people with an intersex variation aged 16 and over had thoughts about suicide on the basis of issues related to having congenital sex variation[xv]
- 22% of Same-Gender Attracted and Gender Diverse young people between 14 and 21 years have thoughts of suicide, which increases to 30% for those who have experienced verbal abuse and to 60% who have experienced physical abuse[xvi]

Statistics for the General Population

- 13.3% of the general population (15% females; 11.5% males) aged 16 and over in Australia have had suicidal ideation in their lifetime; 2.3% of general population (2.7% females; 1.8% males) in the last 12 months[xvii]
- 3.4% of the general population (1.7% of males and 5.1% of females) aged 16 to 24 in Australia have had suicidal ideation in the past 12 months[xviii]

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[3] Note: the majority of research targeting adult LGBTI populations in Australia has not included questions regarding if participants have attempted suicide

[4] Note: of 1032 survey participants, only three young people identified as having an intersex variation

[5] Note: of 2651 survey participants, 20.4% were male and 79.6% were female. Transgender and gender diverse people were not included in the analysis

[6] Note: of 859 survey participants, 74.4% were assigned female at birth, 25.6% were assigned male at birth, and 1.6% identified as intersex

[7] Note: of 5467 survey participants, only 1.8% identified as transgender, and 0.3% identified as having an intersex variation

[8] Note: of 2651 survey participants, 20.4% were male and 79.6% were female. Transgender and gender diverse people were not included in the analysis

Self-Harm[9]

Compared to the general population, LGBTI people are more likely to have engaged in self-harm in their lifetime, specifically:

- LGBT young people are nearly <u>twice as likely</u> to engage in self-injury
- Transgender people are <u>six and a half times</u> more likely
- People with an intersex variation are <u>three times more</u> likely
- LGBT young people who experience abuse and harassment are even more likely to have self-harmed

Statistics for LGBTI Populations

- 33% of LGBTI[10] young people aged 16 to 27 reported having self-harmed, 41% had thoughts of harming themselves[xix]
- 53% of transgender people aged 18 and over[11] have self-harmed in their lifetime, 11% currently self-harming[xx]
- 79.7% of transgender and gender diverse[12] people aged 14 to 25 have self-harmed in their lifetime[xxi]
- 26% of people with an intersex variation aged 16 and over have self-harmed on the basis of issues related to having a congenital sex variation, 42% have had thoughts about self-harm[xxii]
- 18% of Same-Gender Attracted and Gender Diverse young people between 14 and 21 years have self-harmed, which increases to 32% for those who have experienced verbal abuse, and to 54% for those who have experienced physical abuse

Statistics for the General Population

- 8.1% of people (8.7% females; 7.5% males) aged 16 and over have engaged in self-injury in their lifetime; and 1.1% of people (1.2% females; 1% males) in the past four weeks[xxiii]
- 14.1% of people (16.6% females; 11.6% males) aged between 15 and 19; and 21.25% of people (24.4% females; 18.1% males) aged between 20 and 24 have engaged in self injury in their lifetime[xxiv]

MENTAL HEALTH OUTCOMES

Mental Health Disorders[13]

Compared to the general population, LGBT people are more likely to experience and be diagnosed with a mental health disorder, specifically:

- Lesbian, gay and bisexual people are <u>twice as likely</u> to have symptoms that the criteria for a mental health disorder in the past 12 months
- LGBT people are <u>twice as likely</u> to be diagnosed and treated for mental health disorders

Statistics for LGBTI Populations

- 41.4% of homosexual/bisexual people aged 16 and over met the criteria for a mental disorder and had symptoms in the last 12 months[xxv]
- 37.2% of LGBT people aged 16 and over reported being diagnosed or treated for any mental disorder in the past three years[xxvi]

Statistics for the General Population

- 20% of people (22.3% female; 17.6% male) aged 16 and over met the criteria for a mental disorder and had symptoms in the last 12 months[xxvii]

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[9] Note: the majority of research targeting adult LGBTI populations in Australia has not included questions regarding if participants have engaged in self-harm

[10] Note: of 1032 survey participants, only 3 young people identified as having an Intersex variation

[11] Scottish research of participants in the UK

[12] Note: of 859 survey participants, 74.4% were assigned female at birth, 25.6% were assigned male at birth, and 1.6% identified as intersex

Depression

Compared to the general population, LGBTI people are more likely to experience and be diagnosed with depression, specifically:

- Lesbian, gay and bisexual people aged 16 and over are nearly six times more likely to currently meet the criteria for a depressive episode
- LGBTI people aged 16 and over are nearly three times more likely to diagnosed with depression in their lifetime
- Transgender people aged 25 and under are nearly ten times more likely to be diagnosed with depression in their lifetime
- Gender diverse people aged 18 and over are nearly five times more likely to be diagnosed with depression in their lifetime
- People with an intersex variation are nearly twice as likely to be diagnosed with depression

Statistics for LGBTI Populations

- 24.4% LGBTI people aged 16 and over[14] currently meet the full criteria for a major depressive episode[xxviii]
- 30.5% of LGBT people aged 16 and over[15] have been diagnosed or treated for depression in the last three years[xxix]
- 57.2% of transgender and gender diverse people aged 18 and over have been diagnosed with depression in their lifetime[xxx]
- 74% of transgender and gender diverse[16] people aged 14 to 25 have been diagnosed with depression in their lifetime[xxxi]
- 21.3% of people with intersex variations aged 16 and over have been diagnosed with depression[xxxii]

Statistics for the General Population

- 11.6% of people (14.5% females; 8.8% males) aged 16 and over have experienced a depressive episode in their lifetime; 4.1% of people (5.1% females; 3.1% males) in the last 12 months[xxxiii]

Anxiety

Compared to the general population, LGBTI people are more likely to experience and be diagnosed with anxiety, specifically:

- LGB people aged 16 and over are more than twice as likely to currently meet the criteria for an anxiety disorder
- LGB people aged aged 16 and over are three and a half times more likely to be diagnosed with anxiety in their lifetime
- Transgender people aged 25 and under are ten to thirteen times more likely to be diagnosed with anxiety in their lifetime
- People with an intersex variation aged 16 and over are twice as likely to be diagnosed with anxiety in their lifetime

Statistics for LGBTI Populations

- 31.5% of homosexual/bisexual people aged 16 and over in Australia met the criteria for an anxiety disorder in the last 12 months[xxxiv]
- 20.3% of LGBTI people aged 16 and over[17] reported that they had been diagnosed with anxiety in their lifetime[xxxv]
- 39.9% of transgender and gender diverse people aged 18 and over have been diagnosed with an anxiety disorder in their lifetime[xxxvi]
- 72.5% of transgender and gender diverse[18] people aged 14 to 25 have been diagnosed with an anxiety disorder in their lifetime[xxxvii]
- 12.9% of people with an intersex variation aged 16 and over reported being diagnosed with anxiety[xxxviii]

Statistics for the General Population

- 26.3% of people (32% females; 20.4% males) aged 16 and over have had an anxiety disorder in their lifetime; 14.4% of people (17.9% females; 10.8% of males) in the last 12 months (includes Panic Disorder, Agoraphobia, Social Phobia, Generalised Anxiety Disorder (GAD), Obsessive-Compulsive Disorder (OCD), and Post-Traumatic Stress Disorder (PTSD)[xxxix]
- 5.9% of people (7.3% females; 4.4% males) aged 16 and over have had Generalised Anxiety Disorder in their lifetime; 2.7% of people (3.5% females; 2% males) in the past 12 months[xl]

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[14] Note: of 5467 survey participants, 1.8% identified as transgender, and 0.3% identified as having an intersex variation

[15] Note: of 3835 survey participants, 7.41% identified as transgender, and people with an intersex variation were not included in data collection

[16] Note: of 859 survey participants, 74.4% were assigned female at birth, 25.6% were assigned male at birth, and 1.6% identified as intersex

[17] Note: of 5467 survey participants, only 1.8% identified as transgender, and 0.3% identified as having an intersex variation

[18] Note: of 859 survey participants, 74.4% were assigned female at birth, 25.6% were assigned male at birth, and 1.6% identified as intersex

Psychological Distress

Compared to the general population LGBTI people experience higher levels of psychological distress, specifically:

- LGBT people score higher on the Kessler Psychological Distress (K10) Scale indicating moderate levels of psychological distress
- LGBT people who have experienced verbal abuse, physical abuse and harassment score higher on the K10 scale indicating high levels of psychological distress

Statistics for LGBTI Populations

- LGBT people aged 16 and over[19] scored an average K10 score of 19.6, indicating moderate psychological distress[xli]
- LGBT people aged 16 and over who have experienced abuse and harassment scored an average K10 score of 22.83, indicating a high level of psychological distress
- Bisexual[20] people aged 18 and over scored an average K10 score of 24.34, indicating high psychological distress[xlii]
- 7.7% of people with an intersex variation reported being diagnosed with Post-Traumatic Stress Disorder[xliii]

Statistics for the General Population

- National average K10 score for the general population aged 16 and over in Australia is 14.5 indicating low psychological distress[xliv]
- 70% of the general population aged 16 and over in Australia has a K10 score in the low range, 20% in the moderate range, 7% in the high range and 3% in the very high range[xlv]
- 50.9% of the general population aged 11 and 17 in Australia has a K10 score in the low range, 29.1% in the moderate range, 13.3% in the high range and 6.6% in the very high range[xlvi]

USE OF CRISIS SUPPORT SERVICES

LGBTI+ People

- 71% of LGBTI+ people[21] aged 16 to 27 indicated that they did not use a crisis support service during their most recent personal or mental health crisis[xlvii]
- 32.6% of LGBTI+ people aged 16 to 27 who had not used a crisis support service during their most recent personal or mental health crisis indicated that their decision was due to anticipated discrimination[xlviii]
- 29% of LGBTI+ people aged 16 to 27 who had not used a crisis support service during their most recent personal or mental health crisis indicated that their decision was due to not thinking that their experience warranted crisis intervention[xlix]
- 28.8% of LGBTI+ people aged 16 to 27 who had not used a crisis support service during their most recent personal or mental health crisis indicated that their decision was due to being unaware of crisis support services or unaware of LGBTI+ specialist services[l]

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[19] Note: of 3835 survey participants, 7.41% identified as transgender, and people with an intersex variation were not included in data collection

[20] Note: of 2651 survey participants, 20.4% were male and 79.6% were female. Transgender and gender diverse people were not included in the analysis

[21] Note: of 472 participants, 3% identified as agender, 47% identified as female, 8% identified as genderqueer, 20% identified as male, 3% identified as trans-male, 9% identified as trans-female and 10% identified as other. Only one participant identified they were born with an intersex variation.

DISAGGREGATING LGBTI

Lesbian and Gay People

The mental health and wellbeing of gay men and lesbian women differs, specifically:

- Lesbian women are more likely to be diagnosed and treated for mental disorder or anxiety, and are more likely to engage in self-harm and attempt suicide than gay men
- Gay men are more likely to have thoughts about suicide, but are less likely to attempt suicide than lesbian women
- Gay men and lesbian women have a similar level of psychological distress

Population Statistics for Lesbian Women

- 44% of lesbian women aged 16 to 27 reported thoughts about suicide, 20% have attempted suicide[li].
- 46% of lesbian women aged 16 to 27 reported having self-harmed, 48% reported thoughts about harming themselves[lii]
- 39.1% of lesbian women aged 16 and over reported being diagnosed or treated for any mental disorder in the past three years[liii]
- 31% of lesbian women aged 16 and over reported being diagnosed or treated for anxiety in the last three years[liv]
- Lesbian women aged 16 and over average a K10 score of 19, indicating a moderate level of psychological distress [lv]

Population Statistics for Gay Men

- 46% of gay men aged 16 to 27 reported thoughts about suicide, 14% have attempted suicide[lvi].
- 21% of gay men aged 16 to 27 reported having self-harmed, 40% have had thoughts about harming themselves[lvii].
- 29.8% of gay men aged 16 and over reported being diagnosed or treated for any mental disorder in the past three years[lviii]
- 23.5% of gay men aged 16 and over reported being diagnosed or treated for anxiety in the last three years[lix]
- Gay men aged 16 and over average a K10 score of 18.8, indicating a moderate level of psychological distress[lx]

Bisexual People

There are differences between the mental health and wellbeing of gay men and lesbian women, and bisexual people, specifically:

- Bisexual people are more likely to be diagnosed and treated for mental disorder or anxiety
- Bisexual people have higher levels of psychological disress
- Gay men and lesbian women are more likely to self-harm, have thoughts about suicide, and attempt suicide

There are also differences between the mental health and wellbeing of bisexual men and bisexual women, specifically:

- Bisexual women are more likely to be diagnosed or treated for a mental disorder or anxiety, to have higer levels of psychologcal distress, and to self-harm
- Bisexual men are more likely to think about suicide, but both bisexual women and bisexual men have similar rates of suicide attempts

Statistics for Bisexual Women

- 29% of bisexual women aged 16 to 27 reported thoughts about suicide, 10% have attempted suicide[lxi]
- 30% of bisexual women aged 16 to 27 reported having self-harmed, 31% reported thoughts of harming themselves[lxii]
- 50.6% of bisexual women aged 16 and over reported being diagnosed or treated for any mental disorder in the past three years[lxiii]
- 38.8% of bisexual women aged 16 and over reported being diagnosed or treated for anxiety in the last three years[lxiv]
- Bisexual women aged 16 and over average a K10 score of 21.8, indicating moderate levels of psychological distress [lxv]

Statistics for Bisexual Men

- 32% of bisexual men aged 16 to 27 reported thoughts about suicide, 9% have attempted suicide[lxvi]
- 17% of bisexual men aged 16 to 27 reported having self-harmed, 32% reported thoughts about harming themselves[lxvii]
- 34.1% of bisexual men aged 16 and over reported being diagnosed or treated for any mental disorder in the past three years[lxviii]
- 20.9% of bisexual men aged 16 and over reported being diagnosed or treated for anxiety in the last three years[lxix]
- Bisexual men aged 16 and over average a K10 score of 20.5, indicating moderate levels of psychological distress [lxx]

Transgender People

There are differences between the mental health and wellbeing of lesbian, gay and bisexual people, and transgender and gender diverse people people, specifically:

- Transgender people experience a higher rate of suicide attempts than LGB people, and are nearly eleven times more likely to attempt suicide than the general population
- Transgender people are nearly three times more likely to have had thoughts of suicide than LGB people combined, and are twelve times more likely to have thoughts about suicide than the general population
- Transgender people experience high levels of psychological distress, compared to moderate levels experienced by lesbian, gay and bisexual people
- Transgender people are nearly twice as likely to be diagnosed or treated with a mental disorder and anxiety than lesbian and gay people, and nearly three times than the general population
- Transgender and gender diverse people are nearly four times more likely to have experienced sexual violence or coersion

There are also differences between the mental health and wellbeing of transgender men, transgender women and non-binary people, specifically:

- Transgender women are more likely to have thoughts of suicide than transgender men and non-binary people
- Transgender men are more likely to be diagnosed with depression and anxiety in their lifetime than transgender women
- Transgender men and transgender women have similar levels of psychological distress
- Transgender people are more likely to experience depression than non-binary people, but non-binary people are more likely to experience anxiety than transgender people

Statistics for Transgender and Gender Diverse People

- 35% of transgender people aged 18 and over[22] have attempted suicide in their lifetime[lxxi]
- 41% of transgender people and non-binary people aged 18 years and over reported thoughts of suicide or self-harm in the last two weeks[lxxii]
- 39.9% of transgender and gender diverse people aged 18 and over have been diagnosed with an anxiety disorder in their lifetime, with 62.1% of of these were diagnosed in the past 12 months[lxxiii]
- 57.2% of transgender and gender diverse people aged 18 and over have been diagnosed with depression in their lifetime, with 54.2% of these were diagnosed in the past 12 months[lxxiv]
- 53.2% of transgender and gender diverse people aged 16 and over have experienced sexual violence or coercion, compared with 13.3% of the general population[lxxv]

Statistics for Transgender Women

- 44.2% of transgender women aged 18 and over reported current thoughts about suicide or self-harm in the last two weeks[lxxvi]
- 57.4% of transgender women aged 16 and over reported being diagnosed or treated with any mental disorder in the past three years [lxxvii]
- 58.9% of transgender women aged 18 and over have been diagnosed with depression in their lifetime [lxxviii]
- 34.4% of transgender women aged 16 and over reported being diagnosed or treated for anxiety in the last three years[lxxix]
- Transgender women average a K10 score of 23.2, indicating high levels of psychological distress [lxxx]

Statistics for Transgender men

- 40.5% of transgender men aged 18 and over and reported current thoughts about suicide or self-harm in the last two weeks[lxxxi]
- 55.3% of transgender men aged 16 and over reported being diagnosed or treated with any mental disorder in the past three years [lxxxii]
- 62.1% of transgender men aged 18 and over have been diagnosed with depression in their lifetime [lxxxiii]
- 42.6% of transgender men aged 16 and over reported being diagnosed or treated for anxiety in the last three years[lxxxiv]
- Transgender men average a K10 score of 23.22, indicating high levels of psychological distress [lxxxv]

Statistics for Non-Binary people

- 37.5% of non-binary people assigned female at birth, and 30.2% of non-binary people assigned male at birth aged 18 years and over reported thoughts of suicide or self-harm in the last two weeks[lxxxvi]
- 54.4% of non-binary people assigned female at birth, and 40.6% of non-binary people assigned male at birth aged 18 and over have been diagnosed with depression in their lifetime[lxxxvii]
- 49.3% of non-binary people assigned female at birth and 30.2% of non-binary people assigned male at birth aged 18 and over have been diagnosed with an anxiety disorder in their lifetime [lxxxviii]
- 66.1% of non-binary people assigned female at birth and 44.5% of non-binary people assigned male at birth, aged 16 and over, have experienced sexual violence or coercion[lxxxix]

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[22] Scottish research of participants in the UK

Intersex

There are significant differences between the mental health and wellbeing of lesbian, gay, bisexual and transgender people, and people with an intersex variation, with social and medical constructions playing an important role in how people feel about their own bodies and intersex variations. For many, wellbeing is impacted as a result of having undergone medical interventions, including unwanted surgery, beginning hormone therapies and feeling emotionally impacted or unlike themselves[xc].

Statistics for People with an Intersex Variation

- 60% of people with an intersex variation reported that they had experienced a medical treatment intervention related to their intersex variation, with over half being before they were aged under 18 years[xci]
- 19% of people with an intersex variation aged 16 and over had attempted suicide on the basis of issues related to having a congenital sex variation[xcii]
- 60% of people with an intersex variation aged 16 and over had thought about suicide on the basis of issues related to having a congenital sex variation[xciii]
- 42% of people with an intersex variation aged 16 and over had thought about self-harm, and 26% had engaged in self-harm on the basis of issues related to having a congenital sex variation[xciv]
- 41% of people with an intersex variation aged 16 and over describe their mental health as fair or poor[xcv]
- 21.3% of people with intersex variations aged 16 and over have been diagnosed with depression[xcvi]
- 12.9% of people with an intersex variation aged 16 and over have been diagnosed with anxiety[xcvii]
- 7.7% of people with an intersex variation have being diagnosed with Post-Traumatic Stress Disorder[xcviii]

ACROSS THE LIFE SPAN

There are differences between the mental health and wellbeing of younger LGBTI people and older LGBTI people, specifically:

- LGBTI young people are five times more likely to attempt suicide than their similar aged peers
- LGBT young people are nearly twice as likely to engage in self-injury than their similar aged peers
- LGBT young people aged 16 to 24 have a higher rate of being diagnosed with a mental disorder than older LGBT people
- LGBT young people aged 16 to 24 have the highest psychological distress of all age groups
- Rates of psychological distress for gay men, lesbian women, bisexual men, bisexual women and transgender women declined with age. Rates for psychological distress among transgender men were consistently high across all age groups.
- The number of transgender people who met the criteria for a depressive or anxiety disorder decreased with age[xcix]

Statistics for LGBTI Younger People

- 16% of LGBTI[23] young people aged 16 to 27 reported that they had attempted suicide[c]
- 42% of LGBTI[24] young people aged 16 to 27 reported having thoughts about suicide[ci]
- 33% of LGBTI[25] young people aged 16 to 27 reported having self-harmed, 41% reported thoughts of harming themselves[cii]
- 47.7% of LGBT people (48.2% women; 29.3% men) aged 16 to 24 reported being diagnosed or treated for any mental disorder in the past three years[ciii]
- 71% of LGBTI+ people aged 16 to 27 indicated that they did not use a crisis support service (CSS) during their most recent personal or mental health crisis[civ]
- 43.5% of transgender and gender diverse people aged 18 to 19 have a major depressive syndrome[cv]
- 72.5% of transgender and gender diverse[26] people aged 14 to 25 have been diagnosed with an anxiety disorder in their lifetime[cvi]
- LGBT young people aged 16 to 24 average K10 score of 23.8, indicating high levels of psychological distress [cvii]

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[23] Note: of 1032 survey participants, only 3 young people identified as having an Intersex variation

[24] Note: of 1032 survey participants, only 3 young people identified as having an Intersex variation

[25] Note: of 1032 survey participants, only 3 young people identified as having an Intersex variation

[26] Note: of 859 survey participants, 74.4% were assigned female at birth, 25.6% were assigned male at birth, and 1.6% identified as intersex

Statistics for LGBTI Older People

- 32.5% of LGBT people aged 45 to 59 (28.7% men and 36.2% women) reported being diagnosed or treated for any mental disorder in the past three years[cviii]
- 19.2% of LGBT people aged 60 to 89 (21.6% men and 16.7% women) reported being diagnosed or treated for any mental disorder in the past three years[cix]
- 19.4% of transgender and gender diverse people aged 50 and over have a major depressive syndrome[cx]
- 10.2% of transgender and gender diverse people aged 50 and over have an anxiety syndrome
- LGBT older people aged 49 to 59 average a K10 score of 19.11, indicating moderate levels of psychological distress [cxi]
- Gay men and lesbian women and transgender women and aged 60 to 89 average a K10 score is 16, indicating moderate levels of psychological distress[cxii]

Statistics for the General Population aged 16 to 24

- 1.1% of people (1.7% females; 0.5% males) aged 16 to 24 have attempted suicide in the past 12 months[cxiii]
- 3.4% of the general population (1.7% of males and 5.1% of females) aged 16 to 24 in Australia have had suicidal ideation in the past 12 months[cxiv]
- 14.1% of people (16.6% females; 11.6% males) aged between 15 and 19; and 21.25% of people (24.4% females; 18.1% males) aged between 20 and 24 have engaged in self injury in their lifetime[cxv]
- 26.4% of young people (30.1% females, 22.8% males) aged 16 to 24 met the criterial for a diagnosis of a mental disorder in the last 12 months.[cxvi]
- 6.3% of young people (8.4% females, 4.3% males) in the general population aged 16 to 24 met the criteria for an affective disorder, and 2.8% for a depressive episode in the past 12 months[cxvii]
- 15.4% of of young people (21.7% females, 9.3% males) aged 16 to 24 met the criteria for an anxiety disorder, 1.3% for a Generalised Anxiety Disorder in the past 12 months[cxviii]

Statistics for the General Population aged 55 and over

- 1.5% of people (1.7% males; 1.4% females) aged 55 to 64, 1.1% aged 65 to 77 and 0.8% aged 75 to 85 have had suicidal ideation in the past 12 months[cxix]
- 13.6% of the general population aged 55 to 64, 8.6% aged 65 to 74, and 5.9% aged 75 to 85 have been diagnosed with a mental disorder in the last 12 months
- 11.3% of the general population aged 55 to 64, 6.3% aged 65 to 74, and 4% aged 75 to 85 have been diagnosed with a anxiety disorder in the last 12 months
- 4.2% of the general population aged 55 to 64, 2.8% aged 65 to 74, and 1.8% aged 75 to 85 have been diagnosed with a affective disorder in the last 12 months

INTERSECTIONS

When considering mental health statics for LGBTI people, it is vital to consider how intersections with other identities and experiences may impact on an individual's wellbeing; however, available research often has not provided a comprehensive analysis of data.

Population Group	What We Know
Aboriginal and Torres Strait Islander People	▪ 4% of people with an intersex variation[cxx] ▪ 1.5% of LGBTI young people aged 16 to 27 [cxxi] ▪ 3% of LGBT young people aged 14 to 21[cxxii] ▪ 3.7% of transgender and gender diverse[27] people aged 14 to 25[cxxiii] ▪ 2.3% LGBT people aged 16 and over[cxxiv] ▪ 2.3% of transgender and gender diverse people aged 18 and over[cxxv]
People with a Cultural and Linguistic Diversity	▪ 28.6% of LGBTI young people aged 16 to 27 identify with a racial or ethnic background other than Anglo-Celtic. 18% report having experienced a conflict between their cultural background and their sexuality or gender identity[cxxvi] ▪ 18% of LGBT young people aged 14 to 21 identify as being culturally and linguistically diverse[cxxvii] ▪ 16% of transgender and gender diverse young people aged 14 to 25 were born outside of Australia[cxxviii] ▪ 18.2% LGBT aged 16 and over were born overseas[cxxix] ▪ 20.2% of transgender and gender diverse people aged 18 and over were born overseas, and 5.5% are from a non-English speaking background[cxxx]
People with Disabilities	▪ 27% of people with an intersex variation aged 16 and over identify as having one or more disabilities[cxxxi] ▪ 36% of transgender people aged 18 and over[28] identify as having a mental health issue that they described as being a disability or chronic health condition[cxxxii]
People From Rural, Regional and Remote Areas	▪ 5.9% of transgender and gender diverse people aged 18 and over (1.7% transgender men, 8.1% transgender women) live in regional or remote Australia[cxxxiii] ▪ 18% of LGBT young people aged 14 to 21 live in rural areas, 2% in remote areas [cxxxiv] ▪ 20% of LGBT people aged 16 and over live in inner and outer regional areas, and 0.7% in rural and remote areas [cxxxv]
People Experiencing Homelessness	▪ 6% of intersex people report they have precarious accommodation or homelessness, couch surfing or living on the street.[cxxxvi] ▪ 22% of transgender and gender diverse[29] people aged 14 to 25 report experiencing accommodation issues and homelessness[cxxxvii] ▪ 51% of LGB young people, and 71% of gender diverse young people aged 14 to 21 don't live at home with family [cxxxviii]

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[27] Note: of 859 survey participants, 74.4% were assigned female at birth, 25.6% were assigned male at birth, and 1.6% identified as intersex

[28] Scottish research of participants in the UK

[29] Note: of 859 survey participants, 74.4% were assigned female at birth, 25.6% were assigned male at birth, and 1.6% identified as intersex

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LGBTI

National LGBTI
Health Alliance

ANZ donates to QLife this Mardi Gras to support, connect and empower Australia's LGBTIQ+ community

ANZ today announced a $100,000 donation to QLife, an LGBTIQ+ support service, demonstrating ANZ's long term support for the LGBTIQ+ community and as principal partner of Sydney Gay and Lesbian Mardi Gras.

During the second half of 2020, QLife experienced a 58% increase in the number of people wanting to access its telephone and web services. It also recorded a 31% increase in calls from people who said they had experienced feelings of "isolation" and "loneliness".

The social effects of the pandemic proved to be particularly challenging for LGBTIQ+ Australians living in rural and remote communities, where QLife experienced a 78% increase in the total number of calls made to the service, year-on-year.

Additional QLife Research Findings:

COVID-19 & Lockdown Effects

- 31% **increase in calls pertaining to loneliness** and feelings of isolation made by LGBTIQ+ Australians, year-on-year
- One in 10 calls pertained to **loneliness and isolation**, making it the most frequent topic in 2020 (12%), followed by family relationships
- Spikes of calls corresponded with **national/state-based lockdowns**, including Australia's first national lockdown where the volume of calls on **loneliness and isolation themes** increased by approximately 52% between May and August 2020.

Volume of Calls/Enquiries:

- 22% **increase in total support calls** made by LGBTIQ+ Australians YOY from 2019 to 2020
    - 78.4% call increase in regional and remote communities
    - 10.7% call increase in cities and major metropolitan areas
    - 70.5% call increase in support calls from under 18s and 54% increase in support enquiries across all contact methods among the 51 – 75 age group.
- 58% **increase during the second half of 2020** compared to the first (Jan – June, compared to July – Dec)
    - 25.79% call increase in regional and remote communities
    - 38.96% call increase in cities and major metropolitan areas
- Webchats increased by 13.3% in 2020, compared to 2019
- Emails increased by 6.9%

Breakdown by Region:

- 74% increase in Tasmania
- 65% increase in ACT
- 54% increase in South Australia
- 47% increase in Northern Territory
- 37% increase in Victoria
- 22% increase in New South Wales
- *-11% decrease in Queenslanders*
- *-34% decrease in demand from Western Australians*

Breakdown by Age:

- 70.5% increase in demand from Under 18's
- 14.4% increase in demand from 18 – 25 year olds
- 48.8% increase in demand from 26 – 34 year olds
- *-8.1% decrease in demand from 35 – 50 year olds*
- 38.5% increase in demand from 51 – 65 year olds
- 43.1% increase in demand from 66 – 75 year olds
- *-52.4% decrease in demand from 76 – 85 year olds*
- *-14.3% decrease in demand from 85+*

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The Health and Well-Being of Transgender Australians: A National Community Survey

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Abstract

Purpose: Transgender, including gender diverse and nonbinary (trans), people experience significant health disparities. We aimed to better understand the health status and needs of Australian trans people to guide resources and health and well-being programs.
Methods: This anonymous, cross-sectional online survey utilized nonprobability snowball sampling of Australian adults (18 years and over) who self-identified as trans between September 2017 and January 2018. This descriptive study assessed demographic data, community views on access to health care, health burden, access to health resources, and priorities for government funding in transgender health.
Results: Of 928 participants, 37% reported female, 36% reported male, and 27% reported nonbinary gender identities. Despite 47% having tertiary qualifications, the unemployment rate was 19%, with 33% reporting discrimination in employment due to being trans. Discrimination in accessing health care was reported by 26% and verbal abuse and physical assault were reported by 63% and 22%, respectively. Lifetime diagnosis of depression was reported by 73% and anxiety by 67%. Sixty-three percent reported previous self-harm and 43% had attempted suicide. Autism spectrum disorder and attention-deficit/hyperactivity disorder were reported by 15% and 11%, respectively. The most preferred method of receiving health information was through online resources, with the most popular source being Reddit, an online peer discussion board. Better training for doctors in trans health issues was the top priority for government funding.
Conclusions: Barriers, including widespread discrimination and unemployment, contribute to health inequity and prevalent mental health conditions. Better training for health professionals in the provision of safe, gender-affirming and general health care for trans people is urgently required.

Keywords: barriers to care, gender-affirming endocrine care, gender-affirming surgical care, gender dysphoria, transgender

Introduction

The number of transgender, including gender diverse and nonbinary (trans), individuals seeking gender-affirming health care worldwide is rising,[1] yet global studies have demonstrated that trans people face many barriers to accessing health care, including discrimination[2] and the inability to find doctors willing to provide care,[3] as well as high rates of depression and attempted suicide.[1,4] Mental health distress is driven, in part, by barriers to accessing health care as well as by discrimination.[1,5–8] In addition, co-occurring autism spectrum disorders (ASD) and attention-deficit/hyperactivity disorder (ADHD) may also be more prevalent among trans individuals for unclear reasons, with difficulties with attention or social interaction potentially posing greater barriers by affecting the ability to understand health information or engage in clinical care.[1,9]

There are little data describing the health of the Australian adult trans population. Due to a lack of population data, it is unknown how many Australians identify as trans. A nonpeer-reviewed publication described very high levels of mental health conditions, particularly depression and anxiety syndromes, poor quality of life, and high rates of discrimination among Australian trans adults in 2013 (Ref.[10]). Similarly, high rates of mental health conditions were observed in trans adults attending specialized

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gender affirmation clinics in the state of Victoria; however, these findings may not be generalizable.[1]

Australia's universal health care system provides free or low-cost, government-subsidized general health services, including general or specialist consultations, pathology collection, and medications, including gender-affirming hormones. However, in regions with fewer specialized gender services, access to low-cost options may be limited.

Access to gender-affirming interventions in Australia typically follows one of two pathways; either a formal assessment and approval by a mental health professional as per the World Professional Association for Transgender Health Standards of Care[11] or an alternative informed consent model of care where a decision to commence gender-affirming hormones is shared between a primary care general practitioner and a trans individual without mandating a formal mental health review.[12] Due to a lack of publicly funded gender-affirming surgery, this is provided almost entirely in the private health sector, which carries significant out-of-pocket costs.

This community-based survey sought to better understand the health needs of Australian trans individuals to direct local health resources to best meet health care needs. We hypothesized that transgender individuals have significant barriers to accessing health care, including socioeconomic disadvantage, high burden of co-occurring mental health conditions, and discrimination. The aim of this descriptive study was to assess the sociodemographic characteristics and medical and mental health conditions affecting adult trans Australians; to obtain views on health burden, ability to access health care, and ability to access health resources; and to understand community views on funding priorities for trans health.

Methods

This anonymous community survey utilized a nonprobability snowball sampling approach to survey trans Australian adults aged 18 years and over using an online survey platform (SurveyMonkey, Inc., USA) between September 1, 2017, and January 31, 2018. The full survey is listed in Supplementary Appendix SA1. Participants were recruited through the Trans Health Research group Facebook page and the study also was promoted at the Australian and New Zealand Professional Association for Transgender Health Biennial Meeting in Sydney, Australia, in September 2017 and at the Midsumma LGBTIQ+ Festival in Melbourne, Australia, in January 2018. Written informed consent was not possible given the anonymous online design; however, the survey preamble outlined that completion of the survey implied consent. The survey link was available as a URL and did not require access to a specific social media account. The study was approved by the Austin Health Human Research and Ethics Committee (HREC/17/Austin/372).

Inclusion criteria were assessed through a positive response to three screening questions: (1) residency in Australia; (2) identification as trans or had previously identified as such; and (3) aged 18 years or over. The inclusion of those who had previously identified as trans was intended to include those who identified as their affirmed gender (male or female) rather than with the term transgender. Individuals were eligible to complete the survey on one occasion only and duplicate responses from the same internet protocol address were excluded. All included individuals had discordance between their assigned sex at birth and their gender identity. Other than the initial screening questions, all subsequent survey questions were optional.

Demographic data

Participants' birth years and postcodes were obtained. Postcodes were coded as per the Australian Standard Geographical Classification–Remoteness Area (RA) coding[13] to one of five groups; RA1 (inner cities) to RA5 (very remote). Participants were asked to select their sex assigned at birth (male, female, or intersex) and their gender identity (see Table 1 for options). To enable meaningful statistical analyses, gender identities were then further categorized into three groups: trans man/trans male/trans masculine and male gender identities were coded as male identities; trans woman/trans female/trans feminine and female were coded as female identities; and gender nonbinary, gender queer, gender neutral, gender fluid, intersex, and agender were coded as nonbinary gender identities. Those who selected ''other'' also entered free text and were reclassified accordingly. Formal education, requirement for government financial assistance, and employment status were assessed (responses as outlined in Table 1). Participants were able to select more than one employment status. To reflect engagement with the workforce, if two options were selected, individuals were classified in the group that reflected the most workforce engagement. For example, if a person was a student and casually employed, they were classified as casually employed.

Access to health care and health burden

Current smoking and past 12-month illicit drug use were self-reported, and self-perception of overall health was evaluated (responses available outlined in Table 2). Participants were asked about their access to various types of health care providers, including availability of general practitioners and their confidence in discussing health issues of concern with their treating doctor. As discrimination has been identified as a barrier to health care in previous surveys,[14] participants were asked if they had perceived discrimination in employment, housing, accessing health care, and government services and/or whether they had experienced physical assault, verbal abuse, and domestic violence because of their gender identity. trans individuals were asked whether they had experienced any difficulty accessing hormonal treatment (such as the inability to find a doctor who is willing to prescribe, financial costs of prescriptions, financial costs of doctor's appointments, or other [specify]). Participants were also asked if they had taken any hormonal treatments without a prescription.

To assess the community's value of mental health assessments before commencing gender-affirming hormonal treatment, participants were asked ''Do you feel that a mental health assessment for trans and gender diverse individuals should be performed prior to accessing hormonal treatment?'' Assessment of access to and desire for gender-affirming hormonal and surgical treatments and previous medical and mental health conditions relied on self-reporting, and no specific diagnostic tools were used. History of self-harm or attempted suicide was also ascertained.

Table 1. Sociodemographic Parameters of the Participants

Parameter	*Number of responses received*	*Frequency,* n *(%)*
State of residence	911	
Victoria		282 (31)
New South Wales		195 (21)
Queensland		143 (16)
Western Australia		126 (14)
South Australia		92 (10)
Tasmania		37 (4)
Australian Capital Territory		34 (4)
Northern Territory		2 (<1)
Age group (years)	928	
18–24		289 (31)
25–29		216 (23)
30–39		193 (21)
40–49		125 (13)
50–59		71 (8)
60–69		30 (3)
70–79		4 (<1)
Sex assigned at birth	928	
Female		520 (56)
Male		403 (43)
Intersex		5 (1)
Gender identity	928	
Male		91 (10)
Female		140 (15)
Trans man/trans male/trans masculine		239 (26)
Trans woman/trans female/trans feminine		202 (22)
Gender nonbinary		133 (14)
Gender queer		41 (4)
Gender neutral		11 (1)
Gender fluid		19 (2)
Intersex		2 (<1)
Agender		20 (2)
Other		30 (3)
Education level	928	
Never attended school		1 (<1)
Primary school		0
Some high school		98 (11)
Completed high school		222 (24)
Trade/technical certificate or apprenticeship		170 (18)
University or tertiary qualifications		437 (47)
Employment status	928	
Employed on a full-time basis		274 (30)
Employed on a part-time or casual basis		224 (24)
Home duties full-time		13 (1)
Student		176 (19)
Retired		20 (2)
Unemployed		177 (19)
Other (free text)		44 (5)

Access to health resources and priorities for government funding

Preferred methods (i.e., social media, online resources, videos, forums, and print) of receiving health information were assessed, including involvement in support groups and websites used to locate information on trans health. Desire for local, Australian-based, trans health resources was also determined. Participants selected the areas of priority to which they thought resources should be directed (education about gender diversity, gender clinics, support groups, trans advocacy groups, counseling, better training for doctors in trans issues, transgender medical research, psychology/psychiatry services, or other [free text]). Qualitative analysis results of several open-ended questions regarding health issues of concern have been reported separately.[15]

Statistical analysis

Statistical analysis was performed using SPSS Statistics, version 23 (IBM Corporation, Armonk, NY). Descriptive frequencies are reported and medians (interquartile range) are reported for non-normally distributed data.

Results

The survey social media post was shared by 275 individuals and transgender support groups on the social media site Facebook. A total of 964 responses to the survey were obtained. After excluding duplicates from the same IP address, blank surveys, or those that did not meet the inclusion criteria (based on the previously described screening questions), 928 eligible responses remained.

Sociodemographic data

As shown in Table 1, responses were received from every Australian state and territory. The greatest number of participants ($n=282$, 31%) resided in Victoria. Eighty-three percent ($n=752$) of those that responded resided in inner city areas (RA1). Median age was 28 years (interquartile range 23–39). Thirty-seven percent ($n=342$) reported female identities, 36% ($n=330$) reported male identities, and 27% ($n=256$) reported nonbinary gender identities. Participants had high levels of education, with 47% ($n=437$) holding a university qualification. The unemployment rate was 19% ($n=177$). The majority ($n=376$, 57%) reported receiving some form of government financial assistance.

Access to health care and health burden

Table 2 outlines responses describing access to health care and health burden. Current smoking in 15% ($n=141$) of participants is comparable with national data indicating that 11.6% of Australian adults reported smoking cigarettes daily.[16] Illicit drug use was high, with 33% ($n=305$) of respondents reporting use of illicit drugs in the past 12 months and is approximately double the general Australian population rate of illicit drug use of 16.4% in the preceding 12 months in 2019 (reported in people aged 14 years and over).[17] Nearly 80% ($n=711$) described at least good health and 80% ($n=732$) had a regular family doctor or general practitioner. When asked if individuals had ever experienced any difficulty accessing hormonal treatment, 41% ($n=372$) selected ''none.'' A third ($n=284$) reported that the pathway to accessing hormones was too difficult. Discrimination because of gender identity was widespread, with 33% ($n=304$) reporting discrimination related to employment and 26% ($n=244$) related to accessing health care. Verbal

TABLE 2. ACCESS TO HEALTH CARE AND HEALTH BURDEN

Parameter	*Number of responses received*	*Frequency,* n *(%)*
Self-perception of overall health	907	
Excellent		86 (9)
Very good		224 (25)
Good		401 (44)
Poor		171 (19)
Very poor		25 (3)
Health care providers utilized[a]	928	
GP		779 (84)
Psychologist		631 (68)
Psychiatrist		508 (55)
Endocrinologist		413 (45)
Surgeon		298 (32)
Nurse		235 (25)
Speech pathologist		117 (13)
Gender clinic within a hospital		103 (11)
Gynecologist		87 (9)
None		89 (10)
Other (free text)		32 (3)
Discrimination[a]	927	
Discrimination in employment		304 (33)
Discrimination in accessing health care		244 (26)
Discrimination in government services		149 (16)
Discrimination in housing		95 (10)
Verbal abuse		584 (63)
Physical assault		200 (22)
Domestic violence		133 (14)
Difficulty accessing hormonal treatment[a]	905	
None		372 (41)
Unable to find a doctor to prescribe		148 (16)
Financial costs of prescriptions		124 (14)
Financial costs of doctor's appointments		156 (17)
Pathway to accessing hormones was too difficult		284 (31)
Other (specify)		100 (11)
Views on informed consent—Should trans people undertake a formal mental health practitioner assessment?	913	
Yes, in all cases		285 (31)
Yes, but only in some circumstances		392 (43)
No		187 (20)
Unsure		48 (5)
Masculinizing hormone treatments in birth-assigned females[a]	509	
None		191 (38)
Testosterone injections		267 (53)
Testosterone creams, gels, or patches		45 (9)
Testosterone implants		2 (<1)
GnRH analogs		2 (<1)
Progestins		4 (<1)
Other		7 (1)
Feminizing hormone treatments in birth-assigned males[a]	402	
None		75 (19)
Estradiol oral tablets		205 (51)
Estradiol transdermal patches		56 (14)
Estradiol gels		33 (8)
Estradiol implants		52 (13)
Combined oral contraceptive pill		14 (3)
Spironolactone		130 (32)
Cyproterone acetate		106 (26)
Bicalutamide		1 (<1)
GnRH analogs		2 (<1)
Progestins or micronized progesterone		63 (16)
Other (i.e., finasteride or estradiol injections)		11 (3)
Overseas surgery	914	
Yes		72 (8)
No		841 (92)
Unsure/prefer not to say		1 (<1)
Medical conditions	914	
Depression		663 (73)
Anxiety		613 (67)
Fractures (broken bone)		191 (21)
Autism spectrum or Asperger's syndrome		137 (15)
ADHD		96 (11)
Bipolar disorder		75 (8)
Diabetes mellitus		25 (3)
Cancer		19 (2)
Blood clots (pulmonary embolus or deep vein thrombosis)		16 (2)
Liver disease		13 (1)
Stroke		11 (1)
HIV/AIDS		5 (<1)
Ischemic heart disease		4 (<1)
Emphysema		3 (<1)
Kidney or renal disease		3 (<1)
None of the above options selected[b]		136 (15)

[a] Multiple responses were allowed for this question, so total responses do not sum to 100%.

[b] None was not an option in the survey but was presumed if no medical conditions were selected but answers were completed to the remaining questions in Section 2: Your Health of the survey.

ADHD, attention-deficit/hyperactivity disorder; GnRH, gonadotropin-releasing hormone; GP, general practitioner; trans, transgender, including gender diverse and nonbinary.

abuse because of their trans status was reported by 63% of respondents and physical assault because of their trans status was reported by 22%.

There were mixed responses to the need for a formal mental health assessment prior to commencement of hormonal therapy and it is acknowledged that wording of this question may have contributed to ambiguity (Table 2). There was a very high prevalence of self-reported depression and anxiety

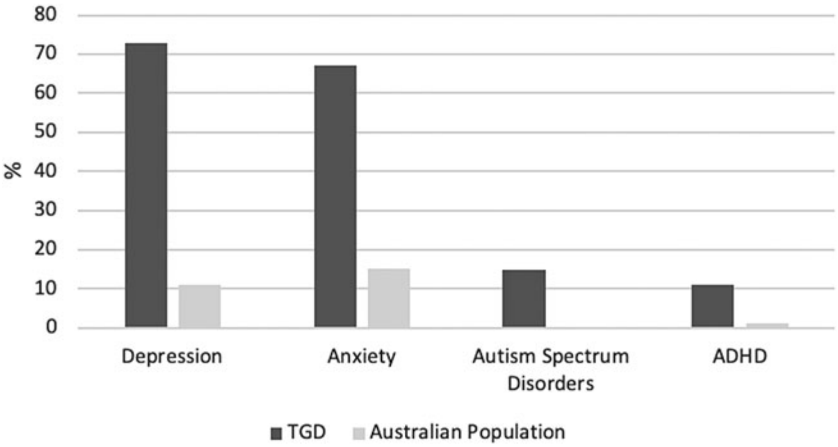

FIG. 1. Self-reported diagnoses in trans individuals versus the Australian population (age-matched).[18–20] ADHD, attention-deficit/hyperactivity disorder; trans, transgender, including gender diverse and nonbinary.

as well as ASD and ADHD (Fig. 1).[18–20] Intentional self-harm was reported by 63% ($n=577$) of participants and 43% ($n=394$) reported having previously attempted suicide.

Gender-affirming surgical interventions are summarized in Table 3. Genital reconstruction surgery was the most common procedure undertaken by those assigned male at birth ($n=71$, 18%); however, a further 64% ($n=243$) desired this surgery in the future. The most frequent procedure undertaken by those assigned female at birth was bilateral mastectomy or chest reconstruction ($n=159$, 31%). Similarly, a further 58% ($n=297$) desired this procedure in the future.

Access to health resources and priorities for government funding

The most preferred method of receiving health information was through online resources ($n=400$, 50%) (Table 4). Forty-three percent ($n=369$) of participants used existing online sources for health information. The most popular source reported in this study was Reddit, an online discussion board with user-generated content, followed by Facebook, Susan's Place, FtM Australia, Wikipedia, YouTube, and Tumblr. The majority (95%, $n=814$) supported the development of a comprehensive online website with local, Australian-based, trans health resources, and 89% of the participants ($n=768$) used social media daily. Better training for doctors in trans issues was the most frequently selected priority for government funding (32%, $n=267$); complete responses are listed in Table 4.

Discussion

This large community-based survey involving 928 participants described persistent, concerning health statistics among trans Australian adults: high rates of self-reported mental health morbidities, such as anxiety and depression, as well as high rates of self-reported self-harm (63%) and attempted suicide (43%). There were widespread experiences of discrimination, especially in health care settings (26%). Moreover, a majority of the participants had experienced verbal abuse (63%), with fewer reporting physical assault (22%) because of their trans status. There were barriers to employment (19% unemployed) despite high levels of tertiary education. Additional barriers to accessing health care existed, such as difficult ambiguous pathways for accessing gender-affirming hormonal therapy; difficulty finding doctors to prescribe treatment; and the potentially high, out-of-pocket financial costs of surgical care. Although the use of gender-affirming hormone therapy was common, significant difficulties existed in accessing gender-affirming surgery. Even though most of the participants accessed health information from peer-generated online websites, there was support for development of reliable, local health resources. Better training for doctors in trans health issues was highlighted as the top priority for government funding by 32% of participants.

Sociodemographic data

We observed a breadth of gender identities in the trans community across Australia with approximately equal

TABLE 3. ACCESS TO AND DESIRE FOR GENDER-AFFIRMING SURGERY

	Total number of responses	*Have had,* n *(%)*	*Want someday,* n *(%)*	*Don't want,* n *(%)*
Surgical procedures in birth-assigned males ($n=403$)				
Breast augmentation	362	32 (9)	196 (54)	134 (37)
Genital reconstruction surgery	384	71 (18)	243 (64)	70 (18)
Facial feminization surgery	372	23 (6)	235 (63)	114 (31)
Voice surgery	348	6 (2)	149 (43)	193 (55)
Surgical procedures in birth-assigned females ($n=520$)				
Chest surgery/mastectomy	511	159 (31)	297 (58)	55 (11)
Genital reconstruction surgery	481	10 (2)	213 (44)	258 (54)
Voice surgery	405	1 (<1)	15 (4)	389 (96)

Percentages are rounded to whole numbers.

Table 4. Access to Health Resources and Priorities for Government Funding

Parameter	*Number of responses received*	*Frequency,* n *(%)*
Most preferred method of receiving health information	799	
Online (websites and e-mail, etc.)		400 (50)
Social media (e.g., Facebook)		150 (19)
Videos or podcasts		57 (7)
Telephone contact		43 (5)
Hardcopy print materials (e.g., brochures)		41 (5)
Small local community talks/seminars		39 (5)
Apps (on mobile devices)		35 (4)
Online group forums (e.g., webinars)		24 (3)
Larger group gatherings (e.g., conferences)		10 (1)
Social media use	859	
Daily		768 (89)
Couple of times a week		55 (6)
Occasionally (e.g., once a week)		19 (2)
Rarely (e.g., once a fortnight)		10 (1)
Not at all		7 (<1)
Top priority for government funding	824	
Better training for doctors in trans issues		267 (32)
Gender clinics		205 (25)
Education about gender diversity (i.e., community or schools)		197 (24)
Trans or gender-related medical research		83 (10)
Psychology or psychiatry services		32 (4)
Support groups		18 (2)
Trans advocacy groups		14 (2)
Counseling		8 (1)
Other (free text)		0

thirds of the participants having female, male, and nonbinary identities. This contrasts with historical reports that the prevalence of trans female individuals outnumbered trans male individuals.[21] The high proportion of people with nonbinary gender identities is consistent with rates observed in our primary care clinics in Australia[1] and may reflect increasing societal views that challenge binary gender stereotypes.

The unemployment rate of 19% was three times that of the Australian general population rate of 5.5% in May 2018 and well above the youth unemployment rate (12.2%).[22] Notably, 33% of respondents perceived discrimination in employment. Unemployment may also occur due to difficulty with name and identity documents, discrimination in basic housing and health care,[5] and the impact of mental health conditions such as depression and anxiety on an individual's ability to seek or maintain employment. Conversely, levels of depression and anxiety may be higher due to unemployment.[23]

Access to health care and health burden

Similar to prior reports,[5] discrimination in all aspects of life was frequently reported by trans Australians, which is not only harmful but also perpetuates inequity. Most concerning is that safe access to health care, which should be accessible to all, is not a reality for trans Australians and this is supported by the participants' selected top priority for government funding being better training for doctors in trans health issues. Access to surgery is a major challenge in Australia, with (anecdotally) few surgeons experienced in providing gender-affirming surgery. Moreover, surgery is predominantly provided in the private health system, which is associated with prohibitive financial costs. There is a need for education and training to target the number of surgeons providing gender-affirming surgery.

Self-reported depression and anxiety were highly prevalent in $\sim$70% of individuals, as were self-reported diagnoses of ASD and ADHD (Fig. 1). These are consistent with data from individuals attending specialized gender clinics[1] as well as from international reports.[24] Notably, a diagnosis of ADHD in childhood is associated with a higher risk of having at least one mental health condition and a higher risk of death by suicide.[25] As positive screening tools for ASD may reflect elevated social anxiety experienced by trans people, data describing the coexistence of ASD are conflicting and further research is needed.[9]

The most concerning data are the self-reported self-harm and attempted suicide rates, a reflection of the severe distress and despair that many trans individuals have faced. These suicidality rates are much higher than the lifetime prevalence of suicide attempts in Australian adults (3.3%).[26] Our Australian data mirror findings in the U.S. National Transgender Discrimination Survey of 6450 trans Americans, which first highlighted widespread discrimination in many aspects of life, including double the rate of unemployment; 19% being refused medical care due to their trans status; and 41% of suicide attempts (compared with 1.6% of the general population).[27] Lack of acceptance in the community and, at times, among health professionals leaves few resources for trans individuals to access help and support. This is a significant public health concern and there is an urgent need for a coordinated and combined suicide prevention response.

Health resources and priorities for government funding

The top priority for government funding was better training in trans health issues for doctors. Although greater awareness of and more coordinated training in trans health need to occur, in response to findings from this study, an evidence-based local position statement was published regarding the hormonal management of trans adults to provide a point-of-care resource for doctors caring for trans individuals.[12] In response to the community desire for Australian-based trans health information, we contributed to the development of trans community-led online health resources (Trans Health Research and TransHub).[28,29]

Limitations

There are multiple limitations to this study. The online-based recruitment may explain why a greater proportion of responders were younger individuals and may not accurately reflect the views of the older trans community. There may be self-selection bias and not all areas of Australia were equally represented as recruitment was not targeted. There was a predominance of respondents from southeastern states, which may be related to physical promotion of the study at one event in Victoria and one in New South Wales. However, distribution of respondents was similar to a previous 2013 Western Australian-based survey.[10] Ethnicity data were not collected, so we were unable to ascertain if this was a factor associated with additional barriers when accessing health care. Medical conditions were self-reported, and we were not able to utilize any diagnostic measures to confirm diagnoses. Furthermore, we did not gauge temporal trends in diagnoses and did not distinguish current from past medical conditions, which may be particularly relevant in the interpretation of the prevalence of ADHD. Participants were asked whether a mental health assessment for trans and gender diverse individuals should be performed prior to accessing hormonal treatment. There was likely a response bias in favor of the mental health assessment model as we did not make it clear that we were referring to a formal mental health assessment by a psychologist or psychiatrist rather than by the primary care physician in the wording of this question.

However, this survey provided a platform for participants to express their views anonymously, which potentially facilitated the expression of more honest responses than a face-to-face interview or government statistics form. The fact that many of our findings, although self-reported (such as rates of self-harm), replicate those from prior similar studies conducted with other transgender populations supports both the validity and the generalizability of our findings. Despite the limitations, this is one of the largest published studies of adult trans individuals in the Australian population and provides valuable insight on the status of health and health needs of a traditionally marginalized community that is underrepresented in research.

Conclusions

This large community survey highlights a myriad of challenges faced by trans adult Australians, including discrimination, abuse, unemployment, and inability to find doctors to access general health care and gender-affirming care. Reducing the high attempted suicide rate and burden of mental health conditions needs to be prioritized. The participants in this study identified the training of doctors in trans health as a priority. This should be one of the first steps to ensure that basic health needs are met. Urgent action is required from a policy perspective to address the concerning health disparities described herein and to ensure that all trans people are safe and empowered to live a life without barriers.

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Author Disclosure Statement

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Supplementary Material

Supplementary Appendix SA1

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The First Australian National Trans Mental Health Study

Summary of Results

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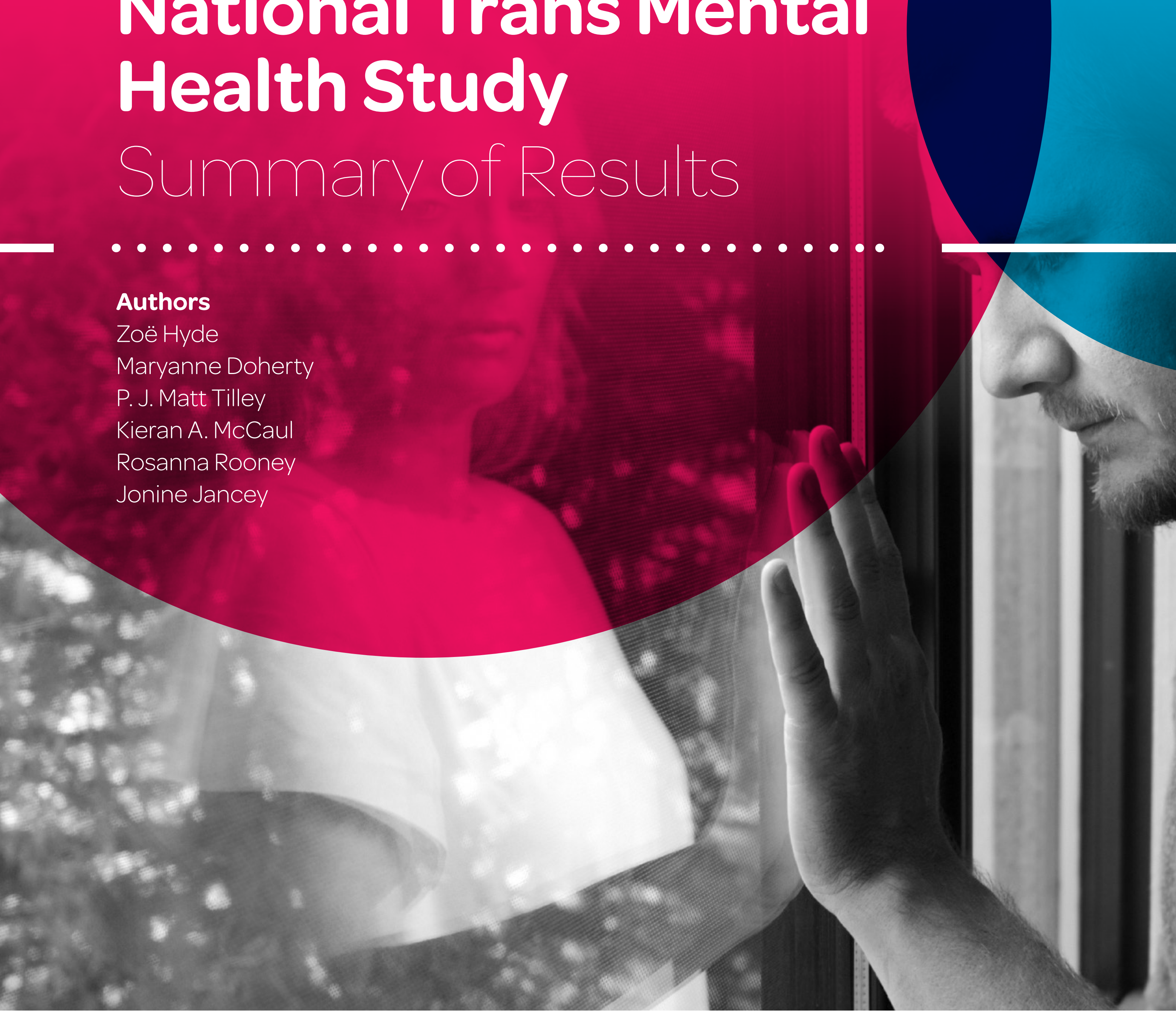

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The First Australian National Trans Mental Health Study: Summary of Results

2013

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Copies of this report and other publications arising from this project may be obtained by visiting the study website at **transoz.org** or by writing to:

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Preface

The health of trans people in Australia is in a state of crisis. While it is true that some trans people are living healthy and happy lives, this is not true for all. The findings detailed in this report show that at least in absolute terms, an alarmingly large number of trans people experience high levels of mental distress (particularly depression and anxiety syndromes) and poor quality of life.

During the period our research team was conducting this study, we became aware of a number of suicides in the trans community. These were not the first such suicides that we knew had occurred. Sadly, neither will they be the last unless urgent action is taken to address the health disparity experienced by this population.

One such suicide took place in the researchers' home city a few weeks after the study began. This suicide is no more or less tragic than any other, but what was significant for us was that this woman had written about what life was like as a young trans person in Western Australia shortly before she died. We think her story is now especially poignant, and we present an extract below. The full article (*"Amber's story"*) can be found on page 18 of Red Flag issue 4 (24 July 2013), available online at:
http://redflag.org.au/article/amber%E2%80%99s-story

> *As a young trans person living in Perth, my experience attempting to find housing illustrates the discrimination that transgender people face on a daily basis. I've been rejected from share-houses on the basis that the advert specified they were looking for a female and I don't "fit that criterion". Several times I was rejected on the basis that the house was looking for "real girls".*
>
> *When I sought their assistance, Youth Futures, Western Australia's TINOCA (Teens In Need Of Crisis Accommodation) service, informed me that it is their policy to house young people with people of the same physical sex ... A different service hung up on me after telling me that they only had spaces for females (evidently I didn't sound female enough).*
>
> ...

> *While initially attempting to access services to help me transition, I came across a "youth specialist" who after three sessions informed me that he had only ever met one other person my age who identified as transgender. He then went on to explain that he had convinced this person that it was not in their best interests to transition and that consequently he neither could nor would help me.*
>
> *In addition to this, my experiences with doctors from whom I've sought assistance for other issues made clear the serious lack of suitable health care for trans people. I was admitted to hospital in December last year with an admission document that, I later found out, described me as a "transitioning transvestite".*
>
> *I was also told by another doctor that though the staff were aware of my status as a trans person and aware that I identified as female, I would have to constantly remind people and correct them if they misgendered me. This same doctor also asked me whether I planned to have genital surgery, regardless of the fact that this had no relevance to the issue I was hospitalised for.*
>
> ...

The people who participated in this study shared with us many stories like this. It is clear that experiences like those described above, although extremely tragic, are far from unique.

This report is dedicated to all of the trans people who we have lost to suicide.

We hope that the findings of this report are acted upon with urgency, so that trans people do not continue to die unnecessarily.

List of abbreviations

AFAB	Assigned female at birth
AMAB	Assigned male at birth
ATSI	Aboriginal and/or Torres Strait Islander
BP	Bodily pain (SF-36 summary scale)
DSM	Diagnostic and Statistical Manual of Mental Disorders
FTM	Female to male
GH	General health (SF-36 summary scale)
GLBTI	Gay, lesbian, bisexual, trans, and intersex
GnRH	Gonadotropin-releasing hormone
GP	General practitioner
HILDA	2001 Household Income and Labour Dynamics in Australia survey
ICD	International Classification of Diseases and Related Health Problems
ID	Identifying documents
LGB	Lesbian, gay, and bisexual
LGBTI	Lesbian, gay, bisexual, trans, and intersex
MBS	Medicare Benefits Schedule
MH	Mental health (SF-36 summary scale)
MTF	Male to female
NESB	Non-English speaking background
NHMRC	National Health and Medical Research Council of Australia
NHS	1995 National Health Survey
NITV	National Indigenous Television channel
PBS	Pharmaceutical Benefits Scheme
PDRQ-9	Patient-Doctor Relationship Questionnaire
PF	Physical functioning (SF-36 summary scale)
PHQ	Patient Health Questionnaire
QOL	Quality of life
RE	Role-emotional (SF-36 summary scale)
RP	Role-physical (SF-36 summary scale)
SF	Social functioning (SF-36 summary scale)
SF-36	36-item Short Form Health Survey
TAFE	Technical and Further Education
VT	Vitality (SF-36 summary scale)
WHO	World Health Organisation

Synopsis

This report provides an overview of the findings of The First Australian National Trans Mental Health Study. The study, which ran for 5 months between August and December 2013, was designed to investigate the mental health and well-being of trans people living in Australia. The study was anonymous, Internet-based, and open to anyone who self-identified as trans (or could have been described as such) and was aged 18 years or older. Participants were recruited through social media; through flyers and posters sent to doctors, service providers, and other organisations working with this population; and with snowball sampling. After excluding people who did not fit the inclusion criteria for the study, 946 people took part. Participants included 482 trans women (51.0%), 232 trans men (24.5%), 136 people who were assigned female at birth but now had a non-binary identity (14.4%), and 96 people who were assigned male at birth but now had a non-binary identity (10.1%). The study is the largest study of its kind in Australia, and one of the largest in the world.

The study found that trans people experience very high levels of mental health problems, particularly depression and anxiety syndromes. At the time they completed the questionnaire, 43.7% of the sample were currently experiencing clinically relevant depressive symptoms; 28.8% met the criteria for a current major depressive syndrome; 5.4% for another depressive syndrome; 18.3% for a panic syndrome; and 16.9% for another anxiety syndrome. One in 5 participants (20.9%) reported thoughts of suicidal ideation or self-harm on at least half of the days in the 2 weeks preceding the survey.

Over half of participants (57.2%) had been diagnosed with depression at some point in their lives. Of those diagnosed with depression, 54.2% had been diagnosed in the last 12 months. Roughly 2 out of every 5 participants (39.9%) had been diagnosed with an anxiety disorder at some point, and of these, 62.1% had been diagnosed in the last 12 months.

To place these results in context, trans people appear to be 4 times more likely to have ever been diagnosed with depression than the general population, and approximately 1.5 times more likely to have ever been diagnosed with an anxiety disorder. Of even greater concern, is that the proportion of participants who were *currently* affected by a depression or anxiety syndrome was greater than the *lifetime* prevalence of depression and anxiety disorders in the general population. This finding held after the data were age-standardised to the Australian population.

There was a marked difference in the proportion of people who were currently experiencing clinically relevant depressive symptoms by both hormone use, and surgical status. In those taking hormone therapy the proportion was 39.8%, while in those who were not taking it (but wished to do so), the proportion was 58.4%. Of those who had undergone at least some form of transition-related surgery, the proportion with clinically relevant depressive symptoms was 34.6%. Among those who desired (but had not undergone) surgery, it was 51.3%. This supports previous research that access to hormones and surgery improves quality of life.

In multivariate regression analyses, the factors associated with poor mental health were: sex identity (trans men, and especially trans women, were more likely to have clinically relevant depressive symptoms than non-binary individuals, while non-binary individuals were more likely to have been diagnosed with an anxiety disorder or to currently have an anxiety syndrome); lower educational attainment; being unemployed or unable to work; low income; poor self-rated health; wanting to take hormone therapy; wanting to undergo surgery; difficulty changing identifying documents; not feeling comfortable telling doctors about being trans; and a recent experience of discrimination.

Participants were also asked to describe the factors they thought influenced their mental health; what their experiences accessing healthcare were like; how they felt about changing identifying documents; and experiences of discrimination. The personal stories shared by participants were consistent with the findings of the regression analyses.

Overall, participants reported that obtaining hormone therapy was often a difficult and frustrating experience, but immensely rewarding and affirming once they were able to commence hormone therapy. They reported that it was often very difficult, if not impossible to access some kinds of surgery in Australia, because they were either unable to afford the cost or because the desired surgery was unavailable. Participants reported that changing their identifying documents was often a difficult and frustrating process, and recounted the negative impact that not being able to change these documents had on their life.

Experiences of discrimination and harassment were common. Nearly two thirds of participants (64.8%) reported at least one instance, with experiences ranging from social exclusion to violence and assault. Many participants reported changing their behaviour for fear of being subject to further instances. Participants also reported discrimination when accessing healthcare, and that the healthcare system generally failed to meet their needs. Some participants did report good relationships with medical practitioners, but this was often a matter of luck in finding a supportive doctor and knowing where to go for help.

These findings suggest trans people experience worse mental health than possibly any other community in Australia, and demonstrate an urgent need to address the factors underlying this disparity, such as poor healthcare and discrimination. This report concludes with a series of recommendations that could dramatically improve the quality of life of trans people. They are relatively simple to implement. In particular, key areas for reform include:

(i) Provision of a multidisciplinary clinic in each state and territory (operating within the public health system), which can provide healthcare for trans people;
(ii) Health departments must develop clear referral pathways and protocols for trans people, so that trans people and their doctors know the exact steps to follow to achieve a medical transition;
(iii) Healthcare for trans people should be based on an informed consent model, rather than a "gatekeeping" approach;
(iv) Trans health must become a part of multidisciplinary health curriculums, including (but not limited to) medicine, nursing, social work, and psychology;
(v) State and territory governments must develop a simplified and consistent procedure common to all Australian jurisdictions for changing an individual's legal sex. Medical intervention should not be a prerequisite, and married trans people must not be forced to divorce in order to change their legal sex;
(vi) Government agencies, service providers, and other organisations should ensure that their staff are adequately trained to work with trans people in a respectful and affirmative manner. They must develop policies to actively prevent discrimination and to make trans people feel welcome when accessing their services;
(vii) Governments and education providers must develop policies to ensure that educational settings are secure and safe places for trans people of all ages;
(viii) Mental health services should develop mental health promotion interventions and programs targeting trans people, in consultation with trans people;
(ix) Suicide-prevention interventions and research must specifically target trans people; and,
(x) Funding bodies such as the NHMRC should consider making the health and well-being of trans people a research priority area.

These recommendations would go a considerable way toward addressing the health disparity observed between trans people and the general population. Trans people deserve the same quality of life, and deserve to receive the same quality of care as any other Australian. To quote one participant: *"We are not monsters. I do not expect to be treated as one"*.

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1 Introduction

In this chapter, we present an overview of the study and its rationale; a very brief introduction to trans issues; and a summary of the demographic characteristics of the 946 participants in this study.

1.1 About this report

This report should be read as a summary document. While we were conducting this study, we were overwhelmed with the level of support we received, and the number of personal stories that participants chose to share with us. Sadly, we cannot possibly report everything that people shared with us in the detail that we would like. Therefore, in order to properly analyse the stories and information that participants gave us, we plan to release an on-going series of articles that will explore aspects of this study in greater depth.

Because we want this research to have an impact on policy and healthcare, we hope to publish these articles in medical and public health journals. These are the publications that people who interact with trans people on a professional basis (such as healthcare workers) are likely to read. As these are published, we will announce them on the study website (**transoz.org**). Many articles in scientific journals are not readily accessible to the public, but state and territory reference libraries may be able to provide access to these. University libraries usually also have access to these journals.

1.2 Background to the study

Despite the growing visibility of trans people, there has been very little research conducted with this population, especially in Australia. This is important, because mounting evidence suggests that trans people experience worse health than the general population, particularly with regard to mental health. There is an urgent need to understand why this is so, and more importantly, to find out how this can be addressed.

This study builds on previous research conducted in Australia, such as the *Transgender Lifestyles and HIV/AIDS Risk* project [1], the *Western Australian Transgender and Transsexual Health and Well-being Survey* [2], the *TranZnation study* [3], the *Gender Identity Australia* study [4], and some studies of lesbian, gay, bisexual, trans, and intersex (LGBTI) people, such as the *Private Lives* study [5] and the *Writing Themselves In* studies [6-8].

Although pioneering, a limitation of these studies is their relatively small sample size, and limited exploration of the prevalence of mental health problems and the factors associated with this.

With nearly 1,000 participants, we hope that this study will provide a comprehensive overview of the state of the mental health and well-being of trans people in Australia, and provide the evidence base needed for reform of the healthcare sector and other areas.

Ethical approval for this study was granted by the Curtin University Human Research Ethics Committee.

1.3 Who are trans people?

There are many different ways that people define the term *trans*. Some people feel very strongly about terminology, and prefer some words over others. Some common words that people use include *transsexual*, *transgender*, *androgynous*, and *genderqueer*. Some communities, such as Aboriginal and Torres Strait Islander (ATSI) people, might use culturally-specific terms such as *sistergirl* or *brotherboy*. Sometimes, ATSI people may use words from the Aboriginal language(s) which they speak to describe themselves.

For the purpose of this report, we use the word *trans* to describe a person who experiences an incongruence between the sex assigned to them at birth and the sex they feel they belong to, and/or a person who has a gender expression (e.g., masculine, feminine) that is inconsistent with societal expectations of their sex.

Owing to the many different ways that trans people describe themselves, and the many unique ways that people experience being trans, it is necessary to pick some form of umbrella term. We recognise that some of the participants in our study used a different word to describe themselves (or in some cases, no label at all), but owing to the sheer variety of terminology used, we hope that readers will understand the need to use a single term for the purpose of this report.

However, one danger in using an umbrella term is that it can obscure differences between sub-populations within the trans community. The findings of this study show that there are groups within the trans community who have different legal, medical, and social needs. This should be borne in mind when working with this population, planning policy, and designing interventions to improve the health of trans people.

We also use the words *sex* and *gender* slightly differently to common usage. We use the word *sex* to describe whether someone feels themselves to be male or female (or both, or neither), and we use the word *gender* to describe someone's behaviour (i.e., whether they are masculine, feminine, some mix of the two, or neither).

It is important to recognise that sex and gender are not always aligned. For example, a person who was raised as a girl but feels that they are male and later goes on to live as a man (a trans man), may not always be masculine. Most trans men in this report did describe themselves as masculine, but some may feel uncomfortable with the strict way that men and women are expected to behave[a], and may enjoy activities that would be perceived as feminine. Similarly, a trans woman might feel very strongly female, but have an androgynous gender expression, or might like to do things that are considered masculine.

So, although sex and gender are often used as synonyms, it is important to note that these words are best used to describe different concepts. Accordingly, when we talk about a participant's sex (or *sex identity*) we are talking about whether they described themselves as a man or a woman (or neither). When we talk about gender (or *gender expression*), we are describing behaviour.

It is also important to note that everyone has a sex identity and gender expression, regardless of whether they are trans. Everyone has the right to determine their sex identity for themselves, and to express their gender in their own way, without fear of discrimination.

Everyone is assigned a sex at birth, but some people do not neatly fit into the categories of male and female. Some people are born with reproductive systems or genetic factors that are neither exclusively male nor female. These people are *intersex*. Most intersex people identify strongly as male or female, but some feel they are neither, or a combination of both. Owing to the complexity of the intersex experience, which sometimes includes non-consensual surgery to "fix" the genitals in childhood[b], this study was designed to investigate the experiences of trans people only. (However, it is important to note that some intersex people may identify as trans as well as intersex). Regardless, there is an equal need for research to explore the health and well-being of intersex people.

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[a] The social expectations for how men and women are expected to behave are known as *gender roles*. It is important to note that gender roles vary across cultures, and have not remained fixed over time. For some people, being expected to fit a rigid gender role is a considerable source of stress.

[b] This can be catastrophic if the "wrong" sex is chosen, and sometimes the surgery can result in lasting sexual dysfunction. For more information about intersex issues, see the recent Senate Report into the involuntary sterilisation of intersex people [9].

A final point to note is that it remains unclear how sex identity and gender expression are formed. We do know that the brain undergoes sexual differentiation *in utero*. We know that people who have complete androgen insensitivity syndrome, a state in which a person has the sex chromosomes of a male (XY) but lacks the ability to respond to testosterone, identify strongly as female except in a handful of very rare cases [10]. In situations where the body can respond to some or nearly all testosterone (partial androgen insensitivity syndrome), sex identity is more likely to be male. This suggests that exposure to sex hormones such as testosterone and oestrogen plays at least some role in determining sex identity.

There is mounting evidence to suggest that hormonal and/or genetic factors may influence sex identity and gender expression [11-20]. Unfortunately, being trans is currently considered a mental disorder by both the American Psychiatric Association, who publish the Diagnostic and Statistical Manual of Mental Disorders (DSM) [21], and the World Health Organisation (WHO), who publish the International Classification of Diseases and Related Health Problems (ICD) [22]. How this might affect the relationship between doctors and trans people is unknown. However, this classification may change in the next revision of the ICD [23].

It is our position that being trans is not a mental disorder, but probably a variation of sex development. Or, to simplify, a situation in which the brain and the rest of the body develop along different pathways, similar to being intersex, but not affecting the reproductive system.

1.4 Trans people and the LGBTI community

The term *LGBTI* (lesbian, gay, bisexual, trans, intersex) is an acronym for the most common labels that people use to describe either their sexuality, or sex and/or gender.

Trans people, like non-trans people, can be heterosexual, homosexual, bisexual[c], or asexual (experience little or no sexual desire and/or attraction to other people). For analysis purposes, we generally use these well-known terms to describe the sexuality of participants, but it is important to note that participants used a wide range of labels (or no label at all) to describe their sexuality. Participants used such a variety of language to describe their sexuality, that it was necessary to aggregate their responses into these four basic categories in order to analyse the data. We also did not wish to prioritise any particular label over another. The manner in which we aggregated the data should therefore not be interpreted to mean that participants only described themselves using these terms.

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[c] Some people prefer to use the term *pansexual* or *omnisexual* rather than bisexual.

However, it should be noted that some trans people (and also some intersex people) do not consider themselves to be members of the LGBTI community, or even that such a community exists. Some people feel that the issues that affect trans people (sex and gender) should not be conflated with sexuality. Conversely, others believe that people who are not heterosexual are not conforming to the gender role expected of them, and thus commonality exists between trans people and LGB people. Also, people can be both trans and LGB, and therefore feel part of a broader community on that basis.

It must be remembered though, that discrimination sometimes occurs between groups in the LGBTI community. Trans people have, and continue to experience discrimination from some non-trans LGB people (and occasionally *vice versa*), and there is continuing tension between some members of these respective groups.

Most important of all, it should be noted that trans people have specific social, legal, and medical needs that are not shared with non-trans LGB people. Given that non-trans LGB people vastly outnumber trans people, care should be taken when speaking of the LGBTI community to ensure that trans people are not marginalised, and that the different needs of these diverse groups of people are not assumed to be the same. In particular, care should be taken to ensure that the language often used to describe LGB people is not applied to trans people unless it is appropriate to do so.

For example, the concept of “coming out” operates very differently between non-trans LGB people and trans people. For LGB people, coming out is hopefully an empowering experience, correcting a misconception in the way that others see them. For trans people, “coming out” can be radically disempowering, because people may no longer see them as how they present themselves to the world, but rather as the sex assigned to them at birth. However, for non-binary trans people, coming out may be a necessary and desirable way to articulate their identity as something other than a man or woman.

1.5 What was the aim of the study?

Previous research indicates that trans people appear to experience health disparity compared with the general population. However, most research has been conducted overseas, and the majority of Australian studies feature small numbers of trans people. For example, the TranZnation Study (one of the largest studies of trans people living in Australia and New Zealand) recruited only 253 people [3]. This means that previous studies may not be representative. Previous studies might also have sampled people from either high- or low-risk groups, evidenced by high levels of educational attainment in some studies.

Unfortunately it is impractical to conduct a random sample of trans people owing to the relatively small size of this population. The exact size of the trans population is unknown. A 2008 study of New Zealand passport holders found at least 1 in 6,364 people were trans [24]. However, not all trans people hold a passport or seek to change it, so this number is probably an underestimate. Others have suggested between 1 in 1,000 and 1 in 2,000 is a more realistic figure, and perhaps as many as 1 in 500 people might be trans [25]. A recent study of New Zealand high school students found that 1.2% described themselves as trans [26]. Given that trans people are a stigmatised group, many prefer not to disclose their trans status to anyone, or only to some people. This makes recruiting this population difficult.

This study shared this unavoidable limitation with regard to achieving a representative sample of trans people, but by using a wide range of recruitment techniques, we aimed to recruit a much larger sample than previous studies. This means that our findings are much more likely to accurately reflect the health and well-being of trans people.

We designed The First Australian National Trans Mental Health study to gain a national snapshot of the mental health and well-being of trans people living in Australia. We aimed to:

- determine the prevalence of depression and anxiety syndromes;
- determine how many people had been diagnosed with depression and anxiety disorders and were receiving treatment;
- determine whether depression and anxiety syndromes are associated with risky health behaviours such as illicit drug use;
- explore the patient-doctor relationship between trans people and their general practitioners, and health workers generally;
- explore the factors that encourage and discourage trans people from accessing healthcare; and,
- explore the factors that protect and promote mental health in trans people.

We hope that our findings will enable healthcare workers and other relevant bodies to engage effectively with trans people, and to develop interventions and make legislative and policy changes that will improve the mental and physical health of this population.

1.6 How were participants recruited, and who was eligible?

We used a range of non-probability sampling techniques to recruit participants because random sampling methods are not feasible with this population. We used an anonymous, Internet-based questionnaire that was accessible between August 2013 and December 2013 (inclusive). We chose to conduct the study anonymously, because some trans people are *stealth* (i.e., they prefer other people not to know about their trans status, or prefer to only tell some people). We thought that some trans people might choose not to participate in the study if they thought they could be identified, and for this reason did not seek written informed consent from participants. The website explained the purpose of the study to participants, and stated that if they chose to proceed to the questionnaire, then they "consent[ed] voluntarily to be a participant in this study".

People were eligible to participate if they were aged at least 18 years and self-identified as trans, or had done so in the past (some people no longer consider themselves trans after completing a medical transition). The study website explained to potential participants that we "used the word trans in an inclusive way, and would like to hear from people who use words like transsexual, transgender, sistergirl, brotherboy, androgynous, or genderqueer to describe themselves. All trans people, including those who just describe themselves as men or women are encouraged to participate".

The study website also explained that the study was "not intended for people who are intersex". The website noted that there may be some similarities between the experiences of trans and intersex people, and that we thought that "transsexualism and intersex states are likely to both be variations of sex development". However, the website noted that some intersex people face challenges that trans people do not, such as non-consensual genital surgery in childhood. One questionnaire could not adequately address the experiences of both groups, and our focus was on the experiences of trans people. However, the health and well-being of intersex people is also a neglected area, and there is a need for research to address the specific concerns of the intersex population.

We promoted our study by sending promotional materials (fliers and posters) to approximately 150 doctors (mostly general practitioners, endocrinologists, psychiatrists, and sexual health physicians) and other service providers that we knew worked with this population. Because there are very few clinics for trans people in Australia, people tend to access only a small number of doctors who work in this area and/or have a good understanding of trans medicine. Knowledge of these doctors is largely spread by word of mouth within the community.

We advertised the study in LGBTI media that we thought trans people might be likely to access, including Blaze, Fuse Magazine, LOTL, Out in Perth, Polare Magazine, Melbourne Community Voice, Q Magazine, Q News, Queensland Pride, SX, and Star Observer. Where LGBTI media was not available in some states and territories, we placed advertisements in local media including Darwin Suns, Launceston Examiner, The Mercury, and Northern Territory Weekly. We also promoted the study through radio interviews.

We made extensive use of social media, and shared the link to the study website on Twitter and Facebook. We posted links to the study website in trans-specific Facebook groups, and groups that we thought trans people might be likely to access. To ensure ATSI people and people from ethnic minority communities who were trans were aware of the study, we also posted links to the study in groups specific to these sub-populations. We followed a similar procedure for sex workers. We also asked people to share the study with their friends using social media, and the website featured Facebook *"Like"* and *"Share"* buttons and a Twitter *"Tweet"* button to make this easy[d]. We also posted links to the study on trans-specific support websites, some LGBTI websites, and the Facebook pages of LGBTI and mental-health related organisations.

Numerous service providers, including ACON, headspace, Queensland AIDS Council, Victorian AIDS Council/Gay Men's Health Centre, and the West Australian AIDS Council helped us to promote the study to people accessing their service.

We also made use of a simple snowball sampling technique. Both study participants and visitors to the website were able to register their e-mail address to receive news about the study if they wished to do so. (People did not need to take part in the study in order to register their e-mail address). Approximately 250 people registered their e-mail address, and we sent an e-mail to these people asking them to tell their trans friends about the study.

Finally, our study was guided by an advisory group comprising individuals from the peak organisations for trans people in Australia, and other interested parties. In addition to reviewing our study materials and this report, the group provided invaluable assistance by promoting the study to their respective communities.

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[d] The study received 1,455 Facebook "Likes" during the data collection period, and 36 tweets.

1.7 How was mental health and well-being assessed?

This was both a quantitative and qualitative study. We used a number of validated instruments that are widely used in the field to assess mental health and well-being. We chose these particular instruments because population norms were available for Australia. Our findings are therefore directly comparable to the general population, and other groups.

However, it should be noted that at least one of the instruments we used was not ideal to gather data from trans people, because it contained questions with the wording “people of my own sex” and “people of the other sex” [27]. Although this instrument was suitable for most people who took part in our study, some participants (particularly those who identified as something other than male or female), found these questions difficult to answer. We would have preferred to have used a more appropriate instrument in this instance, but a suitable alternative for the trans population was not available, and we did not have the resources to develop one. This highlights the importance of further research to develop psychometric instruments that are reliable and validated with this population.

Instruments that we used included the Patient Health Questionnaire (a screening and diagnostic tool for depression and anxiety syndromes) [28], 36-item Short Form Health Survey (a measure of health status and quality of life) [29], Patient-Doctor Relationship Questionnaire [30], Body Image Quality of Life Inventory [27], and selected items assessing alcohol, tobacco, and illicit drug use from the National Drug Strategy Household Survey [31]. We also included some demographic items, and items assessing whether mental health problems had been previously diagnosed and treated.

We developed a number of qualitative questions to investigate what participants’ experiences of healthcare were like, what they thought their health care needs were, factors that participants felt affected their mental health, and factors that encouraged and discouraged participants from seeking healthcare. We asked participants about their attitudes toward and ability to obtain hormone therapy and surgery, their experiences with changing identifying documents (such as the birth certificate, driver’s license, passport, and educational awards), and whether participants had experienced discrimination and harassment (and if so, how this had affected their life).

Our questionnaire was piloted with members of our advisory group, who ensured that the materials were culturally appropriate. We subsequently revised some questions and text on the study website based on their feedback.

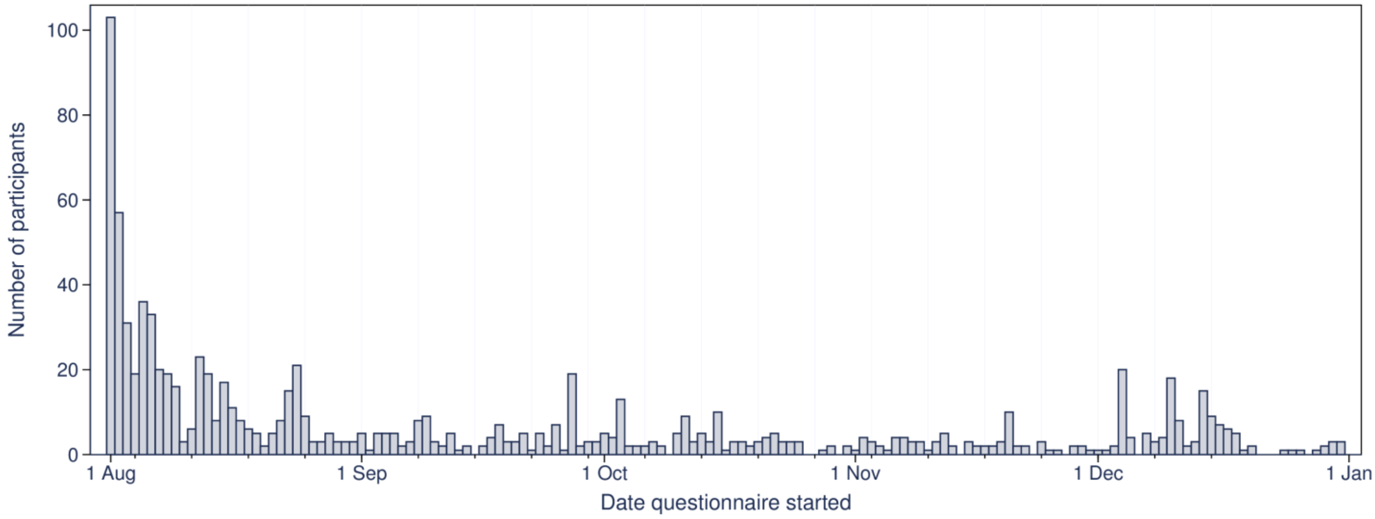
2 Who took part in the study?

This chapter describes who took part in the study and their demographic characteristics. Between August 2013 and December 2013 (inclusive), 1024 surveys were completed. From these, we had to remove 13 that were received from people not living in Australia, 2 from people aged less than 18 years, 6 duplicate surveys, 35 people who did not report the sex they were assigned at birth and how they now identified (a mandatory question), and an additional 22 people who were either not trans, or appeared to have provided malicious responses. This left 946 people in the study.

2.1 Timing and location of responses

As shown in Figure 1, there was an initial surge of responses on the day the survey opened, which corresponded to the initial promotion of the study on social media. Subsequent peaks in August (and to a lesser extent in later months) probably correspond to the time at which adverts for the study appeared in print media. Finally, there was another peak in December, which corresponds with the time at which we sent e-mails to everyone who had registered an e-mail address with us, asking them to please remind their trans friends about the survey.

Figure 1: Frequency of survey responses by date



As shown on the next page in Table 1, the majority of participants came from the states of Victoria and New South Wales. This is expected, given that the majority of the Australian population lives in these two states. However, we appeared to have over-recruited people from Victoria by about 5%, and under-recruited people from New South Wales by about 6%. People from all other states and territories appeared to be appropriately represented. Interestingly, a similar pattern was also observed in the TranZnation study [3]. This could be due to chance. Alternatively, it is possible that it is harder to recruit people from New South

Wales because there are fewer services there than in Victoria (several participants made comments about the limited number of doctors working with trans people in this state), or because some trans people choose to leave New South Wales for Victoria. This could be because Victoria has a clinic for trans people within the public health system (The Southern Health Gender Dysphoria Clinic) [32]. This clinic is the main publicly-funded clinic in Australia. Alternatively, perhaps trans people perceive Victoria to be a state in which it is easier to transition and/or a state that is more welcoming to trans people.

Table 1: Proportion of participants recruited by state and territory, and proportion of the general population living in each state and territory

State or territory	This study n (%)	Australian population[e] %
Australian Capital Territory (ACT)	28 (3.0)	1.6
New South Wales (NSW)	242 (25.6)	32.0
Northern Territory (NT)	11 (1.2)	1.0
Queensland (QLD)	175 (18.5)	20.1
South Australia (SA)	91 (9.6)	7.2
Tasmania (TAS)	19 (2.0)	2.2
Victoria (VIC)	282 (29.8)	24.8
Western Australia (WA)	98 (10.4)	10.9

The majority of participants lived in one of the major cities of Australia. Almost all (93.3%, n=883) lived in either a major city or inner regional Australia (as defined by the Australian Bureau of Statistics), while 5.9% (n=56) lived in regional or remote Australia. Seven people did not disclose their postcode, and so we could not determine this.

Using the postcodes provided by participants, we were able to generate a geo-coded map showing the approximate distribution of respondents across Australia (Figure 2). Each black circle represents a postcode where at least one participant lived. Note that the location of the circles may not match the exact location of the participant for privacy reasons, and because postcodes in regional and remote areas can cover a very large area.

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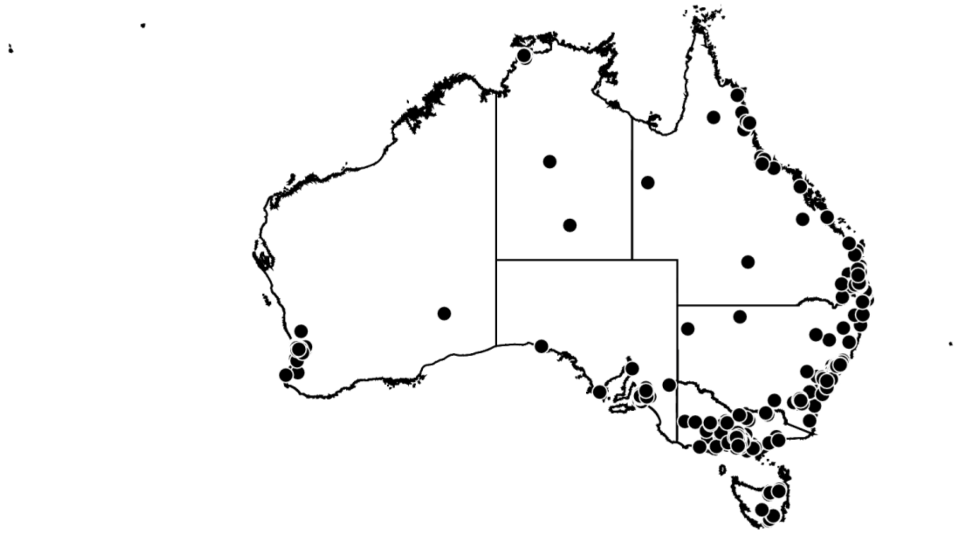
[e] Based on the estimated resident population of Australia at 30 September 2013 [33].

Figure 2: Map of Australia showing the distribution of participants



2.2 Sex and gender of participants

Participants were asked what sex they were assigned at birth; 578 (61.1%) were assigned male and 368 (38.9%) were assigned female. Participants were also asked if they now described themselves as “a man/male”, “a woman/female”, or “other”. Those who answered *other* could write their own description. For analysis purposes, people who described themselves as something other than male or female were classified as *non-binary*. The number and proportion of people in each category is shown in Table 2.

Table 2: Number, proportion, and age of participants by identification

Category	**n (%)**	**Mean age** (years)
Assigned female at birth (AFAB) non-binary	136 (14.4)	27.2
Man/male	232 (24.5)	28.2
Woman/female	482 (51.0)	41.6
Assigned male at birth (AMAB) non-binary	96 (10.1)	42.2

Trans women accounted for the majority of the sample, followed by trans men, and AFAB non-binary individuals. Trans women were older than trans men (p<0.001; Mann-Whitney U test). AMAB non-binary participants were also older than AFAB non-binary participants (p<0.001; Mann-Whitney U test).

Participants were also asked what word or words they used to describe their sex and/or gender. There are too many to list in this report (although we intend to report on the diversity of language that trans people used to describe themselves in future analyses). However, some of the more common terms are given below.

Descriptions used by trans men included: *"transgender"*, *"transsexual"*, *"trans man"*, *"transguy"*, *"dude"*, *"boy"*, *"bloke"*, *"FTM"*, *"I was born a woman but am now a man"*, *"male"*, *"I would only ever describe myself as male, without any other qualifier"*, and *"man with transsexualism"*.

Examples of terms used by trans women included *"transgender"*, *"transsexual"*, *"trans woman"*, *"trans girl"*, *"female"*, *"MTF"*, *"lady"*, *"sistergirl", "straight female born with a defect"*, "*tomboy, female*", *"woman with a trans history"*, *"big gorgeous tranny"*, *"transwoman and proud of it"*, *"a girl with an errant Y chromosome and an annoying penis :P But basically I just describe myself as a woman who grew up as a boy",* and *"approximately ninety percent female, seventy percent feminine and zero percent lady"*.

Common words that non-binary people used to describe themselves were *"genderqueer"*, *"agender"*, *"bi-gender"*, *"genderfluid"*, *"androgynous"*, *"transmasculine"*, *"no label"*, *"combination of male and female"*, and *"gender non-conforming"*.

Some people used different terminology based on context. For example, one person explained that they described themselves as genderqueer around their queer friends, and that their friends used neutral pronouns (e.g., "they"), but in other contexts such as work, they would describe themselves as female and colleagues would use female pronouns.

In addition to asking participants whether they felt themselves to be a man/male, a woman/female, or something else, we also asked participants to describe how masculine or feminine they felt themselves to be (i.e., their gender expression). Responses are summarised in Table 3.

Table 3: Gender of participants by category of identification

Gender	Category of identification			
	AFAB non-binary	Trans men	Trans women	AMAB non-binary
	n (%)	n (%)	n (%)	n (%)
Very masculine	6 (4.4)	51 (22.0)	0 (0)	2 (2.1)
Somewhat masculine	42 (30.9)	121 (52.2)	19 (3.9)	6 (6.3)
Neither masculine nor feminine	26 (19.1)	15 (6.5)	25 (5.2)	11 (11.5)
Both masculine and feminine	52 (38.2)	40 (17.2)	90 (18.7)	48 (50)
Somewhat feminine	7 (5.2)	3 (1.3)	224 (46.5)	23 (24.0)
Very feminine	2 (1.5)	0 (0)	120 (24.9)	6 (6.3)
No answer	1 (0.7)	2 (0.9)	4 (0.8)	0 (0)

As expected, most trans men felt themselves to be at least *very* or *somewhat* masculine, and most trans women described themselves as *very* or *somewhat* feminine. But it is important to note that not everyone's gender expression matched their sex identity. So, while someone might strongly feel that they are a man or male, they may not necessarily feel particularly masculine. Similarly, one should not expect all trans women to be feminine.

Trans people should not be expected to want to conform to gender roles (just as some non-trans people also feel uncomfortable doing so). Additionally, this highlights the importance of not confusing sex with gender[f].

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[f] This point is especially pertinent in light of the debate as to whether the diagnostic categories "gender identity disorder of childhood" (ICD-10) and "gender dysphoria in children" (DSM-5) are scientifically defensible. It has been noted that young children diagnosed with these conditions generally do not transition in adulthood (although adolescents who feel this way generally do) and instead simply grow up to be feminine men and masculine women. Some are gay, lesbian, or bisexual.

Some have therefore argued that "gender identity disorder" in children is unlikely to persist into adulthood, and could therefore be "treated" [34]. (Others go further, and question whether "treatment" could prevent the development of homosexuality [35]). However, the lack of persistence probably reflects the very poor sensitivity and specificity of the diagnostic categories, and their failure to distinguish between gender expression and sex identity. Young children may not be able to easily articulate the difference, and should not be pathologised if their gender expression is not consistent with the social expectations of their sex.

However, adolescents who seek to transition should be able to receive treatment under an appropriate, non-psychopathologising diagnostic category, which should be located in the ICD rather than the DSM. Such a diagnostic category should not be included in the chapter of mental disorders.

2.3 Other demographic characteristics of participants

Other key demographic characteristics of the sample are shown below and overleaf.

Table 4: Other demographic characteristics of participants

Variable	**Category of identification**				
	Entire sample n (%)	**AFAB non-binary** n (%)	**Trans Men** n (%)	**Trans women** n (%)	**AMAB non-binary** n (%)
Age (years)					
18-19	92 (9.7)	29 (21.3)	38 (16.4)	20 (4.2)	5 (5.2)
20-29	321 (33.9)	67 (49.3)	111 (47.8)	121 (25.1)	22 (22.9)
30-39	168 (17.8)	25 (18.4)	49 (21.1)	79 (16.4)	15 (15.6)
40-49	140 (14.8)	8 (5.9)	20 (8.6)	96 (19.9)	16 (16.7)
50+	216 (22.8)	6 (4.4)	10 (4.3)	163 (33.8)	37 (38.5)
Missing data	9 (1)	1 (0.7)	4 (1.7)	3 (0.6)	1 (1)
Live in a regional or remote area	56 (5.9)	7 (5.2)	4 (1.7)	39 (8.1)	6 (6.3)
Missing data	7 (0.7)	1 (0.7)	1 (0.4)	3 (0.6)	2 (2.1)
Born overseas	191 (20.2)	24 (17.7)	35 (15.1)	104 (21.6)	28 (29.2)
Missing data	7 (0.7)	1 (0.7)	2 (0.9)	4 (0.8)	0 (0)
Parent(s) born overseas	452 (47.8)	73 (53.7)	115 (49.6)	214 (44.4)	50 (52.1)
Missing data	8 (0.9)	1 (0.7)	1 (0.4)	5 (1.0)	1 (1)
ATSI person	22 (2.3)	5 (3.7)	2 (0.9)	13 (2.7)	2 (2.1)
Missing data	9 (1)	2 (1.5)	3 (1.3)	4 (0.8)	0 (0)
NESB	52 (5.5)	10 (7.4)	16 (6.9)	19 (3.9)	7 (7.3)
Missing data	9 (1)	2 (1.5)	3 (1.3)	4 (0.8)	0 (0)
Education					
Primary school	6 (0.6)	0 (0)	0 (0)	6 (1.2)	0 (0)
Some high school	124 (13.1)	11 (8.1)	24 (10.3)	76 (15.8)	13 (13.5)
Year 12	231 (24.4)	40 (29.4)	72 (31.0)	99 (20.5)	20 (20.8)
TAFE/trade certificate	242 (25.6)	29 (21.3)	62 (26.7)	125 (25.9)	26 (27.1)
University degree	335 (35.4)	54 (39.7)	71 (30.6)	173 (35.9)	37 (38.5)
Missing data	8 (0.9)	2 (1.5)	3 (1.3)	3 (0.6)	0 (0)

Table 4: Other demographic characteristics of participants (continued)

Variable	Category of identification				
	Entire sample	**AFAB non-binary**	**Trans Men**	**Trans women**	**AMAB non-binary**
	n (%)	n (%)	n (%)	n (%)	n (%)
Gross annual income					
<$20,000	427 (45.1)	88 (64.7)	120 (51.7)	185 (38.4)	34 (35.4)
$20,000 to $39,999	163 (17.2)	23 (16.9)	32 (13.8)	90 (18.9)	18 (18.8)
$40,000 to $59,999	131 (13.9)	8 (5.9)	40 (17.2)	72 (14.9)	11 (11.5)
$60,000 to $79,999	91 (9.6)	11 (8.1)	14 (6.0)	54 (11.2)	12 (12.5)
$80,000 to $99,999	49 (5.2)	2 (1.5)	10 (4.3)	30 (6.2)	7 (7.3)
≥$100,000	72 (7.6)	3 (2.2)	11 (4.7)	46 (9.5)	12 (12.5)
Missing data	13 (1.4)	1 (0.7)	5 (2.2)	5 (1.0)	2 (2.1)
Employment status					
Employed	487 (51.5)	63 (46.3)	120 (51.7)	249 (51.7)	55 (57.3)
Unemployed	120 (12.7)	12 (8.8)	27 (11.6)	72 (14.9)	9 (9.4)
Unemployed student	165 (17.4)	28 (28.7)	59 (25.4)	52 (10.8)	15 (15.6)
Unable to work	112 (11.8)	20 (14.7)	21 (9.1)	63 (13.1)	8 (8.3)
Other	55 (5.8)	2 (1.5)	2 (0.9)	42 (8.7)	9 (9.4)
Missing data	7 (0.7)	0 (0)	3 (1.3)	4 (0.8)	0 (0)
Living alone	215 (22.7)	18 (13.2)	25 (10.8)	154 (32.0)	18 (18.8)
Missing data	5 (0.5)	0 (0)	2 (0.9)	3 (0.6)	0 (0)
Single	458 (48.4)	50 (36.8)	109 (47.0)	262 (54.4)	37 (38.5)
Missing data	48 (5.1)	8 (5.9)	11 (4.7)	20 (4.2)	9 (9.4)
Health Care Card	509 (53.8)	79 (58.1)	130 (56.0)	251 (52.1)	49 (51.0)
Missing data	8 (0.9)	0 (0)	4 (1.7)	4 (0.8)	0 (0)
Health insurance	412 (43.6)	60 (44.1)	118 (50.9)	196 (40.7)	38 (39.6)
Missing data	9 (1)	2 (1.5)	2 (0.9)	3 (0.6)	2 (2.1)

It is notable that 62.4% of the sample reported a gross annual income below $40,000. After excluding unemployed students, 55.9% of the sample earned less than $40,000 per year. (The mean Australian income in 2013 was $58,000) [36]. Also notable is the high proportion of participants possessing a Heath Care Card, and the high proportion of trans women who were single or lived alone. This may have implications for social support and well-being.

3 Mental health

This chapter details the mental health of participants, as measured by the Patient Health Questionnaire (PHQ), 36-item Short Form Health Survey (SF-36), and self-report. The PHQ is a screening tool for depression and anxiety syndromes, while the SF-36 provides a general measure of health status and quality of life. These instruments gave us a measure of the health status of participants at the time they took the questionnaire. We also asked participants if they had *ever* been diagnosed with depression by a doctor, and in the last 12 months. Similar questions asked about an "anxiety disorder". These latter questions gave us a lifetime and 12-month history of depression and anxiety diagnoses in participants.

3.1 Current prevalence of depression and anxiety syndromes

The PHQ was completed by 827 participants, and the results are shown in Table 5. Proportions are calculated without removing missing responses, because we did not want to overestimate the proportion of people with mental health problems. Therefore, the proportions quoted below may underestimate the true prevalence.

Table 5: Prevalence of depressive and anxiety syndromes, by identification

Mental health status	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	n (%)	n (%)	n (%)	n (%)	n (%)
Clinically relevant depressive symptoms	413 (43.7)	60 (44.1)	101 (43.5)	218 (45.2)	34 (35.4)
Major depressive syndrome	272 (28.8)	43 (31.6)	69 (29.7)	138 (28.6)	22 (22.9)
Other depressive syndrome	51 (5.4)	6 (4.4)	5 (2.2)	35 (7.3)	5 (5.2)
Panic syndrome	173 (18.3)	36 (26.5)	42 (18.1)	82 (17.0)	13 (13.5)
Other anxiety syndrome	160 (16.9)	32 (23.5)	49 (21.1)	72 (14.9)	7 (7.3)

Significant differences between groups were observed for all mental health syndromes ($p<0.05$; Chi-square test).

To investigate whether mental health differed by age, we calculated the prevalence of mental health syndromes by age group. These are shown in Table 6.

Table 6: Prevalence of depressive and anxiety syndromes, by age

Mental health status	**Age group** (years)				
	18-19 (n=92) n (%)	**20-29** (n=321) n (%)	**30-39** (n=168) n (%)	**40-49** (n=140) n (%)	**50+** (n=216) n (%)
Clinically relevant depressive symptoms	56 (60.9)	155 (48.3)	68 (40.5)	65 (46.4)	66 (30.6)
Major depressive syndrome	40 (43.5)	97 (30.2)	47 (28.0)	43 (30.7)	42 (19.4)
Other depressive syndrome	5 (5.4)	21 (6.5)	6 (3.6)	8 (5.7)	11 (5.1)
Panic syndrome	25 (27.2)	68 (21.2)	28 (16.7)	33 (23.6)	18 (8.3)
Other anxiety syndrome	20 (21.7)	65 (20.3)	30 (17.9)	21 (15.0)	22 (10.2)

Proportions were significantly different by age (p<0.05; Chi-square test), with the exception of other depressive syndrome by age (p=0.425; Chi-square test). The proportion of people who met the criteria for a mental health syndrome was lower with older age. Nonetheless, proportions remained high in all age groups.

To enable an accurate comparison between trans men, trans women, and non-binary participants (all of whom had different age distributions), and also to facilitate comparisons with the general population, we age-standardised these data using the direct method. Our reference population was the estimated resident population of Australia at 30 June 2013 as determined by the Australian Bureau of Statistics[g]. Age-standardised prevalence data for any depressive syndrome and the anxiety syndromes are shown in Table 7.

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[g] We used the estimated Australian population at 30 June 2013 for all age standardisation, unless otherwise stated. For illicit substance use (chapter 9), we age-standardised our data using the population described in the 2010 National Drug Strategy Household Survey report [31]. The 2010 report is based on the estimated resident population of Australia at 30 June 2010.

Table 7: Age-standardised prevalence of depressive and anxiety syndromes, by identification

Mental health status	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	%	%	%	%	%
Any depressive syndrome	31.0	41.0	30.5	34.3	26.7
Panic syndrome	15.6	10.2	23.2	16.0	12.8
Other anxiety syndrome	14.7	31.9	16.8	14.4	6.1

Because we used a screening tool (the PHQ) to investigate mental health, we cannot be sure that participants who met the criteria for a mental health syndrome actually had the corresponding disorder. Clinical interviews would be necessary to establish this. For example, someone who met the criteria for a depressive syndrome may actually have been affected by bereavement, and therefore generally would not be considered to have depression. However, this seems an unlikely explanation for the very high prevalence of mental health syndromes observed. It is probable that many of the people who met the criteria for an anxiety syndrome or a depressive syndrome were actually affected by an anxiety disorder or depression.

To place these results in context, the lifetime and 12-month prevalence of mental disorders in the general population in 2007 were as follows: depressive episode (11.6% and 4.1%); dysthymia (1.9% and 1.3%); panic disorder (5.2% and 2.6%); and any anxiety disorder (26.3% and 14.4%) [37]. In comparison, the proportion of participants in this study who were *currently* affected by a mental health syndrome was markedly higher.

3.2 Lifetime and 12-month prevalence of depression and anxiety disorders

To gauge the lifetime and 12-month prevalence of diagnosed depression and anxiety disorders, we asked participants whether they had been diagnosed with "depression" or an "anxiety disorder" by a doctor. We also asked participants whether they were currently receiving treatment for these conditions.

Lifetime prevalence of diagnosed depression and anxiety disorders is shown in Table 8, stratified by current identification, and by age.

Table 8: Self-reported history of depression and anxiety, by identification and by age

Mental health status	**Category of identification**				
	Entire sample n (%)	**AFAB non-binary** n (%)	**Trans Men** n (%)	**Trans women** n (%)	**AMAB non-binary** n (%)
Ever diagnosed with depression	541 (57.2)	74 (54.4)	144 (62.1)	284 (58.9)	39 (40.6)
Ever diagnosed with an anxiety disorder	377 (39.9)	67 (49.3)	95 (41.0)	186 (38.6)	29 (30.2)
	Age group (years)				
	18-19 (n=92) n (%)	**20-29** (n=321) n (%)	**30-39** (n=168) n (%)	**40-49** (n=140) n (%)	**50+** (n=216) n (%)
Ever diagnosed with depression	40 (43.5)	204 (63.6)	103 (61.3)	82 (58.6)	108 (50.0)
Ever diagnosed with an anxiety disorder	30 (32.6)	150 (46.7)	64 (38.1)	59 (42.1)	70 (32.4)

Of the 57.2% of participants who had ever been diagnosed with depression, 54.2% (n=293) were diagnosed in the last 12 months, and 44.2% (n=239) were currently being treated for depression. Of the 39.9% of participants who had been diagnosed with an anxiety disorder, 62.1% (n=234) had been diagnosed in the last 12 months, and 47.8% (n=180) were receiving treatment. We did not ask participants what form of treatment they were receiving for their mental health problems.

To compare self-reported history of a diagnosis of a mental disorder in our sample with the general population (and between sub-groups), we age-standardised our data (Table 9).

Table 9: Age-standardised history of depression and anxiety, by identification

Mental health status	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	%	%	%	%	%
Ever diagnosed with depression	55.9	74.7	59.0	57.9	39.7
Ever diagnosed with an anxiety disorder	37.9	56.5	39.9	37.6	28.9

Based on the previously quoted prevalence data for the general population, it appears that trans people are 4 times more likely to have ever been diagnosed with depression than the general population, and approximately 1.5 times more likely to have ever been diagnosed with an anxiety disorder. Also concerning is the high proportion of participants who reported suicidal ideation or thoughts of self harm. As part of the PHQ, participants were asked whether they had “thoughts that you would be better off dead or of hurting yourself in some way” in the last two weeks. Responses to this question are shown in Table 10 below.

Table 10: Suicidal ideation or thoughts of self-harm, by identification

Response	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	n (%)	n (%)	n (%)	n (%)	n (%)
Not at all	440 (46.5)	62 (45.6)	106 (45.7)	224 (46.5)	48 (50.0)
Several days	189 (20.0)	20 (14.7)	45 (19.4)	104 (21.6)	20 (20.8)
More than half the days	85 (9.0)	10 (7.4)	22 (9.5)	50 (10.4)	3 (3.1)
Nearly every day	113 (12.0)	21 (15.4)	27 (11.6)	59 (12.2)	6 (6.3)
No answer	119 (12.6)	23 (16.9)	32 (13.8)	45 (9.3)	19 (19.8)

One fifth (20.9%) of participants reported suicidal ideation or thoughts of self-harm on at least half of the days in the last 2 weeks. In 2007, the 12-month prevalence of suicidal ideation (excluding self-harm) in the general population was 2.3% [37]. We did not ask participants directly about suicide, or whether they had previously attempted suicide. However, coupled with the high prevalence of mental health syndromes observed in the sample, and the extremely high proportion of participants who had ever been diagnosed with depression (57.2%), our results strongly suggest that trans people living in Australia are a high-risk group for suicide. This is borne out by longitudinal studies of this population. In a recent study of 1,331 trans people from The Netherlands who were followed for at least 18 years, suicide was a leading cause of death. The authors of that study reported that trans women were 5.7 times more likely to die from suicide than expected, while trans men were 2.2 times more likely to die from suicide [38].

Given that the prevalence of mental health problems in our study was similar between trans men and trans women, it is unclear why this discrepancy should exist. It may be that trans women have fewer sources of support to draw upon. As we noted in chapter 2, trans women were more likely to live alone and to be single. Alternatively, it may be because the effects of puberty on the skeleton are generally more obvious and much harder, if not impossible, to reverse for trans women. Some trans women find it very difficult to blend[h] with other women because of the powerful effects of testosterone on bone structure. These may be particularly obvious with regard to facial features. Some trans women opt for facial feminisation surgery to address this, but the cost typically runs into tens of thousands of dollars. Given the low incomes reported by participants, this surgery is simply out of reach for many. Being unable to blend may pose a constant source of dysphoria, expose trans women to discrimination, and may affect others' perception of their attractiveness and desirability as a partner, further negatively affecting body image and self-esteem. An additional factor to consider is the use of hormones. Sex hormones have effects on nearly all organ systems of the body, including the brain. Oestrogen generally has anti-depressant properties[i], although some people can experience negative effects on mood. Some trans women also take progestogens, such as the anti-androgenic progestin cyproterone acetate (which acts to stop the production of testosterone, and also to prevent testosterone from binding to testosterone receptors). However, some progestogens, and cyproterone acetate

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[h] The term *passing* or *to pass* is also sometimes used to describe being accepted by others as the sex with which a person identifies. Some have argued that the term is pejorative and suggestive of deception. We have therefore opted to use the more neutral term *blend* instead.

[i] Oestradiol, the most potent naturally occurring oestrogen in humans, acts as a weak monoamine oxidase inhibitor, and prevents the breakdown of neurotransmitters such as serotonin and noradrenaline [39].

in particular, are known to cause depression in some individuals [40]. Testosterone can also have both positive and negative effects on mood, both directly and after conversion to oestrogen in the body, but generally has a mood-elevating effect [41]. Very high doses of testosterone can cause mania in susceptible individuals [42].

3.3 Mental health status by hormone use and surgery

Generally, most trans people who take hormone therapy or undergo surgery report that it has a strongly beneficial effect on mood and well-being [43-45]. In this study, we found that the desire to take hormone therapy and/or being on hormone therapy was significantly associated with mood, as was surgery. In the following table (Table 11) we present associations between hormone therapy and clinically relevant depressive symptoms.

Table 11: Clinically relevant depressive symptoms by use of hormone therapy

Clinically relevant depressive symptoms	**Use of hormone therapy**					
	Never taken and unsure or unwanted n (%)	**Never taken but would like to** n (%)	**No longer taking - unsure or unwanted** n (%)	**No longer taking but would like to** n (%)	**Taking hormone therapy** n (%)	**Missing data** n (%)
No	56 (45.5)	55 (27.9)	12 (48.0)	11 (35.5)	280 (49.5)	0 (0)
Yes	46 (37.4)	115 (58.4)	12 (48.0)	15 (48.4)	225 (39.8)	0 (0)
Missing data	21 (17.1)	27 (13.7)	1 (4.0)	5 (16.1)	61 (10.8)	4 (100)

We observed a marked and statically significant difference between categories (p<0.001; Chi-square test). The proportion of people with clinically relevant depressive symptoms was lowest in those currently taking hormone therapy (39.8%) and in those who were not taking it, but either did not desire it, or were unsure if they wanted it (37.4%). In contrast, those with the highest proportion of clinically relevant depressive symptoms were participants who had not taken hormone therapy, but wanted to (58.4%). A similar picture emerged with regard to surgery, as shown in Table 12 overleaf. People who had undergone at least some surgery were much less likely to have clinically relevant depressive symptoms (p<0.001; Chi-square test). Although these results are cross-sectional (meaning that we cannot infer causality), our results are supportive of previous research showing that mental health improves when trans people are given access to hormone therapy or surgery [43-47].

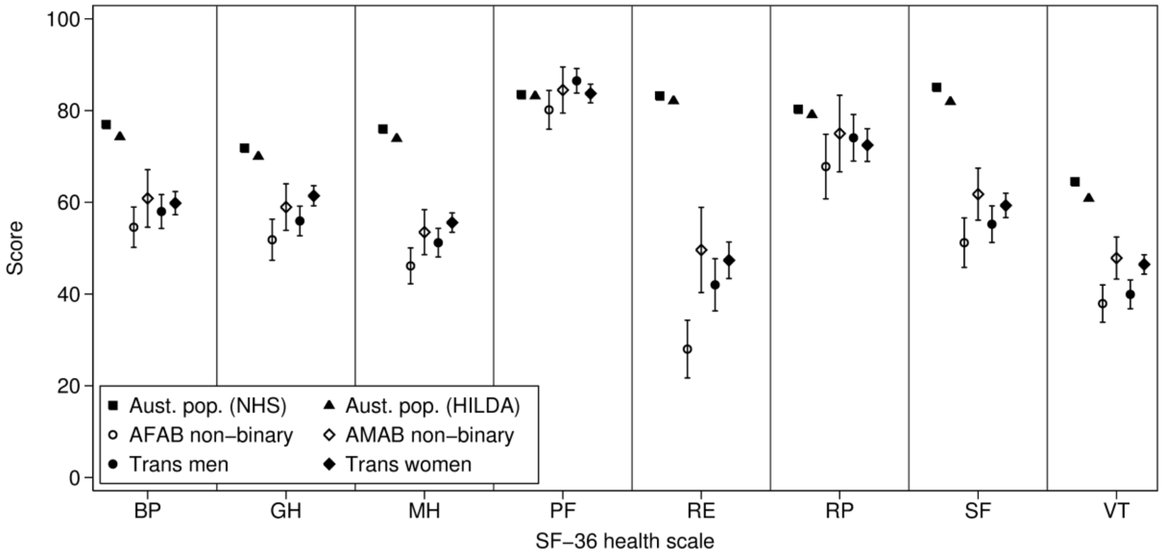
Table 12: Clinically relevant depressive symptoms by surgical status

Clinically relevant depressive symptoms	Surgical status Don't want n (%)	 Would like n (%)	 Have had n (%)	 Missing data n (%)
No	82 (45.3)	184 (37.6)	148 (56.3)	0 (0)
Yes	71 (39.2)	251 (51.3)	91 (34.6)	0 (0)
Missing data	28 (15.5)	54 (11.0)	24 (9.1)	13 (100)

3.4 Quality of life

In addition to determining the prevalence of depressive and anxiety syndromes, we also measured participants' general health status and quality of life with the SF-36. This instrument measures a series of physical and mental health domains, which we compared against data from two recent studies of the general population. This is depicted in Figure 3 below.

Figure 3: Quality of life in study participants and in the general population



Notes: Higher scores indicate better quality of life. BP=bodily pain; GH=general health; MH=mental health; PF=physical functioning; RE=role-emotional; RP=role-physical; SF=social functioning; VT=vitality. NHS=1995 National Health Survey [48]; HILDA=2001 Household Income and Labour Dynamics in Australia survey [49]. The 95% confidence intervals are not shown for the reference populations because they are sufficiently small to overlap the data points.

Participants experienced demonstrably worse quality of life in almost all domains (particularly those associated with mental health) than the general population. The SF-36 also has two summary scores for physical and mental well-being: the Physical Component Summary (PCS) score, and the Mental Component Summary (MCS) score. Scores range from 0 to 100, and are standardised to have a mean of 50 and a standard deviation of 10. The mean PCS score for participants in this study was 51.2 ± 10.7, while the mean MCS score was 33.7 ± 14.9.

This indicates that the physical health of participants was similar to the general population, but mental health and well-being were not. It also strongly suggests that the poor quality of life we observed in participants is not due to poor physical health, but rather to poor mental health.

3.5 Factors associated with mental health problems and quality of life

To investigate the factors that were associated with mental health problems and quality of life, we performed a series of binary logistic regression analyses (for dichotomous outcomes such as ever being diagnosed with depression), and linear regression (for quality of life).

We entered participants' demographic characteristics into these models, along with factors such body mass index, self-rated health[j], use of (or desire for) hormone therapy, surgical status, whether participants had changed any identifying documents (ID), whether they told doctors about being trans, whether they had a GP, their relationship with their GP (measured with the Patient-Doctor Relationship Questionnaire), whether they had experienced discrimination relating to being trans, and use of alcohol, tobacco, and illicit drugs.

After adjustment, we found the following factors were associated with poor mental health and/or poor quality of life in regression analyses: sex identity (trans men, and especially trans women, were more likely to have clinically relevant depressive symptoms than non-binary individuals, while non-binary individuals were more likely to have been diagnosed with an anxiety disorder or to currently have an anxiety syndrome); lower educational attainment; being unemployed or unable to work; low income; poor self-rated health; wanting to take hormone therapy; wanting to undergo surgery; difficulty changing ID; not feeling comfortable telling doctors about being trans; and a recent experience of discrimination. People who were younger had worse mental health than participants who were older.

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[j] Self-rated health was not included in the models assessing quality of life with the SF-36 MCS, because self-rated health is a component of this scale.

3.6 Participants' thoughts about their mental health

We asked participants to describe the things that they thought affected their mental health in a good way, the things that affected their mental health in a bad way, and what participants did to look after their mental health. Some comments that illustrate the major themes that emerged are shown below.

3.6.1 Factors that positively affected mental health

"feeling 'man enough' feeling accepted spending time with those I care most"

"being treated as male, being with my girlfriend, being fit and muscular, having time to relax"

"Being able to be a woman and interact with people in a no[r]mal female way"

"Having the freedom to be myself around my friends family and the public"

"Being accepted as female means everything to me. Also having a lot of love and support from friends goes a long way. I also have a wonderful GP ... who is always there to help me with any medical problems"

"Transitioning fixed a lot for me, I retained some social anxiety but nothing like what I suffered in the past"

"Transition has completely changed my mental health. I no longer suffer depression, anxiety is rare, and it's been more than a year since I have felt suicidal. I consider myself entirely recovered. What's more, the change was rapid"

"Knowing that I am now the person I should have been. The bright colours I now see because every day is precious"

Participants reported that feeling accepted by others, and being able to express their sex identity and/or gender expression freely had a positive effect on mental health. Participants who wished to transition, and had done so, noted that transitioning made an enormous difference to their mental health. Prior to transitioning, some participants suffered from depression, anxiety and suicidal ideation. Transitioning "completely changed" this, because they now felt that they were living as "the person I [always] should have been".

"Good sleep, healthy food, being at home, talking with friends, reading, writing"

"friends, motorcycle riding, exercise, feeling useful, seeing health care workers I connect with"

"Exercise and company and good diet"

"Good attitude, support of friends and family"

"Supportive friends and family, regular counselling sessions, self affirming behaviour, truthful portrayals of people like me or experiences I share socially and in the media"

"Positive reinforcement, caring for my pets, being with my family, being at home by myself, singing, being with good, safe friends for short bursts. Sunshine"

Participants noted the supportive role that friends and family could play in their lives. For some, friends and family provided praise, love, and acceptance. However, not everyone was fortunate to have supportive friends and family. Resources such as *Families Like Mine* [50] may be able to help friends and family understand the life experiences and challenges that trans people face, and help friends and family accept and support them. It is also important to note that many of the factors that participants thought positively affected their mental health are the same that would be expected for the general population, such as "feeling useful", and keeping socially active. This suggests that mental health promotion programs such as *Act-Belong-Commit* [51] could either actively target trans people, or similar programs could be developed for this population.

"Just being understood and love[d] for who I am"

"people being nice to me. it's very easy to read how people feel about you from their faces as much as what they say"

"Acceptance by friends and family. General normal conversation when talking to friends. Being pronouned [correctly] or called my prefer[red] name"

"Feeling that I am supported by the people around me. Being reassured that things will get better"

"Being with my boyfriend. And being away from my parents as they ar[e]n't supportive at all"

"Personal achievements. Affirmation from others that I am a good, helpful & honest person. Contact with people who through actual experience, understand my trans identification"

"singing, being with people, helping people, exercise, achieving goals, travel, reading, taking photographs, good regular meals, focusing on today"

"Seeing friends (or other people) who I feel I can connect to, seeing myself look good"

A key theme was participants' need for acceptance. Participants also needed reassurance that "things will get better". This stresses the need for better resources and information for both trans people and their friends and families. Information and/or educational materials that include personal stories and factual information about transitioning throughout the life cycle need to be developed and disseminated in appropriate formats. Materials should be in simple English and also available in multilingual formats. It must be remembered, however, that the trans population is not homogenous and materials need to be respectful of these differences. (For example, the needs of non-binary trans people are likely to differ in some respects from those of trans men and trans women). Participants also expressed a need to have people that they "can connect to". This stresses the importance of services that organisations such as Twenty10 [52] and the Freedom Centre [53] provide. However, more services are required. Given the high prevalence of mental health problems in all age groups (Table 6) services are needed for people of all ages.

3.6.2 Factors that negatively affected mental health

“being verbally abused by people on the street if I get read. And secluding myself away makes me more depressed”

“general societal attitudes towards trans people, and negative interactions with people”

“I think a lifetime of accumulated stress about trans stuff has left me permanently damaged. Even though life is much better post-transition, the damage has been done”

“Job opportunities, feelings that my life has been wasted, feelings of lost opportunities, loneliness”

“Feeling stuck in a situation I have no control over - especially concerning money and job. And also body dysphoria - not relating to what I see in the mirror, at all. Actually hating my body to the point of never swimming in public etc or doing activities I would do if my body was different”

“Not being able to progress my transition (at the moment it is the facial hair that is getting me down and the lack of money for electrolysis)”

“Lack of access to some desired surgeries. The lack of understanding of the average person. The things that can never be ‘corrected’ by either of those things”

Factors that had negative effects on participants’ mental health included discrimination and harassment, and also for many, a strong sense of dysphoria that they were unable to address because surgery and/or other procedures were unavailable or unaffordable. For those who seek a medical transition, the cost can run into tens of thousands of dollars and make take several years to complete. This may lead to a sensation of their life being on hold, or that years of their life are “wasted” while they wait for transition to be complete. For some people, transition may never be complete, either because the changes they desire are not possible or unattainable. This stresses the importance of providing easy and affordable access to hormone therapy, surgery, and other interventions such as speech therapy and hair removal, through both public and private health systems.

“Looking on my facebook at all the friends I will probably lose. Also wondering how the community in general will react when I start going out as a woman”

“Having to be female at work. Worrying about the social ramifications of ‘coming out’ at work”

“Interacting with people who are transphobic, biphobic, and belittle me for having depression and anxiety”

“Dealing with medical professionals. Even my current GP who I like and respect a lot, he still makes me very anxious because I have such a bad history with doctors. I also don’t like large crowds, or feeling trapped”

Transitioning participants who were yet to live in their new role expressed fear about how others would react. To some extent, this could perhaps be reduced through workplace education, such as that offered by the *Opening Closets* program [54]. It also reinforces the need for the development and wide dissemination of educational materials and information. Such materials should target multiple audiences, such as the general public, employers, families, and health workers. Some participants reported a “bad history with doctors”, suggesting an urgent need to improve attitudes and knowledge among the medical profession. Changes to the medical curriculum are necessary so that doctors understand how to care for trans people, and can do so in an appropriate and respectful manner.

“stress, financial insecurity, relationship difficulties, issues with family/friends etc not understanding my identity, etc”

“Being isolated, without community or friends. Not enough sleep. Being around people who aren’t my mob”

“Violence, abuse, discrimination, hard to find a relationship. Sometimes it’s difficult as so many transpeople around me suffer from poor mental health”

“Not being valued, being mocked or humiliated, being disrespected, not being accepted”

“insults discrimination comments made not feeling ‘man enough’”

“Work-related stress, family-related stress”

Discrimination and harassment during interactions with others was a recurring theme. In addition to educational materials and workplace training, this suggests a need to strengthen anti-discrimination protections for this population.

“Winter. Poor self image, especially body image. Loneliness. Frustration. Feelings of disapproval or rejection”

“When people use the wrong pronouns or ask inappropriate questions”

“Anything that is associated with revealing my transsexual history. It’s awful and makes me absolutely miserable. I really hate it and always feel completely full of shame”

“Having to face being transsexual - i live in stealth and being forced to reveal my past upsets me”

People must not be forced to disclose their trans history or be placed in a situation where they have to constantly educate people about what it means to be trans. Although there are occasions where respectful questions might be appropriate, trans people should not bear the burden of having to repeatedly educate others. Trans people should never be asked “inappropriate questions” such as whether or not they have undergone surgery. Educational materials could be helpful here, explaining respectful ways of interacting and communicating with trans people.

These comments also reveal some of the problems that are associated with living "stealth". Although being stealth is a perfectly valid choice, the fear of discovery is likely an ongoing source of stress for many trans people. In an ideal world, a person disclosing that they are trans should not matter. "Coming out" could potentially be empowering. However, it is more likely that "coming out" results in trans people being treated as the sex assigned to them at birth, negating who they are and their lived experience. However, for non-binary people, coming out may be necessary to articulate their non-binary status. It is likely that the experience of coming out differs markedly for sub-populations within the trans community.

3.6.3 Things participants do to look after their mental health

"cycling, rock climbing, yoga, chin ups, play video games, relax with my girlfriend, always present as male, take time at the end of the day to wind down and watch telly with my girlfriend"

"Go to the gym regularly. Ensure that I get regular 'me'/down time Invest time in my relationship Make sure I enjoy my work, and the place I'm living Spend time with my dog"

"Yoga, medication, study, volunteering, socialising. Looking after my partner and our two dogs. Reading"

"Meditate, mindfulness, follow the dharma.. Listen to Ajahn Brahm.. Music.."

"reading. going to church"

"I place great store in my faith. It keeps me grounded and connected with life"

Participants engaged in a range of activities to look after their mental health, including those of an athletic, leisure, self-care, and spiritual nature. Several participants reported that they spent time with, and cared for animals. This suggests that interventions modelled on the *Act-Belong-Commit* [51] program could work with this population, and should be a research priority.

"Exercise, share any problems with someone I can trust"

"I've stopped watching the news. I walk a lot. I spend time with family and friends"

"fresh air, exercise, pleasant social activities - book club, lectures, meeting friends, occasional contact with trans support groups"

"look after my cat, take my medication, try to reach out to and socialise with friends"

"I try not to let the ignorant parasites get me down, I am glad that I am not fake like they are. I spend time with my boyfriend and my two friends on the weekend and keep in touch with other friends on facebook"

"Keep a positive outlook and avoid people who are idiots and dickheads"

"I eat very particular foods, and I try to meditate or at least reflect on my life and goals each day. I also try to be nice to others, because I find then they are nice back"

Participants' comments reinforce the importance of having supportive friends, partners, and family with whom they can talk and share problems. They also note the importance of maintaining and building social relationships, trying to develop a "positive outlook", and avoiding perceived negative influences on mental health (insofar as this is possible).

"I regularly see a psychiatrist and physiologist plus I am taking medication to offset the effects of my mood disorder"

"Sometimes when I feel really awful I just sleep for a few days or until I'm ready to go back outside"

"Not much, I'm not very good at looking after my own mental health"

"Have a good cry and try to pull myself together. Generally it has worked, but I know that one day it won't. Then I will probably call it quits"

Several participants reported that they saw mental health professionals and/or took medication to help with mental health problems. However, some participants may have difficulty locating trans-friendly mental health professionals. There is a need for either centralised clinics in each state and territory specialising in trans health which can refer people to appropriate practitioners, and/or for trans people to be able to easily access a directory of health professionals who are trained to work with this population. This stresses the need to improve health curriculums. Participants should not need to seek out a trans-friendly doctor or psychologist. All health workers should be trans-friendly.

Some participants noted that they weren't good at looking after their mental health. The final comment by the participant in the above block of quotes (and similar comments by others) is very worrying, and reflects the disproportionate suicide risk in this population [38]. There is an urgent need to address this disparity, and to reach out to people who feel they are "not very good at looking after my own mental health". Further research should investigate how this especially vulnerable group can be assisted.

4 Hormone use

This chapter explores participants' attitudes toward, and use of hormone therapy. As shown in Table 13, there was a marked contrast between use and desire for hormone therapy by category of identification (p<0.001; Chi-square test). Non-binary participants were less likely to desire or to be taking hormone therapy than trans men and trans women. (More than two thirds of trans men and women were currently taking hormone therapy). Although the attitudes of participants toward hormone therapy may change over time, this strongly suggests that there are clear differences between sub-populations in the trans community, and that members of these sub-populations desire different transition pathways.

Table 13: Desire for, and use of hormones, by identification

Response	**Category of identification**				
	Entire sample n (%)	**AFAB non-binary** n (%)	**Trans Men** n (%)	**Trans women** n (%)	**AMAB non-binary** n (%)
Never taken and don't want or are unsure	123 (13.0)	73 (53.7)	3 (1.3)	7 (1.5)	40 (41.7)
Never taken, but would like to	197 (20.8)	31 (22.8)	61 (26.3)	81 (16.8)	24 (25.0)
Not currently taking and don't want or are unsure	25 (2.6)	7 (5.2)	1 (0.4)	11 (2.3)	6 (6.3)
Not currently taking, but would like to	31 (3.3)	5 (3.7)	2 (0.9)	19 (3.9)	5 (5.2)
Currently taking hormone therapy	566 (59.8)	20 (14.7)	163 (70.3)	362 (75.1)	21 (21.9)
No answer	4 (0.4)	0 (0.0)	2 (0.9)	2 (0.4)	0 (0.0)

4.1 Factors preventing participants from using hormone therapy

Participants who were not currently using hormone therapy were asked if there were any factors that prevented them from taking it. Some comments that illustrate the different themes that emerged are shown overleaf.

“I’d like to be a parent and I’m not sure if I could live with being sterile”

“Long-term health concerns about taking testosterone. There really haven’t been any studies and there are no long term research papers on the affects of someone taking testosterone”

“Had a small heart attack and was taken off oral estrogen and put on a gel, kind of got fed up with it so haven’t used it for a while. Probably linked to feelings about the heart, and other things which cause stress at the moment so have given up”

“I got depression after being on T”

As noted in Table 13, nearly a quarter of participants who were not currently taking hormone therapy wished to do so. However, the actual and perceived negative experiences of some participants, together with the limited knowledge regarding the long-term effects of hormone therapy present a challenging situation for some. In particular, what does it mean for participants who need hormone therapy for their mental health and well-being, but are unable to take it due to physical or mental health problems? Additionally, there is a need for the long-term effects of hormone therapy to be studied, and the results made available and accessible in appropriate educational materials for the trans population.

“Fear of social stigma (especially as a non-binary trans person who would be taking hormones, rather than as a trans man), Having to come out, Being trans on official records”

“I don’t want feminine features, but I don’t want masculine features either. There’s no hormone therapy that can give that without other medical issues”

“Too old and too late but if I could go back 40 years and have the knowledge of such [a] thing, life would have been much different”

Some non-binary participants expressed reservations about hormone therapy, in that either it could not provide them with the body that they desire, or that they fear that doctors and other people will not understand their identities because they do not fit a typical transsexual narrative. The final comment about being “too old and too late” reinforces the need for educational materials to be easily accessible so trans people (especially young trans people) know what options are available to them, and can pursue a medical transition if they wish.

“Scared of what others would think”

“My job prospects. I can’t imagine being able to get a job after transitioning since the industry I work in is pretty intimate and everyone would know. They would just think that was way too much baggage”

“Fear of family’s reactions, worried that it’s not the right path”

“My partner would possibly have too much difficulty coping with the changes that would occur”

The legitimate concerns that many trans people have about how others will react to them beginning a medical transition reinforces the need for educational materials for friends and family, and also workplace education and anti-discrimination measures. For some people with partners, these concerns may be insurmountable, because their partner may have “difficulty coping”. Depending on their sexuality, some partners may find that their sexual attraction to their trans partner lessens. Some partners may not know how to cope with what may be either a perceived or real change in their sexuality, and how others may react to this.

“Money, not knowing a doctor I would be comfortable with”

“Just getting it prescribed from doctor”

“Yea my location I live in a small aboriginal community”

“Finding out how to start, since I have pretty limited knowledge and don’t feel comfortable talking about it with any of the GPs I’ve had contact with, as well as possible associated costs”

“Not sure how to go about getting hormone therapy, Due to lack of education about such things, unknown as to whether there is a professional that specialists in gender identity within my area. Lack of information”

All doctors (and especially general practitioners, since they are usually the first point of contact with the medical system), need to be educated about trans health while they are studying medicine. Upon graduation, continuing professional development programs as well as workplace training may be useful and/or necessary. Clear referral pathways and protocols must be developed. Trans people should not have to face the burden of finding a trans-friendly doctor, and all doctors should have some knowledge of trans health.

“Having to wait nearly a whole year just to see the one damn psych in this state that focuses on transgender issues. Without his say I cannot legally start HRT. At least that’s what the doctor said. Perhaps I was lied to”

“the insanely traumatic ignorant hoops of gate keepers you have to jump through to access hormones. having to convince a psychiatrist who has no understanding or consideration of gender diverse people to let me take hormones is totally degrading”

“IT SHOULDN"T TAKE A YEAR OF GATEKEEPING TO GET IT. Gatekeeping killed my friend - her psych didn’t let her have them for over a year. It should be available at request from a GP”

People who want to begin a medical transition generally first have to see a psychiatrist or psychologist. Mental health professionals can help people to understand what is involved in transition, and provide support during what may be a stressful journey. However, participants criticised the “gatekeeping” role that some are perceived to play. This suggests that an informed consent model may be more appropriate [55]. Participants’ comments also suggest an urgent need for more doctors to work in this area to reduce waiting times.

4.2 Other comments about hormone therapy

Participants were also asked if there were any other comments they wanted to make about hormone therapy. Typical responses are shown below.

“Best thing I have ever done in my life. I went through puberty wishing there was a pill that would make me a girl so I wouldn’t be a boy and now I have found it. Best ever....Life saving”

“Having taken Hormones for [the] last 7 months has made me feel happier and so much more at ease with myself”

“I would be lost without it”

“It makes the person in the mirror look like the person within”

Not every trans person desires a medical transition, but for those who do, hormones can be “life saving”. Hormone therapy has radically improved the lives of some participants, particularly with regard to mental health. All forms of hormone therapy must be easily accessible and included in Australia’s Pharmaceutical Benefits Scheme (PBS). This would ensure that participants do not face large out-of-pocket expenses. Both Medicare and private health insurance schemes must recognise that hormone therapy is an essential medical need for many trans people.

“It’s expensive. Additionally, had I know[n] such a thing was possible I’d have dearly wanted to go on puberty blockers when younger, but that information plain wasn’t available to me at the time”

“I use injectable hormones and have to get them overseas because it’s not available here. It’s also cheaper and more effective and I don’t waste my time and money going to doctors that ar[e]n’t qu[a]lified in treating Trans people”

“There are so many gatekeepers, none of which have a lived trans experience, most of them are super patronizing and some just outright transphobic”

Given the low incomes reported by participants, the cost of hormone therapy is an issue requiring urgent attention. Some products, such GnRH analogues and the anti-androgen cyproterone acetate, may be prohibitively expensive. This is of particular concern for trans adolescents, who may require access to these drugs. Addressing this issue would require changes to the PBS so that such products are authorised for the treatment of trans people. Participants also reiterated that it is sometimes difficult to find information about hormones and their effects, difficult to find doctors who have the knowledge to prescribe and monitor hormone therapy, and difficult to find doctors who are accepting of trans people and prepared to adopt a more flexible approach to transition (such as the use of an informed consent model).

5 Surgery

This chapter examines participants' attitudes toward, and uptake of transition-related surgery. We hypothesised that desire for, and access to surgery might affect mental health. Similar to the pattern observed with regard to hormone therapy, there was a marked difference in desire for surgery between sub-populations in the trans community. As shown in Table 14, more than half of AFAB non-binary individuals desired or had undergone chest reconstruction, but genital surgery and hysterectomy were only desired by a minority.

Table 14: Attitudes toward surgery among AFAB non-binary participants

Surgery	**Attitude**					
	Have had n (%)	**Would like** n (%)	**Not sure if wanted** n (%)	**Don't want** n (%)	**N/A** n (%)	**Missing data** n (%)
Chest reconstruction	9 (6.6)	67 (49.3)	28 (20.6)	29 (21.3)	1 (0.7)	2 (1.5)
Metaoidioplasty	0 (0.0)	10 (7.4)	37 (27.2)	83 (61.0)	4 (2.9)	2 (1.5)
Phalloplasty	0 (0.0)	7 (5.2)	31 (22.8)	93 (68.4)	3 (2.2)	2 (1.5)
Hysterectomy	1 (0.7)	29 (21.3)	43 (31.6)	59 (43.4)	2 (1.5)	2 (1.5)

In contrast, trans men were more likely to desire or have undergone chest reconstruction, and were also more likely to desire genital surgery and/or hysterectomy.

Table 15: Attitudes toward surgery among trans men

Surgery	**Attitude**					
	Have had n (%)	**Would like** n (%)	**Not sure if wanted** n (%)	**Don't want** n (%)	**N/A** n (%)	**Missing data** n (%)
Chest reconstruction	86 (37.1)	132 (56.9)	4 (1.7)	3 (1.3)	0 (0.0)	7 (3.0)
Metaoidioplasty	3 (1.3)	66 (28.5)	89 (38.4)	58 (25.0)	9 (3.9)	7 (3.0)
Phalloplasty	4 (1.7)	53 (22.8)	84 (36.2)	73 (31.5)	11 (4.7)	7 (3.0)
Hysterectomy	34 (14.7)	103 (44.4)	57 (24.6)	29 (12.5)	2 (0.9)	7 (3.0)

However, it is important to note that not all men desired this kind of surgery. This could be because some see procedures such as hysterectomy as unnecessary (having no effect on their outward appearance); because of issues such as cost and/or availability (trans men generally have to travel overseas for phalloplasty and the procedure costs tens of thousands of dollars); or because some surgeries (particularly phalloplasty) are complex procedures which can fail and/or cause lasting sexual dysfunction. The result may be unsatisfactory for some men, and many already feel "man enough" and that surgery is unnecessary [56].

Table 16: Attitudes toward surgery among trans women

Surgery	Attitude					
	Have had n (%)	**Would like** n (%)	**Not sure if wanted** n (%)	**Don't want** n (%)	**N/A** n (%)	**Missing data** n (%)
Breast enlargement	60 (12.5)	160 (33.2)	120 (24.9)	115 (23.9)	17 (3.5)	10 (2.1)
Facial feminisation	49 (10.2)	209 (43.4)	83 (17.2)	110 (22.8)	21 (4.4)	10 (2.1)
Orchidectomy	106 (22.0)	198 (41.1)	70 (14.5)	64 (13.3)	34 (7.1)	10 (2.1)
Vaginoplasty	117 (24.3)	240 (49.8)	72 (14.9)	31 (6.4)	12 (2.5)	10 (2.1)

In contrast to men, trans women were more likely to desire or have undergone genital surgery (Table 16). This may reflect the relatively lower cost, lower rate of complications, and better cosmetic result for this type of surgery. However, relatively few women had undergone the procedure, which may be attributable to cost (typically $20,000 - $30,000), and the necessity to travel overseas to find a surgeon skilled in performing this surgery.

Table 17: Attitudes toward surgery among AMAB non-binary participants

Surgery	Attitude					
	Have had n (%)	**Would like** n (%)	**Not sure if wanted** n (%)	**Don't want** n (%)	**N/A** n (%)	**Missing data** n (%)
Breast enlargement	1 (1.0)	30 (31.3)	21 (21.9)	37 (38.5)	2 (2.1)	5 (5.2)
Facial feminisation	4 (4.2)	30 (31.3)	18 (18.8)	36 (37.5)	3 (3.1)	5 (5.2)
Orchidectomy	3 (3.1)	17 (17.7)	23 (24.0)	48 (50.0)	0 (0.0)	5 (5.2)
Vaginoplasty	0 (0.0)	21 (21.9)	22 (22.9)	46 (47.9)	2 (2.1)	5 (5.2)

Like their AFAB non-binary counterparts, AMAB non-binary participants were less likely to have undergone or to desire genital surgery (Table 17). However, they were more likely to desire genital surgery than AFAB non-binary participants, and their desire for genital surgery was similar to trans men, although lower than trans women.

These findings highlight the importance of recognising the existence of sub-populations within the trans community, and their different medical needs. They also stress that it is unrealistic to insist that surgical intervention should be required for a legal change of sex. Surgical intervention may be unwanted, unnecessary, unaffordable, or otherwise unavailable. Some individuals may also have health problems that are barriers to surgery.

5.1 Factors that led participants to have surgery overseas

Overall, 27.8% of participants (n=263) had undergone surgery. Of these, 35.0% (n=92) had a procedure performed overseas. This proportion rose to 50.3% for trans women. The corresponding proportion for trans men was 13.2%. Knowing that participants often travel overseas for surgery, we asked participants why they made this choice.

"I had gender reassignment surgery in Thailand because the surgeons there are better AND cheaper than surgeons in Australia"

"The surgeons overseas are better for some things, I had FFS done in Chicago. Also I went to Thailand for BA so I could see if I liked the doctor enough to choose him for SRS"

"Because they didn't offer all the surgeries I wanted in Australia - I wanted forehead reconstruction"

"Lack of experience with Australian surgeons compared to the U.S. I wanted the best I could find for specific procedures"

"No surgeon available in Perth, superior technique and lower cost in Thailand"

"Surgery in Thailand did not require the consent of Australian medical authorities"

"The costs were prohibitive, the doctors were inexperienced and did not perform the best SRS possible. They also have strange requirements that made little to no sense"

Trans people may need to undergo a variety of surgical procedures. However, many of these procedures (such as facial feminisation surgery or phalloplasty) may be unavailable in Australia, or may not be fully covered by Medicare or private health insurance schemes. Additionally, since many trans people understandably want to see a surgeon likely to provide the best possible surgical outcome, these factors often necessitate overseas travel to surgeons who perform many of these procedures on a near-daily basis. Trans people may still choose to travel overseas to visit their surgeon of choice, but people should not be forced to leave Australia in order to meet their health needs. What of people who cannot afford to travel overseas? There is an urgent need for health departments across the country to address this issue. Ideally, each state and territory should have a hospital-based trans health clinic, where trans people can at the very least access some of the less complex surgeries such as chest reconstruction and orchidectomy. It may be necessary for one central clinic in Australia to specialise in more complex surgical procedures, such as vaginoplasty, phalloplasty, and facial feminisation surgery. Adequate financial resources must be directed to such clinics to ensure that waiting times are kept to a minimum.

5.2 Factors associated with participants not having surgery

Given the large proportion of participants who desired surgery, but had not yet undergone a surgical procedure, it is important to understand the factors that might prevent participants from having surgery. Comments that illustrate participants' responses are shown below.

"Fear of complications and bad health"

"My family would oppose it and I would be ostracised by them; also there are so many hoops and procedures to be gone through before a surgeon will perform the required surgery"

"Cost and the additional burdens of combating these costs as a lone young person with no family support was and still is an issue. These are several surgeries costing in total tens of thousands of dollars and this is simply to get an average looking body"

"There are the usual financial and gatekeeping restraints. In particular, it looks like I will be forced into sex work as the only way to fund this"

"The cost, money, don't want to have to see a therapist for 2 years prior to surgery as I know I'm a male and I shouldn't need to prove it to anybody"

"The cost of surgery is unaffordable and the medical system which won't offer us the kind of surgery options here in Australia. Can't even get a hysterectomy!!!!!"

"Money is a large factor in not having surgery. Another big factor is a fear of surgical complications and possible loss of sensation during sex if I choose to have a vaginoplasty"

"It took me 2 years of 2x psychiatrists referrals to get approval for mastectomy, and money and Australian access to surgeons has prevented me from having meta or any lower genital surgery. My full/radical hysto was performed early in my transition as an emergency procedure as I had cysts on my ovaries and was in a great deal of pain (exasperated by starting testosterone). It also took me years to save enough money for the surgeries I have had"

Key factors preventing those who wanted surgery from obtaining it, were cost, lack of availability, and "gatekeeping". Given that the cost of some surgeries can run into tens of thousands of dollars, many surgeries are simply out of reach, particularly for young people. As noted previously, Medicare and private health insurance schemes must regard trans-related surgery as essential medical treatment, rather than cosmetic. Tax rebates must also apply, as they would for any other essential medical procedure. It is particularly worrying that some participants might be "forced into sex work" to fund their healthcare.

"I managed to save enough money myself to have chest reconstruction by a local well respected surgeon who personally I'm happy with my results... I would have loved to have been able to have a full hysto including removal of ovaries but neither are covered by Medicare"

"If lower surgery outcomes were better, and if surgery was available in Australia I might consider it more seriously. I would only have hysterectomy/oophrectomy surgery if medically necessary (or if required as part of having full lower surgery)"

"Current surgical outcomes (i.e. success rate, limitations of what medical science can currently achieve) are making me hold off on getting any bottom surgery for the time being"

"Metaoidioplasty and phalloplasty is not available in Australia, and the expense is too great to go overseas (it would probably be too expensive if it was available in Australia as well)"

"There is nowhere in Australia to have phalloplasty performed. I've heard rumours about a new doctor in Melbourne but it's very hard to get real information about that. The surgery I am looking into is only performed in Europe ($AU40,000) and America ($US56,000). I have been saving for years for this surgery. I'm 31 now and still about $20,000 away from the FIRST of three or four procedures. ... In Australia, there is no such recognition [as a legitimate medical condition] and no insurance company will cover these procedures, as they are not deemed 'medically necessary'"

Some participants were able to undergo some kinds of surgery in Australia and were happy with the results. However, overwhelmingly participants reported that many of the surgeries they wanted were either not available in Australia, or they were concerned about the state of the art. This stresses this importance of surgery not merely being available, but hospitals offering the very latest surgical techniques and aftercare. For some of the more advanced procedures, such as vaginoplasty and phalloplasty, it might be necessary for Australian surgeons to visit some of the "expert" surgeons elsewhere in the world to receive training. Some participants felt that certain surgeries were not "medically necessary" for them (which currently may present a barrier to a legal change of sex), while others wanted such surgeries, but were either denied them, or could only obtain them for "legitimate" reasons, such as having cystic ovaries. This highlights the fact that at least some doctors do not seem to regard trans-related surgery as a legitimate medical need.

"I have an excellent and healthy sexual life with my 'original plumbing', and I am not emotionally or psychologically impacted by not having male genitalia. I think if I was younger, in my late teens or early twenties I might want to have phalloplasty. However, my sense from research and other transguy's experiences is, that the operation is very expensive, there are many surgeries, for what in the end is ostensibly a skin-covered dildo with no sexual sensation"

Not everyone desired genital surgery. Some were happy with their "original plumbing". Educational materials, which include personal narratives and factual information about all transition-related surgical procedures, need to be developed and made accessible in formats appropriate to the trans population, so that they can make evidence-based informed decisions.

6 Changing identifying documents

It is common for trans people to want to change their name and sex on important legal documents, such as the passport and birth certificate. This is often essential to being accepted as one's preferred sex. Not being able to change identifying documents can result in discrimination, difficulty accessing services (including medical care), and an on-going source of distress. However, the situation may be more complex for some individuals (particularly those with non-binary identities) who choose not to pursue a medical transition. Participants' attitudes to changing identifying documents are shown in Table 18 below.

Table 18: Attitudes toward changing identifying documents, by identification

Response	**Category of identification**				
	Entire sample	**AFAB non-binary**	**Trans Men**	**Trans women**	**AMAB non-binary**
	n (%)	n (%)	n (%)	n (%)	n (%)
Not tried, and don't want to or are unsure	107 (11.3)	35 (25.7)	3 (1.3)	28 (5.8)	41 (42.7)
Not tried, but would like to	293 (31.0)	58 (42.7)	67 (28.9)	131 (27.2)	37 (38.5)
Tried, but could not	35 (3.7)	9 (6.6)	3 (1.3)	21 (4.4)	2 (2.1)
Tried, and changed some	285 (30.1)	20 (14.7)	101 (43.5)	154 (32.0)	10 (10.4)
Tried, and changed all documents	200 (21.1)	11 (8.1)	51 (22.0)	137 (28.4)	1 (1.0)
No answer	26 (2.8)	3 (2.2)	7 (3.0)	11 (2.3)	5 (5.2)

The low proportion of those who tried to change their documentation but could not, together with the qualitative data in the following section, suggests that many trans people do not attempt to change their documentation because they know they will be unsuccessful. In many states and territories, it is a requirement for trans people who are currently married to divorce before the birth certificate can be changed. Understandably, many do not wish to do so, and should not be forced to. Additionally, some form of surgical intervention is generally required, but this may not be possible for people to obtain (even if desired). Individuals who were born overseas may find it difficult, if not impossible to change certain documents, while non-binary individuals may wish to change documents such as the birth certificate, but wish to be recognised as something other than male or female (which is generally not possible).

6.1 Impact of not being able to change identifying documents

Being forced to live with identifying documents that do not match one's sense of self and outward appearance can have a profound negative effect on mental health and well-being. It may also place trans people in danger of discrimination or violence. Some comments that illustrate the impact of not being able to change identifying documents are shown below.

"It's a nasty, alienating bureaucratic process that costs a lot of money and seems never ending"

"I fear going anywhere that identification may be needed, and I still get called by my legal name at doctors and other such appointments which has been very distressing"

"Travelling on a passport that didn't match my gender presentation saw me incarcerated on claims of a false passport. Not having this document reflect my appearance was traumatic and impacted my right to privacy as I had to come out at work as a consequence"

"what do you think. I hate the drivers license, I have it facing backwards in my purse so I can't see the picture or the name. same with all the other cards"

"Even though I think I am pretty robust - I must admit it does impact me and for a period of time it can make me feel angry, sad, frustrated. It creates administrative difficulties that can get in the way - impact me financially or else make me fear being outed"

"As an FtM trans person, having female on a birth certificate and driver's licence is very awkward. Employment, health care, centrelink, housing and anything requiring identity documents are all very stressful. It basically means you have to 'out' yourself as trans at every turn"

"Still being identified as male with centrelink (due to not having reassignment surgery) and identified with female by my university creates headaches a few times a year when I have my payments suspended until I can prove my enrolment. The idea of being legally male for the foreseeable future scares and upsets me"

Being unable to change their identifying documents had a profound negative effect on participants' mental health and well-being, and created many unnecessary and stressful difficulties for them. Furthermore, changing identifying documents is not the simple process it should be, because different rules operate at the Commonwealth level (e.g., changing the sex marker on passports and the Medicare record), and at the state and territory level (e.g., changing the birth certificate or driver's license). People who were born overseas may face additional barriers. Generally, changing one's legal sex at the Commonwealth level does not require surgery, as mandated by the Australian Government Guidelines on the Recognition of Sex and Gender [57]. However, almost all state and territory jurisdictions require at least some medical intervention to have taken place. Complex and costly surgical procedures such as vaginoplasty may be required.

There is an urgent need for reform of state and territory legislation so that a legal change of sex becomes a simple administrative matter, and does not require medical intervention. The Australian Government Guidelines on the Recognition of Sex and Gender could be used as a model for such legislation. However, even at the Commonwealth level, problems remain. The Australian Government Guidelines on the Recognition of Sex and Gender are gradually being adopted by Commonwealth departments, but do not need to be implemented until 2016. This must be accelerated. Furthermore, the entire process of changing one's legal sex must be simplified. Ideally, trans people should be able to make a single application with one authority. All other agencies should be notified on their behalf automatically.

"Yes, it causes great distress not being able to change the gender marker (you must have vaginoplasty, which I can't afford and likely will never be able to afford) ... "

"The inability to change my gender marker on my birth certificate without having sterilised myself (hysto) is very demeaning. When having a hysto is not a medical necessity, why should I be required to go through this surgery when I've been able to change all of my other documentation (i.e. drivers licence, passport, Medicare etc.) to read 'Male'?"

"The marriage act makes it unlawful to change my primary birth marker, without a divorce"

"Had a problem with Medicare who did change my sex to male but then wanted my permission to change back to female so they could process my claim for ovaries removed. They said their system would not allow the claim to go through because males can't have the procedure done. I would not allow them to change my sex and said they had to change their system. It was processed in the end but I did not allow [them] to change to my sex and it took some time"

" ... Documentation can often be changed but is purposely delayed, for example changing my sex to 'male' wherever I can (ie medicare) will mean I have to pay more for 'female' surgeries - in my case I was not ready (financially and otherwise) for top surgery for years, so have been keeping my documentation 'female'. It is also weird documentation-wise to get papsmears etc. as a 'male'. There are many different government agencies that have differing levels of what is required to change sex, and being [a] different sex to different agencies can create problems and is very confusing for everyone. There are also issues such as PBS benefits changing depending on your sex"

Given the experiences of participants in this study, it is unrealistic to insist that medical intervention be a prerequisite for a legal change of sex, because there is no one-size-fits-all approach. Furthermore, participants found it "demeaning" to have to sterilise themselves in order to receive legal recognition. Trans people who are married are also often prevented from changing their legal sex. It is grossly unfair to force married trans people to choose between legal recognition and remaining married. Further problems arise when certain hormone therapies or medical procedures are only subsidised on the PBS or the Medicare Benefits Schedule (MBS) for people of a specific sex. Even after surgical intervention, trans people may still retain some of their original reproductive organs. (For example, the prostate is generally not removed during vaginoplasty). Thorough reform of the PBS and MBS is required so that no medical intervention that trans people might require is dependent on the Medicare sex marker.

“Not at all, I present as who I want to be, police and anyone who requires ID are polite and understanding”

“There is no legal recognition for my status as a non-binary individual, and I am instead treated medically, legally and socially as female. I do not identify as female or male”

“The fact that the only options for documentation is to be either male or female is frustrating. I feel greatly invalidated, and this has fuelled my depression”

“It’s even more difficult to change your documents if you were born in another country, and the cost is astronomical as well. It basically just feels like the government wants to take a giant shit on you anytime you want to do anything if you’re trans. Like at least let me do this. because I’m not ever going to be able to afford surgery or anything”*

Not all participants reported that being unable to change their identifying documents created problems for them. However, the majority of participants felt otherwise. It is also important not to overlook the experiences of people with non-binary identities. People who identify as something other than male or female must have the option to identify themselves this way on Commonwealth, and state and territory records and identifying documents. This could be achieved by having an “X” option as with passports, or the ability to have one’s sex recorded as “indeterminate” (or similar) on the birth certificate. Clearly, though, there is an urgent need to reform what trans people experience as a “nasty, alienating bureaucratic process”.

6.2 Participants’ thoughts on changing identifying documents

We asked participants if they had any other comments to make about changing identifying documents. Overwhelmingly, participants thought that the process should be simplified and the requirements much easier to meet.

“I think it would be good if the law could be changed. So instead of needing surgery to record a change of sex, if a doctor and a psychiatrist could sign off on it that would be fantastic and make life so much easier”

“Name changes are simple enough, though expensive with no allowance for necessity. You cannot use the cheaper name change upgrade for passports that people can use when marrying. The sex marker requires surgery and letters and things that are not possible or wanted for many people”

“It is essential for trans people to have the option to change their documentation, to get on with their lives”

In summary, there are at least two key areas requiring urgent action: (i) the implementation of the Australian Government Guidelines on the Recognition of Sex and Gender; and, (ii) for state and territory authorities to simplify the process required for a legal change of sex. Medical intervention must not be a prerequisite, and upon a successful change of sex, the relevant state or territory authority should notify all state, territory, and Commonwealth government departments on the applicant’s behalf.

7 Discrimination

Discrimination and harassment is a daily reality for many trans people. This chapter explores participants' experiences of discrimination and harassment, and how they responded and tried to remain safe. As shown in Table 19, almost two thirds of the sample had experienced discrimination or harassment at some point in their life. Almost half experienced this in the last 12 months.

Table 19: Experiences of discrimination and harassment, by identification

Response	**Category of identification**				
	Entire sample	**AFAB non-binary**	**Trans Men**	**Trans women**	**AMAB non-binary**
	n (%)	n (%)	n (%)	n (%)	n (%)
Never experienced	296 (31.3)	44 (32.4)	75 (32.3)	143 (29.7)	34 (35.4)
Experienced, but not in the last 12 months	152 (16.1)	13 (9.6)	39 (16.8)	84 (17.4)	16 (16.7)
Experienced in the last 12 months	461 (48.7)	72 (52.9)	107 (46.1)	241 (50.0)	41 (42.7)
No answer	37 (3.9)	7 (5.2)	11 (4.7)	14 (2.9)	5 (5.2)

Of the 613 people who experienced discrimination or harassment (64.8% of participants), an alarming 76.3% (n=468) reported that they had changed their activities or behaviour to avoid further experiences.

7.1 Experiences of discrimination and harassment

We asked participants to describe the discrimination and harassment that they had experienced. Below are some examples of participants' comments.

> *"I'm a non-binary gender and people tend to disregard that and assume we're just playing around. Like this is a game. It's not"*
>
> *"Just small things like people whispering behind my back and strange looks all the time"*
>
> *"General condescension, being treated as strange or other, being told I'm faking it, being told I should get over it, being told that I'm mentally ill"*

"Nobody knew how to approach someone in my situation so they opted to just not talk to me at all. It was isolating. When I didn't pass I would get verbally abused/harassed daily by strangers on the street"

"Isolation due to being invisible in society both within the gay and lesbian community and heterosexual communities. Loss of social connection due to assumptions that I'm male"

"violence, verbal harassment, as a volunteer in so-called GLBTI orgs, especially the mess called [media organisation in Victoria]. From [telephone counselling service] (as both volunteer and client) many years ago"

Participants detailed the multiple ways discrimination and harassment play out in their lives, which often result in social isolation. It is important to note that discrimination occurred in a variety of contexts, including within the LGBTI community. Discrimination could perhaps be mitigated to some extent by education. As previously noted, this could take the form of workplace education and resources for family and friends. School sex education curriculums should also discuss trans issues in a positive and inclusive manner. Education campaigns for the general public, such as the *Stop. Think. Respect.* campaign [58] may also be effective at reducing stigma and increasing understanding.

"I started falling for a girl, and I thought before things got too serious I should tell her about my medical history, so I wouldn't one day be quietly nodding along while she complained of reproductive pains, seeking some sense of sisterhood where there is none. She used to be really excited to talk to me. I never hear from her anymore"

Establishing and maintaining relationships can be daunting for trans people, particularly those who are "stealth". Trans people face the dilemma of disclosing their trans status early to appear "honest", before a potential partner has got to know them well, or to wait until they have built rapport with a potential partner only to face the possibility of being accused of "deception" and possibly violence. Trans people who are not stealth may still face similar problems, and may not be seen as desirable partners. At the other extreme, trans people are sometimes fetishised, which may increase the chances of finding a partner at the cost of their identities being disrespected.

"doctors not wanting to treat me"

"I'm having a hard time acquiring paid work because of my 'trans status'. While I can't prove it, as soon as a potential employer finds out I'm trans the interview ends suddenly. They find out because they ask for proof of my right to work and see the female marker on my birth certificate"

"Forced to resign my job, verbally abused and belittled in front of co workers, stalked, threatened, hate mail"

"Tafe teacher using transphobic language in class for 'laughs' even tho she knew about me. other students in the class followed up with more 'jokes'"

"Been openly called numerous names (e.g. 'ladyboy', 'shemale', 'tranny'), been asked if i was male or female, unwelcome stares and whispers in the past. Was labelled 'gay' and 'queen' in school. Other forms include racist remarks from transgender folk, General harassment from men ranging from car honks, solicitation and unwelcome advances"

"Worst was being fired [the] day after I announced my intention to transition. Have had people try and kick me out of bathrooms, sports teams. Have been excluded from social situations. And if I ever have to hear another tranny joke.... Only choice is either to out yourself or smile nod and condone it. Makes me sick"

Participants reported discrimination in a wide range of settings, including healthcare, their workplace, and educational institutions. They reported being the focus of hurtful comments and "jokes" from their peers and teachers. Participants had difficulty securing employment, and some reported losing their job after announcing their intention to transition, or during the transition process. Some participants resigned from work because their peers made life unbearable for them.

Some participants also reported experiencing racism from other trans people. In this regard, it is important to note that the trans community is not necessarily a welcoming and inclusive place for all. Apart from interventions to address racism (and other forms of discrimination) within the trans community, research on the intersection of race, sex, and gender expression should be made a priority area.

Can discrimination and harassment be eradicated or at least minimized through education? Hopefully, it can. As mentioned previously, campaigns such as *Stop. Think. Respect.* [58], workplace education, inclusion of trans people in school education curriculums, and enforcement of the new protections included in the Sex Discrimination Act 1984 (Cth) which came into force on 1 August 2013, may help to mitigate this.

"I was chased along the Yarra River by a bunch of youths throwing stones. Also general refusal to provide services, people laughing and pointing at you or talking about you behind your back socially"

"As a child I was bullied for being effeminate, by peers and siblings. Parents would not allow me to express myself"

"Being called a poofter; was bashed once because they thought I belonged in a mental institution"

"Assaulted at a tram stop. A man asked man or woman? I answered does it matter. he said 'I hate you' and hit me"

The Australian Institute of Criminology should collect information about, and report on hate crimes against trans people. Legislation to outlaw vilification of people based on their trans status should be considered.

7.2 Changing behaviour to avoid discrimination

Participants who had experienced discrimination or harassment often went to great lengths to avoid future experiences. Comments illustrating their coping strategies are shown below.

"I feel obliged to make myself seem inconspicuous when I am by myself in public if I am presenting a more feminine exterior so as to divert attention from myself to avoid any discrimination and/or harassment"

"Not getting undressed completely and undressing partially in the corner of gym locker rooms to avoid revealing my genitals and chest scars. Avoid using urinals, and always shut stalls to urinate, limit the amount of chest (scar) exposure, keep shirt on and rarely wear singlets in summer, have grown facial hair at times to help in being publicly identified as male (even though I hate facial hair and would much rather be clean shaven), had to make up stories of a male childhood when asked to avoid any suspicion of having grown up female"

"Constantly maintaining awareness of people out on the streets, changing sides of the road when I see large groups of young drunk guys, groups of us going out of our ways to make sure that everyone makes it ok to a car or train station, staying over at people's houses or taking taxis rather than risking public transport on football nights"

"I do not venture to straight clubs. I rarely go out into public nightlife. I move quickly through public, and am hyper vigilant of anything I consider dangerous"

"Keep social life to a minimum. in other words go home lock myself up throw away the key"

"Stopped playing sport, ceased going to usual venue. Left a job"

"I've dropped out of uni and TAFE because of bullying and because neither administrations cared. I've pretty much given up on tertiary education"

"Not dating and being afraid to seek out a romantic partner ..."

"I have avoided people from before my transition, moved interstate to be anonymous and start a new life, avoided changing rooms and sports, changed doctors, lied about my past, not let new acquaintances get close to me... it affects every facet of my life. I constantly feel on edge about someone outing me and I worry what would happen if someone exposed me"

"public toilets is the worst. every fight i've been in has been after i use a public toilet so i now avoid using them"

"As a general rule, I live what is known as 'stealth' - namely, I don't make it known, and actively avoid telling people, that I'm not just a normal guy. Things like, if I'm asked why I only took two subjects during the semester in which I had chest reconstructive surgery, I have a consistent story about an injury sustained during working on a [workplace environment], which is something I do often. This has been the case ever since I started transitioning. I used to lie and say I was younger than I am, pre-testosterone, because I was lucky enough to be able to pass as a younger guy. When binding my chest, I was called on it once, and immediately responded that it was a back brace ..."

Participants reported numerous ways that they protect themselves from discrimination and harassment. All likely have a negative effect on mental health even if they "work" to some degree. For example, being stealth protects individuals' privacy (and is a perfectly valid choice), but the fear of discovery may be an ongoing source of stress and a self-imposed prison of sorts. The provision of a unisex option for toilets in public places, workplaces, and schools, may help trans people avoid potentially dangerous confrontations with others.

8 Accessing healthcare

This chapter explores participants' relationship with general practitioners (GPs) and health workers generally. As shown in Table 20, over 80% of trans men and women had a GP, but only approximately two-thirds of non-binary participants did. This may be because many non-binary participants do not seek a medical transition (having a regular and supportive GP is generally essential to the transition process), or because they fear that GPs will not understand what it means to have a non-binary identity. However, finding a supportive GP may be equally difficult for trans men and women, as participants' comments in the following sections illustrate.

Table 20: Participants who had a general practitioner, by identification

Response	Category of identification				
	Entire sample n (%)	AFAB non-binary n (%)	Trans Men n (%)	Trans women n (%)	AMAB non-binary n (%)
No	106 (11.2)	26 (19.1)	16 (6.9)	45 (9.3)	19 (19.8)
Yes	736 (77.8)	90 (66.2)	187 (80.6)	397 (82.4)	62 (64.6)
No answer	104 (11.0)	20 (14.7)	29 (12.5)	40 (8.3)	15 (15.6)

Of those who had GP, 82.3% (n=606) had told their GP that they were trans. We also asked participants who had a GP about their relationship with that doctor, using the Patient-Doctor Relationship Questionnaire (PDRQ-9). Only 51.2% (n=377) met the criteria for a good relationship with their GP.

8.1 Reasons for not having a GP

Participants who did not have a GP were asked why this was the case. Responses that illustrate the themes that emerged are shown below.

"Because I generally am dissatisfied with how I'm treated"

"because you don't get treated well. ... because they don't know how to treat you. no knowledge"

"The GPs where I live do not generally provide bulk-billed services"

"I live in a remote community where there is no GP. I do have a Transgender friendly clinic that I attend when I am able to and I am in Melbourne - usually about twice a year"

While the majority of participants had a GP, and some reported a good relationship with that person, this was not universal. Some participants expressed dissatisfaction with how they were treated, and that their doctor lacked the knowledge to provide adequate healthcare. This appears to support other research. In a recent survey conducted in the U.S., half of trans people reported that they had to educate their doctor about their healthcare needs [59].

Participants also reported difficultly locating a GP, especially in rural and remote areas of Australia. This problem is likely acute for ATSI people living in remote communities. There are likely to be few health professionals who specialise in trans health in regional and remote Australia. Those that do may attract a large caseload of trans people, and could become overwhelmed, resulting in them choosing to leave this area of medicine. This stresses the importance of all GPs having some knowledge of trans health – at the very least they must be aware of appropriate referral pathways. Telemedicine may also be an option for people living in rural and remote areas. Doctors working in the major cities of Australia who are able to offer telemedicine must consider providing this service.

Cost was another barrier reported by participants. Given the low incomes reported by participants, having access to doctors who bulk bill is essential.

8.2 Disclosing being trans to healthcare workers

We asked participants about their experiences of healthcare generally, and how they felt about disclosing being trans to health workers. Only one-fifth (20.4%, n=193) always disclosed, 25.0% (n=236) sometimes disclosed, 33.8% (n=320) disclosed only if they had to, and 12.2% (n=115) never disclosed. The remaining 82 participants did not answer this question.

Although it is not always necessary for a doctor to know that a patient is trans, there may be times when not knowing could result in the patient receiving sub-optimal care. For example, a trans man who looks unambiguously male is unlikely to be offered routine reproductive health checks, such as a Pap smear. It is also concerning that participants felt that they could not be open with healthcare workers. This may be due to a fear of discrimination, privacy and safety concerns, a way to manage the burden of having to educate healthcare workers, and/or not wishing to draw attention to this aspect of their lives.

To further explore this issue, we asked how participants felt about telling people that they were trans when accessing healthcare. Typical responses are shown overleaf.

“Being ‘post-op’ I don't feel the need to I’d rather not ‘out’ myself”

“My policy is to confirm my status if asked, otherwise I do not mention. I see myself as female, not someone pretending to be female”

“I get uncomfortable as most health care workers seem unsure how to deal with a trans patient”

“Frustrated. Embarrassed. Nervous”

“Very nervous because I often have to educate the health professional, whether they think they need it or not”

“Mostly unsafe. I’m never sure who I can trust. Although so far everyone I’ve told has been very professional about it, some people have had bad experiences with refusal of care or being outed (or worse), which scares me.   I feel like not enough doctors are educated in transgender issues, and most of the ones I have talked to have been going with their gut feelings and some vague knowledge”

“Concerned about my privacy, concerned that they will start screwing up with pronouns, concerned they will see me as less of a man, concerned they will think I have a mental health problem, concerned that my friends and classmates will find out somehow (I’m a medical student at present)”

“I’m not really worried because I go to a trans friendly doctor, but I have had a bad experience at the start of my transition with a very judgmental doctor”

“I prefer not to but when it comes to health care I understand it may sometimes be necessary and when pressed will not hide or lie about it even if it isn’t relevant to the situation at hand”

“Pretty cautious. On one hand I know they should treat me impartially and provide good care regardless, but snarky comments, and body language can do a lot to show disapproval”

“I am proud of being trans, and I love talking about it”

Only a minority of participants (20.4%) always told health workers that they were trans. Many participants were clearly uncertain how disclosure would be received, and reported feelings of fear, frustration, embarrassment, and nervousness. Many felt unsafe and lacked trust in doctors, worrying about whether the doctor would be judgemental and whether being trans would be treated as confidential information. Some who were stealth saw no reason to disclose at all. While being stealth is a valid choice, if the doctor is unaware of their patient’s trans status, they may not provide optimal care and may miss opportunities for disease prevention. (e.g., offering a Pap smear to trans men, or a prostate check to trans women).

Given that many participants reported experiences of poor treatment by doctors, fear of disclosure is understandable. Although trans people should not be forced to disclose, medical services must create a welcoming environment so that trans people know that disclosure will be received positively if they choose to do so. This could be achieved by displaying trans-friendly materials and resources such as posters and fliers, and brochures about trans health.

All staff working in healthcare settings (including support staff), must be educated about trans health, to improve the likelihood that trans people will feel comfortable that they can be open about being trans (if they wish to do so). Information and educational materials that include personal stories and factual information about what it means to be trans are needed for healthcare workers. These materials must be disseminated in appropriate formats to everyone working in the healthcare sector to increase their knowledge and skills, and acquire a trans-positive attitude. Several guidelines have already been developed for this purpose, and could easily be adapted for use in the Australian setting [60-63].

8.3 Factors affecting disclosure to healthcare workers

We expected that participants would be reluctant to disclose their trans status. We therefore asked about the factors that encouraged and discouraged participants to do this.

8.3.1 Factors that encourage disclosure

Below are some comments that are representative of the factors that encouraged disclosure.

"Nothing ! Don't see the point"

"When I'm in an environment that seems positive I might tell them. And when I'm forced to say what medications I'm taking"

"It is kinda obvious, especially with health care. Not really something I can hide"

"When the procedure is of a nature that the information about my history would be relevant to diagnosis or treatment"

"If they seem positive towards me and seem understanding and friendly"

"Alluding to my non-binary status and judging their response to be positive"

"If I know that they have knowledge regarding transgender people"

"Well that they have GLBTI posters or info in the reception area. Although I went to a local community health centre that had all that once and ended up making a complaint about a GPs conduct - He said 'I was depressed because I was too muscly and masculine'.../! What tha?"

"When clinics specifically advertise themselves as trans-friendly, or when a friend recommends someone"

"Just makes me feel good as I hid this for 47 years off my life only person who ever knew was myself"

Participants generally disclosed only when they felt it was relevant to the medical issue that they were being treated for, or if they thought that health workers seemed "understanding and friendly". A visibly trans-friendly environment can encourage openness. As noted previously, the prominent display of trans-friendly materials and resources could encourage this. But organisations must do more than simply state that they are trans-friendly. A trained workforce is essential to ensure that medical care is genuinely trans-friendly. Health workers must also clearly know the difference between populations that comprise the LGBTI community, and not assume that the needs of LGB people are the same as trans or intersex people. Resources such as *Is Your T Written in Disappearing Ink?* [64] can help providers ensure that the “T” in LGBTI is not a token gesture, and make their service truly inclusive.

8.3.2 Factors that discourage disclosure

Below are some comments typical of the factors that discouraged disclosure.

“It’s always humiliating to admit to physical aspects of the other sex”

“Nothing, except it is outing myself”

“I still feel shame, fear and embarrassment”

“Fear that they won’t adequately help me due to the fact I’m trans, or limited medical knowledge of trans issues and medicine”

“Confidentiality breaches/people overhearing Reactions can be worrying”

“The fact that the few times I have had to, they completely disregard what I have told them or have no idea what I am on about and require me to spell it out slowly for them. I go to the doctors because I’m sick, not to teach the ignorant”

“Past negative experiences”

“Always feel slightly more trepidation telling males that I am trans”

“lack of visible diversity / inclusivity statements”

“if the[y] have voiced conservative or offensive views about sex or gender, they are apathetic or don’t care about me in general”

Factors that discouraged trans people from disclosing included fear of negative reactions, healthcare workers’ lack of knowledge regarding trans health, an unwelcoming environment (lacking “diversity / inclusivity statements”), and the desire not to “out” themselves. Non-disclosure is a perfectly valid choice, but in some cases could indicate a degree of internalised transphobia, as indicated by comments about “shame ... and embarrassment” about being trans. This stresses the importance of improving awareness and acceptance of trans people by the general population in all spheres of life. Although being trans can be a challenging and difficult experience for many, encompassing not just the struggle of self-acceptance and the decision to transition, but also a long and costly process of medical intervention, mental health promotion programs may possibly help to alleviate distress. A priority for mental health research should be to examine how greater self-esteem and self-worth can be fostered in trans people.

8.4 Experiences of accessing healthcare

We asked participants what accessing healthcare as a trans person was like. Some comments that illustrate the themes that emerged are shown below.

"Avoid it when possible. Don't have the knowledge about how to seek it as well"

"Great in terms of general health care. Pretty close to terrible as far as trans specific health care is concerned"

"Good and bad. Some healthcare providers have been surprisingly understanding and helpful, others have out rightly denied me even an appointment due to being trans"

"I have had good and bad experiences with accessing healthcare. The worst experience was when doctors at a local hospital refused to treat me after I disclosed to them that I was trans and had a sexual reassignment surgery. I had developed complications post-operatively after my first mastectomy and approached numerous hospitals about it and none of them would treat me, I had to fly back to Sydney so my surgeon could treat me. But other than that, there are a number of trans friendly and trans experienced healthcare professionals in my city that I utilise and feel there is good access to a variety of them"

"I have had no major issues, I found good doctors and stuck with them, I've only really had uncomfortable experiences when I had to use other doctors [at] short notice. In fact I have been very happy with the fact that I found doctors/surgeons happy to work with me outside the current psychiatric pathologising system"

"Very occasionally you find a good practitioner. They are like gold. Most however are useless and know nothing but won't admit the limits of their knowledge. Some are rude. Others just unprofessional. Some are inappropriately sexual"

Participants reported mixed experiences. Positive experiences were associated with the medical health professional being knowledgeable about trans health and having a trans-positive attitude. Poor experiences arose from lack of knowledge, negative attitudes, and experiences of discrimination.

Trans people's experiences of accessing healthcare appear to be very much contingent upon the attitudes and knowledge of the medical health professional. Trans people should not have to search for "good practitioner[s]" who are "like gold". Trans health must become part of the medical curriculum, professional development programs, and workplace training. Clear referral pathways are also urgently needed, so people are not left wondering "how to seek" trans healthcare.

"Typically good, the larger the organisation the more likelihood they would have dealt with other trans people before so I try to stick to large practices or go on recommendations"

"Fairly good, I don't get many doctors that would be discriminatory very often but there is definitely some out there"

"Pretty good. A few surprised looks, but usually accepting. I changed GP a few years ago, the previous one was ok but not overwhelmingly interested. My current GP is great. She even asked me to explain what trans life is all about"

Some participants reported mostly positive experiences with doctors, but this was sometimes a matter of luck and/or knowing where to go. Trans friends were often a valuable source of knowledge, but trans people should not have to rely upon the knowledge of their friends and peers in order to locate qualified health practitioners.

8.5 Factors influencing the decision to access healthcare

Given that trans people experience high levels of discrimination, including in the healthcare setting, we wanted to understand the factors that might influence the decision to access healthcare. The following sections explore the factors that encouraged and discouraged participants from accessing healthcare.

8.5.1 Factors that encourage healthcare access

"The need to access hormones, surgery and keep good health during transition/life"

"Explicitly stating on their website or promotional material that they are trans experienced or trans friendly. When the healthcare professionals have a reputation for being friendly and professional, open communication and genuine interest health. When it's affordable and they bulk bill"

"Health care facilities and providers who are up to date, that is, are at least vaguely aware/open to transsexual people and issues"

"A doctor / staff that use the right pronouns. Would be a massive improvement, if they have no idea what to use then they should ask"

"if someone in the community recommends a service"

"I access health care only if I need it, and for annual blood tests"

"When I am so ill I have no other option"

Although some trans people accessed healthcare only if they felt they needed it and/or for transition-related purposes, other factors were important in encouraging trans people to access healthcare. These included explicit statements that the service was trans-friendly, doctors and staff who were knowledgeable about trans health (or were willing to learn more in respectful ways, such as appropriate questions about which pronouns people preferred), and recommendations from friends and peers. However, some participants' negative experiences of healthcare and/or fear of discrimination resulted in some accessing it only when they had "no other option". This reflects an urgent need to improve health services for this population.

8.5.2 Factors that discourage healthcare access

"Nothing really"

"An absence of bulk billing and competent psychiatrists in my area (Newcastle, NSW)"

"The lack of specialists in Australia who deal with trans-specific health services. The lack of financial cover for trans-specific health services from Medicare and private health funds"

"Being discriminated against is my biggest fear when accessing health care, because it has happened in the past, and I believe it will happen again"

"Doctors make me nervous and in the past I have felt they didn't respect my ability to make adequate choices for myself"

"The risk of having a 'gatekeeping' doctor"

"People that abuse their power to give health care by not giving it because of their beliefs. The lack of long term knowledge understanding of trans health and bodies"

"Pap smears, it means I have to show my genitals to a stranger, I hate my female genitals"

For some, there were no barriers to healthcare, but participants who lived in major cities with access to a wide variety of doctors and specialists were more likely to feel this way. Others who lived in smaller cities reported difficulty finding competent doctors, especially specialists. Discrimination, "gatekeeping", and general lack of knowledge of trans health were the most common factors discouraging people from accessing healthcare. Financial barriers, such as lack of Medicare and private health insurance coverage, and difficulty finding doctors who were prepared to bulk bill, were also common. Finally, some participants were discouraged from accessing healthcare if it meant revealing parts of their body that were a source of dysphoria for them. Addressing this latter issue may prove difficult. Doctors who are knowledgeable about trans health, and who can provide a welcoming environment and reassurance to their patients may help, but this may not be sufficient to overcome the intense dysphoria felt by some people. There is a need for research to investigate whether it is possible for the dysphoria experienced by this latter group to be minimised in the healthcare setting, and how important preventive health checks such as Pap smears can be performed while causing minimum distress.

8.6 Participants' perceptions of their healthcare needs

Finally, we wanted to understand what participants thought their healthcare needs were, and also if these needs were being met. In this section, we present the key aspects of healthcare that participants felt were specifically needed by trans people.

"I need hormone treatment to be prescribed so that I don't have to pay exorbitant black market internet prices. I need a proper hormone regime that is monitored and adjusted as required. I need acceptance"

"Need ongoing access to testosterone prescriptions, need regular monitoring (blood work) of my hormone levels and other areas that can be affected by testosterone (e.g. liver function tests). Need a GP experienced in administering testosterone. Knowledgeable of trans surgeries, understands the effects they can have on my body both physiologically and psychologically, and has a good referral database of trans friendly health professionals"

"Regular endocrinologist visits, regular psychologist visits, regular GP appointments. Consultations with surgeons and other specialists. Medications (e.g. testosterone) 3-weekly nurse visits for assistance in injecting testosterone"

"Speech therapy, counselling, electrolysis, endocrinology, psychiatrist, and specialist surgeons"

"The main issue that I have as a trans person that I may not have otherwise is the need for regular psychological care to work toward feeling comfortable with myself and manage the sometimes distressing reaction[s] of those around me"

"I would be more comfortable in my skin if I was able to fund the rest of my surgeries"

"To be always treated like a woman even though I have a penis"

"support and respect and understanding"

Participants' needs included: affordable access to hormone therapy and surgery; ongoing monitoring of the effects of hormone therapy; doctors with comprehensive knowledge of trans health (including both physical and psychological aspects); easy access to specialist services, such as endocrinology, psychiatry, psychology, surgery, and speech therapy; easy access to other (but nonetheless vital) services such as hair removal; and above all, "respect and understanding".

Many services must currently be accessed privately, particularly speech therapy and hair removal. The latter is unlikely to be covered by health insurance schemes, and will be considered a cosmetic procedure for tax purposes (despite genital hair removal being required for some surgical procedures, and facial hair removal being essential for some trans women to blend and to reduce dysphoria). Hair removal, particularly electrolysis, may take several years and cost tens of thousands of dollars. At the least, a tax rebate should apply to such procedures, and ideally they should be covered by Medicare. Health systems require urgent reform so that surgery and hormone therapy are fully covered by Medicare.

Although specialist care is required by many, much of the work currently performed by specialists could be performed by GPs or nurses with training in trans health (such as administering testosterone injections). If GPs were adequately trained in trans health, the cost to people requiring a medical transition could be substantially reduced.

Psychological care was also reported to be an important need for some participants. Although some participants were very critical of psychiatrists and/or psychologists who followed a “gatekeeping” model, appropriate psychiatric and/or psychological care is vital for some. However, mental health professionals must adopt non-psychopathologising models of treatment and be perceived to work with, and support trans people, rather than an obstacle to surmount.

8.7 Fulfilment of participants’ healthcare needs

We asked participants if they thought that their healthcare needs were being met. Below are some comments that illustrate participants’ thoughts:

“No, there is a systematic lack of care for trans people at all levels of the health system”

“Absolutely not. Trans people have to navigate the health care system more or less alone. Everywhere trans people turn to for medical treatment and advocacy, we’re met with under-funded, under-staffed, under-educated and old-fashioned gatekeeper healthcare workers. Both government-run and not-for-profit organisations lack the resources to deal with the volume and diversity of trans people that require their services, and private clinics are only accessible if you have the money to do so ...”

“No. Although hormone therapy from my experience has been affordable for the most part surgery is not affordable for a lot of people including myself and this slows down the process immensely”

“I’d say no: it’s actually quite difficult to find doctors or mental health professionals who know anything about transitioning within my state, especially if you aren’t a member of the understandably insular trans community already”

“no, I have waited 6 months+ just to see a psych, all the trans people I know are my age and I don’t know anyone personally who can advise me on anything about any form of transition”*

“No. My GP is supportive, but reproductive specialists such as gynaecologists continue to treat me as female, encouraging me to use hormones such as the contraceptive pill to ‘normalise’ my hormone levels and refusing to perform a hysterectomy”

“Mostly. It’s hard though because there is not a lot of help where I am and I have to travel to places like Sydney to see my specialist”

“Sometimes yes, largely no. That is to say yes amongst clinics that care and not at all amongst regular GPs and staff”

“yes and no - I know that I have good healthcare providers I can turn to but sometimes the info just isn’t out there - what is my cervical cancer risk? As I am in a relationship with a bio guy, what is my pregnancy risk? If you do blood tests for my hormones levels, what should my idea[l] hormone levels look like?”

"I receive good hormone support from a specialist and regular consultations with my GP. These visits are quite expensive and I suspect that any trans person without above-average income might well have difficulty receiving adequate health care"

"Only because I have a great doctor"

Overwhelmingly, participants reported that their health needs were not being met. Participants often felt "alone" on their journey, and that both government and non-government organisations were either inadequate or underfunded, and overwhelmed by the demand for services. The cost of transition was a recurring theme. Given the low incomes reported by participants, how many trans people in Australia are prevented from commencing or completing a medical transition due the inability to afford it?

Lack of knowledge by doctors was a recurring theme. However, participants need not only doctors who can provide hormone therapy, surgery, and/or appropriate referrals, but also more specialised information. For example, what hormone levels are appropriate for people receiving hormone therapy, and information about their specific sexual health needs. This is particularly relevant for trans people who are in relationships with people of the same sex (for example a trans man who is in a relationship with a gay or bisexual non-trans man). Some doctors may assume that trans people will be heterosexual, and may either be uncomfortable with other types of relationships, or simply lack the knowledge to answer questions such as "what is my pregnancy risk?".

"Yes. I have a wonderful GP"

"Yes, though I feel that most of the blood work results could be handled by a GP if the right training were offered broadly. This would help reduce cost incurred by needing to see a specialist"

"For a female yes but not as a genderqueer or gender questioning person"

Some participants reported that their healthcare needs were met, but often only because they had "a wonderful GP". This stresses the importance of all GPs having at least some knowledge of trans health, and the need for trans-specific content in medical curriculums. Much of trans healthcare is not complex. If participants could access more services from GPs (rather than specialists) costs could be markedly reduced.

Some participants with non-binary identities reported that their health needs were only partially met. Medical training for health professionals must be inclusive of all trans people. Some people do not desire a medical transition, or desire only a partial transition. Education about trans health must stress that not everyone fits a typical transsexual narrative.

8.8 A vision of trans healthcare for the future

Participants were asked to describe what they would like healthcare for trans people to look like in the future. Below are some responses that illustrate what participants wanted to see, and how they wanted to be treated:

“Non judgement and treat[ed] with respect”

“FRIENDLY! I don’t need people who are politically correct, or have all the answers, or to have specialists who just deal with trans folk. I just need friendly open honest practitioners who are prepared to educate themselves a little”

“Unbiased and equal to that of services for non trans people”

“I would like to see a trans person treated with respect, compassion and understanding. We are not monsters. I do not expect to be treated as one. ...”

Participants’ comments demonstrate that trans people want to be treated like any other patient: with “respect, compassion and understanding”. As previously noted, negative societal attitudes towards trans people could hopefully be minimized through education campaigns such as *Stop. Think. Respect* [58]. All healthcare staff need access to information and educational materials about trans people and their health needs, and must work toward making their services friendly and accessible to trans people. Guidelines on how this can be achieved have been developed [60-63].

“more lead by the patient, and a focus on informed consent for access to medications and surgical procedures”

“... I guess more education of health professionals wouldn’t hurt. Better funding for surgery would have helped. My life stagnated for a decade with depression while I tried to sort out the financial side of being trans”

“Access to all surgery via medicare”

“I would like to see an ‘informed choice’ model of treatment, particularly considering I can get tattoos, dermal implants, etc without proving my sanity, but I can’t have my breasts removed... it seems a bit ridiculous to me”

“Surgery and hormones and related health needs covered by Medicare. Education in schools. Support offered”

“Perhaps a more combined care with all specialists in the one centre to make the journey much more accessible”

“My GP who practiced in the UK summed it up. In the UK if a person presents to their GP saying they are trans they have a process to follow that lays out every step of transition, where to access services and what happens next. In Australia no such process exists and patients and doctors have to fumble their way through”

“Mandatory training component in medical/nursing courses, and workplace training for new and existing health care professionals to prepare doctors/nurses etc for the possibility of treating trans patients across all health streams. If there is thorough training given alongside the rest of their study content, it would make the treatment of trans people less of an enigma, and provide a more

standardised knowledge base. If every health care provider was queer-friendly and had a basic understanding of the needs of trans and other non-conforming patients, it would be much easier and less stressful seeking access to health care"

"Early childhood education is a big issue as most trans [people] have no materials when they are young to help themselves understand what they are going through. This is the single most important reform that could be done"

"early and easy access to hormones before/during puberty"

"More open discussion about non-binary and bisexual/pansexual identities"

"For no one to even bat an eye-lid at the word trans"

In summary, participants wanted to see trans healthcare become more patient-led, with a move away from "gatekeeping" models toward an informed consent approach [55]. They wanted to see all aspects of trans health covered by Medicare, including (but not limited to) hormone therapy and surgery. This change alone would considerably reduce the financial burden faced by trans people and would almost certainly have a positive flow-on effect with regard to mental health. Participants thought that specialised clinics for trans people where they can access all of the services they require, would "make the journey much more accessible". However, historically, some trans clinics have been regarded as inflexible and paternalistic [65,66]. That mistake must not be repeated or perpetuated. Representatives from the trans community must have a governance role in such clinics (e.g., sitting on the board of management). At the very least, clear referral pathways and protocols must be developed for each state and territory (and made easily available) so that trans people know where to go for help, and what can be expected at each stage of their journey (and when).

Education for both the general public and healthcare workers is essential. Education is effective. In a study of second-year medical students, Safer and Pearce [67] reported that introduction of trans-specific content to the medical curriculum resulted in a 67% drop in discomfort in providing care to trans people. The proportion of students who felt unwilling to treat trans patients dropped from 15-18% to 3% [67]. However, education must reflect the needs of all sub-populations within the trans community, and include education about the lived experience and needs of non-binary trans people, as well as trans men and women.

Young people need better access to information about their options for pursuing a medical transition, and exploring sex and gender expression generally. Adolescents must have access to puberty-blocking drugs to prevent the development of irreversible sexual characteristics, and hormone therapy (i.e., testosterone or oestrogen) should be offered where appropriate. Finally, participants wanted to see societal attitudes to trans people change, and for "no one to even bat an eye-lid at the word trans".

9 Illicit drug use

This chapter investigates the use of illicit drugs by participants in the last 12 months, and the factors associated with their use. These data are age-standardised to allow comparisons between sub-populations in the study, and also the general population. Data for the general population are drawn from the 2010 National Drug Strategy Household Survey [31].

Table 21: Age-standardised prevalence of illicit drug use in the last 12 months, by identification

Substance	**Category of identification**					
	Australian population	**Entire trans sample**	**AFAB non-binary**	**Trans Men**	**Trans women**	**AMAB non-binary**
	%	%	%	%	%	%
Cannabis	10.1	25.5	30.0	40.3	24.0	18.9
Ecstasy	3.1	6.7	17.2	10.0	4.7	7.3
Meth/amphetamine	2.2	7.6	15.2	9.4	7.3	5.7
Cocaine	2.3	4.0	3.0	10.4	2.5	4.8
Any illicit drug[k]	14.7	28.5	36.8	42.0	26.4	21.2

Participants were approximately twice as likely to have used an illicit drug than the general population in the last 12 months. These differences were statistically significant (95% confidence intervals not shown). Trans men and AFAB non-binary individuals were more likely than trans women and AMAB non-binary individuals to use cannabis, ecstasy, and methamphetamine. Trans men were more likely to use cocaine than any other group. Although the marked discrepancy between the general population and this study is concerning, and suggests that urgent action is required to address illicit drug use by all trans people, health promotion efforts may need to focus more on trans men and AFAB non-binary individuals in particular. These individuals may be at greatest risk of drug-related harm.

To investigate the factors that were associated with drug use, we performed multivariate binary logistic regression analyses. Being unable to work (but not unemployment) was associated with increased risk, as was being heterosexual or bisexual (but not homosexual),

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[k] Although not shown in the table due to the relatively low proportion of people reporting the use of these substances, we also asked participants if they had used hallucinogens, heroin, ketamine, or GHB. We included these substances when calculating the proportion of people who had used any illicit drug.

having a normal body mass index, and always telling doctors about being trans. Older age was associated with reduced risk, as was having health insurance.

One explanation for the association between drug use and being heterosexual or bisexual may be the stress associated with belonging to a minority group. Although heterosexual trans people have a sexuality that is in accordance with the majority of the population, in reality their sexuality may be not be accepted and they may face increased difficulty finding a partner. Trans women in particular may find it hard to find a heterosexual male partner. Heterosexual men are unlikely to consider trans women desirable sexual partners (or may be ashamed to admit that they experience sexual attraction to them), because they may assume that being attracted to a trans woman makes them gay. There have been several incidents where trans women have been attacked or even murdered when a potential partner has discovered that they are trans [68,69]. Trans women may find themselves in a particularly difficult situation in this regard. If they do not blend well, they are a more visible target for discrimination, but perhaps less likely to attract heterosexual men who are unaware of their trans status (and therefore are less likely to be assaulted by such a person). On the other hand, if they blend “too well”, they may attract men who will react violently when they discover that they have been “deceived” [68]. Heterosexual trans men may also face problems attracting a heterosexual female partner who will accept them as a man, particularly if the trans man has not undergone genital surgery.

One might expect bisexual people to fare better attracting a partner, but bisexual people may face not only the problems described above if they seek a heterosexual partner, but also biphobia from members of the gay and lesbian community. Bisexual people have been shown to have worse mental health and a greater risk for suicide than homosexual people [70]. It is likely that the homophobia that they can experience from heterosexual people, combined with biphobia that they often experience from homosexual people, leaves bisexual people with a sense of not belonging to any community. This is likely further compounded by the lived experience of being trans, transphobia, and associated difficulties.

10 Aboriginal and Torres Strait Islander people

Of the people who took part in this study, 22 (2.3%) described themselves as an Aboriginal and/or Torres Strait Islander (ATSI) person. We therefore had insufficient numbers to investigate the issues affecting this population from a quantitative perspective. However, we explored some of these issues in discussions with members of the advisory group who were either ATSI people, or who worked closely with ATSI communities. The stories that they shared with us indicate that trans ATSI people (sistergirls and brotherboys) are a population that is at high risk of discrimination, violence, and poor mental health.

Sistergirls and brotherboys face a number of problems not shared by non-indigenous trans people. In part, this is due to the intersection of their race, sex identity, and gender expression. For example, ATSI people may find it harder to mix with the mainstream trans community (and therefore find support), because they may experience racism from non-indigenous trans people. Those who come from very traditional backgrounds may also find it especially challenging to access and/or be accepted by mainstream trans support groups and services. They may also face rejection from their ATSI peers, because being a sistergirl or brotherboy may be seen as violating traditional Aboriginal laws and/or customs in some communities. For example, if a sistergirl has gone through men's business, they may be subject to tribal punishment if they transition, because it is against the law for a woman to know men's business. A sistergirl in this situation is also unlikely to be allowed to do women's business, and therefore cannot participate fully as a woman in her culture.

In some communities, sistergirls may be forced to go through men's business, because their elders may think that it will change them and make them want to be a man. However, some ATSI communities are more supportive of sistergirls and brotherboys than others. Some family members are understanding and will prevent them from having to go through men's or women's business. Advocacy work by trans people has also seen some improvements for this population, such as the acceptance of sistergirls at the Alice Springs Women's Shelter.

However, life for a sistergirl or brotherboy is difficult in many ATSI communities. Some health services refuse to acknowledge their identity, and treat sistergirls as male. Like non-indigenous people, sistergirls and brotherboys often face rejection by their families, and sistergirls and brotherboys who live in remote communities are unlikely to be able to access trans-related healthcare at their local health clinic. Sistergirls and brotherboys may have to travel far from their communities to bigger cities such as Darwin. They not only face the cost of accessing healthcare, but also travel and accommodation expenses.

Sistergirls and brotherboys living in remote communities may find it especially difficult to connect with others in their situation. The sense of isolation may be compounded by rejection from their peers. Like non-indigenous trans women, sistergirls may also face violence from male partners, and may be victimised by abusive or controlling partners. Some sistergirls may feel pressured to “settle for less”, since having a male partner reinforces their sense of being a woman, and also because sistergirls (like non-indigenous heterosexual trans women) often have difficulty finding partners who will accept them.

Therefore, in addition to the recommendations we make in the following chapter, we think it important to make some recommendations specific to trans ATSI people.

There is a need for greater awareness and understanding of sistergirls and brotherboys among the wider ATSI community. This could be achieved by featuring their stories on the SBS television programme *Living Black*, and/or programming on the National Indigenous Television channel (NITV). Schools could also consider inviting a sistergirl or brotherboy to speak to students.

Both Aboriginal and non-Aboriginal health services must do more to meet the health needs of sistergirls and brotherboys. This must include not only providing access to hormone therapy, but also working to improve the mental health of sistergirls and brotherboys.

Resources developed for and about trans people should include trans ATSI people. The *beyondblue* Families Like Mine resource [50] is a good example of how this can be achieved.

There is a need for research specifically addressing the health and well-being of sistergirls and brotherboys. However, such research will probably have to be qualitative in nature and will require fieldwork. Researchers must bear in mind that some sistergirls and brotherboys (particularly those from remote communities) may not speak English as a first language and/or have limited English skills. Researchers must be aware of the cultural sensitivities required when working with ATSI people, and with sistergirls and brotherboys in particular. Sistergirls and brotherboys should be involved at all stages of the research and help guide it.

Finally, there is a need for greater funding for programs and organisations that work with sistergirls and brotherboys, and for those led by ATSI people in particular.

11 Summary and recommendations

The findings of this study demonstrate that a substantial proportion of trans people experience alarmingly high rates of mental health problems. Participants also reported difficulty accessing basic healthcare that the majority of the general population take for granted, and numerous legal and administrative difficulties which result in social exclusion and distress. Equally alarming is the high proportion of trans people who reported experiencing discrimination and harassment as a result of being trans. Owing to the high risk of suicide in this population, these issues must be addressed with urgency.

We therefore propose the following recommendations[l]:

Health

Recommendation	**Notes**
1. Healthcare for trans people should be based on an informed consent model, rather than a "gatekeeping" approach.	For a review of the informed consent model, see Deutsch (2012) [55]. Rates of regret with this system appear to be <1%. This does not preclude the involvement of mental health professionals in the healthcare of trans people. Some people may require ongoing mental health support. However, mental health professionals must work with trans people in a supportive role. Their role should be to assist and support, and to determine whether trans people have the capacity to provide informed consent.
2. Each state and territory should establish a multidisciplinary clinic within the public health system to provide the health care that trans people need. This would include (but not be limited to), hormone therapy, mental health care, and surgery. Owing to population size, it may be	Given the low incomes noted in this study, and the medical necessity of healthcare for trans people, the public health system must provide specialised services for this population. However, trans people who would prefer to be treated privately must retain the option to do so. Mental health

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[l] Note that the order in which recommendations appear does not necessarily reflect their priority.

	necessary for only one or two centres in Australia to specialise in certain surgeries, such as vaginoplasty or phalloplasty.	professionals should have a team role in multidisciplinary clinics, but not lead them. Historically, clinics for trans people have been perceived by many as inflexible and paternalistic [65,66]. Trans people should have a governance role in such clinics.
3.	Health departments must develop clear referral pathways and protocols for trans people. This information must be made available to trans people, and to all health professionals working in the relevant state or territory, so that they know where to refer a trans person if they are unable to provide the necessary care themselves.	Protocols should clearly specify what services are available to trans people (e.g., hormone therapy, surgery, and speech therapy); what, if any requirements apply; and a timeline for service provision so that trans people know when they can typically expect to receive these services. These materials should use flow-charts and simple English and be available in multilingual formats.
4.	Medical intervention for trans people must be flexible with regard to the individual's preferences, and personal circumstances.	Clinicians should not assume that all trans people wish to follow the same transition pathway. Clinicians must recognise that the degree of intervention required differs from person to person. Individuals may also re-prioritise certain medical interventions during the transition process. Together with appropriate medical guidance, trans people must be allowed to set their own pace for a medical transition.
5.	Medical assessments and referrals between service providers and doctors must take place in a timely manner.	It is important to realise that many trans people have considered transitioning for many years, but were prevented by their personal circumstances. However, the final decision to embark on a medical transition is often made with some urgency. Delays in the referral and medical assessment process may be very frustrating, result in distress, and harm the patient-doctor relationship.

6.	Both the public health system and private health insurance schemes must recognise that surgery for trans people is an essential, rather than cosmetic medical procedure.	Medicare and tax rebates should apply to all trans-related medical procedures. The Australian Taxation Office must recognise that certain “cosmetic” procedures such as facial feminisation surgery are vital for the mental health of some trans people. Surgery should never be denied on the grounds that there is no need to remove “healthy” tissue. (e.g., hysterectomy).
7.	Trans health must become a part of multidisciplinary health curriculums, including (but not limited to), medicine, nursing, social work, and psychology. Education must take an affirmative and respectful approach to trans health.	Trans people should not be forced to seek treatment for all medical problems they experience at a trans-specific, or known “trans-friendly” clinic. Trans people should be able to access any medical service and expect to be treated equitably.
8.	Mental health services should develop programs specific to trans people.	Programs and interventions for trans people must be developed in partnership with trans people from inception to evaluation. Programs must target all sub-populations within the trans community.
9.	Suicide-prevention interventions and research must specifically target trans people.	
10.	Healthcare providers (such as hospitals and general practitioners) must create a welcoming environment for trans people, and develop specific anti-discrimination policies and protocols to ensure they adequately meet the health needs of this population.	Healthcare providers should ensure that their policies and protocols are widely known to staff and people accessing the service. For example, the provider could prominently display a statement such as “this organisation welcomes people of any sex identity or gender expression” on promotional materials, posters, or their website. Existing guidelines for working with trans people could be used as a template [60-63].
11.	Where possible, the Pharmaceutical Benefits Scheme (PBS) should be reformed so that all necessary forms of hormone therapy (e.g., GnRH analogues) are available to trans people.	This may require the manufacturers of some hormonal products to conduct clinical trials with trans people, before requesting that their product be listed on the PBS for that indication.

Identifying documents

Recommendation	**Notes**
12. State and territory governments must develop a simplified and consistent procedure common to all Australian jurisdictions for changing an individual's legal sex. Medical intervention should not be a prerequisite. Married individuals must not be required to divorce.	The Australian Government Guidelines on the Recognition of Sex and Gender [57] could be used as a model, in which a registered medical practitioner or registered psychologist can provide a letter stating the applicant "has had, or is receiving, appropriate clinical treatment". A template is available from the Guidelines website. The Australian Capital Territory has recently adopted legislation based on this approach.
13. State and territory authorities responsible for noting a legal change of sex should become integrated within the existing system for registering births, deaths, and marriages. Their role should simply be to determine whether the applicant has provided sufficient information to meet the simplified criteria outlined in these recommendations.	An appearance before a judicial board may be a stressful and potentially humiliating experience. Trans people must never be placed in the position where they have to prove that they "really are" a man or woman (or neither). A change of legal sex should be a simple administrative matter.
14. When an individual has changed their legal sex in one state or territory, other state and territory governments should automatically recognise this change.	At present, an individual can change their legal sex in one state or territory, but this may not be recognised by another.
15. Where an individual born overseas has changed their legal sex in that jurisdiction, the relevant Australian state or territory authority should automatically recognise their new legal status.	Some states offer a *recognised details certificate*, but the requirements for a legal change of sex in that state still apply (e.g., surgical intervention). These certificates are therefore not useful for people born overseas who have changed their legal sex in a jurisdiction that does not require surgery to have taken place (e.g., the United Kingdom).

16. Like some intersex people, not all trans people feel that they are exclusively male or female. Trans people should have the option to identify themselves as something other than male or female on both Commonwealth, and state and territory records and identifying documents.	This could be achieved by having an “X” option as with passports, or the ability to have one’s sex recorded as “indeterminate” (or similar) on the birth certificate. Other options may be required, and will require consultation with non-binary individuals.
17. State and territory authorities responsible for noting a legal change of sex should clearly state the process and required evidence on websites and in published materials.	Published guidelines for some jurisdictions are vague in nature. Trans people should not have to guess whether or not they meet the requirements for a legal change of sex.
18. The authority responsible for noting a change of legal sex at the state or territory level should change all identifying information for trans people in that jurisdiction, and also notify relevant Commonwealth agencies.	At present trans people are required to contact a myriad of state/territory and Commonwealth departments and agencies (e.g., licensing authorities, hospital records, Australian Electoral Commission, Centrelink). This process should be centralised so that the individual only has to make one application, and then all relevant agencies are notified automatically.
19. Government departments and agencies should work to implement the Australian Government Guidelines on the Recognition of Sex and Gender [57] as quickly as practicable.	The guidelines took effect on 1 July 2013 and make it easier for trans people to change records and identifying documents associated with the Commonwealth government, because surgery and hormone therapy are no longer required to change the sex marker on official records. However, the guidelines do not have to be implemented until 1 July 2016.
20. Electronic health records should provide a voluntary option for trans people to identify themselves if they wish to.	Trans people must never be forced to disclose this information, and must also have the option to remove their trans history from electronic health records if they wish to do so.

Research

Recommendation	Notes
21. Funding bodies should consider making the health and well-being of trans people a research priority area.	Government funding bodies such as the National Health and Medical Research Council, and Australian Research Council should take a leadership role in this area.
22. All research conducted with trans people should be informed by an advisory group comprising trans people from a wide range of social and cultural backgrounds.	Advisory groups should reflect the diversity of the trans community, and not comprise people from similar backgrounds.
23. When trans people are included in research conducted with LGBTI populations, the data for trans people must be analysed separately from LGB people.	Trans people have different needs than non-trans LGB people. LGB people also outnumber trans people. When research data is aggregated, the needs of trans people may go unrecognised. For example, a survey of LGBTI people might find that marriage is a priority issue, whereas if the data were analysed separately, access to healthcare might rank as the most important issue for trans people.
24. Longitudinal studies are needed to determine the safety and effectiveness of hormone therapy in trans people.	
25. The Australian Institute of Criminology and relevant agencies should collect and report on hate crimes against trans people.	This data should not be aggregated with hate crimes against LGB people.

General	
Recommendation	**Notes**
26. Government agencies, service providers, hospitals, and other organisations should ensure that their staff are adequately trained to work with trans people in respectful and affirming ways. In particular, staff should be aware of the privacy needs of this group.	Staff should be mindful that some trans people may not have changed all their identifying documents. Staff should discretely ask for, and use the preferred name and pronoun of their clients. Staff should take special care not to "out" trans people by referring to trans people by their old name or pronouns in front of other staff or people accessing the service. An individual's trans status should be treated as confidential medical information.
27. All agencies, government departments, and service providers who interact with trans people must allow trans people to define themselves using the language that they choose. Trans people should never be forced to identify themselves as trans.	Trans people may use a variety of language to describe themselves, and some people no longer consider themselves trans after completing a medical transition.
28. Data collected by government agencies should provide a voluntary option for trans people to identify themselves if they wish to do so. Trans people must never be required to identify themselves as such to government agencies.	Existing population-based data collections (such as the Census) could then be used for research purposes, and may enable research into the needs of trans people to be more representative.
29. Agencies and organisations working with trans people must not make assumptions about the sexuality of trans people.	Trans people, like non-trans people, may be heterosexual, homosexual, bisexual, or asexual.
30. Education providers must develop clear and inclusive policies for trans students which accommodate their needs in a way that is consistent with their sex identity. Policies must address structural issues	For example, students should be allowed to use a toilet consistent with their sex identity, rather than being forced to use a toilet for people with disabilities. Policies regarding uniform codes and participation

	such as bullying and harassment.	in sport should be similar. Teachers require education about trans issues at the university level, and also via workplace training and professional development courses.
31.	Where exemptions apply to anti-discrimination legislation with respect to trans people, those exemptions should be removed.	If being trans is a variation of sex development, and necessitates medical treatment for many people, it should be regarded as a legitimate medical condition. Therefore, exemptions on the grounds of religious belief should not apply.
32.	The Commonwealth government should consider funding a national body (similar to the National LGBTI Health Alliance), with the terms of reference being to eliminate the health disparity observed in this study.	
33.	Organisations that cater for LGBTI people must ensure they include all sup-populations within this umbrella grouping, and provide services appropriate to the individual needs of each sub-population.	To be truly "trans-friendly" an organisation must do more than state that it caters for LGBTI people. Too often, the needs of trans people are overlooked or assumed to be the same as lesbian and gay people.
34.	Organisations providing supported accommodation and/or shelter to trans people seeking refuge from homelessness or domestic violence must review their policies to ensure they align with the new anti-discrimination guidelines.	Trans people must be housed in accommodation appropriate to their sex identity.
35.	Trans prisoners must be placed in a facility which is the most safe and appropriate for their sex identity.	The degree of medical intervention undertaken should not determine where trans prisoners are housed. Prisoners must be able to receive trans-related medical care, such as hormone therapy and surgery.

Miscellaneous	
Recommendation	**Notes**
36. Australian representatives participating in the ICD-11 revision process must advocate strongly for the declassification of transsexualism as a mental disorder.	A diagnostic classification such as transsexualism must be retained elsewhere in the ICD so that people can continue to access health services in both public and private health systems. However, the classification should reflect that transsexualism is likely a variation of sex development, not a mental disorder. Classification as a mental disorder results in a negative perception of trans people, and causes problems such as the inability of adolescents to access hormone therapy without the consent of the Family Court of Australia (which can be a costly and stressful process).
37. Australian members of the American Psychiatric Association must advocate for the removal of Gender Dysphoria (and related diagnostic categories) from the DSM.	Once transsexualism has been reclassified in the ICD, no justification remains for the retention of these diagnostic categories. Absence of a diagnostic category in the DSM will not affect delivery of mental healthcare to trans people. For example, trans people suffering psychological distress could be diagnosed with an adjustment disorder.
38. There is a need to develop validated psychometric instruments to assess health, well-being, and body image in this population.	Some well-known instruments are suitable for use with trans people, but others (particularly those that assume people will locate themselves within a binary model of sex and/or gender) may be less useful.

12 The final word

At the end of the survey, we asked participants if there was anything else that they would like to tell us. Nearly 400 participants left a response. As we noted in the introduction, participants shared far more information with us than we can possibly include in this report. Accordingly, we plan to release an on-going series of articles to further explore the health and well-being of trans people in Australia. However, we think it is appropriate to conclude this report with some of the final comments left by participants.

“Thanks for doing this study and for letting me contribute in some small way. It’s nice to know someone out there is looking into this because it needs looking into”

“Thanks for directing some attention to trans mental health! You made my day :)”

“Thank you for conducting this survey - there is still much more research (and social change) needed to respond to the issues which affect the lives of trans people”

“please tell medical professionals to be kind to their transgender patients. I had a suicide plan ready just before I was put in touch with [doctor’s name] in Cairns, the doctor who prescribed me hormones and helped me so much - he saved my life. And he did it by being kind and respectful”

“I would be dead if not for having transitioned, I experience exquisite joy most days now for being who I am. Thanks”

“For me starting HRT was the best antidepressant I have ever had I am so happy and proud of being a Tranny”

“Love being who I am now and love to get out there and educate the general public on trans people and their needs. We are not axe murderers just members of the public”

“I’m a human being and I deserve adequate healthcare, a right to marry and a right to live peacefully in my community without fear of vilification, bullying or attack”

“trans people have the worst mental health and are at the largest risk of violence and suicide. please do anything you can to make trans people safer and have a better quality of life. thank you for doing this survey”

“I wish there was more help for depressed trans people, I know there are trans groups but they don’t receive enough funding to be so readily available. I’m lucky I live in the city and I still receive little help, I can’t imagine what others in rural areas struggle with”

“My life is miserable, and I know it’s even worse for a lot of people. I hope that this survey brings well-needed change. I want to be able to survive myself”

“Although the rainbow is pretty, having to choose a colour sucks”

“I believe that other trans (sistergirls) need attention in other Aboriginal communities because they need more help than the ones that are already open in life about it. They need to know that there is help for all this and that there is support for everything they need in life because in remote communities we can’t access them because we are limited to what can be done because acceptance hasn’t been fully recognised yet for us so hoping that all this will change everything for all of us in life”

“When I was 19-22 I went through massive drug addiction due to the violence and discrimination I experienced. I am now a 36 year old translady whom is [an] empowered individual whom is active in the trans community advocating for social change. I however suffered from depression, anxiety and drug dependency due to the violence and discrimination I experienced in life. Up until I moved to [town in the Northern Territory] four years ago I would say that I faced discrimination or abuse on a daily basis. I now work with indigenous communities in remote Australia. I see the sistergirl/brotherboy community in urgent need of support in terms of advocacy, mental health support and community education. They suffer from discrimination due to their gender, sexuality and race. Some health services refuse to acknowledge their existence. Some communities do not believe they exist though they are there, or they want to change them. It is very hard for them, harder than for even most trans people. Something needs to be done for them, though people either aren’t listening, feel it’s too complicated to help or don’t know how to help. They are forgotten!”

“I think it is terrific this survey is happening :-) Thank you! I think generally it would be terrific if there was less pathologising of trans people and more deconstructing and dissolving of gender in our society as a whole. i.e. There needs to be a lot more deeper meaningful discussion in the media and in public forums about ways we can dissolve the traditional gender divide rather than the sensationalist reporting of those who fully transition as if that is the only way. This kind of reporting will not do anything to break down the gender divide, it only reinforces it. We need more people to be talking about the in-betweeners that truly combine both genders or who identify with another gender/s not usually associated with their body type. Those that do not go on hormones or have surgery and why they do not. More discussion around this is needed. Hopefully then society will begin to dissolve the boundaries that restrict our potential as humans to be ourselves in which ever way we feel suits us at any given time. It’s happening, but very slowly at the moment”

“I want people, both health professionals and the general public, to know that being trans does not automatically equate to hating your body. When I tell non-queer people I want top surgery they often respond with ‘But your breasts are beautiful’ and ‘Why do you hate your chest?’ and ‘But you're gorgeous the way you are!’. I know, I never said I hated any part of my body. I just wish to have surgery to align my body with how I feel on the inside. Just as someone who wants breast implants doesn’t hate their breasts, or someone who wants children doesn’t hate their life not being a parent, or someone who wants to travel doesn’t necessarily hate their home, trans* people don’t necessarily hate their bodies. This doesn’t mean that they don’t want gender related surgery. But it does mean that while they are waiting for the surgery for whatever reason, they can still go about life as perfectly functioning individuals, as long as they are aware that at some point in the future they will be able to alter their bodies to reflect how they feel on the inside. I just want people to know this, it is neither the rule not the exception, but one possibility that does not make someone any less trans*”*

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Notes

National report

Writing Themselves In 4

THE HEALTH AND WELLBEING OF LGBTQA+ YOUNG PEOPLE IN AUSTRALIA

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Writing Themselves In 4

THE HEALTH AND WELLBEING OF LGBTQA+ YOUNG PEOPLE IN AUSTRALIA

National report

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The Australian Research Centre in Sex, Health & Society (ARCSHS) at La Trobe University specialises in social research into sexuality, health and the social dimensions of human relationships. It works collaboratively and in partnership with communities, community-based organisations, government and professionals in relevant fields to produce research that advances knowledge and promotes positive change in policy, practice and people's lives. www.latrobe.edu.au/arcshs

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About this report

This report describes findings from *Writing Themselves In 4*: a national survey of health and wellbeing among LGBTQA+ young people in Australia.

Writing Themselves In 4 involved an online survey of people living in Australia aged between 14 and 21 years who identified as LGBTIQA+. The survey was open for completion between 2 September and 28 October 2019.

Summaries of the data broken down at the state and territory level are available for the following:

- Australian Capital Territory
- New South Wales
- South Australia
- Victoria

Further outputs relating to *Writing Themselves In 4* can be found at https://www.latrobe.edu.au/arcshs/publications/writing-themselves-in-publications/writing-themselves-in-4

Chapters 3 to 14 of this report provide an overview of key findings across the entire sample of *Writing Themselves In 4* and, where possible, a breakdown of responses by gender and sexuality.

In Chapters 16 to 18, we replicate some of the analyses reported in earlier chapters, to show how responses to certain questions relating to health and wellbeing vary for participants who reported disability, those living in different parts of their state (i.e. metropolitan, rural, and remote locations) and those from ethnically diverse backgrounds. In addition to presenting results to questions that were asked only of trans and gender diverse young people, Chapter 15 also provides a similar breakdown of findings according to whether non-binary participants had been assigned male or female sex at birth.

Acknowledgements

It is important to acknowledge the generous help of a great many people who supported the design, development, implementation and analysis of this 4th iteration of *Writing Themselves In*.

First thanks go to Lynne Hillier and Anne Mitchell who, as the founders of *Writing Themselves In* back in 1998 had the vision to craft a research study that could get to the heart of experiences and challenges faced by LGBTIQA+ young people. Their drive and determination ensured three rounds of the project, in 1998, 2005 and 2009, the findings from which have contributed to policy and program design across the country. Both Lynne and Anne have been a great source of support and wisdom as we sought to undertake *Writing Themselves In 4* and their contribution to LGBTIQ research in Australia cannot be overstated. We also wish to acknowledge other research assistants and colleagues who worked on these previous iterations, including Deborah Dempsey, Lyn Harrison, Lisa Beale, Lesley Matthews, Doreen Rosenthal, Alina Turner, Tiffany Jones, Marisa Monagle, Naomi Overton, Luke Gahan and Jennifer Blackman.

Writing Themselves In 4 benefitted significantly from the expert advice and guidance of our **Community Advisory Board**. This included the following members:

Tim Bavinton Family Planning ACT (Australian Capital Territory)

Peter Waples-Crowe Thorne Harbour Health, Aboriginal and Torres Strait Island Program (Victoria)

Tracey Hutt SHINE SA (South Australia)

Micah Scott Minus 18 (Victoria)

Starlady Zoe Belle Gender Collective (Victoria)

Terence Humphries Twenty10 (New South Wales)

Bonnie Hart Intersex Peer Support Australia (Queensland)

Sarah Lambert ACON (New South Wales)

Josh Muller Psychologist (Victoria)

This group, and often their broader organisations, played a vital role in securing funding for the study, shaping the objectives, providing substantial input into the design of survey questions, helping shape and refine the recruitment strategy, providing guidance in priority analyses, and providing feedback on drafts of this report. We are immensely grateful for all their support.

The **Community Advisory Board** was complimented by an additional expert group that convened to consider how best to represent gender diversity among participants in the survey. Members of this **Gender Advisory Board** included Rory Blundell (Zoe Belle Gender Collective), Teddy Cook (ACON), Misty Farquhar (Curtin University), Ivy McGowan (ARCSHS), and Starlady (Zoe Belle Gender Collective). This group gave invaluable advice regarding conceptualisation of gender categories in the survey and provided input into many aspects of the data analysis. We greatly appreciate the time they gave so generously to this project.

A large number of other individuals contributed to the conception and design of this study. These include Ro Allen, Vera Babida, Amy Peacock, Margherita Coppolino, Nathan Despott, David Momcilovic, Miranda Coffee, Rachel Cecilio, Susan Ditter, James Gray, Rebecca Reynolds, Brenda Appleton, Craig Comrie, Holley Skene, Bryan Stewart, Derm Ryan, Paul Tobias, Erik Denison, Susanne Prosser, Matt Dixon, Jax Jacki Brown, Adrian Murdoch, Rebecca Mery, Lesley Champion and Elizabeth Smith.

A great many organisations supported promotion of the survey to LGBTIQA+ young people via their online networks. These include HEY partners in Victoria and members of the Rainbow Network as well as those working in support of young people with an intersex variation, or their parents. To all those organisations or individuals who also contributed to the promotion of the survey but whose efforts and names we were not able to document, please accept our very sincere thanks for your help with this research and for your ongoing efforts to improve the lives of LGBTIQA+ young people.

In addition to this remarkable group of professional stakeholders, *Writing Themselves In 4* was supported by passionate and enthusiastic **Youth Advisory Groups** of young people in both Victoria and South Australia. Group members played a pivotal role in ensuring that the questions we asked were meaningful to young people and were asked in the most appropriate way. Without their involvement we would not have successfully engaged such a large number of LGBTQA+ young people from all across the country. Members of the group who feel comfortable in us sharing their names include Rory Blundell, Lachlan Houen, Freya Corlis-Richards, Rose Simonsen, Sunny Baek, Jamil Nabole, Max Taylor and Claire Bostock.

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Finally, our thanks go to LGBTQA+ young people themselves. We asked you to tell us your story and you did, in your thousands. We hope this report does justice to your experience and that the findings will be used to affirm and support LGBTQA+ young people everywhere.

Dr Adam Bourne
Associate Professor and
Lead Investigator on behalf
of all study authors
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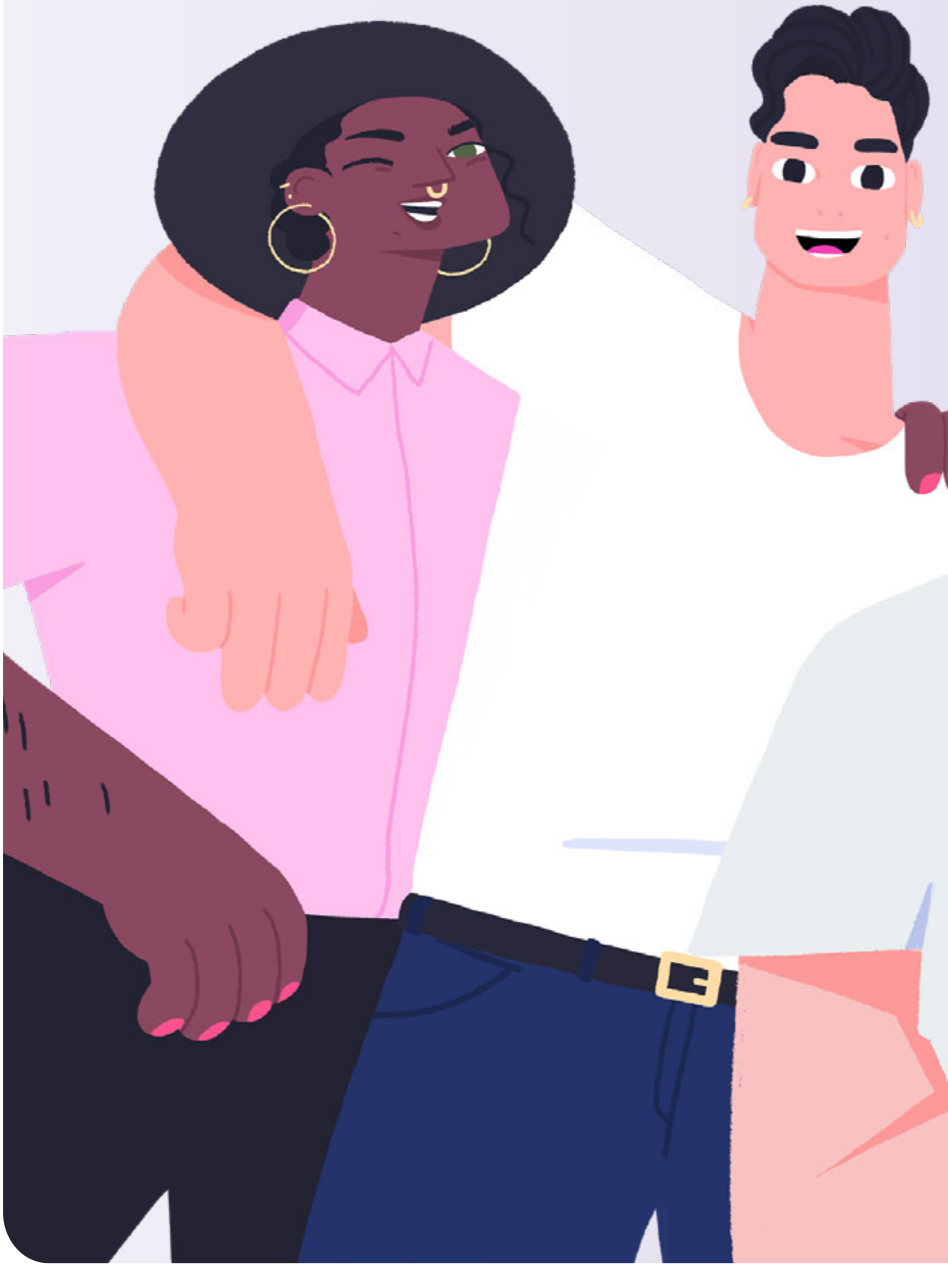
- The Victorian Department of Premier and Cabinet
- The Australian Capital Territory Government Office for LGBTIQ+ Affairs
- The New South Wales Department of Health
- SHINE SA, with support from the Office of the Chief Psychiatrist in South Australia

Terminology

LGBTQA+

Within this report we use the term LGBTQA+ to refer to people who identify as lesbian, gay, bisexual, trans, queer or asexual. The '+' reflects our engagement with others who identify as same or multigender attracted or gender diverse but who use a wide range of different identity terms.

As discussed in further detail in chapter 2.6, we were unfortunately not able to recruit a sufficient number of young people with an intersex variation/s to enable analysis and disaggregation of the data to reflect their experiences. As such, and after close consultation with a leading representative of the intersex community on our **Community Advisory Board**, the difficult decision was made to refer only to LGBTQA+ young people. To do otherwise would risk



suggesting that the findings speak for young people with an intersex variation/s when this is not the case. Where we refer to our efforts to ensure inclusion in the survey (such as in the methods section) we use the term 'LGBTIQA+'. Similarly, numerous questions within the survey used the term 'LGBTIQA+' and the original wording is retained for accuracy where responses to these are reported in later chapters.

In a variety of places throughout this report we make comparisons to other relevant literature, the authors of which may not have used the same terminology or who may have focussed only on specific communities (e.g. lesbian, gay or bisexual young people). We have reflected this in the report, which means in several sections we use terms such as LGB, LGBT, or LGBTQ, depending upon the original terms used. The language used in relation to gender and sexuality in *Writing Themselves In* has itself developed over the past 22 years; in 1998 the term 'same-sex attracted' was used, while 'gender-questioning' was used to reflect gender diversity in 2010. While we do not promote the use of such terms now, we retain reference to them where relevant in this report to reflect the populations who were included at the time.

Executive summary

In 1998, the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University conducted *Writing Themselves In* (1), the first ever national survey of same-sex attracted[1] young people in Australia. The research highlighted the marginalisation of same-sex attracted young people and identified very high levels of stigma and discrimination. Some of the first specific services and supports for sexually diverse young people in Australia were launched in response to this first iteration of *Writing Themselves In*. The survey was repeated in 2004 (2) and 2010 (3), and the series was expanded to include a survey targeting trans and gender diverse young people, From Blues to Rainbows, in 2014 (4). Each new iteration of the study provided additional insights into the identities and lives of these young people, as well as further evidence of the importance of services that meet the needs of young people. We hope that this 4th iteration of the survey makes a similarly positive impact on the lives of young people by improving understanding of the diversity of their lived experiences; advancing advocacy; informing government policy for programs and services, and assisting health and community organisations to work effectively; empowering LGBTIQA+ young people; and improving their health and wellbeing.

Writing Themselves In 4 was developed in consultation with a **Community Advisory Board**, which included expert representatives from all states and territories that had contributed funding for the study. Their work was complemented by the support of two Youth Advisory Groups, one each in Melbourne and Adelaide. Questions were drawn from a variety of sources, including previous iterations of *Writing Themselves In* (revised where necessary), the Australian Bureau of Statistics and the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Further items were developed specifically for the purpose of understanding the needs of LGBTIQA+ young people and subject to extensive consultation with the **Community Advisory Board** and Youth Advisory Groups. The survey was specifically designed for online completion and as such included multiple question routes that were contingent on prior responses. The survey was provided in English and was restricted to participants who resided in Australia at the time of the survey, were 14 to 21 years of age, and identified as LGBTIQA+ (or used a synonymous term). The survey was promoted through a mixture of still images and a short video distributed via paid advertising on Facebook and Instagram, online networks of community organisations working with and for LGBTIQA+ young people, and promotional posters provided to community organisations. Despite considerable efforts, we were unable to recruit a sufficient sample of young people with an intersex variation. For that reason, *Writing Themselves In 4* should be considered a survey of LGBTQA+ young people only.

About the young people who participated

- In total, *Writing Themselves In 4* received 6,418 valid responses. This makes the survey the largest ever of LGBTQA+ young people in Australia.
- *Writing Themselves In 4* heard from a diverse sample of LGBTQA+ people, including 4.0% of participants who identified as Aboriginal and/or Torres Strait Islander, 11.0% who were born overseas, and 39.0% who identified as having disability or a long-term health condition.
- Half (50.6%) of participants were cisgender women, 22.3% cisgender men, 19.5% non-binary, 6.5% trans men, and 1.2% trans women.
- Almost half (45.0%) of participants identified as multi-gender attracted. In total, 33.8% participants identified as bisexual, 16.6% as gay, 12.0% as lesbian, 11.2% as pansexual, 8.4% as queer, 4.6% as asexual, and 13.4% as something else.
- The vast majority (95.3%; n = 6,114) of participants reported attending an educational institution in the past 12 months, with three-fifths (60.0%) attending secondary school, a quarter (24.1%) university, and 5.9% TAFE.

PARTICIPANTS

6,418

ACROSS AUSTRALIA

17.3

MEAN AGE

11.0%

BORN OVERSEAS

4.0%

ABORIGINAL/TORRES STRAIT ISLANDER

39.0%

IDENTIFIED AS HAVING A DISABILITY OR LONG-TERM HEALTH CONDITION

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[1] *Although this was the terminology used at the time of this study, this does not represent the way in which gender identity and sexuality are reflected in Writing Themselves In 4.*

Disclosure and support from others

- More than nine-tenths (95.5%) of participants had disclosed their sexuality or gender identity to friends, followed by seven-tenths to family (71.9%) or some classmates (70.5%). Less than half of participants had come out to co-workers (43.2%) or teachers (36.0%), and less than a third to sports teammates (28.8%).
- Friends were most likely to be supportive when told about the person's sexuality or gender identity (88.3%), followed by teachers (65.2%), teammates (63.6%) and co-workers (60.8%); while family (57.3%) and classmates (42.1%) were reported as the least supportive. (However, the number of participants who are out to teachers, teammates and co-workers is very low.)
- Three-fifths (60.6%) of participants attending university who had disclosed their sexuality or gender identity reported feeling supported by their classmates, compared to one-third (35.3%) at secondary school and 43.2% at TAFE.

Educational settings: Supportive structures and practices

- A greater proportion of participants attending university (77.7%) reported being aware of an LGBTIQA+ gender–sexuality alliance, gay–straight alliance, Stand Out group, or similar supportive club for LGBTIQA+ students at their educational institution, compared to participants attending secondary school (24.8%) or TAFE (11.1%).
- In total, 13.7% of secondary school participants in Australia reported that LGBTIQA+ people received a lot of attention or discussion in a supportive or inclusive way as part of their schooling, while one-quarter (27.3%) reported that LGBTIQA+ people were never mentioned in a supportive or inclusive way.

Educational settings: Discriminatory and affirming experiences

- More than three-fifths (60.2%) of participants said that they had felt unsafe or uncomfortable in the past 12 months at secondary school due to their sexuality or gender identity. This compares to approximately three-tenths (29.2%) of participants at university and one-third (33.8%) of participants at TAFE.
- More than three-quarters of trans men (74.3%) and trans women (67.7%) said that they felt unsafe or uncomfortable at their educational institution, followed by two-thirds (65.8%) of non-binary participants, and more than two-fifths of cisgender men (44.2%) and cisgender women (42.2%).
- Almost two-thirds (63.7%) of participants at secondary school reported frequently hearing negative remarks regarding sexuality at their school, compared to one-fifth (20.2%) at TAFE and 15.0% at university in the past 12 months.
- Over one-third of secondary school (38.4%) and TAFE (34.4%) students and one-sixth of university students (17.2%) reported missing day/s at their educational setting in the past 12 months because they felt unsafe or uncomfortable.

Experiences of affirmation or discrimination in the workplace

- Overall, participants were less likely to report feeling unsafe or uncomfortable due to their sexuality and/or gender identity in the workplace than in educational settings.
- Two-fifths (40.3%) of participants said that they felt unsafe or uncomfortable at full-time work in the past 12 months due to their sexuality or gender identity. This was also true for around one-third of participants who worked part-time (35.6%) and casually (31.0%).
- One-tenth (10.0%) of participants who engaged in full-time work, 8.4% of those who worked part-time, and 6.5% in casual employment reported missing day/s at their work setting in the past 12 months because they felt unsafe or uncomfortable.

50.6%
CISGENDER WOMEN

6.5%
TRANS MEN

22.3%
CISGENDER MEN

19.5%
NON-BINARY

1.2%
TRANS WOMEN

16.6%
GAY

12.0%
LESBIAN

11.2%
PANSEXUAL

8.4%
QUEER

4.6%
ASEXUAL

13.4%
SOMETHING ELSE

33.8% IDENTIFIED AS BISEXUAL

Experiences of harassment or assault

- Two-fifths (40.8%) of participants reported in the past 12 months experiencing verbal harassment based on their sexuality or gender identity.
- Almost one-quarter (22.8%) of participants reported in the past 12 months experiencing sexual harassment or assault based on their sexuality or gender identity.
- Almost one-tenth (9.7%) of participants reported in the past 12 months experiencing physical harassment or assault based on their sexuality or gender identity.
- The proportions of participants reporting ever experiencing verbal harassment (57.6%) or physical harassment or assault (15.4%) based on their sexuality or gender identity were only slightly lower than those reported in *Writing Themselves In 3* (61% and 18%, respectively).
- Over one-quarter (28.1%) of participants at secondary school experienced verbal harassment relating to their sexuality or gender identity in this setting in the past 12 months. This was approximately three times the 9.5% of participants at TAFE and four times the 7.2% who had this experience at university.

Mental health and wellbeing

Rates of mental ill-health were very high within this sample of LGBTQA+ young people. The best available comparison we can make to the general population is drawn from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (5). While the report of that survey does not break down responses in the 14- to 21-year-old range, it does do so for those aged 16 to 17, hence the comparison we make here.

- High or very high levels of psychological distress among 16- to 17-year-old participants of *Writing Themselves In 4* (83.3%) were more than three times that of the 27.3% reported among the general population aged 16 to 17 years.
- Almost three-fifths (59.1%) of participants aged 16 to 17 years had experienced suicidal ideation in the past 12 months, more than five times the proportion observed in the general population aged 16 to 17 (11.2%).
- More than one-tenth (11.0%) of participants aged 16 to 17 years had attempted suicide in the past 12 months, almost three times the 3.8% observed in the general population aged 16 to 17.
- Over one-quarter (25.6%) of participants aged 16 to 17 years had attempted suicide in their lifetime, almost five times the 5.3% reported among the general population aged 16 to 17.
- One-fifth (20.0%) of trans women had attempted suicide in the past 12 months, followed by 16.7% of trans men, 13.2% of non-binary participants, 9.1% of cisgender women, and 6.7% of cisgender men.
- Among participants who had experienced suicidal ideation, planning or attempts, or self-harm in the past 12 months, less than two-fifths (38.1%) had accessed a professional counselling or support service in regard to suicide or self-harm in the past 12 months.

Experiences of homelessness

- Almost one-quarter (23.6%) of participants had experienced one or more forms of homelessness in their lifetime, and over one-tenth (11.5%) had this experience in the past 12 months.
- Trans men and trans women were the most likely to have reported experiencing homelessness. Almost one in five trans men (19.5%) and trans women (17.6%) reported experiencing one or more forms of homelessness in the past 12 months, followed by 15.3% of non-binary participants, 9.9% of cisgender men, and 8.4% of cisgender women.
- More than a quarter (26.0%) of participants who had experienced homelessness felt that this experience was related to being LGBTIQA+. This was most common among trans men (45.2%) and trans women (37.9%).

Alcohol, tobacco and other drug use

- Over one-tenth (11.5%) of participants were current smokers, including 8.0%

EDUCATION

60.2%

HAD FELT UNSAFE OR UNCOMFORTABLE AT SECONDARY SCHOOL IN THE PAST 12 MONTHS

27.3%

SAID LGBTIQA+ PEOPLE WERE NEVER MENTIONED IN A SUPPORTIVE OR INCLUSIVE WAY IN THEIR SCHOOLING

AFFIRMATION OR DISCRIMINATION IN THE WORKPLACE

40.3%

OF PARTICIPANTS FELT UNSAFE OR UNCOMFORTABLE AT WORK IN THE PAST 12 MONTHS

HARASSMENT OR ASSAULT

40.8%

HAD EXPERIENCED VERBAL HARASSMENT IN THE PAST 12 MONTHS BASED ON THEIR SEXUALITY OR GENDER IDENTITY of participants aged 14 to 17 years, and over one-eighth (16.6%) aged 18 to 21 years.

- Less than half (47.7%) of participants aged 14 to 17 years and more than two-fifths (85.8%) of participants aged 18 to 21 reported drinking alcohol.
- Over one-quarter (26.5%) of participants aged 14 to 17 and over two-fifths (42.5%) of participants aged 18 to 21 reported using any drug for non-medical purposes in the past six months.
- Almost one-quarter (23.5%) of participants who reported drug use for non-medical purposes in the past six months reported ever having been concerned about their drug use, 11.8% of whom had sought professional support in relation to this in the past six months.

Engagement with professional support services

- Nearly two-thirds (62.9%) of participants had accessed an in-person professional counselling or support service, over one-fifth (21.2%) a professional text or webchat support service, and over one-tenth (13.2%) a professional telephone support service in their lifetime.
- Overall, almost two-thirds (63.2%) of participants who accessed an LGBTIQA+-specific service the most recent time they accessed a professional support service reported that it had made the situation 'better/much better', compared to half (50.2%) of those accessing an in-person professional counselling or support service, two fifths (39.6%) of those accessing a professional telephone support service, and one third (34.9%) of those accessing a professional text or webchat support service.
- Two-thirds (67.9%) of participants said they would prefer to access a professional support service in person if they were to need one in future, followed by 19.1% who preferred text or webchat, and 2.1% telephone. It should be noted these data were collected prior to COVID-19, which might influence preferences now.

LGBTIQA+ community connection

- Almost one-fifth (17.2%) of participants had attended a school/university LGBTIQA+ youth group in the past 12 months.
- Almost one-quarter (22.9%) of participants accessed LGBTIQA+-specific sexual health information, and one-fifth (19.6%) LGBTIQA+-specific mental health information online in the past 12 months.
- A third (33.9%) had stood up for the rights of LGBTIQA+ people at an educational institution or at work in the past 12 months.

Feeling good as LGBTQA+ young people

Towards the end of the survey, *Writing Themselves In 4* asked participants, 'What makes you feel good about yourself?' A number of themes emerged that speak to the creativity and confidence of LGBTIQA+ young people, as well as some of the challenges they are still seeking to overcome. In total, 4,754 participants wrote short answers describing what makes them feel good about themselves as a young LGBTIQA+ person. Key themes that emerged in their responses include:

- The value of social connectivity to friends and family
- Romantic connection and partnerships
- Satisfaction derived from creativity and achieving
- The importance of affirmation from within (how I feel about myself)
- Being affirmed by others (how I am seen and treated by my social world)
- Having an influence on others and effecting positive change within their community

These findings offer valuable insight into the activities and practices valued by young people, including those that affirm their sexuality and gender identity, which could form the inspiration for interventions aimed at supporting LGBTQA+ young people moving forwards.

MENTAL HEALTH & WELLBEING

25.6%

ATTEMPTED SUICIDE AT SOME POINT IN THEIR LIFETIME

HOMELESSNESS

11.5%

HAD EXPERIENCED HOMELESSNESS IN THE PAST 12 MONTHS

26.0%

WHO HAD EXPERIENCED HOMELESSNESS FELT THAT THIS EXPERIENCE WAS RELATED TO BEING LGBTIQA+

ALCOHOL, TOBACCO & OTHER DRUG USE

26.5%

OF THOSE AGED 14-17 USED ILLICIT DRUGS IN THE PREVIOUS 6 MONTHS

Trans and gender diverse participants

- Less than three-quarters (74.8%) of trans and gender diverse participants had ever affirmed their gender identity socially, compared to the 97.4% that reported ever wanting to affirm their gender identity socially.
- One-fifth (22.5%) of trans and gender diverse participants had ever affirmed their gender identity legally, compared to the 75.2% that reported ever wanting to affirm their gender identity socially.
- Less than one-quarter (29.4%) of trans and gender diverse participants had ever affirmed their gender identity medically, compared to the 72.3% that reported ever wanting to affirm their gender identity medically.
- Over seven-tenths (71.7%) of all trans and gender diverse participants had faced issues relating to toilet access in the past 12 months, including 93.2% of trans men, 79.2% of trans women, and 62.0% of non-binary participants.
- Over three-fifths (61.4%) of trans and gender diverse participants avoided using the toilets, 59.5% felt uncomfortable or unsafe accessing toilets, and more than one-third (38.5%) had limited how much they ate or drank to avoid having to go to the toilet in the past 12 months.
- The vast majority (86.8%) of trans and gender diverse participants had been misgendered by others in the past 12 months.

In order to better understand and respond to the needs of LGBTQA+ young people from diverse communities, this report breaks down responses to key questions according to whether participants reported having disability or a long-term health condition, by their ethnic or cultural background and by their area of residence. Responses to these key questions for each of these groups are as follows.

Disability or long-term health conditions

- Overall, 39.0% of participants in the sample reported disability or a long-term health condition and approximately one-quarter (22.5%) reported a disability or long-term health condition other than mental illness.
- There was a sufficient sample to disaggregate findings according to whether they reported any disability, intellectual disability, neurodiversity/autism, or physical/sensory disability. It is notable that the definition of disability or long-term health condition used in the survey included mental illness, so to better enable comparison to other studies, participants who indicated only mental illness are not included within the 'any disability' category.
- Over half (56.7%) of participants who reported disability said that they had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity. This compares to 45.1% of participants without disability.
- A greater proportion of participants with disability or a long-term health condition reported experiencing high/very high psychological distress (90.9%) than those not reporting disability (70.6%).
- Participants with disability or a long-term health condition reported experiencing in the past 12 months greater levels of verbal (52.7%), physical (15.0%) and sexual (31.7%) harassment or assault based on their sexuality or gender identity than was the case for those without disability or a long-term health condition (verbal 34.7%; physical 7.5%; sexual 18.5%).
- More than twice as many participants with disability (15.0%) reported suicide attempts in the past 12 months, compared to those with no disability (6.0%). The group with the highest proportion reporting suicide attempts in the past 12 months was participants with intellectual disability (21.0%), followed by those with physical/sensory disability (15.9%), and participants experiencing neurodiversity/autism (12.6%).
- Less than one quarter (21.5%) of participants with disability or long-term health condition felt that their LGBTIQA+ identity was supported by the NDIS/disability support providers.

Ethnic and cultural background

- Over half (51.8%) of participants from a multicultural background reported they had felt unsafe or uncomfortable

PROFESSIONAL SUPPORT SERVICES

62.9%

HAD ACCESSED COUNSELLING OR OTHER PROFESSIONAL SUPPORT SERVICE IN THEIR LIFETIME

LGBTIQA+ COMMUNITY CONNECTION

86.8%

OF TRANS AND GENDER DIVERSE PARTICIPANTS HAD BEEN MISGENDERED BY OTHERS IN THE PAST 12 MONTHS

TRANS & GENDER DIVERSE

33.9%

HAD STOOD UP FOR LGBTIQA+ RIGHTS IN THE PAST 12 MONTHS

at their educational setting in the past 12 months due to their sexuality or gender identity.

- Fewer participants from a multicultural background (53.1%) reported feeling supported by family about their sexual identity, gender identity and/or gender expression than those from an Anglo-Celtic background (62.4%).
- Participants from a multicultural background reported in the past 12 months experiencing higher levels of verbal (41.6%), physical (10.5%) and sexual (23.2%) harassment or assault based on their sexuality or gender identity, compared to those from an Anglo-Celtic background (verbal 38.7%; physical 7.7%; sexual 21.6%).
- A greater proportion of multicultural participants (10.4%) reported experiencing a suicide attempt in the past 12 months, compared to Anglo-Celtic participants (8.4%).

Area of residence

- A majority of participants (57.8%) lived in the suburbs of state or territory capital cities, while 24.9% lived in regional towns or cities, 10.5% in rural or remote locations and 6.8% in the centre of capital cities.
- Almost three-fifths (57.0%) of participants in rural/remote areas reported they had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity, followed by 52.7% in regional cities or towns, 50.0% in outer suburban areas, and 40.1% in inner suburban areas.
- A greater proportion of participants in inner suburban areas reported feeling supported by classmates about their sexual identity, gender identity and/or gender expression (52.9%) than was the case for those in outer suburban areas (45.3%), regional cities or towns (36.1%), or rural/remote areas (29.6%).
- More participants in rural/remote areas reported experiencing high/very high psychological distress (87.5%) than those in regional cities or towns (83.3%), outer suburban areas (79.8%), or inner suburban areas (73.2%).
- More participants in rural/remote areas reported in the past 12 months experiencing verbal harassment based on their sexuality or gender identity (45.4%) than those in regional cities or towns (41.0%), outer suburban areas (40.4%), or inner suburban areas (37.0%).
- Almost two-thirds (65.1%) of participants in rural/remote areas reported experiencing suicidal ideation in the past 12 months, followed by three-fifths (60.5%) in regional cities or towns, 57.1% in outer suburban areas, and 49.2% in inner suburban areas.
- Participants in rural/remote areas reported the highest levels of suicide attempts in the past 12 months (14.0%), almost twice that of those in inner suburban areas (7.1%).

Recommendations

Despite legal advancements and social changes, a great many LGBTQA+ young people experience challenges in their everyday life, often a consequence of – or connected to – experiences of stigma, discrimination and violence. In Chapter 19 we outline a series of recommendations aimed at addressing inclusion and ensuring adequate service provision in mental health settings, educational environments and in other health and social care settings. We also propose new efforts to tackle upstream drivers of stigma and violence, encourage community inclusion initiatives and make recommendations for future research with and for LGBTIQ young people.

DISABILITY OR LONG-TERM HEALTH CONDITIONS

67.9%

OF PARTICIPANTS WITH A DISABILITY REPORTED VERY HIGH LEVELS OF PSYCHOLOGICAL DISTRESS

56.7%

HAD FELT UNSAFE OR UNCOMFORTABLE IN THE PAST 12 MONTHS AT THEIR EDUCATIONAL SETTING

ETHNIC & CULTURAL BACKGROUND

10.5%

OF PARTICIPANTS FROM MULTICULTURAL BACKGROUNDS REPORTED PHYSICAL HARASSMENT OR ASSAULT IN THE PAST 12 MONTHS

AREA OF RESIDENCE

14.0%

OF PARTICIPANTS FROM RURAL/ REMOTE AREAS REPORTED ATTEMPTING SUICIDE IN THE PAST 12 MONTHS

1 Background

In 1998, the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University conducted *Writing Themselves In* (1), the first ever national survey of same-sex attracted young people in Australia. The research highlighted the marginalisation of same-sex attracted young people and identified the shocking levels of stigma and discrimination that they had experienced.

The survey was repeated in 2004 (2), documenting similarly high levels of hostility directed towards them, but also the impact that such stigma and discrimination had on their health and wellbeing. This survey showed that young people who had experienced homophobic abuse were more likely to report self-harm and feel less safe at school. A third iteration of the survey in 2010 (3) retained core questions about the nature of stigma, discrimination and harm, but also sought to better understand where homophobic abuse took place and to whom same-sex attracted young people turned when in need. This showed that a high number of young people were experiencing homophobic bullying and discrimination in schools. The second and third iterations included questions about gender diversity, and in 2004, nine transgender people took part, while in 2010, 91 'gender-questioning' young people did so (see Terminology on page 12 for discussion of historic use of terminology related to sex, gender and sexuality).

Given the limited engagement of trans and gender diverse young people in earlier surveys, in 2013 ARCSHS conducted a specific study with this population, From Blues to Rainbows (4). This project examined the mental health and wellbeing of gender diverse and transgender young people in Australia and observed that almost half the young people had been diagnosed with depression by a health professional, while more than a third had experienced recent thoughts of suicide. The study also found that people reporting supportive parents were more likely to report better mental health outcomes, while many participants spoke of feeling better when engaging in community activism.

Some of the first LGBTIQA+-specific services and supports for young people in Australia were launched in response to the first iteration of *Writing Themselves In*. In the years since, findings have informed a variety of policies and programs within South Australia and at a national level, including initiatives by the Australian Human Rights Commission, the Commonwealth Department of Health, and Suicide Prevention Australia. Each iteration of the study has provided new insights into the identities and lives of these young people as well as further evidence of the importance of, impact of, and effective approaches for services that meet the needs of LGBTIQA+ young people. In turn, we have seen the growth of targeted services, affirmative support and dedicated funding for the health and wellbeing of LGBTIQA+ young people. We hope that this 4th iteration of the survey makes a similarly positive impact on the lives of young people by letting their voices be heard, and in doing so, advances advocacy, informs government policies, and assists health and community organisations to work effectively. All of this is important both in empowering LGBTIQA+ young people and ultimately improving their health and wellbeing.


LOVE WINS

2 **Methods**

2.1 Community and youth consultation

A great many social, cultural and technological changes have come about in the 10 years since the last iteration of *Writing Themselves In*. As a consequence, a significant revision of the survey was required to take account of the world that LGBTIQA+ young people inhabit and to better reflect their experiences. This revision was guided by in-depth consultation with a wide variety of stakeholders from across Australia who provide specialist programs to support LGBTIQA+ young people (outlined in the opening Acknowledgements section).

Development of this 4th iteration of *Writing Themselves In* began with a full-day, face-to-face stakeholder meeting held in Melbourne, where LGBTIQA+ youth experts from across the country were brought together to help identify priority issues that required attention and investigation. This initial meeting (funded by a La Trobe University seed grant) was crucial in helping us to focus the scope of enquiry, and in ensuring analysis of the broader cultural and social events that had influenced the lives of LGBTIQA+ young people in the decade since *Writing Themselves In* was last conducted.

Once the project funding was secured, a **Community Advisory Board** of knowledgeable and passionate LGBTIQA+ experts working with young people was established, including representatives from Victoria, New South Wales, South Australia and the Australian Capital Territory (which had each contributed funding to the study). This board played a vital role in helping to devise new lines of questioning, prioritise areas of investigation, provide feedback on recruitment strategies and in the framing of many of the analyses detailed in the following chapters.

Their work was complemented by the support of two **Youth Advisory Groups**, one each in Victoria (consisting of members aged 16 to 23 years) and South Australia (consisting of members aged 14 to 21 years). The Victoria-based committee met throughout the life of the project to inform key areas of inquiry; to shape and refine questions, their wording and sequence; to give valuable input into the promotional materials to ensure they were engaging for fellow young people; and to offer advice as to the areas requiring particular attention in the written outputs of the study (including this report). The South Australia-based group was more focussed in its activities and primarily contributed to the survey design and promotion, but it was vital in ensuring that the voices of young people in different parts of the country could be heard by this study.

The **Youth Advisory Groups** were an important part of making sure that the survey accounted for the needs and concerns of LGBTIQA+ young people and that it accurately reflected their everyday experiences. Care was taken to ensure participant diversity in gender, sexuality and expression of sex characteristics within both groups. The groups comprised young people with various lived experiences, including diversity in relation to culture, ethnicity, religious upbringing and geographical location in cities and regional or rural areas.

Writing Themselves In 4 promotional material

2.2 Survey development

Questions ultimately used in *Writing Themselves In 4* were drawn from a variety of sources, including previous iterations of the survey, as well as questions used by the Australian Bureau of Statistics and the second Australian Child and Adolescent Survey (5) of Mental Health and Wellbeing in order to allow comparisons. Where possible, we have utilised standardised measures (such as those examining mental health or perceptions of school connection), which typically comprise validated scales to assess particular health outcomes or experiences and which have been used in many other studies. However, a survey such as *Writing Themselves In 4* also required the development of bespoke questions to understand the nuanced and specific needs and experiences of LGBTIQA+ young people. Questions were finalised following extensive consultation with the **Community Advisory Board**, **Youth Advisory Groups** and individual expert stakeholders in certain domains, such as disability or homelessness. A full draft of the survey underwent repeated pilot testing with young people to ensure comprehension and sufficiency of response options.

The survey was specifically designed for online completion and, as such, included multiple question routes that were contingent on prior responses. Numerous studies have demonstrated how online surveys provide an effective means of reaching populations that have historically been harder to reach via face-to-face recruitment methods (6,7).

2.3 Recruitment

To be eligible to participate in *Writing Themselves In 4*, participants needed to be aged between 14 and 21 years, be resident in Australia at the time of completing the survey, and identify as LGBTIQA+ (or use a synonymous term). The survey was launched on 2 September and closed on 28 October 2019. It was promoted in a variety of ways:

- Through paid advertising on Facebook and Instagram
- Via the online networks of community organisations working with and for LGBTIQA+ young people
- Through promotional posters provided to community organisations, which carried website information for participation

As with previous iterations of *Writing Themselves In*, a recruitment brand was developed to facilitate engagement. This emerged and was refined through consultation with the **Community Advisory Board** and, in particular, the **Youth Advisory Groups**. The resulting theme, 'This is Me', aimed to capture a sense of celebration and affirmation of LGBTIQA+ identities. Through a mixture of still images and a short video, young people were encouraged to 'tell their story' through their participation in the survey. In an effort to increase participation among historically underrepresented groups, specific versions were created to enhance recruitment effort with Aboriginal and Torres Strait Islander communities, people with intersex variation/s and trans women.

Unique URLs were used with each recruitment platform to allow analysis of how many participants engaged with the study through different approaches. This, along with close monitoring of the survey via the hosting software (Qualtrics), allowed for targeting and tailoring of recruitment efforts in real time to try to ensure adequate participation from different sections of the LGBTIQA+ community. Many community organisations promoted the survey, and those we were able to identify are duly noted in the Acknowledgements section of this report. We are immensely grateful for their support.

After reading a detailed description of the study and providing informed consent, young people were taken through a series of largely fixed response (quantitative) questions pertaining to their health and wellbeing. Care was taken to ensure a balance of questions that could be considered more challenging to answer (such as those about mental health or experiences of stigma or discrimination) as well as those that allowed space for young people to affirm their LGBTIQA+ identities and share experiences of what makes them feel good about themselves and how they envision their futures. Young people who participated were free to leave any question unanswered, which is reflected in the following chapters where the total sample size for each question may vary slightly.

Writing Themselves In 4 promotional material

Writing Themselves In 4 received approval from the Human Ethics Committee of La Trobe University. It was also endorsed by the ACON Research Ethics Review Committee.

2.4 Analysis and categorisation of data

Descriptive and comparative data analyses were undertaken using Stata SE16. Where possible, these have been descriptively compared to *Writing Themselves In 3* or general population data sources where possible. Only questions related to age and informed consent were compulsory, and participants could skip any questions they did not feel comfortable answering. The sample size for each analysis can thus vary slightly and is displayed either within each table or figure or is provided in the immediately preceding text.

2.4.1 Gender identity

Young people were first asked, 'Which options best describe your gender?' Response options were 'male', 'female', 'non-binary', 'I use a different term', and 'gender questioning/unsure'. Participants could choose more than one response. Those who responded with 'non-binary', 'something different', or identified with a gender that was different to that assigned at birth were subsequently asked, 'Which of the following additional options best describes your gender?' Response options included 19 gender identities (developed by consideration of existing literature and close consultation with the **Community Advisory Board** and Youth Advisory Groups). Participants could choose more than one response, and those who did were invited to answer a third question, 'We understand it may be difficult to choose, but if you feel comfortable, which of the following options to describe your gender do you have the strongest attachment to?' They could select from the same list of 19 options displayed in the previous question or select 'I don't find it possible to choose one term'. This was done to facilitate analysis and ensure participant information was not lost in cases where data needed to be groups or collapsed.

A very broad range of identities were reflected in the findings. While it is important not to erase such identities, for the purpose of statistical analysis it was necessary to merge some categories. We endeavoured to do so in an ethical and transparent manner and convened a gender diversity advisory group specifically to help us examine these issues and devise suggestions for analysis categories. This was subject to further consultation with the **Community Advisory Board**.

This exercise resulted in five gender categories: cisgender man, cisgender woman, trans man, trans woman, and non-binary; these terms are used throughout the remainder of this report to enable disaggregation of key findings.

2.4.2 Sexuality

Young people were first asked, 'Which option best describes your sexuality?' and were presented with 10 possible response options plus the opportunity to type in another term. While they could select more than one option, those who did so were subsequently asked, 'We understand it may be difficult to choose. If you feel comfortable, which of the following options to describe your sexuality do you have the strongest attachment to?' They were presented with the same list of 10 options and could also indicate that they were unable to select only one term. Following a similar process to that for gender identity, outlined above, these responses were merged into seven core sexuality categories: lesbian, gay, bisexual, pansexual, queer, asexual, and 'something different'. The 'something different' category was made up of participants who identified as 'homosexual', 'prefer not to have a label', 'cannot choose only one sexuality', as well as the trans men, trans women and non-binary participants who identified as heterosexual. These seven categories are used to disaggregate key findings throughout the remainder of this report.

2.4.3 Intersectionality

LGBTIQA+ young people are as diverse as any other section of the population, and hold numerous intersecting identities and social positions relating to their ethnicity, Aboriginal or Torres Strait Islander identity and heritage, ableness, age, migration status and area of residence (amongst others). Prior public health research would suggest that these identities have relevance to, and impact upon, health-related behaviours and outcomes, although there is less existing research about how this plays out for LGBTIQA+ young people.

Within this report we provide a breakdown of data relating to experiences of having a disability, area of residence (e.g. a metropolitan or rural area) and ethnicity. Data relating to the experience of Aboriginal and Torres Strait Islander LGBTIQA+ young people will be analysed separately subsequent to this report, in collaboration with colleagues and peers from Aboriginal communities as we seek to make sense and find meaning in these experiences. These interpretations will be the subject of a dedicated output to be published in the future.

With a significant number of overlapping identities and experiences included within the data, it is not possible to analyse all of them in one report. Therefore, in addition to the national and state level reports, the investigator team will be undertaking a range of analyses in the coming months to further understand and give voice to the experiences of LGBTQA+ young people who hold such intersecting identities. These will be the subject of additional reports and academic journal articles, all of which will be detailed on the *Writing Themselves In* pages of the ARCSHS website

LGBTIQA+ young people are as diverse as any other section of the population and hold numerous intersecting identities and social positions relating to their ethnicity, Aboriginal or Torres Strait Islander identity and heritage, ableness, age, migration status and area of residence (amongst others).

2.5 Interpreting the data

Writing Themselves In 4 uses convenience sampling, meaning that participants are drawn from a range of community-based recruitment efforts. As such, it is not considered a 'representative' survey of LGBTIQA+ young people and cannot be used to determine, for example, the prevalence of certain identities within the many communities. Larger or smaller proportions of participants in various states or territories may reflect greater levels of engagement from local community groups or stakeholders. It also means that care must be taken when considering the population-prevalence of the health outcomes reported in later chapters. A truly representative sample can only be accomplished by random sampling, which aims to reflect the population as a whole. At the time of writing, questions that fully identify LGBTIQA+ people are not likely to be captured within the national census of Australia, which complicates efforts to achieve truly representative samples of LGBTIQA+ communities. In February of 2021 *Writing Themselves In 4* represents the largest sample of LGBTIQA+ young people ever recruited in Australia and confidence can be found in the weight and volume of their responses. Data from this sample provide a robust understanding of experience and need to inform policy and programming.

Wherever possible, we include comparisons to the same experiences and outcomes documented within surveys of the general population in Australia. For example, in comparisons of mental health experiences for *Writing Themselves In 4* participants, we draw on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (5). While such comparisons are illustrative of disparity that exists in health and social experiences for LGBTQA+ young people and their age-matched counterparts, these are imperfect and cannot fully account for differences in study designs and recruitment methods that can influence findings. At present, and in the absence of sufficient attention to gender diversity and sexuality within most general population health and social surveys in Australia, these remain the best available means of comparing experiences of LGBTQA+ young people with their cisgender and/or heterosexual counterparts.

2.6 Young people with intersex variation/s

Intersex is an umbrella term used to describe people born with sex characteristics – including genitals, gonads and chromosome patterns – that do not fit typical binary notions of male or female bodies, and can manifest at birth or in later life.

In the development of *Writing Themselves In* 4, the study team made a concerted effort to ensure inclusion of people with intersex variation/s and attendance to issues that are of central importance to them. Prior to the study being funded, we worked with a leading intersex community advocate to ensure that the proposal for the study was inclusively framed, and at every stage of the survey design process we worked collaboratively to ensure questions were sensitive to the needs and unique experience of young people with intersex variation/s. Outcomes included appropriate response options in the main body of the survey (e.g. in the experience of stigma or discrimination specifically directed towards people with intersex variation/s) as well as a targeted module of questions that were seen only by participants who indicated that they had intersex variation/s. This module aimed to examine experiences that are unique to people with intersex variation/s, including medical interventions, perceptions of bodily autonomy, and access to appropriate and supportive therapeutic interventions, if required.

In the promotion of the survey, we worked with Intersex Peer Support Australia to ensure that people with intersex variation/s were represented in the marketing materials, including within the promotional video, which facilitated the highest number of click-throughs to the survey. In addition, with their support, we created a survey promotions pack that used intersex-inclusive language, which was distributed to intersex community and support organisations, including those in support of parents of children with intersex variation/s.

Writing Themselves In 4 included the following question regarding whether young people were born with a variation in their sex characteristics:

> *Intersex is an umbrella term used to describe people born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary ideas of male or female bodies.*
>
> *Were you born with a variation in your sex characteristics? There are many different intersex variations, some of which are associated with a medical diagnosis (e.g. DSD, CAH, AIS, Klinefelter syndrome, Turner syndrome, hypospadias, MRKH etc.)*

Despite extensive recruitment and community engagement efforts, 0.3% (n = 20) participants identified themselves as a person with intersex variation/s, 8.5% (n = 547) reported that they 'don't know', and 91.1% (n = 5,831) reported they did not have intersex variation/s. Twenty young people indicated that they had intersex variation/s in this study, which is too small a number to reliably report on or to break down responses for individual questions. Of the 20, eight went on to complete the supplementary section of questions that asked about experiences specific to people with intersex variation/s. The low figure reflects an ongoing challenge engaging young people with intersex variation/s in surveys promoted as LGBTIQA+, as many people with intersex variation/s may not understand their bodies in these terms or identify with

LGBTIQA+ communities. It should be noted, however, that these young people also identified as lesbian, gay, bisexual, pansexual, queer, or asexual, or as trans or gender diverse. As such, their responses are still included within analyses for *Writing Themselves In* 4. However, it would be wrong to suggest that the reports arising from this project can in any meaningful way reflect the needs and experiences of people with intersex variation/s, and treating the reports as representative of them could serve to render invisible some of their unique strengths and challenges. As a consequence, and after careful consultation with the Community Advisory Board, the difficult decision was made to refer to *Writing Themselves In 4* as a survey of LGBTQA+ young people only. All authors and others connected with the project share a deep sense of sadness that we were not able to engage a larger cohort of young people with intersex variation/s, and we remain committed to better understanding, and giving voice to, their experiences. There are specific recommendations in Chapter 19 regarding how research could better account for, and give voice to, experiences of young people with intersex variation/s in the future.

As the *Writing Themselves In 4* survey was designed to include young people with intersex variations in the analyses, some questions originally included wording asking participants about intersex variation/s. For example, participants were asked, 'Have you felt unsafe or uncomfortable at your educational setting due to your sexuality, gender identity, or intersex variation/s in the past 12 months?' Because no analyses were performed regarding only participants with intersex variation/s, and all participants in the survey reporting intersex variation/s also reported an LGBTQA+ identity, the text regarding intersex variation/s in these questions has been removed in order to better reflect and contextualise the actual responses of participants in this survey. Taking the above example, in the *Writing Themselves In 4* report the question has therefore been written as, 'Have you felt unsafe or uncomfortable at your educational setting due to your sexuality or gender identity in the past 12 months?' Similar questions in the survey were also amended in this way. Responses relating to questions asked regarding awareness and perceptions of intersex in various settings, such as 'Experiences of hearing negative language at work settings' have been retained and reported accordingly.

2.7 Trans women

It is important to note that while no representative population-level studies exist of trans and gender diverse populations, studies of adult trans and gender diverse populations tend to observe varying proportions of trans women and trans men. For example, similar numbers of these two groups have been found in some adult surveys, such as Private Lives 3 and the Australian Trans and Gender Diverse Sexual Health Survey (8,9). However, trans women are sometimes found in larger proportions in surveys of older populations, as was the case in Rainbow Ageing.

In *Writing Themselves In* 4, there was a large difference between the number of participants who identified as trans men (n = 406) and trans women (n = 75), despite efforts during survey recruitment to specifically recruit trans women. This is not a unique result in *Writing Themselves In* 4, and a variety of studies involving trans and gender diverse participants in Australia and internationally have observed similar recruitment trends, particularly among young people. For example, in Trans Pathways, 29.7% identified as trans men, compared to 15.0% as trans women (10). Similarly, in Transcending Cancer Care, 33.0% identified as trans men, compared to 22.7% as trans women (11). These differences are most pronounced among younger participants. For example, in Private Lives 3, which is the largest national survey of LGBTIQ adults in Australia, 51.0% of participants of trans men were 18 to 24 years old, compared to 19.0% of trans women. Similar patterns have emerged in large international surveys of trans and gender diverse populations. For example, 43% of trans men were 18 to 24 years old, compared to 24% of trans women in the 2015 US Transgender Survey (12).

The lower proportion of trans women/trans girls in *Writing Themselves In* 4, as well as in other studies involving younger age groups, is possibly due to a combination of factors:

Greater proportions of participants assigned female at birth. A greater proportion of participants in *Writing Themselves In 4* were assigned female at birth (73.2%) than male at birth (26.1%). The tendency for surveys to be completed by more participants who are assigned female at birth is not unique to this study, as this group generally tends to be more likely to respond to surveys. For example, the Australian Trans and Gender Diverse Sexual Health Survey reported 61.1% of participants were assigned female at birth, compared to 38.3% assigned male at birth (9), Trans Pathways reported 74.4% of participants were assigned female at birth and 25.6% assigned male at birth (10) and Transcending Cancer Care reported 70.9% were assigned female at birth and 26.6% assigned male at birth (11). In *Writing Themselves In* 4, there was approximately three times the number of potential participants who were trans men (defined as people who identify as a man, trans man/trans boy, or Brotherboy and were assigned female at birth) as trans women (defined as people who identify as a woman, trans woman/trans girl, or Sistergirl and were assigned male at birth). There was also approximately three times the number of potential participants who were non-binary AFAB (assigned female at birth) as non-binary AMAB (assigned male at birth) in this study.

Global trends around transition. The 2015 US Transgender Survey observed that non-binary participants and trans men were more likely to have transitioned or be living full-time in a gender other than that on their original birth certificate at a younger age than trans women, with 24% of non-binary respondents and 17% of trans men transitioning under the age of 18, which is more than three times and two times, respectively, than the 7% of trans women (12). Similarly, four-fifths (80%) of non-binary participants and two-thirds (64%) of trans men had started transitioning before the age of 25, compared to one-third (37%) of trans women (12). In the UK, findings from the National LGBT Survey (13) observed that almost 80% of trans participants aged 16 to 17 were assigned female at birth, and 60% of those aged 18 to 24. Globally, a greater proportion of young people being referred to gender clinics for support with gender dysphoria were assigned female at birth. These patterns might also be reflected in the proportions of trans men and trans women in *Writing Themselves In* 4, given its focus on younger people.

Future recruitment. It is not clear from *Writing Themselves In 4* whether the lower proportion of trans women is necessarily due to later transitioning for those assigned male at birth or simply a lower tendency for this group to respond to surveys, a mix of both these reasons, or some other reason. Future qualitative research using focus groups of young trans women are needed to address these issues and may be helpful in identifying ways in which future surveys can successfully engage more trans women, trans girls, and other non-binary young people who were assigned male at birth and have trans feminine gender expressions or identities. Qualitative research with parents and carers of young trans women may also be helpful to identify possible barriers at a familial level.

2.8 Aboriginal and Torres Strait Islanders

There has been an ongoing underrepresentation of Aboriginal and Torres Strait Islander Peoples in research on LGBTIQA+ issues (14) and little investigation into the social and emotional wellbeing of Aboriginal and Torres Strait Islander People who are LGBTIQA+ (2). This has led to a lack of visibility of the Aboriginal and Torres Strait Islander sexuality and gender diverse population and difficulties of identifying their specific needs and formulating policies and strategies to support the health and wellbeing of this group.

In the preparation of *Writing Themselves In* 4, we sought expert advice from a prominent member of the LGBTIQA+ Aboriginal and Torres Strait Islander Community in Victoria, who assisted us in designing questions based placed to understand the experiences of Indigenous young people as well. He also provided advice on how best to promote the survey to LGBTIQA+ Aboriginal and Torres Strait Islander young people, the outcome of which was a specific 'character' within the promotional images and video who was designed to connect with Indigenous young people. Our combined efforts were, by some measures, a success, and *Writing Themselves In 4* heard from 256 Aboriginal or Torres Strait Islanders (4.0% of the total study sample). This is higher than the estimated proportion of Aboriginal and Torres Strait Islander People in Australia (3.3%) (15), and comparable to the proportion of Aboriginal and Torres Strait Islanders (4.2%) among young people in Australia aged 15 to 24 (16). To the best of our knowledge, this represents the largest ever survey sample of LGBTIQA+ Aboriginal or Torres Strait people.

We are committed to working with these data in a culturally safe and ethical manner. At the time of writing, the authors of this report have been in contact with a number of Aboriginal and Torres Strait Islander community-controlled organisations to discuss the nature of the data and to indicate some of the early findings. A partnership between researchers (both Indigenous and non-Indigenous) and community-controlled organisations, including those focussing on the needs of LGBTIQA+ Aboriginal and Torres Strait Islanders, is being formed to disaggregate and make sense of these findings. Our aspiration is to soon be able to produce and co-publish a summary report of *Writing Themselves In 4* that focusses specifically on Aboriginal and Torres Strait Islanders and can be accompanied by community-generated recommendations for action.

3 **Demographic characteristics of the sample**

3.1 State of residence

In total, there were 6,418 complete and valid responses to the survey. Table 1 displays the numbers and percentages of participants residing in each state or territory.

Table 1 Distribution of participants by state and territory

State and territory (n = 6,418)	**n**	**%**
Victoria	1,859	29.0
New South Wales	1,619	25.2
Queensland	1,008	15.7
Western Australia	723	11.3
South Australia	640	10.0
Australian Capital Territory	300	4.7
Tasmania	226	3.5
Northern Territory	43	0.7

Participants in *Writing Themselves In 4* resided in all states and territories in Australia. Almost three-tenths (29.0%; n = 1,859) of participants resided in Victoria, followed by a quarter in New South Wales (25.2% (n = 1,619), 15.7% (n = 1,008) in Queensland, 11.3% (n = 723), 10.0% (n =640) in South Australia, 4.7% (n = 300) in the Australian Capital Territory, 3.5% (n = 226) in Tasmania, and 0.7% (n = 43) in the Northern Territory.

3.2 Age of participants

Writing Themselves In 4 involved participants from a diverse age range, as displayed in Table 2 below.

Table 2 Age of participants

Age (n = 6,418)	**n**	**%**
14	559	8.7
15	815	12.7
16	1,099	17.1
17	1,297	20.2
18	784	12.2
19	644	10.0
20	640	10.0
21	580	9.0

The mean age of participants was 17.3 (SD = 2.2), with ages ranging from 14 to 21 years. This mean age was the same as the national sample of *Writing Themselves In 3* (17 years), and a year older than *Writing Themselves In 2* (16 years). Of the total sample, 58.7% (n = 3,770) of participants were aged between 14 and 17 years, and 41.3% (n = 2,648) were aged between 18 and 21 years.

3.3 Area of residence

Writing Themselves In 4 participants were asked 'How would you describe the area in which you live?' Responses were as follows in Table 3.

Table 3 **Area of residence**

Area of residence (n = 6,411)	**n**	**%**
Capital city (city centre)	434	6.8
Capital city (suburbs)	3,705	57.8
Regional city or town	1,598	24.9
Rural (countryside)	637	9.9
Remote (countryside and far from any towns or cities)	37	0.6

Almost three-fifths of participants resided in capital city suburbs (57.8%; n = 3,705), followed by one-quarter (24.9%; n = 1,598) in regional cities or towns, one-tenth (9.9%; n = 637) in rural areas, 6.8% (n = 434) in city centres, and 0.6% (n = 37) in remote areas.

For an overview of the health and wellbeing of *Writing Themselves In 4* participants across these urban and rural settings, see Chapter 18.

3.4 Gender identity and sexuality

Participants in *Writing Themselves In 4* were provided a series of questions to establish their gender identity and whether this differed from the sex they were assigned at birth. Participants were provided with 19 gender identity terms from which they could select and could also type in different terms they use. To enable comparison of data, responses were grouped into a smaller number of gender identity categories. These categories, and identities they comprise, were designed in careful consultation with our Community Advisory Board and a reference group of gender identity specialists. A full account of this process can be found in Section 2.4.1.

In the formulation of these categories, we were attentive to the fact that trans men and trans women can have many unique experiences, leading to vastly differing experiences compared to cisgender men and cisgender women at educational and health settings, and in terms of mental health, harassment and assault, support and family life. In order to capture and understand trans experiences, this study therefore separates participants by cisgender and trans experiences as well as by gender identities, to provide five gender categories in total. The number of participants falling into each of these categories is outlined in Table 4.

Table 4 **Gender of participants, by category**

Gender (n = 6,253)	**n**	**%**
Cisgender woman	3,162	50.6
Cisgender man	1,394	22.3
Trans woman	75	1.2
Trans man	406	6.5
Non-binary	1,216	19.5

Half (50.6%; n = 3,162) of participants were cisgender women, slightly lower than the 57% reported in *Writing Themselves In 3* (3). In total, 1,697 of participants identified as trans or non-binary, almost 20 times the 90 participants who participated the last time we ran this survey. These categories are used as the basis for gender comparisons throughout the remainder of this report. The possible reasons for a smaller number of trans women in the study is discussed in detail in Section 2.7.

In a similar process to that for gender identity, participants were presented with a list of 11 options to describe their sexuality, or they could enter a different preferred term. To enable analysis and comparison, these were grouped into a smaller number of categories following careful consultation with our Community Advisory Board. For a full account of this process, see Section 2.4.2.

Table 5 **Sexuality of participants, by category**

Sexuality (n = 6,407)	**n**	**%**
Lesbian	771	12.0
Gay	1,063	16.6
Bisexual	2,164	33.8
Pansexual	717	11.2
Queer	540	8.4
Asexual	295	4.6
Something else	857	13.4

Almost half (45.0%; n = 2,881) of *Writing Themselves In 4* participants identified as multi-gender attracted. 'Queer' and 'asexual' were not presented as sexuality categories in *Writing Themselves In* 3; however, they made up 8.4% (n = 540) and 4.6% (n = 295), respectively, of the total sample in *Writing Themselves In* 4. It is of note that queer participants may also, but not necessarily, be multi-gender attracted. Around one-sixth (13.4%; n = 857) of participants in *Writing Themselves In 4* were categorised within the 'something else' response category. The 'something else' category was made up of participants who identified as 'homosexual' (n = 95), 'something else' (n = 193), 'prefer not to have a label' (n = 228), 'cannot choose only one sexuality' (n = 187), 'don't know my sexuality' (n = 121), and trans men (n = 18), trans women (n = 8) and non-binary (n = 6) participants who identified as 'heterosexual'. Participants who choose 'prefer not to answer' questions are not included in Table 5 but are included in the total sample. These seven categories are used as the basis for sexuality comparisons throughout the remainder of this report.

3.5 Intersections of gender and sexuality

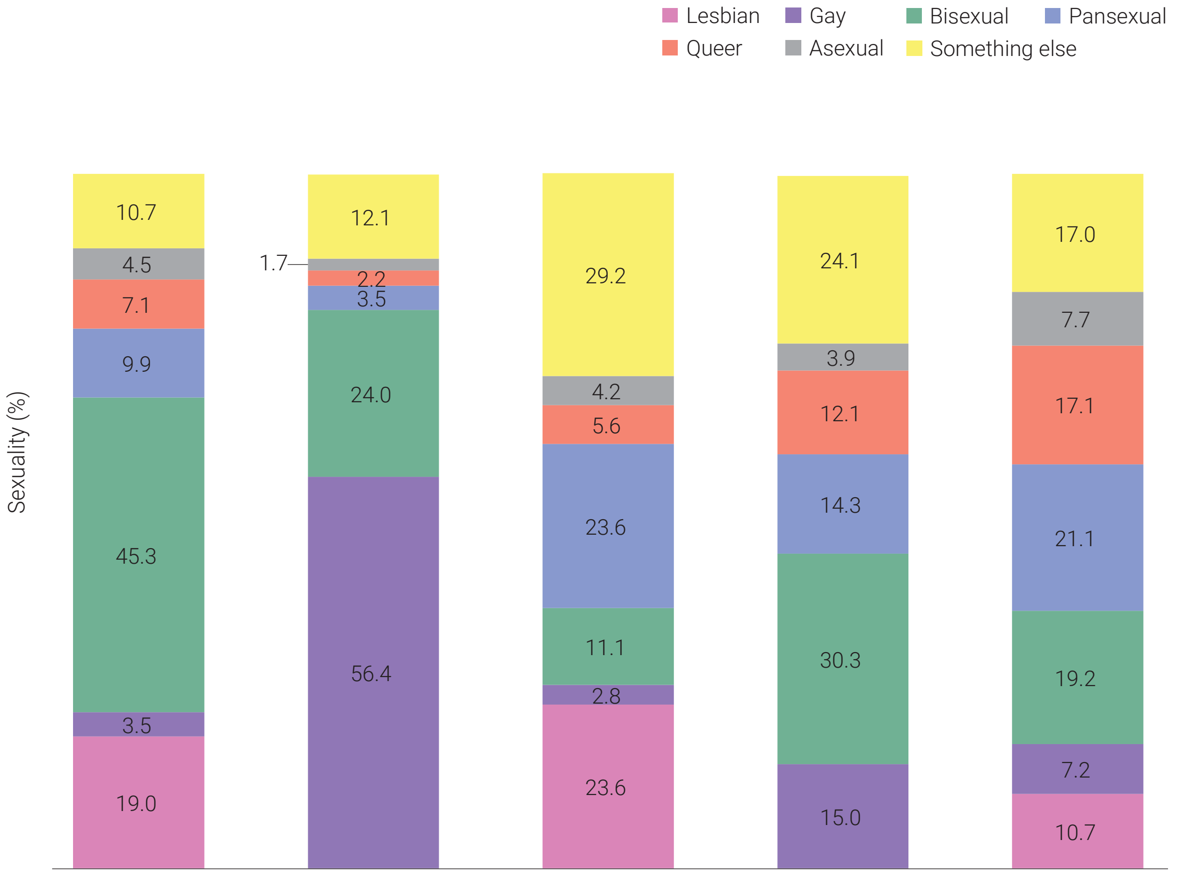
LGBTQA+ young people have multiple, intersecting identities. For example, a person may identify their sexual orientation as gay and have a gender identity that is categorised as cisgender man, cisgender woman, trans man, trans woman, or non-binary. Similarly, a person whose gender identity is non-binary may identify their sexual orientation as lesbian, gay, bisexual, pansexual, queer, asexual, or something else. Identities can be fluid and the ways in which they intersect can vary depending upon the social and political context as well as personal circumstances and stage of the life course. The way young people talk about their identities, particularly regarding sexuality and gender, is rapidly changing and more recent gender terminology has outgrown some of the sexual orientation terminology that was created in earlier binary discourse. Just as definitions of bisexuality have developed to include non-binary genders, terminology regarding same-gender, monosexual attraction such as lesbian and gay may be undergoing similar transitions. For example, a non-binary person who is attracted to women may identify as lesbian, while a non-binary person who is attracted to men may identify as gay. Moreover, the way a person identifies their sexual orientation may represent a cultural or community identity rather than a tightly defined sexual orientation; for instance, a queer identity may represent alliance with a queer community. A person may also use different terms privately and publicly and/or in different contexts.

Figure 1 displays how sexual orientation and gender identity intersect among *Writing Themselves In 4* participants (n = 6,242).

Cisgender women were twice as likely as cisgender men to identity as bisexual or pansexual. Figure 1 shows that 45.3% (n = 1,431) of cisgender women identified as bisexual and 9.9% (n = 311) as pansexual. In comparison, 24.0% (n = 334) of cisgender men identified as bisexual and 3.5% (n = 48) as pansexual. This is consistent with *Writing Themselves In 3* and previous studies in Australia and internationally (3,17).

A higher proportion of trans women (23.6%; n = 18) identified as lesbian than of cisgender women (19.0%; n = 601) or of non-binary participants (10.7%; n = 10.6). Just over half of cisgender men (56.4%; n = 784) identified as gay, compared to 15.0% (n = 61) of trans men, 7.2% (n = 88) of non-binary participants, 3.5% (n = 111) of cisgender women, and 2.7% (n = 2) of trans women. The identity term 'queer' was most commonly used by non-binary participants (17.0%, n = 207), then by trans men (12.1%, n = 49), and cisgender women (7.1%, n = 223). In total, 18 trans men, eight trans women and six non-binary participants identified as heterosexual.

Figure 1 **Intersections of sexual orientation and gender identity**



3.6 Ethnicity, visa status and country of birth

The majority of participants were born in Australia (89.0%, n = 5,712), while 11.0% (n = 705) were born overseas. This is a similar figure to that for *Writing Themselves In 3* (90% Australia born), and is slightly higher than the figure for Australia as a whole, in which 78% of children and young people (aged 15 to 24) were born in Australia (18). Among the 705 participants born overseas, 690 reported their country of birth. Among these, slightly over half (54.9%; n = 379) were born in English-speaking countries (the United Kingdom, New Zealand, the Republic of Ireland, Canada, the United States and South Africa), and 55.1% (n = 326) were born in all other countries. In total, 18.7% (n = 100) of participants born overseas had lived in Australia for five years or less.

Of participants who were born in mainly non-English-speaking countries, the most common countries of birth were the Philippines (n = 45), China (n = 25), Hong Kong (n = 19), Malaysia (n = 19), Singapore (n = 17), Vietnam (n = 16), India (n = 15) and Indonesia (n = 14). These findings are similar to those reported among young people aged 15 to 24 in the general population in Australia (18).

Of participants born in in mainly English-speaking countries, the largest proportions were from the United Kingdom (n = 171) and New Zealand (n = 102), which is the same as among young people aged 15 to 24 in the general population in Australia (18); the next largest proportions were the United States (n = 50) and South Africa. Table 6 outlines the citizenship or visa status of those not born in Australia.

Table 6 **Current citizenship or visa status of those born overseas**

Citizenship or visa status (n = 699)	**n**	**%**
Australian citizen	474	67.8
Permanent resident	127	18.2
International student	58	8.3
Working visa	15	2.2
New Zealand citizen	8	1.1
Refugee	2	0.3
Other	15	2.2

Among participants born overseas, two-thirds (67.8%; n = 474) were Australian citizens, almost one-fifth (18.2%; n = 127) permanent residents, and 8.3% (n = 58) international students.

One-twentieth (5.1%; n = 325) of participants spoke a language other than English at home. It is of note that this survey was only accessible in English and may have therefore been less likely to engage young people who were not native English speakers.

Table 7 shows that majority of participants identified as Anglo-Celtic or European, similar to national and general population data (19). Chapter 17 contains a breakdown of key health and social experiences according to ethnicity and multicultural background.

Table 7 **Ethnicity of participants**

Ethnic background (n = 6,074)	**n**	**%**
Anglo-Celtic	3,920	64.5
Other European	1,097	18.1
Southern European	808	13.3
Eastern European	732	12.1
South-East Asian	239	3.9
Chinese	214	3.5
Other Asian	156	2.6
Maori/Pacific Islander	153	2.5
Middle Eastern	153	2.5
Indian	116	1.9
Latin American	87	1.4
African	76	1.3
Different ethnicity	467	7.7

3.7 Aboriginal and Torres Strait Islanders

At a national level, *Writing Themselves 4* heard from a large number of LGBTQA+ Aboriginal or Torres Strait Islanders. In total, 4.0% (n = 256) of participants identified as Aboriginal or Torres Strait Islander, higher than the estimated proportion of Aboriginal and Torres Strait Islander People in Australia (3.3%) (15), and comparable to the proportion of Aboriginal and Torres Strait Islanders (4.2%) among young people in Australia aged 15 to 24 (16). A further 0.3% (n = 22) of participants reported identifying with Aboriginal and Torres Strait Islander spirituality. At the time of publication, we are working with colleagues from Indigenous communities to make sense of the experiences participants reported, which will be the subject of a focussed publication in the future (discussed further in Section 2.8).

3.8 Religious or spiritual identity

Participants were asked how they identified with regards to religion or spirituality. Table 8 displays these results.

Table 8 Religious or spiritual identity

Religion (n = 6,382)	n	%
No religion	4,679	73.3
Catholic	447	7.0
Anglican (Church of England)	158	2.5
Buddhism	77	1.2
Uniting Church	76	1.2
Judaism	52	0.8
Islam	44	0.7
Greek Orthodox	42	0.7
Presbyterian	24	0.4
Aboriginal and Torres Strait Islander spirituality	22	0.3
Hinduism	20	0.3
Sikhism	2	0.0
Other	739	11.6

Almost three-quarters (73.3%; n = 4,679) of participants reported having no current religion or spirituality, higher than the 52% among people aged 13 to 18 years in the general Australian population (20). Religious or spiritual affiliation was not recorded in *Writing Themselves In* 3. Of participants reporting a religious or spiritual identity, 7.0% (n = 447) were Catholic, 2.5% (n = 158) Anglican, 1.2% (n = 77) Buddhist, 1.2% (n = 76) Uniting Church, 0.8% (n = 52) Jewish, and 0.7% (n = 44) Muslim, and 0.7% (n = 42) Greek Orthodox.

Participants were also asked if their family or household was religious. Nearly three-tenths (28.3%; n = 1,814) of participants reported having a religious family or household. In total, 19.8% (n = 926) of participants reported that while they held no religious identity or spirituality, they came from a religious family or household.

3.9 Disability or long-term health conditions

The approach to defining disability or long-term health conditions taken by the Australian Bureau of Statistics (ABS) is based on whether a condition restricts a person's daily living, rather than what the condition itself is. For example, a person may report loss of sight as a health condition, but if they are able to see and function without limitations by wearing corrective glasses, they are not considered (for the purposes of research) to have a disability. In contrast, a person who, even when wearing glasses, is still restricted in everyday activities by their vision, may still be considered to have a disability (21).

The Survey of Disability, Ageing and Carers (SDAC) defines disability as any limitation, restriction or impairment which restricts everyday activities and has lasted or is likely to last for at least six months. In 2018, 17.7% of the general population was identified as having a disability under this definition (22).

In the survey development of *Writing Themselves In* 4, a more inclusive instrument for measuring disability was developed in consultation with the Youth Disability Advocacy Service (YDAS), and an LGBTIQA+ disability advisory board of experts in the field. As such, the broader definition of disability used in *Writing Themselves In 4* is not directly comparable to national, ABS data.

Disability was defined in *Writing Themselves In 4* as follows:

> *Do you identify as having a disability, experiencing neurodiversity/autism, or having a long-term physical or mental health condition? Long-term health conditions could include things like epilepsy, mental health conditions, speech or sensory impairments. A disability could include things like the loss of – or difficulty using – a body part, or difficulty managing everyday activities.*

Almost two-fifths (39.0%; n = 2,500) participants reported having disability or a long-term health condition, 8.7% (n = 558) reported they 'did not know', and 1.4% (n = 87) 'preferred not to say'. Almost nine-tenths (87.0%; n = 2,160) participants with disability or a long-term health condition reported acquiring one or more of these conditions later in life (after they were born). In total, 92.5% (n = 2,028) participants with a mental illness reported acquiring one or more of these conditions later in life.

Participants reporting disability or long-term health condition were asked to further describe them. Table 9 displays these results.

Table 9 Type of disability or long-term health condition

Disability/long-term health condition (n = 6,408)	n	%
Mental illness	2,206	34.4
Neurodiversity/autism	866	13.5
Physical	422	6.6
Sensory	419	6.5
Intellectual	347	5.4
Acquired brain injury	10	0.1
Other	132	2.1

When asked to further describe the nature of their disability (if relevant), one-third of participants reported mental illness (34.4%; n = 2,206), 13.5% (n = 866) reported neurodiversity/autism, 6.6% (n = 422) physical disability, 6.5% (n = 419) sensory disability, 5.4% (n = 347) intellectual disability, 0.1% (n = 10) acquired brain injury and 2.1% (n = 132) a different type of disability. Data pertaining to disability were not captured in *Writing Themselves In* 3. It is notable that the relatively high proportion of people reporting a disability in this study (compared to 7% of young people aged 15 to 24 in the general population (18) who reported some form of disability) is likely due to the inclusion of mental illness: approximately one-quarter (22.5%; n = 1,440) of the total sample reported disability or a long-term health condition other than a mental illness as a result of the more inclusive model of self-identified disability used in *Writing Themselves In* 4.

60.0%

of participants were at secondary school and

24.1%

were at university

3.10 Current or recent engagement with education

Participants were asked if they were currently attending a school or other educational institution, or if they had attended one in the past 12 months. Table 10 displays these results.

Table 10 Educational institution attended in past 12 months

Education (n = 6,417)	**n**	**%**
Secondary school	3,850	60.0
University	1,545	24.1
TAFE	379	5.9
No schooling or other education	303	4.7
Alternative education program	152	2.4
Private college	76	1.2
Special needs school	16	0.2
Other	96	1.5

The vast majority (95.3%; n = 6,114) of *Writing Themselves In 4* participants reported attending an educational institution in the past 12 months. Participants at secondary school, an alternative education program or special needs school were asked which of the following best described their school (n = 4,015), and the number of responses is given here:

- 81.6% (n = 3,277) a mixed-gender school
- 12.1% (n = 486) a single-sex girls school
- 2.8% (n = 112) a single-sex boys school
- 1.6% (n = 63) distance education
- 1.1% (n = 42) home school
- 0.9% (n = 35) something else

Of participants at secondary school who reported their high school type (n = 3,847):

- 63.1% (n = 2,428) reported attending a government school
- 24.5% (n = 941) reported attending a religious school
- 11.8% (n = 453) reported attending a non-religious private school
- 0.7% (n = 25) responded ‘not sure’

Among participants who reported attending religious schools (n = 940), two-thirds (67.1%; n = 631) reported attending a Catholic school, 28.1% (n = 264) a non-Catholic Christian school, and 4.8% (n = 45) a school with a non-Christian religious or spiritual affiliation.

In total, 89.8% (n = 272) of participants not engaged in schooling or other education were aged 18 to 21.

3.11 Employment status

Two-thirds (60.5%; n = 3,879) of participants reported being engaged in paid employment in the past 12 months, as outlined in Table 11.

Table 11 **Employment status in past 12 months**

Employment (n = 6,413)	**n**	**%**
No employment	2,534	39.5
Work (casual)	2,324	36.2
Work (part-time)	1,178	18.4
Work (full-time)	207	3.2
Apprenticeship	51	0.8
Other	119	1.9

In total, 98.4% (n = 6,244) of participants were engaged in full-time or part-time employment or study. Among participants who were not engaged in full-time or part-time employment or study (n = 168), 91 participants reported engaging in casual work, and 77 participants reported no work or study in the past 12 months. Four-fifths (80.5%; n = 62) of these 77 participants were aged 18 to 21.

3.12 Housing and household

Participants were asked where they live most of the time. Table 12 displays the results.

Table 12 **Housing situation**

Housing (n = 6,410)	**n**	**%**
House	5,516	86.1
Apartment	387	6.0
Rooming house/shared house	327	5.1
Public housing	31	0.5
Couch surfing	21	0.3
Crisis/emergency accommodation	14	0.2
Somewhere else – please specify	114	1.7

The majority of participants (86.1%; n = 5,516) reported living in a house, followed by 6.0% (n = 387) in an apartment, and 5.1% (n = 327) in a shared or rooming house.

Participants were then asked whom they lived with (multiple responses were permitted). Table 13 displays the results.

Table 13 **Household**

Household (n = 6,407)	**n**	**%**
My family	5,575	87.0
Friends	426	6.7
Others	283	4.4
Partner/s	262	4.1
Live alone	116	1.8

The majority of participants (87.0%; n = 5,575) reported living with their family, followed by friends (6.7%; n = 426) and others (4.4%; n = 283). Two-thirds (67.6% (n = 1,043) of participants attending university reported living with their family, 17.3% (n = 267) with friends, 10.1% (n = 156) with others, and 4.7% (n = 73) lived alone. In comparison, 97.6% (n = 3,747) of participants attending secondary school reported living with family.

Participants were asked, 'Do you have any close family members who are LGBTIQA+? (e.g. siblings, cousins)', and almost one-third (32.0%; n = 2,056) responded 'yes', 16.7% (n = 1,071) were 'unsure', and 51.3% (n = 3,291) responded 'no'. Table 14 displays how these family members were described by participants reporting any close family members who were LGBTIQA+. Multiple responses were permitted.

Table 14 **LGBTIQA+ close family members**

LGBTIQA+ family members (n = 2,049)	**n**	**%**
Parent/carer	236	11.5
Sibling	911	44.5
Grandparent	30	1.5
Known donor (egg/sperm donor)	3	0.2
Other relative/s	1,235	60.3

Among participants reporting any close family members who were LGBTIQA+, over four-tenths (44.5%; n = 911) had a sibling, one-tenth (11.5%; n = 236) a parent/carer, and 60.3% (n = 1,235) other relative/s who were LGBTIQA+.

3.13 Recent engagement in sport

Participants were asked which sports they had played in the past 12 months. Multiple responses were permitted. Responses are displayed below in Table 15.

Table 15 Engagement in sport in past 12 months

Sport (n = 6,144)	**n**	**%**
Swimming	1,358	22.1
Dancing	1,214	19.8
Netball	728	11.9
Soccer	700	11.4
Cycling	695	11.3
Basketball	629	10.2
Badminton	480	7.8
Tennis	465	7.6
Aussie rules football	343	5.6
Cricket	218	3.6
Rugby	186	3.0
Other sport	1,158	18.9
Have not played any sports in the past 12 months	2,320	37.8

In total, almost four-tenths (37.8%; n = 2,320) of participants had not played any sports in the past 12 months. The most popular sports played or engaged in during the previous 12 months were swimming (22.1%; n = 1,358), dancing (19.8%; n = 1,214), netball (11.9%; n = 728), soccer (11.4%; n = 700), cycling (11.3%; n = 695), and basketball (10.2%; n = 629).

Among the 1,158 participants who chose 'other sport', volleyball (n = 128), martial arts (n = 126), hockey (n = 98), fencing (n = 25), and softball (n = 24) were the most commonly recorded.

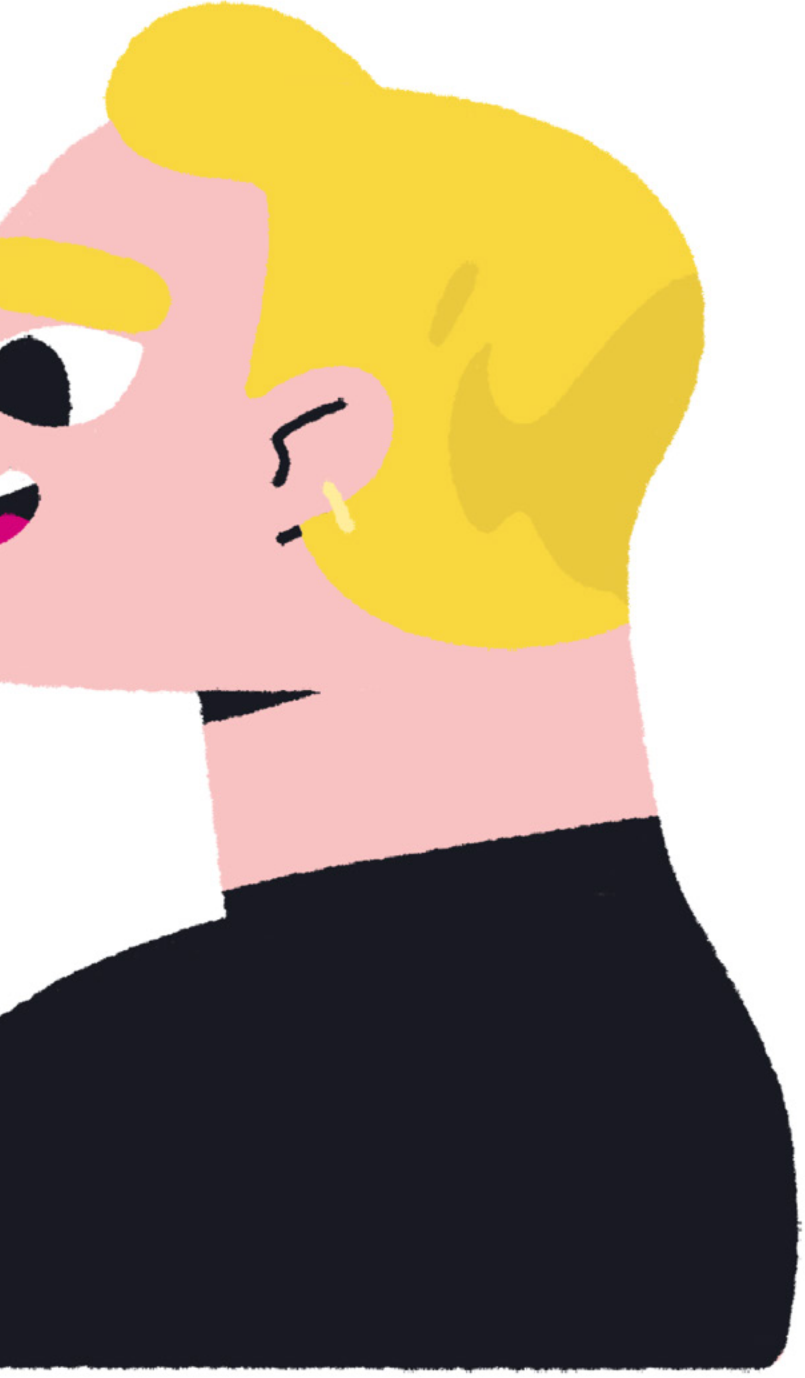
Participants who had not played any sports in the past 12 months were asked, 'If you haven't played any sports in the past 12 months, is this to avoid discrimination due to your sexuality, gender identity and/or gender expression?' In total, 12.3% (n = 286) participants responded 'yes', 74.1% (n = 1,719) 'no', and 13.5% (n = 314) 'not sure'.

3.14 Summary

With a total of 6,418 participants, *Writing Themselves In 4* represents the largest ever survey of LGBTQA+ young people in Australia and one of the largest in the world. Just as important as the total sample size is that the study also engaged a very wide diversity of young people, including those living in metropolitan, regional and rural areas; those from culturally and linguistically diverse backgrounds; those with disability; those participating in sports; and those born overseas. Large samples for each of these groups allows for specific, in-depth analyses of their intersectional experiences, some of which are presented in later chapters. *Writing Themselves In 4* also heard from a large number of Aboriginal and/or Torres Strait Islander LGBTQA+ young people, and we look forward to further work in partnership with Indigenous organisations to analyse and interpret these data in the future.

The sample of *Writing Themselves In 4* is also diverse in terms of the gender and sexuality of participants. While over half were cisgender women, nearly a quarter were cisgender men, and a similar proportion were trans or non-binary. This also represents one of the largest ever samples of trans and gender diverse people in Australia. Nearly half of participants identified as either bisexual or pansexual, with large numbers identifying as queer or asexual.

4 Experiences of disclosing sexuality or gender identity



Previous studies have shown an increasing trend towards disclosure, with more young people in Australia ‘coming out’ or disclosing their same-sex attractions to at least one other person. In *Writing Themselves In* 3, 97.5% of young people had disclosed their same-sex attractions to at least one person, a continuing trend to openness from previous *Writing Themselves In* studies in 2004 (95%) and 1998 (82%) (2,3). There is also a growing trend towards acceptance of lesbian, gay, and bisexual identities, as documented by support expressed by family members (3).

‘Coming out’ in and of itself has not necessarily been found to be protective of wellbeing and mental health for LGBTQ+ young people. Indeed, for some young people in unsupportive environments, it may present a risk. However, support at the time of disclosure has shown to be protective, particularly when it comes from family members (4,23). Supportive relationships with family members are not only associated with lower levels of self-harm or suicidal behaviour, but can also foster resilience against the impact of abuse and discrimination experienced in other contexts (4). Previous studies have shown high rates of family support to be a strong protective factor against suicidal ideation and suicide attempts among young people, while LGB youth reported significantly lower levels of family support than their non-LGB peers (24). Conversely, parental rejection of a child’s sexuality or gender identity is associated with higher rates of suicide attempts and self-harm (25).

For many trans and gender diverse young people, the experience of coming out is markedly different to the experiences people have coming out about sexuality. Many trans and gender diverse young people feel that they do not have the same level of control over the process as their cisgender peers (26). Recent research has highlighted that, from a young age, many trans and gender diverse people will be considered by others as not meeting the expectations of the sex they were assigned at birth and identified by others as gender non-conforming (26).

71.9%

had disclosed their sexuality and/or gender identity to at least some family members. Only 28.8% of those who played sports had disclosed to teammates

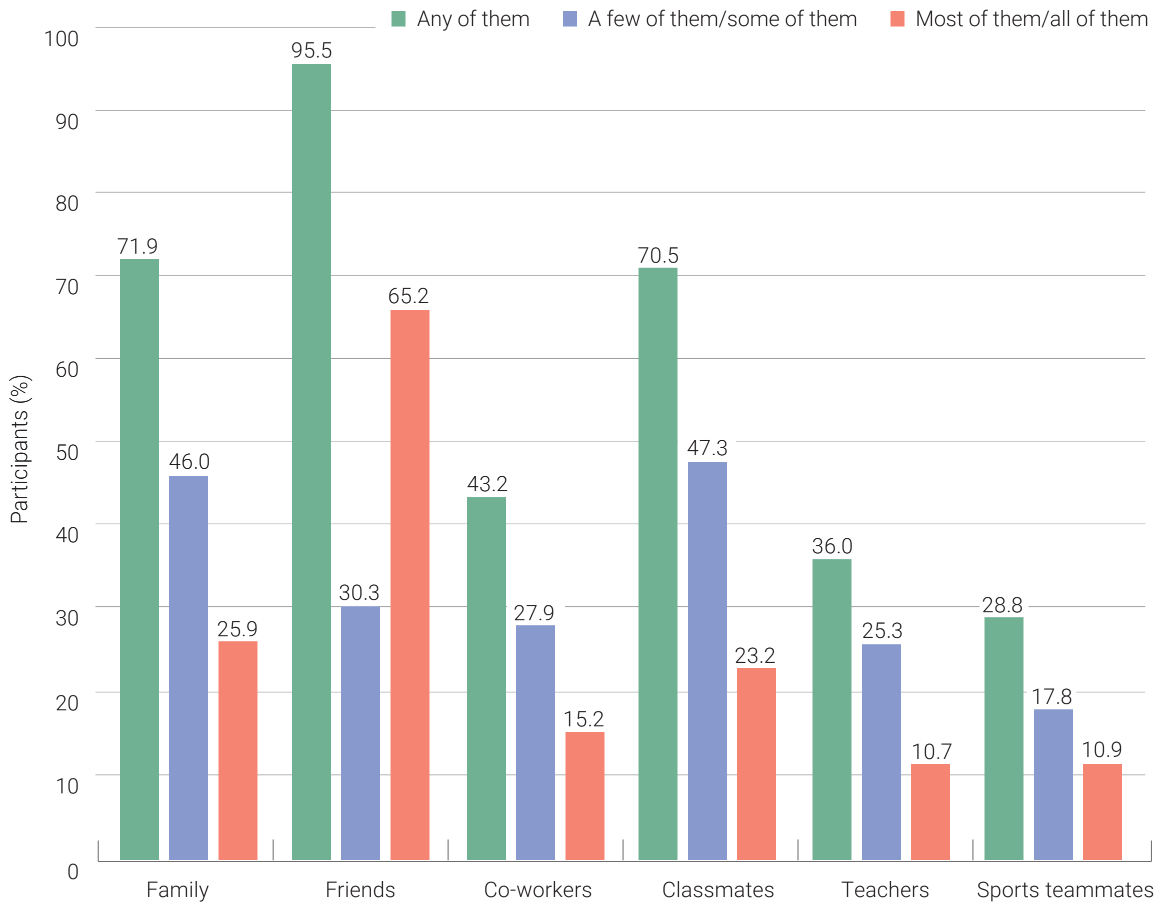
4.1 Disclosing sexuality or gender identity

Disclosure comes in many forms and is not always encompassed by the term 'coming out'. Disclosure can also involve trusted people being 'invited in' by a young person to a discussion about sexuality or gender identity. Participants were asked, 'Have you come out to or talked with any of the following people about your sexual identity or gender identity?' The range of possible people shown was contingent upon answers to previous questions. For example, only those who reported playing sport were shown the option regarding sports teammates. Sample sizes for each option were, therefore, as follows:

- Family (n = 6,263)
- Friends (n = 6,319)
- Co-workers (n = 3,861)
- Classmates (n = 5,814)
- Teachers (n = 5,661)
- Sports teammates (n = 2,834)

Participants could indicate if aspects of the question were not relevant to them (such as people not working or not participating in sports). Figure 2 displays these responses.

Figure 2 **Proportion of participants disclosing their sexuality or gender identity to different groups**



The majority of participants (95.5%; n = 6,033) had disclosed to some friends and/or some family members (71.9%; n = 4,502), and/or to some classmates (70.5%; n = 4,098). People were less likely to be 'out' at work or their educational institution or to sports teams. Less than half of participants had come out to any co-workers (43.2%; n = 1,667) or teachers (36.0%; n = 2,037), and less than a third to sports teammates (28.8%; n = 815).

Overall, trans and gender diverse participants were more likely than cisgender participants to have disclosed their sexuality or gender identity to family, friends, classmates, and teachers.

A large majority (93.3%; n = 378) of trans men and trans women (83.8%; n = 62) and non-binary participants (78.8%; n = 939) had disclosed their sexuality or gender identity to some family. By comparison, just over two in three cisgender men (69.3%; n = 935) and cisgender women (66.8%; n = 2,059) had disclosed to some family.

Trans and gender diverse participants were also more likely to have disclosed their sexuality or gender identity at their educational institution. The proportion of trans men (71.5%; n = 253) who had disclosed to their teachers was twice that of cisgender women (25.2%; n = 715) or cisgender men (38.7%; n = 464).

Figure 3 Proportion of participants disclosing their sexuality or gender identity, by gender

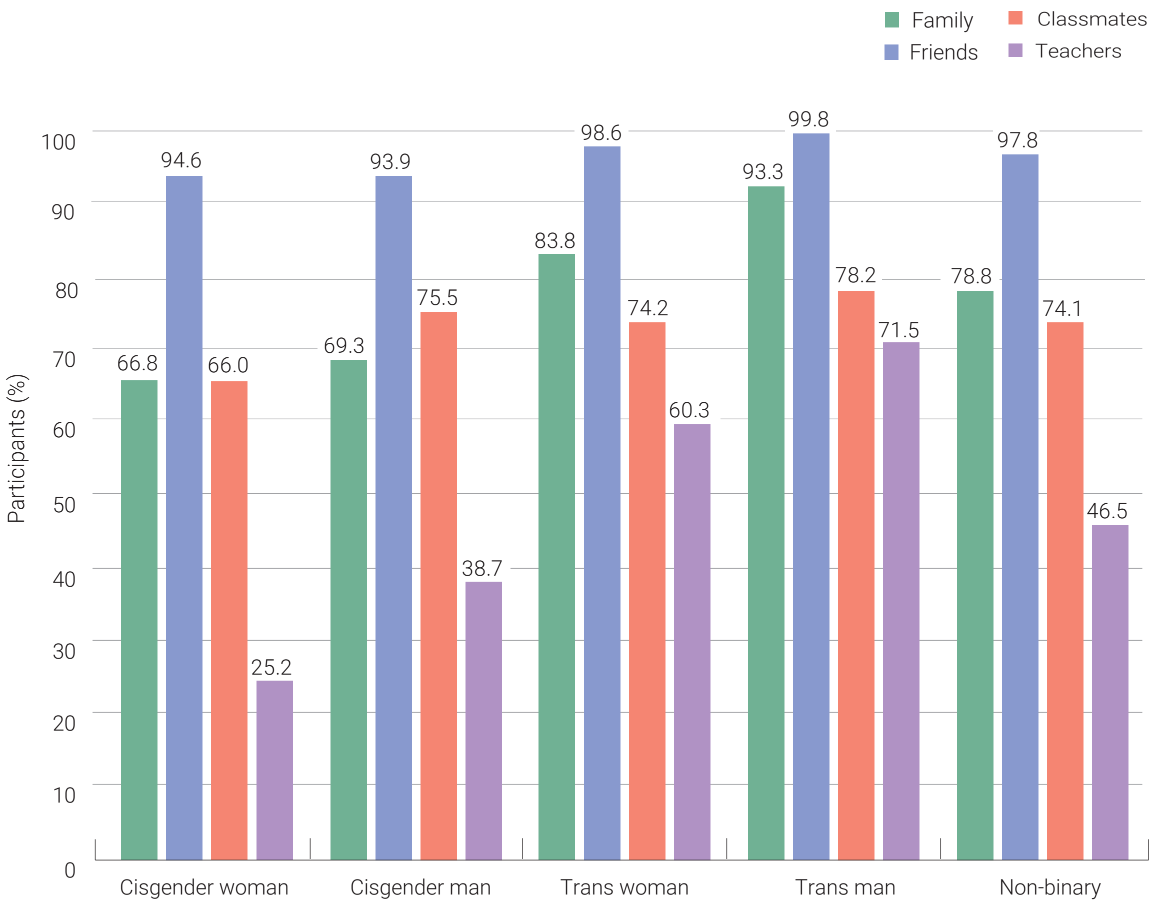


Figure 4 Proportion of participants disclosing their sexuality or gender identity, by sexuality

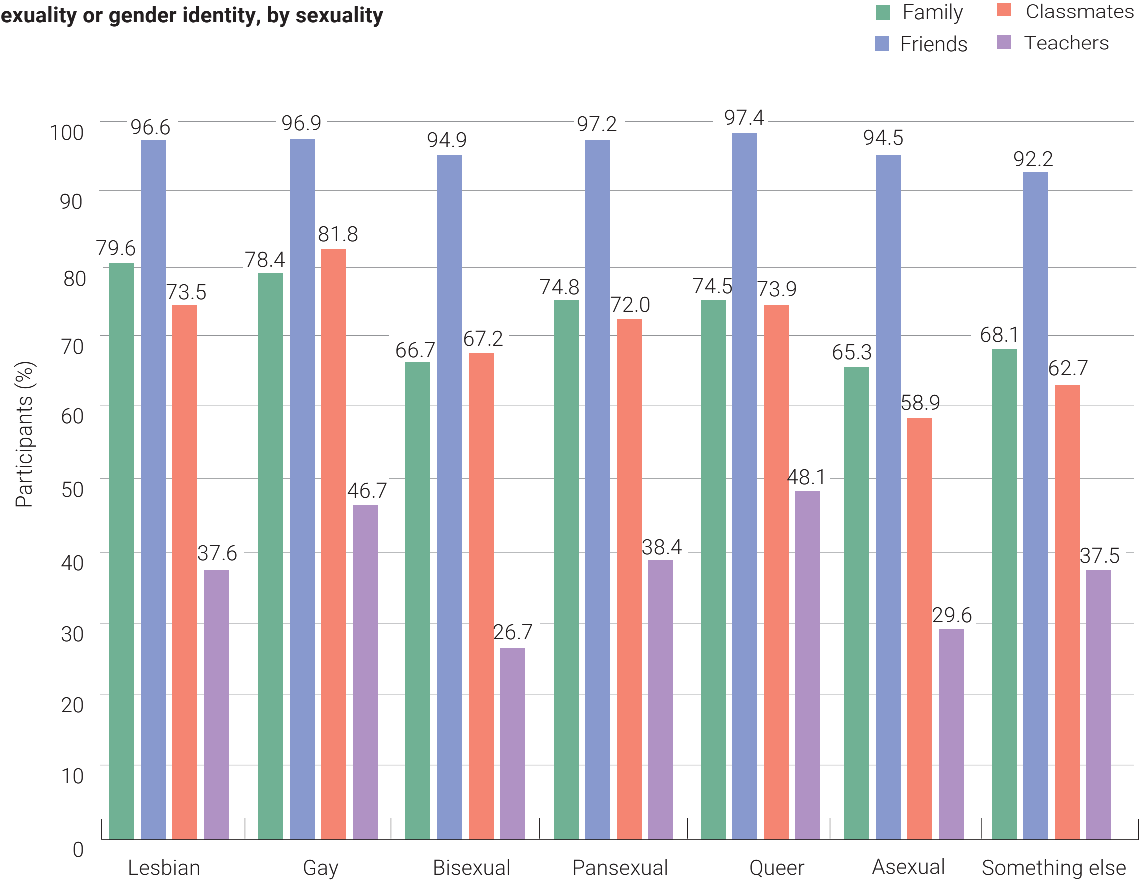
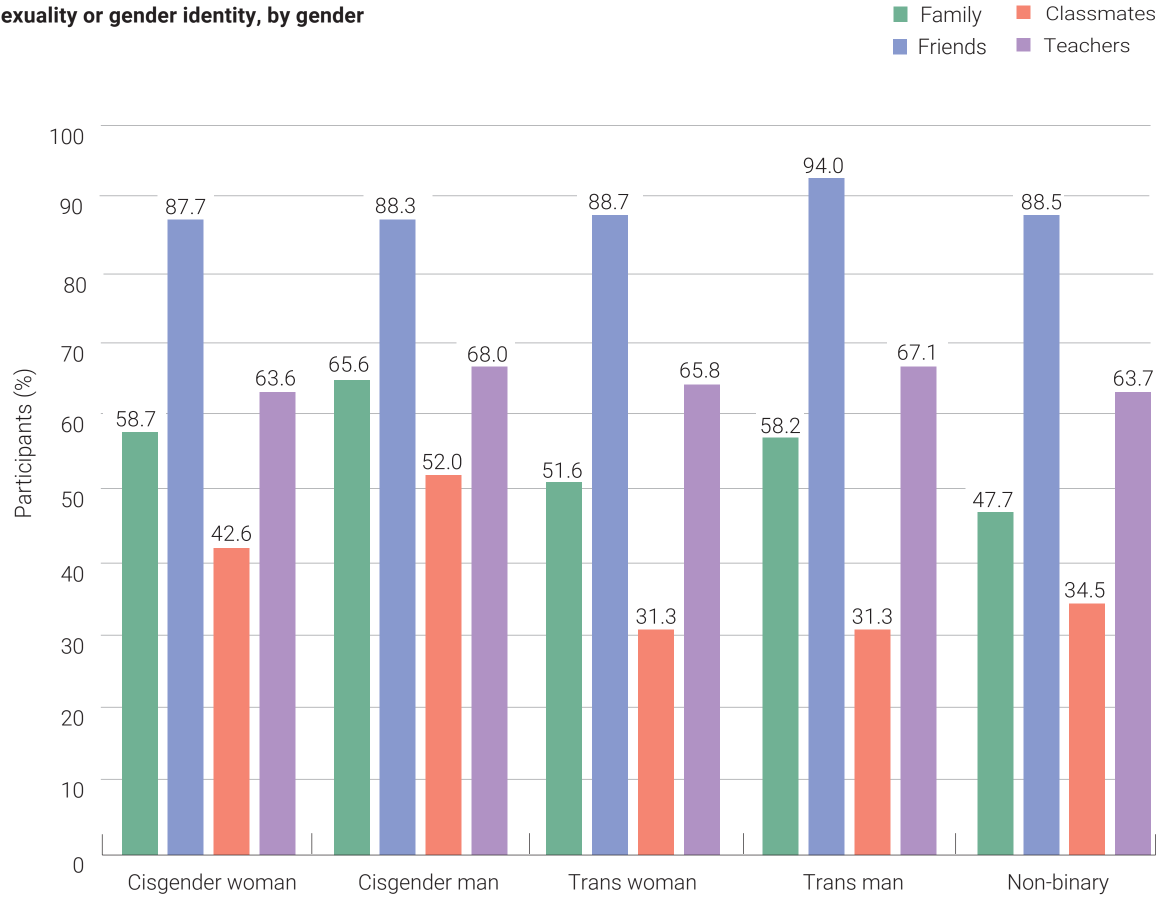


Figure 5 Proportion of participants who feel supported about their sexuality or gender identity, by gender



Bisexual and asexual participants were less likely to have disclosed their sexuality or gender identity to family, friends, classmates, and teachers. Over 80% of gay participants (81.8%; n = 783) had disclosed their sexuality or gender identity to some classmates, 73.9% (n = 368) of queer participants, 73.5% (n = 519) of lesbian participants, and 72.0% (n = 455) of pansexual participants. In comparison, less than 70% (67.2%; n = 1,346) of bisexual participants and less than 60% (58.9%; n = 152) of asexual participants had disclosed to some classmates.

Asexual and bisexual participants were also less likely to have disclosed their sexuality or gender identity to teachers. Close to half of queer participants (48.1%; n = 235) and gay participants (46.7%; n = 431) had disclosed to teachers. In comparison, less than one-third of asexual (29.6%; n = 75) or bisexual (26.7%; n = 517) participants had disclosed to teachers.

4.2 Feelings of support about sexuality or gender identity

Participants who responded they had come out to or talked with people about their sexuality or gender identity were asked, ‘Overall, how supported do you feel about your sexual identity, gender identity and/or gender expression?’ The question was asked in relation to the categories of people they had previously stated they had disclosed to. For example, only participants who indicated that they had come out to or talked with family were asked how supported they felt by family.

Table 16 Proportion of participants who feel supported about their sexuality, gender identity and/or gender expression

	n	%
Friends’ support (n = 6,015)		
Not supportive	701	11.7
Supportive/very supportive	5,314	88.3
Teachers’ support (n = 2,033)		
Not supportive	708	34.8
Supportive/very supportive	1,325	65.2
Sports teammates’ support (n = 813)		
Not supportive	296	36.4
Supportive/very supportive	517	63.6
Co-workers’ support (n = 1,663)		
Not supportive	652	39.2
Supportive/very supportive	1,011	60.8
Family support (n = 4,496)		
Not supportive	1,918	42.7
Supportive/very supportive	2,578	57.3
Classmates’ support (n = 3,166)		
Not supportive	1,833	57.9
Supportive/very supportive	1,333	42.1

Most participants (88.3%; n = 5,314) who had disclosed their sexuality or gender identity to friends reported that overall they felt supported about their sexual identity, gender identity and/or gender expression. Nearly two-thirds (65.2%; n = 1,325) of those who had disclosed felt supported about their sexuality or gender identity by their teachers, sports teammates (63.6%; n = 517), and co-workers (60.8%; n = 1,011); however, the number of participants who reported they were out to teachers, co-workers, and teammates is very low. Less than three-fifths (57.3%; n = 2,578) of participants who had disclosed to their family reported their family as being supportive about their sexuality or gender identity, and two-fifths (42.1%; n = 1,333) of those who had disclosed to classmates reported their classmates as being supportive about their sexuality or gender identity.

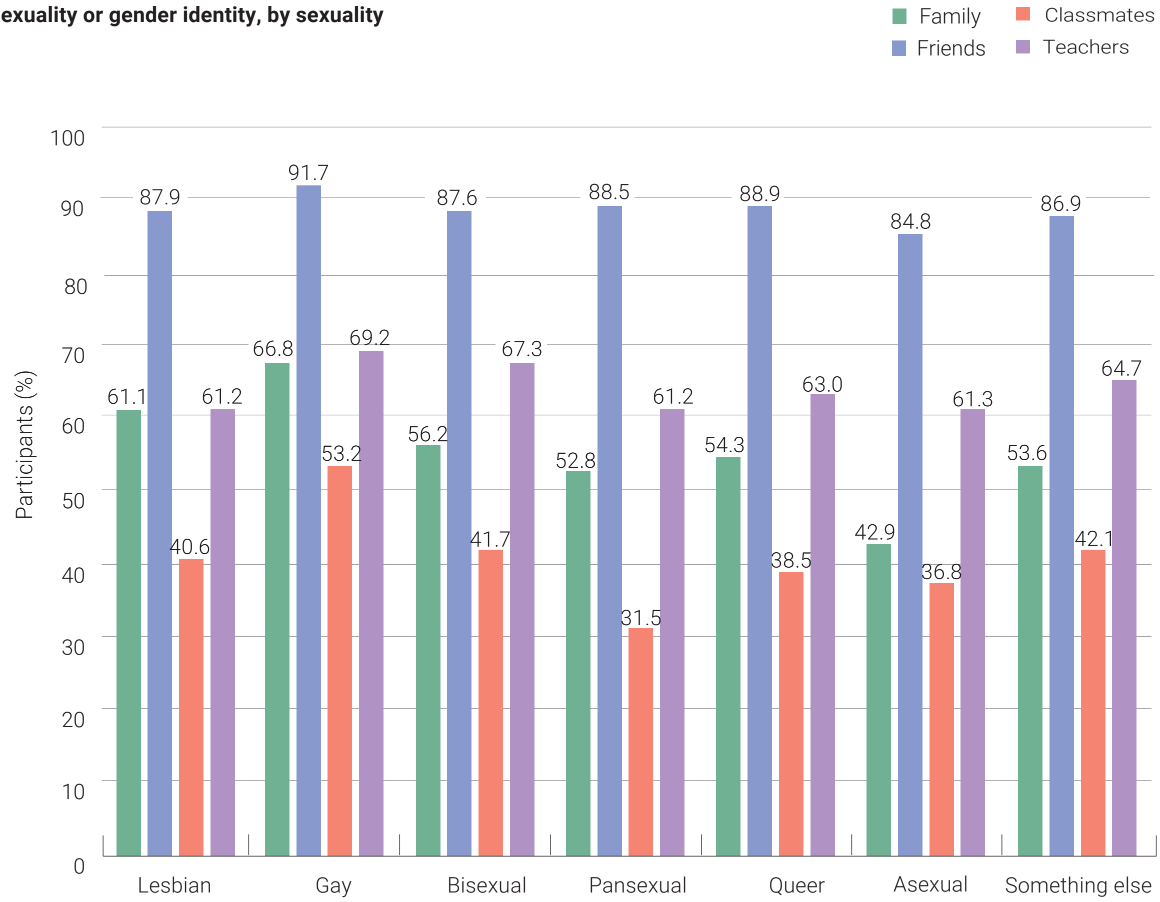
Participants attending university were more likely to feel supported than those attending TAFE or secondary school. Over half (60.6%; n = 493) of participants attending university who had disclosed to classmates reported feeling supported by their classmates about their sexual identity, gender identity and/or gender expression. In comparison, of participants who had disclosed to classmates, 43.2% (n = 76) attending TAFE and 35.3%; (n = 685) attending secondary school reported feeling supported by their classmates about their sexuality or gender identity.

Secondary school students were also slightly less likely than university or TAFE students to report feeling supported by sport teammates. Of those who had disclosed to their sports teammates, 69.8% (n = 139) attending university reported feeling supported about their sexuality or gender identity by their sports teammates, compared to 69.4% (n = 25) of those attending TAFE. This figure was lower among secondary students, with 61.2% (n = 316) reporting feeling supported by sports teammates.

Teachers were also more supportive of participants at university: of those participants who had disclosed to teachers, seven-tenths (69.4%; n = 274) of students at university reported feeling supported about their sexuality or gender identity by teachers, compared to 64.0% (n = 850) at secondary school and 59.6% (n = 81) at TAFE.

Cisgender men were more likely to report feeling supported about their sexuality or gender identity by family, classmates, and teachers compared to cisgender women, trans women, trans men, or non-binary participants. This was most pronounced regarding classmates, with half (52.0%; n = 368) of cisgender men feeling supported about their sexuality or gender identity by classmates, compared to 42.6% (n = 657) of cisgender women, 34.5% (n = 212) of non-binary participants, 31.3% (n = 10) of trans women, and 31.3% (n = 60) of trans men. However, trans men reported the highest levels of feeling supported by friends.

Figure 6 **Proportion of participants who feel supported about their sexuality or gender identity, by sexuality**



A greater proportion of gay participants reported feeling supported about their sexuality or gender identity than of those who held different sexual identities. In terms of family and friends, asexual participants reported feeling the least supported of the various sexual identity groups; while in terms of classmates, pansexual participants felt the least supported. The difference between gay participants and other sexual identity groups in how many felt supported about their sexuality or gender identity is most marked when it comes to classmates, with over half (53.2%; n = 300) of gay participants feeling supported by classmates, compared to 41.7% (n = 460) of bisexual, 40.6% (n = 153) of lesbian, 38.5% (n = 109) of queer, 36.8% (n = 46) of asexual, and 31.5% (n = 108) of pansexual participants.

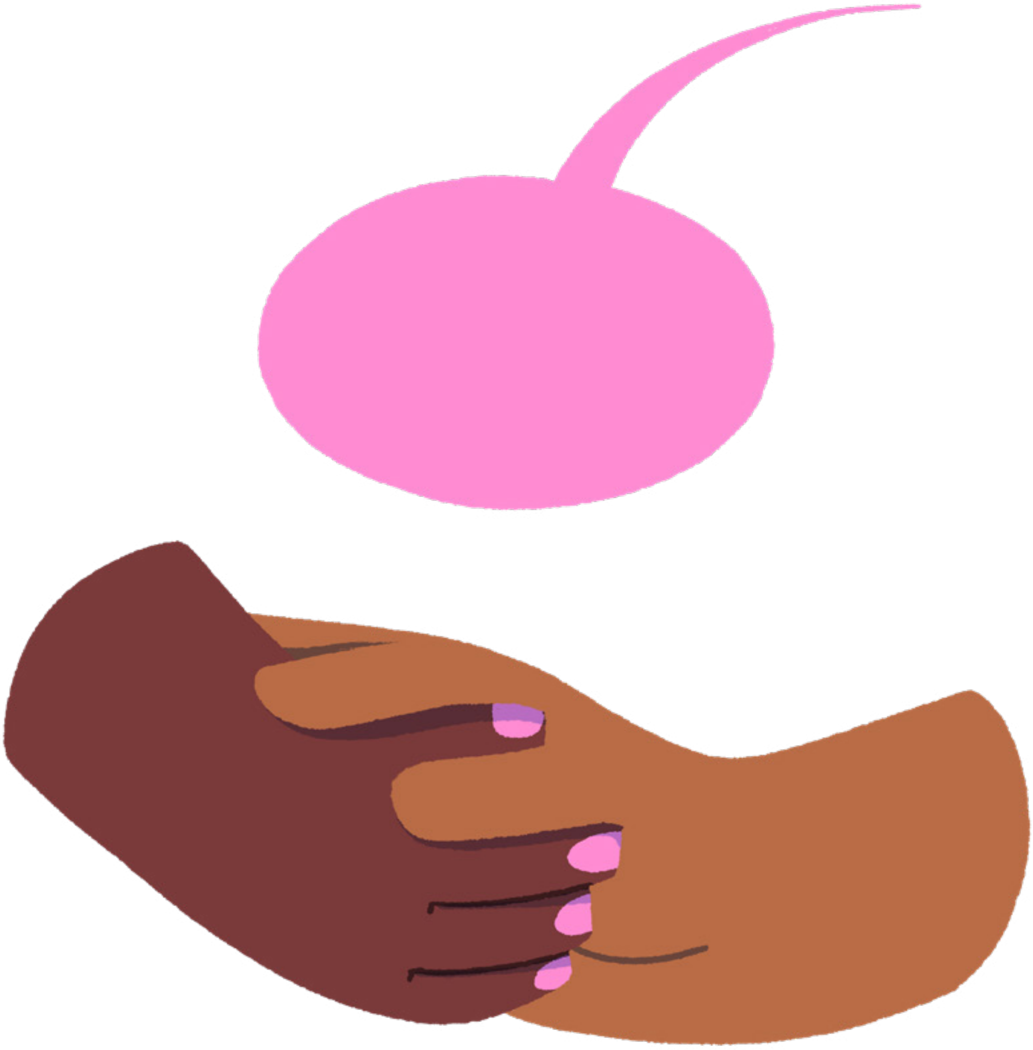
A greater proportion of gay participants reported feeling supported about their sexuality or gender identity than of those who held different sexual identities.

4.3 Summary

The majority of young people told us that they had disclosed their sexuality or gender identity to at least some of their friends or family or classmates. People were less likely to have disclosed to their co-workers, teachers, or (for those who played sport) their sports teammates.

For the most part, young people found people to whom they had disclosed their sexuality or gender identity to be supportive. They most commonly felt supported by friends, with 88.3% reporting their friends were supportive about their sexuality or gender identity. Fewer young people who had disclosed to their family reported that their family was supportive, with 57.3% reporting they felt supported by their family about their sexuality or gender identity.

Young people who had disclosed their sexuality or gender identity in a university or TAFE environment were more likely to feel supported about their sexuality or gender identity than those within secondary schools. Just over one in three (35.3%) participants attending secondary school said that they felt supported by classmates when they disclosed. Within educational institutions, more young people who had disclosed reported feeling supported about their sexuality or gender identity by their teacher (65.2%) than by their classmates (42.1%). Cisgender men who had disclosed their sexuality or gender identity were more likely than other participants to report feeling supported by classmates.



5 Educational settings: Supportive structures and practices

Educational settings that have supportive structures and practices in place have been shown to have a positive impact on wellbeing and educational outcomes of LGBT students (3). Positive associations have been established between a school's supportiveness and how same-sex attracted students felt about their sexuality (3). When asked in previous research what they wanted most from their school experience, LGBT young people wanted schools to be teaching that homophobia is wrong and shouldn't be tolerated, and to ensure sexuality education is more inclusive of same-sex attraction and gender diversity. Students also wanted more representation, asking that their schools include curriculum content about same-sex attraction and/or gender diversity (3).

Previous research has demonstrated how visual cues such as rainbow posters and stickers can result in positive feelings among LGBT young people viewing such symbols and that these contribute to a greater sense of affiliation within particular contexts, such as an educational setting (27). In a similar vein, the existence of policies and established process in support of LGBT people, designed to combat stigma or discrimination, is known to lead to better mental health outcomes and reduced prevalence of suicidal attempts (28).

Writing Themselves In 4 asked numerous questions about the experiences of LGBTIQA+ young people in their educational settings. This included questions about their awareness of structures or practices that work to support LGBTIQA+ young people, such as policies or positive inclusion of LGBTIQA+-related issues within curriculum. There were a sufficient number of responses to break down these responses according to whether they were in secondary school, TAFE or at university.

5.1 Visual images demonstrating support for LGBTIQA+ young people

In total, 63.1% (n = 3,853) of participants had seen a flag, sticker or poster that they felt was supportive of LGBTIQA+ people in their educational institution in the past 12 months. Nine-tenths (90.2%; n = 1,392) of participants attending university reported seeing a flag, sticker or poster supportive of LGBTIQA+, compared to half (54.3%; n = 2,091) at a secondary school or TAFE (50.0%; n = 188).

5.2 LGBTIQA+ supportive alliance

Previous research has found that belonging to a LGBTIQA+ supportive alliance or group leads to significant improvements in how young people feel about themselves, despite experiences of homophobic abuse (29). Such groups can provide a space where young LGBTIQA+ people feel accepted and safe, and help young people develop strategies to deal with homophobia and transphobia (29).

Around one-third (36.9%; n = 2,254) of participants reported being aware of an LGBTIQA+ gender–sexuality alliance, gay–straight alliance, Stand Out group, or similar supportive club for LGBTIQA+ students in their educational setting in the past 12 months. A greater proportion of participants attending university (77.7%; n = 1,199) reported being aware of an LGBTIQA+ alliance, compared to participants attending secondary school (24.8%; n = 953) or TAFE (11.1%; n = 42).

5.3 Awareness of bullying policies at educational institution

Several studies have found a correlation between school safety, the existence of school policy-based protection against homophobia and positive outcomes for gay, lesbian and bisexual students in the areas of self-harm, suicide, feelings of safety, and positive feelings about their sexuality (3,24). Students' knowledge of school policies about homophobic and transphobic bullying has been shown to be a protective factor (3).

Participants attending an educational institution were asked if they knew whether it had a bullying policy, and if this covered LGBTIQA+ people. Table 17 presents the responses.

Two-thirds (64.8%; n = 3,956) of participants reported knowing whether their educational institution had a bullying policy. A greater proportion of participants attending university (69.6%; n = 1,074) reported knowing whether their educational institution had a bullying policy than of those attending secondary school (65.3%; n = 2,511) or TAFE (48.1%; n = 182).

Participants who reported their educational institution had a bullying policy were asked if they knew whether the bullying policy specifically mentioned particular issues of importance to LGBTIQA+ young people. Responses are displayed in Table 18.

Among participants who reported that their educational institution had a bullying policy, one-fifth (20.4%; n = 507) of secondary school participants responded that they were aware it covered all aspects of LGBTIQA+, compared to more than two-fifths (46.7%; n = 84) at TAFE, and over half (52.7%; n = 565) at university.

Table 17 Awareness of educational institution bullying policy

	Secondary school		TAFE		University		Total	
Knowledge of any bullying policy (n = 6,107)	n	%	n	%	n	%	n	%
No	422	11.0	12	3.2	27	1.7	494	8.1
Yes	2,511	65.3	182	48.1	1,074	69.6	3,956	64.8
Don't know	914	23.8	184	48.7	442	28.6	1,657	27.1

43.5%

said that lesbian people were never mentioned in an inclusive or supportive way in any aspect of education

In contrast, three-tenths (29.8%; n = 743) of secondary school participants who reported their educational institution had a bullying policy said that they did not think it included mention of LGBTIQA+ people. It should be noted that not all young people would be aware of the contents of organisational policy, but an awareness of the inclusion of LGBTIQ people may be affirming.

5.4 An education supportive or inclusive of LGBTIQA+ people

Several studies have documented how a greater perceived inclusivity of LGBT people within sex education was associated with lower anxiety, depression, and suicidality (30). Participants within *Writing Themselves In 4* were asked, 'To what extent are aspects of your current educational institution (textbooks, assignments, sex education) supportive or inclusive of LGBTIQA+ people?' Table 19 displays the responses.

Previous research has found that 91% of all students and teachers and 100% of LGBTIQA+ young people expressed a need for more LGBTQIA+ education and awareness (31).

Across all settings, 43.5% said that lesbian people were never mentioned in an inclusive or supportive way in any aspect of education. Among secondary students, less than one-tenth (7.1%; n = 273) reported that lesbian people received a lot of supportive or inclusive attention in course materials, assignments or other aspects of education. This compares to one-fifth (20.4%; n = 304) of those at university and 8.5% (n = 31) at TAFE.

Conversely, more than two-fifths (44.9%; n = 1,717) of secondary school participants reported that lesbian people were never mentioned in an inclusive or supportive way, compared to one-third (35.4%; n = 528) of those at university, and over one-half (56.8%; n = 208) at TAFE (see Table 20).

Table 18 Awareness of the contents of educational institution bullying policies

	Secondary school		TAFE		University		Total	
Bullying policy areas (n = 3,928)	n	%	n	%	n	%	n	%
Sexuality	288	11.6	17	9.4	116	10.8	441	11.2
Gender identity	186	7.5	10	5.6	98	9.1	307	7.8
Intersex variation/s	11	0.4	2	1.1	11	1.0	25	0.6
All aspects of LGBTIQA+	507	20.4	84	46.7	565	52.7	1,224	31.2
No aspects of LGBTIQA+	743	29.8	2	1.1	24	2.2	799	20.3
Don't know	939	37.7	77	42.8	367	34.2	1,450	36.9

Table 19 Extent to which aspects of education are supportive or inclusive of lesbian people

	Secondary school		TAFE		University		Total	
Lesbian people (n = 6,005)	n	%	n	%	n	%	n	%
Never mentioned	1,717	44.9	208	56.8	528	35.4	2,611	43.5
Mentioned in passing	1,831	47.9	127	34.7	658	44.2	2,739	45.6
A lot of attention or discussion	273	7.1	31	8.5	304	20.4	655	10.9

Across all settings, 32.9% said that gay people were never mentioned in a supportive or inclusive way in any aspect of education. Among secondary students, less than one-tenth (10.6%; n = 403) reported that gay people received a lot of supportive or inclusive attention in course materials, assignments or other aspects of education. This compares to one-quarter (25.7%; n = 382) of those at university and 11.0% (n = 40) at TAFE.

Conversely, one-third (32.6%; n = 1,245) of secondary school participants reported that gay people were never mentioned in a supportive or inclusive way, compared to three-tenths (28.1%; n = 418) of those at university, and one-half (48.8%; n = 178) at TAFE (see Table 21).

Across all settings, more than half (56.5%; n = 3,378) said that bisexual people were never mentioned in a supportive or inclusive way in any aspect of education. Among secondary students, less than one-twentieth (5.3%; n = 201) reported that bisexual people received a lot of supportive or inclusive attention in course materials, assignments or other aspects of education. This compares to 14.9% (n = 382) of those at university and 7.4% (n = 27) at TAFE.

Conversely, three-fifths (59.9%; n = 2,283) of secondary school participants reported that bisexual people were never mentioned in a supportive or inclusive way, compared to almost half (46.7%; n = 692) of those at university, and two-thirds (64.7%; n = 235) at TAFE (see Table 21)).

Across all settings, two-thirds (66.7%; n = 3,579) said that queer people were never mentioned in a supportive or inclusive way in any aspect of education. Among secondary students, less than one-twentieth (4.7%; n = 179) reported that queer people received a lot of supportive or inclusive attention in course materials, assignments or other aspects of education. This compares to one-fifth (20.4%; n = 303) of those at university and 7.1% (n = 26) at TAFE (see Table 22).

Conversely, two-thirds (66.7%; n = 2,532) of secondary school participants reported that queer people were never mentioned in a supportive or inclusive way, compared to two-fifths (42.4%; n = 629) of those at university, and almost two-thirds (63.7%; n = 232) at TAFE (See Table 23).

Table 20 Extent to which aspects of education are supportive or inclusive of gay people

	Secondary school		TAFE		University		Total	
Gay people (n = 5,995)	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Never mentioned	1,245	32.6	178	48.8	418	28.1	1,971	32.9
Mentioned in passing	2,167	56.8	147	40.3	688	46.2	3,145	52.5
A lot of attention or discussion	403	10.6	40	11.0	382	25.7	879	14.7

Table 21 Extent to which aspects of education are supportive or inclusive of bisexual people

	Secondary school		TAFE		University		Total	
Bisexual people (n = 5,981)	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Never mentioned	2,283	59.9	235	64.7	692	46.7	3,378	56.5
Mentioned in passing	1,325	34.8	101	27.8	568	38.4	2,111	35.3
A lot of attention or discussion	201	5.3	27	7.4	221	14.9	492	8.2

Table 22 Extent to which aspects of education are supportive or inclusive of queer people

	Secondary school		TAFE		University		Total	
Queer people (n = 5,968)	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Never mentioned	2,532	66.7	232	63.7	629	42.4	3,579	60.0
Mentioned in passing	1,086	28.6	106	29.1	550	37.1	1,846	30.9
A lot of attention or discussion	179	4.7	26	7.1	303	20.4	543	9.1

Across all settings, almost four-fifths (78.9%; n = 4,706) said that pansexual people were never mentioned in a supportive or inclusive way in any aspect of education. Among secondary students, one-fiftieth (2.0%; n = 74) reported that pansexual people received a lot of supportive or inclusive attention in course materials, assignments or other aspects of education. This compares to 6.8% (n = 100) of those at university and 5.2% (n = 19) at TAFE (see Table 23).

Conversely, over four-fifths (83.3%; n = 3,161) of secondary school participants reported that pansexual people were never mentioned in a supportive or inclusive way, compared to two-thirds (68.8%; n = 1,018) of those at university, and four-fifths (80.5%; n = 293) at TAFE (see Table 24).

Across all settings, almost half (47.7%; n = 2,860) said that trans and gender diverse people were never mentioned in a supportive or inclusive way in any aspect of education. Among secondary students, 7.2% (n = 274) reported that trans and gender diverse people received a lot of supportive or inclusive attention in course materials, assignments or other aspects of education. This compares to one-fifth (19.5%; n = 289) of those at university and one-tenth (9.6%; n = 35) at TAFE.

Conversely, one-half (51.2%; n = 1,953) of secondary school participants reported that trans and gender diverse people were never mentioned in a supportive or inclusive way, compared to one-third (36.8%; n = 547) of those at university, and almost three-fifths (57.0%; n = 208) at TAFE (See Table 24).

Across all settings, three-quarters (74.9%; n = 4,476) said that people with intersex variation/s were never mentioned in a supportive or inclusive way in any aspect of education. Among secondary students, one-fiftieth (2.6%; n = 100) reported that people with intersex variation/s received a lot of supportive or

Table 23 Extent to which aspects of education are supportive or inclusive of pansexual people

	Secondary school		TAFE		University		Total	
Pansexual people (n = 5,968)	n	%	n	%	n	%	n	%
Never mentioned	3,161	83.3	293	80.5	1,018	68.8	4,706	78.9
Mentioned in passing	559	14.7	52	14.3	362	24.5	1,043	17.5
A lot of attention or discussion	74	2.0	19	5.2	100	6.8	216	3.6

Table 24 Extent to which aspects of education are supportive or inclusive of trans and gender diverse people

	Secondary school		TAFE		University		Total	
Trans and gender diverse people (n = 5,993)	n	%	n	%	n	%	n	%
Never mentioned	1,953	51.2	208	57.0	547	36.8	2,860	47.7
Mentioned in passing	1,587	41.6	122	33.4	649	43.7	2,493	41.6
A lot of attention or discussion	274	7.2	35	9.6	289	19.5	640	10.7

inclusive attention in course materials, assignments or other aspects of education. This compares to 9.0% (n = 133) of those at university and 6.1% (n = 22) at TAFE.

Conversely, over four-fifths (79.3%; n = 3,016) of secondary school participants reported that people with intersex variation/s were never mentioned in a supportive or inclusive way, compared to three-fifths (63.5%; n = 940) of those at university, and three-quarters (77.1%; n = 280) at TAFE (see Table 25).

Across all settings, over four-fifths (82.2%; n = 4,899) said that asexual people were never mentioned in a supportive or inclusive way in any aspect of education. Among secondary students, only 1.4% (n = 55) reported that asexual people received a lot of supportive or inclusive attention in course materials, assignments or other aspects of education. This compares to 4.8% (n = 71) of those at university and 3.9% (n = 14) at TAFE.

Conversely, over four-fifths (84.8%; n = 3,219) of secondary school participants reported that asexual people were never mentioned in a supportive or inclusive way, compared to three-quarters (76.0%; n = 1,125) of those at university, and four-fifths (83.4%; n = 301) at TAFE (see Table 26).

Figure 7 outlines the extent to which one or more aspects of LGBTIQA+ people were given a lot of attention or discussion, or no aspect of LGBTIQA+ people was mentioned in an inclusive or supportive way, at educational settings in the past 12 months.

Despite previous research showing an overwhelming majority (86%) of Australian young people aged 13 to 18 years supported secondary school students' right to learn about LGBTIQA+ people as part of their schooling (20), only 13.7% (n = 523) of secondary school participants in Australia reported that one or more aspect of LGBTIQA+ people received a lot of attention or discussion in a supportive or inclusive way within textbooks, assignments or other aspects of their education. Moreover, over one-quarter (27.3%; n = 1,041) of participants at secondary school and over two-fifths (45.2%; n = 165) of participants at TAFE reported never having any aspect of LGBTIQA+ people mentioned in a supportive or inclusive way.

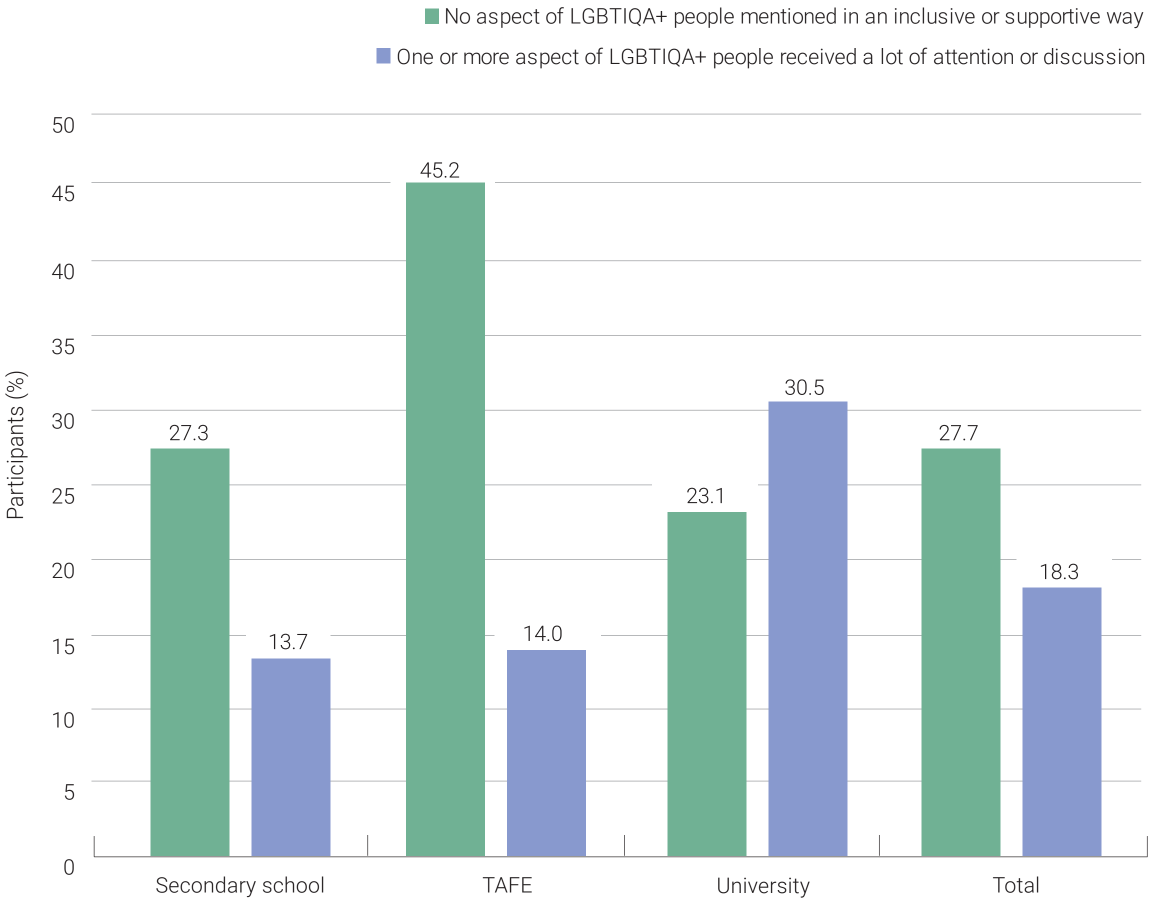
Table 25 **Extent to which aspects of education are supportive or inclusive of people with intersex variation/s**

	Secondary school		TAFE		University		Total	
People with intersex variation/s (n = 5,977)	n	%	n	%	n	%	n	%
Never mentioned	3,016	79.3	280	77.1	940	63.5	4,476	74.9
Mentioned in passing	689	18.1	61	16.8	408	27.5	1,231	20.6
A lot of attention or discussion	100	2.6	22	6.1	133	9.0	270	4.5

Table 26 **Extent to which aspects of education are supportive or inclusive of asexual people**

	Secondary school		TAFE		University		Total	
Asexual people (n = 5,961)	n	%	n	%	n	%	n	%
Never mentioned	3,219	84.8	301	83.4	1,125	76.0	4,899	82.2
Mentioned in passing	520	13.7	46	12.7	284	19.2	911	15.3
A lot of attention or discussion	55	1.4	14	3.9	71	4.8	151	2.5

Figure 7 Extent to which aspects of education are supportive or inclusive of any LGBTIQA+ people



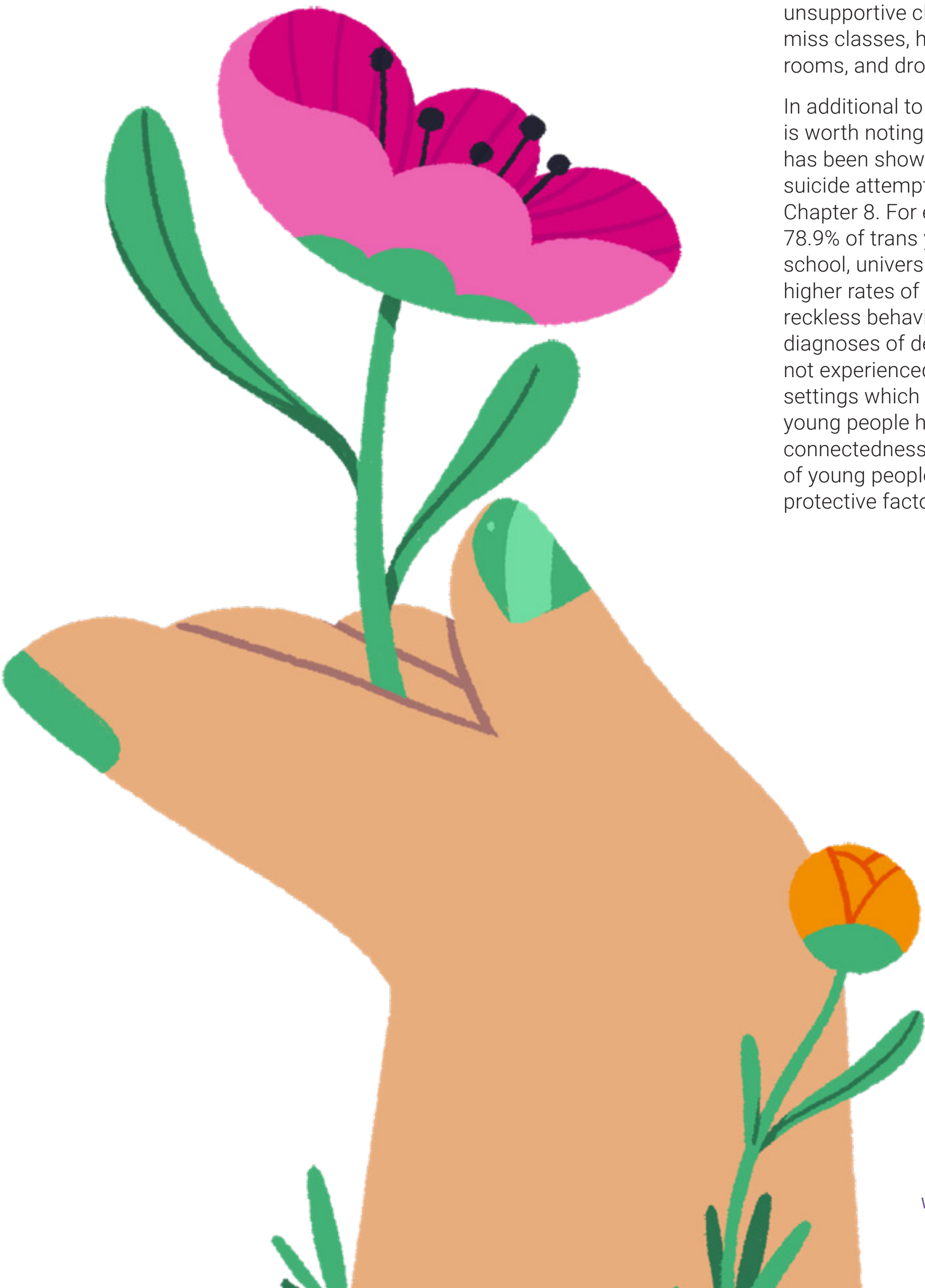
5.5 Summary

While sizable proportions of participants in this study reported supportive structures or practices in their educational setting, many others did not feel that their education was attentive to, or inclusive of, the needs of LGBTQA+ young people. There was evidence of LGBTQA+-affirming efforts being made, with a majority of those at university reporting that they had seen a flag, sticker or poster supportive of LGBTQA+ people in these settings, although only half of those at secondary school or TAFE reported the same. Similarly, a higher proportion of those at university reported being aware of clubs or societies supportive of LGBTQA+ people in this setting than was the case for those at secondary school of TAFE. Around two-thirds of participants reported that their educational setting had an anti-bullying policy, but a much smaller proportion were aware of whether it specifically covered issues of importance to LGBTQA+ young people.

When asked about inclusion of LGBTQA+-related issues within education (such as textbooks, assignments or sex education), the vast majority of participants reported that these were never mentioned in a supportive or inclusive way, or were mentioned only in passing. This was especially the case for issues relating to bisexual, asexual or pansexual people, but included all groups. Most participants reported that there was no mention of people with intersex variation/s within their education.

6 Educational settings: Discriminatory and affirming experiences

In addition to questions pertaining to awareness of supportive structures or processes in educational settings (see preceding chapter), *Writing Themselves In 4* included numerous questions about how comfortable or safe LGBTQA+ young people felt at school or university, including whether they felt able to engage in gender- or sexuality-affirming practices in these spaces. It also included questions regarding negative comments that participants may have been heard about LGBTIQA+ people in these settings, and an indicator of how such experiences may have impacted their studies.



There is much research detailing the high levels of discrimination and high levels of verbal and physical homophobic and transphobic abuse experienced by LGBTIQA+ young people in Australian educational settings, particularly in secondary schools (3,4,32). These studies found that school was the place these young people were most likely to experience this abuse and discrimination (3). Young people in discriminatory or unsupportive educational environments were found to have poorer educational outcomes, including being unable to concentrate in class, having their marks drop, or leaving school altogether (3,4,32). Participants with unsupportive classmates are more likely to move schools, miss classes, hide at recess or lunch, not use the change rooms, and drop out of extra-curricular activities (4).

In additional to poor social and educational outcomes, it is worth noting that this kind of abuse and discrimination has been shown to increase the risk of suicidal thoughts, suicide attempts and forms of self-harm (4), detailed more in Chapter 8. For example, the Trans Pathways study found that 78.9% of trans young people had experienced transphobia at school, university or TAFE, and that these participants had higher rates of wanting to hurt themselves, self-harming, reckless behaviour, suicidal thoughts, suicide attempts, and diagnoses of depression and anxiety than those who had not experienced transphobia (33). Conversely, educational settings which are affirming and supportive of LGBTIQA+ young people had a positive impact on the mental health, connectedness and educational outcomes of this group of young people (3,4). Supportive classmates are a key protective factor for LGBTIQA+ students (4).

6.1 Experiences of feeling unsafe or uncomfortable.

Participants were asked if they had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity. Table 27 displays the results.

More than three-fifths (60.2%; n = 2,316) of participants said that they had felt unsafe or uncomfortable in the past 12 months at secondary school due to their sexuality or gender identity, compared to approximately three-tenths (29.2%; n = 450) of participants at university and one-third (33.8%; n = 128) of participants at TAFE.

6.1.1 Experiences of feeling unsafe or uncomfortable, by gender

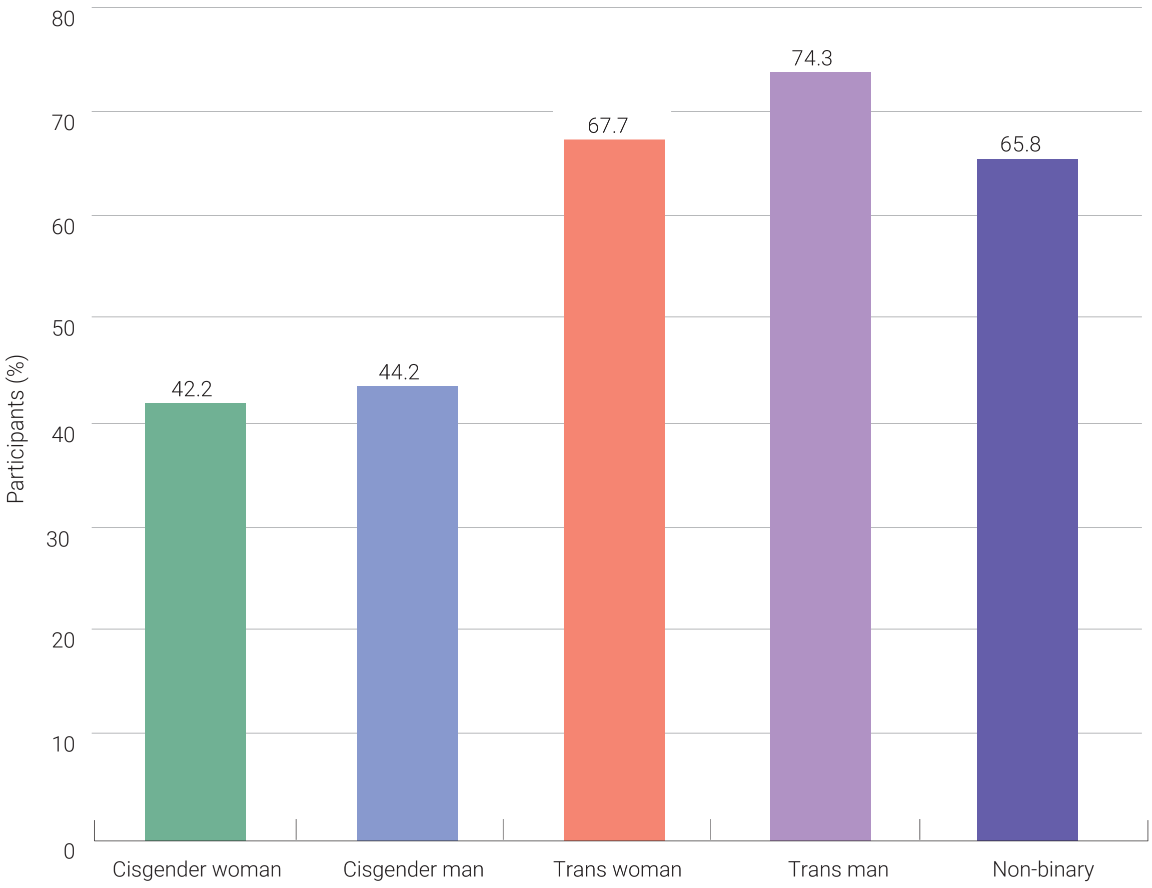
Figure 8 outlines how feelings of safety or comfort in educational contexts varied by gender (n = 5,531).

Almost three-quarters of trans men (74.3%; n = 278) and two-thirds of trans women (67.7%; n = 46) and non-binary participants (65.8%; n = 746) said that in the past 12 months they had felt unsafe or uncomfortable at their educational institution due to their sexuality or gender identity, followed more than two-fifths of cisgender men (44.2%; n = 581) and cisgender women (42.2%; n = 1,289).

Table 27 **Felt unsafe or uncomfortable due to their sexuality or gender identity, in past 12 months at their educational setting**

	Secondary school		TAFE		University		Total	
Felt unsafe or uncomfortable (n = 6,106)	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
No	1,528	39.8	251	66.2	1,093	70.8	3,064	50.2
Yes	2,316	60.2	128	33.8	450	29.2	3,042	49.8

Figure 8 **Felt unsafe or uncomfortable due to their sexuality or gender identity, in past 12 months at their educational setting, by gender**



6.1.2 Experiences of feeling unsafe or uncomfortable, by sexuality

Figure 9 outlines how feelings of safety or comfort in educational contexts varied by sexuality (n = 5,658).

More than three-fifths of queer participants (62.2%; n = 318) responded that in the past 12 months they felt unsafe or uncomfortable at their educational institution due to their sexuality or gender identity, followed by 57.4% (n = 426) of lesbian, 51.4% (n = 341) of pansexual, 50.6% (n = 507) of gay, 43.8% (n = 917) of bisexual, and 44.2% (n = 118) of asexual participants.

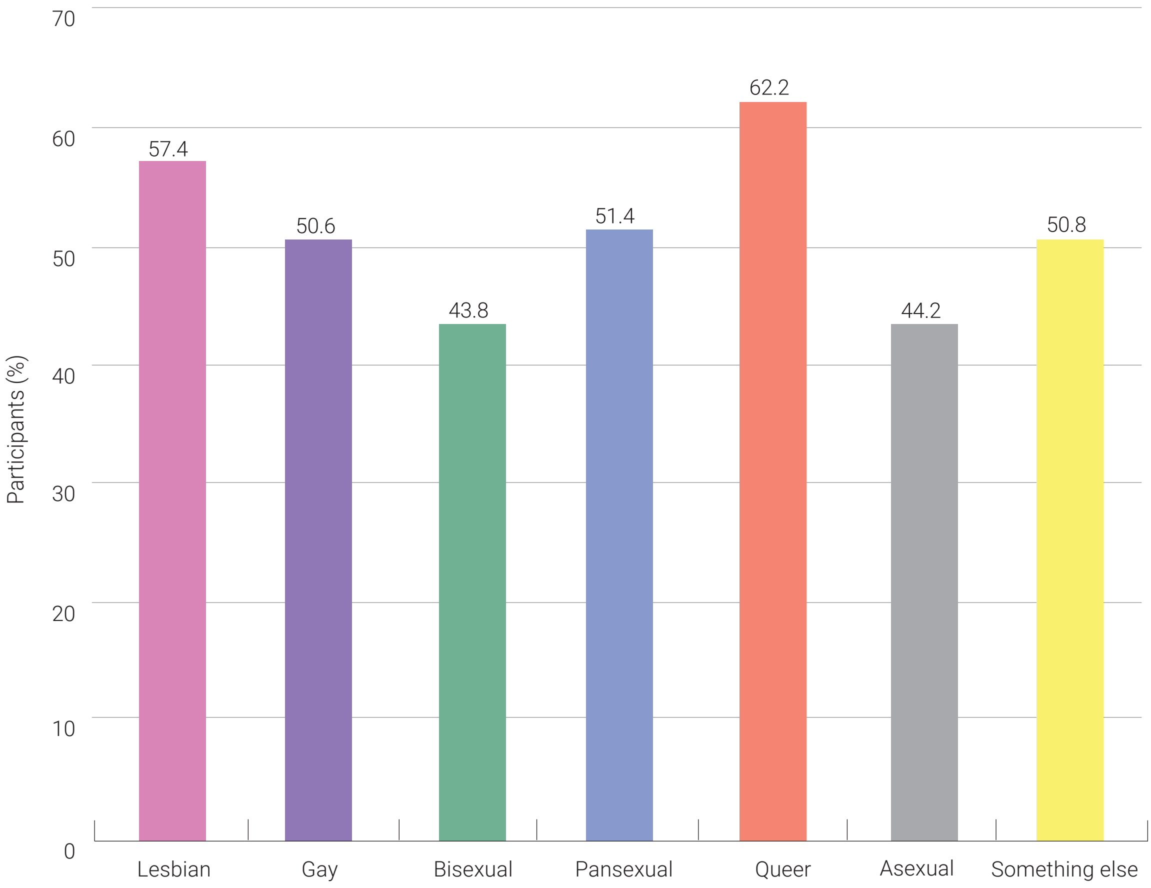
6.2 Feeling safe to engage in LGBTQA+ affirming activities

Participants who reported attending an educational institution in the past 12 months were asked to respond to a series of statements about feelings of safety, preceded with the statement, 'During the past 12 months, at your educational setting have you felt that you could safely …' Responses are displayed in Table 28.

Overall, a greater proportion of participants at university reported feeling that in the past 12 months they could safely engage in public affection with other LGBTIQA+ people, openly identify as LGBTIQA+, or celebrate an LGBTIQA+ day of significance safely than the proportion at secondary school or TAFE.

Less than three-tenths (27.5%; n = 1,046) of participants felt that in the past 12 months they could safely engage in public affection with other LGBTIQA+ people at secondary school, one-third (33.5%; n = 1,274) felt that they could safely attend a school dance with someone of the same gender, one-half (52.3%; n = 1,987) felt that they could openly identify as LGBTIQA+, and two-fifths (41.7%; n = 1,583) felt that they could safely celebrate 'Wear It Purple Day', IDAHOBIT, Transgender Day of Visibility or another LGBTIQA+ day of significance.

Figure 9 **Felt unsafe or uncomfortable due to their sexuality or gender identity,in past 12 months at their educational setting, by sexuality**



Less than two-fifths (37.2%; n = 139) of participants felt that in the past 12 months they could safely engage in public affection with other LGBTIQA+ people at TAFE, over two-thirds (66.3%; n = 248) felt that they could openly identify as LGBTIQA+, and less than half (46.3%; n = 173) felt that they could safely celebrate 'Wear It Purple Day', IDAHOBIT, Transgender Day of Visibility or another LGBTIQA+ day of significance.

Less than two-fifths (42.8%; n = 652) of participants felt that in the past 12 months they could safely engage in public affection with other LGBTIQA+ people at university, three-quarters (75.2%; n = 1,147) felt that they could openly identify as LGBTIQA+, and over three-fifths (65.4%; n = 997) felt that they could safely celebrate 'Wear It Purple Day', IDAHOBIT, or Transgender Day of Visibility or another LGBTIQA+ day of significance.

Trans and gender diverse participants were then asked if 'During the past 12 months, at your educational setting have you felt that you could safely …' Responses are displayed in Table 29.

Overall, universities were experienced as more gender-affirming environments than were schools or TAFE. Half (51.1%; n = 190) of participants felt that in the past 12 months they could safely use the bathrooms that match their gender identity at university, compared to under three-tenths (29.2%; n = 269) of participants at secondary school. Three-tenths (30.4%; n = 113) of participants at university felt that in the past 12 months they could safely use the changing rooms that match their gender identity, compared to one-fifth (22.0%; n = 203) of participants at secondary school. More participants felt that in the past 12 months they could safely use their chosen name or pronouns at university (66.4%; n = 247) or wear clothes that match their gender identity (84.1%; n = 313) than participants at secondary school (41.0%; n = 378 and 50.9%; n = 469, respectively). It is notable that more than one-third (34.1%; n = 314) of participants at secondary school felt that in the past 12 months they could not do any of these things safely, compared to 7.8% (n = 29) of participants at university.

Table 28 Perceived safety when engaging in LGBTIQA+-affirming practices, in the past 12 months at their educational setting

	Secondary school		TAFE		University		Total	
During the past 12 months at your educational setting have I felt that I could safely … (n = 6,031)	n	%	n	%	n	%	n	%
Engage in public affection (PDA) with LGBTIQA+ people	1,046	27.5	139	37.2	652	42.8	1,948	32.3
Attend a school dance with someone of the same gender	1,274	33.5	N/A	N/A	N/A	N/A	N/A	N/A
Openly identify as LGBTIQA+	1,987	52.3	248	66.3	1,147	75.2	3,574	59.3
Celebrate 'Wear It Purple Day', IDAHOBIT, or Transgender Day of Visibility or another LGBTIQA+ day of significance	1,583	41.7	173	46.3	997	65.4	2,908	48.2
None of the above	1,276	33.6	96	25.7	230	15.1	1,703	28.2

Table 29 Perceived safety engaging in gender-affirming acts in educational settings, in the past 12 months

	Secondary school		TAFE		University		Total	
During the past 12 months at your educational setting have you felt that you could safely … (n = 1,559)	n	%	n	%	n	%	n	%
Use the bathrooms that match my gender identity	269	29.2	75	51.0	190	51.1	590	37.8
Use the changing rooms that match my gender identity	203	22.0	36	24.5	113	30.4	391	25.1
Use my chosen name or pronouns	378	41.0	87	59.2	247	66.4	785	50.4
Wear clothes that match my gender identity	469	50.9	122	83.0	313	84.1	988	63.4
None of the above	314	34.1	15	10.2	29	7.8	379	24.3

6.3 Experiences of hearing negative language at educational settings

Participants were asked if they had heard any of the following negative language about LGBTIQA+ people at their educational setting in the past 12 months, regardless of whether or not it was directed at them:

- Negative remarks regarding sexuality (e.g. 'that's so gay') (n = 6,103)
- Negative remarks regarding gender identity and/or gender expression (e.g. 'he throws like a girl') (n = 5,755)
- Negative remarks regarding transgender people (e.g. 'trans women aren't real women') (n = 5,802)
- Negative remarks regarding people with intersex variation/s (e.g. 'intersex is a birth defect') (n = 5,927)

Figure 10 displays findings according to the frequency with which such negative language was heard.

Over three-quarters (76.4%; n = 4,663) of participants reported in the past 12 months sometimes or frequently hearing negative remarks regarding sexuality, compared to over three-fifths (61.5%; n = 3,537) who reported sometimes or frequently hearing negative remarks regarding gender identity or gender expression, 46.4% (n = 2,690) regarding transgender people, and 13.6% (n = 805) regarding people with intersex variation/s. The reported lower levels of negative language regarding people with intersex variation/s likely reflects the lack of awareness among school-age populations about intersex issues. Chapter 5 includes the finding that over three-quarters (79.3%; n = 3,016) of participants reported that they had never received any education about people with intersex variation/s.

Figure 10 Frequency of hearing negative language regarding sexuality, gender identity or gender expression, transgender people, or people with intersex variation/s, at an educational setting in the past 12 months

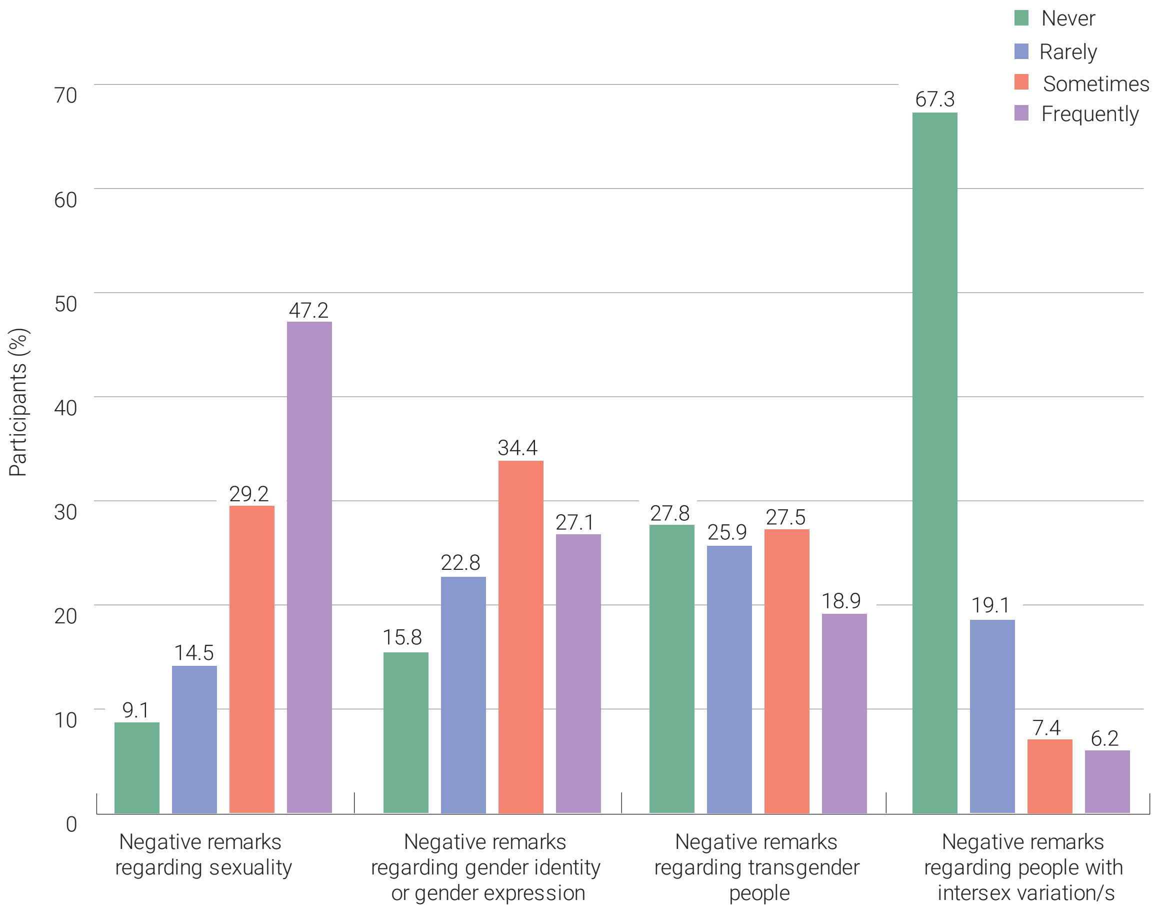


Figure 11 **Frequency of hearing negative remarks regarding sexuality at secondary school, TAFE and university**

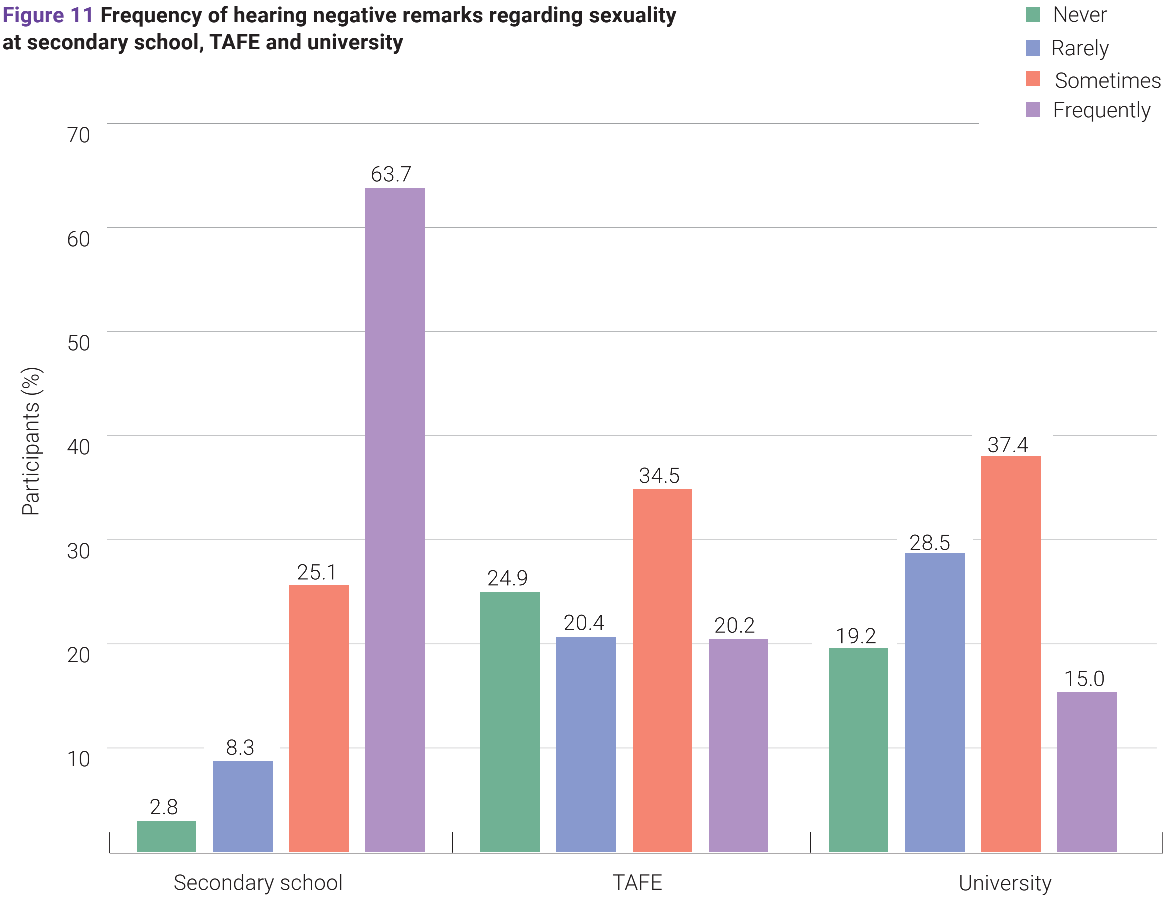


Figure 12 **Frequency of hearing negative remarks regarding gender identity or gender expression at secondary school, TAFE and university**

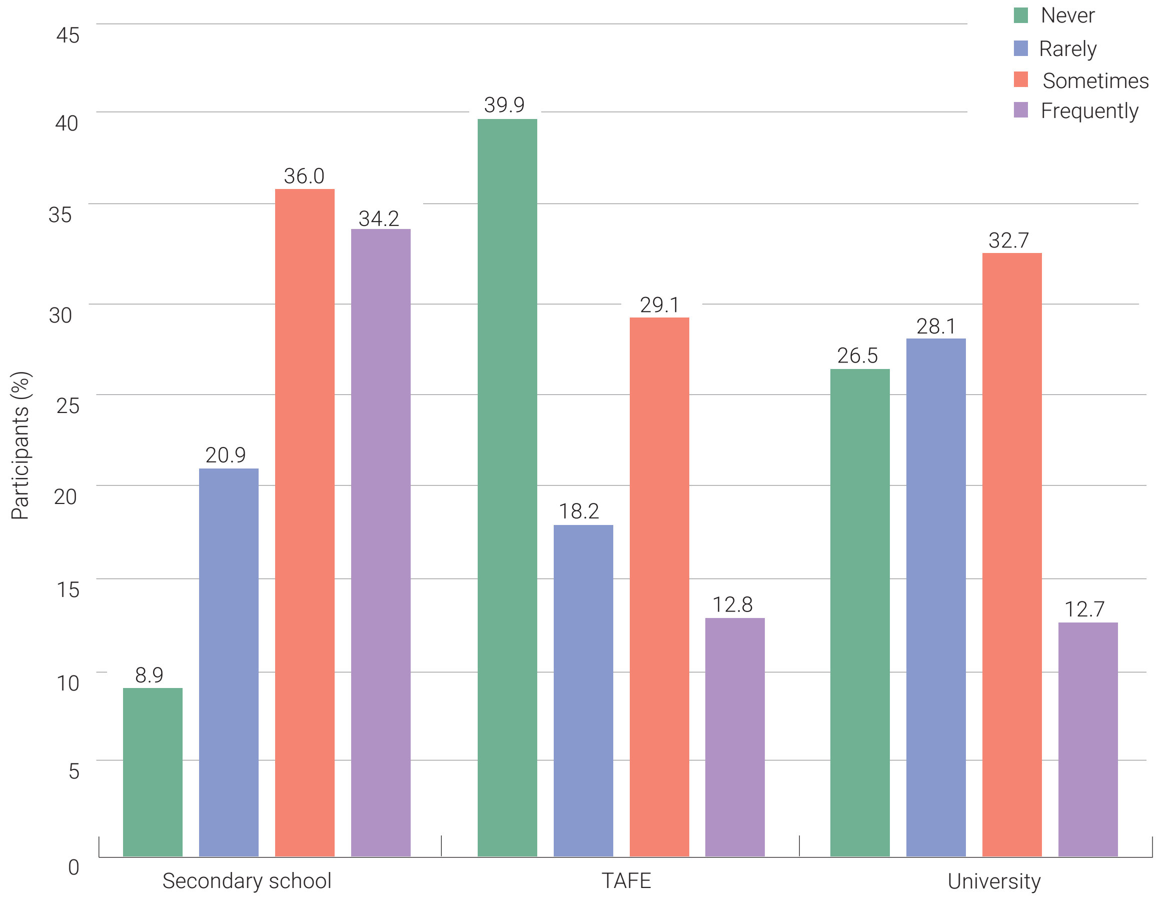


Figure 11 below shows how the frequency of hearing negative remarks specifically relating to sexuality varied according to educational context: secondary school (n = 3,845), TAFE (n = 377), and university (n = 1,543).

Figure 11 shows that in in total, 97.2% (n = 3,739) of participants reported hearing negative language regarding sexuality at secondary school in the past 12 months. There was a marked difference among the proportion of participants who reported frequently hearing negative remarks regarding sexuality according to educational context: almost two-thirds (63.7%; n = 2,451) of participants in secondary school reported frequently hearing such remarks, compared to one-fifth (20.2%; n = 76) at TAFE, and 15.0% (n = 231) at university.

Figure 12 below shows how the experience of hearing negative remarks specifically relating to gender identity or gender expression varied according to educational context: secondary school (n = 3,673), TAFE (n = 296), and university (n = 1,467).

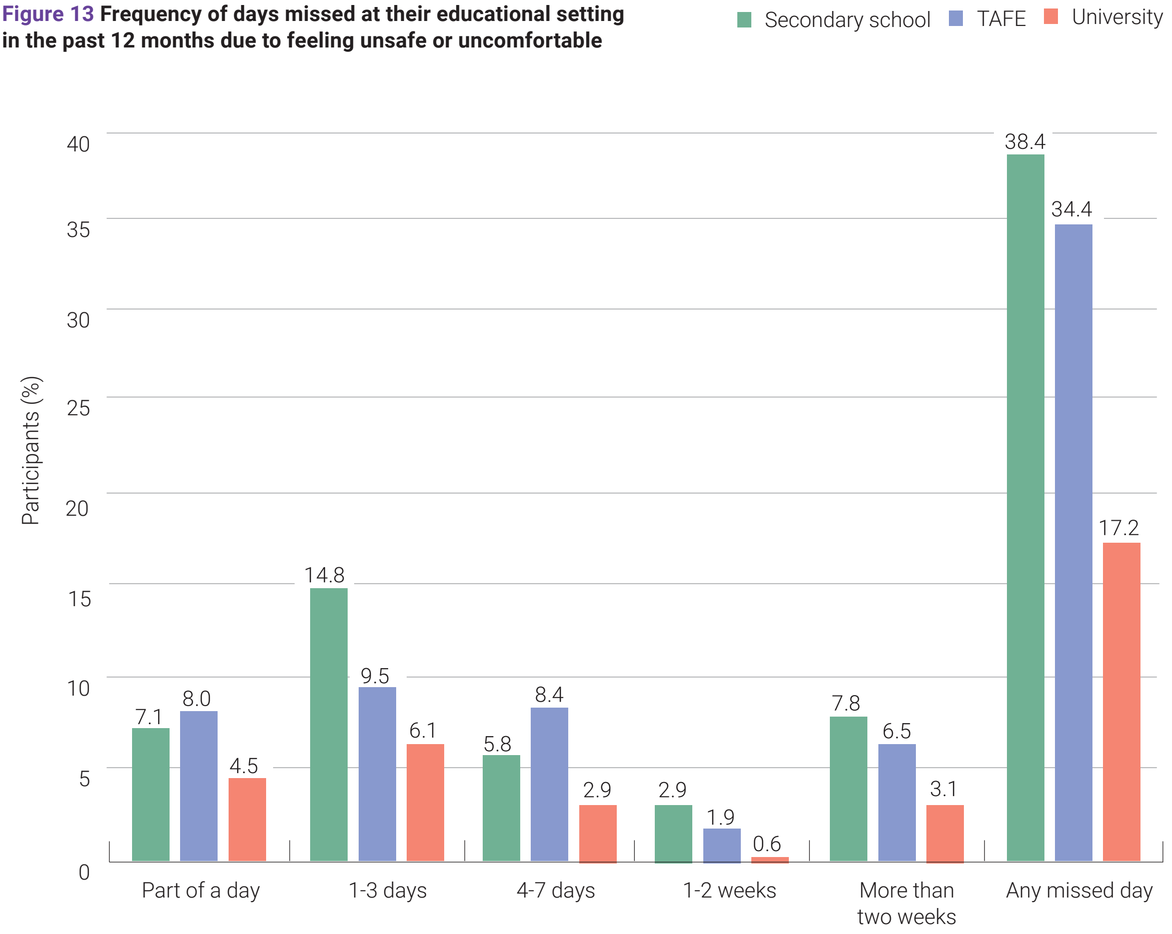
Figure 12 shows that participants attending secondary school were more likely to report frequently hearing negative language about gender identity or gender expression, compared to participants attending TAFE or university. Over seven-tenths (70.2%; n = 2,579) of secondary school participants, 45.4% (n = 666) of university participants, and 41.9% (n = 124) of TAFE participants reported hearing negative language about gender identity or gender expression sometimes or frequently in the past 12 months.

6.4 Frequency of days missed in the past 12 months

Participants were asked how many days of their educational setting they had missed due to feeling unsafe or uncomfortable in the past 12 months. The wording of the question was tailored to those at secondary school (n = 3,655), TAFE (n = 262), and university (n = 1,436).

Over one-third of secondary school (38.4%; n = 1,404) and TAFE (34.4%; n = 90) students and one-sixth of university students (17.2%; n = 247) reported missing day/s at their educational setting in the past 12 months because they felt unsafe or uncomfortable. Students attending secondary school were more than twice as likely to report missing any day at their educational setting in the past 12 months because they felt uncomfortable, compared to participants attending university. One-twelfth (7.8%; n = 286) of participants at secondary school, 6.5% (n = 17) at TAFE, and 3.1% (n = 44) at university reported missing more than two weeks in the past 12 months because they felt unsafe or uncomfortable.

Figure 13 Frequency of days missed at their educational setting in the past 12 months due to feeling unsafe or uncomfortable



Almost two-thirds (64.3%) of trans women, more than half (54.4%) of trans men, and 44.6% of non-binary participants reported missing day/s at their educational setting in the past 12 months due to feeling unsafe or uncomfortable.

6.4.1 Frequency of days missed in past 12 months, by gender

Figure 14 illustrates the proportion of participants who missed a day at their educational setting in the past 12 months due to feeling unsafe or uncomfortable, by gender (n = 5,525).

Almost two-thirds (64.3%; n = 36) of trans women, more than half (54.4%; n = 180) of trans men, and 44.6% (n = 456) of non-binary participants reported missing day/s at their educational setting in the past 12 months due to feeling unsafe or uncomfortable. This compares to almost three-tenths (29.2%; n = 847) of cisgender women and almost one-quarter (23.0%; n = 281) of cisgender men.

6.4.2 Frequency of days missed in past 12 months, by sexuality

Figure 15 illustrates the proportion of participants who missed a day at their educational setting in the past 12 months due to feeling unsafe or uncomfortable, by sexuality (n = 5,652).

More than two-fifths (43.8%; n = 261) of pansexual participants reported missing day/s at their educational setting in the past 12 months, followed by one-third of lesbian (36.4%; n = 250) and queer (36.3%; n = 172) participants, three-tenths of bisexual participants (30.2%; n = 594), and over one-quarter of asexual (27.8%; n = 68) and gay participants (27.4%; n = 253).

Figure 14 **Any missed day at their educational setting in the past 12 months due to feeling unsafe or uncomfortable by gender**

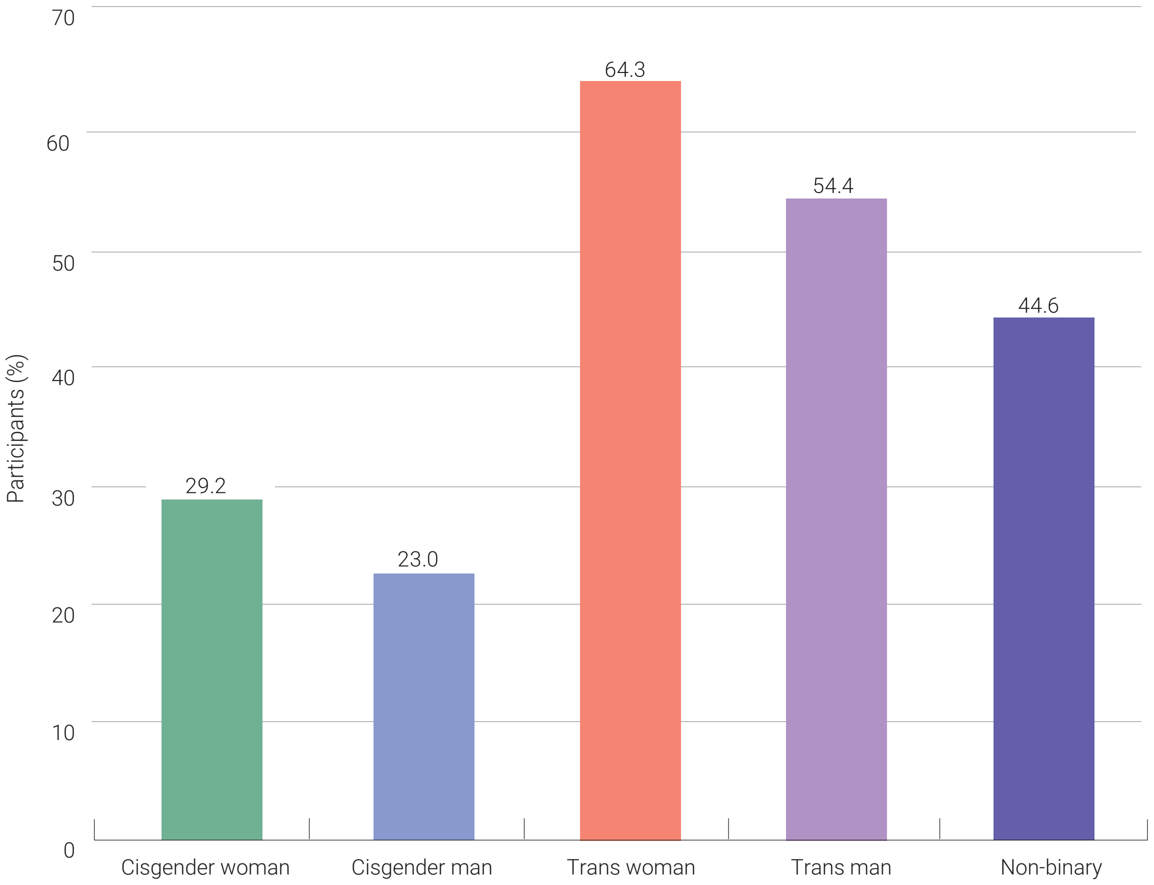
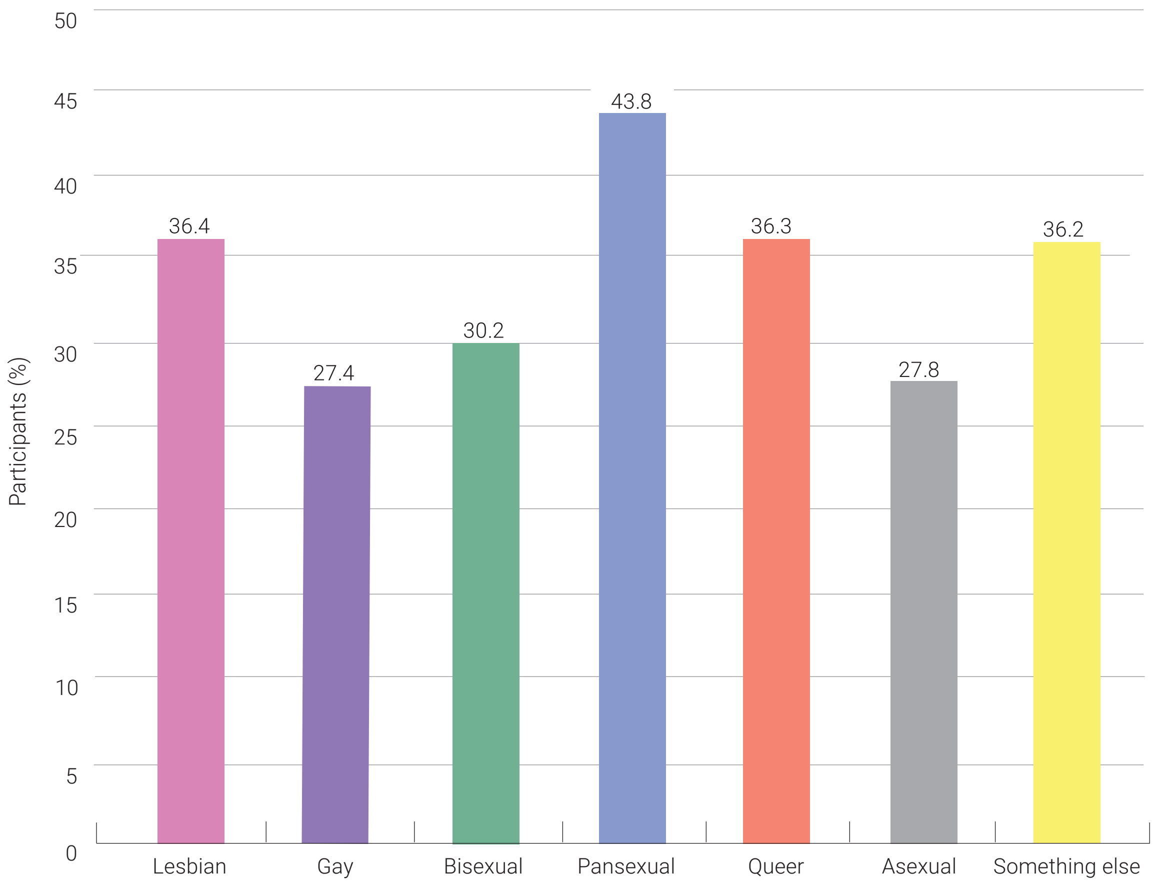


Figure 15 **Any missed day at their educational setting in the past 12 months due to feeling unsafe or uncomfortable, by sexuality**



6.5 Summary

More than three-fifths (60.2%) of participants said that in the past 12 months they felt unsafe or uncomfortable at secondary school due to their sexuality or gender identity. The proportion of those feeling uncomfortable at TAFE or university was slightly lower although still sizeable. The experience of feeling unsafe or uncomfortable in an educational setting was considerably more common among trans men and trans women, compared to cisgender men and women. Only around a quarter of participants at secondary school felt that in the past 12 months they could safely engage in public affection with other LGBTQA+ people, while only a third felt that they could safely attend a school dance with someone of the same gender. Around half of participants at secondary school felt that in the past 12 months they could openly identify as LGBTQA+.

Over three-quarters of participants reported sometimes or frequently hearing negative remarks regarding sexuality in their educational setting in the past 12 months, while over three-fifths sometimes or frequently heard negative remarks relating to gender identity or gender expression. Over a third of participants at secondary school and TAFE, as well as one-sixth of university students, reported missing day/s at their educational setting in the past 12 months because they felt unsafe or uncomfortable. This experience of missing days of education was more commonly reported by trans and gender diverse participants, compared to cisgender men and women.

7 Experiences of affirmation or discrimination in the workplace

While previous research in Australia has documented experiences of stigma, discrimination and safety concerns faced by LGBTIQ adults in the workplace (34), no such quantitative data has been collected among LGBTIQA+ young people. *Writing Themselves In 4* asked numerous questions about the experiences of LGBTIQA+ young people in their work settings, including feelings of safety and comfort, perceived ability to engage in LGBTIQA+-affirming practices, and hearing negative language pertaining to gender and sexuality. The survey included questions about their awareness of workplace bullying policies that may operate in support of LGBTIQA+ people.

There were a sufficient number of responses to break down employment-related experiences according to whether they were engaged in full-time (n = 207), part-time (n = 1,178), or casual work (n = 2,324), and thus these distinctions are presented where possible. Participants who indicated they were engaged in an apprenticeship (n = 51) or other employment (n = 119) were included in the 'total' category.

7.1 Experiences of feeling unsafe or uncomfortable in the workplace

Participants were asked if they had felt unsafe or uncomfortable at their work setting in the past 12 months due to their sexuality or gender identity. Table 30 displays the results.

Two-fifths (40.3%; n = 83) of participants who worked full-time said that they felt unsafe or uncomfortable at work in the past 12 months due to their sexuality or gender identity, compared to one-third of participants who worked part-time (35.6%; n = 418) and casually (31.0%; n = 718).

7.2 Feeling safe to engage in LGBTIQA+-affirming practices

Participants who reported working in the past 12 months were asked to respond to a series of statements about feelings of safety, preceded with the statement, 'During the past 12 months, at your work setting have you felt that you could safely …' Responses are displayed in Table 31.

In total, in the past 12 months only 45.8% of participants felt able to openly identify as LGBTIQA+ in the workplace and only 31.8% felt able to celebrate LGBTIQA+ days of significance.

Overall, a greater proportion of participants engaged in full-time employment reported feeling that they could safely openly identify as LGBTIQA+ or celebrate an LGBTIQA+ day of significance at work, compared to those engaged in part-time or casual employment.

Less than three-fifths (56.2%; n = 113) of participants engaged in full-time employment reported that in the past 12 months they could safely openly identify as LGBTIQA+ in the workplace, compared to one-third (32.0%; n = 364) of those in part-time and three-tenths (30.1%; n = 682) in casual employment.

Table 30 Experiences of feeling unsafe or uncomfortable due to sexuality or gender identity, in past 12 months in the workplace

	Full-time		Part-time		Casual		Total	
Felt unsafe or uncomfortable (n = 3,866)	n	%	n	%	n	%	n	%
No	123	59.7	756	64.4	1,599	69.0	2,585	66.9
Yes	83	40.3	418	35.6	718	31.0	1,281	33.1

Table 31 Perceived safety when engaging in LGBTIQA+-affirming practices, in the past 12 months in the workplace

	Full-time		Part-time		Casual		Total	
During the past 12 months at your work setting have you felt that you could safely ... (n = 3,768)	n	%	n	%	n	%	n	%
Openly identify as LGBTIQA+	113	56.2	496	43.6	1,040	45.9	1,726	45.8
Celebrate 'Wear It Purple Day', IDAHOBIT, or Transgender Day of Visibility or another LGBTIQA+ day of significance	85	42.3	364	32.0	682	30.1	1,198	31.8

7.3 Experiences of hearing negative language at work settings

Participants in employment were asked if in the past 12 months they had heard any of the following negative language about LGBTIQA+ people at their work setting, regardless of whether or not it was directed at them:

- Negative remarks regarding sexuality (e.g. 'that's so gay') (n = 3,845)
- Negative remarks regarding gender identity and/or gender expression (e.g. 'he throws like a girl') (n = 3,479)
- Negative remarks regarding transgender people (e.g. 'trans women aren't real women') (n = 3,599)
- Negative remarks regarding people with intersex variation/s (e.g. 'intersex is a birth defect') (n = 3,693)

Figure 16 displays findings according to the frequency with which such negative language was heard.

Almost two-fifths (37.9%; n = 1,454) of participants reported in the past 12 months sometimes or frequently hearing negative remarks regarding sexuality, compared to over three-tenths (31.1%; n = 1,081) who reported sometimes or frequently hearing negative remarks regarding gender identity or gender expression, 16.3% (n = 587) regarding transgender people, and 6.2% (n = 227) regarding people with intersex variation/s. The lower levels of negative language regarding people with intersex variation/s reported likely reflects the lack of awareness among school- and university-age populations about intersex issues, and is reflected in Chapter 5 which notes that over three-quarters (79.3%; n = 3,016) of participants reported they had never received any education about people with intersex variation/s.

Figure 17 shows that over half (55.5%; n = 112) of participants engaged in full-time employment reported sometimes or frequently hearing negative language regarding sexuality, at work in the past 12 months, followed by two-fifths (42.2%; n = 492) in part-time employment, and one-third (34.2%; n = 1,454) in casual employment.

Figure 16 **Frequency of hearing negative language regarding sexuality, gender identity or gender expression, transgender people, or people with intersex variation/s, at a work setting in the past 12 months**

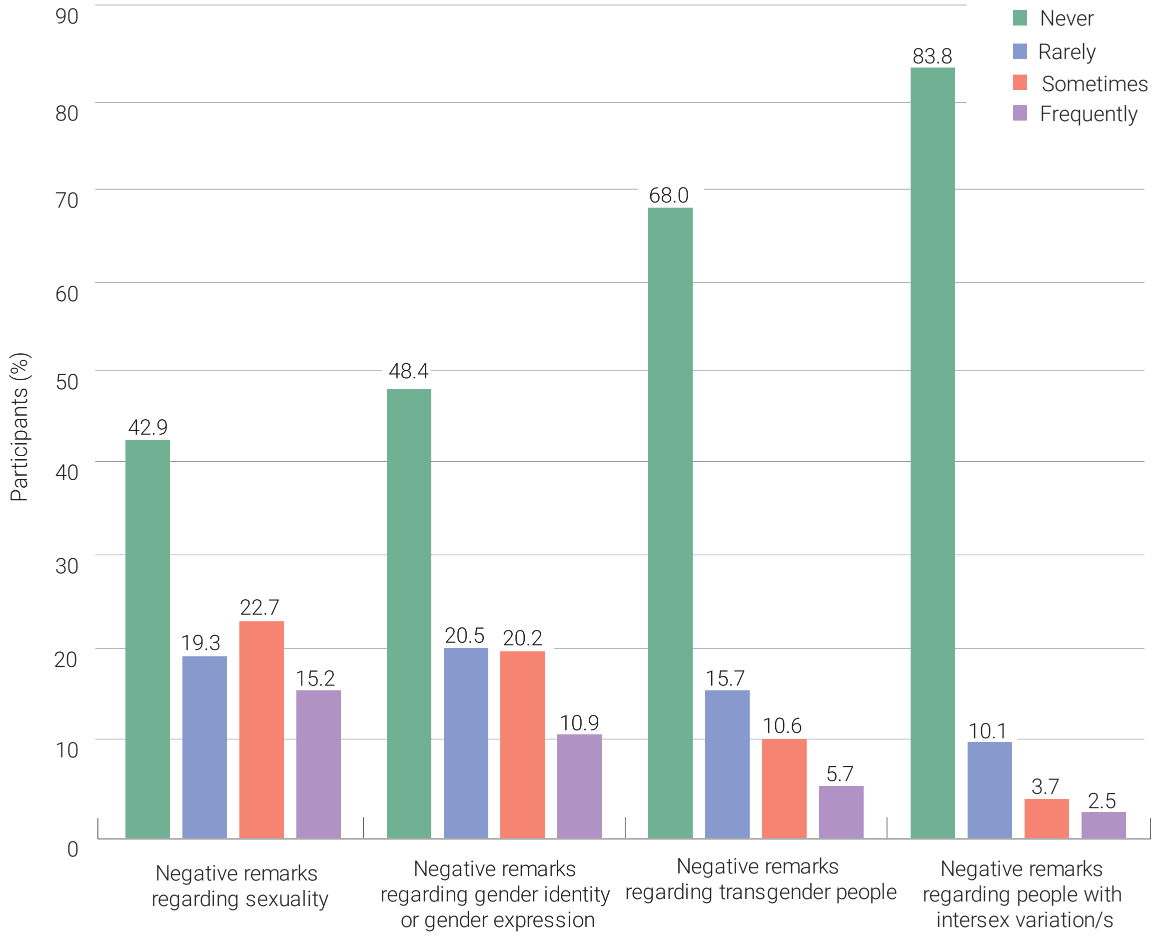


Figure 17 **Frequency of hearing negative remarks regarding sexuality, at work settings in the past 12 months**

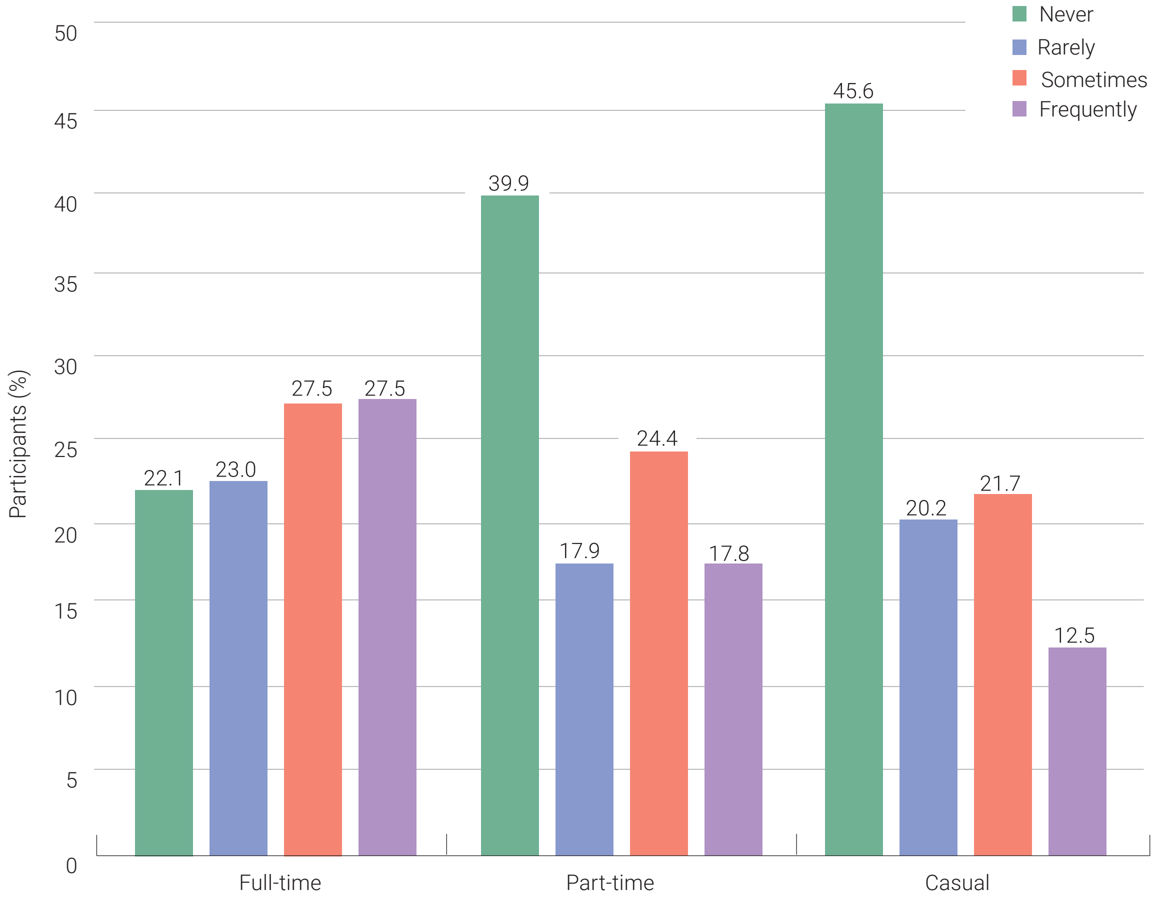


Figure 18 **Frequency of hearing negative remarks regarding gender identity or gender expression, at work in the past 12 months**

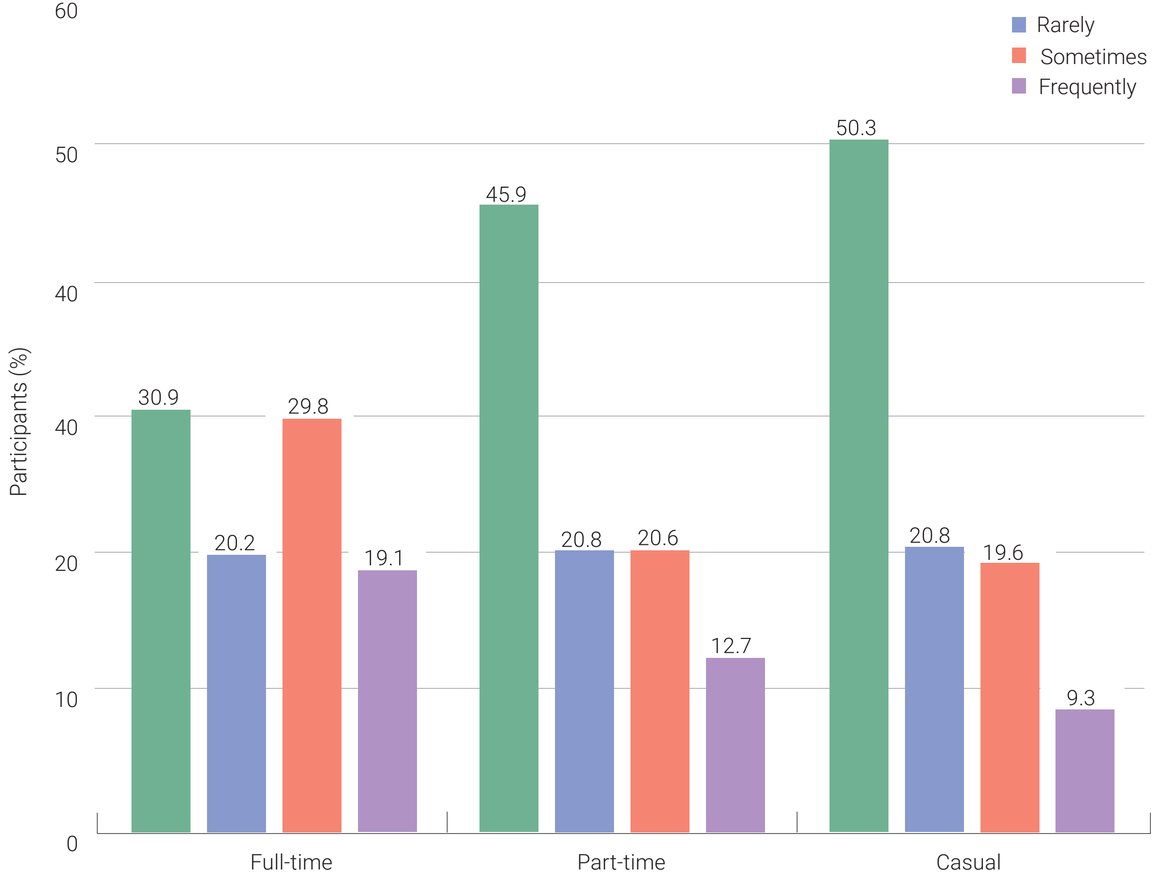


Figure 18 below shows how the experience of hearing negative remarks specifically relating to gender identity or gender expression varied according to work context. It shows that almost half (48.9%; n = 87) of participants engaged in full-time employment reported sometimes or frequently hearing negative language regarding gender identity or gender expression, at work in the past 12 months, followed by one-third (33.3%; n = 343) in part-time and almost three-tenths (28.9%; n = 614) in casual employment.

7.4 Frequency of days of work missed in the past 12 months

Participants were asked how many days of work they had missed due to feeling unsafe or uncomfortable in the past 12 months. The wording of the question was tailored to those engaged in full-time (n = 206), part-time (n = 1,174), and casual (n = 2,317) work. Results are displayed in Table 32.

One-tenth of participants engaged in full-time (10.0%; n = 17), 8.4% (n = 79) in part-time, and 6.5% (n = 126) in casual employment reported missing day/s at their work setting in the past 12 months because they felt unsafe or uncomfortable. This was more than three times lower than the one-third of secondary school (38.4%; n = 1,404) and TAFE (34.4%; n = 90) students, and markedly lower than the 17.2% (n = 247) of university students that reported missing day/s at their educational setting in the past 12 months because they felt unsafe or uncomfortable.

Table 32 **Frequency of days missed at their work setting in the past 12 months due to feeling unsafe or uncomfortable**

	Full-time		Part-time		Casual		Total	
Missed any day/s of work (n = 3,197)	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
No	153	90.0	864	91.6	1,826	93.5	2,950	92.3
Yes	17	10.0	79	8.4	126	6.5	247	7.7

37.9%

of participants reported sometimes or frequently hearing negative remarks regarding sexuality in their workplace in the past 12 months

7.5 Awareness of bullying policies in the workplace

Participants in employment were asked if they knew if their workplace had a bullying policy, and if it covered LGBTIQA+ people. Table 33 presents the responses.

Two-thirds (62.9%; n = 129) of participants working full-time reported knowing if their workplace had a bullying policy, compared to slightly less than half (48.0%; n = 560) of those in part-time or casual employment (47.6%; n = 1,100).

Participants who reported their workplace had a bullying policy were asked if they knew whether the bullying policy specifically mentioned issues of particular importance to LGBTIQA+ young people. Responses are displayed in Table 34.

A large proportion of participants (44.0%) were unaware of the contents of bullying policy in their workplace.

Among participants who reported their place of employment had a bullying policy, two-fifths (40.3%; n = 52) of participants engaged in full-time employment responded that they were aware it covered all aspects of LGBTIQA+, followed by three-tenths of those engaged in part-time (28.6%; n = 160) or casual (29.8%; n = 327) employment.

In contrast to the three-tenths (29.8%; n = 743) of secondary school participants who reported their educational institution had a bullying policy and said that they did not think it included mention of LGBTIQA+ people, one-tenth (10.0%; n = 185) of participants engaged in employment said that they did not think their workplace bullying policy included mention of LGBTIQA+ people. It should be noted that not all young people would be aware of the contents of organisational policy, but an awareness of if or how it relates to LGBTIQ people may be affirming.

7.6 Summary

A third of participants reported that they had felt unsafe of uncomfortable in their workplace in the past 12 months due to their sexuality and/or gender identity. This proportion is lower than that in educational settings. One tenth of those in full-time employment reported missing days of work in the past 12 months because they felt unsafe or uncomfortable. Just over half (56.2%) of participants engaged in full-time employment reported that they could safely openly identify as LGBTIQA+ at work, a proportion that was lower among those in part-time or casual employment. Over half (55.5%) of participants engaged in full-time employment reported in the past 12 months at work sometimes or frequently hearing negative language regarding sexuality. Approximately half of participants in employment were not aware whether their workplace had anti-bullying policies.

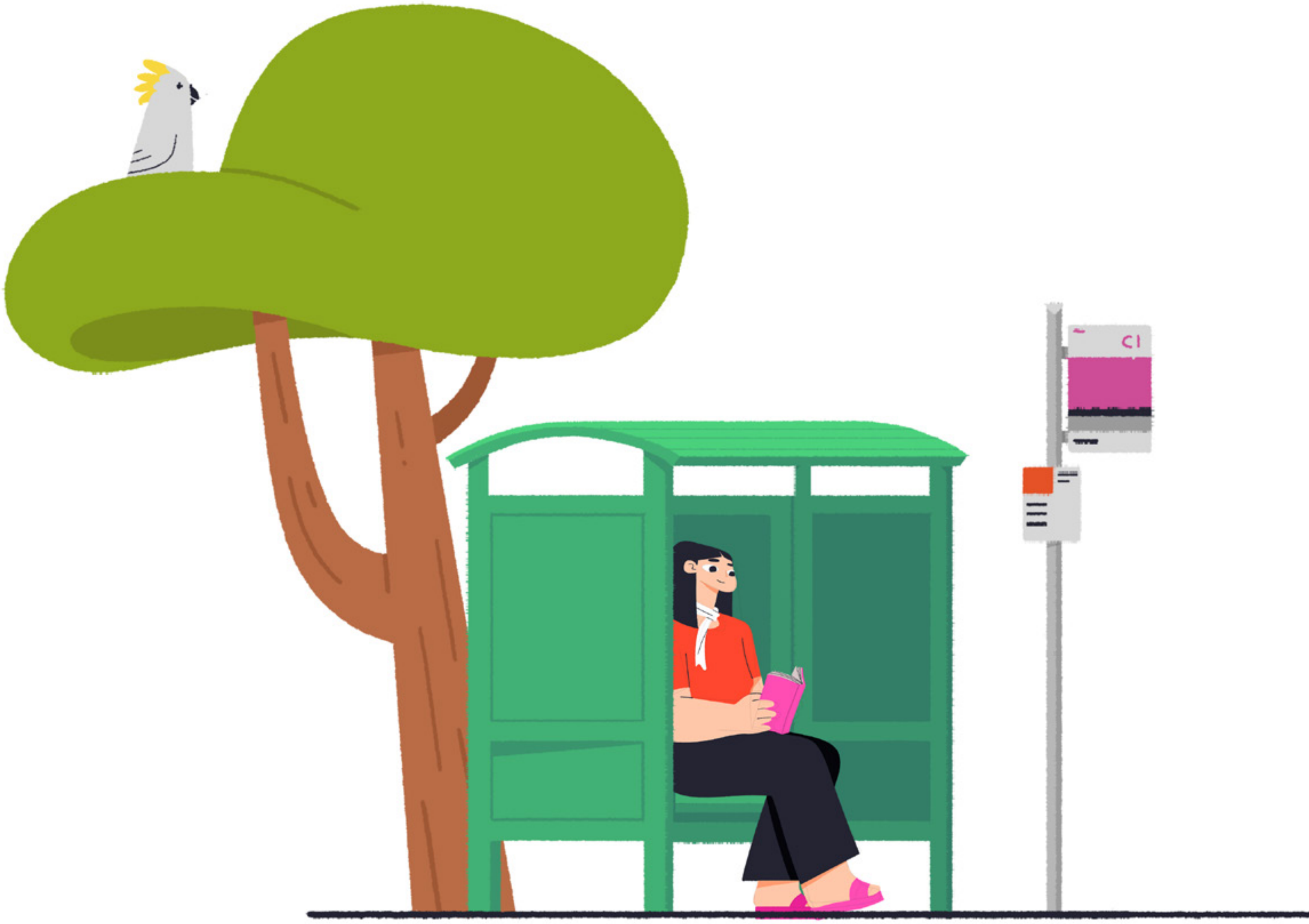
Table 33 Awareness of work bullying policy

	Full-time		Part-time		Casual		Total	
Knowledge of any bullying policy (n = 3,851)	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
No	26	12.7	253	21.7	417	18.0	741	19.2
Yes	129	62.9	560	48.0	1,100	47.6	1,855	48.2
Don't know	50	24.4	353	30.3	796	34.4	1,255	32.6

Table 34 Awareness of the contents of workplace bullying policies

	Full-time		Part-time		Casual		Total	
Bullying policy areas (n = 1,851)	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Sexuality	31	24.0	82	14.7	162	14.8	279	15.1
Gender identity	18	14.0	50	8.9	110	10.0	183	9.9
Intersex variation/s	0	0.0	2	0.4	3	0.3	5	0.3
All aspects of LGBTIQA+	52	40.3	160	28.6	327	29.8	567	30.6
No aspects of LGBTIQA+	10	7.8	68	12.2	98	8.9	185	10.0
Don't know	35	27.1	248	44.4	507	46.2	814	44.0

8 Experiences of harassment or assault



Research in Australia and internationally has observed that young LGBT people experience frequent harassment based on their sexuality or gender identity, and that this occurs most at school (3). Young LGBT people who experience harassment based on their sexuality or gender identity face higher risk of suicidal ideation and behaviours, and are more likely to miss school to avoid further harassment (3,35).

The experience of harassment and assault can take many forms. In *Writing Themselves In 4* we have sought to increase our understanding of the experiences LGBTQA+ young people by exploring not only the nature of harassment and assault but also where such acts occurred, their perpetrators and the experience of accessing professional support or advice in response or as a consequence.

8.1 Experiences of harassment or assault based on sexuality or gender identity

Participants were asked if in the past 12 months or ever in their lifetime they had experienced any of the following forms of harassment or assault based on their sexuality or gender identity:

- Verbal (e.g. been called names or threatened)
- Physical (e.g. being shoved, punched, or injured with a weapon)
- Sexual (e.g. unwanted touching, sexual remarks, sexual messages or being forced to perform any unwanted sexual act)

In total, 6,179 participants responded to questions regarding experiences of verbal harassment, 5,461 participants responded to questions regarding experiences of physical harassment or assault, and 5,588 participants responded to questions regarding experiences of sexual harassment or assault. Figure 19 displays their responses.

In the past 12 months, two-fifths (40.8%; n = 2,524) of participants had experienced verbal harassment, almost one-quarter (22.8%; n = 1,273) sexual harassment or assault, and almost one-tenth (9.7%; n = 529) physical harassment or assault based on their sexuality or gender identity.

Writing Themselves In 3 (3) asked participants about lifetime experiences of verbal and physical harassment or assault based on sexuality, but did not ask participants about experiences of harassment or assault in the past 12 months. Nonetheless, in *Writing Themselves In* 3, 61% reported ever experiencing verbal harassment and 18% physical harassment or assault based on their sexuality or gender identity (3), which is comparable to the proportion of participants reporting ever experiencing verbal harassment (57.6%; n = 3,559) or physical harassment or assault (15.4%; n = 839) in *Writing Themselves In 4*.

In total, among participants who indicated a gender identity, 6,023 participants responded to questions regarding experiences of verbal harassment, 5,319 participants responded to questions regarding experiences of physical harassment or assault, and 5,446 participants responded to questions regarding experiences of sexual harassment or assault in the past 12 months. Figure 20 displays their responses.

Trans and non-binary participants reported higher rates of verbal, physical, and sexual harassment or assault in the past 12 months, based on their sexuality or gender identity, than cisgender men or cisgender women. Nearly three-quarters (71.2%; n = 52) of trans women and 63.3% (n = 252) of trans men reported experiencing in the past 12 months verbal harassment based on their sexuality or gender identity, followed by over half (52.8%; n = 619) of non-binary participants, 45.0% (n = 607) of cisgender men, and 30.2% (n = 915) of cisgender women.

Figure 19 Experienced verbal, physical, and sexual harassment or assault based on sexuality or gender identity

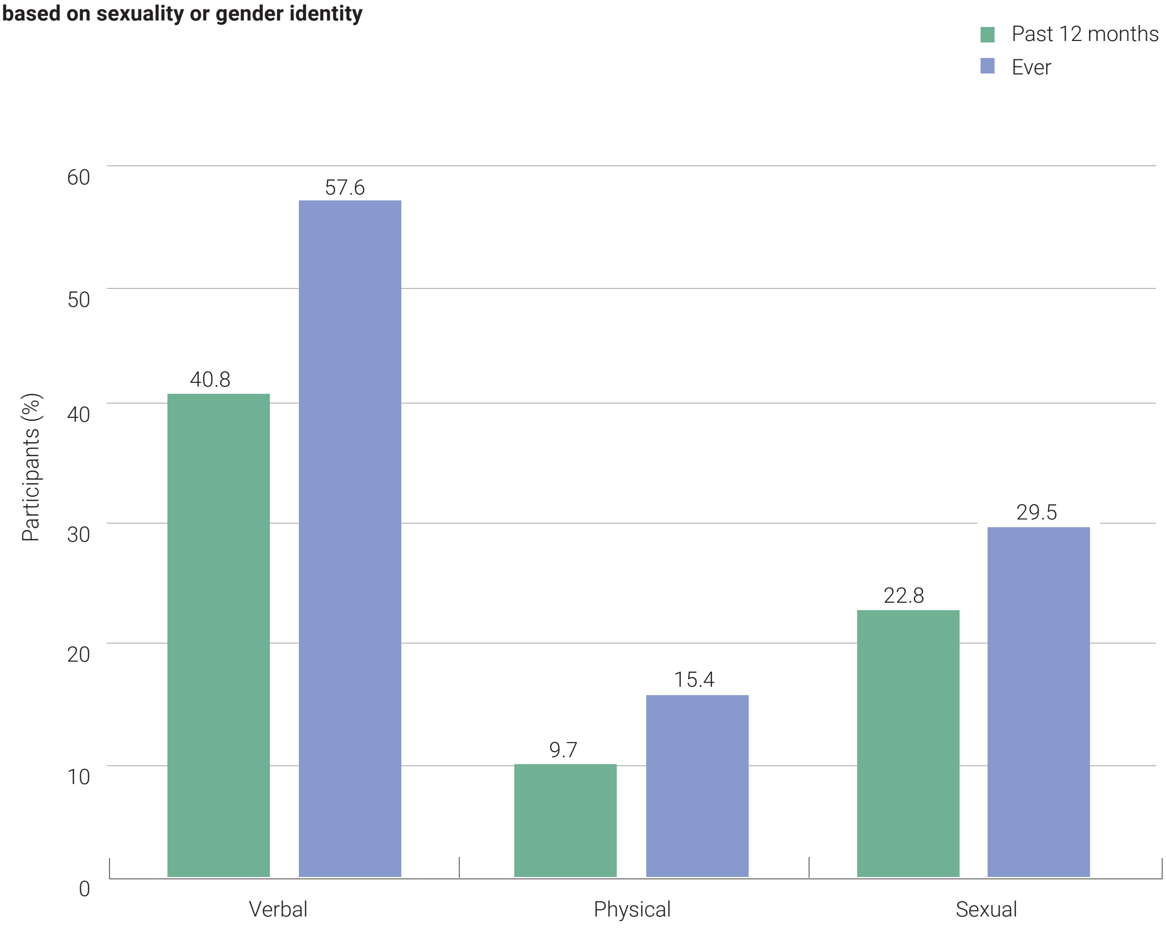


Figure 20 **Experienced verbal, physical, and sexual harassment or assault based on sexuality or gender identity, in the past 12 months, by gender**

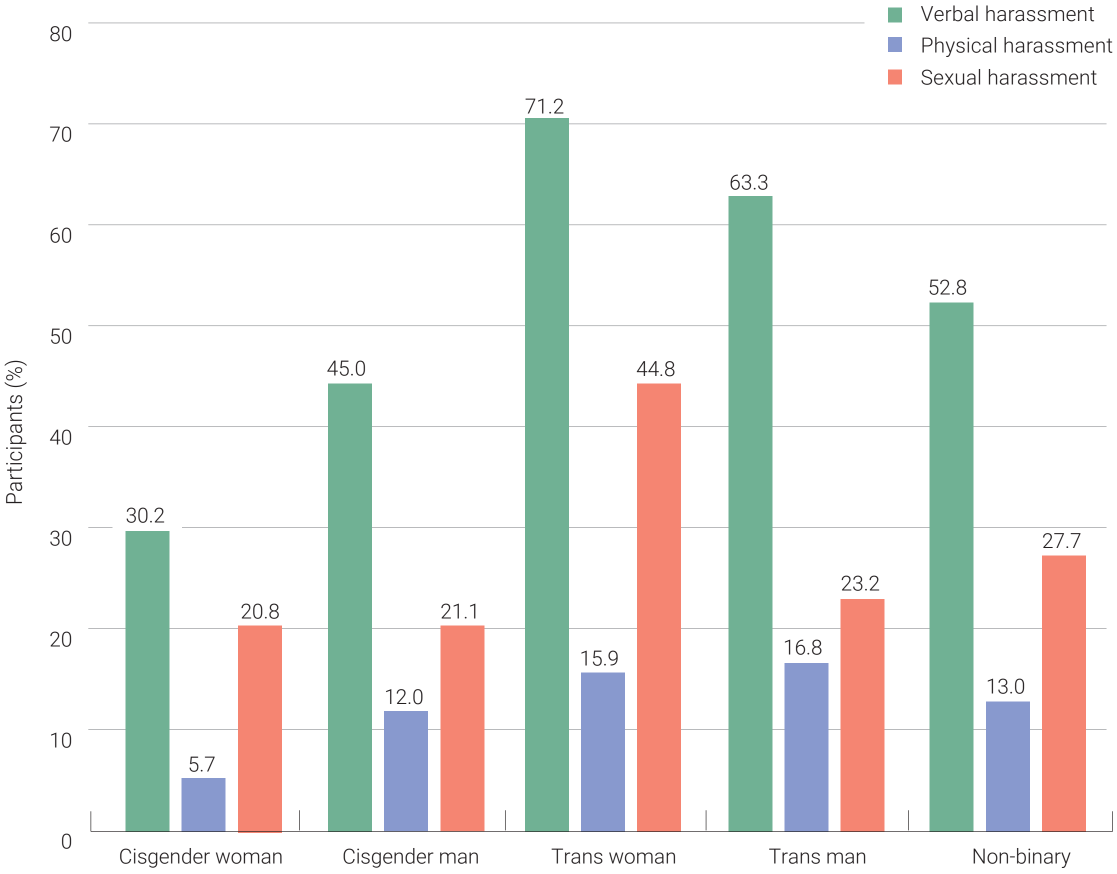
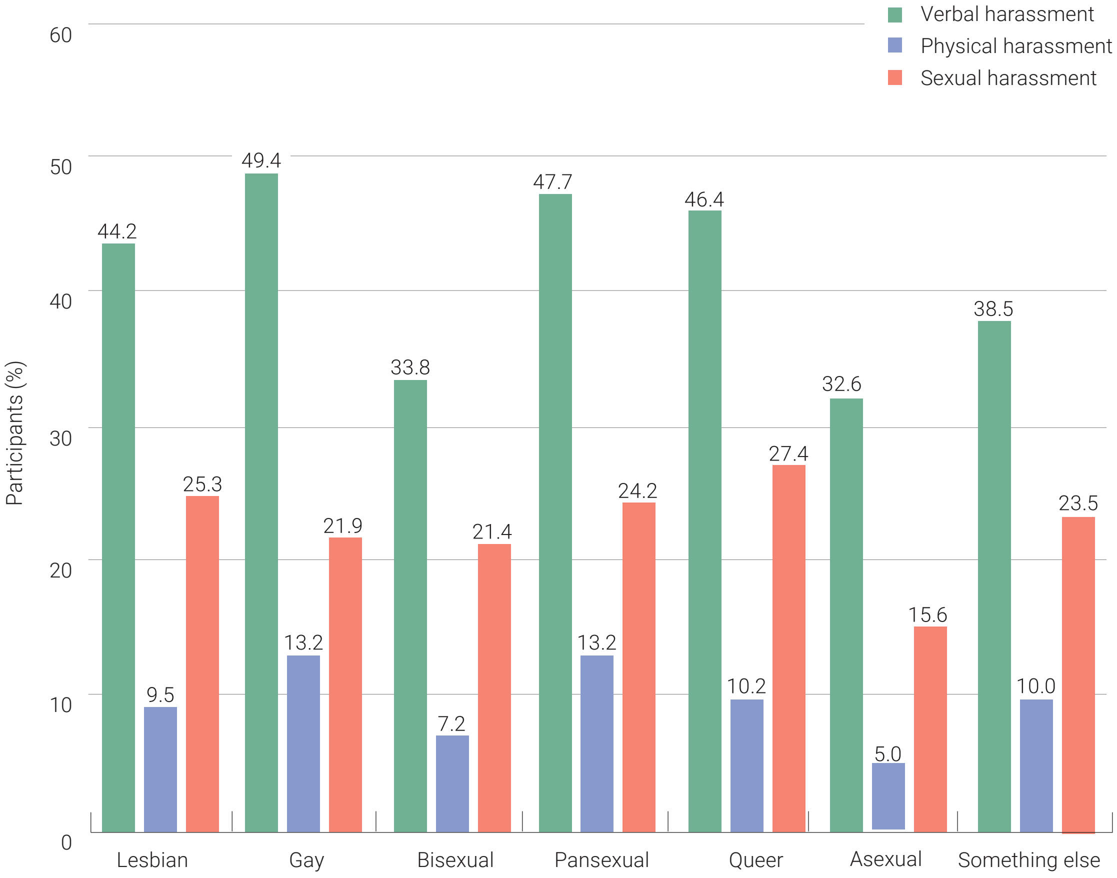


Figure 21 **Experienced verbal, physical, and sexual harassment or assault based on sexuality or gender identity, in the past 12 months, by sexuality**



Cisgender women, compared to other gender identities, reported lower levels of physical harassment or assault in the past 12 months, based on their sexuality or gender identity. Nearly a third (30.2%) had experienced verbal harassment and a fifth (20.8%) had experienced sexual harassment or assault.

More than two-fifths (44.8%; n = 30) of trans women reported experiencing sexual harassment or assault in the past 12 months, based on their sexuality or gender identity, approximately twice the proportion of other gender identities.

In total, among participants who indicated a sexuality, 6,169 participants responded to questions regarding experiences of verbal harassment, 5,451 participants responded to questions regarding experiences of physical harassment or assault, and 5,578 participants responded to questions regarding experiences of sexual harassment or assault in the past 12 months. Figure 21 displays their responses.

Gay and pansexual participants reported the highest levels of verbal and physical harassment or assault in the past 12 months, based on their sexuality or gender identity. Queer and lesbian participants reported the highest levels of sexual harassment or assault, in the past 12 months, based on their sexuality or gender identity.

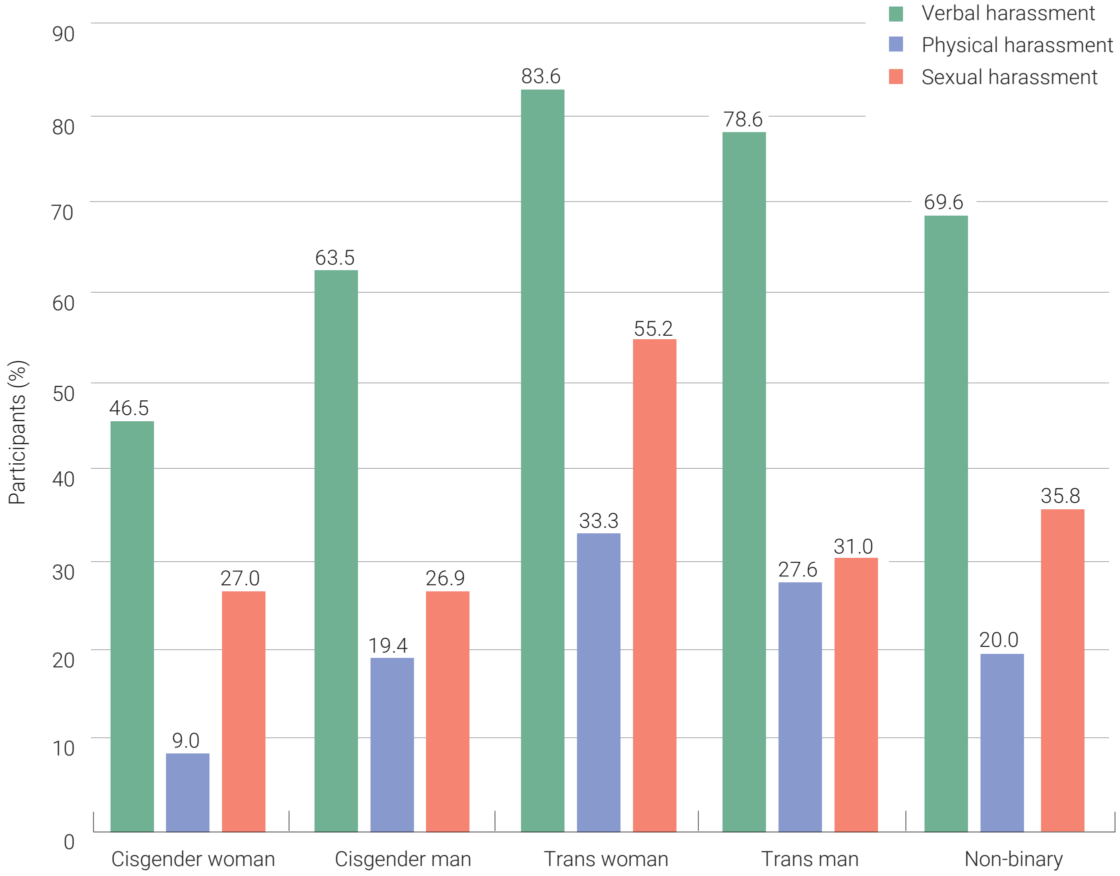
Bisexual and asexual participants reported lower levels of verbal, physical, and sexual harassment or assault in the past 12 months, based on their sexuality or gender identity, compared to other sexual identities. This may be related to their lower levels of disclosure regarding their sexuality or gender identity (see Chapter 4).

In total, among participants who indicated a gender identity, 6,023 responded to questions regarding experiences of verbal harassment, 5,319 participants responded to questions regarding experiences of physical harassment or assault, and 5,446 participants responded to questions regarding experiences of sexual harassment or assault ever in their lifetime. Figure 22 displays their responses.

Trans and non-binary participants reported higher rates of ever in their lifetime experiencing verbal, physical, and sexual harassment or assault based on their sexuality or gender identity, compared to cisgender men or cisgender women. Approximately four-fifths (83.6%; n = 61) of trans women and trans men (78.6%; n = 313) reported ever experiencing verbal harassment based on their sexuality or gender identity, followed by seven-tenths (69.6%; n = 816) of non-binary participants, almost two-thirds (63.5%; n = 856) of cisgender men, and 46.5% (n = 1,409) of cisgender women.

Cisgender women reported lower levels than other gender identities of ever in their lifetime experiencing physical harassment or assault based on their sexuality or gender identity.

Figure 22 Ever experienced verbal, physical, and sexual harassment or assault based on sexuality or gender identity, by gender



Participants reported experiencing verbal and physical harassment or assault based on their sexuality or gender identity most frequently at an educational institution

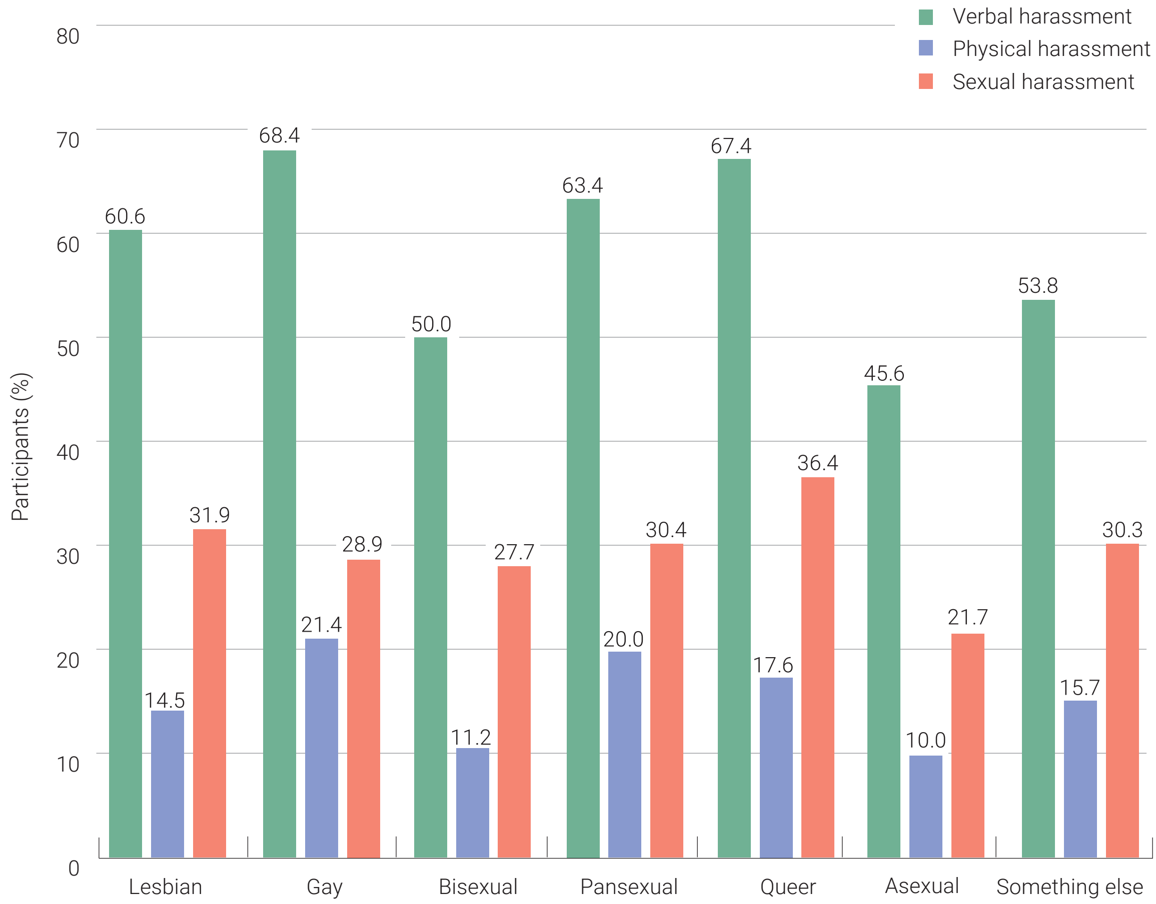
More than half (55.2%; n = 37) of trans women reported having ever experienced sexual harassment or assault based on their sexuality or gender identity. This was almost two times that of cisgender women (27.0%; n = 739) and cisgender men (26.9%; n = 322).

In total, among participants who indicated a sexuality, 6,169 participants responded to questions regarding experiences of verbal harassment, 5,451 participants responded to questions regarding experiences of physical harassment or assault, and 5,578 participants responded to questions regarding experiences of sexual harassment or assault ever in their lifetime. Figure 23 displays their responses.

Bisexual and asexual participants reported lower levels than other sexualities of ever in their lifetime experiencing verbal, physical, and sexual harassment or assault based on their sexuality or gender identity. This may be related to their lower levels of disclosure regarding their sexuality or gender identity (see Chapter 4).

Gay, pansexual and queer participants reported the highest levels of ever in their lifetime experiencing verbal and physical violence harassment or assault based on their sexuality or gender identity. Queer and lesbian participants reported the highest levels of ever in their lifetime experiencing sexual harassment or assault based on their sexuality or gender identity.

Figure 23 **Ever experienced verbal, physical, and sexual harassment or assault based on sexuality or gender identity, by sexuality**



8.2 Experiences of harassment or assault based on sexuality or gender identity, in the past 12 months, by setting

Participants who reported having in the past 12 months experienced verbal, physical, or sexual harassment or assault based on their sexuality or gender identity were asked to indicate where these experiences had occurred. They were presented with the following list of locations and could select all those that applied:

- Educational institution (e.g. school, university, TAFE)
- Home
- Public (e.g. transport, street)
- Sport
- Work
- Somewhere else
- None

Note that the analysis of responses was contingent upon their answers to prior questions about their background. For example, educational institution was analysed among participants who reported being at an educational institution in the past 12 months, sport was analysed among participants who reported participating in sport in the past 12 months, and work was analysed among participants who reported working in the past 12 months.

- Verbal harassment was analysed among 5,889 participants at an educational institution in the past 12 months, 3,925 participants participating in sport in the past 12 months, and 3,726 participants working in the past 12 months.
- Physical harassment or assault was analysed among 5,205 participants at an educational institution in the past 12 months, 3,455 participants participating in sport in the past 12 months, and 3,287 participants working in the past 12 months.
- Sexual harassment or assault was analysed among 5,322 participants at an educational institution in the past 12 months, 3,543 participants participating in sport in the past 12 months, and 3,375 participants working in the past 12 months.

Table 35 displays their responses (participants may have had experienced harassment or assault at more one than one setting and percentages do not add up to 'one or more of the above').

Participants reported experiencing verbal and physical harassment or assault based on their sexuality or gender identity most frequently at an educational institution.

One-fifth (21.2%; n = 1,250) of participants reported experiencing verbal harassment, based on their sexuality or gender identity, at an educational institution, followed by 18.3% (n = 1,125) in public, 10.3% (n = 637) at home, 4.9% (n = 183) at work, 1.8% (n = 71) at sport, and 8.3% (n = 511) somewhere else.

Approximately one-twentieth (4.7%; n = 245) reported experiencing physical harassment or assault, based on their sexuality or gender identity, at an educational institution, followed by 3.4% (n = 185) in public, 2.3% (n = 127) at home, 0.5% (n = 17) at work, 0.5% (n = 15) at sport, and 1.6% (n = 87) somewhere else.

Almost one-tenth (8.5%; n = 473) reported experiencing sexual harassment or assault, based on their sexuality or gender identity, in public, followed by 6.7% (n = 358) at an educational institution, 3.5% (n = 117) at work, 2.0% (n = 109) at home, 0.4% (n = 13) at sport, and 10.2% (n = 567) somewhere else.

Table 35 **Experiences of verbal, physical, and sexual harassment or assault based on sexuality or gender identity, in the past 12 months, by setting**

	Verbal (n = 6,178)		**Physical** (n = 5,461)		**Sexual** (n = 5,588)	
Setting	**n**	**%**	**n**	**%**	**n**	**%**
Educational institution	1,250	21.2	245	4.7	358	6.7
Home	637	10.3	127	2.3	109	2.0
Public	1,125	18.3	185	3.4	473	8.5
Sport	71	1.8	17	0.5	13	0.4
Work	183	4.9	15	0.5	117	3.5
Somewhere else	511	8.3	87	1.6	567	10.2
One or more of the above	2,524	40.8	529	9.7	1,273	22.8

8.3 Experiences of harassment or assault based on sexuality or gender identity, in the past 12 months, at an educational setting

A much higher proportion of participants at secondary school reported experiencing harassment or assault based on their sexuality or gender identity, occurring at their educational setting, compared to those at TAFE or university, as displayed in Figure 24.

In the past 12 months, over one-quarter (28.1%; n = 1,037) of participants at secondary school experienced verbal harassment based on their sexuality or gender identity at their educational institution. This was approximately **three times** the 9.5% (n = 35) of participants at TAFE and **four times** the 7.2% (n = 107) or participants at university.

Similarly, in the past 12 months, 6.7% (n = 216) of participants at secondary school experienced physical harassment or assault based on their sexuality or gender identity at their educational institution. This was **more than five times** the 1.3% (n = 4) of participants at TAFE and **almost 10 times** the 0.7% (n = 9) participants at university.

Overall, in the past 12 months, 8.6% (n = 283) of participants at secondary school experienced sexual harassment or assault based on their sexuality or gender identity at their educational institution. This was higher than the 5.2% (n = 39) of participants at TAFE and **more than twice** the 2.8% (n = 39) of participants at university.

Figure 25 (shown on next page) displays the number of participants who experienced verbal, physical, and sexual harassment or assault based on their sexuality or gender identity, in the past 12 months at an educational institution, by gender.

Trans women, trans men, non-binary participants and cisgender men reported higher rates than cisgender women of experiencing verbal, physical, and sexual harassment or assault based on their sexuality or gender identity, in the past 12 months at their educational institutions. Approximately one-third (34.3%; n = 25) of trans women and three-tenths of trans men (29.2%; n = 116) reported experiencing verbal harassment based on their sexuality or gender identity, in the past 12 months at their educational institution, followed by one-quarter (24.5%; n = 287) of non-binary participants and cisgender men (24.9%; n = 336), and 15.0% (n = 454) of cisgender women.

Cisgender women (2.7%; n = 71) reported lower levels than other gender identities of ever in their lifetime experiencing physical harassment or assault based on their sexuality or gender identity, at an educational institution.

In total, 14.9% (n = 10) of trans women reported having ever experienced sexual harassment or assault based on their sexuality or gender identity, at an educational institution. This was almost two times that of other genders.

Figure 24 Experienced verbal, physical, and sexual harassment or assault based on sexuality or gender identity, in the past 12 months at an educational institution, by educational setting

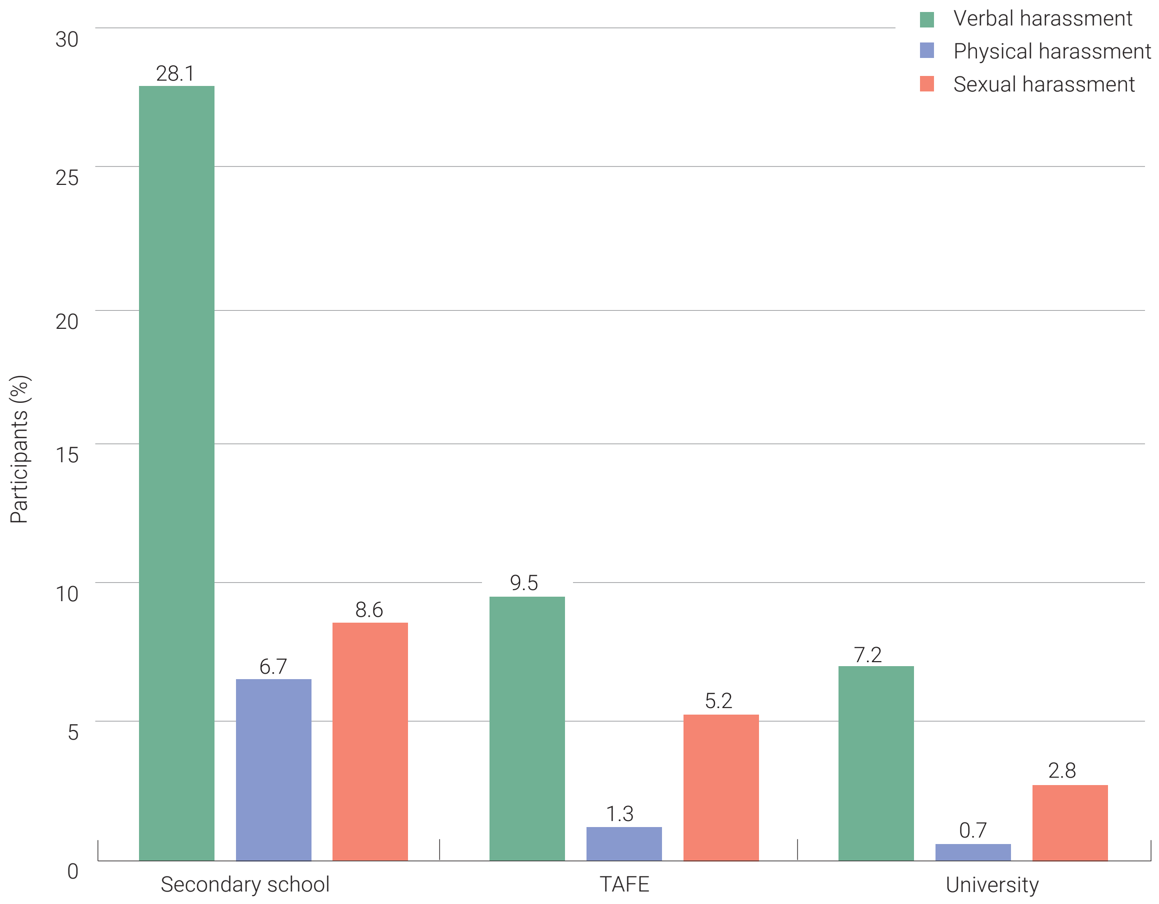


Figure 25 **Experienced verbal, physical, and sexual harassment or assault based on sexuality or gender identity, in the past 12 months at an educational institution, by gender**

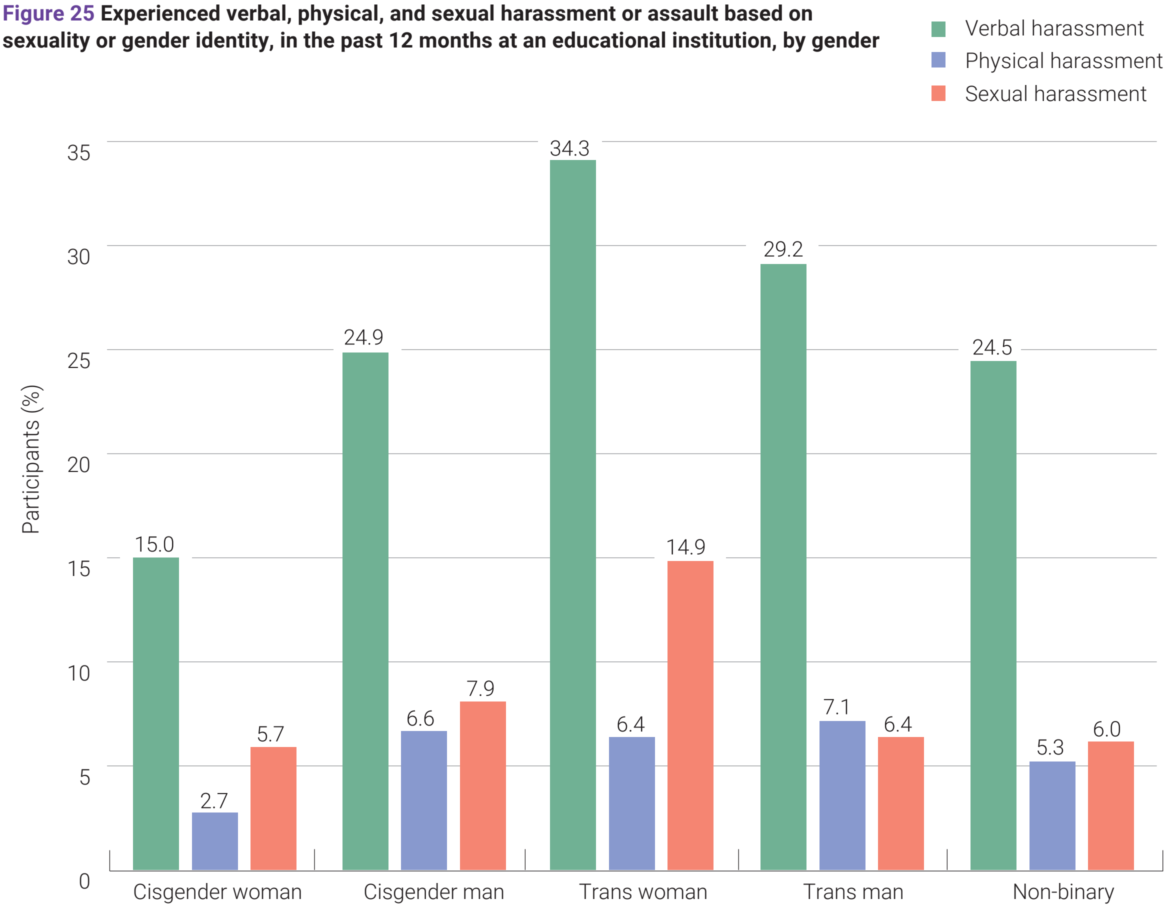


Figure 26 **Experienced verbal, physical, and sexual harassment or assault based on sexuality or gender identity, in the past 12 months at an educational institution, by sexuality**

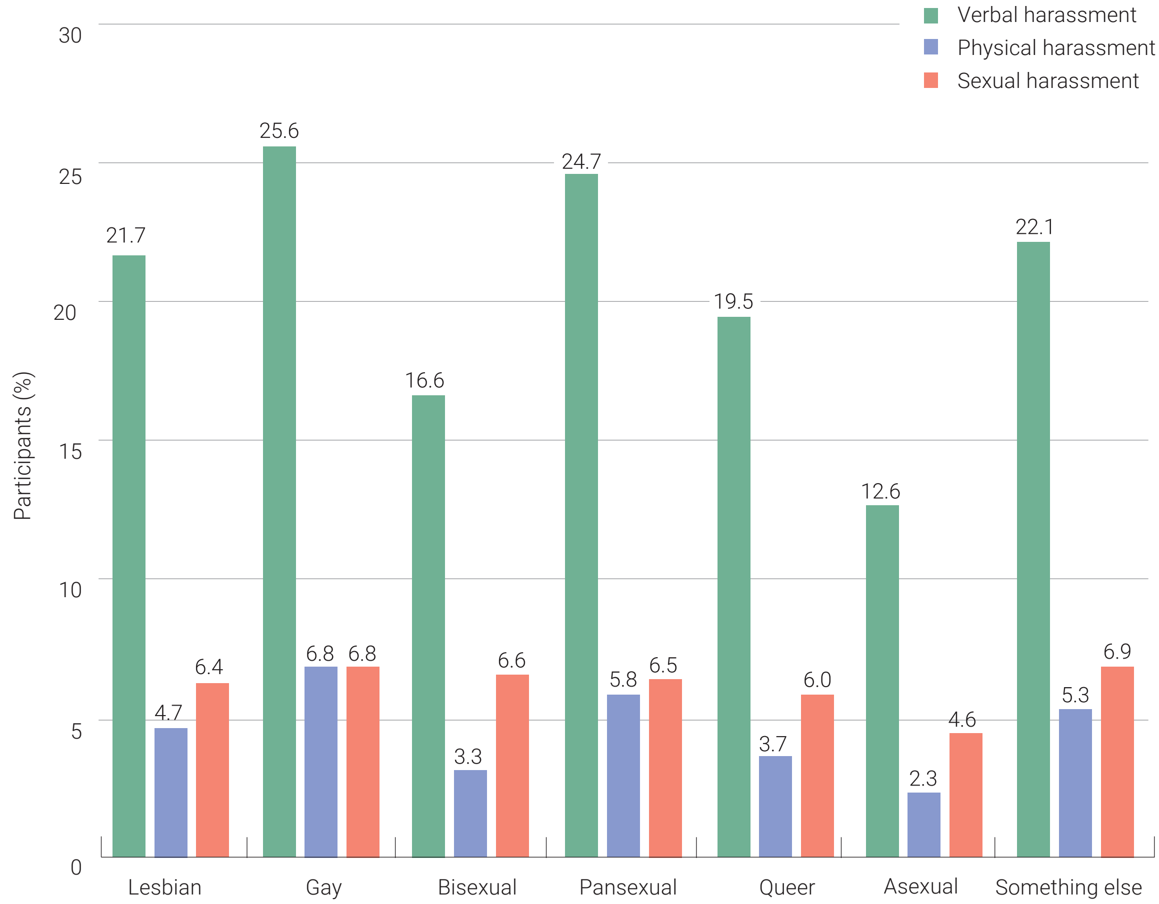


Figure 26 displays the number of participants who experienced verbal, physical, and sexual harassment or assault based on their sexuality or gender identity, in the past 12 months at an educational institution, by sexuality.

Compared to participants of other sexualities, bisexual and asexual participants reported lower levels of experiencing verbal, physical, and sexual harassment or assault based on their sexuality or gender identity, in the past 12 months at their educational institutions. This may be related to their lower levels of disclosure regarding their sexuality or gender identity (see Chapter 4).

Gay and pansexual participants reported the highest levels of verbal and physical harassment or assault based on their sexuality or gender identity, in the past 12 months at their educational institutions. Gay, pansexual and lesbian participants reported the highest levels of sexual harassment or assault based on their sexuality or gender identity, in the past 12 months at their educational institutions.

28.1%

of participants at secondary school experienced verbal harassment based on their sexuality or gender identity in the last 12 months at their educational setting.

8.4 Harassment or assault perpetrators

After being asked where it occurred, those participants who experienced one or more forms of harassment or assault were asked who was the perpetrator of this act or these acts. The response options presented were tailored to each context.

8.4.1 Perpetrators of harassment or assault in educational settings

Participants who reported having experienced harassment or assault based on their sexuality or gender identity, in the past 12 months at an educational institution (n = 1,398) were asked who was the perpetrator/s. Table 36 displays the results. Multiple responses were permitted.

Table 36 Perpetrators of harassment or assault based on their sexuality or gender identity, in educational settings in the past 12 months

Perpetrator (n = 1,398)	**n**	**%**
Student/s from my year	1,158	82.8
Student/s from another year	636	45.5
Teacher/s	107	7.7
Principal or executive team	26	1.9
School nurse or counsellor	15	1.1
Other school staff	11	0.8
Someone else	92	6.6
Prefer not to say	66	4.7

Among participants who reported having experienced harassment or assault based on their sexuality or gender identity, at an educational institution in the past 12 months, four-fifths (82.8%; n = 1,158) reported the perpetrator as a student/s from their year, more than two-fifths (45.5%; n = 636) a student/s from another year, and 7.7% (n = 107) a teacher.

8.4.2 Perpetrators of harassment or assault at work

Those who had experienced harassment or assault based on their sexuality or gender identity, at work in the past 12 months (n = 269) were asked to indicate the perpetrator/s. Results are shown in Table 37. Multiple responses were permitted.

Table 37 Perpetrators of harassment or assault based on their sexuality or gender identity, at work in the past 12 months

Perpetrator (n = 269)	**n**	**%**
Customer/visitor	132	49.1
Co-worker	120	44.6
Manager	59	21.9
Other staff member	26	9.7
Someone else	14	5.2
Prefer not to say	12	4.5

Among participants who reported experiencing harassment or assault based on their sexuality or gender identity, at work in the past 12 months, almost half (49.1%; n = 132) reported the perpetrator as a customer or visitor, over two-fifths (44.6%; n = 120) a co-worker, one-fifth (21.9%; n = 59) a manager, and one-tenth (9.7%; n = 26) another staff member.

8.4.3 Perpetrators of harassment or assault in the home

Those who had experienced harassment or assault based on their sexuality or gender identity, in the home in the past 12 months (n = 712) were asked to indicate the perpetrator/s. Results are shown in Table 38. Multiple responses were permitted.

Table 38 Perpetrators of harassment or assault based on their sexuality or gender identity, in the home in the past 12 months

Perpetrator (n = 712)	**n**	**%**
Parent/carer	412	57.9
Sibling	230	32.3
Grandparent/s	78	11.0
Older relative (uncle, aunt)	72	10.1
Partner of parent/carer	52	7.3
Friends of carers/parents	40	5.6
Someone else	92	12.9
Prefer not to say	72	10.1

Among participants who reported experiencing harassment or assault based on their sexuality or gender identity, at home in the past 12 months, almost three-fifths (57.9%; n = 412) reported the perpetrator as a parent or carer, one-third (32.3%; n = 230) a sibling, and one-tenth a grandparent or grandparents (11.0%; n = 78) or older relative (10.1%; n = 72).

8.4.4 Perpetrators of harassment or assault in sporting contexts

Those who had experienced harassment or assault based on their sexuality or gender identity, in sporting contexts in the past 12 months (n = 95) were asked to indicate the perpetrator/s. Results are shown in Table 39. Multiple responses were permitted.

Table 39 Perpetrators of harassment or assault based on their sexuality or gender identity, in sporting contexts in the past 12 months

Perpetrator (n = 95)	**n**	**%**
Player from my team	61	64.2
Player from another team	49	51.6
Spectator/s	20	21.1
Coach/es	16	16.8
Parent/carer	7	7.4
Teacher/s	6	6.3
School nurse or counsellor/s	3	3.2
Other school staff	3	3.2
Someone else	9	9.5
Prefer not to say	6	6.3

Among participants who reported experiencing harassment or assault based on their sexuality or gender identity, at sport in the past 12 months, almost two-thirds (64.2%; n = 61) reported the perpetrator was a player/s from their team, one-half (51.6%; n = 49) student/s from another year/player from another team, one-fifth spectator/s (21.1%; n = 20), and 16.8% (n = 16) coach/es.

8.5 Experiences of accessing support regarding harassment or assault

Participants reporting any verbal, physical or sexual harassment or assault based on their sexuality or gender identity, in the past 12 months, were asked if they received any help or support dealing with this in the past 12 months (multiple responses were permitted).

Table 40 Received any help or support in dealing with harassment or assault based on sexuality or gender identity, in the past 12 months

Help or support provider (n = 2,922)	**n**	**%**
LGBTIQA+ friends I have met in real life	1,081	37.0
Non-LGBTIQA+ friends	879	30.1
LGBTIQA+ friends I have never met in real life	545	18.7
Parent/s or carer/s	348	11.9
Teacher/s	248	8.5
GP or medical service	205	7.0
Other family member/s	176	6.0
Manager or co-worker	62	2.1
Police	59	2.0
Someone else	143	4.9
No, I didn’t receive help from anyone	1,153	39.5

In total, two-fifths (39.5%; n = 1,153) of participants who reported verbal, physical or sexual harassment or assault based on their sexuality or gender identity, in the past 12 months, did not receive any help or support in dealing with these experiences.

Where help or support was received, participants reported that friends were their main source. Specifically, over one-third (37.0%; n = 1,081) received help or support from LGBTIQA+ friends they met in real life, three-tenths (30.1%; n = 879) from non-LGBTIQA+ friends, and almost one-fifth (18.7%; n = 545) from LGBTIQA+ friends they connect with online but have never met in real life.

Fewer participants reported receiving support or help from a parent/parents or a carer/carers, or from authority figures. Specifically, one-tenth (11.9%; n = 348) received help or support from a parent/parents or a carer/carers, 8.5% (n = 248) from teachers, and 7.0% (n = 205) from a GP or medical service.

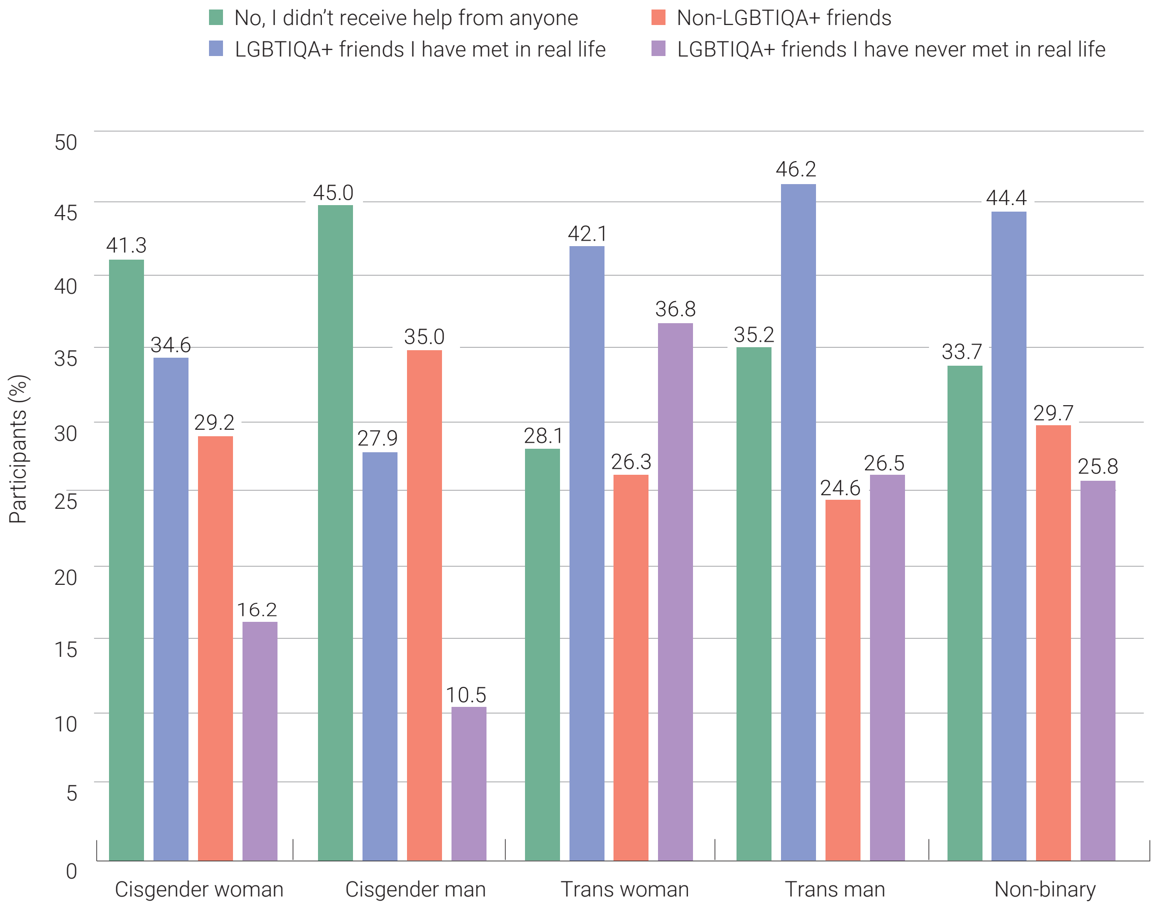
Figure 27 displays the responses of 2,836 participants who indicated if they received any help or support dealing with this in the past 12 months, by gender.

In total, more than two-fifths (45.0%; n = 305) of cisgender men who reported verbal, physical or sexual harassment or assault based on their sexuality or gender identity, in the past 12 months, did not receive any help or support with these experiences. This compares to 41.3% (n = 477) of cisgender women, 35.2% (n = 93) of trans men, 33.7% (n = 230) of non-binary participants, and 28.1% (n = 16) of trans women.

Trans and gender diverse participants reported receiving more support from LGBTIQA+ friends they have met in real life, while cisgender women and cisgender men reported receiving more support from non-LGBTIQA+ friends, compared to other groups.

Twice the proportion of trans men (11.4%; n = 30), trans women (10.5%; n = 6) and non-binary participants (8.8%; n = 60) received help or support from a GP or medical service, compared to the proportion of cisgender men (4.4%; n = 30). This may reflect the higher frequency with which trans and gender diverse participants visit GPs and medical services, as well as the higher proportion of trans and gender diverse participants using LGBTIQA+-specific health services.

Figure 27 **Received help or support in dealing with harassment or assault based on sexuality or gender identity, in the past 12 months, by gender**



8.6 Summary

A large proportion (40.8%) of participants reported experiencing verbal harassment based on their sexuality or gender identity, in the past 12 months; while almost one-quarter experienced sexual harassment or assault and almost one-tenth physical harassment or assault based on their sexuality or gender identity, in the past 12 months. While the last iteration of *Writing Themselves In* did not ask about such experiences in the past 12 months, the proportion reporting having ever had such experiences is similar to that observed in 2010. The number of participants experiencing verbal, physical and/or sexual harassment or assault was highest among trans and gender diverse participants.

In terms of the settings in which harassment based on sexuality or gender identity occurred, over a quarter experienced verbal harassment at secondary school, and a markedly lower proportion of participants at TAFE or university. Similarly, the number of participants who experienced physical harassment or assault based on their sexuality or gender identity was highest among those at secondary school, compared to those at TAFE or university. Overall, in the past 12 months at their educational institution, 8.6% of participants at secondary school experienced sexual harassment or assault based on their sexuality or gender identity, higher than was the case for those at TAFE or university. The perpetrators of such harassment or assault in educational settings were most commonly other students from their year or another year, while a small proportion of participants reported it was a teacher.

Around one in ten participants reported experiencing verbal harassment in the home, with smaller proportions having experienced physical or sexual harassment or assault based on their sexuality or gender identity, in the past 12 months. Among those who reported any of these experiences in the home, the most commonly identified perpetrator was a parent or carer, followed by siblings and grandparents. Nearly one in five participants reported experiencing verbal harassment in public, while close to one in ten had experienced sexual harassment or assault in this context within the past 12 months. A relatively small proportion of participants had experienced any form of harassment or assault, based on their sexuality or gender identity, in sport, although it should be noted that a large number of those engaging in sport previously stated they had not disclosed their sexuality or gender identity within sporting contexts.

In total, two-fifths (39.5%) of participants who reported any verbal, physical or sexual harassment or assault based on their sexuality or gender identity, in the past 12 months, did not receive any help or support in dealing with it from anyone in the past 12 months.

9 Mental health and wellbeing

There is a substantial body of research observing significant differences between the health of mental health and wellbeing of LGBT communities and the general population (36–40). Poorer mental health and wellbeing among LGBTIQ+ people has been attributed to stigma, prejudice and discrimination which create a hostile and stressful social environment (41,42). These findings have also been observed in studies regarding young people. A study of young LGBT people found that perceived discrimination was associated with increased depressive symptoms, and accounted for an elevated risk of self-harm and suicidal ideation (43). LGBT young people have also been found to be at higher risk of major depression, generalised anxiety disorder, suicidal ideation and suicide attempts, compared to the general population (3,32,44). Furthermore, research suggests that there are distinct differences in types and severity of mental health conditions and suicidality between populations within the LGBT community (45,46). For instance, trans and gender diverse adults and young people consistently report higher levels of psychological distress than cisgender men and women (32,39), and bisexual people tend towards poorer mental health outcomes than single-gender-attracted people (36,47–49), possibly due to bisexual invisibility, biphobia and historical monosexism in society (50–52). Beyond mental health specifically, recent and robust evidence arising from the Victorian Population Health Survey has shown considerable differences in a range of health outcomes between LGBTIQ population and those who are cisgender, heterosexual and without a variation in sex characteristics (53).

While we recognise that many LGBTIQA+ young people live well and are confident and happy, there are also many who struggle with mental health at some point in their life and may have limited access to support. As such, it is important that a survey such as this collects information about the mental health and wellbeing of LGBTIQA+ young people to inform service delivery and specialist programs.

9.1 Self-rated health

Writing Themselves In 4 used the self-rated health (SRH) scale (54), a validated instrument asking participants, 'In general, would you say your health is' with the response items 'excellent', 'very good', 'good', 'fair', or 'poor'. Although there are no direct comparisons that can be drawn from the national population for the age range used in this study, Figure 28 compares *Writing Themselves In 4* participants aged 15 to 21 years (n = 5,856) to participants aged 15 to 24 years in the general population 2017-2018 Australian National Health Survey (55).

Writing Themselves In 4 participants reported lower self-rated health than has been observed among samples of young people in the Australian general population. Over one-third (35.6%; n = 2,087) of *Writing Themselves In 4* participants aged 15 to 21 rated their health as poor/fair, more than **three times** the 9.1% among the general population aged 15 to 24 years. Similarly, less than one-third (27.7%; n = 1,623) of *Writing Themselves In 4* participants aged 15 to 21 rated their health as very good or excellent, **less than half** the 63.4% of the general population aged 15 to 24 years.

In total, among all participants in *Writing Themselves In 4* who indicated a gender identity, 6,251 participants responded to the self-rated health (SRH) scale. Figure 29 (displayed on next page) displays their responses.

Cisgender men were the only gender group who were more likely to report their health was very good/excellent than poor/fair. More than half of trans women (53.3%; n = 40) and trans men (53.9%; n = 219) rated their health as poor/fair, followed by 45.0% (n = 547) of non-binary participants and one-third (35.1%; n = 1,108) of cisgender women. In comparison, one-fifth (20.9%; n = 292) of cisgender men reported their health to be poor/fair.

Two-fifths (40.8%; n = 569) of cisgender men rated their health as very good or excellent, compared to less than one-third of cisgender women (28.2%; n = 892), and less than one-fifth of non-binary participants (17.9%; n = 218), trans women (16.0%; n = 12) and trans men (13.5%; n = 55).

In total, among all participants in *Writing Themselves In 4* who indicated a sexuality, 6,404 participants responded to the self-rated health (SRH) scale. Figure 30 displays their responses (displayed on next page).

Figure 28 Self-rated health of *Writing Themselves In 4* participants aged 15-21 years compared to general population aged 15-24 years, National Health Survey (2017-2018)

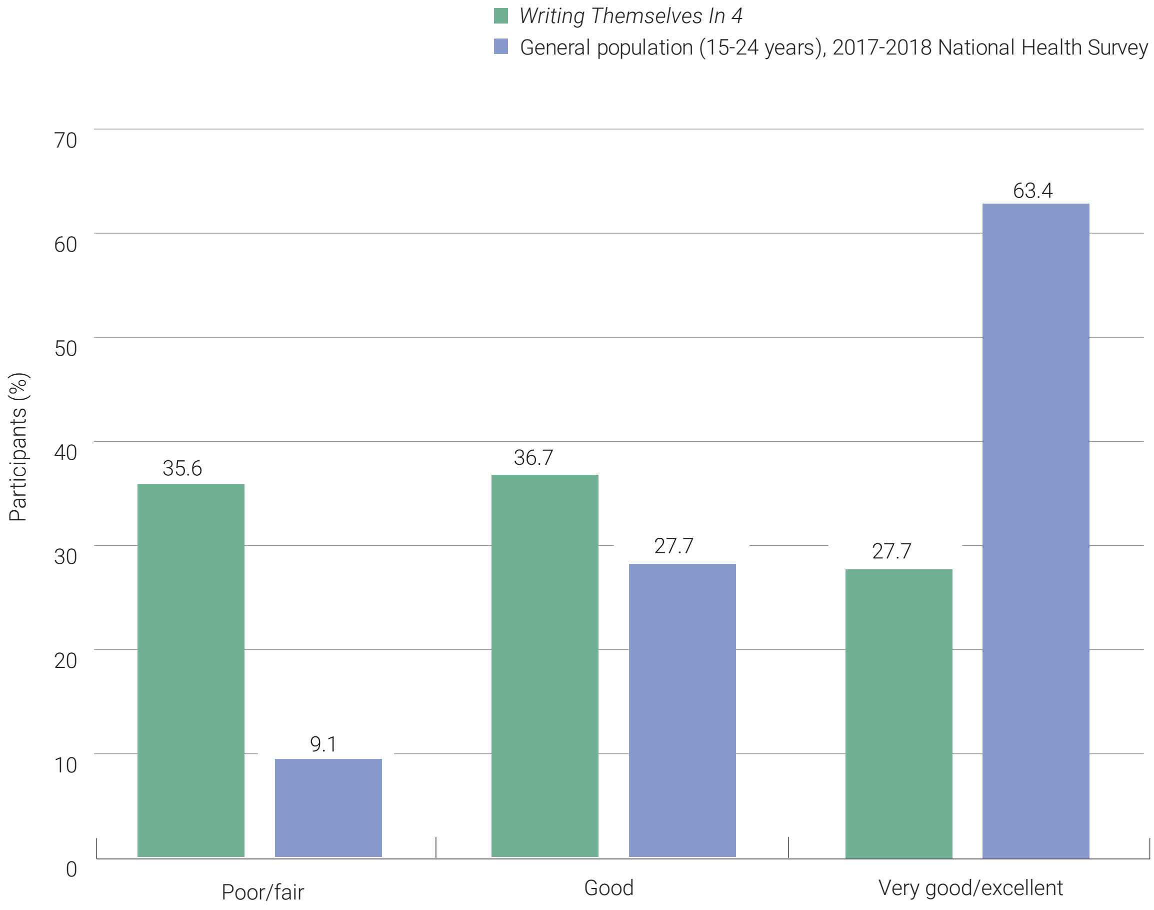


Figure 29 **Self-rated health of *Writing Themselves In 4* participants, by gender**

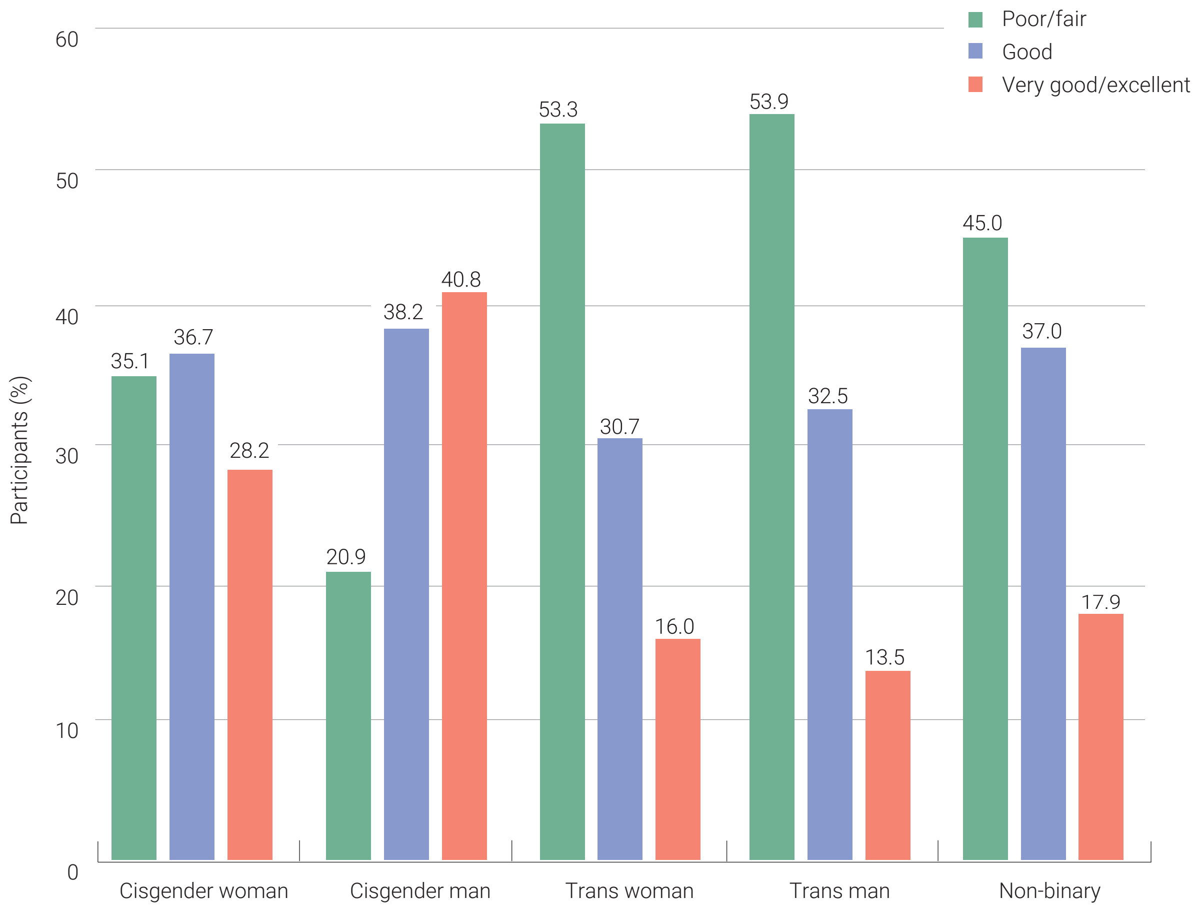
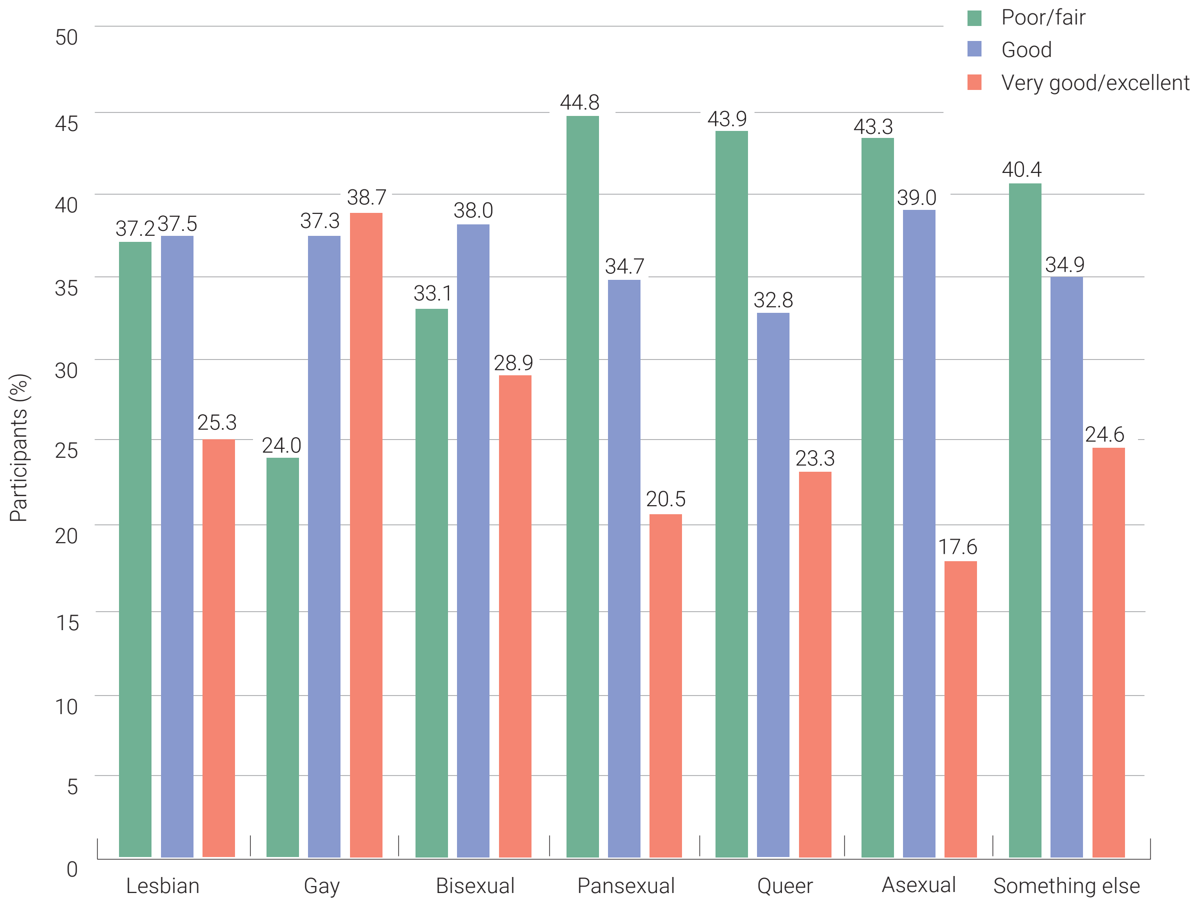


Figure 30 Self-rated health of *Writing Themselves In 4* participants, by sexuality



A greater proportion of trans and gender diverse participants reported very high levels of psychological distress than cisgender men or cisgender women.

Gay participants were least likely to rate their health as poor/fair and most likely to rate it as very good/excellent. More than two-fifths of pansexual (44.8%; n = 321), queer (43.9%; n = 237) and asexual (43.4%; n = 128) participants rated their health as poor or fair, compared to 37.2% (n = 287) of lesbian participants and one-quarter (24.0%; n = 255) of gay participants.

Almost two-fifths (38.7%; n = 411) of gay participants rated their health as very good or excellent, compared to less than three-tenths of bisexual participants (28.9%; n = 626), approximately one-quarter of lesbian (25.3%; n = 195) and queer (23.3%; n = 126) participants, one-fifth of pansexual participants (20.5%; n = 147) and less than one-fifth of asexual participants (17.6%; n = 52).

9.2 Psychological Distress (K10)

The Kessler Psychological Distress Scale (K10) is a 10-item standardised scale developed to measure psychosocial distress, based on questions about people's level of nervousness, agitation, psychological fatigue and depression in the past four weeks. Responses to the questionnaire are summed to create a scale ranging from 10 to 50, with a higher score indicating higher levels of psychological distress. *Writing Themselves In 4* follows the ABS K10 scoring and categorisation (56).

The mean K10 score was 30.0 (SD = 8.9) for the *Writing Themselves In 4* survey sample. Table 41 below shows that over four-fifths (81.0%; n = 5,172) of participants reported high or very high levels of psychological distress.

Table 41 Proportion of participants experiencing psychological distress

K10 score (n = 6,385)	**n**	**%**
Low (10-15)	363	5.7
Moderate (16-21)	850	13.3
High (22-29)	1,849	29.0
Very high (30-50)	3,323	52.0

Overall, 81.0% (n = 5,172) of participants reported high or very levels of psychological distress. A greater proportion (83.1%; n = 3,184) of those at secondary school than those at university (73.2%; n = 1,126) reported high or very high levels of psychological distress.

Similarly, a greater proportion (83.9%; n = 3,143) of participants aged 14 to 17 reported high or very high levels of psychological distress than participants aged 18 to 21 (76.9%; n = 2,029).

9.2.1 Experience of psychological distress, by gender

Figure 31 shows the proportion of participants who experienced low, moderate, high, or very high levels of psychological distress, broken down by gender (n = 6,222).

A greater proportion of trans and gender diverse participants reported very high levels of psychological distress than cisgender men or cisgender women. Nine-tenths (90.4%; n = 1,097) of non-binary participants and trans men (89.9%; n = 364) reported experiencing high or very high levels of psychological distress, followed by 88.0% (n = 66) of trans women, 82.0% (n = 2,578) of cisgender women, and 66.9% (n = 926) of cisgender men.

Figure 31 Proportion of participants experiencing psychological distress, by gender

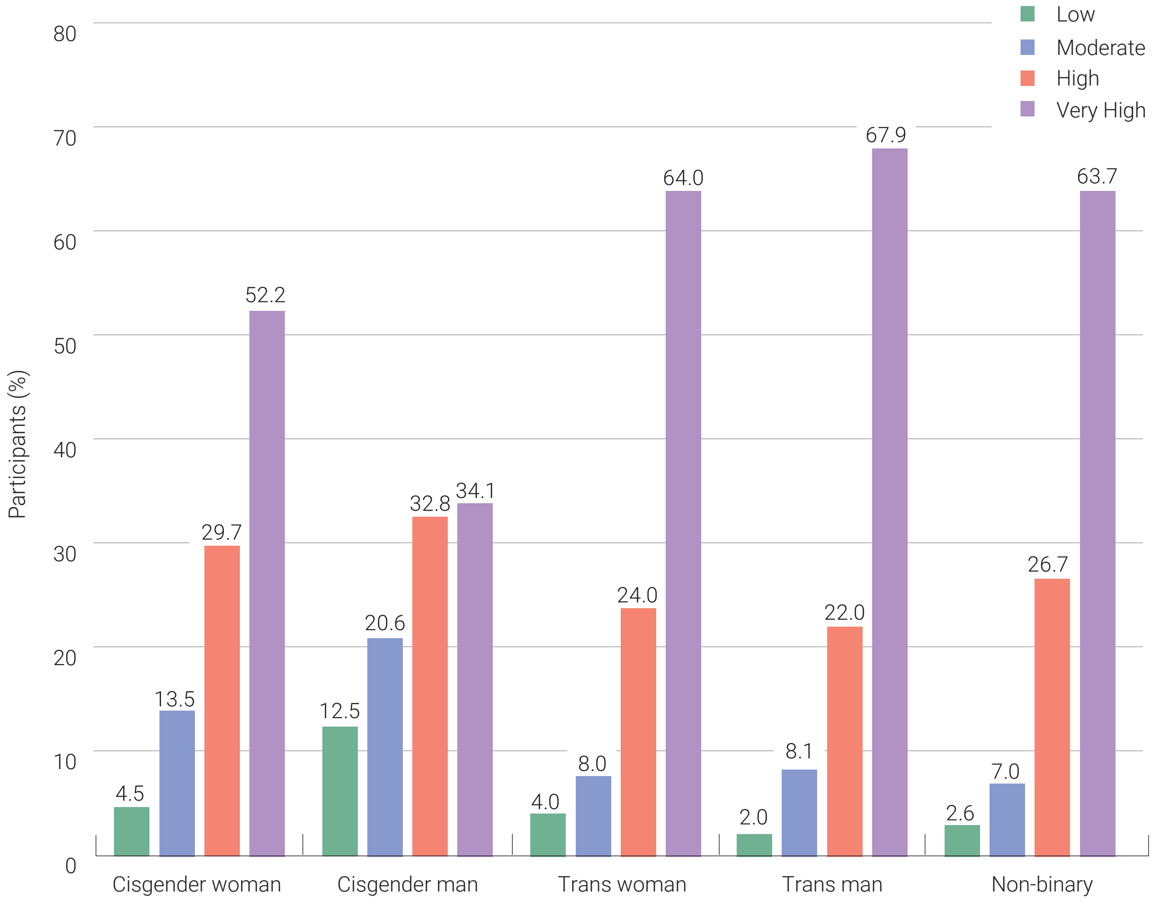
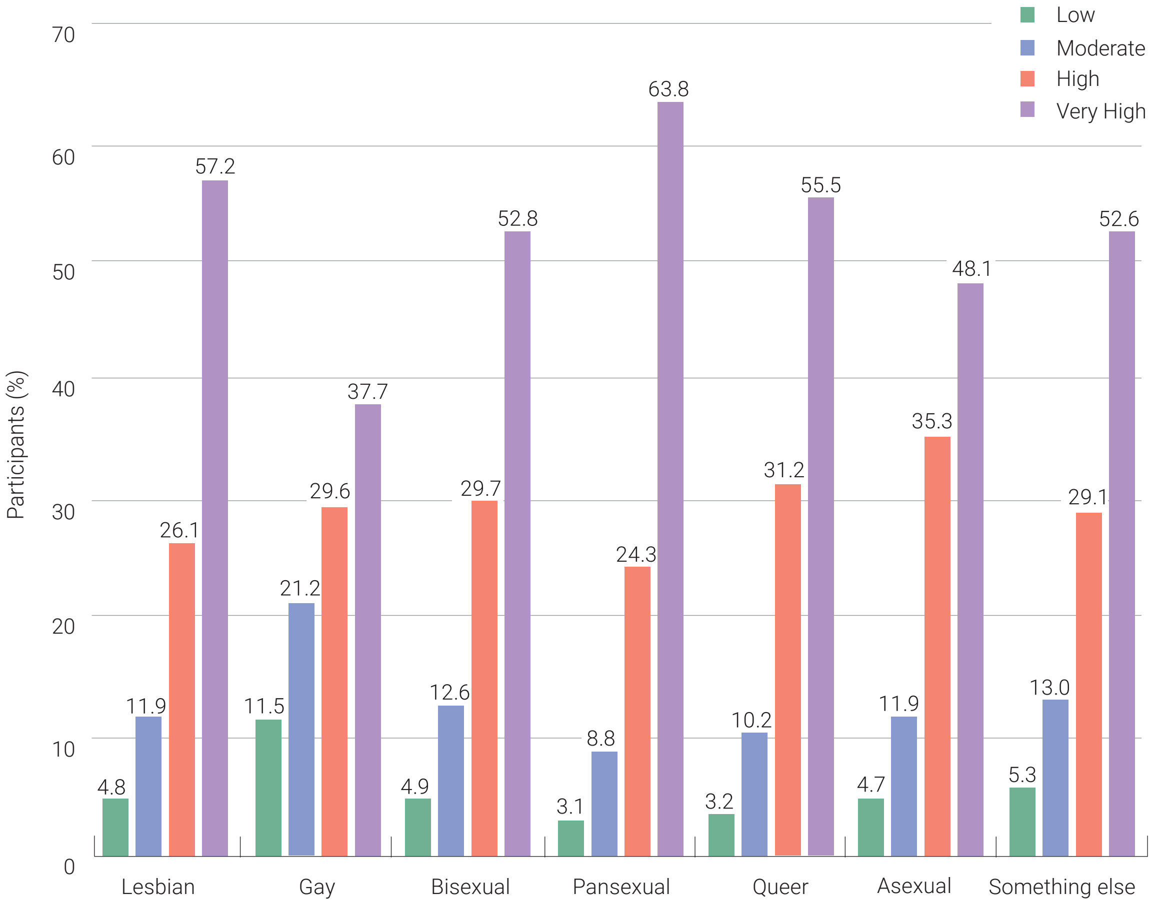


Figure 32 Proportion of participants experiencing psychological distress, by sexuality



9.2.2 Experience of psychological distress, by sexuality

Figure 32 shows the proportion of participants who experienced low, moderate, high, or very high levels of psychological distress, broken down by sexuality (n = 6,375).

A greater proportion of pansexual participants reported very high levels of psychological distress than other sexual identities. Almost nine-tenths (88.1%; n = 630) of pansexual participants reported experiencing high or very high levels of psychological distress, followed by 86.6% (n = 467) of queer, 83.4% (n = 246) of asexual and 83.3% (n = 638) of lesbian participants, and 67.3% (n = 709) of gay participants.

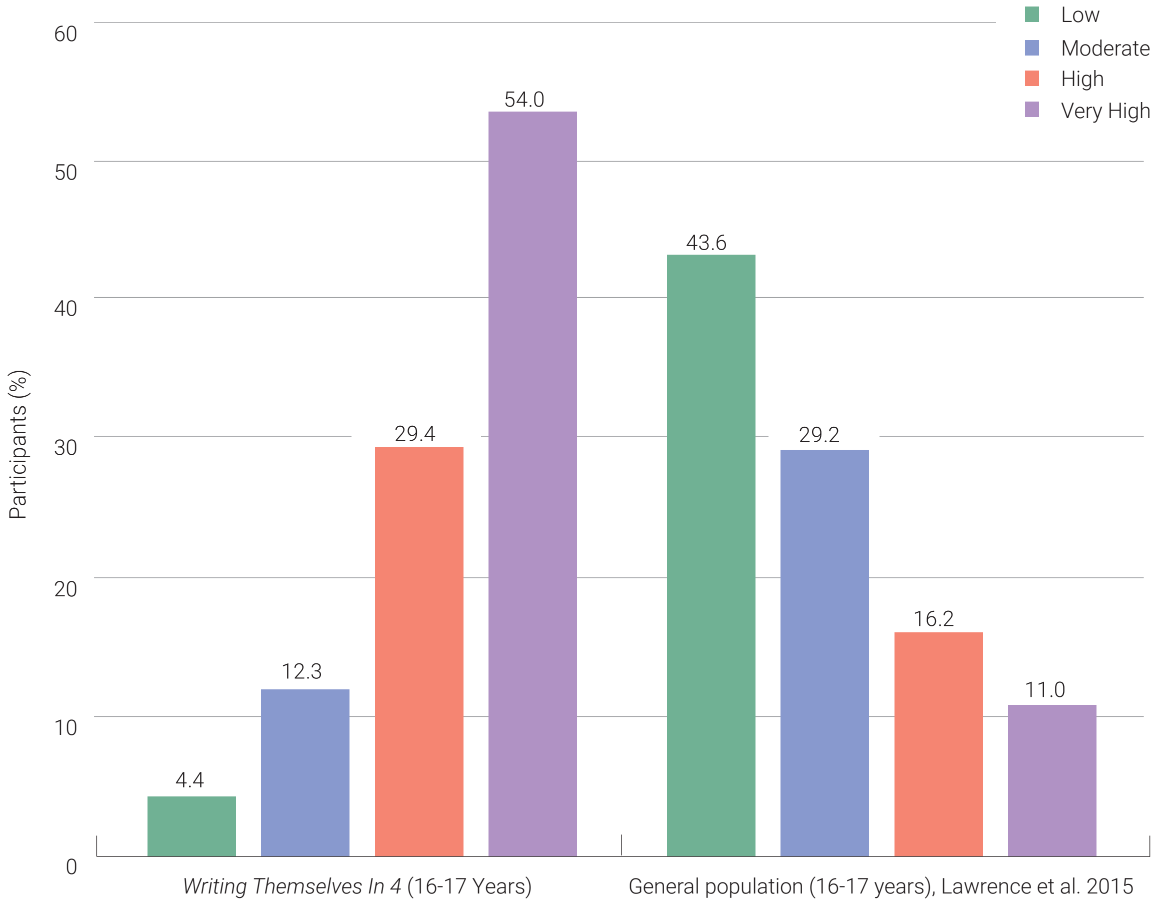
9.2.3 Psychological distress – general population comparisons among 16- to 17-year-olds

There is no data source that enables a direct comparison to the *Writing Themselves In 4* sample age range (14 to 21) with respect to mental health status. However, the report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (5), a general population survey, provides a breakdown of responses for 16- to 17-year-olds (which represents the midpoint of the age range used in *Writing Themselves In* 4).

Compared to this sample, high or very high levels of psychological distress among 16- to 17-year-old participants in *Writing Themselves In 4* (83.3%; n = 1,984) were **more than three times** that of the 27.3% reported among the general population aged 16 to 17 years. Figure 34 below displays a breakdown of results across the spectrum of K10 scores from *Writing Themselves In 4* (n = 2,310) in comparison to responses from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (5).

Figure 33 shows the proportion of participants aged 16 to 17 years who experienced low, moderate, high or very high levels of psychological distress (n = 6,375).

Figure 33 **K10 scores of *Writing Themselves In 4* participants aged 16-17 years compared to among the general population aged 16-17 years**



9.3 Mental health diagnoses

Previous research has observed that gay, lesbian and bisexual young people were at higher risk of major depression and generalised anxiety disorder than the general population (44). Research has also shown that trans and gender diverse young people experienced a high prevalence of mental health conditions such as anxiety and depression compared with their cisgender counterparts (57).

Participants were asked if they had ever been diagnosed with one or more mental health conditions at some point in their lives. Those who reported having ever been diagnosed with a mental health condition were then asked if they had received treatment or support in relation to those conditions in the past 12 months. Table 42 displays these results.

Table 42 Proportion of participants diagnosed with one or more mental illness in their lifetime and who received treatment or support for this in the past 12 months

	Ever received diagnosis		Received treatment or support in past 12 months	
Condition (n = 6,071)	**n**	**%**	**n**	**%**
Generalised anxiety disorder	3,004	49.5	2,010	33.1
Depression	2,934	48.3	1,993	32.8
Eating disorder	753	12.4	251	4.1
Post-traumatic stress disorder	651	10.7	362	6.0
Social phobia	566	9.3	271	4.5
Panic disorder	487	8.0	281	4.6
Obsessive-compulsive disorder	447	7.4	198	3.3
Bipolar disorder	190	3.1	101	1.7
Agoraphobia	84	1.4	30	0.5
Schizophrenia	54	0.9	16	0.3
Other mental health challenge	634	10.4	387	6.4
Any of the above	3,870	63.8	2,704	44.5

Almost two-thirds (63.8%; n = 3,870) of participants reported having ever been diagnosed with a mental health condition, and over two-fifths (44.5%; n = 2,704) reported receiving treatment or support for a mental health condition in the past 12 months. Almost half (49.5%; n = 3,004) of participants reported ever being diagnosed with generalised anxiety disorder or depression (48.3%; n = 2,934).

Almost seven-tenths (69.9%; n = 2,704) of participants who reported being diagnosed with a mental illness in their lifetime had received professional treatment or support in the past 12 months.

9.3.1 Mental health diagnoses, by gender

The proportion of participants who received treatment or support for depression or generalised anxiety disorder in the past 12 months is analysed by gender (n = 5,913) in Figure 34 (displayed on next page).

The number of participants experiencing depression and generalised anxiety disorder was high across all gender categories, and very high among certain groups.

Half (50.5%; n = 203) of trans men reported receiving treatment or support for depression in the past 12 months, followed by 47.9% (n = 34) of trans women, 40.1% (n = 476) of non-binary participants, 31.2% (n = 940) of cisgender women, and 21.9% (n = 271) of cisgender men.

More than two-fifths of trans men (44.5%; n = 179) and non-binary participants (40.1%; n = 476) reported receiving treatment or support for generalised anxiety disorder in the past 12 months. This compares to one-third of cisgender women (33.5%; n = 1,009) and trans women (31.0%; n = 22) and one-fifth of cisgender men (n = 20.7%; n = 257).

9.3.2 Mental health diagnoses, by sexuality

The proportion of participants who received treatment or support for depression or generalised anxiety disorder in the past 12 months is analysed by sexuality (n = 6,062) in Figure 35 (displayed on next page).

The numbers of those experiencing depression and generalised anxiety disorder was high among all participants, and very high among certain groups.

More than two-fifths of pansexual (41.2%; n = 285) participants reported receiving treatment or support for depression in the past 12 months. This compares to 39.1% (n = 206) of queer, 35.9% (n = 267) of lesbian, 32.3% (n = 93) of asexual, and 23.8% (n = 230) of gay participants.

A greater proportion of queer (43.1%; n = 227), lesbian (38.2%; n = 284) and pansexual (37.1%; n = 257) participants reported receiving treatment or support for generalised anxiety disorder in the past 12 months, compared to bisexual (31.7%; n = 644), asexual (31.6%; n = 91) or gay (23.4%; n = 226) participants.

Figure 34 Proportion of participants who received treatment or support for depression or generalised anxiety disorder in the past 12 months, by gender

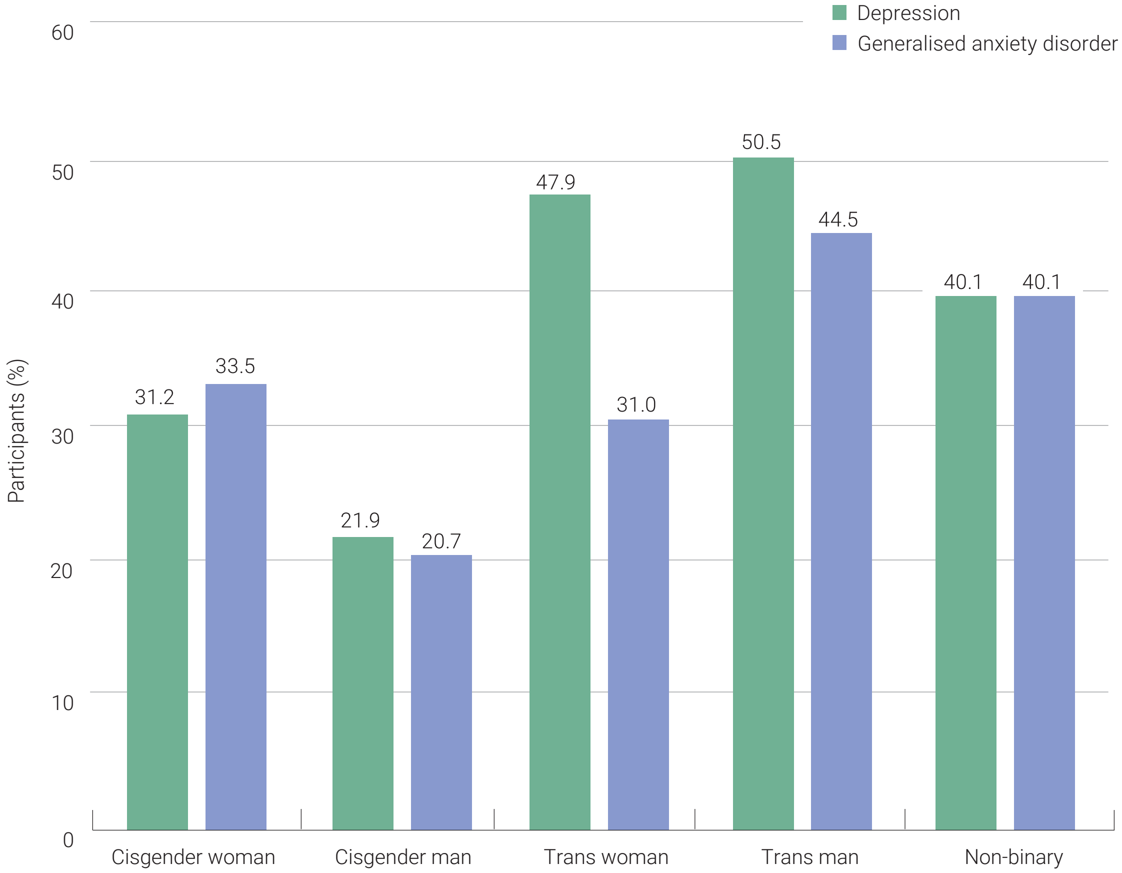
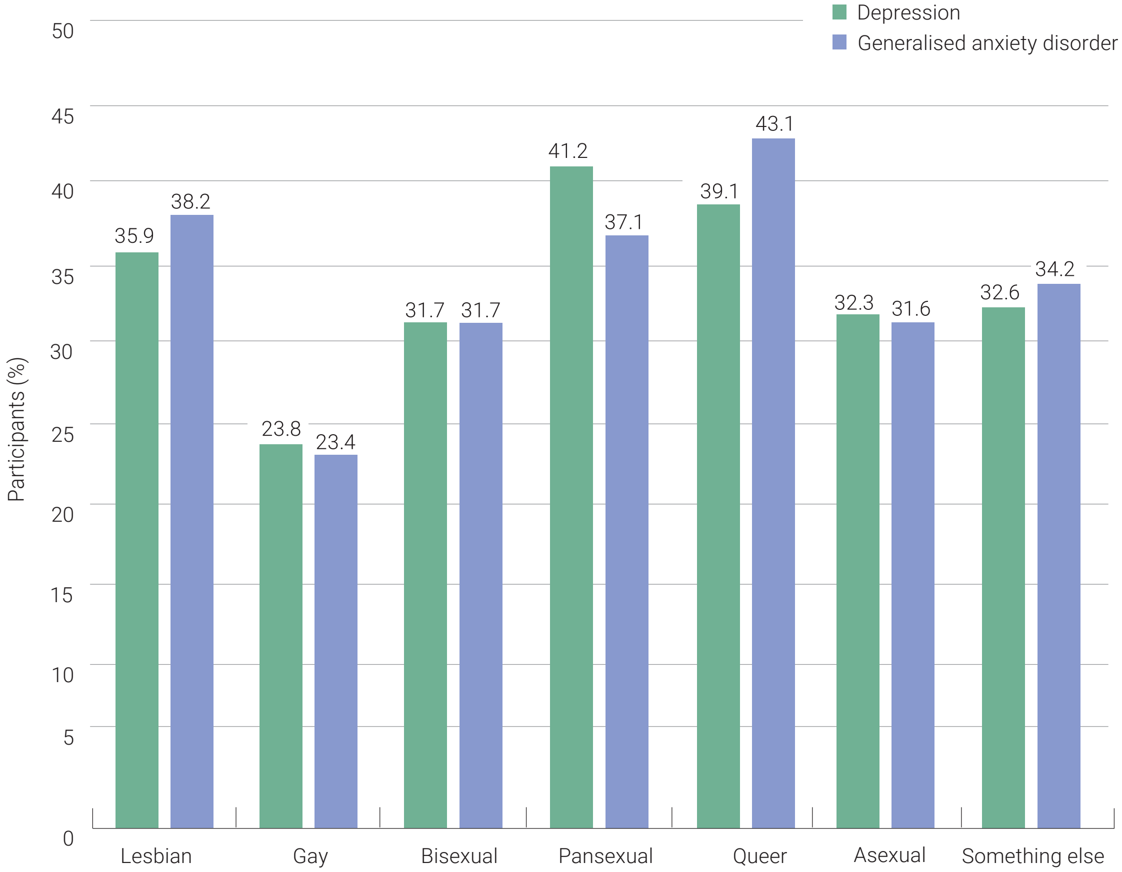


Figure 35 Proportion of participants who received treatment or support for depression or generalised anxiety disorder in the past 12 months, by sexuality



9.4 Suicidal ideation, planning and attempts

Suicide is the leading cause of death among people aged between 15 to 24 years in Australia (58). Young LGBTIQ people in Australia reported high levels of suicidal ideation, attempts and self-harm in both *Writing Themselves In 3* (3) and the Growing Up Queer study of 1,032 young Australians aged 16 to 27 (32).

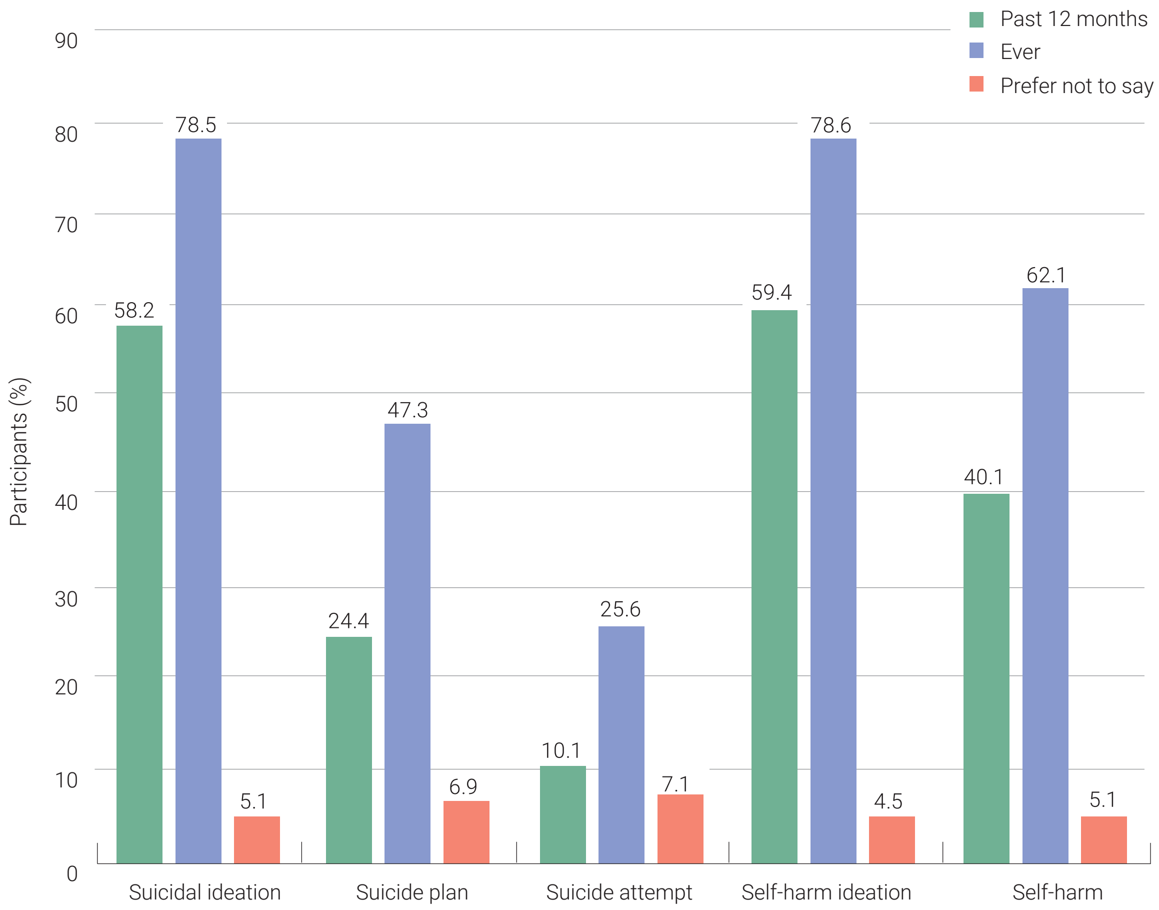
Writing Themselves In 4 asked participants about suicidal ideation (defined as 'experiences of thoughts about suicide, wanting to die, or about ending your life'), suicide plans (defined as having 'made a plan to attempt suicide or end your own life'), suicide attempts (defined as having 'attempted suicide or to end your life'), self-harm ideation (defined as 'thoughts about harming yourself on purpose'), and self-harm (defined as 'injured or harmed yourself on purpose').

Previous research has found that asking people about suicide does not increase the risk of suicide (59). Nonetheless, as a precaution, online and telephone resources were provided for Qlife and Kids Helpline prior to these questions as well as at the end of the survey. Prior to the questions being asked, participants were given the option to choose 'prefer not to answer these questions' with, in bold text, 'If you feel uncomfortable answering these questions, please skip them', followed by 'Skipping this question does not make your other responses any less valuable.' Participants were also given the option of 'prefer not to answer' for each question regarding suicidal ideation, suicide plans, suicide attempts, self-harm ideation and self-harm attempts.

Figure 36 displays the proportion of all *Writing Themselves In 4* participants who responded to questions regarding suicide ideation, planning or attempts, as well as self-harm. Not all participants gave a response to all of these items, hence the sample size for each analysis is shown in brackets below:

- Experiences of thoughts about suicide, wanting to die, or about ending your life (n = 6,373)
- Made a plan to attempt suicide or end your own life (n = 6,296)
- Attempted suicide or to end your life (n = 6,271)
- Thoughts about harming yourself on purpose (n = 6,314)
- Injured or harmed yourself on purpose (n = 6,287)

Figure 36 **Suicidal ideation, suicide plan, suicide attempt, self-harm ideation, and self-harm**



- Almost three-fifths (58.2%; n = 3,712) of participants had seriously considered attempting suicide in the previous 12 months
- Almost one-quarter (24.4%; n = 1,536) had made a suicide plan in the previous 12 months.
- One-tenth (10.1%; n = 632) had attempted suicide in the past 12 months while over one-quarter (25.6%; n = 1,605) had attempted suicide at some point in their lifetime.
- Almost two-thirds of participants (62.1%; n = 3,903) reported having ever self-harmed, and four in ten (40.1%; n = 2,521) in the past 12 months.
- Between 4.5% and 7.1% of participants answered 'prefer not to say' to the questions. The proportion of young people who have ever experienced suicidal ideation, planning or attempts, or self-harm ideation or attempts may therefore be higher than indicated in these estimates.

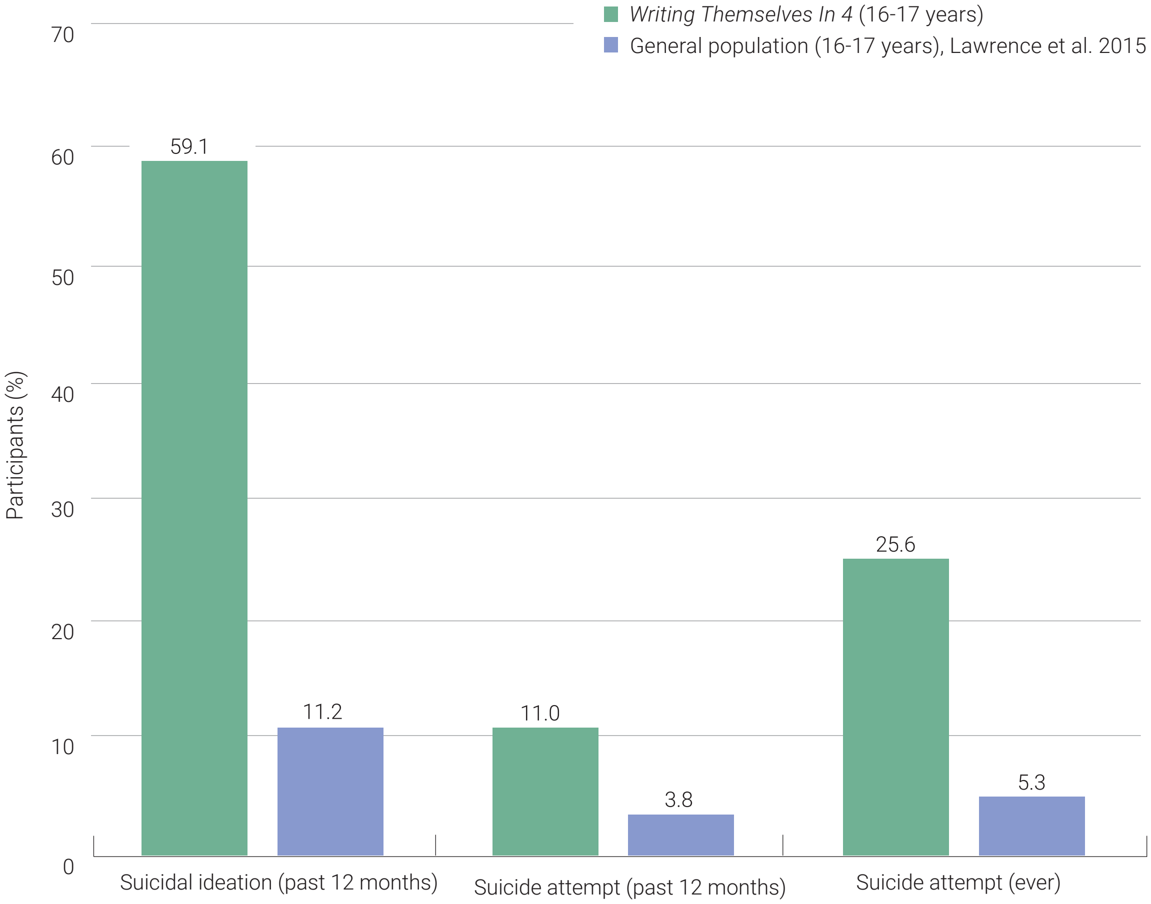
9.4.1 Suicidal ideation and attempts – general population comparisons among 16- to 17-year-olds

Again, the closest comparable population-based data comes from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing where data from 16- to 17-year-olds is the most appropriate reference point. A summary of this comparison of suicidal ideation (n = 2,380) and suicide attempts (n = 2,338) among participants aged 16 to 17 years in *Writing Themselves In 4* and those in the general population aged 16 to 17 years is shown in Figure 37 below.

Almost three-fifths (59.1%; n = 1,407) of *Writing Themselves In 4* participants aged 16 to 17 years had seriously considered attempting suicide in the previous 12 months, **more than five times** the proportion observed in a sample of the general population aged 16 to 17 (11.2%) (5).

- More than one-tenth (11.0%; n = 257) of *Writing Themselves In 4* participants aged 16 to 17 years had attempted suicide in the past 12 months, **almost three times** the 3.8% observed in samples of the general population aged 16 to 17 years (5).
- Over one-quarter (25.6%; n = 598) of *Writing Themselves In 4* participants aged 16 to 17 years had attempted suicide in their lifetime, **almost five times** the 5.3% reported among an age-matched sample of the general population aged 16 to 17 years (5).

Figure 37 Suicidal ideation and suicide attempts among *Writing Themselves In 4* participants and the general population aged 16-17 years



9.4.2 Suicidal ideation, planning and attempts in the past 12 months, by gender

Young people who participated were free to leave any question unanswered, which is reflected in the following questions where the total sample size for each question may vary slightly. The number of participants experiencing suicidal ideation (n = 6,209), planning (n = 6,133) and attempts (n = 6,111) in the past 12 months is analysed by gender in Figure 38 below.

The numbers of those experiencing suicidal ideation, suicide planning and suicide attempts were high among all participants, and very high among certain groups. Over three-quarters (77.3%; n = 58) of trans women and seven-tenths of trans men (73.1%; n = 296) and non-binary participants (69.8%; n = 844) reported experiencing suicidal ideation in the past 12 months. In comparison, 56.2% (n = 1,762) of cisgender women and 46.4% (n = 643) of cisgender men reported suicidal ideation in the past 12 months.

One-fifth (20.0%; n = 15) of trans women had attempted suicide in the past 12 months, followed by 16.7% (n = 67) of trans men, 13.2% (n = 158) of non-binary participants, 9.1% (n = 279) of cisgender women, and 6.7% (n = 91) of cisgender men.

9.4.3 Suicidal ideation, planning and attempts in the past 12 months, by sexuality

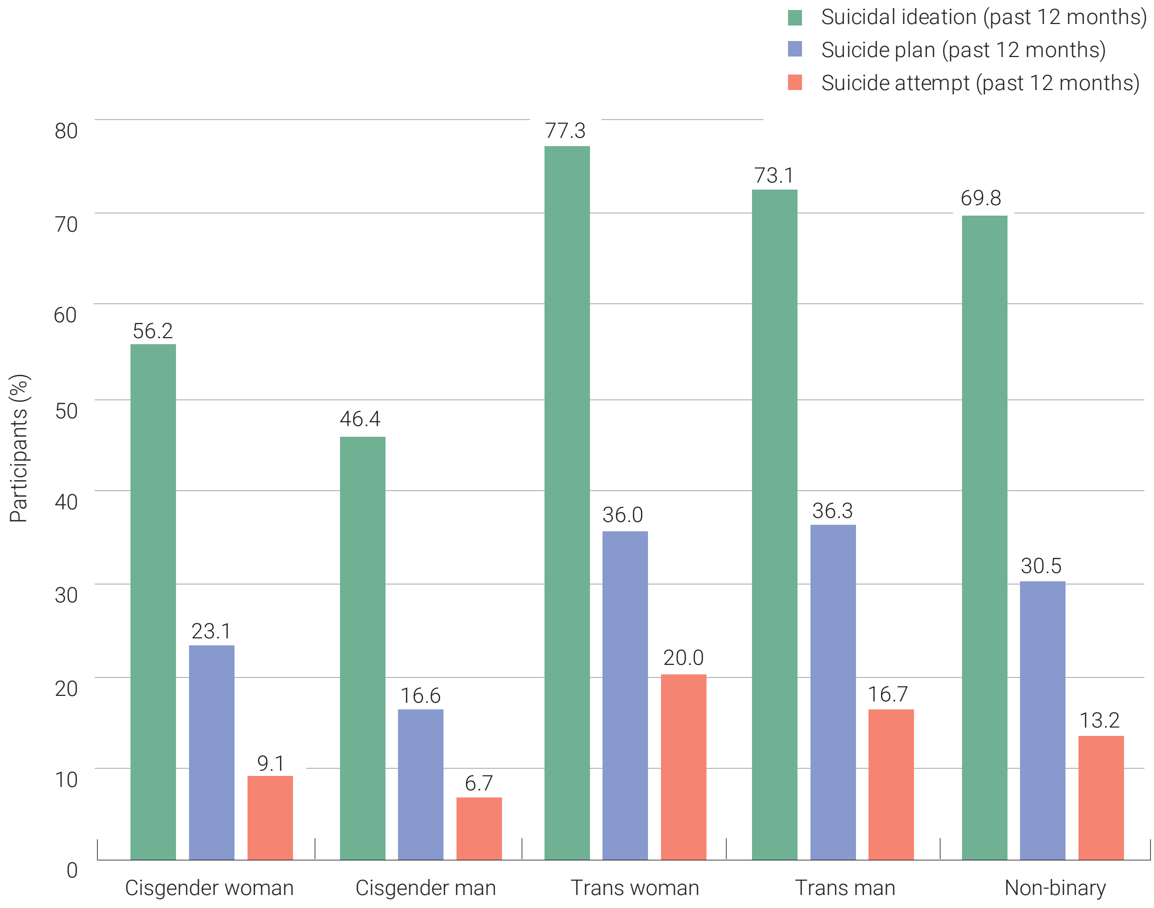
The number of participants experiencing suicidal ideation (n = 6,363), planning (n = 6,286) and attempts (n = 6,261) in the past 12 months is analysed by sexuality in Figure 39 (displayed on next page).

The numbers of those experiencing suicidal ideation, suicide planning and suicide attempts were high among all participants, and very high among certain groups.

More than three-fifths of pansexual (67.4%; n = 480), queer (62.4%; n = 335), and lesbian (61.7%; n = 473) participants had experienced suicidal ideation in the previous 12 months, followed by 59.2% (n = 1,273) of bisexual, 54.6% (n = 160) of asexual, and 47.3% (n = 499) of gay participants.

Lesbian participants reported the highest levels of recent suicide attempts in the past 12 months (14.1%; n = 107), almost twice that of gay participants (7.8%; n = 81).

Figure 38 Suicidal ideation, planning and attempts in past 12 months, by gender



Lesbian participants reported the highest levels of recent suicide attempts in the past 12 months (14.1%), almost twice that of gay participants (7.8%).

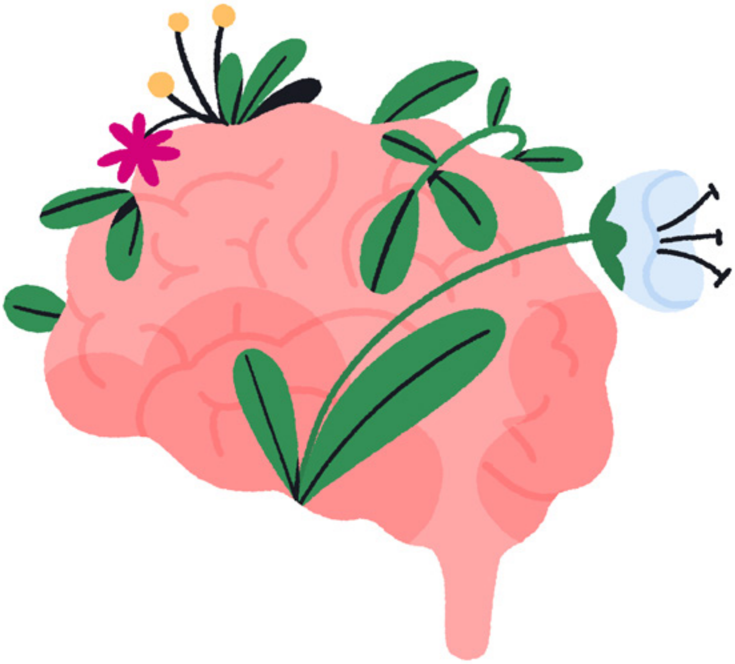
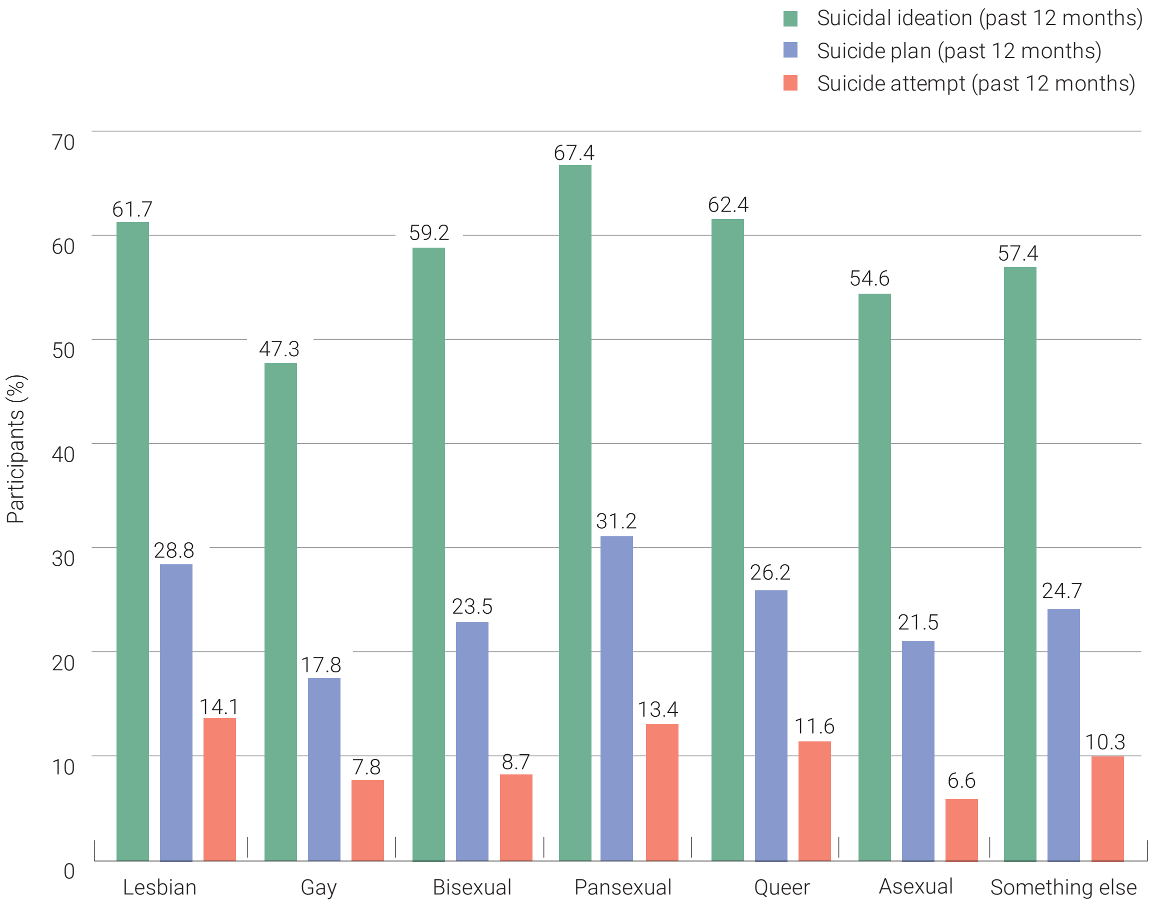


Figure 39 **Suicidal ideation, planning and attempts in past 12 months, by sexuality**



9.4.4 Suicidal ideation, planning and attempts ever, by gender

The number of participants experiencing suicidal ideation (n = 6,209), planning (n = 6,133) and attempts (n = 6,111) ever in their lifetime is analysed by gender in Figure 40 below.

The numbers of those experiencing suicidal ideation, suicide planning and suicide attempts were high among all participants, and very high among certain groups.

Nine-tenths of trans women (90.7%; n = 68), trans men (92.1%; n = 373) and non-binary participants (87.5%; n = 1,059) had ever experienced suicidal ideation in their lifetime. This compares to three-quarters 77.5% (n = 2,427) of cisgender women and two-thirds 67.6% (n = 937) of cisgender men.

Over two-fifths (46.9%; n = 417) of trans men and two-fifths (40.0%; n = 30) of trans women had ever attempted suicide in their lifetime, followed by 34.8% (n = 417) of non-binary participants, one-fifth (22.7%; n = 697) of cisgender women, and 16.6% (n = 226) of cisgender men.

9.4.5 Suicidal ideation, planning and attempts ever, by sexuality

The number of participants experiencing suicidal ideation (n = 6,363), planning (n = 6,286) and attempts (n = 6,261) ever in their lifetime is analysed by sexuality in Figure 41 (displayed on next page).

The numbers of those experiencing suicidal ideation, suicide planning and suicide attempts were high among all participants, and very high among certain groups.

More than four-fifths of pansexual (84.8%; n = 604), queer (83.1%; n = 446) and lesbian (81.5%; n = 624) participants had ever experienced suicidal ideation in their lifetime, followed by 79.3% (n = 1,705) of bisexual, 75.4% (n = 221) of asexual, and 68.8% (n = 727) of gay participants.

Pansexual (35.1%; n = 247), queer (30.0%; n = 158) and lesbian (30.0%; n = 227) participants reported the highest levels of ever attempting suicide.

9.4.6 Experience of self-harm, by gender

The number of participants who experienced self-harm in the past 12 months and ever is displayed, broken down by gender, in Figure 42 (next page) (n = 6,126).

The numbers of those experiencing self-harm, in the past 12 months and ever, were high among all participants, and very high among certain groups.

A greater proportion of trans men (55.5%; n = 223), non-binary participants (53.9%; n =647) and trans women (48.0%; n = 36) had self-harmed in the past 12 months than the 39.6% (n = 1,224) of cisgender women and 23.1% (n = 314) of cisgender men.

Figure 40 Suicidal ideation, planning and attempts ever, by gender

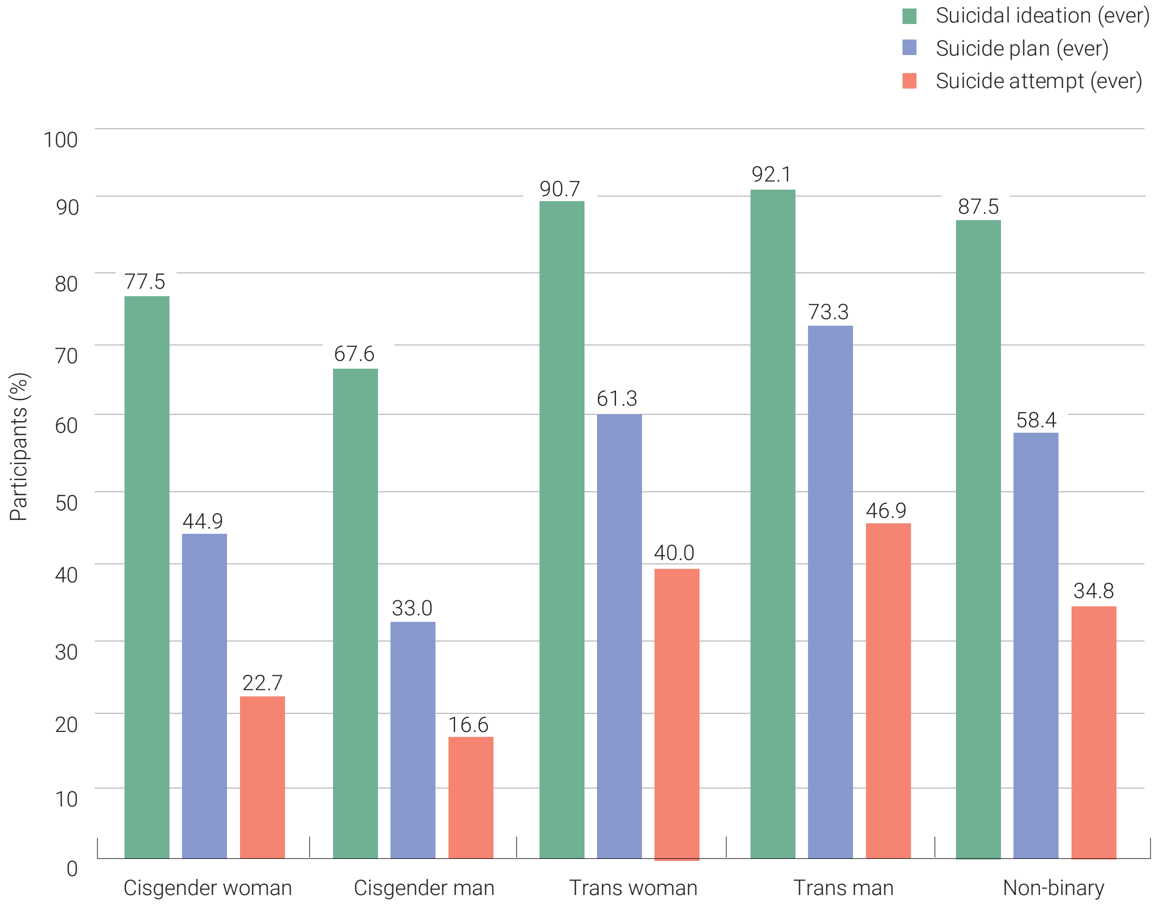


Figure 41 **Suicidal ideation, planning and attempts ever, by sexuality**

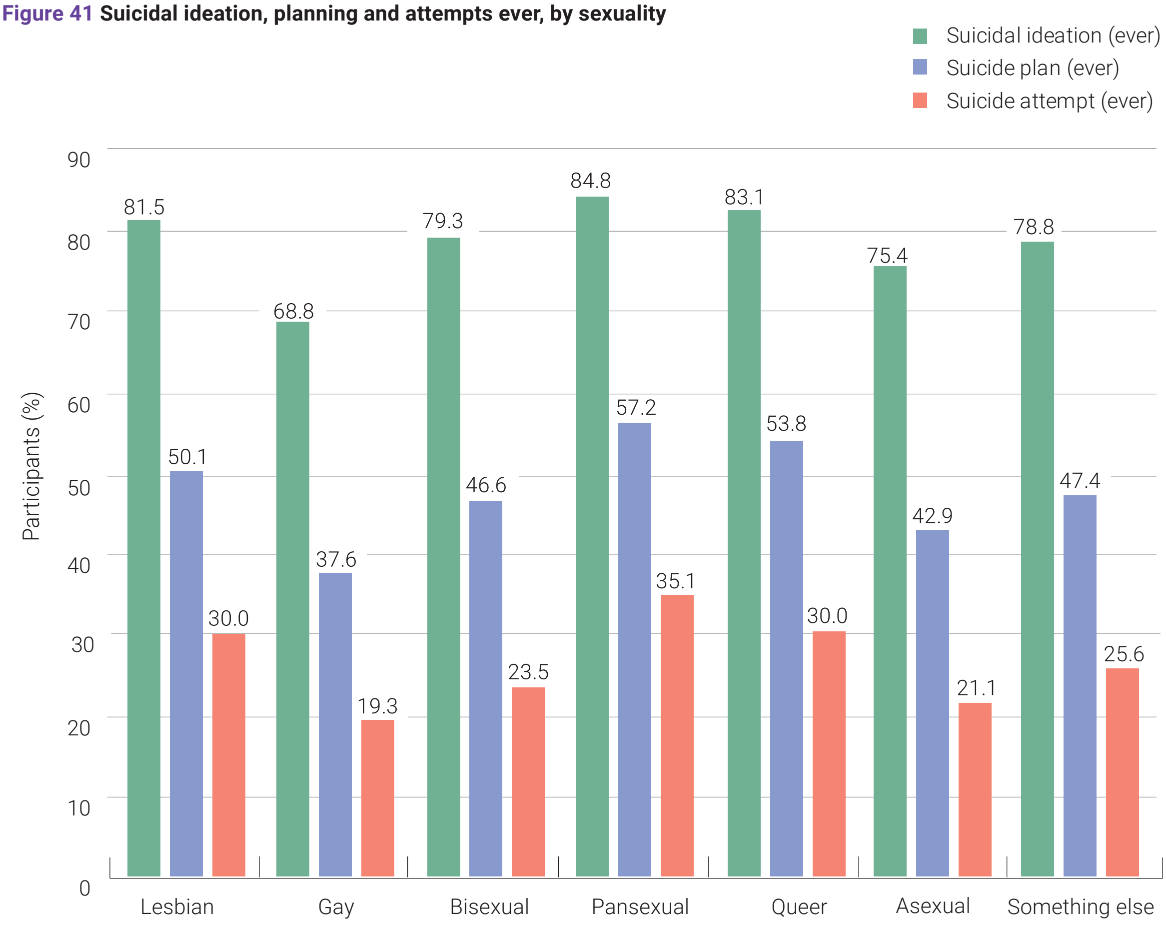
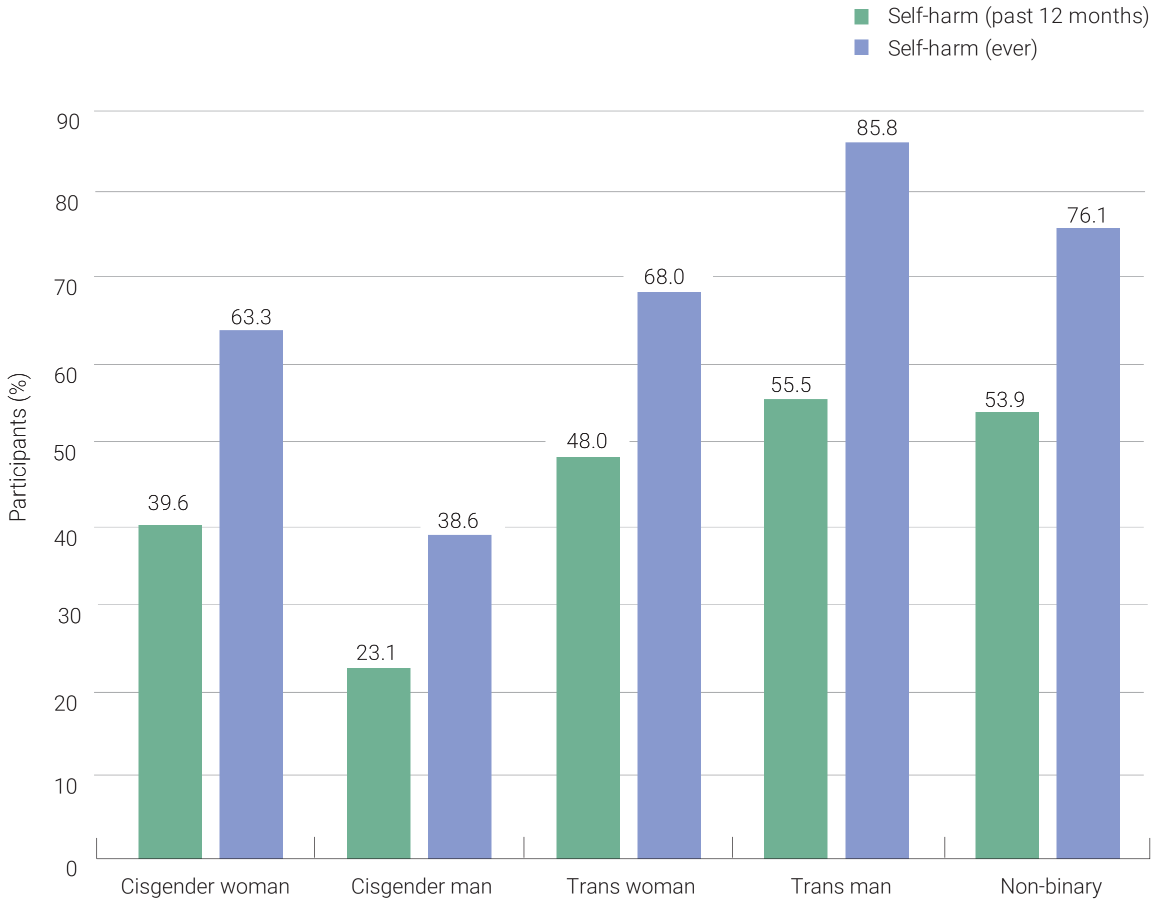


Figure 42 **Experienced self-harm in the past 12 months and ever, by gender**



Over four-fifths (85.8%; n = 345) of trans men, three-quarters (76.1%; n = 913) of non-binary participants and seven-tenths of trans women (68.0%; n = 51) had ever self-harmed. This compares to 63.3% (n = 1,957) of cisgender women and 38.6% (n = 524) of cisgender men.

9.4.7 Experience of self-harm, by sexuality

The number of participants who experienced self-harm in the past 12 months and ever is displayed, broken down by sexuality, in Figure 43 below (n = 6,277).

The numbers of those experiencing self-harm, in the past 12 months and ever, were high among all participants, and very high among certain groups.

Pansexual participants reported the highest levels of self-harm in the past 12 months (51.4%; n = 362) and ever (74.3%; n = 523). This was almost twice that of gay participants (26.4%; n = 275 and 45.1%; n = 469).

9.5 Support for those in distress

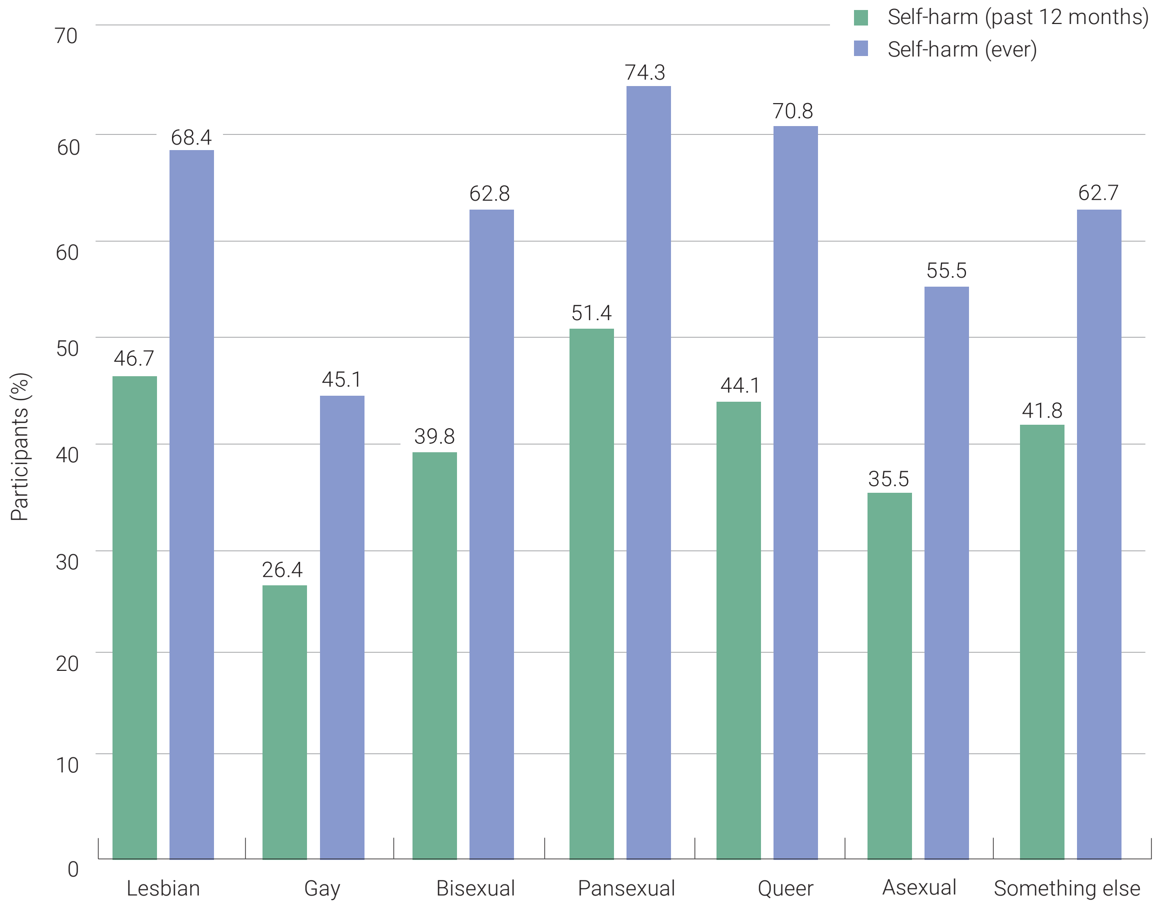
Participants who answered that they had ever experienced suicidal ideation, planning or attempts, or self-harm ideation or attempts in their lifetime were asked if they had ever accessed an in-person professional counselling or support service, a professional telephone support service, or a professional text or webchat support service in relation to suicide or self-harm. Table 43 displays the results.

Table 43 Ever accessed professional support services among those who have experienced suicidal ideation, planning or attempts or self-harm ideation or attempts

Professional support service accessed (n = 5,365)	**n**	**%**
In-person professional counselling or support service	2,507	46.7
Professional text or webchat support service	700	13.1
Professional telephone support service	512	9.5
Any of the above*	2,773	51.7

** 'Participants may have used more than one type of service*

Figure 43 Experienced self-harm in the past 12 months and ever, by sexuality



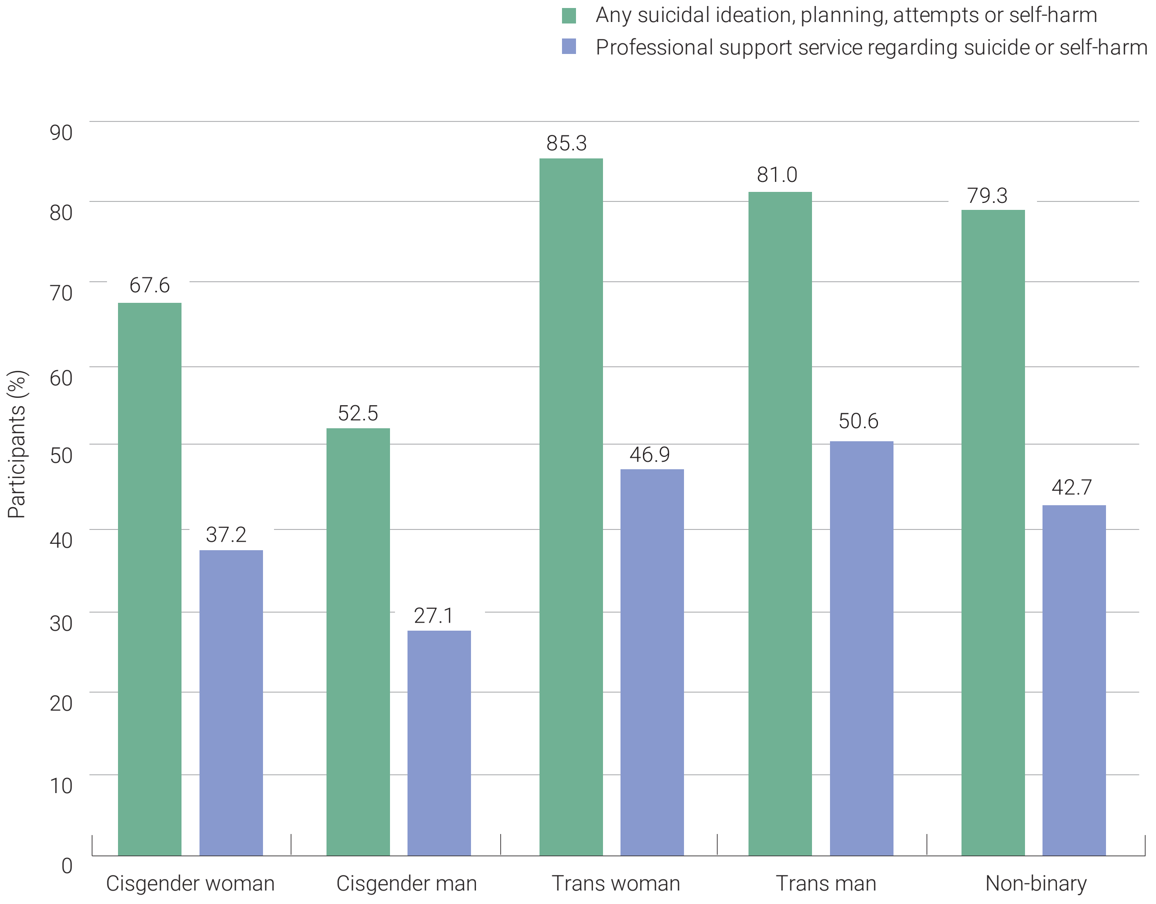
Over half (51.7%; n = 2,773) of participants who had experienced any suicidal ideation, planning or attempts, or self-harm ideation or attempts in their lifetime had ever accessed a professional support service regarding suicide or self-harm. Over two-fifths (46.7%; n = 2,507) had accessed an in-person professional counselling or support service, 13.1% (n = 700) a professional text or webchat support service, and 9.5% (n = 512) a professional telephone support service in relation to suicide or self-harm in their lifetime.

In total, less than one-third (38.1%; n = 1,641) of participants who had experienced any suicidal ideation, planning or attempts, or self-harm ideation or attempts in the past 12 months had accessed a professional service regarding suicide or self-harm in this time frame.

Figure 44 displays engagement with professional support services regarding suicide or self-harm in the past 12 months among those who had experienced suicidal ideation, planning for suicide, suicide attempts or self-harm in this time frame, by gender.

Overall, a greater proportion of trans and gender diverse participants than cisgender men and women experienced any suicidal ideation, planning or attempts, or self-harm ideation or attempts in the past 12 months. However, a greater proportion of trans and gender diverse participants who had experienced any suicidal ideation, planning or attempts, or self-harm ideation or attempts in the past 12 months had accessed professional support services regarding suicide or self-harm in this time frame.

Figure 44 Engagement with professional support services regarding suicide or self-harm in the past 12 months among those who had experienced suicidal ideation, planning, attempts or self-harm in this time frame, by gender



81.0%

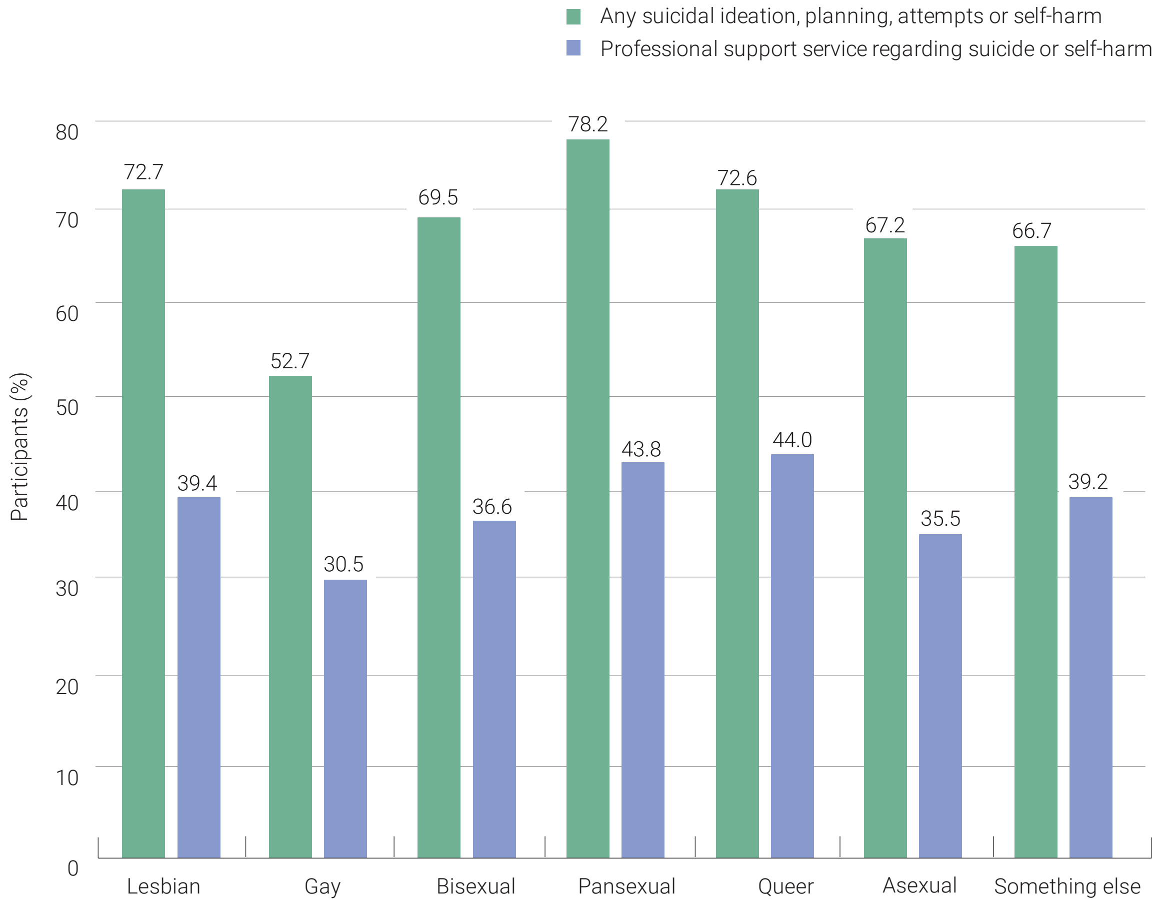
of trans men had experienced any suicidal ideation, planning or attempts, or self-harm ideation or attempts in the past 12 months

Four-fifths of trans women (85.3%; n = 64), trans men (81.0%; n = 329) and non-binary participants (79.3%; n = 960) had experienced any suicidal ideation, planning or attempts, or self-harm ideation or attempts in the past 12 months, compared to two-thirds (67.6%; n = 2,126) of cisgender women and half (52.5%; n = 730) of cisgender men.

Over half of trans men (50.6%; n = 166) and two-fifths (46.9%; n = 30) of trans women and non-binary participants (42.7%; n = 409) who had experienced any suicidal ideation, planning or attempts, or self-harm ideation or attempts in the past 12 months accessed a professional counselling or support service regarding suicide or self-harm in this this time frame. This compares to one-third (37.2%; n = 787) of cisgender women and one-quarter (27.1%; n = 195) of cisgender men.

Almost four-fifths (78.2%; n = 559) of pansexual participants experienced any suicidal ideation, planning or attempts, or self-harm ideation or attempts in the past 12 months. This compares to half (52.7%; n = 559) of gay participants. However, a greater proportion of pansexual participants who had experienced any suicidal ideation, planning or attempts, or self-harm ideation or attempts in the past 12 months had accessed a professional support service in relation to suicide or self-harm in this time frame (43.8%; n = 243), compared to gay participants (30.5%; n = 170). Figure 45 displays these results.

Figure 45 Engagement with professional support services regarding suicide or self-harm in the past 12 months among those who had experienced suicidal ideation, planning or attempts or self-harm in this time frame, by sexuality



9.6 Most recent experience accessing professional support services regarding suicide or self-harm

9.6.1 Services accessed

Participants who reported ever accessing professional support services in relation to suicide or self-harm were asked which service they accessed the most recent time. Table 44 displays these results.

Table 44 Professional support service accessed in relation to suicide or self-harm, most recent time

Professional support service accessed, most recent time (n = 2,768)	n	%
In-person professional counselling or support service	2,323	83.9
Professional text or webchat support service	315	11.4
Professional telephone support service	130	4.7

More than four-fifths (83.9%; n = 2,323) of participants reported accessing in-person professional counselling or support services the most recent time they accessed a professional support service in relation to suicide or self-harm, followed by one-tenth (11.4%; n = 315) accessing a professional text or webchat support service, and 4.7% (n = 130) accessing a professional telephone support service.

9.6.2 Services specifically for LGBTIQA+ people

In total, 3.5% (n = 98) of participants accessed a service that was specifically for LGBTIQA+ people the most recent time they accessed a professional support service in relation to suicide or self-harm. A further 7.6% (n = 210) did not know if the service was specifically for LGBTIQA+ people.

Of those accessing a service that was specifically for LGBTIQA+ people the most recent time they accessed a professional support service in relation to suicide or self-harm, 70.1% (n = 68) accessed an in-person professional counselling or support service, 23.7% (n = 23) accessed a professional text or webchat support service, and 6.2% (n = 6) a professional telephone support service.

A greater proportion of trans women and trans men reported accessing a service that was specifically for LGBTIQA+ people the most recent time they accessed a professional support service in relation to suicide or self-harm. Overall, 10.6% (n = 29) of trans men and 9.1% (n = 4) trans women reported accessing a service that was specifically for LGBTIQA+ people the most recent time they accessed a professional support service in relation to suicide or self-harm, followed by 3.9% (n = 150) of cisgender men, 3.6% (n = 23) of non-binary participants, and 1.6% of (n = 21) cisgender women.

Gay (5.3%; n = 17), queer (4.6%; n = 13), asexual (4.3%; n = 5) and pansexual (4.0%; n = 16) participants reported higher levels than lesbian (2.5%; n = 9) and bisexual (2.4%; n = 22) participants of accessing a service that was specifically for LGBTIQA+ people the most recent time they accessed a professional support service in relation to suicide or self-harm.

9.6.3 Professional support service outcomes

Participants were asked if the professional services they accessed regarding suicide or self-harm the most recent time helped to improve the situation. Responses were on a five-point scale ranging from 'no, made it much worse' to 'yes, made it much better'. Table 45 displays the responses for participants who responded 'yes, made it better' or 'yes, made it much better'.

Table 45 Professional support service contacted regarding suicide or self-harm, made situation better/much better

Professional support service accessed, most recent time	**Made the situation better/much better**	
	n	%
LGBTIQA+-specific service (n = 98)	63	64.3
In-person professional counselling or support service (n = 2,322)	1,357	58.4
Professional telephone support service (n = 130)	61	46.9
Professional text or webchat support service (n = 315)	104	33.0

Overall, almost two-thirds (64.3%; n = 63) of participants who accessed an LGBTIQA+-specific service the most recent time when accessing a professional support service regarding suicide or self-harm reported that it had made the situation better or much better. This compared to three-fifths (58.4%; n = 1,357) of those who accessed an in-person professional counselling or support service, 46.9% (n = 61) of those who accessed a professional telephone support service, and one-third (33.0%; n = 104) of those who accessed a professional text or webchat support service.

Figure 46 is a cascade that shows the number of *Writing Themselves In 4* participants who answered the suicide or self-harm questions (n = 6,390), of whom approximately two-thirds (67.8%; n = 4,334)2 of *Writing Themselves In 4* participants had experienced suicidal ideation, planning or attempts or self-harm ideation or attempts in the past 12 months, of which less than two-fifths (38.1%; n = 1,641) had accessed any professional counselling or support service in regard to suicide or self-harm in the past 12 months. Of the group who had accessed any professional counselling or support service in regard to suicide or self-harm in the past 12 months, almost three-fifths (59.3%; n = 972) reported that the support service resulted in their situation improving (either reported as being better or much better) the last time they accessed it in the past 12 months.

9.7 Preferences for accessing professional support services

Participants were then asked if they were to ever need professional help for suicide or self-harm in the future, how they would prefer to receive it. Responses are shown in Table 46.

Table 46 Participant preferences for future access to professional suicide support services

Suicide support access method preference (n = 6,396)	**n**	**%**
In person	3,871	60.5
By text or webchat	1,201	18.8
By telephone	318	5.0
Other	31	0.5
Don’t know	975	15.2

Three-fifths of participants (60.5%; n = 3,871) reported a preference for accessing a professional suicide support service in person, followed by one-fifth (18.8%; n = 1,201) via text or webchat and 5.0% (n = 318) via telephone.

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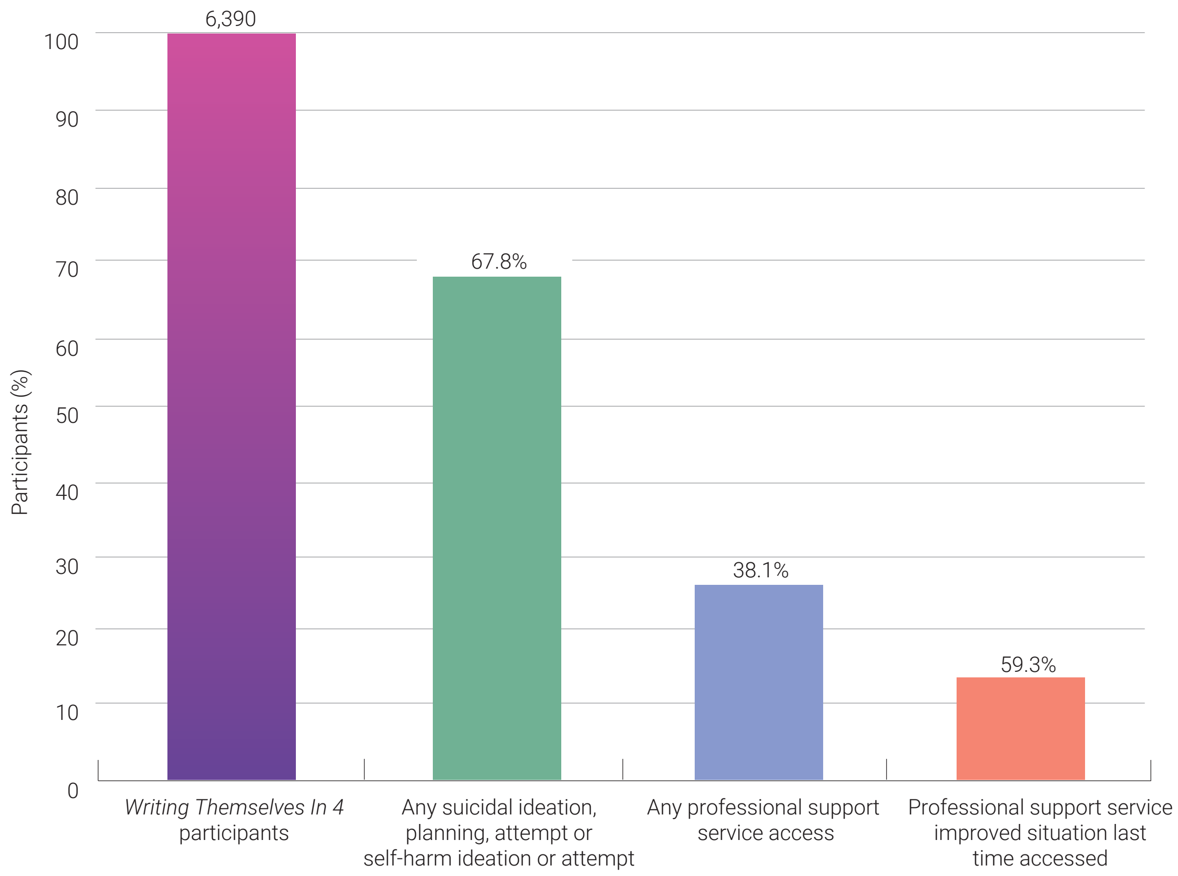
2 *A further 3.2% (n = 201) participants responded ‘prefer not to answer’ to all of these questions.*

Figure 46 Cascade of mental health outcomes, support service access and service-related experience in the past 12 months



64.3%

of participants who accessed an LGBTIQA+ specific service regarding suicide or self-harm reported that doing so had made the situation better

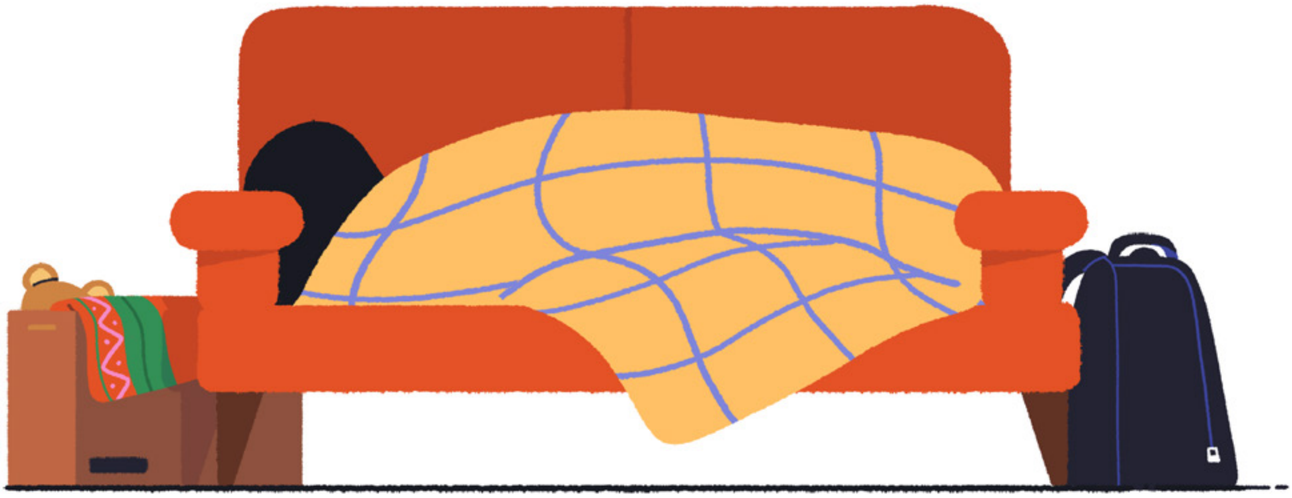
9.8 Summary

Consistent with previous Australian and international research, *Writing Themselves In 4* participants reported high levels of psychological distress, poor mental health and suicidality. Among young people aged 16 to 17 years, *Writing Themselves In 4* participants were more than three times as likely as young people in the general Australian population to report high/very high levels of psychological distress (83.3% compared to 27.3%). *Writing Themselves In 4* participants were also markedly more likely than young people in the general population to have seriously considered suicide in the past 12 months (59.1% compared to 11.2%) or to have attempted suicide in the past 12 months (11.0% compared to 3.8%).

One in ten (10.1%) *Writing Themselves In 4* participants had attempted suicide within the past 12 months, while one in four (25.6%) had attempted suicide at some point in their life. This was most prevalent among trans and gender diverse participants, with 20.0% of trans women and 16.7% of trans men reporting a suicide attempt in the past 12 months. Among participants who had experienced suicidal ideation, planning, attempts or self-harm in the past 12 months, just over one in three (38.1%) had accessed any professional counselling or support service in regard to suicide or self-harm in the past 12 months. In-person counselling was the most common type of service accessed, and the majority of young people who had used this service reported that their situation had improved as a result.

Almost two-thirds (63.8%) of *Writing Themselves In 4* participants reported having ever been diagnosed with a mental health condition. The most commonly reported conditions were generalised anxiety disorder and depression, followed by eating disorders and post-traumatic stress disorder. The majority of people with a mental health diagnosis had received treatment, with 44.5% of *Writing Themselves In 4* participants reporting that they had received treatment or support for a mental health condition in the past 12 months.

10 **Experiences of homelessness**



Youth homelessness is a serious population health concern, with research showing young people who experience homelessness to be at high risk of mental health problems, including depression, post-traumatic stress disorder and anxiety; sexually transmitted infections; as well as challenges managing substance use (60,61). Growing evidence suggests that a higher proportion of LGBTIQA+ people have experienced homelessness than the general population (62), often due to rejection from family. However, there has been limited systematic research in Australia, as many mainstream data collections do not record or inadequately record diverse genders, sex characteristics, and sexuality, and Australia lags behind other high income countries in developing research, policy and best practice regarding LGBTIQA+ homelessness (63). There has, to date, been a limited policy and programmatic response to LGBTIQA+ homelessness in Australia (64).

A variety of measures and definitions of homelessness exist, with no fixed standard. Under the ABS definition, a person is homeless if they do not have suitable accommodation alternatives and their current living arrangement: is in a dwelling that is inadequate; has no tenure, or if their initial tenure is short and not extendable; or does not allow them to have control of, and access to, space for social relations (65). Young people have been found to not identify as homeless when asked directly (66). As such, for *Writing Themselves In 4* a set of questions was used based on a previously successful study of 26,161 young people in the United States (67) to capture the broadest aspects of homelessness among young LGBTIQA+ people. These questions capture the experiences of participants who have 1) run away, 2) left home because of being asked to leave, 3) couch surfed, or 4) been homeless in the past 12 months or ever in their lifetime.

10.1 Experiences of homelessness

Participants were first given the following options, asking if they had ever:

- Run away from home or the place you live
- Left home or the place you live because you were asked/made to leave
- Couch surfed because you had no other place to stay
- Been homeless

Participants who responded 'yes' to any of the above were then asked if they were currently experiencing this, if it was within the past 12 months, or if it was more than 12 months ago, in relation to each response. Participants could select as many options as applied (i.e. currently experiencing this, and also did so more than 12 months ago). Results for the full sample are shown in Table 47.

Table 47 shows that almost one-quarter (23.6%; n = 1,501) of participants had experienced one or more forms of homelessness in their lifetime, including 11.5% (n = 733) who experienced this in the past 12 months. One-seventh (17.4%; n = 1,105) of participants had ever run away from home or the place they lived, and over one-tenth (10.5%; n = 667) had ever left home or the place they live because they were asked or made to leave. In total, 1.9% (n = 121) of participants reported currently experiencing homelessness at the time of the survey.

The number of participants experiencing homelessness ever (n = 6,200) and in the past 12 months (n = 6,195) is analysed by gender in Figure 47 (displayed on next page).

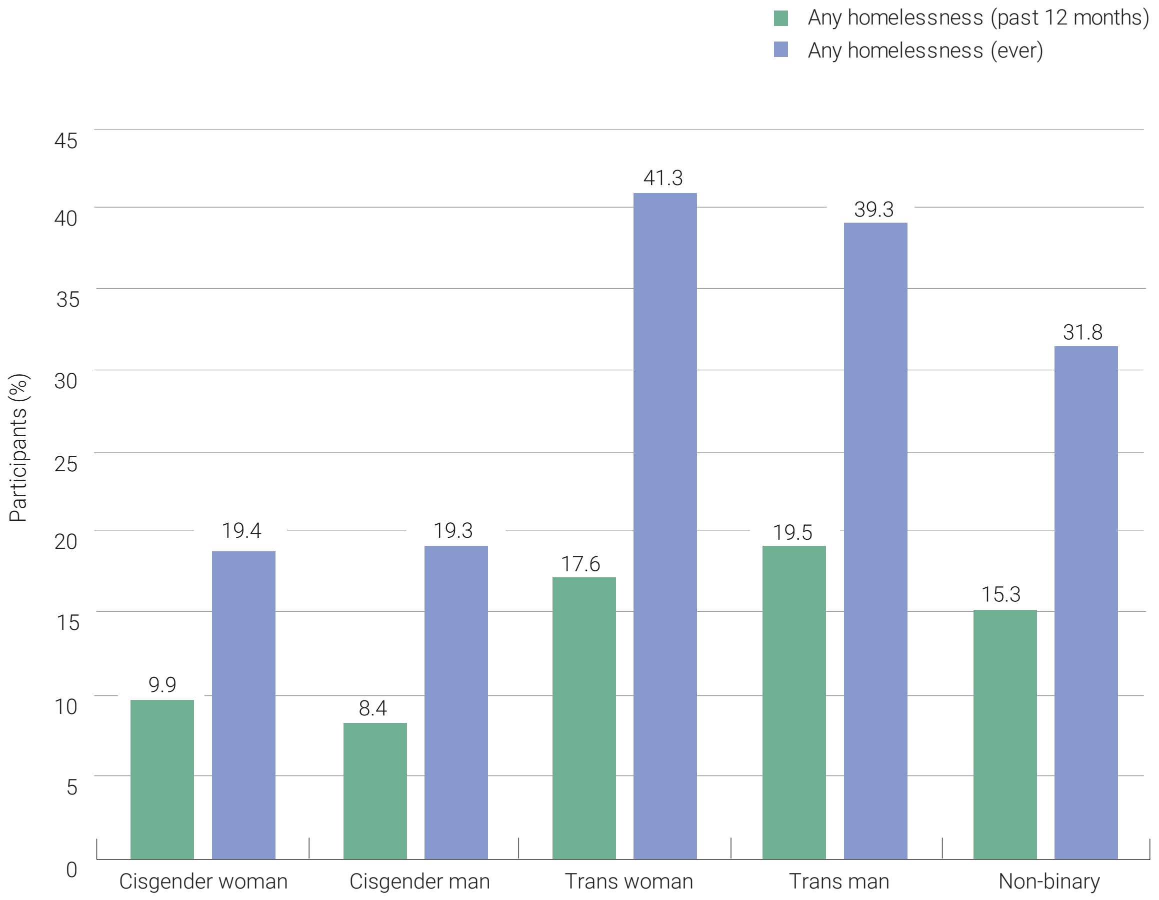
Almost one-fifth of trans men (19.5%; n = 78) and trans women (17.6%; n = 13) reported experiencing one or more forms of homelessness in the past 12 months, followed by 15.3% (n = 184) of non-binary participants, 9.9% (n = 116) of cisgender men, and 8.4% (n = 116) of cisgender women.

Similarly, two-fifths of trans women (41.3%; n = 31) and trans men (39.3%; n = 78) reported ever having experienced one or more forms of homelessness, followed by 31.8% (n = 382) of non-binary participants, 19.4% (n = 609) of cisgender women, and 19.3% (n = 266) of cisgender men.

Table 47 Proportion of participants who had experienced homelessness in their lifetime and in the past 12 months

	Ever		Past 12 months	
Homelessness (n = 6,363)	**n**	**%**	**n**	**%**
Run away from home or the place you live	1,105	17.4	446	7.0
Left home or the place you live because you were asked/made to leave	667	10.5	296	4.7
Couch surfed because you had no other place to stay	423	6.7	223	3.5
Been homeless	260	4.1	105	1.7
One or more experience of homelessness	1,501	23.6	733	11.5

Figure 47 Experience of homelessness ever and in the past 12 months, by gender



The number of participants experiencing homelessness ever (n = 6,352) and in the past 12 months (n = 6,345) is analysed by sexuality in Figure 48 below.

Pansexual participants were the most likely to report homelessness in the past 12 months (16.2%, n = 115). Gay participants were the least likely (8.6%, n = 90).

Pansexual (16.2%; n = 115) and queer (15.0%; n = 80) participants reported higher levels of one or more forms of homelessness in the past 12 months than lesbian (11.7%; n = 89), asexual (10.5%; n = 31), bisexual (10.1%; n = 217) or gay (8.6%; n = 90) participants. Similarly, a greater proportion of pansexual (31.4%; n = 223) and queer (28.8%; n = 154) participants reported ever experiencing one or more forms of homelessness than lesbian (22.8%; n = 174), gay (21.0%; n = 221), bisexual (20.5%; n = 441) or asexual (19.3%; n = 57) participants.

10.2 Homelessness in relation to being LGBTQA+

Participants were asked if any experience/s of homelessness in their lifetime were related to being LGBTQA+. Over one-quarter (26.0%; n = 388) of participants reported that their experience/s of homelessness in their lifetime were related to being LGBTQA+. Figure 49 displays this experience, broken down by gender (see next page).

A greater proportion of trans men (45.2%; n = 71), trans women (37.9%; n = 11), and non-binary participants (30.3%; n = 115) than cisgender men (25.4%; n = 67) and cisgender women (17.2%; n = 104) reported that their experience/s of homelessness were related to being LGBTQA+.

Figure 50 (next page) displays this experience broken down by sexuality. Gay (37.0%; n = 81) and queer (35.9%; n = 55) participants were the most likely to report their experience/s of homelessness being related to being LGBTQA+, followed by lesbian (28.3%; n = 49), pansexual (21.3%; n = 21.3), asexual (21.1%; n = 12), and bisexual (18.7%; n = 82) participants.

Figure 48 **Experience of homelessness ever and in the past 12 months, by sexuality**

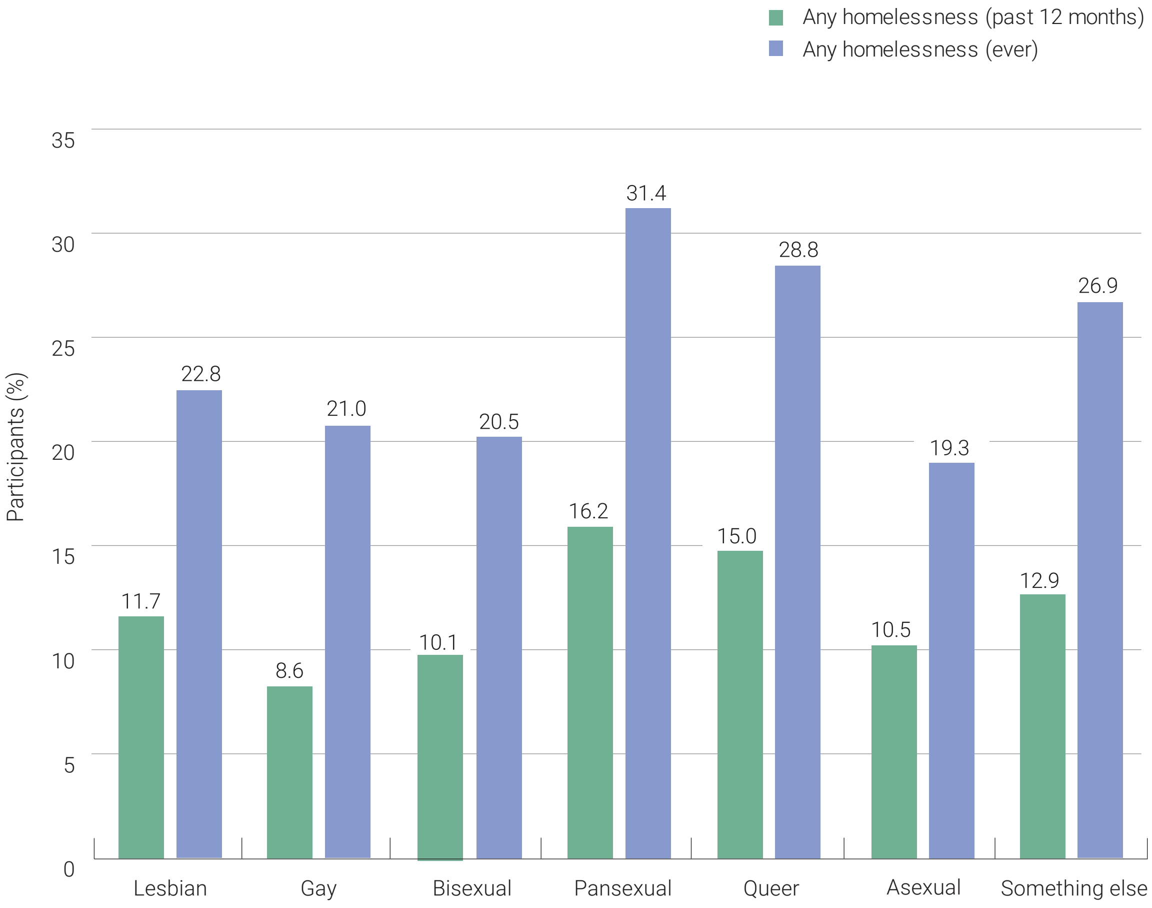


Figure 49 Experience/s of homelessness related to being LGBTQA+, by gender

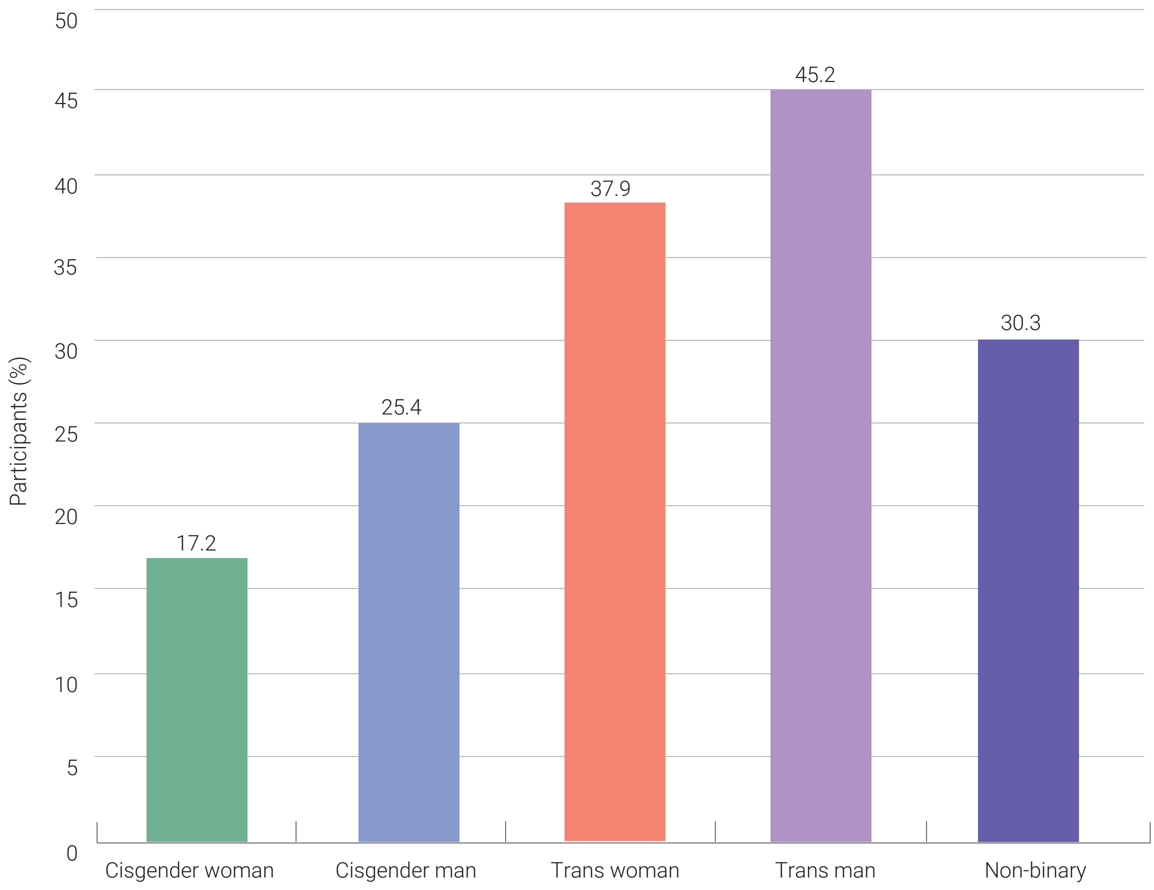
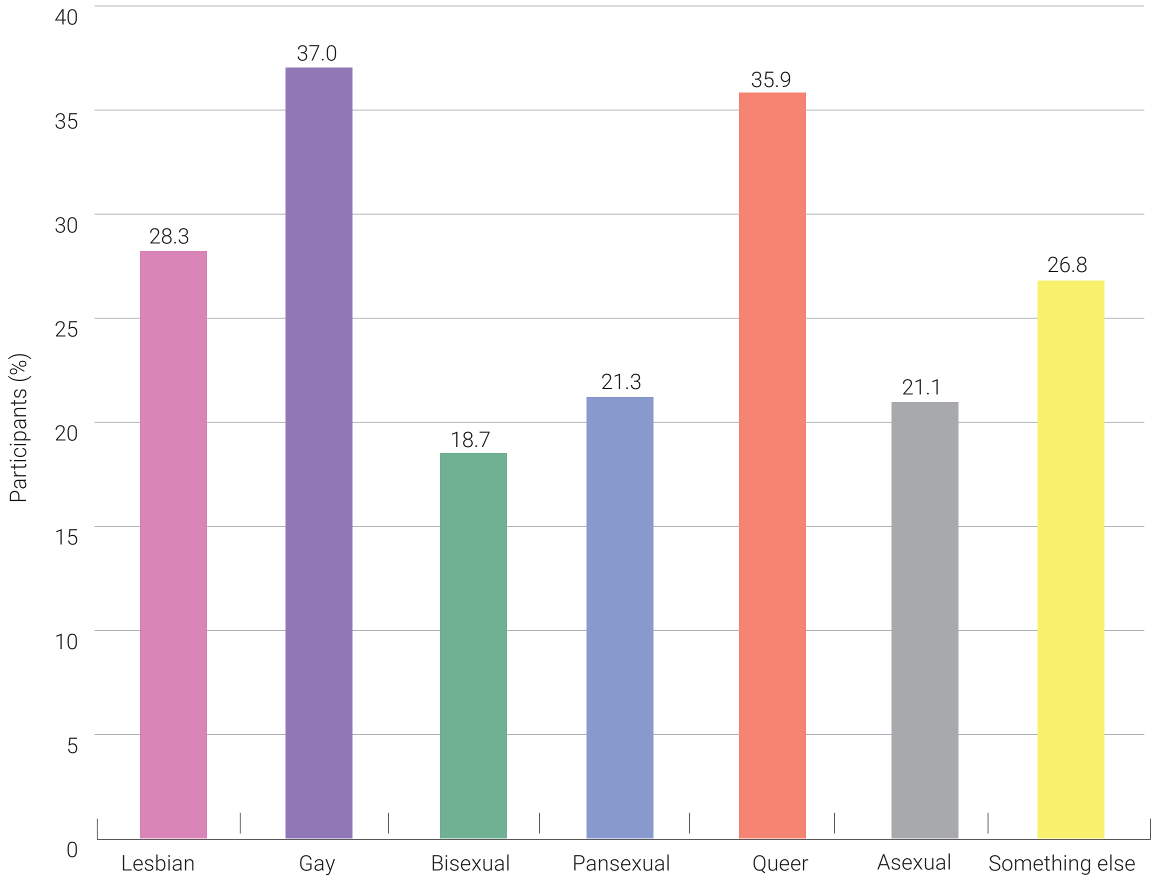


Figure 50 Experience/s of homelessness related to being LGBTQA+, by sexuality



26.0%

of participants reported that their experience/s of homelessness in their lifetime were related to being LGBTQA+

10.3 Perceived causes of homelessness

Participants who reported experiences of homelessness were asked about specific causes of their homelessness. Participants could select more than one response. Table 48 displays these results.

Table 48 **Perceived causes of homelessness**

Perceived cause of homelessness (n = 1,464)	n	%
Mental health issues	913	62.4
Rejection from family	654	44.7
Family violence	634	43.3
Financial stress	287	19.6
Violence/harassment in previous accommodation	190	13.0
Discrimination (such as from school, employment, services)	162	11.1
Rejection from peers	148	10.1
Substance use	136	9.3
Unemployment/underemployment	135	9.2
Disability	70	4.8
Chronic illness	59	4.0
Other	134	9.2

Table 48 shows that of the 1,464 participants who reported specific causes of the experiences of homelessness, over three-fifths (62.4%; n = 913) cited mental health issues as the cause of their homelessness, over two-fifths cited rejection from family (44.7%; n = 654) or family violence (43.3%; n = 634), and one-fifth (19.6%; n = 287) cited financial stress as the cause of their homelessness.

10.4 Summary

Almost one in four (23.6%) *Writing Themselves In 4* participants had experienced one or more forms of homelessness in their lifetime while, for 11.5%, this had occurred within the past 12 months. Trans men and trans women were the groups most likely report experiences of homelessness. Almost one in five trans men (19.5%) and trans women (17.6%) reported experiencing one or more forms of homelessness in the past 12 months.

Over one-quarter (26.0%) of participants reported that their experience/s of homelessness in their lifetime were related to being LGBTQA+. This percentage was higher for trans men (45.2%) and trans women (37.9%). Further specific causes of homelessness reported by participants were mental health issues, rejection from family, family violence, and financial stress. Close to one in five participants reported that they had become homeless after running away from home or the place they live (17.4%) or being asked to leave home (10.5%).

11 Alcohol, tobacco and other drug use

Australian and international research suggests that LGBT people tend to use alcohol and other drugs more commonly and at higher rates than those observed among heterosexual people (39,68–70). In one study, proportions of alcohol and other drug use among LGBT young people were markedly higher than that of their peers in the general population (71). A number of potential explanations have been posed regarding this higher rate of use, including differing social norms relating to alcohol and other drug use among LGBTIQ+ communities, as well as observations that a large part of social and cultural life in many LGBT communities is centred around licensed bars and clubs where alcohol is served and other drugs may be accessible (itself serving to shape social norms around drug use) (72,73). Marginalisation, discrimination and poorer mental health among LGBTIQ+ people have also been suggested as potential explanations for these disparities (74).

Differences in substance use have been identified within sub-populations of LGBT communities. For example, in one study, psychological distress and sexual orientation-based victimisation were associated with increased alcohol use for young LGBT women only, whereas perceived family support was negatively associated with alcohol use for all LGBT young people (75).

11.1 Tobacco use

Participants were asked if they had prior or current experience of smoking cigarettes or any other tobacco product. Table 49 displays smoking-related experience for the total sample as well as those aged 14 to 17 and 18 to 21, separately.

Over one-tenth (11.5%; n = 740) of participants were current smokers, including 8.0% (n = 300) of participants aged 14 to 17 years, and over one-eighth (16.6%; n = 440) aged 18 to 21 years. Smoking rates were much lower than reported in the national sample of *Writing Themselves In* 3, in which 23% of participants reported smoking cigarettes daily. Rates of daily smokers observed among *Writing Themselves In 4* participants aged 18 to 21 (7.8%; n = 206) were lower than those observed in a survey of young people aged 18 to 24 years in the general population (76).

Among participants aged 14 to 17, over one-tenth (12.5%; n = 4) of trans women and trans men (11.0%; n = 26) were current smokers, followed by cisgender men (9.6%; n = 67), non-binary participants (8.3%; n = 95) and cisgender women (6.8%; n = 138).

Among participants aged 18 to 21 one-fifth (21.8%; n = 37) of trans men and cisgender men (20.0%; n = 139) were current smokers, followed by 17.6% (n = 95) of non-binary participants, 14.3% (n = 6) of trans women, and 13.5% (n = 153) of cisgender women.

Of the full *Writing Themselves In 4* sample, 5.0% (n = 324) of participants reported currently using e-cigarettes or vaping. Approximately one-twenty-fifth (4.2%; n = 159) of participants aged 14 to 17 years, and 6.2% (n = 165) of participants aged 18 to 21 years reported currently using e-cigarettes or vaping.

11.2 Alcohol use

To assess levels of alcohol consumption, *Writing Themselves In 4* included the three-item AUDIT-C scale. Responses to the first and third items of this scale, 'How often do you have a drink containing alcohol?' and 'How often do you have six or more drinks on one occasion?', pertaining to frequency and amount of alcohol consumption, are shown in below in Tables 50 and 51.

Less than half (47.7%; n = 460) of participants aged 14 to 17 years reported drinking alcohol, fewer than the 66% among young people aged 12-17 years in the general population (77). Overall, 85.8% of participants aged 18 to 21 years reported drinking alcohol, while less than one-fifth (17.5%; n = 463) drank alcohol more than twice per week. Similar to cigarette smoking, there was a lower rate of reported drinking than found by *Writing Themselves In 3*, in which 48% of participants reported weekly drinking (3).

Participants who drank alcohol (n = 4,072) were asked how often they consumed six or more alcoholic drinks on one occasion. Table 51 displays the results.

Among those who drank alcohol, under one-quarter (23.0%; n = 937) reported drinking six or more drinks on one occasion monthly or more frequently. Also among participants who drank alcohol, half (51.0%; n = 917) of those aged 14 to 17 years and almost one-quarter (23.8%; n = 541) of those aged 18 to 21 years never drank six or more drinks on one occasion.

Table 49 Proportion of participants reporting tobacco use

	14-17 years		18-21 years		Total	
Smoking (n = 6,413)	**n**	**%**	**n**	**%**	**n**	**%**
No, I have never smoked	3,207	85.2	1,902	71.9	5,109	79.7
No, I used to smoke but I no longer smoke	259	6.9	305	11.5	564	8.8
Yes, I smoke less often than weekly	172	4.6	234	8.8	406	6.3
Yes, I smoke at least weekly (but not daily)	61	1.6	63	2.4	124	1.9
Yes, I smoke daily	67	1.8	143	5.4	210	3.3

Table 50 Frequency of alcohol consumption

	14-17 years		18-21 years		Total	
Alcohol consumption (n = 6,418)	**n**	**%**	**n**	**%**	**n**	**%**
Never	1,971	52.3	375	14.2	2,346	36.6
Monthly or less	1,279	33.9	910	34.4	2,189	34.1
2-4 times per month	439	11.6	900	34.0	1,339	20.9
2-3 times per week	69	1.8	373	14.1	442	6.9
4 or more times a week	12	0.3	90	3.4	102	1.6

11.3 Other non-medicinal drug use

Participants were asked if they had used one or more drugs for non-medical purposes in the past six months. Approximately one-third (33.4%, n = 1,875) of participants reported using any drug for non-medical purposes in the past six months. Almost three-tenths (28.2%; n = 1,581) had used cannabis in the past six months, followed by 7.0% (n = 395) who had used ecstasy/MDMA, 5.6% (n = 315) antidepressants, 4.0% (n = 222) amyl nitrite, 3.4% (n = 193) LSD, 3.4% (n = 188) nitrous oxide, 3.0% (n = 170) cocaine, and 1.3% (n = 70) meth/amphetamine.

Drug use was analysed among participants aged 14 to 17 years (n = 3,199) and those aged 18 to 21 years (n = 2,418), as displayed in Table 52 below.

Table 51 **Frequency of consuming six or more drinks on one occasion**

	14-17 years		18-21 years		Total	
Six or more drinks on one occasion (n = 4,069)	**n**	**%**	**n**	**%**	**n**	**%**
Never	917	51.0	541	23.8	1,458	35.8
Less than monthly	642	35.7	1,032	45.4	1,674	41.1
Monthly	201	11.2	480	21.1	681	16.7
Weekly	33	1.8	204	9.0	237	5.8
Daily or almost daily	5	0.3	14	0.6	19	0.5

Table 52 **Drug use for non-medical purposes in the past six months by participants aged 14-17 and 18-21 years**

	14-17 years (n = 3,199)		18-21 years (n = 2,418)	
Drug	**n**	**%**	**n**	**%**
Cannabis	709	22.2	872	36.1
Ecstasy/MDMA	104	3.3	291	12.0
Amyl nitrite/alkyl nitrite	32	1.0	190	7.9
Antidepressants	161	5.0	154	6.4
Nitrous oxide	58	1.8	130	5.4
Cocaine	30	0.9	140	5.8
LSD	63	2.0	130	5.4
Benzodiazepines	78	2.4	103	4.3
Natural hallucinogens	50	1.6	81	3.4
Ketamine	28	0.9	70	2.9
Pharmaceutical opioids	42	1.3	54	2.2
Antipsychotics	38	1.2	26	1.1
Synthetic cannabis	28	0.9	15	0.6
Meth/amphetamine	22	0.7	48	2.0
GHB/GBL/1,4-BD	5	0.2	12	0.5
Heroin	8	0.3	5	0.2
Steroids	5	0.2	7	0.3
Mephedrone	1	0.0	2	0.1
Other drug	50	1.6	43	1.8
Any drug use	848	26.5	1,027	42.5

Table 52 shows that when analysed by age, over one-quarter (26.5%; n = 848) of participants aged 14 to 17 years and over two-fifths (42.5%; n = 1,027) of participants aged 18 to 21 years reported using any drug for non-medical purposes in the past six months, compared to 18% having ever used illicit drugs in their lifetime among people aged 12 to 17 years in the general population (77).

Over one-quarter (28.2%; n = 1,581) of participants reported using cannabis in the past six months, followed by ecstasy/MDMA (7.0%; n = 395) and amyl nitrite/alkyl nitrite (4.0%; n = 222). Among participants aged 14 to 17 years, one-fifth (22.2%; n = 709) of participants reported using cannabis in the past six months, followed by antidepressants (5.0%; n = 161), ecstasy/MDMA (3.3%; n = 104) and nitrous oxide (1.8%; n = 58). Among participants aged 18 to 21 years, 36.1% (n = 872) of participants reported using cannabis in the past six months, followed by ecstasy/MDMA (12.0%; n = 291), amyl nitrite/alkyl nitrite (7.9%; n = 190), and cocaine (5.8%; n = 140).

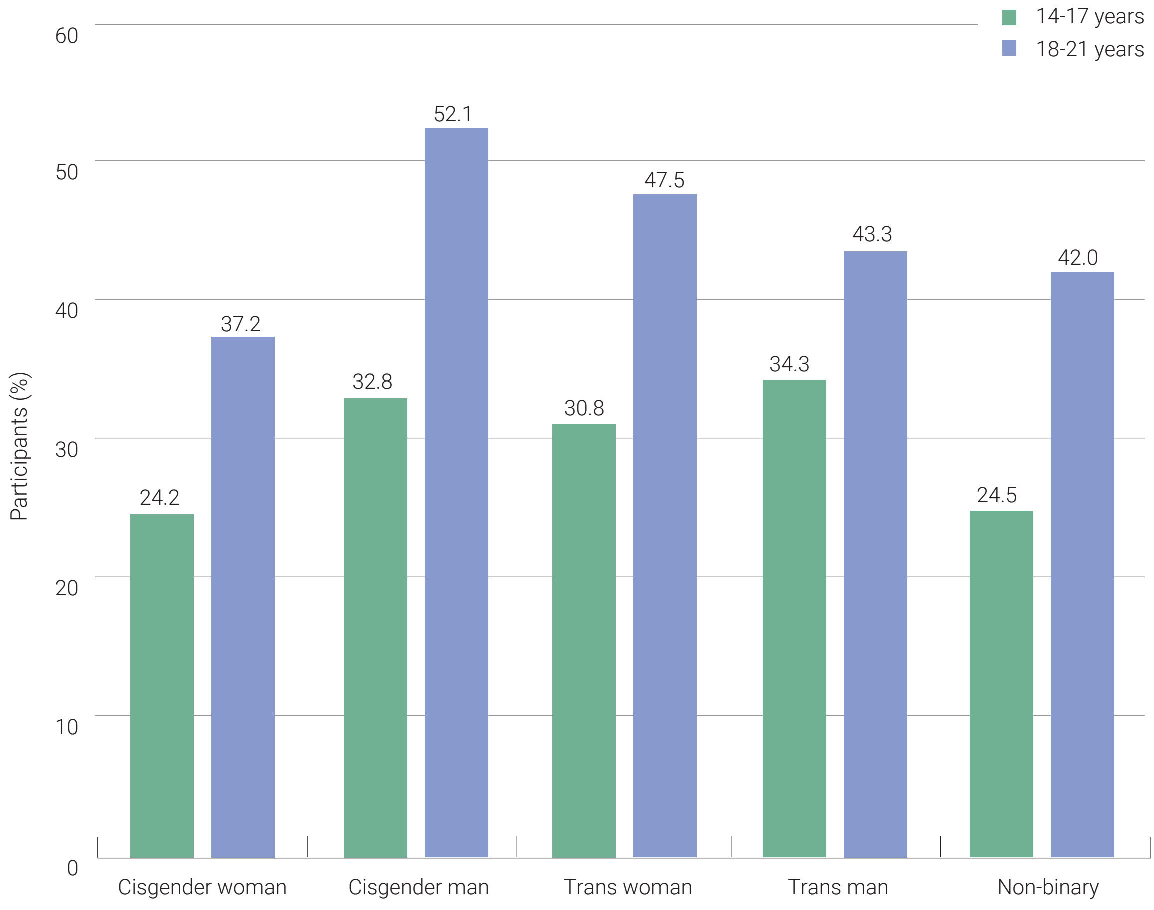
11.3.1 Drug use in past six months, by gender

Any drug use for non-medical purposes in the past six months among participants aged 14 to 17 years (n = 3,119) and those aged 18 to 21 (n = 2,356) was analysed by gender, as displayed in Figure 51 below.

Among participants aged 14 to 17 years, the proportion reporting any drug use for non-medical purposes in the past six months was highest among trans men (34.3%; n = 74), cisgender men (32.8%; n = 188) and trans women (30.8%; n = 8), followed by non-binary participants (24.5%; n = 144) and cisgender women (24.2%; n = 415).

Among participants aged 18 to 21 years, the proportion reporting any drug use for non-medical purposes in the past six months was highest among cisgender men (52.1%; n = 322), followed by trans women (47.5%; n = 19), trans men (43.3%; n = 65), non-binary participants (42.0%; n = 214) and cisgender women (37.2%; n = 386).

Figure 51 **Any drug use in the past six months among participants aged 14-17 and 18-21, by gender**



11.3.2 Drug use in past six months, by sexuality

Any drug use for non-medical purposes in the past six months among participants aged 14 to 17 years (n = 3,194) and those aged 18 to 21 years (n = 2,412) was analysed by sexuality in Figure 52 below.

Among participants aged 14 to 17 years, any drug use for non-medical purposes in the past six months was highest among queer participants (32.2%; n = 76) and lowest among asexual participants (8.4%; n = 10).

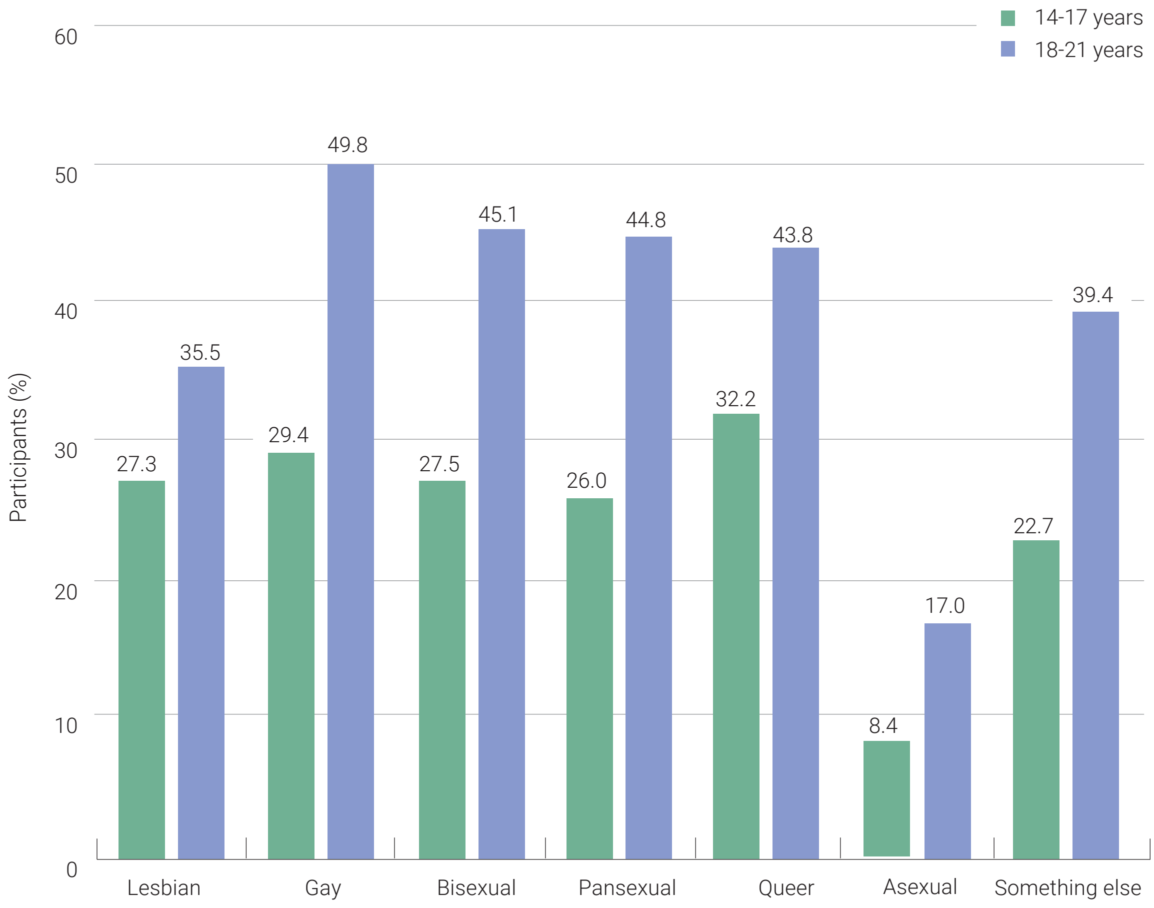
Among participants aged 18 to 21 years, any drug use for non-medical purposes in the past six months was highest among gay participants (49.8%; n = 236), followed by bisexual (45.1%; n = 331), pansexual (44.8%; n = 117), and queer participants (43.8%; n = 106). Lesbian (35.5%; n = 94) and asexual participants (17.0%; n = 25) reported lower drug use for non-medical purposes in the past six months than those of other sexual orientations.

11.3.3 Concern about drug use

Participants who reported using drugs (n = 1,875) in the past six months were asked if they had ever been concerned about their drug use, or if their friends or family had ever expressed concern about their drug use.

- Almost one-quarter (23.5%; n = 440) reported ever being concerned about their drug use, with 25.9% (n = 220) of 14- to 17-year-olds and 21.4% (n = 220) of 18- to 21-year-olds reporting this.
- Three-tenths (29.1%; n = 545) reported their family or friends ever being concerned about their drug use, with 34.7% (n = 294) of 14- to 17-year-olds and 24.5% (n = 545) of 18- to 21-year-olds reporting this.

Figure 52 **Any drug use in the past six months among participants aged 14-17 and 18-21, by sexuality**



23.5%

of those using drugs reported ever being concerned about their use but only 11.8% of these same participants had accessed professional support in relation to their drug use in the past six months

11.3.4 Professional support access among participants concerned about drug use

Of participants who reported ever being concerned about their drug use (n = 440), 88.2% (n = 388) had not sought professional support for drug use in the past six months.

Of participants who reported ever being concerned about their drug use, 11.8% (n = 52) in total sought professional support for drug use in the past six months, 9.3% (n = 41) sought professional support from a mainstream drug service, 3.6% (n = 16) from a mainstream drug service that was LGBTIQA+ inclusive, and 0.7% (n = 3) from a drug service that is only for LGBTIQA+ people. No participants reported seeking professional support from a drug service that is only for Aboriginal or Torres Strait Islanders.

11.4 Future support preferences

Participants were asked if they were to need help in relation to drug use in the future, where they would prefer to receive it. Table 53 displays their responses from all participants (n = 6,370) and those who had used drugs in the past six months (n = 1,872)

When asked where participants would prefer to access support services if they struggled with drug use in the future, one-third (34.6%; n = 2,202) responded 'from a mainstream drug service that is LGBTIQA+ inclusive', one-tenth (12.6%; n = 235) from 'a mainstream drug service', and 6.0% (n = 384) 'from a drug service that caters only to LGBTIQA+', and 0.3% (n = 18) from 'a drug service that caters to Aboriginal/Torres Strait Islanders' (7.1% of Aboriginal or Torres Strait Islander participants reported a preference for this service). A further 49.0% (n = 3,120) reported not knowing or not having a preference.

Participants who reported using drugs in the past six months were asked where they would prefer to access support services if they struggled with drug use in the future, almost one-third (32.2%; n = 602) responded 'from a mainstream drug service that is LGBTIQA+ inclusive', over one-tenth (12.6%; n = 235) from 'a mainstream drug service', 7.5% (n = 140) 'from a drug service that caters only to LGBTIQA+', and 0.2% (n = 4) from 'a drug service that caters to Aboriginal/Torres Strait Islanders' (4.7% of Aboriginal or Torres Strait Islander participants who had used drugs in the past six months reported a preference for this service). A further 47.6% (n = 891) reported not knowing or not having a preference.

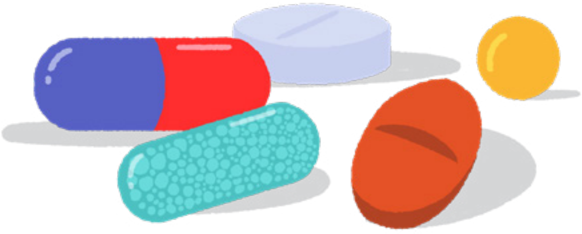
Table 53 **Preference for drug-use-related support in the future, if required**

	All participants (n = 6,370)		Participants who had used drugs in past six months (n = 1,872)	
Service	**n**	**%**	**n**	**%**
From a mainstream service	646	10.1	235	12.6
Mainstream service that is known to be LGBTIQA+ inclusive	2,202	34.6	602	32.2
Service that only caters to LGBTIQA+ people	384	6.0	140	7.5
Drug service that caters to Aboriginal/Torres Strait Islanders	18	0.3	4	0.2
I don't know	1,511	23.7	388	20.7
I have no preference	1,609	25.3	503	26.9

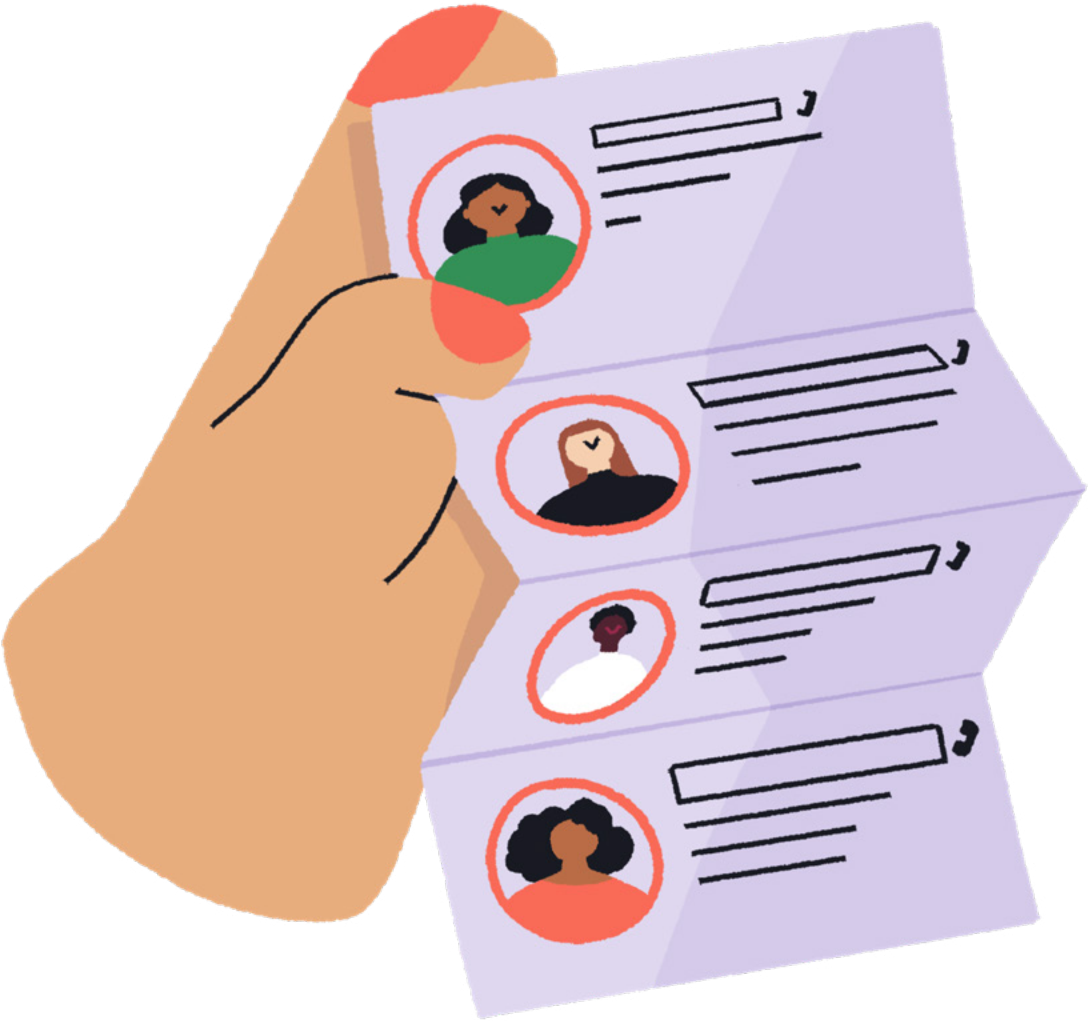
11.5 Summary

Just over one in ten participants were current smokers, including 8.0% of participants aged 14 to 17 years, and 16.6% aged 18 to 21 years. Less than half (47.7%) of participants aged 14 to 17 years reported drinking alcohol, which is slightly lower than the proportion of 14- to 17-year-olds documented in general population studies. A much higher proportion of 18- to 21-year-olds (85.8%) reported drinking alcohol, with around one-fifth doing so more than twice per week.

Around a third of participants reported using any drug for non-medical purposes in the past six months, and the most popular of these were cannabis, ecstasy, amyl nitrite and antidepressants. While there were differences according to age, use of any illicit drug tended to be highest among cisgender men, with high rates also reported by trans women and trans men. Around a quarter of those who had used illicit drugs reported they had been concerned about their use at some point in the past, with a similar proportion reporting that friends or family had expressed concern about their drug use. Only a small proportion of those expressing concern had accessed professional support relating to their drug use.



12 Engagement with professional support services



Previous research has identified significant barriers for LGBTIQ young people when accessing professional support services such as counselling or mental health services. Australian and international studies show that LGBTI people under-utilise health services and delay seeking treatment due to actual or anticipated bias from service providers. In a large study of LGBT adults, Private Lives 2, nearly 34% of LGBT Australians reported 'usually or occasionally' hiding their sexual orientation or gender identity when accessing services to avoid possible discrimination and abuse (39).

The Trans Pathways study (23) found that young people seeking health services encountered inexperienced or transphobic service providers, and long waiting lists to see providers who were seen as 'trans-friendly'. Feeling isolated from services was found to have a significant negative impact on mental health (23). Community-controlled, or LGBTIQA+, health services may help overcome this issue, but access to such services may be limited for some, particularly in rural or remote locations. Meanwhile, various efforts have been made in the last decade to improve the inclusion of LGBTIQ people within mainstream services, in order to encourage people to access services and improve their experiences and promote positive outcomes.

12.1 Understanding experiences of access to professional support services

In order to understand their experiences of accessing professional support services, including the outcomes achieved in doing so, a sequence of questions was asked to step through specific experiences of service engagement in detail.

All *Writing Themselves In 4* participants were initially asked, 'Have you ever accessed any of the following professional support services?' (Multiple responses were permitted.) Response options were as follows:

- In-person professional counselling or support service (e.g. school counsellor, Headspace)
- Professional telephone support service (e.g. Qlife, Kids Helpline)
- Professional text or webchat support service (e.g. Qlife, Kids Helpline)
- No, I have never accessed professional support services

Participants who had accessed any of the above professional services were then asked if it was 'in the previous 12 months' or 'more than 12 months ago' (multiple responses permitted).

Participants who had ever accessed any professional services in their lifetime were then asked, 'The most recent time you received professional help, which of the following did you access?'

- In-person professional counselling or support service (e.g. school counsellor, Headspace)
- Professional telephone support service (e.g. Qlife, Kids Helpline)
- Professional text or webchat support service (e.g. Qlife, Kids Helpline)

Participants were then asked, regarding the most recent time they accessed a professional service, 'Was it in relation to your sexuality or gender identity?' Response options were 'yes' or 'no'.

Participants were then asked, regarding the most recent time they accessed a professional service, 'Was this service specifically for LGBTIQA+ people?' Response options were 'yes' or 'no'.

Finally, participants were asked, regarding the most recent time they accessed a professional service, 'Did they help improve the situation?' Response options were on a five-point scale ranging from 'no, made it much worse' to 'yes, made it much better'.

47.5%

of participants had ever accessed a professional counselling or support service in the past 12 months.

12.2 Experiences of accessing professional support services

Participants were asked if they had accessed one of the following professional support services ever in their lifetime.

Table 54 Professional support service accessed, ever

Professional support service (n = 6,388)	**n**	**%**
In-person professional counselling or support service	4,018	62.9
Professional telephone support service	840	13.2
Professional text or webchat support service	1,357	21.2
Any of the above	4,343	68.0

Over three-fifths (62.9%; n = 4,018) of participants had accessed an in-person professional counselling or support service, over one-tenth (13.2%; n = 840) a professional telephone support service, and over one-fifth (21.2%; n = 1,357) a professional text or webchat support service in their lifetime.

In total, over two-thirds (68.0%; n = 4,343) of participants had ever accessed a professional counselling or support service in their lifetime, and 47.5% (n = 3,032) had accessed one in the past 12 months.

12.3 Most recent experience accessing professional support services

12.3.1 Services accessed

Participants reporting ever accessing professional support services were asked which service they accessed the most recent time. Table 55 displays these results.

Table 55 Professional support service accessed, most recent time

Professional support service accessed, most recent time (n = 4,331)	n	%
In-person professional counselling or support service	3,684	85.1
Professional telephone support service	139	3.2
Professional text or webchat support service	508	11.7

More than four-fifths (85.1%; n = 3,684) of participants reported accessing in-person professional counselling or support services the most recent time they accessed a professional support service, followed by one-tenth (11.7%; n = 508) a professional text or webchat support service, and 3.2% (n = 139) a professional telephone support service.

12.3.2 Accessing a service specifically to address LGBTIQ-related concerns

Overall, over one-quarter (28.9%; n = 1,252) of participants said that the most recent time they accessed a professional support service was to discuss matter specifically relating to their sexuality or gender identity.

Table 56 Professional support service accessed in relation to sexuality or gender identity, most recent time

	No		Yes	
Professional support service (n = 4,331)	n	%	n	%
In-person professional counselling or support service	2,701	73.3	983	26.7
Professional telephone support service	98	70.5	41	29.5
Professional text or webchat support service	282	55.5	226	44.5

The most recent time participants accessed a professional support service, it was in relation to their sexuality or gender identity for more than two-fifths (44.5%; n = 226) of those accessing a professional text or webchat support service, compared to three-tenths (29.5%; n = 41) of those accessing a professional telephone support service, and one-quarter (26.7%; n = 983) of those accessing an in-person professional counselling or support service.

12.3.3 Accessing services specifically for LGBTIQA+ people

In total, 6.2% (n = 267) of participants said that the most recent professional support service they accessed was one that specifically caters for LGBTIQA+ people. Of those, 70.4% (n = 188) accessed an in-person professional counselling or support service, 25.5% (n = 68) accessed a professional text or webchat support service, and 4.1% (n = 11) accessed a professional telephone support service.

Trans women and trans men were more likely to report recently accessing a service that was specifically for LGBTIQA+ people: (29.4%, n = 20 and 22.8%, n = 79, respectively). This compared to 8.8% (n = 82) of non-binary participants, 3.6% (n = 25) of cisgender men, and 2.4% of (n = 52) cisgender women.

Similarly, pansexual (9.3%; n = 50) and queer (9.5%; n = 40) participants were more likely to have recently accessed a service that was specifically for LGBTIQA+ people, compared to lesbian (4.3%; n = 24), bisexual (4.9%; n = 70), asexual (4.6%; n = 9), or gay (6.4%; n = 39) participants.

12.3.4 Professional support service outcomes

Participants were asked if the professional services they accessed the most recent time helped to improve the situation. Responses were on a five-point scale ranging from 'no, made it much worse' to 'yes, made it much better'. Table 57 displays the responses for participants who responded 'yes, made it better' or 'yes, made it much better'.

Table 57 Professional support service made situation better/much better

Professional support service accessed most recent time made situation better/ much better	n	%
LGBTIQA+-specific service (n = 267)	168	63.2
In-person professional counselling or support service (n = 3,633)	1,822	50.2
Professional telephone support service (n = 139)	55	39.6
Professional text or webchat support service (n = 505)	176	34.9

Overall, almost two-thirds (63.2%; n = 168) of participants who accessed an LGBTIQA+-specific service the most recent time they accessed a professional support service reported that it had made the situation 'better/much better', compared to half (50.2%; n = 1,822) of those accessing an in-person professional counselling or support service, two fifths (39.6%; n = 55) of those accessing a professional telephone support service, and one third (34.9%; n = 176) of those accessing a professional text or webchat support service.

12.4 Preferences for accessing professional support services

Participants were asked, 'If you were to ever need help or support from a professional counselling service in the future, where would you prefer to receive it?' Table 58 displays their responses.

Table 58 Preferences for accessing types of professional support service, if required in the future

Professional support service (n = 6,414)	**n**	**%**
From a mainstream service that is known to be LGBTIQA+ inclusive	2,934	45.7
From a service that is only for LGBTIQA+ people	750	11.7
From a mainstream service	556	8.7
From an Aboriginal/Torres Strait Islander service	16	0.2
I don't know	864	13.5
I have no preference	1,294	20.2

More than two-fifths (45.7%; n = 2,934) of participants said they would prefer to access a mainstream service that is LGBTIQA+ inclusive, compared to approximately one-tenth (11.7%; n = 750) who preferred a service that is only for LGBTIQA+ people, and 8.7% (n = 556) who preferred a mainstream service. In total, 6.3% (n = 16) of Aboriginal or Torres Strait Islander participants said they would prefer to access an Aboriginal/Torres Strait Islander service.

Over one-quarter (26.9%; n = 109) of trans men and trans women (26.7%; n = 20) said they would prefer to access a service that is only for LGBTIQA+ people, followed by one-fifth (19.8%; n = 241) of non-binary participants, 8.3% (n = 116) of cisgender men, and 7.5% (n = 237) of cisgender women. It is notable that over a third of participants did not know or had no preference.

Participants were asked, 'If you were to ever need help or support from a professional counselling service in the future, how would you prefer to receive it?' Table 59 represents their responses.

Table 59 Preferences for method of access to professional support service, if required in the future

Method of access to professional support service (n = 6,408)	**n**	**%**
In person	4,351	67.9
By text or webchat	1,226	19.1
By telephone	135	2.1
Other	36	0.6
I don't know	660	10.3

Over two-thirds (67.9%; n = 4,351) of participants reported in the future they would prefer to access a professional support service in person, followed by 19.1% (n = 1,226) by text or webchat, and 2.1% (n = 135) by telephone.

12.5 Summary

A large proportion of participants had accessed a professional support service at some point in their lives, including nearly two-thirds who had accessed an in-person professional counselling or support service, with smaller proportions who had accessed telephone helplines, or text or webchat support services. Around half of participants had accessed a professional support service in the past 12 months.

Of those who had accessed a professional support service of any kind, almost two-thirds (63.2%) of participants who accessed an LGBTIQA+-specific service the most recent time they accessed a professional support service reported that it had made the situation 'better/much better', compared to half (50.2%) of those accessing an in-person professional counselling or support service, two fifths (39.6%; n = 55) of those accessing a professional telephone support service, and one third (34.9%) of those accessing a professional text or webchat support service.

When asked to indicate their preference for the type of service if they were ever to need help or support from a professional counselling service in the future, the most common response was for a mainstream service that is known to be LGBTQA+ inclusive. Smaller proportions reported a preference for services that are only for LGBTQA+ people, but this finding should be interpreted in the context of limited access to and awareness of such services in the first place. Over two-thirds of participants reported they would prefer to access a professional support service in the future in person, with around one-fifth preferring a text or webchat service and a smaller proportion expressing a preference for telephone-based support.

13 **Community connection**

A sense of community connection is known to support resilience among lesbian, gay, bisexual, trans and gender diverse people. Community connection can foster social support and companionship, both of which enable people to cope with stress and live well (78–80). A study of trans and gender diverse young people, From Blues to Rainbows (4), found that many trans and gender diverse youth spoke of community activism as a means of building connections with other queer young people and of facilitating gender affirmation. International research has observed that family support is a strong protective factor against poorer mental health outcomes among LGBT young people, while LGBQ community connectedness is associated with resilience and wellbeing among LGBQ adults (81). It is most likely that both these forms of support and connection are important. LGBTIQA+ community connections and supports, working in conjunction with supportive family, friends, educational settings and professional support services, could foster improved wellbeing for LGBTQA+ young people in Australia.

13.1 Engagement with LGBTIQA+ support groups or organisations

Participants were asked how often they had attended a range of supportive groups or event within the past 12 months. Responses for 'School/university LGBTIQA+ youth group', and 'Trans and gender diverse youth group' were analysed only among participants reporting participation in school/university, or who were trans or gender diverse, respectively. The sample for each is thus indicated below.

- School/university LGBTIQA+ youth group (n = 6,040)
- Non-school/university LGBTIQA+ youth group (n = 6,304)
- Trans and gender diverse youth group (n = 1,472)
- LGBTIQA+ youth event (n = 6,269)
- Other LGBTIQA+ support group (n = 5,410)

The frequency of engagement with such groups or events in the past 12 months is displayed in Figure 53.

Almost one in five (17.2%; n = 1,037) participants had attended a school/university LGBTIQA+ youth group in the past 12 months, 11.6% (n = 734) a non-school/university LGBTIQA+ youth group, 10.6% (n = 156) a trans and gender diverse youth group, 14.7% (n = 920) an LGBTIQA+ youth event, and 3.2% (n = 171) an other LGBTIQA+ support group.

13.2 Community volunteering and engagement

All participants were asked whether they had engaged in any face-to-face activities supportive of LGBTIQA+ people within the previous 12 months. Table 60 displays the findings.

Table 60 Proportion of participants engaging in LGBTIQA+-supportive activities in the past 12 months

LGBTIQA+-supportive activity engagement (n = 6,290)	**n**	**%**
Created or posted something online supporting LGBTIQA+	2,368	37.7
Stood up for the rights of LGBTIQA+ people at school/work	2,131	33.9
Attended a rally or protest about LGBTIQA+ rights	1,288	20.5
Volunteered for an LGBTIQA+ organisation or cause	493	7.8
Any of the above	3,635	57.8

Figure 53 Proportion of participants attending LGBTIQA+ groups/events in the past 12 months

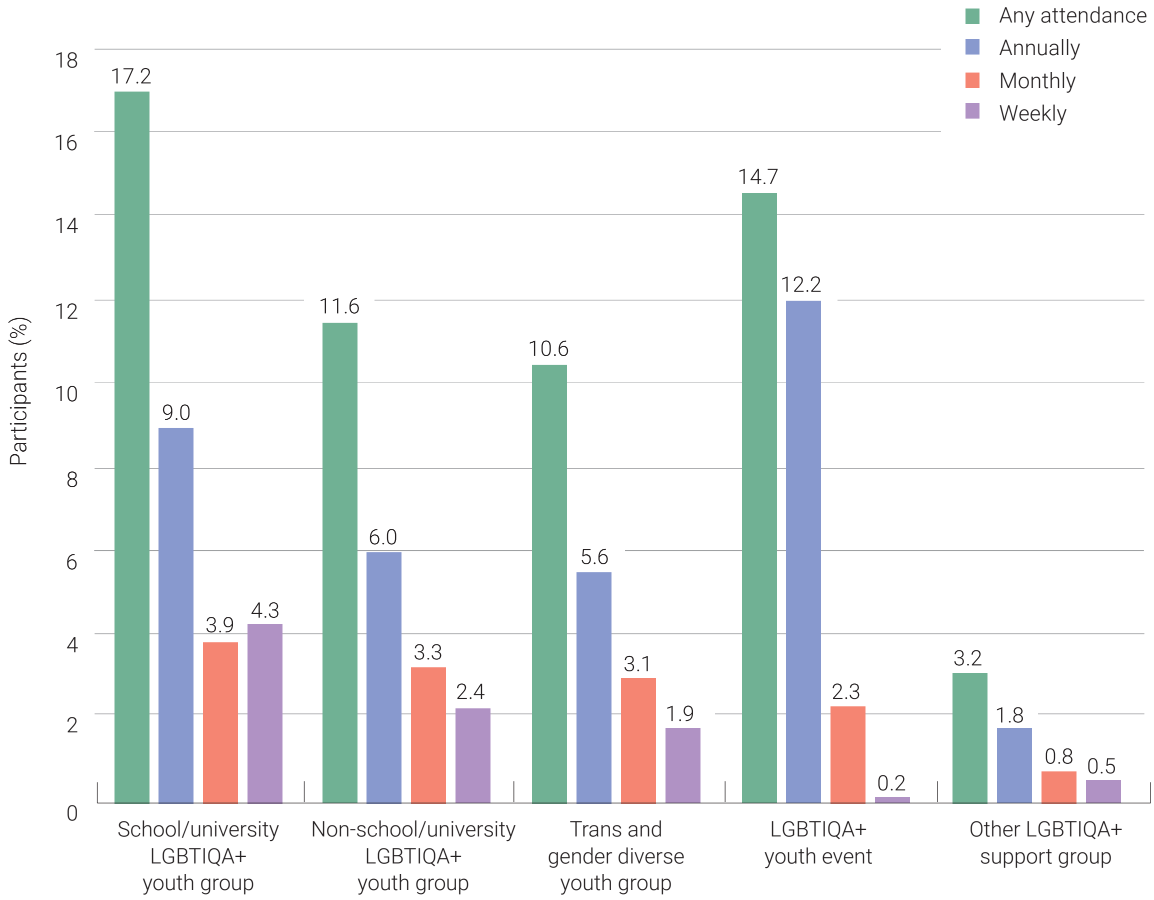


Figure 54 **Proportion of participants engaging in one or more LGBTIQA+-supportive activities in the past 12 months, by gender**

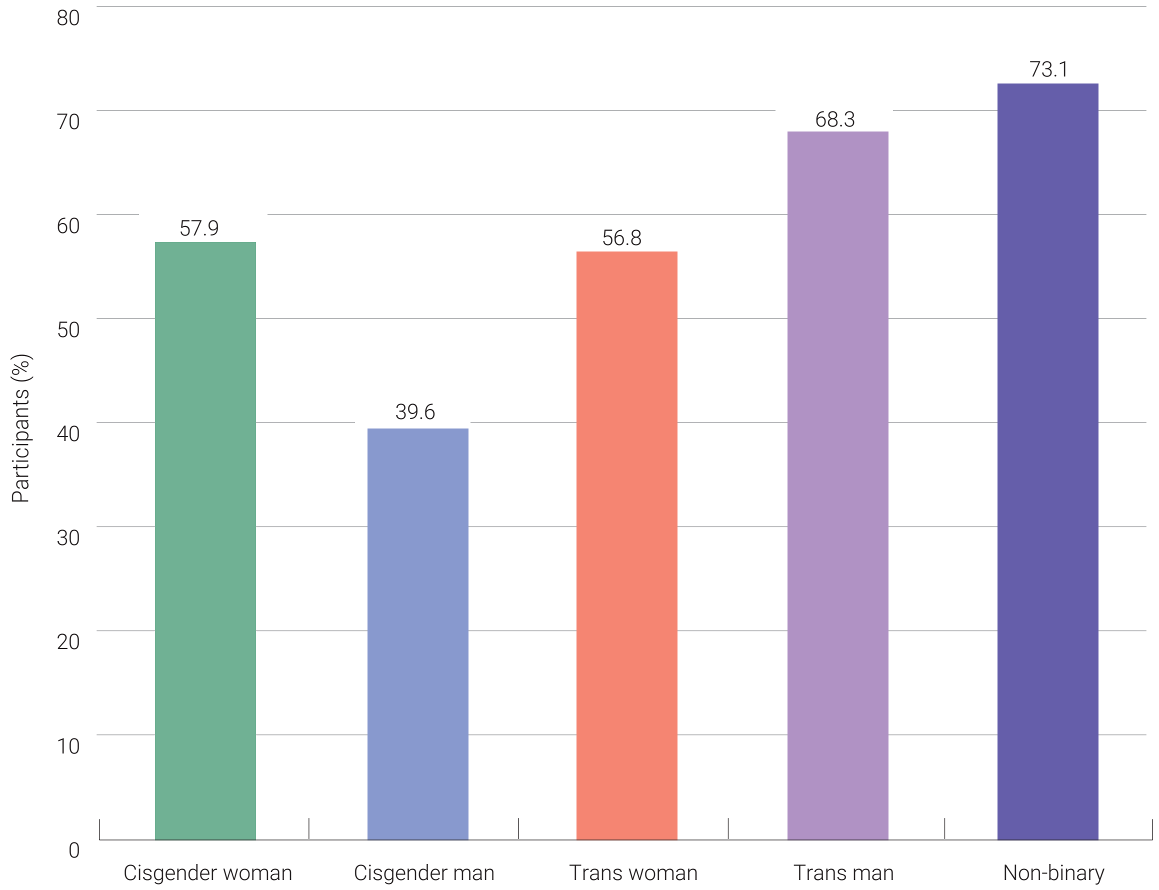
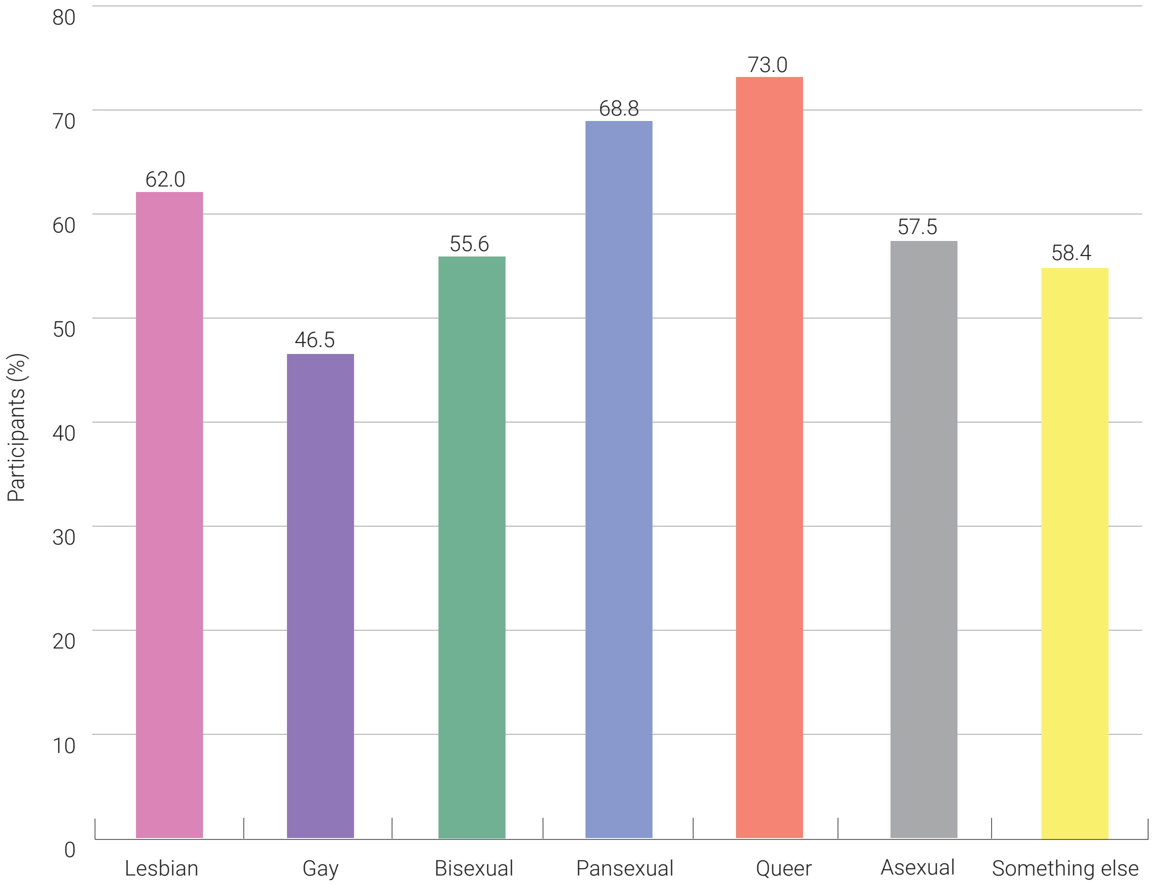


Figure 55 **Proportion of participants engaging in one or more LGBTIQA+-supportive activities in the past 12 months, by sexuality**



Over half the participants (57.8%; n = 3,635) had engaged in one or more community engagement or volunteering activities in the past 12 months. Online political engagement was the most common form of community volunteering or engagement. Over one-third (37.7%; n = 2,368) of participants had created or posted something online supporting LGBTIQA+. However, a similar number were involved in face-to-face community action, with 33.9% (n = 2,131) of participants stating that they had stood up for the rights of LGBTIQA+ people at school or work, 20.5% (n = 1,288) had attended a rally or protest about LGBTIQA+ rights, and 7.8% (n = 493) had volunteered for an LGBTIQA+ organisation or cause in the past 12 months.

Figure 54 displays the proportion of participants engaging in one or more LGBTIQA+-supportive activities in the past 12 months, by gender (n = 6,126).

Non-binary participants and trans men were more actively engaged in the LGBTIQA+ community than other gender identities. Almost three-quarters (73.1%; n = 877) of non-binary participants had engaged in one of more LGBTIQA+-supportive activities in the past 12 months, followed by 68.3% (n = 276) of trans men, 57.9% (n = 1,798) of cisgender women, 56.8% (n = 42) of trans women and 39.6% (n = 530) of cisgender men.

Figure 55 displays the proportion of participants engaging in one or more LGBTIQA+-supportive activities in the past 12 months, by sexuality (n = 6,282).

Queer (73.0%; n = 389) and pansexual (68.8%; n = 485) participants were the most actively engaged in the LGBTIQA+ community, followed by lesbian (62.0%; n = 470), asexual (57.5%; n = 168), bisexual (55.6%; n = 1,179), and gay (46.5%; n = 480) participants.

33.9%

of participants had stood up for the rights of LGBTIQA+ people at school or at work

13.3 Online LGBTIQA+ engagement

All participants were asked whether they had engaged in any online activities relating to LGBTIQA+ friendship, health or wellbeing. Table 61 displays the findings.

Table 61 Proportion of participants using mobile applications or websites for LGBTIQA+ purposes in the past 12 months

Mobile app/website use (n = 6,376)	n	%
Become a member or follow any social media groups specifically for LGBTIQA+ people	2,825	44.3
Make new friendships with LGBTIQA+ people	2,376	37.3
Access LGBTIQA+-specific sexual health information	1,459	22.9
Access LGBTIQA+-specific mental health information	1,249	19.6
Any of the above	4,046	63.5

Almost two-thirds (63.5%; n = 4,046) of participants had used a website or mobile application to engage with the LGBTIQA+ community or to access LGBTIQA+ information in the past 12 months. Just under half (44.3%; n = 2,825) became a member or follower of social media groups specifically for LGBTIQA+ people, 37.3% (n = 2,376) made new friendships with LGBTIQA+ people, 22.9% (n = 1,459) accessed LGBTIQA+-specific sexual health information, and 19.6% (n = 1,249) accessed LGBTIQA+-specific mental health information.

13.4 Attachment in educational settings

To assess participant levels of attachment to their educational institution, *Writing Themselves In 4* included the three-item 'school connection' scale. Participants were asked three questions regarding their attachment to their educational institution on a five-point scale ranging from strongly disagree to strongly agree. Figure 56 (displayed on next page) below displays the results by educational setting for participants who responded 'agree' or 'strongly agree' with the following questions:

- You feel close to people at your school (n = 6,045)
- You feel like you are a part of your school (n = 6,041)
- You are happy to be at your school (n = 6,040)

Participants at secondary school reported the highest levels of feeling 'close to people at your educational institution' (50.7%; n = 1,939), followed by university (43.5%; n = 664), and TAFE, with almost half the proportion (27.3%; n = 102).

A greater proportion of participants at university (66.8%; n = 1,019) agreed or strongly agreed with the statement 'You are happy to be at your educational institution' than those at TAFE (46.6%; n = 173) or secondary school (42.2%; n = 1,611).

More than half of cisgender men and approximately half of cisgender women were attached to their educational institution and peers, compared to approximately one-third of non-binary participants and trans men, and one-quarter of trans women (analysis displayed in Figure 57 on next page). For example, approximately half of cisgender men (55.4%; n = 718) and cisgender women (49.3%; n = 1,498) reported feeling close to people at their educational institution, compared to one-third of trans men (35.7%; n = 131) and non-binary participants (36.6%; n = 411), and less than three-tenths of trans women (28.4%; n = 19). These findings may reflect the higher levels of verbal, physical, and sexual harassment or assault faced by trans and gender diverse participants (see Chapter 8) and the higher rates of feeling uncomfortable at their educational institution in the past 12 months, as well as a higher number of days at their educational institution missed by trans and gender diverse participants than cisgender participants (see Chapter 5).

Overall, more gay, bisexual, and queer participants were attached to their educational institution and peers, compared to lesbian, pansexual and asexual participants (analysis displayed in Figure 58 on next page)

. For example, 52.4% (n = 518) of gay participants, 50.8% (n = 1,055) of bisexual participants, and 46.9% (n = 235) of queer participants reported feeling close to people at their educational institution, compared to 42.6% (n = 315) of lesbian, 39.7% (n = 261) of pansexual, and 37.1% (n = 99) of asexual participants.

More cisgender men and women were attached to their education institution compared to trans and gender diverse participants

Figure 56 **Perceived connection to educational institution, by educational setting**

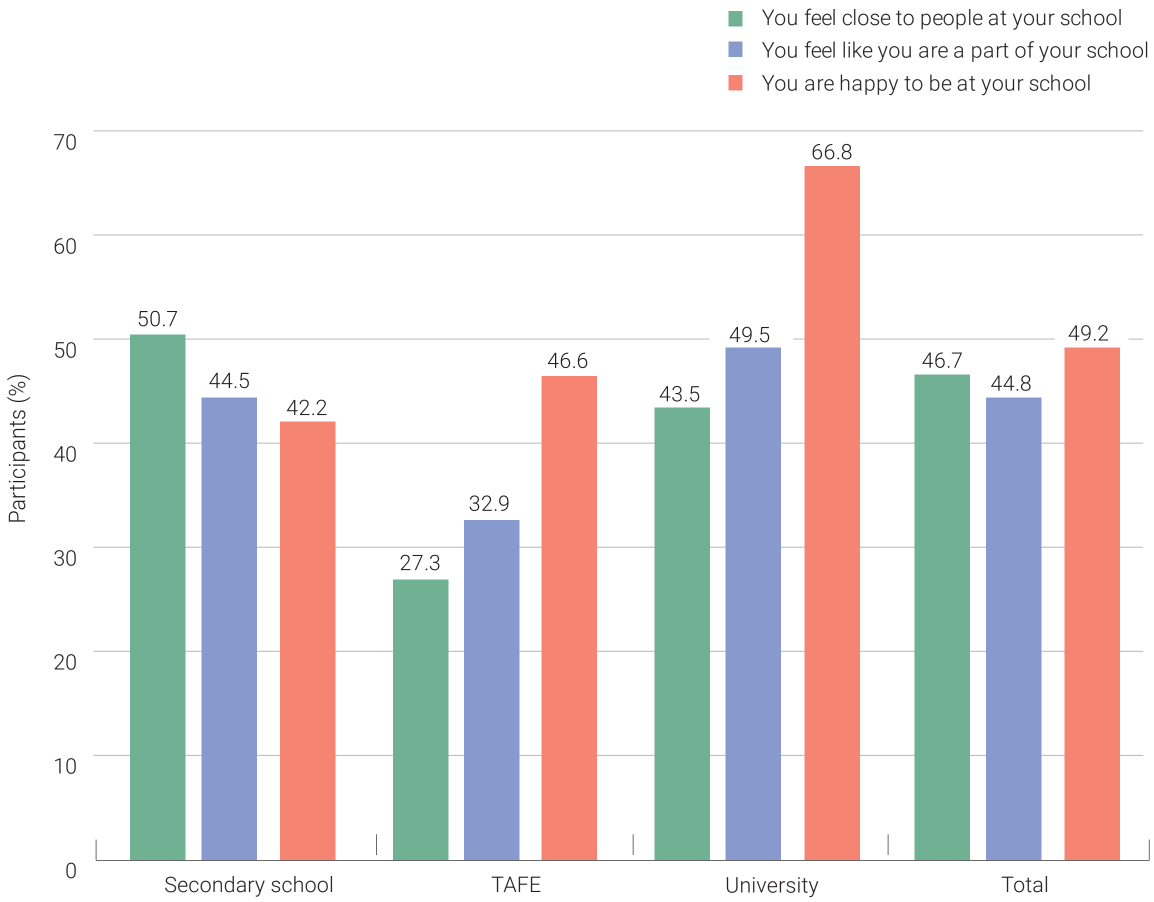


Figure 57 **Perceived connection to educational institution, by gender**

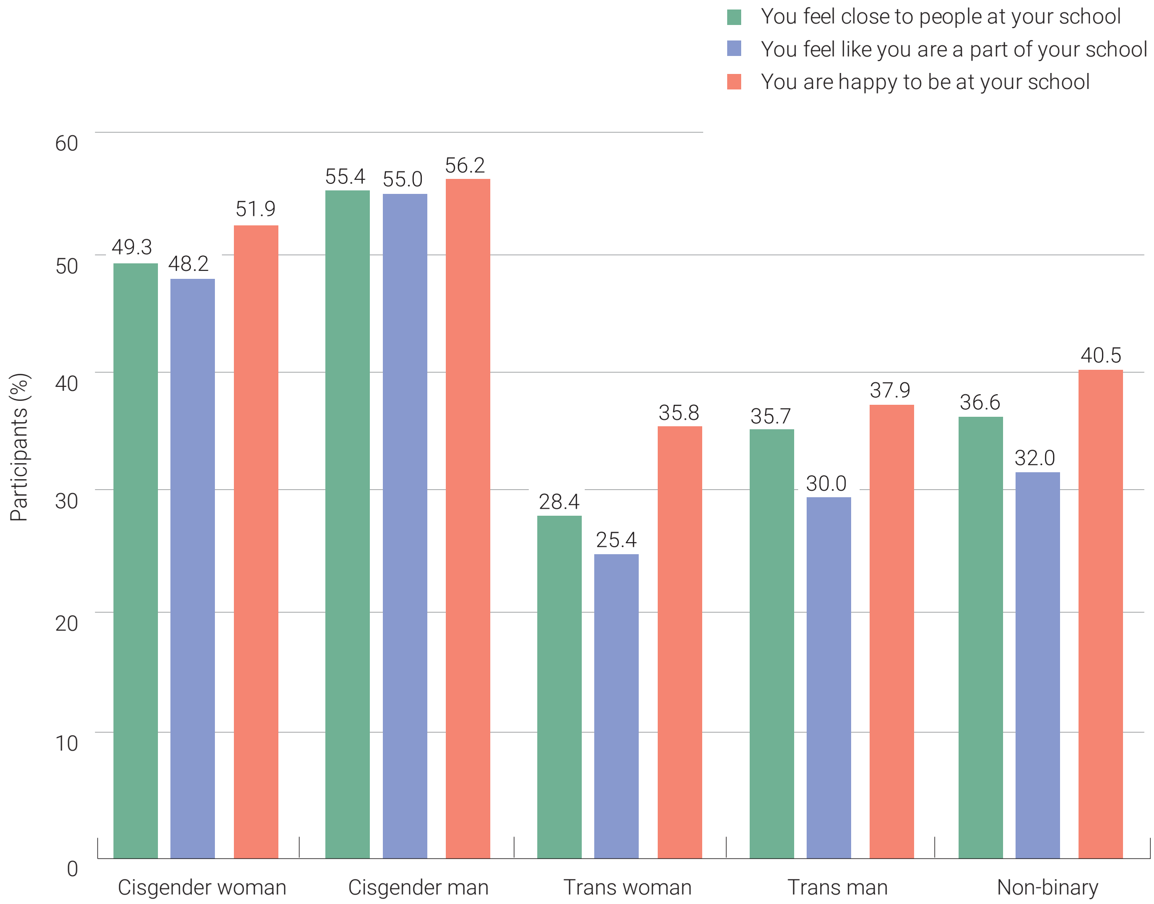
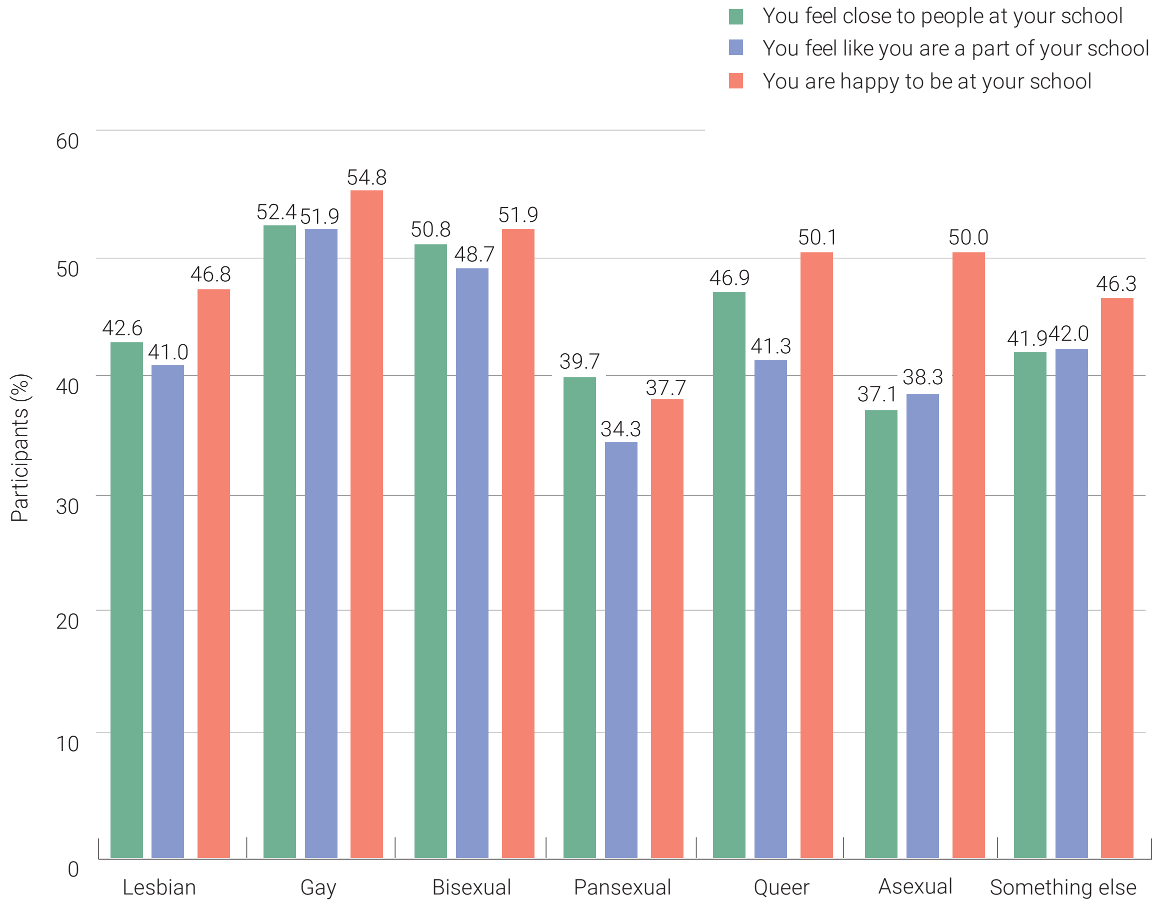


Figure 58 Perceived connection to educational institution, by sexuality



13.5 Summary

Approximately one in five *Writing Themselves In 4* participants were involved with LGBTIQA+ groups or activities at their school or university or a peer support group. However, a larger proportion connected with the LGBTIQA+ community online; two in five reported they were a member or followed any social media groups specifically for LGBTIQA+ people online and one in three reported they had made new friends from the LGBTIQA+ community online. Participants were also involved in online activism relating to LGBTIQA+ issues, with one in three indicating they had created or posted something online in support of LGBTIQA+ people within the past 12 months.

Activism was part of the lives of many *Writing Themselves 4* in participants, with more than one in three indicating that they had stood up for the rights of LGBTIQA+ people at their educational institution or workplace, while one in five had attended a rally or protest in the past 12 months. Non-binary participants and trans men were more actively engaged in the LGBTIQA+ community, compared to other gender identities.

We asked participants to tell us how connected they felt to their school, TAFE or university. Secondary school students were more likely than TAFE or university students to report that they felt close to people at their educational institution, although they were least likely to report being happy at their educational institution. Trans and gender diverse participants were less likely than cisgender young people to report feeling close to others and happy at their educational institution.

14 Feeling good as an LGBTQA+ young person

Writing Themselves In 4 asked participants, 'What makes you feel good about yourself?' This question was asked towards the very end of the survey, in part to step participants out of the survey in a positive manner after answering many questions that they may have found emotionally challenging. Importantly, this question also provided participants a space to share more about themselves, their strengths and the ways in which they affirm their LGBTQA+ identity. Much previous research among this population has focussed on 'problems' and challenges. While it is crucial to capture data about experiences of harm and mental health issues to inform health and social care interventions, it is also essential that research highlights what LGBTQA+ young people value, and what supports and promotes their wellbeing. Such findings are needed to inspire health promotion and community interventions that seek to improve the health and wellbeing of young LGBTQA+ communities. They can illuminate the more complex stories and lives of LGBTQA+ young people, and allow more nuance than a focus only on risk and protective factors. Without depictions of the positive aspects of young LGBTQA+ people's lives, there is risk that young people will come to understand themselves and their peers only as an 'at risk' group (82)

In total, 4,754 participants provided an answer to this question, and responses ranged in length from a few words to a paragraph or more of text. The responses from young LGBTQA+ people in Australia as to what makes them feel good about themselves were both detailed and diverse. They indicated that, for many young people, they are not merely developing resilience strategies to 'cope' with being lesbian, gay, bisexual, pansexual, queer, asexual, trans or gender diverse, but are finding creative and diverse ways of celebrating their identities. These responses help paint a picture of what can happen for young LGBTQA+ people when they are surrounded by affirming friends, family, romantic partners and other adults in educational institutions, workplaces, or other social networks. They show us how many young LGBTQA+ people find happiness in volunteering, in helping others, and in their creative and extra curricula pursuits. Throughout this report there are findings that may leave many sad or unsettled. The responses from young LGBTQA+ people in this chapter give us a valuable insight into what we can be enhancing, embracing or transforming to ensure LGBTQA+ young people in Australia are able to feel good about themselves more of the time.

However, it is also important to note that some young people found this question hard or impossible to answer, perhaps representing either a difficulty considering or expressing feelings, or an absence of things in their lives that made them feel good about themselves (or both). Many young people simply responded that nothing made them feel good. The breadth of responses indicates the vastly different experiences young LGBTQA+ people are having across Australia. A number of themes emerged following textual analysis of these responses, the most common of which are described below.

Social connectivity to friends and family

A large proportion of responses reflected the value young people found in their connection to friends and family. Such individuals or groups were frequently described as sources of support, affirmation and facilitators of joy. In some instances, participants described friends or family members who also identified as LGBTIQA+, and reported how they could provide important support, advice and guidance. Often face-to-face connection was considered important, but online friendship and engagement was also commonly valued.

When I'm laughing with my friends and I'm able to forget anxiety and depression because I love them and they make me happy.

(Aged 17, WA)

Being around my friends who I know will affirm my identity.

(Aged 18, VIC)

Talking about gay things I have in common with my other queer friends.

(Aged 19, VIC)

Talking online with my friends.

(Aged 20, ACT)

Being surrounded by people that understand.

(Aged 16, TAS)

Being supported by other LGBTQ+ people and feeling like a part of a community/family.

(Aged 16, QLD)

Romantic connection

Many *Writing Themselves In* participants were clear to reflect the ways in which their romantic and sexual partners helped to facilitate happiness in their lives. Participants provided numerous examples as to how they have felt affirmed and valued by partners, especially in cases where they may have felt uncertain or anxious about their bodies or feelings. Feelings of happiness were not limited to experiences of committed, romantic relationships but also extended to 'crushes' and fun found in flirting.

When my girlfriend says she loves me out of nowhere.

(Aged 20, WA)

That I have a boyfriend.

(Aged 14, SA)

My Partner, how amazing our future immediate family will be – raising two babies into the LGBT community

(Aged 20, VIC)

My boyfriend telling me how masculine I am and pointing out changes from HRT that I don't notice.

(Aged 20, NSW)

Creating and achieving

Creativity and a sense of accomplishment was central to feeling good about oneself for a great many participants. A large number of their responses spoke to the importance and value of playing, learning, dancing, and performing, especially in circumstances where such experiences provided opportunities to affirm their sexuality or gender identity.

Going to rehearsal and being in shows.

(Aged 14, VIC)

Writing, painting, baking and mending clothes (but only when they work out well).

(Aged 19, SA)

When I achieve in something and I get congratulated. Because other than those events I don't really get recognized. So sporting and gaming are my way of getting recognition in school and in general life.

(Aged 15, VIC)

Writing. When I can express myself and hide behind a website or fake screen name. I can be me but no one knows who I am. I love expressing myself through poems and stories.

(Aged 15, WA)

Being really masculine like playing sport.

(Aged 14, NSW)

When I complete an assignment or when I work really hard it makes me feel useful and good.

(Aged 17, ACT)

Affirmation from within

This theme speaks to how being 'me' was central to how many participants described what helped them feel good and confident. Such self-affirmation could take many forms, including feeling confident about styling their hair, the freedom to wear gender-affirming clothes, or feeling confident in their bodies and their abilities. These responses highlight how when young people feel safe, they can explore new and comforting ways to affirm their sense of self, and present in ways that enable them to hold on to an inner strength. Often their responses here spoke to a sense of self-growth, which may have emerged over time as they found pride in their identity.

When I think I look like the gender I'm feeling that day.

(Aged 14, QLD)

When I look in a mirror and don't see a gender, which rarely happens.

(Aged 18, SA)

I like my hair; I've cut it to collarbone length and I really enjoy it. It's the one thing I wouldn't change about myself. It makes me feel good.

(Aged 16, VIC)

When I dress the way I want to without noticing judging stares.

(Aged 18, QLD)

Wearing baggy clothes. Small amounts of make-up and a mixture and masculine and feminine jewellery.

(Aged 17, QLD)

Thinking of me as a girl.

(Aged 14, QLD)

Wearing clothes that are androgynous and affirm my gender (or lack of gender). (Aged 21, VIC)

Being affirmed by others

Participants described feeling good about oneself in ways that were often influenced by the degree, sense or nature of affirmation received from others. This could take many forms, including representation in the media, or compliments or praise from others. Affirmation from others often, but not exclusively, focussed on receiving comments that affirmed gender or sexuality (including in relation to clothing or appearance). For some, however, affirmation came in the form of the absence of comment from others as this indicated they were safe from homophobic or transphobic violence or harassment.

Seeing representation of people like me! And more diversity in media!

(Aged 15, VIC)

When someone tells me I look handsome or masc.

(Aged 17, QLD)

When I (a girl) tell people about my girlfriend and they react just like they would if I were dating a boy.

(Aged 16, VIC)

When people tell me I'm doing a good job and that they are proud of me.

(Aged 19, QLD)

When my friends call me handsome and a boy.

(Aged 14, NSW)

When people use correct pronouns.

(Aged 20, NT)

When I see or hear anything supportive of the community.

(Aged 16, VIC)

Seeing people actively trying to use my correct name and pronouns.

(Aged 19, ACT)

Wearing the clothes and makeup I want without being judged.

(Aged 16, QLD)

Having influence on others – making a difference

A great many participants used this opportunity to emphasise how they want to make a positive impact on the world around them, and that doing so helps them to feel good about themselves. This could involve volunteering or community activism, sometimes linked to LGBTQA+ human rights but often encompassing other matters of social justice, such as protecting the environment. It was especially rewarding for many participants to have a positive influence on LGBTQA+ peers younger than themselves. Influence on others also included everyday experiences, such as making others laugh or caring for those in need.

I feel good about myself when I make other people feel good.

(Aged 15, NT)

Attending LGBTQIA+ events and having the opportunity to provide guidance and advice to younger queeros.

(Aged 20, WA)

When I make other people happy.

(Aged 19, TAS)

Helping others especially when I help them grow in their gender identity or sexuality or helping with mental health issues.

(Aged 17 VIC)

Volunteering, going to rallies, being involved in political action.

(Aged 19, NSW)

Standing up for what's right.

(Aged 17, NSW)

That I am I leader for the younger gay boys at my school.

(Aged 16, NSW)

Not feeling good

Crucially, it is important to recognise that some young people who participated in *Writing Themselves In 4* stated that nothing made them feel good about themselves. Such responses must be understood the context of the very high rates of psychological distress and suicidal ideation reported earlier, as well as the experience of stigma, discrimination, violence and abuse that is so pervasive.

Nothing, I'm surrounded by negativity and LGBT-phobia. I am worthless.

(Aged 17, South Australia)

Summary

In total, 4,754 Writing Themselves 4 In participants wrote short answers describing what makes them feel good about themselves. While a small number found it difficult to answer this question or indicated that there is very little, or nothing, that makes them feel good, the majority of young people were able to identify people, situations or activities that helped them feel good about themselves. What is striking is the 'everyday' nature of these responses. Most young people felt good about themselves when they felt connected to friends, family or partners; when they were able to make someone else laugh or feel happy; or when they achieved something in their schoolwork or creative pursuits. Affirmation was also important to young people in the sense of being recognised for who they are with respect to gender or sexuality, including from connection with the LGBTIQA+ community. These responses show that supporting young LGBTQA+ people is not just about provision of mental health services, although these are crucially important in response to the high levels of poor mental health and suicidality shown in this report, but to ensure programs are in place that support and affirm LGBTQA+ young people in their everyday lives. This might include school-based programs that affirm LGBTQA+ people, such as gay–straight alliances or other forms of peer-based programs that help to build connections and friendship between LGBTQA+ young people. Family and parents also clearly play an important part in ensuring young LGBTQA+ young people feel good and confident about themselves. Information and support for families of LGBTQA+ young people may also play an important role in supporting young people in their everyday lives.

15 **Trans and gender diverse participants**

It is difficult to estimate how many young people in Australia identify as trans or gender diverse, as questions about gender identity are rarely included in population-based surveys and not included in the Australian census. A systematic review of studies published internationally between 2009-2019 found that estimates of the number of trans of gender diverse adults in the population ranged from 0.3% to 0.5% in surveys that specifically enquired about 'transgender' identity. In surveys that inquired about a broader category of 'gender diversity', estimates are slightly higher at 0.5% to 4.5% of the adult population (83). Over time, there has been a trend toward more people identifying as trans or gender diverse in surveys where gender identity questions are asked.

This chapter presents data relating to key findings regarding all trans and gender diverse participants, as well as those who completed the subsequent supplemental questions. In total, 75 trans women, 406 trans men and 1,216 non-binary participants (a total of **1,697 trans and gender diverse participants**) completed the *Writing Themselves In 4* survey. To the best of our knowledge, this is the largest sample of trans and gender diverse young people in Australia at the time of publication. Trans and gender participants were presented with a supplementary section of the survey specifically designed in consultation with a trans and gender diverse expert advisory board. In total, 1,411 trans and gender diverse participants completed these questions. The findings below are presented in a way that shows responses from trans women, trans men, and non-binary participants, as well as the total number of responses from all trans and gender diverse participants.

15.1 Gender affirmation

Participants were asked, ‘Have you ever wanted to affirm your gender identity in the following ways?’ Response options were as follows:

- Socially (i.e. change your name/pronouns or gender presentation)
- Legally (i.e. change your legal name or gender markers on ID documents)
- Medically (i.e. puberty blockers, hormone therapy, gender-affirming surgeries)
- No, none of the above

Participants who responded that they had ever wanted to affirm their gender identity were then asked, ‘Have you ever affirmed your gender identity in the following ways?’ and given the same response options. Figures 59 to 61 (shown across the next 3 pages) display these results.

Figure 59 displays the proportion of participants who had ever wanted to affirm their gender socially (n = 1,416) and, of those, who had ever affirmed their gender socially (n = 1,379).

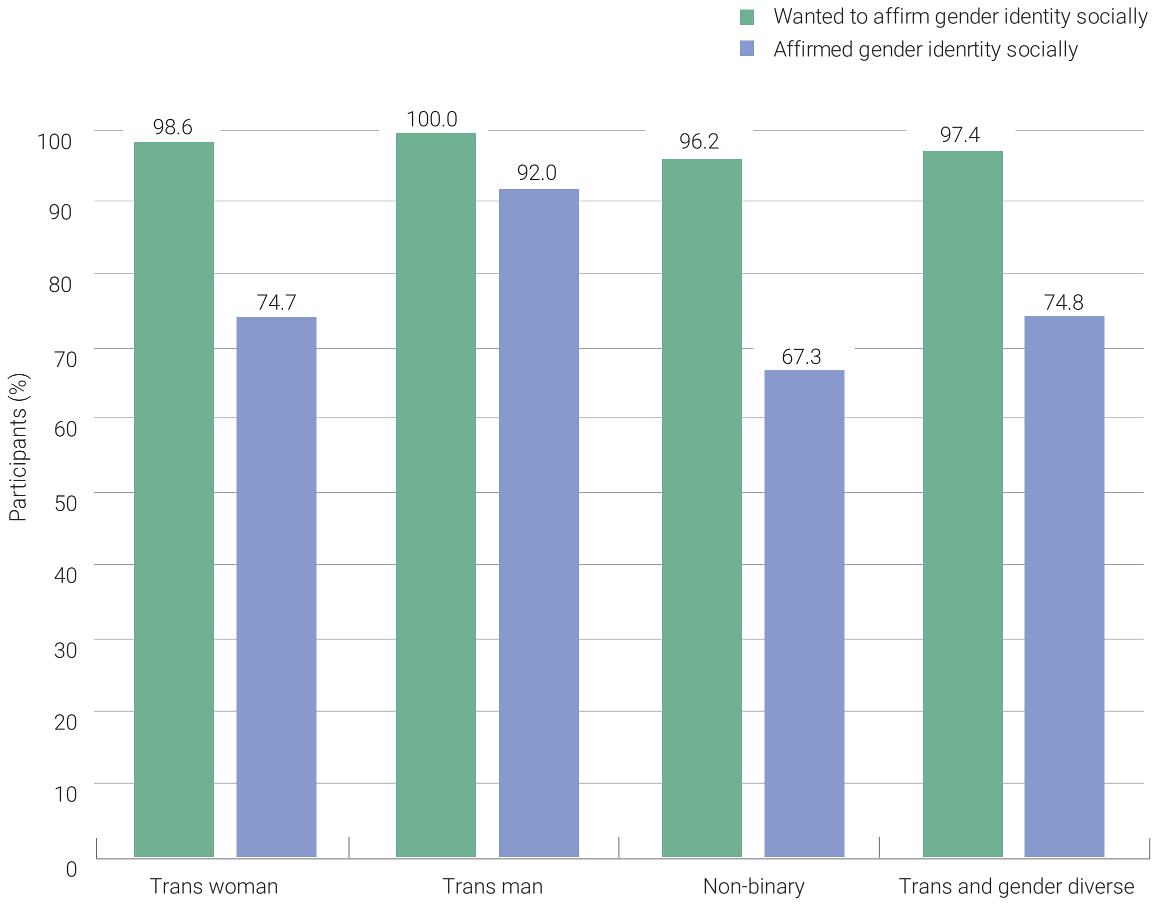
The majority of trans and gender diverse participants (97.4%; n = 1,379) reported ever wanting to affirm their gender identity socially, while just under three-quarters (74.8%; n = 1,032) of those participants had ever affirmed their gender identity socially. Trans men were most likely to report ever wanting to affirm their identity socially (100%, n = 401) and having ever taken steps to affirm their gender identity socially (92.0%; n = 369). Trans women were similarly likely to report ever wanting to affirm their gender identity socially (98.6%, n = 71), but less likely than trans men to have ever taken steps to do so (74.7% of those reporting ever wanting to; n = 53). This was also the case for non-binary participants, the vast majority of whom reported wanting to affirm their gender identity socially (96.2%; n = 907), while around two-thirds of those ever wanting to had taken steps to do so (67.3%; n = 610).

Figure 60 displays the proportion of participants who ever wanted to affirm their gender legally (n = 1,416) and, of those, who had ever affirmed their gender legally (n = 1,065).

Compared to socially affirming their gender identity, young people were less likely to report wanting to legally affirm their gender or ever having taken steps to do so. Overall three in four (75.2%; n = 1,065) trans and gender diverse participants reported ever wanting to affirm their gender identity legally; however, less than one-quarter of those who reported this (22.5%; n = 240) had done so.

Trans men and women were more likely than non-binary participants to report ever wanting to affirm their gender identity legally. Over nine in ten trans men (98.3%; n = 394) and

Figure 59 Ever wanted to affirm gender socially and ever affirmed gender socially



trans women (94.4%; n = 68) reported ever wanting to affirm their gender identity legally, compared to six in ten (63.9%; n = 603) non-binary participants.

Trans men and women were similarly more likely than non-binary participants to report having taken steps to legally affirm their gender identity. However, the majority of participants had not legally affirmed their gender identity. Approximately one-third (33.5%; n = 132) of trans men and one-quarter of trans women (27.9%, n = 19) had ever affirmed their gender legally, compared to one in seven (14.8%; n = 89) non-binary participants.

Figure 61 displays the proportion of participants who had ever wanted to affirm their gender medically (n = 1,416) and, of those, who had ever affirmed their gender medically (n = 1,024).

The majority of trans men (98.0%; n = 393 and trans women (98.6%; n = 71) reported that they had ever wanted to affirm their gender medically. Fewer non-binary participants reported ever wanting this (59.4%; n = 560). In total, 72.3% (n = 1,024) reported ever wanting to affirm their gender medically. However, just three-tenths of participants (29.4%; n = 301) reported that they had taken steps to affirm their gender medically. Just under half of all trans women (47.9%; n = 34) and trans men (45.0%; n = 177) had affirmed their gender identity medically, compared to less than one-fifth of non-binary participants (16.1%; n = 90).

Finally, participants who indicated that they had medically affirmed their gender identity were asked, 'Have you accessed any of the following?' Response options were:

- Puberty blockers
- HRT (hormone therapy)
- Gender-affirming surgeries
- No, none of the above

Figure 62 displays the proportion of participants among those who reported medically affirming their gender identity who had accessed puberty blockers, HRT (hormone therapy), or gender-affirming surgeries (n = 301).

Hormone therapy was the most common type of medical gender affirmation. Almost nine-tenths (87.4%; n = 263) of trans and gender diverse participants who reported medically affirming their gender identity had accessed hormone therapy. Hormone therapy was accessed most by non-binary participants (88.9%; n = 80), followed by trans men (87.6%; n = 155), and trans women (82.4%; n = 28).

Figure 60 Ever wanted to affirm gender legally and ever affirmed gender legally

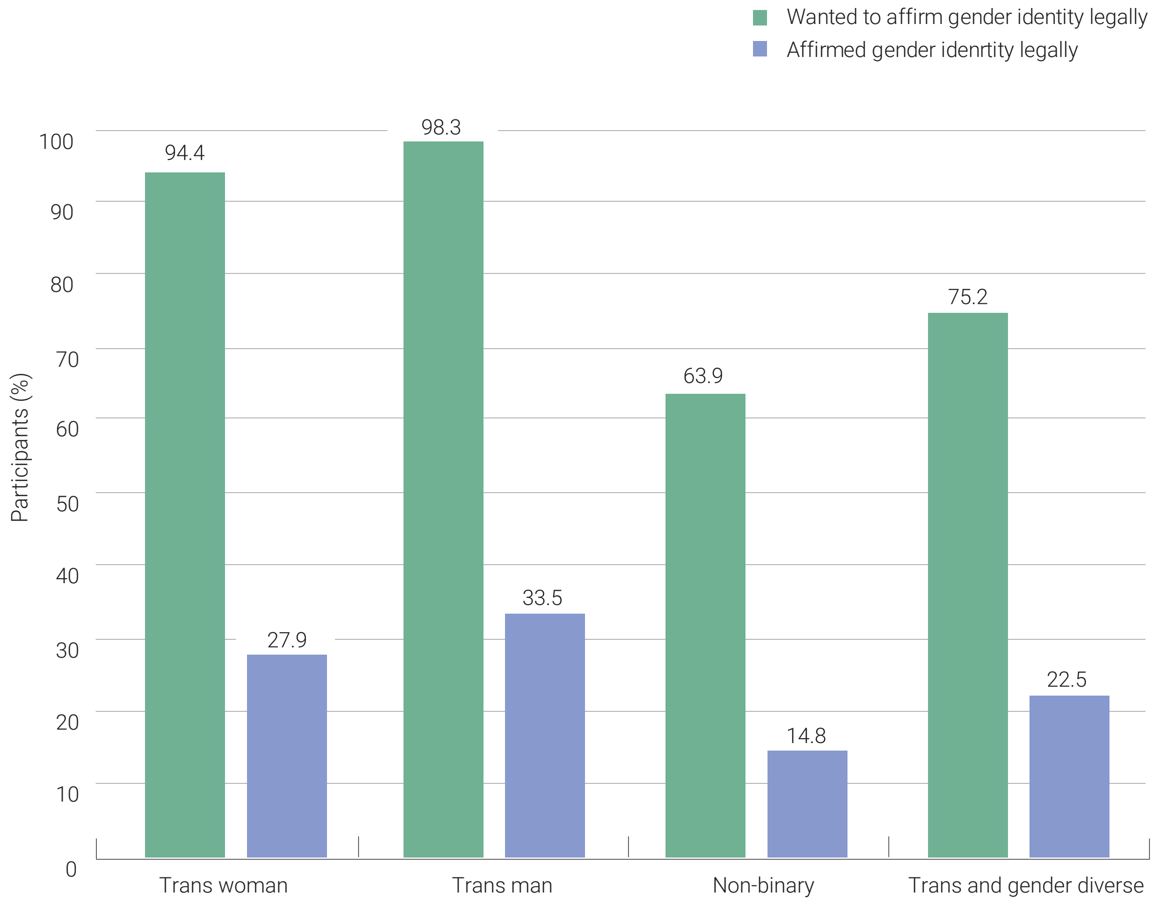


Figure 61 **Ever wanted to affirm gender medically and ever affirmed gender medically**

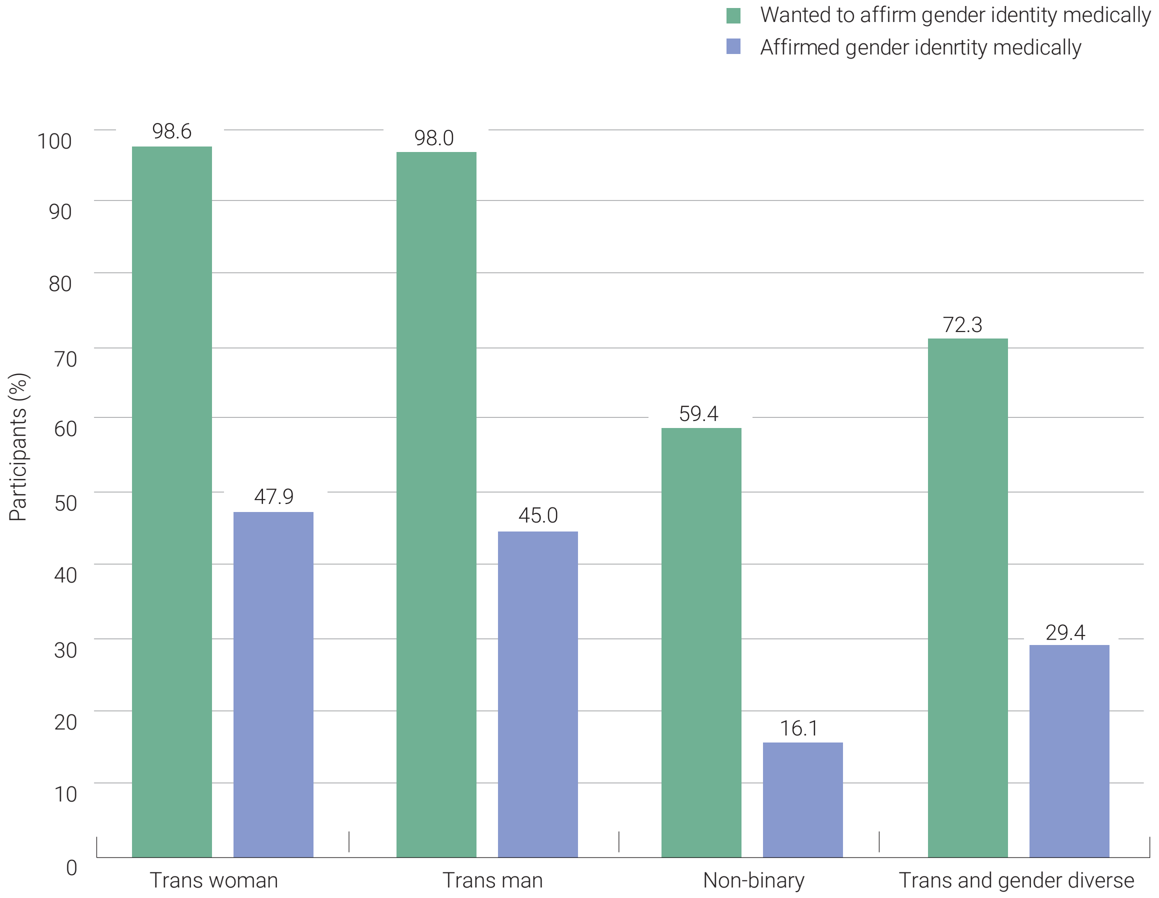
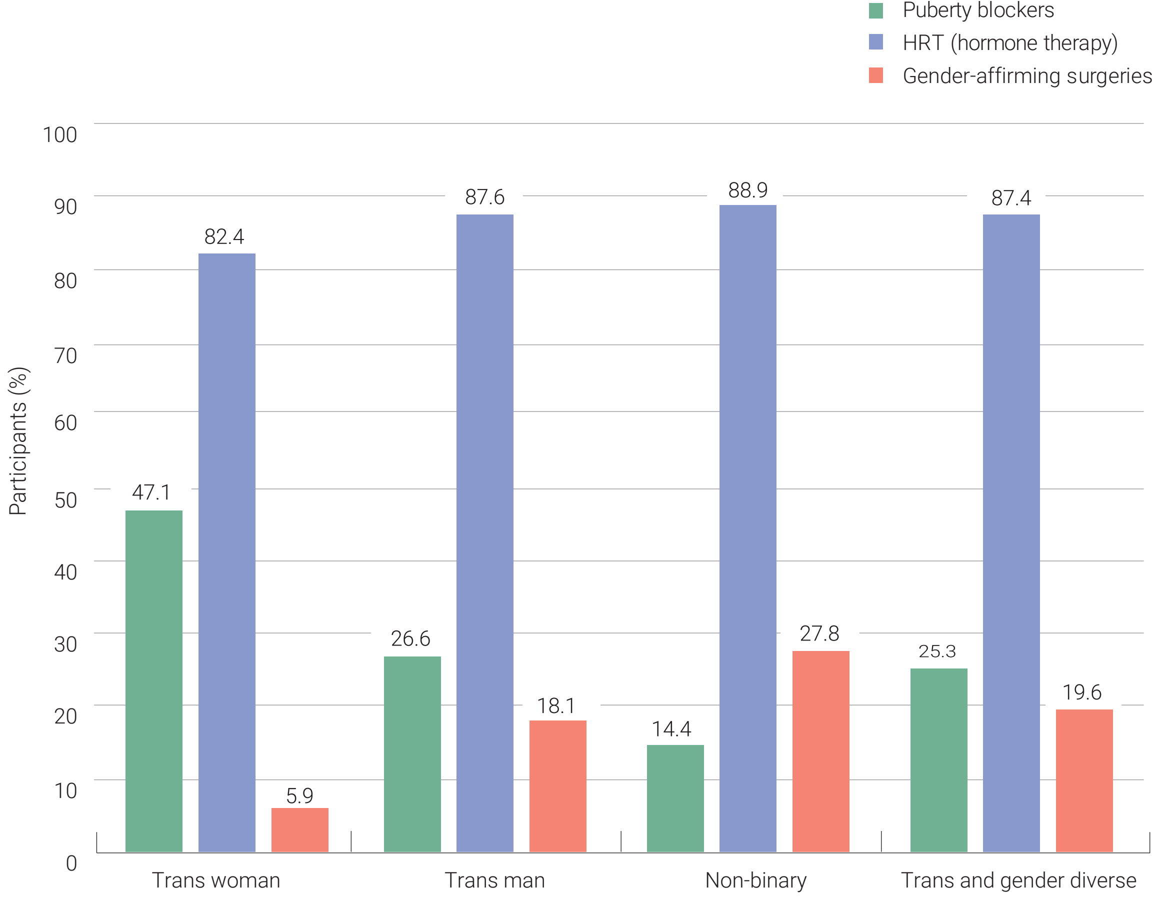


Figure 62 **Ever accessed puberty blockers, HRT, or gender-affirming surgeries, among those who had medically affirmed gender identity**



Trans women were most likely to report accessing puberty blockers, with nearly half the trans women who reported medically affirming their gender reporting use of puberty blockers (47.1%; n = 16). Use of puberty blocking medication was less common among trans men (26.6%; n = 47) and non-binary young people (14.4%, n = 13).

Gender-affirming surgery was less common than other forms of medical gender affirmation, with a total of 19.6% (n = 59) of young people reporting they had had gender affirmation surgery. Non-binary young people were most likely to report having had surgery (27.8%; n = 25), followed by trans men (18.1%; n = 32) and trans women (5.9%; n = 2).

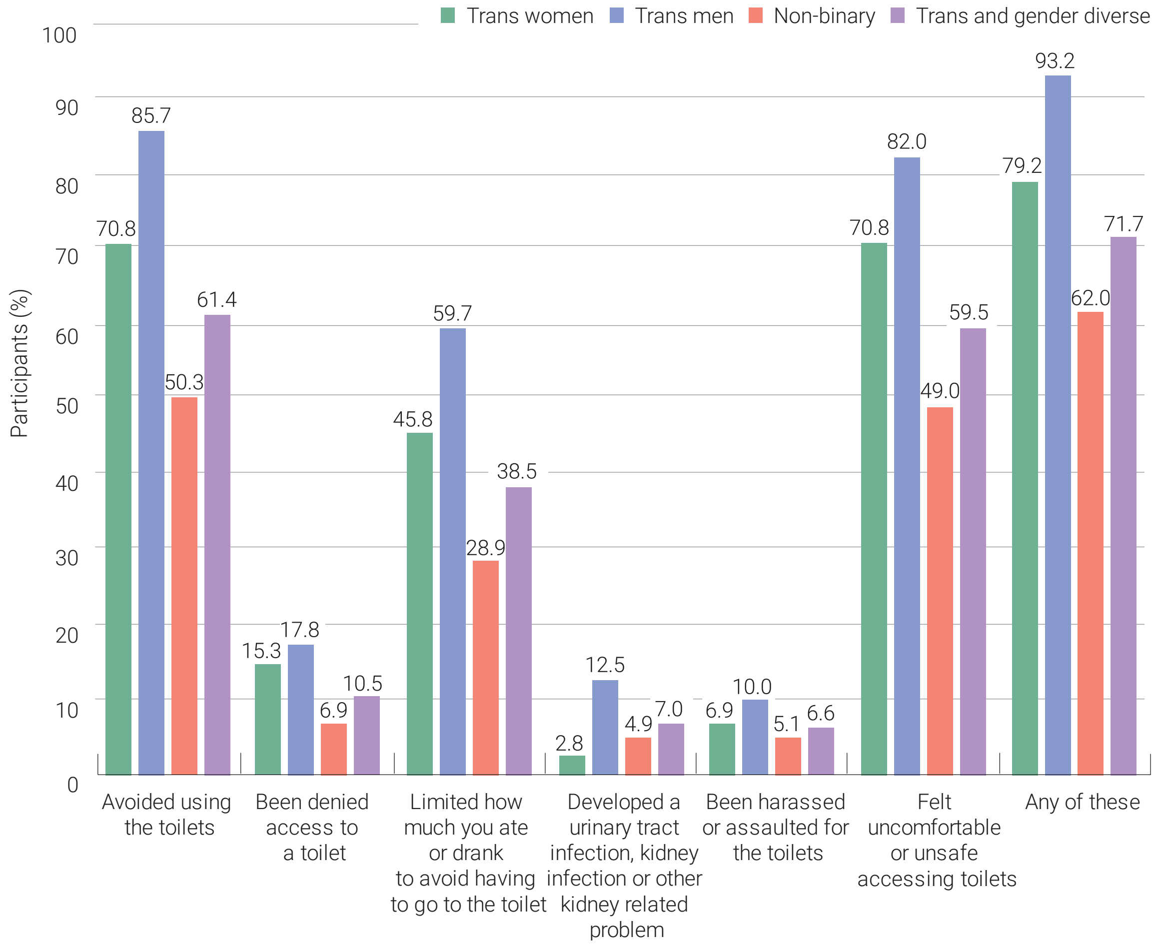
15.2 Accessing toilets

Many trans and gender diverse young people have difficulties accessing toilets that align with their gender identities, which can result in discrimination, embarrassment or health problems, including kidney infections (12). In order to quantitatively assess the particular difficulties trans and gender diverse participants were asked the following questions regarding toilet access: 'In the past 12 months, have you …'

- Avoided using the toilets
- Been denied access to a toilet
- Limited how much you ate or drank to avoid having to go to the toilet
- Developed a urinary tract infection, kidney infection or other kidney-related problem as a result of avoiding the toilets
- Been harassed or assaulted for using the toilets
- Felt uncomfortable or unsafe accessing toilets
- No, none of the above

Responses of the 1,407 trans and gender diverse participants who responded are displayed in Figure 63 below.

Figure 63 Issues relating to toilet access in the past 12 months



Seven-tenths of all trans and gender diverse young people (71.7%; n = 1,009) reported they had difficulties relating to toilet access in the past 12 months. Trans men were most likely to report this, with over nine in ten trans men (93.2%; n = 372) reporting they had problems accessing toilets in the past 12 months. Similarly, nearly eight in ten trans women (79.2%; n = 57) and six in ten non-binary people (62.0%, n = 580) reported issues relating to toilet access in the past 12 months.

The most commonly reported difficulties with toilet access were avoiding using toilets, feeling uncomfortable or unsafe using toilets, or limiting food or drink to avoid having to use the toilet. Trans men were most likely to report these. In the past 12 months, more than four-fifths of trans men avoided using the toilets (85.7%; n = 342) or felt uncomfortable or unsafe accessing toilets (82.0%; n = 327), and approximately three-fifths (59.7%; n = 238) limited their eating or drinking to avoid having to go to the toilet.

Trans women were similarly likely to report these difficulties accessing toilets. In the past 12 months, seven out of ten trans women felt uncomfortable or unsafe accessing toilets (70.8%; n = 51) or avoided using the toilets (70.8%; n = 51), and almost half (45.8%, n = 33) limited food or drink to avoid having to go to the toilet. Half (50.3%; n = 471) of non-binary participants avoided using the toilets or felt uncomfortable or unsafe accessing toilets (49.0%; n = 459) and over one-quarter (28.9%; n = 270) limited how much they ate or drank to avoid having to go to the toilet.

The findings are comparable to the findings of the 2015 US Transgender Survey (84), in which 59% of participants had avoided bathrooms, 12% had been harassed or assaulted in a bathroom, 31% avoided drinking or eating to avoid using the bathroom, 9% were denied access to a toilet, and 8% had developed a urinary tract infection.

15.3 Experiences of pressure to conform

Participants were given the following options, asking if they had ever felt or experienced pressure to:

- Prove that you are 'trans enough' or 'really trans' (n = 1,178)
- Express your gender in a binary way (i.e. to express your gender only as either a man or a woman) (n = 1,336)
- Meet typical gender stereotypes (n = 1,379)
- Pass as cisgender (someone whose gender identity corresponds to their sex assigned at birth) (n = 1,340)

Participants could respond 'not applicable' to any questions that were not relevant to them. Questions were on a five-point scale ranging from 'strongly disagree' to 'strongly agree'. Table 62 displays the proportion of participants who responded 'agree' or 'strongly agree' below.

Approximately nine-tenths of all trans and gender diverse participants reported ever feeling pressured to pass as cisgender (90.1%; n = 1,207), to express their gender in a binary way (88.5%, n = 1,183) or to meet typical gender stereotypes (87.2%, n = 1,203), and more than four-fifths (86.5%, n = 1,019) felt pressured to prove they were 'trans enough' or 'really trans'.

Non-binary participants felt the most pressured to prove they were 'trans enough' or 'really trans' (88.0%; n = 638), compared to trans women (85.7%; n = 60) or trans men (83.8%; n = 321). Trans women felt the most pressured to express their gender in a binary way (90.8%; n = 59), followed by non-binary participants (89.7%; n = 808) and trans men (85.4%; n = 316). Furthermore, trans women felt the most pressured to pass as cisgender (94.2%; n = 65), followed by trans men (91.3%; n = 356) and non-binary participants (89.2%; n = 786).

Table 62 Perceived pressures in gender conformity

	Trans woman		Trans man		Non-binary		All trans and gender diverse	
Have you ever felt or experienced pressure to …	n	%	n	%	n	%	n	%
Prove that you are 'trans enough' or 'really trans'	60	85.7	321	83.8	638	88.0	1,019	86.5
Express your gender in a binary way	59	90.8	316	85.4	808	89.7	1,183	88.5
Meet typical gender stereotypes	63	88.7	343	87.5	797	87.0	1,203	87.2
Pass as cisgender	65	94.2	356	91.3	786	89.2	1,207	90.1

15.4 Experiences of being misgendered in the past 12 months

Trans and gender diverse participants were asked, 'In the past 12 months how often have you been misgendered (called by a pronoun that does not reflect the gender which you identify with)?' Table 63 represents the results.

Close to nine-tenths (86.8%, n = 1,198) of all trans and diverse participants were misgendered in the past 12 months, including 94.5% (n = 376) of trans men, 91.5% (n = 65) of trans women, and 83.1% (n = 757) of non-binary participants. More than half (52.9%; n = 482) of non-binary participants, trans women (50.7%, n = 36) and trans men 50.5% (n = 201) were misgendered more than once a day.

Participants who reported being misgendered in the past 12 months were asked, 'Who did this?' Multiple responses were permitted. Table 64 displays the results.

Table 64 Perpetrators of misgendering in the past 12 months

Misgendered in the past 12 months by … (n = 1,188)	**n**	**%**
Family member	931	78.4
Classmate	753	63.4
Teacher	670	56.4
Friend	596	50.2
Co-worker	363	30.6
Service provider (e.g. mental health worker, counsellor, youth worker)	283	23.8
Boss	266	22.4
Someone else	186	15.7

Family members were most likely to be reported as the person or people who misgendered trans and gender diverse young people, followed by classmates, teachers and friends. Over three-quarters (78.4%; n = 931) of trans and gender diverse participants were misgendered by a family member in the past 12 months, over three-fifths (63.4%; n = 753) by a classmate, over half (56.4%; n = 670) by a teacher, and half (50.2%; n = 596) by a friend.

Misgendering was less commonly reported within the service sector, although it is worth noting that many young people would likely have had less contact with these services than they would with family, friends and educational institutions. Less than half of all trans and gender diverse young people reported that they had been misgendered by a co-worker (30.6%; n = 363), service provider (23.8%; n = 283), boss (22.4%; n = 266), or 'someone else' (15.7%; n = 186) in the past 12 months.

Table 63 Experiences of being misgendered in the past 12 months

	Trans woman		**Trans man**		**Non-binary**		**All trans and gender diverse**	
Misgendered in the past 12 months (n = 1,380)	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Never	6	8.5	22	5.5	154	16.9	182	13.2
Once a day or less	29	40.8	175	44.0	275	30.2	479	34.7
More than once a day	36	50.7	201	50.5	482	52.9	719	52.1

54.2%

of all trans and gender diverse young participants had their gender identity disclosed without their consent at some point in their life

15.5 Experiences of having gender disclosed without consent

Participants were asked, 'Have you ever been outed (having your gender identity disclosed without your consent)?' Response options were 'no', 'yes, in the past 12 months', and 'yes, more than 12 months ago'. Multiple responses were permitted. Table 65 displays the results.

Just over half (54.2%; n = 754) of all trans and gender diverse participants had had their gender identity disclosed without their consent at some point in their life. This was most commonly reported by trans men, with 76.6% (n = 406) reporting have been outed, along with 59.7% (n = 43) of trans women and 44.1% (n = 406) of non-binary participants.

Trans men were also most likely to report having been outed in the past 12 months, with over half (56.3%; n = 224) reporting this, followed by 45.8% (n = 33) of trans women and 33.3% (n = 306) of non-binary young people.

Participants who reported having ever being outed in their lifetime were asked, 'Who did this?' Multiple responses were permitted. Table 66 displays the results.

Table 66 Outed in their lifetime by …

Outed in their lifetime by … (n = 1,188)	**n**	**%**
Friend	432	57.4
Family member	277	36.8
Classmate	244	32.4
Teacher	62	8.2
Co-worker	42	5.6
Service provider (e.g. mental health worker, counsellor, youth worker)	28	3.7
Boss	21	2.8
Someone else	41	5.4

Over half (57.4%; n = 432) of trans and gender diverse participants had been outed by a friend in their lifetime, more than one-third (36.8%; n = 277) by a family member, and 32.4% (n = 244) by a classmate. Less than one-tenth had been outed by a teacher (8.2%; n = 62), co-worker (5.6%; n = 42), service provider (3.7%; n = 28), or boss (2.4%; n = 21), whilst 5.4% (n = 41) had been outed by 'someone else'.

Table 65 Experiences of being outed

	Trans woman		**Trans man**		**Non-binary**		**All trans and gender diverse**	
Experience of being outed (n = 1,390)	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Past 12 months	33	45.8	224	56.3	306	33.3	563	40.5
Ever	43	59.7	305	76.6	406	44.1	754	54.2

15.6 Experiences of autonomy in gender affirmation process

Participants were asked if they had ever felt that other people had controlled, denied, or delayed their gender affirmation process socially, medically, or legally. Multiple responses were permitted. Figure 64 displays the proportion of trans and gender diverse participants who reported feeling their social gender affirmation process had been controlled, denied, or delayed, or that they had been 'supported to affirm'. Participants could respond 'not applicable' to any questions that were not relevant to them.

Figure 64 displays these results by gender (n = 1,184).

Young people were more likely to report that social affirmation of their gender identity had been delayed than that it had been denied, controlled, or supported. Trans women and trans men were more likely to report that their gender affirmation process had been supported than they were to report that it had been controlled or denied. However, this was not the case for non-binary people, who were least likely to report that their gender affirmation had been supported, and most likely to report that it had been denied. Close to one in three trans and gender diverse young people (30.7%; n = 363) reported that their gender affirmation had been denied, including 33.0% (n = 245) of non-binary participants, 27.3% (n = 18) of trans women, and 26.7% (n = 100) of trans men.

Nearly half (47.3%; n = 560) of trans and gender diverse participants reported feeling their social gender affirmation process had been delayed, with trans women least likely to report that their gender affirmation had been delayed. Within the specific gender categories, 48.3% (n = 181) of trans men, 47.5% (n = 353) of non-binary participants, and 39.4% (n = 26) of trans women reported their gender affirmation had been delayed.

One-quarter (25.4%; n = 301) of trans and gender diverse participants felt their social gender affirmation process had been controlled, including 25.8% (n = 17) of trans women, 25.7% (n = 191) of non-binary participants, and 24.8% (n = 93) of trans men.

Trans women were most likely to report feeling supported in their gender affirmation, with 37.9% (n = 25) of trans women reporting feeling supported, compared to 29.1% (n = 109) of trans men, and 19.9% (n = 48) of non-binary participants. In total, less than one-quarter (23.8%; n = 282) had felt supported to affirm their gender.

Figure 64 **Social gender affirmation process autonomy**

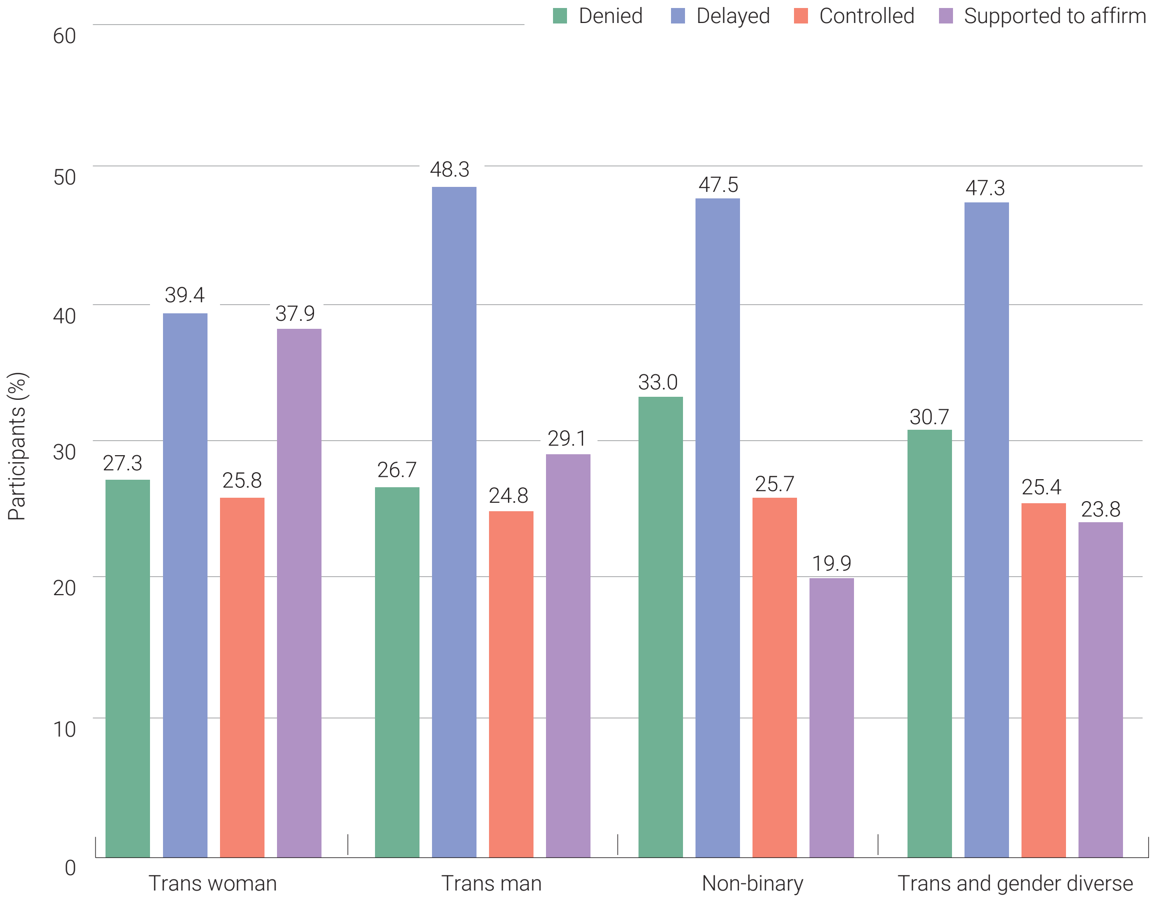


Figure 65 displays the proportion of trans and gender diverse participants who reported feeling their legal gender affirmation process had been controlled, denied, or delayed, or that they had been 'supported to affirm'. Participants could respond 'not applicable' to any questions that were not relevant to them. Figure 65 displays these results by gender (n = 603).

Half (50.9%; n = 307) of trans and gender diverse participants reported feeling their legal gender affirmation process had been delayed, including more than half of trans women (52.8%; n = 19) and trans men (52.1%; n = 149), and half (49.5%; n = 139) of non-binary participants. More than one-third (37.2%; n = 224) felt their legal gender affirmation process had been denied, including over two-fifths (42.7%; n = 120) of non-binary participants, one-third (33.6%; n = 96) of trans men, and over one-fifth (22.2%; n = 8) of trans women.

One-fifth (21.4%; n = 129) of trans and gender diverse participants felt their legal gender affirmation process had been controlled, including one-quarter (25.0%; n = 9) of trans women, 21.3% (n = 61) of trans men, and 21.0% (n = 59) of non-binary participants.

Similarly to with social affirmation, non-binary participants were least likely to report feeling supported in legal gender affirmation. Just over one in ten (11.7%; n = 33) of non-binary participants reported feeling supported, compared to one-quarter (25.0%; n = 9) of trans women and one-fifth (19.9%; n = 57) of trans men. In total, less than one-fifth (16.4%; n = 99) felt they had been supported to affirm their gender legally,

Figure 65 **Legal gender affirmation process autonomy**

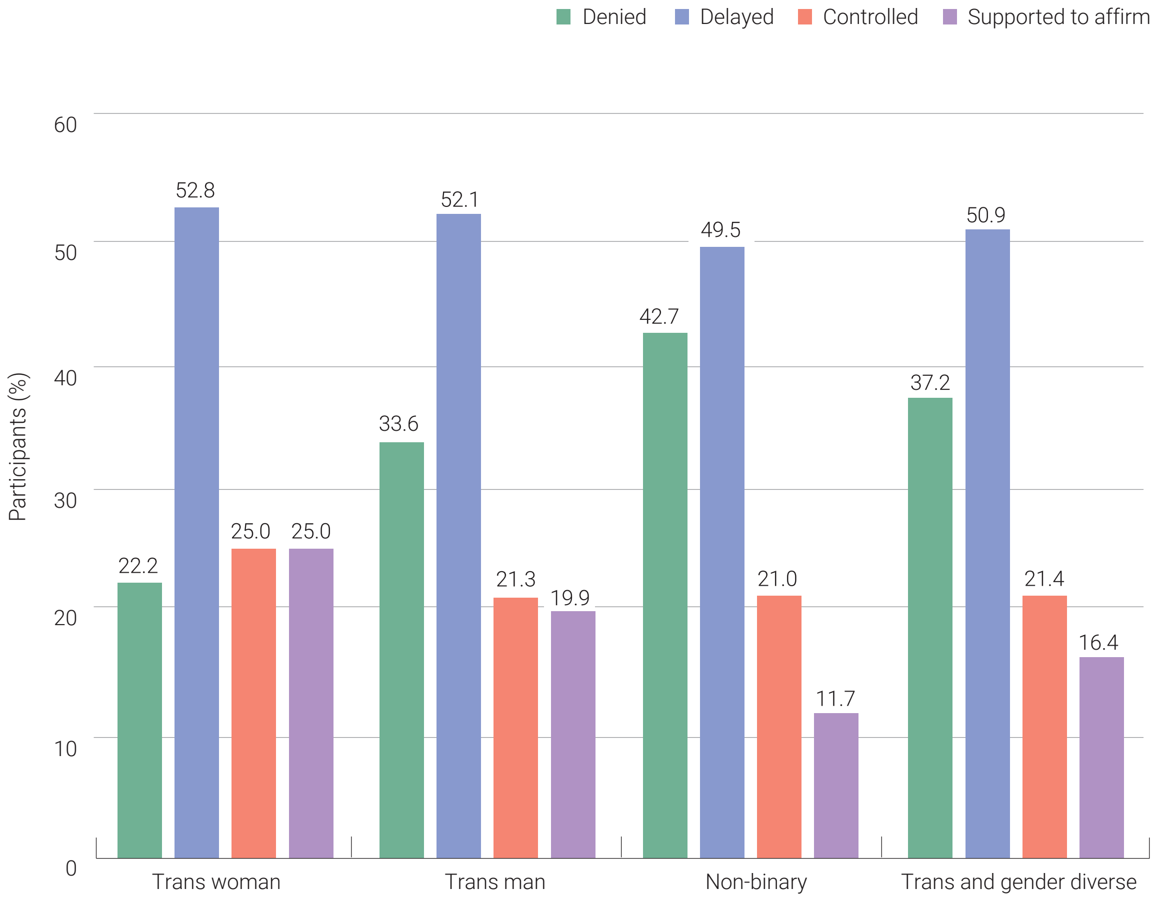


Figure 66 displays the proportion of trans and gender diverse participants who reported feeling their access to puberty blockers had been controlled, denied, or delayed, or that they had been 'supported to affirm' (n = 356). Participants could respond 'not applicable' to any questions that were not relevant to them.

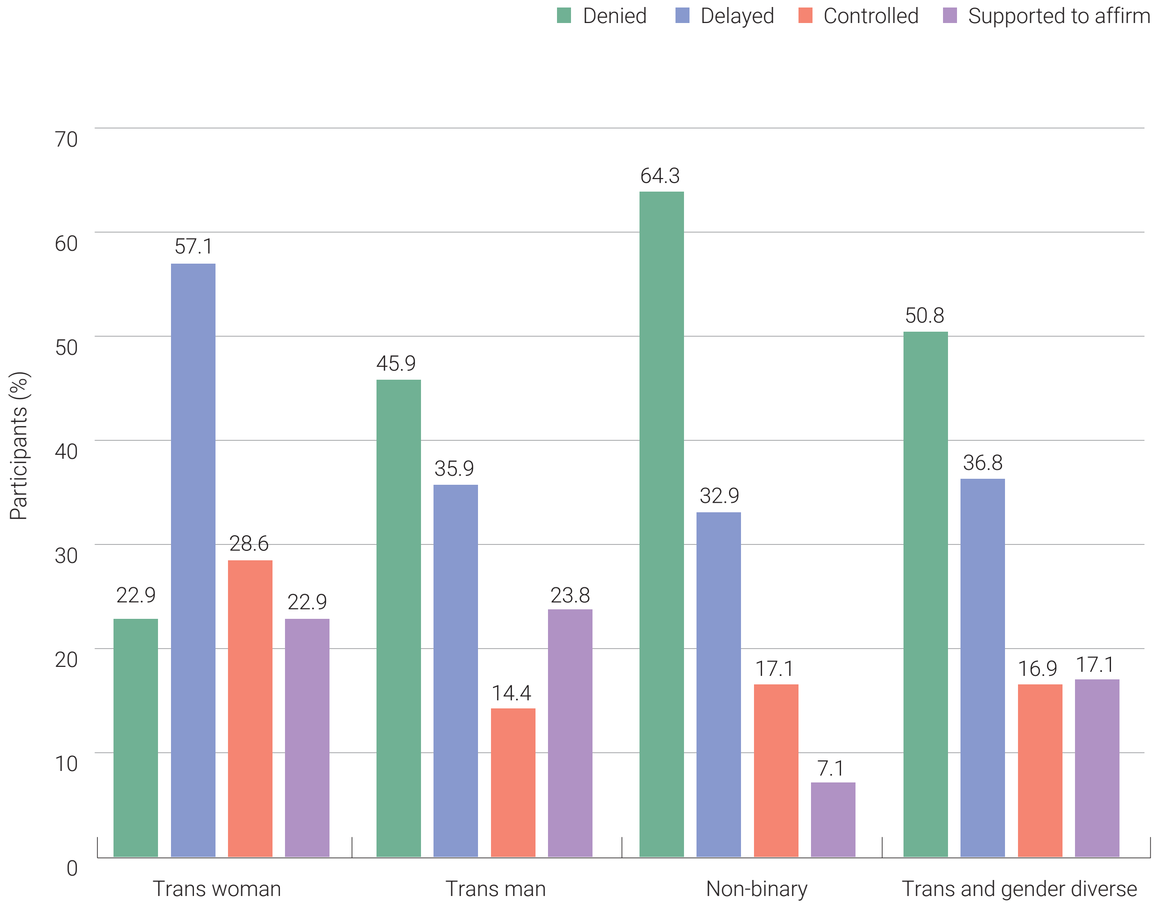
'Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents' advises that the withholding of gender-affirming treatment potentially exacerbates distress and increases risk of self-harm or suicide (85). Non-binary participants and trans men were more likely to report that puberty blockers had been denied to them than that they had been delayed or controlled. This is a different pattern to that for trans women, who were more likely to report puberty blockers had been delayed or controlled than they had been denied. Over two-thirds (64.3%; n = 90) of non-binary participants reported that puberty blockers had been denied, compared to 45.9% (n = 83) of trans men and 22.9% (n = 8) of trans women. In total, 50.8%; n = 181 of trans and gender diverse participants reported feeling their access to puberty blockers had been denied.

More than one-third (36.8%; n = 131) of trans and gender diverse participants reported they felt that their access to puberty blockers had been delayed, including almost three-fifths (57.1%; n = 20) of trans women, over one-third (35.9%; n = 65) of trans men, and one-third (32.9%; n = 46) of non-binary participants.

More than one-eighth (16.9%; n = 60) of trans and gender diverse participants felt their access to puberty blockers had been controlled, including over one-quarter (28.6%; n = 10) of trans women, 17.1% (n = 24) of non-binary participants, and 14.4% (n = 26) of trans men.

Again, non-binary participants were least likely to report feeling supported. Fewer than one in ten (7.1%; n = 10) of non-binary participants reported feeling supported to access puberty blockers, compared to 23.8% (n = 43) of trans men and 22.9% (n=8) of trans women. In total, 17.1% (n = 61) of trans and gender diverse participants felt they had been supported to affirm their gender identity via access to puberty blockers.

Figure 66 **Puberty blocker access autonomy**



23.2%

of trans and gender diverse participants had attended an LGBTIQA+ youth event at least once in the past 12 months

15.7 Non-binary participants, by sex assigned at birth

Non-binary assigned female at birth (AFAB) and non-binary assigned male at birth (AMAB) refer to the gender that was assigned at birth. 'Non-binary (AFAB)' and 'non-binary (AMAB)' may be useful for describing different non-binary experiences, and disparities in suicidal ideation have been found between those who are non-binary (AFAB) and those who are non-binary (AMAB) (86). By examining non-binary experiences through the lens of birth assignment, we can begin to see the impacts of socialisation as a particular gender, which leads to the differing experiences of non-binary (AFAB) and non-binary (AMAB) people. It should be understood that being assigned male or female at birth can shape the experiences that different non-binary people have, but these are not the identities that people carry. Non-binary people should be respected for who they are and how they identify.

In the remainder of this chapter, we report on key experiences described in the preceding chapters with a breakdown of findings according to whether participants were non-binary and assigned male or female at birth.

In total, 2.1% (n = 25) of non-binary participants (n = 1,219) responded 'prefer not to say' or 'something else' when asked, 'What was the sex on your original birth certificate?' These participants were not included in the following analyses but have been included throughout the main body of the report in analyses as 'non-binary' and in the 'all trans and gender diverse' category. The following variables are reported for non-binary (AFAB) (n = 1,011), non-binary (AMAB) (n = 183), and all trans and gender diverse participants (n = 1,697). It is of note that other studies of trans and gender diverse people in Australia also recruited a significantly larger proportion of non-binary (AFAB) than non-binary (AMAB) participants (87). For a more detailed explanation, see Chapter 2.

15.8 Engagement with LGBTQA+ events

Participants were asked how often they had attended an LGBTIQA+ youth event in the past 12 months. Response options were 'never', 'annually', 'monthly' and 'weekly'. Table 67 displays the results for any attendance in the past 12 months (n = 1,665).

Almost one-quarter (23.2%; n = 386) of trans and gender diverse participants had attended an LGBTIQA+ youth event at least once in the past 12 months. Non-binary (AMAB) participants reported slightly higher attendance than non-binary (AFAB) participants, with 22.7% (n = 40) and 21.6% (n = 215), respectively, having attended an LGBTIQA+ youth event in the past 12 months.

Table 67 **Attended an LGBTIQA+ youth event in the past 12 months, by gender assigned at birth**

	Non-binary (AFAB)		Non-binary (AMAB)		All trans and gender diverse	
Attended an LGBTIQA+ youth event in the past 12 months (n = 1,665)	n	%	n	%	n	%
No	780	78.4	136	77.3	1,279	76.8
Once or more	215	21.6	40	22.7	386	23.2

15.9 Experiences of feeling unsafe or uncomfortable in educational settings

Participants were asked if they had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity. Table 68 displays the results by gender assigned at birth.

Two-thirds of all the trans and gender diverse participants (67.9%; n = 1,070) reported feeling unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity. Approximately two-thirds (66.2%; n = 630) of non-binary (AFAB) participants reported feeling unsafe or uncomfortable in the past 12 months at their educational due to their sexuality or gender identity, compared to three-fifths (61.3%; n = 100) of non-binary (AMAB) participants.

15.10 Disclosing sexuality or gender identity

Disclosure comes in many forms and is not always encompassed by the term 'coming out'. Disclosure can also involve being 'invited in' to a discussion about sexuality or gender identity. Participants were asked, 'Have you come out to or talked with any of the following people about your sexual identity or gender identity?' Response options included 'never', 'a few of them', 'some of them', 'most of them', and 'all of them'. Responses were dichotomised to 'a few or more' or 'none' for this analysis.

- Friends (n = 1,675)
- Family (n = 1,671)
- Classmates (n = 1,494)

Participants could indicate if aspects of the question were not relevant to them (such as people not attending an educational institution). Tables 69-71 display these responses by gender assigned at birth..

Table 68 Felt unsafe or uncomfortable in past 12 months at their educational setting, by gender assigned at birth

	Non-binary (AFAB)		Non-binary (AMAB)		All trans and gender diverse	
Felt unsafe or uncomfortable (n = 1,575)	n	%	n	%	n	%
No	322	33.8	63	38.7	505	32.1
Yes	630	66.2	100	61.3	1,070	67.9

Table 69 Proportion of participants who disclosed their sexuality or gender identity to friends, by gender assigned at birth

	Non-binary (AFAB)		Non-binary (AMAB)		All trans and gender diverse	
Disclosed to friends (n = 1,675)	n	%	n	%	n	%
None of them	23	2.3	3	1.7	29	1.7
A few of them/some of them	264	26.4	52	28.9	421	25.1
Most of them/all of them	714	71.3	125	69.4	1,225	73.1

Table 70 Proportion of participants who disclosed their sexuality or gender identity to family, by gender assigned at birth

	Non-binary (AFAB)		Non-binary (AMAB)		All trans and gender diverse	
Disclosed to family (n = 1,671)	n	%	n	%	n	%
None of them	202	20.3	47	26.4	292	17.5
A few of them/some of them	546	54.9	76	42.7	813	48.7
Most of them/all of them	246	24.7	55	30.9	566	33.9

The vast majority of trans and gender diverse participants had disclosed their sexuality or gender identity to some (25.1%; n = 421) or most/all (73.1%; n = 1,225) of their friends. Over seven-tenths (71.3%; n = 714) of non-binary (AFAB) participants and 69.4% (n = 125) of non-binary (AMAB) participants had disclosed to most/all of their friends. Almost three-tenths (28.9%; n = 52) of non-binary (AMAB) and over one-quarter (26.4%; n = 264) of non-binary (AFAB) participants had disclosed to a few/some friends.

Less than one-fifth (17.5%; n = 292) of trans and gender diverse participants had not disclosed to any of their family.

Non-binary (AMAB) participants were more likely to disclose to most/all of their family (30.9%; n = 55) than non-binary (AFAB) participants (24.7%; n = 246). More than one-quarter (26.4%; n = 47) of non-binary (AMAB) participants had not disclosed to any of their family, compared to one-fifth (20.3%; n = 202) of non-binary (AFAB) participants.

Approximately one-quarter (24.9%; n = 372) of trans and gender diverse participants had not disclosed their sexuality or gender identity to any of their classmates.

More non-binary (AMAB) participants (29.7%; n = 47) had disclosed to most/all of their classmates than non-binary (AFAB) participants (23.0%; n = 208).

Over one-quarter of non-binary (AFAB) participants (26.7%; n = 241) and more than one-fifth (22.2%; n = 35) of non-binary (AMAB) participants had not disclosed to any of their classmates.

Table 71 **Proportion of participants who disclosed their sexuality or gender identity to classmates, by gender assigned at birth**

	Non-binary (AFAB)		Non-binary (AMAB)		All trans and gender diverse	
Disclosed to classmates (n = 1,494)	n	%	n	%	n	%
None of them	241	26.7	35	22.2	372	24.9
A few of them/some of them	455	50.3	76	48.1	720	48.2
Most of them/all of them	208	23.0	47	29.7	402	26.9

15.11 Feelings of support about sexuality or gender identity

Participants who responded they had come out to or talked with people about their sexual identity or gender identity were asked, 'Overall, how supported do you feel about your sexual identity, gender identity and/or gender expression?' The question was asked in relation to all those to whom they previously stated they had disclosed. For example, only participants who indicated that they had come out to or talked with family were asked how supported they felt by family.Table 72 displays responses to this questions by gender assigned at birth.

Approximately nine-tenths (89.8%; n = 1,477) of trans and gender diverse participants reported feeling supported by their friends about their sexuality or gender identity, half (50.7%; n = 699) felt supported by family, and one-third (33.7%; n = 282) felt supported by their classmates.

Non-binary (AMAB) participants (89.8%; n = 159) and non-binary (AFAB) participants (88.3%; n = 864) reported similar levels of support from friends. However, over half (53.4%; n = 70) of non-binary (AMAB) participants reported feeling supported by their family, compared to less than half (46.9%; n = 371) of non-binary (AFAB) participants. Furthermore, non-binary (AMAB) participants (43.4%; n = 43) felt more supported by their classmates than non-binary (AFAB) participants (33.3%; n = 168).

15.12 Psychological distress (K10)

The Kessler Psychological Distress Scale (K10) is a 10-item standardised scale developed to measure psychosocial distress, based on questions about people's level of nervousness, agitation, psychological fatigue and depression in the past four weeks. Responses to the questionnaire are summed to create a scale ranging from 10 to 50, with a higher score indicating higher levels of psychological distress. Table 73 displays the findings.

Nine-tenths of trans and gender diverse participants (90.2%; n = 1,527) reported experiencing high/very high psychological distress in the past four weeks. More than nine-tenths (91.4%; n = 924) of non-binary (AFAB) participants experienced high/very high psychological distress, compared to 84.0% (n = 152) of non-binary (AMAB) participants.

Table 72 **Proportion of participants who feel 'supported' or 'very supported' about their sexuality, gender identity and/or gender expression by friends, by gender assigned at birth**

	Non-binary (AFAB)		**Non-binary (AMAB)**		**All trans and gender diverse**	
Feel supported by …	**n**	**%**	**n**	**%**	**n**	**%**
Friends	864	88.3	159	89.8	1,477	89.8
Family	371	46.9	70	53.4	699	50.7
Classmates	168	33.3	43	43.4	282	33.7

Table 73 **Proportion of participants experiencing psychological distress, by gender assigned at birth**

	Non-binary (AFAB)		**Non-binary (AMAB)**		**All trans and gender diverse**	
K10 (n = 1,693)	**n**	**%**	**n**	**%**	**n**	**%**
Low	19	1.9	12	6.6	42	2.5
Moderate	67	6.6	17	9.4	124	7.3
High	266	26.3	53	29.3	431	25.5
Very high	658	65.1	99	54.7	1,096	64.7

15.13 Experiences of harassment or assault based on sexuality or gender identity

Participants were asked if in the past 12 months or ever in their lifetime they had experienced the following forms of harassment or assault based on their sexuality or gender identity:

- Verbal (e.g. been called names or threatened)
- Physical (e.g. being shoved, punched, or injured with a weapon)
- Sexual (e.g. unwanted touching, sexual remarks, sexual messages or being forced to perform any unwanted sexual act)

Tables 74-76 display responses to these questions by gender assigned at birth. Over half (56.2%; n = 923) of all trans and gender diverse participants reported in the past 12 months experiencing verbal harassment based on their sexuality or gender identity. Higher levels of verbal harassment were reported by non-binary (AMAB) participants (61.7%; n = 108) than non-binary (AFAB) participants (51.1%; n = 499).

Over one-eighth (14.0%; n = 208) of all trans and gender diverse participants reported in the past 12 months experiencing physical harassment or assault based on their sexuality or gender identity. A higher proportion of non-binary (AMAB) participants (21.7%; n = 34) than non-binary (AFAB) participants (11.6%; n = 103) reported in the past 12 months experiencing physical harassment or assault based on their sexuality or gender identity.

Over one-quarter (27.4%; n = 415) of all trans and gender diverse participants reported in the past 12 months experiencing sexual harassment or assault based on their sexuality or gender identity. One-third (33.3%; n = 54) of non-binary (AMAB) participants reported in the past 12 months experiencing sexual harassment or assault based on their sexuality or gender identity, compared to one-quarter (26.6%; n = 241) of non-binary (AFAB) participants.

Table 74 Experienced verbal harassment based on sexuality or gender identity, by gender assigned at birth

	Non-binary (AFAB)		Non-binary (AMAB)		All trans and gender diverse	
Verbal harassment (n = 1,643)	n	%	n	%	n	%
Past 12 months	499	51.1	108	61.7	923	56.2
Ever	669	68.5	132	75.4	1,190	72.4

Table 75 Experienced physical harassment or assault based on sexuality or gender identity, by gender assigned at birth

	Non-binary (AFAB)		Non-binary (AMAB)		All trans and gender diverse	
Physical harassment or assault (n = 1,482)	n	%	n	%	n	%
Past 12 months	103	11.6	34	21.7	208	14.0
Ever	156	17.5	54	34.4	331	22.3

Table 76 Experienced sexual harassment or assault based on sexuality or gender identity, by gender assigned at birth

	Non-binary (AFAB)		Non-binary (AMAB)		All trans and gender diverse	
Sexual harassment or assault (n = 1,514)	n	%	n	%	n	%
Past 12 months	241	26.6	54	33.3	415	27.4
Ever	313	34.5	70	43.2	538	35.5

15.14 Experiences of homelessness

Participants were first given the following options, asking if they had ever:

- Run away from home or the place you live
- Left home or the place you live because you were asked/made to leave
- Couch surfed because you had no other place to stay
- Been homeless

Participants who responded 'yes' to any of the above were then asked for each response if they were currently experiencing this, if it was within the past 12 months, or if it was more than 12 months ago. Participants could select as many options as applied (i.e. currently experiencing this, and more than 12 months ago). 'Current' experiences of homelessness were merged with 'past 12 months'. Table 77 displays the results for experiences of homelessness in their lifetime (n = 1,678) and in the past 12 months (n = 1,676), by gender.

Over one-eighth (16.4%; n = 275) of trans and gender diverse participants reported having experienced homelessness in the past 12 months, including more than one-eighth of non-binary (AFAB) participants (15.1%; n = 151) and non-binary (AMAB) participants (15.1%; n = 27).

15.15 Suicide and self-harm

Writing Themselves In 4 asked participants about suicidal ideation, defined as 'experiences of thoughts about suicide, wanting to die, or about ending your life'; suicide plans, defined as having 'made a plan to attempt suicide or end your own life'; suicide attempts, defined as having 'attempted suicide or to end your life'; self-harm ideation, defined as 'thoughts about harming yourself on purpose'; and self-harm attempts, defined as having 'injured or harmed yourself on purpose'.

Previous research has found that asking people about suicide does not increase the risk of suicide (59). Nonetheless, as a precaution, online and telephone resources were provided for Qlife and Kids Helpline prior to these questions, as well as at the end of the survey. Prior to the questions being shown, participants were given the option to choose 'prefer not to answer these questions', with in bold text, 'If you feel uncomfortable answering these questions, please skip them. Skipping this question does not make your other responses any less valuable.' Participants were also given the option of 'prefer not to answer' for each question regarding suicidal ideation, suicide plans, suicide attempts, self-harm ideation, and self-harm attempts.Tables 78-80 display responses to these questions by gender assigned at birth.

While there were no substantial differences between the proportion of non-binary (AFAB) and non-binary (AMAB) participants who reported experiences of suicide ideation or attempts, non-binary (AFAB) participants were more likely to report a history of self-harm that non-binary (AMAB) participants, as the following results show.

Table 77 Experienced homelessness in their lifetime and in the past 12 months, by gender assigned at birth

	Non-binary (AFAB)		Non-binary (AMAB)		All trans and gender diverse	
Any homelessness	n	%	n	%	n	%
Past 12 months	151	15.1	27	15.1	275	16.4
Ever	316	31.5	57	31.8	570	34.0

Table 78 Experienced suicidal ideation in their lifetime and in the past 12 months, by gender assigned at birth

	Non-binary (AFAB)		Non-binary (AMAB)		All trans and gender diverse	
Suicidal ideation (n = 1,690)	n	%	n	%	n	%
Past 12 months	710	70.5	120	66.3	1,198	70.9
Ever	885	87.9	154	85.1	1,500	88.8
Prefer not to say	34	3.4	8	4.5	61	3.6

Seven-tenths (70.9%; n = 1,198) of all trans and gender diverse participants reported having experienced suicidal ideation in the past 12 months. A greater proportion of non-binary (AFAB) participants (70.5%; n = 710) reported experiencing suicidal ideation in the past 12 months than non-binary (AMAB) participants (66.3%; n = 120).

Almost nine-tenths (88.8%; n = 1,500) of all trans and gender diverse participants reported ever having experienced suicidal ideation in their lifetime. Non-binary (AFAB) participants (87.9%; n = 885) were more likely to report ever having experienced suicidal ideation in their lifetime than non-binary (AMAB) participants (85.1%; n = 154).

More than one-eighth (14.3%; n = 240) of all trans and gender diverse participants reported having attempted suicide in the past 12 months. More non-binary (AFAB) participants (13.5%; n = 135) reported having attempted suicide in the past 12 months than non-binary (AMAB) participants (12.3%; n = 22).

Almost two-fifths (37.9%; n = 635) of all trans and gender diverse participants reported ever having attempted suicide in their lifetime. A similar proportion of non-binary (AFAB) participants (34.8%; n = 347) reported ever having attempted suicide in their lifetime to non-binary (AMAB) participants (34.6%; n = 347).

Over half (54.0%; n = 906) of all trans and gender diverse participants reported having self-harmed in the past 12 months. More non-binary (AFAB) participants (56.3%; n = 562) reported self-harming in the past 12 months than non-binary (AMAB) participants (40.6%; n = 73).

37.9%

of all trans and gender diverse participants reported having attempted suicide at some point in their life

Almost four-fifths (78.1%; n = 1,309) of all trans and gender diverse participants reported ever having self-harmed in their lifetime. Almost four-fifths (78.6%; n = 784) of non-binary (AFAB) participants reported ever having self-harmed in their lifetime, compared to over three-fifths (61.1%; n = 110) of non-binary (AMAB) participants.

Table 79 Experienced suicide attempt in their lifetime and in the past 12 months, by gender assigned at birth

	Non-binary (AFAB)		Non-binary (AMAB)		All trans and gender diverse	
Suicide attempt (n = 1,675)	**n**	**%**	**n**	**%**	**n**	**%**
Past 12 months	135	13.5	22	12.3	240	14.3
Ever	347	34.8	62	34.6	635	37.9
Prefer not to say	59	5.9	11	6.2	118	7.0

Table 80 Self-harmed in their lifetime and in the past 12 months, by gender assigned at birth

	Non-binary (AFAB)		Non-binary (AMAB)		All trans and gender diverse	
Self-harm (n = 1,677)	**n**	**%**	**n**	**%**	**n**	**%**
Past 12 months	562	56.3	73	40.6	906	54.0
Ever	784	78.6	110	61.1	1,309	78.1
Prefer not to say	40	4.0	9	5.0	75	4.4

15.16 Experiences of gender affirmation

All trans and gender diverse people who completed this section were asked, 'What are some of the things that have most helped, or would help you feel that your gender identity is affirmed?' A total of 942 people provided an open-text response, which ranged from a few words to several paragraphs in length. A content analyses of their responses saw the emergence of five themes, which spanned what has helped, what has not helped, and what could help in the future.

Self-exploration and expression

This theme captures all the comments that spoke of factors at a personal level that have helped to affirm their gender. This included a variety of ways that people express their gender through their physical selves outside of medical affirmation: hair (e.g. dyeing, cutting and shaving/growing body hair); body contouring (e.g. packing and chest binding); clothing; make-up and hygiene products (e.g. deodorant); and jewellery (including piercings). In addition to this, participants reported exercising to shape their bodies and to promote a sense of wellbeing. Some reported moving out of home or to a different area, particularly when this was seen as facilitating further opportunities for affirming expression. There were other creative self-affirmation practices, including redecorating one's room. Self-exploration was also reported – through reflecting, writing, art, talking about and sharing their identity with others, including through the use of pronouns and other gendered language.

> **Realising, through therapy, that the only person I need affirmation from is myself.**

> **Using my pronouns, using neutral to masculine language, cutting my hair, trying out new names.**

> **Wearing male-designed clothes, cutting my hair short, being gendered correctly, redesigning my room, wearing a sports bra (they are tighter and help dysphoria) or wearing baggy clothes (oversized hoodies especially).**

> **I was allowed to wear the male uniform and was referred by my correct pronouns/name.**

Engaging with healthcare services

Participants described accessing gender-affirming medical and mental health services, especially in relation to hormones (including puberty blockers) and surgery. While some made general statements that surgery had helped their gender affirmation (without describing its form), most responses specified an experience of – or desire for – 'top surgery', that is, having chest/breast tissue removed. It should be noted that a smaller number of trans women participated in *Writing Themselves In* 4, which likely influenced the reporting of other forms of gender-affirming surgeries. Some young people spoke of issues they had accessing formal and appropriate services. Such issues included lengthy waiting lists for referral or consultation, a lack of availability of services locally, challenges in accessing more advanced services (e.g. 'bottom surgery' techniques), concerns about the age at which someone can access medical care related to gender affirmation, and a lack of education regarding trans and gender diverse issues on the part of healthcare professionals. Many participants used this question as an opportunity to express their and other trans and gender diverse people's need for Medicare-funded access to surgeries and greater access to safe medical services.

> **Getting surgery. However, that came with an $18k price tag. So, all trans cosmetic surgeries and procedures should be covered by Medicare – this should be inclusive of those not on HRT/those who haven't changed legal markers.**

> **I started HRT in the last year which has really helped my mental health. I want to get affirming surgery in the future, but I just can't see it happening any time soon because it's so expensive.**

> **Having greater access to 'gender-affirming' services as a minor and having health professionals (particularly those in the mental health field) be more educated and empathetic towards transgender people and transgender medicine.**

Reflections on institutions and social structures

Many participants used their response to this question to reflect upon the broader structures and institutions in society that they felt could, or did, influence gender affirmation. Numerous people described how the social construction of a gender binary, and stereotypes of gender roles, were significant barriers to feeling affirmed in their own gender identity. Beyond these social-level challenges, numerous participants articulated challenges they have faced accessing gender-neutral toilets or relayed frustrations about options on forms that do not go beyond the male/female binary, and the lack of representation of trans and gender diverse people in documents used by organisations. A major enabler of gender affirmation for some related to legal documentation, including permissible changes to birth certificates and the ability to change one's name and/or sex marker.

We should have no 'boy toys,' no 'girl toys,' and the same should apply to clothes, social situations, and a whole host of other things.

To not have every aspect of life gendered, clothes, colours, food. To not have just male or female options on forms or surveys.

There needs to be movements to break down the gender binary. It ruins trans people's lives and mental health. We can exist how we want, we shouldn't have to follow cisgender rules about gender.

Having my name and gender marker legally changed.

Trans community connection and representation

Numerous participants described ways in which their gender was affirmed through connecting with, or becoming more aware of, the community of trans and gender diverse people. Many related comments centred on the value of online connectivity and a sense of inclusive spaces on the internet, including YouTube, blogs, social media facilitated support groups and social media generally, particularly in the diverse ways gender can be represented. Responses on this theme also encompassed the value of friends (both online and in person), books, television, movies, and trans and gender diverse networks and events (e.g. pride) in helping to affirm one's gender identity. Positive representation in both mainstream and non-mainstream media was seen as important for ensuring a sense of inclusion, fostering an understanding that they were not alone, raising awareness and allowing for celebration of trans and gender diverse people.

Webchats, support groups, queer events, other LGBTIQA+ events.

Watching transgender people on YouTube cuz it makes me feel not so alone.

By reading others experiences on social media. Looking at memes (jokes) that I could possibly relate too.

Being with other trans people, seeing positive trans role models.

Family, friends and networks: Affirmation from others

A large proportion of participants described how their gender identity was affirmed by those close to them (e.g. family, friends and partners) as well as other networks of which they were a part (e.g. work, educational institutions, religious organisations). Cutting across all of these interactions, participants valued the use of specific language and pronouns, and that could be facilitated simply by another person asking instead of assuming. In relation to those who were most significant in their lives, participants said that their gender was affirmed when their family, friends and partners understood, supported, advocated for and celebrated them. This was similarly the case for workplaces, educational institutions and religious organisations. In terms of people in the general community more broadly, participants felt affirmed for the following reasons: when they were correctly gendered; when they were assumed to be cisgender (if that was their personal aspiration); when people acknowledged genders outside of the binary; or when they felt affirmed due to a lack of interest from strangers (for example, not having others passing comment on clothing or other characteristics of gender expression).

> **Friends validating my identity by using name and pronouns and gender specific compliments.**

> **Having a partner that affirms my gender identity, especially in intimate situations has helped. Having supportive parents would enable me to further transition without tonnes of anxiety and second-guessing myself. I fear being scolded for transitioning without their consent.**

> **Having my friends immediately accept me, my mum buying me pronoun badges and looking into groups for queer/trans people and for parents of queer/trans kids.**

> **Having teachers talk to students about gender identity and respecting people's names and pronouns. This is applicable both for school settings and theatre classes.**

15.17 Summary

As has been observed in other studies, a large proportion of the trans and gender diverse young people who participated in *Writing Themselves In 4* were experiencing high levels of psychological distress, suicidal ideation, self-harm, and verbal harassment related to their sexuality or gender identity. Trans and gender diverse participants reported feeling supported by friends, family and classmates. Friends, in particular, were an important source of support for trans and gender diverse young people in this survey.

The majority of trans and gender diverse participants (97.4%) said they had ever wanted to affirm their gender identity socially, and close to three-quarters (74.8%) of them had taken steps to affirm their gender identity socially. Fewer trans and gender diverse young people had been able to access legal or medical gender affirmation, despite the majority saying that they would like to. Less than one-quarter of all trans and gender diverse participants felt supported to affirm their gender socially (23.8%) or legally (16.4%). Non-binary participants were less likely than trans men or trans women to feel supported to pursue legal or social gender affirmation or to take puberty blockers.

Safe and comfortable access to public toilets was a problem reported by a large number of trans and gender diverse participants in *Writing Themselves In* 4. Over 70% of all trans and gender diverse participants had faced issues relating to toilet access in the past 12 months, including avoiding using toilets (61.4%), feeling uncomfortable or unsafe using toilets (59.5%), or limiting how much they ate or drank to avoid having to go to the toilet (38.5%).

Non-binary (AFAB) participants (91.4%) were more likely to report high/very high levels of psychological distress than non-binary (AMAB) participants (84.0%). Similarly, a higher proportion of non-binary (AFAB) participants (56.3%) than non-binary (AMAB) participants (40.6%) reported self-harm in the past 12 months.

16 **Disability or long-term health conditions**

Thus far, this report has described health, education and social experiences based on the whole sample of LGBTQA+ young people (with the exception of the preceding chapter, focussed on trans and gender diverse participants). In these last three chapters on results, we seek to shine a spotlight on the needs and experiences of young people within specific communities, particularly those that have not received as much attention in research in the past. As such, this chapter revisits some of the key questions we asked LGBTQA+ young people and reports what responses looked like for those with disability or a long-term health condition.

The approach to defining disability or long-term health conditions that is taken by the Australian Bureau of Statistics (ABS), and many other public bodies, is based on whether a condition restricts daily living, rather than what the condition itself is. For example, a person may report loss of sight as a health condition, but if they are able to see and function without limitations by wearing corrective glasses, they are not considered (for the purposes of research) to have a disability. In contrast, a person who, even when wearing glasses, is still restricted in everyday activities by their vision, may be considered to have a disability (21).

The Survey of Disability, Ageing and Carers (SDAC) defines disability as any limitation, restriction or impairment which restricts everyday activities and has lasted, or is likely to last, for at least six months. In 2018, 17.7% of the general population identified as having a disability under this definition (22).

In the survey development of *Writing Themselves In* 4, a more inclusive instrument for measuring disability was developed in consultation with the Youth Disability Advocacy Service (YDAS), and an LGBTIQA+ disability advisory board of experts in the field. As such, the broader definition of disability used in *Writing Themselves In 4* is not directly comparable to national Australian Bureau of Statistics data.

Disability was defined in *Writing Themselves In 4* as follows:

> *Do you identify as having a disability, experiencing neurodiversity/autism, or having a long-term physical or mental health condition? Long-term health conditions could include things like epilepsy, mental health conditions, speech or sensory impairments. A disability could include things like the loss of – or difficulty using – a body part, or difficulty managing everyday activities.*

Almost two-fifths (39.0%; n = 2,500) of participants reported having a disability or long-term physical or mental health condition, 8.7% (n = 558) reported they 'did not know', and 1.4% (n = 87) 'preferred not to say'. Almost nine-tenths (87.0%; n = 2,160) of participants who reported a disability or long-term health condition reported acquiring one or more of these conditions later in life (after they were born). Overall, 92.5% (n = 2,028) of participants reporting a mental illness reported acquiring one or more of these conditions later in life.

Participants reporting a disability or long-term health condition were asked to further describe it from the following choices (and could select as many options as appropriate):

- Physical (your body and/or mobility)
- Intellectual (difficulty communicating, making decisions, engaging with others, or learning or retaining information)
- Mental illness (your emotional state and/or behaviours)
- Sensory (sight, hearing, smell, touch, taste, or spatial awareness)
- Neurodiversity/autism (ADHD, dyslexia, Tourette syndrome, dyspraxia etc.)
- Acquired brain injury (ABI, TBI, dementia)
- Something else

Table 81 displays these results.

Table 81 Type of disability or long-term health condition reported

Disability/long-term health condition (n = 6,408)	**n**	**%**
Mental illness	2,206	34.4
Neurodiversity/autism	866	13.5
Physical	422	6.6
Sensory	419	6.5
Intellectual	347	5.4
Acquired brain injury	10	0.1
Other	132	2.1

When asked to further describe the nature of their disability, one-third of participants reported mental illness (34.4%; n = 2,206), 13.5% (n = 866) reported neurodiversity/autism, 6.6% (n = 422) physical disability, 6.5% (n = 419) sensory disability, 5.4% (n = 347) intellectual disability, 0.1% (n = 10) acquired brain injury and 2.1% (n = 132) a different type of disability. It is notable that the relatively high proportion of people reporting disability in this study, compared to 9.3% of young people aged 15 to 24 years in the general population who reported disability (18), is likely to arise from the inclusion of mental illness: approximately one-quarter (22.5%; n = 1,440) of the total sample reported a disability or long-term health condition other than a mental illness. This is a result of the more inclusive model of self-identified disability used in *Writing Themselves In 4*.

In order to best analyse findings in *Writing Themselves In 4* regarding the reporting of a disability or long-term health condition, they were categorised as follows:

- Any disability[3]
- Intellectual disability
- Neurodiversity/autism[4]
- Physical/sensory disability

It is important to note that while these categories provide new insight into the health and wellbeing of young LGBTQA+ people living in Australia, they are subject to a variety of limitations. Firstly, these categories are self-reported and are not medical diagnoses. However, other research such as national census data reported by the ABS also uses similarly self-reported data. Secondly, while these categories are useful in understanding the perspectives of these young people, they are not comparable to national data. We have therefore created the 'any disability' category, which does not include participants reporting 'mental illness' and no other disability or long-term health condition. This provides the best comparison with general population data, which does not include mental illness as a disability or long-term health condition. Lastly, the data in this report does not measure subjective severity of disability or long-term health conditions, and comparisons between categories must therefore be made with caution.

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[3] *In order to be comparable with general population data, 'any disability' does not include participants reporting only 'mental illness' and no other disability or long-term health condition.*

[4] *'Neurodiversity/autism' does not include participants reporting 'intellectual disability' in addition to 'neurodiversity/autism'. This distinction was drawn in order to separate findings in recognition of the differing lived experiences of these disabilities.*

Participants reporting disability or a long-term health condition were more likely to have felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity than those not reporting disability or a long-term health condition

16.1 Engagement with LGBTIQA+ events

Participants were asked how often they had attended an LGBTIQA+ youth event in the past 12 months. Response options were 'never', 'annually', 'monthly' and 'weekly'. Table 82 displays the results for any attendance in the past 12 months.

The proportion of participants who had attended an LGBTIQA+ youth event in the past 12 months was higher for those reporting disability or a long-term health condition compared with those reporting no disability or long-term health condition. Over one-fifth (22.4%; n = 158) of participants reporting physical/sensory disability had attended an LGBTIQA+ youth event in the past 12 months, followed by 21.7% (n = 139) of those reporting neurodiversity/autism, 21.0% (n = 71) reporting intellectual disability and 20.4% (n = 287) reporting any disability or long-term health condition. This compares to 12.2% (n = 390) of those reporting no disability or long-term health condition.

16.2 Experiences of feeling unsafe or uncomfortable in educational settings

Participants were asked if they had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity. Table 83 displays the results by disability or long-term health condition.

Participants reporting disability or a long-term health condition were more likely to have felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity than those not reporting disability or a long-term health condition. Almost two-thirds (63.9%; n = 204) of participants reporting intellectual disability had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity, followed by 58.4% (n = 388) with physical/sensory disability, and 55.3% (n = 339) of those reporting neurodiversity/autism.

Table 82 Attended an LGBTIQA+ youth event in the past 12 months, by disability or long-term health condition

	Disability									
	None		Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Attended LGBTIQA+ youth event (n = 6,261)	n	%	n	%	n	%	n	%	n	%
No	2,800	87.8	1,121	79.6	267	79.0	501	78.3	547	77.6
Once or more	390	12.2	287	20.4	71	21.0	139	21.7	158	22.4

Table 83 Felt unsafe or uncomfortable in past 12 months at their educational setting, by disability or long-term health condition

	Disability									
	None		Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Felt unsafe or uncomfortable (n = 6,097)	n	%	n	%	n	%	n	%	n	%
No	1,717	54.9	583	43.3	115	36.1	274	44.7	276	41.6
Yes	1,412	45.1	763	56.7	204	63.9	339	55.3	388	58.4

16.3 Disclosing sexuality or gender identity

Disclosure comes in many forms and is not always encompassed by the term 'coming out'. Disclosure can also involve being 'invited in' to a discussion about sexuality, gender identity. Participants were asked, 'Have you come out to or talked with any of the following people about your sexual identity or gender identity?' Response options included 'never', 'a few of them', 'some of them', 'most of them', and 'all of them'. Responses were dichotomised to 'a few or more' or 'none' for this analysis, in order to examine participants who had made any disclosure to friends, family, or classmates.

- Friends (n = 6,310)
- Family (n = 6,254)
- Classmates (n = 5,805)

Participants could indicate if aspects of the question were not relevant to them (such as people not attending an educational institution). Table 84 displays these responses by disability or long-term health condition.

A similar proportion of participants reporting disability or a long-term health condition (96.5%; n = 1,363) had disclosed their sexuality or gender identity to friends, compared with participants reporting no disability or long-term health condition (94.5%; n = 3,044). The vast majority of participants reporting neurodiversity/autism (97.8%; n = 627) had disclosed to friends, followed by 96.2% (n = 677) reporting physical/sensory disability, and 95.2% (n = 321) reporting intellectual disability.

Participants reporting disability or a long-term health condition (81.0%; n = 1,139) were more likely to have disclosed to family, compared to those reporting no disability or long-term health condition (66.7%; n = 2,126). Four-fifths (83.3%; n = 280) of participants reporting intellectual disability had disclosed to family, followed by 82.5% (n = 581) reporting physical/sensory disability, and 81.1% (n = 522) reporting neurodiversity/autism.

Almost three-quarters (73.4%%; n = 916) of participants reporting disability or a long-term health condition had disclosed their sexuality or gender identity to classmates, compared to seven-tenths (69.1%; n = 2,080) of those reporting no disability or long-term health condition. Three-quarters (75.0%; n = 433) of participants reporting neurodiversity/autism had disclosed to classmates, followed by 74.0% (n = 448) reporting physical/sensory disability, and 72.8% (n = 211) reporting intellectual disability.

16.4 Feelings of support about sexuality or gender identity

Participants who responded they had come out to or talked with people about their sexual identity or gender identity were asked, 'Overall, how supported do you feel about your sexual identity, gender identity and/or gender expression?' The question was asked in relation to all categories where some level of disclosure had been reported. For example, only participants who indicated that they had come out to, or talked with, family were asked how supported they felt by family. Table 85 displays the proportion of participants who reported feeling supported by friends (n = 6,007), family (n = 4,489) and classmates (n = 3,160).

The proportion of those who felt supported by friends was slightly higher among participants reporting disability or a long-term health condition (89.5%; n = 1,216), compared to those reporting no disability or long-term health condition (87.5%; n = 2,656). Over nine-tenths of participants reporting neurodiversity/autism (90.9%; n = 90.9) or intellectual disability (90.7%; n = 291) felt supported by friends, compared to just under nine-tenths of those reporting physical/sensory disability (87.9%; n = 593).

However, participants reporting disability or a long-term health condition felt slightly less supported by family (56.2%; n = 638) than those reporting no disability or long-term health condition (59.1%; n = 1,256). Three-fifths (60.4%; n = 314) of participants reporting neurodiversity/autism felt supported by family, compared to just over half reporting intellectual disability (55.4%; n = 155) or physical/sensory disability (54.1%; n = 314).

Participants reporting disability or a long-term health condition also felt less supported by classmates (39.3%; n = 266) than those not reporting disability or a long-term health condition (45.1%; n = 724). Almost two-fifths (38.5%; n = 122) of participants experiencing neurodiversity/autism reported feeling supported by classmates, compared to 37.8% (n = 127) of participants with physical/sensory disability, and approximately one-third (32.9%; n = 48) of participants with intellectual disability.

Table 84 Proportion of participants who disclosed their sexuality or gender identity, by disability or long-term health condition

	Disability									
	None		Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Disclosed to any	n	%	n	%	n	%	n	%	n	%
Friends	3,044	94.5	1,363	96.5	321	95.2	627	97.8	677	96.2
Family	2,126	66.7	1,139	81.0	280	83.3	522	81.1	581	82.5
Classmates	2,080	69.1	916	73.4	211	72.8	433	75.0	448	74.0

Table 85 **Proportion of participants who feel 'supported' or 'very supported' about their sexuality, gender identity and/or gender expression, by disability or long-term health condition**

	Disability									
	None		Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Feel supported by…	n	%	n	%	n	%	n	%	n	%
Friends	2,656	87.5	1,216	89.5	291	90.7	568	90.9	593	87.9
Family	1,256	59.1	638	56.2	155	55.4	314	60.4	314	54.1
Classmates	724	45.1	266	39.3	48	32.9	122	38.5	127	37.8

16.5 Psychological distress (K10)

The Kessler Psychological Distress Scale (K10) is a 10-item standardised scale developed to measure psychosocial distress based on questions about people's level of nervousness, agitation, psychological fatigue and depression in the past four weeks. Responses to the questionnaire are summed to create a score ranging from 10 to 50, with a higher score indicating higher levels of psychological distress.

Reported experiences of high/very high psychological distress were much more common among participants reporting disability or a long-term health condition (90.9%; n = 1,302), compared to participants reporting no disability or long-term health condition (70.6%; n = 2,296). Over nine-tenths of participants with intellectual disability (94.8%; n = 327) reported experiencing high/very high psychological distress, followed by those with physical/sensory disability (91.2%; n = 653), and those with neurodiversity/autism (90.9%; n = 590).

Experiences of high/very high psychological distress were much more common among people reporting disability or a long-term health condition than participants reporting disability or a long-term health condition

Table 86 **Proportion of participants experiencing psychological distress, by disability or long-term health condition**

	Disability									
	None		Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
K10 (n = 6,377)	n	%	n	%	n	%	n	%	n	%
Low	321	9.9	21	1.5	3	0.9	12	1.8	7	1.0
Moderate	634	19.5	110	7.7	15	4.3	47	7.2	56	7.8
High	1,072	33.0	329	23.0	56	16.2	158	24.3	166	23.2
Very high	1,224	37.6	973	67.9	271	78.6	432	66.6	487	68.0

16.6 Experiences of harassment or assault based on sexuality or gender identity

Participants were asked if in the past 12 months or ever in their lifetime they had experienced any of the following forms of harassment or assault based on their sexuality or gender identity:

- Verbal (e.g. being called names or threatened)
- Physical (e.g. being shoved, punched, or injured with a weapon)
- Sexual (e.g. unwanted touching, sexual remarks, sexual messages or being forced to perform any unwanted sexual act)

Table 87 displays the number of *Writing Themselves In 4* participants who, in the past 12 months or ever in their lifetime, had experienced verbal harassment based on their sexuality or gender identity, by disability or long-term health condition.

Over half of participants reporting disability or a long-term health condition (52.7%; n = 730) reported in the past 12 months experiencing verbal harassment relating to sexuality or gender identity, more than the one-third of participants reporting no disability or long-term health condition (34.7%; n = 1,089). Three-fifths of participants with intellectual disability (62.0%; n = 209) in the past 12 months experienced verbal harassment relating to sexuality or gender identity, followed by over half with physical/sensory disability (53.8%; n = 371), or neurodiversity/autism (50.6%; n = 317).

Table 88 displays the number of *Writing Themselves In 4* participants who, in the past 12 months or ever in their lifetime, had experienced physical harassment or assault based on their sexuality or gender identity, by disability or long-term health condition.

Over one-eighth of participants reporting disability or a long-term health condition (15.0%; n = 185) reported in the past 12 months experiencing physical harassment or assault based on their sexuality or gender identity, twice the 7.5% (n = 207) of participants reporting no disability or long-term health condition. Over one-fifth of participants with intellectual disability (21.8%; n = 64) in the past 12 months experienced physical harassment or assault based on their sexuality or gender identity, followed by 16.4% (n = 101) of participants with physical/sensory disability, and over one-tenth of participants experiencing neurodiversity/autism (11.9%; n = 68).

These findings follow similar trends to adults with disability in the Australian general population, in which 43.1% of adults with disability have experienced physical violence after the age of 15, compared to 32.1% without disability (88).

Table 87 Experienced verbal harassment based on sexuality or gender identity, by disability or long-term health condition

			Disability							
	None		Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Verbal harassment (n = 6,171)	n	%	n	%	n	%	n	%	n	%
Past 12 months	1,089	34.7	730	52.7	209	62.0	317	50.6	371	53.8
Ever	1,609	51.3	985	71.1	260	77.2	436	69.6	497	72.0

Table 88 Experienced physical harassment or assault or assault based on sexuality or gender identity, by disability or long-term health condition

			Disability							
	None		Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Physical harassment or assault (n = 5,455)	n	%	n	%	n	%	n	%	n	%
Past 12 months	207	7.5	185	15.0	64	21.8	68	11.9	101	16.4
Ever	333	12.1	301	24.3	93	31.7	124	21.7	166	27.0

Table 89 displays the number of *Writing Themselves In 4* participants experiencing sexual harassment or assault based on their sexuality or gender identity, in the past 12 months or ever in their lifetime, by disability or long-term health condition.

Three-tenths of participants reporting disability or a long-term health condition (31.7%; n = 406) reported experiencing in the past 12 months sexual harassment or assault based on their sexuality or gender identity, almost twice the proportion of participants who did not report disability or a long-term health condition (18.5%; n = 517). Over one-third of participants with an intellectual disability (34.2%; n = 103) experienced sexual harassment or assault in the past 12 months followed by over three-tenths of participants with a physical/sensory disability (32.0%; n = 203) or neurodiversity/autism (31.4%; n = 186).

These findings follow similar trends to adults with disability in the Australian general population, in which 16.3% of adults with disability have experienced sexual violence after the age of 15, compared to 9.6% without disability (88).

16.7 Experiences of homelessness

Participants were first given the following options, asking if they had ever:

- Run away from home or the place you live
- Left home or the place you live because you were asked/made to leave
- Couch surfed because you had no other place to stay
- Been homeless

Participants who responded 'yes' to any of the above were then asked, for each item, whether they were currently experiencing this, whether it was experienced within the past 12 months, or whether it was experienced more than 12 months ago. Participants could select as many options as applied (i.e. currently experiencing this, and more than 12 months ago). 'Current' experiences of homelessness were merged with 'past 12 months'. Table 90 displays these results for the past 12 months (n = 6,348) and ever in their lifetime (n = 6,355).

Participants reporting disability were twice as likely to report homelessness within the past 12 months (17.6%; n = 251) compared with those not reporting disability (8.0%; n = 260). Higher rates of homelessness in the past 12 months were reported for participants with an intellectual disability (21.9%; n = 76), compared to those with a physical/sensory disability (19.6%; n = 140) or experiencing neurodiversity/autism (16.4%; n = 105).

Table 89 **Experienced sexual harassment or assault based on sexuality or gender identity, by disability or long-term health condition**

	Disability									
	None		Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Sexual harassment or assault (n = 5,582)	n	%	n	%	n	%	n	%	n	%
Past 12 months	517	18.5	406	31.7	103	34.2	186	31.4	203	32.0
Ever	654	23.3	529	41.3	135	44.9	241	40.7	272	42.9

Table 90 **Experienced homelessness in their lifetime and in the past 12 months, by disability or long-term health condition**

	Disability									
	None		Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Any homelessness	n	%	n	%	n	%	n	%	n	%
Past 12 months	260	8.0	251	17.6	76	21.9	105	16.4	140	19.6
Ever	549	16.9	508	35.6	151	43.5	221	34.5	269	37.7

39.8%

of participants with disability reported attempting suicide in their lifetime, more than double the rate of those without disability

16.8 Suicide and self-harm

Writing Themselves In 4 asked participants about suicidal ideation, defined as 'experiences of thoughts about suicide, wanting to die, or about ending your life', suicide plans, defined as having 'made a plan to attempt suicide or end your own life', suicide attempts, defined as having 'attempted suicide or to end your life', self-harm ideation, defined as 'thoughts about harming yourself on purpose', and self-harm attempts, defined as having 'injured or harmed yourself on purpose'.

Previous research has found that asking people about suicide does not increase the risk of suicide (59). Nonetheless, as a precaution, online and telephone resources were provided for Qlife and Kids Helpline prior to these questions, as well as at the end of the survey. Prior to the questions being shown, participants were given the option to choose 'prefer not to answer these questions', with in bold text, 'If you feel uncomfortable answering these questions, please skip them. Skipping this question does not make your other responses any less valuable.' Participants were also given the option of 'prefer not to answer' for each question regarding suicidal ideation, suicide plans, suicide attempts, self-harm ideation, and self-harm attempts.

Table 91 below displays the numbers of *Writing Themselves In 4* participants who experienced suicidal ideation in their lifetime and in the past 12 months, by disability or long-term health condition (n = 6,365).

A greater proportion of participants reporting disability (69.6%; n = 998) had experienced suicidal ideation in the past 12 months compared to those not reporting disability (47.9%; n = 1,550). Approximately three-quarters (74.5%; n = 257) of participants with intellectual disability reported experiencing suicidal ideation in the past 12 months, followed by approximately seven-tenths of those with physical/sensory disability (70.9%; n = 508), and neurodiversity/autism (68.5%; n = 443).

More participants reporting disability (88.3%; n = 1,265) had ever experienced suicidal ideation in their lifetime than those not reporting disability (69.4%; n = 2,244). Over nine-tenths (91.3%; n = 315) of participants with intellectual disability reported ever experiencing suicidal ideation in their lifetime, followed by approximately nine-tenths of those with physical/sensory disability (89.2%; n = 639) and those with neurodiversity/autism (88.1%; n = 570).

Table 91 **Experienced suicidal ideation in their lifetime and in the past 12 months, by disability or long-term health condition**

	Disability									
	None		Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Suicidal ideation	n	%	n	%	n	%	n	%	n	%
Past 12 months	1,550	47.9	998	69.6	257	74.5	443	68.5	508	70.9
Ever	2,244	69.4	1,265	88.3	315	91.3	570	88.1	639	89.2
Prefer not to say	190	5.8	57	3.9	12	3.5	24	3.7	28	3.9

Table 92 below displays the numbers of *Writing Themselves In 4* who experienced suicide attempts in their lifetime and in the past 12 months, by disability or long-term health condition (n = 6,263).

Over one-eighth (15.0%; n = 214) of participants reporting disability had attempted suicide in the past 12 months, more than double the rate of those not reporting disability (6.0%; n = 191). One-fifth (21.0%; n = 72) of participants with intellectual disability reported experiencing a suicide attempt in the past 12 months, followed by 15.9% (n = 113) of participants with physical/sensory disability, and one-eighth of those reporting neurodiversity/autism (12.6%; n = 81).

Approximately two-fifths (39.8%; n = 567) of participants with disability reported experiencing a suicide attempt in their lifetime, more than double the rate of those without disability (15.7%; n = 498). Half (50.7%; n = 174) of participants with intellectual disability reported ever experiencing a suicide attempt in their lifetime, followed by two-fifths (43.1%; n = 307) of participants with physical/sensory disability, and over one-third of those with neurodiversity/autism (35.6%; n = 229).

Table 93 below displays the number of *Writing Themselves In 4* participants who experienced self-harm in their lifetime and in the past 12 months, by disability or long-term health condition (n = 6,279).

Over half (52.9%; n = 754) of participants with disability reported self-harming in the past 12 months, almost twice the proportion of those without disability (28.1%; n = 891). Over half (56.7%; n = 195) of participants with intellectual disability reported self-harming in the past 12 months, followed by 55.4% (n = 394) of participants with physical/sensory disability, and 51.7% (n = 332) of those with neurodiversity/autism.

Participants with disability (77.5%; n = 1,103) reported higher rates of ever self-harming in their lifetime, compared to those without disability (48.6%; n = 1,541). Four-fifths (80.5%; n = 277) of participants with intellectual disability reported ever self-harming in their lifetime, followed by 79.5% (n = 307) of participants with physical/sensory disability, and over three-quarters of those with neurodiversity/autism (78.0%; n = 501).

Table 92 **Experienced suicide attempt in their lifetime and in the past 12 months, by disability or long-term health condition**

	Disability									
	None		Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Suicide attempt	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Past 12 months	191	6.0	214	15.0	72	21.0	81	12.6	113	15.9
Ever	498	15.7	567	39.8	174	50.7	229	35.6	307	43.1
Prefer not to say	208	6.6	94	6.6	23	6.7	41	6.4	45	6.3

Table 93 **Experienced self-harm in their lifetime and in the past 12 months, by disability or long-term health condition**

	Disability									
	None		Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Self-harm	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Past 12 months	891	28.1	754	52.9	195	56.7	332	51.7	394	55.4
Ever	1,541	48.6	1,103	77.5	277	80.5	501	78.0	565	79.5
Prefer not to say	177	5.6	58	4.1	15	4.3	23	3.6	32	4.5

16.9 Service accessibility

Participants reporting disability or a long-term health condition were asked specific questions, which were developed with a disability advisory board, in order to best inform service provision and models of best practice. Participants reporting disability or a long-term health condition were asked, 'Thinking about your disability/neurodiversity or long-term health condition, please answer the following questions on a scale from "very easy" to "very hard".' Participants could respond 'not applicable' to any questions that were not relevant to them (e.g. questions regarding work settings for participants not engaged in employment.) Questions were on a five-point scale ranging from 'very easy' to 'very hard'. The following results display the proportion of participants who responded 'easy' or 'very easy'. Participants were asked the following questions:

- Does your educational institution make it easy or hard for you to learn? (n = 2,347)
- Does your workplace make it easy or hard for you to work efficiently? (n = 1,635)
- Do LGBTIQA+ social or community venues in your area make it easy for you to use them? (n = 1,785)
- Do LGBTIQA+ services or support groups in your area make it easy or hard for you to use them? (n = 1,779)

Table 94 displays the proportion of participants who selected 'easy' or 'very easy' for each question.

Approximately three-tenths (29.2%; n = 395) of participants reporting disability or a long-term health condition felt that their educational institution makes it easy/very easy for them to learn. Participants with physical/sensory disability (30.7%; n = 207) or experiencing neurodiversity/autism (29.4%; n = 181) reported easier learning than those with intellectual disability (24.0%; n = 78). Approximately one-third (35.8%; n = 471) of participants reporting disability or a long-term health condition felt that their educational institution makes it hard/very hard for them to learn.

Less than two-fifths (35.8%; n = 334) of participants reporting disability or a long-term health condition felt that their workplace makes it easy/very easy for them to work efficiently. A slightly greater proportion of participants experiencing neurodiversity/autism (36.5%; n = 151) reported that their workplace makes it easy/very easy to work efficiently, compared to participants with physical/sensory disability (34.2%; n = 153) or intellectual disability (30.0%; n = 64). Almost three-tenths (28.4%; n = 265) of participants reporting disability or a long-term health condition felt that their workplace makes it hard/very hard for them to work efficiently.

Less than half (44.2%; n = 461) of participants reporting disability or a long-term health condition felt that LGBTIQA+ social or community venues make it easy/very easy for them to use. More participants experiencing neurodiversity/autism (44.9%; n = 215) and those with physical/sensory disability (44.6%; n = 238) reported that LGBTIQA+ social or community venues in their area make it easy/very easy to use them, compared to participants with intellectual disability (39.9%; n = 97). One-quarter (24.1%; n = 251) of participants reporting disability or a long-term health condition felt that LGBTIQA+ social or community venues are hard/very hard for them to use.

Less than half (47.6%; n = 486) of participants reporting disability or a long-term health condition felt that LGBTIQA+ services or support groups make it easy/very easy for them to use them. Participants experiencing neurodiversity/autism (51.3%; n = 243) reported slightly easier access to LGBTIQA+ services or support groups than those with physical/sensory disability (48.9%; n = 250) or intellectual disability (40.6%; n = 97). One-fifth (22.1%; n = 226) of participants reporting disability or a long-term health condition felt that LGBTIQA+ services or support groups make it hard/very hard for them to use them.

Overall, participants with intellectual disability reported less ease in learning, working efficiently, or accessing LGBTIQA+ venues or services, compared to participants experiencing neurodiversity/autism or physical/sensory disability.

Table 94 **Accessibility of educational settings, workplaces, LGBTIQA+ venues or LGBTIQA+ services, among those with disability or a long-term health condition**

	Disability							
	Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Accessibility (easy/very easy)	n	%	n	%	n	%	n	%
Educational institution makes it easy/very easy for you to learn	395	29.2	78	24.0	181	29.4	207	30.7
Workplace makes it easy/very easy for you to work efficiently	334	35.8	64	30.0	151	36.5	153	34.2
LGBTIQA+ social or community venues in your area make it easy/very easy for you to use them	461	44.2	97	39.9	215	44.9	238	44.6
LGBTIQA+ services or support groups in your area make it easy/very easy for you to use them	486	47.6	97	40.6	243	51.3	250	48.9

16.10 Perceptions of community inclusion

Participants reporting disability or a long-term health condition were then asked, 'How strongly do you agree with the following statements?':

- I feel like I am included within the LGBTIQA+ community (n = 2,453)
- I feel like the voices of LGBTIQ+ people with disabilities are heard and understood (n = 2,411)
- I feel like my LGBTIQA+ identity is supported by my peers with disabilities (n = 2,158)
- I feel that my LGBTIQA+ identity is supported by the NDIS/disability support providers (n = 1,665)

Participants could respond 'not applicable' to any questions that were not relevant to them. Questions were on a five-point scale ranging from 'strongly disagree' to 'strongly agree. Table 95 displays the proportion of participants who responded 'agree' or 'strongly agree'.

Over half (57.3%; n = 808) of all participants with disability or a long-term health condition felt included in the LGBTIQA+ community, with more participants experiencing neurodiversity/autism (60.5%; n = 389) feeling included than those with physical/sensory (56.7%; n = 402) or intellectual disability (55.0%; n = 183).

Less than three-tenths (27.2%; n = 378) of participants with disability or a long-term health condition felt that the voices of LGBTIQ+ people with disability were heard and understood, with similar proportions for each type of disability or long-term health condition.

Over half (55.3%; n = 692) of participants with disability or a long-term health condition felt that their LGBTIQA+ identity was supported by their peers with disability, with approximately three-fifths (59.3%; n = 339) of participants experiencing neurodiversity/autism, over half (56.0%; n = 346) of those with physical/sensory disability, and almost half (48.7%; n = 148) with intellectual disability reporting that they felt supported.

Only one-fifth (21.5%; n = 211) of participants with disability or a long-term health condition felt that LGBTIQA+ services or support groups in their area make it easy for them to use them.

16.11 Summary

Overall, compared to those without disability or a long-term health condition, participants with disability or a long-term health condition reported feeling less supported by family and classmates about their sexuality or gender identity, and experienced higher levels of psychological distress, suicide ideation and attempts, self-harm, and verbal, physical, and sexual harassment or assault based on their sexuality or gender identity, in the past 12 months.

Specifically, over half (56.7%) of participants with disability reported they had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity, compared to 45.1% of those without disability. Similarly, participants with disability reported feeling less supported by classmates (39.3%) about their sexual identity, gender identity and/or gender expression than those without disability (45.1%).

Participants with disability or a long-term health condition reported experiencing greater levels of verbal (52.7%), physical (15.0%) and sexual (31.7%) harassment or assault based on their sexual identity or gender identity in the past 12 months than those without disability or a long-term health condition (verbal 34.7%; physical 7.5%; sexual 18.5%).

Almost seven-tenths (69.6%) of participants with disability reported experiencing suicidal ideation in the past 12 months, compared to 47.9% of participants without disability. Participants with intellectual disability (74.5%) reported the highest suicidal ideation in the past 12 months, followed by 70.9% of those with physical/sensory disability, and 68.5% of participants experiencing neurodiversity/autism. Participants with disability (15.0%) reported over twice the level of suicide attempts in the past 12 months than those without disability (6.0%). These findings indicate the need for specific mental health strategies and interventions for young LGBTQA+ people with disability, particularly intellectual disability, who are more likely to experience a range of access barriers and increased discrimination, as observed across all data relating to disability.

Table 95 **Perception of inclusion within LGBTIQA+ communities, among people with disability or a long-term health condition**

	Disability							
	Any disability		Intellectual		Neurodiversity /autism		Physical /sensory	
Agree/strongly agree	n	%	n	%	n	%	n	%
I feel like I am included within the LGBTIQA+ community	808	57.3	183	55.0	389	60.5	402	56.7
I feel like the voices of LGBTIQ+ people with disabilities are heard and understood	378	27.2	90	27.1	164	26.0	181	25.9
I feel like my LGBTIQA+ identity is supported by my peers with disabilities	692	55.3	148	48.7	339	59.3	346	56.0
I feel that my LGBTIQA+ identity is supported by the NDIS/disability support providers	211	21.5	54	22.0	90	20.4	102	20.8

17 **Ethnic and cultural background**

In this chapter we revisit some of the key questions asked of LGBTQA+ young people (described in Chapters 3 to 13) and report what responses looked like for those from diverse ethnic and cultural backgrounds.

Analysing by ethnicity and cultural background can often reveal powerful social factors that have a compounding impact on health outcomes. Race, migration status, language ability and other factors often result in marginalisation, discrimination and socio-economic disadvantage, and are also associated with disparities in income (89), education (90) and access to medical care (91). This is reflected in differences in mental health outcomes between people of Anglo-Celtic and European descent and culturally and linguistically diverse people in Australia (92,93). While research on the topic is limited, evidence points to these disparities existing among LGBTQ young people in Australia, where challenges may be magnified by minority stressors related to sexuality or gender identity in complex and intersecting ways (94). Ethnically and culturally diverse LGBTQ young people can experience unique challenges such as racial discrimination (95), and may also experience alienation from their cultural communities (96). Due to difficulties in accurately and authentically defining participants in ways that fully reflect the complexity of self-identifications and cultural contexts, Australian data examining these differences is largely lacking. The following chapter provides a broad initial overview regarding the health and wellbeing of *Writing Themselves In 4* participants from diverse ethnic and cultural backgrounds.

In *Writing Themselves In* 4, participants were asked, 'How would you describe your ethnic background?' Multiple responses were permitted and are shown in Table 96 below.

Table 96 Ethnic background of participants

Ethnic background (n = 6,074)	n	%
Anglo-Celtic	3,920	64.5
Other European	1,097	18.1
Southern European	808	13.3
Eastern European	732	12.1
South-East Asian	239	3.9
Chinese	214	3.5
Other Asian	156	2.6
Maori/Pacific Islander	153	2.5
Middle Eastern	153	2.5
Indian	116	1.9
Latin American	87	1.4
African	76	1.3
Different ethnicity	467	7.7

Response options were based on previous Australian research (97). The majority of participants identified as Anglo-Celtic or European, similar to national and general population data (19). Many participants reported more than one ethnicity. Due to the numerous combinations, which resulted in small sample sizes for each combination, we have focussed analyses on those who reported a single ethnicity. In doing so, we identified five groups who selected a single ethnicity and comprised a sufficiently large sample for analysis as follows:

- Anglo-Celtic (n = 2,635)
- South-East Asian (n = 123)
- Chinese (n = 113)
- Southern European (n = 246)
- Eastern European (n = 220)

As is common in other surveys, it is also the case that many participants identified with more than one ethnicity (e.g. Anglo-Celtic and Chinese, or Southern European and South-East Asian). For that reason, we include a 'multicultural' category, which captures all those who selected more than one ethnicity option or identified a different ethnicity to the five groups listed above. This multicultural category also includes those who identified as South-East Asian, Chinese, Southern European or Eastern European. In this respect, the 'multicultural' category should thus be considered an overarching point of comparison to Anglo-Celtic participants in the sample. Further nuance can be found in consideration of the five specific ethnicities listed above.

'Multicultural' is a broad categorisation that was utilised to accommodate the complexity and wide diversity in cultural, religious and/or ethnic backgrounds. It is intended to provide macro-level quantitative analyses regarding the unique lived experiences faced by multicultural LGBTQA+ people in general. We anticipate further analyses of these data, in collaboration with colleagues in multicultural communities, in the near future.

It is important to note that these analyses do not include the Aboriginal and/or Torres Strait Islanders who participated in this survey (n = 256). Specific outputs are planned for the analysis and interpretation of Aboriginal and Torres Strait Islander data, in close collaboration with Aboriginal and Torres Strait Islander organisations (see Section 2.8) in order to meaningfully document and interpret their unique experiences. It also of note that the *Writing Themselves In 4* survey was only available in English and therefore provides limited representation of participants who have less capacity in reading and responding to written English. Future iterations of this research would benefit greatly from translations and promotional materials in languages spoken commonly among culturally and linguistically diverse LGBTIQA+ young people in Australia.

17.1 Experiences of engagement with LGBTIQA+ events

Participants were asked how often they had attended an LGBTIQA+ youth event in the past 12 months. Response options were 'never', 'annually', 'monthly' and 'weekly'. Table 97 displays the results for any attendance in the past 12 months.

Participants from multicultural backgrounds reported slightly lower attendance at LGBTIQA+ youth events in the past 12 months than Anglo-Celtic participants. In total, 15.3% (n = 393) of Anglo-Celtic participants attended an LGBTIQA+ youth event in the past 12 months, compared to 13.4% (n = 15) of Chinese participants, 12.8% (n = 30) of Southern European participants, 12.4% (n = 27) of Eastern European participants, and 10.0% (n = 12) of South-East Asian participants.

17.2 Experiences of feeling unsafe or uncomfortable in educational settings

Participants were asked if they had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity. Table 98 displays the results by ethnic background.

A greater proportion of participants from multicultural backgrounds (51.8%; n = 1,621) reported feeling unsafe or uncomfortable at their educational institution in the past 12 months due to their sexuality or gender identity than Anglo-Celtic participants (46.5%; n = 1,152). More than half (54.6%; n = 118) of Southern European participants reported feeling unsafe or uncomfortable due to their sexuality or gender identity, followed by Eastern European (54.6%; n = 118), South-East Asian (52.0%; n = 64), and Chinese (47.3%; n = 53) participants.

Table 97 **Attended an LGBTIQA+ youth event in the past 12 months, by ethnic background**

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
LGBTIQA+ youth event in past 12 months	n	%	n	%	n	%	n	%	n	%	n	%
No	2,729	85.6	2,176	84.7	97	86.6	108	90.0	205	87.2	190	87.6
Yes, once or more	459	14.4	393	15.3	15	13.4	12	10.0	30	12.8	27	12.4

Table 98 **Felt unsafe or uncomfortable in past 12 months at your educational setting due to sexuality or gender identity, by ethnic background**

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
Felt unsafe or uncomfortable	n	%	n	%	n	%	n	%	n	%	n	%
No	1,510	48.2	1,326	53.5	59	52.7	59	48.0	110	47.6	98	45.4
Yes	1,621	51.8	1,152	46.5	53	47.3	64	52.0	121	52.4	118	54.6

17.3 Disclosing sexuality or gender identity

Disclosure comes in many forms and is not always encompassed by the term 'coming out.' Disclosure can also involve being 'invited in' to a discussion about sexuality, gender identity. Participants were asked, 'Have you come out to or talked with any of the following people about your sexual identity or gender identity?' Response options included 'never', 'a few of them', 'some of them', 'most of them', and 'all of them'.

- Friends (n = 6,312)
- Family (n = 6,257)
- Classmates (n = 5,807)

Participants could indicate if aspects of the question were not relevant to them (such as people not attending an educational institution). Tables 99-101 display these responses by ethnic background (see next page).

Similar proportions of multicultural (4.9%; n = 158) and Anglo-Celtic (4.2%; n = 108) participants had not disclosed their sexuality or gender identity to any of their friends. More Chinese participants (7.1%; n = 8) had not disclosed to any of their friends than Eastern European (6.0%; n = 13), Southern European (5.8%; n = 14), or South-East Asian (5.7%; n = 7) participants.

Those from an Anglo-Celtic background were most likely to have disclosed to most/all of their friends (66.7%, n = 1,723), compared to those from a multicultural background (63.7%; n = 2,048), South-East Asian background (64.8%; n = 79), Southern European (63.2%; n = 153), Eastern European (58.7%; n = 128), and Chinese (50.9%; n = 57) backgrounds.

Almost half (49.5%; n = 53) of Chinese participants had not disclosed their sexuality or gender identity to their family, similar to the proportion of those from South-East Asian backgrounds (47.2%; n = 56). Around a third of Eastern Europeans (34.9%; n = 75), Southern Europeans (31.8%; n = 75) and multicultural participants (30.3%; n = 961) had not disclosed their sexuality or gender identity to their family. This compares to 26.0% (n = 670) of Anglo-Celtic participants.

Compared to participants from an Anglo-Celtic background (28.6%; n = 735), fewer participants from a multicultural background (23.0%; n = 729) had disclosed to most or all of their family. This number was particularly low among participants of Chinese (13.1%; n = 14) or South-East Asian (9.2%; n = 11) backgrounds.

Approximately three-tenths of multicultural (30.5%; n = 912) participants had not disclosed their sexuality or gender identity to any of their classmates, a larger proportion than of Anglo-Celtic participants (28.5%; n = 672).

Approximately two-fifths of Chinese participants (39.8%; n = 41) had not disclosed their sexuality or gender identity to any of their classmates, followed by over one-third of Eastern European (35.3%; n = 71), over three-tenths of South-East Asian (31.6%; n = 37), and approximately three-tenths of Southern European (29.1%; n = 64) participants.

Table 99 **Disclosed their sexuality or gender identity to friends, by ethnic background**

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
Disclosed to friends	n	%	n	%	n	%	n	%	n	%	n	%
None	158	4.9	108	4.2	8	7.1	7	5.7	14	5.8	13	6.0
A few/some	1,010	31.4	754	29.2	47	42.0	36	29.5	75	31.0	77	35.3
Most/all	2,048	63.7	1,723	66.7	57	50.9	79	64.8	153	63.2	128	58.7

Table 100 **Disclosed their sexuality or gender identity to family, by ethnic background**

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
Disclosed to family	n	%	n	%	n	%	n	%	n	%	n	%
None	961	30.3	670	26.0	53	49.5	56	47.1	75	31.8	75	34.9
A few/some	1,484	46.8	1,167	45.4	40	37.4	52	43.7	107	45.3	99	46.0
Most/all	729	23.0	735	28.6	14	13.1	11	9.2	54	22.9	41	19.1

Table 101 **Disclosed their sexuality or gender identity to classmates, by ethnic background**

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
Disclosed to classmates	n	%	n	%	n	%	n	%	n	%	n	%
None	912	30.5	672	28.5	41	39.8	37	31.6	64	29.1	71	35.3
A few/some	1,420	47.5	1,116	47.3	49	47.6	55	47.0	103	46.8	91	45.3
Most/all	660	22.1	570	24.2	13	12.6	25	21.4	53	24.1	39	19.4

17.4 Feelings of support about sexuality or gender identity

Participants who responded that they had come out to or talked with people about their sexual identity or gender identity were asked, 'Overall, how supported do you feel about your sexual identity, gender identity and/or gender expression?' The question was asked in relation to all those to whom they previously stated they had disclosed. For example, only participants who indicated that they had come out to or talked with family were asked how supported they felt by family.

Almost nine-tenths (87.3%; n = 2,661) of participants from a multicultural background reported feeling supported by their friends, a slightly lower proportion than of Anglo-Celtic (90.2%; n = 2,228) participants. Almost nine-tenths of Eastern European (89.8%; n = 184), Southern European (88.5%; n = 201), and South-East Asian (87.0%; n = 100) participants reported feeling supported by their friends, compared to three-quarters of Chinese (76.9%; n = 80) participants.

Fewer multicultural participants (53.1%; n = 1,174) reported feeling supported by their family than Anglo-Celtic participants (62.4%; n = 1,185). Less than three-fifths of Southern European (57.8%; n = 93) participants reported feeling supported by their family, followed by just over half of Eastern European (53.6%; n = 75), three-tenths of South-East Asian (30.2%; n = 19), and one-quarter of Chinese (25.9%; n = 14) participants.

Similar proportions of multicultural (42.6%; n = 685) and Anglo-Celtic (42.6%; n = 555) participants reported feeling supported by their classmates. Approximately two-thirds of South-East Asian (65.6%, n = 40) participants, followed by half (51.2%, n = 62) of Southern European and over two-fifths of Eastern European (46.6%; n = 48) and Chinese (46.3%; n = 25) participants felt supported by their classmates.

Table 102 **Proportion of participants who feel 'supported' or 'very supported' about their sexuality, gender identity and/or gender expression by friends, family or classmates, by ethnic background**

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
Feel supported by …	n	%	n	%	n	%	n	%	n	%	n	%
Friends	2,661	87.3	2,228	90.2	80	76.9	100	87.0	201	88.5	184	89.8
Family	1,174	53.1	1,185	62.4	14	25.9	19	30.2	93	57.8	75	53.6
Classmates	685	42.6	555	42.6	25	46.3	40	65.6	62	51.2	48	46.6

Fewer multicultural participants reported feeling supported by their family than did Anglo-Celtic participants

17.5 Psychological Distress (K10)

The Kessler Psychological Distress Scale (K10) is a 10-item standardised scale developed to measure psychosocial distress, based on questions about people's level of nervousness, agitation, psychological fatigue and depression in the past four weeks. Responses to the questionnaire are summed to create a scale ranging from 10 to 50, with a higher score indicating higher levels of psychological distress.Table 103 displays these results

A slightly higher proportion of participants from a multicultural background (81.4%; n = 2,643) reported experiencing high/very high levels of psychological distress, compared to Anglo-Celtic (79.3%; n = 2,070) participants. Southern European (82.8%; n = 201) participants reported the highest levels of distress, followed by Eastern European (80.0%; n = 176), South-East Asian (76.4%; n = 94), and Chinese (69.6%; n = 78) participants.

Table 103 **Proportion of participants experiencing psychological distress, by ethnic background**

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
K10	n	%	n	%	n	%	n	%	n	%	n	%
Low	184	5.7	159	6.1	12	10.7	11	8.9	12	4.9	10	4.5
Moderate	419	12.9	381	14.6	22	19.6	18	14.6	30	12.3	34	15.5
High	900	27.7	806	30.9	38	33.9	39	31.7	66	27.2	52	23.6
Very high	1,743	53.7	1,264	48.4	40	35.7	55	44.7	135	55.6	124	56.4

17.6 Experiences of harassment or assault based on sexuality or gender identity

Participants were asked if in the past 12 months or ever in their lifetime they had experienced any of the following forms of harassment or assault based on their sexuality or gender identity:

- Verbal (e.g. been called names or threatened)
- Physical (e.g. being shoved, punched, or injured with a weapon)
- Sexual (e.g. unwanted touching, sexual remarks, sexual messages or being forced to perform any unwanted sexual act)

Tables 104-106 display responses to these questions. A greater proportion of multicultural participants (41.6%; n = 1,307) reported in the past 12 months experiencing verbal harassment based on their sexuality or gender identity than Anglo-Celtic (38.7%; n = 982) participants. This was also reported by over two-fifths of Eastern European (47.4%; n = 99) and Southern European (41.2%; n = 98) participants, one-third (33.9%; n = 40) of South-East Asian participants, and one-quarter (24.5%; n = 27) of Chinese participants.

More participants from a multicultural background (10.5%; n = 294) reported in the past 12 months experiencing physical harassment or assault based on their sexuality or gender identity than Anglo-Celtic (7.7%; n = 172) participants. Southern European (12.1%; n = 26) and Eastern European (12.1%; n = 22) participants reported experiencing more physical harassment or assault in the past 12 months, compared to South-East Asian (7.6%; n = 8) and Chinese (2.9%; n = 3) participants.

More participants from a multicultural background (23.2%; n = 659) reported in the past 12 months experiencing sexual harassment based on their sexuality or gender identity than participants from Anglo-Celtic background (21.6%; n = 497). One-quarter (25.3%; n = 46) of Eastern European participants had experienced sexual harassment or assault within the past 12 months, followed by Southern European (23.4%; n = 50), South-East Asian (16.0%; n = 17), and Chinese (12.4%; n = 13) participants.

Table 104 Experienced verbal harassment based on sexuality or gender identity, by ethnic background

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
Verbal harassment	n	%	n	%	n	%	n	%	n	%	n	%
Past 12 months	1,307	41.6	982	38.7	27	24.5	40	33.9	98	41.2	99	47.4
Ever	1,821	57.9	1,424	56.2	46	41.8	57	48.3	132	55.5	129	61.7

Table 105 Experienced physical harassment or assault based on sexuality or gender identity, by ethnic background

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
Physical harassment or assault	n	%	n	%	n	%	n	%	n	%	n	%
Past 12 months	294	10.5	172	7.7	3	2.9	8	7.6	26	12.1	22	12.1
Ever	444	15.9	303	13.6	8	7.6	14	13.3	35	16.3	37	20.3

Table 106 Experienced sexual harassment or assault based on sexuality or gender identity, by ethnic background

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
Sexual harassment or assault	n	%	n	%	n	%	n	%	n	%	n	%
Past 12 months	659	23.2	497	21.6	13	12.4	17	16.0	50	23.4	46	25.3
Ever	846	29.7	656	28.5	22	21.0	24	22.6	67	31.3	54	29.7

79.1%

of participants from a multicultural background reported ever experiencing suicidal ideation in their lifetime

17.7 Experiences of homelessness

Participants were first given the following options, asking if they had ever:

- Run away from home or the place you live
- Left home or the place you live because you were asked/made to leave
- Couch surfed because you had no other place to stay
- Been homeless

Participants who responded 'yes' to any of the above were then asked if they were currently experiencing this, if it was within the past 12 months, or if it was more than 12 months ago, for each response. Participants could select as many options as applied (i.e. currently experiencing this, and more than 12 months ago). 'Current' experiences of homelessness were merged with 'past 12 months'. Table 107 displays these results.

More participants from a multicultural background (11.9%; n = 386) had experienced homelessness in the past 12 months than Anglo-Celtic (10.1%; n = 263) participants.

Southern European participants (12.4%; n = 30) reported the highest levels of homelessness in the past 12 months, followed by Eastern European (10.5%; n = 23), Chinese (6.2%; n = 7), and South-East Asian (5.7%; n = 7) participants.

Table 107 **Experienced homelessness in their lifetime and in the past 12 months, by ethnic background**

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
Homelessness	n	%	n	%	n	%	n	%	n	%	n	%
Past 12 months	386	11.9	263	10.1	7	6.2	7	5.7	30	12.4	23	10.5
Ever	752	23.2	568	21.9	17	15.0	21	17.1	58	24.1	52	23.7

17.8 Suicide and self-harm

Questions relating to suicide and self-harm were carefully considered on the basis of prior research in this area. The approach used in *Writing Themselves In 4* is outlined in Section 9.4.

Participants from a multicultural background (58.3%; n = 1,891) reported similar levels of suicidal ideation in the past 12 months to those of Anglo-Celtic (57.1%; n = 1,486) background. Almost two-thirds (61.2%; n = 148) of Southern European participants reported experiencing suicidal ideation in the past 12 months, followed by over half of Eastern European (58.5%; n = 127), South-East Asian (52.8%; n = 65), and Chinese (52.2%; n = 59) participants.

Approximately four-fifths of participants from a multicultural background (79.1%; n = 2,566) reported ever experiencing suicidal ideation in their lifetime, a similar proportion to Anglo-Celtic (77.8%; n = 2,024) participants. Four-fifths (80.6%; n = 195) of Southern European participants reported ever experiencing suicidal ideation in their lifetime, followed by over three-quarters of Eastern European (76.5%; n = 166), and Chinese (76.1%; n = 86) participants, and approximately seven-tenths of South-East Asian (69.1%; n = 85) participants.

One-tenth of multicultural participants (10.4%; n = 331) reported attempting suicide in the past 12 months, more than the 8.4% (n = 215) of Anglo-Celtic participants. One-eighth (12.8%; n = 31) of Southern European participants reported attempting suicide in the past 12 months, followed by 8.6% Eastern European (n = 18), South-East Asian (8.4%; n = 10), and one-twentieth of Chinese (5.4%; n = 6) participants. However, it is of note that approximately one-tenth of Chinese, South-East Asian, and Eastern European participants reported 'prefer not to say'.

More participants from a multicultural background (25.8%; n = 825) reported ever attempting suicide in their lifetime, compared to Anglo-Celtic (23.7%; n = 606) participants. Approximately one-third (31.4%; n = 76) of Southern European participants reported ever attempting suicide in their lifetime, followed by one-fifth of South-East Asian (20.2%; n = 24), and Eastern European (20.1%; n = 42) participants, and over one-eighth of Chinese (17.9%; n = 20) participants.

Table 108 **Experienced suicidal ideation in their lifetime and in the past 12 months, by ethnic background**

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
Suicidal ideation	n	%	n	%	n	%	n	%	n	%	n	%
Past 12 months	1,891	58.3	1,486	57.1	59	52.2	65	52.8	148	61.2	127	58.5
Ever	2,566	79.1	2,024	77.8	86	76.1	85	69.1	195	80.6	166	76.5
Prefer not to say	175	5.4	107	4.1	5	4.4	8	6.5	12	5.0	14	6.4

Table 109 **Experienced suicide attempt in their lifetime and in the past 12 months, by ethnic background**

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
Suicide attempt	n	%	n	%	n	%	n	%	n	%	n	%
Past 12 months	331	10.4	215	8.4	6	5.4	10	8.4	31	12.8	18	8.6
Ever	825	25.8	606	23.7	20	17.9	24	20.2	76	31.4	42	20.1
Prefer not to say	236	7.4	141	5.5	10	9.0	11	9.2	8	3.4	26	12.4

Two-fifths (40.4%; n = 1,294) of participants from a multicultural background reported self-harming in the past 12 months, a slightly larger proportion than Anglo-Celtic (38.2%; n = 982) participants. Over two-fifths (44.0%; n = 92) of Eastern European participants reported self-harming in the past 12 months, followed by approximately two-fifths of Southern European (38.6%; n = 93), and over three-tenths of Chinese (32.1%; n = 36) and South-East Asian (31.7%; n = 38) participants.

Similar proportions of participants from a multicultural background (61.3%; n = 1,961) and an Anglo-Celtic background (62.0%; n = 1,593) reported ever self-harming in their lifetime. Approximately two-thirds (63.5%; n = 153) of Southern European participants reported ever self-harming in their lifetime, followed by over three-fifths of Eastern European (62.7%; n = 131), and less than half of South-East Asian (48.3%; n = 58), and Chinese (47.3%; n = 53) participants.

Table 110 **Experienced self-harm in their lifetime and in the past 12 months, by ethnic background**

	Ethnic background											
	Multicultural		Anglo-Celtic		Chinese		South-East Asian		Southern European		Eastern European	
Self-harm	n	%	n	%	n	%	n	%	n	%	n	%
Past 12 months	1,294	40.4	982	38.2	36	32.1	38	31.7	93	38.6	92	44.0
Ever	1,961	61.3	1,593	62.0	53	47.3	58	48.3	153	63.5	131	62.7
Prefer not to say	171	5.3	105	4.1	9	8.1	10	8.3	10	4.2	12	5.7

17.9 Summary

This is the first major study in Australia to examine multiple ethnic and cultural backgrounds in a sample of young LGBTQA+ people and thus provides useful information to assist organisations and services in understanding and addressing challenges related to intersecting identities.

Overall, participants from multicultural backgrounds reported lower health and wellbeing outcomes, higher levels of harassment and assault, and lower levels of support regarding sexual identity, gender identity and/or gender expression than those from Anglo-Celtic backgrounds.

Participants from multicultural backgrounds reported lower feelings of support and comfort regarding their sexuality or gender identity in educational settings and at home: over half (51.8%) of participants from a multicultural background reported they had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity, compared to 46.5% of Anglo-Celtic participants. Similarly, fewer participants from a multicultural background (53.1%) reported feeling supported by family about their sexual identity, gender identity and/or gender expression than those from an Anglo-Celtic background (62.4%). This was markedly lower among South-East Asian (30.2%), and Chinese (25.9%) participants.

Participants from a multicultural background reported in the past 12 months experiencing higher levels of verbal (41.6%), physical (10.5%) and sexual (23.2%) harassment or assault based on their sexuality or gender identity than those from an Anglo-Celtic background (verbal 38.7%; physical 7.7%; sexual 21.6%).

These findings highlight the complexities and challenges facing LGBTQA+ young people from multicultural backgrounds. The importance of family support for the wellbeing of LGBT youth is well documented (98), and may be of particular importance for those from multicultural backgrounds.

18 **Area of residence**

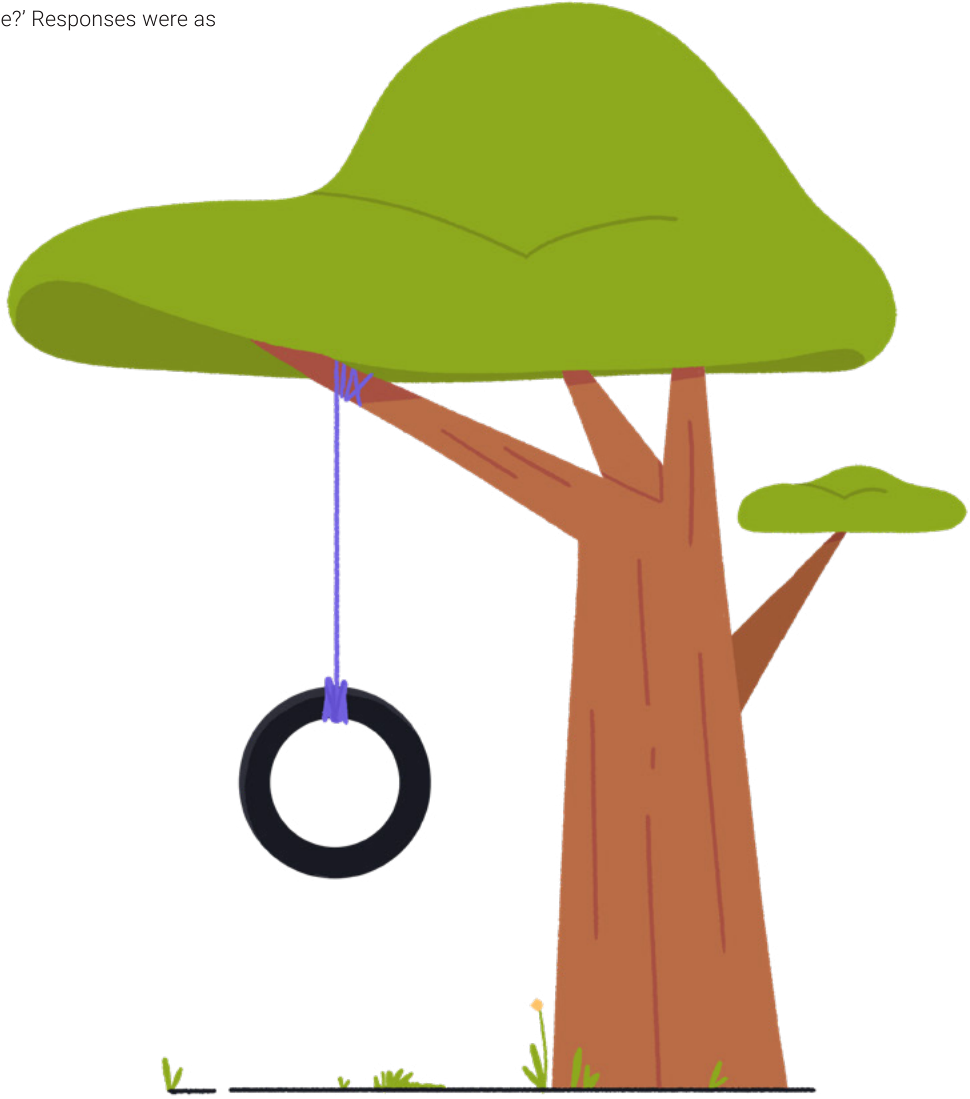
In this chapter we revisit some of the key questions asked of LGBTQA+ young people (described in Chapters 3 to 13) and report what responses looked like for those living in different parts of the country.

LGBTIQA+ young people who live in regional and rural areas may face additional challenges, such as limited access to LGBTIQA+ inclusive and affirmative health and support services, cultures and social spaces, and peer support networks of other LGBTIQA+ people. For example, LGBT young people residing in rural areas were found to face particularly high levels of homophobic remarks and victimisation due to sexual orientation or gender expression (99). Furthermore, young LGBTIQ people in rural and remote areas in Australia have been repeatedly observed to experience higher rates of isolation and social discrimination, and to feel less safe at school, at social occasions and on the internet than their peers in more urban areas (100).

Writing Themselves In 4 participants were asked 'How would you describe the area in which you live?' Responses were as follows:

- Capital city (city centre) (n = 434)
- Capital city (suburbs) (n = 3,705)
- Regional city or town (n = 1,598)
- Rural (countryside) (n = 637)
- Remote (countryside and far from any towns or cities) (n = 37)

Responses for 'rural' and 'remote' were combined into one category for analysis purposes. This chapter therefore analyses participant responses across four broad categories: 'capital city, city centre', 'capital city, suburbs', 'regional city or town', and 'rural/remote area' in order to provide an overview of the health and wellbeing of *Writing Themselves In 4* participants across a range of urban and rural settings.



18.1 Engagement with LGBTIQA+ events

Participants were asked how often they had attended an LGBTIQA+ youth event in the past 12 months. Response options were 'never', 'annually', 'monthly' and 'weekly'. Table 111 displays the results for any attendance in the past 12 months.

A greater proportion of participants in inner suburban areas (20.4%; n = 86) attended an LGBTIQA+ youth event in the past 12 months than those in outer suburban areas (14.8%; n = 536), regional cities or towns (n = 202), or rural/remote areas (14.5%; n = 95).

18.2 Experiences of feeling unsafe or uncomfortable in educational settings

Participants were asked if they had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity. Table 112 displays the results by area of residence.

Almost three-fifths (57.0%; n = 331) of participants in rural/remote areas reported they had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity, followed by 52.7% (n = 733) in regional cities or towns, 50.0% (n = 1,665) in outer suburban areas, and 40.1% (n = 152) in inner suburban areas.

18.3 Disclosing sexuality or gender identity

Disclosure comes in many forms and is not always encompassed by the term 'coming out'. Disclosure can also involve being 'invited in' to a discussion about sexuality or gender identity. Participants were asked, 'Have you come out to or talked with any of the following people about your sexual identity or gender identity?' Response options included 'never', 'a few of them', 'some of them', 'most of them', and 'all of them'. Responses were dichotomised to 'a few or more' or 'none' for this analysis, in order to examine participants who had made any disclosure to friends, family, or classmates.

- Friends (n = 6,312)
- Family (n = 6,257)
- Classmates (n = 5,807)

Participants could indicate if aspects of the question were not relevant to them (such as people not attending an educational institution). Table 113 displays these responses by area of residence.

Across all areas of residence, a similar proportion of participants responded that they had come out to or talked with friends about their sexuality or gender identity. More participants in rural/remote areas (76.7%; n = 503) responded that they had come out to or talked with family than those in regional cities or towns (72.7%; n = 1,136), outer suburban areas (70.7%; n = 2,561), or inner suburban areas (71.6%; n = 300).

However, differences are evident in relation to family and classmates; three-quarters (75.6%; n = 295) of participants in inner suburban areas had had come out to or talked with classmates, compared to seven-tenths (70.4%; n = 2,381) of participants in outer suburban areas or regional cities or towns (70.3%; n = 1,008) and 68.5% (n = 411) in rural/remote areas.

Table 111 Attended an LGBTIQA+ youth event in the past 12 months, by area of residence

	Area of residence							
	Capital city, city centre		Capital city, suburbs		Regional city or town		Rural/ remote area	
Attended an LGBTIQA+ youth event in the past 12 months (n = 6,263)	n	%	n	%	n	%	n	%
No	335	79.6	3,094	85.2	1,354	87.0	561	85.5
Once or more	86	20.4	536	14.8	202	13.0	95	14.5

Table 112 Felt unsafe or uncomfortable in past 12 months at their educational setting, by area of residence

	Area of residence							
	Capital city, city centre		Capital city, suburbs		Regional city or town		Rural/ remote area	
Felt unsafe or uncomfortable (n = 5,662)	n	%	n	%	n	%	n	%
No	227	59.9	1,657	50.0	657	47.3	250	43.0
Yes	152	40.1	1,655	50.0	733	52.7	331	57.0

Table 113 Proportion of participants who disclosed their sexuality or gender identity area of residence

	Area of residence							
	Capital city, city centre		Capital city, suburbs		Regional city or town		Rural/ remote area	
Disclosed to any …	n	%	n	%	n	%	n	%
Friends	405	95.3	3,484	95.6	1,513	96.1	627	94.4
Family	300	71.6	2,561	70.7	1,136	72.7	503	76.7
Classmates	295	75.6	2,381	70.4	1,008	70.3	411	68.5

18.4 Feelings of support about sexuality or gender identity

Participants who responded they had come out to or talked with people about their sexuality or gender identity were asked, 'Overall, how supported do you feel about your sexual identity, gender identity and/or gender expression?' The question was asked in relation to all those they previously stated they had disclosed to. For example, only participants who indicated that they had come out to or talked with family were asked how supported they felt by family.

A similar proportion of participants reported feeling supported by friends and family in all locations. However, a greater proportion of participants in inner suburban areas (52.9%; n = 126) reported feeling 'supported' or 'very supported' by classmates, compared to participants in outer suburban areas (45.3%; n = 839), regional cities or towns (36.1%; n = 274), or rural/remote areas (29.6%; n = 93).

18.5 Psychological distress (K10)

The Kessler Psychological Distress Scale (K10) is a 10-item standardised scale developed to measure psychosocial distress, based on questions about people's level of nervousness, agitation, psychological fatigue and depression in the past four weeks. Responses to the questionnaire are summed to create a scale ranging from 10 to 50, with a higher score indicating higher levels of psychological distress.

A greater proportion of participants in rural/remote areas reported experiencing high/very high psychological distress (87.5%; n = 581), compared to those in regional cities or towns (83.3%; n = 1,239), outer suburban areas (79.8%; n = 1,329), or inner suburban areas (73.2%; n = 317).

Table 114 Proportion of participants who feel 'supported' or 'very supported' about their sexuality, gender identity and/or gender expression by friends, by area of residence

	Area of residence							
	Capital city, city centre		Capital city, suburbs		Regional city or town		Rural/ remote area	
Feel supported by …	n	%	n	%	n	%	n	%
Friends	356	88.3	3,105	89.4	1,319	87.5	530	84.8
Family	177	59.0	1,443	56.4	676	59.7	280	55.8
Classmates	126	52.9	839	45.3	274	36.1	93	29.6

Table 115 Proportion of participants experiencing psychological distress, by area of residence

	Area of residence							
	Capital city, city centre		Capital city, suburbs		Regional city or town		Rural/ remote area	
K10 (n = 6,378)	n	%	n	%	n	%	n	%
Low	40	9.2	230	6.2	74	4.6	19	2.9
Moderate	76	17.6	516	14.0	193	12.1	64	9.6
High	130	30.0	1,087	29.5	452	28.3	178	26.8
Very high	187	43.2	1,852	50.3	877	54.9	403	60.7

18.6 Experiences of harassment or assault based on sexuality or gender identity

Participants were asked if in the past 12 months or ever in their lifetime they had experienced any of the following forms of harassment or assault based on their sexuality or gender identity:

- Verbal (e.g. been called names or threatened)
- Physical (e.g. being shoved, punched, or injured with a weapon)
- Sexual (e.g. unwanted touching, sexual remarks, sexual messages or being forced to perform any unwanted sexual act)

Table 116 displays the number of participants who experienced verbal harassment based on their sexuality or gender identity below.

A greater proportion of participants in rural/remote areas reported in the past 12 months experiencing verbal harassment based on their sexuality or gender identity (45.4%; n = 294) compared with those in regional cities or towns (41.0%; n = 630), outer suburban areas (40.4%; n = 1,447), or inner suburban areas (37.0%; n = 151).

Table 117 displays the number of participants who experienced physical harassment or assault based on their sexuality or gender identity below.

Similarly to verbal harassment, a greater proportion of participants in rural/remote areas reported in the past 12 months experiencing physical harassment or assault based on their sexuality or gender identity (13.9%; n = 79) compared with those in regional cities or towns (10.3%; n = 139), outer suburban areas (8.7%; n = 139), or inner suburban areas (9.1%; n = 33).

Table 118 displays the number of participants who experienced sexual harassment or assault based on their sexuality or gender identity below.

Unlike verbal harassment and physical harassment or assault, the greatest proportion of participants reporting in the past 12 months experiencing sexual harassment based on their sexuality or gender identity was in inner suburban areas (28.5%; n = 106), followed by in rural/remote areas (24.7%; n = 143), then in regional cities or towns (22.1%; n = 305), and outer suburban areas (22.1%; n = 717).

Table 116 Experienced verbal harassment based on sexuality or gender identity, by area of residence

	Area of residence							
	Capital city, city centre		Capital city, suburbs		Regional city or town		Rural/ remote area	
Verbal harassment (n = 6,172)	n	%	n	%	n	%	n	%
Past 12 months	151	37.0	1,447	40.4	630	41.0	294	45.4
Ever	219	53.7	2,054	57.4	889	57.9	394	60.8

Table 117 Experienced physical harassment or assault based on sexuality or gender identity, by area of residence

	Area of residence							
	Capital city, city centre		Capital city, suburbs		Regional city or town		Rural/ remote area	
Physical harassment or assault (n = 5,455)	n	%	n	%	n	%	n	%
Past 12 months	33	9.1	276	8.7	139	10.3	79	13.9
Ever	60	16.6	448	14.1	215	15.9	114	20.1

Table 118 Experienced sexual harassment or assault based on sexuality or gender identity, by area of residence

	Area of residence							
	Capital city, city centre		Capital city, suburbs		Regional city or town		Rural/ remote area	
Sexual harassment or assault (n = 5,582)	n	%	n	%	n	%	n	%
Past 12 months	106	28.5	717	22.1	305	22.1	143	24.7
Ever	139	37.4	926	28.5	400	29.0	181	31.3

18.7 Experiences of homelessness

Participants were first given the following options, asking if they had ever:

- Run away from home or the place they live
- Left home or the place they live because they were asked/made to leave
- Couch surfed because they had no other place to stay
- Been homeless

Participants who responded 'yes' to any of the above were then asked if they were currently experiencing this, if it was within the past 12 months, or if it was more than 12 months ago, for each response. Participants could select as many options as applied (i.e. currently experiencing this, and more than 12 months ago). 'Current' experiences of homelessness were merged with 'past 12 months'. Table 119 displays the proportions of participants who experienced homelessness in their lifetime (n = 6,357) and in the past 12 months (n = 6,411) by area of residence.

Participants in rural/remote areas reported the highest levels of homelessness in the past 12 months (14.1%; n = 94), followed by those in regional cities or towns (13.0%; n = 206), inner suburban areas (11.0%; n = 47), and outer suburban areas (10.5%; n = 385).

18.8 Suicide and self-harm

Questions relating to suicide and self-harm were carefully considered on the basis of prior research in this area. The approach used in *Writing Themselves In 4* is outlined in Section 9.4.

Table 120 displays the number of participants who experienced suicidal ideation, by area of residence below.

Almost two-thirds (65.1%; n = 434) of participants in rural/remote areas reported experiencing suicidal ideation in the past 12 months, followed by three-fifths (60.5%; n = 960) in regional cities or towns, 57.1% (n = 2,103) in outer suburban areas, and 49.2% (n = 213) in inner suburban areas.

More than four-fifths (82.5%; n = 550) of participants in rural/remote areas reported ever experiencing suicidal ideation in their lifetime, followed by 79.5% (n = 1,261) in regional cities or towns, 78.3% (n = 2,883) in outer suburban areas, and 70.7% (n = 306) in inner suburban areas.

Table 119 Experienced homelessness in their lifetime and in the past 12 months, by area of residence

	Area of residence							
	Capital city, city centre		Capital city, suburbs		Regional city or town		Rural/ remote area	
Any homelessness	n	%	n	%	n	%	n	%
Past 12 months	47	11.0	385	10.5	206	13.0	94	14.1
Ever	104	24.2	799	21.8	421	26.5	175	26.2

Table 120 Experienced suicidal ideation in their lifetime and in the past 12 months, by area of residence

	Area of residence							
	Capital city, city centre		Capital city, suburbs		Regional city or town		Rural/ remote area	
Suicidal ideation (n = 6,366)	n	%	n	%	n	%	n	%
Past 12 months	213	49.2	2,103	57.1	960	60.5	434	65.1
Ever	306	70.7	2,883	78.3	1,261	79.5	550	82.5
Prefer not to say	27	6.2	182	4.9	83	5.3	32	4.8

More participants in inner-suburban areas reported feeling supported by classmates, compared to participants in other locations

Table 121 displays the number of participants who experienced suicide attempts, by area of residence below.

Participants in rural/remote areas reported the highest levels of suicide attempts in the past 12 months (14.0%; n = 92), almost twice that of those in inner suburban areas (7.1%; n = 30).

Three-tenths (30.0%; n = 197) of participants in rural/remote areas reported ever experiencing a suicide attempt in their lifetime, followed by 27.2% (n = 424) in regional cities or towns, 24.3% (n = 882) in outer suburban areas, and 23.8% (n = 101) in inner suburban areas.

Table 122 displays rates of participant self-harm by area of residence below.

A greater proportion of participants in rural/remote areas reported self-harming in the past 12 months (46.7%; n = 308) than in regional cities or towns (42.6%; n = 666), outer suburban areas (38.9%; n = 1,414), or inner suburban areas (31.0%; n = 131).

Seven-tenths (70.9%; n = 467) of participants in rural/remote areas reported ever self-harming in their lifetime, followed by two-thirds (65.3%; n = 1,022) in regional cities or towns, three-fifths (60.0%; n = 1,022) in outer suburban areas, and over half (54.1%; n = 229) in inner suburban areas.

Table 121 Experienced suicide attempt in their lifetime and in the past 12 months, by area of residence

	Area of residence							
	Capital city, city centre		Capital city, suburbs		Regional city or town		Rural/ remote area	
Suicide attempt (n = 6,264)	n	%	n	%	n	%	n	%
Past 12 months	30	7.1	339	9.4	171	11.0	92	14.0
Ever	101	23.8	882	24.3	424	27.2	197	30.0
Prefer not to say	25	5.9	247	6.8	128	8.2	38	5.7

Table 122 Experienced self-harm in their lifetime and in the past 12 months, by area of residence

	Area of residence							
	Capital city, city centre		Capital city, suburbs		Regional city or town		Rural/ remote area	
Self-harm (n = 6,280)	n	%	n	%	n	%	n	%
Past 12 months	131	31.0	1,414	38.9	666	42.6	308	46.7
Ever	229	54.1	2,182	60.0	1,022	65.3	467	70.9
Prefer not to say	22	5.2	184	5.1	84	5.4	30	4.5

18.9 Summary

This is the first major study in Australia to examine area of residence in a sample of young LGBTQA+ people and thus provides useful information to assist organisations and services in understanding and addressing challenges related living in metropolitan, rural or remote locations. While there is some variation, overall it appears that health, education and social outcomes are often poorer for those living in rural or remote locations compared to those living in regional towns, outer suburbs, or inner-suburban locations (in that order).

Overall, participants in rural/remote and regional areas reported feeling less supported by classmates about their sexual sexuality or gender identity, and reported experiencing higher levels of psychological distress, and, in the past 12 months, suicidal ideation and attempts, and verbal harassment based on their sexuality or gender identity, compared to those in outer suburban and inner suburban capital cities. Almost three-fifths (57.0%) of participants in rural/remote areas reported they had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity compared to 40.1% in inner-suburban areas. Those living in rural/remote areas were also more likely to have experienced verbal or physical harassment or assault based on their sexuality or gender identity, compared to those living in other locations. Participants in rural/remote areas reported the highest levels of suicide attempts in the past 12 months (14.0%), followed by 11.0% in regional cities or towns, 9.4% in outer suburban areas and 7.1% in inner suburban areas.

These findings suggest that LGBTQA+ young people in rural and regional areas face lower levels of support in educational institutions, more frequent verbal and physical harassment or assault based on their sexuality or gender identity, and higher levels of psychological distress and suicidality than those in larger metropolitan areas. A push for campaigns embracing diversity to be conducted in educational settings, and the development and expansion of LGBTIQA+ services in regional towns and rural/remote areas, in combination with future qualitative research, may play an important part in improving the health and wellbeing of young LGBTIQA+ people living outside of large metropolitan areas in Australia.

19 **Conclusion and recommendations**

Important legal changes have occurred in the decade since the last *Writing Themselves In* report, including federal legislation for marriage equality and greater anti-discrimination protections, along with state-based legislation for birth certificate reform, equal rights to adoption, expunging of historical convictions for homosexual 'offences' and banning of conversion practices in some states and territories of Australia.

These legislative changes are neither perfect nor complete, but they continue to have impact on the everyday lives of LGBTQA+ people, including children and young people. Beyond legislative change, numerous surveys have documented shifting public perceptions of homosexuality and, in general, suggest more support for lesbian, gay and bisexual people than was the case 10 years ago. Changes in the way LGBTQA+ people are reflected in the media, in politics and other aspects of the public sphere are undoubtedly linked to this shifting public opinion. The lives of many have also undoubtedly been impacted positively through targeted interventions seeking to ensure LGBTQA+ inclusion in health and social care settings, schools and sports (to name a few), along with social support and 'pride' programs. However, the data presented in this report suggest there is still a long road ahead in ensuring safe environments for LGBTQA+ young people to grow, live and thrive.

Writing Themselves In 4 represents the largest ever survey of LGBTQA+ young people in Australia. The findings articulated in this report reflect both the strengths of LGBTQA+ young people and challenges they experience. The results illustrate how young people are connected within their communities, how they draw support from friends and family, and what makes them feel good. Findings detailed in Chapter 14, in particular, suggest strengths that can be built upon by continuing to focus on affirming young people's identities and providing safe spaces in which they can create, develop, affirm and celebrate one another.

The report also details a range of findings that are of significant concern. We observed very high rates of psychological distress, self-harm, suicidal ideation and attempted suicide. Such significant mental health related challenges should be considered within the context of continuing verbal, physical, and sexual harassment or assault experienced by LGBTQA+ young people. This occurred in many areas of their lives, including in the home, at educational institutions and in public. In educational settings, a significant number of LGBTQA+ young people do not feel safe, do not feel able to engage in gender- or sexuality-affirming practices (often as simple as holding hands with a same-sex partner) or do not feel that existing structures or policies take account of their needs. A sizeable proportion of LGBTQA+ young people had experienced one or more forms of homelessness, often linked to experience of rejection from family or other forms of family violence. A large proportion of LGBTQA+ young people use drugs for non-medicinal purposes and, particularly of note, are the significant number who have been concerned about their drug use.

For the first time, we have sufficient data to shine a spotlight on sections of the LGBTQA+ community that have historically been overlooked. People with disability are known to experience varied forms of stigma and discrimination in many aspects of their everyday lives, and data from *Writing Themselves In 4* would suggest this is even more so the case for LGBTQA+ young people with disability. In relation to every indicator of health and wellbeing, outcomes for people with disability appear worse than for those without, a scenario that is especially concerning for people with intellectual disability. In relation to ethnicity, considerable diversity in experience is evident among LGBTQA+ young people from different backgrounds, which may reflect differing cultural norms or expectations relating to gender and sexuality, a lack of attention to ethnic or cultural diversity within existing programs aimed at fostering safety and inclusion, or a range of other potential explanations that are yet to be explored in detail. For LGBTQA+ young people living in rural areas, it would appear that health outcomes, educational and safety-related experiences are worse than is the case for those living in cities. The reasons for such disparities are likely diverse and may reflect difficulties in accessing LGBTQA+ cultural or social spaces in rural areas, as well as more challenging cultural environments. Beyond these intersecting identities, *Writing Themselves In 4* also heard from a large number of people who identified as pansexual or asexual allowing, for the first time in Australia, a spotlight to be shone on their unique experiences and needs related to health and education.

In all the recommendations that follow, it is important to consider how these intersecting identities and experiences may need to be especially accommodated by policy or interventions. These findings will be of interest to many stakeholders across all jurisdictions in Australia (and internationally), including health and social care providers, those working in educational contexts, prevention of violence policy and program specialists, those working to reduce homelessness or harms associated with alcohol and other drug use, as well as many others.

The importance of primary prevention

Experiences of poor mental health need to be understood within a context of prevailing homophobia, biphobia and transphobia that is embedded in many parts of society and is illustrated by LGBTQA+ young people's experiences of verbal, physical, and sexual harassment or assault. It is not sufficient or appropriate to expect LGBTQA+ young people to become more resilient to such experiences, or to simply offer opportunities to cope better in the face of such hostility. Rather, it is crucial that efforts are made to prevent abuse, harassment or assault being directed towards LGBTQA+ communities in the first place.

1. **Tackling stigma and violence.** Governments and other relevant stakeholders in all jurisdictions need to tackle stigma directed towards LGBTQA+ communities and violence enacted against them. This could include (but not be limited to) community messaging campaigns, programs aimed at embedding positive representation of LGBTQA+ people in media, efforts to ensure LGBTQA+ inclusion in government policy frameworks and prioritisation in funding areas, such as community-inclusion grants. It could also include efforts to address gender stereotypes and norms that challenge the ability of trans and gender diverse young people to live openly and safely within their communities.
2. **Embracing and celebrating diversity.** Health outcomes that are already poor among LGBTQA+ communities appear elevated among further marginalised or isolated groups, such as those with disability, those from culturally or ethnically diverse backgrounds, or those living in remote locations. We recommend campaigns be conducted in the broader community, as well as within LGBTQA+ communities, to embrace diversity and ensure full inclusivity of people with all backgrounds and abilities. While data relating to the experiences of Aboriginal and Torres Strait Islanders will be the subject of a subsequent report, all efforts to embrace and celebrate diversity must be attentive to the needs and circumstances of Indigenous Australians.

Mental health sector

Chapter 9 of this report outlines alarming levels of psychological distress, suicidality and self-harm among LGBTQA+ young people. These experiences are commonplace across all groups but are particularly elevated among trans and gender diverse young people, those with disability and those living in rural or remote locations. In addition to a focus on prevention, the responses required to tackle such needs span a spectrum of early interventions through to acute service provision.

3. **Early intervention programs** are required to support communities, families and young people to better recognise and understand signs of mental ill-health among LGBTQA+ young people and to promote entry into care, as well as referrals into expert centres of care, such as LGBTQA+ community-controlled organisations, which should receive increased funding to broaden their service provision.
4. **Inclusive mental health services.** Linked to the recommendation above, mental health services working with LGBTQA+ young people need to be safe environments, attentive to the diversity within this group and inclusive of their needs. Given the extent of mental ill-health documented in this report, we recommend all mental health services (especially those targeted specifically for young people) undergo LGBTQA+ cultural safety training and develop long-term plans to build their organisational capacity to meet the needs of this population. Central to improved mental health service provision, it is crucial that service providers do not seek to pathologise young people in relation to their sexuality or gender identity.
5. **Access to specialist services.** Numerous LGBTQA+ community-controlled organisations exist across the country, and these provide bespoke services for the community, in recognition of their unique experiences and needs. Findings outlined in this report indicate that while LGBTQA+-specific services were used only by a minority of respondents, the experiences of those who did were more positive than of those accessing mental health support from other providers. Extending the provision of LGBTQA+ services will enable a larger number of young people to access expert services where, from the outset, they can feel safe and affirmed, an issue of particular importance to trans and gender diverse young people.
6. **Facilitating dialogue.** We recommend convening a forum for further examination of how and why poor mental health for LGBTQA+ young people does not appear to be alleviated by current mental health service provision. Dialogue on this issue could be assisted by a mapping of LGBTQA+-specific interventions and an assessment of emerging best-practice services and models in working to support LGBTQA+ young people. These approaches could be taken up by a broader range of organisations. A national forum could consider activities ranging from mental health messaging and outreach through to the forms of therapeutic practice considered to show promise with different sections of the LGBTQA+ community.

Other health and social care settings

A high proportion of young people in the survey had experienced homelessness or housing insecurity. This may reflect a number of factors, including experiences of family violence or rejection on the basis of their gender diversity or sexuality. A number of LGBTQA+ young people also reported that they were concerned about their drug use and/or that their friends or family had expressed concern regarding their drug use. While these measures provide a high level rather than a detailed assessment of need, they indicate the importance of considering LGBTQA+ young people within both housing and homelessness, and drug and alcohol services.

7. **Addressing homelessness.** The causes and consequences of homelessness can be multifaceted and often require a holistic response that brings together experts in family violence, mental health, alcohol and other drug use, employment, and community inclusion. We recommend resourcing of LGBTQA+ community-controlled organisations, or other accredited and culturally safe organisations, to design and deliver homelessness interventions that can connect the range of relevant services to meet the needs of this population.
8. **Inclusive and accessible drug and alcohol interventions.** As reflected in recommendations 4 and 5 above, there is a need to ensure access to both inclusive and culturally safe mainstream alcohol and other drug services, as well as extended provision of specialist LGBTQA+-specific services, where they exist, to meet harm reduction needs of this population. Other appropriate interventions in this context could include programs based on a treatment methodology of facilitating reflection among young people about how and when their use of drugs may be becoming problematic, and steps they could take to alleviate this experience, if appropriate.
9. **Access to trans-affirming care.** Many trans and gender diverse participants reported challenges accessing gender-affirming care, or they felt that such care was being controlled or denied by others. Efforts need to be made to expand such service provision and to provide safe access points and referral pathways that are attentive to the needs of young people.

Families, allies and communities

Families, allies and communities can provide essential social support, fostering a sense of empowerment and affirmation. Previous research has documented the important role that each play as a protective factor for mental health in LGBTQA+ young people. As such, it is crucial that interventions continue within these contexts and are scaled up wherever possible to help ensure safe spaces for LGBTQA+ young people to live and grow.

10. **Community connection.** The affirmative role and impact of LGBTQA+ community connection is significant. Engaging with other LGBTQA+ young people provides opportunities for shared learning, peer support and collective advocacy. We recommend such interventions, typically delivered by LGBTQA+ community-controlled organisations and their allies, are maintained and scaled up wherever possible. They should be especially attentive to inclusion of people from culturally and ethnically diverse backgrounds and for those with disability, as well as being promoted within rural locations.
11. **Opportunities for creativity.** Linked to the recommendation above, and in light of data described in Chapter 14, creative activities provide many LGBTQA+ young people opportunities to feel good about themselves and feel affirmed in their gender identity or sexuality. Governments at all levels should fund a variety of creative arts initiatives and these should, wherever possible, provide enhanced opportunities for creative expression and affirmation among LGBTQA+ young people.
12. **Investing in family support.** Some LGBTQA+ people have not been met with support at the point of ‘coming out’ or disclosing their gender identity with family, and some have faced homelessness or housing insecurity as a result of family rejection. We recommend support for interventions that seek to support and affirm young people and their families in this process and to empower all parties with an understanding of gender diversity and sexuality. Greater understanding might serve to mitigate embedded societal stigma.

Educational settings

A broad range of interventions have been delivered in schools, TAFEs and universities over the past decade to help ensure a better learning environment for LGBTQA+ young people. However, data described in this report suggest more is still to be done in ensuring a respectful environment where young people can feel safe to affirm their gender or sexuality and actively engage in their education.

13. **Promotion of LGBTQA+-specific anti-bullying policies.** Many young people were not aware whether their school, TAFE or university had a bullying policy and whether it mentioned issues of importance to LGBTQA+ young people. While it is possible that in many instances such policy does exist, awareness of its existence can itself help to foster a feeling of safety and inclusion. We recommend that all educational institutions develop, adopt and promote policies that cover bullying, stigma or discrimination directed towards LGBTQA+ young people, and have in place systems to address such behaviour should it occur.
14. **Preventing violence or abuse in educational settings.** A large proportion of participants in this study reported feeling unsafe at school, TAFE, or university, and described experiences of verbal, physical or sexual harassment/assault in these contexts. This situation requires intervention to tackle homophobia, biphobia, transphobia or any other forms of discrimination that is experienced by LGBTQA+ young people within education communities.
15. **Supporting affirmation.** At school, TAFE or in university, LGBTQA+ young people should be supported if they wish to engage in sexuality- or gender-affirming practices, so they can feel able to safely celebrate LGBTQA+ days of significance, openly identify as LGBTQA+ or wear clothes that match their gender identity, for instance. Within educational settings, such affirmation also includes access to toilet and changing room facilities that are aligned with the young person's gender identity and which trans and gender diverse young people can feel safe accessing.
16. **Feeling seen and heard.** A large proportion of young people in this survey said that their education included no mention of LGBTQA+ people in supportive or affirming ways, and this can foster a sense of invisibility or exclusion. Efforts should be made to ensure positive representation of LGBTQA+ people in varied aspects of education curricula.

Future research

No one survey can ever hope to examine all aspects of health, wellbeing and daily life. The LGBTQA+ community is as diverse as any other and different groups within this will have unique and nuanced needs or experiences, which cannot always be captured in a broad survey that covers the whole community. In many respects, the data shown in the preceding chapters generate as many questions as they answer. As acknowledged in Section 2.6, the needs and experiences of young people with intersex variation/s were not adequately captured in *Writing Themselves In* 4, warranting specially designed and directed studies of this population. We specifically recommend the following:

17. **Qualitative research.** While survey research can answer the 'how much' or 'how often' questions regarding health, education and social experiences, they cannot fully capture 'why' such things may be occurring or the nuanced lived experience of LGBTQA+ young people. We recommend qualitative research to examine topics such as: experiences of family violence, including perceived drivers and supportive responses; how, why and in what circumstances alcohol or drug use may come to be perceived as problematic, and what support might best address need where it exists; the circumstances of homelessness and barriers to accessing housing support; and the lived experiences of young people who hold non-binary identities, including how this shapes health service access. Qualitative research is also required to understand the lived experiences of Aboriginal and Torres Strait Islander LGBTIQA+ young people, including how intersecting experiences of stigma, as well as sources of strength, might shape their wellbeing.
18. **Intersex-focussed research.** Significant rethinking is required about the ways to meaningfully engage young people with intersex variation/s in research. Approaches badged as 'LGBTIQA+' may continue to struggle to engage people with intersex variation/s if they do not consider themselves a part of a broader LGBTQA+ community or when they feel such research does not adequately reflect their needs. We recommend provision of dedicated funding for community-based participatory research which is reflective of community priorities and specifically directed to and by people with intersex variation/s. This might include, for example, targeted surveys that only involve people from this population, or qualitative studies that can explore their lived experiences at home, educational institutions, work, and in their personal lives and communities. To achieve this, exploratory research is required to understand how young people with intersex variation/s make sense of their experience as service users, including the circumstances and consequences of medical interventions (including those performed at an age before personal informed consent was possible), or the accessibility and effectiveness of therapeutic and support interventions. Such research should be undertaken in partnership with intersex-led organisations and peer advocates, and should include sufficient funding to ensure their meaningful involvement and peer outreach activities to both collect data and disseminate findings.

19. **Evaluation of interventions.** Over the past two decades, a variety of interventions operating at the policy, organisational and service delivery levels have emerged in support of LGBTQA+ young people. These have often emerged organically and in response to local community need. To meet the extensive need documented in this report, existing interventions showing promise and impact need to be scaled up and implemented across settings. Such efforts should be evidence based, and thus there is a clear need for funding of intervention evaluation to identify best practice across the country.
20. **Periodic monitoring.** Data drives evidence-based policymaking as well as service and intervention design and delivery. There is considerable nuance in the needs and expectations of LGBTQA+ young people, which can shift over time and be shaped by social and political events. Periodic surveys of LGBTQA+ young people, such as *Writing Themselves In* 4, facilitate a snapshot of their lives, and more regular collection of data in this form can be used to track performance against jurisdictional health, education or whole of LGBTQA+ population strategies.

Maximising impact of the findings

The recommendations outlined in this chapter principally speak to the findings of *Writing Themselves In 4*. There is, of course, a broader body of knowledge that can inform thinking and practice, which exists within the academic literature as well as within the health, social care, youth and LGBTQA+ sectors. The present study reflects a wide range of identities, intersections, experiences and settings and, coupled with these existing bodies of knowledge, necessitates strategic conversations in all jurisdictions and in partnership with all levels of government.

21. **Strategic action planning.** Extending beyond a dialogue focussed on mental health and suicidality (recommendation 5), there is a need for forums at national, state, territory and council level to further consider the findings outlined in this report and ways in which they can inform policy and practice across a broad range of sectors. Such forums should bring together government and LGBTQA+-sector specialists alongside mainstream service and education providers, to jointly explore opportunities to address the many challenging experiences outlined in previous chapters and to pose more detailed recommendations that can inform work across jurisdictions.

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