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On behalf of the *Private Lives 3*, *Writing Themselves In 4*, *SWASH*, *Trans Pathways*, *Walkern Katatdjin*, and *Pride and Pandemic* teams

RAINBOW REALITIES

In-depth analyses of large-scale LGBTQA+ health and wellbeing data in Australia

LA TROBE UNIVERSITY | Australian Research Centre in Sex, Health and Society | TELETHON KIDS INSTITUTE | THE UNIVERSITY OF SYDNEY | THE UNIVERSITY OF WESTERN AUSTRALIA | LGBTIQ+ HEALTH AUSTRALIA

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ABOUT RAINBOW REALITIES

The *Rainbow Realities* report has been commissioned by the Commonwealth Department of Health and Aged Care to inform development of the 10-year LGBTIQA+ Health and Wellbeing Action Plan.

It reflects the commitment of the Australian Government to ensure the needs and experiences of LGBTIQA+ people are carefully considered in the development of the Action Plan. This report represents one component of the national consultation process, which also includes engagement of an Expert Advisory Group, a report on LGBTIQA+ inclusion within State, Territory, Commonwealth and Public Health Network strategies and action plans, an examination of perceptions on primary care provision for LGBTIQA+ communities and other targeted consultation activities.

Rainbow Realities provides a synthesis of pre-existing findings as well as **more than 50 new analyses** derived from the data of six surveys of LGBTQA+ populations in Australia:

- *Private Lives 3*
- *Writing Themselves In 4*
- *SWASH*
- Trans Pathways
- Walkern Katatdjin (Rainbow Knowledge)
- *Pride and Pandemic*

In total, **more than 20,000 LGBTQA+ people participated in these surveys**, spanning all parts of the country and a wide range of intersectional backgrounds. The report has been thematically organised into 10 chapters relating to either a key determinant or contributing factor to LGBTQA+ health outcomes, or a topic of particular interest. The teams for each survey comprise the following people:

- ***Private Lives 3:*** Adam Hill, Adam Bourne, Ruth McNair, Marina Carman, Anthony Lyons.
- ***Writing Themselves In 4:*** Adam Hill, Anthony Lyons, Jami Jones, Ivy McGowan, Matthew Parsons, Jennifer Power, Adam Bourne.
- ***SWASH*:** Julie Mooney-Somers, Rachel Deacon, Ania Anderst, Karen Price, Nicolas Parkhill
- ***Trans Pathways:*** Penelope Strauss, Angus Cook, Sasha Bailey, Dani Wright Toussaint, Vanessa Watson, Sam Winter, Ashleigh Lin.
- ***Walkern Katatdjin:*** Shakara Liddelow-Hunt, Bep Uink, Kate Douglas, James Hill, Lily Hayward, Natasha Stretton, Yael Perry, Braden Hill, Ashleigh Lin.
- ***Pride and Pandemic:*** Natalie Amos, P.G. Macioti, Adam Hill, Adam Bourne.

Funding

The *Rainbow Realities* report was made possible by generous funding from the **Australian Government**, working in partnership with LGBTIQ+ Health Australia. We are grateful for their support and the opportunity to further examine the needs and experiences of LGBTQA+ people in Australia. Further sincere thanks go to the funders of the individual surveys:

- *Private Lives 3* was funded by the Victorian Government Department of Health and Human Services and the Department of Premier and Cabinet.
- *Writing Themselves In 4* was funded by: (i) the Victorian Department of Premier and Cabinet, (ii) the Australian Capital Territory Government Office for LGBTIQ+ Affairs, and (iii) the New South Wales Department of Health and SHINE SA, with support from (iv) the Office of the Chief Psychiatrist in South Australia.
- *SWASH* has been supported since 1996 by ACON.
- Trans Pathways was funded by the Western Australian State Department of Health and Telethon Kids Institute.
- Walkern Katatdjin was funded by a grant from the National Health and Medical Research Council.
- *Pride and Pandemic* was funded by the National Mental Health Commission.

Additionally, several of the new analyses presented in the report were supported by funding from the Australian Institute of Health and Welfare (AIHW), Cancer Council Victoria, the Disability Royal Commission, and the Australian Lesbian Medical Association (ALMA).

A note on people with an intersex variation/s

Despite efforts to collect data from participants with an intersex variation/s, a relatively small sample size of participants with an intersex variation/s participated in the surveys (n = 47 in *Private Lives 3*; n = 20 in *Writing Themselves In 4*; n = 5 in *SWASH*; n = 14 in Trans Pathways; n = 36 in *Pride and Pandemic*). These participants also identified as being LGBTQA+ and are therefore included in the analyses according to their sexual and/or gender identities where relevant. However, the data arising from these projects are not able to meaningfully reflect the needs and experiences of people with intersex variation/s and therefore the report does not directly explore data from participants with intersex variation/s.

Serious consideration is needed for future research to re-think approaches to meaningfully engage people with intersex variation/s. Research badged as 'LGBTIQA+' may continue to struggle to engage people with intersex variation/s who do not see themselves as part of the broader LGBTQA+ community or feel that such research would not appropriately reflect their needs. Dedicated funding is needed for research that is designed to meet the needs and community priorities of people with intersex variation/s. This research needs to be specifically directed to and conducted by people with intersex variation/s, in partnership with intersex-led organisations and peer advocates.

Acknowledgement of Country

La Trobe University proudly acknowledges the Traditional Custodians of the lands where its campuses are located in Victoria and New South Wales. We recognise that Indigenous Australians have an ongoing connection to the land and we value their unique contribution, both to the University and the wider Australian society.

La Trobe University is committed to providing opportunities for Aboriginal and Torres Strait Islander people, both as individuals and communities, through teaching and learning, research and community partnerships across all of our campuses.

The wedge-tailed eagle (*Aquila audax*) is one of the world's largest.

The Wurundjeri people – traditional owners of the land where the Australian Research Centre in Sex, Health and Society is located and where our work is conducted – know the wedge-tailed eagle as Bunjil, the creator spirit of the Kulin Nations.

There is a special synergy between Bunjil and the La Trobe logo of an eagle. The symbolism and significance for both La Trobe and for Aboriginal people challenges us all to 'gamagoen yarrbat' – to soar.

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ACKNOWLEDGMENTS

We wish to express our gratitude toward the numerous individuals who offered their support and guidance during the compilation of this report.

The report benefited greatly from the involvement of the LGBTIQ+ Health Australia Members who guided the content of the report, helped to prioritise analyses and key areas of focus and ensured that the report would meet the needs of the LGBTQA+ community.

We also wish to acknowledge Sasha Bailey, Ruby Grant, Rachel Deacon, Penelope Strauss, Bep Uink, Thomas Norman, Darcy Wallis, Joel Anderson, Emily Goodnow Bjaalid and Kris Wilson for their input and advice on the analyses included in the report, and Elinor McDonald for her thoughtful and creative graphic design of the report.

We would also like to acknowledge the generous help of a great many people who supported the design, development, implementation and analysis of each of the projects detailed in this report. These projects benefitted significantly from the expert advice and guidance of their respective advisory boards. For full details of those who contributed to the development and success of each survey, please see the full reports of each project.

Finally, our thanks go to the thousands of LGBTQA+ people who generously gave their time to share their stories with us through these surveys. We hope this report does justice to your experience and that the findings will be used to affirm and support LGBTQA+ people everywhere.

Terminology

Bisexual typically refers to identities that are characteristic of attraction to more than one gender – for example, one's own gender and other genders.

Pansexual identities are characteristic of attraction towards people irrespective of their (birth registered) sex or gender.

Queer refers to sexual or gender identities that are not heterosexual or cisgender, respectively. The term 'queer' was once used as a derogatory term and some older LGBTQA+ people may still consider this term to be derogatory. However, it has been reclaimed by parts of the community and many now use this term to describe their identity.

Asexual refers to a spectrum of identities characteristic of attraction to only a few or specific people, or no attraction to others. While asexual and aromantic identities are often conflated, asexuality typically pertains to variation in sexual attraction, whereas aromantic identities are typically characterised by variation in romantic attraction. A person who identifies as asexual or a different asexual spectrum identity (e.g.,grey sexual, demisexual, etc.) may also use additional labels to describe their sexual orientation/attraction, such as asexual and pansexual; demisexual, aromantic and queer; or asexual and heterosexual.

Lesbian is a term that typically describes attraction to only women, among women.

Gay is a term describing attraction to only one's own gender – typically this is attraction to men among men, although people of various sexual orientations and genders may also use this term to describe their identities.

Bisexual+ refers to identities that are characteristic of attraction to more than one gender. This includes people who identify as bisexual, pansexual, or who use other terms to describe their sexual and/or romantic identity/attraction. These identities may also be described as **plurisexual** or non-monosexual.

Monosexual identities are those characterised by attraction to one gender, such as lesbian, gay and heterosexual identities.

Sexual minority refers to non-heterosexual populations.

Trans and gender diverse people have gender identities that are different from their birth-registered sex and gender. While the terms 'trans' and 'gender diverse' are often considered to be non-mutually exclusive labels, not all trans people identify as gender diverse, neither do all non-cisgender or non-binary people identify as trans (and some of these people identify as neither). There is also a multitude of terms that trans and gender diverse people use to describe their identities including but not limited to 'trans woman/girl', 'trans man/guy,' 'woman,' 'man,' 'genderqueer,' 'Sistergirl,' 'Brotherboy,' 'demi boy,' 'demi girl,' 'agender' and/or 'genderfluid.' Importantly, the terms 'trans man,' 'trans woman' and 'non-binary' used in this report are often not the only terms participants used to describe themselves.

Cisgender is used in reference to people whose gender identities are aligned with their birth registered sex and gender.

Gender minority refers to non-cisgender populations.

Intersex people are born with natural variations in their sex characteristics that don't fit medical and social norms of female or male bodies. This may include variations in chromosomes, genitals, gonads, hormones, and other reproductive anatomy, as well as secondary characteristics that emerge from puberty.

Use of acronyms to describe the populations

Throughout the report we have used specific acronyms to refer to different populations:

- **LGBTIQA+** refers to lesbian, gay, bisexual+, trans, intersex, queer and asexual identified people, in addition to people with other diverse sexual orientations and gender identities.
- **LGBTQA+** refers to lesbian, gay, bisexual+, trans, queer and asexual identified people, in addition to people with other diverse sexual orientations and gender identities.
- **LGBQA+** refers to lesbian, gay, bisexual+, queer and asexual identified people, in addition to people with other diverse sexual orientations.
- **GBQ+** refers to gay, bisexual+ and queer sexual identities.
- **LBQ+** refers to lesbian, bisexual+ and queer sexual identities.
- **LGB+** refers to lesbian, gay and bisexual+ identities.
- **Bi+** refers to bisexual+ identities.

EXECUTIVE SUMMARY

The *Rainbow Realities* report provides a synthesis of pre-existing research as well as 52 new analyses derived from the findings of six surveys of LGBTQA+ populations in Australia. These analyses examine a wide range of health concerns, challenges and experiences that underpin LGBTQA+ health and wellbeing while also investigating the prevalence and impact of health-enabling factors within the populations and communities.

The report details pre-existing evidence as well as new analyses that have been thematically organised into 10 themes relating to either a key determinant or contributing factor to LGBTQA+ health outcomes, or a topic of particular concern. The themes include:

- Mental Health and Suicidality
- Income Inequality, Housing and Experiences of Homelessness
- Discrimination and Abuse
- Family Violence and Sexual Assault
- Alcohol and Other Drugs
- Relationships, parenting and Sexual and Reproductive health
- Gender Affirmation and Trans-Affirming Practices
- General Healthcare
- Aboriginal and Torres Strait Islander People
- Intersectional Identities

The surveys

Private Lives 3

Private Lives 3 is the largest national survey of the health and wellbeing of 6,835 LGBTQA+ adults in Australia aged 18 years or older. Participants were recruited from all states and territories, and the survey was open from July 2019 to October 2019. Recruitment was advertised through promotion by LGBTQA+ community organisations as well as paid targeted advertising on Facebook and Instagram.

Writing Themselves In 4

Writing Themselves In 4 is the largest national survey of the health and wellbeing of LGBTQA+ young people in Australia aged 14–21 years. The survey was open for completion from September 2019 to October 2019. Participants were recruited from all states and territories, and recruitment was advertised through paid targeted advertising on Instagram and Facebook, and from promotion through LGBTQA+ community organisation networks.

SWASH

The *SWASH* survey is a comprehensive survey of important health issues relevant to lesbian, bisexual, queer and other non-heterosexual identifying (LBQ+) women (cisgender and trans) and non-binary people living in Sydney aged 16 years and older. *SWASH* is the longest running regular survey of LBQ+ women's health and wellbeing and the most recent iteration also included non-binary people. It has been conducted during the Sydney Mardi Gras season every two years since 1996. For the purpose of the forthcoming report, data from 2,860 women and non-binary people who participated in the most recent iteration (2022) of the *SWASH* survey are used.

Trans Pathways

Trans Pathways is the largest national survey with a specific focus on the mental health and care pathways of 859 trans and gender diverse young people in Australia aged 14–26 years. An anonymous online, self-report questionnaire was conducted between February 2016 and August 2016. Participants were largely recruited using social media (Twitter, Facebook and Tumblr), gender clinics, youth mental health services, support groups, parent and youth groups, and word of mouth.

Walkern Katatdjin (Rainbow Knowledge)

Walkern Katatdjin is the first survey to focus on the health and wellbeing of Aboriginal and Torres Strait Islander LGBTQA+ young people in Australia. The dataset includes 619 Aboriginal and Torres Strait Islander LGBTQA+ young people aged 14–25 years from across Australia. The survey was promoted via LGBTQA+ community organisations, Aboriginal and Torres Strait Islander community organisations, and paid advertising on social media.

Pride and Pandemic

Pride and Pandemic was a cross-sectional exploration of the experiences of 3,135 LGBTQA+ adults aged 18 and over in Australia during the COVID-19 pandemic, with a focus on experiences of mental health and wellbeing during the pandemic. The survey was launched in November 2021 and closed in February 2022. The survey was promoted via LGBTQA+ community organisations as well as paid advertising through Facebook and Instagram.

Theme 1: Mental health and suicidality

- Psychological distress, subjective wellbeing, and reported experiences of suicidality, self-harm, and support-seeking amongst LGBTQA+ populations reflect the negative mental health impacts of discrimination and marginalisation experienced in Australia.
- Disparities exist not only in access to mental health services for the LGBTQA+ community but also in the positive outcomes from receiving care, necessitating tailored mental health services for this population.
- Interpersonal connection, support, and engagement with the LGBTQA+ community can potentially serve as protective factors against poorer mental health and wellbeing.
- Various groups within the LGBTQA+ community, including trans or gender-diverse individuals, cisgender women, those with disability, non-monosexual individuals, those living in non-metropolitan areas, younger people, those born in a non-English-speaking country, high-school students, and those experiencing discrimination or abuse, face significant disadvantage and suboptimal mental health outcomes, often due to the cumulative impact of multiple sources of discrimination.

Theme 2: Income inequality, housing and experiences of homelessness

- The marginalisation and disadvantage faced by LGBTQA+ individuals profoundly affect their health and wellbeing, with certain sub-groups within the community being more adversely affected.
- Analysis of income and housing data revealed an uneven distribution of economic deprivation within the LGBTQA+ community in Australia, demonstrating how economic and housing insecurity can contribute to poorer health and wellbeing.
- Among the LGBTQA+ community, trans and gender-diverse individuals, cisgender women, disabled individuals, Bi+ individuals, and those living in non-metropolitan areas faced significant economic disadvantage and limited access to opportunities.
- The findings further show the cumulative impact of multiple sources of disadvantage, such as sexism and ableism, which compound and obstruct access to economic participation and opportunities for groups like cisgender women and disabled individuals within the LGBTQA+ community.

Theme 3: Discrimination and abuse

- The chapter presents evidence of the direct and significant impact of sexual and gender identity discrimination on the mental health and wellbeing of LGBTQA+ individuals, with the type, source, and recency of discrimination influencing the severity of these outcomes.
- Discrimination impacts are unevenly distributed among different LGBTQA+ subgroups, which can influence the scale of mental health and wellbeing outcomes.
- Access to positive, identity-affirming experiences within family, workplace, and with other LGBTQA+ individuals can attenuate the negative impacts of discrimination on health outcomes.
- Facilitating access to such positive, identity-affirming experiences can serve as a strategy to lessen the associations between discrimination and negative health outcomes for LGBTQA+ individuals.

Theme 4: Family violence and sexual assault

- The chapter emphasises the need for professional services that are not only inclusive of LGBTQA+ individuals, but also equipped to provide appropriate and emotionally safe care for LGBTQA+ victim-survivors.
- Experiences of sexual assault and family violence cause considerable mental health burdens among sexual minority individuals.
- The findings corroborate the importance of primary prevention initiatives targeted to address gendered and patriarchal norms around consent, dominance and control to minimise perpetrating behaviours, as well as other awareness-raising strategies to support LGBTQA+ individuals in recognising the contours of family violence and sexual assault within their own relationships.

Theme 5: Alcohol and other drugs

- The chapter acknowledges the high prevalence of alcohol and drug use within LGBTQA+ communities, partly attributed to the normalisation of these behaviours in many LGBTQA+ subcultures, and notes the tangible health disparities these contribute to within these communities.
- Substance use within the LGBTQA+ community is closely associated with various mental health concerns and demographic factors linked to significant disadvantage or marginality, although a clear causal relationship has not been established.
- Findings highlight features in patterns of substance use within the community, including a high prevalence of engagement in the use of multiple substances at the same time (polysubstance use), association of substance use with social and mental health challenges in younger trans and gender diverse individuals, and variations in usage between age groups for substances like nicotine.
- The findings underscore the need for tailored professional supports and interventions attentive to the diverse features and underlying drivers of substance use among different LGBTQA+ subgroups.

Theme 6: Relationships, parenting and sexual and reproductive health

- Disparities in sexual and reproductive health among LGBTQA+ populations are directly linked to the stigma associated with sexual and gender diversity and non-heteronormative sexual practices.
- Uptake of STI/HIV screening among LGBTQA+ populations, crucial for minimising health disparities, is often hindered by factors such as poor sexual health literacy, anticipated discrimination from service providers, confidentiality concerns, and shame and fear related to STI/HIV stigma.
- Evidence indicates significant gaps in sexual healthcare utilisation within the LGBTQA+ community, with certain subgroups like sexual minority women typically considered 'low risk' but underrepresented in service utilisation, making it difficult to accurately assess their STI burden and other health needs.
- Findings suggest the need to improve general awareness and health literacy, particularly surrounding certain STIs like Hepatitis C, to bolster screening rates within the LGBTQA+ community.

Theme 7: Gender affirmation and trans affirming practices

- Gender affirmation is integral to the health and wellbeing of trans and gender diverse individuals, with access to gender-affirming medical care having profound impacts on their quality of life.
- In the current social climate marked by hostility towards trans and gender diverse individuals, reliable access to gender-affirming medical care and socio-legal recognition can be challenging, especially for younger members of the community.
- The chapter underlines the necessity of all aspects of gender affirmation - social, medical, and legal - to ensure positive mental health outcomes for trans and gender diverse individuals, while also revealing a high degree of unmet needs leading to considerable mental health concerns.
- The diversity and complexity of gender-affirming needs among trans and gender diverse individuals necessitate a tailored approach, not a one-size-fits-all strategy, to gender-affirming care. Thus, policies governing gender-affirming care must account for this diversity within gender minority populations.

Theme 8: General healthcare

- Regardless of specific health concerns, common factors that undermine healthcare quality and access for LGBTQA+ individuals include healthcare provider discrimination, which significantly impacts health-seeking behaviours and decisions.
- The evidence suggests that even when health concerns of LGBTQA+ individuals are not directly related to their sexual or gender identities, identity-affirming care remains essential to their healthcare preferences and experiences.
- While LGBTQA+ patients often prefer LGBTQA-inclusive, population-non-specific services, this is not a rejection of LGBTQA+-specific services but may reflect concerns about disclosing sexual identity or a preference against isolating LGBTQA+-affirming care to a limited number of services.

- The chapter highlights uneven access to identity-affirming experiences within healthcare contexts among LGBTQA+ subgroups, with trans and gender diverse individuals reporting lower rates of such experiences even in reputedly LGBTQA+-inclusive or specific services.
- The findings also indicate a lack of trans-appropriate expertise among GPs, even those who are affirming of trans and gender diverse patient's gender identities.

Theme 9: Aboriginal and Torres Strait Islander people

- Aboriginal and Torres Strait Islander LGBTQA+ individuals face greater mental health disparities compared to their non-Indigenous peers, likely due to increased discriminatory and exclusionary experiences in various settings.
- Protective factors such as participation in cultural practices, family and kinship ties, and positive media representation enhance the psychological well-being of these individuals. However, barriers like disconnection from Country and rejection due to sexual/gender identities may limit their access to these protective factors.
- Many may face challenges accessing identity-affirming experiences within the LGBTQA+ community due to experiences of racism and exclusion.
- There's a notable gap in healthcare services that are both culturally appropriate and affirming of the LGBTQA+ identity for Aboriginal and Torres Strait Islander LGBTQA+ people.
- Current data on the implementation of culturally sensitive and LGBTQA+-affirming care is limited, highlighting a need for further investigation and clarity on best practices.

Theme 10: Intersectional identities

- This chapter explored the intersectional experiences of: people from a multicultural background; people with disability; intersections of sexual orientation and gender; residential location; and ageing populations.
- The findings outline the diverse challenges and unique needs faced by individuals with multiple intersectional identities, pointing to the importance of an intersectional lens when understanding and addressing health and wellbeing outcomes and inequalities, respectively.
- While intersectional identities can sometimes be subject to poorer health outcomes due to heightened unmet needs, they can also result in better outcomes in some cases. This could be attributed to positive intersectionality, where these identities provide access to unique sources of resilience and support.
- The concept of intersectionality goes beyond mere diversity or difference, describing context-specific experiences resulting from intersecting identities. Therefore, a more nuanced understanding of intersectional identity is needed that considers more than just discrimination and focuses on structural factors mediating met and unmet needs.

Key findings at a glance

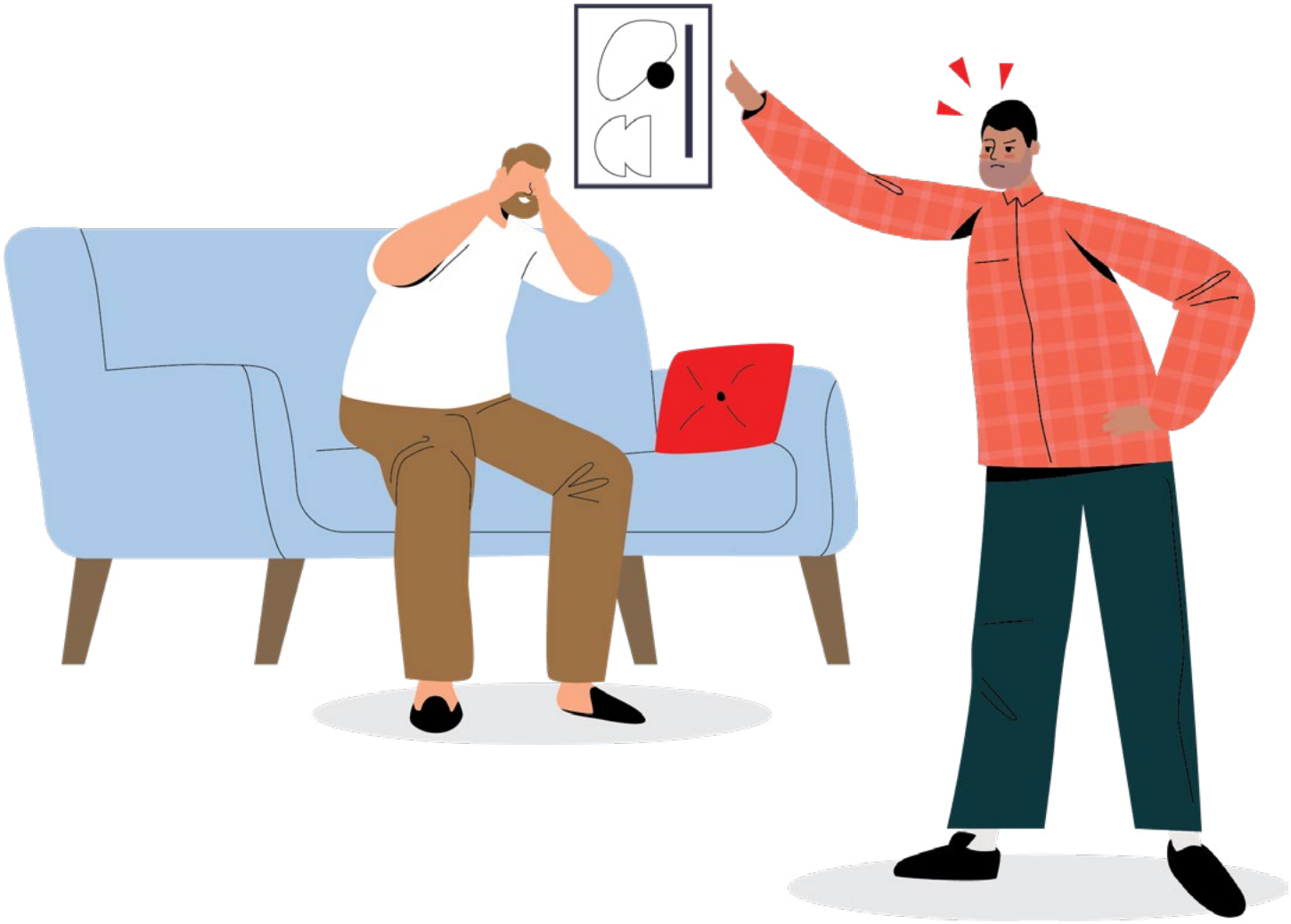
The report asked and answered 52 research questions using data from the six surveys. Details of the research questions, dataset, sample population and key findings are presented in the table below.

Title	Dataset	Sample	Key findings
Theme 1: Mental Health and Suicidality			
What factors are associated with access to professional mental health support and the perceived effectiveness of these services among LGBTQA+ young people with a need for mental healthcare?	*Writing Themselves In 4*	5,215 LGBTQA+ young people who may have required mental health support based on lifetime experiences of self-harm, suicidal ideation or suicide attempt.	More than four-fifths of young LGBTQA+ people reported having ever experienced suicidal ideation, attempted suicide or self-harmed. Among these young people with a mental health need, more than one-quarter had never accessed mental health support. Less than half of those who had accessed mental health support reported that this support helped to improve their mental health. Specific subpopulations were particularly disadvantaged in these domains, with cisgender men and those living outside of inner-city areas among the least likely young people to have accessed mental healthcare. Importantly, family support was a crucial determinant of young people's engagement and positive experiences with mental health services.
During the COVID-19 pandemic, which parts of the LGBTQA+ community were likely to prefer services specifically catering to LGBTQA+ people?	*Pride and Pandemic*	1,532 LGBTQA+ adults who may have required mental health support based on experiences of suicidal ideation or suicide attempt during the pandemic.	More than half of LGBTQA+ adults reported having experienced suicidal ideation and/or attempted suicide during the pandemic. One-quarter of these participants reported a preference for mental health services catered specifically to LGBTQA+ people compared to mainstream mental health services. Trans and gender diverse people, LGBTQA+ people living in rural/remote areas and those aged 25–34 were the most likely to report a preference for LGBTQA+-specific mental health services.

Title	Dataset	Sample	Key findings
What was the impact of COVID-19 lockdowns on the mental wellbeing of LGBTQA+ people?	*Pride and Pandemic*	3,135 LGBTQA+ adults.	Disproportionate effects of the pandemic were observed on the mental wellbeing of specific subpopulations of LGBTQA+ people, particularly among cisgender women, trans men, trans women and non-binary people, those living in outer-suburban or regional areas and those of younger age. The analyses further suggest that the impact of the pandemic on mental wellbeing was worsened by extended periods of lockdown in Victoria and New South Wales.
Is participation in LGBTQA+ events or activities associated with better subjective wellbeing and reduced psychological distress among trans and gender diverse adults?	*Private Lives 3*	1,488 trans and gender diverse adults	Participation in LGBTQA+ community events or social events may have protective effects against or reduce feelings of distress among trans and gender diverse individuals and contribute to improvements in their subjective sense of wellbeing. However, elevated levels of psychological distress were indicated among those who engaged with LGBTQA+ social media.
What factors are associated with seeking psychological support among LBQ+ women in the past five years?	*SWASH*	1,991 LBQ+ women who indicated ever having a need for mental healthcare based on lifetime experiences of suicidality or self-harm.	A high need for mental healthcare was observed among LBQ+ women. A very high rate of engagement with professional mental healthcare was also observed within this group. LBQ+ women who indicated a need for mental healthcare were most likely to have accessed professional mental health support if they spoke English at home and if they reported having a disability.
What are the predictors of psychological distress and suicidal ideation among GBQ+ cisgender men?	*Private Lives 3*	1,394 GBQ+ cisgender men.	High levels of psychological distress and experiences of suicidal ideation were associated with a combination of demographic factors and experiences of discrimination and social exclusion on the basis of sexual orientation. Interpersonal connection, including romantic relationships and connection to the LGBTQA+ community, appear to be protective of GBQ+ cisgender men's mental health. Inequalities for those living with a disability/long-term health condition were observed for both outcomes.
What factors are associated with recent non-suicidal self-injury (NSSI) among LGBTQA+ young people?	*Writing Themselves In 4*	5,964 LGBTQA+ young people who answered questions about NSSI engagement.	Both sexual and physical harassment were associated with recent NSSI engagement. The magnitude of these associations was roughly comparable between cisgender and trans and gender diverse participants. Physical harassment appeared to be the strongest non-demographic predictor of recent NSSI engagement. Attachment to one's school had a significant, protective effect against recent NSSI engagement.

Title	Dataset	Sample	Key findings
Theme 2: Income Inequality, Housing and Experiences of Homelessness			
What are the risk and protective factors associated with experiences of homelessness among LGBTQA+ adults?	*Private Lives 3*	6,052 LGBTQA+ adults who answered questions about their prior experiences of homelessness.	Lifetime experiences of homelessness were most prevalent among LGBTQA+ adults who are trans and gender diverse as well as cisgender women, and those who identify as bisexual, pansexual and queer. Both cisgender and trans and gender diverse individuals were found to experience a comparable profile of risk factors that conferred vulnerability to housing insecurity and homelessness. These factors include having a disability, prior experiences of violence from a family member or intimate partner and self-reported struggle with alcohol.
What are the risk and protective factors associated with experiences of homelessness among LGBTQA+ young people?	*Writing Themselves In 4*	6,114 LGBTQA+ young people who answered questions about experiences of homelessness.	Several demographic factors were associated with experiences of homelessness among LGBTQA+ young people. These included gender, sexual orientation and multicultural background. Homelessness was associated with experiencing physical, verbal and sexual harassment, and analyses point to a clustering effect of these factors on risk. These experiences inform pathways to homelessness and are also more likely to occur to homeless individuals.
What are the risk and protective factors associated with experiences of homelessness among trans and gender diverse young people?	Trans Pathways	859 trans and gender diverse young people.	Young trans and gender diverse people were found to face high rates of homelessness, this was especially true for those who are not supported by their family. The results also suggest the protective role that a supporting family can play in protecting young people from negative impacts of discrimination and harassment outside of the family.

Title	Dataset	Sample	Key findings
What are the schooling experiences of cisgender LGBQA+ young persons who experience homelessness? How do these impact their engagement with schooling?	*Writing Themselves In 4*	4,317 cisgender LGBQA+ young people who were enrolled in educational institutions at the time of participation or within 12 months prior.	Young LGBQA+ cisgender people with experiences of homelessness were more likely than those not reporting homelessness to have experienced physical and/or sexual harassment within education settings but their mental health was not more affected by bullying than other LGBQA+ youth. Instead, this group were more likely to respond to experiences of bullying by absenting themselves from schools. Therefore, homeless students' schooling experiences themselves may constitute an obstacle to school attendance.
Who among LGBTQA+ adults are most likely to be on low incomes and what factors are associated with reporting a low-income level?	*Private Lives 3*	5,521 LGBTQA+ adults who reported their weekly income bracket.	Low income was defined as an average pre-tax weekly income of $0–$799 based on criteria to qualify and retain eligibility for Low Income Health Care Card. Cisgender women and trans and gender diverse adults were the most likely of LGBTQA+ adults to report a low income, as were those who identified as a sexual orientation other than gay or lesbian. Income inequality is not implicitly linked to sexual orientation or gender; rather, this is likely the result of systemic forms of discrimination that confer barriers to workforce participation and access to well-paid job opportunities for people of diverse sexual orientations and genders. The findings further demonstrate the geographical maldistribution of well-paid job opportunities and impacts of disability on financial security among LGBTQA+ adults.
Theme 3: Discrimination and Abuse			
Findings relating to discrimination and abuse have been the subject of numerous papers already published from these datasets or are reported on as key issues shaping health outcomes in other chapters of this report. As such, this section details the key findings from previously published research relating to discrimination and abuse but does not present any new analyses relating to discrimination and abuse.			



Title	Dataset	Sample	Key findings
Theme 4: Family Violence and Sexual Assault			
What are GBQ+ cisgender adult men's experiences surrounding family of origin violence and intimate partner violence?	*Private Lives 3*	2,125 GBQ+ cisgender men, and 2,711 LBQ+ cisgender women for comparison.	A high rate of family violence was observed among GBQ+ cisgender men. Among those who had experienced either family of origin or intimate partner violence, 23.3% indicated that they had disclosed this experience to someone compared to 28.5% of LBQ+ cisgender women. While interactions with healthcare providers provide a crucial opportunity for GBQ+ cisgender men to disclose their experiences of family and/or intimate partner violence, GBQ+ cisgender men may only feel comfortable disclosing experiences of violence to healthcare providers with whom some degree of rapport has previously been established.
How is the prevalence of intimate partner violence distributed across subgroups of LBQ+ women, and who perpetrates intimate partner violence against this population??	*SWASH*	2,621 LBQ+ women.	Among LBQ+ women, those who identify with a bi+ identity and those with a disability were the subpopulations most likely to experience intimate partner violence. Cisgender men were identified as the largest group of intimate partner violence perpetrators, followed by cisgender women. A small minority of participants identified the persons using violence against them as non-cisgender.

Title	Dataset	Sample	Key findings
Were high rates of family violence exacerbated by COVID-19 lockdowns among LGBTQA+ adults?	*Pride and Pandemic*	3,135 LGBTQA+ adults.	A high proportion of LGBTQA+ adults experienced violence from family members and intimate partners during the pandemic. These experiences were reported at higher rates by specific subpopulations. Most notably, violence from family members as well as worsening violence from family members during the pandemic were most frequently reported among trans and gender diverse adults, and intimate partner violence highest among people from Asian or ethnicities other than White. However, experiences of violence from an intimate partner or family member were not found to be impacted by extended periods lockdowns (i.e. among participants in Victoria/NSW compared to those residing in other states/territories). Many facets of the COVID-19 pandemic, such as loss of employment and housing, returning home to live with unsupportive family and longer time spent with abusers due to self-isolation would likely have exacerbated experiences of family violence, even in those states/territories without extended periods of lockdowns.
What factors are associated with LGBTQA+ individuals reporting their most recent experience of family violence and are they feeling supported when they report?	*Private Lives 3*	4,607 LGBTQA+ adults who had ever experienced either intimate partner violence or family of origin violence.	Only one-quarter of LGBTQA+ adults who had experienced some form of family of origin violence had reported their most recent experience of violence to someone. Similar rates of reporting were found across all genders with the exception of non-binary participants who were more likely to have reported their most recent experience of family violence. The analyses also reveal a significant socio-economic component to victim-survivors' opportunities for reporting abuse. Importantly, the higher likelihood of participants with regular GPs to report experiences of abuse suggest that primary care physicians can play a significant role in supporting LGBTQA+ victim-survivors' engagement in support.
What is the prevalence of sexual assault and poor mental health among bi+ cisgender women, and what are the associations between these two experiences?	*Private Lives 3*	1,439 bisexual (n = 876), queer (n = 338) and pansexual (n = 225) cisgender women.	Sexual abuse within heterosexual-presenting intimate partnerships and casual sexual encounters are high prevalence experiences for bi+ cisgender women. Experiences of sexual abuse were significantly associated with negative mental health outcomes (psychological distress, suicidal ideation and suicide attempts). The negative mental health consequences of experiencing sexual abuse for bi+ cisgender women may be underscored by low levels of support from their monosexual (i.e. attracted to one gender) peers.

Title	Dataset	Sample	Key findings
Theme 5: Alcohol and Other Drugs			
Which LBQ+ women are currently smoking?	*SWASH*	2,621 LBQ+ women.	Higher rates of smoking were reported among LBQ+ women who had ever used drugs, ever felt concern about their drug use or felt concern about their alcohol use in the last 12 months.
Which LBQ+ women are currently vaping?	*SWASH*	2,621 LBQ+ women, including 383 participants who answered a question about desire to quit smoking.	The prevalence of reported vape use was highest among younger age cohorts. Vape use was also associated with high levels of psychological distress, in addition to previous drug and alcohol use. Among LBQ+ women who were currently cigarette smokers, vape use was significantly associated with a desire for smoking cessation.
What demographic factors and social experiences are associated with self-perceived problematic alcohol consumption among LGBTQA+ adults?	*Private Lives 3*	5,851 LGBTQA+ adults who reported any alcohol consumption.	Self-reported alcohol struggle differed across various intersections of the LGBTQA+ adult population. Adults were at a greater likelihood of struggling with alcohol consumption if they had been sexually assaulted in the past 12 months or had been treated unfairly based on their sexual orientation or gender identity in the past 12 months. Struggling with alcohol was also associated with greater indicated psychological distress, lifetime experience of homelessness, being born in an English-speaking country (Australia or other), and inner-suburban residential location.

Title	Dataset	Sample	Key findings
Among LGBTQA+ adults, who is most likely to indicate a preference for community-controlled or mainstream alcohol support services?	*Private Lives 3*	3,587 LGBTQA+ adults who expressed a preference for the type of service they would choose to access alcohol support from should they ever need it.	Almost one-fifth of LGBTQA+ adults who held a preference for alcohol support service provider expressed a preference for a service that catered specifically to LGBTQA+ people. A further 55% held a preference for a service that is mainstream but known to be inclusive of LGBTQA+ people. Preference for LGBTQA+-specific services, compared to mainstream services (whether or not they are known to be LGBTQA+-inclusive), differed across the population, with those more likely to prefer specific services being trans or gender diverse and aged 25-44 years old.
What are the patterns of drug use among LGBTQA+ adults and how are they associated with health and wellbeing outcomes?	*Private Lives 3*	6,835 LGBTQA+ adults.	Four distinct typologies of alcohol and other illicit drug (AOD) risk were identified: No AOD risk (13.3% of the sample), low AOD risk (15.1% of the sample), moderate AOD risk (30.1% of the sample) and moderate alcohol-only risk (41.5% of the sample). Non-uniform AOD risk and further associated harms were observed across LGBTQA+ adult subpopulations. Higher odds of reporting sexual assault were observed within the moderate AOD risk group. The lowest odds of experiencing verbal abuse, harassment, and physical threats were observed within the moderate alcohol-only risk group. Trans or gender-diverse individuals were most likely to belong to the 'no risk' and 'low risk' classes.
What are the risk and protective factors of substance use among trans and gender diverse young people?	Trans Pathways	702 trans and gender diverse young people who responded to questions regarding past six-month smoking, alcohol or illicit drug use.	Trans and gender diverse young people were more likely to report recent smoking if they had experienced discrimination, intimate partner violence, peer rejection, or lack of family support. Supportive friends and family therefore play a critical role in trans and gender diverse young people's coping and mental wellbeing. Experiences of discrimination and intimate partner violence were both additionally associated with recent alcohol and illicit drug use. Alcohol, smoking and other drug use may serve as a way of coping or managing the stress resulting from these negative experiences.
What is the prevalence and correlates of co-occurring mental ill-health and substance use among trans young people?	Trans Pathways	845 trans and gender diverse young people who completed questions regarding mental health, suicidality and self-harm, and 702 trans and gender diverse young people who completed questions regarding recent AOD or tobacco use.	Most trans and gender diverse young people who had ever received a substance use disorder diagnosis reported a comorbid psychiatric disorder diagnosis. Most of those who had recently used alcohol and/or other drugs alone also reported comorbid mental health diagnosis. Trans and gender diverse young people who had experienced bullying, discrimination, intimate partner violence, peer rejection, and/or lack of family support were at increased risk of experiencing negative mental health outcomes (such as depression, anxiety, self-harm desires/behaviour and suicidal thoughts/attempts) in co-occurrence with smoking, alcohol use, and/or illicit drug use.

Title	Dataset	Sample	Key findings
Theme 6: Relationships, parenting and Sexual and Reproductive Health			
What is the impact of heterosexism, stigma and financial cost on parenting desires among LGBTQA+ people in Australia?	*Private Lives 3*	3,421 LGBTQA+ adults who indicated a desire to have children or were uncertain about having children and were aged <45 years	Negative experiences of broader society, such as distress felt during the marriage equality debate and unfair treatment due to sexuality or gender identity, were associated with reported barriers to having children. Positive experiences with others, such as acceptance from family, were associated with a lower likelihood of expressing these barriers.
Are LBQ+ women who should be seeking STI and HIV testing, getting tested?	*SWASH*	2,319 LBQ+ women who indicated they were sexually active.	A high proportion of LBQ+ women reported having ever had sex with a man who has sex with men. These women were more likely to have ever accessed both STI and HIV screening. LBQ+ women are evidently proactive about their sexual health screening.
How does participation in cervical cancer screening vary among LGBTQA+ individuals? What factors are associated with screening participation?	*Private Lives 3*	2,424 LGBTQA+ people who are likely to require cervical screening, including cisgender women, trans men or non-binary people with a birth registered sex as female and aged 25-74 years old.	Trans men, lesbian/gay-identifying and asexual-identifying adults were the least likely to have accessed cervical screening. These findings likely reflect concerns with the intimate and gendered nature of the procedure, as well as possible misconceptions regarding how HPV is spread and the need for cervical screening. LGBTQA+ people were more likely to have had a cervical screen if they attended a regular GP, reported that their GP was aware of the sexual or gender identity or had attended an LGBTQA+-inclusive or LGBTQA+-specific health service in the past 12 months. The findings suggest the importance of affirming and trusting healthcare relationships.

Title	Dataset	Sample	Key findings
Theme 7: Gender Affirmation and Trans Affirming Practices			
What mental health and wellbeing outcomes are associated with access to medical and legal gender affirmation among trans and gender diverse adults?	*Private Lives 3*	1,359 trans and gender diverse adults.	Only one-third of trans and gender diverse adults felt they could easily access gender affirming care. Non-binary people who wanted to access gender affirming care reported greater difficulty accessing it than trans men and women. Compared to binary trans people, non-binary people were more likely to want to access hormone therapies but had not been able to. Having affirmed one's gender via medical or legal processes were both associated with reduced distress and increased likelihood of experiencing gender euphoria.
Does gender euphoria act as a protective factor against mental ill-health among trans and gender diverse adults?	*Private Lives 3*	1,359 trans and gender diverse adults.	Under one-quarter of trans and gender diverse adults reported currently experiencing gender euphoria, while 30.9% had never experienced it. Those who reported past, but not current, experiences of euphoria reported similar levels of mental health and suicidal ideation to those who had never experienced euphoria. Immediate improvements in mental wellbeing may therefore be, in part, contingent upon the temporal presence of gender euphoria.

Title	Dataset	Sample	Key findings
What mental health and wellbeing outcomes are associated with access to social, medical, and legal gender affirmation among trans and gender diverse young people?	*Writing Themselves In 4*	1,411 trans and gender diverse young people.	Having affirmed one's gender legally or medically were factors associated with positive subjective mental wellbeing and lower levels of psychological distress for trans and gender diverse young people. No associations were observed between social gender affirmation and mental wellbeing variables. While increased likelihood of drug use among trans and gender diverse youth who have affirmed their gender may be interpreted as a coping mechanism for those experiencing stigma or other challenges, it may also reflect involvement in community sub-groups where drug use is normalised.
How do trans and gender diverse young people affirm their identity and imagine their future?	*Writing Themselves In 4*	1,483 trans and gender diverse young people.	Seeing trans and gender diverse young people flourish is contingent on their abilities to undertake autonomous processes of gender exploration and have access to opportunities to shape their own futures. This involves ensuring they have access to safe, affirming spaces (school, workplace, home, broader society), accessible medical care (including trans affirming practices in mainstream medical care as well as access to surgical/hormonal intervention to facilitate gender exploration and embodiment), and the broader radical acceptance and normalisation of all forms of identification and expression.
Is feeling supported to affirm gender associated with better health and wellbeing outcomes among trans and gender diverse young people?	*Writing Themselves In 4*	1,697 trans and gender diverse young people.	Trans and gender diverse youth who are supported to affirm their gender in ways that are meaningful to them, whether medically, legally or socially, had considerably better wellbeing outcomes. Feeling supported to affirm their gender resulted in less suicidality, less mental health concerns and greater happiness. Those who felt supported to affirm their gender were also less likely to experience homelessness and less likely to be subject to verbal harassment in the past 12 months.
What are trans and gender diverse young people's positive experiences of their gender identities?	Trans Pathways	386 trans and gender diverse young people.	Trans and gender diverse young people conceptualise their experiences of gender identity in a plurality of ways. Most young people could identify and articulate positive elements of their experiences as a trans and gender diverse young person, and these positive aspects ostensibly facilitated feelings of pride and self-acceptance among some respondents. For a minority of respondents, however, their experience surrounding their gender identity seemed inextricably tied to concurrent experiences of stigma and prejudice. Accordingly, several respondents were insistent that there were no positive aspects of their gender identity.

Title	Dataset	Sample	Key findings
Theme 8: General Healthcare			
Do LGBTQA+ adults feel that their sexual and gender identities are respected while accessing healthcare services, and is respect within services associated with health and wellbeing outcomes?	*Private Lives 3*	6,829 LGBTQA+ adults.	LGBTQA+ adults demonstrated clear preferences for either mainstream healthcare services with a reputation for LGBTQA+ inclusivity, or population-specific services. They were also more likely to want to use a service if it had received a formal accreditation for working with LGBTQA+ patients. However, participants largely utilised mainstream services with no reputation of LGBTQA+ inclusivity. This likely reflects the constrained availability of both population-specific services, as well as mainstream services that were known to be LGBTQA+-inclusive. Those who had attended a service that was either LGBTQA+-specific or mainstream inclusive service were more likely to feel that their sexual orientation or gender identity had been respected within that setting, compared to those who attended a mainstream clinic that was not known to be inclusive.
What is the influence of care continuity and disclosure of sexual orientation in general practice on LBQ+ cisgender women's engagement with mental health services?	*Private Lives 3*	2,707 LBQ+ cisgender women.	Having accessed mental health services was associated with having a regular GP. Younger LBQ+ cisgender women aged 18-25 had the lowest odds of having a regular GP. Having accessed services catering specifically to LGBTQA+ populations was reported more frequently among those whose GPs knew about their sexual orientation. Barriers to disclosure of sexual orientation in general practice are therefore likely conferring barriers to appropriate forms of mental health support for specific subpopulations of LBQ+ cisgender women.

Title	Dataset	Sample	Key findings
Theme 9: Aboriginal and Torres Strait Islander People			
What factors contribute to Aboriginal and Torres Strait Islander LGBTQA+ young people's social and emotional wellbeing (SEWB)?	Walkern Katatdjin	590 Aboriginal and Torres Strait Islander LGBTQA+ people aged 14-25 years.	Acceptance of LGBTQA+ identity from parents, community, and pride in Aboriginal and Torres Strait Islander heritage positively impact the social and emotional wellbeing (SEWB) of Aboriginal and Torres Strait Islander LGBTQA+ young people. SEWB interventions should build on these strengths, while consideration of Aboriginal and Torres Strait Islander LGBTQA+ young people's health using the SEWB framework can help to centre an Indigenous perspective and ensure that research and policy about Aboriginal and Torres Strait Islander LGBTQA+ people address the indicators of health that are significant to them. Acceptance of LGBTQA+ identity from Elders is significant to several culturally based SEWB outcomes and should be facilitated in programs that seek to increase young people's sense of connection to Culture or community.

Title	Dataset	Sample	Key findings
How do racist and cisheterosexist microaggressions impact Aboriginal and Torres Strait Islander LGBTQA+ young people's social and emotional wellbeing?	Walkern Katatdjin	590 Aboriginal and Torres Strait Islander LGBTQA+ people aged 14-25 years.	Discrimination within Aboriginal and Torres Strait Islander Community negatively affects the SEWB of Indigenous LGBTQA+ young people. While some positive associations between wellbeing and racism in the context of romantic relationships were unexpected, this finding should not condone relationship racism, but points to the complexity of intersectional identities. Community-owned interventions are needed to improve capacity within these communities to support Aboriginal and Torres Strait Islander LGBTQA+ youth.
What key factors are associated with mental health outcomes among Aboriginal and Torres Strait Islander LGBTQA+ adults, and how do their mental health and experiences of harassment compare those of non-Indigenous LGBTQA+ adults?	*Private Lives 3*	183 Aboriginal and Torres Strait Islander LGBTQA+ adults.	Aboriginal and Torres Strait Islander LGBTQA+ individuals face even higher rates of poor mental health outcomes than their non-Indigenous peers, including higher levels of psychological distress, suicidal ideation, and suicide attempts. High rates of harassment towards this group contributes to these challenges, emphasising the need for targeted efforts to prevent abuse and improve cultural safety in mental health services
What key factors are associated with mental health outcomes among Aboriginal and Torres Strait Islander LGBTQA+ young people, and how do their mental health and experiences of harassment compare those of non-Indigenous LGBTQA+ young people?	*Writing Themselves In 4*	256 Aboriginal and Torres Strait Islander LGBTQA+ young people.	Aboriginal and Torres Strait Islander LGBTQA+ youth experience alarmingly high rates of poor mental health, including suicidal ideation, self-harm, as well as verbal, physical and sexual assault. These experiences of assault were associated with increased risk of recent suicidality or self-harm. Feeling a part of their school was associated with a lower likelihood of suicide attempt and self-harm. It is crucial that all education settings are spaces within which Aboriginal and Torres Strait Islander LGBTQA+ youth feel their identity is affirmed and are able to feel connected. Culturally appropriate mental health support and prevention of harassment are also crucial for these youth.
How do cisgender and trans and gender diverse Aboriginal and Torres Strait Islander LGBTQA+ young people differ in terms of mental health, social and emotional wellbeing, and experiences of services?	Walkern Katatdjin	590 Aboriginal and Torres Strait Islander LGBTQA+ people aged 14-25 years.	Trans and gender diverse Aboriginal and Torres Strait Islander youth faced higher risks of psychological distress and lifetime suicide attempts than their cisgender sexuality-diverse peers. Trans and gender diverse people also experienced more cisheterosexism from within the Aboriginal and Torres Strait Islander community, as well as less time spent participating in cultural practices, and lower Connection to Mind and Emotions, Connection to Family and Kinship, and Connection to Body. They also report poorer experiences at ACCHOs and general health services. However, their Aboriginal and LGBTQA+ identity is more important to their sense of self, as shown through their greater Identity Centrality. These young people may struggle to participate in cultural practices due to prejudice in the community, or because of poorer family relationships. Trans and gender diverse Aboriginal and Torres Strait Islander youth require greater support and more targeted interventions for their mental health and social and emotional wellbeing.

Title	Dataset	Sample	Key findings
Theme 10: Intersectional Identities			
People with a disability			
What are the health and wellbeing outcomes among LGBTQA+ young people with disability?	*Writing Themselves In 4*	5,438 LGBTQA+ young people who answered questions about their disability status.	LGBTQA+ individuals with disability had higher odds of experiencing poor health-related outcomes than their LGBTQA+ counterparts without disability. The strength of these associations was particularly pronounced for psychological health and wellbeing outcomes. While still significant, associations between disability status and drug and tobacco use were comparatively modest. The burden of most of these outcomes disproportionately affected individuals with an intellectual disability.

Title	Dataset	Sample	Key findings
Do LGBTQA+ young people with disabilities who feel safe and connected within community experience better mental health and wellbeing outcomes?	*Writing Themselves In 4*	2,453 LGBTQA+ young people who reported having a disability.	All domains of perceived inclusion were significantly associated with positive mental health and wellbeing outcomes. Inclusion within community settings exerted a particularly noticeable, protective effect. Acceptance amongst one's peers with disability appeared to be the most important domain of inclusion, for which higher subjective happiness scores and lower frequency of reporting negative mental health outcomes were observed.
What factors are associated with experiences of harassment or abuse among LGBTQA+ young people with disability?	*Writing Themselves In 4*	2,500 LGBTQA+ young people who reported having a disability.	Rates of verbal, physical and sexual harassment among LGBTQA+ young people with disability were high. Various factors were associated with an even greater risk of experiencing these forms of harassment. Gender was associated with all forms of harassment, with trans men and trans women reporting the worst outcomes. Additionally, those with an intellectual, physical or sensory disability were more likely to have experienced harassment. Concerningly, young LGBTQA+ people with disability who had disclosed their LGBTQA+ identity to most or all of their family were more likely to report verbal harassment. Young people who are out to their family are likely to be more visible in broader society too and consequently subject to discrimination and harassment due to their LGBTQA+ identity.
Race and ethnicity			
What are racially-minoritised LGBTQA+ individuals' experiences of unfair treatment, and protective factors against psychological distress?	*Private Lives 3*	6,052 LGBTQA+ adults who answered questions about their race and ethnicity.	Racially-minoritised LGBTQA+ individuals differ significantly from white European LGBTQA+ individuals in terms of the challenges that they encounter in everyday life. Participants' racial minority identities may supersede sexual minority identity in terms of visibility, as the LGBTQA+ individual is often implicitly racialised as white. Racially-minoritised LGBTQA+ individuals were more likely to report unfair treatment attributed to their race or ethnicity, compared to white European participants, but less likely to report unfair treatment due to sexual or gender identity.
Residential location			
How does LGBTQA+ adults' mental health and wellbeing differ by residential location?	*Private Lives 3*	5,174 cisgender LGBQA+ adults and 1,466 trans and gender diverse adults.	Residential location was associated with mental health outcomes among cisgender LGBQA+ adults, with those living in outer-suburban areas, regional cities or towns and rural or remote areas faring worse than those who are living in inner-suburban areas. Residential location was also associated with community connection for both cisgender and trans and gender diverse participants. Residential location may shape affiliation, access to, and involvement with LGBTQA+ community groups, events, organisations, and services. Trans and gender diverse people living in inner-suburban areas were the most likely to express that their local community had affirmed their gender in supportive ways.

Title	Dataset	Sample	Key findings
How is residential location associated with health and wellbeing outcomes among LGBTQA+ youth?	*Writing Themselves In 4*	4,556 cisgender LGBQA+ young people and 1,697 trans and gender diverse young people.	Residential location was associated with mental health outcomes for LGBTQA+ cisgender young people, with those living in rural and remote areas faring worse than those in the outer-suburban or inner-city areas. Cisgender youth were happiest living in inner-suburban areas, and trans and gender diverse youth were unhappiest living in rural or remote areas. Residential location was additionally associated with experiences of harassment among cisgender young people, with the experiences of verbal and physical harassment found most frequently in rural and remote areas, and highest sexual assault in inner-suburban areas. These experiences did not differ by area for trans and gender diverse young people, who may be experiencing high rates of harassment regardless of residential location. LGBTQA+ cisgender young people were particularly vulnerable to experiencing homelessness when living in regional towns and rural and remote areas. This finding may suggest greater experiences of family rejection in these regions resulting in young people needing to leave their homes.
Intersections of sexual orientation and gender			
What do we know about the health and wellbeing needs and experiences of asexual LGBTQA+ adults?	*Private Lives 3*	6,815 LGBTQA+ adults who answered questions about their sexual identity.	Asexual identified adults within the sample were of younger age, mostly cisgender women or trans or gender diverse, and were less likely to be in a committed relationship. No mental health differences between asexual and non-asexual participants were observed, with the exception of a lower likelihood among asexual participants to have ever attempted suicide. However, asexual participants were less likely to feel connected to or participate in the LGBTQA+ community, and less likely to feel that their sexual identity was respected in a mainstream healthcare service that is not known to be LGBTQA+-inclusive.
What is the role of relationship status and gender of relationship partner in shaping health and wellbeing outcomes among bi+ cisgender adults?	*Private Lives 3*	1,261 bi+ cisgender adults who reported on their relationship status.	Bi+ cisgender women in an opposite-gender relationship indicated higher psychological distress than those in same-gender relationships. Additionally, bi+ cisgender women in opposite-gender relationships reported greater distress than bi+ cisgender men in opposite-gender relationships, but these differences were not observed in the context of same-gender relationships. bi+ cisgender women in same-gender relationships similarly experienced less suicidal ideation and less anxiety. Relationship orientation was also associated with lifetime experiences of homelessness for both cisgender men and women. Single bi+ cisgender women were most likely to have ever experienced homelessness, while bi+ cisgender men in a same-gender relationship were most likely to have ever experienced homelessness.

Title	Dataset	Sample	Key findings
Ageing populations			
How do older LGBTQA+ adults differ from younger cohorts in terms of loneliness, LGBTQA+ community belonging and number of friends?	*Private Lives 3*	6,835 LGBTQA+ adults, including 223 participants aged 65 or older.	Older adults within our sample appeared less likely than younger cohorts to report feelings of loneliness, and generally had a greater number of close friends. This may reflect the preeminent role of community connectedness as a means of navigating the societal and institutional discriminations of yesteryear. Less loneliness was associated with a greater number of close friends, and feelings of belonging to the LGBTQA+ community. Greater loneliness was associated with experiencing unfair treatment due to one's sexual and/or gender identity.
What are older LGBTQA+ adults engagement with and experiences within healthcare settings and what are their preferences for service provider?	*Private Lives 3*	6,835 LGBTQA+ adults, including 223 participants aged 65 or older.	LGBTQA+ older adults clearly regarded LGBTQA+ inclusivity as an important factor in decisions about healthcare service utilisation. LGBTQA+ older adults were more likely than their younger counterparts to report accessing a mainstream medical service that had a reputation for LGBTQA+ inclusivity. Compared to their younger counterparts, LGBTQA+ older adults were also more likely to report that their sexual orientation was respected by health providers in mainstream medical services that had no reputation for LGBTQA+ inclusivity. This perhaps relates to differing identities expressed or disclosed by these cohorts or even a greater tolerance for discrimination and disrespect due to a greater history of these experiences.
What is the role of connection to community in shaping mental health outcomes among LGBTQA+ older adults?	*Private Lives 3*	223 LGBTQA+ older adults aged 65 and older.	High levels of psychological distress and recent suicidal ideation were indicated the most frequently among trans and gender diverse older adults. Those who recently experienced unfair treatment due to sexual orientation and/or gender identity more frequently indicated high psychological distress and recent suicidal ideation. Feelings of belonging to the LGBTQA+ community exerted a protective effect against psychological distress but not suicidal ideation. High or very high psychological distress was further indicated more frequently among individuals residing within outer suburban areas – these LGBTQA+ older adults may be uniquely disadvantaged in terms of access to community ties or social relationships that buffer against psychological distress (i.e. outside both metropolitan centres of LGBTQA+ community and the close community relationships associated with rural and regional locales).

1. ABOUT THE REPORT

While LGBTQA+ communities in high income nations have won significant social and legal rights in recent decades, the health disparities associated with the marginalisation of sexual and gender minority persons have largely persisted – and in some instances, have even widened.[1 2 3 4 5]

It is therefore imperative that the drivers of health and wellbeing within LGBTQA+ populations are critically re-examined, and that the resultant findings steer policy interventions to minimise social inequity and inequality relating to health.[1] The *Rainbow Realities* report aims to provide a synthesis of pre-existing research as well as over 50 new analyses derived from the findings of six surveys of LGBTQA+ populations in Australia. These surveys include:

Private Lives 3: the largest national survey of the health and wellbeing of 6,835 LGBTQ+ adults in Australia aged 18 years or older.

- ***Writing Themselves In 4:*** the largest national survey of the health and wellbeing of LGBTQA+ young people in Australia aged 14-21 years.
- ***The SWASH Survey:*** a long-running biennial survey of health issues relevant to lesbian, bisexual, queer and other non-heterosexual identifying (LBQ+) women (both cisgender and trans) living in Sydney aged 16 years and older.
- ***Trans Pathways:*** the largest national survey with a specific focus on the mental health and care pathways of 859 trans and gender diverse young people in Australia aged 14-26 years.
- ***Walkern Katatdjin (Rainbow Knowledge):*** the first national survey to focus on the health and wellbeing of Aboriginal and Torres Strait Islander LGBTQA+ young people in Australia. The dataset includes 619 Aboriginal and Torres Strait Islander LGBTQA+ young people aged 14-25 years from across Australia.
- ***Pride and Pandemic:*** a cross-sectional exploration of the experiences of 3,135 LGBTQA+ adults aged 18 and over in Australia during the COVID-19 pandemic, with a focus on experiences of mental health and wellbeing during the pandemic.

1.1 Thematic focus of the chapters

The analyses included in this report examine a wide range of health concerns, challenges and experiences that underpin LGBTQA+ health and wellbeing while also investigating the prevalence and impact of health-enabling factors within these populations and communities.

The intended purpose of this report is to both consolidate recent evidence, and to generate new knowledge specific to the Australian context. This report will inform the forthcoming 10-Year National Action Plan for the Health and Wellbeing of LGBTQA+ People (currently being led by the Department of Health and Aged Care in partnership with the community), state-level policy strategies, as well as other initiatives or interventions intended to improve health outcomes among LGBTQA+ communities and individuals. The research presented in the report highlights specific areas of concern or need within the LGBTQA+ community, identifies gaps in the available data and provides direction to guide future research and data collection within this population.

Both pre-existing evidence and new analyses have been thematically organised into 10 chapters:

- Mental Health and Suicidality
- Income Inequality, Housing and Experiences of Homelessness
- Discrimination and Abuse
- Family Violence and Sexual Assault
- Alcohol and Other Drugs
- Relationships, Parenting and Sexual and Reproductive Health
- Gender Affirmation and Trans-affirming Practices
- General Healthcare
- Aboriginal and Torres Strait Islander People
- Intersectional Communities

A myriad of factors contribute to both positive experiences and health challenges in LGBTQA+ populations. Given the relatedness of many of the outcomes – for example, the association between experiences of abuse and poorer mental health, or disparities in discrimination and abuse among LGBTQA+ people with a disability – these themes are not entirely siloed according to their designated chapters and the analyses reported may cross multiple themes.

1.1.1 Intersectionality

Theme 9 is dedicated specifically to LGBTQA+ Aboriginal and Torres Strait Islander LGBTQA+ people and presents findings relevant to the health-themed chapters for this population.

Similarly, Theme 10: Intersectional Communities draws on data relevant to the health-themed chapters but is intended to dedicate specific attention to groups which are underserved and/or marginalised, and often overlooked in population-level research. It focuses on intersections and intersectional experiences of groups that were identified as priority populations during consultation for the report:

- People from a multicultural background
- People with disability
- Intersections of sexual orientation and gender
- Residential location
- Ageing populations

1.2 Chapter format

Each chapter begins with a brief overview of key existing research, including basic descriptive data of the frequency and proportions of health outcomes within the data samples, and an overview of published peer-reviewed research based on findings from each of the surveys. Links are provided to freely access these journal articles where available.

New, analyses are then presented as a research question. With each research question, we report the rationale for the analysis, details of the sample and dataset, details of the variables used and analyses conducted, key findings from the analyses, and a summary and implications of the findings. Research questions were developed through gaps in the existing literature and consultation with the LGBTIQ+ Health Australia full members. The number of new analyses presented in each chapter is dependent on the available data and on how much published research already exists. In the Discrimination and Abuse chapter, no new analyses are presented; however, across the studies, the authors collectively have previously published six papers relating to discrimination and abuse, and experiences of discrimination and abuse are shown to shape a range of health outcomes in other chapters of this report.

Each chapter ends with a summary of all the findings and their implications.

The chapter on Aboriginal and Torres Strait Islander People follows a slightly different format. The amount of data from the studies that has been previously published for this population is very limited. As such, this chapter provides key descriptive findings from the surveys, followed by new analyses in the format described above.

1.3 Analysis and catergorisation of the data

Various statistical methods were employed across the analyses presented in this report. The statistical methods are briefly described for each new analysis in the relevant chapters. For ease of reading and interpreting the findings, only meaningful or statistically significant outcomes are presented (a cut-off p-value of 0.05 was used). The results of the analyses are presented in tables in the key findings sections. Statistics presented throughout the report may include the following:

- Sample or group size, including number of participants (n) and proportions (%).

- Odds ratios (OR) and 95% confidence intervals (CI) when presenting the results of a univariable logistic regression. Univariable logistic regression analyses are used to determine whether there is an association between two variables and are often used to determine the population burden of an outcome (e.g., which sexual orientation may be most likely to report a specific outcome).
- Adjusted odds ratios (AOR) and CI when presenting the results of a multivariable logistic regression that controls for the confounding impacts of other variables. Multivariable logistic regressions explore the association between multiple predictor variables an outcome variable, this may be used to explore patterns of risk and protective factors that influence an outcome or to explore the effect of a specific predictor variable on an outcome while controlling for the confounding effects of other variables, typically sociodemographic factors.
- Beta coefficient (β) and CI when presenting the results of a linear regression. Linear regressions are used to explore associations between variables when the outcome is a continuous variable, such as psychological distress scores or happiness scores.
- Chi-square ($\chi 2$) and degrees of freedom (df) when reporting the results of a chi-square analysis. Chi-square analyses are used to determine whether there is a statistically significant difference between groups on a particular outcome.
- P-values (p). The p-value is used as a means of determining statistical significance. Only results with a p-value < 0.05 are reported.
- Where variables used in a regression analysis contain more than two categories, the reference category is reported next to the variable name in the table. All other categories within these variables are compared to the reference category.

2. ABOUT THE SURVEYS

Data used in the analyses presented in this report were collected through six different surveys, each focusing on different segments of the LGBTQA+ population.

The responses collected through these surveys presents a 'snapshot' of each participants' lived experiences at a specific point in time and no causal inferences can be made from the analyses. To better understand the findings presented in this report, it is also important to understand the kinds of questions asked in these surveys, the individuals who participated in them, and the prevailing social climate – as well as any other factors that might have some influence on the responses which these individuals provided. The current chapter therefore aims to provide some of this much-needed context by: (i) describing these surveys, (ii) the design process undertaken in formulating these surveys, (iii) recruitment strategies, (iv) specific contextual events (e.g., COVID-19-relate stay-at-home orders, the 2017 Australian marriage plebiscite, etc.), as well as (v) the demographic characteristics of each sample population.

2.1 *Private Lives 3*

Private Lives 3 is Australia's largest national survey of the health and wellbeing of LGBTQA+ Adults and was conducted by the Australian Research Centre in Sex, Health and Society (ARCSHS). The third iteration of a series of surveys which began in 2005, *Private Lives 3* aimed to generate vital information for researchers, health professionals, service providers, community organisations and governments to better understand and support the health and wellbeing of LGBTQA+ persons in Australia. The *Private Lives 3* survey was hosted on an online domain using the Qualtrics survey engine. The survey consisted primarily of multiple-choice quantitative question items, with a small handful of open-ended qualitative questions. For more detailed information relating to *Private Lives 3*, please refer to the full published report.

Survey Design and Consultation

The questionnaire for *Private Lives 3* was designed in extensive consultation with several advisory bodies and key stakeholders, these collaborators provided crucial expertise, support and feedback on survey design, recruitment and data interpretation. Questions included in the survey were formulated with assistance from an expert advisory group that was comprised of representatives from across a variety of states and territories as well as different segments of the LGBTQA community. To ensure that the survey accurately captured the gender diversity inherent within these communities, a gender advisory board was also formed to guide the development of measures that maximised the inclusion of broad range of gender identities.

Recruitment

Eligibility criteria for participation in *Private Lives 3* was as follows – participants had to be: (i) aged 18 years or older, (ii) identify as LGBTQA+ and (iii) reside in Australia or an Australian territory. Recruitment for *Private Lives 3* participants relied heavily on social networking sites and other social media, with most participants (86.8%, n = 5,879) stating that they responded to paid targeted advertisements on Facebook. In comparison, 7.6% (n = 515) reported accessing the survey through an LGBTQA+ community organisation and 6.1% (n = 415) through word of mouth. Many LGBTQA+ community organisations and their staff also promoted the survey through Facebook and other forms of social media. All survey respondents participated in the survey online.

Timing

Private Lives 3 was launched on 24th July 2019 and closed on 1st October 2019. This was slightly over a year after the Australian Marriage Equality Postal Survey – which took place over the latter months of 2017. The plebiscite ultimately resulted in the enshrining of same-sex marriage in federal law. However, this was also accompanied by a period of intensified anti-LGBTQA+ sentiment within both public life and the media. Participants were therefore likely more aware of discrimination targeting their sexual and/or gender identities during this time.

Sample Population

Private Lives 3 drew responses from a total of 6,835 participants aged 18-88 who were living in Australia at the time of the survey. The mean age of the sample was 34.1 years (SD = 13.8 years), with individuals aged 18-24 (31.3%, n = 2142) and 25-34 (29.0%, n =1980) comprising the best represented age groups within our sample.

Gender identity and sexual orientation were captured in *Private Lives 3, Pride and Pandemic* and *Writing Themselves In 4* using the same sets of questions.

Gender identity was captured through three items. Participants were asked to select all relevant responses from 'man,' 'woman,' 'non-binary' and 'I use a different term.' Participants who responded with 'non-binary,' 'I use a different term,' or who indicated in a previous question that their current gender is not the same as their presumed gender at birth, were offered 17 gender identity labels to choose from: 'man,' 'woman,' 'trans woman,' 'trans man,' 'trans femme,' 'trans masc,' 'trans,' 'genderqueer,' 'gender diverse,' 'gender non-binary,' 'sistergirl,' 'brotherboy,' 'agender,' 'prefer not to have a label,' 'prefer not to answer,' and 'something different' with an accompanying text box where participants could volunteer another term. Those who selected more than one of these 17 responses were then asked to choose the one label they identified with the most. Cisgender women made up the largest group by gender identity, comprising 43.5% (n = 2948) of participants. Cisgender men accounted for over a third of the sample (34.3%, n = 2328), with the next largest group being non-binary people (13.6%, n = 921).

Sexual orientation was assessed through two questions. The first offered asked participants to choose all relevant labels from 12 options: 'gay,' 'lesbian,' 'bisexual,' 'pansexual,' 'queer,' 'asexual,' 'homosexual,' 'heterosexual,' 'prefer not to answer,' 'prefer not to have a label,' 'don't know,' and 'something different' with an accompanying text box where participants could volunteer another term. Those who selected more than one sexuality label were then asked to choose the one label they identified with the most. Gay men constituted the largest group of participants (28.7%, n = 1958), but robust proportions of lesbian (20.5%, n = 1394), and bisexual participants (20.4%, n = 1387) comprising the next largest groups in the sample.

Demographic characteristics	n	%
Age		
18-24	2142	31.3
25-34	1980	29.0
35-44	1,142	16.7
45-54	823	12.0
55-64	525	7.7
65+	223	3.3
Gender identity		
Cisgender men	2328	43.5
Cisgender women	2948	34.3
Trans men	285	4.2
Trans women	300	4.4
Non-binary	921	13.6
Sexual identity		
Lesbian	1394	20.5
Gay	1958	28.7
Bisexual	1387	20.4
Pansexual	503	7.4
Queer	833	12.2
Asexual	215	3.2
Something else	525	7.7

2.2 *Writing Themselves In 4*

Writing Themselves In 4 is the largest national survey of LGBTQA+ young people in Australia. It was an online survey investigating the health and wellbeing of young LGBTQA+ persons living in Australia and was conducted by ARCSHS. As the fourth iteration of a survey series that first began in 1998, WTI4 aimed to provide a contemporary perspective on the experiences and challenges of LGBTQA+ young persons in Australia. The *Writing Themselves In 4* survey was optimised for online completion and was exclusively hosted on an online domain using the Qualtrics survey engine. The survey consisted primarily of multiple-choice quantitative question items, with a handful of open-ended qualitative questions. For more detailed information relating to *Writing Themselves In 4*, please refer to the full published report.

Survey Design and Consultation

The survey was designed in consultation with several advisory bodies, as well as a variety of stakeholders across Australia that provided specialist support to LGBTQA+ youth. A community advisory board consisting of expert representatives from across all states helped to develop and refine the survey and was complemented by a youth advisory group and a gender advisory group. The youth advisory consisted of youth representatives from both Victoria and South Australia and helped the survey authors to ensure that *Writing Themselves In 4*, the promotional materials used for recruitment, and the subsequent outputs were engaging and appropriate for young persons. As with *Private Lives 3*, a gender advisory group was also consulted to ensure the inclusion of broad range of gender identities.

Recruitment

To be eligible for participation, individuals had to be: (i) between the ages of 14-21, (ii) identify as LGBTQA+, and (iii) be residing in Australia or an Australian territory. Participation in *Writing Themselves In 4* was promoted in several ways, the first was through targeted, paid advertisements on both Facebook and Instagram. Both the online and in-person networks of LGBTQA+ community organisations were also leveraged for the purposes of recruiting participants.

Timing

Writing Themselves In 4 was launched on 2nd September 2019 and closed on 28th October 2019. Like *Private Lives 3*, the data collection period for *Writing Themselves In 4* took place soon after the Australian Marriage Law Postal Vote, and participants may have been more sensitised to anti-LGBTQA+ discrimination in their daily lives.

Sample Population

Writing Themselves In 4 drew a total of 6418 valid responses. The mean participant age was 17.1 years (SD = 2.2 years). Over half of all participants were in the 14-17 age group (58.7%, n = 3770), with participants in the 18-21 age group comprising 41.3% (n = 2648) of the sample.

Writing Themselves In 4 used the same questions as *Private Lives 3* to capture gender identity and sexual orientation. For full details please refer to the description under *Private Lives 3* above. Cisgender women accounted for over half of the overall sample (50.6%, n = 3162), followed by cisgender men (22.3%, n =1394) and non-binary persons (19.5%, n = 1216), respectively. Over a third of the sample (33.8%, n =2164) identified as bisexual, with the next largest groups comprised of gay (16.6%, n =1063) and lesbian (12.0%, n =771), respectively.

Demographic characteristics	n	%
Age		
14-17	3770	58.7
18-21	2648	41.3
Gender identity		
Cisgender men	1394	22.3
Cisgender women	3162	50.6
Trans men	406	6.5
Trans women	75	1.2
Non-binary	1216	19.5
Sexual identity		
Lesbian	771	12.0
Gay	1063	16.6
Bisexual	2164	33.8
Pansexual	717	11.2
Queer	540	8.4
Asexual	295	4.6
Something else	857	13.4

"PSYCHOLOGICAL DISTRESS, SUBJECTIVE WELLBEING, AND REPORTED EXPERIENCES OF SUICIDALITY, SELF-HARM, AND SUPPORT-SEEKING AMONGST LGBTQA+ POPULATIONS REFLECT THE NEGATIVE MENTAL HEALTH IMPACTS OF DISCRIMINATION AND MARGINALISATION EXPERIENCED IN AUSTRALIA."

2.3 *SWASH*

SWASH is the longest running periodic survey on the health and wellbeing of lesbian, queer and bisexual (LBQ+) women in the world. Originally designed to generate knowledge about HIV risk for women engaged with the LGBTQA+ community in Sydney, it quickly broadened to mental health, sexual health, preventative health, substance use, and experiences of abuse, and re-focused on LBQ+ women. *SWASH* is a repeated cross-sectional survey that takes place every two years in February during the Sydney Mardi Gras season. Designed for face-to-face completion at Mardi Gras events, the 2022 iteration ran primarily online (via REDCap) due to COVID-19 restrictions. The survey was comprised mostly of fixed response quantitative questions, with a handful of open response qualitative questions. More detailed information about *SWASH* will be available in a forthcoming report.

Survey Design and Consultation

In 1996, the Sydney Women and Sexual Health survey (*SWASH*) was initiated by health promotion staff at the AIDS Council of NSW (now ACON) who were faced with a lack of empirical evidence on which to base their health promotion work. Researchers from UNSW supported the development of the research; *SWASH* is now collaborative effort between ACON and researchers at the University of Sydney. The *SWASH* survey instrument has evolved over time. Together, ACON staff and university researchers review it prior to each iteration to take account of changes in the community, emerging health issues or evidence gaps impeding health promotion. For example, while *SWASH* inclusion criteria have always been inclusive of trans women, community feedback prompted significant changes to the 2018 and 2020 surveys to ensure all questions were inclusive and relevant for trans and non-binary people who experienced 'woman' or 'femininity' as part of their gender identity, and those whose sexual partners were gender diverse. The university researchers drive the survey design, research ethics, and data analysis, while ACON takes responsibility for developing and implementing recruitment, training peer recruiters, and running data collection. The final community report is a joint output.

Recruitment

SWASH is a repeated cross-sectional survey; it has always employed in-person venue-based recruitment. ACON health promotion staff identify venues and events likely to have a high concentration and diversity of LBQ+ women and peer recruiters work across these venues collecting paper-based surveys. In 2022, COVID-19 restrictions presented considerable challenges and indoor venues were deemed a WHS risk. The Mardi Gras Fair Day was the sole in-person recruitment site, with the usual peer recruiter approach used. All other recruitment (and survey completion) was conducted online though ACON's social media networks. *SWASH* 2022 respondents were living in Australia, aged 16 years or older, engaged with LGBTQ+ community, identifying as lesbian, bisexual, queer or otherwise not heterosexual, and in whole or part with the identity woman.

Timing

In person recruitment took place on 19th February 2022, then the online survey ran until 20th March.

Sample Population

2,860 valid responses were recorded for *SWASH* 2022, with only 15% recruited in person. For the purpose of the Rainbow Realities report, only respondents who selected 'woman or female' in response to a gender identity question were included, this left an analysis sample of 2,621 participants.

Respondents were not restricted to selecting one gender option; however, the vast majority chose a single option. 95.6% (n = 2,505) of the sample selected only 'woman or female', 3.6% (n = 94) selected woman or female and non-binary, and 0.8% (n = 22) selected woman or female as well as one or more of another gender term.

The age range was 16-81 years, with a mean age of 33 years, with more than a quarter aged 16-24 years (27.1%, n = 990), 37.8% (n = 990) aged 25-34 years, 18.3% (n = 480) aged 35-44 years and 16.8% (n = 440) 45 years or older.

Although not restricted to selecting one sexuality option, three quarters of respondents chose a single option: 33.4% (n = 873) lesbian, 29.5% (n = 772) bisexual and 12.0% (n = 315) queer. Among the remaining, 6.0% (n = 158) selected a different label and 19.1% (n = 500) ticked multiple options (the most common being queer + bisexual (8.2%, n = 214) and queer + lesbian (5.6%, n = 146). Age and sexual identity have been correlated in every iteration of *SWASH*, with younger respondents more likely to select multiple options (mean age = 29) or identify as bisexual (mean age = 30), queer (mean age = 32), or a different label (mean age = 32), compared to lesbian (mean age = 38).

Three percent (n = 80) of respondents self-identified as Aboriginal and/or Torres Strait Islander. Most respondents (84.4%, n = 2,209) were born in Australia and most (88.3%, n = 2,309) spoke only English at home. The *SWASH* sample does not capture the diversity seen in the broader population.

Despite the shift to online recruitment in 2022 the sampled remained Sydney focused with 87.3% (n = 2,267) of respondents in the Sydney metropolitan region: 40.3% (n = 1,043) lived in the city, inner west or eastern suburbs of Sydney, 18.5% (n = 480) in Sydney's western suburbs and the Blue Mountains, 18.5% (n = 481) in the northern suburbs and 7.5% (n = 195) in the southern suburbs. Only 2.4% (n = 63) lived in what has traditionally been considered 'gay Sydney' (Darlinghurst, Potts Point, Kings Cross, and Surry Hills).

Demographic characteristics	n	%
Age		
16-24	709	27.1
25-34	990	37.8
35-44	480	18.3
45+	440	16.8
Sexual identity		
Lesbian/dyke/gay/ homosexual	873	33.4
Bisexual	772	29.5
Queer	315	12.0
Multiple labels selected	500	19.1
Different label	158	6.0
Gender identity selected		
Woman/female	2,505	95.6
Woman/female and non-binary	94	3.6
Woman/female and another identity	22	0.8

2.4 *Trans Pathways*

Trans Pathways is the largest national survey specifically designed to investigate the mental health and care pathways of trans and gender diverse young persons in Australia. It was conducted by the Telethon Kids Institute. *Trans Pathways* sought to understand the mental health challenges experiences by trans and gender diverse young people, as well as their experiences accessing both mental healthcare and gender-affirming care. The survey utilised a mix methods approach and included both fixed response quantitative questions and open-ended qualitative questions. *Trans Pathways* was designed for online completion and was hosted on an online domain using the Qualtrics survey engine. More detailed information about *Trans Pathways* can be accessed in the full report.

Survey Design and Consultation

Trans Pathways was designed in community consultation with both trans and gender diverse young people, as well as their parents and guardians. Within these focus groups, community members highlighted potential drivers of, and protective factors against poor mental health among trans and gender diverse people. These insights helped to guide both the questions posed to survey participants, as well as the wording and terminology used in asking these questions.

Recruitment

Participants were recruited widely using social media. Additionally, advertisements promoting survey participation was also disseminated through gender clinics, youth mental health services, support groups, and through participant referrals.

Timing

Trans Pathways was launched in February 2016 and remained open until August 2016.

Sample Population

859 valid responses were recorded for *Trans Pathways*. Participants ranged from 14-25 years of age, and mean age of the sample was 19.4 years (SD = 3.2). Participants under 18 comprised 42.9% (n = 369) of the sample, while those aged 18 and above made up over half (57.1%, n = 490) of the sample.

Participant gender identity was captured through two items which asked for participants' sex assigned at birth (male/female) and an open-response question asking them about their gender identity. Participant gender identities were thereafter categorised into male/trans man, female/trans woman, non-binary and 'something else'. Nearly half of the sample (48.5%, n = 417) identified as non-binary, followed by trans man (29.7%, n = 255) and trans woman (15.0%, n = 120), respectively.

Similarly, participants were asked to how to identify sexual orientation via open-text responses where they were able to describe their sexual orientation in their own words. Responses were then categorised for analysis purposes by the study investigators. Nearly a third (30.5%, n = 263) identified as pansexual, with the next best represented groups being bisexual (13.9%, n = 119) and asexual (8.8%, n = 76) participants, respectively.

Demographic characteristics	n	%
Age		
14	45	5.2
15	53	6.2
16	88	10.3
17	101	11.8
18	81	9.4
19	86	10.0
20	90	10.5
21	79	9.2
22	66	7.7
23	56	6.5
24	51	5.9
25	53	7.3
Gender identity		
Trans man	255	29.7
Trans woman	120	15.0
Non-binary	417	48.5
Something else	58	6.8
Sexual identity		
Lesbian	63	7.3
Gay	58	6.8

Demographic characteristics	n	%
Bisexual	119	13.9
Pansexual	263	30.6
Heterosexual	63	7.3
Asexual	76	8.8
Something else	217	25.3

2.5 *Walkern Katatdjin* (Rainbow Knowledge)

Walkern Katatdjin was a large project conducted by researchers from the Telethon Kid's Institute, Kulbardi Aboriginal Centre (Murdoch University) and Kurongkurl Katitjin (Edith Cowan University). The study sought to understand the needs of Aboriginal and Torres Strait Islander LGBTQA+ young people as they relate to social and emotional wellbeing and mental health. The aim of *Walkern Katatdjin* was to improve current understandings of the risk and protective factors for social and emotional wellbeing and mental health among Aboriginal and Torres Strait Islander LGBTQA+ young people, and to use these findings to guide health services in supporting these populations. Analyses presented in the current report draw from the findings of the *Walkern Katatdjin* national survey. The *Walkern Katatdjin* national survey was hosted and completed online using the Qualtrics survey engine, with additional options to complete a paper version of the survey, complete the survey over the phone or contact the research team to organise an alternate way to complete the survey. Further detail about *Walkern Katatdjin* can be viewed in the full report.

Survey Design and Consultation

The online survey was designed in collaboration and consultation with a Youth Advisory Group comprised of Aboriginal and Torres Strait Islander LGBTQA+ young people from 14–25 years of age, as well as a Governance Committee made up of respected Aboriginal and Torres Strait Islander LGBTQA+ people. Both groups provided feedback and support in formulating the research questions asked, the research methods adopted, and reviewed both the reports and publications derived from the survey. This review mechanism ensures that Indigenous Data Sovereignty over the project is maintained. The Youth Advisory Group and Governance Committee additionally assisted in participant recruitment, and in data governance. The survey was conducted in partnership or with support from Aboriginal Community Controlled Organisations and LGBTQA+ Health Services across Australia. All organisations had the opportunity to provide input into the survey design and the interpretation of findings.

"ACCESS TO POSITIVE, IDENTITY-AFFIRMING EXPERIENCES WITHIN FAMILY, WORKPLACE, AND WITH OTHER LGBTQA+ INDIVIDUALS CAN ATTENUATE THE NEGATIVE IMPACTS OF DISCRIMINATION ON HEALTH OUTCOMES."

Recruitment

Participants were recruited through paid social media advertising on Facebook and Instagram. Recruitment posts were also shared in Facebook groups for Aboriginal and Torres Strait Islander People, LGBTQA+ people, and Aboriginal and Torres Strait Islander LGBTQA+ people. Additionally, participants were recruited through researchers' personal and professional networks; calling or emailing services to ask them to share the survey with their staff and consumers and mailing hard-copy posters to all Aboriginal Community Controlled Health Organisations in Australia.

Timing

The survey was open for completion between February and June 2022.

Sample Population

619 responses were recorded for the online survey. The mean age of the sample was 17.5 (SD = 2.9). Participants under 18 years of age made up over half of the sample (70.8%, n = 437), and those above 18 years of age accounted for 29.2% of the sample (n = 180).

Aboriginal participants constituted most of the sample (86.4%, n = 535), with Torres Strait Islander participants (6.6%, n = 41) or both Aboriginal and Torres Strait Islander participants (6.9%, n = 43) slightly over-represented compared to the proportion of Torres Strait Islander and both Aboriginal and Torres Strait Islander People recorded in the last census.

Gender identity and sexual orientation were asked via open ended questions to allow participants to describe their gender and sexuality using their own terms. These were then grouped in close collaboration with the Youth Advisory Group. In terms of gender identity, women were best represented within the sample (42.8%, n = 264), followed by non-binary individuals (35.3%, n = 218) and men (16.4%, n = 101). A relatively even distribution of gender diversity was observed within the sample, with roughly equal proportions of both trans (46.2%, n = 286) and cisgender (45.3%, n = 280) participants.

Bisexual and pansexual participants made up over half of the sample (56.6%, n = 349), with the next largest groups being gay and lesbian participants (21.1%, n = 130) and those identifying as Queer (7.8%, n = 48).

Demographic characteristics	n	%
Age		
14–18	437	70.8
19–21	180	29.2
Indigeneity		
Aboriginal	535	86.4
Torres Strait Islander	41	6.6
Aboriginal and Torres Strait Islander	43	6.9
Gender identity		
Woman	264	42.8
Man	101	16.4
Non-binary	218	35.3
Questioning	12	2.0
Something else	7	1.1
Gender diversity		
Trans and gender diverse	286	46.2
Cisgender	280	45.3
Unsure	48	7.8
Prefer not to say	4	0.7
Sexual identity		
Bisexual/pansexual	349	56.6
Lesbian/gay	130	21.1
Queer	48	7.8
Asexual	45	7.3
Questioning	21	3.4
Something else	20	3.2

2.6 *Pride and Pandemic*

Pride and Pandemic was a survey that sought to explore the experiences of LGBTQA+ individuals and communities during the COVID-19 pandemic. The survey focused on the mental health impact of the pandemic, and on the coping strategies that participants relied on during this time. The survey was conducted by ARCSHS in collaboration with LGBTIQ+ Health Australia (LHA). *Pride and Pandemic* was intended for online completion and was hosted on an online domain using the REDCAP survey engine. The survey consisted mostly of fixed response quantitative question items, as well as a handful of open response qualitative questions. For more detailed information relating to *Pride and Pandemic*, please refer to the full published report.

Survey Design and Consultation

Questions included in *Pride and Pandemic* were developed in consultation with a community advisory board consisting of experts, representatives and stakeholders from LGBTQ+ community organisations. To facilitate ease of comparison between the findings of *Pride and Pandemic* and other large-scale national surveys, standardised instruments were used where possible. Additionally, a select number of items from *Private Lives 3* were included in *Pride and Pandemic* to enable direct comparisons between pre- and post-COVID-19 mental health-related outcomes. Many of these items – including those which captured sexual and gender identity had previously been developed in consultation with the community advisory boards for *Private Lives 3*.

Recruitment

Individuals were eligible for participation in *Pride and Pandemic* If they were: (i) aged 18 years or older, (ii) identified as LGBTQA+, (iii) currently resided in Australia or an Australian territory, and (iv) had resided in Australia or an Australian territory for most of the COVID-19 pandemic. Participation was promoted via paid targeted advertising on Facebook and Instagram, as well as through the social media accounts of several LGBTQA+ community organisations.

Timing

Pride and Pandemic was launched in November 2021 and remained open to responses through to February 2022. At the time of launch, Australia had recorded a large surge in the Delta variant of COVID-19 cases, and strict lockdowns in both Melbourne and Sydney were instated. Both Melbourne and Sydney experienced the end of lockdowns in October 2021, followed by a progressive easing of restrictions. In December 2021, Australia reported its first cases of the fast-spreading COVID-19 Omicron variant. Stricter social distancing restrictions were once again implemented, though no stay-at-home orders would be issued henceforth. The uncertainty surrounding these events is likely to have impacted the mental wellbeing and responses of participants depending on when they completed the survey.

Sample Population

3135 valid responses were recorded for *Pride and Pandemic*. The mean age of participants was 35.7 years (SD = 14.2) and ranged from 18-85 years. The best-represented age groups within this sample were those in the 25-34 (28.0%, n = 879) and the 18-24 (27.6%, n = 865) age brackets, respectively.

Pride and Pandemic used the same questions as *Private Lives 3* to capture gender identity and sexual orientation. For full details please refer to the description under *Private Lives 3* above. Roughly equal proportions of both cisgender women (38.2%, n = 1137) and cisgender men (35.2%, n = 1066) were present within the sample, with the next largest group being non-binary people (13.0%, n = 476). Gay men comprised the largest group of participants (31.2%, n = 1948), followed by lesbian women (21.1%, n = 1394) and bisexual participants (17.0%, n = 642).

Demographic characteristics	n	%
Age		
18-24	865	27.6
25-34	879	28.0
35-44	560	17.9
45-54	426	13.6
55+	405	3.3
Gender Identity		
Cisgender men	1066	35.2
Cisgender women	1137	38.2
Trans men	128	4.3

Demographic characteristics	n	%
Trans women	170	5.7
Non-binary	476	13.0
Sexual identity		
Lesbian	642	21.1
Gay	948	31.2
Bisexual	516	17.0
Pansexual	244	8.0
Queer	438	14.4
Asexual	115	3.8
Something else	135	4.4

2.7 Measures used by the surveys

Description of how sexual orientation and gender identity were collected for each of the surveys can be found in Chapter Two, which provides information about each of the surveys.

A range of further outcomes measures were used across the surveys. Some of these were validated measures, such as the Kessler Psychological Distress Scale or Standard Disability Flag Model, and others were developed for the purposes of the respective surveys. Therefore, some topics were not covered in all surveys and where data on a specific topic were collected across all or many of the surveys, the questions that participants responded to may have been worded differently. Where necessary, the measures used have been described in brief but for the sake of brevity, full details of all the measures used have not been provided. For more extensive detail of each of the measures used, please refer to the published overview reports for each survey.

- *Private Lives 3*
- *Writing Themselves In 4*
- *SWASH*
- *Trans Pathways*
- *Walkern Katatdjin*
- *Pride and Pandemic*

3. MENTAL HEALTH AND SUICIDALITY

The mental health disparities seen among LGBTQA+ people relative to the general population, are one of the most direct and enduring effects of prejudice, stigma, and discrimination in everyday life experienced by LGBTQA+ individuals. Evidence suggests that from an early age, these stressors are internalised, with detrimental effects to health and wellbeing[1]. In addition, these experiences further sensitise LGBTQA+ individuals to discrimination and potential rejection[1 2], engendering a sense of hypervigilance[3] and self-monitoring behaviours[4].

These factors take a significant cumulative toll on LGBTQA+ people's mental health. Compared to non-LGBTQA+ people, LGBTQA+ individuals across virtually all societal contexts experience elevated rates of psychological distress, mood-related disorders such as depression and anxiety, and demonstrate high rates of suicidal ideation and suicide attempts.[5 6 7 8 9 10] Despite this wealth of evidence, LGBTQA+ groups are frequently conceptualised monolithically, and certain subgroups are either excluded or underrepresented (e.g., asexual, or trans and gender diverse individuals)[11]. This necessitates a more granular understanding of mental health outcomes and associated experiences across LGBTQA+ subpopulations.

3.1 Mental health and wellbeing

This section details the key findings relating to mental health and wellbeing as well as explorations of:

- What factors are associated with access to professional mental health support and the perceived effectiveness of these services among LGBTQA+ young people with a need for mental healthcare? (*Writing Themselves In 4*)
- During the COVID-19 pandemic, which parts of the LGBTQA+ community were likely to prefer services specifically catering to LGBTQA+ people? (*Pride and Pandemic*)
- What was the impact of COVID-19 lockdowns on the mental wellbeing of LGBTQA+ people? (*Pride and Pandemic*)
- Is participation in LGBTQA+ events or activities associated with better subjective wellbeing and reduced psychological distress among trans and gender diverse adults? (*Private Lives 3*)
- What factors are associated with seeking psychological support among LBQ+ women in the past five years? (*SWASH*)

3.1.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 57.2% (n = 3,818) of LGBTQA+ adults reported high or very high levels of psychological distress on the 10-item Kessler Psychological Distress Scale (K10). This proportion is four-times greater than the 13.0% reported among the general population in Australia12.
- 73.2% (n = 4,794) reported having ever been diagnosed with a mental health condition at some point in their lives.
- 60.5% (n = 3,965) reported having ever been diagnosed with depression 47.2% (n = 3,093) with generalised anxiety disorder. 18.2% (n = 1,194) had been diagnosed with post-traumatic stress disorder and 10.5% (n = 685) with an eating disorder.
- 51.9% (n = 3,404) had received a mental health diagnosis or treatment in the past 12 months.

LBQ+ Women (*SWASH*)

- 58.5% (n = 1,510) of LBQ+ women reported high or very high levels of psychological distress on the 6-item Kessler Psychological Distress Scale (K6).
- 70.2% (n = 1,830) reported ever being diagnosed with a mental health condition, incusing 71.1% (n = 501) of LBQ+ women aged 16-24, 73.9% (n = 729) of those aged 25-34, 68.5% (n = 326) of those aged 35-44 and 62.4% (n = 272) of those aged 45+.
- 87.2% (n = 2,272) reported having accessed any mental health services in their lifetimes and 50.1%, (n = 1,306) in the past 5 years.

LGBTQA+ Young People (*Writing Themselves In 4*)

- 81.0% (n = 5,172) of LGBTQA+ young people indicated high or very high levels of psychological distress on the K10.
- 63.8% (n = 3,870) reported having ever been diagnosed with a mental health condition, 44.5% (n = 2,704) reported having received mental health treatment/support in the past 12 months.
- Almost half had ever been diagnosed with generalised anxiety disorder (49.5%, n = 3,004) or depression (48.3%, n = 2,934).

Trans and Gender Diverse Young People (*Trans Pathways*)

- 74.6% (n = 571) of trans and gender diverse young people had ever been diagnosed with depression. 76.4% (n = 562) indicated clinically relevant symptoms of depression in the last 2 weeks on the Patient Health Questionnaire (PHQ).
- 72.2% (n = 552) had ever been diagnosed with an anxiety disorder. 62.1% (n = 525) indicated moderate to severe symptoms of anxiety in the last 2 weeks on the Generalised Anxiety Disorder Scale (GAD-7).
- Of those who had a current diagnosis of depression, 24.2% (n = 92) were not receiving professional treatment. Of those who had a current diagnosis of anxiety, 28% (n = 110) were not receiving professional treatment.
- 22.7% (n = 174) had ever been diagnosed with an eating disorder, and 25.1% (n = 192) had ever been diagnosed with post-traumatic stress disorder (PTSD).

RESEARCH PAPERS

Health intervention experiences and associated mental health outcomes in a sample of LGBTQA+ people with intersex variations in Australia. The intersections between LGBTQA+ identities and intersex variations are poorly understood. Using data from 46 LGBTQA+ people with an intersex variation/s, this paper illustrates associations between suicidal thinking, suicide attempts, depression or anxiety and negative healthcare experiences. Specifically, poorer mental health outcomes were most notable among those who were subjected to non-consensual medical procedures or who experienced challenges accessing appropriate psychological support.

Mental Health Issues and Complex Experiences of Abuse Among Trans and Gender Diverse Young People: Findings from *Trans Pathways*. This paper illustrates complex experiences of abuse and their association with mental health outcomes among trans and gender diverse young people. Extrafamilial physical abuse, familial physical abuse, extrafamilial sexual abuse, familial sexual abuse, abuse within an intimate relationship, and other familial abuse (including emotional or verbal abuse and neglect) were also associated with poor mental health.

Religious Conversion Practices and LGBTQA+ Youth. This paper demonstrates that LGBTQA+ youth who had been exposed to conversion practices were more likely to report poor mental health outcomes, including increased suicidality and self-harm. The findings of this paper also illustrate increased exposure to social rejection, negative remarks and harassment, and decreased education, sport and housing opportunities among those who had been exposed to conversion practices.

Associations between negative life experiences and the mental health of trans and gender diverse young people in Australia: findings from *Trans Pathways*. This paper illustrates high rates of self-harm, suicidal thoughts and suicide attempt among a sample of trans and gender diverse young people, as well as high rates of depression and anxiety diagnoses. Many of the sample had also experienced high rates of peer rejection, precarious accommodation, bullying and discrimination. Many of the negative mental health outcomes were associated with negative experiences. The strongest of these associations were with precarious accommodation and issues within educational settings.

Affirming educational and workplace settings are associated with positive mental health and happiness outcomes for LGBTQA+ youth in Australia. This paper demonstrates the importance of affirming education setting and workplace environments for the wellbeing of LGBTQA+ youth. Both cisgender youth and trans and gender diverse youth were found to report better wellbeing outcomes if they reported that their education setting, or workplace were affirming of their identity. This included not only reduced psychological distress, but also greater subjective happiness.

Community connection is associated with lower psychological distress for sexual minority women who view community connection positively. This paper illustrates that feeling a part of the LGBTQA+ community in Australia is associated with lower levels of psychological distress among LBQ+ cisgender women, but only for those women who felt that connection to community was a positive experience for them. Additionally, this paper suggests differences in experiences of community connection across this population, with bisexual cisgender women and LBQ+ cisgender women living in an outer-suburban area least likely to feel that connection to the LGBTQA+ community is a positive experience for them. The findings demonstrate that connection to community among LBQ+ cisgender women may be complex and while important for the mental wellbeing of some women, it is not a solution that can solve the negative wellbeing outcomes experienced by all LBQ+ cisgender women.

3.1.2 What factors are associated with access to professional mental health support and the perceived effectiveness of these services among LGBTQA+ young people with a need for mental healthcare?

Rationale

There are considerable barriers to accessing mental healthcare, which for young LGBTQA+ people – who face barriers associated with their age in addition to their minoritised sexual and/or gender identities – are especially heightened. The following analyses examine, among those with a mental health need, the sociodemographic predictors of: i) having previously accessed mental health professional support, and ii) whether pro fessional support reportedly improved their mental health situation.

Dataset and sample population

This analysis included data from 5,215 Writing Themselves In 4 participants who may have required mental health support on the basis of their having ever experienced suicidal ideation, attempted suicide or self-harmed.

Variables and analysis

Multivariable logistic regression analyses were computed for the outcomes 'access to any mental health support ever in lifetime' and 'mental health support improved mental health situation' (among participants who accessed any mental health support). These outcomes were self-reported and coded to binary variables (yes/no). The following correlates were included in the analyses: age group, gender identity, sexual orientation, education setting, language spoken in country of birth, residential location, and young LGBTQA+ people's reported supportiveness of family members in relation to their sexual orientation or gender identity.

Key findings

83.7% (n = 5,215) of young people reported having ever experienced suicidal ideation, suicide attempt or self-harm.

Among these LGBTQA+ young people with a mental health need, 72.6% (n = 3,776) had ever accessed professional support. These participants more frequently:

- Were cisgender women, trans women, trans men or non-binary people.
- Identified their sexual orientation as queer.
- Attended TAFE.
- Had family members who were supportive or very supportive of their sexual orientation or gender identity.
- Were born in Australia or a different English-speaking country.
- Resided in inner suburban areas.

Accessed any mental health support	AOR (CI)
Gender identity (ref: cisgender man)	
Cisgender woman	2.03 (1.63 - 2.52)
Trans woman	14.21 (3.41 - 59.15)
Trans man	5.04 (3.34 - 7.61)
Non-binary	2.47 (1.89 - 3.21)
Sexual orientation (ref: gay/lesbian)	
Queer	1.83 (1.25 - 2.69)
Education setting (ref: secondary school)	
TAFE	1.46 (1.01 - 2.12)
Other	1.96 (1.30 - 2.95)
Language/country of birth (ref: Australia)	
Non-English-speaking country	0.63 (0.43 - 0.92)
Residential location (ref: inner-suburban)	
Capital city, outer suburban	0.64 (0.43 - 0.95)
Regional city or town	0.56 (0.37 - 0.86)
Rural/remote	0.54 (0.34 - 0.85)
Family supportive of sexuality or gender (ref: No)	
Yes	1.35 (1.14 - 1.60)

Of the young LGBTQA+ people with a mental health need who had ever accessed any professional support for their mental health, less than half (47.0%, n = 1,758) reported that the support improved their mental health situation. The participants who indicated improvement more frequently:

- Identified their sexual orientation as bisexual or 'something else.'
- Had family members who were supportive or very supportive of their sexual orientation or gender identity.
- Were cisgender men, trans men or trans women.

Professional support improved mental health situation	AOR (CI)
Gender identity (ref: cisgender man)	
Cisgender woman	0.72 (0.56 - 0.92)
Non-binary	0.75 (0.57 - 0.99)
Sexual orientation (ref: gay/lesbian)	
Bisexual	1.27 (1.03 - 1.57)
Something else	1.37 (1.04 - 1.79)
Family supportive of sexuality or gender (ref: No)	
Yes	1.71 (1.45 - 2.00)

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NOTABLY, THE HIGHER RATES OF MENTAL HEALTH ACCESS OBSERVED AMONG SOME GROUPS (E.G., TRANS AND GENDER DIVERSE PEOPLE) DOES NOT IMPLICITLY REFLECT THE DEGREE OF MET MENTAL HEALTH NEEDS.

The more frequent mental health support seeking behaviours among trans and gender diverse participants likely reflects greater mental health needs in this group as illustrated in prior research.

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The observed discrepancies in mental health service access and perceived effectiveness of support according to both sexual orientation and gender identity suggest that people belonging to these different sexuality/gender groupings experience variable levels of mental health concerns and experience unique barriers to access. Mental health services need to provide care that is responsive to individuals' unique needs and underpinned by an understanding of the ways cumulative forms of disadvantage and marginalisation influence poor mental health outcomes and barriers to care among LGBTQA+ young people.

3.1.3 During the COVID-19 pandemic, which parts of the LGBTQA+ community were likely to prefer services specifically catering to LGBTQA+ people?

Rationale

A lack of LGBTQA+-inclusive practice in healthcare has been shown to lead to reduced care continuity and foregone care among LGBTQA+ populations12. Even providers working within mainstream services that claim to be LGBTQA+-inclusive may lack competence in supporting these populations. Services catering specifically to the needs of LGBTQA+ people are therefore key in addressing the mental health inequalities observed among LGBTQA+ people compared to the general population; however, these services are inequitably distributed across the country and lack capacity to support all LGBTQA+ people who require access. The aim of these analyses is to identify the groups who are the most and least likely to prefer LGBTQA+-specific services and explore unmet needs among these groups.

Dataset and sample population

Data from 1,532 Pride and Pandemic participants, who may have required mental health support on the basis of their having experienced suicidality (suicidal ideation or suicide attempt) during the pandemic, were included in this analysis.

Variables and analyses

Multivariable logistic regression analysis was computed to examine which participants reported a preference for accessing mental health services catering specifically to LGBTQA+ people. This involved a binary outcome variable comparing preference for LGBTQA+-specific services with preference for mainstream services that are either known or not known to be inclusive of LGBTQA+ populations. The correlates explored in the analyses were age group, gender identity, sexual orientation, country of birth (Australian, other English-speaking country, non-English speaking country), state of residence and residential location.

Key findings

More than half (53.5%, n = 1,532) of the whole participant sample of LGBTQA+ adults reported having experienced suicidal ideation and/or attempted suicide during the pandemic.
Of these individuals, one-quarter (24.2%, n = 235) reported a preference for LGBTQA+-specific mental health services compared to mainstream mental health services. These individuals were more frequently:

- Aged 25-34 years.
- Trans women, trans men, or non-binary people.
- Residing in rural or remote areas.

Queer-identifying participants also had reasonably high odds of reporting preference for LGBTQA+-specific services (p = 0.052), although this finding did not meet significance threshold levels.

Prefers LGBTQA+-specific mental health services	AOR (CI)
Age group (ref: 18-24 years)	
25-34 years	1.47 (1.05 - 2.05)
Sexual orientation (ref: lesbian)	
Queer	1.52 (1.00 - 2.31)
Gender identity (ref: cis woman)	
Trans woman	3.63 (2.18 - 6.03)
Trans man	2.85 (1.76 - 4.62)
Non-binary	2.18 (1.51 - 3.15)
Residential location (ref: inner-suburban)	
Rural or remote	1.86 (1.09 - 3.17)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

AMONG LGBTQA+ ADULTS WITH PAST EXPERIENCES OF SUICIDALITY,

there were no differences in preference for mainstream or LGBTQA+–specific services according to state/territory of residence, country of birth, or sexual orientation.

TRANS AND GENDER DIVERSE PEOPLE, LGBTQA+ PEOPLE LIVING IN RURAL/ REMOTE AREAS AND THOSE AGED 25-34

were those most likely to report a preference for mental health services catered specifically to LGBTQA+ people.

THE FINDINGS SUGGEST A NEED FOR ACCESSIBLE LGBTQA+-SPECIFIC SERVICES

that are available across the country and suitable for people of all sexual orientations, gender identities and cultural backgrounds.

Preference for LGBTQA+–specific mental health services may be a result of negative experiences with mainstream providers, such as their lack knowledge of LGBTQA+ identities, or insensitive or discriminatory treatment toward LGBTQA+ people. Consequently, many LGBTQA+ people may not feel comfortable or safe to access mental health support through mainstream services, even when these services have an inclusive reputation. Improved access to LGBTQA+–specific mental health services is necessary, particularly for trans and gender diverse people, LGBTQA+ people living in rural/remote areas, and those aged 25–34.

3.1.4 What was the impact of COVID-19 lockdowns on the mental wellbeing of LGBTQA+ people?

Rationale

The COVID-19 pandemic has had a significant impact on the mental health and wellbeing of individuals in Australia, with lockdowns and stay-at-home orders resulting in loss of work and increased experiences of loneliness, social isolation, and limited access to social or professional supports. While little is known about the experiences of LGBTQA+ communities in Australia during the pandemic, it is well understood that LGBTQA+ communities entered into the pandemic with already disproportionately high rates of poor mental health compared to the general population, and already faced additional challenges such as discrimination, exclusion and barriers to accessing healthcare. These analyses examine the impact of the pandemic and associated lockdowns on the mental wellbeing of LGBTQA+ adults living in Australia.

Dataset and sample population

The following analyses included 3,135 LGBTQA+ adult participants of Pride and Pandemic.

Variables and analyses

Sociodemographic factors (age, gender, sexual orientation, ethnicity, residential location) associated with experiences of mental wellbeing were identified using a series of ordinary least squares regression (for the outcome of psychological distress) and logistic regression (for the outcome of self-reported change in mental wellbeing during the pandemic) models. Taking advantage of a natural experiment with varying degrees of lockdown across the country, the effects of lockdown measures on psychological distress and mental wellbeing were examined by comparing two states, Victoria and New South Wales (which implemented more rigorous lockdowns) with other states/territories. These analyses used an augmented inverse probability weighting estimator with all covariates as matching factors and computed the average treatment effect (ATE) and; the average treatment effects on the treated (ATT) to compare outcomes between Victoria, New South Wales and the rest of Australia.

Key findings

Psychological distress scores during the pandemic differed across the sample population. LGBTQA+ adults who most frequently indicated higher levels of psychological distress were:

- Trans men or non-binary people. Cisgender women and trans women also more frequently indicated higher levels of psychological distress than cisgender men.
- Bisexual, pansexual, queer or asexual people. Lesbian-identifying participants also more frequently indicated higher levels of psychological distress than gay-identifying participants.
- Of a race other than 'Asian' or 'white'.
- Residing in outer suburban, regional or rural/remote areas compared to those in inner suburban areas.
- Younger in age, with an inverse association between age and psychological distress scores identified.

"SOLUTIONS TO PROTECT AND ADDRESS MENTAL WELLBEING CONCERNS WITHIN LGBTQA+ POPULATIONS ARE NEEDED IN GENERAL, AS WELL AS IN-FACE OF FUTURE CRISES."

Psychological distress	ß (CI)
Ethnicity (ref: white)	
Other	1.55 (0.13 - 2.97)
Gender (ref: cis woman)	
Cis man	-4.97 (-5.74 - -4.20)
Trans man	2.90 (1.41 - 4.38)
Non-binary	3.18 (2.20 - 4.17)
Sexual orientation (ref: lesbian)	
Gay	-4.13 (-5.07 - -3.19)
Bisexual	1.35 (0.29 - 2.42)
Pansexual	4.08 (2.69 - 5.47)
Queer	1.77 (0.63 - 2.92)
Asexual	2.35 (0.50 - 4.20)
Area of residence (ref: capital city, inner suburb)	
Capital city, outer suburb	2.46 (1.64 - 3.28)
Regional city or town	2.16 (1.27 - 3.04)
Rural or remote	2.35 (0.79 - 3.91)
Age (from 18 years, in units of 10)	
Linear	-3.58 (-4.3 - -2.87)
Quadratic	0.24 (0.09 - 0.39)

The impact of the pandemic on LGBTQA+ adults' mental wellbeing also varied across the population:

- Cisgender women, trans men and non-binary people most frequently reported their mental health worsened.
- LGBTQA+ adults who lived in outer suburban or regional areas more frequently reported their mental health worsened.
- The frequency of reporting negative mental health consequences decreased with participant age, although a plateau in the rate of relative improvement was observed between the ages of 36 and 55.
- LGBTQA+ adults who identified as gay were more likely to report a positive impact of the pandemic on their mental wellbeing compared to those of other sexual orientations.

Perceived change in mental wellbeing	OR (CI)
Gender (ref: cis woman)	
Cis man	1.58 (1.36 - 1.84)
Trans woman	1.62 (1.14 - 2.29)
Sexual orientation (ref: lesbian)	
Gay	1.41 (1.18 - 1.69)
Area of residence (ref: capital city, inner suburb)	
Capital city, outer suburb	0.79 (0.68 - 0.93)
Regional city or town	0.84 (0.71 - 0.99)
Age (from 18 years, in units of 10)	
Linear	1.78 (1.32 - 2.40)
Quadratic	0.84 (0.73 - 0.97)
Cubic	1.02 (1.00 - 1.04)

While no difference in psychological distress scores were observed between Victoria, New South Wales and the rest of the country at the time of the survey, LGBTQA+ adults subjected to more severe lockdown regimes (i.e., those residing in Victoria or New South Wales) reported greater perceived impacts of the pandemic on mental wellbeing compared to those living in other states or territories.

Self-reported change in mental wellbeing	ATE/ATT ß (CI)
Rest of Australia	1.38 (1.32 - 1.43)
NSW	-0.13 (-0.21 - -0.05) / -0.14 (-0.23 - -0.05)
Victoria	-0.15 (-0.23 - -0.07) / -0.15 (-0.23 - -0.07)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

THE OBSERVED VARIABILITY IN PSYCHOLOGICAL DISTRESS

infers that the pandemic was experienced differently across various intersections of the LGBTQA+ population, and further reflects ongoing disparities that existed in this population prior to the pandemic.

THE MAJORITY (NEARLY TWO-THIRDS) OF PARTICIPANTS REPORTED THAT THEIR MENTAL WELLBEING HAD DETERIORATED DURING THE PANDEMIC.

Disproportionate effects of the pandemic on mental wellbeing were further observed for specific subpopulations, particularly among cisgender women, trans men, trans women and non-binary people, those living in outer-suburban or regional areas, and those of younger age.

THE ANALYSES FURTHER SUGGEST THAT SELF-REPORTED IMPACT OF THE PANDEMIC ON MENTAL WELLBEING WAS WORSENED BY THE EXTENDED PERIODS OF LOCKDOWN IN VICTORIA AND NEW SOUTH WALES.

A lack of significant difference in psychological distress scores may reflect the timing of the survey and timeline of the psychological distress measure. The survey questions asked about experiences of psychological distress over the past 4 weeks, and at the time of the *Pride and Pandemic* survey, the spread of the virus had slowed and social distancing restrictions had been easing. Consequently, psychological distress among those in Victoria and New South Wales may have lowered to meet the experiences of those residing outside of these states.

Efforts are needed to address any enduring impacts of the COVID-19 pandemic through prioritising the needs of those who experienced worsening mental wellbeing. Solutions to protect and address mental wellbeing concerns within LGBTQA+ populations are needed in general, as well as in-face of future crises. Localised disasters, such as floods and bushfires, may lead to similar mental wellbeing challenges for LGBTQA+ individuals impacted.

3.1.5 Is participation in LGBTQA+ events or activities associated with better subjective wellbeing and reduced psychological distress among trans and gender diverse adults?

Rationale

Participation in peer-led safe spaces has been shown to improve subjective perceptions of community connection and have protective effects against poor wellbeing outcomes among some subpopulations of LGBTQA+ people. Trans and gender diverse adults are more likely than cisgender LGBTQA+ adults to experience abuse or harassment in mainstream settings, contributing to the greater mental health needs observed in this population. The following analyses examine the protective effects of participation in LGBTQA+ social or community events/activities, as well as LGBTQA+ social media platforms, on experiences of recent psychological distress and subjective wellbeing.

Dataset and sample population

A total of 1,488 trans and gender diverse adult participants of Private Lives 3 were included in the analysis.

Variables and analyses

Univariable logistic and linear regression analyses were undertaken to examine associations of participation in LGBTQA+ social events/venues, LGBTQA+ social media, or any LGBTQA+ activities, with psychological distress (K10 scores dichotomised to low/moderate compared to high/very high) and subjective wellbeing scores. The univariable findings were confirmed in multivariable regressions controlling for demographic variables: age group, sexual orientation and gender identity. The findings of the multivariable analyses are reported.

Key findings

Almost three-quarters (71.3%, n = 1,066) of trans and gender diverse adults had participated in LGBTQA+ community events/activities in the last 12 months. These individuals who reported participation in community events/activities:

- Less frequently indicated high or very high levels of psychological distress.
- More frequently indicated positive subjective wellbeing.

69.9% (n = 1,038) of trans and gender diverse adults had participated in LGBTQA+ social events/activities in the past 12 months. These individuals who reported participation in social events/activities:

- Less frequently indicated high or very high levels of psychological distress.
- More frequently indicated positive subjective wellbeing.

Most (93.3%, n = 1,399) trans and gender diverse adults had engaged with LGBTQA+ social media. These individuals who had engaged with social media more frequently indicated high or very high levels of psychological distress.

	Subjective wellbeing ß (CI)	High/ very high psychological distress AOR (CI)
LGBTQA+ community event	0.18 (0.07 - 0.29)	0.68 (0.51 - 0.92)
LGBTQA+ social activity	0.12 (0.02 - 0.23)	0.69 (0.52 - 0.94)
LGBTQA+ social media	-0.14 (-0.34 - 0.06)	1.75 (1.09 - 2.82)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

Participation in LGBTQA+ community or social events/activities may have protective effects against or reduce feelings of distress among trans and gender diverse individuals and contribute to improvements in their subjective sense of wellbeing.

ELEVATED LEVELS OF PSYCHOLOGICAL DISTRESS WERE INDICATED AMONG THOSE WHO

ENGAGED WITH LGBTQA+ SOCIAL MEDIA

COMPARED TO THOSE WHO HAD NOT ENGAGED IN ONLINE SOCIAL PLATFORMS.

This is perhaps a consequence of witnessing discriminatory rhetoric on these platforms or because the use of LGBTQA+ social media was an ineffective strategy to cope with pre-existing feelings of distress.

Trans and gender diverse people's participation within the LGBTQA+ community exerts protective effects on their mental wellbeing. It is therefore essential that trans and gender diverse people have opportunities to connect with peers in non-social-media LGBTQA+ spaces. Additionally, better reporting and response mechanisms to expressions of discrimination and abuse on social media, as well as clear safeguarding guidance within online environments, and education around online safety, may be necessary.

3.1.6 What factors are associated with psychological support seeking among LBQ+ women in the past five years?

Rationale

LBQ+ women in high income nations are thought to experience significant health disparities in comparison to their heterosexual counterparts, likely due to frequent exposure to both gender and sexuality-based stressors. A factor contributing to these disparities is that LBQ+ women may delay or abstain from accessing mental health services. This has been attributed to a complex raft of factors, such as experienced and anticipated discrimination from service workers, as well as a lack of access to appropriate or inclusive services. To improve mental health service engagement among LBQ+ women, it is therefore crucial to first understand these patterns of service utilisation, so that targeted and tailored interventions and health promotion efforts can be undertaken. The current section aims to elucidate the demographic factors associated with mental health service utilisation among LBQ+ women.

Dataset and sample population

Data from 1,991 participants from the SWASH survey who indicated ever having a need for mental healthcare support on the basis of their having ever experienced suicidality or self-harm were included in the current analyses.

Variables and analyses

Multivariable logistic regressions were performed to understand associations between accessing the services of either a counsellor or psychiatrist, and demographic factors such as: sexuality, disability/long-term condition, languages spoken at home and perceptions of LGBTQA+ community connection, while controlling for the confounding impact of age.

Key findings

Both mental health needs and the proportion having accessed mental health services within this sample were high. While over three-quarters (76.6%, n = 1,991) reported previous self-harm or suicidal behaviour, most of those (90.8%, n = 1,803) reported previously accessing the services of a mental health professional.

LBQ+ women who indicated a need for mental healthcare were most likely to have accessed professional mental health support if they:

- Reported having a disability/long-term condition.
- Spoke English at home. While this result was not statistically significant, it approached significance (p = 0.056).

Accessed mental health support	OR (CI)
Living with a disability/ long-term condition	6.39 (4.34 - 9.52)
Language other than English spoken at home	0.65 (0.42 – 1.01)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

FINDINGS ILLUSTRATE A HIGH NEED FOR MENTAL HEALTHCARE AMONG LBQ+ WOMEN.

They also illustrate a very high rate of engagement with professional mental healthcare within this group. This sample of LBQ+ women are predominantly from socio-economically advantaged metropolitan Sydney and may have more healthcare options compared to their peers in less advantaged or rural areas.

While respondents appear empowered to access care, the quality or effectiveness of this care is unknown, and the results are not necessarily indicative of a high degree of met mental health needs.

THE INCREASED LIKELIHOOD FOR PEOPLE WITH DISABILITY/ LONG-TERM CONDITION TO REPORT PREVIOUS MENTAL HEALTH SERVICE ENGAGEMENT

may reflect the high prevalence of mental health needs among this demographic and for some the disability/long-term condition they reported may have been related to mental health itself. Additionally, these findings may be generally indicative of a high degree of engagement with professional health services among those reporting disability.

LANGUAGE MAY HAVE BEEN A BARRIER

to mental health service access among some LBQ+ women in the sample, further pointing to the obstacles which linguistically diverse individuals experience in accessing professional mental health services.

While the results suggest that LBQ+ women may be proactive in seeking the professional supports that they require, there remain some populations that are comparatively underserved, in particular LBQ+ women from culturally and linguistically diverse backgrounds. Those with a disability may also have a greater mental health need than people without disability, and whether these mental health needs are met by available services is unclear. Regardless of access levels, service level data is necessary to understand how effective the mental healthcare was for alleviating the high rates of mental health need evident within this population.

3.2 Suicidality and self-harm

This section details the key findings relating to suicidal ideation, suicide attempts, suicide planning and self-harm as well as further explorations of:

- **What are the predictors of psychological distress and suicidal ideation among GBQ+ cisgender men?** (*Private Lives 3*)
- **What factors are associated with recent non-suicidal self-injury (NSSI) among LGBTQA+ young people?** (*Writing Themselves In 4*)

3.2.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 74.8% (n = 5,084) of LGBTQA+ adults reported having ever experienced suicidal ideation in their lives, and 41.9% (n = 2,848) reported experiencing suicidal ideation in the past 12 months.
- 30.3% (n = 1,606) reported having ever attempted suicide in their lives, and 5.2% (n = 274) reported having attempted suicide in the past 12 months.

LBQ+ Women (*SWASH*)

- 71.7% (n = 1,868) of respondents reported ever having felt that life isn't worth living, and 35.0% (n = 912) had felt life isn't worth living sometime in the last 12 months.
- 54.8% (n = 1,423) had ever deliberately hurt themselves or done something they knew might harm or kill them, 15.7% (n = 412) had done so in the past 12 months; among 16–24 year old respondents 26.6% (n = 188) had harmed themselves in the past 12 months.

LGBTQA+ Young People (*Writing Themselves In 4*)

- 58.2% (n = 3,712) of LGBTQA+ young people had experienced suicidal ideation in the past 12 months and 24.4% (n = 1,536) had made a suicide plan.
- 25.6% (n = 1,605) had attempted suicide at some point in their lifetime and 10.1% (n = 632) had attempted suicide the past 12 months.
- 62.1% (n = 3,903) reported having ever self-harmed, and 40.1% (n = 2,521) had self-harmed in the past 12 months.
- Between 4.5% and 7.1% of young people answered 'prefer not to say' to these questions. The proportion that had ever experienced suicidal ideation/planning/attempts or self-harm ideation/attempts, may therefore be higher than indicated.
- Only 38.1% (n = 1,641) of the LGBTQA+ young people who had experienced suicidal ideation, planning, attempts or self-harm ideation/attempts in the past 12 months had accessed any professional counselling or support service for this in the past 12 months.
- Of those who had accessed any professional counselling or support in regard to suicide or self-harm in the past 12 months, only 59.3% (n = 972) reported that the support resulted in their situation improving.

Trans and Gender Diverse Young People (Trans Pathways)

- 79.7% (n = 561) of trans and gender diverse young people had experienced self-harm ever in their lives and 43.6% (n = 322) had self-harmed in the last 12 months.
- 82.4% (n = 568) had experienced suicidal thoughts ever in their lives and 48.8% (n = 361) experienced suicidal thoughts in the last 12 months.
- 48.1% (n = 333) had attempted suicide ever in their lives and 16.1% (n = 119) had attempted suicide in the last 12 months.

RESEARCH PAPERS

Demographic and psychosocial factors associated with recent suicidal ideation and suicide attempts among lesbian, gay, bisexual, pansexual, queer, and asexual (LGBQ) people in Australia: Correlates of suicidality among LGBQ Australians. This paper illustrates high rates of suicidal ideation and suicide attempt among LGBQ cisgender adults. Several factors were further identified to be associated with these experiences. Specifically, the likelihood of suicidal ideation was greater for those who identified as queer or felt that they had been treated unfairly or socially excluded due to their sexual identity, and lower among those in a committed relationship, who felt part of the LGBTQA+ community, or felt accepted in family, work and healthcare settings. The likelihood of attempting suicide was higher for those aged younger or had recently experienced verbal abuse or social exclusion, and lower for those in a committed relationship or felt a part of the LGBTQA+ community.

Demographic and psychosocial factors associated with recent suicidal ideation and suicide attempts among trans and gender diverse people in Australia. This paper illustrates high rates of suicidal ideation and suicide attempt among trans and gender diverse adults. The likelihood of suicidal ideation was found to be higher for young participants and those who felt that they had been treated unfairly or socially excluded due to their gender identity in the past year, and lower for those with a postgraduate degree, who felt accepted by family or at work, and who felt that their gender identity was respected when accessing a mainstream medical clinic. The likelihood of suicide attempts was higher among those aged younger or who had recently experienced sexual harassment based on their gender or sexual orientation, and lower for those who were non-binary.

Suicidal Ideation and Suicide Attempts Among Lesbian, Gay, Bisexual, Pansexual, Queer, and Asexual Youth: Differential Impacts of Sexual Orientation, Verbal, Physical, or Sexual Harassment or Assault, Conversion Practices, Family or Household Religiosity. High rates of recent suicidal ideation and suicide attempt among LGBQA youth are illustrated in this paper. Several sociodemographic traits were associated with a higher likelihood of experiencing suicidal ideation or suicide attempt in the past year. These include younger age (14–17 years), lesbian identifying and living in a rural or remote location. Additionally, the paper illustrates higher likelihood of suicidal ideation among young people who had experienced any verbal, physical or sexual harassment based on their sexual orientation or gender identity, those who came from a religious family or household, and those who had experienced conversion practices in the past 12 months. Lower likelihood of experiencing suicidal ideation or attempt were found among reported feeling a part of their school.

Religious Conversion Practices and LGBTQA+ Youth. This paper demonstrates associations between exposure to conversion practices and poor mental health outcomes among LGBTQA+ youth, including increased suicidality and self-harm. The findings also illustrate increased exposure to social rejection, negative remarks and harassment, and decreased education, sport and housing opportunities among those who had been exposed to conversion practices.

Associations between negative life experiences and the mental health of trans and gender diverse young people in Australia: findings from *Trans Pathways*. This paper illustrates high rates of self-harm, suicidal thoughts and suicide attempt among a sample of trans and gender diverse young people, as well as high rates of depression and anxiety diagnoses. Many of the sample had also experienced high rates of peer rejection, precarious accommodation, bullying and discrimination. Many of the negative mental health outcomes were associated with negative experiences. The strongest of these associations were with precarious accommodation and issues within educational settings.

Health intervention experiences and associated mental health outcomes in a sample of LGBTQA+ people with intersex variations in Australia. The intersections between LGBTQA+ identities and intersex variations are poorly understood. Using data from 46 LGBTQA+ people with an intersex variation/s, this paper illustrates associations between suicidal thinking, suicide attempts, depression or anxiety and negative healthcare experiences.

3.2.2 What are the predictors of psychological distress and recent suicidal ideation among GBQ+ cisgender men?

Rationale

Rates of poor mental health remain high among GBQ+ cisgender men relative to their heterosexual counterparts. However, as GBQ+ cisgender men are shown to have relatively positive psychosocial health and wellbeing outcomes when compared to other subsections of the LGBTQA+ community, the mental health needs of this population, and the potential variability in mental health burdens across GBQ+ cisgender male subpopulations, are frequently overlooked. Evidence shows that experiences of harassment, social exclusion and LGBTQA+ community connectedness influence mental health and wellbeing outcomes for other LGBTQA+ groups but there is a lack of evidence on the effect of these experiences on GBQ+ cisgender men's mental health specifically. The following analyses examine the sociodemographic risk and protective factors associated with recent psychological distress and suicidal ideation among GBQ+ cisgender men.

Dataset and sample population

Data from 1,394 gay, bisexual, pansexual and queer cisgender men who participated in Private Lives 3 were included in the analysis.

Variables and analyses

To examine GBQ+ cisgender men's indicated levels of psychological distress, their K10 scores were converted to a binary variable comparing high/very high psychological distress and low/moderate psychological distress. Suicidal ideation was also examined using a binary variable comparing participants who had or had not experienced suicidal ideation in the last 12 months and omitting those who selected 'prefer not to say'. Separate multivariable logistic regression analyses were computed for each of these outcomes. The multivariable models included the following sociodemographic factors: sexual orientation, age group, educational attainment, weekly pre-tax income, employment status, residential location, disability (categorised according to the Australian Bureau of Statistics Disability Flag, a standardised instrument assessing activity limitation or participation restrictions - 'none,' 'mild', 'moderate' or 'severe'), committed relationship status, experiences of unfair treatment, social exclusion or verbal abuse on the basis of sexual orientation in the last 12 months, and feelings of being a part of the LGBTQA+ community in Australia.

Key findings

43.2% (n = 898) of cisgender GBQ+ men indicated high or very high levels of psychological distress.

The men who more frequently indicated high/very high psychological distress:

- Were younger than 55 years.
- Reported a pre-tax income of less than $1,000 per week.
- Reported high school or an undergraduate degree as their highest level of education.
- Were living with a disability or long-term health condition (with the highest rates among those reporting severe activity limitation/participation restriction).
- Had experienced unfair treatment based on their sexual orientation in the past 12 months.
- Had experienced social exclusion based on their sexual orientation in the past 12 months.

Those who were less likely to indicate high/very high psychological distress:

- Were in a committed romantic relationship.
- Felt they were a part of the LGBTQA+ community in Australia.

High/very high psychological distress	AOR (CI)
Age group (ref: 18-24)	
55+	0.41 (0.26 - 0.64)
Educational attainment (ref: high school)	
University-postgraduate	0.65 (0.45 - 0.94)
Net weekly income (ref: $0-$399)	
$1,000 - $1,999	0.63 (0.41 - 0.96)
$2,000+	0.50 (0.31 - 0.83)
Disability (ref: No disability)	
Mild disability	3.22 (1.89 - 5.50)
Moderate disability	4.52 (3.08 - 6.63)
Severe disability	4.29 (2.35 - 7.82)

High/very high psychological distress	AOR (CI)
Experienced anti-GBQ+ unfair treatment (ref: No)	
Yes	1.62 (1.25 - 2.10)
Experienced anti-GBQ+ social exclusion (ref: No)	
Yes	2.47 (1.88 - 3.26)
In a committed romantic relationship (ref: No)	
Yes	0.70 (0.56 - 0.89)
Feel a part of the LGBTQA+ community (ref: No)	
Yes	0.55 (0.44 - 0.69)

32.3% (n = 667) of cisgender GBQ+ men reported experiences of suicidal ideation in the last 12 months.

Those most likely to report having experienced suicidal ideation:

- Identified their sexual orientation as bisexual or queer.
- Reported high school as their highest level of education.
- Were living with a disability or long-term health condition (with the highest rates among those reporting severe activity limitation/participation restriction).
- Had experienced unfair treatment based on their sexual orientation in the past 12 months.
- Had experienced social exclusion based on their sexual orientation in the past 12 months.

Those least likely to have experienced suicidal ideation in the last 12 months:

- Were in a committed romantic relationship.
- Felt they were a part of the LGBTQA+ community in Australia.

Recent suicidal ideation	AOR (CI)
Sexual orientation (ref: gay)	
Bisexual	1.62 (1.12 - 2.35)
Queer	2.09 (1.15 - 3.81)
Educational attainment (ref: high school)	
Non-university tertiary	0.65 (0.46 - 0.94)
University-undergraduate	0.69 (0.50 - 0.95)
University-postgraduate	0.62 (0.43 - 0.90)
Disability (ref: no disability)	
Mild disability	3.31 (2.04 - 5.37)
Moderate disability	2.29 (1.65 - 3.18)
Severe disability	2.18 (1.27 - 3.76)
Experienced anti-GBQ+ unfair treatment (ref: No)	
Yes	1.36 (1.04 - 1.79)
Experienced anti-GBQ+ social exclusion (ref: No)	
Yes	1.47 (1.13 - 1.92)
In a committed romantic relationship (ref: No)	
Yes	0.56 (0.44 - 0.71)
Felt part of the LGBTQA+ community (ref: No)	
Yes	0.70 (0.55 - 0.87)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

GBQ+ cisgender men's recent experiences of psychological distress and suicidal ideation seem to co-occur with negative social experiences such as

ANTI-GBQ+ DISCRIMINATION AND SOCIAL EXCLUSION.

While different demographic factors mediated experiences of psychological distress and suicidal ideation,

INEQUALITIES FOR THOSE LIVING WITH A DISABILITY/LONG-TERM HEALTH CONDITION WERE OBSERVED ACROSS BOTH OUTCOMES.

THE IMPORTANCE OF INTERPERSONAL CONNECTION,

INCLUDING ROMANTIC RELATIONSHIPS AND CONNECTION TO THE LGBTQA+ COMMUNITY,

was also highlighted; these factors evidently having a protective effect on GBQ+ cisgender men's mental health and wellbeing.

Enhancing GBQ+ cisgender men's connection to the broader LGBTQA+ community, addressing discrimination and ableist attitudes among the broader population in Australia, and ensuring GBQ+ cisgender men, particularly those with a disability, have access to necessary social and mental health supports, may contribute to preventing experiences of psychological distress and suicidality in this cohort.

3.2.3 What factors are associated with recent non-suicidal self-injury (NSSI) among LGBTQA+ young people?

Rationale

NSSI is the deliberate self-inflicted harm to one's body – such as through cutting, burning, bruising or some other forms of self-battery. NSSI is a high prevalence experience among LGBTQA+ young people that is thought to potentiate future vulnerability to suicidal behaviour and is strongly associated with negative health outcomes and even loss of life. Dominant perspectives on NSSI suggest that LGBTQA+ young persons may rely on NSSI as a means of emotional self-regulation13, and that the minority stressors which LGBTQA+ youth experience motivate their disproportionate engagement with NSSI-related behaviours. While LGBTQA+ youth populations are well-established to be vulnerable to engaging in NSSI, a granular understanding of how NSSI engagement is distributed among the subgroups within LGBTQA+ populations in Australia, is currently lacking. This section aims to provide insight into the demographic predictors of NSSI engagement among LGBTQA+ youth in Australia.

Dataset and sample

5,964 Writing Themselves In 4 participants who provided valid responses to questions pertaining to NSSI engagement were included in these analyses.

Variables and analyses

Three separate multivariable logistic regression analyses were run for (i) the full sample, (ii) cisgender participants only, and (iii) trans and gender diverse participants only. Multivariable logistic regression analyses were used to explore the factors associated with NSSI. Independent variables included demographic traits (e.g., age, sexual orientation, gender identity, education, residential location) as well as experiences of verbal, physical and sexual harassment and feeling a part of one's school environment.

Key findings

Among the full sample of LGBTQA+ youth, those who were more likely to report NSSI in the past 12 months were:

- Aged 14-17 years.
- Cisgender women, trans men, trans women or non-binary people, with the highest odds among trans men.

Among cisgender youth, recent NSSI engagement was higher among:

- Those aged 14-17 years.
- Cisgender women.
- Participants attending TAFE.
- Those who reported recently experiencing verbal, sexual or physical harassment.

Among trans and gender diverse youth, recent NSSI engagement was higher among:

- Those aged 14-17 years.
- Those who reported recently experiencing verbal, sexual or physical harassment.
- Regardless of gender identity, participants who felt a part of their school were less likely to report recent engagement with NSSI.

SUMMARY AND IMPLICATIONS OF THE FINDINGS

BOTH SEXUAL AND PHYSICAL HARASSMENT

were associated with recent NSSI engagement, with physical harassment being the strongest predictor of recent NSSI engagement. The magnitude of these associations was roughly comparable between cisgender and trans and gender diverse participants.

HIGHER LIKELIHOOD OF RECENT NSSI ENGAGEMENT AMONG CISGENDER WOMEN AND TRANS MEN LIKELY REFLECTS THE MENTAL HEALTH BURDEN ASSOCIATED WITH GENDER-BASED DISCRIMINATION (E.G., SEXISM AND TRANSPHOBIC DISCRIMINATION).

Simultaneously, cisgender men might report self-harming less because of societal pressures, as some types of self-harm are seen as 'feminine.' Higher likelihood of recent NSSI engagement among both cisgender women and trans men maybe reflect the predisposition of conventional feminine gender role socialisation (which both groups are exposed to) to NSSI.

ATTACHMENT TO ONE'S SCHOOL

had a significant protective effect against recent NSSI engagement.

Efforts to prevent experiences of discrimination and abuse toward sexuality and gender diverse young people is essential for protecting their mental health and wellbeing. Moreover, the findings suggest that by bolstering LGBTQA students' feelings of belonging and acceptance within education settings, educators and school administrators may be uniquely positioned to minimise the incidence of negative emotional events that motivate NSSI engagement among LGBTQA+ young people.

3.3 Chapter summary

Through examining indicators of psychological distress, subjective wellbeing, and reported experiences of suicidality, self-harm and support seeking among LGBTQA+ populations, this chapter highlights the ways experiences of discrimination and marginalisation coalesce into the poorer mental health outcomes commonly observed among LGBTQA+ people compared to the general population in Australia.

Across the referenced sample populations, participants who are (i) trans or gender diverse, (ii) cisgender women, (iii) disabled, (iv) Bi+ identified, (v) residing in non-metropolitan locations, (vi) younger in age, (vii) born in a non-English-speaking country or linguistically diverse, and (viii) high-school students, experienced significant disadvantage in relation to many of the measured outcomes. As this relates to groups such as trans women and disabled people, our findings further reflect how experiencing multiple sources marginalisation (e.g., transphobia, sexism, ableism simultaneously) results in poorer mental health outcomes. As such, various forms of targeted discrimination or abuse because of one's LGBTQA+ identity were consistently shown to be detrimental to mental health and wellbeing.

A more nuanced understanding of the concept of unmet needs within LGBTQA+ populations can be taken from the findings. Access to mental health services varied across subpopulations; as did perceptions of the effectiveness of mental health support. For specific groups, the availability of services catering specifically to LGBTQA+ populations may be a pertinent mediator of one's positive engagement with mental health support when it's needed. The potential protective effects of interpersonal connection/support, engagement with the LGBTQA+ community, or feeling a part of one's school, were also demonstrated. Poorer mental health and wellbeing may therefore co-occur with factors that preclude one's access to peer support, inclusive school environments, or preferred (e.g., LGBTQA+-inclusive) mental health providers.

There are several gaps in the available data, which need to be addressed. At a population level, an understanding of the cumulative mental health consequences of experiencing multiple forms of disadvantage among LGBTQA+ adults belonging to two or more minority or disadvantaged groups (e.g., LGBTQA+ adults of colour or disabled people) and barriers to care experienced by these populations, is pertinent to improving culturally appropriate care and addressing inequities. Data that more reliably demonstrates unmet mental health need are also required, with attention paid specifically to the factors that facilitate one's navigation of health systems to access appropriate and culturally safe forms of mental health support. This is in addition to understanding the psychosocial consequences of the long appointment wait-times and inequitable distribution of LGBTQA+-specific services currently seen in Australia's mental health system (e.g., psychological distress, suicidal ideation, suicide attempts, death by suicide, or impacts on subjective wellbeing, employment and experiences of homelessness). The collection of service level data, which includes patients' sexual orientation and gender identity, is also necessary for assessing the effectiveness of mental health services for the community. Most notably, a robust evaluation of specifically tailored professional and peer support mental health/suicidality interventions for youth and adult LGBTQA+ populations is needed. Finally, research is needed regarding experiences of severe psychological distress that may require hospitalisation. LGBTQA+ people facing involuntary treatment or hospitalisation lose autonomy and may encounter gender or sexuality stigma and discrimination that echoes their original distress.

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4. INCOME INEQUALITY, HOUSING AND EXPERIENCES OF HOMELESSNESS

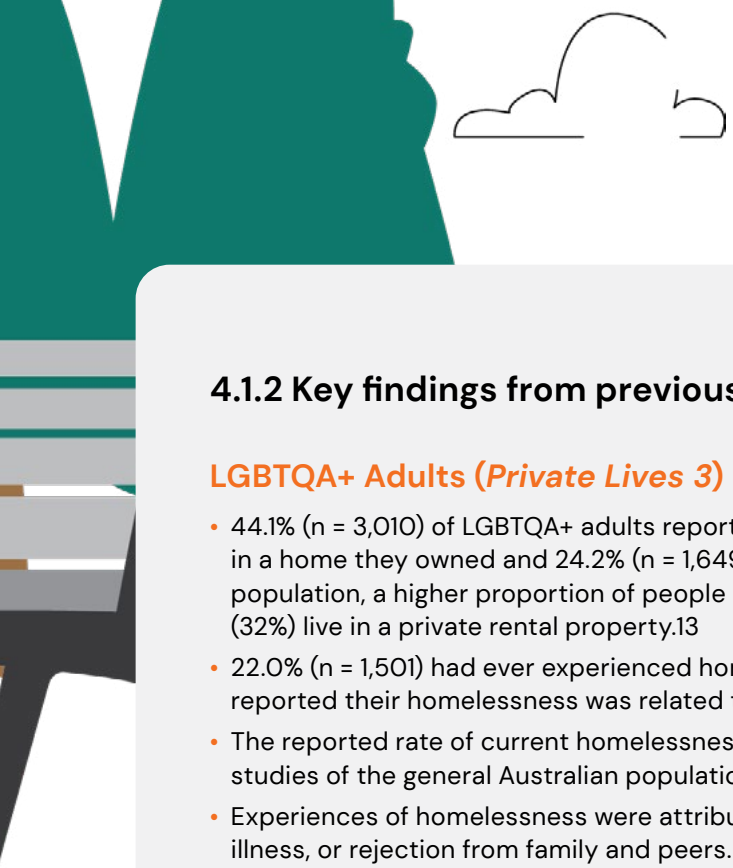
Homelessness and housing insecurity are preventable, yet increasingly pressing and prevalent public health issues,[1] convincingly linked to a variety of immediate and long-term consequences for the mental[2 3 4] and physical[5 6] health and wellbeing of people experiencing homelessness.

Even before experiencing homelessness, vulnerable persons typically report poorer general health, higher rates of both chronic and acute health conditions, and are predisposed to developing mental health conditions as well as issues with substance dependence.[7 8] Recent evidence shows that LGBTQA+ individuals in Australia are more vulnerable to experiencing homelessness and housing insecurity, due to a combination of: (i) familial rejection, (ii) constrained access to economic opportunities, and (iii) housing discrimination due to their sexual and/or gender minority identities.[9 10] Compared to other high-income nations, however, both policy and service responses to homelessness within Australia have been slow to recognise LGBTQA+ individuals as a priority population.[11] Available evidence within this domain is therefore largely either nascent, qualitative, or is predominantly focused on LGTBQA+ youths' experiences.[12]

4.1 Housing and homelessness

This section details the key findings relating to housing and experiences of homelessness among LGBTQA+ people, as well as the following further analyses of homelessness experiences:

- What are the risk and protective factors associated with experiences of homelessness among LGBTQ adults? (*Private Lives 3*)
- What are the risk and protective factors associated with experiences of homelessness among LGBTQA+ young people? (*Writing Themselves In 4*)
- What are the risk and protective factors associated with experiences of homelessness among trans and gender diverse young people? (*Trans Pathways*)
- What are the schooling experiences of LGB+ cisgender young persons who experience homelessness? How do these impact their engagement with schooling? (*Writing Themselves In 4*)



4.1.2 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 44.1% (n = 3,010) of LGBTQA+ adults reported living in a private rental property, 29.2% (n = 1,994) in a home they owned and 24.2% (n = 1,649) at home with their family. In the general Australian population, a higher proportion of people (66%) live in a home they own, and a lower proportion (32%) live in a private rental property.13
- 22.0% (n = 1,501) had ever experienced homelessness. 25.7% (n = 384) of these individuals reported their homelessness was related to being LGBTQA+.
- The reported rate of current homelessness (1.1%; n = 77) was more than twice that observed in studies of the general Australian population.
- Experiences of homelessness were attributed to a range of factors such as disability, chronic illness, or rejection from family and peers. The most common factors cited were financial stressors (42.6%, n=559), and unemployment/underemployment (37.5%, n=492).
- Experiences of homelessness were particularly prevalent among trans and gender diverse people (31.9% of trans women, 33.8% of non-binary people and 34.3% of trans men had experienced homelessness in their lives).
- A high proportion of trans and gender diverse people also reported having experienced barriers to housing and/or homelessness services because of their gender identity.

LGBTQA+ Young People (*Writing Themselves In 4*)

- 23.6% (n = 1,501) of LGBTQA+ young people had experienced at least one form of homelessness in their lives, including 11.5% (n = 733) who experienced homelessness in the past 12 months.
- 1.9% (n = 121) reported currently experiencing homelessness at the time of completing the survey.
- 17.4% (n = 1,105) had ever run away from home or the place they lived, and 10.5% (n = 667) had ever left home or the place they live because they were asked or made to leave. Further causes of homelessness reported by participants were mental health issues, rejection from family, family violence, and financial stress.
- 26.0% (n = 388) of the young people who'd ever experienced homelessness reported this was related to being LGBTQA+. This proportion was much higher for trans men (45.2%, n = 71) and trans women (37.9%, n = 11).

Trans and Gender Diverse Youth (*Trans Pathways*)

- 22.0% (n = 147) of trans and gender diverse young people had experienced issues with accommodation, including a lack of stable accommodation, homelessness or couch-surfing. These young people had higher rates of suicidal thoughts, wanting to hurt themselves, suicide attempts, self-harming, reckless behaviour, and diagnoses of PTSD, depression, anxiety, eating disorders, psychosis, personality disorders and autism spectrum disorders than those who did not experience issues with accommodation.
- Of the 17.8% (n = 116) of the trans and gender diverse youth who had been homeless, 38.9% (n = 44) had accessed crisis accommodation. 43.2% (n = 19) of these young people felt their gender identity was not respected when accessing crisis accommodation.

4.1.3 What are the risk and protective factors associated with experiences of homelessness among LGBTQ adults?

Rationale

While it is generally accepted that LGBTQA+ populations within Australia are disproportionately impacted by housing insecurity and homelessness, a more granular understanding of this issue is presently underde veloped. In particular, (i) the relative distribution of homelessness burden among LGBTQA+, as well as (ii) protective and (iii) predisposing factors associated with homelessness risk is poorly established among LGBTQA+ populations in Australian contexts. These are crucial components to the development and implementation of targeted interventions for addressing housing insecurity within this demographic and are thusly the objective of the analyses described below.

Dataset and sample population

Data from 6,052 Private Lives 3 participants who recorded a response to items investigating prior experiences of homelessness were analysed.

Variables and analyses

For all analyses conducted, previous and/or ongoing experiences of homelessness were set as the output variable (i.e., ever experiencing homelessness). Input variables comprised socio-demographic characteristics (age, income, employment, residential location, sexual orientation, gender identity, disability, country of origin), previous experience of family and intimate partner violence, as well as previous problems with alcohol use. Univariable logistic regression analyses were first performed to answer the question of how homelessness burden is distributed within the LGBTQA+ population. Subsequently, multivariable logistic regression analyses were performed to understand the risk factors associated with experiencing homelessness. Separate multivariable analyses were conducted for both cisgender and trans and gender diverse participants, as the profile of factors which confer vulnerability to housing insecurity likely differ between these groups.

Key findings

Rates of reporting any experience of homelessness were:

- More prevalent among cisgender women, trans men, trans women and non-binary as compared to cisgender men.
- More prevalent among persons who identified as lesbian bisexual, pansexual, queer or something else in comparison to gay.
- Individuals residing in either a regional city or town, or in a rural or remote location, compared to participants residing within the inner suburbs of capital cities.
- Participants in either the 25-34, 35-44 or 45-54 age brackets, relative to their counterparts in the 18-24 age bracket.

Among **cisgender** participants, individuals were more likely to report any experience of homelessness if:

- They reported having ever experienced either intimate partner violence or violence from a family member.
- They have a disability, whether mild, moderate or severe.
- They were 25-34 years, 35-44 years, 45-54 years or 55+ years, relative to their counterparts in the 18-24 age bracket.
- They identified as either pansexual or queer.
- They resided in a remote or rural locale.
- They reported struggling with alcohol use.

Among **trans and gender diverse** participants, individuals were more likely to report prior experience of homelessness if:

- They reported having previously experienced either intimate partner violence or violence from a family member.
- They have a disability, whether mild, moderate or severe.
- Were in either the 35-44 or 45-54 age brackets.
- They reported struggling with alcohol use.

Any experience of homelessness	AOR (CI)
Sexual Orientation (ref: lesbian)	
Pansexual	1.55 (1.23 - 1.95)
Queer	1.37 (1.06 - 1.76)
Gender (ref: cisgender women)	
Trans man	2.93 (1.83 - 4.68)
Trans woman	2.69 (2.16 - 3.35)
Non-binary	1.94 (1.66 - 2.25)
Residential location (ref: inner-suburban)	
Regional city or town	1.27 (1.12 - 1.45)
Rural or remote	1.25 (1.04 - 1.51)
Age (ref: 14-17 years)	
18-21 years	1.17 (1.04 - 1.32)
Ethnicity (ref: Anglo-Celtic)	
Multicultural	1.18 (1.04 - 1.33)
Household Religiosity (ref: non-religious)	
Religious	1.25 (1.10 - 1.43)
Disability (ref: No disability)	
Disability	2.19 (1.92 - 2.49)

Recent experience of homelessness	AOR (CI)
Gender (ref: cisgender women)	
Trans man	1.93 (1.05 - 3.56)
Trans woman	2.19 (1.67 - 2.89)
Non-binary	1.64 (1.34 - 1.99)
Age (ref: 14-17 years)	
18-21 years	0.76 (0.64 - 0.89)
Ethnicity (ref: Anglo-Celtic)	
Multicultural	1.29 (1.01 - 1.52)
Residential location (ref: inner-suburban)	
Regional city or town	1.26 (1.05 - 1.51)
Rural or remote	1.38 (1.09 - 1.76)
Household religiosity (ref: non-religious)	
Religious	1.23 (1.04 - 1.45)
Recent physical harassment (ref: No)	
Yes	5.64 (4.68 - 7.05)
Recent verbal harassment (ref: No)	
Yes	3.49 (2.96 - 4.13)
Recent sexual harassment (ref: No)	
Yes	3.42 (2.88 - 4.06)

Ongoing experience of homelessness	AOR (CI)
Residential location (ref: inner-suburban)	
Regional city or town	1.57 (1.07 - 2.34)
Rural/Remote	1.39 (0.79 - 2.46)
Disability (ref: no disability)	
Disability	2.00 (1.37 - 2.92)

Homelessness and psychological distress	β (CI)
Recent Homelessness	6.62 (5.98 - 7.24)

Homelessness and problematic alcohol use	IRR (CI)
Recent Homelessness	1.26 (1.2 - 1.32)

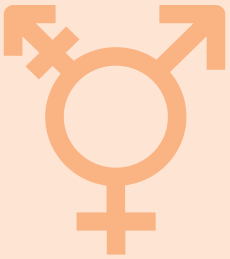
LIFETIME EXPERIENCES OF HOMELESSNESS

are most prevalent among LGBTQA+ adults who are trans and gender diverse as well as cisgender women, and those who identify as bisexual, pansexual and queer.

THE FINDINGS ALSO ILLUSTRATE HIGHER RATES OF LIFETIME HOMELESSNESS AMONG INDIVIDUALS RESIDING OUTSIDE OF METROPOLITAN CENTRES.

Homelessness is predominantly conceptualised as an issue specific to urban settings. However, these findings highlight a need for available support and resources outside of urban settings, where they are otherwise relatively absent.

BOTH CISGENDER AS WELL AS TRANS AND GENDER DIVERSE INDIVIDUALS WERE FOUND TO EXPERIENCE A COMPARABLE PROFILE OF RISK FACTORS,



which confer vulnerability to housing insecurity and homelessness. These factors include having a disability, prior experiences of violence from a family member or intimate partner and self-reported struggle with alcohol.

Interventions addressing homelessness within LGBTQA+ populations should ideally be tailored to the needs of the above-identified subgroups, and disseminated through channels that are most accessible to individuals within said groups. It is also important to note that LGBTQA+ people who have previously or are currently experiencing homelessness may require additional services and supports such as family violence supports or alcohol support services, and vice versa.

4.1.4 What are the risk and protective factors associated with experiences of homelessness among LGBT QA+ young people?

Rationale

For young LGBTQA+ persons, homelessness is a high prevalence experience which can represent a structural risk for both their immediate and future health outcomes and may undermine their future life chances. Though LGBTQA+ young persons are collectively established to be a vulnerable group, the distribution of homelessness burden among different LGBTQA+ subgroups is poorly understood.

Furthermore, homelessness and housing insecurity are also informed by a matrix of structural, institutional, and biographical factors that inform individual homelessness trajectories. Despite this, other biographic factors such as race and ethnicity, family religiosity, location of residence and disability have been omitted in Australian homelessness research. The current analyses therefore pursue these gaps in the literature and aims to investigate the factors associated with homelessness prevalence among LGBTQA+ young persons.

Dataset and sample population

Data from 6,114 *Writing Themselves In 4* participants who provided valid responses to questions about experiences of homelessness were included in these analyses.

Variables and analyses

A series of logistic regression models (both binomial and poisson models) were used to explore associations between homelessness and biographic characteristics, including age sexual identity, gender identity, race and ethnicity, family religiosity, residential location and disability. Associations between experiences of homelessness, experiences of physical and sexual harassment, and psychological distress and problematic alcohol use were also investigated.

Key findings

Lifetime experiences of homelessness were more prevalent among the following groups:

- Trans women, trans men and non-binary participants.
- Persons with disability.
- Participants who identified as either pansexual or queer.
- Multicultural participants.
- Participants from religious households.

Recent experiences of homelessness were more common among:

- Trans women, trans men and non-binary participants.
- Persons with disability.
- Multicultural participants.
- Participants from religious households.
- Participants from rural and remote locations.

Recent experiences of homelessness were less common among:

- Gay men.
- Participants in the 18-21 age group.

Ongoing experiences of homelessness were most likely to be reported by:

- Trans men
- Persons with disability.
- Participants from rural and remote locations.

Significantly higher odds of experiencing physical, sexual, and verbal harassment were noted for participants who reported experiences of homeless in the last 12 months. Participants who reported any experiences of homelessness were both more likely to report high or very high levels of psychological distress, as well as problematic levels of alcohol consumption.

Lifetime Experiences of Homelessness

Outcome	OR(CI)
Sexual Orientation (ref: lesbian)	
Pansexual	1.55 (1.23-1.95)
Queer	1.37 (1.06-1.76)
Gender (ref: cisgender women)	
Trans Man	2.93 (1.83-4.68)
Trans Woman	2.69 (2.16-3.35)
Non-Binary	1.94 (1.66-2.25)
Residential location (ref: inner-suburban area)	
Regional city or town	1.27 (1.12-1.45)
Rural or remote area	1.25 (1.04-1.51)
Age (ref: 14-17 years)	
18-21 years	1.17 (1.04-1.32)
Ethnicity (ref: Anglo-Celtic)	1.18 (1.04-1.33)
Household Religiosity (ref: non-religious)	
Religious	1.25 (1.10-1.43)
Disability (ref: No disability)	2.19 (1.92-2.49)

Recent Experiences of Homelessness

Outcome	AOR(CI)
Gender (ref: cisgender women)	
Trans Man	1.93 (1.05-3.56)
Trans Woman	2.19 (1.67-2.89)
Non-Binary	1.64 (1.34-1.99)
Age (ref: 14-17 years)	
18-21 years	0.76 (0.64 - 0.89)
Ethnicity (ref: Anglo-Celtic)	
Multicultural	1.29 (1.01-1.52)
Residential location (ref: inner-suburban area)	
Regional city or town	1.26 (1.05-1.51)
Rural or remote area	1.38 (1.09-1.76)
Household Religiosity (ref: non-religious)	
Religious	1.23 (1.04-1.45)

Outcome	AOR(CI)
Recent Physical Harassment (ref: no)	
Yes	5.64 (4.68-7.05)
Recent Verbal Harassment (ref: no)	
Yes	3.49 (2.96-4.13)
Recent Sexual Harassment (ref: no)	
Yes	3.42 (2.88-4.06)

Ongoing Experiences of Homelessness

Outcome	AOR(CI)
Residential location (ref: inner-suburban area)	
Regional city or town	1.57 (1.07-2.34)
Rural/Remote	1.39 (0.79-2.46)
Disability (ref: no disability)	
Disability	2.00 (1.37-2.92)

Homelessness and Psychological Distress

Outcome	ß (CI)
Recent Homelessness	6.62 (5.98-7.24)

Homelessness and Alcohol Consumption

Outcome	IRR (CI)
Recent Homelessness	1.26 (1.2-1.32)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

The findings illustrate several biographic factors associated with experiences of homelessness. Including gender, sexual orientation and multicultural background.

PANSEXUAL AND QUEER IDENTITIES ARE POORLY UNDERSTOOD OUTSIDE THE LGBTQA+ COMMUNITY, SUCH THAT THEY MAY CONSTITUTE A SOURCE OF POTENTIAL CONFLICT WITHIN FAMILIAL CONTEXTS WHICH LEADS TO EXPERIENCES OF PARENTAL REJECTION AND HOMELESSNESS.

The findings additionally highlight the material dimensions of disadvantage experienced by trans and gender diverse individuals and suggests that their experiences of housing insecurity and precarity may begin from an early age.

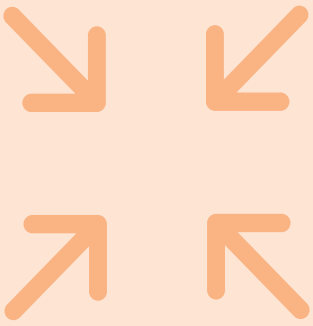
Higher prevalence of homelessness among non-Anglo-Celtic LGBTQA+ young persons may simultaneously indicate higher rates of parental rejection, as well as these youths' disproportionate reliance on family networks for support. Similarly, associations between family religiosity and experiences of homelessness may reflect experiences of familial/parent rejection due to religious objections towards sexual and/or gender diversity.

ELEVATED ALCOHOL CONSUMPTION LEVELS MAY REFLECT ATTEMPTS TO COPE WITH THE NEGATIVE SUBJECTIVE EXPERIENCE OF HOMELESSNESS

and/or may be a contributing factor to participants' pathways to homelessness.

FINALLY, HOMELESSNESS APPEARS TO BE ASSOCIATED WITH EXPERIENCING PHYSICAL, VERBAL AND SEXUAL HARASSMENT,

and present analyses point to a general clustering of risk. These experiences inform pathways to homelessness and are also more likely to occur to homeless individuals.



Efforts to minimise experiences of parental rejection, discrimination, harassment and reducing alcohol consumption among LGBTQA+ youth may indirectly attenuate their homelessness risk.

4.1.5 What are the risk and protective factors associated with experiences of homelessness among trans and gender diverse young people?

Rationale

More than one-fifth of *Trans Pathways* participants had experienced issues with housing and accommodation, including 18% who had ever experienced homelessness. Young trans and gender diverse people face high rates of discrimination and may be subject to rejection or abuse from family leading to unsafe home environments and housing instability. The aim of these analyses is to explore risk and protective factors that are associated with experiences of homelessness among young trans and gender diverse people.

Dataset and sample population

The 859 trans and gender diverse young people who participated in Trans Pathways were included in this analysis.

Variables and analyses

A multivariable logistic regression analysis was used to explore several factors that may be associated with participants reporting that they had ever experienced homelessness. This includes factors relating to support and discrimination, including lack of family support; any bullying, harassment, or verbal abuse; rejection from peers; and any discrimination. The analyses also included ever experiencing suicidal ideation or suicide attempt. Participants gender and age (under 18 or 18+ year) were included as confounding variables.

Key findings

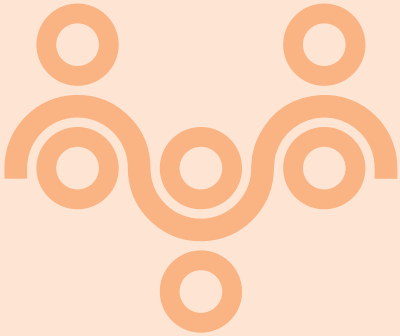
- While peer rejection, bullying or harassment, and experiences of discrimination were not associated with experiences of homelessness, young trans and gender diverse people who felt that they were supported by their family were substantially less likely to have experienced homelessness.
- Suicidal ideation was not associated with homelessness but those who had ever attempted suicide were more likely to report having experienced homelessness.

Outcome	AOR(CI)
Felt supported by family	0.33 (0.18-0.59)
Ever attempted suicide	2.83 (1.56-5.13)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

YOUNG TRANS AND GENDER DIVERSE PEOPLE FACE HIGH RATES OF HOMELESSNESS,

this is especially true for those who are not supported by their family. Ensuring affirming home environments is essential for protecting the welfare of young trans and gender diverse people.



THE RESULTS MAY ALSO SUGGEST THE PROTECTIVE ROLE THAT A SUPPORTING FAMILY CAN PLAY IN PROTECTING YOUNG PEOPLE FROM NEGATIVE IMPACTS OF DISCRIMINATION AND HARASSMENT OUTSIDE OF THE FAMILY.

YOUNG TRANS AND GENDER DIVERSE PEOPLE WHO EXPERIENCED HOMELESSNESS WERE ALSO MORE LIKELY TO HAVE EVER ATTEMPTED SUICIDE.

The directionality of this relationship is opaque, given that both suicidality and homelessness are underpinned by a common raft of factors (e.g., discrimination, familial rejection, behavioural problems). However, as both are mutually implicated as contributing factors, it is possible that these associations reflect a bi-directional relationship.

These findings reflect the importance of providing services that can address the unique needs of trans and gender diverse youth in crisis. It is essential to recognise that those experiencing homelessness may require mental health support, and vice versa. Additionally, the research highlights the crucial role of supportive families in ensuring welfare of trans and gender diverse youth. Therefore, supporting families to provide the necessary support to young people in this population may lead to better welfare and housing security.

4 .1.6 What are the schooling experiences of cisgender LGB+ young persons who experience homelessness? How do these impact their engagement with schooling?

Rationale

Access to educational opportunity is often viewed as a long-term structural solution to homelessness, and educational attainment appears to exert protective direct and indirect effects against future likelihood of homelessness. However, for young persons experiencing homelessness, accessing the benefits of education can be a challenging prospect. Homelessness is both highly disruptive to continual engagement with schooling and predisposes affected individuals to experiencing factors which greatly hinder educational achievement. Cisgender Lesbian, Gay and Bi+ young persons are a group which is disproportionately impacted by homelessness, yet little is understood about LGB+ young persons' experiences of homelessness. Research that investigates the disruptive impact of homelessness on LGB+ youths' engagement in schooling, and interfaces between schooling and homelessness experiences in Australia is currently lacking. These analyses therefore attends to this gap in the evidence.

Dataset and sample population

Data from 6,114 *Writing Themselves In 4* participants who were enrolled in educational institutions such as secondary school, university, and TAFE (Technical and Further Education) at the time of participation or within the past 12 months were included in these analyses.

Variables and analyses

Data was multiply imputed over 40 times using fully conditional specifications with homelessness as a grouping variable, including as auxiliary variables, gender, sexual orientation, disability, family religiosity, location (capital city, regional city, remote/rural) and ethnicity. After testing the relationship between experience of homelessness and harassment via bivariate regression, two multiple groups structural equation models were estimated, and mediational pathways between any form of harassment, mental distress, and truancy. This was further stratified by previous experiences of homelessness.

Key findings

- Previous experiences of homelessness were associated with experiences of physical and sexual harassment within education settings.
- Experiences of physical and sexual harassment in turn underpin associations between psychological distress and truant behaviours among cisgender LGB+ youth with experiences of homelessness.
- Mediational models linking harassment, mental distress and truancy were similar in several respects between those with and without experience of homelessness.
- Previous experiences of homelessness appeared to uniquely potentiate the associations between school-based harassment and truancy.

"IMPROVING THE SCHOOLING EXPERIEN HOMELESSNESS IS LIKELY A KEY PRERE OUTCOMES FOR THESE INDIVIDUALS, AN TO EXPERIENCING HOME

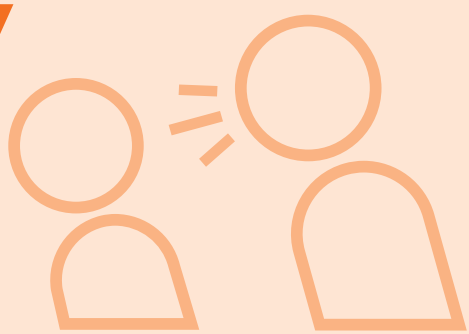
Mediation Model Path/Effect	OR (CI)
Experience of Homelessness -> Physical Harassment	4.08 (3.08–5.41)
Experience of Homelessness -> Sexual Harassment	2.82 (2.18–3.64)
Multiple-Groups Structural Equation Models for Physical Harassment	**Estimate (CI)**
Harassment -> Mental Distress (Without Homelessness)	3.69 (1.99–5.35)
Harassment -> Mental Distress (With Homelessness)	4.06 (2.47–5.63)
Harassment -> Truancy (Without Homelessness)	1.31 (0.85–1.78)
Harassment -> Truancy (With Homelessness)	1.40 (0.90, 1.90)
Mental Distress -> Truancy (Without Homelessness)	0.08 (0.07–0.09)
Mental Distress -> Truancy (With Homelessness)	0.12 (0.10–0.14)
Multiple-Groups Structural Equation Models for Sexual Harassment	**Estimate (CI)**
Harassment -> Mental Distress (Without Homelessness)	2.17 (0.82–3.52)
Harassment -> Mental Distress (With Homelessness)	2.76 (1.05–4.46)
Harassment -> Truancy (Without Homelessness)	0.81 (0.45–1.16)
Harassment -> Truancy (With Homelessness)	0.68 (0.16, 1.22)
Mental Distress -> Truancy (Without Homelessness)	0.08 (0.07–0.09)
Mental Distress -> Truancy (With Homelessness)	0.12 (0.10–0.14)
Re-estimated Multiple-Groups Models	**Estimate (CI)**
Indirect Effect (Without Homelessness)	0.30 (0.21–0.39)
Indirect Effect (With Homelessness)	0.45 (0.30–0.61)
Difference in Indirect Effects	0.15 (0.07–0.26)
Indirect Effect (Without Homelessness)	0.30 (0.16–0.44)
Indirect Effect (With Homelessness)	0.19 (0.10–0.28)
Difference in Indirect Effects	0.11 (0.05–0.19)

CES OF LGB+ STUDENTS EXPERIENCING EQUISITE FOR BETTERING EDUCATIONAL D FOR REDUCING THEIR VULNERABILITY ELESSNESS AS ADULTS."

SUMMARY AND IMPLICATIONS OF THE FINDINGS

Both LGB+ and homeless persons are vulnerable to experiences of physical and sexual harassment, and these vulnerabilities may be compounded for LGB+ people with experiences of homelessness.

YOUNG PEOPLE WITH EXPERIENCES OF HOMELESSNESS ARE MORE LIKELY TO EXPERIENCE BULLYING



but are not more affected by bullying compared to other LGB+ youth. Instead, this group is more likely to respond to experiences of bullying by absenting themselves from schools.

HOMELESS STUDENTS MAY EXPERIENCE CONSIDERABLE OBSTACLES TO SCHOOL ATTENDANCE – INCLUDING THOSE RELATING TO MOBILITY AND STABILITY.

Our findings additionally suggest that homeless students' schooling experiences themselves may constitute a further obstacle to school attendance.

Given that homeless students' truanting may reflect the prioritization of their own emotional safety, punitive responses to these behaviours may prove counterintuitive to effort to ensure homeless students' continued engagement in schooling. Improving the schooling experiences of LGB+ students experiencing homelessness is likely a key prerequisite for bettering educational outcomes for these individuals, and for reducing their vulnerability to experiencing homelessness as adults.

4.2 Income inequality

This section details the findings relating to income reported among LGBTQA+ people, in addition to the following further analyses of income inequality:

- Who among LGBTQA+ adults are most likely to be on low incomes and what factors are associated with reporting a low-income level? (*Private Lives 3*)

4.2.1 Key findings from previously published research

LGBTQA+ Adults (Private Lives 3)

- 42.8% (n = 2,890) of participants reported an income of $1,000 or more per week.
- Almost one third (31.3%; n = 2,113) of participants reported an income of less than $400 per week (below the Australian poverty line of $457 per week).
- According to Pride and Pandemic data, 23.4% (n = 685) of LGBTQA+ adults reported that they were not able to live comfortably on their income during the pandemic. 17.0% (n = 515) had received Job Seeker payments and 16.9% (n = 513) had received Job Keeper payments.
- Many LGBTQA+ adults expressed at least some concern about the impact of the pandemic on their employment (71.4%; n = 2,020), and financial situation (75.7%; n = 2,293)

LBQ Women (SWASH)

- 18.2% (n = 470) LBQ+ women reported an annual pre-tax income of below $20,000, 14.8% (n = 382), earned between $20,000 and $39,999, 14.4% (n = 371) earned between $40,000 and $59,999, 30.7% (n = 793) earned between $60,000 and $99,999, and 21.9% (n = 565) earned $100,000+.
- More than one-third (36.3%, n = 948) of LBQ+ women experienced reduced income, work hours or a loss of work as a result of the COVID-19 pandemic.

Trans and Gender Diverse Youth (TransPathways)

- 41.9% (n = 281) of trans young people had experienced issues with employment

4.2.2 Who among LGBTQA+ adults are most likely to be on low incomes and what factors are associated with reporting a low-income level?

Rationale

LGBTQA+ populations are disproportionately impacted by employment and income insecurity. A better understanding of income inequality within the LGBTQA+ population is therefore necessary to enhance efforts to better align policy and services with the needs of economically disadvantaged LGBTQA+ people. With the goal of informing the development of targeted solutions to address inequities mediating both workforce participation and income levels, and ensuring that those unable to work have adequate financial support, this analysis is aimed at determining the sociodemographic factors associated with low income attainment among LGBTQA+ adults.

Dataset and sample population

Data from 5,521 *Private Lives 3* participants who reported their weekly income bracket were included in the analysis.

Variables and analyses

Low income was defined as an average weekly income of $0-$799, based on the criteria to qualify and retain eligibility for Low-income Health Care Card. Univariable logistic regression analyses were used to compare rates of low-income across gender and sexual orientation. A multivariable logistic regression analysis was also conducted to assess sociocultural factors among participants reporting no income or an income below $800/week, compared to those reporting an income of $800/week or more, with no/low-income versus medium/high income as the outcome variable. Correlates of low-income explored included residential location (inner-suburban, outer-suburban, regional, rural or remote), connection within the LGBTQA+ community, unfair treatment based on gender identity or sexual orientation, family or intimate partner violence, disability severity; and born in a country other than Australia. Age, gender and sexual orientation were included in the model as confounding factors.

Key findings

The frequency of reporting an average weekly income of $0-$799 per week (i.e., a low weekly earnings) were:

- More prevalent among cisgender women compared to cisgender men, and substantially higher still among trans men, trans women, and non-binary people.
- More prevalent among those who identified as bisexual, pansexual, queer, asexual or something else.

LGBTQA+ adults were more likely to report receiving an average weekly income of $0-$799 per week (i.e., a low weekly earnings) if they:

- Lived outside of inner-suburban areas.
- Were living with a mild disability, moderate disability, or severe disability.

Outcome	AOR(CI)
Gender (ref: cisgender men)	
Cisgender women	1.87 (1.67-2.09)
Trans men	4.19 (3.21-5.46)
Trans women	3.34 (2.57-4.34)
Non-binary	3.67 (3.12-4.33)
Sexual orientation (ref: gay)	
Bisexual	2.88 (2.52-3.28)
Pansexual	3.26 (2.67-3.98)
Queer	2.10 (1.80-2.46)
Asexual	4.83 (3.51-6.64)
Something else	2.26 (1.87-2.73)
Residential location (ref: inner-suburban area)	
Outer-suburban area	1.36 (1.15-1.60)
Regional city or town	1.62 (1.35-1.93)
Rural or remote area	2.24 (1.69-2.98)
Disability (ref: no disability)	
Mild disability	1.64 (1.26-2.13)
Moderate disability	2.71 (2.28-3.23)
Severe disability	5.98 (4.74-7.53)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

THE FINDINGS ILLUSTRATE A NEED TO ADDRESS INCOME INEQUALITY WITHIN THE LGBTQA+ POPULATION.

Cisgender women and trans and gender diverse adults were the most likely to report low income attainment, as LGBTQA+ adults who identified as a sexual orientation other than gay or lesbian.

LGBTQA+ ADULTS WERE ALSO MORE LIKELY TO REPORT LOW-INCOMES IF THEY WERE LIVING OUTSIDE OF INNER-SUBURBAN AREAS AND IF THEY HAD A DISABILITY.

NO DIFFERENCE IN INCOME LEVELS WERE OBSERVED

according to country of birth, experiences of LGBTQA+ community connection, discrimination based on sexual orientation or gender, or experience of intimate partner or family of origin violence.

Income inequality is not implicitly linked to sexual orientation or gender; rather, these observed inequalities are likely the result of systemic forms of discrimination which confer barriers to workforce participation, income security, and high salary positions for people with minoritised sexual orientations and genders. The findings further demonstrate the geographical maldistribution of, and impacts of disability on, financial security.

4.3 Chapter summary

There is a substantial material component to the marginalisation and disadvantage that LGBTQA+ individuals experience. This profoundly impacts the health and wellbeing of this group, impacting some LGBTQA+ communities more noticeably than others. Seeking to elaborate upon prior evidence and explore expand knowledge in the Australian context, the current chapter presented findings of the relative prevalence of material disadvantage within LGBTQA+ population. By analysing income and housing data, this chapter demonstrates the uneven distribution of economic deprivation within the LGBTQA+ community and identifies several sub-groups of especial concern.

In conjunction, these findings shed some light on the mechanisms by which disadvantage, and marginality can coalesce into group-level disparities in health and wellbeing commonly observed within LGBTQA+ populations. Economic deprivation and housing insecurity reliably cooccur with factors that engender poorer health and wellbeing. It is therefore likely that those groups most impacted by homelessness and housing insecurity simultaneously experience factors which contribute to poorer health and wellbeing.

Across all referenced sample populations, participants who are (i) trans or gender diverse, (ii) cisgender women, (iii) disabled, (iv) who identified as non-monosexual (i.e., not Lesbian or Gay) and (v) who live in non-metropolitan locales experienced significant disadvantage in relation to the measured outcomes. As this relates to groups such as cisgender women and disabled persons, our findings further reflect the compounding or cumulative impact of multiple sources of disadvantage (e.g., as stems from sexism and ableism, respectively) in obstructing access to economic participation and opportunity.

There are several gaps in the available data to be mindful of, which could be addressed by future research. Analyses are needed which utilize data measures that may provide a more comprehensive illustration of LGBTQA+ individuals' socioeconomic circumstances and potential experiences of economic deprivation, such as measures of self-reported financial stress and more hollistic measures of poverty.

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5. DISCRIMINATION AND ABUSE

The stigma and discrimination that LGBTQA+ individuals encounter daily takes many forms, ranging from explicit forms of violence and abuse[1] to subtler kinds of prejudice[2]. LGBTQA+ individuals are more likely to experience violence and victimisation than their heterosexual/cisgender counterparts[3 4].

These experiences, in turn, contribute significantly to the sizeable health disparities between these groups[5 6 7]. When such experiences of discrimination and/or abuse transpire within settings where LGBTQA+ individuals expect to feel safe and accepted – such as in family settings – the negative consequences of discrimination and abuse can be profound[7]. Despite this, the burden and incidence of discrimination and abuse is seldom evenly distributed among the various LGBTQA+ subgroups, but instead concentrated amongst those individuals who experience disadvantage or marginality unrelated to sexual or gender minority identity[8]. Much of this evidence is derived from settings outside of Australia and so there is a lack of understanding of these experiences for LGBTQA+ individuals in Australia.

5.1 Discrimination and abuse

Findings relating to discrimination and abuse have been the subject of numerous papers already published from these datasets or are reported on as key issues shaping health outcomes in other chapters of this report. As such, while this section details the key findings from previously published research relating to discrimination and abuse, it does not present any further exploration of data relating to discrimination and abuse.

5.1.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 57.0% (n = 3,769) of LGBTQA+ adults had been treated unfairly because of their sexual orientation in the past 12 months. Comparatively, 77.5% (n = 1,278) of trans and gender diverse adults had been treated unfairly because of their gender identity.
- The most frequently reported forms of heterosexist violence or harassment were social exclusion (39.5%, n = 2,405), verbal abuse (34.6%, n = 2,100), being spat at or offensive gestures (23.6%, n = 1,415), written threats of abuse (22.1%, n = 1,310) or refusal of service (10.0%, n = 597).
- 11.8% (n = 698) of participants had been sexually assaulted and 3.9% (n = 231) had been physically attacked or assaulted with a weapon in the past 12 months due to their sexual orientation or gender identity.
- Low proportions of LGBTQA+ adults felt accepted by others.
- Participants felt more accepted at LGBTQA+ events/venues (67.5%, n = 3,552) than at mainstream events/venues (28.7%, n = 1,695). Only 30.5% (n = 1,965) felt accepted in other public spaces.
- 43.4% (n = 2,695) reported feeling accepted when accessing a health or support service.
- Trans and gender diverse adults reported higher levels of harassment and abuse than cisgender adults. For example, a greater proportion of trans women (51.6%, n = 130), non-binary participants (49.4%, n = 412) and trans men (45.0%, n = 118) reported verbal abuse in the past 12 months due to their sexual orientation or gender identity compared to 28.7% (n = 748) of cisgender women and 32.7% (n = 675) of cisgender men.

LBQ+ Women (*SWASH*)

- 33.5% (n = 865) of LBQ+ women had experienced at least one form of anti-LBQ+ behaviour in the last 12 months. Specifically, 28.6%, (n = 744) of LBQ+ women had experienced verbal abuse or harassment in the past 12 months and 12.6% (n = 326) had received personal threats or abuse online. Less common forms of anti-LBQ+ behaviour included physical threats or intimidation (7.2%, n = 187), been pushed or shoved (3.6%, n = 94), workplace discrimination such as refusal of employment or promotion (3.2%, n = 82), refused service (3.2%, n = 83) and been beaten up (1.2%, n = 32).

LGBTQA+ Young People (*Writing Themselves In 4*)

- 60.2% (n = 2,316) of LGBTQA+ young people felt unsafe or uncomfortable in the past 12 months at secondary school due to their sexuality or gender identity, compared to 29.2 (n = 450) of participants at university and 33.8% (n = 128) of participants at TAFE.
- 74.3% (n = 278) of trans men, 67.7% (n = 46) of trans women and 65.8% (n = 746) of non-binary people had felt unsafe or uncomfortable at their education setting compared to 44.2% (n = 581) of cisgender men and 42.2% (n = 1,289) of cisgender women.
- In their lifetime, 57.6% (n = 3,559) of young LGBTQA+ people had experienced verbal harassment and 15% (n = 839) had experienced physical harassment or assault.
- In the past 12 months, 40.8% (n = 2,524) had experienced verbal harassment, 22.8% (n = 1,273) experienced sexual harassment or assault, and 9.7% (n = 529) experienced physical harassment or assault, based on their sexuality or gender identity.
- 71.2% (n = 52) of trans women and 63.3% (n = 252) of trans men reported experiencing verbal harassment based on their sexuality or gender identity in the past 12 months, followed by 52.8% (n = 619) of non-binary participants, 45.0% (n = 607) of cisgender men, and 30.2% (n = 915) of cisgender women.
- Experiences of verbal (21.2%, n = 1,250) and physical (4.7%, n = 245) harassment or assault based on sexuality or gender identity were reported to have occurred at education institutions more frequently than any other setting.

Trans and Gender Diverse Young People (*Trans Pathways*)

- 74% (n = 497) of trans and gender diverse young people had ever experienced bullying, 68.9% (n = 454) had ever experienced discrimination, 16.2% (n = 109) had ever experienced extrafamilial physical abuse and 24.3% (n = 161) had ever experienced extrafamilial sexual abuse.

RESEARCH PAPERS

Associations between negative life experiences and the mental health of trans and gender diverse young people in Australia: findings from *Trans Pathways*. This paper illustrates high rates of rates of peer rejection, precarious accommodation, bullying and discrimination among a sample of trans and gender diverse young people. These negative experiences were associated with poor mental health outcomes.

Mental Health Issues and Complex Experiences of Abuse Among Trans and Gender Diverse Young People: Findings from *Trans Pathways*. This paper illustrates complex experiences of abuse and their association with mental health outcomes among trans and gender diverse young people. Extrafamilial physical abuse, familial physical abuse, extrafamilial sexual abuse, familial sexual abuse, abuse within an intimate relationship, and other familial abuse (including emotional or verbal abuse and neglect) were also associated with poor mental health overall.

Factors associated with experiences of abuse among lesbian, gay, bisexual, trans, queer, and asexual (LGBTQA+) adults with disability in Australia. This paper illustrates high rates of verbal abuse, sexual assault and social exclusion based on their sexual or gender identity in the past 12 months among LGBTQA+ adults with a disability. Verbal abuse was more likely among trans women and non-binary participants and among those classified with more severe disability. Sexual assault was more likely among those who lived in a rural area or had a higher income. Social exclusion was more likely among those who were trans woman or non-binary, identified as bisexual, aged 18-24 years, or born in an English-speaking country other than Australia.

Demographic and psychosocial factors associated with recent suicidal ideation and suicide attempts among lesbian, gay, bisexual, pansexual, queer, and asexual (LGBQ) people in Australia: Correlates of suicidality among LGBQ Australians. This paper illustrates that experiences of harassment, discrimination and abuse are associated with suicidal ideation and/or suicide attempts among LGBQ people, while community connection and social acceptance are protective against suicidality. The likelihood of suicidal ideation was greater for those who identified as queer or felt that they had been treated unfairly or socially excluded due to their sexual identity, and lower among those in a committed relationship, who felt part of the LGBTQA+ community, or felt accepted in family, work and healthcare settings. The likelihood of attempting suicide was higher for those aged younger or had recently experienced verbal abuse or social exclusion, and lower for those in a committed relationship or felt a part of the LGBTQA+ community.

Demographic and psychosocial factors associated with recent suicidal ideation and suicide attempts among trans and gender diverse people in Australia. This paper illustrates that experiences of harassment, discrimination and abuse are associated with suicidal ideation and/or suicide attempts among trans and gender diverse people, while social acceptance and trans affirming medical practices were observed to be protective. Likelihood of suicidal ideation was higher among participants who felt that they had been treated unfairly or socially excluded due to their gender identity in the past year or were younger in age, and lower for those with a postgraduate degree, who felt accepted by family or at work, and who felt that their gender identity was respected when accessing a mainstream medical clinic. The likelihood of suicide attempts was higher among those who had recently experienced sexual harassment based on their gender or sexual orientation or who were younger, and lower for those who were non-binary.

Suicidal Ideation and Suicide Attempts Among Lesbian, Gay, Bisexual, Pansexual, Queer, and Asexual Youth: Differential Impacts of Sexual Orientation, Verbal, Physical, or Sexual Harassment or Assault, Conversion Practices, Family or Household Religiosity. This paper illustrates higher likelihood of suicidal ideation among young people who had experienced any verbal, physical or sexual harassment based on their sexual orientation or gender identity. Further factors associated with suicidal ideation included having a religious family or household or experiencing conversion practices in the past 12 months. Factors associated with suicidal ideation and attempts included younger age (14-17 years), lesbian identifying and living in a rural or remote location. Lower likelihood of experiencing suicidal ideation or attempt was found among participants who reported feeling a part of their school.

5.2 Chapter summary

The evidence presented in this chapter demonstrates that experiences of discrimination based on sexual and gender identity have a direct and undeniable impact on the mental health and wellbeing of LGBTQA+ individuals. The type, source and recency of discrimination play a significant role in determining the extent of these negative outcomes and comprise factors that are non-uniformly distributed among various LGBTQA+ subgroups. These finding concurrently suggest that these negative outcomes can be attenuated by accessing positive, identity-affirming experiences within one's family, workplace and with other LGBTQA+ individuals. This indicates that one way to temper associations between discrimination and negative health outcomes is by facilitating LGBTQA+ individuals' access to such positive experiences.

Presently, however, there is a lack of clear understanding regarding the specific relationship between identity-affirming social experiences and the extent to which they provide protective benefits against negative mental health outcomes. Future research is required to attend to this gap, and advance current understanding about how this association is differentiated by demographic variations inherent within the LGBTQA+ population. The findings presented in this chapter further suggest that investigating this relationship among both trans and gender diverse, as well as disabled individuals, may be an important priority, given the elevated incidence of discriminatory experiences and heightened levels psychological distress within this group.

5.3 References

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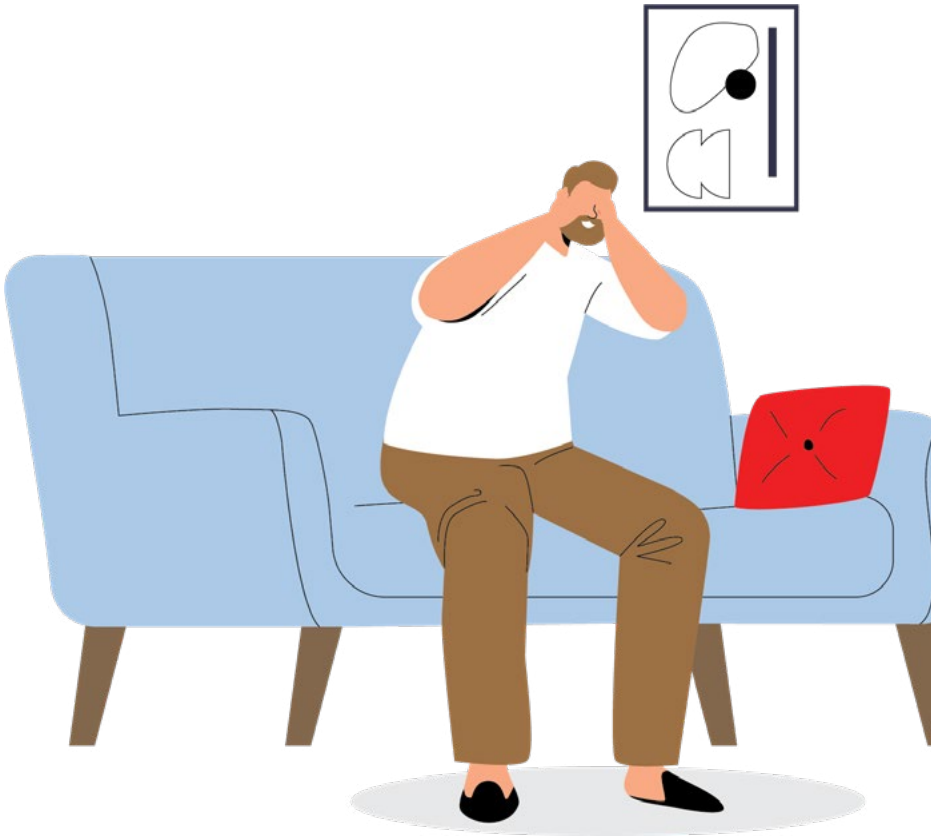
6. FAMILY VIOLENCE AND SEXUAL ASSAULT



Family violence (defined here as either violence from an intimate partner or from a member of one's family of origin) is a high prevalence experience among LGBTQA+ people, which shapes negative immediate and long-term outcomes for individuals impacted by it.[1 2 3 4] Current framings of family violence, which often focus on heterosexual and parent-child relationships, can obscure the recognition of abusive patterns within LGBTQA+ individuals' own relationships[5].

Additionally, LGBTQA+ people may face distinct forms of abuse that involve the use of sexual and/or gender identity discrimination against them as victim-survivors[6]. Population-level data describing the incidence of family violence among LGBTQA+ populations is lacking within the Australian context[7]. However, current estimates suggest that LGBTQA+ populations experience family violence at rates either comparable to, or greater than the general population[8]. Further, experiences of sexual assault, within or external to the context of family violence, appear to disproportionately impact members of the LGBTQA+ community[9]. Seeking support after an experience of sexual assault is made particularly challenging for LGBTQA+ victim-survivors due to cis-and-heteronormative articulations of sexual assault in professional support contexts, and the problematic stereotyping of LGBTQA+ individuals which is said to minimise sexual violence experiences and justify victim-blaming to these groups[10]. As such, LGBTQA+ people more frequently anticipate and experience negative treatment at support services[11].

6.1 Intimate partner and family of origin violence

This section details the key findings relating to experiences of family violence, as well as further explorations of:

- What are GBQ+ cisgender men's experiences surrounding family of origin violence and intimate partner violence? (*Private Lives 3*)
- How is the prevalence of intimate partner violence distributed across subgroups of LBQ+ women, and who perpetrates intimate partner violence against this population? (*SWASH*)
- Were high rates of family violence exacerbated by COVID-19 lockdowns among LGBTQA+ adults? (*Pride and Pandemic*)
- What factors are associated with LGBTQA+ individuals reporting their most recent experience of family violence and are they feeling supported when they report? (*Private Lives 3*)

6.1.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 41.7% (n = 2,846) of LGBTQA+ adults reported they had ever been in an intimate relationship in which they felt they were abused by their partner/s. 27.3% (n = 1,864) reported one intimate relationship in which they felt they were abused in some way and 14.4% (n = 982) reported more than one.
- 60.7% (n = 3,716) reported experiences indicative of intimate partner violence.
- Emotional abuse (48.1%, n = 2,942) was the most commonly reported form of intimate partner violence, followed by verbal abuse (42.4%, n = 2,594), physical violence (25.0%, n = 1,528) and sexual assault (21.8%, n = 1,332).
- 38.5% (n = 2,629) stated they had ever been abused by a family member. 21.3% (n = 1,454) reported being abused by one family member, and 17.2% (n = 1,175) by more than one family member.
- 64.9% (n = 4,019) reported experiences indicative of abuse from a family member.
- Verbal abuse (41.5%, n = 2,568) was the most commonly reported form of violence from a family member, followed by LGBTQA+ related abuse (40.8%, n = 2,526), emotional abuse (39.3%, n = 2,433), physical violence (24.2%, n = 1,497) and sexual assault (9.7%, n = 599).
- 18.7% (n = 886) had reported the most recent incident of family violence to a counselling service or psychologist, followed by 5.9% (n = 279) to the police and 4.4% (n = 210) to a doctor or hospital.
- Participants reported feeling most supported by a counselling service or psychologist (89.4%, n = 788) and least supported by police (including LGBTQA+ liaison officers) (45.0%, n = 125).

LBQ+ Women (*SWASH*)

- 48.2% (n = 1,252) of LBQ+ women had experienced intimate partner violence in their lifetime.

Trans and Gender Diverse Young People (*Trans Pathways*)

- 24.8% (n =164) of trans and gender diverse young people had ever experienced physical abuse within the family, 7.5% (n = 50) had ever experienced familial sexual abuse, and 57.9 (n = 377) had ever experienced other forms of familial abuse (verbal, emotional or neglect)
- 30.9%, n = 205) had ever experienced abuse within an intimate relationship.

RESEARCH PAPERS

Naming and recognition of intimate partner violence and family of origin violence among LGBTQA+ communities in Australia. This paper explored naming and recognition of family violence among LGBTQA+ adults through analysis of responses two questions. Experiences of intimate partner violence and family of origin violence were assessed in two ways: a direct question relating to abuse from a partner/s or family member/s, and a second question (asked irrespective of the previous answer) which sought to establish experience of a nuanced list of abusive acts that can constitute violence (including, for example, emotional abuse, LGBTQA+-specific forms of violence, and enforced social isolation). When asked about experiences of intimate partner violence and family of origin violence using the second nuanced question, more people reported these experiences than indicated through the direct question. The findings indicate that some LGBTQA+ people may struggle to recognise or name their family or relationship experiences as abusive or violent.

Mental Health Issues and Complex Experiences of Abuse Among Trans and Gender Diverse Young People: Findings from *Trans Pathways*. This paper illustrates complex experiences of abuse and their association with mental health outcomes among trans and gender diverse young people. Extrafamilial physical abuse, familial physical abuse, extrafamilial sexual abuse, familial sexual abuse, abuse within an intimate relationship, and other familial abuse (including emotional or verbal abuse and neglect) were also associated with poor mental health overall.

Preferences for types of inclusive family violence services among LGBTQA+ people in Australia. This paper explored preferences for family violence services, whether from a mainstream service that is not known to be LGBTQA+-inclusive, from a mainstream service that is known to be inclusive or from a service that caters specifically to LGBTQA+ people. The majority of LGBTQA+ adults expressed a preference for a service that was LGBTQA+-inclusive or catered specifically to LGBTQA+ people. The paper further explores who was most likely to hold these preferences, with differences observed across gender, sexual orientation, attending a regular GP, and previous experience with reporting family violence.

Family violence within LGBTQA+ communities in Australia: intersectional experiences and associations with mental health outcomes. This paper illustrates high rates of intimate partner violence and family of origin violence among LGBTQA+ adults. Experiences of violence were found to be associated with gender, age, and educational attainment. Participants with a moderate or severe disability as well as those who had ever experienced homelessness were more likely to have experienced intimate partner violence family of origin violence. Additionally, recent experiences of suicidal ideation, suicide attempt and high/very high psychological distress were associated with experiences of family of origin violence and intimate partner violence.

6.1.2 What are GBQ+ cisgender men's experiences surrounding family of origin violence and intimate partner violence?

Rationale

Both violence from a family member[12] and intimate partner violence[13] are high prevalence experiences for sexual minority persons, including GBQ+ cisgender men. Sexual minority individuals may hold lower relationship expectations and a higher tolerance of violence from loved ones, due to past experiences of discrimination[12] as well as the internalisation of homophobia and other forms of oppression[14 15 16] Findings from previous *Private Lives 3* research, further suggest that gay men are least likely to directly identify their experiences of family violence[9]. The aim of these analyses is to explore the occurrence of, and factors associated with, experiences of family violence among cisgender GBQ+ men.

Dataset and sample population

Data from 2,125 GBQ+ cisgender men who participated in *Private Lives 3* were included in the present analyses, along with data from 2,711 LBQ+ cisgender women for comparison.

Variables and analyses

Descriptive data relating to the prevalence of lifetime experiences of (i) violence from a family member, (ii) intimate partner violence, (iii) whether they had reported their most recent experience of violence to an authority, health provider or someone else, and (iv) perceived support when reporting these experiences was collected.
A chi-square test was further performed to understand how rates of reporting the most recent experience of violence from a family member or intimate partner to an authority, health provider or someone else differs between cisgender GBQ+ men and cisgender LBQ+ women. Subsequently, to understand the demographic factors associated with reporting experiences of family of origin or intimate partner violence, a logistic regression was performed. Input variables included sexual orientation, gender identity, location of residence, income, previous experiences of homelessness, and having a regular GP.

Key findings

- Nearly one-third of GBQ+ cisgender men (31.9%, n = 591) in the sample had ever experienced family of origin violence, whereas slightly over half of all GBQ+ men (53.1%, n = 979) had ever experienced intimate partner violence.
- GBQ+ men (23.3%, n = 280) were less likely than LBQ+ cisgender women (28.5%, n = 561) to have reported their most recent experience of violence to an authority, health provider or someone else.
- Most GBQ+ cisgender men (84.5%, n = 235) who reported their experiences of violence to someone said that they felt supported when doing so.
- Among GBQ+ cisgender men, having reported their most recent experience of either violence from a family member or intimate partner was significantly associated with (i) having a regular GP and (ii) previous experience of homelessness.

Comparison between GBQ+ cisgender men and LBQ+ cisgender women

	Chi2 (p)
Reported most recent experiences of family violence	10.68 (0.001)

Cisgender GBQ+ men: odds of having reported most recent experience of family violence

	OR (CI)
Regular healthcare provider (ref: regular GP at regular health centre)	
No regular GP, but regular health centre	0.69 (0.49 - 0.98)
No regular GP and no regular health centre	0.55 (0.32 - 0.95)
Any experience of homelessness (ref: No)	
Yes	1.67 (1.21 - 1.29)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

HIGH RATES OF FAMILY VIOLENCE WERE OBSERVED AMONG GBQ+ CISGENDER MEN.

However, GBQ+ cisgender men were less likely than LBQ+ cisgender women to have reported their most recent experience of violence to someone.

GBQ+ CISGENDER MEN HAD REPORTED

their most recent experience of violence to a variety of both informal and professional sources of support, and largely felt that these experiences were supportive.

THOSE WHO HAD A REGULAR GP WERE ALSO MORE LIKELY TO HAVE REPORTED THEIR EXPERIENCES OF VIOLENCE TO SOMEONE,

suggesting that while interactions with healthcare providers provide a crucial opportunity for GBQ+ cisgender men to disclose their experiences of family and/or intimate partner violence, GBQ+ men may only feel comfortable disclosing experiences of violence to healthcare workers with whom some degree of rapport has previously been established.

ASSOCIATIONS WERE FURTHER OBSERVED BETWEEN EXPERIENCES OF HOMELESSNESS AND FAMILY VIOLENCE REPORTING.

While an experience of homelessness itself may not predict family violence reporting, GBQ+ cisgender men who experience homelessness as a result of family violence may be more inclined to report these experiences.

It is essential that family violence services and supports are available to meet the needs of GBQ+ cisgender men who are subject to these forms of violence. Additional resourcing of LGBTQA+ community-controlled organisations to provide support for victim-survivors of family violence, as well as training within the mainstream family violence sector to provide safe and inclusive services to all LGBTQA+ community members, is necessary to meet the needs of GBQ+ cisgender men.

6.1.3 How is the prevalence of intimate partner violence distributed across subgroups of LBQ+ women, and who perpetrates intimate partner violence against this population?

Rationale

LBQ+ women experience high rates of intimate partner violence[17], however, there is little quantitative evidence that examines whether there are differences among this demographic group in terms of the prevalence of this experience[17]. The present analyses therefore offer an exploratory perspective on the relative prevalence of intimate partner violence among a large sample of LBQ+ women and provide initial insights into the gendered dynamics surrounding these experiences of abuse.

Dataset and sample population

Data from 2,621 participants from *SWASH* were included in the current analyses.

Variables and Analyses

Multivariable logistic regressions were first performed to explore associations between lifetime experiences of intimate partner violence, and demographic factors including sexual orientation, disability and language spoken at home, while controlling for the confounding effect of participant age. Subsequently, descriptive statistics pertaining to the gender of intimate partner violence perpetrators were also conducted. Participants were asked to select as many perpetrator genders as applied, consequently proportions may add to greater than 100%).

Key findings

Almost half (48.2%, n = 1,252) of LBQ+ women reported having experienced intimate partner violence in their lifetime. Rates of experiences of intimate partner violence were found to differ between some subgroups of participants, specifically:

- Relative to lesbian participants, participants who identified as bisexual, queer or selected multiple sexual orientations were the most likely to report having experienced intimate partner violence.
- Individuals who reported a disability or long-term health condition were significantly more likely than their counterparts without a disability to have experienced intimate partner violence during their lifetime.

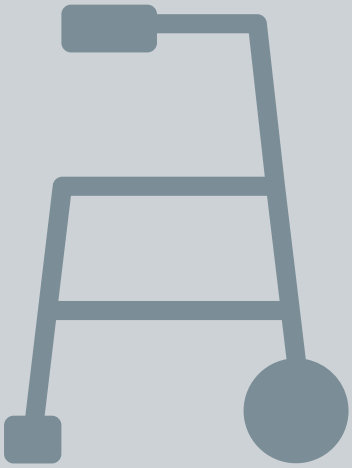
Intimate partner violence	AOR (CI)
Sexual orientation (ref: lesbian)	
Bisexual	1.41 (1.14 - 1.74)
Queer	1.43 (1.09 - 1.87)
Multiple selected	1.35 (1.07 - 1.72)
Disability (ref: No)	
Yes	1.95 (1.66 - 2.29)

Proportionally, cisgender men were identified as the largest group of intimate partner violence perpetrators by participants who had experience intimate partner violence (64.7%, n = 813), followed by cisgender women (41.0%, n = 515). Only a small proportion of participants identified the individuals using violence against them as trans or gender diverse (8.7%, n = 109).

SUMMARY AND IMPLICATIONS OF THE FINDINGS

FINDINGS DEMONSTRATE THAT

BI+ INDIVIDUALS AND THOSE WITH A DISABILITY ARE MORE VULNERABLE TO INTIMATE PARTNER VIOLENCE.



A unifying commonality among the vulnerable groups identified within these analyses which predisposes them to intimate partner violence may relate to a lack of

SOCIAL SUPPORT AND RECOGNITION

FROM BOTH MAINSTREAM SOCIETY AND LGBTQA+ COMMUNITIES.

LGBTQA+-inclusive intimate partner violence service provision means refraining from making unqualified assumptions about any woman seeking support around abuse. The most likely perpetrator of intimate partner violence was a cisgender man - a heterosexual-presenting relationship may involve an LBQ+ woman, and an LBQ+ woman may seek support for violence experienced in a current or past heterosexual-presenting relationship. However, violence by cisgender women and gender diverse partners is not uncommon. Assuming a heterosexual relationship, or a cisgender male perpetrator, may leave LBQ+ women feeling excluded and miss crucial nuance in providing support to women victim-survivors.

6.1.4 Were high rates of family violence exacerbated by COVID-19 lockdowns among LGBTQA+ adults?

Rationale

The potential exacerbation of violence from family members and intimate partners during the COVID-19 pandemic and associated lockdowns was of concern for those living in Australia[18]. Within LGBTQA+ communities the impacts of the pandemic may have been disproportionately felt, with high rates of family violence reported by the community even prior to the pandemic. This paper explored rates of violence from family members and intimate partners as well as whether this violence was new or worsening during the pandemic. Additionally, the impacts of lockdowns on family violence were examined, taking advantage of a natural experiment by comparing reports of family violence among those living the states that experienced the most extensive lockdowns (Victoria and New South Wales) to the rest of the country.

Dataset and sample population

Data from 3,135 LGBTQA+ participants from *Pride and Pandemic* were included in these analyses.

Variables and analyses

Sociodemographic factors (age, gender, sexual orientation, ethnicity, residential location) associated with experiences of family violence were identified using a series of univariable regression models for each outcome (violence from an intimate partner, new/worsening violence from an intimate partner, violence from a family member, new/worsening violence from a family member). To account for missing data, 20 datasets were multiply imputed using fully conditional specifications. Age was imputed using predictive mean matching, and all other variables were imputed using logit link with augmentation for sparseness. Additionally, the impact of lockdowns was estimated using an augmented inverse probability weighting estimator with all covariates as matching factors. Results from each of the 20 multiply imputed datasets were combined and balance of covariates (i.e., success of the reweighting) for each dataset were checked separately.

Key findings

The study revealed high rates of violence from an intimate partner (16.9%) or family member (29.1%) during the pandemic, with 8.5% and 10.4% respectively indicating that this violence was new or worsening during the pandemic.

Experiences of violence from an intimate partner during the pandemic varied across different sociodemographic traits. Specifically, violence from an intimate partner was found to:

- Most likely to be experienced by participants of an ethnicity other than Asian or White.
- Least likely to be experienced by cisgender men.
- Least likely to be experienced by participants who identified as gay.
- Most likely to be experienced by participants living outside of inner-suburban areas (in outer suburban, regional and rural or remote areas).

Reports of new or more frequently occurring violence from an intimate partner during the pandemic were:

- Highest among participants of Asian ethnicity.
- Lowest among cisgender men.
- Highest among participant living in a rural or remote area.

Any violence from an intimate partner	AOR (CI)
Ethnicity (ref: white)	
Ethnicity other than Asian or White	1.71 (1.19 - 2.46)
Gender (ref: cisgender women)	
Cisgender men	0.74 (0.58 - 0.95)
Sexual orientation (ref: lesbian)	
Gay	0.72 (0.54 - 0.96)
Residential location (ref: inner-suburban)	
Outer-suburban	1.29 (1.01 - 1.64)
Regional city/town	1.36 (1.06 - 1.76)
Rural/remote	1.58 (1.04 - 2.42)
New or worsening violence from an intimate partner	
Ethnicity (ref: white)	
Asian ethnicity	1.97 (1.21 - 3.22)

New or worsening violence from an intimate partner

Gender (ref: cisgender women)	
Cisgender men	0.69 (0.50 - 0.96)
Residential location (ref: inner-suburban)	
Rural or remote	1.83 (1.10 - 3.05)

Experiences of violence from a family member during the pandemic also varied across different sociodemographic traits. Specifically, violence from a family member was found to:

- Most likely be experienced by participants of an Asian ethnicity.
- Least likely be experienced by cisgender men.
- Most likely to be experienced by trans and gender diverse participants.
- Most likely to be experienced by participants who identified as bisexual, pansexual, or asexual.
- Most likely to be experienced by participants living outside of inner-suburban areas (in outer suburban, regional and rural or remote areas).

Reports of new or more frequently occurring violence from a family member during the pandemic were:

- Highest among trans and gender diverse participants.
- Highest among pansexual and asexual participants.
- Highest among participants living in outer-suburban areas and regional cities or towns.

Any violence from a family member	OR (CI)
Ethnicity (ref: white)	
Asian ethnicity	1.69 (1.21 - 2.36)
Gender (ref: cisgender women)	
Cisgender men	0.41 (0.33 - 0.52)
Trans women	1.55 (1.04 - 2.32)
Trans men	2.59 (1.87 - 3.60)
Non-binary	1.96 (1.56 - 2.45)

Any violence from a family member	OR (CI)
Sexual orientation (ref: lesbian)	
Gay	0.45 (0.35 - 0.58)
Bisexual	1.56 (1.21 - 2.01)
Pansexual	2.37 (1.74 - 3.24)
Asexual	1.92 (1.25 - 2.94)
Residential location (ref: inner-suburban)	
Outer-suburban	1.69 (1.39 - 2.06)
Regional city or town	1.67 (1.36 - 2.07)
Rural/remote	1.71 (1.20 - 2.45)

New or worsening violence from a family member

Gender (ref: cisgender women)	
Cisgender men	0.61 (0.43 - 0.85)
Trans women	2.34 (1.40 - 3.90)
Trans men	1.91 (1.21 - 3.00)
Non-binary	1.87 (1.36 - 2.57)
Sexual orientation (ref: lesbian)	
Gay	0.59 (0.40 - 0.86)
Pansexual	1.62 (1.05 - 2.50)
Asexual	1.88 (1.07 - 3.31)
Residential location (ref: inner-suburban)	
Outer-suburban	1.94 (1.45 - 2.59)
Regional city or town	1.45 (1.05 - 2.00)

Rates of violence from a family member or from an intimate partner, as well as rates of new or worsening violence from a family member or from an intimate partner, during the pandemic did not significantly differ between Victoria or New South Wales and the rest of Australia, suggesting that lockdowns did not impact the prevalence of family violence within the LGBTQA+ community, as self-reported by participants at the time of the survey.

SUMMARY AND IMPLICATIONS OF THE FINDINGS

VIOLENCE FROM FAMILY MEMBERS AND INTIMATE PARTNERS WERE EXPERIENCED AT HIGH RATES DURING THE PANDEMIC.

These experiences, while high across the community, were experienced more by some parts of the LGBTQA+ community more than others. Most notably, violence from family members as well as worsening violence from family members during the pandemic was highest among trans and gender diverse adults, and intimate partner violence highest among people from Asian backgrounds or ethnicities other than White.

NEW AND MORE FREQUENTLY OCCURRING INCIDENTS OF VIOLENCE FROM AN INTIMATE PARTNER OR FAMILY MEMBER

indicate the challenges many LGBTQA+ people living with a partner during the pandemic or returning to live with their family of origin may have experienced.

EXPERIENCES OF VIOLENCE FROM AN INTIMATE PARTNER OR FAMILY MEMBER

WERE NOT FOUND TO BE IMPACTED

BY EXTENDED PERIODS OF LOCKDOWNS.

These findings likely reflect broader contexts of the pandemic. Many facets of the COVID-19 pandemic, such as loss of employment and housing, returning home to live with unsupportive family and longer time spent with abusers due to self-isolation would likely have exacerbated experiences of family violence, even in those states without extended periods of lockdowns.

Efforts are needed to address enduring impacts of the COVID-19 pandemic through prioritising the needs of those who experienced new or worsening family violence, as well as a focus on prevention. The findings from these analyses re-enforce a need for direct policy solutions aimed at continuing to address the structures, systems and social factors that drive high levels of family violence for LGBTQA+ people. These solutions are needed in general as well as in-face of future crises, including localised disasters such as floods and bushfires, that may lead to similar challenges relating to isolation and displacement for the LGBTQA+ communities impacted.

6.1.5 What factors are associated with LGBTQA+ individuals reporting their most recent experience of family violence and are they feeling supported when they report?

Rationale

Most professional family violence supports are tailored to the needs of cisgender, heterosexual clients. This is likely to contribute to the low utilisation of these services by LGBTQA+ individuals19. LGBTQA+ victim-survivors may refrain from utilising mainstream family violence services due to a combination of anticipated discrimination, and perceptions that these services are ill-equipped to support to LGBTQA+ individuals11 19. Instead, LGBTQA+ victim-survivors may rely primarily on a patchwork of informal supports, as well as the occasional professional service that has been determined to be LGBTQA+-inclusive.[19] Because LGBTQA+ victim-survivors present to family violence services at lower rates than the general population, data capturing broader patterns of reporting and support-seeking are currently lacking from the literature. The present analyses pursue this gap in the evidence by investigating the factors associated with reporting experiences of family violence among LGBTQA+ victim-survivors and explores their experiences of support in relation to reporting experiences of family violence.

Dataset and sample population

4,607 *Private Lives 3* participants who had ever experienced either intimate partner violence or family of origin violence were included in these analyses.

Variables and Analyses

Two multivariable variable logistic regression analyses were performed. In each model, the outcome variable was set as: (i) reporting an experience of violence (to an emergency service, authority, healthcare provider or other non-professional support) and (ii) feeling supported after reporting this experience, respectively. Predictor variables included demographic factors (age, gender, sexual orientation, level of education, current engagement in paid employment, weekly net income, area of residence, country of birth), homelessness and having a regular GP. Additionally, descriptive analyses were conducted to determine proportions of participants who reported to individual services and the frequency with which they felt supported by these services/individuals.

"VICTIM-SURVIVORS MUST NOT ONLY HAVE ACCESS TO AND KNOWLEDGE OF SUPPORT SERVICES OR AUTHORITIES THAT THEY CAN REPORT TO, BUT THEY NEED TO FEEL THAT THEIR REPORTS WILL BE TAKEN SERIOUSLY, AND THAT THEY WILL BE SAFE AND TREATED RESPECTFULLY WHEN DOING SO."

Key findings

Nearly three-quarters of *Private Lives 3* participants (73.4%) had ever experienced family violence. Among these participants, however, only one-quarter (25.4%) stated that they had reported their most recent experience of family violence to someone. Among those who reported their experiences of family violence, most (84.6%) reported that they felt supported by the service/individual they reported this violence to.

Of those who reported their most recent experience of family violence:

- The largest proportion (18.7%, n = 886) reported to a counselling service or psychologist, followed by just 5.9% (n = 279) who reported to police (including LGBTQA+ liaison officer).
- They most frequently indicated feeling supported by a counselling service of psychologist (89.4%) and a substantially smaller proportion felt supported by police (45.0%).

Reporting one's experiences of family violence was more likely among participants who:

- Were non-binary.
- Attended a regular GP.
- Had ever experienced homelessness.
- Had some form of post-secondary education.

Reporting one's experiences of family violence was less likely among participants who:

- Were from a non-English speaking country.

Feeling supported while reporting experiences of family violence was:

- More likely among participants who had a regular GP.
- Less likely among participants who had ever experienced homelessness.

Reported most recent instance of family violence	OR (CI)
Gender Identity (ref: cisgender man)	
Non-binary	1.33 (1.04 - 1.69)
Birth Country (ref: Australia)	
Non-English-Speaking Country	0.64 (0.43 - 0.94)
Education (ref: secondary school)	
Non-university tertiary/ post-secondary	1.24 (1.00 - 1.53)
University-undergraduate	1.31 (1.06 - 1.62)
University-postgraduate	1.41 (1.11 - 1.79)
Felt supported when reporting family violence	
Attended a regular GP	2.00 (1.18 - 3.37)
Any experience of homelessness	0.55 (0.39 - 0.77)
Attended a regular GP (ref: No)	
Yes	1.59 (1.25 - 2.04)
Lifetime experience of Homelessness (ref: No)	
Yes	1.60 (1.37 - 1.86)

Felt supported when reporting family violence

Attended a regular GP (ref: No)	
Yes	2.00 (1.18 - 3.37)
Any experience of homelessness (ref: No)	
Yes	0.55 (0.39 - 0.77)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

PARTICIPANTS MOST FREQUENTLY REPORTED ABUSE TO A COUNSELLING SERVICE OR PSYCHOLOGIST

with much smaller proportions reporting to the police or a domestic or family violence service. This may reflect participant preferences for reporting or the accessibility and quality of care that they receive when reporting to these services.

PARTICIPANTS BORN OUTSIDE ENGLISH-SPEAKING COUNTRIES MAY EXPERIENCE SIGNIFICANT CULTURAL AND LINGUISTIC BARRIERS TO ACCESSING SUPPORT.

Victim-survivors from socially conservative communities may also wish to avoid risking incidental sexual or gender identity disclosure.

PRESENT ANALYSES ALSO REVEAL A SIGNIFICANT SOCIO-ECONOMIC COMPONENT TO VICTIM-SURVIVORS' OPPORTUNITIES FOR REPORTING ABUSE.

Individuals reporting higher educational attainment may have a greater level of literacy regarding family violence and greater access to options for reporting family violence.

Similar rates of reporting were found across all genders with the exception of non-binary participantswho were more likely to have reported their most recent experience of family violence.

IMPORTANTLY, THE HIGHER LIKELIHOOD OF PARTICIPANTS WITH REGULAR GPS TO REPORT EXPERIENCES OF ABUSE SUGGEST THAT

PRIMARY CARE PHYSICIANS

can play a significant role in supporting LGBTQA+ victim-survivors' engagement in professional services.

The findings from these analyses suggest an urgent need to shift narratives around family violence to re-frame heteronormative assumptions of violence dynamics among family violence responders and service providers. Victim-survivors must not only have access to and knowledge of support services or authorities that they can report to, but they need to feel that their reports will be taken seriously, and that they will be safe and treated respectfully when doing so. Engagement with a regular GP and establishing family violence services that cater to the specific needs of LGBTQA+ communities, as well as training mainstream service providers to recognise diverse relationship dynamics in family violence, are necessary for improving support outcomes of LGBTQA+ survivors of family violence.

6.2 Sexual assault

This section details the key findings relating to experiences of sexual assault, as well as further explorations of:

- What is the prevalence of sexual assault and poor mental health among bi+ cisgender women, and what are the associations between these two experiences? (*Private Lives 3*)

6.2.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- Almost half (48.6%, n = 3,314) of all LGBTQA+ adults reported having ever been coerced or forced into sexual acts they did not want to engage in: 64.3% (n = 123) non-binary people compared to 54.5% (n = 1,604) of cisgender women, 54.9% (n = 164) of trans men, 41.8% (n = 119) of trans women and 34.7% (n = 806) of cisgender men.
- Queer (66.5%, n = 552), pansexual (62.0%, n = 311) and bisexual (57.1%, n = 792) identifying participants reported the highest rates of ever experiencing sexual assault, followed by 46.2% (n = 642) of lesbian, 44.7% (n = 96) of asexual and 34.4% (n = 671) of gay identifying participants.
- 8.9% (n = 607) of participants had experienced sexual assault in the past 12 months: 13.4% (n = 123) of non-binary people, 9.1% (n = 267) of cisgender women, 7.5% (n = 174) of cisgender men, 7.4% (n = 21) of trans women and 6.4% (n = 19) of trans men.
- For the most recent time a sexual assault occurred, participants' reported perpetrators were most commonly former intimate partners (21.9%, n = 725), followed by current intimate partners (19.4%, n = 641), friends (19.4%, n = 642), casual encounters (19.1%, n = 632) and strangers (18.4%, n = 609).
- For the most recent time a sexual assault occurred, participants' reported perpetrators were most commonly cisgender men (84.3%, n = 2,710), followed by cisgender women (14.4%, n = 464), non-binary people (1.8%, n = 59), trans women, (1.3%, n = 41) and trans men (1.2%, n = 37).

6.2.2 What is the prevalence of sexual assault and poor mental health among bi+ cisgender women, and what are the associations between these two experiences?

Rationale

Sexual abuse is a high prevalence experience among bi+ (e.g., multi-gender attracted) cisgender women that is thought to be significantly associated with negative mental health outcomes,[20 21] yet remains largely underexamined within the Australian context. Bi+ cisgender women experience unique forms of stereotyping and discrimination which can originate from both heterosexual and LGBTQA+ communities.[17] Further, there are unique forms of sexual objectification which contribute to significant health disparities relative to their monosexual (i.e., lesbian-identifying) counterparts.[22] Past analyses have grouped bi+ and monosexual cisgender women together. This approach overemphasises the commonalities between these groups and fails to portray the nuances of bi+ women's experiences.[21] To address this gap, these analyses explore the prevalence and correlates of psychological distress and experiences of sexual abuse, and further examine the gender of and relationship participants shared with perpetrators.

Dataset and sample population

1,439 bisexual (n = 876), queer (n = 338) and pansexual (n = 225) cisgender women who participated in *Private Lives 3* were included in the present analysis.

Variables and analyses

Participants responded to a question asking whether they had ever been coerced or forced into sexual acts they did not want to engage in. They then reported (i) whether this occurred in the past 12 months or longer than 12 months ago, (ii) whether this abuse occurred in the context of an intimate relationship, and (iii) the perpetrator's gender. In the analysis, descriptive statistics were used to determine perpetrator gender and relationship context. Univariable logistic regression was used to explore the distribution of reported sexual abuse among bi+ subgroups. Multivariable logistic regressions explored associations between sexual identity, experiences of sexual abuse, and mental health outcomes (e.g., psychological distress, past year suicidal ideation and suicidal attempt).

Key findings

- 67% of bisexual, queer, or pansexual cisgender women had ever experienced sexual assault in their lifetime (n = 973), while 12% indicated experiences of sexual assault had occurred in the past 12 months (n = 181).
- 80% of bi+ cisgender women who reported recent (past 12 months) experiences of sexual abuse also reported high and very high levels of psychological distress. Concurrently, 64% reported recent (past 12 months) suicidal ideation and 18% had attempted suicide in the past year.
- Perpetrators were predominantly identified as cisgender men: comprising 89% of all perpetrators overall (93% among bisexual, 92% among pansexual and 81% among queer-identifying cisgender women).
- Perpetrators were most commonly an intimate partner (51% - 25% were current and 26% were former partners), and 17% indicated their experiences of abuse occurred in the context of a casual sexual encounter. Most perpetrators were previously known to the victim-survivor, with only 14% indicating the perpetrator had been a stranger.
- Participants reporting recent (past 12 months) experiences of sexual assault were significantly more likely to experience high or very high levels of psychological distress, recent (past 12 months) suicidal ideation, and report a recent (past 12 months) suicidal attempt.

Factors associated with recent sexual assault	AOR (CI)
High/very high psychological distress	1.93 (1.23 - 3.05)
Past-year suicidal ideation	3.01 (2.05 - 4.40)
Past-year suicide attempt	7.04 (3.16 - 15.72)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

The findings suggest that experiences of sexual assault are significantly associated with negative mental health outcomes among bi+ cisgender women and therefore contribute substantially to mental health burdens in this populations.

THE FINDINGS FURTHER SUGGEST THAT SEXUAL ABUSE WITHIN HETEROSEXUAL-PRESENTING INTIMATE PARTNERSHIPS – AND INTIMATE PARTNER VIOLENCE, MORE GENERALLY – ARE HIGH PREVALENCE EXPERIENCES FOR BI+ CISGENDER WOMEN.

THE NEGATIVE CONSEQUENCES OF EXPERIENCING SEXUAL ABUSE FOR BI+ CISGENDER WOMEN MAY BE UNDERSCORED BY

LOW LEVELS OF SUPPORT

experienced from their monosexual peers and professional support services.

Professional services and service workers should avoid making assumptions about the sexual identities of female clients presenting with experiences of heterosexual sexual abuse and should ideally be adept at recognising and responding to non-heterosexual sexual abuse. These findings further suggest that support for individuals who have experienced sexual abuse should optimally be paired with interventions intended to reduce suicidal ideation and intention, as well as engagement with self-harming behaviours. Mental health services need to be attentive to very high rates of sexual assault, and their possible contribution to presenting distress.

6.2 Chapter summary

Evidence presented in this chapter highlights the need for family violence and sexual assault services which are not only LGBTQA+-inclusive, but which are equipped to provide appropriate and emotionally safe forms of care for LGBTQA+ victim-survivors of family violence and sexual assault. Experiences of sexual assault and family violence cause considerable mental health burdens among sexual minority individuals, and these findings corroborate the value of primary prevention targeted to address gendered and patriarchal norms around consent, dominance and control to minimise perpetrating behaviours, as well as other awareness-raising initiatives to support LGBTQA+ individuals in recognising the contours of family violence within their own relationships.

LGBTQA+ individuals' experiences of family of origin violence remain understudied and these experiences may be implicitly normalised within LGBTQA+ individuals' own understandings of family relationships, particularly with regard to rejection of their identities. Given the implicitly heteronormative and cisnormative construction and organisations of family units and relationships, individuals who fail to conform to these expectations may experience both rejection and considerable hostility within these settings. Further research is required to investigate these experiences more thoroughly.

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7. ALCOHOL AND OTHER DRUGS

LGBTQA+ individuals are more likely to use a range of licit and illicit substances when compared to the general population of cisgender and/or heterosexual people.

There are also indications that many within the LGBTQA+ communities are likely to have a more problematic relationship with alcohol or other drugs[1]. As with other minority populations, recreational substance use among LGBTQA+ populations has sometimes been unfairly sensationalised within public discourses and co-opted into narratives that pathologise LGBTQA+ identities[2 3]. Simultaneously, problematic substance use can shape a range of social, mental, physical and sexual health experiences.[4 5 6] Previous research indicates that the disproportionate incidence of substance use among LGBTQA+ populations can be understood within the context of (i) using substances to cope with holding a stigmatised or socially disadvantaged sexual or gender identity, (ii) the normalisation of substance use within LGBTQA+ subcultures[7], and in the case of alcohol, (ii) advertising and promotion efforts specifically targeting LGBTQA+ consumers.[8] As such, data derived from both global and Australian contexts generally demonstrates higher rates of substance use among LGBTQA+ individuals compared to the general population.[9 10 11] Some evidence further suggests that smoking[12], vaping[13] recreational drug use[14] is increasing among LGBTQA+ populations.

7.1 Tobacco

This section details the key existing findings, already published, relating to prevalence of tobacco consumption, as well as further explorations of:

- Which LBQ+ women are currently smoking? (*SWASH*)
- Which LBQ+ women are currently vaping? (*SWASH*)

7.1.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 19.5% (n = 1,337) of LGBTQA+ adults reported being current smokers, with 10.2% (n = 699) of those being daily smokers. One quarter (25.2%, n = 1,719) were ex-smokers. This compares to 15.2% current smokers, and 13.8% daily smokers, in the general Australian population[15].
- Approximately one fifth of gay (21.9%, n = 428), queer (21.2%, n = 176), pansexual (20.7%, n = 104) and bisexual (20.7%, n = 286) identifying participants were current smokers. As were 14.6% (n = 203) of lesbian and 6.5% (n = 14) of asexual participants.
- 24.0% (n = 559) of cisgender men were current smokers, compared to 18.4% (n = 169) of non-binary people, 17.7% (n = 53) of trans men, 16.7% (n = 493) of cisgender women and 16.1% (n = 46) of trans women.
- 12.9% (n = 883) reported having ever used vapes. 5.7% (n = 392) reported currently using vapes and 7.2% (n = 491) reported having used them but no longer using them. This is higher than the 11.3% of people reporting having ever used vapes, 2.5% currently using them and 5.2% no longer using them in the general Australian population.[15]

LBQ+ Women (*SWASH*)

- 6.2% (n = 162) of LBQ+ women reported smoking cigarettes daily. A further 5.8% (n = 152) reported current smoking on a less frequent basis. One-quarter (25.3%, n = 660) were ex-smokers and 62.6% (n = 1,632) were never-smokers.
- 55.9% (n = 214) of current smokers desired to reduce their level of smoking or quit.
- Among 16-24-year-olds, 11.9% (n = 84) were current smokers, as were 11.6% (n = 115) of 25-34-year-olds, 15.2% (n = 72) of 35-44-year-olds, and 9.9% (n = 43) of participants aged 45+.
- 50.6% (n = 1,320) of respondents had ever tried or used vapes. This proportion includes the 10.1% (n = 264) of respondents who reported daily vape use.

LGBTQA+ Young People (*Writing Themselves In 4*)

- 11.5% (n = 740) of LGBTQA+ young people were current smokers; including 8.0% (n = 300) of those aged 14 to 17 years, and 16.6% (n = 440) of those aged 18 to 21 years.
- The proportion of those aged 18 to 21 years who were daily smokers (7.8%, n = 206) was lower than that observed in a survey of young people of the same age in the general population (closest available data for comparison).[16]
- 5.0% (n = 324) reported currently using vapes; 4.2%, (n = 159) of those aged 14 to 17 years, and 6.2% (n = 165) aged 18 to 21 years.

Trans and Gender Diverse Young People (*Trans Pathways*)

- 29.5% (n = 218) of trans and gender diverse young people had ever used tobacco.

RESEARCH PAPERS

Alcohol and tobacco consumption among Australian sexual minority women: Patterns of use and service engagement This paper from *Private Lives 3* highlights that alcohol and tobacco consumption differ across sexual minority women and intersecting characteristics. It also illustrates that alcohol and tobacco consumption frequently cooccur among LBQ+ women and that self-identifying alcohol struggle is an important predictor of seeking support for alcohol use. Suggestions are made in the paper for future research, health practice and policy initiatives.

7.1.2 Which LBQ+ women are currently smoking?

Rationale

Globally, tobacco use is a leading preventable cause of mortality and morbidity. Concerted government intervention within Australia, as well as changing societal attitudes towards tobacco use has precipitated a general decline in consumption among the general population in recent decades. These trends appear to be reversed among LGBTQA+ populations, however, and may instead be gaining in popularity among LGBTQA+ communities in Australia.[17] The key demographic driving these trends appear to be LBQ+ women, among whom rates of tobacco consumption are high.[18] This likely contributes significantly to the health disparities frequently observed between LBQ+ women, and the general population. At present, however, there is little clarity regarding the sociodemographic factors which are associated with tobacco use, aside from sexuality. As a granular understanding of the subgroups of LBQ+ women who are most likely to engage in tobacco use precedes the successful implementation of tailored and targeted interventions, the present analyses aim to provide some clarity on this subject.

Dataset and sample population

Data from 2,621 participants from the *SWASH* survey were included in the current analyses.

Variables and analyses

A multivariable logistic regression was performed to examine associations between current tobacco use and the following demographic characteristics: age, sexuality, linguistic diversity, income, presence of dependent children, high or very high psychological distress, whether or not participants had a regular GP, connectedness to the LGBTQA+ community, lifetime alcohol and other drug use, and concerns regarding one's alcohol and other drug use.

Key findings

A small proportion (12.1%, n = 314) of LBQ+ women were currently smoking tobacco. Reporting current tobacco use was significantly more likely among LBQ+ women who:

- Reported lifetime other drug use.
- Reported concerns regarding their alcohol use in the last 12 months.
- Reported concerns regarding their use of other drugs in the last 12 months or earlier.

Current tobacco use	AOR (CI)
Concerns about alcohol use (ref: never)	
Yes, in the last 12 months	1.38 (1.02 – 1.89)
Lifetime other drug use (ref: No)	
Yes	3.06 (2.22 - 4.22)
Concerns about drug use (ref: never)	
Yes, more than 12 months ago	1.87 (1.32 – 2.67)
Yes, in the last 12 months	3.41 (2.31 – 5.05)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

While only a relatively small proportion of LBQ+ women were currently using tobacco, those who were current smokers were more likely to have ever used or felt concern regarding drug consumption or who have felt concern in the past 12 months regarding alcohol consumption.

Associations between drug and/or alcohol use or concern and smoking may reflect some degree of engagement in the use of multiple substances (polysubstance use) among LBQ+ women and their engagement within social spaces where substance use is more common. However, it is also important to note the timeframe of the *SWASH* survey, which was open for completion shortly after an extended period of COVID-19 lockdowns in Sydney.

IT IS POSSIBLE THAT THE ISOLATION FROM SOCIAL SPACES IN WHICH SUBSTANCE USE IS MORE COMMON ALLOWED SPACE FOR PARTICIPANTS TO REFLECT ON THEIR PATTERNS OF CONSUMPTION.

TO BETTER UNDERSTAND THESE OUTCOMES, MOTIVATIONS FOR SUBSTANCE USE NEED TO BE EXPLORED WITHIN THIS COMMUNITY.

The findings suggest that current tobacco use may be an indication of other, concurrent health concerns for LBQ+ women, such as problematic alcohol or drug use. Healthcare providers need to consider the cooccurrence of these health behaviours to best meet the needs of LBQ+ women and assist current smokers to reduce their tobacco consumption.

7.1.3 Which LBQ+ women are currently vaping?

Rationale

Vaping refers to the recreational usage of electronic cigarette devices which commonly aerosolises a nicotine solution for easy inhalation. Originally conceived as a cigarette replacement to aid in smoking cessation, the popularity of these devices among younger cohorts in high income nations is alarming. Rates of vaping are also elevated among LBQ+ women.[19] A raft of psychological, chemical and social incentives may be driving the popularity of vaping, however the underlying mechanisms which engender its widespread use among LGBTQA+ populations, and LBQ+ women in particular, remain poorly understood. To better understand the apparent popularity of vapes among sexual minority women, these analyses aim to explore the demographic factors associated with vape use, and to understand whether vaping is associated with smoking cession (i.e., its intended use) among LBQ+ women.

Dataset and sample population

Data from 2,621 participants from the SWASH survey were included in the current analyses, including a sample of 383 participants who answered a question about desire to quit smoking.

Variables and analyses

A multivariable logistic regression was performed to explore associations between demographic factors and vape use. Demographic factors assessed as input variables in this analysis were as follows: age, sexuality, linguistic diversity, income, high or very high psychological distress, whether or not participants had a regular GP, connectedness to the LGBTQA+ community, lifetime drug and/or alcohol use, concerns regarding one's alcohol or other drug use, and smoking status (never smoked, current smoker or ex-smoker). A second logistic regression was also undertaken to investigate associations between vape use and smoking cessation intention and controlled for the effects of participants' age.

Key findings

50.3% (n = 1,433) of respondents had ever tried or used vapes. This proportion includes the 10.1% (n = 288) of respondents who reported daily vape use. Current vape use was more likely among LBQ+ women who:

- Were aged 18-24.
- Reported having previously used either alcohol or other drugs.
- Reported high or very high levels of psychological distress.
- Reported recent (past 12 months) concerns regarding alcohol use.

Among LBQ+ women who were currently smokers, participants were more likely to vape if they wanted to quit smoking.

Current vape use	AOR (CI)
Age (ref: 18-24)	
25-34	0.49 (0.35 - 0.69)
35-44	0.14 (0.08 - 0.22)
45+	0.07 (0.39 - 0.13)
High/very high psychological distress (ref: No)	
Yes	1.41 (1.07 - 1.85)
Lifetime alcohol use (ref: No)	
Yes	2.43 (1.41 - 4.20)
Concerns about alcohol use in past 12 months (ref: No)	
Yes	1.44 (1.05 – 1.97)
Lifetime other drug use (ref: No)	
Yes	4.44 (3.28 – 6.00)
Smoking status (ref: non-smoker)	
Ex-smoker	8.24 (5.99 – 11.33)
Current smoker	9.42 (6.53 - 13.57)
Intention to quit smoking (among current smokers) (ref: No)	
Yes	1.79 (1.16 - 2.76)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

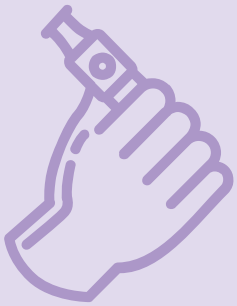
THE CONCENTRATION OF REPORTED VAPE USE WITHIN YOUNGER AGE GROUPS DEMONSTRATES A CLEAR COHORT EFFECT.

Concurrently, that high levels of psychological distress were significantly associated with current vape use within this sample suggests that LBQ+ women within the sample may be motivated by the psychological and chemical incentives of vaping (e.g., to cope with psychological distress), and in the past these women may have been using tobacco.

THE CONNECTIONS OBSERVED BETWEEN VAPING AND PRIOR DRUG AND ALCOHOL USE AMONG LBQ+ WOMEN

may indicate a tendency among LBQ+ women to engage in polysubstance use and reflect social engagement within spaces where these are commonly occurring substances.

THE FINDINGS FURTHER SUGGEST A CONSIDERABLY GREATER LIKELIHOOD OF VAPING AMONG THOSE LBQ+ WOMEN WHO WERE CURRENT SMOKERS.



Additionally, among current smokers, vape use was associated with desires for smoking cessation. These outcomes may suggest the use of vaping as an active tobacco reduction effort, but also may simply reflect engagement in dual use of tobacco and vapes.

FURTHER RESEARCH IS NECESSARY TO UNDERSTAND MOTIVATION FOR VAPE USE AND ITS RELATIONSHIP TO TOBACCO USE.

Additional research investigating the qualitative dimensions of population- and cohort-specific factors underpinning the popularity of vaping among young LBQ+ women is needed. Furthermore, future research should attend to the possibility that the disproportionate prevalence of vaping may contribute to widening health disparities between LBQ+ women and their non-LBQ+ counterparts within the general population.

7.2 Alcohol

This section details the key findings relating to frequency of alcohol consumption, self-reported problematic alcohol use and alcohol support service access, experiences and preferences, as well as further explorations of:

- What demographic factors and social experiences are associated with self-perceived problematic alcohol consumption among LGBTQA+ adults? (*Private Lives 3*)
- Among LGBTQA+ adults, who is most likely to indicate a preference for community-controlled or mainstream alcohol support services? (*Private Lives 3*)

7.2.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3, Pride and Pandemic*)

- 26.8% (n = 1,815) of LGBTQA+ adults reported drinking monthly or less, 27.5% (n = 1,866) 2–4 times per month, 18.7% (n = 1,268) 2–3 times per week and 13.3% (n = 902) four or more times per week.
- Of those who reported drinking alcohol, 71.6% (n = 4,183) reported ever drinking six or more drinks on one occasion. 16.4% (n = 960) of these individuals reported drinking six or more drinks monthly, 12.4% (n = 727) weekly and 2.1% (n = 123) daily.
- 16.9% (n = 991) reported that they had struggled to manage their alcohol use or that it negatively impacted their everyday life in the past 12 months.
- 18.3% (n = 182) of those who expressed some struggle with alcohol consumption had sought professional support. 68.5% (n = 135) of those had sought support from a mainstream service that is not known to be LGBTQA+-inclusive, 33.0% (n = 65) from a mainstream service that is known to be LGBTQA+-inclusive, and only 7.6% (n = 15) from a service that caters only to LGBTQA+ people.
- 46.0% (n = 1,198) of LGBTQA+ adults who consumed alcohol during the Covid-19 pandemic reported their drinking had increased during the pandemic and 25.1%, (n = 654) reported drinking less during the pandemic.
- 17.4% (n = 432) of LGBTQA+ adults reported struggling to manage their alcohol consumption or where it negatively impacted their life during the pandemic.

LBQ+ Women (*SWASH*)

- 19.1% (n = 444) of LBQ+ women reported binge drinking (defined as 5 or more drinks on one occasion) once per week or more, including 1.1% (n = 25) who reported binge drinking every day.
- 20.4% (n = 531) reported drinking alcohol 3 days per week or more, including 3.3% (n = 87) who reported drinking alcohol every day.
- 41.6% (n = 1,088) reported ever having felt concern about their alcohol use or feeling that it negatively impacted their life. Almost half of those (21.8% of the whole sample, n = 569) felt concerned about their alcohol use in the past 12 months.
- Of those who ever felt concern about their alcohol use, 79.7% (n = 867) had never accessed professional support.

LGBTQA+ Young People (*Writing Themselves In 4*)

- 63.7% (n = 3,986) of LGBTQA+ young people reported drinking alcohol. 34.2% (n = 2,140) of those reported drinking monthly or less, 21.0% (n = 1,315) 2–4 times per month, 6.9% (n = 433) 2–3 times per week and 1.6% (n = 98) four or more times per week.

Trans and Gender Diverse Young People (*Trans Pathways*)

- 68.5% (n = 508) of trans and gender diverse young people had ever drunk alcohol.
- 24.7% (n = 179) had never used alcohol or other drugs. The Trans Pathways survey asked trans and gender diverse young people about their use of alcohol or drugs. These data cannot be disaggregated to report on rates of drug and alcohol use separately.
- 13.5% (n = 103) of reported a current diagnosis of a substance use disorder.
- Of those who had used alcohol or other drugs, 6.5% (n = 47) used alcohol/other drugs daily, 16.6% (n = 120) used alcohol/other drugs weekly and 10.6% (n = 77) used alcohol/other drugs on weekends only.
- 43.2% (n = 313) used alcohol/other drugs alone in the past 6 months.

RESEARCH PAPERS

Alcohol and tobacco consumption among Australian sexual minority women: Patterns of use and service engagement. This paper from *Private Lives 3* highlights that alcohol and tobacco consumption differ across SMW and intersecting characteristics. It also illustrates that alcohol and tobacco consumption frequently cooccur among SMW and that self-identifying alcohol struggle is an important predictor of seeking support for alcohol use. Suggestions are made in the paper for future research, health practice and policy initiatives.

7.2.2 What demographic factors and social experiences are associated with self-perceived problematic alcohol consumption among LGBTQA+ adults?

Rationale

A range of experiences and individual traits may contribute to LGBTQA+ people's likelihood to report concern with their alcohol consumption. Exploring factors associated with self-reported concern with alcohol consumption would allow health providers and support services to recognise those who may be at risk and in need of support, while also enabling tailored interventions and health messaging to target those most at risk.

Dataset and sample population

Data from 5,851 Private Lives 3 participants who reported any alcohol consumption were included in the analysis.

Variables and analyses

Private Lives 3 participants were asked if there was a time in the past 12 months that they had struggled to manage their alcohol or where it had negatively impacted their everyday life. To explore the risk and protective factors that may be associated with self-reported problematic alcohol consumption a multivariable logistic regression analysis was conducted with self-reported alcohol struggle in the past 12 months as the outcome variable. Predictor variables explored included demographic characteristics (age, gender, sexual orientation, income, residential location, country of birth and level of education), disability, mental health (high or very high/low or moderate psychological distress), experiences of abuse in the past 12 months (verbal assault, sexual assault) or discrimination (treated unfairly based on their sexual orientation of gender identity in the past 12 months) and ever experiencing homelessness.

Key findings

Participants were more likely to report a struggle with alcohol consumption if they:

- Were aged 35-54 years.
- Earned income in the highest brackets ($1,000+ net weekly income).
- Had been sexually assaulted.
- Had been treated unfairly based on their LGBTQA+ identity in the past 12 months.
- Had ever experienced homelessness.
- Reported high or very high levels of psychological distress.

Participants were less likely to report struggles with alcohol consumption if they:

- Lived outside of inner-suburban areas, including outer suburban areas, regional cities or towns and rural or remote areas.
- Were born in a non-English speaking country.

Alcohol struggle	AOR (CI)
Age (ref: 18-24 years)	
35-44 years	1.50 (1.13 - 2.00)
45-54 years	1.41 (1.02 - 1.94)
Net weekly income (ref: nil)	
$1,000 - $1,999	1.98 (1.28 - 3.06)
$2,000+	1.97 (1.21 - 3.20)
Residential location (ref: inner-suburban)	
Outer-suburban	0.74 (0.61 - 0.90)
Regional city or town	0.67 (0.53 - 0.83)
Rural or Remote	0.53 (0.35 - 0.80)
Country of birth (ref: Australian born)	
Non-English speaking country	0.39 (0.23 - 0.67)
Sexual assault in the past 12 months (ref: No)	
Yes	1.44 (1.13 - 1.83)
Treated unfairly in the past 12 months (ref: No)	
Yes	1.29 (1.06 - 1.56)
Homelessness ever (ref: No)	
Yes	1.50 (1.23 - 1.82)
High/very high psychological distress (ref: No)	
Yes	2.09 (1.72 - 2.55)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

SELF-REPORTED ALCOHOL STRUGGLE

differs across various intersections of the LGBTQA+ adult population in Australia.

Adults are at a greater risk of struggling with alcohol consumption if they have been sexually assaulted in the past 12 months or have been treated unfairly based on their sexual orientation or gender identity in the past 12 months.

STRUGGLING WITH ALCOHOL WAS ALSO ASSOCIATED WITH HIGHER PSYCHOLOGICAL DISTRESS AND A GREATER LIKELIHOOD TO HAVE EXPERIENCED HOMELESSNESS.

PARTICIPANTS LIVING OUTSIDE OF INNER SUBURBAN AREAS

reported less struggles with alcohol consumption as did those born in non-English speaking countries, suggesting potential cultural influences on alcohol consumption and self-perceived struggles with consumption.

These outcomes highlight a need for future alcohol health promotion strategies to acknowledge and address the contributing societal factors that may impact problematic alcohol consumption, including experiences of discrimination and abuse, as well as addressing within group differences that relate to struggling with alcohol consumption. Interventions to encourage reflection on alcohol consumption, with a view to supporting AOD service engagement for those in need, are warranted.

7.2.3 Among LGBTQA+ adults, who is most likely to indicate a preference for community-controlled or mainstream alcohol support services?

Rationale

Among the adult sample of Private Lives, 3,991 participants reported struggling with their alcohol consumption. However, less than one-fifth (18.3%, n = 182) of these participants had sought professional alcohol support. To provide adequate alcohol support services that meet the needs of LGBTQA+ people and encourage them to access services, it is important to understand the type of service providers that would be preferred by those in the community.

Dataset and sample population

Data from 3,587 *Private Lives 3* participants who expressed a preference for the type of service they would choose to access alcohol support from should they ever need it were analysed. A total of 3,220 participants were either unsure of their preference or did not hold a preference for service provider, these participants were not included in the analyses.

Variables and analyses

All participants of *Private Lives 3* were asked what service they would prefer to use if they ever required support for alcohol consumption. Response options included a mainstream service not known to be LGBTQA+-inclusive, a mainstream service that is known to be LGBTQA+-inclusive, and a service that caters specifically to LGBTQA+ people. Multivariable logistic regression analyses were conducted to explore the demographic factors (age, gender, sexual orientation, income, area of residence, level of education) associated with a preference for an LGBTQA+-specific service over a mainstream service (known or not known to be LGBTQA+-inclusive).

Key findings

Of those who held a preference for alcohol support service type half expressed a preference for a service that was mainstream and known to LGBTQA+-inclusive (55.1%, n = 1,975) and a further one-quarter expressed a preference for a mainstream service that was not known to be LGBTQA+-inclusive (26.0%, n = 931). One-fifth of participants expressed a preference for a service that catered specifically to LGBTQA+ communities (19.0%, n = 681).

LGBTQA+ adults were more likely to hold a preference for LGBTQA+-specific service if they were:

- Trans men, trans women or non-binary.
- Aged 25-44 years.

LGBTQA+ adults were less likely to hold a preference for LGBTQA+-specific services if they:

- Earned a net income of $2,000+ per week
- Lived outside of an inner-suburban area, including those in outer-suburban areas, regional cities or towns and rural or remote areas.

Preference for LGBTQA+ specific alcohol support provider	AOR (CI)
Gender (ref: cisgender man)	
Trans man	2.31 (1.56 - 3.43)
Trans woman	2.44 (1.66 - 3.59)
Non-binary	2.91 (2.26 - 3.73)
Age (ref: 18-24 years)	
25-34 years	1.48 (1.14 - 1.92)
35-44 years	1.62 (1.19 - 2.21)
Net weekly income (ref: nil-$399)	
$2,000+	0.61 (0.38 - 0.99)
Residential location (ref: inner-suburban)	
Outer-suburban	0.77 (0.62 - 0.95)
Regional city or town	0.69 (0.53 - 0.88)
Rural or emote	0.62 (0.40 - 0.96)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

ALMOST ONE-FIFTH OF PARTICIPANTS

who held a preference for alcohol support service provider, expressed a preference for a service that catered specifically to LGBTQA+ people, with a further 55% holding a preference for a service that is mainstream but known to be inclusive of LGBTQA+ people.

PREFERENCE FOR LGBTQA+-SPECIFIC SERVICES, COMPARED TO MAINSTREAM SERVICES (WHETHER OR NOT THEY ARE KNOWN TO BE LGBTQA+-INCLUSIVE), DIFFERED ACROSS THE POPULATION,

with those more likely to prefer specific services being trans or gender diverse and aged 25–44 years old. Experiences of discrimination and un-affirming care within healthcare settings, particularly among those who are trans and gender diverse, may be considerable barriers to accessing care and are likely to lead to preference for support services with specific knowledge of and purposefully designed to meet the needs of LGBTQA+ communities.

NOTABLY, PARTICIPANTS LIVING OUTSIDE OF INNER-CITY AREAS WERE MORE LIKELY TO HOLD A PREFERENCE FOR MAINSTREAM SERVICES.

Given the sparsity of general health services and more-so of LGBTQA+ appropriate services outside of inner-city areas, preference may be held for those services that are proximally accessible and stress the need for more resourcing outside of inner-city areas to appropriately train mainstream services to meet the needs of the LGBTQA+ community.

These findings may reflect differing support needs and experiences of discrimination within healthcare settings, with trans and gender diverse people experiencing greater challenges within mainstream services. However, with mainstream services more readily available, these findings may also reflect a desire for accessible alcohol support and a desire to receive appropriate care in all support settings. Importantly, the findings stress the need for increased resourcing of community-led alcohol support services as well as training for mainstream service to meet the needs of LGBTQA+ communities.

7.3 Illicit drugs

This section details the key findings relating to prevalence of drug consumption, self-reported problematic drug use and support service engagement, as well as further explorations of:

- What are the patterns of drug use among LGBTQA+ adults and how are they associated with health and wellbeing outcomes? (*Private Lives 3*)
- What are the risk and protective factors of substance use among trans and gender diverse young people? (*Trans Pathways*)
- What is the prevalence and correlates of co-occurring mental ill-health and substance use among trans and gender diverse young people? (*Trans Pathways*)

7.3.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- Almost half (44.4%, n = 2,781) of LGBTQA+ adults reported using one or more drugs for non-medical purposes in the past 6 months. The most frequently reported illicit drugs were cannabis (30.4%, n = 1,904), followed by ecstasy/MDMA (13.9%, n = 872) and cocaine (9.6%, n = 601). A further 11.9% (= 745) had used amyl nitrate/alkyl nitrite in the past 6 months.
- Drug use was higher among LGBTQA+ adults than in the general Australian population. In the general population, the most commonly used illicit drugs in the past 12 months were cannabis (10.4%), cocaine (2.5%), ecstasy (2.2%) and meth/amphetamines (1.4%)14.

LBQ+ Women (*SWASH*)

- More than half (52.3%, n = 1,364) of LBQ+ women had ever used illicit drugs.
- 3.2% (n = 83) reported injecting drug use ever in their lifetimes.
- 31.3% (n = 817) reported poly drug use (i.e., 2 or more on one occasion) in the last 6 months.
- 20.5% (n = 535) reported ever experiencing concern in relation to their drug use or that it negatively impacted their life. 67.5% (n = 361) of those had never accessed professional support to manage their drug use.

LGBTQA+ Young People (*Writing Themselves In 4*)

- 33.4% (n = 1,875) of LGBTQA+ young people reported using any drug for non-medical purposes in the past six months. 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.
- Over one-quarter (26.5%, n = 848) of LGBTQA+ young people aged 14 to 17 years and over two-fifths (42.5%, n = 1,027) of those 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 population20.
- Almost one-quarter (23.5%, n = 440) reported ever being concerned about their drug use; 25.9% (n = 220) of 14- to 17-year-olds and 21.4% (n = 220) of 18- to 21-year-olds.
- 29.1% (n = 545) reported their family or friends ever being concerned about their drug use; 34.7% (n = 294) of 14- to 17-year-olds and 24.5% (n = 545) of 18- to 21-year-olds.
- Of the LGBTQA+ young people who reported ever being concerned about their drug use, 11.8% (n = 52) sought professional support for drug use in the past six months; 9.3% (n = 41) 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.

Trans and Gender Diverse Young People (*Trans Pathways*)

- The *Trans Pathways* survey asked trans and gender diverse young people about their use of alcohol or drugs. These data cannot be disaggregated to report on rates of drug and alcohol use separately.
- One-quarter (24.7%, n = 179) of trans and gender diverse young people had never used alcohol or other drugs.
- 29.0% (n = 215) had ever used cannabis, 17.5% (n = 130) had ever used sedatives, 6.9% (n = 51) had used amphetamine type stimulants and 5.9% (n = 44) had used opioids.
- 13.5% (n = 103) of reported a current diagnosis of substance use disorder.
- 6.5% (n = 47) used alcohol or other drugs daily, 16.6% (n = 120) used alcohol or other drugs weekly and 10.6% (n = 77) used alcohol or other drugs on weekends only.
- 43.2% (n = 313) used alcohol/other drugs alone in the past 6 months.

RESEARCH PAPER

Illicit drug use among lesbian, gay, bisexual, pansexual, trans and gender diverse, queer and asexual young people in Australia: Intersections and associated outcomes. Rates of illicit drug use among LGBTQA+ young people in this study were considerably higher than those observed in general population youth studies in Australia and were further elevated among those who had experienced LGBTQA-related prejudice or harassment, or homelessness.

7.3.2 What are the patterns of drug use among LGBTQA+ adults and how are they associated with health and wellbeing outcomes?

Rationale

While the prevalence and patterns of alcohol and other drug use are well known among specific sub-populations of sexuality and gender diverse adults, less is known about the patterns of risky alcohol and other drug (AOD) use among LGBTQA+ people. These analyses aim to determine typologies of AOD risk among LGBTQA+ adults in Australia.

Dataset and sample population

Data from the full sample of 6,835 LGBTQA+ adults who participated in *Private Lives 3*.

Variables and analyses

Latent class analysis is a statistical method that identifies unobserved (latent) subgroups within a population based on patterns of responses to a set of observed variables. For the present analyses, a latent class analysis was performed to determine distinct patterns of AOD risk within the sample, as measured by the Alcohol Use Disorder Identification Test (AUDIT-C) and Drug Abuse Screening Tool (DAST-10) respectively. Demographic characteristics (sexuality, gender identity, area of residence), experience of harms (experience of verbal abuse, harassment such as being spat at or receiving offending gestures, physical threats, or sexual assault based on gender or sexual orientation in the past 12 months), LGBTQA+ connectedness, and acceptance by family were then assessed across emergent latent classes using chi-square analyses.

Key findings

Four distinct latent classes ('typologies') of AOD risk emerged within the data. These risk profiles were characterised as:

- No AOD risk (13.3% of the sample).
- Low AOD risk (15.1% of the sample).
- Moderate AOD risk (30.1% of the sample).
- Moderate alcohol only risk (41.5% of the sample).

Several differences were found between these groups:

- Participants classed as 'no AOD risk' were more likely to be living in a regional city or town or a rural or remote area, while those classed as 'moderate AOD risk' were more likely to be living in an inner-suburban area.
- Participants who reported being trans or gender-diverse were most likely to belong to the 'no AOD risk' and 'low AOD risk' classes.
- Participants in the 'no AOD risk' class were the least likely to report being connected to the LGBTQA+ community.
- Participants in the 'moderate AOD risk' class were markedly more likely to report being the victim of sexual assault in the previous 12 months.
- Participants in the 'moderate alcohol only risk' group were the least likely to report past-year verbal abuse, harassment such as being spat at or receiving offending gestures, and physical threats.

Comparison of AOD risk profiles	Chi², p
Connection to community	
Feel a part of the LGBTQA+ community	30.47, <0.001
Residential location	
Capital city (inner or outer suburban)	72.41, <0.001
Regional city or town	31.61, <0.001
Rural or remote	42.30, <0.001
Harassment or abuse in the past 12 months	
Verbal abuse	53.31, <0.001
Harassment such as being spat at or receiving offending gestures	53.64, <0.001
Physical threats	51.95, <0.001
Sexual assault	73.45, <0.001
Gender	
Trans or gender diverse	46.05, <0.001

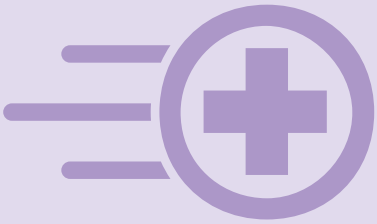
SUMMARY AND IMPLICATIONS OF THE FINDINGS

THE FINDINGS INDICATE THAT AOD RISK AND ASSOCIATED HARMS ARE NOT UNIFORM ACROSS LGBTQA+ SUBPOPULATIONS IN AUSTRALIA.

Most of the sample belonged to the 'moderate alcohol only risk' or 'moderate AOD risk' groups. There was an uneven distribution of associated harms experienced by individuals in these risk categorisations. Higher rates of reporting sexual assault were observed among the moderate AOD risk group, and the lowest rates of experiencing verbal abuse, harassment, and physical threats were observed among the moderate alcohol only risk group. These findings may reflect the role of AOD for managing stressors and experiences of abuse or discrimination among LGBTQA+ people.

NOTABLY, PARTICIPANTS IN THE 'NO AOD RISK' GROUP

were the least likely to feel a part of the LGBTQA+ community in Australia. These findings are difficult to interpret without further nuanced understanding of the experiences of these participants, and may reflect increased exposure to discrimination among those more engaged with community or increased opportunity for social use of AOD. However, further research is necessary to better understand this outcome.



Tailored harm-reduction interventions may attenuate the observed harms associated with different AOD risk profiles; most pertinently, for cisgender individuals living in capital cities who engage in risky alcohol and non-prescription drug behaviours.

7.3.3 What are the risk and protective factors of substance use among trans and gender diverse young people?

Rationale

Higher burden of substance use has been consistently documented among trans and gender young people;[21] however, little is known regarding risk and protective factors for effective treatment and prevention. These analyses aim to identify factors that are associated with substance use among trans and gender diverse youth.

Dataset and sample population

Data from 702 *Trans Pathways* participants (81.7%) who responded to questions regarding past six-month smoking, alcohol or illicit drug use were analysed.

Variables and analyses

Multivariable logistic regression models were constructed to test associations between age, gender (trans man, trans woman, or non-binary/gender-diverse), bullying, discrimination, intimate partner violence, peer rejection, and lack of family support, with past six-month smoking, alcohol use, and illicit drug use (cannabis, amphetamine type stimulants, inhalants, sedatives/sleeping pills, hallucinogens, opioids, or other stimulants) outcome variables.

Key findings

Trans and gender diverse young people were more likely to report past six-month smoking if they:

- Had experienced discrimination.
- Had experienced abuse from an intimate partner.
- Felt rejected by their peers.
- Felt a lack of family support.

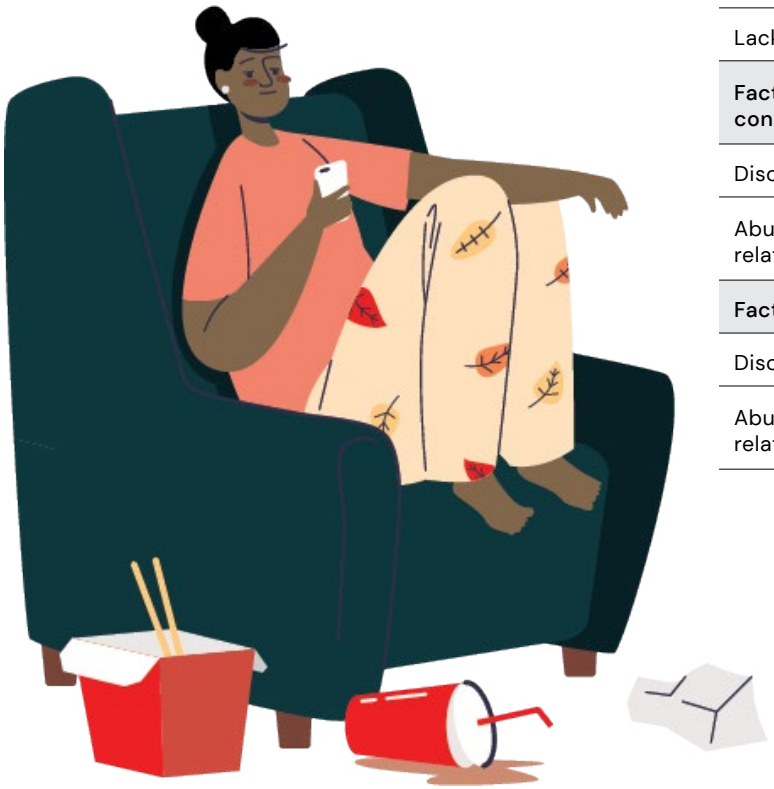
Participants were more likely to report past six-month alcohol consumption if they:

- Had experienced discrimination.
- Had experienced abuse from an intimate partner.

Participants were more likely to report past six-month illicit drug use if they:

- Had experienced discrimination.
- Had experienced abuse from an intimate partner.

Factors associated with past six-month smoking	AOR (CI)
Discrimination	2.1 (1.4 - 3.2)
Abuse within an intimate relationship	3.0 (2.1 - 4.4)
Lack of family support	1.5 (1.0 - 2.2)
Factors associated with past six-month alcohol consumption	
Discrimination	1.8 (1.2 - 2.7)
Abuse within an intimate relationship	1.6 (1.0 - 2.5)
Factors associated with past six-month illicit drug use	
Discrimination	1.9 (1.3-2.8)
Abuse within an intimate relationship	2.0 (1.4-2.9)



SUMMARY AND IMPLICATIONS OF THE FINDINGS

TRANS AND GENDER DIVERSE YOUNG PEOPLE WHO EXPERIENCED DISCRIMINATION, INTIMATE PARTNER VIOLENCE, PEER REJECTION, OR LACK OF FAMILY SUPPORT WERE MORE LIKELY TO REPORT RECENT SMOKING.

Experiences of discrimination and intimate partner violence were both additionally associated with recent alcohol and illicit drug use. These findings may suggest that alcohol, smoking and other drug use may, for some, serve as a way of coping or managing the stress resulting from these negative experiences.

ASSOCIATIONS BETWEEN PEER REJECTION OR LACK OF PARENTAL SUPPORT AND SMOKING LIKELY ALSO HIGHLIGHT THE CRITICAL ROLE OF FRIENDS AND FAMILY FOR COPING AND MENTAL HEALTH PROMOTION.

Treatment and prevention of substance use among trans and gender diverse young people requires a holistic view of the individual in the context of affirming and supportive peer and family relationships. Additionally, efforts to prevent experiences of discrimination and abuse directed toward trans and gender diverse young people, as well as promoting acceptance by friends and family may curb alcohol, smoking and other drug use within this population of young people.

7.3.4 What is the prevalence and correlates of co-occurring mental ill-health and substance use among trans and gender diverse young people?

Rationale

Research has consistently identified mental ill-health and substance use disparities among trans young people, although little research has considered the co-occurrence of these conditions, and associated correlates for effective prevention, early intervention, and treatment of this comorbidity.

Dataset and sample population

Data from 845 *Trans Pathways* participants who completed questions regarding recent depressive symptoms, anxiety symptoms, self-harm thoughts and behaviours, and suicide thoughts and behaviours; and 702 Trans Pathways participants who completed questions regarding recent alcohol, tobacco or illicit drug use were included in these analyses.

Variables and analyses

Prevalence ratios were used to estimate the prevalence of lifetime psychiatric disorders (depression, anxiety disorder, post-traumatic stress disorder, personality disorder, psychosis, eating disorder, and autism spectrum disorder) among participants who had ever received a substance use disorder diagnosis. Binary logistic regression models also tested associations between co-occurring mental ill-health and substance use variables with predictor variables (bullying, discrimination, intimate partner violence, peer rejection, lack of family support).

Key findings

Participants who had ever received a substance use disorder diagnosis were significantly more likely to also report all lifetime psychiatric disorder diagnoses examined. Specifically, among trans young people with a lifetime substance use disorder diagnosis (n =103):

- 99% reported a lifetime depression diagnosis.
- 93% reported an anxiety disorder diagnosis.
- 83% reported an eating disorder diagnosis.
- 80% reported a post-traumatic stress disorder diagnosis.
- 79% reported a personality disorder diagnosis.
- 75% reported a psychosis diagnosis.
- 69% reported an autism spectrum disorder diagnosis

Compared with non-smokers, participants who reported past six-month smoking were more likely to:

- Present with a current probable anxiety disorder.
- Report lifetime self-harm.
- Report lifetime suicide thoughts.
- Report lifetime suicide attempt.

Compared with non-drinkers, participants who reported past six-month alcohol consumption were more likely to:

- Report lifetime suicide thoughts.
- Report lifetime suicide attempt.

Compared with non-users, participants who reported past six-month illicit drug use were more likely to:

- Present probable current depressive disorder.
- Present probable current anxiety disorder.
- Report lifetime desire to self-harm.
- Report lifetime self-harm.
- Report lifetime suicide thoughts.
- Report lifetime suicide attempt.

Compared with those who were not bullied, participants who were bullied were more likely to:

- Report co-morbid probable depressive disorder and smoking.
- Report co-morbid probable depressive disorder and illicit drug use.
- Report comorbid probable anxiety disorder and alcohol consumption.
- Report comorbid probable anxiety disorder and illicit drug use.

Compared with those who did not experience discrimination, participants who had recently experienced discrimination were more likely to:
- Report comorbid probable depressive disorder and smoking.
- Report comorbid probable depressive disorder and alcohol use.
- Report comorbid probable depressive disorder and illicit drug use.
- Report comorbid probable anxiety disorder and smoking.
- Report comorbid probable anxiety disorder and alcohol consumption.
- Report comorbid probable anxiety disorder and illicit drug use.

Compared with those who did not experience intimate partner violence, participants who had experienced intimate partner violence were more likely to:
- Report comorbid probable depressive disorder and smoking.
- Report comorbid probable depressive disorder and alcohol use.
- Report comorbid probable depressive disorder and illicit drug use.
- Report comorbid probable anxiety disorder and smoking.
- Report comorbid probable anxiety disorder and alcohol consumption.
- Report comorbid probable anxiety disorder and illicit drug use.
- Report comorbid self-harm desires/behaviour and smoking.
- Report comorbid suicidal thoughts/attempts and smoking.

Compared with those who had not recently experienced peer rejection, participants who had recently experienced peer rejection were more likely to:
- Report comorbid probable depressive disorder and smoking.
- Report comorbid probable depressive disorder and alcohol use.
- Report comorbid probable depressive disorder and illicit drug use.

Compared with those who had not experienced lack of family support, participants who had experienced a lack of family support were more likely to:
- Report comorbid probable depressive disorder and smoking.
- Report comorbid probable depressive disorder and illicit drug use.
- Report comorbid probable anxiety disorder and smoking.
- Report comorbid probable anxiety disorder and illicit drug use.

	OR (CI)
Factors associated with current smoking (ref: non-smokers)	
Current probable anxiety disorder	1.7 (1.2 - 2.5)
Lifetime self-harm	3.5 (2.2 - 5.8)
Lifetime suicidal ideation	2.0 (1.3 - 3.1)
Lifetime suicide attempt	3.2 (2.3 - 4.5)
Factors associated with current use of alcohol (ref: no current drinking)	
Lifetime suicidal ideation	2.0 (1.4 - 2.9)
Lifetime suicide attempt	1.6 (1.2 - 2.3)

	OR (CI)
Factors associated with use of other drugs (ref: no current use of other drugs)	
Current probable depressive disorder	1.8 (1.2 - 2.6)
Current probable anxiety disorder	1.6 (1.2 - 2.2)
Lifetime self-harm ideation	1.8 (1.2 - 3.0)
Lifetime self-harm	2.3 (1.6 - 3.4)
Lifetime suicidal ideation	2.5 (1.7 - 3.7)
Lifetime suicide attempt	2.5 (1.8 - 3.4)
Factors associated with any experience of bullying (ref: no bullying)	
Co-morbid probable depressive disorder and smoking	1.7 (1.1 - 2.3)
Co-morbid probable depressive disorder and drug use	1.5 (1.0 - 2.2)
Co-morbid probable anxiety disorder and alcohol consumption	1.6 (1.1 - 2.3)
Co-morbid probable anxiety disorder and drug use	1.9 (1.3 - 2.8)
Factors associated with any experience of discrimination (ref: no discrimination)	
Co-morbid probable depressive disorder and smoking	2.4 (1.5 - 3.7)
Co-morbid probable depressive disorder and alcohol consumption	2.5 (1.7 - 3.7)
Co-morbid probable depressive disorder and dug use	2.7 (1.7 - 3.7)
Co-morbid probable anxiety disorder and smoking	2.7 (1.7 - 4.2)
Co-morbid probable anxiety disorder and alcohol consumption	1.7 (1.2 - 2.3)
Co-morbid probable anxiety disorder and drug use	2.1 (1.5 - 3.0)
Factors associated with any experience of intimate partner violence (ref: no experience of IPV)	
Co-morbid probable depressive disorder and smoking	3.1 (2.1 - 4.5)
Co-morbid probable depressive disorder and alcohol consumption	1.9 (1.4 - 2.7)
Co-morbid probable depressive disorder and drug use	2.2 (1.6 - 3.1)
Co-morbid probable anxiety disorder and smoking	3.1 (2.1 - 4.5)
Co-morbid probable anxiety disorder and alcohol consumption	1.9 (1.3 - 2.6)
Co-morbid probable anxiety disorder and drug use	2.1 (1.5 - 3.0)
Co-morbid self-harm behaviours/ideation and smoking	2.0 (1.2 - 3.2)
Factors associated with lack of family support (ref: family support present)	
Co-morbid probable depressive disorder and smoking	1.7 (1.1 - 2.5)
Co-morbid probable depressive disorder and Drug use	1.6 (1.2 - 2.4)
Co-morbid probable anxiety disorder and Smoking	1.9 (1.2 - 2.8)
Co-morbid probable anxiety disorder and Drug use	1.6 (1.1 - 2.2)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

MOST TRANS AND GENDER DIVERSE YOUNG PEOPLE WHO HAVE EVER RECEIVED A SUBSTANCE USE DISORDER DIAGNOSIS HAVE ALSO RECEIVED A COMORBID PSYCHIATRIC DISORDER DIAGNOSIS

(between 69%–99%, depending on the psychiatric disorder). Most of those who had recently used alcohol and/or other drugs alone also report comorbid mental ill-health (59%–90%, depending on mental ill-health symptoms).

THE FINDINGS FURTHER SHOW THAT TRANS AND GENDER DIVERSE YOUNG PEOPLE WHO EXPERIENCE BULLYING, DISCRIMINATION, INTIMATE PARTNER VIOLENCE, PEER REJECTION, AND/OR LACK OF FAMILY SUPPORT ARE AT INCREASED RISK OF EXPERIENCING MENTAL ILL-HEALTH

(such as depression, anxiety, self-harm desires/ behaviour and suicidal thoughts/attempts) in co-occurrence with smoking, alcohol use, and/or illicit drug use.

Findings from these analyses illustrate that the mental health and substance use treatment and prevention needs of trans and gender diverse young people should be addressed in an integrated fashion, considering the critical affirmative role of peers, partner, and family.

7.4 Chapter summary

Alcohol and drug use is often highly prevalent within LGBTQA+ communities. Presenting substance use as problematic among sexual and gender minority individuals has often been used to stigmatise these communities. It is, however, crucial to acknowledge and address the significant impact that substance use can have on the health disparities experienced by LGBTQA+ communities.

Substance use across all investigated sample populations were highly associated or co-morbid with mental health concerns, as well as other demographic factors which pertain to either disadvantage and/or marginality. As the directionality of these associations are not determined within our analyses, a causal relationship cannot be established. It is wholly possible that these factors simply co-occur, or that LGBTQA+ individuals' mental health concerns may motivate their use of substances as a means of coping with psychological distress.

Additionally, the current findings highlight several notable features in the broad patterns of alcohol and drug use among the sampled populations. Firstly, they indicate a significant degree of polysubstance use and problematic polysubstance use among LGBTQA+ individuals. Secondly, as in the case of younger trans and gender individuals, substance use may be associated with substantial social and mental health challenges (e.g., bullying, family rejection). Finally, we also noted the effect of age. Collectively, these point to the need for specialised support and intervention that is attentive to the diversity of features and underpinning drivers of substance use among various LGBTQA+ subgroups.

Apart from GBQ+ men however, relatively little is understood about the qualitative dimensions of substance use among sexual and gender minority groups – problematic or otherwise. Predominant theoretical understandings of substance use among (e.g., as a behavioural response to stigma and discrimination) have only been intermittently verified within the research. As such, further research is needed to explore the motivations, subcultural contexts and experiences surrounding alcohol and drug use among other segments of the LGBTQA+ community.

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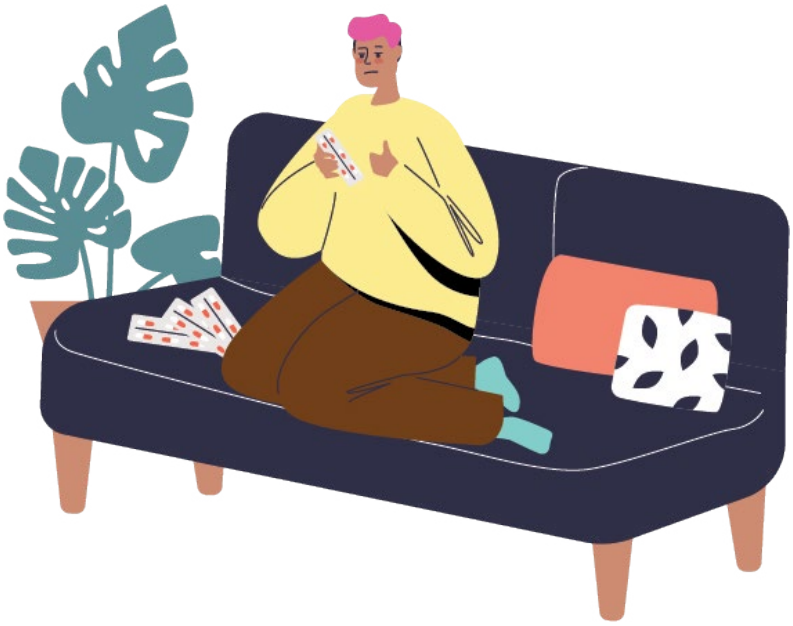

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8. RELATIONSHIPS, PARENTING AND SEXUAL AND REPRODUCTIVE HEALTH

The pursuit of sexual rights has long formed a cornerstone of the LGBTQA+ community's struggle for social and legal recognition. Sexual rights refer to the right to pursue mutually consensual, pleasurable, and satisfying romantic, intimate, and sexual relationships of one's choosing,[1 2] and to a state of physical, emotional, mental, and social wellbeing in all aspects of one's sexuality and reproductive matters.[3]

Like heterosexual and/or cisgender populations, LGBTQA+ individuals' relationships,[4 5] and their sexual and reproductive health contribute significantly to their health and wellbeing. LGBTQA+ persons encounter unique challenges and obstacles within this domain that stem from their sexual and gender minority identities. This includes both a historic lack of avenues for relationship formalisation and socio-legal recognition for those individuals in same-gender relationships[6] as well as barriers to both sexual6 [7 8] and reproductive healthcare.[9 10 11]

8.1 Sex, relationships and parenting desires

This section details the key findings relating to sex and relationships as well as well as further explorations of:

- What is the impact of heterosexism, stigma and financial cost on parenting desires among LGBTQA+ people in Australia? (*Private Lives 3*)

8.1.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 54.4% (n = 3,715) of LGBTQA+ adults were in a committed romantic relationship/s. 67.5% (n = 2,505) of these individuals reported cohabiting with their partner/s.
- 48.1%, n = 1,785) of those in a relationship had been in their relationship for five years or more and 26.9% (n = 999) for more than ten years.

LBQ+ Women (*SWASH*)

- 37.7% (n = 995) of LBQ+ women reported not being in a regular relationship with a sexual partner. 59.4% (n = 1,548) were in a sexual relationship with 1 regular partner and 3.9% (n = 102) were in sexual relationships with 2 or more regular partners.
- 71.2% (n = 1,808) reported ever having sex with a cisgender or trans man.

8.1.2 What is the impact of heterosexism, stigma and financial cost on parenting desires among LGBTQA+ people in Australia?

Rationale

The number of LGBTQA+ people choosing to become parents has increased in recent decades.[12 13] Among other demographic and societal shifts, this reflects increased social acceptance of LGBTQA+ parent families (sometimes termed 'Rainbow Families'), legal recognition of same-gender couples, and an expansion of access to assisted reproduction services.[14] However, both parents and children of Rainbow Families still experience stigma and discrimination, or a sense of not belonging or feeling supported. These experiences are often associated with heterosexist views about parenthood.[15] These analyses explore common barriers to having children expressed by LGBTQA+ adults, including societal heterosexism, heterosexism within assisted reproductive services, and the cost of raising a child. The analyses also explore who is most or least likely to perceive these as barriers to having children.

Dataset and sample population

Data from 3,421 LGBTQA+ adults from *Private Lives 3* who indicated a desire to have children or were uncertain about having children and were aged under 45 years were analysed.

Variables and analyses

Participants who expressed a desire to have children or were undecided about having children were asked about the barriers they perceived to having children. Participants chose from a list of barriers including "Concerns of raising a child in a heterosexist society," "Concerned about heterosexist treatment at an Assisted Reproductive Treatment service," and "Cost of raising a child." Three multivariable logistic regression analyses were conducted to explore the factors associated with perceiving these concerns as barriers to having children. Predictor variables included in the models were gender, sexual orientation, residential location, any current children, felt distress during the 2017 marriage equality debate, treated unfairly in the past 12 months due to gender or sexual orientation, and felt accepted by most/all family members. The confounding effects of age, income and education were controlled for in each model.

Key findings

Approximately one-third (35.0%, n = 1,842) of LGBTQA+ adults expressed a desire to have children in the future, and a further 30.1% (n = 1,580) were undecided. Among them:

- Half (51.2%, n = 1,583) felt that societal heterosexism was a barrier to having children
- Half (51.4%, n = 1,589) felt that cost of raising children was a barrier to having children
- 39.0% (n = 1,205) felt that the cost of reproductive services was a barrier
- One-quarter (24.4%, n = 756) felt that encountering heterosexism in reproductive services was a barrier. These barriers were not perceived equally across the sample.

Several factors were associated with reporting that societal heterosexism was a barrier to having children. Specifically:

- Participants who experienced distress during the 2017 marriage equality debate and those who had been treated unfairly in the past 12 months due to their gender or sexual orientation were more likely to feel that societal heterosexism was a barrier.
- Trans men or women, asexual people and those living in a regional city or town or in a rural or remote area were less likely to feel that societal heterosexism was a barrier.
- LGBTQA+ people who felt accepted by their family were less likely to feel that societal heterosexism was a barrier.

Societal heterosexism is a barrier to having children	AOR (CI)
Gender (ref: cisgender man)	
Trans man	0.34 (0.23 – 0.52)
Trans woman	0.57 (0.35 – 0.92)
Sexual orientation (ref: gay)	
Asexual	0.36 (0.21 – 0.63)
Residential location (ref: inner-suburban)	
Regional city or town	0.73 (0.59 – 0.91)
Rural or Remote	0.56 (0.39 – 0.80)
Marriage equality debate distress (ref: No)	
Yes	2.51 (2.05 – 3.09)
Treated unfairly due to gender or sexual orientation (ref: No)	
Yes	1.86 (1.56 – 2.23)
Felt accepted by family a lot/always (ref: No)	
Yes	0.81 (0.69 – 0.95)

Several factors were associated with reporting concerns about heterosexist treatment within assisted reproductive treatment services as a barrier to having children. Specifically:

- Cisgender women, trans men and non-binary people as well as those who were lesbian and gay were more likely to feel that potential heterosexism within a fertility service was a barrier.
- Those living in a regional city or town, or a rural or remote area were less likely to feel that this was a barrier.
- Participants who experienced distress during the 2017 marriage equality debate and those who had been treated unfairly in the past 12 months due to their gender or sexual orientation were more likely to feel that heterosexism in a fertility service was a barrier.
- LGBTQA+ people who felt accepted by their family were less likely to feel that heterosexism in a fertility service was a barrier.

Heterosexism with assisted reproduction services is a barrier to having children	AOR (CI)
Gender (ref: cisgender man)	
Cisgender woman	1.62 (1.15 – 2.29)
Trans man	2.09 (1.34 – 3.24)
Non-binary	1.75 (1.20 – 2.53)
Sexual orientation (ref: gay)	
Bisexual	0.41 (0.31 – 0.55)
Pansexual	0.57 (0.40 – 0.83)
Asexual	0.48 (0.26 – 0.86)
Something else	0.61 (0.39 – 0.94)
Residential location (ref: inner-suburban)	
Regional city or town	0.77 (0.60 – 0.99)
Rural or Remote	0.65 (0.43 – 0.98)
Marriage equality debate distress (ref: No)	
Yes	1.76 (1.35 – 2.28)
Treated unfairly due to gender or sexual orientation (ref: No)	
Yes	1.76 (1.41 – 2.20)
Felt accepted by family a lot/always (ref: No)	
Yes	0.74 (0.62 – 0.89)

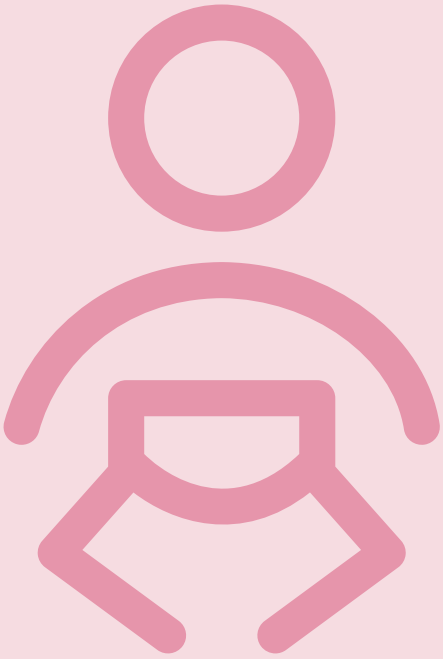
Several factors were associated that the cost of raising a child was a barrier to having children. Specifically:

- Trans men were less likely to report that the cost of raising a child is a barrier to having children, while those who were sexual orientation other than gay or lesbian were more likely to feel that the cost of raising children is a barrier.
- Those living outside of inner-suburban areas were less likely to report the cost of raising a child is a barrier, including those in outer-suburban areas, regional cities or towns and rural or remote areas.
- Participants who already had children were also less likely to report cost as a barrier.
- Distress during the marriage equality debate was associated with a greater likelihood to feel that cost of raising a child is a barrier.
- Participants who felt accepted by their family were less likely to feel that the cost of raising children is a barrier to having children.

The cost of raising children is a barrier	AOR (CI)
Gender (ref: cisgender man)	
Trans man	0.62 (0.42 – 0.91)
Sexual orientation (ref: gay)	
Bisexual	1.43 (1.13 – 1.82)
Pansexual	2.21 (1.58 – 3.09)
Queer	1.70 (1.27 – 2.27)
Asexual	1.68 (1.03 – 2.72)
Something else	1.88 (1.29 – 2.72)
Residential location (ref: capital city, inner-suburban)	
Capital city, outer suburban	0.82 (0.68 – 0.99)
Regional city or town	0.71 (0.58 – 0.88)
Rural/Remote	0.58 (0.41 – 0.82)
Any current children (ref: No)	
Yes	0.64 (0.46 – 0.87)
Marriage equality debate distress (ref: No)	
Yes	1.32 (1.09 – 1.61)
Felt accepted by family a lot/always (ref: No)	
Yes	0.73 (0.62 – 0.85)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

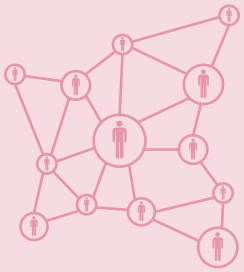
NEGATIVE EXPERIENCES FROM BROADER SOCIETY, SUCH AS DISTRESS FELT DURING THE MARRIAGE EQUALITY DEBATE AND UNFAIR TREATMENT DUE TO SEXUALITY OR GENDER IDENTITY, WERE ASSOCIATED WITH



BARRIERS TO HAVING CHILDREN.

Positive experiences with others, such as acceptance from family were associated with a lower likelihood of expressing these barriers.

Differences according to sexual orientation may reflect broader social supports of individual within these subgroups but may also depend on the gender of their partner with whom they choose to pursue parenthood for those who are multi-gender attracted (bisexual, pansexual or queer).



ACCEPTANCE FROM FAMILY

on the other hand highlights the crucial role of a support network and the potential safety net for those who are considering having children.

These findings further necessitate polices and regulations to better support the rights and needs of LGBTQA+ people wanting families. This includes policies to address discrimination, both within services and community more broadly, as well as to foster inclusivity and provide support to those in the LGBTQA+ community who wish to become parents.

8.2 Sexual and reproductive health

This section details key findings relating to sexual and reproductive health as well as well as further explorations of:

- Are LBQ+ women who should be seeking STI and HIV testing, getting tested? (*SWASH*)
- How does participation in cervical cancer screening vary among LGBTQA+ individuals? What factors are associated with screening participation? (*Private Lives 3*)

8.2.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 6.5% (n = 409) of LGBTQA+ adults had been diagnosed with or treated for a sexually transmitted infection, not including HIV.
- 58.8% (n = 4,015) reported having ever been tested for HIV and 29.4% (n = 2,008) had undergone HIV testing in the past 12 months. 3.9% (n = 155) of these individuals reported that they were HIV-positive, 1.2% (n = 49) did not know their HIV status and 0.2% (n = 9) preferred not to say.
- 53.5% (n = 3,652) reported having ever been tested for hepatitis C and 25.0% (n = 1,706) had undergone testing in the past 12 months. Nearly all (95.5%, n = 3,488) of these participants were negative for hepatitis C, while 1.8% (n = 65) had been positive but had now cleared the virus following treatment.
- 73.3%, (n = 5,007) of LGBTQA+ adults reported having ever heard of pre-exposure prophylaxis (PrEP). 10.5% (n = 526) of these participants had successfully accessed it in the past 12 months, including 22.7% (n = 472) of cisgender men, 6.7% (n = 15) of trans men, 6.2% (n = 12) of trans women, 3.3% (n = 524) of non-binary people and 0.1% (n = 1) of cisgender women.
- 60.5% (n = 4,127) of LGBTQA+ adults had heard of post-exposure prophylaxis (PEP). 2.1% (n = 88) of these participants had successfully accessed it in the past 12 months, including 3.9% (n = 70) of cisgender men, 4.2% (n = 3) of trans men, 2.1% (n = 4) of trans women, 0.7% (n = 4) of non-binary people and 0.2% (n = 3) of cisgender women.

LBQ+ Women (*SWASH*)

- 61.3% (n = 1,597) of the sample of LBQ+ women had never had an STI test. In the last 6 months, 12.9% (n = 336) reported having an STI test, and 48.4% (n = 1,261) reported having one more than 6 months ago.
- 40.0% (n = 1,043) had ever been tested for HIV and 7.8% (n = 221) were uncertain as to whether they had been tested.
- 20.1% (n = 572) had received all 3 doses of the HPV vaccine (Gardasil/Cervarix). 38.6% (n = 1098) had received less than 3 doses or did not know how many doses they'd received, and 41.3% (n = 1173) reported not having been vaccinated or were uncertain as to whether they had been vaccinated.
- 66.1% (n = 1,725) of LBQ+ women reported having ever had a cervical screening test – 56.6% (n = 1,476) less than 5 years ago and 9.5% (n = 249) more than 5 years ago. 33.9% (n = 884) had never had a cervical screening test or were uncertain as to whether they'd had a cervical screening test.

8.2.2 Are LBQ+ women who should be seeking STI and HIV testing, getting tested?

Rationale

Regular engagement in STI and HIV screening are important health-promoting behaviours for sexually active individuals of all gender identities and sexual orientations. LBQ+ women who have sexual partners that are men who have sex with men (MSM) may be at higher risk of acquiring a sexually transmitted infection. However, there is little evidence investigating sexual health behaviours among LBQ+ women with sexual partners who are men who have sex with men. These analyses explore the proportions of LBQ+ women that have ever had a sexual relationship with MSM and difference in rates of STI/HIV screening between LBQ+ women whose partners are MSM and those who do not report partners that are MSM.

Dataset and sample population

Data from 2,319 LBQ+ women from the *SWASH* survey who indicated that they were sexually active were included in the current analyses.

Variables and analyses

Associations between having ever had sex with MSM and STI or HIV testing were explored using two multivariable logistic regressions, with output variables set as lifetime STI screening and lifetime HIV screening. Each of these models controlled for the potential confounding effects of age and sexual orientation.

Key findings

- One-third of LBQ+ women (32.3%, n = 847) reported having ever had sex with a MSM.
- Most LBQ+ women who has ever had sex with a MSM (81.1%, n = 685) had ever had an STI test and 63.7% (n = 485) had ever had an HIV test.
- Individuals who reported ever having sexual contact with a partner who was a MSM were more likely to have ever engaged in either STI or HIV screening than those whose partners were not MSM.

Sexual contact with MSM	AOR (95% CI)
Ever been tested for STI	2.42 (1.96 - 3.00)
Ever been tested for HIV	2.40 (1.96 – 2.93)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

While the timing of sex with MSM and testing may not be concurrent as the variables reflect lifetime occurrence, the results still suggest that the majority of LBQ+ women in this sample of participants who had sex with MSM were pro-active about their healthcare and screening access.

A HIGH PROPORTION OF RESPONDENTS REPORTED HAVING EVER HAD SEX WITH A MAN WHO HAS SEX WITH MEN.

These individuals were more likely to have ever accessed both STI and HIV screening.

These findings may reflect an awareness of elevated STI/HIV burden among MSM and their partners and/or that MSM's high rate of engagement with STI/HIV screening may encourage similar behaviours in their partners.

CONTINUED SEXUAL HEALTH MESSAGING AMONG LBQ+ WOMEN IS NECESSARY TO ENCOURAGE ACTIVE PARTICIPATION IN SEXUAL HEALTH SCREENING.

Additionally, it is important that health service providers are well versed in the healthcare needs of LBQ+ women and refrain from making assumptions about the nature of the sexual relationships in which they are engaged.

8.2.3 How does participation in cervical cancer screening vary among LGBTQA+ individuals? What factors are associated with screening participation?

Rationale

For Australia to meet cervical cancer elimination targets, it is essential that we reach high rates of cervical screening and target potentially underserved populations. LGBTQA+ populations already experience barriers to healthcare, and in relation to cervical screening, the barriers to healthcare are likely to be further nuanced given the highly gendered and intimate nature of the procedure.[16] Perceptions of low cervical cancer risk among both patients and healthcare providers, anticipated discrimination from healthcare providers, as well as discomfort with cervical screening process itself are likely to be barriers to cervical screening access among LGBTQA+ people who require it.[17] Many of these barriers are likely to be alleviated by access to healthcare that is knowledgeable of LGBTQA+ healthcare needs and affirming of patients' identities.[18] Therefore, the aim of these analyses is to explore sociodemographic factors and affirming healthcare experiences that are associated with cervical screening access among LGBTQA+ people with a cervix.

Dataset and sample population

Data from 2,424 LGBTQA+ participants from *Private Lives 3* who were cisgender women, trans men or non-binary people assigned female at birth and aged 25–74 years old were included in the analyses. This study sample represents those LGBTQA+ people most likely to require cervical screening.

Variables and analyses

All participants were asked 'Have you had any of the following health checks in the past 2 years?' and selected all relevant items from a list which included 'Pap smear test (cervical screening).' Responses were coded as 'Yes' if the pap smear item was selected and 'No' if it was not selected and the responses to this question were not missing. It is important to note that 5-yearly cervical screening intervals were introduced nationally in December 2017, but given the timing of the *Private Lives 3* survey (July–October 2019), most if not all participants with a cervix would have required a cervical screen within the prior two years which is why a 2-year interval was chosen for this measure. A multivariable analysis was performed to investigate the factors associated with cervical screening attendance within the past 2 years set as the output variable. Input variables included demographic factors including age, gender identity, sexual orientation, disability, country of birth, socioeconomic factors, as well as past-year engagement with healthcare services and professionals.

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Key findings

Over half of cisgender women (58.3%) indicated that they had attended cervical cancer screening in the previous 2 years. This rate dropped to only 38.3% for trans men.

Participants were least likely to access screening if they were:

- Lesbian/gay or asexual.
- Living with a disability.
- Residing outside inner-suburban areas (in an outer suburban area, regional city or town, rural or remote area).
- Born in a non-English speaking country.

Participants were most likely to access screening if they:

- Attended a regular GP.
- Reported that their GP or healthcare practice were aware of their sexual and/or gender identities.
- Attended an LGBTQA+-inclusive health services or services catering specifically to LGBTQA+ populations in the past 12 months compared to those who had only attended a mainstream health service that wasn't known to be inclusive.
- Held a post-graduate degree.

Access to screening in past 2 years	AOR (CI)
Age (ref: 25-34)	
65-74	0.45 (0.24 - 0.86)
Gender (ref: cisgender woman)	
Trans man	0.29 (0.19 - 0.44)
Sexual orientation (ref: lesbian/gay)	
Bisexual	1.98 (1.52 - 2.57)
Pansexual	1.67 (1.18 - 2.37)
Queer	1.49 (1.13 - 1.95)
Asexual	0.41 (0.24 - 0.72)
Country of birth (ref: Australian born)	
Non-English speaking country	0.61 (0.39 - 0.94)
Education (ref: secondary or below)	
University-postgraduate	1.42 (1.01 – 2.00)
Residential location (ref: capital city, inner-suburban)	
Capital city, outer-suburban	0.76 (0.61 - 0.95)
Regional city or town	0.71 (0.56 - 0.91)
Disability (ref: no disability)	
Mild disability	0.62 (0.45 - 0.86)
Moderate disability	0.64 (0.51 - 0.81)
Severe disability	0.63 (0.47 - 0.85)
Regular GP (ref: no regular GP, and attend different health centres)	
Yes, attend a regular GP at a regular clinic	1.64 (1.18 - 2.29)
GP/clinic is aware of sexual orientation or gender (ref: no)	
Yes	1.82 (1.42 - 2.32)
Medical service accessed in past 12 months (ref: accessed mainstream medical clinic)	
Never accessed any medical clinic	0.36 (0.21 - 0.62)
Accessed inclusive or specific LGBTQ medical clinic	1.37 (1.09 - 1.72)

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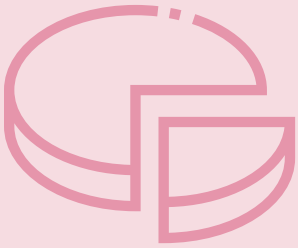
SUMMARY AND IMPLICATIONS OF THE FINDINGS

LOW RATES OF CERVICAL SCREENING WERE OBSERVED AMONG THE SAMPLE POPULATION.



TRANS MEN AND LESBIAN/GAY AND ASEXUAL ADULTS WERE THE LEAST LIKELY TO HAVE ACCESSED CERVICAL SCREENING.

These findings likely reflect concerns with the intimate and gendered nature of the procedure, as well as possible misconceptions regarding how HPV is spread and the need for cervical screening.

IMPORTANTLY, THE FINDINGS ILLUSTRATE GREATER SCREENING AMONG THOSE WHO INDICATED TRUSTING RELATIONSHIPS WITH THEIR GP OR HAD ACCESSED AFFIRMING HEALTHCARE SERVICES.

These findings highlight the crucial role that supportive and inclusive primary care plays in encouraging or enabling cervical screening uptake among LGBTQA+ individuals with a cervix.

LOW RATES OF ATTENDANCE FROM INDIVIDUALS LIVING OUTSIDE INNER-SUBURBAN REGIONS, AS WELL AS MIGRANTS FROM NON-ENGLISH-SPEAKING CONTENTS,

suggests a need for cervical cancer screening initiatives to broaden outreach to these underserved communities.

Inclusive and targeted public health initiatives may enhance understanding of cervical screening, promote knowledge of various screening methods such as self-collection, and boost participation among under-represented groups. Moreover, implementing affirming care strategies may play a crucial role in improving cervical screening access within LGBTQA+ communities. It is therefore essential to ensure healthcare providers engage their patients in sensitive and appropriate discussions about their health needs and provide a space where they feel comfortable to disclose their sexual or gender identity. Widespread education and training within healthcare is necessary to ensure healthcare providers can form trusting and affirming provider-patient relationships.

8.3 Chapter summary

Disparities in the sexual and reproductive health of LGBTQA+ populations, more so than other domains of health, are shaped by the stigma affixed to sexual and gender diverse populations, and sexual practices that fall outside the bounds of heteronormativity. Improving STI/HIV screening uptake has been identified as a crucial component of interventions to minimise these disparities. However, screening uptake among LGBTQA+ populations is often hindered by challenges relating to sexual health literacy and misconceptions,[19 20] anticipated discrimination from service providers,[21 22] confidentiality concerns,[23] and feelings of shame and fear stemming from STI/HIV stigma.[24]

The evidence presented above points to significant intracommunity gaps in sexual healthcare utilisation. While some segments of the LGBTQA+ community – particularly GBQ+ men – appear to regularly engage with sexual healthcare services, rates of utilisation among other subgroups are less robust. This is often occurs in groups which are typically considered 'low risk' (e.g., LBQ+ cisgender women); however, low rates of presentation to sexual healthcare services mean that it is difficult to accurately gauge the STI burden and other sexual or reproductive health needs experienced by this group. Our findings also suggest that improving general awareness and health literacy about the sexual transmission of viruses like Hepatitis C and HPV may be necessary for bolstering screening rates. Finally, the findings further reflect concerns with the intimate and gendered nature of cervical screening.

The present section chiefly focused on LGBTQA+ individuals' presentation to sexual healthcare services. While this is a cornerstone of sexual and reproductive health prevention and treatment strategies, sexual healthcare service utilisation is not the sole determinant of sexual health, and both individual and collective sexual health behaviours also play a contributing role in this regard. Apart from GBQ+ men, however, little is known about the sexual health beliefs, attitudes or behaviours of individuals within other LGBTQA+ subgroups. Additional research is therefore needed to identify the sexual health-enabling factors specific to LGBTQA+ people.

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9. GENDER AFFIRMATION AND TRANS AFFIRMING PRACTICES

The affirmation of trans and gender diverse people's gender identities is recognised as a core determinant of health and wellbeing for this group,[1 2] and buffers against the negative consequences of discrimination.[3]

Gender affirmation refers to the reiterative process of recognition and support in inhabiting one's gender identity, expression and/or role. It constitutes a crucial, ongoing need for gender minority persons that, when unmet, can contribute to poor health and wellbeing.[2] These processes can be articulated as four contiguous dimensions, comprising social, legal, psychological and medical domains. Social gender affirmation pertains to the validation of trans and gender diverse individuals' identities by institutions and individuals through, for instance, the adoption of their chosen name and preferred pronouns.[4] Legal affirmations involve the ability to amend legal documents and official records to accurately reflect one's gender identity. Psychological affirmation pertains to the subjective, internal process of self-actualising and validating one's gender. Medical affirmation relates to hormonal or surgical interventions intended to bring one's physical attributes in alignment with one's internal reality. While each domain is not of equal relevance to each trans and gender diverse individual, the presence of these factors within the lives of trans and gender diverse individuals often predicates their health and wellbeing.

9.1 Gender affirmation and trans affirming practice

This section details the key findings relating to gender affirmation and affirming medical practice as well as further explorations of:

- What mental health and wellbeing outcomes are associated with access to medical and legal gender affirmation among trans and gender diverse adults? (*Private Lives 3*)
- Does gender euphoria act as a protective factor against mental ill-health among trans and gender diverse adults? (*Private Lives 3*)
- What mental health and wellbeing outcomes are associated with access to social, medical, and legal gender affirmation among trans and gender diverse young people? (*Writing Themselves In 4*)
- How do trans and gender diverse young people affirm their identity and imagine their future? (*Writing Themselves In 4*)
- Is feeling supported to affirm gender associated with better health and wellbeing outcomes among trans and gender diverse young people? (*Writing Themselves In 4*)
- What are trans and gender diverse young people's positive experiences of their gender identities? (*Trans Pathways*)

9.1.1 Key findings from existing research

Trans and Gender Diverse Adults (*Private Lives 3*)

- 70.8% (n = 155) of trans women, 67.7% (n = 159) of trans men and 63.5% (n = 403) of non-binary people agreed/strongly agreed that 'My sexual and romantic partners have affirmed my gender in ways that support me.'
- 43.2% (n = 111) of trans women, 40.9% (n = 106), trans men and 29.7% (n = 201) of non-binary people agreed/strongly agreed that 'My local community has affirmed my gender in ways that support me.'
- 93.5% (n = 275) of trans men, 87.9% (n = 247) of trans women and 70.3% (n = 546) of non-binary people had ever altered the appearance of their body to affirm their gender identity.
- 83.1% (n = 236) of trans men, 61.4% (n = 164) of trans women and 31.6% (n = 184) of non-binary people agreed/strongly agreed that 'Gender affirming surgery has been a high priority for me.'
- 84.3% (n = 237) of trans women, 75.9% (n = 223) of trans men and 22.2% (n = 172) of non-binary people were currently taking hormonal medications.
- 95.7% (n = 267) of trans women, 94.5% (n = 277) of trans men and 41.5% (n = 246) of non-binary people agreed/strongly agreed that 'Gender affirming hormonal therapy has been a high priority for me.'
- Only 49.5% (n = 142) of trans men, 49.5% (n = 136) of trans women and 25.8% (n = 154) of non-binary people agreed/strongly agreed that 'I have been easily able to access gender affirming care when I have needed to.

Trans and Gender Diverse Young People (*Trans Pathways*)

- 58.3% (n = 353) of trans and gender diverse young people had socially transitioned and 24.8% (n = 150) had partially socially transitioned or were in the process of doing so. Many of these young people said they were 'out' in select circles, e.g., to close friends only, but not publicly.
- Not all trans people seek to transition medically: 4.7% (n = 30) reported current/past use of puberty blockers as children or adolescents, 28.3% (n = 183) reported current/past use of masculinising/feminising hormones and 34% (n = 220) wanted hormones in the future.
- 6.3% (n = 41) had undergone gender-affirming surgery/ies and 20.9% (n = 135) said they would like surgeries in the future.
- 35.4% (n = 251) had accessed medical transition and associated services. 16.1% (n = 31) of those were dissatisfied with the care they received.
- 65.2% (n = 463) had accessed a GP in relation to their gender identity. 19.6% (n = 75) were dissatisfied with the care they received.
- 64.4% (n = 457) had accessed a therapist or counsellor in relation to their gender identity. 16.3% (n = 66) were dissatisfied with the care they received.
- 43.0% (n = 305) had accessed a psychiatrist in relation to their gender identity. 31.7% (n = 86) were dissatisfied with the care they received.

- 43.0% (n = 305) had accessed a psychiatrist in relation to their gender identity. 31.7% (n = 86) were dissatisfied with the care they received.
- 78.9% (n = 542) had experienced issues with school, university or TAFE. These young people had higher rates of wanting to hurt themselves, self-harming, reckless behaviour, suicidal thoughts, suicide attempts, diagnoses of depression and anxiety than those who did not experience issues with school, university or TAFE.

Writing Themselves In 4

- 97.4% (n = 1,379) of trans and gender diverse young people reported ever wanting to affirm their gender identity socially and 74.8% (n = 1,032) had socially affirmed their identities.
- 75.2% (n = 1,065) reported ever wanting to affirm their gender identity legally. Only 22.5% (n = 240) of those had legally affirmed their identities.
- 72.3% (n = 1,024) reported ever wanting to affirm their gender medically. Just 29.4% (n = 301) reported that they had taken steps to affirm their gender medically - most often with hormone therapy (87.4%, n = 263).
- A greater proportion felt that in the past 12 months they could safely use the bathrooms that match their gender identity at university (51.1%, n = 190), use their chosen name or pronouns (87.4%, n = 263), or wear clothes that match their gender identity (84.1%, n = 313) than participants at secondary school (29.2%, n = 269; 41.0%, n = 378 and; 50.9%, n = 469, respectively). 34.1% (n = 314) of young people at secondary school felt they could not do any of these things safely.

RESEARCH PAPERS

Affirming educational and workplace settings are associated with positive mental health and happiness outcomes for LGBTQA+ youth in Australia. This paper demonstrates the importance of affirming education setting and workplace environments for the wellbeing of trans and gender diverse youth. Trans and gender diverse youth were found to report better wellbeing outcomes if they reported that their education setting, or workplace were affirming of their identity. This included not only reduced psychological distress, but also greater subjective happiness.

Perspectives of trans and gender diverse young people accessing primary care and gender-affirming medical services: Findings from *Trans Pathways*. Trans and gender diverse young people in Australia report experiencing difficulties when accessing primary care and gender-affirming medical services. This paper found that trans and gender diverse young people frequently reported negative experiences of care due to practitioners' lack of expertise in providing gender-affirming care, resulting in them needing to navigate the healthcare system unsupported. Just over half (54.8%) of trans and gender diverse young people felt that their gender identity was respected by staff within primary care settings, with one-quarter indicating that they were only sometimes respected and 15.5% felt that their gender identity was not respected.

9.1.2 What mental health and wellbeing outcomes are associated with access to medical and legal gender affirmation among trans and gender diverse adults?

Rationale

The benefits of gender affirmation for trans and gender diverse people are now well-established, yet the specific mental health outcomes associated with different types of affirmation are less clear.[5] Understanding how medical and legal gender affirmation may affect trans and gender diverse people's mental health is essential for informing service provision, policy, and potential legal reform. Exploring the benefits of different types of gender affirmation would also help to identify the most effective approaches to best support trans and gender diverse people's mental health. Additionally, this knowledge would highlight areas where greater support is needed and enable the development of strategies to improve access to these resources.

Dataset and sample population

Data from 1,359 trans and gender diverse *Private Lives 3* participants were included in the analysis.

Variables and analyses

A series of multivariable logistic regression analyses were performed with psychological distress, suicidal ideation, suicide attempt, and gender euphoria as the outcome variables. Gender affirming predictor variables (easily able to access gender affirming care, use of hormone therapies, and any legal gender affirmation) were explored individually in separate multivariable logistic regressions for each of the outcome variables. Additionally, these multivariable logistic regression analyses adjusted for the potential confounding effects of sociodemographic traits, including gender (trans women, trans men, non-binary), sexual orientation, age, level of education, weekly income, and residential location.

Key findings

Only one-third (37.3%, n = 430) of the sample felt that they could easily access gender affirming care, half (50.9%, n = 683) had accessed hormone therapies at some time in their life, and half (50.6%, n = 437) had accessed legal affirmation of their gender.

Gender affirmation was associated with positive mental health outcomes:

- Participants who felt that they could easily access gender affirming care were less likely to report high or very high levels of psychological distress, and less likely to have experienced suicidal ideation in the past 12 months.
- Participants who had their gender recognised legally, through passport, driver's license or birth certificate, were also less likely to report high or very high psychological distress.

Conversely, barriers to accessing gender affirmation may reduce trans and gender diverse wellbeing:

- Those who wanted to access hormones, but had not, were more likely to report high or very high psychological distress, compared with those who had never pursued hormone therapy.

Gender affirmation may increase the likelihood of experiencing gender euphoria:

- Those who had easily accessed gender affirming care, who had received hormone therapy, or had legally affirmed their gender were all more likely to have experienced gender euphoria in their lifetimes.
- Participants who wanted to access hormone therapy, but had not, were more likely to have experienced gender euphoria than those with no desire to take hormones.

Easily able to access gender affirming care	AOR (CI)
High/very high psychological distress	0.60 (0.44 - 0.83)
Recent suicidal ideation	0.73 (0.55 - 0.96)
Legally affirmed gender	
Recent suicidal ideation	0.58 (0.39 - 0.86)
Gender euphoria	1.92 (1.31 - 2.83)
Accessed hormone therapy	
Gender euphoria	2.43 (1.71 - 3.45)
Desire for but no access to hormones	
High/very high psychological distress	1.65 (1.06 - 2.58)
Gender euphoria	1.49 (1.04 - 2.12)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

Access to gender affirming care, and legal or medical affirmation of gender, were found to be associated with

POSITIVE MENTAL HEALTH AND EXPERIENCES OF EUPHORIA

AMONG TRANS AND GENDER DIVERSE ADULTS.

THE FINDINGS FURTHER ILLUSTRATE THAT THOSE WHO WANTED TO ACCESS HORMONE THERAPY BUT HAD NOT BEEN ABLE TO, WERE MORE LIKELY TO REPORT HIGH OR VERY HIGH PSYCHOLOGICAL DISTRESS, suggesting that barriers to accessing desired medical affirmation of gender is likely to be detrimental to the mental health and wellbeing of trans or gender diverse people.

Participants who had affirmed their gender legally or medically, as well as those who desired but had not accessed hormones, were more likely to report having ever experienced gender euphoria.

EXPERIENCING GENDER EUPHORIA MAY BE A CATALYST FOR SEEKING OUT FORMAL MEANS OF GENDER AFFIRMATION, SUCH AS HORMONE THERAPY OR LEGAL GENDER RECOGNITION.

The provision of accessible, inclusive, and affirming healthcare for trans and gender diverse people is essential to promote greater opportunities for mental wellbeing, gender euphoria, and to address health inequalities faced by this population. Gender euphoria is a complex and important aspect of many trans and gender diverse people's experiences that requires further consideration in the provision of gender affirming healthcare.

9.1.3 Does gender euphoria act as a protective factor against mental ill-health among trans and gender diverse adults?

Rationale

Gender euphoria is widely described as a positive emotional response to having one's gender entirely affirmed, yet there is limited awareness of its role in promoting trans and gender diverse people's overall wellbeing.[6] Understanding the benefits of gender euphoria and its association with mental health could assist in further developing approaches to gender affirming care. Increasing our understanding of the role of gender euphoria in the lives of trans and gender diverse individuals can expand our view of their experiences beyond just gender dysphoria. This broader perspective can promote more individual-focused care that better meets their unique needs and experiences.

Dataset and sample population

Data from 1,359 trans and gender diverse *Private Lives 3* participants were included in the analysis.

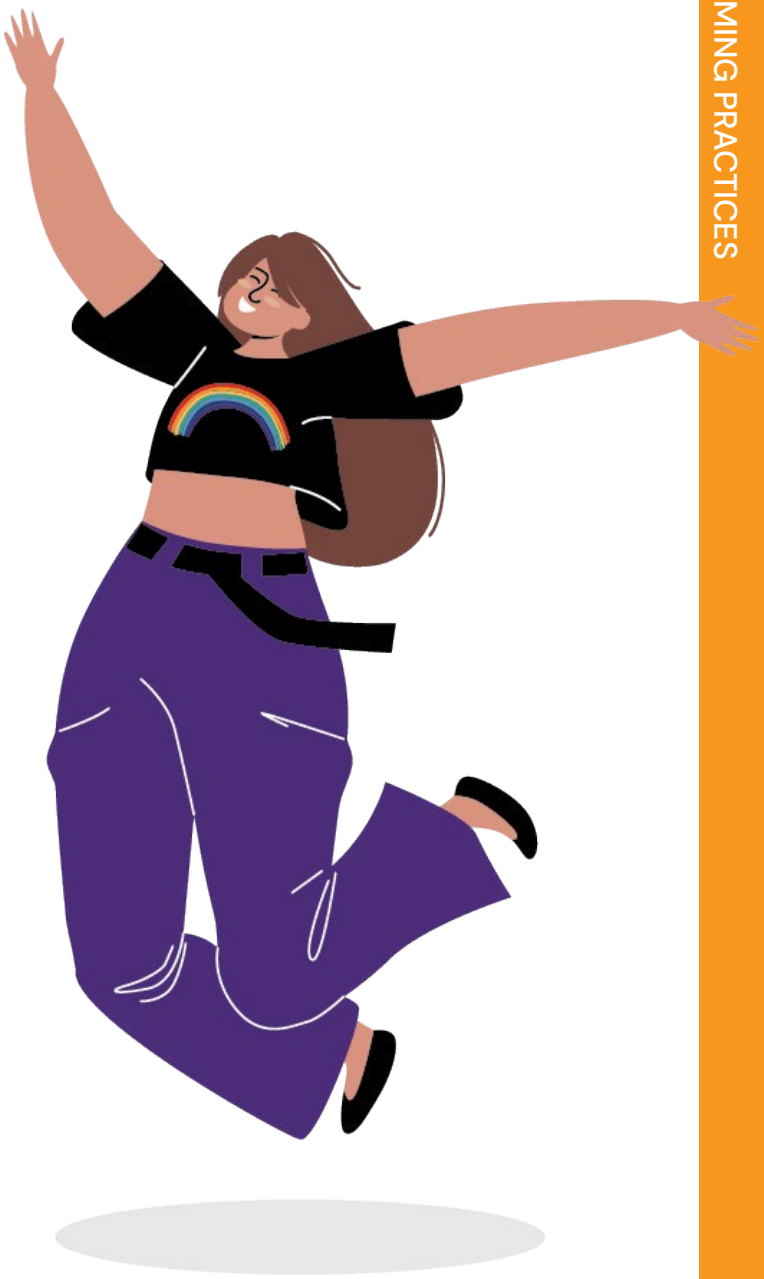
Variables and analyses

Several multivariable logistic regressions were conducted using psychological distress, suicidal ideation and suicide attempt as the outcome variables and experience of gender euphoria as the predictor variable. These models additionally controlled for the confounding effects of sociodemographic factors, including gender (trans women, trans men, non-binary), sexual orientation, age, level of education, weekly income and residential location.

Key findings

- Less than a quarter (21.6%, n = 289) of participants reported currently experiencing gender euphoria, while 30.9% (n = 413) had never experienced it before. No statistically significant gender differences in past or current experiences of gender euphoria were observed in the sample.
- Compared to those who had never experienced gender euphoria, participants currently experiencing gender euphoria were less likely to report high or very high levels of psychological distress, and recent suicidal ideation.
- No difference in distress was found between those who had experienced euphoria in the past but not currently, and those who had never or were unsure if they had experienced euphoria.

Currently experiencing euphoria (ref: never experienced euphoria)	AOR (CI)
High/very high psychological distress	0.42 (0.29 - 0.61)
Recent suicidal ideation	0.61 (0.44 - 0.86)



SUMMARY AND IMPLICATIONS OF THE FINDINGS

When trans and gender diverse people experience gender euphoria, they see

REDUCTIONS IN MENTAL ILL-HEALTH,

INCLUDING A LOWER LIKELIHOOD OF EXPERIENCING HIGH OR VERY HIGH PSYCHOLOGICAL DISTRESS AND A LOWER LIKELIHOOD OF EXPERIENCING SUICIDAL IDEATION.

Given that those who had past, but not current, experiences of euphoria reported similar levels of mental health and suicidal ideation to those who had never experienced euphoria,

IT IS LIKELY THAT THE MORE IMMEDIATE THE FEELINGS OF EUPHORIA, THE GREATER IMPACT THEY HAVE ON OVERALL WELLBEING.

These findings demonstrate the need to increase opportunities for gender euphoria through more consistent and ongoing gender affirmation in multiple contexts for trans and gender diverse people of all ages.

9.1.4 What mental health and wellbeing outcomes are associated with access to social, medical, and legal gender affirmation among trans and gender diverse young people?

Rationale

Understanding how social, legal, and medical gender affirmation may affect trans and gender diverse young people's mental health and wellbeing is essential for informing service provision, policy, and potential legal reform. Exploring the benefits of different types of gender affirmation can also help identify the most effective approaches to support trans and gender diverse young people. Additionally, this knowledge would highlight areas where greater support is needed and enable the development of strategies to improve access to these resources. These analyses aim to identify the associations between legal, medical and social affirmation and mental health and wellbeing outcomes among trans and gender diverse youth.

Dataset and sample population

Data from 1,411 trans and gender diverse *Writing Themselves In 4* participants were included in the analysis.

Variables and analyses

A series of multivariable logistic regression analyses were performed with psychological distress, suicidal ideation, suicide attempt, recent experiences of verbal harassment, homelessness, and drug use as the outcome variables. Gender affirming predictor variables (access among those wanting to access to social, legal, and medical gender affirmation) were explored individually in separate multivariable logistic regressions for each of the outcome variables. Additionally, these multivariable logistic regression analyses adjusted for the potential confounding effects of sociodemographic traits, including gender, sexual orientation, age, level of education, weekly income and residential location.

Key findings

Access to gender affirmation was associated with positive mental health outcomes for trans and gender diverse youth:

- Young people who had affirmed their gender medically and legally reported lower levels of psychological distress and reported lower levels of anxiety.
- Legal affirmation was also associated with greater happiness and lower likelihood of having experienced suicidal ideation in the past year.

Mental health and wellbeing	β (CI)
Psychological distress score	
Medical affirmation	-1.63 (-2.99 - -0.27)
Legal affirmation	-2.68 (-4.05 - -1.31)
Anxiety	
Medical affirmation	-1.01 (-1.96 - -0.06)
Legal affirmation	-1.39 (-2.37 - -0.40)
Happiness	
Legal affirmation	0.32 (0.07 - 0.56)

Recent suicidal ideation	AOR (CI)
Legal affirmation	0.59 (0.39 - 0.89)

Trans and gender diverse youth who had affirmed their gender also experienced the following challenges:

- Young people who had socially affirmed their gender were more likely to report experiencing homelessness and experiencing verbal harassment based on their gender or sexual identity in the past 12 months.
- All forms of gender affirmation were associated with a higher likelihood of using drugs other than alcohol.

Other health outcomes	AOR (CI)
Use of drugs other than alcohol	
Medical affirmation	1.75 (1.17 - 2.6)
Legal affirmation	1.57 (1.06 - 2.33)
Social affirmation	1.52 (1.04 - 2.21)
Homelessness	
Social affirmation	1.53 (1.06 - 2.21)
Verbal harassment	
Social affirmation	1.85 (1.37 - 2.5)

THE ABILITY TO AFFIRM ONE'S GENDER LEGALLY AND MEDICALLY PROMOTES GREATER MENTAL WELLBEING

and reduces distress for trans and gender diverse young people, while no associations were observed between social gender affirmation and mental wellbeing variables.

TRANS AND GENDER DIVERSE YOUTH WHO HAD SOCIALLY AFFIRMED THEIR GENDER WERE MORE LIKELY TO HAVE EXPERIENCED HOMELESSNESS AND VERBAL HARASSMENT IN THE PAST YEAR.

These findings likely reflect an increased vulnerability to stigma and discrimination among those who have socially affirmed their gender, resulting in increased abuse and the potential for family rejection.

The findings reinforce the importance of social support and equitable access to gender affirmation for trans and gender diverse youth, highlighting the need for more consistent gender recognition laws and affirming healthcare options for trans and gender diverse young people throughout Australia.

9.1.5 How do trans and gender diverse young people affirm their identity and imagine their future?

Rationale

Future perspectives are implicitly linked to the present moment. These imagined futures shape our life trajectories, or our perceptions of future potential may be dimmed by experiences of discrimination and disaffirmation. Young trans and gender diverse people are not always afforded the same opportunities to imagine and shape their own futures as their cisgender peers due to a range of complex factors including experiences of overt discrimination, microaggressions, pressure to conform to binary gender constructs, experiences of peer and parental rejection, and barriers to affirming medical care. While these experiences are often attributed to the mental health inequalities observed among trans and gender diverse young people, understanding the ways gender affirmation relates to their broader life aspirations could help to challenge dominant narratives of what their futures might look like, and provide opportunities to promote their positive development and wellbeing.

Dataset and sample population

This analysis includes 1,483 trans and gender diverse young people who participated in *Writing Themselves 4* and who provided the relevant qualitative data (outlined below).

Variables and analyses

Responses to the qualitative data items "What are some of the things that have most helped, or would help you feel that your gender identity is affirmed?" and "How do you imagine your future?" were analysed thematically. We used both line-by-line and iterative coding methods to explore meaning within and across the "gender affirmation" and "your future" codes, and developed themes iteratively. To deepen our understanding of participants' unique experiences and how these materialised in their quotes, we also collected demographic characteristics including age, gender identity, residential location, ethnicity and whether participants lived with a disability. This process allowed us to explicate a nuanced understanding of their experiences of affirmation across time and space and portray a holistic representation of their aspirations for their future selves.

Key findings

Trans and gender diverse young peoples' intersecting desires for affirmation, belonging and gender embodiment re-emerged in their future imaginaries or seemingly underscored aspirations. By examining a combination of trans and gender diverse youths' experiences of dis/affirmation and their future hopes and aspirations, we identified number of themes, described below.

- Bodily affirmations. Participants' bodies and physical and sensory experiences were a central focus, and many spoke about how feelings of gender affirmation and disaffirmation collided. Some quotes described their dysphoria with certain body parts, which were the target of their attempts to affirm their gender. In contrast, other participants perceived the body as a complex landscape where experiences of affirmation and aspiration coexisted without contradiction. As articulated by one participant who is undeterred by his 'female' secondary sex characteristics in his self-characterisation as 'very masculine':

  I am a very masculine person, having a male body would help me feel better but I'm fine with just getting a mastectomy, or wearing a binder. I prefer he/him pronouns and my chosen name currently is a 'boys' name.'
  (15 years, trans / non-binary)

- Gender affirming medical care. Not all young people desired surgery or hormones to affirm their gender, although the barriers to affirming medical care experienced by those who did want to affirm their gender medically had considerable affective consequences. Within these thematically similar quotes was participants' profound awareness of the long-term psychosocial costs of not accessing life-changing surgeries, and the reality that doing so would place them at a considerable economic disadvantage relative to cisgender peers.

  'Instead of saving for a car or uni like other I am forced to save my money for a surgery that should be free.'
  (21 years, trans man/non-binary)

Being out, supported and affirmed in a cisnormative world. Participants' senses of belonging in the past and present were related to the complex and dynamic relationship between spaces and others. Informed and supportive individuals, including professionals, parents and peers, played critical roles in their everyday experiences of belonging and supporting their wellbeing. As described by one participant,

'all I needed to get through high school was one friend who i reached out to, who had no idea what non binary people were, who did her research and used my pronouns. she saved my life.' (14 years, trans)

- **However, experiences of isolation and discrimination were not uncommon.** School, the home, sports teams and medical settings were areas of concern. As such, youths often gravitated to spaces in which they were inherently accepted, inspired, and/or found space to breathe (i.e., LGBTQA+ media, memes, trans friends, alone time, imagined worlds and creative expression).
- **Recognising there's no one way to transition or identify.** While many young people identified a specific affirming moment in which they realised 'I'm not who I was born,' most described struggling with the process of learning how to be trans or identify, or feelings of being 'not trans enough.' In response to such feelings, embracing fluid processes of self-exploration and growth, biding time, eventually coming to physically and/or intrinsically inhabit their identities, and being open to their future selves embodying new ways of expression/identification, was chiefly affirming for many.

'I remind myself that I'm still growing and discovering my identity, and it's okay to change between labels, because I'm not going to get it right the first time and that's okay... I'm still a beautiful person inside and out and whatever gender I finally settle into, is not a prison to my expression or identity.'
(16 years, prefers no gender labels)

Aspirations, anxieties and transition dualities. The collective and subjective challenges experienced or perceived by trans young people (e.g., discrimination, climate crisis, the 'rise of fascism') were impasses to many participants' abilities envision their future selves flourishing. For others, these experiences allowed them to draw hope from the idea that the future will be better than the present. Participants aspired to leave the family home, travel, live in isolation (from humans - usually with an abundance of animals) or queer polyamorous communes, stable monogamous relationships, with service animals, or start families or housing services to support LGBTQA+ people through hardship.

'...these fantasies also let me road test ideas... In these futures I don't have to prove that I'm real to myself. That would be nice.' (21 years, genderqueer/non-binary)

- **Young people also desired the process of gender identity formation, expression and identification to be self-driven, autonomous and unquestioned.** In the future, they aspired for more progressive understandings of trans identities, transnormalcy (i.e., embracing and normalising the experiences and expressions of trans people without imposing restrictive norms or expectations), and/or 'undoing' gender.

SUMMARY AND IMPLICATIONS OF THE FINDINGS

Participants' characterisations of their present realities and aspirations make evident that seeing trans and gender diverse young people flourish is contingent on their abilities to undertake autonomous processes of gender exploration and have access to opportunities to shape their own futures.

Many trans and gender diverse young people's aspirations reflected those often articulated by cisgender young people –

FOR FREEDOM, INDEPENDENCE, STABLE LIVES, COMPANIONSHIP AND ACCEPTANCE.

These aspirations however were embroiled in a range of contradictory experiences that are unique to trans young people, such as discrimination and inequity on the basis of their gender identities as well as empowering forms of gender exploration, affirmation and euphoria. Trans and gender diverse young people's desires, struggles and aspirations are therefore resemblant of the dual liminalities associated with their transitions to both adulthood and gender actualisation.

Efforts are needed to ensure that trans and gender diverse young people have access to safe, affirming spaces (school, workplace, home, broader society), accessible medical care (including trans affirming practices in mainstream medical care as well as access to no-cost surgery/hormones), and the broader radical acceptance and normalisation of all forms of identification and expression.

9.1.6 Is feeling supported to affirm gender associated with better health and wellbeing outcomes among trans and gender diverse young people?

Rationale

Trans and gender diverse youth experience disproportionately high rates of poor mental health and wellbeing outcomes. These outcomes are exacerbated by experiences of discrimination, abuse, family rejection and poor access to affirming care. The aim of these analyses is to examine whether feeling supported to affirm their gender medically, legally or socially is associated with mental health outcomes, as well as experiences of homelessness and abuse.

Dataset and sample population

Data was analysed from 1,697 trans and gender diverse youth who participated in *Writing Themselves In 4*.

Variables and analyses

Trans and gender diverse youth who indicated that they had ever hoped to affirm their gender medically, legally or socially, further reported whether they had felt supported to do so or if they felt their access to these forms of gender affirmation had been denied, delayed or controlled by others. Multivariable logistic regression analyses were performed using support to affirm medical, legally or socially as the independent variable and controlling for confounding effects of age, gender (trans man, trans women, non-binary), sexual orientation, current level of education and residential location. Outcomes included recent suicidal ideation, suicide attempt or self-harm (past 12 months); levels of psychological distress, generalised anxiety and happiness, any lifetime experiences of homelessness; and experiences of verbal abuse in the past 12 months.

Key findings

Trans and gender diverse youth who felt supported to affirm their gender, whether medically, legally or socially, were:

- Less likely to have experienced suicidal ideation, attempted suicide, or self-harmed in the past 12 months.
- Reported lower levels of psychological distress and generalised anxiety.
- Reported greater levels of happiness (with the exception of support to affirm medically).
- Less likely to have ever experienced homelessness.
- Less likely to have experienced verbal abuse in the past 12 months.

	AOR or β* (CI)
Supported to affirm medically	
Recent suicidal ideation (past 12 months)	0.51 (0.31 - 0.84)
Recent suicide attempt (past 12 months)	0.33 (0.17 - 0.65)
Recent self-harm (past 12 months)	0.57 (0.35 - 0.92)
Homelessness (ever)	0.58 (0.35 - 0.95)
Verbal harassment (past 12 months)	0.34 (0.21 - 0.55)
Psychological distress	-3.07* (-4.96 - -1.19)
Anxiety	-1.62* (-2.98 - -0.27)

"SUPPORTING TRANS YOUTH
THE WAYS THAT ARE MEANING
HEALTH AND

	AOR or β* (CI)
Supported to affirm legally	
Recent suicidal ideation (past 12 months)	0.37 (0.22 - 0.62)
Recent suicide attempt (past 12 months)	0.32 (0.16 - 0.65)
Recent self-harm (past 12 months)	0.44 (0.27 - 0.73)
Homelessness (ever)	0.34 (0.19 - 0.62)
Verbal harassment (past 12 months)	0.26 (0.16 - 0.44)
Psychological distress score	-4.61* (-6.69 - -2.52)
Anxiety	-3.24* (-4.65 - -1.83)
Happiness	0.49* (0.14 - 0.84)
Supported to affirm socially)	
Recent suicidal ideation (past 12 months)	0.57 (0.41 - 0.78)
Recent suicide attempt (past 12 months)	0.67 (0.46 - 0.97)
Recent self-harm (past 12 months)	0.65 (0.48 - 0.87)
Homelessness (ever)	0.49 (0.35 - 0.68)
Verbal harassment (past 12 months)	0.43 (0.32 - 0.58)
Psychological distress score	-3.24* (-4.40 - -2.08)
Anxiety	-1.67* (-2.48 - -0.87)
Happiness	0.33* (0.14 - 0.52)

TO AFFIRM THEIR GENDER IN
GFUL TO THEM IS KEY TO THEIR
WELLBEING."

SUMMARY AND IMPLICATIONS OF THE FINDINGS

TRANS AND GENDER DIVERSE YOUTH WHO ARE

SUPPORTED TO AFFIRM THEIR GENDER

in ways that are meaningful to them, whether medically, legally or socially, have considerably better wellbeing outcomes.

Feeling supported to affirm their gender not only resulted in less suicidality, and less mental health concern,

IT ALSO RESULTED IN GREATER HAPPINESS.

Of further interest, those who felt supported additionally reported less likelihood of ever experiencing homelessness and less likelihood of being subject to verbal abuse in the past 12 months.

Supporting trans youth to affirm their gender in the ways that are meaningful to them is key to their health and wellbeing. Families and others who are in a position to support trans youth to affirm their gender as desired must be encouraged and supported to do so.

9.1.7 What are trans and gender diverse young people's positive experiences of their gender identities?

Rationale

Much of the existing literature on trans and gender diverse youth accurately captures the oftentimes negative experiences which trans and gender diverse youth contend with throughout the course of their gender affirmation journeys, yet rarely attends to the positive aspects of trans and gender diverse youths' experiences of their gender. As such, trans and gender diverse identity is frequently framed as a risk factor that predicts negative health and wellbeing. Furthermore, by fixating on the deficits associated with trans and gender diverse identity, these perspectives also foreclose on a more holistic understanding of the facilitating factors of positive health and wellbeing among trans and gender diverse youth. This qualitative analysis explores trans and gender diverse youths' positive experiences of being trans and/or gender diverse.

Dataset and sample population

Data from 386 participants from *Trans Pathways* who provided a response to an open-ended question which asked, 'If you'd like, please tell us some positive aspects of being trans.'

Variables and analyses

Textual responses to the above item were isolated from the wider dataset, alongside sociodemographic characteristics. Exploratory content analysis was conducted to identify emergent themes within the data. A coding framework comprising five core themes was developed through both initial analyses of the data, and a review of the existing literature. Using this preliminary framework, line-by-line codes were subsequently assigned to relevant tracts of text.

Key findings

Four core positive themes emerged from these analyses, these included: (i) connection and companionship with other trans and gender diverse individuals, (ii) emancipation from rigid gender role expectations, (iii) gender euphoria, (iv) camaraderie and commiseration with other marginalised groups. In addition, a fifth theme emerged from participants' negative views of trans and gender diverse identity.

- **Connection and companionship with other trans and gender diverse individuals and broader LGBTQA+ communities were cited by participants as a positive aspect of their identities.** This was articulated as inextricable from their trans and gender diverse identities, as these relationships were facilitated by a mutual understanding of the challenges and triumphs unique to sexual and gender minority individuals. For many participants, these responses were not only contexts wherein identity affirming experiences could be accessed, but also where they could offer other trans and gender diverse individuals the recognition and acceptance that they needed. One participant noted:

'Most of my friends are [trans], it's like a little community, which is really nice, and nothing feels better than the feeling of knowing someone sees me how I want them to see me.' (16 years, genderqueer/agender, bisexual)

- **Participants cited their inhabitation of a trans and gender diverse identity as emancipating them from rigid gender role expectations.** Participants' traversals of, and nebulous positioning within dichotomous male/female gender binaries seemed to inform their scepticism towards – and in some instances, outright rejection of – prescriptive norms regarding gendered behaviour, dress and interests. These changes in participants' perspectives were unilaterally cited as positive developments that represented an assertion of trans and gender diverse young people's personal agency in the context of their own experiences of gender socialisation. One participant stated:

  'well, being trans means not I'm no longer limited to societies idea of male and female. When I was younger, I would have not done or worn certain things because it wasn't for my gender, but now, I don't care about that. I feel more free to express myself and be myself because I have let go of what is considered normal, and instead go with what makes me happy.' (25 years, agender, bisexual)

- **A related theme pertained to experiences of gender euphoria - a positive subjective experience that accompanies the alignment of one's gender identity with one's gender expression.** This is diametrically opposite to gender dysphoria, or the psychological distress that arises from perceived disjunctions between one's gender identity and expression. Gender euphoric experiences were described as a pleasurable experience unique to trans and gender diverse individuals that were profound instances where a participant's decision to socially or medically transition was validated. Participants often characterised these experiences as 'gender euphoria', the following response exemplifies this theme:

  '[for me, being trans has meant] working hard for a body that you love and treasure and knowing what it is to really fight to have that love.' (21 years, male/trans man, queer)

- **Participant responses further described how experiences of transphobic discrimination and exclusion fostered a greater appreciation for the challenges which individuals of other minoritised groups faced.** This engendered both a sense of sympathy and camaraderie between some participants and individuals from these groups. Participants demonstrated especial awareness of the contours of gender privilege and were keenly attuned to the oppressive and/or hierarchical elements of cisnormative constructions of gender. As one participant cites:

  'I think I have a lot more perspective. I can definitely see the divide in terms of how people respond to me now that I start to pass. It's kind of terrifying to realise that, as a man, there is a distinct difference in how people treat you. I'm being inducted into a society of strict masculinity, but also one that is very privileged. It's interesting to be able to see this.' (20 years, male/trans man, pansexual)

- **A minority of participants did not identify any positive aspect of being trans and gender diverse.** Many such perspectives were substantiated with participants' own experiences of transphobic discrimination and exclusion or qualified with references to the significant challenges trans and gender diverse populations face in accessing gender-affirming care, legal recognition and/or social acceptance. A minority of responses within this category involved some degree of self-stigmatisation. Given the widespread nature of anti-trans prejudice, it is unsurprising that some trans and gender diverse individuals may internalise and subsequently express such beliefs. One participant expressed that:

  'I know there are positive aspects, but I [have] yet to find them.' (18 years, male/trans man, pansexual)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

The findings illustrate the plurality of ways trans and gender diverse individuals conceptualise their experiences relating to gender identity.

Most participants were able to identify and articulate positive elements of their experiences as trans and gender diverse persons, such as the sense of community shared with other trans and gender diverse individuals, and other minoritised groups.

THESE POSITIVE ASPECTS OSTENSIBLY FACILITATED FEELINGS OF PRIDE AND SELF-ACCEPTANCE AMONG SOME PARTICIPANTS.

For a minority of participants, however, their experience surrounding their gender identity seemed closely tied to their simultaneous experiences of

STIGMA AND PREJUDICE.

ACCORDINGLY, SEVERAL PARTICIPANTS WERE INSISTENT THAT THERE WERE NO POSITIVE ASPECTS OF THEIR GENDER IDENTITY.

These findings point to the relevance of trans and gender diverse individuals' perceptions of and relationship to their gender identities in understanding the socioemotional wellbeing of gender minority individuals.

Much of the presented evidence appears to suggest that positive perceptions of one's gender identity result from a complex web of factors such as access to identity-affirming experiences, trans and gender diverse peers and the presence of other positive social relationships.

Future research which investigates processes of positive identity development and maintenance among trans and gender diverse individuals, and which attends to the role of such outlooks in facilitating the psychological resilience of trans and gender diverse individuals is needed.

9.2 Chapter summary

Gender affirmation, in its many forms, constitutes an integral and non-negotiable prerequisite of trans and gender diverse individuals' health and wellbeing. Access to gender-affirming medical care can often have profound and lasting consequences for trans and gender diverse individuals' quality of life – as indeed the participants within this section articulate.

The present social climate is one marked by considerable hostility towards trans and gender diverse individuals, and access to gender affirming medical care and socio-legal recognition can be difficult for trans and gender diverse individuals to reliably access. This is especially true for young trans and gender diverse individuals; in addition to the prejudice they face due to their gender identities, significant doubt may also be cast on their gender identities, as well as their intentions to acquire access to gender-affirming medical care.[8] Additionally, the cost of gender-affirming medical care can be a considerable barrier to access or may lead to further economic disadvantage for those who access this care.

The current chapter demonstrates the necessity of all domains of gender affirmation – whether social, medical or legal – to ensuring positive mental health outcomes for trans and gender diverse individuals who wish to affirm their gender in these ways. Simultaneously, our findings suggest a high degree of unmet need in this regard and demonstrate

considerable mental health concerns in relation to these unmet needs. Complicating this is the diversity and complexity in the profile of gender-affirming needs among trans and gender diverse individuals themselves. These, in turn, relate to difference in gender identity, goals in gender transition, and a host of other factors. As such, it is clear from the evidence presented here that there is no one-size-fits-all approach to gender affirming care for trans and gender diverse individuals, and policies pertaining to gender affirming care must account for the diversity in transition goals and intentions within the trans and gender diverse population.

Several gaps in the data also bear mentioning which should be considered in future research. Firstly, there is little available evidence which quantifies the mental health burdens associated with unmet needs for gender affirming care within trans and gender diverse populations. Secondly, there is little data regarding the needs of non-binary and other gender diverse groups which are neither trans men nor trans women. Finally, the needs of trans and gender diverse individuals who hold culturally specific gender identities (e.g., Brotherboy, Sistergirl, two-spirit, kathoey, etc.) as they pertain to gender-affirming care are largely absent from the literature.

9.3 References

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10. GENERAL HEALTHCARE

The cumulative impact of daily indignities, stigma and discrimination takes a significant toll on the health and wellbeing of LGBTQA+ individuals over the course of their lifetime.[1] Contemporary perspectives suggest that these experiences are internalised as stressors which exert a profound impact upon physical and mental health outcomes for LGBTQA+ individuals.[2] This contributes to entrenched health disparities between LGBTQA+ individuals and the general population and corresponds to an increased need for healthcare services among LGBTQA+ individuals.[3]

Despite this, LGBTQA+ individuals commonly experience constrained access to care,[3] refusal of care, substandard care and/or discrimination and mistreatment within healthcare settings.[4] Until relatively recently, medical institutions were implicit in upholding the pathologisation of LGBTQA+ identities, and an accumulation of negative experiences within healthcare settings may underpin distrust towards healthcare service among some segments of the LGBTQA+ community.[5] This also contributes to LGBTQA+ individuals' mistrust and avoidance of healthcare settings and limit access to much-needed healthcare services due to real and/or anticipated discrimination from healthcare providers,[6] as well as a general lack of LGBTQA+-affirming care options. Progress towards implementing inclusive and affirming services within healthcare services has been significant but uneven[7] and examining LGBTQA+ individuals' experiences within these services is crucial to guiding further improvement.

10.1 General healthcare

This section details the key existing findings relating to general healthcare as well as further explorations of the following questions:

- Do LGBTQA+ adults feel that their sexual and gender identities are respected while accessing healthcare services, and is respect within services associated with better health and wellbeing? (*Private Lives 3*)
- What is the influence of care continuity and disclosure of sexual orientation in general practice on LBQ+ cisgender women's engagement with mental health services? (*Private Lives 3*)

10.1.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 51.5% (n = 3,220) of LGBTQA+ adults had recently been diagnosed with/treated for one or more health conditions. The most frequently reported health conditions were low iron level (17.1%, n = 1,072), asthma (14.0%, n = 877), hypertension (7.6%, n = 474) and sexually transmitted infections, not including HIV (6.5%, n = 409).
- 65.5% (n = 4,456) reported having a regular GP. Most trans women (80.8%, n = 227) and trans men (80.2%, n = 239) reported having a regular GP, followed 64.1% (n = 1,484) of cisgender men, 64.1% (n = 1,484) of cisgender women and 63.9% (n = 586) of non-binary people. These rates among cisgender men and women are lower than those observed in the general population in Australia.
- The health service most commonly accessed by LGBTQA+ adults in the past 12 months was a mainstream medical clinic (82.3%, n = 5,684). 5.7% (n = 389) accessed medical clinics that cater only to LGBTQA+ people, and 3.8% (n = 259) accessed mental health services that cater only to LGBTQA+ people.
- 58.6% (n = 3,166) of LGBTQA+ people felt their sexual orientation was respected at mainstream services. 90.9% (n = 1,045) felt their sexual orientation was respected at a mainstream medical clinic that has a reputation for LGBTQA+ inclusivity and 94.9% (n = 351) felt their sexual orientation was respected at a medical clinic catered specifically to LGBTQA+ people.
- 37.7% (n = 480) of trans and gender diverse people felt their gender identity was respected in the past 12 months at a mainstream medical clinic, and 35.4% (n = 223) felt their gender was respected at a hospital. 78.6% (n = 471) felt their gender was respected at a mainstream medical clinic known to be LGBTQA+-inclusive and 90.2% (n = 165) felt their gender was respected at a medical clinic catered specifically to LGBTQA+ people.
- 46.9% (n = 3,201) of LGBTQA+ adults would prefer to receive future support from a mainstream health or support service that is LGBTQA+-inclusive, 21.4% (n = 1,461) from a health or support that caters only to LGBTQA+ people, and 31.7% (n = 2,167) had no preference.

LBQ+ Women (*SWASH*)

- 63.9% (n = 1,666) of LBQ+ women had a regular GP, 21.4% (n = 559) saw different GPs at a single health clinic. 81.5% (n = 1,803) of these women reported they were satisfied or very satisfied with their regular GP or health clinic. 14.7% (n = 382) of LBQ+ women did not have a regular GP or health clinic.
- 34.4% (n = 764) had not disclosed their sexuality or gender identity to their regular GP. 65.6% (n = 1,457) had disclosed either their sexuality, gender identity, or both.
- 33.6% (n = 875) of LBQ+ women rated their health as very good/excellent, 37.5% (n = 977) rated their health as good and 28.9% (n = 754) rated their health as fair/poor.
- 84.4% (n = 232) of those aged 50+ had ever had a mammogram and 15.6% (n = 43) had never or were not eligible.
- 73.9% (n = 210) of participants aged 50 years or older had ever had a bowel screen and 25.1% (n = 74) had never, were not eligible or unsure.
- 99.2% (n = 2,589) were partially or fully vaccinated against COVID-19.

LGBTQA+ Young People (*Writing Themselves In 4*)

- 85.1% (n = 3,684) of LGBTQA+ young people reported accessing in-person professional counselling or support services the most recent time they accessed a professional support service, followed by 11.7% (n = 508) who accessed a professional text or webchat support service, and 3.2% (n = 139) who accessed a professional telephone support service.
- 63.2% (n = 168) of those who accessed an LGBTQA+-specific service reported that it had made the situation 'better/much better', compared to between 34.9% (n = 176) and 50.2% (n = 1,822) of those who accessed a mainstream service (in-person, phone or webchat/text).
- 45.7% (n = 2,934) said they would prefer to access a mainstream service that is LGBTQA+-inclusive, 11.7% (n = 750) preferred a service that is only for LGBTQA+ people, and 8.7% (n = 556) preferred a mainstream service.

Trans and Gender Diverse Young People (*Trans Pathways*)

- 42.1% (n = 263) of trans and gender diverse young people had reached out to a service provider who did not understand, respect or have previous experience with trans and gender diverse people.
- 60.1% (n = 404) experienced feeling isolated from medical and mental health services. These participants experienced significantly higher rates of self-harm, suicidal thoughts, suicide attempts, and diagnoses of PTSD, current severe anxiety, and current severe depression than those who did not feel isolated.
- Many trans and gender diverse young people reported seeing multiple GPs before being satisfied with the care they received.
- Some reported that their GPs were inexperienced with trans and gender diverse people but what mattered was the way they handled the situation. Some were open-minded and tried to be helpful, despite lacking experience in the area, and some young people appreciated when their GPs tried to understand their needs.
- They also described that services with good reputations for helping trans and gender diverse people get overwhelmed and trans young people are then left waiting too long for an appointment, which is detrimental to their overall health.

10.1.2 Do LGBTQA+ adults feel that their sexual and gender identities are respected while accessing healthcare services, and is respect within services associated with better health and wellbeing?

Rationale

Experiences of discrimination profoundly shape LGBTQA+ individuals' engagement with healthcare and may contribute to health disparities between LGBTQA+ populations and their non-LGBTQA+ counterparts. These experiences also inform future engagement with healthcare providers by engendering an expectation of discrimination from healthcare professionals, which may cause LGBTQA+ individuals to delay or abstain from help-seeking.[8 9 10] This likely also informs LGBTQA+ individuals' preference of healthcare services, though little is known about either these preferences, or the relevant experiences that inform them among Australian populations. The current analyses aim to illustrate preferences for and access to health service providers, as well as the importance of respectful healthcare experiences for health and wellbeing outcomes.

Dataset and sample population

Data from 6,829 LGBTQA+ adult participants from *Private Lives 3* were analysed.

Variables and analyses

Descriptive data were used to detail participants' preference of healthcare services, and the most recent service type they had utilised. This was delineated into: (i) mainstream service with a reputation for LGBTQA+ inclusivity, and (ii) LGBTQA+-specific service. Participants were further asked about their preferences in relation to healthcare provider and worker training and accreditation for working with LGBTQA+ populations. Additionally, participants were asked whether they felt that their sexual orientation and gender identity was respected by healthcare providers during their most recent interaction with a healthcare service. A series of univariable linear regressions were used to investigate associations between experiences of respect of their sexual orientation or gender identity within healthcare services, and psychological distress and subjective evaluation of general health. These analyses included mainstream health clinics that are not known to be LGBTQA+-inclusive and mainstream health clinics that are known to be LGBTQA+-inclusive. LGBTQA+-specific services were not included in these analyses because the sample sizes were too small.

Key findings

- Almost half of participants 46.9% (n = 3,201) held a preference for a mainstream service that is known to be LGBTQA+-inclusive, while 21.4% (n = 1,461) held a preference for a service that only caters to LGBTQA+ people. The remaining 31.7% (n = 2,167) did not have a preference.
- Participants overwhelmingly expressed that they were more likely use a service if it had received a formal accreditation for working with LGBTIQA+ patients (75.3%, n = 5,133).
- During the past 12 months, most participants reported that they had attended a service that lacked any reputation of LGBTQA+ inclusivity (83.5%, n = 5,684), just one-quarter (25.0%, n = 1,699) had accessed a mainstream service that was known to LGBTQA+-inclusive, and few (5.7%, n = 389) had accessed a service that catered specifically to LGBTQA+ people.
- The vast majority of participants felt that their sexual orientation was respected within an LGBTQA+-specific service (94.9%, n = 351) and in a mainstream LGBTQA+-inclusive service (90.7%, n = 1,492). However, reports of respect dropped to 58.6% (n = 3,166) from those who attended a mainstream service not known to be inclusive.
- The vast majority of trans and gender diverse participants felt that their gender identity was respected within an LGBTQA+-specific service (90.2%, n = 165), but this dropped to 78.6% (n = 471) in a mainstream LGBTQA+-inclusive service, and to as low as 37.7% (n = 480) in a mainstream service not known to be inclusive.
- Participants who felt that their sexual orientation was respected within a mainstream clinic, whether or not it was known to be inclusive, reported lower psychological distress and higher subjective general health.
- Similarly, participants who felt that their gender identity was respected within a mainstream clinic, whether or not it was known to be inclusive, reported lower psychological distress and higher subjective general health.

Psychological distress score	β (CI)
Sexual orientation respected	
Mainstream clinic not known to be inclusive	-2.03 (-2.27 - -1.80)
Mainstream clinic known to be inclusive	-2.22 (-2.86 - -1.58)
Gender respected	
Mainstream clinic not known to be inclusive	-1.27 (-1.65 - -0.88)
Mainstream clinic known to be inclusive	-1.52 (-2.24 - -0.79)

Subjective general health

Sexual orientation respected	
Mainstream clinic not known to be inclusive	0.18 (0.15 - 0.20)
Mainstream clinic known to be inclusive	0.20 (0.13 - 0.26)
Gender respected	
Mainstream clinic not known to be inclusive	0.12 (0.07 - 0.16)
Mainstream clinic known to be inclusive	0.12 (0.03 - 0.20)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

These findings demonstrate a link between subjective indicators of health and wellbeing and having one's sexuality and gender identity respected within healthcare settings, highlighting the importance of knowledgeable and inclusive practice.

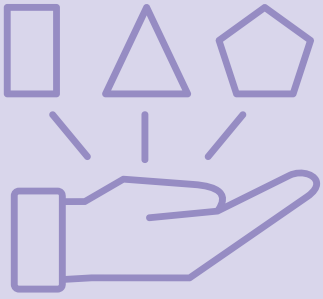
Healthcare service utilisation intention among LGBTQA+ populations may improve when assurance is provided to LGBTQA+ people that they will not experience discrimination within these contexts – such as through

OBTAINING FORMAL ACCREDITATION OR OTHER LGBTQA+-SPECIFIC EXPERTISE.

IRRESPECTIVE OF PREFERENCE, HOWEVER, PARTICIPANTS LARGELY UTILISED MAINSTREAM SERVICES WITH NO REPUTATION OF LGBTQA+ INCLUSIVITY.

This likely reflects the constrained availability of both population-specific services, as well as mainstream services that were known to be LGBTQA+-inclusive.

The disparity in rates of reported identity affirmation as they relate to both gender and sexual identity suggest that the uptake of trans and gender diverse-inclusive practices within healthcare contexts is lagging behind the uptake of sexual diversity-inclusive practices.



Training of mainstream health services to be able to provide inclusive and affirming care to LGBTQA+ patients is essential to meet the health needs of LGBTQA+ people and improve their wellbeing and health outcomes. Appropriate accreditation of these services, such as the Rainbow Tick, is necessary to ensure that these services are providing adequate care and that prospective patients are made aware of this accreditation when choosing a service provider. Additionally, there is a clear need for increased resourcing of community organisation led health services that can provide care specifically to LGBTQA+ people and shrink the very large gap of unmet need for those wishing to access a population-specific service.

10.1.3 What is the influence of care continuity and disclosure of sexual orientation in general practice on LBQ+ cisgender women's engagement with mental health services?

Rationale

LBQ+ cisgender women face considerable barriers to accessing healthcare and may be less likely to have a regular GP than heterosexual cisgender women or to receive healthcare that is knowledgeable and affirming of their identity.[11] Sexual orientation – often a key aspect of one's holistic sense of identity and also pertinent to one's healthcare in many respects – may not be consistently acknowledged in clinical consultations.[12] Whether an individual discloses their sexual orientation to a provider may be contingent upon perceived risks such as discrimination or medical gatekeeping, making disclosure of a minoritised sexual orientation indicative of a trustworthy doctor-patient relationship.[13] While GPs have a key role in facilitating access to mental health services, many LGBTQA+ groups prefer to seek mental health support from services catering to LGBTQA+ populations,[14 15] and the way GPs can facilitate access to these services is not well understood. The following analyses therefore examine i) which LBQ+ cisgender women have a regular GP and whose regular GPs are aware of their sexual orientation; ii) how LBQ+ cisgender women's engagement with GPs shapes their engagement with any mental health services, in addition to mainstream services with a reputation for LGBTQA+ inclusivity or services catered only to LGBTQA+ populations.

Dataset and sample population

Data from 2,707 LBQ+ identified cisgender women who participated in *Private Lives 3* were analysed.

Variables and analyses

Respondents were asked whether they had a regular GP, and whether their regular GP was aware of their sexual orientation. Multivariable logistic regression analyses were used to examine sociodemographic factors (age, sexual orientation, disability according to the Standard Disability Flag Model [SDFM], weekly income, country of birth, area of residence and educational attainment) associated with having a regular GP and GP awareness of respondent's sexual orientation. Additional multivariable logistic regressions further explored whether having a regular GP and GP's awareness of participant's sexual orientation was associated with their engagement with mental health services in the past 12 months, as well as the type of mental health service accessed (mainstream non-inclusive versus mainstream-inclusive or specific LGBTQA+ services), controlling for potential confounding effects of the above demographic variables.

Key findings

Less than two-thirds (64.2%) of LBQ+ cisgender women had a regular GP. Those who most frequently reported having a regular GP were:

- 35 years or older.
- Living with a disability or long-term health condition.

Regular GP	AOR (CI)
Age (ref: 18-24)	
35-44	1.83 (1.35 - 2.48)
45-54	2.26 (1.56 - 3.26)
55-64	3.76 (2.28 - 6.20)
65+	6.07 (2.53 - 14.52)
Disability (ref: none)	
Mild	1.83 (1.31 - 2.55)
Moderate	1.74 (1.40 - 2.16)
Severe	2.51 (1.85 - 3.40)

Less than two-thirds (58.3%) of LBQ+ cisgender women believed their GPs were aware of their sexual orientation. LBQ+ cisgender women who believed their GP was aware of their sexual orientation were more frequently:

- 25 years or older.
- Highly educated.
- On high incomes ($2000+ net weekly income).
- Lesbian-identifying (i.e., monosexual).
- Living in inner suburban or rural areas.

Regular GP aware of sexuality	AOR (CI)
Age (ref: 18-24)	
25-34	2.82 (1.96 - 4.05)
35-44	4.08 (2.70 - 6.17)
45-54	5.22 (3.20 - 8.50)
55-64	4.50 (2.58 - 7.88)
65+	4.58 (2.01 - 10.42)
Sexual orientation (ref: lesbian)	
Bisexual	0.19 (0.14 - 0.25)
Pansexual	0.28 (0.18 - 0.43)
Queer	0.46 (0.32 - 0.65)
Education (ref: secondary or below)	
Non-university tertiary	1.36 (0.93 - 1.99)
University-undergraduate	1.46 (1.01 - 2.12)
University-postgraduate	1.68 (1.11 - 2.54)
Net weekly income (ref: nil)	
$2,000+	2.17 (1.08 - 4.37)
Residential location (ref: inner-suburban)	
Outer-suburban	0.65 (0.49 - 0.87)
Regional city or town	0.70 (0.51 - 0.96)

- Around half (51.8%) of LBQ+ cisgender women reported having accessed any mental health service in the last 12 months. LBQ+ cisgender women who had a regular GP more frequently reported having accessed mental health services.
- Only 16.4% of the total sample reported having accessed a mental health service that is known to be inclusive of or catered specifically for LGBTQA+ people. Inclusive or specific LGBTQA+ mental health services were most frequently accessed by the LBQ+ cisgender women who believed their regular GPs were aware of their sexual orientation.

Accessed any mental health service	AOR(CI)
Regular GP	1.57 (1.31 - 1.88)
Accessed an inclusive or LGBTQA+-specific mental health service	
Regular GP	1.28 (0.97 - 1.68)
GP aware of sexual orientation	1.81 (1.29 - 2.54)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

YOUNGER LBQ+ CISGENDER WOMEN HAD THE LOWEST ODDS OF HAVING A REGULAR GP

and therefore may represent the group with the poorest access to mental healthcare.

Barriers to disclosure of sexual orientation in general practice are likely conferring barriers to appropriate forms of mental health support for LBQ+ cisgender women aged 18–24, identifying as Bi+ or queer, with below undergraduate-level education, earning <$2000/week or living in an outer-suburban or regional area.

Young LBQ+ cisgender women's mental health needs may be particularly underserved relative to the general population given that

18-25-YEAR OLDS IN AUSTRALIA

HAVE BEEN SHOWN IN POPULATION-LEVEL DATA TO BE THE MOST LIKELY OF ALL AGE COHORTS TO ACCESS SUBSIDISED MENTAL HEALTHCARE.

Past research further shows that queer identifying people are more likely to prefer services with a reputation for LGBTQA+ inclusivity and are more reluctant than other sexual minority groups to access mental healthcare. This makes identity-affirming GP relationships especially pertinent to addressing their mental health needs.

GPs are likely missing opportunities to promote continuity of care through developing trusting relationships with specific subpopulations of LBQ+ cisgender women, potentially with detrimental consequences to their mental health. GPs should work to improve LGBTQA+ inclusivity in their regular practice as honest, open discussion about sexuality is a necessary precursor of accurate clinical assessment and linkage to mental health services. Because disclosure of sexual orientation is contingent on a history of trust and rapport, eliciting disclosure of a minoritised sexual orientation may be inappropriate. Rather than assuming heterosexuality or monosexuality, or eliciting unwanted identity disclosure, GPs referring to specialist mental health services may consider it appropriate to ask patients whether LGBTQA+ inclusivity is important to them.

10.2 Chapter summary

LGBTQA+ individuals experience a plethora of health concerns that do not necessarily stem from a common systemic origin. Nevertheless, regardless of the specific concern, healthcare provider discrimination – whether anticipated or experienced – profoundly informs LGBTQA+ individuals' health-seeking behaviours and decisions. Evidence presented in this chapter suggests that even where LGBTQA+ individuals' health concerns are not directly related to their sexual or gender identities, identity-affirming care remained relevant to these individuals' healthcare preferences and experiences.

The current chapter also highlights several concerns regarding the uneven distribution of identity-affirming experiences within healthcare contexts among LGBTQA+ subgroups. Rates of identity-affirming experiences within healthcare appeared lower for trans and gender diverse individuals. This remained the case even with regards to healthcare services which had a reputation for LGBTQA+ inclusivity. The findings call for increased resourcing to ensure adequate availability of LGBTQA+-specific health services as well as increased training and accreditation of mainstream services to provide inclusive and affirming healthcare to LGBTQA+ populations.

Several knowledge gaps remain which should be addressed in future research. Firstly, the implementation of LGBTQA+-inclusive care from a service-level perspective has not been examined in Australian research. Secondly, the availability and distribution of LGBTQA+ affirming physicians and healthcare services within Australian service ecosystems is poorly understood, and there is little indication of which jurisdictions and contexts are in greatest need of intervention. Lastly, service-level data that includes LGBTQA+ information about patients is necessary to further understand the effectiveness of healthcare services for LGBTQA+ populations.

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11. ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The health disparities experienced by Aboriginal and Torres Strait Islander People relative to non-Indigenous Australians are well-documented.[1] In comparison, while it is generally established that Aboriginal and Torres Strait Islander LGBTQA+ individuals are poorly supported and resourced within the domain of health promotion, education and social support services,[2] little else is understood about the drivers of positive health and wellbeing for this group.[3]

Aboriginal and Torres Strait Islander People navigate a complex matrix of historical and ongoing structural and systemic oppressions which are profoundly detrimental to their health and wellbeing.[4] While LGBTQA+ individuals experience qualitatively similar conditions, the extent to and mechanisms by which these factors comingle to impact Aboriginal and Torres Strait Islander LGBTQA+ individuals are poorly understood. What is known is that Aboriginal and Torres Strait Islander LGBTQA+ individuals may experience homophobic discrimination from within the Aboriginal and Torres Strait Islander community,[5] as well as marginalisation and exclusion within the largely white-dominated LGBTQA+ community.[2] Simultaneously, Aboriginal and Torres Strait Islander LGBTQA+ individuals may be uniquely able to access certain forms of resilience that can temper the negative outcomes which result from these experiences.[6]

11.1 Who are Aboriginal and Torres Strait Islander LGBTQA+ People?

This section details the key survey findings regarding the demographic characteristics of Aboriginal and Torres Strait Islander LGBTQA+ People. Most of these findings have not been published elsewhere previously.

11.1.1 Key descriptive findings

Aboriginal and Torres Strait Islander LGBTQA+ People (*Private Lives 3, Writing Themselves In 4* and *Trans Pathways*)

- Across the *Writing Themselves In, Private Lives 3* and *Trans Pathways* surveys, 36.8% (n = 163) of Aboriginal and Torres Strait Islander participants were cisgender women, 25.5% (n = 113) were cisgender men, 1.6% (n = 7) were trans women, 10.2% (n = 45) were trans men, and 25.7% (n = 114) were non-binary.
- 13.0% (n = 60) identified as lesbian, 17.6% (n = 81) identified as gay, 23.0% (n = 106) identified as bisexual, 14.5% (n = 67) identified as pansexual, 12.4% (n = 57) identified as queer, 3.9% (n = 18) identified as asexual, and 15.6% (n = 72) identified their sexual orientation as 'something else.'
- Most (34.6, n = 160) Aboriginal and Torres Strait Islander participants resided in New South Wales. There were slightly lower numbers of people participating from Queensland, the Northern Territory and Western Australia than we might normally expect, and slightly more people from Victoria, the ACT and Tasmania.
- Most (44.5%, n = 193) Aboriginal and Torres Strait Islander participants of *Private Lives 3* and *Writing Themselves In 4* lived in inner or outer suburban areas of capital cities. 35.0% (n = 152) lived in a regional area and 20.5% (n = 152) lived in a rural or remote area.
- Most Aboriginal and Torres Strait Islander participants of across the three surveys were under 35 years. In *Private Lives 3*, 14.7% (n = 27) of Aboriginal and Torres Strait Islander adults were 35-44 years, 11.5% (n = 21) were 45-54 years, 7.1% (n = 13) were 55-64 years and only 1.6% (n = 3) were 65 years or older. There may be many reasons for this, including a lack of promotion of the survey in ways or in places that were accessible or appealing to older Aboriginal and Torres Strait Islander People.
- *In Writing Themselves In 4*, 92.9% (n = 239) reported attending an educational institution in the 12 months prior to the survey. The vast majority of those who were not engaged in education were employed.
- In *Private Lives 3*, 68.9% (n = 126) had attained some form of tertiary education. Only 5.5% (n = 10) of respondents were earning comfortably above the national average weekly income. The majority of respondents (67%, n = 122), had a pre-tax income of less than $1000 per week.
- A large proportion (53.8%, n = 236) of Aboriginal and Torres Strait Islander participants of *Private Lives 3* and *Writing Themselves In 4* reported they had a disability. Among young people, this was particularly the case for those with a mental illness or neurodiversity.

11.2 Relationships, families and children

This section details the key survey findings regarding Aboriginal and Torres Strait Islander LGBTQA+ people's relationships, families, and children. Most of these findings have not been published elsewhere previously.

11.2.1 Key descriptive findings

Aboriginal and Torres Strait Islander LGBTQA+ People (*Private Lives 3* and *Writing Themselves In 4*)

- 50.5% (n = 92) of Aboriginal and Torres Strait Islander participants of *Private Lives 3* reported being in a committed romantic relationship(s). Most (30.1%, n = 64) of these individuals were in ongoing, long-term relationships spanning 2 years of more.
- 29.5% (n = 54) of *Private Lives 3* participants either expressed no desire to marry, or a desire to solemnise their relationships in other ways.
- Only 44.3% (n = 46) of Aboriginal and Torres Strait Islander participants of *Private Lives 3* said they felt accepted a lot/always on LGBTQA+ dating apps or websites, and only 20.9% (n = 18) felt accepted a lot/always on non-LGBTQA+ dating apps or websites.
- 12.0% (n = 22) of Aboriginal and Torres Strait Islander participants of *Private Lives 3* reported they had any children or stepchildren. Most (41.5%, n = 76) expressed no desire for future children. Over half of all participants (54.7%, n = 79) felt that they experienced barriers to having children related to their sexual orientation at least some of the time, while a slightly larger portion of trans and gender diverse participants (56.4%, n = 26) felt similarly about their gender identity.
- Among young Aboriginal and Torres Strait Islander LGBTQA+ participants in *Writing Themselves In 4*, 39.1% (n = 100) had an LGBTQA+ family member.
- Three-quarters (75.0%, n = 192) of Aboriginal and Torres Strait Islander LGBTQA+ participants in *Writing Themselves In 4* were 'out' to at least a few family members including 12.9% (n = 33) who were out to all family members. 52.6% (n = 61) of those who had come out felt supported or very supported by family members upon disclosing their LGBTQA+ identities. Nearly half (44.5%, n = 81) felt accepted by family a lot or always.

11.3 Feeling good as an Aboriginal and Torres Strait Islander LGBTQA+ young person

This section details the key survey findings regarding what helps LGBTQA+ Indigenous young people feel supported and feel good about themselves.

11.3.1 Key descriptive findings

Aboriginal and Torres Strait Islander LGBTQA+ Young People (*Writing Themselves In 4*)

- Almost half (46.8%, n = 117) of Aboriginal and Torres Strait Islander participants in *Writing Themselves In 4* had created or posted something online supporting LGBTQA+ in the past 12 months, followed by 36.8% (n = 92) having stood up for the rights of LGBTQA+ people at school or work, and 18% (n = 45) attending a rally or protest about LGBTQA+ rights. 38.4% (n = 96) of participants had not engaged in any of these LGBTQA+ supportive activities in the past 12 months.
- Similarly, only 15.3% (n = 38) were involved in a school/university LGBTQA+ youth group, 16% (n = 40) in a non-school/university LGBTQA+ youth group, and 17.3% (n = 43) had attended an LGBTQA+ youth event. A similar percentage of trans and gender diverse participants (16%, n = 12) had attended a trans and gender diverse specific youth group in the past 12 months.
- When asked 'What makes you feel good about yourself?' Aboriginal and Torres Strait Islander Young People in *Writing Themselves In 4* described in free text the importance of, i) social connectivity to family and friends, ii) romantic connection, iii) creating and achieving, iv) self-mastery and self-efficacy, v) personal expression and appearance, vi) being affirmed by others, and vii) having influence on others. Some participants found this question difficult or impossible to answer. This could represent an absence in their lives of things that made them feel good, a difficulty in considering or expressing feelings, or both. A few participants also gave responses that reflected pride and affirmation in their Aboriginal and Torres Strait Islander identities and heritage.

11.4 Experiences of affirmation among trans and gender diverse Aboriginal and Torres Strait Islander People

This section details the key survey findings regarding experiences of gender affirmation among trans and gender diverse Aboriginal and Torres Strait Islander People.

11.4.1 Key descriptive findings

Aboriginal and Torres Strait Islander Trans and Gender Diverse People (*Private Lives 3* and *Writing Themselves In 4*)

- 174 Aboriginal and Torres Strait Islander participants across the three surveys identified as trans and gender diverse.
- Nearly one-in-five (19.6%, n = 10) Aboriginal and Torres Strait Islander trans and gender diverse participants in *Private Lives 3* said they do not live in their affirmed gender. 89.8% (n = 44) of participants said that having their gender affirmed by others was important for them, 63.0% (n = 29) said that accessing gender affirming hormonal therapy was a priority for them, and 47.8% (n = 22) said that accessing gender affirming surgery was a priority for them. Of the participants who said they had altered the appearance of their body to affirm their gender identity, 59% (n = 23) were either satisfied or very satisfied with these changes.
- Among Aboriginal and Torres Strait Islander trans and gender diverse young people who participated in *Writing Themselves In 4*, 96.8% (n = 61) wanted to affirm their gender socially and only 71.4% (n = 45) had done so. 73.0% (n = 46) wanted to affirm their gender medically and only 20.6% (n = 13) had done so. 68.3% (n = 43) wanted to affirm their gender legally and only 6.4% (n = 4) had done so.
- Among Aboriginal and Torres Strait Islander trans and gender diverse adults who participated in *Private Lives 3*, 61.4% (n = 27) stated they had not found it easy to access gender affirming surgery when they had needed to. 52.4% (n = 22) stated their sexual and romantic partners had not affirmed their gender in ways that supported them. 65.1% (n = 28) stated their local community had not affirmed their gender in ways that supported them.
- Among Aboriginal and Torres Strait Islander trans and gender diverse participants in *Writing Themselves in 4*, 85.7% (n = 54) had been misgendered at least once in the past 12 months. 58.7% (n = 37) had been misgendered more than once a day during this period.
- Further, 59.0% (n = 36) *Writing Themselves in 4* respondents stated they'd ever been non-consensually outed. This was most commonly by a friend (55.6%, n = 20).
- Only 31.3% (n = 25) of Aboriginal and Torres Strait Islander trans and gender diverse *Writing Themselves In 4* participants felt able to safely use the bathrooms at their place of employment or education that matched their gender identity in the past 12 months. Only 25.0% (n = 20) felt able to use changing rooms that matched their gender identity. Similarly, 63 participants reported challenging experiences related to toilet use as a trans or gender diverse person. 55.6% (n = 35) of these participants had avoided using the toilets and felt uncomfortable or unsafe accessing toilets, 41.3% (n = 26) had limited the amount they drank or ate to avoid using the toilet, 11.1% (n = 7) had developed health complications as a result of toilet avoidance, and 7.9% (n = 5) had been denied access and harassed for using the toilet.

11.5 Health, wellbeing and healthcare experiences

This section details some key findings from the Walkern Katatdjin survey about engagement with health services and mental health challenges among Aboriginal and Torres Strait Islander LGBTQA+ people, as well as further analyses of their health and wellbeing:

- What factors contribute to Aboriginal and Torres Strait Islander LGBTQA+ young people's social and emotional wellbeing? (Walkern Katatdjin)
- How do racist and cisheterosexist microaggressions impact Aboriginal and Torres Strait Islander LGBTQA+ young people's social and emotional wellbeing? (Walkern Katatdjin)
- What key factors are associated with mental health outcomes among Aboriginal and Torres Strait Islander LGBTQA+ adults, and how do their mental health and experiences of harassment compare those of non-Indigenous LGBTQA+ adults? (Private Lives 3)
- What key factors are associated with mental health outcomes among Aboriginal and Torres Strait Islander LGBTQA+ young people, and how do their mental health and experiences of harassment compare those of non-Indigenous LGBTQA+ young people? (Writing Themselves In 4)
- How do cisgender and trans and gender diverse Aboriginal and Torres Strait Islander LGBTQA+ young people differ in terms of mental health, social and emotional wellbeing, and experiences of services? (Walkern Katatdjin)

11.5.1 Key descriptive findings

Aboriginal and Torres Strait Islander LGBTQA+ People (*Walkern Katatdjin*)

- The most common self-reported mental health diagnoses in the population were depression (68.1%, n = 320) generalised anxiety (64%, n = 301) and social anxiety (55.3%, n = 260).
- 77% (n = 353) of participants indicated very high levels of psychological distress in the 5-item Kessler Psychological Distress scale (K5). 92% (n = 423) reported either high or very high levels of psychological distress. The mean psychological distress score was 17.46, which indicates generally very high levels of psychological distress among the whole sample.
- 45.5% (n = 212) of participants had attempted suicide in their lifetime. In the last 12 months, 57.1% (n = 268) had seriously considered suicide (suicidal ideation), 42.1% (n = 197) had made a plan about how they would attempt suicide (suicidal intent), and 19% (n = 89) had attempted suicide.
- 41.1% (n = 174) of participants preferred to attend general health services, 37.4% (n = 158) of participants preferred to attend Aboriginal Community Controlled Health Organisations (ACCHOs), 36.6% (n = 155) of participants preferred to attend LGBTQA+ health services, and 13.7% (n = 58) of participants had no preference.
- 49.5% (n = 225) of participants attended ACCHOs. Some reported negative experiences: 4.7% (n = 10) felt they had not received care because they were LGBTQA+, 7.4% (n = 16) felt they received worse service because of their LGBTQA+ identity, 9.8% (n = 21) reported the service made them feel like they matter less because they are LGBTQA+, 23.0% (n = 49) heard rude, hurtful or ignorant comments about their identity, 23.9% (n = 51) agreed/strongly agreed that they did not feel safe telling services that they are LGBTQA+, and 31.3% (n = 67) agreed/strongly agreed that they usually expect to have a bad experience because they are LGBTQA+.
- Many also had positive experiences at ACCHOs: 51.7% (n = 105) agreed/strongly agreed that there have been LGBTQA+ inclusive health workers at the service, 36.0% (n = 76) said staff used the right language for LGBTQA+ people, 48.5% (n = 99) agreed/strongly agreed they were treated equally as an LGBTQA+ person, 24.9% (n = 50) agreed/strongly agreed that services know about their needs as an LGBTQA+ person, 28.4% (n = 56) agreed/strongly agreed that services were able to give them good resources and link them up to places for LGBTQA+ people.
- 21.8% (n = 101) of participants attended LGBTQA+ health services. Some reported negative experiences: 10.3% (n = 10) said the LGBTQA+ service would not see them because they were Aboriginal and/or Torres Strait Islander, 16.5% (n = 16) felt they were given worse service because they were Aboriginal and/or Torres Strait Islander, 15.5% (n = 15) were made to feel like they matter less because they were Aboriginal and/or Torres Strait Islander, 43.3% (n = 42) heard rude, hurtful or ignorant comments about their Aboriginal and/or Torres Strait Islander identity, 23.7% (n = 23) agreed/strongly agreed they expected to have a bad experience because they were Aboriginal and/or Torres Strait Islander, 28.5% (n = 28) agreed/strongly agreed that they usually do not tell services that they are Aboriginal and/or Torres Strait Islander because it's not important to.
- Many also had positive experiences at LGBTQA+ health services: 77.3% (n = 75) said the LGBTQA+ service listened to their opinion about involving family or friends in their care, 80.4% (n = 78) saw visible signs that Aboriginal and/or Torres Strait Islander people are welcome, 52% (n = 51) agreed/strongly agreed that they were treated equally as an Aboriginal and/or Torres Strait Islander person, 36.1% (n = 35) agreed/strongly agreed that services were able to give them good resources and link them up to places for Aboriginal and/or Torres Strait Islander People.
- General health services were the most utilised of the service types. 91.7% (n = 410) of participants had attended these services.
- Many had negative experiences within general health services: 23.2% (n = 91) said staff made them feel like they mattered less because of their Aboriginal and/or Torres Strait Islander and LGBTQA+ identities, 31.3% (n = 123) reported

hearing rude, hurtful or ignorant comments, 49.4% (n = 198) agreed/strongly agreed that they usually do not tell services that they are Aboriginal and/or Torres Strait Islander or LGBTQA+ because it's not important to, 38.3% (n = 198) agreed/strongly agreed they expect to have a bad experience because of their identities, 35.5% (n = 151) agreed/strongly agreed they have found it hard to find health workers who are positive towards Aboriginal and/or Torres Strait Islander LGBTQA+ people.

- Many also reported positive experiences at general health services: 49.4% (n = 192) agreed/strongly agreed that they feel comfortable using general health services, 56.3% (n = 218) said staff used the right language, 57.5% (n = 226) saw visible signs of welcome and inclusion, 42.2% (n = 160) agreed/strongly agreed that they were treated equally, 18.4% (n = 69) agreed/strongly agreed that services gave them good resources and linked them up with places for Aboriginal and/or Torres Strait Islander LGBTQA+ people, 38.3% (n = 145) agreed/strongly agreed that they felt respected by the staff.
- When service attendance was considered by regionality, ACCHOs were underutilised in remote communities and LGBTQA+ health services were underutilised in very remote communities.

11.5.2 What factors contribute to Aboriginal and Torres Strait Islander LGBTQA+ young people's social and emotional wellbeing?

Rationale

Social and emotional wellbeing (SEWB) provides a framework for understanding Aboriginal and Torres Strait Islander people's health from an Aboriginal perspective. Aboriginal and Torres Strait Islander young people who are LGBTQA+ may draw from diverse sources of strength to counter the impacts of multiple marginalisation, and these strengths provide a likely starting point for interventions or policy aimed at improving their SEWB. *Walkern Katatdjin* is the first piece of research to examine the SEWB of Aboriginal and Torres Strait Islander LGBTQA+ young people.

Dataset and sample population

Data from 590 *Walkern Katatdjin* survey participants (i.e., Aboriginal and Torres Strait Islander LGBTQA+ people aged 14–25 years old from across Australia).

Variables and analyses

Associations between protective factors and SEWB outcomes were explored through multiple linear regression. Predictor variables consisted of potential protective factors (parent/caregiver acceptance, sibling acceptance, Elder acceptance, identity centrality, pride, and media representation). Outcomes are items that represent the seven domains of SEWB according to Gee et al.'s (2014) model: Connection to Mind and Emotions, Connection to Body, Connection to Family and Kinship, Connection to Community, Connection to Culture, Connection to Spirit, Spirituality and Ancestors, Connection to Country. Standardised regression coefficients are reported here. In addition, an overall SEWB score was calculated using standardised scores from each of the SEWB domains.

Key findings

Better overall SEWB was associated with:

- Acceptance of LGBTQA+ identity from parents/caregivers.
- Acceptance of LGBTQA+ identity from community.
- Being proud to be Aboriginal and Torres Strait Islander.

Better Connection to Mind and Emotions was associated with:

- Acceptance of LGBTQA+ identity from parents/caregivers.
- Acceptance of LGBTQA+ identity from community.

Better Connection to Family and Kinship

- The importance participants attributed to their family relationships was positively associated with acceptance of LGBTQA+ identity from parents or caregivers and being proud to be Aboriginal and Torres Strait Islander; and negatively associated with the acceptance of their LGBTQA+ identity from extended family.
- Family getting along well together was positively associated with acceptance from parents or caregivers, and acceptance from siblings.
- A strong sense of family and kinship links was positively associated with acceptance form parents, acceptance from extended family and being proud to be Aboriginal and Torres Strait Islander.

Better Connection to Community:

- Being proud to be Aboriginal and Torres Strait Islander was associated with a higher frequency at which participants attended community events.
- A higher sense of belonging to the LGBTQA+ community was associated with acceptance of LGBTQA+ identity from any community and being proud to be LGBTQA+.
- A higher sense of belonging to the Aboriginal and Torres Strait Islander community was associated with acceptance of LGBTQA+ identity from Elders and being proud to be Aboriginal and Torres Strait Islander.
- A higher sense of belonging to the Aboriginal and Torres Strait Islander LGBTQA+ community was positively associated with seeing fair media representation of Aboriginal and Torres Strait Islander LGBTQA+ people, feeling seen by fair media representation, LGBTQA+ pride, and being proud to be Aboriginal and Torres Strait Islander.
- A higher sense of belonging to a youth community was associated with seeing fair media representation and being proud to be LGBTQA+.

Better Connection to Culture:

- Elder acceptance of LGBTQA+ identity was positively associated with time spent learning about culture, as was identity centrality, and being proud to be Aboriginal and Torres Strait Islander). Feeling seen by fair media representation was inversely associated with time spent learning about culture.
- Acceptance from Elders was positively associated with time spent taking part in cultural practices, as was the importance attributed to fair media representation, and being proud to be Aboriginal and Torres Strait Islander.

Better Connection to Spirit, Spirituality and Ancestors:

- Higher identity centrality, and higher pride in being Aboriginal and Torres Strait Islander, were associated with stronger connection to spirit, spirituality and ancestors.

Better Connection to Country:

- Feeling proud to be Aboriginal and Torres Strait Islander was associated with a higher level of belonging to Country.
- Participants with higher pride in being Aboriginal and Torres Strait Islander were more likely to be living on Country compared to being unsure of where their Country was. Participants with higher acceptance from parents/caregivers were more likely to be living on Country compared to not knowing where one's Country was, and more likely to be living off Country compared to not knowing where one's Country was.

Connection to Body was not associated with any of the factors considered.

Outcome	β (CI)
Overall SEWB	
Acceptance of LGBTQA+ identity from parents/caregivers	0.19 (0.10 - 0.29)
Acceptance of LGBTQA+ identity from Community	0.12 (0.02 - 0.23)
Proud to be Aboriginal and Torres Strait Islander	0.25 (0.15 - 0.36)
Connection to Mind and Emotions	
Acceptance of LGBTQA+ identity from parents/caregivers	0.14 (0.03 - 0.24)
Acceptance of LGBTQA+ identity from Community	0.11 (0.02 - 0.21)

Connection to Family and Kinship

Importance attributed to family relationships	
Acceptance of LGBTQA+ identity from parents/caregivers	0.32 (0.22 - 0.41)
Proud to be Aboriginal and Torres Strait Islander	0.14 (0.02 - 0.26)
Acceptance of LGBTQA+ identity from extended family	-0.09 (-0.19 - -0.00)
Family getting along well together	
Acceptance of LGBTQA+ identity from parents/caregivers	0.32 (0.23, - 0.41)
Acceptance of LGBTQA+ identity from siblings	0.12 (0.03 - 0.21)
Strong sense of kinship links	
Acceptance of LGBTQA+ identity from parents/caregivers	0.27 (0.18 - 0.36)
Acceptance of LGBTQA+ identity from extended family	0.10 (0.01 - 0.19)
Proud to be Aboriginal and Torres Strait Islander	0.11 (0.00 - 0.21)

Connection to Community

Sense of belonging to LGBTQA+ community	
Acceptance of LGBTQA+ identity from any Community	0.14 (0.06 - 0.23)
Proud to be LGBTQA+	0.35 (0.24 - 0.46)
Sense of belonging to Aboriginal and Torres Strait Islander community	
Acceptance of LGBTQA+ identity from Elders	0.12 (0.00 - 0.23)
Proud to be Aboriginal and Torres Strait Islander	0.36 (0.23 - 0.42)
Sense of belonging to Aboriginal and Torres Strait Islander LGBTQA+ community	
Fair media representation of LGBTQA+ Aboriginal and Torres Strait Islander people	0.16 (0.07 - 0.24)
Feeling seen by fair media representation	0.16 (0.07 -0.26)
Proud to be LGBTQA+	0.13 (0.04 - 0.22)
Proud to be Aboriginal and Torres Strait Islander	0.15 (0.06 - 0.25)

Outcome	β (CI)
Sense of belonging to youth community	
Fair media representation of LGBTQA+ Aboriginal and Torres Strait Islander People	0.11 (0.03 - 0.19)
Proud to be LGBTQA+	0.12 (0.02 - 0.22)
Time spent taking part in community events	
Proud to be Aboriginal and Torres Strait Islander	0.18 (0.08 - 0.28)

Connection to Culture

Time spent learning about Culture	
Feeling seen by fair media representation	-0.10 (-0.19 - -0.01)
Acceptance of LGBTQA+ identity from Elders	0.15 (0.05 - 0.25)
Identity centrality	0.11 (0.00 - 0.23)
Proud to be Aboriginal and Torres Strait Islander	0.26 (0.17 - 0.35)
Time spent taking part in Cultural Practices	
Acceptance of LGBTQA+ identity from Elders	0.12 (0.20 - 0.22)
Importance attributed to fair media representation	0.14 (0.02 - 0.26)
Proud to be Aboriginal and Torres Strait Islander	0.22 (0.12 - 0.32)
Connection to Spirit, Spirituality and Ancestors	
Identity centrality	0.11 (0.00 - 0.21)
Proud to be Aboriginal and Torres Strait Islander	0.39 (0.31 - 0.46)

Connection to Country

Feelings of belonging to Country	
Proud to be Aboriginal and Torres Strait Islander	0.37 (0.30 - 0.44)
Living on Country (ref: not knowing where one's Country is)	
Acceptance of LGBTQA+ identity from parents/caregivers	0.43 (0.17 - 0.68)
Proud to be Aboriginal and Torres Strait Islander	0.46 (0.17 - 0.77)
Living off Country (ref: not knowing where one's Country is)	
Acceptance of LGBTQA+ identity from parents/caregivers	0.49 (0.13 -0.84)

ACCEPTANCE OF LGBTQA+ IDENTITY FROM PARENTS/CAREGIVERS AND COMMUNITY AND A SENSE OF PRIDE IN ABORIGINAL AND TORRES STRAIT ISLANDER IDENTITY

emerge as important factors associated with higher SEWB among Aboriginal and Torres Strait Islander LGBTQA+ young people. Interventions to improve SEWB should build on these strengths to ensure success.

Consideration of Aboriginal and Torres Strait Islander LGBTQA+ young people's health using the SEWB framework can help to centre an Indigenous perspective and ensure that research and policy about Aboriginal and Torres Strait Islander LGBTQA+ people address the indicators of health that are significant to them. Acceptance of LGBTQA+ identity from Elders is significant to several culturally based SEWB outcomes and should be facilitated in programs that seek to increase young people's sense of connection to Culture or community.

11.5.3 How do racist and cisheterosexist microaggressions impact Aboriginal and Torres Strait Islander LGBTQA+ Young People's social and emotional wellbeing?

Rationale

Social and emotional wellbeing (SEWB) provides a framework for understand Aboriginal and Torres Strait Islander people's health from an Indigenous perspective. Young people who are Aboriginal and Torres Strait Islander and LGBTQA+ are uniquely impacted by overlapping cisheterosexism and racism. These factors may jeopardise the connections that make up SEWB.

Dataset and sample population

Data from 419 *Walkern Katatdjin* survey participants (i.e., Aboriginal and Torres Strait Islander LGBTQA+ people aged 14-25 years old from across Australia).

Variables and analyses

Associations between microaggressions and SEWB outcomes were explored through multiple linear regression. Predictor variables were: i) cisheterosexist microaggressions for Aboriginal and Torres Strait Islander community; ii) dating racial microaggressions; iii) racial microaggressions from other LGBTQA+ people (items adapted from Balsam et al.'s LGTQA+ POC microaggressions scale). Outcomes are items that represent the seven domains of SEWB according to Gee et al.'s (2014) model: Connection to Mind and Emotions, Connection to Body, Connection to Family and Kinship, Connection to Community, Connection to Culture, Connection to Spirit, Spirituality and Ancestors, Connection to Country.

Key findings

Experiencing homophobic and transphobic microaggressions (cisheterosexism) from other Aboriginal and Torres Strait Islander People was associated with:

- Worse overall SEWB.
- Poorer sense of family and kinship links (part of Connection to Family and Kinship).
- Poorer feelings of belonging to the Aboriginal and Torres Strait Islander community (part of Connection to Community).
- Poorer feelings of belonging to the Aboriginal and Torres Strait Islander LGBTQA+ community (part of Connection to Community).
- Poorer Connection to Spirit, Spirituality and Ancestors.

Experiencing racial microaggressions from a romantic/sexual partner (racial dating microaggressions) was associated with:

- Better overall SEWB.
- More frequent participation in community events (part of Connection to Community).
- Stronger feelings of belonging to the Aboriginal and Torres Strait Islander community (part of Connection to Community).
- Stronger feelings of belonging to the Aboriginal and Torres Strait Islander LGBTQA+ community (part of Connection to Community).
- Greater time participating in cultural practices (part of Connection to Culture).

Experiencing racial microaggressions from other LGBTQA+ people was associated with:

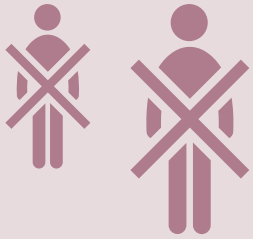
- Stronger feelings of Connection to Country.
- Greater time participating in cultural practices (part of Connection to Culture).

Racist and cisheterosexist microaggressions	β (CI)
Cisheterosexist microaggressions from other Aboriginal and Torres Strait Islander people	
Overall SEWB	-0.13 (-0.22- -0.03)
Sense of Family and Kinship Links	-0.10 (-0.19 - -0.01)
Belonging to Aboriginal and Torres Strait Islander community	-0.17 (-0.25 - -0.08)
Belonging to Aboriginal and Torres Strait Islander LGBTQA+ community	-0.13 (-0.29 - -0.04)
Connection to Spirit, Spirituality and Ancestors	-0.13 (-0.22 - -0.04)
Racial microaggressions from romantic/sexual partners	
Overall SEWB	0.12 (0.03 - 0.22)
Participation in Community Events	0.16 (0.04 - 0.28)
Belonging to Aboriginal and Torres Strait Islander community	0.17 (0.08 - 0.26)
Belonging to Aboriginal and Torres Strait Islander LGBTQA+ community	0.20 (0.11 - 0.29)
Time spent taking part in Cultural Practices	0.31 (0.21 - 0.41)
Racial microaggressions from other LGBTQA+ people	
Connection to Country	0.15 (0.04 - 0.25)
Time spent taking part in Cultural Practices	0.15 (0.01 - 0.23)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

DISCRIMINATION

from other members of the Aboriginal and Torres Strait Islander community results in lower SEWB.



THE POSITIVE ASSOCIATION BETWEEN SOME DOMAINS OF WELLBEING AND RELATIONSHIP RACISM WAS AN UNEXPECTED FINDING.

This may be because: experiences of racism result in youth identifying more strongly with their Aboriginal identity; young people feel bonded to their Aboriginal communities through negative experiences; experiences of racism prompt young people to engage with community and Elders as a coping strategy; or because young people with strong connections to Aboriginal community and culture are more visible targets for racism.

This finding should not condone relationship racism, but points to the

COMPLEXITY OF INTERSECTIONAL IDENTITIES.

These findings demonstrate a need for community-owned interventions within the Aboriginal community to improve communities' capacity to support Aboriginal and Torres Strait Islander LGBTQA+ young people.

11.5.4 What key factors are associated with mental health outcomes among LGBTQA+ Aboriginal and Torres Strait Islander adults, and how do their mental health and experiences of harassment compare to those of non-Indigenous LGBTQA+ adults?

Rationale

Underrepresentation of Aboriginal and Torres Strait Islander LGBTQA+ people in research means little is known regarding their mental health outcomes and experiences of discrimination and harassment as compared to non-Indigenous LGBTQA+ people. The aim of these analyses is to identify how mental health outcomes and experiences of harassment differ between Indigenous and non-Indigenous LGBTQA+ adults, as well as to identify the key factors that are associated with mental health among LGBTQA+ Aboriginal and Torres Strait Islander adults.

Dataset and sample population

Data from 183 Aboriginal and Torres Strait Islander participants from *Private Lives 3* were included in the analyses, along with comparisons to 6,631 participants who did not indicate any Aboriginal or Torres Strait Islander heritage.

Variables and analyses

Using chi-square analyses, rates of any reports of lifetime suicidal ideation, lifetime suicide attempt and high or very high levels of psychological distress were compared between Aboriginal and Torres Strait Islander LGBTQA+ adults and non-Indigenous LGBTQA+ adults. Chi-square analyses were additionally used to compare rates of reporting verbal harassment, sexual assault, social exclusion or being treated unfairly based on their gender or sexual orientation in the past 12 months. Univariable logistic regression analyses were performed to identify factors that were associated with experiences of suicidal ideation and attempt in the past 12 months and reporting of high or very high psychological distress. Potential associated factors explored through these analyses included experiences of verbal harassment, sexual assault, social exclusion and being treated unfairly based on their gender or sexual orientation in the past 12 months.

Key findings

Mental health outcomes and experiences of harassment and discrimination differed between Indigenous and non-Indigenous LGBTQA+ adults. Indigenous LGBTQA+ adults:

- Reported higher rates of suicidal ideation and attempt in their lifetime.
- More frequently indicated high or very high levels of psychological distress
- Experienced higher rates of verbal abuse, sexual assault and social exclusion based on their gender or sexual orientation in the past 12 months.

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- Reported higher rates of unfair treatment based on their gender or sexual orientation in the past 12 months.

Comparison of Aboriginal and Torres Strait Islander and non-Indigenous LGBTQA+ adults	χ^2 (df)
Psychological distress	13.52 (1)
Lifetime suicidal ideation	14.71 (1)
Lifetime suicide attempt	24.24 (1)
Verbal abuse	12.76 (1)
Sexual assault	31.41 (1)
Socially excluded	9.44 (1)
Treated unfairly	7.03 (1)

Rates of reporting high or very high psychological distress among Indigenous LGBTQA+ people were:
- Highest among those who had experienced verbal abuse, sexual assault or social exclusion based on their gender or sexual orientation in the past 12 months.

Rates of reporting suicidal ideation in the past 12 months among Indigenous LGBTQA+ people were:
- Highest among those who had experienced social exclusion or been treated unfairly based on their gender or sexual orientation in the past 12 months.

Rates of reporting suicide attempt in the past 12 months among Indigenous LGBTQA+ people were:
- Highest among those who had experienced verbal abuse, sexual assault or social exclusion based on their gender or sexual orientation in the past 12 months.

Psychological distress, suicidal ideation and suicide attempt among Aboriginal and Torres Strait Islander LGBTQA+ adults	OR (CI)
Associated with psychological distress	
Verbal abuse	1.56 (0.77 - 3.13)
Sexual assault	4.44 (1.46 - 13.51)
Socially excluded	4.13 (1.96 - 8.71)
Suicidal ideation	
Socially excluded	2.06 (1.09 - 3.91)
Treated unfairly	2.52 (1.26 - 5.05)
Associated with recent suicide attempt	
Verbal abuse	3.65 (1.09 - 12.25)
Sexual assault	4.21 (1.31 - 13.51)
Socially excluded	4.48 (1.19 - 16.89)

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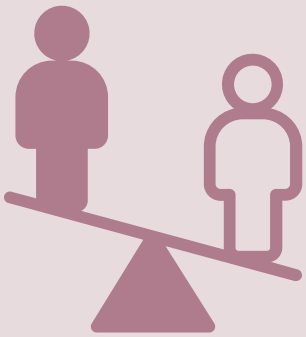
DER LGBTQA+ PEOPLE."

SUMMARY AND IMPLICATIONS OF THE FINDINGS

LGBTQA+ POPULATIONS IN GENERAL HAVE VERY HIGH RATES OF POOR MENTAL HEALTH OUTCOMES.

Concerningly, findings from these analyses suggest even higher rates of high psychological distress, suicidal ideation and suicide attempt among LGBTQA+ people who are of Aboriginal or Torres Strait Islander descent.

ABORIGINAL AND TORRES STRAIT ISLANDER LGBTQA+ PEOPLE ARE ALSO MORE LIKELY TO EXPERIENCE HARASSMENT AND DISCRIMINATION THAN NON-INDIGENOUS LGBTQA+ PEOPLE.



EXPERIENCES OF HARASSMENT AND DISCRIMINATION ARE LIKELY CONTRIBUTING TO HIGH RATES OF POOR MENTAL HEALTH.

This is of significant concern given the even higher rates of harassment and discrimination reported by Aboriginal and Torres Strait Islander LGBTQA+ people.

While the LGBTQA+ community in general requires increased resourcing and appropriate services, as well as prevention efforts, relating to poor mental health and suicidality, specific concerted efforts are additionally required to meet the needs of Aboriginal and Torres Strait Islander LGBTQA+ people. Key to improving the mental health of this population are efforts to prevent discrimination and abuse targeted toward Aboriginal and Torres Strait Islander LGBTQA+ people.

11.5.5 What key factors are associated with mental health outcomes among Aboriginal and Torres Strait Islander LGBTQA+ young people, and how do their mental health and experiences of harassment compare those of non-Indigenous LGBTQA+ young people?

Rationale

Due to the underrepresentation of LGBTQA+ Aboriginal and Torres Strait Islander youth in research, there is a significant knowledge gap about their mental health experiences and encounters with harassment. These analyses aim to identify any differences in mental health outcomes and experiences of harassment between Indigenous and non-Indigenous LGBTQA+ youth, as well as to identify risk and protective factors associated with mental health outcomes.

Dataset and sample population

Data from 256 Aboriginal and Torres Strait Islander participants from *Writing Themselves In 4* were included in the analyses, along with comparisons to 6,151 participants who did not indicate any Aboriginal or Torres Strait Islander heritage.

Variables and analyses

Using chi-square analyses, rates of any reports of lifetime suicidal ideation, lifetime suicide attempt, lifetime self-harm and high or very high levels of psychological distress were compared between Aboriginal and Torres Strait Islander LGBTQA+ youth and non-Indigenous LGBTQA+ youth. Chi-square analyses were additionally used to compare rates of reporting any experiences of verbal harassment, physical harassment and sexual assault based on their gender or sexual orientation in the past 12 months. Univariable logistic regression analyses were also performed to identify factors that were associated with experiences of suicidal ideation, suicide attempt and self-harm in the past 12 months and reporting of high or very high psychological distress. Potential associated factors explored through these analyses included experiences of verbal, physical or sexual harassment in the past 12 months and feeling a part of their school or education institution.

Key findings

Mental health outcomes and experiences of harassment differed between Indigenous LGBTQA+ youth compared to non-Indigenous LGBTQA+ youth. Aboriginal and Torres Strait Islander LGBTQA+ youth:

- Reported higher rates of suicidal ideation, suicide attempt and self-harm in their lifetime.
- More frequently indicated high or very high levels of psychological distress
- Experienced higher rates of verbal, physical and sexual harassment based on their gender or sexual orientation in the past 12 months.

Comparison of Aboriginal and Torres Strait Islander and non-Indigenous LGBTQA+ young people	Chi² (df)
Lifetime suicidal ideation	8.95 (1)
Lifetime suicide attempt	28.6 (1)
Lifetime self-harm	19.20 (1)
Psychological distress	13.22 (1)
Verbal harassment	20.64 (1)
Sexual harassment	5.19 (1)
Physical harassment	19.45 (1)

Rates of reporting suicidal ideation in the past 12 months among Aboriginal and Torres Strait Islander LGBTQA+ youth were:

- Highest among those who had experienced sexual harassment based on their gender or sexual orientation in the past 12 months.

Rates of reporting suicide attempt in the past 12 months among Aboriginal and Torres Strait Islander LGBTQA+ youth were:

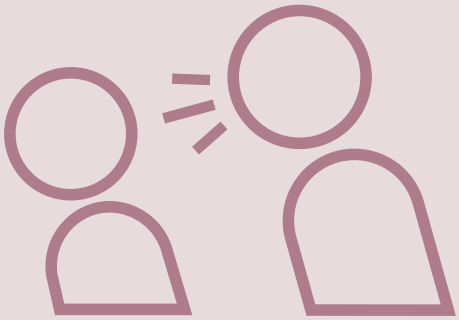
- Highest among those who had experienced physical or sexual harassment based on their gender or sexual orientation in the past 12 months.
- Lowest among those who felt that they were a part of their school or education institution.
- Rates of reporting self-harm in the past 12 months among indigenous LGBTQA+ people were:
- Highest among those who had experienced verbal or physical harassment based on their gender or sexual orientation in the past 12 months.
- Lowest among those who felt that they were a part of their school or education institution.

Suicidal ideation, suicide attempt and self-harm among Aboriginal and Torres Strait Islander LGBTQA+ young people	OR (CI)
Associated with recent suicidal ideation	
Sexual harassment	2.11 (1.00 - 4.45)
Recent suicide attempt	
Sexual harassment	3.23 (1.51 - 6.91)
Physical harassment	3.76 (1.60 - 8.84)
Feel a part of school	0.38 (0.17 - 0.89)
Recent self-harm	
Verbal harassment	2.42 (1.41 - 4.15)
Physical harassment	2.22 (1.03 - 4.78)
Feel a part of school	0.53 (0.30 - 0.93)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

ABORIGINAL AND TORRES STRAIT ISLANDER YOUTH REPORT EVEN HIGHER RATES OF POOR MENTAL HEALTH THAN NON-INDIGENOUS LGBTQA+ YOUTH.

This includes higher rates of suicidal ideation, suicide attempt, self-harm and high psychological distress.



Additionally, Aboriginal and Torres Strait Islander youth experienced higher rates of verbal, physical and sexual assault.

Experiences of harassment were associated with a greater likelihood of experiencing suicidal ideation, attempting suicide or self-harm in the past 12 months. This is particularly concerning given the high rates of harassment experienced by Aboriginal and Torres Strait Islander young people.

IMPORTANTLY, FEELING A PART OF THEIR SCHOOL MAY BE PROTECTIVE

FOR YOUNG ABORIGINAL AND TORRES STRAIT ISLANDER LGBTQA+ PEOPLE, AND WAS ASSOCIATED WITH A LOWER LIKELIHOOD OF SUICIDE ATTEMPT AND SELF-HARM IN THE PAST 12 MONTHS.

Aboriginal and Torres Strait Islander LGBTQA+ youth experience concerningly high rates of poor mental health as well as experiences of harassment. Higher than the already high rates among their non-Indigenous LGBTQA+ peers. It is essential that efforts are made to ensure access to culturally appropriate and affirming mental health and suicide support services, along with efforts to prevent harassment targeted at Aboriginal and Torres Strait Islander LGBTQA+ youth. Additionally, it is crucial that all education settings are spaces within which Aboriginal and Torres Strait Islander LGBTQA+ youth feel their identity is affirmed and are able to feel connected.

11.5.6 How do cisgender and trans and gender diverse Aboriginal and Torres Strait Islander LGBTQA+ young people differ in terms of mental health, social and emotional wellbeing, and experiences of services?

Rationale

Trans and gender diverse youth experience poorer mental health, higher rates of suicidal thoughts and behaviours and poorer health service access than their cisgender sexuality-diverse peers.[7] We explored whether this same differential outcome was evident for Aboriginal and Torres Strait Islander LGBTQA+ youth.

Dataset and sample population

Data from 560 *Walkern Katatdjin* survey participants, all Aboriginal and Torres Strait Islander LGBTQA+ people aged 14-25 years old. We compared those who were trans or gender diverse (n = 283) to those who were cisgender (n = 277).

Variables and analyses

Outcomes of interest were: psychological distress (Kessler-5), suicidal thoughts and behaviours, the experience and impact of microaggressions (cisheterosexist microaggressions for Aboriginal and Torres Strait Islander community; dating racial microaggressions; racial microaggressions from other LGBTQA+ people (items adapted from Balsam et al.'s LGTQA+ POC microaggressions scale)), the seven domains of social and emotional wellbeing according to Gee et al.'s (2014) model (Connection to Mind and Emotions, Connection to Body, Connection to Family and Kinship, Connection to Community, Connection to Culture, Connection to Country, and Connection to Spirit, Spirituality and Ancestors), identity centrality, and experiences of LGBTQA+ health services, general health services and ACCHOs. Linear regressions and logistic regressions were used to explore whether gender diversity (trans or cis) was associated with outcomes. Standardised β coefficients and odds ratios with 95% CIs are presented.

Key findings

Mental health and suicidal thoughts and behaviours: Compared to cisgender participants, trans and gender diverse participants:

- Reported higher psychological distress.
- Were more likely to report a suicide attempt in their lifetime.
- Were more likely to report suicide ideation in the last 12 months.

Experiences of microaggressions: Compared to cisgender participants, trans and gender diverse participants:

- Were more likely to report cisheterosexist microaggressions within the Aboriginal and Torres Strait Islander community. However, the impact of cisheterosexist microaggressions when experienced did not differ between trans and cis participants.
- The levels of reported relationship racism and LGBTQA+ racism were comparable between cisgender and trans and gender diverse participants. However, trans and gender diverse participants reported a greater impact of LGBTQA+ Racism when they experienced it.

Social and emotional wellbeing: Compared to cisgender participants, trans and gender diverse participants:

- Reported less time learning about Culture (part of Connection to Culture).
- Reported less time spent in cultural practices (part of Connection to Culture).
- Reported lower Connection to Mind and Emotions
- Reported lower Connection to Body.
- Were less likely to agree or strongly agree that their family relationships were important to them (part of Connection to Family and Kinship)
- Were less likely to agree or strongly agree that their family gets on well together (part of Connection to Family and Kinship).
- Were less likely to agree or strongly agree that they have a strong sense of family and kinship links (part of Connection to Family and Kinship).
- Were more likely to be unsure about where their Country is (Chi2 = 7.49 (2), p = 0.02)
- Were more likely to feel like they belonged to the LGBTQA+ community.
- Reported higher Identity Centrality.

When attending ACCHOs, trans and gender diverse people were more likely than cis participants to:

- Feel like they mattered less because they were LGBTQA+
- Hear rude, hurtful or ignorant comments about their LGBTQA+ identity.

Trans and gender diverse participants were less likely than cisgender participants to:

- Not disclose their LGBTQA+ identity because they didn't think it was important to do so.

When attending general health services, trans and gender diverse participants were more likely than cisgender participants to:

- Feel like they mattered less because they were Aboriginal and Torres Strait Islander and LGBTQA+.
- Expect that they would have a bad experience because they are Aboriginal and Torres Strait Islander and LGBTQA+.

Trans and gender diverse participants were less likely than cisgender participants to:

- Report that staff used the right language for Aboriginal and Torres Strait Islander LGBTQA+ people.
- Feel comfortable using these services as an Aboriginal and Torres Strait Islander LGBTQA+ person
- Believe the service know abouts their needs as an Aboriginal and Torres Strait Islander LGBTQA+ person.
- Feel respected by staff as an Aboriginal and Torres Strait Islander LGBTQA+ person.

When attending LGBTQA+ health services, trans and gender diverse participants were more likely than cisgender participants to:

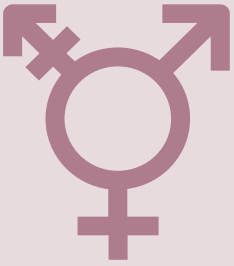
- Not disclose their LGBTQA+ identity because they didn't think it was important to do so.

Comparisons between cisgender and trans and gender diverse participants (ref: cisgender participants)	OR (CI) or β* (CI)
Mental Health, Suicidal Thoughts & Behaviours	
Lifetime suicide attempt	1.89 (1.25 – 286)
Recent suicidal ideation	1.76 (1.15 – 2.69)
Psychological distress	0.17* (0.60 – 2.19)
Experiences of Microaggressions	
Cisheterosexist microaggressions from Aboriginal and Torres Strait Islander community	0.14* (0.10 – 0.60)
Impact of racism from LGBTQA+ community	0.12* (0.03 – 0.44)
Social and Emotional Wellbeing	0.12* (0.03 – 0.44)
Time spent learning about Culture	-0.09* (-0.47 – -0.01)
Time spent participating in cultural practices	-0.14* (-0.62 – -0.12)
Connection to Mind and Emotions	-0.18* (-1.29 – -0.38)
Connection to Body	-0.13* (-1.00 – -0.16)
Importance of family relationships	-0.16* (-0.55 – -0.18)
Family gets on well together	-0.16* (-0.58 – -0.19)
Sense of Family and Kinship links	-0.18* (-0.66 – -0.24)
Feelings of belonging to the LGBTQA+ community	0.22* (0.28 – 0.64)
Identity centrality	0.10* (0.01 – 0.38)

Experiences of Health Services

ACCHOs	
Felt they matter less because they're LGBTQA+	3.33 (1.24 – 8.99)
LGBTQA+ identity non-disclosure due to perceived irrelevance	-0.21* (-0.91 – -0.85)
Heard rude, hurtful or ignorant comments about LGBTQA+ identity	1.99 (1.02 – 3.90)
General Health Services	
Felt they matter less because they're Aboriginal/Torres Strait Islander and LGBTQA+	1.81 (1.09 – 2.98)
Staff used appropriate language	0.54 (0.35 – 0.83)
Anticipated negative experience	0.12* (0.05 – 0.61)
Felt comfortable using service	0.15* (-0.59 – -0.10)
Felt confident service knew about their needs	-0.11* (-0.49 – -0.006)
Felt respected by staff	-0.14* (-0.53 – -0.08)
LGBTQA+ Health Services	
Aboriginal and Torres Strait Islander identity non-disclosure due to perceived irrelevance	0.22* (0.02 – 1.26)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

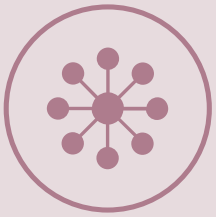


CONSISTENT WITH FINDINGS FROM TRANS AND GENDER DIVERSE PEOPLE IN THE GENERAL POPULATION,

trans and gender diverse Aboriginal and Torres Strait Islander youth are at higher risk for psychological distress and lifetime suicide attempt than their cisgender sexuality-diverse peers.

TRANS AND GENDER DIVERSE PEOPLE EXPERIENCE MORE CISHETEROSEXISM FROM WITHIN THE ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITY.

This suggests that sexuality diversity may be more accepted in communities than gender diversity and greater education about gender diversity is required.



Trans and gender diverse Aboriginal and Torres Strait Islander youth experience less time spent participating in cultural practices, and lower Connection to Mind and Emotions, Connection to Family and Kinship, and Connection to Body than their cisgender sexuality diverse counterparts. Poorer Connection to Mind and Emotions (poorer mental wellbeing), Body (poorer physical health), and Family and Kinship (e.g., issues with unsupportive families) are consistent with much of the existing literature about trans and gender diverse young people's experiences.

HOWEVER, FOR THESE YOUTH, THEIR ABORIGINAL AND LGBTQA+ IDENTITY IS MORE IMPORTANT TO THEIR SENSE OF SELF, AS SHOWN THROUGH THEIR GREATER IDENTITY CENTRALITY WHEN COMPARED TO CISGENDER ABORIGINAL AND TORRES STRAIT ISLANDER YOUNG PEOPLE.

The experience of trans and gender diverse and cisgender Aboriginal and Torres Strait Islander LGBTQA+ youth did not appear to differ in LGBTQA+ health services.

HOWEVER, TRANS AND GENDER DIVERSE ABORIGINAL AND TORRES STRAIT ISLANDER PARTICIPANTS HAD POORER EXPERIENCES AT ACCHOS AND GENERAL HEALTH SERVICES.

Trans and gender diverse Aboriginal and Torres Strait Islander young people may struggle to participate in cultural practices due to prejudice in the community, gender-restrictions within cultural practices, or because of poorer family relationships. Trans and gender diverse Aboriginal and Torres Strait Islander youth require greater support and more targeted interventions for their mental health and social and emotional wellbeing. There is also a need for better training in trans-inclusive healthcare at ACCHOs and general health services.

11.6 Chapter summary

Evidence presented in this chapter further highlights stark disparities between the mental health outcomes of Aboriginal and Torres Strait Islander LGBTQA+ individuals and their non-Indigenous peers. This is likely associated with the elevated incidence of discriminatory and exclusionary experiences reported by this group. Concerningly, these experiences appear to be heightened across a variety of contexts – including in school, community, and even healthcare settings – likely reflecting their structural underpinnings.

Several important protective factors against negative psychological outcomes within this group were identified, and collectively point to significant cultural components to the health and wellbeing of Aboriginal and Torres Strait Islander LGBTQA+ persons. Findings presented here emphasise the contribution of active participation in the cultural practices of one's community, and the cultivation of family and kinship ties to fostering positive psychological outcomes for this group. The present analyses also shed light on the importance of positive media representations of Aboriginal and Torres Strait Islander people as a factor predicating positive self-identity and feelings of acceptance within broader society. This broadly aligns with a large body of evidence that corroborates the importance of these factors among cisgender, heterosexual Aboriginal and Torres Strait Islanders. Differing from the latter, however, Aboriginal and Torres Strait Islander LGBTQA+ people may experience additional barriers to accessing health-

facilitating cultural factors or rejection due to their sexual and/or gender identities. In parallel to this, Aboriginal and Torres Strait Islander LGBTQA+ persons also experience significant difficulties accessing identity-affirming experiences through the LGBTQA+ community, where they are instead rejected due to their racial identities. Troublingly, these experiences appear to persist even among non-Indigenous friends and even intimate partners and is demonstrative of the extent to which experiences of racism and exclusion are prevalent within the lives of Aboriginal and Torres Strait Islander people.

These findings also demonstrate a significant degree of unmet need among Aboriginal and Torres Strait Islander LGBTQA+ individuals in relation to healthcare services that are both culturally appropriate and affirming of their LGBTQA+ identity. Evidence presented above suggest that at present, healthcare services that serve minority populations are often under-optimised to meet the needs of individuals within these populations who hold other minority identities, and who experience needs relating to said identities. Recent evidence suggests that there is a paucity of services that are adequately equipped to holistically meet the intersecting needs of Aboriginal and Torres Strait Islander LGBTQA+ people.[8]

At the time of writing, however, research that examines the implementation of LGBTQA+-affirming and/or culturally sensitive care paradigms within clinical contexts is limited. Scholars have more recently investigated the challenges associated with providing LGBTQA+ identity-affirming care within ACCHOs[9] and the experiences of individual service workers providing care to Aboriginal and Torres Strait Islander LGBTQA+ clients.[10] By and large, however, both service- and individual-level perspectives on the implementation of LGBTQA+-affirming and culturally appropriate service paradigms represent significant gaps within our knowledge. This contributes to a lack of clarity regarding best practice principles as they relate to inclusive service implementation and should ideally form the subject of future inquiry.

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12. INTERSECTIONAL IDENTITIES

The LGBTQA+ population encompasses a broad range of identities and experiences. For example, an individual may be bisexual but also be trans and from a culturally or linguistically diverse background or living with a disability.

For many individuals within the LGBTQ+ community, discrimination may not solely be experienced due to their sexual or gender identity. Historically, scholars have presumed that individuals who hold multiple intersectional identities and experiences face the additive effects of various forms of disadvantage.[1] However, more contemporary perspectives propose that these identities are unified and cannot be separated.[2] Consequently, LGBTQA+ individuals who hold intersectional identities often experience unique challenges that arise from the overlap of these identities but are simultaneously able to tap into specific resources accessible only to individuals who hold those intersectional identities.[3] Hence, there can be both challenges and strengths that arise from the intersection(s).[4 5 6]

In the current chapter, we examine the intersections of LGBTQA+ identity and: (i) disability, (ii) race and ethnicity, (iii) residential location and (iv) ageing. We explore how these intersectional identities inform LGBTQA+ individuals' experiences of community, belonging and health outcomes. This section additionally explores differences in these outcomes between various LGBTQA+ identity subgroups - (v) according to gender and sexuality.

While these identities and experiences are not mutually exclusive and often simultaneously inhabited or held, the research presented primarily examine the intersection of two identities. More granular analyses (e.g., three or more identities) are unfeasible due to small sample sizes within each intersectional category.

12.1 People with a disability

LGBTQA+ persons with disability may experience discrimination and alienation from non-LGBTQA+ people with disability and disability services due to their sexual and/or gender minority identities, while also experiencing discrimination within LGBTQA+ spaces due to their disability.[7] Concurrently, these individuals are largely underserved by existing services, which are seldom adequately equipped to comprehensively meet the needs of this group.[7] LGBTQA+ individuals with a disability may additionally contend with overly protective or controlling attitudes from caregivers regarding their sexuality and sexual autonomy.[8] Due to assumptions that persons with disability are either asexual or implicitly heterosexual, LGBTQA+ people with a disability may experience significant barriers in accessing the LGBTQA+ community, relevant information about sex and sexuality, and even to participating in consensual intimate relationships.[9]

The confluence of these factors translates into poorer health and wellbeing among individuals located at the intersection of these identities.[10 11] This section details the key findings relating to disability as well as further explorations of:

- What are the health and wellbeing outcomes among LGBTQA+ young people with disability? (*Writing Themselves In 4*)
- Do LGBTQA+ young people with a disability who feel safe and connected within community experience better mental health and wellbeing outcomes? (*Writing Themselves In 4*)
- What factors are associated with experiences of harassment or abuse among LGBTQA+ young people with disability? (*Writing Themselves In 4*)

12.1.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 47.9% (n = 3267) of LGBTQA+ adults identified as having a disability or long-term health condition, 47.9% (n = 3,272) did not indicate having a disability, 3.5% (n = 236) were unsure, and 0.8% (n = 53) preferred not to say. Notably, the proportion of participants with a disability is higher than the 17.7% observed within the general population.[12]
- 3,261 participants who identified as having a disability answered the Standard Disability Flag Model (SDFM). 19.4% (n = 632) of those indicated no activity limitation, 13.3% (n = 433) indicated mild activity limitation, 42.8% (n = 1394) indicated moderate activity limitation, and 24.6% (n = 802) indicated severe activity limitation.
- 62.2% (n =1,545) of people with a disability reported feeling accepted at an LGBTQA+ venue/event compared to 72.8% (n = 1,883) of those not reporting a disability. Only 55.3% (n = 324) of participants reporting severe activity limitation felt accepted at an LGBTQA+ venue/event compared to 68.2% (n = 335) of those reporting no activity limitation associated with their disability.
- 22.9% (n = 635) of people with a disability reported feeling accepted at a mainstream venue/event compared to 35.1% (n = 1016) of those not reporting a disability/long-term health condition. Just 16.2% (n = 107) of participants reporting severe activity limitation felt accepted at a mainstream venue/event compared to 34.3% (n = 184) of those reporting no activity limitation.

LBQ+ Women (*SWASH*)

- 49.8% (n =1,305) of LBQ+ women reported having a disability or long-term health condition.

LGBTQA+ Young People (*Writing Themselves In 4*)

- 39.0% (n = 2,500) of LGBTQA+ young people reported having a disability or long-term physical or mental health condition, 8.7% (n = 558) were unsure, and 1.4% (n = 87) preferred not to say.
- 34.4% (n = 2,206) had a mental illness diagnosis, 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. Notably, 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[13]), is likely to arise, in part, from the inclusion of mental illness.

- More LGBTQA+ young people with a disability had attended an LGBTQA+ youth event in the past 12 months (20.4%, n = 287) than those reporting no disability or long-term health condition (12.2%, n = 390).
- Those with a disability more frequently reported feeling unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity (56.7%, n = 763) than those not reporting disability or a long-term health condition (45.1%, n = 1,412).
- LGBTQA+ young people with a disability more frequently reported feeling supported by friends (89.5%, n = 1,216), compared to those reporting no disability (87.5%, n = 2,656). However, they less frequently felt supported by family (56.2%, n = 638) than those reporting no disability (59.1%, n = 1,256). They also felt less supported by classmates (39.3%, n = 266, compared to 45.1%, n = 724).
- 52.7% (n = 730) of young LGBTQA+ people with a disability experienced verbal harassment relating to sexuality or gender identity in the past 12 months. This proportion was considerably greater than that observed among LGBTQA+ young people without a disability (34.7%, n = 1,089).

Trans and Gender Diverse Young People (*Trans Pathways*)

- 22.5% (n = 172) of trans and gender diverse youth had been diagnosed with Autism.

RESEARCH PAPERS

Factors associated with experiences of abuse among lesbian, gay, bisexual, trans, queer, and asexual (LGBTQA+) adults with disability in Australia. This paper illustrates high rates of verbal abuse, sexual assault and social exclusion based on sexual or gender identity in the past 12 months among LGBTQA+ adults with a disability. Among LGBTQA+ adult with disability, verbal abuse was more likely among trans women and non-binary participants and among those classified with more severe disability. Sexual assault was more likely among those who lived in a rural area or had a higher income. Social exclusion was more likely among those who were trans woman or non-binary, identified as bisexual, aged 18-24 years, or born in an English-speaking country other than Australia.

Mental health difficulties among trans and gender diverse young people with an autism spectrum disorder (ASD): Findings from *Trans Pathways*. This paper investigated the prevalence of ASD in trans young people, their mental health (psychiatric diagnoses and self-harm and suicidal behaviours) and experiences in accessing gender-affirming care. Approximately one-fifth of the study sample had received an ASD diagnosis. This paper illustrates that this group were more likely to exhibit current psychopathology, have engaged in self-harming and suicidal behaviours, and were also more likely than the non-ASD diagnosed reference group to have received a psychiatric diagnosis. The ASD-diagnosed group were also more likely to experience barriers in accessing gender-affirming care.

12.1.2 What are the health and wellbeing outcomes among LGBTQA+ young people with disability?

Rationale

LGBTQA+ individuals and people with disability are individually recognised as populations which experience significantly worse health and wellbeing-related outcomes relative to the general population. It is uncertain whether this disadvantage is compounded for individuals at the nexus of these minoritised identities – and if so, in relation to which outcomes. This is made further opaque by the unique forms of resilience that may emerge among these populations in response to these challenges. There is a lack of population-level data about how health disparities are distributed within the LGBTQA+ community along the lines of disability. Therefore, these analyses will explore associations between having a disability, type of disability, psychological distress, suicidality, homelessness and substance use.

Dataset and sample population

A total of 5,438 *Writing Themselves In 4* participants who provided information relating to their disability status were included in these analyses.

Variables and analyses

Participants in *Writing Themselves In 4* indicated whether or not they had a disability or long-term health condition, including a mental health condition. Those that reported having a disability were further asked about the type of disability. A series of univariable logistic regressions were performed to investigate associations between having a disability other than mental health and a variety of outcomes, including: (i) psychological distress, (ii) recent (<12 months) suicidal ideation, (iii) a recent (<12 months) suicide attempt, (iv) lifetime experiences of homelessness; (v) past 6-months drug use and (vi) any lifetime tobacco use. Thereafter, a second series of univariable regressions compared these outcomes among participants with a disability, according to whether they reported either an intellectual disability, a physical or sensory disability, or being neurodiverse.

Key findings

Compared to LGBTQA+ young people not reporting a disability, those with a disability had greater odds of reporting:

- Recent suicidal ideation.
- A recent suicide attempt/s.
- Past experience/s of homelessness.
- High/very high levels of psychological distress.

Non-mental-health disability	OR (CI)
Recent suicidal ideation	2.01 (1.76 - 2.30)
Recent suicide attempt	1.87 (1.56 - 2.25)
High/very high psychological distress	3.10 (2.36 – 3.76)
Any experience of homelessness	2.19 (1.92 – 2.50)

Among LGBTQA+ young people with a disability, those who had an intellectual disability had greater odds of reporting:

- A recent suicide attempt/s.
- High/very high levels of psychological distress.
- A past experience/s of homelessness.
- Tobacco use.

Among LGBTQA+ young people with a disability, greater odds of reporting a past experience/s of homelessness were additionally found among:

- Those who were neurodiverse.
- Those who reported a physical or sensory disability.

Intellectual disability	OR (CI)
Recent suicide attempt	1.54 (1.15 - 2.05)
High/very high psychological distress	1.68 (1.02 – 2.76)
Any experience of homelessness	1.32 (1.10 – 1.58)
Any tobacco use	1.49 (1.10 – 2.01)
Neurodiversity	
Any experience of homelessness	1.25 (1.05 – 1.49)
Physical or sensory disability	
Any experience of homelessness	1.67 (1.33 – 2.11)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

The findings demonstrate that LGBTQA+ young people with a disability experience a greater burden of

MENTAL HEALTH CHALLENGES

AND HOMELESSNESS COMPARED TO THOSE WITHOUT A DISABILITY.

THE PREVALENCE OF HOMELESSNESS AMONG LGBTQA+ PERSONS WITH DISABILITY ALSO DIFFERS IN RELATION TO THE KINDS OF DISABILITY EXPERIENCED

and is more common among those who reported an intellectual disability, were neurodiverse or reported a physical or sensory disability.

PARTICIPANTS WITH AN INTELLECTUAL DISABILITY WERE ALSO FOUND TO BE MORE LIKELY TO EXPERIENCE HIGH OR VERY HIGH LEVELS OF PSYCHOLOGICAL DISTRESS, MORE LIKELY TO HAVE RECENTLY ATTEMPTED SUICIDE AND MORE LIKELY TO HAVE EVER SMOKED TOBACCO.

It is essential that mental health and homelessness services are equipped and well trained to provide knowledgeable and inclusive care for youth at an intersection of LGBTQA+ identity and disability. This will likely include disability training for LGBTQA+-specific support services as well as LGBTQA+ inclusivity training for disability services, and a combination of both for mainstream services.

12.1.3 Do LGBTQA+ young people with a disability who feel safe and connected within LGBTQA+ communities experience better mental health and wellbeing outcomes?

Rationale

A common factor contributing to the health disparities experienced by LGBTQA+ individuals with disability is their simultaneous exclusion within mainstream LGBTQA+ and disability community contexts.[14] Previous research suggests that LGBTQA+ individuals with disability may experience mainstream LGBTQA+ community spaces as exclusionary and unaccommodating of their needs. While these concerns may be attenuated within the disability community, and among disability service providers,[15] experiences of heterosexism and transphobia are instead more common in these spaces.[14] The resulting lack of a space where LGBTQA+ individuals with disability can access identity-affirming experiences without caveat may profoundly and negatively impact the health and wellbeing of this group.[16] The aim of these analyses is to explore experiences within and connection to community may be associated with mental health and wellbeing outcomes among LGBTQA+ young people with a disability.

Dataset and sample population

Responses from 2,453 *Writing Themselves In 4* participants who reported having a disability were included in the current analyses.

Variables and analyses

A series of linear regressions were used to explore the relationships between several community connection factors and wellbeing outcomes, including psychological distress and subjective happiness. Input variables consisted of different forms of perceived inclusion such as: (a) feeling included in the LGBTQA+ community, (b) feeling that the voices of LGBTQA+ people with disability are heard and understood within the LGBTQA+ community, (c) feeling one's LGBTQA+ identity is supported by peers with disability, and (d) feeling that one's LGBTQA+ identity is supported by disability support providers. Multivariable logistic regressions were similarly used to explore associations between the above input variables and recent (<12 months) suicidal ideation and suicide attempts. Each regression model additionally controlled for the confounding impact of sociodemographic factors including age, sexual identity, gender, educational level and country of origin.

Key findings

56.2% (n = 1,379) of participants with disability felt that they were a part of the LGBTQA+ community in Australia. Feeling a part of the LGBTQA+ community was significantly associated with:

- A lower likelihood of reporting high or very high levels of psychological distress.
- A lower likelihood of recent suicidal ideation.
- Greater subjective happiness.

Only 28.2% (n = 680) felt that the voices of LGBTQA+ individuals with disability were heard and understood within the LGBTQA+ community, and this was significantly associated with:

- A lower likelihood of reporting high or very high levels of psychological distress.
- Greater subjective happiness.

57.3% (n = 1,237) felt that their LGBTQA+ identity is supported by peers with disability, and this was significantly associated with:

- A lower likelihood of reporting high or very high levels of psychological distress.
- A lower likelihood of reporting recent suicidal ideation.
- A lower likelihood of reporting a recent suicidal attempt.
- Greater subjective happiness.

Less than one-quarter (23.0%, n = 383) felt that their LGBTQA+ identity is supported by the NDIS/disability support providers. Feeling that their identity was supported by NDIS/disability support providers was significantly associated with:

- A lower likelihood of reporting high or very high levels of psychological distress.
- A lower likelihood reporting a recent suicide attempt.

High/very high psychological distress	β (CI)
Feel a part of the LGBTQA+ community	-0.67 (-0.99 – -0.37)
Voice heard/understood	-0.39 (-0.72 – -0.06)
Identity supported by peers	-0.91 (-1.28 – -0.54)
Identity supported by NDIS/ support worker	-0.59 (-1.03 – -0.15)

Happiness score	β (CI)
Feel a part of the LGBTQA+ community	0.14 (0.89 – 0.19)
Voice heard/understood	0.08 (0.25 – 0.14)
Identity supported by peers	0.18 (0.12 – 0.25)

Recent suicidal ideation	OR (CI)
Feel a part of the LGBTQA+ community (ref: disagree/strongly disagree)	
Neutral	0.71 (0.52 – 0.96)
Agree/strongly agree	0.64 (0.49 – 0.84)
Identity supported by peers (ref: disagree/strongly disagree)	
Neutral	0.37 (0.23 – 0.57)
Agree/strongly agree	0.37 (0.25 – 0.56)
Identity supported by NDIS/support worker (ref: disagree/strongly disagree)	
Neutral	0.70 (0.52 – 0.93)

Recent suicide attempt	OR (CI)
Identity supported by peers (ref: disagree/strongly disagree)	
Neutral	0.55 (0.37 – 0.81)
Agree/strongly agree	0.56 (0.39 – 0.79)
Identity supported by NDIS/support worker (ref: disagree/strongly disagree)	
Neutral	0.54 (0.39 – 0.74)
Agree/strongly agree	0.61 (0.42 – 0.89)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

While all domains of perceived inclusion were significantly associated with positive mental health and wellbeing related outcomes, it was evident that inclusion within LGBTQA+ community settings exerted a particularly noticeable, protective effect.

ACCEPTANCE AS AN LGBTQA+ PERSON AMONGST PEERS WITH DISABILITY APPEARED TO BE THE MOST IMPORTANT DOMAIN OF INCLUSION

AND WAS ASSOCIATED WITH A LOWER LIKELIHOOD OF REPORTING NEGATIVE MENTAL HEALTH OUTCOMES, AND WITH HIGHER SUBJECTIVE HAPPINESS SCORES.

The disproportionate significance of this domain of inclusion may reflect the especial importance of peer relationships and acceptance to psychosocial health during adolescence.

Efforts toward disability inclusion and LGBTQA+ inclusion within community contexts and among service providers may have a direct impact on the mental health and wellbeing of LGBTQA+ youth with disability. Given the high proportion of young LGBTQA+ people reporting a disability, it is essential that efforts are made within both LGBTQA+ and disability communities and service providers to ensure inclusivity and affirmation of LGBTQA+ young people with disability.

12.1.4 What factors are associated with experiences of harassment or abuse among LGBTQA+ young people with disability?

Rationale

LGBTQA+ young people face high rates of discrimination and abuse from others. The prevalence of these experiences is not felt equally across this population and LGBTQA+ youth with disability are at a heightened risk of discrimination and abuse.[17] However, little is known about the factors that may be associated with a greater risk of harassment among LGBTQA+ youth with a disability. These analyses explore factors that are associated with verbal, physical or sexual harassment experienced by LGBTQA+ youth with a disability in the past 12 months.

Dataset and sample population

Data from 2,500 LGBTQA+ youth with disability from the *Writing Themselves In 4* survey were included in these analyses.

Variables and analyses

Three multivariable logistic regression analyses were conducted exploring factors that were associated with either verbal harassment, physical harassment or sexual harassment. Predictor variables included in each of these models were age, sexual orientation, gender, education, current employment, country of birth (Australia, other English-speaking country, other non-English-speaking country), residential location, disclosure of LGBTQA+ identity to family, type of disability (neurodivergent, intellectual, physical, mental health, other disability)

Key findings

48.4% of participants with disability reported experiencing verbal harassment or abuse, 12.4% physical harassment or abuse, and 29.7% sexual assault or harassment in the past 12 months. Experiences of verbal harassment in the past 12 months differed between subgroups of young LGBTQA+ people with a disability. Specifically:

- Those ages 18-21 years were less likely than those aged 14-17 years to report verbal harassment.
- Cisgender women were the least likely, while trans men were most likely.
- Those who were currently employed were more likely to have experienced verbal harassment.
- Young people who were 'out' to most or all of their family were more likely to have experienced verbal harassment.
- Those who indicated having an intellectual disability, physical or sensory disability, or a mental illness were all more likely to have reported experiencing verbal harassment.

Verbal harassment	AOR (CI)
Age (ref: 14-17 years)	
18-21 years	0.75 (0.57 - 0.99)
Gender (ref: cisgender man)	
Cisgender woman	0.36 (0.26 - 0.51)
Trans man	1.76 (1.15 - 2.67)
Currently employed (ref: No)	
Yes	1.27 (1.05 - 1.54)
Out to family (ref: none)	
Most or all	1.36 (1.04 - 1.77)

"48.4% OF PARTICIPANTS WITH DIS VERBAL HARASSMENT OR ABUSE, 12.4 AND 29.7% SEXUAL ASSAULT OR HAR

Verbal harassment	AOR (CI)
Intellectual disability (ref: No)	
Yes	1.63 (1.23 - 2.15)
Physical or sensory disability (ref: No)	
Yes	1.26 (1.02 - 1.55)
Mental illness (ref: No)	
Yes	1.83 (1.37 - 2.44)

Experiences of physical harassment in the past 12 months differed between subgroups of young LGBTQA+ people with a disability. Specifically:

- Cisgender women and non-binary young people were the least likely to have experienced physical harassment in the past 12 months.
- Those who indicated having an intellectual disability, physical or sensory disability, or a mental illness were all more likely to have reported experiencing physical harassment.

Physical harassment	AOR (CI)
Gender (ref: cisgender man)	
Cisgender woman	0.23 (0.14 - 0.38)
Non-binary	0.48 (0.29 - 0.80)
Intellectual disability (ref: No)	
Yes	1.61 (1.09 - 2.39)
Physical or sensory disability (ref: No)	
Yes	1.69 (1.22 - 2.33)
Mental illness (ref: No)	
Yes	3.52 (1.86 - 6.65)

Experiences of sexual harassment in the past 12 months differed between subgroups of young LGBTQA+ people with a disability. Specifically:

- Young trans women were most likely to have experienced sexual harassment.
- Those who were currently employed were more likely to experience sexual harassment.
- Young people living in outer-suburban or regional cities or towns were least likely to have experienced sexual harassment.
- Those who indicated having a mental illness were most likely to have experienced sexual harassment.

Sexual harassment	AOR (CI)
Gender (ref: cisgender man)	
Trans woman	3.40 (1.57 - 7.33)
Currently employed (ref: No)	
Yes	1.69 (1.36 - 2.10)
Residential location (ref: inner-suburban)	
Outer-suburban	0.64 (0.44 - 0.95)
Regional city or town	0.63 (0.41 - 0.97)
Mental illness (ref: No)	
Yes	2.10 (1.47 - 2.99)

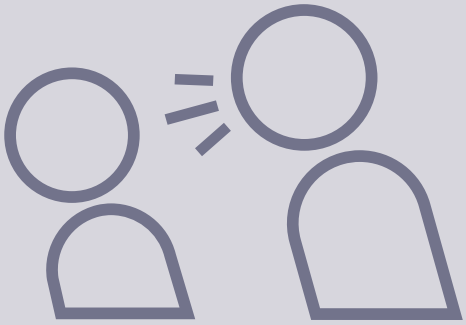
SABILITY REPORTED EXPERIENCING % PHYSICAL HARASSMENT OR ABUSE, RASSMENT IN THE PAST 12 MONTHS."

SUMMARY AND IMPLICATIONS OF THE FINDINGS

Rates of verbal, physical and sexual harassment among LGBTQA+ young people with disability were high.

VARIOUS FACTORS WERE ASSOCIATED WITH AN EVEN GREATER RISK OF EXPERIENCING THESE FORMS OF HARASSMENT. IN PARTICULAR,

GENDER WAS ASSOCIATED WITH ALL FORMS OF HARASSMENT,



WITH TRANS MEN AND TRANS WOMEN REPORTING WORSE OUTCOMES.

Additionally, those with an intellectual, or physical or sensory disability were more likely to have experienced harassment.

CONCERNINGLY, YOUNG LGBTQA+ PEOPLE WITH DISABILITY WHO HAD DISCLOSED THEIR LGBTQA+ IDENTITY TO MOST OR ALL OF THEIR FAMILY WERE MORE LIKELY TO REPORT VERBAL HARASSMENT.

Young people who are out to their family are likely to be more visible in broader society too and consequently subject to discrimination and harassment due to their LGBTQA+ identity.

It is essential that organisations, including health, social and disability services, as well as education institutions and workplaces, are creating positive spaces not only for people with disability but for young people of LGBTQA+ identities. This includes ensuring young people feel safe and free from the negative impact of stigma and harassment.

12.2 Race and ethnicity

LGBTQA+ people from a multicultural background report significant experiences of discrimination and alienation within the broader LGBTQA+ community,[18] as well as their multicultural communities of origin.[19] Within either setting, LGBTQA+ people from multicultural backgrounds constitute a 'minority within a minority' and frequently experience discrimination targeting either their race and ethnicity or their sexual and/or gender identities. As LGBTQA+ people from multicultural backgrounds typically rely on these spaces for both support as well as identity-affirming experiences, disaffiliating or distancing themselves from these communities is seldom a viable option for these individuals.[20] The combination of an additional axis of oppression and disadvantage, and their proximity to experiences of discrimination, has been cited as key factors underpinning disparities in measures of health and wellbeing among these groups, comparative to their racial majority and/or cisgender/heterosexual counterparts.[21]

This section details the key findings relating to race and ethnicity, as well as further explorations of racially-minoritised LGBTQA+ individuals' experiences of unfair treatment, and protective factors against psychological distress, including:

- What are racially-minoritised LGBTQA+ individuals' experiences of unfair treatment, and protective factors against psychological distress? (*Private Lives 3*)

12.2.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 84.0% (n = 5,730) of LGBTQA+ adults were born in Australia (and 16.0% (n = 1,095) were born overseas. Of participants born overseas, 12.8% (n = 139) had lived in Australia for five years or less and one quarter (27.9%, n = 303) had lived in Australia for ten years or less.
- The most common countries of birth outside of Australia were the United Kingdom (n = 360), New Zealand (n = 199), United States (n = 84), South Africa (n = 54), Malaysia (n = 35), Canada (n = 30), Germany (n = 28), Ireland (n = 26), Philippines (n = 21), Singapore (n = 17), Netherlands (n = 14), France (n = 11), India (n = 11), Sri Lanka (n = 11), Hong Kong (n = 9), Zimbabwe (n = 7), China (n = 5), Indonesia (n = 5), Italy (n = 5), South Korea (n = 5) and Russia (n = 5).
- Over 50 languages were spoken among the 2.4% (n = 161) of participants who spoke a language other than English at home.
- 57.7% (n = 1,009) of participants from a multicultural background agreed or strongly agreed that they felt a part of the Australian LGBTQA+ community, compared to 56.7% (n = 2,369) of those from an Anglo-Celtic background.

- A smaller proportion of participants from multicultural backgrounds reported feeling accepted a lot/always in almost all settings. For example, 45.8% (n = 769) of those with multicultural backgrounds reported feeling accepted a lot or always by family members compared to 55.2% (n = 2,231) of those with an Anglo-Celtic background.
- 33.0% (n = 575) of participants from multicultural backgrounds reported feeling that they had been treated unfairly by others due to their ethnicity, cultural identity or heritage in the past 12 months, compared to 6.5% (n = 271) of participants from an Anglo-Celtic background.

LBQ+ Women (*SWASH*)

- 11.7% (n = 306) of LBQ+ women spoke a language other than English at home and 15.7% (n = 410) were born in a country other than Australia.

LGBTQA+ Young People (*Writing Themselves In 4*)

- LGBTQA+ young people from multicultural backgrounds reported slightly lower attendance at LGBTQA+ youth events in the past 12 months than Anglo-Celtic participants.
- 51.8% (n = 1,621) of participants from multicultural backgrounds reported feeling unsafe or uncomfortable at their educational institution in the past 12 months due to their sexuality or gender identity, compared to 46.5% (n = 1,152) of Anglo-Celtic participants.
- Those from an Anglo-Celtic background were most likely to have disclosed their sexuality or gender to most/all of their friends (66.7%, n = 1,723), compared to those from a multicultural background (63.7%, n = 2,048). This includes South-East Asian (64.8%, n = 79), Southern European (63.2%, n = 153), Eastern European (58.7%, n = 128), and Chinese (50.9%, n = 57) backgrounds.
- Compared to LGBTQA+ youth from an Anglo-Celtic background (28.6%, n = 735), fewer of those from a multicultural background (23.0%, n = 729) had disclosed their sexuality or gender to most/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.
- 87.3% (n = 2,661) of LGBTQA+ youth from a multicultural background reported feeling supported by their friends compared to 90.2% (n = 2,228) of Anglo-Celtic youth. Fewer multicultural participants (53.1%, n = 1,174) also reported feeling supported by their family than Anglo-Celtic participants (62.4%, n = 1,185). However, similar proportions of multicultural (42.6%, n = 685) and Anglo-Celtic (42.6%, n = 555) youth reported feeling supported by their classmates.
- A greater proportion of multicultural participants (41.6%, n = 1,307) reported experiencing verbal harassment based on their sexuality or gender identity in the past 12 months, than Anglo-Celtic (38.7%, n = 982) participants.

12.2.2 What are racially-minoritised LGBTQA+ individuals' experiences of unfair treatment, and protective factors against psychological distress?

Rationale

Australian research investigating the intersection of minority racial and sexual and/or gender identities is relatively limited. Consequently, there is little clarity about the relative profile of discriminatory experiences and protective factors between racial-minority LGBTQA+ individuals and their counterparts of white European descent.

Racially-minoritised LGBTQA+ individuals may have access to fewer avenues of support than their racial majority counterparts, and experience marginalisation along specific axes (e.g., race and ethnicity) that the latter are exempt from.[22] These analyses explore the association between multicultural background and experiences of discrimination and community connection, as well as factors that are associated with psychological distress among racially-minoritised participants.

Dataset and sample population

Data from 6, 052 *Private Lives 3* participants who provided valid responses to items asking about race and ethnicity were included in the current analyses, including 246 who were of a background other than white European.

Variables and analyses

A Chi-square test was performed to determine whether rates of high or very high psychological distress differed between white European participants and participants from a multicultural background. Multivariable logistic regression analyses were performed to examined how protective (community and family belonging) and risk factors (unfair treatment due to ethnic/racial identity and sexual and/or gender identity) were associated with psychological distress among participants from a multicultural background. These regression analyses controlled for the confounding effects of sociodemographic factors, including sexual orientation, gender identity, income and residential location. Another set of multivariable logistic regressions were also used to explore the prevalence of these factors among participants from a multicultural background, again controlling for socio-demographic factors.

Key findings

Findings revealed several factors associated with racial identity. Racially-minoritised LGBTQA+ individuals were:

- Less likely to feel they are a part of the LGBTQA+ community.
- Less likely to feel accepted by their families.
- More likely to report unfair treatment attributed to their race or ethnicity.

Participants from a multicultural background were more likely to report high/very high psychological distress if they:

- Had been treated unfairly due to their ethnic/racial identity.
- Had been treated unfairly due to their sexual and/or gender identity.

Participants from a multicultural background were less likely to report high/very high psychological distress if they:

- Felt they were a part of the LGBTQA+ community in Australia.
- Felt that being a part of the LGBTQA+ community was a positive thing for them.

Connection to community and family	AOR (CI)
Feelings of belonging to the LGBTQA+ community (ref: white European)	
Multicultural background	0.76 (0.58 - 0.99)
Feelings of acceptance by family (ref: white European)	
Multicultural background	0.35 (0.26 - 0.47)
Experiences of unfair treatment	**AOR (CI)**
Unfair treatment due to ethnic/racial identity (ref: white European)	
Multicultural background	38.7 (27.4 - 54.6)
High/very high psychological distress	**AOR (CI)**
Unfair treatment due to ethnic/ racial identity	2.11 (1.00 - 4.43)
Unfair treatment due to sexual and/or gender identity	2.74 (1.47 - 5.10)
Feelings of belonging to the LGBTQA+ community	0.45 (0.25 - 0.86)
Positive perception of participating in LGBTQA+ community	0.52 (0.28 - 0.98)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

LGBTQA+ individuals from multicultural backgrounds differ significantly from White participants in terms of the challenges that they encounter in everyday life.

THE ADDITIONAL MINORITY STRESSORS ENCOUNTERED BY THIS GROUP MAY POTENTIATE WORSE MENTAL HEALTH OUTCOMES.

One of these challenges relates to experiences of simultaneous rejection from both the LGBTQA+ community, and their families of origin.

Similar rates of high or very high psychological distress among participants across these racial categories should not be interpreted as in absence of negative outcome associated with discriminatory or exclusionary experiences. Instead, these findings suggest that participants from multicultural backgrounds

MAY BE MORE PRACTISED AT MANAGING MINORITY STRESSORS,

DUE TO THEIR EXPERIENCES WITH RACIAL DISCRIMINATION, OR MAY RELY ON OTHER FORMS OF SUPPORT TO MANAGE THESE STRESSORS.

These supports include other multicultural LGBTQA+ individuals, but may not include family supports, given the low rates of family acceptance reported by participants.

Efforts to prevent experiences of stigma and discrimination based on LGBTQA+ identity as well as race or ethnicity are necessary to facilitate the wellbeing of racial minority LGBTQA+ people. Additionally, competency training is important for those working with LGBTQA+ communities to cater to the needs of LGBTQA+ people from multicultural background, as well as for those working with culturally and linguistically diverse communities to meet the needs of those who are LGBTQA+.

12.3 Residential location

Available evidence suggests that LGBTQA+ individuals residing in non-metropolitan localities may experience lower levels of social support, as well as material disadvantages compared to their urban-based counterparts.[22 23 24] LGBTQA+ community spaces and sites, population-specific resources and other such services are typically concentrated within urban or metropolitan centres and are less accessible to LGBTQA+ individuals residing outside these settings.[23 24] Simultaneously, healthcare providers in non-metropolitan contexts commonly lack the resources, skills and experience necessary for providing appropriate or culturally sensitive care to sexual and gender minority persons.[24 25] These factors may contribute to significant disparities in health and wellbeing between LGBTQA+ persons residing in metropolitan and non-metropolitan locations.

This section details the key findings relating to residential location, as well as further explorations of:

- How does LGBTQA+ adults' mental health and wellbeing differ by residential location? (*Private Lives 3*)
- How is residential location associated with health and wellbeing outcomes among LGBTQA+ youth? (*Writing Themselves In 4*)

12.3.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 71.3% (n = 4,827) of LGBTQA+ adults lived in capital cities, 22.3% (n = 1,506) in regional cities or towns and 6.4% (n = 432) in rural and remote regions.
- 62.3% (n = 1,842) of those residing in inner suburban locations agreed or strongly agreed that they feel a part of Australia's LGBTQA+ community. This compared to 51.2% (n = 955) of those residing in outer suburban areas, 51.2% (n = 770) of those in regional cities or towns and 50.1% (n = 216) of those in rural/remote areas.
- Participants residing in an inner suburban area were the most likely to have felt accepted a lot or always. In many cases, outer suburban participants reported feeling accepted a lot or always at lower proportions than those in regional or rural areas. For example, a lower proportion of participants in outer suburban areas (38.5%, n = 648) reported feeling accepted a lot or always when accessing a health or support service compared to those in regional cities or towns (40.9%, n = 549) or rural/remote areas (43.1%, n = 162).

- Among those who indicated high/very high psychological distress, access to LGBTQA+–inclusive mental health services was more frequently reported among those living in an inner suburban area (27.3%, n = 399) than those living in outer suburban areas (19.0%, n = 223), regional towns or cities (18.4%, n = 167) or rural/remote areas (17.6%, n = 41). Furthermore, a higher proportion of those in an inner suburban area reported accessing any mental health service (63.2%, n = 923) than those living in outer suburban areas (57.8%, n = 678), regional towns or cities (54.5%, n = 494) or rural/remote areas (56.3%, n = 130).

LBQ+ Women (*SWASH*)

- 2.4% (n = 67) of LBQ+ women lived in 'gay Sydney,' 5.8% (n = 151) lived in the Eastern suburbs, 34.5% (n = 897) lived in the City and Inner West region, 7.5% (n = 195) lived in the southern suburbs, 18.5% (n = 481) lived in the Northern suburbs, 18.5% (n = 480) lived in Western Sydney and 12.7% (n = 331) lived outside Sydney.

LGBTQA+ Young People (*Writing Themselves In 4*)

- A greater proportion of participants in inner suburban areas (20.4%, n = 86) attended an LGBTQA+ 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).
- 57.0% (n = 331) of participants in rural/ remote areas had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity, as did 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.
- 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).
- 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).
- 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).
- 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).
- 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).

12.3.2. How does LGBTQA+ adults' mental health and wellbeing differ by residential location?

Rationale

The association between residential location and LGBTQA+ adults' mental health and wellbeing is well-established.[23 24 25] Residential location can often denote proximity and access to population-specific services, community spaces, as well as factors such as economic and housing opportunities. In addition, space and location may impact perceptions of belonging and opportunities for participation among LGBTQA+ individuals.[26] LGBTQA+ individuals living outside metropolitan centres may be less inclined towards self-alignment with the broader LGBTQA+ community and may meet their needs for community connection through local communities.[27 28] However, within the Australian context, little is presently understood about how LGBTQA+ adults' health outcomes and relationship to the LGBTQA+ community may vary by geographical locale, and of trans and gender diverse adults' experiences of identity affirmation within these contexts. The current analyses therefore aim to explore differences in health, wellbeing and community connection outcomes across geographic locations including inner-suburban, outer-suburban, regional cities or towns and rural or remote areas.

Dataset and sample population

Data from 5,174 cisgender participants and 1,466 trans and gender diverse participants from *Private Lives 3* were included in these analyses.

Variables and analyses

Multivariable logistic regression analyses were used to explore the association between participants' residential location, LGBTQA+ community connectedness and feeling that being a part of the LGBTQA+ community is a positive thing. Residential location was included as a predictor variable, and models controlled for the confounding effects of several sociodemographic traits including age, sexual orientation, gender, income, level of education achieved, and employment status. Multivariable logistic regression models were run separately between cisgender participants (n = 5,276) and trans and gender diverse participants (n = 1,506). This approach was chosen considering differences in mental health outcomes between cisgender and trans people.

Key findings

- Cisgender participants living in outer suburban areas and regional cities or towns were more likely than those living in inner suburban areas to report high or very high psychological distress, lifetime suicidal ideation, and lifetime suicide attempts.
- Among trans and gender diverse participants, residential location was not associated with psychological distress, lifetime suicidal ideation, or lifetime suicide attempt.

Factors associated with residential location (ref: inner-suburban)	AOR (CI)
Cisgender participants	
Psychological distress	
Outer-suburban	1.28 (1.10 - 1.49)
Regional city or town	1.24 (1.05 - 1.46)
Suicide ideation (lifetime)	
Outer-suburban	1.28 (1.09 - 1.51)
Regional city or town	1.29 (1.08 - 1.53)
Suicide attempt (lifetime)	
Outer-suburban	1.28 (1.06 - 1.55)
Regional city or town	1.47 (1.20 - 1.79)
Rural or remote	1.78 (1.30 - 2.42)
Feel a part of the LGBTQA+ community	
Outer-suburban	0.63 (0.55 - 0.73)
Regional city or town	0.68 (0.58 - 0.79)
Rural or remote	0.67 (0.53 - 0.86)
Being a part of the LGBTQA+ community is a positive thing	
Outer-suburban	0.66 (0.57 - 0.76)
Regional city or town	0.77 (0.66 - 0.90)
Rural or remote	0.65 (0.51 - 0.84)

Factors associated with residential location (ref: inner-suburban)	AOR (CI)
Trans and gender diverse participants	
Feel a part of the LGBTQA+ community	
Regional city or town	0.68 (0.51 - 0.91)
Rural or remote	0.58 (0.36 - 0.93)
Being a part of the LGBTQA+ community is a positive thing	
Rural or emote	0.47 (0.29 - 0.77)
Local community has affirmed gender in supportive ways	
Outer-suburban	0.54 (0.40 - 0.74)
Regional city or town	0.54 (0.39 - 0.76)
Rural or Remote	0.36 (0.19 - 0.70)

- Cisgender participants were less likely to feel connected to the LGBTQA+ community, and less likely to have a positive perception of participation in the LGBTQA+ community if they lived outside of an inner-suburban area.
- While no significant differences were found between trans and gender diverse adults living in inner and outer suburban areas, those living in regional, rural, and remote areas reported low levels of LGBTQA+ community connection.
- Trans and gender diverse people who lived in outer suburban areas, or rural or remote areas were considerably less likely than those living in inner suburban areas to report that their local community was affirming of their gender identity.

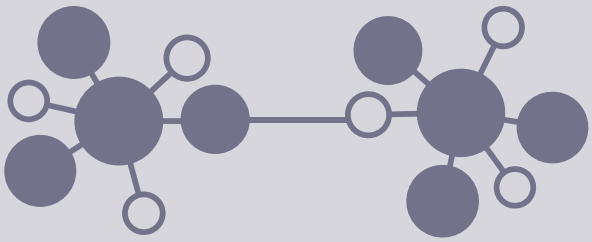
SUMMARY AND IMPLICATIONS OF THE FINDINGS

RESIDENTIAL LOCATION IS ASSOCIATED WITH MENTAL HEALTH

for cisgender LGBQA+ adults, with those living in outer-suburban areas, regional cities or towns and rural or remote areas (in that order) faring worse than those who are living in inner-suburban areas.

RESIDENTIAL LOCATION WAS NOT ASSOCIATED WITH DIFFERENCES IN MENTAL HEALTH FOR TRANS AND GENDER DIVERSE PARTICIPANTS.

Given the location non-specific nature of stigma, discrimination, and abuse that trans people face, it is likely that this population's mental health is poor regardless of residential location.



RESIDENTIAL LOCATION WAS ALSO ASSOCIATED WITH COMMUNITY CONNECTION FOR BOTH CISGENDER AND TRANS PARTICIPANTS.

Residential location may shape affiliation, access to, and involvement with LGBTQA+ community groups, events, organisations, and services.

Trans and gender diverse people living in inner-suburban areas were the most likely to express that their local community had affirmed their gender in supportive ways, likely reflecting the progressiveness and broader LGBTQA+ inclusivity of inner-suburban areas.

These findings highlight the need for greater community education in support of LGBTQA+ identities, and in particular gender diversity. Increased efforts to provide professional development for local governments and community services are necessary, along with increased resourcing and accessibility of LGBTQA+-inclusive services and community-led services in a range of locations nationally. They also suggest a need to nuance discussion of health and wellbeing where a binary assumption is often made that LGBTQA+ people in cities fare better than those in regional or rural locations. In fact, those in outer-suburbs of major cities often face the worst health outcomes of all.

12.3.3 How is residential location associated with health and wellbeing outcomes among LGBTQA+ youth?

Rationale

A growing body of research has examined how social environments contribute to LGBTQA+ wellbeing, including consideration of the role of residential location in LGBTQA+ mental health, safety, and inclusion.[29] However, the experiences of young people are often absent within this research, which largely focuses on adult populations in urban environments. LGBTQA+ youth may face unique challenges when it comes to finding safe and welcoming spaces, as they may not have the same level of autonomy, resources, and mobility as adults to navigate hostile environments. Public venues catering to LGBTQA+ communities often prohibit young people (e.g., bars, clubs), leaving them with fewer options for community engagement, even in urban settings.[30] Understanding how geographic location can promote or prevent LGBTQA+ youth wellbeing will enable targeted policy and service provision that can address localised challenges.

Dataset and sample population

Data from 4,556 cisgender and 1,697 trans and gender diverse participants from *Writing Themselves In 4* were included in these analyses.

Variables and analyses

Descriptive statistics were used to detail the sociodemographic characteristics of the sample. Multivariable logistic regression analyses were used to explore the association between participants' residential location, mental health outcomes, safety outcomes (e.g., experiences of harassment and homelessness) and community participation. Outcome variables for each multivariable logistic regression were psychological distress, suicidal ideation, suicide attempt, and overall happiness. Residential location was included in the model as a predictor variable. Each model additionally controlled for the confounding effects of several sociodemographic traits including age, sexual orientation, gender, level of education achieved, and employment status. Finally, all multivariable logistic regression models were run individually for cisgender participants (n = 5,174) and for trans and gender diverse participants (n = 1446).

Key findings

- Both cisgender sexual minority and trans and gender diverse youth living in rural and remote areas were more likely than those in outer-suburban areas to report high or very high levels of psychological distress.
- Cisgender young people living in rural or remote areas were more likely than those living in outer-suburban areas to have experienced recent

"THE FINDINGS DEMONSTRATE T RESIDENTIAL LOCATION ON YOUTH AND WELLBEING, HIGHLIGHTING EQUITABLE DISTRIBUTION OF RE SUPPORT FOR LGBTQA+ YOUNG PE AND REMOTE AREAS

(<12 months) verbal and physical harassment. Cisgender individuals living in an inner-suburban area were more likely to experience recent (<12 months) sexual harassment compared to those living in an outer-suburban area.

- Cisgender young people living in rural or remote areas were more likely than those living in outer-suburban areas to have experienced suicidal ideation and to have attempted suicide in the last 12 months.
- Cisgender young people were most likely to have experienced homelessness if they were living in a regional city or town or in a rural or remote area. Trans and gender diverse young people in a regional city or town were more likely than those in an outer suburb to have experienced homelessness.
- Residential location was not associated with cisgender participants' participation in LGBTQA+ youth events. In contrast, trans and gender diverse young people living in an inner-suburban area had the highest odds of participating in LGBTQA+ youth events.
- Young trans and gender diverse people living in rural or remote areas reported the lowest levels of happiness, whereas cisgender young people living in inner-suburban areas reported greater happiness than all other areas.

Factors associated with residential location (ref: outer-suburban)	AOR or β* (CI)
Cisgender participants	
High/very high psychological distress (past 4 weeks)	
Regional city or town	1.25 (1.04 - 1.51)
Rural or remote	1.36 (1.02 - 1.80)
Suicide ideation (past 12 months)	
Rural or remote	1.32 (1.05 - 1.65)
Suicide attempt (past 12 months)	
Rural or remote	1.47 (1.05 - 2.06)
Physical harassment (past 12 months)	
Rural or remote	1.65 (1.12 - 2.41)
Verbal harassment (past 12 months)	
Rural or remote	1.30 (1.04 - 1.62)
Sexual assault (past 12 months)	
Rural or remote	1.37 (1.02 - 1.84)
Subjective happiness score	
Inner-suburban	0.24* (0.04 - 0.43)
Homelessness (ever)	
Regional city or town	1.22 (1.01 - 1.47)
Rural or remote	1.32 (1.03 - 1.71)
Trans and gender diverse participants	
High/very high psychological distress (past 4 weeks)	
Rural or remote	3.30 (1.42 - 7.68)
Subjective happiness score	
Rural or remote	-0.26* (-0.45 - -0.06)
Participation in LGBTQA+ youth events (past 12 months)	
Inner-suburban	1.93 (1.20 - 3.12)
Homelessness (ever)	
Regional city or town	1.33 (1.03 - 1.72)

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SUMMARY AND IMPLICATIONS OF THE FINDINGS

Residential location is associated with mental health for LGBTQA+ young people, with those living in rural and remote areas faring worse than those in the outer-suburban or inner-city areas. Locations beyond urban centres may exhibit greater social conservativism, limited LGBTQA+ social groups, organisations, and services, resulting in reduced visibility and broader public acceptance of LGBTQA+ people, including youth.

CISGENDER YOUTH WERE HAPPIEST LIVING IN INNER-SUBURBAN AREAS,

AND TRANS AND GENDER DIVERSE YOUTH WERE UNHAPPIEST LIVING IN RURAL OR REMOTE AREAS.

Residential location was additionally associated with experiences of harassment among cisgender young people, with the highest experiences of verbal and physical harassment found in rural and remote areas, and highest sexual assault in inner-suburban areas. These experiences did not differ by area for trans and gender diverse young people, who may be experiencing high rates of harassment regardless of residential location.

PARTICIPATION IN YOUTH EVENTS DID NOT DIFFER BY LOCATION FOR CISGENDER YOUTH, BUT TRANS AND GENDER DIVERSE YOUTH WERE MORE LIKELY TO ENGAGE WITH LGBRTQA+ EVENTS IF THEY WERE LIVING IN AN INNER-SUBURBAN AREA.

Finally, the results suggest that LGBTQA+ young people may be particularly vulnerable to experiencing homelessness when living in regional towns and rural and remote areas. This finding may suggest greater experiences of family rejection in these regions resulting in young people needing to leave their homes.

The findings demonstrate the impacts of residential location on youth mental health and wellbeing, highlighting the need for equitable distribution of resources and support for LGBTQA+ young people in rural and remote areas. There is an urgent need for increased support for LGBTQA+ youth in these areas, including access to safe housing, mental health services, and community resources.

12.4 Sexual orientation and gender

The individual subgroups within the LGBTQA+ community are united by common experiences of homophobic stigma and discrimination, as well as a pursuit of social acceptance and legal recognition - but are otherwise considerably distinct from one another. Indeed, existing evidence points to significant disparities in health and wellbeing between individual sub-groups and implicates both minority stressors, as well as intra-minority discrimination within the LGBTQA+ community itself in producing these disparities.[31 32] Certain subgroups like bisexual people[31 32] and trans and gender diverse individuals[33 34] may experience alienation and exclusion from both broader society as well as their counterparts within the LGBTQA+ community. Concurrently, LGBTQA+ individuals who identify as female may additionally contend

with gender-based discrimination that their male-identifying counterparts are exempt from.[35]

This section details key findings relating to sexual orientation and gender, as well as further explorations of:

- What do we know about the health and wellbeing needs and experiences of asexual LGBTQA+ adults? (*Private Lives 3*)
- What is the role of relationship status and gender of relationship partner in shaping health and wellbeing outcomes among bi+ cisgender adults? (*Private Lives 3*)

12.4.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 76.9% (n = 1,786) of cisgender men identified as gay compared to 17.3% (n = 52) of trans men, 2.0% (n = 60) of cisgender women and 5.6% (n = 51) of non-binary participants.
- Over three times as many cisgender women identified as bisexual (29.8%, n = 876) or pansexual (7.6%, n = 225) compared to cisgender men (9.3% [n = 217] as bisexual and 2.2% [n = 50] as pansexual).
- Non-binary participants were most likely to identify as queer (37.1%, n = 825).

LGBTQA+ Young people (*Writing Themselves In 4*)

- 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.
- A higher proportion of trans women (23.6%, n = 18) identified as lesbian than cisgender women (19.0%, n = 601) or non-binary participants (10.7%, n = 10.6).
- 56.4% (n = 784) of cisgender men 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.

12.4.2 What do we know about the health and wellbeing needs and experiences of asexual LGBTQA+ adults?

Rationale

Despite growing recognition of asexuality as a social and sexual identity, asexual individuals continue to contend with invisiblisation and erasure from broader community.[36] This is in addition to pathologisation and stigmatisation from both health providers and broader society, who may perceive asexual individuals' lack of sexual interest as disordered or abnormal.[37] These social conditions are likely to preface significant disparities in health outcomes between asexual individuals and their LGBTQ+ counterparts. However, the invisibilisation of asexuals within extant conceptualisations of the LGBTQA+ community has contributed to a significant paucity of data relating to the health and wellbeing of this group. These analyses will explore the sociodemographic characteristics of asexual adults, as well as their mental health, suicidality, homelessness and alcohol and other drug outcomes as compared to non-asexual LGBTQ+ adults.

Dataset and sample population

Data from 6,815 *Private Lives 3* participants who provided valid responses to questions about their sexual identity.

Variables and analyses

Several univariable logistic regressions were performed to investigate the sociodemographic characteristics of asexual-identifying participants compared to non-asexual participants including their gender, age and relationship status. Thereafter, a series of multivariable logistic regressions were performed to explore and compare associations between asexuality/non-asexuality and a range of output variables, including psychological distress, recent (<12 months) suicidal ideation and attempts, participation and perceptions of the LGBTQA+ community, and experiences with healthcare providers. Gender and age were also included in these models to control for their confounding effects.

Key findings

Individuals who identified as asexual were:

- More likely to be either cisgender women, trans men, trans women, and non-binary individuals than was the case for cisgender men.
- Less likely to be in either the 35-44, 45-54 or 55+ age groups.
- Less likely to report being in a committed relationship.

Who is more likely to identify as asexual?	OR (CI)
Gender identity (ref: cisgender men)	
Cisgender woman	4.19 (2.94 - 8.24)
Trans man	8.66 (4.41 - 16.99)
Trans woman	7.08 (3.45 - 14.54)
Non-binary	9.67 (5.61 - 16.64)
Age group (ref: 18-24)	
35-44	0.45 (0.29 - 0.70)
45-54	0.26 (0.13 - 0.49)
55+	0.14 (0.04 - 0.06)
Residential location (ref: inner-suburban)	
Outer-suburban	2.37 (1.67 - 3.35)
Regional city or town	2.19 (1.51 - 3.17)
Rural or remote	2.58 (1.53 - 4.34)
Relationship status (ref: not in a committed relationship)	
In a committed relationship	0.24 (0.17 - 0.33)

Compared to non-asexual individuals, asexual identified participants were:

- Less likely to report ever attempting suicide.
- Less likely to feel that they belonged to the LGBTQA+ community.
- Less likely to feel that being a part of the LGBTQA+ community was a positive thing for them.
- Less likely to feel that their sexual identity was respected in a mainstream healthcare service that was not known to be LGBTQA+-inclusive.

However, no difference in feelings of being respected at LGBTQA+–inclusive mainstream services was observed between these groups.

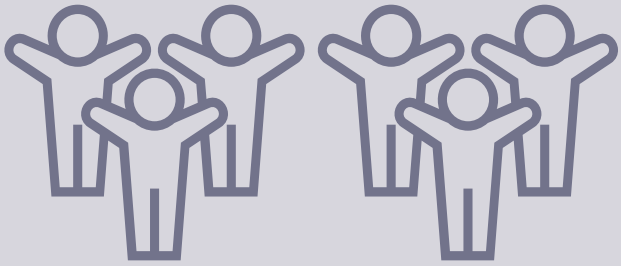
Health and wellbeing among asexual compared to non-asexual participants (ref: non-asexual identified LGBTQ+ people)	AOR (CI)
Lifetime suicide attempt	0.63 (0.45 – 0.88)
Community Participation	
Feelings of belonging to LGBTQA+ community	0.57 (0.44 – 0.75)
Being a part of the LGBTQA+ community is a positive thing	0.75 (0.56 – 0.99)
Sexual Identity Respected within Services	
Mainstream service not known to be inclusive	0.69 (0.51 – 0.96)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

Asexual identified participants within the sample were of younger age, mostly cisgender women or trans or gender diverse, and were less likely to be in a committed relationship.

THE FINDINGS SUGGEST SIMILAR MENTAL HEALTH PROFILES

between asexual and non-asexual LGBTQA+ people, with few mental health differences between asexual and non-asexual participants observed, with the exception of a lower likelihood among asexual participants to have ever attempted suicide.



ASEXUAL INDIVIDUALS' LOWER LIKELIHOOD OF FEELINGS OF BELONGING TO, AND PARTICIPATION IN THE LGBTQA+ COMMUNITY

may reflect experiences of exclusion within community contexts, but also align with the lower likelihood of asexual people to feel that connection to the LGBTQA+ community is a positive thing for them.

FINALLY, ASEXUAL PEOPLE WERE ALSO LESS LIKELY TO FEEL THAT THEIR SEXUAL IDENTITY WAS RESPECTED IN A MAINSTREAM HEALTHCARE SERVICE THAT IS NOT KNOWN TO BE LGBTQA+-INCLUSIVE,

with no difference in experience of respect within LGBTQA+–inclusive health services. These findings likely indicate a lack of knowledge of asexual identities within mainstream services resulting in care that is not appropriate and experienced as disrespectful.

The findings suggest similar health needs for asexual individuals compared to non-asexual LGBTQA+ people. However, little is known about asexual individuals and their health needs. More research is needed to understand asexual experiences and investigate the role of asexual-specific forms of resilience (e.g., connection to other asexual individuals) in facilitating the health and wellbeing for asexual individuals.

12.4.3 What is the role of relationship status and gender of relationship partner in shaping health and wellbeing outcomes among bi+ cisgender adults?

Rationale

Bi+ people frequently report worse mental health outcomes than their gay or lesbian peers. However, the experiences of bi+ cisgender people and resulting mental health outcomes are frequently overlooked or are subsumed in broader LGBTQA+ research where the experiences of this population are not explored independently. Bi+ cisgender people can face experiences of stigma or discrimination from both heterosexual and sexual minority communities. While those is same-gender relationships may be subject to anti-LGBTQA+ discrimination or abuse, those in opposite-gender relationships may experience greater distress associated with the invisibility or erasure of their sexual identities. The aim of the present analyses is to explore the mental health and wellbeing outcomes of bisexual and pansexual cisgender adults as a function of their current relationship orientation (opposite gender partner, same gender partner or single).

Dataset and sample population

Data from 1,261 bisexual and pansexual cisgender adults from *Private Lives 3* who reported on their relationship status were included in these analyses. This includes 1,009 cisgender women and 252 cisgender men.

Variables and analyses

The research examined a range of variables among bi+ cisgender men and women, with a specific focus on psychological distress, anxiety, suicidal ideation, smoking behaviours, and experiences of homelessness. These variables were analysed in relation to participants' gender and relationship orientation (i.e., being single, in a same-gender relationship, or in an opposite-gender relationship). A series of statistical analyses were conducted, including Analysis of Variance (ANOVA) to explore differences in psychological distress based on participants' gender and relationship orientations, as well as post-hoc multiple comparisons to identify specific group differences. Chi-square tests of independence and Fisher's Exact Tests were used to compare the frequency of reporting certain variables as a function of relationship orientation. The results were then examined for statistical significance to determine the impact of these factors on the bi+ population's mental health outcomes and behaviours.

"RELATIONSHIP ORIENTATION MAY BE AN IMPORTANT FACTOR ASSOCIATED WITH PSYCHOLOGICAL DISTRESS IN BI+ CISGENDER INDIVIDUALS."

Key findings

- Almost half of the cisgender women (45.9%, n = 463) were single, 38.9% (n = 392) were in a relationship with an opposite gender partner and 15.3% (n = 154) were in a relationship with a same gender partner.
- Half of the cisgender men (50.8%, n = 128) were single, one-third (33.3%, n = 84) were in a relationship with an opposite gender partner and 15.9% (n = 40) were in a relationship with a same gender partner.

Mental health outcomes differed according to participants' gender and relationship orientation. Specifically:

- Bi+ cisgender women in same-gender relationships had lower levels of psychological distress than those who were single or in opposite-gender relationships, with similar levels of distress observed across these latter two relationship orientation categories.
- For bi+ cisgender men, relationship orientation did not significantly impact levels of psychological distress.
- Bi+ cisgender women who were either single or in opposite-gender relationships reported higher levels of psychological distress than bi+ cisgender men with these relationship orientations. However, when comparing bi+ cisgender men and women in same-gender relationships, there was no significant difference in psychological distress levels.
- Less frequent reports of anxiety and suicidal ideation were found among bi+ cisgender women in same-gender relationships, as compared to those who were either single or in opposite-gender relationships.

Homelessness was also associated with gender and relationship status among bi+ cisgender people. Specifically:

- Single bi+ cisgender women were more likely to have ever experienced homelessness compared to those in any relationship.
- Bi+ cisgender in same-gender relationships were more likely to have ever experienced homelessness than those in opposite-gender relationships.

Bi+ relationship orientation	$\chi 2$ (p)
Anxiety	
Women: opposite-gender partner vs same-gender partner	5.92 (p = .015)
Recent suicidal ideation	
Women: single vs same-gender partner	112.49 (p < .001)
Women: opposite-gender partner vs same-gender partner	56.84 (p < .001)
Homelessness	
Men: opposite-gender partner vs same-gender partner	4.46 (p = .034)
Women: single vs opposite-gender partner	7.99 (p = .005)
Psychological distress	
Women: relationship orientation	F (2,1165) = 17.07

SUMMARY AND IMPLICATIONS OF THE FINDINGS

THE FINDINGS INDICATE THAT RELATIONSHIP ORIENTATION MAY BE AN IMPORTANT FACTOR ASSOCIATED WITH PSYCHOLOGICAL DISTRESS IN BI+ CISGENDER INDIVIDUALS, IN PARTICULAR FOR BI+ CISGENDER WOMEN.

Bi+ cisgender women in an opposite-gender relationship expressed higher psychological distress than those in same-gender relationships. Additionally, gender differences in distress are apparent among singles and those in opposite-gender relationships, with bi+ cisgender women reporting more distress than bi+ cisgender men. However, these differences between bi+ cisgender men and bi+ cisgender women were not evident in the context of same-gender relationships.

BI+ CISGENDER WOMEN IN SAME-GENDER RELATIONSHIPS SIMILARLY EXPERIENCED LESS SUICIDAL IDEATION AND LESS ANXIETY.

This implies that same-gender relationships offer some mental health advantages, particularly for bi+ cisgender women, potentially reflecting experiences of bi-erasure and biphobia felt more acutely by bi+ cisgender women in opposite-gender relationships.

RELATIONSHIP ORIENTATION WAS ALSO ASSOCIATED WITH LIFETIME EXPERIENCES OF HOMELESSNESS FOR BOTH CISGENDER MEN AND WOMEN. SINGLE BI+ CISGENDER WOMEN WERE MOST LIKELY TO HAVE EVER EXPERIENCED HOMELESSNESS, WHILE BI+ CISGENDER MEN IN A SAME-GENDER RELATIONSHIP WERE MOST LIKELY TO HAVE EVER EXPERIENCED HOMELESSNESS.

These results do not indicate cause but may indicate the role of homelessness experiences in partner choice or vice versa. Experiences of intimate partner violence are high among bi+ cisgender men and women, and these experiences may result in experiences of homelessness. Often the perpetrators of intimate partner violence are cisgender men, consequently partnering with a cisgender man, regardless of sexual orientation or gender, may lead to higher incidence of homelessness.

These findings highlight the importance of a nuanced approach to understanding and addressing the experiences of bi+ cisgender individuals, recognising that their needs and experiences can vary significantly depending on factors like gender and relationship orientation. This may be especially important in healthcare and housing services. The findings also highlight the need for efforts to prevent stigma and discrimination directed specifically at bi+ cisgender people, as well as developing awareness and inclusion of bi+ identities within both broader community and LGBTQA+ community.

12.5 Ageing

LGBTQA+ subcultures are often highly youth-oriented, and older LGBTQA+ adults may experience ostracism and rejection from their younger counterparts within the LGBTQA+ community.[38] Older LGBTQA+ adults came of age during an era where the pathologisation, criminalisation and repression of LGBTQA+ identities and individuals was the norm.[39] Consequently, many still contend with the impact of chronic minority stressors. This contributes to both significant health disparities between these groups and their non-LGBTQA+ counterparts, as well as more pronounced, age-related decline in health and wellbeing.[40] LGBTQA+ adults may also face discrimination and hostility from both service providers and other service users,[41] necessitating the concealment of their identities in their later years.

This section details the key findings relating to older LGBTQA+ adults as well as further explorations of:

- How do older LGBTQA+ adults differ from younger cohorts in terms of loneliness, LGBTQA+ community belonging and number of friends? (*Private Lives 3*)
- What are older LGBTQA+ adults' engagement with and experiences within healthcare settings and what are their preferences for service provider? (*Private Lives 3*)
- What is the role of connection to community in shaping mental health outcomes among LGBTQA+ older adults? (*Private Lives 3*)

12.5.1 Key findings from previously published research

LGBTQA+ Adults (*Private Lives 3*)

- 7.7% (n = 525) of LGBTQA+ adults were aged 55-64 and 3.3% (n = 233) were aged 65+.
- More than half of participants aged 55+ were cisgender men (55.3%, n = 410), 31.4% (n = 233) were cisgender women, 0.3% (n = 2) were trans men, 8.4% (n = 62) were trans women and 4.6% (n = 34) were non-binary.
- 43.2% (n = 322) identified as gay, 29.0% (n = 216) as lesbian, 9.0% (n = 67) as bisexual, 1.3% (n = 10) as pansexual, 3.9% (n = 29) as queer, 0.7% (n = 5) asexual, and 12.9% (n = 96) as a different sexual orientation.
- Similar proportions of LGBTQA+ adults aged 55-64 and aged 65+ agreed or strongly agreed that they felt a part of the LGBTQA+ community in Australia: 58.3% (n = 305) of 55-64-year-olds and 59.2% (n = 132) of those aged 65+.
- 59.5% (n = 311) of LGBTQA+ adults aged 55-64 and 56.4% (n = 124) of those aged 65+ also agreed/strongly agreed that participating in the LGBTQA+ community is a positive experience for them.
- While a very low proportion of LGBTQA+ adults aged 55+ reported having attempted suicide in the previous 12 months (1.25%, n = 5), almost one-quarter (23.3%, n = 173) had experienced recent suicidal ideation.
- Of LGBTQA+ adults aged 55+, 17.7% (n = 132) had ever experienced homelessness and of these, 5% (n = 7) were experiencing homelessness at the time they completed the survey.

12.5.2 How do older LGBTQA+ adults differ from younger cohorts in terms of loneliness, LGBTQA+ community belonging and number of friends?

Rationale

Experiences of social isolation and loneliness are adjacent factors that may be a persistent concern for LGBTQA+ individuals, due to the stigma and discrimination levelled against sexual and gender minority individuals.[42] These concerns may be amplified for LGBTQA+ older adults, who came of age in an era where homosexuality was highly pathologised and criminalised and lived through the HIV/AIDS epidemic, which decimated many of their social networks.[43] This makes it challenging to disentangle the effects of age on social isolation and loneliness for LGBTQA+ individuals. However, there is little literature that adopts a comparative perspective on LGBTQA+ older adults' social and community ties within the Australian context. These analyses will explore the health and wellbeing outcomes of older LGBTQA+ adults including feelings of belonging to, and perceptions of participating in the LGBTQA+ community, loneliness and number of close friends.

Dataset and sample population

Data from the 6,835 *Private Lives 3* participants were analysed, including 223 participants aged 65 and older.

Variables and analyses

We conducted two multivariable logistic regression analyses examining the relationship between age and the following output variables: (i) Perceived belonging to the LGBTQA+ community, an (ii) Perception of participating in the LGBTQA+ community. Thereafter, a set of linear regressions were performed to investigate associations between age and: (i) loneliness score and (ii) number of close friends.

For both models, gender and sexual orientation were included as confounding variables. We further performed a set of multivariable linear regressions to investigate factors associated with loneliness, these included (i) feelings of belonging to the LGBTQA+ community, (ii) number of friends, (iii) experiences of unfair treatment due to sexual orientation and/or gender identity and (iv) geographic location among older adults. These models included both gender and sexual orientation to account for their confounding effects.

Key findings

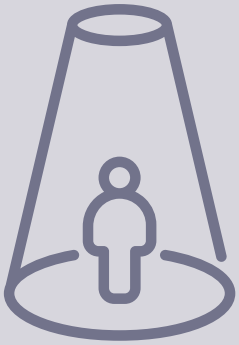
- Feelings of belonging to the LGBTQA+ community, or perceiving participation in the LGBTQA+ community as a positive thing were not associated with participant age.
- Loneliness scores were significantly lower for each progressive age group with participants in the 55-64 and 65+ age ranges reporting the lowest loneliness scores.
- Age was associated with number of friends with those older LGBTQA+ people reporting a higher number of friends than younger people. Those aged 65+, in particular, had a considerably higher number of close friends compared to those aged 18-24.

Several factors were associated with loneliness among those aged 65+, specifically:

- Loneliness scores decreased as the number of close friends reported increased.
- Loneliness scores were lower among those who felt they were a part of the LGBTQA+ community.
- Loneliness score were higher among those who reported being treated unfairly in the past 12 months due to their sexual orientation or gender.

Loneliness score	β (CI)
Age (ref: 18-24)	
25-34	-0.80 (-0.92 – -0.69)
35-44	-0.94 (-1.11 – -0.84)
45-54	-1.19 (-1.36 – -1.03)
55-64	-1.32 (-1.52 – -1.13)
65+	-1.60 (-1.89 – -1.31)
Number of friends	
Age (ref: 18-24)	
25-34	0.41 (0.11 – 0.72)
35-44	0.72 (0.29 – 1.17)
45-54	0.63 (0.99 – 1.15)
55-64	0.84 (0.52 – 1.35)
65+	2.39 (1.04 – 3.72)
Correlates of loneliness	
Number of friends	-0.06 (-0.11 – 0.19)
Feelings a part of the LGBTQA+ community	-1.04 (-1.64 – -0.45)
Unfair treatment due to sexual/gender identity	1.32 (0.60 – 2.04)

SUMMARY AND IMPLICATIONS OF THE FINDINGS



Older adults within our sample appeared less likely than younger cohorts to report feelings of loneliness, and generally had a greater number of close friends. This may reflect the preeminent role of community connectedness as a means of navigating the societal and institutional discriminations of yesteryear.

FEELINGS OF BELONGING TO THE LGBTQA+ COMMUNITY APPEARED TO EXERT A MORE SIGNIFICANT PROTECTIVE EFFECT AGAINST LONELINESS

than the number of close friends reported, reflecting the subjective nature of the construct.

LIKEWISE, EXPERIENCING UNFAIR TREATMENT TARGETING ONE'S SEXUAL AND/OR GENDER IDENTITY APPEARED TO PREDICT GREATER FEELINGS OF LONELINESS.

In tandem, these findings point to the contributions of identity affirmation and disaffirmation to feelings of loneliness in LGBTQA+ older adults.

It is important to note that the *Private Lives 3* survey was chiefly disseminated online via community channels and social media advertising, it is therefore possible that older participants comprise a particularly well-connected subset of LGBTQA+ older adults. Nonetheless, the results highlight the importance of community connection and close friendships for older adults and indicate a need for resources and services to assists older LGBTQA+ adults in accessing community and fostering social networks. Moreover, efforts to prevent experiences of discrimination and stigma among older LGBTQA+ adults is essential to further protect their wellbeing and mitigate feelings of loneliness.

12.5.3 What are older LGBTQA+ adults engagement with and experiences within healthcare settings and what are their preferences for service provider?

Rationale

Low rates of healthcare utilisation among LGBTQA+ older adults relative to the general population may account for a significant proportion of the health disparities that impact this group.[44]). For example, LGBTQA+ older adults may delay treatment due to anticipating discrimination from healthcare providers – a common concern given the historic, but relatively recent role that medical institutions have played in pathologising non-heterosexual orientations and identities.[45] Additionally, inclusive and affirming healthcare is often implemented unevenly, or is entirely absent within certain contexts. Amidst these considerations, there is furthermore a paucity of data that examines LGBTQA+ older adults' preferences in relation to inclusive healthcare. These analyses explore healthcare and GP access, experiences of identity respect within healthcare settings and healthcare preferences among older LGBTQA+ people.

Dataset and sample population

Data from the 6,835 *Private Lives* 3 participants were analysed, including 223 participants aged 65 and older.

Variables and analyses

A series of logistic regressions analyses were performed to explore associations between age group (18-64 years vs. 65+ years) and a variety of outcome variables including: (i) accessing a medical service not known to be inclusive within the past 12 months, (ii) accessing a medical service known to be inclusive in the past 12 months, (iii) accessing a medical service that catered specifically to LGBTQA+ people in the past 12 months, as well as (Iv) whether or not participants' sexual identities were respected within mainstream medical services that were known or not known to be LGBTQA+-inclusive. All models controlled for the confounding effects of gender identity and sexual orientation. Factors associated with access to and respect within LGBTQA+-specific services could not be explored due to small sample sizes.

Key findings

- Given a choice between a mainstream health service that is known to be inclusive or a service that caters specifically to LGBTQA+ populations, 53.2% (n = 118) of older adults preferred a mainstream service that is inclusive, while 14.9% (n = 33) preferred a service that was LGBTQA+-specific, and a further 32.0% (n = 71) did not hold a preference. Additionally, 61.5% (n = 136) of older adults reported that they would be more likely to attend a health service if it had been accredited as LGBTQA+-inclusive. However, only 5.4% (n = 12) of older participants had accessed an LGBTQA+-specific service, 33.2% (n = 74) had accessed a mainstream inclusive service, while three-quarters (75.8%, n = 169) had accessed a mainstream health service that was not known to be inclusive.
- LGBTQA+ older adults were more likely than their younger counterparts to report accessing a general population medical service that had a reputation for LGBTQA+ inclusivity and less likely than their younger counterparts to have accessed a mainstream service that had no reputation of LGBTQA+ inclusivity. No association was found between age and access to an LGBTQA+-specific service.
- Compared to their younger counterparts, LGBTQA+ older adults were more likely to report that their sexual orientation was respected by health providers in mainstream services that had no reputation for LGBTQA+ inclusivity, but no difference in experiences of respect were observed in mainstream services that were known to be inclusive.

Age and healthcare access (ref: 18-64 years)	AOR (CI)
Utilisation of Healthcare Service	
Mainstream clinic (non-inclusive)	0.70 (0.51 – 0.97)
Mainstream clinic (Inclusive)	1.42 (1.04 – 1.93)
Sexual identity respected within services	
Mainstream clinic (non-inclusive)	2.65 (1.75 – 4.01)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

LGBTQA+ OLDER ADULTS REGARDED LGBTQA+ INCLUSIVITY AS AN IMPORTANT FACTOR IN THEIR HEALTHCARE SERVICE UTILISATION.

However, the findings demonstrate a misalignment between their service provider preferences of healthcare service provider and the services that they have actually accessed.

FAR MORE PARTICIPANTS EXPRESSED A PREFERENCE FOR AN LGBTQA+-SPECIFIC SERVICE

or a mainstream LGBTQA+-inclusive service than had accessed one in the past 12 months, with most participants accessing mainstream services that were not known to be LGBTQA+-inclusive. This likely reflects availability of LGBTQA+-specific services in their locality.

COMPARED TO THOSE AGED UNDER 65, OLDER LGBTQA+ ADULTS WERE MORE LIKELY TO HAVE ACCESSED A MAINSTREAM CLINIC IN THE PAST 12 MONTHS THAT WAS LGBTQA+-INCLUSIVE AND LESS LIKELY TO HAVE ACCESSED A MAINSTREAM CLINIC THAT WAS NOT INCLUSIVE.

Older LGBTQA+ people are likely to have more extensive experience with accessing healthcare and the time to tryout services and find one that is inclusive of their identities or may have learned to be more discerning of the clinics that they choose to attend.

While respectful treatment within inclusive services was experienced similarly across age groups, adults aged 65+ experienced greater respect within non-inclusive services.

As for all LGBTQA+ people, access to knowledgeable and affirming healthcare is challenging with limited service that are LGBTQA+-inclusive and fewer that cater specifically to LGBTQA+ people. Further resourcing is required to ensure availability of healthcare services that cater specifically to LGBTQA+ communities for those who desire this more of service provision. Additionally, all mainstream services must be trained to provide appropriate LGBTQA+-inclusive care to meet the needs of the LGBTQA+ community regardless of age.

12.5.4 What is the role of connection to community in shaping mental health outcomes among LGBTQA+ older adults?

Rationale

There is presently little research that explores the relative profile of mental health challenges among LGBTQA+ older adults. Insofar as LGBTQA+ older adults are no more a homogenous category than their younger counterparts, it can be reasonably assumed that the mental health outcomes of individual subgroups within the LGBTQA+ initialism are likely to demonstrate considerable variation. While older LGBTQA+ adults are largely understudied, existing evidence suggests that LGBTQA+ subgroups are differentiated both in psychographic profiles, as well as the relative presence of both risk factors and health-enabling factors. These analyses therefore aim to explore risk and protective factors associated with mental health outcomes (psychological distress, suicidal ideation) among older LGBTQA+ adults.

Dataset and sample population

Data from 223 participants aged 65 and older from *Private Lives 3* were analysed.

Variables and analyses

A series of univariable logistic regressions were performed to investigate the relationships between gender identity (cisgender or trans or gender diverse) or sexual orientation (lesbian/gay, bisexual/pansexual, queer or something else) and mental health outcomes including high and very high psychological distress and recent (<12 months) suicidal ideation. Additionally, several multivariable logistic regression analyses were conducted to explore associations between (i) residential location, (ii) feelings of belonging to the LGBTQA+ community, and (iii) previous experiences (<12 months) of unfair treatment due to either sexual orientation and/or gender identity and the mental health outcomes. These multivariable logistic regressions controlled for the potential confounding impacts of gender identity and sexual orientation.

Key findings

Univariable analyses revealed that older LGBTQA+ adults were more likely to report high and very high levels of psychological distress if they:

- Were trans or gender diverse.
- Identified a sexual orientation categorised as 'something else.'

Trans and gender diverse participants were also more likely than cisgender participants to report a recent suicide attempt.

Multivariable analyses showed that rates of reporting high or very high levels of psychological distress were:

- Higher among participants living in an outer-suburban area.
- Higher among participants who had been treated unfairly in the past 12 months due to their sexual or gender identity.
- Lower among participants who felt they are a part of the LGBTQA+ community.

Multivariable analyses showed that the frequency of reporting an experience of suicidal ideation in the past 12 months was:

- Highest among people who'd been treated unfairly due to their sexual orientation or gender identity in the past 12 months.

High/very high psychological distress	AOR (CI)
Outer-suburban residential location (ref: inner-suburban)	3.88 (1.29 – 11.68)
Unfair treatment due to sexual/ gender identity (past 12 months)	4.32 (1.99 – 9.33)
Feelings of belonging to LGBTQA+ community	0.28 (0.13 – 0.61)
Recent suicidal ideation	
Unfair treatment due to sexual/ gender identity (past 12 months)	3.86 (1.76 – 8.43)

SUMMARY AND IMPLICATIONS OF THE FINDINGS

THE FINDINGS ILLUSTRATE GREATER MENTAL HEALTH CONCERNS AMONG OLDER ADULTS WHO ARE TRANS OR GENDER DIVERSE COMPARED TO THEIR CISGENDER COUNTERPARTS.

This likely reflects the lagging social recognition and acceptance for trans and gender diverse populations within many societal contexts and may be exacerbated among older cohorts.

FEELINGS OF BELONGING TO THE LGBTQA+ COMMUNITY MAY EXERT A PROTECTIVE EFFECT AGAINST PSYCHOLOGICAL DISTRESS.

While experiences of discrimination may lead to a greater risk of poor mental health outcomes, including a greater likelihood of reporting high psychological distress and experiencing suicidal ideation.

THE FINDINGS ADDITIONALLY SUGGEST THAT INDIVIDUALS RESIDING WITHIN OUTER SUBURBAN AREAS EXPERIENCE HIGHER PSYCHOLOGICAL DISTRESS.

Older adults living in outer-suburban areas may be uniquely disadvantaged in terms of access to community ties or social relationships that buffer against negative mental health outcomes, being simultaneously situated outside both metropolitan centres of LGBTQA+ community and the close community relationships associated with rural and regional locales.

Efforts are needed to improve opportunities for older LGBTQA+ adults to engage and connect with the LGBTQA+ community. This may be particularly important for those living in outer-suburban areas and trans and gender diverse older adults. Additionally, preventing discrimination and stigma toward LGBTQA+ older adults is necessary to improve their mental health and wellbeing.

12.6 Chapter summary

These findings demonstrate the diverse ways that individuals who hold multiple intersecting identities and/or experiences experience unique challenges and barriers to health and wellbeing. They also highlight the specific needs which persons with intersectional identities may hold.

While poorer health-related outcomes can be a consequence of these needs being unmet, notable instances where the reverse was true were also observed, and where individuals with intersectional identities sometimes reported better outcomes than the rest of the sample. This may reflect the effect of positive intersectionality,[46] where individuals' intersectional identities allow them to access sources of resilience and support.

Our findings point to the need for a more nuanced understanding of intersectional identity that is not solely focused on discrimination. There is also a need for more data that investigates intersectional identities which relate to more than two identities. While individuals who held these intersectional identities were present within our dataset, they comprised sample sizes too small to analyse.

Future research should attend to the forms of intersectional identity under-represented within our data and the broader literature. These investigations should seek to understand how intersectional identity relates to the drivers and enablers of health among these groups. Finally, existing research suggests that intersectionality is underutilised

within public administration,[47] [48] both as an analytic tool and guiding principle. Implementing the tenets of intersectionality more broadly within policymaking may present a promising way to reduce persistent social inequities. As much of this research is conducted in other high-income nations (e.g., the U.S.), future scholarship should also be conducted to investigate how intersectionality can be incorporated into Australian public health policy.

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