LA TROBE UNIVERSITY

PRIVATE LIVES 3
THE HEALTH AND WELLBEING OF LGBTIQ PEOPLE IN AUSTRALIA

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Private Lives 3 Expert Advisory Group

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- **Nicky Bath** (National LGBTI Health Alliance)
- **Teddy Cook** (ACON)
- **Michael Daly** (Victorian Department of Premier and Cabinet)
- **Misty Farquhar** (Curtin University)
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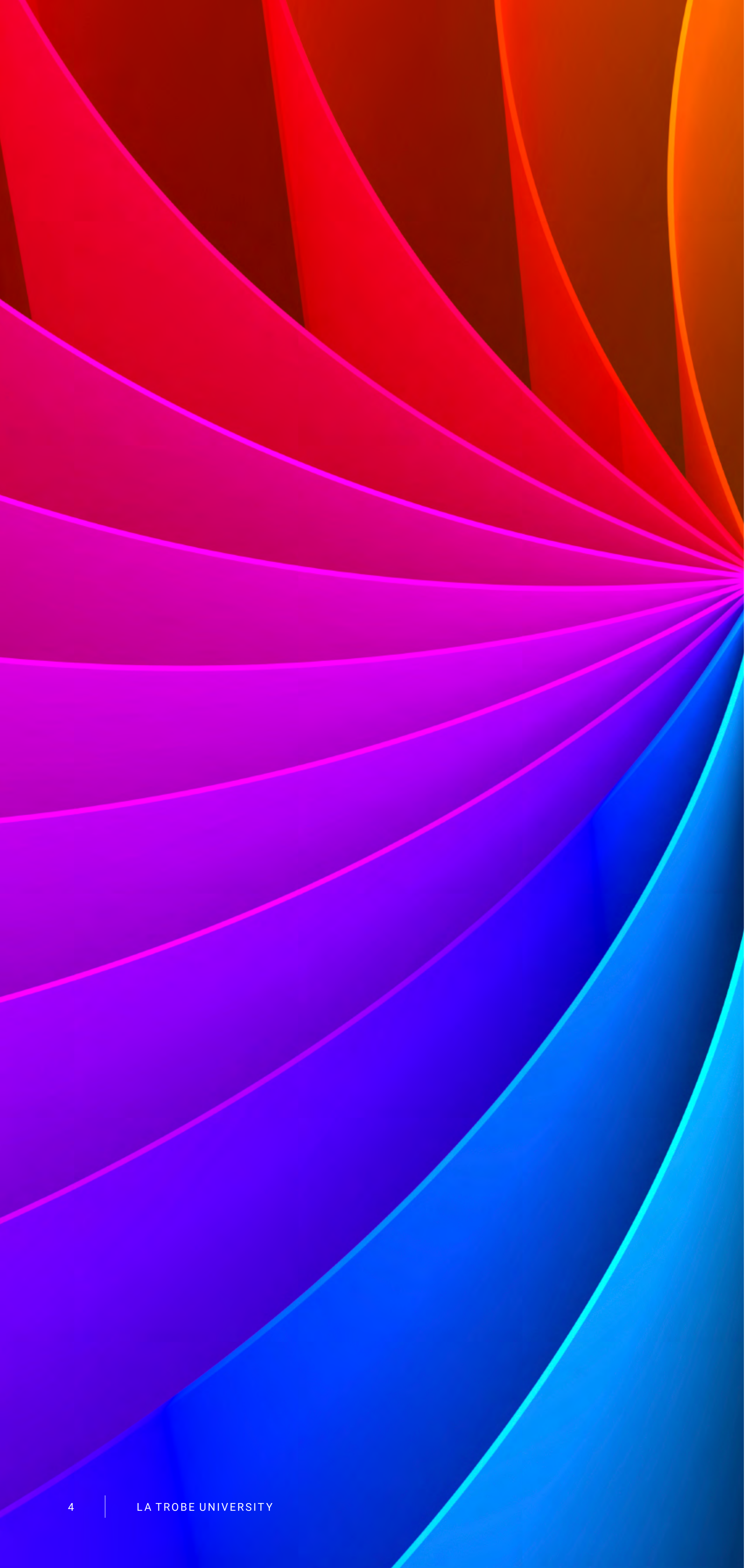
Associate Professor and Lead Investigator
On behalf of all study authors



Contents

List of tables

List of figures

Executive summary

Background

Private Lives 3 (PL3) is the third iteration of the Private Lives surveys, with the first conducted in 2005 and the second in 2011. PL3 is Australia's largest national survey of the health and wellbeing of lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people to date. It was conducted by the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University. The survey provides vital information for health professionals, service providers, community organisations and governments to better understand and support the health and wellbeing of LGBTIQ people in Australia. PL3 was jointly funded by the Victorian Department of Health and Human Services and the Victorian Department of Premier and Cabinet. This report presents data from participants of PL3 who were living in Australia at the time of the survey.

Methodology

PL3 was developed in consultation with an Expert Advisory Group comprising representatives from across a variety of states and territories as well as different sections of the LGBTIQ community. PL3 involved an online national survey promoted through paid Facebook advertising and via LGBTIQ community organisations and their networks. Paper copies of the survey were also available on request. The survey was provided in English and was restricted to participants who resided in Australia at the time of the survey who were aged 18 years and above. Questions in the PL3 survey were not compulsory and the total sample size for questions therefore varies slightly. Where a 'number' is reported for gender and sexual orientation breakdowns, it represents the number of participants for a specific gender or sexual orientation who reported the condition/situation. For example, when reporting that 'two fifths (40.0%; n = 926) of cisgender men rated their health as very good or excellent', 40.0% (n = 926) of a total of 2,315 cisgender men rated their health as very good or excellent.

About the participants

- In total, 6,835 participants completed the PL3 survey. The majority of participants reported residing in a capital city (71.3%; n = 4,827), followed by 22.3% (n = 1,506) in regional cities or towns and 6.4% (n = 432) in rural and remote regions.
- The mean age of participants was 34.1 years (SD = 13.8), ranging from 18 to 88 years. PL3 obtained a diverse sample of participants, including 2.7% who identified as Aboriginal and/or Torres Strait Islander (n = 183) and 16.0% (n = 1,095) who were born overseas.
- One third (34.3%; n = 2,328) of participants were cisgender men, 43.5% (n = 2,948) cisgender women, 4.4% (n = 300) trans men, 4.2% (n = 285) trans women and 13.6% (n = 921) non-binary. There were 47 participants with an intersex variation/s.
- One fifth (20.5%; n = 1,394) of participants identified as lesbian, 28.7% (n = 1,958) as gay, 20.4% (n = 1,387) as bisexual, 7.4% (n = 503) as pansexual, 12.2% (n = 833) as queer, 3.2% (n = 215) as asexual and 7.7% (n = 525) reported 'something else' with regard to their sexual orientation.

Households and relationships

- Over half (54.4%; n = 3,715) of participants were in a committed romantic relationship/s, of whom almost half (48.1%; n = 1,785) had been in this relationship/s for five or more years.
- Approximately one eighth (13.3%; n = 906) of participants reported having children or stepchildren.

Housing and homelessness

- More than two fifths (44.1%; n = 3,010) of participants reported living in a private rental property, almost one third (29.2%; n = 1,994) in a home they owned and one quarter (24.2%; n = 1,649) at home with their family.
- One fifth (22.0%; n = 1,501) reported having ever experienced homelessness.
- Trans and gender diverse participants reported higher rates of ever experiencing homelessness than cisgender participants. Over one third (34.3%; n = 103) of trans men, 33.8% (n = 311) of non-binary participants, 31.9% (n = 91) of trans women, 19.8% (n = 584) of cisgender women and 16.8% (n = 391) of cisgender men reported ever experiencing homelessness.

Discrimination, harassment and feelings of acceptance

- Almost three fifths (57.0%; n = 3,769) of participants reported that they had been treated unfairly because of their sexual orientation in the past 12 months.
- Over three quarters (77.5%; n = 1,278) of trans and gender diverse participants reported that they had been treated unfairly because of their gender identity in the past 12 months.
- Two fifths (39.5%; n = 2,405) of participants reported experiencing social exclusion, 34.6% (n = 2,100) verbal abuse, 23.6% (n = 1,415) harassment such as being spat at or offensive gestures, 11.8% (n = 698) sexual assault and 3.9% (n = 231) physically attacked or assaulted with a weapon due to their sexual orientation or gender identity in the past 12 months.

General health and wellbeing

- PL3 participants reported lower self-rated health than the general Australian population. Less than one third (31.2%; n = 2,117) of participants rated their health as very good or excellent compared to more than half (56.4%) of the general Australian population aged over 15 years.
- Two fifths (40.0%; n = 926) of cisgender men rated their health as very good or excellent compared to less than one third of cisgender women (29.3%; n = 858), one quarter of trans women (26.3%; n = 75) and one fifth of trans men (19.8%; n = 59) and non-binary participants (20.1%; n = 184).

Mental health and wellbeing

- More than half (57.2%; n = 3,818) of participants reported high or very high levels of psychological distress during the past four weeks.
- Three fifths (60.5%; n = 3,965) reported having ever been diagnosed with depression and almost half (47.2%; n = 3,093) with generalised anxiety disorder.
- Over two fifths (41.9%; n = 2,848) reported that they had considered attempting suicide in the previous 12 months and almost three quarters (74.8%; n = 5,084) had considered attempting suicide at some point during their lives.
- One 20th (5.2%; n = 274) reported having attempted suicide in the past 12 months and almost one third (30.3%; n = 1,606) reported having attempted suicide at some point during their lives. These rates are considerably higher than those observed within studies of the general population.
- One seventh (13.7%; n = 36) of trans men, 10.9% (n = 27) of trans women, 6.8% (n = 54) of non-binary participants, 4.2% (n = 76) of cisgender women and 3.3% (n = 56) of cisgender men reported having attempted suicide in the past 12 months.
- In total, 7.8% (n = 33) of pansexual, 6.0% (n = 69) of bisexual, 5.1% (n = 35) of queer, 4.2% (n = 8) of asexual, 4.1% (n = 42) of lesbian and 3.3% (n = 46) of gay identifying participants reported having attempted suicide in the past 12 months.

Health services

- Mainstream health services were more frequently accessed by participants than health services that were known to be LGBTIQ-inclusive or that catered only to lesbian, gay, bisexual, trans and/or intersex people.
- Of a range of health services, mainstream medical clinics had the lowest proportion of participants who felt that their sexual orientation or gender identity was very or extremely respected (58.6% and 37.7% respectively).
- The proportion of participants who felt that their sexual orientation or gender identity was very or extremely respected was highest for those who attended a medical clinic that caters only to lesbian, gay, bisexual, trans and/or intersex people people (94.9% and 90.2% respectively) or a mainstream medical clinic that is known to be LGBTIQ-inclusive (90.9% and 81.9% respectively).
- Over three quarters (75.3%; n = 5,133) of participants reported that they would be more likely to use a service if it has been accredited as LGBTIQ-inclusive.

Alcohol, tobacco and other drug use

- One sixth (16.9%; n = 998) of participants reported experiencing a time in the past 12 months when they had struggled to manage their alcohol use or a time where it negatively impacted their everyday life.
- Almost half (44.4%; n = 2,781) reported using one or more drugs for non-medical purposes in the past 6 months. The most frequently reported drugs were cannabis (30.4%; n = 1,904), ecstasy/MDMA (13.9%; n = 872) and cocaine (9.6%; n = 601).
- One seventh (14.0%; n = 388) reported experiencing a time within the past 6 months when they had struggled to manage their drug use or where it negatively impacted their everyday life.

Intimate partner and family violence

- More than two fifths (41.7%; n = 2,846) of participants reported having ever been in an intimate relationship where they felt they were abused in some way by their partner/s.
- Almost two fifths (38.5%; n = 2,629) reported ever feeling abused by a family member.
- Of the participants who reported having experienced intimate partner or family violence, 28.0% (n = 1,325) said that they reported the incident to a relevant service at the most recent time this occurred.
- Almost half (48.6%; n = 3,314) of participants reported having ever been coerced or forced into sexual acts they did not want to engage in and 8.9% (n = 607) in the past 12 months.

Community connection

- Participants were presented with the following statement, 'the following questions are about LGBTIQ communities. By LGBTIQ communities, we do not mean any particular neighbourhood or social group, but in general, groups of gay men, bisexual men and women, lesbians, transgender and intersex individuals.'
- More than half (56.1%; n = 3,824) of participants reported that they 'agree' or 'strongly agree' that they feel a part of the Australian LGBTIQ community.
- More than six in ten (61.8%; n = 4,207) reported that they 'agree' or 'strongly agree' that participating in Australia's LGBTIQ community is a positive thing for them.

Trans and gender diverse people

- Overall, trans and gender diverse participants reported higher rates of psychological distress, suicidal ideation and attempts and poorer self-rated health than cisgender women and cisgender men in PL3.
- Three fifths (61.8%; n = 113) of trans women reported gaining legal recognition for their gender identity in their passport, followed by 45.4% (n = 90) of trans men and 17.2% (n = 72) of non-binary participants.
- Less than one third of trans women (32.0%; n = 74) and trans men (29.0%; n = 75), and one 10th (10.0%; n = 48) of non-binary participants, reported gaining legal recognition for their gender identity in their birth certificate.
- Less than half of trans women (49.5%; n = 142) and trans men (49.5%; n = 136), and one quarter (25.8%; n = 154) of non-binary participants, agreed or strongly agreed with the statement, 'I have been easily able to access gender affirming care when I have needed to.'

People with an intersex variation/s

- Almost one fifth (19.6%; n = 9) of participants with an intersex variation/s reported having one or more family members with an intersex variation/s and more than half (51.8%; n = 28) reported having one or more friends with an intersex variation/s.
- More than three fifths (61.7%; n = 29) of participants with an intersex variation/s reported having experienced an occasion where they felt they did not have sufficient say over medical decisions that related to them.
- More than half (54.4%; n = 25) reported having undergone a medical intervention relating to their intersex variation/s. Of these, almost seven in ten (68.0%; n = 17) responded that this had occurred when they were a child.
- Of those who had undergone a medical intervention relating to their intersex variation/s, less than one quarter (24.0%; n = 6) responded that they were mostly or completely able to provide full and informed consent and 27.3% (n = 6) responded that their parent/s or carer/s were mostly or completely able to provide full and informed consent.
- More than half (55.6%; n = 25) of participants reported having experienced discrimination in a healthcare setting related to their intersex variation/s.

Disability or long-term health condition

- More than a third (38.5%; n = 2,629) of participants reported a disability or long-term health condition. Approximately one 10th (11.8%; n = 802) reported a profound or severe disability, one fifth (20.4%; n = 1,394) a moderate disability and 6.4% (n = 433) a mild disability or long-term health condition.
- Fewer participants with a severe disability or long-term health condition (29.9%; n = 223) felt accepted 'a lot' or 'always' when accessing a health or support service than participants not reporting a disability or long-term health condition (50.6%; n = 1,785).
- More than three quarters (77.7%; n = 617) of participants with a severe disability or long-term health condition reported being treated unfairly by others in the past 12 months as a result of their disability or long-term health condition. This was followed by more than half (55.8%; n = 771) of participants who reported a moderate disability or long-term health condition and two fifths (42.7%; n = 184) who reported a mild disability or long-term health condition.

Multicultural background

- Overall, a smaller proportion of participants from multicultural backgrounds reported feeling accepted a lot or always in almost all settings compared to those from an Anglo-Celtic background. Differences between the groups were greatest for family members, where 45.8% (n = 769) of those from multicultural backgrounds reported feeling accepted a lot or always by family members compared to 55.2% (n = 2,231) of those from an Anglo-Celtic background.
- Participants from multicultural backgrounds were more likely to report very high levels of psychological distress (31.7%; n = 541) compared to those from an Anglo-Celtic background (26.7%; n = 1,094).

- One third (33.0%; n = 575) of participants from multicultural backgrounds reported feeling that they had been treated unfairly by others as a result of their ethnicity, cultural identity or heritage in the past 12 months. This is more than five times the 6.5% (n = 271) of participants from an Anglo-Celtic background.

Geographic location

- More than one third (36.7%; n = 158) of participants residing in a rural/remote location rated their health as 'poor' or 'fair', followed by 34.6% (n = 516) in a regional city or town, 34.9% (n = 649) in outer suburban areas and 25.7% (n = 758) in inner suburban areas.
- Outer suburban areas had the largest proportion of participants who reported high or very high levels of psychological distress (64.3%; n = 1,176). This was followed by those in regional cities or towns (61.9%; n = 910) and those in rural/remote areas (55.7%; n = 233). Inner suburban areas had the lowest proportion (50.7%; n = 1,466).
- Of participants who reported high or very high psychological distress, a larger proportion of those living in an inner suburban area reported accessing a mental health service access that is LGBTIQ-inclusive (27.1%; n = 413) than those living in outer suburban areas (18.6%; n = 226), regional towns or cities (17.9%; n = 168) or rural/remote areas (17.1%; n = 42).

Recommendations

While not all LGBTIQ people experience challenges in their lives, many do, as reflected in the PL3 data. Mental health challenges, suicidal thoughts and attempts, harassment and abuse, homelessness, challenges with alcohol and drug use and intimate partner and family violence are some of the areas that are disproportionately experienced by LGBTIQ people, with specific subgroups experiencing additional burdens. At a minimum, addressing these requires further policy and program development, service development and improvements to future data collection. Specific recommendations include:

- Inclusion of sexual orientation, gender identity and intersex variation/s in all government health and wellbeing policy frameworks as key priority populations, including trans and gender diverse populations
- Broader campaigns, in partnership with LGBTIQ community-controlled organisations, that tackle stigma directed towards LGBTIQ communities
- Ongoing funding of surveys to track LGBTIQ health and wellbeing over time and review of national and state-based health and coronial data reporting to ensure inclusion of questions that adequately capture sexual orientation, gender identity and intersex variation/s
- Campaigns within LGBTIQ communities and in the broader community to further embrace diversity and to ensure full inclusivity of all groups, particularly LGBTIQ people with disabilities, LGBTIQ people from multifaith and culturally and linguistically diverse backgrounds and LGBTIQ people from Aboriginal and/or Torres Strait Islander backgrounds
- Expansion of funded services specifically catering to the needs of lesbian, gay, bisexual, trans and gender diverse and/or people with an intersex variation/s, including in regions outside inner suburban areas, that are fully informed and shaped by consultation with all relevant communities
- A requirement for organisations providing support in areas such as mental health, alcohol and other drugs or homelessness and in receipt of public funding, to take steps to ensure LGBTIQ-inclusive practice, such as undertaking organisational cultural safety training and working in partnership with community-controlled LGBTI health organisations
- Increased funding of LGBTIQ community-controlled organisations to support LGBTIQ-inclusive services and service development, including the establishment and recourses of communities of practice and other capacity building initiatives
- Ongoing evaluation of the outcomes of LGBTIQ-inclusive care for LGBTIQ people to help inform and drive further improvements
- Significant investment in outreach and peer support initiatives in consultation with intersex community organisations and sufficient funding and resources for intersex organisations to increase outreach initiatives, as well as the provision of dedicated funding for community participatory research specifically directed to people with an intersex variation/s, for example, surveys that only involve people from this population
- Further funding for community participatory research to attend to the diversity and heterogeneity of LGBTIQ people more broadly in Australia, including the specific needs of sub-populations such as LGBTIQ Aboriginal or Torres Strait Islanders, LGBTIQ people with disabilities or long-term health conditions and LGBTIQ people from culturally and linguistically diverse backgrounds
- Priority community participatory research that focuses on a broader diversity of gender and sexual identities. In particular, non-binary identities are rapidly changing and non-binary participants reported poorer health outcomes when compared with other participants. People who identify as queer, bisexual or pansexual also appear to be growing and reported poorer health outcomes compared to lesbian and gay identifying participants. These groups also require specific attention in future research.

1 Introduction

Since it was first undertaken in 2005, the Private Lives surveys have been completed by thousands of participants across the country, in urban, regional and rural areas and provide essential snapshots of health and wellbeing. Private Lives 3 (PL3) is the third iteration of the Private Lives surveys. It is Australia's largest national survey of the health and wellbeing of LGBTIQ people, conducted by the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University. PL3 aims to provide vital information for researchers, health professionals, service providers, community organisations and governments to better understand and support the health and wellbeing of LGBTIQ people in Australia. The survey collected data on a diverse range of topics and is the only study conducted on this scale that provides a detailed picture about what it is like to live as an LGBTIQ person in Australia today.

Lesbian, gay, bisexual, trans and gender diverse, intersex and queer (LGBTIQ) people are often challenged by significant levels of stigma and discrimination. Existing literature shows that these populations experience disproportionately higher rates of mental health issues, suicide, drug use and smoking, as well as poorer life satisfaction and general health compared to the general population (e.g., Leonard et al., 2012, 2015; McKay, 2011; Perales, 2019). Important legislative advances have been made in many areas, which reflects increasing social acceptance, such as the implementation of marriage equality in Australia and the ability for birth certificates to reflect gender identity in some states and territories. Private Lives was last conducted in 2011 and much has changed since then. It is therefore more important than ever to continue tracking the lives of LGBTIQ people.

PL3 was jointly funded by the Victorian Department of Health and Human Services and the Victorian Department of Premier and Cabinet. This national report presents data from the PL3 participants who were living in Australia at the time of the survey.

1.1 Scope of this report

This report provides a comprehensive snapshot of the LGBTIQ population in Australia, based on data from PL3. It covers a wide range of topics such as households, mental health, use of health services, intimate partner and family violence, experiences of stigma and discrimination, and more. It is intended to provide a broad picture. However, where possible, results are broken down by gender identity and sexual orientation or other variables. While analysing all possible intersections is beyond the scope of this report, data are provided for people who report a disability or long-term health condition, people from multicultural backgrounds and variations according to geographical location, specifically whether people live in urban, regional or rural and remote areas. Please note that specific in-depth outputs are planned for the analysis and interpretation of Aboriginal and Torres Strait Islander data in close collaboration with Aboriginal and Torres Strait Islander organisations.

1.2 Gender identity and sexual orientation

Survey questions regarding gender identity and sexual orientation were developed in consultation with members of the Private Lives 3 Expert Advisory Group, with the aim of maximising inclusion of the broad range of identities and experiences of LGBTIQ people.

1.2.1 Gender identity

Participants were asked, 'which options best describe your gender?' Response options were 'male', 'female', 'non-binary' and 'I use a different term.' Participants could choose more than one response. Participants who responded with 'non-binary', 'something different' or identified with a gender that was different to that assigned at birth were then asked, 'which of the following additional options best describes your gender?' Response options included 17 gender identities and participants could choose more than one response. To facilitate aspects of the analysis, participants who chose more than one gender identity were then asked a third gender identity question, 'for the purposes of this survey, if you had to choose only one way to describe your gender, what would you choose?' Response options included 17 gender identities and 'I don't find it possible to choose one term', where participants chose one answer for this particular question.

The PL3 survey was able to capture data that highlights the considerable diversity in gender identity among trans and gender diverse people in Australia. For the purposes of statistical analysis, it was necessary to merge some categories together. The gender categories were developed by an overarching Gender Advisory Board that was established to make decisions about the gender categories to be used in reporting the results. Five gender categories were established as follows:

1. Cisgender female: participants who were assigned female at birth and who chose only female as their gender identity
2. Cisgender male: participants who were assigned male at birth and who chose only male as their gender identity
3. Trans woman: participants who were assigned male at birth and who chose only 'female', 'trans woman' or 'sistergirl' as their gender identity
4. Trans man: participants who were assigned female at birth and who chose only 'male', 'trans man' or 'brotherboy' as their gender identity
5. Non-binary: participants who chose only a gender identity that was not a binary identity or who 'did not find it possible to choose a single gender identity'

In order to allow analysis of potential differences in health, wellbeing and service access between non-binary participants assigned female at birth (AFAB) and those assigned male at birth (AMAB), an additional section focussing on key differences in outcomes for these two groups is included in this report. However, throughout the main report itself, 'non-binary' participants are presented as a single category in order to avoid reinforcing notions of gender binaries. Although participants who responded 'prefer not to answer' were removed from the gender categories, participants who responded this way were still included in the overall sample.

1.2.2 Sexual orientation

Participants were asked if they were 'gay', 'lesbian', 'bisexual', 'pansexual', 'queer', 'asexual', 'homosexual', 'heterosexual', 'prefer not to answer', 'prefer not to have a label', 'don't know' and 'something different.' For data analysis purposes and due to relatively low numbers in each of the following groups, participants who identified as 'homosexual', 'prefer not to have a label' or 'something different' were combined into the 'something different' category. This was also done for trans and gender diverse participants and those with an intersex variation/s who identified as 'heterosexual.' Although 'prefer not to answer' did not form part of the sexual orientation classification, participants who responded in this way were still included in the overall sample.

1.3 Intersex

Intersex is an umbrella term used to describe people born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies and can manifest at birth or in later life. The broadly accepted approximation of intersex variations in the population is 1.7% (Blackless et al., 2000; Fausto-Sterling, 2000). This estimation comes from a review of medical literature over a 50-year period (Fausto-Sterling, 2000) but has historically been contested for being too broad, including variations other than those resulting in atypical genitalia (Sax, 2002), and for not taking into account potential underreporting (Jones, 2016).

In 2006, the medical community released the 'consensus statement on management of intersex disorders' where the term, Disorders of Sex Development (DSD), was introduced as an umbrella term to categorise intersex variations (Hughes, 2008). DSD is rejected by many intersex advocates (OII, 2009; Organisation Intersex International in the United Kingdom, 2014) and contested terminology remains one of a number of differences in clinical and community-based approaches to the classification, diagnosis, treatment and research into intersex variations (Griffiths, 2018). Different approaches to intersex treatment, together with a lack of standardised and longitudinal data collection, has led to significant gaps in our knowledge of intersex health and wellbeing in Australia.

1.3.1 Understanding issues facing people with an intersex variation/s

For intersex people, early medical interventions, including hormonal treatment and surgeries, can take place in the absence of any medical emergency to 'normalise' bodies, assigning a sex and instilling a sense of binary gender on intersex individuals (Carpenter, 2016; Jones, 2016; Lee et al., 2014; Schönbucher et al., 2010). Medical interventions are characterised by a loss of bodily autonomy and are often accompanied by attempts to raise a child 'unambiguously' in line with an assigned gender. There is evidence that critical information about medical intervention can be withheld from children and adults during these processes, raising ethical issues about disclosure and consent to treatment (Migeon et al., 2002; Tamar-Mattis et al., 2014). Non-consensual medical procedures influence mental health and wellbeing because they can convey a sense of 'differentness' and can be experienced as unpleasant, intrusive and aversive (Meyer-Bahlburg et al., 2017) and are internationally regarded as human rights abuses (Amnesty International, 2017; Carpenter, 2016; Human Rights Watch, 2017). Qualitative interview data involving women with Congenital Adrenal Hyperplasia (CAH) suggests that adults also recall childhood genital examinations as stigmatising and that adverse medical experiences have effects on future healthcare and intimate relationships (Meyer-Bahlburg et al., 2017). In particular, medical intervention has implications for sexual quality of life and the development of positive self-esteem and body image (Schönbucher et al., 2010; Schweizer et al., 2017).

The evidence regarding intersex mental health is heavily influenced by clinical approaches. Selected medical studies have found that people with an intersex variation/s have increased risk of mental health challenges (Engberg et al., 2015; Khorashad et al., 2018). Other studies contend that the overall mental health of people with an intersex variation/s is not worse than the population at large (Fagerholm et al., 2012). However, there is a lack of studies that go beyond correlation to think about the processes of meaning-making that are inherent to mental health and wellbeing (Roen, 2019).

1.3.2 People with an intersex variation/s in Private Lives

PL3 engaged with stakeholders from intersex community organisations from its inception through survey design, recruitment, data collection and data analyses. Key informants assisted in the design of survey questions to ensure that these were inclusive of people with an intersex variation/s. A range of recruitment strategies were utilised in the participant recruitment process, including specific targeted advertising on Facebook and Instagram. In addition, intersex organisations sent out recruitment texts and posts to promote the survey to people with an intersex variation/s.

The PL3 survey was informed by the Yogyakarta Principles plus 10 in 'recognising that the needs, characteristics and human rights situations of persons and populations of diverse sexual orientations, gender identities, gender expressions and sex characteristics are distinct from each other' (International Commission of Jurists 2017, p. 7). PL3 therefore asked the following question regarding sex characteristics, which was asked separately from gender identity or sexual orientation:

> 'Intersex is an umbrella term used to describe people born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies.
>
> Were you born with a variation in your sex characteristics? There are many different intersex variation/s, some of which are associated with a medical diagnosis (e.g., DSD, CAH, AIS, Klinefelter's syndrome, Turner Syndrome, Hypospadias, MRKH etc.).'

Of the total PL3 sample, 0.9% (n = 62) of participants responded 'yes', 6.2% (n = 418) responded 'don't know' and 92.9% (n = 6,313) responded 'no' to the above question. Of the 62 participants who reported having been born with a variation in their sex characteristics, 90.3% (n = 56) also identified as lesbian (n = 12), gay (n = 10), bisexual (n = 5), pansexual (n = 9), queer (n = 10), asexual (n = 3) or something different (n = 13). Six participants identified as heterosexual.

The 62 participants who reported having an intersex variation/s were invited to complete a specific supplementary section. Around one quarter (23.0%; n = 14) of participants selected that this section was 'not applicable' to them and one participant did not respond to the question. It was therefore not clear whether this group were in fact people who were born with an intersex variation/s or if they had an understanding of intersex which differed from that presented in PL3. This left 47 participants in the PL3 sample who could be reliably classified as a person born with an intersex variation/s. Although this figure is more than three times the previous iterations of the Private Lives surveys, it was not a large enough sample to provide statistically meaningful comparisons with other groups in the survey. This is not a unique issue with the Private Lives surveys and there are numerous examples of surveys that are framed as 'LGBTIQ' that have struggled to reach a broader intersex community (e.g., Robinson et al., 2013). This may arise for a number of reasons, including: 1) not all people with an intersex variation/s identify as part of the LGBTIQ community; and 2) not all may use the term intersex to describe their body but rather use a term that specifically denotes their sex characteristics or use clinical language such as DSD or the name of a syndrome. In addition, identifying people with an intersex variation/s has always been difficult (Rich et al., 2016). The current method of recruiting participants with an intersex variation/s through an LGBTIQ-branded survey is also likely to be drawing upon a similar pool of individuals associated with known intersex organisations (many of whom may hold other LGBTQ identities), potentially contributing to a sense of survey fatigue, particularly among those who have undergone medical interventions and find repeatedly engaging in such research difficult, and lower levels of participation over time.

1.3.3 Recommendations for future research with people with an intersex variation/s

Future surveys may be able to recruit a sufficient number and diversity of participants who have an intersex variation/s if these surveys are specific to this community and framed as entirely focussed on their needs and experiences. To ensure this, community-based participatory research models should be employed that engage intersex community members at each stage of the research process. Recruitment should be led by or conducted in close consultation with intersex organisations and could involve incentivised approaches, such as respondent driven sampling (RDS) or online respondent driven sampling (ORDS) methodologies and/or with the support of healthcare providers with whom many people with an intersex variation/s maintain frequent interaction, such as general practitioners or endocrinologists. This could help facilitate recruitment of participants from a wider population who may have different needs or experiences to those who are active participants of LGBTIQ communities. For such efforts to be successful, it is recommended that both professional researchers and those working in intersex organisations receive sufficient funding and resources to increase outreach initiatives, which will in turn increase their reach, scope and messaging. It is also recommended that dedicated funding be provided for research that is specifically directed to people with an intersex variation/s, for example, surveys that only involve people from this population. This not only enables essential information to be gained of the full range of life experiences and challenges of people with an intersex variation/s but is also more likely to attract participants who do not identify as part of an LGBTQ population. Lastly, it is important that affirmative and specialised intersex support groups be funded to ensure participants who experience distress recounting their lived experience have access to appropriate supports.

1.3.4 Inclusion of people with an intersex variation/s in reports of Private Lives 3 data

Due to the relatively small sample size of participants with an intersex variation/s (n = 47), comparisons with other LGBTQ participants cannot be meaningfully drawn. For that reason, direct comparisons are not made between this group and the gender identity or sexual orientation groups. However, as current research into the lives of people with an intersex variation/s in Australia is lacking and in order to acknowledge the valuable contributions of the people with an intersex variation/s who did contribute to the PL3 survey, data from the 47 participants are presented along with key variables in a dedicated chapter in this report.

2 Methodology

The PL3 survey was available for completion online or as a paper survey. All of the participants who met criteria for inclusion in the analysis completed the survey online. This is similar to other recent national surveys, such as Rainbow Ageing (2018) and Trans Pathways (2017). Online surveys have been shown to provide an effective method of accessing populations that can be hard to reach, including LGBTQ people (Guillory et al., 2018; Marpsat & Razafindratsima, 2010). The online PL3 survey was hosted by Qualtrics, with the paper version available by request. The PL3 survey received ethical approval from the La Trobe University Human Ethics Committee, as well as from The ACON Research Ethics Review Committee and the Community Research Endorsement Panel of Thorne Harbour Health.

2.1 Survey design

The PL3 survey was designed in consultation with the Private Lives 3 Expert Advisory Group. The PL3 survey was designed to be as inclusive and accessible as possible while also utilising a variety of standardised measures and instruments in order to allow comparisons with general population data where appropriate, including the Australian Bureau of Statistics (ABS) and Victorian Population Health Survey (2017). The questionnaire was largely quantitative involving fixed response questions. The survey was presented in English and was available for completion by LGBTIQ people who resided in Australia at the time of the survey and who were aged 18 years or older.

2.2 Advertising and recruitment

PL3 was launched on the 24th July 2019 and closed on the 1st October 2019. The survey was advertised through a combination of paid targeted advertising on Facebook and promotion by LGBTIQ community organisations. A press release was also sent to the Private Lives 3 Expert Advisory Group, professional networks including those of LGBTIQ Aboriginal and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds and LGBTIQ organisations including Intersex Peer Support Australia, the National LGBTI Health Alliance, the Diversity Department of Health and Human Services, ACON, Thorne Harbour Health, LGBTIQ offices and organisations in universities throughout Australia as well as other government and non-government organisations. In total, 86.8% (n = 5,879) of participants reported finding out about the survey through Facebook, 7.6% (n = 515) through an LGBTIQ community organisation and 6.1% (n = 415) through word of mouth. It is important to note that many community organisations and their staff promoted the survey through Facebook.

2.3 Data analysis

Quantitative data were analysed using STATA SE 16. Descriptive and comparative analyses were undertaken. Results were descriptively compared with data from the national sample of Private Lives 2 (2012), national data from the ABS, Australian Institute of Health and Welfare National Drug Strategy Household Survey, the Personal Safety Survey (2017) and other sources where appropriate.

3 Demographics

3.1 About this report

This report presents the results from the 6,835 participants who were living in Australia at the time of undertaking the PL3 survey.

3.2 Distribution/residence

Table 1: Distribution of participants by state and territory (n = 6,834) compared to the general Australian population

	PL3		General population
State	**Number**	**%**	**%**
Victoria	2,333	34.1	26.0
New South Wales	1,678	24.6	31.9
Queensland	1,239	18.1	20.1
Western Australia	668	9.8	10.3
South Australia	434	6.4	6.9
Australian Capital Territory	260	3.8	1.7
Tasmania	185	2.7	2.1
Northern Territory	37	0.5	1.0

Table 1 shows the numbers and percentages of participants residing in each state or territory. Distribution of participants was comparable to the general population (Australian Bureau of Statistics, 2019h), although Victoria and the ACT had greater proportions of participants than their respective population estimates in the ABS population estimates of June 2019.

The majority of participants reported residing in a capital city (71.3%; n = 4,827), followed by 22.3% (n = 1,506) in regional cities or towns and 6.4% (n = 432) in rural and remote regions. This distribution is similar to the general population, in which 71% of Australians reportedly live in major cities (Australian Bureau of Statistics, 2018b).

3.3 Age of participants

Table 2: Distribution of participants by age (n = 6,835)

Age	Number	%
18 – 24	2,142	31.3
25 – 34	1,980	29.0
35 – 44	1,142	16.7
45 – 54	823	12.0
55 – 64	525	7.7
65+	223	3.3

The mean age of participants was 34.1 years (SD = 13.8), ranging from 18 to 88 years. More than one quarter (31.3%; n = 2,142) were aged between 18 and 24 years, 29.0% (n = 1,980) between 25 and 34 years, 16.7% (n = 1,142) between 35 and 44 years, 12.0% (n = 823) between 45 and 54 years and 11.0% (n = 748) at 55 years and over. The proportion of participants aged 60 years and over was 6.1% (n = 420), similar to the 7.2% in Private Lives 2 (PL2).

3.4 Gender identity and sexual orientation

Table 3: Gender identity (n = 6,782)

Gender identity	Number	%
Cisgender woman	2,948	43.5
Cisgender man	2,328	34.3
Trans woman	285	4.2
Trans man	300	4.4
Non-binary	921	13.6

Although participants were offered and selected a wide range of gender identities, for the purpose of analysis respondents were categorised into five broad gender categories. Two fifths (43.5%; n = 2,948) of participants were categorised as cisgender women, 34.3% (n = 2,328) as cisgender men, 4.2% (n = 285) as trans women, 4.4% (n = 300) as trans men and 13.6% (n = 921) as non-binary. The PL3 survey was completed by 1,506 trans and gender diverse participants, more than five times the number of trans and gender diverse participants in PL2 (n = 285).

Table 4: Sexual orientation (n = 6,815)

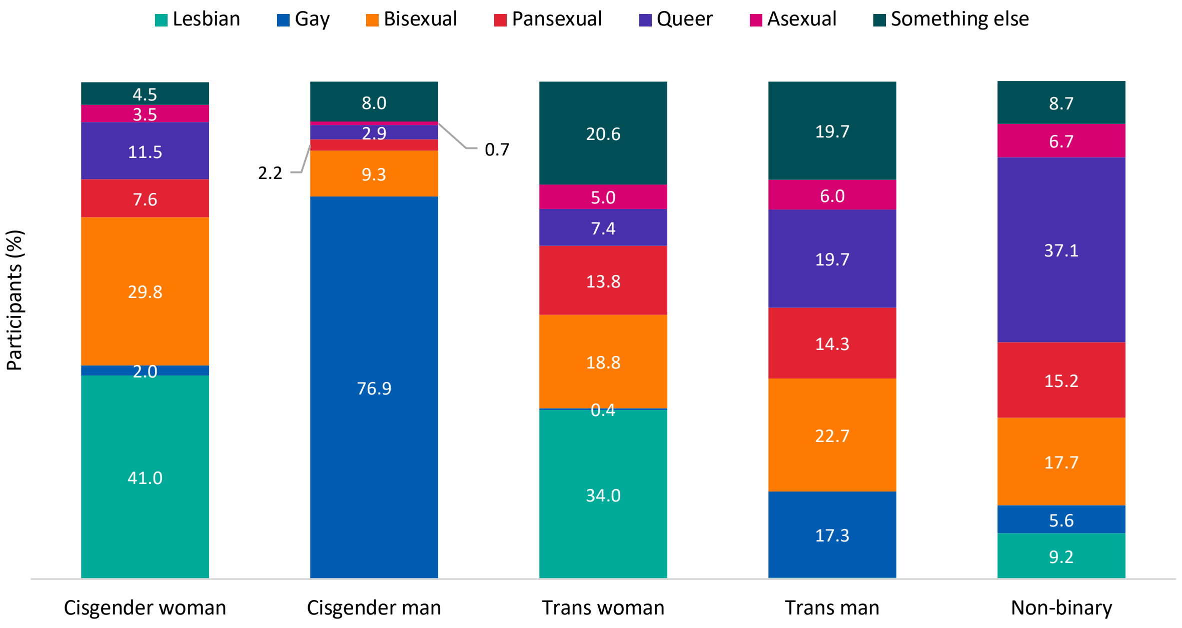
Sexual orientation	Number	%
Lesbian	1,394	20.5
Gay	1,958	28.7
Bisexual	1,387	20.4
Pansexual	503	7.4
Queer	833	12.2
Asexual	215	3.2
Something else	525	7.7

Although participants were offered and selected a wide range of sexual orientations, for data analysis purposes and due to relatively low numbers in each of the following groups, participants who identified as 'homosexual', 'prefer not to have a label' or 'something different' were combined into the 'something else' category. This was also done for trans and gender diverse participants and those with an intersex variation/s who identified as 'heterosexual.' In contrast with PL2, in which gay and lesbian identifying participants made up almost three quarters (72.7%) of the total national sample, less than half (49.2%; n = 3,352) of participants in PL3 identified as gay or lesbian. Over one quarter (27.8%; n = 1,890) identified as multi-gender attracted (bisexual = 20.4%; pansexual = 7.4%) compared to 11.8% as bisexual in PL2 (pansexual was not a sexual orientation category in PL2). Almost twice the proportion (12.2%; n = 833) of participants identified as queer in the PL3 sample than in PL2 (7.1%). Although asexual was not presented as a sexual orientation category in PL2, it made up 3.2% (n = 215) of the sample in PL3. Finally, 7.7% (n = 525) of participants were categorised as 'something else', which was the same proportion in the national sample of PL2. The 'something else' category was made up of participants who chose homosexual (n = 141), 'prefer not to have a label', 'cannot choose only one sexuality' and trans men (n = 26), trans women (n = 31) and non-binary participants (n = 7) who identified as heterosexual. Participants who chose 'prefer not to answer' for the sexual orientation questions were not included in the 'something else' category. The responses from such participants are included in overall percentages in the sections that follow but do not form part of the gender identity and sexual orientation sub-analyses. Note that because 1) homosexual-identifying participants were from all genders and 2) participants chose 'homosexual' as a distinct choice from other sexual orientations, in order to accurately reflect identities of PL3 participants, 'homosexual' was not combined into other sexual orientation categories such as gay or lesbian. Due to the relatively low numbers of homosexual identifying participants, they were therefore combined into 'something else.'

3.5 Intersections of gender and sexual orientation

People can have multiple, intersecting identities. Gender and sexual orientation are among many intersecting identities such as religion, cultural or ethnic background, disability or Aboriginal or Torres Strait Islander backgrounds that an LGBTIQ person may have. For example, a person may identify their sexual orientation as gay and have a gender identity that is categorised as cisgender man, cisgender woman, trans man, trans woman or non-binary. Similarly, a person whose gender identity is non-binary may identify their sexual orientation as lesbian, gay, bisexual, pansexual, queer, asexual or something else. Identities can be fluid and the ways in which they intersect varies depending upon the social and political context. Identity discourse, particularly regarding sexual orientation and gender, is rapidly changing and more recent gender terminology has outgrown some of the sexual orientation terminology that was created in earlier binary discourse. Just as definitions of bisexuality have developed to include non-binary genders, terminology regarding same-gender monosexual attraction such as lesbian and gay may be undergoing similar transitions. For example, a non-binary person who is attracted to women may identify as lesbian while a non-binary person who is attracted to men may identify as gay. Moreover, the way a person identifies their sexual orientation may represent a cultural or community identity rather than a tightly defined sexual orientation. A person may also use different terms privately and publicly and/or in different contexts. Figure 1 displays how sexual orientation and gender identity intersect among participants.

Figure 1: Intersections of gender and sexual orientation (n = 6,765)



Just over three quarters of cisgender men (76.9%; n = 1,786) 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). This pattern is broadly consistent with PL2 and previous studies in Australia and internationally (Hillier et al., 2010; Leonard et al., 2012; Office for National Statistics, 2015). Non-binary participants were most likely to identify as queer (37.1%; n = 825).

3.6 Country of birth

The majority of participants were born in Australia (84.0%, n = 5,730) and 16.0% (n = 1,095) were born overseas. This is similar to PL2 (81.2%) but higher than the national Australian figure of 70.3% (Australian Bureau of Statistics, 2020). 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. Among the 1,095 participants born overseas, the most common countries of birth 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.

3.7 Aboriginal and Torres Strait Islander descent

In total, 2.7% (n = 183) of participants identified as Aboriginal and/or Torres Strait Islander. This is similar to the general population in Australia (3.3%) (Australian Bureau of Statistics, 2018c). The representation of Aboriginal and/or Torres Strait Islander participants is a major strength of the sample. Please note that specific in-depth outputs are planned for the analysis and interpretation of Aboriginal and Torres Strait Islander data, in close collaboration with Aboriginal and Torres Strait Islander organisations.

3.8 Education, employment and income

3.8.1 Education

Table 5: Educational qualification (n = 6,834)

Education	Number	%
Secondary or below	1,793	26.2
Non-university tertiary	1,520	22.2
University - undergraduate	1,925	28.2
University - postgraduate	1,596	23.4

More than half (51.6%; n = 3,521) of PL3 participants reported attaining a bachelor degree or above, comparable to PL2 (49.0%) and higher than among the general population aged 20-64 years (33%) (Australian Bureau of Statistics, 2019g). Cisgender men (54.1%; n = 1,260), cisgender women (53.6%; n = 1,578) and non-binary participants (48.9%; n = 450) reported higher levels of university attainment than trans men (31.0%; n = 93) and trans women (42.4%; n = 121). A significantly higher proportion of trans men reported their educational attainment as secondary or below (41.0%; n = 123) than other participants.

3.8.2 Employment

Table 6: Employment (n = 6,819)

Employment	Number	%
Full-time employment	2,624	38.5
Studying full-time or part-time	1,791	26.3
Casual employment	1,144	16.8
Unemployed or unable to work	1,098	16.1
Part-time employment	1,067	15.7
Volunteering	675	9.9
Self-employed	539	7.9
Doing domestic duties or parenting	377	5.5
Under-employed	279	4.1
Retired	235	3.5

Note: Multiple responses were available thus percentages do not add up to 100.

Over three quarters (73.5%; n = 5,009) of participants were currently engaged in some form of paid employment, slightly higher than in PL2 (70.3%). The percentage of participants in PL3 who reported being unemployed or unable to work (16.1%; n = 1,098) was more than double the national rate of 5.3% at the time this survey was undertaken (Australian Bureau of Statistics, 2019e). A larger proportion of cisgender men (50.6%; n = 1,176) reported having full-time employment than cisgender women (35.2%; n = 1,035), trans women (30.9%; n = 88), trans men (26.3%; n = 79) or non-binary participants (25.0%; n = 230). Unemployment/unable to work was reported more frequently by trans women (31.2%; n = 89), trans men (26.7%; n = 80) and non-binary participants (26.3%; n = 242) than cisgender women (14.3%; n = 420) or cisgender men (10.6%; n = 246). A larger proportion of non-binary participants (16.9%; n = 155), trans men (12.7%; n = 38), trans women (9.8%; n = 28) and cisgender women (10.9%; n = 321) reported being engaged in volunteering than cisgender men (5.5%; n = 128).

3.8.3 Income

Table 7: Total weekly income before tax of all wages/salaries, government benefits, pensions, allowances and other income (n = 6,752)

Income	Number	%
Nil income	467	6.9
$1 - $399	1,646	24.4
$400 - $599	802	11.9
$600 - $799	504	7.5
$800 - $999	443	6.6
$1,000 - $1,599	1,389	20.6
$1,600 - $1,999	659	9.8
$2,000+	842	12.5

One in four (42.8%) participants reported an income of $1,000 or more per week, similar to PL2 (44.6%). The proportion of cisgender men (56.3%; n = 1,290) reporting an income of $1,000 or more per week was greater than that of cisgender women (40.6%; n = 1,185), trans women (29.1%; n = 82), non-binary participants (26.7%; n = 243) and trans men (23.6%; n = 70).

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). The proportion of participants reporting an income of less than $400 per week was highest among trans men (46.5%; n = 138), followed by non-binary participants (46.3%; n = 442), trans women (42.0%; n = 118) and cisgender women (32.9%; n = 960). One fifth (19.9%; n = 457) of cisgender men reported an income of less than $400 per week.

3.9 Religion

Table 8: Identity with regard to beliefs/religion/spirituality (n = 6,818)

Religion	Number	%
No religion	5,056	74.2
Catholic	328	4.8
Anglican (Church of England)	205	3.0
Buddhism	139	2.0
Uniting Church	90	1.3
Judaism	83	1.2
Islam	27	0.4
Greek Orthodox	30	0.4
Presbyterian	20	0.3
Hinduism	15	0.2
Other	825	12.1

Almost three quarters (74.2%; n = 5,056) of participants reported having no current religion or spirituality, higher than the 59.9% in PL2. Of participants reporting a religious or spiritual identity, 4.8% were catholic, 3.0% Anglican and 2.0% Buddhist. Religious or spiritual affiliation was much lower than among the general Australian population, in which 30% report having no religion (Australian Bureau of Statistics, 2017b).

Participants who indicated a religion other than 'no religion' and reported belonging to a religious/spiritual community were asked to what extent they feel it is LGBTIQ inclusive/friendly. Of the 1,236 participants who identified as being religious and who indicated that this question was relevant to them, one third (35.1%; n = 434) responded 'very' or 'extremely', 20.6% (n = 254) 'somewhat', 22.6% (n = 279) 'a little' and 21.8% (n = 269) 'not at all.'

3.10 Summary

These data represent the largest and most diverse sample of LGBTIQ people ever surveyed in Australia. This includes participants from all across the country with viable samples in every state and territory, with the exception of the Northern Territory. While the distribution clusters in the lower age range, PL3 still recruited over 1,500 people aged 45 and older. This diversity is further reflected in the gender identities and sexual orientations of those who participated, which included over 1,500 trans and gender diverse people and over 2,000 people who used terms other than lesbian, gay or bisexual to describe themselves. This represents a significant shift in how people choose to identify in the time since PL2.

The PL3 sample also reflects diversity in income, educational attainment, religious affiliation and migrancy. These intersections are crucial to understand as they are known to influence both health-related behaviours and outcomes at a population level.

4 Households and relationships

4.1 Household structure

Participants were asked who lived in the same household with them. Table 9 displays these results.

Table 9: Who lives with you (n = 2,331)

Household	Number	%
Partner/s	2,657	42.1
Parent or carer/s	1,475	21.6
Other family member/s	1,279	18.7
I live alone	1,171	17.1
Friend/s	781	11.4
Housemate/s	769	11.3
Children (including those of a partner)	710	10.4
Other/s	130	1.9

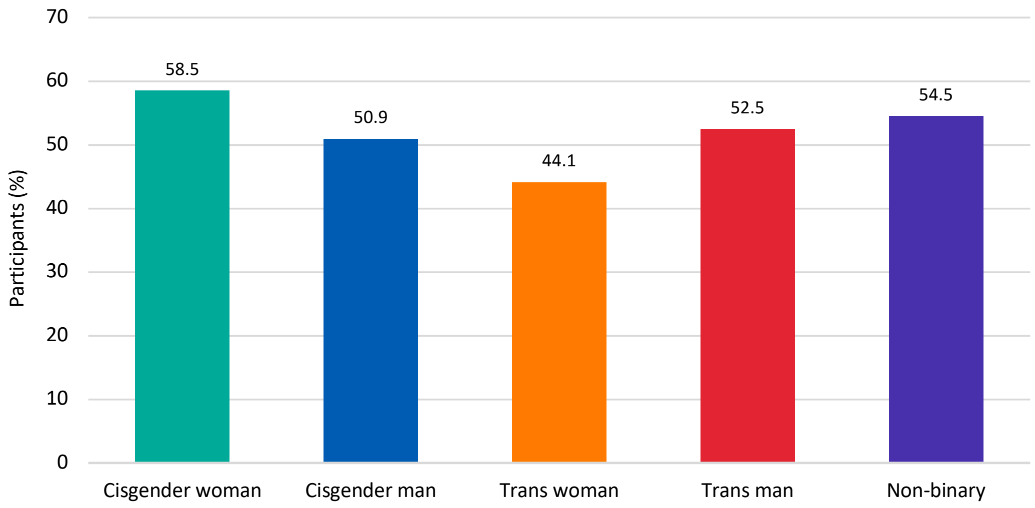
Note: multiple responses were available thus percentages do not add up to 100.

Over four in ten (42.1%; n = 2,657) PL3 participants reported living with their partner/s and 10.4% (n = 710) with children. This is similar to PL2, in which 39.6% reported living with their partner and 11.2% with children. A slightly lower proportion of PL3 participants lived alone (17.1%) compared to PL2 (23.0%) and the 24.4% reported in the general Australian population aged 15 years or over (Australian Bureau of Statistics, 2017c).

4.2 Current relationship status

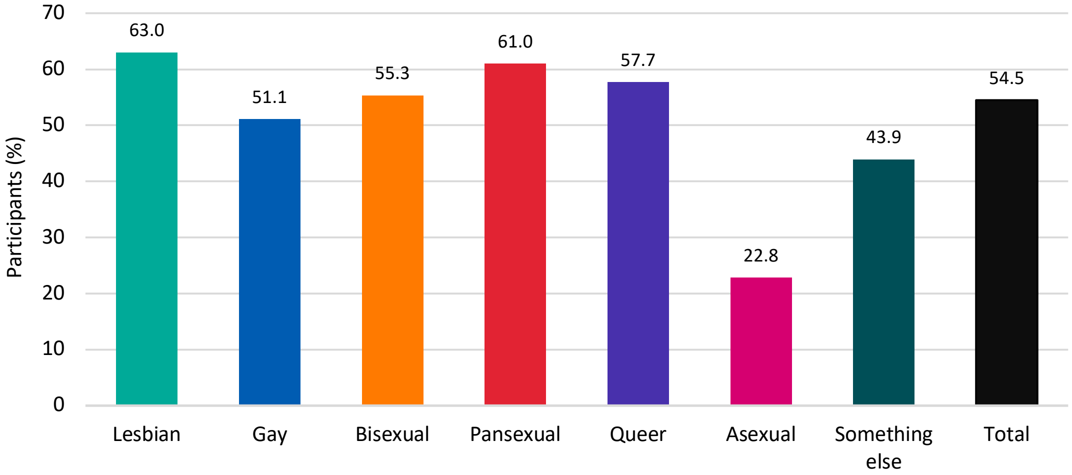
Over half (54.4%; n = 3,715) of participants were in a committed romantic relationship/s, similar to the 55.3% in PL2. Of participants in a committed romantic relationship/s, seven in ten (67.5%; n = 2,505) reported cohabiting with their partner/s, closely resembling PL2 (71.7%).

Figure 2: In a relationship by gender (n = 6,777)



Almost six in ten cisgender women (58.5%; n = 1,725) reported currently being in a relationship/s, followed by non-binary participants (54.5%; n = 501), trans men (52.5%; n = 149), cisgender men (50.9%; n = 1,185) and trans women (44.1%; n = 132).

Figure 3: In a relationship by sexual orientation (n = 6,809)



Approximately six in ten lesbian (63.0%; n = 855), pansexual (61.0%; n = 481), queer (57.7%; n = 481) and bisexual (55.3%; n = 767) identifying participants reported currently being in a relationship/s. Five in ten (51.1%; n = 999) gay identifying participants, four in ten (43.9%; n = 230) participants who identified as 'something else' and one fifth (22.8%; n = 49) of asexual identifying participants reported currently being in a relationship/s.

Participants who were currently in relationship/s were asked how long they had been in the relationship. Table 10 displays these results.

Table 10: Current relationship length (n = 3,711)

Relationship length	Number	%
Less than one year	747	20.1
Between 1 and 2 years	446	12.0
Between 2 and 5 years	882	23.8
Between 5 and 10 years	786	21.2
More than 10 years	999	26.9

Note: multiple responses were permitted if in more than one relationship thus percentages do not add up to 100.

Almost half (48.1%; n = 1,785) of participants in a relationship reported having been in a relationship for five years or more and over one quarter (26.9%; n = 999) for more than ten years, slightly higher than reported in PL2 (44.1% in a relationship for five years or more; 25.8% more than ten years).

4.3 Marital status

Participants were asked if they had ever formalised any of their current or previous relationships through marriage. Table 11 displays these results.

Table 11: Marital status of all participants (n = 6,812)

Marital status	Number	%
No, but I hope to be married	3,055	44.9
No, I don't hope to be married	1,798	26.4
Yes, I am currently married	872	12.8

Yes, I was previously married	466	6.8
Yes, through a non-marriage ceremony	186	2.7
Prefer not to say	152	2.2
Something different	596	8.8

Of the total PL3 sample (n = 6,812), approximately one in eight (12.8%; n = 872) were currently married and 2.7% (n = 186) had formalised their relationship through a non-marriage ceremony. A further 6.8% (n = 466) reported having been married previously.

Of those participants who were currently in a relationship (n = 3,715), 22.7% (n = 840) were currently married and 3.8% (n = 141) had formalised their relationship through a non-marriage ceremony. This compared to just under 18% of participants who had formalised their commitment through marriage or some other ceremony in PL2.

A greater proportion of participants who were currently not married reported being receptive to marriage in the future (44.9%; n = 3,055) than in PL2 (34.4%).

4.4 Marriage equality debate

Marriage equality came into effect in Australia in December 2017. Participants were asked how they felt during the marriage equality debate in 2017 and how they felt marriage equality might impact their lives in the future. Recent research observed that more frequent exposure to negative media messages about same-sex marriage was associated with greater psychological distress during the 2017 marriage equality debate (Verrelli et al., 2019).

Table 12: The extent that participants agreed with the statement, 'I felt distressed during the 2017 marriage equality debate' (n = 6,801)

I felt distressed during the 2017 marriage equality debate	Number	%
Strongly disagree	498	7.3
Somewhat disagree	442	6.5
Neither agree nor disagree	739	10.9
Somewhat agree	2,366	34.8
Strongly agree	2,756	40.5

Consistent with recent research, three quarters (75.3%; n = 5,122) of participants agreed with the following statement, 'I felt distressed during the 2017 marriage equality debate' and 13.8% (n = 940) disagreed.

Table 13: The extent that participants agreed with the statement, 'The 2017 marriage equality results will have a positive impact on my life' (n = 6,791)

2017 marriage equality results will have a positive impact on my life	Number	%
Strongly disagree	211	3.1
Somewhat disagree	232	3.4
Neither agree nor disagree	1,356	20.0
Somewhat agree	2,223	32.7
Strongly agree	2,769	40.8

Almost three quarters (73.5%; n = 4,992) of participants agreed with the following statement, 'The 2017 marriage equality results will have a positive impact on my life' and 6.5% (n = 443) disagreed.

4.5 Children and dependents

Approximately one in seven (13.3%; n = 906) participants reported having children or stepchildren, lower than in PL2 (22.1%). This may be due to the lower proportion of cisgender women and higher proportion of other groups in PL3 than PL2. Overall, one in five cisgender women in PL3 (19.8%; n = 581) reported having children or stepchildren, followed by 18.5% (n = 52) of trans women, 9.3% (n = 28) of trans men, 8.5% (n = 72) of non-binary participants and 6.8% (n = 158) of cisgender men. Participants who reported being primary carers of children were asked what methods they or their partner/s (if co-parenting) used to have children. Table 14 displays these results.

Table 14: Conception method of participants who reported being the primary carer for a child (n = 688)

Conception method	Number	%
Sexual intercourse with a relationship partner	285	41.4
Gametes (i.e., eggs or sperm) and embryo donated from a person I know	107	15.6
Gametes (i.e., eggs or sperm) donated from a person I do not know (i.e., sourced by an Assisted Reproductive Treatment service)	100	14.5
Gametes (i.e., eggs or sperm) and embryo donated from a person I do not know (i.e., anonymous donor)	49	7.1
Fostering	29	4.2
Surrogacy from a person I had not previously known before they became a surrogate	18	2.6
Sexual intercourse with a non-relationship partner	17	2.5
Adoption	15	2.2
Surrogacy from a person I had previously known before they became a surrogate	4	0.6
Other	56	8.1
None of the above	89	12.9

The most commonly reportedly methods for conceiving a child involved sexual intercourse with a partner with whom they were in a relationship, gametes and embryo donated from a person they knew and gametes sourced through an Assisted Reproductive Treatment service. Other methods, such as surrogacy, fostering and adoption were less common and reported by relatively small percentages of those who were primary carers of children. These forms of family creation are generally difficult to access, which creates significant barriers for people who desire children in the future (see 4.5.2.) but remain the main methods that couples without a uterus or ovaries can use to achieve parenting.

4.5.1 Desire for children in the future

More than one quarter (28.0%; n = 1,912) of participants reported a desire for having children or more children in the future. However, 47.1% (n = 3,218) reported that they did not desire to have children and 24.9% (n = 1,698) were undecided or did not know. A greater proportion of participants ('nearly 38%') in PL2 reported wanting to have a child or more children in the future.

4.5.2 Barriers for having children in the future

Participants who reported a desire for having children or more children in the future and participants who reported that they were undecided or did not know if they wanted children in the future were asked the extent to which they felt they faced barriers to having children in relation to their sexual orientation or gender. Response options included 'this is not relevant to me', 'not at all', 'a little', 'somewhat', 'a lot' and 'extremely.' Participants who responded, 'this is not relevant to me' (n = 158 in relation to their sexual orientation and n = 41 in relation to their gender) were not included in these analyses. Almost four in ten (37.5%; n = 1,332) participants who desired having children or more children in the future reported 'a lot' or 'extremely' when asked if they faced barriers to having children in relation to their sexual orientation. Almost half (50.8% n = 439) of trans and gender diverse participants reported 'a lot' or 'extremely' when asked if they faced barriers to having children in relation to their gender.

Participants who desired or were undecided if they wanted children in the future were then presented with a list of potential barriers and asked which, if any, they faced. Table 15 displays these results.

Table 15: Potential barriers to having children among participants who desired them or were undecided (n = 3,372)

Barriers to having children	Number	%
Cost of raising a child	1,625	48.2
Concerns of raising a child in a heterosexist society	1,615	47.9
Cost of accessing Assisted Reproductive Treatment services	1,231	36.5
No relationship partner	1,033	30.6
Don't know a potential sperm donor	979	29.0
Don't know a potential surrogate	888	26.3
Concerned about heterosexist treatment at an Assisted Reproductive Treatment service	771	22.9
Don't know the location of an Assisted Reproductive Treatment service	762	22.6
No stable income	749	22.2
Cost of egg storage	689	20.4
Lack of commercial surrogacy in Australia	688	20.4
Don't know a potential egg donor	680	20.2
Infertility	527	15.6
Too old	428	12.7
Don't have an Assisted Reproductive Treatment service near where I live	225	6.7
I don't face any barriers	125	3.7
Other	638	18.9

Note: multiple responses were available thus percentages do not add up to 100.

The vast majority (96.3%; n = 3,247) of participants who desired or were undecided if they wanted children in the future reported facing one or more perceived barriers to having children. Almost half (48.2%; n = 1,625) reported the cost of raising a child and concerns of raising a child in a heterosexist society (47.9%; n = 1,615) as barriers to having children. Over a third (36.5%; n = 1,231) reported the cost of accessing Assisted Reproductive Treatment services and three in ten (30.6%; n = 1,033) reported not having a relationship partner and not knowing a potential sperm donor (29.0%; n = 979). Approximately one quarter reported not knowing a potential surrogate (26.3%; n = 888), concern about heterosexist treatment at an Assisted Reproductive Treatment service (22.9%; n = 771), not knowing the location of an Assisted Reproductive Treatment service (22.6%; n = 726) or not having a stable income (22.2%; n = 749) as barriers. Only 3.7% (n = 125) reported not facing any barriers to having children.

4.6 Summary

More than half of participants were in a committed romantic relationship/s, of whom almost half had been in this relationship for five or more years. Fewer participants reported having children or stepchildren. This may reflect the fact that more than nine in ten participants who desired or were undecided if they wanted children in the future perceived barriers to doing so, which included cost, heterosexist norms and challenges in accessing reproductive services.

Despite these findings, recent reforms in Assisted Reproductive Treatment services and adoption legislation in different states have increasingly included LGBTIQ people. In Victoria, for example, in vitro fertilisation (IVF) is no longer restricted to married women and legal arrangements for altruistic surrogacy were introduced. The Victoria Assisted Reproductive Treatment Services Inquiry recommended removing unnecessary or discriminatory barriers to access, especially for the LGBTIQ community. This included increased access to public donor sperm and egg banks, inclusive practice training for clinics developed to promote inclusive practice for LGBTIQ people and providing Medicare rebates for micro testicular sperm extraction, a procedure necessary for some people with intersex variation/s to have children (Gorton, 2019). Furthermore, there have been gradual improvements for surrogacy legislation around the country. However, as the PL3 data suggest, there is still some way to go with regard to supporting family formation and assisting with this process.

5 Housing and homelessness

5.1 Current living situation

Participants were asked to select which options best described their current living situation from a range of choices and could select more than one option if applicable. Table 16 displays these results.

Table 16: Current living situation (n = 6,822)

Housing situation	Number	%
Private rental	3,010	44.1
Home I own	1,994	29.2
At home with family	1,649	24.2
Public housing	90	1.3
Rooming house	66	1.0
Couch surfing	48	0.7
Transitional housing	32	0.5
Crisis/emergency accommodation	11	0.2
Caravan park	9	0.1
Street/abandoned property/squatting	6	0.1
Youth foyer	4	0.1
Somewhere else	177	2.6

Note: multiple responses were available thus percentages do not add up to 100.

More than four in ten (44.1%; n = 3,010) participants reported living in a private rental property, three in ten (29.2%; n = 1,994) in a home they owned and one quarter (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 (Australian Bureau of Statistics, 2019b). Among participants living in a private rental property, 40.8% (n = 1227) shared with a partner, 22.3% (n = 672) shared with friend/s and 21.7% (n = 653) lived alone. Among participants who were living in their own home (n = 1,994), 73.8% (n = 1,472) owned it with a mortgage and 26.2% (n = 522) owned it without a mortgage.

5.2 Homelessness

Homelessness is a serious population health concern, with research showing that people who experience homelessness in their lifetimes tend to have poorer general health and higher rates of chronic and acute diseases, mental illness and alcohol and drug dependence than the general population (Fazel et al., 2008; Lebrun-Harris et al., 2013). Growing evidence suggests that a higher proportion of LGBTIQ people have experienced homelessness than the general population (McNair et al., 2017). However, there has been limited research in Australia. Many surveys of the general population either do not record or inadequately record diverse genders, sex characteristics and sexual orientation, and Australia is generally regarded as being behind other developed countries in developing research, policy and best practice in the area of LGBTIQ homelessness (Andrews et al., 2019).

A variety of measures and definitions of homelessness exist, with no fixed standard. The ABS defines a person as homeless if 'they do not have suitable accommodation alternatives and their current living arrangement: is in a dwelling that is inadequate; has no tenure or if their initial tenure is short and not extendable; or does not allow them to have control of and access to space for social relations' (Australian Bureau of Statistics, 2018a). For the PL3 survey, a definition of homelessness was developed in consultation with homelessness specialists, the PL3 Expert Advisory Committee and other key stakeholders. It was designed to be more easily understood by participants from culturally and linguistically diverse backgrounds while remaining comparable to the ABS definition. It asked participants the following:

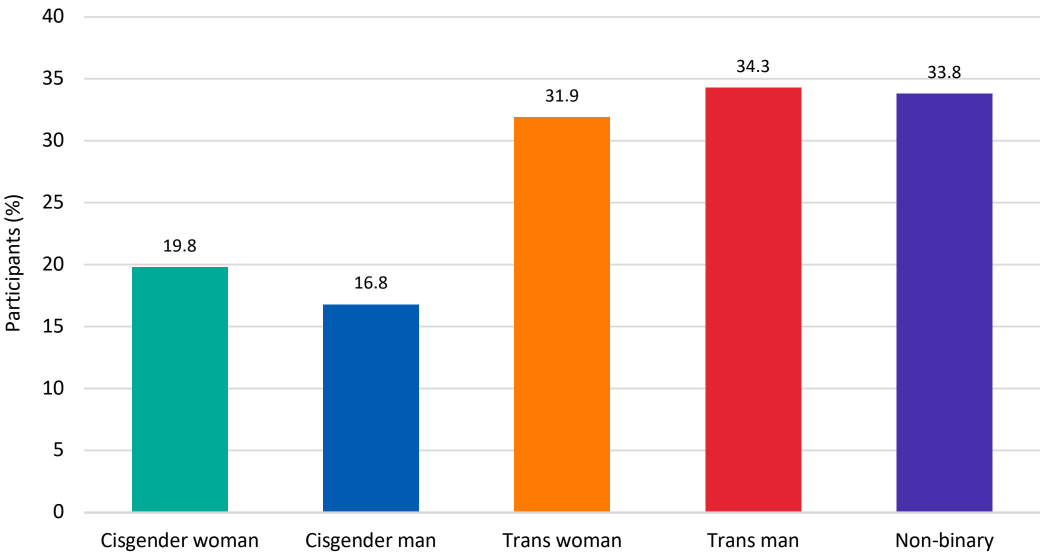
'Being homeless means not having a stable or safe place to live. Homelessness can include: couch surfing; sleeping outside; living or sleeping in a car; staying in a shelter, hostel or refuge; living in an abandoned house or building; staying in overcrowded housing; living in temporary accommodation. Are you experiencing or have you ever experienced homelessness?'

5.3 Experiences of homelessness

One fifth (22.0%; n = 1,501) of the PL3 sample reported having ever experienced homelessness. This is comparable to findings from secondary analyses of the General Social Survey, in which 33.7% of lesbian/gay participants and 25.8% of bisexual participants reported ever experiencing homelessness compared to 13.4% of heterosexual participants (McNair et al., 2017). Of participants who had ever experienced homelessness, 1.1% (n = 77) reported currently experiencing homelessness at the time of completing the survey, which compares to 0.5% (n = 116,427) of the general population on census night in the 2016 census (Australian Bureau of Statistics, 2018a). Of participants who reported ever experiencing homelessness, almost two thirds (60.7%; n = 911) reported having experienced homelessness once and were not currently experiencing homelessness, 34.2% (n = 513) experienced homelessness more than once and were not currently experiencing homelessness, 2.0% (n = 30) were currently experiencing homelessness for the first time and 3.1% (n = 47) were currently experiencing homelessness and had also previously experienced homelessness.

Figure 4 displays the proportion of participants who had ever experienced homelessness broken down by gender.

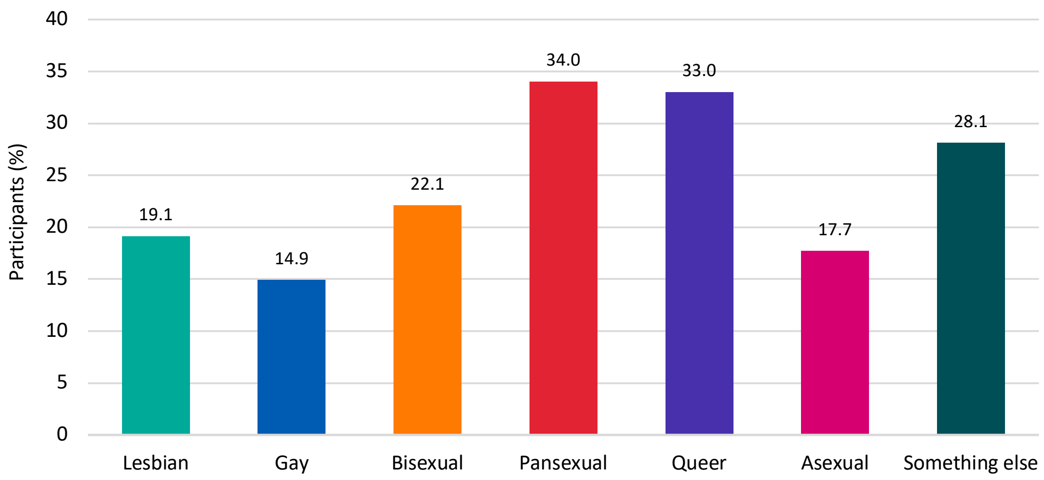
Figure 4: Ever experienced homelessness by gender (n = 6,782)



Trans and gender diverse participants reported higher rates of ever experiencing homelessness than cisgender participants. More than one third (34.3%; n = 103) of trans men, 33.8% (n = 311) of non-binary participants and (31.9%; n = 91) of trans women reported ever experiencing homelessness compared to 19.8% (n = 584) of cisgender women and 16.8% (n = 391) of cisgender men. This much higher burden of homelessness experiences amongst trans and non-binary participants was foreshadowed in a small interview-based study of LGBT people in Victoria (McNair et al, 2017).

Figure 5 displays the proportion of participants who had ever experienced homelessness broken down by sexual orientation.

Figure 5: Ever experienced homelessness by sexual orientation (n = 6,815)



Pansexual and queer participants reported higher rates of ever experiencing homelessness than other groups. One third (34.0%; n = 171) of pansexual and 33.0% (n = 275) of queer participants reported ever experiencing homelessness. This compared to 22.1% of bisexual (n = 307), 19.1% (n = 266) of lesbian, 14.9% (n = 291) of gay and 17.7% (n = 38) of asexual participants.

Participants who reported ever experiencing homelessness were asked if their homelessness experience/s related to being LGBTIQ. One quarter (25.7%; n = 384) reported that their homelessness experience/s was related to being LGBTIQ. A greater proportion of trans women (44.0%; n = 40), trans men (43.7%; n = 45) and non-binary participants (35.6%; n = 110) reported that their homelessness experience/s related to being LGBTIQ than cisgender men (22.6%; n = 88) and cisgender women (15.8%; n = 92).

Participants who reported ever experiencing homelessness were then asked if their experience/s of homelessness related to a range of possible circumstances. Table 17 displays these results.

Table 17: Circumstances related to experience/s of homelessness (n = 1,462)

Circumstances related to homelessness	Number	%
Financial stress	624	42.7
Mental health issues	584	40.0
Unemployment/underemployment	558	38.2
Rejection from family	492	33.7
Family violence	435	29.8
Violence/harassment in previous accommodation	213	14.6
Substance use	196	13.4
Discrimination (such as from school, employment, services)	154	10.5
Disability	134	9.2
Rejection from peers	128	8.8
Chronic illness	121	8.3
Other	260	17.8

Note: multiple responses were available thus percentages do not add up to 100.

Approximately four in ten participants (42.7%; n = 624) reported having experienced homelessness related to financial stress, mental health issues (40.0%; n = 584) or unemployment/underemployment (38.2%; n = 558). One third (33.7%; n = 492) reported experiencing homelessness due to rejection from their family and around three in ten (29.8%; n = 435) due to family violence. Approximately one in seven (14.6%; n = 213) reported experiencing homelessness related to violence or harassment at their previous accommodation, 13.4% (n = 196) to substance use and 10.5% (n = 154) to discrimination. The reported circumstances related to homelessness among PL3 participants aligns with some aspects of those reported among the general Australian population. These include family breakdown, psychological distress, joblessness, use of illicit substances and experiences of physical and sexual violence (Bevitt et al., 2015). However, a greater likelihood of family violence or rejection for LGBTQ young people compared to the general population seems to be a key driver of the higher levels of homelessness in this group (Dempsey et al., 2020).

5.4 Barriers to secure housing

Participants were asked the extent to which they felt they faced barriers to housing and/or accessing homelessness services because of their sexual orientation or gender identity, with response options including 'not at all', 'a little', 'somewhat', 'very' and 'extremely.' Very few (1.4%; n = 93) reported 'very' or 'extremely' in relation to their sexual orientation. However, one in fifteen (7.6%; n = 124) trans and gender diverse participants reported 'very' or 'extremely' in relation to their gender identity. In total, 15.9% (n = 1,063) of participants reported having experienced any barriers to housing and/or accessing homelessness services because of their sexual orientation and three in ten (29.8%; n = 487) trans and gender diverse participants reported having experienced any barriers to housing and/or accessing homelessness services because of their gender identity. These findings reflect research in the United States observing that when trying to rent or buy a home, one in five transgender people (19%) have been refused a home or apartment and more than one in ten (11%) have been evicted because of their gender identity (Grant et al., 2011). It suggests that people with diverse gender identities face higher levels of discrimination in relation to housing than cisgender people, regardless of sexual orientation.

5.5 Summary

Overall, PL3 participants reported more than twice the rates of current homelessness compared to those observed in studies among the general Australian population. More than a fifth reported experiencing homelessness one or more times in their lives. Experiences of homelessness were particularly high among trans and gender diverse participants, which is consistent with previous findings in Australia and abroad (Fraser et al., 2019; McNair et al., 2017).

Notably, one quarter of participants reported that their experiences of homelessness were related to being LGBTIQ and around a third reported family rejection or family violence as circumstances related to homelessness. Furthermore, three in ten trans and gender diverse participants reported having experienced barriers to housing and/or accessing homelessness services because of their gender identity. These data suggest the importance of addressing both the circumstances for homelessness, with attention paid to issues such as LGBTIQ family violence and rejection, as well as barriers to accessing secure housing for LGBTIQ people, particularly among trans and gender diverse people.

6 Discrimination, harassment and feelings of acceptance

6.1 Feelings of acceptance

Participants were asked to report on the extent to which they currently felt accepted in a variety of situations. Response options included 'not applicable', 'not at all', 'a little', 'somewhat', 'a lot' and 'always.' Responses were analysed only among participants who reported that a situation was applicable to them. Table 18 displays the numbers and percentages of participants in the PL3 sample who felt they were accepted a lot or always in each situation.

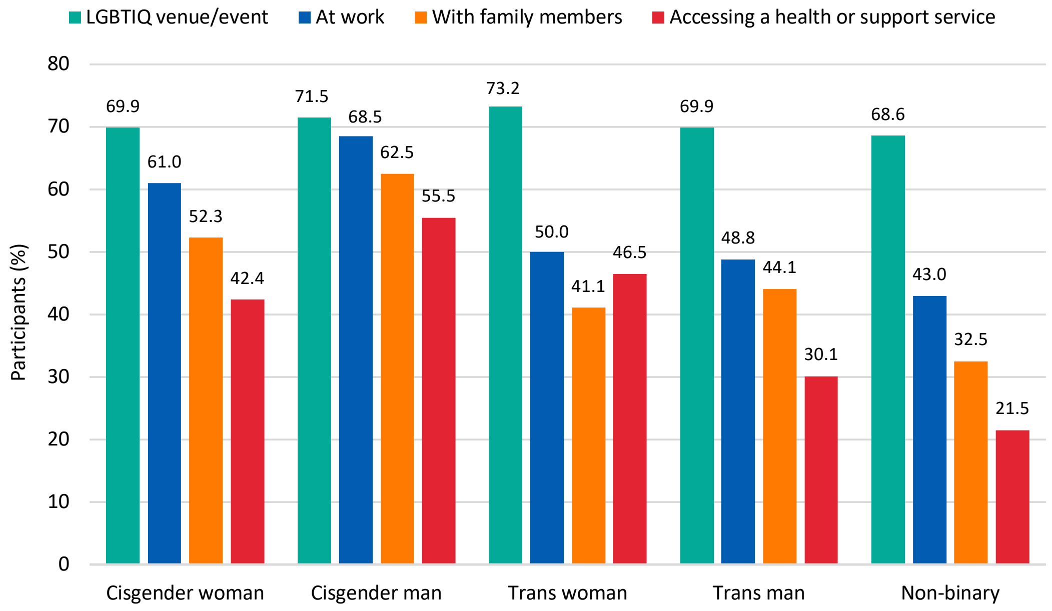
Table 18: Currently feel accepted 'a lot' or 'always'

Currently, to what extent do you feel accepted in the following situations?	Number	%
LGBTIQ event/venue	3,552	67.5
At work	3,211	60.7
At an educational institution	2,388	55.3
LGBTIQ dating app or website	2,049	52.7
With family members	3,431	52.2
Accessing a health or support service	2,695	43.4
Social/community events	2,193	35.4
In public (e.g., in the street/park)	1,965	30.5
Mainstream event/venue	1,695	28.7
Non-LGBTIQ dating app or website	676	21.7
Religious/faith-based events or services	376	10.5

Note: responses were analysed among participants who reported that a situation was applicable to them therefore an overall 'n' is not provided.

Overall, the proportions of PL3 participants who felt accepted were relatively low, with most situations having half or fewer participants feeling this way. Notably, more than twice the proportion of participants felt accepted at an LGBTIQ event/venue (67.5%; n = 3,552) than at a mainstream event/venue (28.7%; n = 1,695). Similarly, less than one third (30.5%; n = 1,965) felt this way in other public spaces. In addition, less than half (43.4%; n = 2,695) of participants reported feeling accepted a lot or always when accessing a health or support service. Only a small proportion (10.5%; n = 376) of participants reported that they felt accepted at religious/faith-based events or services and slightly more than half (52.2%; n = 3,431) felt that they were accepted with family members.

Figure 6: Currently feel accepted 'a lot/always' by gender



Overall, similar proportions of the five gender groups felt accepted a lot or always at LGBTIQ venues/events. However, smaller proportions of trans men, trans women and non-binary participants felt accepted a lot or always at work, with family members or accessing a health or support service compared to cisgender men or women.

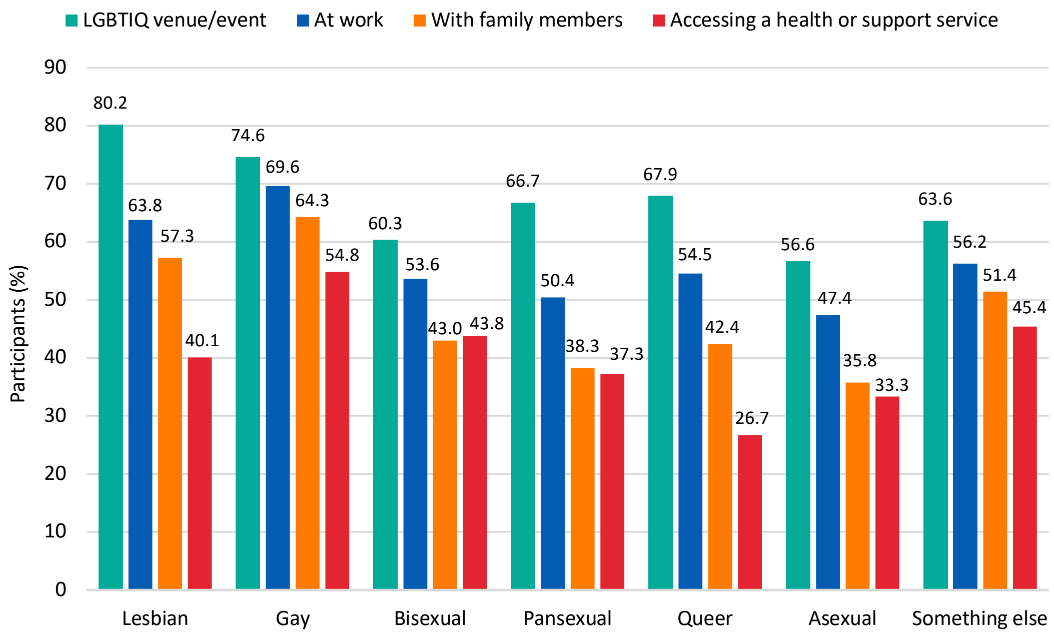
Specifically, approximately seven in ten cisgender women (69.9%; n = 1,757), cisgender men (71.5%; n = 1,412), trans women (73.2%; n = 156), trans men (69.9%; n = 165) and non-binary participants (68.6%; n = 549) felt accepted a lot or always at LGBTIQ venues/events.

Seven in ten (68.5%; n = 1,327) cisgender men felt accepted a lot or always at work compared to six in ten cisgender women (61.0%; n = 1,401), one in two trans women (50.0%; n = 88) and trans men (48.8%; n = 100) and four in ten (43.0%; n = 278) non-binary participants.

Similarly, a higher proportion of cisgender men (62.5%; n = 1,400) reported feeling accepted a lot or always with family members than cisgender women (52.3%; n = 1,480), trans men (44.1%; n = 131), trans women (41.1%; n = 113) and non-binary participants (32.5%; n = 289).

One in five (21.5%; n = 186) non-binary participants reported feeling accepted a lot or always when accessing a health or support service. This compared to 30.1% (n = 86) of trans men, 42.4% (n = 1,134) of cisgender women, 46.5% (n = 127) of trans women and 55.5% (n = 1,150) of cisgender men.

Figure 7: Currently feel accepted 'a lot/always' by sexual orientation



Overall, most participants reported feeling accepted a lot or always at LGBTIQ venues/events, although bisexual identifying participants were least likely to report this. Specifically, approximately four fifths (80.2%; n = 999) of lesbian identifying women felt accepted a lot or always at an LGBTIQ venue/event. This compared to 74.6% (n = 1,250) of gay, 60.3% (n = 668) of bisexual, 66.7% of pansexual (n = 270), 67.9% of queer (n = 516) and 56.6% of asexual (n = 90) identifying participants.

Approximately two thirds of lesbian (63.8%; n = 718) and gay (69.6%; n = 1,160) identifying participants felt accepted a lot or always at work. This compared to 53.6% (n = 535) of bisexual, 50.4% (n = 172) of pansexual, 54.5% (n = 359) of queer and 47.4% (n = 64) of asexual identifying participants.

Similarly, a higher proportion of lesbian (57.3%; n = 782) and gay (64.3%; n = 1,228) identifying participants felt accepted a lot or always with family members than bisexual (43.0%; n = 561), pansexual (38.3%; n = 186), queer (42.4%; n = 341) or asexual (35.8%; n = 64) identifying participants.

Around one third of pansexual (37.3%; n = 168) and asexual (33.3%; n = 63) identifying participants and one quarter (26.7%; n = 213) of queer identifying participants, felt accepted a lot or always when accessing a health or support service. Just over half of gay identifying participants (54.8%; n = 973), 40.1% (n = 523) of lesbian identifying participants and 43.8% (n = 537) of bisexual identifying participants felt accepted a lot or always when accessing a health or support service.

6.2 Unfair treatment due to sexual orientation and/or gender identity

Participants were asked to what extent they felt they had been treated unfairly because of their sexual orientation in the past 12 months, with response options including 'not at all', 'a little', 'somewhat', 'a lot' and 'always.' In addition, trans and gender diverse participants were asked to what extent they felt they had been treated unfairly because of their gender identity in the past 12 months, with the same response options as above. These were general questions designed to capture the degree to which people encountered discrimination in any area of their lives. Table 19 displays these results.

Table 19: Extent to which you feel you have been unfairly treated due to sexual orientation (n = 6,607) or gender identity (n = 1,649)

In the past 12 months, to what extent do you feel you have been treated unfairly because of your...	Sexual orientation		Gender identity	
	Number	%	Number	%
Not at all	2,828	42.3	371	22.5
A little	2,363	35.8	465	28.2
Somewhat	1,111	16.8	487	29.5
A lot	261	4.0	292	17.7
Always	34	0.5	34	2.1

Almost six in ten (57.0%; n = 3,769) participants reported that they had been treated unfairly to some degree (either a little, somewhat, a lot or always) because of their sexual orientation in the past 12 months, with 4.5% (n = 295) reporting a lot or always. Over three quarters (77.5%; n = 1,278) of trans and gender diverse participants reported that they had been treated unfairly to some degree because of their gender identity in the past 12 months, with 19.8% (n = 326) reporting a lot or always.

6.3 Experiences of violence based on sexual orientation and/or gender identity

Participants were asked if they had experienced specific forms of heterosexist violence or harassment based on their sexual orientation or gender identity in the past 12 months. Table 20 displays these results.

Table 20: Experiences of violence and harassment due to sexual orientation or gender identity in the past 12 months

Type of violence or harassment	Number	%
Socially excluded	2,405	39.5
Verbal abuse (including hateful or obscene phone calls)	2,100	34.6
Harassment such as being spat at and offensive gestures	1,415	23.6
Received written threats of abuse via emails, social media	1,310	22.1
Threats of physical violence, physical attack or assault without a weapon	874	14.6
Sexual assault	698	11.8
Received written threats of abuse in other ways	661	11.4
Refusal of service	597	10.0
Refused employment/promotion	554	9.9
Received written threats of abuse via graffiti	301	5.3
Deliberate damage to property or vandalism – House	284	4.8
Physical attack or assault with a weapon (knife, bottle, stones)	231	3.9
Deliberate damage to property or vandalism – Car	210	3.7
Theft – Money	214	3.6
Theft – Property	195	3.4
Break in – House	151	2.6
Deliberate damage to property or vandalism – Work	119	2.1
Theft – Car	80	1.4
Other	166	21.9

Note: responses were analysed among participants who reported that a situation was applicable to them therefore an overall 'n' is not provided.

The most frequently reported forms of heterosexist violence or harassment were non-physical, including social exclusion (39.5%; n = 2,405), verbal abuse (34.6%; n = 2,100), harassment such as 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). Forms of physical abuse were less common but not unusual, with 11.8% (n = 698) of participants reporting sexual assault and 3.9% (n = 231) reporting a physical attack or assault with a weapon in the past 12 months due to their sexual orientation or gender identity.

The proportions of some forms of heterosexist violence and harassment reported by participants in PL3 were somewhat higher than in PL2. For example, 25.5% of participants in PL2 reported verbal abuse (compared to 34.6% in PL3), 15.5% reported harassment such as being spat at or offensive gestures (compared to 23.6% in PL3), 2.9% reported sexual assault (compared to 11.8% in PL3) and 1.8% reported experiencing a physical attack or assault with a weapon (compared to 3.9% in PL3). The high levels of heterosexist violence and harassment reported by participants in PL3 are indicative of findings in the 2014 General Social Survey, in which a greater proportion of bisexual (23.1%) and lesbian/gay (13.1%) participants reported being a victim of any physical or threatened violence in the past 12 months than heterosexual participants (7.8%) (McNair et al., 2017).

Overall, trans and gender diverse participants reported higher levels of harassment and abuse than cisgender participants. 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. Similarly, a greater proportion of non-binary participants (57.3%; n = 481), trans men (56.3%; n = 153) and trans women (52.4%; n = 131) reported being socially excluded in the past 12 months due to their sexual orientation or gender identity than cisgender women (38.6%; n = 1,016) and cisgender men (29.5%; n = 603).

6.4 Summary

PL3 participants reported high levels of heterosexist violence or harassment, with more than one third reporting verbal abuse, one quarter harassment and one in ten sexual assault in the past 12 months due to their sexual orientation or gender identity.

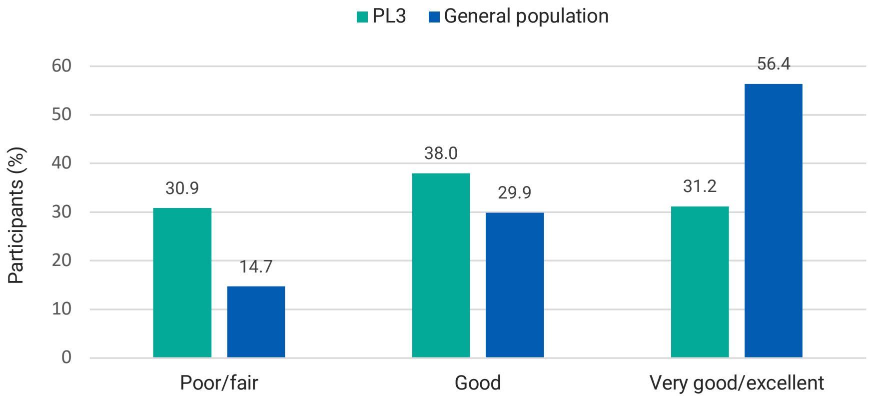
Despite efforts towards preventing and addressing stigma and discrimination of LGBTIQ people in Australia, including enhanced legal rights, these findings in PL3 are consistent with the findings of PL2, captured in 2011. In addition to the many social impacts on the lives who are victimised, experiences of discrimination and violence are commonly associated with poorer health. Previous research in Australia has found that verbal abuse and physical assault were associated with higher levels of feeling suicidal among gay and bisexual men (Abelson et al., 2006). Experiences of victimisation have also been shown to be associated with poorer self-rated physical health and other health-related indicators (Bariola et al., 2016) and the health and wellbeing of trans and gender diverse people was found to be associated with how they are treated by others (Dolan et al., 2020; Strauss et al., 2020).

7 General health and wellbeing

7.1 Self-rated general health

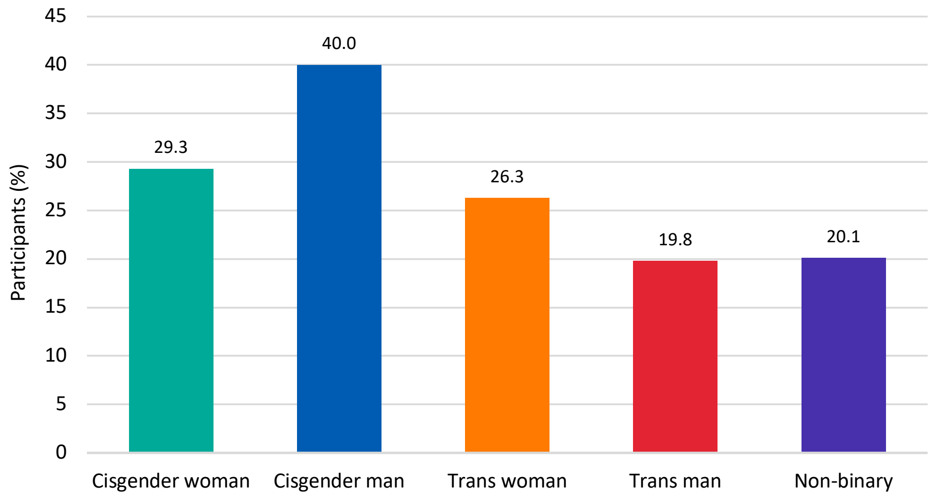
Participants were asked to rate their health on a 5-point scale from 'poor' to 'excellent.' Figure 8 displays these responses compared to the 2017-2018 National Health Survey (Australian Bureau of Statistics, 2018g).

Figure 8: General health (n = 6,792)



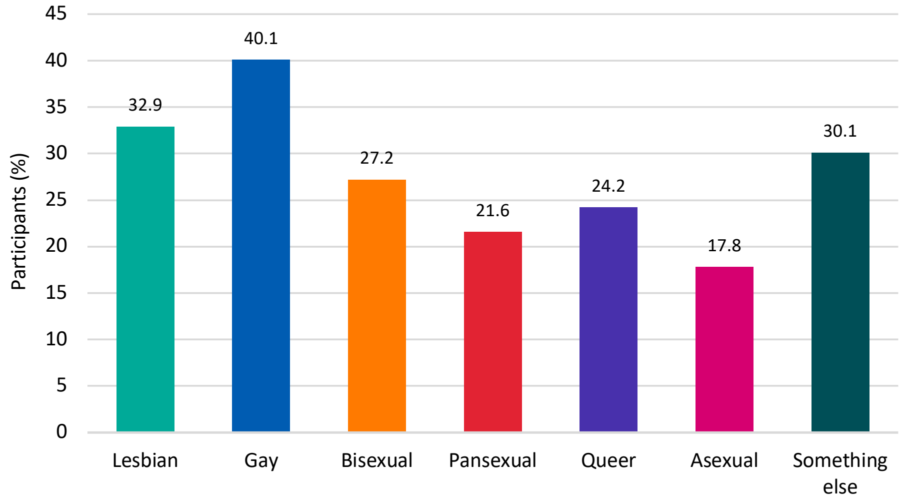
PL3 participants reported lower self-rated health than the general population. Over one quarter (30.9%; n = 2,097) rated their health as poor or fair compared to 14.7% of the general population and 17.9% of PL2 (Leonard et al., 2012). In addition, only three in ten (31.2%; n = 2,117) participants rated their health as very good or excellent compared to more than half (56.4%) of the general population aged over 15 years (Australian Bureau of Statistics, 2018g) and 51.5% of PL2 (Leonard et al., 2012).

Figure 9: 'Very good/excellent' general health by gender (n = 6,739)



Two fifths (40.0%; n = 926) of cisgender men rated their health as very good or excellent compared to three in ten cisgender women (29.3%; n = 858), one quarter of trans women (26.3%; n = 75) and one fifth of trans men (19.8%; n = 59) and non-binary participants (20.1%; n = 184).

Figure 10: ‘Very good/excellent’ general health by sexual orientation (n = 6,772)



Four in ten (40.1%; n = 781) gay identifying participants rated their health as very good or excellent, followed by three in ten (32.9%; n = 454) lesbian identifying and one quarter of bisexual (27.2%; n = 375) and queer (24.2%; n = 200) identifying participants. Approximately one fifth of pansexual (21.6%; n = 108) and asexual (17.8%; n = 38) identifying participants rated their health as very good or excellent.

7.2 Common health conditions

Participants were asked if they had been diagnosed with or treated for a range of health conditions in the past 12 months (mental health conditions are discussed in Section 8.2). Table 21 displays their responses.

Table 21: Health conditions diagnosed or treated in the past 12 months (n = 6,256)

Health condition	Number	%
Low iron level (iron deficiency or anemia)	1,072	17.1
Asthma	877	14.0
Hypertension (high blood pressure)	474	7.6
Sexually transmitted infection, not including HIV	409	6.5
Osteoarthritis	230	3.7
Other arthritis	217	3.5
Diabetes	204	3.3
Chronic fatigue	196	3.1
HIV	155	2.5
Heart disease (including heart attack, angina)	122	2.0
Cancer	108	1.7
Osteoporosis/osteopenia	81	1.3
Rheumatoid arthritis	80	1.3
Impaired glucose tolerance	75	1.2
Thrombosis (a blood clot)	43	0.7
Emphysema	29	0.5
Stroke	24	0.4

Viral hepatitis C	17	0.3
Viral hepatitis A or B	12	0.2
Other major illness	882	14.1
Any of these conditions	3,220	51.5

Note: multiple responses were available thus percentages do not add up to 100.

More than half (51.5%; n = 3,220) of participants reported one or more health conditions. The most commonly reported health conditions were low iron levels (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). By comparison, 47.3% of people reported one or more chronic health conditions[1] among the general Australian population in 2017-2018 (Australian Bureau of Statistics, 2018f), including 15.0% with arthritis, 11.2% asthma, 4.9% diabetes mellitus, 3.8% osteoporosis, 1.8% cancer and 4.8% heart, stroke and vascular disease.

Participants who reported they had been diagnosed or treated for cancer in the past 12 months were asked what type of cancer it was. The most common forms of cancer reported were skin cancer (non-melanoma) (n = 27), melanoma (n = 14), prostate cancer (n = 10) and leukemia (n = 10). Skin cancer is the most commonly reported form of cancer among the Australian general population, followed by prostate cancer and breast cancer (Australian Bureau of Statistics, 2018e).

7.3 Sexual health

7.3.1 HIV

Participants were asked if they had ever been tested for HIV. A little less than six in ten (58.8%; n = 4,015) reported having ever been tested and just under three in ten (29.4%; n = 2,008) reported having undergone testing in the past 12 months.

Half (50.0%; n = 1,165) of cisgender men had been tested for HIV in the past 12 months, followed by 32.3% (n = 92) of trans women, 26.7% (n = 264) of non-binary participants, 24.1% (n = 72) of trans men and 14.2% (n = 419) of cisgender women. Four in five (80.2%; n = 1,867) cisgender men had ever been tested for HIV, followed by six in ten (n = 173) trans women, one half (52.4%; n = 482) of non-binary participants, 46.5% (n = 139) of trans men and 44.9% (n = 1,321) of cisgender women.

Of participants who had ever undergone HIV testing, 3.9% (n = 155) reported that they were HIV-positive, 94.7% (n = 3,802) reported that they were HIV-negative, 1.2% (n = 49) did not know their HIV status and 0.2% (n = 9) preferred not to say. The highest proportion of HIV positive participants was cisgender men (7.9%; n = 148), followed by 1.2% (n = 2) of trans women, 0.4% (n = 2) of non-binary participants and 0.1% (n = 1) of cisgender women. No trans men reported being HIV positive. Of those who were HIV-positive, 98.7% (n = 153) reported that they were taking combination antiretroviral therapy, while 94.8% (n = 147) reported that they had an undetectable viral load in their last test, 3.9% (n = 6) reported a detectable viral load and 1.3% (n = 2) reported that they 'don't know.'

7.3.2 Hepatitis C

Participants were asked if they had ever undertaken hepatitis C testing. Over half (53.5%; n = 3,652) reported having ever been tested for hepatitis C and one quarter (25.0%; n = 1,706) reported having undergone testing in the past 12 months. Of participants who had undergone hepatitis C testing, 95.5% (n = 3,488) were negative, 1.8% (n = 65) had been positive but were now negative following successful treatment, 0.1% (n = 3) were positive and currently receiving treatment, 0.2% (n = 8) were positive and not currently receiving treatment, 2.3% (n = 84) did not know their current hepatitis C status and 0.1% (n = 3) preferred not to say. Of those who had ever been diagnosed positive for hepatitis C (n = 76), 92.1% (n = 70) reported having accessed treatments and 30.1% (n = 22) also reported being HIV-positive.

7.3.3 Pre-Exposure Prophylaxis (PrEP)

PrEP involves HIV-negative people taking antiretroviral drugs to prevent them from acquiring HIV. Almost three quarters (73.3%; n = 5,007) of participants reported having ever heard of PrEP. Cisgender men reported the highest awareness of PrEP (89.4%; n = 2,081), compared to 59.3% (n = 1,746) of cisgender women, 74.3% (n = 223) of trans men, 68.4% (n = 195) of trans women and 78.7% (n = 723) of non-binary participants.

Of participants who had ever heard of PrEP, 10.5% (n = 526) had successfully accessed it in the past 12 months. Almost one quarter of cisgender men (22.7%; n = 472) had successfully accessed it in the past 12 months, followed by 6.7% of trans men (n = 15), 6.2% of trans women (n = 12), 3.3% (n = 524) of non-binary participants and 0.1% (n = 1) of cisgender women.

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[1] The selected chronic health conditions among the general Australian population were as follows: arthritis, asthma, back problems, cancer, chronic obstructive pulmonary disease (COPD), diabetes mellitus, heart, stroke and vascular disease, kidney disease, mental and behavioural conditions and osteoporosis.

Some participants (1.3%; n = 66) had tried to access PrEP but were not successful. Overall, 2.8% (n = 58) of cisgender men had tried to access PrEP but were not successful in the past 12 months, followed by 1.5% (n = 3) of trans women, 0.4% (n = 3) of trans men and 0.4% (n = 3) of non-binary participants. There were no cisgender women who reported trying but not being successful in accessing PrEP.

7.3.4 Post-Exposure Prophylaxis (PEP)

PEP is a 4-week course of anti-HIV medication that is shown to be effective in preventing HIV infection if started within 72 hours of exposure. Six in ten (60.5%; n = 4,127) participants reported having ever heard of PEP. Cisgender men reported the highest awareness of PEP (77.3%; n = 1,799). This compared to 47.2% (n = 1,390) of cisgender women, 55.9% (n = 167) of trans men, 50.2% (n = 143) of trans women and 65.1% (n = 598) of non-binary participants.

Of participants who had ever heard of PEP, 2.1% (n = 88) had successfully accessed it in the past 12 months. Around one in thirty cisgender men (3.9%; n = 70) reported successfully accessing it in the past 12 months, followed by 4.2% (n = 3) of trans men, 2.1% (n = 4) of trans women, 0.7% (n = 4) of non-binary participants and 0.2% (n = 3) of cisgender women.

Of participants who had ever heard of PEP, 0.8% (n = 33) had tried to access it but were not successful. Around one in eighty cisgender men (1.2%; n = 22) reported that they had tried to access it but were not successful, followed by 0.5% (n = 6) of cisgender women, 0.7% (n = 4) of non-binary participants and 0.6% (n = 1) of trans men. There were no trans women who reported trying but not being successful in accessing PEP.

7.4 Summary

PL3 participants reported lower self-rated health and a higher burden of certain health conditions, particularly sexually transmitted infections and HIV, than the general Australian population.

Important differences were apparent in general health across different groups, with cisgender men and gay identifying participants consistently reporting higher levels of self-rated health than trans and gender diverse and pansexual, bisexual and queer identifying participants. It is notable that this pattern reflects findings in Chapters 5 and 6, in which cisgender men and gay identifying participants reported lower levels of discrimination and harassment, higher perceived acceptance in non-LGBTIQ settings such as places of work and healthcare settings and lower levels of homelessness or barriers to secure housing than trans and gender diverse and pansexual, bisexual and queer identifying participants, which may reflect links between stigma and health (Hatzenbuehler et al., 2013). Addressing stigma, including issues related to accessing inclusive and affirmative health services, is likely to play an important part in improving health outcomes.

Further disparities were also apparent regarding sexual health knowledge and access among populations at risk for HIV, with cisgender men and gay identifying participants reporting higher awareness and access to PrEP and PEP than trans and gender diverse participants. Consistent with this, the 2018 Australian Trans and Gender Diverse Sexual Health Survey found that trans and gender diverse people reported experiences of marginalisation in sexual healthcare and sex education (Callander et al., 2019).

8 Mental health and wellbeing

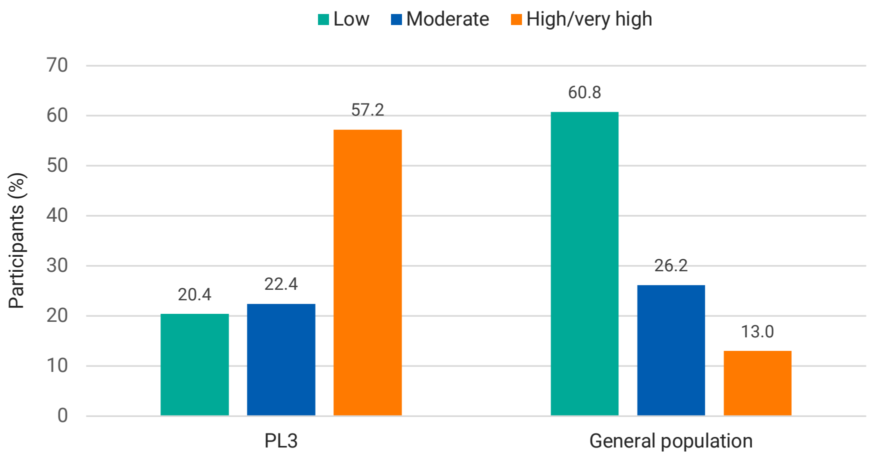
There is a substantial body of research revealing that LGBT communities experience higher rates of depression and anxiety than the general population (Bostwick et al., 2010; Corboz et al., 2008; Herek & Garnets, 2007; King et al., 2008; McNair et al., 2011; Szalacha et al., 2017), which has been associated with stigma, prejudice and discrimination that creates a hostile and stressful social environment (Hatzenbuehler, 2009; Meyer, 2003). Previous research has revealed that LGBTQ people have comparatively higher levels of suicidal ideation and suicide attempts than in general populations (King et al., 2008).

8.1 Psychological distress (K10)

The Kessler Psychological Distress Scale (K10) is a ten-item standard scale developed to measure psychological distress. It includes questions that cover symptoms of depression and anxiety, with items answered in relation to experiences over the past four weeks. Total scores on the scale range from 10 to 50, with a higher score indicating higher levels of psychological distress. Scores of less than 20 are clinically regarded as low risk or normal.

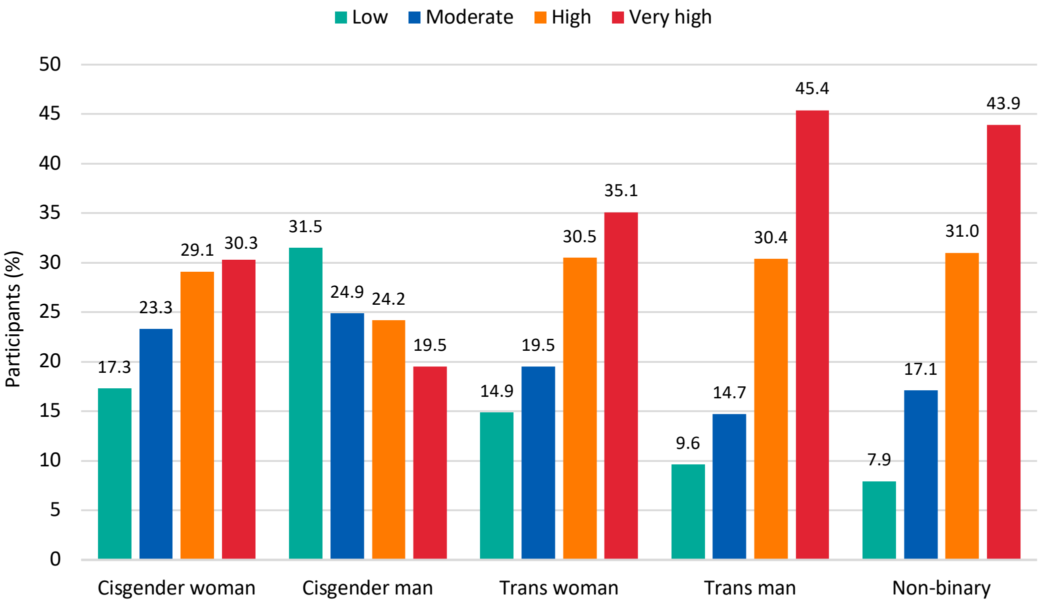
The mean K10 score in PL3 was 24.3 (with a standard deviation of 9.2), thus trending toward poorer mental health overall than PL2 where the mean K10 score was 19.6 (Leonard et al., 2012).

Figure 11: Proportion of participants experiencing low, moderate, high or very high psychological distress (n = 6,676)



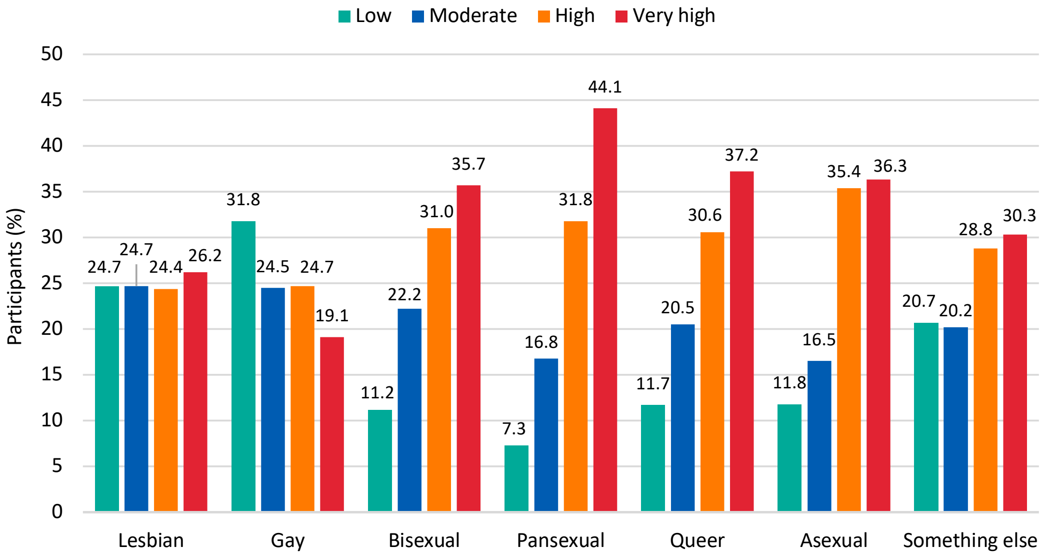
K10 scores were classified as either low, moderate, high or very high psychological distress according to criteria used by the ABS (Australian Bureau of Statistics, 2017d). Approximately two fifths of participants in PL3 reported experiencing low (20.4%; n = 1,364) or moderate (22.4%; n = 1,494) levels of psychological distress. Over one quarter (27.8%; n = 1,855) reported high levels of psychological distress and 29.4% (n = 1,963) reported very high distress. Overall, more than half (57.2%; n = 3,818) of participants reported high or very high levels of psychological distress. This is four times higher than the proportion of people reporting high or very high levels of psychological distress among the general population (13.0%) (Australian Bureau of Statistics, 2018h).

Figure 12: Proportion of participants experiencing low, moderate, high or very high psychological distress by gender (n = 6,627)



When analysed by gender, almost three quarters (75.8%; n = 222) of trans men, 65.6% (n = 185) of trans women and 74.9% (n = 674) of non-binary participants reported experiencing high or very high levels of psychological distress. This compared to 59.4% (n = 1,708) of cisgender women and 43.7% (n = 993) of cisgender men.

Figure 13: Proportion of participants experiencing low, moderate, high or very high psychological distress by sexual orientation (n = 6,658)



When analysed by sexual orientation, three quarters (75.9%; n = 375) of participants who identified as pansexual, 66.7% (n = 902) as bisexual, 71.7% (n = 152) as asexual and 67.8% (n = 556) as queer reported experiencing high or very high levels of psychological distress. This compared to 50.6% (n = 685) of lesbian and 43.7% (n = 837) of gay identifying participants.

8.2 Mental health diagnoses

Previous research has found that LGBTQ people are more likely to be diagnosed with depression and anxiety than the general population (Fergusson et al., 1999; Ross et al., 2018). Participants were asked if they had ever been diagnosed with one or more mental health conditions at some point in their lives. Participants who reported having ever been diagnosed with a mental health condition at some point during their lives were then asked if they had been diagnosed or treated for that condition in the past 12 months. Table 22 displays these results along with the 12-month prevalence rates for mental health conditions (defined as people who met the criteria for diagnosis of a mental disorder) in the general Australian population from the 2007 National Survey of Mental Health and Wellbeing (Slade et al., 2009).

Table 22: Ever diagnosed with one or more mental health conditions and diagnosed or treated in the past 12 months (n = 6,554) by prevalence rates among the general Australian population in the past 12 months

	PL3				General population
	Ever		Past 12 months		Past 12 months
Condition	**Number**	**%**	**Number**	**%**	**%**
Depression	3,965	60.5	2,562	39.1	4.1
Generalised anxiety disorder	3,093	47.2	2,186	33.4	2.7
Post-traumatic stress disorder	1,194	18.2	729	11.1	6.4
Eating disorder	685	10.5	216	3.3	-
Social phobia	518	7.9	260	4.0	4.7
Panic disorder	504	7.7	287	4.4	2.6
Obsessive-compulsive disorder	402	6.1	201	3.1	1.9
Bipolar disorder	371	5.7	241	3.7	1.8
Agoraphobia	145	2.2	65	1.0	2.8
Schizophrenia	59	0.9	33	0.5	-
Other mental health challenge	874	13.3	607	9.3	-
Any of the above	4,794	73.2	3,404	51.9	20.0

Nearly three quarters (73.2%; n = 4,794) of participants reported having ever been diagnosed with a mental health condition at some point during their lives. This compares to 45.5% among the general Australian population[2] (Slade et al., 2009). Six in ten (60.5%; n = 3,965) participants reported having ever been diagnosed with depression and almost half (47.2%; n = 3,093) with generalised anxiety disorder. Almost one in five (18.2%; n = 1,194) had been diagnosed with post-traumatic stress disorder and one in ten (10.5%; n = 685) an eating disorder.

One in two participants (51.9%; n = 3,404) reported being diagnosed or treated for a mental health condition in the past 12 months. This is more than twice the 20% reported among the general Australian population[3] (Slade et al., 2009). Four in ten (39.1%; n = 2,562) participants reported having been diagnosed or treated for depression in the past 12 months, nearly ten times the 4.1% reporting 'a depressive episode' in the past 12 months in the general population (Slade et al., 2009). One third (33.4%; n = 2,186) reported having been diagnosed or treated for generalised anxiety disorder in the past 12 months, more than ten times the 2.7% among the general population (Slade et al., 2009) and one in ten (11.1%; n = 729) reported having been diagnosed or treated for post-traumatic stress disorder in the past 12 months, almost double the 6.4% among the general population (Slade et al., 2009).

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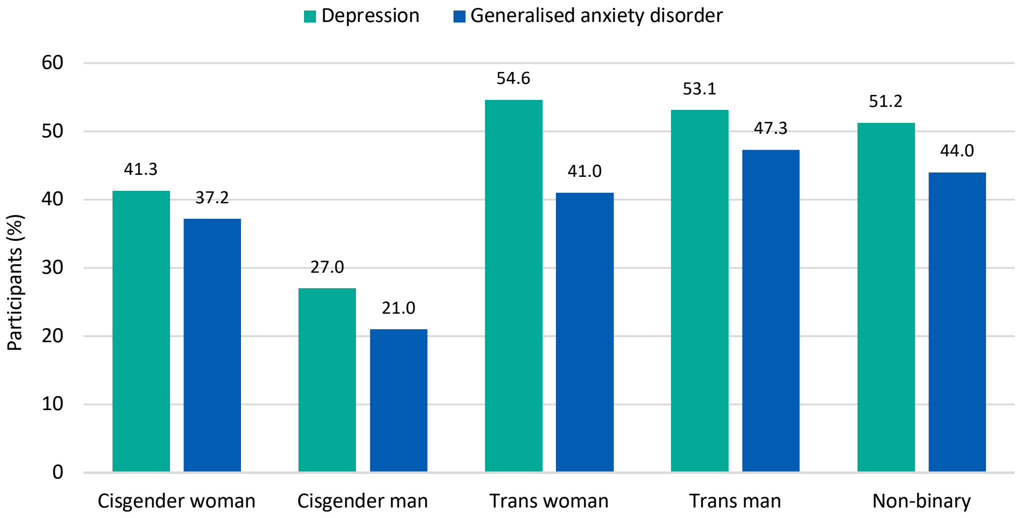
[2] This figure includes 24.7% of participants who reported lifetime 'substance use disorders'.

[3] This figure includes 5.1% of participants who reported 'substance use disorders' in the past 12 months.

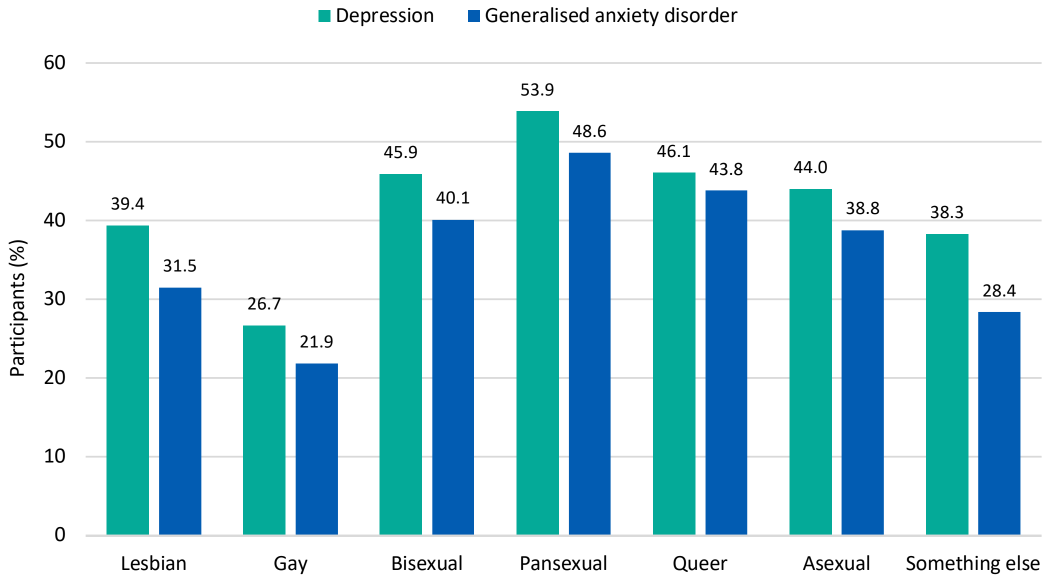
Figure 14: Diagnosed or treated for depression or generalised anxiety disorder in the past 12 months by gender (n = 6,502)



More than half of trans men (53.1%; n = 156), trans women (54.6%; n = 149) and non-binary participants (51.2%; n = 465) reported being diagnosed or treated for depression in the past 12 months. This compared to 41.3% (n = 1,174) of cisgender women and 27.0% (n = 588) of cisgender men.

Nearly half of trans men (47.3%; n = 139) and over four in ten trans women (41.0%%; n = 112) and non-binary participants (44.0%; n = 400) reported being diagnosed or treated for generalised anxiety disorder in the past 12 months. This compared to 37.2% (n = 1,058) of cisgender women and 21.0% (n = 458) of cisgender men.

Figure 15: Diagnosed or treated for depression or generalised anxiety disorder in the past 12 months by sexual orientation (n = 6,537)



More than half of pansexual identifying participants (53.9%; n = 156) reported being diagnosed or treated for depression in the past 12 months, followed by 46.1% (n = 379) of queer, 45.9% (n = 620) of bisexual, 44.0% (n = 92) of asexual, 29.4% (n = 523) of lesbian and 26.7% (n = 488) of gay identifying participants.

Nearly half of pansexual identifying participants (48.6%; n = 238) reported being diagnosed or treated for generalised anxiety disorder in the past 12 months, followed by 43.8% (n = 360) of queer, 40.1% (n = 542) of bisexual, 38.8% (n = 81) of asexual, 31.5% (n = 418) of lesbian and 21.9% (n = 401) of gay identifying participants.

8.3 Suicidal ideation and suicide attempts

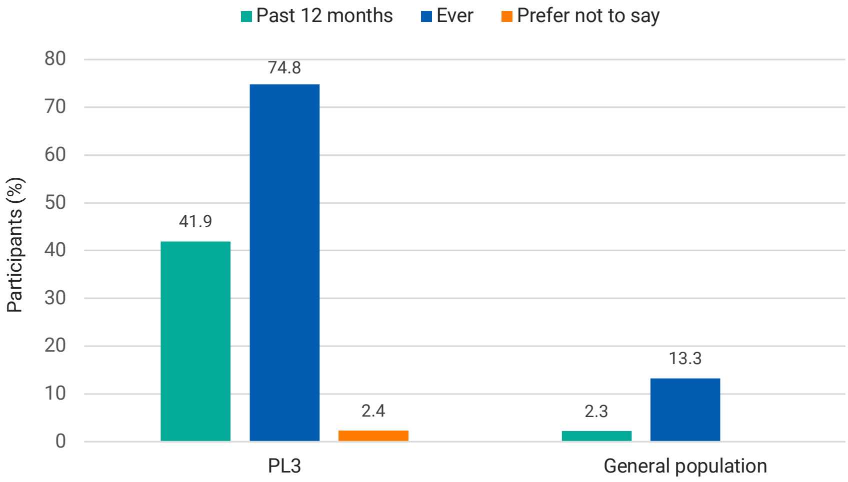
Suicide is a major public health issue. It is the leading cause of death among people aged between 15 and 44 years in Australia (Australian Bureau of Statistics, 2019d) and accounts for the highest number of years of potential life lost among leading causes of death in the general Australian population (Australian Bureau of Statistics, 2019c). Previous research has revealed that LGBTQ people have comparatively higher levels of suicidal ideation and suicide attempts than the general population internationally (King et al., 2008), while gay and bisexual men in Australia were more at risk for suicidality than heterosexual men (Abelson et al., 2006). An analysis of the Queensland Suicide Register also found that depression was more frequently mentioned in suicide cases involving LGBT people compared to non-LGBT people (Skerrett et al., 2014).

PL3 asked participants about suicidal ideation, 'have you experienced thoughts about suicide, wanting to die or about ending your life' and suicide attempts, 'have you attempted suicide or to end your life.'

Previous research has repeatedly found that asking people about suicide does not increase suicide risk (Mathias et al., 2012). However, as a precaution, online and telephone resources were provided to participants, including contact details for QLife, Lifeline, Beyondblue, suicide call-back services and emergency services, prior to these questions appearing in the survey. Participants were also given the option to skip the survey section on suicide by selecting 'I prefer not to answer these questions' without viewing the questions and, for those who chose to respond to the questions, an option was further provided for each question where they could select 'prefer not to answer.'

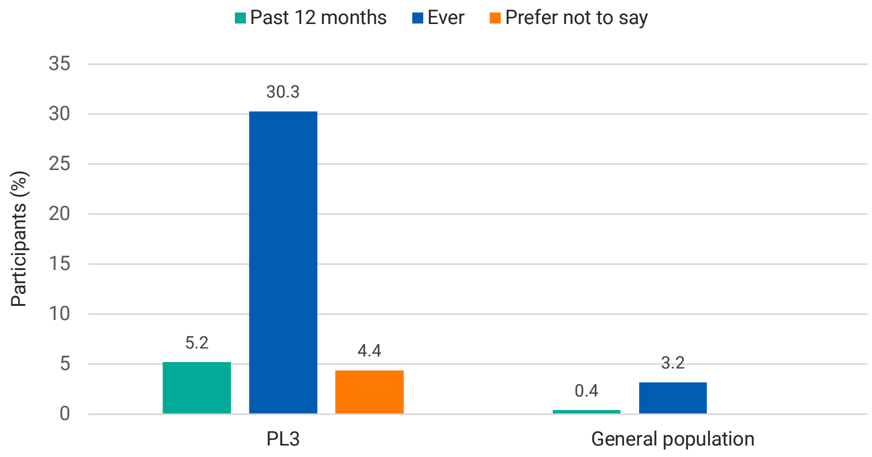
Figures 16 and 17 display the responses to these questions. Note, participants who skipped the section by indicating 'I prefer not to answer these questions' and those who selected 'prefer not to answer' for a particular question were combined to form a single category of 'prefer not to say.' For comparison purposes, Figures 16 and 17 also display general population data from the 2007 National Survey of Mental Health and Wellbeing (Johnston et al., 2009).

Figure 16: Suicidal ideation (n = 6,799) in the past 12 months and ever among PL3 participants and the general Australian population



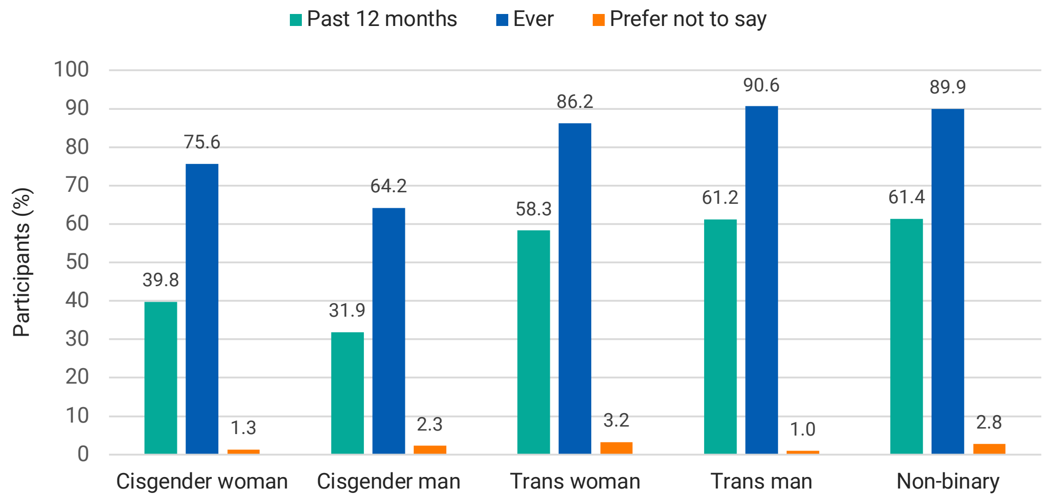
Over one in four (41.9%; n = 2,848) participants reported that they had considered attempting suicide in the previous 12 months, almost twenty times higher than the 2.3% reported among the general Australian population (Johnston et al., 2009). Almost three quarters (74.8%; n = 5,084) reported having ever considered attempting suicide at some point during their lives, which is more than five times higher than the 13.3% reported among the general Australian population (Johnston et al., 2009).

Figure 17: Suicide attempts (n = 5,306) in the past 12 months and ever among PL3 participants and the general Australian population



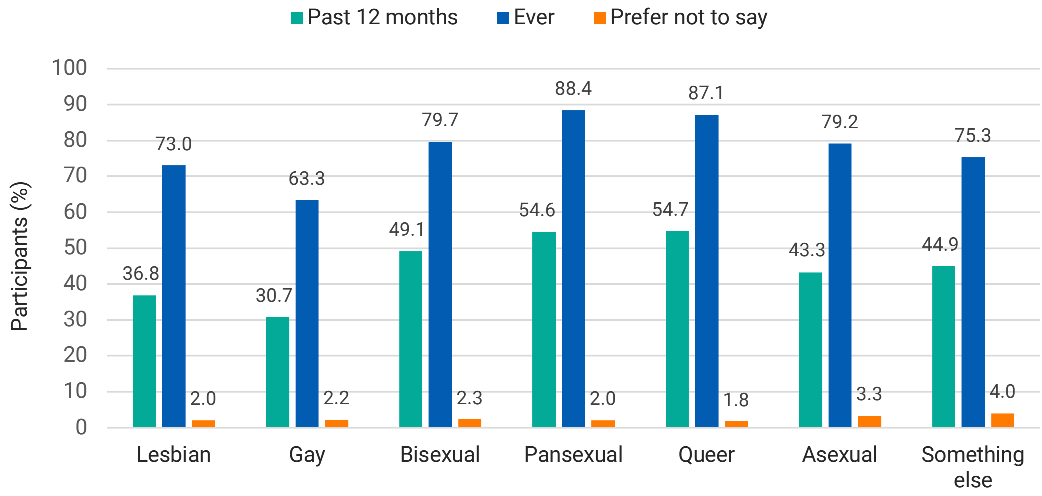
One in twenty (5.2%; n = 274) reported having attempted suicide in the past 12 months, ten times higher than the 0.4% reported among the general Australian population (Johnston et al., 2009). Over one in three (30.3%; n = 1,606) reported having ever attempted suicide at some point during their lives, which is eight times higher than the 3.2% reported among the general Australian population (Johnston et al., 2009).

Figure 18: Suicidal ideation in the past 12 months and ever by gender (n = 6,747)



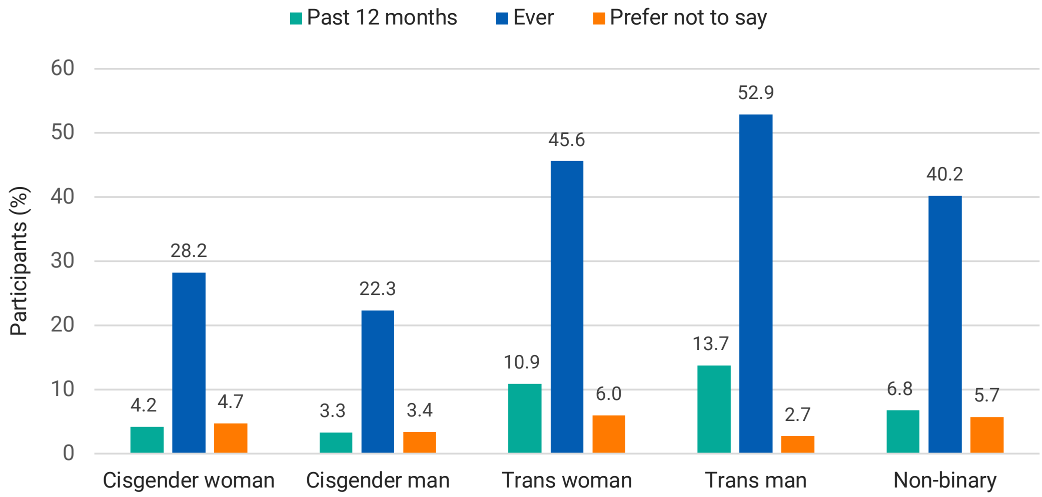
Six in ten (61.2%; n = 183) trans men, 58.3% (n = 165) of trans women and 61.4% (n = 562) of non-binary participants reported having seriously considered attempting suicide in the past 12 months compared to four in ten (39.8%; n = 1,168) cisgender women and 31.9% (n = 740) of cisgender men. Nine in ten (90.6%; n = 271) trans men, 86.2% (n = 244) of trans women and 89.9% (n = 823) of non-binary participants reported having ever seriously considered attempting suicide compared to 75.6% (n = 2,218) of cisgender women and 64.2% (n = 1,488) of cisgender men.

Figure 19: Suicidal ideation in the past 12 months and ever by sexual orientation (n = 6,779)



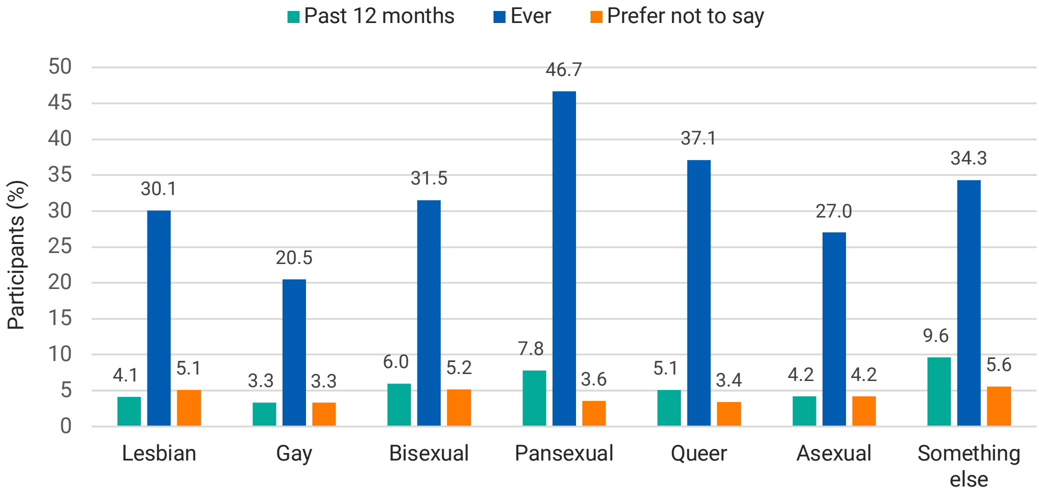
A greater proportion of pansexual (54.6%; n = 274), queer (54.7%; n = 452) and bisexual (49.1%; n = 679) identifying participants reported having seriously considered attempting suicide in the past 12 months compared to 43.4% (n = 92) of asexual, 36.8% (n = 509) of lesbian and 30.7% (n = 599) of gay identifying participants. Almost nine in ten pansexual (88.4.%; n = 444) and queer (87.1%; n = 720) identifying participants reported having ever seriously considered attempting suicide, followed by 79.7% (n = 1,103) of bisexual, 79.2% (n = 168) of asexual, 73.0% (n = 1,009) of lesbian and 63.3% (n = 1,234) of gay identifying participants.

Figure 20: Suicide attempts in the past 12 months and ever by gender (n = 5,263)



One in seven (13.7%; n = 36) trans men, 10.9% (n = 27) of trans women and 6.8% (n = 54) of non-binary participants reported having attempted suicide in the past 12 months compared to 4.2% (n = 76) of cisgender women and 3.3% (n = 56) of cisgender men. Over half (52.9%; n = 139) of trans men, 45.6% (n = 113) of trans women and 40.2% (n = 318) of non-binary participants reported having ever attempted suicide compared to 28.2% (n = 636) of cisgender women and 22.3% (n = 380) of cisgender men.

Figure 21: Suicide attempts in the past 12 months and ever by sexual orientation (n = 5,291)



In total, 7.8% (n = 33) of pansexual, 6.0% (n = 69) of bisexual, 5.1% (n = 35) of queer, 4.2% (n = 8) of asexual, 4.1% (n = 42) of lesbian and 3.3% (n = 46) of gay identifying participants reported having attempted suicide in the past 12 months. Almost one in two pansexual (46.7%; n = 197) participants reported having ever attempted suicide, followed by 37.1% (n = 255) of queer, 31.5% (n = 361) of bisexual, 30.1% (n = 305) of lesbian, 27.0% (n = 51) of asexual and 20.5% (n = 287) of gay identifying participants.

8.4 Summary

PL3 participants reported much higher rates of mental health challenges, particularly depression and anxiety, high and very high levels of psychological distress as well as suicidal ideation and suicide attempts, than is observed in studies of the general population in Australia. Consistent with previous studies, trans and gender diverse participants reported higher levels of psychological distress than cisgender participants (Leonard et al., 2012; Strauss et al., 2017) and should be considered in light of the higher levels of discrimination and abuse reported by this population (Chapter 6). With regard to sexual orientation, the overall patterns for pansexual identifying participants suggested poorer mental health compared to other groups. Bisexual identifying participants also tended to report overall poorer mental health compared to lesbian or gay identifying participants. Previous studies have also found bisexual people report poorer mental health than their gay or lesbian counterparts (Leonard et al., 2012; Taylor et al., 2019).

However, it is important to note that although cisgender women and cisgender men reported better overall mental health and wellbeing when compared to other participants in PL3, they were much lower than among the general Australian population. Thus, addressing mental health challenges is a significant issue for all groups, but PL3 data suggests that trans and gender diverse people carry a disproportionate burden, which requires particular attention.

9 Health service engagement

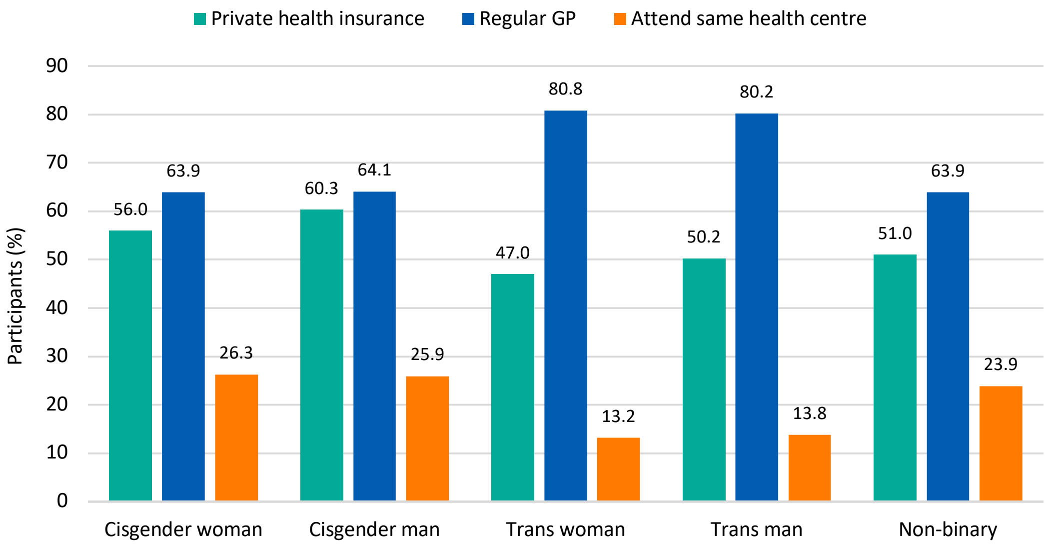
9.1 Medicare and health insurance

The vast majority (96.6%; n = 6,599) of participants reported that they were currently eligible to access Medicare. Over one third (37.4%; n = 40) of participants who reported being ineligible to access Medicare were Australian citizens, 30.8% (n = 33) were international students and 23.3% (n = 25) were on working visas. Just over half of participants (56.2%; n = 3,831) had private health insurance, slightly lower than PL2 (60%) but similar to the general Australian population (57.1%) aged 18 years and over (Australian Bureau of Statistics, 2017a).

9.2 Regular general practitioner

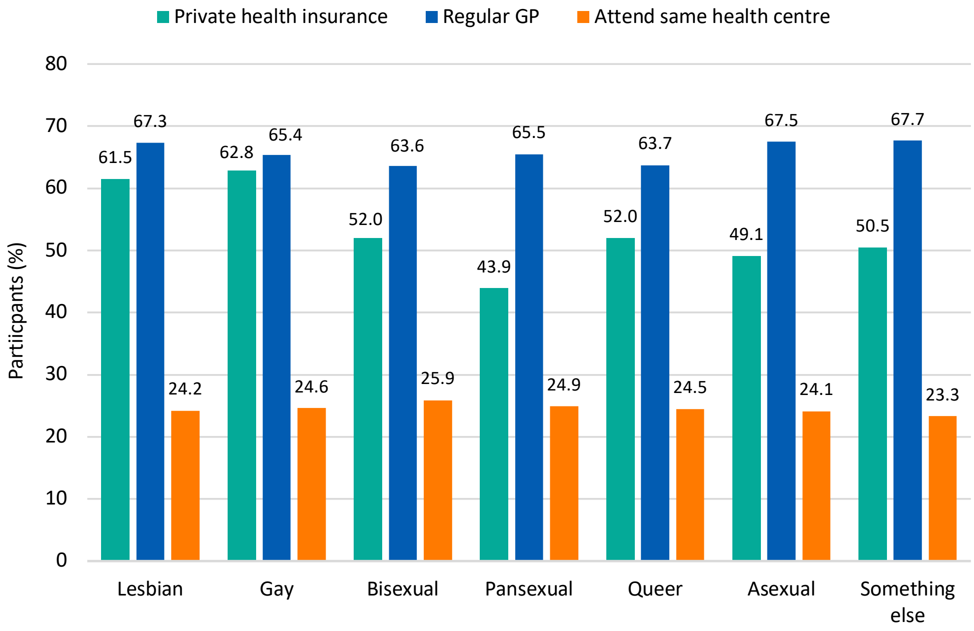
Slightly less than two thirds (65.5%; n = 4,456) of participants reported having a regular General Practitioner (GP) compared to almost 70% in PL2 and 81% of female patients and 73% of male patients in the general Australian population (Royal Australian College of General Practitioners, 2017). A further one quarter (24.7%; n = 1,679) reported that they did not have a regular GP but attended the same health centre. Nearly one in ten (9.8%; n = 670) participants reported not having a regular GP and attending different health centres. Nearly four fifths (78.2%; n = 5,342) reported seeing a GP at least twice a year and one third (32.1%; n = 2,195) at least quarterly.

Figure 22: Private health insurance (n = 6,767) and regular GP or attending same health centre by gender (n = 6,753)



Six in ten (60.3%; n = 1,402) cisgender men reported having private health insurance, followed by 56.0% (1,649) of cisgender women, 51.0% (n = 468) of non-binary participants, 50.2% (n = 149) of trans men and 47.0% (n = 134) of trans women. Eight in ten trans women (80.8%; n = 227) and trans men (80.2%; n = 239) reported having a regular GP, followed by almost two thirds of cisgender men (64.1%; n = 1,484), cisgender women (63.9%) and non-binary participants (63.9%).

Figure 23: Private health insurance (n = 6,800) and regular GP or attending same health centre by sexual orientation (n = 6,785)



Six in ten lesbian (61.5%; n = 857) and gay (62.8; n = 1,227) identifying participants reported having private health insurance compared to one in two bisexual (52.0%; n = 720), queer (52.0%; n = 432) and asexual (49.1%; n = 104) identifying participants. Fewer pansexual identifying participants reported having private health insurance than any other sexual orientation.

9.3 Experiences of health services

The following data present findings relating to three possible groupings of health services: those that are 'mainstream'; those that are 'mainstream but known to be LGBTIQ-inclusive'; and those that 'only cater to lesbian, gay, bisexual, transgender and/or intersex people.' When interpreting responses to questions using this terminology, please note the following: 1) preference for a particular service may be shaped by prior awareness or familiarity with the service (e.g., awareness of or access to services that cater only to lesbian, gay, bisexual, transgender and/or intersex people); 2) interpretations of 'mainstream but known to be LGBTIQ-inclusive' may vary and likely take into account a range of known or perceived service attributes, such as displays of LGBTIQ-related imagery, existence of LGBTIQ supportive policy and/or formal accreditation of services as LGBTIQ culturally safe environments; 3) the preference for a service may be context, time and situation dependent, in that one form of service may be preferred for particular health conditions or because the issue of concern has greater perceived connection to LGBTIQ identity or communities than others; and 4) these questions were not multiple choice, hence participants with multiple preferences may not be fully represented. As such, findings presented here should be viewed as broadly indicative of service preferences. Further research is required to better understand the characteristics of services valued by LGBTIQ communities and how preferences intersect with context, awareness and perceived accessibility, as well as how these vary among different LGBTIQ communities.

Participants were asked if they had used a range of health services in the past 12 months. They were then asked to what extent they felt that their sexual orientation or gender was respected at each of the services they reported using in the past 12 months. Table 23 displays the numbers and percentages of participants who accessed each service.

Table 23: Health services accessed in the past 12 months (n = 6,808)

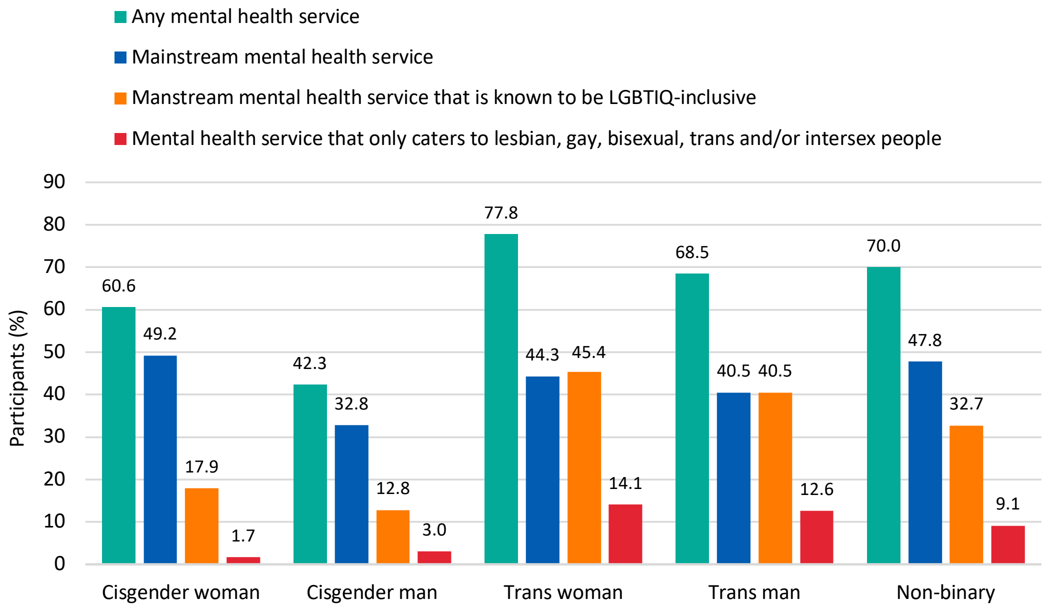
Service use in past 12 months	Number	%
Mainstream medical clinic	5,684	83.5
Mainstream mental health service (e.g., psychologist, counsellor)	2,371	34.8
Hospital	2,400	35.3
Allied health service (e.g., physiotherapist, osteopath)	1,989	29.2
Mainstream medical clinic that is known to be LGBTIQ-inclusive	1,699	25.0
Mainstream mental health service that is known to be LGBTIQ-inclusive	1,190	17.5
Medical clinic catering only to lesbian, gay, bisexual, transgender and/or intersex people	389	5.7
Mental health service catering only to lesbian, gay, bisexual, transgender and/or intersex people	259	3.8

Mainstream health services were more frequently accessed by participants than health services that were known to be LGBTIQ-inclusive or that catered only to lesbian, gay, bisexual, trans and/or intersex people. The health service most commonly accessed by participants in the past 12 months was a mainstream medical clinic (82.3%; n = 5,684), followed by a mainstream mental health service (34.2%; n = 34.8), hospital (35.3%; n = 2,400) and an allied health service (29.2%; n = 1,989). Medical clinics that cater only to lesbian, gay, bisexual, trans and/or intersex people were accessed by approximately one in twenty (5.7%; n = 389) participants and mental health services that cater only to lesbian, gay, bisexual, trans and/or intersex people were accessed by 3.8% (n = 259) of participants.

9.3.1 Experiences of health services among participants reporting psychological distress

Of participants in the PL3 sample who reported high or very high levels of psychological distress (defined as a K10 score between 22 and 50 (Australian Bureau of Statistics, 2017d), six in ten (58.9%; n = 2,242) reported having accessed any mental health service in the past 12 months. Specifically, four in ten (44.0%; n = 1,672) reported having accessed a mainstream mental health service, 21.9% (n = 834) a mainstream mental health service known to be LGBTIQ-inclusive and 4.7% (n = 179) a mental health service that caters only to lesbian, gay, bisexual, trans and/or intersex people.

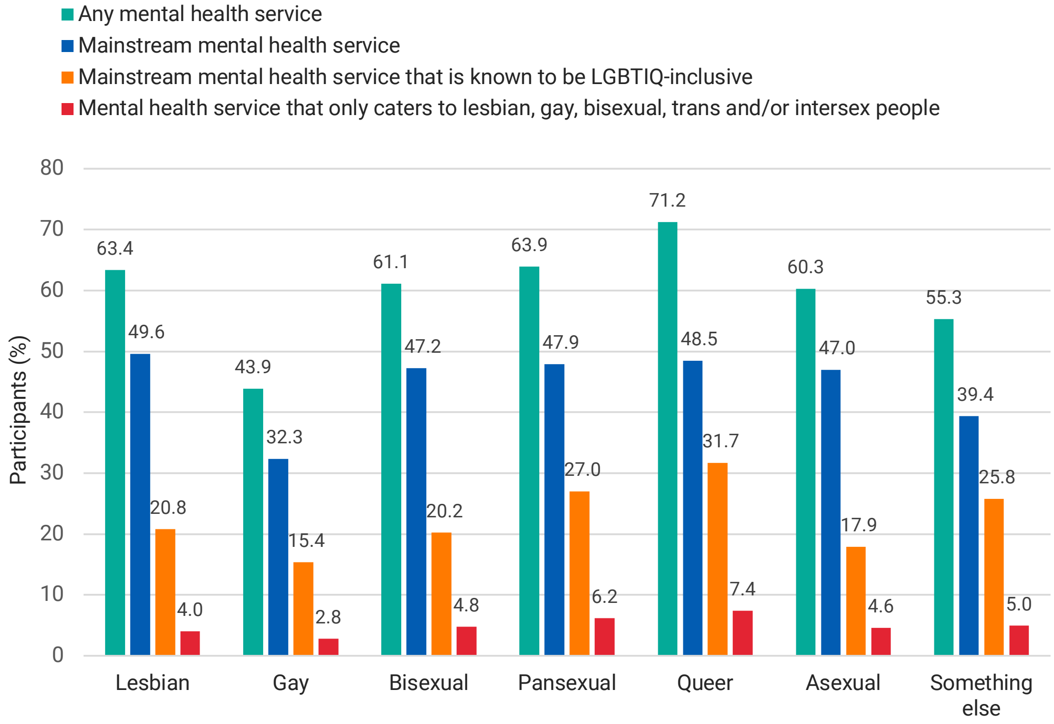
Figure 24: Mental health service access in the past 12 months among participants reporting high or very high levels of psychological distress by gender (n = 3,768)



Almost eight in ten (77.8%; n = 144) trans women who reported high or very high levels of psychological distress reported having accessed a mental health service in the past 12 months, followed by seven in ten non-binary participants (70.0%; n = 469) and trans men (68.5%; n = 152) and six in ten (60.6%; n = 1,032) cisgender women. Only four in ten (42.3%; n = 418) cisgender men who reported high or very high levels of psychological distress reported having accessed a mental health service in the past 12 months.

A greater proportion of trans men (40.5%; n = 90), trans women (45.4%; n = 84) and non-binary participants (32.7%; n = 219) who reported high or very high levels of psychological distress accessed a mental health service that is known to be LGBTIQ-inclusive than cisgender women (17.9%; n = 305) and cisgender men (12.8%; n = 126). Similarly, a greater proportion of trans women (14.1%; n = 26), trans men (12.6%; n = 29) and non-binary participants (9.1%; n = 61) accessed a mental health service that caters only to lesbian, gay, bisexual, trans and/or intersex people than cisgender men (3.0%; n = 30) and cisgender women (1.7%; n = 29). In the latter case, this likely reflects the small number of such services in Australia and their currently limited capacity to address these concerns.

Figure 25: Mental health service access in the past 12 months among participants reporting high or very high levels of psychological distress by sexual orientation (n = 3,795)



Gay identifying participants comprised the lowest proportion (43.9%; n = 365) of participants who reported high or very high levels of psychological distress and who reported having accessed a mental health service in the past 12 months. This compared to seven in ten queer (71.2%; n = 395) identifying participants and approximately six in ten lesbian (63.4%; n = 433), bisexual (61.1%; n = 549), pansexual (63.9%; n = 239) and asexual (60.3%; n = 91) identifying participants. Almost one third (31.7%; n = 176) of queer identifying and one quarter (27.0%; n = 101) of pansexual identifying participants reported accessing a mainstream mental health service known to be LGBTIQ-inclusive, compared to 20.2% (n = 181) of bisexual, 17.9% (n = 27) of asexual, 20.8% (n = 142) of lesbian and 15.4% (n = 128) of gay identifying participants. Likewise, slightly more of the queer (7.4%; n = 41) and pansexual (6.2%; n = 23) identifying participants reported accessing a mental health service that caters only to lesbian, gay, bisexual, trans and/or intersex people than bisexual (4.8%; n = 43), asexual (4.6%; n = 7), lesbian (4.0%; n = 27) or gay (2.8%; n = 23) identifying participants.

Table 24 displays the percentage of participants who had accessed each service in the past 12 months and who reported that they felt that their sexual orientation or gender identity was 'very respected' or 'extremely respected' when accessing them.

Table 24: Proportion of participants who had accessed each health service and felt that their sexual orientation or gender identity was very/extremely respected in the past 12 months

	Sexual orientation very/ extremely respected		Gender identity very/ extremely respected	
	Number	%	Number	%
Mainstream medical clinic	3,166	58.6	480	37.7
Mainstream mental health service (e.g., psychologist, counsellor)	1,649	71.9	383	57.0
Hospital	1,251	55.2	223	35.4
Allied health service (e.g., physiotherapist, osteopath)	1,342	71.3	240	52.2
Mainstream medical clinic that is known to be LGBTIQ-inclusive	1,492	90.7	471	78.6
Mainstream mental health service that is known to be LGBTIQ-inclusive	1,045	90.9	443	81.9
Medical clinic catering only to lesbian, gay, bisexual, transgender and/or intersex people	351	94.9	165	90.2
Mental health service catering only to lesbian, gay, bisexual, transgender and/or intersex people	220	89.8	136	87.7

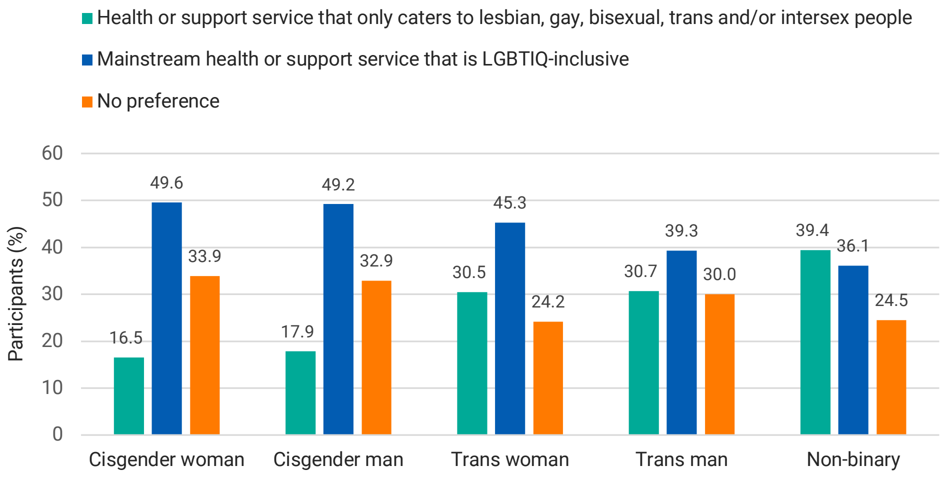
Note: responses were analysed among participants who reported that a situation was applicable to them therefore an overall 'n' is not provided.

Although mainstream medical clinics were the most frequently accessed health service in the past 12 months, they had the lowest proportion of participants who felt that their sexual orientation or gender identity was very/extremely respected (58.6%; n = 3,166 and 37.7%; n = 480 respectively). The proportion of participants who felt very/extremely respected was higher for those who attended a medical clinic that caters only to lesbian, gay, bisexual, trans and/or intersex people or a mainstream medical clinic that is known to be LGBTIQ-inclusive. Overall, participants reported that they felt their gender identity was respected less frequently than their sexual orientation across all health services. Of particular note is that only one third of trans and gender diverse participants reported feeling that their gender identity was very/extremely respected at a mainstream medical clinic (37.7%; n = 480) or hospital (35.4%; n = 223) in the past 12 months.

9.4 Preferences for accessing health or support services in the future

When asked where participants would prefer to access health or support services in the future, 46.9% (n = 3,201) reported from a mainstream health or support service that is LGBTIQ-inclusive, 21.4% (n = 1,461) from a health or support service that caters only to lesbian, gay, bisexual, trans and/or intersex people and 31.7% (n = 2,167) 'I have no preference.' It is of note that among participants who reported high or very high levels of psychological distress (n = 3,815), one quarter (25.1%; n = 959) reported that they would prefer to access a health or support service that caters only to lesbian, gay, bisexual, trans and/or intersex people, compared to 16.5% (n = 471) of participants who reported low or moderate levels of psychological distress. It is of further note that responses to preferences for accessing health or support services in the future may be contingent on whether participants are aware of services that cater only to lesbian, gay, bisexual, trans and/or intersex people in their locality. For example, 27.5% (n = 327) of participants in inner suburban areas in Victoria preferred a health or support service that caters only to lesbian, gay, bisexual, trans and/or intersex people compared to 18.6% (n = 72) in Victorian regional cities or towns.

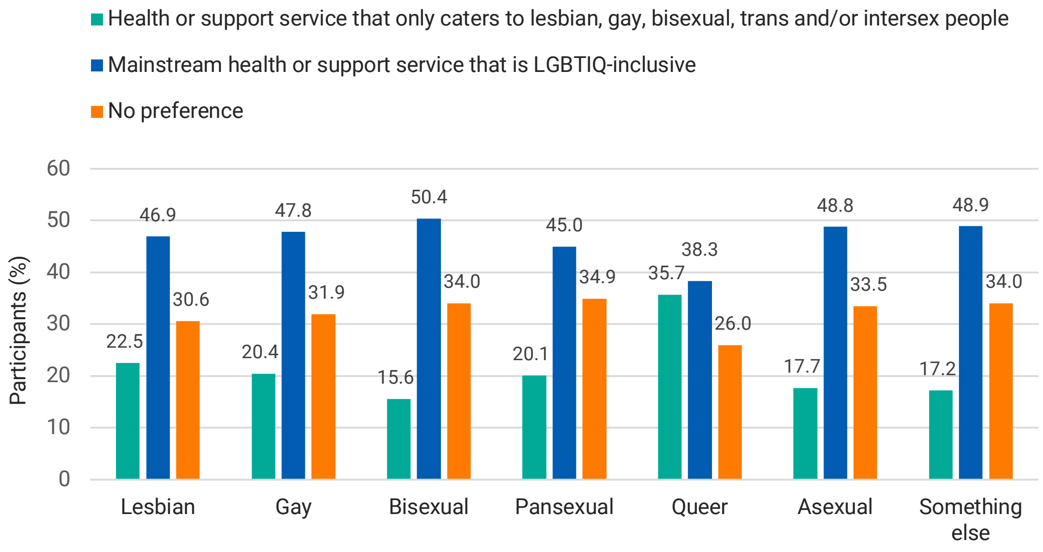
Figure 26: Future health or support service preference by gender (n = 6,776)



Note: participants chose one response thus results do not reflect multiple preferences.

Four in ten (39.4%; n = 362) non-binary participants reported that they would prefer to access a health or support service that caters only to lesbian, gay, bisexual, trans and/or intersex people, compared to one in three trans men (30.7%; n = 92) and trans women (30.5%; n = 87) and 17.9% (n = 416) of cisgender men and 16.5% (n = 487) of cisgender women. Almost half (49.2%; n = 1,144) of cisgender men and cisgender women (49.6%; n = 1,461) reported that they would prefer to access a mainstream health or support service that is LGBTIQ-inclusive, followed by 45.3% (n = 129) of trans women, 39.3% (n = 118) of trans men and 36.1% (n = 332) of non-binary participants.

Figure 27: Future health or support service preference by sexual orientation (n = 6,810)



Note: participants chose one response thus results do not reflect multiple preferences.

Over one third (35.7%; n = 297) of queer identifying participants reported that they would prefer to access a health or support service that caters only to lesbian, gay, bisexual, trans and/or intersex people. This compared to 22.5% (n = 313) of lesbian, 20.4% (n = 399) of gay, 20.1% (n = 101) of pansexual, 17.7% (n = 38) of asexual and 15.6% (n = 217) of bisexual identifying participants.

Participants were asked, 'how important is it to you that a health service or support service you use is known to be LGBTIQ-inclusive?' and responded on a 5-point scale from 'not at all important' to 'extremely important.' Table 25 displays these results.

Table 25: The extent that participants agreed with the statement, how important is it to you that a health service or support service you use is known to be LGBTIQ-inclusive?' (n = 6,827)

How important is it to you that a health service or support service you use is known to be LGBTIQ-inclusive	Number	%
Not at all important	466	6.5
A little important	570	8.4
Somewhat important	1,447	21.2
Very important	2,071	30.3
Extremely important	2,293	33.6

Two thirds (63.9%; n = 4,364) of participants responded that using a health service or support service that is LGBTIQ-inclusive is 'very important' or 'extremely important.' One in twenty (6.5%; n = 466) reported that it was not at all important.

9.5. Accessing a service that has been accredited as LGBTIQ-inclusive in the future

Finally, participants were asked if they would be more likely to use a service that has been accredited as LGBTIQ-inclusive. Over three quarters (75.3%; n = 5,133) responded that they would be more likely to use a service that has been accredited as LGBTIQ-inclusive. One in twenty (5.1%; n = 347) reported that they would not be more likely to use a service that has been accredited as LGBTIQ-inclusive and 19.7% (n = 1,314) reported no preference. Note that 'accreditation' may have different meanings in different contexts and participants may have understood or interpreted this question differently.

9.6 Summary

A very high proportion of participants in PL3 reported having a regular GP or clinic. Prior research has established that having a regular GP is associated with improved access to screening, such as cervical screening, as well as better access to mental healthcare (McNair et al., 2011).

Mainstream health services were accessed more frequently by participants than LGBTIQ-inclusive health services, reflecting the fact that these are the most commonly available service. Smaller proportions had accessed LGBTIQ-specific services or those that are currently considered LGBTIQ-inclusive, although a high proportion of participants reported they would prefer to use such services if they had a need for them in the future. This suggests a need to expand their provision and accessibility going forward.

Among those who reported experiencing high/very high psychological distress, a greater proportion of trans and gender diverse participants, as well as queer and pansexual identifying participants, reported using health services that catered only to lesbian, gay, bisexual, transgender and/or intersex people, which may indicate that they specifically sought these out and may therefore have a high degree of importance for them. It is also notable that trans and gender diverse participants were much more likely to report that their gender identity was respected within LGBTIQ-specific services compared to mainstream services. Potential outcomes of heteronormative attitudes held by health professionals include delaying care, lack of disclosure and a lack of targeted health promotion and care (Alencar Albuquerque et al., 2016; McNair et al., 2018).

10 Alcohol, tobacco and other drug use

Australian and international research suggests that LGBTQ people tend to use alcohol and other drugs two to four times more than heterosexual people (Green & Feinstein, 2012; Roxburgh et al., 2016; Smith et al., 1999). For example, the Australian Institute of Health and Welfare's National Drug Strategy Household Survey conducted in 2016 observed that 'homosexual' and bisexual people in Australia were 3.2 times as likely to use cannabis, 5.8 times as likely to use ecstasy and 3.7 times as likely to use cocaine when compared to heterosexual people (Australian Institute of Health and Welfare, 2017). This study did not include questions for identifying trans and gender diverse people. Longitudinal analysis of the household survey also showed that, while rates of smoking have been decreasing overall, this was not the case for all groups, especially lesbian and bisexual women (Praeger et al., 2019). Furthermore, LGB people reported an overall increased level of drug use between 2010 and 2016 (Australian Institute of Health and Welfare, 2017). Numerous questions on alcohol and other drug use and smoking were included in PL3.

10.1 Smoking

Participants were asked if they smoked cigarettes or any other tobacco product. Table 26 displays these results.

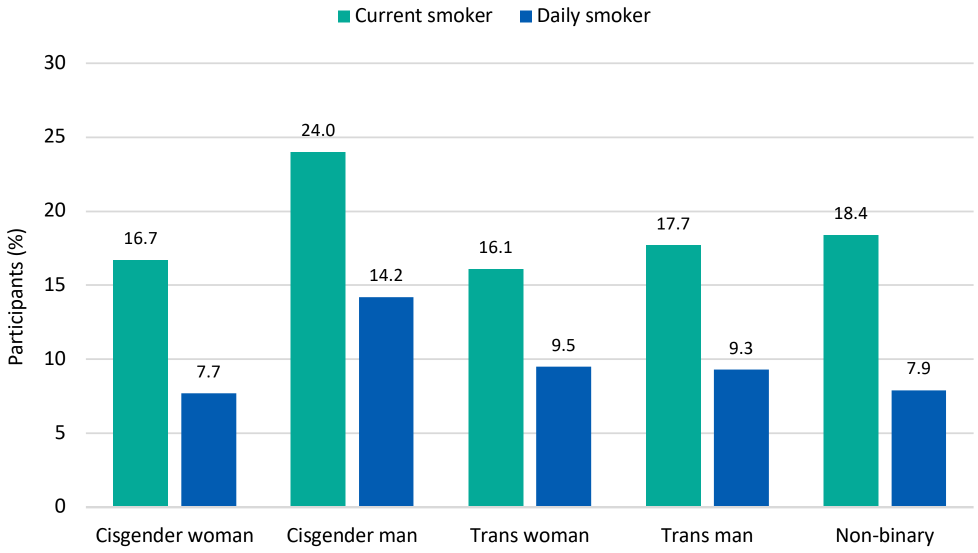
Table 26: Proportion of current smokers (n = 6,830)

Smoke cigarettes or other tobacco product	Number	%
No, I have never smoked	3,774	55.3
No, I used to smoke but I no longer smoke	1,719	25.2
Yes, I smoke less often than weekly	453	6.6
Yes, I smoke at least weekly (but not daily)	185	2.7
Yes, I smoke daily	699	10.2

One in five (19.5%; 1,337) PL3 participants reported being current smokers, with one in ten (10.2%; n = 699) being daily smokers. One quarter (25.2%; n = 1,719) of participants were ex-smokers. This compares to 15.2% current smokers, with 13.8% daily smokers, in the general Australian population (Australian Bureau of Statistics, 2019a) and 16.1% current smokers in PL2 (Leonard et al., 2012).

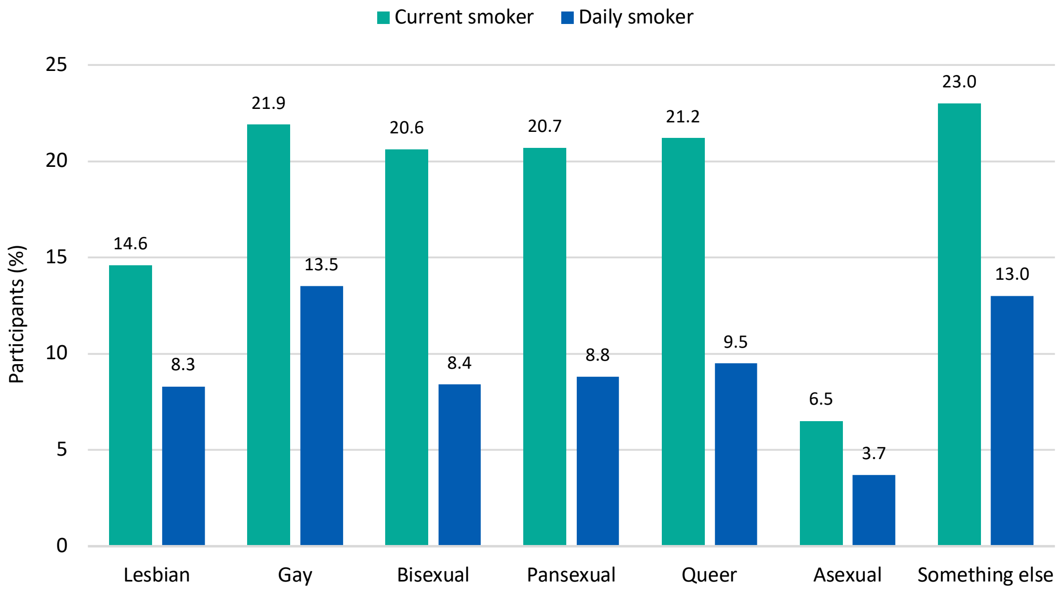
Almost one in seven (12.9%; n = 883) participants reported having ever used e-cigarettes. One in twenty (5.7%; n = 392) reported currently using e-cigarettes and 7.2% (n = 491) reported having used them but no longer using them. This is higher than the 8.8% of people reporting having ever used e-cigarettes, 1.2% currently using them and 1.6% no longer using them in the general Australian population (Australian Institute of Health and Welfare, 2016a).

Figure 28: Current and daily smokers by gender (n = 6,777)



Almost one quarter of cisgender men (24.0%; n = 559) were current smokers, compared to approximately one in six non-binary participants (18.4%; 169), trans men (17.7%; n = 53), cisgender women (16.7%; n = 493) and trans women (16.1%; n = 46).

Figure 29: Current and daily smokers by sexual orientation (n = 6,777)



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. A lower proportion of lesbian (14.6%; n = 203) and asexual (6.5%; n = 14) participants were current smokers.

10.2 Alcohol

10.2.1 Alcohol consumption

Participants were asked how frequently they consumed alcohol. Table 27 displays these results.

Table 27: Frequency of alcohol consumption (n = 6,831)

Alcohol consumption	Number	%
Never	938	13.7
Monthly or less	1,826	26.7
2-4 times per month	1,880	27.5
2-3 times per week	1,274	18.7
4 or more times a week	913	13.4

The majority (86.3%; n = 5,893) of participants reported drinking alcohol. This is slightly less than the 88.4% in the general Australian population (Australian Bureau of Statistics, 2018d) and also less than the 'nearly 92%' reported in PL2 (Leonard, et al. 2012). One quarter (26.7%; n = 1,826) of PL3 participants reported drinking alcohol monthly or less, 27.5% (n = 1,880) 2-4 times per month, 18.7% (n = 1,274) 2-3 times per week and 13.4% (n = 913) four or more times per week.

One quarter (25.3%; n = 1,725) of participants reported drinking more than two standard drinks per day on average, exceeding the 2009 National Health and Medical Research Council guidelines for lifetime health risks associated with the consumption of alcohol, defined as 'drinking no more than two standard drinks a day.' This is higher than in the general population aged 18 years and over, where 16.1% exceed two standard drinks per day (Australian Bureau of Statistics, 2018d).

Participants who reported drinking alcohol were asked how often they engaged in ‘risky drinking’, defined as consuming six or more drinks on one occasion.

Table 28: Frequency of consumption of six or more drinks on one occasion (n = 5,881)

How often do you have six or more drinks on one occasion?	Number	%
Never	1,670	28.4
Less than monthly	2,384	40.5
Monthly	968	16.5
Weekly	732	12.4
Daily or almost daily	127	2.2

Of participants who reported drinking alcohol, 71.6% (n = 4,211) reported engaging in ‘risky’ drinking at some point. One third (31.1 %; n = 1,827) of these reported engaging in risky drinking monthly, 12.4% (n = 732) weekly and 2.2% (n = 127) daily.

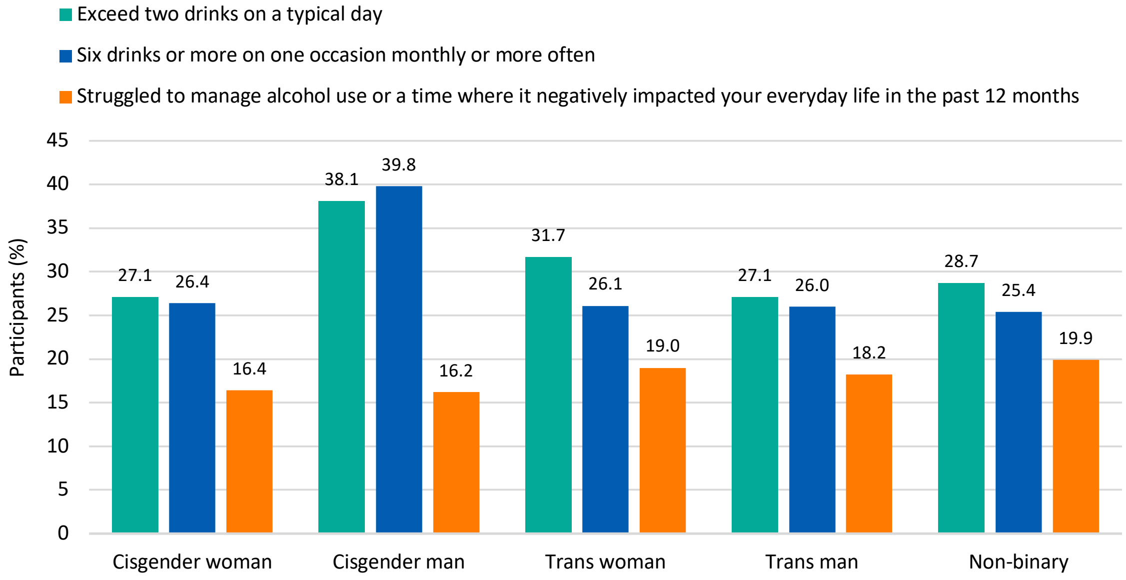
10.2.2 Managing alcohol consumption and professional support

One in six (16.9%; n = 998) participants reported experiencing a time in the past 12 months when they had struggled to manage their alcohol use or a time where it negatively impacted their everyday life.

Of those who reported struggling to manage their alcohol use in the past 12 months, 18.3% (n = 182) reported seeking professional support for their alcohol use at some time during this period. Among participants who had sought professional support for their alcohol use in the past 12 months, 68.5% (n = 135) sought support from a mainstream service, 33.0% (n = 65) from a mainstream service that was known to be LGBTIQ-inclusive and 7.6% (n = 15) from a service that caters only to lesbian, gay, bisexual, transgender and/or intersex people.

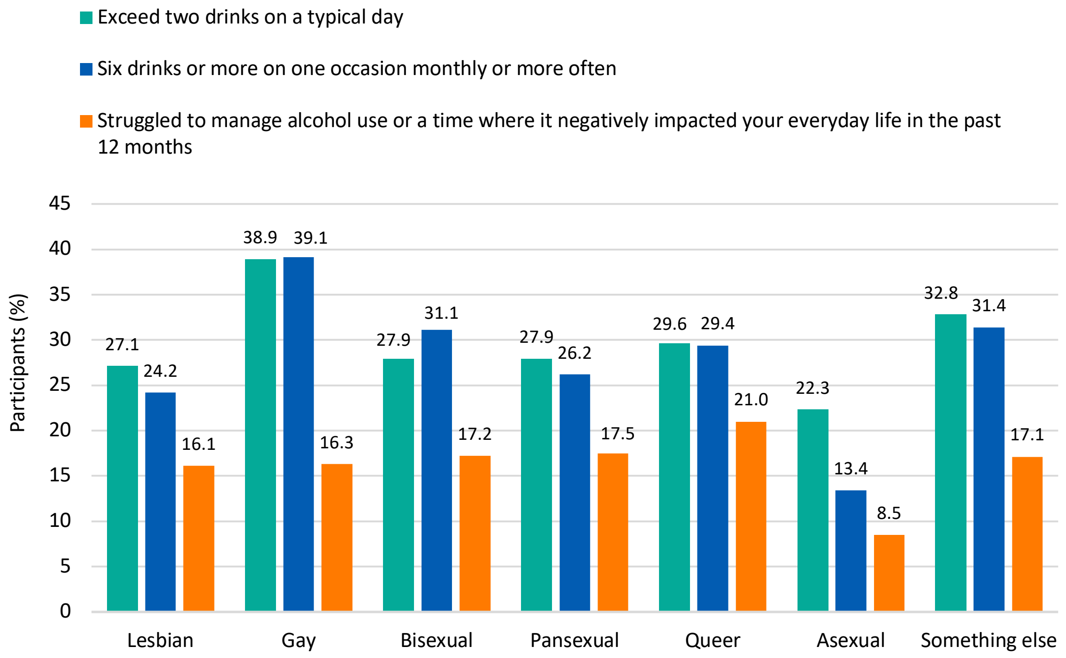
Participants who had sought professional support for their alcohol use in the past 12 months (n = 197) were asked to rate how satisfied they were with the support services they had used. Response options included a 5-point scale ranging from ‘very dissatisfied’ to ‘very satisfied.’ Slightly over half (57.1%; n = 76) reported that they were somewhat satisfied or very satisfied with a mainstream service, almost three quarters (73.8%; n = 48) were somewhat satisfied or very satisfied with a mainstream service known to be LGBTIQ-inclusive and one in two (53.3%; n = 8) were somewhat satisfied or very satisfied with a service that caters only to lesbian, gay, bisexual, transgender and/or intersex people. However, it should be noted that due to the relatively low number of participants who reported using a professional support service for their alcohol use in the past 12 months, these data on satisfaction with services should be interpreted with caution. Figures 30 and 31 display results broken down by gender and sexual orientation.

Figure 30: Exceed two drinks or more on a typical day (n = 5,433), six drinks or more on one occasion monthly or more often (n = 5,840), struggled to manage alcohol use or a time where it negatively impacted everyday life in the past 12 months (5,850) by gender



A greater proportion of cisgender men reported exceeding two drinks on a typical day (38.1%; n = 751) and six drinks or more on one occasion monthly or more often than monthly (39.8%; n = 829) compared to the other groups. However, a similar proportion of cisgender men reported struggling to manage alcohol use or a time where it negatively impacted their everyday life in the past 12 months. The highest proportion was for the non-binary group (19.9%; n = 150) and the lowest was for cisgender men (16.2%; n = 338).

Figure 31: Exceed two drinks or more on a typical day (n = 5,457), six drinks or more on one occasion monthly or more often (n = 5,865), struggled to manage alcohol use or a time where it negatively impacted everyday life in the past 12 months (5,876) by sexual orientation



Participants who identified as gay were the most likely group to report exceeding two drinks on a typical day (38.9%; n = 648) and six drinks or more on one occasion monthly or more often than monthly (39.1%; n = 685). However, queer identifying participants (21.0%; n = 150) had the largest proportion who reported struggling to manage alcohol use or a time where it negatively impacted their everyday life in the past 12 months. The lowest proportion was for the asexual group (8.5%; n = 12).

10.3 Drug use

Participants were presented with a range of drugs and asked which, if any, they had used for non-medical purposes in the past 6 months. A 6-month time frame was specified because shorter time frames have been observed to have more reliable recall about drug use (Janssen et al., 2017). Table 29 displays these results.

Table 29: Drug use (not prescribed by doctor) in the past 6 months (n = 6,271)

Drug use in past 6 months	Number	%
Cannabis	1,904	30.4
Ecstasy/MDMA	872	13.9
Cocaine	601	9.6
Benzodiazepines (e.g., Valium, Serepax, Xanax)	549	8.8
Pharmaceutical opioids	327	5.2
LSD/synthetic hallucinogens/Psilocybin/PCP	285	4.5
Ketamine (Special K)	277	4.4
Meth/amphetamine	277	4.4
Pharmaceutical stimulants (e.g., Ritalin)	262	4.2
Antidepressants	236	3.8
Nitrous oxide	232	3.7
Naturally occurring hallucinogens	228	3.6
GHB/GBL/1,4-BD (Liquid e)	99	1.6
Antipsychotics	67	1.1
Steroids	34	0.5
Heroin (including homebake)	18	0.3
Synthetic cannabis	20	0.3
Mephedrone	7	0.1
Other drug	75	1.2
Any drug use other than alcohol[4]	**2,781**	**44.4**

Note: multiple responses were available thus percentages do not add up to 100.

Almost half (44.4%; n = 2,781) of participants reported using one or more drugs for non-medical purposes in the past 6 months. The most frequently reported 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% (n = 745) participants reported using amyl nitrate/alkyl nitrite in the past 6 months.

Although participants were asked about their drug use in the past 6 months, rates of drug use were similar to some other studies of drug use among LGBTQ Australians in the past 12 months. For example, in PL2, 24.2% of participants reported using cannabis, 12.3% ecstasy and 7.1% cocaine in the past 12 months. In the general population aged over 14 years, 12.9% reported using cannabis, 2.2% reported using ecstasy and 2.5% reported using cocaine in the past 12 months (Leonard et al., 2012).

Drug use was higher among participants in PL3 than in the general Australian population, among whom the most commonly used illegal drugs that were used at least once in the past 12 months were cannabis (10.4%), followed by cocaine (2.5%), ecstasy (2.2%) and meth/amphetamines (1.4%) (Australian Institute of Health and Welfare, 2017). Trends in drug use among participants in PL3 were somewhat reflected by findings in the Australian Institute of Health and Welfare's National Drug Strategy Household Survey conducted in 2016 in which 31% of lesbian, gay and bisexual participants reported using cannabis, 8.9% had used cocaine and approximately 12% had used ecstasy in the past 12 months (Australian Institute of Health and Welfare, 2017).

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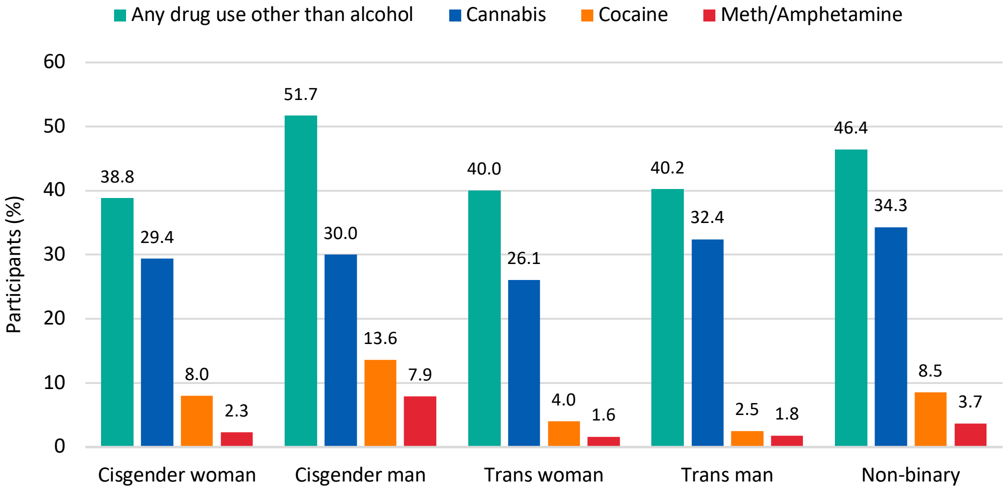
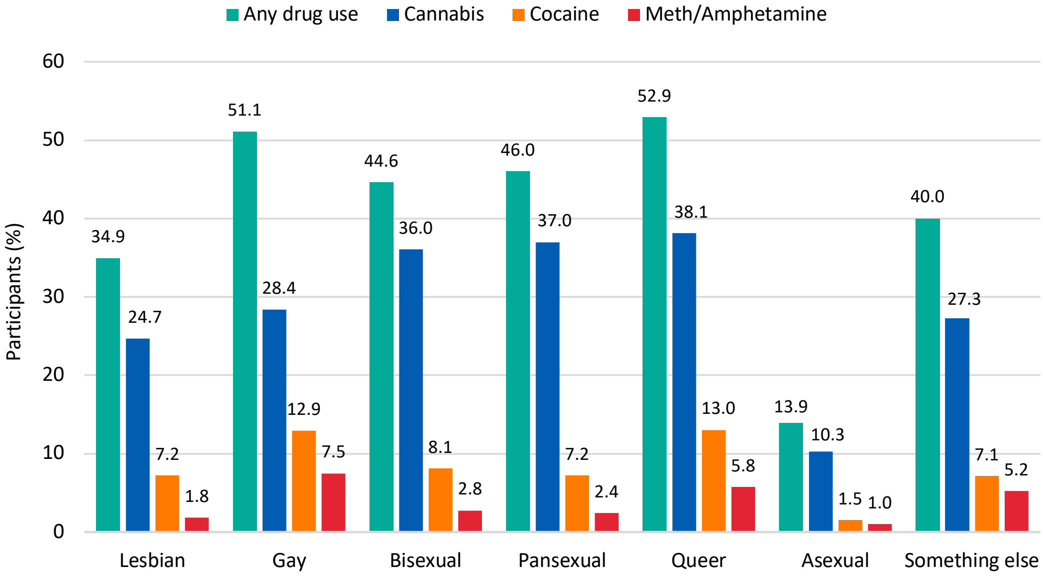
[4] 'Any drug use other than alcohol' includes participants using amyl nitrate/alkyl nitrite in the past 6 months.

Figure 32: Any drug use other than alcohol,[4] cannabis, cocaine, meth/amphetamine use in the past 6 months by gender (n = 6,225)



Over half (51.7%; n = 1,112) of cisgender men had used drugs for non-medical purposes in the past 6 months, followed by 46.4% (n = 397) of non-binary participants and four fifths of trans men (40.2%; 113), trans women (40.0%; n = 92) and cisgender women (38.8%; n = 1,044). Cannabis use was reported by approximately three in ten participants across all genders. A greater proportion of cisgender men (13.6%; n = 292) used cocaine than non-binary participants (8.5%; n = 73), cisgender women (8.0%; n = 215), trans women (4.0%; n = 10) and trans men (2.5%; n = 7). Similarly, the 7.9% (n = 170) of cisgender men who reported meth/amphetamine use was more than twice that of non-binary participants (3.7%; n = 32), cisgender women (2.3%; n = 63), trans men (1.8%; n = 5) or trans women (1.6%; n = 4). Finally, a greater proportion of non-binary participants (9.8%; n = 84) used benzodiazepines (e.g., Valium, Serepax, Xanax) than cisgender men (9.5%; n = 204), cisgender women (8.0%; n = 214), trans women (8.0%; n = 20) and trans men (7.8%; n = 22).

Figure 33: Any drug use other than alcohol,[4] cannabis, cocaine, meth/amphetamine use in the past 6 months by sexual orientation (n = 6,257)



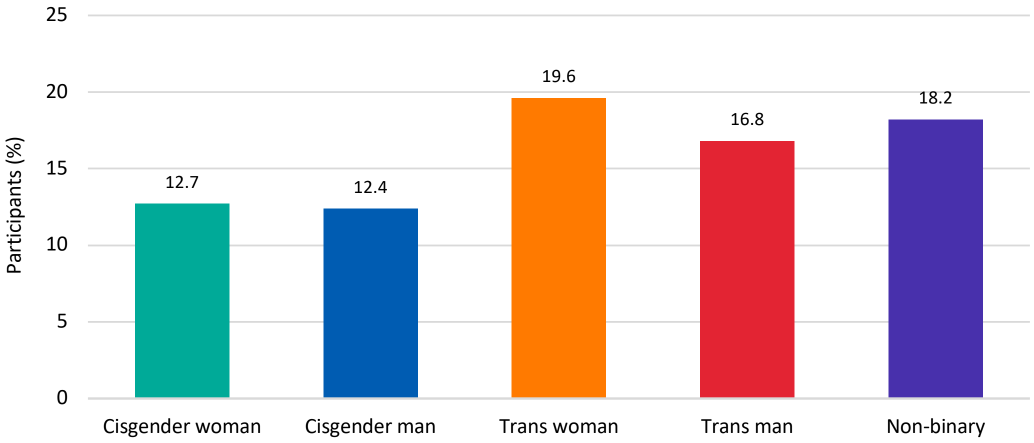
Over half of gay (51.1%; n = 929) and queer (52.9%; n = 414) identifying participants had used drugs for non-medical purposes in the past 6 months, followed by 46.0% (n = 210) of pansexual, 44.6% (n = 566) of bisexual, 34.9% (n = 440) of lesbian participants and 13.9% (n = 27) of asexual identifying participants. Cannabis use was reported more frequently by bisexual (36.0%; n = 457), pansexual (37.0%; n = 169) and queer (38.1%; n = 298) identifying participants than gay (28.4%; n = 516), lesbian (24.7%; n = 311) and asexual (10.3%; n = 20) identifying participants. Cocaine and meth/amphetamine were used by a greater proportion of gay (12.9%; n = 235 and 7.5%; n = 136 respectively) and queer (13.0%; n = 102 and 5.8%; n = 45 respectively) identifying participants than other participants.

10.3.1 Managing drug use and professional support

Participants who reported using drugs (n = 2,781) in the past 6 months were asked if they experienced a time where they had struggled to manage their drug use or where it negatively impacted their everyday life. In interpreting the meaning of this question, participants may have drawn upon prior experience managing their drug use as well as other experiences that have had a negative impact on their everyday life. These might include issues such as the financial impacts of drug acquisition or drug-related investigations or prosecution by the police. Almost one in seven (14.0%; n = 388) reported that it had. Of the more frequently used drugs in the past 6 months, 16.1% (n = 306) of participants who reported using cannabis, 20.1% (n = 121) who reported using cocaine, 20.3% (n = 177) who reported using ecstasy, 32.9% (n = 91) who reported using meth/amphetamine and 33.3% (n = 33) who reported using GHB also reported having experienced a time where they had struggled to manage their drug use or where it negatively impacted their everyday life in the past 6 months.

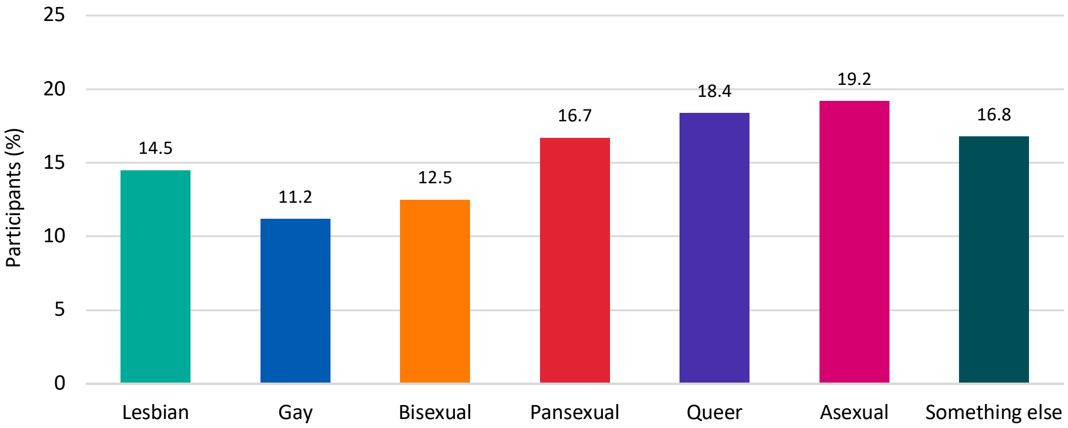
Of participants who reported having experienced a time where they struggled to manage their drug use or where it negatively impacted their everyday life in the past 6 months (n = 387), 22.2% (n = 86) reported having sought professional support for their drug use in the past 6 months. Of these, 66.3% (n = 57) sought support from a mainstream service, 38.4% (n = 33) from a mainstream service that was known to be LGBTIQ-inclusive and 11.6% (n = 10) from a service that caters only to lesbian, gay, bisexual, transgender and/or intersex people. Among all participants (including those who did not report experiencing a time where they struggled to manage their drug use or where it negatively impacted their everyday life in the past 6 months), 66.4% (n = 85) sought support from a mainstream service, 39.8% (n = 51) from a mainstream service that was known to be LGBTIQ-inclusive and 7.8% (n = 10) from a service that caters only to lesbian, gay, bisexual, transgender and/or intersex people.

Figure 34: Experienced a time where they have struggled to manage drug use or when it negatively impacted their everyday life in the past 6 months among drug users by gender (n = 2,754)



Among participants who had used drugs for non-medical purposes in the past 6 months, almost one fifth (19.6%; n = 18) of trans women experienced a time where they had struggled to manage drug use or when it negatively impacted their everyday life in the past 6 months, followed by 18.2% (n = 72) of non-binary participants, 16.8% (n = 19) of trans men, 12.7% (n = 132) of cisgender women and 12.4% (n = 138) of cisgender men.

Figure 35: Experienced a time where they have struggled to manage drug use or when it negatively impacted their everyday life in the past 6 months among drug users by sexual orientation (n = 2,773)



Among participants who had used drugs for non-medical purposes in the past 6 months, almost one fifth of asexual identifying participants (19.2%; n = 5) experienced a time where they had struggled to manage drug use or when it negatively impacted their everyday life in the past 6 months, followed by 18.4% (n = 76) of queer, 16.7% (n = 35) of pansexual, 14.5% (n = 64) of lesbian, 12.5% (n = 71) of bisexual and 11.2% (n = 104) of gay identifying participants. It is of note that only 13.9% (n = 27) of asexual identifying participants reported any drug use in the past 6 months.

10.3.2 Future support preferences

Participants were asked, if they were to ever need help from a support service in relation to their drug use in the future, where they would prefer to receive it. Table 30 displays these results.

Table 30: Future support preference for concerns regarding drug use among all participants (n = 6,796) and participants who reported experiencing a time when they had struggled to manage their drug use or a time where it negatively impacted their everyday life in the past 12 months (n = 388)

	All participants		Participants reporting struggling to manage drug use in past 12 months	
Future alcohol support service preference	**Number**	**%**	**Number**	**%**
From a mainstream service	844	12.4	42	10.8
From a mainstream service that is known to be LGBTIQ inclusive	2,036	30.0	132	34.0
From a service that only caters to lesbian, gay, bisexual, transgender and/or intersex people	783	11.5	87	22.4
I don't know	1,325	19.5	57	14.7
I have no preference	1,808	26.6	70	18.0

Note: participants chose one response thus results do not reflect multiple preferences.

Three in ten (30.0%; n = 2,036) participants reported that they would prefer support 'from a mainstream service that is LGBTIQ-inclusive', 11.5% (n = 783) 'from a service that caters only to lesbian, gay, bisexual, transgender and/or intersex people people' and 12.4% (n = 844) 'from a mainstream service.' A further 46.1% (n = 3,133) reported not knowing or not having a preference.

Among participants who reported experiencing a time when they struggled to manage their drug use or where it negatively impacted their everyday life in the past 6 months, one third (34.0%; n = 132) reported that they would prefer support 'from a mainstream service that is LGBTIQ-inclusive', almost one quarter (22.4%; n = 87) 'from a service that caters only to lesbian, gay, bisexual, transgender and/or intersex people' and one in ten (10.8%; n = 42) 'from a mainstream service.' A further 32.7% (n = 127) reported not knowing or not having a preference.

10.4 Summary

There were high levels of drug use among PL3 participants, consistent with findings from the Australian Household Drug Survey (Australian Institute of Health and Welfare, 2017). The Australian Household Drug Survey did not report on trans and gender diverse people but these groups generally reported similar levels of overall drug use to cisgender men and women in PL3. However, the type of drug used varied with sexual orientation and gender. For example, a higher proportion of bisexual, pansexual and queer identifying participants had used marijuana in the past 6 months than gay identifying participants, whereas a higher proportion of gay identifying participants had used meth/amphetamine. Asexual identifying participants reported much lower levels of smoking, alcohol and drug use than any other sexual orientations.

Overall, cisgender men and gay identifying participants reported the highest levels of smoking, alcohol and illicit drug use. However, they reported the lowest levels of struggling to manage their drug or alcohol use or it negatively impacting their everyday life in the past 6 months. This may reflect either that a larger proportion feel confident they are managing their drug use well or may experience challenges in recognising when their use may have become problematic.

Service use was relatively low for those who reported experiencing problems with drug or alcohol use, with only around one fifth of these participants seeking professional support in the past 6 months, which may indicate that participants are reluctant to access support or unaware of where to access appropriate support.

11 Intimate partner and family violence

LGBTQ people can face abuse and violence across their lifespan due to the various effects of stigma, discrimination and prejudice. They may also experience a range of unique circumstances where they are subject to violence that may not be experienced by other groups, such as rejection or abuse after 'coming out' to family members (Asquith & Fox, 2016; D'augelli et al., 2008; Ryan et al., 2009). There has been little research in Australia on the experiences of intimate partner or family violence among LGBTIQ people. The PL3 survey asked several questions on this topic and in this chapter we present the results from the PL3 sample.

Intimate partner violence refers to forms of violence (such as verbal, physical, sexual or psychological) that occur within the context of an intimate (a close, though not necessarily sexual) relationship, such as a marriage, a de facto partnership or other kinds of less formal relationships (Our Watch, 2014).

Family violence refers to forms of violence within a family, which may include immediate family, extended family or broader kinship networks.

11.1 Experiences of intimate partner and family violence

Online and telephone resources were provided to participants, including contact details for QLife, Lifeline, Beyondblue, suicide call-back services and emergency services, prior to these questions appearing in the survey. Participants were also given the option to skip this survey section.

PL3 participants were asked, 'have you ever been in an intimate relationship where you felt you were abused in some way by your partner/s? (intimate relationships may be either sexual or not sexual in nature)' and 'have you ever felt you were abused in some way by a family member/s? (family includes both birth and chosen family).' It is important to note that results from these questions are based on ever having experienced violence rather than from within a specific time frame. Tables 31 and 32 display these results.

Table 31: Proportion of participants reporting ever being in an intimate relationship where they felt they were abused in some way by their partner/s (n = 6,820)

Intimate partner violence	Number	%
No	3,788	55.5
Yes, once	1,864	27.3
Yes, in more than one relationship	982	14.4
Don't know/not sure	186	2.7

More than four in ten (41.7%; n = 2,846) participants reported ever being in an intimate relationship where they felt they were abused in some way by their partner/s. Over one quarter (27.3%; n = 1,864) of participants reported being in one intimate relationship where they felt they were abused in some way by their partner/s, while 14.4% (n = 982) reported being in more than one intimate relationship where they felt they were abused in some way by their partner/s.

Table 32: Proportion of participants reporting ever feeling abused by a family member (n = 6,815)

Family violence	Number	%
No	3,860	56.6
Yes, by one family member	1,454	21.3
Yes, by more than one family member	1,175	17.2
Don't know/not sure	326	4.8

Almost four in ten (38.5%; n = 2,629) participants reported ever feeling abused by a family member (family includes both birth and chosen family). One fifth (21.3%; n = 1,454) reported ever feeling abused by one family member, while 17.2% (n = 1,175) participants reported ever feeling abused by more than one family member.

11.2 Forms of intimate partner and family violence experienced

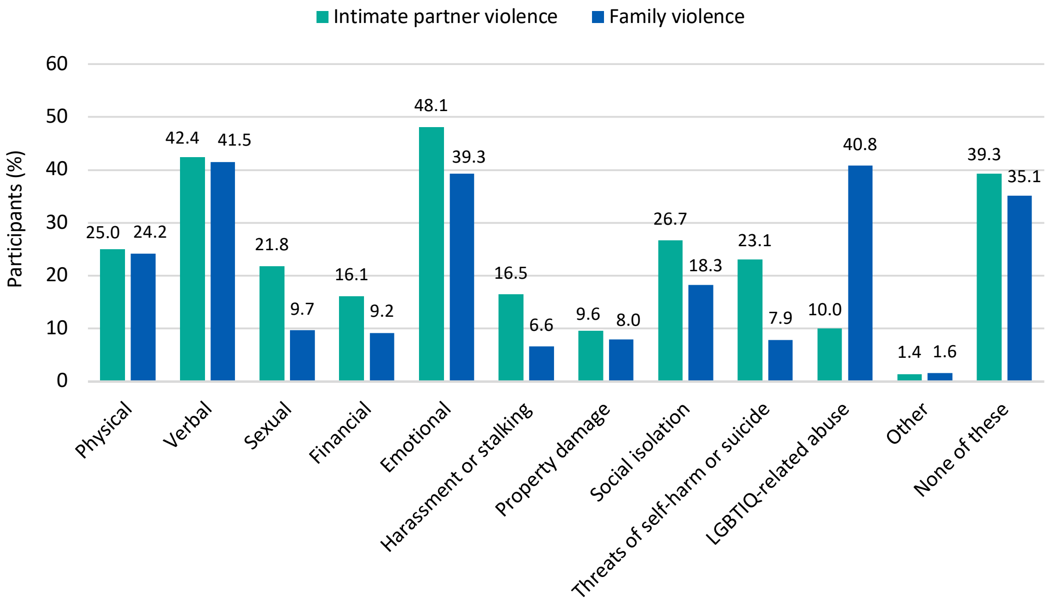
There are no generally agreed or accepted standards for defining what constitutes intimate partner or family violence in Australia (Australian Bureau of Statistics, 2017e). To gain as comprehensive a picture as possible, PL3 participants were asked to report on whether they had ever experienced one or more different forms of violence from intimate partners or family members from the list shown below.

Participants were asked, 'have you experienced any of the following from intimate partner/s' and 'have you experienced any of the following from family members.' Response choices included:

- physical violence (e.g., hitting, throwing heavy objects or threats and physical intimidation regardless of whether an injury resulted)
- verbal abuse (e.g., regular criticism, insults or demeaning language)
- sexual assault (e.g., undesired sexual behaviour through force or other means)
- financial abuse (e.g., had money stolen or access controlled, prevented from working or studying, had debts accrued by them in your name)
- emotional abuse (e.g., regularly manipulated, humiliated in front of others, gaslighted, bullied, blamed for abuse)
- harassment or stalking (e.g., monitoring movements, coerced into a relationship commitment or religious practice, forced to stop practicing your own religious or spiritual practices)
- property damage (e.g., destroying or threatening to destroy possessions or property, including pets)
- social isolation (e.g., made it difficult to see friends, family or community)
- threats of self-harm or suicide (e.g., partner or family member threatened self-harm or suicide)
- LGBTIQ-related abuse (e.g., shamed you about being LGBTIQ, threatened to 'out' you or your HIV status, withheld hormones or medication)
- Additional options of 'other' and 'I have not experienced any of these from an intimate partner'

Figure 36 displays these results.

Figure 36: Proportion of participants ever experiencing violence from an intimate partner (n = 6,121) or family member (n = 6,195)



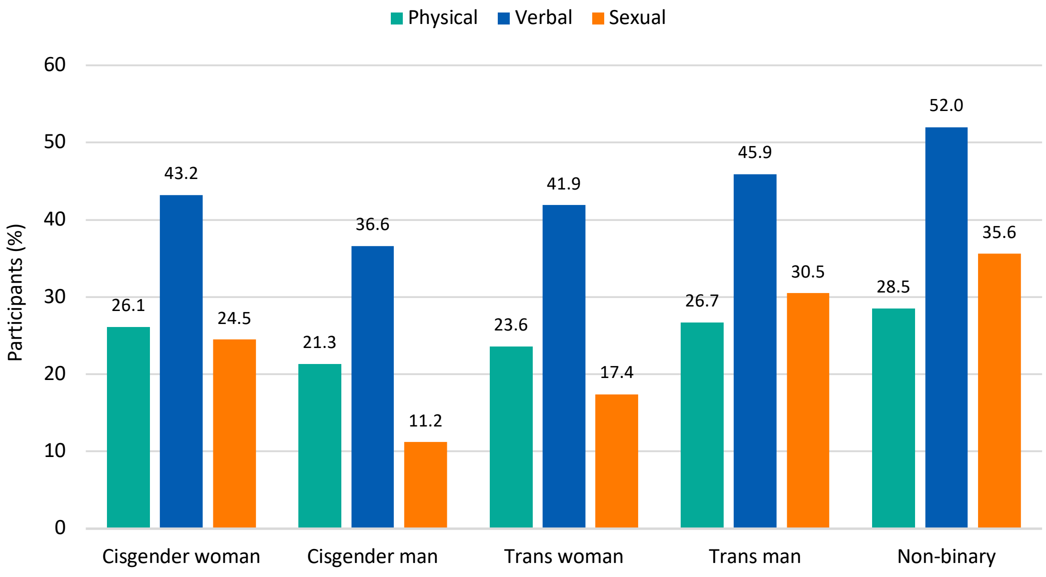
When asked to report on specific forms of violence, six in ten (60.7%; n = 3,716) participants reported ever experiencing intimate partner violence. Emotional abuse (48.1%; n = 2,942) was the most commonly reported form of intimate partner violence, followed by verbal abuse (42.4%; n = 2,594), physical violence (25.0%; n = 1,528) and sexual assault (21.8%; n = 1,332). In the first Private Lives Survey, conducted in 2005, 33% of participants reported lifetime experience of physical or verbal abuse in intimate relationships (Pitts et al., 2006).

More than six in ten (64.9%; n = 4,019) participants reported ever experiencing family violence. Verbal abuse (41.5%; n = 2,568) was the most commonly reported form of family violence, followed by LGBTIQ-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). A greater proportion of participants reported ever experiencing sexual assault from an intimate partner (21.8%; n = 1,332) than from a family member (9.7%; n = 599).

It is notable that the proportions of participants who reported having ever experienced intimate partner or family violence were higher than in previous studies. This is likely due to PL3 having provided a comprehensive list of different forms of violence as response items. These items were developed to measure a more diverse range of forms of violence and utilise more inclusive definitions of family and partners that better reflect the diverse communities of PL3 than other surveys in Australia. This approach may have gone some way towards helping to address previous literature that has observed differing levels of self-identified intimate partner violence and subsequent under-reporting (Caetano et al., 2009; Gracia, 2004; Roller et al., 2016).

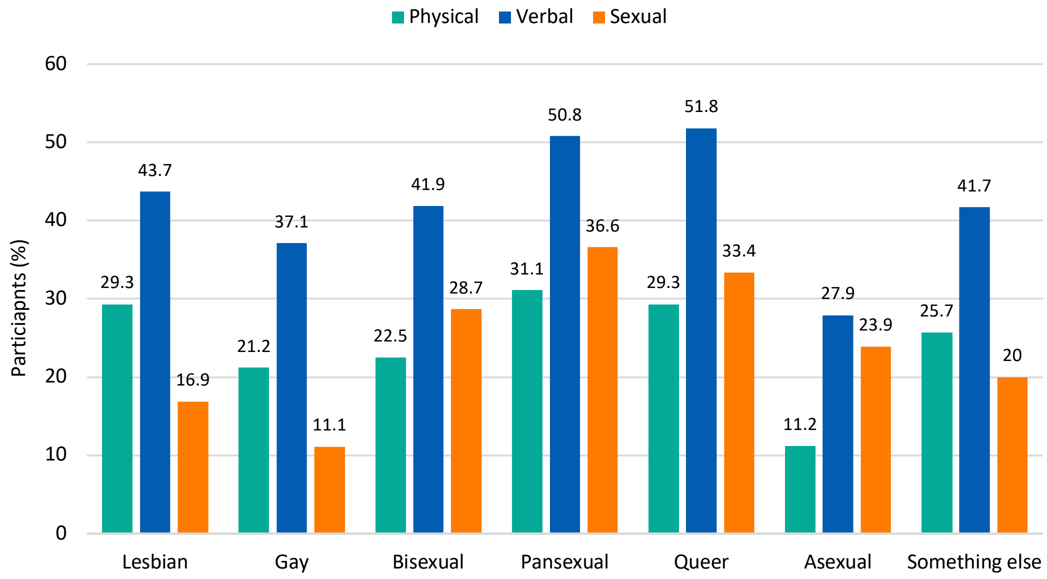
Reflecting this, a greater proportion of participants reported an experience of violence when they responded to this question than when they were asked more generally about experiences of violence, as reported in Section 11.1 above. Previous studies in the general population largely focus on heterosexual women and pose challenges for making valid comparisons. For example, the 2016 Personal Safety Survey in Australia reported that 17% of women and 6% of men had experienced physical and/or sexual violence from a partner (Australian Bureau of Statistics, 2017e) but this is limited to a current and previous partner with whom they have cohabited and does not include less formal relationships more common among LGBTQ people.

Figure 37: Proportion of participants ever experiencing physical, verbal and sexual violence from an intimate partner, by gender (n = 6,071)



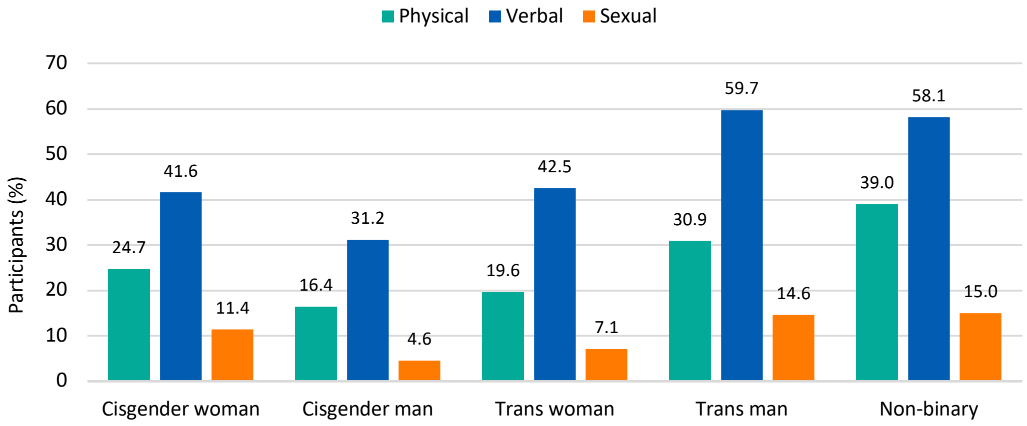
Experiences of physical violence from an intimate partner ranged from 21.3% (n = 432) among cisgender men to 28.5% (n = 243) among non-binary participants. More than half (52.0%; n = 443) of non-binary participants had experienced verbal harassment from an intimate partner, followed by 45.9% (n = 122) of trans men, 43.2% (n = 1,154) of cisgender women, 41.9% (n = 108) of trans women and 36.6% (n = 740) of cisgender men. More than three in ten non-binary (35.6%; n = 303) participants and trans men (30.5%; n = 81) had experienced sexual violence from an intimate partner, compared to 24.5% (n = 654) of cisgender women, 17.4% (n = 45) of trans women and 11.2% (n = 227) of cisgender men.

Figure 38: Proportion of participants ever experiencing physical, verbal and sexual violence from an intimate partner, by sexual orientation (n = 6,106)



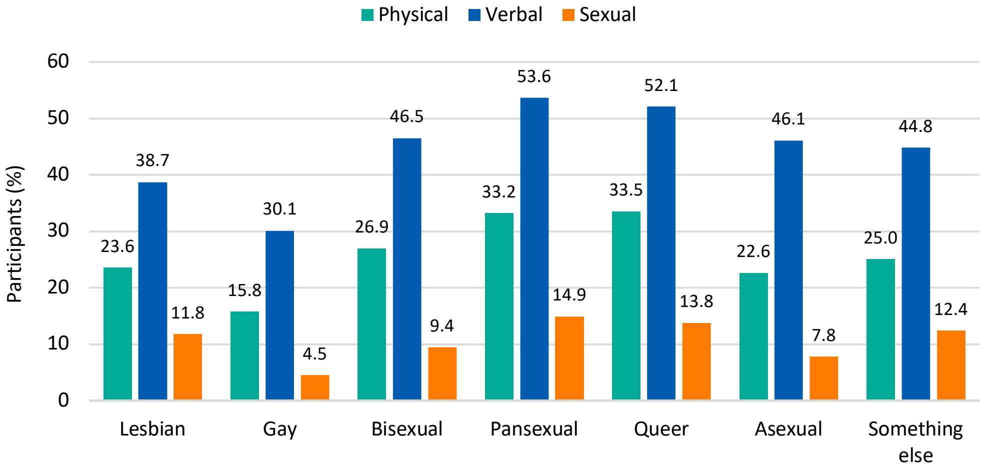
Three in ten lesbian (29.3%; n = 369), pansexual (31.1%; n = 145) and queer (29.3%; n = 224) identifying participants had experienced physical violence from an intimate partner, compared to two in ten gay (21.2%; n = 360) and bisexual (22.5%; n = 282) identifying participants and one in ten (11.2%; n = 22) asexual identifying participants. Half of pansexual (50.8%; n = 237) and queer (51.8%; n = 396) identifying participants had experienced verbal violence from an intimate partner, followed by roughly four in ten lesbian (43.7%; n = 550), bisexual (41.9%; n = 524) and gay (37.1%; n = 630) identifying participants and one quarter (27.9%; n = 55) of asexual identifying participants. Sexual violence was experienced most frequently by pansexual (36.6%; n = 171), queer (33.4%; n = 255), bisexual (28.7%; n = 359) and asexual (23.9%; n = 47) identifying participants, compared to 16.9% (n = 213) of lesbian identifying and 11.1% (n = 189) of gay identifying participants.

Figure 39: Proportion of participants ever experiencing physical, verbal and sexual violence from a family member, by gender (n = 6,146)



Almost four in ten (39.0%; n = 336) non-binary participants reported ever experiencing physical violence from a family member, followed by three in ten (30.9%; n = 89) trans men, one quarter (24.7%; n = 667) of cisgender women, one fifth (19.6%; n = 52) of trans women and 16.4% (n = 667) of cisgender men. Verbal abuse from a family member was experienced by almost six in ten (59.7%; n = 172) trans men and non-binary participants (58.1%; n = 501), four in ten trans women (42.5%; n = 113) and cisgender women (41.6%; n = 1,124) and three in ten (31.2%; n = 632) cisgender men. Sexual assault from a family member was experienced by three times as many non-binary participants (15.0%; n = 129) and trans men (14.6%; n = 42) compared to cisgender men (4.6%; n = 94).

Figure 40: Proportion of participants ever experiencing physical, verbal and sexual violence from a family member, by sexual orientation (n = 6,179)



Three in ten pansexual (33.2%; n = 158) and queer (33.5%; n = 257) identifying participants had experienced physical violence from a family member, compared to two in ten lesbian (23.6%; n = 301), bisexual (26.9%; n = 344) and asexual (22.6%; n = 46) identifying participants and 15.8% (n = 268) of gay identifying participants. Half of pansexual (53.6%; n = 255) and queer (52.1%; n = 400) identifying participants had experienced verbal violence from a family member, followed by approximately four in ten bisexual (46.5%; n = 595) and lesbian (38.7%; n = 493) identifying participants, three in ten gay (30.1%; n = 512) identifying participants and one quarter (22.6%; n = 94) of asexual identifying participants. Sexual violence from a family member was experienced most frequently by pansexual (14.9%; n = 71), queer (13.8%; n = 106), lesbian (11.8%; n = 150) and bisexual (9.4%; n = 120) identifying participants, followed by 7.8% (n = 16) of asexual identifying and 4.5% (n = 76) of gay identifying participants.

11.3 Perpetrators of intimate partner violence

Participants who reported having ever experienced violence from an intimate partner were asked 'in the most recent relationship where you experienced this, how did your partner/s describe their gender?' Over half (57.0%; n = 2,121) of PL3 participants reported 'cisgender man', 34.5% (n = 1,322) reported 'cisgender woman', 3.4% (n = 131) 'non-binary', 2.0% (n = 78) 'trans woman', 2.0% (n = 76) 'trans man', 1.8% (n = 68) 'someone different' and 1.0% (n = 40) 'prefer not to say.'

11.4 Perpetrators of family violence

Participants who reported having ever experienced family violence were asked to select 'the relation the family member/s had to you at the most recent time this occurred.' Almost three quarters (72.7%; n = 2,943) responded 'parent' (including guardian, foster carer, step-parent, adoptive parent), 18.4% (n = 746) 'older sibling', 12.0% (n = 486) 'younger sibling', 20.3% (n = 821) 'extended family member', 5.0% (n = 200) 'in-laws', 1.4% (n = 55) 'child or grandchild', 3.5% (n = 140) 'other family member/s' and 3.1% (n = 125) 'prefer not to say.'

11.5 Experiences related to being LGBTIQ

Participants who reported having ever experienced violence from an intimate partner or family member were asked, 'Do you feel you were targeted for this abuse because of your sexual orientation, gender identity and/or gender expression or intersex variation/s?' Almost four in ten (42.6%; n = 1,734) responded 'yes', 39.0% (n = 1,585) responded 'no' and 18.4% (n = 748) responded 'not sure.'

11.6 Reporting violence and experiences of support

Participants who reported having ever experienced violence from an intimate partner or family member were asked whether they had reported the most recent instance in which this occurred to a professional service, such as the police, doctor or domestic or family violence service. Those who indicated that they had reported it to a particular service were also asked whether or not they felt supported by that service. Table 33 displays these results.

Table 33: Service to which intimate partner or family violence was reported the most recent time it occurred and proportion reporting feeling supported (n = 4,731)

Service to which assault was reported the most recent time	Number	%	Felt supported (%)
Counselling service or psychologist	886	18.7	89.4
Police (including LGBTIQ liaison officers)	279	5.9	45.0
Doctor or hospital	210	4.4	68.4
Lawyer, legal service, court system	119	2.5	57.1
Telephone helpline	117	2.5	58.6
Domestic or family violence service	109	2.3	65.1
Employer	80	1.7	71.3
Teacher or educational institution	84	1.8	69.9
Sexual assault service	44	0.9	79.6
LGBTIQ organisation	46	1.0	73.9
Religious or spiritual community leader or elder	37	0.8	64.9
Other	206	4.4	84.3
I did not report this abusive behaviour	**3,406**	**72.0**	-

Of participants who reported having ever experienced family or intimate partner violence, 28.0% (n = 1,325) responded that they reported the incident at the most recent time in which this occurred. This is somewhat consistent with some previous research in which 36% of female victims of physical assault and 19% of female victims of sexual assault reported it (Australian Bureau of Statistics, 2017e).

Almost one fifth (18.7%; n = 886) of participants reported the most recent incident 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. Few (1.0%; n = 46) participants reported the incident to an LGBTIQ organisation. Participants reported feeling most supported by a counselling service or psychologist (89.4%; n = 788) and least supported by police (including LGBTIQ liaison officers) (45.0%; n = 125).

11.7 Preferences for future support

All participants (n = 6,794) were asked where they would prefer to access support services if they ever experienced intimate partner or family violence in the future. Just over one third (35.1% ; n = 2,383) reported ‘from a mainstream domestic violence service that is LGBTIQ-inclusive’, 20.6% (n = 1,402) ‘from a domestic violence service that caters only to lesbian, gay, bisexual, transgender and/or intersex people, 5.3% (n = 363) from ‘a mainstream domestic violence service’, 21.3% (n = 1,446) ‘did not know’ and 17.6% (n = 1,200) had ‘no preference.’

11.8 Experiences of sexual assault

Participants were asked if ‘anyone ever coerced or forced you into sexual acts you did not want to engage in?’ This included such acts as kissing, touching, sexual intercourse or being forced to watch pornography or unwanted sexual acts. Almost half (48.6%; n = 3,314) reported having ever been coerced or forced into sexual acts they did not want to engage in and 8.9% (n = 607) in the past 12 months.

Participants were then asked who perpetrated the sexual assault at the most recent time in which this occurred. Table 34 displays these results.

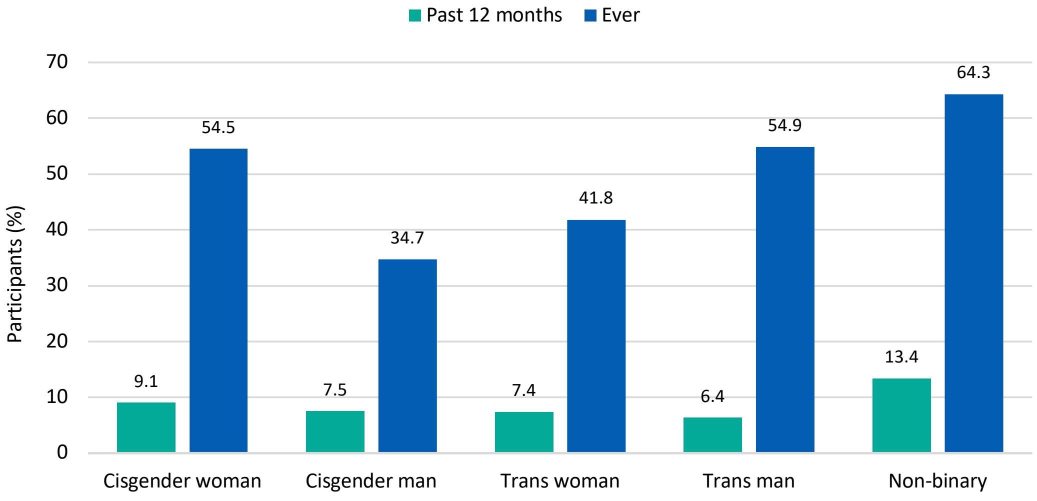
Table 34: Relation of sexual assault perpetrator to participants (n = 3,309)

Sexual assault perpetrator	Number	%
Former intimate partner	725	21.9
Intimate partner	641	19.4
Friend	642	19.4
Casual encounter (e.g., a hook-up)	632	19.1
Stranger	609	18.4
Another family member	135	4.1
Family-like relation	107	3.2
A co-worker or boss	93	2.8
Parent or guardian	90	2.7
Sibling	75	2.3
Someone in a professional setting	59	1.8
A sex work client	45	1.4
Someone else	184	5.6
Prefer not to say	62	1.9

For the most recent time in which it occurred, sexual assault was most commonly reported as perpetrated by former intimate partners (21.9%; n = 725), intimate partners (19.4%; n = 641), friends (19.4%; n = 642), casual encounters (19.1%; n = 632) and strangers (18.4%; n = 609).

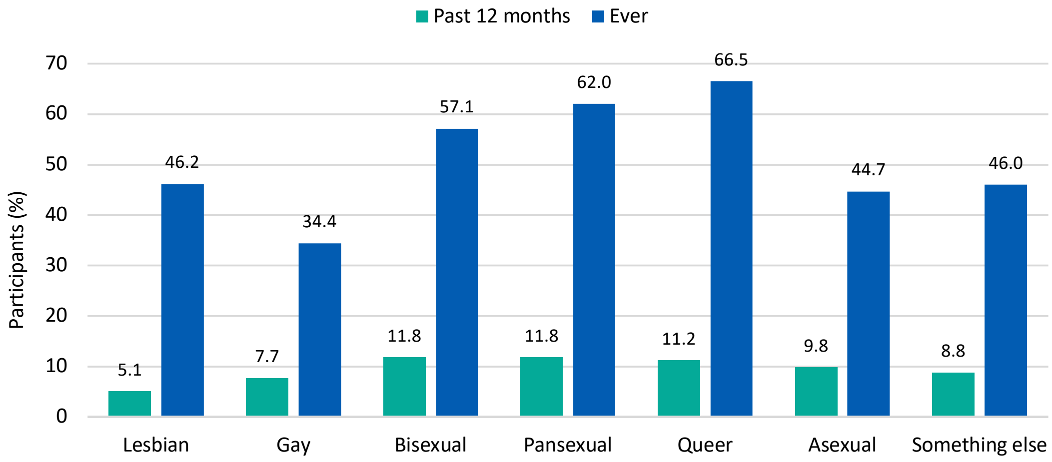
When asked about the gender of the perpetrator of sexual assault in which this most recently occurred, a cisgender man (84.3%; n = 2,710) was most frequently reported, followed by cisgender woman (14.4%; n = 464), non-binary person (1.8%; n = 59), trans woman, (1.3%; n = 41) and trans man (1.2%; n = 37).

Figure 41: Proportion of participants experiencing sexual assault in the past 12 months and ever by gender (n = 6,767)



More than one in ten (13.4%; n = 123) non-binary participants experienced sexual assault in the past 12 months, followed by 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. More than six in ten (64.3%; n = 123) non-binary participants had ever experienced sexual assault compared to more than five in ten cisgender women (54.5%; n = 1,604) and trans men (54.9%; n = 164), 41.8% (n = 119) of trans women and 34.7% (806) of cisgender men.

Figure 42: Proportion of participants experiencing sexual assault in the past 12 months and ever by sexual orientation (n = 6,799)



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.

11.9 Summary

Reported rates of family and intimate partner violence were high among PL3 participants. Previous research is limited but some past studies conducted in Australia have also found high rates (Leonard et al., 2015; O'Halloran, 2015; Pitts et al., 2006). Generally, lower proportions of cisgender men reported experiencing intimate partner or family violence compared to cisgender women, trans men, trans women and non-binary participants. Rates of sexual assault were highest among cisgender women, trans men and non-binary people, which further reflects the gendered nature of violence toward people socialised as women. It also resembles patterns in the first Private Lives Survey, in 2005, in which trans men and cisgender women reported the highest levels of intimate partner violence (non-binary was not included as a gender category at the time) (Pitts et al., 2006).

Fewer participants reported having ever experienced intimate partner or family violence when asked directly if they had ever experienced violence compared to responding to a list of specific forms of violence. This supports previous findings indicating lower levels of recognition of intimate partner and family violence among LGBTIQ people than heterosexual people (O'Halloran, 2015) and highlights the importance of asking about specific experiences when assessing exposure to violence.

One quarter of participants reported an incident of intimate partner or family violence to a service at the most recent time they had experienced violence. Only 5.9% had reported it to the police, which is less than the one in ten who reported an experience of abuse from an intimate partner to the police in the first Private Lives Survey (Pitts et al., 2006). Low levels of reporting to services, including the police (and LGBTIQ liaison officers), might indicate that LGBTIQ people feel that sufficient support is not available to them or they are unaware about services they could access. It is notable that a large proportion of participants expressed a preference for LGBTIQ-inclusive services or services that cater only to lesbian, gay, bisexual, transgender and/or intersex people if they were to require support relating to family violence in the future.

12 Community connection

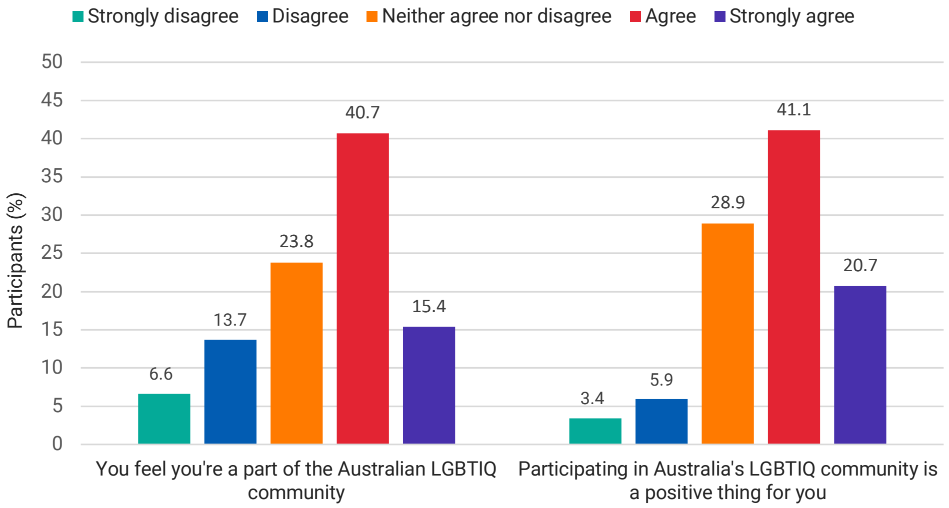
Lesbian, gay, bisexual, transgender and/or intersex communities are often a source of support, companionship and resilience (Ceatha et al., 2019; Roe, 2015). This chapter looks at experiences of community connections among the PL3 participants.

12.1 Community belonging

Participants were presented with the following statement, ‘The following questions are about LGBTIQ communities. By LGBTIQ communities, we do not mean any particular neighbourhood or social group, but in general, groups of gay men, bisexual men and women, lesbians, transgender and intersex individuals.’

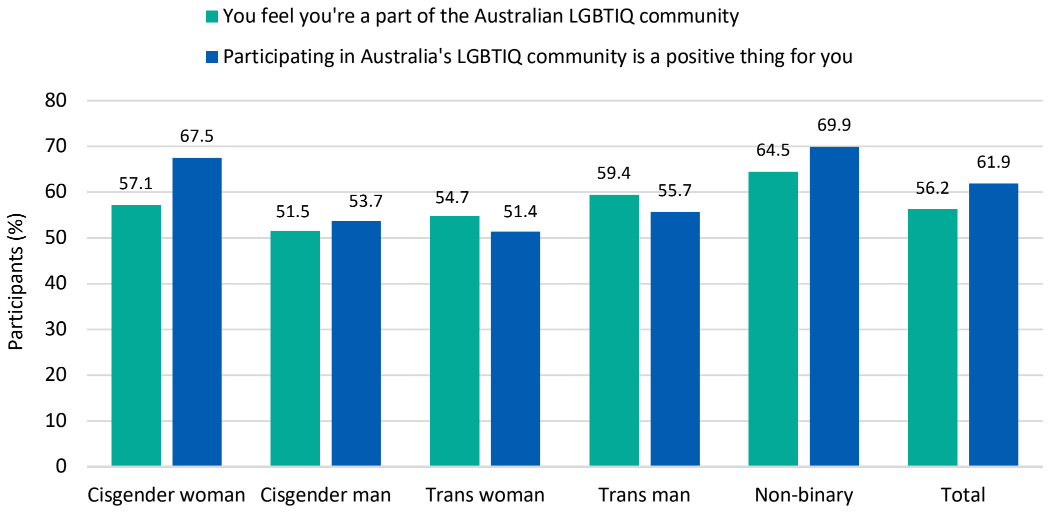
Participants were then asked the extent to which ‘you feel you’re a part of the Australian LGBTIQ community’ and ‘participating in Australia’s LGBTIQ community is a positive thing for you’, with response options provided on a 5-point scale ranging from ‘strongly disagree’ to ‘strongly agree.’ Figure 43 displays these results.

Figure 43: Feelings about participating in Australia’s LGBTIQ community (n = 6,825) and feeling part of the LGBTIQ community (n = 6,813)



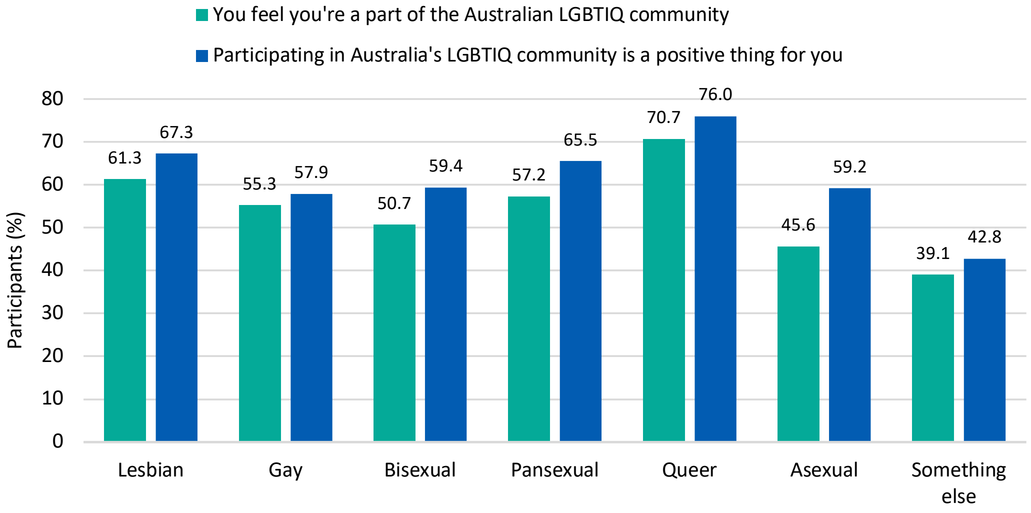
More than half (56.1%; n = 3,824) of participants agreed or strongly agreed that they feel a part of the Australian LGBTIQ community. More than six in ten (61.8%; n = 4,207) agreed or strongly agreed that participating in Australia’s LGBTIQ community is a positive thing for them.

Figure 44: Feelings about participating in Australia's LGBTIQ community (n = 6,772) and feeling part of the LGBTIQ community (n = 6,760) by gender



A greater proportion (64.5%; n = 592) of non-binary participants agreed or strongly agreed that they feel a part of the Australian LGBTIQ community compared to 57.1% (n = 1,683) of cisgender women, 51.5% (n = 1,196) of cisgender men, 54.7% (n = 156) of trans women and 59.4% (n = 177) of trans men. Similarly, a greater proportion (69.9%; n = 642) of non-binary participants agreed or strongly agreed that participating in Australia's LGBTIQ community is a positive thing for them compared to 67.5% (n = 1,982) of cisgender women, 53.7% (n = 1,246) of cisgender men, 51.4% (n = 146) of trans women and 55.7% (n = 167) of trans men.

Figure 45: Feelings about participating in Australia's LGBTIQ community (n = 6,772) and feeling part of the LGBTIQ community (n = 6,760) by sexual orientation

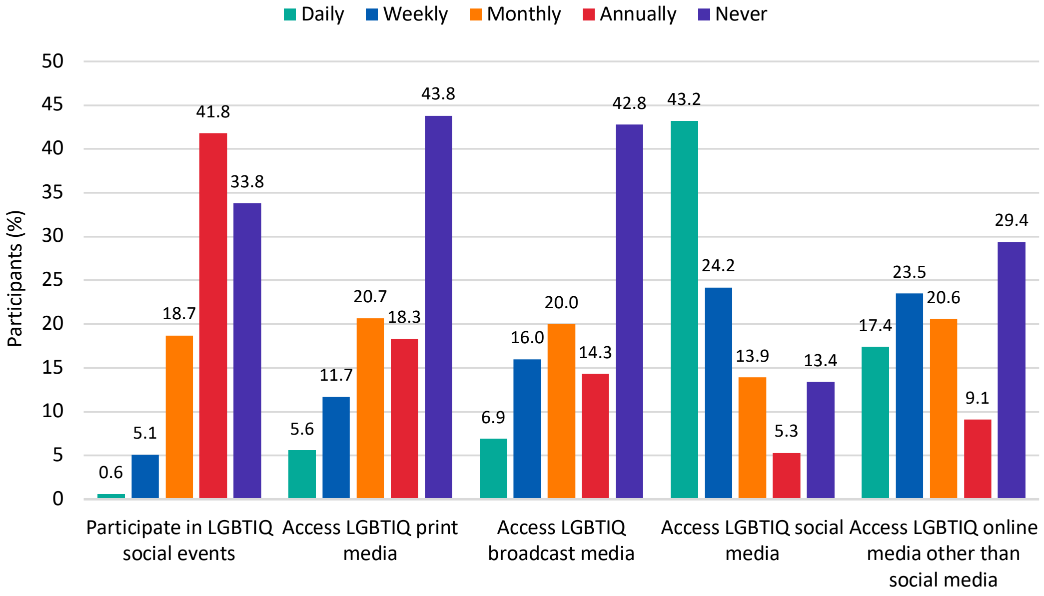


Seven in ten (70.7%; n = 588) queer identifying participants agreed or strongly agreed that they feel a part of the Australian LGBTIQ community followed by six in ten lesbian (61.3%; n = 854), 57.3% (n = 286) of pansexual, 55.3% (n = 1,082) of gay, 50.7% (n = 702) of bisexual and 45.6% (n = 98) of asexual identifying participants. While almost three quarters (76.0%; n = 632) of queer identifying participants agreed or strongly agreed that participating in Australia's LGBTIQ community is a positive thing for them, only 57.9% (n = 1,082) of gay identifying participants did.

12.2 Community participation and media consumption

Participants were asked how often they engage with a range of lesbian, gay, bisexual, trans, intersex or queer (LGBTIQ) events and media. Figure 46 displays these results.

Figure 46: LGBTIQ community participation and media consumption frequency (n = 6,776)



Almost seven in ten (66.2%; n = 4,503) participants reported having participated in LGBTIQ social events at some time, while 56.3% (n = 3,794) had accessed LGBTIQ print media, 57.2% (n = 3,852) LGBTIQ broadcast media, 86.6% (n = 5,851) LGBTIQ social media and 70.6% (n = 4,742) LGBTIQ online media other than social media at some time.

Almost three quarters of non-binary participants (74.8%; n = 684) reported having participated in LGBTIQ social events at some time, followed by two thirds of cisgender women (66.1%; n = 1,945), trans men (65.9%; n = 197) and trans women (65.4%; n = 185) and 63.2% (n = 1,462) of cisgender men.

More than eight in ten (82.1%; n = 682) queer identifying participants reported having participated in LGBTIQ social events at some time, followed by 73.5% (n = 1,023) of lesbian, 67.3% (n = 1,309) of gay, 64.2% (n = 321) of pansexual, 54.3% (n = 749) of bisexual, 55.3% (n = 119) of asexual identifying participants and 55.0% (n = 287) of participants who identified as 'something else.'

LGBTIQ social media was the most commonly accessed form of media, with 43.2% (n = 2,916) participants accessing it daily. This compared to 17.4% (n = 1,166) who reported accessing LGBTIQ online media other than social media daily, 6.9% (n = 465) accessing LGBTIQ broadcast media daily and 5.6% (n = 376) accessing LGBTIQ print media daily.

12.3 Summary

Community networks are often important sources of support and companionship for LGBTIQ people. Relatively large proportions or participants felt connected to community but quite large numbers did not. It is worth noting that not all people have easy access to community events or support and in some cases may be limited by challenges such as their health or where they live. Many participants reported accessing LGBTIQ social media and such online forums may be beneficial in further connecting and engaging people who are either not aware of physical community networks that are available to them or face limitations in engagement.

13 Trans and gender diverse people

Empirical evidence and data (including from a Census) about the size of the Australian trans and gender diverse populations are limited. However, a systematic review of studies published internationally from 2009-2019 found that estimates among adults ranged from 0.3% to 0.5% for surveys that specifically enquired about 'transgender' identity and 0.5% to 4.5% when definitions included broader reference to 'gender diversity' (Zhang et al., 2020). Numbers were observed to increase across all trans and gender diverse categories over time.

Trans and gender diverse participants in PL3 were given the opportunity to complete a supplementary section of the survey that asked additional questions related to this group. In total, 1,359 trans and gender diverse participants completed the supplementary section, with findings presented in this chapter.

13.1 Living life in a gender different from the one assigned at birth

Participants were asked whether they currently live their life in a gender that is different from the one assigned at birth. Table 35 displays these results.

Table 35: Currently live your life in a gender that is different from the one assigned at birth (n = 1,326)

	Trans woman		Trans man		Non-binary		Total	
	Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
No	41	14.9	21	7.2	129	17.0	191	14.4
Yes	225	81.8	265	91.1	501	65.9	991	74.7
I don't know	9	3.3	5	1.7	130	17.1	144	10.9

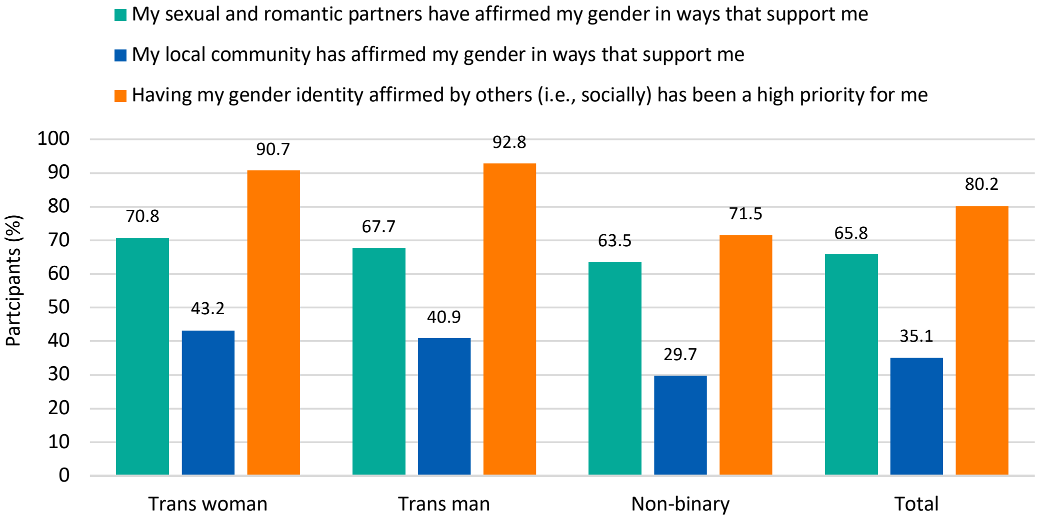
Nine in ten trans men (91.1%; n = 265) reported currently living their lives in a gender that is different from the one assigned at birth, followed by eight in ten trans women (81.8%; n = 225) and two thirds (65.9%; n = 501) of non-binary participants.

13.2 Gender affirmation

Participants were then asked, 'thinking about the last three years, to what extent do you agree with the following statements?' Response options were provided on a 5-point scale ranging from 'strongly disagree' to strongly agree.' Participants could indicate if an item was not relevant to them and were not included in the analyses for that item. Figures 47 and 48 display the results for participants who reported that they 'agree' or 'strongly agree' with the following statements:

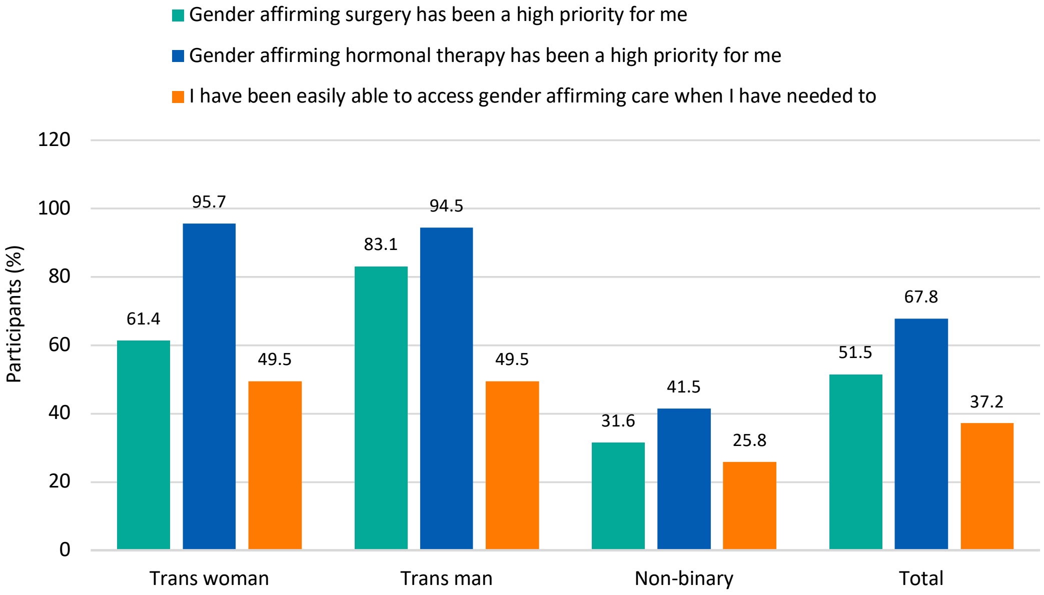
- 'I have been easily able to access gender affirming care when I have needed to' (n = 1,160)
- 'My sexual and romantic partners have affirmed my gender in ways that support me' (n = 1,089)
- 'My local community has affirmed my gender in ways that support me' (n = 1,192)
- 'Gender affirming surgery has been a high priority for me' (n = 1,134)
- 'Gender affirming Hormonal therapy has been a high priority for me' (n = 1,165)
- 'Having my gender identity affirmed by others (i.e., socially) has been a high priority for me' (n = 1,324)

Figure 47: ‘Agree’ or ‘strongly agree’ with the following statements



Seven in ten (70.8%; n = 155) trans women agreed or strongly agreed that ‘My sexual and romantic partners have affirmed my gender in ways that support me’, followed by 67.7% (n = 159) of trans men and 63.5% (n = 403) of non-binary participants. Four in ten trans women (43.2%; n = 111) and trans men (40.9%; n = 106) agreed or strongly agreed that ‘My local community has affirmed my gender in ways that support me’ compared to three in ten (29.7%; n = 201) non-binary participants. Nine in ten trans men (92.8%; n = 270) and trans women (90.7%; n = 253) agreed or strongly agreed that ‘Having my gender identity affirmed by others (i.e., socially) has been a high priority for me’, followed by seven in ten (71.5%; n = 539) non-binary participants.

Figure 48: ‘Agree’ or ‘strongly agree’ with the following statements



A higher proportion of trans men (83.1%; n = 236) agreed or strongly agreed that 'Gender affirming surgery has been a high priority for me' compared to trans women (61.4%; n = 164) and non-binary participants (31.6%; n = 184). More than twice as many trans men (94.5%; n = 277) and trans women (95.7%; n = 267) agreed or strongly agreed that 'Gender affirming hormonal therapy has been a high priority for me' than non-binary participants (41.5%; n = 246). Almost twice the proportion of trans men (49.5%; n = 142) and trans women (49.5%; n = 136) agreed or strongly agreed with the statement 'I have been easily able to access gender affirming care when I have needed to' than non-binary participants (25.8%; n = 154).

Participants were then asked if they had ever altered the appearance of their body to affirm their gender identity. Table 36 displays these results.

Table 36: Ever altered the appearance of your body to affirm your gender identity (n = 1,352)

	Trans woman		Trans man		Non-binary		Total	
	Number	%	Number	%	Number	%	Number	%
No	41	14.9	21	7.2	129	17.0	191	14.4
Yes	225	81.8	265	91.1	501	65.9	991	74.7
I don't know	9	3.3	5	1.7	130	17.1	144	10.9

More than nine in ten trans men (93.5%; n = 275) reported having ever altered the appearance of their body to affirm their gender identity, followed by almost nine in ten trans women (87.9%; n = 247) and seven in ten (70.3%; n = 546) non-binary participants.

Participants who reported that they had ever altered the appearance of their body to affirm their gender identity were asked how satisfied they were with these changes. Table 37 displays these results.

Table 37: How satisfied were you with these changes? (n = 1,066)

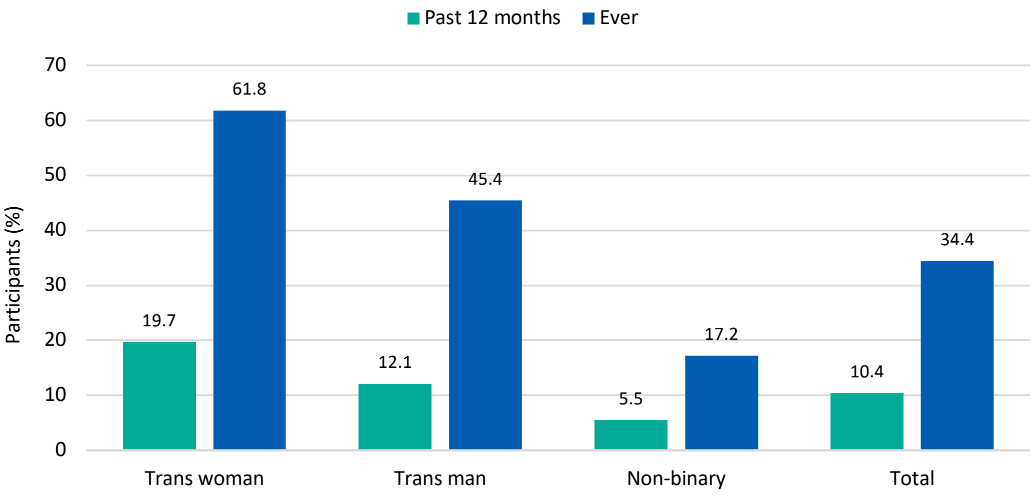
	Trans woman		Trans man		Non-binary		Total	
	Number	%	Number	%	Number	%	Number	%
Very unsatisfied	13	5.3	4	1.5	12	2.2	29	2.7
Unsatisfied	18	7.3	27	9.8	83	15.2	128	12.0
Neither satisfied nor dissatisfied	42	17.1	36	13.1	131	24.0	209	19.6
Satisfied	110	44.7	119	43.3	248	45.5	477	44.7
Very satisfied	63	25.6	89	32.4	71	13.0	223	20.9

Three quarters (75.7%; n = 208) of trans men reported being satisfied or very satisfied with these changes, followed by seven in ten trans women (70.3%; n = 173) and 58.5% (n = 319) of non-binary participants.

13.3 Legal recognition of gender identity

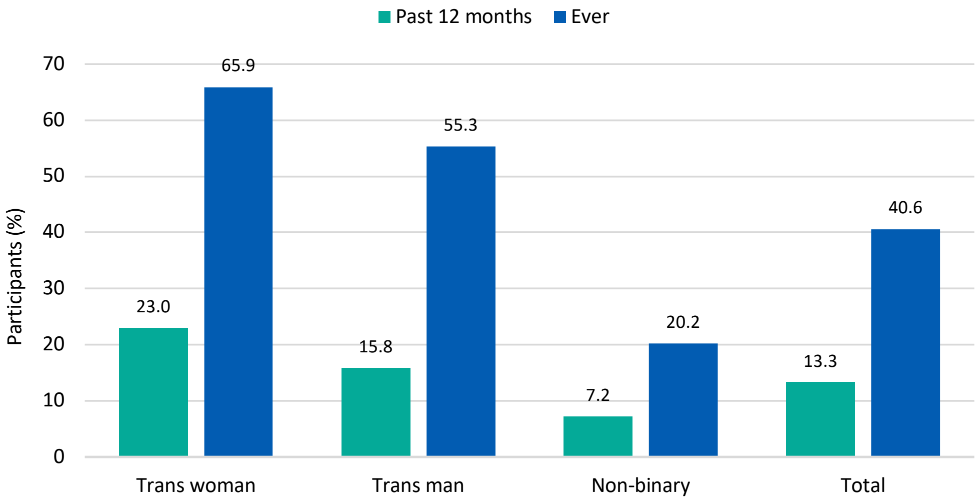
Participants were asked, 'in which of the following areas have you been able to gain legal recognition for your gender identity?' Figures 49 to 51 display these results.

Figure 49: Gained legal recognition for your gender identity – passport (n = 801)



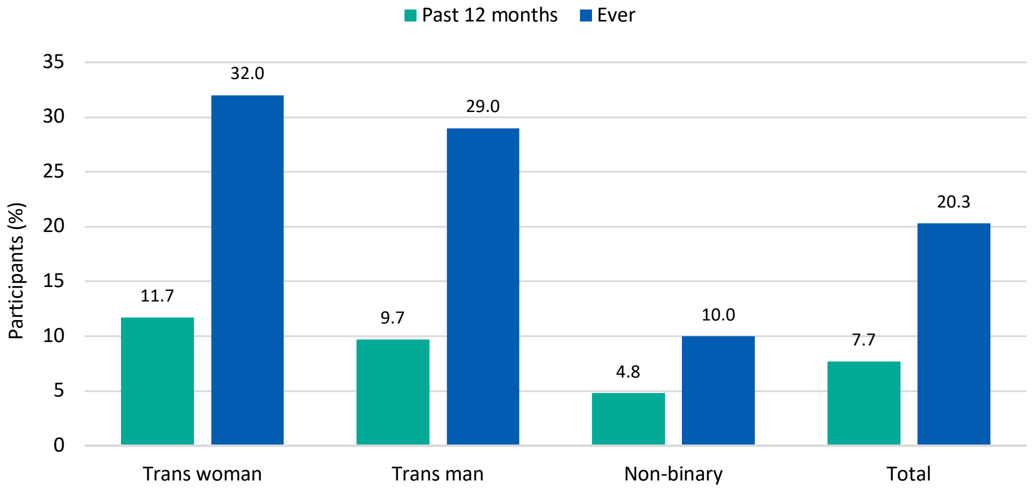
Six in ten (61.8%; n = 113) trans women reported ever gaining legal recognition for their gender identity in their passport, followed by 45.4% (n = 90) of trans men and 17.2% (n = 72) of non-binary participants.

Figure 50: Gained legal recognition for your gender identity – driver's licence (n = 877)



Less than two thirds (65.9%; n = 143) of trans women reported ever gaining legal recognition for their gender identity in their driver's licence. A smaller proportion of trans men (55.3%; n = 126) and non-binary (20.2%; n = 87) participants reported ever gaining legal recognition for their gender identity in their driver's licence.

Figure 51: Gained legal recognition for your gender identity – birth certificate (n = 971)



Less than a third of trans women (32.0%; n = 74) and trans men (29.0%; n = 75) and one in ten (10.0%; n = 48) non-binary participants, reported ever gaining legal recognition for their gender identity in their birth certificate.

13.4 Experiences with hormonal medications

Participants were asked about their current experiences taking hormonal medicines and if they had ever wanted to use PrEP but were concerned about possible complications from undergoing hormonal therapy. Tables 38 and 39 display these results.

Table 38: What is your current experience with hormonal medications, which are sometimes referred to as hormone therapy? (n = 1,350)

	Trans woman		Trans man		Non-binary		Total	
	Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
I am currently taking them	237	84.3	223	75.9	172	22.2	632	46.8
I have taken them in the past but am not currently	9	3.2	7	2.4	38	4.9	54	4.0
I have never taken them but I plan to in the future	35	12.5	57	19.4	183	23.6	275	20.4
I have never taken them and I do not plan to in the future	0	0.0	7	2.4	382	49.3	389	28.8

Approximately eight in ten (84.3%; n = 237) trans women and three quarters (75.9%; n = 223) of trans men were currently taking hormonal medications compared to one fifth (22.2%; n = 172) of non-binary participants. Less than one quarter (23.6%; n = 183) of non-binary participants had never taken hormonal medications but planned to in the future. Conversely, less than one half (49.3%; n = 382) of non-binary participants had never taken hormonal medicines and did not plan to in the future compared to 2.4% (n = 7) of trans men and none of the trans women.

Table 39: Ever wanted to use PrEP but were concerned about possible complications from undergoing hormonal therapy (n = 1,351)

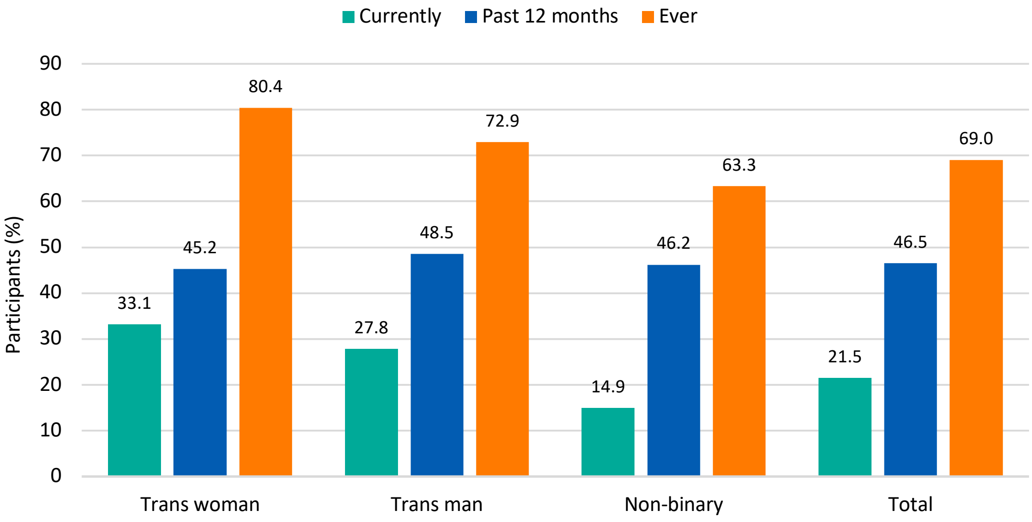
	Trans woman		Trans man		Non-binary		Total	
	Number	%	Number	%	Number	%	Number	%
No	204	72.6	195	66.3	639	82.3	1038	76.8
Yes	17	6.0	21	7.1	27	3.5	65	4.8
I don't know	60	21.4	78	26.5	110	14.2	248	18.4

Approximately one in twenty trans men (7.1%; n = 21) and trans women (6.0%; n = 17) and 3.5% (n = 27) of non-binary participants reported ever wanting to use PrEP but were concerned about possible complications with hormonal therapy. None of the participants who were HIV-positive (n = 3) reported ever avoiding taking HIV treatment out of concern for complications with hormone therapy.

13.5 Gender euphoria

Participants were asked about 'gender euphoria.' Gender euphoria has been defined in a variety of ways but broadly refers to an experience of feeling totally affirmed in one's gender where there is a sense of positive gender fulfillment (Benestad, 2010). Figure 52 displays these results.

Figure 52: Experiences of gender euphoria (n = 927)



A higher proportion of trans women (80.4%; n = 226) reported ever experiencing gender euphoria than trans men (72.9%; n = 212) or non-binary (63.3%; n = 489) participants. One in three (27.8%; n = 81) trans men, about one third (33.1%; n = 93) of trans women and 14.9% (n = 115) of non-binary participants reported currently experiencing gender euphoria.

13.6 Non-binary participants by assigned gender at birth

Non-binary AFAB (assigned female at birth) and non-binary AMAB (assigned male at birth) refer to the gender that was assigned at birth. Non-binary (AFAB) and non-binary (AMAB) may be useful for describing different non-binary experiences and significant disparities in suicidal ideation have been found between those who are non-binary (AFAB) and those who are non-binary (AMAB) (Newcomb et al., 2020). Notable differences between non-binary (AFAB) and non-binary (AMAB) participants in PL3 are therefore described here. However, it is important to note that these are not gender identities and thus should not be used to refer to non-binary people.

In total, 4.4% (n = 40) of non-binary participants responded, 'prefer not to say' or 'something else' when asked, 'what was the sex on your original birth certificate?' These participants were not included in the following analyses but have been included in analyses as 'non-binary' throughout the main body of the report.

13.6.1 Feelings of acceptance

Table 40 displays the numbers and percentages of non-binary (AFAB) and non-binary (AMAB) participants who felt they were accepted 'a lot' or 'always' in a range of situations.

Table 40: Currently feel accepted 'a lot' or 'always' by non-binary (AMAB) and non-binary (AFAB)

Gender assigned at birth	Non-binary (AFAB)		Non-binary (AMAB)	
	Number	%	Number	%
LGBTIQ event	399	66.4	107	64.1
LGBTIQ venue	385	65.6	105	63.3
At work	201	41.6	66	48.2
At an educational institution	162	35.5	59	46.5
With family members	208	31.5	74	38.9
LGBTIQ dating app or website	156	41.9	45	37.8
Accessing a health or support service	120	18.5	64	35.4
Social/community events	109	17.5	43	25.0
In public (e.g., in the street/park)	85	13.1	35	18.9
Mainstream venue	68	10.8	33	18.4
Mainstream event	64	10.1	31	17.3
Non-LGBTIQ dating app or website	35	9.5	21	18.9
Religious/faith-based events or services	27	7.6	10	9.4

Note: responses were analysed among participants who reported that a situation was applicable to them therefore an overall 'n' is not provided.

Overall, low proportions of non-binary (AFAB) and non-binary (AMAB) participants reported currently feeling accepted a lot or always in most situations. However, more of the non-binary (AMAB) participants reported currently feeling accepted a lot or always in non-LGBTIQ spaces than non-binary (AFAB) participants. For example, 35.4% (n = 64) of non-binary (AMAB) participants reported currently feeling accepted a lot or always when accessing a health or support service compared to 18.5% (n = 120) of non-binary (AFAB) participants. Similarly, 46.5% (n = 59) of non-binary (AMAB) participants reported currently feeling accepted a lot or always at an educational institution compared to 35.5% (n = 162) of non-binary (AFAB) participants.

13.6.2 Self-rated health

Participants were asked to rate their health on a 5-point scale from 'poor' to 'excellent.' Table 41 displays these results according to non-binary (AFAB) and non-binary (AMAB) status.

Table 41: Self-rated health by non-binary (AFAB) and non-binary (AMAB) (n = 871)

Gender assigned at birth	Non-binary (AFAB)		Non-binary (AMAB)	
	Number	%	Number	%
Poor	83	12.3	17	8.7
Fair	234	34.7	53	27.0
Good	232	34.4	75	38.3
Very good	108	16.0	43	21.9
Excellent	18	2.7	8	4.1

A greater proportion of non-binary (AFAB) participants (47.0%; n = 317) reported poor or fair health compared to non-binary (AMAB) participants (35.7%; n = 70). Similarly, a smaller proportion of non-binary (AFAB) participants (18.7%; n = 126) reported very good or excellent health compared to non-binary (AMAB) participants (26.0%; n = 51).

13.6.3 Psychological distress (K10)

Table 42 displays the K10 psychological distress levels of participants according to non-binary (AFAB) and non-binary (AMAB) status.

Table 42: K10 by non-binary (AFAB) and non-binary (AMAB) (n = 857)

Gender assigned at birth	Non-binary (AFAB)		Non-binary (AMAB)	
	Number	%	Number	%
Low	49	7.4	19	9.9
Moderate	107	16.1	40	20.8
High	210	31.6	58	30.2
Very high	299	45.0	75	39.1

Over three quarters (76.6%; n = 509) of non-binary (AFAB) participants reported high or very high levels of psychological distress compared to 69.3% (n = 133) of non-binary (AMAB) participants.

13.6.4 Mental health diagnoses

Participants were asked if they had been diagnosed or treated for a mental health condition in the past 12 months. Table 43 displays these results according to non-binary (AFAB) and non-binary (AMAB) status.

Table 43: Diagnosed or treated for a mental health condition in the past 12 months by non-binary (AFAB) and non-binary (AMAB) (n = 867)

Gender assigned at birth	Non-binary (AFAB)		Non-binary (AMAB)	
	Number	%	Number	%
Depression	361	53.4	82	42.9
Generalised anxiety disorder	321	47.5	60	31.4
Any mental health condition	472	69.8	110	57.6

Almost seven in ten (69.8%; n = 472) non-binary (AFAB) participants reported being diagnosed or treated for a mental health condition in the past 12 months compared to 57.6% (n = 110) of non-binary (AMAB) participants.

13.6.5 Suicidal ideation and suicide attempts

Participants were asked about any experiences they had related to suicide ideation and attempts. Tables 44 and 45 display these results according to non-binary (AFAB) and non-binary (AMAB) status.

Table 44: Suicidal ideation by non-binary (AFAB) and non-binary (AMAB) (n = 873)

Gender assigned at birth	Non-binary (AFAB)		Non-binary (AMAB)	
	Number	%	Number	%
Past 12 months	417	61.6	118	60.2
Ever	615	90.8	173	80.3
Prefer not to say	17	3.0	4	2.0

Overall, non-binary (AMAB) and non-binary (AFAB) participants showed similar patterns with regard to suicidal ideation, with just over 60% reporting thoughts about suicide in the past 12 months.

Table 45: Suicide attempts by non-binary (AFAB) and non-binary (AMAB) (n = 753)

Gender assigned at birth	Non-binary (AFAB)		Non-binary (AMAB)	
	Number	%	Number	%
Past 12 months	38	6.4	10	6.2
Ever	249	42.1	53	32.9
Prefer not to say	29	5.1	10	4.5

Four in ten (42.1%; n = 249) non-binary (AFAB) participants reported having ever attempted suicide compared to one third (32.9%; n = 53) of non-binary (AMAB) participants.

13.6.6 Experiences of health services among participants reporting psychological distress

Participants reporting high or very high levels of psychological distress were asked if they had ever been diagnosed or treated for a mental health condition in the past 12 months. Table 46 displays these results according to non-binary (AFAB) and non-binary (AMAB) status.

Table 46: Mental health service access in the past 12 months among participants reporting high or very high levels of psychological distress by non-binary (AFAB) and non-binary (AMAB) (n = 658)

Gender assigned at birth	Non-binary (AFAB)		Non-binary (AMAB)	
	Number	%	Number	%
Mainstream mental health service	262	50.3	56	40.9
Mainstream mental health service that is LGBTIQ-inclusive	168	32.2	43	31.4
Mental health service that only caters to lesbian, gay, bisexual, transgender and/or intersex people	40	7.7	20	14.6
Any mental health service	372	71.4	90	65.7

Half (50.3%; n = 262) of non-binary (AFAB) participants who reported high or very high levels of psychological distress reported having accessed a mainstream mental health service in the past 12 months compared to four in ten (40.9%; n = 56) non-binary (AMAB) participants. Conversely, nearly twice (14.6%; n = 20) the proportion of non-binary (AMAB) participants with high or very high psychological distress had accessed a mental health service that caters only to lesbian, gay, bisexual, transgender and/or intersex people than non-binary (AFAB) participants (7.7%; n = 40).

13.7 Trans women and trans men

This section spotlights key findings from elsewhere in the report for binary trans women and trans men with the aim of providing a more comprehensive chapter on trans and gender diverse participants.

13.7.1 Feelings of acceptance

Table 47 displays the numbers and percentages of trans women and trans men who felt they were accepted ‘a lot’ or ‘always’ in a range of situations.

Table 47: Currently feel accepted ‘a lot’ or ‘always’ by trans women and trans men

	Trans woman		Trans man	
	Number	%	Number	%
LGBTIQ event	145	69.0	158	66.7
LGBTIQ venue	145	68.7	153	65.9
At work	88	50.0	100	48.8
At an educational institution	52	38.2	84	41.8
With family members	113	41.1	131	44.1
LGBTIQ dating app or website	39	37.5	45	28.7
Accessing a health or support service	127	46.5	86	30.1
Social/community events	76	29.9	67	25.7
In public (e.g., in the street/park)	84	30.7	89	30.5
Mainstream venue	67	26.1	53	20.7
Mainstream event	69	28.0	51	20.4
Non-LGBTIQ dating app or website	14	12.3	14	9.3
Religious/faith-based events or services	14	12.2	14	9.6

Note: responses were analysed among participants who reported that a situation was applicable to them therefore an overall ‘n’ is not provided.

Overall, low proportions of trans women and trans men reported currently feeling accepted a lot or always in most situations. However, a greater proportion of trans women reported currently feeling accepted a lot or always than trans men. For example, 46.5% (n = 127) of trans women reported currently feeling accepted a lot or always when accessing a health or support service compared to 30.1% (n = 86) of trans men. Similarly, 28.0% (n = 69) of trans women reported currently feeling accepted a lot or always at a mainstream event compared to 20.4% (n = 51) of trans men. However, slightly more trans men (44.1%; n = 131) reported currently feeling accepted a lot or always with family members than trans women (41.1%; n = 113).

13.7.2 Self-rated health

Participants were asked to rate their health on a 5-point scale from 'poor' to 'excellent.' Table 48 displays these results for trans women and trans men.

Table 48: Self-rated health by trans women and trans men (n = 583)

	Trans woman		Trans man	
	Number	**%**	**Number**	**%**
Poor	24	8.4	35	11.7
Fair	75	26.3	91	30.5
Good	111	39.0	113	37.9
Very good	55	19.3	52	17.5
Excellent	20	7.0	7	2.4

A greater proportion of trans men (42.2.%; n = 126) reported poor or fair health compared to trans women (34.7%; n = 99). Similarly, a smaller proportion of trans men (19.8%; n = 59) reported very good or excellent health compared to trans women (26.3%; n = 75).

13.7.3 Psychological distress (K10)

Table 49 displays the K10 psychological distress levels for trans women and trans men.

Table 49: K10 by trans women and trans men (n = 575)

	Trans woman		Trans man	
	Number	**%**	**Number**	**%**
Low	42	14.9	28	9.6
Moderate	55	19.5	43	14.7
High	86	30.5	89	30.4
Very high	99	35.1	133	45.4

Over three quarters (75.8%; n = 222) of trans men reported high or very high levels of psychological distress compared to 65.6% (n = 185) of trans women.

13.7.4 Mental health diagnoses

Participants were asked if they had been diagnosed or treated for a mental health condition in the past 12 months. Table 50 displays these results for trans women and trans men.

Table 50: Diagnosed or treated for a mental health condition in the past 12 months by trans women and trans men (n = 567)

	Trans woman		Trans man	
	Number	**%**	**Number**	**%**
Depression	149	54.6	156	53.1
Generalised anxiety disorder	112	41.0	139	47.3
Any mental health condition	184	67.4	192	65.3

More than two thirds of trans women (67.4%; n = 184) and trans men (65.3%; n = 192) reported being diagnosed or treated for a mental health condition in the past 12 months. A slightly larger proportion of trans men (47.3%; n = 139) reported being diagnosed or treated for generalised anxiety disorder than trans women (41.0%; n = 112).

13.7.5 Suicidal ideation and suicide attempts

Participants were asked about any experiences they had related to suicide ideation and attempts. Tables 51 and 52 display these results for trans women and trans men.

Table 51: Suicidal ideation by trans women and trans men (n = 582)

	Trans woman		Trans man	
	Number	**%**	**Number**	**%**
Past 12 months	165	58.3	183	61.2
Ever	244	86.2	271	90.6
Prefer not to say	9	3.2	3	1.0

More than nine in ten trans men (90.6%; n = 271) and 86.2% (n = 244) of trans women reported ever having thoughts about suicide. Approximately six in ten (61.2%; n = 183) trans men and 58.3% (n = 165) of trans women reported having thoughts about suicide in the past 12 months.

Table 52: Suicide attempts by trans women and trans men (n = 511)

	Trans woman		Trans man	
	Number	**%**	**Number**	**%**
Past 12 months	27	10.9	36	13.7
Ever	113	45.6	139	52.9
Prefer not to say	15	6.1	7	2.7

Both trans women and trans men reported very high levels of suicide attempts, with more than half (52.9%; n = 139) of trans men and 45.6% (n = 113) of trans women reported having ever attempted suicide.

13.7.6 Experiences of health services among participants reporting psychological distress

Participants reporting high or very high levels of psychological distress were asked if they had ever been diagnosed or treated for a mental health condition in the past 12 months. Table 53 displays these results for trans women and trans men.

Table 53: Mental health service access in the past 12 months among trans women and trans men who reported high or very high levels of psychological distress (n = 407)

	Trans woman		Trans man	
	Number	**%**	**Number**	**%**
Mainstream mental health service	82	44.3	90	40.5
Mainstream mental health service that is LGBTIQ-inclusive	84	45.4	90	40.5
Mental health service that only caters to lesbian, gay, bisexual, transgender and/or intersex people	26	14.1	28	12.6
Any mental health service	144	77.8	152	68.5

Approximately four in ten (45.4%; n = 84) trans women and trans men (40.5%; n = 90) who reported high or very high levels of psychological distress reported having accessed a mainstream mental health service in the past 12 months. Relatively few reported having accessed a mental health service that caters only to lesbian, gay, bisexual, transgender and/or intersex people, with 14.1% (n = 26) of trans women and 12.6% (n = 27) of trans men.

13.8 Summary

There are very important differences in health-related experiences among subgroups of trans and gender diverse people. Trans and gender diverse people are not a single homogeneous group in terms of their experiences of gender identity, community support, healthcare or experiences of harassment or violence. For example, trans women were the most likely to have acquired legal recognition documents of their gender identity and were also the most likely to have experienced gender euphoria. Trans men were the most likely to have used gender affirming treatments or changed their appearance and reported the highest levels of satisfaction with these procedures. More than half of non-binary participants reported that they currently used or intended to undertake hormonal medications. While the majority of non-binary participants reported having changed their appearance, more were unsatisfied with the result than trans men or trans women, possibly related to a lack of accessible knowledge regarding non-binary gender affirmation. Non-binary participants also reported less community and healthcare support than trans women and trans men, although all trans and gender diverse participants reported much lower community and healthcare support than cisgender women and men. There were also some important differences between non-binary (AFAB) and non-binary (AMAB) participants, with non-binary (AFAB) participants reporting lower self-rated health and higher levels of psychological distress, mental health challenges and suicide attempts than non-binary (AMAB) participants.

Findings from PL3 tell us that six years on from the First Australian Trans Mental Health Study (Hyde et al., 2014), large health and wellbeing disparities between trans and gender diverse people and cisgender men and women within Australian LGBTIQ communities continue to exist. Although many trans and gender diverse people in Australia live healthy and connected lives, overall, there appear to be substantial disparities across almost all areas of the PL3 data between these groups, possibly indicative of previous research that has observed associations between the ways by which trans and gender diverse people are treated and poor health and wellbeing outcomes (Dolan et al., 2020; Strauss et al., 2020).

Addressing these disparities will be important going forward. Including trans and gender diverse populations as a key priority population across all federal, state and territory policy frameworks in Australia, as a priority population that is distinct from, but still very much part of, the LGBTIQ human rights movement would comprise an important step. It will also be important to give attention to improving access to gender affirming hormones and surgical interventions, identity documentation updates and dedicated programming for and by trans and gender diverse professionals, as part of addressing issues of equity and wellbeing.

14 People with an intersex variation/s

Chapter 1 provided an overview of participants who reported having an intersex variation/s, including a breakdown by gender and sexual orientation. In total, 47 participants completed the Private Lives 3 survey who could be reliably classified as a person born with an intersex variation/s, with a variety of intersex variation/s represented among the 25 participants who described their intersex variation/s. They also completed a supplementary section that asked additional questions related to this group. Given this relatively small number of participants, caution should be exercised when interpreting these results and this group will not be representative of all people with an intersex variation/s, as noted in Chapter 1. However, there has been little previous data available of people with an intersex variation/s. This chapter therefore provides results from those who completed the Private Lives 3 survey.

14.1 Community belonging

Participants were asked the extent to which 'you feel you're a part of the Australian LGBTIQ community' and 'participating in Australia's LGBTIQ community is a positive thing for you', with response options provided on a 5-point scale ranging from 'strongly disagree' to strongly agree.' Tables 54 and 55 display these results for participants who reported having an intersex variation/s.

Table 54: You feel you're part of Australia's LGBTIQ community (n = 47)

	Number	%
Do not agree	26	55.3
Agree/strongly agree	21	44.7

In total, less than half (44.7%; n = 21) of participants with intersex variation/s reported that they agree or strongly agree that they feel a part of the Australian LGBTIQ community

Table 55: Participating in Australia's LGBTIQ community is a positive thing for you (n = 47)

	Number	%
Do not agree	18	38.3
Agree/strongly agree	29	61.7

More than six in ten (61.7%; n = 29) participants with intersex variation/s reported that they agree or strongly agree that participating in Australia's LGBTIQ community is a positive thing for them.

14.2 Feelings of acceptance

Table 56 displays the numbers and percentages of participants with an intersex variation/s in the PL3 sample who felt they were accepted 'a lot' or 'always' in a range of situations.

Table 56: Currently feel accepted 'a lot' or 'always'

	Number	%
LGBTIQ event	23	54.8
LGBTIQ venue	22	55.0
At work	16	50.0
At an educational institution	12	46.2
With family members	13	27.7
LGBTIQ dating app or website	9	40.9
Accessing a health or support service	13	30.2
Social/community events	14	34.1
In public (e.g., in the street/park)	9	21.4

Mainstream venue	9	20.5
Mainstream event	8	18.6
Non-LGBTIQ dating app or website	2	11.8
Religious/faith-based events or services	7	21.9

Note: responses were analysed among participants who reported that a situation was applicable to them therefore an overall 'n' is not provided.

More than twice the proportion of participants with an intersex variation/s reported feeling accepted a lot or always at an LGBTIQ event (54.8%; n = 23) or venue (55.0%; n = 22) than at a mainstream venue (20.5%; n = 9) or mainstream event (18.6%; n = 8). Less than a third reported they felt accepted a lot or always when accessing a health or support service (30.2%; n = 13).

14.3 Self-rated health

Participants were asked to rate their health on a 5-point scale from 'poor' to 'excellent.' Table 57 displays these results among participants with an intersex variation/s.

Table 57: Self-rated health (n = 47)

	Number	%
Poor	8	17.0
Fair	11	23.4
Good	11	23.4
Very good	13	27.7
Excellent	4	8.5

Four in ten (40.4%; n = 19) participants with an intersex variation/s rated their health as poor or fair, one quarter (23.4%; n = 11) as good and one third (36.2%; n = 17) as very good or excellent.

14.4 Mental health diagnoses

Participants were asked if they had ever been diagnosed or treated for a mental health condition in the past 12 months. Table 58 displays these results.

Table 58: Diagnosed or treated for a mental health condition in the past 12 months (n = 46)

	Number	%
Depression	19	41.3
Generalised anxiety disorder	12	26.1
Any mental health condition	28	60.9

Four in ten (41.3%; n = 19) participants with an intersex variation/s reported being diagnosed or treated for depression in the past 12 months, one quarter (26.1%; n = 12) reported being diagnosed or treated for a generalised anxiety disorder in the past 12 months and six in ten (60.9%; n = 28) reported being diagnosed or treated for any mental health condition in the past 12 months.

14.5 Psychological distress (K10) and mental health service access

Table 59 displays the K10 psychological distress levels among participants with an intersex variation/s.

Table 59: K10 (n = 45)

	Number	%
Low	8	17.8
Moderate	10	22.2
High	11	24.4
Very high	16	35.6

Six in ten (60.0%; n = 27) participants with an intersex variation/s reported high or very high levels of psychological distress.

14.6 Experiences of health services among participants reporting psychological distress

Table 60 displays the proportion of participants who accessed a mental health service in the past 12 months among those who reported high or very high levels of psychological distress.

Table 60: Mental health service access in the past 12 months among participants reporting high or very high levels of psychological distress (n = 27)

	Number	%
Mainstream mental health service	11	40.7
Mainstream mental health service that is LGBTIQ-inclusive	14	51.9
Mental health service that only caters to lesbian, gay, bisexual, transgender and/or intersex people	4	14.8
Any mental health service	20	74.1

Note: multiple responses were available thus percentages do not add up to 100.

Nearly three quarters (74.1%; n = 20) of participants with an intersex variation/s and who reported high or very high levels of psychological distress reported accessing a mental health service in the past 12 months. Four in ten (40.7%; n = 11) accessed a mainstream mental health service, 51.9% (n = 14) a mainstream mental health service that is LGBTIQ-inclusive and 14.8% (n = 4) a mental health service that caters only to lesbian, gay, bisexual, transgender and/or intersex people.

14.7 Suicidal ideation and suicide attempts

Tables 61 and 62 display the responses to questions regarding experiences of suicidal ideation, defined as 'thoughts about suicide, wanting to die or about ending your life' and suicide attempts, defined as having 'attempted suicide or to end your life.' Note, participants who skipped the section by indicating 'I prefer not to answer these questions' and those who selected 'prefer not to answer' for a particular question were combined to form a single category of 'prefer not to say' (see Section 8.3 for further information).

Table 61: Suicidal ideation (n = 47)

	Number	%
Past 12 months	23	48.9
Ever	41	87.2
Prefer not to say	0	0.0

Almost one in two (48.9%; n = 23) participants with an intersex variation/s reported having experienced suicidal ideation in the past 12 months. Almost nine in ten (87.2%; n = 41) reported having ever experienced suicidal ideation.

Table 62: Suicide attempt (n = 41)

	Number	%
Past 12 months	5	12.2
Ever	20	48.8
Prefer not to say	2	4.9

Over one in ten (12.2%; n = 5) participants with an intersex variation/s reported having attempted suicide in the past 12 months. Almost one in two (48.8%; n = 20) reported having ever attempted suicide.

14.8 Family and friends with intersex variation/s

Participants were asked if they had any family or friends with intersex variation/s. Tables 63 and 64 display these results.

Table 63: Family members with an intersex variation/s (n = 46)

	Number	%
No	25	54.4
Yes, same as me	5	10.9
Yes, different to me	4	8.7
Don’t know	14	30.4

Almost one fifth (19.6%; n = 9) of participants with an intersex variation/s reported having one or more family members with an intersex variation/s.

Table 64: Friends with an intersex variation/s (n = 46)

	Number	%
No	17	31.5
Yes, same as me	10	18.5
Yes, different to me	18	33.3
Don’t know	9	16.7

More than half (51.8%; n = 28) of participants with an intersex variation/s reported having one or more friends with an intersex variation/s.

14.9 Informed about intersex variation/s

Participants were asked who first told them about the nature of their intersex variation/s and if they were informed of any kinds of support services when this occurred. Tables 65 and 66 display these results.

Table 65: Who informed you about your intersex variation/s (n = 46)

	Number	%
Endocrinologist	16	34.8
Family doctor	10	21.7
Parent/carer	9	19.6
Gynaecologist	4	8.7
Other family member	2	4.4
Other person	9	19.6
No one told me directly	9	19.6
Can't remember	1	2.2

Note: multiple responses were available thus percentages do not add up to 100.

One third of participants were informed about their intersex variation/s by an endocrinologist (34.8%; n = 16), followed by one fifth (21.7%; n = 10) by a family doctor or a parent/carer (19.6%; n = 9). A further fifth (19.6%; n = 9) of participants reported that no one told them directly.

Table 66: Informed of support services when told about intersex variation/s (n = 46)

	Number	%
No	35	76.1
Genetic Counselling	4	8.7
Intersex information website	3	6.5
In-hospital psychologist	2	4.4
General intersex peer support	2	4.4
Support group specific to your diagnosis	2	4.4
Mainstream counselling service	1	2.2
Other	3	6.5

Note: multiple responses were available thus percentages do not add up to 100.

More than three quarters (76.1%; n = 35) reported that they were not informed about any support services when they were told about their intersex variation/s. Genetic counselling (8.7%; n = 4) and an intersex information website (6.5%; n = 3) were the most commonly reported support services for which they were provided information.

14.10 Experiences related to an intersex variation/s

Table 67 displays the numbers and percentages of participants with an intersex variation/s in the PL3 sample who responded 'agree' or 'strongly agree' with a series of statements referring to potential experiences related to having an intersex variation/s.

Table 67: Participants who agreed or strongly agreed with the following statements

	Number	%
I have had to educate health service providers to have my needs met	31	79.5
I have found it hard to identify affirmative, professional psychological support	26	76.5
I have experienced challenges in accessing health service providers that have expertise in my intersex variation/s	28	75.7
I faced unnecessary or unmanageable costs in accessing appropriate hormone replacement therapy or reparative treatment	21	70.0
I have needed to manage comorbidities (i.e., the co-occurrence of other conditions) associated with my intersex variation	21	63.6
I have experienced problems accessing historical medical records	18	60.0
I have had autonomy over my body and able to make informed healthcare choices	24	55.8
I have experienced problems keeping my medical records private or secure	16	51.6
My intersex variation is completely managed and does not require ongoing attention	21	47.7
I have been able to access intersex peer support networks or services	13	37.1
I have experienced challenges accessing reproductive health services	8	34.8

Note: responses were analysed among participants who reported that a situation was applicable to them therefore an overall 'n' is not provided.

Almost eight in ten (79.5%; n = 21) participants with an intersex variation/s agreed or strongly agreed with the statement that 'I have had to educate health service providers to have my needs met.' Three quarters (76.5%; n = 26) agreed or strongly agreed that 'I have found it hard to identify affirmative, professional psychological support' and 'I have experienced challenges in accessing health service providers that have expertise in my intersex variation/s' (75.7%; n = 28). Seven in ten (70.0%; n = 21) agreed or strongly agreed that 'I faced unnecessary or unmanageable costs in accessing appropriate hormone replacement therapy or reparative treatment', almost two thirds (63.6%; n = 21) 'I have needed to manage comorbidities (i.e., the co-occurrence of other conditions) associated with my intersex variation' and six in ten (60.0%; n = 18) 'I have experienced problems accessing historical medical records.' Slightly over half (55.8%; n = 24) agreed or strongly agreed that 'I have had autonomy over my body and able to make informed healthcare choices' and almost half (47.7%; n = 21) that 'my intersex variation is completely managed and does not require ongoing attention.' Slightly over one third of participants (37.1%; n = 13) agreed or strongly agreed that 'I have been able to access intersex peer support networks or services.'

14.11 Experiences of medical intervention/s

Participants with an intersex variation/s were asked about their experiences with medical interventions. Tables 68 to 74 display these results.

Participants were asked, 'has there ever been an occasion when you felt you did not have sufficient say over medical decisions that related to you? Sometimes this is referred to as 'autonomy' over your body.' Table 68 displays these results.

Table 68: Ever felt you did not have sufficient say over medical decisions that related to you (n = 47)

	Number	%
No	18	38.3
Yes, once	5	10.6
Yes, more than once	24	51.1
Ever	29	61.7

More than six in ten (61.7%; n = 29) participants with an intersex variation/s reported ever having experienced an occasion where they felt they did not have sufficient say over medical decisions that related to them. More than half (51.1%; n = 24) responded that this had occurred on more than one occasion.

Participants were then asked if they had ever undergone a medical intervention relating to their intersex variation/s and if this had occurred when they were a child. Table 69 displays these results.

Table 69: Undergone a medical intervention relating to your intersex variation/s (n = 46) and did any medical interventions happen when you were a child? (n = 25)

	Ever		As a child	
	Number	%	Number	%
No	21	45.6	8	32.0
Yes	25	54.4	17	68.0

More than half (54.4%; n = 25) of participants reported ever having undergone a medical intervention relating to their intersex variation/s. Of these, almost seven in ten (68.0%; n = 17) responded that this had occurred when they were a child. Those who reported that they had undergone a medical intervention were aged 43.5 (SD = 12.7) years on average at the time of the survey while those who reported that they had not undergone a medical intervention had an average age of 37.9 (SD = 12.7) years.

Participants who reported that they had ever undergone a medical intervention relating to their intersex variation/s were asked the extent to which they were able to provide full and informed consent and the extent to which their parents or carers were able to provide full and informed consent. Table 70 displays these results.

Table 70: Extent to which you were able to provide full and informed consent? (n = 25) and extent to which parents or carers were able to provide full and informed consent? (n = 22)

	Ever		Parent/carer	
	Number	%	Number	%
Not at all	13	52.0	13	59.1
A little	5	20.0	2	9.1
Somewhat	1	4.0	1	4.6
Mostly	4	16.0	5	22.7
Completely	2	8.0	1	4.6

Less than one quarter (24.0%; n = 6) of participants responded that they were mostly or completely able to provide full and informed consent and 27.3% (n = 6) of participants responded that their parent/s or carer/s were mostly or completely able to provide full and informed consent. Over half (52.0%; n = 13) responded 'not at all' and six in ten (59.1%; n = 13) responded that their parent/s or carer/s were not at all able to provide full and informed consent.

Participants who reported that they had ever undergone a medical intervention relating to their intersex variation/s were then asked, 'overall, how satisfied are you with the outcomes of the medical intervention/s?' Table 71 displays these results.

Table 71: Satisfaction with medical intervention outcomes (n = 25)

	Number	%
Very dissatisfied	10	40.0
Somewhat dissatisfied	4	16.0
Neutral	4	16.0
Somewhat satisfied	6	24.0
Very satisfied	1	4.0

Overall, more than half (56.0%; n = 14) reported being somewhat dissatisfied or very dissatisfied with the medical intervention outcomes. Slightly over one quarter (28.0%; n = 7) reported being somewhat satisfied or very satisfied with the outcomes.

Participants who reported that they had ever undergone a medical intervention relating to their intersex variation/s (n = 24) were then asked, 'what outcomes have you experienced from any interventions you have undergone?', 'have you experienced a change or loss of sensitivity or function?' and 'have you ever required ongoing hormone replacement therapy (HRT) as a result of the interventions experienced?' Tables 72 to 74 display these results.

Table 72: Outcomes of medical interventions relating to intersex variation/s (n = 24)

	Number	%
I have scarring	13	54.2
I have psychological impairments	10	41.7
I have functional impairments	7	29.2
Does not align with my gender	6	25.0
Aligns with my gender	5	20.8
Aligns with my sexual behaviour	4	16.7
Does not align with my sexual behaviour	4	16.7
Other outcome/s	6	25.0

Note: multiple responses were available thus percentages do not add up to 100.

More than half (54.2%; n = 13) of participants who reported that they had ever undergone a medical intervention relating to their intersex variation/s reported scarring, followed by four in ten (41.7%; n = 10) reporting psychological impairments and three in ten (29.2%; n = 7) reporting functional impairments.

Table 73: Experienced a change or loss of sensitivity or function? (n = 24)

	Number	%
No	11	45.8
Yes	8	33.3
Not sure	5	20.8

One third (33.3%; n = 8) of participants who reported that they had ever undergone a medical intervention relating to their intersex variation/s reported a loss of sensitivity or function, one fifth (20.8%; n = 5) were not sure and 45.8% (n = 11) reported that they did not experience a loss of sensitivity or function.

Table 74: Ever required ongoing hormone replacement therapy (HRT) as a result of the interventions experienced (n = 25)

	Number	%
No	8	32.0
In the past 12 months	11	44.0
Ever	17	68.0

Note: multiple responses were available thus percentages do not add up to 100.

More than two thirds (68.0%; n = 17) of participants reported ever requiring ongoing hormone replacement therapy as a result of the interventions experienced. More than four in ten (44.0%; n = 11) reported requiring ongoing hormone replacement therapy during the past 12 months.

14.12 Experiences of discrimination in healthcare settings

Participants were asked if they had ever experienced discrimination in a healthcare setting related to their intersex variation/s, what form of discrimination this had taken and whether they reported an experience of discrimination to hospital management, Australian Medical Association or other health professional body. Tables 75 to 77 display these results.

Table 75: Ever experienced discrimination in a healthcare setting relating to your intersex variation/s (n = 45)

	Undergone a medical intervention		Have not undergone a medical intervention		Total	
	Number	%	Number	%	Number	%
No	9	36.0	11	55.0	20	44.4
Yes	16	64.0	9	45.0	25	56.6

Almost two thirds (64.0%; n = 16) of participants who had ever undergone a medical intervention relating to their intersex variation/s reported having experienced discrimination in a healthcare setting related to their intersex variation/s. This compared to 45.0% (n = 9) of those who had not undergone a medical intervention.

Participants who reported having ever experienced discrimination in a healthcare setting related to their intersex variation/s were then asked what form of discrimination they had experienced. Table 76 displays these results.

Table 76: Form of discrimination (n = 24)

	Number	%
Dismissal of your worries or concerns relating to your health	21	84.0
Inappropriate questions about your body	20	80.0
Inaccurate, false or misleading information provided or key information omitted	17	68.0
Whispering or gossiping about you by medical staff	16	64.0
Invasive medical examinations you did not consent to	13	52.0
Invasive medical interventions you did not consent to	8	32.0
Other	6	24.0

Note: multiple responses were available thus percentages do not add up to 100.

Of participants who reported having ever experienced discrimination in a healthcare setting related to their intersex variation/s, more than four fifths (84.0%; n = 21) reported experiencing a dismissal of their worries or concerns relating to their health, eight in ten (80.0%; n = 20) reported inappropriate questions about their body, almost seven in ten (68.0%; n = 17) reported inaccurate, false or misleading information provided or key information omitted, 64.0% (n = 16) reported whispering or gossiping about them by medical staff, more than half (52.0%; n = 13) reported invasive medical examinations they did not consent to and 32.0% (n = 8) reported invasive medical interventions they did not consent to.

Table 77: Did you report or complain about this discriminatory behaviour to the hospital management, Australian medical association or other health professional body? (n = 25)

	Number	%
No	22	88.0
Yes	3	12.0

Of participants who reported having ever experienced discrimination in a healthcare setting related to their intersex variation/s, only around one in ten (12.0%; n = 3) reported or complained about this discriminatory behaviour to the hospital management, Australian Medical Association or other health professional body. The participants who reported this discriminatory behaviour were further asked to what extent they were satisfied with the response on a 5-point scale ranging from 'very dissatisfied' to 'very satisfied.' Overall, one participant responded, 'very dissatisfied' and two participants 'neutral.'

14.13 Summary

It is important to note, as outlined earlier in this report, that the sample of 47 participants with an intersex variation/s who completed PL3 should not be taken as representative of the broader population of people with an intersex variation/s. While it was not a large enough sample to provide statistically meaningful comparisons with other groups in the survey, some important themes emerged in this particular sample. Significant proportions of people with an intersex variation/s did not seem to be connected to or accepted by the broader LGBTIQ community. Many participants reported that they were unable to provide informed consent to medical interventions, with low levels of satisfaction with such interventions, as well as high levels of discrimination in healthcare settings. Participants with an intersex variation/s also reported high levels of suicidal ideation and attempts, psychological distress and low levels of feeling accepted by family or in healthcare or other mainstream settings. Although further research is required to collect data across a broader spectrum of people with intersex variation/s in Australia, these data suggest that much more work is required to support the health, wellbeing and human rights of people with an intersex variation/s.

15 Disability or long-term health condition

This chapter presents results from PL3 according to whether participants self-reported living with a disability or long-term health condition. The PL3 survey used the Australian Institute of Health and Welfare's Standardised Disability Flag Module (SDFM) (Australian Institute of Health and Welfare, 2016b) to identify individuals with a long-term health condition or disability (defined as someone who reports an activity limitation, a specific education participation restriction and/or a specific employment participation restriction). The SDFM is based on the International Classification of Functioning, Disability and Health, a classification of health domains put forward by the World Health Organisation. It is intended for use across a wide range of sectors, enabling nationally consistent collection of information used to identify people with disabilities or long-term health conditions who experience difficulties or need assistance in various areas of their life.

The SDFM consists of eight questions concerning activity participation and need for assistance on a 4-point scale, ranging from 'have no difficulty' to 'always/sometimes need help or supervision.' Two subsequent questions follow that ask about whether participants experience education and employment participation restrictions that require a 'yes' or 'no' response.

In total, almost four in ten (38.5%; n = 2,629) participants reported experiences categorised by the SDFM as having a disability or long-term health condition. One in ten (11.8%; n = 802) reported a profound or severe disability, 20.4% (n = 1,394) a moderate disability and 6.4% (n = 433) a mild disability. It is notable that there was a higher proportion of people reporting a disability in this study than in PL2 (22.7%) and the general Australian population (17.7%) (Australian Bureau of Statistics, 2019f). This is likely to arise because the SDFM was designed as a more inclusive and comprehensive measure of disability or long-term health condition than those used in PL2 or the ABS and includes questions regarding difficulties with personal relationships, managing tasks and situations and community life. While one of its strengths is a focus on individuals self-reporting their circumstances rather than relying on a medical diagnosis, it is important to note its limitations. The SDFM is a quantitative tool used to categorise a disability or long-term health condition according to how participants report its impact on aspects of their lives but this may not be how these participants would describe their own disability in a qualitative study. As such, it may not accurately reflect or correspond with how structural and systemic barriers influence, impact or cause some of the limitations and restrictions reported by people with disabilities or long-term health conditions through the SDFM. It has further limitations in accessibility for people with intellectual disability both in its usability for this cohort as well as access barriers regarding guardianship and assumptions of cognitive capacity and consent made by gatekeepers in their lives that may limit people with intellectual disability responding to a survey such as PL3.

These data are intended to provide a macro-level comparison of the health and wellbeing of LGBTIQ people who report a disability or long-term health condition and those who do not report a disability or long-term health condition and the SDFM is a useful means of gaining this broader understanding.

15.1 Community belonging

Participants were asked the extent to which 'you feel you're a part of the Australian LGBTIQ community' and 'participating in Australia's LGBTIQ community is a positive thing for you', with response options provided on a 5-point scale ranging from 'strongly disagree' to strongly agree.' Tables 78 and 79 display these results for participants who reported having a disability or long-term health condition.

Table 78: You feel you're part of Australia's LGBTIQ community by disability or long-term health condition (n = 6,524)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Do not agree	1,651	42.3	184	42.5	642	46.1	364	45.5
Agree/strongly agree	2,248	57.7	249	57.5	750	53.9	436	54.5

Lower proportions of participants who reported a severe (54.5%; n = 436) or moderate (53.9%; n = 750) disability or long-term health condition reported that they agree or strongly agree that they feel a part of the Australian LGBTIQ community. This compared to 57.7% (n = 2,248) of participants not reporting a disability or long-term health condition and 57.5% (n = 249) of those who reported a mild disability or long-term health condition.

Table 79: Participating in Australia's LGBTIQ community is a positive thing for you by disability or long-term health condition (n = 6,512)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Do not agree	1,453	37.3	155	36.0	550	39.6	327	41.0
Agree/strongly agree	2,440	62.7	276	64.0	840	60.4	471	59.0

A greater proportion of participants who reported a mild disability or long-term health condition (64.0%; n = 276), but a lower proportion of those who reported a severe (59.0%; n = 471) or moderate (60.4%; n = 840) disability or long-term health condition, indicated that they agree or strongly agree that participating in Australia's LGBTIQ community is a positive thing for them. This compared to 62.7% (n = 2,440) of those not reporting a disability or long-term health condition.

15.2 Feelings of acceptance

Table 80 displays the numbers and percentages of participants with a disability or long-term health condition who felt they were accepted 'a lot' or 'always' in a range of situations.

Table 80: Currently feel accepted 'a lot' or 'always' by disability or long-term health condition

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
LGBTIQ event	2,384	71.5	248	65.6	719	61.9	362	55.4
LGBTIQ venue	2,335	70.4	242	65.2	691	60.2	351	54.8
At work	2,262	67.9	205	59.1	475	48.0	173	42.4
At an educational institution	1,540	62.7	156	56.1	410	46.2	197	40.5
With family members	2,215	58.8	223	52.7	582	43.3	286	37.6
LGBTIQ dating app or website	1,338	58.7	111	47.0	366	46.9	156	36.9
Accessing a health or support service	1,785	50.6	167	40.7	449	35.2	223	29.9
Social/community events	1,524	42.6	134	33.0	322	26.0	152	21.5
In public (e.g., in the street/park)	1,319	35.5	137	33.3	301	23.2	147	19.8
Mainstream venue	1,277	35.2	115	28.8	254	20.4	117	16.8
Mainstream event	1,286	35.8	115	29.5	253	20.5	115	16.8
Non-LGBTIQ dating app or website	449	26.9	37	18.0	106	15.0	53	13.7
Religious/faith-based events or services	232	11.4	28	12.0	63	8.7	43	10.1

Note: responses were analysed among participants who reported that a situation was applicable to them therefore an overall 'n' is not provided.

Overall, the proportions of PL3 participants who reported a disability or long-term health condition who felt accepted 'a lot' or 'always' were lower than among participants not reporting a disability or long-term health condition.

More than three times the proportion of participants who reported a severe disability or long-term health condition reported feeling accepted a lot or always at an LGBTIQ event (55.4%; n = 362) or venue (54.8%; n = 351) than at a mainstream event (16.8%; n = 115) or mainstream venue (16.8%; n = 117).

Less than a third (29.9%; n = 223) of participants who reported a severe disability or long-term health condition felt accepted a lot or always when accessing a health or support service. This compared to one half (50.6%; n = 1,785) of participants not reporting a disability or long-term health condition.

15.3 Self-rated health

Participants were asked to rate their health on a 5-point scale from ‘poor’ to ‘excellent.’ Table 81 displays these results according to disability or long-term health condition.

Table 81: Self-rated health by disability or long-term health condition (n = 6,494)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Poor	77	2.0	32	7.4	167	12.0	194	24.4
Fair	597	15.4	128	29.7	471	33.9	315	39.6
Good	1,531	39.5	173	40.1	533	38.3	216	27.2
Very good	1,284	33.1	90	20.9	192	13.8	60	7.5
Excellent	389	10.0	8	1.9	27	1.9	10	1.3

Around two thirds (64.0%; n = 509) of participants who reported a severe disability or long-term health condition rated their health as poor or fair, followed by 45.9% (n = 638) who reported a moderate disability or long-term health condition and 37.1% (n = 160) of participants who reported a mild disability or long-term health condition. This compared to 17.4% (n = 674) of participants not reporting a disability and 14.7% of the general population aged over 15 years (Australian Bureau of Statistics, 2018i).

15.4 Psychological distress (K10)

Table 82 displays the K10 psychological distress levels of participants according to those who reported a disability or long-term health condition.

Table 82: K10 by disability or long-term health condition (n = 6,385)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Low	1,165	30.5	54	12.7	97	7.1	27	3.5
Moderate	1,059	27.8	97	22.9	215	15.8	76	9.7
High	974	25.5	140	33.0	450	33.0	206	26.4
Very high	618	16.2	133	31.4	603	44.2	471	60.4

More than four in five (86.4%; n = 677) participants who reported a severe disability or long-term health condition, three in four (77.2%; n = 1,053) who reported a moderate disability or long-term health condition and 64.4% (n = 273) who reported a mild disability or long-term health condition reported high or very high levels of psychological distress. This compared to 41.7% (n = 1,592) of participants not reporting a disability or long-term health condition and 13.0% among the general Australian population (Australian Bureau of Statistics, 2018h).

15.5 Mental health diagnoses

Participants were asked if they had ever been diagnosed or treated for a mental health condition in the past 12 months. Table 83 displays these results according to those who reported disability or long-term health condition.

Table 83: Diagnosed or treated for a mental health condition in the past 12 months by disability or long-term health condition (n = 6,260)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Depression	892	24.4	240	56.1	773	56.1	541	68.1
Generalised anxiety disorder	777	21.2	189	44.2	666	48.3	464	58.4
Any mental health condition	1,271	34.7	307	71.7	1,003	72.8	666	83.8

More than four in five (83.8%; n = 666) participants who reported a severe disability or long-term health condition had been diagnosed or treated for a mental health condition in the past 12 months, followed by 72.8% (n = 1,003) who reported a moderate disability or long-term health condition, 71.7% (n = 307) who reported a mild disability or long-term health condition and 34.7% (n = 1,271) of participants not reporting a disability or long-term health condition.

15.6 Experiences of health services among participants reporting psychological distress

Table 84 displays the proportion of participants who accessed a mental health service in the past 12 months among those who reported high or very high levels of psychological distress and according to disability or long-term health condition.

Table 84: Mental health service access in the past 12 months among participants reporting high or very high levels of psychological distress according to disability or long-term health condition (n = 3,583)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Mainstream mental health service	506	31.9	150	55.2	528	50.2	408	60.4
Mainstream mental health service that is LGBTIQ-inclusive	253	16.0	55	20.2	260	24.7	231	34.2
Mental health service that only caters to lesbian, gay, bisexual, transgender and/or intersex people	56	3.5	11	4.0	51	4.9	45	6.7
Any mental health service	709	44.8	184	67.7	706	67.1	529	78.4

Of participants who reported high or very high levels of psychological distress, a larger proportion of those who reported a severe (78.4%; n = 547), moderate (67.1%; n = 706) or mild (67.7%; n = 184) disability or long-term health condition said that they had accessed a mental health service compared to those who did not report a disability or long-term health condition (44.8%; n = 709).

15.7 Suicidal ideation and suicide attempts

Tables 85 and 86 display the responses to questions regarding experiences of suicidal ideation, defined as 'thoughts about suicide, wanting to die or about ending your life' and suicide attempts, defined as having 'attempted suicide or to end your life.' Note, participants who skipped the section by indicating 'I prefer not to answer these questions' and those who selected 'prefer not to answer' for a particular question were combined to form a single category of 'prefer not to say' (see Section 8.3 for further information).

Table 85: Suicidal ideation by disability or long-term health condition (n = 6,499)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Past 12 months	1,125	29.0	228	53.1	795	57.2	544	68.0
Ever	2,526	65.1	365	85.1	1,217	87.6	727	90.9
Prefer not to say	76	2.0	11	2.5	33	2.4	20	2.5

Seven in ten (68.0%; n = 544) participants who reported a severe disability or long-term health condition, 57.2% (n = 795) of participants who reported a moderate disability or long-term health condition and 53.1% (n = 228) of participants who reported a mild disability or long-term health condition reported having experienced suicidal ideation in the past 12 months. This compared to 29.0% (n = 1,125) of participants not reporting a disability or long-term health condition and 2.3% among the general Australian population (Johnston et al., 2009).

More than nine in ten (90.9%; n = 727) participants who reported a severe disability or long-term health condition, 87.6% (n = 1,217) of participants who reported a moderate disability or long-term health condition and 85.1% (n = 365) of participants who reported a mild disability or long-term health condition reported having ever experienced suicidal ideation. This compared to 65.1% (n = 2,526) of participants not reporting a disability or long-term health condition and 13.3% among the general Australian population (Johnston et al., 2009).

Table 86: Suicide attempt by disability or long-term health condition (n = 5,043)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Past 12 months	73	2.6	17	5.0	81	7.0	86	12.4
Ever	593	20.8	121	35.8	482	41.6	347	50.1
Prefer not to say	98	3.4	22	6.5	60	5.1	33	4.7

More than one in ten (12.4%; n = 86) participants who reported a severe disability or long-term health condition, 7.0% (n = 81) of participants who reported a moderate disability or long-term health condition and 5.0% (n = 17) of participants who reported a mild disability or long-term health condition reported having attempted suicide in the past 12 months. This compared to 2.6% (n = 73) of participants not reporting a disability or long-term health condition and 0.4% among the general Australian population (Johnston et al., 2009).

Half (50.1%; n = 347) of participants who reported a severe disability or long-term health condition, 41.6% (n = 482) of participants who reported a moderate disability or long-term health condition and 35.8% (n = 121) of participants who reported a mild disability or long-term health condition reported having ever attempted suicide. This compared to 20.8% (n = 593) of participants not reporting a disability or long-term health condition and 3.2% among the general Australian population (Johnston et al., 2009).

15.8 Unfair treatment as a result of disability or long-term health condition

Participants who reported a disability or long-term health condition were asked the extent to which 'you feel that you have been treated unfairly by others as a result of your disability or long-term health condition' in the past 12 months, with response options provided on a 5-point scale ranging from 'not at all' to 'always.' Table 87 displays these results.

Table 87: Treated unfairly by others in the past 12 months due to a disability or long-term health condition (n = 5,913)

Disability	Mild		Moderate		Severe	
	Number	%	Number	%	Number	%
Not at all	247	57.3	612	44.3	178	22.4
A little	106	24.6	377	27.3	173	21.8
Somewhat	54	12.5	245	17.7	198	24.9
A lot	21	4.9	135	9.8	204	25.7
Always	3	0.7	14	1.0	42	5.3

More than three quarters (77.7%; n = 617) of participants who reported a severe disability or long-term health condition reported being treated unfairly by others in the past 12 months as a result of their disability or long-term health condition. This was followed by more than half (55.8%; n = 771) of participants who reported a moderate disability or long-term health condition and four in ten (42.7%; n = 184) who reported a mild disability or long-term health condition.

15.9 Summary

In line with previous studies observing higher rates of discrimination and reduced service access among LGBTIQ people with disabilities in Australia (Leonard & Mann, 2018), PL3 participants who were classified by their responses on the SDFM as having a severe or moderate disability or long-term health condition reported feeling less connected to the Australian LGBTIQ community and less accepted at a health or support service compared to other participants. Those who reported a disability or long-term health condition also reported higher levels of psychological distress, suicidal ideation and suicide attempts and lower self-rated health than those not reporting a disability or long-term health condition. Although a majority of those who reported a disability or long-term health condition reported feeling accepted at LGBTIQ events and venues, this was lower than those who did not report a disability or long-term health condition. Moreover, they were generally less likely to feel accepted in a range of non-LGBTIQ settings, including in health or support service settings. Taken together, these data suggest that LGBTIQ people who report a disability or long-term health condition experience a range of additional challenges that warrant supportive intervention.

More than three quarters of participants who reported a severe disability or long-term health condition, more than half who reported a moderate disability or long-term health condition and four in ten who reported a mild disability or long-term health condition reported being treated unfairly by others as a result of their disability or long-term health condition in the past 12 months. These data are significantly higher than the one in eleven people in the general population aged 15 years and over with a disability who have reported experiencing disability-related discrimination in the past 12 months (Australian Institute of Health and Welfare, 2019). However, it needs to be noted that there are differences in the question wording in PL3, so caution is required in making direct comparisons. Nevertheless, the findings from PL3 indicate a need for further research to identify and address the specific contexts in which discrimination is experienced among LGBTIQ people with disabilities or long-term health conditions.

It is of note that there is an ongoing deliberate shift in the culture of self-definition and self-advocacy among LGBTIQ people with disabilities and long-term health conditions. While there is a need to capture data comparable to people with a disability or long-term health condition among the general population, it is also important to use more accessible, refined and ecologically valid tools for research regarding LGBTIQ people with disabilities or long-term health conditions, particularly with regard to intellectual disabilities, which have long been marginalised within disability scholarship studies (Vehmas, 2019). It will be important to utilise updated tools and frameworks in future studies involving LGBTIQ communities in Australia, including in the next iteration of Private Lives. However, a quantitative study such as PL3 will not be able to capture the nuance of this shift easily and qualitative studies and research in formats that are more accessible to LGBTIQ people with intellectual disability are also needed.

16 Multicultural backgrounds

Australia is ethnically diverse, with one in four people born overseas and 46% with at least one parent who was born overseas as of 2015 (Human Rights Watch, 2015). Some LGBTIQ people from multicultural backgrounds are known to experience heightened levels of heterosexism within their communities (McAllister & Snagovsky, 2018) and may face family violence when disclosing their sexualities (Asquith et al., 2019). LGBTIQ people from multicultural backgrounds can also experience discrimination from both mainstream sources as well as intra-minority stressors from within the LGBTIQ community (Balsam et al., 2011; Callander et al., 2015), where they may face physical and discursive exclusion (Lim & Hewitt, 2018; Pallotta-Chiarolli, 2016). LGBTIQ people from multicultural backgrounds may also face multiple layers of discrimination depending on their intersectional identities (Tang et al., 2020). Furthermore, there is a distinct lack of data regarding LGBTIQ people from multicultural backgrounds both internationally (Balsam et al., 2011) and in Australia, where it is compounded by significant and complex challenges in accurately and authentically defining people in regard to their ancestry and ethnicity.

In PL3, participants were asked to describe their ethnic background with a text response and were subsequently separated into two broad categories: 1) individuals from multicultural backgrounds; and 2) individuals of Anglo-Celtic heritage. Multicultural is a broad categorisation that was utilised to accommodate the complexity and wide diversity in cultural, religious and/or ethnic backgrounds and is intended to provide macro-level quantitative analyses regarding the unique lived experiences faced by multicultural LGBTIQ people in general.

In total, 6,008 participants responded to this question, with three in ten (29.1%; n = 1,750) identifying as being from culturally diverse backgrounds compared to almost seven in ten (69.4%; n = 4,184) Anglo-Celtic and 1.2% (n = 74) unknown. These analyses do not include the Aboriginal and/or Torres Strait Islanders who participated in this survey (n = 183). Specific in-depth outputs are planned for the analysis and interpretation of Aboriginal and Torres Strait Islander data, in close collaboration with Aboriginal and Torres Strait Islander organisations (see Section 1.1) in order to meaningfully and appropriately document their unique experiences.

16.1 Community belonging

Participants were asked the extent to which 'you feel you're a part of the Australian LGBTIQ community' and 'participating in Australia's LGBTIQ community is a positive thing for you', with response options provided on a 5-point scale ranging from 'strongly disagree' to strongly agree.' Tables 88 and 89 display these results according to whether participants were from multicultural backgrounds or an Anglo-Celtic background.

Table 88: You feel you're part of Australia's LGBTIQ community by background (n = 5,924)

Background	Multicultural		Anglo-Celtic	
	Number	%	Number	%
Do not agree	740	42.3	1,806	43.3
Agree/strongly agree	1,009	57.7	2,369	56.7

Table 89: Participating in Australia's LGBTIQ community is a positive thing for you by background (n = 5,918)

Background	Multicultural		Anglo-Celtic	
	Number	%	Number	%
Do not agree	652	37.3	1,569	37.6
Agree/strongly agree	1,094	62.7	2,603	62.4

A slightly smaller proportion of PL3 participants from multicultural backgrounds (57.7%; n = 1,009) agreed or strongly agreed that they felt a part of the Australian LGBTIQ community compared to those who reported an Anglo-Celtic background (56.7%; n = 2,369). A similar pattern was also found when asked about whether participating in Australia's LGBTIQ community was a positive thing for them.

16.2 Feelings of acceptance

Table 90 displays the numbers and percentages of participants in the PL3 sample who felt they were accepted 'a lot' or 'always' in a range of situations according to whether participants were from multicultural backgrounds or an Anglo-Celtic background.

Table 90: Currently feel accepted 'a lot' or 'always' by background

Background	Multicultural		Anglo-Celtic	
	Number	%	Number	%
LGBTIQ event	962	64.5	2,406	68.0
LGBTIQ venue	956	64.3	2,337	66.7
At work	809	60.2	2,023	61.5
At an educational institution	649	54.9	1,463	56.9
With family members	769	45.8	2,231	55.2
LGBTIQ dating app or website	524	50.5	1,272	53.9
Accessing a health or support service	671	42.0	1,717	44.6
Social/community events	546	34.4	1,386	36.3
In public (e.g., in the street/park)	485	29.2	1,238	31.2
Mainstream venue	450	27.9	1,145	29.9
Mainstream event	444	27.8	1,149	30.4
Non-LGBTIQ dating app or website	206	23.9	388	20.9
Religious/faith-based events or services	124	12.0	204	9.8

Note: responses were analysed among participants who reported that a situation was applicable to them therefore an overall 'n' is not provided.

Overall, a smaller proportion of participants from multicultural backgrounds reported feeling accepted a lot or always in almost all settings. The exception was a non-LGBTIQ dating app or website, where 23.9% (n = 206) reported feeling accepted a lot or always compared to 20.9% (n = 388) of Anglo-Celtic participants. Differences between the groups were greatest for family members, where 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.

16.3 Self-rated health

Participants were asked to rate their health on a 5-point scale from 'poor' to 'excellent.' Table 91 displays these results according to whether participants were from multicultural backgrounds or an Anglo-Celtic background.

Table 91: Self-rated health by background (n = 5,901)

Background	Multicultural		Anglo-Celtic	
	Number	%	Number	%
Poor	134	7.7	280	6.7
Fair	429	24.6	921	22.1
Good	634	36.4	1,625	39.1
Very good	436	25.0	1,051	25.3
Excellent	109	6.3	282	6.8

Just over 32% (n = 563) of participants from multicultural backgrounds rated their health as 'poor' or 'fair.' This compares to 14.7% of the general population aged over 15 years (Australian Bureau of Statistics, 2018g). It was also slightly greater than the 28.8% (n = 1,201) of those with an Anglo-Celtic background.

16.4 Psychological distress (K10)

Table 92 displays the K10 psychological distress levels of participants according to whether participants were from multicultural backgrounds or an Anglo-Celtic background.

Table 92: K10 by background (n = 5,803)

Background	Multicultural		Anglo-Celtic	
	Number	%	Number	%
Low	315	18.5	889	21.7
Moderate	405	23.7	917	22.4
High	446	26.1	1,196	29.2
Very high	541	31.7	1,094	26.7

Participants from multicultural backgrounds had a larger proportion of participants who reported high or very high levels of psychological distress than participants from an Anglo-Celtic background. This compares to 13.0% among the general Australian population (Australian Bureau of Statistics, 2018h). Notably, participants from multicultural backgrounds were more likely to report very high levels of psychological distress (31.7%; n = 541) compared to those from an Anglo-Celtic background (26.7%; n = 1,094).

16.5 Mental health diagnoses

Participants were asked if they had ever been diagnosed or treated for a mental health condition in the past 12 months. Table 93 displays these results according to whether participants were from multicultural backgrounds or an Anglo-Celtic background.

Table 93: Diagnosed or treated for a mental health condition in the past 12 months by background (n = 5,702)

Background	Multicultural		Anglo-Celtic	
	Number	%	Number	%
Depression	659	39.1	1,557	38.8
Generalised anxiety disorder	544	32.3	1,338	33.3
Any mental health condition	877	52.0	2,073	51.6

A slightly greater percentage of participants from multicultural backgrounds (39.1%; n = 659) reported having been diagnosed or treated for depression in the past 12 months compared to those from an Anglo-Celtic background (38.8%; n = 1,557). However, a slightly smaller percentage of participants from multicultural backgrounds (32.3%; n = 544) reported having been diagnosed or treated for a generalised anxiety disorder in the past 12 months compared to those from an Anglo-Celtic background (33.3%; n = 1,338).

16.6 Experiences of health services among participants reporting psychological distress

Table 94 displays the proportion of participants who accessed a mental health service in the past 12 months among those that reported high or very high levels of psychological distress according to whether participants were from multicultural backgrounds or an Anglo-Celtic background.

Table 94: Mental health service access in the past 12 months among participants reporting high or very high levels of psychological distress by background (n = 3,271)

Background	Multicultural		Anglo-Celtic	
	Number	%	Number	%
Mainstream mental health service	440	44.7	1,012	44.3
Mainstream mental health service that is LGBTIQ-inclusive	220	22.3	514	22.5
Mental health service that only caters to lesbian, gay, bisexual, transgender and/or intersex people	47	4.8	106	4.6
Any mental health service	589	59.8	1,367	59.8

Among those that reported high or very high levels of psychological distress, the same proportion of participants from multicultural backgrounds reported having used a mental health service in the past 12 months as those from an Anglo-Celtic background. This pattern was also found for use of a mainstream mental health service, a mainstream mental health service that is LGBTIQ-inclusive and a mental health service that caters only to lesbian, gay, bisexual, transgender and/or intersex people.

16.7 Suicidal ideation and suicide attempts

Tables 95 and 96 display the responses to questions regarding experiences of suicidal ideation, defined as 'thoughts about suicide, wanting to die or about ending your life' and suicide attempts, defined as having 'attempted suicide or to end your life.' Note, participants who skipped the section by indicating 'I prefer not to answer these questions' and those who selected 'prefer not to answer' for a particular question were combined to form a single category of 'prefer not to say' (see Section 8.3 for further information).

Table 95: Suicidal ideation by background (n = 5,907)

Background	Multicultural		Anglo-Celtic	
	Number	%	Number	%
Past 12 months	761	43.7	1,696	40.7
Ever	1,320	75.7	3,098	74.4
Prefer not to say	36	2.0	81	1.9

Participants from multicultural backgrounds reported high rates of suicidal ideation, both ever (75.7%; n = 1,320) and in the past 12 months (43.7%; n = 761). This compares to 2.3% in the past 12 months among the general Australian population (Johnston et al., 2009). It is also somewhat higher than participants from an Anglo-Celtic background, especially in the past 12 months.

Table 96: Suicide attempt by background (n = 4,646)

Background	Multicultural		Anglo-Celtic	
	Number	%	Number	%
Past 12 months	72	5.2	148	4.5
Ever	432	31.0	940	28.9
Prefer not to say	65	4.7	123	3.7

Participants from multicultural backgrounds reported high rates of suicide attempts, both ever (31.0%; n = 432) and in the past 12 months (5.2%; n = 72). This compares to 0.4% in the past 12 months among the general Australian population (Johnston et al., 2009). As with rates of suicidal ideation, it is also somewhat higher than participants from an Anglo-Celtic background, for both ever and in the past 12 months.

16.8 Unfair treatment as a result of ethnicity, cultural identity or heritage

Participants were asked the extent to which 'you feel that you have been treated unfairly by others as a result of your ethnicity, cultural identity or heritage' in the past 12 months, with response options provided on a 5-point scale ranging from 'not at all' to 'always.' Table 97 displays these results according to whether participants were from multicultural backgrounds or an Anglo-Celtic background.

Table 97: Treated unfairly by others due to ethnicity, cultural identity or heritage in the past 12 months by background (n = 5,913)

Background	Multicultural		Anglo-Celtic	
	Number	%	Number	%
Not at all	1,171	67.0	3,896	93.5
A little	296	17.0	191	4.6
Somewhat	181	10.4	61	1.5
A lot	75	4.3	14	0.3
Always	23	1.3	5	0.1

One third (33.0%; n = 575) of participants from multicultural backgrounds reported feeling that they had been treated unfairly by others as a result of their ethnicity, cultural identity or heritage in the past 12 months. This is more than five times the 6.5% (n = 271) of participants from an Anglo-Celtic background.

16.9 Summary

Participants from multicultural backgrounds reported similarly high levels of mental health challenges, including suicidal ideation and suicide attempts, compared to those from an Anglo-Celtic background. They were also less likely to feel accepted in a range of situations, such as work, health or support services and particularly among family. However, they were only slightly less likely than those from an Anglo-Celtic background to report feeling a part of the LGBTIQ community. Self-rated health was generally poorer and a greater proportion reported very high levels of psychological distress. These patterns suggest that LGBTIQ people from multicultural backgrounds have poorer health and wellbeing outcomes compared to those from an Anglo-Celtic background and face additional challenges with feeling accepted in some areas of life. The importance of peer acceptance (Russell & Fish, 2016) and family support (Ryan et al., 2010) for the wellbeing of LGBTIQ individuals has been consistently demonstrated in the literature. However, these data suggest that many participants from multicultural backgrounds may face greater difficulty accessing some forms of support.

One third of participants from multicultural backgrounds reported experiences of unfair treatment by others, which they attributed to their ethnicity, cultural identity or heritage in the past 12 months. These findings reflect research regarding racial inequalities in Australian contexts (Bastos et al., 2018; Kwansah-Aidoo & Mapedzahama, 2018). Efforts to enhance inclusion, collaboratively with LGBTIQ people from multicultural backgrounds, through the challenging of biases, assumptions and stereotypes and the provision of culturally and linguistically-sensitive support that takes into account LGBTIQ identities and experiences within ethnic, religious and cultural diversity, are likely to be important considerations for improving health and wellbeing in this population.

17 Geographic location

LGBTIQ who live outside urban areas may face additional challenges, such as accessing inclusive and affirmative health and support services. For example, LGBT people residing in rural areas have been found to face higher levels of stigma and discrimination in accessing healthcare than those residing in urban areas (Rosenkrantz et al., 2017). Depending on where they live, establishing community networks and support that involve other LGBTIQ people may also be challenging, which may have further implications for health and wellbeing. This chapter presents results from PL3 according to broad geographical locations of participants, specifically whether they lived in inner suburban, outer suburban, regional or rural/remote areas.

17.1 Community belonging

Participants were asked the extent to which 'you feel you're a part of the Australian LGBTIQ community' and 'participating in Australia's LGBTIQ community is a positive thing for you', with response options provided on a 5-point scale ranging from 'strongly disagree' to strongly agree.' Tables 98 and 99 display these results by geographic location.

Table 98: You feel you're part of Australia's LGBTIQ community by geographic location (n = 6,756)

Geographic location	Inner suburban		Outer suburban		Regional city or town		Rural/remote	
	Number	%	Number	%	Number	%	Number	%
Do not agree	1,114	37.7	911	48.8	733	48.8	215	49.9
Agree/strongly agree	1,842	62.3	955	51.2	770	51.2	216	50.1

Six in ten (62.3%; n = 1,842) participants residing in inner suburban locations agreed or strongly agreed that they feel a part of Australia's LGBTIQ community. This compared to five in ten participants residing in outer suburban areas (51.2%; n = 955), regional cities or towns (51.2%; n = 770) or rural/remote areas (50.1%; n = 216).

Table 99: Participating in Australia's LGBTIQ community is a positive thing for you by geographic location (n = 6,744)

Geographic location	Inner suburban		Outer suburban		Regional city or town		Rural/remote	
	Number	%	Number	%	Number	%	Number	%
Do not agree	988	33.5	790	42.4	607	40.4	199	46.2
Agree/strongly agree	1,961	66.5	1,073	57.6	894	59.6	232	53.8

A greater proportion of participants residing in inner suburban locations (66.5%; n = 1,961) agreed or strongly agreed that participating in Australia's LGBTIQ community is a positive thing for them compared to those residing in outer suburban areas (57.6%; n = 1,073), regional cities or towns (59.6%; n = 894) or rural/remote areas (53.8%; n = 232).

17.2 Feelings of acceptance

Table 100 displays the numbers and percentages of participants in the PL3 sample who felt they were accepted 'a lot' or 'always' in a range of situations by geographic location.

Table 100: Currently feel accepted ‘a lot’ or ‘always’ by geographic location

Geographic location	Inner suburban		Outer suburban		Regional city or town		Rural/remote	
	Number	%	Number	%	Number	%	Number	%
LGBTIQ event	1,816	67.9	989	64.9	795	67.0	217	69.8
LGBTIQ venue	1,783	67.3	975	63.6	759	65.9	210	67.7
At work	1,610	65.4	805	56.9	590	55.3	182	61.1
At an educational institution	1,094	58.8	673	55.7	473	50.1	129	49.4
With family members	1,586	55.4	868	47.9	716	50.1	229	55.6
LGBTIQ dating app or website	966	54.1	523	50.9	434	52.1	109	53.4
Accessing a health or support service	1,309	47.6	648	38.5	549	40.9	162	43.1
Social/community events	1,108	40.3	520	31.0	405	30.6	140	36.6
In public (e.g., in the street/park)	921	32.5	482	27.6	413	29.4	127	32.3
Mainstream venue	848	30.7	449	26.7	368	27.5	125	33.2
Mainstream event	845	30.9	454	27.3	375	28.3	119	32.2
Non-LGBTIQ dating app or website	313	22.9	169	18.9	141	20.9	45	28.7
Religious/faith-based events or services	142	9.5	109	10.7	87	10.8	29	13.3

Note: responses were analysed among participants who reported that a situation was applicable to them therefore an overall ‘n’ is not provided.

Overall, the proportions of PL3 participants residing in an inner suburban area who felt accepted a lot or always were higher than among participants residing in outer suburban areas, regional cities or towns or rural/remote areas. Patterns were generally similar between those living in outer suburban areas and regional, rural or remote areas. However, in many cases, proportions of participants in outer suburban areas who reported feeling accepted a lot or always were lower 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).

17.3 Self-rated health

Participants were asked to rate their health on a 5-point scale from ‘poor’ to ‘excellent.’ Table 101 displays these results according to geographic location.

Table 101: Self-rated health by geographic location (n = 6,724)

Geographic location	Inner suburban		Outer suburban		Regional city or town		Rural/remote	
	Number	%	Number	%	Number	%	Number	%
Poor	168	5.7	149	8.0	109	7.3	55	12.8
Fair	590	20.0	500	26.9	407	27.3	103	23.9
Good	1,075	36.5	733	39.5	580	38.8	164	38.1
Very good	850	28.9	390	21.0	329	22.0	84	19.5
Excellent	261	8.9	84	4.5	68	4.6	25	5.8

Just over a third (36.7%; n = 158) of participants residing in a rural/remote location rated their health as poor or fair, followed by 34.6% (n = 516) in a regional city or town, 34.9% (n = 649) in outer suburban areas and 25.7% (n = 758) in inner suburban areas. This compares to 14.7% of the general population aged over 15 years (Australian Bureau of Statistics, 2018g).

17.4 Psychological distress (K10)

Table 102 displays the K10 psychological distress levels of participants according to geographical location.

Table 102: K10 by geographic location (n = 6,610)

Geographic location	Inner suburban		Outer suburban		Regional city or town		Rural/remote	
	Number	%	Number	%	Number	%	Number	%
Low	695	24.0	283	15.5	261	17.8	100	23.9
Moderate	732	25.3	370	20.2	299	20.3	85	20.3
High	790	27.3	534	29.2	417	28.4	97	23.2
Very high	676	23.4	642	35.1	493	33.5	136	32.5

Outer suburban areas had the largest proportion of participants who reported high or very high levels of psychological distress (64.3%; n = 1,176). This was followed by those in regional cities or towns (61.9%; n = 910) and those in rural/remote areas (55.7%; n = 233). Inner suburban areas had the lowest proportion (50.7%; n = 1,466). This compares to 13.0% among the general Australian population (Australian Bureau of Statistics, 2018h).

17.5 Mental health diagnoses

Participants were asked if they had ever been diagnosed or treated for a mental health condition in the past 12 months. Table 103 displays these results according to geographic location.

Table 103: Diagnosed or treated for a mental health condition in the past 12 months by geographic location (n = 6,260)

Geographic location	Inner suburban		Outer suburban		Regional city or town		Rural/remote	
	Number	%	Number	%	Number	%	Number	%
Depression	1,006	35.9	752	41.6	620	42.6	165	39.1
Generalised anxiety disorder	858	30.6	660	36.5	524	36.0	126	29.9
Any mental health condition	1,384	49.4	1,002	55.4	779	53.5	213	50.5

Overall, outer suburban areas had the largest proportion (55.4%; n = 1,002) of participants who reported being diagnosed or treated for a mental health condition in the past 12 months, followed by 53.5% (n = 779) in regional cities or towns, 50.5% (n = 213) in rural/remote areas and 49.4% (n = 1,384) in inner suburban areas.

17.6 Experiences of health services among participants reporting psychological distress

Table 104 displays the proportion of participants who accessed a mental health service in the past 12 months among those that reported high or very high levels of psychological distress by geographic location.

Table 104: Mental health service access in the past 12 months among participants reporting high or very high levels of psychological distress by geographic location (n = 3,771)

Geographic location	Inner suburban		Outer suburban		Regional city or town		Rural/remote	
	Number	%	Number	%	Number	%	Number	%
Mainstream mental health service	622	42.6	527	44.9	400	44.2	108	46.8
Mainstream mental health service that is LGBTIQ-inclusive	399	27.3	223	19.0	167	18.4	41	17.6
Mental health service that only caters to lesbian, gay, bisexual, transgender and/or intersex people	94	6.4	50	4.3	25	2.8	10	4.3
Any mental health service	923	63.2	678	57.8	494	54.5	130	56.3

Of participants who reported high or very high levels of psychological distress, a higher proportion of those living in an inner suburban area reported accessing a mental health service that is LGBTIQ-inclusive (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).

17.7 Suicidal ideation and suicide attempts

Tables 105 and 106 display the responses to questions regarding experiences of suicidal ideation, defined as 'thoughts about suicide, wanting to die or about ending your life' and suicide attempts, defined as having 'attempted suicide or to end your life.' Note, participants who skipped the section by indicating 'I prefer not to answer these questions' and those who selected 'prefer not to answer' for a particular question were combined to form a single category of 'prefer not to say' (see Section 8.3 for further information).

Table 105: Suicidal ideation by geographic location (n = 6,730)

Geographic location	Inner suburban		Outer suburban		Regional city or town		Rural/remote	
	Number	%	Number	%	Number	%	Number	%
Past 12 months	1,108	37.7	862	46.3	659	44.0	198	45.8
Ever	2,085	71.0	1,473	79.1	1,162	77.5	318	73.6
Prefer not to say	64	2.2	36	1.9	44	3.0	10	2.4

Overall, 46.3% (n = 862) of participants in outer suburban areas, 45.8% (n = 198) in rural/remote areas and 44.0% (n = 659) in regional towns or cities reported having experienced suicidal ideation in the past 12 months. This compared to 37.7% (n = 1,108) of participants in an inner suburban area and 2.3% among the general Australian population (Johnston et al., 2009).

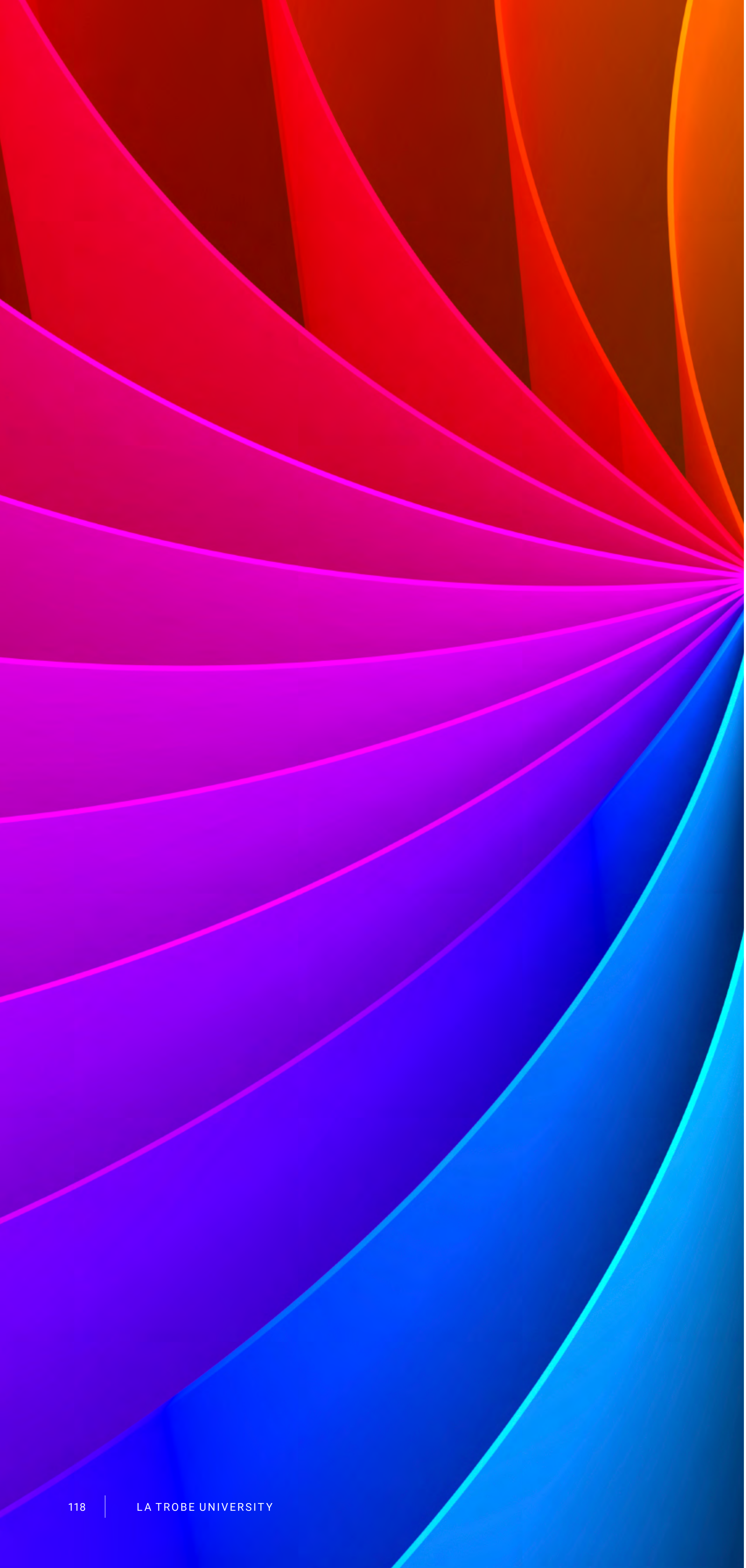
Table 106: Suicide attempt by geographic location (n = 5,248)

Geographic location	Inner suburban		Outer suburban		Regional city or town		Rural/remote	
	Number	%	Number	%	Number	%	Number	%
Past 12 months	86	3.8	87	5.9	73	6.2	27	8.4
Ever	588	25.8	477	32.5	400	33.9	124	38.4
Prefer not to say	96	4.2	61	4.1	58	4.9	18	5.6

Rural and remote areas had the largest proportion (8.4%; n = 27) of participants who reported having attempted suicide in the past 12 months, followed by 6.2% (n = 73) in regional towns or cities, 5.9% (n = 87) in outer suburban areas and 3.8% (n = 86) in inner suburban areas. This compares with 0.4% among the general Australian population (Johnston et al., 2009).

17.8 Summary

Participants residing in inner suburban locations reported lower levels of psychological distress, suicidal ideation and attempts and better self-rated health than participants in outer suburban areas, regional cities or towns or rural/remote locations. Furthermore, among participants reporting high or very high psychological distress, a greater proportion of participants residing in inner suburban areas reported accessing a mental health service, as well as services that were LGBTIQ-inclusive or catered only to lesbian, gay, bisexual, transgender and/or intersex people, which, in the latter case, may reflect the lack of availability of such services in their locality. It is worth noting that results from PL3 suggest that outer suburban areas are generally not faring better than regional, rural or remote areas in several areas, including mental health, feeling accepted and connecting with LGBTIQ communities, and in some cases may be faring slightly worse. Greater access to services and community networks may at least be part of the reason behind the comparatively better health and wellbeing for those in inner suburban areas. Overall, the results suggest that additional challenges related to health and wellbeing may be present where people are residing in any geographic location outside inner suburban areas.



18 Recommendations

18.1 Implications

Findings from the Private Lives 3 survey suggest that many LGBTIQ people continue to experience high levels of discrimination, stigma, abuse and marginalisation in many aspects of their lives. Significant social, economic and health disparities for LGBTIQ communities continue to exist. In the past eight years since the Private Lives 2 report in 2012, there have been a number of important legislative reforms either nationally or at the state or territory level, including marriage equality and legal recognition for trans and gender diverse people. Many PL3 participants reported volunteering and engaging positively with LGBTIQ communities, which are often sources of support and resilience. However, the findings from the PL3 survey suggest that further investment toward improving health and wellbeing is necessary, as rates of mental health and other challenges remain high and the proportion of LGBTIQ people accessing LGBTIQ-inclusive or specific services are still low.

18.2 Policy and program development

The data and analysis emerging from PL3 will be vital in the future targeting of policy and service responses to promote health and wellbeing for LGBTIQ communities overall and for specific sub-groups of LGBTIQ people. Overall, many LGBTIQ people report close and positive community connections. These affirming aspects of life for LGBTIQ communities can be emphasised or capitalised upon through interventions seeking to de-pathologise LGBTIQ experiences. While PL3 data can facilitate a better understanding of the nature and extent of health and wellbeing challenges among LGBTIQ populations, further research is required to develop and evaluate interventions that seek to address them. As with other populations, a diverse range of interventions may be required and it is crucial that these are evidence-based and subject to rigorous evaluation if we hope to effect positive change.

Specific initiatives should be prioritised to target the following key issues for LGBTIQ people in Australia, as revealed in the findings of Private Lives 3:

- High rates of suicidal ideation, suicide attempts, depression and anxiety, particularly among trans and gender diverse people
- High rates of harassment and abuse based on sexual orientation and/or gender identity
- High levels of homelessness, particularly among trans and gender diverse people
- Common experiences of finding it difficult to manage alcohol or other drug use or where such use negatively impacts everyday life
- High levels of intimate partner and family violence and low levels of reporting or satisfaction with support from services

The broader evidence base on LGBTIQ health and wellbeing in Australia is limited because larger population level studies have not included adequate questions about sex, gender and sexuality. The Australian Census does not allow for an accurate estimate of LGBTIQ population size or an assessment of other health and wellbeing measures for these communities. Data collection at the health service system level or in coronial reporting, also often does not currently capture LGBTIQ identities or does so imperfectly. Despite this, Private Lives 3 provides large-scale, robust and diverse data that indicate an urgent and targeted policy response to address LGBTIQ health and wellbeing.

Specifically, we recommend:

- Inclusion of sexual orientation, gender identity and intersex variation/s in all government health and wellbeing policy frameworks as key priority populations, including trans and gender diverse populations
- Broader campaigns, in partnership with LGBTIQ community-controlled organisations, that tackle stigma directed towards LGBTIQ communities
- Ongoing funding of surveys to track LGBTIQ health and wellbeing over time and review of national and state-based health and coronial data reporting to ensure inclusion of questions that adequately capture sexual orientation, gender identity and intersex variation/s
- Campaigns within LGBTIQ communities and in the broader community to further embrace diversity and to ensure full inclusivity of all groups, particularly LGBTIQ people with disabilities, LGBTIQ people from multifaith and culturally and linguistically diverse backgrounds and LGBTIQ people from Aboriginal or Torres Strait Islander backgrounds

18.3 Service development

LGBTIQ community-controlled organisations play a crucial role in providing essential services and are expert sources of practice-based knowledge. However, services are not available everywhere, which reflects PL3 findings indicating that services specifically catering to the needs of lesbian, gay, bisexual, trans and/or intersex people were the least accessed by participants. Furthermore, PL3 found that many LGBTIQ people in need of mental health services are not accessing them and although mainstream medical clinics were the most utilised health service, they had the lowest proportion of participants who felt that their sexual orientation or gender identity was respected.

Formal accreditation of services as LGBTIQ-inclusive was important to participants. There is increasing recognition that LGBTIQ inclusion requires more than base-level awareness training but rather a high-level commitment from services to undergo organisational change towards 'cultural safety' for LGBTIQ staff and clients.

The findings here suggest that the following should be prioritised:

- Expansion of funded services specifically catering to the needs of lesbian, gay, bisexual, trans, gender diverse and/or intersex people, including in regions outside inner suburban areas, that are fully informed and shaped by consultation with all relevant communities
- A requirement for organisations providing support in areas such as mental health, alcohol and other drugs or homelessness, and in receipt of public funding, to take steps to ensure LGBTIQ-inclusive practice, such as undertaking organisational cultural safety training and working in partnership with community-controlled LGBTI health organisations.
- Increased funding of LGBTIQ community-controlled organisations to support LGBTIQ-inclusive services and service development, including the establishment and recourses of communities of practice and other capacity building initiatives
- Ongoing evaluation of the outcomes of LGBTIQ-inclusive care for LGBTIQ people to help inform and drive further improvements

18.4 Future research directions

As noted in Chapter 1.3, future research will be needed to adequately include and analyse the experiences of people with an intersex variation/s. Such research needs to involve community input and participation at every level and would most likely need to be specifically directed to people with an intersex variation/s, for example, surveys that only involve people from this population and associated outreach initiatives.

- Significant investment in outreach and peer support initiatives in consultation with intersex community organisations and sufficient funding and resources for intersex organisations to increase outreach initiatives, as well as the provision of dedicated funding for community participatory research specifically directed to people with an intersex variation/s, for example, surveys that only involve people from this population
- Further funding for community participatory research to attend to the diversity and heterogeneity of LGBTIQ people more broadly in Australia, including the specific needs of sub-populations such as LGBTIQ Aboriginal and/or Torres Strait Islanders, LGBTIQ people with disabilities or long-term health conditions and LGBTIQ people from culturally and linguistically diverse backgrounds
- Priority community participatory research that focuses on a broader diversity of gender and sexual identities. In particular, non-binary identities are rapidly changing and non-binary participants reported poorer health outcomes when compared with other participants. People who identify as queer, bisexual or pansexual also appear to be growing and reported poorer health outcomes compared to lesbian and gay identifying participants. These groups also require specific attention in future research.

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