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Australian Research Centre
in Sex, Health and Society

A Closer Look at Private Lives 2

Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians

William Leonard, Anthony Lyons and Emily Bariola

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GLHV
GAY AND LESBIAN HEALTH VICTORIA

beyondblue

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April 2015

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Acknowledgements

Thank you to *beyondblue* and the Movember Foundation for their work in tackling the high rates of mental health problems among LGBT Australians and for providing additional funds to carry out this closer look at the *Private Lives 2* mental health data. Thanks also to those involved in the design, implementation and publication of the original *Private Lives 2* survey and report.

Many thanks to all those LGBT Australians who contributed to the findings of *Private Lives 2*. We hope that this companion report reflects the diversity of your everyday lives and values and affirms our gender identities and sexual identities.

La Trobe University
215 Franklin Street
Melbourne 3000
Australia
Tel (03) 9479 8700
Fax (03) 9479 8899
Email: arcshs@latrobe.edu.au
Website: www.latrobe.edu.au/arcshs

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Contents

Executive summary

A Closer Look at Private Lives 2 is a companion to the second Private Lives report released in 2012. The research and writing of both reports were funded by *beyondblue* and the Movember Foundation. The project was jointly managed by GLHV and ARCSHS, La Trobe University.

Background

The first *Private Lives* was released in 2006 and at the time was one of the largest reports on LGBT health and wellbeing anywhere in the world. Both the first and second reports provided a snapshot of LGBT Australian's everyday lives. They included demographic data on diversity within LGBT communities and data on LGBT Australian's physical and mental health, health service use, relationships, experiences of discrimination and community connections.

This companion report, in contrast, focuses on the mental health and wellbeing of LGBT Australians. It relies on the mental health data from *Private Lives 2* and looks, in detail, at variations in psychological distress and resilience *between* LGBT and mainstream communities and variations *within* LGBT communities according to gender identity, sexual identity, age and socio-economic status. It also looks at the relationships between LGBT Australians mental wellbeing and their experiences of heterosexist discrimination, drug use, LGBT and mainstream community engagement, and health service use.

The report concludes with an evidence-based LGBT mental health policy and program framework to guide the development of policies, programs and services aimed at promoting LGBT Australians' positive mental health and their access to quality care.

Methodology

Private Lives 2 reported on the findings of a national, online survey of the lives of 3,835 LGBT Australians. Respondents came from all states and territories and from rural, regional and remote areas.

The companion report used two of the validated scales from *Private Lives 2* as measures of mental health outcomes: the K10 Psychological Distress Scale; and the Brief Resilience Scale.

The development of the LGBT mental health policy and program framework involved a review of recent Australian population and health promotion strategies and a separate review of the research and grey literature on LGBT-inclusive service provision in Australia and overseas.

Key Findings

Psychological distress, resilience, and diagnosis and treatment across the lifespan

- Mental health appeared to improve with age for most of the gender identity and sexual identity groups. For example, rates of psychological distress decreased with age among all sexual identity groups. However, among bisexual females there was less variation in levels of psychological distress across the age groups.

- Psychological distress decreased with age among trans females, but for trans males remained consistently high across all age groups.

- Resilience increased with age among all gender identity and sexual identity groups. However, there was less variation in resilience according to age among bisexual females whose resilience remains relatively low for all age groups.

- In late adolescence and early adulthood (16 – 24 years) rates of diagnosis or treatment for a mental disorder were considerably higher among lesbian females (47.1%) than gay males (29.5%). However, by late adulthood (60 – 89 years) the order was reversed with gay males reporting higher rates of diagnosis or treatment than lesbian females (22.5% vs 14.9%).

The impact of socio-economic disadvantage

- Lower socio-economic status was a strong indicator of mental health problems among LGBT respondents.

- For all gender identity and sexual identity groups, respondents who were unemployed had higher rates of psychological distress and lower rates of resilience than those who were currently working.

- Trans males and trans females fared worse on a number of socio-economic indicators, including education and income, than nearly all the other gender identity and sexual identity groups. This suggests that socio-economic disadvantage may be a key driver of higher rates of psychological distress and reduced resilience among trans males and trans females.

The impact of heterosexist harassment and abuse

- A large percentage of *Private Lives 2* respondents reported having been subjected to an incident of harassment or abuse based on their gender identity or sexual identity in the past 12 months.

- Trans males and trans females reported the highest levels of abuse (55.3% and 49.2% respectively) and bisexual females the lowest (30.9%). However, there was little variation in rates of heterosexist harassment or abuse by sexual identity, with gay males (35.1%) reporting only slightly higher rates than the other sexual identity groups.

- The experience of heterosexist harassment or abuse was an indicator of poorer mental health. Respondents who reported having experienced one or more incidents of heterosexist harassment or abuse in the past 12 months had higher levels of psychological distress than those who reported no such incidents in the same period.

Drug use and mental health

- Rates of drug use were considerably higher among LGBT people than the general population with the exception of heroin.

- Illicit drug use was an indicator of poorer mental health for *Private Lives 2* respondents.

- Trans males reported the highest rates of cannabis use (38.3%) followed by bisexual females (30.6%). Those who had used cannabis reported higher psychological distress than non-users for all gender identity and sexual identity groups, with the exception of bisexual males.

- While gay males and lesbian females reported similar levels of cannabis use (23.8% and 21.2% respectively), gay males reported much higher rates of party drug use (20.2% and 9.6% respectively).[1]

- Among gay males, lesbian females and bisexual males, those who had used party drugs reported higher psychological distress than those who hadn't.

[1] Which in this report includes Ecstasy, Meth/amphetamine, Cocaine, Ketamine and GHB.

LGBT and mainstream community engagement and resilience

- For trans males, trans females, lesbians females and bisexual females, participation in LGBT community events was associated with increased resilience. This was not the case for bisexual males and gay males.

- Participation in mainstream (non-LGBT specific) community events was associated with increased resilience for all sexual and gender identity groups.

Use of mental health services

- Rates of mental health service use were highest among trans females (67.2%) and trans males (59.6%).

- Rates of mental health service use varied significantly according to sexual identity, with bisexual females reporting the highest rate (52.5%) and gay males the lowest (29.4%).

- Rates of psychological distress were higher among respondents who reported having used a mental health service recently compared with those who reported no recent use of services.

LGBT Mental Health Policy and Program Framework

The report concludes with a detailed LGBT mental health policy and program framework aimed at improving the mental health and wellbeing of LGBT Australians. The framework is evidence-based, informed by best practice health promotion, and reflects a commitment to the principles of justice, equity and diversity.

Introduction

> *Two-thirds of earth's surface is ocean, and all we can see with the naked eye is the surface: the skin*.[2]

> *It has been difficult to make strong, life-long friendships when you hold back being open…*(Lesbian female 38 yrs, PL2)

Until quite recently, many lesbian, gay, bisexual and transgender (LGBT) Australians have not been made welcome or felt at home, an experience of alienation and *unbelonging* they share with members of other minority and marginal populations. In a world where heterosexuality and cisgender[3] are privileged, those whose gender identity or sexual identity departs from these *norms* are subject to varying types and degrees of discrimination and abuse (Grant et al, 2010; Hillier et al., 2010; Leonard et al., 2008; Lyons et al., 2013c; Berman and Robinson, 2010).

Private lives 2 (PL2), the second national survey of the health and wellbeing of LGBT Australians (Leonard et al., 2012), is part of a growing and compelling body of research documenting the effects of heterosexist discrimination on the health and wellbeing of gender identity and sexual identity minorities (Logie and Gadalla, 2009; Lyons et al., 2014; Lyons et al., 2013b; UNAIDS 2007; Conron et al, 2010; Corboz et al., 2008; Couch et al., 2007; Dodds et al. 2005; Leonard and Metcalf, 2014; Leonard et al. 2012; Robinson et al., 2014; Rosenstreich, 2011). The research demonstrates how heterosexist discrimination leads to social isolation and alienation, which, in turn, are drivers of reduced health and wellbeing among LGBT people compared with the population at large. One of the most confronting findings of PL2 was that while the general health of LGBT Australians has improved since the first Private lives report was released in 2006, their risk of mental health problems has remained the same (Leonard and Metcalf, 2014, p.6; Leonard et al., 2012, p.vii; Pitts et al., 2006). LGBT Australians continue to self-report rates of depression, anxiety and psychological distress that are much higher than the national averages and these rates have not changed since 2006.

This report takes a closer look at the mental health data from PL2. It explores the relationships between increased risk of depression and psychological distress among this population and a number of demographic and psychosocial variables including: gender identity and sexual identity; age; and socio-economic status (education, employment and income). It also looks

[2] Haruki Murakami (2011) *The Wind-Up Bird Chronicle* trans. Jay Rubin, New York: Random House

[3] Cisgender refers to people whose gender conforms to the sex they were assigned at birth. Cisgenderism refers to a belief that such conformity is normal or natural and that those whose gender does not match the sex they were assigned at birth are unnatural and a threat to society (Blumer, Ansara and Watson, 2013; Preciado, 2013).

more closely at the relationships between LGBT Australians' mental health and their experiences of heterosexist discrimination and abuse, drug use, community engagement (both LGBT and mainstream) and health service use. At the same time, the report identifies some key indicators of resilience among this population and assesses how building LGBT people's sense of belonging and social connection and value can offset the effects of systemic discrimination and abuse.

The report aims to inform the development of policies, programs and services that address the health of LGBT people, and in particular their mental well-being, and ensure their access to timely, appropriate and effective health care. This includes specialist LGBT programs and services and the development of LGBT-inclusive mainstream services that address the needs of this population as part of their core business. It also includes broader social, political and legislative reforms that tackle the underlying determinants of reduced mental health and well-being amongst this diverse population.

This report, however, pushes *beyond* the limits of current LGBT policy frameworks and debates. Recent US studies show improvements in the mental health of LGBT people in those states where same-sex marriage was first legalised in the early 2000s, regardless of whether individuals were partnered or had exercised their right to marry (Wight et al., 2013; Hatzenbuehler et al., 2010). The comparative mental health data from PL2 raise the question of why the mental health of LGBT people continues to lag far behind that of the general population despite improvements in LGBT people's general health and more than a decade of state and Commonwealth reforms tackling heterosexism and its effects. Perhaps these two examples point to the difference between *tolerating* and *affirming* LGBT people (Leonard and Metcalf, 2014, p.6). As Raymond Gaita argues, it is possible to object to discrimination against LGBT people while nonetheless continuing to feel uncomfortable with their gender identities and sexual identities (Leonard, 2013, p.10). In the absence of overt and public affirmation of LGBT Australians lives and relationships, many will struggle to achieve that sense of personal and collective worth on which good mental health and wellbeing depend.

beyondblue's engagement with the LGBT community over the past 5 years has followed a similar trajectory to the one proposed in this report. In seeking to address the high rates of mental health problems among LGBT people and other minority and marginal populations, *beyondblue* has shifted its attention from the individual determinants to the social determinants of mental health. It has implemented population-based interventions that address the causes and effects of deeply ingrained prejudice and systemic discrimination against LGBT people[4]. At the same time, *beyondblue*, like *Gay and Lesbian Health Victoria*

[4] See *beyondblue's* Stop.Think.Respect campaigns. The first campaign was directed at prejudice against LGBT people, the second, at prejudice against Aboriginal Australians (www.beyondblue.org.au/resources/for-me/stop-think-respect-home/is-it-ok-to-be-left-handed- and www.beyondblue.org.au/resources/for-me/stop-think-respect-home/the-invisible-discriminator)

(GLHV) and a growing number of organisations, has begun to push beyond a singular focus on discrimination and its effects. They are beginning to explore new models based on wellness that value LGBT people and their lives independent of their experiences of discrimination and abuse. This is perhaps the challenge that now confronts all of us who share a commitment to improving LGBT Australian's everyday lives: how to affirm the dignity and value of LGBT people's gender identities and sexual identities, *while* addressing a history of heterosexist discrimination and its continued impact on their mental health and wellbeing (Leonard and Metcalf, 2014, p.6).

Background

The majority of LGBT population surveys have focused on a single health issue or subpopulation within the LGBT community. PL2, however, gathers information on different aspects of LGBT Australians' lives, providing data on LGBT people as a whole and on different subpopulations within LGBT communities (Leonard et al., 2012, p.3). These include demographic data, health and lifestyle factors, LGBT Australian's experiences of discrimination, and their degree of community connectedness and belonging.

The survey is one of the largest of its kind conducted anywhere in the world with 3,835 respondents. The large sample enables meaningful comparisons to be made not only *between* the health and well-being of LGBT people and the population as a whole but also between different groups *within* LGBT communities according to differences in gender identity, sexual identity, age and socio-economic status (among others).

Rationale and objectives

This report looks more closely at the mental health data from *Private Lives 2*. It functions as a companion to the 2012 report and aims to:

- Compare the mental health of LGBT and mainstream communities
- Enable a better understanding of the social determinants of higher rates of depression and psychological distress among LGBT compared with mainstream communities
- Look at variations in psychological distress and resilience within the LGBT community according to differences in gender identity and sexual identity and how these are affected by differences in age, socio-economic status, and other demographics
- Look at variations in psychological distress and resilience among different groups within the LGBT community according to their experiences of heterosexist discrimination and abuse, drug use, community engagement (both LGBT and mainstream) and health service use; and
- Assist in the ongoing development of evidence-based LGBT mental health policy, programs and services in the government, community, health and academic sectors.

Method

Participant recruitment and survey administration

The PL2 survey was publicised through LGBT community networks and social media including Facebook, Twitter and YouTube. Hard copies were distributed to LGBT seniors' organisations in order to increase the number and percentage of respondents aged 55 years and above. The online survey was hosted by www.demographix.com and data was collected between 12 January and the 31 April 2011.

Ethics approval for the survey was granted by the La Trobe University Human Research Ethics Committee (Reference No. 10-063).

The survey's method, design and administration are described in more detail in the original report www.glhv.org.au/files/PrivateLives2Report.pdf (Leonard et al., 2012).

Survey content

The PL2 survey consisted of both quantitative and qualitative questions assessing a range of individual demographics, health and lifestyle factors, and psychosocial factors. The questionnaire also included several validated and widely used scales to assess physical and mental health outcomes.

Data analysis

Identity categories – *gender identity and sexual identity*

The PL2 data was analysed according to gender identity and sexual identity, producing two data sets. This companion report uses these two data sets, analysing variations in mental health according to *gender identity* and *sexual identity* separately.

When cut according to *gender identity*, the total PL2 sample (*N*=3,835) was divided into five categories: 'females', 'males', 'trans females', 'trans males' and respondents who chose another term to describe their gender identity ('other preferred'). Respondents who identified as 'male' or 'female' are 'cisgender' or 'cis-male' or 'cis-female.' That is, their gender conforms to the sex they were assigned at birth (Blumer et al., 2013). Throughout the report, cisgendered respondents are referred to as 'male' or 'female.'

When cut according to *sexual identity,* the sample (*N*=3,754) was divided into six categories: 'lesbian females', 'bisexual females', females who chose another term to describe their

sexual identity ('other females'), 'gay males', 'bisexual males' and males who chose another term to describe their sexual identity ('other males').[5]

Respondents who identified as 'other preferred' were not included in comparative analyses. This was due to the variation in types of identities provided which precluded collapsing them into a single category. For gender identity this included 113 respondents and for sexual identity 508 respondents (142 'other males' and 366 'other females').

Mental health and wellbeing indicators – *K10 and Brief Resilience Scale*

The companion report uses two of the validated scales from PL2 as measures of mental health and well-being. The first is the **K10 Psychological Distress Scale**, a ten-item scale measuring non-specific psychological distress (Kessler et al., 2002). The K10 scores range from 10 to 50, with a higher sore indicating a higher rate of psychological distress. The second is the **Brief Resilience Scale**, a six-item scale that measures an individual's ability to bounce back or recover from stress (Smith et al., 2008). The Brief Resilience Scale ranges from 1 to 5 with a higher score indicating higher resilience.[6]

Key variables – *demographic and psychosocial*

The report offers a detailed analysis of variations in levels of psychological distress and resilience *within* LGBT communities according to gender identity and sexual identity, and how these are affected by differences in age and socio-economic status. It also looks at variations in mental health within LGBT communities according to different subpopulations' experiences of heterosexist discrimination and abuse, drug use, community engagement (both LGBT and mainstream) and health service use. The report also examines levels of psychological distress and resilience *between* LGBT and mainstream communities.

Literature review

A review was undertaken of recent Australian population health and health promotion policies and programs at Commonwealth, State and Territory jurisdictions (Australian Policy On Line, Google and Google Scholar, using a wide range of LGBT and policy descriptors). The review focused on mental health but included women's and men's health, drug and alcohol policy, sexual health, youth policy and ageing and aged care. The review also included research and policy on the development and delivery of both LGBT specialist and LGBT-inclusive mainstream mental health services in Australia and overseas. This review informs all aspects of this report, and literature is cited throughout.

[5] The reduced sample size reflects the 81 respondents who could not be placed into one of the six sexual identity categories (see Leonard et al., 2012 p.4 for a fuller discussion of the use of gender identity and sexual identity categories).

[6] This score range is different to that used in the first PL2 report. It has been updated so that it is the same as the scoring range used by test developers (Smith et al., 2008).

Chapter 1: Gender identity and sexual identity

There is a growing body of research showing higher rates of mental health problems among LGBT Australians compared with the general population. The *National Survey of Mental Health and Wellbeing 2007* was one of the first Australian population surveys to include a question on sexual orientation. While the survey relied on a very narrow definition of sexuality, offering respondents only two options, "heterosexual" or "homosexual/bisexual", the results did show significantly higher rates of anxiety, affective, and substance-use disorders among non-heterosexuals compared with heterosexual Australians (Australian Bureau of Statistics, 2008; Corboz et al., 2008).

The findings of PL2 are consistent with the findings of the *National Survey of Mental Health and Wellbeing*, with non-heterosexuals self-reporting much higher rates of psychological distress and poorer general mental health than the national averages. However, PL2 included a larger number of sexual identity descriptors and also a set of gender identity descriptors. This allowed for comparisons not only *between* the mental health and wellbeing of LGBT and mainstream communities, but also an analysis of variations in rates and patterns of mental health *within* LGBT communities. The PL2 data revealed significant differences in mental health and wellbeing between same sex attracted and bisexual people, and between bisexual women and men. These findings are consistent with those of US and UK studies (Dodge and Sandfort 2007; Mathy, Lehmann and Kerr 2004). The data also highlighted higher rates of mental health problems among trans people compared with cis-males and cis-females within the LGBT community and how heterosexist discrimination impacts differently on gender identity and sexual identity minorities (Leonard et al., 2012, p.4).

The first cut: Gender identity and sexual identity

Table 1 – A description of the PL2 sample by gender identity and sexual identity[7]

	n	%
Gender identity		
Male	1701	44.4
Female	1852	48.3
Trans male[8]	47	1.2
Trans female	122	3.2
Other	113	3.0
Sexual identity		
Lesbian female	1314	35.0
Bisexual female	324	8.6
Other female	366	9.8
Gay male	1479	39.4
Bisexual male	129	3.4
Other male	142	3.8

When the PL2 sample is cut according to gender identity, 48.3 per cent of respondents identify as female, 44.4 per cent as male, 3.2 per cent as trans female and 1.2 per cent as trans male. When the sample is cut according to sexual identity, 39.4 per cent of respondents identify as gay male, 35.0 per cent as lesbian female, 8.6 per cent as bisexual female, and 3.4 per cent as bisexual male.

Throughout the report, data on those who did not identify with any of the categories provided or who preferred another term to describe their gender identity or sexual identity are excluded from analyses. There was significant diversity and variation in the other types of identities that respondents provided so it was not possible to collapse them into one category.

Some examples of other types of gender identities included:

trans identifying as male and female

trans identifying as masculine femme androgyne

queer or gender queer (for me this means that I don't identify strongly with either of the binary genders)

Some examples of other types of sexual identities included:

panromantic asexual lesbian

unstraight

pansexual - gender blind

heteroflexible

[7] The figures and percentages differ slightly from those reported in PL2 (pp. 11 and 13). This is due to some recoding of data and the reclassification of 3 respondents from 'other' to 'female' under *gender identity* and one respondent as 'bisexual male' who had not been assigned a *sexual identity* in PL2. Respondents who identified as 'other' for their gender identity or sexual identity were excluded from analyses in this report.

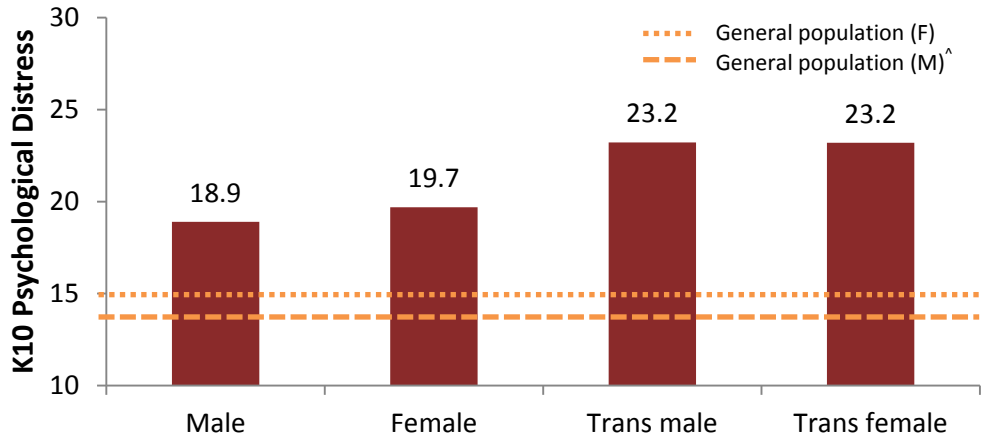
[8] In some instances trans males were not included in comparative analyses due to the small number of respondents (n=47).

Psychological distress (K10)

PL2 used two validated scales to measure mental health among LGBT Australians: the K10 scale which assesses an individual's level of psychological distress and the SF36 mental health subscale which assesses an individual's general mental health (Leonard et al., 2012, pp. 35 & 37; Andrews and Slade 2001; The University of Melbourne 2009). The results showed that rates and variations in levels of psychological distress (K10) and general mental health (SF36) were almost identical for LGBT respondents as a whole and for different subpopulations within LGBT communities. Given the similarity in results between the two scales, this report relies on the K10 data from PL2 as an indicator of LGBT people's overall mental health. The K10 scale ranges from 10 to 50 with a higher score indicating higher levels of psychological distress and poorer mental health.

According to the PL2 data, LGBT Australians report higher rates of psychological distress than the general population, a K10 mean of 19.6 versus the national average of 14.5 (Leonard et al., 2012, p. 35; Slade, Grove and Burgess 2011). However, a closer look at the PL2 data reveals significant variations in rates of mental health problems within LGBT communities according to gender identity and sexual identity.

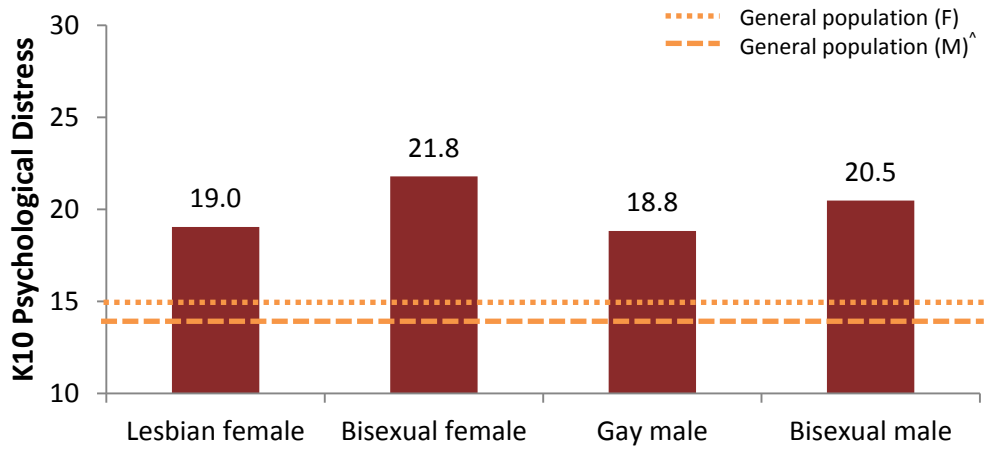
Figure 1 – Mean K10 Psychological Distress scores by gender identity



^National male (M=14.0) and female (M=15.0) average psychological distress scores in the Australian general population (Slade et al., 2011).

Figure 1 presents the average K10 scores by gender identity. The horizontal lines present the national averages (2007) according to sex/gender with females reporting a higher average K10 score than males (15.0 versus 14.0). All the gender identity groupings in the PL2 sample report markedly higher rates of psychological distress than the national averages, with males reporting the lowest K10 average (18.9) and trans males and trans females equally the highest (23.2).

Figure 2 – Mean K10 Psychological Distress scores by sexual identity



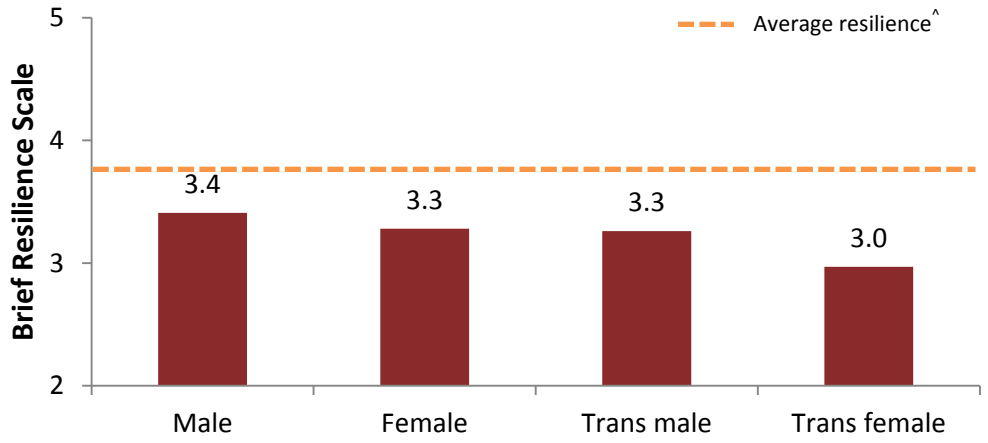
^National male (M=14.0) and female (M=15.0) average psychological distress scores in the Australian general population (Slade et al., 2011).

All sexual identity groupings report higher rates of psychological distress than the national averages, with gay males reporting the lowest average K10 score (18.8) and bisexual females the highest (21.8). Bisexual women and bisexual men both report higher rates of psychological distress than their same-sex attracted counterparts. However, rates of psychological distress are higher among bisexual women (21.8) compared with bisexual men (20.5).

Resilience (Brief Resilience Scale)

PL2 used a single measure to assess respondent's resilience. The Brief Resilience Scale relies on six questions to assess individual's ability to cope and bounce back from difficult or stressful events. The scale ranges from 1 (low resilience) to 5 (high resilience). Australian general population data were not available so comparative analyses rely on the findings of a US survey (Smith et al., 2013).

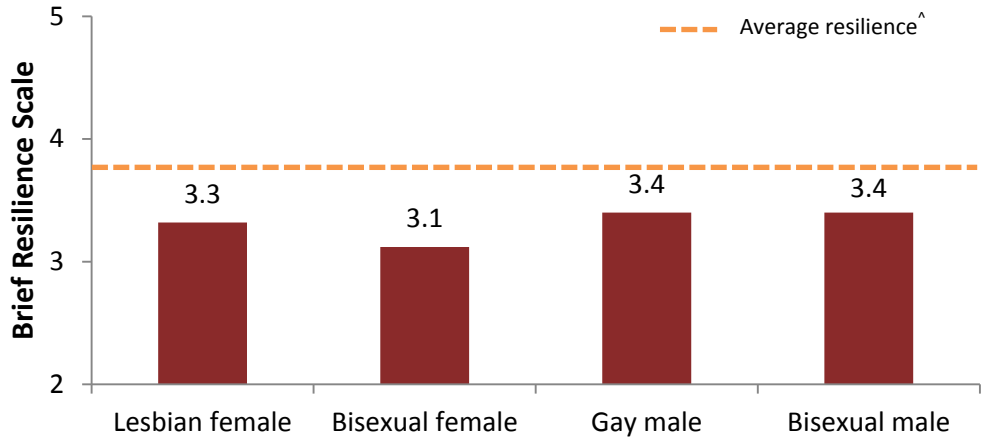
Figure 3 – Mean resilience scores by gender identity



^Average resilience score = 3.7. Cut offs established from U.S. data with a sample of healthy, patient and at-risk groups (Smith et al., 2013).

Figure 3 presents the mean resilience scores according to gender identity. All the gender identity groupings in PL2 reported low levels of resilience. In the PL2 sample, males reported the highest mean resilience score (3.4) and trans females the lowest (3.0). Males and females reported higher rates of resilience than trans-males and trans-females respectively.

Figure 4 – Mean resilience scores by sexual identity



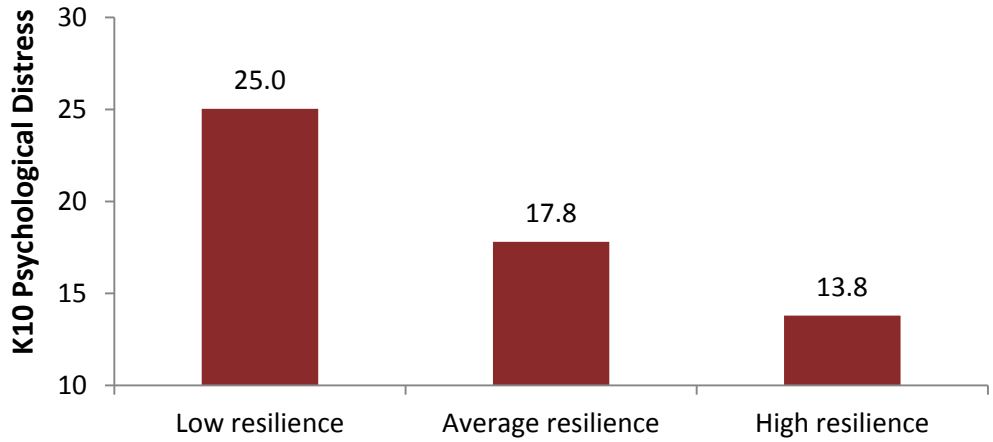
^Average resilience score = 3.7. Cut offs established from U.S. data with a sample of healthy, patient and at-risk groups (Smith et al., 2013).

All sexual identity groupings report low levels of resilience. Gay males and bisexual males report the highest mean resilience score (3.4) followed by lesbian females (3.3) and bisexual females (3.1).

The relationship between psychological distress and resilience

Figure 5 shows the relationship between psychological distress and resilience for the PL2 sample as a whole.

Figure 5 – Mean K10 Psychological Distress scores by level of resilience^ among all LGBT respondents



^Level of resilience based on cut offs: Low: 1.0 – 2.9; Average: 3.0 – 4.2; High: 4.3 – 5.0 (Smith et al., 2013).

As shown in Figure 5, there is a strong relationship between psychological distress and resilience among PL2 respondents. LGBT individuals who reported higher levels of psychological distress had lower resilience, while those who reported lower levels of psychological distress reported higher resilience. These findings are consistent with the research literature, which documents an *inverse* relationship between psychological distress and resilience (Perron et al., 2014).

Mental health diagnoses

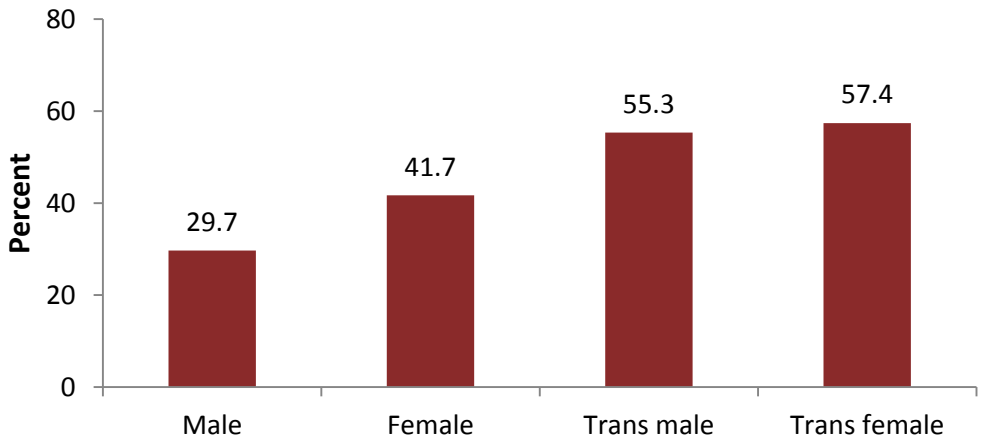
According to the Australian Bureau of Statistics (2008), 45 per cent of Australians aged 16-85 years would meet the criteria for a diagnosis of a mental disorder in their lifetime, while 1 in 5, or 20 per cent of the population, would have had a mental disorder in the past 12 months.

Table 2 – Proportion of all PL2 respondents who had been diagnosed or treated for a mental disorder in the past three years

Mental disorder	%
Depression	30.5
Anxiety	22.4
Other mental disorder (not specified)	5.8
Any mental disorder	*37.2*

Nearly 31 per cent of LGBT respondents in PL2 reported having been diagnosed with or treated for depression in the past three years, and 22.4 per cent with or for anxiety.

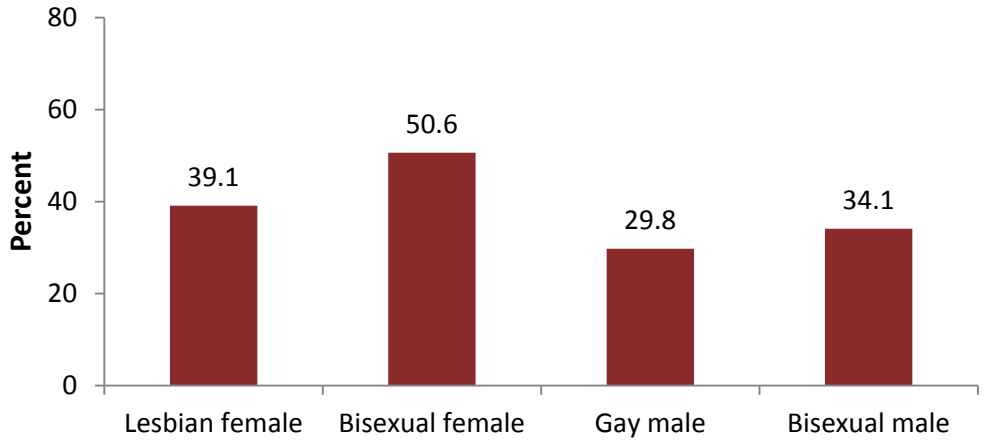
Figure 6 – Proportion of all respondents who had been diagnosed or treated for any mental disorder^ in the past three years by gender identity



^ Includes depression, anxiety and other mental disorder.

When the PL2 data is cut according to gender identity, trans females report the highest rates of diagnosis or treatment for a mental health problem (57.4 per cent), followed closely by trans males (55.3 per cent). Rates of diagnosis or treatment are considerably higher among females (41.7) compared with males (29.7) in the PL2 sample.

Figure 7 – Proportion of all respondents who had been diagnosed or treated for any mental disorder^ in the past three years by sexual identity



^ includes depression, anxiety and other mental disorders.

When the PL2 data is cut according to sexual identity, bisexual females report the highest rates of diagnosis or treatment for a mental health problem, followed by lesbian females. While both gay males and bisexual males report lower levels of diagnosis or treatment than lesbian females and bisexual females respectively, bisexual males report higher levels of diagnosis or treatment than gay males.

Chapter 2: Across the lifespan

Much of the research on LGBT ageing has focused on how historical changes in attitudes toward gender identity and sexual identity minorities have affected the mental health and wellbeing of different generations and age cohorts of LGBT people (Cronin and King, 2010; Heaphy, 2007; Leonard et al., 2013; Lyons et al., 2013c). Older LGBT people have lived through a period of systemic and rabid heterosexism that is assumed to have had a primarily negative impact on their sense of personal and social value and ability to form and maintain relationships (de Vries 2014; Cronin and King, 2014; McCann et al., 2013). Young LGBT Australians, in contrast, are coming of age at a time when heterosexism is on the decline and it is assumed that they will be able to achieve the same levels of mental health and wellbeing as their exclusively heterosexual and cisgender peers.

However, a closer look at the data reveals a much more complex picture. Recent reviews of the research on LGBT ageing show that contrary to dominant stereotypes, the majority of studies record positive mental health among older LGBT people and that many older LGBT people have well established, diverse and supportive social networks (Fredriksen-Goldsen 2012, Harber, 2009; Lo 2006; Lyons et al., 2013b). These findings are consistent with PL2 data showing improvements in LGBT people's mental health as they age, with LGBT people aged 60 years and above self-reporting levels of psychological distress *lower* than the national average (Leonard et al., 2012, p.36). What the PL2 data also suggest are that rates of psychological distress are highest among the youngest age cohort, 16-24 years. The data show that LGBT young people experience intense stress and pressure as they negotiate environments that are still hostile to people who are not exclusively heterosexual or gender normative. Furthermore, these stresses are not distributed equally among LGBT young people, with bisexual young women reporting higher rates of psychological distress than lesbian young women and gay and bisexual young men.

The second cut: Age

> *I celebrated 22 years of being in a relationship with my life partner*
> (Lesbian female 62yrs, PL2)

Respondents ranged in age from 16 to 89 years with a mean age of 37.7 years (*SD*=13.3). Over 50 per cent of the respondents were aged between 25 and 44 years.

Table 3 – A description of the PL2 sample by age group

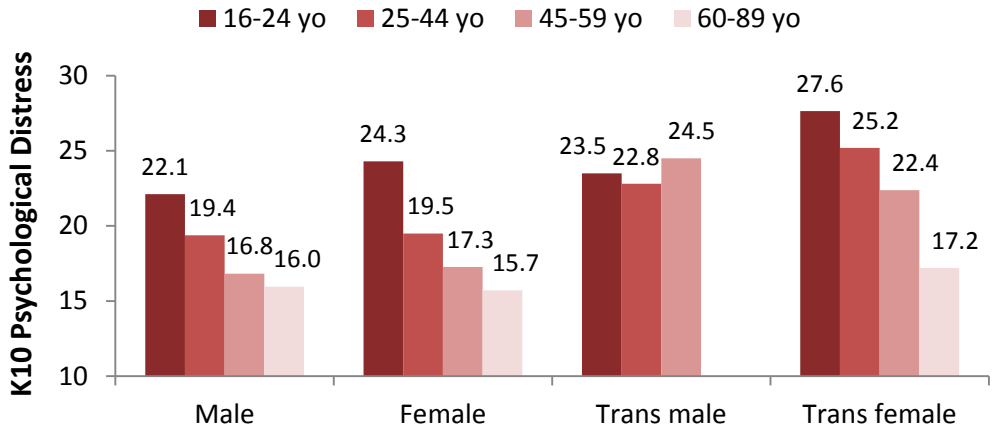
Age range	*n*	%
16-24 year olds	680	18.6
25-44 year olds	1902	51.9
45-59 year olds	815	22.3
60-89 year olds	265	7.2

The following analyses of the age-related trends in mental health and wellbeing divide the PL2 sample into four age cohorts. Nearly 19 per cent of respondents were aged 16-24 years while 7.2 per cent were aged 60-89 years.

Psychological distress by age

Figures 8 and 9 show variations in psychological distress according to age for the gender identity and sexual identity groupings, respectively.

Figure 8 – Mean K10 Psychological Distress scores by age group and gender identity*

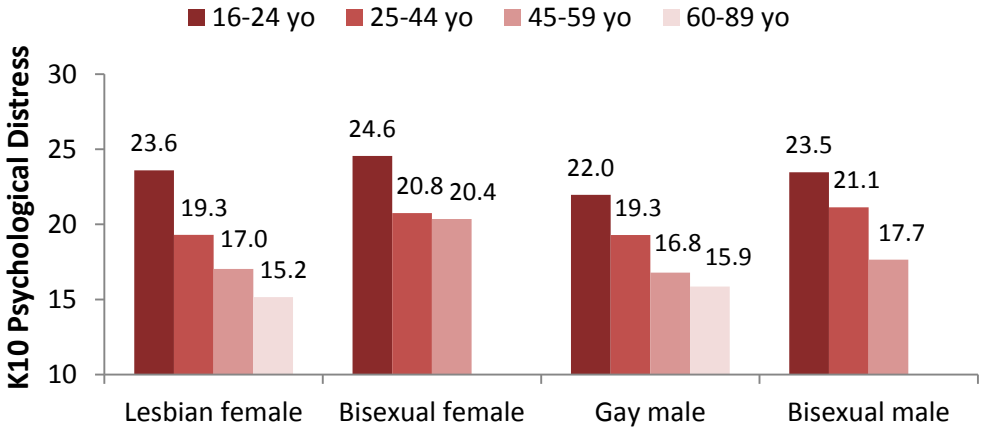


* Figures for some age groups are excluded because of small sample sizes.

As shown in Figure 8, for males, females and trans females, rates of self-reported psychological distress declined with age. Whereas among trans males, rates of psychological distress were consistently high across the age groups. However, figures for trans males must be interpreted with caution due to small sample sizes.

There was a marked difference in rates of psychological distress between females and males in late adolescence (average K10 scores of 24.3 versus 22.1 respectively). However, this gendered difference disappeared with age, with females and males reporting similar K10 scores in all subsequent age cohorts.

Figure 9 – Mean K10 Psychological Distress scores by age group and sexual identity*



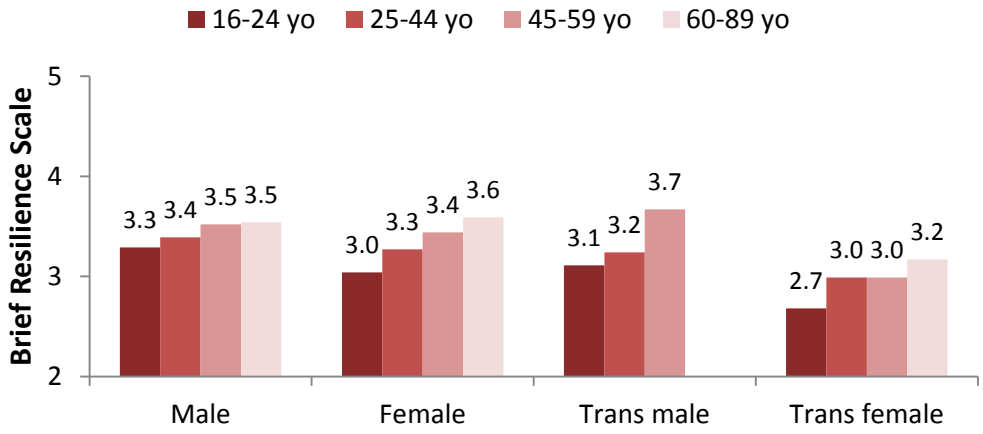
*Figures for some age groups are excluded because of small sample sizes.

Levels of self-reported psychological distress declined with age for all of the sexual identity groupings, although the decline in age was less steep for bisexual females. Bisexuals, both females and males, report higher levels of psychological distress than their respective same-sex attracted counterparts, in three of the four age cohorts listed.

Resilience (Brief Resilience Scale) by age

Figures 10 and 11 present mean resilience scores according to age for gender identity and sexual identity groupings respectively.

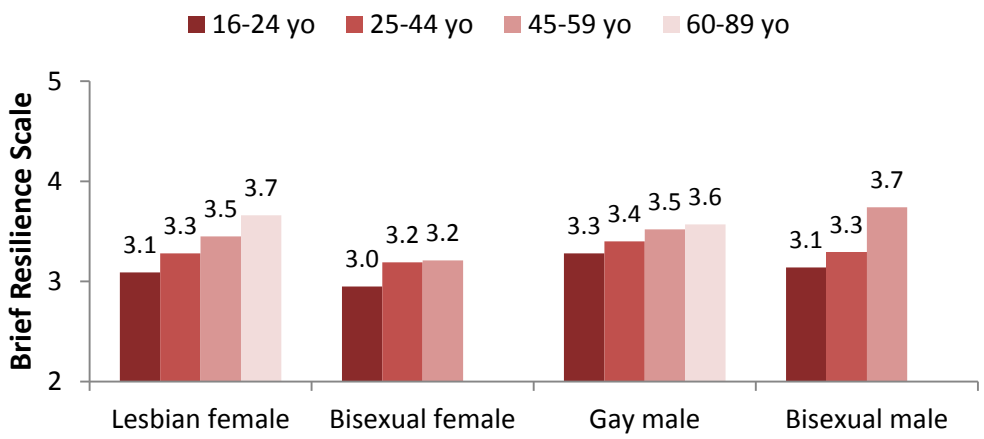
Figure 10 – Mean resilience scores by age group and gender identity*



* Figures for some age groups are excluded because of small sample sizes.

Rates of resilience are low to average for all gender groupings across all four age groups. Resilience increased slowly but steadily with age for all gender identity groupings. The figures for trans males must be interpreted with caution due to small sample sizes.

Figure 11 – Mean resilience scores by age group and sexual identity*



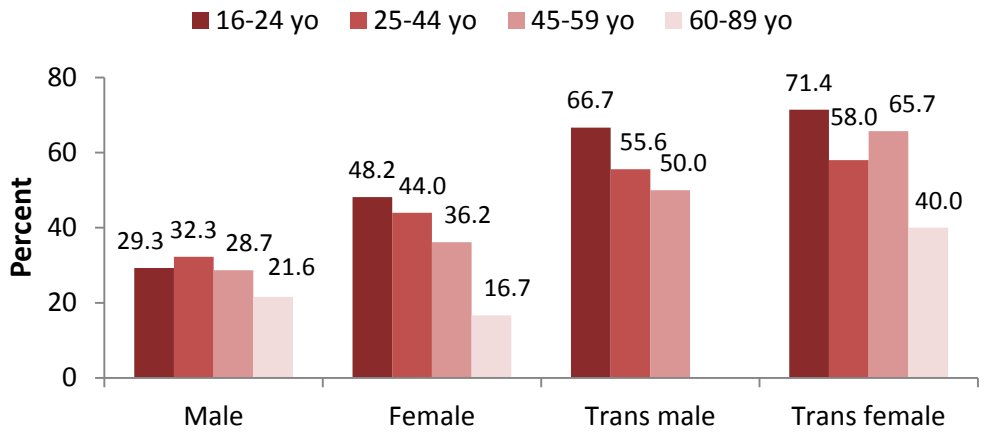
* Figures for some age groups are excluded because of small sample sizes.

Again, low to average mean resilience scores were reported across all four age cohorts for each of the sexual identity groupings. Resilience increased slightly with age among all sexual identity groups, with bisexual males and lesbian females having the greatest variation. Conversely, bisexual females had the least age related variation in resilience, from 3.0 for 16-24 year olds to 3.2 for those aged 45-59 years. This suggests that resilience remains low at all ages for bisexual females.

Mental health diagnoses by age

Figures 12 and 13 show variations in rates of treatment and diagnoses of mental disorders in the past three years according to age, for gender identity and sexual identity groupings respectively.

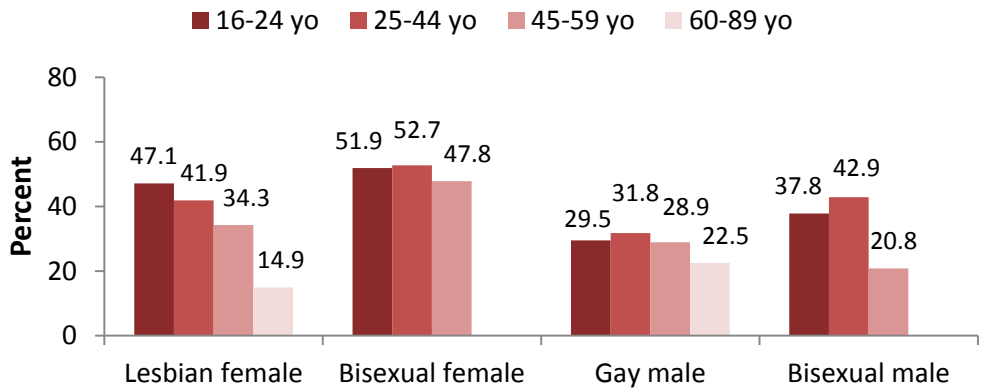
Figure 12 – Proportion of respondents who had been diagnosed or treated for a mental disorder^ in the past three years by age group and gender identity*



^ Includes depression, anxiety and other mental disorder.
* Figures for some age groups are excluded because of small sample sizes.

Nearly half of the young females aged 16-24 years report having been diagnosed or treated for a mental disorder. This is a rate of diagnosis 1.5 times higher than that for young males. Rates of diagnosis remain higher for females during early and middle adulthood. The gender difference is reversed in late adulthood (60 years and above) with 21.6 per cent of males reporting a diagnosis or treatment compared with 16.7 per cent of females. Among female and trans male respondents, rates of diagnosis and treatment decrease with age. Among males, however, rates of diagnosis and treatment peak at 25-44 years and then decrease with age. Among trans females, rates of diagnosis are highest among 16-24 year olds. Figures for trans males must be interpreted with caution due to small sample sizes.

Figure 13 – Proportion of respondents who had been diagnosed or treated for a mental disorder^ in the past three years by age group and sexual identity*



^ Includes depression, anxiety and other mental disorder.
* Figures for some age groups are excluded because of small sample sizes.

When the data is cut according to sexual identity, rates of diagnosis or treatment for a mental disorder are highest among bisexual females across the first three age categories. Rates of diagnosis for bisexual females are high and vary only slightly between the three age categories, from 52.7 per cent in early adulthood to 47.8 per cent in mid adulthood. Rates of diagnosis are considerably higher among lesbian females than gay males in late adolescence and early adulthood, but by late adulthood, gay males have higher rates than lesbian females.

Unfortunately, the small numbers of bisexual male and bisexual female respondents aged 60 years and above makes it hard to compare rates of diagnosis according to age and gender between bisexual and same sex attracted respondents. However, the data show significant differences in the impact of ageing on diagnosis or treatment for a mental disorder between gay and bisexual males. While bisexual males report much higher rates of diagnoses in late adolescence and early adulthood (37.8 per cent and 42.9 per cent for bisexual males versus 29.5 per cent and 31.8 per cent for gay males), this order is reversed into middle adulthood (20.8 per cent for bisexual males versus 28.9 per cent for gay males).

Chapter 3: Socio-economic status

Socio-economic disadvantage is a key predictor of poor health, including increased risk of mental health problems and suicidal behaviours (ABS, 2011; Kawachi et al., 2002; Commonwealth of Australia 2009; Leonard and Metcalf, 2014; McKenzie et al., 2002; Page et al., 2013; Suicide Prevention Australia, 2009). Key indicators of socio-economic status include level of education, employment status, and income.

Few studies have explored the relationships between socio-economic status and the mental health of gender identity and sexual identity minorities. However, the studies that have been done suggest that institutionalised heterosexist discrimination has a negative impact on many LGBT people's socio-economic status which, in turn, increases their risk of mental health problems. US and UK studies, for example, link higher rates of mental health problems among trans and gender diverse people to their experiences of transphobic discrimination (Grant et al., 2011; McNeil et al., 2012). Australian data show that many transgender people leave their employment due to acute discrimination and lack of support during and after transition (Couch et al., 2007, pp.63-66). The PL2 data suggest that heterosexism interacts with other forms of discrimination within and outside LGBT communities including discrimination related to age, geographic location, race, HIV status and disability, placing particular LGBT subpopulations at increased risk of socio-economic marginality and with that increased risk of mental health problems (Leonard et al., 2012).

The third cut: Socio-economic status

> *Accepting that even though I identify as female I may never be able to afford the cost of transitioning from male to female* (Trans female 38 yrs, PL2)

Respondents provided information on their annual income, highest level of education and current employment status.

Table 4 – A description of the PL2 sample by highest level of education achieved

	n	**%**
Highest education achieved		
Did not finish secondary school	242	6.3
All of secondary school	264	6.9
Still studying	408	10.7
Trade certificate	462	12.1
University degree (undergraduate)	1110	29.1
University degree (postgraduate)	877	22.9
Other qualification	467	12.2

52 per cent of the PL2 sample was university educated. This compares with a national average of 24 per cent (ABS, 2011). The results are consistent with other Australian research showing higher rates of tertiary education among LGBT people than among the population as a whole (Berman and Robinson, 2010, p.27; Leonard et al., 2012, p. 18; Pitts et al., 2006).

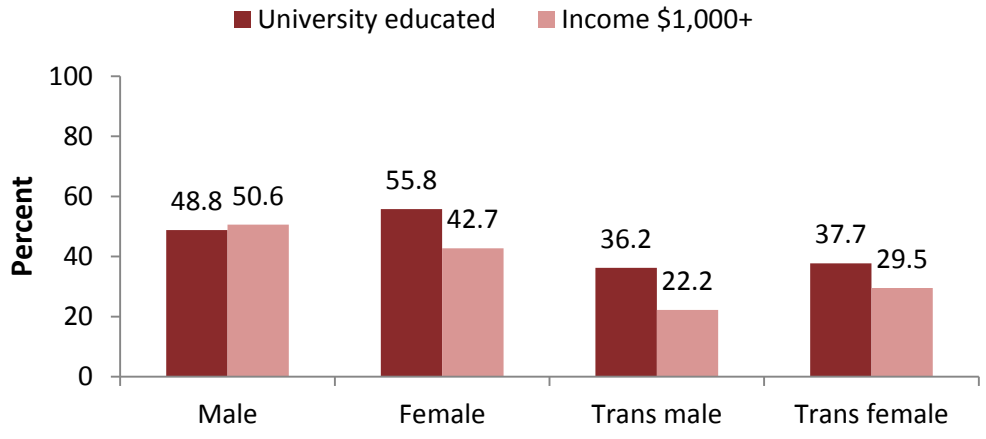
Table 5 – A description of the PL2 sample by employment status and income

	n	%
Employment status		
Full time	1828	47.8
Part time	429	11.2
Casual	206	5.4
Self employed	224	5.9
Student	691	18.1
Retired	159	4.2
Not in paid employment	289	7.6
Income		
$0 - $399 per week	944	24.8
$400 - $999 per week	1163	30.5
$1,000 - $1,999 per week	1332	35.0
$2,000 or more per week	370	9.7

Less than 48 per cent of the PL2 sample was currently employed full-time. Nearly 17 per cent were in part-time or casual employment, 7.6 per cent were not in paid employment, and 4.2 per cent were retired. Close to 45 per cent of the total sample earned $1,000+ per week. The national median weekly income for full-time and part-time workers at the time of survey was AUD$900 (ABS, 2011).

Figures 14 and 15 present data on PL2 respondents who reported high education and income levels by gender identity and sexual identity respectively.

Figure 14 – Proportion of PL2 respondents who reported high education^ and income levels^^, by gender identity

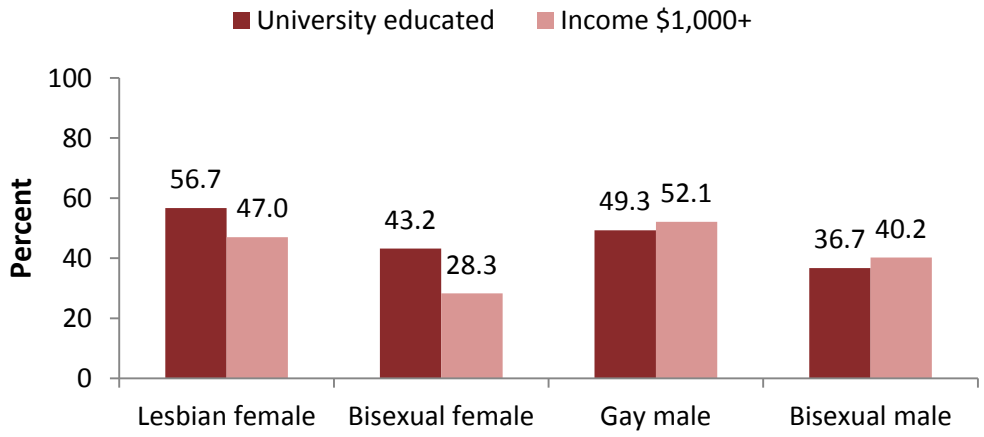


^ Including those who had completed an undergraduate or postgraduate university degree.
^^ Income per week.

When the PL2 data is cut according to gender identity, females report the highest level of tertiary education and trans males the lowest (55.8 per cent and 36.2 per cent respectively). Gender identity is an indicator of levels of education, with a larger percentage of females and trans females reporting having completed a university degree than males and trans males, respectively.

The proportion of PL2 respondents earning above $1000 per week was highest among males (50.6 per cent) and lowest among trans males (22.2 per cent). The percentages of trans females and trans males who reported high weekly income are markedly lower than males and females respectively. These trans-related differentials in income are reflected in employment rates, with trans males and trans females reporting significantly lower rates of full-time employment than males and females respectively (32.4 per cent of trans males and 32.8 per cent of trans females compared with 52.4 per cent of males and 46.3 per cent of females) (Leonard et al., 2012, p.18).

Figure 15 – Proportion of PL2 respondents who reported high education^ and income levels^^, by sexual identity



^ Including those who had completed an undergraduate or postgraduate university degree.
^^ Income per week.

When the PL2 data is cut according to sexual identity, lesbian females report the highest level of tertiary education and bisexual males the lowest (56.7 per cent and 36.7 per cent respectively). Bisexual respondents, both female and male, report lower levels of university education than their exclusively same-sex attracted gender counterparts, 43.2 of bisexual females compared with 56.7 of lesbians females and 36.7 per cent of bisexual males compared with 49.3 per cent of gay males.

The proportion of respondents who were earning a high income was greatest among gay males (52.1 per cent) and lowest among bisexual females (28.3 per cent). Lesbian and bisexual females are less likely than their male counterparts to have a high income, 47.0 per cent of lesbian females compared with 52.1 per cent of gay males and 28.3 per cent of bisexual females compared with 40.2 per cent of bisexual males. What these same data also show are that bisexual females and bisexual males are less likely than lesbian females and gay males to be earning a high income.

Socio-economic status and psychological distress

Figures 16 and 17 represent the association between employment status as an index of socio-economic status and psychological distress for gender identity and sexual identity groupings, respectively.

Figure 16 – Mean K10 Psychological Distress scores by employment status and gender identity

For all gender identity groupings, those who reported being employed at the time they completed the survey reported lower levels of psychological distress than those who reported being unemployed.

Figure 17 – Mean K10 Psychological Distress scores by employment status and sexual identity

Again, for all sexual identity groupings, those who reported being employed at the time they completed the survey reported lower levels of psychological distress than those who reported being unemployed.

Socio-economic status and resilience

Figures 18 and 19 present socio-economic status, indexed by employment status, against mean resilience scores, for gender identity and sexual identity groupings, respectively.

Figure 18 – Mean resilience scores by employment status and gender identity

Respondents who were employed at the time they completed the survey had higher rates of resilience than those who were not employed. This was true for all four gender identity groupings.

Figure 19 – Mean resilience scores by employment status and sexual identity

For all sexual identity groupings, those who were employed had higher mean resilience scores than those who were unemployed.

Chapter 4: Heterosexist harassment and abuse

Research shows that cultures that marginalise and devalue minority populations lead to individual and collective behaviours and practices that increase their risk of mental health problems including drug and alcohol misuse, reduced social participation and economic disengagement (McClintock, 2005).

Much of the international research on heterosexist discrimination and abuse has focused on acts of physical and sexual violence against LGBT people. A large UK study and annual reports prepared by ILGA[9] and the US National Coalition of Anti-Violence Programs highlight the above average rates of physical violence against LGBT people (Bruce-Jones and Itaborahy, 2011; Dick, 2008; McClintock, 2005; Patton, 2007). However, two state-based Australian studies suggest that these random and sometimes repeat acts of physical and sexual violence depend on, as they feed off, an everyday culture of heterosexist harassment and abuse (Berman and Robinson 2010; Leonard et al., 2008). Models that highlight acts of physical violence often fail to acknowledge or address the profound impact of less visible but systemic forms of heterosexist harassment and abuse on LGBT people's everyday lives and their sense of personal and collective value.

The PL2 data foreground current levels of heterosexist harassment and abuse and the effects of this abuse on LGBT people's physical and mental health and wellbeing (Leonard et al., 2012). The data show variations in rates and types of discrimination within LGBT communities according to differences in gender identity, sexual identity, and age which, in turn, lead to different rates of mental health problems and resilience. The PL2 data also show that LGBT people who identify with other minority populations or who experience other forms of marginality may be subject to the interaction of heterosexism and other forms of discrimination. The compounding effects of multiple forms of discrimination place particular subpopulations within LGBT communities at increased risk of mental health problems.

Incidence of heterosexist harassment and abuse

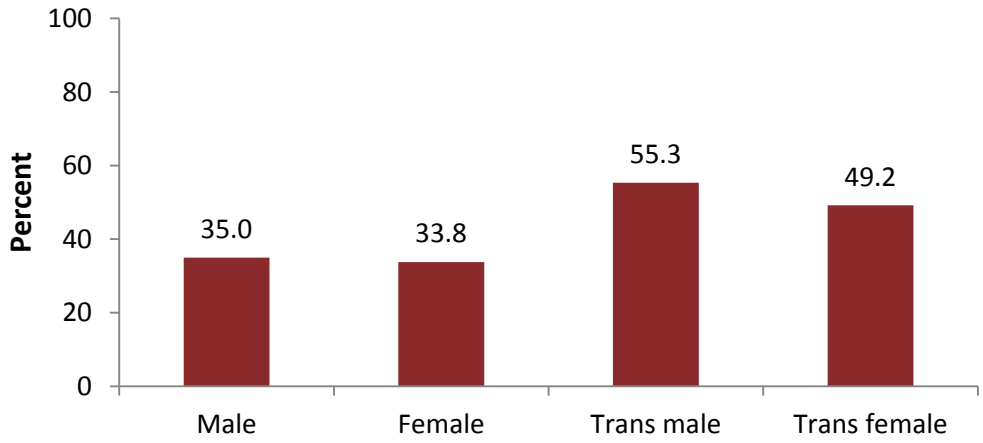
> *Discovering that I could move on from my discrimination at work and get a better job in a more accepting organisation* (Gay male 48 yrs, PL2)

PL2 respondents were asked to report on whether they had experienced an incident of heterosexist harassment or abuse in the 12 months prior to completing the survey. They were presented with a list of 14 options (including "other") ranging from experiences of non-physical harassment and abuse (E.g. written threats including emails and graffiti) to acts of physical and sexual assault (E.g. physical attack or assault with a weapon; sexual assault) (Leonard et al., 2012, pp. 47-48).

[9] The International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) is a world-wide network of national and local groups dedicated to achieving equal rights and freedoms for LGBTI people everywhere.

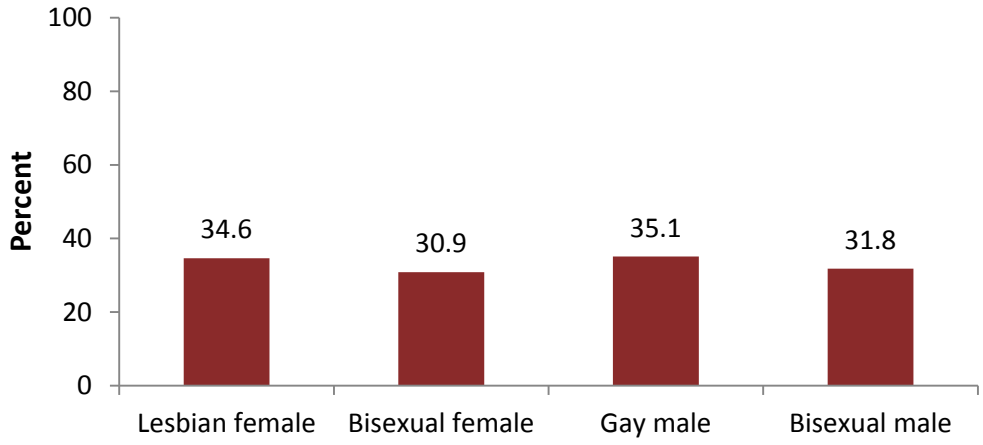
Figures 20 and 21 present the proportion of respondents who indicated that they had experienced at least one incident of heterosexist harassment or abuse in the past 12 months according to gender identity and sexual identity, respectively.

Figure 20 – Proportion of PL2 respondents who had experienced an incident of heterosexist harassment or abuse, by gender identity



Trans males reported the highest incidence of heterosexist harassment and abuse (55.3 per cent) followed by trans females (49.2) with females in the PL2 sample reporting the lowest incidence of abuse (33.8 per cent). Rates were markedly higher for both trans females and trans males compared with females and males respectively.

Figure 21 – Proportion of PL2 respondents who had experienced an incident of heterosexist harassment or abuse, by sexual identity



There was little variation in the incidence of heterosexist harassment and abuse according to sexual identity among PL2 respondents, ranging from 30.9 for bisexual females to 35.1 for gay males. Both gay males and lesbian females reported a higher incidence of abuse than their respective bisexual counterparts while gay males reported a slightly higher incidence of abuse than lesbian females (35.1 per cent versus 34.6 per cent).

Impact of heterosexist harassment and abuse

Psychological distress (K10)

Figures 22 and 23 show the relationship between heterosexist harassment and abuse, and psychological distress, for gender identity and sexual identity respectively.

Figure 22 –Mean K10 psychological distress scores by experience of heterosexist harassment and abuse, by gender identity

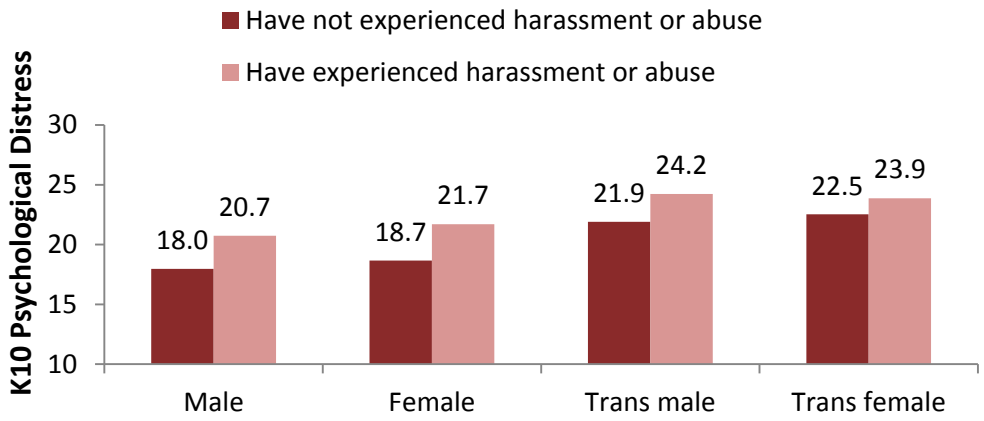
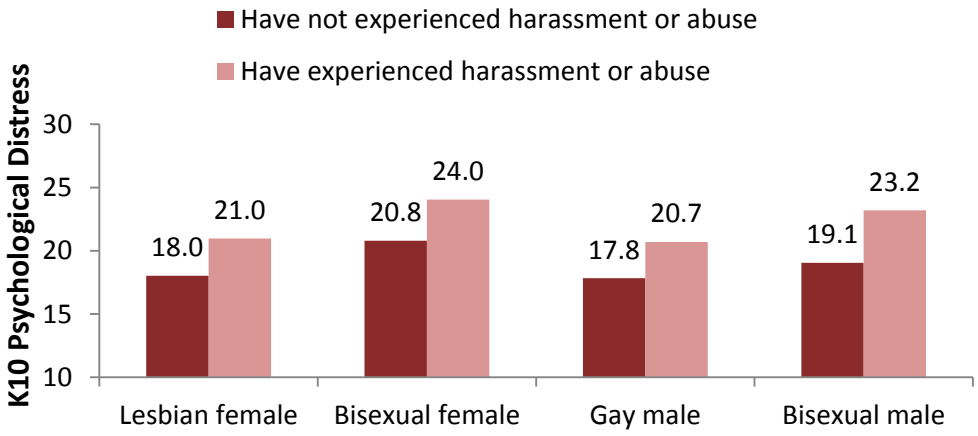


Figure 22 shows a relationship between incidents of heterosexist harassment and abuse and psychological distress for all four gender identity groupings. In all cases, those respondents who reported having experienced one of more incidents of heterosexist harassment or abuse in the past 12 months reported higher mean K10 scores than those who reported no such incidents in the same period.

Figure 23 – Mean K10 psychological distress scores by experience of heterosexist harassment and abuse, by sexual identity



Again, the data show a relationship between incidents of heterosexist harassment and abuse and psychological distress for all four sexual identity groupings. For each grouping, those respondents

who reported having experienced one of more incidents of heterosexist harassment or abuse in the past 12 months reported higher mean K10 scores than those who reported no such incidents in the same period.

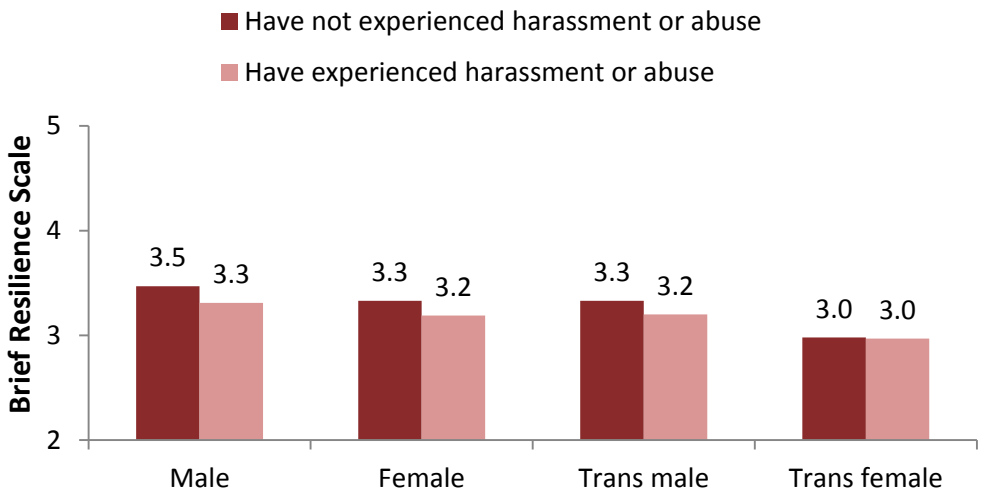
Type of heterosexist harassment or abuse and psychological distress

Further analyses were conducted to determine whether the type of harassment (i.e. physical or non-physical harassment or abuse) [10] differentially related to psychological distress among the total PL2 sample. Results revealed that mean psychological distress scores were greater among those who had experienced both types of harassment or abuse (physical or non-physical) than those who had not.

Resilience (Brief Resilience Scale)

Figures 24 and 25 show the relationship between heterosexist harassment and abuse, and resilience, by gender identity and sexual identity respectively.

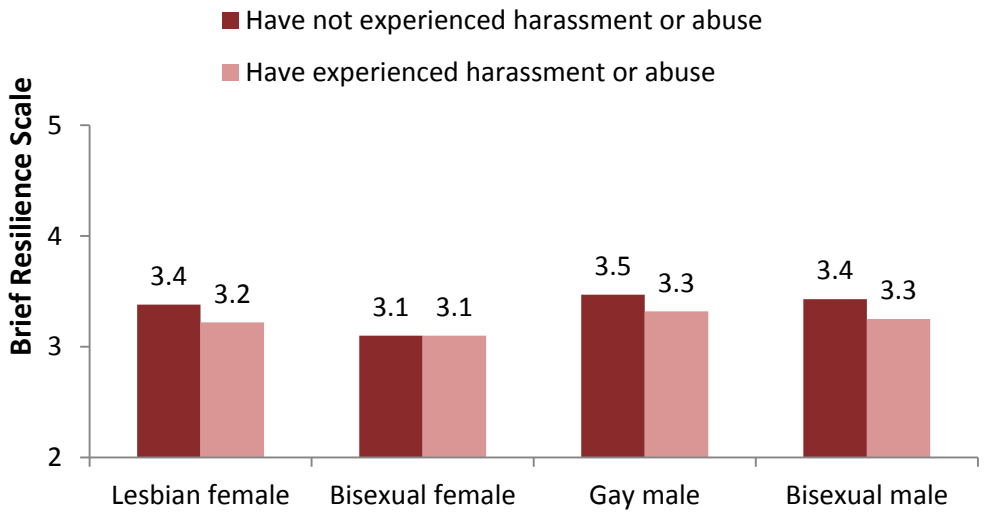
Figure 24 – Mean resilience scores by experience of heterosexist harassment and abuse, by gender identity



For males, females and trans males, there is a relationship between having been subject to an incident of heterosexist harassment in the past 12 months and resilience. The resilience scores are higher for those respondents who report not having been subject to an incident of abuse compared with those who report having been subject to one or more incidents. This relationship was not observed among trans females.

[10] Physical harassment or abuse includes: being spat at or offensive gestures, physical attack or assault with a weapon, sexual assault. Non-physical harassment or abuse includes: written threats of abuse, verbal abuse, threats of physical violence.

Figure 25 – Mean resilience scores by experience of heterosexist harassment and abuse, by sexual identity



For lesbian females, gay males and bisexual males, there is a relationship between having been subject to an incidence of heterosexist harassment in the past 12 months and resilience. The resilience scores are higher for those respondents who report not having been subject to an incident of abuse compared with those who report having been subject to one or more incidents. This relationship was not observed among bisexual females.

Chapter 5: Drug use

Research shows an association between problematic drug use and mental health problems (Green and Feinstein 2012; Herrman et al., eds, 2005; McNair et al., 2003). This is of particular concern to LGBT people given Australian and international studies showing considerably higher rates of drug use among this population compared with rates of use among the general population (King et al., 2008; Leonard et al., 2012; Leonard 2008; Lyons et al., 2013a; Mayock et al. 2008).

Behavioural and sociological studies have identified two discrete but overlapping psychosocial determinants of increased drug use among LGBT people and communities (Halkitis et al., 2003; Leonard et al., 2008; McNair et al., 2014). The first is tied to LGBT individuals' experiences of heterosexist discrimination; the second to the normalisation of drug use on the commercial gay scene. Research suggests that LGBT individuals who are particularly vulnerable to heterosexist discrimination and abuse, including LGBT young people and those affiliated with certain religious and cultural communities, use drugs as a way of dealing with their feelings and experiences of anxiety, depression and social isolation (Amadio and Chung, 2004; Brubaker et al., 2009; Green 2003; McCabe 2010). At the same time, a growing body of research documents wide spread drug use on the commercial gay scene. Here drug use is a collective activity that helps individuals 'fit in' and facilitates social and, for some, sexual interactions (Cochran and Cauce 2006; Leonard 2008).

However, these two psychosocial determinants are subject to variations within LGBT communities according to gender identity and sexual identity and to the degree of LGBT community engagement and variations in the type and degree of heterosexist discrimination.

Drug use

Respondents were asked to report on their non-medical drug use in the past 12 months. They were given a list of 14 illicit and pharmaceutical drugs, and rates of use were compared with national averages where data was available.

Table 6 – Proportion of PL2 respondents who reported having used drugs for non-medical purposes in the last 12 months, by drug type

Drug type	PL2 %	General population %^
Illicit drugs (excluding pharmaceuticals)		
Cannabis/marijuana	24.2	10.3
Ecstasy	12.3	3.0
Meth/amphetamine	9.0	2.1
Cocaine	7.1	2.1
Hallucinogens	4.6	1.4
Ketamine	2.8	0.2
GHB	2.3	0.1
Kava	0.9	-
Heroin	0.3	0.2
Other illicit drug	0.2	-
Any illicit drug excluding pharmaceuticals	31.5	-
Pharmaceuticals		
Pain-killers/analgesics*	20.6	3.0
Tranquillisers/sleeping pills	12.6	1.5
Steroids	0.9	0.1
Barbiturates	1.3	-
Other pharmaceutical	2.5	-
Any pharmaceutical	26.7	-
Other drugs		
Amyl Nitrate/poppers**	0.9	-
Other drug not specified	0.3	-

^General population estimates are extracted from the 2010 National Drug Strategy Household Survey report and includes those aged 14 years and above (AIHW, 2011).

*Considered to be an overestimate – it is likely that a number of respondents did not consider the disclaimer "for non-medical purposes."

**Considered to be an underestimate (Amyl Nitrate/poppers was not included in the list of drugs in the survey) - The proportion above reflects the number of respondents who recorded 'Amyl Nitrate' under 'other (please specify)'

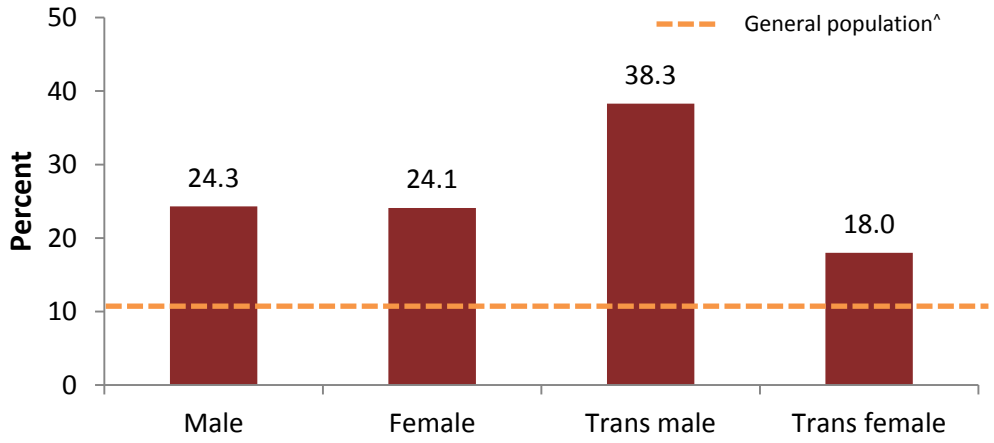
Rates of drug use among LGBT Australians were considerably higher than the national averages for all the drugs listed with the exception of heroin. The rate of cannabis use among LGBT Australians was particularly high at 24.2 per cent, more than twice the national average (10.3 per cent). LGBT people also reported markedly higher rates of party drug use, defined here as ecstasy, meth/amphetamine, cocaine, ketamine and GHB. For example, the rates of meth/amphetamine and ecstasy use among LGBT Australians are over four times the national averages (9.0 per cent versus 2.1 per cent for meth/amphetamine and 12.3 per cent versus 3.0 per cent for ecstasy). PL2 respondents also report higher rates of use of pharmaceuticals than the general population.

The following section considers the rates of illicit drug use and the relationship between illicit drug use and psychological distress among PL2 respondents according to gender identity and sexual identity. Cannabis and party drugs are examined separately because the high rates of cannabis use among LGBT people suggest that it is being used in a much broader range of social contexts than party drugs. The higher rates also suggest that cannabis is being used by both males and females in the LGBT community, unlike party drug use, which research shows is much higher among gay and bisexual males (de Wit et al., 2013; Gay and Lesbian Medical Association 2006; Green 2003; Hickson et al. 2007; Lyons et al., 2013a).

Cannabis use

Figures 26 and 27 present rates of cannabis use among PL2 respondents according to gender identity and sexual identity, respectively, and include the national average for comparison.

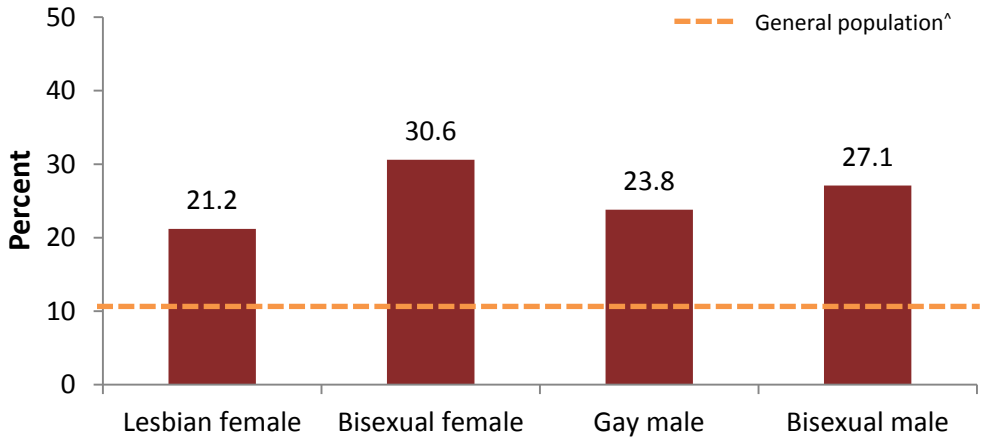
Figure 26 – Proportion of respondents who had used cannabis for non-medical purposes in the last 12 months, by gender identity



^General population estimates are extracted from the 2010 National Drug Strategy Household Survey report and includes those aged 14 years and above (AIHW, 2011).

Figure 26 shows that rates of cannabis use were considerably higher than the national average for all gender identity groupings. Trans males had the highest rates of cannabis use (38.3 per cent). Trans females reported the lowest levels of use (18.0 per cent), with rates of use almost identical for males and females.

Figure 27– Proportion of respondents who had used cannabis for non-medical purposes in the last 12 months, by sexual identity



^General population estimates are extracted from the 2010 National Drug Strategy Household Survey report and includes those aged 14 years and above (AIHW, 2011).

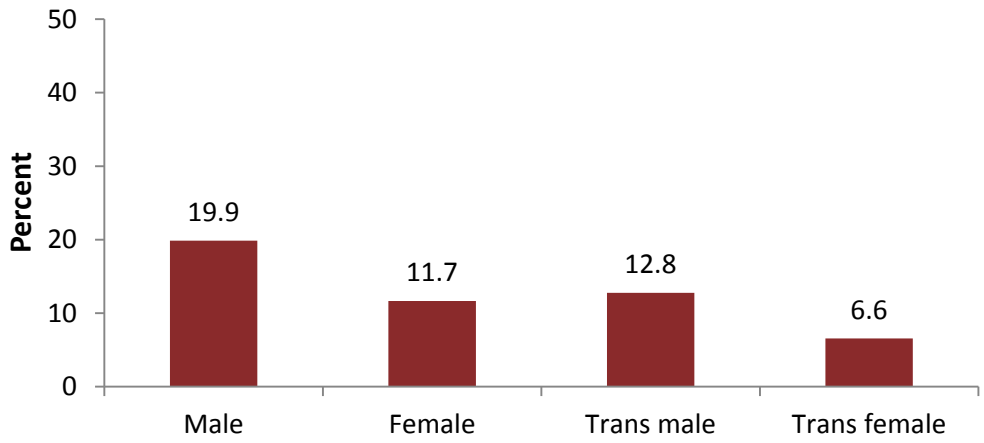
Figure 27 shows that rates of cannabis use are higher than the national average for all sexual identity groupings. Bisexual females had the highest levels of use (30.6 per cent)[11] with rates of use higher among both bisexual females and bisexual males compared with their exclusively same-sex attracted counterparts (30.6 per cent for bisexual females versus 21.2 for lesbian females and 27.1 per cent for bisexual males versus 23.8 per cent for gay males).

[11] Higher rates of cannabis use among bisexual females compared to other sexual minority groups has also been reported in a recent study conducted in the UK with a sample of 4,206 LGB individuals (Buffin et al., 2012).

Party drug use

Figures 28 and 29 present rates of party drug use by gender identity and by sexual identity respectively. Here, the term 'Party drug' includes Ecstasy, Meth/amphetamine, Cocaine, Ketamine and GHB.

Figure 28 – Proportion of respondents who had used any party drug^ for non-medical purposes in the last 12 months, by gender identity



^ Ecstasy, Meth/amphetamine, Cocaine, Ketamine, GHB.

Rates of party drug use are higher among males and trans males compared with females and trans females, respectively. Rates of use are highest among males (19.9 per cent) and lowest among trans females (6.6 per cent).

Figure 29 – Proportion of respondents who had used any party drug^ for non-medical purposes in the last 12 months, by sexual identity

^ Ecstasy, Meth/amphetamine, Cocaine, Ketamine, GHB.

Figure 29 shows that rates of party drug use were highest among gay males, with just over a fifth (20.2 per cent) of gay male respondents reporting having used party drugs in the past 12 months. Rates of party drug use were lowest among lesbian females (9.6 per cent). While gay males had

higher rates of party drug use than bisexual males (20.2 per cent versus 14.0 per cent), the findings were reversed for females, with bisexual females having higher rates of use than lesbian females (13.0 per cent versus 9.6 per cent).

Cannabis use and psychological distress

Figures 30 and 31 show the relationship between cannabis use and psychological distress for gender identity and sexual identity, respectively.

Figure 30 – Mean K10 Psychological Distress scores by cannabis use and gender identity

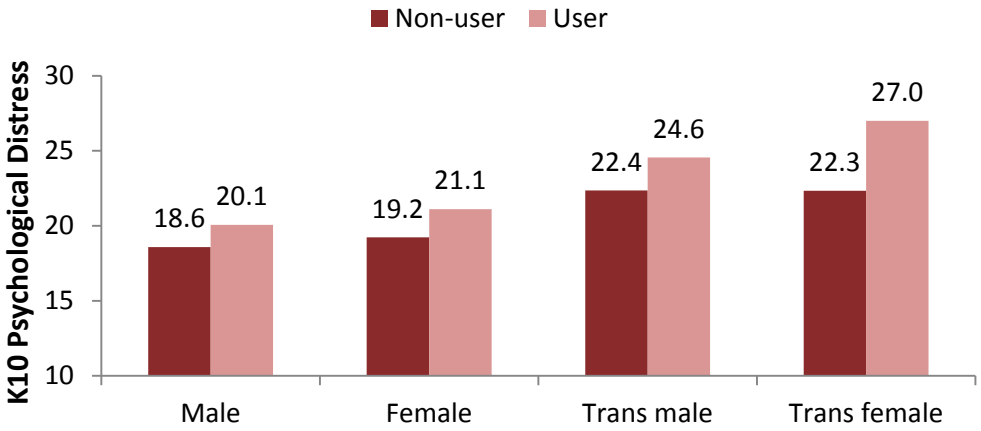


Figure 30 shows a relationship between cannabis use and psychological distress for all gender identity groupings. The association between cannabis use and increased psychological distress was greatest for trans females, a mean K10 score of 27.0 for users versus 22.3 for non-users.

Figure 31 – Mean K10 Psychological Distress scores by cannabis use and sexual identity

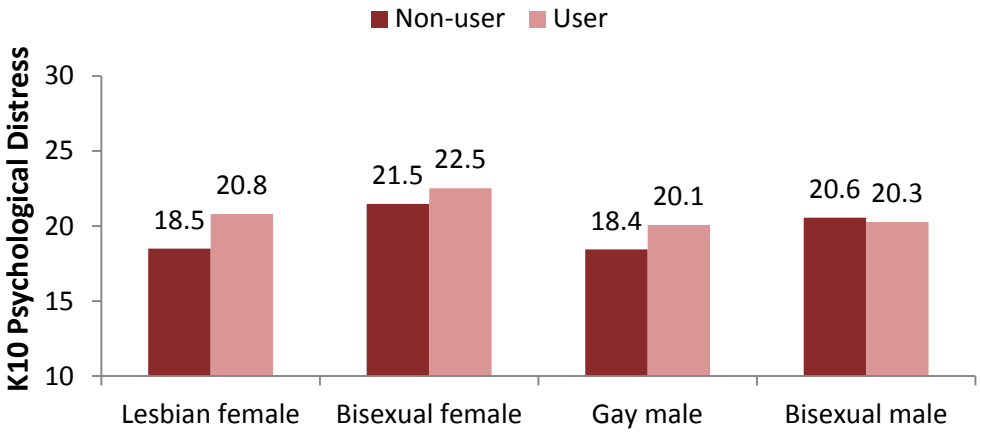


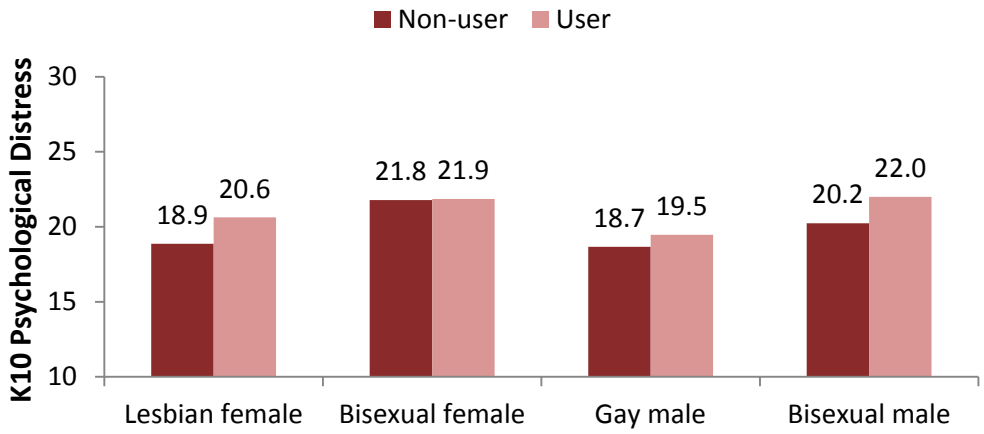
Figure 31 shows that cannabis use was associated with increased psychological distress for lesbian females, gay males and bisexual females. For lesbian females, those who reported having used cannabis for non-medical purposes in the past 12 months had a mean K10 score of 20.8 compared

with a mean score of 18.5 for those who reported no use. This relationship was not observed among bisexual males.

Party drug use and psychological distress

Figure 32 presents the relationship between party drug use and psychological distress for sexual identity.

Figure 32 – Mean K10 Psychological Distress scores by party drug^ use and sexual identity



^ Ecstasy, Meth/amphetamine, Cocaine, Ketamine, GHB.

For lesbian females, bisexual males and gay males, rates of psychological distress were higher among those who had used party drugs. This was not observed among bisexual females.

Chapter 6: Community engagement

In PL2, three quarters of respondents rated 'GLBT friends' most highly for emotional support, while nearly 61 per cent reported that they were most likely to turn to family for care if they were ill (Leonard et al., 2012, p.24). These data indicate the importance of social engagement and connection in LGBT people's lives, an engagement that spans LGBT community connectedness and familial association.

The World Health Organization (WHO) has identified three key protective factors against the onset or recurrence of mental illness: strong social networks, supportive relationships and a sense of belonging (Herrman et al. eds., 2005). For LGBT people, research shows that connection and belonging to LGBT *and* mainstream communities and to family are predictors of improved mental health (Carmen et al., 2012; Lyons et al., 2013b; Lyons et al., 2014; McLaren, 2009; Riggle et al., 2008). A national study of same-sex attracted and gender diverse (SSASGD) young people's health and wellbeing showed that acceptance by family and supportive school environments are predictors of a reduction in levels of self-harm and mental health problems (Hillier et al., 2010).

According to the findings of PL2, LGBT people's access to and engagement in LGBT and mainstream community varies according to sexual identity, age, geographic location and their experiences of heterosexist discrimination and abuse (Leonard et al., 2012, pp.49-54).

Participation in mainstream and LGBT community events

> *Joining the active GLBT community has made me realise I'm not as alone as I once believed and people will always be there to catch me if I fall* (Gay male 17 yrs, PL2)

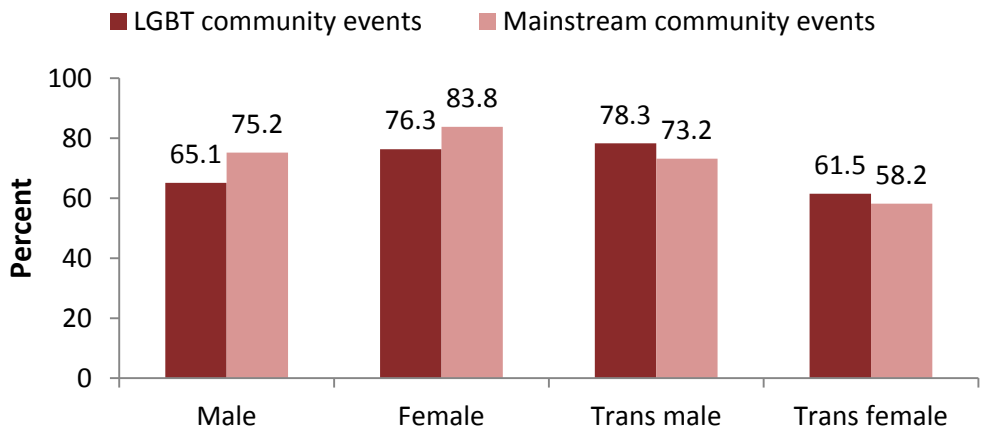
> *I saved my money so I was able to attend Mardi Gras in Sydney for the first time. The experience was not only incredible it was also very inspiring and important to my self-esteem* (Bisexual female 19 yrs, PL2)

PL2 used a range of indicators of LGBT and mainstream community participation including: organisational membership; participation at community events; percentage of LGBT friends and acquaintances, and use of LGBT media (Leonard et al., 2012, pp.49 -52). In the following section participation in LGBT and mainstream community events is used as a proxy measure of community engagement more broadly.

Figures 33 and 34 show the proportion of PL2 respondents who reported that they participated in LGBT and mainstream community events at least once annually, by gender identity and sexual identity respectively.[12]

[12] Respondents were asked to indicate whether they had participated in mainstream or LGBT community events arranged by an organisation of which they may or may not have been a member. Responses to these series of questions included: "Daily", "Weekly", "Monthly", "Annually" or "Never."

Figure 33 – Proportion of respondents who had participated in LGBT and mainstream community events, by gender identity



Participation in LGBT community events was highest among trans males (78.3 per cent) and lowest among trans females (61.5 per cent). Males and females reported a higher rate of participation in mainstream compared with LGBT community events but the reverse was true for trans males and females.

Figure 34 – Proportion of respondents who had participated in LGBT and mainstream community events, by sexual identity

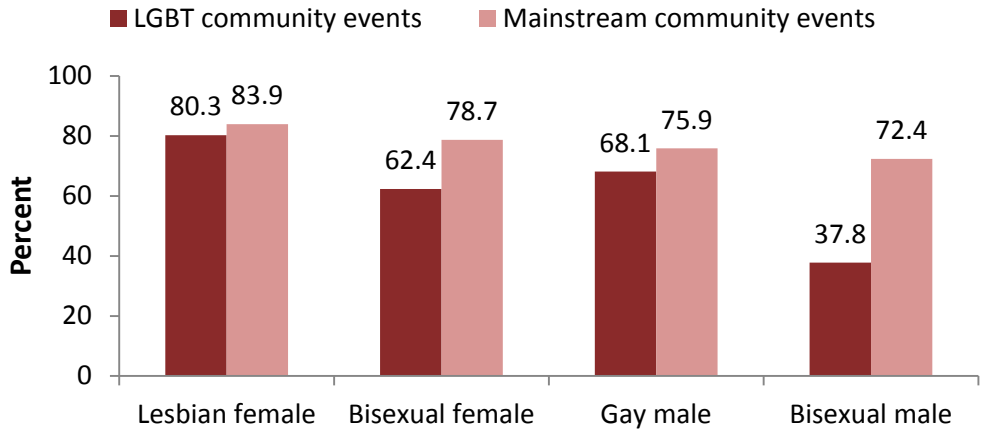
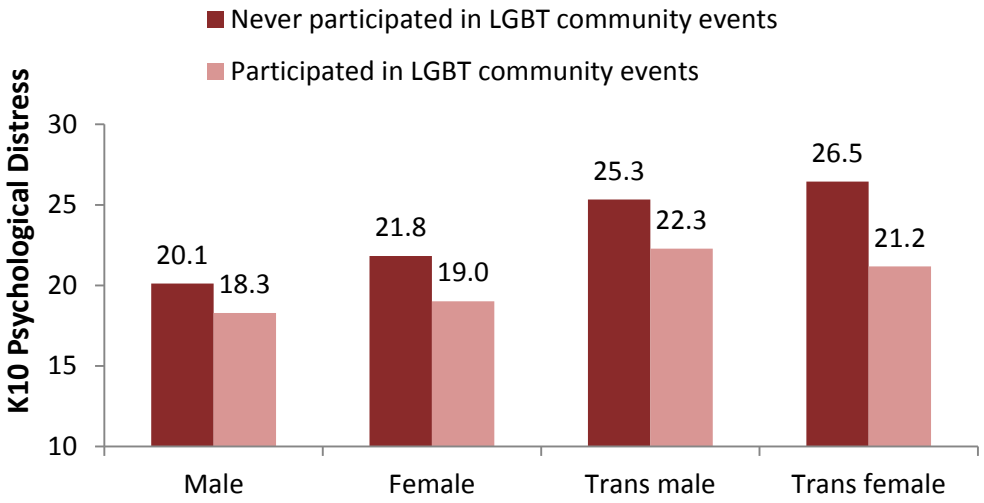


Figure 34 shows that rates of mainstream community participation were higher than rates of LGBT community participation for all sexual identity groupings. Lesbian females reported the highest rates of mainstream and LGBT community participation (83.9 per cent and 80.3 per cent) while bisexual males reported the lowest rates for both (72.4 per cent and 37.8 per cent respectively).The difference between participation in mainstream and LGBT community was higher for bisexual females and bisexual males compared with their exclusively same sex attracted counterparts. The difference, however, was considerably larger for bisexual males who were nearly twice as likely to have attended a mainstream community event than an LGBT community event.

Participation in LGBT community events and psychological distress

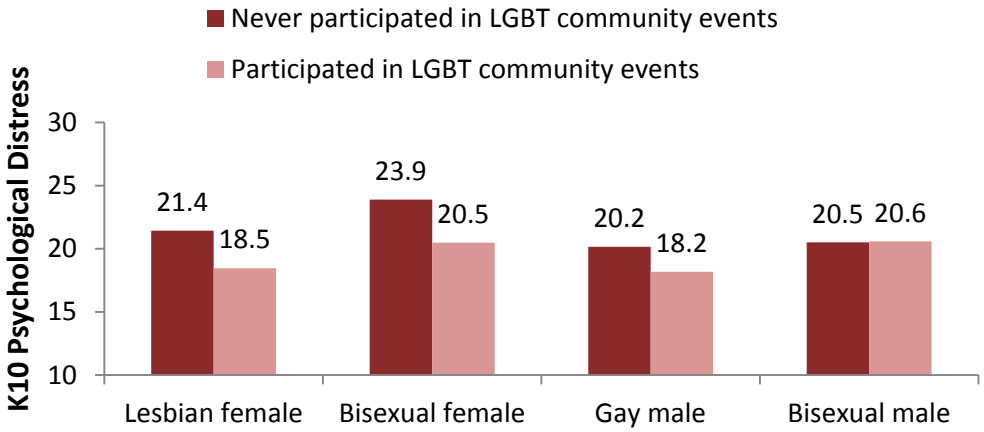
Figures 35 and 36 present variations in rates of psychological distress according to LGBT community participation for gender identity and sexual identity respectively.

Figure 35 – Mean K10 Psychological Distress scores by participation in LGBT community events and gender identity



Respondents who had participated in LGBT community events had lower rates of psychological distress than those who had not, among all gender identity groupings. The difference in mean K10 scores between having participated and not having participated in LGBT community events was higher for trans males and trans females compared with males and females, respectively. The difference in mean K10 scores was greatest for trans females, with those reporting having participated in LGBT community events recording markedly lower levels of psychological distress than those who had never participated in LGBT community events (mean K10 score of 21.2 versus a score of 26.5).

Figure 36 – Mean K10 Psychological Distress scores by participation in LGBT community events and sexual identity



As Figure 36 shows, participation in LGBT community events was linked with lower levels of psychological distress for all sexual identity groupings with the exception of bisexual males. As PL2 notes, bisexual males are the least LGBT-community connected or affiliated of all the sexual identity groupings according to a number of other measures including percentage of friends who are LGBT and use of LGBT media (Leonard et al., 2012, pp. 50-52).

The protective mental health effects of LGBT community participation were greatest among bisexual females, who reported the largest variation in levels of psychological distress between having participated in and not having participated in LGBT community events (mean K10 scores of 20.5 and 23.9 respectively).

Participation in LGBT community events and resilience

Figures 37 and 38 show the relationship between participation in LGBT community events and resilience according to gender identity and sexual identity, respectively.

Figure 37 – Mean resilience scores by participation in LGBT community events and gender identity

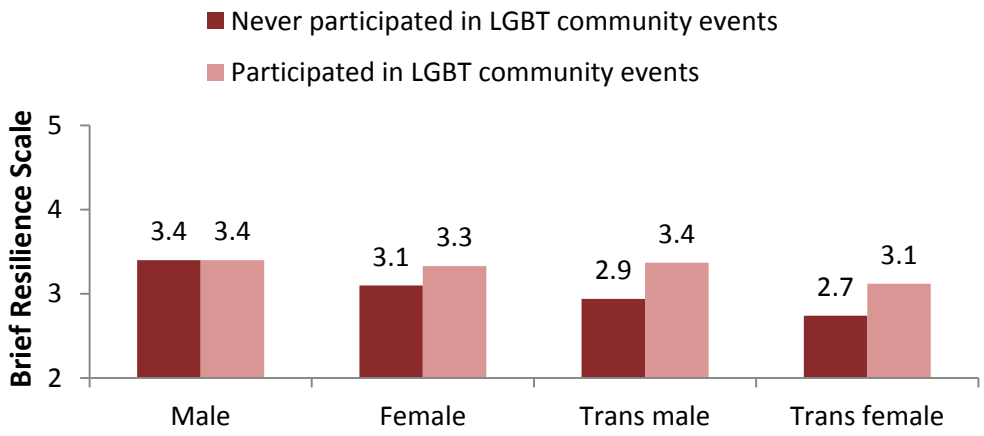
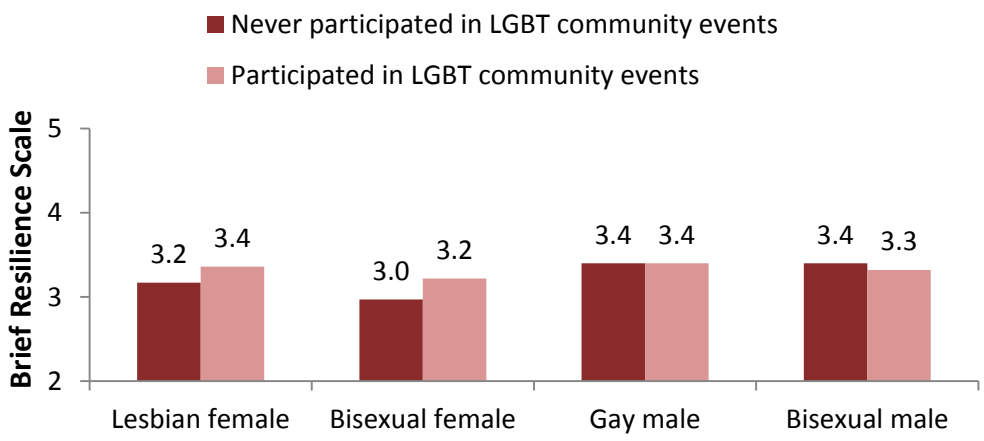


Figure 37 shows a positive association between participation in LGBT community events and resilience. Mean resilience scores were higher for those PL2 respondents who reported having participated in LGBT community events compared with those who reported never having participated in LGBT community events for all gender identity groupings except males.

Figure 38 – Mean resilience scores by participation in LGBT community events and sexual identity



For lesbian females and bisexual females, those who had participated in LGBT community events had higher resilience than those who had not participated.

Participation in mainstream community events and psychological distress

Figures 39 and 40 show the relationship between participation in mainstream community events and psychological distress according to gender identity and sexual identity, respectively.

Figure 39 – Mean K10 Psychological Distress scores by participation in mainstream community events and gender identity

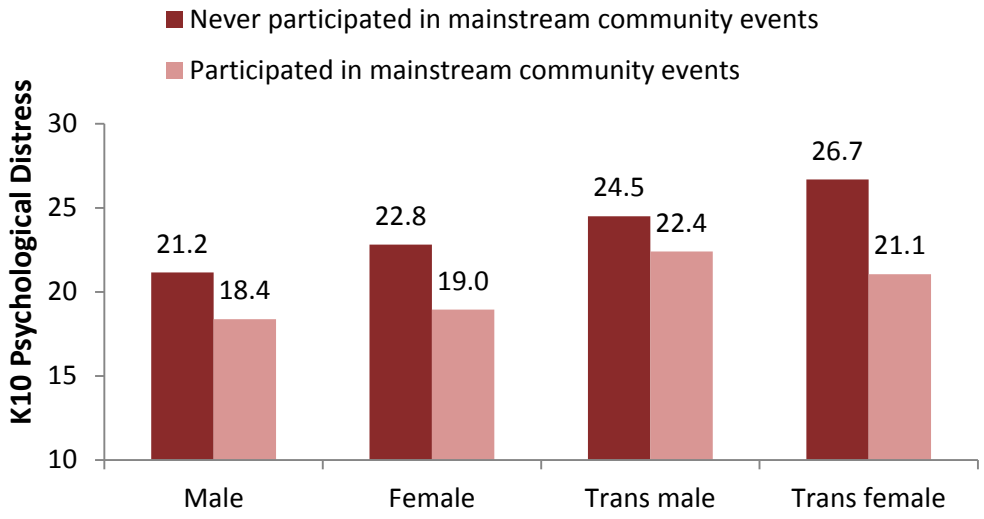
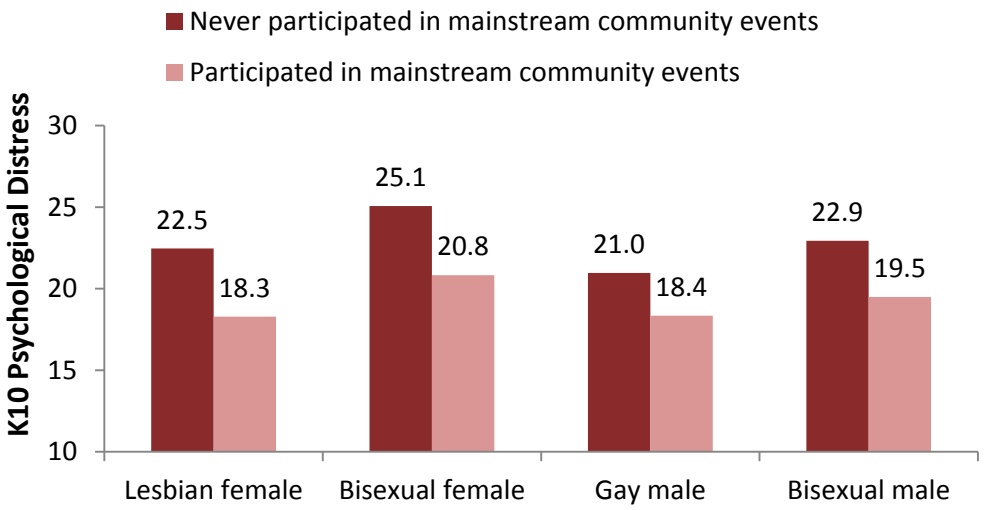


Figure 39 shows that participation in mainstream community events was associated with lower levels of psychological distress for all gender identity groups. This association was greatest for trans females and weakest for trans males.

Figure 40 – Mean K10 Psychological Distress scores by participation in mainstream community events and sexual identity



Those who had participated in mainstream community events had lower levels of psychological distress than those who had not, for all sexual identity groupings. The difference was greatest for bisexual females and lesbian females compared to gay males and bisexual males.

Participation in mainstream community events and resilience

Figures 41 and 42 show the relationship between participation in mainstream community events and resilience according to gender identity and sexual identity, respectively.

Figure 41 – Mean resilience scores by participation in mainstream community events and gender identity

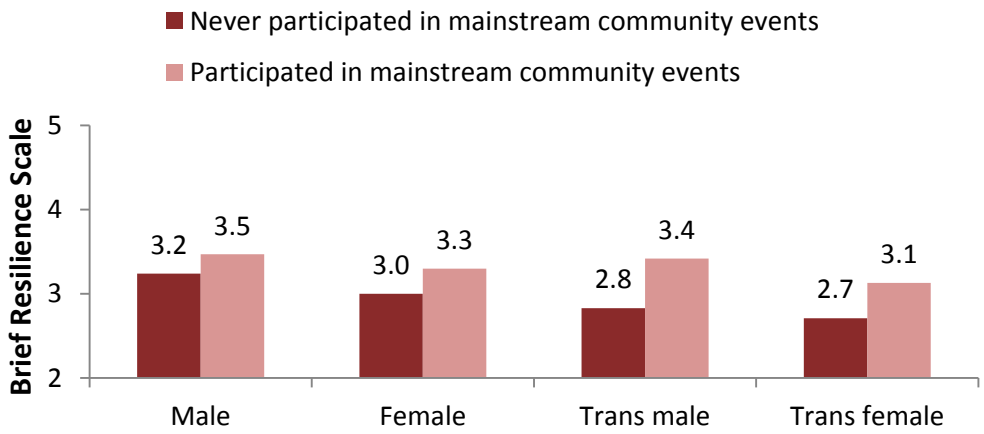
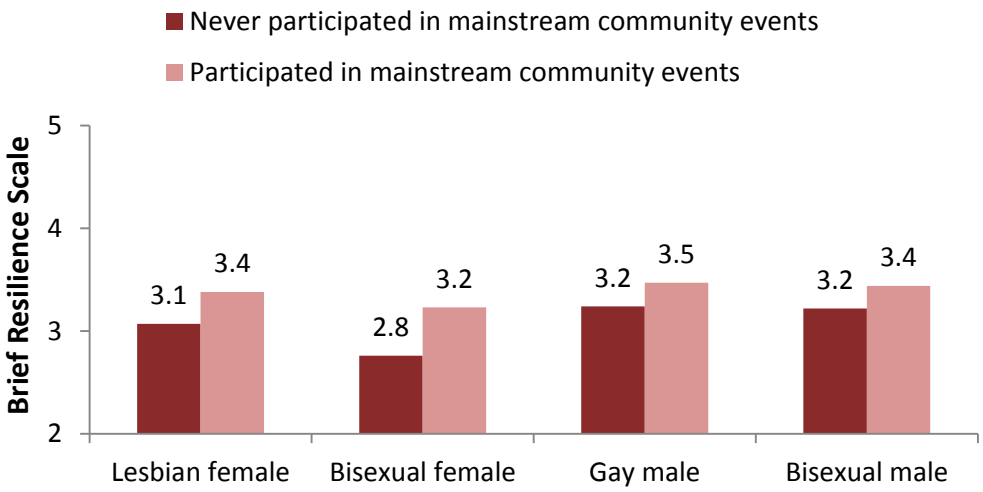


Figure 41 shows that those who had participated in mainstream community events had higher levels of resilience than those who had not, for all gender identity groupings.

Figure 42 – Mean resilience scores by participation in mainstream community events and sexual identity



For all sexual identity groupings, those who had participated in mainstream community events had higher rates of resilience than those who had not participated in mainstream community events.

Chapter 7: Health service use

Studies of LGBT people's use of health services suggest a complex relationship between service use and quality of care. A number of population surveys have highlighted LGBT people's reluctance to access mainstream health services because of past experiences of discrimination or because they anticipate such experiences in the future (Heck et al., 2006; Mayer et al., 2008; Pitts et al., 2006). However, recent studies have shown higher than average rates of health service use for particular subpopulations within LGBT communities. For example, studies of women's health suggest that lesbians are more likely than heterosexual women to access health care (Bakker et al., 2006; McNair et al., 2014; McNair et al., 2011). Lesbians, however, are also more likely to report dissatisfaction with the quality of care they receive and to demonstrate reduced continuity of care as a consequence (McNair et al., 2014; Pennant et al., 2009; Tjepkema 2008).

Heterosexist discrimination can also lead to social isolation and economic disadvantage, which, in turn, can reduce access to health services generally and to private health care in particular. This is true for subpopulations within LGBT communities who experience high levels of heterosexist discrimination. According to PL2 data, trans females were more likely to have a regular GP (84.3 per cent) but less likely to have private health insurance (44.6 per cent) than other gender identity groups (Leonard et al., 2012, pp.41-42).

U.S. studies on LGBT people's use of mental health services show that reduced access, combined with reduced quality of care, contributes to LGBT people's sense of social marginality and exclusion. In turn, this can increase their levels of anxiety and psychological distress leading to further reductions in their mental health and wellbeing.

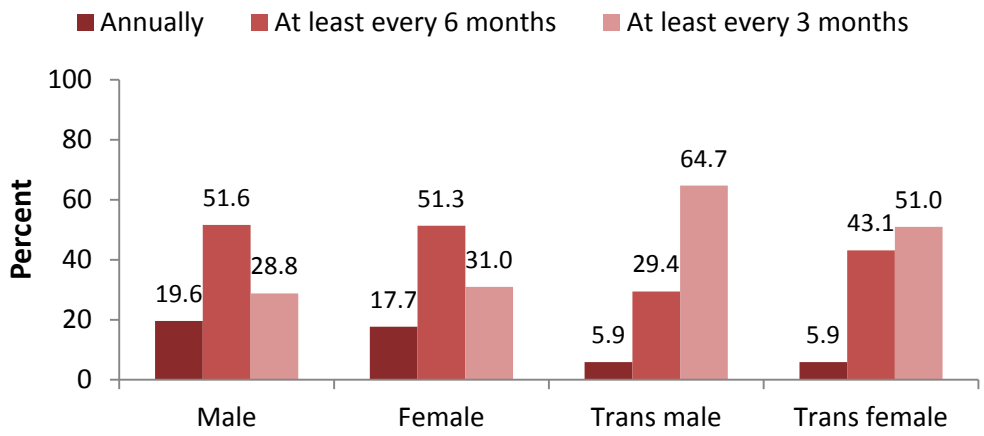
Frequency of GP visits

> *I live here for the lifestyle, work and to be close to my family but I still feel like I'm suffocating…I have found a GP I feel safe with and who does not judge me like some that I have visited which makes me feel really good…I can be honest and open about what I am up to and get regular check-ups*
> (Gay male 37 yrs, PL2)

Nearly 76 per cent of PL2 respondents (*N*=2,881) reported that they had a regular GP. These respondents were asked how often they visited their GP in the past 12 months.[13] Figures 43 and 44 present frequency of GP visits according to gender identity and sexual identity, respectively.

[13] Those who responded 'Never' (*n*=72) were excluded from analysis.

Figure 43 – Frequency of GP visits among respondents with a regular GP, by gender identity



The frequency of GP visits was highest among trans females and trans males, with the majority reporting visiting their GP at least every 3 months (64.7 per cent of trans males and 51.0 per cent of trans females). For males and females, the majority reported visiting their GPs at least every six months (51.6 per cent of males and 51.3 per cent of females).

Figure 44 – Frequency of GP visits among respondents with a regular GP, by sexuality identity

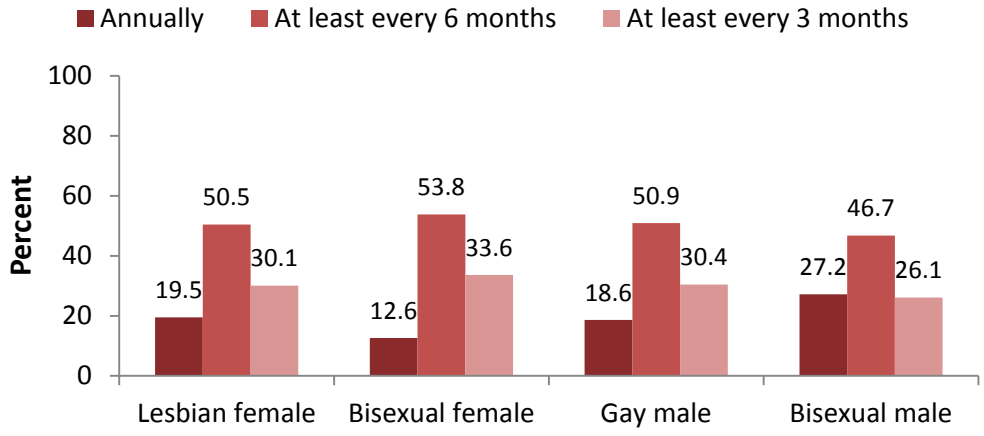
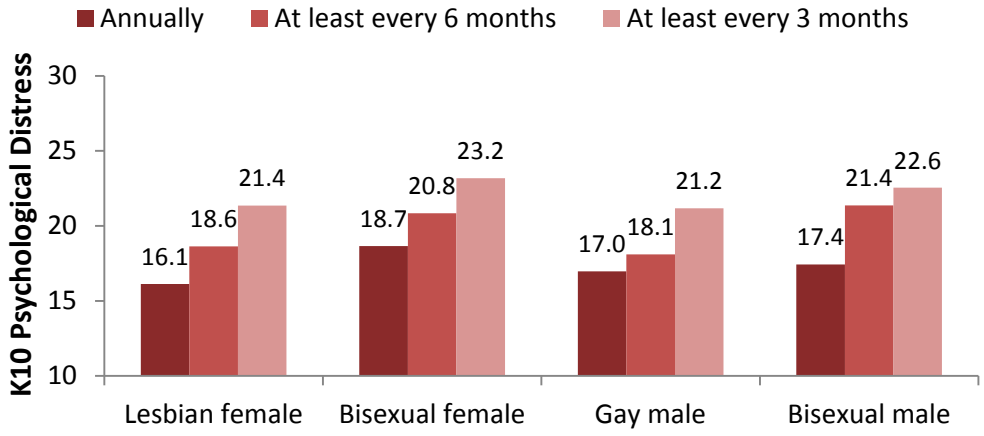


Figure 44 shows similar patterns of GP attendance for all four sexual identity groupings and almost identical patterns for lesbian females and gay males. Bisexual females reported the highest frequency of visits and bisexual males the lowest, with 87.4 per cent of bisexual females reporting visiting their GP at least once in the past six months compared with 72.8 per cent of bisexual males.

Frequency of GP visits and psychological distress

Figure 45 shows the relationship between frequency of GP visits and psychological distress by sexual identity.

Figure 45 – Mean K10 Psychological Distress Scores by frequency of GP visits and sexual identity



Increasing frequency of GP visits was associated with higher psychological distress for all sexual identity groupings. Those who reported visiting their regular GP at least every three months had the highest level of psychological distress, followed by those who reported visiting their GP at least every six months, with the lowest level of distress recorded by those who reported visiting their GP once in the past year.

Frequency of GP visits and resilience

Figure 46 shows the association between rates of resilience and frequency of GP visits for sexual identity.

Figure 46 – Mean resilience scores by frequency of GP visits and sexual identity

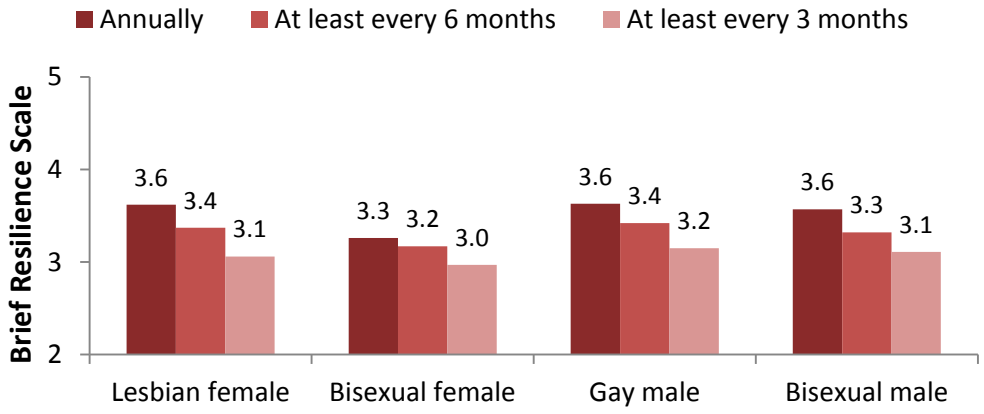


Figure 46 shows an inverse relationship between resilience and frequency of visits to a regular GP for all sexual identity groups: mean brief resilience scores decreased as frequency of visits increased.

Mental health services

PL2 respondents were asked to report on the different types of health services they had accessed in the past 12 months. They were presented with a list of 13 service types including mental, allied and alternative health services (Leonard et al., 2012, pp. 42-43).

The following section looks at PL2 respondents' access to mental health services and the relationship between access and psychological distress and resilience, according to gender identity and sexual identity.

Mental health services included those provided by psychiatrists, psychologists, counsellors, and social workers. Rates of access to mental health services by gender and sexual identity are described below.

Gender identity

Rates of mental health service use were higher among both trans females and trans males compared with males and females (67.2 per cent for trans females and 59.6 per cent for trans males compared with 45.2 per cent for females and 30.1 per cent for males). The rates of mental health service use among transgender respondents in PL2 are higher than those reported in an earlier study of the health and wellbeing of transgender people living in Australia and New Zealand, where 47.4 per cent of respondents reported having used the services of a mental health professional in the 12 months prior to completing the survey (Couch et al., 2007).

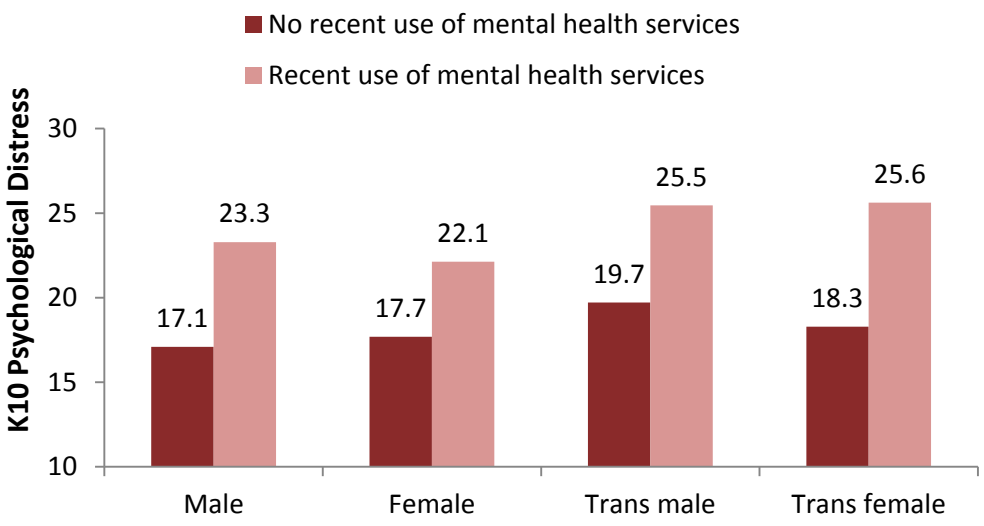
Sexual identity

Rates of mental health service use were higher among bisexual females and bisexual males compared with their exclusively same-sex attracted counterparts. Rates were highest among bisexual females (52.5 per cent), followed by lesbian females (42.9 per cent), bisexual males (37.2 per cent) and then gay males (29.4 per cent).

Mental health service use and psychological distress

Figures 47 and 48 look at the association between mental health service use and psychological distress according to gender identity and sexual identity respectively. Respondents who reported having used the services of any mental health professional were classified under 'Recent use of mental health services'. Respondents who had not used the services of any of the listed mental health specialists were classified under 'No recent use of mental health services.'

Figure 47 – Mean K10 Psychological Distress scores by mental health service use and gender identity



For all gender identity groups, those who had recently used mental health services had higher psychological distress than those who had not recently used mental health services. This was particularly true for trans females.

Figure 48 – Mean K10 Psychological Distress scores by mental health service use and sexual identity

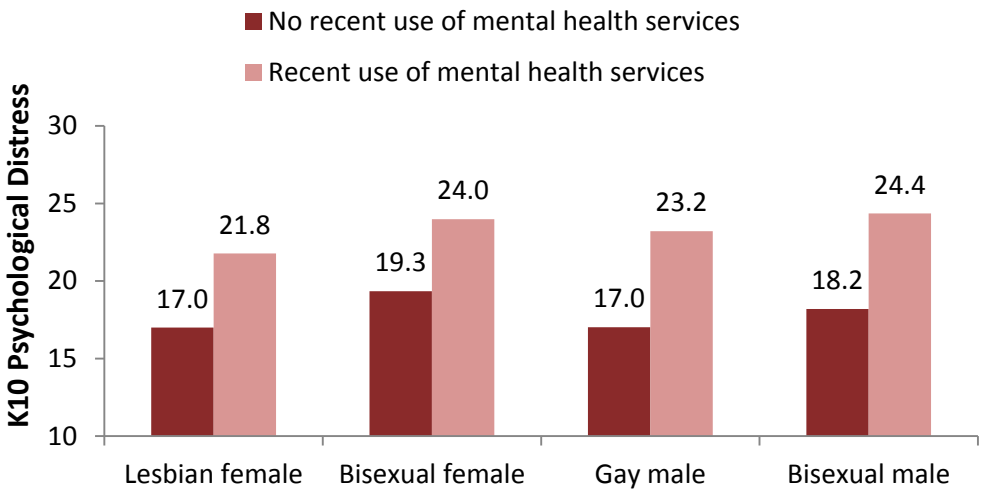
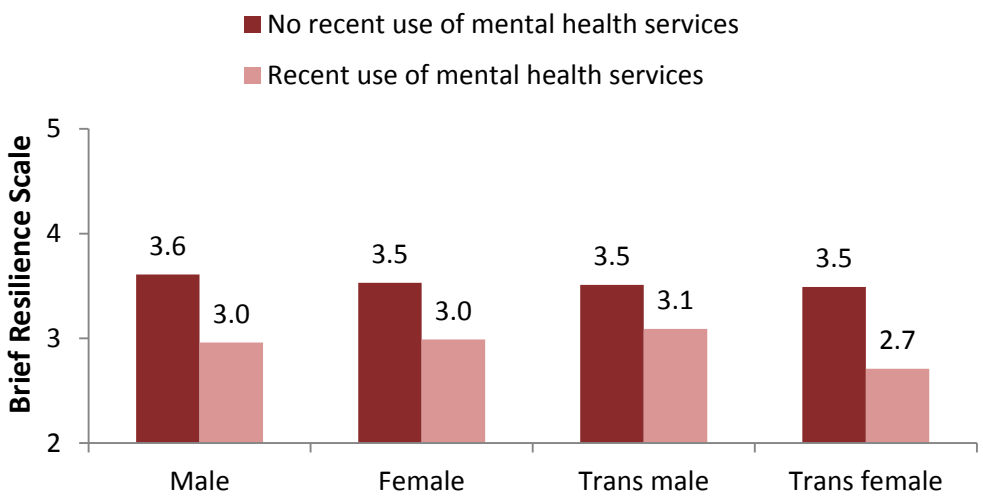


Figure 48 shows that psychological distress was higher among those who reported recent use of mental health services than those who reported no recent use, for all sexual identity groupings. The difference in K10 scores between no recent use and recent use of mental health services was greater for bisexual males and gay males than for bisexual females and lesbian females respectively (differences in K10 scores of 6.2 for both bisexual and gay males compared with 4.7 and 4.8 for bisexual and lesbian females respectively).

Mental health service use and resilience

Figures 49 and 50 show the association between mental health service use and resilience according to gender identity and sexual identity respectively.

Figure 49 – Mean resilience scores by mental health service use and gender identity



Resilience was lower among those who reported recent use of mental health services for all gender identity groupings.

Figure 50 – Mean resilience scores by mental health service use and sexual identity

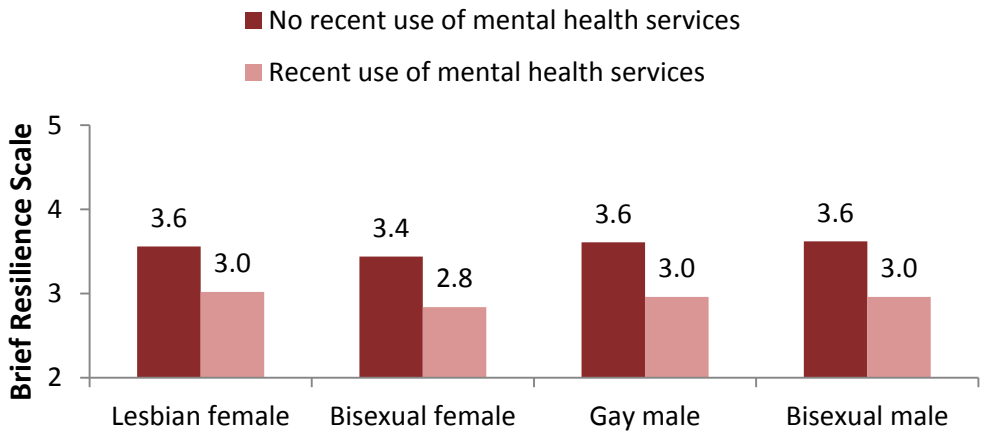


Figure 50 shows that resilience was lower among those respondents who reported recent use of mental health services for all sexual identity groupings.

Chapter 8: From private lives to public policy

A closer look at the PL2 mental health data reveals the ways in which heterosexism interacts with other social forces to influence LGBT people's collective *and* individual health and wellbeing. These interactions lead to variations in rates and patterns of mental health not only *between* LGBT and mainstream populations, but also *within* LGBT communities.

The PL2 data show that ongoing and systemic heterosexist discrimination lead to higher rates of psychological distress and illicit drug use and lower levels of service satisfaction among LGBT Australians compared with the population at large. A closer look at the data reveals significant variations in psychological distress and resilience *within* LGBT communities according to gender identity, sexual identity, age and socio-economic status and higher risk of mental ill-health among LGBT people who identify with other minority and marginal populations. A closer look also reveals how processes of legislative and social reform that challenge heterosexism and promote justice and equity can protect LGBT people against the debilitating effects of discrimination and abuse.

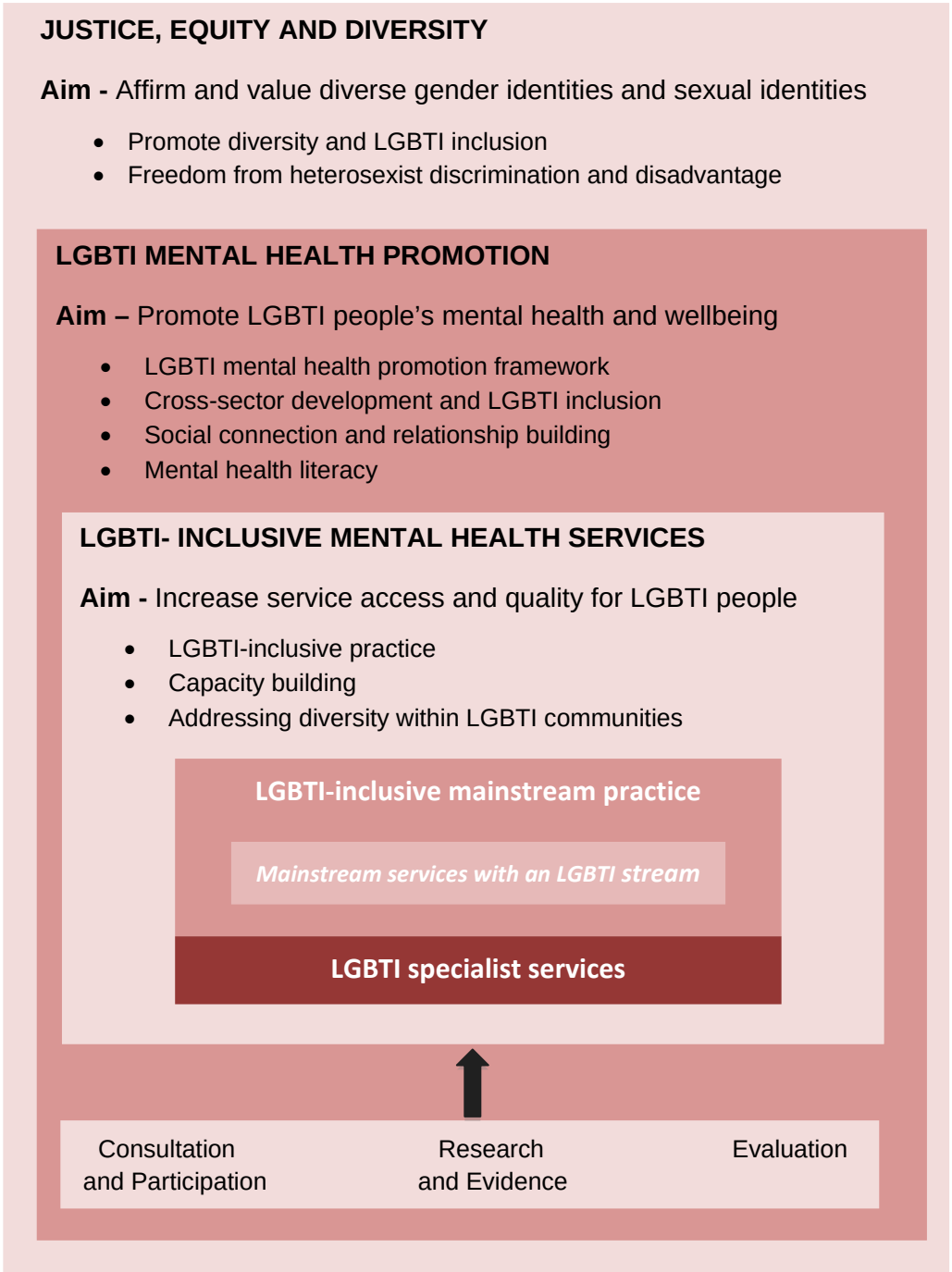
At the same time, a closer look hints at the limits of an approach that focuses solely on discrimination and disadvantage. It suggests the need for a new approach that values and affirms 'being LGBT' as particular expressions of the diversity of gender identities and sexual identities we all share.

Introducing the framework

> *Last Xmas my once conservative Catholic mother walked out of church because they said something against gay marriage. And she made all her friends walk out too. Because she later told me, going to our wedding was one of the best days of her life* (Lesbian female 30 yrs, PL2*)*

The following sections present a policy and program framework aimed at improving the mental health and wellbeing of LGBT Australians (Figure 51). The framework is evidence-based, informed by best practice health promotion and reflects a commitment to the principles of justice, equity and diversity. It draws on the findings of this report and other research and policies that identify key social processes or determinants that impact on LGBT people's health and wellbeing. The framework acknowledges that the same social determinants that lead to variations in rates and patterns of mental health both *between* LGBT and mainstream populations and *within* LGBT communities also have a direct impact on LGBT Australians' access to appropriate and effective care.

Figure 51 – A policy and program framework for improving LGBTI Australians' mental health and well-being[14]



[14] People with intersex conditions were not recruited for *Private Lives 2*. This was due to the difficulty in recruiting respondents with an intersex condition for the first Private lives study. However, it is important that intersex and people with intersex conditions are included in equality frameworks that address gender identity and sexual identity diversity. See Leonard et al., 2012, p.59.

The framework is divided into three levels.

Level 1 – Justice, Equity and Diversity

The first level applies the principles of justice, equity and diversity to the affirmation of LGBT people's lives and relationships. It recognises the value of gender identity and sexual identity diversity to the population *as a whole* while addressing the ongoing effects of heterosexist discrimination and disadvantage on LGBT Australians' everyday lives.

Level 2 – LGBT Mental Health Promotion

The second level sits within the first and applies the principles of justice, equity and diversity to the development a new *affirmative* approach to LGBT mental health promotion (Leonard and Metcalf 2014, p.29). This approach addresses the upstream determinants of LGBT mental health and wellbeing and, in particular, increased social participation and relationship building. It provides a blueprint for the development of policies, programs and services across a range of sectors aimed at promoting greater social recognition and inclusion of LGBT people and, with that, improvements in their mental health and wellbeing.

Level 3 – LGBT-inclusive Mental Health Services

The third level nests within the preceding two. It seeks to develop LGBT-inclusive mainstream and, where appropriate, targeted mental health services. This involves developing professional practice and organisational procedures and protocols that affirm LGBT people and are sensitive to and able to address the particularities of their lives, including those practices and processes that place LGBT people at increased risk of certain mental health problems. It also involves developing services that can address the diversity within LGBT communities, including differences in gender identity and sexual identity and how these are cross-cut by other social determinants including, among others, age, HIV status, racial background, religious and ethnic affiliation, disability, and socio-economic status.

Unpacking the framework

Each of the three levels is indebted to and reflects a common set of principles - justice, equity and diversity. The framework is not prescriptive; it does not tell agencies what to do. Rather, it details different types of interventions at different levels, from legislative reform to the delivery of LGBT-inclusive services. The framework assists agencies and services in identifying where and how they can implement change and how their work depends on and reinforces work being undertaken at different levels and by other organisations. However, while individual agencies or instrumentalities might focus on interventions at any one level, the overall aim of promoting positive mental health among LGBT Australians depends on a coordinated effort across all three.

1. Justice, equity and diversity

In Australia, efforts to secure justice and equality for LGBT people have focused on legislative and social reforms aimed at reducing, if not eliminating, heterosexist discrimination. However, the

findings of PL2 hint at the limits of this approach and the need to address discrimination and abuse within a broader framework that values and affirms LGBT people's lives and relationships. A focus on heterosexist discrimination has been successful in getting sexual orientation and gender identity included as protected attributes in equal opportunity and anti-discrimination legislation and as social determinants in some population health and health promotion policies (Irlam 2013; Leonard 2014, p.346-47; Leonard and Metcalf 2014; Leonard 2005). However, as the introduction to this report notes, it is possible to object to discrimination and violence against LGBT people while continuing to view their gender identities and sexual identities as problematic.

We need to move beyond policies and frameworks that construct LGBT people as little more than victims, as objects of abuse. What is needed is a new approach that values gender identity and sexual identity diversity as social goods in their own right. Such an approach no longer takes heterosexuality and gender normativity as the gold standard against which other sexual identities and gender identities are judged and necessarily found wanting. Rather, it values different gender identities and sexual identities as part of the diversity of human expression we all share.

The framework developed here recognises and values diversity, and with that, the different kinds of diversity that constitute the Australian population as a whole. These include, among others, racial, ethnic and religious diversity and a diversity of gender identities and sexual identities of which LGBT people are a part. Within this framework, discrimination is understood not simply or even primarily as a barrier to members of minority and marginal populations accessing services. Rather, discrimination also includes an unwillingness or inability to value difference and diversity and with that an inability to recognise the value and dignity of minority and marginal groups. This weakens our collective ability to understand and value the differences that make up the society of which we are all part and fosters intolerance and division. For members of minority populations, including LGBT people, this inability leads to feelings of reduced individual and collective worth and with that increased risk of mental ill-health.

This framework also highlights the need for policies and programs that recognise and value minority and marginal groups *independent* of their experiences of discrimination and abuse. For LGBT individuals and communities these include Government support for representative bodies and inclusion of LGBT issues in diversity policies and programs across the public sector, from health and community services to school curriculum.

Table 7 presents possible action areas and responsibilities for promoting a culture that values and affirms gender identity and sexual identity diversity while at the same time addressing the impact of historical and ongoing heterosexist discrimination on LGBT people's lives. This also involves acknowledging and valuing difference and diversity within LGBT communities and how other forms of discrimination and disadvantage can affect the lives of LGBT people who identify with other minority or marginal populations. While responsibility for legislative reform sits primarily with government, policies that promote diversity and include LGBT people are the joint responsibility of government and non-government agencies, including private companies and representative bodies of all stripes (E.g. PEAK bodies and ethnic and religious councils).

Table 7 – Promoting a culture that values and affirms gender identity and sexual identity diversity

JUSTICE, EQUITY AND DIVERSITY

Affirm and value diverse gender identities and sexual identities

Action Areas	Responsibility	
	Government	**Non-Government**
Promote diversity and LGBT inclusion		
Policy	• Include gender identity and sexual identity and LGBT people in: ➢ All diversity policies; and ➢ Policies addressing discrimination, disadvantage and the social determinants of well-being • Address the impact of multiple forms of discrimination and material disadvantage on subpopulations within LGBT communities • Mandate LGBT-inclusion in all government-funded services • Bring together representatives from different communities to discuss the value of gender identity and sexual identity diversity	• Mission statement and policies that: ➢ Acknowledge and value difference and diversity including gender identity and sexual identity diversity ➢ Express a clear and unambiguous commitment to the principles of equity, justice and diversity and freedom from discrimination and how they apply to LGBT people • Head of organisation and senior staff to take a proactive role in profiling LGBT people and issues
Data collection	• Inclusion of questions on minority gender identities and sexual identities in: ➢ National population surveys; and ➢ Client data collection (as appropriate)	• Collect data on the experiences of LGBT staff , members and, where appropriate, clients, which can be used to increase their social participation and wellbeing
Representation and participation	• LGBT representation on Government committees and boards • LGBT-specific advisory groups and structures	• LGBT representation on boards, committees and working groups • LGBT representative group within the organisation to promote greater LGBT visibility and inclusion
Value contribution	• Publicly promote and value the unique contribution of LGBT people to Australian life	• Publicly value the contribution of LGBT people (E.g. organisational web sites, promotional materials, e-newsletters)
Community organisations and events	• Inclusion of LGBT people in government-funded, public events that acknowledge difference and diversity • Increased funding and support for LGBT community organisations and events. • Public events recognising key dates and issues for LGBT people	• Events that recognise and value LGBT staff and clients
Freedom from heterosexist discrimination and disadvantage		
Legislative reform	• Full legal recognition of gender identity and sexual identity minorities including same-sex and non-cisgender couples • Full protection of all LGBT people under Equal Opportunity and Anti-discrimination legislation *without exemption*	
Public campaigns	• Work collaboratively with the LGBT community and, where appropriate, mainstream organisations to develop and deliver public campaigns that: ➢ Recognise and value LGBT people; and ➢ Challenge heterosexism	• Where appropriate support and/or develop public campaigns and resources that: ➢ Challenge heterosexism; and ➢ Recognise and value LGBT people
Research	• Fund research aimed at: ➢ Promoting a culture that values diversity ➢ Increasing LGBT people's visibility and social participation; and ➢ Combating heterosexism	

The following are two examples of broad-based initiatives aimed at promoting a culture that values and affirms gender identity and sexual identity diversity. The first is the establishment of a Victorian Government advisory body that will provide a whole-of-government response to LGBTI issues. The second is a national program that promotes greater understanding of the impact of discrimination on LGBTI Australian's mental health and wellbeing while affirming the value of LGBTI people's lives and relationships.

Whole-of-government LGBTI advisory group

In 2015, the Victorian Government will establish a dedicated Cabinet role for LGBTI issues that includes a Premier's whole-of-government LGBTI advisory group. The Government will also appoint a Commissioner for Gender and Sexuality whose responsibilities include LGBTI issues. These initiatives are an acknowledgement by Government that more needs to be done to ensure full equality for LGBTI Victorians. However, the initiatives do not focus solely on equality and justice. The Government has located LGBTI issues within a diversity and equity framework that values and affirms LGBTI people as part of the rich network of differences that all Victorians share and which contribute to the vitality and health of the state.
www.viclabor.com.au/wp-content/uploads/2014/05/Victorian-Labor-Platform-2014.pdf

Stop.Think.Respect

Stop.Think.Respect is a national campaign run by *beyondblue* that challenges heterosexist discrimination and encourages LGBTI people who are at risk of or experiencing mental health problems to seek help. The program includes a national ad campaign that challenges homophobic behaviours and attitudes by highlighting the effects of discrimination on the lives and mental wellbeing of LGB people. The program also includes a suite of online resources consisting of Real Life Stories from 6 LGBTI people and printed materials.

Stop.Think.Respect was developed in consultation with LGBTI community and professional representatives. It is the first national anti-homophobia program in Australia and the first to be funded and managed by a mainstream organisation. It is part of processes of social and cultural change that address the impact of heterosexist discrimination on LGBTI Australian's lives within a broader framework that values and affirms gender identity and sexual identity diversity.
www.beyondblue.org.au/resources/for-me/gay-lesbian-bi-trans-and-intersex-glbti-people

2. LGBT mental health promotion

This section outlines strategies aimed at developing an LGBT mental health-promoting culture. It focuses on the upstream determinants of positive mental health and in particular those that promote LGBT people's increased social inclusion and participation and their capacity to form long-term meaningful relationships within and outside LGBT communities. The WHO has identified a sense of belonging and supportive relationships and networks as protective factors against the onset and recurrence of mental ill-health (de Leeuw and WHO 2006). However, the framework being proposed here suggests that LGBT people's relations and networks are valuable not only as protective factors against increased risk of mental health problems. It is important that they are also valued as social goods in their own right that contribute to the health and wellbeing of LGBT people and the community as a whole.

Affirming LGBT people as LGBT involves not only recognition of the injustice and debilitating effects of historical and ongoing heterosexist discrimination on their health and wellbeing. It has the added and profound effect of helping LGBT people gain a sense of individual and collective worth on which good mental health depends. This upstream approach *minimises* the demand for mental health services by *maximising* the conditions that promote positive mental health among LGBT people and communities (Leonard and Metcalf 2014, p.9).

This section identifies four interrelated strategies aimed at developing an LGBT mental health promoting culture. They are:

- The development of an LGBT mental health promotion framework
- Cross-sector development and LGBT inclusion
- Social connection and relationship building; and
- Mental health literacy

The four strategies sit across a range of different sites but all depend on, as they contribute to, broader social and legislative reforms that value and affirm gender identity and sexual identity diversity.

LGBT mental health promotion framework

A comprehensive LGBT mental health promotion framework provides a blueprint for the development of policies, programs and services across a range of sectors aimed at promoting LGBT Australians' mental health and wellbeing. The framework applies the principles of justice, equity and diversity to the lives of gender identity and sexual identity minorities. It addresses the upstream determinants of LGBT mental health and wellbeing, and in particular increased social participation and relationship building.

The framework enables organisations beyond the health sector to understand that by developing and implementing policies and programs that increase LGBT people's visibility and participation they are also contributing to the development of an LGBT mental health promoting culture. At the same time, it provides a rationale for providing resources and developing a diverse range of programs to

increase the capacity of LGBT individuals and organisations to generate and maintain relationships and networks within the LGBT community and between LGBT and mainstream communities.

The responsibility for developing and implementing such a framework lies with government in partnership with key LGBT and mainstream representative organisations across a range of different sectors.

Going upstream

In 2014, the National LGBTI Health Alliance released *Going upstream: A framework for promoting the mental health of lesbian, gay, bisexual, transgender and intersex (LGBTI) people*. The document presents a comprehensive framework to guide the development of policies and programs that promote LGBTI people's mental health and wellbeing and a reduction in their burden of mental ill-health and suicide. The document presents Australian and international data on the mental health and wellbeing of LGBTI people and identifies the key determinants of increased mental ill-health among this community. The framework focuses on the upstream determinants of LGBTI health and wellbeing and on creating environments that are conducive to positive LGBTI mental health through advocacy, legislative reform, capacity building and community strengthening.
http://lgbtihealth.org.au/sites/default/files/going-upstream-online-o-lgbti-mental-health-promotion-framework.pdf

Cross-sector development and LGBT inclusion

> *Discovering a sporting league I have become a member of. It has increased my confidence and allowed me to discover myself. I also kick ass at the sport!* (Lesbian female 30 yrs, PL2)

Increased visibility and social inclusion are vital to improving the mental health and wellbeing of LGBT people. This involves:

- Ensuring that LGBT people are valued and active participants in all areas of social life including work, education, sport and recreation, politics, art and culture
- Ensuring that initiatives promoting LGBT visibility and participation address the ways in which diversity within LGBT communities impacts differentially on LGBT people's ability to participate, including differences in gender identity and sexual identity and how these are cross-cut by other social determinants including age, HIV status, racial background, religious and ethnic affiliation, disability, and socio-economic status
- Developing sector-specific strategies (E.g. sport, arts and culture, politics) to guide organisations in how to develop and implement policies and programs that increase the visibility and participation of LGBT people; and
- Drawing these sector-specific strategies together under a single LGBT mental health promotion framework that makes clear the links between increasing participation and positive mental health. These strategies are necessarily double-edged, removing the barriers that have reduced LGBT people's participation while actively supporting and valuing their contribution.

At the same time, there is an opportunity to use these various sectors and organisations as sites for the delivery of LGBT mental health promotion, including information, resources and referrals. This requires linkages and partnerships among organisations from different sectors, including partnerships between mental health and LGBT health and community organisations and representative bodies from each of the sectors listed above.

Fair go, sport!

Fair go, sport! was launched in 2010 and is run by the Victorian Equal Opportunity and Human Rights Commission (VHREOC) and funded by the Australian Sports Commission. The project aims to promote greater awareness of sexual and gender identity within sport and safe inclusive sporting environments where all people can participate. The project has worked with a range of sporting codes including Hockey, Basketball, Cycling, Football and Skate Victoria/Roller Derby.

In 2012, VHREOC applied the Fair go, sport! model to sport, health and physical education programs in secondary schools. The project aims to assist schools develop strategies for promoting inclusion in school sport and to make sport a safe and supportive environment for all students regardless of their gender or sexual identity.
www.humanrightscommission.vic.gov.au/index.php/fair-go-sport-home

Social connection and relationship building

> *I made a huge change to move to Melbourne…it was mostly to get away from my parents who made my life very difficult since coming out. I was diagnosed with depression but with the help of my loving partner and friends I can see the light at the end of the tunnel* (Lesbian female 29 yrs, PL2)

There is a growing body of research showing the positive impact of social connection and relationship building on people's mental health. Social connection and meaningful relationships provide that sense of belonging, value and purpose on which positive mental health depends (de Leeuw WHO 2006). For minority and marginal populations, including LGBT people, these networks and relationships may also mitigate the trauma associated with experiences of discrimination and abuse (VicHealth 1999).

Efforts to promote greater connection among LGBT people should draw on the strengths and resilience of LGBT communities. This involves resources and capacity building aimed at:

- Consolidating existing LGBT programs and services within and outside the health system; and
- Identifying gaps in the provision of social support to LGBT communities including increased funding for vulnerable and under-resourced groups

At the same time, resources and programs are needed to increase LGBT people's capacity to build and sustain friendships, and familial and intimate relationships. According to the findings of PL2, LGBT Australians rate LGBT friends most highly for emotional support. However, they are most likely to seek support from biological family when sick (Leonard et al., 2012 p.24). These findings

demonstrate the complex network of relationships within and outside LGBT communities that can have an impact on LGBT people's mental health and wellbeing.

LGBT people need open and supportive environments within and outside LGBT communities where they can develop friendships and intimate relationships, particularly for vulnerable subpopulations such as SSASGD young people and people who are trans or gender diverse. Many LGBT people face added pressures in negotiating familial relationships. These include:

- Fear of being rejected by other family members if they come out as out as LGB or T (this includes both children and parents who are LGBT)
- The added pressures on LGBT people from religious and ethnic communities that privilege 'family' and traditional gender roles
- Difficulties in maintaining familial relations for LGBT people who have come out as they renegotiate their personal, public and familial identities; and
- The pressures that LGBT parents and their children experience in a world that continues to privilege heteronormative and cisgendered families.

Finally, studies from the US clearly show improvements in LGBT people's mental health and wellbeing in jurisdictions that have legalised marriage equality or introduced other official processes for recognising the legal status and symbolic value of same sex and non-cisgendered relationships (Buffie 2011; Wight 2013).

Mental health literacy

There are no studies assessing the levels of mental health literacy among LGBT communities. However, a national survey revealed poor levels of literacy among the Australian population (Reavley and Jorm 2011). The survey found that a minority of Australians could recognise specific mental health disorders and that many people's understandings of the causes and effective treatment of mental disorders varied considerably from those of medical experts.

For the population as a whole, an improved understanding of the causes of mental ill-health and treatment options is crucial to early identification and prevention and to more timely and effective treatment. However, for LGBT people this involves an understanding of how heterosexist discrimination and abuse increase their risk of particular mental disorders and how this risk may be greater for LGBT people who identify with other minority and marginal populations. It also involves an understanding of how LGBT cultural norms and practices can be implicated in behaviours that are known to impact negatively on mental health, including high levels of alcohol consumption and illicit drug use, and how these vary according to gender identity and sexual identity within LGBT communities.

At the same time, there is a need for education and training to help LGBT people develop skills to identify the warning signs of possible mental health problems, including problematic use of alcohol and drugs, in their lives and in the lives of their LGBT friends. This needs to be accompanied by an open and ongoing discussion within LGBT and mainstream communities of the complex factors that lead to higher rates of mental disorders among LGBT people.

At a minimum, developing education, training and resources aimed at improving mental health literacy for LGBT people should be:

- Accessible
- Evidence-based
- Relevant to LGBT people's lives; and
- Focused on the mental health pressures specific to LGBT communities and particular subpopulations within those communities.

3. LGBT-inclusive mental health services

A 2007 systematic review of research on counselling and psychotherapy for LGBT people in the UK found that one of the major barriers to LGBT people seeking mental health care was the lack of an affirmative provider (King et al. 2007; Owens et al. 2007). For many LGBT people, affirmation was closely linked to feeling safe and supported, and included not only being safe from abuse by staff and other clients but also feeling supported and valued by services and individual practitioners (Owens et al. 2007). Historically, this level of sensitivity and awareness was most likely to be found among service providers who had strong ties to LGBT communities. Until very recently, most mainstream services were insensitive to the pressures faced by LGBT people in their everyday lives and many displayed the very heterosexist biases that contributed to higher rates of mental health problems among this population (Hellman & Klein, 2004).

However, in Australia over the past decade, there has been a growing expectation among LGBT people and representative health bodies that mainstream health services will be LGBT-inclusive as part of their everyday business (Allen 2008; Royal College of Nursing 2004; Victorian Government 2009). Recent research findings from the US show that many LGBT people are less concerned about the gender identity or sexual identity of individual practitioners and more concerned that services can demonstrate that they are supportive and open to LGBT people (King et al. 2007; Owens et al. 2007).

These findings suggest that a focus on LGBT-inclusive and affirmative practice undermines any simple division between mainstream and LGBT-specific mental health care. All mental health care agencies should be able to provide services that meet the diverse needs of their clients, including the delivery of culturally appropriate care to LGBT people. At the same time, LGBT specialist mental health and allied services are required where detailed knowledge and understanding of LGBT people and their lives are needed or where access to LGBT practitioners and LGBT-driven care is integral to treatment and recovery. What is common to both types of service delivery, however, is a new approach that addresses the risk factors that contribute to LGBT people's mental health and possible sources of resilience within a broader organisational and therapeutic culture that affirms and values LGBT people's gender identities and sexual identities and their lives and relationships.

Figure 52 – The provision of LGBT-inclusive mental health services

Figure 52 represents an integrated model for the development of an LGBT-inclusive mental health sector. The model makes a distinction between two different types of LGBT-inclusive mainstream services:

- Mainstream services committed to LGBT-inclusive practice, where all of the organisation's practices, procedures and protocols are non-discriminatory and LGBT-affirmative; and
- Mainstream services that have developed a dedicated program or programs to assist their LGBT clients. This may include services where LGBT people are overrepresented (such as mental health and drug and alcohol services) and where an understanding of the unique pressures driving this overrepresentation is vital to the provision of effective care.

The development of an LGBT-inclusive mental health sector relies on integration and coordination between mainstream and LGBT-specialist mental health and allied services. It also depends on the participation of LGBT community organisations, professionals and consumers in the ongoing development of models of LGBT-inclusive practice and service delivery. Finally, mental health services need to be aware of and able to respond to differences within LGBT communities. These include differences in gender identity and sexual identity, and how LGBT people who are members of other minority and marginal populations may be subject to added pressures associated with other forms of discrimination and material disadvantage. This is a flexible model of integrated LGBT-inclusive mental health care, able to accommodate the needs of LGBT communities and the particular needs of individual LGBT clients.

The following are current examples of LGBT-inclusive mainstream mental health care and LGBT specialist services. However, greater efforts are needed to ensure that LGBT-inclusive practice is provided as part of core business and good professional practice by all mental health and allied services.

LGBT-inclusive mainstream practice

In Australia, LGBTI organisations in different states and territories have begun to provide LGBTI training to mainstream mental health care workers and services to assist them in developing LGBTI-inclusive practice. In Victoria, GLHV delivers a range of staff training modules on LGBTI health and wellbeing, including targeted modules on drug and alcohol and mental health issues. Similar training has been developed and delivered by LGBTI organisations in Queensland, Western Australia and NSW. In 2013/14 in NSW, ACON developed the Peace of Mind program in partnership with the Mental Health Coordinating Council (MHCC) and in collaboration with The National LGBTI Health

Alliance and GLHV. The education program assists professionals understand LGBTI mental health and identity issues and helps LGBTI people experiencing mental ill-health.

The National LGBTI Health Alliance delivers the MindOUT! Project, a national, Commonwealth-funded, LGBTI mental health and suicide prevention project (www.lgbtihealth.org.au/mindout). The Project works with, and delivers a range of workshops and training to, LGBTI organisations and mainstream mental health providers to improve mental health and suicide prevention outcomes for LGBTI people and populations. As part of MindOUT!, The Alliance also hosted a national webinar series that critically engaged with topics relevant to mental health and suicide prevention for LGBTI people and a Champion's Program that identifies and supports champions to promote LGBTI inclusive practice and culture change within their organisations.

The Rainbow Tick Program

The Rainbow Tick consists of six standards of LGBTI-inclusive practice for the health and human services sectors, developed by GLHV in partnership with Quality Innovation Performance (QIP), a national, not-for-profit accreditation organisation. In order to gain Rainbow Tick accreditation organisations must demonstrate that all their practices, procedures and protocols are LGBTI-inclusive.

As part of the Rainbow Tick Program, organisations can undertake LGBTI inclusivity training provided by GLHV, including the HOW2 Program. The HOW2 consists of four workshops run over six months and takes organisational representatives through each of the six Rainbow Tick standards. In order to demonstrate compliance with the Rainbow Tick standards, organisations undertake an internal audit, followed by an independent on-site assessment conducted by a QIP assessment team. Organisations that gain Rainbow tick accreditation will be listed on a national registry of LGBTI-inclusive, rainbow ticked agencies.
www.glhv.org.au/glbti-inclusive-practice
www.qip.com.au/standards/rainbow-tick-standards/

Mainstream services with an LGBT stream

There are a number of GP clinics and mental health care organisations in capital cities across Australia that target LGBT people and provide a range of mental health services including counselling and cross referrals. *beyondblue* has developed a separate LGBTI stream which includes resources and research targeting LGBTI consumers. *beyondblue* provides online tools to assist LGBTI consumers assess their levels of psychological distress and develop action plans to deal with anxiety and depression, and information for understanding how heterosexist discrimination might be contributing to their mental ill-health.

Carers Victoria – Lesbian, gay, bisexual, trans* and intersex (LGBTI) carers

Carers Victoria provides advice, information and support for carers to improve their health, wellbeing, capacity, financial security and resilience. The organisation has worked in partnership with LGBTI communities to improve services and advocacy for LGBTI carers. Carers Victoria has dedicated staff, resources and training to support LGBTI people in a variety of care relationships including carers who identify as LGBTI and carers of LGBTI people. The support services acknowledge that LGBTI people take on caring roles not only for biological family but also for friends and 'family of choice'.
www.carersvictoria.org.au/how-we-help/LGTBI-carers/

LGBT specialist services

In some states and territories, publicly-funded LGBTI organisations such as VAC/GMHC and ACON offer direct support for LGBTI people at risk of or experiencing mental ill-health.

QLife is a national counselling and referral service for LGBTI Australians funded as part of the Commonwealth Department of Health's Teleweb project and directed by the National LGBTI Health Alliance. QLife provides peer-supported telephone and web-based services to LGBTI people who are experiencing a range of mental health issues, including those related to their experiences of heterosexist discrimination.

The Healthy Equal Youth (HEY) Project

The HEY Project aims to reduce self-harm and suicide among same sex attracted and sex and gender diverse (SSASGD) young people in Victoria and improve their mental health and wellbeing. The project provides funding for seven agencies, each of which has particular expertise and experience in working with and on behalf of SSASGD young people. The project aims to build the capacity of each organisation while enabling the seven organisations to work collaboratively with each other and the youth and mental health sectors to create an SSASGD youth platform within the mainstream youth sector. The HEY Project also includes an annual funding round that provides one-off small grants for SSASGD youth projects at the local level.

The HEY Project is funded by the Victoria Government and is jointly managed by GLHV and the Youth Affairs Council of Victoria I(YACVic).

www.heyproject.org.au/

Reference list

Allen, O. (2008). *Lesbian, Gay & Bisexual Patients: The Issues for General Practice Gay and Lesbian Equality Network (GLEN)* Working for equality for gay, lesbian and bisexual people in Ireland. http://www.glen.ie/

Amadio, D., & Chung, Y. (2004). Internalized homophobia and substance use among lesbian, gay and bisexual persons. *Journal of Gay and Lesbian Social Services: Issues in Practice, Policy and Research 17*(1), 83-101.

Australian Bureau of Statistics. (2008). 4326.0 - National Survey of Mental Health and Wellbeing: Summary of Results, 2007. Canberra: ABS.

Australian Bureau of Statistics. (2011). 6310.0 - Employee earnings, benefits and trade union membership. Canberra, Australia: ABS.

Australian Bureau of Statistics. (2013). 6523.0 - Household Income and Income Distribution, Australia, 2011-12. Canberra: ABS.

Australian Institute of Health and Welfare. (2011). 2010 National Drug Strategy Household Survey report. Drug statistics series no. 25. Cat. no. PHE 145. Canberra: AIHW.

Bakker, F., Sandfort, T., Vanwesenbeeck, I., van Lindert, H., & Westert, G. (2006). Do homosexual persons use health care services more frequently than heterosexual persons? Findings from a Dutch population survey. *Social Science Medicine 63*(8), 2022-2030.

Berman, A., & Robinson, S. (2010). *Speaking Out: Stopping Homophobic and Transphobic Abuse in Queensland*. Bowen Hills, Queensland: Australian Academic press.

Blumer, M., Ansara, G., & Watson, C. (2013). Cisgenderism in family therapy: How everyday clinical practices can delegitimize people's gender self-designations (Special Section: Essays in Family Therapy). *Journal of Family Psychotherapy*, *24*(4), 267-285.

Bruce-Jones, E., & Itaborahy, L. P. (2011). *State-sponsored Homophobia: A world survey of laws criminalising same-sex sexual acts between consenting adults*. ILGA, The International Lesbian, Gay, Bisexual, Trans and Intersex Association.

Brubaker, M., Garrett, M., & Dew, B. (2009). Examining the relationship between internalized heterosexism and substance abuse among lesbian, gay, and bisexual individuals: A critical review. *Journal of LGBT Issues in Counselling, 3*(1), 62-89.

Buffie, W. C. (2011). Public health implications of same-sex marriage. *American Journal of Public Health, 101*(6), 986-990.

Buffin, J., Roy, A., Williams, H., & Winter, A. (2012). *Part of the picture: Lesbian, gay and bisexual people's alcohol and drug use in England (2009-2011).* United Kingdom: The Lesbian & Gay Foundation & The University of Central Lancashire.

Cochran, B., & Cauce, A. (2006). Characteristics of lesbian, gay, bisexual and transgender individuals entering substance abuse treatment. *Journal of Substance Abuse Treatment*, *30*(2), 135-146.

Cochran S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*(1):53-61.

Commonwealth of Australia. (2009). *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014*, Commonwealth of Australia Barton ACT.

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health, 100*(10), 1953-1960.

Corboz, J., Dowsett, G., Mitchell, A., Couch, M., Agius, P., & Pitts, M. (2008) *Feeling Queer and Blue: A Review of the Literature on Depression and Related Issues among Gay, Lesbian, Bisexual and Other Homosexually Active People*, Australian Research Centre in Sex, Health and Society, La Trobe University, prepared for *beyondblue*: The National Depression Initiative.

Couch, M., Pitts, M., Mulcare, H., Croy, S., Mitchell, A., & Patel, S. (2007). *TranZnation: A report on the health and wellbeing of transgender people in Australia and New Zealand.* Monograph Series Number 65. Melbourne: The Australian Research Centre in Sex, Health & Society, La Trobe University.

Cronin, A., & King, A. (2010). Power, inequality and identification: Exploring diversity and intersectionality amongst older LGB adults. *Sociology*, *44*(5), 876-892.

Cronin, A., & King, A. (2014). Only connect? Older lesbian, gay and bisexual (LGB) adults and social capital. *Ageing and Society, 34*(2), 258-279.

de Leeuw, E. and WHO (2006) 6th Global Conference on Health Promotion, Bangkok, August 2005. A Special Edition *Health Promotion International, 21*(S1), 1-98.

De Vires, B. (2014). LG(BT) persons in the second half of life: The intersectional influences of stigma and cohort. *LGBT Health, 1*(1), 18-23.

De Wit, J., Mao, L., Holt, M., & Treloar, C. (Eds.) (2013). *HIV/AIDS, hepatitis and sexually transmissible infections in Australia: Annual report of trends in behaviour 2013* (Monograph 6/2013). Sydney: Centre for Social Research in Health, The University of New South Wales.

Dick, S. (2008). *Homophobic Hate Crime: The Gay British Crime Survey*. Stonewall: UK

Dodds, C., Keogh, P., & Hickson, F. (2005). *It Makes Me Sick: Heterosexism, Homophobia and the Health of Gay Men and Bisexual Men.* Sigma Research at www.sigmaresearch.org.uk/downloads/report05a.pdf

Fredriksen-Goldsen, K., & Muraco, A. (2010). Aging and sexual orientation: A 25-year review of the literature. *Research on Aging, 32*(3), 372-413.

Gay and Lesbian Medical Association. (2006). *Breaking the Grip: Treating Crystal Methamphetamine Addiction Among Gay and Bisexual Men*. GLMA San Francisco: US.

Grant, J., Mottet, L., Tanis, J., Harrison, J., Herman, J., & Keisling, M. (2011) *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington: The National Gay and Lesbian Task Force and the National Centre for Transgender Equality.

Green, A. (2003). 'Chem friendly': The institutional basis of 'club drug' use in a sample of urban gay men. *Deviant Behavior, 24*(5), 427-447.

Green, K., & Feinstein, B. (2012). Substance use in lesbian, gay and bisexual populations: An update on empirical research and implications for treatment. *Psychology of Addictive Behaviors, 26*(2), 265-278.

Haber, D. (2009). Gay aging. *Gerentology & Geriatric Education,* 30(3), 267-280.

Halkitis, P., Parsons, J., & Wilton, L. (2003). An exploratory study of contextual and situational factors related to methamphetamine use among gay and bisexual men in New York City. *Journal of Drug Issues, 33*(2), 413-432.

Hatzenbuehler M. L. (2009). How does sexual minority stigma "Get Under the Skin"? A psychological mediation framework. *Psychological Bulletin, 135*(5):707-730.

Hatzenbuehler, M. L., McLaughlin, K. A., Keyes, K. M., & Hasin, D. S. (2010). The impact of institutional discrimination in lesbian, gay, and bisexual populations: A prospective study. *American Journal of Public Health, 100*(3), 452-459.

Heaphy, B. (2007). Sexualities, gender and aging: Resources and social change. *Current Sociology*, *55*(2), 193-210.

Heck, J., Sell, R., & Gorin, S. (2006). Health care access among individuals involved in same-sex relationships. *American Journal of Public Health, 96*(6), 1111-1118.

Hellman, R.E. & Klein, E. (2004). A Program for Lesbian, Gay, Bisexual and Transgender individuals with Major Mental Illness. *Journal of Gay and Lesbian Psychotherapy,* 8(3-4), 67-82.

Herrman, H., Saxena, S., & Moodie, R. (Eds.) (2005). *Promoting Mental Health: Concepts, Emerging Evidence, Practice*. World Health Organization: Singapore.

Hickson, F., Weatherburn, P., Reid, D., Jessup, K., & Hammond, G. (2007). *Consuming Passions: Findings from the United Kingdom Gay Men's Sex Survey 2005*. Sigma Research, London.

Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J., & Mitchell, A. (2010). *Writing Themselves In 3: The third national study of the sexual health and wellbeing of same sex attracted and gender questioning young people*. Monograph series No. 78. Melbourne, Australian Research Centre in Sex, Health and Society.

Irlam, C.B. (2013) *LGBTI Data: Developing and evidence-informed environment for LGBTI health policy*. Sydney, National LGBTI Health Alliance at www.lgbthealth.org.au/

Kawachi, I., Subramanion, S.V., & Almeida-Filho, M. (2002). A glossary of health inequalities. *Journal of Epidemiology and Community Health, 56*(9), 647-652.

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L. T., Walters, E. E., & Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine, 32*(6), 959-976.

King, M., Semlyen, J., Killapsy, H., Nazareth, I. & Osborn, D. (2007). *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people.* British Association for Counselling and Psychotherapy, Lutterworth, UK.

King, M., Semlyen, S., See Tai, S., Killapsy, H., Osborn, D., Popelyuk, D., & Nazereth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry, 8*(70), 1-17.

Leonard, W. (2005) Queer occupations: Development of Victoria's gay, lesbian, bisexual, transgender and intersex health and wellbeing action plan. *Gay and Lesbian Issues and Psychology Review 1*(3), 92-97.

Leonard, W. (2014). From disease prevention to health promotion, in Temple-Smith, M. ed. *Sexual Health: A Multidisciplinary Approach,* IP Communications, Melbourne, pp.335-350.

Leonard, W., Duncan, D., & Barrett, C. (2013). "What a difference a gay makes: The constitution of the 'older gay man'" in Kampf, A., Marshall, B. L. & Petersen, A. (Eds.) *Aging Men, Masculinities and Modern Medicine*. Oxon, Routledge.

Leonard, W., & Metcalf, A. (2014) *Going upstream: A framework for promoting the mental health of lesbian, gay, bisexual, transgender and intersex (LGBTI) people*. Produced on behalf of the MindOUT! LGBTI Mental Health and Suicide Prevention Project, National LGBTI Health Alliance.

Leonard, W., Mitchell, A., Patel, S., & Fox, C. (2008). *Coming forward: The underreporting of heterosexist violence and same sex partner abuse in Victoria*. Monograph Series Number 69. Melbourne: La Trobe University, The Australian Research Centre in Sex, Health and Society.

Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., Couch, M., & Barrett, A. (2012). *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians.* Monograph Series Number 86. Melbourne: The Australian Research Centre in Sex, Health & Society, La Trobe University.

Lo, C. (2006). We are aged, we are queer, we are here. *Gay and Lesbian Issues and Psychology Review, 2*(2), 93-97.

Logie, C., & Gadalla, T. M. (2009). Meta-analysis of health and demographic correlates of stigma towards people with living HIV. *AIDS Care, 21*(6), 742-753.

Lyons, A., Hosking, W., & Rozbroj, T. (2014). Rural-urban differences in mental health, resilience, stigma, and social support among young Australian gay men. *The Journal of Rural Health*. Epub-ahead-of-print.

Lyons, A., Pitts, M., & Grierson, J. (2013a). Methamphetamine use in a nationwide online sample of older Australian HIV-positive and HIV-negative gay men. *Drug and Alcohol Review, 32*(6), 603-610.

Lyons, A., Pitts, M., & Grierson, J. (2013b). Factors related to positive mental health in a stigmatized minority: An investigation of older gay men. *Journal of Aging and Health, 25*(7), 1159-1181.

Lyons, A., Pitts, M., & Grierson, J. (2013c). Growing old as a gay man: Psychosocial wellbeing of a sexual minority. *Research on Aging, 35*(3), 275-295.

Mayer, K., Bradford, J., Makadon, H., Stall, R., Goldhammer, H., & Landers, S. (2008). Sexual and gender identity minority health: What we know and what needs to be done. *American Journal of Public Health, 98*(6), 989-995.

Mayock, P., Bryan, A., Carr, N., & Kitching, K. (2008). *Supporting LGBT lives: A study of mental health and wellbeing*. Gay and Lesbian Equality Network (GLEN), Ireland.

McCabe, S., Bostwick, W., Hughes, T., West, B., & Boyd, C. (2010). The relationship between discrimination and substance use disorders among lesbian, gay and bisexual adults in the United States. *American Journal of Public Health, 100*(10), 1946-1952.

McCann, E., Sharek, D., Higgins, A., Sheerin, F., & Glacken, M. (2013). Lesbian, gay, bisexual and transgender older people in Ireland: Mental health issues. *Aging & Mental Health, 17*(3), 358-365.

McClintock, M. (2005). *Everyday Fears: A Survey of Violent Hate Crimes in Europe and North America*. A Human Rights First Report.

McKenzie, K., Whitley, R., & Weich, S. (2002). Social capital and mental health. *The British Journal of Psychiatry, 181*, 280-283.

McNair, R. (2014). *ALICE Study: Final Report to beyondblue*. The Department of General Practice, The University of Melbourne: Melbourne.

McNair, R., Anderson, S., & Mitchell, A. (2003). Addressing health inequalities in Victorian lesbian, gay, bisexual and transgender communities. *Health Promotion Journal of Australia, 11*(1), 32-38.

McNair, R., Szalacha, L., & Hughes, T. (2011). Health status, health service use, and satisfaction according to sexual identity of young Australian Women. *Women's Health Issues, 21*(1), 40-47.

McNeil, J., Bailey, L., Ellis, S., Morton, J., & Regan, M. (2012). *Trans Mental Health Study 2012*. Equality Network: Lesbian, Gay, Bisexual and Transgender Rights – Scotland accessible at http://www.glhv.org.au/files/trans_mh_study.pdf

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674-697.

Murakami, H. (2011). *The Wind-Up Bird Chronicle*. Jay Rubin, New York: Random House.

Owens, G.P., Riggle, E. D.B. and Rastosky, S.S. (2007). Mental health services access for sexual minority individuals. *Sexuality Research and Social Policy* 4(3), 92-99.

Page, A., Milner, A., & Morrell, S. (2013). The role of under-employment and unemployment in recent birth cohort effect in Australian suicide. *Social Science and Medicine, 93*, 155-162.

Patton, C. (2007). *Anti-Lesbian, Gay, Bisexual and Transgender Violence in 2006: A report of the National Coalition of Anti-Violence Programs*. National Coalition of Anti-Violence Programs: New York, NY.

Pennant, M., Bayliss, S., & Meads, C. (2009). Improving lesbian, gay and bisexual healthcare: A systematic review of qualitative literature for the UK. *Diversity in Health & Care, 6*(3), 193-203.

Perron, J. L., Cleverley, K., & Kidd, S. A. (2014). Resilience, loneliness, and psychological distress among homeless youth. *Archives of Psychiatric Nursing, 28*(4), 226-229.

Pitts, M., Smith, S., Mitchell, A., & Patel, S. (2006). *Private Lives: A report on the health and wellbeing of GLBTI Australians*. Monograph Series Number 57. Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University.

Preciado, B. (2013). *Testo Junkie: Sex, Drugs, and Biopolitics in the Pharmacopornographic Era* (trans. Bruce Benderson). The Feminist Press, New York City.

Reavley, N. & Jorm, A. (2011). *National Survey of Mental Health Literacy and Stigma*. Department of Health and Aging, Canberra.

Riggle, E., Whitman, J., Olson, A., Rostosky, S. S., & Strong, S. (2008). The positive aspects of being a lesbian or gay man. *Professional Psychology: Research and Practice, 39*(2), 210-217.

Robinson, K., Bansel, P., Denson, N., Ovenden, G., & Davies, C. (2014). *Growing up Queer: Issues facing young Australians who are gender variant and sexually diverse*. Young and Well Proud Cooperative Research Centre, Melbourne.

Rosenstreich, G. (2011). *LGBTI People: Mental Health and Suicide*. National LGBTI Health Alliance, Sydney.

Royal College of Nursing. (2004). *Not 'just' a friend: best practice guidance on health care for lesbian, gay and bisexual service users and their families.* Royal College of Nursing, UK and UNISON: UK trade union for public sector workers, London.

Slade, T., Grove, R., & Burgess, P. (2011). Kessler Psychological Distress Scale: normative data from the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry,* 45(4), 308-316.

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: Assessing the ability to bounce back. *International Journal of Behavioral Medicine, 15*(3), 194-200.

Smith, B. W., Epstein, E. M., Ortiz, J. A., Christopher, P. J., & Tooley, E. M. (2013). The Foundations of Resilience: What Are the Critical Resources for Bouncing Back from Stress? In S. Prince-Embury & D. Saklofske, H. (Eds.), *Resilience in Children, Adolescents, and Adults*: *Translating Research into Practice* (pp 167-187). New York: Springer.

Suicide Prevention Australia. (2009). *Suicide and self-harm among gay, lesbian, bisexual and transgender communities*. SPA, Sydney.

Tjepkema, M. (2008). Health care issues among gay, lesbian and bisexual Canadians. *Health Reports, 19*(1), 53-64.

UNAIDS. (2007). *Reducing HIV Stigma and Discrimination: A Critical Part of National AIDS Programs*. Geneva: Joint United Nations Programme on HIV/AIDS.

VicHealth (1999) *Mental Health Promotion Plan: Foundation document*. Victorian Health Promotion Network: Melbourne, Australia.

Victorian Government. (2009). *Well proud: A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services*. Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing. Department of Health: Victorian Government, Melbourne, Victoria.

Wight, R. G., LeBlanc, A. J. & Badgett, M. V. J. (2013). Same-sex legal marriage and psychological well-being: Findings from the California Health Interview Survey. *American Journal of Public Health*, *103*(2), 339-346.

CONTACT

Australian Research Centre
in Sex Health and Society

General enquiries
T +61 3 9479 8700
F +61 3 9478 8711
E arcshs@latrobe.edu.au

CS 31939 03/15

latrobe.edu.au/arcshs