LA TROBE UNIVERSITY

PRIVATE LIVES 3

THE HEALTH AND WELLBEING OF LGBTQ PEOPLE IN VICTORIA

VICTORIA SUMMARY REPORT

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Private Lives 3 Expert Advisory Group

Private Lives 3 was generously supported by an Expert Advisory Group. Members included:

- **Nicky Bath** (LGBTIQ+ Health Australia)
- **Teddy Cook** (ACON)
- **Michael Daly** (Victorian Department of Premier and Cabinet)
- **Misty Farquhar** (Curtin University)
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Gender Advisory Board

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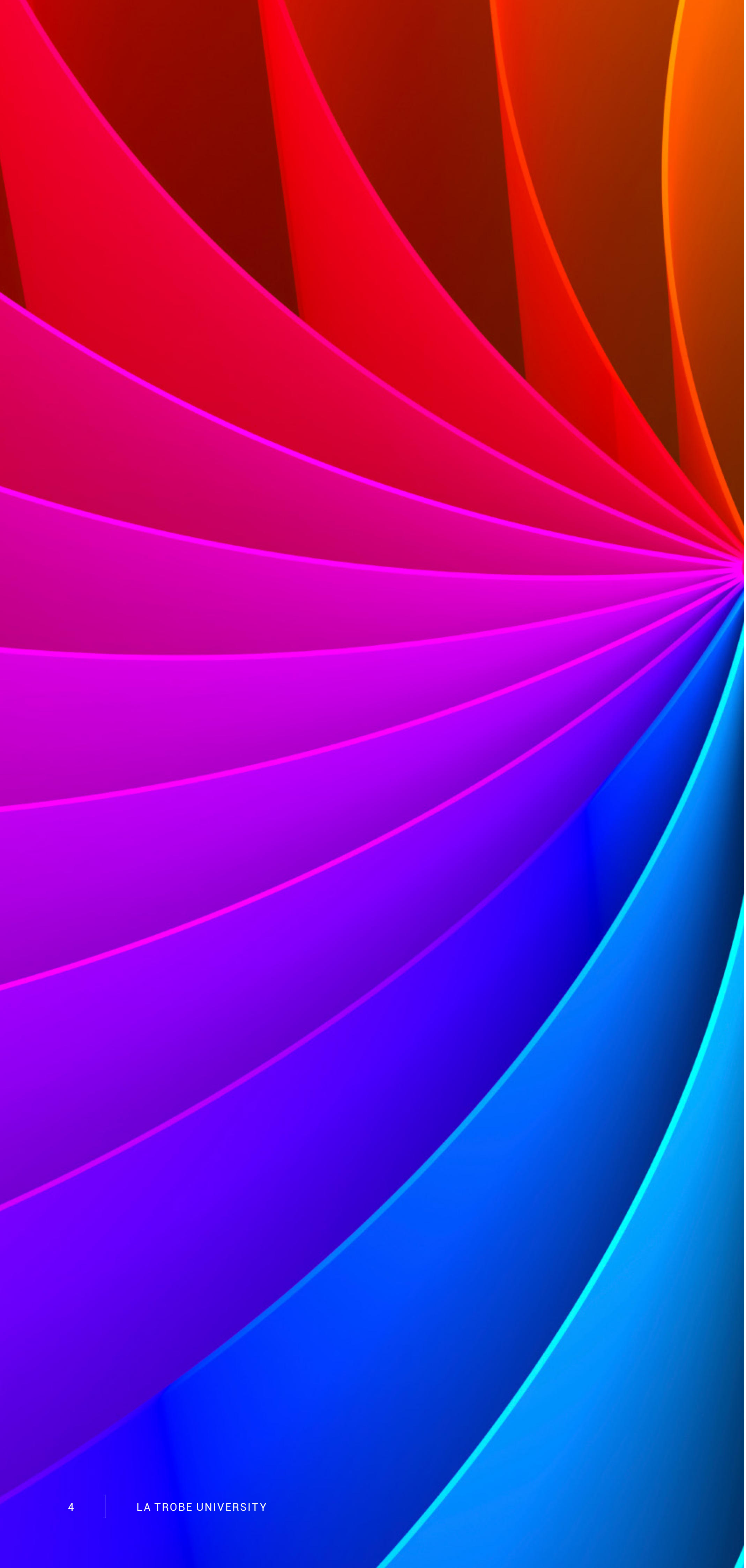
Dr Anthony Lyons
Associate Professor and Lead Investigator
On behalf of all study authors



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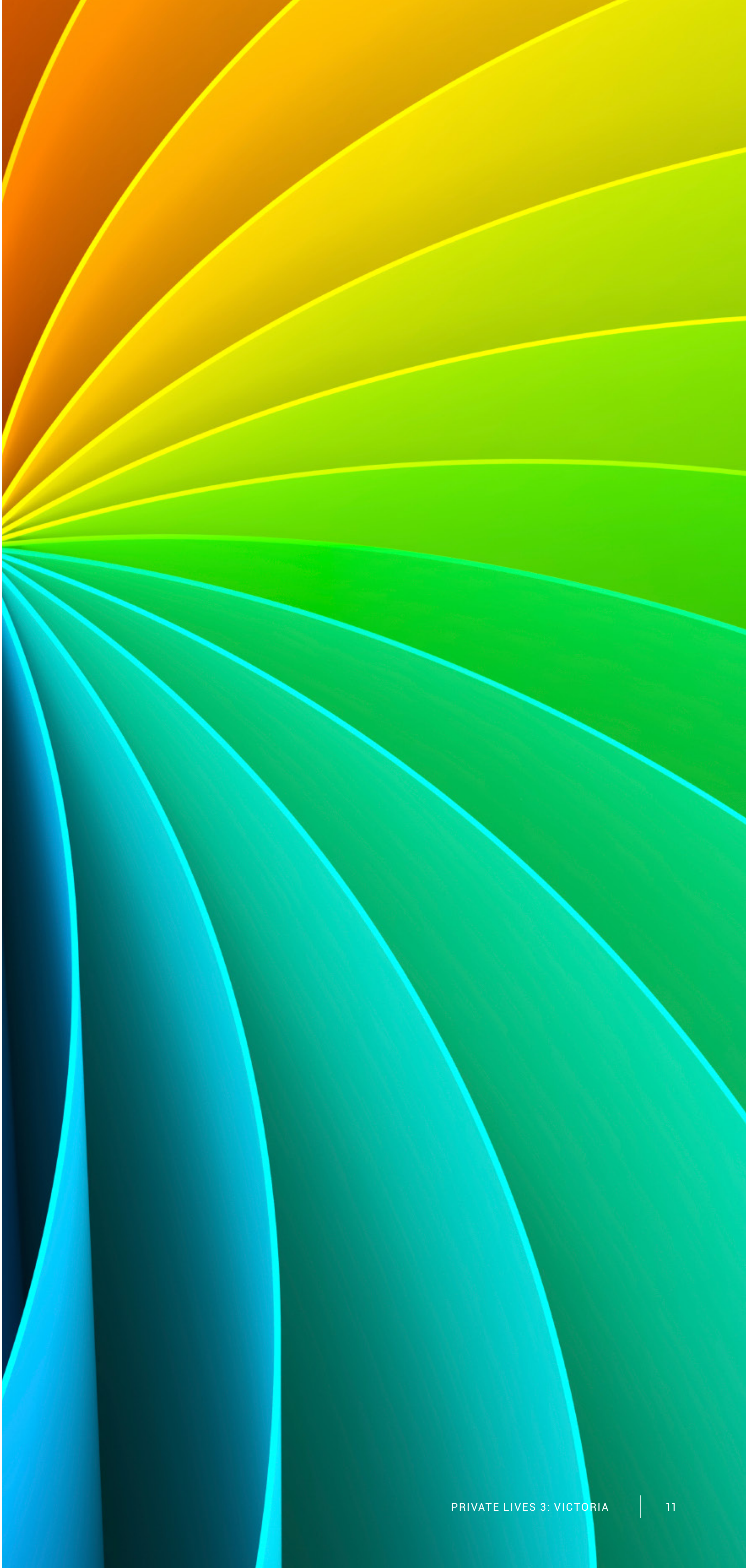

Executive summary

Background

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

Methodology

Private Lives 3 was developed in consultation with an Expert Advisory Group comprising representatives from across a variety of states and territories as well as different sections of the LGBTIQ community. *Private Lives 3* involved an online national survey promoted through paid Facebook advertising and via LGBTIQ community organisations and their networks. Paper copies of the survey were also available on request. The survey was provided in English and was restricted to participants who resided in Australia at the time of the survey who were aged 18 years and above. Questions in the *Private Lives 3* survey were not compulsory and the total sample size for questions therefore varies slightly. Where a 'number' is reported for gender and sexual orientation breakdowns, it represents the number of participants for a specific gender or sexual orientation who reported the condition/situation.

About the Victorian participants

- In total, 2,333 participants who completed the *Private Lives 3* survey were living in Victoria. Just over three-quarters resided in the capital city (77.7%; n = 1,803), 16.7% (n = 387) in regional cities or towns and 5.6% (n = 130) in rural or remote regions.
- The mean age of participants was 35.2 years (SD = 13.5), ranging from 18 to 88 years. *Private Lives 3* obtained a diverse sample, including 1.5% of participants who identified as Aboriginal and/or Torres Strait Islander (n = 36), 16.4% (n = 381) who were born overseas and 38.1% (n = 889) who had a disability or long-term health condition.
- One-third (32.8%; n = 761) of participants were cisgender men, 45.4% (n = 1,053) cisgender women, 3.2% (n = 74) trans men, 3.6% (n = 84) trans women and 15.0% (n = 348) non-binary.
- One-fifth (20.6%; n = 480) of participants identified as lesbian, 26.9% (n = 625) as gay, 21.2% (n = 494) as bisexual, 6.3% (n = 146) as pansexual, 14.8% (n = 345) as queer, 2.8% (n = 65) as asexual and 7.4% (n = 171) reported 'something else' with regard to their sexual orientation.

Households and relationships

- Over half (57.2%; n = 1,334) of participants were in a committed romantic relationship, of whom half (50.5%; n = 674) had been in this relationship for five or more years.
- Approximately one in ten (11.1%; n = 258) reported being the primary carer of a child or stepchild.

Housing and homelessness

- One-fifth (21.3%; n = 496) of participants reported having ever experienced homelessness.
- Almost half (47.0%) reported living in a private rental property, one-third (31.2%) in a home they owned and one-fifth (19.9%) at home with their family.

Discrimination, harassment and feelings of acceptance

- Almost six in ten (58.0%; n = 952) participants reported that they had been treated unfairly because of their sexual orientation and over three-quarters (77.7%; n = 426) of trans and gender diverse participants reported that they had been treated unfairly because of their gender identity in the past 12 months.
- One-third (36.4%; n = 758) of participants reported experiencing social exclusion, 32.7% (n = 678) verbal abuse, 22.6% (n = 462) harassment such as being spat at or offensive gestures, 10.3% (n = 210) sexual assault and 3.4% (n = 68) physically attacked or assaulted with a weapon due to their sexual orientation or gender identity in the past 12 months.

General health and wellbeing

- *Private Lives 3* participants reported lower self-rated health than the general Victorian population. Over one-quarter (28.2%) rated their health as 'poor' or 'fair' compared to one-fifth (20.3%) of the general Victorian population.

Mental health

- More than half (54.3%; n = 1,231) of participants reported high or very high levels of psychological distress during the past four weeks.
- Six in ten (59.3%; n = 1,333) reported having ever been diagnosed with depression and almost half (46.3%; n = 1,040) with generalised anxiety disorder.
- Four in ten (40.4%; n = 1,696) reported that they had considered attempting suicide in the past 12 months and almost three-quarters (73.2%; n = 1, 696) had considered attempting suicide at some point during their lives.
- Almost one in twenty (4.5%; n = 82) reported having attempted suicide in the past 12 months and over one in four (28.1%; n = 501) reported having ever attempted suicide at some point during their lives. These rates are considerably higher than those observed within studies of the general population.

Health services

- Mainstream health services were more frequently accessed by participants than health services that were known to be LGBTIQ-inclusive or that cater only to lesbian, gay, bisexual, trans and/or intersex people.
- Victorian participants reported accessing health services that were LGBTIQ-inclusive or that cater only to lesbian, gay, bisexual, trans and/or intersex people more frequently compared to the rest of the national *Private Lives 3* sample.
- Of a range of health services, mainstream medical clinics had the lowest proportion of participants who felt that their sexual orientation or gender identity was very or extremely respected (57.5% and 33.6% respectively).
- The proportion of participants who felt that their sexual orientation or gender identity was very or extremely respected was higher for those who attended a medical clinic that cater only to lesbian, gay, bisexual, trans and/or intersex people (94.8% and 89.4% respectively) or a mainstream medical clinic that is known to be LGBTIQ-inclusive (91.7% and 79.8% respectively).
- A greater proportion of participants in Victoria who reported high or very high levels of psychological distress had accessed a mental health service in the past 12 months (62.3%; n = 766) compared to the rest of the national *Private Lives 3* sample (57.3%; n = 1,475).
- Over three-quarters (76.8%; n = 1,790) of participants reported that they would be more likely to use a service that has been accredited as LGBTIQ-inclusive.

Alcohol, tobacco and other drug use

- Almost one in five (17.9%; n = 365) participants experienced a time within the past 12 months when they had struggled to manage their alcohol use or a time where it negatively impacted their everyday life.
- Almost half (45.9%; n = 993) of participants reported using one or more drugs for non-medical purposes in the past 6 months. The most frequently used drugs were cannabis (31.9%; n = 689), ecstasy/MDMA (15.7%; n = 339) and cocaine (11.7%; n = 253).
- Almost one in seven (14.2%; n = 141) reported experiencing a time within the past 6 months when they had struggled to manage their drug use or where it negatively impacted their everyday life.

Intimate partner and family violence

- More than four in ten (42.9%; n = 999) participants reported having ever been in an intimate relationship where they felt they were abused in some way by their partner/s.
- Almost four in ten (38.1%; n = 887) participants reported ever feeling abused by a family member.
- Of the participants (n = 1,750) who reported having ever experienced intimate partner or family violence, one-quarter (26.9%; n = 432) said that they reported the incident to a relevant service at the most recent time this occurred.

Disability or long-term health condition

- Almost four in ten (38.1%; n = 889) participants reported having a disability or long-term health condition. One in ten (10.6%; n = 212) reported a profound or severe disability, 20.6% (n = 480) a moderate disability and 6.9% (n = 161) a mild disability.
- More than four in five (84.0%; n = 200) participants reporting a severe disability or long-term health condition, 76.2% (n = 360) reporting a moderate disability or long-term health condition and 61.4% (n = 97) reporting a mild disability or long-term health condition reported high or very high levels of psychological distress.
- Only around one-quarter (27.4%; n = 64) of participants reporting a severe disability or long-term health condition felt accepted 'a lot' or 'always' when accessing a health or support service compared to one-half (50.5%; n = 622) of participants not reporting a disability or long-term health condition.

Community connection

- Almost six in ten (59.2%; n = 1,379) participants 'agreed' or 'strongly agreed' that they feel a part of the Australian LGBTIQ community.
- More than six in ten (62.6%; n = 1,457) 'agreed' or 'strongly agreed' that participating in Australia's LGBTIQ community is a positive thing for them.

1 Introduction

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

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

Private Lives 3 was jointly funded by the Victorian Government Department of Health and Human Services and the Victorian Government Department of Premier and Cabinet. This state-based report presents data from the *Private Lives 3* participants who were living in **Victoria** at the time of the survey.

1.1 Scope of this report

This report provides a comprehensive snapshot of the LGBTQ population in Victoria, based on data from *Private Lives 3*. It covers a wide range of topics such as households, mental health, use of health services, intimate partner and family violence, experiences of stigma and discrimination, and more. Where possible, results are broken down by gender identity and sexual orientation. As this was not always feasible, due to small samples for a number of analyses, please see the *Private Lives 3* national report for a full breakdown of results by gender identity and sexual orientation.

1.2 Gender identity and sexual orientation

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

1.2.1 Gender identity

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

The gender categories used in this report were derived from the above questions and then organised into categories to facilitate analysis. For a full account of how this was done, see the *Private Lives 3* national report.

1.2.2 Sexual orientation

Participants were asked if they were 'gay', 'lesbian', 'bisexual', 'pansexual', 'queer', 'asexual', 'homosexual', 'heterosexual', 'prefer not to answer', 'prefer not to have a label', 'don't know' and 'something different'. For data analysis purposes and due to relatively low numbers in each of the following groups, participants who identified as 'homosexual', 'prefer not to have a label' or 'something different' were combined into the 'something different' category. This was also done for trans and gender diverse participants and those with an intersex variation/s who identified as 'heterosexual'. Although 'prefer not to answer' did not form part of the sexual orientation classification, participants who responded in this way were still included in the overall sample. Further information on the classification process can be found in the *Private Lives 3* national report.

1.3 Intersex

Intersex is an umbrella term used to describe people born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies and can manifest at birth or in later life (Jones, 2016; Lee et al., 2006). The broadly accepted approximation of intersex variations in the population is 1.7% (Blackless et al., 2000; Fausto-Sterling, 2000). This estimation comes from a review of medical literature over a 50-year period (Fausto-Sterling, 2000), but has historically been contested for being too broad — including variations other than than those resulting in atypical genitalia (Sax, 2002) and for not taking into account potential underreporting (Jones, 2016).

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

1.3.1 Understanding issues facing people with an intersex variation/s

For intersex people, early medical interventions, including hormonal treatment and surgeries, can take place in the absence of any medical emergency to 'normalise' bodies, assigning a sex and instilling a sense of binary gender on intersex individuals (Carpenter, 2016; Jones, 2016; Lee et al., 2014; Schönbucher et al., 2010). Medical interventions are characterised by a loss of bodily autonomy and are often accompanied by attempts to raise a child 'unambiguously' in line with an assigned gender (Carpenter, 2016). There is evidence that critical information about medical intervention can be withheld from children and adults during these processes, raising ethical issues about disclosure and consent to treatment (Migeon et al., 2002; Tamar-Mattis et al., 2014). Non-consensual medical procedures influence mental health and wellbeing because they can convey a sense of "differentness" and can be experienced as unpleasant, intrusive and aversive (Meyer-Bahlburg et al., 2017), and are internationally regarded as human rights abuses (Amnesty International, 2017; Carpenter, 2016; Human Rights Watch, 2017). Qualitative interview data involving women with Congenital Adrenal Hyperplasia (CAH) suggests that adults also recall childhood genital examinations as stigmatising (Meyer-Bahlburg et al., 2017) and that adverse medical experiences have effects on future health care and intimate relationships (Fagerholm et al., 2012; Meyer-Bahlburg et al., 2017). In particular, medical intervention has implications for sexual quality of life and the development of positive self-esteem and body image (Schönbucher et al., 2010; Schweizer et al., 2017).

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

1.3.2 People with an intersex variation/s in *Private Lives*

Private Lives 3 engaged with stakeholders from intersex community organisations from its inception through survey design, recruitment, data collection and data analyses. Key informants assisted in the design of survey questions to ensure that these were inclusive of people with an intersex variation/s. A range of recruitment strategies were utilised in the participant recruitment process, including specific targeted advertising on Facebook and Instagram. In addition, intersex organisations sent out recruitment texts and posts to promote the survey to people with an intersex variation/s.

The *Private Lives 3* survey was informed by *the Yogyakarta Principles plus 10* by "recognising that the needs, characteristics and human rights situations of persons and populations of diverse sexual orientations, gender identities, gender expressions and sex characteristics are distinct from each other" (International Commission of Jurists (ICJ), 2017, p. 7). *Private Lives 3* therefore asked the following question regarding sex characteristics, which was asked separately from gender identity or sexual orientation:

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

Of the total *Private Lives 3* sample in Victoria, 0.7% (n = 15) of participants responded 'yes', 6.0% (n = 140) responded 'don't know' and 93.3% (n = 2,163) responded 'no' to the above question. Of the 15 participants who reported having been born with a variation in their sex characteristics, 93.3% (n = 14) also identified as lesbian (n = 5), gay (n = 1), bisexual (n = 1), pansexual (n = 2), queer (n = 2), asexual (n = 2) or something else (n = 1). One participant identified as heterosexual.

The 15 participants who reported having an intersex variation/s were invited to complete a specific supplementary section. Around one-third (35.7%; n = 5) of participants selected that this section was 'not applicable' to them and one participant did not respond to the question. It was therefore not clear whether this group were in fact people who were born with an intersex variation/s. This left 9 participants in the Victorian *Private Lives 3* sample who could be reliably classified as a person born with an intersex variation/s.

The national *Private Lives 3* sample involved 47 participants who selected that the supplementary section for participants with intersex variation/s was 'applicable' to them and could be reliably classified as a person who was born with an intersex variation/s. Although this figure is more than three times the previous iterations of the *Private Lives* surveys, it was not a large enough sample to provide statistically meaningful comparisons with other groups in the survey. This is not a unique issue with the *Private Lives* surveys, and there are numerous recent examples of surveys that are framed as 'LGBTIQ' that have struggled to reach a broader intersex community (Demant, 2018). This may arise for a number of reasons, including: 1) not all people with an intersex variation/s identify as part of the LGBTIQ community; and 2) not all may use the term intersex to describe their body, but rather use a term that specifically denotes their sex characteristics, or use clinical language such as DSD or the name of a syndrome. In addition, identifying people with an intersex variation/s has always been difficult due to a degree of underreporting from people who find out later in life, or who choose not to disclose (Lee et al., 2006). The current method of recruiting participants with an intersex variation/s through an LGBTIQ-branded survey is also likely to be drawing upon a similar pool of individuals associated with known intersex organisations (many of whom may hold other LGBTQ identities), potentially contributing to a sense of survey fatigue, particularly among those who have undergone medical interventions and find repeatedly engaging in such research difficult, and lower levels of participation over time.

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

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

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

Due to the relatively small sample size of participants with an intersex variation/s (n = 47 in the national sample; n = 9 in the Victorian sample), comparisons with other LGBTQ participants cannot be meaningfully drawn. For that reason, direct comparisons are not made between this group and the gender identity or sexual orientation groups. This Victoria summary report therefore acknowledges this by referring to LGBTQ rather than LGBTIQ. Furthermore, in order to acknowledge the valuable contributions of the people with an intersex variation/s who did contribute to the *Private Lives 3* survey, data from the national sample of 47 participants are presented along with key variables in a dedicated chapter in the *Private Lives 3* national report.

2 Methodology

The *Private Lives 3* survey was available for completion online or as a paper survey. All of the participants who met criteria for inclusion in the analysis completed the survey online. This is similar to other recent national surveys, such as Rainbow Ageing (2018) and Trans Pathways (2017). Online surveys have been shown to provide an effective method of accessing populations that can be hard to reach, including LGBTQ people (Guillory et al., 2018; Marpsat & Razafindratsima, 2010). The online *Private Lives 3* survey was hosted by Qualtrics, with the paper version available by request. The *Private Lives 3* survey received ethical approval from the La Trobe University Human Ethics Committee, as well as from The ACON Research Ethics Review Committee and the Community Research Endorsement Panel of Thorne Harbour Health.

2.1 Survey design

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

2.2 Advertising and recruitment

Private Lives 3 was launched on the 24th July 2019 and closed on the 1st October 2019. The survey was advertised through a combination of paid targeted advertising on Facebook and promotion by LGBTIQ community organisations. A press release was also sent to the Private Lives 3 Expert Advisory Committee, professional networks including those of LGBTIQ Aboriginal and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds, and LGBTIQ organisations including Intersex Peer Support Australia, the National LGBTI Health Alliance, the Diversity Department of Health and Human Services, ACON, Thorne Harbour Health, LGBTIQ offices and organisations in universities throughout Australia and other government and non-government organisations. In Victoria, 83.0% (n = 1,914) of participants reported finding out about the survey through Facebook, 8.8% (n = 202) through an LGBTIQ community organisation and 9.2% (n = 211) through word of mouth. It is important to note that many community organisations and their staff promoted the survey through Facebook.

2.3 Data analysis

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

3 Demographics

3.1 About this Victorian summary report

This report presents the results from the 2,333 participants who were living in Victoria.

3.2 Distribution/residence

Table 1: Distribution of participants by state and territory (n = 6,834)

State	Number	%
Victoria	2,333	34.1
New South Wales	1,678	24.6
Queensland	1,239	18.1
Western Australia	668	9.8
South Australia	434	6.4
Australian Capital Territory	260	3.8
Tasmania	185	2.7
Northern Territory	37	0.5

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

The majority of participants in Victoria reported residing in the capital city (77.7%; n = 1,803), followed by 16.7% (n = 387) in regional cities or towns and 5.6% (n = 130) in rural and remote regions. This distribution was slightly more urban than the general population, in which 68.4% of the general Victorian population reportedly live in a major urban area, 19.2% in other urban areas and 13.4% in rural and remote regions (Australian Bureau of Statistics, 2018b). This may reflect LGBTQ human geographies and population movements to areas where there are more LGBTQ people and/or social environments.

3.3 Age of participants

The mean age of participants in Victoria was 35.2 years (SD = 13.5), ranging from 18 to 88 years. More than one-quarter (25.8%; n = 602) of participants were aged between 18 and 24 years, 30.5% (n = 711) between 25 and 34 years, 19.2% (n = 448) between 35 and 44 years, 13.6% (n = 318) between 45 and 54 years and 10.8% (n = 253) at 55 years and over. The proportion of participants aged 60 years and over was 5.8% (n = 136), similar to the 7.2% in the national sample of *Private Lives 2*.

3.4 Gender identity and sexual orientation

Table 2: Gender identity (n = 2,320)

Gender identity	Number	%
Cisgender man	761	32.8
Cisgender woman	1,053	45.4
Trans man	74	3.2
Trans woman	84	3.6
Non-binary	348	15.0

One-third (32.8%; n = 761) of participants were categorised as cisgender men, 45.4% (n = 1,053) as cisgender women, 3.2% (n = 74) as trans men, 3.6% (n = 84) as trans women and 15.0% (n = 384) as non-binary. The *Private Lives 3* survey was completed by 506 trans and gender diverse participants in Victoria, almost twice the number of trans and gender diverse participants in the entire national sample of the *Private Lives 2* survey (n = 285).

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1. Based on the ABS national population estimates of June 2019, NSW accounts for 31.9%, VIC 26.0%, QLD 20.1%, SA 6.9%, WA 10.3%, TAS 2.1%, NT 1.0%, ACT 1.7%.

Table 3: Sexual orientation (n = 2,326)

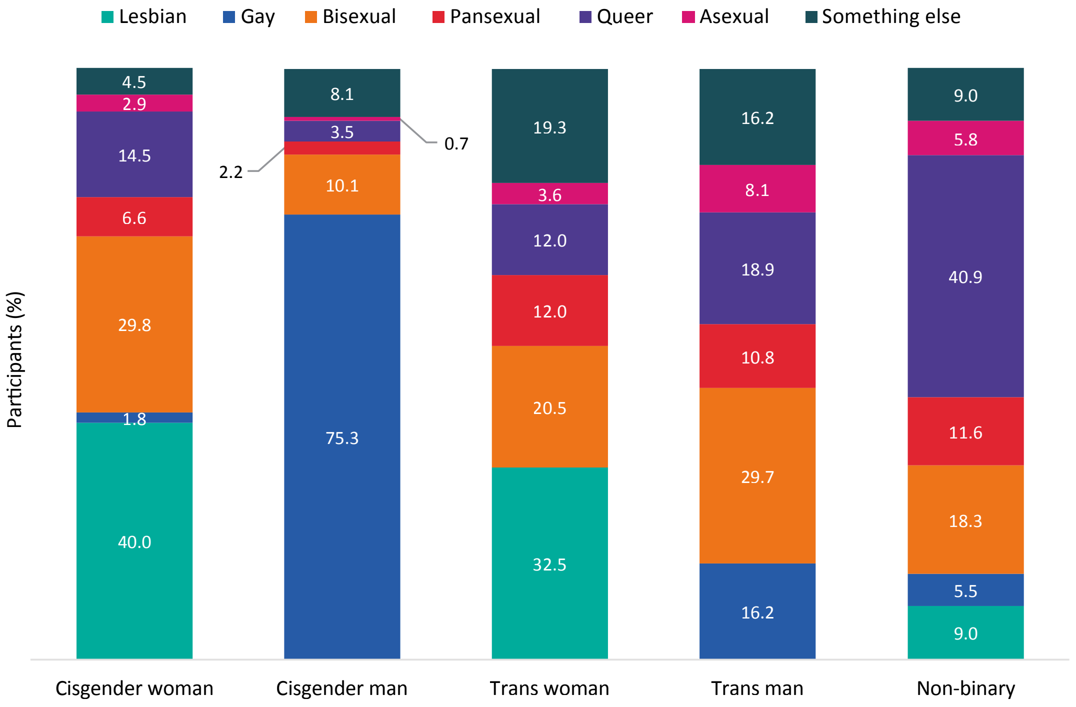
Sexual orientation	Number	%
Lesbian	480	20.6
Gay	625	26.9
Bisexual	494	21.2
Pansexual	146	6.3
Queer	345	14.8
Asexual	65	2.8
Something else	171	7.4

In contrast with *Private Lives 2*, in which gay and lesbian-identifying participants made up almost three-quarters (72.7%) of the total national sample, less than half (47.5%; n = 1,105) of participants residing in Victoria in *Private Lives 3* identified as gay or lesbian. Over one-quarter (27.5%; n = 640) identified as multi-gender attracted (bisexual = 21.2%; pansexual = 6.3%) compared to 11.8% identifying as bisexual in *Private Lives 2* (pansexual was not a sexual orientation category in *Private Lives 2*). Twice the proportion (14.8%; n = 345) of participants identified as queer in the Victorian *Private Lives 3* sample than in the national *Private Lives 2* sample (7.1%). Although asexual was not presented as a sexual orientation category in *Private Lives 2*, it made up 2.8% (n = 65) of the Victorian sample in *Private Lives 3*. Finally, 7.4% of participants were categorised as 'something else', which was the same proportion in the national sample of *Private Lives 2*. The 'something else' category was made up of participants who chose homosexual, 'prefer not to have a label', 'cannot choose only one sexuality', and trans men (n = 4), trans women (n = 6) and non-binary participants (n = 3) who identified as heterosexual. Participants who chose 'prefer not to answer' for the sexual orientation questions were not included in the 'something else' category. The responses from such participants are included in overall percentages in the sections that follow but do not form part of gender identity and sexual orientation sub-analyses.

3.5 Intersections of gender and sexual orientation

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

Figure 1: Intersection of sexual orientation and gender identity (n = 2,315)



Just over three-quarters of cisgender men (75.3%; n = 573) identified as gay compared to 16.2% (n = 12) of trans men, 1.8% (n = 19) of cisgender women and 5.5% (n = 19) of non-binary participants. Over three times as many cisgender women identified as bisexual (29.8%; n = 313) or pansexual (6.6%; n = 69) compared to cisgender men (10.1%; n = 77 identified as bisexual and 2.2%; n = 17 as pansexual). This is consistent with *Private Lives 2* and previous studies in Australia and internationally (Hillier, Jones et al. 2010; Pitts, Smith, Mitchell & Patel 2006). Non-binary participants were most likely to identify as queer (40.9%; n = 141).

3.6 Country of birth

The majority of Victorian participants were born in Australia (83.6%, n = 1,948) and 16.4% (n = 381) were born overseas. This is similar to the national sample of *Private Lives 2* (81.2%), but higher than the general Victorian population figure of 64.9% (Australian Bureau of Statistics, 2016a). Of participants born overseas, 11.9% (n = 55) had lived in Australia for less than five years and one-quarter (26.8%; n = 117) had lived in Australia for less than ten years. Over 35 languages were spoken among the 3.1% (n = 70) of participants who spoke a language other than English at home.

3.7 Aboriginal and Torres Strait Islander descent

Thirty-six (1.5%) participants identified as Aboriginal and/or Torres Strait Islander. This is higher than among the general population in Victoria (0.9%) (Australian Bureau of Statistics, 2018c). The representation of Aboriginal and Torres Strait Islander participants is a major strength of the sample. Please note that specific in-depth outputs are planned for the analysis and interpretation of Aboriginal and Torres Strait Islander data, in close collaboration with Aboriginal and Torres Strait Islander organisations.

3.8 Education, employment and income

3.8.1 Education

Table 4: Educational qualification (n = 2,331)

Education	Number	%
Secondary or below	511	21.9
Non-university tertiary	494	21.2
University-undergraduate	667	28.6
University-postgraduate	659	28.3

More than half (56.9%) of *Private Lives 3* participants in Victoria reported attaining a bachelor degree or above, comparable to the national sample of *Private Lives 2* (49.0%) and double that reported by the general Victorian population (24.3%) (Australian Bureau of Statistics, 2017c).

3.8.2 Employment

Table 5: Employment (n = 2,310)

Employment	Number	%
Full-time employment	940	40.7
Part-time employment	432	18.7
Casual employment	388	16.8
Self-employed	214	9.3
Unemployed or unable to work	329	14.2
Under-employed	112	4.9
Doing domestic duties or parenting	136	5.9
Retired	70	3.0
Studying full-time or part-time	547	23.7
Volunteering	258	11.2

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

Over three-quarters (77.9%) of participants were currently engaged in some form of paid employment, slightly higher than the national sample of *Private Lives 2* (70.3%). Full-time (40.7%) and part-time (18.7%) employment were lower than the general Victorian population average (57.0% and 31.4% respectively). The percentage of Victorian participants in *Private Lives 3* who reported being unemployed (14.2%) was more than double the general Victorian population average of 6.6%.

3.8.3 Income

Table 6: Total weekly income before tax of all wages/salaries, government benefits, pensions, allowances and other income (n = 2,309)

Income	Number	%
Nil income	143	6.2
$1 - $399	502	21.7
$400 - $999	586	25.4
$1,000 - $1,999	769	33.3
$2,000+	309	13.4

Almost half (46.7%) of participants reported an income of $1,000 or more per week, similar to the national sample of *Private Lives 2* (44.6%). The median weekly personal income for people aged 15 years and over in the general Victorian population is $644 (Australian Bureau of Statistics, 2016).

4 Households and relationships

4.1 Household structure

Participants were asked who lived in the same household with them. Table 7 displays these results.

Table 7: Who lives with you (n = 2,331)

Household	Number	%
Partner/s	982	42.1
Parent or carer/s	418	17.9
I live alone	384	16.5
Other family member/s	376	16.1
Housemate/s	302	13.0
Friend/s	279	12.0
Children (including those of a partner)	270	11.6
Other/s	39	1.7

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

Over four in ten (42.1%) *Private Lives 3* participants in Victoria reported living with their partner/s and 11.6% with children, comparable to the national sample of *Private Lives 2*, in which 39.6% reported living with their partner and 11.2% with children. A slightly lower proportion of *Private Lives 3* participants lived alone (16.5%) compared to the national sample of *Private Lives 2* (23.0%) and the 24.7% reported in the general Victorian population (Australian Bureau of Statistics, 2016).

4.2 Current relationship status

Over half (57.2%; n = 1,334) of participants were in a committed romantic relationship, similar to the 55.3% in the national sample of *Private Lives 2*. Of participants in a committed romantic relationship, seven in ten (69.1%; n = 920) reported cohabiting with their partner/s, closely resembling the national sample of *Private Lives 2* (71.7%).

Participants who were currently in relationship/s were asked how long they had been in the relationship. Table 8 displays these results.

Table 8: Current relationship length (n = 1,334)

Relationship length	Number	%
Less than one year	231	17.3
Between 1 and 2 years	147	11.0
Between 2 and 5 years	331	24.8
Between 5 and 10 years	284	21.3
More than 10 years	386	28.9

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

Half (50.5%; n = 674) of participants in a relationship reported having been in a relationship for five years or more, and over one-quarter (28.9%; n = 386) for more than ten years, slightly higher than reported in the national sample of *Private Lives 2* (44.1% in a relationship for five years or more; 25.8% more than ten years).

4.3 Marital status

Participants were asked if they had ever formalised any of their current or previous relationships through marriage.

Table 9: Marital status of all participants in Victoria (n = 2,324)

Marital status	Number	%
No, but I hope to be married	931	40.1
No, I don't hope to be married	732	31.5
Yes, I am currently married	305	13.1
Yes, I was previously married	154	6.6
Yes, through a non-marriage ceremony	62	2.7
Prefer not to say	42	1.8
Something different	219	9.4

Of the total Victorian *Private Lives 3* sample (n = 2,324), approximately one in eight (13.1%; n = 305) were currently married and 2.7% (n = 62) had formalised their relationship through a non-marriage ceremony. A further 6.6% (n = 154) reported having been married previously.

Of those participants who were currently in a relationship (n = 1,334), 21.7% (n = 289) were currently married and 3.2% (n = 43) had formalised their relationship through a non-marriage ceremony compared to 'just under 18%' of participants who had formalised their commitment through marriage or some other ceremony in the national sample of *Private Lives 2*.

A greater proportion of participants who were currently not married reported being receptive to marriage in the future (40.1%; n = 931) than in the national sample of *Private Lives 2* (34.4%). A further one-third (31.5%; n = 732) who were not currently married did not hope to be married in the future compared to 33.1% in the national sample of *Private Lives 2*.

4.4 Marriage equality debate

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

Table 10: The extent that participants agreed with the statement, 'I felt distressed during the 2017 marriage equality debate' (n = 2,323)

I felt distressed during the 2017 marriage equality debate	Number	%
Strongly disagree	162	7.0
Somewhat disagree	168	7.2
Neither agree nor disagree	182	7.8
Somewhat agree	786	33.8
Strongly agree	1,025	44.1

Consistent with recent research, almost eight in ten (78.0%; n = 1,811) participants in Victoria agreed with the following statement, 'I felt distressed during the 2017 marriage equality debate' and 14.2% (n = 330) disagreed.

Table 11: The extent that participants agreed with the statement, 'The 2017 marriage equality results will have a positive impact on my life' (n = 2,316)

The 2017 marriage equality results will have a positive impact on my life	Number	%
Strongly disagree	71	3.1
Somewhat disagree	99	4.3
Neither agree nor disagree	494	21.3
Somewhat agree	770	33.3
Strongly agree	882	38.1

Over seven in ten (71.3%; n = 1,652) participants agreed with the following statement, 'The 2017 marriage equality results will have a positive impact on my life' and 7.4% (n = 170) disagreed.

4.5 Children and dependents

Approximately one in seven (14.5%; n = 337) participants reported having children or stepchildren, slightly lower than in the national sample of *Private Lives 2* (22.1%). One in five cisgender women (20.5%; n = 216) reported having children or stepchildren, followed by 20.2% (n = 17) of trans women, 17.6% (n = 13) of trans men, 9.8% (n = 34) of non-binary participants and 7.2% (n = 55) of cisgender men. Participants who reported being primary carers of children were asked what methods they or their partner/s (if co-parenting) used to have children. Table 12 displays the results.

Table 12: Conception method of participants who reported being the primary carer for a child (n = 256)

Conception method	Number	%
Sexual intercourse with a relationship partner	104	40.6
Gametes (i.e., eggs or sperm) and embryo donated from a person I know	50	19.5
Gametes (i.e., eggs or sperm) and embryo donated from a person I do not know (i.e., anonymous donor)	34	13.3
Gametes (i.e., eggs or sperm) donated from a person I do not know (i.e., sourced by an Assisted Reproductive Treatment service)	17	6.6
Fostering	8	3.1
Surrogacy from a person I had not previously known before they became a surrogate	8	3.1
Sexual intercourse with a non-relationship partner	3	1.2
Adoption	2	0.8
Other	25	9.8
None of the above	33	12.9

Of this group, 40.6% (n = 104) reported conceiving a child through sexual intercourse with a relationship partner, 19.5% (n = 50) from gametes and embryo donated from a person they know, 13.3% (n = 34) from gametes and embryo donated from an anonymous donor, 6.6% (n = 17) from gametes sourced through an Assisted Reproductive Treatment service, 3.1% (n = 8) through fostering, 3.1% (n = 8) through surrogacy from a person they had not previously known before they became a surrogate, 1.2% (n = 3) through sexual intercourse with a non-relationship partner, 0.8% (n = 2) through adoption and 9.8% (n = 25) through other methods.

4.5.1 Desire for children in the future

Almost one-quarter (24.7%; n = 576) of the Victorian sample in *Private Lives 3* reported a desire for having children or more children in the future. However, 50.9% (n = 1,185) reported that they did not desire having children and 24.4% (n = 567) were undecided or did not know. A greater proportion of participants ("nearly 38%") in the national sample of *Private Lives 2* reported wanting to have a child or more children in the future.

4.5.2 Barriers for having children in the future

Participants who reported a desire for having children or more children in the future, and participants who reported that they were undecided or did not know if they wanted children in the future were asked the extent to which they felt they faced barriers to having children in relation to their sexual orientation or gender identity. Response options included 'this is not relevant to me', 'not at all', 'a little', 'somewhat', 'a lot' and 'extremely'. There were 55 participants who responded 'this is not relevant to me' and were therefore not included in this analysis. Almost four in ten (39.1%; n = 419) reported 'a lot' or 'extremely' when asked if they faced barriers to having children in relation to their sexual orientation. Almost half (47.5% n = 126) of trans and gender diverse participants reported 'a lot' or 'extremely' in relation to their gender identity.

Participants who desired or were undecided if they wanted children in the future were then presented with a list of potential barriers and asked which, if any, they faced. Table 13 displays these results.

Table 13: Potential barriers to having children (n = 1,342)

Barriers to having children	Number	%
Cost of raising a child	529	49.7
Concerns of raising a child in a heterosexist society	525	49.3
Cost of accessing Assisted Reproductive Treatment services	386	36.3
No relationship partner	319	30.0
Don't know a potential sperm donor	315	29.6
Don't know a potential surrogate	275	25.9
Concerned about heterosexist treatment at an Assisted Reproductive Treatment service	257	24.2
No stable income	236	22.2
Don't know the location of an Assisted Reproductive Treatment service	216	20.3
Cost of egg storage	212	19.9
Lack of commercial surrogacy in Australia	208	19.6
Don't know a potential egg donor	204	19.2
Infertility	151	14.2
Too old	135	12.7
Don't have an Assisted Reproductive Treatment service near where I live	64	6.0
I don't face any barriers	40	3.8
Other	221	20.8

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

The vast majority (96.2%) of participants who desired or were undecided if they wanted children in the future reported facing one or more perceived barriers to having children. Almost half reported the cost of raising a child (49.7%; n = 529) and concerns of raising a child in a heterosexist society (49.3%; n = 525) as barriers to having children. Over one-third (36.3%; n = 386) reported the cost of accessing Assisted Reproductive Treatment services and three in ten (29.6%; n = 315) reported not knowing a potential sperm donor. Approximately one-quarter reported not knowing a potential surrogate (25.9%; n = 275), concern about heterosexist treatment at an Assisted Reproductive Treatment service (24.2%; n = 257) or not having a stable income (22.2%; n = 236) as barriers to having children. Only 3.8% (n = 40) reported not facing any barriers to having children.

5 Housing and homelessness

5.1 Current living situation

Participants were asked to select which options best described their current living situation from a range of choices and could select more than one option if applicable. Table 14 displays these results.

Table 14: Current living situation (n = 2,327)

Housing situation	Number	%
Private rental	1,094	47.0
Home I own	726	31.2
At home with family	463	19.9
Rooming house	17	0.7
Public housing	17	0.7
Couch surfing	13	0.6
Transitional housing	8	0.3
Caravan park	3	0.1
Crisis/emergency accommodation	3	0.1
Somewhere else	60	2.6

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

Almost half (47.0%) of participants reported living in a private rental property, one-third (31.2%) in a home they owned and one-fifth (19.9%) at home with their family. This compares to 28.7% living in a private rental property and 67.6% in a home they own in the general Victorian population (Australian Bureau of Statistics, 2016). Among participants living in a private rental property, 41.2% (n = 451) shared with a partner, 38.8% (n = 424) shared with friend/s and 23.3% (n = 254) lived alone. Among participants who were living in their own home, 73.3% (n = 532) owned it with a mortgage and 26.7% (n = 194) owned it without a mortgage.

5.2 Homelessness among LGBTQ people

Homelessness is a serious population health concern, with research showing that people who experience homelessness in their lifetimes tend to have poorer general health and higher rates of chronic and acute diseases, mental illness and alcohol and drug dependence than the general population (Arnold et al., 2020; Fazel et al., 2008; Lebrun-Harris et al., 2013). Growing evidence suggests that a higher proportion of LGBTIQ people have experienced homelessness than the general population (McNair et al., 2017). However, there has been limited systematic research in Australia. Many surveys of the general population either do not record or inadequately record diverse genders, sex characteristics and sexual orientation, and Australia is generally regarded as being behind other developed countries in developing research, policy and best practice in the area of LGBTIQ homelessness.

A variety of measures and definitions of homelessness exist, with no fixed standard. The ABS defines a person as homeless if "they do not have suitable accommodation alternatives and their current living arrangement: is in a dwelling that is inadequate; has no tenure, or if their initial tenure is short and not extendable; or does not allow them to have control of, and access to space for social relations" (Australian Bureau of Statistics, 2018a). For the *Private Lives 3* survey, a definition of homelessness was developed in consultation with LGBTIQ homelessness specialists, the *Private Lives 3* Expert Advisory Committee and other key stakeholders. It was designed to be more easily understood by participants from culturally and linguistically diverse backgrounds while remaining comparable to the ABS definition. It asked participants the following:

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

5.3 Experiences of homelessness

One-fifth (21.3%; n = 496) of the Victorian sample in *Private Lives 3* reported having ever experienced homelessness. Of participants who reported ever experiencing homelessness, two-thirds (61.1%; n = 303) reported having experienced homelessness once and were not currently experiencing homelessness, 33.1% (n = 164) experienced homelessness more than once and were not currently experiencing homelessness and 5.8% (n = 29) were currently experiencing homelessness.

Trans and gender diverse participants reported higher rates of ever experiencing homelessness than cisgender participants. More than one-third (35.7%; n = 30) of trans women, 34.5% (n = 120) of non-binary participants and 35.1% (n = 26) of trans men reported ever experiencing homelessness compared to 18.7% (n = 197) of cisgender women and 15.8% (n = 120) of cisgender men.

Participants who reported ever experiencing homelessness were asked if their homelessness experience/s related to being LGBTIQ. One-quarter (25.1%; n = 124) reported that their homelessness experience/s was related to being LGBTIQ.

Participants who reported ever experiencing homelessness were then asked if their experience/s of homelessness related to a range of possible circumstances. Table 15 displays these results.

Table 15: Circumstances related to experience/s of homelessness (n = 478)

Circumstances related to homelessness	Number	%
Financial stress	204	42.7
Mental health issues	197	41.2
Unemployment/underemployment	181	37.9
Rejection from family	160	33.5
Family violence	142	29.7
Violence/harassment in previous accommodation	66	13.8
Substance use	62	13.0
Discrimination (such as from school, employment, services)	53	11.1
Disability	49	10.3
Rejection from peers	44	9.2
Chronic illness	41	8.6
Other	94	19.7

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

Approximately four in ten participants (42.7%; n = 204) reported having experienced homelessness related to financial stress, mental health issues (41.2%; n = 197) or unemployment/underemployment (37.9%; n = 181). One-third (33.5%; n = 160) reported experiencing homelessness due to rejection from their family and around three in ten (29.7%; n = 142) due to family violence. Slightly over one in ten reported experiencing homelessness due to violence or harassment at their previous accommodation (13.8%; n = 66), substance use (13.0%; n = 62) or discrimination (11.1%; n = 53). The reported circumstances related to homelessness among *Private Lives 3* participants align with some aspects of those reported among the general Australian population. These include family breakdown, psychological distress, joblessness, use of illicit substances and experiences of physical and sexual violence (Bevitt et al., 2015).

5.4 Barriers to secure housing

Participants were asked the extent to which they felt they faced barriers to housing and/or accessing homelessness services because of their sexual orientation or gender identity, with response options including ‘not at all’, ‘a little’, ‘somewhat’, ‘very’ and ‘extremely’. Very few (1.3%; n = 30) reported ‘very’ or ‘extremely’ in relation to their sexual orientation. However, one in fifteen (7.5%; n = 41) trans and gender diverse participants reported ‘very’ or ‘extremely’ in relation to their gender identity. These findings reflect research in the United States observing that when trying to rent or buy a home, one in five transgender people (19%) have been refused a home or apartment and more than one in ten (11%) have been evicted because of their gender identity (Grant et al., 2011).

6 Discrimination, harassment and feelings of acceptance

6.1 Feelings of acceptance

Participants were asked to report on the extent to which they currently felt accepted in a variety of situations. Response options included 'not applicable', 'not at all', 'a little', 'somewhat', 'a lot' and 'always'. Responses were analysed only among participants who reported that a situation was applicable to them. Table 16 displays the numbers and percentages of participants in the Victorian *Private Lives 3* sample who felt they were accepted 'a lot' or 'always' in each situation.

Table 16: Currently feel accepted 'a lot' or 'always'

Currently, to what extent do you feel accepted in the following situations?	Number	%
LGBTIQ event	1,345	66.3
LGBTIQ venue	1,315	65.7
At work	1,148	61.4
At an educational institution	807	56.4
With family members	1,186	52.6
LGBTIQ dating app or website	692	52.2
Accessing a health or support service	913	42.5
Social/community events	748	35.0
In public (e.g., in the street/park)	660	29.8
Mainstream venue	613	28.5
Mainstream event	603	28.2
Non-LGBTIQ dating app or website	228	21.7
Religious/faith-based events or services	123	10.6

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

Overall, the proportions of *Private Lives 3* participants in Victoria who felt accepted a lot or always were relatively low, with most situations having half or fewer participants feeling this way. Notably, more than twice the proportion of participants felt accepted a lot or always at LGBTIQ events (66.3%; n = 1,345) and LGBTIQ venues (65.7%; n = 1,315) than at mainstream events (28.2%; n = 603) and mainstream venues (28.5%; n = 660). Similarly, less than one-third (29.8%; n = 660) felt this way in other public spaces. In addition, less than half (42.5%; n = 913) reported feeling accepted a lot or always when accessing a health or support service. Only a small proportion (10.6%; n = 123) of participants reported that they felt accepted a lot or always at religious/faith-based events or services and slightly more than half (52.6%; n = 1,186) felt that they were accepted a lot or always with family members.

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

Participants were asked to what extent they felt they had been treated unfairly because of their sexual orientation in the past 12 months, with response options including ‘not at all’, ‘a little’, ‘somewhat’, ‘a lot’ and ‘always’. In addition, trans and gender diverse participants were asked to what extent they felt they had been treated unfairly because of their gender identity in the past 12 months, with the same responses options as above. These were general questions designed to capture the degree to which people encountered discrimination in any area of their lives. Table 17 displays these results.

Table 17: Extent to which you feel you have been unfairly treated due to sexual orientation (n = 2,226) or gender identity (n = 548)

In the past 12 months, to what extent do you feel you have been treated unfairly because of your...	Sexual orientation		Gender identity	
	Number	**%**	**Number**	**%**
Not at all	952	42.0	122	22.3
A little	827	36.5	160	29.2
Somewhat	390	17.2	150	27.4
A lot	85	3.8	105	19.2
Always	12	0.5	11	2.0
To some degree	1,314	58.0	426	77.7

Almost six in ten (58.0%; n = 1,314) participants reported that they had been treated unfairly to some degree because of their sexual orientation in the past 12 months, with 4.3% (n = 97) reporting ‘a lot’ or ‘always’. Over three-quarters (77.7%; n = 426) of trans and gender diverse participants reported that they had been treated unfairly to some degree because of their gender identity in the past 12 months, with 21.2% (n = 116) reporting ‘a lot’ or ‘always’.

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

Participants were asked if they had experienced specific forms of heterosexist violence or harassment based on their sexual orientation or gender identity in the past 12 months. Table 18 displays these results.

Table 18: Experiences of violence and harassment due to sexual orientation or gender identity in the past 12 months

Type of violence or harassment	Number	%
Socially excluded	758	36.4
Verbal abuse (including hateful or obscene phone calls)	678	32.7
Harassment such as being spat at and offensive gestures	462	22.6
Received written threats of abuse via emails, social media	430	21.3
Threats of physical violence, physical attack or assault without a weapon	286	14.0
Received written threats of abuse in other ways	224	11.3
Sexual assault	210	10.3
Refusal of service	186	9.1
Refused employment/promotion	164	8.5
Received written threats of abuse via graffiti	114	5.8
Deliberate damage to property or vandalism – House	80	4.0
Physical attack or assault with a weapon (knife, bottle, stones)	68	3.4
Theft – Money	63	3.1
Deliberate damage to property or vandalism – Car	58	2.9
Theft – Property	51	2.6
Break in – House	41	2.1
Deliberate damage to property or vandalism – Work	34	1.7
Theft – Car	32	1.7
Other	60	22.7

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

The most frequently reported forms of heterosexist violence or harassment were non-physical, including social exclusion (36.4%; n = 758), verbal abuse (32.7%; n = 678), harassment such as being spat at or offensive gestures (22.6%; n = 462), written threats of abuse (21.3%; n = 430) or refusal of service (9.1%; n = 186). Forms of physical abuse were less common but not unusual, with 10.3% (n = 210) of participants reporting sexual assault and 3.4% (n = 68) reporting a physical attack or assault with a weapon in the past 12 months due to their sexual orientation or gender identity.

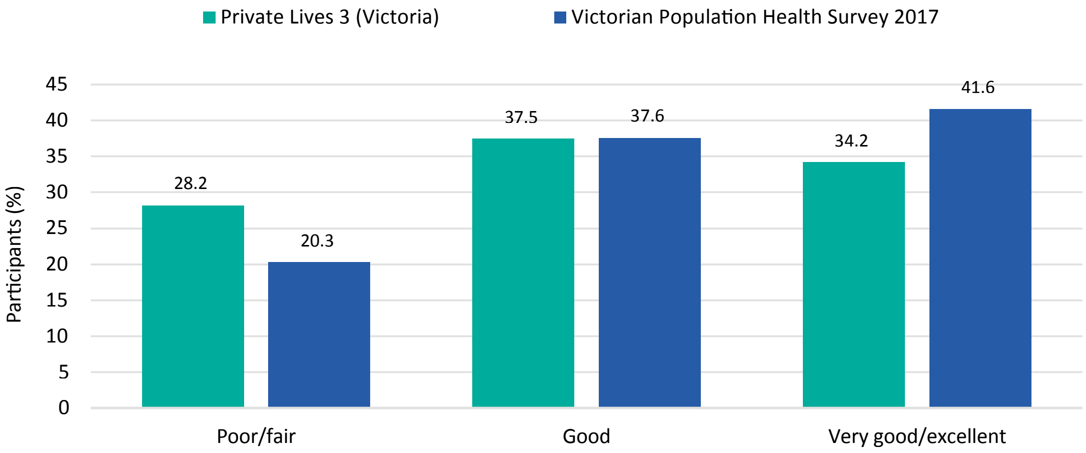
The proportions of some forms of heterosexist violence and harassment reported by participants in the Victorian sample of *Private Lives 3* were somewhat higher than in the national sample of *Private Lives 2*. For example, 25.5% of participants in *Private Lives 2* reported verbal abuse (compared to 32.7% in *Private Lives 3*), 15.5% reported harassment such as being spat at or offensive gestures (compared to 22.6% in *Private Lives 3*), 2.9% reported sexual assault (compared to 10.3% in *Private Lives 3*) and 1.8% reported experiencing a physical attack or assault with a weapon (compared to 3.4% in *Private Lives 3*).

7 General health and wellbeing

7.1 Self-rated general health

Participants were asked to rate their health on a 5-point scale from 'poor' to 'excellent'. Figure 2 represents the responses compared to the 2017 *Victorian Population Health Survey* (Victorian Department of Health and Human Services, 2017).

Figure 2: General health (n = 2,312)



As shown in Figure 2, *Private Lives 3* participants in Victoria reported lower self-rated health than the general Victorian population. Over one-quarter (28.2%) rated their health as 'poor' or 'fair' compared to one-fifth (20.3%) of the general Victorian population. In addition, fewer (34.2%) participants rated their health as 'very good or 'excellent' compared to 41.6% in the general Victorian population (Victorian Department of Health and Human Services, 2017).

7.2 Common health conditions

Participants were asked if they had been diagnosed with or treated for a range of health conditions in the past 12 months. Table 19 displays their responses.

Table 19: Health conditions diagnosed or treated in the past 12 months (not including HIV) (n = 1,342)

Health condition	Number	%
Low iron level (iron deficiency or anemia)	363	17.0
Asthma	307	14.4
Sexually transmitted infection, not including HIV	165	7.7
Hypertension (high blood pressure)	158	7.4
Osteoarthritis	82	3.9
Other arthritis	70	3.3
Chronic fatigue	66	3.1
Diabetes	63	3.0
Heart disease (including heart attack, angina)	35	1.6
Cancer	32	1.5
Rheumatoid arthritis	23	1.1
Impaired glucose tolerance	22	1.0
Osteoporosis/osteopenia	18	0.8
Thrombosis (a blood clot)	13	0.6
Emphysema	10	0.5
Stroke	7	0.3
Viral hepatitis C	4	0.2
Viral hepatitis A or B	3	0.1
Other major illness	304	14.3
Any of these conditions	1,101	51.6

The most commonly reported health conditions were low iron levels (17.0%), asthma (14.4%), sexually transmitted infections, not including HIV (7.7%), and hypertension (7.4%). Participants who reported they had been diagnosed or treated for cancer in the past 12 months were asked what type of cancer it was. The most common form of cancer reported was skin cancer (non-melanoma) (n = 11) followed by prostate cancer (n = 4).

7.3 Sexual health

7.3.1 HIV

Participants were asked if they had ever been tested for HIV. A little less than two-thirds (60.9%; n = 1,419) had ever been tested and just under a third (30.2%; n = 705) had undergone testing in the past 12 months. Of participants who had ever undergone HIV testing, 4.1% (n = 58) reported that they were HIV-positive, 94.6% (n = 1,342) reported that they were HIV-negative, 1.1% (n = 16) did not know their HIV status and 0.2% (n = 3) preferred not to say. Almost one in ten (8.6%; n = 54) cisgender men were HIV-positive, followed by 1.9% (n = 1) of trans women, 0.5% (n = 1) of non-binary participants and 0.2% (n = 1) cisgender women. No trans men reported being HIV-positive. Of those who were HIV-positive, 98.7% (n = 57) reported that they were taking combination antiretroviral therapy. All participants taking antiretroviral therapy (n = 57) reported that they had an undetectable viral load in their last test.

7.3.2 Hepatitis C

Participants were asked if they had ever undertaken Hepatitis C testing. Over half (56.1%; n = 1,308) reported having ever been tested for hepatitis C and one-quarter (25.7%; n = 599) reported having undergone testing in the past 12 months. Of participants who had undergone hepatitis C testing, 96.1% (n = 1,256) were negative, 1.5% (n = 20) had been positive but were now negative following successful treatment, 0.1% (n = 1) were positive and currently receiving treatment, 0.1% (n = 1) were positive and not currently receiving treatment, 2.1% (n = 27) did not know their current hepatitis C status and 0.2% (n = 2) preferred not to say. Of those who had ever tested positive for hepatitis (n = 22), 27.3% (n = 6) participants also reported being HIV-positive.

7.3.3 Pre-Exposure Prophylaxis (PrEP)

PrEP involves HIV-negative people taking antiretroviral drugs to prevent them from acquiring HIV. Over three-quarters (77.1%; n = 1,796) of participants reported having ever heard of PrEP. Cisgender men reported the highest awareness of PrEP (91.5%; n = 695), compared to 64.6% (n = 680) of cisgender women, 77.0% (n = 57) of trans men, 73.8% (n = 62) of trans women and 83.9% (n = 292) of non-binary participants.

Of participants who had ever heard of PrEP, 10.4% (n = 186) had successfully accessed it in the past 12 months. Almost one-quarter of cisgender men (24.0%; n = 166) had successfully accessed it in the past 12 months, followed by 8.1% of trans women (n = 8.1%), 5.3% of trans men (n = 3), 3.8% (n = 11) of non-binary participants and 0.2% (n = 1) of cisgender women.

Some participants (1.8%; n = 32) had tried to access PrEP but were not successful. Most of these participants were cisgender men (3.9%; n = 27), followed by trans women (3.2%; n = 2) and non-binary participants (1.0%; n = 3). No cisgender women or trans men reported having tried to access PrEP but were not successful.

7.3.4 Post-Exposure Prophylaxis (PEP)

PEP is a 4-week course of anti-HIV medication that is shown to be effective in preventing HIV infection if started within 72 hours of exposure. Almost two-thirds (63.3%; n = 1,474) of participants reported having ever heard of PEP. Cisgender men reported the highest awareness of PEP (80.4%; n = 612), compared to 50.7% (n = 533) of cisgender women, 54.1% (n = 40) of trans men, 53.6% (n = 45) of trans women and 68.4% (n = 238) of non-binary participants.

Of participants who had ever heard of PEP, 1.6% (n = 24) had successfully accessed it in the past 12 months. Almost one in thirty cisgender men (3.0%; n = 18) had successfully accessed it in the past 12 months, followed by trans men (7.5%; n = 3), non-binary participants (0.8%; n = 2) and trans women (2.2%; n = 1). No cisgender women reported successfully accessing PEP.

Of participants who had ever heard of PEP, 1.1% (n = 16) had tried to access it but were not successful. Almost one in fifty cisgender men (1.8%; n = 11) had tried to access it but were not successful, followed by cisgender women (0.8%; n = 4) and non-binary participants (0.4%; n = 1). No trans men or trans women reported trying but not being successful in accessing PEP.

8 Mental health and wellbeing

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

8.1 Psychological distress (K10)

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

The national *Private Lives 2* sample had a mean K10 score of 19.6 (Leonard et al., 2012). The mean K10 score among the *Private Lives 3* sample in Victoria was 23.7 (with a standard deviation of 8.9), thus trending toward poorer mental health overall than among the national *Private Lives 2* sample.

Figure 3: Proportion of participants experiencing low, moderate, high or very high psychological distress (n = 2,297)

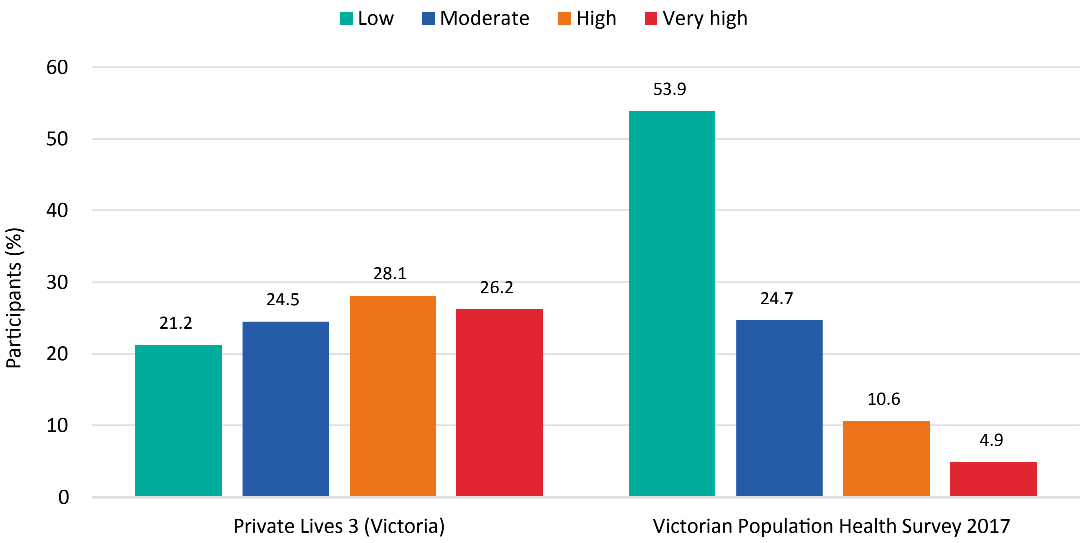
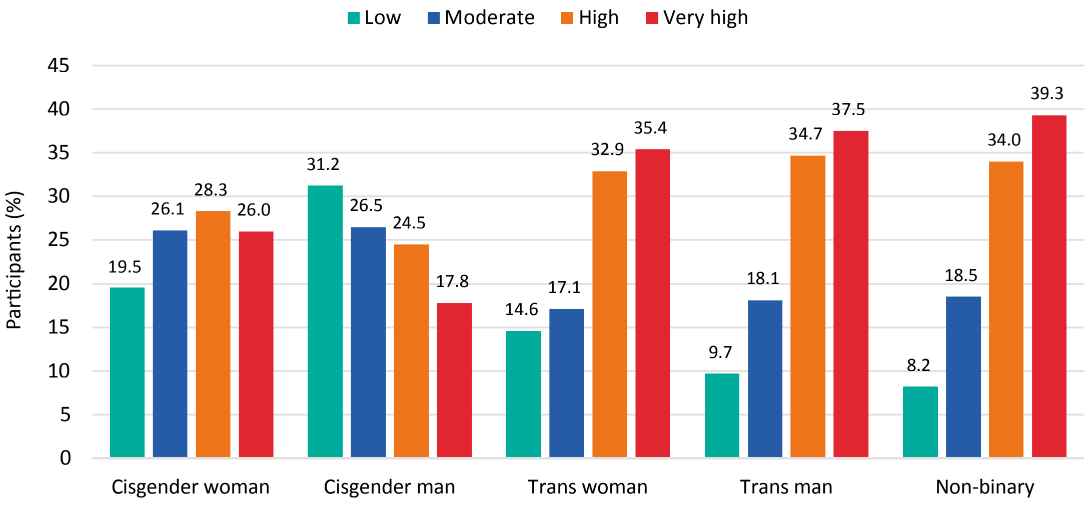


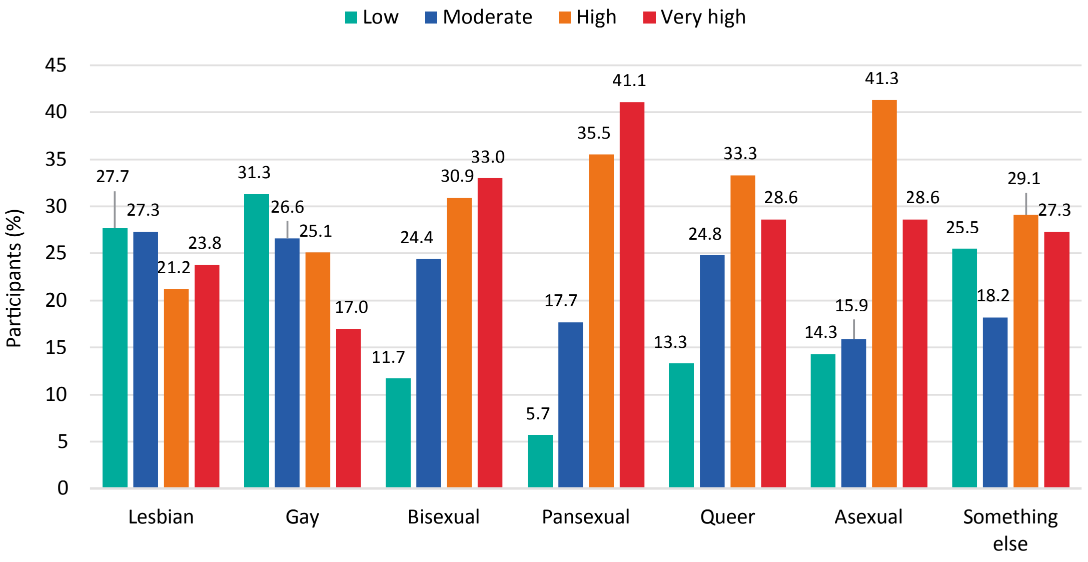
Figure 3 shows that more than half (54.3%; n = 1,231) of *Private Lives 3* participants in Victoria experienced high or very high levels of psychological distress according to criteria used by the Australian Bureau of Statistics (Australian Bureau of Statistics, 2017b). This is three times higher than the proportion of people reporting high or very high levels of psychological distress among the general Victorian population (15.4%) (Australian Bureau of Statistics, 2016). Over one-quarter (26.2%; n = 593) of *Private Lives 3* participants in Victoria reported experiencing very high levels of psychological distress, which is over five times higher than among the general Victorian population (4.9%) (Australian Bureau of Statistics, 2016).

Figure 4: Proportion of participants experiencing low, moderate, high or very high psychological distress by gender identity (n = 2,256)



When analysed by gender identity, almost three-quarters (72.2%; n = 72) of trans men, 68.3% (n = 56) of trans women and 73.3% (n = 250) of non-binary participants reported experiencing high or very high levels of psychological distress compared to 54.3% (n = 553) of cisgender women and 42.3% (n = 314) of cisgender men.

Figure 5: Proportion of participants experiencing low, moderate, high or very high psychological distress by sexual orientation (n = 2,263)



When analysed by sexual orientation, three-quarters (76.6%; n = 108) of participants who identified as pansexual, 63.8% (n = 306) as bisexual, 69.8% (n = 44) as asexual and 61.2% (n = 210) as queer reported experiencing high or very high levels of psychological distress compared to 45.0% (n = 210) of lesbian and 42.1% (n = 257) of gay identifying participants.

8.2 Mental health diagnoses

Previous research has observed LGBTQ people are more likely to be diagnosed with depression and anxiety than the general population (Fergusson et al., 1999; Ross et al., 2018). Participants were asked if they had ever been diagnosed with one or more mental health conditions at some point in their lives. Participants who reported having ever been diagnosed with a mental health condition at some point during their lives were then asked if they had been diagnosed or treated for that condition in the past 12 months. Table 20 displays these results.

Table 20: Ever diagnosed with one or more mental health conditions (n = 2,245) and diagnosed or treated in the past 12 months

	Ever		Past 12 months	
Condition	**Number**	**%**	**Number**	**%**
Depression	1,332	59.3	864	38.5
Generalised anxiety disorder	1,040	46.3	729	32.5
Post-traumatic stress disorder	394	17.6	237	10.6
Eating disorder	238	10.6	83	3.3
Panic disorder	153	6.8	74	3.7
Social phobia	138	6.2	63	2.6
Obsessive-compulsive disorder	121	5.4	59	2.6
Bipolar disorder	103	4.6	58	2.6
Agoraphobia	37	1.7	19	0.9
Schizophrenia	23	1.0	15	0.7
Other mental health challenge	298	13.3	207	9.2
Any of the above	1,615	72.0	1,158	51.6

Over seven in ten (72.0%) participants reported having ever been diagnosed with a mental health condition at some point during their lives. Six in ten (59.3%; n = 1,332) reported having ever been diagnosed with depression and almost half (46.3%; n = 1,040) with generalised anxiety disorder. One in six (17.6%; n = 396) had been diagnosed with post-traumatic stress disorder and one in ten (10.6%; n = 238) an eating disorder. Taken together, approximately seven in ten (70.4%; n = 1,494) participants reported having ever been diagnosed with either depression or generalised anxiety, almost three times the proportion reported among the general Victorian population (27.4%) (Victorian Department of Health and Human Services, 2017).

Over one-third (38.5%; n = 864) of participants reported having been diagnosed or treated for depression in the past 12 months. Slightly less than a third (32.5%; n = 729) reported having been diagnosed or treated for generalised anxiety disorder in the past 12 months and one in ten (10.6%; n = 237) reported having been diagnosed or treated for post-traumatic stress disorder in the past 12 months.

8.3 Suicidal ideation and suicide attempts

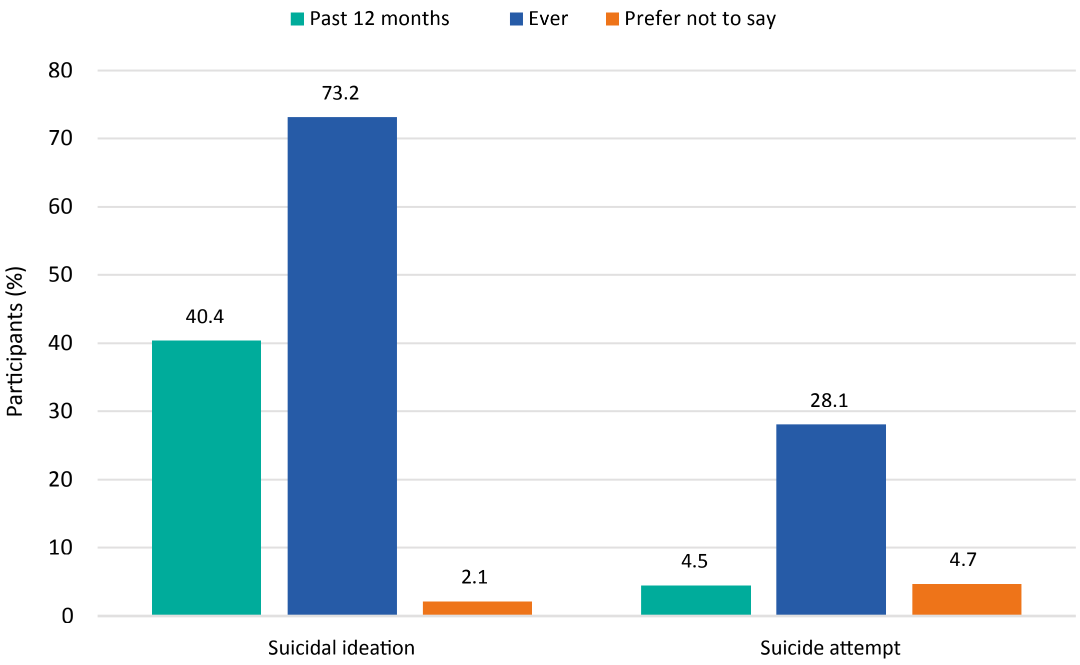
Suicide is a major public health issue. It is the leading cause of death among people aged between 15 and 44 years in Australia (Australian Bureau of Statistics, 2019b) and accounts for the highest number of years of potential life lost among leading causes of death in the general Australian population (Australian Bureau of Statistics, 2019a). Previous research has revealed that LGBTQ people have comparatively higher levels of suicidal ideation and suicide attempts than the general population (King et al., 2008).

Private Lives 3 asked participants about *suicidal ideation*, defined as 'thoughts about suicide, wanting to die, or about ending your life' and *suicide attempts*, defined as having 'attempted suicide or to end your life'.

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

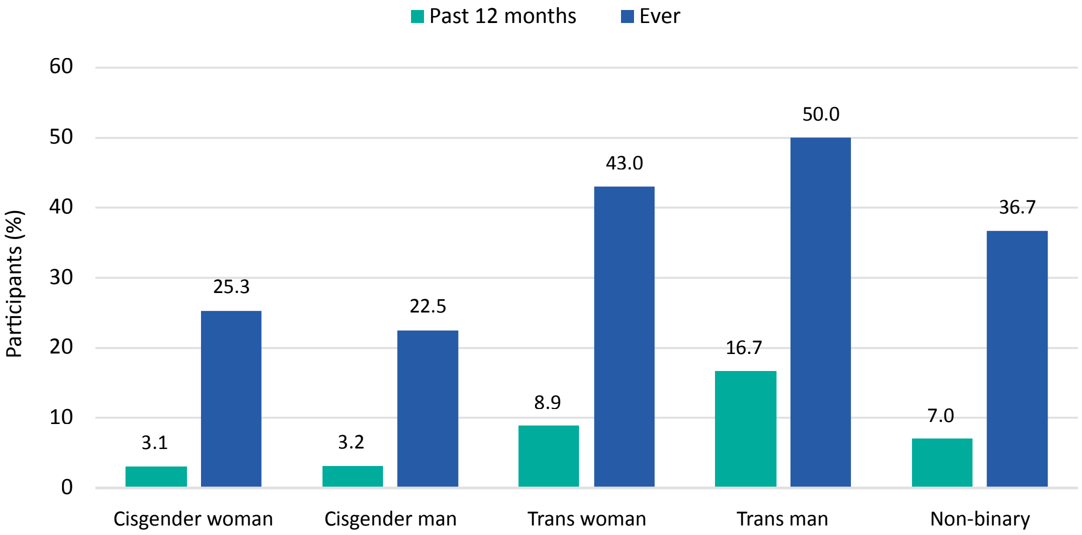
Figure 6 displays the responses to these questions. Note, participants who skipped the section by indicating 'I prefer not to answer these questions' and those who selected 'prefer not to answer' for a particular question were combined to form a single category of 'prefer not to say.'

Figure 6: Suicidal ideation (n = 2,317) and suicide attempts (n = 1,809) in the past 12 months and ever



Over one in four (40.4%; n = 937) participants reported that they had considered attempting suicide in the previous 12 months, twenty times higher than the 2.3% reported among the general Australian population (Johnston et al., 2009). Almost three-quarters (73.2%; n = 1,696) reported having ever seriously considered attempting suicide at some point during their lives, which is four times higher than the 13.3% reported among the general Australian population (Johnston et al., 2009). Almost one in twenty (4.5%; n = 82) reported having attempted suicide in the past 12 months, ten times higher than the 0.4% reported among the general Australian population (Johnston et al., 2009). Over one in four (28.1%; n = 508) reported having ever attempted suicide at some point during their lives, which is eight times higher than the 3.2% reported among the general Australian population (Johnston et al., 2009).

Figure 7: Suicide attempts in the past 12 months and ever by gender identity



One in six (16.7%; n = 11) trans men, 8.9% (n = 7) of trans women and 7.0% (n = 21) of non-binary participants reported having attempted suicide in the past 12 months compared to 3.1% (n = 25) of cisgender women and 3.2% (n = 18) of cisgender men. One in two (50.0%; n = 33) trans men, 43.0% (n = 34) of trans women and 36.7% (n = 110) of non-binary participants reported having ever attempted suicide compared to 25.3% (n = 202) of cisgender women and 22.5% (n = 125) of cisgender men.

There were 2.1% of participants who answered ‘prefer not to say’ to the questions regarding suicidal ideation and 4.7% of participants who answered ‘prefer not to say’ to questions regarding suicide attempts.

9 Health services

9.1 Medicare and health insurance

The vast majority (96.9%; n = 2,329) of participants reported that they were currently eligible to access Medicare. One-quarter (27.8%; n = 10) of participants who reported being ineligible to access Medicare were Australian citizens, 38.9% (n = 14) were international students and 18.4% (n = 7) were on working visas. Just over half (52.7%; n = 1,229) had private health insurance, slightly lower than the national sample of *Private Lives 2* (60%), the general Australian population (57.1%) aged 18 years and over (Australian Bureau of Statistics, 2017a) and the general Victorian (56.9%) population aged 18 years and over (Australian Bureau of Statistics, 2019d).

9.2 Regular general practitioner

Slightly less than two-thirds (63.6%; n = 1,475) of participants reported having a regular General Practitioner (GP) compared to almost 70% in the national sample of *Private Lives 2* and 81% of female patients and 73% of male patients in the general Australian population (Royal Australian College of General Practitioners, 2017). A further one-quarter (27.3%; n = 633) reported that they did not have a regular GP but attended the same health centre. Four-fifths of participants (80.2%; n = 1,869) reported seeing a GP at least twice a year and one-third (33.3%; n = 776) at least quarterly.

9.3 Experiences of health services

Participants were asked if they had used a range of health services in the past 12 months. Participants were then asked to what extent they felt that their sexual orientation or gender identity was respected at each of the services they reported using in the past 12 months. Table 21 displays the numbers and percentages of participants who accessed each service.

Table 21: Health services accessed in the past 12 months (n = 2,328)

Service use in past 12 months	Number	%
Mainstream medical clinic	1,915	82.3
Mainstream mental health service (e.g., psychologist, counsellor)	795	34.2
Allied health service (e.g., physiotherapist, osteopath)	781	33.6
Hospital	778	33.4
Mainstream medical clinic that is known to be LGBTIQ-inclusive	662	28.4
Mainstream mental health service that is known to be LGBTIQ-inclusive	461	19.8
Medical clinic catering only to lesbian, gay, bisexual, transgender and/or intersex people	201	8.6
Mental health service catering only to lesbian, gay, bisexual, transgender and/or intersex people	131	5.6

Mainstream health services were more frequently accessed by participants than health services that were known to be LGBTIQ-inclusive or that catered only to lesbian, gay, bisexual, trans and/or intersex people. The health service most commonly accessed by participants in the past 12 months was a mainstream medical clinic (82.3%), followed by a mainstream mental health service (34.2%), allied health service (33.6%) and a hospital (33.4%). Medical clinics that cater only to lesbian, gay, bisexual, trans and/or intersex people were accessed by less than one in ten (8.6%) participants and mental health services that cater only to lesbian, gay, bisexual, trans and/or intersex people were accessed by around one in twenty (5.6%) participants.

However, Victorian participants in *Private Lives 3* reported accessing health services that were LGBTIQ-inclusive or that cater only to lesbian, gay, bisexual, trans and/or intersex people more frequently compared to the rest of the national *Private Lives 3* sample. More than twice (8.6%; n = 201) the proportion of participants in Victoria reported accessing a medical clinic that caters only to lesbian, gay, bisexual, trans and/or intersex people in the past 12 months than in the national *Private Lives 3* sample (not including Victoria; n = 4,479), in which 4.2% (n = 188) of participants reported accessing a medical clinic that caters only to lesbian, gay, bisexual, trans and/or intersex people in the past 12 months.

More participants in Victoria also accessed a mainstream medical clinic that is known to be LGBTIQ-inclusive in the past 12 months (28.4%; n = 662) than in the national *Private Lives 3* sample (not including Victoria) (23.2%; n = 1,037).

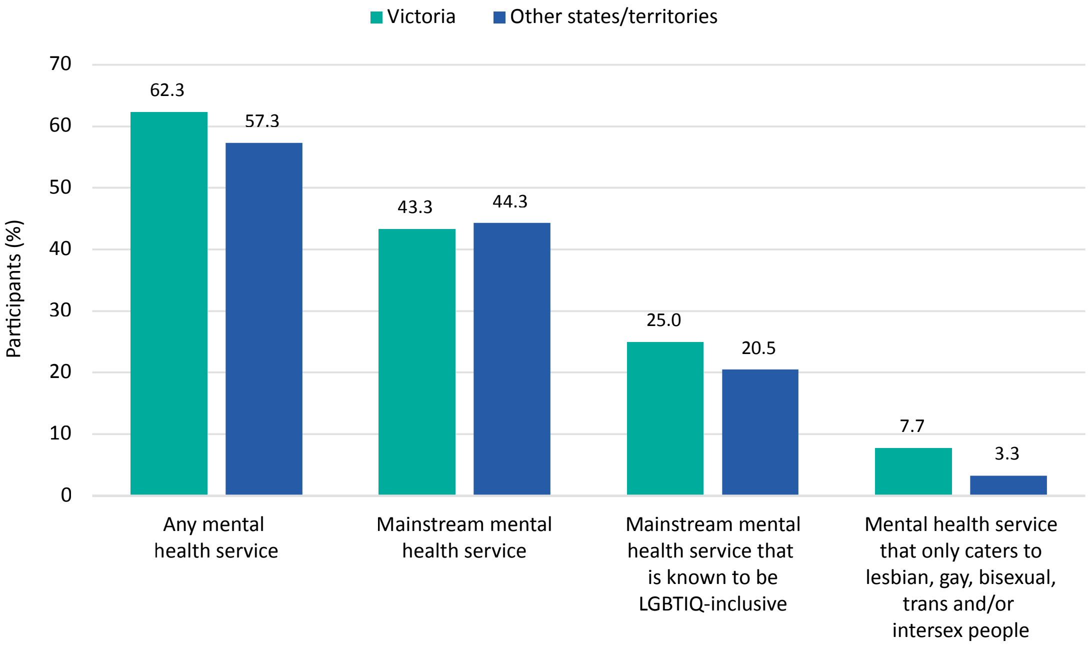
Almost twice (5.6%; n = 131) the proportion of participants in Victoria reported accessing a mental health service that caters only to lesbian, gay, bisexual, trans and/or intersex people in the past 12 months than in the national *Private Lives 3* sample (not including Victoria) (2.9%; n = 128).

More participants in Victoria also accessed a mainstream mental health service that is known to be LGBTIQ-inclusive (19.8%; n = 461) than in the national *Private Lives 3* sample (not including Victoria) (16.3%; n = 729).

9.3.1 Experiences of health services among participants reporting psychological distress

Of participants in the Victorian *Private Lives 3* sample who reported high or very high levels of psychological distress according to criteria used by the Australian Bureau of Statistics (Australian Bureau of Statistics, 2019c, p. 10), six in ten (62.3%; n = 766) reported having accessed a mental health service in the past 12 months. Specifically, four in ten (43.3%; n = 532) reported having accessed a mainstream mental health service, 25.0% (n = 307) a mainstream mental health service known to be LGBTIQ-inclusive and 7.7% (n = 94) a mental health service that caters only to lesbian, gay, bisexual, trans and/or intersex people.

Figure 8: Mental health service access in the past 12 months among participants reporting high or very high levels of psychological distress in Victoria (n = 1,231) and other states/territories combined (n = 2,586)



A greater proportion of participants in Victoria who reported high or very high levels of psychological distress had accessed a mental health service in the past 12 months (62.3%; n = 766) than in the national *Private Lives 3* sample (not including Victoria) (57.3%; n = 1,475). Slightly more participants in the national *Private Lives 3* sample (not including Victoria) (44.3%; n = 1,139) had accessed a mainstream mental health service than participants in Victoria (43.3%; n = 532). However, one-quarter (25.0%; n = 307) of Victorian participants had accessed a mainstream mental health service known to be LGBTIQ-inclusive compared to 20.5% (n = 527) in the national *Private Lives 3* sample (not including Victoria) and more than double (7.7%; n = 94) had accessed a mental health service that caters only to lesbian, gay, bisexual, trans and/or intersex people in Victoria than in the national *Private Lives 3* sample (not including Victoria) (3.3%; n = 85).

Table 22 displays the percentage of participants from the Victorian sample of *Private Lives 3* who had accessed each service in the past 12 months and who reported that they felt that their sexual orientation or gender identity was 'very respected' or 'extremely respected' when accessing them.

Table 22: Proportion of participants who had accessed each health service and felt that their sexual orientation or gender identity was very/extremely respected in the past 12 months

	Sexual orientation very/ extremely respected (%)	Gender identity very/ extremely respected (%)
Medical clinic that caters only to lesbian, gay, bisexual, trans and/or intersex people	94.8	89.4
Mental health service that caters only to lesbian, gay, bisexual, trans and/or intersex people	93.5	87.2
Mainstream mental health service that is known to be LGBTIQ-inclusive	91.7	79.8
Mainstream medical clinic that is known to be LGBTIQ-inclusive	89.0	76.2
Allied health service (e.g., physiotherapist, osteopath)	74.4	55.1
Mainstream mental health service (e.g., psychologist, counsellor)	72.4	52.9
Hospital	55.1	34.0
Mainstream medical clinic	57.5	33.6

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

Although mainstream medical clinics were the most frequently accessed health service in the past 12 months, they had the lowest proportion of participants who felt that their sexual orientation or gender identity was very/extremely respected (57.5% and 33.6% respectively). The proportion of participants who felt very/extremely respected was higher for those who attended a medical clinic that caters only to lesbian, gay, bisexual, trans and/or intersex people or a mainstream medical clinic that is known to be LGBTIQ-inclusive. Overall, participants reported that they felt their gender identity was respected less frequently than their sexual orientation across all health services. Of particular note is that only one-third of trans and gender diverse participants reported feeling that their gender identity was very/extremely respected at a mainstream medical clinic (33.6%, n = 136) or hospital (34.0%, n = 66) in the past 12 months.

9.4 Preferences for accessing health or support services in the future

When asked where participants would prefer to access health or support services in the future, 45.2% (n = 1,053) reported 'from a mainstream health or support service that is LGBTIQ inclusive', 24.2% (n = 570) 'from a health or support service that caters only to lesbian, gay, bisexual, trans and/or intersex people' and 30.4% (n = 709) 'I have no preference'.

Participants were asked, 'How important is it to you that a health service or support service you use is known to be LGBTIQ-inclusive?' and responded on a 5-point scale from 'not important at all' to 'extremely important'. Two-thirds (66.4%; n = 1,547) of participants responded, 'very important' or 'extremely important'.

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

Finally, participants were asked if they would be more likely to use a service that has been accredited as LGBTIQ-inclusive. Over three-quarters (76.8%; n = 1,790) responded that they would be more likely to use a service that has been accredited as LGBTIQ-inclusive, 5.4% (n = 125) responded that they would not be more likely to use a service that has been accredited as LGBTIQ-inclusive and 17.8% (n = 416) had no preference.

10 Alcohol, tobacco and other drug use

Australian and international research suggests that LGBTQ people tend to use alcohol and other drugs (AOD) two to four times more than heterosexual people (Green & Feinstein, 2012; Leonard et al., 2012; Roxburgh et al., 2016; Smith et al., 1999). For example, the Australian Institute of Health and Welfare's *National Drug Strategy Household Survey* conducted in 2016 observed that 'homosexual' and bisexual people in Australia were 3.2 times as likely to use cannabis, 5.8 times as likely to use ecstasy and 3.7 times as likely to use cocaine when compared to heterosexual people (Australian Institute of Health and Welfare, 2017). Longitudinal analysis of this household survey also shows that while rates of smoking have been decreasing overall, this is not true of some sections of the LGBTQ community, especially lesbian and bisexual women (Praeger et al., 2019). Questions on AOD use and smoking were included in *Private Lives 3*.

10.1 Smoking status

Participants were asked if they smoked cigarettes or any other tobacco product.

Table 23: Proportion of current smokers (n = 2,331)

Smoke cigarettes or other tobacco product	Number	%
No, I have never smoked	1,240	53.2
No, I used to smoke but I no longer smoke	623	26.7
Yes, I smoke less often than weekly	139	6.0
Yes, I smoke at least weekly (but not daily)	71	3.1
Yes, I smoke daily	258	11.1

One in five (20.1%) participants in Victoria were current smokers and one-quarter (26.7%) were ex-smokers. This compares to 16.7% current smokers and 24.4% ex-smokers in the general Victorian population (Australian Bureau of Statistics, 2016).

Approximately one in ten participants (11.1%) were daily smokers and 9.1% occasional smokers, compared to 12.4% daily smokers and 4.3% occasional smokers in the general Victorian population (Australian Bureau of Statistics, 2016).

Almost one in seven (13.4%; n = 311) participants reported having ever used e-cigarettes. One in twenty (6.1%; n = 141) reported currently using e-cigarettes and 7.3% (n = 170) reported no longer using them. This is higher than the 8.8% of people reporting having ever used e-cigarettes, 1.2% currently using them and 1.6% no longer using them in the general Australian population (Australian Institute of Health and Welfare, 2016a).

10.2 Alcohol

10.2.1 Alcohol consumption

Participants were asked how frequently they consumed alcohol. Table 24 displays these results.

Table 24: Frequency of alcohol consumption (n = 2,322)

Alcohol consumption	Number	%
Never	293	12.6
Monthly or less	585	25.1
2-4 times per month	643	27.6
2-3 times per week	476	20.4
4 or more times a week	335	14.4

The majority (87.4%) of participants reported drinking alcohol, compared to 78.2% in the general Victorian population (Victorian Department of Health and Human Services, 2017). One-quarter (25.1%) reported drinking alcohol monthly or less, 27.6% 2-4 times per month, 20.4% 2-3 times per week and 14.4% four or more times per week.

Over one-quarter (27.8%; n = 603) of participants reported drinking more than two standard drinks per day on average, exceeding the 2009 National Health and Medical Research Council (NHMRC) guidelines for lifetime health risks associated with the consumption of alcohol, defined as 'drinking no more than two standard drinks a day'. This is markedly higher than in the general population aged 18 years and over, where 16.1% exceed two standard drinks per day (Australian Bureau of Statistics, 2018d).

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

Table 25: Frequency of consumption of six or more drinks on one occasion (n = 2,036)

How often do you have six or more drinks on one occasion?	Number	%
Never	588	28.9
Less than monthly	833	40.9
Monthly	322	15.8
Weekly	254	12.5
Daily or almost daily	39	1.9

Of participants who reported drinking alcohol, 71.1% (n = 1,448) reported engaging in 'risky' drinking. One in three (30.2%; n = 615) reported engaging in risky drinking monthly, 12.5% (n = 254) weekly and 1.9% (n = 39) daily.

10.2.2 Managing alcohol consumption and professional support

Almost one in five (17.9%; n = 365) participants reported experiencing a time in the past 12 months when they had struggled to manage their alcohol use or a time where it negatively impacted their everyday life.

Of those who reported struggling to manage their alcohol use in the past 12 months, 21.1% (n = 77) reported seeking professional support for their alcohol use at some time during this period.

Among participants who had sought professional support for their alcohol use in the past 12 months, 68.8% (n = 53) sought support from a mainstream service, 31.2% (n = 24) from a mainstream service that was known to be LGBTIQ-inclusive and 11.7% (n = 9) from a service that caters only to lesbian, gay, bisexual, trans and/or intersex people.

Participants who had sought professional support for their alcohol use in the past 12 months (n = 77) were asked to rate how satisfied they were with the support services they had used. Response options included a 5-point scale ranging from very dissatisfied to very satisfied. Slightly over half (55.8%; n = 29) reported that they were 'somewhat satisfied' or 'very satisfied' with a mainstream service, almost three-quarters (70.9%; n = 17) were 'somewhat satisfied' or 'very satisfied' with a mainstream service known to be LGBTIQ-inclusive and about two-thirds (66.6%; n = 6) were 'somewhat satisfied' or 'very satisfied' with a service that caters only to lesbian, gay, bisexual, trans and/or intersex people. However, it needs to be noted that due to the relatively low number of participants in Victoria who reported using a professional support service for their alcohol use in the past 12 months, these data on satisfaction with services should be interpreted with caution.

10.3 Future support service preferences

Participants were asked if they were to ever need help from a support service in relation to alcohol use in the future, where they would prefer to receive it. Table 26 displays these results.

Table 26: Future support preference for concerns regarding alcohol support (n = 2,323)

Future alcohol support service preference	Number	%
From a mainstream service	277	11.9
From a mainstream service that is known to be LGBTIQ inclusive	734	31.6
From a service that caters only to lesbian, gay, bisexual, trans and/or intersex people	281	12.1
I don't know	468	20.1
I have no preference	563	24.2

Almost a third (31.6%; n = 734) reported that they would prefer support 'from a mainstream alcohol support service that is LGBTIQ-inclusive', 12.1% (n = 281) 'from a service that caters only to lesbian, gay, bisexual, trans and/or intersex people' and 11.9% (n = 277) 'from a mainstream service'. It is notable that 44.3% (n = 1,031) reported not knowing or not having a preference.

Among participants who reported experiencing a time when they had struggled to manage their alcohol use or a time where it negatively impacted their everyday life in the past 12 months, a third (32.8%; n = 120) reported that they would prefer support 'from a mainstream service that is LGBTIQ-inclusive', 17.8% (n = 65) 'from a service that caters only to lesbian, gay, bisexual, trans and/or intersex people' and 10.7% (n = 39) 'from a mainstream service'. A further 38.6% (n = 141) reported not knowing or not having a preference.

10.4 Drug use

Participants were presented with a range of drugs and asked which, if any, they had used for non-medical purposes in the past 6 months. A 6-month time frame was specified because shorter time frames have been observed to have more reliable recall about drug use (Janssen et al., 2017). Table 27 displays these results.

Table 27: Drug use (not prescribed by doctor) in the past 6 months (n = 2,162)

Drug use in past 6 months	Number	%
Cannabis	689	31.9
Ecstasy/MDMA	339	15.7
Cocaine	253	11.7
Benzodiazepines (e.g., Valium, Serepax, Xanax)	212	9.8
Ketamine (Special K)	153	7.1
LSD/synthetic hallucinogens/Psilocybin/PCP	131	6.1
Pharmaceutical opioids	121	5.6
Meth/amphetamine	112	5.2
Naturally occurring hallucinogens	108	5.0
Pharmaceutical stimulants (e.g., Ritalin)	96	4.4
Nitrous oxide	91	4.2
Antidepressants	83	3.8
GHB/GBL/1,4-BD (Liquid e)	32	1.5
Antipsychotics	18	0.8
Heroin (including homebake)	11	0.5
Steroids	7	0.3
Synthetic cannabis	4	0.2
Mephedrone	2	0.1
Other drug	25	1.2
Any drug use other than alcohol[2]	993	45.9

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

Almost half (45.9%; n = 993) of participants reported using one or more drugs for non-medical purposes in the past 6 months. The most frequently reported drugs were cannabis (31.9%; n = 689), followed by ecstasy/MDMA (15.7%; n = 339) and cocaine (11.7%; n = 253). A further 13.6% (n = 294) of participants reported using amyl nitrate/alkyl nitrite in the past 6 months.

Although participants were asked about their drug use in the past 6 months, rates of drug use were similar to some other studies of drug use among LGBTQ Australians in the past 12 months. For example, in the national sample of *Private Lives 2*, 24.2% of participants reported using cannabis, 12.3% ecstasy and 7.1% cocaine in the past 12 months. In the general population aged over 14 years, 12.9% reported using cannabis, 2.2% reported using ecstasy and 2.5% reported using cocaine in the past 12 months (Leonard et al., 2012).

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

Drug use was higher among participants in *Private Lives 3* than the general Australian population, among whom the most commonly used illegal drugs that were used at least once in the past 12 months were cannabis (10.4%), followed by cocaine (2.5%), ecstasy (2.2%) and meth/amphetamines (1.4%) (Australian Institute of Health and Welfare, 2017). Trends in drug use among participants in *Private Lives 3* were somewhat reflected by findings in the Australian Institute of Health and Welfare's *National Drug Strategy Household Survey* conducted in 2016 in which 31% of lesbian, gay and bisexual participants reported using cannabis, 8.9% had used cocaine and approximately 12% had used ecstasy in the past 12 months (Australian Institute of Health and Welfare, 2017).

10.4.1 Managing drug use and professional support

Participants who reported using drugs (n = 993) in the past 6 months were asked if they experienced a time where they had struggled to manage their drug use or where it negatively impacted their everyday life. In interpreting the meaning of this question, participants may have drawn upon prior experience managing their drug use as well as other experiences that have had a negative impact on their everyday life. These might include issues such as the financial impacts of drug acquisition or drug-related investigations or prosecution by the police. Almost one in seven (14.2%; n = 141) reported that it had. Of the more frequently used drugs in the past 6 months, 17.4% (n = 120) of participants who reported using cannabis, 21.0% (n = 53) who reported using cocaine, 20.7% (n = 70) who reported using ecstasy, 35.7% (n = 40) who reported using meth/amphetamines and 43.8% (n = 14) who reported using GHB also reported having experienced a time where they had struggled to manage their drug use or where it negatively impacted their everyday life in the past 6 months.

10.5 Future support preferences

Participants were asked, if they were to ever need help from a support service in relation to their drug use in the future, where they would prefer to receive it. Table 28 displays these results.

Table 28: Future support preference for concerns regarding drug use (n = 2,322)

Future drug support service preference	Number	%
From a mainstream service	250	10.8
From a mainstream service that is known to be LGBTIQ-inclusive	726	31.3
From a service that caters only to lesbian, gay, bisexual, trans and/or intersex people	330	14.2
I don't know	434	18.7
I have no preference	582	25.1

Almost one-third of participants (31.3%; n = 726) reported that they would prefer support 'from a mainstream service that is LGBTIQ-inclusive', 14.2% 'from a service that caters only to lesbian, gay, bisexual, trans and/or intersex people' and 10.8% 'from a mainstream service'. A further 43.8% reported not knowing or not having a preference.

Among participants who reported experiencing a time when they struggled to manage their drug use or where it negatively impacted their everyday life in the past 6 months, three in ten (32.6%; n = 46) reported that they would prefer support 'from a mainstream service that is LGBTIQ-inclusive', one-quarter (26.2%; n = 37) 'from a service that caters only to lesbian, gay, bisexual, trans and/or intersex people' and 7.8% (n = 11) 'from a mainstream service'. A further 33.3% (n = 47) reported not knowing or not having a preference.

11 Intimate partner and family violence

LGBTQ people can face abuse and violence across their lifespan due to the various effects of stigma, discrimination and prejudice. For this reason, LGBTQ people may experience a range of unique circumstances where they are subject to violence that may not be experienced by other groups, such as rejection or abuse after 'coming out' to family members (Asquith & Fox, 2016; D'augelli et al., 2008; Ryan et al., 2009). There has been little research in Australia on the experiences of intimate partner or family violence among LGBTQ people. The *Private Lives 3* survey asked several questions on this topic and in this chapter we present the results from the Victorian sample.

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

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

11.1 Experiences of intimate partner and family violence

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

Private Lives 3 participants were asked, 'have you ever been in an intimate relationship where you felt you were abused in some way by your partner/s? (intimate relationships may be either sexual or not sexual in nature)' and 'have you ever felt you were abused in some way by a family member/s? (family includes both birth and chosen family)'. It is important to note that results from these questions are based on ever having experienced violence rather than from within a specific time frame. Tables 29 and 30 display these results.

Table 29: Proportion of participants reporting ever being in an intimate relationship where they felt they were abused in some way by their partner/s (n = 2,328)

Intimate partner violence	Number	%
No	1,262	54.2
Yes, once	663	28.5
Yes, in more than one relationship	336	14.4
Don't know/not sure	67	2.9

More than four in ten (42.9%; n = 999) *Private Lives 3* participants in Victoria reported ever being in an intimate relationship where they felt they were abused in some way by their partner/s. Over one-quarter (28.5%; n = 663) of participants reported being in an intimate relationship where they felt they were abused in some way by their partner/s once, while 14.4% (n = 336) participants reported being in more than one intimate relationship where they felt they were abused in some way by their partner/s.

Table 30: Proportion of participants reporting ever feeling abused by a family member (n = 2,328)

Family violence	Number	%
No	1,335	57.4
Yes, by one family member	485	20.8
Yes, by more than one family member	402	17.3
Don't know/not sure	106	4.6

Almost four in ten (38.1%; n = 887) participants reported ever feeling abused by a family member (family includes both birth and chosen family). One-fifth (20.8%; n = 485) reported ever feeling abused by one family member, while 17.3% (n = 402) participants reported ever feeling abused by more than one family member.

11.2 Forms of intimate partner and family violence experienced

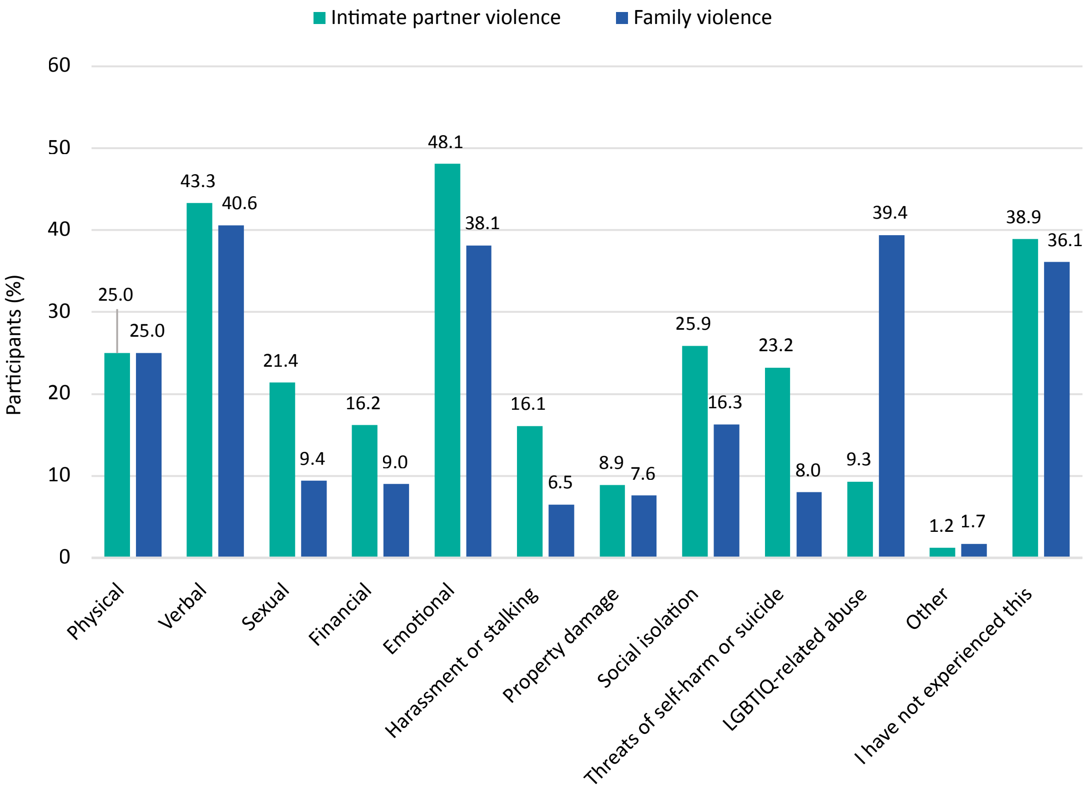
There are no generally agreed or accepted standards for defining what constitutes intimate partner or family violence in Australia (Australian Bureau of Statistics, 2017d). To gain as comprehensive a picture as possible, *Private Lives 3* participants were asked to report on whether they had ever experienced one or more different forms of violence from intimate partners or family members from the list shown below.

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

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

Figure 9 displays these results.

Figure 9: Proportion of participants ever experiencing violence from an intimate partner (n = 2,108) or family member (n = 2,109)



As shown in Figure 9, when asked to report on specific forms of violence, six in ten (61.1%; n = 1,288) *Private Lives 3* participants in Victoria reported ever experiencing intimate partner violence. More than half (50.7%; n = 1,070) reported ever experiencing verbal, physical or sexual intimate partner violence. Emotional abuse (48.1%; n = 1,014) was the most commonly reported form of intimate partner violence, followed by verbal abuse (43.3%; n = 914), physical violence (25.0%; n = 527) and sexual assault (21.4%; n = 451).

More than six in ten (63.9%; n = 1,347) participants reported ever experiencing family violence. More than two in five (45.2%; n = 952) reported ever experiencing verbal, physical or sexual violence from a family member. Verbal abuse (40.6%; n = 855) was the most commonly reported form of family violence, followed by LGBTIQ-related abuse (39.4%; n = 830), emotional abuse (38.1%; n = 803), physical violence (25.0%; n = 526) and sexual assault (9.4%; n = 197). A greater proportion of participants reported ever experiencing sexual assault from an intimate partner (21.4%; n = 451) than from a family member (9.4%; n = 197).

It is notable that the proportions of participants who reported having ever experienced intimate partner or family violence were higher than in previous studies. This is likely due to *Private Lives 3* having provided a comprehensive list of different forms of violence as response items. These items were developed to measure a more diverse range of forms of violence and utilise more inclusive definitions of family and partners that better reflect the diverse communities or *Private Lives 3* than other surveys in Australia. This approach may have gone some way towards helping to address previous literature that has observed differing levels of self-identified intimate partner violence and subsequent under-reporting (Caetano et al., 2009; Gracia, 2004; Roller et al., 2016).

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

11.3 Perpetrators of intimate partner violence

Participants who reported having ever experienced violence from an intimate partner (n = 1,288) were asked 'in the most recent relationship where you experienced this, how did your partner/s describe their gender?' Over half (55.6%; n = 718) of *Private Lives 3* participants in Victoria reported 'cisgender man', 37.8% (n = 488) reported 'cisgender woman', 3.6% (n = 47) 'non-binary', 2.4% (n = 31) 'trans woman', 1.9% (n = 25) 'trans man', 1.6% (n = 20) 'something else' and 0.8% (n = 10) 'prefer not to say'.

11.4 Perpetrators of family violence

Participants who reported having ever experienced family violence (n = 952) were asked to select 'the relation the family member/s had to you at the most recent time this occurred'. Over three-quarters (77.0%; n = 730) of *Private Lives 3* participants in Victoria responded 'parent', 19.2% (n = 182) 'older sibling', 12.2% (n = 116) 'younger sibling', 17.1% (n = 162) 'extended family member', 5.1% (n = 48) 'in-laws', 0.6% (n = 6) 'child or grandchild', 3.6% (n = 34) 'other family member/s' and 2.6% (n = 25) 'prefer not to say'.

11.5 Experiences related to being LGBTIQ

Participants who reported having ever experienced violence from an intimate partner or family member (n = 1,750) were asked, 'Do you feel you were targeted for this abuse because of your sexual orientation, gender identity and/or gender expression, or intersex variation/s?' Four in ten (41.7%; n = 568) responded 'yes', 41.3% (n = 563) responded 'no' and 17.0% (n = 232) responded 'not sure'.

11.6 Reporting violence and experiences of support

Participants who reported having ever experienced violence from an intimate partner or family member (n = 1,750) were asked whether they had reported the most recent instance in which this occurred to a professional service, such as the police, doctor or domestic or family violence service. Those who indicated that they had reported it to a particular service were also asked whether or not they felt supported by that service. Table 31 displays these results.

Table 31: Service to which intimate partner or family violence was reported the most recent time it occurred and proportion reporting feeling supported (n = 1,606)

Service to which assault was reported the most recent time	Number	%	Felt supported (%)
Counselling service or psychologist	298	18.6	87.8
Police (including LGBTIQ liaison officers)	99	6.2	40.8
Doctor or hospital	65	4.1	65.6
Lawyer, legal service, court system	47	2.9	51.1
Telephone helpline	41	2.6	63.1
Domestic or family violence service	36	2.2	65.7
Employer	35	2.2	60.0
Teacher or educational institution	23	1.4	81.8
Sexual assault service	19	1.2	79.0
LGBTIQ organisation	9	0.6	66.7
Religious or spiritual community leader or elder	6	0.4	66.7
Other	67	4.2	76.2

Of participants (n = 1,750) who reported having ever experienced family or intimate partner violence, one-quarter (26.9%; n = 432) said that they reported the incident at the most recent time in which this occurred. This is somewhat consistent with some previous research in which 36% of female victims of physical assault and 19% of female victims of sexual assault reported it (Australian Bureau of Statistics, 2017d).

Almost one-fifth (18.6%; n = 298) of participants reported the most recent incident to a counselling service or psychologist, followed by 6.2% (n = 99) to the police and 4.1% (n = 65) to a doctor or hospital. Few (0.6%; n = 9) participants reported the incident to an LGBTIQ organisation. Participants reported feeling most supported by a counselling service or psychologist (87.8%; n = 260) and least supported by police (including LGBTIQ liaison officers) (40.8%; n = 40).

11.7 Preferences for future support

All participants (n = 2,316) were asked where they would prefer to access support services if they ever experienced intimate partner or family violence in the future. Just over one-third (35.2%; n = 814) reported 'from a mainstream domestic violence service that is LGBTIQ-inclusive', 24.1% (n = 558) 'from a domestic violence service that caters only to lesbian, gay, bisexual, trans and/or intersex people', 4.7% (n = 110) from 'a mainstream domestic violence service', 20.3% (n = 469) 'did not know' and 15.8% (n = 365) had 'no preference.'

11.8 Experiences of sexual assault

Participants were asked if 'anyone ever coerced or forced you into sexual acts you did not want to engage in?' This included such things as kissing, touching, sexual intercourse or being forced to watch pornography or sexual acts. Almost half (49.7%; n = 1,158) reported having ever been coerced or forced into sexual acts they did not want to engage in and 8.3% (n = 193) in the past 12 months.

Participants were then asked who perpetrated the sexual assault at the most recent time in which this occurred. Table 32 displays these results.

Table 32: Relation of sexual assault perpetrator to participants (n = 1,155)

Sexual assault perpetrator	Number	%
Former intimate partner	260	22.5
Casual encounter (e.g., a hook-up)	230	19.9
Intimate partner	226	19.6
Stranger	221	19.1
Friend	209	18.1
Another family member	48	4.2
Parent or guardian	32	2.8
A co-worker or boss	29	2.5
Family-like relation	25	2.2
Sibling	23	2.0
A sex work client	21	1.8
Someone in a professional setting	17	1.5
Someone else	65	5.6
Prefer not to say	19	1.7

For the most recent time in which it occurred, sexual assault was most commonly reported as perpetrated by former intimate partners (22.5%; n = 260), casual encounters (19.9%; n = 230), intimate partners (19.6%; n = 226), strangers (19.1%; n = 221) and friends (18.1%; n = 209).

When asked about the gender of the perpetrator of sexual assault in which this most recently occurred, a cisgender man (84.7%; n = 942) was most frequently reported, followed by cisgender woman (14.0%; n = 156), non-binary person (2.2%; n = 24), trans woman (1.3%; n = 14) and trans man (1.0%; n = 11).

12 Disability or long-term health condition

The *Private Lives 3* survey used the Australian Institute of Health and Welfare Standardised Disability Flag Module (SDFM) (Australian Institute of Health and Welfare, 2016b) to identify individuals with a long-term health condition or disability (defined as someone who reports an activity limitation, a specific education participation restriction and/or a specific employment participation restriction). The SDFM is based on the International Classification of Functioning, Disability and Health, a classification of health domains put forward by the World Health Organisation. It is intended for use across a wide range of sectors, enabling nationally consistent collection of information used to identify people with disabilities or long-term health conditions who experience difficulties or need assistance in various areas of their life.

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

In total, almost four in ten (38.1%; n = 889) participants reported having a disability or long-term health condition. One in ten (10.6%; n = 212) reported a profound or severe disability, 20.6% (n = 480) a moderate disability and 6.9% (n = 161) a mild disability. It is notable that there was a higher proportion of people reporting a disability in this study than in the national sample of *Private Lives 2* (22.7%) and the general Australian population (17.7%) (Australian Bureau of Statistics, 2019c). This is likely to arise because the SDFM was designed as a more inclusive and comprehensive measure of disability or long-term health condition than those used in *Private Lives 2* or the ABS and includes questions regarding difficulties with personal relationships, managing tasks and situations and community life. While one of its strengths is a focus on individuals self-reporting their circumstances rather than relying on a medical diagnosis, it is important to note its limitations. The SDFM is a quantitative tool used to categorise a disability or long-term health condition according to how participants report its impact on aspects of their lives but this may not be how these participants would describe their own disability in a qualitative study. As such, it may not accurately reflect or correspond with how structural and systemic barriers influence, impact or cause some of the limitations and restrictions reported by people with disabilities or long-term health conditions through the SDFM. It has further limitations in accessibility for people with intellectual disability both in its usability for this cohort as well as access barriers regarding guardianship and assumptions of cognitive capacity and consent made by gatekeepers in their lives that may limit people with intellectual disability responding to a survey such as *Private Lives 3*.

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

12.1 Community belonging

Participants were asked the extent to which 'you feel you're a part of the Australian LGBTIQ community' and 'participating in Australia's LGBTIQ community is a positive thing for you', with response options provided on a 5-point scale ranging from 'strongly disagree' to strongly agree'. Tables 33 and 34 display these results for participants who reported having a disability or long-term health condition.

Table 33: You feel you're part of Australia's LGBTIQ community according to disability or long-term health condition (n = 2,221)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Do not agree	504	37.8	61	37.9	207	43.2	113	45.7
Agree/strongly agree	830	62.2	100	62.1	272	56.8	134	54.3

Lower proportions of participants reporting a severe (54.3%; n = 134) or moderate (56.8%; n = 272) disability or long-term health condition reported that they 'agree' or 'strongly agree' that they feel a part of the Australian LGBTIQ community compared to 62.2% (n = 830) of participants not reporting a disability or long-term health condition and those who reported a mild disability or long-term health condition (62.1%; n = 100).

Table 34: Participating in Australia's LGBTIQ community is a positive thing for you according to disability or long-term health condition (n = 2,219)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Do not agree	483	36.2	53	32.9	184	38.4	100	40.8
Agree/strongly agree	851	63.8	108	67.1	295	61.6	145	59.2

A greater proportion of participants reporting a mild disability or long-term health condition (67.1%; n = 108), but a lower proportion of those reporting a severe (59.2%; n = 145) or moderate (61.6%; n = 295) disability or long-term health condition, reported that they 'agree' or 'strongly agree' that participating in Australia's LGBTIQ community is a positive thing for them compared to those not reporting a disability or long-term health condition (63.8%; n = 851).

12.2 Feelings of acceptance

Table 35 displays the numbers and percentages of participants reporting a disability or long-term health condition in the Victorian *Private Lives 3* sample who felt they were accepted 'a lot' or 'always' in a range of situations.

Table 35: Currently feel accepted 'a lot' or 'always' according to disability or long-term health condition

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
LGBTIQ event	828	69.9	98	66.2	251	61.1	121	59.0
LGBTIQ venue	817	70.0	94	64.4	239	58.9	115	58.4
At work	811	69.4	76	57.6	166	48.0	60	42.0
At an educational institution	517	64.5	53	54.6	146	47.1	61	39.9
With family members	765	59.2	85	53.5	214	45.8	77	32.9
LGBTIQ dating app or website	449	58.6	40	44.0	124	44.6	51	40.8
Accessing a health or support service	622	50.5	60	39.0	139	31.7	64	27.4
Social/community events	518	41.7	52	34.2	110	25.8	44	19.6
In public (e.g., in the street/park)	445	34.7	51	33.1	97	21.7	42	18.2
Mainstream venue	427	34.0	44	28.6	82	18.9	39	18.2
Mainstream event	427	34.3	41	27.3	78	18.1	37	17.1
Non-LGBTIQ dating app or website	149	27.5	12	16.2	37	14.6	17	13.9
Religious/faith-based events or services	71	10.9	11	13.9	21	8.9	15	11.6

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

Overall, the proportions of *Private Lives 3* participants in Victoria reporting a disability or long-term health condition who felt accepted 'a lot' or 'always' were lower than among participants not reporting a disability or long-term health condition.

More than three times the proportion of participants reporting a severe disability or long-term health condition reported feeling accepted 'a lot' or 'always' at an LGBTIQ event (59.0%; n = 121) or venue (58.4%; n = 115) than at a mainstream venue (18.2%; n = 39) or mainstream event (17.1%; n = 37).

Only around one-quarter (27.4%; n = 64) of participants reporting a severe disability or long-term health condition felt accepted ‘a lot’ or ‘always’ when accessing a health or support service compared to one-half (50.5%; n = 622) of participants not reporting a disability or long-term health condition.

12.3 Self-rated health

Participants were asked to rate their health on a 5-point scale from ‘poor’ to ‘excellent’. Table 36 displays these results according to disability or long-term health condition.

Table 36: Self-rated health according to disability or long-term health condition (n = 2,207)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Poor	26	2.0	12	7.5	56	11.7	59	24.1
Fair	166	12.5	48	30.2	161	33.6	89	36.3
Good	503	38.0	60	37.7	183	38.2	73	29.8
Very good	477	36.0	35	22.0	66	13.8	21	8.6
Excellent	152	11.5	4	2.5	13	2.7	3	1.2

Six in ten (60.4%; n = 148) participants reporting a severe disability or long-term health condition rated their health as ‘poor’ or ‘fair’, followed by 45.3% (n = 217) reporting a moderate disability or long-term health condition and 37.7% (n = 60) of participants reporting a mild disability or long-term health condition. This compared to 14.5% (n = 192) of participants not reporting a disability or long-term health condition and one-fifth (20.3%) of the general Victorian population (Victorian Department of Health and Human Services, 2017).

12.4 Mental health diagnoses

Participants were asked if they had ever been diagnosed or treated for a mental health condition in the past 12 months. Table 37 displays these results according to disability or long-term health condition.

Table 37: Diagnosed or treated for a mental health condition in the past 12 months according to disability or long-term health condition (n = 2,207)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Depression	298	23.7	94	59.5	266	55.6	158	63.7
Generalised anxiety disorder	247	19.7	70	44.3	229	47.9	144	58.1
Any mental health condition	425	33.8	117	74.1	352	73.6	201	81.0

More than four in five (81.0%; n = 201) participants reporting a severe disability or long-term health condition had been diagnosed or treated for a mental health condition in the past 12 months, followed by 73.6% (n = 352) reporting a moderate disability or long-term health condition, 74.1% (n = 117) reporting a mild disability or long-term health condition and 33.8% (n = 425) of participants not reporting a disability or long-term health condition.

Almost three times (63.7%; n = 158) the proportion of participants reporting a severe disability or long-term health condition and more than twice the proportion of participants reporting a moderate (55.6%; n = 266) or mild (59.5%; n = 94) disability or long-term health condition had been diagnosed or treated for a mental health condition in the past 12 months than participants not reporting a disability or long-term health condition (23.7%; n = 298).

12.5 Psychological distress (K10) and mental health service access

Table 38 displays the K10 psychological distress levels of participants according to disability or long-term health condition.

Table 38: Low, moderate, high and very high psychological distress according to disability or long-term health condition (n = 2,164)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
Low	403	31.0	26	16.5	29	6.2	13	5.5
Moderate	399	30.7	35	22.2	79	16.9	25	10.5
High	325	25.0	45	28.5	167	35.7	69	29.0
Very high	173	13.3	52	32.9	193	41.2	131	55.0

More than four in five (84.0%; n = 200) participants reporting a severe disability or long-term health condition, three in four (76.2%; n = 360) reporting a moderate disability or long-term health condition and 61.4% (n = 97) reporting a mild disability or long-term health condition reported high or very high levels of psychological distress. This compared to 38.3% (n = 498) of participants not reporting a disability or long-term health condition and 15.4% among the general Victorian population (Australian Bureau of Statistics, 2016).

12.6 Experiences of health services among participants reporting psychological distress

Table 39 displays the proportion of participants who accessed a mental health service in the past 12 months among those that reported high or very high levels of psychological distress and a disability or long-term health condition.

Table 39: Mental health service access in the past 12 months among participants reporting high or very high levels of psychological distress according to disability or long-term health condition (n = 1,155)

Disability	None		Mild		Moderate		Severe	
	Number	%	Number	%	Number	%	Number	%
No, not accessed	253	50.8	28	28.9	105	29.3	39	19.4
Yes, accessed	245	49.2	69	71.1	254	70.7	162	80.6

A higher proportion of participants who reported high or very high levels of psychological distress reporting a severe (80.6%; n = 162), moderate (70.7%; n = 254) or mild (71.1%; n = 69) disability or long-term health condition accessed a mental health service than those not reporting a disability or long-term health condition (49.2%; n = 245).

12.7 Suicidal ideation and suicide attempts

Tables 40 and 41 display the responses to questions regarding experiences of *suicidal ideation*, defined as 'thoughts about suicide, wanting to die, or about ending your life' and *suicide attempts*, defined as having 'attempted suicide or to end your life'. Note, participants who skipped the section by indicating 'I prefer not to answer these questions' and those who selected 'prefer not to answer' for a particular question were combined to form a single category of 'prefer not to say' (see Section 8.3 for further information).

Table 40: Suicidal ideation in the past 12 months or ever according to disability or long-term health condition (n = 2,211)

Disability	None		Mild		Moderate		Severe	
	Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Past 12 months	357	26.9	72	45.6	282	58.8	172	69.4
Ever	827	62.4	134	84.8	421	87.7	225	90.7
Prefer not to say	19	1.5	4	2.6	11	2.3	7	1.0

Seven in ten (69.4%; n = 172) participants reporting a severe disability or long-term health condition, 58.8% (n = 282) of participants reporting a moderate disability or long-term health condition and 45.6% (n = 72) of participants reporting a mild disability or long-term health condition reported having experienced suicidal ideation in the past 12 months. This compared to 26.9% (n = 357) of participants not reporting a disability or long-term health condition and 2.3% among the general Australian population (Johnston et al., 2009).

More than nine in ten (90.7%; n = 225) participants reporting a severe disability or long-term health condition, 87.7% (n = 421) of participants reporting a moderate disability or long-term health condition and 84.8% (n = 134) of participants reporting a mild disability or long-term health condition reported having ever experienced suicidal ideation. This compared to 62.4% (n = 827) of participants not reporting a disability or long-term health condition and 13.3% among the general Australian population (Johnston et al., 2009).

Table 41: Suicide attempt in the past 12 months or ever according to disability or long-term health condition (n =1,712)

Disability	None		Mild		Moderate		Severe	
	Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Past 12 months	23	2.3	2	1.7	23	5.8	27	12.0
Ever	194	20.0	34	29.0	167	42.0	94	43.0
Prefer not to say	32	4.1	10	8.5	25	6.3	10	4.6

More than one in ten (12.0%; n = 27) participants reporting a severe disability or long-term health condition, 5.8% (n = 23) of participants reporting a moderate disability or long-term health condition and 1.7% (n = 2) of participants reporting a mild disability or long-term health condition reported having attempted suicide in the past 12 months. This compared to 2.3% (n = 23) of participants not reporting a disability or long-term health condition and 0.4% among the general Australian population (Johnston et al., 2009).

More than four in ten (43.0%; n = 94) participants reporting a severe disability or long-term health condition, 42.0% (n = 167) of participants reporting a moderate disability or long-term health condition and 29.0% (n = 34) of participants reporting a mild disability or long-term health condition reported having ever attempted suicide. This compared to 20.0% (n = 194) of participants not reporting a disability or long-term health condition and 3.2% among the general Australian population (Johnston et al., 2009).

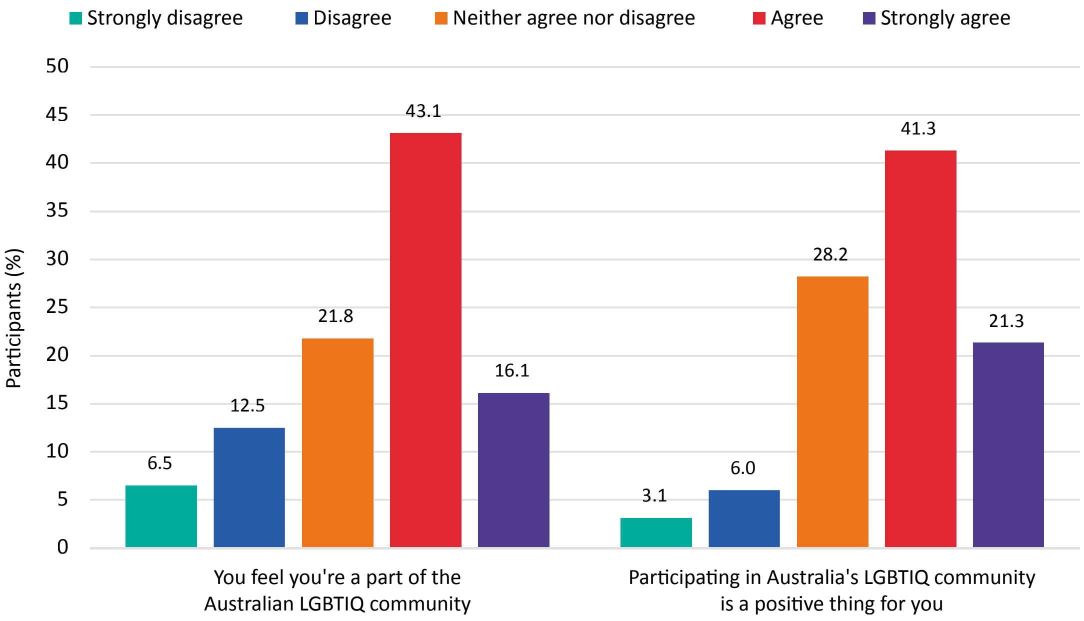
13 Community connection

13.1 Community belonging

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

Participants were then asked the extent to which 'you feel you're a part of the Australian LGBTIQ community' and 'participating in Australia's LGBTIQ community is a positive thing for you', with response options provided on a 5-point scale ranging from 'strongly disagree' to strongly agree'. Figure 10 displays these results.

Figure 10: Feelings about participating in Australia's LGBTIQ community (n = 2,326) and feeling part of the LGBTIQ community (n = 2,328)



Almost six in ten (59.2%; n = 1,379) participants reported that they 'agree' or 'strongly agree' that they feel a part of the Australian LGBTIQ community. More than six in ten (62.6%; n = 1,457) reported that they 'agree' or 'strongly agree' that participating in Australia's LGBTIQ community is a positive thing for them.

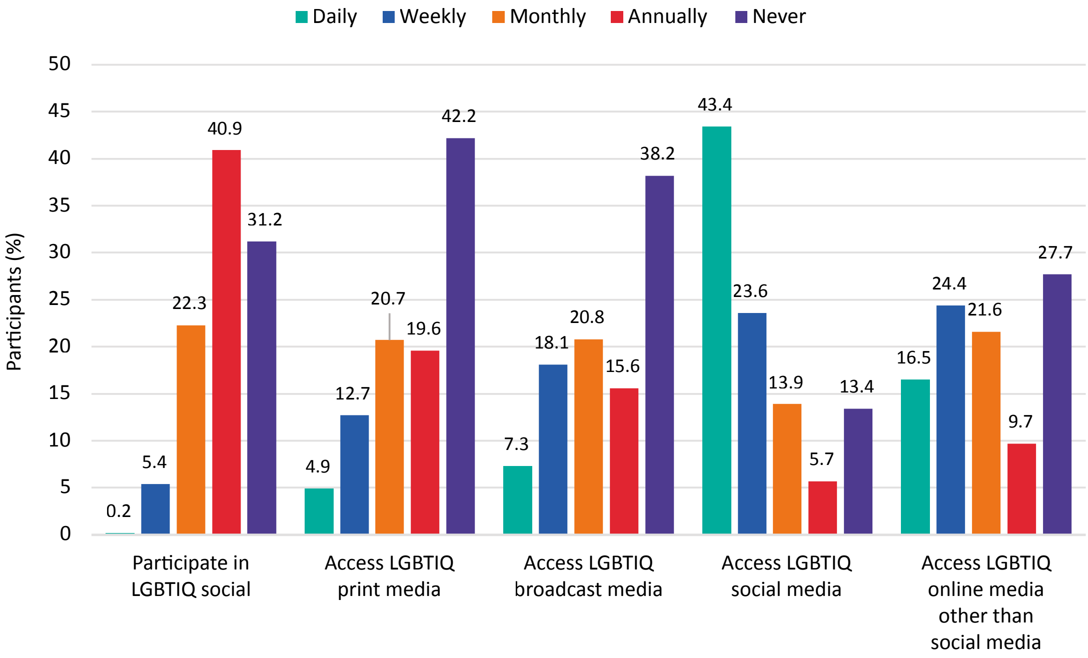
A greater proportion (70.9%; n = 246) of non-binary participants reported that they 'agree' or 'strongly agree' that they feel a part of the Australian LGBTIQ community compared to 55.5% (n = 422) of cisgender men, 58.6% (n = 616) of cisgender women, 53.4% (n = 39) of trans men and 60.7% (n = 51) of transwomen.

Similarly, a greater proportion (71.0%; n = 247) of non-binary participants reported that they 'agree' or 'strongly agree' that participating in Australia's LGBTIQ community is a positive thing for them compared to 55.8% (n = 424) of cisgender men, 67.3% (n = 706) of cisgender women, 46.0% (n = 34) of trans men and 49.3% (n = 41) of transwomen.

13.2 Community participation and media consumption

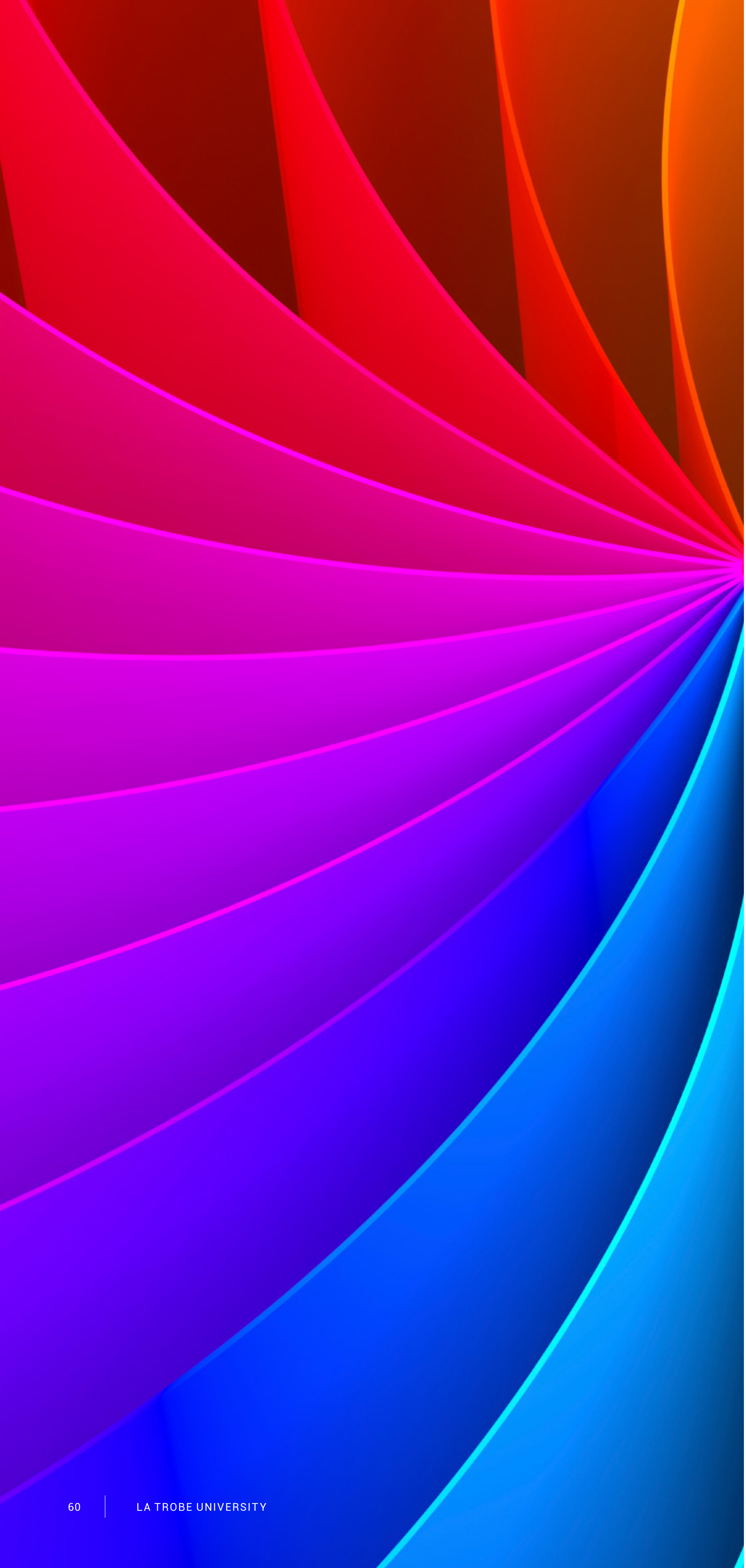
Participants were asked how often they engage with a range of lesbian, gay, bisexual, trans, intersex or queer (LGBTIQ) events and media. Figure 11 displays these results.

Figure 11: LGBTIQ community participation and media consumption frequency (n = 2,324)



Almost seven in ten (68.8%; n = 1,585) *Private Lives 3* participants in Victoria reported having participated in LGBTIQ social events at some time, while 57.8% (n = 1,334) had accessed LGBTIQ print media, 61.8% (n = 1,428) LGBTIQ broadcast media, 86.6% (n = 2,000) LGBTIQ social media and 72.3% (n = 1, 660) LGBTIQ online media other than social media at some time.

LGBTIQ social media was the most commonly accessed form of media, with 43.4% (n = 1,003) participants accessing it daily. This compared to 16.5% (n = 379) of participants who had accessed LGBTIQ online media other than social media daily, 7.3% (n = 168) who had accessed LGBTIQ broadcast media daily and 4.9% (n = 113) who had accessed LGBTIQ print media daily.



14 Recommendations

14.1 Implications

There have been important legislative reforms, including marriage equality (2017) and the expungement of historic indecency charges for consenting homosexual sex in Victoria (2014) in the past eight years since the *Private Lives 2* report in 2012. Furthermore, Victoria has made significant investments in the health and wellbeing of LGBTIQ people in the state. Evidence of this investment can be seen in the greater proportion of Victorian participants in *Private Lives 3* who reported accessing health services that were LGBTIQ-inclusive or that cater only to lesbian, gay, bisexual, trans and/or intersex people than in other states and territories. The proportion of participants feeling that their sexual orientation or gender identity was respected was much higher for participants who attended services that cater only to lesbian, gay, bisexual, trans and/or intersex people or that are known to be LGBTIQ-inclusive and may contribute to the higher rates of engagement with mental health services among participants currently experiencing psychological distress in Victoria than in other states and territories. However, the findings from the *Private Lives 3* survey in Victoria suggest that further investment is necessary, as the proportion of LGBTIQ people accessing LGBTIQ-inclusive services are still low. LGBTIQ people also continue to experience high levels of discrimination, stigma and abuse in many aspects of their lives. Subsequently, significant social, economic and health disparities for LGBTIQ communities continue to exist.

14.2 Policy and program development

The data and analysis emerging from *Private Lives 3* will be vital in the future targeting of policy and service responses to promote health and wellbeing for LGBTQ and for specific sub-groups of LGBTQ communities. Overall, LGBTQ people report being in loving relationships and close community connections. These positive and affirming aspects of life for LGBTQ communities can be emphasised or capitalised upon through interventions seeking to de-pathologise LGBTQ experiences. While *Private Lives 3* data can facilitate a better understanding of the nature and extent of health and wellbeing challenges among LGBTQ populations, further research is required to develop and evaluate interventions that seek to address them. As with other populations, a diverse range of interventions may be required and it is crucial that these are evidence-based and subject to rigorous evaluation if we hope to effect positive change.

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

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

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

Specifically, we recommend:

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

14.3 Service development

LGBTIQ community-controlled organisations play a crucial role in providing essential services and are expert sources of practice-based knowledge. However, services are not available everywhere, which reflects *Private Lives 3* findings indicating that services specifically catering to the needs of lesbian, gay, bisexual, trans and/or intersex people were the least accessed by participants. Furthermore, *Private Lives 3* found that many people in need of mental health services are not accessing them, and although mainstream medical clinics were the most utilised health service, they had the lowest proportion of participants who felt that their sexual orientation or gender identity was respected.

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

The findings here suggest that the following should be prioritised:

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

14.4 Future research directions

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

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

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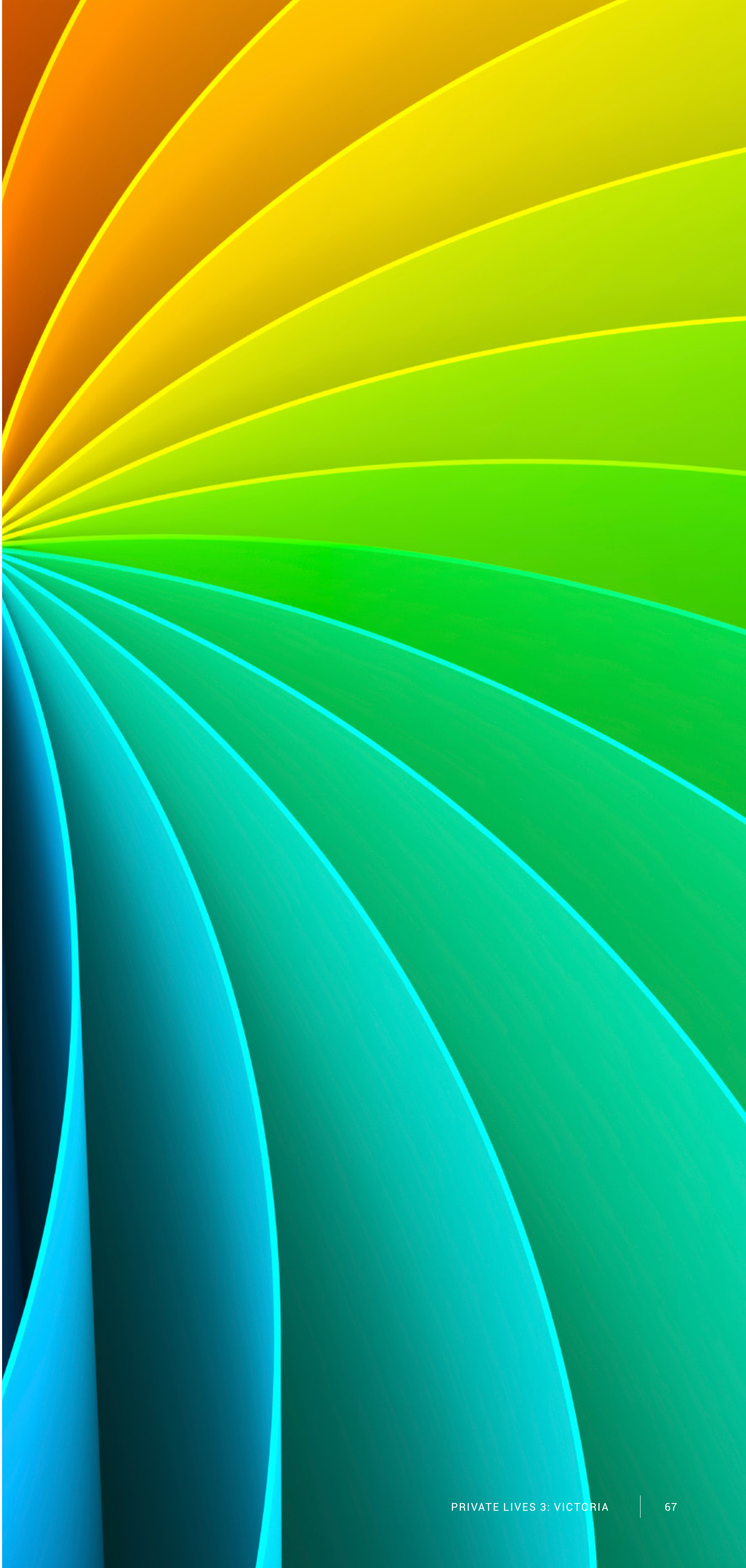

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