Women's Health Tasmania

Talking to LGBTIQ+ women about health, Tasmania 2020

LUCINDA SHANNON

For further information contact:

Women's Health Tasmania
PO Box 248
North Hobart TAS 7002

Email: info@womenshealthtas.org.au

Website: www.womenshealthtas.org.au

Background

A word about definitions and language

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

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

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

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

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

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

Who did we talk to?

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

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

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

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

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

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

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

How did we reach them?

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

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

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

What did we hear?

What's working well?

Place, home and relationships

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

Home

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

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

Geography/place

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

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

Access to amenities

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

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

Social connection and LGBTIQ+ specific community groups

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

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

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

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

Inclusion at work and in the community

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

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

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

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

What's *not* working well?

Access and cost of mental health support

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

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

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

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

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

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

A lack of community services and face to face contact

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

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

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

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

Health care for trans and gender diverse women

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

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

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

Trans women we spoke to said it was rare to access a doctor who understood important elements of gender affirmation – either medically or socially. In other cases, medical professionals had outdated and harmful

views about transgender people, believing that being transgender was a mental illness.[3] The women described these experiences as intensely negative and invalidating. Women we spoke to avoided interacting with these health professionals if they could – shrinking the pool of doctors who these women felt confident accessing.

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

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

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

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

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

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

Access to inclusive GPs

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

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

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

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

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

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

Affordability of primary health care

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

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

Discrimination in health settings

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

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

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

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

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

Siloed health services

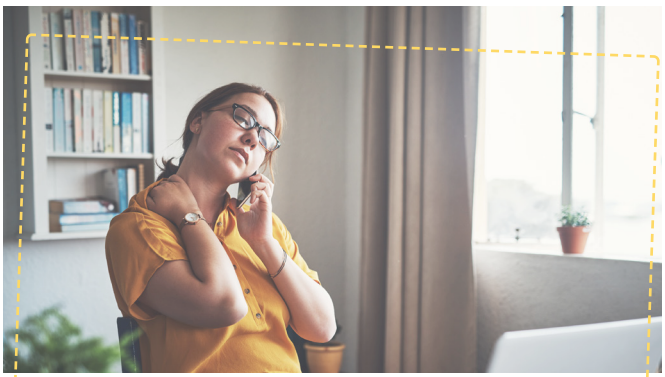
The women told us maintaining health when living with chronic health conditions was burdensome. Women said a siloed approach to health care meant there was no 'one place' people could go to get their health care sorted. This put women in the position of needing to retell their story to multiple health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

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

A health system lacking in humanity

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

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



What hasn't begun but needs to start?

Free, universal health care

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

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

Holistic health spaces putting diversity at their core

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

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

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

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

Mandatory, systemic training and education for health workers

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

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

Normalising transgender identities and experiences

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

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

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

There were two issues involved in this idea.

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

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

Documentation and access to notes and medical information

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

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

Postscript: impacts of COVID-19

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

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

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

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

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

Appendix 1

General health

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

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

Mental health

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

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

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

Young people

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

People with an intersex variation

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

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

Lesbians

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

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

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

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

9 Leonard et al (2012). Page 28.

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

11 Leonard et al (2012). Page 15.

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

13 National LGBTI Health Alliance, 2020. Page 2.

14 Leonard et al, 2012. Page 38.

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

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

17 Jones et al, 2016. Page 120.

18 Jones et al, 2016. Page 3.

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

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

Bisexual People

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

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

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

Transgender people

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

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

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

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

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

21 Taylor, J., Power, J., Smith, E., & Rathbone, M, 2019, Bisexual mental health: Findings from the 'who I am study'. *Australian journal of general practice, 48*(3), 138. doi: 10.31128/AJGP-06-18-4615.
22 Leonard et al, 2015. Page 2.
23 National LGBTI Health Alliance, ibid.
24 Leonard et al, 2012. Page 37.
25 Hyde Z, Doherty M, Tilley PJM, McCaul KA, Rooney R, Jancey J, *The First Australian National Trans Mental Health Study: Summary of Results. School of Public Health*, 2014, Curtin University, Perth, Australia. Page iv.
26 Hyde et al, 2014. Page iv.
27 National LGBTI Health Alliance, 2020. Page 7.
28 National LGBTI Health Alliance, ibid.
29 Hyde et al, 2014. Page 23.
30 Hyde et al, 2014. Page 26-7.

Discrimination, health and accessing health services

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

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

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

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

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

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

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

31 Beyond Blue, *In My Shoes: Experiences of discrimination, depression and anxiety among gay, lesbian, bisexual, trans and intersex people*, 2012. https://humanrights.gov.au/sites/default/files/FTFLGBTI.pdf
32 Ecker, S., Riggle, E. D., Rostosky, S. S., & Byrnes, J. M. , 2019, Impact of the Australian marriage equality postal survey and debate on psychological distress among lesbian, gay, bisexual, transgender, intersex and queer/questioning people and allies. *Australian Journal of Psychology*, 71(3), 285-295. DOI: https://doi.org/10.1111/ajpy.12245
33 Verrelli, S., White, F. A., Harvey, L. J., & Pulciani, M. R., 2019, Minority stress, social support, and the mental health of lesbian, gay, and bisexual Australians during the Australian Marriage Law Postal Survey. *Australian Psychologist, 54*(4), 336-346. DOI: https://doi.org/10.1111/ap.12380
34 Just Equal, *Religious Freedom and Transgender Debates: Survey Report*, 2019. https://drive.google.com/file/d/1GgGusJV7K10EdUWxDPyus_VuB_bwuEwE/view. Page 4.
35 Ibid.
36 Australian Human Rights Commission, *Resilient Individuals: Sexual Orientation, Gender Identity and Intersex Rights National Consultation Report*, 2015. Chapter 7.
37 Leonard et al, 2012. Page 46.
38 Hyde et al. Page 50; Leonard et al, page 42.
39 Hyde et al, 2014. Page 49-50.
40 Hyde et al, 2014. Page 49.
41 Australian Human Rights Commission, 2015. Page 37.

Appendix 2

Language and definitions

Bisexual

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

Cisgender

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

Family of Choice

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

Gay

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

Heteronormativity

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

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

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

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

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

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

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

Intersex

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

Lesbian

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

Non-binary

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

Queer

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

Transgender

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

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

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

50 Ibid.

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

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

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

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

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

Women's Health Tasmania
25 Lefroy Street
North Hobart, Tasmania 7002
Open 9.15am–4pm Mon–Thurs
P: **6231 3212** F: **6236 9449**
Women's Health Information Line: **1800 675 028**

info@womenshealthtas.org.au
www.womenshealthtas.org.au
Fb: Women's Health Tasmania
Twitter: WomensHealthTAS