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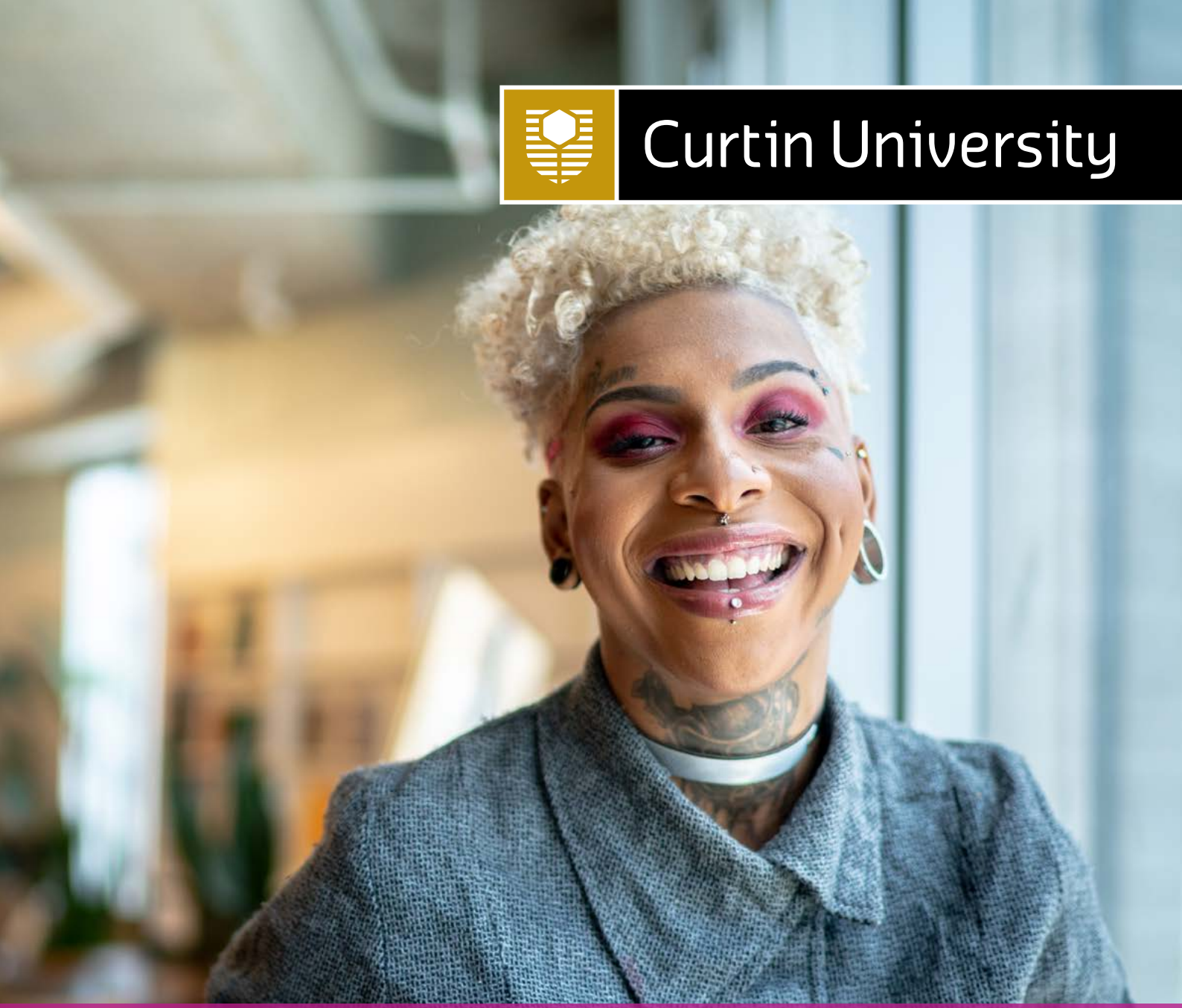

LGBTIQA+ primary health care priorities in Western Australia: Insights for advocacy and action

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Curtin School of Population Health

Make tomorrow better.

CERIPH

Living Proud
LGBTIQ+ Community Services of WA

We acknowledge that this research has taken place on Country across Western Australia and pay our respects to Elders past and present. Our research team is based in Boorloo (Perth) on the lands of the Whadjuk Noongar people, who have been custodians of this boodjar since time immemorial. We acknowledge all Traditional Custodians and their continuing connection to culture, community, land, sea and rivers.

We are indebted to the many individuals and organisations who enthusiastically and thoughtfully contributed their time, expertise and insights to shape this important piece of work shining a light on gaps in primary health care and lead an agenda for action.

We acknowledge the essential contributions made by First Peoples Rainbow Mob, GLBTI Rights in Ageing, Intersex Peer Support Australia, PFLAG+, Rainbow Futures, Transfolk of WA, Freedom Centre, members of the Regional Pride Network and many others to advancing the health and dignity of LGBTIQA+ communities in Western Australia.

We are grateful to Dani Wright-Toussaint, Misty Farquhar, Jane Armstrong, Elizabeth Leahy and Jeff McDonald for their strategic insights to this research. We would also like to recognise Sage Harlow for ably supporting the project and Christina Kadmos for exceptional facilitation throughout the community consultation.

Thank you to the WA Primary Health Alliance for recognising the need for this work. The provision of funding to Living Proud has enabled this critical body of research to support future efforts to reduce health disparities for our communities.

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A note about LGBTIQA+ terminology

Throughout this document the acronym LGBTIQA+ is used to refer to lesbian, gay, bisexual, transgender, intersex, queer, asexual and other people with diverse sexualities and gender expression. We recognise that every LGBTIQA+ person has terms and language they prefer when describing their own sex characteristics, gender and sexuality. The use of this acronym is not intended to be limiting or exclusive of certain groups and we recognise that not all people will identify with this acronym or use these specific terms. When describing the findings of other studies, the terminology applied by those researchers will be used instead.

Preface from Living Proud

In an era where the LGBTIQA+ community continues to face significant health and wellbeing challenges, the need for comprehensive, evidence-based insights has never been more critical. Living Proud recognised a clear evidence gap here in Western Australia and successfully applied for funding from the WA Primary Health Alliance (WAPHA) to commission this report.

On behalf of the Living Proud Board, I would like to extend deep thanks to the numerous staff, volunteers, community members and community organisations who all contributed their time and personal insights to this valuable research, and to the team at CERIPH who expertly and sensitively led the facilitation, co-design, mapping and compilation of this extensive report. I would also like to thank WAPHA for supporting and funding this vital work.

It is our belief that this report will help usher in a new, informed, approach to understanding and responding to LGBTIQA+ health needs and priorities in Western Australia, and influence policy direction and strategic planning across the entire primary health care ecosystem.

This research also represents the foundation for enhanced efforts to reduce the health and wellbeing disparities that the LGBTIQA+ community continues to experience.

Thank you for taking the time to read this report and for your commitment to our Agenda for Action.

Barry Cosker
Chair
Living Proud

About Living Proud

Living Proud was founded more than 50 years ago by a group of courageous community members who established the first gay and lesbian rights movement in Australia, called the Campaign Against Moral Persecution WA (CAMP WA). While lobbying to decriminalise homosexuality, CAMP WA established a telephone support line, called 'Phone a Friend'. That initial phone service has grown into the organisation now known as Living Proud.

Today, Living Proud is one of the oldest organisations of its kind in the southern hemisphere, and the largest LGBTIQA+ organisation in WA, supporting the community across the state, wherever they live or work.

Living Proud is the WA partner and founding member of the QLife national LGBTIQ+ telephone and web chat peer support and referral service. QLife provides anonymous, LGBTIQA+ peer support and referral for people in Australia wanting to talk about a range of issues including sexuality, identity, gender, bodies, feelings, or relationships. QLife operates as a partnership between LGBTIQ+ Health Australia (LHA) and the 4 partner organisations that deliver the services: Living Proud (WA), Diverse Voices (Qld), Switchboard (Vic) and Twenty10 (NSW), and has been operational since mid-2013.

Living Proud also runs health and wellbeing initiatives, community capacity building programs, advocacy and awareness campaigns, delivers fee-for-service training programs and high-profile community projects such as Queer and Accessible. We strive to improve the health, wellbeing and inclusion of lesbian, gay, bi+, transgender, intersex, queer and other diverse people.

www.livingproud.org.au

About CERIPH

The Collaboration for Evidence, Research and Impact in Public Health (CERIPH) is located in the Curtin School of Population Health, in the Faculty of Health Sciences at Curtin University in Perth, Western Australia. We seek solutions that promote health, prevent disease and protect populations from harm.

CERIPH began as the Western Australian Centre for Health Promotion Research. It was established in 1986 and was the first health promotion research centre in the southern hemisphere. For more than 35 years the centre has sought to undertake applied and real world research and evaluation, and delivered a range of capacity building activities to support health promotion action. We have contributed to the establishment and development of key health promotion and public health programs and policies in Western Australia, nationally and globally.

Recognising the complexity of health and its determinants, our collaboration generates evidence to support action across educational, organisational, socio-economic, environmental and political domains to improve population health in our region. Our staff are highly skilled researchers, advocates, practitioners, leaders and educators who have built strong partnerships locally and internationally. We are committed to creating meaningful outcomes for individuals, communities and populations. We create synergies by integrating our research, evaluation, consultancy and our capacity building with our award winning teaching programs.

CERIPH has built and demonstrated high level expertise and strengths in:

- Approaches using community and settings-based strategies, co-design, peer and social influence, social marketing, advocacy, community mobilisation and sector capacity building.
- Applied, participatory, intervention and social research.
- Building sustained partnerships and collaborations with vulnerable and priority communities and populations and relevant community, government and private sector organisations.
- Provision of research training, education and capacity building activities to students, professionals and community.
- Dissemination and translation of evidence informed practice and building practice informed evidence.

www.ceriph.org

Contents

Acronyms

ABS	Australian Bureau of Statistics
AFAB/AMAB	Assigned Female/Male at Birth
AIHW	Australian Institute of Health and Welfare
BBV	Blood-Borne Viruses
CaLD	Culturally and Linguistically Diverse
DV/IPV	Domestic Violence / Intimate Partner Violence
GBM	Gay and Bisexual Men
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
LGBT	Lesbian, Gay, Bisexual, Transgender
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual. The plus symbol represents the inclusion of other sexual orientations, gender identities, and communities not specifically covered in the other letters.
MSM	Men who have Sex with Men
PHC	Primary Health Care
PLHIV	People Living with HIV
PrEP	Pre Exposure Prophylaxis
STI	Sexually Transmissible Infection
WA	Western Australia
WSW	Women who have Sex with Women

Glossary and Terminology

All definitions have been reproduced from Australian Institute of Family Studies* unless otherwise noted.

Bodies and variations in sex characteristics

AFAB/AMAB: an acronym for Assigned or presumed Female/Male at Birth.

Endosex: people whose innate sex characteristics meet medical and conventional understandings of male and female bodies.

Intersex: people who have innate sex characteristics that don't fit medical and social norms for female or male bodies, and that create risks or experiences of stigma, discrimination and harm.†

Sex: a classification that is often made at birth as either male or female based on a person's external anatomical characteristics. However, sex is not always straightforward, as some people may be born with an intersex variation, and anatomical and hormonal characteristics can change over a life span.

Sex characteristics: a term used to refer to physical parts of the body that are related to body development, regulation and reproductive systems. Primary sex characteristics are gonads, chromosomes, genitals and hormones. Secondary sex characteristics emerge at puberty and can include the development of breast tissue, voice pitch, facial and pubic hair, etc.

Gender

Cisgender/cis: a term used to describe people whose gender corresponds to what they were assigned at birth.

Dead name: an informal way to describe the former name a person no longer uses because it does not align with their current experience in the world or their gender. Some people may experience distress when this name is used.

Gender/gender identity: Broadly, gender is a set of socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate. Gender identity is a person's deeply held core sense of self in relation to gender and does not always correspond to a person's assigned sex. People become aware of their gender identity at many different stages of life, from as early as 18 months and into adulthood. Gender identity is a separate concept from sexuality and gender expression.‡

* https://aifs.gov.au/resources/resource-sheets/lgbtiqa-glossary-common-terms
† https://ihra.org.au/18106/what-is-intersex/
‡ https://pflag.org/glossary/

Gender affirmation: the personal process or processes a trans person determines is right for them in order to live as their defined gender and so society recognises this. This may involve social, medical and/or legal steps that affirm a person's gender. A trans person who hasn't medically or legally affirmed their gender is no less the man, woman or non-binary person they've always been. A person's circumstances may inhibit their access to steps they want to take to affirm their gender (TransHub, 2021).

Gender binary: something that is binary consists of two things or can refer to one of a pair of things. When talking about genders, binary genders are male and female, and non-binary genders are any genders that are not just male or female, or aren't male or female at all (TransHub, 2021).

Gender dysphoria: is the discomfort a person feels with how their body is perceived and allocated a gender by other people. The experience may occur when a person feels their biological or physical sex doesn't match their sense of their own gender (Health Direct, 2019). This feeling, that there is a mismatch, can trigger a range of responses. Some people experience serious distress, anxiety and emotional pain, which can affect their mental health. Others experience only low-level distress — or none at all. For this reason, gender dysphoria is no longer considered a mental illness. (Not to be confused with 'Body Dysmorphia'). (Victoria Sate Government, 2016)*

Gender euphoria: the experience of comfort, connection and celebration related to a trans person with their internal sense of self and gender. The pride of feeling and being affirmed as who they are.

Gender expression: refers to how a person chooses to publicly express or present their gender. This can include behaviour and outward appearance, including clothing, hair, make-up, body language and voice. Western expectations of gender expression are based on a binary of men as masculine and women as feminine but many people do not fit into binary gender expressions. Failing to adhere to the norms associated with one's gender can result in ridicule, intimidation and violence (Hill et al., 2020; Robinson, Bansel, Denson, Ovenden, & Davies, 2014).

Gender fluid: a term used to describe a person with shifting or changing gender.

Gender pronouns: refer to how a person publicly expresses their gender identity through the use of a pronoun. Pronouns can be gender-specific or gender-neutral (Rainbow Health Australia (formerly GLHV), 2016). This can include the traditional he or she, as well as gender-neutral pronouns such as they, their, ze and hir (see Transgender/Trans).

Genderqueer: a gender identity that does not conform to traditional gender norms and may be expressed as other than woman or man or both man and woman, including gender neutral and androgynous.

Gender questioning: not necessarily an identity but sometimes used in reference to a person who is unsure which gender, if any, they identify with.

Non-binary: is a term used to describe a person who does not identify exclusively as either a man or a woman. Genders that sit outside of the female /male binary are often called non-binary. A person might identify solely as non-binary, or relate to non-binary as an umbrella term and consider themselves genderfluid, genderqueer, trans masculine, trans feminine, agender, bigender, or something else (ACON Health, 2020)†

* https://www.prideinhealth.com.au/wp-content/uploads/2020/07/Language-and-terminology.pdf

† https://www.prideinhealth.com.au/wp-content/uploads/2020/07/Language-and-terminology.pdf

Sistergirl/Brotherboy: terms used for trans people within some Aboriginal or Torres Strait Islander communities. How the words Sistergirl and Brotherboy are used can differ between locations, countries and nations. Sistergirls and Brotherboys have distinct cultural identities and roles. Sistergirls are Indigenous people assigned male at birth but who live their lives as women, including taking on traditional cultural female practices (Rainbow Health Australia, 2016). Brotherboys are Indigenous people assigned female at birth but are a man or have a male spirit (Rainbow Health Australia, 2016).

Transgender/Trans: umbrella terms used to refer to people whose assigned sex at birth does not match their gender identity. Trans people may choose to live their lives with or without modifying their body, dress or legal status, and with or without medical treatment and surgery. Trans people may use a variety of terms to describe themselves including but not limited to: man, woman, trans woman, trans man, non-binary, agender, genderqueer, genderfluid, trans guy, trans masculine/masc, trans feminine/femme. Trans people have the same range of sexual orientations as the rest of the population. Trans people's sexual orientation is referred to in reference to their gender identity, rather than their sex. For example, a woman may identify as lesbian whether she was assigned female or male at birth. Trans people may also use a variety of different pronouns (see Gender pronouns). Using incorrect pronouns to refer to or describe trans people is disrespectful and can be harmful (see Misgendering under 'Societal attitudes/issues' below).

Sexual orientations

Aromantic/aro: refers to individuals who do not experience romantic attraction. Aromantic individuals may or may not identify as asexual.

Asexual/ace: a sexual orientation that reflects little to no sexual attraction, either within or outside relationships. People who identify as asexual can still experience romantic attraction across the sexuality continuum. While asexual people do not experience sexual attraction, this does not necessarily imply a lack of libido or sex drive.

Bisexual/bi: an individual who is sexually and/or romantically attracted to people of the same gender and people of another gender. Bisexuality does not necessarily assume there are only two genders (Flanders, LeBreton, Robinson, Bian, & Caravaca-Morera, 2017).

Gay: an individual who identifies as a man and is sexually and/or romantically attracted to other people who identify as men. The term gay can also be used in relation to women who are sexually and romantically attracted to other women.

Heterosexual: an individual who is sexually and/or romantically attracted to the opposite gender.

Lesbian: an individual who identifies as a woman and is sexually and/or romantically attracted to other people who identify as women.

Pansexual: an individual whose sexual and/or romantic attraction to others is not restricted by gender. Pansexuality can include being sexually and/or romantically attracted to any person, regardless of their gender identity.

Queer: a term used to describe a range of sexual orientations and gender identities. Although once used as a derogatory term and still considered derogatory by many older LGBTIQA+ people, 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.

QTPOC: an acronym for Queer and Trans People of Colour.

Sexual orientation: refers to an individual's sexual and romantic attraction to another person. This can include, but is not limited to, heterosexual, lesbian, gay, bisexual and asexual. It is important to note, however, that these are just a handful of sexual orientations – the reality is that there are an infinite number of ways in which someone might define their sexuality. Further, people can identify with a sexuality or sexual orientation regardless of their sexual or romantic experiences. Some people may identify as sexually fluid; that is, their sexuality is not fixed to any one identity.

Societal attitudes/issues

Biphobia: refers to negative beliefs, prejudice and/or discrimination against bisexual people. This can include a dismissal of bisexuality, questioning whether bisexual identities are authentic or a focus on the sexual desires and practices of bisexual people (Ross et al., 2018).

Cisgenderism: where something is based on a discriminatory social or structural view that positions (either intentionally or otherwise) the trans experience as either not existing or as something to be pathologised. Cisgenderism believes that gender identity is determined at birth and is a fixed and innate identity that is based on sex characteristics (or 'biology') and that only binary (male or female) identities are valid and real (TransHub, 2021).

Cisnormativity: assumes that everyone is cisgender and that all people will continue to identify with the gender they were assigned at birth. Cisnormativity erases the existence of trans people.

Heteronormativity: the view that heterosexual relationships are the natural and normal expression of sexual orientation and relationships. This is an extension of cisgenderism, which is a discriminatory social structure that positions cis and binary genders as the only real or valid experiences of gender.

Heterosexism: describes a social system that privileges heteronormative beliefs, values and practice. Heterosexism provides the social backdrop for homophobic and transphobic prejudices, violence and discrimination against people with non-heteronormative sexualities, gender identities and intersex varieties (McKay, Lindquist, & Misra, 2019).

Homonormativity: a term that describes the privileging of certain people or relationships within the queer community (usually cisgender, white, gay men). This term also refers to the assumption that LGBTIQA+ people will conform to mainstream, heterosexual culture; for example, by adopting the idea that monogamy, marriage and having children is a natural and normal relationship progression.

Homophobia: refers to negative beliefs, prejudices, stereotypes and fears that exist towards same-sex attracted people. It can range from the use of offensive language to bullying, abuse and physical violence; and can include systemic barriers, such as being denied housing or being fired due to a person's sexual orientation.

Misgendering: an occurrence where a person is described or addressed using language that does not match their gender identity (Rainbow Health Australia, 2016). This can include the incorrect use of pronouns (she/he/they), familial titles (dad, sister, uncle, niece) and, at times, other words that traditionally have gendered applications (pretty, handsome, etc.).

Transphobia: refers to negative beliefs, prejudices and stereotypes that exist about trans people.

Executive Summary

Executive Summary

Background

This study sought to better understand the existing services available for LGBTIQ+ people in Western Australia (WA) to provide recommendations for addressing gaps and improving services and policy. The project facilitated a primary health care needs assessment and consultation process to support priority setting for LGBTIQ+ health in WA. Living Proud is one of the main community-controlled organisations for LGBTIQ+ people living in WA. This project assists Living Proud in understanding how future programs and resources are constructed to better address the specific health needs of WA's LGBTIQ+ communities. The objectives were to:

- explore service provider perspectives on LGBTIQ+ primary health care needs and priorities
- describe the health status of LGBTIQ+ Western Australians using existing data sources.
- identify relevant policy frameworks and documented strategic direction for LGBTIQA+ primary health care needs in WA.

It is critical that state-funded health services become more inclusive of LGBTIQA+ people. Addressing stigma is key to improving the health of LGBTIQA+ people. This involves addressing stigma-related barriers that reduce LGBTIQA+ interaction with mainstream PHC services and the development of community-controlled health services that address the specific risk factors experienced by LGBTIQA+ people.

Approach

We conducted a mixed method examination of the health status and service provision for LGBTIQA+ individuals in WA. Our methods included a two-part desktop review, encompassing both evidence and policy analysis. The evidence review involved a narrative review of both peer-reviewed and grey literature, synthesising findings into health domain snapshots and identifying gaps in WA data. Concurrently, we audited public domain government policies in WA and nationally for LGBTIQA+ content and priority setting.

We also engaged in a consultation process to inform the evidence review and gain further insights. This involved stakeholder surveys and workshops with various groups: community-controlled LGBTIQA+ health services, metropolitan and regional LGBTIQA+ community groups, and representatives from mainstream organisations offering LGBTIQA+ targeted programs. These activities aimed to map existing service provision, discuss unaddressed health needs, and explore service gaps in both metropolitan and regional WA. The consultations were purposefully designed to include authoritative voices on LGBTIQA+ health and involved a sensemaking process with key stakeholders to refine the final recommendations.

Key insights

1. Community inclusion forms a consistent thread throughout the research on improving LGBTIQA+ health, as it enables local communities to shape health services according to their needs and ensures that health care providers remain attuned to the needs of their LGBTIQA+ clients and broader community.
2. The WA LGBTIQA+ community-controlled sector is primarily volunteer-driven, with scarce infrastructure to support operations however, services form a crucial and unique part of LGBTIQA+ health care.
3. An underfunded community-controlled sector relies on partnership and collaborative approaches with mainstream Government and Community Health Services.
4. There remain significant health disparities affecting LGBTIQA+ people across a broad range of health outcomes. More accurate and localised data on the health experiences and outcomes for LGBTIQA+ people in WA is still needed.
5. There are multiple intersecting factors that influence health and wellbeing for LGBTIQA+ people. Accordingly, a range of priority populations have been identified requiring additional consideration in all primary health care responses.
6. While there are significant gaps in providing LGBTIQA+ inclusive health care globally, rural and remote LGBTIQA+ communities experience greater inequity and barriers to accessing appropriate and safe health care.
7. Both global and Australia-specific research indicates a need for significant improvements amongst health care professionals and medical training institutes (particularly mainstream organisations) to provide quality care to LGBTIQA+ people.
8. The operations and physical spaces of clinics and other medical environments where health care is delivered provide a significant opportunity to improve LGBTIQA+ inclusion.
9. Health promotion action can contribute to population-level benefits in health and quality of life outcomes. However current programs and strategies are limited that specifically address the health needs of LGBTIQA+ people.
10. Government and policy changes can significantly improve LGBTIQA+ health outcomes. Without government-level support and funding, adverse health outcomes experienced by many LGBTIQA+ Western Australians will remain.

Agenda for Action

This research has yielded important implications to support future action to support action on LGBTIQA+ health disparities in Western Australia. While we have identified priority actions we recognise that further work is required. However, acting on these priorities will make some inroads into a currently underserved area of health and social policy.

Our Agenda for Action proposes specific strategies to address each of the following action areas including assigning priority responsibilities:

- Mobilising Resources for LGBTIQA+ Community Controlled Services
- Prioritising Policy and Legal Reform to Improve LGBTIQA+ Health
- Involving LGBTIQA+ People in Mainstream Health and Social Service Provision
- Improving Primary Health Care for LGBTIQA+ People
- Improving Prevention and Health Promotion for LGBTIQA+ People
- Developing a Research Agenda to Support LGBTIQA+ Health
- Supporting Intersectional Priority Populations

By proposing a series of interconnected strategies within each of these action areas, the Agenda for Action is intended to support the move from rhetoric to action on LGBTIQA+ health in WA. It is envisaged that the proposed Agenda for Action will be discussed, considered and debated by stakeholders and our communities, playing a support role in guiding action in new LGBTIQA+ health strategies and action.

Background

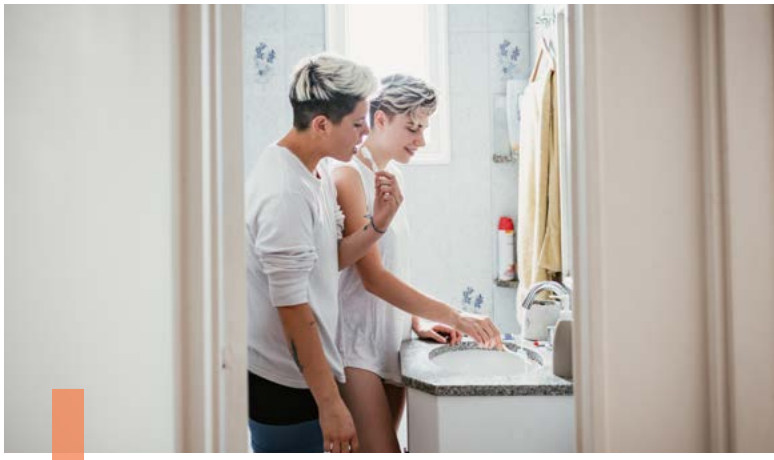
Background

LGBTIQA+ health

Despite being identified as a priority population in various state and national strategies, LGBTIQA+ people experience elevated health risks and overall poorer health than cisgender heterosexual people. These outcomes have been linked to experiences of discrimination, stigma, and exclusion. While regular engagement with primary health care (PHC) is acknowledged as a determinant of general health, the provision of services in a culturally safe and appropriate way, is imperative to optimise LGBTIQA+ health outcomes. LGBTIQA+ community-controlled organisations play a crucial role in providing essential services and demonstrate utility in supporting health outcomes for LGBTIQA+ people. However, in Western Australia (WA), the limited presence and funding of LGBTIQA+ community-controlled organisations exacerbate reliance on mainstream PHC services where reports of insufficient acknowledge of and respect for diverse sexualities prevail.

Nationally there are a range of efforts underway, including by LGBTIQ+ Health Australia, to advance LGBTIQA+ health research and advocate for the policies and resourcing required to improve the health of LGBTIQA+ populations. The Western Australian LGBTI Health Strategy 2019-2024 provides direction to the WA health system and services on policy development and service delivery to achieve optimal health and wellbeing outcomes for LGBTI populations.

Despite the formulation of these policies and strategies to address LGBTIQ+ people' needs, significant knowledge gaps persist necessitating further research and community input to refine and enhance existing public health frameworks. This is particularly true when considering the intersecting needs of LGBTIQA+ people who experience other forms of marginalisation and discrimination. There is little research and reporting on these intersecting issues, and direction and evidence for WA-specific health care needs is poorly addressed by national policies or existing WA health directives.



This project aims to develop an understanding of the current primary health care needs of LGBTIQA+ people living in WA. The project provide recommendations to address gaps, improve services and policy and contribute to the development of the WA LGBTI strategy now underway.

A note about LGBTIQA+ terminology

Throughout this document the acronym LGBTIQA+ is used to refer to lesbian, gay, bisexual, transgender, intersex, queer, asexual and other people with diverse sexualities and gender expression. We recognise that every LGBTIQA+ person has terms and language they prefer when describing their own sex characteristics, gender and sexuality. The use of this acronym is not intended to be limiting or exclusive of certain groups and we recognise that not all people will identify with this acronym or use these specific terms. When describing the findings of other studies, the terminology applied by those researchers will be used instead.

Approach

Approach

Context

This project was a collaboration between Curtin University and Living Proud, one of the main health support services for LGBTIQA+ people living in WA. The project aim was to facilitate a primary health care (PHC) needs assessment to establish an evidence base to support priority setting by community and health services to address health and wellbeing needs for LGBTIQA+ people in WA. The objectives were to:

- describe the health status of LGBTIQA+ Western Australians using existing data sources.
- identify relevant policy frameworks and documented strategic direction for LGBTIQA+ primary health care needs in Western Australia.
- explore service provider perspectives on LGBTIQ+ primary health care needs and priorities.

Research team

The project team was composed of researchers with experience in community-facing evaluation and qualitative and mixed methods research. Senior researchers had previous experience conducting similar research and had experience within and with organisations that support LGBTIQA+ communities. Members of the research team were:

- Dr Jonathan Hallett (Lead): Senior Lecturer, Health Promotion and Sexology, School of Population Health
- Dr Shoshana Rosenberg, Research Associate, CERIPH, School of Population Health
- Dr Gemma Crawford: Associate Professor, Health Promotion and Sexology, School of Population Health
- Michael Atkinson, Programs Manager, Living Proud
- Corie Gray, Research Assistant, CERIPH, School of Population Health
- Thomas Trainer, Research Assistant, CERIPH, School of Population Health

Project advisory meeting

At the outset of the project a steering group meeting was held with representatives from a combination of community-controlled LGBTIQA+ services, government and non-government health services to discuss the approach to the consultation process, stakeholder identification and the focus of survey questions.

Definitions used in this research

For the purposes of this research the following definitions have been used.

Primary health care

"*Primary health care covers health care that is not related to a hospital visit, including health promotion, prevention, early intervention, treatment of acute conditions, and management of chronic conditions.*"*

Intersectionality

"*looking beyond a person's individual identities and focusing on the points of intersection that their multiple identities create". and "This creates different layers and types of discrimination or disadvantage for either an individual or group. Categories include gender, sexual orientation, sex characteristics, ethnicity, language, faith, class, socio-economic status, ability and age.*"†

* https://www.aihw.gov.au/reports/primary-health-care/primary-health-care-in-australia/contents/about-primary-health-care

† http://www.lgbtiqintersect.org.au/learning-modules/intersectionality/

Community led LGBTIQA+ services

"*organisations, projects, programs or services led by LGBTIQA+ communities on behalf of and for LGBTIQA+ people… This can mean LGBTIQA+ people run them, steer their boards, or that they are known in community for offering services for LGBTIQA+ people*."*

Mainstream services

Mainstream services in this research were framed as those services that may not tailor services for LGBTIQA+ people or may offer some specific LGBTIQA+ services or programs but the organisation is not LGBTIQA+ focused or led.

Process

A mixed methods approach was used to explore the objectives via:

1. A desktop review – encompassing a policy review and health and wellbeing snapshots; and
2. Consultation – encompassing a cross-sectional survey and stakeholder workshops.

The table below presents a summary of the process (Table 1).

Desktop review

The desktop review was completed in two parts.

Evidence review

To understand the health status of LGBTIQA+ people in WA, a narrative review of relevant literature was conducted. Data included published peer reviewed literature as well as publicly available grey literature (e.g. government or NGO reports). Findings were synthesised into health domain snapshots and key population groupings to present current research and highlight gaps in available WA data.

Table 1. Project process and timeline

Activity	Timeline	Stakeholders
Ethical approval (Curtin)	Feb 2023	Curtin University
Evidence review	Jan-Dec 2023	Curtin University, Living Proud
Project advisory meeting	Mar 2023	Rainbow Futures, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, Cancer Council of WA, Living Proud, Curtin University
Policy review	Jun-Sep 2023	Curtin University, Living Proud
Stakeholder consultation	Mar 2023	Rainbow Futures LGBTIQA+ peer-led services
Stakeholder consultation	May 2023	Metropolitan LGBTIQA+ community services
Stakeholder consultation	Jun 2023	Regional LGBTIQA+ community services
Ethical approval (WA Health)	Oct 2023	Curtin University, Child and Adolescent Mental Health Services, Department of Health, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, WA Country Health Service
Stakeholder consultation	Nov 2023	Mainstream services
Data integration and reporting	Dec 2023	Curtin University
Community sense checking	Mar 2024	Curtin University, Living Proud, Rainbow Futures LGBTIQA+ peer-led services, Metropolitan LGBTIQA+ community services, Regional LGBTIQA+ community services, LGBTIQA+ community leaders from mainstream services

* https://www.vic.gov.au/pride-our-future-victorias-lgbtiqa-strategy-2022-32/definitions-and-key-terms

Policy review

A policy review was conducted of LGBTIQA+ content in WA and Australian health, wellbeing and social policies. The process involved searching for government strategies and policy documents in the public domain. Documents were then audited for LGBTIQA+ content and data were extracted. The following content was extracted: policy name; responsible institution(s); description of document; any mention of sexuality, diverse gender and/or intersex status; and whether LGBTIQA+ people were identified as a priority population (see Appendix 2).

Consultation

Consultation involved stakeholder surveys and workshops in three phases. Participants were over 18 years of age based in the Perth metropolitan or regional WA and either: representatives of community controlled LGBTIQA+ services; or employees (over 18 years of age) of government and non-government health organisations who engage in primary health care service provision. Participants were purposefully sampled to speak authoritatively on existing service provided by their organisations for LGBTIQA+ people. Participants were contacted by Living Proud and Curtin researchers by email to complete an online survey hosted on Qualtrics and take part in a face-to-face stakeholder workshop.

First, community controlled LGBTIQA+ health service representatives (n=10) completed an online survey to map existing service provision and participated in a three-hour workshop (n=10) meeting to discuss aspects of LGBTIQA+ health needs which were not addressed in existing literature and policies. The discussion also explored emerging themes from the survey data and the concepts of 'peer-led' and 'community control' in the context of LGBTIQA+ service provision.

Then, representatives from metropolitan LGBTIQA+ community groups (n=3) completed an online survey to map their existing service provision and participated in a three-hour workshop meeting (n=5) to discuss emerging themes from the survey data and discuss their perspectives of LGBTIQA+ service provision and gaps in metropolitan WA.

Then, representatives from regional LGBTIQA+ community groups (n=5) completed an online survey to map their existing service provision and participated in a three-hour workshop meeting (n=13) to discuss emerging themes from the survey data and discuss their perspectives of LGBTIQA+ service provision and gaps in regional WA.

Finally, organisational representatives who deliver LGBTIQA+ targeted programs or services within mainstream services (n=45) completed an online survey to map existing service provision and participated in a three-hour workshop meeting (n=32) to discuss aspects of LGBTIQ+ health needs not addressed in existing literature and policies, barriers to action and opportunities for enhancing service provision for LGBTIQA+ Western Australians.

A sensemaking process was conducted at the end of the project with key LGBTIQA+ organisational stakeholders (n=6) to confirm representation of participant priorities and refine the recommendations.

Analysis

Consultations were audio-recorded and transcribed; all names were de-identified. Qualitative data were analysed using deductive content analysis to identify broad themes. Verbatim quotations from participants were selected to support themes. Descriptive statistics summarised and described quantitative data.

Ethical approval

The research received ethical approval from the Curtin University Human Research Ethics Committee (HRE2023-0073) and the Western Australian Department of Health Human Research Ethics Committee (RGS6073).

A note on data

Data collection regarding LGBTQ populations, in particular data regarding trans status, remains absent from official national data collection projects such as the census, despite being supported by the Australian Attorney-General's Department and the Australian Bureau of Statistics [1,2]. Despite this, some attempts have been made to estimate the size of LGBTQ populations, and to better categorise gender and sexuality within population research more broadly.

Figures from various national studies globally, estimate that LGBTQ people comprise between 0.9% to 11% of the population [3,4]. However, the type of data being collected has significant impact on estimated LGBTQ population size. For example, the Australian national census has consistently provided low estimates due to the way non-heterosexual sexualities are defined, namely that only same-sex couples cohabiting and declaring their partnership status are counted [5]. A recent study estimates that rates of homosexuality and bisexuality are following an upwards trend, and there may soon be anywhere from 1.25 to 1.57 million Australians who do not identify as heterosexuals [6], which suggests 'sexual minorities' may constitute up to 6% of the Australian population.

Findings from the Trans and Gender Diverse Sexual Health Survey [7] suggest that the majority of existing approaches to categorising sex and gender in quantitative research are lacking the nuance required to accurately depict transness and other gender experiences [8]. Other studies support this view, with several suggesting that the complexity of sex and gender requires much more nuanced collection tools in order to provide accurate population estimates [9,10]. Recent data from a US study suggests that rates of people identifying as trans vary across the lifespan, and suggests that these rates run between 1.43% of the population for people aged 13-17 to 0.32% for adults over the age of 65, with an overall average of 0.52% across the adult lifespan [11].

Currently there is no consistency or consensus regarding data collection on gender in Australia [12], which results in the wide variations in outcomes shown in various national surveys. It is imperative for future research to consider the nuances of data collection around gender, switching from a focus on 'gender vs. sex' (with sex being seen as binary and immutable) and towards recording gender experiences in a way that is meaningful and expressive of participants experiences [13–15]. While there is limited research on the number of people with intersex variations, and has historically been based on a range of problematic definitions, it is estimated that 1.7% of live births are people with an intersex variation [3].

While there are significant gaps in LGBTIQA+ health data there are key sources available in some areas for service providers seeking additional insights. A list of these are provided in Appendix 1.

Policy Context

Policy Context

Western Australian policy documents

Of the 61 WA policies reviewed, 41 referred to sexuality and/or gender within the body of the document. This varied in detail and ranged from incorporating commentary on health disparities and inclusion of epidemiological data to inclusion of terms in a glossary (see summary in Table 2).

Of the 36 WA policies that formally identified priority populations, 22 identified LGBTIQA+ communities.

Three documents were exclusively focused on LGBTIQA+ populations: the Public Sector Commission's *People of Diverse Sexualities and Genders: Action Plan to Improve WA Public Sector Employment Outcomes 2020-2025*, the Department of Health's *WA Lesbian, Gay, Bisexual, Transgender, Intersex Health Strategy 2019-2024* and the Royal Perth Bentley Group's (East Metropolitan Health Service) *LGBTIQ+ Inclusivity for Patients Policy*. The latter two were the only policy documents to refer to intersex status with any specificity. No policies referred to asexuality outside reference within an acronym.

Table 2. WA Policy Summary

Policy	Glossary	Commentary	Priority	Comparison to Previous
A Safe Place: WA Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025	✗	✓	✓	−
A Western Australia for Everyone: State Disability Strategy 2020-2030	✗	✓	−	−
Ageing with Choice: Future directions for seniors housing 2019-2024	✗	✗	✗	−
All Paths Lead to a Home: WA's 10-Year Strategy on Homelessness 2020-2030	✗	✗	✗	−
At Risk Youth Strategy 2022-27	✗	✓	✓	↑
Building a Better Future: Out-of-Home Care Reform Program	✗	✗	✗	−
Child and Adolescent Health Service Strategic Plan 2023-2025	✗	✓	−	−
Department of Communities Strategic Plan 2019-2023	✗	✗	✗	−
EMHS LGBTIQ+ Inclusivity for Patients Policy	✓	✓	✓	−
EMHS Strategic Plan 2021-2025	✗	✗	✗	−
Full Response to the Western Strategy Australian Methamphetamine Action Plan	✗	✓	−	−
Healthway's Strategic Plan 2024-2029	✗	✗	✓	↑
Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025	✗	✓	−	−
NMHS Workforce Diversity and Inclusion Strategy (2022-2025)	✗	✓	−	−

Table 2. WA Policy Summary

Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030	✗	✓	✓	–
People of Diverse Sexualities and Genders: Action Plan to Improve WA Public Sector Employment Outcomes 2020-2025	✓	✓	✓	–
Social Assistance and Allied Health Workforce Strategy (2018)	✗	✓	–	–
SHMS Equity, Diversity and Inclusion Plan 2021-2025	✓	✓	✓	–
SMHS Strategic Plan 2021-2025	✗	✗	–	–
State Disability Strategy 2020-2030 Action Plan	✗	✓	–	–
State Oral Health Plan 2016-2020	✗	✗	✗	–
State Public Health Plan for Western Australia. Objectives and Policy Priorities for 2019-2024	✗	✓	✗	–
Strategic Directions 2021-2026	✗	✓	✗	–
Sustainable Health Review: Final Report to the WA Government (2019)	✗	✓	–	–
Veterans and Families Strategy	✗	✗	–	–
WA Aboriginal Health and Wellbeing Framework 2015-2030	✗	✓	–	–
WA Aboriginal Sexual Health and Blood-borne Virus Strategy 2019-2023	✗	✓	✓	↑
WA Cancer Plan 2020-2025	✓	✗	✓	↑
WA Carers Strategy	✗	✓	–	–
WA Chronic Health Conditions Framework 2011-2016	✗	✗	✗	–
WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024	✓	✓	✓	↑
WA Disability Health Framework 2015-2025	✓	✓	–	–
WA Disability Health Framework Companion Resource	✗	✓	–	–
WA End-of-Life and Palliative Care Strategy 2018-2028	✗	✓	–	–
WA Health and Medical Research Strategy 2023-2033	✗	✗	–	–
WA Health Digital Strategy (2020-2030)	✗	✗	–	–
WA Health Promotion Strategic Framework 2022-2026	✗	✓	–	↑
WA Healthy Weight Action Plan 2019-2024	✗	✗	✗	–
WA Hepatitis B Strategy 2019-2023	✗	✓	✓	✓
WA Hepatitis C Strategy 2019-2023	✗	✓	✓	↑
WA HIV Strategy 2019-2023	✗	✓	✓	✓
WA Housing Strategy 2020-2030	✗	✗	–	–
WA Industry Participation Strategy 2019	✗	✗	–	–
WA Lived Experience (Peer) Workforce Framework	✗	✓	–	–
WA Men's Health and Wellbeing Policy (2019)	✗	✓	✓	–
WA Lesbian, Gay, Bisexual, Transgender, Intersex Health Strategy 2019-2024	✓	✓	✓	–
WA Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025	✗	✓	✓	–

Table 2. WA Policy Summary

WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Draft Plan Update 2018	✗	✓	–	–
WA Multicultural Policy Framework	✗	✓	–	–
WA Sexually Transmissible Infections (STI) Strategy 2019-2023	✗	✓	✓	✓
WA State Priorities Mental Health, Alcohol and Other Drugs 2020-2024	✗	✗	✗	–
WA Strategy to Respond to the Abuse of Older People 2019-2029	✗	✓	✗	–
WA Suicide Prevention Framework 2021-2025	✓	✓	✓	–
WA Women's Health and Wellbeing Policy (2019)	✓	✓	✓	✓
WA Youth Health Policy 2018-2023	✓	✓	✓	–
WA Youth Health Policy 2018-2023 Companion Resource: Understanding young people in Western Australia	✓	✓	✗	–
Workforce Diversification and Inclusion Strategy for WA Public Sector Employment 2020-2025	✓	✓	–	–
Working together for Western Australia to reform our criminal justice system	✗	✗	–	–
Working Together Toolkit: Designed to support the practical implementation of the Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025	✗	✓	–	–
Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025	✗	✓	–	–
You Matter: A guideline to support engagement with consumers, carers, communities and clinicians in health (2017)	✗	✓	✓	–

Key: ✗ Absent ✓ Present ↑ Increased ↓ Reduced – N/A

All WA policies related to sexual health and blood-borne viruses mentioned sexuality or gender diversity and referred to LGBTI communities as priority populations of greater risk of infection, these policies included:

- WA Aboriginal Sexual Health and Blood-borne Virus Strategy 2019-2023
- WA Hepatitis B Strategy 2019-2023
- WA Hepatitis C Strategy 2019-2023
- WA HIV Strategy 2019-2023
- WA Sexually Transmissible Infections (STI) Strategy 2019-2023

The *WA Aboriginal Sexual Health and Blood-borne Virus Strategy 2019-2023* referred to gender and sexually diverse Aboriginal people as priority populations, specifically mentioning gay and bisexual Aboriginal men who have sex with men as well as brotherboys and sistergirls. This policy also cited several factors the greater vulnerability of this population, such as low testing rates, inconsistent condom use and health care access and equity. Policies such as the *WA Hepatitis B Strategy 2019-2023* and *WA Hepatitis C Strategy 2019-2023* identified gay and bisexual men, and men who have sex with men as populations of greater risk of infection, as well as mentioning sexuality and gender diversity among other factors contributing to access and equity. Both the *WA HIV Strategy 2019-2023* and *WA Sexually Transmissible Infections (STI) Strategy 2019-2023* identified gay and bisexual men and, men who have sex with men as priority populations, as well as sexually and gender diverse people. Additionally, these policies provided justification for labelling these populations as vulnerable, and further identified susceptible subpopulations to both LGBTI populations previously mentioned.

Most WA policies regarding substance use, such as alcohol and drugs, mentioned sexuality or gender diversity:

- A Safe Place: WA Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025
- Full Response to the Western Strategy Australian Methamphetamine Action Plan
- Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025

- WA Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025
- WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Draft Plan Update 2018
- Working Together Toolkit: Designed to support the practical implementation of the Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025
- Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025

Only *A Safe Place: WA Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025* and *WA Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025* identified LGBTI communities as priority populations. While included in the policy documents, the mentions of sexuality and diverse genders in both *Working Together Toolkit: Designed to support the practical implementation of the Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025* and *Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025* were relatively insignificant in their inclusion.

Additionally, all WA policies with a specific focus on youth issues mentioned gender diversity and sexuality and defined LGBTIQ adolescents as high-risk young populations:

- At Risk Youth Strategy 2022-27
- WA Youth Health Policy 2018-2023
- WA Youth Health Policy 2018–2023 Companion Resource: Understanding young people in Western Australia.

None of these policies defined any further subpopulations, instead referring to the LGBTIQA+ community as a collective.

Several of the current versions of some WA policies now mentioned sexuality or gender diversity, as well as identifying LGBTIQA+ communities as a priority population, which previous versions of the policy had not included, these were:

- At Risk Youth Strategy 2022-27
- Healthway's Strategic Plan 2024-29
- WA Aboriginal Sexual Health and Blood-borne Virus Strategy 2019-2023
- WA Cancer Plan 2020-2025
- WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024
- WA Health Promotion Strategic Framework 2022-2026
- WA Hepatitis C Strategy 2019-2023.

National policy documents

Of the 14 national policy documents reviewed, nine referred to sexuality and/or gender identity within the body of the document. This varied in detail and ranged from incorporating commentary on health disparities and inclusion of epidemiological data to inclusion of terms in a glossary (see summary in Table 3). Of the 10 national policies that formally identified priority populations, eight identified LGBTI communities. One policy was exclusively focused on LGBTI populations: the Department of Health and Ageing's *LGBTI Ageing and Aged Care Strategy 2012-2017*. None of these national policies made specific reference to intersex status or asexuality separate from the acronym.

Table 2. National Policy Summary

Policy	Glossary	Commentary	Priority	Comparison to Previous
Australia's Disability Strategy 2021-2031	✗	✓	–	✓
Australian Work Health and Safety Strategy 2023-3033	✗	✗	–	✗
Equally Well: Improving the physical health and wellbeing of people living with mental illness in Australia	✗	✗	✗	–
Fifth National Mental Health and Suicide Prevention Plan 2017-2022	✗	✓	✓	↑
Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015-2024	✗	✗	✗	–
LGBTI Ageing and Aged Care Strategy 2012-2017	✓	✓	✓	–
National Action Plan for the Health of Children and Young People 2020-2030	✗	✓	✓	–
National Alcohol Strategy 2019-2028	✗	✓	✓	–
National Drug Strategy 2017-2026	✗	✗	✓	✓
National Injury Prevention Strategy 2020-2030 - Draft for consultation	✗	✓	✗	–
National Obesity Strategy 2022-2032	✓	✓	✓	–
National Preventive Health Strategy 2021-2030	✗	✓	✓	✓
National Strategic Framework for Chronic Conditions	✗	✗	✗	–
National Tobacco Strategy 2023-2030	✗	✓	✓	–

Key: ✗ Absent ✓ Present ↑ Increased ↓ Reduced – N/A

While most of these national policies did not further stratify the LGBTI population, several policies identified subpopulations. For example, LGBTI children and adolescents were a subpopulation identified by the *National Action Plan for the Health of Children and Young People 2020-2030* and the *National Obesity Strategy 2022-2032*. Additionally, the *National Preventive Health Strategy 2021-2030* identified challenges for LGB individuals, but did not refer to trans and intersex populations separately from the LGBTIQA+ community as whole.

Like the WA policies, all national policies focusing on substance use mentioned sexuality or gender diversity, these included:

- National Alcohol Strategy 2019-2028
- National Drug Strategy 2017-2026
- National Tobacco Strategy 2023-2030

All these policies did not mention specific subpopulations as vulnerable groups, simply referring to LGBTI communities as priority populations.

Additionally, the *National Preventive Health Strategy 2021-2030* identified LGBTI communities as priority populations, attributing the higher rates of alcohol and other drug usage in this population to negative health outcomes such as cancer. The *Fifth National Mental Health and Suicide Prevention Plan 2017-2022* expanded from previous policies to identify LGBTI communities as a priority population and mentioned sexuality and diverse genders throughout the policy document. However, there remains no mention of LGBTI communities in the *Australian Work Health Safety Strategy 2023-2033*, continuing the lack of representation seen in the previous *Australian Work Health Safety Strategy 2012-2022*.

Consultation

Consultation

LGBTIQA+ service surveys

Organisation identify and structure

55% (n=11) of surveyed organisations described themselves as a registered charity, 30% (n=6) were incorporated associations, and 10% (n=1) were unincorporated associations or groups. A majority (75%) (n=15) had been providing their services for more than five years, with a further 45% (n=7) providing services for over 10 years. Of the newer organisations, only one had been operational for less than a year, with the remainder providing services for between one and five years (n=4).

Of the surveyed organisations, 85% (n=17) identified as LGBTIQA+ peer-based organisations and 95% (n=20) as LGBTIQA+ community-controlled service organisations. Three organisations did not identify as peer-based organisations or were unsure, while a singule organisation was unsure if they identified as a community-controlled service. These outcomes are displayed in Table 4.

In terms of organisational structure, 31.1% (n=14) had a board of management, 15.6% (n=7) had a management structure, 20% (n=9) were governed by members and/or shareholders, 15.6% (n=7) had formal policies and procedures, while 13% (n=6) were governed by a community advisory group.

Table 4. Organisation type compared to peer-based service provision, whether they are controlled by the community and mean community-control rating

Community Organisation Type	Provides Peer-Based Services?		Community-Controlled Organisation?		Community-Control Rating (mean)
Registered Charity (n=10)	Yes	7 (70%)	Yes	9 (90%)	9.8
	No	2 (20%)	No	0 (0%)	
	Unsure	1 (10%)	Unsure	1 (10%)	
Incorporated Organisation (n=5)	Yes	5 (100%)	Yes	5 (100%)	9.8
	No	0 (0%)	No	0 (0%)	
	Unsure	0 (0%)	Unsure	0 (0%)	
Unincorporated Organisation/Group (n=2)	Yes	2 (100%)	Yes	2 (100%)	7.5
	No	0 (0%)	No	0 (0%)	
	Unsure	0 (0%)	Unsure	0 (0%)	
Other (n=1)	Yes	1 (100%)	Yes	1 (100%)	10
	No	0 (0%)	No	0 (0%)	
	Unsure	0 (0%)	Unsure	0 (0%)	
Total (n=18)	**Yes**	**15 (83.3%)**	**Yes**	**17 (94.4%)**	**9.56**
	No	**2 (11.1%)**	**No**	**0 (0%)**	
	Unsure	**8 (5.6%)**	**Unsure**	**1 (5.6%)**	

Only 15% (n=3) of organisations had more than two full-time equivalent (FTE) paid staff, while over 55% (n=11) of organisations had no paid staff. Conversely, 75% (n=8) of organisations had the volunteer equivalent of more than one FTE paid staff member, with 35% (n=7) of organisations having more than two FTE equivalent volunteers. A summary of organisations' FTE staff and FTE equivalent volunteers can be seen in Table 5 and Table 6, respectively.

Table 5. Community organisation type compared to number of FTE paid staff dedicated to serving LGBTIQA+ communities

Community Organisation Type	Number of FTE Paid Staff	
Registered Charity (n=10)	0	4 (40%)
	<1	0 (20%)
	1-2	4 (40%)
	2+	2 (20%)
Incorporated Organisation (n=5)	0	4 (80%)
	<1	1 (20%)
	1-2	0 (0%)
	2+	0 (0%)
Unincorporated Organisation/ Group (n=2)	0	2 (100%)
	<1	0 (0%)
	1-2	0 (0%)
	2+	0 (0%)
Other (n=1)	0	1 (100%)
	<1	0 (0%)
	1-2	0 (0%)
	2+	0 (0%)
Total (n=18)	**0**	**11 (61.1%)**
	<1	**1 (5.6%)**
	1-2	**4 (22.2%)**
	2+	**4 (11.1%)**

Table 6. Community organisation type compared to number of FTE unpaid volunteers dedicated to serving LGBTIQA+ communities

Community Organisation Type	Number of FTE Unpaid Volunteers	
Registered Charity (n=10)	0	1 (10%)
	<1	1 (10%)
	1-2	5 (50%)
	2+	3 (30%)
Incorporated Organisation (n=5)	0	1 (20%)
	<1	2 (40%)
	1-2	1 (20%)
	2+	1 (20%)
Unincorporated Organisation/ Group (n=2)	0	0 (0%)
	<1	0 (0%)
	1-2	1 (50%)
	2+	1 (50%)
Other (n=1)	0	0 (0%)
	<1	0 (0%)
	1-2	1 (100%)
	2+	0 (0%)
Total (n=18)	**0**	**2 (11.1%)**
	<1	**3 (16.7%)**
	1-2	**8 (44.4%)**
	2+	**5 (27.8%)**

Funding

The amount of funding received annually by organisations to serve the LGBTIQA+ community and the sources of funding varied. More than one-third (35%, n=7) of organisations received no funding, 10% (n=2) received less than $10,000, 15% (n=3) received $10,000 to $25,000, 5% (n=1) received $25,000 to $50,000, while a further 35% (n=7) received over $100,000. Common sources of funding to serve the LGBTIQA+ community included donations (n=7), project grants (n=3), as well as state (n=5) and federal (n=1) funding.

If more funding became available, over half (51.9%, n=14) of organisations had the capacity to extend their existing services, while 37% (n=10) would have the capacity to take on new services. On the other hand, even with increased availability of funding, 11.1% (n=3) of organisations did not have the capacity to scale up their service delivery.

Provided services

Common provided services across the surveyed organisations were peer-support services, such as trans support groups, safe places and social events. Many organisations also provided additional services such as advocacy training, referral of other respectful organisations, and consultation and policy development.

Infrastructure gaps

Increased physical resources such as increased office space, meeting rooms and therapy rooms were also common infrastructure gaps noted by organisations. Staffing limitations were also identified, with roles such as human resources, operational support, volunteer coordinators and IT services desired by many organisations. Additionally, increased funding for more full-time staff such as therapists was desirable.

Priority health care issues

A primary health care priority identified by many organisations was addressing stigma, discrimination and cis-heteronormative assumptions. Increased training regarding the health care needs of LGBTIQA+ people, particularly trans and intersex people, was also a priority. Some organisations reported that improvements in these areas would facilitate greater quality of health care, as well as a more affirming care environment.

Additionally, all metropolitan health services identified mental health care to address issues such as isolation and depression as a primary health care priority. Improvements in youth and adolescent services were also identified as a priority by some regional organisations.

Importance of community-controlled organisations

When asked to rate the importance of community-controlled organisations in LGBTIQA+ service provision on a scale from 1-10, the mean score was 9.56. All but one (n=17) of the surveyed organisations rated the importance of community-controlled organisations as a nine or higher. Common reasoning included the significance of LGBTIQA+ lived experiences, empowerment of the LGBTIQA+ community, and previous evidence that community-controlled organisations provide quality and affirming services to the LGBTIQA+ community. However, one organisation reported that specialist LGTBIQA+ care may require the involvement of non-LGBTIQA+ organisations, while a regional organisation suggested that geographical limitations resulted in isolation of regional LGBTIQA+ communities.

Community-controlled LGBTIQA+ service workshop

Community leaders involved with WA-based community-controlled LGBTIQA+ peer-led services (n=10) participated in the community leaders workshop. Broadly, results highlight defining features both peer-led and community-controlled services and their differences. Common across experiences were shared challenges in defining service delivery, the need for organisational support to deliver services, and the importance of delivering safe and inclusive services.

“The beautiful mess of community services”: Defining service delivery and primary health care

Participants took a broad approach to their conceptualisation of primary health service delivery, drawing on the social determinants of health and a “well-being” approach. Mental health, community-connectedness, relationships, employment, and housing were all considered to be part of health. Amongst participants there were diverse definitions of what constituted ‘service delivery’. For some, services were individual-focused, described as part of a structured project and formalised organisation, and in line with government funding; for example, providing clinical health care or running events. Other participants

viewed service delivery more broadly, defining sporting events and informal coffee chats as services. In addition, participants noted a difference between services for community (i.e., advocacy, Pride-events) and services for an individual community member (i.e., peer support, capacity building) and services for those outside the community (i.e., workplace training). The following quote captures the definitional challenges.

> *"There's a difficult line – when does it become a peer support service, and when does that become having a cup of coffee? Where do you draw the line of whether it's a service? And when it's not (a service) – just when it gets the funding?"* (P8)

"You can breathe": Peer-led services as a value-based approach delivered by people with lived experience

Participants described a peer as someone with "lived experience"; by extension, a peer-led service involved the delivery of a service by someone who had a similar experience or identity as the target group. In doing so, this facilitated "an understanding" that services were then built on, negating the need for members of the community to have to describe the shared experience, for example:

> *"I can expect to see people in the room who are exactly like me... You don't have to spend an hour explaining yourself".* (P3)

However, peer-led services were *"not just a simple thing"* – they required a balance of skillsets, and qualifications, alongside the insights of being a peer. Additionally, peer-led services had foundations in a set of values and ethics that distinguished its approach, described as *"human-based"* and *"bottom-up community"*. To create a *"safe approach"*, peer work had to involve genuine consultation with community and have a willingness to resist current systems or structures that did not support community, as noted here:

> *"...there's also a bunch of other values that's about, like, navigating power and race and class and medical systems... it gets really into the grassroots stuff".* (P5)

"It's in the DNA": Community-controlled services have genuine community collaboration

Community-controlled organisations were broadly seen as organisations being run by a peer, in this case someone, or a group of people who are LGBTIQA+. Like peer-led services, there was an inherent value-base for delivering quality services. Participants described "quality" organisations as those where community consultation with members outside of the organisation was built into the organisation's governance. This meant trying to reject medicalised and colonised ways of working or conceptualising health and delivering services that were culturally safe. Community-controlled organisations were also expected to be collaborative, working with other organisations within the LGBTIQA+ space:

> *"So it's not just its systems, it's a form of governance, it's the way in which it actually moves as an organisation."* (P9)

Participants reflected on the challenges of delivering genuine, community-controlled services that met this value-base. Most community-controlled services were not incorporated and unable to access government funding, so that they could remain receptive to the needs of their community and stay genuine to their values, as evidenced here.

> *"We have tried to do some of that resisting of power structures. And what it means is, you know, not incorporating, which means not being able to access resources in a way that you might be able to access resources if you did go through those systems."* (P1)

As a result, funding for services often went to non-community-controlled services, which were observed by participants as not necessarily providing services in line with the value-base expected:

> *"I think the current climate has elicited, that those that are doing (services) well are kind of almost de-professionalised because of it, because they don't have that funding base behind them. And then you've got others that are getting the funding... but perhaps not delivering it in the way...we feel it should be."* (P9)

"Built into the infrastructure": Organisational support for delivering quality peer-led and community-controlled services

Community-controlled services did not always deliver peer-led services; participants noted that peer-led services were often delivered by non-community-controlled organisations. Again, participants described a set of values that determined the quality of services regardless of the organisation type. Quality peer-led services were reported as those that had a safe approach and were delivered by organisations (community-controlled or not) where there was genuine support for peer-led or peer-controlled and willingness to collaborate with community. Participants suggested that this was built into organisational governance, with meaningful community-consultation and shared decision-making stated within policies and procedures. Community was expected to be visible in decision-making positions, such as senior management or as board members. Additionally, participants suggested that organisations were expected to consult with community members beyond those involved within the organisation and required to have a certain flexibility to be able to pivot to the needs of community. One participant reflected:

> *"Do you have (community) as staff? Do you have (community) on your board? Because at the end of the day, you can't represent a community unless there's proper engagement."* (P3)

"It's not a monolith of people": Delivering safe, inclusive services

Participants reflected both on the diversity of their community and being mindful of intersectionality in delivering peer-led or community-controlled services. Their narratives highlighted that there were "communities within communities," and that not all peer-led or community-controlled services were safe or relevant for all members. For example, an LGBTIQA+ organisation may have services that are led by peers who are gay men, and therefore may not be relevant for someone who is trans. Thus, participants reported a need to provide very specific peer-led or community-controlled services as noted here:

> *"...delivering services that are specific to a community that is more vulnerable than other communities within the acronym is really important. I think you can't really have an LGBTIQA plus organisation without some kind of specializations within that."* (P1)

Likewise, participants reflected that services were not necessarily culturally safe for people of colour and First Nations people. A need for services that were safe and developed in collaboration with a diverse range of community members, was described:

> *"But I think within all queer and trans communities having culturally informed culturally safe and culturally relevant programs, or supports or whatever, for First Nations people and people of colour within all of those groups... And people can be completely, like, shut out of queer spaces, because they're just not relevant."* (P2)

Western Australian LGBTIQA+ organisation workshops

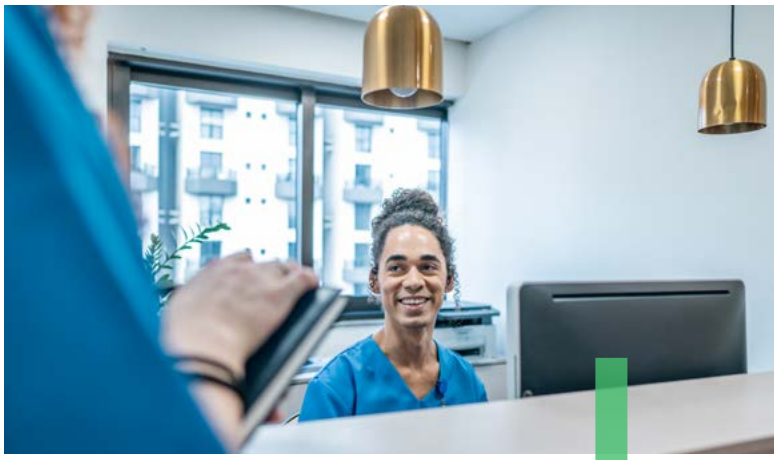
Five metropolitan and thirteen regional LGBTIQA+ community leaders participated in two consultation workshops on LGBTIQA+ health and service provision. Results have been combined and are themed against the domains of inquiry below.

Health and wellbeing priorities for LGBTIQA+ communities

All participants identified priorities including physical and mental health but also broader priorities relating to the social determinants of health such as safe housing. Metropolitan participants noted physical health priorities including sexual and reproductive health (including STI and PrEP awareness), smoking and vaping and support for gender affirmation. Regional participants also highlighted issues such as alcohol and substance use. Social and cultural priorities for metropolitan participants included: elder visibility (relating to social inclusion); workplace discrimination; and parenting, surrogacy, and family support while regional participants also highlighted broader issues, such as employment. All participants reported issues related to violence and physical safety (including assault, family and domestic violence, and intimate partner violence and sexual abuse).

Mental health priorities were also highlighted by all participants. Metropolitan participants noted the need for neurodiversity support, mental health support and suicide prevention, and peer-led crisis support. Regional participants suggested that poor mental health outcomes were exacerbated by limited social connections within small communities where social isolation was intensified due to experiences of homophobia, transphobia, and racism, for example:

> *"... (queer) people have rising levels of fear about accessing services and going out in public and with all the various things are happening in other countries and over east, and they're just (staying at home), that's impacting on the mental health."* (P9, Regional)



Compounding this was a lack of culturally appropriate services, with regional participants noting this as a particular challenge for First Nations and people from culturally and linguistically diverse backgrounds. Consistently, participants reported a need for health services and other spaces where LGBTIQ+ people felt safe and welcomed. All participants cited a need for health care that was appropriate, and affordable for all as noted here by a metropolitan participant.

> *"Joining in on the affordable health care... GPs that they can go to and not have to like, explain their pronouns... Like, they can just go and get some health care."* (P5, Metropolitan)

Participants emphasised a lack of supportive, accessible services for queer people within the regions, including GPs and mental health services. Regional participants also suggested that limited services were particularly evident for those seeking gender affirming care, with difficulty finding supportive and experienced health professionals or spaces in which people were safe. One participant described the longer term impacts when care was not gender-affirming.

> *"...people I rescue from our hospital, people who have been in there for mental health, and they've been misgendered the whole time and treated badly... the person is worse than they were then when they went in."* (P12, Regional)

Existing programs and services for LGBTIQA+ communities

Participants were aware of several types of services for LGBTIQA+ communities. Services included: government-funded organisations for sexual and reproductive health and mental health; hospital-based services for gender affirming care; local advisory groups providing community visibility (i.e., being visible at community events, participating in research) and social support (such as board game nights, bingo, and dinner events); and community-controlled organisations that provided advocacy (individual and community), service referrals or advice, and/or peer support for queer communities.

Regional participants also identified other known services counselling (including specifically on gender or sexuality and/or young people), research projects, and educational workshops for young people. However, regional participants also reflected that services and programs were often too narrow in scope, for example, only providing support for people within a specified age range or with a particular concern.

Metropolitan participants reflected that many services were community-controlled, which were often volunteer-based or with very small staff time, with few services provided via state or federal government:

> *"All of these are community led. And if the government is doing anything, none of us know about it... And I think 'mental load', I think the entire community is servicing themselves."*
> (P2, Metropolitan)

Experiences accessing mainstream and LGBTIQA+ programs and services

Participants recounted problems accessing supportive, trained health professionals in a timely manner. Participants accessing mainstream services, described having to take on "a bit of an education role" (P5, Metropolitan) with health care providers to receive appropriate health care. This included providing instructions on language or educating providers on relevant health issues, even when a health care provider was supportive and had undertaken training on servicing queer communities.

Participants described being cautious as to which service providers they disclosed their sexuality to, despite recognition that this may impact service provision. For example, this included not disclosing sexuality and discussing relevant health issues with their GP (i.e., PrEP):

> *"I've been going to this doctor for quite a while... but we never ever broach the subject (sexuality)... I got a sort of a very careful approach to what I say and how I approach my words."*
> (P4, Metropolitan)

Other participants described a hyperfocus from health professionals on their gender and/or sexuality in unrelated consults, as described by this regional participant:

> *"And yeah it's not that they're (GP) transphobic – they are too interested. I've gone in about like, "Oh, this weird mole" ... then after spend 10 to 15 minutes discussing my transition, which is like... not relevant. Like can we... stop talking about it, but like, they're the ones with the power like I'm not gonna sit there and be like, I'm not answering these questions."*
> (P13, Regional)

Regional participants also cited challenges related to a lack of confidentiality due to their located in a small community, with previous incidences of health professionals disclosing patient information to friends or family or participants being put in a position where they had to disclose sexuality in unrelated consults. As a result, participants described delaying or avoiding care, or deciding to drive into Perth to receive appropriate care:

> *"The GP (asking) 'what about the father?' ... Having to go 'I am a lesbian' ... Just give me the referral. My son needs help... why do I have to out myself every single time I'm here? ... I quite often will avoid going to a doctor... it's been a couple times I've ended up in emergency care."* (P10, Regional)

Where there weren't appropriate services in the region (i.e., gender affirming care), a lack of telehealth service options or shared care options meant participants had long distances to travel. One participant described the impact of distance as a barrier to access:

> *"I had an appointment... I had to drive from Geraldton to down here (Perth). The appointment took 10 minutes... we got back in the car and drove home. They would not let me do telehealth... It's scary as a parent, you know, and everyone knows what your kid needs, and you cannot trust the system to not put multiple roadblocks in place."* (P12, Regional)

Overall, participants reflected that they didn't feel as *"valued or as comfortable"* (P3, Metropolitan) when accessing some mainstream services, with one participant comparing their experience to that in a queer service which was more *"familiar"* (P3, Metropolitan) and provided more personalised care.

> *"(Accessing LGBTIQA+ services) you feel that the person is listening to you, that they've asked the right questions, and that you're getting the outcome that you wanted."* (P3, Metropolitan)

Challenges and gaps in programs and services for LGBTIQA+ communities

Identified gaps in programs and services predominately centred on having affordable, appropriate and culturally responsive health care. The importance of mainstream services that were inclusive was also highlighted.

Participants highlighted the need for trained health professionals in the areas of mental health, sexual health, general health, and gender affirming care. Participants also identified the need for mental health services related to crisis support (including peer support groups), mental health appointments and neurodivergent assessments and support. Gaps in physical health services reported by participants included: peer-led sexual health education, queer-friendly specialist sexual health services, fertility and surrogacy support, peer support for trans and intersex people and gender affirming surgery.

A lack of services was cited as particularly problematic for remote communities. When participants did find a trained, queer-friendly health professional, high staff turnover in the regions meant that that staff member was likely to move on in a few months as reported by participants here:

> *"The junior trainee doctors come in, they do their regional stint and they're gone."* (P13, Regional)

"I found that churn again is a problem in the regional towns. You finally get a good psych. And three months later, they've moved on somewhere else. And that just happens over and over again." (P12, Regional)

Where some of these services were available, participants described them as often volunteer based and underfunded. Consistently, further resourcing was identified as required to increase reach. Regional participants highlighted that there was a lack of core funding available to queer community-led groups with limited capacity to apply for grants. Consequently, participants reported that organisational time was often spent advocating for individuals or the community, which could instead be provided by a dedicated, funded services:

"Well, if the services were there and working for us... fully government funded, not dysfunctional... you (would) just point them in the right direction... if we no longer have to do so much advocacy... we could just be a nice community volunteer organisation that organises the get togethers and has drinks once a month." (P13, Regional)

Regional participants also identified gaps in other services, such as domestic violence and housing. Existing services were often funded for specific groups and excluded others, or were services delivered by homophobic and transphobia organisations. This was often compounded where other federal services were lacking such as Centrelink as described here by several regional participants:

"... for young people trying to access Centrelink, they couldn't because Centrelink would have to go through their parents who were typically violent and abusive. So they were financially cut off... Left on the street with no finances, or housing, no family support, nothing." (P3, Regional)

"... we have 74 people homeless at the moment... And we have the added problem that the local resource for homelessness is also deeply anti trans. Right. It's like the idea that any of those kids out there that are homeless might be trans – It's horrifying." (P5, Regional)

Responding to gaps in LGBTIQA+ programs and services

Participants presented a range of suggestions to address identified gaps, relating both to health care and broader societal factors including at the policy level. For example, regional participants identified the need to establish an LGBTIQ+ portfolio into state government:

"Because our biggest challenge in getting funding is there's no portfolio.... And the responsibility is everybody's responsible, which in practice means no one is responsible." (P12, Regional)

Other societal factors included more affordable and accessible legal services for LGBTIQA+ communities (including executor services for bequests to queer community groups), abolishment of same sex schools, visibility of LGBTIQA+ people in professional sports (including the inclusion of trans people) and funding non-gendered sport, and reforms to insurance industry to remove increased premiums for LGBTIQA+ people.

Health care changes included affordable and accessible (including free) services (particularly in the areas of mental health, surrogacy and fertility, domestic violence and improved access to GPs) including more services available in regional areas. Proximity was highlighted as a challenge:

"Having localised services in the regions... So people don't have to like move away from their communities or leave their homes or travel hundreds of kilometres... So I think having like health care available, where everyone is in their local place." (P5, Metropolitan)

Participants made other suggestions including for service providers to undertake mandatory training on LGBTIQA+ health issues, removal of questions relating to sexuality in blood donations, cessation of non-consented medical interventions on intersex minors, and changes to health services forms to accurately record sex, gender and identity. Additional suggestions from regional participants included LGBTIQA+ training embedded in health professional education, decentralised care (particularly for gender affirming care), accreditation processes for queer-friendly health professionals with ongoing training,

Participants also suggested the need for increased funding to community-led services and outreach services, including for LGBTIQA+ nursing homes, a specific LBGTIQA+ health clinic and specific First Nations LGBTIQA+ services. Participants recommended services should be established with representation from peers from different backgrounds (i.e., CaLD, First Nations):

"Having like, in all of the services, peers with diverse identities and backgrounds, so queer peers aren't just white people, and aren't just young people that it's like, all ages, all sorts of backgrounds and experiences." (P5, Metropolitan)

Additionally, metropolitan participants identified a need for a directory of LGBTIQA+ health services supported by peer navigators, that connected people to relevant services in a timely manner. As reported by one participant:

"So if you're a young person who's struggling with a particular issue, and there's a whole range of disparate services, whether there's a navigation function to help that person... also, in my mind a joining up of a service sort of way."
(P1, Metropolitan)

Related, participants described a want for a 'one stop shop' for queer health in regional towns, that included mental health, sexual health, and queer-friendly GPs:

"LGBTQI+ health centre, drop in with everything in one place... like amazing GPs, all the mental health care you can ever shake a stick at, sexual health services, even like legal services, just everything... it would all be there... it's a wonderland."
(P13, Regional)

Mainstream service surveys

Organisation identity and structure

Of the 45 surveyed organisations, 57.8% (n=26) described themselves as health services managed by the state government, 35.6% (n=16) were non-governmental organisations, with a further 4.4% (n=2) and 2.2% (n=1) describing themselves as local government organisations and a clinical/medical service, respectively. Around one-quarter (26.2%, n=11) of organisations considered their LGTBIQA+ services as peer-based. These outcomes are displayed in Table 7.

Table 7. Organisation type compared to peer-based service provision and mean community-control rating

Community Category	Provides Peer-Based Services?		Community-Control Rating (mean)
Community Organisation (n=14)	Yes	5 (36.4%)	9.29
	No	7 (54.5%)	
	Unsure	2 (9.1%)	
State Government Service (n=25)	Yes	3 (12.0%)	8.84
	No	12 (48.0%)	
	Unsure	10 (40.0%)	
Local Government Authority (n=2)	Yes	2 (100%)	8.00
	No	0 (0%)	
	Unsure	0 (0%)	
Clinical/Medical Service (n=1)	Yes	1 (100%)	-
	No	0 (0%)	
	Unsure	0 (0%)	
Total (n=42)	**Yes**	**11 (26.2%)**	**8.95**
	No	**19 (45.2%)**	
	Unsure	**12 (28.6%)**	

Two-thirds (65.7%, n=23) of surveyed organisations had been providing specific services for LGBTIQA+ communities for less than 5 years, with just under half (48.6%, n=17) providing specific LGBTIQA+ services for less than a year. One in five organisations (20.0%, n=7) had been providing services for more than ten years.

Just over a quarter (28.6%, n=12) of organisations currently had a specific LGBTIQA+ inclusion or action plan that was available either publicly or internally, while 38.1% (n=16) did not have an inclusion or action plan but referred to LGBTIQA+ communities in broader strategies. Several organisation reported no current plan related to LGBTIQA+ communities, while almost one in ten organisation (9.5%, n=4) had discussed plans but were yet to action them.

Two in five (40%, n=16) surveyed organisations' reported their services/initiatives were limited to the Perth metropolitan area, 42.5% (n=11) had a reach that was state-wide, while 5% (n=2) operated in regional WA. A summary of organisations reach of services/initiatives can be seen in Table 8.

Table 8. Organisation category compared to reach of LGBTIQA+ specific services/initiatives

Community Category	Service/Initiative Reach	
Community Organisation (n=16)	Metropolitan Perth	7 (43.75%)
	Regional WA	1 (6.25%)
	State-Wide	7 (43.75%)
	Other	1 (6.25%)
State Government Service (n=21)	Metropolitan Perth	7 (33.3%)
	Regional WA	1 (4.8%)
	State-Wide	9 (42.9%)
	Other	4 (19.0%)
Local Government Authority (n=2)	Metropolitan Perth	2 (100%)
	Regional WA	0 (0%)
	State-Wide	0 (0%)
	Other	0 (0%)
Clinical/Medical Service (n=1)	Metropolitan Perth	0 (0%)
	Regional WA	0 (0%)
	State-Wide	1 (100%)
	Other	0 (0%)
Total (n=40)	**Metropolitan Perth**	**16 (40.0%)**
	Regional WA	**2 (5.0%)**
	State-Wide	**17 (42.5%)**
	Other	**5 (12.5%)**

Just over one in ten (12.8%, n=5) organisations had more than two FTE paid staff dedicated to serving LGBTIQA+ communities, 7.7% (n=3) had one to two FTE staff, while almost one-quarter of organisations (23.1%, n=9) had less than one FTE staff. More than half (56.4%, n=22) of organisations had no paid staff. A summary of organisational FTE staff can be seen in Table 9.

Table 9. Organisation category compared to number of FTE paid staff dedicated to serving LGBTIQA+ communities

Community Category	Number of FTE Paid Staff	
Community Organisation (n=14)	0	8 (57.14%)
	<1	4 (28.57%)
	1-2	1 (7.14%)
	2+	1 (7.14%)
State Government Service (n=22)	0	14 (63.6%)
	<1	3 (13.6%)
	1-2	2 (9.1%)
	2+	3 (13.6%)
Local Government Authority (n=2)	0	0 (0%)
	<1	2 (100%)
	1-2	0 (0%)
	2+	0 (0%)
Clinical/Medical Service (n=2)	0	0 (0%)
	<1	0 (0%)
	1-2	0 (0%)
	2+	1 (100%)
Total (n=39)	**0**	**22 (56.4%)**
	<1	**9 (23.1%)**
	1-2	**3 (7.7%)**
	2+	**5 (12.8%)**

A similar trend was evident in organisations' volunteer staff, with 81.1% (n=30) having no volunteer staff dedicated to providing services to LGBTIQA+ communities. One organisation (2.7%) had one to two FTE equivalent volunteers, while 13.5% (n= 5) of organisations had more than two FTE paid staff equivalent volunteers. A summary of organisational FTE equivalent volunteer staff can be seen in Table 10.

Table 10. Organisation category compared to number of FTE unpaid volunteers dedicated to serving LGBTIQA+ communities

Community Category	Number of FTE Unpaid Volunteers	
Community Organisation (n=14)	0	12 (85.71%)
	<1	1 (7.14%)
	1-2	0 (0%)
	2+	1 (7.14%)
State Government Service (n=20)	0	15 (75.0%)
	<1	0 (0%)
	1-2	1 (5.0%)
	2+	4 (20.0%)
Local Government Authority (n=2)	0	2 (100%)
	<1	0 (0%)
	1-2	0 (0%)
	2+	0 (0%)
Clinical/Medical Service (n=1)	0	1 (100%)
	<1	0 (0%)
	1-2	0 (0%)
	2+	0 (0%)
Total (n=37)	**0**	**30 (81.1%)**
	<1	**1 (2.7%)**
	1-2	**1 (2.7%)**
	2+	**5 (13.5%)**

Diversity training

While several organisations required their staff to undertake LGBTIQA+ inclusion training at least once a year, with the remainder of surveyed organisations either not having such training available, or it was not mandatory for staff to complete. Many organisations had internal initiatives to support LGBTIQA+ staff. This included 'pride committees' which allowed LGBTIQA+ staff to regularly meet and organise LGBTIQA+ events, this was often supported by a diversity officer. Some organisations also updated their document and management systems to include options for pronouns, gender identity and preferred names.

Services provided

Commonly reported services provided by organisations included promotion of cancer screening to the LGBTIQA+ community, education services, AOD rehabilitation and housing programs, as well as community support groups.

While many surveyed organisations reported that they did not provide services to the LGBTIQA+ community directly, some reported providing indirect services such as collaborating with Pride events and LGBTIQA+ diversity employment programs.

Priority health care issues

Providing affirming healthcare environments was identified as a priority issue for LGBTIQA+. Organisations reported this could be resolved through training to improve the knowledge and cultural competency of healthcare staff, employment of LGBTIQA+ inclusive staff, in addition to addressing health care stigma and discrimination. The mental health of the LGBTIQA+ community was also a commonly reported priority, with organisations also highlighting concern regarding the higher prevalence of mental disorders, AOD use and suicide rates in LGBTIQA+ communities. Organisations reported that expanding mental health and AOD services for LGBTIQA+ communities in mainstream service providers as well as establishing specialist services were the most effective mechanisms to tackle this issue. Additionally, barriers for LGBTIQA+ communities to cancer screenings were also reported by several organisations as priorities, suggesting that this could be addressed through self-screening services and greater education and awareness of screening programs in the community.

Importance of community-controlled organisations

Participants were asked to rate the importance of community-controlled organisations in LGBTIQA+ service provision on a scale from 1-10. The mean score was 8.95; over half (n=23) of organisations rated the importance of community-controlled organisations as a 10. Most of the organisations that strongly supported community-control believed that lived experiences allowed for greater understanding and responsiveness to the needs of the LGBTIQA+ community, in addition to contributing to significant empowerment and connectivity of the community.

Organisations who did not rate the importance of community-controlled organisations highly, believed that services did not always have to be provided by LGBTIQA+ controlled organisations and integration into mainstream health care was desirable. However, these same organisations reported that LGBTIQA+ board representation and strong collaboration between organisations was crucial to providing LGBTIQA+-specific services.

Mainstream services workshop

Thirty-two representatives from mainstream health care services were consulted about their experiences providing care for LGBTIQA+ people. They were asked about current barriers to including and further welcoming LGBTIQA+ people to attend their services, as well as current gaps in mainstream services' capacity to support these communities.

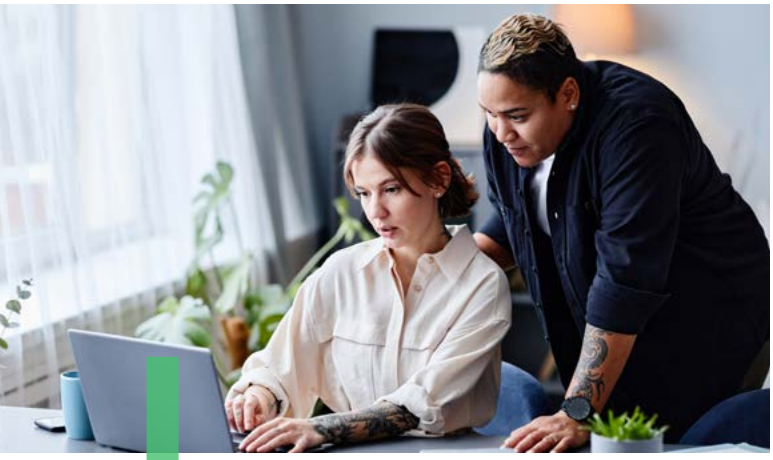
Gaps in LGBTIQA+ health

Participants discussed current LGBTIQA+ health care gaps, as well as barriers to care. Participants identified a lack of treatment *"tailored to LGBTIQA+ patients"*. Participants reported that this lack of LGBTIQA+ specialisation and education ultimately affect attendance rates and quality of care provided to the LGBTIQA+ community. Other barriers included a lack of inclusive language, LGBTIQA+ visibility, challenging cultural beliefs, unconscious bias, and institutional barriers. This included overt and *"soft"* discrimination at the interpersonal, organisational, and institutional level. For example, one participant stated:

"sometimes I think it is there is a level of ignorance, but it's also not understanding the difference between equity and equality". (P24)

Another topic discussed by participants was current knowledge gaps regarding the interaction between LGBTIQA+ lived experience and other marginalising identities or life factors. As highlighted by one participant, *"LGBTIQA+ people themselves are not homogenous group"*, and the heterogeneity and specific needs of individuals require greater consideration. Another gap identified was the *"lack of research into the intersectionality"* of LGBTIQA+ experiences, which means services are often relying on incomplete or contradicting evidence for care.

Participants were asked to list what they viewed as the most significant barriers to LGBTIQA+ people accessing mainstream services. With regards to client-related barriers, participants reported: stigma and discrimination (e.g. misgendering or exclusionary language used by staff, shame-based narratives around HIV and other sexual health matters, previous discriminatory health care experiences); site accessibility (e.g. issues with transport or location, inaccessibility for disabled people); lack of visible inclusivity in the space (e.g. binary gender options in forms, no visual LGBTIQA+ signs, no LGBTIQA+ staff); and incomplete or LGBTIQA+ exclusionary care and treatment approaches (e.g. lack of LGBTIQA+ training for clinical staff).



When asked about service-provider related barriers, participants discussed a wide range of issues, including: lack of in-depth intersectional approaches to LGBTIQA+ health care (e.g. tokenism, perpetuation of exclusionary practices, lack of cultural sensitivity around LGBTIQA+ people's experiences as they intersect with other cultural matters); insufficient capacity to service the entire community (e.g. lack of flexible and timely training and ongoing funding, inability to care for people without familial support); issues within organisational teams (e.g. bullying, conflicting cultural beliefs); and administrative issues (e.g. lack of appropriate fields on intake forms and software; lack of proper recordkeeping, inefficient complaints and resolution processes).

Institutional and site-based barriers to LGBTIQA+ health care were also discussed. These included: architectural issues (e.g. building codes leading to inaccessibility); lack of holistic, site-wide health care approaches (i.e. trauma-informed, intersectional, culturally sensitive care); organisational attitudes and values (e.g. patriarchal work structures, acceptance of homophobic and transphobic attitudes, unwelcoming work culture, uneven expectations around training, behaviour, and contribution across levels); bureaucratic and policy issues (e.g. non-existent or difficult to find policies, lack of buy-in from executives on policy and procedure improvement, incomplete or missing client demographic data); lack of visible diversity (e.g. lack of LGBTIQA+ staff, LGBTIQA+ inclusive signage); and lack of support for existing or future LGBTIQA+ staff (e.g. lack of equitable recruitment and career pathways, LGBTIQA+ staff often solely burdened with LGBTIQA+ matters).

Solutions to Barriers

Participants were asked to identify approaches that would be most useful to address existing barriers and prevent or minimise future barriers. Responses were broadly categorised into three themes, discussed below.

Community participation and peer work

The first major theme that arose was the need for a stronger focus on the LGBTIQA+ peer work and community participation within mainstream services. The group discussed the importance of focusing on capacity-building as well as forming career pathways for LGBTIQA+ people in health, to ensure peer work can exist consistently and sustainably within mainstream services. However, in relation to building mainstream services' capacity and knowledge base around LGBTIQA+ health care best practices, one participant stated that there are:

> *"very few funded LGBT community-controlled, peer-led organisations, but they are essential partners".* (P6)

Participants agreed on the need for *"strong consumer representation"*, and that LGBTIQA+ communities are not *"seeing themselves represented in staffing"* across mainstream services, increasing the likelihood of non-attendance or client attrition. Alongside the necessity of peer work, the group also discussed the growing need for meaningful inclusion of community members. For example, one participant said there is a need to focus on:

> *"genuinely welcoming inclusion, not just rainbow-washing or tokenistic, surface level inclusion".* (P15)

Another participant suggested that alongside purposive, community-focused staff recruitment, there was a need to ensure all employees:

> *"can respectfully communicate with their colleagues and the people they are providing a service to".* (P21)

Participants suggested that ensuring community members feel safe and included within a heath service begins with how welcoming the space and staff are, and ensuring that all staff across all levels are adequately trained and educated in appropriate language and approaches to LGBTIQA+ communities.

Structural change and advocacy

The second theme raised by participants was the need for structural change at executive and governmental levels, and the need for further advocacy for LGBTIQA+ equity that is *"driven by the staff, by the leadership, by the board, by everybody"*. This included advocating for more equitable laws and policies around reproductive rights, Medicare access, and other institutional issues which affect LGBTIQA+ people. For example, one participant suggested that future policy development and delivery:

> *"should consider LGBTIQA+ people, their family, significant others, carers and the impacts those policies may have [on those people]".* (P8)

Participants also spoke to the role of evaluation and research in improving health care conditions for LGBTIQA+ people. One participant suggested a need for *"partnership between services, consumers and researchers"* to make sure that the perspectives of LGBTIQA+ health care users are central: *"... because they're the ones who are going to be affected by it"*.

Participants also stated that the *"lack of data collection"* by the public sector commission, as well as mainstream service providers, is an ongoing contributing factor to lack of quality evidence and benchmarking. Participants reported that mainstream services were *"not encouraged to try [to collect data] for ourselves because we're not resourced for it"*.

One participant also referred to the need for organisations to take on more community feedback, including negative feedback:

> *"If people share their experiences, even bad experiences, from a health organisation, that's the data that organisations should take seriously."* (P31)

Overall participants agreed that *"we need to bring policy makers, decision makers along with the process of change"* to bring about more effective support for LGBTIQA+ people and the health providers who support them.

Funding and resources

The last theme centred on issues surrounding funding and resources. Participants reported feeling that organisations were *"competing over resources"*, made increasingly difficult by the lack of stable funding provided to LGBTIQA+ inclusive health services. Participants reported that this meant that service providers had to compromise on delivery and provide incomplete or lower quality LGBTIQA+ support. For example, one participant asked:

> *"How can we signal to all that we are as inclusive as possible while also trying to keep the lights on and run the service?"* (P17)

Participants agreed there is a desperate need for *"long-term, protected funding"* that is also targeted towards a broad range of treatments and service types. This includes the need for stable funding around issues which specifically affect LGBTIQA+ people such as gender affirming surgery and mental health, as well as funding for structural necessities such as professional development and *"getting people who want to work in the field to actually become [...] clinicians"*. Participants suggested that this meant investing in both upskilling existing staff and ensuring future LGBTIQA+ employees are sustainably supported to do their crucial work and develop a meaningful career path.

Peer work and community control

Peer work

"The majority of community controlled and peer led organisations are largely volunteer-run."
LGBTIQA+ Service Stakeholder

Peer work has been a mainstay of LGBT health services from their inception, with early AIDS councils and other LGBT support organisations having been developed and maintained by grassroots LGBT activists from local communities [16]. Peer work (and leadership) continues to play a vital role in the work of AIDS councils and other HIV programs in Australia, despite ongoing systemic barriers which impede the influence of those peers [17]. Although there is little research specifically on LGBT peer work in Australia, organisations such as TransFolk of WA [18], Thorne Harbour Health [19], and ACON [20] place a significant emphasis on LGBT peer work across their advocacy and support programs. The Western Australian LGBTI Health Strategy [21] also emphasises the importance of LGBT peer work, particularly peer-led programs.

"We want peer led services, but we also want to be able to access what everyone else accesses, and know that we're going to get good service."
LGBTIQA+ Service Stakeholder

Not all peer work is approached equally or consistently, particularly in organisations that are not LGBT-specific. In a study about job recruitment and disability in Australia Davies and Butler [22] suggest that many employers do not conduct targeted peer hiring instead including disability and LGBT status amongst many marginalised identities who are 'encouraged' to apply for an otherwise non-peer-specific role. While those organisations may benefit from the lived experiences of their employees, many workplaces who hire peers do not adequately address the specific needs of marginalised peers, such as consistent supervision, modified work conditions to combat burnout/overwork, and filling in skill gaps in areas where lived experience workers may be under-experienced or under-educated [23].

Community controlled services

"Community control as part of the future [of healthcare] gives us best outcomes."
LGBTIQA+ Service Stakeholder

Though peer work has been shown to be a highly effective means of engaging with LGBT peoples around a variety of health issues, most of the peer work continues to be conducted in services which are owned and operated by people outside of the community. Emerging research on LGBT health engagement suggests that community controlled services (i.e. services which are governed and managed by LGBT peers) have a significant positive impact on LGBT clients' sense of safety and comfort in accessing the service [24,25]. Community control has been shown to be crucial for facilitating access, particularly for more sensitive services such as family and domestic violence support [26], mental health care [27], and sexual health clinics [7]. Community-controlled services have been highlighted as a major pathway to addressing health inequalities and providing holistic and targeted care to LGBT people, especially trans people [28].

"Our community wants choice and control. We're talking about a community that is under resourced, so to have full choice, we also need to be fully resourced."
LGBTIQA+ Service Stakeholder

LGBTIQ+ Health Australia has recommended that the government provides additional funding and support for community-controlled LGBT health services [29]. This is supported by the collaborative submission

made to the Royal Commission into Victoria's Mental Health System co-signed by Thorne Harbour Health, Rainbow Health Victoria, and Switchboard [30]. The submission argues that community-controlled services are vital for providing LGBT people with safe, supportive, holistic, and truly inclusive care and have benefits across a variety of services including mental health, housing, and drug and alcohol services [30]. In WA, the City of Perth has committed to promoting grants and sponsorships for community-controlled organisations in order to improve their capacity to provide the unique care these organisations provide to LGBT peoples in the city [31]. The WA LGBTI Health Strategy [21] also states a need for "LGBTI specific" services, though it does not clarify whether this term exclusively refers to community-controlled organisations or whether it also includes LGBTI-specific services that are not owned and run by members of the WA LGBTI community.

"Community-controlled service provision ensures services are tailored to nuanced and specific needs of people in LGBTIQA+ communities. these needs are not well understood by non-LGBTIQA+ people and current models of mainstream service provision are not working to meet the needs of LGBTIQA+ people. This is demonstrated by the higher risks of poor health and mental health outcomes for LGBTIQA+ people."
State Government Stakeholder

"Research clearly demonstrates peer and community based interventions or programs are the most effective. It also allows for better project design. Nothing about us without us. This is the case for all the priority populations we work with."
Mainstream NGO Stakeholder

"...government organisations need to go through a lot of bureaucracy for little change, and even then - it will not consult the right people so it is not guaranteed to get it right when it does change. If community controlled, LGBTQIA+ people have access to better health care and an organisation that can change more easily as more information becomes available on trans-inclusive and LGBTQIA+ health care."
State Government Stakeholder

"We still have a long way to go in supporting community led groups and initiatives. But it is clear that undertaking actions that are not co-designed with community and do not have strong community support are less effective. We know that our strategic plans require extensive input from community and specifically priority populations such as LGBTIQA+ groups to ensure they are comprehensive."
Local Government Stakeholder

"The WA Health system has failed to provide LGBTQIA+ services and failed to action any of its 2019-2024 LGBTIQ Health Strategy. Community organisations and volunteer groups are the only support many LGBTQ+ people have in regional WA."
State Government Stakeholder

LGBTIQA+ Health and Wellbeing: A Snapshot

LGBTIQA+ Health and Wellbeing: A Snapshot

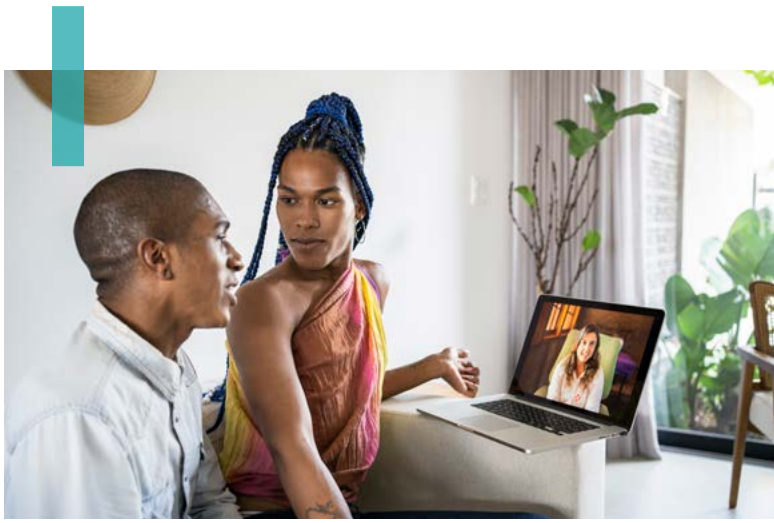
General health care

LGBTIQA+ people experience a variety of experiences within health care contexts, with significant impact on their access to and quality of appropriate health care. For example, just over half (56.2%) of LGBT Australians have private health care [32] while around two-thirds (65.5%) have a regular GP, lower than the national average [32]. Around one in ten (9.8%) do not have a regular GP or clinic [32], which can affect continuity of care. The majority of LGBT Australians attend mainstream health services (83.5%), with only a quarter attending a stated LGBT-inclusive clinic and only 5.7% attending an LGBT-specific medical service [32]. LGBT Australians are more likely to report fair/poor overall health (27.5%) compared to their non-LGBT counterparts (19.9%) [33].

> *"I'm always very excited to hear when the whole GP practice has done training on trans healthcare."*
> LGBTIQA+ Service Stakeholder

Across all health care, LGBT people are challenged by a lack of LGBT-specific medical education [34]. Lack of LGBT-inclusive education can result in GPs and other point-of-access health workers providing care that does not adequately address the needs of patients, for example those who may be seeking gender-affirming care [35,36]. This lack of LGBT-specific medical education often results in LGBT patients receiving incomplete care, and contending with clinicians who may be biased against LGBT people [24]. One Australian study has suggested that systemic stigma (in particular around events such as the Marriage Equality referendum) correlates strongly with reduced visitations to GPs and other clinical services, as well as increased use of antidepressants and similar medications [37]. Although the National Preventative Health Strategy 2021-2030 [38] names LGBT people as a priority population for prevention and health promotion, the document provides no LGBT-specific intervention strategies or frameworks.

Trans and intersex people are especially affected by current understandings in the health system of their specific needs. Trans people often experience both direct and indirect exclusion from general health care [39] as well as ongoing lack of trans-specific health care training for clinicians and health workers [40] leading to many of their specific needs remaining unaddressed. Similarly, intersex people continue to experience discriminatory health practices, with over half of reported intersex 'treatments' being conducted before the age of 18 with the majority conducted without the individual receiving any information about the treatment or being given the opportunity to opt out [41]. These medical interventions disempower intersex people and often cause more harm than good [42,43]. The majority of intersex people included in the Intersex: Stories and Statistics From Australia report [41] have experienced at least one negative impact as a result of intersex-specific medical intervention, including some which had potentially life-threatening consequences. While studies in other countries indicate that there are significant intra-community differences in experiences of health care [44], there is little information about these



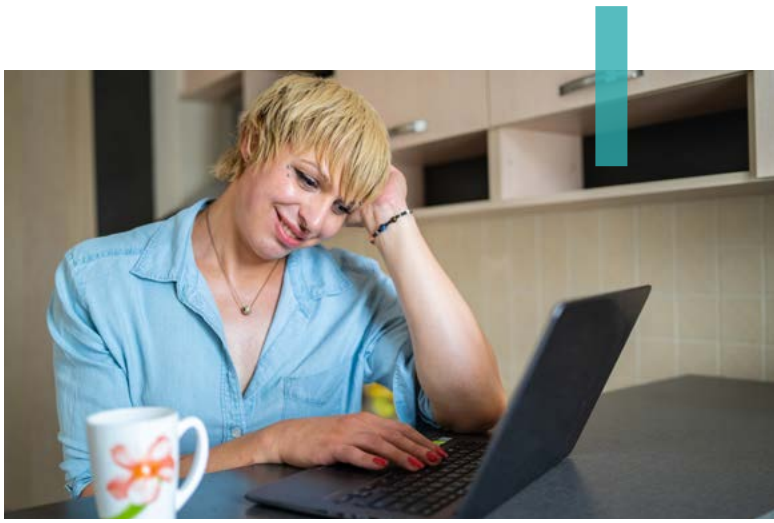
differences in an Australian context. Additionally, though some research does discuss barriers to health care access, particularly in broader global contexts [45], there is a need to better understand barriers to access in the context of Australian health care.

> *"There are GPs locally. But you want one that will do transformative healthcare."*
> Regional LGBTIQA+ Stakeholder

Within a WA context, LGBTI+ people have been declared as one of the 'communities experiencing enduring disadvantage' in health care by the WA Primary Health Alliance [46]. The Western Australian Health Promotion Strategic Framework 2022-2026 identifies LGBTI people as at increased risk for several behavioural risk factors including tobacco consumption and alcohol use, noting that data for trans and intersex people is lacking [47]. In terms of current LGBT legislation, WA continues to be one of the few states which does not allow intersex people to change their birth certificate in order to reflect an intersex person's true gender [48]. This joins other institutional directives that do not comply with the demands of Australian intersex activists [49], including several which directly negate the community demands made in the Darlington Statement [50]. Despite certain improvements, such as the increased discouragement to perform 'corrective' procedures on intersex infants and children due to recent legislature [51], many of these interventions are still performed in WA [52].

Unfortunately, like some other groups within the broader Australian LGBTQI+ population, there is still little research on the specific health needs of intersex people [41]. This means that clinicians, legislators, and organisations seeking to work with intersex people in WA remain unaware of their unique psychological, physiological, and community needs.

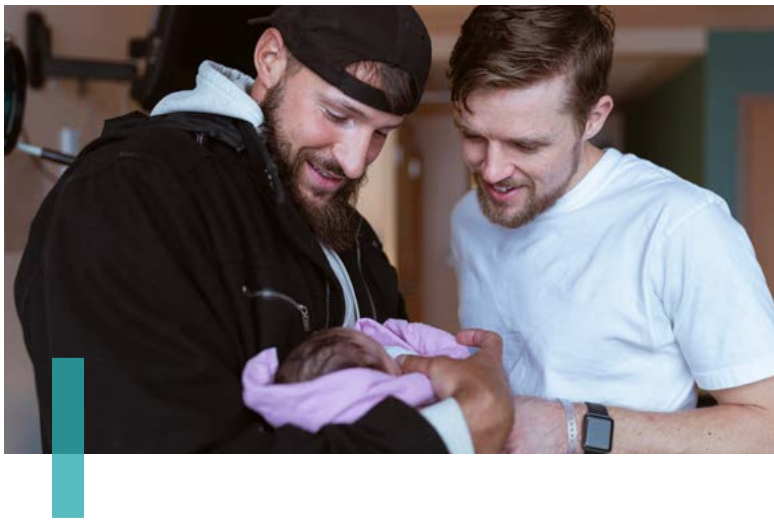
Trans people living in WA also face a variety of policy-based and practical issues when it comes to receiving appropriate health care. Education about the very existence of trans people remains a politically charged topic, with many opponents, reducing the likelihood of inclusion of trans people's lived experiences, and by extension their unique needs, into curriculum at all education levels 53. This discrimination extends beyond curriculum, with many trans young people in WA experiencing discrimination regarding their trans status at school [54] Trans people are less likely to disclose their trans status in health care settings [55], making any care incomplete. The prevalence of non-inclusive health care providers in WA has meant that there is a reliance on community services to create lists of safe and trans-inclusive practitioners [56] in order to help community members reduce the likelihood of negative health care experiences. Trans people in WA also experience significant workplace and employment discrimination [57,] preventing many from accessing consistent and stable employment and therefore reduces their likelihood of having a liveable income.



Social connectedness and isolation

"That's what we're about: connecting community and letting people know that they're not alone."
Regional LGBTIQA+ Stakeholder

LGBT people overall report lower quality of life and satisfaction compared to non-LGBT people [58]. A 2017 Victorian population study indicated that more than a quarter (27.1%) of participants reported a low or medium level of life satisfaction compared with a fifth (20.1%) of non-LGBT participants [33]. Social isolation and loneliness are significant factors influencing quality of life in LGBT health, with one study reporting that 46.2% of LGBT participants were currently single, in comparison to only 24.4% for non-LGBT, and only 10.9% were legally married compared to 34.4% [59]. The COVID-19 pandemic has also significantly affected social connectedness for LGBT Australians, with 20.1% of participants in the Pride and Pandemic study reporting living alone during lockdowns [60]. Additionally, just under half (48.7%) of participants reported a reduction in contact with their family and 51.5% in contact with chosen family or other social networks as a result of the pandemic [60]. Broader research on quality of life, in particular factors such as loneliness and social isolation, suggests that there are complex factors to consider when evaluating quality of life [61]. However, most research utilising validated quality of life measurements is focused on older LGBT adults [62–64] and more research is needed on quality of life for other LGBTIQA+ demographics.



Stigma and discrimination

"I've spoken to parents [of trans kids, including] adults in their 20s, and it's almost always trans feminine people, and they just do not leave the house. They don't go out into public."
LGBTIQA+ Service Stakeholder

While there has been some broader societal move towards greater LGBT acceptance in Australia, stigma and discrimination continue to affect the health and wellbeing of this population, including direct hate crimes against LGBT people [65]. Private Lives 3 [32] data indicates that discrimination remains a significant issue for Australian LGBTIQ people, with the most significant behaviours reported including social exclusion (39.5%), verbal abuse either in person or over the phone (34.6%), harassment (including spitting) (23.6%), online threats (22.1%), threats of physical violence (14.6%), and sexual assault (11.8%). More than half (61%) of young LGBTI people report verbal abuse, 18% physical abuse, and other types of abuse related to gender or sexuality [66]. The SWASH report [67] also provides insight specifically into the experiences of queer women in Australia, with 45% of their participants reporting experiencing some kind of discriminatory behaviour. These behaviours include verbal abuse (41%), online threats and targeting (16%), physical threats or intimidation (15%), physical harassment (9%) and outright assault (4%), as well as being refused service (7%) and being denied employment or promotion within a workplace (6%) due to participants' LBQ status [67]. One study has also indicated that secondary discrimination may be a significant and under-researched issue, specifically discrimination against children of LGBT people regarding their parents' sexuality or gender [68]. Across the board, LGBT stigma has been shown to have a significant negative impact on LGBT people's wellbeing, particularly in its effect on LGBT people's mental health and suicidality [69].

Although the Western Australian Equal Opportunity Commission provides some resources on addressing discrimination based on trans status [70] and sexuality [71], there are few directive policies. The City of Perth's LGBTQIA+ Plan [31] states that nearly half of participants had either feared

for their safety due to discrimination (49%) or have had direct experiences of discrimination or harassment (41%). Additionally, nearly three-quarters (73%) believed they are likely to be targets for anti- LGBTQIA+ behaviours [31].

Though there is little data on Australian trans people's experiences of discrimination, the Writing Themselves In 4 study [72] reported that 71.2% of trans women, 63.3% of trans men, and 52.8% of the non-binary young people who participated in the study reported experiencing anti-trans verbal, physical, or sexual assault in the 12 months leading up to the survey. The most significant form of abuse was verbal (40.8% in the past 12 months; 57.6% across lifetime), followed by sexual abuse (22.8%; 29.5%) and physical assault (9.7%; 15.4%). This mirrors data from earlier national studies such as the 2007 TranzNation report [73], which stated that 87.4% of participants had experienced some form of discrimination in their lifetime, with the most common reported experiences being verbal abuse (53.4%), social exclusion or being the subject of rumours (47.4%), threats of violence (33.6%), being poorly treated due to issues with gender documents (32.4%), being refused employment or promotion (31.6%), and/or being refused service (26.9%).

"They made sure my preferred name is my email, even though it's the same email with my old first name, computer magic. I'm not sure of the specific initiatives in place but this is the only employer that has treated me well as a gender diverse person."
State Government Stakeholder

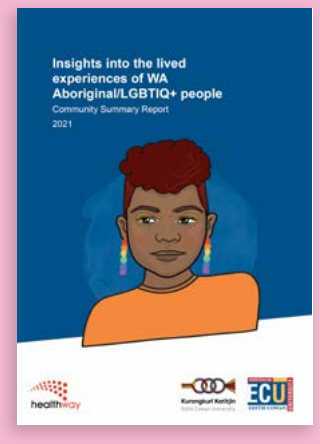
LGBT Australians report stigmatising and discriminatory experiences in a variety of settings, including at work, in educational and health care settings, as well as street harassment [74]. Data from the In Their Own Words [74] report suggests that while 47% of participants reported experiencing discrimination in an institutional setting (e.g. health care, workplace), only 23.2% pursued a complaint or took another action to address a discriminatory experience. It is important to note that trans and intersex people in particular were not legally recognised under the Recognition of Sex and Gender Act until 2013 [2], which affected their capacity to advocate for safer and non-discriminatory work environments due to the lack of legal protections. This reflects the ongoing nature of discrimination in Australia at a policy level. Transphobic stigma in particular has been a mainstay issue in Australia, including historically, through government policies such as the Sexuality Discrimination Bill [75] as well as more recent controversies such as the proposed Education Legislation Amendment which sought to exclude trans children from educational settings [76]. While all stigma and discrimination must be addressed, the recent uptick in transphobic opposition [77] has highlighted the need for trans-specific discrimination protection policies. Despite anti-trans violence being a significant issue that has been recognised globally [78–80], especially transmisogynistic violence [81], there is little data at either a state or national level on experiences of violence among Australian trans people. [31].

"I've never lied about my sexuality in my adult life. Going to the Red Cross, every time I did."
Metropolitan LGBTIQA+ Stakeholder

WA RESEARCH HIGHLIGHT

Breaking the Silence: Insights into the Lived Experiences of WA Aboriginal/LGBTIQ+ People, Community Summary Report 2021 [82]

This research aimed to explore the lived experiences of WA Aboriginal/LGBTQI+ people. The research examined experiences of homophobia, violence, discrimination, relationships, wellbeing and use of health/social services. The sample (n=63) comprised Aboriginal an/or Torres Strait Islander members of the LGBTQI+ community aged 18 years and over, living in WA. A mixed methods approach was used, with participants completing a survey that provided qualitative and quantitative data on lived experiences within the community.



Key Findings

- Nearly three-quarters of participants experienced discrimination in the past year.
- More participants cited Aboriginal identity as a reason for experiencing discrimination, compared to LGBTQI+ identity.
- Nearly two-thirds of participants experienced violence perpetrated by family members/family friends.
- Average levels of wellbeing were described as 'moderate'.
- 21% of participants reported a lack of acceptance for their sexuality/gender identity by their cultural community.
- Lack of belonging in the broader LGBTIQ+ community was reported by 45.2% of participants.
- General practitioners and psychologists were the most commonly accessed health/social services.
- Participants reported positive aspects of both identities, including feeling unique and supporting others with similar identities/experiences.

Recommendations

Authors proposed several recommendations related to:

- Policy and financial commitment at all levels of government
- Recognition of identified issues in organisational policies
- Addressing discrimination in services at a management and employee level
- Community engagement and projects
- Training and education of service providers
- Professional development
- Safe use of social media and dating apps
- Further research

Mental health and suicidality

Mental health continues to be one of the most significant health issues for LGBTIQA+ Australians. Depression diagnoses for LGBT Australians are 5.5 to 6 times greater than the national average, and mental health diagnoses overall are 2.5 more prevalent [83]. The most recent National Study of Mental Health and Wellbeing [84] found that more than half (58.7%) of non-heterosexual identifying people had a mental disorder in the previous 12 months, compared to 19.9% of people identifying as heterosexual. Alongside issues such as depression and anxiety, suicidality in particular remains a significant risk [69]. Several factors are likely to exacerbate suicidality and increase the likelihood of completed suicide, including family rejection, negative self-perceptions regarding gender/sexuality, and dissatisfaction with their appearance overall [85]. LGBT young people 16-17 are five times more likely to attempt suicide, while intersex people aged 16 and over are nearly six times more likely to attempt suicide, and trans people 14-25 are fifteen times more likely to attempt suicide [86]. Trans young people are particularly vulnerable, with nearly three-quarters reporting a diagnosis of depression or anxiety, an around 80% reporting self-harm and suicidal thoughts alongside 48.1% reporting a suicide attempt [87].

> *"[One of] the big ticket issues that we see [is] mental health access in the regions"*
> Regional LGBTIQA+ Stakeholder

Experiences of abuse (including physical, emotional, and sexual) relating to gender and sexuality have been shown to have significant negative mental health impact on LGBT people [88,89]. Specific groups within the LGBT population also have different experiences of mental ill health, for example. (cisgender) bi+ people [90] have different factors which affect their experience compared to transpeople [91]. Bi+ people report a variety of factors which negatively affect their mental health, including internalised biphobia and significant lack of support or recognition from intimate partners [90], as well as feeling excluded from community-controlled health services [92]. Trans and intersex people in particular have been shown to experience unique mental health impacts. Nearly half (46%) of young trans people involved in the From Blues to Rainbows study [93] indicated significant gender dysphoria, second only to experiencing generalised stress (48%). For intersex people, early 'corrective' interventions regarding their intersex status had significant negative effects on mental health [94].

LGBT people in Australia experience challenges accessing mental health services, including crisis support hotlines [95]. These services are also often not adequately trained in LGBT-specific mental health care, especially trans-specific mental health care [96]. Some services and clinicians who may position themselves as LGBT mental health supports may also engage in conversion therapy, despite the practice being outlawed [97,98]. One study also found that while a third of their LGB participants reported accessing some kind of mental health service, only 18.2% of LGB Australians accessed mental health services when they were experiencing active distress [99]. A growing body of knowledge indicates that a protective factor is informal supports, by fellow LGBT peers or other non-professional supportive relationships [100,101]. It is important to note that while this peer support is effective, it may introduce additional stressors for those peers providing informal mental health support [102].

WA RESEARCH HIGHLIGHT

Trans Healthcare Experiences and Needs in Boorloo/Perth [103]

This research aims to capture information on the experiences of trans people within the health care system. This includes barriers to receiving affirming care, which have informed recommendations for improving care and how quality of care will be evaluated. The sample (n=107) comprised transgender, gender-diverse and non-binary people in the Greater Perth Area (Boorloo). An online survey, community workshop, focus group and one-on-one interviews were used to collect quantitative and qualitative data. Qualitative data was analysed through thematic analysis.

Key Findings

Barriers related to the following broad areas were identified:

- Inaccessibility of services due to cost
- Lack of providers with knowledge in trans health care
- Long wait times for care
- Experiencing discouraging practices (e.g. outdated terminology)
- Lack of practitioner education, leading to the patient having to educate
- Cultural insecurity, and un-affirming interactions and services
- Inaccessibility due to disability, neurodivergence, and chronic illness

Recommendations

Based on consultation with participants, recommendations in the following broad areas were made:

- Access to affirming hormonal therapies/surgeries
- Ensuring that information is accessible, easy to navigate, and clearly identifies rights and treatment options
- Holistic care encompassing all aspects of health, like mental health, sexual health, social services and other non-medical aspects. Services should consider specific needs of trans individuals (e.g. speech therapy services providing voice training)
- Services that advocate for trans people and empower self-advocacy, such as those related to housing or disability support
- Trauma-informed, culturally secure, neurodivergent-friendly care
- Systems that do not create dysphoria (e.g. pronoun options on forms)
- Employing trans staff
- Accessible services with reduced wait times
- Training of practitioners and other service providers.

Fertility preservation and assisted reproductive treatments

Parenting, especially fertility program-assisted parenting, is a significant aspect of LGBTIQA+ life which is receiving some more recent focus from research and policies. Data from Private Lives 3 [32] indicates that 13.3% of participants were either biological or step-parents, and though this rate is lower than rates of parenting than previously reported (22.1%), it is still a significant proportion of the Australian LGBTIQ population. While the majority of LGBTIQ parents reported they had conceived a child through sexual intercourse (43.9%), 37.2% of the participants had accessed fertility assistance services to conceive [32]. For potential parents considering fertility services, barriers to accessing treatment included fertility service costs (36.5%), concern about discriminatory treatment in fertility service settings (22.9%), cost of egg preservation (20.4%), and lack of geographically accessible fertility services (6.7%) [32].

A recent study indicates that more than half (52%) of (cisgender) queer women who are parents conceived through a fertility service, with 41% indicating they utilised these services as a result of having fertility issues [104]. Many queer cisgender women seeking to conceive through fertility clinics are forced to utilise more expensive interventions such as in vitro fertilisation (IVF) as opposed to the more affordable intrauterine insemination (IUI) method due to current legislation as well as the profit incentive of IVF for fertility clinics [105]. Queer women seeking fertility assistance services experience a broad range of barriers, including lack of information about their specific circumstances, a lack of supportive and inclusive clinicians, and issues finding donors [106]. In contrast, queer women significantly benefit from reproductive health services and clinicians who use inclusive language, take a non-judgmental approach, and are willing to educate themselves [107]. As recognition of same-sex marriage is a relatively recent development in Australia [108], there is little research on how legislative changes affects aspects of parenting-via-fertility treatment, such as issues around parental rights of non-birthing parents in queer couples [109] and dynamic differences between birthing parents and non-birthing parents in an LGBT context [110].

For trans peoples in Australia, fertility preservation remains a relatively underutilised option. Many fertility clinicians are not trained to provide trans-inclusive care [111], and fertility preservation can be significantly financially prohibitive [112], particularly for those who have other costly gender-affirmation-related medical needs [113]. WA policies around reproductive assistance also maintain strict binary gender terminology [114], which reflects ongoing challenges for trans-inclusivity in fertility service environments. Though certain trans health services provide fertility support, particularly for younger people accessing gender-affirming medical care [115], many trans people report receiving little-to-no information from their treating clinicians about the impact of medical transitioning on future fertility [116]. There are also specific needs for trans people who can become pregnant. For example, Australian trans men who have experienced gestational pregnancy report exclusionary experiences in formal fertility settings, as well as personal issues with the pregnancy such as rising dysphoria from pregnancy-related bodily changes and withdrawal from testosterone treatment [117]. Some research in the United States also indicates that trans people may utilise 'biohacking' as a means of preserving fertility and resisting restrictive medical narrative around trans fertility and pregnancy [118].

HIV

"[We need] HIV specialist remote care as well."
Regional LGBTIQA+ Stakeholder

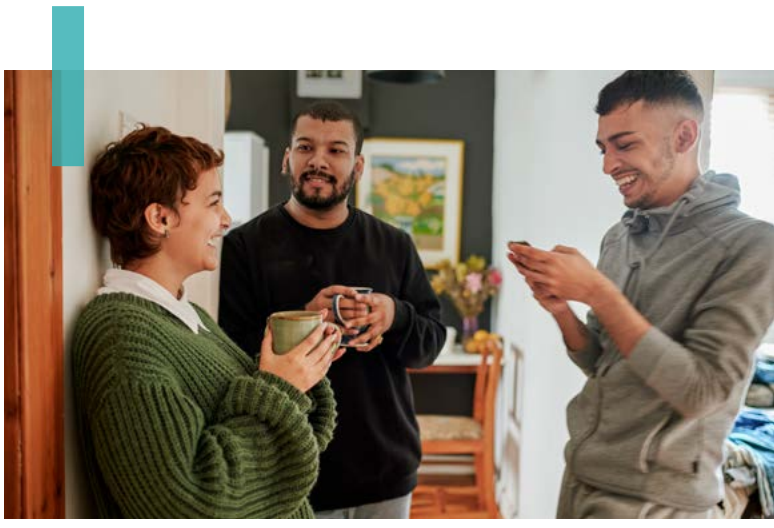
Despite vast improvements in prevention and treatment, HIV remains a significant health issue affecting many LGBTIQA+ people. The most recent national survey on HIV indicates that 86.5% of people reporting a HIV diagnosis were cisgender men who had sex with men, 1.4% were non-binary and a further 0.4% identified as a gender other than the categories provided in the survey [119]. Over three-quarters (77.3%) of people diagnosed identified as gay, 5.9% as bisexual, 3.6% as queer, 0.7% as pansexual, 0.6% as asexual, and a further 1.4% who identified as something other than the categories provided in the survey [119]. Although HIV rates amongst gay and bisexual men (GBM) remain high in Australia, HIV transmissions diagnosed in Australia are declining, with the Kirby Institute reporting 333 HIV diagnoses amongst GBM in 2021 compared to 709 just five years prior [120]. The number of HIV notifications for GBM in WA remain relatively stable [121].

While testing rates for HIV among GBM remain relatively high, there are barriers to testing. These include assuming HIV-negative status due to a perceived lack of 'risky' sex or visible symptoms, lack of education or clinical support around HIV, the need to return to a clinic to receive results, stressful clinic environments, fear of a positive test result, and having recently been tested [122–124]. HIV testing rates amongst GBM dropped in the 2020-2021 time period from 74% to 66%, likely as a result of the COVID-19 pandemic disrupting access to clinical services [120].

Living with HIV has been identified as a significant mental health risk factor for gay men [125], particularly for those who had not receiving a formal diagnosis or who were not undergoing treatment [126]. One study identified a significant link between GBM men living with HIV and suicide in Australia [127], though further research is needed to understand the correlation. Protective factors against mental health issues for GBM living with HIV include collective resilience and community connection, having consistent employment, and experiencing low-or-no internalised stigma about HIV status or sexuality [128,129]. Receiving a HIV diagnosis also appears to be a double-edged sword for gay men, with some experiencing better socioeconomic and social conditions following diagnosis while others reporting a significant downturn in those life factors [130]. There are also significant intra-community differences in mental health experiences for GBM living with HIV; compared to gay men, bisexual men living with HIV report experiencing higher rates of internalised stigma, self-image issues, poor emotional wellbeing, and disconnection other PLHIV and LGBTQ people [131].

There is minimal data on HIV prevalence amongst trans Australians. The 2018 Australian Trans and Gender Diverse Sexual Health Survey 7 reported 1.2% of participants were living with HIV. Other Australian studies have returned figures ranging from 7% to 9.2% HIV-positive serostatus [132,133], which highlights the need for more consistent data collection on HIV within the Australian trans population. Trans people living in Australia also face significant issues in being tested for HIV, with many clinics and other testing services continuing to be insufficiently inclusive or discriminatory towards trans people [134]. Considering the significant rates of HIV among trans populations in other countries [135–137], it is vital to gain a better understanding of how HIV affects trans Australians.

Pre-exposure prophylaxis (PrEP) is now an important centrepiece in the global HIV response, particularly amongst GBM. However, there are still factors which affect rates of uptake, including people who are eligible for PrEP being uninformed about its side effects, lack of access to Medicare, or inconsistent use and discontinuation due to life factors such as affordability or entering a monogamous



relationship [138,139]. Health promotion campaigns by HIV organisations continue to face issues with promoting PrEP in their communities; health promotion messaging varies from organisation to organisation, and PrEP requires health promotion approaches which go against the decades-long 'barrier method only' prevention campaigns [140]. However, PrEP also provides a prominent opportunity for rewriting well-established narratives about HIV, namely the narrative that only HIV-positive people are responsible for HIV prevention [140].

There are areas of HIV research and policy requiring further attention. While reports such as HIV Futures provide data on HIV amongst women, including trans women (9.6% of HIV Futures participants in 2021), the report does not indicate whether the cisgender women included in the category were part of the LGBT population [119]. This is an ongoing issue with perceptions of (cisgender) queer women and HIV, which exclude them from narratives of being 'at-risk' and assumes that queer women are incapable of contracting HIV [141,142]. Critically, there is also need to continue to centre the voices of those living with HIV in the media [143]. This is important to increase public understanding of HIV.

Hepatitis B and C

Although hepatitis is a health issue for many LGBTIQA+ people, it is relatively underserved in health care. Testing for hepatitis C (HCV) remains relatively low amongst LGBTIQ Australians. Just over half (53.5%) of Private Lives 3 participants reported ever being tested and one-quarter (25%) testing for HCV in the preceding year [32]. In the same study, 1.8% of participants reported receiving a HCV diagnosis and successfully achieving negative status following treatment, 0.1% who were HCV-positive and receiving treatment, and an additional 0.3% who were HCV-positive but were not undergoing treatment at the time of the survey [32]. The 2018 Australian Trans and Gender Diverse Sexual Health Survey [7] reported that 0.3% of their participants had received a HCV diagnosis, with all but two of those participants achieving a negative diagnosis following treatment.

Hepatitis C remains highly stigmatised, with many HCV-positive LGBT people avoiding disclosing their status, especially when their seroconversion was as a result of other stigmatised activities such as injecting drug use [144]. This is particularly true for people existing at multiple points of marginalisation, such as LGBT women who inject drugs [145]. One study indicates that this stigma persists even for people with other stigmatised diagnoses, namely HIV. GBM living with HIV who participated in the study expressed feeling shocked and ashamed about their hepatitis C diagnosis, differentiating their feelings about this diagnosis in comparison to a diagnosis of HIV which some felt was 'inevitable' [146]. HCV/HIV coinfection produces a variety of specific health needs that are different to both HCV-negative and HCV mono-infected people, including the need to receive HCV information from specific services, as well as preferring to receive treatment and support from HIV and/or LGBT-specific services [147]. There is also a strong correlation between certain types of drug use and HCV-positive serostatus amongst GBM, for example GBM who inject drugs are significantly more likely to have a HCV diagnosis [148], and the use of drugs such as crystal methamphetamine has also shown a significant connection with a HCV diagnosis [149].

The 2019-2023 Western Australian Hepatitis B and Hepatitis C Strategies [150,151] do not include LGBTIQA+ people as priority populations, though some WA Department of Health informational pamphlets do indicate that GBM are a high

priority for hepatitis vaccination [152]. LGBTIQA+ women in WA appear to have significantly low rates of hepatitis testing, with the 2012 Women's Western Australian Sexual Health Survey indicating that while 40% of participants reported testing for HCV, 7% of participants indicated they were unsure of the types of hepatitis they had been tested for [153]. Other WA-specific reports, such as the Gay Community Periodic Survey [154], do not include statistics on hepatitis testing and diagnosis rates.

Less is known about Hepatitis B in an Australian context, though research does indicate that men who have sex with men are a high risk group for HBV seroconversion [155,156]. Despite the National Hepatitis B Strategy includes GBM living with hepatitis B as a priority population [157], there are no specific guidelines on how to engage with and provide inclusive treatment for this population. HBV continues to be sidelined in health research [158], particularly in LGBTIQA+ populations. There is a need for more data about HBV transmission pathways, as well as enabling factors for seroconversion in an Australian context. Research on novel HBV and HCV testing methods suggests that testing rates can be increased by a variety of methods, including integrating hepatitis testing into HIV testing, providing testing in harm reduction and addiction support services, and increasing clinical surveillance to better target at-risk populations [159]. However, these approaches have little research data in Australia.

Sexually transmissible infections

"[Young LGBT people] lack sexual education that is LGBTQI+ inclusive."
Regional LGBTIQA+ Stakeholder

LGBTIQA+ Australians continue to be a high-risk category for a variety of sexually transmissible infections, though most research focuses on STI rates amongst cisgender queer men. Queer men have experienced a rise in a number of STI diagnoses in the last few years, with the ACCESS project reporting significant increases in gonorrhoea (15%), chlamydia (27%), and infectious syphilis (54%) between 2016 and 2020 [160]. Though rates of positive STI diagnoses among queer men dropped between 2019 and 2021, this is most likely due to the impact of COVID-19 on access to testing [161]. Though there are some statistical differences between men who have sex with men exclusively compared to men who have sex with men as well as other genders, STI rates remain high for both populations [162]. According to the Perth Gay Community Periodic Survey, the most common STI diagnoses among GBM were chlamydia (12.3%), gonorrhoea (7.3%), and syphilis (3.7%), as well as an additional 2.4% who reported another STI. [54]

"STIs or sexual health are [crucial], specifically elder awareness and youth awareness."
Regional LGBTIQA+ Stakeholder

There are significant barriers to successful testing rates for STIs among queer men, including fear of getting tested, unwillingness to discuss sexual activity with health professionals, concerns about privacy and disclosure, self-perception of sexual behaviours as 'low risk', lack of funding and support for alternative testing strategies such as Point-of-Care and self-testing, as well as current testing technologies for STIs such as syphilis requiring further research [163,164]. While health campaigns have shown some efficacy in increasing testing rates among queer men, structural barriers and enablers to testing continue to be the most significant factor affecting testing rates in the population [165]. Some Australian research also suggests

that the increasing prevalence of PrEP use among queer men has contributed to a decrease in condom use, which increases the likelihood of non-HIV STI transmission [166,167]. While there is some knowledge on the ways PrEP use affects rates of condomless sex amongst queer men [168,169], more research is needed in an Australian context.

There is also a need for better understanding of prophylactic use, such as HPV vaccinations. HPV vaccination rates among queer men in Australia remain low, with one study suggesting that only 52.6% of participants in a male-male having both partners vaccinated, 32.1% having only one partner vaccinated, and the remaining 15.3% being in partnerships where neither partner is vaccinated [170]. One study of queer Australian men and nonbinary people has suggested that these communities are aware of the risks associated with Monkeypox, and would be willing to be vaccinated if they weren't already [171]. However, the lack of LGBT data collection for Monkeypox, a communicable disease with a significant sexual transmission vector, continues to disrupt evaluation and engagement strategies for testing and treatment [172], despite queer men in particular being identified as a high risk population for transmission [173].

Although studies such as SWASH [67] have collected data on STI rates among Australian queer women, this data is not currently available to the public. Current research suggests that Australian queer women are rarely exposed to information about queer safe sex practices, though most consider themselves well-versed in safe sex within heterosexual relationships [174,175]. Similarly, current LGBT HPV prevention strategies focus largely on cisgender gay men, despite cisgender women (regardless of sexuality) being at risk of a variety of unique HPV-related complications such as cervical, vulva, and vaginal cancers [176]. Current Australian research on HPV among women and trans people does not seem to include trans women and other trans people assigned male at birth [177], despite research indicating that this population is at a particularly high risk for HPV infection [178].

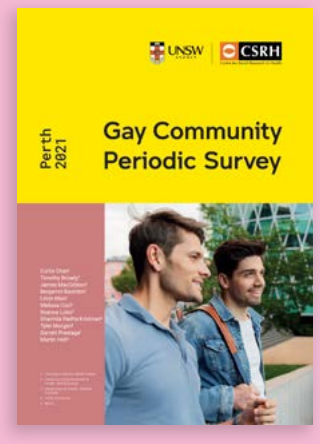
With regards to STI rates amongst Australian trans people, the Australian Trans and Gender Diverse Sexual Health Survey [7] identified the most common STI diagnoses among trans people as chlamydia (10.8%), gonorrhoea (6.4%), genital herpes (4.9%), genital warts (4.4%), and syphilis (2.5%). Though negligible, the report also states that 0.9% of participants reported a diagnosis of mycoplasma genitalium and 0.3% of participants had received a positive

shigella diagnosis. Rates of HPV vaccination among trans Australians remain low; the TRANScending Discrimination in Health & Cancer Care study [179] reported vaccination rates of 47% amongst 18-24 year olds, 52.2% in the 25-34 bracket, 18.2% in 35-44, and 0% in participants over the age of 45. Additionally, less than a quarter (18.7%) of eligible participants reported undergoing regular cervical examinations, despite over a quarter of cervical examinations performed on participants yielding abnormal results [179]. More research is needed on how to best address STI testing, treatment, and vaccination rates amongst Australian trans people.

WA RESEARCH HIGHLIGHT

Gay Community Periodic Survey: Perth 20211 [54]

This research aimed to present data on behaviours related to the transmission of STIs, including HIV. Behaviours studied included sexual practices, STI testing and treatment, and drug use. HIV status and demographic data were also collected. The sample (n = 1013) comprising WA men aged 16 years and over identifying as gay or bisexual. In-person and online recruitment were used to deliver the survey to participants.



Key Findings

- Nearly 87% of participants reported being tested for HIV at some point, with 48 participants reporting a positive result. Those taking PrEP tested more frequently.
- Over one-third of participants had casual sexual partners only. Just over one-quarter (27.9%) of participants reported sex with monogamous partners. Rates of group sex decreased from previous years.
- Sexual partners were most often met through apps. Meeting partners while travelling was less common compared to previous years.
- Condom use occurred less often with regular partners than casual partners.
- Rates of STI testing decreased among HIV-positive and HIV-negative participants. STI rates also decreased since 2019. Chlamydia was the most reported STI.
- Increasing trends in PrEP use were seen.
- Over a half-55% of participants reported using drugs in the past 6 months, with over 3% of participants reporting injecting drug use.
- Many differences in results from previous years were attributed to the COVID-19 pandemic.

COVID-19

"[COVID has] really impacted on our community and coming together physically."
LGBTIQA+ Service Stakeholder

The Pride and Pandemic [60] study reports that a significant portion of LGBTQ+ Australians experienced disruptions to their employment as a result of the COVID-19 pandemic, with 30.3% having their hours reduced, 28.2% either struggling to find work or being outright unemployed, 27% having inconsistent or unreliable work, 18.9% receiving a reduction in pay, and many participants either being temporarily (14.7%) or permanently (8.4%) stood down from their positions. Financial issues affected LGBTQ+ people across the lifespan. Participants aged 18-24 reported the highest rates of financial security concerns (83.7%); however, despite being the most financially secure demographic in the study, more than half of participants aged 65 and over (54.8%) reported experiencing concerns about their financial security as a result of the pandemic [60]. Similar figures were reported regarding employment and housing stability, with 18-24-year-olds being most affected (81.2% and 62.4% respectively) and participants aged 65 and over reporting lower, though still significant, rates of concern (35.7% and 20.7% respectively).

Participants reported significant pandemic-related impact on their physical health, with people in the 35-44 age bracket reporting the highest rates (58.3%) and people 65 years reporting lower but still significant rates (41.1%) [60]. More than two-thirds (70%) of participants aged 18-24 reported experiencing significant mental health issues as a result of the pandemic, and while participants aged 65 and over reported the lowest rates of pandemic-related mental health issues, 39.6% of that population indicated being negative affected by the pandemic [60]. A large proportion of participants indicated a significant reduction in contact with their birth family (48.7%), chosen family (51.5%), and friends (75%) because of the pandemic. Many participants reported experiencing a reduction in support, including from a variety of groups such as religious communities (32.7%), friends (28.5%), LGBTQ+ organisations (22.5%), work colleagues (21.2%), family (19%), and neighbours (17.1%) [60]. Data from the 2020 FLUX COVID-19 Baseline Report [180], conducted among GBM in the early months of the pandemic, indicated that participants began avoiding a range of social and interpersonal experiences as a result of the pandemic including group events with family and friends (94.4%), any close physical contact (90.9%), casual sex (62.2%), kissing (60.7%), and having sex with their regular intimate partner (12.2%).

Trans people were also significantly affected by the pandemic. The Trans in the Pandemic report [181] noted similar issues to those in the Pride in Pandemic and FLUX reports, with a significant proportion of participants experiencing issues such as income and housing instability. Just over one in ten (11.7%) participants reported losing their job because of the pandemic, with a further 22% reporting reduced work hours. A quarter of participants (27%) reported impactful shifts in their housing situation, and one in ten participants (11.7%) reported feeling unsafe in their home during the first two years of the pandemic. The pandemic had significant consequences for trans people seeking gender affirming surgeries; the report notes that more than half of participants (60%) who had planned gender affirming surgeries either had to cancel or postpone their surgery dates to accommodate for pandemic-related hospital overload, and a similar proportion (61.8%) who had undergone surgery in the three months leading up to the pandemic were unable to access appropriate surgical aftercare. As a result of these compounding stressors, a significant proportion of participants reported declining physical health (21.9%) and mental health (44.2%). As the pandemic progresses, there is a need for more consistent monitoring of the impacts of

COVID-19 on LGBTIQA+ people, including the potential for "long COVID" to disproportionately affect these populations into the future [182].

Alcohol

Harmful alcohol consumption is a significant health factor for LGBTIQA+ Australians. LGBT people are at a significantly increased risk of lifetime alcohol-related health issues (18.1%) compared to their non-LGBT counterparts (13.3%) [33]. Almost half (46%) of participants in the Pride and Pandemic study [60] have also indicated that their consumption of alcohol increased significantly as a result of the pandemic. Demant and Saliba's [183] study of young queer people's alcohol consumption habits indicated that 51.2% reported regular high risk alcohol consumption. The authors also reported that around 16.8% experienced their level of alcohol use as having negative health, social, legal or financial ramifications [183]. Figures on hazardous alcohol use by LGBT young Australians suggest that up to 85% who use alcohol, do so in a way which exceeds healthy levels [184]. Some research has also tied these high rates of alcohol consumption to the targeting by the alcohol industry of LGBT people [185].

"Alcohol and substance abuse [within LGBT communities] is extremely high."
Regional LGBTIQA+ Stakeholder

According to the data tables for Private Lives 3, one quarter of participants consumed more than 2 standard drinks per day, higher than the general population (16.1%). People who identified as gay were most likely to report drinking alcohol exceeding the recommended guidelines (39.1%); people identifying as asexual formed the lowest proportion of those reporting struggling to manage their alcohol use [186]. Amongst cisgender LBQ women, in the SWASH study, nearly half (48%) reported alcohol consumption habits which exceeded national health recommendations [67]. In a WA context, results from the Western Australian Lesbian and Bisexual Women's Health and Well-Being Survey reported that a quarter of participants (25.7%) drank alcohol in excess of the national alcohol consumption guidelines [187]. Same-sex attracted women have also been shown to experience higher rates of alcohol dependency and lower rates of accessing addiction support services compared to their cisgender counterparts [188].

Despite evidence indicating LGBTIQA+ people are at a high risk of alcohol (and other drug) misuse, AOD treatment services collect inadequate demographic data on gender and sexuality, important to quantify rates of alcohol dependence and problematic use in Australian LGBTQ communities [189]. Most contemporary alcohol intervention frameworks continue to inadequately include LGBTQ+ people's needs [190], and subsequently provide incomplete care. Most research on alcohol dependence interventions appears to have little to no inclusion of trans people [190], despite research indicating high risk for binge drinking and subsequent psychosocial issues such as suicidality, alcohol-driven sexual assault, and abuse [191,192]. This is in part due to lack of trans-inclusive research methods in alcohol treatment research [193]. More research is needed to create better policies and procedural frameworks for addressing harmful alcohol use amongst these under-researched populations.

Tobacco use and vaping

"Smoking and vaping [is] a priority issue in the community."
Metropolian LGBTIQA+ Stakeholder

Data on tobacco use suggests that it is still a prominent issue amongst LGBTIQA+ Australians. According to Private Lives 3, around one in ten people (10.2%) reported smoking daily. Those who identified as gay reported the highest proportion of daily use with around one-quarter (21.9%). Lesbians were the lowest proportion of current smokers (14.6%) [186]. LGBT people overall are significantly more likely to be daily (17.8%) or occasional (6.3%) smokers compared to their non-LGBT counterparts (12.3% and 4.2% respectively). The Pride and Pandemic study [60] indicates that a significant portion of participants increased their tobacco use during the pandemic, with participants aged 18-24 reporting the highest rates of increased use (16.4%) and people aged 65 and over reporting the lowest rates of increased use (4.6%). Data from SWASH indicates that 59% of participants reported a daily smoking habit, though there appeared to be a downward trend from 30% in 2016 to 22% in 2018 for younger women using tobacco [67]. Rates of smoking amongst younger women appear to have plateaued at around 24% [67]. Results from the Western Australian Lesbian and Bisexual Women's Health and Well-Being Survey indicated that over a quarter (28.1%) were regular smokers [187].

Alongside high rates of tobacco use, many (cisgender) LGB people report significantly high rates of utilising medical interventions to support quitting [194]. LBQ women were more likely to quit smoking if they had non-smoking friends or a non-smoking partner [195]. While responses from the SWASH indicate high rates of desire to quit (68%) [67], overall smoking rates remain high. Though quit rates appear to be relatively high for LGBT Australians, most existing programs appear to appeal largely to (cisgender) gay men and may not adequately include other members of the LGBT population in their policies and data collection [196]. Additionally, despite LGBT people being included in the National Tobacco Strategy [197], recommendations by groups such as the Australian Council on Smoking and Health do not currently list LGBT people as a focus population in their state-wide tobacco use elimination strategy [198].

Factors which are likely to enable higher rates of smoking include employment and income issues, as well as levels of psychological distress [199–201]. Gay men living with HIV are also more likely to report a history of smoking, regardless of current level of tobacco use, compared to their non-HIV-positive counterparts [202]. There is a need for further Australian research on LGBT-specific enabling factors for smoking, such as psychological responses to societal and relational homophobia [203]. RResearch on the smoking habits of trans people is particularly pertinent, as some global research indicates significantly higher rates of tobacco consumption compared to the cisgender population [192].

Finally, though there is little research on vaping in LGBT communities [204], particularly in Australia, some global research indicates that there are many psychosocial crossovers with smoking in regards to enabling factors for regular vape use (e.g. discrimination and other psychological distress) [205,206]. Additionally, the persistence of misinformation regarding the relative 'safety' of vaping [207] may have specific effects on LGBT people who already have elevated substance use rates compared to the broader population.

Other drugs

Recreational drug use is common among some parts of the Australian LGBTIQA+ population. Studies suggest that members of the LGBT population are more likely to use a variety of drugs, including opioids and methamphetamine, compared to their cisgender/heterosexual counterparts [184,208]. Australian LGBT people are particularly high risk for substance misuse issues as a result of a variety of factors including peer pressure, high exposure to others' substance misuse within the community, and the proliferation of licensed venues as primary third spaces for LGBT people [209]. 'Problematic' or higher end substance use has been found to correlate significantly with experiences of LGBT discrimination [184], especially when those experiences have a notable negative effect on that person's mental health [210]. Data from the Pride and Pandemic study [60] also indicates that the pandemic increased rates of substance use including ecstasy/MDMA (39.7%), stimulants (32.9%), psychedelics (29%), dissociatives (22.9%), cannabis (18.1%), downers (16.6%), and heroin (12.8%). Despite these increases, it is worth noting that a significant proportion of participants reported their use of these substances has either remained the same or decreased.

Around half (50.5%) of Australian gay men report using illicit substances, with 28% reporting the specific use of 'party drugs' [211]. One in ten (10.3%) report injecting drug use, with crystal (91.4%) and speed (9.7%) [212] the most commonly injected drugs. GBM appear to have high rates of lifetime (38%) and recent (24%) use of poppers, though reports of dependency or risky consumption appear to be negligible [213]. The 2019 National Drug Strategy Household Survey reported that the proportion of LGB people who had used an illicit drug in the previous 12 months was 40% with use of some drugs higher than among heterosexual people [214]. Alongside recreational drugs, the use of anabolic androgenic steroids (AAS) is heightened for GBM in Australia, with 5.2% reporting actively using AAS and an overall 25.4% having considered using these steroids [215,216]. Bisexual and lesbian women's substance use appears to be equally prominent. Just over half (54%) reported lifetime illicit substance use, including cannabis (37%), ecstasy (23%) amphetamines (8%), benzodiazepams or other relaxants (20%), poppers (14%), LSD or other psychedelics (10%), ketamine (11%), and GHB (2%) [67]. Bisexual and queer women have also been shown to have higher rates of injected drug use compared to their heterosexual counterparts. [217]

Despite common social perceptions, substance misuse is not necessarily a consistent aspect of life for many LGBT people [218]. In fact, certain social misconceptions around the relationship between LGBT status and substance use can contribute to worse treatment and less holistic comprehension of LGBT people's substance use experiences in Australia [219]. While many LGBT people may be knowledgeable about their drug use, the stigma attached to certain types of drug use (e.g. chemsex) may prevent them from accessing health care [220]. Some research suggests that peer-based services may be better equipped to support LGBT people in reducing their substance use issues compared to mainstream services [221]. Some treatments for illicit substance use have been shown to be effective when delivered by LGBT-specific services (e.g. methamphetamine cessation programs [222]. Despite existing research, there are many knowledge gaps regarding LGBT people's experiences of substance use. One particularly neglected aspect of substance use is injecting drug use; there remains little research on the experiences of Australia LGBT people who inject drugs, particularly for those who have seroconverted as a result of their injecting drug use [144].

Cancer screening, prevention and care

"If I want to be screened for cancer, I want to go to an organisation that I feel has the knowledge base in cancer screening, not [just] a community controlled organisation."
LGBTIQA+ Service Stakeholder

Though LGBTIQA+ people are not currently listed as a key population by the AIHW [223], and there is therefore no national data on cancer statistics for the population, estimated rates of cancer amongst LGBTIQA+ Australians indicate that it is a significant health issue. According to the Cancer Council of Australia, there may be over 7,500 LGBT people diagnosed with cancer each year, and approximately a further 23,000 cancer survivors [224]. Although LGBTI people are listed as a priority population in the WA Cancer Plan 2020-2025 [225], the strategy does not provide any specific guidelines on supporting LGBTI people living with cancer. This is despite the fact that many of the health issues discussed in previous sections form significant risk factors for cancer, including heightened alcohol and drug consumption and exposure to viral infections such as HPV, HCV, and HIV [223,226–229]. These issues were included as part of ACON's submission to the national cancer plan 2023-2033 [230]. Sexual minority women's cancer risk factors, alongside those mentioned above, include higher rates of depression, experiences of physical abuse, and experiences of intimate partner violence in particular [231]. GBM who have experienced prostate cancer also report higher rates of cancer-related distress, including sexual dysfunction, low self-esteem, lower reported quality of life, and higher overall psychological distress [232].

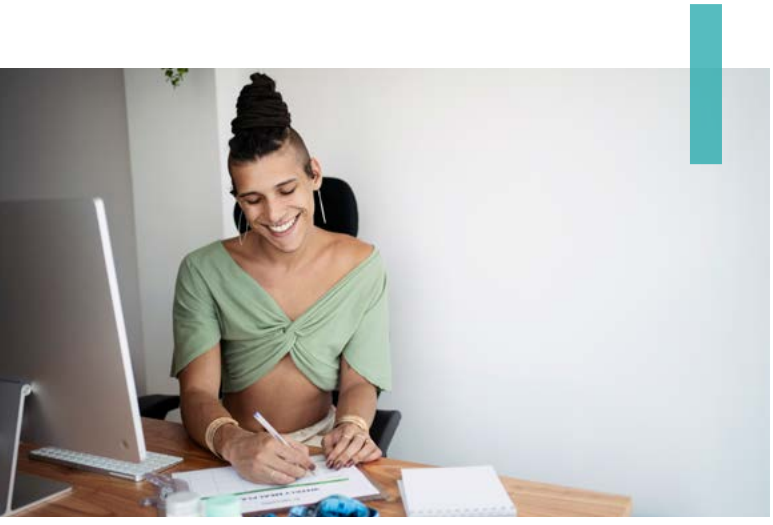
Ongoing disparities in LGBT people's experiences of oncological health care can have significant negative effects on their cancer pathway outcomes [233]. These include feelings of exclusion (from community, family, or broader society), lack of social support, as well as having to negotiate oncological support while also experiencing significantly higher rates of distress compared to their non-LGBT counterparts [234,235]. LGBTQI+ people also report both explicit and implicit discrimination (i.e. microaggressions) in oncological settings, which further impact quality of care [236]. Much of this type of discrimination is the result of heteronormative health care settings which do not adequately accommodate for specific care needs [107]. Lack of LGBTI competence among oncological clinicians has been shown to affect rates of cancer screening uptake across the LGBT population [237,238], however it appears that these issues are particularly impactful for trans people [239–241]. Knowledge of trans and intersex-specific cancer treatment approaches is particularly low amongst oncological clinicians [242]. This is despite the fact that there are many trans-specific issues in cancer care, such as addressing gynaecological cancer issues with trans men and other trans people who may not be comfortable discussing 'female anatomy' issues [243]. The delays which result from these barriers to timely screening and treatment also mean that many LGBTQ people often experience poorer cancer care outcomes and later stage diagnosis [228,231,244].

LGBTQI-specific information remains absent from the majority of cancer support resources in Australia [245], although *Screening Saves Lives* is a notable local example of a targeted campaign by Cancer Network WA. A recent publication by the Cancer Council provides information on navigating oncological care specifically for LGBTQI+ people [224]. Similarly, there is still little information about the psychosocial effects of different types of cancer for LGBTIQA+ people in Australia. In addition, most LGBT cancer research does not provide data on how cancer diagnosis and care is affected by the type of cancer. This is noteworthy as some cancers appear to be more common in LGBT populations, namely breast, prostate,

and gynaecological cancers [244,246], and further research is needed to understand how LGBT people might be affected by other common cancers such as anal cancer, Kaposi's sarcoma, and lung cancer [247]. It is worth noting that some research indicates that the type of cancer may be less distressing than issues surrounding cancer diagnosis and treatment [248], however more research is required on this.

Chronic disease

There is currently a dearth of information regarding chronic disease rates among LGBTIQA+ Australians. However, the Victorian Agency for Health Information has collected some vital information in this area. According to their 2017 survey, compared to the broader population, LGBT Australians are at a significantly higher risk of asthma (29% vs 20.1%) and chronic anxiety or depression (44.8% vs 26.7%), as well as being significantly more likely to have two or more comorbid chronic conditions (36.1% vs 25.1%) [33]. Similarly, Private Lives 3 32 data indicates that the most common chronic health conditions reported by LGBT Australians are irony deficiency or anaemia (17.1%), asthma (14%), hypertension (7.6%), diabetes (3.3%), chronic fatigue (3.1%), and HIV (2.5%). More information is needed on how these conditions affect LGBTIQA+ Australians, and the specific needs of those populations within health care settings.



Disordered eating

Disordered eating disproportionately affects LGBT people [249–251], particularly when body image issues such as gender dysphoria are present [252]. Trans people and lesbian women appear to have the highest correlation between body image issues and disordered eating within the LGBT population [253–255], with many engaging in a range of disordered eating practices including binge-and-purging, restrictive eating, and eating habits formed specifically around attempts to navigate and control specific body image issues such as gender dysphoria [253,256]. Though there are few Australian studies inquiring about disordered eating, body image issues, and related health outcomes, existing research also indicates a high correlation between these factors and issues such as anabolic steroid use as a means of weight and muscle mass control [215]. There is also some research which suggests that the COVID-19 pandemic has had a significant impact on LGBTQ+ people's body image issues [257,258], though there is no data on this intersection of issues within an Australian context.

Private Lives 3 reports that 10.5% of participants had been diagnosed with an eating disorder in their lifetime, with 3.3% receiving their diagnosis in the 12 months leading up to the survey [32]. Writing Themselves In participants reported 12.4% lifetime eating disorder diagnosis, with 4.1% receiving support or treatment in the 12 months leading up to the survey [72]. With regards to trans people, TransPathways reported nearly a quarter (22.75%) of young trans participants had received an eating disorder diagnosis [259]. However, of those diagnosed, less than half (48.8%) reported receiving treatment for their disordered eating [259]. From Blues to Rainbows [93] data also indicates that 16% of their participants reported having an eating disorder, with 10% of participants reporting that they have been diagnosed with an eating disorder by a health professional.

Eating disorders among sexual and gender minorities are affected by a variety of factors, including discrimination, family rejection, lateral violence, internalised stigma, and media (including social media) depictions of body image ideals [260,261]. It is worth noting that one study identified lesbian community connection as a protective factor against body image issues for homosexual and bisexual women [262], though the study's overall outcomes provide mixed results regarding correlation between queerness and disordered eating in its sample. Despite some knowledge in this area, there is a dearth of research into eating disorders in Australian LGBTIQA+ populations.

Oral health

Although there appears to be little Australian data on LGBTIQA+ experiences in oral health, broader research suggests that perceived discrimination as well as actual experiences of cisgenderism and heterosexism have deleterious effects on LGBT people's quality of and access to oral health care [263–265]. As with other areas of health, barriers to oral health access can result in LGBT people reporting poorer oral health outcomes compared to their cisgender and/or heterosexual counterparts [266,267]. Though not statistically significant, LGBT people overall report slightly worse oral health outcomes, but are significantly more likely to delay oral treatment due to lack of affordability [33]. One study also suggests that oral health may suffer as a result of a broader reduction in self-care related to issues such as transitioning [268]. More research is needed to better understand how LGBTIQA+ stigma and discrimination affect oral health.

Domestic, family, and intimate partner violence

> *"[There are issues with] domestic violence [services for] same sex couples, there isn't necessarily a lot of help or assistance that we see around that."*
> Regional LGBTIQA+ Stakeholder

Domestic, family, and intimate partner violence (DFV/IPV) remains an under-researched and poorly understood aspect of LGBTIQA+ health in Australia. There is currently no reliable count of DV/IPV prevalence among LGBT people [269], though advocacy for further inclusion has been enacted [270]. Despite this, some data is available. The Victorian Agency for Health Information reported that 13.4% of Australian LGBTIQ people have experienced family violence between 2015 and 2017, at significantly higher rates compared to their cisgender and heterosexual counterparts across all types of violence: financial/economic abuse (5.4% vs 1.8%), emotional or psychological abuse (12.7% vs 4.3%), spiritual abuse (3.3%. vs 0.6%), physical abuse (6.4% vs 2.3%), sexual abuse (2.8% vs 0.4%), and other types of abuse (2.7% vs 1.1%) [33]. Private Lives 3 indicates that 27.3% of participants experienced DV/IPV at least once in their life, with 14.4% stating they have experienced it multiple times [32]. With regards to family violence, 21.3% report experiencing violence from one family member, while 17.2% reported experiencing violence or abuse from more than one family member [32]. Data from the Pride and Pandemic report [60] also indicated that 25.1% of their participants experienced an increase in family violence (including intimate partner violence) as a result of the pandemic, with a further 11.2% reporting having their first experience of family violence during the pandemic.

"Domestic violence is domestic violence, [and LGBT people] need support around that."
Regional LGBTIQA+ Stakeholder

One of the most prominent barriers in providing adequate DV/IPV support for LGBTQ people is the lack of understanding around the impact of cisgenderism and heteronormativity on perceptions of abusive vs 'healthy' relationship dynamics [271]. There are many myths surrounding the nature and outcomes of domestic violence which erase or distort the experiences of LGBTQ people and lead to inadequate violence support [272]. Additionally, while some experiences of DV/IPV are easily identified as abuse, other controlling behaviours (e.g. accessing personal information, financial control, limiting social contacts) appear to be more acceptable and less well-understood in the Australian GBTIQ context [273]. These factors do not only impact the quality of services provided to victim/survivors, but also affect the efficacy of domestic violence perpetrator intervention programs [274]. Domestic violence within LGBT communities is significantly affected by the communities' experiences of marginalisation, often compounding issues surrounding DV and other forms of intimate violence [275]. This is particularly true for trans people who are often excluded from domestic violence narratives entirely [276], with domestic violence support workers reporting a lack of basic training to effectively engage trans clients [277]. As a result, LGBTQ people report significantly low rates of access to mainstream domestic or family violence services compared with specific LGBTQ-inclusive services [25]. According to Private Lives 3, the most likely services to be accessed were counselling services or a psychologist (18.7%), police (5.9%), and a doctor or hospital (4.4%); however, 72% of participants did not report their abuse to any support service or formal agency [32].

The WA Family and Domestic Violence Framework (2021-2026) [278] identifies LGBTQI+ people as a high risk group for DV/IPV. However, it does not provide specific guidelines for service providers or other DV/IPV-relevant agencies. There is also a need to gain a better understanding of the role that police play in LGBTIQA+ domestic violence, as they are the most common service accessed by people experiencing DV/IPV. Comments made in the WA LGBTIQ+ Community Crime and Safety Survey [279] indicate multiple instances where people mishandled LGBT domestic violence incidents, but there is no substantive data on WA police handling of LGBT DV/IPV. More research is needed on best practices and current issues with LGBT DV/IPV, including which interventions might be doing more harm than good.

"Empowerment of LGBTIQA+ community members to drive improvement is critical. For [program name], it was imperative to have community-led input to guide resource development to ensure messaging resonated and could be trusted. Safety - including for information sharing - is a fundamental component for development and implementation of activities."
State Government Stakeholder

WA RESEARCH HIGHLIGHT

Safer Options: Building the Capacity of Primary Care Providers to Support LGBTIQA+ Individuals Experiencing or at Risk of Intimate Partner Violence in Western Australia [280]

Safer Options aimed to strengthen the capacity of primary care providers in WA to deliver accessible primary care services to LGBTIQA+ individuals experiencing intimate partner violence (IPV). The research used a multi-method approach involving a scoping review, state-wide survey, consultation with LGBTIQA+ people and primary care providers in WA, and co-design.

Key Findings

1. Prevalence of IPV:
   - 51% (n=260) reported experiencing IPV.
   - 24% (n=121) experienced IPV in more than one relationship.
   - 68% (n=346) reported abusive behaviours from an intimate partner.
   - Emotional abuse was the most commonly reported abusive behaviour (53%; n=269).
2. Help-Seeking Behaviour:
   - 48% (n=165) who experienced IPV did not seek professional support.
   - LGBTIQA+ Western Australians struggle to recognise IPV in their experiences due to cisgendered and heteronormative understanding, which meant they were not seeking support.
   - Difficulty accessing or knowing what inclusive primary care services was reported, due to lack of service commitment to establish a positive reputation among the community.
3. Provider Challenges:
   - Primary care providers in WA revealed a lack of confidence in recognising IPV in LGBTIQA+ clients.
   - Identifying and referring to suitable LGBTIQA+ inclusive primary care services presented challenges.
   - Both providers and individuals emphasised the need to increase awareness and knowledge of how IPV manifests in LGBTIQA+ relationships.

Co-Design Resources

Educational and awareness-raising resources were co-designed with LGBTIQA+ individuals and primary care providers. These resources included a website, brochures, and posters available at www.saferoptions.org.au.

Recommendations

Two key recommendations were proposed:

- Primary care providers receive ongoing education about IPV within the context of LGBTIQA+ relationships and integrate these learnings to increase inclusivity of services.
- LGBTIQA+ individuals have access to information to assist them in recognising IPV in their relationships and to seek support.

Homelessness and housing

"[There are many] young people [who have] had to move out of home and don't have [other] secure housing."
Metropolitan LGBTIQA+ Stakeholder

Though there are currently no national reports on LGBTIQA+ homelessness, global research indicates that LGBT people are overrepresented in homelessness data [281,282]. Data from Private Lives 3 indicates that a fifth of participants (22%) had experienced homelessness or precarious housing at some point, with 6.6% reporting living somewhere other than a home they own, a rental, or a family home at the time of the survey [32]. Data from the Pride and Pandemic study 60 indicated that 3.4% of participants were homeless during the pandemic. Additionally, a significant proportion of participants reported experiencing concerns regarding housing stability during the pandemic. Although people aged 18-24 reported the highest rates of housing anxiety (62.4%), it is worth noting that even amongst those least affected by housing concerns (those aged 65+), one in five (20.7%) reported concerns around housing security. Participants across the lifespan reported experiencing homelessness for the first time during the pandemic, with the highest rates of first-time homelessness experienced by participants aged 18-24 (3.5%).

Australian LGBTIQ people are more likely than their non-LGBTIQ counterparts to rent rather than own their home, and many experience dissatisfaction and instability regarding their housing situation [283]. Despite these national data points, reports on homelessness in WA, such as the Western Australian Alliance to End Homelessness's 2022 report [284], fail to include LGBTIQA+ people as a priority population. Similarly, the WA Department of Communities 2020-2030 homelessness strategy [285] does not mention LGBTIQA+ people as a priority population despite existing data from other national reports. This is in part due to the lack of LGBTIQA+ data collection in national surveys such as the national Census [286], which informs these documents.

"[LGBT people] can't access services, you can't get the delivery of support if you don't have [...] a stable place to call home."
LGBTIQA+ Service Stakeholder

There are a variety of LGBTIQA+-specific issues which lead to homelessness, including direct experiences of violence and LGBTQ discrimination, implicit discrimination (e.g. homophobia and transphobia), as well as broader vulnerability factors such as family conflict, experiencing homelessness at an early age, mental health issues, and substance use issues [287,288]. Dempsey et al. [289] suggest that a variety of negative early childhood experiences can accumulate to form a higher risk profile of houselessness for young LGB people in particular, including early experiences of familial abuse, inadequate food and shelter, childhood sexual abuse, and parental divorce early in life. Homelessness and DV/IPV also have significant overlap, with 15.2% of Australians who have reported experiencing DV/IPV or family violence also reporting accessing homelessness services [33]. One of the most prominent factors which continues to impact the efficacy of homelessness support, particularly for young queer people, is housing services' monolithic approach to housing support which often fails to take into account clients' LGBTIQ-specific needs and issues [290]. Despite these issues, it is worth noting that the limited research on LGB homelessness in Australia does indicate some protective factors, such as having a support network in times of crisis, as well as other points of community inclusion such as belonging to political groups or other communities [291].

Research on LGBTQ homelessness in other countries indicates that there are a variety of issues which require further investigation within an Australian context. LGBTQ people experiencing homelessness have unique needs around life factors such as being HIV positive and experiencing substance use issues [292]. Trans people experiencing homelessness also report significant issues around lack of safety both on the street and within housing services, as well as struggling to gain access to gender-affirming care [292,293]. Housing affordability has also been identified as a significant precipitating factor for LGBT homelessness [294], an issue which is becoming increasingly relevant in Australia as the effects of the rental crisis become apparent across the entire Australian population [295]. More effective data collection is needed to gain a better understanding of how LGBTIQA+ Australians are impacted by these risk factors, and how to best address the issues which lead LGBTIQA+ people to experience housing issues in such disproportionate numbers.

WA RESEARCH HIGHLIGHT

State of Play Report: LGBTIQA+ Young People's Experiences of the Youth Accommodation System – Youth Pride Network (2021) [296]

TThis research aimed to study experiences with homelessness of young Western Australians identifying as LGBTIQA+. This included examples of discrimination and barriers in accessing services, the impact of these, and qualities that make a service LGBTIQA+-inclusive. The sample (n=166) comprised people aged 15-30 years living in WA identifying as LGBTIQA+, as well as individuals working with this population. A mixed-methods design was used, with online surveys and face-to-face interviews collecting data from both subsets of the sample.

Key Findings

- Less than half of those who had experienced homelessness had accessed homelessness services
- Lack of awareness of available services was the most common barrier to accessing services
- 60% of those who accessed services did not disclose their LGBTIQA+ identity to staff
- All cisgender participants who had accessed services had a negative experience attributed to their sexuality
- 70% of those who had experienced homelessness could not access services. 1 in 5 of those accessing services were rejected due to their sexuality/gender identity
- Discrimination from connected systems (e.g. schools, hospitals) exacerbated difficulties in engaging with services
- Displays of inclusivity (e.g. displayed pride flags, encouraging advocacy, LGBTIQA+ staff) and supportive connected services were examples of affirming practice.

Recommendations

The following recommendations were proposed:

- Hire and retain LGBTIQA+ staff through inclusive workplaces and training
- Ensure inclusion is a focus of service delivery
- Collect data on this population in a safe way
- Ensure service components do not create further discrimination
- LGBTIQA+ inclusion mentioned in government frameworks.

Employment

"[Many queer people have] got no means of income, and then they're put in situations where they have to do things to survive which then become controlling situations."
Regional LGBTIQA+ Stakeholder

While recent improvements in employment discrimination policies have improved working conditions for some LGBTIQA+ Australians, employment remains a significant issue for many members of these communities. LGBTIQA+ people are employed across a wide range of industries, though some industries have much higher rates of LGBTIQA+ employment compared to others. Industries most likely to employ LGBTQ people include public service (16.6% of the overall sector), law enforcement and banking (8.9%), and education or legal work (6.8% and 6.4% respectively) [297]. Some of the industries least likely to report LGBTQ workers include aged care (0.8%), computer software development (0.8%), recruitment work (0.8%), and manufacturing (0.2%) 297. Data from the Australian Workplace Equity Index Survey [298] indicates that 15.7% of participants stated they had a sexual orientation other than heterosexual, and of those LGBTQ participants, 5.9% reported having a lived experience of being trans [298]. Of LGBTQ participants, less than half (48.9%) were fully out at work, with 22.9% being out to most of their co-workers, 19.1% only out to a select few co-workers, and 12.5% not being out about their gender or sexuality at all in the workplace. More than half of the AWEI survey's trans participants indicated that recruitment processes either failed to meet their expectations for trans inclusion (26.5%) or were entirely unsupportive of their needs (31.3%) [298].

Cisgender gay men report significantly higher rates of wellbeing in the workplace compared to all other categories of people belonging to the LGBTQ+ population [299]. However, LGBQ workers in Australia continue to report high rates of discriminatory expressions in the workplace, as well as being affected by witnessing discriminatory behaviours and language [300]. This is particularly true of GLBTI people who disclose their sexuality in workplace settings [301]. Employment for LGB Australians may also be unstable due to working in significantly heteronormative spaces such as fly in/fly out [302]. Some LGBT workers may also experience employment instability due to religious freedom clauses within existing legislature [303], particularly for those who work in politically-charged environment such as Australian schools [304,305]. For trans people navigating the workforce, issues of transphobia and other gender-based discrimination position the labour market as a whole as inaccessible to trans people [57]. This is further exacerbated by a lack of trans-inclusive structural and organisational frameworks and spaces, which often create unsafe work environments for Australian trans people [306,307]. One study suggests that while trans people have relatively high levels of employment within the population, this is partly due to socioeconomic disparities which make it difficult to survive while unemployed [308].

"Front line [organisation] staff have not been trained - little awareness of issues regarding people of diverse gender identity. LGBTQ+ staff have reporting experiencing/hearing homophobic and transphobic comments from other staff - unsafe workplace."
State Government Stakeholder

While LGBQ people do report constructing strategies to mitigate the harms of workplace homophobia, these issues remain a part of Australian work culture [309]. Inclusive language and other inclusive practices have been shown to improve LGBTQ+ people's workplace wellbeing [310], particularly trans people [311], though it must be noted that

LGBT diversity training may not always be effective at reducing anti-LGBT stigma in workplaces but rather reduces explicit discriminatory behaviours while increasing implicit discriminatory behaviours [312]. While some comprehensive resources on LGBT inclusion in the workplace do exist [313], employers still need to take up these resources and meaningfully include them in their workplace structuring.

Global employment research suggests that LGBT people bring unique perspectives and approaches to the workplace, though these often result in career disadvantages when working in heteronormative workplaces [314]. Research also indicates that LGBT are likely to experience significant isolation in the workplace, and often feel unable to improve their conditions within normative work environments [315]. There is a need for more Australian research on how LGBT people navigate discriminatory workplaces, as well as how these populations can and do work towards improving work conditions [316].

Palliative care

End-of-life care continues to be an under-researched aspect of LGBT health care, despite the significant support needs of LGBT Australians [317]. This is in part due to the significant under-use of palliative care options by Australians in general. One study has suggested that 38% of the general population did not access any palliative care support despite having a terminal illness 318. Within WA, LGBTIQ people are recognised as a priority group in the 2018–2028 WA End-of-Life and Palliative Care Strategy [319]. Additionally, a report from the Joint Select Committee on Palliative Care in Western Australia [320] provides several guidelines for providing LGBT-inclusive palliative care. These include providing LGBT-specific palliative care resources, creating a formal LGBT cultural safety registry for palliative care service providers, and addressing LGBT-specific issues in the field such a client who is unable to disclose their LGBT status, family conflict, lack of same-sex partner recognition, and inadequate service provision or service denial due to a service provider's personal religion or faith [320]. Despite these policy provisions, little is known about rates of palliative care uptake amongst LGBTIQA+ Australians.

LGBTIQA+ people in palliative care have multiple factors which affect their capacity to access appropriate care, including their 'outness', palliative care staff attitudes towards LGBT people, capacity for independent decision-making, issues with biological families, as well as loneliness and isolation as a result of a terminal illness [321]. Bias amongst palliative care clinicians remains a significant issue, with many clinicians refusing to acknowledge the validity of same-sex partners [322]. Many LGBTQ+ people facing the potential of having to access palliative care express concern about receiving sub-optimal care as a result of bias and lack of education on specific palliative care needs [323]. Even in instances where a particular organisation may provide some LGBT-inclusive care, LGBT palliative care patients' uptake of Advanced Care Planning such as assigning power of attorney or creating an advanced directive remain significantly low [324]. This is in part due to lack of legal recognition of relationships for many LGBT people, or having either inadequate legal documentation or legal documentation which does not reflect their current identity (e.g. documents with a previous name). [325]

Research on LGBT palliative care suggests there are significant barriers to access which are not addressed in current Australian research, including how LGBT palliative care needs intersect with issues such as policy-based exclusion, criminalisation, persecution, and limited knowledge of palliative care processes [326,327]. Additionally, while some research on LGBT palliative care addresses the needs of certain age demographics (i.e. older people) [328], there is a need to better understand how younger LGBT people and their support networks navigate palliative care services and processes in Australia.

Intersectional Populations

Intersectional Populations

Aboriginal and Torres Strait Islander people

"We've got Aboriginal communities that are quite a distance from the main town centres."
Regional LGBTIQA+ Stakeholder

One of the least researched yet most at-need communities in WA is Aboriginal and Torres Strait Islander LGBTIQ+ people. Aboriginal and Torres Strait Islander LGBT+ people are often at odds with the broader LGBT+ community, and experience racism and other types of microaggressions from non-Aboriginal LGBT+ people [329]. The experiences and needs of Aboriginal and Torres Strait Islander LGBTIQ+ people are also rarely included in formal education and educator training [330], meaning these communities are also less likely to find information and other resources about their specific experiences, which in turn affects how they can navigate family relationships as well as their personal journeys of self-discovery [331]. These issues extend beyond personal and interpersonal issues. Lack of tailored/specific information and resourcing also results in Aboriginal and Torres Strait Islander LGBTIQ+ people being less able to access appropriate referral pathways, have less accurate and constructive organisational discrimination policies, and by extension are therefore less likely to receive health care through models and frameworks which are appropriate to their needs and lived experiences [82]. These gaps have significant impact on the quality of health care that Aboriginal and Torres Strait Islander LGBTQ+ people receive, and therefore requires more unique clinical and organisational practices in order to improve these conditions [332,333].

"If you haven't included Aboriginal consultation your work is irrelevant to the space of LGBTQ health."
LGBTIQA+ Service Stakeholder

Though Aboriginal and Torres Strait Islander LGBTIQA+ people share many of the same issues as non-Aboriginal LGBTIQA+ people, there are a number of ways in which the intersecting lived experiences of Aboriginality and LGBTIQA+ status increase the likelihood of certain health issues. One of the most prominent issues significantly affecting Aboriginal and Torres Strait Islander LGBT people is suicidality [334]. Suicidality amongst Aboriginal and Torres Strait Islander LGBT people has significant impacts not only on the person experiencing suicidality but also on their families and community [335]. A key factor for suicidality and other mental health issues is a dual sense of exclusion; many Aboriginal and Torres Strait Islander LGBT people experience exclusion from their families due to their gender/sexuality, while simultaneously experiencing racism within non-Aboriginal LGBT communities [336]. This same systemic racism has also been shown to significantly affect the quality of health care provision for this population, with many Aboriginal and Torres Strait Islander LGBT people having to

negotiate health care providers' potential racial, gendered, and sexuality-based biases [337].

Global research has shown these experiences of intersecting discrimination is a significant risk factor for a variety of sexual health issues amongst First Nations LGBT people, including HIV transmission [338]. Aboriginal men who have sex with men (both cisgender and transgender) have previously reported high rates of inconsistent condom use and lower HIV testing rates compared to their non-Aboriginal counterparts [339–341]. Brotherboys and sistergirls in particular have reported high rates of HIV diagnoses, as well as sexual assaults which have their own significant health consequences [342,343]. Many brotherboys and sistergirls living in more rural and remote areas have also reported having little access to trans-inclusive care, which impacts both their gender-affirmation-related health as well as their health more broadly [344].

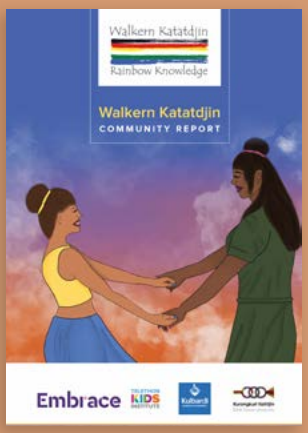
To provide improved health care for Aboriginal and Torres Strait Islander LGBT people, there are several key focus areas. Firstly, there is a need for health services to familiarise themselves with the appropriate language to describe Aboriginal and Torres Strait Islander LGBT experiences (e.g. brotherboy, sistergirl) [345]. There is also a need for more meaningful inclusion of Aboriginal and Torres Strait Islander perspectives across health care both at a local and national level [335,346], as each community has unique health care needs and specific approaches to how health care is understood and delivered [347]. This is particularly pertinent for brotherboys and sistergirls, who are often excluded from discussions of Aboriginal and Torres Strait Islander LGBT experiences despite being some of the most marginalised within these communities [348,349].

> *"Nobody knows the community's needs better than the community itself."*
> State Government Stakeholder

WA RESEARCH HIGHLIGHT

Walkern Katatdjin Community Report 1 [350]

This research aimed to study how the intersections of youth, LGBTQA+ and Aboriginal and Torres Strait Islander identity affect mental health, barriers and contributors to mental wellbeing, and experiences with mental health services. The sample (n=14) included participants in the Perth metropolitan area aged 14-25 years identifying as LGBTQA+ and Aboriginal. Participants took part in interviews and/or yarning circles discussing mental wellbeing and experiences with services. Thematic analysis was used to analyse responses.



Key Findings

- Seven themes related to mental health/wellbeing were identified - 'identity', 'family', 'community', 'visibility', 'services', 'stigma, fear and shame', and 'navigating'
- Factors associated with mental wellbeing included pride in one's identity, family support representation of identities, and LGBTQA+ family
- commonly identified barriers to mental wellbeing included lack of acceptance from family, fear or rejection, lack of Aboriginal representation within the LGBTQA+ community, traditional and religious ideas of sexuality and gender
- Positive and negative experiences were identified in interactions with Elders and practicing culture
- Mental health services tailored to Aboriginal LGBTQA+ youth and workers from these communities were identified as needs
- Barriers to service access included price, waitlists, location and stigma

Recommendations

Authors did not specify any recommendations. However, participants highlighted aspects of services that may increase engagement and positive experiences:

- Services with a focus on empowerment
- Outreach/raising awareness of available services
- Connected services, including sexual health services – these provide holistic care and effectively utilise resources
- Visual displays of support (e.g. flags or Aboriginal artwork).

Incarcerated people

LLGBTIQA+ people who are currently incarcerated face a significant level of health risks, and by extension have several unique health needs. Research on LGBT people in prison indicates that incarceration has significant impacts on their psychological and physiological wellbeing [351], and can have lasting consequences for their relationship with their sexuality and gender [352]. Some research has also indicated that queer in women in particular are overrepresented in Australian prisons [353]. Trans people are also particularly impacted by living in a prison environment. There are few protective policies in Australia regarding recognition of transr status in current legal proceedings, resulting in many trans people being incarcerated in gendered prisons which do not align with their own genders (i.e. trans women in men's prisons and vice versa) [354]. This means that many Australian prisons will segregate trans prisoners from the general population as a safety measure [355,356], though this supposed safety may be counterbalanced with the negative effects of segregation such as psychological distress and depression [357]. Global research on incarcerated trans people indicates that trans people, particularly juveniles, trans women, and trans people who are visibly non-gender-conforming, experience high rates of victimisation in prison [358,359]. They are also significantly likely to be denied gender affirming as well as other basic human rights, often resulting in high levels of psychological distress and self-harming behaviours compared to non-trans prisoners [360].

Another LGBTIQA+ group disproportionately affected by incarceration is Aboriginal and Torres Strait Islander LGBTIQA+ people. Aboriginal and Torres Strait Islander LGBT people exist at a nexus of criminalisation relating to both their race and their gender/sexuality, which produces a significant overrepresentation of LGBT Aboriginal and Torres Strait Islander people in the prison system [361]. Aboriginal people are over-represented in WA prisons [362], and though there is little research there has been indications that Aboriginal LGBTQI+ people's experiencing incarceration are particularly at-risk compared to non-Aboriginal LGBTIQA+ people [21]. Aboriginal brotherboys and sistergirls also bear a large proportion of the burden of incarceration, partly as a result of their historical treatment throughout colonisation [363]. There is a significant need for greater Australian research and policy around prisoner treatment in general and the conditions which affect LGBT prisoners' wellbeing in particular.

Disabled people

> *"Even if services exist, they're often not that accessible, particularly [for] queer neurodivergent people."*
> Metropolitan LGBTIQA+ Stakeholder

AArguably one of the least serviced groups in the Australian LGBTIQA+ community is disabled people. A recent national survey found that half of their LGBTQ+ participants identified as having a disability, including psychological, intellectual, and physical conditions [60]. LGBTIQ+ people with disabilities have also been identified as a priority group nationally [364], with disability being a point of marginalisation which requires further attention for inclusion efforts within and beyond LGBTIQ+ health [365]. Although there is little WA-specific research, broader national studies have indicated that LGBTIQ+ people with disabilities are more likely to experience abuse, less likely to be employed, and are overall more likely to have a lower quality of life compared to their non-disabled counterparts [366,367].

Data from Writing Themselves in 4 and Private Lives 3 has indicated that 38.5% of LGBTQA+ adults meet the Disability Flag criteria for being a person living with a disability [368]. Disabled LGBTIQA+ people experience significant difficulties in accessing health care services as a result of having to manage multiple identities in health care environments which are not inclusive to their needs as both disabled and LGBTIQA+ people [369]. While this is true across the disability spectrum, the limited research on Australian LGBTIQA+ disability does indicate that different types of disabilities affect health care experiences differently. Namely, while there is little statistical data in Australia about the experiences of LGBTIQ people with intellectual disability, with the majority of research being either exploratory or descriptive rather than providing population-based data [370]. There appears to be even less research specifically on the experiences of trans people with intellectual disabilities, though some existing research indicates people existing at this intersection experience additional issues which their cisgender counterparts do not [371].

Writing Themselves in 4 and Private Lives 3 data suggests that participants with mild, moderate, and severe disabilities reported consistently higher rates of discrimination based on their sexuality (56.9%, 62.1%, and 67.5% respectively) and gender identity (83.3%, 81.4%, and 83.5%) compared to their pre-disabled counterparts (52.8% for sexuality-based discrimination and 70.6% for gender-based discrimination) [368]. More than half (58.1%) of severely disabled LGBTQA+ adults included in the review reported feeling socially excluded in comparison to 31.7% of pre-disabled participants, with similar statistical differences regarding experiences of verbal abuse (48.5%; 29.2%), harassment (36.1%; 18.7%), threats of physical violence (27.3%; 10.5%), and sexual assault (22.2%; 7.8%) [368]. Despite research indicating that disabled LGBTI people are at significantly higher risk of victimisation compared to their pre-disabled LGBTI counterparts, few Australian studies adequately evaluate differences in these experiences between the two groups [367]. There is a need for further investigation on disabled LGBT Australians' lived experiences, unique needs, and areas of policy which can improve quality of care and overall living conditions.

> *"Historically people with disabilities and specifically those who are LGBTQIA+ have not been involved in the creation of services to cater to their needs and this is a great disservice to the community and continues to perpetuate harmful stereotypes."*
> Mainstream NGO Stakeholder

Older people

Older LGBTI* people continue to experience unique age-related marginalisation across Australia. Many older gay and lesbian people report feeling unable to access health services due to a combination of lack of inclusive services and age-specific access issues [372]. Many older gay and lesbian people may also feel uncomfortable disclosing their sexuality due previous experiences of homophobia, particularly persistent experiences across the lifetime 373. Alongside the psychological impact of these experiences of exclusion, discrimination, especially recent, has significant adverse impacts on older gay and lesbian people's physical health and wellbeing [374].

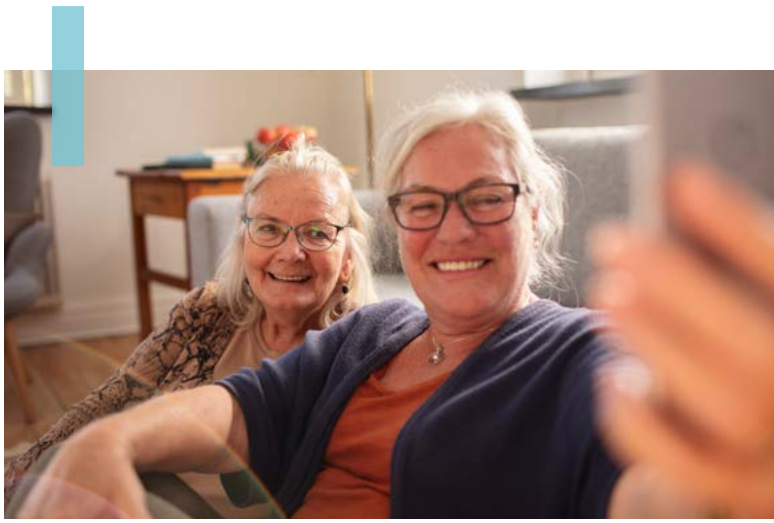
"[Many older LGBT] also experience elder abuse."
Regional LGBTIQA+ Stakeholder

Global research has also indicated that older LGBT people are significantly affected by the COVID-19 pandemic, with many reporting a significant loss of supports, including not having any support in case of emergencies [375–377]. Older LGBT people have also reported increases in experiences of elder abuse since the onset of the pandemic [378]. Overall, older LGBT people report a range of complex issues regarding relationships, particularly family relations, which are often negatively affected by familial attitudes towards gender and sexuality [379]. The isolation of older people has been shown to have significant negative mental health consequences for older gay and lesbian people [380–382]. The combined impact of discrimination and increased vulnerability to elder abuse is particularly prominent for older trans people, who often encounter abuse and discrimination due to their gender, as well as being unsupported to access necessary gender-affirming care [383].

There are also additional health concerns for older trans people related to ageing, particularly around potential complications arising from hormonal treatment and other gender-affirming interventions [384].

"[It's important we promote] elders of the community as peer role models, especially for a lot of kids."
Metropolitan LGBTIQA+ Stakeholder

Older LGBTI people living in WA, particularly those who are living in residential care facilities, face several specific issues. Many older LGBTI people receiving aged care services in WA are unlikely to disclose their gender/sexuality with their service providers in fear of transphobic/homophobic reactions [385]. The erasure and lack of visibility of older LGBTI people in WA means that those people who seek age care-related support are less likely to receive inclusive and supportive care [386]. This means that some older gay and lesbian people may have to rely on their social circles and intimate partners for support [387]. While few studies have been conducted specifically in WA, broader research on the topic indicates that older LGBTI people often receive inadequate care and experience significant psychological issues as a result of having to consider their gender and/or sexuality when navigating care facilities and other aged care providers [388].



* Community-controlled organisation GLBTI Rights in Ageing (GRAI) recommends the initialism LGBTI to refer to older people (50+) of diverse genders, sexualities and sex characteristics, as this reflects their lived experience and recognises that some terms like 'queer' were used as a slur when they were younger. GRAI recognises that the initialism does not capture the full diversity of sexualities, bodies, identities, and experiences that exist within our community, however also recognise the value of the term LGBTI when exploring collective experiences of stigma, discrimination, and marginalisation, and when advocating for LGBTI rights and inclusivity for older people.

WA RESEARCH HIGHLIGHT

LGBT+ and 50+: Loneliness and Quality of Life Under the Rainbow [389]

This research aimed to provide cross-sectional data on the wellbeing of older LGBT Australians, with a focus on loneliness. This included measuring physical and mental health, social connections, living arrangements, financial wellbeing and distress. The sample (n=220) comprised Western Australians aged 50 years and over, identifying as LGBT. Participants either completed an online or hard copy survey. A mixed-methods design was used, with open-ended and closed questions collecting qualitative and quantitative data.

Key Findings

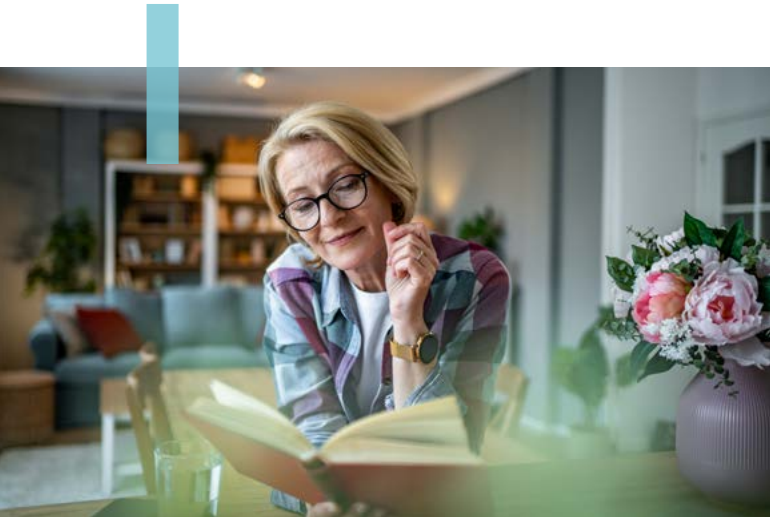
- High levels of loneliness were found in 36% of participants. Low social interactions with other LGBT people were linked with loneliness, and were found in over a quarter of participants.
- Those living alone had higher rates of loneliness.
- Financial insecurity was more prevalent among those with 'high' loneliness levels.
- A statistically significant relationship between psychosocial decline (e.g. changes in mood and connections) and loneliness was observed. Transgender and asexual participants tended to have higher levels of psychosocial decline than their counterparts.
- Most participants experienced 'low-moderate' psychological distress.
- Most participants rated their busyness as 'moderate'. Participants preferred intergenerational activities to senior-only/LGBT-only activities. A walking group was the most favoured activity.
- Cost, distance, and COVID-19-related effects were commonly cited barriers to activity.
- Social support was the most commonly cited factor in addressing loneliness.

Recommendations

- More opportunities for intergenerational connection.
- Resource allocation for the running of activities outside of working hours, so they can be attended by older adults who work.
- Interventions targeting those living alone.
- Providing volunteering opportunities to improve social connectedness.
- Continued funding of data collection of older LGBT people, and priority populations within this group.

Sex workers

LGBTIQA+ sex workers remain relatively under-represented in discussions of health care support, and have received minimal consideration in research or policy focus within an Australian context. Global research has shown that LGBT sex workers are more likely to experience significant mental health issues compared to non-LGBT sex workers [390], as well as being more vulnerable to sexual violence both within and outside of work [391,392]. Sex workers in Australia face significant stigma regarding their occupation, partly because of current policies which criminalise sex workers and their clients. Though federal Australian policies regarding sex work are relatively progressive in comparison to many other nations [393], there are ongoing policy issues at state levels which affect both cisgender/heterosexual and LGBTIQA+ sex workers' safety and wellbeing.



In Australia, NSW and Victoria are the only states to have decriminalised sex work [394,395]. By contrast, WA continues to criminalise sex workers, despite sex in exchange for money is considered legal [396]. Criminalisation impacts not only the legal status of LGBT (and non-LGBT) sex workers, but also further exacerbates the financial precarity which many LGBT sex workers experience [397]. Criminalisation (and other repressive models such as The Swedish Model) has also been shown to negatively affect LGBT sex workers' access to health services, and perpetuates stigma and sex work-based discrimination [398]. Although sex work is not an indicator of higher risk for STI and BBVs [399], much of the work of maintaining safe sex practices for sex workers in WA remains in the hands of individual workers and sex work-focused organisations (such as Magenta and SWEAR) rather than broader health organisations and government departments.

Decriminalisation has been shown to have significant positive health outcomes for sex workers, in particular trans sex workers, who are often the most marginalised within these populations [400]. As a result of these issues, Scarlet Alliance have included sex work law reform as one of their main priorities for the 2023 agenda [401], alongside improving the health conditions, knowledge, and support structures for all Australian sex workers.

People from migrant and culturally and linguistically diverse (CaLD) backgrounds

> *"There's a big absence of CALD (culturally, linguistically diverse) community queer research and communities of faith [research]"*
> Metropolitan LGBTIQA+ Stakeholder

PPrivate Lives 3 data indicated that nearly one in three participants (29.1%) identified as culturally and linguistically diverse [32], making the needs of LGBTIQA+ Australians from CaLD backgrounds a pertinent issue. LGBT Australians from CaLD backgrounds are at significant risk of mental health issues [402] and compounded discrimination based on both their cultural and linguistic diversity and gender/sexuality 403(pp2022-2027),404. Private Lives 3 participants from CaLD backgrounds reported significantly higher rates of mental distress (31.7%), suicidal ideation both across the lifespan and in the 12 months leading up to the survey (75.7% and 43.7% respectively), and suicide attempts across lifespan and leading up to the survey (31% and 5.2% respectively). Participants also reported significantly high rates of discrimination based on their race and ethnicity (33%), which has been shown to further elevate risks to health experienced by LGBT people [405].

Though it is important to note that being from a migrant or CaLD background is not in and of itself a risk factor, LGBT Australians from CaLD backgrounds do report significantly heightened experiences of family discrimination and violence, particularly around experiences such as coming out [406]. As is the case in other countries, trans women from CaLD and/or immigrant backgrounds are particularly at risk of violence, including sexual assault, due to their intersecting lived experiences [407]. LGBT migrants' experiences of sexual racism and racial stereotypes significantly also affect their quality of life, and are inseparable from their broader experiences as migrants [408]. The health of LGBT people from CaLD backgrounds remains an under-researched area, though one systematic review notes that alongside CaLD-specific issues around family violence and other types of intimate violence, there are many protective factors that can be cultivated through both personal and collective community work [409,410].

For migrants from CaLD backgrounds who are also seeking refuge or asylum, there are additional structural issues. There continue to be few resources for newly arrived LGBT immigrants and refugees or asylum seekers [411]. Asylum seeking based on LGBT status is contentious, with many people having their process of achieving asylum seeker status either delayed or denied despite experiencing LGBT-based persecution in their home country [412,413]. This is in part due to the "questionably high" standards set by Australian asylum seeking policies regarding establishing a person's sexuality [414], which often require applicants to over-emphasise their LGBT status in order to move through these processes [415]. These issues are further magnified by a lack of inclusion of these marginalised voices in the development and implementation of LGBT refugee and asylum seeker policies and programs across Australia [416], as well as the inherent sociocultural biases around race, gender, and sexuality which are embedded within existing refugee and asylum seeker processes [417,418]. As a result of these biased processes, many LGBT people continue to experience displacement in significantly higher rates than their cisheterosexual counterparts, and are often invisibilised in discussions around refuge and asylum seeking [419].

Religiously affiliated people

"There are lots of people that are still exposed to conversion practices and rhetoric in schools"
Regional LGBTIQA+ Stakeholder

Religious affiliation, whether by personal practice or community, can significantly impact the lived experiences of LGBTIQA+ Australians. A prominent issue facing LGBT people in religious communities is conversion therapy, which often utilises religious paradigms to position diverse genders and sexualities as disordered, pathological, and/or sinful [98]. Despite this practice being thoroughly debunked and shown to be both ineffective and psychologically damaging to recipients [420], many LGBT Australians may still experience gender/sexual 'corrective' coercion from religious communities and leaders. While some religious institutions such as schools have shown a shift towards greater LGBT acceptance [421], many conservative religious institutions and their proponents have continued to push to secure their ability to legally deny LGBT people access to workplaces, schools, health care, and other forms of social welfare [422,423]. Across faiths, LGBT discrimination is often perpetuated by religious and community leaders [410]. Subsequently, many LGBT Australians have been ostracised from their religious communities due to their genders and sexualities, in particular Christianity and its related subgroups [424,425]. Despite this, one quarter of Private Lives 3 participants (25.8%) reported an affiliation with a religion

or faith [32], and advocacy work for LGBT inclusion in religious spaces continues to happen across Australia through organisations such as the Australian GLBTIQ Multicultural Council (AGMC) [426].

Young people

> *"If I was a young person struggling with mental health issue I'd be having to fit, I feel I'd be having to work quite hard [to find a service]"*
> Metropolitan LGBTIQA+ Stakeholder

Young LGBTIQA+ Australians are significantly affected by many of the issues discussed across this report. According to Writing Themselves In 4 data, LGBT young people regularly report significantly high rates of family rejection (42.7%) and feeling unsafe at school (60.2%). Participants also reported high rates of both recent and lifetime abuse, including verbal (40.8% and 57.6% respectively), sexual (22.8%; 29.5%), and physical abuse (9.7%; 15.4%). Experiences of discrimination leave LGBT young people feeling compelled to miss school days; 38.4% of participants in secondary school reported avoiding school days, alongside 34.4% of TAFE students and 17.2% of university students [72]. Alongside discrimination from peers and friends, LGBT young people have been the target by police, often under the guise of perceived vulnerability and "at-risk" status [427], meaning that many are forced to navigate the legal system from a young age [428]. These experiences of discrimination also manifest in significant rates of mental health issues, with more than half (52%) of Writing Themselves In 4 participants reporting very high levels of mental distress [72]. The most common mental health diagnoses across the lifetime amongst participants included generalised anxiety disorder (49.5%), depression (48.3%), eating disorders (12.4%), and post-traumatic stress disorder (PTSD) (10.7%).

Beyond experiences of abuse, LGBT young people face a variety of health risk factors. Writing Themselves In 4 participants reported high rates of houselessness and displacement, with nearly one quarter (23.6%) reporting one or more experiences of homelessness across their lifetime. These included running away from home (17.4% across the lifetime, 7% in the past 12 months), being forced out of their home or residence (10.5%; 4.7%), couch surfing (6.7%; 3.5%), and sleeping rough (4.1%; 1.7%). Many participants also reported significant substance use issues; one in ten participants (11.5%) reported being daily smokers, and alcohol use was reported in significant rates amongst both 14–17-year-olds (47.7%) and 18-21 year olds (85.8%).

Overall, trans young people report significantly higher rates of abuse based on their gender [429], which significantly affect their health and wellbeing. The Trans Pathways study reported that nearly three quarters of participants (74.6%) had been diagnosed with depression, with 75.8% of those currently diagnosed with depression (52.2%) currently receiving treatment for their depression. Similar rates were reported for anxiety, with 72.2% of participants reporting a lifetime diagnosis of anxiety and 71.9% of the 55.3% of participants with a current diagnosis of anxiety undergoing treatment. Other mental health diagnoses reported both across the lifetime and currently included PTSD (25.1% and 10.7% respectively), personality disorders (20.1%; 9%), psychosis (16.2%; 2.6%), and eating disorders (22.7%; 48.8%). Just over half of participants currently diagnosed with one of these conditions reported undergoing treatment (66.2%, 55.7%, and 52.9% respectively). Trans participants in Writing Themselves In 4 reported higher numbers of missed school days compared to their cisgender counterparts, with trans women (64.3%), trans men (54.4%), and non-binary people (44.6%) all reporting absconding from school due to anti-trans discrimination.

"[There is a] lack of gender affirming care and specialists in the regions. The costs associated with travelling up to Perth to access those services instead, the lack of support for kids in the 8-16 year old range, and rising levels of fear about accessing services and going out in public [are] impacting their mental health."
Regional LGBTIQA+ Stakeholder

There are also trans-specific issues which have significant consequences for youth, particularly young trans people who are currently still underage and therefore legally subject to their guardians' decisions. Recent legal developments in Australia and elsewhere have made gender-affirming care inaccessible to trans youth without the support of their parents or guardians [430]. This lack of access is further compounded by the impact of discriminatory clinician behaviour, which has been shown to significantly stimy or even prevent trans people (both youth and adults) from accessing necessary trans care [431]. Access to gender-affirming care is a crucial aspect of trans young people's' wellbeing [432], and its denial exacerbates existing distress around gender dysphoria and other gender-related issues [433]. This lack of autonomy is an experience shared by both trans youth who are denied gender-affirming care and young intersex people who had been forced to undergo 'corrective' medical interventions; in both cases, these youths have been denied control of their own bodies and have been forced to capitulate to the decisions of their parents, guardians, and clinicians [72].

People living in rural and remote areas

"If you're looking for a GP or anyone else, that's pretty hard to find, and you've got only limited options".
Regional LGBTIQA+ Stakeholder

Living in rural or remote areas can be a significant risk factor for many LGBTIQA+ people. The geographic component of rural living alone can significantly affect the ability to access health care into the future [99]. Some of the main issues facing LGBT people living rurally include lack of health care provider literacy on LGBTQ+ issues, lack of advocacy both within and outside the medical system, low rates of support from local community and health care services, and issues which affect empowerment in medical spaces [434]. Living rurally can have significant impact on LGBTIQA+ people's wellbeing, with more than a third (36.7%) of participants in Private Lives 3 reporting their overall wellbeing as either poor or fair at best [32]. In terms of sexual health, gay men people living rurally are significantly less likely to be diagnosed and treated for STI and BBVs [435], making this a particularly notable area of concern for the health care system. Trans people appear to be one of the most affected rural LGBT populations; around one in five trans people live outside of urban centres [436], leaving a significant proportion of Australia's trans population without local services which provide trans-inclusive gender-affirming care, which forms significant mental health and transition-related issues [437].

"There's pretty much nothing [aside from] the likes of headspace, etc. But that's for young people. What about the rest of the population?"
Regional LGBTIQA+ Stakeholder

Although there are many intersecting factors to consider, living regionally or rurally has been shown to have significant detrimental impact on LGBT people's mental health [438,439]. Some of the most substantial precipitating factors include isolation, sexuality and gender-based discrimination, and a lack of appropriate and inclusive services [440]. Mental health issues can also be exacerbated by other issues facing LGBT people living rurally, such as substance misuse related psychological issues [441,442]. LGBTIQA+ people living rurally or remotely are also significantly at risk for houselessness due to rejection in smaller communities [291], which in itself is a significant health risk.

There is a need to recognise that many LGBTIQA+ people do not transition to more urban settings and require local health care support [443], and that LGBT people living rurally are navigating finding balance between developing and harnessing a sense of belonging to their local communities while acknowledging there are risks involved in living rurally as LGBTIQA+ people [444]. This means that there is a need to further focus on supporting LGBT people living in more remote regions. Prior negative experiences in clinical spaces or other support spaces (e.g. mainstream mental health helplines [95]) can reduce likelihood of participation for all LGBTIQA+, but this leaves those people who live rurally with even fewer options than more urban-based people. This creates an even more significant gap between the health of urban-based and rural-based LGBTQA+ people, as many rural and regional communities have no dedicated LGBTIQA+ health services [445]. Additionally, LGBT people living in smaller and more tight-knit communities may avoid accessing health care services, especially LGBT-specific ones, due to a fear of being outed [445,446].

A holistic approach which considers individual, community, and systemic level issues around perceived and legitimate inaccessibility for health services is ultimately the most vital step towards improving LGBTIQA+ rural health [447]. Some useful approaches to addressing rural health issues have been the use of internet-based services [448], point-of-care STI and BBV testing [449], proactive clinical and community-based advocacy [434], more inclusive and rural-specific health campaigns [450], and increasing cultural awareness on LGBTIQA+ and intersecting issues (e.g. disability) [451], in particular cultural awareness amongst clinicians and allied health workers [452]. Additionally, one of the areas of health care most affected by geographic location is access to psychological counselling. Alongside remote options for counselling appointments, access to these services can be improved in a number of ways including: flexible work hours, reduced rates, client autonomy in choosing where the service is provided including outreach-focused programs [438,453].

"[There is a] lack of spaces, safe spaces, whatever that looks like in different places"
Regional LGBTIQA+ Stakeholder

It is important to consider the role that personal perceptions around homophobia and transphobia significantly affect people's likelihood of forming kinships and communities in rural settings, and that perception must be remedied alongside systematic improvements [454]. Many LGBTIQA+ people living rurally report having little connection to a broader LGBTIQA+ community in their area [455], and that sense of disconnection can have noticeable consequences in terms of health care access. This makes community connection and peer supported (whether formal or informal) vital aspects of appropriate LGBTIQA+ rural health care. Peer support provides a significant protective factor regarding wellbeing in rural contexts [456], and LGBTIQA+ peers providing informal support also play a major positive role in improving mental health for LGBTIQA+ people living rurally [100]. Community activism and peer support groups create a space for validating LGBTIQA+ lived experiences and challenge assumptions about LGBTIQA+ rural life [457] as well as promoting the social justice aspects of LGBTIQ+ people's lives [458]. Rural Pride events also encourage social cohesion both within local LGBTIQA+ communities and between those communities and the broader communities the members live in [459], particularly when those events are well-organised [460] and focus on bridging gaps between LGBT people and their broader community [461].

Primary Health Care Access and Exclusion

Primary Health Care Access and Exclusion

Consumer and community barriers

Intrinsic Factors

There are a range of factors outlined in previous literature that may influence LGBTI+ Australians' ability and willingness to access health care services [462–465]. Financial barriers exist for adolescent and gender diverse Australians due to the high costs of services, such as private surgeons, and a lack of personal funds or financial support from family, making these services unaffordable [462]. Many adolescent Australians may not be able to access gender-affirming medical services until they are adults. This is attributable to various reasons, such as wanting to wait until they are adults, a lack of guardian support or awareness of gender identity, lack of affordable services for young people, and participants not yet developing their gender identity [463]. These Australian findings align with challenges reported by WA trans and gender diverse adolescents; further barriers identified locally were a lack of awareness of mental health and affirming care services due to ineffective promotion, as well as difficulty identifying which services are trustworthy [465].

Concerningly, one Australian study of LGBTI+ individuals demonstrated that, in a personal health or mental crisis, 71% of participants chose not to seek help from crisis support services [464]. Participants cited several reasons for this unwillingness, such as believing they were not worthy of support, lack of knowledge of services, privacy concerns, fears of discrimination, and concerns of forced institutionalisation.

> *"If you haven't disclosed your gender or sexual identity, it can prevent you from disclosing health conditions to your GP."*
> Metropolitan LGBTIQA+ Stakeholder

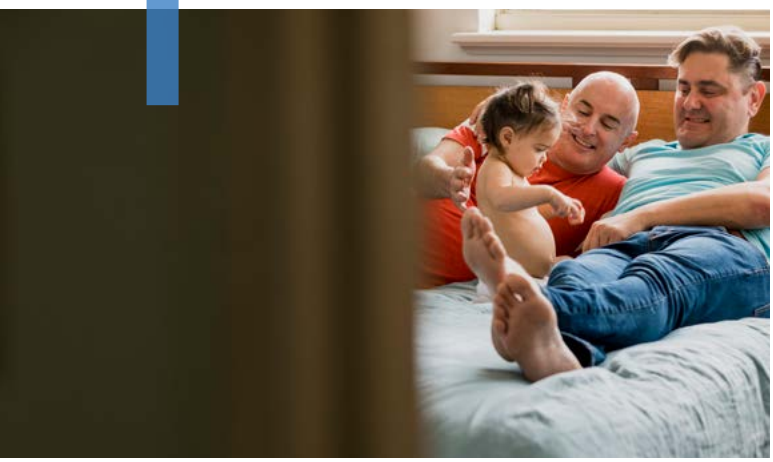
Stigma and discrimination

Previous Australian studies have demonstrated that prior experience of stigma or abuse, as well as anticipation of mistreatment, has resulted in LGBTIQA+ individuals avoiding or delaying care [134,466–471]. Discrimination has been shown to further exacerbate health inequities for LGBT Australians [470,472], with greater levels of regional structural stigma attributed to reduced willingness to seek care and poorer health outcomes [468,469]. Higher levels of regional gender insensitivity experienced by Australian trans and gender diverse people has been associated with reduced likelihood and frequency of testing for HIV/STIs [134]. Minority stress has also been identified as a barrier to accessing mental health care among LGBTI Australians [466–468,471]. Furthermore, same sex attracted women who experienced general practitioners pathologising their sexual orientation had a reduced likelihood of returning to that practice [467]. These contemporary findings are consistent with an earlier survey of the WA LGBTI community, with participants identifying discrimination as the most crucial social determinant of their health [466].

Disclosure of sexual orientation and gender identity

Australian literature suggests there are challenges in disclosing patient sexual orientation or gender identity in health care, contributing to reduced quality of care and poor patient-provider relationships [134,467,473–475]. Australian sexual minority men diagnosed with prostate cancer often had difficulty navigating disclosure of sexual orientation to health care professionals [476]. In addition, the greater stigma experienced by rural sexual minority men also leads to concealment of sexual orientation [473]. Only 12.4% of trans and gender diverse Australians reported they always disclose their gender identity to health care workers [474]. Concerns about damaging the patient-provider relationship and previous experiences of practitioners avoiding acknowledgement of sexual orientation caused many Australian same sex attracted women to not disclose their sexual orientation [467]. This non-disclosure to general practitioners has also been demonstrated to reduce the capacity for LBQ+ women in Australia to access inclusive mental health services [475].

> *"If you haven't disclosed your gender or sexual identity, it can prevent you from disclosing health conditions to your GP."*
> Metropolitan LGBTIQA+ Stakeholder



Health service barriers

Insufficient training of health care staff

> *"There's still parts of the queer community that need TransFolk to do their training around trans and gender diverse folks so that they can be more inclusive, too."*
> LGBTIQA+ Service Stakeholder

A lack of training of health care providers about the clinical needs of LGBTIQA+ people has been extensively outlined by Australian literature [372,470,474,475,477,478]. The most common barrier to health and aged care services for older lesbian and gay Australians was inadequate training of providers to work with LGBTIQA+ people [372]. The majority of a cohort of trans and gender diverse Australians reported their health care provider had never discussed cancer screenings; and they reported that greater training of health care workers on the health needs of trans and gender diverse patients was desirable [474]. Australian literature also suggests that opportunities for continuity of care for LGBTIQA+ people are missed by practitioners [474,475].

Previous literature has demonstrated that Australian medical schools have limited focus on LGBTIQA+ health, with any content mostly focusing on sexuality [470,477,478]. This suggests the need for an expansion of Australian medical curricula to include more training involving the health care of LGBTIQA+ populations; specifically in understanding gender diverse and intersex health needs [477] and the provision of gender-affirming surgeries [470].

> *"Specific LGBTIQA+ training opportunities are linked on the organisation's internal [policy] page, but this training is not mandatory."*
> State Government Stakeholder

Lack of cultural competency

Previous literature has demonstrated a lack of cultural competency of providers and cis-heteronormative assumptions in Australian care environments [134,467,479,480]. Trans and gender diverse individuals report a desire for improvements in provider professionalism and cultural competency [479], and over half of a cohort of same sex attracted women reported they had experienced heterosexual assumptions in general practice [467]. While there are some reports that experiences of cis-heteronormative assumptions and transphobia have reduced in community-based sexual health services [134], challenges still exist with a lack of inclusive patient intake forms [134,480]. Reasoning given by Australian practitioners for not initiating conversations regarding sexual orientation with patients included wanting to treat all patients the same, believing that the patients' orientation was not their business, and that patients preferred to disclose without being asked [467]. Additionally, despite some novel efforts to make the Australian health care system more inclusive, such as the Rainbow Tick Accreditation, impacts are still limited at the systemic level and in particular lack the capacity to support Aboriginal LGBTIQA+ patients.

"[A lot of community issues stem] from a colonial power structure's conceptions of what is health, what is mental health. So especially in a settler colonial context, that has to be the core foundation to understand everything, because it's the context that we're in."
LGBTIQA+ Service Stakeholder

Lack of relevant or sexuality and gender affirming services

A lack of gender affirming services that meets the health care needs of LGBTIQA+ Australians has been identified [463,481–482]. Young trans Australians experience challenges in accessing providers who have both experienced working with trans patients and knowledge of their health needs, often using recommendations from trans or LGBTIQA+ support groups [463]. While studies demonstrate Australian trans adolescents experience greater levels of informed and affirming care from dedicated gender clinics compared to traditional health care [463,482], barriers remain to accessing their affirming care. Professionals in gender clinics were found to not always be able to address all the needs of

young trans Australians or be in a position to provide the frequency of services desired [482], with this often resulting in significant wait times [463]. A panel of WA LGBTI young people also identified challenges their communities faced, such as accessing mental support services and availability of support for those undergoing gender affirmation.[481] Health care systems have also been cited as acting as barriers to accessing affirming treatment [463,482], with miscommunication between clinics and referrals being lost contributing to patient frustrations [463]. Specialist services for LGBTI adolescents in WA are limited in number and often lack the resources and capacity to provide care state-wide [481]. WA lacks specialised health care services for intersex adolescents. [481]

"[We need to consider] gender affirming hormones and surgery and also access for children and young people to [access] gender affirmation."
LGBTIQA+ Service Stakeholder

Additionally, health care professionals were found to be barriers of accessing affirming treatment [463,482], with miscommunication between clinics and referrals being lost contributing to patient frustrations [463].

Systemic barriers

Geographic disparities in health care access

In Australian non-metropolitan areas, challenges exist in accessing quality primary health care, with even further barriers for LGBTIQA+-inclusive care in these regions [465,483–486]. While both metropolitan and regional trans and gender diverse adolescents in WA navigate a difficult system to access suitable mental health care, this was found to be more challenging in regional areas [465]. Additionally, accessing face-to-face services in regional WA was poor, causing patients to use alternative services or requirements fortravel [465,484]. The cost of travelling significant distances for metropolitan services was also frequently cited as a barrier to care access [465]. The challenges of online and telephone services in regional Australia have been previously outlined by Bowman and colleagues [485], who indicated that stigma toward LGBT individuals was still present online and poor internet access in regional areas may require the use of public services to access internet-based care, raising confidentiality concerns.

"WA has a tyranny of distance that the other states don't experience either."
LGBTIQA+ Service Stakeholder

Poor representation in literature

There are significant gaps in literature regarding the experiences to barriers to health care for LGBTIQA+ Australians [479,480,481,487–489]. Further Australian research is desired to describe non-binary experiences, aged care, intersex conditions, and adolescent conditions [479]. Additionally, intersex Australians continue to be heavily unrepresented not only in the broader literature, but studies focusing on LGBTIQA+ health[94,481,487]. There are also further deficiencies in literature investigating the experiences of Aboriginal and Torres Strait Islander LGBTIQA+ people living in WA [480].

"We need this research now for the work that we're doing."
Regional LGBTIQA+ Stakeholder

Lack of screening coverage

A lack of coverage and awareness of appropriate screenings for LGBTIQA+ Australians has also been highlighted in previous literature [474,489]. As outlined by Ussher and colleagues [489] there is poor LGBTIQA+ representation in Australian cancer resources, with only 13% of Australian cancer organisation websites directly referred to LGBTIQA+ individuals. Of those that did mention LGBTIQA+ populations the tendency was to homogenise experiences rather than reflect the differing needs of individuals. A study of trans and gender diverse Australians by Kerr and colleagues [474] suggested that if participants believed they had a cancer symptom, they would still delay care. This was attributed to a systemic lack of awareness campaigns for this community, as well as health care providers not inquiring about patient gender identity.

"If we're actually the only choice you have the mainstream organisations that have all the resources to provide counseling, or screening, or any of those things that you might need. It's not full choice. So to have full choice, we also need to be fully resourced."
LGBTIQA+ Service Stakeholder

Agenda for Action

Agenda for Action

Key insights

1. Community inclusion forms a consistent thread throughout the research on improving LGBTIQA+ health, as it enables local communities to shape health services according to their needs and ensures that healthcare providers remain attuned to the needs of their LGBTIQA+ clients and broader community.

2. The WA LGBTIQA+ community-controlled sector is primarily volunteer-driven, with scarce infrastructure to support operations however, services form a crucial and unique part of LGBTIQA+ healthcare.

3. An underfunded community-controlled sector relies on partnership and collaborative approaches with mainstream Government and Community Health Services.

4. There remain significant health disparities affecting LGBTIQA+ people across a broad range of health outcomes. More accurate and localised data on the health experiences and outcomes for LGBTIQA+ people in WA is still needed.

5. There are multiple intersecting factors that influence health and wellbeing for LGBTIQA+ people. Accordingly, a range of priority populations have been identified requiring additional consideration in all primary health care responses.

6. While there are significant gaps in providing LGBTIQA+ inclusive healthcare globally, rural and remote LGBTIQA+ communities experience greater inequity and barriers to accessing appropriate and safe health care.

7. Both global and Australia-specific research indicates a need for significant improvements amongst healthcare professionals and medical training institutes (particularly mainstream organisations) to provide quality care to LGBTIQA+ people.

8. The operations and physical spaces of clinics and other medical environments where health care is delivered provide a significant opportunity to improve LGBTIQA+ inclusion.

9. Health promotion action can contribute to population-level benefits in health and quality of life outcomes. However current programs and strategies are limited that specifically address the health needs of LGBTIQA+ people.

10. Government and policy changes can significantly improve LGBTIQA+ health outcomes. **Without government-level support and funding, adverse health outcomes experienced by many LGBTIQA+ Western Australians will remain.**

Mobilising resources for LGBTIQA+ community controlled services

Action	By Who?
Secure and maintain long-term core funding for LGBTIQA+ community-controlled organisations.	Department of Premier and Cabinet Department of Treasury Department of Health Department of Communities
Resource a peak LGBTIQA+ community-controlled health organisation to lead coordinated responses to health disparities and participate in policy processes.	Department of Premier and Cabinet Department of Treasury Department of Health Department of Communities
Fund the development and implementation of a statewide, community-controlled comprehensive primary health service for LGBTIQA+ individuals, ensuring equitable access through telehealth and transport support for those in regional and remote areas.	Department of Premier and Cabinet Department of Treasury Department of Health WA Primary Health Alliance
Fund a community-controlled, peer-led trans-specific service that includes co-located specialist medical care, gender-competent mental and allied health services, and gender-affirming health services.	Department of Premier and Cabinet Department of Treasury Department of Health WA Primary Health Alliance
Collaborate with intersex advocacy organisations to determine their resource and service needs, including funding for psychosocial support programs based on the National InterLink pilot.	Department of Health Mental Health Commission Office of Alcohol and Other Drugs WA Primary Health Alliance Metropolitan Health Services WA Country Health Service
Fund the development and establishment of a comprehensive capacity-building program for LGBTIQA+ community-controlled groups and organisations.	Department of Premier and Cabinet Department of Treasury Department of Health Department of Communities
Fund a scoping study to document the volunteer experience and needs across LGBTIQA+ services to support workforce planning.	Department of Health Department of Communities Lotterywest
Develop a LGBTIQA+ volunteer hub to enhance workforce capacity through volunteer support and training, brokerage of volunteering opportunities and guidance for organisations.	Department of Premier and Cabinet Department of Treasury Department of Communities Lotterywest
Fund the development and establishment of an online hub that provides easy access to technical, governance, financial and infrastructure support for LGBTIQA+ groups and organisations.	Department of Premier and Cabinet Department of Treasury Department of Communities Lotterywest
Fund the development and establishment of an online Service Portal for consumers that maps and markets existing LGBTIQA+ services, groups, and supports.	Department of Premier and Cabinet Department of Treasury Department of Communities Department of Health Lotterywest
Fund community-controlled organisations to develop, deliver and evaluate health promotion strategies that address priority primary health care issues.	Department of Health Mental Health Commission Office of Alcohol and Other Drugs WA Primary Health Alliance Healthway
Provide additional resources for rural and remote health providers to support LGBTIQA+ people living in rural and remote communities.	Department of Premier and Cabinet Department of Health WA Country Health Service WA Primary Health Alliance
Support the Regional Pride Network with the implementation of an annual face-to-face conference and fund targeted capacity building for Regional Pride Groups.	Department of Communities Department of Local Government, Sport & Cultural Industries Lotterywest

Prioritising policy and legal reform to improve LGBTIQA+ health

Action	By Who?
Deliver the second WA LGBTI Health Strategy by 2025.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs
Establish and maintain mechanisms for authentic co-design with LGBTIQA+ community and services in policy development across all Departments.	Department of Premier and Cabinet
Deliver a whole-of-government strategy to eliminate LGBTIQA+ discrimination and disadvantage planned in collaboration with LGBTIQA+ communities.	Department of Premier and Cabinet
Establish a 'Rainbow Portfolio' (LGBTIQA+ government portfolio) based on the Victorian/Tasmanian model with funding that allows LGBTIQA+ services to build capacity and plan for the long-term.	Department of Premier and Cabinet
Investigate a new LGBTIQA+ health equity impact statement and declaration policy to guide the development and implementation of WA Health system policies, programs and initiatives.	Department of Health
Strengthen anti-discrimination protections to protect all LGBTIQA+ people and remove exemptions for faith-based organisations.	Department of Premier and Cabinet Law Reform Commission of Western Australia Equal Opportunity Commission
Prohibit deferrable medical interventions for people with innate variations of sex characteristics without their consent and increase broader legal protections across the lifespan safeguarding bodily autonomy.	Department of Premier and Cabinet Law Reform Commission of Western Australia Health Practitioner Associations
Support the implementation of the "Call for action on intersex health and human rights in WA".	Department of Premier and Cabinet Law Reform Commission of Western Australia Equal Opportunity Commission
Abolish the Gender Reassignment Board and ensure that trans and gender-diverse people can easily update their documents for legal gender recognition without the need for medical or surgical treatment.	Department of Justice Department of Premier and Cabinet Law Reform Commission of Western Australia Equal Opportunity Commission
Improve accessibility to and affordability of gender-affirming surgeries, including advocacy towards systemic improvements such as more accurate Medicare coding and reviewing WA's Department of Health listing of surgical gender affirmation procedures under excluded procedures.	Department of Health Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations Health Practitioner Associations
Adopt trans health care recommendations from other states, specifically ACON's "A Blueprint for Improving the Health and Wellbeing of the Trans and Gender Diverse Community in NSW".	Department of Health
Improve existing guidelines on trans care in WA through meaningful and longitudinal consultation with community members and professionals with lived experience.	Department of Health Metropolitan Health Services WA Country Health Service Health Practitioner Associations
End LGBTIQA+ conversion and similar practices that seek to change or suppress sexual orientation or gender identity through robust legislation developed in partnership with community and ensure support for survivors.	Department of Premier and Cabinet Law Reform Commission of Western Australia
Ensure surrogacy laws do not discriminate based on partnership status or gender so that children have the security of legal recognition of their parents.	Department of Premier and Cabinet Law Reform Commission of Western Australia Department of Health
Advocate for inclusion of the *ABS Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation* in the 2026 Census.	Department of Health Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations Health Practitioner Associations Research Institutions
Increase the quality and inclusion of LGBTIQA+ data and health strategy planning in areas of life that affect health (e.g. housing, employment, education, foster care system, seniors/ageing, sport and recreation, volunteering).	Department of Communities Department of Education Department of Justice Department of Training and Workforce Development Office of Homelessness Department of Local Government, Sport and Cultural Industries

Involving LGBTIQA+ people in mainstream health and social service provision

Action	By Who?
Increase support for LGBTIQA+ practitioners in both mainstream and LGBTIQA+ specific health care to complete health practitioner qualifications and enter the workforce.	Health Practitioner Associations Higher & Further Education Institutions Department of Health Metropolitan Health Services WA Country Health Service Department of Training and Workforce Development Public Sector Commission LGBTIQA+ Community-Controlled Organisations
Compensate, train and support peer workers across the health care sector.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Health & Social Service Organisations Health Practitioner Associations Health Consumer Organisations LGBTIQA+ Community-Controlled Organisations
Ensure LGBTIQA+ organisational representation on key state advisory bodies such as immediate inclusion in the Supporting Communities Forum 2024-2025.	Department of Premier and Cabinet Department of Health Department of Communities
Ensure the meaningful inclusion of LGBTIQA+ community voices in health and social services through co-design, consultation and employment.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Health & Social Service Organisations Health Practitioner Associations Health Consumer Organisations LGBTIQA+ Community-Controlled Organisations
Engage people with intersecting lived experiences in research, policy, and program implementation.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Communities Commissioner for Children and Young People Health & Social Service Organisations Health Practitioner Associations Health Consumer Organisations LGBTIQA+ Community-Controlled Organisations Research Institutions Higher & Further Education Institutions
Utilise the expertise of peer-led organisations to facilitate service improvement, including providing LGBTIQA+ inclusion training for staff with adequate and sustained resourcing.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Communities Commissioner for Children and Young People Health & Social Service Organisations Health Practitioner Associations Health Consumer Organisations LGBTIQA+ Community-Controlled Organisations
Establish funding, sponsorship, and procurement criteria for contract eligibility that necessitate recipients report active engagement in LGBTIQA+ inclusion actions.	Department of Health Department of Communities
Ensure adequate and sustainable resourcing is provided to foster the development of LGBTIQA+ inclusive services in the regions by connecting community services to Regional Pride Groups.	Department of Health Health & Social Service Organisations WA Country Health Service LGBTIQA+ Community-Controlled Organisations

Improving primary health care for LGBTIQA+ people

Action	By Who?
Capacity Building	
Include LGBTIQA+ topics in the core education of health care practitioners.	Higher & Further Education Institutions Health Practitioner Associations LGBTIQA+ Community-Controlled Organisations WA Primary Health Alliance
Mandate participation in LGBTIQA+ health care upskilling as part of clinicians' and other allied health workers' professional development requirements including gender affirming care skills development, including surgical and endocrinological specialties across the lifespan.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Justice Department of Education Department of Communities Health Practitioner Associations Higher & Further Education Institutions LGBTIQA+ Community-Controlled Organisations WA Primary Health Alliance
Implement training for mental health services and practitioners focusing on the needs of all LGBTIQA+ people, including the unique experiences of trauma and minority stress.	Mental Health Commission Office of Alcohol and Other Drugs Department of Health Metropolitan Health Services WA Country Health Service Department of Justice Department of Education Department of Communities Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations Health Consumer Organisations WA Primary Health Alliance
Support an enhanced focus on trans-inclusive and trans-specific medical care in health care training and accreditation settings, including gender-affirming care based on informed consent and bodily autonomy.	Higher & Further Education Institutions Health Practitioner Associations Department of Justice Department of Education Department of Communities Trans Community-Controlled Organisations
Collaborate with intersex organisations to educate health care professionals about best practice care for people with variations of innate sex characteristics across the lifespan.	Higher & Further Education Institutions Health Practitioner Associations Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Justice Department of Education Department of Communities Intersex Community-Controlled Organisations

Improving primary health care for LGBTIQA+ people (cont)

Action	By Who?
Targeted Services	
Improve the quality and utilisation of relevant LGBTIQA+ information in the intake process (e.g. pronouns, gender identity, sexuality, preferred name in cases where a person has yet to change their legal name, safety information for sharing any of these details in various contexts).	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Justice Department of Education Department of Communities LGBTIQA+ Community-Controlled Organisations
Enhance the quality and increase the use of relevant screening protocols for significant LGBTIQA+ health care issues.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Justice Department of Education Department of Communities LGBTIQA+ Community-Controlled Organisations WA Primary Health Alliance
Provide accessible and visible forums for feedback from LGBTIQA+ community attending health care sites.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Justice Department of Education Department of Communities LGBTIQA+ Community-Controlled Organisations
Fund and implement community recommendations regarding the inclusivity and accessibility of health care spaces for LGBTIQA+ people, particularly in established rural and remote clinics and other health care sites that serve large or isolated communities.	Department of Health Metropolitan Health Services WA Country Health Service LGBTIQA+ Community-Controlled Organisations WA Primary Health Alliance

Improving primary health care for LGBTIQA+ people (cont)

Action	By Who?
Inclusive Service Delivery	
Provide holistic and integrated care to LGBTIQA+ populations to better address intersecting and compounding health care issues.	Department of Health Health & Social Service Organisations
Adopt the recommendations outlined in *Trans healthcare experiences and needs in Boorloo/Perth*.	Department of Health Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations
Integrate trans-specific expertise across the lifespan (e.g. gender-affirming medical therapies), skillsets (e.g. physiotherapy with knowledge of safe binding techniques), and services (e.g. laser hair removal, electrolysis) into service delivery and referral pathways.	Department of Health Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations
Provide specialist support for intersex people who are experiencing health issues because of infancy or childhood 'corrective' medical interventions.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Justice Department of Education Department of Communities Health & Social Service Organisations Health Consumer Organisations LGBTIQA+ Community-Controlled Organisations
Build capacity in fertility services to support LBQ women and trans and gender diverse people who have uteruses to access non-judgemental and appropriate fertility preservation and assisted reproductive treatments.	Department of Health Metropolitan Health Services WA Country Health Service Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations

Improving prevention and health promotion for LGBTIQA+ people

Action	By Who?
Develop and implement health promotion strategies addressing stigma and discrimination towards LGBTIQA+ populations at all levels, all ages and in all settings.	Health & Social Service Organisations Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Commissioner for Children and Young People Department of Justice Department of Education Department of Communities Equal Opportunity Commission Law Reform Commission of Western Australia Western Australia Police Force Healthway Lotterywest
Adapt existing socio-ecological health promotion frameworks and programs to ensure that LGBTIQA+ health issues are understood and discussed within the broader context of anti-LGBTIQA+ bias, including homophobia, transphobia and biphobia.	Health & Social Service Organisations Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Education Department of Communities Healthway
Include LGBTIQA+ representation and information within existing universal health promotion strategies (e.g. those that address alcohol and other drug use) and incorporate community co-design as a minimum standard in future program development.	Department of Health Metropolitan Health Services WA Country Health Service Health & Social Service Organisations Healthway
Maintain and expand investment in prevention, testing and treatment efforts for HIV and other STIs and BBVs for people with diverse sexualities and people who are trans and gender diverse.	Department of Health Health & Social Service Organisations Metropolitan Health Services WA Country Health Service
Resource and implement targeted alcohol, tobacco and other drug health promotion programs tailored for people with diverse sexualities and people who are trans and gender diverse.	Office of Alcohol and Other Drugs Health & Social Service Organisations Metropolitan Health Services WA Country Health Service Healthway
Increase the focus of health promotion action to expand the use of outreach models to reach underserved communities.	Department of Health Health & Social Service Organisations Metropolitan Health Services WA Country Health Service Healthway
Scale up primary prevention strategies to address interpersonal and family violence among LGBTIQA+ populations.	LGBTIQA+ Community-Controlled Organisations Department of Health Department of Communities Health & Social Service Organisations
Scale up informal peer support programs and invest more widely in psychosocial support services (e.g. Qlife, Freedom) to address social isolation and mental health and wellbeing challenges across the life span.	LGBTIQA+ Community-Controlled Organisations Department of Health Mental Health Commission Office of Alcohol and Other Drugs Department of Communities Health & Social Service Organisations

Developing a research agenda to support LGBTIQA+ health

Action	By Who?
Establish a mechanism to provide advice and oversight for ethical research with LGBTIQA+ people in WA to prevent duplication, reduce community burden, ensure effective translation and meaningful community involvement in research governance.	LGBTIQA+ Community-Controlled Organisations Research Institutions Higher & Further Education Institutions WA Health Translation Network Health Consumer Organisations
Encourage wide-spread adoption of the *ABS Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation* as a minimum standard to increase data quality and opportunities for comparison.	Department of Health Research Institutions Higher & Further Education Institutions
Develop more inclusive and intersectional data indicators and collection methods that explore ways that gender, sex, and sexuality intersect with other life factors and health areas.	Department of Health Research Institutions Higher & Further Education Institutions LGBTIQA+ Community-Controlled Organisations Future Health Research and Innovation Fund WA Health Translation Network WA Primary Health Alliance
Establish a *WA LGBTIQ+ Research Consortium* to foster local research priorities and identify opportunities to translate evidence into practice.	Research Institutions Higher & Further Education Institutions LGBTIQA+ Community-Controlled Organisations Future Health Research and Innovation Fund WA Health Translation Network
Address existing research gaps comprehensively to enhance policy and improve all aspects of LGBTIQA+ health (e.g. intra-community differences in health care experiences and outcomes, LGBTIQA+ experiences of disability, reproductive and fertility-related health, bisexual and asexual health, cancer, chronic health conditions, palliative care, non-binary gender-affirming care).	Research Institutions Higher & Further Education Institutions Department of Health Department of Communities LGBTIQA+ Community-Controlled Organisations Future Health Research and Innovation Fund WA Health Translation Network WA Primary Health Alliance
Develop an expanded *WA LGBTIQA+ Community Evaluation Framework* to support evaluation of peer-led services building on Curtin's youth framework My-Peer Toolkit and ConnectGroups' *LGBTI+ Peer Support: A step by step guide*.	CERIPH LGBTIQA+ Community-Controlled Organisations
Fund and develop independent evaluation and monitoring of LGBTIQA+ health care programs to improve efficacy and reach of future program delivery.	Department of Health Health & Social Service Organisations
Prioritise and utilise community knowledge through peer employment and meaningful inclusion within research and evaluation.	Research Institutions Higher & Further Education Institutions Health & Social Service Organisations Department of Health Health Consumer Organisations LGBTIQA+ Community-Controlled Organisations
Integrate peer-based research findings and best practices within peer-based community-controlled groups and services.	LGBTIQA+ Community-Controlled Organisations Research Institutions Higher & Further Education Institutions
Undertake further research to understand the role of peer-based community-controlled groups and services in meeting the primary health care needs of their members.	Research Institutions Higher & Further Education Institutions LGBTIQA+ Community-Controlled Organisations Department of Health Healthway WA Primary Health Alliance

Supporting intersectional priority populations

Action	By Who?
LGBTIQA+ Aboriginal and Torres Strait Islander peoples	
Advocate for adopting and implementing recommendations outlined in *Walkern Katatdjin Community Reports 1 and 2*.	LGBTIQA+ Community-Controlled Organisations Aboriginal Community-Controlled Organisations Health & Social Service Organisations
Advocate for adopting and implementing recommendations outlined in *Breaking the Silence: Insights into the Lived Experiences of WA Aboriginal/LGBTIQ+ People, Community Summary Report*.	LGBTIQA+ Community-Controlled Organisations Aboriginal Community-Controlled Organisations Health & Social Service Organisations
Fund state-wide consultation and scoping to inform the development of an LGBTIQ+ Aboriginal and Torres Strait Islander Health and Wellbeing Strategy.	Department of Health
Fund the development of Aboriginal and Torres Strait Islander Rainbow Training and other LGBTIQA+ Aboriginal and Torres Strait Islander programs.	Department of Health Department of Communities
Fund LGBTIQA+ Aboriginal and Torres Strait Islander health promotion to address priority health issues.	Department of Health Healthway
LGBTIQA+ justice-involved people	
Provide better support and protection for LGBTIQ+ prisoners currently in the correctional system.	Department of Justice
Improve trans-inclusive policies regarding gendered correctional facility placement.	Department of Justice Trans Community-Controlled Organisations
Enhance research and policy implementation addressing the treatment of LGBTIQA+ people within the correctional system to better understand the health impact of imprisonment.	Department of Justice Western Australia Police Force Department of Health Mental Health Commission Research Institutions Higher & Further Education Institutions
Provide LGBTIQA+-specific health care support, including gender affirmative care, for incarcerated LGBTIQA+ people.	Department of Justice Department of Health
Improve data collection on intersections between LGBTIQA+ identity, rates of incarceration, police violence and health impacts.	Department of Justice Western Australia Police Force Research Institutions Higher & Further Education Institutions
Fund programs assisting LGBTIQA+ people transitioning out of correctional facilities, and providing material support for LGBTIQA+ prisoners (e.g. Beyond Bricks and Bars)	Department of Justice Department of Health Department of Communities
LGBTIQA+ people with disability	
Improve the inclusion of LGBTIQA+-specific disability information among health care professionals and health care sites.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Communities Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations
Improve the accessibility of brick-and-mortar clinics and other health care resources (e.g. websites, apps) through the application of universal design principles.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Communities
Fund programs that assist LGBTIQA+ people with a disability to connect with health care and community.	Department of Health Department of Communities

Supporting intersectional priority populations (cont)

Action	By Who?
Develop relationships with LGBTIQA+ disability advocates and advocacy services and include them in LGBTIQA+ and disability specific consultation processes.	Department of Communities Department of Health Health & Social Service Organisations Health Consumer Organisations LGBTIQA+ Community-Controlled Organisations
LGBTIQA+ older people	
Advocate for adopting and implementing recommendations outlined in *LGBT+ and 50+ Loneliness and quality of life under the rainbow*.	Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations Health Consumer Organisations
Educate health care workers generally, and allied health workers in aged care contexts specifically, on the unique needs of LGBTI older people.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Communities Health & Social Service Organisations Higher & Further Education Institutions Health Practitioner Associations LGBTIQA+ Community-Controlled Organisations
Create more inclusive policies around support for LGBTI older people across health care.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Communities Health & Social Service Organisations
Fund programs that improve the wellbeing of LGBTI older people through community connection and health care access support.	Department of Health Department of Communities
Ensure LGBTI older people are included across all aspects of health care, including research, policy, program delivery, and employment where possible.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Department of Communities Health & Social Service Organisations Higher & Further Education Institutions Research Institutions
LGBTIQA+ sex workers	
Advocate for adopting and implementing recommendations outlined in *Western Australian Law and Sex Worker Health (LASH) Study 2.0*.	Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations
Support further research on the impact of sex work decriminalisation on the health and wellbeing of both LGBTIQA+ and non-LGBTIQA+ sex workers.	Department of Health Department of Justice
Support further research and policy implementation on health issues relevant to LGBTIQA+ sex workers such as police targeting, experiences of violence, and occupation-based discrimination in health care settings.	Department of Health Department of Justice Western Australia Police Force Law Reform Commission of Western Australia
Increase funding for peer-led services and grassroots organisations supporting LGBTIQA+ sex workers and include them in relevant consultation processes.	Department of Health

Supporting intersectional priority populations (cont)

Action	By Who?
LGBTIQA+ people from migrant and culturally and linguistically diverse (CaLD) backgrounds	
Ensure consideration of migration, cultural and linguistic diversity in policy development for LGBTIQA+ people.	Department of Health Department of Communities Health & Social Service Organisations Office of Multicultural Interests
Increase cultural responsiveness and multicultural readiness of individuals and organisations in health and social services.	Department of Health Department of Communities Health & Social Service Organisations Office of Multicultural Interests
Foster collaborative research opportunities across LGBTIQA+, migrant and CaLD health.	Research Institutions Higher & Further Education Institutions Department of Health Department of Communities Office of Multicultural Interests Health & Social Service Organisations
Fund and support existing organisations supporting LGBTIQA+ migrant and CaLD health and social services and provide support to create more inclusive services for LGBTIQ+ people from migrant and CaLD backgrounds.	Department of Health Department of Communities Office of Multicultural Interests
Include relevant LGBTIQA+ migrant and CaLD health and social service organisations and staff in policy and guideline development.	Department of Health Department of Communities Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations Office of Multicultural Interests
LGBTIQA+ people who are religiously affiliated	
Advocate to improve protective policies and legislation around religion-based discrimination against LGBTIQA+ people in health care settings.	Faith Organisations Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations
Provide targeted support for religious health organisations to initiate and implement LGBTIQA+-inclusive policy and practice.	Department of Health Department of Communities LGBTIQA+ Community-Controlled Organisations
Educate/support health care workers to navigate clinical relationships with LGBTIQ+ people currently or previously affiliated with a religious group, particularly if that group is discriminatory towards LGBTIQA+ people.	Faith Organisations Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations
Establish and maintain relationships with religiously-affiliated LGBTIQA+ organisations and advocates and include them in relevant health care consultation processes.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations Faith Organisations

Supporting intersectional priority populations (cont)

Action	By Who?
LGBTIQA+ young people	
Advocate for adopting and implementing recommendations outlined in *State of Play Reports: I: LGBTIQA+ Young People's Experiences of the Youth Accommodation System, II: LGBTIQA+ Young People's Experiences of High School,* and upcoming ones including *III: LGBTIQA+ Young People's Experiences of the Health Care system.*	Commissioner for Children and Young People Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations Department of Communities Department of Education Department of Health
Support youth service organisations to establish or improve inclusive health policies to address the specific health needs for LGBTIQA+ young people, including gender affirming care.	Department of Health Commissioner for Children and Young People Department of Communities Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations Health Consumer Organisations
Improve inclusive policies and practices in the foster care and CPFS systems to be safe and inclusive for LGBTIQA+ young people.	Department of Communities
Improve intake and health screening protocols to include LGBTIQA+-specific life factors for young people attending health care centres.	Department of Health Metropolitan Health Services WA Country Health Service Mental Health Commission Office of Alcohol and Other Drugs Health & Social Service Organisations Health Consumer Organisations
Fund and co-design tailored health promotion strategies with LGBTIQA+ young people.	Department of Health Department of Education Mental Health Commission Office of Alcohol and Other Drugs Health & Social Service Organisations Healthway
Fund programs supporting LGBTIQA+ young people (e.g. Rainbow Community House).	Department of Health Mental Health Commission Office of Alcohol and Other Drugs Department of Communities
Develop mechanisms to embed perspectives of LGBTIQA+ young people in policy and program development.	Department of Health Commissioner for Children and Young People Department of Education Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations
LGBTIQA+ people living rurally and remotely	
Upskill existing health care sites and personnel serving rural and remote communities to provide inclusive LGBTIQA+ health care.	WA Country Health Service Department of Health Health & Social Service Organisations LGBTIQA+ Community-Controlled Organisations Higher & Further Education Institutions
Fund and maintain alternative methods of receiving health care (e.g. telehealth, outreach, transport support) for LGBTIQA+ people living rurally or remotely where their local health service may be considered unsafe or inaccessible.	WA Country Health Service Department of Health
Strengthen partnerships between WA Country Health Service and local LGBTIQA+ health workers and activists in rural and remote locations including through the development a community of practice.	WA Country Health Service LGBTIQA+ Community-Controlled Organisations Health & Social Service Organisations
Establish programs to incentivise health care workers and recent graduates to deliver LGBTIQA+-specific health care rurally and remotely.	WA Country Health Service Department of Health

Appendices

Appendix 1: Key LGBTIQA+ Data Sources

Western Australian research

Walkern Katatdjin (Rainbow Knowledge) Phase 2 Community Report
Liddelow-Hunt, S., Uink, B., Hill, B., Perry, Y., Munns, S., Talbott, T., Lin, A. (2023)
Youth Mental Health Team, Telethon Kids Institute; Kulbardi Aboriginal Centre, Murdoch University; and Kurongkurl Katitjin, Edith Cowan University.

LGBT+ and 50+: Loneliness and quality of life under the rainbow
Brooker, R. & GRAI (2023)
LBTI Rights in Ageing Inc. (GRAI)

Trans healthcare experiences and needs in Boorloo/Perth
Transfolk of WA (2023)

Hearing from trans and gender diverse children and young people in WA
Commissioner for Children and Young People (2023)

Gay Community Periodic Survey: Perth 2021
Chan, C., Broady, T., MacGibbon, J., Bavinton, B., Mao, L., Coci, M., Lobo, R., Radha Krishnan, S., Morgan, T., Prestage, G. & Holt, M. (2022)
Centre for Social Research in Health, UNSW Sydney.

Walkern Katatdjin (Rainbow Knowledge) Phase 1 Community Report
Liddelow-Hunt, S., Uink, B., Hill, B., Perry, Y., Munns, S., Talbott, T., Lin, A. (2021)
Youth Mental Health Team, Telethon Kids Institute; Kulbardi Aboriginal Centre, Murdoch University; and Kurongkurl Katitjin, Edith Cowan University.

Breaking the Silence: Insights into the Lived Experiences of WA Aboriginal/LGBTIQ+ People, Community Summary Report 2021
Hill, B., Uink, B., Dodd, J., Bonson, D., Eades, A. & S. Bennett (2021)
Kurongkurl Katitjin, Edith Cowan University.

State of Play Report: LGBTIQA+ Young People's Experiences of the Youth Accommodation System
Glance, C. (2021)
Youth Pride Network.

National research

Rainbow Realities
Amos, N., Lim, G., Buckingham, P., Liddelow-Hunt, S., Mooney-Somers, J., & Bourne, A. (2024)
Australian Research Centre in Sex, Health and Society, La Trobe University.

National Study of Mental Health and Wellbeing, 2020-2022
Australian Bureau of Statistics (2023)

Aboriginal & Torres Strait Islander LGBTQISB+ People and the COVID-19 Pandemic: a survey of impacts experienced as at mid-2021
Day, M., Bonson, D., Farrell, A., & Bakic, T. (2022)
Black Rainbow & Department of Indigenous Studies, Macquarie University.

Pride and Pandemic: Mental health experiences and coping strategies among LGBTQ+ adults during the COVID-19 pandemic in Australia
Amos, A., Macioti, P. G., Hill, A. O., Bourne, A. (2022)
Australian Research Centre in Sex, Health and Society, La Trobe University.

HIV Futures 10: Quality of life among people living with HIV in Australia
Norman, T., Power, J., Rule, J., Chen, J., & Bourne., A. (2022)
Australian Research Centre in Sex, Health and Society, La Trobe University.

Writing Themselves In 4: The health and wellbeing of LGBTQA+ young people in Australia
Hill, A., Lyons, A., Jones, J., McGowan, I., Carman, M., Parsons, M., Power, J., & Bourne, A. (2021).
Australian Research Centre in Sex, Health and Society, La Trobe University.

Private Lives 3: The health and wellbeing of LGBTIQ people in Australia
Hill, A. O., Bourne, A., McNair, R., Carman, M. & Lyons, A. (2020)
Australian Research Centre in Sex, Health and Society, La Trobe University.

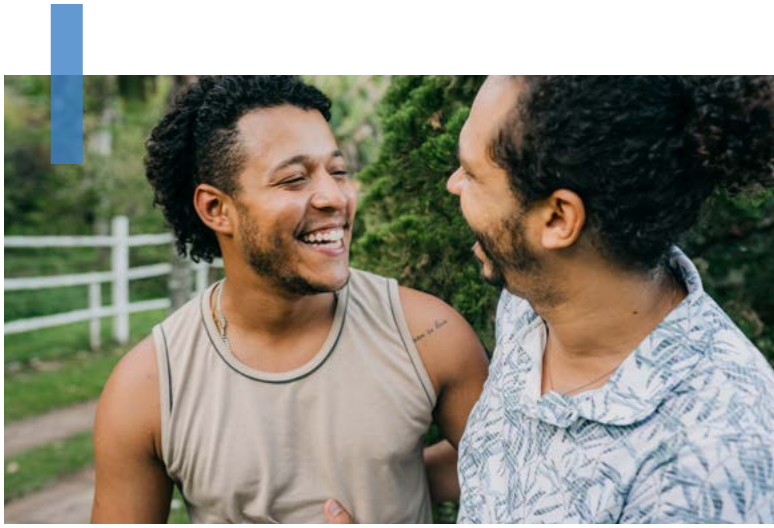
Women in contact with the Sydney LGBTIQ communities: Report of the SWASH Lesbian, Bisexual and Queer Women's Health Survey 2016, 2018, 2020
Mooney-Somers, J., Deacon, R.M., Anderst, A., Rybak, L.S.R., Akbany, A.F., Philios, L., Keeffe, S., Price, K., & Parkhill, N. (2020)
Sydney Health Ethics, University of Sydney.

National Drug Strategy Household Survey, 2019.
Australian Institute of Health and Welfare (2020)

The 2018 Australian Trans and Gender Diverse Sexual Health Survey: Report of Findings
Callander, D., Wiggins J., Rosenberg, S., Cornelisse, V.J., Duck-Chong, E., Holt, M., Pony, M., Vlahakis, E., MacGibbon, J., Cook, T. (2019)
The Kirby Institute, UNSW Sydney

Trans Pathways: the mental health experiences and care pathways of trans young people
Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., Lin, A. (2017)
Telethon Kids Institute.

Growing up queer: issues facing young Australians who are gender variant and sexuality diverse.
Robinson, K.H., Bansel, P., Denson, N., Ovenden, G. & Davies, C. (2014)
Young and Well Cooperative Research Centre.



Appendix 2: Policy Tables

Western Australian Policy Documents

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
A Safe Place: WA Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025 Mental Health Commission, Department of Communities	This strategy provides a framework to guide stakeholders in the development of appropriate accommodation and support for people with mental health and AOD issues.	Yes, under the section 'Young People' in 'Specific Population Groups' it states: *"There are limited data collections that relate specifically to Lesbian, Gay, Bisexual, Transgender, Intersex and Questioning (LGBTIQ+) people. This Strategy acknowledges that this cohort is at greater risk of experiencing mental health and AOD issues, particularly in young people."* (p30)	Yes, strategy acknowledged that LGBTIQ+ people are of greater risk of experiencing mental health and AOD issues (p30).
A Western Australia for Everyone: State Disability Strategy 2020-2030 Department of Communities	This is a plan aimed at ensuring inclusivity and equal rights for people with disabilities in WA. The plan outlines specific actions that will be taken over the next decade to address key issues and improve outcomes for individuals with disabilities.	Yes, the document refers to the intersection of LGBTI and disability in the introductory remarks: *"For some people, life with disability can also intersect with other parts of their identity that can influence the way they experience the world. Many people with disability are Aboriginal, from a culturally and linguistically diverse background or identify as LGBTQI."* (p14)	No priority populations are formally referred to.
Ageing with Choice: Future directions for seniors housing 2019-2024 *Department of Communities*	Ageing with Choice provides direction over the next five years to improve housing choice and outcomes for older Western Australians.	No mention.	Not identified as a priority population.
All Paths Lead to a Home: WA's 10-Year Strategy on Homelessness 2020-2030 *Department of Communities*	The Action Plan 2020-2025 focuses on building a No Wrong Door approach to service delivery, increasing low-barrier crisis responses, ending rough sleeping and supporting innovation. It is also recognises the need to provide culturally appropriate support and to acknowledge the specific vulnerabilities of rough sleepers, Aboriginal and Torres Strait Islander people and young people.	No mention.	Not identified as a priority population.

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
At Risk Youth Strategy 2022-27 Department of Communities	The Strategy responds to the needs of young people aged 10 to 24 years with multiple and complex problems who are at risk of harm and have increased vulnerability of experiencing poor life outcomes.	Yes, under the heading 'Focus area three: Strengthening the service system for at risk young people': *"The consultations highlighted that services and supports must be trauma-informed, understand issues impacting at risk young people and have capacity to respond to the diversity of their needs, including young people with disability and young people who identify as LGBTIQA+ and be culturally responsive for Aboriginal young people and young people from a culturally and linguistically diverse background." (p15)* Consultations identified what was needed most in services, including 'inclusion': *"Young people valued services that could respond effectively and sensitively to diversity, both in age and specific populations. Some young people felt there was a lack of LGBTIQA+ friendly services, especially in supported accommodation and that they did not always feel safe using mainstream services."* (p21)	Yes, young people who identify as LGBTIQA+ are identified as at-risk young people (p15).
Building a Better Future: Out-of-Home Care Reform Program *Department of Communities*	The Building a Better Future – Out-of-Home Care Reform Program Roadmap (the roadmap) has been drafted as a communication tool with the intention of articulating the context in which the new program plan for improving OOCH services will be developed and includes the background, justification, scope and high-level overview of work packages and a timeline for their implementation.	No mention.	Not identified as a priority population.
Child and Adolescent Health Service Strategic Plan 2023-2025 *Child and Adolescent Health Service*	This strategic plan describes priorities for focus and investment in community health and describes where to organisation expects to be in the future.	Yes. *"We promise to listen to, learn from, and partner with our consumers, carers, and broader community to make CAHS inclusive and equitable for all, but especially for people who are Aboriginal, culturally and linguistically diverse, LGBTQIA+ or who have disability."* (p5) It is also listed as one of eight priorities under the heading 'Inclusivity, diversity and equity': *"We will respect, embrace and champion the diversity of our community. We will uphold equal opportunity and we will not tolerate racism or discrimination.* *Our care will be culturally safe and inclusive for people who are Aboriginal, culturally and linguistically diverse, LGBTQIA+ or who have disability, and we will work towards equal health outcomes."* (p14)	No priority populations are formally referred to.

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Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
		← *From previous page* Under the heading 'Inclusivity, diversity and equity': *"We will respect, embrace and champion the diversity of our community. We will uphold equal opportunity and we will not tolerate racism or discrimination. Our care will be culturally safe and inclusive for people who are Aboriginal, culturally and linguistically diverse, LGBTQIA+ or who have disability, and we will work towards equal health outcomes."* (p14) As well as listed as a strategic initiative under the heading '4. We will deliver care that is more inclusive for LGBTIQA+ children and young people': • *"Co-design inclusive engagement and feedback mechanisms that improve our ability to meet the needs of LGBTQIA+ children, young people, and their families.* • *Deliver supportive and welcoming health services that improve the experiences and inclusion of LGBTQIA+ children, young people, and their families."* (p17)	
Department of Communities Strategic Plan 2019-2023 *Department of Communities*	Plan of how the Department will focus its efforts between 2019 to 2023.	No mention.	Not identified as a priority population.
EMHS LGBTIQ+ Inclusivity for Patients Policy *Royal Perth Bentley Group, East Metropolitan Health Service*	This policy assists clinicians to provide holistic treatment of LGBTIQ+ consumers while in the care of RPBG.	Focus of the entire document.	Focus of the entire document.
EMHS Strategic Plan 2021-2025 *East Metropolitan Health Service*	The EMHS Strategic Plan 2021-2025 describes their health service goals over the next four years.	No mention.	Not identified as a priority population.

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
Full Response to the Western Strategy Australian Methamphetamine Action Plan *Mental Health Commission*	The Methamphetamine Action Plan (MAP) outlines a comprehensive plan of actions that are aimed at reducing methamphetamine related demand, supply and harm, in recognition of the complexities associated with drug use. The Full Government Response (the Response) to the Methamphetamine Action Plan Taskforce Final Report (the Taskforce Report) reaffirms the State Government's commitment to addressing issues associated with methamphetamine use in WA.	Yes. The acronym is listed: *"LGBTI – Lesbian, Gay, Bisexual, Transgender, Intersex."* (p4) Under the heading 'Lead Agency: Department of Health' No. 42 reads: *"The Department of Health in consultation with the Mental Health Commission and representatives from the LGBTIQ community, include in the development of the WA Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) Health Strategy – the impact of illicit drug use on the LGBTI community (including methamphetamine); relevant approaches to addressing illicit drug use, and consideration of the Rainbow Tick Accreditation Program."* (p38) *"The Government supports this recommendation, acknowledging the importance of providing tailored and appropriate interventions and support to the Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) population who have been identified as a group at high risk of methamphetamine related harm. The Department of Health and Mental Health Commission will continue to provide peer based and other related support services to LGBTI people using methamphetamine and explore the development of targeted outreach programs and resources. The continued development of the LGBTI Health Strategy will also support this recommendation."* (p38)	No priority populations are formally referred to.
Healthway's Strategic Plan 2024-2029 *Healthway*	A plan to promote healthy eating, active living and mental wellbeing; prevent and reduce use of tobacco, e-cigarettes and other novel tobacco products; and prevent and reduce use of alcohol.	No mention.	LGBTQIA+ community dentified as a priority population.
Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025 *Mental Health Commission*	This is a comprehensive plan aiming to enhance the workforce capacity and quality across mental health, alcohol, and drug sectors. The framework provides a roadmap for developing and strengthening the workforce, ensuring that it is adequately equipped to meet the challenges and demands of the mental health and substance abuse landscape.	Yes, the document refers to 'PRIORITY AREA 1 STRATEGIES': *"7. Support the workforce to deliver services and programs that meet the requirements of the dynamic and diverse WA population (for example: people with disability, older adults, youth, CALD peoples, and lesbian, gay, bisexual, transgender, intersex and questioning (LGBTIQ+) individuals)."* (p34) With suggested actions: *"Promote the recruitment of suitably qualified, diverse workers across the service spectrum, ensuring that there are appropriate training and development opportunities available.*	No priority populations are formally referred to.

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Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
		← *From previous page* *Strengthen relevant links between mental health, AOD and other relevant agenciesxi with strong connections to diversity at clinical, professional and management levels and ensure appropriate interagency referral processes are in place.* *Ensure workforce development programs are available to increase workers' capacity to deliver appropriate services for specific populations including people with disability, Aboriginal peoples, LGBTIQ+, CALD, ageing and youth populations.* *Where relevant, include in contracts and service agreements a requirement for workers to undergo diversity training."* (p34)	
NMHS Workforce Diversity and Inclusion Strategy (2022-2025) *North Metropolitan Health Service*	This strategy outlines NMHS's dedication to employing and supporting a diverse workforce that reflects on the community, building on their previous .	Yes. *"To cultivate understanding and increase equity and inclusion of employees, we have developed initiatives to educate, develop, empower and celebrate the broad range of employees who make up the NMHS workforce. Whilst Our People Strategy 2019-2024 and NMHS Values outline actions to be more inclusive and supportive of all employees, in this strategy we have developed specific initiatives to attract and retain Aboriginal^ employees, people with disability, people who are culturally and linguistically diverse, women*, young people and those who identify as LGBTQIA+."* (p2) There is also a section regarding LGBTIQA+ diversity: • *Maintain a dedicated LGBTQIA+ hub page for employees to access relevant resources.* • *Educate on terms related to LGBTQIA+ culture to increase understanding and acceptance.* • *Schedule regular meetings and activities of NMHS Pride Network to enable peer support.* • *Promote NMHS as a LGBTQIA+ supportive employer.* • *Review language use on forms to be more inclusive of gender diverse employees.* • *Build an inclusive culture to ensure LGBTQIA+ employees feel safe and accepted.* • *Recognise and celebrate LGBTQIA+ diversity events.* (p8)	No priority populations are formally referred to.
Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030 *Department of Communities*	The Strategy is supported by three action plans that set out what needs to be done to achieve the long-term vision of all Western Australian's living free from family and domestic violence.	Yes, under the title 'Understanding family and domestic violence' it says: *"It takes many forms and occurs across all cultural groups, ages and sexual diversity groups."* (p18) *The report refers to gender, gender inequality and gendered violence as key drivers of violence against women. The following statement identifying expressions of gender inequality, may be relevant to gender diversity:* *Continued next page* →	Yes. *"Some groups are at a greater risk of family and domestic violence and/or face barriers to supports:* • *people who identify as LGBTIQ+"* (p19 & p36)

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
		← *From previous page* *"Rigid gender roles and stereotyped constructions of masculinity and femininity."* (p18) *"The intersectional approach will prioritise the experiences and needs of Aboriginal people, people from culturally and linguistically diverse backgrounds, refugees and migrants, people with disability, older people, people who identify as LGBTIQ+, people living in regional and remote areas, sex workers and people who are or have been incarcerated."* (p19)	
People of Diverse Sexualities and Genders: Action Plan to Improve WA Public Sector Employment Outcomes 2020-2025 *Public Sector Commission*	This plan aims to support inclusive work environments for people of diverse sexualities and genders in the WA public sector. This action plan outlines a number of activities that commit the public sector to providing opportunities for inclusion and fostering workplace cultures that allow people to bring their true selves to work.	Focus of the entire document.	Focus of the entire document.
Social Assistance and Allied Health Workforce Strategy (2018) *State Training Board*	This strategy focuses on attracting and retaining skilled professionals in the social assistance and allied health sectors by providing opportunities for professional development, mentoring, and career advancement.	Yes, in the Terms of Reference, it states: *"The Steering Committee is to provide advice on… the future workforce requirements, including… challenges and opportunities associated with access of delivery of services to and by Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups, people with disability, young people, and the LGBT community"* (p7) Under 'Social Assistance Services' LGBTI communities are identified: *"All social assistance and allied health sector workers need to be responsive to the diversity and complexity of Western Australia's community, including… people from lesbian, gay, bisexual, trans/transgender and intersex (LGBTI) communities."* (p18) And: *"Lesbian, gay, bisexual, transgender and intersex (LGBTI)* *It is estimated that the LGBTI community account for approximately 11% of Australia's population[22].* *The growing numbers of LGBTI people accessing aged care services represents an emerging and potentially challenging area for aged care service providers. People of diverse sexual orientation, sex or gender identity are a group requiring particular attention due to their experience of discrimination and the limited recognition of their needs by service providers and in policy frameworks and accreditation processes.* *Continued next page →*	No priority populations are formally referred to.

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
		← *From previous page* *As with any group, LGBTI people also have other diverse characteristics that overlap and influence their specific needs and how they access services. This 'diversity within diversity' includes LGBTI veterans; care leavers; people from culturally and linguistically diverse backgrounds; Aboriginal and Torres Strait Islander people; people living with HIV; people living with dementia; those in palliative care; those suffering financial disadvantage; and those living in rural and regional areas."* (p19)	
SMHS Equity, Diversity and Inclusion Plan 2021-2025 *South Metropolitan Health Service*	The Equity, Diversity, and Inclusion Plan (EDIP) addresses the need to correct historical disadvantages faced by diverse groups, aiming for a workforce that mirrors community diversity. It stands on principles of equity (ensuring fair access to opportunities), diversity (representation of varied backgrounds in all workforce levels to enhance healthcare quality), and inclusion (creating a work environment where all staff feel valued, heard, and empowered to innovate).	Two initiatives identified: • Achieve Quality Innovation Performance Limited Rainbow Tick Accreditation through developing LGBTQI+ inclusive practices. • Establish an Ally network and introduce training to increase awareness. (SMHS Initiatives) *"LGBTQIA+2 (lesbian, gay, bisexual, trans and gender diverse, queer or questioning, intersex, asexual or allies and others on the spectrum of gender): PSC's Workforce Diversification and Inclusion Strategy 2020 – 2025 uses the term People of Diverse Sexualities and Genders defined as people of diverse sexual orientations, gender identities and expressions, and sex characteristics. SMHS will be working towards Rainbow Tick Accreditation* (see Action Plan 19.1) *therefore will use LGBTQIA+ throughout the EDIP."* (Appendix 1: Workforce Diversity Groups Definitions)	'People of diverse sexualities and genders' is specifically identified as an Other Diversity Group.
SMHS Strategic Plan 2021-2025 *South Metropolitan Health Service*	This strategic plan describes how engagement with patients, families, staff and communities will continue to be improved in order to deliver safe and quality clinical care.	No mention.	No priority populations are formally referred to.
State Disability Strategy 2020-2030 Action Plan *Department of Communities*	This action plan outlines specific actions that will be implemented to realise the objectives of the State Disability Strategy 2020-2030.	Yes, the document mentions LGBTQI+ people in the action for Outcome 15: *"One community for everyone.* *Ensure access to safe, welcoming and culturally responsive services are available for vulnerable cohorts of people living with disability. This includes young people, CaLD people, LGBTQI+ people and Aboriginal and Torres Strait Islanders."* (p36)	No priority populations are formally referred to.

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
State Oral Health Plan 2016-2020 *Department of Health*	The policy outlines key elements to improve oral health in WA, including oral health promotion, accessible oral health services, systems alignment and integration, safety and quality, workforce development, and research and evaluation.	No mention.	Not identified as a priority population.
State Public Health Plan for Western Australia. Objectives and Policy Priorities for 2019-2024 *Department of Health*	The plan outlines the public health needs, objectives, and policy priorities for WA. It establishes a framework for identifying and responding to public health risks and describes the formation of partnerships for undertaking public health initiatives, projects, and programs.	Yes, the document mentions the LGBTQI+ community in the context of mental health: *"Groups that experience higher rates of mental health issues include but are not limited to: Aboriginal people, regional, rural and remote populations, young people, people with disabilities and the LGBTQI+ community.[49]"* (p21) *"Suicide in youth populations: A meta-analysis of 35 studies from across the world estimated that among young people aged 12-20 years, suicide attempts are 3.5 times more likely for LGBTQI+ and nearly six times more likely for transgender youths compared with their heterosexual peers."* (p22)	Not identified as a priority population.
Strategic Directions 2021-2026 *Commissioner for Children and Young People's*	The Commissioner's Strategic Directions 2021-2026 outlines the broad focus areas of the Commissioner for Children and Young People and aims to both inform and engage the community in the work of the Commissioner. The Commissioner's annual work plan supports the strategic plan.	Yes, in the key actions for key platform 3, 'Prioritising the needs of disadvantaged and vulnerable children and young people': *"Ongoing development of work to recognise, celebrate and educate others on issues relating to diverse groups of children and young people including those who identify as LGBTIQ+, living with disability and those from culturally and linguistically diverse backgrounds."* (p4)	Not identified as a priority population.
Sustainable Health Review: Final Report to the WA Government (2019) *Government of Western Australia*	This is a comprehensive report that outlines the findings and recommendations of the WA Government on how to improve the sustainability of the healthcare system. The report examines various aspects of healthcare, including workforce planning, innovative service models, digital health technology, and infrastructure investment.	Yes, the document contains an 'Appendix 5: Health inequality in WA' that includes 'Key facts and health outcomes' on 'Key groups' (p26): *"The LGBTI community* • *Australians of diverse sexual orientation, sex or gender identity may account for up to 11 per cent of the Australian population.[23]* • *LGBTI young people report experiencing verbal homophobic abuse (61 per cent), physical homophobic abuse (18 per cent) and other types of homophobia (nine per cent), including cyberbullying, social exclusion and humiliation.[24]* • *LGBTI people are at a higher risk of suicidal behaviours and have the highest rates of suicidality compared with any population in Australia.[25]* • *Rates of illicit drug use reportedly higher among homosexual or bisexual people and among people who reported high or very high psychological distress.[26]"* (p26)	No priority populations are formally referred to.

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
Veterans and Families Strategy *Department of Communities*	The Veterans and Families Strategy will guide the activities of the Veterans Issues portfolio. It's purpose is to: 1. Recognise and support veterans and their families. 2. Encourage and enable their ongoing participation and contribution to the broader community. 3. Understand who and where WA veterans are, and their interests and needs. 4. Commemorate the service and sacrifice of Australian service personnel. 5. Educate the broader community on the significance and impact of Australia's wars on our nation.	No mention.	No priority populations are formally referred to.
WA Aboriginal Health and Wellbeing Framework 2015-2030 *Department of Health*	The framework identifies key guiding principles, strategic directions and priority areas for the next 15 years, to improve the health and wellbeing of Aboriginal people in WA.	No mention.	No priority populations are formally referred to.
WA Aboriginal Sexual Health and Blood-borne Virus Strategy 2019-2023 *Department of Health*	This strategy outlines the guiding principles, goals, targets and priority areas needed for an effective, coordinated and comprehensive state-wide response to the impact of bloodborne viruses and sexually transmissible infections on Aboriginal people in WA.	Yes, the document refers to 'Guiding Principles' including: *"2. Human rights* *People living with an STI or those at risk of STIs have the right to live without stigma and discrimination. It is vital to safeguard the human rights of priority populations so as not to face stigma and discrimination based on their actual or perceived health status, cultural background, socio-economic status, age, sex, sexual or gender orientation or identity. They have the same rights to comprehensive and appropriate information and health care as other members of the community, including the right to the confidential and sensitive handling of personal and medical information.*	Yes, gender and sexually diverse Aboriginal people were identified priority population (p6).

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Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
		← *From previous page* *3. Access and equity* *Health and community care in WA should be accessible to all, based on need. The multiple dimensions of inequality should be addressed, whether related to gender, sexuality, disease status, drug use, occupation, socio-economic status, migration status, language, religion, culture or geographic location, including in custodial settings. Health and community services should be welcoming and should work towards increasing access for priority populations."* (p15) Under 'Priority populations' it includes 'Gender and sexually diverse Aboriginal people' and states: *"In comparison to their heterosexual and cisgender counterparts, Aboriginal men who have sex with men (MSM), sistergirls and brotherboys* are more susceptible to STIs and BBVs. Inconsistent condom use, substance use, including people who inject drugs (PWID), and lower testing rates or higher viral loads for HIV are more common among Aboriginal gay and bisexual MSM (both cisgender and transgender) than their non-Aboriginal counterparts. In addition, this priority population also experiences higher levels of discrimination, which can have a negative impact on their health and wellbeing."* (p19)	
WA Cancer Plan 2020-2025 *Department of Health*	This plan provides direction for the next five years to reduce the burden of cancer in the community. It includes every aspect of care, from prevention and early detection to curative treatment and palliative care. The plan outlines priority areas to strengthen existing partnerships and develop new ones to achieve cancer control suitable to all people affected by cancer.	Yes, this document includes a definition: *"Throughout this document the acronym LGBTI is used to refer to lesbian, gay, bi-sexual, transgender, intersex or otherwise diverse people in sex characteristics, gender and sexuality. It is recognised that many people and populations have additional ways of describing their distinct histories, experiences and needs beyond this acronym. The use of this acronym is not intended to be limiting or exclusive of certain groups[36]."* (p50)	Yes. The Plan acknowledges the unique needs of population groups such as people who are… part of the Lesbian, Gay, Bi-sexual, Trans-gender and Intersex (LGBTI) community. It acknowledges these people often experience stigma, discrimination and/or racism, which causes significant barriers to accessing cancer services and negatively impact health and wellbeing. Providing programs and services that are responsive, competent, respectful and accessible to all is essential to improving cancer outcomes for Western Australians." (p10).

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
WA Carers Strategy *Department of Communities, Carers Advisory Council and Carers WA*	The Strategy guides the WA community on how to better recognise and support carers. It outlines areas of priority, as identified by carers themselves and the organisations that support them, with strategies and actions for the community to follow.	Yes. *"Carers, and the people they care for, are as diverse as the rest of the community. They range in age from children through to seniors and come from diverse cultural, linguistic and religious backgrounds, socio-economic circumstances, and gender and sexual identities."* (p4) In the section 'Carers diversity'. *"Carers are diverse in terms of the condition of the person they care for, their life circumstances, age, gender, religious conviction, race and ethnicity, language, geographic location and sexual orientation."* (p9) *"Carers of diverse sexual orientations are less likely to self-identify as carers or access services because they have witnessed or experienced prejudice and discrimination within the services sector and wider community."* (p10) *"Some carers may feel uncomfortable disclosing or discussing their sexual or gender identity."* (p10)	No priority populations are formally referred to.
WA Chronic Health Conditions Framework 2011-2016 *Department of Health*	The framework aims to provide a coordinated approach to the prevention and management of chronic health conditions in WA. It outlines priority areas and strategies to improve the health outcomes of people with chronic conditions.	No mention.	No priority populations are formally referred to.
WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024 *WA Country Health Service*	The policy outlines key elements to improve mental health and wellbeing in WA, including contemporary mental health and substance use disorder services, sustainable and skilled workforce, innovation through technology, partnerships and research, and leadership, culture and governance.	Yes, the document mentions LGBTI people as a vulnerable population: *"People who identify as LGBTI experience disproportionate rates of mental health problems. Major depressive episodes can be four to six times higher than the general population, psychological distress rates are reported as twice as high, and suicide rates are higher than the general population.[20] Young LGBTI people coming to terms with their sexual orientation and gender are particularly vulnerable. Service providers must be cognisant of the high correlation between experiences of stigma, prejudice, discrimination and abuse with the impact upon mental health and wellbeing outcomes. There is a demonstrated need for a set of skills and understanding of issues around sexual orientation, gender identity and intersex conditions to be incorporated into person-centred mental health service delivery."* (p12)	Yes, the document refers to 'people who identify as lesbian, gay, bisexual, transgender, or intersex (LGBTI)' as a vulnerable group in country WA (p12).

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Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
		← *From previous page* It also refers to a 'Sustainable and Skilled Workforce' including: *"A WACHS mental health peer workforce (see Glossary), including people whose lived experience includes being from vulnerable groups such as Aboriginal people or the LGBTI community, is implemented across all regions."* (p17) And defines the term LGBTI: *"Lesbian, gay, bisexual, trans, intersex or otherwise diverse in sexuality or gender. It is recognised that many people and populations have additional ways of describing their distinct histories, experiences and needs."* (p21)	
WA Disability Health Framework 2015-2025 *Department of Health*	This framework aims to improve the provision of healthcare services for people with disabilities in WA. The framework recognises the unique health needs of this population and provides a comprehensive plan to address them.	Yes, refers to LGBTI communities in the Diversity entry in 'Key Concepts' (p4): *"Diversity is a broad concept including disability, age, experience, race, ethnicity, under-resourced populations, socio-economic background, education, sexual orientation and gender identification, marginalisation, religion and spirituality. This includes Aboriginal people, people from CaLD backgrounds, and people from Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI+) communities. Diversity also exists within different types of disability such as cognitive, physical, rare, genetic and undiagnosed conditions, chronic or acute. Diversity is about understanding, respect and acceptance."* It also includes a section on 'Diversity within disability' with: *"A supportive and inclusive health system requires understanding and recognising the diversity that exists within disability. Aboriginal people, and people from CaLD and LGBTI+ communities with a disability can experience additional barriers within the healthcare system, creating ongoing health inequities."* (p6) And a specific section: *"Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI+) communities* *People with disability from the LGBTI+ community can experience several barriers to accessing appropriate health services. LGBTI+ young people with a disability reported significantly higher levels of psychological distress, experience of verbal abuse and attempted suicide than those without a disability.[28] The WA LGBTI Health Strategy 2019–2024[29] highlights priority areas for improving the health and wellbeing of LGBTI+ populations."* (p7) There is also a definition: *"LGBTI+ is used to refer to lesbian, gay, bisexual, transgender and intersex people. The use of this acronym is not intended to be limiting or exclusive of certain groups and we recognise that not all people will identify with this acronym or use these specific terms."* (p17)	No priority populations are formally referred to.

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
WA Disability Health Framework Companion Resource *Department of Health*	This resource provides guidance and support in implementing the WA Disability Health Framework. This resource is designed to assist health professionals and service providers in delivering high-quality care to people with disabilities.	Yes, under the heading "Diversity': *"Diversity is a broad concept including disability, age, experience, race, ethnicity, under-resourced populations, socio-economic background, education, sexual orientation and gender identification, marginalisation, religion and spirituality. This includes Aboriginal people, people from Culturally and Linguistically Diverse (CaLD) backgrounds, and people from Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI+) communities."* (p3)	No priority populations are formally referred to.
WA End-of-Life and Palliative Care Strategy 2018-2028 *WA Cancer and Palliative Care Network, Department of Health*	The Strategy is a non-mandatory supporting document to the mandated Clinical Services Planning and Programs Policy Framework. It supports and informs the implementation of this Policy Framework and provides a blueprint to achieve areas of focus and key elements of delivery. It aims to provide clinical and health system leadership and advice to support health reform across the priority areas. It also supports performance monitoring via system-wide trends and data to provide assurance that the health system is delivering high-quality end-of-life and palliative care to Western Australians.	Yes, the document mentions LGBTI under Priority One: *"Improve access to care for marginalised groups, e.g. homeless people and refugees and lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) communities."* (p8)	No priority populations are formally referred to.
WA Health and Medical Research Strategy 2023-2033 *Department of Health*	The WA Health and Medical Research Strategy 2023-2033 outlines priorities for medical and health research in WA.	No mention.	No priority populations are formally referred to.
WA Health Digital Strategy (2020-2030) *Department of Health*	The WA Health Digital Strategy 2020-2030 outlines how innovations transforming healthcare will be used to improve WA health outcomes.	No mention.	No priority populations are formally referred to.

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
WA Health Promotion Strategic Framework 2022-2026 *Department of Health*	This is a comprehensive plan that outlines the health promotion priorities for the region over the next four years. The framework aims to improve the health and well-being of Western Australians by addressing the underlying determinants of health, such as social, economic, and environmental factors. The framework sets out three key strategic directions: promoting health equity and reducing inequalities, empowering individuals and communities, and creating supportive environments for health. These directions are supported by a range of priority areas, including healthy eating and active living, tobacco control, alcohol harm reduction and injury prevention.	Yes, the document mentions LGBTI populations with an infographic (p18) with 'LGBTI more likely smoke (35%) and drink (28%)' and: *"People who identify as lesbian, gay or bisexual are more likely to smoke (35 per cent) and drink alcohol at risky levels (28 per cent) than heterosexual people (29 per cent and 22 per cent, respectively).[40] People who identify as transgender and intersex are likely to have similar increased risks, however data for these groups are lacking. Some people who identify as lesbian, gay, or bisexual, transgender or intersex (LGBTI) may use these substances to cope with discrimination and other life difficulties they experience, and tobacco and alcohol use may also be more normalised in some LGBTI social settings.[40]"* (p18) *"Three-quarters of people who take their own life are male,[245] in WA the suicide rate for Aboriginal people is 2.6 times higher than for non-Aboriginal people,[246] and LGBTI people aged between 16 and 27 are 5 times more likely to attempt suicide than the general population.[247]"* (p62) There is also a section on 'Suicide and self-harm': *"Suicide is the leading cause of death in people aged between 15 and 44.[245] Three-quarters of people who take their own life are male,[245] in WA the suicide rate for Aboriginal people is 2.6 times higher than for non-Aboriginal people,[246] and LGBTI people aged between 16 and 27 are 5 times more likely to attempt suicide than the general population.[247] The Mental Health Commission's WA Suicide Prevention Framework 2021-2025 sets directions for action to reduce the rate of suicide attempts and death by suicide in Western Australia.[248]"* (p62)	No priority populations are formally referred to.
WA Healthy Weight Action Plan 2019-2024 *Health Networks / Department of Health*	The WA Healthy Weight Action Plan 2019-2024 is a map for action over the next five years to support coordinated activity that will positively impact the early intervention and management of overweight and obesity in WA.	No mention.	Not identified as a priority population.

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
WA Hepatitis B Strategy 2019-2023 *Department of Health*	The WA Hepatitis B Strategy 2019-2023 builds on the strengths and progress from our previous strategies, and is closely aligned to the Third National Hepatitis B Strategy 2018-2022. This strategy outlines a coordinated and comprehensive state-wide response to the impact of hepatitis B on target populations in WA.	Yes, the document refers to 'Guiding Principles' including: *"2. Human rights* *People living with an STI or those at risk of STIs have the right to live without stigma and discrimination. It is vital to safeguard the human rights of priority populations so as not to face stigma and discrimination based on their actual or perceived health status, cultural background, socio-economic status, age, sex, sexual or gender orientation or identity. They have the same rights to comprehensive and appropriate information and health care as other members of the community, including the right to the confidential and sensitive handling of personal and medical information.* *3. Access and equity* *Health and community care in WA should be accessible to all, based on need. The multiple dimensions of inequality should be addressed, whether related to gender, sexuality, disease status, drug use, occupation, socio-economic status, migration status, language, religion, culture or geographic location, including in custodial settings. Health and community services should be welcoming and should work towards increasing access for priority populations."* (p15)	Yes. 'Gay and bisexual men, and men who have sex with men (MSM)' are identified as key subpopulations among 'Other unvaccinated adults at higher risk of infection' (p19).
WA Hepatitis C Strategy 2019-2023 *Department of Health*	The WA Hepatitis C Strategy 2019-2023 builds on the strengths and progress from our previous strategies, and is closely aligned to the Fifth National Hepatitis C Strategy 2018-2022. This strategy outlines a coordinated and comprehensive statewide response to the impact of hepatitis C on target populations in WA.	Yes, the document refers to 'Guiding Principles' including: *"2. Human rights* *People living with an STI or those at risk of STIs have the right to live without stigma and discrimination. It is vital to safeguard the human rights of priority populations so as not to face stigma and discrimination based on their actual or perceived health status, cultural background, socio-economic status, age, sex, sexual or gender orientation or identity. They have the same rights to comprehensive and appropriate information and health care as other members of the community, including the right to the confidential and sensitive handling of personal and medical information.* *3. Access and equity* *Health and community care in WA should be accessible to all, based on need. The multiple dimensions of inequality should be addressed, whether related to gender, sexuality, disease status, drug use, occupation, socio-economic status, migration status, language, religion, culture or geographic location, including in custodial settings. Health and community services should be welcoming and should work towards increasing access for priority populations."* (p15)	Yes. 'Gay and bisexual men, and men who have sex with men (MSM)' are identified as key subpopulations among 'People living with hepatitis C' (p18) and 'People who inject drugs' (p18).

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
WA HIV Strategy 2019-2023 *Department of Health*	The WA HIV Strategy 2019-2023 sets out WA Health's plan for working with sector partners to reduce the transmission and impact of HIV in the WA community.	Yes, the document refers to 'Guiding Principles' including: *"2. Human rights* *People living with an STI or those at risk of STIs have the right to live without stigma and discrimination. It is vital to safeguard the human rights of priority populations so as not to face stigma and discrimination based on their actual or perceived health status, cultural background, socio-economic status, age, sex, sexual or gender orientation or identity. They have the same rights to comprehensive and appropriate information and health care as other members of the community, including the right to the confidential and sensitive handling of personal and medical information.* *3. Access and equity* *Health and community care in WA should be accessible to all, based on need. The multiple dimensions of inequality should be addressed, whether related to gender, sexuality, disease status, drug use, occupation, socio-economic status, migration status, language, religion, culture or geographic location, including in custodial settings. Health and community services should be welcoming and should work towards increasing access for priority populations."* (p15) Under 'Snapshot of HIV in Western Australia' it includes numerous mentions: *"The number of new HIV diagnoses in 2017 (n = 79) was the lowest number of annual cases reported in WA since 2009 (n = 75), representing a 27% decrease in annual cases since 2015 (n = 108). In 2017, 47% (n = 37) of new HIV diagnoses were notified in men who have sex with men (MSM), followed by male heterosexual (35%; n = 28) and female heterosexual (13%; n = 10).[1] Where injecting drug use was reported as the main risk factor, cases remain low with only one notification in this category for 2017.[1] The decline in HIV notifications was mainly driven by a decrease in cases among MSM, which decreased by 42% between 2016 (n = 64) and 2017(n = 37).1"* (p12) *"In WA, gay and bisexual men make up a significant proportion of HIV notifications. Condom use among gay and bisexual men has declined, as reported by participants in the 2017 Perth Gay Community Periodic Survey (PGCPS)[2]. The 2017 PGCPS reported that 44.6% of participants had unprotected anal intercourse with casual male partners in the six months prior to the survey. This was the highest ever reported in the PGCPS and an increase from 39.8% (n = 200) reported in the 2010 survey. While reported condom use has declined, there was also an increase in the proportion of PGCPS participants aware about the availability of pre-exposure prophylaxis (PrEP), which rose from 21.7% (n = 148) in 2014 to 67.8% (n = 415) in 2017."* (p13)	Yes, the following are included as priority populations (p6): • gay and bisexual men, and men who have sex with men • sexually and gender diverse people.

Continued next page →

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
		← *From previous page* Under 'Priority populations', it states for 'Gay and bisexual men, and men who have sex with men': *"Gay and bisexual men, and MSM continue to be disproportionally affected by HIV, accounting for around 59% of all HIV notifications in WA in 2017.[1] In the 2017 PGCPS, which interviewed a sample of 612 men, 89% had taken an HIV test at some point in time, signalling an increase in HIV testing when compared to previous surveys.[2] However, the 2017 PGCPS highlighted that condomless anal intercourse (CLAI) with either regular or casual partners had increased, along with serosorting and awareness of PrEP.[2]* *Supporting findings of the 2017 PGCPS, other behavioural research suggests that subpopulations of MSM continue to be at increased risk of acquiring HIV when compared to other population groups due to a combination of risk behaviours including increased CLAI with multiple casual sex partners, often in conjunction with the use of illicit drugs as a part of those sexual encounters.[2,19,20] With high rates of STIs in MSM in WA,[1] along with decreasing condom use and evolving use of PrEP for HIV prevention, there will be a greater need for increased efforts to promote combination approaches to HIV and STI prevention, PrEP adherence and routine comprehensive HIV and STI testing.* Key subpopulations of gay and bisexual men, and MSM include: • PLWH • PWID • people from CALD backgrounds." *(p21)* Under 'Priority populations', it states for 'Sexually and gender diverse people': *"The prevalence of HIV in sexually and gender diverse people in Australia is unknown, due limitations in the data.[4] However, internationally the high prevalence of adverse health outcomes in this population, including HIV, STIs and other BBVs, are often elevated due to complex biological, social and structural factors, which increase risk and reduce access and options to health care.[27] Sexually and gender diverse people may have individual risk factors that vary, and likewise specific sexual health needs across the HIV cascade of care. Concentrated initiatives for this priority population should prioritise training and quality standards within the health care workforce to ensure inclusive and stigma-free service delivery.* *Continued next page →*	

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
		← *From previous page* *Key subpopulations of sexually and gender diverse people include those who are:* • *youth* • *PLWH* • *Aboriginal, including brotherboys and sistergirls[1*]* • *undergoing hormonal or medical treatment or procedures to assist with gender affirmation."* (p24) 'Transgender and gender diverse people' are identified as key subpopulations among People living with HIV (p20). Gender and sexually diverse' people are identified as key subpopulations among Aboriginal people (p21) and Sex workers (p23). 'Gay and bisexual men, and MSM from high prevalence countries' are identified as key subpopulations among Culturally and linguistically diverse people from high HIV prevalence countries (p22). 'Gay and bisexual men, and MSM' are identified as key subpopulations among People who inject drugs (p23). Under 'Consultation findings' it states: *"There is a need to increase priority population's engagement with HIV testing and PrEP, particularly among subpopulations such as Southeast Asian MSM."* (p26) Under 'Surveillance, monitoring and evaluation framework' there are targets and indicators to 'Reduce the incidence of HIV transmission' in MSM and sexually and gender diverse people. (p37-38)	
WA Housing Strategy 2020-2030 *Department of Communities*	The WA Housing Strategy 2020-2030 is a call to action for all sectors to work together to improve housing choices and access to suitable and affordable homes – particularly for the most vulnerable.	No mention.	No priority populations are formally referred to.
WA Industry Participation Strategy 2019 *Department of Jobs, Tourism, Science and Innovation*	The WA Industry Participation Strategy (WAIPS) provides local industry, in particular small and medium sized businesses, with greater opportunities to access and compete for State Government contracts. It was developed as a requirement of the WA Jobs Act 2017.	No mention.	No priority populations are formally referred to.

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
WA Lived Experience (Peer) Workforce Framework *Mental Health Commission*	The WA Lived Experience (Peer) Workforce Framework is designed to aid the development of the Lived Experience (Peer) Workforces, as well as being practical and accessible for all stakeholders.	Yes, the document mentions LGBTIQ+ communities and sexuality and diverse gender throughout: *"People from ethnoculturally linguistically diverse (ELD) and Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual plus other, Sistergirls and Brotherboys (LGBTIQA+SB) communities are more likely to seek help from services or engage with research, advocacy or engagement activities which demonstrate understanding of and competency to work with their cultures."* (p7) *"Additionally, there are overlapping and intersecting experiences of race, culture, class, age, gender, sexuality, (dis)ability etc. that also impact people as relational human beings. To narrow emotional distress and its impacts to purely a biological cause limits the potential pathways to recovery/ wellbeing and full citizenship."* (p9) *"ensuring that Lived Experience (Peer) Workforces are developed within and for specific communities such as those additional to, and included, under the LGBTIQA+SB umbrella as well as in ELD communities."* (p10) It is also mentioned under workforce specialisations: *"ELD, Disability, Neurodivergency, LGBTIQA+SB, Veteran, Refugee etc."* (p19)	No priority populations are formally referred to.
WA Lesbian, Gay, Bisexual, Transgender, Intersex Health Strategy 2019-2024 *Department of Health*	This Strategy provides practical guidance and identifies priorities for action for health providers and their partners, which aim to improve the physical, mental, social and emotional wellbeing of LGBTI people and which will raise awareness of the specific challenges we face.	Focus of the entire document.	Focus of the entire document.
WA Men's Health and Wellbeing Policy (2019) *Department of Health*	This policy outlines key elements to improve the health and wellbeing of men, including attitudes of men and the community's attitudes towards men, education/awareness, access to services, and community support and intervention. It is intended to inform local planning, delivery, and evaluation strategies for health services and programs.	Yes, the document defines 'men' broadly: *"For the purpose of this Policy, the term 'men' refers to a male of any age, including boys. It is acknowledged that there is diversity in our bodies, sex characteristics, sexualities and gender identities."* (p5) It also contains 'Areas for action': *"consider the interaction of the social determinants of health on sex, age and different population groups of males, including those from gay, bisexual and transgender groups and culturally diverse population groups."* (p11) *"Promote opportunistic screening or referral to appropriate services when men access services related to major life events such as: gay, bisexual and transgender related transitions (e.g. coming out)."* (p19)	Yes. the document identifies "males with diverse sexualities, intersex men, and men with transgender experience" as priority populations (p2).

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
WA Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 *Mental Health Commission*	This policy is intended to inform local planning, delivery, and evaluation strategies for mental health, alcohol and other drug services and programs. It includes broad strategies that can have a positive impact on a large number of people and can be adapted and tailored to suit particular populations and groups.	Yes, the document mentions LGBTIQ+ individuals and communities: *"Principle 8: Valuing diversity, equity, cultural inclusivity and human rights is a priority... Certain groups in the community (for example, Aboriginal peoples and LGBTIQ+ communities) are disproportionately impacted by mental illness and alcohol and other drug-related harm. Consideration of diversity, equity, cultural inclusivity and cultural security is therefore paramount."* (p24) *"The mental health of LGBTIQ+ people is among the poorest in Australia, with more than twice as many homosexual/bisexual Australians experiencing anxiety disorders compared to heterosexual people (31% and 14% respectively) 65."* (p40) Appendix E refers to Example Strategies for Population Groups and includes: *"LGBTIQ+ people and communities: Deliver targeted programs that promote good mental health and wellbeing and reduce the risk of mental illness for LGBTIQ+ people. This may include: promoting social connection and increasing a sense of belonging; increasing self-esteem; increasing mental health literacy and help seeking; and promoting the use of self-help."* (p57)	
WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Draft Plan Update 2018 *Mental Health Commission*	This policy outlines key elements to inform local planning, delivery, and evaluation strategies for mental health, alcohol and other drug services and programs. These areas of focus for the Government will form the priority work by the Mental Health Commission, Department of Health and health service providers towards the WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025.	Yes, refers under 'Achievements – Community Support Services' to: *"Implementation of peer support weekend workshops for rural and remote LGBTI+ by the WA AIDS Council's Freedom Centre."* (p45) And the following under 'Current Strategic Context – System-Wide Reform': *"Commission's Procurement Schedule 2018-2025* *Implementation of the Commission's Procurement Schedule 2017-2025 for non-government community-based services will also affect further system wide changes by embedding service providers' contractual requirements to deliver quality assured, recovery focussed, individualised care and supports. This includes requirements for service providers to demonstrate their capabilities to meaningfully engage in co-production with consumers, families and carers, provide trauma informed care, be culturally competent in the design and delivering of services and be able to provide services that are accessible and sensitive to the needs of people with co-occurring issues, Aboriginal people, people from culturally and linguistically diverse backgrounds and LGBTI+ communities."* (p81)	No priority populations are formally referred to.

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
WA Multicultural Policy Framework *Office of Multicultural Interests*	The framework is outcome-focused, providing a structure for agencies to direct their efforts in achieving the government's vision for multiculturalism in WA — through effective leadership, planning, service provision and engagement with communities. The WAMPF sets out measurable strategies for the public sector, to ensure that operations, services and programs are inclusive and accessible for everyone.	Yes. *"Some groups, such as women, young people, seniors, people with disability, people who are Deaf or hard of hearing and LGBTQI+ may experience particular barriers when accessing services."* (p12) The report makes comments relating to diversity, including: *"Diversity embraces all human differences including but not limited to sex, ethnicity, physical ability, social class, marital status, religion, political conviction, age or gender history."* (p9) *"Diversity – Diversity is a statement of fact that encompasses the range of visible and invisible attributes, experiences and identities that shape each individual. Diversity embraces all human differences including but not limited to ethnicity, sex, gender, gender identity, sexual orientation, age, social class, physical ability or attributes, religious or ethical values systems and national origin."* (p19)	No priority populations are formally referred to.
WA Sexually Transmissible Infections (STI) Strategy 2019-2023 *Department of Health*	This strategy outlines the guiding principles, goals, targets and priority areas needed for an effective, coordinated and comprehensive state-wide response to the impact of sexually transmissible infections on vulnerable target populations in WA.	Yes, the document refers to 'Guiding Principles' including: *"2. Human rights* *People living with an STI or those at risk of STIs have the right to live without stigma and discrimination. It is vital to safeguard the human rights of priority populations so as not to face stigma and discrimination based on their actual or perceived health status, cultural background, socio-economic status, age, sex, sexual or gender orientation or identity. They have the same rights to comprehensive and appropriate information and health care as other members of the community, including the right to the confidential and sensitive handling of personal and medical information.* *3. Access and equity* *Health and community care in WA should be accessible to all, based on need. The multiple dimensions of inequality should be addressed, whether related to gender, sexuality, disease status, drug use, occupation, socio-economic status, migration status, language, religion, culture or geographic location, including in custodial settings. Health and community services should be welcoming and should work towards increasing access for priority populations."* (p15)	Yes, the following are included as priority populations (p19): • sexually and gender diverse people • gay and bisexual men, and men who have sex with men.

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Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	Description	Any mention of sexuality, diverse gender and/or intersex status?	Any LGBTIQA+ identified as a priority population?
		← *From previous page* It also details specific priority populations: *"Sexually and gender diverse people* *Sexually and gender diverse people have specific sexual health care needs and risks, and may experience barriers to accessing appropriate prevention and education, treatment and care. This may include stigma and discrimination or difficulty finding a healthcare provider who is competent in sexually and gender diverse care. Legal frameworks and policies may create barriers to equitable access of health services for transgender and gender diverse people and need to be addressed alongside the provision of more inclusive education and appropriately skilled health services.*[5] *Key subpopulations sexually and gender diverse people include those who are:* • *young* • *living with HIV* • *Aboriginal, including brotherboys and sistergirls** • *undergoing hormonal or medical treatment or procedures to assist with gender affirmation."* (p20) And: *"Gay and bisexual men, and men who have sex with men* *Gay and bisexual men, and MSM are disproportionately affected by all STIs and have a higher prevalence and risk of acquiring STIs and BBVs such as syphilis and HIV when compared to the general population. The transmission of other viruses during sexual contact via the faecaloral route, such as hepatitis A and shigellosis, is also an emerging issue among MSM.*[7] *Gay and bisexual men, and MSM may have specific sexual health needs, though they may also experience stigma or discrimination related to their sexual identity or disease status. Appropriate prevention education and healthcare services should emphasise the importance of safer sex practices and condom use, alongside regular testing and early treatment. This is particularly important in the context of the use of pre-exposure prophylaxis (PrEP) for HIV prevention.* *Key subpopulations of gay and bisexual men, and MSM include those who are:* • *living with HIV* • *engaging in chem-sex* • *migrants or from CALD backgrounds."* (p22) It also has references under other Priority Populations: *Women "...includes both cisgender and transgender women."* (p19) *Continued next page →*	

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
		← *From previous page* 'Sexually and gender diverse' are identified as key subpopulations among Young people (p19) and Sex workers (p21). 'People with mental health issues' includes *"Research also suggests that several priority populations, including sexually and gender diverse people, may experience mental health issues such as depression and anxiety at higher rates than the general population, indicating an important intersection.[16,17]"* (p22) Under 'Consultation findings' it states: *"Research and health service evaluation are needed to determine how sexually and gender diverse people experience accessing sexual health care and looking after their sexual health." (p24)* Under 'Prevention and education' in 'Evidence to support actions' it states: *"Trends in declining condom use, particularly among gay and bisexual men and sex workers, emphasise the need for ongoing targeted health promotion initiatives in this area.[6,7]"* (p25) Under 'Enabling environment' in 'Evidence to support actions' it states: *"There is a strong need to address the legal, regulatory and institutional frameworks that are known to create barriers to good sexual health and service access for priority populations such as sex workers and transgender people."* (p26) In 'Action areas' for 'Prevention and education' it refers to Comprehensive RSE (relationships and sexuality education) including: *"a positive, sexually and gender diverse inclusive view of relationships and sexuality"* (p27) In 'Action areas' for 'Data collection, research and evaluation' it refers to it being essential to: *"Increase research efforts, utilising peer researchers where appropriate, in relation to STI prevalence and sexual health outcomes of priority populations for which there is a paucity of data, including transgender people and people who are currently in or have recently exited custodial settings, so as to inform and enhance programs and policies affecting these populations."* (p31)	

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
WA State Priorities Mental Health, Alcohol and Other Drugs 2020-2024 *Mental Health Commission, Department of Health, Health Service Providers*	The policy outlines key elements to reform and improve the mental health, alcohol and other drug (AOD) sector over the next four years. These areas of focus for the Government will form the priority work by the Mental Health Commission, Department of Health and health service providers towards the WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025.	No mention.	Not identified as a priority population.
WA Strategy to Respond to the Abuse of Older People 2019-2029 *Department of Communities*	The Strategy will drive the delivery of this commitment by guiding government agencies and the community towards greater awareness and understanding of the causes, signs and consequences of elder abuse.	Yes, *"Older people who may be more vulnerable to abuse, and have unique experiences and support needs, compared with the general population include those who: are from diverse backgrounds, including people who identify as Aboriginal and Torres Strait Islander, culturally and linguistically diverse, [and] LGBTI+."* (p8) The strategy has underpinning principles, including: *"2. All older Western Australians are entitled to be equally valued and respected regardless of race, ethnicity, gender, sexuality, religion or impairment."* (p10) The report refers to discrimination based on sexual orientation. *"The compounding of other forms of discrimination for example, but not limited to, racism, sexism and homophobia."* (p15)	Yes, the report states that LGBTI+ people are more vulnerable to abuse (p8).
WA Suicide Prevention Framework 2021-2025 *Mental Health Commission*	This framework aims to reduce the rate of suicide attempts and deaths by suicide among Western Australians. It emphasises the need for a coordinated approach to suicide prevention activity across WA. The framework outlines the need for better data collection, support structures, capability, and resources. It also acknowledges the role of addressing historical and current trauma and the social determinants of health in suicide prevention.	Yes, the document defines LGBTI populations: "Throughout this document the acronym LGBTI is used to refer to lesbian, gay, bisexual, transgender and intersex people. However, it is recognised that many people and populations have additional ways of describing their distinct histories, experiences and needs beyond this acronym[1]." (p6) It also refers to 'Facts about suicide' (p11): "15.5% of LGBTI young people in the Growing up Queer study reported attempting suicide at some point in their life[9]." "48.1% of young transgender people in the Trans Pathways study reported attempting suicide at some point in their life[10]." There is also a quote from a 'Regional LGBTI Teenager': "Suicide and self-harm are not black and white but the responses always are – ED or not, medication or not. You can still have those thoughts every day and self-harm but not want to act on them. ED shouldn't be the first and only option." *(p30)*	Yes, LGBTI persons are identified as a vulnerable population (p7).

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
WA Women's Health and Wellbeing Policy (2019) *Department of Health, Health Service Providers*	This policy outlines the key elements to improve health services for women, including attitudes, building knowledge through education/awareness, achieving equitable health outcomes, access to services, collecting comprehensive data, building skills for effective interactions with all women, community support and intervention.	Yes, the document mentions LGBTI populations: *"Prevalence of mental health issues is found to be higher in LGBTI populations, women from CaLD backgrounds, women experiencing homelessness, and women living with chronic conditions[50-53]."* (p29) It also includes a definition: *"Throughout this document the acronym LGBTI is used to refer to lesbian, gay, bisexual, transgender, intersex or otherwise diverse people in sex characteristics, gender and sexuality. It is recognised that many people and populations have additional ways of describing their distinct histories, experiences and needs beyond this acronym. The use of this acronym is not intended to be limiting or exclusive of certain groups[8]."* (p36)	Yes, LGBTI populations are identified as a priority population (p4).
WA Youth Health Policy 2018-2023 *Department of Health*	The policy outlines key elements to improve health services for young people, including providing youth-friendly health services, improving access to health services, building knowledge and promoting participation, achieving equitable health outcomes, collecting comprehensive data, and building skills for effective interactions with young people.	Yes, includes a definition for 'Lesbian, Gay, Bisexual, Trans, Intersex or Queer +': *"Lesbian, Gay, Bisexual, Trans, Intersex, Queer and questioning or otherwise diverse in their sexuality or gender. It is recognised that many people and communities have additional ways of describing their distinct histories, experiences, and needs beyond the six letters in LGBTIQ[35]."* (p37) and 'Trans': *"Trans individuals describe their gender in different ways. We use the word trans to be open to people who describe themselves as transgender or transsexual or as having a transgender or transsexual experience or history. Trans people generally experience or identify their gender as not matching their sex assigned at birth. This includes people who identify as transgender, non-binary, agender, genderqueer and more[36]."* (p38)	Yes, the document identifies "Lesbian, Gay, Bisexual, Transgender, Intersex or Queer +" as a priority youth population who are at higher risk of poor health and wellbeing, greater barriers to access, and/or higher health risk behaviours (p10).
WA Youth Health Policy 2018-2023 Companion Resource: Understanding young people in Western Australia *Department of Health*	This Companion Resource aims to provide an understanding of young people in WA and their health. This is achieved through a discussion of: the developmental stages of adolescence; a demographic overview; priority populations of young people who are at higher risk of health issues; access to health services; the social determinants affecting young people's health.	Yes, this document has a 'Lesbian, Gay, Bisexual, Transgender, Intersex or Queer +' section under 'Priority youth populations' (p13): *"Over 10 per cent of the Australian population identify as Lesbian, Gay, Bisexual, Transgender, Intersex, Queer or questioning (LGBTIQ+). There is little data on the proportion of young people who identify themselves as (LGBTIQ+).64 In 2012-14, 5 per cent of Australian youth aged 14 to 19 years identified as homosexual and this rose to 7 per cent for youth aged in their 20s.[65]* *The umbrella term 'trans' is used to refer to people who identify as a gender that does not match the sex they were assigned at birth. This is in comparison to 'cisgender' people – those whose gender does match the sex they were assigned at birth.[66,67]* *International studies estimate that between 0.7 per cent and 1.2 per cent of young people identify as trans. There are no estimates of young people who are trans in Australia.[66,67]* *Continued next page →*	Yes, the document identifies "Lesbian, Gay, Bisexual, Transgender, Intersex or Queer +" as a priority youth population (p8).

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
		← *From previous page* *LGBTIQ+ young people have higher rates of psychological distress, mental health issues (e.g. depression and anxiety) and suicidal thoughts compared to the general population[68,69] as a result of homophobic discrimination and marginalisation.[70]* *A large proportion of LGBTIQ+ young people (16 to 24 years) reported being diagnosed or treated for a mental health disorder in the past three years.[71] Over a third (41%) of gender variant and sexually diverse young people aged between 16 to 27 years had thought about self-harm while 42 per cent had thought about suicide.[72] Around 75 per cent of trans young people in an Australian study had been diagnosed with depression and over 70 per cent with anxiety. Almost 80 per cent had self-harmed and 48 per cent had attempted suicide.[73]* *LGBTIQ+ youth experience higher rates of bullying and exclusion than their heterosexual and cisgender peers.[74] LGBTIQ+ young people feel isolated, and face higher rates of homophobia and transphobia in rural and remote areas of Australia.[71] They often feel unsupported by peers and family members, are more likely to leave school due to discrimination, with many having experienced abuse.[75] LGBTIQ+ young people are more likely to use alcohol and drugs.[68] They have difficulty accessing relevant sexual health education as it is focused predominantly on heterosexual relationships and reproduction and doesn't address gender diversity and same-sex attraction.[70]* *Health services need to be accessible and sensitive to the needs of LGBTIQ+ young people. Approximately 40 per cent of young trans people had reported reaching out to a service that did not understand, respect or have experience with trans young people. Trans young people reported higher rates of self-harm and suicide if they experienced isolation from health services.[73]* *Primary health providers should reassure individuals about confidentiality, offer information about safer sex options, and, if appropriate, offer counselling or referral to counselling. In addition, dedicated mental health teams need to offer services to people who require support around gender identity.[76]"* It also includes a definition: *"Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Questioning or otherwise diverse in their sexuality or gender. We recognise that many people and communities have additional ways of describing their distinct histories, experiences, and needs beyond the six letters in 'LGBTIQ'.[64]"* (p40)	

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
Workforce Diversification and Inclusion Strategy for WA Public Sector Employment 2020-2025 *Public Sector Commission*	Developed by the Public Sector Commission, this strategy aims to increase the representation of people from different backgrounds at all levels across the public sector (workforce diversification) and ensure all staff in the sector experience a sense of belonging and inclusion in the work environment (workforce inclusion).	Yes, In the opening from the Premier, it states: *"Organisations that are able to attract and retain diverse talent – diversity of gender, ethnicity/race, age and sexual orientation as well as diversity of experience such as a global mindset and cultural fluency – are likely to have an advantage."* (p2) It also includes a definition for 'People of diverse sexualities and genders': *"People of diverse sexual orientations, gender identities and expressions, and sex characteristics"* (Back Cover)	Yes, people of 'diverse sexualities and genders' are an identified diversity group with an associated action plan (p5). Yet there are aspirational targets for all diversity groups except people of diverse sexualities and genders (p6).
Working together for Western Australia to reform our criminal justice system *Government of Western Australia*	This report outlines the Justice Planning and Reform Committee's (JPRS) holistic and collaborative approach to making the criminal justice system work more effectively and efficiently, and focusing on slowing the growth of the adult prisoner population.	No mention.	Not identified as a priority population.
Working Together Toolkit: Designed to support the practical implementation of the Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025 *Mental Health Commission*	This Working Together Toolkit accompanies the Engagement Framework and aims to provide a process to planning, developing, actioning and reviewing engagement strategies and practices in line with the five guiding principles.	Yes, includes 'Appendix 1. Engagement Evaluation Template' question '3. Do you identify as (you can select more than one):' *"A person from the LGBTIQ+ Community"* (p40)	No priority populations are formally referred to.
Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025 *Mental Health Commission*	This framework aims to assist government, non-government organisations (including private enterprise), and the community to effectively engage and work together to achieve better outcomes for people whose lives are affected by mental health issues and/or alcohol and other drug use.	Yes, LGBTI people and communities are mentioned as a Diverse Group (p20).	No priority populations are formally referred to.

Western Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
You Matter: A guideline to support engagement with consumers, carers, communities and clinicians in health (2017) *Department of Health*	This guideline was developed to support WA Health Services Providers (HSPs) in their engagement with consumers, carers, communities and clinicians to improve health services.	Yes, this document includes a specific section on 'People from the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) community' (p22): *"Groups within the LGBTI community have specific social, cultural, psychological, medical and care needs. They share the experience of being part of a minority population likely to have been subjected to exclusion, social isolation, hate crimes, discrimination and stigma throughout most of their lives.* *LGBTI Australians are more likely to experience higher rates of self-harm, suicide and mental health issues. Higher rates of use of alcohol, tobacco and illicit drugs are also experienced by this group. Family support structures can be different or fewer.*[71,72] *While the inclusion of LGBTI people has grown over time, the older generation of LGBTI people grew up knowing that they could be imprisoned or forced to undergo medical 'cures' if their sexual orientation or gender identity was known. Consequently, many older people hide their sexual orientation and gender identity from service providers, believing that it is still not safe to disclose. Fear of discrimination can lead to delays in seeking health care, lower use of services and underuse of screening.*[73] *Up to 11 per cent of the Australian population may be of diverse sexual orientation, sex or gender. National LGBTI Ageing and Aged Care Strategy, 2012.* *This population is now recognised by the Commonwealth Government in some federal legislation, policies, and programs. From 1 August, 2013 the Sex Discrimination Act 1984 has provided federal protection from both direct and indirect discrimination on the basis of sexual orientation, relationships status, gender identity, and intersex status. LGBTI people are also recognised as a special needs group in the Aged Care Act 1997.*[74] *There are many benefits to engaging with the LGBTI community. Policies and programs can be designed to promote inclusion and prevent discrimination, vilification and harassment based on gender identity and sexual orientation. There is increased awareness of issues and needs within the community, increased community understanding of the lived experience of LGBTI people and the identification of barriers to health service delivery.*[72] *Table 12. Top tips for engaging with LGBTI groups* *Communicate a welcome to the LGBTI community* *Utilise inclusive images, information, posters and resources. Promote through channels accessed by the LBGTI community and organisations, such as social media and radio broadcasts.* *Respect privacy* *Respect that some members of the LGBTI community may want to keep their orientation private."* It also contains an Appendix A with 'Supporting resources for engaging with the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) community' (p36).	Yes, LGBTI persons are identified as a vulnerable population (p22).

Australian Policy Documents

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
Australia's Disability Strategy 2021-2031 *Department of Social Services*	This strategy outlines a vision for a more inclusive and accessible Australian society where all people with disability can fulfil their potential as equal members of the community.	Yes. *"People with disability have specific needs, priorities and perspectives based on their individual identities including their gender, age, sexuality, race and cultural background, and can face additional barriers and inequities." (p5)* *"Other factors such as gender, age, sexuality, race, type of disability, and cultural background can also influence how people with disability are treated in society." (p30)* There is a section on 'Intersectionality and Diversity'. *"Intersectionality recognises that a person or group of people can be affected by multiple forms of discrimination and disadvantage due to their race, sex, gender identity, sexual orientation, impairment, class, religion, age, social origin and other identity markers. It acknowledges identity markers (such as "Woman", "Disabled", "Aboriginal or Torres Strait Islander", "Culturally and Linguistically Diverse", "LGBTIQA+") do not exist independently; rather, each informs the other and can have overlapping and compounding effects." (p36)* In Appendix 5: Guiding Principles, Principle 7: Equality of people: *"Does the proposal support the full development, advancement, empowerment and equality of all people irrespective of differences and identities, including in relation to gender, age, sexuality, race, or cultural background?" (p58)*	No priority populations are formally referred to.
Australian Work Health and Safety Strategy 2023-2033 *Safe Work Australia*	The Australian WHS Strategy 2023-2033 builds upon the AWHS Strategy 2012-2022 and addresses the impact of key WHS contextual factors and challenges, including the shift to the newly harmonised Work Health and Safety Act. The strategy envisions Safe and healthy work for all with the main goal to reduce worker fatalities, injuries and illnesses.	No mention.	No priority populations are formally referred to.
Equally Well: Improving the physical health and wellbeing of people living with mental illness in Australia *National Mental Health Commission*	The National Mental Health Commission's Equally Well consensus statement calls for national commitment to improve the physical health of people with lived experience, and to minimise the gap between their health outcomes and life expectancy and those of the rest of the population.	No mention.	Not identified as a priority population.

Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
Fifth National Mental Health and Suicide Prevention Plan 2017-2022 *COAG (Council of Australian Governments) Health Council*	The National Mental Health and Suicide Prevention Plan sets out the Australian Government's commitment to supporting mental health and suicide prevention for all Australians and responds to the findings of the Productivity Commission Inquiry Report into Mental Health and the National Suicide Prevention Adviser's Final Advice.	Yes, in the section 'Recognising diverse experiences'. *"Mental health needs vary across population groups. It is known that mental health experiences are influenced by age, gender, sexuality, family situation and cultural background.[1] Some of the specific considerations needed for certain population groups are outlined in Figure 4."* (p4) Figure 4: Diversity of experience of mental illness across population groups: *"Australians who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI) have disproportionate experiences of mental health problems and mental illness. Rates of major depressive episodes in the LGBTI community can be four to six times higher than the general population, psychological distress rates are reported as twice as high, and suicide rates are higher than in any other group in the Australian population.[2] Reducing stigma and improving the appropriateness of mental health services is critical for LGBTI communities."* (p6) PRIORITY AREA 6: Reducing stigma and discrimination, has the following headings and information Why is this a priority? *"The impact of stigma and discrimination against people living with mental illness is far-reaching and is compounded for groups who are already marginalised and who experience other forms of discrimination[66,67,68,69], such as Aboriginal and Torres Strait Islander peoples and people who identify as LGBTI."* (p39) What will we do? *"Action 18 – Governments will take action to reduce the stigma and discrimination experienced by people with mental illness that is poorly understood in the community. This will:* • *involve consumers and carers, community groups and other key organisations* • *build on existing initiatives, including the evidence base of what works in relation to reducing stigma and discrimination* • *account for the specific experience of groups already at high risk of stigma, including Aboriginal and Torres Strait Islander peoples and people who identify as LGBTI."* (p40) How will we know things are different? *"This includes information on the extent and impact of stigma in vulnerable communities, including Aboriginal and Torres Strait Islander peoples, people who identify as LGBTI and people from culturally and linguistically diverse or rural and remote communities."* (p41)	Yes, LGBTI communities are identified in Figure 4: Diversity of experience of mental illness across population groups but are not specifically labelled a priority population. *"Australians who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI) have disproportionate experiences of mental health problems and mental illness."* (p6)

Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015-2024 *COAG (Council of Australian Governments) Health Council*	The National Oral Health Plan 2015-2024 has 2 national goals. Firstly, to improve the oral health status of Australians by reducing the incidence, prevalence and effects of oral disease. And secondly to reduce inequalities in oral health status across the Australian population.	No mention.	Not identified as a priority population.
LGBTI Ageing and Aged Care Strategy 2012-2017 *Department of Health and Ageing*	The National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy was released by the Australian Government in December 2012, as part of a wider aged care reform process designed to increase sector accountability and consumer information, choice and control. It was designed to inform the way the Government supports the aged care sector to deliver care that is sensitive to and inclusive of the needs of LGBTI people, their families and carers. The Strategy was given a five-year implementation time frame.	Focus of the entire document.	Focus of the entire document.

Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
National Action Plan for the Health of Children and Young People 2020-2030 *Department of Health*	This plan outlines our approach to improving health outcomes for all children and young people. It aims to ensure that children and young people, from all backgrounds and all walks of life, have the same opportunities to fulfil their potential, and are healthy safe and thriving.	Yes. The Action plan overview identifies LGBTI+ people as a priority action for the priority area, 'Tackling mental health and risky behaviour', on page 2: *"Address mental health conditions among LGBTI+ children and young people."* 'Figure 4: Priority population groups of children and young people' on p 8-9, discusses Health and Wellbeing Indicators: *"Children and young people who identify as LGBTI+* • *Australians identifying as LGBTI+ face health disparities in terms of their mental health, sexual health and rates of substance use.[62]* • *They are significantly more likely than non-LGBTI+ Australians to have a high or very high level of psychological distress - 55% of 16-24 year old women and 40% of 16-24 year old men experience psychological distress at this level (compared with 18% and 7% respectively among heterosexual peers).[63]* • *LGBTI+ people have the highest rate of suicidality of any group in the country, with the average age of a first suicide attempt being 16 years.[64]"* Under the heading 'Priority Area 2: Empowering parents and caregivers to maximise healthy development': *"Promote awareness and guidance in areas of emerging parent information need during adolescence, including resources and strategies covering preventive health, mental health, risky behaviours (alcohol, drugs etc), identity and sexuality, sexual health, relationships, online behaviours and screen time, and autonomy over health decisions."* (p17) 'Priority Area 3: Tackling mental health and risk behaviours': *"The prevalence of mental health conditions is also significantly higher among LGBTI+ young people, who are much more likely to have a high or very high level of psychological distress and higher rates of suicide or attempts to take their lives – the average age of a first suicide attempt is 16 years, often before 'coming out'.[135]"* (p19) *"Working to address the significantly higher prevalence of mental health conditions and suicide among LGBTI+ children and young people and evolving support and services which are proactively inclusive.[152]"* (p20) *"Engage in greater research and consultation to investigate specific influences, experiences and needs of LGBTI+ children and young people in relation to their mental health and wellbeing."* (p21) *"Develop frameworks and approaches for proactive inclusion and specialisation in mental health services for LGBTI+ children and young people, including in prevention and crisis-intervention."* (p21) *"Work to challenge attitudes and norms relating to stigmatisation, discrimination and bullying of at-risk groups, including people with disability and LGBTI+ children and young people."* (p22)	

Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
National Alcohol Strategy 2019-2028 *Department of Health*	The purpose of the new National Alcohol Strategy 2019-2028 is to create a shared approach to reduce the harms from alcohol across Australia. The four priority areas highlighted for action are: Improving community safety and amenity, managing alcohol availability, price and promotion, supporting individuals to obtain help and systems to respond, and promoting healthier communities.	Yes, it provides a brief summary of the priority population group: *"Lesbian, gay, bisexual, transgender, intersex or queer people (LGBTIQ).* *A complex range of compounding issues can result in those who identify as LGBTIQ as being more likely than those who identify as heterosexual to drink alcohol at levels that place themselves at risk of immediate and lifetime alcohol-related harm.* *LGBTIQ people are less likely than heterosexual people to be abstainers or ex-drinkers (14.4% compared to 21.3%); are more likely to be lifetime risk drinkers (25.8% compared to 17.2%); and, more likely to consume 11 or more standard drinks on a monthly and yearly basis (12.6% compared to 6.9%, and 27.8% compared to 15.3%).32"* (p11)	Yes, LGBTIQ people identified as a priority population group (p11).
National Drug Strategy 2017-2026 *Department of Health*	This strategy is a framework to build safe and healthy communities. It aims to reduce and prevent drug-related harm including health, social, cultural and economic harms, and harm to individuals, families and communities. This long-term strategy identifies national priorities, guides action by governments, service providers and the community, and outlines strategies to reduce demand, supply and harm.	Under 'Priority Populations': *"People identifying as gay, lesbian, bisexual, transgender or intersex* *People who identify as lesbian, gay bisexual, transgender and/or intersex (LGBTI) can be at an increased risk of alcohol, tobacco and other drug problems. In 2013, use of licit and illicit drugs was more common in people who identified as homosexual or bisexual in Australia than for those identifying as heterosexual[22]. These risks can be increased by stigma and discrimination, familial issues, marginalisation within their own community as a result of sexually transmitted infections (STIs) and blood borne viruses (BBVs), fear of identification or visibility of LGBTI and a lack of support."* (p29)	Yes, the strategy identifies priority populations of focus including people identifying as lesbian, gay, bisexual, transgender and/or intersex (p18).

Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
National Injury Prevention Strategy 2020-2030 – Draft for consultation *Department of Health*	Outlines the leading causes of injury in Australia as the priority areas for action and identifies key objectives working towards the vision. This report reviews intentional and unintentional injuries by priority group, age group, action area and cross-cutting factors including alcohol, extreme weather and the built environment.	Yes. Glossary and abbreviations. *"LGBTIQ Lesbian, Gay, Bisexual, Transgender, Intersex and Queer/questioning"* (pII) Acknowledges gender identity and sexual orientation when considering Equity as one of the principles that underpin the Strategy: *"Ensure that information is tailored to different needs including culture, race, age, gender identity, sexual orientation, socio-economic standing and geographic location."* (p9) It also mentions under the Adults (25-64 years) sections: *"Other groups in Australia who are more vulnerable to violence include people with a disability, people from culturally and linguistically diverse backgrounds and LGBTQI+ people.[30]"* (p26) *"Evidence on components of successful interventions that reduce the risk of violence experienced by Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, the LGBTQI+ community, people who have been incarcerated and people with a disability;"* (p37)	Not identified as a priority population.
National Obesity Strategy 2022-2032 *Health Ministers' Meeting*	The National Obesity Strategy is a 10-year framework for action to prevent, reduce, and treat, overweight and obesity in Australia. It focuses on prevention, but also includes actions to better support Australians who are living with overweight or obesity, to live their healthiest lives.	Yes, in Part 3: Achieving our ambitions, under 'Example actions': *"Strategies and actions should consider challenges for rural and remote areas, disadvantaged groups and inclusive approaches, for example women and girls, LGBTIQA+ communities and older people."* (p40) *"Ensure consultation and co-design with different age groups and diverse communities of young people and young adults (such as those based in rural and remote areas, living with disabilities and LGBTIQA+, Aboriginal and Torres Strait Islander, refugee and migrant communities) about new activities and facilities in their local public spaces, with plans designed to be inclusive, be age, gender and culturally appropriate, and meet the local community preferences."* (p53) The term LGBTIQA+ is defined in the glossary (p75): *"LGBTIQA+ is an evolving acronym that stands for lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and many other terms (such as non-binary and pansexual) that people use to describe their experiences of their gender, sexuality, and physiological sex characteristics."*	Yes. *"While this Strategy is for all Australians, some population groups have a higher prevalence of overweight or obesity, have specific needs or require additional support to reduce health inequities (for example people living with obesity, people from culturally and linguistically diverse backgrounds, people with mental illness and LGBTIQA+ communities)."* (p20)

Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
National Preventive Health Strategy 2021-2030 *Department of Health*	The National Preventive Health Strategy aims to provide more balance to the health system by enhancing the focus on prevention and by building systems-based change over a 10-year period. The strategy aims to improve the health and wellbeing of all Australians at all stages of life, through a systems-based approach to prevention that addresses the wider determinants of health, reduces health inequities and decreases the overall burden of disease.	Yes. *"Health inequities are, in particular, experienced by certain groups within society. This includes: Aboriginal and Torres Strait Islander people; those living in rural and remote areas; people experiencing socioeconomic disadvantage; people living with mental illness; people with disability; lesbian, gay, bisexual, transgender, queer or questioning, intersex and/or other sexuality and gender diverse people (LGBTQI+); and those from culturally and linguistically diverse (CALD) backgrounds."* (p6) Boosting action in focus areas • *"Compared to the general population, smoking rates are approximately double for lesbian and bisexual women, gay men, transgender people, and people with HIV[274, 275]"* (p50) • *"There are often fewer opportunities for girls, women, people with disability, older adults, LGBTQI+ communities, people of low socioeconomic position, and those living in rural/remote communities to access safe, accessible and affordable spaces to be physically active[325]."* (p57) • *"Compared to the heterosexual population, lesbian and bisexual women and gay men are twice as likely to be diagnosed with cancer. This is partly attributed to higher rates of smoking and alcohol consumption and low rates of cancer screening in LGBTQI+ communities[348]"* (p59) • *"In 2019, homosexual and bisexual people were more likely to exceed lifetime (25% vs 16.9%) and single occasion risky drinking guidelines (35% vs 26%) compared to heterosexual people[257]" (p.65)* • *"In 2019, 31% of homosexual and bisexual people reported recent illicit drug use compared to 16.1% of heterosexual people[257]"* (p66) • *"Compared with the general population, LGBTQI+ people are more likely to have depression, anxiety, be diagnosed with a mental health disorder, have suicidal ideation, engaged in self-harm and/or have attempted suicide in their lifetime[398]"* (p69)	Yes, the strategy identifies *"Lesbian, gay, bisexual, transgender, queer or questioning, intersex and/or other sexuality and gender diverse people (LGBTQI+)"* (p21) as a priority population.
National Strategic Framework for Chronic Conditions *Australian Health Ministers' Advisory Council*	The National Strategic Framework for Chronic Conditions is the overarching policy document for chronic conditions. It sets the directions and outcomes to help Australians live healthier lives through effective prevention and management of chronic conditions.	No mention.	Not identified as a priority population.

Australian Policy Documents (cont)

Policy name *Responsible institution(s)*	**Description**	**Any mention of sexuality, diverse gender and/or intersex status?**	**Any LGBTIQA+ identified as a priority population?**
National Tobacco Strategy **2012-2018** **2023-2030** *Department of Health*	The National Tobacco Strategy aims to improve the health of Australians by reducing smoking rates, highlights the health, social and economic problems caused by tobacco and sets out 11 priority areas for action and mechanisms for monitoring and evaluation.	Yes, identifying LGBTIQ+ in Priority Area 5 (p19).	Yes, Priority Area 5 identified populations in Australia with higher rates of tobacco use than the general population including people identifying as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) (p19).

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