



# LGBTIQA+ Mental Health & Wellbeing

Key Findings and  
considerations

# Contents

<b>Acknowledgements</b> .....	<b>3</b>
<b>Executive summary</b> .....	<b>4</b>
<b>Key Terminology</b> .....	<b>5</b>
<b>List of figures and tables</b> .....	<b>6</b>
<b>Introduction</b> .....	<b>8</b>
Background .....	8
Policy context .....	9
Objectives .....	10
Structure of this report .....	10
Methodology .....	11
Survey .....	12
Client file audit .....	12
Survey and client file audit sample demographics .....	14
<b>Key findings</b> .....	<b>18</b>
Key finding 1: Intersecting and compounding discrimination .....	19
Prevalence of discrimination .....	19
Intersectional discrimination .....	26
Mental health and wellbeing .....	27
Loneliness .....	29
Financial stress .....	31
Discrimination in context .....	34
Discrimination in healthcare .....	34
Discrimination at work .....	34
Discrimination from law enforcement .....	35
Concluding points: Intersecting and compounding discrimination .....	35
Key finding 2: Needs, risks, and complexity .....	36
Needs and risk: survey findings .....	36

Needs and risk: client file audit findings.....	41
Acute risk.....	49
Needs and risks across cohorts .....	55
Concluding points: Needs, risks, and complexity.....	58
<b>Principles for effective service responses.....</b>	<b>60</b>
1. Establishing safety .....	61
2. Intersectional practice .....	65
3. Advocacy at all levels .....	68
4. Flexibility in responding to client need.....	71
5. Coordinated and integrated services .....	72
<b>Conclusion.....</b>	<b>75</b>
References.....	77



# Acknowledgements

Drummond Street Services respectfully acknowledges the Kulin Nation as Traditional Owners of the lands where we deliver our services. We acknowledge Aboriginal and Torres Strait Islanders as the first people of Australia. Sovereignty was never ceded, and Aboriginal and Torres Strait Islander people remain strong in their connection to land, culture and in resisting colonisation.



The authors of this report respectfully thank and acknowledge the invaluable contributions of LGBTIQ+ Australians who participated in this research.

Through conscientious research and careful analysis, we hope to shed light on the challenges and discrimination that many LGBTIQ+ individuals still face, as well as the strides that have been made towards more inclusive support services.



## Creative Commons Licence

Attribution-Non Commercial

CC BY-NC 4.0 DEED



This license lets others distribute, remix and build upon the work, but only if it is for non-commercial purposes and they credit the original creators (and any other nominated parties). They do not have to licence their Derivative Works on the same terms.

## Suggested citation:

McCann, B., Gibson, M., Donnelly, A., & Miles, F. (2024). *LGBTIQ+ Mental Health and Wellbeing: Key Findings and considerations*. The Centre for Family Research & Evaluation, Drummond Street Services. <https://cfre.org.au/the-lgbtiqa-mental-health-wellbeing-project/>

This material was produced with funding from the Victorian Department of Health. Drummond Street Services acknowledges that this work would not have been possible without this support from the government. The findings and opinions represented in this report are those of the authors and cannot be attributed to the Victorian Government.

## Executive summary

The LGBTIQ+ Mental Health and Wellbeing project, undertaken by Drummond Street Service's Centre for Family Research and Evaluation, sought to understand the diverse mental health needs, experiences and challenges of LGBTIQ+ people, and to explore the ways they access (or do not access) services. The specific experiences of LGBTIQ+ sub-cohorts were considered as part of the project, as were the ways in which individual services and broader service systems can improve to better respond to LGBTIQ+ mental health and wellbeing needs.

The LGBTIQ+ Mental Health and Wellbeing Project responds to Recommendation 34 of Victoria's Royal Commission into Mental Health by contributing to the ongoing development, design, implementation, and refinement of the mental health service system. In particular, by providing key considerations for government and service providers to substantively and sustainably respond to the needs of LGBTIQ+ communities, to support mental health and wellbeing needs.

Two key findings were identified throughout this project, based on Drummond Street Service's 2023 LGBTIQ+ health and wellbeing survey and a client file analysis from Drummond Street Service's client record management system. The first finding shed light on the pervasive nature of intersectional discrimination and its profound impact on LGBTIQ+ individuals' mental health, social connectedness, and financial wellbeing. The second emphasised the complexity of needs and risks experienced by LGBTIQ+ people and the compounding impact of discrimination upon these. The findings from this report were synthesised to develop five core principles to improve service responses so that LGBTIQ+ people's mental health and wellbeing is more effectively and cohesively supported.

Considerations for services and for government are provided based on the key findings and to support the implementation of principles for effective service responses. Considerations across both levels recognise that change is necessary across services and systems to address the broad range of needs effectively and sustainably.

---

---

# Key Terminology

**Asexual:** refers to anyone who does not feel sexual attraction to any gender.

**Cisgender:** refers to anyone who identifies as the gender they were assigned at birth, i.e., are not transgender.

**Genderqueer:** refers to anyone who does not identify with either male or female. They may identify as non-binary, bigender, agender, pangender, genderfluid, or another gender identity.

**LGBTIQA+:** refers to Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual and other identities outside of cisgender heterosexuality.

**Multi-gender attracted:** a person who experiences attraction to multiple genders. This includes those who may identify as bisexual, pansexual, omnisexual for example.

**Intersex:** Intersex people 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 (Intersex Human Rights Australia, n.d.).

**Queer (sexuality):** a queer sexuality refers to a sexual identity that is not heterosexual whilst queer as a general term refers to both sexual and gender identities that are not heterosexual and cisgender.

**Discrimination:** defined by the [Equal Opportunity Act \[2010\]](#) as the treatment of a person unfavourably, because that person has a specified personal attribute that is protected. This can include direct discrimination or indirect discrimination:

- **Direct discrimination** occurs if a person treats, or proposes to treat, a person with an attribute unfavourably because of that attribute.
- **Indirect discrimination** occurs if a person imposes, or proposes to impose, a requirement, condition or practice that is likely to have the effect of disadvantaging persons with an attribute.

**Protected attributes:** Age, breastfeeding, employment activity, gender identity, disability, industrial activity, lawful sexual activity, marital status, parental status or status as a carer, physical features, political belief or activity, race, religious belief, sex, sex characteristics, sexual orientation, a spent conviction, personal association (whether as a relative or otherwise) with a person who is identified by reference to any of the above attributes.

**Drummond Street Services (DS):** DS is a not-for-profit community service organisation that works from human-rights based, social justice, intersectionality and public health frameworks. DS offers a wide range of services, inclusive of Queerspace, that help people facing personal challenges and societal barriers connected to living situations, health, identity, relationships and community. The Centre for Family Research and Evaluation (CFRE) is a division of DS that supports the organisation to be at the forefront of innovative program design by gathering evidence from multiple sources with the use of our evidence-based management framework.

# List of figures and tables

Figure 1. Client file audit process.....	14
Figure 2. Age across both samples.....	15
Figure 3. Gender across both samples .....	16
Figure 4. Sexuality across both samples .....	16
Figure 5. Transphobia across settings.....	21
Figure 6. Homophobia or biphobia across settings.....	22
Figure 7. Sexism across settings .....	23
Figure 8. Ableism across settings.....	24
Figure 9. Racism across settings .....	25
Figure 10. Other discrimination.....	26
Figure 11. Mental health and wellbeing scores by discrimination types.....	28
Figure 12. Mental health and wellbeing scores by experience of LGBT (only) discrimination or intersectional discrimination.....	29
Figure 13. Loneliness scores by discrimination types.....	30
Figure 14. Loneliness scores by discrimination settings.....	30
Figure 15. Loneliness scores by LGBT (only) discrimination and intersectional discrimination .....	31
Figure 16. Financial stress scores by discrimination types.....	32
Figure 17. Financial stress scores by discrimination settings .....	32
Figure 18. Financial stress scores by LGBT (only) discrimination or intersectional discrimination .....	33
Figure 19. Loneliness scores by age .....	38
Figure 20. Number of presenting needs (complexity).....	44
Figure 21. Risk factors throughout service engagement.....	46
Figure 22. Risk alerts throughout service engagement.....	46
Figure 23. Number of risk alerts (complexity) among client files.....	50
Figure 24. Five principles for effective service responses .....	61
Table 1. Demographics across the survey and client file audit samples .....	17
Table 2. Prevalence of discrimination across settings .....	20
Table 3. High or overwhelming financial stress.....	40
Table 4. Presenting needs of client file sample.....	43
Table 5. Risk alerts in the client file sample .....	49
Table 6. Co-occurring risk alerts among client files .....	51
Table 7. Suicide risk alerts by gender among client files .....	52

---

Table 8. Risk factors by suicide risk among client files .....	53
Table 9. Risk factors by mental illness among client files .....	54
Table 10. Risk factors by family violence risk among client files .....	55
Table 11. Risk alerts across sub-cohorts of clients .....	56
Table 12. Presenting needs across sub-cohorts of clients.....	56
Table 13. Presenting needs and risk factors among young TGD clients .....	57
Table 14. Presenting needs and risk factors among multicultural LGB clients.....	57
Table 15. Presenting needs and risk factors among LGBTIQ+ clients with disability.....	58





## Introduction

Funded by the Victorian Department of Health (DH) Mental Health and Wellbeing Division, Drummond Street Services' (DS) Centre for Family Research and Evaluation (CFRE) delivered the LGBTIQ+ Mental Health and Wellbeing Project. The project aimed to develop a better understanding of the mental health and wellbeing needs of LGBTIQ+ people, as well as their experiences accessing the service systems.

## Background

Research makes it clear that discrimination, marginalisation, social exclusion, and other experiences of systemic oppression negatively impact the health and wellbeing of people from LGBTIQ+ communities. Minority stress theory links experiences of marginalisation to stress via the negative impacts of stigma and discrimination, which then lead to poorer

health and wellbeing outcomes<sup>1</sup>. The main LGBTIQ+ health and wellbeing reports in Australia<sup>2</sup> have found that LGBTIQ+ communities face substantial health and socio-economic disparities compared to non-LGBTIQ+ people, as well as the general population. A substantial evidence base predicates these health disparities in minority stress theory.

This project builds on these findings, specifically in relation to two points. The first is that in the original theory<sup>3</sup>, a distinction was made between minority stress in relation to the individual, and minority stress in relation to society. The findings within this report demonstrate that a greater burden should be placed on society to lessen the impact that discrimination has on the mental health and wellbeing of LGBTIQ+ people. The second point builds on a recent finding emphasising the 'intersectional nature of minority stress' and 'how this may influence both resilience and psychological injury'<sup>4</sup>. This includes recognition that identity is multi-faceted and made up of several attributes. For example, the same part of an individual's identity that led to them experiencing discrimination may also lead to them experiencing social connection.

## Policy context

Recommendation 34 of the Royal Commission into Victoria's Mental Health System (RCMH) advised that services need to be safe, inclusive, and responsive to the mental health and wellbeing of diverse communities<sup>5</sup>. Specifically, this recommendation prescribed that work towards achieving this should be done in partnership with diverse communities (including culturally and linguistically diverse communities, LGBTIQ+ communities, and people living with disability) to improve accessibility, promote inclusion and address inequities.

This project aims to support the achievement of Recommendation 34, and contribute to the ongoing development, design, implementation, and refinement of the mental health service system, by providing key findings and considerations for the Victorian Government and for

---

<sup>1</sup> Correro, A. N., & Nielson, K. A. (2020). A review of minority stress as a risk factor for cognitive decline in lesbian, gay, bisexual, and transgender (LGBT) elders. *Journal of Gay & Lesbian Mental Health*, 24(1), 2–19. <https://doi.org/10.1080/19359705.2019.1644570>

<sup>2</sup> [Private Lives 3](#) (2020); [Writing Themselves In 4](#) (2021); [Victorian Population Health Survey](#) (2021).

<sup>3</sup> Meyer, I.H. (2003). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin*, 129(5), 674-697. <https://doi.org/10.1037/0033-2909.129.5.674>

<sup>4</sup> Nicholson et al. (2022). A systematic review of the neural correlates of sexual minority stress: towards an intersectional minority mosaic framework with implications for a future research agenda. *European Journal of Psychotraumatology*, 13(1), 2002572. <https://doi.org/10.1080/20008198.2021.2002572>

<sup>5</sup> Victorian Government. (2021). *Recommendation 34: Working in partnership with and improving accessibility for diverse communities*. <https://www.health.vic.gov.au/mental-health-reform/recommendation-34>

service providers to substantively and sustainably respond to the needs of LGBTIQA+ communities.

## Objectives

The LGBTIQA+ Mental Health and Wellbeing Project set the following objectives:

1. To better understand the diverse mental health needs, experiences, and challenges of LGBTIQA+ people.
2. To explore the ways LGBTIQA+ people access (or do not access) services to support their mental health and wellbeing needs.
3. To explore the experiences of particular individuals or cohorts through providing example service pathways to show how different needs may change over time.

## Structure of this report

This report has three sections based on the key findings identified throughout the project. The sections cover:

1. Intersecting and compounding discrimination
2. Needs, risks, and complexity
3. Principles for effective service responses

The report then outlines five Principles for Effective Service responses and key considerations, recognising that a multi-layered approach to change is necessary to address the broad-ranging needs relating to LGBTIQA+ mental health and wellbeing.



## Methodology

To achieve the project objectives outlined above, the following research questions were developed:

1. What are the mental health and wellbeing needs and risk factors of LGBTIQ+ people? How do these vary across LGBTIQ+ communities?
2. How does discrimination, inequality and other forms of marginalisation impact the mental health and wellbeing of LGBTIQ+ people?
3. What are the enablers and barriers for LGBTIQ+ people accessing services to support their mental health and wellbeing? How do these vary across LGBTIQ+ communities?
4. How does Drummond Street respond to the needs of LGBTIQ+ clients?
5. How could service provision be improved to better respond to the needs of LGBTIQ+ clients?

There are two components to this project: Drummond Street's annual LGBTIQ+ health and wellbeing survey and a client file audit of Drummond Street's files. The survey contributed to findings related to research questions two, three, and five. The client file audit contributed to findings related to all five research questions.

CFRE utilised a phased data analysis approach. Each stage of data collection, interpretation and review informed the next, with data analysis and reporting refined and clarified at each stage of evidence-building.

### Consent and ethical practice

Ethics approval was obtained from the Department of Health and Department of Families, Fairness and Housing Human Research Ethics Committee [ERM Project ID 92860] on 4<sup>th</sup> May 2023 for all components of the LGBTIQ+ Mental Health & Wellbeing Project. A waiver of consent was obtained for the client file audit based on ethical guidelines, yet all clients included in the sample provided written consent for their deidentified data to be used for research and evaluation purposes. All methods used within the client file audit were approved by the ethics committee.

The Centre for Family Research and Evaluation follows the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research in the design, implementation and dissemination of all research and evaluation activities.

## Note on presentation of statistics

In this report, decimals are all rounded to the nearest whole number in percentages, to enhance readability. Please note that this may, in some cases, cause the data to not add to 100%, though this is only due to rounding.

## Survey

Drummond Street's LGBTIQ+ Health and Wellbeing Survey is distributed annually. The survey has been in operation for over five years and its design is refined yearly by CFRE. Over the course of the survey's operation, considerable consultation with members of the LGBTIQ+ community have shaped both its content and form.

The survey was adapted for this project to develop a better understanding of the mental health and wellbeing needs and service use among LGBTIQ+ individuals and communities. This included questions and measures about:

- Mental health and wellbeing [**Recovering Quality of Life [ReQoL-10] Questionnaire**]
- Loneliness [**UCLA Loneliness scale short form [UCLA-SF]**]
- Financial stress [**Drummond Street Financial Stress Measure [DSFS]**]
- Experiences of discrimination, inequality, and harm
- Help-seeking and service use
- Barriers to service access

The survey was promoted at the 2023 Midsumma Festival<sup>6</sup> and online using social media and email. It was also promoted through DS' organisational networks.

## Client file audit

The Client File Audit (CFA) comprised of the analysis of client file data to better understand:

- the mental health and wellbeing needs of LGBTIQ+ people
- how discrimination, inequality and other forms of marginalisation impact the mental health and wellbeing of LGBTIQ+ people
- enablers and barriers to service access for LGBTIQ+ people
- how DS responds to the needs of LGBTIQ+ clients

---

<sup>6</sup> Midsumma is an annual LGBTIQ+ cultural festival held in Victoria.

- what is needed to improve wider service provision to better meet the needs of LGBTIQ+ people.

A mixed-methods approach was undertaken, which involved quantitative descriptive and content analysis, and qualitative thematic analysis of client files, across two phases. The first phase entailed an in-depth review of 300 client files<sup>7</sup>, which were selected from a convenience sample<sup>8</sup> of 1,400 closed client files comprised of clients who were from one or more LGBTIQ+ communities.

The purpose of phase one was to improve the validity of descriptive variables for gender, CALD characteristics, relationships, disabilities, presenting needs, risk factors and alerts. To identify distinct presenting needs and risks across sub-cohorts, three client groups were formulated into case studies. Each client group was represented by a client journey through the service. These client groups were:

1. Client group 1: Young (18 to 25 years) trans and gender diverse (TGD) clients.
2. Client group 2: Multicultural lesbian, gay, bisexual and multi-gender attracted (LGB) clients.
3. Client group 3: LGBTIQ+ clients with disability.

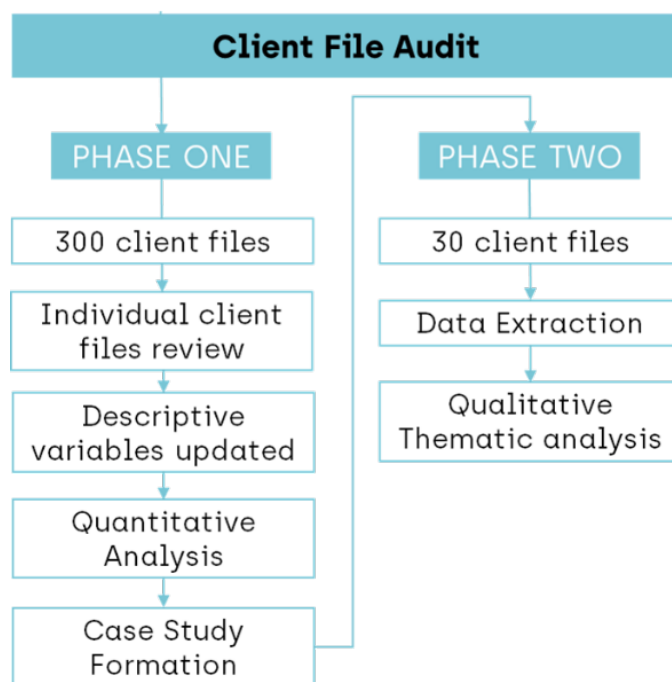
Phase one data extraction also provided better insight into which client files would be suitable for qualitative analysis during phase two.

The second phase of the client file audit included data extraction and qualitative thematic analysis of 30 client files. A tool was developed to guide data extraction for phase two of the CFA. Files were extracted into the tool and then uploaded and coded using NVivo. A codebook was created to guide coding, then codes were analysed in clusters, followed by thematic analysis. Themes were identified and integrated, particularly throughout key finding two (needs, risks, and complexity) and the principles for effective service responses. Figure 1 represents the client file audit process.

---

<sup>7</sup> It is important to recognise that due to the smaller sample size of the client file audit, some counts are quite low. Caution should be taken when interpreting these results as they are not representative of all LGBTIQ+ service users.

<sup>8</sup> Involves selecting a sample based on ease of availability and accessibility to the research team. Rather than being drawn at random from the LGBTIQ+ population, the sample was easily accessible through DS' client record management system.



**Figure 1. Client file audit process**

## Survey and client file audit sample demographics

The demographics for both the survey and the client file audit are presented in the same section of this report to show the similarities and differences across both samples.

### Survey sample

There were 937 LGBTIQA+ respondents who resided in Australia. Almost half of respondents were women (49%), 20% men and around one third had a gender identity that fell outside the gender binary (30%). Around 2% of survey participants were intersex and 8% were unsure.

Survey participants were aged 18-71+ years, with almost half of participants being under 35 years. The most common sexualities were multi-gender attracted (58%) or queer (51%), followed by lesbian (49%), gay (24%), or asexual (14%). A small percentage of respondents identified as straight (3%).

The survey sample was limited in representation of culturally and linguistically diverse LGBTIQA+ respondents (16%). Additionally, a small percentage of respondents were of Aboriginal and/Torres Strait Islander descent (3.2%). Participants were highly educated with the majority completing tertiary education.

## Client file audit sample



A total of 300 clients who identified as LGBTIQ+ and had completed their service engagement with Drummond Street Services (i.e., the client files were closed and inactive) were included in the audit.

Clients were aged 18-68 years, with the majority under 35 years (60%). Gender identities were grouped into women (46%), men (27%), non-binary or gender queer (20%) and other (7%, mostly comprised of undisclosed). Around half of clients were either multi-gender attracted (25%) or queer identified (23%).

Clients received services at one of seven DS locations within Victoria (Collingwood, Carlton, Coburg, North Melbourne, Wyndham, Geelong, and Epping) with the majority of clients seen at the Carlton site.

Figure 2 below presents the age demographics across both the survey and the client file audit samples. Figure 3 presents the gender demographics and Figure 4 presents the sexuality demographics across both samples. Note that the survey allowed participants to select multiple options for sexuality and gender, whereas the client file audit only recorded one gender or sexuality per client file.

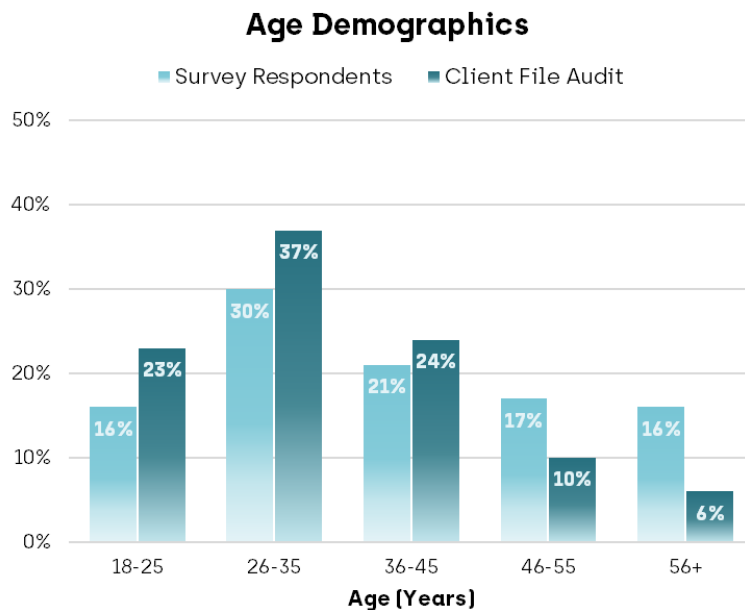
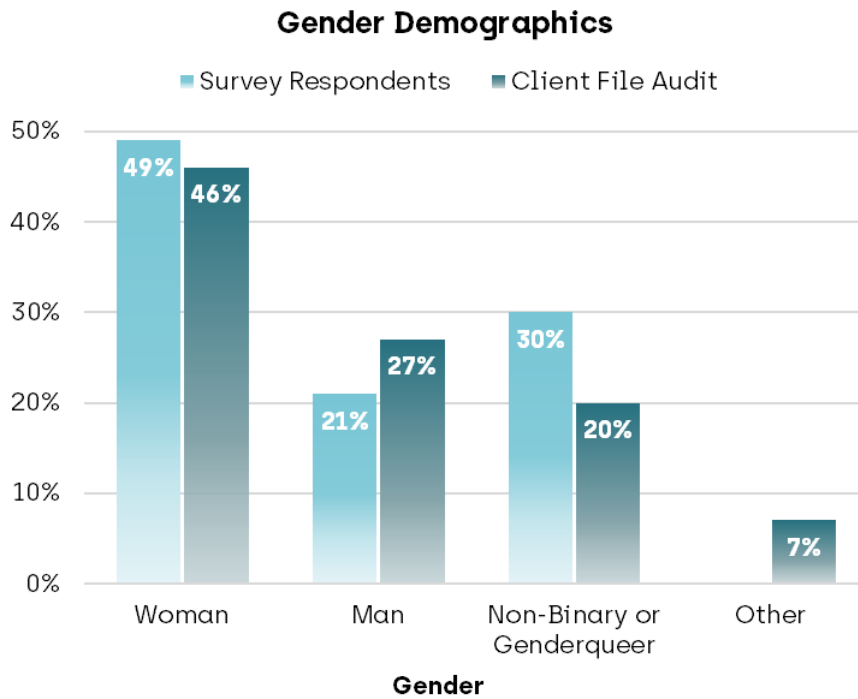
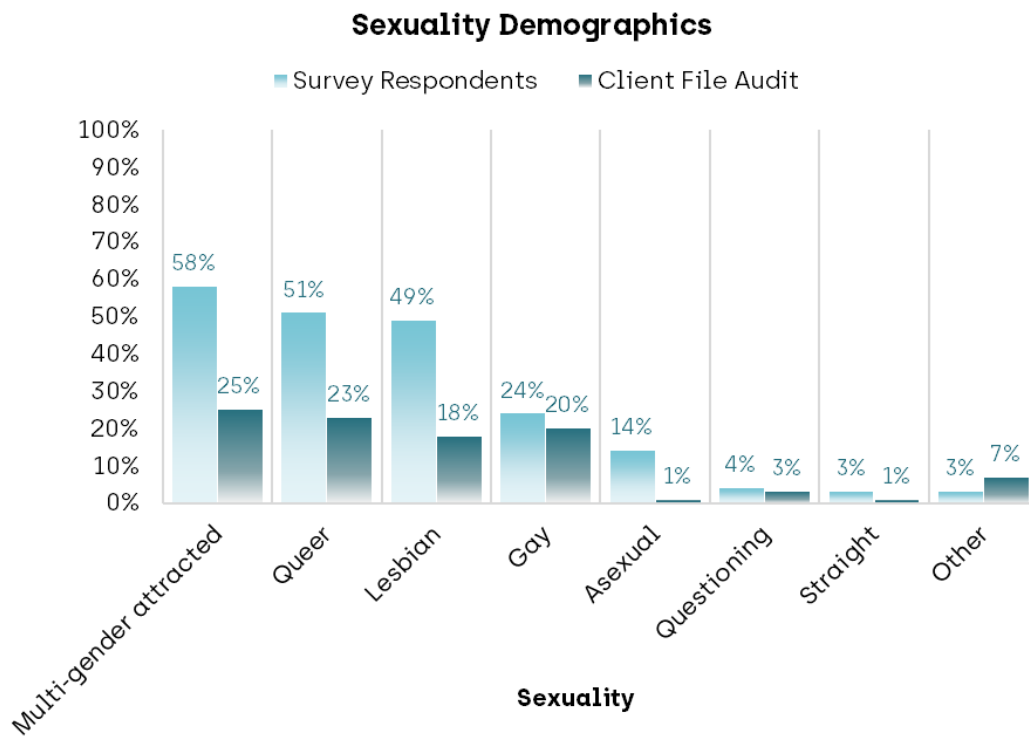


Figure 2. Age across both samples





**Figure 3. Gender across both samples**



**Figure 4. Sexuality across both samples**

Table 1 presents the demographics across both samples. Both samples represented highly educated, Caucasian populations, with a high number of trans and/or gender diverse people. Both samples had similar proportions of trans and/or gender diverse individuals and tertiary educated individuals. Both samples represented 3-4% Aboriginal and/or Torres Strait Islander peoples<sup>9</sup>, yet were under representative of culturally and linguistically diverse people and/or people of colour<sup>10</sup>. Both samples had similar rates of parents/carers of children which were slightly less than other samples of LGBTIQ+ people in Australia<sup>11</sup>.

The survey sample included a substantial proportion of people with disability compared to the client file audit sample. As depicted in the numbers below, some clients identified as living with chronic illness yet did not identify with having disability in the client file audit sample. The client file audit sample recorded additional demographics for neurodivergence, trauma symptoms, and employment/income.

**Table 1. Demographics across the survey and client file audit samples**

Demographic	Survey		Client file audit	
	n	%	n	%
Aboriginal and/or Torres Strait Islander	30	3%	13	4%
Culturally and linguistically diverse	150	16%	44	17%
Age under 35 years	431	46%	180	60%
Parent/carer of a child under 18 years	140	15%	55	18%
Transgender and/or gender diverse	359	42%	119	40%
Intersex	17	2%	-	<1%
Disability	556	61%	63	21%
Chronic illness			86	29%
Neurodivergent			38	13%
PTSD/PTSD symptoms			42	14%
Highest Education				
Primary school	3	<1%	13	4%
Secondary school	138	15%	65	22%

<sup>9</sup> [ABS](#) indicates that 3.8% of the Australian population is Aboriginal and/or Torres Strait Islander.

<sup>10</sup> The diversity within culturally and linguistically diverse groups cannot be represented based on one demographic variable. The multi-dimensionality of the variable was unable to be captured and is thus under representative of the cultural and linguistic diversity in Australia. [AIHW](#) reports that 23% of people in Australia speak a language other than English at home, and 3 in 10 people were born overseas.

<sup>11</sup> In [Private Lives 3](#), 21.6% of LGBTIQ+ Australians were a parent or carer.

<b>Tertiary</b>	654	71%	190	63%
<b>Other/unknown</b>	17	2%	32	11%
<b>Employment</b>				
Employed			161	54%
Unemployed			52	17%
Student			17	6%
Receives income support			74	25%

## Key findings

Two key findings emerged from this project. Firstly, it is evident that LGBTIQ+ people face intersecting and compounding forms of discrimination<sup>12</sup>, which in our data is profoundly associated with lower mental health and wellbeing. Secondly, the needs<sup>13</sup> of this community are highly complex, where multiple needs often co-occur. Additionally, forms of risk often overlap, build upon and compound each other.

These findings have far-reaching implications for the design and delivery of effective services, emphasising the urgent need for safe, responsive and inclusive supports to address the diverse and multifaceted needs of LGBTIQ+ individuals and communities. Based on the two key findings, principles for effective service responses are discussed and considerations for services and government are provided.



<sup>12</sup> For example, a person who is discriminated against based on their sexuality may also experience discrimination based on their age, disability, ethnicity etc. at the same time. Multiple and overlapping forms of discrimination tend to have a cumulative impact on mental health and wellbeing.

<sup>13</sup> In this report, needs are based on Drummond Street Services' client record management system that records individual presenting needs out of a total 33 evidence-informed needs. See p. 40-41 for more information on presenting needs.

## Key finding 1: Intersecting and compounding discrimination

LGBTIQA+ identity is often described as a risk factor for poor mental health outcomes. This project demonstrates however, that there is a need to redefine the discourse around LGBTIQA+ mental health so that it is situated within the context of experiences of discrimination. Discrimination refers to the unjust or prejudicial treatment of individuals or groups based on personal attributes, such as sexual orientation, race, ethnicity, gender identity, disability<sup>14</sup>. It involves making distinctions or treating people differently in a way that is often harmful, unfair, or unequal.

As mentioned in the introduction of this report, much of the academic literature emphasises understandings of 'minority stress' negatively influencing health and wellbeing. This finding moves away from the overemphasis of identity, and towards the harm created by societal, structural and systematic discrimination. In doing so, it reframes the experience of mental health issues within diverse communities from an attribute of identity to the pervasive exposure to discrimination over time.

### Prevalence of discrimination

This section is based on findings from the survey. LGBTIQA+ survey respondents were asked about their experiences of different forms of discrimination within different settings in the past five years. Incidents of discrimination may fall into more than one of the following categories (for example, an incident may be both transphobic and sexist).

This included:

- Ableism
- Transphobia
- Racism
- Sexism
- Homophobia or Biphobia
- Cultural or religious discrimination
- Other

The survey also asked respondents to indicate which settings they experienced discrimination which included:

---

<sup>14</sup> Please refer to definition in Key Terminology, p. 4

- While using public transport, including taxis, rideshare, trains, buses etc.
- By legal systems or law enforcement, including policing, prisons, courts.
- By government, whether local, state, or federal.
- While seeking social or income services (e.g., NDIS, Centrelink).
- At a public space or event.
- Within another cultural or religious community.
- Within the LGBTIQA+ community/ies.
- While seeking or receiving healthcare.
- While accessing housing or accommodation.
- From your family.
- At school, VET, university, or other education setting.
- At work or in formal volunteering.

Based on the survey findings, discrimination was prevalent among LGBTIQA+ individuals in Australia across public, private, and professional settings as well as in larger institutional settings or in healthcare. This is in line with, and expands on, recent findings regarding experiences of discrimination among LGBTIQA+ people<sup>15</sup>. Over 60% of 861<sup>16</sup> respondents had experienced a form of discrimination in the past five years either at work, in public or within family. Around half of respondents had experienced discrimination within healthcare or the LGBTIQA+ community. Table 3 presents experiences of any type of discrimination across settings.

**Table 2. Prevalence of discrimination across settings**

Setting of Discrimination	Experience of Any Discrimination	
	N	%
In public transport, including taxis, rideshare, trains, buses	354	39%
Through legal systems or law enforcement, including policing, prisons, courts	158	18%
Through government, whether local, state or federal	288	32%
In social or income services (e.g. NDIS, Centrelink)	209	23%
In a public space or event	564	62%
Within another cultural or religious community	278	31%

<sup>15</sup> [Private Lives 3](#) [2020]; [Writing Themselves In 4](#) [2021]

<sup>16</sup> All survey questions were voluntary, a total of 861 respondents answered the discrimination questions.

Within the LGBTIQ+ community/ies	446	49%
In healthcare	474	52%
In housing	170	19%
In your family	543	60%
At school, VET, university or other education setting	351	39%
At work or in formal volunteering	569	63%

## Transphobia

In the past five years, 88% of trans and gender diverse (TGD) respondents (n = 334) had experienced transphobia, most commonly within family (65%), at work (56%), in public (53%) or in healthcare (53%).

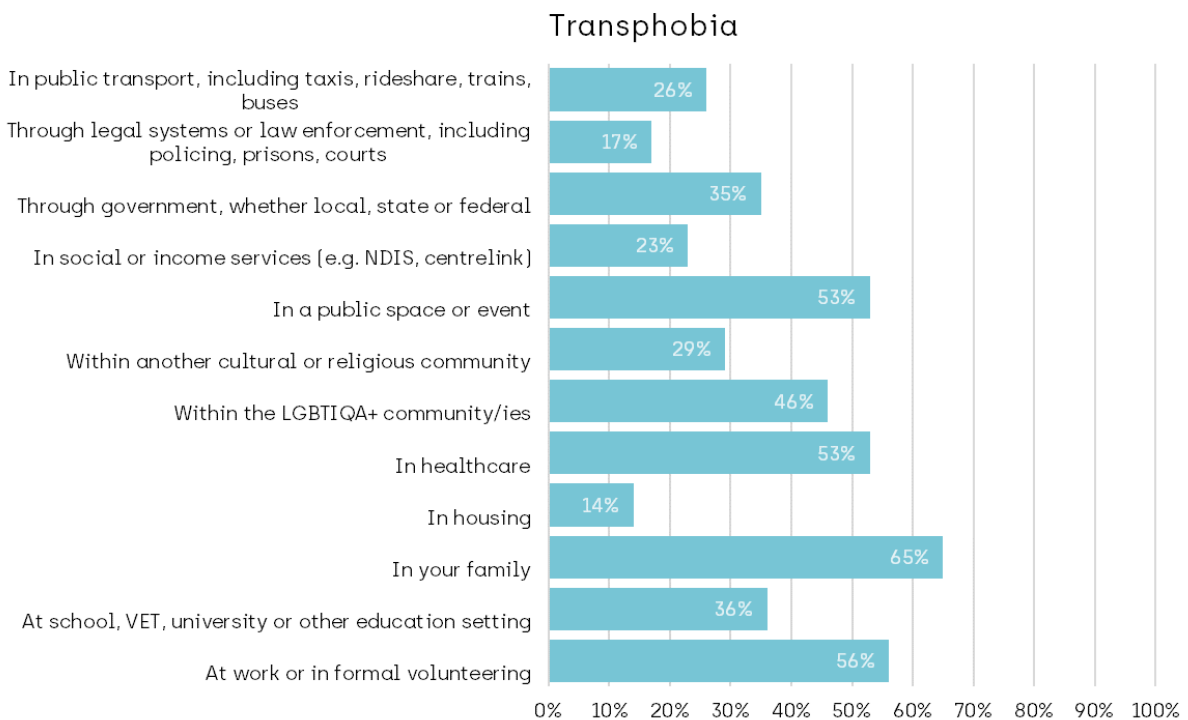
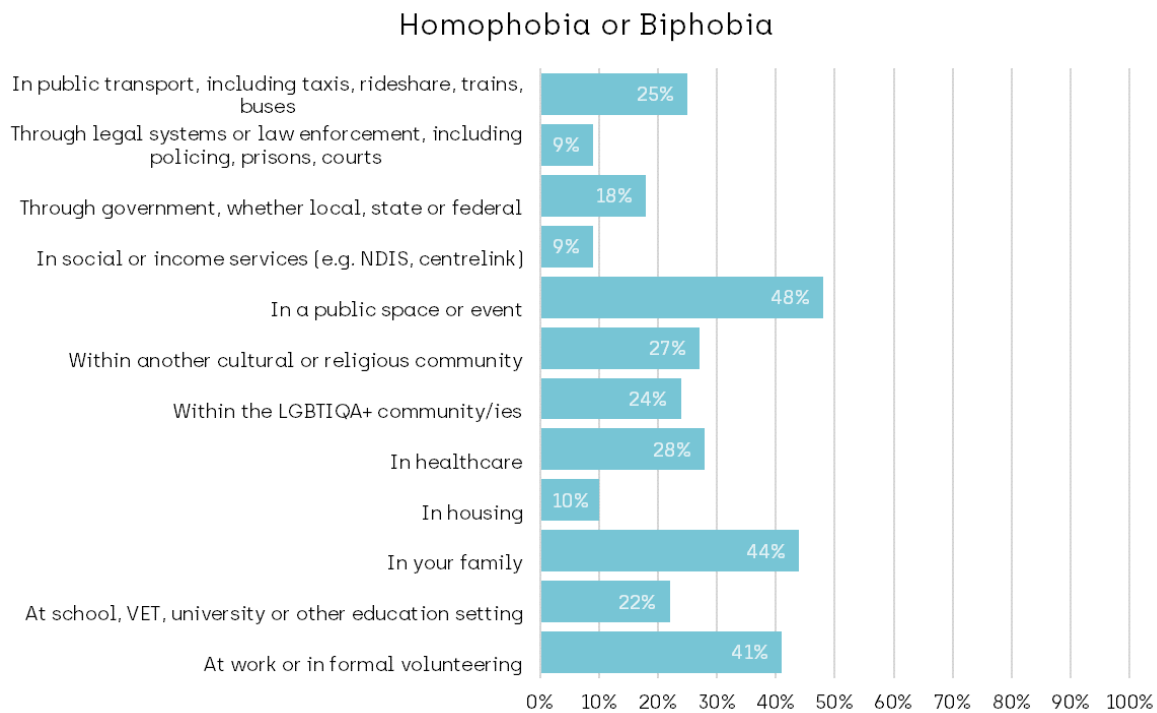


Figure 5. Transphobia across settings

## Homophobia or Biphobia

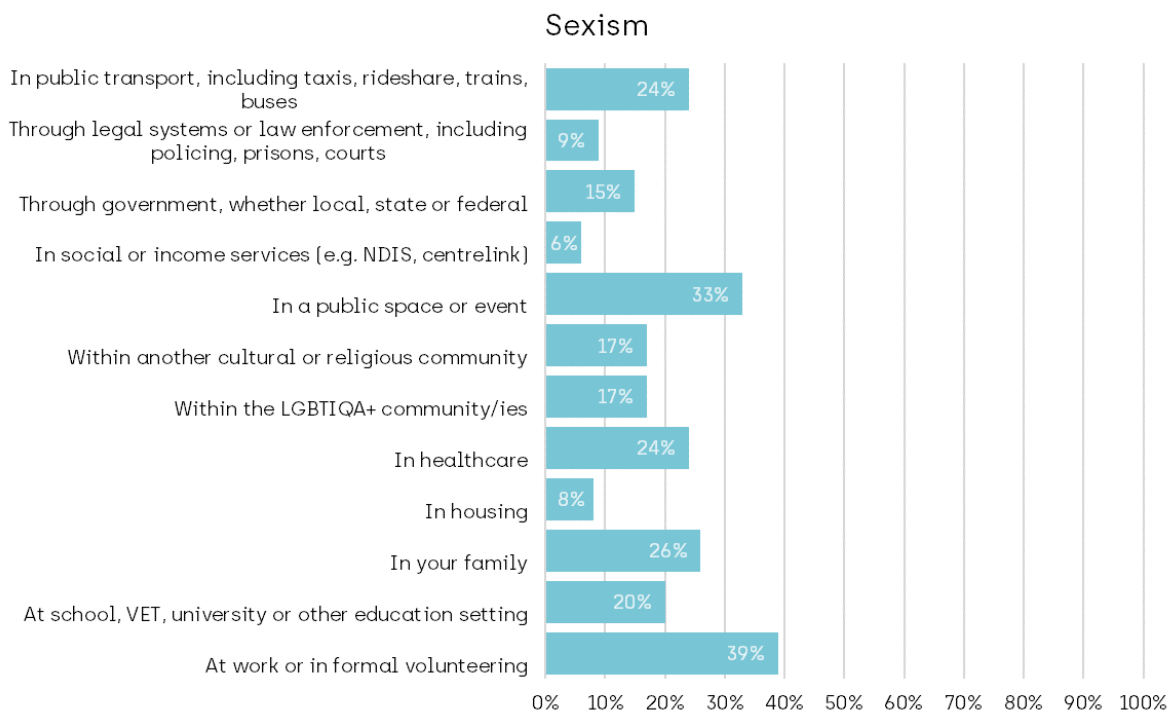
In the past five years, 81% of LGBTQ respondents (n = 820) had experienced homophobia or biphobia, most commonly within a public setting (48%), within the family (44%), or at work (41%).



**Figure 6. Homophobia or biphobia across settings**

## Sexism

In the past five years, 62% of women and non-binary respondents (n = 678) had experienced sexism, and around 1 in 3 women experienced sexism in the workplace and/or in a public space.

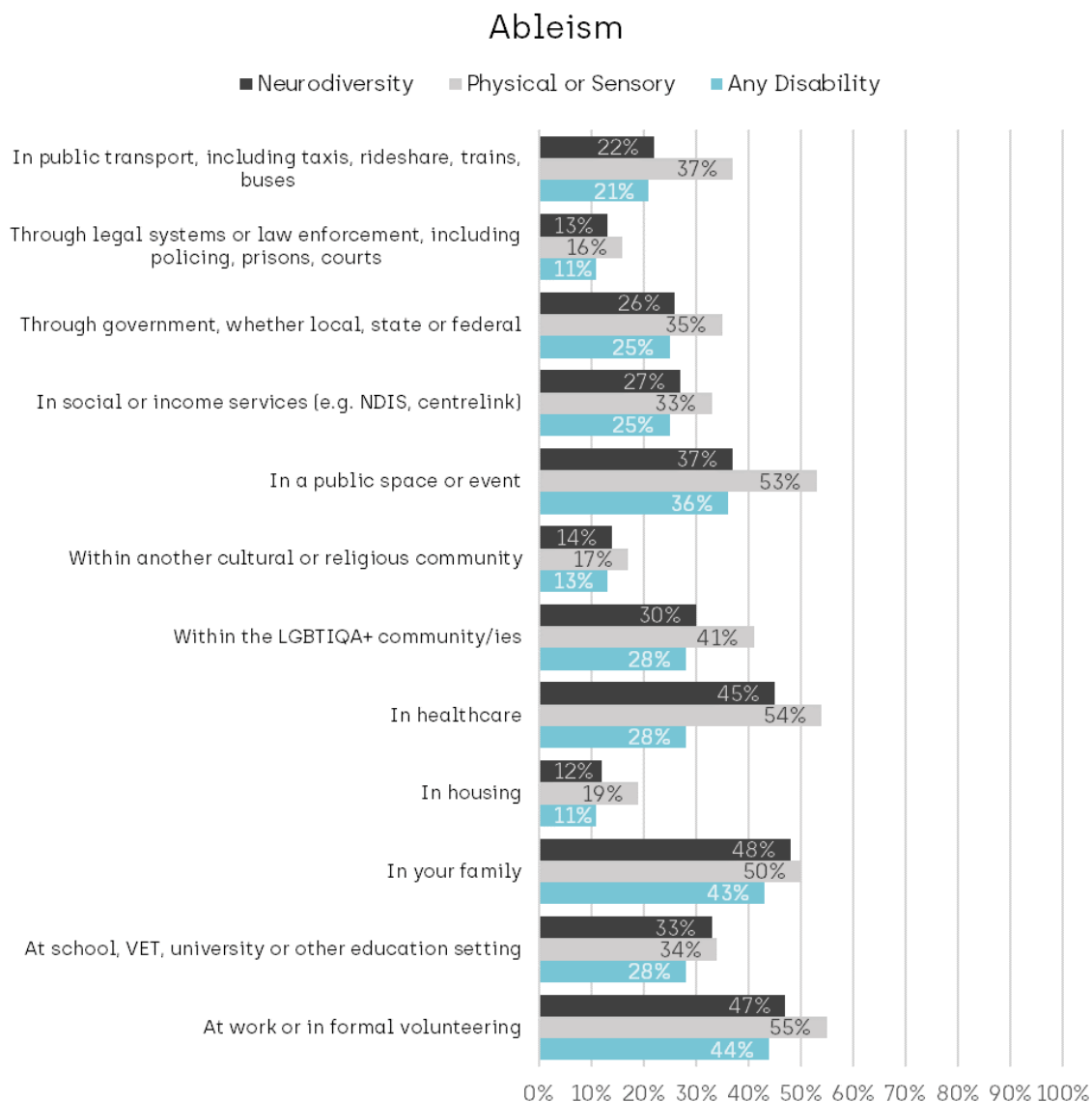


**Figure 7. Sexism across settings**



## Ableism

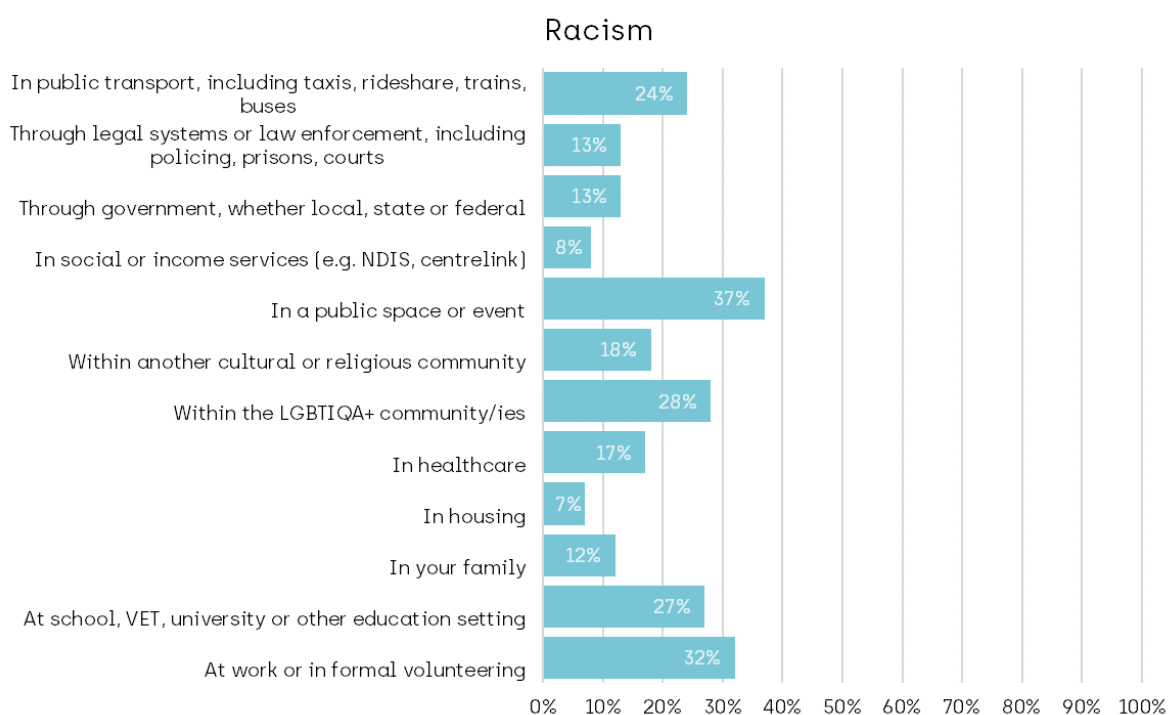
In the past five years, 71% of those with any disability (n = 514), 81% of those with a physical or sensory disability (n = 218) and 76% of neurodivergent respondents (n = 364) had experienced ableism. Half or more of the individuals with physical or sensory disabilities had experienced ableism at work [55%], in healthcare [54%], in public [53%] or within family [50%].



**Figure 8. Ableism across settings**

## Racism

There were only a small number of individuals who identified as a person of colour and/or culturally and linguistically diverse (POC/CALD) within the sample and who completed questions on discrimination (n = 80). Of these individuals, 59% had experienced racism, most commonly in public spaces [37%] and at work [32%]. Due to the small sample of culturally and linguistically diverse and people of colour, these findings are not generalisable to broader experiences of racism.



**Figure 9. Racism across settings**

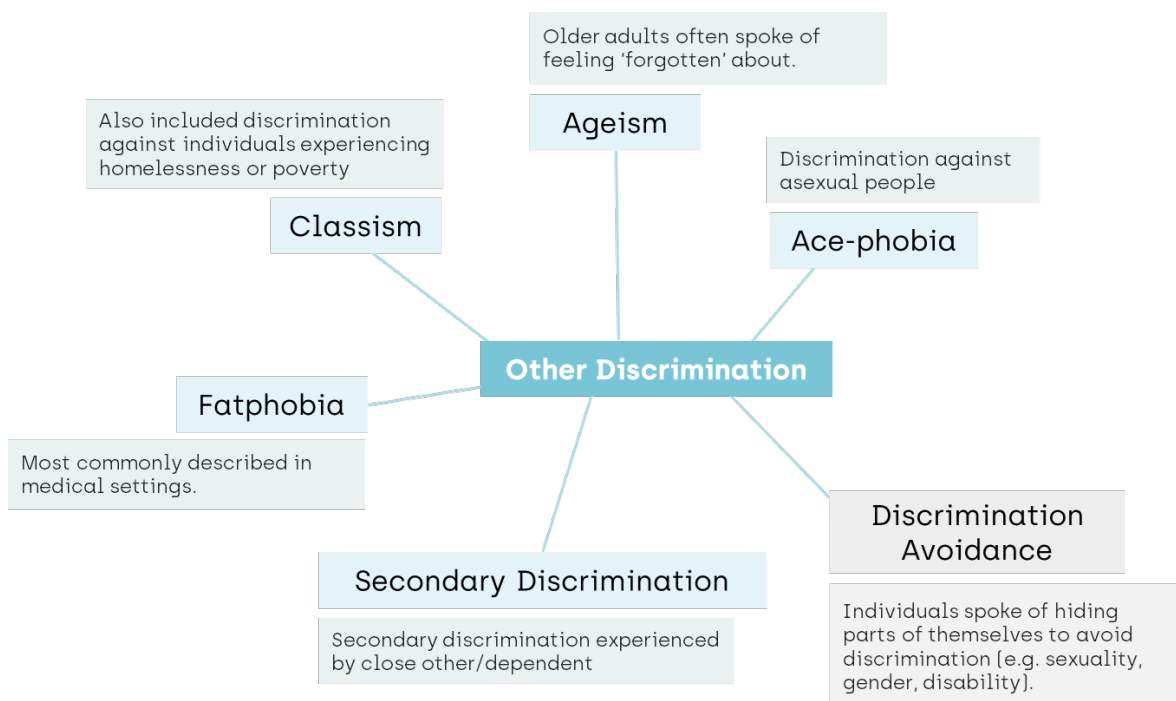
## Other Discrimination

Survey respondents also gave qualitative descriptions of their experiences of discrimination. Additional forms of discrimination that were commonly experienced included classism, ageism, fatphobia and ace-phobia [discrimination against asexual people].

Discrimination did not just impact the individual but also other people in their life (e.g., parent, carer or partner and dependants). There were several participants who explained they were close to someone who experienced discrimination that was a barrier to

accessing necessary health services or mental health supports. This meant that the person close to the individual experiencing discrimination took on a greater caring role. Survey respondents also described how witnessing or hearing about discrimination against their partner/child/person in care, resulted in their own experience of stress.

Many individuals also described avoiding discrimination by not disclosing parts of themselves (e.g., sexuality, gender, disability) in different settings.



**Figure 10. Other discrimination**

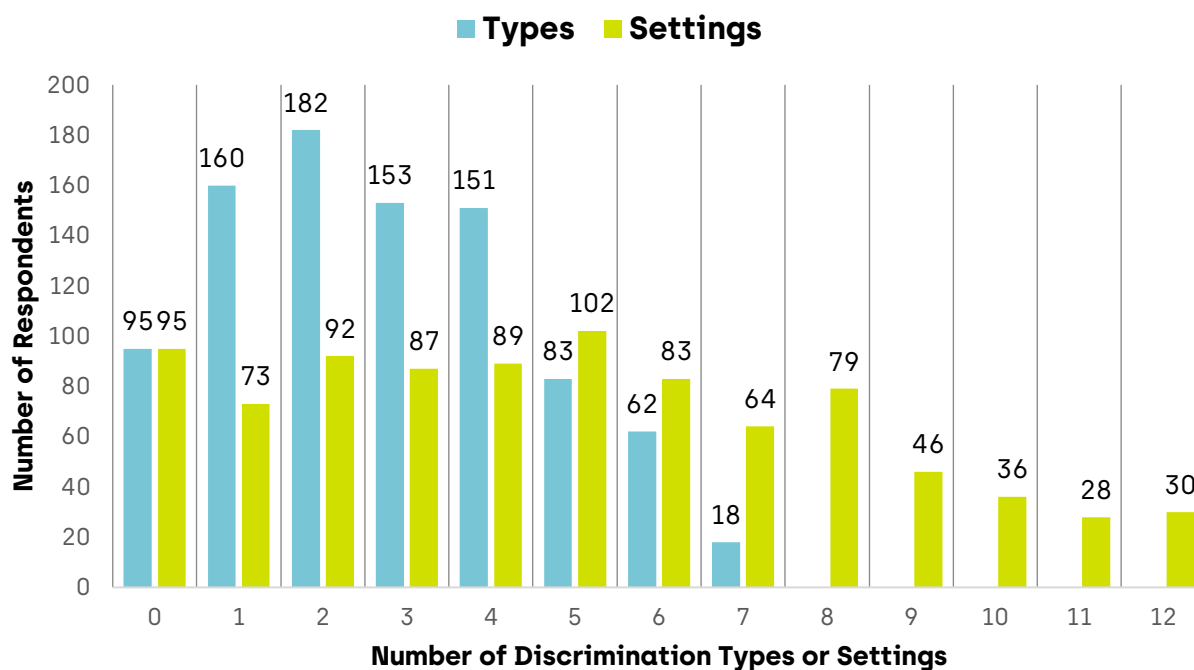
## Intersectional discrimination

Intersectional discrimination<sup>17</sup> was common and was associated with poorer mental health and wellbeing, increased loneliness, and greater financial stress. Individuals experienced multiple types of discrimination, specifically 75% (n = 649) of the total sample had experienced more than one type of discrimination and 37% of individuals (n = 314) had experienced four or more types of discrimination. Figure 11. Demonstrates the frequency of

<sup>17</sup> Intersectional discrimination is understood to be the experience of cumulative forms of discrimination.

individuals who had experienced multiple types of discrimination (0-7 types) in blue and the frequency of settings that discrimination was experienced in (0-12) in green.

**Figure 11. Frequency of Experiencing Multiple Types of Discrimination and Multiple Settings**



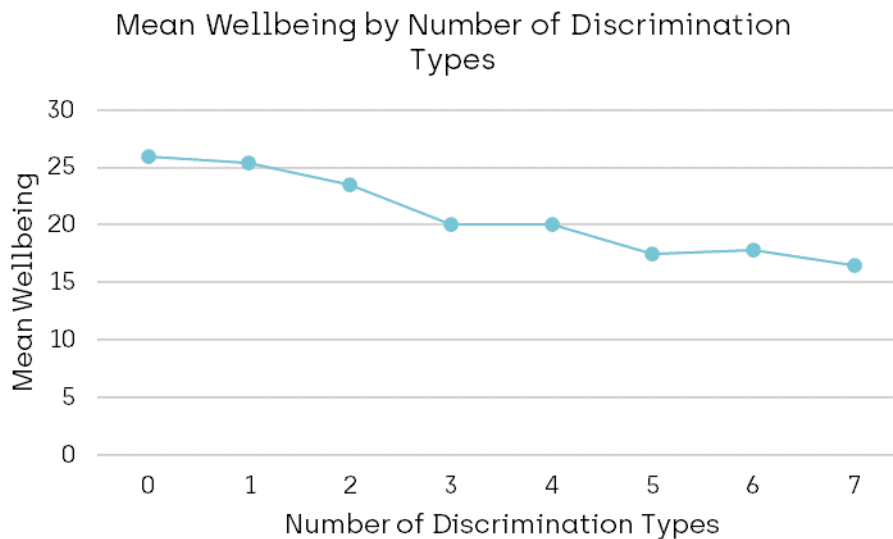
There was a small group of individuals who had only experienced LGBT discrimination, i.e., homophobia or biphobia and/or transphobia (n = 165). These individuals had higher mental health and wellbeing scores, lower financial stress and decreased loneliness scores compared to individuals who had experienced LGBT discrimination in combination with other forms of discrimination (n = 625).

## Mental health and wellbeing

The ReQoL-10<sup>18</sup> was used to measure mental health and wellbeing. Scores range from 0 to 40, where lower scores indicate poorer mental health and wellbeing. A score of 25 or above is considered to fall within the general population. Lower wellbeing scores were associated with a greater number of discrimination types experienced (e.g., transphobia + sexism + ableism...) and a greater number of settings where discrimination was experienced

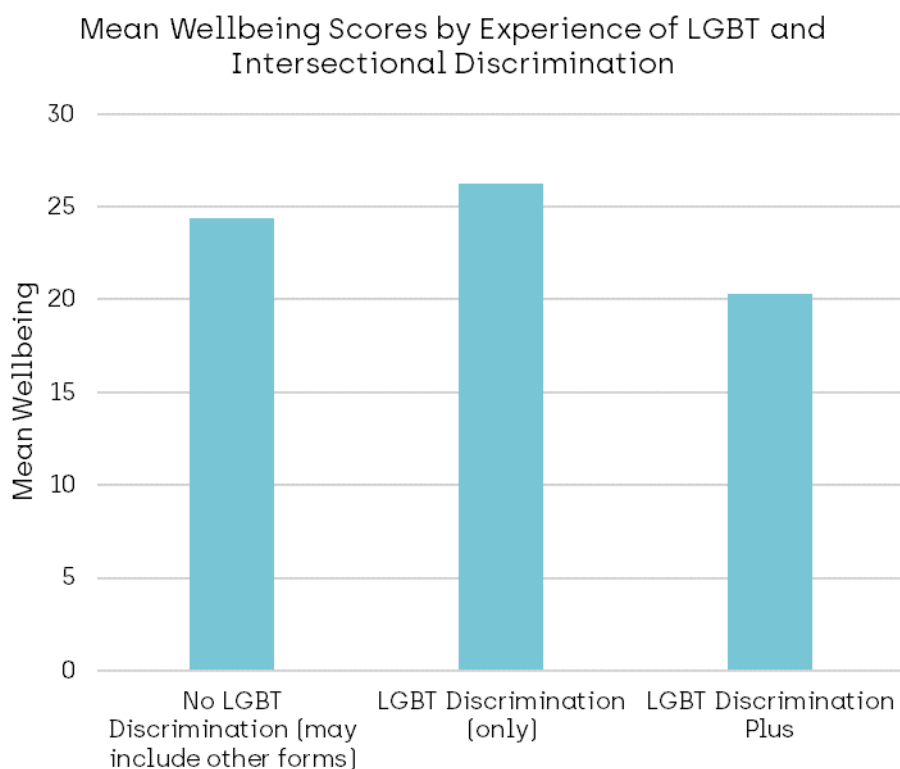
<sup>18</sup> Brazier et al. (2016). *Recovering Quality of Life (ReQoL) Questionnaire*. <https://innovation.ox.ac.uk/outcome-measures/recovering-quality-life-reqol-questionnaire/>

[e.g., workplace + family + public...]. This indicated that the more types of discrimination experienced across more settings, the lower mental health and wellbeing scores would be among LGBTIQA+ survey respondents. This demonstrates the compounding and pervasive nature of discrimination in relation to mental health and wellbeing among the surveyed cohort.



**Figure 12. Mental health and wellbeing scores by discrimination types**

Individuals who experienced LGBT discrimination without other forms of discrimination had mean scores of mental health and wellbeing that were consistent with the general population ( $M = 25.44$ ). These were significantly higher than those who experienced LGBT discrimination in combination with other types of discrimination ( $M = 20.38$ ).

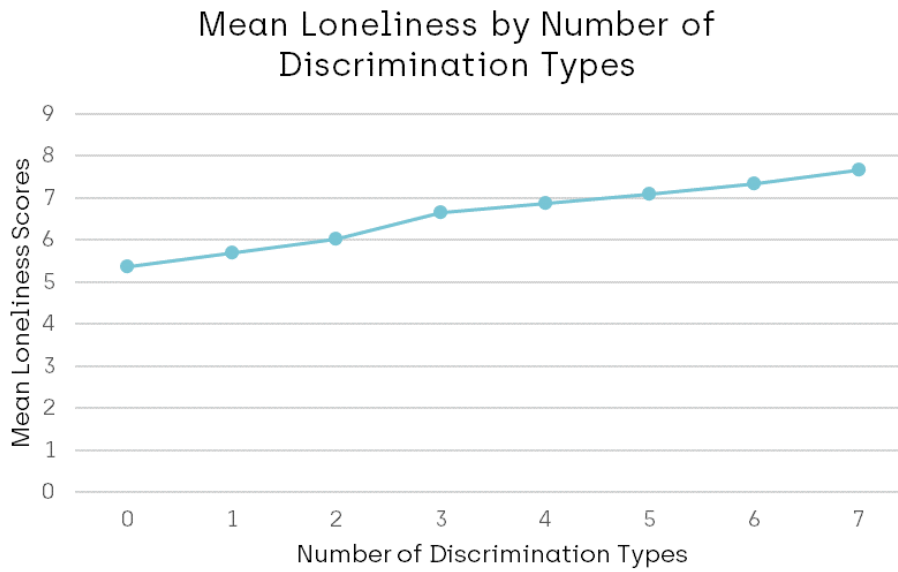


**Figure 13. Mental health and wellbeing scores by experience of LGBT (only) discrimination or intersectional discrimination**

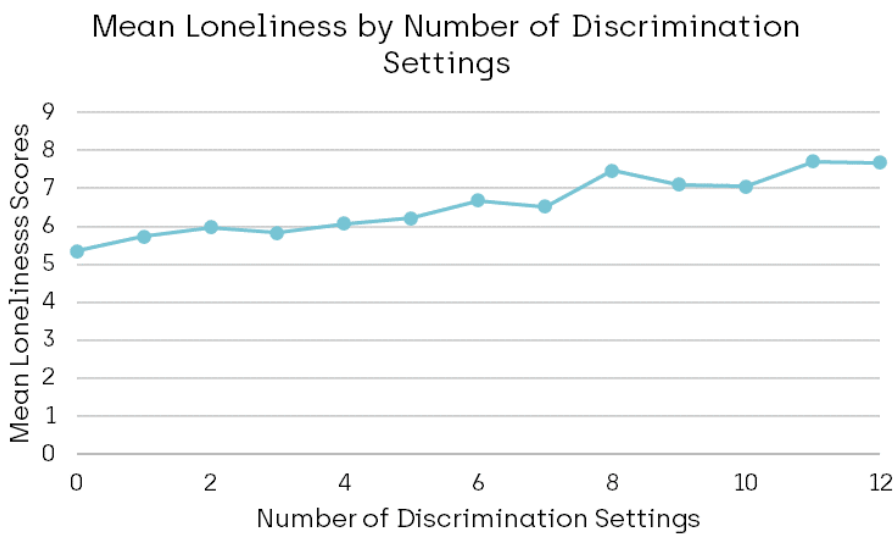
## Loneliness

Loneliness was measured using the UCLA Loneliness Scale<sup>19</sup>. Scores range from 0-9, and higher scores indicate greater loneliness. Lower scores (0-3) can be interpreted as social connectedness. Higher loneliness scores were associated with a greater number of discrimination types experienced (e.g., transphobia + sexism + ableism...) and a greater number of settings where discrimination was experienced (e.g., workplace + family + public...). This indicated that the more types of discrimination experienced across more settings, the higher loneliness scores would be among LGBTIQ+ survey respondents.

<sup>19</sup> Illinois Coalition on Mental Health and Ageing. (2020). *UCLA 3-Item Loneliness Scale*. <https://www.icmha.org/wp-content/uploads/2020/02/UCLA-Loneliness-Scale.pdf>

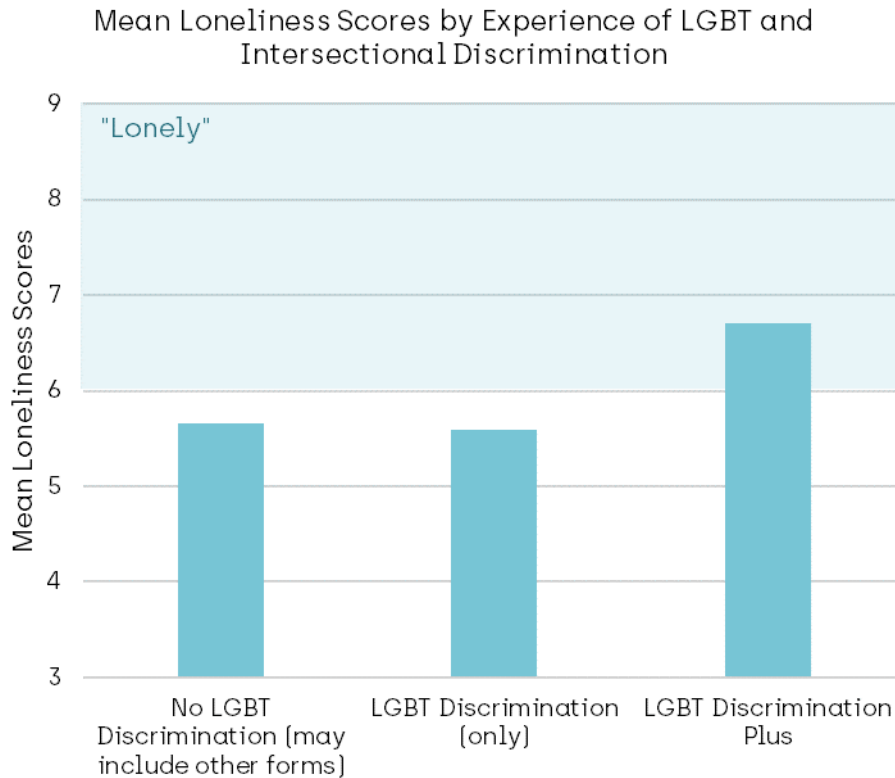


**Figure 14. Loneliness scores by discrimination types**



**Figure 15. Loneliness scores by discrimination settings**

Individuals who experienced LGBT discrimination without other forms of discrimination had mean loneliness scores ( $M = 5.68$ ) that were significantly lower than those who experienced LGBT discrimination in combination with other types of discrimination ( $M = 6.67$ ). This suggests that experiencing LGBT discrimination in combination with other types of discrimination may be more isolating rather than experiencing LGBT discrimination only.



**Figure 16. Loneliness scores by LGBT (only) discrimination and intersectional discrimination**

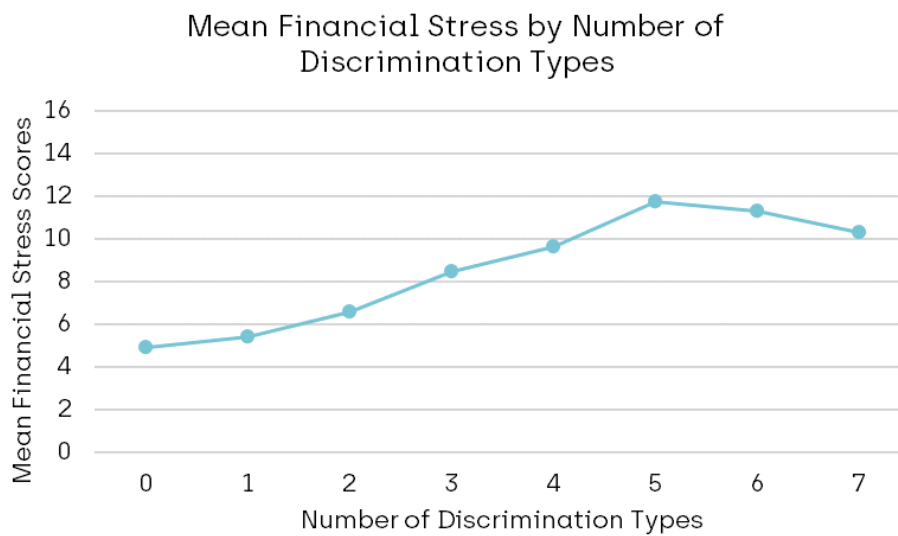
## Financial stress

Financial stress was measured using the Drummond Street Financial Stress Scale<sup>20</sup>. The Drummond Street Financial Stress Scale includes seven items that cover finances across utilities, healthcare, food and household, work or school, housing or household repairs, loans, debts, and payment plans, as well as emergency fund access. Survey respondents could indicate for each item how stressed they feel about being able to pay from 'No stress at all' to 'Overwhelming stress'.

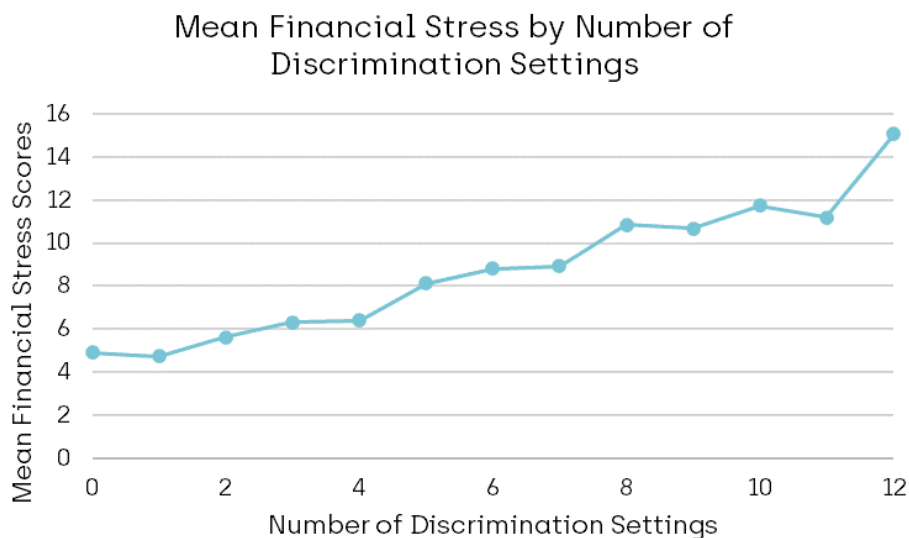
Higher financial stress was associated with a greater number of discrimination types experienced (e.g., transphobia + sexism + ableism...) and a greater number of settings where discrimination was experienced (e.g., workplace + family + public...). Both compounding and pervasive discrimination were associated with higher financial stress in the surveyed cohort.

<sup>20</sup> This measure was developed by Drummond Street for internal evaluation purposes and is not a validated measure.



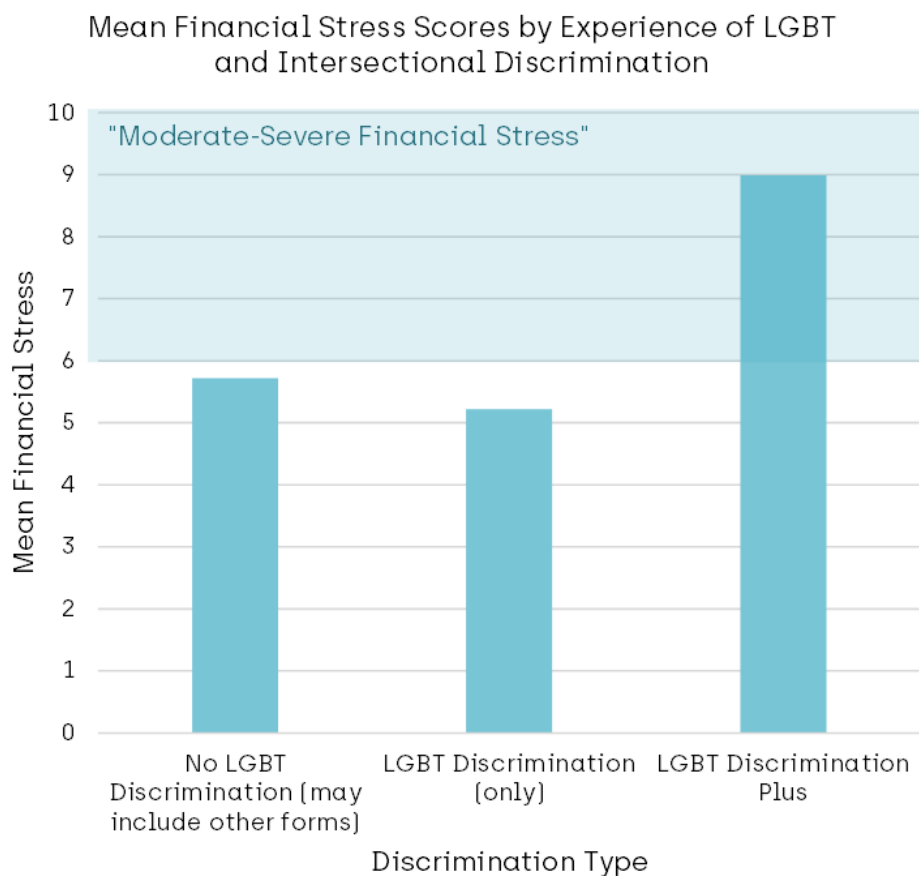


**Figure 17. Financial stress scores by discrimination types**



**Figure 18. Financial stress scores by discrimination settings**

Average financial stress was lower in individuals who experienced LGBT discrimination without other forms of discrimination ( $M = 5.42$ ) compared to those who experienced LGBT discrimination in combination with other types of discrimination ( $M = 8.93$ ) which fell within the 'moderate to severe' financial stress range. This indicated that experiencing LGBT discrimination in combination with other forms of discrimination was related to greater levels of financial stress.



**Figure 19. Financial stress scores by LGBT (only) discrimination or intersectional discrimination**

There was also a relationship between financial stress and discrimination within the workplace. Individuals who had experienced discrimination at work within the last 5 years had significantly higher financial stress scores ( $M = 9.06$ ) compared to those who had not experienced discrimination within the workplace ( $M = 6.01$ ).

Overall, the workplace was the most common setting for experiencing discrimination among LGBTIQ+ survey respondents. This then demonstrated further influence on levels of financial stress. This is one example of how discrimination has flow on effects into other aspects of people's lives. More examples are articulated below based on qualitative analysis of client files.

## Discrimination in context

Based on client file analysis, some examples are provided below depicting experiences of discrimination across contexts, and the influence on needs and risk. Overwhelmingly, these experiences of discrimination relate to clients who were transgender, non-binary, gender diverse and/or questioning and occurred across healthcare, work, and law enforcement settings.

### Discrimination in healthcare

Experiences of discrimination were apparent within healthcare settings and were connected to needs related to gender, trauma and isolation. Some clients experienced transphobic discrimination in healthcare settings. This discrimination was related to rigid binary understandings of gender and some clients were prevented from receiving gender-affirming treatment. There were also descriptions of clients experiencing coercion towards treatments that would result in conformity with rigid binary understandings of gender, yet clients who were non-binary did not want to access these treatments. These experiences of discrimination substantially impacted on clients' mental health. In some cases, discrimination that prevented clients from accessing gender-affirming treatment contributed to suicidal ideation. Experiences of coercion in healthcare settings was also described as contributing to trauma.



### Discrimination at work

Discrimination within employment led some clients to resign or lose their job. In other cases, clients did not share their gender with employers or colleagues to avoid experiencing discrimination or in fear of losing their job. There were also examples of clients that then experienced financial stress, housing instability and social isolation after losing their employment following incidents of workplace harassment or discrimination. Some clients also experienced visa issues and losing employment was particularly detrimental to their wellbeing, and in some cases was seen by clients and practitioners as leading directly to suicidal ideation.

## Discrimination from law enforcement

Experiences of discrimination from law enforcement usually compounded existing need and risk. In times when clients were experiencing transphobic violence in public and would reach out to police, the responses were often delayed or there were no responses to these incidents. Drummond Street [DS] practitioners advocated for clients and contacted the police station to follow up and in some cases, multiple attempts were made before any action was taken. However, in cases where the client retaliated to discrimination in public and the police were called, the response was misdirected, instant and excessive towards the individual experiencing discrimination rather than the public transphobic violence, thereby compounding experiences of discrimination. There were also examples of clients being harassed by law enforcement, and one instance where a client's safety plan was undermined by police.

## Concluding points: Intersecting and compounding discrimination

Overall, these findings shed light on the pervasive nature of discrimination and its profound association with lower mental health, social connectedness, and financial wellbeing.

- LGBTIQ+ individuals often face multiple forms of discrimination across various settings. Most survey participants had encountered more than one type of discrimination, with a large portion experiencing four or more types.
- There is a clear association between the number of discrimination types experienced and lower wellbeing scores, increased loneliness and increased financial stress.
- The cumulative impact of discrimination across multiple settings was associated with poorer outcomes across wellbeing, financial wellbeing, and social connectedness.
- Discrimination against LGBTIQ+ individuals in Australia persists across a broad spectrum of settings including public, private, and professional. Discrimination was experienced in places where anti-discrimination policies are in place, where people should reasonably expect protection and inclusivity.

- Discrimination experiences extended their reach into larger institutional settings, such as social services and healthcare, where individuals often seek support, care, and understanding.
- Nearly half of the survey respondents experienced discrimination even within LGBTIQ+ communities. These findings challenge the assumption that certain settings would naturally provide safe havens, emphasising the urgent need for comprehensive anti-discrimination measures and cultural shifts.

This work highlights the need for paradigm shift from conceptualising LGBTIQ+ identity as the risk factor for poor mental health and instead places the burden on societal discriminatory treatment. By recognising and addressing the multiple layers of discrimination that individuals face across a breadth of settings, we can work towards appropriately targeting initiatives to reduce discrimination and thereby likely contribute to improving the mental health and wellbeing of LGBTIQ+ Australians.

## **Key finding 2: Needs, risks, and complexity**

Both the survey and client file audit found that the needs of LGBTIQ+ people and the risks they face are complex, meaning multiple factors interrelate and work to compound each other. The survey analysis demonstrates relationships between forms of need and risk and the client file analysis demonstrates needs and complexity and provides insight into co-occurring risks and acute risk experienced by LGBTIQ+ clients, especially suicide, mental illness, and family violence.

Sub-cohorts within the broader LGBTIQ+ client sample also presented with similarities and differences in terms of needs and risk, with combinations of needs and risks more common in some groups and less in others. Survey and client file analysis highlight similarities and differences across three groups: young trans and gender diverse (TGD) clients; clients who are LGB [lesbian, gay, bisexual or multi-gender attracted] and multicultural; and LGBTIQ+ clients with disability.

### **Needs and risk: survey findings**

The survey results demonstrate how need related to mental health and wellbeing overlaps with loneliness, financial stress, and risk attributed to experiences of family violence.

## Results Snapshot

The results indicate that a significant portion of respondents reported wellbeing scores below the general population, with wellbeing closely linked to social connection and lower financial stress. Alarming, a high rate of loneliness was observed, disproportionately affecting young adults and individuals with disabilities, surpassing rates in the general Australian population.

Financial stress emerged as a prevalent issue, with around one in three respondents experiencing moderate to severe financial stress, impacting their overall wellbeing, and contributing to increased loneliness. Trans and gender diverse individuals, as well as those with disabilities, faced heightened financial stress, particularly in healthcare-related expenses.

The findings also provided insight into family violence experiences, highlighting that a substantial percentage of respondents had encountered family violence-related behaviours, most commonly from a partner. These experiences were associated with lower wellbeing, increased financial stress, and heightened loneliness. Trans and gender diverse individuals were particularly vulnerable to physical harm or intimidation from parents, emphasizing the need for targeted support and intervention.

## Mental health and wellbeing

The ReQoL-10<sup>21</sup> was used to measure mental health and wellbeing. Scores range from 0 to 40, where lower scores indicate poorer mental health and wellbeing. A score of 25 or above is considered to fall within the general population. A total of 859 participants completed questions about their mental health and wellbeing and 58% (n = 542) had wellbeing scores below the general population indicating poorer mental health and wellbeing.

## Loneliness

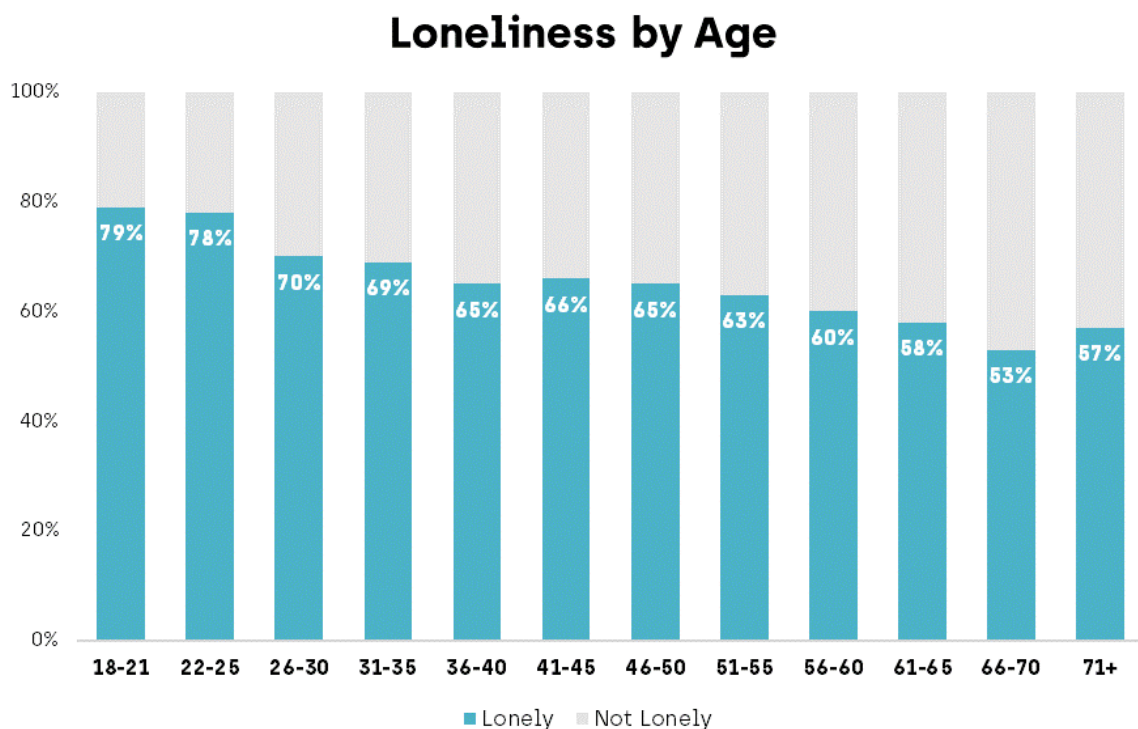
Loneliness was measured using the UCLA Loneliness Scale<sup>22</sup>. Scores range from 0-9, and higher scores indicate greater loneliness. Lower scores (0-3) can be interpreted as social connectedness. There was a high rate of loneliness in the sample. Overall, 67% (n = 560) of

<sup>21</sup> Brazier et al. [2016]. *Recovering Quality of Life (ReQoL) Questionnaire*. <https://innovation.ox.ac.uk/outcome-measures/recovering-quality-life-reqol-questionnaire/>

<sup>22</sup> Illinois Coalition on Mental Health and Ageing. [2020]. *UCLA 3-Item Loneliness Scale*. <https://www.icmha.org/wp-content/uploads/2020/02/UCLA-Loneliness-Scale.pdf>

LGBTIQ+ respondents were experiencing loneliness (UCLA-SF). Increased loneliness was related to lower mental health and wellbeing, and greater financial stress.

Loneliness decreased with age, with LGBTIQ+ young adults aged 18-25 having the highest rate of loneliness (78%, n=105). Compared to research within the general Australian population, only 28% of young adults aged 18-25 were reporting loneliness in 2019<sup>23</sup>. Whilst adults over 65 had the lowest rates of loneliness (53-57%) in the sample, this was still above the 32% of Australian adults aged 60-74 years who experienced loneliness<sup>24</sup>.



**Figure 20. Loneliness scores by age**

There was also a significantly higher rate of loneliness for individuals with disabilities (75%) compared to individuals without (54%). Trans and gender diverse individuals also had significantly higher rates of loneliness (77%) compared to cisgender LGBTIQ+ individuals (58%).

<sup>23</sup> Lim, M., Eres, R., & Peck, C. (2019). The young Australian loneliness survey: Understanding loneliness in adolescence and young adulthood.

<sup>24</sup> Lim, M. H., Manera, K. E., Owen, K. B., Phongsavan, P., & Smith, B. J. (2023). The prevalence of chronic and episodic loneliness and social isolation from a longitudinal survey. *Scientific Reports*, 13(1), 12453.

## Financial stress

Financial stress was measured using the Drummond Street Financial Stress Scale. This tool includes seven items that cover finances across utilities, healthcare, food and household, work or school, housing or household repairs, loans, debts and payment plans, as well as access to emergency funds. Survey respondents could indicate for each item how stressed they feel about being able to make payments across the different areas, from 'No stress at all' to 'Overwhelming stress'.

Around 1 in 3 LGBTIQ+ individuals were experiencing moderate to severe financial stress, indicating that they were feeling a high level of stress at meeting basic expenses. Higher financial stress was associated with lower wellbeing and higher loneliness scores. Table 3 presents the total LGBTIQ+ survey respondents that indicated either 'High stress' or 'Overwhelming stress' for each item.

Trans and gender diverse individuals experienced significantly increased financial stress compared to cisgender survey respondents. This related to almost all areas of finance (aside from loan repayments) and most related to having greater stress in healthcare related expenses. Individuals with disabilities also experienced greater financial stress in all areas, compared to individuals without a disability. This was strongest in relation to healthcare expenses and in paying for a \$1,000 emergency.





**Table 3. High or overwhelming financial stress**

Financial Domain	'High' or 'Overwhelming' Stress	
	N	%
Utility bills	234	27%
Healthcare	375	43%
Food and household items	255	29%
Work or school expenses	203	23%
Housing or basic household repairs	317	35%
Loans and debt repayment	219	25%
A \$1000 emergency	430	49%

## Family violence

In order to provide some insight into family violence, the survey asked about experiences of family violence behaviours<sup>25</sup>. A total of 905 individuals answered questions about their experiences of family violence behaviours from different family members (both current and historic). Of these 905, 74% had experienced family violence related behaviours, most commonly from a partner.

Individuals who had experienced family violence behaviours from parents were twice as likely to have experienced family violence behaviours from a current or previous partner. Individuals who had experienced family violence behaviours from a parent also had significantly lower wellbeing ( $M = 19.53$ ,  $n = 394$ ) compared to individuals who had not experienced family violence behaviours from a parent ( $M = 23.72$ ,  $n = 435$ ). Moreover, those that had experienced family violence behaviours from a parent also experienced significantly higher financial stress, and loneliness.

Compared to cisgender survey respondents, trans and gender diverse individuals were 2.3 times more likely to have experienced physical harm or intimidation from parents.

<sup>25</sup> While these behaviours could indicate family violence, it is important to acknowledge that family violence consists of these behaviours occurring in repeated patterns and tactics, often influenced and driven by power dynamics.

## Needs and risk: client file audit findings

For LGBTIQ+ clients, the client file audit identified that needs and risk are complex. The following results outline key statistics from the phase one quantitative analysis (N = 300), as well as phase two qualitative analysis (n=30). Quantitative analysis of client files provide insight into clients' primary reason for help-seeking, the complexity and interconnected nature of needs they presented with, as well as complex and co-occurring risks they faced. Qualitative analysis provides further understanding about the interconnected and compounding needs and risks, as well as contextualises these experiences of LGBTIQ+ clients.

### Results Snapshot

The client file audit reveals a complex landscape of need and risk among LGBTIQ+ clients. Mental health emerged as the most common primary reason for help-seeking, followed by issues related to family functioning, community participation, relationships, and gender. The client file analysis highlighted the prevalence of mental health-related needs, often intertwined with other forms of need, further emphasising the intricate nature of client presentations.

Clients in our sample exhibited an average of eight needs, with a substantial percentage presenting with five or more needs, highlighting the multifaceted challenges they face. This complexity underscores the importance of holistic and comprehensive support systems for LGBTIQ+ individuals, considering intersecting contexts and circumstances, including the impact of discrimination, as also revealed through the survey analysis.

## Client reasons for help-seeking and presenting needs

DS' client record management system records the client's primary reason for seeking help, in addition to the presenting needs identified during intake and initial engagement with the service. The primary reason for seeking support identifies a single reason the client is seeking support, whereas the presenting needs can be multiple and interconnected. For clients in this sample, the most common primary reason for help-seeking was mental health [40%, n = 121], followed by family functioning [16%, n = 48], community participation/networks [3%, n = 10], relationships, [3% n = 8] and gender [2%, n = 5].

Presenting needs are identified when the client enters the service and during their initial engagement with DS. There are a total of 33 presenting needs including mental health,

anxiety, depression, and stress. As demonstrated in Table 4 below, the most common presenting need was mental health (84%, n = 251), followed by stress (63%, n = 189), anxiety (60%, n = 181), wellbeing and self-care (57%, n = 172), trauma (50%, n = 151), depression (47%, n = 142), family relationship issues (35%, n = 106), financial issues (33%, n = 98), community participation and support networks (33%, n = 98) and family violence (33%, n = 98).

If a client specified anxiety or depression this was recorded as a presenting need, in addition to need related to mental health more generally. While stress can overlap with mental health need or a recent stressful event, if the client only indicated that they were stressed, it was only stress that was recorded. However, if the client indicated that their stress was also related to their mental health and a recent stressful event, then all three presenting needs were recorded. This means that when presenting needs overlapped with each other, both or all needs were counted once individually.

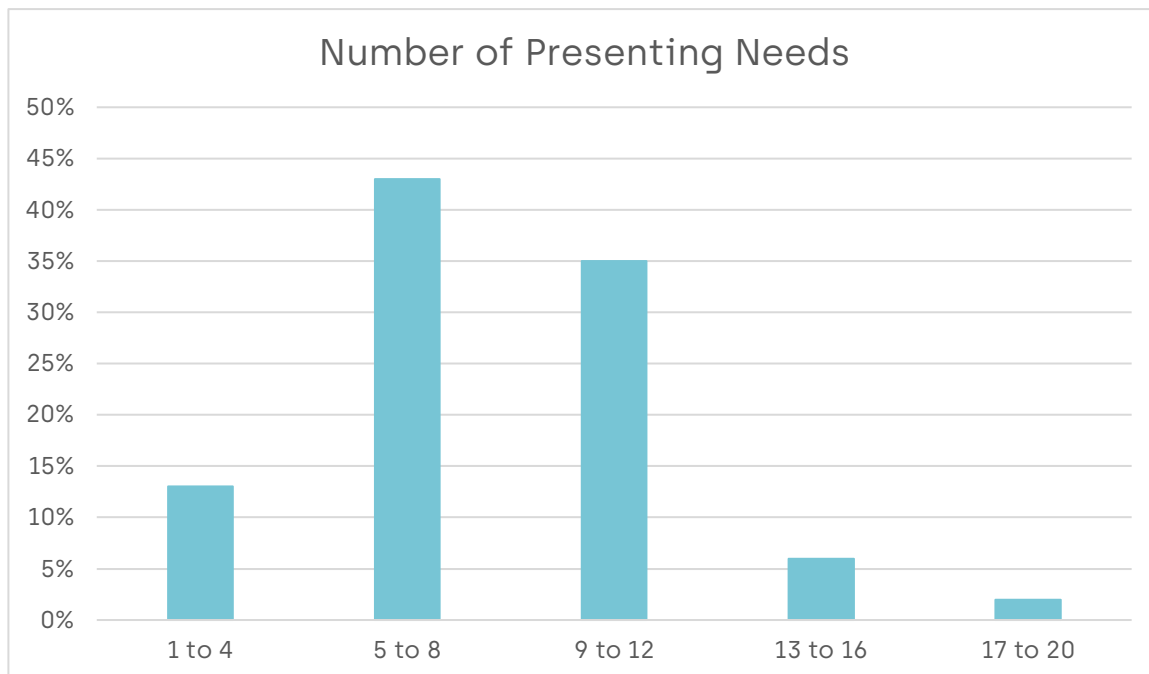
As clients presented with multiple needs, numbers and percentages below are each out of the total sample (100%, N = 300). From these descriptive statistics, the overwhelming majority of clients presented with mental-health related needs, which likely sat alongside and were related to other forms of need.



**Table 4. Presenting needs of client file sample**

Presenting need	n	%
Mental Health	251	84%
Stress	189	63%
Anxiety	181	60%
Wellbeing and Self-care	172	57%
Trauma	151	50%
Depression	142	47%
Family Relationship Issues	106	35%
Financial Issues	98	33%
Community Participation and Support Networks	98	33%
Family Violence	98	33%
Family Functioning	82	27%
Sexuality	75	25%
Couple Relationship Issues	75	25%
Gender	71	24%
Employment, Education and Training	55	18%
Housing/Accommodation Issues	48	16%
Childhood Abuse (Emotional and/or Physical)	47	16%
Personal and Family Safety	42	14%
Self-Harm	41	14%
Parenting	41	14%
Adult Abuse (Emotional and/or Physical)	39	13%
Physical Health	39	13%
Couple Separation	37	12%
Material Wellbeing	34	11%
Alcohol Abuse	34	11%
Childhood Sexual Abuse	29	10%
Drug Abuse	28	9%
Adult Sexual Abuse	20	7%
Post Separation Parenting	18	6%
Disordered Eating	14	5%
Stepfamily	13	4%
Bullying	7	2%
Gambling	3	1%

On average, clients presented with approximately eight needs and a maximum of 20. Highlighting the complexity of presenting needs, **87%** (n =261) of clients **presented with five or more needs**, and **44%** (n = 132) of clients **presented with nine or more needs**.



**Figure 21. Number of presenting needs (complexity)**

Clients' multiple and complex presenting needs demonstrated that mental health need is interconnected with other forms of need. Mental health need may influence other needs and vice versa. They cannot be responded to separately and must be considered holistically. To address mental health need, wrap around services are necessary to holistically respond to complex and interconnected needs that may require non-mental health specific support (e.g., financial support, housing support, legal support).

To further demonstrate how multiple, often interconnected needs presented for LGBTIQA+ clients. Isolation was found to be the most prominent and interconnected need. Isolation was interconnected with need related to discrimination, family violence, family relationship issues, safety, housing, financial issues, alcohol and other drug issues, trauma, and suicidality.

Family violence was the second-most interconnected need and was associated with presenting need related to trauma, alcohol and other drug issues, isolation, suicidality, safety, financial issues, housing issues, family relationships issues, and historical experiences of childhood abuse.

This was followed by the third-most interconnected needs which were financial issues and trauma, respectively. These needs were both interconnected with presenting needs related to family violence, isolation, trauma, legal issues, housing issues, employment issues, visa issues, and discrimination.

## Risk throughout service engagement

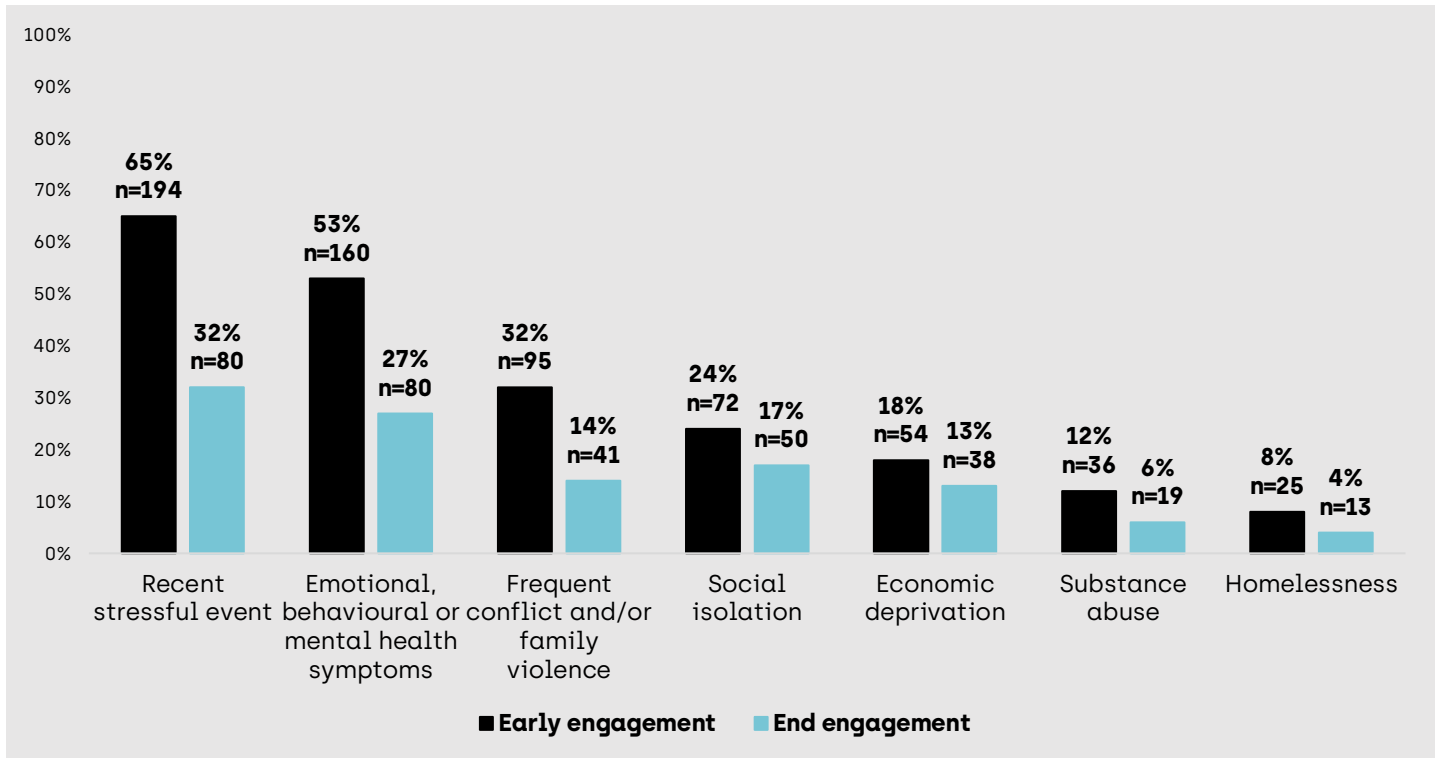
Client risks were determined by risk factors and risk alerts that were present throughout service engagement. Analysis demonstrated that there were reductions in risks, as the clients moved through their service engagement. This was most evident in suicidality, self-harm, and family violence.

### Classification of Risks

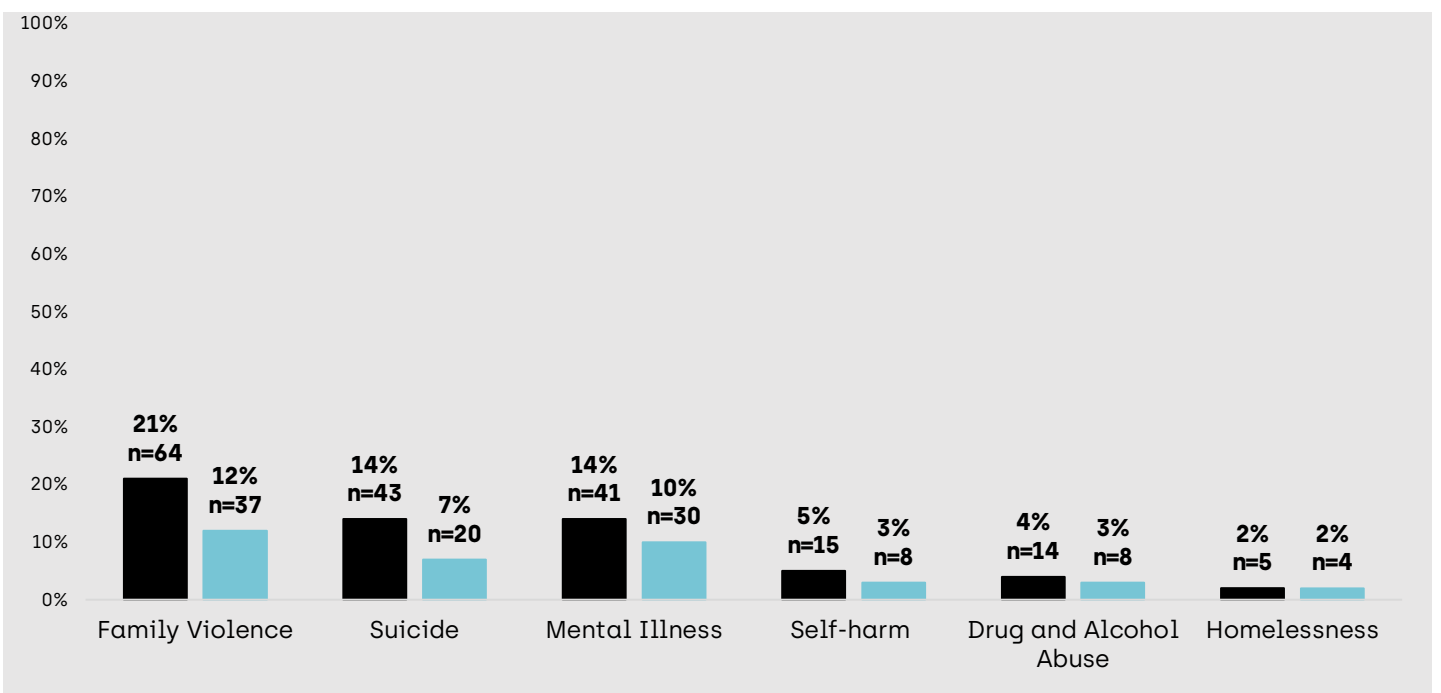
- **Risk alerts** indicate that the person is facing acute risk. Risk alerts were placed on client files when risk levels were likely to cause serious harm. When risk alerts were applied to client files, risk assessments were conducted to aid risk management and safety planning (i.e., safety planning is an actionable aspect of risk management that represents an agreement between a service and client to ensure the client and their family's safety and wellbeing).
- **Risk factors** indicate that circumstances could have reasonably resulted in that risk materialising for clients, or in some cases, where the risk was present but not acute.
- Risk factors and alerts were classified as '**early engagement**' if they presented towards the beginning or during service engagement with DS and were absent at case closure.
- Risk factors and alerts were classified as '**end engagement**' if they presented partway through engagement with DS and/or remained present at the time of case closure.
- One client may have had risk factors and alerts classified as both **early engagement** and **end engagement** if the risks were present throughout the clients' entire service engagement period.

The two charts below depict risk factors and alerts throughout service engagement with DS. This included **early engagement** risk factors and alerts and **end engagement** risk factors and alerts. All percentages are out of the total client file sample (N = 300). As can be seen

below, risk factors and alerts were less apparent at **end engagement** compared to **early engagement**. This indicates that throughout service engagement, overall levels of client risk reduced.



**Figure 22. Risk factors throughout service engagement**



**Figure 23. Risk alerts throughout service engagement**

Across all client files, the **risk factors** that depicted the **greatest change** from early engagement to case closure were:

- Frequent conflict and/or family violence (57% less at case closure)
- Recent stressful event (51% less at case closure)
- Emotional, behavioural, or mental health symptoms (50% less at case closure)

The **risk factors** with the **least change** from early engagement to case closure were:

- Social isolation (31% less at case closure)
- Financial insecurity (30% less at case closure)

These results are unsurprising. While highly important for LGBTIQ+ mental health and wellbeing, it typically takes longer to establish social connectedness and financial wellbeing for clients during service engagement. It is also important to note that the client file sample was drawn from 2016-2022. Given almost all clients resided in metropolitan Melbourne, levels of reduction in **social isolation** were likely impacted by COVID-19 and associated lockdowns in Melbourne. Similar results were also found in a recent report comparing client files prior to COVID-19 with client files during COVID-19, that identified social isolation increased during COVID-19<sup>26</sup>. When auditing client files for this project, it was apparent that COVID-19 restrictions were a barrier for many clients to engage with community.

Levels of change in **financial insecurity** may also have been impacted by the COVID-19 lockdowns. For some clients, COVID-19 lockdowns impacted their employment and financial security, particularly where people may have become unemployed and were ineligible for income support from the government. However, there were also examples of COVID-19 public health measures leading to increased financial security because of additional income support payments made during this time<sup>27</sup>.

Regarding more acute risk presentations, the **greatest change** was apparent in **risk alerts** for:

- Suicide risk (54% less at case closure)
- Self-harm risk (47% less at case closure)

---

<sup>26</sup> McCann, B., Campbell, E., & Carson, R. (2023). *Future-proofing Safety Final Report*. <https://cfre.org.au/wp-content/uploads/2023/09/Future-proofing-Safety-Final-Report.pdf>

<sup>27</sup> Ibid.



- Family violence risk [42% less at case closure]

The **least change** was noted in mental illness [27% less at case closure] and homelessness [20% less at case closure]. Mental illness risk did co-occur with suicide and self-harm risk; however, risk alerts were analysed separately in this instance. Co-occurrences are analysed below (refer to Table 6).

## Discrimination and social isolation

Client files described that clients who were discriminated against commonly expressed loneliness and feelings of isolation. They were excluded from employment, housing, as well as health and social services. They were mocked, bullied, harassed, and violently attacked by family members, friends, intimate partners, housemates, colleagues, employers, health professionals, and acquaintances on the street. Some clients also reported trauma symptoms related to these experiences of discrimination and exclusion. Suicidal ideation was a common theme among clients who experienced discrimination and social isolation.

## Discrimination and financial insecurity

Client files described the compounding nature of discrimination on need related to financial insecurity. Some clients experienced discrimination at work that led to reduced shifts or resignation. Clients looking for employment experienced discrimination that prevented them from obtaining work and compounded their financial insecurity. Some clients were asked inappropriate questions during interviews about their gender. Other clients were ineligible for income support due to their visa status which compounded their need related to financial insecurity, housing instability and isolation.



## Acute risk

A total of 128 clients had a risk alert attached to their file. Among these client files, suicide risk emerged as one of the most common (41%, n = 53), alongside family violence risk (41%, n = 52) followed by mental illness (36%, n = 46). The following table presents risk alerts present at any time during the client's engagement with DS.

**Table 5. Risk alerts in the client file sample**

Risk Alert	n	%
Drug and Alcohol Abuse	16	13%
Mental Illness	46	36%
Self-harm	21	16%
Suicide	53	41%
Family Violence	52	41%
Homelessness	6	5%

These three forms of acute risk are discussed below. When interpreting this information, it is essential that demographic information is *not* taken to indicate risk factors. As made clear in the aforementioned consideration of discrimination and its implications, it is not the case that parts of a person's gender or sexual identity, cultural background or disability status put them at higher risk. Appropriate service and system responses therefore should promote safety and inclusivity for LGBTIQ+ people and all intersecting aspects of their identity.

Among the clients that had a risk alert attached to their file (n=128), over a third (35%, n=45) had two or more risk alerts. To consider **complexity**, individual clients' risk alerts were summed:

- One client experienced five risk alerts.
- Four client files each had four risk alerts.
- 10 client files each had three risk alerts.
- 30 client files each had two risk alerts.
- 83 client files each had one risk alert.

The chart below indicates that acute risk can be complex, and that careful consideration should be given to managing complex risk in which multiple forms of risk can compound one another.



**Figure 24. Number of risk alerts (complexity) among client files**

To demonstrate how risks co-occur for individual LGBTIQ+ clients, the table below presents the most frequent **co-occurring forms of acute risk**. Risk alerts are presented in the first row and column of the table, and the number of times that they co-occurred is demonstrated by the numbers in the matrix. The numbers represent how many client files indicated the co-occurrence of the two risk alerts. For example, suicide risk alerts co-occurred with family violence risk alerts in 18 client files, which represents 14% of client files with a risk alert (n=128).



**Table 6. Co-occurring risk alerts among client files**

Risk Alert	Homelessness	AOD	Mental Illness	Self-Harm	Suicide	Family Violence
Homelessness	0	0	1	1	2 [2%]	2 [2%]
AOD	0	0	6 [5%]	2 [2%]	4 [3%]	4 [3%]
Mental Illness	1	6 [5%]	0	8 [6%]	20 [16%]	8 [6%]
Self-harm	1	2 [2%]	8 [6%]	0	12 [9%]	6 [5%]
Suicide	2 [2%]	4 [3%]	20 [16%]	12 [9%]	0	18 [14%]
Family Violence	2 [2%]	4 [3%]	8 [6%]	6 [5%]	18 [14%]	0

**Qualitative analysis** of client files contextualised how risks co-occur, intersect, and compound each other. There was a notable intersection of experiences of family violence and suicidality. Client files described that experiences of family violence were linked to suicide risk because they were isolating and traumatising. Clients reported that their experiences of not being able to express their true self in front of family members were related to mental health issues and suicidality.

## Suicide risk

Suicide risk alerts were applied when case notes specified that a client either made a suicide attempt or expressed serious intent and/or means to do so. There were 53 total clients who had a suicide risk alert attached to their file, which comprises 18% of the total sample (N = 300).

When considering the gender identities of those with suicide risk alerts, 53% (n=28) were cisgender, and 45% (n=24) were transgender and/or gender diverse. One person did not specify their gender. These findings show marked over representation of gender diverse people among those facing acute suicide risk.

**Table 7. Suicide risk alerts by gender among client files**

Gender	n	%
Cisgender	28	53%
Transgender and/or gender diverse	24	45%

Client files provided further descriptions of the impacts of **discrimination** upon the mental health of **transgender clients** and at times this was explicitly linked to **suicide risk** in case notes. Clients described multiple instances of discrimination in public, at work, and within family that increased their suicidal ideation.

It is important to consider the implications of people's socio-economic position when considering possible contributing factors to acute suicide risk presentations. While the DS client record management system did not record income and financial data, inferences can be made based on descriptive employment data, rates of receiving income support and experiences of homelessness. Out of the 53 clients with suicide risk alerts, a quarter [25%, n = 13] were formally recorded as receiving Centrelink payments, and almost half [47%, n = 25] listed their main source of income as 'government'. Two clients with suicide risk alerts were formally recorded as experiencing homelessness and an additional two were at risk of homelessness. Employment data was only available for 30 clients who had suicide risk alerts. Out of these 30, 50% [n = 15] were unemployed, 20% [n = 6] were employed (including full time, salaried, or unspecified) 17% [n = 5] were employed casually or part time, two were self-employed, and two were studying full time [7% each, or n=2].

**Among client files with a suicide risk alert (n=53)**, clients also had up to seven risk factors present. Risk factors present in client files with a suicide risk alert are presented in the table below. Of the client files with a suicide risk alert:

- 89% [n=47] had two or more risk factors
- 66% [n=35] had three or more risk factors
- 34% [n=19] had four or more risk factors
- 25% [n=13] had five or more risk factors

**Table 8. Risk factors by suicide risk among client files**

Risk factors by suicide risk alert	n	%
Emotional, behavioural, and mental health symptoms	44	83%
Recent stressful event	43	81%
Frequent conflict and/or family violence	25	47%
Social isolation	21	40%
Financial insecurity	17	32%
Substance abuse	11	21%
Homelessness	11	21%

To provide context, client files described several merging circumstances that led to clients then experiencing suicidal ideation. There were often multiple co-occurring risks present for clients that then led to increases in their suicidality. These risks compounded and influenced each other. For example, some clients experienced cumulative stress from family violence and conflicts at home that influenced housing instability and financial stress. Social isolation often increased when clients were experiencing family violence or leaving a family violence situation. Some clients experienced mental health crises in response to cumulative stress and some used self-harm to cope with the stress. Mental health crises sometimes led to increased safety issues when clients were discharged early from the psychiatric ward and had no accommodation. Some clients had to move back into the home where they experienced family violence, and this was often a vicious cycle.

## Mental illness

Mental illness risk alerts were applied when case notes specified that a client experienced an acute episode of severe mental illness that may have led to psychiatric triage, assessment, and care. There were 46 total clients who had a mental illness risk alert attached to their file, which comprises 15% of the total sample (N = 300).

Thirty percent (30%, n=14) had a disability, 54% (n=25) had a chronic illness, and 11% (n=5) were neurodivergent. Notably, of the client files with a mental illness risk alert, 41% (n=19) had trauma symptoms. These **proportions are higher** than the total client file sample, which was 21% with disability, 29% with chronic illness, and 14% with trauma symptoms. These findings provide evidence for the importance of recognising **co-occurring experiences of disability, chronic illness, and trauma** with **acute mental illness risk** presentations among LGBTIQ+ clients.

Twenty-eight percent (28%, n=13) were unemployed, and 61% (n=28) indicated that their main source of income was from Centrelink payments or other income support from the government. **Higher proportions** of unemployment and recipients of income support compared to the overall sample, which were 17% unemployed and 25% receiving income support indicated the **co-occurrence of unemployment and lower socio-economic status with mental illness acute risk**.

**Among client files with a mental illness risk alert (n=46)**, clients also had up to six risk factors present. Risk factors present in client files with a mental illness risk alert are presented in the table below. Of the client files with a mental illness risk alert:

- 73% (n=33) had two or more risk factors
- 42% (n=19) had three or more risk factors
- 30% (n=14) had four or more risk factors
- 13% (n = 6) had five or more risk factors

**Table 9. Risk factors by mental illness among client files**

Risk factors by mental illness risk alert	n	%
Recent stressful event	33	72%
Emotional, behavioural, and mental health symptoms	31	67%
Social isolation	16	35%
Frequent conflict and/or family violence	13	28%
Financial insecurity	10	22%
Substance abuse	9	20%
Homelessness	3	7%

Further context was described within client files regarding the impact of discrimination on help-seeking behaviours when clients experienced mental illness. Clients experienced systemic discrimination within acute mental health settings after involuntary admission and during psychiatric triage and assessment. For example, one client was misdiagnosed after an involuntary admission and they (the client) linked this to transphobia from within clinical settings, including amongst healthcare professionals. Another client file described a client avoiding contacting crisis lines even during a mental health episode because of previous experiences of racism and homophobia from within psychiatric clinical settings.

## Family violence risk

Family violence risk alerts were applied when there was current family violence that required risk management and safety planning. There were 52 total clients who had a family violence risk alert attached to their file, which comprises 17% of the total sample (N = 300).

Among client files with a family violence risk alert (n=52), clients also had up to six risk factors present. Risk factors recorded in client files with a family violence risk alert are presented in the table below. Of the client files with a family violence risk alert:

- 87% (n=45) had two or more risk factors
- 69% (n=36) had three or more risk factors
- 44% (n=23) had four or more risk factors
- 25% (n=13) had five or more risk factors

**Table 10. Risk factors by family violence risk among client files**

Risk factors by family violence risk alert	n	%
Recent stressful event	43	83%
Frequent conflict and/or family violence	43	83%
Emotional, behavioural, and mental health symptoms	29	56%
Social isolation	16	31%
Financial insecurity	14	27%
Homelessness	11	21%
Substance abuse	10	19%

## Needs and risks across cohorts

There were three consistent and prominent cohorts in the client file analysis, that were selected to form case studies. These case studies demonstrate similarities and differences across cohorts in presenting needs and risks during service engagement. There was overlap across cohorts in terms of identities and experiences however, each cohort was separated based on a different aspect of their identity, and this produced understanding of the different needs, risks, and service experiences of each cohort. The three client journeys that were developed included:



- **Client group 1:** Aged 18 – 25 years and trans, non-binary, genderqueer, or questioning (n=33)
- **Client group 2:** Aged 18 – 57 years and from multicultural backgrounds and lesbian, gay, bisexual/multi-gender attracted and/or questioning sexuality (n=35)
- **Client group 3:** Aged 30 – 57 years and living with disability (n=42)

All client groups were on the waitlist for an average of 7 to 8 weeks and attended 15 to 18 sessions across 42 to 50 weeks. All client groups experienced similar rates of risk alerts attributed to mental illness, suicide, and family violence, though clients living with disability did experience a notably higher number of family violence and suicide risk alerts.

**Table 11. Risk alerts across sub-cohorts of clients**

Risk Alert	Young and TGD	Multicultural LGB	LGBTIQ+ Disability
Family violence	17% (n = 6)	14% (n = 5)	29% (n = 12)
Suicide	12% (n = 4)	14% (n = 5)	21% (n = 9)
Mental illness	21% (n = 7)	17% (n = 6)	17% (n = 7)

All client groups also experienced high levels of need related to mental health, trauma, stress, financial issues, and community participation.

**Table 12. Presenting needs across sub-cohorts of clients**

Presenting need	Young and TGD	Multicultural LGB	LGBTIQ+ Disability
Mental health	79% (n=26)	86% (n=30)	90% (n=38)
Trauma	51% (n=17)	66% (n=23)	67% (n=28)
Stress	48% (n=16)	57% (n=20)	64% (n=27)
Community participation	39% (n=13)	46% (n=16)	48% (n=20)
Financial issues	27% (n=9)	37% (n=13)	45% (n=19)

However, there were also differences across cohorts related to other needs and risks. These differences are outlined below.

## Young TGD clients

Compared to other cohorts, young TGD clients more commonly presented with need related to gender, self-harm, and employment.

**Table 13. Presenting needs and risk factors among young TGD clients**

Need or Risk	Presenting need (N)/risk factor (RF)	Young TGD
<b>Gender</b>	<b>N</b>	<b>58% (n = 19)</b>
<b>Self-harm</b>	<b>N</b>	<b>21% (n = 7)</b>
Substance abuse	RF	15% (n = 5)
<b>Employment</b>	<b>N</b>	<b>21% (n = 7)</b>
Homelessness	R	21% (n = 7)
Housing	N	24% (n = 8)

## Multicultural LGB clients

Clients with multicultural backgrounds more commonly presented with need related to family relationships, sexuality, and housing. Across the three cohorts, clients with culturally diverse backgrounds experienced the highest proportion of risk attributed to frequent conflict and/or family violence [40%]. However, upon case closure, these clients had the lowest proportion of risk attributed to frequent conflict and/or family violence [9%].

**Table 14. Presenting needs and risk factors among multicultural LGB clients**

Need or Risk	Presenting need (N)/risk factor (RF)	Multicultural LGB
<b>Family relationship issues</b>	<b>N</b>	<b>51% (n = 20)</b>
<b>Sexuality</b>	<b>N</b>	<b>31% (n = 11)</b>
<b>Housing</b>	<b>N</b>	<b>40% (n = 14)</b>
Homelessness	RF	26% (n = 9)
Material wellbeing	N	34% (n = 11)
Financial insecurity	RF	37% (n = 13)

## LGBTIQA+ clients with disability

Clients with disability had high presenting needs related to physical health, childhood abuse, and risk of social isolation. Among all risk factors experienced by clients living with disability, social isolation was present for 50% of client files upon engagement with DS.

Other cohorts did not experience social isolation as a risk factor to the extent experienced among clients living with disability. Social isolation also remained present for 43% of clients with disability upon case closure.

**Table 15. Presenting needs and risk factors among LGBTIQA+ clients with disability**

Need or Risk	Presenting need (N)/risk factor (RF)	LGBTIQA+ with Disability
<b>Physical health</b>	<b>N</b>	<b>26% (n = 11)</b>
Personal and family safety	RF	24% (n = 10)
Family relationship issues	N	33% (n = 14)
<b>Childhood abuse</b>	<b>N</b>	<b>29% (n = 12)</b>
Financial insecurity	RF	26% (n = 11)
<b>Social isolation</b>	<b>RF</b>	<b>50% (n = 21)</b>

The differences across cohorts in presenting needs and risks are important to understand how to tailor and target services to respond effectively to young trans and gender diverse individuals, LGB multicultural individuals, and LGBTIQA+ individuals with disability. It also highlights the need for service systems to effectively respond to complex and different needs across cohorts.

## Concluding points: Needs, risks, and complexity

Overall, this finding showed that complex and co-occurring needs and risk were inseparable, interconnected and influenced each other. This was especially evident across need and risk related to suicide, family violence, financial insecurity and social isolation. This finding also emphasised the interconnected nature of discrimination and isolation across multiple contexts and settings, including within healthcare settings, in public, within family, and at work. The survey and client file audit identified:

- High rates of loneliness among LGBTIQ+ survey respondents, especially young LGBTIQ+ individuals, trans and gender diverse individuals, and people with disability.
- Financial stress was prevalent and was associated with lower overall wellbeing as well as higher levels of loneliness, especially among trans and gender diverse individuals and those living with disability.
- Mental health-related needs are often intertwined with other forms of need, further emphasising the intricate nature of client presentations.
- Highlighting the complexity of presenting needs, 87% of LGBTIQ+ clients presented with five or more needs, and 44% presented with nine or more needs.
- Complexity of risk was evident in 35% of clients experiencing two or more risk alerts.
- Suicide risk and mental illness frequently co-occurred with family violence risk and homelessness.
- Family violence and suicidality were common co-occurring risks that are also often interconnected with need related to safety, housing, material wellbeing, substance abuse, trauma, self-harm, employment, and community connection.
- Young trans and gender diverse clients, LGB multicultural clients, and LGBTIQ+ clients with disability all experienced high levels of need related to mental health, trauma, stress, financial issues, and community connection. However, there were important differences in presenting needs and risk factors across these sub-cohorts.

The complexity of needs and risks experienced by LGBTIQ+ people, in part, reflects the discrimination they experience that either directly impacts their mental health and wellbeing, or prevents access to services and support.

# Principles for effective service responses

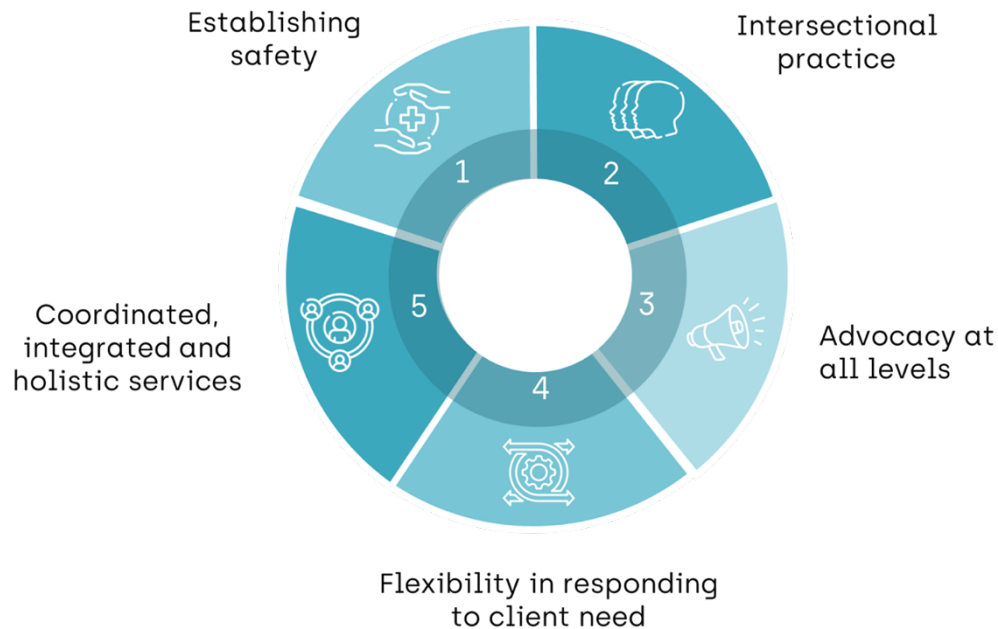
This section integrates key findings from the survey and client file analysis into Five Principles to support the mental health and wellbeing of LGBTIQ+ Victorians. The principles are aligned with the Royal Commission's findings and recommendations. They bolster and extend these recommendations where possible by providing further considerations for government.

While this research looked specifically at the needs of LGBTIQ+ communities, the considerations take an intersectional framing to consider the broad and intersectional needs of other marginalised communities and groups. The principles ask us to consider the need to:

- establish safety for marginalised groups
- bolster intersectional practice across the entire mental health service system
- advocate at all levels of our social ecology for the needs of marginalised groups, including across the umbrella of diverse LGBTIQ+ communities
- respond flexibly to diverse and cooccurring client or consumer needs
- provide coordinated, integrated and holistic mental health services



This section will outline the principles in more detail to identify how they can support and bolster the current mental health system reforms.



**Figure 25. Five principles for effective service responses**

## 1. Establishing safety

Establishing safety is a foundational need to be prioritised in service provision. It forms a key part of any trauma-informed and person-centred approach. Physical and emotional safety are the foundation upon which trust can be built within therapeutic relationships<sup>28</sup>. Part of establishing safety is recognising that people's interactions with services are impacted significantly by experiences of discrimination.

### What survey respondents said

LGBTIQ+ survey respondents identified that services were helpful when they fostered safety and provided good support when people felt their identities were affirmed and accepted.

<sup>28</sup> Sweeney, Angela, Beth Filson, Angela Kennedy, Lucie Collinson, and Steve Gillard. "A Paradigm Shift: Relationships in Trauma-Informed Mental Health Services." *BJPsych Advances* 24, no. 5 [September 2018]: 319–33. <https://doi.org/10.1192/bja.2018.29>.

Respondents described positive experiences within the service system as:

- Creating a sense of safety.
- Accommodating, accepting and respectful of identities.
- Non-judgemental- they did not make assumptions around gender or sexuality.
- Providing trauma-informed and person-centred care.

Respondents also described experiences where they did not feel safe, including:

- Discrimination or fear of discrimination, as well as poor knowledge from service providers about disabilities, gender, sexuality etc. This was mostly observed in medical settings and resulted in individuals avoiding the setting or receiving inadequate care.

## **Learnings from DS service response**

The client file analysis produced findings relating to client safety which illuminated the ways in which people first accessed the service, as well as the types of support they received. Client files indicated that:

- The most common referral source was self-referral (35%), followed by referrals from family or friends (15%). Many clients and external services perceived DS as a safe and inclusive service, and this was one of the reasons, if not the main reason, for self-referral, or for referring a friend or family member.
- DS' service response was accepting and accommodating of clients that were questioning and exploring gender and/or sexuality, which involved discussing related issues with clients openly and respectfully across multiple dimensions of clients' identity including disability, faith, and ethnicity.
- DS' response often involved establishing safety and stability for clients, including meeting immediate and basic needs, and then connecting clients with external and more specific supports (e.g., counsellors specialising in neurodivergence, or counsellors who are representative of community).

The client file audit also identified many system level barriers that impacted the safety of clients within the broader service system, including inadequate service responses, often linked to services lacking capacity and expertise in responding to the intersectional needs of LGBTIQ+ people. There were other examples of overt identity-based discrimination within services. Inadequate service responses were evident across several service systems including AOD, housing, family violence, law enforcement and medical/clinical services. Inadequate service responses often entailed services not

following through with promised support, providing unsafe support or wellbeing options (including in relation to unsafe housing) and not providing flexibility in service responses (including in the provision of outreach services). This often led to the client's disengagement with the service or disengage from the service system more broadly.

## Links to Royal Commission

There were a number of findings from the Royal Commission which related to the key theme of Establishing Safety. They have been grouped into the following key areas:

- Reducing stigma and discrimination
- Improving workforce capabilities
- Improving service access

Each area relating to safety will be described in more detail below.

### Reducing stigma and discrimination

The Royal Commission made a number of key recommendations to reduce stigma and discrimination, including [Recommendation 16](#) to promote good mental health in workplaces, free from stigma and discrimination and to support people experiencing mental illness at work. Meanwhile, [Recommendation 41](#) advocated for ways to address stigma and discrimination related to mental illness and psychological distress, through anti-stigma programs and support for community-led organisations to design and deliver such programs.

While reducing stigma and discrimination is critical, it is imperative to focus on intersectional identity-based discrimination, in addition to mental health stigma and discrimination. As this research highlights, over 60% of 861<sup>29</sup> survey respondents had experienced a form of discrimination in the past five years either at work, in public or within family. Around half of respondents had experienced discrimination within healthcare settings and even from within the LGBTIQ+ community.

### Improving workforce capabilities

The Royal Commission recommended a range of structural workforce reforms to attract, train and transition the staff needed for Victoria's mental health services, including in non-government organisations, community services, and Local, Area and Statewide Mental

---

<sup>29</sup> All survey questions were voluntary, a total of 861 respondents answered the discrimination questions.



Health and Wellbeing Services. [Recommendation 57](#) and [Recommendation 58](#) focus on workforce strategy, planning and structural reforms for a diverse, multidisciplinary workforces; including through the development of a workforce capabilities framework. The [Our workforce, our future: A capability framework for Victoria's mental health and wellbeing workforce](#) includes detail to support different roles within the diverse and multidisciplinary mental health and wellbeing workforce. Meanwhile, [Recommendation 59](#) focuses on oversight, monitoring and support for professional wellbeing, including in relation to lived experience roles.

While the reforms related to workforce capability set up some solid foundations, it is imperative that intersectional approaches sit at the heart of their implementation—considering the ways that intersectional, inclusive and affirming practice can be built in at all levels of the service system, e.g., it is not enough to simply have peer workers but also to consider how their expertise and experience is drawn on and valued within a service. To do this, there is a need to build the capabilities of the whole workforce to consider the role of intersectionality and intersectional practice. There is also a need to continue to fund specialist services that feel like safe entry points into the system for marginalised people, who may have been treated poorly by service systems.

## Improving service access

The Royal Commission acknowledged that the mental health system was complex and fragmented. [Recommendation 6](#) and [Recommendation 7](#) outline key steps to enable better support, including the use of localised and lower intensity services to enable acute services to be better target those most in need. The recommendations look at easier referral pathways into the system, in addition to improved links and connections throughout the system to support people to find the right care for them through triage, access and navigation support.

A large number of recommendations in the Royal Commission centre the role of lived experience within the leadership, design and delivery of reforms. [Recommendation 28](#) focuses on the development of system-wide roles and [Recommendation 29](#) outlines a new non-government agency led by people with lived experience, tasked with delivering accredited training, developing resources and providing collaborative networks between people with lived experience.

There are also specific recommendations specifically designed to support LGBTIQ+ community members, including [Recommendation 9](#)—the codesign of Safe Spaces with young people, [Recommendation 27](#)—the codesign of an aftercare service with and for LGBTIQ+ people, and [Recommendation 34](#)—responding to diverse communities. Key to each of these

reforms will be the application of an intersectional lens to consider the needs of diverse and intersectional LGBTIQ+ community members.

## Considerations

- 1. Government should consider the links between stigma, discrimination and poor mental health and wellbeing.** It is critical that any work carried out in relation to addressing stigma and discrimination of mental health should also address identity-based discrimination. As this research highlights, discrimination is prevalent among LGBTIQ+ individuals in Australia across public, private, and professional settings, as well as in larger institutional settings or in healthcare. Addressing this discrimination will be key to enhancing the mental health and wellbeing of marginalised communities.
- 2. Government should support building the capabilities of the whole workforce to develop intersectional practice.** The workforce capability framework should look beyond multidisciplinary practice to create a mental health system where clinical knowledge can be braided together with cultural knowledge, identity knowledge and lived experience to support a transdisciplinary approach.
- 3. Government should consider the intersectional and compounding needs of diverse communities** across all areas of the mental health reforms. While there is a need for specialist responses, as outlined by recommendations relating to 'diverse communities', it is imperative that all services across the mental health system can provide affirming and inclusive support. Within this research, people found value in having their whole self recognised. They highlighted service limitations when parts of the service system were not inclusive or affirming of their identity.


## 2. Intersectional practice

Intersectional practice involves understanding that individuals exist with multiple aspects of identity and experiences that cannot be separated into cohorts. This includes affirmation of all parts of a person's identity and being educated about the impacts of intersecting and compounding forms of discrimination on mental health and wellbeing. A holistic approach is required at multiple levels to create a top-down authorising environment within services, as well as bottom-up action from workers, clients, and the community.

## What survey respondents found helpful:

Survey respondents highlighted that both mainstream and identity-specific services were helpful for LGBTIQ+ people when they:

- Affirmed identity
- Listened and were open to learning about identities and expressed empathy and understanding
- Had visible signs of inclusion (e.g., rainbow flags)
- Had practitioner(s) which came from a place of understanding (lived experience, cultural knowledge, identity knowledge)
- Had practitioners who were well informed of LGBTIQ+ perspectives so clients did not need to explain their identity
- Had practitioners who were informed of issues relating to identity
- Were knowledgeable of LGBTIQ+ useful resources.



“My therapist is trans and has helped me greatly. They are the first therapist I’ve had who I feel completely safe with and who has helped me the most. They acknowledge and engage with the intersecting parts of my identity even ones that they don’t have lived experience with” [survey respondent].

## Learnings from DS service response:

Client files indicated that DS’ reputation, strong community connections and networks with services and organisations that are safe and inclusive for LGBTIQ+ people facilitated intersectional practice. LGBTIQ+ clients and external agencies that refer clients to DS,

trust DS to not only be safe and inclusive as an organisation itself, but also to link clients with other services that are known to be safe and inclusive. The files highlighted the myriad ways that DS’ Queerspace practitioners assisted clients to navigate the service system, especially when they were hesitant to access specialist services for fear of discrimination and/or (prior) inadequate service interactions. Examples of intersectional practice based on client files include:

- Providing identity-affirming counselling.
- Elevating diverse and marginalised voices across all levels of the service.
- Practitioners drawing on their own cultural, identity, and lived experience knowledge, where safe and appropriate to do so.
- Developing scripts for sharing sexuality and/or gender with family members (if the client wanted to share with family members).
- Providing individual mental health and wellbeing support that considered people's whole self, their context, and relationships, including with other people, communities, organisations, and systems.

## Links to Royal Commission

The Royal Commission called for a 'safe, responsive and inclusive' mental health and wellbeing system to meet the needs of Victoria's diverse populations. Recommendation 34 in particular, recognised that this would entail a whole-of-system effort through the coordination of funding, commissioning, design and delivery of services. Particular target cohorts included:

- LGBTIQ+ Victorians
- Victorians from culturally and linguistically diverse backgrounds
- Victorians with disability.



While there is a need to think about and support the distinct needs of each of these diverse cohorts and communities, fundamental is the need to consider where these communities overlap and what the service system can do to respond in an intersectional way to marginalisation and its impacts.

The findings from this report highlight the profound impact that discrimination has on people's health and wellbeing needs. Intersectional discrimination was common amongst respondents, with 75% (n = 649) of the total sample reporting that they had experienced more than one type of discrimination and 37% of individuals (n = 314) reporting that they had experienced four or more types of discrimination. Intersectional discrimination was associated with poorer mental health and wellbeing, increased loneliness, and greater financial stress.

## Considerations

- 4. Government should consider the need for intersectional approaches when commissioning services.** To create a 'safe, responsive and inclusive' system it is imperative that intersectional identities and factors are considered across the mental health system reforms. As this research demonstrates, it is not simply enough to add cohort specific considerations but rather, services throughout the mental health service system should consider the complex and compounding impacts of discrimination on a person.
- 5. Services should consider how they will elevate lived experience, cultural knowledge and identity knowledge.** This includes adequately supporting and supervising lived experience staff, helping staff to challenge their own assumptions, and establishing safety and accountability to engage with diverse communities.

## 3. Advocacy at all levels

Advocacy involves an understanding of inequities and gaps in services, especially for LGBTIQ+ people who experience cumulative and intersecting forms of discrimination. It requires the skills to challenge and dismantle systemic barriers to advocate for clients, as well as enable clients to advocate for themselves. Advocacy strives to reshape the landscape of services, making them more inclusive, affirming, and equitable.

### What survey respondents said

Survey respondents identified that services were helpful when they:

- Provided connection to another LGBTIQ+ service delivering mental health support.

- Considered context within service response.

Importantly, the survey found that experiences of discrimination were pervasive across multiple settings for LGBTIQ+ communities. Discrimination, especially cumulative and intersecting discrimination, negatively impacted mental health, as well as increased financial stress and loneliness. Advocacy is essential for effective service responses to LGBTIQ+ mental health and wellbeing needs, as experiences of discrimination within healthcare settings are often linked to poor help-seeking behaviours and create barriers to accessing support services<sup>30</sup>.

## **Learnings from DS service response**

Client files demonstrated the importance of purposeful advocacy that was guided by, and responsive to, the needs of clients as they arose. DS' service responses included advocating for clients in the face of structural and systemic barriers. Examples of purposeful advocacy based on client files included:

- Openly listening to clients to understand their perspective and barriers to service access.
- Providing support letters for clients to access services, resources, mitigate financial issues (e.g., debt), access income support, visa applications and legal matters.
- Advocating for more subsidised sessions under a Mental Health Care Plan.
- Advocating for access to Hormone Replacement Therapy or gender-affirming treatment.
- Providing counselling around the negative impacts on mental health and wellbeing that come from people not being free to express themselves as they are (negative reactions from family, employers, health services, and discrimination in general, based on being LGBTIQ+).
- Linking clients with safe and inclusive support services and events.

---

<sup>30</sup> Carman, Marina, Shoshana Rosenberg, Adam Bourne, and Matthew Parsons. "Research Matters: Why Do We Need LGBTIQ-Inclusive Services? A Fact Sheet by Rainbow Health Victoria," 2020.

## Links to Royal Commission

Several of the recommendations from the Royal Commission acknowledge that advocacy is crucial for system reform, including [Recommendation 41](#) which recognises that in order to address systemic discrimination, advocacy is essential. [Recommendation 6](#) and [Recommendation 7](#) focus on helping people find and access treatment, care and support. Importantly, [Recommendation 29](#) emphasises that lived experience workforces are essential to systemic advocacy, and [Recommendation 34](#) identifies the need for community-led organisations to support communities to navigate the mental health system.

## Considerations

- 6. LGBTIQ+ inclusive training and capacity building should be expanded to increase the cultural competency of services** in providing services to LGBTIQ+ people in responsive and affirming ways. This training should centre intersectional practice at its core, considering the need for affirming and inclusive practice that considers the whole person within their context and relationships.
- 7. Government and services should advocate with and for marginalised communities.** This is particularly important when reflecting on the findings of this report, which highlight the pervasive nature of discrimination on the mental health and wellbeing outcomes of marginalised groups across systems, structures and society.



## 4. Flexibility in responding to client need

Flexible service provision incorporates intersectional practice whilst being responsive to the needs of LGBTIQ+ people. It involves being responsive to client need and taking a human-rights and person-centred approach to support all factors contributing to health and wellbeing, such as material wellbeing and community connection.

### What survey respondents said:

The survey found that LGBTIQ+ people experienced lower wellbeing related to higher financial stress, higher loneliness, and greater need related to family violence risk. This indicates that responding to need related to mental health and wellbeing should consider financial wellbeing, social connectedness, and any related risks. Survey respondents identified that services were helpful when they were responsive and flexible to need.

“...it is helpful because I do not worry about having to explain/prove myself, they are responsive and flexible to my needs and they understand, respect and even celebrate my relationship.”

### Learnings from DS service response:

Flexible service provision at DS was demonstrated in several ways across client files and was a defining feature of DS' service response. It was clear that flexible service provision took a human rights-based and social justice approach that enabled practitioners to navigate and advocate for clients in the face of structural and systemic barriers. Flexible service provision meant being responsive to needs interconnected with mental health, including material need and community connection.

Examples of flexible service provision based on client files include:

- Providing material support in the form of emergency relief vouchers, food and groceries delivery, brokerage for rent, appliances, and other goods to improve safety and wellbeing (e.g., headphones to prevent person using violence from overhearing phone calls).
- Writing templates to apply for rent reduction and rent support schemes, support to access superannuation, referrals to employment agencies and support groups, and referral to free financial counselling and advice.



- Internally referring clients to another program or service within DS when sessions were completed and the client required further support.
- Providing outreach services to improve accessibility and reach certain cohorts of clients that may be experiencing higher levels of risk.
- Providing support to the client's family members.
- Proactive and assertive engagement if clients disengaged or did not respond to contact from DS. Sometimes DS practitioners would leave the case open for a few weeks (usually if higher risk) to prevent the client needing to return to the waitlist.
- Re-opening client files for previous clients if they presented with heightened risk to avoid clients having to retell their stories or face waitlists.

**Eligibility requirements** were a systemic barrier described among client files that prevented clients from accessing support they needed and excluded clients from services. Eligibility requirements often did not acknowledge complexity of need and co-occurring risks, which inevitably had a negative impact on client's safety and wellbeing.

## Links to Royal Commission

The need for flexible service responses to multiple, interconnected needs were emphasised in the findings from this report and build on recommendations from the Royal Commission. In particular, [Recommendation 3](#) which outlines key reform areas to create a more responsive and integrated mental health and wellbeing system.

While reforms outlined in Recommendation 3 lay the groundwork for an enhanced service system and improved service access across the state, as highlighted by the client file audit, Government should consider the need for flexibility and responsiveness within services, including considering a hierarchy of needs.

## Considerations for services

The following considerations for services are provided for implementation of this principle:

- 8. Government supports flexibility in commissioning processes to enable services to respond to client needs**, upholding a hierarchy of needs in the support of mental health.

## 5. Coordinated and integrated services

Coordinated and integrated service responses are inherently holistic. This includes within a service and across services and service systems. The integration of wrap-around supports across services is an essential element of working in coordinated ways across service systems. A holistic lens enhances coordination and integration especially if all services utilise this approach when responding to need and risk. Working in coordinated and integrated ways involves:

- Developing strategic partnerships and referral pathways to respond to complexity.
- Responding holistically to a range of needs, including risks and needs related to AOD use, family violence, housing/homelessness, financial insecurity, social isolation, and discrimination.
- Holding risk with a holistic lens that integrates safety planning and risk management across what may typically be assessed in isolation. The findings from this report show that family violence, mental illness and suicidality are common co-occurring risks and should be considered as interconnected and influencing each other when assessing risk and safety planning with LGBTIQ+ clients.

### What survey respondents said

While the survey highlighted that LGBTIQ+ people had high levels of help-seeking behaviour, LGBTIQ+ survey respondents also identified several barriers that prevented them from accessing services to support across a broad range of health and wellbeing needs. Survey respondents described:

- Difficulty accessing services as a neurodivergent person
- Low motivation or self-esteem due to mental health, e.g., 'feeling burdensome'
- Difficulty finding services to meet their needs

Survey respondents found it helpful when:

- Services were able to help them access the external supports they needed.

### Learnings from DS service response

Client files described several examples of coordinated and integrated service responses for LGBTIQ+ clients, including:

- Supporting clients across multiple aspects of their lives including employment, education, housing, relationships, finances, community participation and gender, as well as individual mental health and wellbeing.
- Linking clients with health and support services known to be safe and inclusive, such as queer refugee support groups, legal support for family violence and visa applications, First Nations-specific support services, parenting support groups, as well as employment support and housing support services.
- Case conferences with external services to coordinate care provided across the service system.
- Warmly referring clients to services.
- Supporting clients to attend services including medical, clinical, legal and police.
- Organising sessions with external service providers or professionals to support clients to connect with the service.
- Safety planning for family violence or suicidality that considered co-occurring risks, needs and holistic approaches to safety.

**Service resource strain** was a systemic barrier that was particularly impactful on client experiences. This included the cessation of funding and lengthy waitlists. Limitations on services were linked to experiences of disruption and disengagement and sit at odds with continuity of care models and wrap-around service support.

## Links to Royal Commission

The Royal Commission called for improved service coordination and integration. [Recommendation 3](#) in particular, calls for a responsive and integrated mental health and wellbeing system. [Recommendation 46](#) specifies governance structures enabling coordination and collaboration within Government, while [Recommendation 2](#), [Recommendation 4](#) and [Recommendation 14](#) focus on governance arrangements to support and promote mental health and wellbeing, including integrated regional governance and mental health consultation liaison services.

A number of recommendations emphasised the importance mental health services working alongside other services ([Recommendation 50](#), [Recommendation 51](#)); a focus on the intersection of AOD misuse and mental ill-health ([Recommendation 35](#), [Recommendation 36](#)) and the importance of housing ([Recommendation 25](#)). The integration with additional service systems such as family violence is less emphasised.

While the integration of systems and services is critical to a responsive service system, it is important to link this coordination to the other principles outlined in this report, including establishing safety, intersectional practice, strong advocacy and flexible service responses to diverse and cooccurring needs. As this research highlights, client files described several examples of coordinated and integrated service responses for LGBTIQ+ clients that affirmed the whole person, provided support across multiple aspects of their lives, linked clients with health and support services known to be safe and inclusive, and strongly advocated for the rights of their clients within other services and systems.

## Considerations

- 9. Government should consider extending funding to specialist LGBTIQ+ services.** While the mental health reforms seek to improve the service system and service responses, the Royal Commission and this research highlight high levels of intersectional identity-based discrimination experienced by LGBTIQ+ communities. Reforming the system will take time. In the meantime, it is critical to support, through funding and commissioning processes, specialist LGBTIQ+ services to provide wrap around and coordinated mental health support. This should be considered across metropolitan, regional and rural areas.
- 10. Government should consider further collaboration and integration of family violence and mental health services and support.** This is particularly important for marginalised cohorts, who may experience family violence at higher rates because of their identity. This is particularly important in the design and delivery of suicide prevention and aftercare services, where strong links relating to cooccurring need were emphasised.

## Conclusion

Overall, the findings from the LGBTIQ+ Mental Health and Wellbeing Project shed a glaring light on the pervasiveness of experiences of discrimination among LGBTIQ+ communities across multiple aspects of their lives, that are associated with lower mental health and wellbeing, including financial wellbeing and social connectedness. Intersectional discrimination was associated with even lower mental health and wellbeing. Further, the complex and co-occurring nature of needs and risks were further compounded by experiences of discrimination, especially for marginalised sub-cohorts of LGBTIQ+ communities. Isolation was particularly important and often interconnected with multiple, co-occurring and complex needs and risk including financial insecurity, mental illness, suicidality and experiences of family violence.

These findings call for preventative efforts to address broader societal discrimination, in all its forms (e.g., homophobia, biphobia, transphobia, racism, sexism, and ableism). They also call for a reframing and shifting of the burden of alleviating 'minority stress' from the LGBTIQ+ individual onto society, structures and systems. Alongside this should be the recognition that identity is intersectional, and experiences of discrimination are just as relevant as experiences of affirmation. LGBTIQ+ communities and other diverse communities are resilient, and their identity does not have to mean that they face exclusion and discrimination. Instead, their identity can and should be a source of celebration and connection.

To support services to effectively respond to the needs of LGBTIQ+ people, five principles were developed indicating:

- Effective service responses involve establishing safety.
- Adopting an intersectional approach to practice
- Advocating for clients within services systems.
- Being flexible and responsive in the provision of services.
- Working in coordinated and integrated ways to support holistic wellbeing.

In the face of systemic challenges, it is crucial to consider broader system changes that are required to support effective service responses. Considerations for services and government should work in tandem to create the enabling conditions for substantive and sustainable change which works towards more impactfully supporting LGBTIQ+ communities' mental health and wellbeing.



## References

- Australian Bureau of Statistics [ABS]. (2023). *Aboriginal and Torres Strait Islander Peoples*. <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples#:~:text=Estimates%20of%20Aboriginal%20and%20Torres,under%2015%20years%20of%20age>.
- Australian Institute of Health and Welfare [AIHW]. (2023). *Culturally and linguistically diverse Australians*. <https://www.aihw.gov.au/reports-data/population-groups/cald-australians/overview>
- Brazier et al. (2016). *Recovering Quality of Life (ReQoL) Questionnaire*. <https://innovation.ox.ac.uk/outcome-measures/recovering-quality-life-reqol-questionnaire/>
- Carman, Marina, Shoshana Rosenberg, Adam Bourne, and Matthew Parsons. "Research Matters: Why Do We Need LGBTIQ-Inclusive Services? A Fact Sheet by Rainbow Health Victoria," 2020.
- Correro, A. N., & Nielson, K. A. (2020). A review of minority stress as a risk factor for cognitive decline in lesbian, gay, bisexual, and transgender (LGBT) elders. *Journal of Gay & Lesbian Mental Health*, 24(1), 2–19. <https://doi.org/10.1080/19359705.2019.1644570>
- Hill, A.O., Bourne, A., McNair, R., Carman, M., & Lyons, A. (2020). *Private Lives 3: A national survey of the health and wellbeing of LGBTIQ people in Australia*. Latrobe University. <https://www.latrobe.edu.au/arcshs/work/private-lives-3>
- Hill, A.O., Lyons, A., Jones, J., McGowan, I., Carman, M., Parsons, M., Power, J., & Bourne, A. (2021). *Writing Themselves In 4: The health and wellbeing of LGBTQA+ young people in Australia*. Latrobe University. [https://www.latrobe.edu.au/\\_\\_data/assets/pdf\\_file/0010/1198945/Writing-Themselves-In-4-National-report.pdf](https://www.latrobe.edu.au/__data/assets/pdf_file/0010/1198945/Writing-Themselves-In-4-National-report.pdf)
- Illinois Coalition on Mental Health and Ageing. (2020). *UCLA 3-Item Loneliness Scale*. <https://www.icmha.org/wp-content/uploads/2020/02/UCLA-Loneliness-Scale.pdf>
- Intersex Human Rights Australia. [n.d.]. *What is intersex?*. <https://ihra.org.au/18106/what-is-intersex/>
- Lim, M., Eres, R., & Peck, C. (2019). *The young Australian Loneliness survey: Understanding loneliness in adolescence and young adulthood*. <https://www.vichealth.vic.gov.au/sites/default/files/The-young-Australian-loneliness-survey-Report.pdf>

- Lim, M. H., Manera, K. E., Owen, K. B., Phongsavan, P., & Smith, B. J. (2023). The prevalence of chronic and episodic loneliness and social isolation from a longitudinal survey. *Scientific Reports*, *13*(1), 12453. <https://doi.org/10.1038/s41598-023-39289-x>
- McCann, B., Campbell, E., & Carson, R. (2023). *Future-proofing Safety Final Report*. <https://cfre.org.au/wp-content/uploads/2023/09/Future-proofing-Safety-Final-Report.pdf>
- Meyer, I.H. (2003). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin*, *129*(5), 674-697. <https://doi.org/10.1037/0033-2909.129.5.674>
- Nicholson et al. (2022). A systematic review of the neural correlates of sexual minority stress: towards an intersectional minority mosaic framework with implications for a future research agenda. *European Journal of Psychotraumatology*, *13*(1), 2002572. <https://doi.org/10.1080/20008198.2021.2002572>
- Sweeney, Angela, Beth Filson, Angela Kennedy, Lucie Collinson, and Steve Gillard. "A Paradigm Shift: Relationships in Trauma-Informed Mental Health Services." *BJPsych Advances* 24, no. 5 (September 2018): 319–33. <https://doi.org/10.1192/bja.2018.29>
- Victorian Agency for Health Information. (2021). *The health and wellbeing of lesbian, bisexual, transgender, intersex and queer population in Victoria – Findings from the Victorian Population Health Survey 2017*. <https://vahi.vic.gov.au/reports/population-health/health-and-wellbeing-lgbtq-population-victoria>
- Victorian Government. (2021). *Recommendation 34: Working in partnership with and improving accessibility for diverse communities*. <https://www.health.vic.gov.au/mental-health-reform/recommendation-34>