AUSTRALIAN RESEARCH CENTRE IN **SEX, HEALTH & SOCIETY**
LA TROBE UNIVERSITY, MELBOURNE

PRIVATE LIVES
A report on the health and wellbeing of GLBTI Australians

Marian Pitts
Anthony Smith
Anne Mitchell
Sunil Patel

GAY AND LESBIAN HEALTH VICTORIA
THE AUSTRALIAN RESEARCH CENTRE IN SEX, HEALTH & SOCIETY

LA TROBE UNIVERSITY

GLHV
Gay and Lesbian Health Victoria

AUSTRALIAN RESEARCH CENTRE IN **SEX, HEALTH & SOCIETY**
LA TROBE UNIVERSITY, MELBOURNE

PRIVATE LIVES
A report on the health and wellbeing of GLBTI Australians

Marian Pitts
Anthony Smith
Anne Mitchell
Sunil Patel

MARCH 2006
MONOGRAPH SERIES NUMBER **57**
ISBN **1920948686**

GAY AND LESBIAN HEALTH VICTORIA
THE AUSTRALIAN RESEARCH CENTRE IN SEX, HEALTH & SOCIETY

LA TROBE UNIVERSITY

GLHV Gay and Lesbian Health Victoria

ACKNOWLEDGEMENTS

This study was carried out with a grant from La Trobe University. Early developmental work on the questionnaire was carried out by Francine Hanley and Travis Coleman with advice provided by Nikos Thomacos, Sue Dyson, Philomena Horsley, Christopher Fox, Lynne Hillier and Jeffrey Grierson. Sunil Patel was responsible for the technical oversight and management of the on-line survey and the liaison with Demographix.co.uk who hosted the survey. Artwork and logo for the survey promotion was also the work of Sunil Patel. Much of the literature in this report was researched by Christopher Fox. Philomena Horsley edited the report.

Thanks to Gary Rogers of the University of Adelaide for permission to use, and advice on analysis of, the Prime MD instrument. The analysis and discussion of the "Three Best Things" was carried out as a student placement project by Carly Levison from Swinburne University supervised by Lynne Hillier. We would also like to thank the many community organisations who provided web-links and promotional opportunities for the survey, in particular the help of Health in Difference 5 Conference participants. Our thanks for promotion assistance go to AIDS Councils in all states and territories, especially Hilary Knack from the Queensland AIDS Council and David McGuigan and Ian Down from ACON. Most of all we would like to thank the thousands of GLBTI people who took the time to tell us about their lives and to provide feedback on the survey.

About Gay and Lesbian Health Victoria

Gay and Lesbian Health Victoria (GLHV) is an initiative arising from recommendations made in *Health and Sexual Diversity: A health and wellbeing action plan for GLBTI Victorians* which was developed by the Ministerial Advisory Committee on Gay and Lesbian Health and accepted as government policy in July 2003. GLHV is run as a consortium by the Australian Research Centre In Sex, Health and Society with Women's Health Victoria and the Victorian AIDS Council. Its role is to develop training and health promotion resources relevant to the health and well-being GLBTI Victorians, to educate and train health care planners and workers in these issues and to advocate for systemic reform relating to best practice, data collection and standards of care.

© Australian Research Centre in Sex, Health and Society, La Trobe University, 2006
Published by the Australian Research Centre in Sex, Health and Society, La Trobe University,
First Floor, 215 Franklin St,
Melbourne 3000
Tel +61 3 92855382
Fax +61 3 92855220
Email: arcshs@latrobe.edu.au
Website: www.latrobe.edu.au/arcshs/

Contents

1. BACKGROUND TO THE STUDY 13

2. METHODOLOGY AND RECRUITMENT 15

3. ABOUT THE RESPONDENTS 17

4. HOME AND FAMILY 25

5. HEALTH AND WELLBEING 28

6. HEALTH SERVICE USE 37

7. SEX AND RELATIONSHIPS 44

8. DISCRIMINATION, HARRASSMENT AND VIOLENCE 48

9. CONNECTEDNESS TO COMMUNITY 53

10. THE BEST THINGS IN LIFE... 58

11. CONCLUDING RECOMMENDATIONS 63

List of Tables

Table 1:	Cultural ancestry of participants	18
Table 2:	Gender of participants	18
Table 3:	Identity of participants	19
Table 4:	Sexual self-identification and gender	19
Table 5:	Attraction and gender	20
Table 6:	Experience and gender	21
Table 7:	Attraction and experience	21
Table 8:	Education levels	22
Table 9:	Employment status	22
Table 10:	Length of unemployment	22
Table 11:	Occupations of participants	23
Table 12:	Religion of participants	24
Table 13:	Gay-friendliness of religions	24
Table 14:	Living arrangements	25
Table 15:	Housing tenure	26
Table 16:	Current relationship	26
Table 17:	Interest in a commitment ceremony	27
Table 18:	Pet ownership	27
Table 19:	Types of pets	27
Table 20:	SF36 average scores	28
Table 21:	BMI of participants	30
Table 22:	Obesity rates	30
Table 23:	Types of exercise undertaken by participants	30
Table 24:	Reported health conditions	31
Table 25:	Mental health	32
Table 26:	Previous history of depression	33
Table 27:	Seeing counsellor or psychiatrist in the past five years	33
Table 28:	Main issues of concern	34
Table 29:	Use of drugs on more than five occasions in the previous month	34
Table 30:	Lifetime diagnoses of STIs	35
Table 31:	Health Insurance	38
Table 32:	Doctor know identity?	38
Table 33:	Health check ups	39
Table 34:	Health service use in the past twelve months	39
Table 35:	Experience of negative treatment	40
Table 36:	STI checkups	43
Table 37:	Physical pleasure with most recent sexual partner	44

Table 38: Emotional satisfaction with most recent sexual partner 44
Table 39: Length of time of knowing partner before sex 45
Table 40: Paying for and being paid for sex 46
Table 41: Factors influencing choice of sexual partner 46
Table 42: Internet use 46
Table 43: Have you ever met someone you chatted to on the internet? 47
Table 44: Outcome(s) of meeting someone from the internet 47
Table 45: Does fear of prejudice or discrimination cause you to modify your daily activities? 48
Table 46: Sites of modified daily activity among those who do 49
Table 47: Sites of modified daily activity among those who do by age group 49
Table 48: Frequency of avoiding expressions of affection 49
Table 49: Frequency of avoiding disclosing gender identity or sexuality 50
Table 50: Personal experiences of discrimination, harassment and violence 50
Table 51: Ever in relationship where partner abused you? 51
Table 52: Types of abuse 51
Table 53: Was abuse reported to police? 52
Table 54: I was treated with courtesy and respect 52
Table 55: Appropriate action was taken by the police 52
Table 56: How many of your friends are GLBTI? 53
Table 57: How often do you have contact with gay and lesbian friends and acquaintances? 53
Table 58: Frequency of access to gay media 54
Table 59: Do you feel connected to the gay and lesbian community in your everyday life? 54
Table 60: Connectedness to gay community by locality 55
Table 61: Do you feel connected to the broader community in your everyday life? 55
Table 62: Connectedness to the broader community by locality 55
Table 63: Have you come out to anyone in your life? 56
Table 64: Out to… 56
Table 65: For emotional support would you turn to…? 57
Table 66: For health information and advice, you would turn to…? 57
Table 67: Who would care for you if you were sick? 57
Table 68: Participants first best thing by gender 58
Table 69: Participants three best things by gender 59
Table 70: Participants best things by age 59

List of Figures

Figure 1: Patterns of responses 16

Figure 2: Percentages of respondents by state/territory 17

Figure 3: Self-rated health of participants 29

Figure 4: Health rating comparison with the Australian population 29

Figure 5: Desired frequency of sex 45

Figure 6: Participants responses to the first best thing in life 59

Figure 7: Total responses of the three best things 59

Alison's story

I took Karen into the Emergency Department and got her sitting down while I did as much of the paper work as I could. The woman at the desk sort of got the information by interviewing me so other people could listen in if they were interested, which was a bit of a worry. Anyway, when we got to 'married, single, de facto, divorced?' I said "We're in a same sex relationship" because I wanted to be sure that if she needed urgent surgery that I would be taken seriously as the partner and next of kin.

"Well, you can't have that" the woman said. I asked couldn't she write it in some way and she said the computer would not let us have that. I asked her to skip the question but she said that the computer wouldn't go on to the next question unless we chose one of the options, so I just said "Okay, put de facto". I turned around and everyone was looking at us. I suppose it wasn't that big a deal with everything else we had on our plate right then, but it was a bad start.

Executive summary

BACKGROUND

The *Private Lives* study, carried out in early 2005, is one of the largest surveys of gay, lesbian, bisexual, transgender and intersex (GLBTI) people ever conducted. It aimed to document aspects of the health and wellbeing of a large sample of GLBTI people in Australia, to explore the impact of factors such as homophobia, discrimination, family and community connection on health and wellbeing, and to investigate aspects of health service use. In all, 5476 people between 16 and 92 years of age (mean age 34) completed the on-line survey. This sample provides us with a detailed picture of the lives of GLBTI in Australia in all their diversity and complexity. Of the sample 63% were male and 35% were female; just over half (52%) identified as a "gay man", 18% as "lesbian" and 10% as "bisexual". There were 100 transgender and 18 intersex participants. There was a broadly representational spread of participants from all states and territories, and 22% lived outside major cities (34% in 2001 national census).

METHODOLOGY

The methodology for the survey was developed with a view to recruiting the broadest possible sample of people who self-identified as GLBTI, including rural and remote participants and those who do not identify with GLBTI communities. Recruitment was through internet sites, personal email networks, media publicity, press advertisements and wide distribution of promotional cards.

SEXUAL IDENTITY

Of the males, 83% identified as a gay man, 9% identified as bisexual, 3% did not use an identity label and 2% identified as queer. Amongst the females, 49% identified as lesbian, 14% as a gay woman, 12% as bisexual, 7% did not use a label, 7% identified as a dyke and 6% as queer.

Proportionately more women than men self-identified as bisexual or queer, or did not use a self-identification label. Transgender males were most likely to self-identify as queer whereas transgender females were almost equally likely to self-identify as bisexual or lesbian. Both intersex males and females selected a broad range of identities.

IDENTITY, ATTRACTION AND EXPERIENCE

The majority of men in this sample (92%) reported being attracted exclusively or predominantly to men. Similarly, the majority of women (80%) reported being attracted exclusively or predominantly to women, although women were less likely than men to say they were attracted only to those of their own gender. The situation among transgender and intersex people is more complex, and their numbers are small.

The relationship between sexual attraction and sexual experience is not straightforward but there was an association between people's stated sexual attraction and their reported sexual experience. Nearly all of the men (91%) reported sexual experience that was either predominantly or exclusively with other men. The pattern with women was less clear in that a higher proportion of them reported sexual experience equally with men and women (15%) or mainly with men (16%). The patterns of experience for transgender and intersex participants were more diverse again. It is important to note that for quite a significant numbers of participants there was little association between attraction, experience and identity.

EDUCATION AND EMPLOYMENT

This sample was a highly educated one with nearly 50% of participants having a university degree and 60% being in full time employment. This is higher somewhat than ABS figures for the population in general. A further 17% were in part-time employment, 12% were students at the time of the survey and 3% were on pensions or benefits. Retirees made up 2% of the sample and only 3% were unemployed. Nearly three quarters (74%) of participants were classified as managerial, associate professionals, professionals and administrators.

RELIGION

More than 70% reported no current religion, 8% were currently Catholic, 6% currently Protestant and 3% Buddhists. This was significantly different from the religions in which participants were brought up. The majority of those whose current religion was Catholic described their religious community as anti-gay, as did those whose religion was Islam. The most gay- friendly religious communities were reported to be of the Wicca and Buddhist religions.

LIVING ARRANGEMENTS

Around the quarter of the sample reported that they were living alone and nearly 40% reported that they were living with a partner. Women were more likely than men to be living with a partner. Home ownership was quite common in this sample but lower than ABS rates for the community generally. While just over half reported renting the property in which they lived, approximately a quarter reported that they were in a process of purchasing the property they lived in.

RELATIONSHIP STATUS

Many participants were not in a current relationship. More than half of men (52%) and higher percentages of trans-female and intersex persons were not in a current relationship. However 60% of women reported a current relationship with another woman and 43% of men reported a current relationship with another man. It is also notable that 5% of men and 8% of women were currently in a relationship with an opposite sex partner. The longevity of relationships was similar for men and for women. Only a very small percentage of men and women (between 5-10%) reported formalising the relationship with a marriage or commitment ceremony, while most others had no wish to do so.

GENERAL HEALTH

On the SF36 (which is a five-item scale to assess general health function) men were the only group to score above the average. As a group, women were slightly below average with transgender males and transgender females also scoring slightly below the mean. Intersex males and intersex females scored substantially lower.

The self reported health status of *Private Lives* participants was somewhat worse than the ABS records for all men and women in younger age groups. These differences however diminish with age, so that by 45 years the differences between *Private Lives* participants and the ABS respondents are minimal or non-existent.

WEIGHT AND EXERCISE

In this sample men were less likely to be overweight or obese than the Australian average male (43% vs. 54%) and women more likely (49% vs. 38%) than the Australian average female. Participants engaged in a wide variety of physical activities such as walking, swimming, gardening and bushwalking. Men were more likely than women to use a gym, whereas women are more likely to play golf.

COMMON HEALTH CONDITIONS

The most common reported health condition overall was depression, with averages ranging from 30% of men and 38% of women to 57% of intersex females and 63% of intersex males. Anxiety and asthma were also reported by significant percentages of all participants, with women having slightly higher rates of these than men. For the next two most common conditions, heart disease and high cholesterol, men had slightly higher rates than women.

MENTAL HEALTH

Nearly three quarters of the sample reported some experience of depression in the past. The prevalence of depressive disorders was high, with 49% of men and 44% of women scoring on at least one of the two criteria for a major depressive episode. It is of particular concern that 16% of all respondents indicated suicidal ideation (thoughts) in the two weeks prior to completing the survey. It was encouraging to see there was a significant negative correlation with age – the older the respondent, the less likely they were to be depressed. Half of all participants had seen a counsellor or psychiatrist in the past five years for issues such as depression and anxiety, relationship problems and family problems.

DRUG USE

Patterns of drug use in this sample are somewhat higher than in the Australian population generally. Overall, more than a third of respondents reported using tobacco more than five times in the previous month (37%) and one in six (16%) reported using marijuana at the same level. No other drug was used as frequently. Ecstasy (9%), speed (5%) and crystal (3%) were the next most often used drugs. Men's drug use was slightly higher than women's on all counts.

SEXUALLY TRANSMITTED INFECTIONS (STIS)

We asked about ever being diagnosed with an STI. The most common STIs reported by women in this sample were candidiasis and urinary tract infection, and both are not always sexually transmitted. No other STI was reported by more than 5% of the women. For men the picture was different and more concerning. While the most commonly reported STI for men was pubic lice (40%), one in five reported gonorrheae and more than one in ten men reported NSU, HPV, and Chlamydia. Of the men 8% were HIV positive. For transgender and intersex respondents the rates of STIs overall were low.

HEALTH SERVICE USE

Participants in this survey used a range of health services and the majority had had a general health check up in the past year. Of those participants with a regular GP (around 75%), two thirds believed their GP knew of their sexuality/gender identity. Almost all of the transgender and inter-sex respondents had told their GP about their identity, perhaps because they were more likely to need to discuss issues of medical intervention. Conversely, one in five of male and female respondents indicated their regular GP did not know about their sexuality. Female respondents reported higher use of all services than men, with the exception of HIV and sexual health services and hospital outpatients.

EXPERIENCE OF HEALTH SERVICES

The overwhelming majority of health service contacts were either positive or neutral in relation to identity and sexuality. The number of adverse experiences reported is too few to allow a more extended analysis. However, it would appear that there are particular issues in relation to hospital settings. It is likely that a large number of neutral experiences were so characterised because the health care provider was not told about the identity of the client. Of the 105 women who reported a birth outside of a heterosexual relationship, fewer than half reported that provision was made in the hospital documentation to accommodate their partner's name, or that inclusive language was used in birth classes. However in 66% of cases hospitals did acknowledge the woman's partner.

SCREENING

These questions were only asked of the females in the study, since national screening programs currently are only targeted at women. Of the females, 21% reported never having had a Pap test, although 40% reported having had a Pap test within the last year. Of all the females in the survey, 75% report never having had a mammogram. However, this statistic improved when only those over 50 years were considered, which is the target age group for the national breast screening program. In this group only 17% reported never having had a mammogram, while 44% had had one in the previous year.

SEXUAL HEALTH CHECK UPS

More than twice the number of males compared to females had had a sexual health check up in the last year. Most men who had STI check ups also had HIV tests indicating that STI testing occurs in the context of HIV testing. Of the male sample, 78% reported having had an HIV test at some time. Of those tested, 65.0% had been tested in the previous year with a further 24.8% having been tested in the previous five years. Participants were asked if they had heard of post exposure prophylaxis (PEP) for HIV. Just under half indicated that they had heard of PEP (48.3%) with an additional 2% being unsure and only 8% had attempted to access it. Awareness of pre-exposure prophylaxis (PrEP) was even scarcer.

SEX AND RELATIONSHIPS

On the whole participants reported a good deal of physical pleasure with their most recent sexual partner. Emotional satisfaction ratings, however, were not as high. It is of note that 28% of men compared with 14% of women reported less than moderate emotional satisfaction with their most recent sexual partner. This may partially be explained by the finding that gay men are much more likely than the other groups to have known their most recent sexual partner for less than 24 hours. The factors which influence a choice of sexual partner were explored. The importance of personality and of having similar interests emerged for females in this sample. While looks and age were important along with personality for males. Wealth was not important in making such a decision.

MEN'S SEXUAL BEHAVIOURS

More than half of respondents (59%) reported having fucked and ejaculated with a regular partner without using a condom. Two thirds reported sex with a casual male partner in the past six months (65%). Overall, 24% of the men with casual partners reported at least one occasion of unprotected anal intercourse with ejaculation in the past six months.

WOMEN'S SEXUAL BEHAVIOURS

Female participants reported a range of sexual practices. In relation to the most recent sexual event with another woman, 58% reported receiving oral sex, 60% reported giving oral sex; 90% reported having been vaginally stimulated by their partner's hand and 91% reported having stimulated their partner's vaginal area with their hand. In the most recent sexual event with another women 77% reported they had an orgasm.

IMPACTS OF DISCRIMINATION AND VIOLENCE

Overall, 67% of participants indicated that fear of prejudice or discrimination caused them, at least sometimes, to modify their daily activities in particular environments. This was more common for younger participants and in rural areas. The vast majority (90%) had at some time avoided expressions of affection in public and disclosure of their gender identity or sexuality. Significant numbers of participants (14%), particularly gay men (10%), always avoided disclosing their sexual identity for fear of discrimination. Personal insults or verbal abuse were more common in major cities than in rural, regional or remote areas. However the reverse was true of the experience of threats of violence or physical attack.

INTIMATE PARTNER ABUSE

A disturbingly high percentage (33%) of respondents in this sample reported having been in a relationship in their lifetime where the partner was either verbally or physically abusive. Abuse was reported more frequently by women than men (41% vs 28%), and was highest for transgender males, but the rates for all groups are unacceptably high. Of those participants who had experienced physical abuse, only one in ten had reported such abuse to the police but, of those who had, more than half were satisfied with the response.

CONNECTEDNESS TO COMMUNITY

Relatively few participants reported extreme feelings of connection or disconnection from the gay and lesbian communities. Participants indicated that they had varied social worlds that included a combination of gay and straight friends. More than half (58%) indicated that the majority of their friends were not GLBTI but nearly four in five participants (79%) have contact with gay and lesbian friends at least weekly. Respondents indicated a range of sources of emotional support: GLBTI friends rated most highly for all groups; and higher in every case than their biological families (with the exception of intersex respondents where family and community friends were rated as equally or more important). A similar pattern is evident in who participants turn to for health information and advice. However in times of sickness, relatives (biological family) or partners were rated higher than GLBTI friends.

COMING OUT, BEING OUT

The vast majority of survey respondents were out to at least one person, with slightly more men than women not out to anyone. Overall, participants were likely to be out to family and friends but only one in two respondents was out to work or study supervisors. As it is illegal to discriminate against GLBTI people in the workplace, this was an issue of some concern.

THE BEST THINGS IN LIFE

Despite health inequalities, it is also clear that most GLBTI people live happy and fulfilled lives. The final question of the survey asked *what are the three best things about your life right now?* Overall the largest category responses were friends and work/study, followed by relationships. When the responses were analysed by gender nearly half of the women reported relationships (42%) as their first choice. For men also the most common first choice was relationships (26%) but work/study (18%) and friends (16%) also figured as quite important for men. While friends emerged as an important category for those of all ages, those between 16 and 39 rated it most highly. Relationships were most important for people between the ages of 40 and 69. In all, there is a remarkable accord amongst GLBTI people about the sustaining and positive areas of their lives. They also provide a snapshot of the resilience and optimism present in the daily lives of the participants in this study.

RECOMMENDATIONS

The report concludes with a series of recommendations related to the areas above covering legislative reform, changes in the culture of health services, health care provider training, public education, changes in data collection and further community education.

1. BACKGROUND TO THE STUDY

People who are gay, lesbian, bisexual, transgender and intersex (GLBTI) are frequently hidden within the broader community. Those aspects of their identity which relate to being GLBTI may not be of major significance in relation to other family, work-related, social or political roles that are played out every day. Nevertheless there is now a significant body of anecdotal and research evidence that GLBTI people experience considerable marginalisation and stigmatisation as a result of their identity and that this has a negative impact on their health and health care. In 2004 the Victorian government established Gay and Lesbian Health Victoria (GLHV) which provided a unique opportunity to systematically address the invisibility of GLBTI people in health service provision. Critical to the process of facilitating systematic change is the ability to convincingly demonstrate the shortfalls in the current system and the potential benefits that change will bring. Using a research grant provided by La Trobe University, the *Private Lives* survey was undertaken as one of the initial activities of GLHV. It aimed to address some of the limitations of the data currently available on the health and wellbeing of GLBTI people and on their interactions with the health system. While GLHV is a Victorian initiative the decision to do the survey on-line and the interest from a large number of interstate community groups and organisations made it possible to gather a unique collection of national data.

The survey set out to:

- document aspects of the health and wellbeing of a large sample of GLBTI people in Australia
- explore the impact of factors such as homophobia, discrimination, family and community connection on health and wellbeing
- document patterns of screening and health service use
- explore the nature of interactions with the health care system
- provide information to policy makers and practitioners to assist in making service provision more targeted and appropriate for GLBTI people.

The data collected in this survey constitute the largest study ever undertaken of GLBTI people in Australia and one of the largest in the world. Previous Australian research has been on a smaller scale and has relied on largely unrepresentative samples recruited in restricted geographical areas, through membership lists of community organisations or at community events. Major national surveys of the general population, while providing useful comparisons between heterosexual and non-heterosexual people, inevitably provide only a small number of cases. For example, the recent large scale study of the sexual health of the Australian population, Sex in Australia (Smith, et al 2003), surveyed nearly 20,000 people. Only 2.6% percent of its male participants identified as other than heterosexual, as did 2.3% of the women, yet 8.6% of men and 15.1% of women reported either same-sex attraction or sexual experience. This highlights a further problem of definitions within GLBTI populations which has created ongoing difficulties (Cochran, 2001) in describing research participants and in comparing research findings across different studies. The importance of exploring all three domains of identity, attraction and experience, particularly when transgender and intersex participants are included, is evident. In addition a significant minority of participants in this survey reported minimal contact with the gay community. This demonstrates the reach of the internet to participants that other surveys, such as those run at gay and lesbian community events, cannot. These data can therefore provide us with a detailed picture of the lives of GLBTI in Australia in sufficient numbers that the diversity and complexity of experience can be more fully understood.

The research available on GLBTI people to date, despite its limitations, provides significant evidence of systematic discrimination in health systems and considerable stigma from mainstream society (Saphira &

Glover, 2000; VGRL 2000; McNair & Thomacos, 2005). The subtle pervasiveness of this discrimination is not without its impact on the health and wellbeing of GLBTI people in general. Research on GLBTI health suggests that there are disparities both in health risks and protective behaviours between GLBTI communities and the Australian population as a whole. People who identify as other than heterosexual are more likely to report higher levels of psychosocial distress (Smith et al, 2003); are more likely to report sexual coercion (de Visser et al, 2003); have higher incidences of diagnoses of sexually transmitted infections (Grulich et al, 2003b), and have a history of substance use (Grulich et al, 2003a). In examining the physical health needs of GLBTI populations, McNair and Medland (2002) identified nine key health-related risk factors that are significant to Australian GLBTI populations and are likely to relate to experiences of systematic discrimination. They argue that GLBTI people are more likely to experience drug and alcohol misuse, smoking, reduction in safer sex practices, stress, body image concerns, obesity, reduced health screening, non-compliance with medication, and scepticism regarding service delivery. Each of these health-related risk factors has a likely adverse impact on the individual concerned. Indeed, in this context, the well-documented experience of stigmatisation has formed the basis of an argument that sexual orientation and identity are in themselves key social determinants of health (Leonard, 2002). This is perhaps the most critical factor in understanding many of the health deficits that this study also documents.

Wilton (2000:1) has argued that GLBTI people now live in a highly contradictory environment "with tolerance existing side by side with extremes of prejudice". The improved visibility of gay and lesbian people in particular, and the widespread evidence of increasing social acceptance, have not alleviated the basic problem in accessing health care. A key issue for all GLBTI people remains the uncertainty about whether, in any given interaction, the experience will be one of acceptance or rejection. This uncertainty can lead to late attendance (Diamant et al, 2000), under screening (Rankow and Tessaro, 1998; McNair & Medland, 2002) and a general lack of confidence to use the system. Thus, sexual and gender identity become highly relevant to best practice health service delivery.

The price of allowing this situation to continue goes beyond its impact on GLBTI individuals. In a recent Canadian study (Canadian Rainbow Health Coalition, 2005) it was demonstrated that GLBTI people were significantly more likely to have unmet health needs (21.8%) compared to heterosexual people (12.8%). The cost of these unmet health needs was estimated to translate into 3,300 premature deaths at a cost of $8 billion per annum. Based upon the relative comparability between Canadian and Australian populations and health systems, it is reasonable to conclude that the level of unmet health needs would have a similar economic impact here.

But the lives of GLBTI people are far more than a collection of unmet health needs. The contribution they make to society is a significant one. It is important to note the positive and sustaining elements within participants' lives, are also documented in this study. These factors must be considered and fully acknowledged for their impact on wellbeing.

2. METHODOLOGY AND RECRUITMENT

The methodology for the survey was developed with a view to recruiting the broadest possible sample of people who self-identified as GLBTI. As already indicated, previous research has been characterised by small opportunistically gathered samples, frequently recruited from community events or via community newspapers. These sampling techniques inevitably under-sample from those GLBTI who live outside major metropolitan areas. In order to expand the opportunity for GLBTI Australians to participate, we decided to recruit via an internet site.

The Australian Bureau of Statistics in 2003 reported that 66% of Australian households are connected to the internet, with the numbers rising rapidly every year. We also felt that an on-line survey would have wide acceptance amongst GLBTI people - the proliferation of websites targeting them in Australia indicates that they are likely to be regular users of the internet. In a recent national survey of young same sex attracted people (Hillier et al., 2005), 95% of respondents filled in the survey on line despite being given the option of receiving a survey by mail. This study also showed that the internet was by far the most common source of information about health and relationship issues for these young people. In the UK, Sigma Research have been collecting information on sexual behaviour among gay men since 1993. Initially they collected information from gay men attending the London Lesbian and Gay Pride festival. However, since 2004 they have used two other methods for data collection: a booklet for distribution through health promotion agencies and a website. In 2004 they received 14,757 completed questionnaires on-line in a twelve week period.

The majority of large to medium workplaces now provide internet access, as do libraries and community centres, so that there are increasingly few impediments to internet access in Australia.

ADVERTISING AND OTHER RECRUITMENT STRATEGIES

The survey ran from 19th January until 15th May 2005 inclusive. It was terminated as responses began to fall, indicating that the sample had reached the maximum uptake. We utilised a wide range of strategies designed to publicise the survey and to reach as many of the potential participants as possible. Small business-size cards printed with the project logo and web address were distributed at community events in all states and territories. They were also left in cafes and other businesses patronised by GLBTI people and sent out through personal networks (6,000). The Quackers rural tour in Queensland targeted isolated participants in smaller rural communities. We had T shirts printed for staff to wear at community events and at the Health in Difference 5 conference, which occurred early in the recruitment period. This national conference of health care workers, consumers and advocates from all over Australia provided an excellent networking opportunity to have the promotional materials widely distributed. Similarly, at the end of the recruiting period, the National Women's Health conference provided a network to purposively recruit more female participants.

Extensive internet advertising was undertaken with paid banner ads on www.gaydar.com.au and www.guidetogay.com.au and www.lotl.com.au. AIDS Councils in all states and territories assisted with local recruiting generally and placed banner advertisements on their websites. A number of other organisations provided free advertising through their website. These included: www.darwinpride.com, www.thepinksofa.com, www.qmagazine.com.au, www.queerterritory.com.au, www.twenty10.org.au, www.dvirc.org.au.

Advertisements for the survey appeared in both the gay and mainstream press and through other gay media such as JOY radio (Melbourne). Editorial stories were developed and distributed throughout the recruitment period. Email lists were one of the most successful forms of recruitment: both organisational lists and personal friendship lists created a more personalised invitation to potential participants.

The site was hosted by Demographix.co.uk, an experienced commercial provider of web-based surveys with excellent attention to the issue of security and privacy. Participants aged over 18 were invited to take part and those under that age discouraged from responding. The survey was available only in English and required participants to choose whether they identified as male or female so that they could be channelled into the appropriate questionnaire. We understood that this technological necessity would be unacceptable to many potential transgender and intersex participants who did not identify as either of these genders. This was certainly the case, and we received constructive and thoughtful feedback from many of those for whom the questionnaire did not work. This feedback has been retained to assist in the design of a future survey targeting transgender and intersex participants separately, where the technology can be adapted to elicit more specific detail from them. We appreciated the numbers of transgender and intersex participants who found the gender question to be a stumbling block but persevered with completing the survey in any case.

ETHICS

Ethics approval for the survey was provided by the LaTrobe University Human Research Ethics Committee.

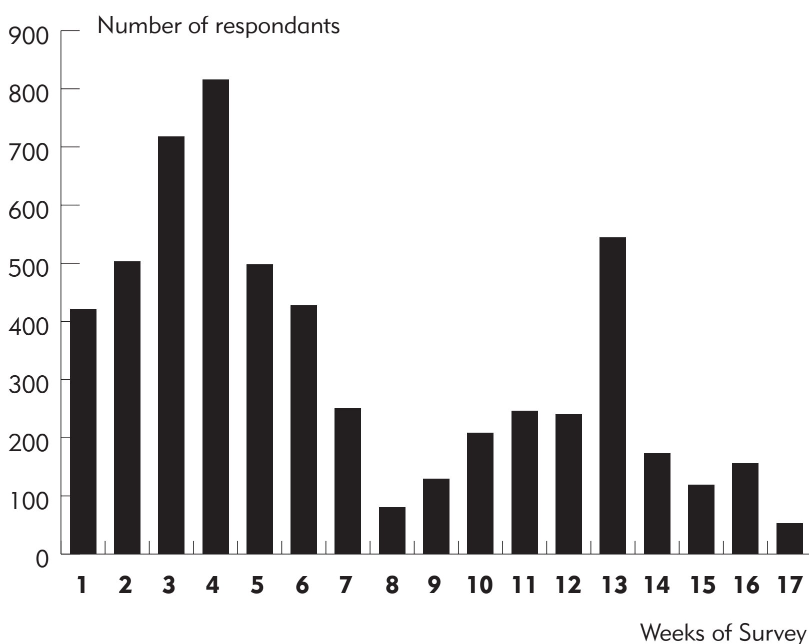
SURVEY DESIGN

A balance of adaptations of existing standardised instruments and the development of items for new content areas was the basis of the survey design. While we wanted to capture the experiences of many diverse groups, we were also aware that standardised measures would allow us to compare our findings with those of other researchers in other countries.

PATTERNS OF RESPONSES

Within 2 weeks of the site being launched we had already received nearly 500 responses. Over the course of recruitment we observed consistent patterns of recruitment in response to specific advertising initiatives, with new banner advertisements on major websites being the most likely to trigger a peak response. The greatest number of responses regularly occurred in the early part of the week and characteristically tapered off towards the weekend.

Figure 1:
Patterns of responses

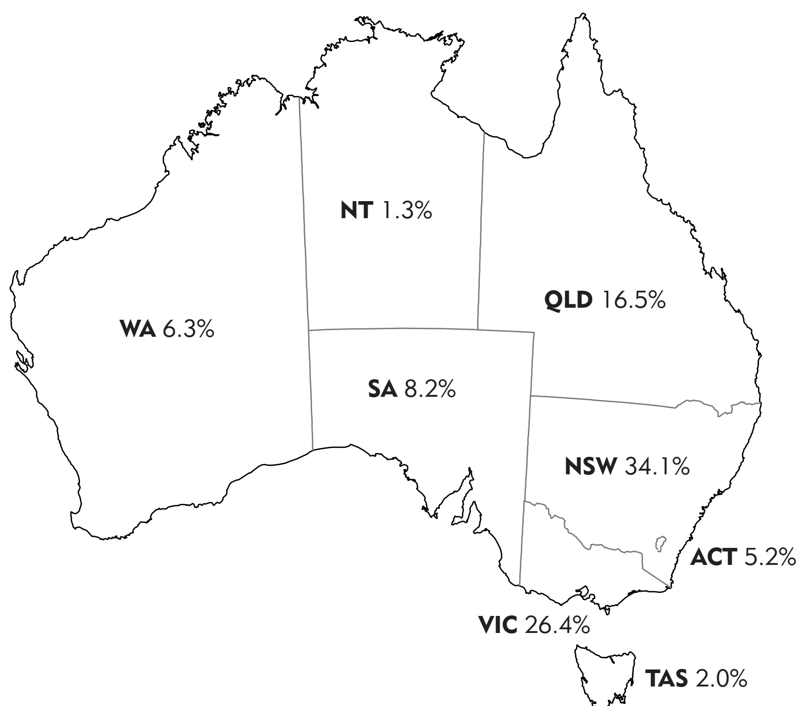


3. ABOUT THE RESPONDENTS

DEMOGRAPHICS

In total, 5,476 people completed the survey.

Figure 2: Percentages of respondents by state/territory



As can be seen from Figure 2 we were successful in recruiting a significant number of participants from all states and territories. This sample is roughly comparable to the percentages of the Australian population (ABS, 2005) for all states and territories except that the *Private Lives* sample for WA is somewhat lower and for Queensland and ACT slightly higher.

Most of the sample (77%) lived in major cities, 15% lived in inner regional Australia, 5% in outer regional Australia and 2% in remote Australia. From the 2001 Census we know that 66% of the Australian population lives in major cities, 21% in inner regional Australia, 11% in outer regional Australia and 3% in remote Australia. While the proportion of *Private Lives* participants living outside major cities is lower than the general population (22% to 34%), it is nevertheless a pleasing spread of respondents. Much research in GLBTI communities has been carried out only in urban populations and it is well known that those outside major centres in Australia experience poorer health and a greater burden of disease (Strong et al, 1998).

The mean age of our sample was 34 years, with a standard deviation of 11.2 and a range from 16 to 86. There were 6.8% participants under the age of 20, 32.2% were in their 20s, 30.6% were in their 30s, 20.0% in their 40s, 8.1% in their 50s, 1.9% in their 60s and 0.4% in their 70s or 80s. Thus we had more than 100 participants over the age of 60. By far the majority (80.7%) of participants were born in Australia, leaving

19.3% born overseas. Of the whole sample 2.0% or 111 participants were of Aboriginal or Torres Strait Islander descent. This is somewhat lower than the percentage in the 2001 census, but it should be borne in mind that we recruited people above the age of 18 years which would have an impact on these percentages.

Of those participants born overseas, 62.8% were Australian citizens, and 70.8% of non-citizens were permanent residents. There were 109 participants who were not permanent residents. Amongst those born overseas, the most common birthplace was the United Kingdom (33%), followed by NZ (17%), the United States (6.7%) and South Africa (4.6%). In all, participants reported more than fifty different countries of birth, with those born in the USA least likely to be permanent residents.

Participants were invited to indicate their cultural ancestry. The majority identified an Anglo ancestry, with Vietnamese and Italian being the next most common and reflecting Australia's large immigrant groups.

Table 1:
Cultural ancestry of participants

	N	Percent
Anglo	4,262	77.8
Vietnam	278	5.1
Italy	195	3.6
Eastern European	147	2.7
China	116	2.1
Philippines	96	1.7
Greece	84	1.5
New Zealand	79	1.4
India	42	0.8
Malaysia	26	0.5
Horn of Africa	21	0.4
Hong Kong	14	0.3
Indonesia	13	0.2
Total	**5,476**	**100**

GENDER AND SEXUALITY

Of the sample, 62.6% were male and 35.2% female. Transgender participants identifying as male made up 0.6% (n=34) of the sample and 1.2% (n=66) were transgender people identifying as female; 2% (n=11) were intersex participants identifying as male and 0.13 (n=7) were intersex people identifying as female. It must be acknowledged that the initial forced choice of a male/female gender was experienced as inappropriate and alienating for some potential participants who provided feedback that they were unable to participate.

Table 2:
Gender of participants

Gender	N	Percent
Males	3,429	62.6
Females	1,929	35.2
Trans-males	34	0.6
Trans-females	66	1.2
Intersex males	11	0.2
Intersex females	7	0.1
Total	**5,476**	**100**

The high number of men is, to some extent, a product of the methodology used. Male-oriented internet sites on which we advertised have much larger client groups than those oriented to women and these were overwhelmingly our most successful recruitment points.

Participants were asked to nominate a sexual identity and the most common was "gay man" with just over half (52.1%) of the participants nominating this identity. The next most common identities were "lesbian" (17.8%) and "bisexual" (10.2%).

Table 3:
Identity of participants

Self-identification	N	Percent
Gay man	2,854	52.1
Lesbian	973	17.8
Bisexual	556	10.2
Gay woman	280	5.1
Don't use label	264	4.8
Queer	211	3.9
Dyke	138	2.5
Heterosexual/straight	79	1.4
Not sure	76	1.4
Other	45	0.8
Total	**5,476**	**100**

The relationship between sexual self-identification and gender was unsurprising. Interestingly, proportionately more women than men self-identified as bisexual or queer, or did not use a self-identification label. This is a pattern similar to that reported by the same sex attracted young people in the *Writing Themselves In Again* study (Hillier et al, 2005) where the young women were also more diverse than the young men in their responses to this question.

Transgender males were most likely to self-identify as queer whereas transgender females were almost equally likely to self-identify as bisexual or lesbian. Both intersex males and females selected a broad range of identities, although the numbers are small. As this study was promoted primarily in queer communities, we cannot comment on how typical this might be of transgender or intersex people generally. Also of interest is the significant number of participants, both male and female, who chose the option of not using a label.

Table 4:
Sexual self-identification and gender

	Males	Females	Trans-males	Trans-females	Intersex males	Intersex females
Heterosexual/straight	27	35	5	8	4	0
Gay woman	0	278	0	2	0	0
Gay man	2,849	0	3	0	2	0
Lesbian	0	956	0	16	0	1
Dyke	0	136	0	1	0	1
Bisexual	305	226	5	15	3	2
Queer	74	115	15	5	1	1
Not sure	44	24	2	5	0	1
Don't use label	109	143	2	9	0	1
Other	21	16	2	5	1	0
Total	**3,429**	**1,929**	**34**	**66**	**11**	**7**

Of the males, 83% identified as a gay man, 9% identified as bisexual, 3% did not use an identity label and 2% identified as queer. Amongst the females, 49% identified as lesbian, 14% as a gay woman, 12% as bisexual, 7% did not use a label, 7% identified as a dyke and 6% as queer.

IDENTITY AND ATTRACTION

The relationship between sexual identity, attraction and experience is complex (Smith et al, 2003) particularly amongst young same sex attracted people (Hillier et al., 2005). Given the nature and broad age range of the sample it is not surprising that the majority of men report being attracted exclusively or predominantly to men. Similarly, the majority of women report being attracted exclusively or predominantly to women, although women are less likely than men to say they are attracted only to those of their own gender.

The situation among transgender males and transgender females is more complex. A majority of transgender male participants reported being predominantly or exclusively attracted to women. A significant minority of transgender males reported being attracted equally to men and women. Among the transgender females, the majority of participants reported being predominantly or exclusively attracted to women, and fewer of the transgender females that transgender males reported being attracted equally to both sexes. Given the smaller numbers is difficult to draw conclusions about the attraction among intersex males and intersex females.

Table 5:
Attraction and gender

Attraction[1]	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Women only	0.2	20.4	8.8	24.2	18.2	14.3
Women mainly	2.9	59.1	47.1	34.9	18.2	14.3
Equally	4.7	14.4	32.4	18.2	18.2	42.9
Men mainly	39.6	5.7	2.9	15.2	18.2	
Men only	52.5	0.2	5.9	7.6	27.3	28.6
No one	0.1	0.23	2.9			

The patterns of sexual experience broadly follow those of sexual attraction. Nearly all of the men reported sexual experience that is either predominantly or exclusively with other men. The pattern with women is less clear: a higher proportion of them report sexual experience equally with men and women or mainly with men. This is similar to the differences Hillier and her colleagues (2005) reported between young men and young women. As with sexual attraction, patterns of sexual experience among transgender males and transgender females are more diverse than is the case for other people. Among intersex people the numbers are too small to provide much insight into the patterns of experience.

[1] The question asked was: *which of the following best describes you?*

The choices were:

- I have felt attracted only to females, never to males;
- More often to females and at least once to a male
- About equally often to females and to males
- More often to males and at least once to a female
- I have felt sexually attracted only to males, never to females
- I have never felt sexually attracted to anyone at all.

Table 6:
Experience and gender

Experience[2]	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Women only	0.4	16.2	11.8	27.3	0	0
Women mainly	3.7	48.2	38.2	36.4	44.4	0
Equally	3.7	15.1	29.4	10.6	0	57.1
Men mainly	45.5	16.2	8.8	15.2	22.2	14.3
Men only	45.5	2.9	8.8	7.6	22.2	14.3
No one	1.2	1.4	2.9	3.0	11.1	14.3

As already noted, the relationship between sexual attraction and sexual experience is complex. As can be seen from table 7, there is a fair degree of correlation between people's stated sexual attraction and their reported sexual experience. Of the people who indicated that they were attracted only to women, nearly half reported having had sexual experience only with women. In relation to attraction to or experience with men the situation is more marked: 70% of those only being attracted to men also reported only having had sexual experience with men. However, it is important to note the quite significant numbers of survey participants for whom there was less correlation between attraction and experience as well as identity. These participants will have particular sexual health information needs and form an important part of this more complex picture.

Table 7:
Attraction and experience

Attraction	Women only %	Women mainly %	Both %	Men mainly %	Men only %	No one %
Experience						
Women only	44.3	11.2	1.9	0.3	0.1	12.5
Women mainly	47.1	63.0	14.7	1.5	0.0	12.5
Both	4.3	13.6	43.3	2.8	0.2	12.5
Men mainly	1.4	9.5	34.2	73.4	28.2	37.5
Men only	0.5	1.6	3.9	20.9	70.2	25.0
No one	2.4	1.1	1.9	1.1	1.3	0.0

[2] The question asked: *Which of the following best describes your sexual experience?* The options followed the same patterns as for 'attraction'.

EDUCATION AND EMPLOYMENT

Nearly 50% of the sample had a university degree and 60% of the sample was in full time employment. A further 16.9% were in part-time employment, 12% were students at the time of the survey and 3.3% were on a pension or benefits. Retirees made up 2% of the sample and only 3.4% were unemployed.

Table 8:
Education levels

Education	N	%
Primary school only	30	0.5
Secondary school	1,445	26.4
Tertiary diploma or trades certificate	1,219	22.3
University degree	1,708	31.3
Post graduate diploma	1,056	19.4
Total	**5,458**	**100**

This is an unusually highly educated sample. In the Australian Bureau of Statistics data for May 2003, 49% of persons aged 16 to 64 had at least one non-school qualification, compared to 73% of this sample. Similarly, 18% of the general population (ABS) had a bachelor degree or higher, compared to 50% of this sample. Rates of employment were also high.

Table 9:
Employment status

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Full-time	62.9	56.7	35.3	44.6	18.2	14.3
Part-time	12.7	24.5	20.6	15.4	18.2	0
Unemployed	3.6	2.6	8.8	12.3	9.1	0
Retired	2.7	0.8	2.9	1.5	9.1	28.6
Household duties	0.3	1.2	2.9	1.5	0	0
On benefits	2.9	3.1	11.8	15.4	36.4	42.9
Student	12.8	10.8	14.7	9.2	0	14.3
Volunteer	0.4	0.3	0	0	0	0
Other	1.7	0	2.9	0	9.1	0

Of the 3.4% who were unemployed more than half had been unemployed for less than six months.

Table 10:
Length of unemployment

Unemployed for	Freq.	%
<1m	8	13.1
1-6 m	26	42.6
6-12 m	6	9.8
1-5 yrs	16	26.2
other	5	8.2
Total	**61**	**100**

Table 11 shows the major occupational classifications of the 4,094 participants who provided us with occupational information. They have been coded according to the Australian Standard Classification of Occupations. As can be seen nearly three quarters (73.9%) were associate professionals, professionals or managers and administrators.

Table 11:
Occupations of participants

Occupation	Males	Females	Trans-males	Trans-females	Intersex males	Intersex females	Total
Managers & administrators	13.9	10.9	5.6	2.5	0	0	12.9
Professionals	42.6	51.5	44.4	60.0	25.0	0	46.1
Associate professionals	16.1	13.9	11.1	12.5	50.0	0	15.2
Trades persons & related workers	4.3	2.5	5.6	12.5	0	0	3.7
Advanced clerical and service	6.6	7.7	5.6	5.0	25.0	100	7.0
Intermediate clerical, sales and service	11.5	8.7	16.7	0	0	0	10.3
Intermediate production and transport workers	1.2	0.72	0	5.0	0	0	1.0
Elementary clerical, sales and service	3.4	3.4	5.6	0	0	0	3.4
Labourers & related workers	0.6	0.7	5.6	2.5	0	0	0.7
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

As might be expected in a highly educated group, participants in the study were much more likely to be in managerial, professional and associate professional occupations and were much less likely to be in production, elementary clerical and labouring occupations.

RELIGION

We asked participants three questions about religion. The first concerned their religious background. When we asked *What religion were you brought up in?*, 29% reported 'No religious background', while 30.7% were brought up Catholics and 27.8% as Protestants. In response to the second question, *What is your current religion?*, we saw some clear changes with a marked drift away from the religion of birth.

Table 12:
Religion of participants

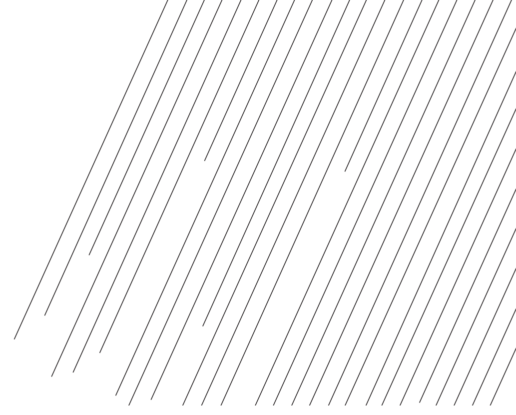
	Religion of birth		Current religion	
	N	%	N	%
None	1,601	29.3	3,863	70.9
Catholic	1,674	30.7	444	8.2
Protestant	1,519	27.8	330	6.1
Buddhist	39	0.7	170	3.1
Hindu	12	0.2	7	0.1
Judaism	69	1.3	47	0.9
Islam	20	0.4	15	0.3
Sikh	1	0.0	0	0.0
Wicca	21	0.4	146	2.7
Other	500	9.1	424	7.8
Total	**5,456**	**100**	**5,446**	**100**

As can be seen, more than 70% reported no current religion, 8.2% were currently Catholic, 6.1% currently Protestant and 3.1% Buddhists. This is undoubtedly a reflection of the difficulty of reconciling a non-heterosexual identity with the strictures of much religious doctrine. Only two religions were more common as 'current' than 'background' and they were Buddhism and Wicca.

Respondents were invited to rate their current religious community as 'gay friendly', 'neutral' or 'anti-gay'. The majority of those whose current religion was Catholic described their religious community as anti-gay, as did those whose religion was Islam. The religious communities participants perceived as most gay- friendly were of the Wicca and Buddhist religions, probably explaining the increased number of participants in them.

Table 13:
Gay-friendliness of religions

	Gay friendly	Neutral	Anti-gay
Catholic	38	174	229
Protestant	63	165	100
Buddhist	78	83	3
Hindu	1	4	2
Judaism	9	28	9
Islam	2	3	10
Wicca	114	29	2
Total	**308**	**491**	**361**



4. HOME AND FAMILY

In relation to the three best things in the lives of participants right now, friends, family, home and habitat were shown to be very important. Relationships were the "first choice" by far for participants. This choice would primarily reflect the importance of the domestic scene, given the large number of participants who lived with their partner.

LIVING ARRANGEMENTS

Participants in the survey were asked to describe their living arrangements and provided responses indicating a diverse range of home situations.

Table 14:
Living arrangements

	Males %	Females %	Trans-males %	Trans-females %	Intersex male %	Intersex female %
Lives alone	27.4	18.9	20.6	37.9	54.6	42.9
Live with partner	33.1	47.9	47.1	31.8	27.3	14.3
Lives with children	3.7	15.9	11.8	13.6	18.2	0
Lives with parents	18.6	14.1	14.7	10.6	0	28.6
Lives with housemates	18.5	14.3	5.9	13.6	9.1	0
Lives with friends	8.1	6.3	5.9	6.1	27.3	14.3

Nearly 40% reported that they were living with a partner while around a quarter of the sample reported that they were living alone. Women were more likely than men to be living with a partner. Of the remainder, most reported living with their parents, with their children or housemates. Women were more likely than men to report living with children and somewhat less likely to report living with parents. Significantly more of the transgender female, intersex male, and intersex female respondents reported living alone, but transgender males were more likely to be living with a partner.

HOUSING TENURE

Home ownership was quite common in this sample. While just over half reported renting the property in which they lived, approximately a quarter reported that they were buying a home. A further 17% reported that they owned the property in which they lived. However, this is a much lower rate of home ownership than in the community generally (ABS, 2004)

Table 15:
Housing tenure

Tenure	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Renting a private dwelling	54.1	51.6	70.4	53.7	20.0	75.0
Renting govt. housing	2.9	2.9	11.1	9.3	40.0	25.0
Buying your home	23.8	30.5	14.8	18.5	20.0	0
Living in a home you own	19.2	14.7	3.7	16.7	20.0	0
Homeless at the moment	0.1	0.3	0	1.9	0	0
Total	**2,603**	**1,534**	**27**	**54**	**10**	**4**

RELATIONSHIP STATUS

Many participants were not in a current relationship (self defined): more than half of men (52.0%) and higher percentages of transgender female and intersex people were not in a current relationship. However, 59.5% of women reported a current relationship with another woman and 42.9% of men reported a current relationship with another man. It is also notable that 5.1% of men and 7.6% of women were currently in a relationship with an opposite sex partner.

Table 16:
Current relationship

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
With a Woman	5.2	59.5	41.2	28.8	18.2	0.0
With a Man	42.9	7.6	11.8	9.1	9.1	28.6
No one	51.9	32.9	47.1	62.1	72.7	71.4

For those in relationships there was a marked similarity between men and women in the longevity of these relationships. Of the men in relationships, 78% had been in the relationship for more than one year, 41% for five years or more and 20% for 10 years or more. Of the total sample of men, one in 12 was in a relationship of ten years or more. Of the women in relationships, 76% had been in the relationship for more than one year, 32% for five years or more and 14% for 10 years or more. Of the total sample of women, one in 12 was in a relationship of ten years or more.

Respondents were asked how long they had known their most recent sexual partner before having sex with them. Men were much more likely than women to report having known their partner for less than 24 hours before having sex (37% vs 7%), whereas women were more likely than men to report having known their partner for more than a year before having sex (30% vs 17%).

The 2,984 participants who reported a current relationship were asked, *Have you and your partner formalised your commitment through marriage or some other ceremony?* Only a very small percentage of men and women (between 5-10%) reported a formal commitment. It is of interest that the majority of respondents (between 52% of men and 39% of women) indicated no intention or wish to formalise their current relationship. This result appears to provide some contrast to the approximately 75% of respondents to a

Victorian survey who were in favour of same sex marriage or formal domestic partnership being available throughout Australia (McNair and Thomacos, 2005). The discrepancy may also be explained by the fact that participants in the latter study reported being in favour of the option being available rather than whether or not they personally wished to take advantage of such an option.

Table 17:
Interest in a commitment ceremony

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %
Yes	5.1	10.3	0	42.1	0
No, but we have planned to	5.5	9.6	0	10.5	100
No, but we would like to	20.3	25.0	50.0	31.6	0
No, we have no intention	52.1	39.3	25.0	10.5	0
Undecided	17.1	15.7	25.0	5.3	0

PETS

Pets play an important role in the lives of many GLBTI people and they were nominated by many as among the three best things in their life. It is therefore not surprising that many households were augmented by a pet.

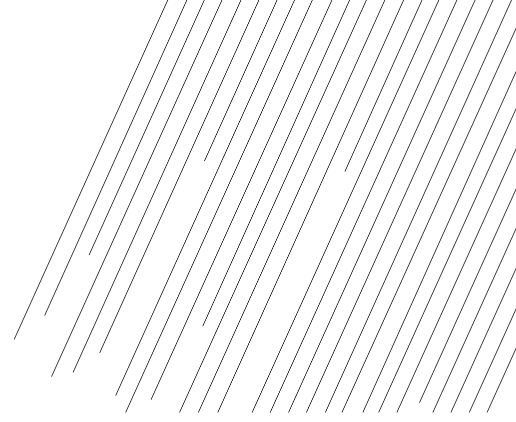
Table 18:
Pet ownership

Any pets	N	%
yes	2,986	54.9
no	2,458	45.2

Just over half (54%) reported that they had a pet or pets. This is a slightly lower rate than Australian households in general (64%). Dogs were the most common, closely followed by cats. Smaller numbers reported having fish, birds, rodents or some other animal.

Table 19:
Types of pets

	%
Dog	57.9
Cat	51.1
Fish	15.9
Bird	11.0
Rodent	5.1
Farm animal	3.8
Reptile	0.8



5. HEALTH AND WELLBEING

GENERAL HEALTH

The health of non-heterosexual people has been frequently seen to be poorer on a number of measures than that of their heterosexual counterparts (see for example Hillier et al, 2005; McNair and Medland, 2002). This can be largely attributed to the climate of heteronormativity, heterosexism and discrimination in which they live and attempt to access health services. The impact of this phenomena cannot easily be measured, although Hillier (2005) and her colleagues have clearly demonstrated a relationship between levels of homophobic abuse and rates of alcohol and drug use and self harm.

In this study we used a number of means to assess health status. We used the SF36 which is a five-item scale to assess general health function. The scale is scored from 1 to100, with a higher score indicating better health. In the total sample the average was 68.6. Men were the only group to score above the average and women were slightly below average. Transgender males and transgender females scored slightly below the mean, whereas intersex males and intersex females scored substantially lower.

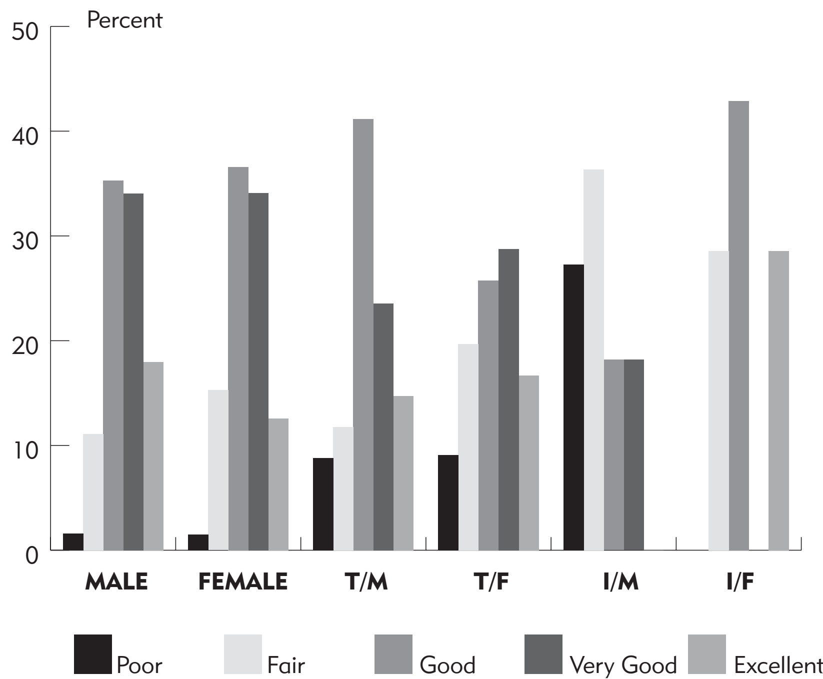
Table 20:
SF36 average scores

Gender	Mean
Males	69.6
Females	67.1
Trans-males	65.1
Trans-females	66.1
Intersex males	39.8
Intersex females	47.3
Total sample	**68.6**

The SF36 has been standardised on the American population; the average score in the United States is 71.9. All our participant groups scored lower on this general health measure. The extremely low score for intersex people, despite their small numbers, is cause for some concern.

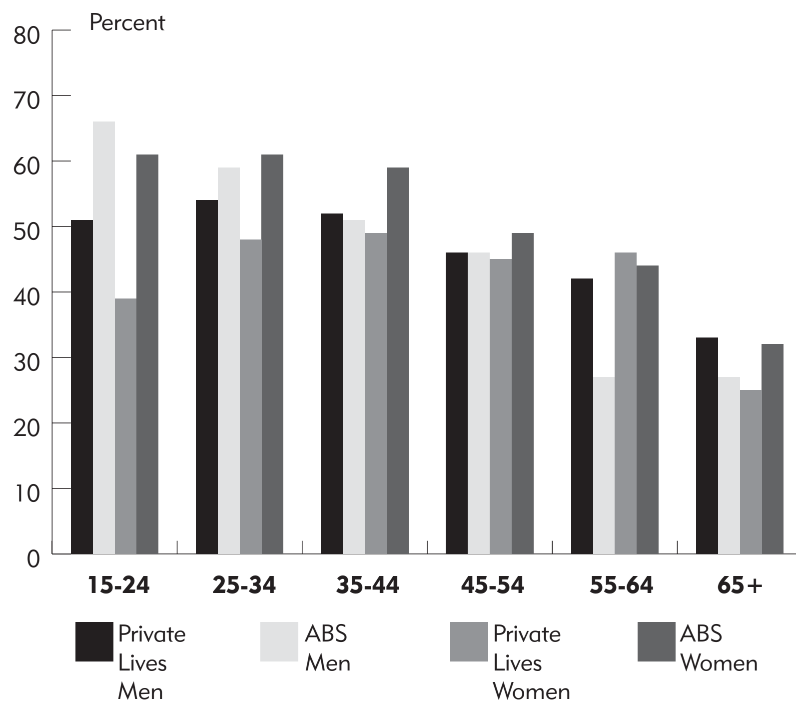
We also asked participants to rate their general health on a five point scale from *poor* to *excellent*. Figure 3 indicates the percentages from each of our groups who indicated that their health was poor, fair, good, very good or excellent.

Figure 3:
Self-rated health of participants



It is possible to compare the responses from our participants with those of the general Australian population as measured in the National Health Survey 2001 conducted by the Australian Bureau of Statistics (ABS). In Figure 4 we show the percentage of participants in each age group who indicated that their health was either *excellent* or *very good*, compared against equivalent age responses in the ABS survey.

Figure 4:
Health rating comparison with the Australian population



It is very interesting to note from this figure that the percentage of *Private Lives* participants, both men and women, who report very good or excellent health, is considerably lower than the ABS men and women in the younger age groups. However, these differences diminish with age: by 45 years the differences between *Private Lives* participants and the ABS respondents are minimal or non-existent. This may trace a developing confidence in participants in their sexual orientation and the progressive establishment of supportive social networks over time. Concerns relating to health may thus diminish and participants feel better about themselves in later life. This is one of the most encouraging findings of the study.

WEIGHT AND EXERCISE

Table 21 shows the heights and weights for all *Private Lives* participants with the exception of those who were inter-sex. The number of intersex participants who provided these data was too small to allow calculation. Body Mass Index (BMI) is a common calculation of whether weight is within the normal range. When the percentages from *Private Lives* are compared with the National Health Survey 2001 (ABS) we find very similar outcomes. Thirty one per cent of Australian adults in the ABS survey were overweight and 15% obese. Among Australian male adults the percentage overweight or obese is 54%, compared with 43% of *Private Lives* men. For Australian women, 38% are overweight or obese and in the *Private Lives* sample it is 49%.

Table 21:
BMI of participants

	Males	Females	Trans-males	Trans-females
Height in cms (mean)	179	166	167	176
Weight in kgs (mean)	80	73	73	79
BMI	25	26	26	25

Table 22:
Obesity rates

	All	Males	Females	Trans-males	Trans-females
	%	%	%	%	%
Underweight	4.8	4.5	5.0	10.3	7.3
Acceptable	50.2	52.9	45.8	44.8	42.8
Overweight	28.8	30.3	25.6	27.6	36.4
Obese	16.2	12.3	23.6	17.2	14.5

We asked which of a number of forms of exercise *Private Lives* participants engaged in.

Table 23:
Types of exercise undertaken by participants

	All	Males	Females	Trans-males	Trans-females	Intersex males	Intersex females
	%	%	%	%	%	%	%
Walking	79.9	81.5	77.9	75.8	63.6	45.5	57.1
Swim	28.0	28.9	27.1	18.2	15.2	9.1	28.6
Aerobics	11.6	13.2	9.2	18.2	4.6	9.1	
Gym	31.8	37.5	23.1	30.3	3.0		28.6
Cycle	18.9	18.0	20.6	21.2	16.7	9.1	0.0
Golf	3.1	2.5	4.3	3.0	6.1		14.3
Tennis	6.4	7.3	5.2		1.5		
Run	13.8	16.4	9.6	12.1	6.1		14.3
Bushwalking	13.1	13.3	12.8	9.1	15.2	9.1	
Outdoor soccer	2.9	1.6	5.3		1.5		
Netball	1.5	1.2	2.2	3.0			14.3
Gardening	26.2	24.4	29.8	18.2	22.7	27.3	14.3

Leisure activities, which included those activities listed above, were also strongly nominated as among the three best things in the life of participants. There are strong similarities across all groups in the most favoured recreational activities, such as walking, swimming, gardening and bushwalking. Men are more likely than women to use a gym, whereas women are more likely to play golf. Individual sports appear to be more popular than team sports, which may suggest that homophobia in team environments is a deterrent to participation (McKay et al., 2000; Griffin, 1998)

COMMON HEALTH CONDITIONS

We asked participants to indicate whether they had ever been told by a doctor that they were suffering from any of a range of common disorders and diseases.

**Table 24:
Reported health conditions**

	All	Males	Females	Trans-males	Trans-females	Intersex males	Intersex females
	%	%	%	%	%	%	%
Anxiety	20.2	17.6	23.6	38.2	37.9	27.3	42.9
Asthma	24.0	20.9	29.2	32.4	30.3	27.3	28.6
Bowel cancer	0.2	0.2	0.2				
Depression	33.0	29.5	37.9	58.8	48.5	63.6	57.1
Diabetes	2.9	3.3	1.7	5.9	9.1	27.3	14.3
Heart disease	10.3	12.1	6.8	8.8	13.6	36.4	28.6
Hepatitis B	3.1	4.6	0.5		1.5		
Hepatitis C	1.9	2.2	1.7	2.9	1.5		
High cholesterol	11.2	12.2	8.9	8.8	16.7	36.4	28.6
Other cancer	1.6	1.9	0.9		3.0	18.2	
Other major health problem	10.7	10.3	10.8	14.7	18.2	54.6	28.6
Other psychological problem	5.4	4.1	7.1	17.7	15.2	0	57.1
Skin cancer	4.5	5.2	3.4	2.9	4.6	0	14.3
Stroke	0.6	0.7	0.4			9.1	
Thrombosis	0.3		0.7		4.6		
Breast cancer	0.3		0.8				
Cervical cancer	0.5		1.5				
Endometriosis	2.5		7.0				
Osteoporosis	0.7		2.0				
Ovarian cancer	0.1		0.3				
Polycystic ovaries	2.6		7.3				

As can be seen from Table 24 the most common reported condition overall was depression, with averages ranging from 29.5% of men to 63.3% of intersex males. This finding confirms many previous studies with smaller samples that have reported disturbingly high levels of depression among GLBTI communities. This finding will be discussed further in the following section on mental health. Anxiety and asthma were also reported by significant percentages of all participants, while heart disease and high cholesterol were also reported by around 1 in 10 participants.

MENTAL HEALTH

A number of studies have suggested that mental problems such as anxiety, depression and self-harm are more common amongst GLBTI people. Analysis of the same sex attracted women in the younger cohort (22 – 27 years) of the Longitudinal Study of the Health of Australian Women (McNair et al, 2003) showed that these women were significantly more likely than the other women in the study to report being depressed (38% vs 19%). The SSAY women had higher levels of anxiety (17.1% vs 7.9%) and significantly more reported having tried to harm or kill themselves in the last 6 months (12.6 vs 2.7%). A recent study in the UK (Warner et al. 2004) demonstrated that, in a sample of 1285 gay, lesbian and bisexual people, 43% had high rates of clinical mental disorders and 361 of the respondents had attempted suicide. In a retrospective study of suicide attempts amongst young adults (mean age 21 years) Nicholas and Howard (2001) found higher rates of self-reported suicide attempts by gay men (20.8% vs 5.4%), lesbians (28% vs 8.3%) and bisexuals (34.9%) compared to heterosexual people. Out of the 20,000 participants in the *Sex In Australia* study, those who are same sex attracted reported higher levels of psychosocial distress (Smith et al, 2003). The authors attribute this phenomena to levels of homophobia in Australian society. This conclusion is born out by the work of Warner (2004) and Hillier et al (2005), both of whom are able to demonstrate the connection between mental health problems and experiences of verbal and physical abuse which is presumptively homophobic.

In this study we also found a quite distressing picture of depression and suicidal ideation (thoughts). We used the Prime MD to investigate psychological well-being, in particular rates of depressive symptoms. Prime MD was designed to diagnose mental health problems in the primary health care setting. It is considered to be an appropriate screening tool for adults (eighteen years plus). It is short (nine items) and easy to answer. It was recommended by Gary Rogers from the University of South Australia who has used it extensively in his clinic for gay men in Adelaide.

The instrument contains two screening questions that ask about reduced interest or pleasure in doing things and about depressed feelings. If either question is answered affirmatively then all other items are scored. Overall, 32.4% of respondents answered affirmatively to the question: *In the past two weeks have you experienced little interest or pleasure in doing things?* In addition, 41.2% answered affirmatively the question: *Feeling down, depressed or hopeless?*

Table 25:
Mental health: in the past two weeks have you experienced any of the following?

	Males %	Females %	Total sample %
Trouble falling asleep or sleeping too much	55.3	55.3	55.4
Feeling tired or having little energy	69.5	71.3	70.1
Poor appetite or over-eating	40.7	43.0	41.7
Little interest or pleasure in doing things	34.7	27.9	32.4
Feeling down, depressed or hopeless	41.8	39.1	41.2
Feeling bad about yourself	35.3	39.1	37.0
Trouble concentrating	23.0	24.5	23.7
Change in activity levels	23.7	23.8	23.9
Feeling you would be better off dead	15.7	14.6	15.7

It can be seen from the table that there are only very minor differences between the male and female respondents.

It is of particular concern that 15.7% of all respondents indicated suicidal ideation (thoughts) in the two weeks prior to completing the survey. This result closely matches the figures from the Rogers et al (2004) study of gay men in South Australia which reported that 14% of HIV + men and 17% of HIV-ve gay men answered this question affirmatively. Their study also offers a comparison figure from a study undertaken by Jorm and colleagues in 1999-2001. A survey of 2,243 heterosexual men yielded a rate of 10% of suicidal ideation in the past year. Both studies show considerably higher levels of suicidal ideation in the short two week time frame, than in heterosexual men in the past year.

In our sample, the prevalence of depressive disorders was high, with 48.6% of men and 44.4% of women scoring on at least one of the two criteria for a major depressive episode (MDE).

An MDE is defined as when the respondent scores on at least one of the two screening questions and answers in the affirmative to a further five from the nine items. In all, 24.4% of our respondents scored at this level.

We also asked about any previous history of depression. Nearly three quarters of the sample reported some depression in the past, and of these nine out of ten reported problems such as trouble sleeping and/or concentrating, feeling tired, poor appetite and little interest in doing things.

Table 26:
Previous history of depression

	Males %	Females %	Total sample %
Ever been depressed?	69.5	80.4	73.7
If yes, did you have problems?	87.9	92.5	89.7
Over past two years have you felt depressed on more than half the days?	32.9	32.2	32.9
If yes, was it hard to do your work?	83.8	88.1	85.6

Dysthymic disorder (DD) is a less intense condition of depressed mood which has been present and significantly impacted on a person's functioning on the majority of days in the past two years. One third of all respondents reported that they had felt down or depressed or had little pleasure in doing things on more than half of days in the past two years. Of these, 85% reported that it had been hard to do work, take care of things at home or get along with other people. Rogers et al. report that 27% of their cohort of gay men was diagnosed with DD on enrolment into their study. They also cite a comparative percentage from a Canadian primary health care unit of 3.9% for adult male attenders.

Our figures of 70% of men and 80% of women reporting a lifetime prevalence of a depressive disorder are considerably high than Rogers et al (2004) figure of 48% for gay men.

It was encouraging to see there was a significant negative correlation with age – the older the respondent the less likely they were to score highly on Prime MD. There is also a significant negative correlation with self reported health.

Given these figures, it is not surprising that half of all participants had seen a counsellor or psychiatrist in the past five years. This translates to around one in four men and almost one in three women, rising to the majority of transgender and intersex respondents.

Table 27:
Seeing counsellor or psychiatrist in the past five years

	All %	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
	50.1	42.2	62.2	88.2	80.3	72.7	85.7

Issues raised by those who had seen a counsellor or psychiatrist in the past five years were largely related to depression and anxiety. Relationship problems were the second most common reason for a consultation, while family problems also figured largely.

Table 28:
Main issues of concern

	All %	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Coming out	13.7	13.3	13.7	23.3	22.6	0.0	33.3
Depression / anxiety	62.8	64.8	60.7	63.3	50.9	87.5	83.3
Family problems	31.0	26.8	36.7	30.0	18.9	25.0	33.3
Grief and loss	20.4	18.3	22.9	13.3	20.8	37.5	33.3
HIV issues	5.6	10.3	0.3	0	0	0	16.7
Improved self understanding	29.7	27.4	32.6	36.7	20.8	62.5	33.3
Relationship break up	26.6	25.3	29.6	6.7	9.4	0.0	33.3
Relationship problems	38.8	39.2	39.5	23.3	26.4	25.0	33.3
Relationship with children	4.1	2.7	5.6	3.3	7.6	0	0
Sexual abuse	11.5	8.5	15.0	13.3	7.6	25.0	33.3
Sexual identity	18.8	18.3	16.8	36.7	56.6	25.0	83.3
Sexual problems	10.1	12.4	7.1	13.3	3.8	25.0	50.0
Workplace issues	22.8	23.1	23.2	10.0	13.2	12.5	33.3

DRUG USE

There is a significant body of research which links same sex attraction with elevated levels of drug use. Some of this may be cultural (Southgate et al., 1999), particularly for gay men, but much of it is clearly a response to a homophobic environment. Hillier et al (2005) found evidence of high levels of drug use directly mirroring patterns of homophobic abuse. The same sex attracted women in the younger cohort (22 – 27) of the Longitudinal Study of the Health of Australian Women (Hillier et al, 2004) were significantly more likely to report risky alcohol use (7% compared to 3.9%), marijuana use (58.2% compared to 21.5%), other illicit drugs (40.7% compared to 10.2%) and injecting drug use (10.8% compared to 1.2%) than their heterosexual counterparts. Higher rates of tobacco use amongst GLBTI people are also well documented with lesbians' rates of use being of particular concern (Murnane et al 2000; Richters et al, 2000).

Patterns of drug use in this sample again appear somewhat higher than in the Australian population. Tobacco use is higher for all groups in the *Private Lives* sample than in the National Health Survey (ABS), where the comparable percentage is 24%. Overall, more than a third of respondents reported using tobacco more than five times in the previous month (37.3%) and one in six (15.7%) reported using marijuana at the same level. No other drug was used that frequently by the entire sample. Ecstasy (9.1%), speed (5.1%) and crystal (3.1%) were the next more often used drugs. Others were more rare and used more than five times in the previous month by less than 1.5% of the total sample

Table 29:
Use of drugs on more than five occasions in the previous month

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Tobacco	38.3	35.6	44.1	35.4	36.4	42.9
Marijuana	16.6	14.5	14.7	10.8	9.1	14.3
Ecstasy	11.8	4.7	3.0	3.1		
Speed	6.0	3.7			9.1	
Crystal	4.2	1.3		3.1	9.1	
GBH	1.7				9.1	
Cocaine	1.6	1.0			9.1	
Steroids	0.8	0.4	21.2	3.1	9.1	14.3
LSD	0.6	0.1			9.1	
Heroin	0.3	0.2			0.0	

The most marked variations in drug use with respect to gender included more men than women using LSD, ecstasy, speed and crystal more than five times in the previous month. This would appear to reflect cultural patterns of drug use. Intersex males, intersex females, transgender males and transgender females appear to be more likely to report frequent use of steroids.

SEXUALLY TRANSMITTED INFECTIONS (STIs)

Studies of the sexual health of GLBTI populations have largely been restricted to gay men with an understandable focus on HIV. Both HIV and other STIs remain a significant health concern for gay men (Grulich et al, 2003). Studies of lesbians have been fewer in the face of a perception that lesbians do not get STIs, an assumption which has been challenged from a number of sources (Fethers, 2000; Horsley et al, 2001; Bentley et al, 2002), as well as documentation that lesbians also have sex with men (Richters et al, 2005). There is very little research on STI rates in transgender and intersex people.

Table 30:
Lifetime diagnoses of STIs

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Pubic lice	38.9	4.2	11.8	4.6		14.3
Gonorrhoea	19.0	0.5		1.5	9.1	
Non-specific urethritis	14.9			0.0	9.1	
Genital or anal warts (HPV)	12.3	6.4	8.8	9.1	9.1	
Chlamydia	10.4	3.9	2.9	6.1		
Herpes	7.8	5.1	8.8	4.6		14.3
HIV	7.8	0.0				
Syphilis	3.7	0.1				
AIDS	1.3					
Candidiasis		49.3		15.2		28.6
Urinary tract infection		34.1		22.7		28.6
Vaginitis		3.9		3.0		
PID		2.2				14.3
Trichomonas		1.9				

The most common STI reported by women in this sample was candidiasis (recognising that this can

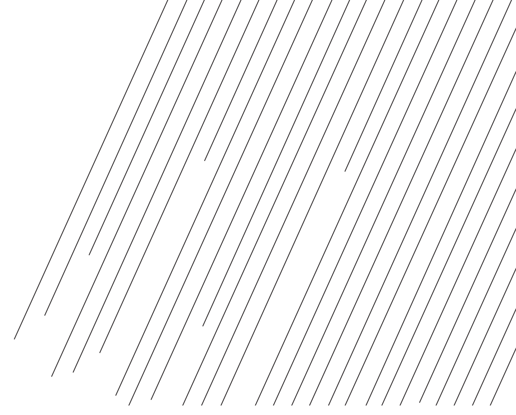
frequently be non-sexually transmitted), followed by urinary tract infection. No other STI was reported by more than 5% of the women. For men the picture was different and more concerning. While almost 40% cent of men reported having had pubic lice, one in five reported gonorrhea and more than one in ten men reported NSU, HPV, and Chlamydia. For trans-gender and inter-sex respondents the rates overall were low.

PREGNANCY AND PREGNANCY OUTCOMES

Just under a third of women in the sample (30.3%) reported having been pregnant. Many of these pregnancies would have been within a heterosexual relationship, as only 5% of all women reported having children outside a heterosexual relationship. Of those reporting a pregnancy, 63.9% reported a live birth and 53.4% reported having had a termination. Nearly two thirds of those women who reported a termination (62.5%), reported only one termination. An experience of miscarriage was reported by 36.8% of those women who indicated they had been pregnant. As with other pregnancy outcomes, the most common number of reported miscarriages was one (72.6%). The least common pregnancy outcome was a still birth: 1.9% of women who reported a pregnancy indicated the outcome was a still birth. Of these 337 live births, the most common number of live births per woman was one (42.3%), with a further 34.3% reporting two live births. The highest number of live births per woman reported was six.

Of 1,909 women, nearly half (44.7%) indicated they wanted more children. This was much less common among those women with children (24.5%) than among women without children (51.0%). Four hundred and ninety two women (25.6%) reported having children. In total, 951 children were reported. Women reported a mean number of 1.9 children. Children's ages ranged from newborn to 58 years old; the average age was 17 years.

6. HEALTH SERVICE USE



Kate's Story

While I was transitioning I had lived in (capital city) for about five years and when I moved back to (regional centre) I went back to my old health centre. The first time I went there the receptionist asked if I'd been there before. Without really thinking I said "Yes, about five years ago" and gave her my old address. "We only have a file on Keith there," she said. "Is that your husband?"

"No," I said, "It's me, it's my file."

For a moment she really just stared at me while she worked it all out and then she just asked me my current name and address and adjusted the file in a very matter-of-fact way.

I was pretty heartened by that experience and it gave me the confidence to talk to the doctor about it up front.

It has been demonstrated that health service use of GLBTI people is less than that of the population generally, that GLBTI people are under screened for a number of common conditions, and that they present later for treatment (Roberts & Sorensen 1995; Diamont et al., 2000; McNair & Medland, 2002). A previous Victorian study (VGRL 2000) reported that 23% of GLBTI people had experienced discrimination from health care providers. The same sex attracted women in the younger cohort (22 – 27) of the Longitudinal Study of the Health of Australian Women (Pitts & Horsley, unpublished data, 2005) were more likely to be dissatisfied with the service provided by their GP, than are heterosexual women. They were also more likely to shop around for a sensitive GP and to consult allied/alternative health practitioners.

We asked a range of questions to establish the extent of health service utilisation of our participants. Around three quarters of the sample had a regular GP and around one in two had private health insurance. This is a higher rate of health insurance than the 42% of the general population who are insured (PHIAC, 2005)

Table 31:
Health Insurance

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Regular GP	72.4	70.7	76.5	87.9	90.9	71.4
Private insurance	56.6	51.1	47.1	53.0	45.5	42.9

Of those participants with a regular GP, only two thirds believed their GP knew of their sexuality/gender identity. This rose to almost all of the transgender and inter-sex respondents who may have been more likely to need to discuss issues of medical intervention. Conversely, one in five of male and female respondents indicated their regular GP did *not* know about their sexuality.

Cheryl's story

My GP is fantastic and I really get on with her well. We are about the same age and we talk about our grandchildren and all that sort of thing. I honestly couldn't say if she knows I'm a lesbian or not, it's never come up which is quite surprising really. And as long as it doesn't come up I suppose there's a little bit of fear in me that if I do tell her it will change the way she treats me, you know, ruin that really good relationship.

Table 32:
Doctor knows identity?

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Yes	67.2	65.7	84.6	96.6	90.0	100
No	22.6	21.4	7.7	3.5	10.0	
Don't know	10.2	12.9	7.7			

In spite of some of the uncertainty about health care that this might imply, the majority of participants had had a general health check up in the past year, and many had used a range of health services.

Table 33:
Health check ups

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Check up in last year?	68.1	65.9	73.5	81.8	90.9	28.6

Table 34:
Health service use in the past twelve months

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Chiropractor	14.9	21.1	17.7	76	18.2	
Dentist	59.6	57.9	38.2	39.4	54.6	57.1
HIV specialist	7.1	0.2				
Hospital emergency	9.9	11.4	20.6	15.2	27.3	42.9
Hospital in-patients	10.6	10.8	5.9	22.7	27.3	42.9
Hospital out-patients	11.3	10.0	20.6	16.7	27.3	28.6
Masseur	31.4	37.1	17.7	15.1	36.4	28.6
Naturopath	6.3	14.5	2.9	12.1		14.3
Physiotherapist	11.6	19.5	11.7	12.1	27.3	28.6
Sexual health	22.9	6.3	8.8	15.2	18.2	28.6
Telephone advice line	3.3	4.7	5.9	7.6	9.1	28.6
Traditional Chinese Medicine	5.5	13.5	5.9	7.6		
Maternal and child health		2.0				
Obstetrics and gynaecology		12.1		12.1		14.3
Women's health service		10.9		4.6		28.6

Participants used a wide range of health services from dental services through complementary and alternative therapists to mainstream hospital services. Around one in ten of respondents had used hospital based services in the past twelve months. Female respondents reported high use of all services in comparison with men, with the exception of HIV and sexual health services and hospital outpatients. An extremely high percentage on intersex males and intersex females had been in contact with hospitals in the past 12 months.

Table 35:
Experience of negative treatment

	N	Percent
Dentist	64	6.3
Sexual health service	17	2.0
Masseur	25	2.7
Naturopath	4	1.3
TCM	5	2.1
Chiropractor	15	3.1
Physiotherapist	16	5.1
Hospital in-patient	26	8.3
Hospital out-patients	25	9.4
Hospital emergency	28	10.8
HIV specialist	0	0
Telephone advice line	10	6.9
Women's health service	6	3.5
Maternal & child health	2	6.7
Obstetrics and gynaecology	14	7.8
Psychologist	11	1.8

As can be seen from Table 35, the overwhelming majority of health service contacts are either positive or neutral in relation to identity and sexuality. The number of adverse experiences reported is too few to allow a more extended analysis. However, it would appear that are particular issues in relation to hospital settings. It is likely that a large number of neutral experiences were so characterised because the health care provider was not told about the identity of the participant.

Of the 105 women who reported a birth outside of a heterosexual relationship, 41% reported that provision was made in the hospital documentation to accommodate the name of someone other than the biological father. Of the 105 women, 45% also reported that inclusive language was not used in birth classes. However, it was pleasing that in 66% of cases, the hospitals acknowledged the woman's partner. While it is not clear how many women did not have a partner, concern must be expressed for any women who were not acknowledged as a couple at this important time of family formation.

Among all those women who had ever been pregnant, 60% agreed or strongly agreed that the doctor/midwife listened carefully to what they said. Most (65%) reported that they were treated with courtesy and respect by all staff, and most (66%) would recommend their doctor/midwife to other people. These figures show that significant change to accommodate lesbian mothers is happening in obstetric services, although there are still too many women for whom the services are unsatisfactory.

SCREENING

For men who have sex with men anal cancer is an important health concern. There is an above average incidence in this population, particularly amongst those who are HIV positive (Palefsky et al, 1998). Screening programs need to be increased in this area, but there are currently no formal programs in place. We therefore asked screening questions only of female participants as national screening programs currently only target women. Concerns have been expressed about under-screening of lesbians for cervical cancer (Ferris et al., 1996) and efforts made by health promoters in recent years to improve screening rates. Nevertheless, of the females, 20.7% reported never having had a Pap test; although 39.5% reported having had a Pap test within the last year.

I've been to a male GP (who I don't see any more) who was adamant I didn't need to worry about pap smears because I'm a lesbian. He also didn't see my being sexually active as really having sex because I wasn't - in his heterosexual terms - having sexual intercourse!

I couldn't really "educate" him. I just sensed it wouldn't go down well and it could have compromised my treatment. After I'd finished with him I posted the "Lesbians need pap smears too" brochure to his office.

Of those who had had a Pap test, 26.5% indicated that they had had an abnormal smear test result. Of all the females in the survey, 74.5% report never having had a mammogram. However, when only those over 50 were considered - which is the targeted 'at risk' group for the national screening program - only 17.2% reported never having had a mammogram. Nearly half (44.26%) of those aged fifty or more reported having had a mammogram in the past year indicating that their screening was up to date. These rates are broadly consistent with the national picture of screening of all women in the 50-69 age group (55%) (Zorbas, 2003).

HIV AND STI TESTING

Most of the men who had STI check ups also had HIV tests indicating that STI testing occurs in the context of HIV testing for males. Of the male sample, 78% reported having had an HIV test at some time. Of those tested, 65.0% had been tested in the previous year, with a further 24.8% having been tested in the previous five years. The outcome of the test was a positive result in 9.7% of cases (N=261) with a further 1% (N=27) declining to disclose the outcome of the test or being unsure of the outcome. The majority of those tested (65.9%) indicated that they had not engaged in HIV risk practices since their last test, with a further 7.1% being unsure. More than half of the male participants (59.8%) reported having shared their status with their most recent sexual partner. Fewer than 10% indicated that they had not shared their status but nearly a third of the sample (30.6%) did not know, or could not recall, whether they had shared their status with their most recent sexual partner.

Rob's story

It got so I thought I would go mad if I didn't find a way of getting a HIV test. I couldn't go to the local woman as she knew my wife and kids and I'd barely ever been to her in my life. So the next time I went in to (regional town) I booked in with the GP there but I didn't know how to broach the subject. Finally I started off telling him I had been unfaithful to my wife. Before I could tell him anything more he had just assumed it was with a woman and got me set up for STI tests I didn't really want. He seemed a bit embarrassed and not really wanting to talk about it. I just didn't know how to make the situation work so I paid my bill and bolted out of there never to return. I think he thought I was mad. It was quite funny really I suppose, but I was shaking as I was driving home and I didn't see what I could do. Finally, I just bit the bullet and rang a sex clinic in (capital city) and asked over the phone to book in for the test. So I drove down and back in one day when I was supposedly at work and got it done. Thankfully, it came back all clear.

Male participants were asked if they had heard of post exposure prophylaxis (PEP) for HIV. Just under half of the men indicated that they had heard of PEP (48.3%) with an additional 2.3% being unsure. There was considerable geographic variation in relation to having heard of PEP. NSW was the only state in which the majority of participants (54.3%) had heard of PEP. Between 40% and 50% of men in Victoria, the ACT and Queensland had heard of PEP. Between 27% and 35% of men in the remaining States and Territories had heard of PEP. Given the relatively limited awareness of PEP, it is unsurprising that only 8.3% of those who had heard of PEP had attempted to access it. This was most common in NSW, Victoria and Queensland where between 8.1% and 11.1% of those who had heard of PEP had attempted to access it. The distribution of those who had used PEP was broadly similar and ranged between 6.1% and 8.4% of those from NSW, Victoria and Queensland who had heard of PEP.

Given the limited awareness of PEP, it is unsurprising that the awareness of pre-exposure prophylaxis (PrEP) is even scarcer. Only 16.5% of men in the sample had heard of PrEP with an additional 4.1% being unsure. Of those than had heard of PrEP, only 4.6% had used it. There are clear implications here for improved promotion of the availability of PEP within this population.

Table 36:
STI check-ups

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Last year	56.7	25.4	38.2	29.7	27.3	57.1
Last 5 years	18.0	25.1	29.4	26.6	54.6	
More than 5 years	5.7	14.3	11.8	17.2		
Never	19.6	35.2	20.6	26.6	18.2	42.9

It is unsurprising than more than half of the men (56.7%) had an STI check-up in the past year, while the high proportion of intersex female who had never had a check-up is of concern, though numbers are very small. Half of the females had had a check-up in the last 5 years, which suggests that the medical myth of 'lesbian invulnerability' to STIs may be breaking down.

7. SEX AND RELATIONSHIPS

In reporting on the three best things in their lives (chapter 10), participants ranked partners and relationships highest over all and much higher than sex, indicating a strong aspiration towards sexual/emotional relationships rather than simply having sexual partners. As reported earlier, 59.5% of women were currently in a relationship with another woman and 42.9% of men were in relationship with another man. However, in this section we report on sexual partners (with whom participants are not necessarily in a relationship), sexual feelings and behaviour. On the whole participants reported a good deal of physical pleasure with their most recent sexual partner, with fewer than 10.0% overall reporting less than moderate physical pleasure and 69.3% reporting more than moderate pleasure.

Table 37:
Physical pleasure with most recent sexual partner

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Extremely pleasurable	31.9	45.5	27.6	21.4	57.1	25.0
Very pleasurable	32.9	33.6	37.9	30.9		50.0
Moderately pleasurable	24.2	13.6	20.7	26.2	14.3	25.0
Slightly pleasurable	9.1	5.1	6.9	19.1		
Not at all pleasurable	2.0	2.2	6.9	2.4	28.6	

Emotional satisfaction ratings were not as high, with 54% reporting more than moderate emotional satisfaction and 23% reporting less than moderate emotional satisfaction. It is of note that 28% of men, compared with 14% of women, reported less than moderate emotional satisfaction with their most recent sexual partner.

Table 38:
Emotional satisfaction with most recent sexual partner

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Extremely satisfying	21.9	43.9	27.6	30.9	25.0	25.0
Very satisfying	23.6	26.4	24.1	28.5	25.0	50.0
Moderately satisfying	26.3	15.7	17.2	14.3	37.5	
Slightly satisfying	14.2	7.5	20.7	14.3		25.0
Not at all satisfying	13.9	6.1	10.3	11.9	12.5	

We asked how long the most recent sexual partner had been known before sex occurred. We found that gay men are much more likely than the other groups to have known their most recent sexual partner for less than 24 hours.

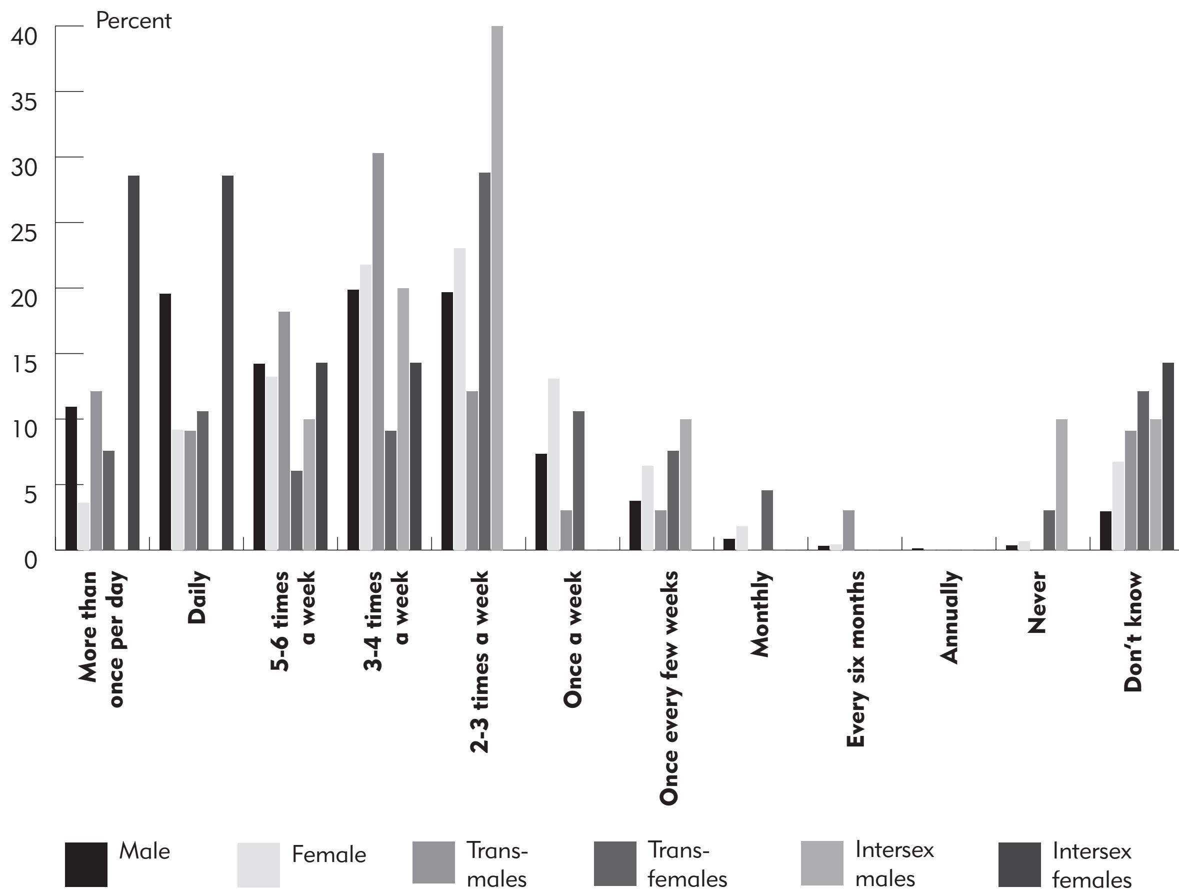
Table 39:
Length of time of knowing partner before sex

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
<24 hrs	37.8	6.9	17.2	14.3	12.5	
1-2 days	6.4	4.5	3.5	7.1		
1 week	10.5	11.0	3.5	7.1		50.0
1 month	15.1	25.4	27.6	21.4		
6 month	8.5	17.1	6.9	14.3	25.0	25.0
1 yr	4.4	5.4	10.3	2.4	12.5	25.0
>1yr	17.3	29.5	31.0	33.3	50.0	

FREQUENCY OF SEX

A quarter of all of respondents wished for sex at least daily, although female respondents were less keen on daily sex. This pattern is consistent with reported desires in the Australian population as a whole (Richters et al, 2003). However, a higher proportion of women in the *Private Lives* sample (12.76%) are interested in sex daily as opposed to 8.3% of women generally.

Figure 5:
Desired frequency of sex



PAID SEX

Six per cent of men had paid for sex in the past twelve months and 5% had received payment for sex. This is higher than the 1.9% of Australian men generally who had paid for sex in the past year and than the 0.1% who had received payment for sex (Rissell et al, 2003).

Table 40:
Paying for and being paid for sex

	Males %	Females %
Paid in last year	6.6	0.8
Been paid in last year	4.7	1.1

CHOOSING SEXUAL PARTNERS

The factors which influence a choice of sexual partner were explored. For females in this sample the importance of personality and of having similar interests emerged as the predominant factors. For males, looks and age were important, along with personality. Willingness to perform particular sexual acts rated more highly for men than women, as did ethnicity. Wealth was not important in making such a decision.

Table 41:
Factors influencing choice of sexual partner

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Looks	87.8	71.1	73.5	48.5	27.3	57.1
Sexual acts	30.8	16.1	50.0	22.7	27.3	57.1
Interests	47.5	66.9	70.6	54.6	9.1	71.4
Personality	73.7	91.6	94.1	81.8	45.5	71.4
Ethnicity	27.8	5.9	8.8	3.0	9.1	14.3
Age	59.5	31.7	35.3	24.2	27.3	28.6
Wealth	5.9	4.0	0	4.6	0	14.3

SEX AND THE INTERNET

Amongst men, the majority (around three out of four) had used chat rooms and visited sex sites in the past twelve months. This is consistent with the finding that same sex attracted young people in Australia have high internet use with 73% using the internet for information about gay relationships and 60% for information about lesbian relationships (Hillier et al, 2005). This rate of internet use is higher than for young people in general on such issues (Smith et al, 2003), and may suggest that contacts and information for many gay and lesbian people are more readily available in a virtual world than in the real world.

Table 42:
Internet use

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Visited sex site	79.4	25.4	67.7	32.3	45.5	83.3
Used chat room	73.2	36.5	50.0	48.5	18.2	71.4

The internet was a source of social contacts as well as possible sexual contacts for the *Private Lives* sample, with a high number of respondents following up an internet contact for a face to face meeting. With the exception of intersex people, most respondents had met someone in person.

Table 43:
Have you ever met someone you chatted to on the internet?

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Yes	91.9	72.3	70.6	71.9		80.0

Having sex was the most likely outcome of such a meeting for males, and forming a friendship for females and transgender people. However many men also formed friendships with internet contacts. It is notable that a high proportion of respondents also formed sexual relationships with internet contacts.

Table 44:
Outcome(s) of meeting someone from the internet

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %
Formed friendship	76.6	86.9	83.3	73.9	100.0
Had sex	82.0	55.9	50.0	73.9	50.0
Formed sexual relationship	41.2	42.5	50.0	39.1	25.0
Formed non-sexual relationship	29.6	37.0	25.0	26.1	25.0
Relationship now ended	29.3	20.4	25.0	34.8	50.0

MALE SEXUAL BEHAVIOURS

Of those men who reported a regular male partner (42.8% of the sample), we asked whether they had fucked him with a condom: 69.5% reported never fucking him with a condom, 70.2% never being fucked with a condom; 71.53% never fucked him without a condom but pulled out; 72.4% never being fucked without a condom but pulling out; 53.5% reporting never fucking him without a condom and coming inside; and 51.3% reported never being fucked without a condom and him coming inside. Thus, more than half of respondents (58.9%) reported having fucked and ejaculated with a regular partner without using a condom.

Two thirds (65.1%) reported sex with a casual male partner in the past six months. Amongst these, 39.9% reported never fucking him with a condom, 46.1% reported never having been fucked with a condom; 78.8% reported never fucking without a condom and pulling out, and 80.1% reported never being fucked without a condom and pulling out; 82.5% reported never having fucked without a condom and coming inside; and 84.4% reported never having been fucked without a condom and coming inside.

Overall, 24.2% of the men with casual partners reported at least one occasion of unprotected anal intercourse with ejaculation in the past six months.

WOMEN'S SEXUAL BEHAVIOURS

The Sex in Australia survey (Grulich et al, 2003) reported positively on the sexual satisfaction of homosexual women, finding that 76% of homosexual women had an orgasm at their most recent sexual encounter as opposed to 69% of heterosexual women. Homosexual women also were more likely than heterosexual women to report that sex in a regular relationship was extremely physically pleasurable (51% v 39%) and emotionally satisfying (82% v 45%).

Most female participants of *Private Lives* (77.4%) reported they had an orgasm in their most recent sexual event with another women. They also reported a range of sexual practices. In relation to the most recent sexual event with another woman, 57.6% reported receiving oral sex, 59.6% reported giving oral sex; 89.9% reported having been vaginally stimulated by their partner's hand and 91.4% reported having stimulated their partner's vaginal area with their hand.

8. DISCRIMINATION, HARASSMENT AND VIOLENCE

IMPACTS OF DISCRIMINATION AND VIOLENCE

Discrimination may be experienced in different ways, ranging from open violence and abuse to subtle or tacit disapproval or neglect. Many GLBTI people have had experiences across this spectrum and are not strangers to the experience of discrimination and violence. A NSW study (Attorney Generals Department NSW, 2003) found over 50% had experienced of violence, with three quarters of those participants who had experienced violence having experienced two or more incidents. A recent Victorian study of GLBTI people showed that over 80% of participants had experienced public insult, 70% verbal abuse, 20% explicit threats and 13% physical assault (McNair & Thomacos, 2005). A national study of same sex attracted young people (Hillier et al, 2005) showed 44% had been verbally abused and 16% had been physically abused. The experiences of participants in the *Private Lives* Survey were no different.

Overall, 67.3% of participants indicated that fear of prejudice or discrimination caused them at least sometimes to modify their daily activities (Table 45). Of those who modified their daily activities at least sometimes, 13.7% did so at home, 53.7% at work and 51.1% in social settings and 42.2% with their family and nearly three quarters (72.9%) in public (Table 46). Of particular concern is the finding that 90% of the sample reported that they had, at some time, avoided expressions of affection. This simple everyday pleasure, which is commonplace amongst heterosexuals, is clearly seldom safely experienced by same sex couples. The majority (87.6%) of the sample had at some time avoided disclosure of their gender identity or sexuality, and some of these instances are clearly with health care providers (see Table 32). It was also notable that significant numbers of participants, particularly gay men, always avoided disclosing their sexual identity for fear of discrimination. This pattern of modifying behaviour for fear of discrimination or prejudice would seem well grounded, given the experiences of harassment, discrimination and violence reported by the participants.

Table 45:
Does fear of prejudice or discrimination cause you to modify your daily activities?

	Males	Females	Trans-males	Trans-females	Intersex males	Intersex females
	%	%	%	%	%	%
Yes	19.3	13.3	26.5	33.3	40.0	28.6
Sometimes	46.6	55.5	52.9	50.0	40.0	42.9
Never	34.1	31.2	20.6	16.7	20.0	28.6

Table 46:
Sites of modified daily activity among those who do

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
At home	17.3	7.9	11.1	10.9		60.0
At work	57.5	48.6	37.0	36.4	37.5	60.0
In social settings	55.8	42.6	66.7	52.7	75.0	40.0
With your family	43.0	41.9	37.0	23.6	12.5	20.0
In public	73.6	71.2	81.5	81.8	75.0	60.0

We compared whether or not people modified their daily activities with their stated locality. This showed that daily activities were more commonly modified in localities other than metropolitan. In particular those living in regional Australia were most likely to report modification in social settings and at home. No such variation was observed in relation to modifying activities at work, with family or in public.

Table 47:
Sites of modified daily activity among those who do by age group

	15-19 %	20-29 %	30-39 %	40-49 %	50-59 %	60-69 %	70+ %
At home	23.7	10.9	5.7	6.4	9.9	10.8	12.1
At work	33.2	37.6	38.1	34.5	34.5	27.5	22.9
In social settings	40.9	35.9	32.9	30.9	36.8	37.3	31.3
With your family	36.2	33.1	25.5	23.9	26.9	26.5	21.7
In public	43.1	47.8	51.2	49.9	51.9	50.0	33.7

It is not surprising that the younger members of the cohort are most likely to modify their behaviour at home, with the family and in social settings, given the well-documented violence and rejection they may experience in these settings (Hillier et al., 2005). Modification of daily activities lessens for those over 70, but it remains steady and unacceptably high for all those under 70. The exception is modification of daily activities at home which from the age of twenty on is of less importance. This suggests that most participants have found home situations which are supportive of their identity. There is also some concern for the small increase in this area for the over 70s, which may indicate a renewed need to "hide" in when accommodation options change with age. This would be consistent with the work of Harrison (2001) who found a high degree of invisibility of GLBTI people in the aged care sector.

Table 48:
Frequency of avoiding expressions of affection

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Never	8.0	11.3	29.4	37.9	30.0	42.9
Rarely	27.8	48.5	47.1	31.8	20.0	
Generally	45.0	35.6	17.7	25.8	50.0	42.9
Always	19.1	4.6	5.9	4.6		14.3

Expressions of affection are avoided, at least some of the time, by the majority of survey participants, indicating a discomfort in some environments on a regular basis. A similar pattern can be seen in disclosure of sexual/gender identity where some vigilance is clearly exercised by the vast majority of participants.

Table 49:
Frequency of avoiding disclosing gender identity or sexuality

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Never	13.9	9.5	15.6	13.6		28.6
Rarely	45.2	59.1	46.9	27.3	25.0	28.6
Generally	30.6	27.9	31.3	51.5	75.0	14.3
Always	10.3	3.4	6.3	7.6		28.6

Personal insults or verbal abuse were the most commonly experienced form of abuse, reported by 59.3% of the total sample. Just under half (44.3%) reported that rumours had been spread about them. Just over a third (35.2%) reported that they had been socially excluded. Threats of violence or intimidation were reported by just under a quarter (23%). Physical attacks or other kind of violence have been experienced by more than one in eight of participants (13.7%), an unacceptably high figure. Another common experience of discrimination, harassment and violence was the threat of being 'outed' which, in a homophobic climate, has the potential to cause extreme distress and negative outcomes - 15.3% reported this experience. Around one in ten (11.9%) reported having objects thrown at them and 10% had received obscene mail or telephone calls.

Discrimination also played out in the workplace where 10.3% of participants reported having been refused employment or promotion as a result of their sexuality. This is particularly worrying given that workplace discrimination on the basis of gender or sexuality is illegal. Similarly, having one's personal property damaged or defaced was reported by 8.5%; somewhat fewer (6.8%) participants reported having suffered hate mail or graffiti. The final six forms of discrimination, harassment and violence were each reported by less than 5% of the sample: rape 3.6%, sexual assault 3.5%, blackmail 3.3%, the refusal of finance 3.1%, refusal of housing 2.2% and the review or revocation of child custody (0.7%). All of these six types of experience are serious matters with the potential to have a major impact on the small numbers of people who experienced them.

Table 50:
Personal experiences of discrimination, harassment and violence

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Personal insults or verbal abuse	61.0	56.4	73.5	69.7	63.6	42.9
Rumours spread about you	45.8	41.0	52.9	51.5	45.5	71.4
Socially excluded or ignored	35.1	34.3	44.1	56.1	45.5	57.1
Threats of violence or intimidation	26.8	15.2	29.4	46.9	27.3	28.6
Physical attack or other kind of violence	17.3	7.2	11.8	18.2	18.2	28.6
Threats to 'out' you	16.8	12.4	17.7	22.7	27.3	28.6
Had objects thrown at you	14.0	7.9	14.7	12.1	27.3	28.6
Obscene mail or telephone calls	10.8	7.9	23.5	18.9	27.3	42.9
Refused employment or promotion	10.4	8.9	23.5	34.9	18.2	28.6
Deliberate damage/defacing of personal property	10.2	5.0	14.7	13.6	9.1	28.6
Hate mail or graffiti	7.9	4.5	8.8	9.1	36.4	42.9
Rape	4.1	2.5	8.8	3.0	18.2	
Sexual assault	3.7	2.7	8.8	10.6	18.2	28.6
Blackmail	3.6	2.4	5.8	7.6	27.3	28.6
Finance refused or made difficult	2.5	3.7	8.8	7.6	9.1	42.9
Been refused housing	1.7	2.5	14.7	9.1	9.1	28.6
Custody of children reviewed or revoked	0.5	0.9	2.9	3.0		14.3

An interesting pattern emerged regarding the experience of abuse and locality. Personal insults or verbal abuse were more common in major cities than in inner regional, outer regional or remote Australia. This is probably associated with the concentration of homophobic people in the cities and the greater visibility of GLBTI people. However, the experience of threats of violence or physical attack was most common in outer regional Australia than in other areas, suggesting a greater visible deterrent to coming out in these regions and more potentially extreme consequences for those who do.

INTIMATE PARTNER ABUSE

Intimate partner abuse or family violence has been a hidden issue in the gay and lesbian community and is likely to be under-reported in general research. A Western Australian report on the issue (Vickers, 1996) cited research suggesting that the prevalence was at least similar to heterosexual family violence and may well be higher. In addition to under-reporting, it is suggested that many GLBTI people do not identify family violence when they experience it because of a lack of recognition of its existence in same sex relationships. When violence is reported, the lack of appropriate services for both perpetrators and victims is likely to contribute to an unsatisfactory response or resolution, which further compounds the problem of silence and distrust.

Estimation of the rates of family violence experienced by Australian women range between 8% and 28% (Hegarty et al., 2000), A disturbingly high percentage (32.7%) of respondents in this sample reported having been in a relationship where the partner was abusive. Abuse was reported more frequently by women than men, and was highest for transgender males, but the rates for all groups are unacceptably high. While it is not clear from these data whether the abuse was from a same sex partner or not, it is likely, given the relationship profile of the sample that a significant amount occurred in same sex relationships. Irrespective of the gender of the perpetrator, the levels of experience of domestic violence represent a considerable burden of distress and injury for GLBTI people.

Table 51:
Ever in relationship where partner abused you?

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Yes	27.9	40.7	61.8	36.4	36.4	42.9

Participants reported experiencing a range of abusive behaviours from their partner including high levels of physical assault and injury, insult and isolation.

Table 52:
Types of abuse

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Forced sex	19.6	25.1	14.3	8.3	25.0	
Hit	47.8	41.5	42.9	45.8	25.0	66.7
Physically injured	36.3	31.7	28.6	41.7		33.3
Needed medical attention	12.3	8.5	14.3	4.2		33.3
Regularly insulted	62.7	60.8	57.1	79.2	75.0	100.0
Isolated from friends/family	48.3	53.9	42.9	62.5	50.0	66.7
Monitored or checked up on	43.7	40.0	38.1	41.7	50.0	
Deprived of financial independence	20.1	20.3	14.3	33.3	50.0	66.7
Ever in fear of life	17.1	14.7	9.5	12.5		66.7

Of those participants who had experienced abuse, only one in ten had reported such abuse to the police. Some categories of abuse are not physical and may not constitute a criminal offence. However, if we only look at those participants who reported having been hit, 18.7% had reported this to the police; of those who reported forced sex, 17.9% had reported this to the police. Of the third of participants who reported having been physically injured, only 20.4% had reported this to the police.

Table 53:
Was abuse reported to police?

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Yes	12.0	10.0	14.3	8.3	25.0	66.7

We asked questions about the experience of reporting abuse to the police.

Table 54:
I was treated with courtesy and respect

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Strongly agree	23.7	20.5	33.3	50.0		50.0
Agree	34.2	34.6	33.3			50.0
Not sure/don't know	8.8	12.8			100.0	
Disagree	19.3	21.8	33.3	50.0		
Disagree strongly	14.0	10.3				

Table 55:
Appropriate action was taken by the police

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Strongly agree	17.7	20.5	66. 7	50.0		50.0
Agree	39.8	30.8				
Not sure/don't know	10.6	10.3			100.0	50.0
Disagree	16.8	15.4	33.0	50.0		
Disagree strongly	15.0	23.1				

Of those who had dealings with the police, more than half (56.4%) agreed they had been treated with courtesy and respect. A similar percentage (54.8%) agreed that appropriate action had been taken by the police. While it is pleasing to see that more than half of these respondents had positive experience of the police, it is also unacceptable that nearly half did not. Around Australia police forces are increasingly instituting affirmative action programs to improve relationships with GLBTI people. These appear to be having some positive impact and should be developed further. Of even greater concern, given these high rates of intimate partner abuse, is the lack of appropriate referral options for female perpetrators and male victims in mainstream services.

9. CONNECTEDNESS TO COMMUNITY

In nominating the three best things in their lives a majority of participants rated friends overall as the best thing in their lives right now. Community involvement was rated as far less significant and may well have been seen as more formal community involvement rather than the participation in a personal community of friends. Community connectedness and social inclusion have been widely documented as social determinants of health (Berkman & Glass, 2000; Sohlman, 2004) and are likely to be more important for GLBTI people who may be alienated from their family of origin. The ideal of community is underpinned by strong social networks which act as predictor of good physical and mental health (Brannon & Feist, 2000). The participants in this survey have varied social worlds that include a combination of gay and straight friends. Indeed, more than half (58.1%) indicated that the majority of their friends were not GLBTI. Nevertheless, it is clear that GLBTI friendships provide the basis for active and social lives, with nearly four in five participants (78.6%) having contact with gay and lesbian friends and acquaintances at least weekly.

Table 56:
How many of your friends are GLBTI?

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
All	1.9	1.1	8.8	1.5		
Most	39.2	41.7	55.9	37.9	30.0	57.1
Some	36.2	42.5	20.6	40.9	30.0	42.9
A few	18.7	13.1	14.7	16.7	40.0	
None	3.9	1.7		3.0		

Weekly contact was the most likely frequency of socialising with GLBTI friends, but many participants spent time with friends on a daily basis.

Table 57:
How often do you have contact with gay and lesbian friends and acquaintances?

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Daily	33.1	27.2	17.7	20.3	30.0	57.1
Weekly	46.3	50.5	61.8	43.8	20.0	28.6
Monthly	11.4	13.0	14.7	10.9	20.0	
A number of times per year	5.9	6.6		18.8	20.0	
Rarely	3.2	2.6	5.9	6.3	10.0	14.3
Never	0.1	0.1				

Gay media also played a role in linking a significant number of survey participants to the community with 42.7% accessing it at least weekly. Just over a third (36.9%) accessed gay media less frequently than monthly.

Table 58:
Frequency of access to gay media

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Almost daily	10.6	9.7	5.9	6.1		28.6
Weekly	34.0	30.8	8.8	21.2	10.0	28.6
Monthly	17.3	25.9	41.2	13.6	10.0	
A number of times per year	14.3	15.4	11.8	18.2	40.0	28.6
Rarely	16.6	13.9	23.5	31.8	30.0	14.3
Never	7.2	4.2	8.8	9.1	10.0	

Relatively few participants reported extreme feelings of connection or disconnection from the gay and lesbian communities: less than a quarter (23%) reported feeling either *very* or *not at all* connected. Given the composition of participants' social networks, their patterns of contact with friends and frequency of their access to gay media, it is unsurprising that the majority report being somewhat or rarely connected to the gay and lesbian communities in their every day lives (58%). Given that a significant minority of participants in this survey reported minimal contact with community, we have clearly demonstrated the reach of the internet to participants that other surveys, such as those that we run at gay and lesbian community events, cannot achieve.

McLaren and her colleagues (McLaren et al, 2002; Jude et al, 2002) found connectedness to the broader community to be more important to the mental health and wellbeing of rural gay men than gay community connectedness, while the reverse was found to be true of lesbians. Our participants were more likely to report being very connected to the broader community than to the gay and lesbian communities. For example, 13% reported being very connected to the broader community, compared with 9% reported being very connected to the gay and lesbian communities. Overall, however, 48% were more connected to the GLBTI community than to the broader community and 37.% were equally connected to both. The remainder (14%) were more connected to the broader than to the gay and lesbian communities.

Table 59:
Do you feel connected to the gay and lesbian community in your everyday life?

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Very	8.6	10.0		4.6	10.0	28.6
Mostly	16.7	22.3	15.6	9.1		
Somewhat	30.6	35.4	37.5	33.3	10.0	14.3
Rarely	26.7	23.5	37.5	33.3	60.0	28.6
Never	17.4	8.8	9.4	19.7	20.0	28.6

We examined degree of connectedness with the gay and lesbian community by locality. As can be seen from Table 60, those who reside in major cities are much more likely to feel very or mostly connected to the community than those in regional Australia. Those living in remote Australia are more likely to feel they are never connected to gay and lesbian communities.

Table 60:
Connectedness to gay and lesbian community by locality

	Major cities	Inner regional	Outer regional	Remote
Very	10.4	6.7	5.1	1.0
Mostly	20.7	12.7	12.3	11.9
Somewhat	33.5	29.4	26.7	33.7
Rarely	24.3	29.9	29.2	21.8
Never	11.1	21.3	26.7	31.7

Table 61 shows the responses to the question *Do you feel connected to the broader community in your every day life ?* These patterns are similar for genders.

Table 61:
Do you feel connected to the broader community in your everyday life?

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Very	14.4	10.8	6.0	13.6	10.0	
Mostly	38.5	39.1	27.3	28.8	20.0	14.3
Somewhat	33.5	35.8	36.4	31.8	50.0	42.9
Rarely	9.8	11.2	27.3	19.7	20.0	
Never	3.7	3.0	3.0	6.1		42.9

The pattern observed with regard to locality does not hold an answer to the broader community question. As can be seen from Table 62, there are few differences in responses between those residing in metropolitan Australia and those in regional and remote Australia.

Table 62:
Connectedness to the broader community by locality

	Major cities	Inner regional	Outer regional	Remote
Very	13.3	13.8	11.8	8.9
Mostly	38.7	36.1	37.6	41.6
Somewhat	34.8	34.6	31.5	34.7
Rarely	10.1	10.7	13.9	9.9
Never	3.1	4.9	5.0	4.9

COMING OUT, BEING OUT

GLBTI people do not have one "coming out" event in their lives but many. These events can sometimes occur on a daily basis, requiring judgements about who can know or not know. While coming out and not having secrets may be a more desirable state than always having something to hide, it must always be weighed up against the risks of exposure in a particular context. The vast majority of survey respondents were out to at least one person, with slightly more men than women not out to anyone.

Table 63:
Have you come out to anyone in your life?

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Yes	94.3	98.2	97.1	100.0	90.9	100.0

We asked participants to tell us who they had told about their sexuality or gender. Percentages are fairly similar for all groups, with women being significantly more likely to be out to all on the list. Overall, this group was likely to be out to family and friends, but only one in two respondents was out to work or study supervisors. This is of particular concern in its implication that workplaces and places of study are not places which are free of discrimination, as the law requires them to be.

Table 64:
Out to…

	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
Friends	89.3	94.6	97.1	98.5	72.7	71.4
Work or study colleague	74.7	82.9	67.7	68.2	63.6	42.9
Parents	69.5	76.5	91.2	77.3	54.6	85.7
Siblings	62.1	74.1	76.5	69.7	72.7	28.6
Extended family members	51.2	56.8	55.9	65.2	72.7	57.1
Work or study supervisors	50.5	52.8	58.8	50.0	45.5	28.6
Neighbours	39.9	43.7	26.5	50.0	36.4	57.1
Community/church acquaintances	16.0	18.1	32.4	16.7	36.4	28.6
Sporting club associates	15.3	23.7	23.5	10.6	18.2	14.3
Children	7.0	17.2	8.8	39.4	27.3	28.6

Respondents indicated a range of sources of emotional support. But for all genders and sexualities, the friends from their communities rated most highly, and higher in every case than their biological families (with the exception of intersex respondents where family and community friends were rated as equally important). Partners were also important, bearing in mind that many respondents did not have a partner.

Table 65:
For emotional support would you turn to?

	All %	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
GLBTI friends	67.4	63.8	73.7	76.5	72.7	45.5	42.9
Straight friends	62.0	59.9	66.0	61.8	51.5	45.5	57.1
Biological family	46.8	44.7	51.2	23.5	37.9	45.5	42.9
Partner	50.9	43.5	64.8	50.0	34.9	18.2	28.6
Ex-partner(s)	18.3	16.9	21.3	11.8	13.6		
Step children	0.5	0.1	1.2		1.5	9.1	

A similar pattern is evident in response to the question, *Who would you turn to for health information and advice?*

Table 66:
For health information and advice, you would turn to…?

	All %	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
GLBTI friends	51.8	50.1	55.2	55.9	46.9	18.2	14.3
Straight friends	38.8	35.2	46.2	32.4	27.3	9.1	
Biological family	32.0	27.2	41.5	17.7	15.2	18.2	42.9
Partner	40.4	33.1	53.8	47.1	30.3	18.2	14.3
Ex-partner(s)	9.9	9.1	11.7	5.9	6.1	9.1	
Step children	0.2		0.4		1.5		

However in times of sickness, relatives (biological family) or partners were rated higher than GLBTI friends. This indicates that family, which rated fourth overall in the best things about participants' lives, remains an important lifeline in a crisis.

Table 67:
Who would care for you if you were sick?

	All %	Males %	Females %	Trans-males %	Trans-females %	Intersex males %	Intersex females %
GLBTI friends	38.5	38.0	39.6	41.2	34.9	36.4	28.6
Straight friends	35.1	35.7	34.7	32.4	24.2	36.4	28.6
Biological family	61.6	61.4	62.9	47.1	39.4	63.6	42.9
Partner	51.0	44.4	63.5	50.0	36.4	18.2	14.3
Ex-partner(s)	10.5	10.1	11.4	2.9	12.1		
Step children	0.8	0.5	1.4		1.5		

10. THE BEST THINGS IN LIFE...

We often think of wellbeing as happiness, but it is more than that. It is about having meaning in our lives—developing as a person and feeling that our lives are fulfilling and worthwhile (The Australia Institute Wellbeing Manifesto, 2005).

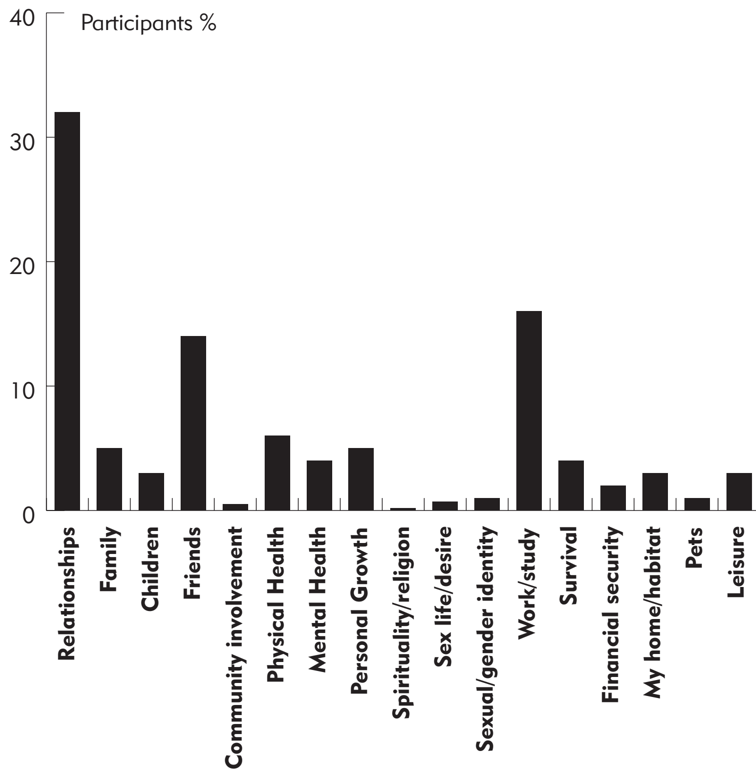
Much research on the well-being of GLBTI people in Australia has focussed on the distressing health outcomes associated with discrimination and marginalisation, particularly highlighting how homophobia can negatively impact on health and wellbeing (Leonard, 2002). Despite these health inequalities, it is also clear that most GLBTI people live happy and fulfilled lives. In order to give us some understanding of the richness and positive aspects of participants' lives, the final question of the survey asked, *What are the three best things about your life right now?*.

The recently released Australia Institute Wellbeing Manifesto (2005) acknowledges the centrality of relationships, community attachment and meaningful work to this concept of wellbeing. In the Australian Survey of Social Attitudes (2003), 2,103 participants (2,027 heterosexual, 76 GLBT) were asked about the relative importance of aspects of their lives. Slightly more than half stated that friends (52%) were extremely important. Many participants also stated that leisure time (39%) and work was extremely important (33%). These results are not very different from what emerged from the large number of *Private Lives* participants (90%) who responded to this question.

A coding system was developed to organise the responses into 17 areas. These codes are listed in *Appendix A*.

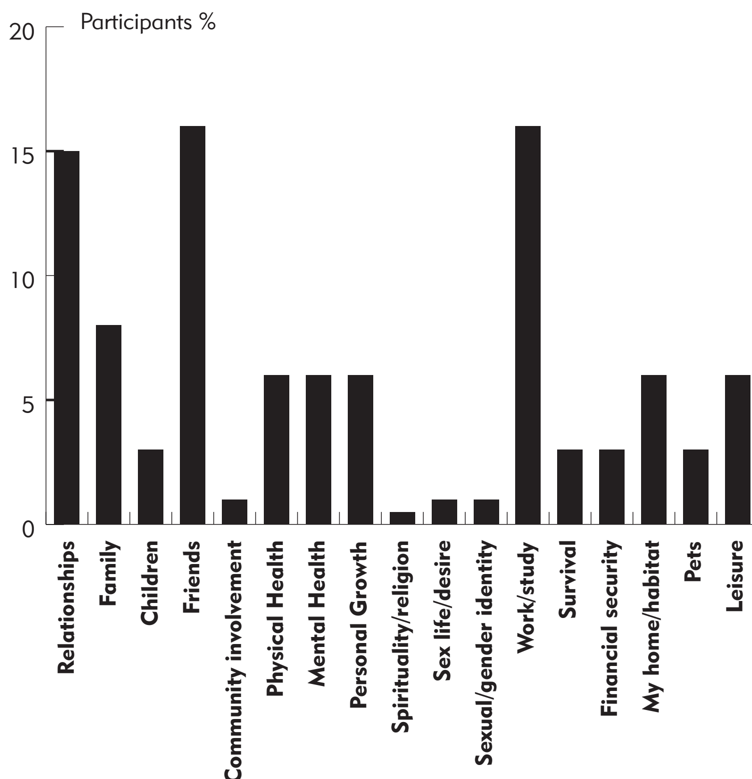
In all, 5,019 responded with a first best thing, 4,899 responded with a second best thing and 4,784 responded with a third best thing. Although participants were not asked to rank the best things in their lives, the choice patterns that emerged between their first, second and third choices indicate that this occurred. In regard to the first best thing (Figure 6), twice as many participants mentioned relationships (32%) compared to those that mentioned work/study (16%). This suggests that personal and intimate relationships are more highly valued by participants than work/study as a first choice. For example, one male respondent reported his first choice as 'having a stable partner' and one female respondent stated her first choice as: 'My wonderful girlfriend'.

Figure 6:
Participants responses to the first best thing in life



The first, second and third best things were combined to display the frequency of each category response (Figure 7). This provided an overall picture of responses. Additionally, this captured a minority of response categories that were mentioned more than once. For example, one female respondent said the three best things in her life were "partner, partner, partner". The largest category responses were friends (16%) and work/study (16%), followed by relationships (15%). These results again suggest that a high proportion of participants value their friends, are content with their current work/study situation and value their personal and intimate relationships.

Figure 7:
Total responses of the three best things



GENDER

There were noticeable differences in both women and men's choice of the first best thing, with nearly half of the women reported relationships (42%) as their first choice. For men also the most common first choice was relationships (26%) but the percentage was considerably lower. However, when all three choices were aggregated (see Table 68), gender differences were remarkably small. Men were slightly more likely to nominate friends rather than relationships and for women the reverse was true.

Table 68:
Participants first best thing by gender (%)

Categories	Females	Males	Total
Relationships	42	26	32
Family	5	5	5
Children	6	2	3
Friend's	11	16	14
Community involvement	0	0	0.3
Physical health	4	7	6
Mental health	3	5	4
Personal growth	4	5	5
Spirituality/religion	0	0	0.2
Sex life/desire	0	1	0.7
Sexual/gender identity	2	0.7	1
Work/study	13	18	16
Survival	2	5	4
Financial security	1	2	2
My home/habitat	3	4	4
Pets	2	1	1
Leisure	3	4	3
Total	**100**	**100**	**100**
Total (N)	**1910**	**3109**	**5019**

Table 69:
Participants Three best things by gender, aggregated

Categories	Females %	Males %
Relationships	19	13
Friends	15	19
Work/study	15	15
Family	9	7
My home/habitat	7	6
Physical health	5	7
Mental health	5	6
Personal growth	5	7
leisure	5	7
Children	4	1
Pets	3	2
Survival	2	3
Financial security	2	3
Community involvement	1	1
Spirituality/religion	1	1
Sex life/desire	1	1
Sexual/gender identity	1	1
Total (N)	**1910**	**3109**

AGE

In order to establish an overall idea of the relative importance of the best things in people's lives according to their age, we added together all the responses and then divided them by three. In this way we lose any priority that participants have implicitly given us but we gain the capacity to compare the overall percentages.

Table 69:
Participants best things by age

Categories	16-19 yrs	20-29 yrs	30-39 yrs	40-49 yrs	50-59 yrs	60-69 yrs	70-79 yrs	80-89 yrs
Relationships	13	10	14	16	17	15	11	10
Family	9	9	10	8	6	6	6	0
Children	1	1	1	4	5	3	3	7
Friends	25	22	19	15	15	12	13	10
Community involvement	0	1	1	1	1	1	1	3
Physical health	4	4	5	7	8	9	10	15
Mental health	5	5	6	6	6	8	6	20
Personal growth	3	5	7	6	6	6	7	5
Spirituality/religion	1	.5	0	.5	1	1	2	0
Sex life/desire	1	1	1	1	1	2	2	0
Sexual/gender identity	7	2	1	1	1	2	2	0
Work/study	15	20	18	15	13	13	10	7
Survival	3	2	2	2	3	4	3	0
Financial security	1	2	2	3	2	4	3	3
My home/habitat	1	4	5	7	8	7	8	3
Pets	1	2	2	3	3	3	3	3
Leisure	8	10	7	6	5	5	11	12
Total (N)	**32**	**437**	**1528**	**1430**	**905**	**344**	**71**	**13**

Friends emerged as an important category, with those between 16 and 39 years rating it most highly. For example, one 19 year old male participant said 'I have strong relationships with my friends'. Those in the 70 -79 year category also nominated friends as the most important. Relationships too were important to people of all ages, and were the most important for people between the ages of 40 and 69 years. For example, one 52 year old female respondent commented on "the company and support of my partner". Work and study remained important across all age ranges including the 80 – 89 years, but was most likely to be nominated by those under 39. For example, one 31 year old transgender participant stated, 'I know now more than ever, which new direction my career should be going'. The importance of leisure lessens for people between 29 and 70, after which it understandably begins to replace work in importance.

Family is an important element in the lives of younger participants. It becomes less significant for those over 50 years who are possibly more confident of the friendships and relationships they value more strongly in their 50s and 60s. It is not surprising too to see mental and physical health being highly valued by the octogenarians in the study, whereas these issues do not figure strongly for younger people. Home and habitat, - 'my lovely home by the sea' as one 72 year old male participant said - also increased in importance over time, although were less important for people in their 80s who may have changed living arrangements associated with their age.

The request to nominate the three best things in their lives elicited a response from 90% of all survey participants, with many people offering more than the three requested answers. The answers indicated a remarkable accord amongst GLBTI people about the sustaining and positive areas of their lives. They also provide a snapshot of the resilience and optimism present in the daily lives of the participants in this study.

The strength and stability of relationships and friendships within GLBTI communities and the value placed on these things indicates a real capacity in our participants to live optimistically and well. The extent to which our participants' *Private Lives* are full of the enjoyment of family, children, pets, socialising, work, study and home-making is a powerful reminder of how health concerns and health care are only part of complex and fulfilling lives.

11. CONCLUDING RECOMMENDATIONS

PUBLIC EDUCATION AND INCREASED LEGITIMACY

The most significant finding of this survey is the widespread prevalence of depression and suicidal ideation (thoughts) amongst participants. This is highly consistent with other studies in the area and indicates a need for significant action, both within the health care system and in society more generally.

The single most important contribution to improved health and wellbeing in GLBTI people is likely to be increased legitimation and acceptance of their lives, their relationships and of the positive contribution they make to society. Legislative reform to remove discrimination and stigmatisation clearly has a large contribution to make.

Other avenues for public education to address heterosexism and homophobia, including countering homophobic abuse directed at GLBTI people, also need to be fully explored as part of both a public health and a human rights agenda.

RELATIONSHIP RECOGNITION

This survey demonstrates the importance of relationships in the lives of many GLBTI people and the longevity of those relationships. While participants did not show a strong interest in formalised commitment ceremonies, legal recognition and rights for couples remain an important reform for the community and are likely to make a contribution to improved health and wellbeing for many GLBTI people.

DISCRIMINATION AND EQUAL OPPORTUNITY

Many forms of discrimination in our society are illegal and the evidence that a significant number of survey participants avoid being "out" in a work or study environment is of concern. Employers, workplaces and educational institutions need to be reminded of their responsibilities to provide a non-discriminatory environment through regular information distribution and education programs. Workplaces and educational institutions need to actively promote their commitment to such an environment to ensure GLBTI people are able to come out if they wish to do so.

DATA COLLECTION

This survey supports the outcomes from other research that found GLBTI people experience different patterns of illness from the rest of the population and have significant unmet health needs. These issues need to be more thoroughly explored by, for example, including sexual and gender orientation as part of collection of population health data collections (e.g. National Health Survey, Negotiating the Life Course, National Drug Strategy Household Survey, etc). This is an important way forward and would greatly assist health policy and service planning at all levels. Additionally, work needs to be undertaken to better understand specific areas of GLBTI health and well-being through targeted research on the seven National Health Priorities, as well as areas of concern identified in *Private Lives*. This work would greatly enhance the visibility of the health issues experienced by GLBTI people, and provide an opportunity to address these health inequities and unmet needs.

MENTAL HEALTH AND OTHER HEALTH SERVICES

Both mental health and primary health care services need to be thoroughly oriented to the need for mental health promotion, intervention and support services to be geared to meet the needs of GLBTI people, particularly young people. Service change appropriate to meet this need is also pertinent to changes needed in all health services and will require:

- implementation of local strategies to encourage GLBTI consumers to be visible and heard
- changes in service planning and priorities
- changes in intake forms and service environment
- training of all staff to provide non-heterosexist services.

Service change at this level requires significant centralised policy change and redirecting of resources. State Health departments should build a response to this area of unmet need into their planning processes.

DRUG USE

Levels of drug use in this study are unacceptably high. While much harm minimisation based health promotion has been directed at cultural substance use within the community, targeted health promotion campaigns for other unsafe substance use have not been undertaken.

The recommendations made by the Australian Drug Foundation (Murnane et al., 2000) are reiterated here. These recommendations call for:

- targeted factual information appropriate and accessible to members of GLBTI communities, particularly young people;
- establishment of networks of sensitive and aware service providers, support groups and peer education programs;
- professional training on issues of sexuality and lifestyle for general health and welfare service providers, including general practitioners.

AGED CARE

While the finding that health and wellbeing improve with age is an encouraging one, some concern must be felt about the small increase in the number of those over 70 who report modifying their behaviour at home for fear of discrimination. This may indicate a renewed need to “hide” as accommodation circumstances change with age.

Aged care services need to ensure that intake, assessment and referral processes, policies and staff training are geared to meeting the needs of GLBTI aged care clients in a positive and non-discriminatory way.

PREGNANCY AND OBSTETRIC SERVICES

The high levels of satisfaction with these services indicate that there are a number of models of best practice available for wider application. These models need to be documented and promoted.

All services need to recognise that they may already be seeing lesbian couples and may, in the future, see more. Language used in birthing classes and policies and procedures relating to the birthing experience should be scrutinised to eliminate heterosexism from the system.

INTIMATE PARTNER ABUSE

The high rates found in this study warrant further investigation. Such information should inform future service planning and provide ways of challenging stereotypical beliefs that violence does not happen within same sex relationships.

In the short term, resources such as the ACON website on domestic violence and appropriate telephone referral services need to be widely promoted to the community. There are clearly urgent issues relating to the current lack of suitable referral options for female perpetrators and male victims in mainstream services. Governments need to consider what shorter term measures can be put in place to meet this need immediately.

INTERACTION WITH POLICE

The fact that more than half of those who reported intimate partner abuse to the police were satisfied with the response was a positive one. Police forces around Australia are increasingly instituting affirmative action programs, such as the appointment of gay and lesbian liaison officers, to improve relationships with GLBTI people and these appear to be having some positive impact. These programs should be protected and further developed, particularly in rural areas where physical violence directed at GLBTI people has been found to be more common. Continuing efforts should be made to inform GLBTI people that these services exist and can be accessed.

SEXUAL HEALTH

Health care providers should have training in taking a sexual history which enables them to ask sensitive, appropriate and non-judgemental questions without assuming heterosexuality. Such should be part of pre-service training for doctors and also provided as part of the Royal Australian College of General Practitioners Continuing Professional Development Program.

More than half the male participants in this study had not heard of post exposure prophylaxis (PEP) for HIV at the time these data were collected. The availability of PEP could be a significant component of HIV prevention in Australia and needs to be more widely and appropriately promoted to the target group.

YOUNG PEOPLE

The results of this survey provide new evidence that some health-related deficits associated with being GLBTI are experienced most acutely by young people. This emphasises the need for appropriate responses to sexuality and gender throughout the education system, including in post-compulsory education.

Youth services which provide support groups, counselling and social opportunities for young GLBTI people are clearly very important. They need to be expanded to ensure they can be accessed by all the young people who need them, particularly in rural areas. The provision of such services should become part of the core youth work for all municipal councils.

Consideration should be given to piloting models for a mentoring program which enables young people to benefit from contact with and support from older GLBTI people who are more experienced in managing discrimination and homophobia.

FURTHER RESEARCH

This study is, by its very nature, one which can only give a broad-brush picture of the health and wellbeing of GLBTI people. There are a number of areas in which there is a need for qualitative research which can build up a more detailed picture of areas where a response is clearly needed. These include intimate partner violence, the need for, and experience of, aged care services, and the nature of discrimination, violence and abuse.

The data collected on transgender and intersex people in this survey is highly indicative of a need for more targeted research within these groups to better reflect their diversity and specific needs.

Appendix A

CODING FOR "THE THREE BEST THINGS…"

1 Relationships: refers to being in love, companionship and commitment, including marriage

2 Family: refers to families of origin, extended families and families of choice

3 Children: refers to daughters/sons, stepchildren and grandchildren

4 Friends: refers to established or developing friendships (including gay and straight), social support and social life

5 Community involvement: refers to ethnic and GLBTI community involvement (such as queer festivals) and political and GLBTI activism

6 Physical health: refers to physical well-being and fitness and positive changes to unhealthy habits (such as quitting smoking)

7 Mental health: refers to establishing stable mental and emotional well being, feeling positive about life, personal attributes, new experiences and opportunities

8 Personal growth: refers to a process of self discovery, reflection, reaching personal goals, inner peace, self acceptance

9 Spirituality/religion: refers to personal spirituality, religious faith (including Catholicism and Buddhism) spiritual goals and spiritual growth

10 Sex life/Desire: refers to enjoying good and/or regular sex (with either current romantic partners and/or casual sex partners), libido and sexual attraction.

11 Sexual/gender identity: refers to the process of coming out, self-acceptance of sexual/gender orientation, others acceptance of sexual/gender orientation and post operation (hormone treatment and surgical gender reassignment)

12 Work/study: refers to the mental stimulation and other personal/professional rewards associated with current work situation (including volunteer work) or tertiary studies

13 Survival: refers to fulfilling the basic needs in life, surviving relationship/marriage break-ups and feelings of security.

14 Financial security: refers to being in a stable financial situation, comfortable lifestyle and being free of debts (particularly mortgage)

15 My home/habitat: refers to a safe comfortable haven, new living arrangements, home ownership (including home renovations)

16 Pets: refers to the company and enjoyment of owning pets, (especially dogs and cats)

17 Leisure: refers to recreational activities ranging from arts/cultural experiences to physical sports (such as rowing).

References

Attorney General's Department of NSW. (2003). *You shouldn't have to hide to be safe: A report on homophobic hostilities and violence against gay men and lesbians in NSW*, Sydney.

Australian Bureau of Statistics. (2002). *National Health Survey: Summary of Results*. Cat. No. 4364.0, Canberra.

Australia Institute. (2005). *A Manifesto for Wellbeing*. Canberra.

Bentleigh, R., Dowsett, G., Smith, A. M. A., Hillier, L., Horsley, P. & Mitchell, A. (2002). Sexual Health Issues for GLBTI Victorians. In Leonard, W. (Ed). *What's The Difference? Health Issues of Major Concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians*, Melbourne, Ministerial Advisory Committee on Gay and Lesbian Health, Department of Human Services.

Berkman, L., & Glass, T. (2000). *Social integration, social networks, social support and health.* In Berkman, L. & Kawachi, I. (Eds). Social Epidemiology, New York: Oxford University Press.

Brannon, L., & Feist, J. (2000). *Health Psychology: An introduction to health and behaviour,* Belmont, CA: Wadsworth.

Canadian Rainbow Health Coalition. (2005). *Social Justice Framework for GLBTT-SQ Wellness*. Saskatoon, Canada: Canadian Rainbow Health Coalition.

Cochran, S. D. (2001). Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter? *American Psychologist*, 56: 931-947.

de Visser, R. O., Smith, A. M. A., Rissel, C. E., Richters, J., & Grulich, A. E. (2003). Experiences of sexual coercion among a representative sample of adults. *Australian and New Zealand Journal of Public Health*, 27(2): 109-203.

Diamont, A., Wold, C., Spritzer, K. & Gelberg, L. (2000). Health behaviours, health status and access and use of health care: a population based study of lesbian, bisexual and heterosexual women. *Archives of Family Medicine*, 9(10): 1043-1051.

Ferris, D., Batish, S., Wright, T., Cushing, C. & Scott, E. (1996). A neglected lesbian health concern: Cervical Neoplasia. *Journal of Family Practice*, 43: 581-584.

Fethers, K., Marks, C., Mindei, A. & Estcourt, C. (2000). Sexually Transmitted infections and risk behaviours in women who have sex with women. *Sexually Transmitted Infections*, 76: 345-349.

Griffin, P. (1998). *Strong women, deep closets: lesbians and homophobia in sport,* Champaign, IL: Human Kinetics.

Grulich, A. E., de Visser, R. O., Smith, A. M. A., Rissel, C. E., & Richters, J. (2003a). Injecting and sexual risk behaviour in a representative sample of adults. *Australian and New Zealand Journal of Public Health*, 27(2): 242-250.

Grulich, A. E., de Visser, R. O., Smith, A. M. A., Rissel, C. E., & Richters, J. (2003b). Sexually transmitted infection and blood-borne virus history in a representative sample of adults. *Australian and New Zealand Journal of Public Health*, 27(2): 234-241.

Harrison, J. (2001). 'It's none of my business': Gay and lesbian invisibility in aged care. *Australian Occupational Therapy Journal,* 48(3): 142-145.

Hillier, L., de Visser, R. O., Kavanagh, A., & McNair, R. (2004). The drug-use patterns of heterosexual and non-heterosexual women: Data from the Women's Health Australia Study. In D.W. Riggs & G.A. Walker, (Eds.) *Out in the Antipodes: Australian and New Zealand Perspectives on Gay and Lesbian Issues in Psychology,* Bentley WA: Brightfire Press.

Hillier, L., Turner, A. & Mitchell, A. (2005). *Writing themselves in again - six years on: the second national report on the sexuality, health and well-being of same sex attracted young people*, Australian Research Centre in Sex Health and Society, La Trobe University, Melbourne.

Holtzen, D. W., & Agresti, A. A. (1990). Parental responses to gay and lesbian children: differences in self-esteem and sex-role stereotyping. *Journal of Social and Clinical Psychology*, 9(3): 390-399.

Horsley, P., McNair, R., & Pitts, M. (2001). *Women's Health and Wellbeing Strategy Population Group – Lesbians*, Australian Research Centre in Sex, Health and Society, La Trobe University; and Department of General Practice, University of Melbourne, Melbourne.

Jude, B., McLaren, S., & McLachlan, A. (2002). *From Mardi Gras to Manangatang: Sense of belonging and mental health in Australian men as a function of sexual orientation*. 38th Annual Conference of the Australian Psychological Society, Perth, Australia.

Leonard, W. (Ed.) (2002). *What's the Difference?: Health Issues of Major Concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians*, Melbourne, Ministerial Advisory Committee on Gay and Lesbian Health, Department of Human Services.

Linzer, M., Spitzer, R., Kroenke, K., Williams, J.B., Hahn, S., Brody, D., & deGruy, F. (1996). Gender, quality of life and mental disorders in primary care: Results from the Prime-MD 1000 study. *American Journal of Medicine*, 101: 526-533.

McKay, J., Messner, M., & Sabo, D. (2000). *Masculinities, Gender Relations, and Sport,* Thousand Oaks, CA: Sage.

McLaren, S. (2002). *Lesbians living in Australia: Issues of belonging and mental health*. 38th Annual Conference of the Australian Psychological Society, Perth, Australia.

McNair, R., & Medland, N. (2002). Physical Health Issues for GLBTI Victorians. In Leonard, W. (Ed). *What's The Difference? Health issues of major concern to gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians*. Melbourne, Ministerial Advisory Committee on Gay and Lesbian Health, Department of Human Services.

McNair, R., & Thomacos, N. (2005). *Not Yet Equal: Report on the VGRL same sex relationships survey 2005*, Melbourne.

McNair, R., Kavanagh, A., Agius, P., & Tong, B. (2004). The mental heath status of young adult and mid-life non-heterosexual Australian women. *Australian and New Zealand Journal of Public Health*, 29(3): 265-271.

Murnane, A., Smith, A. M. A., Compton L., Snow, P., & Munro, G. (2000). *Beyond Perceptions: A report on alcohol and other drug use among gay, lesbian and queer communities in Victoria*. Melbourne, Australian Drug Foundation.

Nicholas, J., & Howard, J. (2001). *Same sex attracted suicide: Why are we still talking about it?* Suicide Prevention Australia, Sydney.

Palefsky, J.M., Holly, E.A., Ralston, M.L., Arthur, S.P., Jay, N., Berry, J.M., DaCosta, M.M., Botts, R., & Darragh, T.M. (1998). Anal squamous intraepithelial lesions in HIV positive and HIV negative homosexual and bisexual men: Prevalence and risk factors. *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology,* 17(4): 320-326.

Pitts, M. & Horsley, P. (2005). H*ealth service usage and level of dissatisfaction with the most recent GP visit of young and middle-aged non-heterosexual Australian women*. Unpublished article.

Private Health Insurance Administrative Council. (2005). *Statistical Trends: Membership and benefit statistics*. Canberra, Australian Government.

Richters, J., Grulich, A., De Visser, R. O., Smith, A. M. A., & Rissel, C. (2003). Sex In Australia: Sexual and emotional satisfaction in regular relationships and preferred frequency of sex among a representative sample of adults. *Australian and New Zealand Journal of Public Health*, 27(2): 171-179.

Richters, J., Song, A., Prestage, G., Clayton, S., & Torner, R. (2005). *The Health of Lesbian, Bisexual and Queer Women in Sydney: Report of the 2004 Women and Sexual Health Survey. Sydney,* National centre for HIV Social Research, University of NSW.

Rissel, C., Richters, J., Grulich, A. De Visser, R. O., & Smith, A. M. A. (2003). Sex in Australia: Experiences of commercial sex in a representative sample of adults. *Australian and New Zealand Journal of Public Health*, 27(2): 191-197.

Roberts, S., & Sorenson, L. (1995). Lesbian Health Care: A review and recommendations for health promotion in primary health care settings. *Nurse Practitioner*, 20(6): 42-47.

Rogers, G., Curry, M., Oddy, J., Makinson, S., Thompson, J. & Beilby, J (2004). *Addressing Inequality: A report on the first five years of the care and prevention Program*. Adelaide, South Australian Department of Human Services.

Saphira, M., Glover, M. (200). New Zealand national lesbian health survey. *Journal of the Gay and Lesbian Medical Association*, 4(2):261-269

Smith, A. M. A., Rissel, C., Richters, J., Grulich, A. & De Visser, R. O. (2003). Sexual Identity, sexual attraction and sexual experience in a representative sample of adults. *Australian and New Zealand Journal of Public Health*, 27(2): 138-145.

Sohlman, B. (2004). *A functional model of mental health as the describer of positive mental health*. STAKES Research Reports 137. Helsinki, National research and Development for Welfare and Health.

Southgate, E., & Hopwood, M. (1999). *The Drug Use and Gay Men Project*. Sydney, National Centre in HIV Social Research, University of NSW.

Steiner, M., Bell, B., Browne, G., Roberts, J., Gafni, A., Byrne, C., Dunn, E., Chalkin, L., Kraemer, J., Mills, M., & Wallik, D. (1999). Prevalence of Dysthymic Disorder in Primary Care. *Journal of Affect Disorders*, 54(3): 303-308.

Vickers, L. (1996). The Second Closet: Domestic violence in lesbian and gay relationships, a Western Australian perspective, *Murdoch University Electronic Journal of Law,* 3(4).

Victorian Gay and Lesbian Rights Lobby. (2000). Enough is enough: *A report on discrimination and abuse experienced by lesbians, gay men, bisexuals and transgender people in Victoria*.

Warner, J., McKeown, E., Groffin, M., Johnson, K., Ramsay, A., Cort, C., & King, M. (2004). Rates and predictors of mental illness in gay men, lesbians and bisexual men and women, *British Journal of Psychiatry*, 185: 479-485.

Wilton, T. (2000). *Sexualities in Health and Social Care*, Buckingham, Open University Press.