POPULATION HEALTH SERIES REPORT

phn MURRAY

An Australian Government Initiative

# LGBTQ+ COMMUNITIES

Leadership Collaboration Respect Accountability Innovation

Murray PHN acknowledges its catchment crosses over many unceded First Nations Countries following the Dhelkunya Yaluk (Healing River).

We pay our respects and give thanks to the Ancestors, Elders and Young People for their nurturing, protection and caregiving of these sacred lands and waterways, acknowledging their continuation of cultural, spiritual and educational practices.

We are grateful for the sharing of Country and the renewal that Country gives us.

We acknowledge and express our sorrow that this sharing has come at a personal, spiritual and cultural cost to the wellbeing of First Nations Peoples.

We commit to addressing the injustices of colonisation across our catchment, and to listening to the wisdom of First Nations communities who hold the knowledge to enable healing.

We extend that respect to all Aboriginal and Torres Strait Islander Peoples.

## Recognition of lived experience

We recognise the individual and collective contributions of people with a lived and/or living experience of health issues, and their families, loved ones and supporters.

It is through listening to and acting on the voices of people with lived experience, those who provide services, those who fund services, and most importantly, those who use services that we will find the expertise we need to move towards the health system that Australia needs.

Every person's story we hear, and every experience shared, helps to develop our understanding of the system that is required to best meet the needs of people who live with or care for someone with health concerns.

## Contributors and attribution

Murray PHN would like to extend sincere thanks to the many contributors to this population health series report, including local healthcare consumers, professionals, community members and other stakeholders. We also acknowledge the contributions of Murray PHN staff, The Australian Research Centre in Sex, Health and Society at La Trobe University, Rainbow Health Australia and Thorne Harbour Country, who were involved in the planning, data collection, analysis and reporting.


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# Executive summary

Murray PHN's Population Health Series report on lesbian, gay, bisexual, transgender, queer and/or questioning and other communities (LGBTQ+) describes the outcomes of a comprehensive health needs assessment process, that examined the health, wellbeing and service access experiences of LGBTQ+ people across the region.

The process included a review of Australian literature on LGBTQ+ health in regional and rural areas, a secondary analysis of available data and local consultations with 21 LGBTQ+ community members across two face-to-face focus groups and one online focus group, and nine service providers through one-to-one interviews.

The project was overseen by a community reference group comprising LGBTQ+ community members, advocates and service providers living and/or working in the Murray PHN catchment, and which met four times throughout the project (from January to June 2026) at the beginning, during and directly after the consultation process, and to review the findings and reporting. The consultations were conducted by Thorne Harbour Health, the Australian Research Centre in Sex, Health and Society, La Trobe University (ARCSHS) and Rainbow Health Australia, a program of ARCSHS.

The findings are intended to inform health planning, service commissioning, workforce development, and local strategies to improve access to safe, inclusive, and culturally responsive care.

# Terminology

The acronym 'LGBTQ+' is being used for this report to reflect best practice and ensure these findings best represents the population meaningfully engaged with through this work. This decision acknowledges the limitations of the available in-depth, local evidence and recommendations relating specifically to intersex and asexual communities. As a result, the report does not present a comprehensive analysis of the health needs of these populations where sufficient evidence was not available. To address this gap, this report provides a brief overview of the literature on intersex health and wellbeing, recognising that intersex people are frequently underrepresented or misrepresented in health planning and research.

# Key insights

| Issue | Insights |
|---|---|
| **Health issue** | |
| **Mental health** | Mental health is a key issue particularly for LGBTQ+ young and older people, with those in regional/rural areas experiencing higher levels of psychological distress, loneliness and suicidality than non-LGBTQ+ people. The local environment and negative experiences of service impact on the mental health of LGBTQ+ people and high treatment costs mean are not accessible to many. |
| **Gender affirming care for trans and gender diverse people** | Trans and gender diverse people experience significantly poorer health outcomes driven by high levels of discrimination, violence and minority stress, alongside significant barriers to timely, affordable and affirming healthcare. There are limited gender affirming care specialists and clinics who are available, and long waitlists for services. People often travel to metropolitan Melbourne to find appropriate care. There are limited informed consent options and young people can age out of waitlists and must start again on adult waitlists. |
| **Aboriginal and Torres Strait Islander people** | Aboriginal and Torres Strait Islander LGBTQ+ people can find it challenging to find services that are affirming of both cultural and LGBTQ+ identity. They may hide parts of their identity from services when seeking care, and experience compounded health inequities and ongoing barriers to accessing culturally safe and LGBTQ+ affirming services. |
| **People from migrant and culturally diverse backgrounds** | LGBTQ+ migrants and people from culturally diverse backgrounds may be significantly isolated from community supports and services because they have limited networks. They may not be able to discuss sexuality or gender within their families or cultural communities, deepening isolation. They can face challenges related to language barriers, visa insecurity, cultural expectations and fears of discrimination, that limits help-seeking and engagement with health and community services. |
| **People living with a disability and/or long-term health condition** | LGBTQ+ people (regardless of geography) are more likely to live with disability or chronic long-term health conditions. Rural LGBTQ+ adults are more likely to be living with multiple chronic conditions. LGBTQ+ people with disabilities can experience assumptions of heterosexuality or asexuality within disability services and inaccessible service environments. Service providers may not be able to holistically address the needs of LGBTQ+ people with disabilities. |
| **Alcohol and drugs (AOD)** | AOD use as an important health issue for LGBTQ+ people, shaped by minority stress, discrimination, social isolation, violence and concealment. Regional and rural LGBTQ+ people may experience elevated tobacco, alcohol and other drug-related risks compared with non-L LGBTQ+ rural residents. Notable tobacco use among LGBTQ+ adults: 14.2% daily smokers and 8.1% regular smokers. Alcohol use showed a mixed pattern, with both low-frequency drinking and frequent consumption; 13.6% reported drinking four or more times per week. |

| Issue | Insights |
|---|---|
| **Homelessness** | Homelessness and housing instability identified as key social determinants affecting LGBTQ+ health and wellbeing. Risk is particularly high for young people, trans and gender diverse people, and those experiencing family violence, discrimination, financial stress or social isolation. Among LGBTQ+ adults in the Murray PHN catchment, 17.8% had experienced homelessness in their lifetime and among young people: 28.8% had experienced homelessness in their lifetime and 13.6% in the past 12 months. |
| **Service issue** | |
| **Availability of services** | There are limited available services which are safe and inclusive of LGBTQ+ people and service providers often have long waitlists. Inclusive practitioners frequently move on from regional/rural areas leaving critical service gaps. |
| **Safety within services and accessing services** | Hostile environments are a determinant of health and safety. LGBTQ+ people frequently experience ignorance, assumptions, discrimination within services and can be targeted on their way to or outside visibly inclusive services. LGBTQ+ people in the Murray PHN catchment were less likely to feel respected within LGBTQ inclusive mainstream services: 69% of adults in the Murray PHN catchment reported feeling respected in LGBTQ inclusive mainstream clinics compared to 90.9% in metropolitan areas. |
| **Visibility of services** | LGBTQ+ people find it challenging to identify which services are inclusive and signs of inclusive practice may not guarantee a safe experience within services. Signs of inclusivity, for example asking about gender identity and pronouns on intake forms, could be tokenistic without meaningful action. Community connections are required to receive referrals to inclusive services, as services are often only known to be inclusive through experience or word-of-mouth. Limited information (such as directories or information on websites) about inclusive services and referral pathways. |
| **Training and accountability within services** | Services may have Rainbow Tick accreditation, but this is not reflected in LGBTQ+ people's experiences within services. Many services have not undergone appropriate training to ensure they are LGBTQ+ inclusive. Training is costly and time consuming; many services may experience this as a barrier to completing appropriate training. Limited avenues for following up complaints and ensuring that training is being provided within services. |

# Recommendations

| Coordinate and integrate local healthcare services | |
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| **1. Increase engagement to improve resource impact and efficiency** | • Ensure LGBTQ+ community members are meaningfully included in planning, commissioning and service design processes across the region. This should include both strengthening existing engagement mechanisms (e.g. advisory groups) and establishing dedicated ones where appropriate and gaps exist.<br>• Incorporate targeted, timely messaging in communications, such as visible signs of support via social media or other channels to coincide with key days of significance, consistent use of inclusive language, imagery and content, as well as transparent communication about strategies for working with and improving support for LGBTQ+ communities.<br>• Update service public-facing resources (e.g. websites) to include up-to-date and relevant information on LGBTQ+ inclusive health services and community supports across the catchment.<br>• Collaborate with local organisations and services working in LGBTQ+ spaces to strengthen knowledge sharing and establish strong networks and a visible presence of inclusive practice across the region.<br>• Produce and share report cards detailing progress and planned initiatives to improve services and healthcare for LGBTQ+ people. |
| **2. Collect accurate and inclusive information and data** | • Collect accurate data and conduct regular evaluation and analyses to understand who is accessing services to inform service delivery and resource efficiency with linkages to existing reporting frameworks from funders.<br>• Support providers to develop and use intake forms and patient experience surveys that collect accurate information about names, pronouns, gender identity and sexuality to ensure that services are gathering and using correct information for clients while recording the information into their existing client register management or health record systems. |
| **3. Demonstrate visible leadership and organisational commitment when engaging with health services and across the sector** | • Publicly and consistently signal LGBTQ+ inclusion (e.g. campaigns, participation in Pride, visible leadership endorsement).<br>• Ensure senior leaders and executive staff visibly champion LGBTQ+ inclusion and regularly communicate its importance to staff and communities.<br>• Demonstrate support during periods of community backlash or heightened discrimination by publicly affirming organisational commitment to LGBTQ+ communities and staff. |

| Inclusive primary care and mental health services | |
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| **4. Support adoption of minimum standards and accountability for inclusive care** | • Support the adoption and uptake of the forthcoming national LGBTQ+ primary care training and accreditation program.<br>• Review and revise processes to actively address barriers to access and inclusion for LGBTQ+ communities.<br>• Create clear accountability mechanisms within services, including accessible and safe compliance processes for service users, monitoring of reports for discriminatory or harmful practice and to ensure that services meet minimum sector compliance standards for training and practice. |
| **5. Inclusive mental health services to address high rates of psychological distress** | • Prioritise specialised local mental health services that are safe and accessible for LGBTQ+ people and support face-to-face services and in-depth mental healthcare.<br>• Ensure mental health services are adequately trained to address LGBTQ+ intersectional experiences, including for people who are disabled, neurodivergent, trans and gender diverse, and from Aboriginal and Torres Strait Islander, migrant and/or culturally diverse backgrounds.<br>• Promote access to mental health services that are affordable and accessible for people from low socio-economic backgrounds.<br>• Support capacity-building across existing services to ensure they are equipped to provide LGBTQ+ people with safe and inclusive care. |
| **6. Improve availability, visibility and distribution of inclusive services** | • Create resources, including directories and referral pathways, which facilitate access to information about inclusive services for both LGBTQ+ consumers and service providers.<br>• Work with services to ensure safe physical access to inclusive services, including risk assessments of service locations and safe entry/exit planning for priority groups (e.g. trans and gender diverse young people).<br>• Ensure that geographically isolated communities and smaller rural towns are adequately serviced beyond online/telehealth (e.g. mobile and locally accessible mental health services).<br>• Develop protocols for responding to harassment or safety threats near service sites.<br>• Engage LGBTQ+ inclusive outreach, telehealth and mobile services to extend access into areas where services are not available and ensure these are widely promoted. |

| Capacity-build and provide practice support to primary care and mental health providers<br>Inclusive primary care and mental health services | |
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| **7. Improve cultural safety alongside inclusion** | • Fund and support training that integrates LGBTQ+ inclusion with cultural safety, rather than treating these as separate or competing priorities.<br>• Champion the *Rainbow Mob Are My Mob Best Practice Model for Rainbow Mob Inclusion* in local Aboriginal Community Controlled Health Organisations (ACCHOs).<br>• Partner with ACCHOs, multicultural organisations, refugee and migrant services, and LGBTQ+ community-controlled organisations to codesign locally relevant approaches.<br>• Develop and promote referral pathways to services that are both culturally safe and LGBTQ+ affirming, including clear guidance for practitioners about where to refer people with intersecting support needs.<br>• Include LGBTQ+ Aboriginal and Torres Strait Islander and multicultural people in advisory, consultation and codesign processes, with appropriate remuneration and support.<br>• Ensure health promotion materials, websites and service directories represent the diversity of LGBTQ+ communities, including Aboriginal and Torres Strait Islander people and culturally diverse communities. |
| **8. Build workforce capacity and reduce reliance on individual champions** | • Expand the number of trained providers across the network to avoid reliance on a small number of "go-to" practitioners.<br>• Provide dedicated funding, supervision and wellbeing supports for staff delivering LGBTQ+ care.<br>• Support and resource LGBTQ+ staff networks, champions and allies rather than relying on unpaid advocacy by individual staff members. This could include facilitating communities of practice and knowledge sharing sessions between organisations and clinicians.<br>• Incorporate LGBTQ+ inclusion into staff induction, ongoing professional development and performance expectations for managers and leaders.<br>• Develop workforce retention strategies (e.g. incentives, professional development pathways) to reduce turnover of trusted practitioners. |

# Contents

# Abbreviations

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| ABS | Australian Bureau of Statistics |
| ACCHO | Aboriginal Community Controlled Health Organisation |
| AIHW | Australian Institute of Health and Welfare |
| DHDA | Department of Health, Disability and Ageing |
| HIV | Human Immunodeficiency Virus |
| HRT | Hormone replacement therapy |
| LGBTQIA+ | Lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual and more |
| LGBTQ+ | Lesbian, gay, bisexual, transgender, queer or questioning and more |
| LBQ | Lesbian, bisexual, queer |
| STI | Sexually Transmitted Infections |

# Introduction

Lesbian, gay, bisexual, transgender (trans), intersex, queer, asexual people, or people otherwise diverse in gender, sexual orientation and/or innate variations of sex characteristics (LGBTQ+) represent approximately 4.5 per cent of the Australian population aged 16 years and older (ABS, 2024).

LGBTQ+ people are represented across all communities nationally, although inner urban areas tend to have more LGBTQ+ people than outer suburban or regional/rural areas (ABS, 2024).

While many LGBTQ+ people lead happy and healthy lives in regional/rural areas, significant health inequities and service barriers persist for this diverse population, requiring a tailored response.

# Background

This report has been created to provide local insights, information and data to:

- identify primary healthcare service gaps for LGBTQ+ community members
- identify health needs for LGBTQ+ community members
- support evidence-based decision making for funding, resource allocation and service design
- identify barriers and enablers to accessing primary healthcare services for LGBTQ+ people
- validate lived experiences and amplify the voices of LGBTQ+ people in primary healthcare planning and service delivery
- identify sub-regional or local government area-level areas of need to support improved access to primary healthcare services for LGBTQ+ people.

# Literature review

### Literature review key results

The literature review found that LGBTQ+ people living in regional and rural Australia experience poorer health and wellbeing outcomes than both non-LGBTQ+ rural residents and metropolitan LGBTQ+ populations.

- These inequities include elevated psychological distress and suicidality, poorer self-rated health, lower engagement with preventative healthcare and screening, greater exposure to violence and housing insecurity, and reduced access to inclusive and specialist healthcare.
- Structural features of rurality intensify these inequities, including limited service choice, workforce shortages, long travel distances, concerns about confidentiality in small communities, and uneven access to LGBTQ+ inclusive practitioners.
- Priority populations identified in the literature include trans and gender diverse people, LGBTQ+ youth and older people, LBQ women, Aboriginal and Torres Strait Islander and culturally and linguistically diverse LGBTQ+ people, people with disability, and people with innate variations of sex characteristics.
- While rural and regional contexts can provide important sources of resilience, community connection and belonging, these strengths often coexist with substantial service barriers, stigma and isolation.

## Purpose

This literature review provides an overview of the current evidence relating to the health, wellbeing and healthcare experiences of LGBTQ+ people living in regional and rural Australia, with a particular focus on Victorian research where available. Its purpose is to identify the key health inequities, strengths, service gaps and barriers to care that have been documented in research, and to highlight evidence-based approaches that may improve health outcomes for LGBTQ+ communities. The review provides an important evidence base for the Murray PHN LGBTQ+ Health Needs Assessment, helping to contextualise local findings and identify issues requiring further exploration through community consultation and analysis of Murray PHN-specific data. These sources of evidence support the development of locally relevant recommendations for inclusive health planning, service delivery and commissioning.

## Summary

This literature review demonstrates that LGBTQ+ people living in rural and regional Australia experience consistently poorer health and wellbeing outcomes than both non-LGBTQ+ rural and metropolitan populations. These inequities span mental, physical and sexual health, alcohol and other drug use, experiences of violence and homelessness, and barriers to accessing gender affirming care. Structural features of rurality intersect with stigma, discrimination and minority stress to compound disadvantage across the life course.

The evidence highlights elevated psychological distress and suicidality, poorer self-rated health, lower uptake of preventative screening, and greater exposure to violence and housing instability among rural LGBTQ+ populations. Trans and gender diverse people, lesbian bisexual and queer women, young people, older adults, and people with intersecting identities experience additional and compounding barriers. While some rural contexts offer protective factors such as strong place attachment and community reciprocity, these benefits are unevenly distributed and frequently coexist with significant challenges.

Although a growing number of LGBTQ+ health initiatives operate in rural Australia, service provision remains fragmented, unevenly targeted and under-evaluated. Many interventions focus on social inclusion, workforce training and sexual health, with comparatively limited attention to mental health, family violence, ageing, and alcohol and other drug support.

These findings support the need for local consultation within the Murray PHN catchment to identify local need, map inclusive services, and understand place-specific barriers and enablers for community wellbeing and inclusive service provision. Key implications for health promotion and service provision include strengthening LGBTQ+ cultural safety across primary care, improving visibility of inclusive services, supporting place-based mental health and alcohol and other drug responses, and enhancing referral pathways for specialist and gender-affirming care.

## Health and wellbeing nationally and internationally

While visibility, rights and recognition of LGBTQ+ people and their families have advanced in Australia and internationally in recent decades, LGBTQ+ people continue to face stigma, discrimination, violence, and structural barriers to inclusive health and social care (Hill et al., 2020). Subsequently, LGBTQ+ people of all ages report reduced health and wellbeing outcomes compared to their cisgender and/or heterosexual counterparts (Hill et al., 2020, 2021). For example, LGBTQ+ people experience:

- Poorer self-assessed physical health (Gonçalves et al., 2026) and increased likelihood of living with disability (Amos, Hill, Lyons, et al., 2023; Fredriksen-Goldsen et al., 2012) or chronic illness (Eliason, 2014)
- High rates of psychological distress and greater likelihood of lifetime mental health diagnoses (Hill et al., 2020)
- Increased suicidal ideation, suicide attempts (Hill, Lyons, et al., 2022; Lyons et al., 2022) and self-harm (Lim, Amos, et al., 2025)
- Lower than average rates of engagement in preventative healthcare access and routine screening, such as cervical, breast, prostate and bowel screening (Gonçalves et al., 2026; Heer et al., 2023; Hill et al., 2020; Kerr et al., 2023)
- Higher than average rates of obesity (Grammer et al., 2019; Stevens, 2023) and eating disorders (Calzo et al., 2017; Nagata et al., 2024; Rasmussen et al., 2023)
- Increased likelihood of various cancers (Quinn et al., 2015), cardiovascular disease (Bonomo et al., 2024), and diabetes (Meads et al., 2018).

In addition to these poorer health outcomes, LGBTQ+ people are also more likely to experience a range of health impacting factors such as:

- High rates alcohol and other drug use (AIHW, 2024a)
- High rates of tobacco smoking and vaping (AIHW, 2024a)
- High rates of family of origin violence (Amos, Hill, Donovan, et al., 2023)
- Greater risk of intimate partner violence (Bourne et al., 2023)
- High rates of lifetime experiences of sexual violence (Hindes et al., 2025)
- High rates of lifetime experiences of homelessness or housing instability (Dempsey et al., 2020; Lim, Melendez-Torres, et al., 2025a).

Within LGBTQ+ populations, these health disparities are experienced differently across the life course and are further compounded for certain population sub-groups. There is a large body of Australian and international research that points to the unique health and wellbeing challenges faced by LGBTQ+ children and young people. This work points to physical and mental health disparities among LGBTQ+ youth (Hill et al., 2021), largely exacerbated by family rejection and violence (Amos et al., 2025; Newman et al., 2020), bullying and non-affirming school environments (Lim, Melendez-Torres, et al., 2025b), and limited access to age-appropriate LGBTIQA-inclusive healthcare and social supports (Hill et al., 2021).

Health and wellbeing outcomes also vary within LGBTQ+ populations along a range of intersecting identities. For example:

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| **Aboriginal and Torres Strait Islander people** | Experience compounded health inequities arising from the intersecting impacts of racism, the ongoing effects of colonisation, geographic disadvantage and sexuality or gender-based stigma, alongside ongoing barriers to accessing culturally safe and LGBTIQA-affirming services (Wallis et al., 2024). |
| **Migrant and culturally and linguistically diverse (CALD) people** | Often face challenges related to language barriers, visa insecurity, cultural expectations, and fears of discrimination, which can limit help-seeking and engagement with health and LGBTQ+ or multicultural community services (Hinton, Amos, Lim, et al., 2025). |
| **People with disabilities** | encounter layered exclusion within both disability and LGBTQ+ service systems, including assumptions of heterosexuality or asexuality within disability services, inaccessible service environments, and limited provision of LGBTQ+ inclusive sexual and mental health support (Hill, Amos, et al., 2022). |
| **Lesbian, bisexual, and queer (LBQ) women** | Are frequently underrepresented in health research and service design, with their specific health needs, particularly relating to mental health (Buckingham et al., 2023), alcohol use (Amos et al., 2022), sexual and reproductive health (Power et al., 2025), and experiences of violence, often rendered invisible within both mainstream and LGBTQ+ - specific services. |
| **Trans and gender diverse people** | Experience some of the poorest health outcomes within LGBTQ+ populations, driven by high levels of discrimination, violence, and minority stress, alongside significant barriers to accessing timely, affordable, and affirming healthcare (Hill et al., 2020, 2021). |

### *Understanding terms*

Although many people with innate variations of sex characteristics may identify as part of LGBTQ+ communities, this is not the case for all, and the uncritical inclusion of people with innate variations of sex characteristics within LGBTQ+ populations for the purpose of policy making, health promotion, research and community consultation has been a point of concern for community members (Carpenter, 2022).

While the community consultation conducted as part of this analysis was not able to capture the needs and experiences of people with innate variations of sex characteristics (sometimes referred to as intersex people) within the Murray PHN catchment, due to small population size, the below overview of current research provides some insight into the distinct needs of this population.

People born with innate variations of sex characteristics have physical sex characteristics that may not align with narrow medical or social definitions of male or female bodies (Carpenter, 2020). These characteristics may include variations in genitals, gonads, chromosomes, hormones or secondary sex characteristics.

'Intersex' is a common umbrella term that includes many different variations, such as androgen insensitivity syndrome, congenital adrenal hyperplasia, Klinefelter syndrome and Turner syndrome (Keane et al., 2026). These variations are increasingly understood to be a natural form of human biological diversity, rather than a disease or abnormality. It is estimated that up to 1.7 per cent of the Australian population is born with innate variations of sex characteristics (Zeeman & Aranda, 2020). However, estimates vary depending on how broadly this is defined, with some narrower medical definitions suggesting just 0.02 per cent and broader estimates suggesting up to 4 per cent (Jones, 2018). Innate variations of sex characteristics may be identified at birth, during puberty, when seeking fertility care, or may never be identified at all (Rosenwohl-Mack et al., 2020).

Having innate variations of sex characteristics relates to physical characteristics and is distinct from gender identity or sexual orientation: people with innate variations of sex characteristics may identify as women, men, non-binary, be cisgender or transgender, and may have any sexual orientation (Carpenter, 2020).

Many community members and advocates call for affirming language, such as the terms "intersex" or "variations of sex characteristics," and reject pathologising terms such as "disorders of sex development" (Carpenter, 2022).

Historically, people with innate variations of sex characteristics have often experienced stigma, secrecy and non-consensual medical interventions (Carpenter, 2024; Haghighat et al., 2023). Contemporary human rights approaches therefore emphasise bodily autonomy, informed consent, self-determination and access to respectful, affirming care (Carpenter, 2020; Zeeman & Aranda, 2020).

People with innate variations of sex characteristics often experience poorer health outcomes than the general ('endosex') population, although experiences vary and many report good overall health (Jones, 2018; Zeeman & Aranda, 2020). These inequities are not often caused by the variations themselves, but are strongly shaped by stigma, discrimination, medical trauma, and the long-term impacts of non-consensual or medically unnecessary interventions (Carpenter, 2024).

**Key health concerns include:**

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| **Mental health** | People with innate variations of sex characteristics report high rates of anxiety, depression, psychological distress and suicidality (Amos et al., 2023). These outcomes are often linked to experiences of shame, isolation, discrimination, medical deception and being encouraged to keep their variation secret (Haghighat et al., 2023). |
| **Physical health** | Some people with innate variations of sex characteristics experience chronic pain, scarring, urinary issues, impaired sexual function, reduced sexual sensation, painful intercourse, infertility, osteoporosis and other long-term complications, particularly where early surgeries or gonad removals have occurred without informed consent (Crocetti et al., 2020; Rosenwohl-Mack et al., 2020). |
| **Healthcare experiences** | Repeated invasive examinations, lack of transparent information and pressure to 'normalise' bodies can contribute to enduring mistrust of healthcare systems (Haghighat et al., 2023). |
| **Positive health outcomes** | Are supported by affirming, trauma-informed and rights-based care that prioritises bodily autonomy, informed consent, honest communication and self-determination (Carpenter, 2020; Rosenwohl-Mack et al., 2020). Peer support, community connection and inclusive education can also reduce isolation, challenge stigma and improve wellbeing across the life course (Keane et al., 2026; Steers et al., 2021). |

Previous research and community advocacy suggest that primary healthcare for people with innate variations of sex characteristics should move away from a "fixing" model and towards care grounded in bodily autonomy, informed consent, transparency and trauma-informed support (Carpenter, 2024; Haghighat et al., 2023). This includes avoiding medically unnecessary surgeries or hormonal interventions on infants and children unless there is an urgent health need and protecting each person's future right to make informed decisions about their own body.

Primary healthcare providers also play an important role in reducing stigma by using affirming language, recognising variations of sex characteristics as part of natural human diversity, and avoiding pathologising assumptions (Crocetti et al., 2020).

Many people with innate variations of sex characteristics have experienced medical trauma, invasive examinations, or inadequate information about their bodies and health histories, making respectful communication and access to records essential (Carpenter, 2020). Care should also include referrals to peer support, mental health support, sexual and reproductive health care and specialist services where needed, alongside lifelong monitoring for variation-specific physical health needs (Amos et al., 2023; Roen 2019).

### *Older peoples' experiences*

Conversely, there is also a growing focus in international and Australian scholarship on LGBTQ+ ageing and aged care, highlighting how older LGBTQ+ people experience additional health disparities as they age related to stigma, discrimination and marginalisation. Many older LGBTQ+ people have lived through periods of significant anti-LGBTQ+ sentiment and pathologisation or criminalisation of same-sex attraction or sexual practices. This often results in life-long challenges that have lasting health and wellbeing impacts (Newman et al., 2020). Although older LGBTQ+ people have demonstrated higher mental resilience compared with younger LGBTQ+ adults in research by Hinton, Amos, Grant, et al., (2025a), many report high rates of loneliness and social isolation.

Compared with their non-LGBTQ+ peers, older LGBTQ+ people tend to have lower average incomes and fewer family connections that they can rely on for support as they age (Waling et al., 2022).

Access to inclusive and affirming healthcare for older LGBTQ+ people has been shown to improve their wellbeing, and older LGBTQ+ people who are open about their sexuality or gender identity to their GP report better health outcomes than those who do not disclose their sexuality or gender identity to healthcare providers (Hinton, Amos, Grant, et al., 2025a).

However, previous research indicates that many older LGBTQ+ people fear accessing aged care services, particularly residential aged care, and express concern about whether these services will be LGBTIQA-inclusive (Preston, 2024). This trepidation can result in reduced or delayed aged care service access, with impacts on quality of life (Grant & Walker, 2020).

### *Regional and rural peoples experiences*

Location plays a critical role in shaping LGBTQ+ health and wellbeing. Living outside metropolitan areas can intensify many of the challenges faced by LGBTQ+ people (Grant, Amos, et al., 2024), including reduced access to inclusive healthcare, fewer specialist services, heightened concerns about privacy and disclosure, and increased social isolation. Structural factors such as workforce shortages, long travel distances, and limited service choice further compound existing inequities. At the same time, emerging research suggests that rural and regional contexts can also offer sources of resilience and wellbeing for some LGBTQ+ people.

#### Population estimates

The Australian Bureau of Statistics (2024) released its first nationally representative estimates in 2022, showing about 4.5 per cent of Australians and 5.3 per cent of Victorians, aged 16 years and older identify as LGBTI+ (note that data on asexuality or queer identity is not collected by the ABS). LGBTQ+ people are highly visible and well represented in inner-city areas (Lea et al., 2015), however, a substantial proportion of LGBTQ+ people reside in regional, rural and remote areas (Vic Health, 2018).

In Victoria, 23 per cent of the population or 1.6 million people live in regional, rural and remote areas (Victorian Agency for Health Information, 2020). Aligned with ABS data, the Victorian Population Health Survey previously estimated that 5.7 per cent of adults in the state identify as LGBTQ+ (Victorian Agency for Health Information, 2020). They also estimated that 4.5 per cent of adults living in rural areas identified at LGBTQ+ (Victorian Agency for Health Information, 2020). So, with about one person in 20 identifying as LGBTQ+ nationally, it is likely that ~70,000-80,000 LGBTQ+ people live in regional and rural Victoria (Gould & McNair, 2025).

US research shows that LGBTQ+ people are more likely to reside in regions and communities that are perceived as LGBTQ+ friendly (Kline et al., 2023), with those living in these areas reporting better health outcomes (Clark, 2024). Notably, while same-gender couples make up one per cent of all couples in Melbourne, they represent 2.5 per cent of couples in Daylesford and 1.5 per cent of couples in Castlemaine (Callander et al., 2020) - areas known for their LGBTQ+ inclusive communities.

The 2019 Loddon Campaspe Active Living Census found that 7.9 per cent (one in 12) participants in Mount Alexander Shire identify as LGBTQ+ (Healthy Loddon Campaspe, 2023), compared with 3.4 per cent across the entire region. In these areas, LGBTQ+ people have high visibility and the need for investment in inclusive services is clear from population numbers alone. However, in many regional and rural areas, there is not a visible LGBTQ+ community. LGBTQ+ people or households may be hidden and isolated and, indeed, there is no easily available data on the population of LGBTQ+ people in many smaller regional or regional areas.

However, research has also shown that LGBTQ+ people living in regional and rural areas can hold significant strength in navigating hostile and isolated environments, including fostering strong community networks and identities (Kemmerer et al. 2025; Page, 2026). In recognising the challenges and barriers facing LGBTQ+ people living in regional and rural areas, it is important to recognise the strengths and opportunities for connection, health, wellbeing and community that LGBTQ+ people hold and work towards in their daily lives.

### *Income inequality, food and housing insecurity*

LGBTQ+ people living in rural Australia experience pronounced socio-economic disadvantage that intersects with sexuality, gender, place and life stage. Research shows that rural LGBTQ+ populations are significantly more likely than both metropolitan LGBTQ+ people and non-LGBTQ+ rural residents to report lower household incomes, unemployment or underemployment, food insecurity and financial stress (Gould & McNair, 2025). These inequities are particularly acute for young people, directly shaping their health and wellbeing.

### *Community attitudes, acceptance and inclusion in rural Australia*

Although many Australians are likely to have family or friends who are LGBTQ+ and interpersonal contact is associated with more positive attitudes to LGBTQ+ rights (Harrison & Michelson, 2019), this familiarity does not necessarily translate into a deep understanding of LGBTQA+ experiences.

Research on minority stress highlights that LGBTQ+ populations face stressors linked to stigma, discrimination and social marginalisation that are not always easily visible (Frost & Meyer, 2023). As a result, even among individuals who are generally supportive of LGBTQ+ communities, there may be limited awareness of these challenges, which can in turn reduce understanding of the need for targeted investment in LGBTQ+ specific services and supports.

There is relatively limited contemporary Australian research that directly examines public attitudes toward LGBTQ+ people, particularly with respect to differences between rural and urban populations. Much of the existing evidence is drawn from earlier studies of rural communities (e.g. Hopwood & Connors, 2002), national social attitudes surveys (e.g. Flood & Hamilton, 2005; Wilson, 2004), and analyses of public opinion surrounding the 2017 marriage equality postal survey (e.g. Anderson et al., 2017). Data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey indicate that since 2005, there has been a steady increase in the proportion of Australians who believe that same-sex couples should have the same rights as heterosexual couples (Laß et al., 2025).

However, this growing acceptance is not uniform across the population. Some studies suggest lower levels of support in regional and rural areas compared with metropolitan areas (Flood & Hamilton, 2005), although these differences are also shaped by broader demographic factors such as age, religiosity and political orientation (Anderson et al., 2017). For example, Bawden et al. (2023), in a study of 250 Australians conducted after the legalisation of marriage equality was enacted, found that metropolitan residents reported more positive attitudes than those in regional or rural areas. At the same time, acceptance of traditional gender norms and religious or political conservatism were significant predictors of less supportive attitudes across all geographic locations.

Importantly, this study also highlights that interpersonal contact and psychosocial factors remain influential: knowing LGBTQ+ people and demonstrating higher levels of empathy were associated with more positive attitudes toward marriage equality. These findings suggest that, while broader structural and demographic influences shape public opinion, there are also potentially modifiable factors – such as increasing meaningful contact and fostering empathy – that may help strengthen community understanding and support for LGBTQ+ populations and the services designed to meet their needs.

Although LGBTQ+ people may report feeling accepted in regional and rural communities due to long-term residence and subsequent belonging (Grant & Walker, 2020), many LGBTQ+ people living in regional or rural Australia navigate environments characterised by heteronormativity, limited LGBTQ+ visibility, and fear of stigma. Compared to their metropolitan counterparts, rural LGBTQ+ people report higher levels of verbal harassment, physical assault and family or intimate partner violence (Hill et al., 2020, 2021), often occurring within close-knit communities where anonymity is limited and disclosure can carry heightened social risk.

The 'close-knit' nature of rural and remote towns can intensify concerns about privacy and disclosure for LGBTQ+ people, often leading individuals to conceal their sexual or gender identity in workplaces, services and social settings (Lewis & Redshaw, 2025). This concealment can reinforce feelings of isolation and disconnection even where overt discrimination is not present. Notably, Australian research shows that LGBTQ+ people in rural areas face greater social isolation, reduced perceptions of physical safety, a lack of trust in others in their area (Gould & McNair, 2025), and lower levels of LGBTIQA-community connectedness (Hinton, Amos, Grant, et al., 2025b). These experiences are key drivers of 'minority stress', a term describing the impact of multiple everyday stressors that result from experiences of alienation, rejection or discrimination as a result of minority identity.

At the same time, research also points to protective factors within some rural contexts. Strong place attachment, connection to natural environments and reciprocal community relationships can support wellbeing, particularly among rural LGBTQ+ people (Grant & Walker, 2020). However, these benefits are unevenly distributed and often coexist with significant marginalisation.

Overall, the evidence indicates that socio-economic disadvantage, limited acceptance and poor mental wellbeing among rural LGBTQ+ populations are not individual failings but the result of structurally produced inequities that demand place-based, inclusive policy and service responses.

### *Mental health and wellbeing in rural Australia*

Mental health outcomes for LGBTQ+ people in rural Australia reflect the cumulative pressures of socio-economic disadvantage, isolation and discrimination. Recent Australian research identifies consistently higher levels of psychological distress, loneliness and suicidality compared with non-LGBTQ+ populations (Hill et al., 2020; Hinton, Amos, Grant, et al., 2025b). For instance, in one national survey, 8.4 per cent of LGBTQ+ adults in rural Australia reported having attempted suicide in the past 12 months (Hill et al., 2020) compared to just 0.3 per cent in the general Australian population (Australian Bureau of Statistics, 2023). Suicide risk is even more pronounced for rural LGBTQA+ youth, with another national survey finding that 14 per cent of LGBTQA+ young people in rural areas had attempted suicide in the past 12 months, compared to seven per cent of those living in inner-city areas (Hill et al., 2021).

In rural Victoria, diagnoses of anxiety and depression were significantly higher among LGBTQ+ adults (49.5%) compared to non-LGBTQ+ adults (31.7%) (Gould & McNair, 2025). In addition, in rural areas, access to mental health support is often constrained by workforce shortages, long wait times and a lack of practitioners with LGBTIQA-specific training, resulting in lower help-seeking and reduced continuity of care (Reynish et al., 2023).

### *Physical and sexual health*

Physical and sexual health outcomes for LGBTQ+ people living in rural Australia are shaped by a combination of service access constraints, stigma and uneven availability of inclusive care. Evidence from Victorian and national studies indicates that LGBTQ+ adults in rural areas report poorer general health than both their metropolitan LGBTQ+ peers and non-LGBTQ+ rural residents. For example, a significantly greater proportion of LGBTQ+ adults in rural Victoria rate their health as fair or poor, with poorer self-rated health reported across regional, rural and outer suburban locations compared with inner urban areas (Gould & McNair, 2025; Hill et al., 2020). Rural LGBTQ+ adults are also more likely to be living with multiple chronic conditions (Gould & McNair, 2025). Engagement with preventative healthcare is consistently lower outside inner urban areas, with LBQ+ women and people with a cervix in regional and rural locations substantially less likely to access cervical screening (Amos, Lim, Buckingham, et al., 2023).

Sexual health outcomes are similarly shaped by place: research shows that gay and bisexual men living in regions with higher levels of structural stigma are less likely to undergo HIV and STI testing or to be aware of, or use, biomedical HIV prevention strategies such as PrEP (Saxby et al., 2022). Structural barriers, including limited specialist services, long travel distances, and heightened concerns about confidentiality in small communities, contribute to delayed care-seeking and reduced engagement, particularly among people who are not openly LGBTQ+.

### *Alcohol, tobacco and other drug use, and service access*

Risky alcohol consumption and daily tobacco smoking is more prevalent outside metropolitan areas, including both inner regional and outer regional areas. For example, 39 per cent of people in outer regional areas consume alcohol at risky levels compared with 29 per cent in major cities (AIHW, 2024b). LGBT people also report higher rates of daily tobacco smoking, risky alcohol consumption and recent illicit drug use compared with non-LGBT people. (AIHW, 2024a). Substance use among LGBTQ+ populations is often understood in relation to minority stress, with smoking, alcohol and drug use linked to experiences of discrimination, social isolation, identity concealment and violence (Race et al., 2026). These patterns are compounded by a lack of LGBTQ+-specific alcohol and other drug use programs in rural Australia (Gould & McNair, 2025), where harm-reduction and treatment services are rarely inclusive, meaning that while many rural LGBTQ+ people fall into low-risk categories, those who do require support face substantial barriers to accessing culturally safe and affirming care.

### *Gender affirmation*

Trans and gender diverse people living in rural Australia experience significant and compounded barriers to accessing gender-affirming healthcare. These include a lack of locally available clinicians with appropriate training, long travel distances to metropolitan specialist services, fragmented referral pathways, and high out-of-pocket costs for specialist consultations and surgeries (Grant, Russell, et al., 2024). Many rural trans and gender diverse people report delaying or forgoing care due to fear of discrimination, misgendering or breaches of confidentiality within small communities (Grant, Russell, et al., 2024). Limited access to peer support networks further exacerbates distress, contributing to poorer mental health outcomes and heightened risk among rural trans and gender diverse populations.

### *Disaster response*

Natural disasters, including bushfires, floods and extreme weather events, create unique and heightened challenges for rural areas, which may intersect with LGBTQ+ needs (Dominey-Howes et al., 2014). Australian research highlights that disaster response and recovery efforts frequently operate on heteronormative assumptions about households, families and care relationships, rendering LGBTQ+ people invisible within planning and service delivery (Dominey-Howes et al., 2014). Emergency accommodation, relief centres and recovery services may feel unsafe or exclusionary, particularly when managed by faith-based providers or when privacy is limited (Gorman-Murray et al., 2014). LGBTQ+ people affected by disasters report increased marginalisation, re-traumatisation and social isolation during both the response and recovery phases. Those already experiencing housing insecurity, family estrangement or violence may be pushed into deeper crisis as support networks fracture and access to affirming services becomes even more constrained. The absence of LGBTQ+ representation in official disaster communications and media further reinforces invisibility and exclusion at a time of heightened vulnerability.

### *Service access, barriers, and existing provision*

Access to healthcare for LGBTQ+ people living in rural Australia is shaped by significant geographical and structural barriers. Rural areas experience persistent shortages of healthcare professionals, fewer specialist services (including gender affirming care, HIV medicine and fertility services), and fragile referral pathways (Gould & McNair, 2025). Inclusive care in these settings is often dependent on individual 'change champions'; when these practitioners leave or retire, inclusive service provision frequently diminishes or ceases altogether (Grant et al., 2021). Concerns about confidentiality and visibility in small communities further discourage engagement, with many LGBTQ+ people avoiding local services due to fears of inadvertent disclosure. While telehealth has expanded since COVID-19, its effectiveness in rural contexts may be constrained by poor internet connectivity, limited digital literacy, and the continued need for in-person specialist care (Gould & McNair, 2025).

The literature consistently highlights substantial gaps and inequities in service provision (Davidson, 2025). Certain populations remain markedly underrepresented in existing rural LGBTQ+ health interventions, including LBQ women, older LGBTQ+ people, and LGBTQ+ people with disabilities. Critical health domains such as family violence, housing instability and substance use have received less attention, despite being well-documented concerns. Interventions targeting gay, bisexual and men who have sex with men are heavily skewed towards sexual health and HIV, often neglecting other health and wellbeing needs for this group. Finally, while some initiatives address Aboriginal and Torres Strait Islander LGBTQ+ peoples, intersectional approaches that account for the combined effects of rurality, disability, ageing and gender diversity remain limited.

### Interventions to support inclusive access to primary and mental healthcare for regional and rural people

Despite these barriers, a growing body of literature documents a wide range of interventions aimed at improving LGBTQ+ health and wellbeing in rural Australia. Research consistently shows that LGBTQ+ barriers to access to GPs and mental health services in rural and regional areas are not geographic, but social, structural and relational. A study in the Geelong-Barwon region (Lucas et al., 2003) recommended the need for healthcare providers to be more "queer literate", noting that visible inclusion, advocacy and safe spaces are central to whether people feel able to seek and engage in primary care. Other studies (Lewis, 2020) similarly reinforce that "access" must include perceived safety and cultural affirmation. Achieving this will involve:

- **Training rural GPs and practice staff** in LGBTQ+ cultural awareness and responsiveness ("queer literacy") so patients feel safe, respected and understood.
- **Incorporating inclusive language, forms and environments** (e.g. asking about pronouns, chosen names, recognising diverse relationships) to reduce fear and enable identity disclosure.
- **Develop policies and practices that embed queer-affirming care** into everyday service delivery, not just specialised clinics.

However, these initiatives do not easily address complexities such as high staff turnover in primary healthcare services, the persistence of stigma in some services and communities or the lack of availability of specialist services (e.g. specialists in hormone therapy for trans people). There is also a need to strengthen advocacy and support networks for LGBTQ+ people. While this does not support a direct pathway to formal services, it enables access to safe spaces and visibility ("Queer Presence", Lucan et al 2023). When people feel connected to peers and community support, they are more likely to feel confident challenging stigma and engaging with health services. Community leaders or advocates may also partner with healthcare services to improve pathways to care.

Since COVID-19, telehealth has been increasingly seen as a strategy to increase access to primary and specialist healthcare for people in rural and remote areas. Qualitative research with LGBTQ people in regional Australia (Bowman et al., 2020) shows that online and telehealth mental health services can help overcome geographic barriers for rural LGBTQ+ people, particularly young people, by offering more anonymity, a wider choice of providers and reduced travel needs. However, not all online services are equally inclusive or suited to LGBTQ+ needs. There is a need to build specific and targeted telehealth services that are tailored for rural LGBTQ+ communities, with training in queer-affirming practice. Community organisations could play a role in supporting digital literacy among LGBTQ+ people to support access to telehealth.

A recent scoping review identified 139 unique interventions to support inclusive practice in rural Australia (Davidson, 2025). These interventions span multiple health domains, delivery formats and target populations, highlighting considerable activity but also uneven coverage. Common intervention formats include workshops and training programs for service providers, development of LGBTQ+-specific health services, targeted health promotion campaigns and policy or organisational change initiatives. Peer support programs and community events also feature prominently in rural communities, reflecting the importance of social connection and visibility in these settings. Many interventions adopt hybrid delivery models, combining digital and in-person approaches or focus on workforce development to improve the capacity of mainstream services to provide inclusive care.

# Secondary analysis of Private Lives 3 and Writing Themselves in 4

**Secondary data analysis key results**

The secondary data analysis identified high levels of psychological distress among LGBTQ+ people in the Murray PHN catchment. Among young people who participated in *Writing Themselves In 4* survey, 78.6 per cent reported high or very high psychological distress. Among adult *Private Lives 3* survey participants, 54.8 per cent reported high or very high psychological distress.

Participants in the Murray PHN catchment (n=162) were less likely than metropolitan participants to report feeling respected by healthcare providers across several service types, including mainstream medical clinics, hospitals, allied health services and mental health services.

Primary healthcare access among LGBTQ+ adults in the Murray PHN catchment was broadly comparable to other areas, with most participants having seen a GP in the previous 12 months and many reporting that they had a regular GP.

Experiences of violence and discrimination were broadly similar across metropolitan, regional, rural/remote and Murray PHN region participants. However, Murray PHN and rural/remote participants reported slightly higher levels of social exclusion and some forms of online harassment or digital threats than metropolitan participants.

## Purpose

While national and state-level research provides valuable insights into the health and wellbeing of LGBTQ+ populations, there is often limited local data available to inform regional health planning and service delivery. To address this gap, a secondary analysis of data from two of Australia's largest studies of LGBTQ+ health and wellbeing: *Private Lives 3* (LGBTQ+ adults) and *Writing Themselves In 4* (LGBTQ+ young people) were conducted. By examining responses from participants living within the Murray PHN catchment, this analysis provides a unique opportunity to better understand the health, wellbeing, healthcare experiences, and service needs of local LGBTQ+ communities.

These findings complement the literature review by moving beyond national trends to identify issues that are particularly relevant within the Murray PHN catchment. They also provide an important evidence base for comparison with the consultation findings, helping to identify areas of convergence, divergence and unmet need. This is best available, relevant data to conduct this triangulation; however, the recency of data collection is a limitation (2019) which should be considered alongside use and interpretation.

## Datasets

| | |
|---|---|
| **Private Lives 3 (PL3)** | A national survey of the health and wellbeing of LGBTQ+ adults. Conducted by the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University, the survey was undertaken in 2019 and included 6835 LGBTQ+ adults aged 18 years and older from across Australia. The study examined a broad range of topics, including physical and mental health, health service use, discrimination, harassment, community connectedness, housing, relationships, substance use, and experiences of violence.<br>Here the findings are presented from respondents to PL3 who were living in Victoria (n=2333) and, specifically, the Murray PHN area at the time of the survey (n=162).<br>Within the Murray PHN catchment, the majority of PL3 participants lived in a regional town or city (n=116, 72%), a rural/remote area (n=44, 27.3%). There was one participant in the Murray PHN region who described the area they live as inner or outer suburban. |
| **Writing Themselves In 4 (WTI4)** | The fourth iteration of a national survey of the health and wellbeing of LGBTQA+ young people. Conducted in 2019 by the Australian Research Centre in Sex, Health and Society at La Trobe University, the survey collected responses from 6418 LGBTQA+ young people aged 14–21 years across Australia.<br>Here the findings are presented specifically related to WTI4 respondents who lived in Victoria (n=1859) and those who resided in the Murray PHN catchment (n=126).<br>Within the Murray PHN catchment, the majority of WTI4 participants lived in a regional town or city (n=68, 54%), a rural/remote area (n=55, 43.7%). There were three participants in the Murray PHN region who described the area they live as inner or outer suburban. |

## Findings

### *Psychological distress*

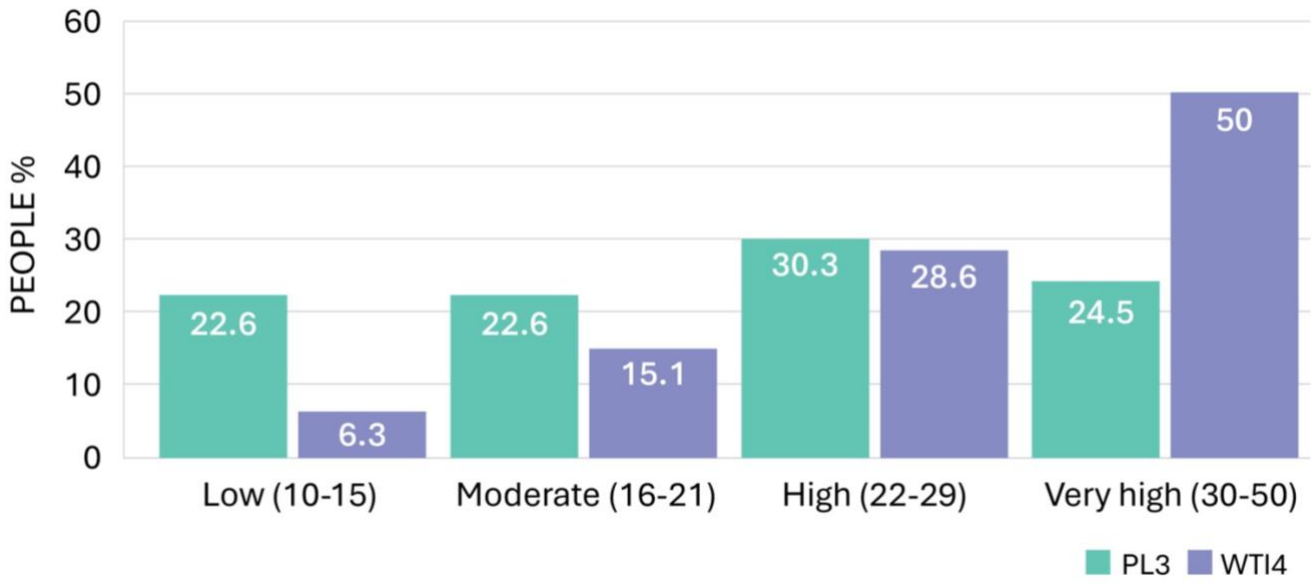
The Kessler Psychological Distress Scale (K10) is a ten-item standardised measure of psychological distress, based on questions about levels of nervousness, agitation, psychological fatigue and depressive symptoms experienced in the past four weeks. Responses are summed to create a total score ranging from 10 to 50, with higher scores indicating greater levels of psychological distress.

Scores between 22–29 indicate a high level of psychological distress, while scores of 30 or above indicate a very high level.

Among young people living in the Murray PHN catchment (WTI4 participants) (n=126), 28.6 per cent (n=36) reported a high level of psychological distress and 50 per cent (n=63) reported a very high level. In total, 78.6 per cent reported high or very high levels of psychological distress.

Among adults living in the Murray PHN catchment (PL3 participants), 30.3 per cent (n=47) reported high levels of psychological distress, while 24.5 per cent (n=38) reported very high levels of psychological distress (Figure 1). In total, 54.8 per cent reported high or very high levels of psychological distress.

***Figure 1. Psychological distress (K10) scores for people living in the Murray PHN from Private Lives 3 (aged 18+) and Writing Themselves in 4 (aged 14-21)***




It is difficult to obtain directly comparable population-based estimates for young people. However, data from the 2020–21 National Study of Mental Health and Wellbeing (ABS, 2021) indicate that 20 per cent of people aged 16–34 years reported high or very high psychological distress on the K10, which is substantially lower than the levels observed in this study.

Among the adult population more broadly, 15.4 per cent of Australians aged 16–85 years reported high or very high levels of psychological distress, again, substantially lower than the figures reported here among LGBTQ+ people in the Murray PHN catchment.

### *Homelessness*

In WTI4, participants were asked whether they had ever experienced any of the following:

- Run away from home or the place they live
- Left home or the place they live because they were asked or made to leave
- Couch surfed because they had no other place to stay
- Been homeless.

Each of these experiences was classified as an indicator of homelessness.

Among young people in the Murray PHN catchment (WTI4 participants) (n=126), 28.8 per cent (n=36) reported a lifetime experience of homelessness, while 13.6 per cent (n=17) reported experiencing homelessness in the past 12 months. This was higher than experiences of homelessness among the national sample in WTI4, where 23.6 per cent reported a lifetime experience of homelessness and 11.5 per cent experienced homelessness in the past 12 months. Among adults in the Murray PHN catchment (PL3 participants), 17.8 per cent (n=29) had experienced homelessness in their lifetime. This was slightly lower than rates of homelessness in the national PL3 sample (22%).

While it is difficult to directly compare these rates of LGBTQ+ lifetime experiences of homelessness with population-level estimates (which typically measure current homelessness), these lifetime rates among LGBTQ+ people in the Murray PHN catchment are much higher than current levels of homelessness in the region (0.7%) (Murray PHN, 2024) and nationally (0.4%) (ABS, 2025).

### *Tobacco use*

Among the PL3 sample who lived in the Murray PHN catchment, 14.2 per cent (n=23) were daily tobacco smokers, a further 8.1 per cent (n=13) were regular smokers, while 25.9 per cent (n=42) were ex-smokers. There were five per cent (n=8) who regularly used vapes or e-cigarettes and 12.5 per cent (n=20) had ever used vapes or cigarettes (noting that these data were collected in 2019 before vaping became more common and widely accessible). Recent national data shows that 10.6 per cent of adults in Australia are daily smokers and 14.4 per cent have used vapes or e-cigarettes (ABS, 2022).

**Alcohol and other drugs**

Table 1 shows alcohol consumption frequency among Victorian respondents to PL3, across metropolitan, regional, rural/remote and Murray PHN areas. People living in cities (inner and outer metropolitan areas) report the highest prevalence of frequent alcohol consumption, with 37.4 per cent reporting drinking two or more times per week. In contrast, regional and rural/remote populations have lower proportions of frequent drinkers (both approximately 25%), although a substantial minority still report at least weekly consumption. Rural/remote areas also show the highest rates of abstinence (19.2%), suggesting a more polarised pattern of use.

The Murray PHN profile is characterised by relatively high levels of both low-frequency drinking (34% monthly or less) and frequent consumption, including 13.6 per cent drinking four or more times per week.

*Table 1. Alcohol consumption frequency among PL3 respondents living in Victoria*

| Frequency | n (%) | | | |
|---|---|---|---|---|
| | Metropolitan: Inner and outer suburban | Regional | Rural/Remote | Murray PHN |
| **Never** | 12.1% (218) | 12.9% (50) | 19.2% (25) | 9.9 % (16) |
| **Monthly or less** | 23.0% (415) | 33.6% (130) | 28.5% (37) | 34.0% (55) |
| **2–4 times per month** | 27.6% (497) | 28.2% (109) | 26.9% (35) | 29.0 % (47) |
| **2–3 times per week** | 22.0% (396) | 14.0% (54) | 18.5% (24) | 13.6% (22) |
| **4 or more times per week** | 15.4% (278) | 11.4% (44) | 6.9% (9) | 13.6% (22) |

### *GP access*

Among LGBTQ+ adults living in the Murray PHN region (PL3 participants), the majority (96%, n=156), had seen a GP at least once in the past 12-months and more than one in three (67.7%, n=109) had a regular GP. Just under half (47.8%, n=76) indicated that their GP is aware of their sexual orientation. This figure was similar to that seen across Victoria, including in metropolitan areas. Among those living in the Murray PHN catchment, 69.8 per cent (N=113) indicated they would be more likely to use a health service that had been accredited as LGBTQ+ inclusive.

### *Feeling respected in healthcare settings*

Among LGBTQ+ adults living in Victoria (PL3 participants), metropolitan respondents were most likely to report feeling "very or extremely" respected across all health service types, with a clear gradient of decreasing positive experiences in regional, rural/remote and Murray PHN areas. However, the small sample size in rural areas means we cannot reliably assess these difference as statistically significant.

The most pronounced disparities appear in LGBTQ-inclusive mainstream clinics, where respect drops sharply from 90.9 per cent in metropolitan areas to 69 per cent in the Murray PHN catchment, and in allied health services (73.8% vs 62.8%). Hospitals and mainstream medical clinics show more modest but consistent declines across geographic categories. The pattern suggests that perceived respect in healthcare settings declines with increasing geographic remoteness, with particularly notable gaps in inclusive and general service environments in the Murray PHN catchment.

***Table 2. PL3 respondents who reported feeling "very or extremely" respected in health settings, comparison between respondents in the Murray PHN and those in other areas of Victoria***

| Health service type | % (n) who reported feeling "very" or "extremely" respected | | | |
|---|---|---|---|---|
| | **Metropolitan: Inner and outer suburban** | **Regional** | **Rural/Remote** | **Murray PHN** |
| **Mainstream medical clinic** | 58.5% (808) | 54.5% (180) | 53.8% (57) | 53.8% (70) |
| **LGBTQ-inclusive mainstream medical clinic** | 90.9% (507) | 75.8% (50) | 81.8% (18) | 69% (20) |
| **LGBTQ-specific medical clinic** | 94.9% (167) | 90.9% (10) | 100% (4) | 100% (5) |
| **Mainstream mental health service** | 72.5% (422) | 71.1% (106) | 77.1% (27) | 66.7% (36) |
| **Hospital** | 56.0% (316) | 52.5% (62) | 50.0% (25) | 49.0% (24) |
| **Allied health service** | 73.8% (445) | 66.7% (24) | 68.6% (24) | 62.8% (27) |

### *Violence and discrimination*

Table 3 shows experiences of harassment and discrimination among Victorian participants in PL3, across metropolitan, regional, rural, and Murray PHN areas. Overall, social exclusion (33.0%) and verbal abuse (29.3%) were the most commonly reported experiences across all regions. Rates were broadly similar across geographic areas, although rural and Murray PHN participants reported slightly higher levels of social exclusion and some forms of digital threats compared with metropolitan respondents.

More severe experiences, including threats of physical violence (12.4%) and sexual assault (9.1%), were reported less frequently but were present across all regions, with slightly higher proportions in regional and rural/remote areas for some outcomes. Property-related crimes such as theft and break-ins were relatively uncommon (generally under 5%) across all geographic groups.

*Table 3. Harassment or threats of violence based on gender or sexuality (LGBTQ+ adults, PL3 survey respondents residing in Victoria) by region of residence*

| Harassment/discrimination experience | Metro % (n) | Regional % (n) | Rural/Remote % (n) | Murray PHN % (n) | Total % (n) |
|---|---|---|---|---|---|
| **Social exclusion** | 32.5% (578) | 34.5% (131) | 36.2% (46) | 37.7% (60) | 33.0% (755) |
| **Verbal abuse** | 29.8% (533) | 28.4% (109) | 24.8% (32) | 25.0% (40) | 29.3% (674) |
| **Harassment (e.g., spat at, offensive gestures)** | 20.3% (363) | 19.8% (76) | 16.9% (22) | 16.8% (27) | 20.0% (461) |
| **Written threats via email/social media/messages** | 17.8% (320) | 20.0% (77) | 23.8% (31) | 22.4% (36) | 18.5% (428) |
| **Threats of physical violence/assault** | 11.3% (202) | 16.4% (63) | 15.5% (20) | 16.3% (26) | 12.4% (285) |
| **Written threats in other ways** | 9.3% (167) | 10.9% (42) | 10.9% (14) | 11.2% (18) | 9.7% (223) |
| **Sexual assault** | 8.8% (157) | 9.7% (37) | 10.9% (14) | 11.3% (18) | 9.1% (208) |
| **Refusal of service** | 7.9% (141) | 8.7% (33) | 10.2% (13) | 8.8% (14) | 8.1% (187) |
| **Refused employment/ promotion** | 6.6% (118) | 9.2% (35) | 7.0% (9) | 8.8% (14) | 7.1% (162) |
| **Other** | 5.2% (42) | 6.6% (12) | 9.8% (6) | 2.9% (2) | 5.7% (60) |
| **Written threats via graffiti** | 4.8% (86) | 4.2% (16) | 6.9% (9) | 2.5% (4) | 4.8% (111) |
| **Property damage/ vandalism – house** | 3.1% (55) | 4.2% (16) | 5.5% (7) | 2.5% (4) | 3.4% (78) |
| **Physical assault with a weapon** | 2.9% (52) | 2.6% (10) | 3.9% (5) | 3.8% (6) | 2.9% (67) |
| **Theft – money** | 2.6% (46) | 3.7% (14) | 1.6% (2) | 1.9% (3) | 2.7% (62) |
| **Property damage/ vandalism – car** | 2.6% (46) | 2.1% (8) | 1.6% (2) | 1.3% (2) | 2.5% (56) |
| **Theft – property** | 2.1% (37) | 3.4% (13) | 0.0% (0) | 1.9% (3) | 2.2% (50) |
| **Break in – house** | 1.7% (30) | 2.1% (8) | 0.8% (1) | 0 | 1.8% (39) |
| **Property damage/ vandalism – work** | 1.4% (25) | 1.3% (5) | 3.1% (4) | 2.5% (4) | 1.5% (34) |
| **Theft – car** | 1.3% (23) | 2.1% (8) | 0.0% (0) | 0 | 1.4% (31) |

## Summary

This secondary analysis of *Private Lives 3* and *Writing Themselves In 4* demonstrates that LGBTQ+ people living within the Murray PHN catchment experience many of the health and wellbeing challenges identified in the broader Australian literature. Of particular concern were the high levels of psychological distress reported by LGBTQ+ young people in the region, highlighting the ongoing need for accessible and affirming mental health and suicide prevention supports. Experiences of discrimination and violence were broadly comparable to those reported by LGBTQ+ people living in other regional and metropolitan areas. However, participants living in the Murray PHN catchment reported slightly higher levels of social exclusion and some forms of online harassment and digital threats.

While access to primary healthcare services was generally comparable to that reported by LGBTQ+ people elsewhere, Murray PHN participants were less likely than those living in metropolitan areas to report feeling respected by healthcare providers, suggesting opportunities to strengthen workforce capability and culturally safe care. These findings provide an important local evidence base that complements the national literature review. Findings from consultations with LGBTQ+ community members and service providers further extend this evidence base and are detailed in the following section.

# Consultation

## Consultation key results

### *Local context, safety and visible support*

Consultation findings reinforced the importance of local context. Community members and service providers described “safe pockets” of inclusion within broader local environments that were often experienced as hostile, unsafe or indifferent to LGBTQ+ needs.

Participants reported that visible support from local institutions, councils, health services and community leaders was inconsistent. Many felt that LGBTQ+ health and wellbeing were not treated as visible or sustained priorities within the region.

Local LGBTQ+ groups, events, advocates and inclusive practitioners were described as important sources of safety, belonging and resilience. However, these supports were often small, informal, unevenly distributed and dependent on a limited number of committed individuals.

### *Community burden and workforce sustainability*

- Participants described a significant burden being placed on LGBTQ+ community members, volunteers, and "go-to" practitioners to create safety, build community, identify inclusive services and advocate for better care. This contributed to burnout, emotional labour and limited service capacity.

### *Availability, visibility and accountability of inclusive services*

- Community members and service providers reported limited availability of genuinely inclusive services, particularly in smaller towns and more remote parts of the region. Inclusive GPs and specialist practitioners were often difficult to find, fully booked or located outside the local area.
- Service visibility was a major issue. Many people relied on word-of-mouth, trusted community networks or prior experience to identify safe practitioners. This created additional barriers for people who were isolated, new to the region, recently migrated or not connected to local LGBTQ+ communities.
- Participants cautioned that visible signs of inclusion, such as rainbow stickers or statements of support were not always matched by safe practice. They emphasised that visible inclusion must be backed by staff training, accountability, respectful intake processes and safe complaints mechanisms.

## *Priority populations and intersectional needs*

- Trans and gender diverse people were identified as a priority population requiring urgent attention. Participants described poor knowledge of trans and gender diverse health needs across mainstream services, experiences of misgendering, long waitlists for gender-affirming care, limited local specialist pathways, and the need for support for families of trans and gender diverse people.
- Participants also highlighted the need for services to better understand intersectional and complex health needs. LGBTQ+ people may also experience disability, neurodivergence, chronic illness, mental health concerns, cultural or language barriers, racism or social isolation, requiring holistic and culturally safe care.
- Aboriginal and Torres Strait Islander LGBTQ+ people and culturally and linguistically diverse LGBTQ+ people were identified as groups who may be required to "split" aspects of their identity across different services, rather than being able to access care that is both culturally safe and LGBTQ+ affirming.
- Older LGBTQ+ people were also identified as a group whose needs may be less visible in local service planning and community initiatives, particularly where services and events are primarily focused on young people.

## Methods and participants

Consultations were conducted with LGBTQ+ community members and service providers across the Murray PHN region to gain further insights into the health needs, experiences and perspectives of the LGBTQ+ community.

In total, 21 LGBTQ+ community members participated across two face-to-face focus groups and one online focus group. In addition to nine service providers in one-to-one online interviews.

LGBTQ+ community members were recruited to the consultations via advertising through the networks of Thorne Harbour Health, Murray PHN communication channels and word-of-mouth. Service providers were recruited by referral from the community reference group and Murray PHN, and by researching local service providers via the internet.

There was limited information about local LGBTQ+ inclusive health practitioners online. Local organisations had limited to no information that indicated they had LGBTQ+ inclusive practitioners. Searching for LGBTQ+ inclusive practitioners led to blogs written by LGBTQ+ people looking for inclusive services in their area. Relying primarily on direct referrals to people who were known for their work in the area. The difficulty faced in identifying service providers who work directly with LGBTQ+ communities points to the challenges LGBTQ+ people may have in finding and accessing inclusive services in their local area.

Consultations and interviews were audio-recorded and subsequently transcribed verbatim. A researcher attended all consultation sessions and maintained detailed field notes to complement the transcripts. Data were analysed using inductive thematic analysis methods.

The analysis involved careful, iterative review of the data to identify patterns, topics and issues that were particularly salient or meaningful to participants. Particular attention was given to participants' experiences and perspectives in relation to place (i.e. the setting in which people lived or where care was accessed) and the healthcare service environment.

Through this process of coding, comparison, and refinement, a set of key themes was developed to represent the central and recurring elements of participants' accounts.

### *Participants*

Focus group participants (hereby referred to as community members) identified with a range of sexual orientations including lesbian, gay, bisexual or asexual, and many were trans and/or gender diverse. Participants' ages ranged from their 20s to 70s. Majority of participants were Caucasian and a smaller number of Asian and Aboriginal people participated. Several participants in the community focus groups were also working as service providers and identified as LGBTQ+ and so provided perspectives as both community members and providers of health or community services.

The service providers represented a range of professions including general practitioners, counsellors, community workers and organisational roles. Service providers worked in clinics, hospitals, not-for-profit health services and advocacy organisations. Some service providers identified as LGBTQ+, and some were parents of LGBTQ+ people.

## Findings

### *Hostile environments are a determinant of health and safety*

Both community members and service providers described their local communities as hostile environments for LGBTQ+ people. Community members described frequent experiences of discrimination and harassment, such as being yelled at or stared at in public. Service providers also described situations where LGBTQ+ people were followed or accosted near or outside health or community services. Community members and service providers shared that the presence of anti-LGBTQ+ protestors in their local areas, along with the growing visibility of far-right politics and in public discourse and media, were key indicators of local hostility towards LGBTQ+ people. Community members and service providers described that local politics and attitudes towards LGBTQ+ people are noticeably worsening in their communities. They also expressed that there were long-term negative impacts from the 2017 Australian Marriage Law Postal Survey, in which LGBTQ+ communities became political targets in their local communities. This political event led to burnout and mental health harms for many LGBTQ+ members, which were still felt by community members today. Many community members noted that it did not feel safe to be an openly LGBTQ+ person in public spaces in their local area. This was even more pronounced for trans and gender diverse people who often experienced the most overt discrimination in public. These environments also have a significant impact on service providers who work with LGBTQ+ people.

*"When the neo-Nazis were quite amplified last year, I would be driving home and I [don't live far] from work. So, I'd be questioning myself saying, how easy would it be for one of these people to actually follow me home? I think there can be an underlying impact on workers in small communities because people know who we are."* - *Service provider*

*"I was speaking to [someone] about this trans and gender diverse program [where] to get to the actual program, the kids have to walk through this [area] and there will be groups of teenagers that will wait [there] to try and assault young trans kids as they're leaving the programs."* - *Service provider*

Community members and service providers felt that the needs and wellbeing of LGBTQ+ people were not a priority in the local community. For example, they felt that local councils and other prominent organisations (including health and community services) did not show outward support for LGBTQ+ people, such as not flying the LGBTQ+ flag or advertising themselves as LGBTQ+ friendly. One participant shared that a local mayor frequently attends community events but does not attend Pride or LGBTQ+ events, which they felt demonstrated a lack of support for LGBTQ+ communities.

Community members noted that strategies or policies to implement LGBTQ+ inclusion were being rolled back, such as steering committees, services or outward support that had been taken away. They also shared that there were very few openly LGBTQ+ people in local councils and leadership positions. Those who were in leadership positions frequently became political targets and suffered from burnout. Service providers also perceived a lack of effort from health services to address the specific needs of LGBTQ+ people.

Community members and service providers acknowledged that a lack of support for LGBTQ+ people and the hostility of the local community are key determinants of the health, wellbeing and safety of LGBTQ+ people in their communities. In particular, community members and service providers noted that the hostile environment has had a significantly negative effect on the mental and physical wellbeing of LGBTQ+ people, such as negatively affecting mental health, leading to isolation and avoidance of public spaces. In fact, some LGBTQ+ community members said that they and people they knew often avoided public spaces due to fear of discrimination. Service providers also shared that the local community culture can have a wearing impact on people working in health and community services, impacting both their mental health and their capacity to provide services.

*"I think it actually impacts on [LGBTQ+ people's] overall health. You know, mental health, social connection. If they've got substance use concerns or issues, that can escalate. So, I think it's actually all of it."* - *Service provider*

*"The backlash increased the workload of queer youth workers dramatically and made it so much harder to continue doing things that were their bread and butter, including youth groups. It just became near impossible to manage all that."* - *Service provider*

Community members and service providers also noted that there are significant differences in the local culture between geographic areas across the Murray PHN catchment. Both community members and service providers felt that communities further north in Victoria were significantly less safe for LGBTQ+ people. Community members also expressed that smaller and more rural towns were noticeably more hostile towards LGBTQ+ people and also had less visibility of LGBTQ+ people and fewer services. Some community members had noticed LGBTQ+ friends and community members leave their communities to live in larger towns or cities that are considered safer for LGBTQ+ people.

*"I was talking to a trans woman from [far north Victoria] and she said, "Victoria ends at Bendigo." And what she means by that is like, it's the Wild West. As soon as you go past Bendigo, no one gives a care...there's so few services, there's so few events."* - *Service provider*

*"Anywhere in that far western corner of the state...it's just like an LGBTQ+ wasteland, it's a big gap, there's just nothing really."* - *Service provider*

Despite the often hostile environment for LGBTQ+ people, community members felt that their communities are resilient and people could find pockets of support. They described their communities as supportive and interconnected and recognised this as a significant strength. LGBTQ+ community members shared that local LGBTQ+ groups and events make their communities feel like home. They described that members of LGBTQ+ communities fight for each other and work hard to make their local communities better for LGBTQ+ people. Service providers also named practitioners and community members who worked hard to improve the community and local health services for LGBTQ+ people.

Community members reported that the presence and visibility of local LGBTQ+ communities made their communities safer and supported them to feel connected. However, community members felt that these spaces were small pockets of safety within an otherwise hostile environment for LGBTQ+ people.

*"It's very much two sides of the coin. There are a lot of places that are welcoming, there's a lot of places that are safe, but there's also the other side of it where it's not. What makes the community welcoming, and I suppose enjoyable, is just the amount of people who keep standing up and fighting and winning."* - *LGBTQ+ community member*

*"When I'm [in LGBTQ+ groups] I feel safe, but when I'm just out on the street in the more general community, I'm reminded that I'm not really seen as normal by other people and that makes me feel unsafe."* - *LGBTQ+ community member*

*"Yes, there's still a lot of hardships, but I think the visibility and the camaraderie of the community has really helped and is one of the reasons why I still live here."* - *LGBTQ+ community member*

### *Safety and inclusion: burden on LGBTQ+ community*

Community members and service providers recognised the hard work that local LGBTQ+ community members and inclusive service providers had done to improve the safety and inclusion of LGBTQ+ people in the local community and health services. However, they also felt that the burden of increasing safety in the community largely fell on LGBTQ+ community members, volunteers and a small number of service providers who were active advocates in this space. Community members felt that this burden needed to be shared and that service providers should play more of a role in creating safe spaces so that this was not reliant on the work of volunteers who were often vulnerable themselves.

*"We are doing the leg work as people that really the organisations should be doing" - LGBTQ+ community member*

*"It takes having those people [community leaders and advocates in health services] to make things happen because no one else cares" - LGBTQ+ community member*

*"The opportunities for [LGBTQ+ events] only occur if they're driven by leadership of local LGBTQ+ people or champions or the organisations they work with. So, the bulk of the work is still being led and driven by local LGBTQ+ people." - Service provider*

Service providers also noted that they were one of only a few people in their organisation or professional community who were actively working towards improving safety for LGBTQ+ people. Service providers described how they were often the one 'go-to' person in their community or organisation – in many cases because they were the only known LGBTQ+ service provider or they were the one person who provided health services for LGBTQ+ people. Often these services providers worked to their limit and had no capacity to take on all clients who needed their services.

*"I think too what can happen is you can become burnt out because you become the go-to." - Service provider*

*"It can be so tiring to have to be the person to constantly stand up for yourself and advocate to say, 'hey, that's not okay, you can't do that'." - LGBTQ+ community member*

*"It's not a space that I want to necessarily work in all the time. I do find it emotionally taxing. There's a lot of mental health particularly complex trauma associated with [LGBTQ+] populations...I think if anything, we need more people who are able to identify and contribute to a community." - Service provider*

*"You know, if something happens in the community, the effect that it has on myself and my mental health and wellbeing is a big one. I think another one would have to be, you know, even though I've clocked off for the day, I still think about the young people, you know, are they safe? Are they okay?" - Service provider*

The burdens described here had a flow-on effect that contributed to significant burnout among LGBTQ+ community members and service providers. For many community members, frequent experiences of standing up for themselves or being advocates for the wider community resulted in burnout, exhaustion and mental health harms. Community members and service providers also described wanting to take a step back from advocacy work or leave professional positions working with LGBTQ+ people because the impact on them became too great.

*"It's not just a once off – it's every single day in and out we deal with it, we internalise it, and then people wonder why we get to a point where we break. Because we are dealing with it every single day." - LGBTQ+ community member*

*"So, there are absolutely some moments of joy, but overwhelmingly people are tired, are exhausted, are pulling back, can't be bothered, don't feel safe enough anyway. And yeah, the feelings of isolation, having to do it alone." - Service provider*

### *Limited availability of inclusive services*

Community members and service providers shared that there are very few services that are perceived as safe for LGBTQ+ people in the Murray PHN region. Community members felt that practitioners often made assumptions about their identities and health needs. Trans and gender diverse people spoke about being frequently misgendered by practitioners and reception staff. For example, one community member shared that a pharmacist ignored the title listed on their medical scripts and listed a different title on their medication based on assumptions about their gender identity. Community members and service providers also explained that some local service providers often conflated LGBTQ+ identity with mental health issues or gave unnecessary focus to LGBTQ+ identity.

*"There was someone who came to see me for their mental health... At the end of the consult, he had said to me, "I'm so grateful that you had identified as being [LGBTQ+] because last year I saw someone and when they put the diagnosis on the mental healthcare plan, they listed the illness as "gay anxiety". And so, he felt a lot of shame that, one, this person didn't understand him at all. And two, we're putting a lot of his sexuality down to his mental health issues and things like that." - Service provider*

*"I've heard of a trans person going to a doctor, a local service here for a sore leg, and immediately they just focus on the person's transness. You know, like, "I'm here for my leg." - Service provider*

Community members also acknowledged that there are very few services in their area that are known to be inclusive for LGBTQ+ people. This was particularly the case for GP services. In the experience of many community members, inclusive GP services are often fully booked and there are long wait lists to see a practitioner who is known to be safe for LGBTQ+ people. Community members and service providers both shared that many practitioners leave the practice or local area. A person from one group shared that if you find a good practitioner, they are likely to leave the area shortly after. Many community members in the group also resonated with this comment. Community members also commented that there are many practitioners who are known to be unsafe who they would never recommend to an LGBTQ+ person.

*"There's fewer clinics that you know are welcoming than there are not." - LGBTQ+ community member*

*"I want a doctor who actually sticks around. Like lots of people have said you find one and then they leave. [I want] someone who you know is going to be there for years and is reliable and stuff." - LGBTQ+ community member*

*"When people make bookings or when they're signing up as a new service user, the books are closed. But then there's no established a way for them to kind of register as a new patient without having to like overtly say, what their sexuality or their gender identity is." - Service provider*

*"It's almost like an experimentation of going somewhere or trying to look online and see if they have information on their website about the providers that have those services and what kind of experience they have, and all these things, and actually knowing that is really hard."- LGBTQ+ community member*

Community members and service providers were concerned that efforts to improve LGBTQ+ inclusion are isolated within organisations and between services. They felt that there are already substantial existing resources on LGBTQ+ inclusion and that collaborating with organisations already doing this work would be a good starting point.

*"I think we see a lot in regional communities, is siloing where people are working independently and it doesn't work because there's no sharing of information." - LGBTQ+ community member*

*"There's a lot of siloing even within organisations where departments don't speak to each other. But outside of that, there's a lot of siloing from health services and whatnot." - Service provider*

Community members and service providers spoke about the importance of training.

*"When I do speak to professionals they're like 'oh look we just don't have time or we can't afford it' there's always an excuse."* - *LGBTQ+ community member*

### *Positive interactions with service providers make an important difference*

Along with limited availability of inclusive services, community members shared that the negative experiences they had with healthcare providers had a significant negative impact on them, affecting their mental health, wellbeing and trust in practitioners. Service providers also noted that many LGBTQ+ people disengaged or avoided services after having a bad experience.

*"If they have one bad experience, usually what you'll find is that person will disengage and then won't access supports."* - *Service provider*

*"After what I've been through, what I've lived through, changed my identity, I've been through years of hormone treatment, years of support, years of mental health, years of vilification. To have my identity [erased] in such a horrific way has such a bad impact on my mental health. The service itself becomes more dangerous than the reason I went to you for help."* - *LGBTQ+ community member*

However, community members and service providers also mentioned times when LGBTQ+ people had positive experiences with service providers. These often occurred in services which were known to be inclusive, and where staff had done appropriate training. These experiences made LGBTQ+ people feel safe, respected and confident that their health concerns would be heard and managed holistically.

*"[In my service] a lot of the young people are quite comfortable because they feel safe coming in here. The staff have all done training, and they feel safe, they feel included, they feel valued in here."* - *Service provider*

*"The feedback from some of the community has been so positive around being able to access a gender clinic and the GPs that are doing it are fabulous. I've had parents say to me "but our young one's been on the waiting list for two years, they've aged out of [other services], now what can we do?" They go and speak to the doctors at the TGD [trans and gender diverse] clinic. They will discuss what options are available, what the person's goals are for their transition."* - *Service provider*

### *Lack of awareness or visibility of inclusive services*

Community members reported that, in addition to the limited availability of LGBTQ+ inclusive services, those that did exist were often difficult for them to identify. Services did not consistently advertise as LGBTQ+ inclusive and there were no publicly available registries or directories of services that have undertaken training in inclusive practice. Community members explained that the only way to find inclusive services was through local community networks and word-of-mouth, often through friends, community leaders, or a service provider they had learned to trust. In many cases, people only knew that services were safe and inclusive through experience.

*"The benefit of being a local community member who works in the field is that people become aware of who you are. And so, people do access services by word of mouth."* - *Service provider*

*"If a service isn't known to be promoting their inclusivity, I don't feel people would really necessarily engage."* - *Service provider*

*"You have to have connections or be already connected to a service to know what is accessible."* - *LGBTQ+ community member*

While community networks are an important source of local knowledge about LGBTQ+ inclusive services, these networks are not available to everyone, particularly people who are new to the area or recent migrants, including international students. Community members and service providers felt that this can compound the negative health impact of limited or inaccessible services as people who are the most isolated or in need of support have the least access to inclusive services.

Community members and service providers agreed that there is not necessarily an easy solution to identifying LGBTQ+ inclusive services. Signs indicating a service is inclusive, such as rainbow stickers or Rainbow Tick accreditation, can be misleading or superficial if training does not extend to all staff or is outdated. Community members had experienced ignorance and discrimination within services that had a rainbow sticker. Service providers also echoed these concerns.

*"You have the stickers, you have the apparent support, and you walk in and you have a person who doesn't understand what they mean."* - *LGBTQ+ community member*

*"When you're using all the services in town, if you've got intake forms, are they inclusive? Do they have the ability for you to choose your title, to choose your pronouns, to self-describe your gender? If they don't, it sort of signals to me I'm not ready to share who I am as a person with your service, but for those that do it well, then I feel safe from the get-go and comfortable and welcomed."* - *LGBTQ+ community member*

*"You've got a rainbow sticker here saying, you're welcome here, and then you're telling me, my identity is not valid on your system."* - *LGBTQ+ community member*

*"There's a lot of lip service, so we say that we support particular communities. But what I have found as a practitioner, but also as a member of the [LGBTQ+] community, is that we say the right things often, but the reality can be different."* - *Service provider*

Community members and service providers both voiced concerns that if LGBTQ+ people have a bad experience in a service, there would be no guarantee that their complaints would be followed up on, or that there would be accountability for clinicians and staff.

*"[Health practitioners] tell me the same thing, which is that you don't have to do any mandatory training. And their colleagues, they know are super homophobic. They don't get slapped over the wrist or anything. Nothing happens. I have written, I have emailed complaints. I have called clinics to complain. I have coached community members into calling clinics to complain. And you're lucky if you get a 'we're sorry'."* - *Service provider*

Service providers also noted that in many cases there are no established standards for training or accreditation in LGBTQ+ inclusive practice for many health services. While Rainbow Tick accreditation was discussed, both service providers and community members noted that this process was not always perceived to be achievable for smaller rural service providers, due to time and resource constraints. Service providers also identified that services and organisations are often hesitant to demonstrate or move towards LGBTQ+ inclusivity due to fear of backlash or fear of getting it wrong.

*"I think you have a lot of healthcare service providers and practitioners especially who are just scared of offending people...But they might not know that [there are] secondary consultation service[s] that they can be accessing to be checking in on their practice. So, I think there's the fear of getting things wrong, which also stands in the way of actually progressing."* - *Service provider*

While visible inclusivity is important for LGBTQ+ people to know where to find services, service providers also identified that visibility can cause safety risks for LGBTQ+ people because it can identify services to anti-LGBTQ+ community members. Service providers indicated that being visible in the community as a service for LGBTQ+ people meant that their services and clients could be targeted by anti-LGBTQ+ protestors, far-right activists and hostile community members.

*"Even my staff have shared with me that they are concerned for, for example, the safety, not only of themselves, which is very valid, but equally for our communities who are coming to [programs and events]. Those events are advertised. We're having to do risk management for people coming to a morning tea. And that's the kind of conversations we're having at work about individuals accessing community and health services."* - *Service provider*

*"Nasty people, ignorant people, are coming to learn where LGBTQ+ people go to access inclusive supportive services. If you are known to be working with the LGBTQ+ community, if you have a rainbow flag out the front, people are now seeing that as an invitation to drive past in a car, to ride past on a bicycle and scream out obscenities."* - *Service provider*

### *Lack of understanding of intersectionality and complex health needs*

Community members and service providers expressed particular concern that health services often do not understand intersectional experiences within the LGBTQ+ community. They described how LGBTQ+ people frequently require holistic care encompassing complex needs including mental health, disability, long term illness, sexual and gender identity, and cultural identity. One community member noted that health practitioners often approach an individual as though they have a single issue to address rather than recognising and responding to the full complexity of their identity and experiences.

*"They just see you as one thing and are only willing to deal with one thing."* - *LGBTQ+ community member*

Many community members and service providers explained that LGBTQ+ people commonly experience disability, neurodivergence, and long-term health conditions but that service providers often lacked capacity to deal with these complex, overlapping experiences. Community members who were disabled and/or neurodivergent described significant barriers to accessing care, such as a lack of accessibility in healthcare services, lack of knowledge about neurodiversity and disabilities, and barriers to social connection and inclusion. Specialist services, such as those for people with disability or mental health services, were rarely also set up to be LGBTQ+ inclusive. These challenges may also lead to increased mental health challenges for disabled and neurodivergent LGBTQ+ people.

*"Disability is across all ages and all kinds of disability...But even trying to, whether it's intellectual or physical disability, affirm someone's sexuality when they're living with a disability, add that to the layers of regional and ruralness."* - *Service provider*

*"[At a health service] I had heaps of challenges. I think it's always been a combo of my queer identity and my disabled identity and then not being supportive of either because those are so interlinked to who I am as a person."* - *LGBTQ+ community member*

Some service providers were also concerned that there is a significant lack of understanding of the needs of Aboriginal and Torres Strait Islander LGBTQ+ people and people from migrant and culturally diverse backgrounds. One service provider shared that Aboriginal and Torres Strait Islander LGBTQ+ people commonly have to put aside either their LGBTQ+ or cultural identity when accessing health services. The service provider noted that inclusive health services could be particularly ignorant about LGBTQ+ people's cultural identities. However, in Aboriginal Controlled Community Organisations, practitioners may be unaware about LGBTQ+ identity and health needs. Another service provider said that migrants

and culturally diverse LGBTQ+ people may be particularly isolated if they are in an environment where it is not safe to talk about sexuality or gender identity.

*"What we were hearing was that people were having to separate their identities to be able to access healthcare services. So, they were leaving their LGBTIQ+ identity at the door to access a service that felt culturally safe. And then when they wanted to have their identity affirmed, they'd have to access a different service and leave their cultural identity at the door. And so, there was sort of like this constant switching of hats and not being able to rock up to one healthcare provider where you could be culturally safe and have your identity affirmed."* - *Service provider*

*"It's all good and well to say, yes, [people from diverse cultural backgrounds] can reach out. The reality is they are so far underground and discreet and hidden that no matter how inclusive even the LGBTI services are, let alone the mainstream health services, we're not getting queer people or people who have diverse genders and sexualities getting the support or health they need, simply because they're not even able to feel safe to verbally let individuals know who they are and what their health needs are, let alone get the service or access for it."* - *Service provider*

Several service providers mentioned that the needs of middle aged and older LGBTQ+ people could be ignored in health and community services. They felt that there was a particular and needed focus on LGBTQ+ young people, but that this meant that LGBTQ+ middle aged and older people often miss out on community events and services that could support their health, wellbeing and community connection. This is especially challenging for LGBTQ+ people who 'come out' (or come to understand and disclose their LGBTQ+ identities) later in life and may require a similar level of support to young people, in terms of understanding and supporting their identities and relationships, yet this is rarely available in their local area.

Many community members and service providers named trans and gender diverse communities as a population that need significantly more prioritisation in health services. Participants described general health services as having significantly poor knowledge and understanding of trans and gender diverse people. Young trans and gender diverse people said it was particularly difficult to access gender affirming care as a young person and were often required to be on long wait lists to access care with a specialist. There was also concern that necessary care such as Hormone Replacement Therapy (HRT) are inaccessible because there are few providers offering informed consent models (where consumers can access HRT without long and strenuous assessments). One service provider shared that young trans and gender diverse people often "age out" of programs while they are on waitlists and then must start again seeking services as adults.

Community members and service providers shared that trans and gender diverse people often accessed gender affirming care in Melbourne, because it was one of the only places they could go for dedicated gender clinics. Community members also shared a fear that gender affirming care services would be rolled back. Many service providers said that more specialised gender clinics were needed in the area, as well as support for families of trans and gender diverse people, and support for young people with trans and gender diverse parents.

*"When I was trying to get into HRT, they basically sent me out to Melbourne for a 14-month waiting list, then about one to three months of being assessed, extra-long because I was mentally ill…The whole process can take years compared to informed consent which would be just being prescribed HRT [upfront]."* - *LGBTQ+ community member*

Community members and service providers also named mental health as a significant priority area for LGBTQ+ people. Community members shared that the local environment and politics, experiences of discrimination in health services, experiences of exclusion from family, friends and the local community, and barriers to gender affirming care all caused significant psychological distress and mental health

challenges for LGBTQ+ people. They also acknowledged that mental health services were financially inaccessible for many LGBTQ+ people. Community members noted that there were several mental health hotlines, but that they preferred to access face-to-face services. They shared that these services were limited and widely inaccessible due to cost and availability.

*"There was very much just a period of time where I was talking to no one waiting for HRT, lying in bed depressed."* - *LGBTQ+ community member*

*"As a person who works full-time…I am lucky that I have the supports, but I do think that there's a lot of people out there that aren't in my position that are really struggling for mental health supports and/or for just support around how you even deal with it. And what I also see is that we then…offload what's happening onto each other. So, people's friendships are getting more difficult and/or people are taking on too much."* - *LGBTQ+ community member*

*"The political environment that we're in now has really changed things for a lot of people. And what happens with that is actually that your mental health declines, but also every facet of your life is then impacted. Because even for me, I have to take sick leave to attend mental health appointments for my job. So, there's a repercussion for every single thing that we see."* - *LGBTQ+ community member*

## Summary

The community consultations provided important local context to the findings from the literature review and secondary data analysis, highlighting both the strengths and challenges experienced by LGBTQ+ people across the Murray PHN catchment.

Community members and service providers described the importance of community connection, supportive healthcare providers and inclusive local organisations in fostering wellbeing and resilience.

At the same time, consultations identified ongoing barriers to accessing healthcare and support services, including inconsistent levels of LGBTQ+ inclusion across services, limited visibility of affirming providers and challenges accessing specialist care.

Community members and service providers also highlighted that experiences varied considerably across different population groups and locations throughout the region, with trans and gender diverse people, young people, older adults and those living in smaller or more remote communities often facing additional barriers. These findings reinforce the need for a coordinated, place-based approach to improving LGBTQ+ health and wellbeing in the Murray PHN catchment.

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