

The LGBT Health System  
Community Consultation Report October 2005

Our Community  
Our Health

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## Glossary of Terms

**Being Outed:** The process of someone exposing a person's gender identity or sexuality to other people without the person's consent.

**Bisexual:** A person who is sexually and emotionally attracted to both sexes.

**Closeted:** A person who is not open about their gender identity or sexuality to many people in the general community, friends or family.

**Coming Out:** The process through which an individual recognises their gender identity or sexuality. This often involves the decision to be open with other people about one's gender identity or sexual orientation.

**Female–Male (F-M) Transsexual:** A biological female whose core gender identity is male. Whether F-M is pre-operative or post-operative their identity is that of a male. Many female to male transsexuals/transgender men choose not to undertake the genital reconstruction phalloplasty (construction of the penis) as the procedure is not highly successful.

**Gay:** A man who is primarily sexually and emotionally attracted to other men.

**Gender Identity:** A person's sense of identity defined in relation to the categories of male and female. The term is primarily used in reference to people whose gender identity does not match their biological sex. However not everyone identifies exclusively with one sex or the other, and people may identify as female in one setting and male in another.

**Gender Dysphoria:** This is a medical term that refers to a person's physical discomfort with their body, caused by their strong gender identification that is opposite to their biological sex. This can result in an individual suffering unusual anxiety, depression or unease. This is also known as Gender Identity Disorder.

**Gender Identity and Sexuality:** Gender Identity and Sexuality are not synonymous nor are they necessarily inter-related. People confronting gender identity issues may take offence at the unnecessary enquiries about an individual's sexuality or sexual practices in relation to their gender identity. Sexual diversity exists within the transgender/transsexual community. However this does not necessarily relate to an individual's gender identity.

**Heterosexism:** The belief that everyone is or should be heterosexual and that any other type of sexuality is not acceptable. Heterosexism also assumes that everyone's biological sex will denote their appropriate gender identity. Heterosexism often includes both homophobia and transphobia.

**Homosexual:** A homosexual is a person whose primary sexual and emotional attraction is toward other people of the same-sex.

**Homophobia:** The fear and hatred of gay, lesbian and bisexual people and of their sexual desires and activities.

**Internalised Homophobia:** The internalisation of negative attitudes and feelings towards same sex attraction and sexual activity experienced by gay, bisexual and lesbian people. These attitudes are often influenced and reinforced by the social and cultural beliefs, values and representations that our societies consider 'normal' and acceptable.

**Internalised Transphobia:** The internalised negative attitudes and feelings towards transgenderism experienced by transgender and transsexual people. These attitudes are often influenced and reinforced by the social and cultural beliefs, values and representations that our societies consider 'normal' and acceptable.

**Lesbian:** A woman who is primarily sexually and emotionally attracted to other women.

**Male–Female (M-F) Transsexual:** A biological male whose core gender identity is female. Whether M-F is pre-operative or post-operative, their identity is that of a female.

**Post-Exposure Prophylaxis (PEP):** PEP is a treatment that may prevent HIV infection after an exposure that has occurred within the previous 72 hours. It is a combination of anti-HIV drugs that must be taken periodically over a four-week period.

**Pre-operative transsexual:** A transsexual/transgender person who has not undertaken reassignment surgery.

**Post-operative transsexual:** A transsexual/transgender person who has undertaken reassignment surgery.

**Reassignment Surgery:** This is a medical procedure that aligns a transsexual/transgender biological body to the gender they identify with. Reassignment surgery is not always an option for all transsexual/transgender people, usually for medical reasons.

**Same-Sex Attraction:** Attraction to people of one's own gender. The term is used for people, especially young people, whose sexuality is not fixed, but who experience sexual desires and feelings towards people of their own sex.

**Sexuality:** Sexuality is the expression of a person's desires, sexual activities, behaviours, characteristics and interpersonal relationships.

**Sistergirls:** This term is often used in Aboriginal and Torres Strait Islander communities to describe biological males who are effeminate, or who live as women and see themselves as akin to women. Sistergirls perform many of the roles of women in the community. Their sexual partners are mainly straight men and they take a usually passive role in sexual activities. Most Sistergirls are respected within their home communities. Not all Sistergirls dress as women. Those Sistergirls who live and dress as women and/or are post-operative are considered to be women by their community. Not all Sistergirls undergo sex-reassignment surgery.

**Transgender:** This report uses the term transgender to primarily refer to transsexuals. However this term is widely recognised as referring to people whose identity or behaviour falls outside the stereotypical gender norms, generally referring to people who do not identify with the gender of their biological sex. This term includes transgenderists (people who live and identify the gender opposite to their biological sex, but do not intend to have sex re-assignment surgery), cross-dressers and transvestites.

**Transitioning:** Transitioning describes the process of transgender/transsexuals recognising their true gender identity and making steps to adopt the lifestyle and/or physical characteristics of the gender that they identify with. This may involve undertaking hormone therapy and/or sex reassignment surgery. This process often takes some time and it is important for people to be supportive, accepting and non-judgemental while a transgender/transsexual person is in the process of transitioning.

**Transphobia:** The fear and hatred of people who are transgendered.

**Transsexual:** A person who is born anatomically male or female but identifies as being a member of the opposite gender to that biologically assigned to them at birth. This term often refers to people who intend to make, or have made the transition to the gender with which they identify, through sexual re-assignment surgery. However the term transsexual also includes people who wish to make the transition but are unable to and those who do not go through the process of sexual re-assignment surgery.

## 1. Executive Summary

The Lesbian, Gay, Bisexual and Transgender (LGBT) Health Systems Consultation Report *Our Community, Our Health* highlights the impact of social pressures related to sexuality and gender identity that affect LGBT people accessing health and health-related services, and addressing health concerns. The statewide consultation identified the different effects of sexuality and gender identity on LGBT youth, transgender people, Aboriginal and Torres Strait Islander people and people with Culturally and Linguistically Diverse (CALD) backgrounds. However these groups were vastly under-represented, resulting in specific consultations being held with each group.

In each consultation, the impact and effects of the experience or expectation of discrimination, service provider's lack of knowledge and the lack of confidentiality within health services were identified as major barriers for LGBT people accessing health services and disclosing sexuality or gender identity issues. These concerns were consistently reinforced by the fear of having sexuality or gender identity issues disclosed to the wider community, resulting in further isolation, prejudice and harassment. Throughout each sector of the LGBT community, the importance of social support and the impact of social isolation on the ability to improve health outcomes and general wellbeing were major concerns.

LGBT youth identified the lack of relevant and accessible resources that addressed same-sex sexual health information, sexuality, gender identity and internal homophobia was considered a barrier to improving the sexual and mental health of LGBT youth. This was reinforced by the lack of people LGBT youth felt they were able to disclose these issues to.

Aboriginal and Torres Strait Islander LGBT and Sistersgirls (LGBTs) sexual health concerns focused upon the inter-relation of identity, culture and community in relation to sexuality and gender identity issues. However the general lack of culturally appropriate service provision was a consistent focus within the consultation. The sexual health concerns for LGBTs people focused upon people who are relocating from regional or remote communities to metropolitan areas to explore their sexuality. These concerns focused upon the lack of education and awareness of sexual health concerns, gay culture and sexual practices encountered in metropolitan areas.

The transgender chapter highlights the barriers related to accessing health services to address gender identity issues and general health concerns. The ability to access services for transgender people was largely impeded by the lack of knowledge, understanding and acceptance of gender dysphoria and transgender people within health and health-related services and the general community.

Issues affecting LGBT people with CALD backgrounds accessing services and improving health outcomes are briefly discussed at the end of this report. The barriers related to improving health outcomes, accessing to health services and health promotion for this group were closely related to the position of men who have sex with men (MSM) but do not identify as gay. However it is recognized that further research needs to be conducted within these communities.

The final chapter of this report identifies the areas of action that relate to the improvement of health outcomes and access to services within the general LGBT population. Specific mechanisms to increase support and improve outcomes for LGBT youth, Aboriginal and Torres Strait Islander LGBTs people, transgender people and LGBT people with CALD backgrounds have also been noted throughout the paper. Finally, the report recognises that the next phase of the LGBT Health Systems project needs to address the policy implications within Queensland Health to assist reducing the barriers to the LGBT population accessing health services and increasing health outcomes.

## 2. Introduction

The Communicable Diseases Unit of Queensland Health funded the Lesbian, Gay, Bisexual and Transgender (LGBT) Health Systems Project as a 12-month pilot project. The aim of the project is to identify how social pressures affect the accessibility of health services and health outcomes for the LGBT community. The project's broader social health framework focuses upon identifying how factors related to sexuality and gender identity can affect the health and wellbeing of LGBT people and may influence the risk of transmission of HIV, Hepatitis C and sexually transmitted infections (STI). Such factors include discrimination, homophobia, violence, low self-esteem, social/geographical isolation and rejection or fear of rejection as a result of sexuality or gender identity.

Sexuality and gender identity are emerging as key social determinants in the health and illness patterns of LGBT people. Evidence suggests that the shared patterns of health within the LGBT community are influenced by the effects of marginalisation and discrimination.<sup>1</sup> The dominant understanding of sexuality and gender identity in society reinforce experiences of marginalisation and discrimination through heterosexism. Heterosexism affects the health and wellbeing of LGBT people by assuming or believing that everyone is heterosexual or that a person's gender identity is fixed through their biological sex. However, LGBT health patterns are also inter-relate with other social and biological processes that are considered to produce patterns of illness specific to each group.

Queensland Health policy does not recognise sexuality or gender identity as social determinants of health in their own right. However, the World Health Organisation's definition of socially disadvantaged or socially poor includes people who face social exclusion or stigmatisation. That definition is recognised as a relevant health determinant by Queensland Health.<sup>2</sup> LGBT people in Queensland experience discrimination, social stigma and isolation on the basis of sexuality and gender identity. This report emphasises how these factors impact upon the ability of LGBT people to access health and health-related services, or adequately address sexuality, gender identity, sexual health or even general health concerns.

The *Queensland HIV, Hepatitis C and Sexually Transmitted Infections Strategy 2005 -2011* recognises the importance of creating environments to enhance the health and wellbeing of LGBT people in relation to HIV, Hepatitis C and STIs. This strategy acknowledges the need to address discrimination, stigma, homelessness and violence that create barriers to improving health outcomes for the LGBT community.<sup>3</sup> The *Smart State: Health 2020* wider approach to health recognises the need to address the wider social, economic and environmental factors that affect the health and wellbeing of individuals. This approach advocates for all government departments to take joint responsibility for addressing these wider social factors that affect the health outcomes of Queenslanders. This report emphasises the need to undertake Queensland Health's *Whole of Government Approach*<sup>4</sup> to address the affects of sexuality and gender identity on the health and wellbeing of LGBT people, and reduce the risk of sexual and mental health concerns within the LGBT community.

The Queensland *Anti-Discrimination Act 1991* protects the LGBT community from being refused service provision, vilified or discriminated against on the basis of sexuality or gender identity. However the community consultation identified that many people in the LGBT community are continuing to encounter direct discrimination on the basis of gender identity and sexuality within

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<sup>1</sup> MACGLHV. (2002) *What's the Difference? Health issues of major concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians*. Department of Human Services: Victoria; *Healthy Living 2010: Companion document for lesbian, gay, bisexual and transgender health*. (2001) San Francisco, CA; Gay and Lesbian Medical Association.

<sup>2</sup> World Health Organization. *Social determinants of health: the solid facts*. 2003. In *Health Determinants Queensland 2004*. Queensland Health, Public health Services at [http://www.health.qld.gov.au/phs/documents/phpru/22418\\_1.pdf](http://www.health.qld.gov.au/phs/documents/phpru/22418_1.pdf)

<sup>3</sup> *Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005-2011*, Queensland Health: 21.

<sup>4</sup> *Smart State: Health 2020 a vision for the future: Directions statement*. (2002) Queensland Government, Queensland Health: 18.

health and health-related services. This is also strongly related to the general lack of awareness and knowledge of LGBT issues held by service providers. The heterosexist knowledge base and presumptions made by service providers and identified within sexual health resources continues to marginalise LGBT people in Queensland and contributes to the increased risk of sexual health concerns and social isolation.

The definition of sexual health is recognised as a state of physical, emotional, mental and social wellbeing in relation to sexuality. This requires a positive and respectful approach to sexuality and sexual relationships and the possibility of having pleasurable and safe sexual practices that are free from discrimination, coercion and violence.<sup>5</sup> The impact of social isolation has continually been identified as a major risk factor for the mental health and wellbeing of LGBT people in Queensland. However, this concern inter-relates with the ability to improve sexual health outcomes and access to health and health-related services in Queensland.

For the improved health and wellbeing of LGBT people the general community needs to recognise the impact of the social attitudes and institutional marginalisation that effect LGBT health generally. This report highlights that the health and wellbeing of LGBT people is strongly inter-related with the lack of awareness, acceptance and knowledge of LGBT issues in the general community. This is recognised as a contributing factor to the social isolation and reluctance to disclose sexuality or gender identity issues to service providers that have detrimental effects upon the health of LGBT people. The following chapters aim to represent the experiences of the LGBT community within Queensland that have affected the accessibility to health and health-related services and the ability to address sexuality, gender identity and other LGBT issues with service providers.

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<sup>5</sup> World Health Organisation. (2004) *Progress in Reproductive Health Research*. 64: 3; WHO Draft working definition, October 2002 at <http://www.who.int/reproductive-health/gender/glossary.html>

### 3. Methodology

The statewide consultation aimed to identify the experiences, barriers and needs within the LGBT community to improve access health and health-related services in Queensland. The purpose of the consultation was to inform the project of the scope of the barriers to improving health outcomes for the LGBT community as a result of sexuality and gender identity. This data proposes to guide the direction and the development of the project in the future.

The consultation was informed by a broader social health framework to identify the inter-connection between social pressures related to sexuality and gender identity and factors that inhibit LGBT people from accessing health services and improving health outcomes in Queensland.

The process of conducting an assessment of the health needs of the LGBT community in Queensland incorporated:

1. The formation of a steering committee to guide the direction of the consultation undertaken;
2. Background information gathered to inform the consultation process and research supporting findings within the consultation;
3. General LGBT community consultation process throughout Queensland; and
4. Further consultation with specific groups within the LGBT community to address the gaps in the data collected after the general consultation.

#### Project Steering Committee

An officer with experience working with the LGBT community and researching LGBT issues was appointed to the project, and a steering committee of interested people was established to guide the development of the project. The steering committee consists of the following people:

Wendell Rosevear	Private General Practitioner	Stonewall Medical Centre
Nikki Smith	HIV Care and Support Officer	Positive Directions (Cairns)
Rodney Goodbun	President of QuAC Board	Queensland AIDS Council
Simon De Voil	Domestic Violence Counsellor	Relationships Australia / F-M Support Group
Jan Gale	Northern Sexual Health Zonal Coordinator	Queensland Health (Townsville)
Gary Boddy	Communicable Diseases Unit	Queensland Health
Wilo Mawudda	Indigenous Project	Queensland AIDS Council
Chris McIntire	Community Development Officer	Open Doors
Ken Glanville	Sexual Health Clinic Worker	Mt Isa Sexual Health Clinic
Vanessa Lee	Student – Masters in Health Promotion	Indigenous Community Member
Paul Martin	General Manager of QuAC	Queensland AIDS Council

The steering committee met three times during the first eight months of the project.

#### Background information

A literature review was undertaken to identify recent national and international reports to inform the project of work that has been conducted and current knowledge regarding the social pressures that affect LGBT health. The *Your Health and Wellbeing Community Consultation Report QLD (2003)*, *Rural, remote and socially-isolated gay, bisexual and other homosexually active men who have sex with men research report QLD (2004)* and the *What's the Difference? Health Issues of Major Concern to Gay, Lesbian, Bisexual, Transgender and Intersex Victorians (2002)* were used as a guide to developing the community consultation process.

## **Consultative Process**

The consultative process took the form of five general LGBT community consultation workshops, open to members of the LGBT community and service providers who work with the LGBT community. Consultations took place in Cairns, Townsville, Sunshine Coast, Gold Coast and Brisbane. Advertisements were placed in the LGBT press, emails and letters were sent to relevant LGBT community and social groups, health and health-related service providers, and information was placed on the QuAC website. A total of 70 people attended the initial consultation workshops. After the general LGBT community consultation was held, it was evident that few participants identified as transgender, youth, Aboriginal and Torres Strait Islander or came from Culturally and Linguistically Diverse Backgrounds had attended the consultations. Further consultation processes were undertaken to address the lack of information in reference to these groups.

### Transgender Consultation

A community consultation was held in Brisbane open only to transgender people. After the consultation, surveys replicating the questions addressed in the consultation were distributed throughout the transgender networks in Queensland. In total 28 transgender community members people were consulted.

### Aboriginal and Torres Strait Islander Consultation

This consultation began with a presentation at the *Yarning Up Sistergirl and Gay Men's Conference* in Cairns held by Queensland Aboriginal and Torres Strait Islander HIV/AIDS Project (QATSIHAP) QuAC. The presentation was followed by an informal group discussion and the opportunity to complete surveys that replicated the questions addressed in the general community consultation. A further consultation workshop was held in Brisbane specifically focusing upon the interactions between culture, sexuality, gender identity and accessing and addressing the health needs of LGBT people in Queensland. In total approximately 32 Aboriginal and Torres Strait Islander people were consulted with the majority of participants were Sistergirls and gay men.

### Youth Consultation

This consultation workshop was held in Brisbane and open to LGBT people 25 years and under. All participants were university students with the majority being actively involved in their University Student Unions' Queer Departments. In total 14 participants attended.

### Culturally and Linguistically Diverse Service Providers Consultation

Due to the difficulties of accessing CALD LGBT people, a consultation workshop was attempted with service providers working within CALD communities. Only three representatives attended from two service providers. An informal discussion was held identifying the barriers to creating interest within service providers working with CALD people and addressing sexuality and gender identity issues in the CALD community generally.

## **Data Analysis**

All data collected from the community consultation and equivalent surveys was collated by the project officer of the LGBT Health Systems project. The findings of the general community consultation were reported in an *Interim Draft Report May 2005 State Wide Community Consultation* listing concerns identified in each region and then collated into a statewide summary of the barriers identified regarding accessing services, improving health outcomes and community support available for LGBT people. Each following consultation was summarised in accordance to the target group of the consultation, drawing upon relevant themes that specifically affect transgender, Aboriginal and Torres Strait Islander, youth and CALD members of the LGBT community.

## 4. Summary of the Statewide LGBT Health Systems Consultations

The summary of the statewide consultation highlights the experiences and concerns raised within the LGBT community regarding the barriers to:

1. Accessing health and health-related services; and
2. Improving LGBT health outcomes.

The consultation identified that the barriers affecting access and health outcomes consistently inter-related with personal expectations of discrimination in various forms and the lack of service provider's knowledge relating to sexuality and gender identity. Concerns related to discrimination and stigma, often influenced decisions to access services or disclose health issues relating to sexuality or gender identity. These concerns were reinforced by attitudes held within the general community in relation to sexuality and gender identity. However, the consultation also identified the lack of communication between service providers and the LGBT community as a barrier to accessing appropriate services and improving health outcomes through various means.

### 4.1 Barriers for Lesbian, Gay, Bisexual and Transgender People Accessing Health Services

#### 4.1.1 Homophobia and Discrimination

The expectation or fear of discrimination from health care providers and the general community was consistently identified as a barrier to accessing health services and disclosing LGBT issues to service providers. Participants considered the social acceptance of homophobic attitudes and social stigma related to sexuality and gender identity reinforced these barriers. The under-utilisation and reluctance to access mental health and other health services by LGBT people in comparison to the general population is considered to relate to the expectations of prejudice, discrimination or lack of knowledge of LGBT issues by service providers.<sup>6</sup> In Victoria, nearly 21 percent of LGBT people considered they had experienced discrimination relating to same-sex relationships within health care settings.<sup>7</sup> However, this may not be representative of the experiences in Queensland considering Queensland was recently reported as the second most homophobic state in Australia with nearly 50 percent of Queensland respondents considering homosexuality immoral.<sup>8</sup>

#### 4.1.2 Sites of Discrimination

Discrimination was most often identified when LGBT clients first disclose their sexuality, gender identity or HIV/AIDS status to health care providers. Many participants identified experiences of discrimination from hospital staff, in relation to HIV status or staff refusing to acknowledge same-sex partners or convey medical information to partners, even when they were identified as next of kin.

#### 4.1.3 Lack of Knowledge in the LGBT community

Not knowing where or how to access health services that address gender identity and sexuality issues was considered one of the largest barriers to accessing health services. A majority of participants considered they would be more willing to discuss LGBT issues with service providers and access services if they were aware that services providers had knowledge or experience with

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<sup>6</sup> McNair, R. and Medland, N. (2002) "Physical Health Issues for GLBTI Victorians." In MACGLHV. *What's the Difference? Health issues of major concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians*. Department of Human Services: Victoria: 13-21; Brown, R., Perlesz, A. and Proctor, K. (2002) "Mental Health Issues for GLBTI Victorians." In MACGLH. *What's the Difference? Health issues of major concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians*. Department of Human Services: Victoria: 29-33.

<sup>7</sup> McNair, R. and Thomacos, N. (July 2005) *Not yet equal: Report of the VGLRL Same Sex Relationships Survey 2005*. Victorian Gay and Lesbian Rights Lobby, Victoria.

<sup>8</sup> In this survey Victorians were reported to have the least homophobic views of any state in Australia. Flood, M. and Hamilton, C. (2005) *Mapping Homophobia in Australia*. The Australia Institute Ltd.

LGBT issues. This concern also related to service providers not being able to provide appropriate referrals to support services in relation to sexuality or gender identity concerns.

The lack of a central referral point for the LGBT community and service providers to obtain information on LGBT health issues and support services that are informed on LGBT issues was considered to reinforce these barriers. The lack of publicity in the LGBT press and mainstream media of health services experienced in sexuality or gender identity issues was also considered to compound this problem, especially in regional areas. The Gay and Lesbian Welfare Association was noted as being able to be used as a referral point but was considered under-resourced to realistically address the extent of this barrier.

## **4.2 Barriers to Improving LGBT Health Outcomes**

### **4.2.1 Disclosure to Health Care Providers**

The expectation or experience of discrimination and breaches in confidentiality was identified as a contributing factor for LGBT people failing to disclose sexuality or gender identity issues to health care providers. Non-disclosure of sexuality or gender identity issues in general is considered to lead to a range of mental health problems for LGBT people, including social isolation, anxiety and stress related to the fear of being outed. However, non-disclosure to health care providers also reduces the ability for LGBT clients to receive appropriate care from services, especially with regard to addressing health concerns in the context of whole-life circumstances.<sup>9</sup>

### **4.2.2 The Fear of Being Outed and the Importance of Confidentiality**

Participants stressed the importance of confidentiality within health services. The fear of being outed to the general community as a result of disclosing LGBT issues to services providers was considered to inhibit people's willingness to address sexuality or gender identity issues with service providers or even access services. The disclosure of gender identity, sexuality and HIV status can result in rejection by family and friends, verbal and physical harassment, loss of employment, social isolation and even geographic relocation due to the social stigma and discrimination related to sexuality, gender identity and HIV status.

The fear of being outed is compounded for LGBT and people living with HIV/AIDS (PLWHA) who have relations or friends working in health services with access to patient records. This has been noted as a concern for gay men in rural areas and Aboriginal and Torres Strait Islander communities due to the limited choice of health services and the higher proportion of LGBT people that are not out in their local community.<sup>10</sup> Victorian research also indicates that LGBT people are more likely to encounter breaches of confidentiality from medical providers within regional or rural areas.<sup>11</sup> However, in this regard, it is also considered that LGBT clients are more likely to access services if they can be assured of confidentiality.<sup>12</sup>

### **4.2.3 The Assumption of Heterosexuality**

The consultation found the expectation of discrimination was influenced by the consistent assumption of heterosexuality encountered within health services. Heterosexist attitudes are considered to reinforce the discomfort and difficulty of LGBT people disclosing sexuality or gender identity concerns. Such attitudes are considered to reinforce scepticism regarding the level of knowledge and standard of care LGBT people will receive in health care settings.<sup>13</sup> This assumption was most commonly identified through the use of language in client consultations and

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<sup>9</sup> McNair, R. and Medland, N. (2002) op cit.

<sup>10</sup> *Rural, Remote and socially-isolated gay, bisexual and other homosexually active men who have sex with men research report* (2004) Smart Strategic Services Pty Ltd.

<sup>11</sup> VGLRL (2000) *Enough is Enough: A report on Discrimination and Abuse Experienced by Lesbian, Gay Men, Bisexuals and Transgender People in Victoria*. Victorian Gay and Lesbian Rights Lobby (VGLR), Melbourne.

<sup>12</sup> Cornelson, B. (1998) Addressing the sexual health needs of gay men and bisexual men in health care settings. *The Canadian Journal of Human Sexuality* (7) 3: pp261-271.

<sup>13</sup> Cornelson, B. (1998) op cit; McNair, R. and Medland, N. (2002) op cit.

the medical forms provided by health services that are not inclusive of same-sex relationships or transgender categories.

#### **4.2.4 Lack of Knowledge of Gender Identity and Sexuality Issues**

The lack of knowledge of gender identity and sexuality issues was identified as the most prevalent barrier for improving the health outcomes of LGBT people. Participants considered that they encountered a general lack of knowledge regarding LGBT issues more frequently than homophobic attitudes from health care providers. The limited understanding of LGBT issues by health care providers was considered to result from the lack of educational and training opportunities in university curricula and professional development courses. There is evidence that already suggests that psychiatrists generally do not receive adequate training in human sexuality.<sup>14</sup> However this was thought to be reinforced by the general community's lack of understanding and awareness of LGBT issues and related health concerns.

As a result of the lack of knowledge of sexuality and gender identity issues, health services often referred LGBT clients to local sexual health clinics. Both members of the LGBT community and representatives of sexual health services considered that most LGBT people would be more comfortable disclosing gender identity and sexuality concerns to sexual health clinic workers. However, it was noted that sexual health clinics do not have the resources to be a referral base for general gender identity and sexuality issues that they are not funded to address.

#### **4.2.5 Stereotypes and Myths of the LGBT community**

The prevalence of health care providers stereotyping LGBT clients was consistently identified as a result of the lack of knowledge and understanding of gender and sexuality issues. These attitudes resulted in LGBT clients encountering assumptions such as: gay men are promiscuous, same-sex relationships are only short term, LGBT people have sexual health concerns over testing for HIV and young LGBT people's sexuality is viewed as 'just a phase'. Experiences of being stereotyped by health care providers reinforced the distrust and scepticism regarding the level of knowledge and standard of care LGBT clients would receive. This contributed to the reluctance to disclose and discuss relevant LGBT issues or their relationships with health care providers.

#### **4.2.6 Lack of Understanding of Broader LGBT Issues**

It was repeatedly identified that health care providers lack an awareness and understanding of the social pressures relating to sexuality and gender identity that affect LGBT health, such as social and internal homophobia and transphobia; mental health concerns related to coming out; social isolation; and the importance of social support for LGBT people. The limited understanding of LGBT issues was considered to contribute to the emphasis on sexual health in relation to sexuality and gender identity, rather than addressing these issues through a holistic view of health care. However this was especially noted as reinforcing the lack of confidence that health care providers would understand the importance and in some cases the necessity of confidentiality for LGBT clients and PLWHA.

#### **4.2.7 Inability of Health Care Providers to Understand HIV/AIDS Issues**

There was a general lack of confidence that health care providers understand HIV/AIDS issues. This was not only noted as a factor that inhibited the health outcomes for PLWHA but was also identified as a barrier to accessing health services. The lack of confidence in health care providers has resulted in PLWHA not accessing local health services. It was noted in Townsville that people are prepared to travel to Cairns to attend general practitioners who understand HIV/AIDS issues.

Hospitals were repeatedly identified as a site of regular discrimination and ignorance regarding HIV and the treatment of PLWHA. Consultation participants considered a universal standard of care and safety procedures need to be in place to prevent discrimination against PLWHA, especially for surgical procedures. Regular incidents were noted where PLWHA were being made to go last in day surgical procedures because the hospital staff were scared of the risk of

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<sup>14</sup> Harrison, A. (1998) "Primary care of lesbian and gay patients: Educating ourselves and out students." *Family Medicine* 28(1): 10-23; Cornelson, B. (1998) op cit.

transmission of HIV to other patients. Concerns were also noted about the lack of privacy and confidentiality in hospital emergency rooms, especially when accessing PEP and HIV medication.

#### **4.2.8 Post-Exposure Prophylaxis (PEP)**

Each consultation identified a lack of awareness of the availability of PEP from 24-hour emergency wards in hospitals by the LGBT community, health care providers and hospital staff. Recent experiences of people being turned away from emergency wards, being told that PEP was only available from sexual health clinics and instances of general practitioners not being aware of PEP raised concerns. The *QLD Gay Periodic Survey* also noted that 50 percent of gay men were not aware of the existence of PEP and 10 percent of men who were aware of PEP did not know the correct time frame within which to take the medication.<sup>15</sup>

#### **4.2.9 Mental Health**

The consultations consistently identified inadequate knowledge of gender identity and sexuality issues and an unwillingness to address these issues seriously among the majority of counselling services. Concerns were especially noted in relation to the lack of awareness, knowledge and training in relation to the impact of social isolation, stigma and the relationship between youth suicide and sexuality in the context of LGBT mental health. Research suggests that the mental health problems within the LGBT community are not attributed to same-sex attraction or gender dysphoria. Rather the risk factors for mental health result from the exposure to homophobia, transphobia and social isolation.<sup>16</sup> The availability and access to informed and affordable mental health services was considered one of the largest barriers to LGBT health and wellbeing in the consultation. This has been noted in previous studies on the mental health of the LGBT community, and especially raises concerns in light of the disproportionately high mental health risk factors such as low self-esteem, depression, suicide, isolation, marginalisation and homelessness in the LGBT community.<sup>17</sup>

Consultation participants considered that counsellors and mental health professionals did not understand or address the importance of social support for LGBT people. Supportive relationships and connectedness to the community is vital for mental health and wellbeing.<sup>18</sup> For the LGBT community, social support is recognised as being a crucial factor in assisting people to overcome internalised homophobia or transphobia and cope with the social pressures and discrimination on the basis of sexuality or gender identity.<sup>19</sup> Many participants considered that it could be more beneficial for some LGBT people to be referred to social support groups rather than mental health professionals to deal with issues relating to sexuality or gender identity.

#### **4.2.10 Inadequacies of Domestic, Sexual and Family Violence Provisions**

It was consistently noted that domestic violence services still lack training, policies and resources addressing same-sex domestic violence and lack emergency accommodation for lesbians, gay and transgender people. The consultations identified recent reports of lesbian and gay men being refused service at domestic violence services because service providers did not consider they held adequate training to deal with same-sex intimate violence. However, participants also identified the inability for some LGBT people living in regional, rural and indigenous communities to access domestic services without outing themselves or their partner to the community. This was noted as preventing services being accessed altogether. It was also noted that many of the sexual assault services are not being trained to address male-to-male sexual assault. As a result men are often referred to the sexual health clinics to address these issues. There is also a general lack of

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<sup>15</sup> Hull, P. et al (2005) *Gay Community Periodic Survey Queensland 2004*. Monograph Series 1. National Centre in HIV Social Research.

<sup>16</sup> Brown, R. et al (2002) op cit.

<sup>17</sup> McNair, R., Anderson, S. and Mitchell, A. (2001) "Addressing the health inequalities in Victorian lesbian, gay, bisexual and transgender communities." *Health Promotion Journal of Australia* (11) 1: 32-38; McNair, R. and Medland N. (2002) op cit; Nuttbrock, L., Rosenblum, A., Blumenstein, R., (2002) Transgender Affirmation and Mental Health. *International Journal of Transgenderism* (6) 4 at [http://www.symposion.com/ijt/ijtvo6no04\\_3.htm](http://www.symposion.com/ijt/ijtvo6no04_3.htm)

<sup>18</sup> McNair, R. and Medland N. (2002) op cit.

<sup>19</sup> *Coming Out Alone: An assessment of the needs of same sex attracted youth, their families and service providers in Western Australia* (2005). Trinity Outreach Services, Perth; Nuttbrock, L. et al. (2002) op cit.

knowledge within the health sector and the LGBT community of services that address gay male sexual assault.

#### **4.2.11 Broader Media Campaigns**

Participants considered the lack of media campaigns on LGBT health issues in both the LGBT press and mainstream media constituted a barrier to improving the health outcomes of the LGBT community. Concern was noted at the lack of Queensland Health campaigns being run through the LGBT press on general issues such as smoking and drink spiking. Participants also considered that campaigns around general health issues in the mainstream media needed to target a more diverse audience and include the representation of LGBT people in relation to health issues that affect the whole community.

#### **4.2.12 Police Liaison Officers**

The lack of continuing LGBT training for LGBT Police Liaison Officers was identified as a barrier to their understanding and involvement with the LGBT community. There is no monitoring or evaluation mechanisms to address how many times the officers are contacted or the concerns these officers are addressing. Difficulty has been encountered trying to identify who the local Liaison Officers are and how to contact them. Participants felt that many people in the LGBT community are not aware of the existence of Liaison Officers within their local area. The LGBT community considers that they are relying on the commitment of individual officers to address LGBT concerns rather than the program being supported by mechanisms in the QLD Police Service.

## 5. LGBT Youth

Addressing sexuality and gender identity issues for LGBT youth often includes the social pressures related to the stigma and prejudice associated with same-sex attraction and gender identity variation. LGBT youth often experience social isolation, rejection from family and friends, harassment, verbal and physical abuse due to their sexuality or gender identity, causing increased levels of anxiety, stress and depression.<sup>20</sup> Evidence indicates that these factors contribute to the over-representation of LGBT youth encountering homelessness,<sup>21</sup> leaving education institutions early,<sup>22</sup> assaults, family violence, sex work,<sup>23</sup> suicide rates,<sup>24</sup> drug and alcohol use, self-harm and reporting STIs. This chapter highlights the impact of social pressures that affect the ability of LGBT youth to access health and health related services and information relating to gender identity, sexuality and sexual health issues.

### 5.1 Barriers to Accessing Health Services

#### 5.1.1 Resources to Access Alternative Health Care Providers

Barriers to disclosing gender identity and sexuality issues to health care providers were influenced by the fear of experiencing negative reactions from health care providers and not being able to access alternative health services. However the reluctance for LGBT youth to access formal services in general is influenced by the fear of breaches in confidentiality or privacy.<sup>25</sup> These factors were especially emphasised in relation to family or local doctors. Consultation participants considered that the option to attend alternative health services as a result of experiencing negative reactions from health care providers or avoid breaches in confidentiality was impeded by having to explain to parents or family why they are attending alternative services and having the finances and transport to access these services.

#### 5.1.2 Fear of Being Outed

The consultation identified the fear of being outed or *being found out* prevented LGBT youth from addressing sexuality or gender identity concerns with friends, family, teachers, health care providers or accessing specific services. Privacy relating to LGBT issues is extremely important. The inherent fear of being outed reflects the lack of acceptance and stigma associated with LGBT issues. The persistent fear of *being found out* is considered to cause high levels of anxiety, depression and stress resulting from the threat of or the actual experiences of discrimination, harassment or rejection from family and friends that is often encountered by SSAY.<sup>26</sup> The threat of discrimination is so real that many LGBT youth would rather access mainstream services than proactively seek LGBT specific services to address these concerns to reduce the risk of being outed to the general community.<sup>27</sup>

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<sup>20</sup> McNair, R., & Harrison, J. (2002) "Life Stage Issues within GLBTI Communities." In MACGLH. *What's the Difference? Health issues of major concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians*. Department of Human Services: Victoria: 37-44.

<sup>21</sup> Rossiter, B., Mallett, S., Myers, P. and Rosenthal, D. (2003) *Living Well? Homeless Young People in Melbourne*, The Australian Research Centre in Sex, Health and Society, La Trobe University; Buchanan R (1995) *Young, Homeless and Gay*, Human Rights: Journal of the Section of Individual Rights and Responsibilities 22 (1): 42 – 44.

<sup>22</sup> Kendell, C. and Walker, S. (1998) *Teen Suicide, Sexuality and Silence*, Alternative Law Journal 23 (5), 216 – 221.

<sup>23</sup> Buchanan R (1995) op cit.

<sup>24</sup> Dyson, S., Mitchell, A., Smith, A., Dowsett, G., Pitts, M. and Hillier, L. (2003) *Don't Ask, Don't Tell. Hidden in the Crowd: The need for documenting Links between Sexuality and Suicidal Behaviours Among Young People*, Monograph Series No 45, Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University

<sup>25</sup> Dyson, S. et al (2003) op cit.

<sup>26</sup> Brown, R., Perlesz, A. and Proctor K. (2002) "Mental Health Issues for GLBTI Victorians." In MACGLH. *What's the Difference? Health issues of major concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians*. Department of Human Services: Victoria: 29-33.

<sup>27</sup> Isle, S., Miller, N. and Carr, K. (August 2003). *Report on the SSAY Townsville Youth Forum 2003 QLD*, The Townsville Anti-Violence Committee.

## 5.2 Barriers to Improving the Sexual Health of LGBT Youth

### 5.2.1 Learning About Safe Sex

The absence of information relating to same-sex sexual health and safe sex practices was noted by consultation participants in high schools' sex education programs, general sexual health resources and by mainstream health care providers. The most prevalent concern this raised was the lack of knowledge relating to the transmission of STIs, especially for women. The sexual health information that was obtained only related to heterosexual sexual activities and safe sex practices. This information was not considered detailed enough to be able to be used in relation to lesbian sexual practices. However, this concern was compounded by the lack of knowledge of how or where to access sexual health and safe sex resources relating to LGBT sexual practices.

The primary source of information on LGBT safe sex practices came from peers, sexual partners, the LGBT press, University Student Union Queer Departments or the internet. This correlates with the findings in the *Writing Themselves in Again 2005* report on same-sex attracted youth in Australia. Eighty percent of SSAY considered sex education in schools useless or fairly useless, and lacked any same-sex information.<sup>28</sup> While 93 percent of SSAY learned about heterosexual safe sex in school, only 27 percent learned about gay safe sex and only 21 percent learned about lesbian safe sex. Lesbians and gay youth mostly access the internet, LGBT friends and LGBT media and lastly general media resources to learn about LGBT safe sex practices.<sup>29</sup>

The reliance upon peers and concern regarding the actual transmission of STIs reflects the tendency for sexual health information, resources and knowledge of health care providers being restricted to heterosexual sexual practices and safe sex techniques. This concern needs to be highlighted with regard to the fact that SSAY, especially those between 15 and 18 years old, are on average more likely to be sexually active earlier than their heterosexual peers (including sexual activity with partners of the opposite sex).<sup>30</sup>

### 5.2.2 Barriers to Safe Sex Practices

Being in a relationship, using drugs and alcohol and not being aware of sexual health concerns were the three main reasons identified for not prioritising safe sex. The relaxed attitudes towards safe sex while under the influence of drugs and alcohol raises concerns in light of the disproportionately high rates of drug and alcohol use by SSAY, especially in regard to social use within the LGBT community.<sup>31</sup> The relaxed attitudes towards safe sex in relationships have been highlighted in the *QLD Gay Periodic Survey 2004*, noting 56 percent of gay men had engaged in some form of unprotected anal intercourse with regular male partners.<sup>32</sup>

Of particular note, the lack of awareness of lesbian sexual health issues was identified as a reason for females not practicing safe sex. Both men and women rarely engaged in the use of dental dams for safe sex. Dental dams were considered messy, too hard to use, expensive and took away the pleasure in sex. While attitudes towards the use of dental dams were extremely negative, participants considered the cost and not knowing where to purchase them in the general community as a barrier to making this a realistic option for practicing safe sex.

### 5.2.3 Higher Rates of Sexually Transmitted Infections (STI) and Risk Taking Behaviour

SSAY are considered to be five times more likely to be diagnosed with an STI and three times more likely to have had Hepatitis at some stage in their lives.<sup>33</sup> While drugs and alcohol were

<sup>28</sup> Hillier, L., Turner, A. and Mitchell A. (2005) *Writing Themselves in Again: 6 years on. The second National report on the sexuality, health and well-being of same sex attracted young people in Australia*. Monograph Series no. 50, Australian Research Centre in Sex, Health and Society, Latrobe University, Melbourne.

<sup>29</sup> Hillier, L. et al. (2005) op cit.

<sup>30</sup> Hillier, L. et al. (2005) op cit.

<sup>31</sup> *Coming Out Alone (2005) op cit.*. Trinity Outreach Services, Perth; Harland, C. (2002) "Drug and Alcohol Use within GLBTI Communities." In MACGLH. *What's the Difference? Health issues of major concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians*. Department of Human Services: Victoria: 37-44.

<sup>32</sup> Hull., P. et al (2005) op cit

<sup>33</sup> Hillier, L. et al. (2005) op cit.

identified as increasing the likelihood of engaging in unsafe sex, consultation participants also considered that not practicing safe sex was another means to rebel against social expectations and engage in self-destructive risk taking behaviour. Evidence suggests that the risk taking behaviours of LGBT youth, including unsafe sex, are attributed to the pressures of dealing with sexuality and gender identity issues.<sup>34</sup> The higher rates of STIs have also been suggested to relate to SSAY sexual partners being in a higher risk group for STIs, being sexually active at an earlier age or that SSAY are more likely to engage in behaviours that pose a risk to their health than their heterosexual peers.<sup>35</sup>

#### **5.2.4 Attitudes Towards Getting Tested**

Sexual health tests were not considered as a precautionary or necessary routine in maintaining a person's sexual health. Rather, sexual health tests were considered as a step taken after a person had been exposed to the real risk of transmission of an STI. Both men and women only considered undertaking a sexual health test if there was a reason to do so, such as finding out they had unsafe sex with a partner that had an STI. Men did not consider that it was necessary to undertake a sexual health test if they were practicing safe sex. However, participants also lacked knowledge of where to access sexual health tests or health services that would Bulk Bill sexual health tests.

#### **5.2.5 Lack of Knowledge of LGBT Issues by Health Care Providers**

Consultation participants considered that the majority of health care providers they had disclosed their sexuality to had very little knowledge in relation to lesbian, gay or bisexual issues. Such experiences with health care providers ranged from consultation participants having to explain same-sex sexual practices, justifying why lesbians needed sexual health tests and service providers not being able to provide safe sex information, or addressing sexuality as a phase or not addressing sexuality concerns when they were raised.

#### **5.2.6 Disclosing to Health Care Providers**

Health care providers were considered as authority figures, and having to discuss LGBT issues was considered extremely intimidating for young people. The assumption of heterosexuality made by service providers makes this process more difficult, carrying with it the expectation of having to deal with an adverse reaction or shock after disclosing sexuality or gender identity issues. And the general sentiment of participants was that *"I just can't be bothered dealing with it."*

The consultation participants' expectations of prejudice or judgemental attitudes resulted in a reluctance to disclose gender identity or sexuality issues with health care providers, especially doctors. There was a general lack of confidence in how service providers would address these issues or how they would be treated as a result. However being able to disclose LGBT issues to health care providers was also related to personal levels of self-confidence surrounding these issues. *"Coming out is hard enough without having to deal with a bad reaction from doctors and stuff."*<sup>36</sup> *Writing Themselves In Again* indicated that only 17 percent of SSAY had disclosed their sexuality to doctors, 20 percent to youth workers, 7 percent to student welfare coordinators and 26 percent to teachers.<sup>37</sup>

#### **5.2.7 Social Support for Same Sex Attracted Youth**

Consultation participants considered that it was important for the self-confidence of LGBT youth to meet other LGBT people. This enabled people to feel comfortable and normalise their sexuality or gender identity. Participants considered that this was crucial for LGBT people to overcome their own internal homophobia. It was noted that LGBT support groups need to focus upon empowering youth rather than concentrating on the negative aspects of LGBT health or the impact of homophobia. Youth primarily wanted a space where they could feel comfortable with their identity.

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<sup>34</sup> McNair, R., & Harrison, J. (2002) op cit.

<sup>35</sup> Hillier, L. et al. (2005) op cit.

<sup>36</sup> LGBT Youth Consultation, (July 2005) LGBT Health Systems Project 2005, QLD AIDS Council, Brisbane.

<sup>37</sup> Hillier, L. et al. (2005) op cit.

## **5.3 Mechanism to Improve Access to Health Services and Health Outcomes for LGBT Youth**

### **5.3.1 Social Acceptance**

Increasing acceptance and understanding of LGBT issues within the general community was considered crucial to improving the health and wellbeing of LGBT youth. The effects of internalised and social homophobia need to be addressed as a general community concern. To increase support, education and the wellbeing of LGBT youth, the stigma and discrimination relating to gender identity and sexuality needs to be addressed. Changing these social attitudes would increase the ability of SSAY to talk to friends, family and health care providers about gender identity, sexuality and sexual health concerns without the threat of discrimination, harassment, isolation or rejection on the basis of sexuality or gender identity.

### **5.3.2 Resources for LGBT Youth**

Consultation participants stressed the importance of providing resources within the LGBT community and mainstream services that address LGBT sexual health and internal homophobia. Internalised homophobia was considered one of the greatest threats to LGBT health and wellbeing. It was considered necessary to emphasise its link to the physical, mental, emotional and sexual health of LGBT youth. This also includes campaigns to change the culture of lesbian safe sex and encourage the use of dental dams within the LGBT community. However, it was considered that general sexual health materials needed to address sexual practices rather than sexual identity. This reflected the heterosexual focus of sexual health resources and also the necessity for LGBT people to access relevant sexual health information without disclosing their sexual orientation.

### **5.3.3 Support and Education in Schools**

Seventy-four percent of the SSAY experiences of unfair treatment, verbal and physical abuse take place in school environments.<sup>38</sup> High schools need to be proactive in addressing students' attitudes towards gender identity, sexuality and homophobia within the school environment. School communities need to be aware of the relationship between sexuality and gender identity concerns and the general mental, emotional and physical wellbeing of young people. Information and appropriate referrals need to be accessible for SSAY students. Many participants spoke of experiences of breaches of confidence when accessing school guidance counsellors and indicated that the most useful source of ongoing support for SSAY had to be accessed outside the school community. Nonetheless, participants wanted support in accessing external services.

### **5.3.4 Reducing Social Isolation**

Feelings of social isolation are described as the most critical issue for young people coming to terms with sexual orientation<sup>39</sup> or gender identity. Recent LGBT youth studies have indicated that the greatest needs for LGBT youth are emotional security, social support and access to information about services and LGBT issues.<sup>40</sup> The consultation highlighted the same needs in regard to increasing support for LGBT youth, prioritising the need to increase accessible information relating to informed services to support for LGBT youth, information on LGBT social venues and groups and resources on sexuality and gender identity. An increased awareness of the mental health issues related to coming out and the importance of social support mechanisms for LGBT youth addressing these issues needs to be addressed within the general community and service providers.

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<sup>38</sup> Hillier, L. et al. (2005) op cit.

<sup>39</sup> *Coming Out Alone* (2005) op cit.

<sup>40</sup> *Coming Out Alone* (2005) op cit; Gottschalk L & Newton J (2003) *Not So Gay in the Bush: 'Coming Out' in Regional and Rural Victoria*, University of Ballarat.

## 6. Aboriginal and Torres Strait Islander Lesbian, Gay, Bisexual, Transgender and Sistergirls

This chapter focuses upon the inter-relationship between culture, community, gender identity and sexuality for Aboriginal and Torres Strait Islander lesbian, gay, bisexual, transgender and sistergirls (LGBTs). The complexity of this relationship affects how issues of sexuality, gender identity and Aboriginal and Torres Strait Islander culture affect accessing health services, risk factors associated with sexual and mental health and improving LGBTs health outcomes.

### 6.1 Culture, Identity and Community

#### 6.1.1 Identity, Family and Community Support

Aboriginal and Torres Strait Islander LGBTs identities are strongly related to identity and culture within the Aboriginal or Torres Strait Islander community.<sup>41</sup> LGBTs identities are primarily based upon a person's Aboriginal or Torres Strait Islander identity before their gender identity or sexuality status.<sup>42</sup> Identifying as LGBTs in Aboriginal and Torres Strait Islander communities was considered to be dependent upon the support an individual received from their family, community and community elders. The main source of support and the basis of an individual's sense of identity and role within the community is based upon their connection with their family.<sup>43</sup> However, the sexuality or gender identity of LGBTs people is often seen as complicating these roles within the family and the community. Many LGBTs people face pressures not to address or assert their gender identity or sexuality due to the importance of respecting their family and role within the community.<sup>44</sup>

#### 6.1.2 LGBTs in Rural and Remote Communities

Many Aboriginal and Torres Strait Islander LGBTs people have strong positive sexual and gender identities and are accepted and supported by their families, their own community and the wider community.<sup>45</sup> However, consultation participants considered that most same-sex relationships and sexual activity is invisible in rural and remote communities. The fulfilment of family and community roles, lack of acceptance, understanding, discrimination and stigma associated with same-sex relationships will often prevent gay men and lesbians from coming out in the community. A contributing factor to these attitudes has been noted as the historical influence and role of Christianity that often still exists, especially within Aboriginal and Torres Strait communities that were originally established as missions.<sup>46</sup>

The invisibility of gay men within the community often relates to this identity being viewed as associated with gay men's sexual activities and its association with paedophilia. This reinforced the pressure upon men having sex with men to conceal their sexuality and sexual activities. However, lesbians are considered even less visible than gay men within Aboriginal and Torres Strait Islander communities. The expectations of raising families and roles as mothers within the community contribute to the invisibility of lesbian women within the community. However, in general the terminology of 'gay', 'lesbian' and 'transgender' is not used within Aboriginal and Torres Strait Islander communities to describe sexual activities or identity. Such terminology is considered urban or western terminology and may be unfamiliar to people in communities.

Sistergirls generally do not identify as being transgender. They are identified and generally accepted as women, fulfilling the roles and responsibilities of women within the community and in

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<sup>41</sup> Lawrence, C. and Prestage, G. et al. (2005) *Queensland Survey of Aboriginal and Torres Strait Islander Men who have Sex with Men 2004*. National Centre in HIV Epidemiology and Clinical Research, Australia.

<sup>42</sup> Lawrence, C. and Prestage, G. et al. (2005) op cit.

<sup>43</sup> McLennan, V. and Khavarpour, F. (2004) Culturally appropriate health promotion: Its meaning and application in Aboriginal communities, *Health Promotion Journal of Australia* 15 (3): 237-239.

<sup>44</sup> Australian Federation of AIDS Organisations (1998) *The National Indigenous Gay and Transgender Project Report and Sexual Health Strategy*, Sydney: Australia Federation of AIDS Organisations.

<sup>45</sup> Lawrence, C. and Prestage, G. et al. (2005) op cit.

<sup>46</sup> *Rural, Remote and socially-isolated* (2004) op cit.

their relationships. The acceptance and visibility of sistergirls is considered to be greater than gay men and lesbians. This was considered to reflect the focus upon Sistergirls identity within the roles and responsibilities of women in the community rather than their sexual practices. However, the identity of sistergirls may vary depending upon whether they take a part time or full time role as a woman. It must be noted that the acceptance and visibility of sistergirls will vary in accordance with the level of acceptance within the community itself. This will often relate to the level of influence of Christianity within the Aboriginal and Torres Strait Islander communities.<sup>47</sup>

### 6.1.3 LGBTs in Urban Communities

LGBTs people were considered to be more likely to be out and identify as LGBTs if they were living in urban areas. Consultation participants considered this may reflect attitudes that prioritise identifying as LGBTs rather than being part of the Aboriginal or Torres Strait Islander community. However, this was not reflected in the *Queensland Survey of Aboriginal and Torres Strait Islander Men having Sex with Men 2004*<sup>48</sup> (QLD MSM Survey). Of the 91 percent of respondents that identified as homosexual, bisexual, sistergirl or transgender, three quarters of the respondents considered themselves "very much a part of the Aboriginal and Torres Strait Islander community"<sup>49</sup> while only half of these respondents considered themselves "very much a part of the gay community".<sup>50</sup>

Consultation participants also considered that Aboriginal and Torres Strait Islander women were less likely to be involved with the lesbian scene in urban areas and generally come out later in life. This was considered to reflect the pressure and the responsibilities of having children and having previously been in heterosexual relationships. While consultation participants considered that lesbians were less likely to be involved in the non-Indigenous lesbian community in urban areas, lesbians were generally out within the Aboriginal and Torres Strait Islander community. However, it was also noted that there are few available support mechanisms for Aboriginal and Torres Strait Islander lesbians, and consultation participants considered that many lesbians suffer large amounts of social isolation as a result.

## 6.2 Transient Sexualities

*"Being gay in an Aboriginal community is the same as being black in a white community. You are not accepted and in some cases forced to leave. Teenagers head for the cities to be themselves because they cannot at home."*<sup>51</sup>

The most prevalent health and wellbeing concern the consultation identified was the lack of awareness and support for LGBTs people relocating from Aboriginal and Torres Strait communities to regional and metropolitan areas to explore their gender identity or sexuality. Consultation participants most often described LGBTs sexuality, especially for gay men, as a *transient sexuality*. This described the alternating identities and sexual roles of LGBTs people between their lives in Aboriginal and Torres Strait Island communities and outside the community in metropolitan areas.

### 6.2.1 Moving to the City

Some LGBTs people leave their community as a result of the social isolation, lack of acceptance and discrimination encountered on the basis of their sexuality and gender identity. The *QLD MSM Survey* reported 41 percent of men had experienced discrimination on the basis of their sexuality within Aboriginal and Torres Strait Islander communities, although most described these experiences as *occasional* rather than *often*.<sup>52</sup> Reasons such as loneliness, lack of sexual

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<sup>47</sup> *Rural, Remote and socially-isolated* (2004) op cit.

<sup>48</sup> Lawrence, C. and Prestage, G. et al. (2005) op cit.

<sup>49</sup> Lawrence, C. and Prestage, G. et al. (2005) op cit.

<sup>50</sup> Lawrence, C. and Prestage, G. et al. (2005) op cit.

<sup>51</sup> Close L. (1992) *Gay, Aboriginal and Proud*, Feature, National AIDS Bulletin, Australian Federation of AIDS Organisations.

<sup>52</sup> Lawrence, C. and Prestage, G. et al. (2005) op cit.

partners, lack or inability to have long term relationships and the inability to come out in communities were also considered factors that contributed to LGBT people relocating to regional and metropolitan areas.

### **6.2.2 Men having Sex with Men in the City**

Consultation participants raised concerns about the vulnerability of Aboriginal and Torres Strait Islander men who move from communities to metropolitan areas to explore their sexuality. Participants considered that gay men in regional and remote communities are introduced and accustomed to undertaking passive and submissive roles, generally being the receptive partner when having sex with other men. Without having adequate sexual health education and available support networks, gay men relocating from regional or remote communities are at risk of continuing to allow other men to dictate their sexual activities and safe sex practices when they relocate to metropolitan areas.

The lack of acceptance and education gay men's sexuality consultation participants considered that these men were likely to lack the necessary knowledge and skills to take control of their own sexual practices and sexual health when they initially relocate to metropolitan areas. The increased ability for these men to access sexual partners and engage in regular sexual activity with other men not only raised concerns relating to sexual health but also with their involvement with the gay scene in general. MSM and gay men who relocate to metropolitan areas were considered to have limited experience and knowledge of the personal and sexual safety practices and sexual etiquette used at gay men's beats and the accepted social interaction of verbal and non-verbal language and sexual games practiced at sex-on-premise venues or in gay men's culture generally. The increased level of exposure to risk taking behaviours and risk of transmission of STI's, HIV and Hepatitis C were attributed to both the lack of adequate resources and education available for MSM before relocating to metropolitan areas and the availability of support networks in those metropolitan areas.

### **6.2.3 Social Isolation and Stigma**

Consultation participants considered that the transition to regional or metropolitan areas was marked by broader social pressures than gender identity and sexuality issues--including racism, unemployment, lack of accommodation and poverty. The vulnerability of MSM and gay men relocating to metropolitan areas was also attributed to the power imbalances that often exist in these men's relationships due to socio-economic inequalities between partners. The *QLD MSM Survey* also noted that 53 percent of MSM described experiencing racial discrimination, with most considering the incidents as occasional rather than often in the gay scene.<sup>53</sup>

Experiences of discrimination on the basis of race and socio-economic factors were considered to contribute to Aboriginal and Torres Strait Islander LGBT people being more defensive about their sexuality and issues of discrimination than non-indigenous LGBT people in metropolitan areas, in both the general community and within the LGBT community. The effects of social isolation, depression, discrimination and the difficulties transitioning to life outside the community were considered to influence the high rates of alcohol consumption and use of illicit drugs amongst MSM and gay men.<sup>54</sup> This also raised concerns for men managing conflict and dispute resolution in relation to sexuality and race. It was considered that men coming from regional and remote areas are more accustomed to environments where it is more socially acceptable to settle disputes through fighting than it is in metropolitan areas.

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<sup>53</sup> Lawrence, C. and Prestage, G. et al. (2005) op cit.

<sup>54</sup> Lawrence, C. and Prestage, G. et al. (2005) op cit.

## **6.3 Barriers for Aboriginal and Torres Strait Islander LGBTS Accessing Health Services**

### **6.3.1 Cultural Awareness and Discrimination**

The lack of understanding of Aboriginality and the Torres Strait Island culture was considered a greater barrier for LGBTS people accessing health services than the lack of understanding towards gender identity and sexuality issues. This concern also related to experiences or expectations of racial discrimination within services generally. As a result it was considered that many Aboriginal and Torres Strait Islander people feel too intimidated to access services or disclose health concerns with health care providers. Discrimination from health care providers was also associated with the lack of understanding, awareness and acceptance of LGBTS issues. This was especially emphasised by Sistergirls.

### **6.3.2 The Choice of Health Services and Confidentiality**

The consultation suggested that if LGBTS people have a choice in health services they generally would not access their usual health service to address gender identity and sexuality issues. This related to the fact that many LGBTS people have relatives working in the health service with access to their medical records, and there is a general concern about breaches of confidentiality if local health services are accessed.<sup>55</sup> This was highlighted in the *QLD MSM Survey*. Half of the male respondents were accessing Aboriginal Community Controlled Health Services (ACCHS), although low rates of MSM accessed ACCHS to obtain HIV tests.<sup>56</sup> However, many rural and remote Aboriginal and Torres Strait Islander communities only have access to ACCHS. This was considered to be a major barrier for LGBTS accessing health services to address or disclose gender identity, sexuality and sexual health concerns.

### **6.3.3 Lack of Knowledge and Resources to Access Services**

The lack of financial resources and transport were also considered barriers to accessing health services. Health care providers were generally not considered to be approachable or friendly. There was a noted lack of information for LGBTS people to access informed services that understand LGBTS issues, relating to both Aboriginal and Torres Strait Islander culture and gender identity and sexuality issues.

## **6.4 Barriers to Improving Health Outcomes for LGBTS People**

### **6.4.1 Health Care Providers' Lack of Knowledge**

Language used by health care providers was considered culturally inappropriate for many Aboriginal and Torres Strait Islander clients, creating a barrier to understanding and discussing personal health issues. Most health care providers were considered to have little knowledge of Aboriginal and Torres Strait Islander communities, their culture and their laws or how these issues impact upon the way Aboriginal and Torres Strait Islanders access health services. The majority of health care professionals are not from Aboriginal and Torres Strait Islander communities. Consultation participants considered that the lack of culturally appropriate service provision prevented many Aboriginal and Torres Strait Islander people from accessing services, understanding, discussing or being able to improve their health. In addition to this, a noted lack of awareness of the gender identity or sexuality issues that exist within Aboriginal and Torres Strait Islander communities, including LGBTS identities, sexual practices and roles within the community was encountered. Without this awareness, LGBTS people are often invisible to health care providers in Aboriginal and Torres Strait Islander communities.

### **6.4.2 Disclosure, Gender Identity and Sexuality**

The threat of discrimination from health care providers, the Aboriginal and Torres Strait Islander community and the non-Indigenous community was considered the major barrier to disclosing gender identity and sexuality issues. This fear was reinforced by the general lack of confidence in

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<sup>55</sup> *Rural, Remote and socially-isolated* (2004) op cit.

<sup>56</sup> Lawrence, C. and Prestage, G. et al. (2005) op cit.

health services keeping information confidential, especially if relatives or people in the community worked in the health service and had access to medical records. In the *QLD MSM Survey*, a quarter of the men had not disclosed their sexuality to any health care providers.<sup>57</sup>

#### **6.4.2 High Staff Turnover in Health Services Within Communities**

The high staff turnover within health services in Aboriginal and Torres Strait Islander communities was considered another barrier to addressing health issues. Consultation participants considered that it is a priority for Aboriginal and Torres Strait Islander clients to build relationships of trust and understanding between health care providers to facilitate the disclosure of health concerns, especially issues relating to gender identity and sexuality. The high staff turnover within health services very often prevents productive relationships being established that would facilitate a greater understanding of health concerns and the ability to improve health outcomes.

#### **6.4.3 Sexual Health and Competing Priorities in Health**

It was considered that for many Aboriginal and Torres Strait Islander communities, sexual health, gender identity and sexuality issues are not a priority in relation to the health needs of the population. Research clearly demonstrates Aboriginal and Torres Strait Islanders suffer poorer health outcomes as a result of a number of preventable illnesses than non-Indigenous Australians.<sup>58</sup> Encouraging sexual health promotion was considered to be complicated by the competing health needs within the community. However, consultation participants also suggested that these issues were not given priority because some ACCHS are not comfortable or willing to address sexual health, gender identity or sexuality issues within the community. There is still a lot of shame and negative stereotypes associated with sexual health and sexuality in Aboriginal and Torres Strait Islander communities.<sup>59</sup> The shame was considered to be a generational issue within communities. In this regard it was recommended that caution needed to be taken when addressing sexual health education within communities, considering the levels of homophobia and the sensitivity or lack of acceptance around issues relating to sex.

#### **6.4.4 Safe Sex for Men Having Sex with Men**

HIV/AIDS in Aboriginal and Torres Strait Islander communities was generally considered to be viewed as a "gay man's disease" or a "Southern disease". These attitudes present the risk that MSM and gay men in Aboriginal and Torres Strait Islander communities would not consider themselves to be at risk of the transmission of HIV, as it is not considered relevant to the communities that they live in or that they do not identify as being gay. Concerns were raised about safe sex practices. The consultation participants noted that MSM, who do not identify as gay, generally dictate the sexual activity and safe sex practices during intercourse with gay men. Gay men were considered to take a passive and submissive sexual role, and while they may be more aware of the sexual health risks related to having sex with other men, they may not be in a position to control whether safe sex is practiced or not. This social practice, therefore, may increase the risk of transmission of HIV, Hepatitis C and sexually transmitted infections.

The impact of childhood sexual abuse and male-to-male sexual violence was raised within the consultation as an issue for LGBT people within relationships and sexual activity. There was concern that patterns of sexual abuse and sexual violence are often normalised within communities and continue to impact upon the sexual practices and relationships of LGBT, especially for men having sex with men.

#### **6.4.5 The Effects of Social Isolation**

The social exclusion LGBT people often experience as a result of gender identity, sexuality and race, within Aboriginal and Torres Strait Islander communities and non-Indigenous communities, has been identified as increasing poor physical, psychological, emotional and spiritual health for

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<sup>57</sup> Lawrence, C. and Prestage, G. et al. (2005) op cit.

<sup>58</sup> *The National Indigenous Australians' Sexual Health Strategy 1996-97: A Report on the ANCARD Working Party on Indigenous Australians' Sexual Health* (March 1997) Commonwealth Department of Health and Family Services: Looking Glass Press.

<sup>59</sup> *Indigenous Australians'* (March 1997) op cit.

Aboriginal and Torres Strait Islander people.<sup>60</sup> Aboriginal and Torres Strait Islander people in general are disproportionately exposed to depression, alcoholism, homelessness, suicide and violence, in part related to the effects of colonisation. However, the effects of social displacement can be even greater for LGBTs and MSM.<sup>61</sup>

## **6.5 Mechanisms to Improve Access and Health Outcomes for Aboriginal and Torres Strait Islander LGBTs**

### **6.5.1 Attitudes Towards Sex Education and Sex**

The consultation stressed the importance of increasing sex education within Aboriginal and Torres Strait Islander communities. The shame associated with topics surrounding sex is considered a generational issue within communities. Younger generations need to be encouraged to talk openly about sex, sexual health, sexuality and sexual relationships to counter attitudes of shame related to these issues, enabling more open and respectful attitudes to develop with regard to these issues.

### **6.5.2 Cultural Awareness in Health Services**

A holistic approach to health promotion and service provision that incorporates Aboriginality and Torres Strait Islander culture was considered essential, to increase the health outcomes and the accessibility of health services for this population.<sup>62</sup> This included approaches to address gender identity, sexuality and sexual health issues within Aboriginal and Torres Strait communities. It was recommended that health care providers undertake cultural awareness training to gain an understanding of the communities, their culture and their laws, to be able to provide culturally appropriate health promotion and service provision.<sup>63</sup> Mechanisms to establish inductions for health care providers working within Aboriginal and Torres Strait Islander communities need to be in place to increase the trust and confidence of community members and increase the accessibility of services for the community itself.

### **6.5.3 Indigenous Health Care Workers**

The consultation considered that Indigenous health care workers need to be recognised as professionals. These workers play a pivotal role in liaising with and understanding the needs of the Aboriginal and Torres Strait Islander communities. The Indigenous health care workers have usually worked with the community the longest and have established trust and confidence within the community. However, it was felt that these workers are often ignored by other staff members within health services. Consultation participants considered that Indigenous health care workers should facilitate inductions for new health care providers. The purpose of this would be to introduce new workers into the community, to gain the trust and an understanding of the community's needs.

### **6.5.4 Indigenous Liaison Officers**

Consultation participants considered that the support of Indigenous Liaison Officers was extremely successful for assisting and increasing access to health services for Aboriginal and Torres Strait Islanders. Increasing the participation of Aboriginal and Torres Strait Islanders within health services was consistently noted as a mechanism that could assist access and improve health outcomes for Aboriginal and Torres Strait Islander LGBTs people.

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<sup>60</sup> *National AIDS Bulletin* (1999) *Sistergirls: Doin' it for themselves*, 12 (5):17

<sup>61</sup> Lawrence, C. and Prestage, G. et al. (2005) op cit.

<sup>62</sup> McLennan, V. and Khavarpour, F. (2004) op cit.

<sup>63</sup> McLennan, V. and Khavarpour, F. (2004) op cit.

## 7. Transgender People

This chapter highlights the barriers to improving health outcomes and access to services for transgender people. The first part of the chapter focuses upon concerns in relation gender dysphoria and transitioning, and the second part concentrates upon the barriers in relation to accessing services and addressing general health concerns for transgender people as well as gender identity issues.

### 7.1 The Impact of Gender Dysphoria and Transitioning on the Health and Wellbeing of Transgender People

#### 7.1.1 Transgender Identity Formation

The consultation findings largely supported research indicating that the lack of information, support and knowledge of gender dysphoria acutely increases the difficulties for transgender people to self-identify and address gender identity issues.<sup>64</sup> Transgender people typically know they have gender identity issues at a young age.<sup>65</sup> However, the predominant social belief that gender and sex are fixed identities leaves few social categories that acknowledge gender variation. As a result many transgender people do not recognise gender identity issues until a much later age.<sup>66</sup> These factors are considered to contribute to the initial phase of some transgender people identifying as lesbian or gay--not realising their difference relates to gender identity rather than sexuality.<sup>67</sup> The process of transgender identity formation is dominated by the experience of shifting identities of gender and sometimes sexuality, affecting an individual's self-perception, social relationships, mental, physical and emotion health.

#### 7.1.2 Transitioning – A Transgender Mental Health Concern

Consultation participants identified the period of transitioning to their desired gender as the most vulnerable stage of transgender mental health. Disclosure and non-disclosure of gender identity issues are considered to impact upon an individual's mental health, resulting in high levels of emotional stress, anxiety, and depression generally.<sup>68</sup> The pressure of internalising gender identity concerns for lengthy periods of time, in conjunction with the experience or fear of social stigma and discrimination, are considered to contribute to low self-esteem, self-loathing (related to negative body images), self-harm and suicidal tendencies within the transgender community.<sup>69</sup> Initiating the transition process often involves informing partners, parents, siblings, children, friends, health care professionals or employers of their transgender identity. During this period, it is considered critical that transgender people gain emotional support, are in contact with other people who are dealing with or have dealt with gender identity issues<sup>70</sup> and are able to engage in the performance of their desired gender identity, such as cross-dressing, in order to reduce negative impacts upon transgender mental health.<sup>71</sup>

#### 7.1.3 Passing in the Community

Passing in the community is the ability of transgender people to be identified as their desired gender--a woman or man--without being identified as a transgender person. It is recognised that the levels of discrimination and marginalisation of the transgender community in general is

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<sup>64</sup> McNair, R. and Harrison, J. (2002) *op cit.*

<sup>65</sup> Stuart K. (1991) *The Uninvited Dilemma: A Question of Gender*. Metamorphous Press: Portland: 38-50.

<sup>66</sup> Bockting, W., Rosser, S. and Coleman, E. (1999) Transgender HIV Prevention: Community involvement and empowerment. *International Journal of Transgender* (3) 1+2 at [http://www.symposion.com/ijt/hiv\\_risk/bockting.htm](http://www.symposion.com/ijt/hiv_risk/bockting.htm)

<sup>67</sup> Kammerer, N., Mason, T. and Connors, M. (1999) Transgender Health and Social Service needs in the Context of HIV Risk, *International Journal of Transgenderism* (3) 1+2 at [http://www.symposion.com/ijt/hiv\\_risk/kammerer.htm](http://www.symposion.com/ijt/hiv_risk/kammerer.htm); Stuart K. (1991), *op cit.*

<sup>68</sup> Nuttbrock, L. et al (2002) *op cit.*; Clements-Nolle, K., Marx, R., Guzman, R. and Katz, M. (2001) HIV Prevalence, risk behaviours, health care use and mental health status of transgender persons: Implications for Transgender persons. *American Journal of Public Health* 91: 915-921; Pauly, F. (1993) Gender identity disorders: Evaluation and Treatment, *Journal of Sex Education Therapy* 16: 2-24.

<sup>69</sup> Brown, R., et al (2002) *op cit.*; Kammerer N. et al (1999) *op cit.*

<sup>70</sup> Kammerer, N. et al (1999) *op cit.*

<sup>71</sup> Nuttbrock, L. et al (2002) *op cit.*

significantly greater than lesbian, gay and bisexual communities.<sup>72</sup> However the levels of discrimination for F-M (female-to-male men) and M-F (male-to-female women) transgender people can differ in relation to their ability to pass as their desired gender identity.<sup>73</sup> Consultation participants noted that many F-M men pass more effectively in the community than M-F transgender women. The effects of hormone therapy do not raise the voice or eliminate excess body hair for M-F women, whereas it will enable the voice of F-M's to lower and increases body hair.<sup>74</sup>

The ability to pass in the community also impacts upon the level of self-confidence and economic stability of transgender people. The ability to pass in the community can impact upon the ability for transgender people to gain and/or maintain employment due to the social stigma and the lack of acceptance of transgender people.<sup>75</sup> However participants also noted that the cost of being able to complete gender transitioning, including sex reassignment surgery, cost of psychiatrists and cosmetic adjustments, often presents a barrier for transgender people, especially M-F women, to pass successfully in the community.

#### **7.1.4 The Importance of Accessing Health Services**

Transgender people are reliant upon utilising health care and mental health professionals to facilitate a complete transition to the desired gender identity. Transgender people seeking sex reassignment surgery and/or hormonal therapy are compelled to disclose gender identity issues to health care providers in order to obtain referrals to psychiatrists. Only after the psychiatric assessment of gender dysphoria can physicians administer hormonal treatment to assist the gender identity transition of transgender people. The consultation identified tension within the transgender community about the reliance upon these professionals. Many of the mental health and health care professionals lack adequate training and understanding of gender identity issues. As a result, many consultation participants reported having negative experiences due to prejudice and ignorance of service providers, especially for those living outside Brisbane.

### **7.2 Barriers to Accessing Health Services for Transgender People**

#### **7.2.1 Self Confidence to Address Health Concerns**

The level of self-confidence surrounding gender identity issues significantly impacts upon the ability of transgender people to access health services and address health concerns. The expectation or experience of negative reactions, discrimination, lack of understanding and knowledge of gender identity issues, and intrusive questions by health care providers affected transgender people's willingness to access health services. Accessing services often involved educating service providers on transgender issues and coping with negative reactions from reception staff, health care providers or other clients.<sup>76</sup> Without the confidence and ability to confront such situations, it was considered that transgender people would avoid accessing health services altogether.

#### **7.2.2 Accessing Services for Sexual Health Concerns**

Research suggests that many transgender people will avoid accessing health services unless the issue is directly related to their gender identity.<sup>77</sup> The consultation noted the reluctance to address sexual health concerns with health care providers was connected to the general reluctance of transgender people to access health and health-related services. The experiences of limited knowledge of gender identity issues, acceptance of transgender people and inappropriate

<sup>72</sup>McNair, R., & Harrison, J. (2002) op cit; Bockting, W. et al (1999) op cit

<sup>73</sup> Kammerer, N. et al (1999) op cit.

<sup>74</sup> Griggs C. (1998) *S/he: Changing Sex and Changing Clothes*, Berg: Oxford in Kammerer, N., Mason, T. and Connors, M. (1999) Transgender Health and Social Service needs in the Context of HIV Risk, *International Journal of Transgenderism*, 3, 1 &2.

<sup>75</sup> Kammerer, N. et al (1999) op cit.

<sup>76</sup> The lack of knowledge of transgender issues by service providers and the occurrence of teaching professionals about transgender and intersex health concerns was also noted within the Transgender community in Victoria. McNair, R. and Medland, N. (2002) op cit.

<sup>77</sup> Kammerer, N. et al (1999) op cit.

questioning by health care providers were considered to prevent transgender people accessing appropriate services and information regarding safe sex and sexual health. The reluctance to access health services generally are likely to increase the risk of transmission of STI's, Hepatitis C and HIV for transgender people, especially M-F women.

### **7.2.3 Discrimination**

The threat or experience of discrimination from health care providers and staff in health services was identified as a barrier for transgender people accessing and addressing health concerns. Experiences of being refused service, verbal abuse, lack of acceptance or belief in gender dysphoria and general disrespect from health care providers were identified by transgender participants throughout Queensland. These experiences were identified in both regional and metropolitan areas in Queensland from hospital staff, sexual health clinic workers, general practitioners, counsellors, psychiatrists, receptionists, chemist staff and staff in government departments. This reinforced the general lack of confidence that transgender people would be treated with respect when accessing health and health-related services. Consistent complaints were made that service providers, whether reception staff or health care providers, failed to acknowledge their gender identity status. The experience of service providers continuing to address transgender women as men was common. Some consultation participants went so far as to say they would not access health services unless they knew that the service providers accepted and understood transgender issues.

### **7.2.4 Lack of Publicity**

The lack of information and advertising for health care providers and services that are informed and understand gender identity issues was considered to prevent many transgender people accessing services in relation to gender identity and general health concerns. Participants considered that the absence of a central point of contact to obtain information on gender dysphoria and referrals to health or health-related services that understand gender identity issues is a barrier to accessing services and improving transgender health outcomes. Most participants identified the Internet and "word of mouth" as the most useful source of information regarding transgender issues and what services were suitable and informed. However, participants also noted that services that are renowned for having knowledge in gender identity issues are difficult to access due to the long waiting lists, and these services not operating on a full time basis.

## **7.3 Barriers to Improving Transgender Health Outcomes**

### **7.3.1 Disclosing to Health Care Providers**

The consultation noted that health care providers are often one of the first people that transgender people disclose gender identity issues to. This process was considered extremely difficult, as gender identity issues have generally been kept a secret their whole lives. However, difficulties in discussing and disclosing these issues were considered to continue throughout the lifespan of transgender people. It was consistently noted that accessing new health care providers often involves relaying transgender histories or attempts to reassess the legitimacy of gender identity issues regardless of whether gender identity was relevant to the specific health enquiry, for example seeing a doctor about the flu.

The lack of knowledge, understanding and negative reactions from health care providers combined with experiences of personal embarrassment, fear of public exposure or breaches in confidence when accessing services, were considered barriers for transgender people to disclose gender identity issues to health care providers. However, the reluctance to disclose was also associated with the need for acceptance of their desired gender identity. Not wanting to disclose transgender histories was identified as an attempt to increase the acceptance and fulfilment of their desired gender identity within the community and their own lives.

### **7.3.2 Lack of Knowledge of Transgender Health Concerns**

The lack of knowledge of gender identity issues resulted in a lack of awareness that transgender people existed, the diversity within the transgender community and confusion between

transsexuals and transvestites. Many health care providers did not understand the difference between gender identity and sexuality. This often resulted in inappropriate questions regarding sexual practices, relationships, sexuality and a primary focus upon genitalia. Few health care providers addressed or understood the mental health effects related to gender identity issues. Many consultation participants considered they had to educate health care providers on transgender issues.

Concerns were also raised about the lack of knowledge health care providers have regarding hormone therapy, its effects and adequate dosage requirements. It was considered that health care providers were often contacting transgender organisations for advice on hormone therapy and general transgender issues. While it is recognised there is no agreed standard level of hormone therapy for transgender people,<sup>78</sup> consultation participants considered that hormone treatment was often over-prescribed to transgender people.

### **7.3.3 Mental Health Professionals**

Consultation participants considered that health care professionals rarely address or understand mental health concerns related to gender dysphoria. The lack of training opportunities and education for mental health professionals was considered to create a large barrier to improving the understanding of transgender mental health concerns and outcomes. The lack of awareness and understanding of gender identity issues was considered to result in mental health professionals over-emphasising sex and sexuality in relation to transgender clients, rather than gender identity and its associated social pressures. Participants again considered that mental health professionals, especially psychiatrists, often relied upon the knowledge of their clients to inform their understanding of gender identity issues.

Challenging the validity of clients' claims of gender dysphoria is standard practice for psychiatrists in identifying whether other mental health problems exist and if the client is ready to undertake transitioning. However, some participants considered this process increased their levels of depression and vulnerability during the transitioning process. Some participants stated they sought alternative psychiatrists because they were so offended. An F-M participant experienced a psychiatrist that considered claims of identifying as a male could not be valid or fulfilled unless they undertook phalloplasticity (construction of a penis), or they would not be able to transition into a "real man" and be left with no gender at all. The risks and failed success of phalloplasticity are well documented.<sup>79</sup> Participants considered that an F-M's choice to undertake this procedure should not invalidate claims of their male gender identity in the consideration of the health risks associated with the procedure.

### **7.3.4 Addressing Mental Health Concerns**

Consultation participants identified three phases that were considered to greatly affect stress and depression levels for transgender people. The first was the effect of internalising and not disclosing gender identity concerns, "*hiding yourself*." The second was the pressure and stress encountered when attempting to access support to address gender dysphoria. The third was not being able to disclose your transgender identity, the threat of having your transgender identity disclosed, "*being found out*," and the effects of coping with continuous discrimination.

Consultation participants attributed many of the mental health concerns that affect transgender people to the threat and experience of discrimination, violence, harassment and isolation. These statements reflect much of the recent research that indicates that transgender mental health is greatly affected by experiences of social stigma and discrimination.<sup>80</sup> Lower levels of mental health, especially depressive symptoms, have been strongly connected to the lack of support, validation and acceptance of gender identity by friends, family, partners and acquaintances.<sup>81</sup>

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<sup>78</sup> McNair, R. and Medland N. (2002) op cit.

<sup>79</sup> Rachlin, K. (1999) Factors Which Influence Individual's Decisions When Considering Female-To-Male Genital Reconstructive Surgery. *International Journal of Transgenderism* (3) 4 at <http://www.symposion.com/ijt/ijt990302.htm>

<sup>80</sup> Brown, R. et al (2002) op cit; Clements-Nolle, K. et al (2001) op cit; Nuttbrock, L. et al (2002) op cit.;

<sup>81</sup> Nuttbrock, L. et al (2002) op cit.;

The need for and access to social support for the wellbeing and empowerment of transgender people was a consistent theme within the consultation. It was repeatedly noted that addressing health concerns and improving health outcomes, whether related to gender identity, sexual health or general health concerns, is related to the self-confidence and ability of transgender people to feel comfortable disclosing transgender histories, gender identity issues and cope with high levels of discrimination and social stigma. It is recognised that social support and acceptance of people's gender identity is crucial to the improve mental health outcomes. However, participants considered that both mental health and health care professionals rarely referred clients to social support groups or were willing to address the mental health concerns relating to transgender issues. The lack of awareness, understanding and willingness to address the social pressures that affect transgender mental health or to refer transgender people (especially while transgender people are in the process of transitioning) to transgender support groups to address these issues, was considered one of the largest barriers to improving mental health outcomes.

## **7.4 Mechanisms to Improve Access to Health Services and Health Outcomes for Transgender People**

### **7.4.1 Holistic Approach to Transitioning and Transgender Health**

Consultation participants considered a holistic approach towards the health care needs of transgender people needs to be taken when addressing the health concerns for transgender people transitioning, incorporating mental health concerns related to affirming transgender identities. Current models of care, such as the Harry Benjamin Standards of Care,<sup>82</sup> have been criticised for focusing upon psychiatric and surgical perspectives of transgender health and not encompassing a more holistic and social approach for the health and wellbeing of transgender people.<sup>83</sup>

### **7.4.2 Guidelines for Individual Medical Practitioners**

Consultation participants recommended that guidelines addressing patient care be established for individual medical practitioners addressing gender identity issues. The purpose of the guidelines aimed to address basic client consultation procedures. Information regarding relevant information, questioning techniques, identifying the difference between sexuality and gender identity and the mental health issues relating to gender identity would need to be included in such guidelines. This suggestion was considered to focus upon client care of transgender people in general and during the initial transitioning process.

### **7.4.3 The Inclusion of Transgender Categories on Medical Forms**

The ability for transgender people to identify their transgender status on medical forms was considered a mechanism that would assist transgender people to address health concerns. This was considered important to save transgender people having to explain their gender identity status to reception staff but also to prevent irrelevant gender specific health information being given to transgender people. Such examples were given as F-M men being sent information on prostate checks from their regular medical centres or M-F women not being given information on breast cancer.

### **7.4.4 Sexual Health**

Consultation participants considered that awareness of sexual health, safe sex and gender specific health concerns need to be raised with transgender people when they are transitioning. This concern was raised especially in regard to M-F health considering transitioning may occur later in life, after long-term relationships, and that people may lack basic knowledge of safe sex practices and not do consider safe sex information as relevant to them.

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<sup>82</sup> *Standards of Care for gender identity disorder*, 6<sup>th</sup> ed. (2000) The Harry Benjamin International Gender Dysphoria Association, USA.

<sup>83</sup> McNair, R. and Medland N. (2002) op cit.

## 8. LGBT People with Culturally And Linguistically Diverse Backgrounds (CALD).

The project attempted to hold a consultation workshop for service providers working with people from Culturally And Linguistically Diverse (CALD) backgrounds in Southeast Queensland. The consultation sought to address sexuality and gender identity issues within these communities. However few services attended resulting in a more informal discussion around these issues. The project encountered difficulties obtaining community participation from both service providers and LGBT CALD community members and recognises that further research is needed to identify LGBT CALD issues.

### 8.1 Identifying as Lesbian, Gay, Bisexual and Transgender in CALD communities

LGBT people from CALD communities were considered to be reluctant to disclose sexuality and gender identity issues to service providers and family or openly identify as LGBT. Although it was noted that in some cultures same-sex attraction is quite accepted the majority of CALD members of the LGBT community face cultural pressures to marry and respect the expectations of their family. These pressures inhibited their ability to identify openly as LGBT and address concerns relating to sexuality, gender identity and sexual health. There has been little research of this population group within Australia. However, a study into gay Vietnamese men in Sydney also noted the importance of family and cultural identity, resulting in pressure for these men to marry.<sup>84</sup>

SSAY in CALD communities have also been reported to be less likely to disclose their sexuality to parents, receive safe sex information from parents or feel safe at home in comparison to Anglo-SSAY.<sup>85</sup> However, there was no difference in the overall health affects related to sexuality compared to the general SSAY population. As a result, it was considered that the lack of disclosure may be a mechanism used to maintain positive relationships with parents, family and cultural identity. The lack of disclosure for LGBT people within this community should not be viewed as entirely negative.

#### 8.1.1 Health Promotion Strategies for CALD LGBT people

The consultation held an informal discussion focusing on what mechanisms may be appropriate to raise awareness and interest in sexuality and gender identity issues for people within the CALD community. The lack of acceptance and disclosure of LGBT issues within the CALD community was considered similar to the situation of MSM. It was identified that sexual health promotion strategies similar to those used to address the health concerns for MSM need to be considered for LGBT people within CALD communities. Recommended sexual health promotion strategies for MSM emphasise the distribution of same-sex sexual health and sexuality information through mainstream services and in mainstream resources (that are not focused upon the LGBT community).<sup>86</sup> Such resources need to be able to be accessed confidentially and presented in a manner that does not identify people as being LGBT.

### 8.2 Recommendations for Education within the CALD Community

Participants considered that education within the CALD communities generally needed to be undertaken to address the stigma and prejudice relating to LGBT issues. A “*Social Rights and Responsibilities*” campaign was suggested to address gender identity and sexuality issues through a general campaign relating to people’s rights in regard to discrimination in Australia. Such a campaign could incorporate people’s rights in regard to racial discrimination, sex discrimination, sexual, family and domestic violence and finally sexuality and gender identity. Consultation

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<sup>84</sup> McMahon, T. (1996) “Passive men are more sissy you know: Experiences of sexuality for men of Vietnamese background living in Sydney who have sex with men”. In Leonarde W. (2002) “The Introductory Paper: Developing a Framework for understanding the health and illness specific to gay, lesbian, bisexual and transgender people.” In MACGLH. *What’s the Difference? Health issues of major concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians*. Department of Human Services: Victoria: 3-13.

<sup>85</sup> Hillier, L. et al (2005) op cit.

<sup>86</sup> *Rural, Remote and socially-isolated* (2004) op cit.

participants considered that attempting to address sexuality and gender identity issues in isolation would not be successful due to existing attitudes of CALD community members, CALD service providers and the invisibility of CALD LGBT people within the community.

## **9. Action Areas Identified to Improve Health Outcomes and Access to Health Services**

The following recommendations are in addition to the specific mechanisms that have been identified in the previous chapters. The identified action areas in this chapter are a summary of the recommendations made in each consultation throughout the project.

### **9.1 Advocating for LGBT Education and Training for Health Care Providers**

Programs and policies need to be implemented to introduce gender identity, sexuality and HIV/AIDS education within medical, nursing, counselling, psychology, social work and medical reception staff courses. Each consultation considered that people entering the health and community sectors should receive gender identity and sexuality education before entering the workforce. This was identified as an essential element for improving the accessibility and health outcomes for the LGBT community.

Recommendations were made to establish LGBT reference groups within the medical, psychology and psychiatry faculties to appropriately address LGBT issues within the course curricula. The consultation also identified the need to incorporate sexuality and gender identity training within already existing training requirements of health care workers such as continuing professional education/training programs for nurses, general practitioners, hospital staff and mental health workers.

Due to the complexity of gender identity and gender dysphoria issues both the general community and transgender consultation considered a specific training program needed to be developed to address these issues with mental health and health care providers. The Indigenous consultation also stressed that before Aboriginal and Torres Strait Islander LGBT health outcomes and access to services could be increased, health care workers, especially those working directly in Aboriginal and Torres Strait Islander communities, need to undertake culturally appropriate training with regard to the influence and impact that traditional laws have upon issues relating to sexual health for men and women.

### **9.2 Further Gender Identity and Sexuality Training for Health and Community Services**

Policy needs to be established to ensure that gender identity and sexuality training is provided to domestic violence, sexual assault, aged care and youth support services. Concerns were raised that services tend to rely on key people to address gender and sexuality issues rather than training workers in services as a whole.

### **9.3 Specific and General Sexual Health Resources Including Information for the LGBT Community**

The consultations identified the need for specific LGBT resources relating to general health risks, sexual health and safe sex practices to be produced and accessible through mainstream services and within the LGBT community. The consultations identified a lack of knowledge regarding LGBT health concerns within the LGBT community and from service providers.

The incorporation of safe sex information relevant to same sex couples within general sexual health information was also regarded as a priority. It was considered that information needed to focus upon sexual practices rather than sexual identity within these resources. Participants, especially within the youth consultation, noted the predominance of safe sex information focusing upon heterosexual practices. This made it difficult for same sex couples to assess the risk of transmission of STIs and how to ensure safe sex practices are maintained. This is especially relevant in regard to the reluctance of the lesbian community to access or use dental dams during sexual intercourse.

### **9.4 School-Based Nurses**

The implementation of training, resources and guidelines for school-based nurses addressing sexuality, gender identity and same sex sexual health concerns for LGBT young people in

Queensland high schools was recommended by the consultation. School-based nurses are a confidential service, unlike school guidance counsellors, and could be accessed as a point of contact for youth questioning their sexuality, gender identity or facing homophobia or transphobia from other students. Consultation participants considered the school-based nurses program as a potential mechanism to provide accessible and visible resources and referrals to appropriate services for young people.

### **9.5 Sex Education in Schools**

The Queensland Education Department, with support from Queensland Health, needs to implement policy requiring mandatory sex education that includes sexual diversity within school curricula. Participants recommended that the Queensland Education Department adopt a similar approach to the New South Wales Education Department to address homophobia in the context of programs focused upon bullying in high schools. The consultations considered that without the systemic support of Queensland Education policy, the efforts to educate high school students on sexuality, gender identity, homophobia and transphobia issues would continue to be time consuming and strongly reliant upon attitudes of individual school communities.

### **9.6 Social Responsibilities Campaign for Culturally and Linguistically Diverse Communities and Service Providers**

Developing mechanisms to implement a social rights campaign to address sexuality, gender identity and sexual health issues within CALD communities was recommended by the consultation. Health promotion strategies need to be in place to encourage an awareness of these issues within relevant services and the community, taking into consideration the limited amount of disclosure of these issues within CALD communities. Further research needs to be undertaken in this area.

### **9.7 Hospital LGBT Liaison Staff**

The introduction of LGBT liaison staff in hospitals was recommended to address specific concerns and complaints in relation to patients' gender identity, sexuality, HIV status and concerns relating to client confidentiality. This staff member would be able to mediate between staff members and clients when necessary, addressing experiences of homophobia from patients and staff, the lack of confidentiality between hospital staff especially in relation to transgender patients and HIV phobia from hospital staff.

The Indigenous consultation considered that introducing more Indigenous liaison officers would increase the access and health outcomes for Aboriginal and Torres Strait Islanders. However, it was also considered that liaison staff need training in LGBT and Sistergirls issues in order to benefit the LGBTS Aboriginal and Torres Strait Islander population.

### **9.8 Hospital Procedures for PLWHA and PEP**

Hospitals were repeatedly identified as a sight of regular discrimination and ignorance regarding HIV and the treatment of PLWHA. The experience of consultation participants considered that the Queensland Health guidelines for universal care, safety and best practice for PLWHA need to be adopted by all Queensland Health services to prevent unnecessary discrimination on the basis of HIV status, especially for surgical procedures. Queensland Health also needs to continue to publicise the availability and existence of PEP to hospital staff and private medical practitioners.

### **9.9 Queensland Health Establish Diversity Campaigns within the Health Sector**

The recognition of diversity within the general community and the impact of social pressures upon the health and wellbeing of LGBT people need to be facilitated by Queensland Health. Campaigns within the health sector need to focus upon diversity within the community. The aim of such campaigns is to reduce discrimination, stigma and raise awareness of sexuality, gender identity and social pressures affecting the health and wellbeing of LGBT people. The purpose is to assist reducing levels of homophobia/transphobia within the community and health services, and increasing the awareness of the effects of homophobia/transphobia and stigma on the health and wellbeing of LGBT community. This was thought likely to encourage inclusive environments within services for LGBT people, assisting and encouraging LGBT people to feel comfortable and safe to

disclose their sexuality, gender identity and discuss personal relationships in a safe and comfortable environment. The success of such campaigns and the distribution of accompanying resources was considered to be reliant upon its coverage of Queensland Health services, non-government organisations and in private practices.

### **9.10 LGBT Health Campaigns**

The emphasis upon having LGBT health campaigns within mainstream media was identified to address the proportion of LGBT people who do not identify with LGBT community or culture, do not access the LGBT press or are not able to access LGBT press due to their geographical location or closeted status within the community. This concern was emphasised within regional areas in Queensland where levels of homophobia are generally higher and more people remain closeted, often resulting in their inability to access LGBT publications.

### **9.11 Encouraging the Recognition of Diversity within Health Services**

The consultation considered health services need to be encouraged to adopt mission statements and guidelines that acknowledge the diversity of cliental, including the impact of gender identity and sexuality on the general health and wellbeing of clients. This proposal was considered in conjunction with the need for health care and health-related services to provide visible LGBT health promotion materials and health resources that clients can also access in confidence. This would include having visible LGBT posters in services was considered to be a mechanism that could indicate that the service is inclusive and accepting of LGBT issues, and could be used to assist breaking down the barriers for disclosing their sexuality or gender identity. Examples of such materials have already been produced by Gay and Lesbian Health Victoria.

### **9.12 LGBT Health Advocacy within the Community**

A peak LGBT Health Body was suggested to raise public awareness of LGBT issues in Queensland, liaise with government bodies and advocate on behalf of the LGBT community. Regional LGBT Community Development Officers were also identified as a mechanism to enhance general community support for LGBT issues, LGBT people and the development of local programs to accommodate the needs of the LGBT community in Queensland. Many participants considered that the LGBT community needed a central point of contact, such as an LGBT community space, where resources, medical and social support referrals could be distributed.

Each consultation recommended the establishment of an LGBT interagency body within each region as a mechanism to increase communication and coordination between services addressing LGBT needs. This would also serve as a means to identify the local needs and issues within LGBT communities throughout the state. The example of the Victorian Government's Department of Human Services' *Ministerial Advisory Committee on Gay and Lesbian Health Victoria* was also suggested as a means to address LGBT issues within Queensland State Government policy and to increase the inclusion of LGBT issues within the development of relevant State Government programs.

### **9.13 Discrimination and Rights for LGBT People in Queensland**

The consultation considered that the LGBT community was generally not aware of their rights in regard to discrimination on the basis of sexuality, gender identity and HIV status. The consultation consistently identified that awareness and education within the LGBT community needed to be increased in relation to Anti-Discrimination provisions generally and especially in the context of services provision.

### **9.13 Queensland Police Service**

The consultation identified the need for the Queensland Police Service to incorporate policy and programs to establish mandatory gender identity and sexuality training within the Queensland Police Academy. There was a general consensus that the majority of police do not understand gender identity and sexuality issues. The inclusion of same sex domestic violence issues also needs to be incorporated within the general domestic violence training for the Queensland Police Service.

Regular gender identity and sexuality training needs to be undertaken by LGBT Police Liaison officers to increase the understanding of the LGBT community and issues relevant to their role. The establishment of a statewide telephone line or point of contact needs to be established within the Queensland Police Service to refer people to the current Police Liaison Officer in the local area. Mechanisms also need to be established to monitor and evaluate the role of the Liaison Officers and the concerns that they are addressing within the LGBT community.

#### **9.14 Queensland Health Policy Implementation**

The implementation of Queensland Health policy was considered a necessary mechanism to implement and ensure that training in sexuality and gender identity issues is mandatory for all Queensland Health staff working in sexual health. This policy needs to be accompanied with procedures and disciplinary action guidelines to address discrimination on the basis of sexuality and gender identity and confidentiality breaches within Queensland Health services.

Queensland Health has to be instrumental to ensure that health services recognise that they have a duty of care to ensure that service environments and service provision encourages disclosure of sexuality and gender identity, being able to provide appropriate and informed service to LGBT clients. This requires increased awareness within the health sector of the lowered standard of care and health outcomes that are caused by the result of not disclosing sexuality and gender identity issues to health and health-related services. Consultation participants considered that the recognition of LGBT issues and providing inclusive environments for LGBT clients could be facilitated by the inclusion of LGBT people as a target group within the Purchasing Unit within Queensland Health funded organisations.

Queensland Health needs to ensure that its relevant policies recognise that sexuality and gender identity are general health concerns that affect the health and wellbeing of individuals. The discrimination and stigma associated with sexuality and gender identity needs to be identified as a general community concern that affects the health outcomes of the LGBT community.

Queensland Health needs to focus upon delivering general health promotional campaigns within the LGBT press to encourage better health outcomes for the LGBT community.

Further research needs to be undertaken to address the gaps in Queensland Health Policy that do not address or identify the needs of the LGBT community and the impact of sexuality and gender identity upon health outcomes.

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