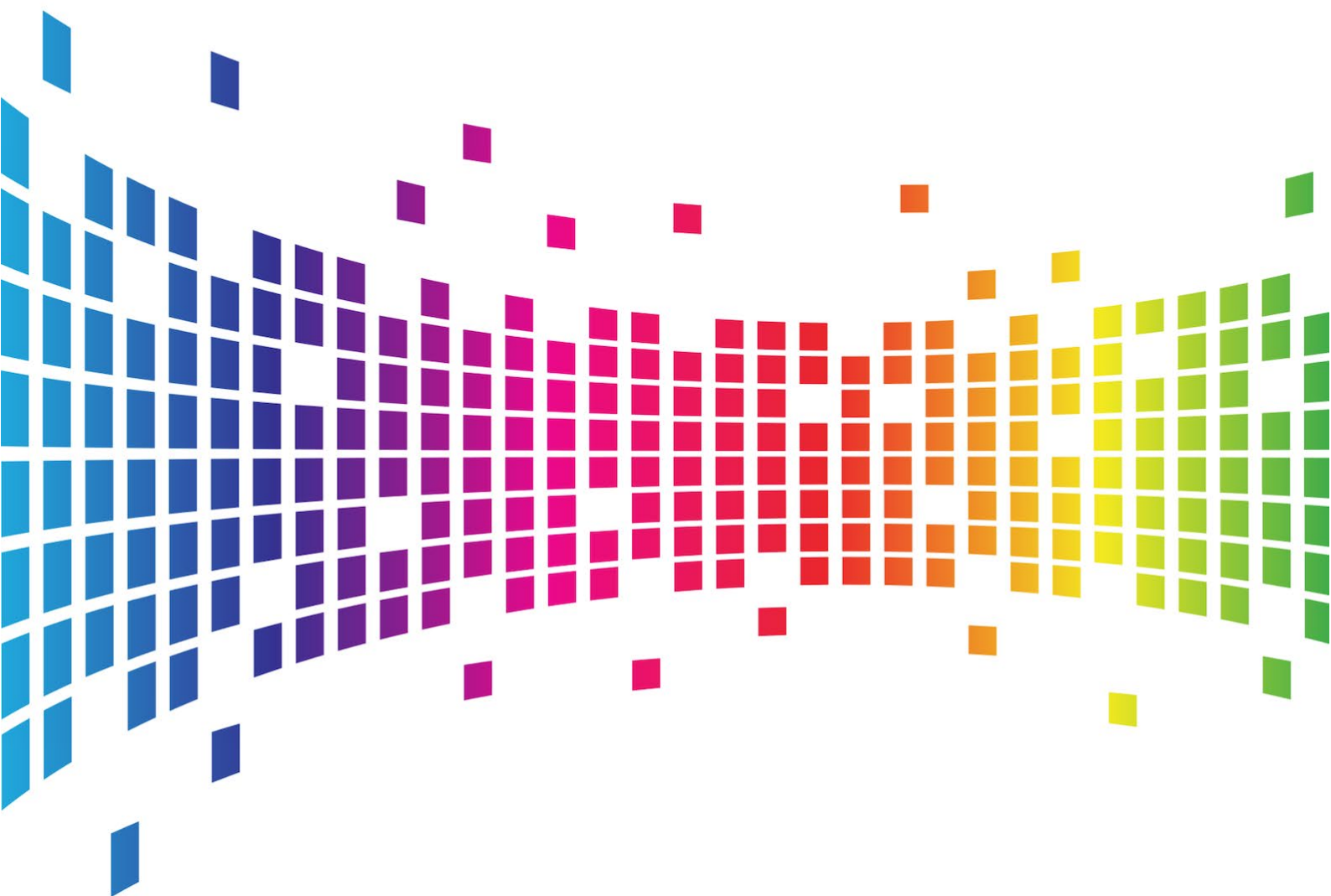




UNDERSTANDING LGBTI+ LIVES IN CRISIS

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Australian Research Centre in Sex, Health & Society
Lifeline Research Foundation

February 2019

Suggested Citation:

Waling, A., Lim, G., Dhalla, S., Lyons, A., & Bourne, A. (2019). *Understanding LGBTI+ Lives in Crisis*. Bundoora, VIC & Canberra, ACT: Australian Research Centre in Sex, Health and Society, La Trobe University & Lifeline Australia. Monograph 112.

Copies of this monograph can be obtained by contacting:

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MONOGRAPH SERIES 112

Understanding LGBTI+ Lives in Crisis

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February 2019

This report is based on research funded by the **Lifeline Research Foundation** seeking to provide better crisis counselling to LGBTI+ people. The research was conducted with ethics approval from the La Trobe University Human Ethics Committee and additional institutional and community ethics committees where appropriate.

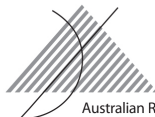
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About

About the Authors

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Daniel Mainville – Director Lifeline Gippsland

About the Reference Group

QLife (1800 184 527) is Australia's first nationally-oriented counselling and referral service for people who are lesbian, gay, bisexual, trans, and/or intersex (LGBTI+). **QLife** provides nation-wide, early intervention, peer supported telephone and web based services to people of all ages across the full breadth of people's bodies, genders, relationships, sexualities, and lived experiences. For more information, visit [www.qlife.org.au](http://www qlife.org.au).

ACON is a New South Wales based health promotion organisation specialising in HIV prevention, HIV support and lesbian, gay, bisexual, transgender and intersex (LGBTI+) health. Established in 1985, it aims to end HIV transmission among gay and homosexually active men, and promote the lifelong health of LGBTI+ people and people with HIV. For more information, visit www.acon.org.au.

About Lifeline Australia

Lifeline (13 11 14) is a national charity and leading provider of services for suicide prevention in Australia, providing all Australians experiencing a personal crisis with access to 24 hour crisis support and suicide prevention services. This service answers around 2500 calls each day. Lifeline's services are now made possible through the efforts of around 1,000 staff and 11,000 volunteers, operating from over 38 sites nationwide. In 2018 82% of the 893,128 total calls were answered from people struggling to cope with issues including suicide, loneliness, mental health, relationship difficulties, and financial stress. For more information, visit www.lifeline.org.au.

About ARCSHS

The Australian Research Centre in Sex, Health and Society (ARCSHS) located at La Trobe University in Melbourne, Australia, is a centre for social research into sexuality, health and the social dimensions of human relationships. It works collaboratively and in partnership with communities, community-based organisations, government and professionals in relevant fields to produce research that advances knowledge and promotes positive change in policy, practice and people's lives. For more information, visit www.latrobe.edu.au/ARCSHS.

About the Terms We Use

This report uses a number of terms that may not be familiar to some readers. **Glossary of LGBTI+ Terms** and **Glossary of Crisis Service Support Terms** has been provided at the end of this report. The **Glossary of LGBTI+ Terms** has been developed and approved by **Gay and Lesbian Health Victoria** in 2016, with consultation with the **Rainbow Tick Advisory Group** with updates where needed.

Executive Summary

In partnership with **Lifeline Australia**, and with support from **QLife** and **ACON**, this research report presents findings of lesbian (L), gay (G), bisexual (B), transgender (T), intersex people (I), and other sexual identity and gender diverse individuals (+) use of crisis support services (CSS) in Australia. This is the first research of its kind in Australia that explores the needs of LGBTI+ people during a time of personal or mental health crises. It focuses on their uptake and familiarity with crisis support services in Australia, their perceptions and experiences with crisis support services, and where they might seek other professional mental health service support during a time of crisis. This study enhances the evidence base for those working to design, resource or deliver services to meet the needs of LGBTI people in Australia during times of crisis.

Background

A significant and robust body of research has established that LGBTI+ people have higher rates of suicidal ideation, self-harm, and poorer mental health compared to heterosexual and cisgender populations.¹ Such rates can be attributed to the systemic, institutionalised and everyday experiences of discrimination, harassment and violence that LGBTI+ people often experience.² However, very little is known about where and whom LGBTI+ people turn to during a time of personal or mental health crises, and why they might choose to access certain pathways over others. Additionally, little is known as to what LGBTI+ people need in crisis support services during a time of personal or mental health crisis.

Approach

This mixed methods study included a survey with **472 participants**, comprised of closed and open-ended questions, and **10 follow-up** interviews. LGBTI+ health organisations and social networks, Facebook, and other social networking sites were used to recruit research participants. The study provides a detailed account of these LGBTI+ peoples' experiences and needs relating to personal and mental health crises, and crisis support services.

Key Findings

The results of this study highlight that over **71% of participants chose not to use a CSS during their most recent personal or mental health crises**. Key barriers to accessing a CSS as well as counselling and mental health support services included **anticipation of discrimination**, **'I don't want to be a burden' narratives**, **lack of awareness** of mainstream CSSs and LGBTI+ specialist counselling and mental health support services, and **physical access**, **technological**, and **financial barriers** to access crisis support services. Participants noted seeking other forms of support, including accessing medical professionals such as general practitioners and therapists, family and friends, and self-coping methods including mindfulness strategies and self-harm.

Recommendations

The results of this study lead us to make a number of recommendations to help mainstream crisis support and mental health support services engage positively with the LGBTI+ community, and to address the barriers that LGBTI+ Australians have identified in accessing crisis support services. These include *LGBTI+ cultural competence and safety training, promotion and awareness, addressing intersecting needs*, and target areas for further research.

UNDERSTANDING LGBTI+ Lives in Crisis



71%

of participants did not reach out to a crisis support service in a time of need

A summary of key findings



39%

of participants cited lifeline as a recognised crisis support service



68%

of participants could name anywhere from 1-5 crisis support services

Participants



35.5% of our participants identify as either Bisexual or Pansexual, 23% Lesbian, 20% Gay, and 3% Asexual

12% of all participants identify as transgender, and 8% Genderqueer, 3% Agender, and 10% Non-binary



77% of participants were Caucasian-Australian, 4% Aboriginal and/or Torres Strait Islanders, and 7% were mixed-race

Participants from across all states were recruited; majority hailed from VIC, NSW, SA, QLD or WA

Barriers to Crisis Support, Mental Health Service uptake



Anticipation, and experiences of discrimination



Lack of awareness of mainstream services



Various technological, physical, religious and cultural barriers

"I don't want to be a burden" narratives



Preference for LGBTI+ inclusive counselling and mental health support services



Background

While LGBTI+ individuals make up approximately 5-10% of the Australian population,³ they have significantly higher rates of suicidal ideation and poorer mental health.⁴⁻⁷ Contributing social factors include experiences of discrimination, harassment and violence, and ongoing social exclusion.⁵ LGBTI+ individuals face ongoing discrimination in a number of settings, including schools, workplaces, and in the general community. This impacts individuals in many ways, and research shows that they are at a higher risk of experiencing mental health, and/or personal crises.⁶ The Australian marriage postal survey of 2017 saw both mainstream and LGBTI+-specific crisis support services experience an increase in LGBTI+ people accessing their services.⁷

A crisis is often thought of as being caused by a negative event; however, it can also be the result of persisting, or underlying factors. LGBTI+ individuals face ongoing discrimination, and the accumulation of stressors relating to experiences of discrimination can lead to experiences of crises.⁸ Higher rates of self-harm, anxiety, depression, and non-prescribed substance use have also been observed amongst these groups.⁹ Australian research also suggests that LGBTI+ individuals report higher levels of psychological distress, but have fewer resources for coping with mental health crises than their non-LGBTI+ counterparts.¹⁰ Discrimination also affects this group's health in more direct ways, and LGBTI+ individuals commonly face discrimination from care providers and professionals.¹¹ As such, they often delay seeking care - both expecting, and fearing discrimination regarding their sexuality and/or gender identity.¹²

In spite of this, we know little about where LGBTI+ people seek crisis support and/or mental health support - much less why certain services are preferred over others. Therefore, in collaboration with **Lifeline Australia**, and with community support from **QLife** and **ACON**, this project investigated the needs of LGBTI+ Australians regarding access to, and use of, crisis support services (CSS). Our ultimate goal is to increase professional service uptake by LGBTI+ persons during times of personal and/or mental health crises.

In 2017, Australia conducted a nationwide postal plebiscite to gauge public opinion on the same-sex marriage debate. Prior to this, same-sex couples in Australia were able to enter civil partnerships in some states, but were not allowed to marry. Results of the plebiscite returned 61.6% "Yes" responses, and 38.4% "No" responses. This subsequently led to the consideration of a same-sex marriage bill in parliament, which was then passed into law.

The postal plebiscite sparked heated debate and extensive publicity efforts, where anti-LGBTI+ sentiments were openly aired. During the survey, crisis support services, helplines, as well as phone-/web-counselling services experienced a surge in demand for their services from LGBTI+ Australians, with certain services experiencing up to a 40% increase in users during this time. Resultantly, state governments in Western Australia, Queensland and Victoria were required to allocate additional funding to these services to meet this surge in demand.

Project Aims

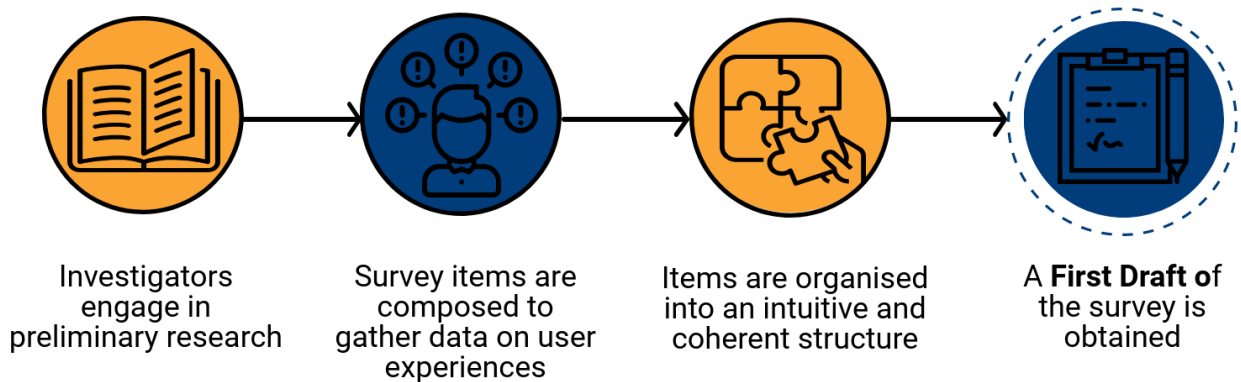
The broad aim of this project was to develop an understanding of the needs that LGBTI+ individuals have in relation to crisis support as well as the challenges they face in seeking crisis support.

Our specific aims were:

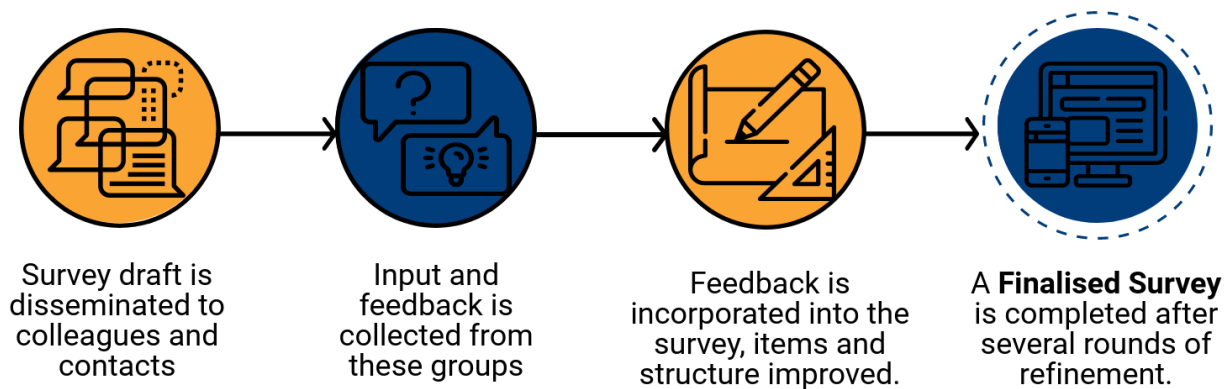
1. To explore how LGBTI+ persons manage mental health, and/or personal crises. Specifically, how support services and support systems play a role in this process;
2. To understand the perceptions, and experiences of challenges preventing LGBTI+ individuals' from accessing crisis support, and/or mental health support services;
3. To understand how LGBTI+ persons cope during a time of personal or mental health crisis, and the steps they may take in seeking support outside of a crisis support service; and
4. To use these insights to make recommendations to crisis support services like **Lifeline Australia**, in the interest of increasing uptake and improving service quality.

Survey Design

Stage 1: Survey development



Stage 2: Refinement



Stage 3: Distribution & Data Collection

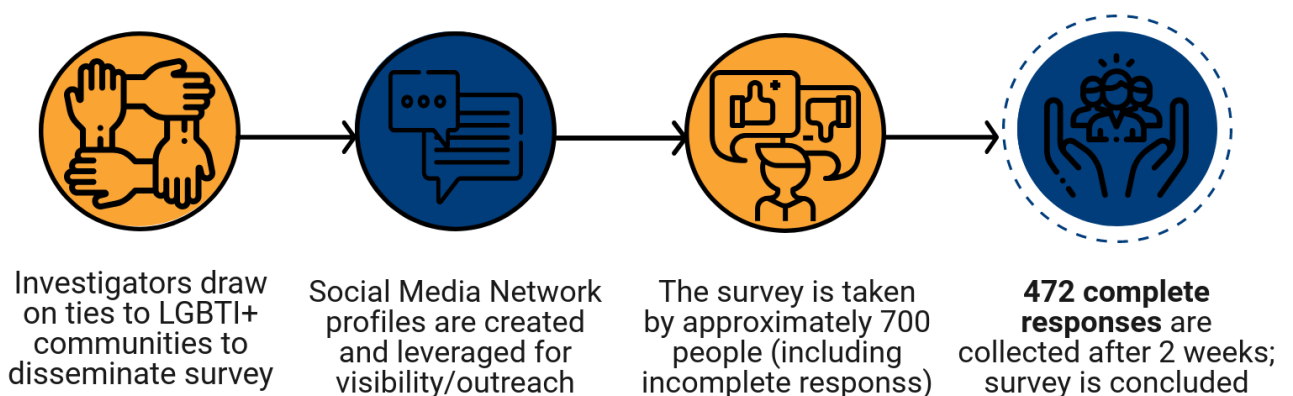


Figure 2: At A Glance Survey Demographics

Methods

To address why members of the LGBTI+ community may use, or not use, certain services in times of crisis, this project utilised the format of a qualitative community-level needs assessment; a systematic process used to determine and address gaps or needs between current and desired conditions within a particular community.¹³

Ethical Considerations

Ethics approval was obtained from the La Trobe Human Research Ethics committee (**Human Ethics ID: HECS18159**), as well as from the equivalent bodies in both the **AIDS Council of New South Wales (ACON RERC Ethics: 2018/15)** and **Thorne Harbour Health** (formerly the Victoria AIDS Council; **Ethics ID: THH/CREP18/001**). Participants had the right to opt out of the survey or interview at any point – without prejudice, and were provided with a list of crisis support services they could utilise, if required.

Sampling

The sample for both the survey and interviews was a convenience sample – it may not represent all the experiences of the LGBTI+ population but does still highlight a diverse range of experiences in this population.

Survey

This project had two parts. The first, an online survey with a mixture of open and closed questions.

Survey Development

Referencing previous research conducted with Crisis Counselling Support (CSS) services, we developed a variety of items that would allow us to examine a participant's experiences relating to crisis support services from multiple points of view. This included both open-ended and multiple-choice questions, across multiple time-periods. These items were then organised in an intuitive order and compiled into a draft version on the survey engine, Qualtrics™.

This draft was shared with the reference group members **QLife and ACON**, and experts within ARCSHS for feedback. This was then collated, evaluated amongst the investigators, and suggestions were incorporated where appropriate. Changes made to our initial survey include: adopting more inclusive and easily-understood word choices, changes to specific items, and improvements to survey layout and user experience. Most notably, later versions of the survey directly explored participants' experiences as LGBTI+ individuals with CSS services. We incorporated items that examined participants' perceptions, and experiences of approaching crisis support workers with LGBTI+-specific problems (i.e., homophobia, coming out, etc.). The finalised version comprised 87 items and took 23 minutes on average to complete.

Recruitment and Data Collection

Various LGBTI+ community organisations were approached, and subsequently enlisted, for assistance to disseminate the survey to their members. Concurrently, paid advertisements were put

up on numerous Social Networking Sites (SNS), and a social media presence was maintained by an investigator on behalf of the project, to answer general queries and to raise awareness of the project. This was done in an effort to recruit a diverse range of participants. Regardless of recruitment method, participants accessed the survey through a provided hyperlink – which redirected them to the site where the survey was hosted. A total of 472 participants completed the survey during the month of July 2018. We concluded survey data collection after 2 weeks, having surpassed our initial goal of 100 valid responses. Survey participants were not required to respond to every question, and could only provide responses to as many, or as few questions. The statistics presented in this report are based on the total number of completed responses.

Interviews

The second phase of this study involved semi-structured, qualitative interviews.

Recruitment

At the end of the survey, participants were given the option of expressing their interest in participating in in-depth interviews. Survey participants were under no obligation to do so, and potential interviewees were redirected to a separate online form, where their contact details were recorded. Potential interviewees were contacted via e-mail; care was taken to ensure demographic diversity. This process continued until we had recruited 10 interviewees. Interviews were conducted between August and September 2018.

Interview Schedule

Interview schedule items were brainstormed among the project's investigators, and were guided both by contemporary research, as well as emerging findings from the survey. These items were then further refined and developed as each interview was conducted, utilising the feedback from the various interviewers. Interview items related to a wide variety of themes; including, but not limited to: experiences of personal crisis, CSS use, life histories, mental health, and interpersonal relationships. The interview schedule was also reviewed by **Lifeline** and the reference group members from **QLife** and **ACON**.

Interviews

10 in-depth, semi-structured interviews were conducted by two project investigators. These spanned anywhere from 30 to 90 minutes and were conducted either using voice-over-IP software (i.e., Zoom), or over the phone.

Data Collection and Analysis

These interviews were recorded and transcribed verbatim. These transcripts were collated into a case file using Nvivo 12™. The project investigators first reviewed and coded each transcript independently, and then collaboratively - discussing, refining, and finally amalgamating our insights and analyses. After several rounds of this process, these codes were streamlined into broader, parent codes. Connections and interfaces between these themes were inferred, which subsequently informed the broad themes that are the basis of the discussions section. Quotations from both interviews and open ended survey questions used in this report may have been edited for clarity. Participants names used throughout are pseudonyms.

Survey Participant Demographics

Total participant count = 472

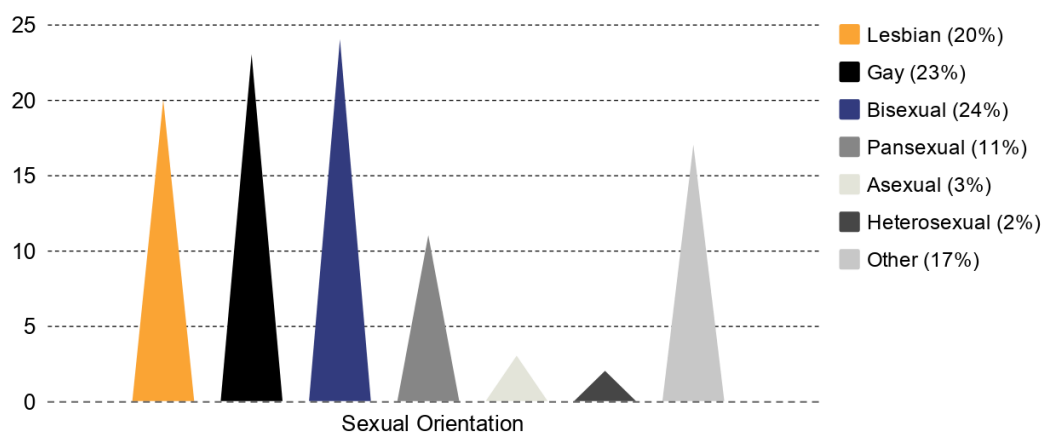
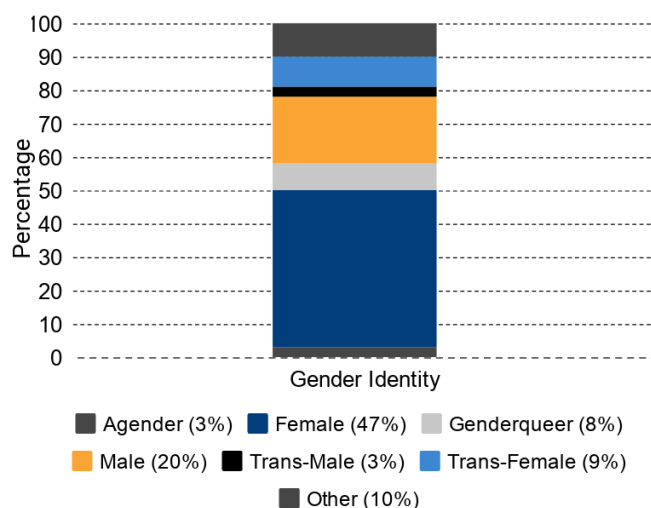
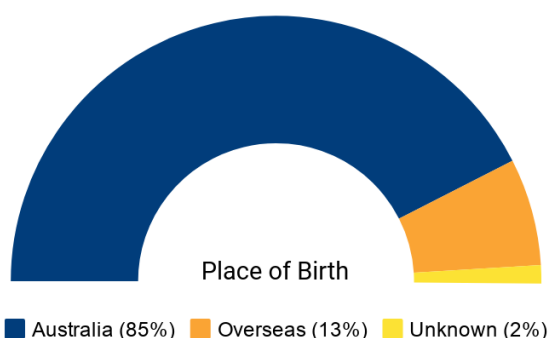
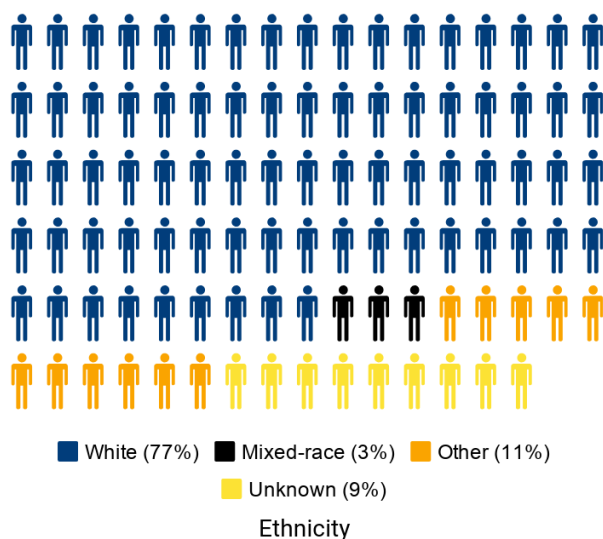
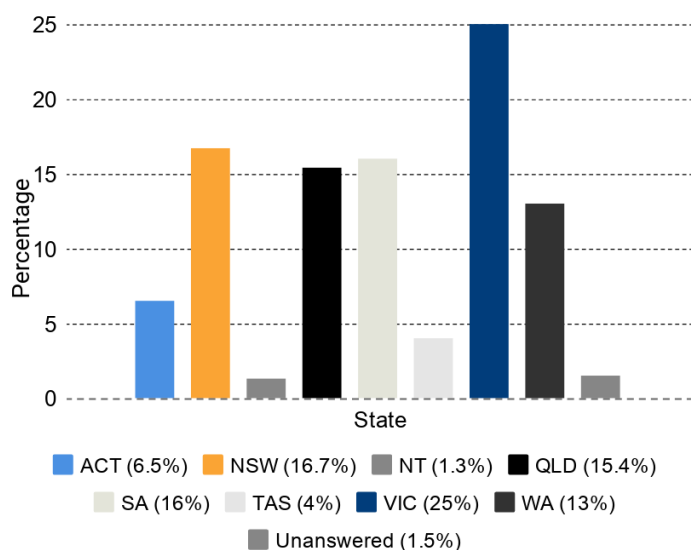


Figure 3: At A Glance Interview Demographics

Survey Participant Demographics

Age, Ethnicity and Place of Birth

The mean participant age was 27.7 years. The majority of participants identified as White (***n*=363, 77%**) and Australian-born (***n*=401, 85%**). LGBTI+ Aboriginal and Torres Strait Islanders comprised **3.9% (*n*=18)** of overall survey participants (***n*=18, 3.9%**). These demographic characteristics should be taken into consideration when interpreting our findings. Since our sample was predominantly White-Australians, the resulting findings and discussion is in no way a holistic, or exhaustive representation of the challenges faced by People of Colour (PoC) and/or Aboriginal and Torres Strait Islanders.

Gender, Sexual identity, & Intersex Variations

We observed a relatively even distribution of sexual orientations – in particular, **24.0%** and **11.5%** of total participants identified as either bisexual (***n*=113**) or pansexual (***n*=52**) respectively. Responses were recorded from significant numbers of transgender participants (***n*= 55, 11.7%**), as well as substantial numbers of participants whose gender identities do not align with the sex they were assigned at birth (***n*=88, 18.7%**). Women (***n*=222, 47.1%**) made up the largest group of participants; together, non-cisgender individuals (***n*=143, 30.4%**) comprised the second largest group of participants. Only one participant indicated they were born with an intersex variation (***n*=1, 0.2%**), and three participants did not disclose their gender (***n*=3, 0.6%**).

Bisexual and pansexual groups are well represented amongst participants. This is significant, as these groups are often underrepresented in research, and/or are simply grouped together with gay or lesbian populations - despite having distinct needs and experiences.¹⁴ A significant proportion of transgender and non-cisgender individuals were also recruited for our survey. The inclusion of responses from these groups is important, as there has been a tendency for existing research to discuss these groups in abstract, while overlooking their unique experiences.¹⁵

Socioeconomic Status

Participants were predominantly engaged in either Full-time (***n*=106, 22.6%**), Casual (***n*=76, 16.1%**) or Part-time (***n*=67, 14.3%**) employment – with these 3 categories comprising **52.9% (*n*=250)** of all participants. Of these, **16.4% (*n*=41)** were on fixed-term contracts. A substantial portion of participants were either Students (***n*=113, 23.9%**) or Unemployed (***n*=66, 14.1%**), and a small minority was retired (***n*=6, 1.3%**).

Most participants either lived in privately rented (***n*=186, 39.48%**), or rent-free accommodation (***n*=145, 30.8%**), while a small minority (***n*=72, 15.2%**) owned their place of residence. The majority of participants (***n*=380, 80.5%**) felt that they were in a secure housing situation, but a substantial minority (***n*=85, 18.0%**) of participants felt insecure in their present housing situation. Participants mostly lived in suburban areas (***n*=198, 41.9%**) or in a capital city (***n*=147, 31.1%**), but many were also located in either a regional (***n*=152, 32.2%**) or in a remote or rural area (***n*=43, 9.1%**).

Participants largely indicated having received at least Full Secondary schooling (***n*=147, 31.1%**) or some form of post-secondary education – and had either a TAFE Certificate or Diploma (***n*=146,**

31.9%), a Bachelor's degree ($n=127$, 26.9%) or a Postgraduate degree ($n=54$, 11.5%). A smaller proportion of our participants either received Lower-Secondary education ($n=24$, 5.2%) or had a Technical/Trade Certification ($n=14$, 3.0%).

State Representation

The states best represented in our sample were Victoria ($n=119$, 25.2%), New South Wales ($n=79$, 16.7%), South Australia ($n=76$, 16.1%), Queensland ($n=73$, 15.4%) and Western Australia ($n=61$, 13.0%). We had fewer participants from the Australian Capital Territory ($n=30$, 6.5%), Tasmania ($n=20$, 4.3%) and the Northern Territory ($n=6$, 1.3%).

Religious/Spiritual Beliefs

Participants in our sample were largely non-religious ($n=316$, 67.5%). However, our sample did also include participants who followed an organised religion or spiritual belief ($n=130$, 27.5%), with the largest subgroups within this category comprising Catholics ($n=25$, 5.2%) and non-institutional forms of religion and spiritual beliefs (e.g., Wicca) ($n=63$, 13.5%).

Relationship Status and Number of Children

A diversity of relationships styles was noted . Participants who were single made up the largest share of the sample ($n=234$, 49.6%), but a significant proportion of participants reported being married or in a de facto relationship ($n=107$, 22.7%), or otherwise in a relationship ($n=117$, 24.8%). A minority of participants ($n=50$, 10.6%) indicated that they were parents to at least one child.

General Health, Mental Health Conditions, and Disabilities

The majority of surveyed participants reported that they were in either 'Good', 'Very Good' or 'Excellent' ($n=296$, 62.7%) health, with a smaller proportion of participants rating their general health as either 'Fair' ($n=129$, 27.5%) or 'Poor' ($n=28$, 0.6%). Participants who had either a physical or cognitive disability which resulted in some form of impairment and/or limited activity accounted for a significant proportion ($n=133$, 28.2%) of our sample. Additionally, the majority of participants reported that they were experiencing a mental health condition ($n=339$, 72.0%), and of these participants, most ($n=235$, 49.8%) reported having had this condition for more than a year. The majority of participants who had a mental health condition were clinically diagnosed ($n=303$, 64.2%), while a minority were self-diagnosed ($n=33$, 0.06%). This suggests that a substantial number of survey participants were likely to have/had been in the care of a mental health professional.

Interviewee Demographics

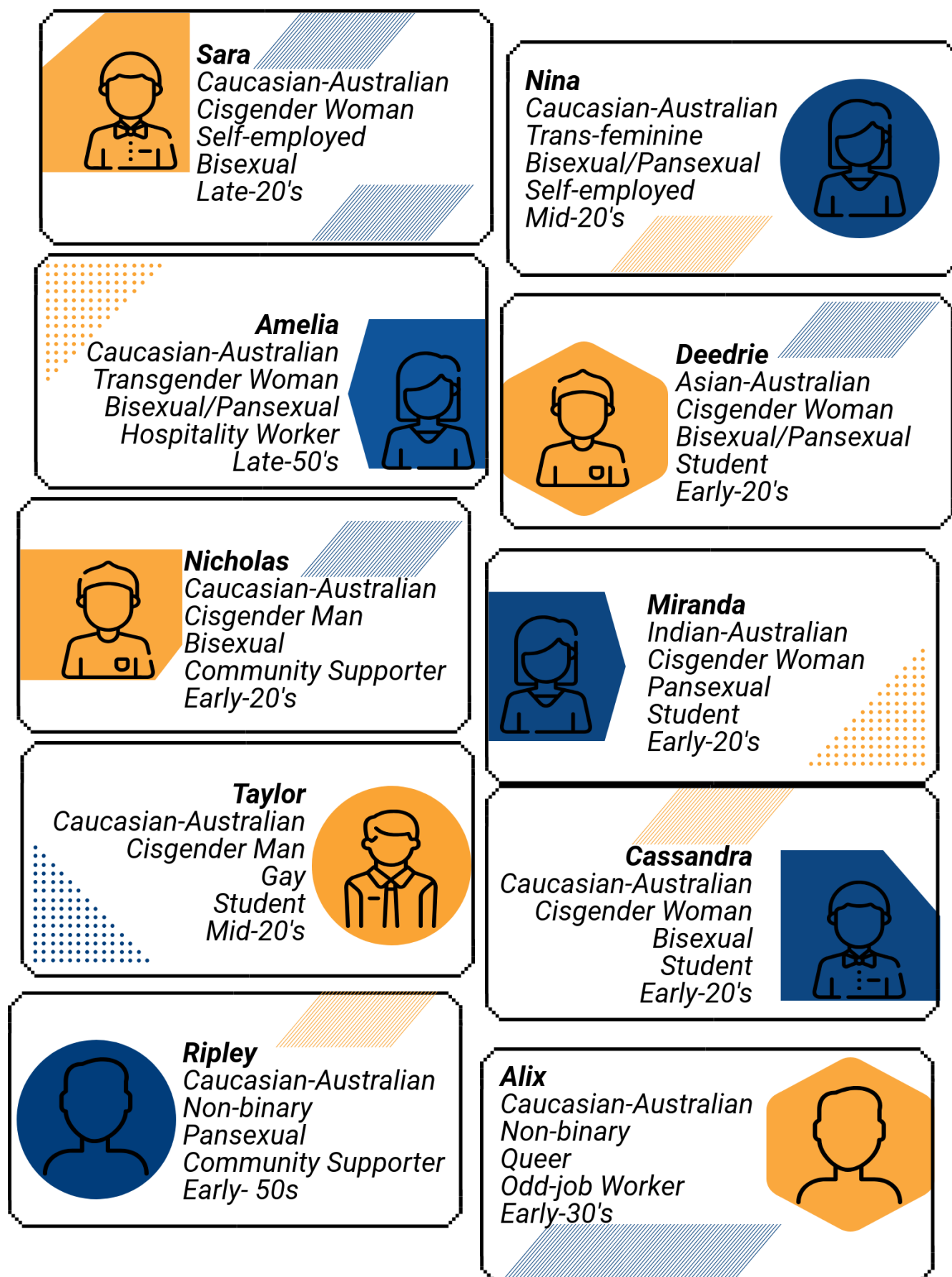


Figure 4: At A Glance Interview Demographics

The Reality of Experiencing a Crisis

In order to contextualise participant experiences, and to gain an understanding of the support structures that a participant could turn to during a time of crisis, we surveyed participants' experiences of personal and/or mental health crises. These were often related to discrimination against their sexual and/or gender identity, but just as often were related to more common personal problems - such as relationship and family issues, school, housing, financial, or work-related stress.

These were often not entirely distinct from one another. While the majority of participants described their crises as being contained within a specific timeframe, some also experienced longer-term problems. These typically arose from ongoing problems, such as financial difficulties, or chronic illnesses, or grief.

While we might think of crises as relatively short-lived events, this is only partially true. "Crisis" refers to a state of distress where an individual's emotional coping mechanisms are overwhelmed, and everyday life is disrupted, and does not occur over a specific duration.¹ For some participants, crises described arose from longitudinal factors that spanned a considerable amount of time.

I was working in a highly transphobic workplace, and was being actively bullied by upper management.

Avie, Queer, Genderqueer/Transman

My wife of three months and partner of 25 years passed away. I'm coping well on a practical level, but I'm feeling lonely, sad, abandoned.

Regan, Lesbian, Cisgender Woman.

I was entirely overwhelmed. I thought that nothing would ever be okay again. I just needed for everything to stop so that I could even begin to feel normal again let alone feel better.

Mark, Asexual, Transmale/Transman

I was experiencing multiple factors - work stress, or burnout, a chronic neurological condition that wasn't responding to medication, and a relapse of major depression and suicidal ideation.

Kenzie, Bisexual, Non-Binary

Findings

The findings of this study highlight the difficulties that LGBTI+ people experience during times of mental health or personal crises, as well as why they may, or may not, choose to utilise a crisis support or counselling service. We present findings from both the survey and interviews throughout this section, and we examine a number of key issues in turn. Participants have been allocated pseudonyms alongside their gender identity and sexual orientation.

We have used the identity terms provided by participants in the surveys and interviews. As such, there will be differences in how participants chose to identify themselves, or multiple uses of a particular term. For example, in regards to gender, some may use the term transgender, or transgender man, while others use transman, transmasculine or transmale. Queer may be used to denote a sexual orientation, a gender identity, or both.

We begin with an overview of **familiarity, uptake, and ratings of, crisis support services**.

We then discuss **barriers to service uptake**, which include *anticipated experiences of discrimination*, *'I don't want to be a burden' narratives*, and *lack of awareness* of both mainstream and LGBTI+ inclusive crisis support and counselling and mental health support services, followed by a brief discussion of *physical, financial, and technological* barriers.

This is followed by a discussion of **participant experiences of non-crisis support**, including *medical professionals, family and friends*, and *self-directed coping strategies*.

The presentation of findings are followed by **recommendations** to improve LGBTI+ access to, and use of, crisis support and counselling and mental health support services during a time of crisis.

User Experiences

Usefulness

47% of respondents who used a service during their last crisis



rated it **'good'** or **'excellent'** for managing feelings of distress

27% of respondents who used a service during their last crisis



rated it **'average'** at helping them manage distress

20% of respondents who used a service during their last crisis



rated it **'poor'** or **'terrible'** for dealing with distress

Uptake

48% of respondents who named **at least one service**



utilised a Crisis Support Service during their last crisis

20% of respondents who cited **Lifeline** as a recognised service



reached out to **Lifeline** during their last crisis

Satisfaction

47% of respondents who used a service during their last crisis



were **'moderately', 'very'** or **'extremely'** satisfied with it

24% of respondents who used a service during their last crisis



were **'slightly'** satisfied with the service

14% of respondents who used a service during their last crisis



were **'not at all'** satisfied with the service

Figure 5: At A Glance User Experiences

Uptake of Crisis Support Services

The majority of participants (***n*=322, 68.3%**) were able to name anywhere from 1-5 crisis support services (CSS), with at least half of these participants (***n*=184, 38.9%**) naming **Lifeline** among the services they recognised. Participants heard of these CSSs through a variety of sources - advertisements on television media, Social Networking Sites (e.g., Facebook), or on search engines (e.g., Google). Participants also heard of CSSs from their General Practitioner, mental healthcare professionals (e.g., psychologists and counsellors) and from schools or workplaces.

Uptake of Crisis Support Services

However, recognition of Australian CSSs did not often translate into participants' uptake of these services. Less than half of participants who could name at least 1 CSS (***n*=139, 29.4%**) reached out to a service during their most recent crisis. Only **37 participants (26.6%)** of the **139 participants** who could name at least 1 service and reached out to a service used **Lifeline** during their most recent crisis.

Breakdown of Results

Lesbian people were more likely to use web-based services, while heterosexual people more likely to use phone-based services, and queer (sexual identity) people a combination of both. Transmale/transmen were more likely to use web-based services, while transfemale/transwomen more likely to use phone-based services, and genderqueer and transfemale/transwomean a combination of both.

Table 1: Breakdown of uptake by sexual identity

	Total who used a service (<i>n</i>)	Lesbian	Gay	Bisexual	Queer	Pansexual	Asexual	Heterosexual	Different term
Web	48	18.4%	9.5%	12.9%	8.9%	11.6%	7.7%	16.7%	15.4%
Phone	66	22.4%	15.9%	18.8%	13.3%	14.0%	15.4%	33.3%	7.7%
Phone & Web	25	4.1%	4.8%	7.1%	11.1%	9.3%	7.7%	0.0%	15.4%

Table 2: Breakdown of uptake by gender identity

Barrier Type	Total who used a service (<i>n</i>)	Male	Female	Trans female/trans woman	Trans male/trans man	Genderqueer	Agender	Different term
Web	48	8.3%	15.7%	13.3%	18.8%	3.3%	18.2%	9.8%
Phone	66	16.7%	18.0%	26.7%	15.6%	13.3%	9.1%	24.4%
Phone & Web	25	5.0%	6.2%	13.3%	6.3%	13.3%	9.1%	4.9%

During their most recent crisis, the majority of participants who used a CSS accessed a service exclusively via telephone (***n*=66, 48.5%**), while a smaller proportion of participants exclusively accessed a CSS through a website or online service (***n*=48, 34.5%**). A proportion of participants also utilised both modalities to access a CSS (***n*=25, 18%**).

A few participants also contacted crisis support on behalf of a loved one during the latter's time of crisis. During these incidences, participants often acted as an intermediary for these individuals, particularly where the latter's emotional or psychological state made it difficult for them to converse directly with a crisis support worker. An example of this was recounted to us by an interviewee, who contemplated reaching out to a service when their partner was experiencing a psychotic episode. Participants who utilised a CSS in this way may feel unequipped to support a loved one through a time of crisis and may use the service both to cope with the stress of providing support, and for advice on how to do so.

LGBTI+ Specific Ratings of Services

Participants who indicated that they had used a crisis support service during their most recent personal crisis were asked to rate these services on dimensions relating to sensitivity to, and knowledge of, **Sexual Identity and Sexuality**, and **Sex, Gender and Gender Identities**. For **Sexual Identity and Sexuality**, the dimensions explored were:

1. Acceptance towards sexually diverse individuals;
2. Familiarity with sexually diverse related concepts; and,
3. Ability to provide support for sexually diverse specific issues.

Of the individuals (***n*=96**) who provided a response for these items, a majority (***n*=76, 80%**) indicated that service counsellors displayed 'Good' or 'Excellent' acceptance towards sexually diverse individuals and identities. Compared to acceptance of sexually diverse individuals, considerably fewer participants rated counsellors' familiarity with sexually diverse related concepts (**57.9%, *n*=55**) or ability to provide support for sexually diverse specific issues (**37.9%, *n*=36**) as either 'Good' or 'Excellent'.

For **Sex, Gender and Gender Identities**, the dimensions explored were:

1. Acceptance shown towards gender/sex diverse individuals;
2. Familiarity with concepts relating to gender/sex diversity; and,
3. Ability to provide Support for issues specific to gender/sex-diverse individuals.

Of the individuals (***n*=71**) who provided a response for these items, a smaller proportion (**56.3%, *n*=40**) rated counsellors' acceptance of gender/sex-diverse individuals as either 'Good' or 'Excellent'. Fewer participants rated counsellors' familiarity (**56.3%, *n*=40**) with sex and gender diverse terminologies as good or excellent. Only **20% (*n*=20)** of these responses rated counsellors' ability to provide support to trans and gender diverse individuals as either 'Good' or 'Excellent'.

Participants were more divided about whether or not Lifeline counsellors were LGBTI+-friendly, with 17 participants agreeing or strongly agreeing that Lifeline was an LGBTI+-friendly service, and 16 being either unsure, or disagreeing with this statement.

My experiences with Lifeline were mixed...I attribute this to the voluntary nature of call takers and they were generally older people. One particularly memorable woman made an offhand comment about my male housemate, who I was struggling to get along with, being handy for opening jars and taking out the bins, which has stuck with me!

Brandi, Queer, Cisgender Woman

I'd assisted a friend using Lifeline once before and they were so 'textbook' and impersonal. I wouldn't trust any service like that with information about my sexuality or gender identity, which makes it difficult to talk honestly about my experiences.

Erin, Bisexual, Cisgender Woman

Lastly, we also surveyed participants on their perceptions of how inclusive crisis support services were of LGBTI+ individuals, such as use of LGBTI+ people in advertising and marketing, or engagement with LGBTI+ organisations and initiatives. Participants largely felt inadequately represented or included in this regard, with less than half (**40.6%, $n=56$**) rating these services 'Good' or 'Excellent' in their inclusion of sexually-diverse persons. Only a minority (**42.0%, $n=58$**) rated services as 'Good' or 'Excellent' in their inclusion of gender/sex-diverse individuals.

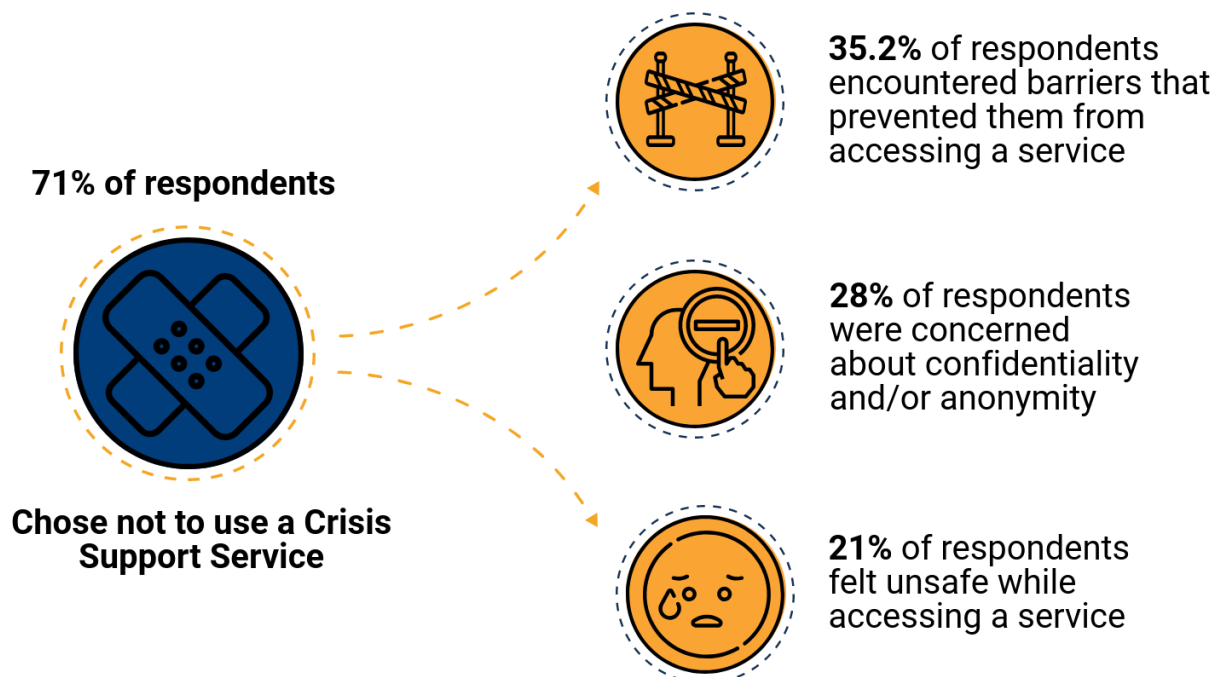
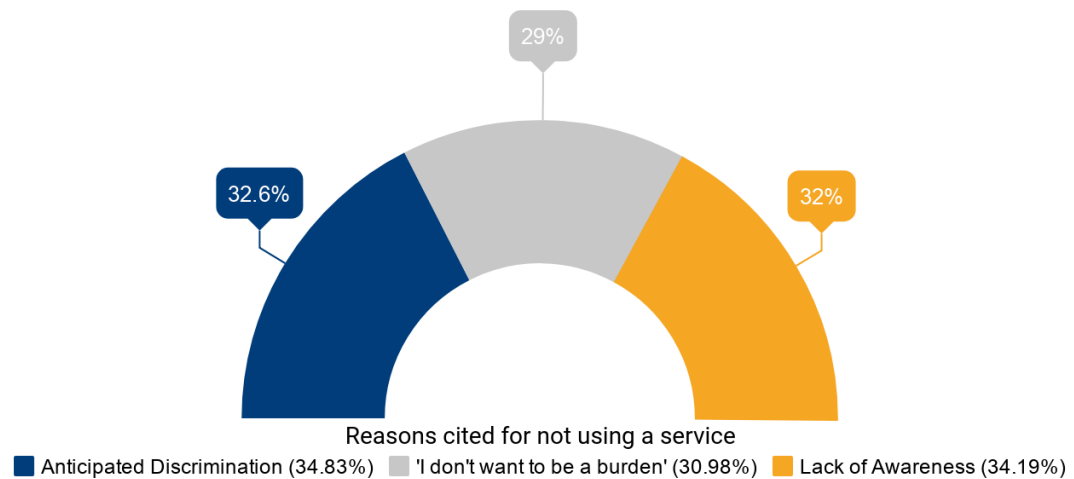
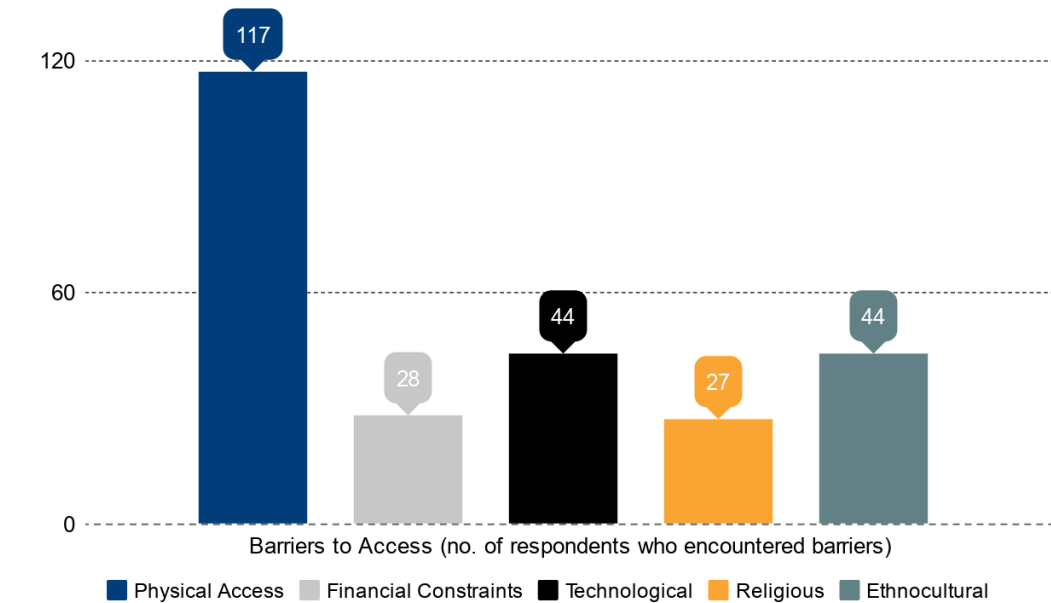


Figure 6: At A Glance Barriers to Service

Key Barriers to Service Uptake

Participants (71%, $n=334$) who indicated that they had not used a CSS during their most recent personal crisis were asked why they chose not to do so via an open-ended comment question. Main reasons included: *anticipated experiences of discrimination*, *"I don't want to be a burden" narratives*, and *lack of awareness* of both mainstream and LGBTI+ inclusive crisis counselling support and counselling and mental health support services. Additional barriers included physical access, financial, and technological barriers. These are discussed in detail below.

Anticipated Experiences of Discrimination

32.6% ($n=109$) of the 334 participants who chose not to use a service cited concerns relating to experiencing discrimination. Participants often stated that their decision not to utilise a CSS was made on the *expectation* or *perception* that they would experience discrimination targeting their sexuality, gender, or any number of other stigmatised or minority identities (e.g., ethno-racial identity, disability status). *Anticipated discrimination* has been described as a detrimental factor to an individual's well-being, not only because it delays health-seeking, but also because it prevents the individual from disclosing important details from care providers that could help them provide more appropriate forms of support.¹⁶

Breakdown of Results

People who used a different term for their sexual identity were more likely to report concerns regarding anticipated experiences of discrimination, while transmen/transmale people were more likely to report concerns regarding anticipated experiences of discrimination.

Table 3: Breakdown of anticipated experiences of discrimination by sexual identity

Total anticipated experiences (n)	Lesbian	Gay	Bisexual	Queer	Pansexual	Asexual	Heterosexual	Different term
109	23.2%	11.6%	23.9%	32.8%	28.3%	33.3%	14.3%	35.7%

Table 4: Breakdown of anticipated experiences of discrimination by gender identity

Total anticipated experiences (n)	Male	Female	Trans female/ trans woman	Trans male/ trans man	Genderqueer	Agender	Different term
109	11.8%	21.1%	40.0%	41.0%	27.0%	16.7%	34.7%

As LGBTI people often face discrimination in their everyday lives and in their engagement with social institutions such as medical and health services, it is not surprising this was a common theme amongst participants who chose not to use a CSS:

Don't have a lot of faith in the public system so I use informal supports while I wait for a psych/GP appointment. Also have quite a stigmatised illness and have had a bunch of bad experiences with counsellors, psychologists and specialists before so don't have a lot of trust for practitioners I don't already know/aren't explicitly at LEAST queer friendly.

Cassie, Bisexual, Cisgender Woman

Feeling as though normal services wouldn't be able to understand the fear of being rejected for being gay as most professionals are straight.

Carrie, Lesbian, Cisgender Woman

There was the worry of being brushed off, or having it affect my goal of surgically transitioning.

Morgan, Gay, Transmale/Transman

Getting assigned a random call centre operator is a gamble I am not able to risk when I'm already in a heightened state of distress. The chance that I could be matched with someone who is well-meaning - but ignorant - is high, and even a small misstep, or misunderstanding on their part...could be the straw that breaks my resolve to not harm myself.

Avie, Queer, Genderqueer/Transman

Anticipation of discrimination could include incidents such as potential misgendering of participants, or assumptions made about a participant's sexual orientation. Expectations of discrimination also affected participants' interactions with crisis support workers. One such way related to the perception that a crisis support worker would use heteronormative, and/or explicitly-gendered language, as well as language which privileged certain romantic orientations above others. This language tended towards the assumption of users as heterosexual, cisgendered, and/or monogamous.

Many participants were under the impression that crisis support workers would not be inclusive of LGBTI+ individuals, and/or alternative relationship styles - or at least not be well-informed on these topics:

The language is still so heteronormative - partner, ex, spouse...crisis support workers have no understanding of concepts like agreed polyamory or loving platonically with someone significant to you... I've used services in the past and have been brushed off, ignored or otherwise made to feel stupid.

Jessica, Bisexual, Cisgender Woman

In this example, Jessica believes that mainstream services will use heteronormative language, which can alienate a user. In Jessica's case, these language choices and assumptions are not so much a problem *per se*, but rather, that Jessica feels a crisis support worker will hold rigid notions about relationship modes and romantic orientations, which is not exclusive to queer-identifying communities, as heterosexual people may also engage in polyamory and ethnical non-monogamy. Further, Jessica has had previous bad experiences with other health services which has impacted their decision to not use a CSS. Many participants like Jessica believed that a crisis support worker would be judgemental, and thus perceived as ill-equipped to support them in their time of need.

Some participants also felt that they were not “queer enough” to access a LGBTI+ specific service, but were too queer to access a mainstream one:

I did not believe I was “queer enough” to access queer-oriented services, but I was too queer for mainstream services to feel comfortable...

Tracy, Lesbian, Transmale/Transman

Tracey’s quote suggests that those who do not perceive themselves as fully accepted by the LGBTI+ communities (i.e., not “queer enough”) can be at a loss as to which service is right for them.¹⁷ As seen above, this group of participants may evaluate both LGBTI+-oriented and mainstream services as being unable to accommodate their experiences and/or needs, and subsequently, refrain from reaching out to either during a period of crisis.

Alongside anticipated experiences of discrimination were concerns about safety and confidentiality with **28% (n= 134) of the 472 total survey participants** reporting concerns about confidentiality and/or anonymity, and **21% (n= 98)** feeling unsafe while accessing a CSS:

I still get concerned about the impact on my career if I present to the public health system and also potentially getting hospitalised in a public setting where I could have a cross over seeing clients. All of these factors are a barrier for me and the only outcome I can see is accessing private support or even support interstate.

Aubrey, Pansexual, Non-binary, who works in mental healthcare.

I have concerns about my identity being known, as I work in the health sector.

Riley, Bisexual, Cisgender Man.

Table 5: Breakdown of concerns about confidentiality and not feeling safe by sexual identity

Barrier Type	Total concerned (n)	Lesbian	Gay	Bisexual	Queer	Pansexual	Asexual	Heterosexual	Different term
Concerned about confidentiality	134	46.4%	34.0%	35.8%	61.5%	54.5%	33.3%	40.0%	45.5%
Do not feel safe using a service	98	36.9%	22.6%	32.8%	36.8%	27.3%	33.3%	20.0%	45.5%

Table 6: Breakdown of concerns about confidentiality and not feeling safe by gender identity

Barrier Type	Total concerned (n)	Male	Female	Trans female/trans woman	Trans male/trans man	Genderqueer	Agender	Different term
Concerned about confidentiality	134	24.5%	38.7%	38.5%	60.0%	37.5%	40.0%	42.4%
Do not feel safe using a service	98	2.0%	15.9%	23.1%	20.0%	12.5%	18.2%	18.2%

Participants often framed these concerns in terms of their fears of being “outed” - many articulating that the disclosure of these identities could threaten their personal safety, and/or their professional lives. Additionally, participants who were aware of LGBTI+ specialist mental health and counselling services also expressed concerns about confidentiality:

Breakdown of Results

People who identified their sexual identity as queer were more likely to be concerned with confidentiality in using a CSS, while lesbian people were more likely than other groups to not feel safe in using a CSS. Transmale/transmen were more likely to be concerned with confidentiality, while transfemale/transwomen were more likely to not feel safe using a CSS service.

LGBTI+ communities - at least in cities - are small, with only one degree of separation between many people who are working in service provision. I’m not sure everyone is as ethical as we would hope. I feel sure that there needs to be better training, and scrutiny around the personal ethics of those working in these fields, both in and out of the workplace.

Aspen, Pansexual, Cisgender Woman

[City name] is a relatively small city, where people are likely to be connected via social circles and this is even more so the case for LGBTI+ people. So, I get nervous about approaching services specifically for LGBTI+ people. I also worked in the health sector, and I don't wish to be recognised.

Blake, Queer, Cisgender Woman

In this context, concerns regarding confidentiality were not strongly associated with concerns about safety, but rather concerns centred on the fact that these services were staffed by members of closely-knit, local LGBTI+ communities, and peer networks. There was therefore a perception that these participants might be paired up with a peer when reaching out to a LGBTI+ specialist counselling and mental health support service, and that a counsellor could identify them.

Participants were not only concerned about potential discrimination based on gender identity and sexuality, but also, on other intersecting factors, including ethnicity, culture, and religious background. **44 (9%) of the total 472 survey participants** noted ethno-cultural barriers in accessing crisis support services.

Table 7: Breakdown of results regarding ethnocultural and religious barriers by sexual identity

Intersecting Needs	Total concerned (n)	Lesbian	Gay	Bisexual	Queer	Pansexual	Asexual	Heterosexual	Different term
Ethnocultural	44	10.7%	17%	9.0%	28.2%	15.2%	8.3%	20.0%	18.2%
Religious	27	6.0%	17.3%	6.0%	7.7%	9.4%	8.3%	0.0%	18.2%

Table 8: Breakdown of results regarding ethnocultural and religious barriers by gender identity

Intersecting Needs	Total concerned (n)	Male	Female	Trans female/trans woman	Trans male/trans man	Genderqueer	Agender	Different term
Ethnocultural	44	22.4%	9.3%	15.4%	16.0%	4.2%	18.2%	30.3%
Religious	27	16.7%	8.1%	0.0%	8.0%	0.0%	9.1%	12.1%

Participants felt that a crisis support worker would be unable to meet the complex needs that these participants can present with. These individuals suggested to us that difficulties in working with a crisis support worker could arise not only from language barriers, but also from culturally-specific or linguistically-specific terminologies and concepts that were not easily explained or communicated. Some participants perceived current CCSs, both mainstream and LGBTI+ specific as being unable to address complex needs relating to ethnicity and culture background:

Breakdown of Results

People who identified as gay were more likely to report ethnocultural and religious barriers while people who identified as male were more likely to report ethnocultural and religious barriers.

I feel like a lot of people don't understand the cultural issues facing LGBTI+ People of Colour. They don't understand family dynamics, and how those play a role in mental health issues, and all social relationships. Without understanding that, doing anything else - including treatment - is hard.

Arjun, Pansexual, Genderfluid.

I didn't know how to properly explain my situation to someone else. A lot of the familial issues I was having tied in to South Asian cultural traditions, and I didn't feel like someone who didn't come from the same background would truly understand it, as some of my closest friends (who are Australian) didn't fully get it. .

Kiaan, Bisexual, Cisgender Man

Arjun refers to a number of factors at play, including familial relationships and their role in the psycho-social well-being of persons from his cultural background. As such, his second-hand experience of homophobia from his family members is all the more challenging to his mental health. Kiaan reported similar issues relating to their South Asian background.

27 (6%) of the total 472 survey participants also noted religious barriers to accessing crisis support services. Specifically, religiously-oriented mental healthcare services were perceived to not be appropriately-equipped to support LGBTI+ individuals, even if they were affirming of LGBTI+ identities:

I didn't know who to go to, or who to trust...I wanted someone who understands my faith, but will not tell me off for my sexuality.

Billie, Bisexual, Cisgender Woman

As a LGBTI person who comes from a community that has been persecuted by religion, accessing a service that is delivered by a faith based organisation is too much of a risk - legally they can still discriminate against LGBTI people, and there is nothing you can do - why would an LGBTI person place themselves at risk of being discriminated against, when that is the cause of our poor mental health??

Kai, Gay, Cisgender Man

Religious participants reported somewhat similar experiences, on account of the fact that their needs with their regard to being religious and their sexual or gender identity were oftentimes not adequately met by services. Similarly, LGBTI+-oriented services were also viewed as not well-equipped to provide support for religious individuals:

The queer community can often be represented as hostile towards religious individuals, so I did not feel safe sharing my faith.

Chris, Gay, Cisgender Man

It's hard to find anyone who doesn't think my religion is a horrid blood sacrificing cult or equivalent.-

Keran, Asexual, Agender

Lastly, some participants were concerned about calling crisis support services in case an ambulance or police service would be sent out. While only done in extreme circumstances, participants noted unintended consequences that can be particularly salient for the LGBTI+ population:

I get worried that they will send an ambulance or the police.

Jean, Pansexual, Transmale/Transman, explaining their decision against reaching out to a CSS.

I needed help, and asked for it and an ambulance was called for. Because of this I was reported to <social services organisation>, as my son was home... I think that was wrong of them...I was doing the right thing, making sure my son and I were safe.

Ainsley, Lesbian, Cisgender Woman

In addition to the distress that arises from unexpectedly encountering ambulance and/or police services, individuals like Ainsley also experience long-term consequences that could precipitate into future crises. It is also important to note that LGBTI+ communities have a long history of trauma experienced from services like the police, such as the history of the criminalisation of homosexuality in Australia.¹⁸ Such histories can inform concerns about using a CSS that may need to deploy an ambulance or police during extreme circumstances and thus prevent users from seeking them out.

“I don’t want to be a burden” Narratives

A recurring theme amongst participants was that CSSs only dealt with the more extreme crises, such as suicidal ideation, where **29% (n=97) of the 334 survey participants who did not use a service** did not think their experience warranted crisis intervention.

Breakdown of Results

Asexual and agender people were more likely to report that they did not want to be a burden to a CSS.

Table 9: Breakdown of results ‘I don’t want to be a burden’ narratives by sexual identity

Total who did not think they needed a CSS (n)	Lesbian	Gay	Bisexual	Queer	Pansexual	Asexual	Heterosexual	Different term
97	18.9%	21.4%	20.4%	17.2%	24.5%	33.3%	0.0%	28.6%

Table 10: Breakdown of results 'I don't want to be a burden' narratives by sexual identity

Total who did not think they needed a CSS (n)	Male	Female	Trans female/trans woman	Trans male/trans man	Genderqueer	Agender	Different term
97	18.3%	22.4%	13.3%	17.9%	16.2%	25.0%	24.5%

As such, many participants believed that unless they were experiencing suicidal thoughts, or were otherwise at immediate risk of self-harming, then their crisis was not “serious enough” to require support from a CSS or a counselling and mental health support service. Some participants also cited their belief that reaching out to a CSS would divert the attention of a crisis support worker away from other callers that participants felt might be in greater need of support:

I don't want to take time and resources away from people who need it more.

Jaden, Bisexual, Genderqueer

I think there is always someone worse off than me that may be trying to access the service.

Lane, Lesbian, Cisgender Woman

Necessity. I didn't feel like I deserved the help.

Jeremy, Gay, Cisgender Man

I didn't want to seem annoying or attention seeking.

Nicki, Lesbian, Cisgender Woman

Felt like my situation wasn't serious enough to justify using crisis services...and that I would be making a bigger deal of the issue than was warranted.

Andi, Gay, Transmale/Transman

I didn't think it was bad enough to use a service.

Tara, Bisexual, Cisgender Woman

My background and upbringing placed a lot of shame on the idea of seeking help, and “burdening” people - which influences when and how I seek help.

Kelsey, Queer, Agender

Many participants' reluctance to use a CSS was also the result of feelings of being “undeserving” of help. Oftentimes, this was the case even when, and if, a participants' needs were appropriately pressing or distressing. This was consistent with previous research which suggests that LGBTI+ individuals experience lower self-esteem and self-worth.^{19 20} This has implications for CSS uptake - and, as demonstrated above, can be a barrier to CSS uptake.

These factors could also be compounded by one's cultural background and upbringing. As Jaden's response indicates, a cultural emphasis on self-sufficiency and independence can be highly relevant to a participant's decision to reach out to a CSS. For participants like Jaden, relying on a CSS for support disrupts, or contradicts their perception of themselves as independent individuals, and can be an important obstacle to seeking care. It was evident that these perceptions are not limited to specific cultures; as one interviewee tells us:

I feel like there's a sense of stoicism in the queer community “It's not so bad”, “I'm ok”, “I'm fine”, and so much of my defence mechanisms is around stuff like this is avoidance – and it really took me by surprise how hard I was hit... maybe that's why the support services didn't really enter my mind...

Marley, Gay, Cisgender Man

Marley’s statements reference wider, popular perceptions about the resilience of the LGBTI+ community - as seen by both popular media²¹ and academic interest on this topic.²² However, this focus on resilience can have a negative impact, implying an expectation that an LGBTI+ individual *ought* to be resilient. In actuality, there are substantial differences between resilience on a community-level, and resilience on an individual-level.²³ As such, this can place an expectation on LGBTI+ individuals to “grin and bear” their feelings of distress during a crisis.

Awareness of Crisis Support Services and LGBTI+ Specialist Services

136 participants (28.8%) were either not aware of crisis support services or LGBTI+ specialist services.

Breakdown of Results

Those who used a different term to describe their sexual identity, and those who identified as agender were the least likely to be aware of services available to them .

Table 11: Breakdown of results of lack of awareness of services by sexual identity

Total not aware (n)	Lesbian	Gay	Bisexual	Queer	Pansexual	Asexual	Heterosexual	Different term
136	29.1%	30.8%	33.0%	27.3%	30.0%	20.0%	14.3%	35.7%

Table 12: Breakdown of results of lack of awareness of services by gender identity

Total not aware (n)	Male	Female	Trans female/ trans woman	Trans male/ trans man	Genderqueer	Agender	Different term
136	33.7%	31.7%	33.3%	30.8%	14.3%	41.7%	21.3%

Participant awareness of CSSs was an important factor which related directly to CSS uptake as well as whether or not participants felt their crisis warranted the attention of a CSS:

I wasn't aware crisis support services existed, or how to access them.
Nico, Pansexual, Genderqueer

I would like to see more information on the services on offer...they are of a good standard already, but can be hard to access or not commonly known of. Once you're in a crisis situation, you're not in the state of mind to start trying to source them, you need to be aware of then beforehand.
Campbell, Lesbian, Cisgender Woman

Campbell’s statements further stress the importance of CSS awareness, and its relationship to user uptake; during a personal crisis, the emotional distress and/or negative affect experienced by an individual can detract from decision-making.²⁴ Consequently, an individual may not think to reach out to a CSS if they are not already aware that it is an option available to them.

Additionally, a participant who was aware of the more “mainstream” CSS might still be unaware that certain kinds of specialised support services - i.e., those that are LGBT-oriented, are available to them:

I think more advertising around queer-focused and queer-friendly services is needed. There were a couple listed in this survey that I hadn't heard of before, so I wouldn't know they were available to me...

Vic, Asexual, Genderfluid

I didn't really know what services were available, I didn't think there was anything to help me with figuring out my sexuality, and realising it was ok for me to feel this way.

Kim, Bisexual, Cisgender Woman

Both Kim's and Vic's quotes highlight a lack of familiarity with LGBTI+-oriented services that they may have reached out to in a time of crisis. This suggests that while individuals who are grappling with their sexual and/or gender identities stand to benefit greatly from LGBTI+-oriented, or LGBTI+-affirmative services, they are also likely to be unaware that these services are available to them.

Finally, individuals who were aware of the CSS available to them may nevertheless be unaware of the nature of services provided, or if the needs they are presenting with will be adequately met by these CSS. As one participant told us:

I would never think to call a crisis hotline, because I perceive those as services you only use when things are really bad...I just don't know about services available to my community and what constitutes as a 'crisis', and therefore what help is available.

Ariel, Lesbian, Genderqueer

Concerns like those voiced by Ariel were centred on the oftentimes vague definition of “crisis.” These individuals weren't sure what was available to them during a time of crisis, or whether or not their condition met service eligibility criteria.

Physical Access and Technological Barriers

Participants were asked whether they felt, or have experienced, physical and technological barriers, with a total of **166 (35.2%)** indicating as such. It is important to note that such barriers are not solely limited to LGBTI+ people, but rather, may be exacerbated by experiences of sexuality and gender discrimination in other aspects of social life, such as access to employment for financial security,²⁵ and access to safe housing.²⁶

Breakdown of Results

People who used a different term regarding their sexual identity were more likely to note report physical access barriers using a CSS, while asexual people were more likely for to report technological barriers. For gender identity, transmen/transmale were more likely to note report physical access barriers, while transwomen /transfemale were more likely to note technological barriers.

Table 13: Breakdown of physical and technological barriers results by sexual identity

Barrier Type	Total experiencing a barrier (n)	Lesbian	Gay	Bisexual	Queer	Pansexual	Asexual	Heterosexual	Different Term
Physical Access	117	42.2%	29.6%	32.8%	42.1%	45.5%	41.7%	20.0%	54.5%
Technological	44	3.7%	16.7%	13.4%	7.7%	18.2%	50.0%	20.0%	27.3%

Table 14: Breakdown of physical and technological barriers results by gender identity

Barrier Type	Total experiencing a barrier (n)	Male	Female	Trans female/trans woman	Trans male/trans man	Genderqueer	Agender	Other
Physical Access	117	24.5%	38.7%	38.5%	60.0%	37.5%	40.0%	42.4%
Technological	44	2.0%	15.9%	23.1%	20.0%	12.5%	18.2%	18.2%

Out of the **166 (35.2%)** participants who noted barriers, a substantial proportion (**n=117, 70.5%**) indicated that they faced **physical access** barriers in using a CSS. Oftentimes, this was related to difficulties in finding a private space to chat at length about their crisis and their gender and/or sexuality, without being overheard by family, peers or work colleagues:

I avoid a lot of web-based services because I don't have the internet at home and my phone data allotment is pretty small - and a lot of web-based things don't load well on a phone...When accessing phone support, it's a challenge to find a safe space to talk - I often end up just walking the streets and talking, which is physically difficult and uncomfortable, especially with my physical disability.

Quinn, Bisexual, Non-binary

I can't find a good place to chat or a safe place unless I am by myself which I hardly ever am. I also cannot leave class or use my phone at work.

Brenda, Pansexual, Cisgender Woman

Privacy to chat in a shared household especially with a family who doesn't value privacy. Talking can be heard in other rooms. I would need to go into a public space to have a chat.

Petra, Queer, Genderqueer

It's rare for me to be alone and unmonitored as I'm either at school where there are people everywhere or at home where it's not comfortable for me to talk about these things and there would be consequences if I was caught

Sandy, Bisexual, Cisgender Woman

These difficulties could also relate to limited operation hours, and the accessibility of service premises:

I most find myself in these situations during the early hours of the morning and most services are closed at this time.

Jett, Pansexual, Genderqueer

Time- as I work full time as a teacher, it's often hard to access services during my hours. People are often around during recess and lunch, which minimises my privacy, and I cannot access Web-based services at work.

Theo, Queer, Transmale/Transman

This can be especially difficult for participants who may be concerned about their family finding out about their gender identity or sexuality.

16.9% (n=28) of the 166 participants who faced physical access and/or technological barriers to accessing a CSS also noted that **financial constraints** played a significant part in these experiences. Financial constraints were a common concern when accessing most forms of mental healthcare and could be relevant even when accessing free crisis support services.

Expenses involved in accessing these services was described as factors that limited or prevented a participant's access to CSS. These expenses were typically in the form of data charges and/or monthly bills for maintaining a phone plan, which are necessary for accessing some CSSs by both web and phone, as seen in the following responses:

We are a low income family, so our technology is slow. Service disruptions can occur, which is the last thing you need when you're acutely suicidal.

Ash, Lesbian, Cisgender Woman, describing financial barriers to service use.

It costs money to call crisis lines, and it shows up on your call history. I didn't want my family to know what was going on.

Rachel, Lesbian, Cisgender Woman

Financial constraints were often also described in tandem with technological and physical access barriers, with **44 participants (26.5%) of the 166 participants** who noted barriers indicating that they faced technological barriers to accessing crisis support services:

I only have access to mobile data, as we don't have cable internet here. And I have a severe stutter, so phone calls don't really work well for me

Rachel, Lesbian, Cisgender Woman

Web based services are useless on a cheap mobile phone and require internet access. Phone based services are hopelessly overwhelmed.

Dan, Bisexual, Transmale/Transman

For instance, while a call made to a crisis support service is free-of-charge, the ability to place the call presupposes that a potential user has access to electronics like a phone or computer. Technological and financial barriers could also collide with physical access barriers, and a participant who lacked the financial resources to reach out to a CSS may be unlikely to afford the transport costs associated with physically accessing a service's premises, or may not reside in a safe place or have access to personal technology.

Seeking Other Forms of Support

Supporting a person experiencing a mental health crisis can require input from a variety of sources. While telephone and web-based crisis support services play a vital role, no single service or intervention could ever meet such significant need. As such, in this section we examine connections to other forms of support, starting with **professional healthcare providers**, followed by **family and friends**, and finally **self-coping strategies**.

Breakdown of Results

People who identified as heterosexual were more likely to use a medical professional, while pansexual people were the most likely to reach out to friends and family, and asexual people to engage with self-coping strategies. Transfemale/transwomen were the most likely to seek support from a medical professional, while those who said 'Other' for their gender were the most likely to reach out to family and friends, while those who identified as agender were the most likely to engage with self-coping strategies.

Table 15: Breakdown of seeking other forms of support by sexual identity

Support Type	Total seeking other support (n)	Lesbian	Gay	Bisexual	Queer	Pansexual	Asexual	Heterosexual	Different term
Medical professionals	191	60.8%	53.2%	48.6%	65.9%	51.4%	53.9%	80.00%	41.67%
Family and friends	243	68.9%	71.1%	77.3%	72.7%	78.4%	53.9%	60%	75%
Self-coping	213	76.1%	60.3%	65.1%	79.4%	66.7%	83.3%	60%	63.6%

Table 16: Breakdown of seeking other forms of support by gender identity

Support Type	Total seeking other support (n)	Male	Female	Trans female/trans woman	Trans male/trans man	Genderqueer	Agender	Different term
Medical professionals	191	43.1%	54.5%	84.6%	63.3%	59.3%	63.6%	61.1%
Family and friends	243	71.2%	70.7%	61.5%	63.3%	70.4%	81.8%	91.7%
Self-coping	213	57.1%	69.8%	76.9%	68%	79.1%	90.9%	75.8%

Professional Healthcare Providers

Over a third of total survey participants (***n=191, 40.5%***) reached out to either a General Practitioner (GP), and/or mental healthcare professional during their most recent crisis. It is crucial to note that participants who did reach out to a health professional did not necessarily eschew other forms of support. GPs and other professionals were often not well-situated to provide **timely emotional or psychological support**. The availability of these practitioners was often constrained by various factors like office hours, location of practice, and participants' financial situation. As such, a person might reach out to multiple forms of support in tandem, particularly when facing ongoing, or long-term problems or difficulties.

General Practitioners

Half of the participants in this group (***n=91, 47.6%***) reached out to a GP during their last crisis. GPs typically assisted with referrals to a specialist, or other service, prescribed medication (i.e., antidepressants or mood stabilisers), and worked with participants to formulate mental health care plans. As such, in most participants' experiences, GPs were often acting as intermediaries, rather than as primary mental healthcare providers:

My GP has been great, best doctor I've had. She has suggested I see a counsellor, and medication has improved my mental state considerably...unfortunately there is a limit to how much she can help me. She is good with referrals and other things she has the capacity to help with. I would not say any of these things have been true about previous GPs I have seen before, though.

-Cas, Bisexual, Non-binary

Some participants noted that GPs often provided some degree of immediate emotional support- particularly in instances where patient-doctor rapport had been previously developed. Additionally, for a small number of participants, GPs were their sole source of emotional, or psychological support, as seen below:

I only discussed physical symptoms...I was under quite a bit of pressure. My GP knows me well and I came away from the session feeling calmer. She listens.

Lane, Lesbian, Agender

During my crisis, I saw my GP face-to-face...I have a long term relationship with them; they know me and my mental health very well. I didn't feel telephone or web services could give me anything in addition to what my GP could.

Sam, Gay, Cisgender Man

However, this was not the same for most of our transgender participants, as GPs often also acted as partial "gatekeepers" for those who wished to access Hormone Replacement Therapies (HRT), or any form of gender-affirming surgery.²⁷ More generally, GPs are typically required to endorse and refer a transgender patient to a psychologist, and subsequently, a psychiatrist, before they are able to prescribe them HRT²⁸ - particularly if a participant wishes for the cost of gender affirming procedures to be subsidised by their health insurance.²⁹

My local doctors put me onto [service name]. The waiting list really was too long... Being over 40 made me suffer more anxiety, I was stressing over if my body will still change.

Nate, Bisexual, Transmale/Transman

I felt my life was on hold while waiting for my first appointment in [location] with [service name]. Then, I stayed awake every night, worrying if I would get referred to an endocrinologist. It really caused me a lot of anxiety.

Lou, Bisexual, Transfemale/Transwoman

Going to a GP was thus perceived as a potential source of stress for these participants, and thus was not utilised during a time of crisis.

Therapists, and other Mental Healthcare Professionals

Over a third (**83.2%, n=159**) of all survey participants reached out to a mental healthcare professional during the course of their most recent crisis. Within the group of participants who reached out to a mental health professional, the majority (**n=65, 40.9%**) reached out to a psychologist, while comparatively fewer participants reached out to either a psychiatrist (**n=20, 12.6%**) or counsellor (**n=29, 18.2%**) during this time. A good working relationship with these professionals appeared to aid the development of successful coping strategies for some:

My psychologist is very helpful. She has been my psychologist since before I was diagnosed with my mental health disability. She is patient, and listens well.

Kat, Asexual, Cisgender Woman, discussing their rapport with their psychologist.

Many participants cited this rapport as an important factor that inspired confidence in these therapists. While therapists were unlikely to provide timely emotional support when a crisis occurred *per se*, therapists were noted as having equipped a number of participants with strategies and techniques that enabled independent crisis management and self-coping:

When I spoke with my psychologist after my personal crisis, she was helpful...listening and supporting, but also gave me some tools. She suggested talking to my GP about some medical options for managing my social anxiety, which triggers my depression.

Laurel, Bisexual, Cisgender Woman, describing how their psychologist helps them cope during a crisis.

However, a number of responses from participants had had negative experiences with a mental healthcare professional. These were predominantly framed in relation to the practitioner's lack of awareness of issues pertaining to sexual and/or gender identities - or, more generally, to the quality of support rendered. These experiences also impacted participants' perceptions of crisis support workers:

I don't feel safe in using mainstream services as a queer person. I've experienced judgement, and done disproportionate educating to psychologists in the past - I can't do that during a time of crisis. That's not safe for my mental health.

Lucky, Bisexual, Non-binary, describing their previous experiences with psychologists.

Telephone and web counselling services are known to not be knowledgeable about LGBTI+ terminology, experiences, community, etc. I don't want to access a service, only to spend all the time educating the person who is supposed to be supporting me.

Chris, Gay, Cisgender Man, describing why they do not reach out to CSS

As Lucky's quote suggests, these experiences could be detrimental to an individual's psychological well-being, particularly during a period of vulnerability - such is commonly the case during a crisis. Additionally "shopping" around for a practitioner whose skill-set and expertise were a match to one's mental health needs was therefore a relatively common experience amongst participants:

We need more Medicare-subsidised access to mental health services - e.g., greater access to counselling etc, more than the 6-10 free visits issued under the mental health plans issued by GPs.

Andy, Lesbian, Cisgender Woman

My partner was let down by crappy psychologists - he tried a few and the process did more harm than good. What could 6 - 10 sessions really achieve anyway?

Kenzie, Gay, Cisgender Man

For participants who relied on health insurance to subsidise the cost of seeing a therapist, having to trial several therapists could leave individuals with only a few subsidised sessions remaining to work with a therapist that was a good match for them. This was seen as part of a bigger issue - specifically, the perception that mental healthcare services were under-subsidised.

Family and/or Peers for Emotional Support

Family and friends can be another source of support during a time of personal or mental health crisis. Almost half of all participants who took the survey ($n=207$, 43.8%) reached out to family and/or peers for emotional support during their last personal crisis. Interpersonal relationships with either family members, or one's peers were a crucial source of support for some participants. Participants were asked to describe their experiences via an open-ended question, and a number of participants noted positive outcomes with relying on friends and family:

Since my friend also goes through the same thing I'm going through, they were willing to listen because they understand. They also know me a lot better personally - being my friend - than a professional, who is essentially a stranger. It helps that I know a lot about my friend too, so it makes talking to them a lot easier.

Avery, Lesbian, Cisgender Woman

Avery's quote demonstrates that reaching out to these individuals could be a highly effective strategy for managing and coping with emotional distress, and that relying on these individuals for support could be a mutually fulfilling experience. However, a number of participants indicated negative experiences in relying on friends and family during a time of crisis, with **93 (27.7%)** of total survey participants indicating that they would not go to family or friends:

They supported me during my crisis, but it was difficult for them to help, as it was painful for them to see me in pain.

Madison, Bisexual, Cisgender Woman

I messaged a friend, but he did not reply. He has previously listened, but has not been helpful.

Finn, Queer, Genderqueer

I tried to talk to them, but they were going through their own issues...so I shut myself away from everybody.

Joey, Lesbian, Transmale/Transman

Participants noted that if one family or peer chose not to engage with them, this heightened their concern about reaching out to other family members or friends during a time of crisis. Others did not want to burden their friends and family, and thus chose to not to enlist the support of a family member or close friend. Knowing that **71%** of participants chose not to enlist the support of a CSS, and that many are concerned with reaching out to friends and family, LGBTI+ people may not be getting the support they may need during a time of crisis.

Self-Directed Coping Strategies

Participants' use of self-directed coping strategies during previous times of crisis was also explored. A significant portion of our participants indicated that they engaged in these strategies during a time of crisis (**n=213, 45.1%**). Many of these participants utilised personal rituals, and even alternative/homeopathic medicine, in tandem with more orthodox coping strategies - including, but not limited to: maintaining proper sleep hygiene; meditation and mindfulness practices; as well as various forms of physical activity:

Trying to engage in mindfulness based practices especially breathing exercises, body scan, and guided meditation. This can be incredibly difficult when highly distressed or disconnected from my body, but I try. I also try to stick to regular sleep and eating routines- again, this can be hard to do.

Jo, Queer, Cisgender Woman

I attempt to use mindfulness and physical engagement to assist with mental health. The catch-22 is that depression makes you want to not move.

Kat, Lesbian, Cisgender Woman

As can be seen, however, being able to utilise these strategies was often a challenge, particularly while one was in the midst of a personal crisis, and was not always successful. Moreover, for individuals

who experience mental health conditions that involve some impairment to executive function, these kinds of strategies could be especially difficult to implement. Additionally, many of the former were longitudinal coping strategies, which could be challenging for a participant to successfully and consistently incorporate into their daily lives.

A number of individuals indicated engaging in substance-use as a means of coping; managing personal crises through the use of intoxicating, and/or psychoactive substances. This is a well-established phenomenon, and recent research suggests that minority stress relating to sexual identity is **not associated with** an increased likelihood of substance use to cope.³⁰ While outside the scope of the current project, current research suggests that individuals who engage in substance use to cope may do so as a way to regulate their emotions.³¹

A smaller number of individuals also indicated turning to self-harm as a way of coping during personal crises. These were typically repetitive instances of low-severity, non-suicidal self-harm. Researchers have documented that this form of self-harm is used to manage feelings of dissociation, regulate one's emotions, and to establish interpersonal boundaries,³² as seen below:

I have unfortunately discovered that self-harm helps me not focus on my negative emotions. So far I've only scratched myself with my nails, and I haven't done it often. Wearing a rubber band on my wrist helps keep me calm because I know if I want to self-harm, I'll use the band instead of scratching. This actually lowers the risk I'll even use the band at all, because knowing that self-harm is a coping mechanism is itself a negative emotion I want to get away from.

-Val, Asexual, Genderfluid

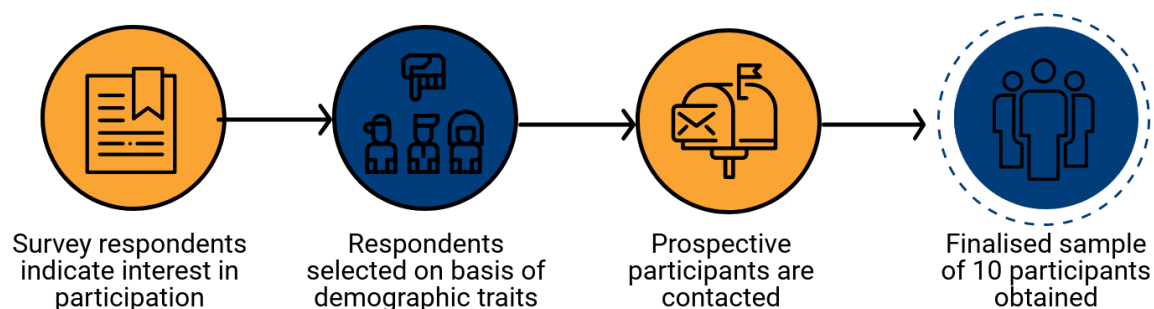
Honestly...and I know it isn't healthy, but going whacko on (repeatedly punching) a wall is always relieving. Sure, it causes a few bruised knuckles, but I feel good after.

-Cameron, Bisexual, Genderqueer

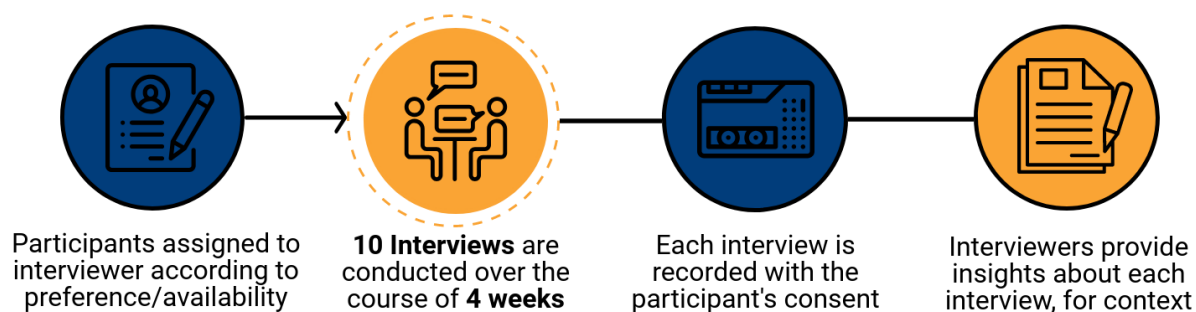
It is crucial to note that individuals who do display these behaviours are not necessarily suicidal, and individuals may even use self-harm as a strategy to put a stop to suicidal thoughts.³³

Recruitment to Recommendations

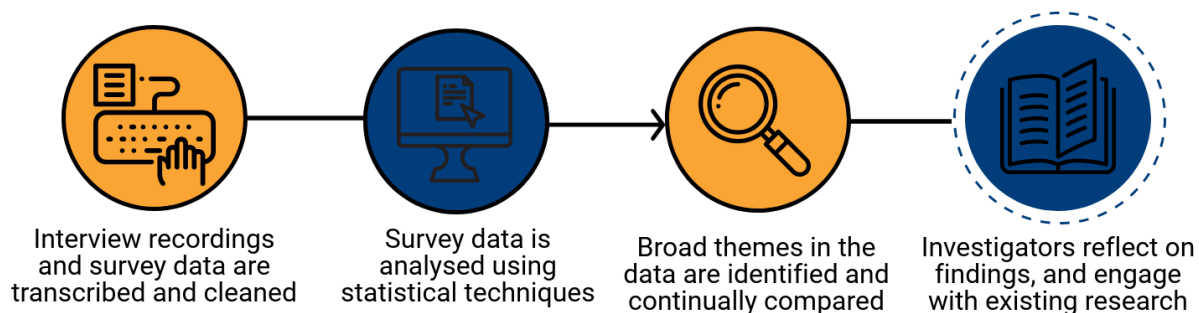
Stage 1: Recruitment



Stage 2: Data Collection



Stage 3: Preliminary Data Analysis



Stage 4: Findings and Recommendations

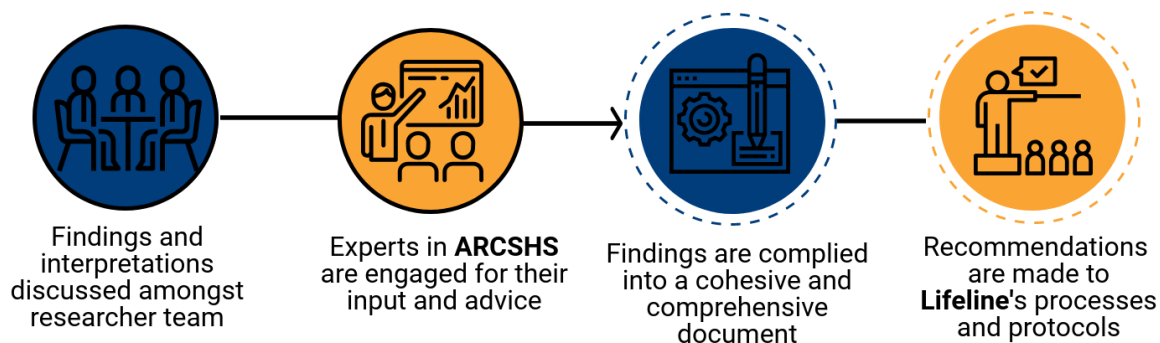


Figure 7: At A Glance: Recruitment to Recommendations

Recommendations

The results of this study lead us to make a number of recommendations to help mainstream crisis support and mental health support services engage positively with the LGBTI+ communities, and to address the barriers that LGBTI+ people living in Australia have identified in accessing crisis support services (CSS). These include *LGBTI+ cultural competence and safety training, promotion and awareness, addressing intersecting needs, and areas for further research.*

LGBTI+ Culturally Competent and Safety Training

First and foremost, the study findings indicate a pressing need for mainstream crisis support services such as Lifeline to engage in LGBTI+ inclusive practice. Engaging in programs such as the Rainbow Tick program by Rainbow Health Victoria (formerly Gay & Lesbian Health Victoria),³⁴ as well as other community-based LGBTI+ training programs would be highly beneficial for crisis support services looking to support LGBTI+ Australians. This would enable the development and support of cultural competency and safety in mainstream service use. Such training would also enable services to gain a deeper and more nuanced understanding of the history of trauma of LGBTI+ Australians, such as negative and discriminatory experiences with community services associated with crisis support, such as the police and concerns about forced institutionalisation.

Such training needs to be on-going rather than one-off workshops and seminars, and specialised in working with the variety of subgroups within the LGBTI+ community, including diversity across sexuality and sexual identity, gender, and relationship styles. For example, bisexual and pansexual clients have a different set of needs to lesbian and gay people. Trans and gender diverse people also have different sets of needs compared to cisgender men and women. As such, training needs to be centred embedding inclusive practice within policies, procedures and operations of organisations, rather than just changing the minds of particular individuals.

While specialist LGBTI+ services can support some of the gaps highlighted in this study, it is important to recognise that some participants felt uncomfortable with using a peer-to-peer service due to concerns that they may encounter someone they know in the LGBTI+ community. As such, it is essential that LGBTI+ Australians have access to both LGBTI+ specialist services and mainstream services during a time a crisis.

Promotion and Awareness

The findings of this study highlight a number of areas that need to be addressed, in terms of promotion and awareness of crisis support and counselling and mental health support services. This appeared to be true for both mainstream and LGBTI-specific service. It is vital that crisis support workers working with these services have undergone appropriate LGBTI+ cultural competence and cultural

safety training, and that publicity efforts for these services are undertaken to ensure that LGBTI+ Australians are aware of what is available to them during a time of personal or mental health crisis.

Awareness of Availability of Varying Service Modalities

Our findings also noted an overall lack of awareness of what is available to LGBTI+ people during times of personal or mental health crises - this was consistent across both mainstream and LGBTI-specific services. Participants on the whole were not aware of the different types of services available to them, or the difference between the kinds of support that different services provided. While such distinctions are apparent for those working in the crisis support service and counselling and mental health support service sector, these differences are not readily apparent to the general population. Rather, participants often considered crisis support services like Lifeline, and counselling and mental health support services such as **QLife** and **beyondblue** as being similar, or interchangeable in functionality. Participants also noted a preference for a variety of service models that would suit their specific needs; a commonly voiced preference was for text messaging-facilitated crisis support, which was seen as more convenient than a call-in phone line or web-based service.

As such, increased promotional awareness of what a service provides and the modes (phone, web, text messaging) that the service is provided is vital, so that LGBTI+ people are aware of what is available to them, and the kinds of support they can access. This may require services to assess the language and phrasing they use in promotional or advertising materials to reach certain populations, and to carefully consider if any assumptions of knowledge are placed upon potential users.

Awareness that Services are LGBTI+ Inclusive

Participants also noted that concerns about the potential experience of discrimination while using a mainstream crisis support service or an LGBTI-specific service meant that they avoided using them during a time of need. Such awareness needs to include that services are LGBTI-friendly (welcoming towards LGBTI+ people) and LGBTI+ inclusive (have knowledge of the specific issues and history of LGBTI+ experiences). Promotional marketing such as highlighting designated Rainbow or LGBTI+ Ally status, featuring LGBTI+ representation in promotional materials, use of LGBTI+ inclusive language, and use of LGBTI+ visual signifiers such as the Rainbow flag among others can help LGBTI+ people realise that a service is LGBTI+ friendly and inclusive. Services should undergo approved and highly recommended LGBTI+ inclusive practice programs prior to engaging in these steps.

Mainstream services could also take a more active role in the LGBTI+ community, by cultivating positive, mutually beneficial, and supportive collaborations and partnerships with LGBTI+ organisations. This can address any preconceived negative perceptions about the service, and reassure LGBTI+ people who may be unsure about accessing the service, particularly a mainstream one during a time of crisis.

Encouragement of Using Crisis Support Services

One of the strongest themes of this research was that a number of participants engaged on some level with an “I don’t want to be a burden” narrative. Participants felt that their personal experiences of crisis did not warrant the attention of a crisis support service like **Lifeline**, or a counselling and mental health support service such as **QLife**, instead often relying on self-direct coping mechanisms, or in other words, merely surviving.

It is vital that promotional activities are not only focused on messaging concerning seeking support for feelings of distress, anxiety, depression and isolation among others, but also, engage in messaging that reassures the population that they are not a burden, and that their feelings and experiences are important. In particular, messaging that reminds people that their issues or experiences of distress are not insignificant, and that a crisis support service or counselling and mental health support service is there to help may encourage more LGBTI+ people to seek the use of a service. This may also include broadening messaging that includes everyday experiences that can lead to feelings to distress, but are not necessarily recognised as distress.

Addressing Intersecting Needs

While not the focus of this particular project, the findings highlighted a number of perceptions that LGBTI+ people with multiple, disadvantaged identities have when choosing not to engage with a CSS. These multiple facets of identity could be a permutation of any of the following - disability, race and ethnicity, cultural background and/or religion. Such findings indicate that LGBTI+ People of Colour, LGBTI+ people with disabilities, and LGBTI+ people of varying religious beliefs and faiths face additional complexities in accessing crisis support, as well as mental health and counselling. These difficulties often related to concerns that counsellors may not be trained to understand these complexities. As such, recommendations for training are not only related to LGBTI-specific needs, but also training that takes into account the diversity of LGBTI+ experiences, with a focus on how other identities and statuses can inform these experiences.

Further Research

A number of key areas have been identified for further research in this study, particularly exploring the **Training of Crisis Support Workers**, and the health and crisis support needs of **Aboriginal and Torres Strait Islander LGBTI+ people**, and **LGBTI+ People of Colour**.

Supporting the Training of Crisis Support Workers

Further research is needed to **explore gaps in the training of crisis support workers** to understand the challenges they may have experienced, or perceive, in engaging with LGBTI+ service users and how these might be addressed by training or organisational development. This will enable services to understand what is needed to ensure cultural competence among such organisations, and how they can be supported. This can also involve research on how existing LGBTI+ organisations can help support the training of mainstream service providers to be LGBTI+ inclusive. This could include a

detailed exploration into how crisis support workers regard their capacity, confidence, and competence in working with LGBTI+ people,³⁵ including – but not limited to – their familiarity with specific issues that can inform higher rates of mental ill-health among this population. This would allow the specific training needs within services to be established so that services are not only aware of LGBTI+ issues, but also feel competent in responding to these and to provide a culturally safe environment for LGBTI+ people

Health and Crisis Support Needs of Aboriginal and Torres Strait Islander LGBTI+ People

Research that specifically sets out to investigate **the mental health needs of Aboriginal and Torres Strait Islander LGBTI+** individuals is also needed. The findings presented within this report may not be an accurate reflection of the experiences and needs of Aboriginal and Torres Strait Islander LGBTI+ individuals. Aboriginal and Torres Strait Islander LGBTI+ individuals experience unique factors that inform their experiences and needs, which may be different to non-indigenous LGBTI+ individuals, and non-LGBTI+ Aboriginal and Torres Strait Islanders. They experience anti-LGBTI+ discrimination within traditional communities, and racism within wider Australian society.³⁶ Additionally, they are also poorly represented on a broad range of social and cultural issues.^{37 38} Researchers argue that this group has been uniquely impacted by European colonisation, which has eroded customary gender and/or sexually-diverse practises.³⁹ Individuals within this group may also identify with culturally-specific gender/sexual identities (i.e., brotherboy, sistergirl, etc.),⁴⁰ and have experiences that cannot be simply derived from the findings of research with non-Indigenous populations.

Health and Crisis Support Needs of LGBTI+ People of Colour

LGBTI+ People of Colour (PoC) were underrepresented in the present report, and are generally also understudied within the Australian context. However, what was evident from the responses provided by ethno-racial minority participants was the need for culturally-sensitive, or culturally-inclusive forms of crisis support. Additionally, larger-scale, quantitative research could be conducted with these groups to more accurately understand the mental health needs of LGBTI+ People of Colour, and how they engage with mental health services. More recent qualitative research with these groups strongly indicates that these individuals may experience alienation from their families, communities of origin, as well as the broader LGBTI+ community.⁴¹ It should be noted that attempts to better meet the mental health needs of this group should take into consideration the inherent diversity of ethno-cultural backgrounds within this group.

Summary

To help provide better support for LGBTI+ Australians during a time of personal or mental health crises, an exploratory study of LGBTI+ Australians experiences with CSS was conducted. The first study of its kind in Australia, a mixed methods survey of **472 participants**, and **10 follow-up interviews** were conducted to gain a better understanding of the current needs of LGBTI+ Australians during a time of personal or mental health crisis, and barriers to accessing CCSs and other counselling and mental health support services.

The findings of this study indicate that **71% of LGBTI+ Australians** chose to not utilise a crisis support service during their most recent personal or mental health crisis, an alarming figure when noting that LGBTI+ people have higher rates of poorer mental health, self-harm, and suicidal ideation than their heterosexual and cisgender peers.⁴² This percentage was premised **on perceptions**, rather than experiences of CCSs, and these were informed by experiences in using other non-crisis support mainstream health and medical services, as well as broader systemic and everyday experiences of discrimination in Australian society. Nearly a third (**29%**) who did use a CSS or counselling and mental health support service during their most recent crisis generally noted favourable experiences.

The anticipation for discrimination was the major reason LGBTI+ Australians did not want to use a CSS, alongside feeling as though their **experience of crisis did not warrant** the attention of a CSS service, and **not being aware** of what was available for them to utilise. Additional barriers included concerns relating to confidentiality and anonymity, concerns relating to the involvement of intervention services such as the police and forced institutionalisation, finding a safe space to use a service, and financial and technological access barriers.

Acknowledgements

We'd like to first acknowledge and thank the participants who took the time to complete the survey, as well as those who offered to be interviewed for this project.

We'd also like to thank the **Lifeline Research Foundation, Lifeline Australia** for funding this important work, as well as the reference group members **QLife** and **ACON** who provided feedback on many aspects of the project, as well as **Thorne Harbour Health** who provided feedback on the ethics component.

We'd like to thank the **Australian Research Centre in Sex, Health and Society** staff and students who assisted with the development of the survey by taking time to test out questions and provide feedback for revision.

We'd like to thank the many organisations and individuals across Australia who supported this project by spreading the survey across their mailing lists and social networks, as well as **Gay and Lesbian Health Victoria** who assisted with the development of the **Glossary of LGBTI+ Terms**.

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Glossary: LGBTI+ Terms

Developed by GLHV@ARCSHS, La Trobe University (2016) The Rainbow Tick guide to LGBTI-inclusive practice. Prepared by Pamela Kennedy, Melbourne: La Trobe University. Some terms have been updated since the publication of this glossary, and additional terms have been added where necessary.

Affirming gender	The process a trans or gender diverse person undertakes to live as their true gender. This may include medical treatment (surgery, hormone therapy and other treatments), a change of name, using a different pronoun, and changing sex on identification documentation such as a birth certificate, passport or drivers licence. This process is also referred to as Gender Affirmation (see Transition below).
Agender	Is a term which can be literally translated as “without gender”. It can be seen either as a non-binary gender identity or as a statement of not having a gender identity.
Asexual	Asexuality is the lack of sexual attraction to others, or low or absent interest in or desire for sexual activity. It may be considered the lack of a sexual orientation, or one of the variations thereof, alongside heterosexuality, homosexuality and bisexuality among others.
Biphobia	The fear, hatred or intolerance of people who are bisexual, or perceived to be bisexual, that often leads to discriminatory behaviour or abuse.
Bisexual/bi	A person who is sexually and/or emotionally attracted to people of more than one sex. Often this term is shortened to “bi”. Related terms include pansexual , hetero/homoflexible , and nonmonosexual .
Bisexual erasure	Bisexual erasure or bisexual invisibility involves a failure to recognise bisexuality in general or individuals who are bisexual. Bisexual erasure can involve a failure to consider that someone who is in a relationship with a person of the same or opposite sex may be attracted to people of more than one sex.
Brotherboy	See Sistergirl in this glossary.
Cis/Cisgender	Cisgender describes a person whose gender conforms to the dominant social expectations of the sex they were assigned at birth.
Cisgenderism	Cisgenderism describes beliefs and practices that privilege cisgender people at the expense of people whose gender does not conform to the dominant social expectations of the sex they were assigned at birth. Cisgenderism devalues people whose experience of their embodied gender does not fit within a binary model of sex and gender.
Coming home and Coming in/Inviting people in	Coming home and Coming in are terms preferred by some people to Coming out (see below) because they don't pressure individuals to publicly declare their sexual identity, gender identity or intersex variation. Some people from non-Anglo cultural backgrounds prefer these terms because they don't rely on dominant, western identity categories. They give them greater choice and flexibility in how they describe themselves and in who they invite in and seek support from.
Coming out	The process through which an LGBTI person comes to recognise and acknowledge to themselves and/or others, their sexual identity, gender identity or intersex status.

Coming out is never a once-off event. Rather, it is a repetitive process where LGBTI people have to make decisions if, when and with whom to be out to in every new personal, social or work situation.

Cultural safety /security (competence)

Cultural safety and security acknowledge and affirm cultural differences while at the same time addressing the power imbalances that exist between marginal and dominant groups. They involve addressing the risks to minority individuals and groups that this power imbalance can bring. An organisation or practitioner develops their cultural competence so as to provide cultural safety for individuals and communities, through an approach to service delivery and professional practice that is responsive to the beliefs, values and practices of different groups or populations. The term is often used to highlight differences between the values and practices of minority and marginal groups and those of the dominant culture. While the term has most commonly been applied to racial, ethnic and religious minorities, it has recently been applied to sexual, sex and gender identity diverse communities and to the provision of LGBTI-inclusive, culturally safe services. Related terms include **cultural awareness**, **cultural proficiency** and more recently **cultural humility**.

Disability

Disability results from interactions between a person's impairment, understood as functional limitations, and the social, physical and attitudinal barriers they face. Addressing disability involves removing these barriers and minimizing the impact of living with an impairment on a person's life.

Discrimination and Indirect Discrimination

Discrimination is when you treat, or propose to treat, a person unfavourably because of a personal attribute or characteristic. Under Commonwealth legislation it is illegal to discriminate against someone on the basis of their sexual orientation, gender identity or intersex status. Indirect discrimination is when you include an unreasonable requirement that is likely to disadvantage someone on the basis of one or more protected attributes.

Equity

Equity is about fairness, and making sure all people have access to the same opportunities. This does not involve treating everyone the same. Rather, it involves recognising that everyone is different and providing individuals and communities with the things they need to ensure that everyone has the same opportunities.

Gay

A person whose primary emotional and sexual attraction is toward people of the same sex. The term is most commonly applied to men, although some women use this term.

Gender diverse

A broad term that encompasses a diversity of gender identities and gender expressions including: **bigender**, **trans**, **transgender**, **genderqueer**, **gender fluid**, **gender questioning**, **gender diverse**, **agender** and **non-binary**. Gender diverse refers to identities and expressions that reject the belief that gender is determined by the sex someone is assigned at birth.

Gender Dysphoria /Gender Identity Disorder

Gender Dysphoria or Gender Identity Disorder is a medical diagnosis given to trans and other gender diverse people who are experiencing discontent and distress resulting from 'gender identity issues'. The term is seen as pathologising by many because it implies that trans and gender diverse people are "disordered".

Gender expression (Gender conforming and non-conforming)

The way someone chooses to publicly express their gender, through name, pronoun, clothing, haircut, mannerisms etc. Gender conforming refers to behaviour and modes of presentation that match the dominant social expectations of the sex someone was assigned at birth. Gender non-conforming involves behaviour and

	modes of presentation that do not match the dominant social expectations of the sex someone was assigned at birth.
Gender identity	Gender identity has a specific meaning under State and Commonwealth Equal Opportunity and anti-discrimination legislation. In broad terms, however, it refers to a person's deeply felt sense of being a man or a woman, both, neither, or in between. For example, an individual who has no gender identity or a gender identity that is neutral may refer to themselves as agender or gender free. Some people's gender identity may vary according to where they are and who they are with.
Genderqueer	A person whose gender identity is not limited to or by the binary categories of male or female. Genderqueer people may identify as masculine, feminine, bigendered or partially male or female. Some genderqueer people may be third-gendered or reject gender roles altogether (see Gender Diverse above).
Gender Questioning	The process of questioning the belief that gender and gender identity are necessarily determined by the sex someone is assigned at birth. People who are gender questioning may express their gender in ways that do not match the expectations of the sex they were assigned at birth or they may reject gender categories all together.
Gender Reassignment Surgery (GRS) (also known as SRS or GCS)	A surgical procedure where an individual's body or sexed anatomy is aligned with their gender identity. Also known as sex reassignment surgery (SRS) or genital confirmation surgery (GCS).
Heteronormativity and Heterosexism	Heteronormativity is the belief that everyone is, or should be, heterosexual and cisgender and that other sexualities or gender identities are unhealthy, unnatural and a threat to society. Heterosexism describes a social system built on heteronormative beliefs, values and practices in which non-heteronormative sexualities and gender identities and people with intersex variations are subject to systemic discrimination and abuse. For example, assuming that someone is heterosexual, and that they are in a monogamous, married relationships can be understood as heteronormative.
Heteroflexible/homoflexible	Hetero/homoflexible is a form of a sexual orientation or situational sexual behaviour characterised by minimal homosexual activity in an otherwise primarily heterosexual orientation, which may or may not distinguish it from bisexuality. It has been characterised as "mostly straight" or "mostly gay."
Homophobia	Fear, hatred or intolerance of people who are same-sex attracted or are perceived to be same sex attracted, including lesbians, gay men and bisexuals, which often leads to discriminatory behaviour or abuse.
Inclusive practice/service provision	The provision of services that is respectful and aware of the culture and beliefs of the recipient. This includes the provision of services to LGBTI people that recognise and affirm the values and practices of the LGBTI community.
Internalised biphobia /homophobia/transphobia	The internalisation by LGBT people of heterosexist beliefs, values and practices that can lead to feelings of reduced self-worth, shame and sadness.
Intersectionality	Intersectionality understands that identity, a person's sense of "who they are", is not singular but rather an effect of multiple, intersecting social categories. These categories are effects of complex socio-historical processes and reflect deeply entrenched relations of power and inequality. For example, many LGBTI people also identify as Aboriginal, religious, having a disability, and more. For any individual,

these categories are not discrete but mutually constitutive. For some people, they are mutually reinforcing; for others, there may be tensions or contradictions between different categories that leads to a fractured or dissonant sense of identity.

Intersex and Intersex status

Intersex people are born with physical sex characteristics that don't fit medical and social norms for female or male bodies. These include a diverse range of genetic, chromosomal, anatomic and hormonal variations. Intersex is understood as a political, embodied identity, and intersex people can have a range of gender identities and sexual orientations.

(Updated from IHRA.org.au 02.12.2018)

Lesbian

A woman whose primary emotional and sexual attraction is toward other women.

LGBTI+

Lesbian, gay, bisexual, trans and gender diverse and intersex people. The + indicates other sexual identity and gender minority groups not listed.

LGBTI+ People of Colour Communities

The term "People of Colour" is used in reference ethno-racial groups who are not white. The term encompasses all non-white people, and emphasises common experiences of systemic racism.

Misgendering

Describing or addressing someone using language that does not match that person's gender identity or expression. For people with intersex variations, this may include a presumption that they have a non-binary gender identity, or that they identify exclusively as a man or a woman.

Monosexism

A belief system grounded in the misconception that people are only attracted to other people of one gender, causing exclusion of and discrimination against **non-monosexual** people.

MSM/WSW

Men who have sex with men (MSM) and women who have sex with women (WSW), terms often used in public health literature and may be more common in non-Anglo speaking countries. Both MSM and WSW are contentious, with some claiming that these terms contribute to erasure of LGBTI identities, while other scholars highlight that LGBTI is an Anglo-centric/Global North concept and erases local meanings in non-Anglo countries.

Non-binary

Non-binary refers to a model of the relationships between sex and gender that does not assume a radical division between sex (a person is either male or female but not both or neither) and gender (a person is masculine or feminine but not both or either). People who are non-binary may have sex characteristics that do not fit a binary model of male or female or may express their gender in ways that do not match the dominant social expectations of the sex they were assigned at birth.

Non-monosexual/nonmonosexual

Nonmonosexual people are attracted to more than one gender. Nonmonosexuals may self-identify as **bisexual**, **pansexual**, **omnisexual**, **polysexual**, or another sexual/ romantic identity.

Open Relationship

See **Polyamory**.

Pansexual/Omnisexual/Polysexual

Terms used to describe people who have romantic, sexual or affectional desire for people of all/multiple genders and sexes.

Polyamory

Polyamory is the practice of, or desire for, intimate relationships involving more than two people with the knowledge and consent of everyone involved. Sometimes

referred to as **multiple ethical relationships** or **consensual or ethical non-monogamy**. May also be used interchangeably with **open relationships**.

Preferred pronoun

A pronoun is a word that refers to either the people talking (I or you) or someone or something that is being talked about (like she, it, them, and this). Gender pronouns (he/she/they/ze etc.) specifically refer to people that you are talking about. A gender pronoun is the pronoun that a person uses for themselves. For example: If Alex's pronouns are *she*, *her*, and *hers*, you could say "Alex ate her food because she was hungry." Preferred pronouns are a recognition that someone's preferred pronoun use may not correspond with their gender identity. Asking and correctly using someone's pronouns is one of the most basic ways to show respect for their gender identity. See also **Pronoun Cueing**.

Pronoun cueing

Using words and actions to send a "cue" about someone's gender. This is a proactive and respectful way of making people aware of someone's gender who might otherwise be misgendered. Examples include using "She" or "The woman who was speaking yesterday..." to talk about a woman who had been misrecognised as male by friends or co-workers.

Queer

Queer is often used as an umbrella term that includes non-heteronormative gender identities and sexual orientations. The term has also been used as a critique of identity categories that some people experience as restrictive and limiting. For some older LGBTI people the term is tied to a history of abuse and may be offensive.

Romantic orientation

Refers to an individual's pattern of romantic attraction based on a person's gender, specifically, who someone feels they generally fall in love with. This is considered distinct from sexual orientation, which refers specifically to a person's patterns of sexual attraction, which is distinct from romantic attraction. This may include:

Aromantic: Lack of romantic attraction towards anyone (aromanticism).

Heteroromantic (or heteromantic): Romantic attraction towards person(s) of the opposite gender (heteroromanticism).

Homoromantic: Romantic attraction towards person(s) of the same gender (homoromanticism).

Biromantic: Romantic attraction towards person(s) of two or more, but not all genders. Sometimes used the same way as panromantic (biromanticism).

Panromantic: Romantic attraction towards person(s) of any, every, and all genders (panromanticism).

Demiromantic: Romantic attraction towards any of the above but only after forming a deep emotional bond with the person(s) (demiromanticism).

Same-sex attraction/attracted

Sexual and/or emotional attraction toward people of one's own sex. This includes lesbian, gay and bisexual people and people who may be questioning their sexuality, or do not want to label themselves. The term has also been used to describe young people whose sense of sexual identity is not fixed and experience sexual feelings toward people of their own sex. Others prefer the term same gender attracted.

Sex/ Sex characteristics	A person's physical characteristics relating to sex, including genitalia, chromosomes or hormones and also secondary sex characteristics that emerge at puberty.
Sexual and/or gender minority	Sexual and/or gender minority is a group whose sexual or gender identity, orientation or practices differ from the majority of the surrounding society. Such terms may be understood as less inclusive.
Sexual orientation	Describes a person's sexual or emotional attraction to another person based on that other person's sex and/or gender. The term is restricted in law to sex only and refers to attraction to persons of: the same sex (gay and lesbian); different sex (heterosexual); or persons of both the same and different sex (bisexual). Pansexual is a term that is used to describe someone who is sexually and emotionally attracted to other people regardless of their sex, gender or gender identity.
Sistergirl/Sistagirl	Some Aboriginal, Torres Strait Islander and South Sea Islander communities use various terms to describe or identify a person assigned female or male at birth and identifying or living partly or fully as another gender. In these communities, Sistergirls have a distinct cultural identity and often take on female roles including looking after children and family. Other communities will use different terms to describe gender diversity. These include Brotherboy which is sometimes used to describe an individual assigned female at birth who has a male spirit. However, in other Aboriginal, Torres Strait Islander and South Sea Islander communities Brotherboys is used as a generic term to describe a group of men who relate to each other – "my brothers" – and similarly Sistergirls is used to describe a group of women.
Trans/ Transgender	A person whose gender identity or expression is different from that assigned at birth or those who sit outside the gender binary. The terms male-to-female and female-to-male may be used to refer to individuals who are undergoing or have undergone a process of gender affirmation. Transgender and trans* are older terms and may now be seen as less inclusive than trans and gender diverse. Terms that may be used now include transman/transmasculine/transmale, and transwoman/transfeminine/transfemale among others.
Transition	The process by which a trans or gender diverse person affirms their gender. Transition may include some or all of the following: cultural, legal or medical adjustments; telling friends, family and/or colleagues; changing one's name and/or sex on legal documents; hormone therapy; or, surgical intervention. For some trans and gender diverse people the social context of transition may be more important than the physical aspect of transitioning.
Transphobia	A fear, hatred or intolerance of people of who are transgender, or perceived to be transgender that often leads to discriminatory behaviour or abuse.

Glossary: Crisis Support Service Terms

Acute or situational crisis	An acute or situational crisis is understood as an unexpected crisis that arises suddenly in response to an external event or a conflict concerning a specific circumstance. The symptoms are transient, and the episode is usually brief.
Crisis Support Service (CSS)	A Crisis Support Service (CSS) is a service specifically designated to provide support during a time of acute crisis. Such services are generally linked in with other intervention or emergency services including the police and ambulances to provide immediate intervention, such as if a caller is at risk of suicide or self-harm. Examples including Lifeline and Suicide Call Back .
Counselling and mental health support services	Counselling and mental health support services are specifically designated to provide support and counselling. Such services are designed to link users in with other mental health and other social services, but are not directly linked with intervention services such as the police. Examples include beyondblue , headspace and QLife among others.
Intervention or emergency services	Intervention or emergency services are services that are designed to provide immediate emergency support or intervention to a situation. Police, ambulances, and firefighters among others can be understood as an intervention service.
Personal & mental health crises	Personal crises refers to everyday life and events that can contribute to an experience of crises, such as family or relationship breakdown, work stress, or a traumatic event. Mental health crises refers to an experience of crisis that may be directly related to a pre-established or undiagnosed mental health issue, such as depression, anxiety or complex mental health disorders such as borderline personality disorder.

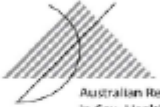
Appendix A: Advertising Flyer



Understanding LGBTI
Lives in Crisis

Human Ethics ID: HEC18159

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 Australian Research Centre
in Sex, Health and Society

Want to help improve Crisis Support
Services for the LGBTI Community?

If you are:

18+,
Identify as LGBTI,
Reside in Australia,
Have ever used, or thought of using a Crisis Support
Service,

We want to hear from you!

Take Our Survey!

 a.waling@latrobe.edu.au

 facebook.com/lgbtilivesincrisis

 latrobe.co1.qualtrics.com/jfe/form/SV_bwJEnXT8A728NRr



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