Safe Connections Toowoomba: Connecting and Supporting LGBTQIA+ Communities

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Acknowledgements

To begin, we would like to acknowledge the Jagera, Giabal and Jarowair peoples, including LGBTQIA+ Sistergirl and Brotherboy peoples, of the lands that Toowoomba region are based on, and where the studies reported on here were conducted.

We would like to thank Lifeline Darling Downs & South West Queensland for funding the *Safe Connection Toowoomba: Connecting and Supporting LGBTQIA+ Communities* program of research, and making the individual studies and this report possible. Specifically, we wish to thank their leadership team, Jacqueline Hudson (Practice and Program Manager), Rachelle Patterson (Chief Operating Officer – Human Service Division), and Darren Tomlinson (Practice and Program Manager); current and past Domestic and Family Violence Support Practitioners Margaret Martin, Alexandra Fort, Rhonda Martindale, and Nathan Anastasi; Rob Nielsen (Positive Relationships Volunteer); and Mitch Jackson-Ryan (Artist of research report front cover and other promotional material).

The Toowoomba LGBTQIA+ Health and Wellbeing Survey was generously endorsed by a Community Advisory Group representing rainbow community members of intersectional backgrounds (First Nations Australians; Culturally and Linguistically Diverse; Abilities; Age; Spiritual Affiliation) in Toowoomba. The group played an important role in the survey development by providing substantial inputs into the design of the survey questions, providing rigorous feedback on the first full draft of the survey informing the final and subsequently released online survey tool, including identifying best avenues to promote and distribute the survey to reach the maximum number of Toowoomba community members. We are immensely appreciative of the Community Advisory Group for all their insights, support and guidance throughout this project.

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Finally, we wish to acknowledge and thank the many caring professionals and practitioners who completed the LGBTQIA+ Awareness Raising Training surveys, and the 111 Toowoomba LGBTQIA+ Sistergirl and Brotherboy community members who voiced their health and wellbeing stories with us. Thank you for generously giving your time to these studies; without your voices and stories this report would not have been possible. We hope this report reflects your voices and experiences and that the findings and recommendations from this report will be used to affirm and support LGBTQIA+ Sistergirl and Brotherboy persons in the Toowoomba region, and beyond.

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Terminology

In this report we use the acronym LGBTQIA+ to refer to people who identify as lesbian, gay, bisexual, trans, queer, intersex or asexual. The '+' symbolises those in our report who identify as gender diverse, same or multigender attracted, however who use a wide range of different terminologies to represent their identity. Some of the identities the '+' include, that readers may be less familiar with, including intersex are:

Brotherboy is an Aboriginal and/or Torres Strait Islander gender-diverse individual (assigned female at birth) who lives and presents as man, who has a male spirit and a specific cultural identity.

Cassgender is a term for people who feel their gender identity is unimportant or irrelevant.

Androsexual refers to the sexual orientation of people who experience sexual attraction to masculine attributes. It does not mean they are exclusively attracted to people who identity as male.

Demisexual is a type of sexual orientation or sexuality and applies to people who only experience sexual attraction on occasion and when a strong emotional bond exists.

Grey-sexual is a term for people who experience sexual attraction infrequently, it is also considered to be on the asexual spectrum.

Heteroflexible refers to a person who is primarily attracted to people of opposite genders but may also experience same sex attractions to the opposite gender.

Hetero-romantic refers to a person's romantic orientation towards a person of the opposite sex.

Intersex is a term for persons who are born with sex characteristics (including genitals, gonads, and chromosome patterns) that do not fit typical binary notions of male or female bodies. It is estimated that between 0.05% and 1.7% of the population is born with variations in sex characteristics (intersex traits). In addition to facing medically unnecessary surgeries and treatment without consent, people with intersex traits also often face stigma and discrimination (United Nations Office of the High Commissioner for Human Rights & United Nations Free & Equal, 2015).

Omnisexual refers to a person's sexual orientation towards all gender identities and sexual attractions.

Sapphic is an umbrella term typically used to describe attraction of a woman to another woman.

Sistergirl is an Aboriginal and/or Torres Strait Islander gender-diverse individual (assigned male at birth) who lives and presents as woman, who has a female spirit and a specific cultural identity.

For the purpose of analysis, and as elaborated in section 3.1.7, it was necessary to collapse people who selected multiple gender identities and sexual identities into one gender and sexuality category, respectively. We reduced the original 14 gender categories (see Table 3) to nine: Trans man, Trans woman, Cisgender man, Cisgender woman, Non-binary, Trans non-binary, Brotherboy, Sistergirl and Not listed. Similar to gender identity, and to adequately convey the multiplicity of the varied and nuanced sexual orientations the original nine categories (see Table 4) were translated into representing 10 categories: Lesbian, Gay, Bisexual, Heterosexual, Pansexual, Pansexual+, Queer, Queer+, Asexual, and Something else.

Executive Summary

Lifeline Darling Downs & South West Queensland in conjunction with the University of Southern Queensland embarked on a program of research seeking to better the health and wellbeing of the LGBTQIA+ community based in the Toowoomba region, in Queensland Australia. Using a multi-pronged approach, this program of research sought to investigate: 1) the experiences of LGBTQIA+ people regarding aspects of their health and wellbeing; and 2) ascertain the impact LGBTQIA+ awareness raising training had on the knowledge, attitudes, and practices of caring professionals and practitioners serving LGBTQIA+ persons in the region. The LGBTQIA+ Health and Wellbeing Survey was distributed to the Toowoomba region LGBTQIA+ community between March and May 2022. The LGBTQIA+ Awareness Raising Training for Caring Professionals (a program of three workshops) was conducted with multiple training groups of caring professionals and practitioners who work within the Toowoomba region between July 2021 and June 2022. Pre and post surveys of workshop participants were administered. The results of these surveys are captured within this report.

LGBTQIA+ Health and Wellbeing Survey

About Participants

- There were 111 LGBTQIA+ participants who at the time of the survey resided in the Toowoomba region, 84.7% from within Toowoomba and the remaining 13.5% from the Greater Toowoomba region.
- The mean age of participants was 32.3 years ranging from 14 to 71 years.
- 5.4% of participants identified as Aboriginal. 91% of participants were born in Australia and 95.5% of participants had English as their first language.
- Participants' gender was diverse and included 70.4% of individuals with one gender identified, and the remaining 29.6% with multi-genders.
- When gender was collapsed into one category per participant there were 29.6% cisgender women, 23.1% non-binary, 20.4% cisgender men, 11.1% trans non-binary, 5.6% trans men, 5.6% trans women, 1.9% Sistergirls, 1.9% not listed, and 0.9% Brotherboys.
- Participants' sexuality was also diverse and included 64.5% of individuals with one identified sexuality and the remaining 35.5% with multi-sexualities.
- When sexuality was collapsed into one category per participant there were 19.1% bisexual, 18.2% gay, 17.3% queer+, 11.8% pansexual+, 10% lesbian, 8.2% queer, 4.5% heterosexual, 4.5% asexual, 3.6% something else, and 2.7% pansexual.
- Three participants were born with an intersex variation.
- 52.2% of participants had a disability, long-term health condition or both.
- 49.1% of participants were in one or more current romantic relationships, 38.2% were not, and 10% were too scared to be in a romantic relationship.
- 80.2% of participants did not have children.
- 22.5% of participants engaged in a religious and/or spiritual practice.

Housing and Homelessness

- 46.2% reported living in their own residence (e.g., house, flat, townhouse etc), 40.6% renting, 5.7% sharing accommodation, 7.5% other (e.g., caravan park, owned by parents/family, couch surfing).
- 42.7% lived with partner/s, 24.5% with parents/carers, 14.5% with children/dependents, and 14.5% were living alone.
- 29% of participants had experienced barriers to housing.
- 15.3% of participants had experienced homelessness with 70.5% due to financial hardship, 52.9% family rejection/abandonment, 52.9% mental health, and 41.2% unemployment among other factors reported.

Discrimination and Harassment

- 58.2% of participants had experienced discrimination within the past 12 months.
- 100% of Sistergirls; 83% of trans men; 68.2% of cisgender men; 66.7% of trans women and trans non-binary; 56.3% of cisgender women; and 37.5% of non-binary people had experienced gender discrimination.
- 75% of pansexual+, 73.7% of queer+, 65% of gay, 63.6% of lesbian, 55.6% of queer, 47.6% of bisexual, 40% of asexual, 33.3% of pansexual, 25% something else, and 20% of heterosexual persons had experienced discrimination based on sexuality.
- Discrimination was experienced across a range of locations including 17% workplace, 14% in a public place within the Toowoomba region, 10.5% educational setting, 9.2% shopping for goods/services, 8.7% religious/spiritual setting, 6.1% community groups, and 5.7% at home.
- The types of discrimination experienced included 60.9% verbal abuse, 56.3% bullying, 54.7% being "outed", 54.7% unfair treatment, 50% social exclusion, and 40.6% offensive gestures.
- All persons with intersex variations reported there were no specific policies and procedures in their workplaces to prevent discrimination.

Feelings of Support, Acceptance and Safety

- Participants who felt a lot/always supported identified 78.1% by friends, 54.7% with LGBTQIA+ Toowoomba communities, 47.9% by family, and 46.1% by health professionals.
- Participants who felt a little or not at all supported identified 82.5% by religious/faith-based settings, 50.9% within sport/physical activity settings, and 34.4% by family.
- 50% of participants did not feel safe to come out or disclose or affirm their gender, sexual orientation and/or sex characteristics.
- Participants reported feeling a lot/always safe to come out or disclose or affirm their gender, sexual orientation and/or sex characteristics with friends (71%), LGBTQIA+ Toowoomba community members (60%), family (41.8%), and with health professionals (37.2%).
- All persons with intersex variations reported there were no specific policies and procedures in workplaces to support the needs (including health-related needs) of people with variations in sex characteristics; and there is a lack of training to appropriately support/accommodate people with intersex variations.

Quality of Life and Psychological Wellbeing

- 27% of participants were either dissatisfied (12.4%) or extremely dissatisfied (14.6%) with their life.
- More than three quarters of trans non-binary participants (77.7%) were dissatisfied with life. Trans women were overall dissatisfied with life. 74% of cisgender women, and 55.6% of cisgender men were more likely to be satisfied with life.
- 70% of lesbian, 66.7% of gay, 62.6% of bisexual, and 56.3% of queer+ participants were more likely to be satisfied with life. Heterosexual, asexual and something else participants were polarised with 50% being either satisfied or dissatisfied with life. 66.6% of pansexual participants were more likely to be slightly satisfied with life. And 83.3% of pansexual+ and 66.7% of queer participants were more likely to be dissatisfied with life.
- 30.8% of participants reported having good, 20.9% very good, and 4.4% excellent general health. Conversely, 30.8% of participants reported having fair and 13.2% poor general health.
- Regarding depression, 20.5% reported no depression. 20.5% of participants reported mild, 25% moderate, 14.8% moderately severe, and 19.3% severe depression.
- 100% trans non-binary, 100% Sistergirl, and 100% Brotherboy participants reported moderate to severe depression. 71.5% non-binary, 66.7% trans men, 50% cisgender women, and 36.9% cisgender men were more likely to report moderate to severe depression, than mild or no depression.
- 80% pansexual+, 75% asexual, 71.5% queer, 66.7% pansexual, 66.6% bisexual, 50.1% queer+, and 37.6% gay participants were more likely to

report moderate to severe depression, than mild or no depression.

Health and Support Service Engagement

- 71.3% of participants see a regular GP, 18.4% go to the same medical clinic and see any of the available GPs, 10.3% don't have a regular GP, 8% use a telehealth service, 6.9% see a GP outside of Toowoomba, and 5.7% go to different medical clinics.
- Regarding the types of health professionals seen in the past 12 months include, 87.4% saw a GP, 48.3% saw an allied health service, 20.7% visited a medical specialist (other), and 18.4% visited a sexual health service.
- 90.8% of participants accessing health care within the Toowoomba region reported experiencing discrimination including: 61.7% lack of LGBTQIA+ supportive services; 55.3% reported incorrect assumptions about health needs/issues; 38.3% reported dismissal of worries/concerns relating to health; and 36.2% reported lack of expertise in gender affirming healthcare.
- 32.5% of participants had accessed healthcare outside the Toowoomba region in the past 12 months.
- Of the participants who had accessed healthcare outside the Toowoomba region, 32% accessed a GP, 32% accessed a surgeon, 20% accessed a medical specialist (other), 16% accessed an endocrinologist, 8% accessed an allied health service, and 4% accessed a sexual health service.
- The most commonly reported reasons for travelling outside Toowoomba to access a health service include 48% the service not being available in Toowoomba; 20% lack of expertise in gender affirming health care; 20% lack of LGBTQIA+ supportive services; and 16% did not feel safe accessing health services in the Toowoomba region (among a range of other reasons).
- 89.5% of participants reported it was either very important (70.9%) or important (18.6%) that their health service is LGBTQIA+ friendly/inclusive.

Domestic, Family and Intimate Partner Violence (DFIPV)

- 53.5% of participants had experienced DFIPV at either some time in their life (44.2%) or within the past 12 months (9.3%).
- All trans women reported experiencing DFIPV.
- Non-binary, cisgender women and Sistergirls were equally likely to experience DFIPV than not. Trans non-binary and trans men were more likely to experience DFIPV (88.9% and 60% respectively) than not.
- 75% of pansexual+, 64.3% of bisexual and 57.1% of queer+ participants were more likely to experience DFIPV than not. Conversely, 75% asexual, 66.7% pansexual, 57.1% queer, 53.3% gay, and 50% of lesbians were less likely to experience DFIPV than to experience DFIPV.
- 28.9% of participants who had experienced DFIPV reported it was due to their LGBTQIA+ identity.
- 47.8% of participants who had experienced DFIPV, did not report the violence to a professional service due to a range of reasons including being unaware they were experiencing DFIPV; being underage and family violence was accepted; fear of disbelief and/or judgement by organisations that lack LGBTQIA+ DFIPV awareness; they chose to leave the relationship; or they had no capacity to report the violence.

LGBTQIA+ Awareness Raising Training for Caring Professionals

About Participants

- There were 42 caring professional and practitioner participants. At the time of the survey, 69% resided within Toowoomba, 26.2% from the Greater Toowoomba region, and 4.8% working in Toowoomba but residing outside the region.
- The mean age of participants was 45.5 years ranging from 24 to 72 years.
- One participant identified as Aboriginal and another as Aboriginal and Torres Strait Islander. 90.5% of participants were born in Australia and all participants reported Australian/English as their first language.
- Participants' gender included 78.6% cisgender women, 19.5% cisgender men, and one participant who preferred not to say.
- Participants' sexuality included 85.7% heterosexual, 7.1% bisexual, with remaining participants identifying as pansexual (2.4%), lesbian (2.4%), gay (2.4%) or other (2.4%).
- Participants were employed by a community organisation (38.1%), allied health (31%), school and education support (19%), and emergency services and safety (14.3%).
- 73.8% of participants were not in a leadership role and 21.4% were in a leadership position.

Knowledge and Familiarity about LGBTQIA+ Concerns

- Post training, participants were more familiar with LGBTQIA+ inclusive language (Pre = 38.1%, Post= 85.7%) and behaviours (Pre = 35.7%, Post= 83.3%). Among the highest areas of increase were in relation to understanding the terms Brotherboy and Sistergirl (66.6%), familiarity with what intersex variations include (66.6%), understanding the term pansexual (59.5%), and being able to distinguish between the letters in the LGBTQIA+ acronym (59.5%).
- Post training participants also reported increased knowledge and familiarity regarding the disproportionate levels of discrimination (Pre = 59.5%, Post = 97.6%) and marginalisation (Pre = 54.8%, Post = 95.2%) LGBTQIA+ persons experience. Among the highest areas of increase were in relation to understanding that LGBTQIA+ people are at a higher risk of psychological distress (2.3%), increased suicide attempts (14.3%), and homelessness (14.3%), and could name barriers to accessing diverse support services (57.1%).
- Regarding DFIPV, post training participants demonstrated increased knowledge and familiarity with the types of DFIPV unique to LGBTQIA+ persons (Pre = 23.8%, Post = 81%), ability to identify complexities of DFIPV within the LGBTQIA+ community (Pre = 19%, Post = 78.6%), and understanding the rates of DFIPV experienced by LGBTQIA+ persons in an intimate partner violence situation (38.1%). Awareness of the barriers precluding LGBTQIA+ people accessing support for DFIPV also increased.

Attitudes about LGBTQIA+ Concerns

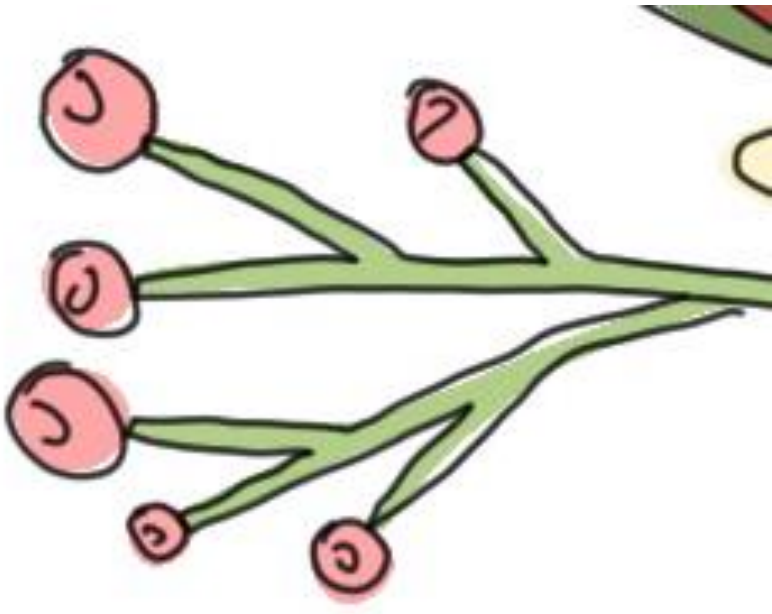
- Post training, participants' attitudes towards gender, sexuality and intersex variations had increased across a number of areas, the highest change in relation to recognising that intersex people are not 'abnormal' or 'disordered'; they typically have healthy bodies (14.3%); and bisexual or pansexual persons are not lesbian or gay (11.9%).
- Post training participants' attitudes towards discrimination and marginalisation had increased across a number of areas, the highest change in relation to recognising that it is not important to ask intersex persons if they have been subjected to intersex genital surgeries (26.2%), and it is not important to ask trans persons about their gender identity and if they have pursued gender affirming surgery (14.3%).
- Post training participants' attitudes towards inclusive health and support service and workplaces had increased across a number of areas, the highest change in relation to recognising that LGBTQIA+ persons should not only access accredited LGBTQIA+ inclusive health and support services (9.6%), and workplaces

with religious ethos should NOT hire/dismiss an employee based on gender identity (7.1%).

- Post training participants' attitudes towards DFIPV experiences by LGBTQIA+ persons had increased across a number of areas, the highest was in relation to recognising that DFIPV is NOT always about control (23.8%); and DFIPV is not a mutual fight (9.5%).

Practices, Procedures and Behaviours about LGBTQIA+ Concerns

- Post training, participants demonstrated increased empathy towards LGBTQIA+ people (Pre = 78.6%, Post = 100%). Participants also reported an increase in use of inclusive language both personally (23.8%) and professionally (14.3%), and inclusive behaviours both personally (26.2%) and professionally (28.6%).
- Post training, participants reported increased confidence in having discussion with LGBTQIA+ people about issues relating to their gender identity (31%), intersex variation/s (23.8%), and sexual orientation (19.1%).
- Post-training, participants reported if they witnessed LGBTQIA+ discrimination, they were more likely to speak up at work (16.7%) and outside work (16.7%). Likewise, if they witnessed LGBTQIA+ marginalisation, participants reported they were more likely to speak up at work (23.9%) and outside work (11.9%). Additionally, practitioners reported an increase of 19.1% in seeking to be an LGBTQIA+ ally.
- Regarding DFIPV, practitioners reported increased levels of confidence in recognising (42.9%), discussing (38.1%), referring (50%) and responding (45.2%) to DFIPV unique to LGBTQIA+ people.



1. Background

Two national reports conducted by the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University, namely *Private Lives 3: The Health and Wellbeing of LGBTIQ People in Australia* (Hill et al., 2020) and *Writing Themselves In 4: The Health and Wellbeing of LGBTQA+ Young People in Australia* (Hill et al., 2021), have been instrumental in demonstrating the health and wellbeing of LGBTQIA+ peoples and communities across Australia. The combined focus of these reports, centre around the identities and experiences of LGBTQIA+ adults and young people in urban, regional, and rural Australia in the areas of housing and homelessness; discrimination; domestic, family, and intimate partner violence; alcohol and other drugs; and mental health and wellbeing, including engagement with support services and community connections. Valuable insights drawn from these reports have led to changes in policy development and implementation practices; altered attitudes, beliefs and behaviours of education bodies, service providers, and government agencies supporting LGBTQIA+ individuals. This report, based on a program of research in the regional and rural setting of the Toowoomba region, aims to: 1) advance existing knowledge, and contribute to new knowledge regarding the specific health and wellbeing experiences of LGBTQIA+ people in this region; and 2) explore and call attention to the knowledge, attitudes and practices of caring professionals and practitioners servicing LGBTQIA+ people in the region, including services that support them.

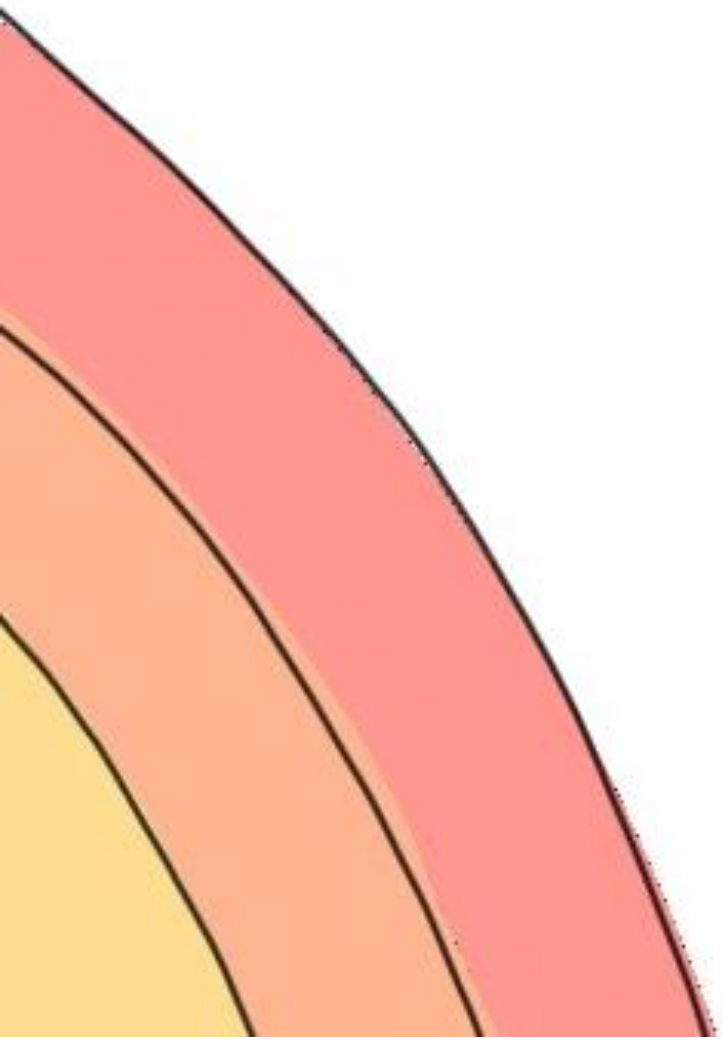
The greater Toowoomba region encompassing the lands of the Jagera, Giabal and Jarowair First Nations peoples, is situated approximately 130kms from the city of Brisbane in Queensland, Australia. With a population size of approximately 150,000 people (Australian Bureau of Statistics [ABS], 2016a), there is currently no knowledge regarding the exact numbers of LGBTQIA+ people that reside in this location. Estimates based on the Australian 2016 census national level data suggest that per 100,000 people approximately 42.9 number of people identify as a gender other than male or female (ABS, 2016b), and 0.17 number of people have an intersex variation/s (ABS, 2016b). Additionally, four percent of the Australian population identify as LGB (ABS, 2020). Due to its distance from the city of Brisbane and its primarily agricultural focus, Toowoomba is classified as an inner-regional location (Queensland Health, 2014). Traditionally a safe Liberal and National Party seat (ABC News, 2022), Toowoomba has a history steeped in conservative values as evidenced by the more recent results of the 2017 Same Sex Marriage referendum which sought the opinion of Australian residents as to whether same-sex couples should be entitled to marriage under Federal legislation (ABS, 2017b). Notably, Groom, the Federal seat encompassing the Toowoomba region, voted 'no'. Groom showed one of the lowest percentages of people to vote 'yes' (49.2%; ABS, 2017a) in any seat of Australia, much lower than both the national average (61.6%; ABS, 2017b), and that of its home state of QLD (60.7%; ABS, 2017b).

Set against this backdrop, the latest ABS (2020) General Social Survey noted that LGBT people nationally were "more likely to report experiencing discrimination than people who described themselves as heterosexual (30% compared to 13%)" (para. 7) and "more likely to have experienced at least one personal stressor in the last 12 months (76% compared to 58%)" (para. 12).

While the challenges posed by LGBTQIA+ persons in Australia are many and well documented, with an emerging understanding of the challenges LGBTQIA+ persons experience in regional/rural Australia (Hill et al., 2021, 2020), there is little to no research explicitly engaging with LGBTQIA+ people in the Toowoomba region. Broader research suggests that LGBTQIA+ persons in regional/rural Australia, similar to those of the Toowoomba region, experience very high psychological distress, and higher levels of suicide ideation than those in inner

suburban areas (Hill et al., 2021). Additionally, more than 13% of LGBTQIA+ persons report homelessness in their lifetime, with perceived causes rooted in mental health issues, rejection from family, and family violence. LGBTQIA+ persons in regional/rural areas also report they have been verbally harassed (41%), physically harassed/assaulted (10%), or sexually harassed/ assaulted (22%) based on their gender and/or sexuality (Hill et al., 2021).

Within this context, this report documents how the health and wellbeing of LGBTQIA+ persons in the Toowoomba region are experienced and affected regarding the following specific domains: demographics; housing and homelessness; discrimination and harassment; feelings of support, acceptance, and safety; quality of life and psychological wellbeing; health and support service engagement; domestic, family and intimate partner violence; and community connection. Drawing on a diverse range of LGBTQIA+ voices, this report elicits a picture of a strong and vibrant LGBTQIA+ population and yet amplifies existing knowledge that there is still much do be done until LGBTIQA+ people feel safe, included, and respected in all aspects of their lives (Hill et al., 2021, 2020). In addition, drawing on the voices of caring professionals and practitioners who provide services to LGBTQIA+ people in the region, this report investigates their knowledge, attitudes and practices regarding LGBTQIA+ people. This report concludes with a range of recommendations to improve the health and wellbeing of the LGBTQIA+ population in the Toowoomba region.



2. Methods

2.1. LGBTQIA+ Health and Wellbeing Survey

Community consultation

On the 15th of June 2021 the research team consulted with a Community Advisory Group (CAG), representing the LGBTQIA+ community in the Toowoomba region to ensure the LGBTQIA+ Health and Wellbeing Survey met the needs of the community. This initial consultation aimed at: 1) identifying the most important and relevant concepts, and areas of concern for health and wellbeing; 2) including factors contributing to feeling supported and affirmed as an LGBTQIA+ person, and positive about one's health and wellbeing; 3) ensuring the survey and outputs capture the diversity of the LGBTQIA+ community; and 4) identifying the best avenues to promote and distribute the survey to reach the maximum number of Toowoomba community members. The CAG meeting was recorded and transcribed verbatim, followed by a thematic analysis to identify key themes and concepts stemming from the CAG leading to the development of the survey. The CAG then provided rigorous feedback on the first full draft of the survey which informed the final and subsequently released online survey tool.

Lifeline Darling Downs & South West QLD was included in the consultation process and participated in the CAG consultation meeting, providing valuable input from their experience in working directly with Toowoomba region LGBTQIA+ community members. Lifeline provided feedback on the first full draft of the survey and then piloted the online version of the survey tool prior to release.

Survey development

The questions developed for the LGBTQIA+ Health and Wellbeing Survey were based on the priorities identified through the CAG consultation process and guided by ARCSHS's national reports, *Private Lives 3: The Health and Wellbeing of LGBTIQ People in Australia* (Hill et al., 2020) and *Writing Themselves In 4: The Health and Wellbeing of LGBTQA+ Young People in Australia* (Hill et al., 2021). Three validated standardised measures were included in the survey: the Satisfaction with Life Scale; the Healthy Days Measure (CDC HRQOL-4; general health, physical health, mental health); and the Patient Health Questionnaire (PHQ-9) to measure depression. The inclusion of standardised measures will allow comparisons of the data to the broader general population and to other LGBTQIA+ communities. The online version of the survey had an intelligent branching design where additional questions were presented based on prior responses to better understand the nuanced experiences of LGBTQIA+ community members in the Toowoomba region.

Participants and recruitment

The target participants were any person who identified as lesbian, gay, bisexual, trans, queer, intersex, asexual, Sistergirl, Brotherboy and/or any other sexually and/or gender diverse person who currently lived within the Toowoomba region and had the capacity to access the survey. Participants provided informed consent/assent. Pseudonyms are used when reporting on participants' open-ended answers in this report.

The CAG and Lifeline assisted with identifying the best channels for advertisement and distribution of the survey recruitment material which included a suite of promotional flyers (e.g., posters, social media images) and artwork from within the rainbow community, such as that representing the front cover of this report commissioned by Lifeline. The flyers and posters were physically distributed around Toowoomba and within businesses and LGBTQIA+ community organisations. The promotional material was additionally circulated via an email distribution lists, social media posts (e.g., diverse open and closed LGBTQIA+ Facebook communities, Ally networks, Queensland Hospital and Health Service networks). In addition, a number of broadcast and digital media appearances were conducted in conjunction with Trans Visibility Day and IDAHOBIT day to promote the survey. Communications were also sent to local Health and Wellbeing support organisations, including Toowoomba regional councillors.

Ethics approval was granted by the University of Southern Queensland Human Research Ethics Committee: H21REA268.

The survey was undertaken from 21 March to 31 May 2022.

2.2. LGBTQIA+ Awareness Raising Training for Caring Professionals

Participants

Participants were recruited by Lifeline Darling Downs & South West QLD. Participants comprised one of four frontline caring professionals in the Toowoomba region, were 18 years of age or older, completed the pre-workshop survey, participated in all three workshops, and completed the post-workshop survey. The four cohorts of caring professionals included:

1. School staff (e.g., principals, teachers, and administrative staff) and education support professionals (e.g., school counsellors, nurses, psychologists, chaplains, and social workers);
2. Emergency services and safety professionals (e.g., police service, fire and emergency service and ambulance service);
3. Frontline allied health service professionals (e.g., social workers, psychologists, counsellors, and others providing essential care for LGBTQIA+ individuals at different stages of their lives); and
4. Community organisations (e.g., non-government organisations, council members).

Participants provided informed consent and pseudonyms are used when reporting on participants' open-ended answers within this report.

Ethics approval was granted by the University of Southern Queensland Human Ethics Research Committee: H21REA146.

Recruitment commenced in July 2021.

Materials

The mixed-methods pre- and post- surveys developed by the research team closely reflected the content of the awareness raising workshops and was designed to assess the effectiveness of the Lifeline LGBTQIA+ awareness raising workshops. The pre- and post-surveys were offered to participants online through the UniSQ Survey Tool, and captured participants' demographic information, and their knowledge, attitudes, and practices around:

1) gender, sexuality and variations in sex characteristics;
2) discrimination and marginalisation experienced by LGBTQIA+ persons; and
3) domestic, family and intimate partner violence within LGBTQIA+ contexts.

Participants self-rated on a 5-point Likert scale how much they agreed/disagreed with a particular statement with responses ranging from 1 = strongly disagree; 2 = disagree; 3 = undecided/not sure; 4 = agree; and 5 = strongly agree. At the conclusion of each section (both pre- and post-surveys), participants were prompted with an open-ended question concerning their hopes and the extent to which the LGBTQIA+ awareness training would/had positively influence/d their caring profession and practise.

Method

Matched data was analysed using a frequency count and an exact McNemar's test to determine the difference in participants' pre- and post-workshop survey responses. Some questions were reverse scored to reflect desired responses of participants. Questions relating to workplace changes were analysed using descriptive statistics and reported on whether their workplace did or did not engage in the practice.

Qualitative responses to the open-ended questions in the pre- and post-surveys were analysed using Braun and Clarke's (2019) revised six-step guide to thematic analysis. The six phases were applied flexibly with the end goal of capturing the "uniting idea" of a theme within each major domain: knowledge, attitudes, and practices (Braun & Clarke, 2019, p. 593).

3. LGBTQIA+ Health and Wellbeing Survey

In total, 111 participants with sufficient responses were included in the dataset. Where participants did not provide an answer for a section of the survey, these cases are excluded from the relevant sections and will be retained in sections where they provided responses. To reflect the missing data, the number of participants per analysis will be reported.

3.1. Demographic Characteristics of Sample

3.1.1. Age of participants

Table 1: Age of participants (N = 111)

Age (years)	N	%
<18	9	8.1
18 to 24	26	23.4
25 to 34	40	36.0
35 to 44	16	14.4
45 to 54	12	10.8
55 to 64	5	4.5
65+	1	0.9

Note. Two participants did not report their age.

The mean age of participants was 32.3 years (Standard Deviation [SD] = 12.4), ranging from 14 to 71 years. Approximately one third (36%, n = 40) were aged between 25 to 34 years.

3.1.2. Location of residence

Most participants (84.7%, n = 94) resided within Toowoomba and the remaining (13.5%, n = 15) were from the Greater Toowoomba region. Two participants did not report their suburb or postcode.

3.1.3. Pronouns

Participants were provided with a list of preferred pronouns and were able to select more than one option. In addition to the list, they were also asked to state in their own words their preferred pronouns.

Table 2: Preferred pronouns (N = 111)

Pronoun	N	%
She/Her/Hers	58	52.3
He/Him/His	48	43.2
They/Them/Theirs	29	26.1
Not listed	4	3.6
No pronoun	3	2.7

Note. Participants could select more than one option. The % column reflects the percentage of the total number of participants (N = 111).

Most participants (80.2%, n = 89) selected one pronoun option, 11.7% (n = 13) two options, and 8.1% (n = 9) three options. The 4 participants who selected 'Not listed', their stated pronouns included Zie/Zir, He/Him/It, Neo-pronouns, and one response has been redacted to maintain the anonymity of the participant.

3.1.4. Gender identity

Participants were provided a list of preferred gender identities and were able to select more than one option to best reflect the multiplicity of gender identity. In addition to the list, they were also asked to state in their own words their preferred gender identity.

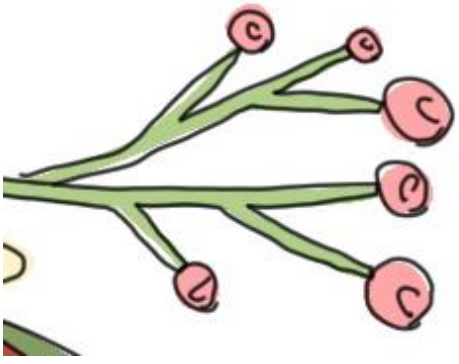


Table 3: Preferred gender identity (N = 108)

Gender	N	%
Cisgender woman/ female (non-trans)	36	33.3
Cisgender man/male (non-trans)	25	23.1
Non-binary	21	19.4
Trans	17	15.7
Genderqueer	14	13.0
Gender non-conforming	12	11.1
Genderfluid	10	9.3
Trans man	10	9.3
Trans woman	7	6.5
Agender	5	4.6
Not listed	3	2.8
Sistergirl	2	1.9
Brotherboy	1	0.9
Pangender	1	0.9

Note. Participants could select more than one option. The % column reflects the percentage of the total number of participants (N = 108).

Most participants (70.4%, n = 76) selected one gender option, 14.8% (n = 16) two options, 9.3% (n = 10) three options, 3.7% (n = 4) four options, and 1.9% (n = 2) five options. The top four preferred gender identities selected by participants were cisgender woman (33.3%), cisgender man (23.1%), non-binary (19.4%), and trans (15.7%). Of the three participants that selected 'Not listed', their stated gender included cassgender and gender diverse.

3.1.5. Sexual orientation

Participants were provided a list of preferred sexual orientations and were able to select more than one option to best reflect the multiplicity of sexual orientation.

Table 4: Preferred sexual orientation (N = 110)

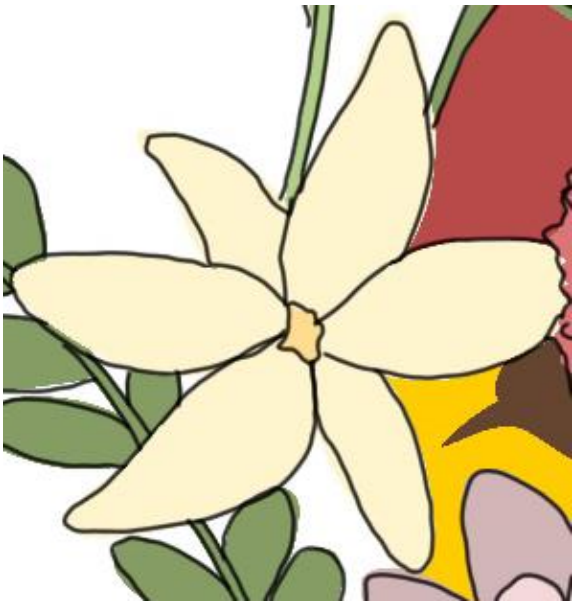
Sexual orientation	N	%
Bisexual	30	27.3
Gay	30	27.3
Queer	28	25.5
Pansexual	22	20.0
Lesbian	18	16.4
Asexual	12	10.9
Something else	9	8.2
Aromantic	5	4.5
Heterosexual	5	4.5

Note. Participants could select more than one option. The % column reflects the percentage of the total number of participants (N = 110).

Most participants (64.5%, n = 71) selected one sexual orientation option, 26.4% (n = 29) two options, and 9.1% (n = 10) three options. The top five preferred sexual orientations selected by participants were bisexual (27.3%), gay (27.3%), queer (25.5%), pansexual (20%), and lesbian (16.4%). Of the nine participants that selected something else, their stated sexual orientation included androsexual, demisexual, fem-attracted, grey-sexual, heteroflexible, hetero-romantic, omnisexual, and sapphic.

3.1.6. Intersex variation

Three participants reported being born with an intersex variation.



3.1.7. Intersection of gender identity and sexual orientation

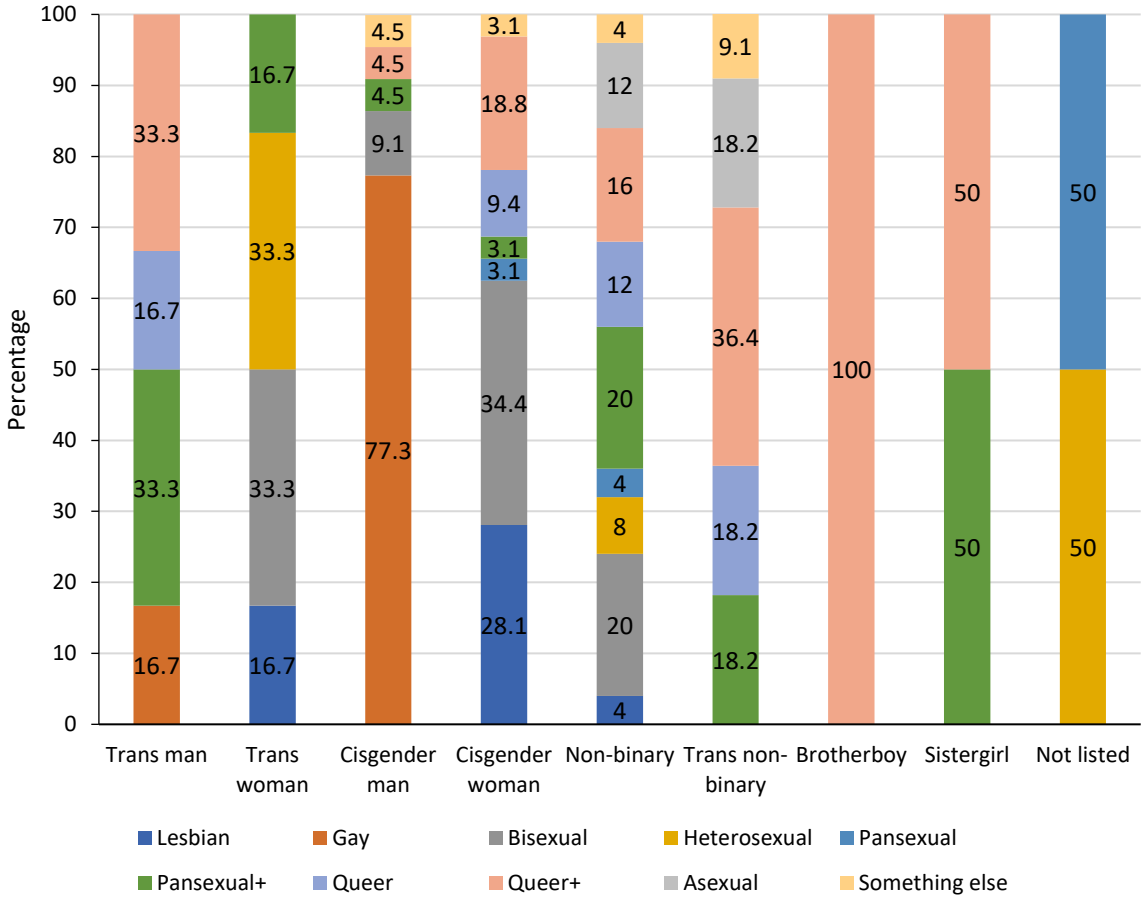
For the purposes of analysis, it was necessary to collapse people who selected multiple gender identities and sexual identities into one gender and sexuality category, respectively. We reduced the original 14 categories for gender (see Table 3) to nine: Trans man, Trans woman, Cisgender man, Cisgender woman, Non-binary, Trans non-binary, Brotherboy, Sistergirl and Not listed. Participants were assigned gender identity categories in the following manner: Trans man included participants who selected trans man plus trans and/or not listed; Trans woman included participants who selected trans woman plus trans; Trans non-binary included participants who selected trans, trans man, trans woman plus any combination of pangender, genderqueer, non-binary, gender fluid, and/or gender non-conforming; Non-binary included participants who selected any combination of pangender, genderqueer, non-binary, gender fluid or gender non-conforming. The categories of Cisgender man and Cisgender woman and Not listed did not require collapsing.

To adequately convey the multiplicity of the varied and nuanced sexual orientations the original nine categories (see Table 4) are now represented by 10 categories: Lesbian, Gay, Bisexual, Heterosexual, Pansexual, Pansexual+, Queer, Queer+, Asexual, and Something else. Similar to gender identity, participants were assigned sexual identity categories in the following manner: Asexual included asexual and/or aromantic; Bisexual included participants who selected bisexual plus any combination of lesbian, gay, asexual, and/or other; Pansexual+ included pansexual plus any combination of asexual, aromantic, bisexual, gay, lesbian, and other; Queer+ included queer plus any combination of asexual, aromantic, bisexual, gay, lesbian, and pansexual. The categories of Gay, Lesbian, Heterosexual, Pansexual, Queer, and Something else did not require collapsing.

Figure 1 displays the intersection of gender and sexual identity of 107 participants. Overall, 18.7% (n = 20) participants identified as Bisexual, 17.8% (n = 19) Queer+, 16.8% (n = 18) Gay, 12.1% (n = 13) Pansexual+, 10.3% (n = 11) Lesbian, 8.4% (n = 9) Queer, 4.7% (n = 5) Heterosexual, 4.7% (n = 5) Asexual, 3.7% (n = 4) Something else, and 2.8% (n = 3) Pansexual.

Trans men (n = 6) identified as Pansexual+ (33.3%), Queer+ (33.3%), followed by Queer (16.7%), and Gay (16.7%). Whereas Trans women (n = 6) were more likely to identify as Bisexual (33.3%) and Heterosexual (33.3%), followed by Lesbian (16.7%) and Pansexual+ (16.7%). Of Cisgender men (n = 22), more than three quarters (77.3%) identified as Gay, followed by Bisexual (9.1%). Of Cisgender women (n = 32), over one third identified as Bisexual (34.4%), followed by Lesbian (28.1%) and Queer+ (18.8%). The sexual identity of Non-binary participants (n = 25) was diverse with two fifths identifying as Bisexual (20%) or Pansexual+ (20%), followed by Queer (16%), Queer+ (12%), Asexual (12%), and Heterosexual (8%). Of Trans non-binary participants (n = 11), over half identified as either Queer (27.3%) or Queer+ (27.3%), followed by Pansexual+ (18.2%) and Asexual (18.2%). The one Brotherboy participant identified as Queer+. The two Sistergirl participants identified as either Pansexual+ or Queer+. The two Not listed participants identified as either Heterosexual or Pansexual.

Figure 1: Intersection of gender identity and sexual orientation (N = 107)



3.1.8. Aboriginal and Torres Strait Islanders

In total 5.4% (n = 6) participants identified as Aboriginal and 1.8% (n = 2) preferred not to say. This is slightly higher than the general population of the Toowoomba region and Australia (4% and 3.3%, respectively; ABS, 2016a, 2018).

3.1.9. Country of birth and language

Most participants (91%, n = 101) were born in Australia. Other countries of birth included South Africa (n = 2) and one participant each from Croatia, England, Malaysia, Scotland, and Taiwan.

English was reported the first language by 95.5% (n = 106) participants. Seventeen (15.3%) participants reported speaking languages other than English which included non-specified Aboriginal language, Afrikaans, Bislama, Chinese, Danish, Dutch, French, German, Japanese, Mandarin, Slavic, and Swedish.

3.1.10. Religious or spiritual practice

Just over one fifth (22.5%, n = 25) of participants reported engaging in religious or spiritual practices. Of these, 23 (92%) participants reported their religious/spiritual belief as Christian (non-specified; n = 8); Catholic (n = 3); Anglican (n = 2); Lutheran (n = 1); Buddhist (n = 1); Jewish (n = 1); Pagan (n = 2); Wiccan (n = 1); Indigenous Australian (n = 1); Buddhist, Hinduist and Quaker (n = 1); combination (undefined; n = 1); and individual spiritual practice (n = 1).

3.1.11.Disability and long-term health conditions

Table 5: Disability and long-term health conditions (N = 111)

Condition	N	%
Disability	21	18.9
Long-term health condition	19	17.1
Both disability and long-term health condition	18	16.2
Unsure disability and/or unsure long-term health condition	7	6.3
Prefer not to say	4	3.6
No	39	35.1
Missing or invalid	3	2.7

Half of the participants (52.2%, n = 58) reported having a current disability, long-term health condition or both (18.9%, 17.1%, 16.2%, respectively; see Table 5). A total of 35.1% (n = 39) participants did not currently experience either a disability and/or long-term health condition.

3.1.12.Education

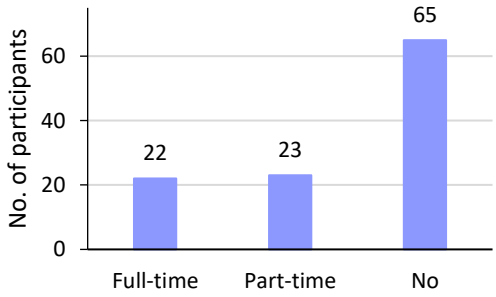
Participants were asked to indicate their highest level of educational achievement.

Table 6: Highest level of educational attainment (N = 111)

Education level	N	%
Less than Grade 10	4	3.6
Grade 10	10	9.0
Grade 12 or equivalent	28	25.2
Certificate II	2	1.8
Certificate III	8	7.2
Certificate IV	6	5.4
Diploma	11	9.9
Advanced Diploma, Associate Degree	1	0.9
Bachelor Degree	21	18.9
Bachelor Honours, Graduate Certificate, Graduate Diploma	11	9.9
Masters Degree	8	7.2
Doctorate/PhD	1	0.9

More than one third of participants (37%, n = 41) reported attaining a bachelor degree or higher, 25% (n = 28) have completed certificate level to advanced diploma/associate degree, 25.2% (n = 28) have completed high school, and 13% (n = 14) have completed less than Grade 12 (see Table 6).

Figure 2: Are you currently studying? (N = 110)



A total of 40.5% (n = 45) participants reported currently studying either full-time or part-time (19.8% and 20.7%, respectively; see Figure 2). Participants who reported currently studying (n = 45) were able to select more than one option from a list of educational institutions and a total of 49 options were selected. Most participants 93.3% (n = 42) selected one option, 4.4% (n = 2)

selected two options, and 2.2% (n = 1) participant selected three options. The most frequent educational institutions selected were 36.7% University (undergraduate), 24.5% secondary school, 18.4% University (postgraduate), 10.2% TAFE, 6.1% Registered Training Organisation, and 4.1% other.

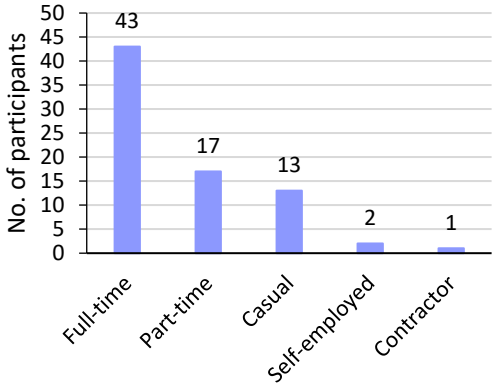
3.1.13. Employment

Table 7: Current employment status (N = 111)

Employment type	N	%
Employed	76	68.5
Unemployed	18	16.2
Unable to work	11	9.9
Domestic/parenting/ caring responsibilities	3	2.7
Retired	2	1.8
Volunteering	1	0.9

Most participants (68.5%, n = 76) reported being employed, 16.2% (n = 18) unemployed, 9.9% (n = 11) unable to work, 2.7% (n = 3), 5.4% (n = 6) domestics duties, retired or volunteering (2.7%, 1.8%, 0.9%, respectively; see Table 7).

Figure 3: Type of employment (N = 76)



Of the participants that reported being employed (n = 76), over half (56.6%, n = 43) were employed full-time, 22.4% (n = 17) part-time, 17.1% (n = 13) casual, and 3.9% (n = 3) self-employed or contractor (2.6% and 1.3%, respectively; see Figure 3).

3.1.14.Romantic relationships

Table 8: Current relationship status (N = 110)

Relationship status	N	%
Yes	54	49.1
No	42	38.2
No - I'm too scared to be in a romantic relationship	11	10.0
Other	3	2.7

Almost half of participants (49.1%, n = 54) reported being in one or more romantic relationship, 38.2% (n = 42) were not currently in a relationship, 10% (n = 11) reported being too scared to be in a romantic relationship (see Table 8). Of the three participants who selected other, one indicated they were coming to terms with being gay and had not been able to have a same-sex relationship; another participant reported being asexual and having no desire to be in a relationship; and the third participant reported engaging in 'hook ups' instead of relationships.

The most stated reason for why participants are fearful of being in a romantic relationship include previous experiences of Intimate Partner and Family Violence and specifically verbal abuse, lying, and sexual assault. Other reported reasons including mental health conditions such as depression complicating being in relationship (Nadine), negative body image impacting self-esteem (Franky), and being a parent (Tony). In addition, Astra felt that as a non-binary person they seldom experienced respect and/or understanding from people in general and had low expectations of prospective partners. They explained:

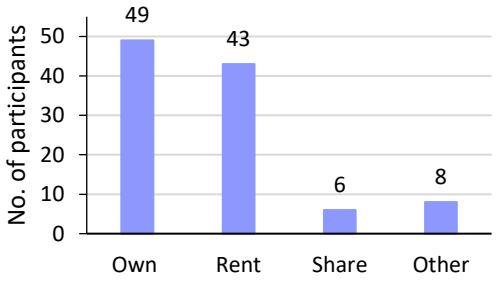
I'm incredibly lonely and miss the companionship of a partner. I rarely receive respect as a nonbinary person from general interactions, so I expect this to be even worse if I attempted to use a dating app etc. I am too scared to even try to make friends in Toowoomba after having people I've known ... repeatedly ... make transphobic insults... Binary trans people seem to have more acceptance on the relationship front, as being nonbinary makes straight people question their identity. I also don't want to have to explain the intimate details of it all to strangers and 99.9% of the time [I] have to perform this emotional labour.

I'm too sore and tired for that. But also, very lonely and lack connection to the community, queer or otherwise, because of chronic illness and disability. I'm scared of most human interactions.

3.2. Housing and Homelessness

3.2.1. Type of housing

Figure 4: Type of housing N = 106)



Participants were asked where they live most of the time. Just under half (46.2%, n = 49) reported living in their own residence (e.g., house, flat, townhouse etc), 40.6% (n = 43) renting, 5.7% (n = 6) share accommodation, and 7.5% (n = 8) other (e.g., caravan park, owned by parents/family, couch surfing; see Figure 4).

3.2.2. Household structure

Participants were asked whom they live with most of the time, and were able to select more than one option to best reflect the multiplicity of living arrangements.

Table 9: Household structure (N = 110)

Household	N	%
Partner/s	47	42.7
Parents or carers	27	24.5
Children/dependents (own or partner/s)	16	14.5
I live alone	16	14.5
Family of origin	13	11.8
Housemates	13	11.8
Friends	8	7.3
Family of choice	3	2.7

Note. Participants could select more than one option. The % column reflects the percentage of the total number of participants (N = 110).

3.1.15. Children

Participants were asked if they had children (n = 111). Most participants (80.2%, n = 89) reported that they did not have children and 19.8% (n = 22) did. Of the participants who had children, the number of children ranged from 1 to 5, with a mean of 2 children (SD = 1.3).

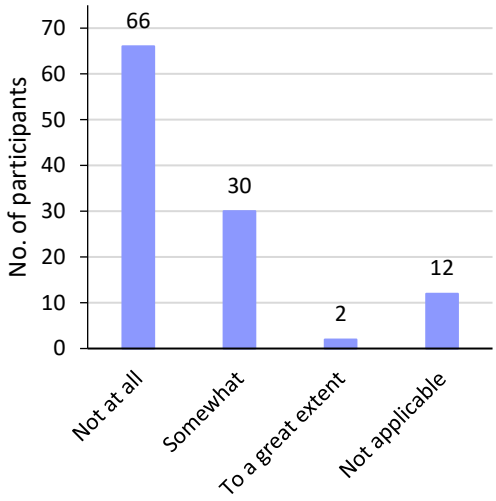
Three quarters of participants 77.3% (n = 85) selected one option, 17.3% (n = 19) two options, 4.5% (n = 5) three options, and 0.9% (n = 1) five options.

The top four household structures selected were 42.7% living with partner/s, 24.5% parents/carers, 14.5% children/dependents, and 14.5% living alone (see Table 9). Among participants that selected one option for household structure (n = 85), 38.8% (n = 33) live with partners, 20% (n = 17) parents/carers, 16.5% (n = 14) live alone, 8.2% (n = 7) housemates, 5.9% (n = 5) children/ dependents, 4.7% (n = 4) family of origin, 3.5% (n = 3) friends, and 2.4% (n = 2) family of choice.

3.2.3. Barriers to housing

Participants were asked if they felt they have ever experienced barriers to housing due to their gender identity or sexual orientation.

Figure 5: Barriers to housing (N =110)



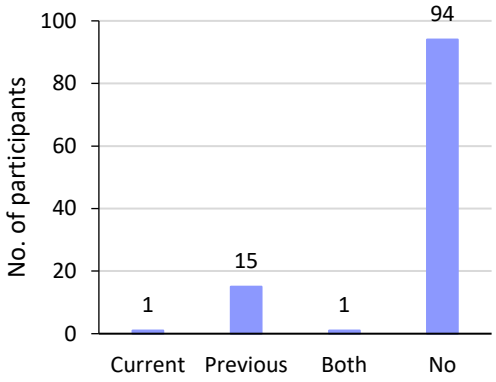
Three fifths of participants (60%, n = 66) reported not experiencing barriers to housing and for 10.9% (n = 12) this question was not applicable (see Figure 5). The remaining 29% (n = 32) of participants reported experiencing barriers to

housing, with two (1.8%) of these participants greatly experiencing barriers.

3.2.4. Homelessness

Participants were asked if they have ever experienced homelessness (current or previous).

Figure 6: Homelessness (N = 111)

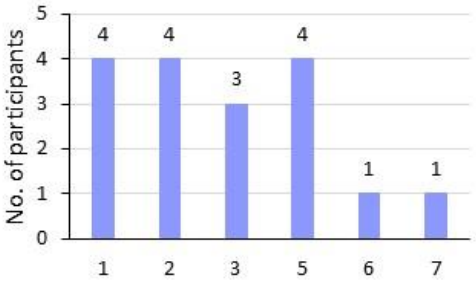


A total of 17 (15.3%) participants had experienced homelessness, 13.5% (n = 15) previous experiences of homelessness, 0.9% (n = 1) currently homeless, and 0.9% (n = 1) both previous and current homelessness (see Figure 6).

3.2.5. Cause of homelessness

The participants who reported experiencing homelessness (current or previous; n = 17), were able to select more than one option to best reflect the multiplicity of causes that led to their homelessness.

Figure 7: Cause of homelessness options selected per participant (N = 17)



Almost one quarter of participants (23.5%, n = 4) selected one option, 23.5% (n = 4) two options, 17.6% (n = 3) three options, 23.5% (n = 4) five options, 5.9% (n = 1) six options, and 5.9% (n = 1) seven options. Most participants 76.5% (n = 13) selected more than one option as the cause of their homelessness indicating this is a highly complex phenomenon (see Figure 7).

Table 10: Cause of homelessness (N = 17)

Cause of homelessness	N	%
Financial hardship	12	70.5
Family rejection/ abandonment	9	52.9
Mental health	9	52.9
Unemployment	7	41.2
Domestic, family and/or intimate partner violence	5	29.4
Rejection from the people I lived with	5	29.4
Rental discrimination (application denied)	4	23.5
Other	1	5.9
Own decision	1	5.9
Substance abuse	1	5.9

Note. Participants could select more than one option. The % column reflects the percentage of the total number of participants (N = 17).

The top four causes of homelessness reported were 70.5% financial hardship, 52.9% family rejection/abandonment, 52.9% mental health, and 41.2% unemployment.

3.3. Discrimination and Harassment

3.3.1. Experiences of discrimination in Toowoomba

Participants were asked to indicate if they had experienced discrimination while living in the Toowoomba region due to identifying as LGBTQIA+. More than half of the participants (58.2%, n = 64) reported experiencing discrimination either within the past 12 months (29.1%, n = 32), more than 12 months ago (20%, n = 22) or both (9.1%, n = 10). Just over one quarter (26.4%, n = 29) had not experienced

discrimination, 12.7% (n = 14) were not sure, and 2.7% (n = 3) preferred not to say.

When considering experiences of discrimination by gender and sexuality the majority of LGBTQIA+ participants were more likely to experience discrimination than not (see Figure 8 and Figure 9). The gender identities more likely to experience discrimination than report no/prefer not to say were 100% (n = 2) Sistergirls, 83.3% (n = 5/6) trans men, 68.2% (n = 15/22) cisgender men, 66.7% (n = 8/12) trans non-binary, 66.7% (n = 4/6) trans women, and 56.3% (n = 18/32) cisgender women. The sexual identities more likely to experience discrimination than report no/prefer not to say were 75% (n = 9/12) pansexual+, 73.7% (n = 14/19) queer+, 65% (n = 13/20) gay, 63.6% (n = 7/11) lesbian, and 55.6% (n = 5/9) queer.

Figure 8: Experiences of discrimination by gender (N = 107)

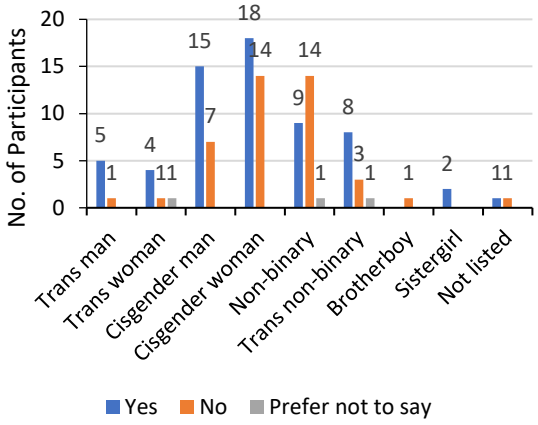
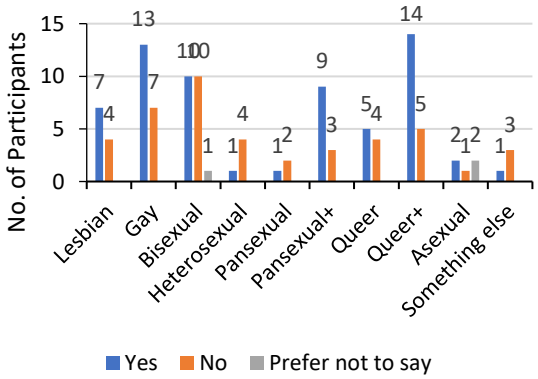


Figure 9: Experiences of discrimination by sexuality (N = 107)



3.3.2. Settings or locations in Toowoomba where discrimination was experienced

Participants who responded yes (n = 64) to experiencing discrimination while living in the Toowoomba region due to identifying as LGBTQIA+ were asked to select from a list of settings/locations where this occurred. Participants were able to select more than one option. One fifth of participants (21.9%, n = 14) selected one option, more than a third (35.6%, n = 23) two options, 6.3% (n = 4) three options, 14.1% (n = 9) four options, and the remaining 22% (n = 14) selected between 5 to 15 options.

Almost three quarters (71.2%) of responses fell within seven categories of where discrimination occurred: 17% workplace; 14% in a public place within the Toowoomba region; 10.5% educational setting; 9.2% shopping for goods/services; 8.7% religious/spiritual setting; 6.1% community groups; and 5.7% at home.

When considering the locations/settings of discrimination by gender and sexuality the reported results are highly complex as shown in Figure 10 and Figure 11. For gender identity among the top seven categories with the highest responses Cisgender men reported the highest discrimination when shopping for goods/services (26.3%, n = 5) and at home (30.8%, n = 4); cisgender women reported the highest discrimination in the workplace (34.2%, n = 13); cisgender men and cisgender women equally reported the highest discrimination in a public place within the Toowoomba region (23.3%, n = 7 and 23.3%, n = 7, respectively) and religious/spiritual settings (26.3%, n = 5 and 26.3%, n = 5, respectively); trans-non-binary participants reported the highest discrimination in community groups (28.6%, n = 4) and in educational settings (25%, n = 6). For sexual identity among the seven categories with the highest responses queer+ participants reported the highest discrimination in educational settings (34.8%, n = 8), in a public place within the Toowoomba region (32.2%, n = 10), and in community groups (30.8%, n = 4); gay participants reported the highest discrimination in the workplace (23.7%, n = 9) and religious/spiritual settings (26.3%, n = 5); queer+ and gay participants reported the highest discrimination when shopping for goods and services (30%, n = 6 and 30%, n = 6, respectively);

and queer+ and bisexual participants reported the highest discrimination at home (23.3%, n = 3 and 23.3%, n = 3, respectively).

Figure 10: Location and settings of discrimination by gender (N = 62)

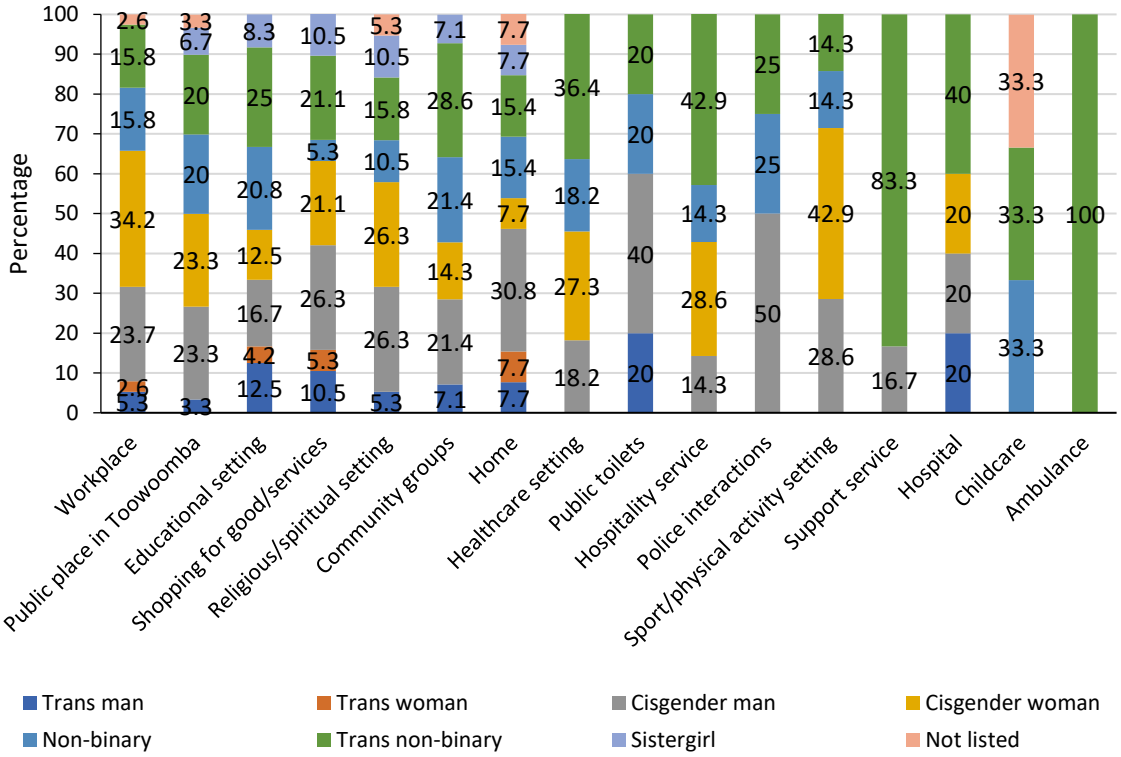
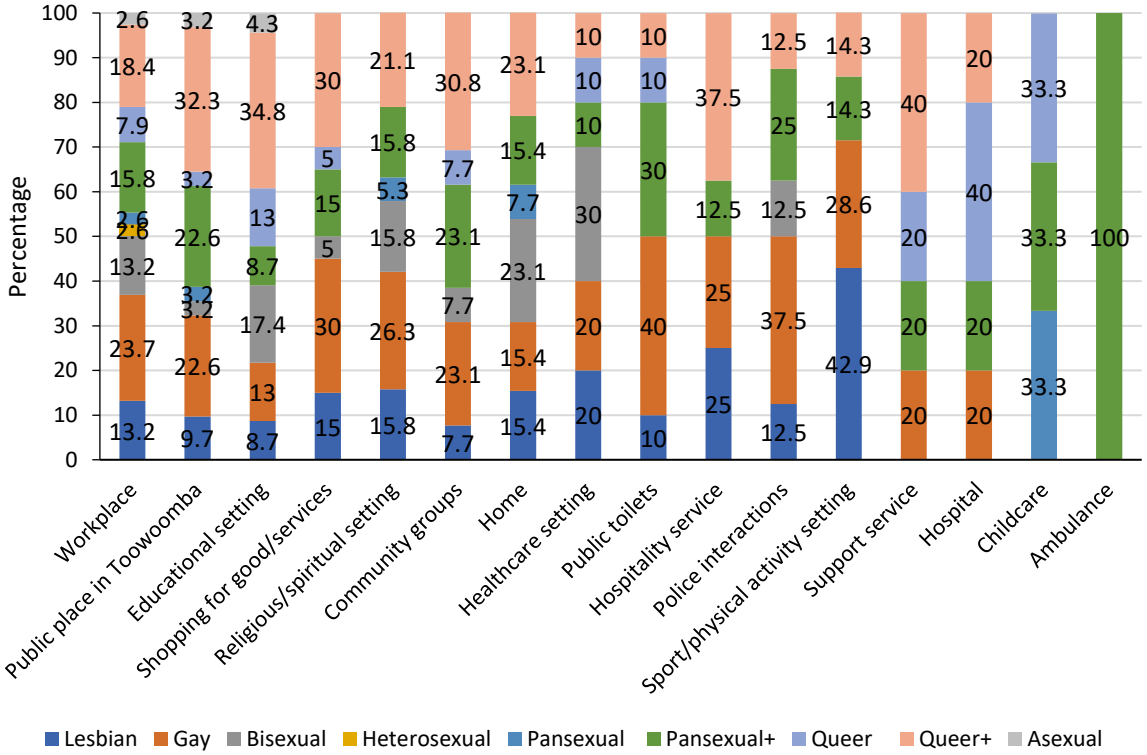


Figure 11: Location and settings of discrimination by sexual identity (N = 63)



3.3.3. Types of discrimination, harassment or violence experience in Toowoomba

Participants who responded yes (n = 64) to experiencing discrimination while living in the Toowoomba region due to identifying as LGBTQIA+ were asked to select from a list of types of discrimination, harassment or violence they experienced. Participants were able to select more than one option. One tenth of participants (10.9%, n = 7) selected one option, 15.6% (n = 10) two options, 15.6% (n = 10) three options, 7.8% (n = 5) four options, 20.3% (n = 13) five options, 10.9% (n = 7) six options, and the remaining 18.9% (n = 12) selected between 7 to 15 options.

The top six types of reported discrimination, harassment or violence experienced include verbal abuse (n = 39), bullying (n = 36), being "outed" (n = 35), unfair treatment (n = 35), social exclusion (n = 32), and offensive gestures (n = 26; see Table 11).

Table 11: Types of discrimination, harassment or violence reported (N = 64)

Category	N	%
Verbal abuse (e.g., threats, name calling)	39	60.9
Bullying	36	56.3
Being "outed" (negative exposure)	35	54.7
Unfair treatment	35	54.7
Social exclusion	32	50.0
Offensive gestures	26	40.6
Misgendering/misnaming (deadnaming)	23	35.9
Threats and/or abuse via online forums (e.g., email, social media, dating apps)	20	31.3
Physical abuse/violence	11	17.2
Sexual abuse/assault	9	14.1
Something else	9	14.1
Vandalism or damage to property	7	10.9
Refusal of service	5	7.8
Dismissal of employment	5	7.8
Refusal of employment	2	3.1
Conversion therapy	1	1.6

Note. Participants could select more than one option. The % column reflects the percentage of the total number of participants (N = 64).

3.4. Feelings of Support, Acceptance and Safety

3.4.1. Feeling supported in different settings/situations

Participants were asked to indicate the extent to which they felt supported as an LGBTQIA+ person in several settings/situations with response options that included: not at all/a little, somewhat, a lot/always, or not applicable (see Figure 12). Note the percentages reported in this section exclude the not applicable responses.

The top four settings/situations where participants reported feeling a lot/always supported were with friends (78.1%, n = 75/96), family (47.9%, n = 46/96), health professionals (46.1%, n = 41/89), and with LGBTQIA+ Toowoomba communities (54.7%, n = 37/81; see Figure 12). While a high percentage of participants reported feeling supported with family, over one third of participants (34.4%, n = 33/96) reported feeling not at all/a little supported with family. Participants reported feeling not at all/a little supported in religious/faith-based settings (82.5%, n = 47/57) and sport/physical activity settings (50.9%, n = 28/55). Religious/faith-based settings had the lowest reported levels of felt support 17.5% (n =

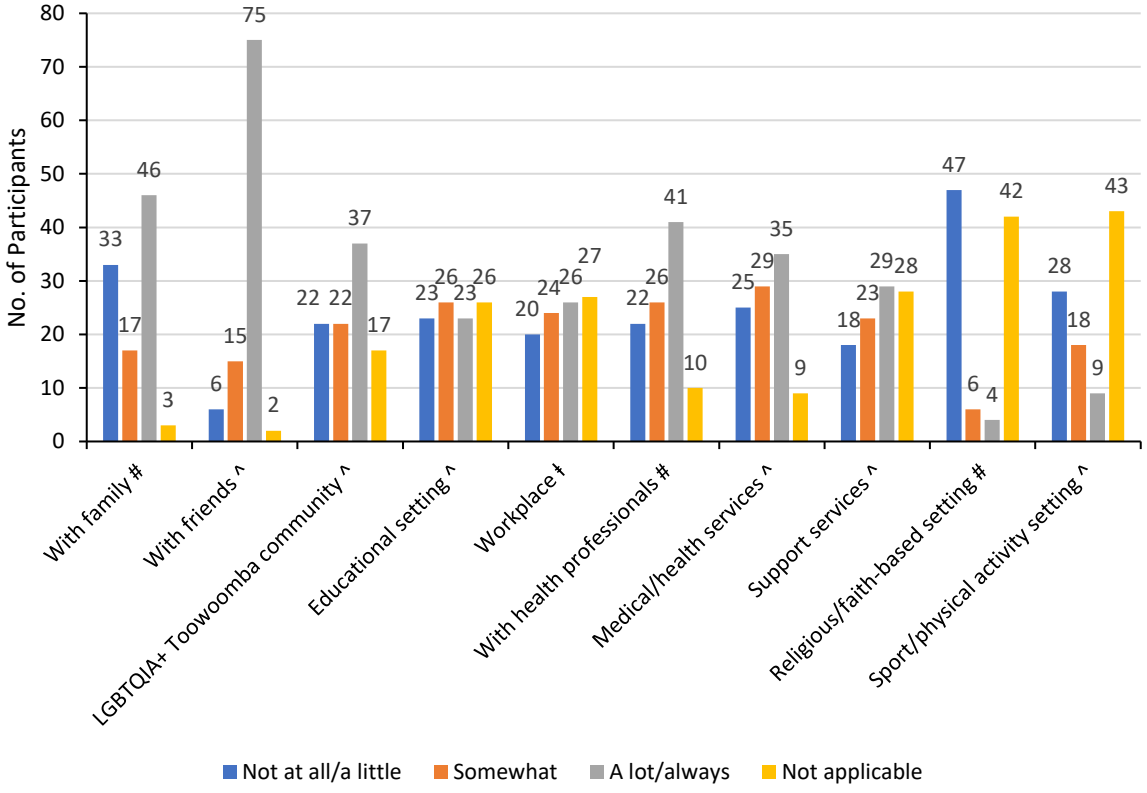
10/57; somewhat 10.5%, n = 6/57, and a lot/always 7%, n = 4/57). A mixed level of felt support was reported for educational settings. In the workplace, with support services, and medical/health services more than a quarter of participants (25.7% [n = 18/70] to 31.9% [n = 23/72]) reported feeling not at all/a little supported within these settings.

3.4.2. Feeling safe in different settings/situations

Participants were asked to indicate the extent to which they felt safe to come out or disclose or affirm their gender, sexual orientation and/or sex characteristics in several settings/situations with response options including: not at all/a little, somewhat, a lot/always, or not applicable (see Figure 13). Note the percentages reported in this section exclude the not applicable responses.

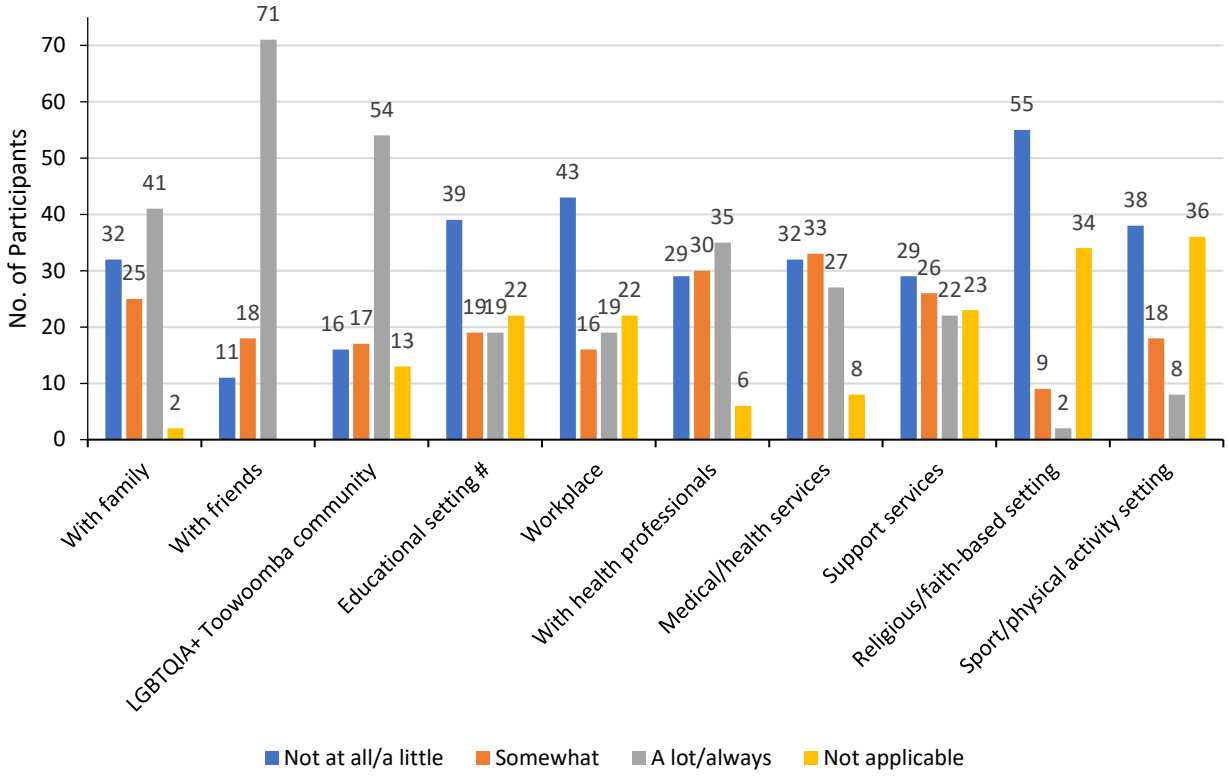
The top four settings/situations where participants reported feeling a lot/always safe were with friends (71%, n = 71/100), LGBTQIA+ Toowoomba community (60%, n = 54/90), family (41.8%, n = 41/98), and with health professionals (37.2%, n = 35/94). While a high percentage of participants reported feeling safe to come out or disclose or affirm their gender, sexual orientation and/or sex characteristics with family, almost one third of participants (32.7%, n = 32/98) reported feeling not at all/a little safe to do so with family. There were four settings/situations where more than 50% of participants did not feel safe to come out or disclose or affirm their gender, sexual orientation and/or sex characteristics: religious/faith-based setting (83.3%, n = 55/66), sport/physical activity settings (59.4%, n = 38/64), in the workplace (55.1%, n = 43/78), and in educational settings (50.6%, n = 39/77). A mixed level of felt safety was reported for support services and medical/health services, however, more than a third of participants (37.7%, n = 29/77 and 34.8%, n = 32/92, respectively) reported feeling not at all/a little safe within these settings.

Figure 12: Settings/situations where participants felt supported as a LGBTQIA+ person (N = 99)



n = 99; ^ n = 98; ǂ n = 97.

Figure 13: Settings/situation where participants felt safe to come out or disclose or affirm gender, sexual orientation and/or sex characteristics (N = 100)



n = 99.

3.4.3. Support for people with intersex variations in various settings

Three participants were born with an intersex variation, and they were asked if they felt their workplace, educational setting, religious/faith-based organisation, and/or sport/physical activity organisation are supportive of people with intersex variations. All participants reported that there were no specific policies and procedures to prevent discrimination or to support the needs (including health-related needs) of people with variations in sex characteristics; there is a lack of training to appropriately support/accommodate people with intersex variations; and intersex variations are not specifically included and/or affirmed among the listed organisations. One participant indicated there was somewhat knowledge/understanding of intersex variations and how intersex variations are distinct from gender and sexual orientation, the remaining two participants reported little or no knowledge of these concepts among the listed organisations.

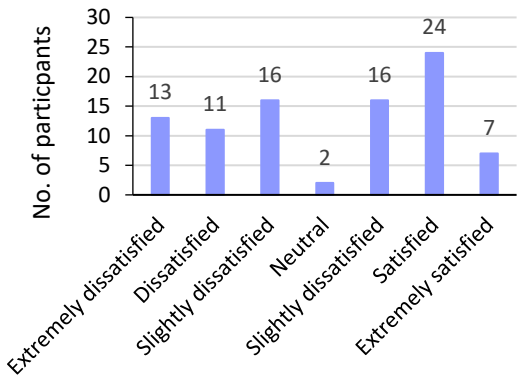
3.5. Quality of Life and Psychological Wellbeing

3.5.1. Satisfaction with life

Participants were asked to rate their current satisfaction with life on a 7-point scale from strongly disagree to strongly agree across five questions which were totalled to provide a summary score. The summary score (range 5-35) was then benchmarked with a validated measure (Diener, 1985) to provide cut-offs to determine the level of overall life satisfaction from extremely dissatisfied to extremely satisfied.

A total of 89 participants reported their current satisfaction with life (Mean [M] = 20, SD = 8.4). Just over one third of participants (34.9%, n = 31) were either satisfied (27%, n = 24) or extremely satisfied (7.9%, n = 7) with their life (see Figure 14). Conversely, 27% (n = 24) of participants were either dissatisfied (12.4%, n = 11) or extremely dissatisfied (14.6%, n = 13) with their life.

Figure 14: Satisfaction with life (N = 89)



When considering satisfaction with life by gender, trans men were polarised with 50% being either satisfied or extremely dissatisfied with life (see Table 12). Cisgender women and cisgender men while mixed, reported being more likely to be satisfied (74%, n = 20 and 55.6%, n = 10, respectively) than dissatisfied (22.2%, n = 6 and 39%, n = 7, respectively) with life. Conversely, non-binary participants while mixed, were more likely to be dissatisfied (59%, n = 13) than satisfied (40.9%, n = 9) with life. More than three quarters of trans non-binary participants (77.7%, n = 7) were dissatisfied with life. Trans women were overall dissatisfied with life.

Table 12: Satisfaction with life by gender (N = 89)

	Extremely dissatisfied	Dissatisfied	Slightly dissatisfied	Neutral	Slightly satisfied	Satisfied	Extremely satisfied
Trans man	3 (50.0)	-	-	-	-	3 (50.0)	-
Trans woman	1 (50.0)	-	1 (50.0)	-	-	-	-
Cisgender man	1 (5.6)	3 (16.7)	3 (16.7)	1 (5.6)	3 (16.7)	4 (22.2)	3 (16.7)
Cisgender woman	-	3 (11.1)	3 (11.1)	1 (3.7)	6 (22.2)	12 (44.4)	2 (7.4)
Non-binary	5 (22.7)	3 (13.6)	5 (22.7)	-	4 (18.2)	4 (18.2)	1 (4.5)
Trans non-binary	3 (33.3)	2 (22.2)	2 (22.2)	-	1 (11.1)	-	1 (11.1)
Brotherboy	-	-	-	-	-	1 (100.0)	-
Sistergirl	-	-	2 (100.0)	-	-	-	-
Not listed	-	-	-	-	1 (100.0)	-	-

Note. Data is displayed as N (%). Percentages run across gender categories to total 100% (due to rounding some totals may slightly exceed 100).

Table 13: Satisfaction with life by sexuality (N = 89)

	Extremely dissatisfied	Dissatisfied	Slightly dissatisfied	Neutral	Slightly satisfied	Satisfied	Extremely satisfied
Lesbian	-	2 (20.0)	-	1 (10.0)	1 (10.0)	4 (40.0)	2 (20.0)
Gay	1 (6.7)	3 (20.0)	1 (6.7)	-	4 (26.7)	3 (20.0)	3 (20.0)
Bisexual	3 (18.8)	2 (12.5)	-	1 (6.3)	5 (31.3)	4 (25.0)	1 (6.3)
Heterosexual	-	-	1 (50.0)	-	1 (50.0)	-	-
Pansexual	1 (33.3)	-	-	-	2 (66.6)	-	-
Pansexual+	4 (33.3)	2 (16.7)	4 (33.3)	-	1 (8.3)	1 (8.3)	-
Queer	2 (33.3)	1 (16.7)	1 (16.7)	-	1 (16.7)	1 (16.7)	-
Queer+	1 (6.3)	1 (6.3)	5 (31.3)	-	-	9 (56.3)	-
Asexual	1 (25.0)	-	1 (25.0)	-	1 (25.0)	1 (25.0)	-
Something else	-	-	2 (50.0)	-	-	1 (25.0)	1 (25.0)

Note. Data is displayed as N (%). Percentages run across sexuality categories to total 100% (due to rounding some totals may slightly exceed 100).

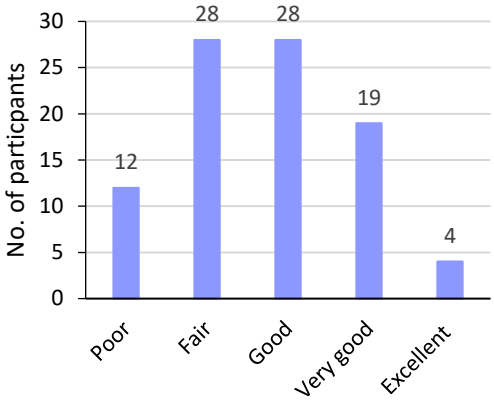
When considering satisfaction with life by sexuality, heterosexual, asexual and something else participants were polarised with 50% being either satisfied or dissatisfied with life (see Table 13). Pansexual participants were more likely to be slightly satisfied (66.6%, n = 2) than extremely dissatisfied (33.3%, n = 1) with life. Lesbian, gay, bisexual, and queer+ participants while mixed, were more likely to be satisfied (70%, n = 7, 66.7%, n = 10, 62.6%, n = 10, and 56.3%, n = 9, respectively) than dissatisfied (20%, n = 2, 33.4%, n = 5, 20.3%, n = 5, and 43.9%, n = 7, respectively) with life. Conversely, pansexual+ and queer participants were more likely to be dissatisfied (83.3%, n = 10 and 66.7%, n = 4, respectively) than satisfied (16.6%, n = 2 and 33.4%, n = 2, respectively) with life.

3.5.2. General health

Participants were asked to rate their general health on a 5-point scale from excellent to poor.

A total of 91 participants reported their general health (Figure 15). Just over half of participants 56.1% (n = 51) reported having either good (30.8%, n = 28), very good (20.9%, n = 19) or excellent (4.4%, n = 4) general health. Conversely, 44% (n = 40) of participants reported having either fair (30.8%, n = 28), or poor (13.2%, n = 12) general health.

Figure 15: General health (N = 91)



When considering general health by gender (n = 90), trans women, Sistergirls and trans men were polarised with 50% either reporting fair or excellent, fair or very good and poor/fair or good (respectively) general health (see Figure 16). Cisgender women, cisgender men and non-binary participants were more likely to report good to excellent (64.2%, n = 18, 63.2%, n = 12 and 54.5%, n = 12, respectively) than poor/fair (35.7%, n = 10, 36.8%, n = 7 and 45.5%, n = 10, respectively) general health. One Brotherboy participant reported fair general health and one not listed participant reported good general health.

Figure 16: General health by gender (N = 90)

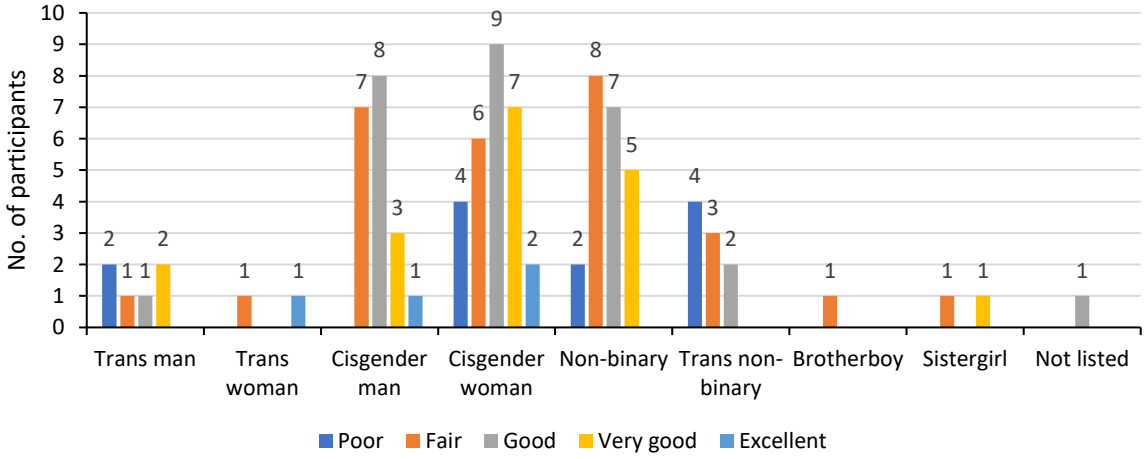
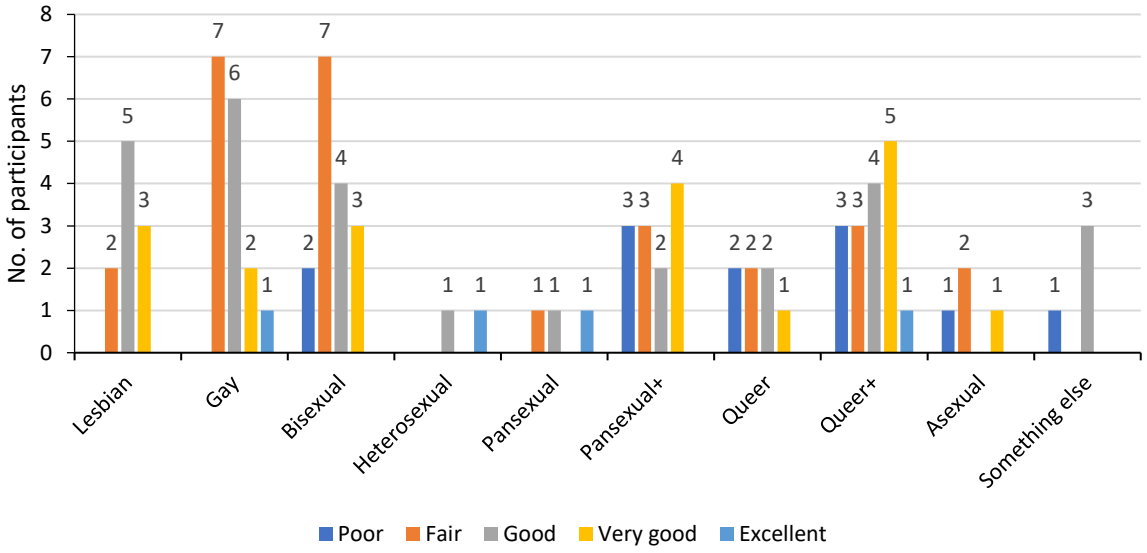


Figure 17: General health by sexuality (N = 90)

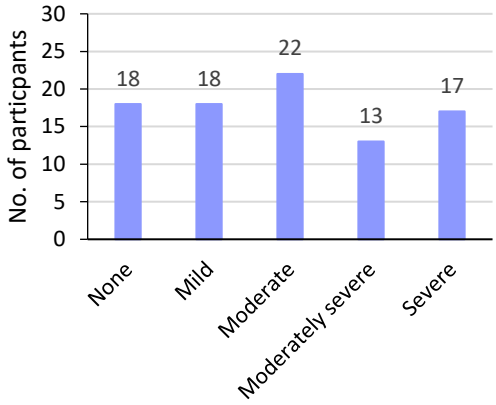


When considering general health by sexuality, pansexual+ participants were polarised with 50% reporting either poor/fair or good/very good general health (see Figure 17). Lesbian, something else, pansexual, queer+, and gay participants were more likely to report good to excellent (80%, n = 8, 75%, n = 3, 66.6% , n = 2, 62.6%, n = 10, and 56.3%, n = 9, respectively) than poor/fair (20%, n = 2, 25%, n = 1, 33.3%, n = 1, 37.6%, n = 6, and 43.8%, n = 7, respectively) general health. Conversely, asexual, queer and bisexual participants were more likely to report poor/fair (75%, n = 3, 57.2%, n = 4 and 56.3%, n = 9, respectively) than good to excellent (25%, n = 1, 42.9%, n = 3 and 43.8%, n = 7, respectively) general health. Among heterosexual participants 50% reported either good or excellent general health.

3.5.3. Depression (PHQ-9)

The Patient Health Questionnaire (PHQ-9) is a 9-item instrument designed to measure depression severity (Kroenke & Spitzer, 2002). Participants were asked to rate each of the nine questions, which included symptoms of depression, over the past 2 weeks on a 4-point scale from not at all to nearly every day. The scores on the instrument range from 0 to 27, validated cut-points were applied to determine the level of depression for none, mild, moderate, moderately sever, and severe depression.

Figure 18: Level of depression (N = 88)



A total of 88 participant reported their current level of depression (M = 12.1, SD = 7.9). One fifth of participants (20.5%, n = 18) reported no depression (i.e., did not meet the minimum threshold; see Figure 18). Conversely, 20.5% (n = 18) of participants reported mild, 25% (n = 22) moderate, 14.8% (n = 13) moderately severe, and 19.3% (n = 17) severe depression.

When considering level of depression by gender (N = 87), 100% (n = 9) trans non-binary, 100% (n = 2) Sistergirl, 100% (n = 1) Brotherboy, and 100% (n = 1) not listed participants reported moderate to severe depression (see Figure 19). Almost three quarters 71.5% (n = 15) non-binary, 66.7% (n = 4) trans men, 50% (n = 13) cisgender women, and 36.9% (n = 7) cisgender men were more likely to report moderate to severe depression than mild or no depression.

When considering level of depression by sexuality (N = 87), 80% (n = 8) pansexual+, 75% (n = 3) asexual, 75% (n = 3) something else, 71.5% (n = 5) queer, 66.7% (n = 2) pansexual, 66.6% (n = 10) bisexual, 50.1% (n = 8) queer+, and 37.6% (n = 6) gay participants were more likely to report moderate to severe depression than mild or no depression (see Figure 20). Conversely, heterosexual participants were equally likely to report (50%, n = 1) moderately severe depression and (50%, n = 1) no depression (see Figure 20). Similarly, cisgender women were equally likely to report (50%, n = 5) moderate to severe depression and (50%, n = 5) no depression.

Figure 19: Level of depression by gender (N = 87)

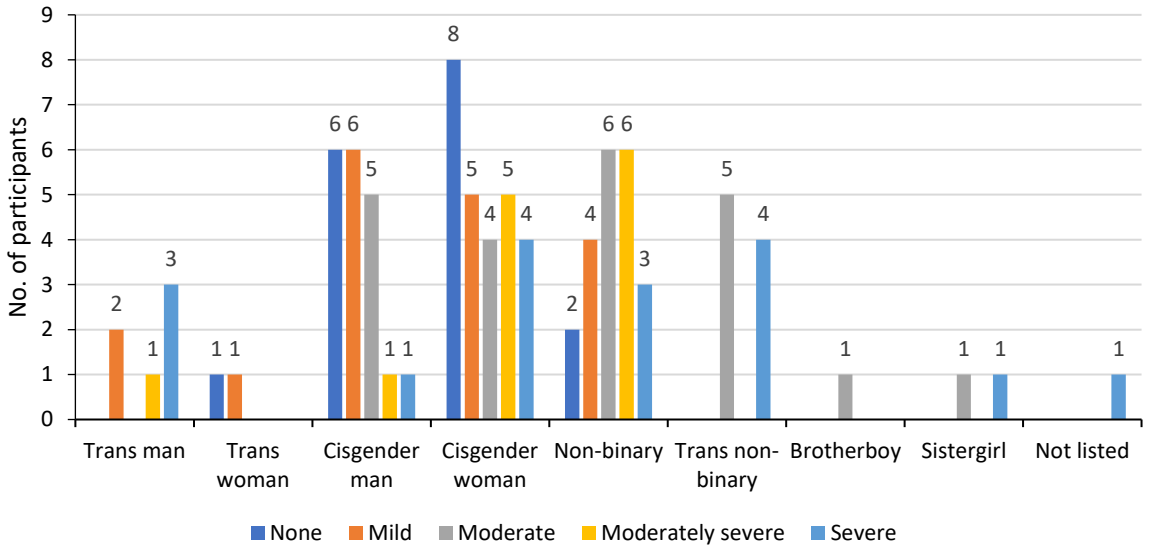
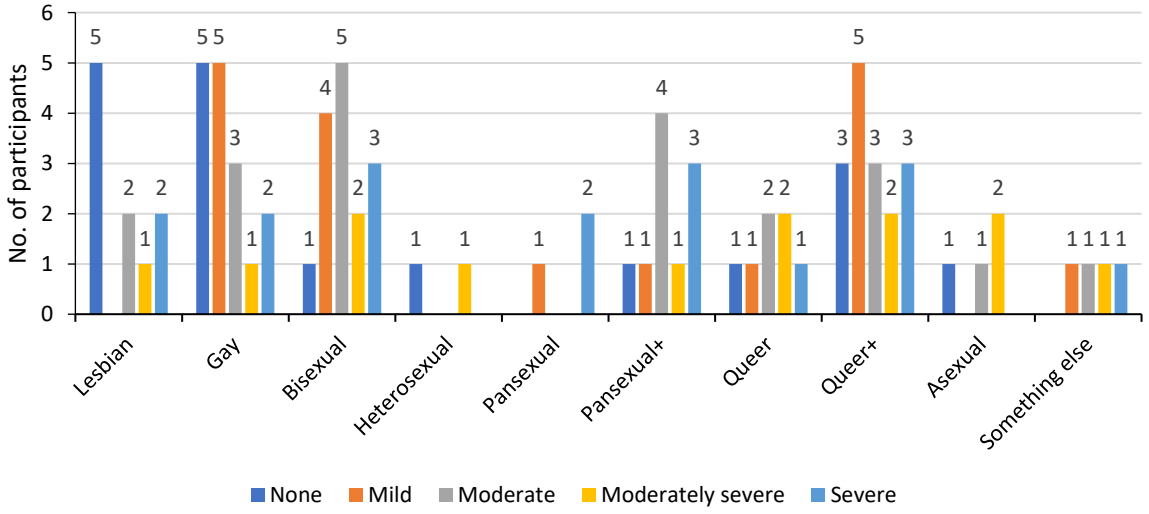


Figure 20: Level of depression by sexuality (N = 87)



3.6. Health and Support Service Engagement

3.6.1. Regular doctor (GP) within Toowoomba region

Participants were asked if they had a regular doctor (GP) within the Toowoomba region. Participants were provided with a list of options, and they were able to select more than one option (N = 87). Most participants (78.2%, n = 68) selected one option, 16.1% (n = 2) two options and 5.7% (n = 3) three options.

The top five regular GP services reported include seeing a regular GP (71.3%, n = 62), going to the same medical clinic, and seeing any of the available GPs (18.4%, n = 16), do not have a regular GP (10.3%, n = 9), using a telehealth service (8%), and seeing a GP outside of Toowoomba (6.9%, n = 6; see Table 14).

Table 14: Doctor (GP) services (N = 87)

Service	N	%
I have a regular doctor (GP)	62	71.3
I go to the same medical clinic and see any of the available doctors	16	18.4
I do not have a regular doctor (GP)	9	10.3
I use a telehealth service	7	8.0
I see a doctor outside of Toowoomba	6	6.9
I go to different medical clinics	5	5.7
Other	3	3.4
I do not go to the doctors at all	2	2.3
Prefer not to say	1	1.1

Note. Participants could select more than one option. The % column reflects the percentage of the total number of participants (N = 87).

3.6.2. Health professionals seen in the past 12 months within the Toowoomba region

Participants were asked if they had seen any health professionals or support services in the past 12 months within the Toowoomba region. A list of different health professionals and support services, along with the option to indicate if they had not seen anyone on the list or prefer not to say was available. Additionally, participants were able to select more than one option (N = 87). Just over one quarter of participants (27.6%, n = 24) selected one option, 35.6% (n = 31) two options, 23% (n = 20) three options, 9.2% (n = 8) four options, and 4.6% (n = 4) five options.

The top four health professional and support services seen in the past 12 months reported include seeing a GP (87.4%), allied health service (48.3%), medical specialist: other (20.7%), and sexual health service (18.4%; see Table 15). The types of medical specialist: other reported included psychiatrist; dentist; ear, nose and throat specialist; and gynaecologist. Six participants reported not seeing any health professionals in the past 12 months within the Toowoomba region.

Table 15: Health professionals seen in past 12 months (N = 87)

Service/response	N	%
General Practitioner (GP)	76	87.4
Allied health services	42	48.3
Medical specialist: other	18	20.7
Sexual health services	16	18.4
Support services	14	16.1
Surgeon	12	13.8
Something else	8	9.2
Not seen any health professionals in past 12 months in Toowoomba	6	6.9
Endocrinologist	4	4.6
Aboriginal and/or Torres Strait Islander health practitioners	2	2.3

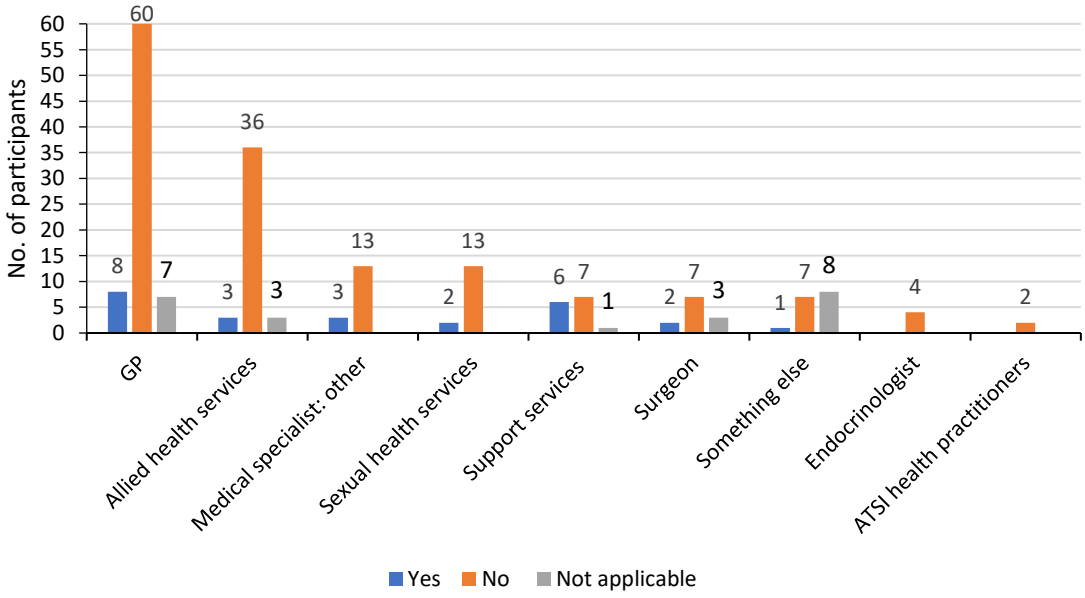
Note. Participants could select more than one option. The % column reflects the percentage of the total number of participants (N = 87).

3.6.2.1 Experiences of discrimination

Participants who reported seeing a health professional or support service in the past 12 months within the Toowoomba region were further asked to indicate if they experienced discrimination while visiting these services due to identifying as an LGBTQIA+ person. The response options included yes, no or not applicable. Of the participants who responded to each personally relevant category within this question, the majority indicated they had not experienced discrimination (see Figure 21). However, there were several participants who had experienced discrimination while accessing GPs (n = 8), support services (n = 6), allied health services (n = 3), medical specialists: other (n = 3), sexual health services (n = 2), surgeons (n = 2), and something else (psychologist; n = 1).

Table 16 shows a breakdown of participant responses (yes/no) to experiences of discrimination across gender and sexuality. When considering gender, trans non-binary participants reported discrimination across seven categories (GP, support services, allied health service, medical specialist: other, sexual health service, surgeon and something else [psychologist]); non-binary participants three categories (GP, sexual health service and support services), cisgender men three categories (GP, medical specialist: other and support services), trans men two categories (allied health service and surgeon), and cisgender women one category (medical specialist: other). When considering sexuality, pansexual+ participants reported discrimination across four categories (GPs, allied health service, sexual health service, and support services), queer participants four categories (GPs, support services, surgeon, and something else [psychologist]), queer+ participants four categories (GPs, medical specialist: other, support services, and surgeon), gay participants three categories (GPs, medical specialist: other and support services), lesbian participants one category (GPs), bisexual participants one category (sexual health service), and pansexual participants one category (support services).

Figure 21: Experiences of health professional discrimination



Note. The number of participants within each category varies according to the service usage reported.

Table 16: Experiences of discrimination when seeing health professionals or support services in the past 12 months within the Toowoomba region

	GP		Allied health services		Medical specialist: other		Sexual health services		Support services		Surgeon		Something else		Endocrinologist		Aboriginal and/or Torres Strait Islander health practitioners	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
GENDER																		
Trans man	-	5 (100.0)	1 (33.3)	2 (66.7)	-	-	-	1 (100.0)	-	1 (100.0)	1 (50.0)	1 (50.0)	-	-	-	-	-	-
Trans woman	-	1 (100.0)	-	-	-	-	-	-	-	1 (100.0)	-	-	-	-	-	-	-	-
Cisgender man	2 (13.3)	13 (86.7)	-	7 (100.0)	1 (50.0)	1 (50.0)	-	5 (100.0)	1 (100.0)	-	-	-	-	3 (100.0)	-	-	-	-
Cisgender woman	-	20 (100.0)	-	12 (100.0)	1 (12.5)	7 (87.5)	-	3 (100.0)	-	3 (100.0)	-	2 (100.0)	-	3 (100.0)	-	-	-	-
Non-binary	1 (7.7)	12 (92.3)	-	9 (100.0)	-	3 (100.0)	1 (25.0)	3 (75.0)	1 (50.0)	1 (50.0)	-	2 (100.0)	-	-	-	2 (100.0)	-	-
Trans non-binary	5 (55.6)	4 (44.4)	2 (28.6)	5 (71.4)	1 (100.0)	-	1 (100.0)	-	4 (80.0)	1 (20.0)	1 (33.3)	2 (66.7)	1 (100.0)	-	-	1 (100.0)	-	-
Brotherboy	-	1 (100.0)	-	-	-	1 (100.0)	-	-	-	-	-	-	-	-	-	-	-	1 (100.0)
Sistergirl	-	2 (100.0)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Not listed	-	1 (100.0)	-	-	-	-	-	-	-	-	-	-	-	1 (100.0)	-	-	-	1 (100.0)
SEXUALTIY																		
Lesbian	1 (11.1)	8 (88.9)	-	5 (100.0)	-	2 (100.0)	-	2 (100.0)	-	-	-	1 (100.0)	-	1 (100.0)	-	-	-	-
Gay	1 (8.3)	11 (91.7)	-	6 (100.0)	1 (33.3)	2(66.7)	-	3 (100.0)	1 (100.0)	-	-	1 (100.0)	-	1 (100.0)	-	1 (100.0)	-	-
Bisexual	-	9 (100.0)	-	4 (100.0)	-	2 (100.0)	1 (25.0)	3 (75.0)	-	2 (100.0)	-	1 (100.0)	-	1 (100.0)	-	-	-	-
Heterosexual	-	1 (100.0)	-	1 (100.0)	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Pansexual	-	3 (100.0)	-	1 (100.0)	-	-	-	1 (100.0)	1 (100.0)	-	-	-	-	1 (100.0)	-	-	-	1 (100.0)
Pansexual+	1 (10.0)	9 (90.0)	2 (33.3)	4 (66.7)	-	1 (100.0)	1 (100.0)	-	1 (33.3)	2 (66.7)	-	1 (100.0)	-	-	-	1 (100.0)	-	-
Queer	2 (33.3)	4 (66.7)	-	2 (100.0)	-	2 (100.0)	-	1 (100.0)	1 (50.0)	1 (50.0)	1 (100.0)	-	1 (50.0)	1 (50.0)	-	-	-	-
Queer+	2 (16.7)	10 (83.3)	-	8 (100.0)	2 (50.0)	2 (50.0)	-	2 (100.0)	1 (50.0)	1 (50.0)	1 (33.3)	2 (66.7)	-	1 (100.0)	-	2 (100.0)	-	1 (100.0)
Asexual	-	2 (100.0)	-	2 (100.0)	-	1 (100.0)	-	-	-	-	-	1 (100.0)	-	-	-	-	-	-
Something else	-	3 (100.0)	-	3 (100.0)	-	1 (100.0)	-	1 (100.0)	-	1 (100.0)	-	-	-	1 (100.0)	-	-	-	-

Note. Data is displayed as N (%). The number of participants within each category varies according to the service usage reported.

3.6.3. Types of discrimination experienced accessing health care within the Toowoomba region

Participants were asked what types of discrimination (if any) they have experienced accessing health care while living in the Toowoomba region. A list of health-related LGBTQIA+ specific discrimination types, along with the option to indicate if they had not experienced discrimination or preferred not to say was available. Additionally, participants were able to select more than one option (N = 78). Most participants (55.1%, n = 43) selected one option, 17.9% (n = 14) two options, 11.5% (n = 9) three options, 6.4% (n = 5) four options, 2.6% (n = 2) five options, 3.8% (n = 3) six options, 1.3% (n = 1) seven options, and 1.3% (n = 1) 10 options.

A total of 27 (16.6%) participants reported not experiencing discrimination while accessing health care in the Toowoomba region and four participants (2.5%) preferred not to say. Of the 47 participants that did report discrimination, the top four responses included: lack of LGBTQIA+ supportive services (61.7%); incorrect assumptions about health needs/issues (55.3%); dismissal of your worries/concerns relating to health (38.3%); and lack of expertise in gender affirming healthcare (36.2%; see Table 17).

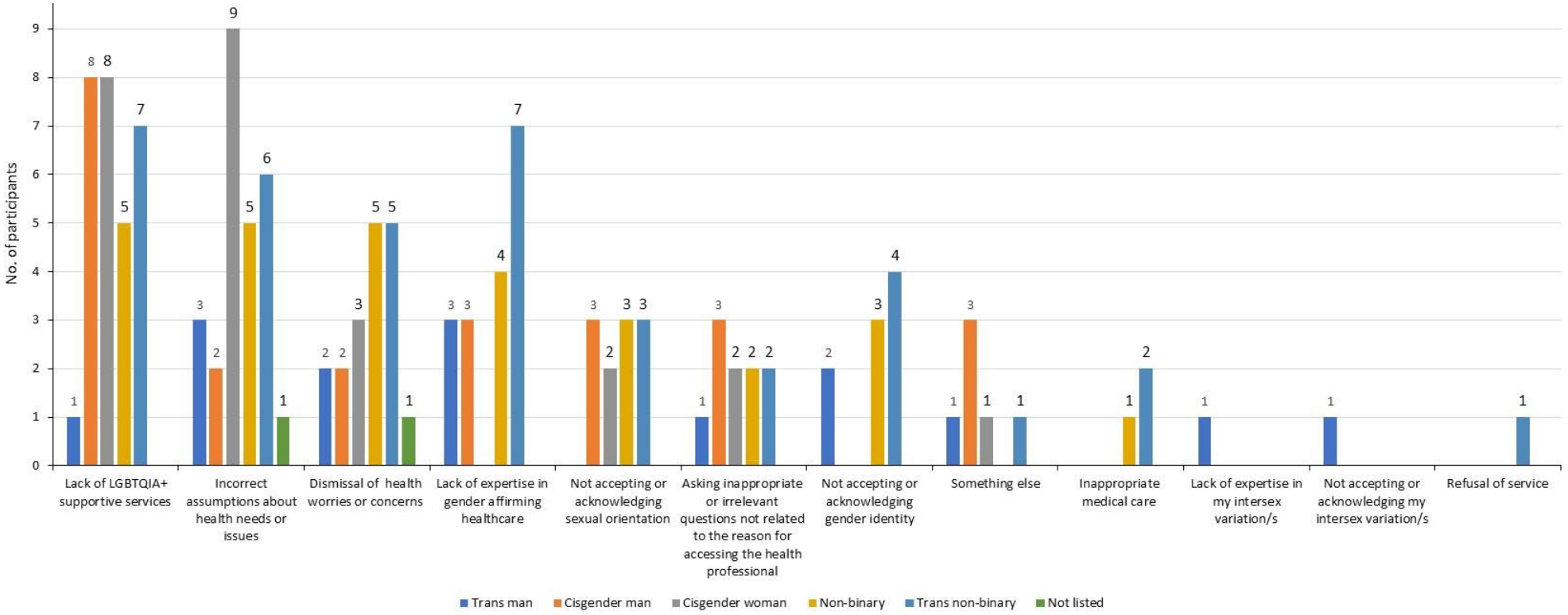
When considering the types of health-related LGBTQIA+ specific discrimination by gender and sexuality the reported results are highly complex as shown in Figure 22, Figure 23 and Table 18. The reported results suggest that LGBTQIA+ people experience a broad range of health-related discrimination, across both gender and sexuality, with high levels of incorrect assumptions about health needs and dismissal of health worries/concerns, paired with a lack of expertise and inappropriate/irrelevant questions indicates (as reported) a significant lack of awareness/expertise in gender affirming health care (including intersex-specific health care) and/or an inability to accept/acknowledge different LGBTQIA+ gender identities and sexual orientations.

Table 17: Types of discrimination (N = 47)

Discrimination type	N	%
Lack of LGBTQIA+ supportive services	29	61.7
Incorrect assumptions about health needs/issues	26	55.3
Dismissal of your worries/concerns relating to health	18	38.3
Lack of expertise in gender affirming healthcare	17	36.2
Not accepting or acknowledging your sexual orientation	11	23.4
Asking inappropriate or irrelevant questions not related to the reason you are accessing the health professional (e.g., your body, sexual health, medical surgeries/ procedures, relationships)	10	22.3
Not accepting or acknowledging your gender identity	9	19.1
Something else	6	12.8
Inappropriate medical care (e.g., prescriptions, dosage, advice, referrals)	3	6.4
Lack of expertise in my intersex variation/s	1	2.1
Not accepting or acknowledging your intersex variation/s	1	2.1
Refusal of service	1	2.1

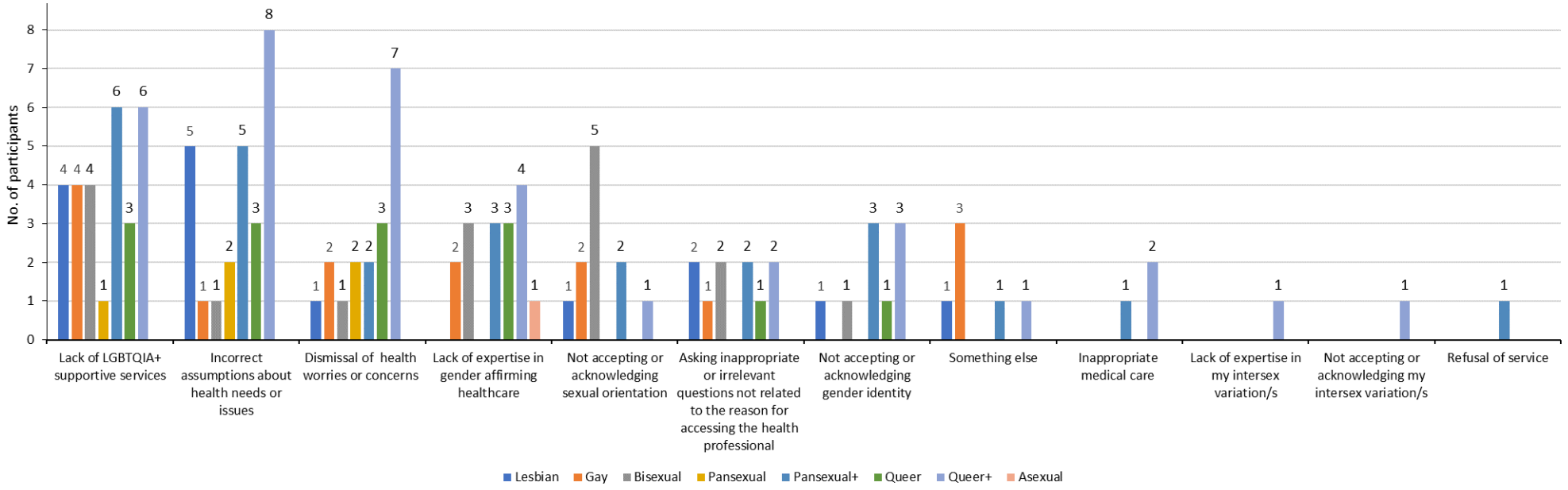
Note. Participants could select more than one option. The % column reflects the percentage of the total number of participants (N = 47).

Figure 22: Types of discrimination by gender



Note. The number of participants within each category varies according to the service usage reported.

Figure 23: Types of discrimination by sexuality



Note. The number of participants within each category varies according to the service usage reported.

Table 18: Types of discrimination experienced accessing health care while living in the region

	Lack of LGBTQIA+ supportive services	Incorrect assumptions about health needs and issues	Dismissal of your worries or concerns relating to your health	Lack of expertise in gender affirming healthcare	Not accepting or acknowledging your sexual orientation	Asking inappropriate or irrelevant questions not related to the reason you are accessing the health professional (e.g., your body, sexual health, medical surgeries/procedures, relationships)	Not accepting or acknowledging your gender identity	Something else	Inappropriate medical care (e.g., prescriptions, dosage, advice, referrals)	Lack of expertise in my intersex variation/s	Not accepting or acknowledging your intersex variation/s	Refusal of service
GENDER (N = 47)												
Trans man	1 (3.4)	3 (11.5)	2 (11.1)	3 (17.6)		1 (10.0)	2 (22.2)	1 (16.7)		1 (100.0)	1 (100.0)	
Cisgender man	8 (27.6)	2 (7.7)	2 (11.1)	3 (17.6)	3 (27.3)	3 (30.0)		3 (50.0)				
Cisgender woman	8 (27.6)	9 (34.6)	3 (16.7)		2 (18.2)	2 (20.0)		1 (16.7)				
Non-binary	5 (17.2)	5 (19.2)	5 (27.8)	4 (23.5)	3 (27.3)	2 (20.0)	3 (33.3)		1 (33.3)			
Trans non-binary	7 (24.1)	6 (23.1)	5 (27.8)	7 (41.2)	3 (27.3)	2 (20.0)	4 (44.4)	1 (16.7)	2 (66.7)			1 (100.0)
Not listed		1 (3.8)	1 (5.6)									
SEXUALITY (N = 46)												
Lesbian	4 (14.3)	5 (20.0)	1 (5.6)		1 (9.1)	2 (20.0)	1 (11.1)	1 (16.7)				
Gay	4 (14.3)	1 (4.0)	2 (11.1)	2 (12.5)	2 (18.2)	1 (10.0)		3 (50.0)				
Bisexual	4 (14.3)	1 (4.0)	1 (5.6)	3 (18.8)	5 (45.5)	2 (20.0)	1 (11.1)					
Pansexual	1 (3.6)	2 (8.0)	2 (11.1)									
Pansexual+	6 (21.4)	5 (20.0)	2 (11.1)	3 (18.8)	2 (18.2)	2 (20.0)	3 (33.3)	1 (16.7)	1 (33.3)			1 (100.0)
Queer	3 (10.7)	3 (12.0)	3 (16.7)	3 (18.8)		1 (10.0)	1 (11.1)					
Queer+	6 (21.4)	8 (32.0)	7 (38.9)	4 (25.0)	1 (9.1)	2 (20.0)	3 (33.3)	1 (16.7)	2 (66.7)	1 (100.0)	1 (100.0)	
Asexual				1 (6.3)								

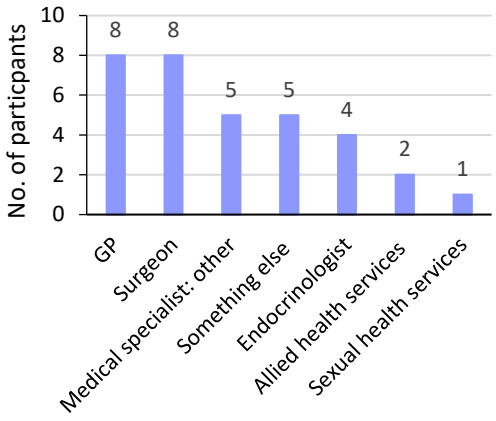
Note. Participants could select more than one option. The number of participants within each category varies according to the service usage reported. For gender and sexuality, the totals of 100% are across the response category (e.g., lack of LGBTQIA+ supportive services).

3.6.4. Travel outside of Toowoomba to access health services in the past 12 months

Participants were asked if they had travelled outside of the Toowoomba region to access health services in the past 12 months. A list of different health services, along with the option to indicate if they had not seen anyone on the list, or prefer not to say, was available. Additionally, participants were able to select more than one option (N = 77). Most participants (92.2%, n = 71) selected one option, 5.2% (n = 4) two options, and 2.6% (n = 2) three options.

More than half of participants (67.5%, n = 52) had not travelled outside of Toowoomba to access health services in the past 12 months. Of the 25 participants that did travel outside of Toowoomba, 32% (n = 8) accessed a GP, 32% (n = 8) surgeon, 20% (n = 5) medical specialist: other, 20% (n = 5) something else, 16% (n = 4) endocrinologist, 8% (n = 2) allied health service, and 4% (n = 1) sexual health service (see Figure 24). The types of medical specialist: other reported included a fertility specialist, immunologist, neurologist, psychiatrist, and rheumatologist. The types of something else services reported included trans health doctor, LGBTQIA+ service, dermatologist, and psychologist.

Figure 24: Health services accessed outside of the Toowoomba region in the past 12 months (N = 25)



Note. Participants could select more than one option.

3.6.4.1 Reasons for travel outside of the Toowoomba region to access health services

Participants who reported travelling outside of the Toowoomba region to access health services were further asked to select from a list of options to indicate the main reasons why. Additionally, participants were able to select more than one option (N = 25). Most participants (72%, n = 18) selected one option, 12% (n = 3) two options and 16% (n = 4) three options.

The main reasons reported by participants (N = 25) for travelling outside of the Toowoomba region to access health services include: the service was 48% not available in Toowoomba; 32% something else; 20% lack of expertise in gender affirming health care; 20% lack of LGBTQIA+ supportive services; 16% did not feel safe accessing health services in the Toowoomba region; and two participants (8%) preferred not to say (see Table 19). The type of something else reasons stated were complex. A sample of the reported reasons included local GPs not listening to worries/concerns; surgeons in Toowoomba were too expensive; needed help with sexual identity and Toowoomba services were not helping; better quality of care and skill; continued

seeing health professional after relocating to Toowoomba; and family circumstance.

Table 19: Reasons for travel outside of Toowoomba to access health services (N = 25)

Service	N	%
Service not available in the Toowoomba region	12	48.0
Something else	8	32.0
Lack of expertise in gender affirming health care	5	20.0
Lack of LGBTQIA+ supportive services	5	20.0
I don't feel safe accessing health services in the Toowoomba region	4	16.0
Prefer not to say	2	8.0

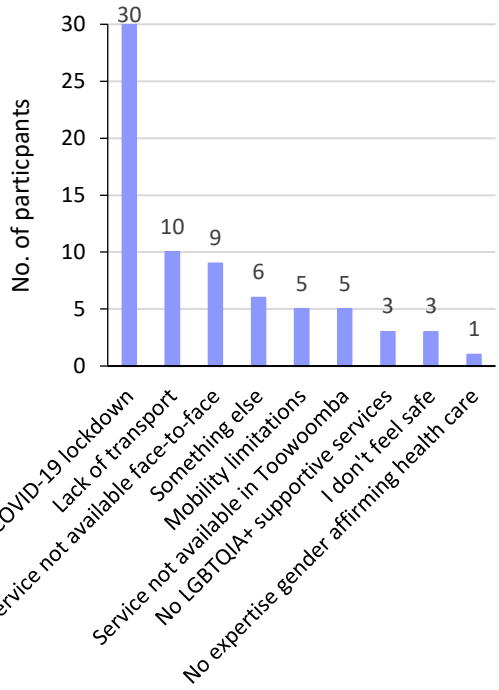
Note. Participant could select more than one option. The % column reflects the percentage of the total number of participants (N = 25).

3.6.5. Reasons for telehealth service access in the past 12 months

Participants were asked if they had accessed telehealth services in the past 12 months and were provided with a list of reasons, along with the option to indicate if they had not used telehealth services or prefer not to say were available. Additionally, participants were able to select more than one option (N = 80). Most participants (77.5%, n = 62) selected one option, 13.8% (n = 11) two options and 8.8% (n = 7) between three to seven options.

Most participants (51.3%, n = 41) did not access telehealth services in the past 12 months and one participant preferred not to say. Of the 38 participants who did access telehealth services, 78.9% (n = 30) was due to COVID-19 lockdown, 26.3% (n = 10) lack of transport, 23.7% (n = 9) service not available face-to-face, 15.8% (n = 6) something else, 13.2% (n = 5) mobility limitations, 13.2% (n = 5) service not available in the Toowoomba region, 7.9% (n = 3) lack of LGBTQIA+ supportive services, 7.9% (n = 3) I do not feel safe, and 2.6% (n = 1) lack of expertise in gender affirming health care (see Figure 25).

Figure 25: Reasons for accessing telehealth services (N = 38)



Note. Participants could select more than one option.

3.6.6. LGBTQIA+ inclusive health service importance

Participants were asked to rate how important it is to them that their health service is LGBTQIA+ friendly/inclusive on a 4-point scale from not important to very important. A total of 86 participants reported their preferences. Most participants (89.5%, n = 77) reported it was either very important (70.9%, n = 61) or important (18.6%, n = 16) that their health service is LGBTQIA+ friendly/inclusive. A further 9.3% (n = 8) reported minor importance and for one participant (1.2%) it was not important at all.

3.7. Domestic, Family and Intimate Partner Violence

3.7.1. Experiences of violence

Participants were asked if they had ever experienced violence from a partner, spouse, family member or someone they lived with (here after referred to as DFIPV; N = 86). Over half of participants (53.5%, n = 46) reported experiencing DFIPV either at some time in their life (44.2%, n = 38) or within the past 12 months (9.3%, n = 8). Conversely, 43% (n = 37) reported not experiencing DFIPV and 3.5% (n = 3) preferred not to say.

When considering experiences of DFIPV by gender (N = 85), all trans women (n = 2) and not listed (n = 1) participants reported experiencing DFIPV and the one Brotherboy did not (see Figure 26). Non-binary, cisgender women and Sistergirls were equally likely to experience DFIPV than not. Tans non-binary and trans men were more likely to experience DFIPV (88.9%, n = 8/9 and 60%, n = 3/5, respectively) than not. Conversely, cisgender men were slightly less likely to not experience DFIPV (55.6%, n = 10/18) than to experience DFIPV. Of the eight participants who experienced DFIPV within the past 12 months, three were non-binary and one of each were trans man, trans woman, cisgender woman, trans non-binary, and Sistergirl.

When considering experiences of DFIPV by sexuality (N = 85), all four something else participants reported experiencing DFIPV (see Figure 27). Three quarters (75%, n = 9/12) of pansexual+, 64.3% (n = 9/14) bisexual and 57.1% (n = 8/14) queer+ participants were more likely to report experiencing DFIPV than not. Conversely, 75% (n = 3/4) asexual, 66.7% (n = 2/3) pansexual, 57.1% (n = 47) queer, 53.3% (n = 8/15) gay, and 50% (n = 5/10) of lesbians were less likely to report experiencing DFIPV than to experience DFIPV. Of the eight participants who experienced DFIPV within the past 12 months, three were pansexual+; two were bisexual; and one of each were lesbian, queer, and something else.

Figure 26: Experiences of DFIPV by gender (N = 85)

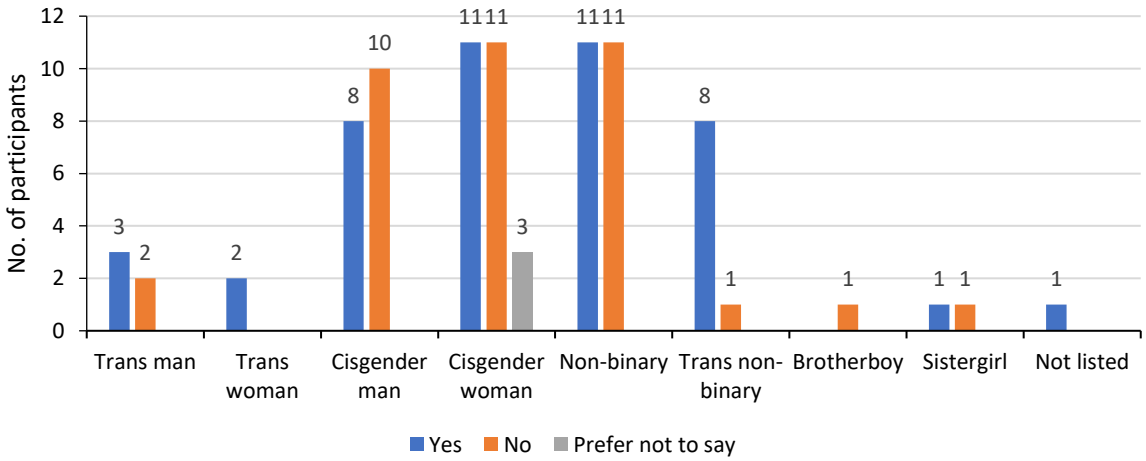
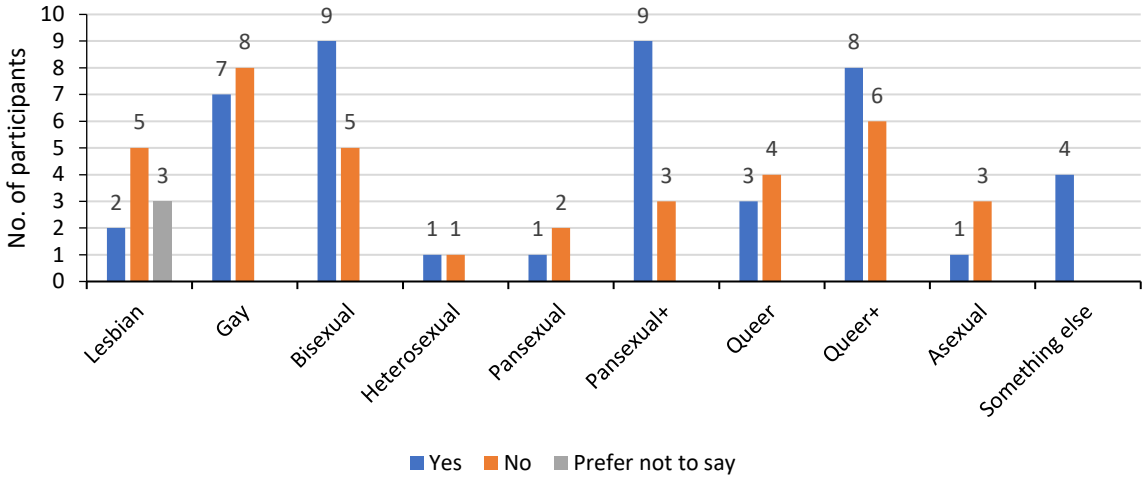


Figure 27: Experiences of DFIPV by sexuality (N = 85)



Participants who responded yes to experiencing DFIPV were further asked if they felt they were targeted due to identifying as an LGBTQIA+ person (N = 45). Over one quarter of participants (28.9%, n = 32) reported yes.

When considering being targeted due to identifying as an LGBTQIA+ person by gender, 100% (n = 2) trans women, 66.7% (n = 2/3) trans men, 42.9% (n = 3/7) trans non-binary, 25% (n = 2/8) cisgender men, 18.2% (n = 2/11) non-binary, and 9.1% (n = 1/11) cisgender women reported yes to this question (see Figure 28).

When considering being targeted due to identifying as an LGBTQIA+ person by sexuality, 100% (n = 1) heterosexual, 50% (n = 1/2) lesbian, 44.4% (n = 4/9) pansexual+, 33.3% (n = 1/3) queer, 28.6% (n = 2/7) gay, 25% (n = 2/8) queer+, and 22.2% (n = 2/9) bisexual participants reported yes to this question (see Figure 29).

Figure 28: Targeted for DFIPV due to identifying as LGBTQIA+ by gender (N = 44)

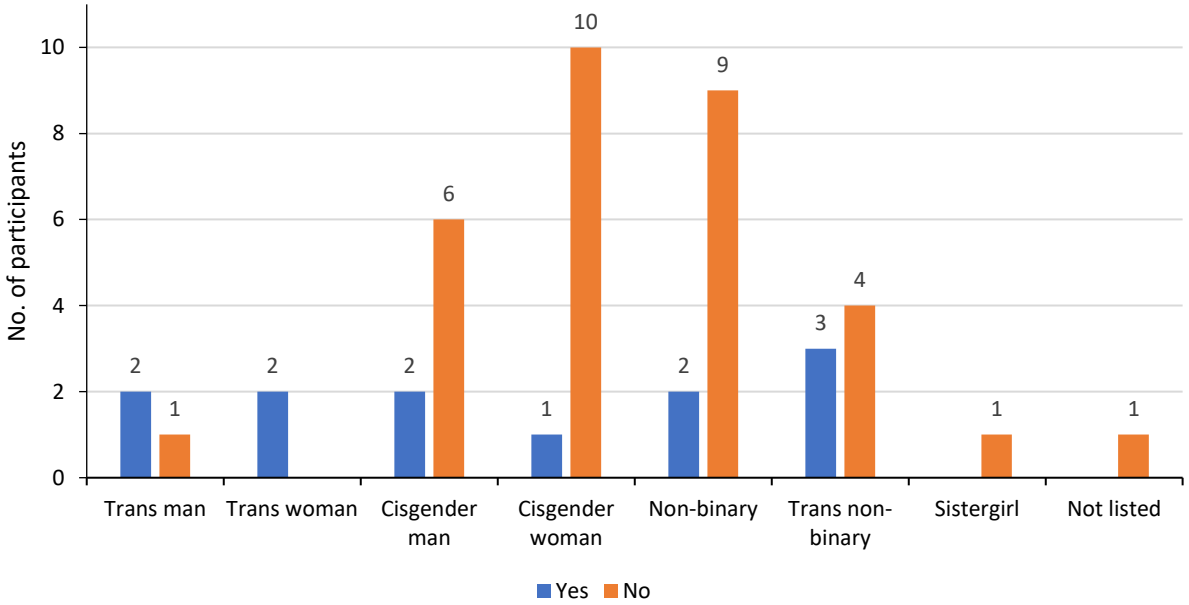
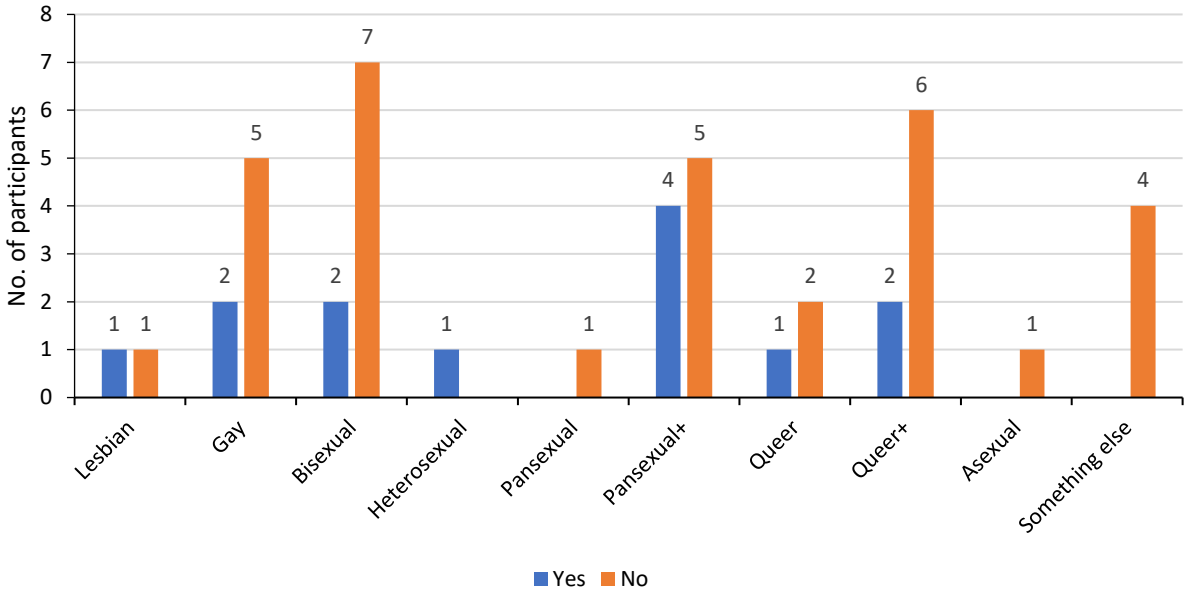


Figure 29: Targeted for DFIPV due to identifying as LGBTQIA+ by sexuality (N = 45)



3.7.2. Reporting domestic, family and intimate partner violence

3.7.2.1 Initial report of violence

Participants who had experienced DFIPV were asked if they had reported an instance of this violence to a professional service. A list of different service providers, along with the option to indicate the violence was not reported or prefer not to say was available. Additionally, participants were able to select more than one option. Most participants (82.6%, n = 38) selected one option, 13% (n = 6) two options, 2.2% (n = 1) four options, and 2.2% (n = 1) seven options.

Almost half of the participants (47.8%, n = 22) did not report the violence and 2.2% (n = 1) preferred not to say (see Table 20). Of the 39 participants that contacted a service, the responses included counselling/psychology service (46.2%, n = 18/39), police (15.4%, n = 6/39), doctor/hospital (12.8%, n = 5/39), domestic or family violence service (10.3%, n = 4/39), LGBTQIA+ organisation (7.7%, n = 3/39), telephone helpline (2.6%, n = 1/39), religious/spiritual community leader or elder (2.6%, n = 1/39), and something else (2.6%, n = 1/39).

Table 20: Professional services where violence was reported (N = 46)

Service	N	%
I did not report this violence	22	47.8
Counselling/psychology service	18	31.1
Police (including LGBTQI liaison officers)	6	13.0
Doctor or hospital	5	10.9
Domestic or family violence service	4	8.7
LGBTQIA+ organisation	3	6.5
Telephone helpline	1	2.2
Religious or spiritual community leader or elder	1	2.2
Other	1	2.2
Prefer not to say	1	2.2

Note. Participants were able to select more than one option. The % column reflects the percentage of the total number of participants (N = 46).

3.7.2.2 Reasons for not reporting DFIPV

Participants who selected 'I did not report this violence' were asked, if they felt comfortable, to explain why they did not report this violence. Responding to this question, five key rationales were provided including: 1) they were unaware they were experiencing DFIPV; 2) they were underage and family violence was accepted; 3) fear of disbelief and/or judgement by organisations that lack LGBTQIA+ awareness; 4) they chose to leave the relationship; and 5) they had no capacity to report the violence.

Of the number of people that elaborated on why they did not report the violence, the most common were the first three rationales. In relation to being unaware they were experiencing DFIPV, several people spoke of not feeling as though the violence was serious/severe enough (Peyton, Kirby, Coby). Regarding being underage and experiencing family violence, Robin reflected that "I was a minor and felt like I would cause trouble for my family by reporting it," whereas Alex suggested that "as a teenager it wasn't seen as family violence," and Quinn remarked regarding abuse by a sibling that their "parents dealt with the problem." A common fear about not being believed and/or judged by organisations is evidenced by Creg stating "there's no organisations that are safe for LGBTIQA people," and Trudy commenting on their concern of what may occur as a trans woman reporting intimate partner violence to the police - "because ... my abuser intended to tell the cops that I was the offender - something they would believe, considering ... transphobia and me being twice the size of many cis girls, I didn't want to do time because *I* [had been] raped." Some participants chose to leave their relationship rather than experience additional violence, whereas others lacked the capacity to leave. Sara explained "[I] just couldn't do it, hard to explain, I was trapped" and Sage stated "[I] didn't have the capacity or the support at the time."

3.7.2.3 LGBTQIA+ knowledge/expertise of professional services contacted

Participants who had experienced DFIPV and contacted a professional service were asked to rate if the service had sufficient knowledge/ expertise in providing support to LGBTQIA+ people experiencing violence on a 4-point scale from 'not at all' to 'to a great extent'. Counselling/psychology services, while mixed, were reported by 70.6% (n = 12/17) participants to have the most (47.1% somewhat and 23.5% to a great extent) knowledge/expertise in providing support to LGBTQIA+ people (see Figure 30). Domestic/family violence services were polarised at 50% (n = 2/4) somewhat and 50% (n = 2/4) not at all. Doctors/hospitals, the police and LGBTQIA+ organisations were mixed and less likely to have knowledge/expertise in providing support to LGBTQIA+ people (40%, n = 2/5, 20% somewhat and 20% to a great extent; 33.3%, n = 2/6, 16.7% somewhat and 16.7% to a great extent; and 33.3%, n = 1/3, somewhat; respectively). One participant each reported that telephone helplines and religious/spiritual community leader or elder were not at all knowledgeable/had expertise in providing support to LGBTQIA+ people experiencing violence.

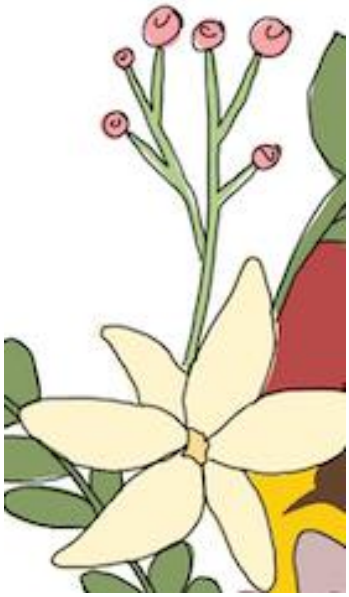
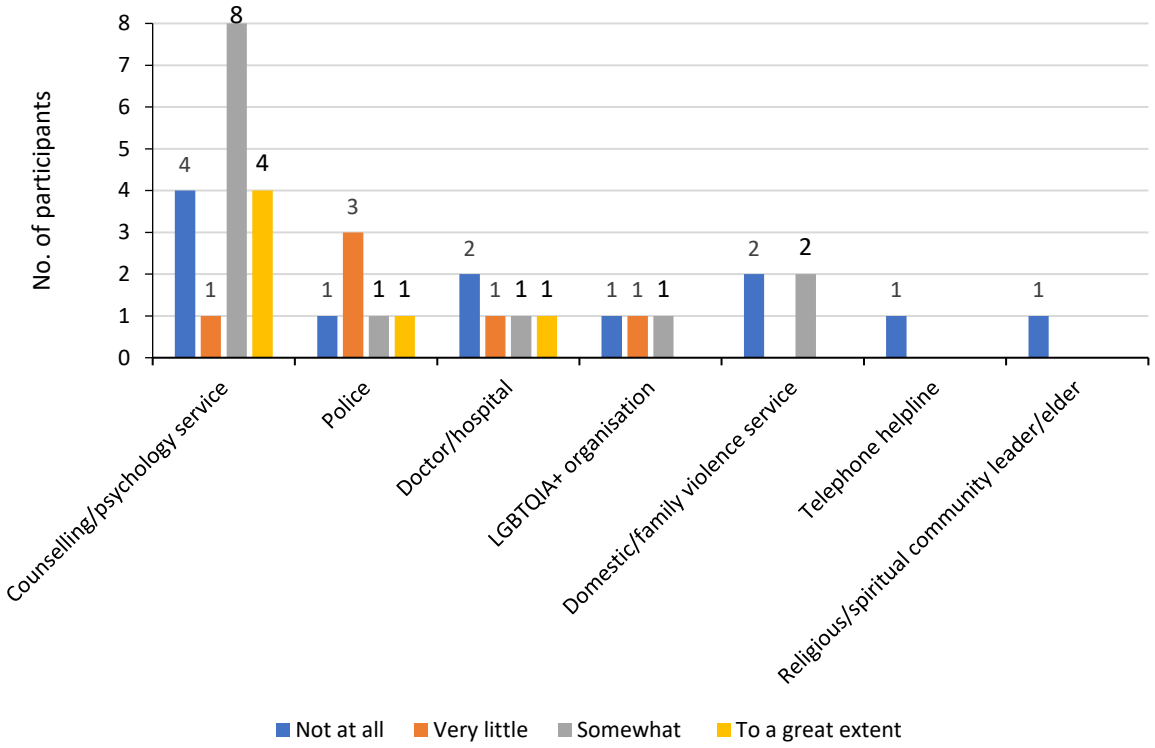


Figure 30: LGBTQIA+ knowledge/expertise of professional services



Note. Counselling/psychology service n = 17; Police n = 6; Doctor/hospital n = 5; LGBTQIA+ organisation n = 3; Domestic/family violence service n = 4; Telephone helpline n = 1; Religious/spiritual community leader/elder n = 1.

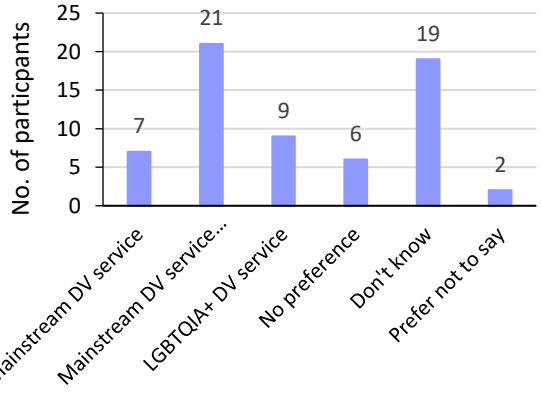
3.7.3. Preferred future support access for DFIPV

Participants were asked, if they were ever to experience DFIPV in the future, where they would prefer to access support. Response options included: a mainstream domestic violence service, a mainstream domestic violence service inclusive of LGBTQIA+ people, a domestic violence service only for LGBTQIA+ people, do not know, or prefer not to say. Participants were able to select more than one option (N = 86).

Most participants (74.4%, n = 64) selected one option, 22.1% (n = 19) two options and 3.5% (n = 3) three options. Of the participants who selected one option (N = 64, see Figure 31), 32.8% (n = 21) preferred a mainstream domestic violence service inclusive of LGBTQIA+ people, 29.7% (n = 19) didn't know, 14.1% a domestic violence service only for LGBTQIA+ people, and 10.9% (n = 7) a mainstream domestic violence service.

Of the participants who selected two options (N = 19), 78.9% (n = 15) preferred either a mainstream domestic service inclusive of LGBTQIA+ people or a domestic violence service only for LGBTQIA+ people, and 21.1% (n = 4) either a mainstream domestic violence service or a mainstream domestic service inclusive of LGBTQIA+ people. Participants who selected three options chose all three domestic violence services listed.

Figure 31: Preferred future support access for participants who selected one response option (N = 64)



3.8. Community Connection

3.8.1. LGBTQIA+ community definition

When asked what defines an LGBTQIA+ community for you, 70.1% (n = 61/87) of the participants provided a response. These responses are grouped into the following categories used to describe the LGBTQIA+ community: attributes, purpose, and members.

Attributes of the LGBTQIA+ community included being and feeling safe; acceptance; understanding; inclusive of gender and sexual diversity; intersectionality including disabilities and health status; respectful of and celebrating gender and sexual diversity. Pip elaborated saying an LGBTQIA+ community includes a "safe space for acceptance and where you can just be yourself and be with like-minded people." Whereas Coby commented that an LGBTQIA+ community is "a specifically inclusive and supportive space for LGBTQIA people." Additionally, Cedar suggests the community is "inclusive, reliable, trustworthy, confidential, and supportive..., [including] people who can relate to me and my experiences."

Participants stated the purpose of the LGBTQIA+ community included to provide support; advocacy; a safe space; friendship, companionship, and a sense of connection; a space for like-minded people. Trudy asserts "it must be radical and revolutionary..., a place of resistance," whereas Emery suggests it is a space "to create friendships/get to know each other to talk about issues specific to the LQBTQIA community, learn, support each other etc, without judgement and with full respect. To give people a safe space of understanding people." Additionally, Angel comments that it "allows for LGBTQ+ people to feel liberated in their identity, and connect with people who understand their experience."

It was predominantly suggested that members of the community include only LGBTQIA+ identifying people as evidenced by Jewell stating that an LGBTQIA+ community includes "a group of friends who are LGBTQIA+," and Jamie and Creg both commenting "a group of LGBTQIA+ identifying persons only." Few participants (n = 4) referred to queer rather than LGBTQIA+ people being part of the LGBTQIA+ community; for example, Trudy suggested the community is made up of "queer genders, queer sex, queer lives... by queer people, to queer ends," and for Lennon they are "social groups with fellow queer folk." A couple of participants (n = 2) suggested that allies be included; Franky said the LGBTQIA+ community is "inclusive of queer people, which can include allies," and Sage also suggested it encompasses the "LGBTQIA+ community and allies." Conversely, one participant, Trudy explained there is no community as such but rather "a loose knit group of tribes who banded together to survive attempts to wipe us out. We are targeted for all the same reasons, so we have the same goals. But we aren't a 'community'."

3.8.2. Factors contributing to feeling positive

Almost three quarters of participants (73.3%, n = 44/60) identified key components that contribute to feeling positive as an LGBTQIA+ person living in the Toowoomba region. These included family, partner/s, children, and friends; being engaged in interests such as gardening, enjoying wildlife, further education; and additionally, self-care activities such as bubble-tea therapy and exercise. Furthermore, a large number of participants stated that feeling safe and connected were integral towards feeling positive about themselves as an LGBTQIA+ person. Madison explained "I feel positive about myself when I feel safe and connected and I can connect to other people from a place where I feel strong. When I feel like I'm in charge of my life and I can achieve things, then I feel positive." Angel also commented specifically regarding the importance of connecting with other LGBTQIA+ people stating "connecting with other LGBTQ+ people also allow me to feel safer in my identity. When I don't feel the need to defend myself or be in fear of others, I can like myself and my identity more." For some, certain places were also important to feeling safe and connected, contributing to a sense of feeling positive about being an LGBTQIA+ person. These included workplaces, online spaces, church groups, and "gender

affirming spaces including barber shops" (Ricki). The use of gender-neutral language and accessing needed health services were also identified as promoting a sense of feeling positive as a trans person. For example, Monroe stated, "I feel positive when people use my preferred name and pronouns," and Gael commented that "being able to access the allied health support I need" led to being "able to finally be my true self."

Assisting others to be and feel empowered as an LGBTQIA+ person was also identified as important to feeling positive about being a rainbow community member in the Toowoomba region. Franky reflected

> *I'm strong [and have] enough sense of self-worth to not care what others think of me. In fact, I have engaged in public speaking where I have not been afraid to disclose personal information, including my past life with drugs, and living with HIV. I like "fighting" for a cause and my interests relate to my lived experience with addiction, HIV, and a man whose sexuality has changed with his life experiences. I have no problem being a voice for others, to educate and reduce stigma, to smash stereotypes, and be an agent of change.*

Terry expands the idea of empowerment to include educating friends to become LGBTQIA+ allies, for example "nobody assumes I'm LGBTQIA+, and they usually become friends with me before finding out. It's like a friendly trap. Then they have an identity crisis of their own and have to question their long-held stereotypes and discriminatory beliefs." And finally, being recognised, "out and proud" (Skyler), and seeing positive images of other LGBTQIA+ people represented in the media were also named as key elements in feeling positive as an LGBTQIA+ person in the Toowoomba region.

Conversely, over one quarter of participants (26.7%, n = 16/60) who responded identified that it is challenging if not impossible to feel positive about oneself as an LGBTQIA+ person in the Toowoomba region. For example, Finley, Averill, Kirby, Riley, Jewell and Presley all stated that "nothing" makes them feel positive; whereas Sidney commented that "I honestly feel very unsafe being openly LGBTQIA+ in Toowoomba." Similarly, Toby further explained

> *Toowoomba has been the most homophobic place I've ever lived. People tease me a about my androgynous appearance, I've had drinks tipped on me and have been ridiculed by strangers many times for no reason other than my queer appearance. I personally feel great about myself as a LGBTQIA+ person. But living in Toowoomba certainly doesn't help.*

3.8.3. Additional reflections

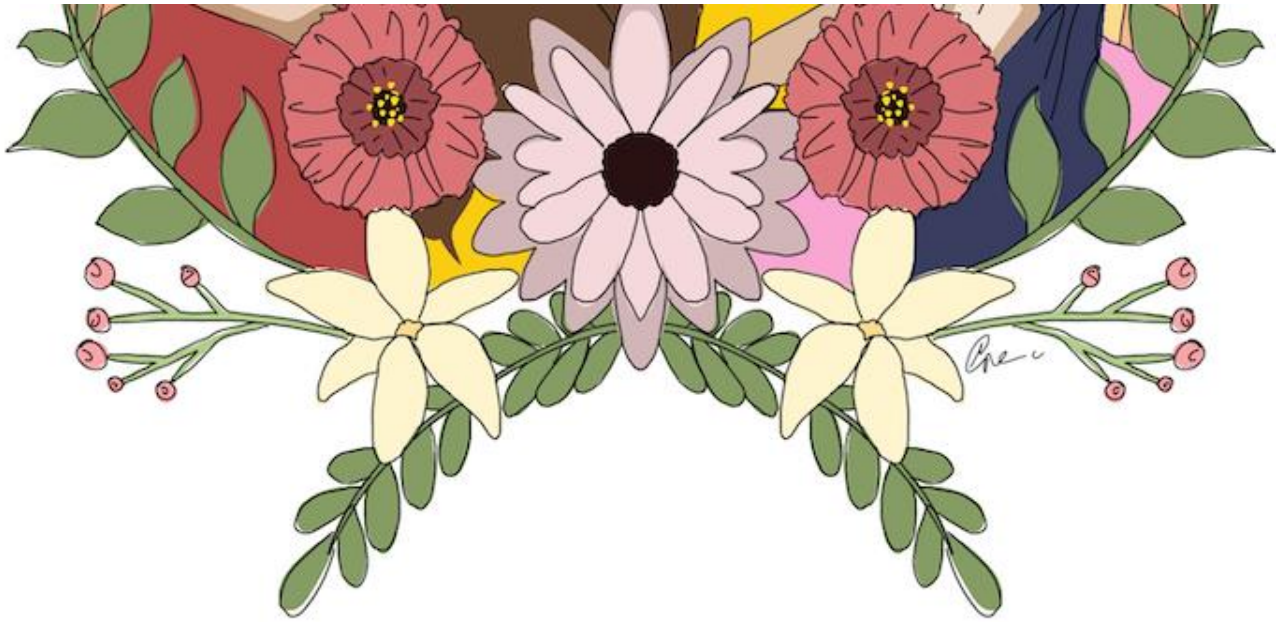
Fourteen participants contributed additional thoughts provoked by the survey. While some participants spoke of a lack of connection to an LGBTQIA+ community in the Toowoomba region, at the same time they acknowledged the presence of a large or several LGBTQIA+ community groups. Veka stated, "I feel that there is a lack of 'community' amongst gay men in Toowoomba, although there is large LGBTQ [community] here. There is a great sexual presence thru App Services." And Bella commented "although I know of and are technically part of many 'community groups' there is very little 'sense of community' in Toowoomba currently." Others spoke of their experiences of identifying as an LGBTQIA+ person in the Toowoomba region, commenting specifically about a sense of isolation and it being easier to appear hetero-normative and/or cis-normative. Astra commented

> *…claiming my identity as nonbinary is far more isolating than outing myself as Autistic, ADHD, PTSD, or various physical disabilities. I don't even bother to talk about being asexual because it's too nuanced and generally say I'm pan if it comes up... It's easier in the moment to pass as a straight woman but in the long run I feel like I don't get to live MY life.*

And Casey stated, "most of the time I blend in with society, I don't think I look particularly 'gay'. It pains me sometimes that I can't fully conform and be straight." In addition, Shan commented on the difficulty with obtaining resources in the Toowoomba region stating that "some of my friends have discussed issues with getting supplies in the region. There is nowhere to buy binders or other items that may make life easier for LGBTQIA+ or intersex people." In addition, reiterating the conversation regarding

experiences of discrimination, harassment and violence noted by participants, George added "Toowoomba is basically a small country town. There are many stories of violence against the [LGBTQIA+] community. But there are also plenty of us here in the [LGBTQIA+] community." Dee concluded with a comment about the strength of LGBTQIA+ individuals and the broader Toowoomba community:

The resistance we have had has often been with young females in their 20s, in Toowoomba. Our local hotel... has been one of our biggest allies living in this community, our selection of friends has given us more allies within the broader community. Nowadays should we experience homophobia we stand strong and use our voice, it at times in the last few years has led to a friendship in the way of people understanding we are decent people but are in a non-traditional relationship [gay/lesbian/queer]. There are still plenty of rednecks in Toowoomba so change will be [a] slower process, however I think that the more people who I come across that realise I'm a decent human regardless of my sexual orientation/relationship will come to understand they have no need to be scared or nothing to fear.



4. LGBTQIA+ Awareness Raising Training for Caring Professionals

Caring professionals and practitioners were surveyed pre and post LGBTQIA+ awareness raising training in relation to three specific domains including: 1) gender, sexuality, and variations in sex characteristics; 2) discrimination and marginalisation linked to LGBTQIA+ persons; and 3) domestic, family and intimate partner violence (DFIPV) unique to LGBTQIA+ persons. This section explores training effectiveness across three areas relating to knowledge and familiarity; attitudes; and practises, procedures, and behaviours about LGBTQIA+ concerns.

4.1. Demographics

4.1.1. Age of participants

Table 21: Age in categories (N = 42)

Age (years)	N	%
20 to 29	4	9.5
30 to 39	11	26.2
40 to 49	9	21.4
50 to 59	14	33.3
60+	4	9.5

The mean age of participants was 45.5 years (SD = 12), ranging from 24 to 72 years. Approximately one third (33.3%, n =14) were aged between 50 to 59 years. Age of participants in categories is shown in Table 21.

4.1.2. Location of residence

Most participants resided within Toowoomba (69%, n = 29) and the Greater Toowoomba region (26.2%, n = 11), while two (4.8%) worked in Toowoomba but resided outside the region.

4.1.3. Length of time residing in Toowoomba

Participants were either born in Toowoomba (23.1%, n = 10) or moved to the region in the past 1 to 41 years (71.4%, n = 30). A total of 83.3% (n = 35) resided in the Toowoomba region prior to the Same Sex Marriage vote in 2017. Note, two participants do not reside in the Toowoomba region.

4.1.4. Gender identity

Participants were provided a list of gender identities and were able to select more than one option to best reflect the multiplicity of gender identity. Most participants identified as a cisgender woman (78.6%, n = 33) or as a cisgender man (19%, n = 8), and one participant preferred not to say.

4.1.5. Gender different to that assigned at birth

Participants were asked to indicate whether their gender was different than what was assigned to them at birth. All participants responded no.

4.1.6. Sexual identity

Participants were provided a list of preferred sexual orientations with an additional 'I use another term'. Most participants (85.7%, n = 36) identified as straight or heterosexual, 7.1% (n = 3) identified as bisexual, with remaining participants identifying as pansexual, lesbian, or gay (see Table 22).

Table 22: Sexual identity (N = 42)

Sexual identity	N	%
Straight or heterosexual	36	85.2
Bisexual	3	7.1
Pansexual	1	2.4
Lesbian	1	2.4
Gay	1	2.4
Other	1	2.4

Note: One participant provided more than one response.

4.1.7. Intersex variation

Two participants reported they did not know if they were born with an intersex variation.

4.1.8. Aboriginal and Torres Strait Islanders

One participant identified as Aboriginal and one participant as both Aboriginal and Torres Strait Islander.

4.1.9. Country of birth and language

Most participants (90.5%, n = 38) were born in Australia, and four participants were born in either Europe or Asia Pacific. English and Australian English were reported as the main languages spoken at home by all participants.

4.1.10. Religious and/or spiritual belief

Participants were asked to self-report which religion and/or spiritual belief best represented them. Most participants (69%, n = 29) reported having a religious or spiritual belief, the most frequent being Christian/ity (16.7%, n = 7) followed by a range of other denominations/ beliefs (see Table 23). Almost one third (31%, n = 13) of participants reported no religion or spiritual belief.

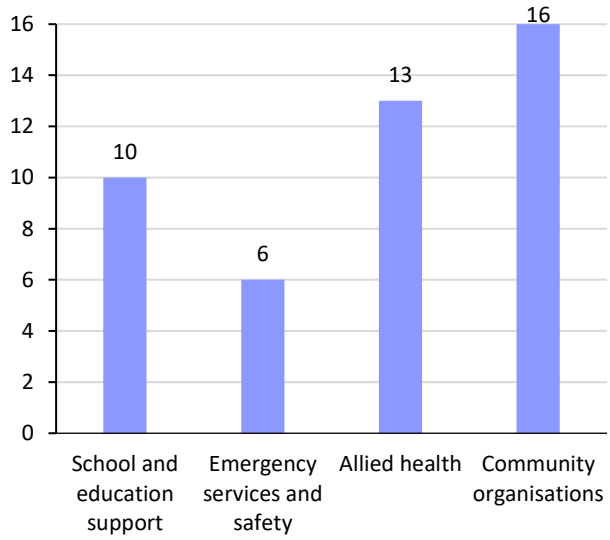
Table 23: Religion and/or spiritual belief (N = 42)

Religion and/or spiritual belief	N	%
None	13	31.0
Christian/ity	7	16.7
Catholic	4	9.5
Atheist/Atheism	4	9.5
Catholic and Christian/ity	2	4.8
Buddhist	2	4.8
Spiritual Agnostic	1	2.4
Spiritual	1	2.4
Roman Catholic	1	2.4
Non-specific	1	2.4
Nature	1	2.4
Lutheran	1	2.4
Jedi	1	2.4
Anglican and Christianity	1	2.4
Anglican	1	2.4
Other	1	2.4

4.1.11. Employment profession

Participants were provided with a list of professions relevant to the training and asked to select their profession. Options included: school staff (e.g., principals, teachers, or administrative staff); education support professional (e.g., school counsellors, nurses, psychologists, chaplains, or social workers); emergency services and safety (e.g., police service, fire and emergency service, ambulance service); allied health professional (e.g., social workers, psychologists, counsellors, and others providing essential care for LGBTQIA+ individuals at different stages of their lives); and community organisations (e.g., non-government organisations, council members). Participants were able to select more than one option, and for the purpose of this report, school staff and education support professionals were combined under school staff and educational support.

Figure 32: Profession (N = 42)



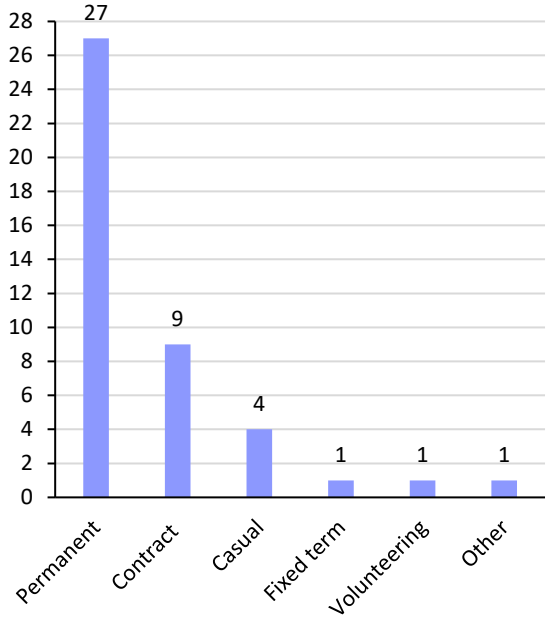
Note. Three participants reported an affiliation with both allied health and community organisations.

Participant professions reported include 38.1% (n = 16) community organisation; 31% (n = 13) allied health; 19% (n = 10) school and education support; and 14.3% (n = 6) emergency services and safety (see Figure 32).

4.1.12. Status of employment

Participants were asked to report on the status of their current employment and provided with response options, with the addition of other please specify. Participants could select more than one response.

Figure 33: Employment status (N = 42)



Note. One participant reported twice.

Most participants (64.3%, n = 27) reported being permanently employed, followed by 21.4% (n = 9) contract employment (temporary or fixed term). The one participant that reported in two categories were employed permanent and contract. The one participant that reported other was a student (see Figure 33).

Participants were asked to report how long they had been employed in their current role (N = 42). One third (33.3%, n = 14) had been in their current role less than 1 year, 31% (n = 13) between 1 and 3 years, 4.8 (n = 2) between 3 and 5 years, and 31% (n = 13) more than 5 years.

4.1.13. Leadership

Participants were asked to report if they were currently in a leadership role. A total of 40 participants reported their leadership status, most (73.8%, n = 31) were not in a leadership role, 21.4% (n = 9) were in a leadership role and two participants preferred not to say.

4.1.14. Education

Participants were asked to indicate their highest level of education completed.

Table 24: Highest level of educational attainment (N = 42)

Education level	N	%
Grade 10	1	2.4
Grade 12 or equivalent	1	2.4
Certificate III	5	11.9
Certificate IV	3	7.1
Diploma	10	23.8
Advanced Diploma	1	2.4
Bachelors Degree	12	28.6
Graduate Diploma	1	2.4
Masters Degree	7	16.7
Doctorate/PhD	1	2.4

Most participants had attained either a Bachelors degree, Diploma or Masters degree in their chosen field (see Table 24). The highest level attained of all participants was a Doctorate or PhD.

4.2. Knowledge and Familiarity about LGBTQIA+ Concerns

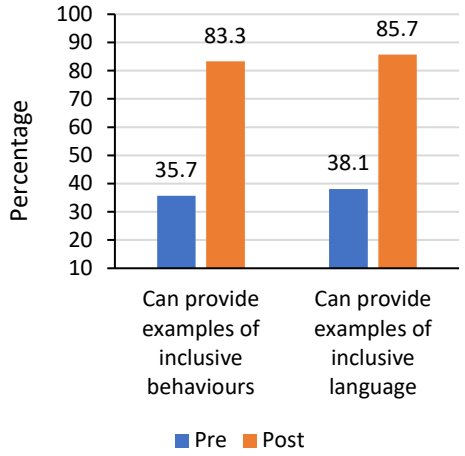
Participant responses were analysed pre- and post-workshop to determine training effectiveness regarding their knowledge and familiarity about gender, sexuality, and variations in sex characteristics; discrimination and marginalisation linked to LGBTQIA+ persons; and DFIPV unique to LGBTQIA+ persons.

Participants were asked to rate their agreement on a list of questions on a 5-point scale from strongly disagree to strongly agree; note some questions were reverse scored due to the wording of the question. Responses were then dichotomised into yes (agree and strongly agree) to indicate agreement and no (strongly disagree, disagree and undecided/not sure) to indicate disagreement. Open-ended questions were also asked at the end of each section and have been integrated throughout this section.

4.2.1. Gender, sexuality and variations in sex characteristics

Post-training, participants were able to demonstrate they were familiar with inclusive behaviours and languages (see Figure 34) and could provide examples of each.

Figure 34: Familiarity of inclusive behaviour and language (N = 42)



Participants' knowledge of the diverse letters represented in the LGBTQIA+ acronym increased post-training. Participants reported their knowledge and familiarity had increased around definitions, complexities, and intersectionality crosses genders, sexualities, and intersex variations (see Table 25). Participants demonstrated increased understanding that LGBTQIA+ people are a diverse group of individuals.

Table 25: Understanding and distinguishing between terms and acronyms (N = 42)

Question/item	Pre Yes %	Post Yes %	Change %
Understand the terms Sistergirl and Brotherboy	28.6	95.2	66.6
Understand the term pansexual	31.0	90.5	59.5
Familiar with what intersex variations include	28.6	95.2	66.6
Understand the terms asexual/aromantic	42.9	90.5	47.6
Can explain how the LGBTQIA+ acronym is connected	54.8	95.2	40.4
LGBTQIA+ people are NOT a homogenous group*	78.6	81.0	2.4
Can distinguish between the letters in the LGBTQIA+ acronym	40.5	100.0	59.5
Can distinguish between non-binary, genderqueer, and gender fluid	16.7	78.6	61.9
Can distinguish between gender identity and sexual orientation	54.8	83.3	28.5
Can distinguish between gender identity and gender expression	42.9	85.7	42.8

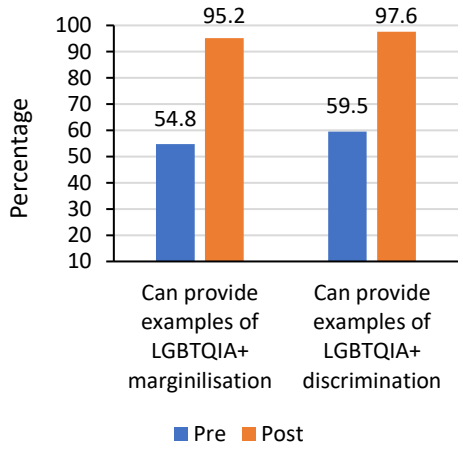
Note. *Reverse scored question.

The need for information regarding people with intersex variations was supported by Rowen who expressed a desire to broaden their knowledge base prior to receiving the training, explaining they needed "specific information regarding variations in sex characteristics" and then reporting after receiving the training that they had "solidified knowledge and boosted confidence."

4.2.2. Discrimination and marginalisation

Participants reported high levels of knowledge and familiarity regarding the disproportionate levels of discrimination and marginalisation LGBTQIA+ persons experience in the Toowoomba region compared to non-LGBTQIA+ persons (see Figure 35). They could also provide examples of both.

Figure 35: Familiarity of discrimination and marginalisation (N = 42)



Additionally, participants increasingly understood that LGBTQIA+ people are at a higher risk of psychological distress, increased suicide attempts, and homelessness, and could name barriers to accessing diverse support services (i.e., medical, psychological, legal, or emergency) unique to LGBTQIA+ persons (see Table 26).

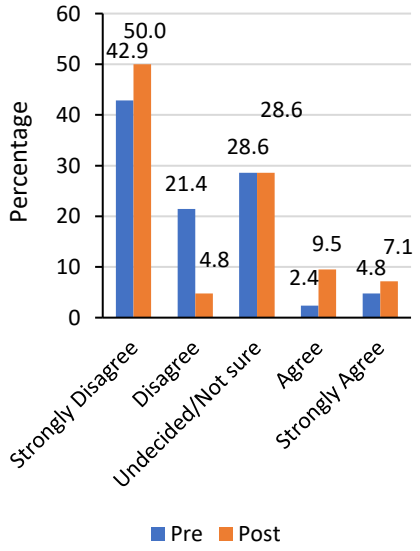
Table 26: Knowledge of LGBTQIA+ unique health risks (N = 42)

Question/item	Pre Yes %	Post Yes %	Change %
Do experience higher psychological distress*	81.0	83.3	2.3
Do attempt suicide at higher rates*	73.8	88.1	14.3
Are at higher risk to experience homelessness*	73.8	88.1	14.3
Can name barriers in accessing diverse health support services	38.1	95.2	57.1

Note. * Reverse scored questions.

Additionally, participants' knowledge regarding how the Electorate of Groom, to which the Toowoomba region belongs to, voted in the Same Sex Marriage vote in 2017 was analysed (see Figure 36). While 50% (n = 21) of participants were able to identify that the Toowoomba region did not vote in support of same sex marriage (i.e., voted no), over one quarter of participants (28.6%, n = 12) were still unsure post-training.

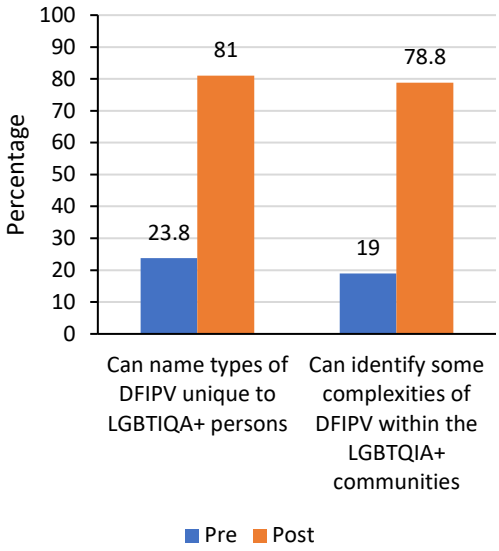
Figure 36: The Electorate of Groom, to which Toowoomba belongs to, voted in support of the Same Sex Marriage vote in 2017 (N = 42)



4.2.3. Domestic, family and intimate partner violence (DFIPV)

Participants demonstrated increased knowledge and familiarity regarding naming types of DFIPV unique to LGBTQIA+ persons (see Figure 37). They gained significant confidence in identifying some complexities of DFIPV within the LGBTQIA+ community.

Figure 37: Knowledge and familiarity of DFIPV unique to LGBTQIA+ persons (N = 42)



Participants demonstrated an increased awareness about the additional barriers LGBTQIA+ persons experience and factors that impact/impede access to supportive and inclusive DFIPV support services for LGBTQIA+ persons in the Toowoomba region (see Table 27). Additionally, participant knowledge increased by 38.1% (Pre 21.4%, n = 9; Post 59.5%, n = 35) with reference to LGBTQIA+ persons experiencing intimate partner violence at comparable rates to non-LGBTQIA persons.

Table 27: Awareness of barriers and DFIPV support services for LGBTQIA+ persons (N = 42)

Question/item	Pre Yes %	Post Yes %	Change %
LGBTQIA+ people who experience DFIPV have NOT told another person about it*	40.5	64.3	23.8
Can name at least one LGBTQIA+ DFIPV service in the Toowoomba region	38.1	85.7	47.6
Can confidently refer LGBTQIA+ people to DFIPV support services	33.3	78.6	45.3
There is NOT a number of 'Safe Houses' for gay men*	42.9	73.8	30.9
There is NOT a number of 'Safe Houses' for trans youth*	40.5	73.8	33.3

Note. *Reverse scored questions.

Several participants remarked that they had specifically increased knowledge and familiarity in the area of DFIPV experienced by members of the LGBTQIA+ community. Emory reflected they had greater awareness with respect to how "deadnaming, misnaming and misgendering is a form [of] domestic and family violence faced by trans people." Where Onyx commented more broadly about the issues of access, stating they "understand more about the prevalence of DV in this community and the barriers to accessing support." Additionally, participants identified awareness of the harm caused by assumptions, generalisations, homophobia, and transphobia (Lyric, Boston, Colby) and the needs for inclusive language and terminology (Jessie, Amani, Landyn).

4.3. Attitudes about LGBTQIA+ Concerns

Participant responses were analysed pre- and post-workshop to determine training effectiveness regarding their attitudes about gender, sexuality and variations in sex characteristics; discrimination and marginalisation linked to LGBTQIA+ persons; and DFIPV unique to LGBTQIA+ persons. Overall, participants' attitudes increased in being affirming and supportive.

Participants were asked to rate their agreement on a list of questions on a 5-point scale from strongly disagree to strongly agree; note some questions were reverse scored due to the wording of the question. Responses were then dichotomised into yes (agree and strongly agree) to indicate agreement and no (strongly disagree, disagree and undecided/not sure) to indicate disagreement. Open-ended questions were also asked at the end of each section and been integrated throughout this section.

4.3.1. Gender, sexuality and variations in sex characteristics

Participant responses reflected increased affirming attitudes towards rainbow community members (see Table 28). Participant attitudes towards people with intersex variations typically having healthy bodies, increased the most by 14.3% (Pre 52.4%, n = 22; Post 66.7%, n = 28), however, of all the questions asked, intersex reported the lowest overall affirming attitudes (66.7%) post-training. While there was no change in participants' reported attitudes towards parents of trans children not having 'failed' as parents, results show participants are affirming and supportive towards parents of trans children.

Table 28: Attitudes towards gender, sexuality and intersex variations (N = 42)

Question/item	Pre Yes %	Post Yes %	Change %
Intersex people are NOT 'abnormal' or 'disordered'; they typically have healthy bodies	52.4	66.7	14.3
Bisexual/pansexual persons are NOT actually lesbian/gay*	83.3	95.2	11.9
Asexual/Aromantic people are NOT going through a phase*	85.7	92.9	7.2
Homosexuality should NOT be pathologised*	92.9	97.6	4.7
Parents of trans children have NOT 'failed' as parents*	95.2	95.2	0.0

Note. *Reverse scored questions.

Most participants identified that developing greater awareness, acceptance, understanding, and confidence regarding overall LGBTQIA+ concerns would positively influence their professional and personal attitudes towards LGBTQIA+ people. For example, Amani suggested that building "greater understanding and appreciation of the more specific issues related to gender, sexuality, variations in sex characteristics would positively contribute to changing attitudes."

4.3.2. Discrimination and marginalisation

Participant responses were positive in nature regarding inclusive, supportive, and affirming safe places for LGBTQIA+ persons (see Table 29). However, participants also identified how further awareness raising training of LGBTQIA+ concerns, would enable more targeted, inclusive and effective advocacy and support. For example, Denver expressed that "further awareness of the issues unique to those in the LGBTQIA+ community [would lead to] better understanding [about] the struggles they may face so that I can provide appropriate and safe support." Likewise, Holland commented, "further understanding [will] create further support."

Participant attitudes towards treating everyone the same regardless of gender identity or sex characteristics increased in affirming attitudes, while there was no change in participants' responses regarding sexual orientation as shown in Table 29. Similarly, participant attitudes towards a person's right to privacy around their sexual life/orientation, gender identity/affirming surgery, including if a person born with an intersex variation has been subjected to intersex genital 'normalisation' surgeries, showed a positive increase in support.

Table 29: Attitudes regarding gender, sexuality and sex characteristics (N = 42)

Question/item	Pre Yes %	Post Yes %	Change %
Everyone should be treated the same regardless of gender identity	88.1	90.5	2.4
Everyone should be treated the same regardless of sexual orientation	90.5	90.5	0.0
Everyone should be treated the same regardless of sex characteristics	88.1	92.9	4.8
It is NOT important to ask LGBA persons about their sexual life/orientation*	66.7	71.4	4.7
It is NOT important to ask trans persons about their gender identity and if they have pursued gender affirming surgery*	61.9	76.2	14.3
It is NOT important to ask intersex persons if they have been subjected to intersex genital 'normalisation' surgeries*	59.5	85.7	26.2

Note. *Reverse scored questions.

Participants reported an increase of support against discriminatory and marginalising practices towards LGBTQIA+ persons in educational settings (data not shown). Specifically, participants reported an 11.9% (Pre 76.2%, n = 32; Post 88.1%, n = 37) increase of support regarding students having a choice of gender-neutral uniforms. They also increased support by 4.8% (Pre 83.3%, n = 35; Post 88.1%, n = 37) against religious schools denying students enrolment based on gender identity. While there was a decrease of 2.4% (Pre 90.5%, n = 38; Post 88.1%, n = 37) in support against religious schools denying students enrolment based on sexual orientation, post-training four participants reported being undecided or not sure, and one participant reported strongly disagreeing pre-training, and strongly agreed post-training.

Participants reported increased support for mainstream health and support services to be inclusive of LGBTQIA+ persons in the Toowoomba region, and not being limited to LGBTQIA+ accredited/ inclusive services (see Table 30).

Table 30: Attitudes towards inclusive health and support service and workplaces (N = 42)

Question/item	Pre Yes %	Post Yes %	Change %
Mainstream health and support services should be LGBTQIA+ inclusive	92.9	97.6	4.7
LGBTQIA+ persons should NOT only access accredited LGBTQIA+ inclusive health and support services*	57.1	66.7	9.6
Workplaces with religious ethos should NOT hire/dismiss based on sexual orientation*	92.9	95.2	2.3
Workplaces with religious ethos should NOT hire/dismiss based on gender identity*	88.1	95.2	7.1

Note. *Reverse scored questions.

Participants indicated that due to attitudinal changes, they felt empowered to provide inclusive and effective support and advocacy to LGBTQIA+ people, including in their workplace, organisation, and/or educational setting. For example, Callahan expressed "[the training] has given me more tools and understanding to draw on when working with clients to make our professional space safer and more inclusive," and similarly Drew explained "better understanding of the marginalisation and discrimination faced by the LGBTI community" enables "better advocacy for the removal of social barriers which prohibit their inclusion in society."

4.3.3. Domestic, family and intimate partner violence (DFIPV)

Participant responses reflected an overall increase in positive and affirming attitudes regarding the intricacies of DFIPV experienced by LGBTQIA+ persons (see Table 31). Participants recognised LGBTQIA+ persons experience DFIPV in unique ways compared to non-LGBTQIA+ persons, with the greatest change in attitudes towards understanding that DFIPV is not caused by loss of control and is not a mutual fight. Participants reported a decrease of 14.3% (Pre 59.5%, n = 25; Post 45.2%, n = 19) in attitude towards DFIPV not being caused by loss of control.

Table 31: Attitudes Towards DFIPV Experienced by LGBTQIA+ Persons (N = 42)

Question/item	Pre Yes %	Post Yes %	Change %
DFIPV is NOT always about control*	38.1	61.9	23.8
Person being abused did NOT do something to provoke the violence*	90.5	97.6	7.1
DFIPV is NOT a mutual fight*	85.7	95.2	9.5
DFIPV is NOT always visible*	92.9	95.2	2.3
When there are 2 men in a relationship, it is NOT normal for it to turn physically violent*	90.5	95.2	4.7
When there are 2 women in a relationship, it is NOT normal for it to be verbally abusive*	92.9	95.2	2.3
It is NOT always obvious who a perpetrator/ victim is in a domestic/ family violence situation*	83.3	90.5	7.2
It is NOT always obvious who a perpetrator /victim is in an intimate partner violence situation*	83.3	90.5	7.2

Note. *Reverse scored questions.

In relation to parents, partners and other family members affirming and supporting trans person identities, participants reported a post-training increase in understanding the importance of appropriate language and access to gender affirming treatments (see Table 32).

For example, Colby spoke of their increased capacity to support LGBTQIA+ clients due to changes in their attitude, stating "I'm now more confident to say acceptable things, know where to refer for support, know what terms means and have had a good change to self-reflect and see some of my own homophobia so I can challenge it." Likewise, Lyric shared

I'm more aware of the importance of not dismissing homosexual domestic violence situations. A large grown man can be physically abused by another man and a woman can seriously inflict verbal abuse on another woman. All persons should be taken seriously regardless of their sexual orientation or gender expression. Children should have access to puberty blockers if they feel their gender identity does not match the body they are in. This is important for their mental well-being.

Table 32: Attitudes towards DFIPV and trans persons (N = 42)

Question/item	Pre Yes %	Post Yes %	Change %
Parents should NOT be allowed to refuse their trans child access to hormone therapy*	66.7	71.4	4.7
It is NOT acceptable for a partner to misgender/ misname their trans partner if they disapprove with their gender affirmation*	88.1	97.6	7.2
It is NOT acceptable for a family member to misgender/misname a trans person if they disapprove with their gender affirmation*	88.1	95.2	7.1

Note. *Reverse scored questions.

Participants (N = 39) reported an increase of 7.2% (Pre 85.7%, n = 36; Post 92.9%, n = 39) in support against religious families enforcing conversion practices on their LGBTQIA+ children (data not shown). Participants also indicated that due to attitudinal changes, they felt empowered to provide inclusive and effective support and advocacy to LGBTQIA+ people regarding DFIPV services. For example, Callahan expressed "[the training] has given me more tools and understanding to draw on when working with clients to make our professional space safer and more inclusive," and similarly Kelly said, "I have gained more knowledge and awareness on how to create a safe environment."

4.4. Practices, Procedures and Behaviours about LGBTQIA+ Concerns

Participant responses were analysed in relation to their practices, procedures and behaviours regarding LGBTQIA+ people and communities prior to attending training; and whether there had been a reported increase regarding their practices, procedures and behaviours post attending LGBTQIA+ awareness training.

Participants were asked to rate their agreement on a list of questions on a 5-point scale from strongly disagree to strongly agree. Responses were then dichotomised into yes (agree and strongly agree) to indicate agreement, and no (strongly disagree, disagree and undecided/not sure) to indicate disagreement. Open-ended questions were also asked at the end of each section and have been integrated throughout this section. Further to this, as the timing of the workshop deliverance varied and thus the time delay between pre and post responses were inconsistent, questions pertaining specifically to workplace procedures and policies were analysed post-training only to capture practitioner responses around whether their workplace currently engaged in affirming practices, procedures and behaviours, as opposed to assessing any change from pre- to post-training.

4.4.1. Gender, sexuality and variations in sex characteristics

Although participant responses indicated that their workplaces had LGBTQIA+ affirming practices, procedures and behaviours, most workplaces did not offer LGBTQIA+ training for new and existing staff (see Table 33).

Table 33: LGBTQIA+ affirming workplace practices and procedures (N = 42)

Question/item	Post Yes %
Workplace provides training that relates to LGBPA people for new and existing employees	45.2
Workplace provides training that relates to trans, gender diverse, and non-binary people for new and existing employees	45.2
Workplace provides training that relates to people with an intersex variation for new and existing employees	40.5
Workplace and staff use inclusive language that recognises diverse sexual relationships	57.1
Workplace and staff use inclusive language that recognises diverse gender identities	57.1
Workplace and staff use inclusive language that recognises variations in sex characteristics	52.4
Workplace has procedures in place regarding concerns that relates to LGBPA people	50.0
Workplace has procedures in place regarding concerns relating to trans, gender diverse, and non-binary people	54.8
Workplace has procedures in place regarding concerns relating to people born with intersex variations	40.5

To enable LGBTQIA+ inclusive and informed services that may not align with workplace practices and procedures, Braeyln reported "assistance with developing practise about inclusion and ways to support diverse young people even if the organisation won't ever do this, systemically" would be of great benefit in supporting LGBTQIA+ youth.

Post-training, participants reported affirming, supportive, and inclusivity in both their personal and professional interactions with LGBTQIA+ people, participants reported an increased use of inclusive language and behaviours when engaging with LGBTQIA+ people and 100% of participants demonstrated an increase in empathy towards LGBTQIA+ people post-training (see Table 34).

Table 34: LGBTQIA+ inclusive language and behaviour – professionally and personally (N = 42)

Question/item	Pre Yes %	Post Yes %	Change %
Professionally, I use inclusive language when engaging with LGBTQIA+ people	66.7	81.0	14.3
In my personal life, I use inclusive language when engaging with LGBTQIA+ people	61.9	85.7	23.8
Professionally, I display inclusive behaviours when engaging with LGBTQIA+ people	64.3	92.9	28.6
In my personal life, I display inclusive behaviours when engaging with LGBTQIA+ people	69.0	95.2	26.2
Both professionally and personally, I demonstrate empathy towards LGBTIQA+ people.	78.6	100.0	21.4

Noting the importance of inclusive terminology and language, Lyric reported "In my workplace I will now be more aware of using inclusive language and realise how important it is for someone to feel safe and accepted for who they are."

While participants' confidence in having discussions with LGBTQIA+ people about issues relating to their sexual orientation, gender identity, and intersex variation/s increased, they were the least confident to discuss issues affecting people with intersex variations (see Table 35).

Table 35: Confidence to discuss gender, sexuality and intersex variations (N = 42)

Question/item	Pre Yes %	Post Yes %	Change %
I can confidently have discussions with LGBTQIA+ people about issues relating to the sexual orientation	57.1	76.2	19.1
I can confidently have discussions with trans, gender diverse and non-binary people about issues relating to their gender identity	47.6	78.6	31.0
I can confidently have discussions with persons born with an intersex variation about issues affecting people living with an intersex variation	40.5	64.3	23.8

Support for LGBTQIA+ festivals and events (i.e., Gay Pride Day, IDAHOBIT, Intersex awareness day) was determined by participants rating their agreement or disagreement with three statements (see Table 36). Overall, participants support LGBTQIA+ festivals and events, and if invited to, would participate.

Table 36: LGBTQIA+ festivals and events (N = 42)

	I do NOT participate as I do NOT see the point		I support but do NOT participate		If I was invited, I would participate	
	Pre %	Post %	Pre %	Post %	Pre %	Post %
Strongly agree	4.8	4.8	9.5	23.8	35.7	42.9
Agree	11.9	4.8	31.0	14.3	21.4	26.2
Undecided/ not sure	26.2	19.0	26.2	19.0	35.7	19.0
Disagree	21.4	31.0	14.3	19.0	4.8	4.8
Strongly disagree	35.7	40.5	19.0	23.8	2.4	7.1

4.4.2. Discrimination and marginalisation

There was a reported gap between workplaces being recognised as an LGBTQIA+ inclusive and/or safe places and being noticeably so (see Table 37). Over half of the participants (54.8%, n = 23) reported their workplaces were recognised as LGBTQIA+ inclusive or a safe place. Conversely, only 35.7% (n = 15) reported their workplace is visibly noticeable as LGBTIQA+ inclusive and 33.3% (n = 13) as visibly LGBTIQA+ safe through the use of pride flag signs/stickers, lanyards, use of pronouns on name badges.

Table 37: Workplace anti-discrimination policies and procedures towards LGBTQIA+ persons (N = 42)

Question/item	Post Yes %
My department has an anti-discrimination policy with a positive statement towards LGBTQIA+ people	54.8
My workplace has agreed policy and procedures to respond to bullying, abuse, or inappropriate behaviour specific to LGBTQIA+ persons	52.4
My place of employment provides me with the time I need to provide affirming care for LGBTQIA+ persons in need	52.4
My place of employment encourages 'thinking outside the box' to come up with a solution that meets the needs of LGBTQIA+ people	59.5
Currently, my workplace is recognised as LGBTQIA+ inclusive	54.8
Currently, my workplace is visibly noticeable as LGBTQIA+ inclusive	35.7
My workplace is LGBTQIA+ inclusive accredited	11.9
Currently, my workplace is recognised as an LGBTQIA+ safe place	54.8
Currently, my workplace is visibly noticeable as an LGBTQIA+ safe place	33.3
My workplace would be willing to support LGBTQIA+ communities publicly	59.5
My workplace would be willing to work with the LGBTQIA+ communities to meet their needs	61.9

Post-training, 61.9% of participants strongly disagreed/disagreed that they had communicated to an LGBTQIA+ person that they could not help them due to a lack of capacity or resources, and 64.3% of participants strongly disagreed/disagreed that their workplace had turned away an LGBTQIA+ persons due to a lack of capacity or resources to help them.

Participants reported an increase in their advocacy for LGBTQIA+ people experiencing discrimination and marginalisation, both at work, and outside work (see Table 38).

Table 38: Advocating against discrimination and marginalisation (N = 42)

Question/item	Pre Yes %	Post Yes %	Change %
I speak up when I witness LGBTQIA+ people being marginalised at work	57.1	81.0	23.9
I speak up when I witness LGBTQIA+ people being marginalised outside work	64.3	76.2	11.9
I speak up when I witness LGBTQIA+ people being discriminated against at work	61.9	78.6	16.7
I speak up when I witness LGBTQIA+ people being discriminated against outside work	59.5	76.2	16.7

Regarding being an ally, participants reported an increase of 19.1% (Pre 61.9%, n = 26; Post 81.0%, n = 34) in seeking to be an LGBTQIA+ ally. As Drew explains, "[I have] a better understanding of the marginalisation and discrimination faced by the LGBTI community, which will enable me to better advocate for the removal of social barriers which prohibit their inclusion in society."

4.4.3. Domestic, family and intimate partner violence (DFIPV)

Post-training, 38.1% (n = 16) of participants reported their workplace provides training that relates to DFIPV unique to LGBTQIA+ persons for new and existing employees. Similarly, 57.1% (n = 24) of participants reported their workplace has procedures in place regarding DFIPV unique to LGBTQIA+ persons (data not shown).

Participants reported increased levels of confidence in recognising, discussing, referring and responding to DFIPV unique to LGBTQIA+ people (see Table 39).

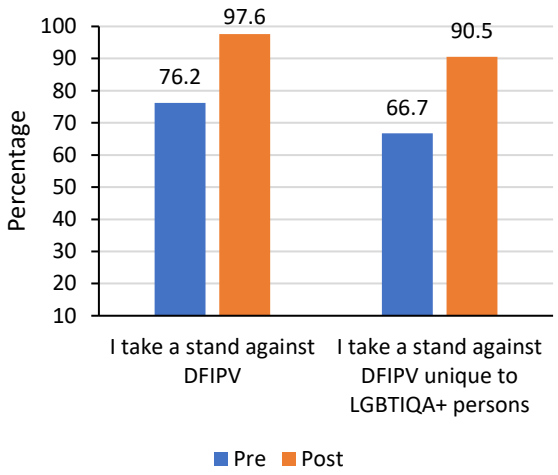
Table 39: Confidence in recognising, discussing and responding to DFIPV (N = 42)

Question/item	Pre Yes %	Post Yes %	Change %
I can confidently recognise DFIPV	38.1	71.4	33.3
I can confidently recognise DFIPV unique to LGBTQIA+ people	23.8	66.7	42.9
I can confidently have discussions about issues relating to DFIPV	45.2	81.0	35.8
I can confidently have discussions with LGBTQIA+ people about issues relating to DFIPV	40.5	78.6	38.1
If I cannot confidently have discussions about issues relating to DFIPV, I know where to refer them to	47.6	85.7	38.1
If I cannot confidently have discussions about issues relating to DFIPV unique to LGBTIQA+ persons, I know where to refer them to	38.1	88.1	50.0
I can respond to DFIPV	59.5	83.3	23.8
I can respond to DFIPV unique to LGBTIQA+ persons	38.1	83.3	45.2

Regarding DFIPV, skills such as being able to identify indicators and having knowledge of appropriate referral pathways, were also emphasised. For example, Denver explains that training in LGBTQIA+ concerns is key "to becoming more aware, more sensitive and [will] positively impact my practice as DV support worker."

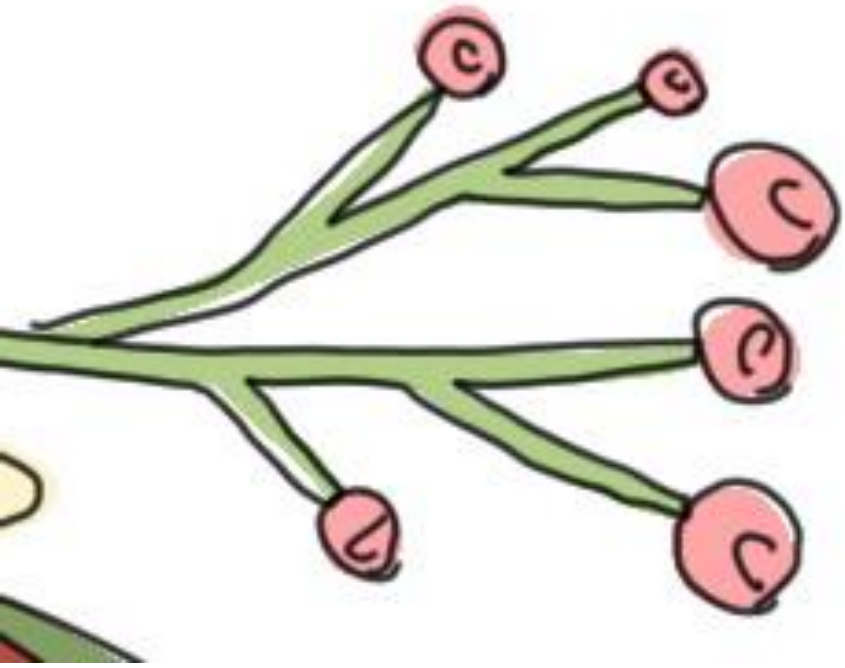
Participants reported an increase in support of people who experience DFIPV and reported strongly that they stand against DFIPV and DFIPV unique to LGBTQIA+ persons (see Figure 38).

Figure 38: Taking a stand against DFIPV (N = 42)



Post-training, 30.9% of participants agreed/strongly agreed that their workplace was visibly noticeable as a safe place for person experiencing DFIPV, and 23.8% of participants agreed/strongly agreed that their workplace was visibly noticeable as a safe place for LGBTQIA+ persons experiencing DFIPV.

Several participants identified areas for improvement in current practices and services, suggesting that more could be done at an organisation level. For example, Cadence noted "this training has shown me that my workplace isn't doing all that they could to be inclusive to the LGBTQIA+ community," and Callahan remarked "It has brought more awareness to professional practices and gaps in service provision."



5. Recommendations

The first part of this report focused on the LGBTQIA+ community of the Toowoomba region, and the second part focused on caring professionals/practitioners and services supporting LGBTQIA+ persons in the region. This report has revealed a number of areas of concern regarding experiences by LGBTQIA+ persons of discrimination and harassment; homelessness; reduced quality of life and overall health and wellbeing; and lack of access to quality and targeted services and support within the broader Toowoomba community. In short, the situation broadly mirrors the findings of other recent reports on LGBTQIA+ populations regarding their health and wellbeing in Australian urban and more regional settings (Hill et al., 2021, 2020). In light of these findings, a number of recommendations are advanced that aim to redress and forward better health and wellbeing outcomes for the Toowoomba region's LGBTQIA+ population. Part of this focus recognises the need to grow the capacity of individuals and organisations tasked with working together and for the better health of LGBTQIA+ persons. As such, several recommendations are made that call this purpose into action.

5.1. LGBTQIA+ Health and Wellbeing

Across the domains covered within this report, the priority areas of recommendation are in relation to health and support services; and domestic, family, and intimate partner violence. Recommendations in these two areas are articulated in the following section.

5.1.1. Health and Support Services

Four priority areas of recommendation regarding factors that would contribute to improving LGBTQIA+ peoples experience with health professionals and services in the region were emphasised in the survey. Listed without a specific order of priority, these include:

a) Promotion of LGBTQIA+ friendly services within the region.

Participants reflected that health services need to more visibly indicate their LGBTQIA+ support and inclusivity, and suggested a variety of methods to achieve this including displaying flags, stickers, and posters on websites as well as physically present at the business location.

b) Practitioners educated and trained in LGBTQIA+ cultural sensitivity and specific health needs.

Participants suggested that practitioners increase their knowledge and awareness of LGBTQIA+ people generally and paying particular attention to their specific health needs including sexual health. Astra explained:

Have staff adequately trained in gender non-conforming identities, not expecting clients/patients to educate and advocate for themselves. I didn't realise how severely lacking this is even though I consider my GP and [their] practice good, until seeing [an] endocrinologist ...[in] Toowoomba ... who was obviously well informed and engaged with the needs of gender diverse people. [It was] the first time I actually had someone 'notice' I was nonbinary, use my preferred name, and apply that information to their role (usually I have to bring it up myself or shove it down and pretend I'm a woman)

c) Incorporating LGBTQIA+ inclusive knowledge, attitudes, and practices into organisational processes and service delivery.

Participants recommended the use of preferred pronouns and gender-neutral language in person and on practice forms; not making assumptions regarding gender, sexuality, and partners; and increasing comfortability by talking openly about sexual health and reproduction. Sole, speaking about contact staff suggested that they "use gender-free language e.g., partner [or] child, rather than assumptions of hetero relationship as default e.g., assuming [a] female's partner would be [their] husband"; and likewise, Brent commented that staff should "not assume everyone is straight." Trudy further suggests "queer" people be engaged in an advisory and/or steering capacity to improve health service delivery

when she says “a queer oversight committee, with only queer members, tasked with assessing the queer friendliness of systems” is recommended.

d) Employment of LGBTQIA+ staff and specific LGBTQIA+ services that are affordable and accessible.

Participants identified the need for more affordable and accessible services across all areas of health including physical and psychological. Regarding affordability and dental care specifically, Nadine commented, “I have almost no enamel on my front teeth and it hurts to eat ... Luckily they look normal but I can't afford a dentist let alone rent.” Again, concerning affordability, participants like Greg recommend a gender clinic in Toowoomba is needed as they are “unable to travel to the gender clinic in Brisbane due to having no car and [not being able to] afford public transport.” Concerning psychological services broadly, participants requested additional services that offer after hours service, cater specifically to youth, and do not have long wait lists. Erika explained there are “very poor mental health options in [the] Toowoomba region. They simply do not care. There are long waiting lists for ... teenagers with serious mental health problems.” Likewise, Shan suggested there be “more services available for both LGBTQIA+ and other young people, especially centred around mental health.” With regard to staffing and overall health service practices, several participants recommend retaining LGBTQIA+ staff including those in “specific roles” (Robin) and “gay doctor[s]” (Neil). In addition, James also highlighted the need for services to be made more accessible by suggesting “a more discrete and specialised health service or sexual health service for LGBTQIA+ [is needed] i.e., not [on] ... the street front of the sole public hospital in town. There's a lot of exposure to the public and potential for being outed along with the general stigma associated with [attending existing services].”

5.1.2. Domestic, family and intimate partner violence (DFIPV)

Two priority areas of recommendation regarding factors that would contribute to improving LGBTQIA+ peoples experience with services and support pertaining to DFIPV include:

a) Improved financial assistance.

Additional financial support would better enable LGBTQIA+ peoples experiencing DFIPV to enact steps toward securing safety in relation to relocation. Terry elaborated that the “Centrelink domestic violence payment was about $350, after one week and two interviews. This is not enough to set up an entire new household with two kids. A fridge and a washing machine are the bare minimum, and you can't buy them with tears.”

b) Build support organisation capacity in relation to LGBTQIA+ peoples experiences of DFIPV.

Overwhelmingly, participants identified a lack of understanding and support from services when sought in relation to DFIPV. Gael commented “I've found mainstream DV services tend to be judgmental of those who report being subjected to DV; and tend to blame the person seeking help, for allowing themselves to be in said situation.”

5.2. Caring Professionals

As evidenced by this report, LGBTQIA+ awareness raising training is beneficial in the sense that it builds knowledge, and improves the attitudes and practices of caring professionals and practitioners when working toward the better health of LGBTQIA+ individuals and community. The two key recommendations based on these findings are in relation to investment by individuals and organisations in continuing to raise awareness of LGBTQIA+ people, their lives, and concerns affecting both policy and practise.

a) **Implementing regular LGBTQIA+ awareness raising training.**

This first recommendation is to deliver regular LGBTQIA+ awareness raising training for individuals and organisations that interact with and employ LGBTQIA+ people. Participants identified a need for awareness of the barriers and issues faced by LGBTQIA+ people and/or general knowledge about diverse gender and sexualities and stated either a need to refresh and update their existing but outdated knowledge, or to build a knowledge base in these areas. For example, Lyric said they hoped to "understand the… physical and psychological differences experienced by LGBTQIA+ [persons]", so they could "use this information to better support the mental and physical health of the LGBTIQA+ community" who they see in their General Practice. And Casey explained that they hoped to gain knowledge of the "unique challenges [LGBTQIA+ individuals] face accessing services and supports within the Toowoomba Region." Additionally, Chandler expressed a need to refresh and update their knowledge, stating "I feel behind in knowledge of the community, after moving from NSW where I … used to be very aware of the community and how I could effectively assist the members; I hope to regain the knowledge to be able to support the anyone at risk."

While participants had increased their knowledge about intersex variations, this was by far the area they felt the least confident about and had the least knowledge. LGBTQIA+ training needs to specifically focus on raising awareness about people with intersex variations, and their unique health needs.

b) **Implementing inclusive policy and practise.**

Caring professionals and practitioners and organisations working with LGBTQIA+ people need to be mindful of the diversity of the LGBTQIA+ community, their individual needs, and how to behave in ways that are welcoming and promote a sense of safety. Policies should guide inclusive practises that are used to remove/reduce stigma and discrimination in the workplace for staff, clients, and students; and further promote positive LGBTQIA+ representation. Additionally, services offered need be focused and inclusive of all LGBTQIA+ people.

5.3. Future Research

Using a multi-pronged approach, this report explored: 1) the experiences of LGBTQIA+ people regarding aspects of their health and wellbeing; and 2) ascertain the impact LGBTQIA+ awareness raising training had on the knowledge, attitudes, and practices of caring professionals and practitioners serving LGBTQIA+ persons in the region. Aligning with the findings noted in both the Private Lives 3, and Writing Themselves in 4 national reports, there are alarming rates of poor health and wellbeing experienced by the LGBTQIA+ population in the Toowoomba region. To gain further insights, and with the aim of creating the opportunity for better health and wellbeing experiences, additional research is needed. In particular, comparing the findings in this report with that of other recent national and regional studies done in Australia, would provide a baseline for understanding how the Toowoomba region-based population are faring compared to their regional and urban neighbours. In addition, follow up studies (focus groups and individual one-on-one interviews) exploring in more detail the particular issues faced by the Toowoomba region LGBTQIA+ population. More specifically, matters involving housing, discrimination and harassment, DFIPV, alcohol and other drug use, and lack of access and support provided by health and caring professionals, would further advocate for improved LGBTQIA+ health and wellbeing. Likewise, research exploring how caring professionals' attitudes, behaviours and practises are implemented and changed over time as a result of LGBTQIA+ awareness raising training, would provide additional insights into the efficacy of existing training and highlight areas needing additional attention.

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