WELCOMING SOCIAL WELLNESS:

EXPLORING THE IMPACT OF LGBTQI-AFFIRMING HEALTH AND COMMUNITY CARE ON OLDER GENDER AND SEXUALITY-DIVERSE WOMEN’S WELLBEING AND SENSE OF BELONGING

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2018
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Project Report for New South Wales Family and Community Services,
Western Sydney University

PROJECT REPORT
October 2018

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Suggested Citation:
Table of Contents

List of Tables ............................................................................................................................. 7
List of Figures ............................................................................................................................... 7
Glossary ........................................................................................................................................ 8
Acknowledgements ...................................................................................................................... 10
Executive Summary ..................................................................................................................... 11
  Introduction ................................................................................................................................. 11
  Research Aim .............................................................................................................................. 11
  Research Design and Method ...................................................................................................... 12
  Summary of the Findings ........................................................................................................... 12
  Recommendations .................................................................................................................... 13
Chapter 1: Introduction ................................................................................................................ 14
  Previous Research ..................................................................................................................... 14
  Research Aims and Questions ................................................................................................... 16
Chapter 2: Design and Methodology ......................................................................................... 17
  Research Design ....................................................................................................................... 17
  Research Methods .................................................................................................................... 17
    Qualitative methods .................................................................................................................. 17
    Quantitative methods ............................................................................................................... 18
  Recruitment ............................................................................................................................... 19
    Interview Recruitment and Sample ........................................................................................ 19
    Online Survey, Forum and Facebook Recruitment and Engagement ........................................ 19
  Advisory Committee ................................................................................................................ 25
  Ethical Requirements ............................................................................................................... 25
Chapter 3: Qualitative Findings: Interview and Online Forum Results ................................... 26
  Heteronormative frameworks and practitioner comfort with gender and sexual diversity ...... 26
    Perceived Stigma in Entering Institutions ............................................................................. 27
    Universalisation of GSD Experiences ..................................................................................... 28
  Practitioners’ knowledge of gender and sexual diversity ......................................................... 31
    Practitioner Training ............................................................................................................... 32
    Preferred Type of Practitioner: Seeking Safe and Supportive Practitioners ....................... 33
  Concerns about homophobia and aged-care services ............................................................. 35
    Home-based care ..................................................................................................................... 35
    Aged Care Facilities ............................................................................................................... 36
  Being and Feeling Connected ................................................................................................... 38
    Social Services ....................................................................................................................... 38
    Early Retirement Issues .......................................................................................................... 39
    Limitations to Participation in Events .................................................................................... 39
  Social Engagement .................................................................................................................. 42
    Invisibility ............................................................................................................................... 42
Chapter 4: Quantitative Results: Survey and Online Engagement Data .................................. 44
  Participant Demographics ......................................................................................................... 44
  Findings ..................................................................................................................................... 48
    Engagement with Local Health and Community Service Providers .................................... 48
    LGBTIQ-Awareness of Health and Social Service Providers ................................................. 50

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Sense of Personal Wellbeing and Belonging ................................................................. 60
Internet Usage ........................................................................................................... 64

Chapter 5: Summary and Interpretation of the Findings .................................................. 69
  Qualitative Findings Summary .................................................................................. 69
  Quantitative Findings Summary .............................................................................. 69
  Interpretation of the Findings ................................................................................... 70
  Study Limitations ..................................................................................................... 72

Chapter 6: Recommendations & Conclusion .................................................................. 74
  Recommendations .................................................................................................... 74
  Conclusion ................................................................................................................ 74

References ................................................................................................................... 76

Appendices .................................................................................................................. 81
  Appendix One: Research Recruitment Material ...................................................... 81
  Appendix Two: Other Project Outcomes ................................................................. 83
  Appendix Three: Interview Protocol, Online Forum Questions and Survey Questions .... 84
    Interview Protocol .................................................................................................... 84
    Online Forum Questions .......................................................................................... 84
    Survey Questions ..................................................................................................... 85
List of Tables

Table 1: Interview participants
Table 2: Facebook Campaign Overview and Impact
Table 3: NSW location of the participants, listed in alphabetical order
Table 4: Frequency table representing the identified sexuality of the participants
Table 5: Comparison of Support Scale item means (M) and standard deviations (SD) by geographic location
Table 6: Correlations between self-reported health, wellbeing and community connection

List of Figures

Figure 1. Project Facebook page likes
Figure 2. Facebook Audience by Gender and Age
Figure 3. Facebook Campaign Impressions and Clicks to Project Website
Figure 4. Facebook Advertising Campaign 1
Figure 5. Facebook Advertising Campaign 2
Figure 6. Facebook Advertising Campaign 3
Figure 7. Facebook Advertising Campaign 4/5
Figure 8. Participant Age by Grouping n = 148
Figure 9. Number of participants (ppts) in regional areas of NSW
Figure 10. Number of participants (ppts) in metropolitan areas of NSW
Figure 11. Birth locations of participants, n=148
Figure 12. Participants’ engagement with local medical centre and/or specialist, n=148
Figure 13. Participants’ engagement with community social services, n=148
Figure 14. Participants’ engagement with aged-care and/or residential health services, n=148
Figure 15. Frequency of connection to local community social services
Figure 16. Health care providers’ presumption of heterosexuality/cisgender
Figure 17. Importance of health care providers’ attitudes towards participant’s sexuality/gender identity
Figure 18. Disclosure of sexuality/gender identity to health care provider
Figure 19. Sense of health care provider’s comfort with disclosure
Figure 20. Sense that health care provider’s attitude influenced treatment
Figure 21. Social service providers’ presumption of heterosexuality/cisgender
Figure 22. Importance of social service providers’ attitudes towards participant’s sexuality/gender identity
Figure 23. Disclosure of sexuality/gender identity to social service provider
Figure 24. Sense of social service provider’s comfort with disclosure
Figure 25. Sense that social service providers’ attitude influenced treatment
Figure 26. Self-reported health rating
Figure 27. WHO-5 mean differences by reported influence of providers’ attitude
Figure 28. Belonging scale mean differences by reported influence of providers’ attitude
Figure 29. Reported internet usage – health information
Figure 30. Reported internet usage – online community
Figure 31. Assumptions about others’ use of the internet
Figure 32. Reported internet usage – LGBTIQ-specific information
Glossary

Advisory Committee

Refers to the group of experts and practitioners who provided expert advice and guidance in the development and implementation of this research project.

Ageing/Older

Refers in this report to women who are aged 55 years and over.

Cisgender

Cisgender (or Cis) is a term for people whose experiences of their own gender identity and/or expression matches the sex they were assigned at birth.

Gender and Sexuality Diverse (GSD)

The term gender and sexuality diverse is used to describe people who do not conform to normative constructions of gender and sexuality. For instance, someone born male may not identify as a man or someone identifying as a woman who is also attracted to women.

Heterosexism

A system of discrimination, prejudice and bias based on the assumption that heterosexuality is the only normal sexuality and superior to other forms of sexuality.

Homophobia

Prejudice and discrimination towards and experienced by people who are attracted to others of the same sex.

LGBTIQ

Acronyms used to refer to the Lesbian, Gay, Bisexual, Trans/transgender, Intersex, and Queer community. This acronym is used at various points within the report to refer to those who identify with a same-sex identity and/or desire and also includes those who identify with or may be questioning a gender identity other than their biological sex and/or assigned gender.

Patient/Client

Refers to those accessing and utilising health services.

Professional /Practitioner/Worker

Refers to someone who is providing a health service, or patient care.
Researcher/s

Where the researcher/s are referred to throughout this document it refers to those undertaking the data collection and analysis of the data.

Transgender/Trans

Umbrella terms used to describe people whose gender identity and/or gender expression is different to the sex they were assigned at birth.

Transphobia

Prejudice and discrimination towards and experienced by trans/transgender people.
Acknowledgements

We gratefully acknowledge the financial and project support of the New South Wales Family and Community Services “Liveable Communities” grants team, particularly Danielle Fox and Erin Donohue, who acknowledged the need for this research and community outreach. We thank all the women who so generously shared their experiences of New South Wales-based health care and social service providers. For ethical reasons, they remain unnamed in this report, but without their contributions and engagement this project could not have taken place.

This project would not have been possible if not for a group of talented individuals who served as research assistants on the project. We thank Zelalem Mengesha, Jack Thepsouririnathone, Brooke Brady, Karen Moloney and Cameron Williams for their research support and technical expertise in the review of the literature, qualitative data gathering and quantitative analysis, respectively.

We would also like to acknowledge and thank the Advisory Committee members for their time and input into the project: Jane Ussher (Western Sydney University), Janette Perz (Western Sydney University), Pranee Liamputtong (Western Sydney University), Mark Hughes (Southern Cross University), Jane Estoesta (Family Planning NSW), Russ Gluyas (ACON), Kimberley Ivory (University of Sydney), Samantha Edmonds (National LGBTI Health Alliance), Lesley Laing (University of Sydney), Jude Irwin (University of Sydney), Diana Bernard (Seniors Rights Service) and Shannon Wright (ACON).

Finally, we acknowledge the support of the Schools of Science and Health and Education at Western Sydney University who provided the infrastructure and support services required to conduct this project, as well as the university’s Research, Engagement, Development and Innovation (REDI) team, whose assistance with project management and communication was invaluable.
Executive Summary

Introduction

Older (e.g., 55 years and older) gender and sexuality diverse women (GSD) in New South Wales (NSW), are underserviced by health, social and aged-care programs. Not only is this a concern for these women in NSW but also an emerging issue for ageing LGBTIQ people across Australia. For instance, a 2010 survey of GSD individuals over 60 found that 78% felt they could not find LGBTIQ social events for people their age, with just over 51% of the cohort reporting difficulties locating health care providers who are knowledgeable about LGBTIQ health issues (Smith, McCaslin, Chang, Paulina, & McGrew, 2010). A 2009 survey of 371 gay and lesbian-identifying Queensland residents also found that over 45% were concerned about experiencing sexuality-based discrimination when entering aged-care. Of these participants, significantly more women (75%) harboured concerns about not finding LGBTIQ-specific residential care later in life (Hughes, 2009).

This is partially the consequence of poorly informed and ill-equipped health and community services resulting in discrimination or exclusion of GSD women. This in turn, causes GSD women to avoid health services and increases social isolation. Additionally, upon accessing these services, it is not surprising that GSD women are less open about their sexuality and more anxious as a result of heteronormative assumptions made by health and community service professionals which render GSD older people “invisible” (Blando, 2001; Duffy & Healy, 2014, p. 578). Case in point: a recent survey of aged-care residential providers in Western Australia found that nearly 90% of participants were unaware of having ever served GSD clients (GRAI and Curtin Health Innovation Research Institute, 2010, as cited in Rosenstreich, Comfort & Martin, 2011), and fewer than half of a stratified random sample of 409 General Practitioners in NSW reported feeling comfortable providing care for gay or lesbian patients (Khan, Plummer, Hussain & Minichiello, 2008). These limitations point to the breadth of the issue within society and missed opportunities to support social cohesion. The research outlined in this report provides critical insights into the negotiated experiences of accessing health and social support from participating GSD women, and serves as tangible action addressing the Government’s recent commitment to improving access to LGBTIQ-friendly aged-care services. Understanding these experiences is imperative as we know that GSD women’s health and wellbeing outcomes are poorer than that of their male and heterosexual counterparts (Leonard et al., 2012) and that these outcomes are even worse for older women (Duffy & Healy, 2014).

Research Aim

This research, funded and commissioned by the New South Wales Family and Community Service’s “Liveable Communities” initiative, aimed to examine and understand older GSD women’s experiences and needs related to health, aged-care and social support services. In particular, this project sought to explore how access and engagement with services was related to women’s sense of community belonging, health and wellbeing.
Research Design and Method

To address the aim of this project a mixed method design was used including the following data collection strategies that sought to gather the perspectives of older GSD women in NSW with regards to their experiences and engagement with health and social support services:

1. In-depth interviews
2. Online survey
3. Project website with a private online forum and a project Facebook page

Summary of the Findings

The findings from our interviews and online platform reveal that older GSD women continue to experience stigma and marginalisation from healthcare institutions, which detrimentally impact their health outcomes. Practitioners often assume patients are heterosexual, and fail to take into account their specific needs as lesbian and/or transwomen with intersecting identities. The women who participated in these elements of the study discussed perceptions of health and social systems’ inability to support their needs due to – at best – systemic heteronormativity within their systems and processes and – at worst – homo/transphobic behaviours. Accordingly, these women adopted strategies to remain safe, including non-disclosure of their sexuality and gender diversity and disengagement from available area services. These participants stressed the need for greater LGBTIQ staff training and LGBTIQ friendly facilities.

Additionally, findings from our survey of 148 participants from across NSW indicated that while most participants had engaged with healthcare providers, such as general practitioners or specialists, only one-quarter of participants had engaged with social services in their local communities. Further, despite the majority of participants indicating that their healthcare providers’ attitude to their diverse sexuality and/or gender identities was important, nearly three-quarters of participants felt that their healthcare providers either “always” or “usually” presumed that they were heterosexual and cisgender. Participants who felt that their healthcare providers reacted in a positive way to their disclosure of their sexuality and/or gender diversity reported significantly higher psychological wellbeing. In addition, women who felt that their local community social service workers reacted in a positive way to their disclosure of their sexuality and/or gender diversity reported a significantly higher sense of community belonging. Finally, the women’s experiences of LGBTIQ-inclusivity from local health and social service providers were significantly correlated with their reported psychological wellbeing, their sense of community belonging and their health self-rating.

These findings point to a relationship between affirming health/social service experiences and enhanced sense of connection, health and wellbeing for this population of women.
Recommendations

1. Given the increasing ageing population and greater recognition of LGBTIQ people and their relationships, there needs to be better supports for older GSD women as they transition into, and through, retirement, age related health care, aged care and palliative care services. There exists a dire need for a re-examination of the quality and care provided at health, social, aged care, and retirement services in order to address these needs.

2. Health, social and aged care providers can change GSD women’s expectations of homophobia, the dilemma of disclosure, and feelings of connection and belonging by engaging in training and making themselves visible allies to LGBTIQ-friendly policies (e.g., displaying a rainbow flag; using inclusive intake forms).

3. There is a need to revise health, social and aged care policies and programs to ensure that they overtly acknowledge and include LGBTIQ identities.

4. There is need for appropriate health, social and aged care services and practices, thus improving the quality and care provided post-retirement—that is, offering LGBTIQ-specific services within health, social and aged care services.

5. As the views and experiences of older GSD women in accessing health, social and aged care services remain largely unknown further research is very much needed.
Chapter 1: Introduction

Previous Research

While attitudes to lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people across the Western world have been steadily improving, Australia ranks as the 7th most homophobic country of the Western nations (Borooah & Mangan, 2007) – and it has been only recently legislated that same-sex couples have the right to marry. It is perhaps not surprising then that whilst research suggests that LGBTIQ individuals’ “physical health is not dissimilar to that of the population as a whole, this is not the case for their mental health which continues to be significantly poorer” (Leonard et al., 2012, p. 29). Other research directly links risk of mental health problems to experiences of heterosexist discrimination and abuse (Hillier et al., 2010). Further, a higher percentage of gender and sexuality diverse (GSD) women report discrimination in their daily lives and discrimination under the law as having the greatest effect on their health and wellbeing (Comfort & McCausland, 2013, p. 21).

Critically, such experiences and concerns affect the ways in which LGBTIQ individuals interact with, or anticipate interacting with, health and service professionals. In a recent investigation of the attitudes of LGBTIQ individuals towards primary health care, a number of participants reported being fearful of accessing health care related to current or previous discriminatory practices by health professionals (Koh, Kang & Usherwood, 2014). Individuals in their study who chose not to disclose their sexuality to their physicians, described this as a “choice to protect their wellbeing” (Koh et al., p. 262). It appears such a lack of disclosure occurs across the country, with a third of LGBTIQ participants (N = 3,835) in a 2012 survey reporting either “occasionally” or “usually” hiding their sexuality or gender identity when accessing health and social services (Leonard et al., p. 46). Additionally, LGBTIQ people may delay seeking treatment for health problems due to fears of discrimination or reduced quality of care (Heck, Sell & Gorin, 2006; McNair & Medland, 2002), with Australian research highlighting the fact that LGBTIQ people are under-screened for common health conditions, consequently presenting at more advanced stages of disease progression (Pitts, et al., 2006). Compared to their Australian heterosexual-identifying counterparts, gender and sexuality diverse women have been repeatedly shown to exhibit lowered health outcomes (Leonard et al., 2012), with significantly higher reported incidences of depression and anxiety.

In terms of seeking health care, according to Chapman et al. (2012), “a significant number of lesbians fail to seek health care and some women avoid health care providers whom they perceive as biased against lesbian, gay, bisexual and transgender (LGBT) people” (p. 1879). Perception of bias is often cited as a rationale for not disclosing their sexuality (McNair, Szalacha & Hughes, 2011) as well as delaying or avoiding seeking care (McNair, 2003). Considering links between the disclosure of sexual orientation and patient satisfaction and continuity of care (Bergeron & Senn, 2003), perhaps it is not surprising that health care usage and satisfaction is lower for GSD women than for heterosexual-identifying women (Heck, Sell, & Gorin, 2006, as cited in McNair, Hegarty & Taft, 2012, p. 209) potentially resulting in compromised health care (McNair et al., 2012).
In Australia, 27.3% of gay men and 19.4% of lesbian women are amongst the ageing population (Richters et al., 2014). A 2010 survey of GSD individuals found that nearly 50% of participants did not feel that their particular needs would be met by aged-care services (Smith, McCaslin, Chang, Paulina, & McGrew, 2010). Hughes (2009) also found that just over 45% of 371 gay and lesbian participants were concerned about experiencing discrimination based on their sexuality when entering aged-care. Of these participants, significantly more women (75%) harboured concerns about not finding LGBTIQ-specific residential care later in life. Discrimination (both actual and expected) is identified as one of many sources of concern for ageing GSD individuals (Metlife Mature Market Institute & The Lesbian and Gay Aging Issues Network of the American Society on Aging, 2010). This population, who may be less open about their sexuality and more anxious about accessing services, become subject to heteronormative assumptions by health and community service professionals, thus making older GSD people “invisible” (Blando, 2001; Duffy & Healy, 2014, p. 578). Indeed, in a recent survey of aged-care residential providers in Western Australia it was found that nearly 90% of participants were unaware of having ever served GSD clients (GRAI and Curtin Health Innovation Research Institute, 2010, as cited in Rosenstreich, Comfort & Martin, 2011). This was validated in another study undertaken by Horner et al. (2012), who examined aged care and retirement services in relation to their inclusion of considerations for GSD individuals revealing that few services accommodated the specific needs of this cohort. Additionally, in a recent interview study, conducted by Barrett, Whyte, Comfort, Lyons, and Crameri (2015), participants reported that the lack of GSD-inclusive services forced them to go back into the ‘closet’, and in doing so, make their identities and their needs invisible in healthcare settings.

As ageing individuals are often perceived as desexualised – asexual (Fileborn et al., 2014), ageing GSD individuals often experience more complex effects of homophobia (Hinrichs & Vacha-Hasse, 2010). Both staff and residents of aged care can be potential sources of sexuality-related discrimination (Johnson, Jackson, Arnette, & Koffman, 2005). Hinrichs and Vacha-Hasse (2010) found that when various romantic/sexual scenario prompts were used to gauge their reaction to older people under their care, aged care staff members tended to rate “two women (who) engaged in sexual contact” more negatively than “heterosexual pairing(s)” (Hinrichs & Vacha-Hasse, 2010, p. 783). Another study by Villar, Serrat, Fabà, and Celdrán (2015) interviewed heterosexual aged care residents on their reactions towards another resident’s hypothetical coming out. Their findings indicated that most residents would behave negatively towards the homosexual resident; reactions ranged from maintaining distance from the resident and to their extreme social rejection. These findings highlight both staff and residents of aged care facilities as sources of GSD bias-based discrimination. Perhaps unsurprisingly, ageing GSD individuals often express a desire for either GSD-exclusive or GSD-friendly aged care services (Johnson et al., 2005).

The above body of work sheds light upon the overall deficiencies in the existing provisions for ageing GSD women. However, missing are tangible links between women’s experiences with local health and social services and their overall wellbeing and social belonging, two known predictors of depression and suicidal ideation in older people (Vanderhorst & Mclaren, 2005). As such, it is imperative that GSD women feel welcomed and empowered to access health and social services in order to address the above concerns. Additionally,
health and service professionals clearly need additional training and support in order to provide a positive, safe space for individuals to ‘land.’

Research Aims and Questions

This project explores older (55+) gender and sexually diverse (GSD) women’s experiences with health, social and aged-care services. Particularly, the project investigates GSD women’s perceptions of LGBTIQ-affirming practices from targeted local health and social services in order to understand their potential impact on clients’ wellbeing and sense of community connection. Given that these services, including participants’ (1) local health centre, (2) community social support, (3) community mental health support, and (4) home care (for ageing GSD), are designed to safeguard clients’ wellbeing and social connection, it is imperative to understand how older GSD women’s interactions with these services may either support or work in direct contrast to the service’s mission.

The following research questions guided this study:

1. What social, health and aged care supports and services do older GSD women need to ensure their wellbeing and social connectedness as they age?
2. To what extent do older GSD women feel that existing supports and services are meeting their health, social and aged care needs?
3. What challenges and facilitators do older GSD women encounter when accessing or navigating health, social and aged care supports and services?
4. How do older GSD women get information about LGBTIQ-friendly/affirming services that support their wellbeing and social connectedness as they age?
Chapter 2: Design and Methodology

Research Design

The current study used a mixed-method design where interview and survey data from a group of New South Wales (NSW)-based women, aged 55+, were explored in order to gain baseline data on their engagement with local health and community services and to better understand how services’ LGBTIQ-inclusivity might enhance women’s engagement. Data collection occurred via three distinct phases: in-depth interviews with a representative cohort of women; online survey data collected from a group of women across NSW; and ongoing online community forums, where participants could engage and interact through sharing of personal stories and comments.

Data collection was undertaken from 1 March 2017 to August 2017.

Research Methods

Qualitative methods

In order to better understand the lived experience of older GSD women, several means for collecting qualitative data were used. Using these data collection methods, older GSD women were asked questions that broadly explored their needs and experiences of engaging with health care, aged-care as well as support services. These questions aligned with the research questions above.

Interviews

The interviews, which lasted between 45 minutes to 1 hour, were conducted via phone. The interviews followed a semi-structured interview schedule which enabled fluidity in the conversation between researcher and interviewee but also worked to help maintain the focus of the interview. The interviews were digitally recorded with the consent of each participant and then transcribed by an external transcription service.

Online forum and Facebook comments

The online forum and Facebook page were used to gather additional qualitative data from women across the state of NSW. The online forum was based within the project website and offered both privacy and anonymity, as only those registered on the password-protected forum page could see, post or make comments on posts from other participants. In conjunction with this, a project-specific Facebook page was also employed, targeting individuals registered with this social media platform.

Open-ended survey questions

The online survey, discussed in greater detail below, included open-ended questions, which allowed respondents to comment on their responses and to give more information to explain why they responded as they had. This was a good opportunity to get additional
information about the women’s lived experiences, particularly around their engagement with online spaces.

Qualitative Analysis

The data was thematically analysed by identifying topics and substantive categories within participants’ accounts in relation to the study’s aims. In addition, Quirkos and NVivo were used to organise topical responses and emergent substantive categories (Liamputtong, 2009).

Quantitative methods

Online Survey

An online survey was used to collect detail on participants’ demographic characteristics, including their age, location, sexuality and gender identities. Additional measures inquired into participants’ engagement with various health and social service providers in their local communities. Participants were asked to self-rate their health as well as respond to a series of items investigating personal experiences and expectations of providers’ attitudes to their sexuality/gender identities.

Furthermore, scale measures included the following:

- Checklist of providers’ awareness and inclusivity of sexuality and gender diversity (8 items; 5 point Likert scale, ranging from “not at all true” to “completely true”). Example item: “In my experience, health practitioners/social service workers would respond in a positive way if I brought a same-sex partner with me to the service.”
- A five item measure of psychological wellbeing (WHO-5, Bech, 2004). This psychometrically-reliable measure was used to ascertain participants’ depressive symptoms as measured on a 6-point Likert scale, ranging from “all of the time” to “at no time”. Example item: “I have felt cheerful and in good spirits.”
- A 17-item measure of community belonging (modified version of the Sense of Belonging Instrument – Psychological subscale [SOBI-P]; Hagerty & Patusky, 1995). This psychologically-reliable measure was used to investigate participants’ sense of belonging within their local communities as measured on a 4-point Likert scale, ranging from “strongly disagree” to “strongly agree”. Example item: “I generally feel like people in my local community accept me.”

Online Engagement Data

As the Internet is fast growing as an alternative source of health information, particularly for individuals who may be socially or geographically isolated, a series of items asked about participants’ internet behaviours, specifically with regards to seeking health-related information.

Quantitative Analysis

Closed-ended survey data was analysed using the SPSS statistical package. Univariate analysis provided information on participant demographics and frequency data (mean,
standard deviations) for key measures. Bivariate analysis included comparison of mean scores (t-tests; ANOVAs) and correlational analysis.

**Recruitment**

*Interview Recruitment and Sample*

In total, eight (8) in-depth interviews were conducted with GSD women over 55 years of age. These participants were recruited using snowball sampling – a common technique used with marginalised groups (Browne, 2005). Their locations, all within New South Wales, ranged from metropolitan Sydney through to the Central Coast and Northern Rivers region. This included participants based in suburban (n=3), regional (n=3) and metropolitan areas (n=2) of NSW (See Table 1).

<table>
<thead>
<tr>
<th>Name</th>
<th>Sexual Identity</th>
<th>Gender Identity</th>
<th>Location</th>
<th>Metro/Suburban/Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Beth</td>
<td>Gay</td>
<td>Woman</td>
<td>Gymea (Sutherland Shire)</td>
<td>Suburban</td>
</tr>
<tr>
<td>2 Carol</td>
<td>Heterosexual</td>
<td>Transwoman</td>
<td>Central Coast</td>
<td>Regional</td>
</tr>
<tr>
<td>3 Joan</td>
<td>Lesbian</td>
<td>Woman</td>
<td>Sydney City</td>
<td>Metro</td>
</tr>
<tr>
<td>4 Linda</td>
<td>Lesbian</td>
<td>Woman</td>
<td>Central Coast?</td>
<td>Regional</td>
</tr>
<tr>
<td>5 Melanie</td>
<td>Lesbian</td>
<td>Woman</td>
<td>Sydney City</td>
<td>Metro</td>
</tr>
<tr>
<td>6 Olive</td>
<td>Lesbian</td>
<td>Woman</td>
<td>Summer Hill (Inner West)</td>
<td>Suburban</td>
</tr>
<tr>
<td>7 Penny</td>
<td>Lesbian</td>
<td>Woman</td>
<td>Lismore (Northern Rivers region)</td>
<td>Regional</td>
</tr>
<tr>
<td>8 Ursula</td>
<td>Lesbian</td>
<td>Woman</td>
<td>Marrickville (Inner West)</td>
<td>Suburban</td>
</tr>
</tbody>
</table>

NB: All names are pseudonyms

*Online Survey, Forum and Facebook Recruitment and Engagement*

For this project an online website was setup ([https://www.silvergsdwomen.com/](https://www.silvergsdwomen.com/)). The website included a pop-up window which linked users to the online survey hosted by Qualtrics. On this website we also established private anonymous online forums. The forums were incorporated into this study, as previous research (Bolding, Davis, Sherr, Hart, & Elford, 2004; DeHaan, Kuper, Magee, Bigelow, & Mustanski, 2013) has found that GSD women often engage in online forums to communicate, socialise and seek opinions and suggestions on key aspects of their lives.

The team also invested in social media, with an emphasis on engaging older women in NSW on Facebook. Using Facebook allowed us to advertise the project and promote the study survey, online forum and link people to the resources on the website.
This strategy was beneficial for recruitment as, at the conclusion of the project, there were 250 people (96% women and 4% men) who had liked the page (see Figure One), with most women above 55 years of age (see Figure Two). Over, 80,000 impressions were made and over 4000 people were reached through Facebook promotion with 485 people clicking on the project (see Figure 3).
Online Recruitment Procedure

Figure 4 illustrates the first recruitment campaign on Facebook used in the first stage of engaging older women to participate in the project. This first step asked them to join and like the Facebook page. In doing so, Facebook then presents the page to other people in their social network and assisted in creating and supporting social engagement in the website, online forum and survey.

*Figure 4. Facebook Advertising Campaign 1*

In order to engage women in the survey and the online forum more specifically we launched Campaigns 2 and 3 (see Figures 5 and 6). After clicking on the link, participants were brought to the project website where they could complete the online survey. Once completed, the women were directed to the forum pages where they could register and begin conversations related to the research questions.
We then began Campaigns 4 and 5 in July of 2017 to promote the online forum on the project website (Figure 77).
In addition to online recruitment processes the team engaged in the following activities to promote survey completion and online forum engagement:

1. Distribution of over 500 project postcards at a stall at the Sydney Gay and Lesbian Mardi Gras Fair Day in February 2017 (See Appendix A)
2. Sent out postcards to NSW health and aged care services to display (8008 postcards to 20 willing services)
3. Sent out postcards using the AvantCard displays across the state (12960 postcards were on display across 128 venues in urban and regional centres) (See Appendix A)
4. Advertised using LOTL (Lesbians on the Loose) newsletter’s online platform - a link to the article advertising the study on LOTL can be found here: [http://www.lotl.com/News/Seeking-Supportive-Services-for-Older-LGBT-Women-1862/](http://www.lotl.com/News/Seeking-Supportive-Services-for-Older-LGBT-Women-1862/)
Table 2. Facebook Campaign Overview and Impact

<table>
<thead>
<tr>
<th>Campaign</th>
<th>Campaign name</th>
<th>Campaign objective</th>
<th>Duration (days)</th>
<th>Results</th>
<th>Reach</th>
<th>Success rate</th>
<th>Impressions</th>
<th>Frequency</th>
<th>Reactions</th>
<th>Comment</th>
<th>Share</th>
<th>Link click</th>
<th>Page likes</th>
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<td>Like &amp; share post</td>
<td>106</td>
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<td>21,042</td>
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<td>68</td>
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Advisory Committee

Given the potentially sensitive nature of participants’ experiences and associated concerns for wellbeing given the marginalised nature of the population, an advisory committee was assembled to offer feedback and support through the various phases of project design, recruitment and analyses. The advisory committee included social and health researchers and academics, LGBTIQ support service providers, health, aged care and social service providers as well as older GSD women from NSW. The role of the advisory committee was to provide expert and insider perspectives on the needs and experiences as well as the support and services structures that impacted on older GSD women’s wellbeing and social connectedness. Expert advice included:

1. Opinions on the best way to design the website interface, website and Facebook page testing
2. Advertising the project and the project website to their stakeholders and communities
3. Developing the most accessible questions for inclusion in the survey and interview protocol
4. Pilot testing the research instruments
5. Assistance with recruitment for all phases of the project
6. Review of the results following data collection
7. Support with the systematic review to help frame the study
8. Discussion and management of ethical issues and concerns
9. Review of parts of the report, presentations at conferences and meetings as well as review of the video detailing the findings of the project

Ethical Requirements

Ethics approval for the research was obtained by Western Sydney University (WSU) in August 2016 (Approval Number: H11751) to undertake a rapid ethnography, an online survey, and data collection in online space/s with GSD women. Subsequent amendments were made, including changing the rapid ethnography data collection to in-depth interviews, due to recruitment issues for the ethnographic component of the study. This addition, along with amendments to the consent form and information sheets were approved in February 2017.
Chapter 3: Qualitative Findings: Interview and Online Forum Results

The qualitative data presented perspectives on barriers and facilitators to engaging with social, health and aged care services and service providers across five main thematic areas:

1. Heteronormative frameworks and practitioner comfort with gender and sexual diversity
2. Practitioners’ knowledge of gender and sexual diversity
3. Concerns about homophobia and aged-care services
4. Being and feeling connected in the community
5. Social engagement

Heteronormative frameworks and practitioner comfort with gender and sexual diversity

Participants noted that they often encountered practitioner/s who assumed they were heterosexual. Participants felt that this assumption blinds providers to the possibilities of sexual diversity and assumes everyone is heterosexual, which is known as compulsory heterosexuality (Rich, 1980). Compulsory heterosexuality, when applied to the medical and health service industries, potentially renders GSD women invisible, marginalised and ‘othered’, leaving them uncomfortable and poorly serviced. For example, inappropriate services may be offered to them and by extension, appropriate service options may be overlooked. On the online forum Shirley explained:

Two years ago I was diagnosed with breast cancer and underwent surgery, chemo and radiotherapy. I live on the North Coast of NSW. I found that information supplied and the support network available were focused on straight women (i.e., information for partners talked [about] husbands/wives, information re sexuality talked straight sex only and so on) ... I am surprised by the general lack of acknowledgement in areas outside the major cities. (Shirley, Forum Comment)

Additionally, the GSD client/patient, if in need of a more targeted response, is required to ‘out’ themselves to the practitioner/service. Shirley explained, “I was surprised by the level of obvious discomfort some medical staff had with my sexuality and felt I had to out myself about 300 times during the process.” In doing so, and especially for older women, this may be particularly anxiety-producing considering the experiences and witnessing of prejudice and discrimination which they have encountered, to varying degrees throughout their lives (Koh, et al., 2014).

Additionally, experiencing encounters that are discordant with one’s life during one’s younger years does not inspire confidence in the profession. Older GSD women have lived histories of such disjuncture. These feelings and experiences were illustrated by the extracts below from participant interviews.
I think services cater for mainstream, as in straight couples and families. (Melanie)

Wherever you go, the expectation is the norm is heterosexuality. So...when you went to a doctor, if the doctor was male - even if it was female - one of the questions they might be asking you is what kind of contraceptive methods are using? So then you have to come - and then you say I don't use contraception. I don't. They look at you and then you might say I don't need it. So the assumption is therefore you're not involved in any intimate sexual activities. When what you're saying is I don't need contraception because I'm making love with other women. But the medical personnel will read that to mean I'm not involved in any sexual activities with some man. So therefore I'm being celibate. (Ursula)

Other examples provided by the participants involved assumptions not only of (hetero)sexuality but of marital status. Melanie recalled a time when she was asked, "What does your husband do?" Such heteronormative questions position GSD women’s sexualities and relationships as invisible and outside of the norm, where their intimate relationships are not within the provider’s realm of consciousness. It is these moments that require GSD women to decide how to respond, as Ursula explains:

You may not want to say I'm actually with women. Sometimes you do and there's that momentary pause. Sometimes they feel uncomfortable and then you know that that connection is over and you just want to get out of there. Or there's that fake bright smile and you can see them thinking I can take this on board. I can deal with this. So those kinds of assumptions around what your sexual history is or who you're with or yeah. (Ursula)

Perceived Stigma in Entering Institutions

Simply entering care institutions can be a confronting or difficult experience for some GSD women. The effects of previous discrimination mean that what may, or may not be a harmless or inconsequential behaviour, may be potentially otherwise.

We were visiting a friend in hospital this weekend, a woman ... my partner went in, and at one stage we actually felt like there were people staring, like, oh, well, where's the family? Where's the husband? Nothing said, but that sort of - I don’t know. So then you start thinking to yourself, what's going on? Or is it just a reaction? So yeah, hard to tell. (Melanie)

Similarly, Linda identified differential behaviours from others towards her, which she felt was likely the result of homo/transphobia.

There's a chemist shop in our local town that I will not go to because the main person on the counter is always really cold and so on to me and yet I've observed her being quite - just okay with other people. I actually asked one or two heterosexual friends - I didn't say I think she's anti me because I'm a les but I said what she's like? She's really nice. She's quite helpful. I think well surely it's not because I've got grey hair. [Laughs]. I probably
haven’t - I haven’t worn a T-shirt that says look here, I’m a lesbian but they get the drift. Maybe I’ve been in there with my partner or something. (Daphne)

Whilst it is impossible to know if the healthcare worker was stigmatising the individual, the reality is that a feeling of stigma or being treated differentially was perceived by the participant. This points to the ideal of having visible evidence of support and inclusion for people with diverse sexualities and gender/s within healthcare services/providers to ensure GSD women feel they are in a safe, supportive and comfortable space. However, clearly this is of little use if it is not reflected in the interpersonal interactions and demeanour of the individual providing the service. As Penny eloquently articulates, there needs to be a whole of service approach.

There is no point in putting up rainbow stickers or posters of same-sex couples in doctors waiting rooms unless the staff including the reception staff have been trained in how to provide culturally sensitive support to people in that group. Because it just invites damage, personal damage if you put up some posters without - and then your staff are still heteronormative. (Penny)

Universalisation of GSD Experiences

Participants in this research were also clearly frustrated that not only did practitioners assume they were heterosexual and had little information about alternate genders and sexualities, but that they also homogenised the experiences of both older people and conflated the experiences of LGBTIQ people. As Daphne pointed out:

To begin with, one of the things that really gives me the shits is that there’s this assumption that those of us who are older [are similar] ...I know trans people but I’m not part of their politics and LGB politics are mixed in together. (Daphne)

Similarly, Olive articulated the conflation of identities and experiences in the following way:

So there’s different cultural needs sometimes for gay men as there are for lesbian women...we’re getting lumped all together, lesbian, gay men and transgender or different stuff. It’s like, I don’t even know whether lumping us together as a group is appropriate. Just because we’re different doesn’t mean we’re all the same, if you get what I mean? (Olive)

Clearly the participants felt that their healthcare was affected by “lumping us together”. As Penny explains:

But I’m conscious also that I have very, very little in common with gay men or trans people, very little in common with them and if only the fact that we share a minority status on similar continuum that have got us banding together in kind of a coalition... As I said, I have got nothing in common with intersex people and I’ve got nothing in common with transgender people. I can see some more similarities with gay men but not many. I
mean their lifestyles tend to be different to mine. Their sexual practices
tend to be different to mine. They have different needs. They are in a
different socio-economic position to me. As men they are members of the
patriarchy. (Penny)

Differences obviously exist not only among groups or communities, but between people
who may identify similarly. However, categories, irrespective of the kind may limit and
exclude. As such, it is critical that healthcare professionals offer services that meet the
needs of individual clients and understand that the LGBTIQ communities are both broad and
diverse.

**Intersecting Needs**

Participants argued that addressing their healthcare needs as GSD women also required
practitioners and professionals recognise and respond to the intersections of their GSD
identities with other aspects of their identity. A few participants felt that practitioners do
not understand the intersections of aging and sexuality. For instance, Beth stated:

> Yes, I think my psychologist is kind of half way there, but I don't think she
understands the gravitas of - she understands the gravitas of moving
someone because of mental health issues. But I don't think she fully
understands me in the gay world at my age in particular. (Beth)

Other participants felt there was limited recognition of their needs as GSD women with
diverse racial and cultural identities. For instance, Ursula shared one experience where she
was seeking counselling after a loved one passed away.

> Also found it even more interesting that I had this cultural background and
also was a lesbian. Like exploring that from a perspective of she is finding it
interesting, making me a subject and an object at the same time. I was
there to work through my grief, not to provide an interest in exotic other
for the counsellor. Later, I actually got a counsellor, an Indigenous
counsellor. I was in New Zealand at the time. A Maori counsellor, and
found it such a relief. Because none of those things were either an issue.
They were important because they had shaped me but she could recognise
and understand that and work through the issues that I was there for. It
was a relief, because you're feeling very vulnerable at that point. (Ursula)

As Ursula points out, it can be critical for healthcare professionals to recognise the multiple,
intersectional identities participants have and take this into consideration when supporting
a client/patient. Although acknowledging that being an older GSD woman is important to
some aspects of receiving care, it is not necessarily the focus.

> What I’m getting at to say is that we need community health centres
dedicated for old people. I tend to use the word old. Maybe elderly. I don’t
say older because that’s a relational thing. Old means old as far as I’m
concerned. (Linda)
Sexuality and gender identity also intersect with socio-economic status, and accessing services was for some of the participants, quite costly. Interestingly, older GSD women in Australia reportedly earn more than their heterosexual counterparts, largely because they are able to work longer hours (Sabia & Wooden, 2015) and these women may also be more likely to work in male-dominated industries which are generally better paid as compared to those dominated by women. Despite this, healthcare costs are still prohibitive for many, particularly if they have had breaks in workforce participation or have worked in lower paying industries. As Beth points out:

I can access these providers, but I don’t know if they are the best providers for me and also it costs a lot of money. I feel I’m one of the fortunate ones, I suppose, because I have got the money but a lot of people don’t. (Beth)

Thus, as GSD women are often paying for services, it is critical that their money is well-spent; that is, that the service provided meets their needs as an older GSD woman.

**Sexism and Sexual Harassment**

A concerning issue that arose in the discussions was the GSD women’s experiences and fears of sexism and sexual harassment within healthcare settings. Carol described a direct experience of sexual harassment that she had when seeing a doctor.

I had to see a doctor at one stage when I was in Melbourne. This was shortly after my operation. I was perhaps a little bit naïve shall I say, and the questions this guy was asking were totally irrelevant to my immediate needs. But I sort of like thought well I’ll play along with this just to see where this is going and I sort of like did have to put an end to it because it wasn’t going in the right direction…The first part of the question was he was asking questions pertaining to my breasts which was not the issue at the time. He was sort of like complimenting me on the size of them. They’re quite natural. They are all natural. And when he mentioned that, I said, but that’s got nothing to do with exactly what I came down here for, so can we focus on my immediate needs. (Carol)

Other participants expressed concerns related to sexist behaviour. As Penny explained:

The last thing I want to do is to invite them [male practitioners] into my private life, and that includes, in particular, I don’t like being stared at by them. I don’t like the uncomfortable feeling that I remain a sexual object to them. (Penny)

It is unclear whether these participants were targeted for sexual harassment because of their perceived or known gender and sexuality diversity or because of their identity as women. Regardless, recognising the fears and concerns of these women is important as is their right to feel safe. This influenced the choice of practitioners that they sought out.
Practitioners’ knowledge of gender and sexual diversity

The perception of practitioner discomfort, and resulting discrimination, is not imagined; for example, research illustrates that many health care professionals feel uncomfortable addressing issues pertaining to gay and lesbian individuals (Khan, et al., 2008).

 Added stress and anxiety to an already stressful experience. Meant I did not feel supported by the breast care nurse as she obviously struggled with my sexuality. Also [I] just got very tired of continually 'coming out' - felt like I should wear a t shirt saying 'big old dyke' just to make it easier! ... should the cancer recur I would almost certainly seek medical support in the city I would not seek treatment locally again. (Shirley)

As noted from participants, such encounters can reduce confidence not only in the professional at hand, but in the service more generally. Notably, participants were keenly aware of how practitioners process their diverse gender and sexuality as something they have to “deal with” and then watch them as they actively make the decision that they “can take this on board”.

An online forum member explains her perspectives in this regard.

 For transwomen in Oz the medical challenges are both chronic & acute. During transition [mine was in the mid noughties] ...services were scant. I was fortunate to find an excellent speech pathologist, electrologist, & endocrinologist, with my GP remaining supportive [albeit I was & still am "her first"]… domestic choices for the big ticket items [facial feminisation surgery & sex reassignment surgery respectively] were dire. It was such that I did what proportionately "many" others did back then too, which was travel OS[overseas] for the various surgeries...my GP...only raised, for the first time ever, the topic of breast health at my recent app't to which I chipped her that yes I was aware of the absence of prior discussion, & I'd been pondering if there might be a hidden meaning wrt [with regards to] how she might privately perceive me. (Aufgegeben, Forum Comment)

A similar comment was made by Carol, a transgender woman, who explained her experience in the following way:

 Being a transsexual, or transgender individual, there’s a profound void of knowledge out there to the extent that you may have to actually establish eye contact with the health profession[al] and say okay, this is how things have gone about, and this is how things happen, yadda, yadda, yadda. Are you on board or not? And essentially determine whether they’re going to exhibit some sort of self - I wouldn’t say self-deprecating, but some sort of discrimination…when they see a patient, particularly patients like me. Thinking oh, God, this is the last bloody thing I wanted to do today. We never studied bloody transgender when I was doing my RN. So, you get the vacant look of despair, and people think oh God, that’s just what I needed
today isn’t it. You know, and you’re the last one here too... You can read the expressions on their face, and you think okay, righto, it’s relationship 101 is it? Okay, well let’s get down and start dealing with this. A, are you interested. B, okay. (Carol)

These extracts illustrate that these GSD women are alert to possible micro-aggressions and re/actions of the healthcare professional they encounter, and pay close attention to how their healthcare professional reacts to disclosure about their gender and sexual diversity. These reactions, by extension, inform participants as to whether they have the knowledge, experience or even resolve to support them, which may not necessarily be the case. Shirley noted on the online forum, “I live in a rural area. My issue in more that local practitioners are totally unfamiliar with the needs of ANYONE who is LGBT.”

Given the perceived lack of practitioner knowledge Ursula pointed out, “You always end up feeling like you have to explain stuff that you don’t want to have to explain. Then there’s all the aging stuff which is another layer on top of that as well.” Research, however, has illustrated that patients are generally willing to respond to routine questions pertaining to their gender identity and sexual orientation, although fear of homophobia and the possibility of consequential negative treatment can impact an individual’s readiness to disclose (Bjarnadottir, Bockting & Dowding, 2016).

Practitioner Training

In response to practitioners’ perceived lack of knowledge Penny highlighted the importance of training:

I advocate training. Absolutely, of course, I advocate training for all health professionals in how to provide culturally sensitive care. A big part of that has to be teaching people how to identify their own bigotries. (Penny)

Training would enable providers to offer not only appropriate services, but services that are implemented in a manner that is culturally sensitive. That is, education is required not only to raise awareness but also provide the professional, regardless of their discipline or role, knowledge that can support the healthcare needs of GSD women.

Well re my GP, in fairness to her... my understanding is that there’s little or nothing in her prior training to particularly equip her & her peers about transpeople. To her credit though she has never in any way been anything less than great in her attitude to & interaction with me... unfamiliarity is regrettable... (Aufgegeben, Forum Comment)

Not only do healthcare workers require the ability to expect that some patients/clients may be GSD and the interpersonal skills to feel able to interact meaningfully with them, but they also require the information and resources to respond to the specific needs of their GSD patient/client in useful, appropriate and comfortable ways; the best method for achieving this is through targeted education and training.
I think it's just to acknowledge that you're gay and then the staff and the particular organisation, if you're going to say you're gay friendly then make sure that your staff receive training and are made aware of some stuff to do with gays and lesbians, that there isn't any undercurrent of prejudice. (Joan)

In effect, GSD women demonstrate a layer of negotiations that they are required to undertake that is not required of their heterosexual counterparts who represent the ‘normal’ patient/client. Moreover, whether or not the healthcare practitioner has the knowledge or experience to provide effective services is another unknown issue. Thus, GSD women negotiate not only their potential differences in relation to healthcare but the client/professional relationship, which may, or may not, be fraught.

Preferred Type of Practitioner: Seeking Safe and Supportive Practitioners

If the participants had a choice, most overwhelmingly supported and preferred a female practitioner. As Joan articulated, “I feel, I wanted a woman doctor. Yeah, I wanted a woman doctor whether she was lesbian or just lesbian friendly, that's fine.” Similarly, Beth when seeking a practitioner acknowledged that “generally speaking I do look for women practitioners”. Penny also pointed out that, “I have a personal preference for a female GP, so I find myself a female GP wherever I live.” Having a female doctor was preferred, and for certain examinations, such as pap smears, it was deemed crucial.

The preference for a healthcare professional that identified as lesbian was preferred by a number of the participants; having a similar sexuality to them was deemed an advantage. As Olive articulated, “If I knew they were lesbian, I'd be much more likely to go to them”. Beth highlighted how she was proactive in sourcing female practitioners. “I actively seek out female practitioners to help me, but it would be nice if they were gay as well, especially the counsellor.” Penny described herself as very fortunate having access to a general practitioner who was not only female but identified as a lesbian. She stated, “In fact, I have been lucky enough to find a lesbian GP. So I feel very comfortable with her because she is a member of the same outgroup that I am a member of.” These extracts illustrate a belief that a female (and lesbian) practitioner would be easier to identify with and understand the needs of individuals with non-normative sexualities and genders.

Even if the practitioner did not necessarily identify as sexually and/or gender diverse some of the participants expressed how they sought practitioners who were explicitly supportive of GSD people.

I do go to a counsellor, a psychologist, who has had a lot of training and experience in the mental health area. She sees a lot of [names occupation], and she sees quite a few gay people, particularly women. I like what she has to say. (Beth)

Beth also pointed out that the healthcare practitioners with whom she was working, despite apparently identifying as heterosexual, provided a level of care beyond the detached service often offered in an appointment room. Being able to be ‘out’ with one’s healthcare professional is important (Bjorkman & Malterud, 2009).
Especially of late because I have accessed naturopaths - a naturopath and a masseur, who is a bit of a life coach, and yoga and pilates teachers. They all know I’m gay, and they all know I’m struggling in life at the moment particularly after a relationship breakdown. They know that I’m new to the area, so they kind of look out for me. They are all lovely straight women. I have no hesitation in talking to them about what is going on in my life. (Beth)

It was important to have a supportive female practitioner available for “stuff done as a woman”; but, having a practitioner who was also comfortable in having a partner present and recognising their relationship was closer to the ideal. Penny highlighted how her lesbian identity is materialised through the visible and bodily presence of her partner who the healthcare practitioner recognised and acknowledged as her significant other.

When I’ve needed health stuff done as a woman I’ve been able to find myself a female clinician and that female clinician was supportive of my partner being [there] and my next of kin being a woman. (Penny)

One of the participants sought health care from a location where exposure to, and acceptance of, diversity was assumed. For Ursula, whilst she cannot remember if she explicitly had a conversation about her sexuality with the practitioner, she believed that the practitioner was supportive and assumed this because of the progressive nature of the institution/service with whom she was connected.

My own doctor, she knows. It’s a female doctor. She’s not from the queer community. But because I’ve been [accessing] university health services since I was at university, so for about 20 years or more, there’s a tiny hope that [at] University, they’re a little bit more in line than because they’re meeting so many young students...you know...they’re...t exposed more. So that’s kind of why I stuck with them. Because they’re seeing people from different cultural backgrounds...... Maybe they don’t see as many old people. But my medical personnel have aged with me. My specialist never - I think she knows. I can’t remember if I talked to her about it. (Ursula)

Whilst some of the participants reported using strategies to seek out progressive practitioners and institutions finding appropriate practitioners iss not always easy.

So if I think specifically then about if I’ve had, say, support, counselling support, with [my] partner and challenges with that, finding someone that we thought would be sensitive to same-sex relationships was a bit of a challenge, but then we found someone, so that was all right. (Melanie)

What emerges from this data is that older GSD women actively seek to engage female healthcare personnel who are also, preferably (in some cases) lesbian identified and likely to be supportive of their diverse sexuality and gender identities. Additionally, they seek respectful and informed practitioners, where they can feel safe/comfortable, which are often spaces where they feel and can be particularly vulnerable.
Concerns about homophobia and aged-care services

Home-based care

One of the key concerns arising from the qualitative interviews centred around aged care services and the perceived homophobia that participants thought inevitable when engaging with them (Grigorovich, 2015a). This perception was largely in response to the fact that many aged care service providers have religious affiliations which traditionally were exempt from anti-discrimination legislation and therefore permitted to discriminate. Such legacies are difficult to eradicate, even when laws change. Although discrimination against clients on the basis of gender or sexual orientation is no longer permitted in aged care services, discrimination can often be subtle and insidious.

I've known a few older friends in their 70s, 80s or just a few incidents where they've had people come into their homes just to help with cleaning ... you've got that really tricky situation where a lot of those, the government, has outsourced all their care stuff often to religious based organisations, that there's not real proper professionalism. I've know[n] of a couple of incidents where women have felt like they have to de-dyke their house before someone comes to help them out with the cleaning or help with some basic health issue. Yeah, I think that's a concern, I really do. Going into retirement villages, I think women have to be, lesbians have to be quite careful about that and I think that's definitely an area which needs to be looked at, yeah. (Joan)

Increasingly, the people who give you service care is through religious organisations. Religious organisations have wonderful reputations in terms of sexuality. Not. (Ursula)

Participant’s concerns centred on their vulnerability and dependence on others; frequently older GSD women have no children or family to provide support and in some cases may be estranged from relations (Grigorovich, 2015b; Rowan & Giunta 2016). This increases their reliance on external services and supports. For GSD people generally, their homes have traditionally been a place of refuge against homo/transphobia. Relying on aged care services within the home risks bringing homo/transphobia into this personal space, conceivably threatening the sanctuary of their home, their sense of security and peace of mind.

When you're older and you're on your own and there aren't other people around, you have more need of services in some way. You're much more vulnerable. So I've had friends who said they've put away any books or posters that may indicate what their sexuality is when people come into your home. ... One of the major issues we have to think about whether we go back into the closet. For me, the thing is okay, before, you close the homophobic world out when you walked in through the doors of your home. But when you've got people coming into your home to care for you, what comes up for you? (Ursula)

To alleviate the potential vulnerability, making one’s GSD identity invisible may be the only solution and studies have shown that lesbian and bi-sexual women, for example, often
choose not to disclose their sexuality with home care workers (Grigorovich, 2015a). This may be done by “de-dyking” the premises, as mentioned above, or taking up passing and covering strategies to avoid revelation (Griffin 1991, 1992). GSD women may well go ‘back into the closet’ (Barrett, Whyte, Comfort, Lyons, and Crameri, 2015). It is not unusual for GSD women to pass by alluding to children when children have been a part of their life. While there may be advantages to passing the consequence is that once more, the GSD individual becomes both voiceless and invisible through this process.

It's only recently I started having carers, so I'm going to suss them out. Because of course you talk about things that seem safe to talk about. So I can talk about children and grandchildren. Nobody has yet asked about a husband. They often, I think, assume that I'm a widow. Whereas, I might have corrected that assumption at some stage, I don't bother. So it's not just only hiding your sexuality, you allow them to make assumptions because it's safer that way. (Ursula)

Some of the participants spoke about their (incorrect) assumptions that carers employed to work in an aged care service would have appropriate cultural sensitivity training prior to being permitted into the field. The realisation that this is not the case was a significant concern for Ursula.

I assumed wrongly, that all the carers that you get that come to your home would have had training [in LGBTIQ issues], if they're not queer themselves. My first choice would be to have a queer carer. At this point, I don't even care if it's a transgender or a young gay man. It's the first time in my life where I'd prefer a male over a female. (Ursula)

The reality that someone who is not trained in LGBTIQ issues or may not be LGBTIQ friendly was a significant worry for Ursula. Although she is highly female-oriented with a strong preference to work with and engage with women in women dominated spaces, Ursula revealed that she would prefer a queer male in her home over someone who is female and not LGBTIQ aware. This contradicts her own comfort or preferences, which is to be around females (see Sinding, Barnoff & Grasseau, 2004). As Ursula points out, this is the first time in her life where she would prefer a [queer] male over a female – a choice she feels compelled to make because of the lack of culturally appropriate services available.

Aged Care Facilities

Aged care facilities were perceived to be, and experienced as, overwhelmingly heteronormative spaces that failed to be inclusive of gender and sexually diverse communities (Phillips & Marks, 2007). Phillips and Marks (2007) argue that although an awareness of diversity may form part of the facility’s ethos, aged-care assessment tools often omit the needs of the GSD ageing community. This perception and the resulting fear that it causes in GSD individuals is supported in the literature (Hinrichs & Vacha-Hasse 2010; Villar, Serrat, Fabà, & Celdrán, 2015). An online forum member explained her perspectives of going into aged care:

I have... turned my mind to this matter... as a future challenge over recent years... just in a purely speculative way. No plans are laid, but I suspect if I ever found myself
needing one of these facilities it would likely go badly for me... to the extent that I currently favour removing myself from the stage [ending my own life] prior to the question even arising in earnest. Some people seem to be discomforted by talk like that, which I never understand. (Aufgegeben)

Additionally, there was no sense of where aged care spaces existed for people of non-normative genders or sexualities, although this would be the preferred model (Johnson et al., 2005). There is currently a void in this critical area of need, with virtually no provisions made that target GSD women (and/or men).

Well, when I see anything to do with aged care facilities, it's always a happy man and a happy woman. ... I straightaway think, I can't relate to that! (Olive)

I've had experience with my sister and that [the aged care facility] would have to be one of the straightest settings in the world. You can see how, even in three years' time, it's going to be a sense of, so where is our place? Because there isn't one, I don’t think. (Melanie)

Thus, not only through their own knowledge of aged care facilities, but through their experience of caring for or visiting others in aged care facilities, participants’ early experiences of these facilities have demonstrated to these GSD women that heteronormativity clearly prevails.

I'm sure - possibly there were some people - residents there that were LGB, but I wouldn't know ... No. I didn't see - and usually there are people who talk about someone's husband and their wife, and were they married? You know, were you married? That's like a key - I guess again, it's like a key life key for people. (Melanie)

As Melanie reported in her interview, despite her long-term partner, Jess, regularly visiting Melanie’s sister alongside Melanie for a decade, there were no visible or articulated inclusions of Jess from the staff at the facility. Although questions posed to the couple may have inadvertently revealed their lesbian couple status, there was no explicit interest in acknowledging their relationship or how it pertained to Melanie’s sister, nor were there any signs of support for them or their relationship.

I suppose language, the celebrations, how they notice family - it's interesting, because my partner, she's always there. ... But they never - they would never say, your partner. (Melanie)

A situation which can result in a sense that being and feeling connected to your partner and community was not a priority in the eyes of services providers.

In a lot of ways lesbians have fallen through the cracks both in services like healthcare. I've just told you we've got a women's health centre near here and an [LGBTIQ service] but neither of them really address our needs to the extent that heterosexual aged women's needs could be. What I'm saying is I
think it would do a lot of services good to have either a continuing reference group - ongoing is the term they use these days - or at least to run consultations from time to time. (Linda)

Feeling part of one’s community as an older GSD woman was not only about being accepted as an LGBTIQ-identifying person but also being recognised for one’s experience and wisdom – an asset in the development and delivery of LGBTIQ-friendly services.

Being and Feeling Connected

Social Services

LGBTIQ social services provided a range of connections for some of the women interviewed, as Gail explains about some of the events she has attended:

I suppose with the [name of club], because there's a heap of gay guys there, and that's really nice, it's nice to have men's company because they're different and there's different energies. They're lovely. Lovely, lovely guys. So I like the male presence there. With the [YYYY] event, I like that they're a bit flashy, they're the professionals and they're a bit all dressed up and power dykes; well, not all of them, but I like that. With [name of venue], I just like that there's a whole variety of people that come through, people who aren't very swishy, people who are older, people who are younger. So [name of venue] is really a complete, across the board, variety of lesbians or bisexuals or people who are just figuring themselves out. (Gail)

However not all social events ‘fitted’ what these participants wanted or could access. For instance, there was acknowledgement that being within easy distance of the community helped one to make connections. Proximity for social inclusion was clearly important.

I think overall, weighing it all up, I do need to move and be closer to my tribe not just because of cutting down my travelling time but also the thinking is many more women in the inner west who have fractured lives. Both straight and gay are more accessible to stuff going on. Down here there is nothing much at all. When I say stuff, it doesn’t have to be gay necessarily. I mean the Older Women’s Network is a very good organisation I know. Yes … my decision to move [closer to LGBTQ community] is based on my sexuality and also my experience of having to end what was a lovely relationship which became dreadful very quickly. So it is all related to being gay, yes. I wish I was straight. It would be much easier. (Beth)

To some degree, the extract above from Beth’s interview illustrates not only issues of proximity to be closer to her ‘tribe’ but the ways that homo/transphobia including marginalisation and difference, structure people’s lives. Carol, a trans woman also pointed out the need for intimate connections with others. This is not necessarily a GSD issue in and
of itself but is more difficult for those who are GSD whose communities and options for partners are statistically smaller and at times, more difficult to identify.

My social needs essentially is really to find a decent man. With the viewpoint of long term relationship, perhaps even going so far as marriage.
(Carol)

Early Retirement Issues

Older GSD women also talked about the isolation that they experienced once retired, when their friends were still engaged with the workforce. This isolation may be greater for GSD woman who have no supportive family or partner. Additionally, proximity to work-like opportunities or activities was seen as critical factor in reducing loneliness, impacting where these women choose to live. It suggests that more visible and targeted services need to be de-centralised to cater to GSD women not close to urban centres with a significant GSD-population.

I think I need to move. I need to move probably to the inner west, a bit closer to my tribe, and perhaps try - I would like to get involved with projects. ... I'm also an odd one - not odd, but unique - because I could afford to leave work relatively early. I was only 59. The ... few good friends I do have they work full-time, and I'm finding it difficult. So that's why I'm thinking I would like to work again. I can get away with doing voluntary work but not five days a week. ... So I'd very much like to get involved with the community. (Raina)

Unsurprisingly, greater need for services that address the needs of sexuality and gender diverse older women and are explicitly LGBTQ-friendly was central to the women’s sense of belonging.

[It] would be fantastic to have a retirement village that was gay and lesbian friendly. It doesn’t have to be completely overtaken but as long as there’s an acceptance that they’ll be gay and lesbian people there. (Joan)

Perhaps the type of environment Joan suggests could reduce the limitations that many older GSD experience when trying to engage and connect with others.

Limitations to Participation in Events

Several issues contributed to the GSD women’s ability to access social services and events. These factors ranged from the physical, through to financial as well issues related to access.

• Physical Limitations

Despite desiring greater connection, some of the participants also talked about the limitations of the body; that is, that there are activities in which they are no longer able to physically participate. For these reasons, they needed to assess the suitability of the activity in line with their physical capabilities.
A lot of my lesbian friends are younger, in their 50s. They're still very much engaged in the workforce and they don't quite get it yet about getting old. They see it and they walk a bit slower for you if you're going for a walk together or something... If they say we're going to go for a bushwalk, one I know which I've done 10 years ago where it was climbing up and down, I go no I can't do that one but I can either meet you at the carpark for a picnic or I'll see you at the next easy one. They'll go yeah well she can't do it but it's the intricacies of it. That's an aspect of it. (Linda)

Other physical impairments, such as hearing loss, can be an obstacle to socialisation. Although this is not an issue specific to GSD women, social options may already be limited for these individuals; when intersected with physical disabilities, potential options are further reduced. As Olive pointed out, even the venue in which activities are held can be problematic.

Sometimes it was at the venues - I just have hearing problems now, so if something is too noisy at a venue, it's no use my going, because I can't follow a conversation. (Olive)

- Financial Limitations

Many older women have reduced access to money to undertake social or other activities (Averett et al., 2011). As a result, they may feel compelled to curb their expenditure on non-essential items or review their social encounters; this has an impact on lifestyle and social engagement. As Linda pointed out:

The other thing is your lifestyle changes a bit because things take a bit longer to do and money's a bit shorter perhaps. You can't go out for meals so often or to the best restaurants that you might have gone to once or twice a year before. You kind of fall out of the social circles a bit. (Linda)

- Communication Difficulties

As the women aged, some reportedly felt it difficult to keep in touch with social event calendars. Carol, for instance, talked about this in relation to knowing when events were to be held and the in/frequency of events. At times, she missed events that she would have attended if she had been aware of them in time to participate; hence, better communications and advertising would be useful to enable individuals to stay engaged. Greater targeting of known older GSD women in terms of events communications would also be useful to provide the best possible opportunities for engagement for them in the community.

Being a fairly outgoing sort of a person, really I can fit in to most situations. Whether it was a night event at a club or a hall, or a day event at an oval, or again a hall to mix and match. I'm fairly comfortable with whatever situation I walk into. The availability of that sort of thing, it's not always happening. If something does happen I usually hear about it three weeks later and I think well that would have been nice to go to that. (Carol)
• **Type and (In)Frequency of Events**

The types of events were an issue raised by some of the participants who generally sought events that were more inclusive of GSD women or were more community based. Greater support for GSD inclusive social events could increase GSD older women’s access to others. Increasing social access limits the potential for isolation, improving overall health and well-being in their later years (Vanderhorst, R., & Mclaren, S, 2005).

*The stuff that I don't particularly like is stuff generally that's run by [community organisation] because they're not really interested in anything by A-list lesbians. ... Yep, that's my, just my reaction to a lot of, well, to anything, to the few things they put on. Well, I suppose, once again, it's also part of my experience. ... as far as I can see it, they're the only place that gets any funding to deal with lesbian health as opposed to [names organisations]. ... These are all voluntary places so they don't get any government funding and yet they provide fantastic services. (Joan)*

The sense that there are few events and activities for older GSD women to choose from highlights the barriers these women report when seeking to engage with other women within their communities.

*My partner and I find it very difficult to meet other lesbians for social activities where we can exchange thoughts, ideas, experiences, have fun, dance, laugh, etc. We have several gay male friends and we love them however it would be nice to speak to other women of our age, etc. (Sally)*

In responses to the lack of events women made suggestions about what they would like to see in their communities.

*Definitely a lot more community events where we all get out of our houses a bit more, and have regular community events. Dances, picnics, barbecues ... I suppose it would have to probably be along the lines of a meet up. (Carol)*

The importance of events as opportunities to connect with others first and foremost reinforced the fact that inclusivity in the community comes from feeling connected and engaged with others.

*If there was a community centre where I could go to, you probably would then be in touch with other meet-up groups. I think a social meetup group is a really good idea. ... So I think more social groups for older lesbians, because there's - at our age, there's a lot of lesbians who are couples, so there actually aren't necessarily - like in my group of friends, I can only think of me and someone else who's single. All the rest are coupled, you know, my immediate group. (Olive)*
Social Engagement

Invisibility

The invisibility of older people in the community was identified as being an issue. The GSD community, in general, has been largely youth focused for decades. Additionally, elderly people have often been ‘closeted’ – in many instances the result of living their younger lives in an environment largely hostile to their sexual and gender diversity and where discriminatory labelling and assumptions were socially acceptable practices. Being GSD meant potentially not having access to the same services and opportunities as heterosexual people, and experiencing socially and legally-condoned discrimination. This was particularly the case for GSD individuals who were known or suspected of being GSD. A growing ageing population more generally, however, also means that increasingly large numbers of GSD women are susceptible to invisibility and are naturally fearful of this occurring.

One thing that I know of in the queer community that is negative that doesn’t exist in other communities, is up until fairly recently, historically, there was no room for older people because they weren’t there, in an obvious way. Also, the queer community is all about to be young and beautiful. It’s more of a push in that than I found in any other community. So they really fear ageing. Huge fear in ageing. So there has been very little that - yeah, activities and events that welcome us or is open. (Ursula)

Interestingly age is also relative. As Joan, who just turned 60 around the time of the interviews pointed out:

The other thing actually, come to think of it, because I’m old myself, is that if you’re in your - well, I’m just about to be 60 and I don’t want to be seen with old people. I know this is stupid. I know that our mothers have been crazy like that but yeah, that guy at {XXXX} I think he puts on film afternoons for the older people and it’s like, well, I wouldn’t feel comfortable about going along to something like even though I’m considered quite old. That’s, I think, probably a bit of an issue I think. (Joan)

There is clearly a social stigma attached to women who are aging and this stigma plays itself out in the broader community. Women are bombarded with messages everyday through the media about products and activities that assist them to look younger. Older women in these contexts are thought to become invisible:

The older you [are you] become invisible. Some of my friends have been telling me this - which is fascinating - but it’s true. You can walk through - walk along somewhere and be invisible. (Melanie)

Clearly, there needs to be events for older GSD women that are well-marketed to target the right demographic. These issues are not, by any means, solely related to the GSD communities but reflect a broader, problematic social positioning. Even so older GSD women make significant efforts not only to engage with but also to empower their GSD communities.
I suppose it's a little bit biased because I actually run a lesbian group so that's a lot of fun I have on a night and it's free and yeah, it's nice. You get to meet a whole bunch of people and apart from that, I really, a regular attender once a month, the XXXX ... I attend that religiously. Also, Sydney Gay Gals which is a Meet-up group, they have lots of events organised and I go to a few of those, I like the variety. Also, I'm a member of the local gay and lesbian running club so I go running every Saturday morning. So, totally a gay gecko... I'm involved in two, three community groups ... they're fantastic. Like I say, they're all voluntary groups and the fun stuff is coming from - there's also events like Red Raw and Polly's which are just fantastic. ... There's a whole lot of little groups who do these fantastic fun things. So yeah, really happy with that and Mardi Gras too. Sorry, I've forgotten about that. There's all these people that give their time completely volunteer and yeah, I really appreciate it, it's great. (Joan)

Olive highlighted the impact of such events on community connectedness and belonging:

It's social. Like, they have a dinner once a week and they have - like, they've organised an Easter weekend away and they organise discussions and they organised another weekend to - I actually - I'm not very much a group person, so I go to these things very occasionally. So they do offer a really good social network and if you wanted any information - like, recently there's a woman at Hurstville who felt isolated, so without identifying her, she sent something into [community organisation] saying she'd like to meet up with other lesbians in the area. So it does serve a really good, valuable social and networking role. (Olive)

As can be seen, although many of the women in this study felt invisible, misunderstood or flat out excluded from many social, aged and health care contexts their agency to engage with their communities demonstrates their determination to create LGBTIQ-friendly environments. This may not be the case for most or many older GSD women who continue to be subjected to the burdens of intolerance, ageism and other challenges related to disability, CALD or Indigenous status.
Chapter 4: Quantitative Results: Survey and Online Engagement Data

Participant Demographics

All 148 participants were from the state of New South Wales (see Table 3, and Figures 8 and 9) and ranged from 55 to 75 years of age (M = 61.35, SD = 4.68; Figure 8). Of these, the majority of participants were from the Sydney metropolitan area, including Central and Northern Sydney (n=35; 24%), Western Sydney (n=27; 18%), and South/South-Western Sydney (n=15; 10%) (see Figure 10). Assessing participant postcodes against the Accessibility/Remoteness Index of Australia (ARIA) showed that while the majority of participants lived in major cities or inner regional areas of Australia (n=119; 80%), 29 participants lived in outer regional areas of NSW.

<table>
<thead>
<tr>
<th>NSW Location</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central &amp; Northern Sydney</td>
<td>35</td>
<td>23.6</td>
</tr>
<tr>
<td>Hunter &amp; Central Coast</td>
<td>20</td>
<td>13.5</td>
</tr>
<tr>
<td>Illawarra &amp; South East NSW</td>
<td>12</td>
<td>8.1</td>
</tr>
<tr>
<td>New England</td>
<td>5</td>
<td>3.4</td>
</tr>
<tr>
<td>North Coast &amp; Mid North Coast</td>
<td>25</td>
<td>16.9</td>
</tr>
<tr>
<td>Riverina</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Southern &amp; South Western Sydney</td>
<td>15</td>
<td>10.1</td>
</tr>
<tr>
<td>Western NSW</td>
<td>5</td>
<td>3.4</td>
</tr>
<tr>
<td>Western Sydney &amp; Blue Mountains</td>
<td>27</td>
<td>18.2</td>
</tr>
</tbody>
</table>

Figure 8. Participant Age by Grouping, n = 148

Age of Participants

Table 3. NSW location of the participants, listed in alphabetical order
Figure 9. Number of participants (ppts) in regional areas of NSW

- Western NSW: 5 ppts (3.4%)
- Riverina: 4 ppts (2.7%)
- Illawarra: 12 ppts (8.1%)
- New England: 5 ppts (3.4%)
- Central Coast: 25 ppts (16.9%)
- North Coast: 20 ppts (13.5%)
Four participants identified as an Aboriginal and/or Torres Strait Islander (ATSI) person (2.7% of the sample) and two additional participants (1.4%) were ‘not sure’ if they identified as an ATSI person. Most of the participants (75%; 111 individuals) were born in Australia, and 25% of the sample (37 participants) reported that they were born overseas (see Figure X for location details). Furthermore, 51 participants (34.5%) reported having at least one parent who was born overseas, and three participants (2%) ‘often’ spoke another language other than English at home (one participant each for French, Hindi, and Vietnamese). In terms of the highest level of education that the individuals had completed, most participants (102 individuals; 68.9%) held a college/university degree; 32 individuals (21.6%) had a TAFE or technical qualification; six individuals (4.1%) had completed year 12; and eight individuals (5.4%) had completed some level of high school.
Figure 11. Birth locations of participants, n=148

The majority of the participants (80.4%; 119 individuals) identified themselves as lesbian (see Table 4 for a full breakdown of identified sexualities). The six individuals who identified as straight/heterosexual were kept as valid participants as this item asked about self-descriptions of identity rather than participants’ past, current or anticipated sexual activity.

Table 4. Frequency table representing the identified sexuality of the participants

<table>
<thead>
<tr>
<th>Identified Sexuality</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesbian</td>
<td>119</td>
<td>80.4</td>
</tr>
<tr>
<td>Bisexual</td>
<td>13</td>
<td>8.8</td>
</tr>
<tr>
<td>Straight/Heterosexual</td>
<td>6</td>
<td>4.1</td>
</tr>
<tr>
<td>Queer</td>
<td>6</td>
<td>4.1</td>
</tr>
<tr>
<td>Questioning</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Other (Please Specify)</td>
<td>3</td>
<td>2.0</td>
</tr>
</tbody>
</table>

N8. N=148; Two of the ‘other’ responses indicated their sexuality as “pansexual” and “lesbian attitudinally; asexual practically”

One hundred and thirty participants (87.8%) stated that they were biologically female (e.g., born female / cisgender female) with an additional two participants who preferred not to identify their sex (1.4%)¹. Furthermore, an additional 16 participants identified as a

¹ One identified their sexuality as lesbian, while the other identified their sexuality as ‘other’ but did not elaborate when prompted.
transgender woman (10.8%), with the majority of these individuals identifying their sexuality as lesbian (n=6), bisexual (n=4) or straight/heterosexual (n=3).

Findings

The following section presents findings from the online survey, organised by key themes including (1) participants’ reported engagement/usage of health and social service providers; (2) participants’ sense of their health and social service providers’ LGBTIQA+-awareness and inclusivity; (3) participants’ reported health, psychological wellbeing and community belonging; and (4) participants reported engagement with the internet.

**Engagement with Local Health and Community Service Providers**

Participants were asked a series of items about their engagement with health care, social services and aged-care providers in their local area (Figures 12, 13 and 14 below). As expected, the majority of participants (92%) indicated that they had visited a medical centre or specialist. Much smaller numbers of participants indicated that they had used community social services (26%) and even fewer had used either aged-care or residential health services (11%).

*Figure 12. Participants’ engagement with local medical centre and/or specialist, n=148*
A series of items asked participants to report on their frequency of engagement with a variety of community social services in their local area on a three-point Likert scale including “often”, “rarely” or “never”. Participants could also indicate that they were “not aware of any such services” in their community or that they did “not require such services.” Figure
15 presents results for those individuals who indicated some form of engagement with these services. As can be seen, participants were most engaged with their local library (n=95; 68% of the eligible sample selecting “often” or “rarely”) and their local women’s and/or LGBTIQ organisations/clubs (n=85; 61% selecting “often” or “rarely”). Participants were least engaged with their local religious organisations, with just over half (n=72; 52%) indicating that they “never” connected with these. Additionally, participants were least aware of women’s and/or LGBTIQ organisations in their communities, with 13% of women (n=19) responding in this manner.

**Figure 15. Frequency of connection to local community social services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Often</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Library</td>
<td>56</td>
<td>34</td>
<td>60</td>
</tr>
<tr>
<td>Carer’s Support</td>
<td>60</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Religious</td>
<td>5</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Aged-Cared</td>
<td>11</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Services for Indigenous Australians</td>
<td>11</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Cultural Centres</td>
<td>20</td>
<td>21</td>
<td>34</td>
</tr>
<tr>
<td>Women’s and/or LGBTIQ Orgs.</td>
<td>59</td>
<td>51</td>
<td>51</td>
</tr>
</tbody>
</table>

NB: N=145 total responses; “Not aware” and “Don’t require” responses for each item were not included in the above graph for ease of interpretation; Three participants had missing data for this item.

**LGBTIQ-Awareness of Health and Social Service Providers**

Eight individual items enquired into participants’ experiences of LGBTIQ-inclusive practices in their interactions with health, community and social services. These original items were designed to ascertain visibility at both an institutional level (e.g. inclusive intake forms; knowledgeable/trained staff; visibility within the physical space) and an interpersonal level (e.g. staff use of inclusive language; demonstrated positivity with regards to sexuality and...
gender diversity). Items asked participants how true each of the eight statements were, as measured on a 5-point Likert scale, ranging from (1) “not at all true” to (5) “completely true”. As can be seen in Table 5, regardless of participant location, women ranked positive statements relating to institutional support (three items shaded grey) as “less true” than interpersonal items, with mean scores hovering between the anchor points of “somewhat untrue” and “neutral”. A comparison of mean scores for those participants located in “major cities” as compared to all other locations revealed higher mean scores for women in city locations across seven of the eight items. While mean differences across these items were not seen to be large enough so as to be statistically significant, it is noteworthy that mean score differences by participant location for the item referring to practitioners being “knowledgeable about LGBTI resources” did approach statistical significance (Table 5).

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3 As previously-outlined, postcode data was categorised using the Accessibility/Remoteness Index of Australia (ARIA).

westernsydney.edu.au
Table 5. Comparison of Support Scale item means (M) and standard deviations (SD) by geographic location

<table>
<thead>
<tr>
<th>Item</th>
<th>Major Cities (n = 86)</th>
<th>All Other Locations (n = 62)</th>
<th>t value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;In my experience, health practitioners/social service workers...&quot;</td>
<td>M: 4.06 SD: 1.03</td>
<td>M: 3.95 SD: 1.05</td>
<td>0.62</td>
<td>0.539</td>
</tr>
<tr>
<td>... would respond in a positive way if I disclosed that I am same-sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>attracted, transgender and/or intersex.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>... are welcoming to same-sex attracted and gender diverse women</td>
<td>M: 3.85 SD: 1.13</td>
<td>M: 3.77 SD: 1.09</td>
<td>0.40</td>
<td>0.689</td>
</tr>
<tr>
<td>... would respond in a positive way if I brought a same-sex partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>with me to the service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>... would provide confidentiality and privacy when seeking support</td>
<td>M: 4.16 SD: 0.99</td>
<td>M: 3.89 SD: 1.10</td>
<td>1.59</td>
<td>.114</td>
</tr>
<tr>
<td>specifically related to my sexuality or gender expression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>... use inclusive language when discussing family life, sexual and/or</td>
<td>M: 3.57 SD: 1.26</td>
<td>M: 3.45 SD: 1.26</td>
<td>0.56</td>
<td>.575</td>
</tr>
<tr>
<td>romantic partners (e.g. ‘partner’ rather than ‘husband’ or ‘boyfriend’)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>... provide access, intake and/or information forms that are</td>
<td>M: 2.81 SD: 1.32</td>
<td>M: 2.87 SD: 1.31</td>
<td>-0.26</td>
<td>.796</td>
</tr>
<tr>
<td>inclusive of diverse sexualities and gender expression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>... are knowledgeable about LGBTI resources</td>
<td>M: 2.84 SD: 1.24</td>
<td>M: 2.50 SD: 1.10</td>
<td>1.72</td>
<td>.088</td>
</tr>
<tr>
<td>... demonstrate a commitment to supporting LGBTI individuals via</td>
<td>M: 2.59 SD: 1.36</td>
<td>M: 2.32 SD: 1.10</td>
<td>1.33</td>
<td>.183</td>
</tr>
<tr>
<td>visual cues (poster, flyers, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N=148; Items measured on a 5-point Likert scale, with anchor points: (1) not at all true; (2) somewhat untrue; (3) neutral; (4) somewhat true; (5) completely true
A series of items asked participants about their interactions with health care professionals with specific regards to their sexuality and/or gender identity. The first of these enquired into participants’ sense of their health care providers’ presumptions of their heterosexuality and or cisgender identity. Majority numbers of participants (72%) indicated that these professionals either “always” (n=45) or “usually” (n=60) presume that they are heterosexual and/or cisgender.

**Figure 16. Health care providers’ presumption of heterosexuality/cisgender**

Do health professionals presume you are heterosexual and/or cisgender?

<table>
<thead>
<tr>
<th>Response</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>3</td>
</tr>
<tr>
<td>I don’t know</td>
<td>15</td>
</tr>
<tr>
<td>Not usually</td>
<td>22</td>
</tr>
<tr>
<td>Yes, always</td>
<td>45</td>
</tr>
<tr>
<td>Yes, usually</td>
<td>60</td>
</tr>
</tbody>
</table>

*NB: N=145; Three participants had missing data for this item.*

Participants were further asked about the importance they place on their health care providers’ attitude to their sexuality and/or gender identity using a 7-point Likert scale item. Almost half of participants (48%) indicated that their provider’s attitude was “very important”, with another quarter of the group indicating the importance of provider’s attitude (i.e., responding either 5 or 6 on the Likert measure, as seen in Figure 17).
In line with this, if participants indicated that they had seen a health care professional within the last three years, they were asked whether or not they had shared their sexuality identity and/or gender identity with this individual. As seen in Figure 18, majority numbers of participants had shared their identity (n=113; 78%), with women identifying as transgender (n=16) significantly more likely to have disclosed their identity to their health care professional (t=2.38, p<.05). Women who had completed university degrees (n=102), as compared to the rest of the sample, were also more likely to have disclosed their identity, with a magnitude of difference approaching statistical significance (t=1.94, p=.056).

Of the 113 individuals who had shared their sexuality and/or gender identity with their health care providers, 64% (n=72) indicated that their health care professional had been “completely comfortable” with their disclosure, with another 20% indicating that their health care professional had been “somewhat comfortable” (Figure 19). Fifteen participants indicated that their health care professional had “ignored” their disclosure of information.
Figure 18. Disclosure of sexuality/gender identity to health care provider

Told that person about your sexuality and/or gender identity?

- Yes: n=113, 78%
- No: n=32, 22%

NB: N=145; Three participants had missing data for this item.

Figure 19. Sense of health care provider’s comfort with disclosure

How comfortable was your healthcare provider with your disclosure?

- Completely comfortable: n=72
- Somewhat comfortable: n=23
- Ignored it: n=15
- I do not recall: n=3

NB: N=113; 32 participants were ineligible for this item; 3 had missing data.

As a follow-up item, participants were asked whether or not they felt their health care provider’s attitude to their sexuality and/or gender identity influenced the quality of the
medical treatment they received. Most felt that there had been no impact (n=88; 61%), with another 25% suggesting that this had had a positive impact on their treatment. Thirteen participants felt that their providers’ attitude had a negative influence on their treatment.

A similar set of items asked participants about their experiences with social service providers in their community or, “the people who staff your library, your aged-care services, the CentreLink providers, etc.” In terms of these individuals’ presumption of participants’ heterosexuality/cisgender status, with the exception of larger numbers of participants indicating that they “did not know”, responses mirrored those provided in the previous set of items. Most participants (62%) responded that social service providers either “always” or “usually” presumed that they were heterosexual and/or cisgender (Figure 21).
A follow-up item asked about the importance participants place on their social service providers’ attitudes towards their sexuality and/or gender identity. As with the previous item, this was measured on a 7-point Likert scale and, likewise, the majority of participants indicated that social services providers’ attitudes were of importance to them, with 43% indicating this was “very important” and another quarter of participants indicating a positive, non-neutral attitude (either 5 or 6 on the 7-point scale; see Figure 22).
To continue this line of questioning, if participants they had engaged with a social service provider within the last three years, they were asked whether or not they had shared their sexuality identity and/or gender identity with this individual. As seen in Figure 23, majority numbers of participants had indicated that they had not engaged with a social service provider within the last three years (n=79; 53%). Of the minority number of participants who had engaged with a social service and disclosed their sexuality and/or gender identity, half indicated that the social service provider had been “completely comfortable” with their disclosure, with another 40% indicating that the social service provider had been “somewhat comfortable” (Figure 24). A small number of participants (n=3) indicated that the social service provider had “ignored” their disclosure of information.

**Figure 23. Disclosure of sexuality/gender identity to social service provider**

<table>
<thead>
<tr>
<th>Told that person about your sexual and/or gender identity?</th>
<th>n=79, 53%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>n=40, 27%</td>
</tr>
<tr>
<td>No</td>
<td>n=24, 16%</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

NB: N=143; Five participants had missing data for this item.
Figure 24. Sense of social service provider’s comfort with disclosure

How comfortable was the social service provider with your disclosure?

- Completely comfortable: 20
- Somewhat comfortable: 16
- Ignored it: 3
- I do not recall: 1

NB: N=40; 103 participants were ineligible for this item; 5 had missing data.

As a follow-up item, participants were asked if, in their general experience, they felt that their social service providers’ attitude toward their sexuality and/or gender identity impacted the quality of the social service they had received. As can be seen in Figure 25, half of the group felt that this had not impacted “in any way”, with an additional 30% indicating that they “did not recall”. Of those who indicated impact, most felt that the impact had been a positive one (n=18). Eleven participants indicated that their social service providers’ attitude toward their sexuality and/or gender identity had a negative impact on the quality of the social service they had received.
Sense of Personal Wellbeing and Belonging

Participants were asked a series of items targeting their sense of health and personal wellbeing as well as their sense of belonging to their local communities. The first of these was a simple 7-point Likert scale self-rating of their health, ranging from “Excellent” to “Terrible”. As can be seen in Figure 26, the majority of participants indicated that their health was positive, as indicated by responses “Excellent”, “Very Good”, “Good” and “Fair” (n=127; 87%). T-tests revealed no significant differences in self-reported health outcomes by participant location; in other words, individuals in major city, inner and outer regional locations were just as likely to indicate positive/negative health.

\[
\begin{align*}
&\text{I do not recall} \quad n=42 \\
&\text{Yes, in a negative way} \quad n=11 \\
&\text{Yes, in a positive way} \quad n=18 \\
&\text{Not in any way} \quad n=72
\end{align*}
\]
Participants also completed the World Health Organisation’s “WHO-5” measure (Bech, 2004) – a reliable⁴, five-item self-reporting measure on overall individual psychological wellbeing. Participants were asked if they had experienced a series of feelings over the last two weeks (e.g. “I have felt calm and relaxed”) with responses measured on a 6-point Likert scale ranging from “At no time” (0) to “All of the time” (5). Looking across the group, the mean (average) score for participants was 2.92 (SD=1.13), indicating that, on average, participants had a sense of psychological wellbeing closest to the Likert response of 3 (e.g. “Most of the time”). Participants who had disclosed their sexuality and/or gender identity to their health care providers within the three years preceding the survey (n=113; M=3.04, SD=1.15) reported a higher mean WHO-5 score than those who had not (n=32; M=2.63, SD=1.01), although this difference was not large enough so as to be statistically significant.

As previously outlined, 13 participants felt that their health care providers’ attitude toward their sexuality and/or gender identity negatively impacted their treatment, with three times as many indicating that their attitude had a positive impact (n=36). The majority felt there was no impact of their providers’ attitude (n=88). A comparison of WHO-5 scale outcomes for each of these response categories was conducted, revealing statistically significantly different mean scores across the cohort [F (3,141) = 2.90, p = 0.037]. Post-hoc testing located this statistically significant difference between the cohorts selecting “Yes, in a positive way” and “Yes, in a negative way” (see Figure 27).

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⁴ The Cronbach’s alpha measure of inter-item reliability for the WHO-5 scale for the current sample was 0.90, with corrected item-total correlations all above 0.70.

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In order to measure participants’ sense of community belonging, a modified version of the psychological subscale of Hagerty and Patusky’s (1995) Sense of Belonging Instrument was used, with the phrase “local community” substituted as the locale of interest. While the scale reliability for the original version of this measure is well-documented, an examination of the data confirmed that this modified version was also reliable. Items enquired as to whether or not participants felt that they “fit in” or were “valued” in their local community and responses were measured on a 4-point Likert scale ranging from “Strongly disagree” (1) to “Strongly agree” (4). Sample items read as follows: “I feel like an outsider in most situations in my local community” and “I don’t feel that there is any place where I really fit in this community”.

Looking across the group, the mean (average) score for participants was 2.67 (SD=0.69), sitting close to the scale mid-point of 2.5 which would represent neutrality (e.g. between “Disagree” and “Agree”). As with the WHO-5 measure, those individuals who indicated that they had shared their sexuality and/or gender identity with their health care providers had a higher reported mean score (M=2.69, SD=0.71 for the group who had disclosed [n=113]; M=2.57, SD=0.62 for the group who had not disclosed [n=32]), although this difference was relatively small.

As previously outlined, 11 participants felt that their social service providers’ attitude toward their sexuality and/or gender identity negatively impacted the quality of the social services they received. Eighteen participants felt that these individuals’ attitudes had had a positive influence on the quality of these services and the majority felt there was no impact of their social service providers’ attitude (n=72). A comparison of the Sense of Belonging – Psychological subscale outcomes for each of these response categories was conducted,

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NB: Chart does not include the n=8 participants who selected “I do not recall”; N=145, Three participants had missing data across these two measures.

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5 The Cronbach’s alpha measure of inter-item reliability for the modified Sense of Belonging, Psychological subscale for the current sample was 0.97, with corrected item-total correlations all above 0.55.
revealing statistically significantly different mean scores across the cohort [F (3,139) = 3.58, p = 0.015]. Post-hoc testing located this statistically significant difference between the cohorts selecting “Yes, in a positive way” and “Yes, in a negative way” (see Figure 28).

**Figure 28. Belonging scale mean differences by reported influence of providers’ attitude**

![Figure 28](image)

*NB: Chart does not include the n=42 participants who selected "I do not recall"; N=139, Nine participants had missing data across these two measures.*

**Inter-measure relationships**

In order to investigate relationships among key variables of study interest, correlations were conducted across four of the main measures as outlined previously, participants’: (1) self-rating of health; (2) sense of community belonging; (3) psychological wellbeing (WHO-5); and (4) perceived LGBTIQ-inclusivity.

With regards to this last variable, a scale measure was created combining eight original items investigating LGBTIQ-inclusive practices of health and social service workers. These items were explored individually in an earlier section of these findings (“LGBTIQ-Awareness of Health and Social Service Providers”). The scale measure was found to be internally consistent within the participant sample\(^6\).

As can be seen in Table 6, each of these four measures was significantly positivity correlated with the others, indicating that participants’ score on one scale measure either increases or decreases, their scores on each of the others tend to follow the same directionality (i.e., either also increasing or decreasing). As expected, participants’ self-rating of their health had the strongest correlation with their self-rating of psychological wellbeing (r=0.59, p<.01), indicating that participants who rated their health highly also reported positive psychological wellbeing, and vice versa. Likewise, participants’ reported psychological

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\(^6\) The Cronbach’s alpha measure of inter-item reliability for the Perceived LGBTIQ-Inclusivity scale for the current sample was 0.91, with corrected item-total correlations all above 0.60.
wellbeing was also strongly positively correlated with their sense of reported local community belonging (r=0.55, p<.01). Of greatest interest to the current study, participants’ experiences of LGBTIQ-inclusivity were also significantly positively correlated with each of these three measures: (1) self-rated health (r=0.25, p<.01); (2) psychological wellbeing (r=.24, p<.01); and (3) sense of community belonging (r=.46, p<.01).

Table 6. Correlations between self-reported health, wellbeing and community connection

<table>
<thead>
<tr>
<th>Measures of Health/Connection</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Health Self-Rating</td>
<td>Pearson Correlation</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>145</td>
<td></td>
</tr>
<tr>
<td>2. Sense of Community Belonging</td>
<td>Pearson Correlation</td>
<td>.391**</td>
<td>___</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>145</td>
<td>146</td>
</tr>
<tr>
<td>3. WHO-5</td>
<td>Pearson Correlation</td>
<td>.588**</td>
<td>.551**</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>145</td>
<td>146</td>
</tr>
<tr>
<td>4. Perceived LGBTI-Inclusivity</td>
<td>Pearson Correlation</td>
<td>.253**</td>
<td>.462**</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>145</td>
<td>146</td>
</tr>
</tbody>
</table>

NB: **p<.01

Internet Usage

A series of items investigated participants’ online behaviours, particularly with regards to online help-seeking behaviours. Participants were asked whether or not they used the Internet to look up health information, inclusive of sexual health and mental health. As can be seen in Figure 29, this cohort appeared to engage with the Internet in this manner at least some of the time with minority numbers reporting that they either “rarely” (n=14; 10%) or “never” (n=12; 9%) looked up health-related information online.
Figure 29. Reported internet usage – health information

Do you use the Internet to look up health information?

- All of the time: n=22
- Often: n=48
- Sometimes: n=43
- Rarely: n=14
- Never: n=12

NB: N=139; Nine participants had missing data for this item.

Two open-ended follow-up items asked participants about what types of health information they looked for online and what they found helpful about looking up health information online. Respondents sought a range of health information to gain a better understanding of their own and other people’s symptoms and diagnoses (e.g., mental and physical); hormone replacement therapy; drug interactions and contraindications; medication, vitamin and alternative therapy efficacy and side effects; sexual and reproductive health for themselves, others and in relation to aged care; trans* health issues; weight management, nutrition and fitness; as well as where to find LGBTIQ-friendly services and practitioners. Respondents felt that looking up health information online was helpful because it allowed them to have quick access to diverse and reputable perspectives on health information and made it easier to understand medical terminology.

One respondent highlighted the perspective of many participants, noting that online information “helps me to have more informed discussions with service providers”. This agency is important, as noted in the qualitative data chapter above, considering that women felt they needed to be well informed in order to navigate health providers and systems in relation to their sexual and/or gender diversity. Given the difficulties women encountered when navigating providers and services it is not surprising that the majority found the anonymity and privacy of online health information to be helpful – possibly because it did not expose them to prejudice or discrimination from others.

Likewise, participants were asked about whether or not they used the Internet for community building/engagement, “to connect with an online community of friends, either via social media or blogging sites”. While percentages of those who indicated engaging in this activity either “rarely” or “never” were roughly the same as above (18%), larger
numbers of women indicated that they engaged in this online activity “all of the time” (n=38; 27%) or “often” (n=54; 39%), as seen in Figure 30.

**Figure 30. Reported internet usage – online community**

An open-ended item continued this line of enquiry asking participants about which sites they used to connect with friends/community online and why. *Facebook* was the most popular way for respondents to connect to their support network. This was because participants’ friends and families used the social media platform. Further, many of the LGBTQI groups that they were interested in or participated with had Facebook Groups and Pages to facilitate a sense of community and belonging as well as local, national and international interaction. One woman used Facebook to connect to “Lesbian or queer, Black/people of Colour events & info”. This allowed her to “Lessen my feelings of isolation while looking for validation & acceptance”. Another woman noted “I have virtual friends in many countries. I travel the world from my office chair”. Other means for connecting online included *Instagram* and *Twitter* while to a much lesser extent LGBTQI specific websites, chatrooms and forums. When asked how or if the internet helped older GSD women, participants mentioned that it kept them connected to family and friends, LGBTQI communities, current affairs but also gave them an avenue to develop sexually intimate relationships in a protected safe and private space.

Participants were further asked to consider the internet habits of other older GSD women, enquiring into whether or not they thought these individuals used the Internet differently than others in the same age demographic (Figure 31). Almost half of the cohort indicated that they were not sure and a minority number of individuals (n=13) felt that this cohort did use the Internet differently. One woman noted that non-GSD women’s “internet use is not
from desperation as they can connect easily elsewhere”, with another woman reinforcing this statement by noting that older GSD women “are more socially isolated” compared to non-GSD women. One woman highlighted the thoughts of many respondents and noted that GSD women “look for self-help answers on [their] own (GSD) physical and mental health, and news on LGBTIQ events, news, government policies, marriage equality...There is No One Local who is any use on this whatsoever!”

**Figure 31. Assumptions about others’ use of the internet**

<table>
<thead>
<tr>
<th>Yes</th>
<th>n=19, 13%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>n=47, 32%</td>
</tr>
<tr>
<td>I’m not sure</td>
<td>n=73, 49%</td>
</tr>
</tbody>
</table>

*NB: N=139; Nine participants had missing data for this item.*

A final item in this series asked participants about whether or not they used the Internet for LGBTIQ-specific information. Most participants indicated that they engaged in this activity “sometimes” (n=47), with almost half indicating that this is something they did “rarely” or “never” (47%).
When asked what kind of information they would like to have available on the internet the majority were in interested in legal issues including: wills, immigration, same-sex marriage and de facto rights, LGBTIQ human rights, discrimination reporting and procedures as well as how to manage the end of a long term same-sex relationship. Others wanted more information about LGBTIQ friendly services, practitioners and supports especially in regional locations where they noted that there was a severe shortage of explicit presence of such supports.
Chapter 5: Summary and Interpretation of the Findings

Qualitative Findings Summary

1. Participants often encountered health practitioner/s who assumed they were heterosexual. They felt that this assumption blinds providers to the possibilities of sexual diversity and assumes everyone is heterosexual.

2. Participants argued that addressing their healthcare needs as GSD women also required practitioners and professionals to recognise and respond to the intersections of their GSD identities with other aspects of their identity.

3. Participants felt that training would enable providers to offer not only appropriate services, but services that are implemented in a manner that is culturally sensitive.

4. Older GSD women actively seek respectful and informed practitioners, where they can feel safe/comfortable, which are often spaces where they feel and can be particularly vulnerable.

5. Aged care facilities were perceived to be, and experienced as, overwhelmingly heteronormative spaces that failed to be inclusive of GSD communities. As such, many participants perceived homophobia to be inevitable when engaging with them aged care services. This perception was largely in response to the fact that many aged care service providers have religious affiliations which traditionally were exempt from anti-discrimination legislation and therefore permitted to discriminate.

6. Several issues contributed to the GSD women's in/ability to access social services and events. These factors included physical disability, communication difficulties, limited types and frequency of events, location of events and financial restrictions.

7. The invisibility of older people in the community was identified as being an issue. The GSD community, in general, has been largely youth-focused for decades. A growing ageing population more generally, however, also means that increasingly large numbers of GSD women are susceptible to invisibility and are naturally fearful of this occurring.

Quantitative Findings Summary

1. While most participants had engaged with healthcare providers, such as general practitioners or specialists, only one-quarter of participants had engaged with social services in their local communities.

2. While the majority of participants felt that their healthcare providers’ attitude to their sexuality and/or gender diversity was important, nearly three-quarters of participants felt that their healthcare providers either “always” or “usually” presumed that they were heterosexual and cisgender.
3. Participants who felt that their healthcare providers reacted in a positive way to their disclosure of their sexuality and/or gender diversity reported significantly higher psychological wellbeing.

4. Participants who felt that their local community social service workers reacted in a positive way to their disclosure of their sexuality and/or gender diversity reported significantly higher sense of community belonging.

5. Participants’ experiences of LGBTIQ-inclusivity from local health and social service providers were significantly correlated with their reported psychological wellbeing, their sense of community belonging and their health self-rating. These findings point to a relationship between affirming health/social service experiences and enhanced sense of connection, health and wellbeing.

Interpretation of the Findings

The current study points to the unique challenges faced by older GSD women as they navigate health, aged and social services. Some of these appear due to a deficiency of provider resources and providers’ – particularly health care service providers’ – inadequate training with regards to gender and sexuality diversity, especially as these pertain to older generations of GSD individuals. GSD women across the state emphasised the need for health care providers to acknowledge their GSD status, yet in many cases their romantic/sexual relationships were ignored or their gender and sexuality presumed as cisgender or heterosexual.

As demonstrated within this study, older GSD women experience challenges related to dominant societal understandings of gender and sexuality. Due to homophobia (Anderson, Healy, Herringer, Isaac, & Perry, 2001; Grigorovich, 2015a; Sinding et al., 2004), fear of discrimination (Sinding et al., 2004), heteronormative assumptions and dominant heterosexual discourses (Barbara, Quandt, & Anderson, 2001; Bjorkman & Malterud, 2009; Hughes & Kentlyn, 2015), older lesbian and bisexual women may not be comfortable disclosing their gender and/or sexual identity to health and social service providers. Consequently, some older GSD women have felt social pressure to outwardly project a heteronormative lifestyle and are, thus, essentially forced back into the closet (Barrett, et al., 2015) with severe implications for their health and access to care. While it is noteworthy that the majority of survey participants reported having disclosed their GSD identities to healthcare providers, other findings from the current study appear to demonstrate such links, with participants reporting feeling as if their gender and sexuality diversity was ‘invisible’ to their service providers, and in many cases felt that keeping this element of their identity invisible was a protective strategy, due to concerns about providers’ attitudes towards GSD more broadly. Yet, such actions appeared to be not without their own set of costs; as survey data analysis revealed, disclosure of one’s sexuality and gender diversity and, most importantly, providers’ positive reactions to this disclosure were linked to women’s self-reports of their psychological wellbeing and sense of community connection.
The key interpersonal challenges experienced by older GSD women participating in this study were fears of homo/transphobia, grappling with the dilemma of disclosure and striving for community connection/belonging in relation to both seeking and receiving support. The literature highlights older women’s diverse attitudes towards the question of disclosure of sexual orientation to care providers, with some viewing disclosure as integral and others viewing disclosure as risky, and one’s sexuality and gender identity as private (Barbara, et al., 2001; Grigorovich, 2015a; Hughes & Kentlyn, 2015). Similar diverse attitudes were apparent in the current study. Both actual and expected discrimination is argued to be one of three major barriers in relation to LGBTIQ individuals’ experiences accessing health care services and is one of many concerns facing LGBTIQ individuals (Koh, et al., 2014). For instance, more than 50% of health care providers have reported that they are uncomfortable dealing with LGBTIQ issues (Khan et al., 2008). Findings from the current study echo such findings, identifying disclosure concerns as an elemental and critical predictor of their engagement with local area services. Given links apparent in the survey data between participants’ experiences of negative reactions to their sexuality or gender diversity by service providers and their reported health and community connection outcomes, there is a demonstrated need for health care practitioners to undergo GSD-inclusivity training. Specifically training that encourages providers to interrogate their own beliefs and work towards making themselves transparent in regards to LGBTIQ-friendly policies and GSD visibility within their specific settings would assist in ameliorating GSD women’s expectations of homophobia and the dilemma of disclosure. Furthermore, as demonstrated, such LGBTI inclusive strategies – both interpersonal and institutional – could tangibly impact older GSD women’s perceptions of their health outcomes and sense of community belonging.

Described as an invisible minority (Blando, 2001), older GSD women are impacted by the intersections of their triple minority status, inclusive of age, gender, and sexuality. As we have found in our own work, these intersections tangibly impact older GSD women’s experiences with health, aged, and social care. Findings of the current project are commensurate with other research in the field specifically highlighting older GSD women’s compromised access to these services (Grigorovich, 2015b). As our participant Linda pointed out, these barriers can be physical as well as social, with tangible physical health barriers impacting an already limited sense of access to local area social groups. Accordingly, this work also highlighted perceptions of GSD-inclusive outreach as being predominantly youth-focused, exposing limited visibility/accessibility of what programs specifically for older GSD do exist.

This work also highlighted older GSD women’s information sharing and community building in online spaces, perhaps as a response to mobility and accessibility concerns. Participants in the current study indicated that they access and engage with health and social support resources online with some regularity. As previous research (Munt, Bassett, & O’Riordan, 2002) has found, online spaces can provide GSD women with information, as well as access to a community of similar individuals, providing an important social connection, support and important (sub)cultural knowledge about their own GSD communities. Women in this study indicated that they use the internet to enhance their sense of social connection and to access to access information regarding a variety of their unique healthcare needs. However, participants also pointed to a dearth of information with regards to their rights as GSD
women as well as content that connects them to local area support networks for this cohort. It, therefore, is crucial that quality online resources are available and promoted specifically where GSD women are, both on- and offline, as a protective factor for their health and wellbeing.

As research from the field highlights, the majority of aged care facilities ignore the issues of diversity regarding gender and sexuality (Phillips & Marks, 2006; Phillips & Marks, 2007). Many participants viewed health/aged care facilities as heteronormative spaces where prejudice toward LGBTIQ communities was expected. This was particularly apparent in qualitative research participants’ expectations around aged care facilities, many of which have religious affiliations. These participants described the lack of LGBTIQ visibility in facilities’ marketing materials and a noticeable lack of facilities’ attempts to promote themselves as GSD-inclusive spaces. Furthermore, some participants accessing (or anticipating accessing) home-care services felt the need to make their own homes adhere to heteronormative standards due to fears of discrimination, particularly given their own previous experiences or the reported experiences of GSD friends.

Findings from the current project highlight that health, social and aged-care support services for NSW older GSD women are not adequately addressing their specific needs and concerns. This work points to the need to reassess and revise current policies, programs and staff training in the area in order to provide LGBTIQ-inclusive practices as a critical strategy for improving quality of care and GSD women’s access to this care. This work further supports the need for community/health care interventions to improve access and quality of care for older GSD women.

**Study Limitations**

Although the study provides a fresh look into the lives and perspectives of older GSD women in NSW, there are some study limitations to be considered.

While interviews exposed critical issues for GSD women in NSW, overall generalisability of the findings are limited due to the small sample size for this element of data collection. Likewise, while key informants were active on the project’s online forum and social media pages, these sites did not attract the breadth of engagement initially hoped for. Thus, the perspectives offered through these methods are not necessarily representative of the larger population of older GSD women in NSW. However, this somewhat limited up-take of online forum engagement reiterates the difficulties inherent in attempting to access this hidden population. Our own experiences provide some explanatory evidence of the overwhelming lack of research with older GSD women. It is also worth noting that research to date on GSD women’s experience with health, aged and home care services has exclusively focused on lesbian-identifying women with only three studies explicitly acknowledging the inclusion of bisexual-identifying women (Smith et al. 2010, Leonard et al., 2012, Grigorovich, A. (2015). Although we did have some diverse engagement with the online survey element of data collection, the current project reiterates the need for further research specifically targeting the voices, views and experiences of bisexual, transgender, queer and intersex women as they navigate access to social, health and aged-care services.
While recruitment efforts for the online survey element of data collection did yield sufficient sample sizes for basic bivariate statistical analyses, larger numbers were needed for more sophisticated multivariate analyses including predictive modelling. We were pleased to have obtained engagement with women from across the state, and were unsurprised to see clustering of participants in metropolitan areas. Nevertheless, the lack of participant diversity (economic, linguistic, cultural) further points to the need for additional research with this population specifically examining points of intersectionality.

A major strength of this study was the ability to meet women where they were (as confirmed by the survey open-ended questions) – on Facebook. The limitation comes in the attempt to engage with women both on an external website as well as social media. However, with the majority of women choosing Facebook to connect with LGBTIQ supports and services this study has confirmed the viability to online platforms to engage older GSD women and improve their social connectedness, visibility and wellbeing.
Chapter 6: Recommendations & Conclusion

Recommendations

1. Given the increasing ageing population and greater recognition of LGBTIQ people and their relationships there needs to be better supports for older GSD women as they transition into, and through, retirement, age related health care, aged care and palliative care services. There exists a dire need for a re-examination of the quality and care provided at health, social, aged care, and retirement services in order to address these needs.

2. Health, social and aged care providers can change GSD women’s expectations of homophobia, the dilemma of disclosure, and feelings of connection and belonging by engaging in training and making themselves allies to LGBTIQ-friendly policies (e.g., displaying a rainbow flag).

3. Education is required not only to raise awareness but also provide the professional, regardless of their discipline or role, knowledge that can support the healthcare needs of GSD women.

4. Given that not all health, social and aged care institutions adequately address the specific needs of older GSD women there is a dire need to re-work the policies and programs of such systems. By addressing these needs, there will be a much higher number of LGBTIQ-inclusive services available for GSD women.

5. There is need for appropriate health, social and aged care services and practices, thus improving the quality and care provided post-retirement—that is, offering LGBTIQ-specific services within health, social and aged care services.

6. As the views and experiences of older bisexual, transgender, queer and intersex women in accessing health, social and aged care services remain largely unknown further research is very much needed.

Conclusion

This research aimed to examine and understand older GSD women’s experiences and needs related to health, aged-care and social support services. Older (e.g., 55 years and older) gender and sexually diverse women (GSD) in New South Wales (NSW), are underserved by health, social and aged-care programs. Not only is this a concern for these women in NSW but also an emerging issue for ageing LGBTIQ people across Australia.

The findings indicate that older women with diverse genders and sexualities continue to experience stigma and marginalisation from healthcare institutions, which impact their health access, engagement and outcomes. Practitioners often assume patients are heterosexual, and fail to take into account their specific needs as lesbian and transwomen with intersecting identities. The women in this study express concerns about aged care
services as being heteronormative, homo/transphobic, and not able to support their needs. They respond by considering and adopting strategies for remaining safe, such as staying invisible to their carer, and recommend the need for greater LGBTIQ staff training and LGBTIQ-friendly facilities.

These findings point to a relationship between affirming health/social service experiences and enhanced sense of connection, health and wellbeing. Importantly, the study indicates that older GSD women experience challenges when accessing health, aged and social services at individual, interpersonal, institutional and cultural levels. This suggests that interventions are needed at all levels to improve access and quality of care to older GSD women.
References


Rowan, N. L., & Giunta, N. (2016). Lessons on social and health disparities from older lesbians with alcoholism and the role of interventions to promote culturally competent services. *Journal of Human Behavior in the Social Environment, 26*(2), 210-216.


Appendices

Appendix One: Research Recruitment Material

Postcards sent out to community organisations:

The Welcoming Social Wellness Project

Are you a gender or sexuality diverse woman over the age of 55?

We want to hear from you!
Researchers at Western Sydney University would like to better understand women’s thoughts and experiences with local health, social and aged care services. This information will help us understand the impact of these services on women’s wellbeing and sense of community.

IF YOU ARE INTERESTED IN PARTICIPATING OR FINDING OUT MORE ABOUT THIS STUDY, PLEASE CONTACT US

Dr. Tinashe Dune
Phone: (02) 46203655 Email: t.dune@westernsydney.edu.au
Website: www.silvergswomen.com

Postcards sent out to regional and urban centres using AvantCard
Appendix Two: Other Project Outcomes

In addition to the important findings produced whilst undertaking this mixed-methods study, the project has also led to the following outcomes:

- **Conference presentation/s** – to present and discuss the project outcomes and recommendations towards sustainable ways to support increased social wellbeing and connectedness amongst older GSD women.
- **Systematic review** – a literature review was conducted to examine the health, social and aged care experiences of older GSD women.
- **Project video** – summarising the project outcomes and recommendations to support increased social wellbeing and connectedness amongst older GSD women.
- **Project website resources** – during the period of the study NSW-based health and social support services for GSD women were added to the project website. In total 33 services were added, this included health services (n=14), social support networks (n=15) and ageing services (n=4) for GSD women. These were added in consultation with community partners, and were promoted via the Facebook page and the discussion forum used in this research project.
- **Capacity building** (Research Assistants, PhD and Master of Research students, Summer scholarship student)

The study, as part of the recruitment, published an article in the online magazine LOTL (June 2016). This provided both an opportunity to extend recruitment through GSD networks (as discussed in the Methodology section of the report), and was used as a tool for knowledge sharing to the GSD community about the needs and concerns facing older GSD women.
Appendix Three: Interview Protocol, Online Forum Questions and Survey Questions

Interview Protocol

1. **What are your social and health care needs as a GSD woman?**
2. **To what extent do the health and social services in your area meet your needs?**
   - How don’t they meet your needs?
   - What are the social, health, aged care services in your area?
   - Have you used them? What services do you access?
   - Why or why not?
   - How did you find out about these services?
   - Do you go elsewhere to access services?
   - What is the impact of engaging in these services on your gender and/or sexual identity?
   - What has been your experiences with these services?
   - What are the challenges and facilitators?
   - What makes you feel comfortable accesses the service?
   - What would make you feel comfortable – visual etc.

Online Forum Questions

1. **Tell us about your Social Needs**
   This forum discusses your social needs as a GSD woman and how well those needs are being met by health & social services.
   - What are your social needs?
   - To what extent do the health and social services in your area meet your social needs?
   - Is there anything else you’d like to add to the discussion on this topic?

2. **Tell us about your Healthcare Needs**
   This forum discusses your healthcare needs as a GSD woman and how well those needs are being met by health & social services.
   - What are your health care needs?
   - To what extent do the health and social services in your area meet your social needs?
   - Is there anything else you’d like to add to the discussion on this topic?

3. **Tell us about the Challenges to your health, wellbeing and belonging**
   This forum discusses challenges with accessing support for your social and health needs.
   - What challenges do you experience when accessing social services?
   - What challenges do you experience when accessing health services?
   - Is there anything else you’d like to add to the discussion on this topic?

4. **Tell us about** what helps you enhance **your health, wellbeing and belonging**
   This forum discusses what currently helps you access support for your social and health needs.
   - How do you find out information about health services? What (or who) helps you when looking for this information?
How do you find out information about social services? What (or who) helps you when looking for this information?

Survey Questions

Section 1: Some background information about yourself

1. What year were you born?

2. Are you an Australian Aboriginal and/or Torres Strait Islander person?
   - Yes
   - No
   - Not Sure

3. Are you?
   - Biologically female (e.g. born female/cis-gender female)
   - Transgender female
   - Intersex
   - I prefer not to identify my sex.

4. How would you describe your sexuality?
   - Lesbian
   - Bisexual
   - Straight/Heterosexual
   - Queer
   - Questioning
   - Other

4a. What sexuality label, if any, do you prefer to use? What do you like about this label?

5. What is your home postcode?

6. Where were YOU born?

7. In which country was your MOTHER/GUARDIAN born?

8. In which country was your FATHER/GUARDIAN born?

<table>
<thead>
<tr>
<th>PLEASE PUT ONE TICK IN ONE APPROPRIATE COLUMN UNDER EACH HEADING</th>
<th>6. Where were YOU born?</th>
<th>7. In which country was your MOTHER/ GUARDIAN born?</th>
<th>8. In which country was your FATHER/ GUARDIAN born?</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUSTRALASIA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Australia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 New Zealand, Fiji, Samoa, or Tonga</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Other in Australasia (please write country under column):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EUROLCE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Greece, or Italy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Poland, or Croatia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Turkey</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 UK: England, Ireland, Scotland</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Other in Europe (please write country under column):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASIA AND MIDDLE-EAST</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Cambodia, Indonesia, or Malaysia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 India, Sri Lanka, or Bangladesh</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Korea, or Japan</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
12. Lebanon, or Iraq
13. Vietnam, or China
14. Other in Asia/M-E (please write country under column):

AFRICA
15. Egypt
16. Somalia, or Ethiopia
17. Sudan, Kenya
18. Other in Africa (please write country under column):

OTHER
19. Other country: (Write country in appropriate column to respond to each question at the top)

Please tick how often you speak English in your household, if you only speak English, tick 5 ‘always’.

<table>
<thead>
<tr>
<th>9. In my household, I/WE speak English:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>Never</td>
</tr>
</tbody>
</table>

If you speak any languages other than English in your household, please answer Q 15 and Q 16. Otherwise, go directly to Q 17.

10. In my household I/WE also speak (pick one language only, the one you mostly speak in your household)

1 Aboriginal English 2 Samoan 3 Tongan 4 Fijian
5 Filipino/Tagalog 6 Malay 7 Cantonese 8 Mandarin
9 Vietnamese 10 Hokkien 11 Khmer 12 Tamil
13 Other Indian language 14 Hindi 15 Sri Lankan Arabic/Lebanese
17 Assyrian 18 Dari 19 Spanish 20 Italian
21 Greek 22 Swahili/ other African language
24 Other: Please write name of language spoken

<table>
<thead>
<tr>
<th>11. How often is this language spoken in your household?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>Rarely</td>
</tr>
</tbody>
</table>

12. WHAT IS THE HIGHEST LEVEL OF EDUCATION YOU HAVE COMPLETED:

<table>
<thead>
<tr>
<th>Grade 6 or less</th>
<th>Completed some of high school</th>
<th>Completed Year 10</th>
<th>Completed Year 12</th>
<th>TAFE or technical qualification</th>
<th>University degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
Section 2: Your feelings about local health and community service providers

Based on your interactions with each of the following health, community and social services, please indicate how true the following statements appear to be of the health practitioners and social service workers you have met at each of these locations:

NB: In final version, table will be modified to reflect specific services including:
1. local area health centre;
2. community social support;
3. community mental health support;
4. home care.

---

<table>
<thead>
<tr>
<th>In my experience, health practitioners/social service workers...</th>
<th>Not at all true</th>
<th>Somewhat untrue</th>
<th>Neutral</th>
<th>Somewhat true</th>
<th>Completely true</th>
<th>I don't know</th>
<th>I haven't accessed this service</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. ...either have responded OR would respond in a positive way if I disclosed that I am same-sex attracted, transgender and/or intersex.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>14. ...are welcoming to same-sex attracted and gender diverse women.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>15. ...provide access, intake and/or information forms that are inclusive of diverse sexualities and gender expression.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>16. ...are knowledgeable about LGBTI resources.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>17. ...demonstrate a commitment to supporting LGBTI individuals via visual cues (posters, fliers, etc.).</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>18. ...either have responded OR would respond in a positive way if I brought a same-sex partner with me to the service.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>19. ...acknowledge and support the needs of same-sex attracted and gender diverse women.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>20. ...either have provided OR would provide confidentiality and privacy when seeking support specifically related to my sexuality or gender expression.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>21. ...use inclusive language when discussing family life, sexual and/or romantic partners (e.g. ‘partner’ rather than ‘husband’ or ‘boyfriend’).</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>22. ...either have made me feel comfortable OR would make me feel comfortable being open about my</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

---

7 Items inspired by: “How to support sexual diversity in schools: A checklist” (ARCSHS, La Trobe University) & “GLBTI-inclusive practice audit for health and human services” (Gay and Lesbian Health Victoria, La Trobe University)
sexuality and/or gender diversity.

Section 3: Feelings about your personal wellbeing and belonging

For each of the five statements below, please indicate which response is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.\(^8\)

<table>
<thead>
<tr>
<th></th>
<th>All of the time</th>
<th>More than half of the time</th>
<th>Less than half of the time</th>
<th>Some of the time</th>
<th>At no time</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. I have felt cheerful and in good spirits.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>24. I have felt calm and relaxed.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>25. I have felt active and vigorous.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>26. I woke up feeling fresh and rested.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>27. My daily life has been filled with things that interest me.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

For each of the 17 statements below, think about your relationship to your local community (your town, suburb or area) and indicate which response most closely reflects your feelings at this moment.\(^9\)

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. I often wonder if I really fit in in my local community.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>29. I would describe myself as a misfit in most social situations in my local community.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>30. I am just not sure if I fit in with my local community.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>31. I generally feel that people in my local community accept me.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>32. I would like to make a difference to people or things around me, but I don’t feel that what I have to offer is valued in my local community.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>33. I feel like an outsider in most situations in my local community.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>34. I am troubled by feeling like I have no place</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

\(^8\) Items from: World Health Organisation – 5 Well-being Scale (WHO-5; Bech, 2004).

\(^9\) Modified Sense of Belonging Instrument – Psychological Subscale (SOBI-P; Hagerty & Patusky, 1995)
### 35. I could disappear for days and it wouldn’t matter to my local community.
- 
- 
- 
- 
- 

### 36. In general, I don’t feel a part of the mainstream in my local community.
- 
- 
- 
- 
- 

### 37. I feel like I observe life in my local community rather than participate in it.
- 
- 
- 
- 
- 

### 38. If I died tomorrow, very few people from my local community would come to my funeral.
- 
- 
- 
- 
- 

### 39. I feel like a square peg trying to fit into a round hole in my local community.
- 
- 
- 
- 
- 

### 40. I don’t feel that there is any place where I really fit in this community.
- 
- 
- 
- 
- 

### 41. I am uncomfortable that my background and experiences are so different from those around me in my local community.
- 
- 
- 
- 
- 

### 42. I could not see people from my local community for days and it wouldn’t matter to them.
- 
- 
- 
- 
- 

### 43. I feel left out of things in my local community.
- 
- 
- 
- 
- 

### 44. I am not valued by or important to my local community.
- 
- 
- 
- 
- 

### 45. Overall, how would you rate your health?\(^{10}\)
- Excellent
- Very good
- Good
- Fair
- Poor
- Very Poor
- Terrible

### 46. In your experience, unless you specifically tell them otherwise, do health professional presume you are heterosexual and/or cis-gender?
- Yes, always
- Yes, usually
- Not usually
- Never
- I don’t know

---

\(^{10}\) Items 45-49 are modified from Neville & Henrickson’s (2006) survey of New Zealand LGB persons' experiences of healthcare providers.
47. When you chose a primary health care provider (like a doctor), how important is that person’s attitude to your sexual and/or gender identity?

<table>
<thead>
<tr>
<th>Very Unimportant</th>
<th>Neither Important or Unimportant</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

48. If you have seen a healthcare professional in the last 3 years, have you told that person about your sexual identity and/or gender identity?

- Yes
- No
- I have not seen a healthcare professional in the last 3 years.

48a. [If yes] How did you feel that your healthcare professional responded? How comfortable was your healthcare provider with your disclosure?

- Completely comfortable
- Somewhat comfortable
- Ignored it
- I do not recall.

49. Do you believe that, in general, your healthcare provider’s attitude to your sexual identity and/or gender identity influenced the medical treatment you received?

- Yes, in a positive way
- Yes, in a negative way
- Not in any way
- I do not recall.

50. How often do connect with the following social services in your community?

<table>
<thead>
<tr>
<th>Service</th>
<th>Often</th>
<th>Rarely</th>
<th>Never</th>
<th>I am not aware of any such services in my community</th>
<th>I do not require such services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Library</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Carer’s Support Organisations</td>
<td>o</td>
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<tr>
<td>Religious place of worship (e.g. church, mosque, synagogue)</td>
<td>o</td>
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<tr>
<td>Aged-Care Services</td>
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<td>o</td>
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<tr>
<td>Services for Indigenous Australians</td>
<td>o</td>
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</tr>
</tbody>
</table>
51. In your experience, unless you specifically tell them otherwise, do social service providers in your community presume you are heterosexual and/or cis-gender?
   - Yes, always
   - Yes, usually
   - Not usually
   - Never
   - I don’t know

52. When you approach a social service provider (like a staff member in aged-care services) how important is that person’s attitude to your sexual and/or gender identity?

<table>
<thead>
<tr>
<th>Very Unimportant</th>
<th>Neither Important or Unimportant</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
</tbody>
</table>

53. If you have worked closely with a social service provider in the last 3 years, have you told that person about your sexual identity and/or gender identity?
   - Yes
   - No
   - I have not worked closely with a social service provider in the last 3 years.

48a. [If yes] How did you feel that the social service provider responded? How comfortable was the social service provider with your disclosure?
   - Completely comfortable
   - Somewhat comfortable
   - Ignored it
   - I do not recall.

54. Do you believe that, in general, your social service providers’ attitude to your sexual identity and/or gender identity influenced the quality of the social service you received?
   - Yes, in a positive way
   - Yes, in a negative way
   - Not in any way
   - I do not recall.

Section 4: Your use of the internet

55. Do you use the internet to look up health information, such as sexual health, mental health information, etc.?
   - Never
   - Rarely
55a. What kind of health information do you look for online? [Open ended]
55b. What do you find helpful about looking up health information online? [Open ended]

56. Do you use the internet to connect with an online ‘community’ of friends, either via social media or blogging sites?
   - Never
   - Rarely
   - Sometimes
   - Often
   - All of the time

56a. Where do you go online to connect with people and why? [Open ended]

57. Do you think other women your age who identify as lesbian, bisexual, transgender or as women who have sex with women (WSW) use the internet differently than other people your age?
   - Yes
   - No
   - I’m not sure

57a. How do you think they use the internet differently? [Open ended]

58. In what ways can (or does) the internet help you and other same-sex attracted and gender diverse women your age?

59. Do you use the internet to get LGBTI-specific information about things like your sexuality, health, legal issues, etc?
   - Never
   - Rarely
   - Sometimes
   - Often
   - All of the time

59a. Please say more about your answer. What kind of information are you looking for and why? [Open ended]