



Pride and pandemic:

Health experiences and coping strategies among LGBTQ+ people during the Covid-19 pandemic in Australia.

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About this report

This report presents findings from *Pride and Pandemic*, a study conducted in partnership between LGBTIQ+ Health Australia (LHA) and the Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University. *Pride and Pandemic* explores experiences of lesbian, gay, bisexual, trans and queer (LGBTQ) adults aged 18 and over in Australia during the COVID-19 pandemic, with a focus on mental health outcomes and the coping strategies used to mitigate these.

The study comprised a large online survey followed by focus group discussions with young people, trans and gender diverse people, LGBTIQ+ people from culturally diverse communities, and those who are part of rainbow families, defined as LGBTIQ+ people who are parents or care for young children.

The chapters of this report present a comprehensive snapshot of the data obtained through the *Pride and Pandemic* survey and focus groups. Throughout the report the data are presented for the full sample. Each chapter also includes a large table to illustrate the role of intersecting identities and how the pandemic may have been experienced differently for different subsections of the LGBTQ+ population. In these tables, key variables are broken down by age, gender, sexual orientation, multicultural background, disability, residential location and state or territory. Additionally, for information that may not have been captured by the survey, outcomes from the focus groups are presented throughout the report to provide more in-depth accounts of the mental health experiences of LGBTIQ+ people during the pandemic and coping strategies used to manage mental health.

Copies of this report or any other publications from this project may be obtained by contacting:

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Dr Adam Bourne
Associate Professor
and Lead Investigator

On behalf of all study authors

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Terminology

LGBTQ+

The acronym 'LGBTQ+' is used throughout this report to refer to people who identify as lesbian, gay, bisexual, trans or queer. The '+' reflects our engagement with additional identities, as there are a wide range of different identity terms, not otherwise identified by the acronym, used by people who identify as same-gender or multi-gender attracted or gender diverse. As we explore further in section 1.3, we were not able to recruit a sufficient number of people with an intersex variation to enable analysis and disaggregation of the data to reflect their experiences. As such, and so as not to misrepresent the experiences of people with an intersex variation, we refer to *Pride and Pandemic* as a study of LGBTQ+ communities. Where we refer to the sector of organisations that work to support people with an intersex variation (including community-controlled organisations) we retain the acronym LGBTQ+. At times we may refer to other research that has utilised different terms (e.g. LGBT, LGBTIQ) and we retain these terms to appropriately reflect the populations from which these other data have been contributed.

Disability

In the *Pride and Pandemic* survey, assessment of disability was based on participants self-identifying and reporting a disability or long-term health condition, whether existing at birth or acquired later in life. Full details of how these questions were asked are provided in Chapter 3. Reflecting this data collection approach, the term 'disability' when used in this report refers to self-identified disability or long-term health condition, as reported by survey participants. In the report, when referring to this group of participants, the phrase 'participants with disability', and variations thereof, are used for ease of reading. It is, however, important to acknowledge that this trait refers only to those who self-reported a disability when completing the survey.

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Executive summary

Background and context

Pride and Pandemic was conducted in partnership between LGBTIQ+ Health Australia (LHA) and the Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University. Through the use of a survey in conjunction with a series of focus groups, *Pride and Pandemic* explores the experiences of the COVID-19 pandemic among lesbian, gay, bisexual, trans, and queer (LGBTQ+) people in Australia. While it covers a range of experiences, the project has a particular focus on the mental health impacts of the pandemic and the strategies used to mitigate these. The outcomes of *Pride and Pandemic* provide new knowledge that can be drawn upon by health professionals, service providers, community organisations and governments to address the needs of LGBTQ+ people, now and the future (were a pandemic or other emergency event to arise again).

Methodology

Pride and Pandemic was developed in consultation with a Community Advisory Board, with representatives from different sections of the LGBTQ+ community and across a number of Australian states and territories. *Pride and Pandemic* involved an online survey and four focus groups. The survey was promoted through social media advertising, email invitations to existing participant lists held by ARCSHS and promotion via community organisations. The survey was provided in English, could be completed online, and was restricted to participants who were 18 years or over, residing in Australia at the time of the survey and who indicated having spent most of the pandemic to date living in Australia. Except for eligibility questions, including age and state or territory of residence, all other survey questions were not mandatory and therefore the total sample sizes vary slightly.

Four focus groups were conducted with specific subsections of the population believed to have experienced unique impacts of the pandemic. These groups included young people aged 18 to 24, trans and gender diverse people, LGBTQ+ people from multicultural backgrounds (backgrounds other than Anglo-Celtic), and LGBTQ+ people with children (rainbow families). Focus group participants were recruited via an expression of interest form completed at the end of the survey, and discussions were held over Zoom.

About the participants

Survey participants

- In total, 3,135 participants completed the *Pride and Pandemic* survey. The majority of participants were residing in Victoria (35.6%; n = 1,115) and New South Wales (28.9%; n = 907) for most of the pandemic, followed by Queensland (15.7%; n = 491), Western Australia (6.5%; n = 204), South Australia (6.4%; n = 201), Australian Capital Territory (3.8%; n = 120), Tasmania (2.6%; n = 82) and Northern Territory (0.5%; n = 15).
- More than one-third (38.2%; n = 1137) of participants were cisgender women, 35.8% (n = 1066) cisgender men, 4.3% (n = 128) trans women, 5.7% (n = 170) trans men, and 16.0% (n = 476) non-binary. There were 36 participants with an intersex variation/s.
- Approximately one-fifth (21.1%; n = 642) of participants identified as lesbian, 31.2% (n = 948) as gay, 17.0% (n = 516) as bisexual, 8.0% (n = 244) as pansexual, 14.4% (n = 438) as queer, 3.8% (n = 115) as asexual, and 4.4% (n = 135) reported 'something else' with regard to their sexual orientation.

Focus group participants

- Twenty-three people took part in the focus groups. Seven participated in the group discussion for young people aged 18 to 24; seven in the trans and gender group; four in the group with people from a multicultural background, that is, a background other than Anglo-Celtic (all four of whom were Asian); and five as rainbow families/people caring for young children.
- The sample of focus group participants was diverse, with an age range of 18 to 64 years, 11 participants from a multicultural background, and 17 indicating that they had a disability or were unsure about whether they had one.
- Five of the focus group participants were cisgender women, three were cisgender men, five were trans women, eight were trans men, and five were non-binary.
- Four participants identified as lesbian, three as gay, nine as bisexual, one as pansexual, two as asexual, and four reported 'something else' with regard to their sexual orientation.

Financial and housing security

- More than half (54.4%) of the participants experienced some form of change to their employment circumstance during the pandemic.
- One-fifth (20.1%) of participants had been either temporarily or permanently stood down during the pandemic, and one-third (33.0%) had worked reduced hours or received reduced pay.
- Almost one-quarter (23.4%; n = 685) of participants reported that they were not able to live comfortably on their income during the pandemic.
- Focus group discussions highlighted how financial instability may have contributed to negative mental health outcomes for LGBTQ+ individuals who had to move back to, or got stuck living with, unsupportive families. There was evidence that migrant LGBTQ+ people may have been especially impacted given they were not able to access government financial support programs (e.g., JobKeeper Payment).

Mental health and wellbeing

- Almost two-thirds (63.8%) of participants felt that their mental wellbeing had got worse since the beginning of the pandemic, while 14.1% felt that their mental wellbeing had improved.
- More than half (57.6%) of participants had received a mental health diagnosis prior to the pandemic. Of participants who received a diagnosis prior to the pandemic, 71.0% felt that their condition had got worse as a result of the pandemic.
- More than one-quarter (26.0%) of participants reported having ever attempted suicide in their lifetime, and 6.6% reported attempting suicide during the pandemic.

Social interactions and informal support

- Most participants reported less social interaction with family of origin (48.7%; n = 1,413), chosen family (51.5%; n = 1,400) and friends (75.0%; n = 2,317), as well as many reporting decreased support from family (19.0%; n = 564) and friends (28.5%; n = 868).
- Decreased interaction and support from friends and family was statistically associated with poorer mental health outcomes.
- Many participants reported an increase in online social interactions. Approximately three-quarters of participants reported an increase in their use of social media (75.8%; n = 2,329), and 45.8% (n = 1,308) of participants reported more online participation in social or learning activities for fun.
- Focus group participants discussed the negative impact of lack of access to in-person support from friends and family during the pandemic, as well as the buffering effect of being able to access support online.

Family violence

- Almost one-fifth (17.2% of participants) had experienced violence from an intimate partner during the pandemic.
- More than one-quarter (28.9%) of participants had experienced violence from a family member during the pandemic.
- Focus group participants expressed concerns for members of the community who during the pandemic were stuck with unsupportive families to whom they may not be 'out', in particular LGBTQ+ young people and LGBTQ+ people from multicultural backgrounds.

Tobacco, alcohol and other drug use

- Nearly a third (30.4%) of participants consumed tobacco. Reflecting the increased stress brought about by the pandemic, of those who consumed tobacco, almost half (46.6%) reported consuming more tobacco during this time.
- Most participants (83.5%) consumed alcohol. Among those who reported alcohol consumption, almost half (46.0%) reported consuming alcohol more frequently during the pandemic.
- Just under one-fifth (17.5%) self-reported that they struggled to manage their alcohol use during the pandemic and approximately one in ten (12.1%) reported that a friend or family member had expressed concern about their alcohol use during the pandemic.

- Of those participants who consumed illicit drugs during the pandemic, 17.2% self-reported struggling to manage their drug use, and approximately one in ten (11.6%) indicated that a friend or family member had expressed concern about their drug use.

Health service engagement and support

- Rates of vaccination among the study sample was high, with 96.1% of participants having received at least two doses of the vaccine by 4 February 2022.
- A small proportion (5.7%; n = 139) of participants reported testing positive for COVID-19, and of those, less than two-thirds (61.2%; n = 85) felt that they were treated with dignity or respect throughout the contact tracing process.
- Many participants with disability reported receiving less or different supports during the pandemic both from NDIS supports (45.2%; n = 47) and non-NDIS support (32.5%; n = 67).
- More than half (56.1%; n = 1,738) of participants sought professional support for their mental health during the pandemic, and of those, most accessed a mainstream service that is known to be LGBTQ+ inclusive (63.6%; n = 1,102) and most received at least some of this support via telehealth (90.9%; n = 1,523).
- Participants most frequently identified the cost of services as a barrier to accessing mental health care during the pandemic (44.7%; n = 738), followed by lack of availability of their preferred service (35.9%; n = 594), and stay-at-home orders (35.3%; n = 584).
- Focus group participants largely felt they would prefer attending LGBTQ+-only services, yet they felt compelled to access mainstream ones due to limited availability and to needing specialised services in particular health areas not linked to gender or sexuality.

Community connection and participation

- Many participants reported less participation in mainstream community events (42.7%; n = 1,333) and LGBTQ+ community events (35.7%; n = 1,112), while many reported increases in accessing LGBTQ+ social media (42.4%; n = 1,320).
- Approximately one in ten (11.0%; n = 342) of participants felt that remote access options introduced during the pandemic had led to them accessing services provided by LGBTQ+ organisations more frequently, and a further 8.8% (n = 258) indicated that remote access options had led to them accessing services provided by LGBTQ+ organisations for the first time.
- Participants who felt that they were a part of the Australian LGBTIQ+ community were less likely to report high or very high psychological distress and less likely to have experienced suicidal ideation during the pandemic.
- Community connection, both physical and online, was viewed as vital by focus group participants, who wished online events would remain, as they grant better accessibility, once physical events resumed.

Other coping strategies

- Many participants reported spending less time during the pandemic dedicated to physical exercise (48.0%; n = 1,473), time outdoors (52.2%; n = 1,615) or hobbies (33.5%; n = 1,027).
- Maintaining pre-pandemic levels of physical exercise, time spent outdoors, and time spent on hobbies were all associated with better mental health outcomes.
- Participants who responded to the open-ended question (n = 1,978) on what helped them most during the pandemic stressed, among other things, meditation, the supportive role of LGBTQ+ community online groups and having regular professional psychological support.
- Some focus group participants described the value of spending more time with family (e.g. rainbow families) while others were pleased to observe how the pandemic had made discussion of mental health issues more acceptable, especially among multicultural communities.

Summary and recommendations

The findings from *Pride and Pandemic* highlight ongoing challenges faced by the LGBTQ community in Australia including poor mental health outcomes, systemic discrimination, and barriers to equitable and affirming healthcare. For the LGBTQ community, the data collected in this study would suggest that the pandemic made an already challenging situation worse. The ramifications of this crisis are likely to be long-lasting within the community and recovery may be slow. Immediate action is required to reduce health disparities and ensure that the wellbeing of LGBTQ communities does not deteriorate further. To address these challenges faced by LGBTQ communities, further policy and program development is required along with service development and future data collection. Specific recommendations based on the outcomes of *Pride and Pandemic* include:

Recommendation 1: Resourcing of LGBTQ+ community organisations to meet extensive mental health need.

Such services were valued by participants and perceived as being experts in the experiences and needs of LGBTQ+ people. A lack of accessibility or a concern about their resource capacity dissuaded some from seeking help when they needed it, a situation that could be addressed with greater investment.



Recommendation 2: Ensuring the provision of culturally safe and affirming practices in mainstream mental health services.

LGBTIQ+ communities have a right to access healthcare services where they are treated with dignity and where their identity and lived experience of their gender or sexual orientation is respected and affirmed. Resourcing is essential to ensure that mainstream services have the support and training required to provide the services that LGBTIQ+ people need at the scale that is required.

Recommendation 3: Enhancing access to LGBTIQ+-affirming family violence services.

LGBTIQ+ people who experience family violence need access to high-quality, culturally safe services when subject to family violence. Resourcing is required for both LGBTIQ+ community controlled organisations to establish or expand their capacity to meet demand as well as mainstream services that currently lack the capacity or skills to meet the family violence support needs of LGBTIQ+ communities.

Recommendation 4: Development and promotion of family of origin violence prevention interventions.

Efforts must be made to support LGBTIQ+ young people who are not safe in their homes. Such interventions should be designed in collaboration with LGBTIQ+ and youth organisations and must ensure involvement of people with disability and those from multicultural backgrounds. They could include, but not be limited to, interventions through educational settings to promote sources of support to young people who may not be safe at home, as well as increased support for families of trans and gender diverse young people.

Recommendation 5: Resourcing of LGBTIQ+ organisations for the provision of drug and alcohol support services.

Due to the trust in such organisations that was reflected in focus group discussions, there is a need to ensure these services are available and accessible to meet the needs of those who find themselves in more difficult circumstances. These organisations may also be well placed to assist in LGBTIQ+-affirming capacity development in mainstream drug and alcohol services.

Recommendation 6: Promotion of LGBTIQ+-affirming support services for drug and alcohol use.

Pending the development of capacity recommended above, it is essential that LGBTIQ+ communities are appraised of the services available to them in times of need. Such promotional work should also seek to disestablish any stigma that may exist regarding drug and alcohol-related concerns and facilitate open discussion of problems if they develop.

Recommendation 7: Funding of LGBTIQ+-community mental health services to provide dedicated support for LGBTIQ+ people during times of crisis.

Data from the survey replicate findings from other research that showed some LGBTIQ+ people do not feel adequately supported or respected in mainstream mental health services and thus LGBTIQ+ community organisations can play a crucial role in addressing acute mental health need.

Recommendation 8: Resourcing of LGBTIQ+ organisations to facilitate accessible peer support groups

Where access may be challenging and enable community interaction in crisis-affected areas. This may involve providing online or remote access to peer support groups as well as the facilitation of in-person peer support groups in affected areas where needed, such as in bushfire-affected or flood-affected communities.

Recommendation 9: Continued resourcing of and access to telehealth services

Across all health services including medical and mental health care, with emphasis given to those organisations that have demonstrated themselves to be providing LGBTIQ+ culturally safe practice.

Recommendation 10: Undertaking of focussed research on the experiences of people with an intersex variation.

This research must involve community consultation throughout all phases of its development and would likely need to be specifically targeted only to people with an intersex variation/s to ensure maximum engagement.

Recommendation 11: Undertaking of research that focuses on a broader diversity of gender and sexual identities.

Non-binary identities are rapidly evolving, and non-binary participants frequently reported poorer health and wellbeing outcomes during the pandemic when compared with other participants. Additionally, people who identify as queer, bisexual or pansexual similarly reported poorer health outcomes compared to participants identifying as lesbian or gay. Qualitative research with these groups would help to ensure a richer body of knowledge to plan interventions for now and in the context of future crisis events that may be experienced.

Recommendation 12: Undertaking of focussed research among First Nations LGBTIQ+ people.

To attain an understanding of experiences of First Nations LGBTIQ+ people during times of crisis requires specific, culturally situated research to explore their experiences relating to health and wellbeing. This research should be led by First Nations researchers and organisations.

Recommendation 13: Monitoring of LGBTIQ+ inclusion in future crisis responses.

Research is required to observe (and enable responses to) LGBTIQ+ health and wellbeing during and in the aftermath of future crises, whether these are local (e.g. bushfires and flooding) or global. This research must include nuanced explorations of the experiences and needs of LGBTIQ+ communities as they cope both during the disaster and while the community recovers, including the strengths and resources they bring as well as the unique recovery needs they may have.

1 Background

Many within the LGBTQ+ community entered the COVID-19 pandemic under already challenging mental health circumstances, perhaps more than may have been the case for other sections of the Australian population.

There is, therefore, reason to be concerned with how the pandemic may have shaped or exacerbated their experiences, including how associated restrictions may have impacted their ability to engage with both formal and informal sources of mental health support. While limited research has been conducted on the experiences of LGBTQ+ people during the COVID-19 pandemic, emerging research suggests that many challenges already faced by LGBTQ+ communities were intensified and new challenges brought about by the pandemic (1), contributing to declining mental health outcomes (2-4).

One of the most reliable protective factors for mental health in LGBTQ+ communities is social connection to other LGBTQ+ people, and this was severely disrupted during periods of lockdown. This, along with financial and housing insecurities, a rise in incidences of family violence, and general heightened anxiety brought about by the pandemic are likely to have taken a large toll on the mental wellbeing of LGBTQ+ communities (5). Through a collaboration between LGBTQ+ Health Australia and ARCSHS, *Pride and Pandemic* explores the impacts of the COVID-19 pandemic on the mental health and wellbeing of LGBTQ+ people in Australia, as well as the strategies that were employed by people within LGBTQ+ communities to manage some of the impacts of this global crisis. The findings presented in this report will help inform efforts to protect the mental health of LGBTQ+ communities as the pandemic continues and in the face of future crises that pose similar challenges.

1.1 Scope of this report

This report provides a comprehensive snapshot of the experiences of LGBTQ+ adults in Australia during the COVID-19 pandemic, based on data from the *Pride and Pandemic* survey and focus groups. The report covers experiences of mental health during the pandemic as well as other factors that may have been reshaped or negatively impacted during the pandemic and further complicate mental health itself. Other issues covered in the report include financial and housing security, social interactions and support, family violence, alcohol and other drug use, health service engagement and support, community connection and participation, and other coping strategies reported by participants to mitigate mental health. Each chapter provides an overview of the data for the full survey sample as well as a breakdown of key variables by intersections of the sample believed to be uniquely impacted by the pandemic. These intersecting traits include age, gender, sexual orientation, ethnicity, disability, residential location and state or territory. In addition, findings from the *Pride and Pandemic* focus groups are described throughout the report to provide further in-depth detail of how the impacts of the pandemic were felt and managed.

1.2 Gender and sexual orientation

Survey questions regarding gender identity and sexual orientation were taken from the *Private Lives 3* survey conducted in 2019 by ARCSHS. These questions were developed in consultation with members of the *Private Lives 3* Expert Advisory Group and Gender Advisory Board and aimed to maximise the inclusion of the broad range of identities and experiences of LGBTQ+ people. Using the same questions as *Private Lives 3* allows us to more meaningfully make comparisons to the *Private Lives 3* data, as it was conducted just prior to the pandemic and may assist in understanding the *Pride and Pandemic* outcomes.

1.2.1 Gender identity

To categorise gender, participants were asked about the sex assigned on their original birth certificate and then asked, 'Which options best describe your gender?' Response options were 'male', 'female', 'non-binary' and 'I use a different term', with the ability to choose more than one response. Participants who selected 'non-binary', 'something different' or who selected a gender that was different to that assigned at birth were then asked, 'Which of the following additional options best describes your gender?' Response options included 17 gender identities with multiple responses allowed. Participants who chose more than one gender identity were additionally asked, 'For the purposes of this survey, if you had to choose only one way to describe your gender, what would you choose?' Response options included 17 gender identities and 'I don't find it possible to choose one term'; participants chose just one answer for this question.

For the purposes of statistical analysis, it was necessary to merge some gender categories together. These gender categories were developed in consultation with the *Private Lives 3* Gender Advisory Board. Five gender categories were established as follows:

- Cisgender female: participants who were assigned female at birth and who chose only female as their gender identity
- Cisgender male: participants who were assigned male at birth and who chose only male as their gender identity
- Trans woman: participants who were assigned male at birth and who chose only 'female', 'trans woman' or 'sistergirl' as their gender identity
- Trans man: participants who were assigned female at birth and who chose only 'male', 'trans man' or 'brotherboy' as their gender identity
- Non-binary: participants who chose only a gender identity that was not a binary identity or who 'did not find it possible to choose a single gender identity'

1.2.2 Sexual orientation

To assess sexual orientation, participants were asked if they identified as 'gay', 'lesbian', 'bisexual', 'pansexual', 'queer', 'asexual', 'homosexual', 'heterosexual', 'prefer not to answer', 'prefer not to have a label', 'don't know' and 'something different.' For the purpose of data analyses and due to small sample sizes in the following responses, participants who identified as 'homosexual', 'prefer not to have a label' or 'something different' were combined into the 'something different' category. This was also done for trans and gender diverse participants and those with an intersex variation/s who identified as 'heterosexual.' Participants who responded with 'prefer not to answer' were not classified under any sexual orientation category but were still included in the overall sample.

1.3 A note on intersex populations

Intersex is an umbrella term used to describe people born with sex characteristics – including genitals, gonads and chromosome patterns – that do not fit typical binary notions of male or female bodies, and these traits may not be discovered until later in life.

Pride and Pandemic included the following question regarding whether participants were born with a variation in their sex characteristics:

'Were you born with a variation in your sex characteristics? There are many different intersex variation/s, some of which are associated with a medical diagnosis (e.g. DSD, CAH, AIS, Klinefelter syndrome, Turner syndrome, hypospadias, MRKH syndrome etc.) Intersex is an umbrella term used to describe people born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies.' Response options included 'no', 'don't know' and 'yes'. Participants who answered 'yes' to this question were then given the opportunity to provide their preferred terminology to talk about their body.

Despite aiming to make the survey and promotional material as accessible for people with an intersex variation as we could, we only received responses from 36 such individuals (1.2% of the total sample). Unfortunately, this is an insufficient sample size to disaggregate these data in such a way that we can be confident they reflect the experiences of people with an intersex variation during COVID-19. It is therefore important to note that the report and its findings do not apply to and cannot be generalised to people with an intersex variation/s.

Therefore, we refer to an LGBTQ+ population when describing the sample but retain LGBTQ+ when describing recruitment efforts, eligibility criteria, original survey questions and the wider sector of organisations that works to support people with an intersex variation.

A lack of participation from among people with an intersex variation in surveys badged as LGBTQ+ has been observed multiple times over the past few years, including in *Private Lives* 3 (6) and *Writing Themselves In* 4 (7). The reasons for this are likely multifaceted but may reflect that some people with an intersex variation do not see themselves as part of the rainbow community, instead choosing to describe themselves in terms of their specific intersex variation or do not occupy the places and spaces (both online and in person) where LGBTQ+ surveys are marketed. We believe there would be considerable value in nationally funded research that specifically explores the health and wellbeing needs of people with an intersex variation. Such work needs to be sufficiently resourced to ensure meaningful involvement and leadership from people with an intersex variation and the community-based organisations that work on their behalf and are often central to the success of surveys of this nature. We return to this point in the recommendations chapter.

1.4 Aboriginal and Torres Strait Islander participants

For many years there has been an underrepresentation of Aboriginal and Torres Strait Islander people in research on LGBTQ issues. This has led to a lack of visibility of the Aboriginal and Torres Strait Islander sexuality and gender diverse population, challenging efforts to develop interventions and services required to support the health and wellbeing of this group.

We were heartened to see a sizable number of Aboriginal and Torres Strait Islander people participate in the *Pride and Pandemic* survey and hope that the data they contributed to this project can be used in ways to support Indigenous communities. We are committed to working with these data in a culturally safe way, which requires meaningful partnership with Aboriginal and Torres Strait Islander people who are LGBTQ. At the time of publication of this report, we are actively exploring ways to examine, interpret and disseminate findings from Aboriginal and Torres Strait Islander participants of this study in ways that centre Indigenous voices and acknowledge their unique contributions. We welcome approaches from interested parties to join these discussions and activities as they unfold over the coming months.

2 Methodology

***Pride and Pandemic* involved a mixed method approach including a national online survey of LGBTQ+ people in Australia coupled with a series of online focus group discussions.**

Online surveys are an effective approach for accessing populations that may ordinarily be hard to reach, including LGBTQ+ people (8,9). The online survey followed a similar format and recruitment approach as the *Private Lives 3* survey conducted by ARCSHS prior to the pandemic in 2019 exploring the health and wellbeing of LGBTQ+ adults in Australia. With over 6,800 participants, *Private Lives 3* is the largest ever survey in Australia of LGBTQ+ adults (6). Focus group discussions were conducted to gain more nuanced and in-depth insights into the experiences of diverse LGBTQ+ people during the pandemic. Four group discussions took place with specific intersections of the LGBTQ+ community where we have reason to believe the impacts of COVID-19 may have been most strongly or uniquely felt, including young people aged 18 to 24, trans and gender diverse people, people from multicultural backgrounds, and people who cared for young children (rainbow families). Further elements of diversity were sought to be addressed by selecting participants from a range of age groups, genders and sexualities, and selecting participants with disability across the four groups. *Pride and Pandemic* received ethical approval from the La Trobe Human Research Ethics Committee, as well as from the ACON Research Ethics Review Committee and the Community Research Endorsement Panel of Thorne Harbour Health.

2.1 Community consultation

LHA and ARCSHS have been joined on this study by a Community Advisory Board of expert stakeholders drawn from the LGBTQ+ community and mental health sectors. The Community Advisory Board comprises a diverse range of members, representing a diverse cross-section of the LGBTQ+ community and organisations from around the country, including Thorne Harbour Health (Vic), ACON (NSW), Working It Out (Tas), Rainbow Families (NSW), and Transgender Victoria (Vic). We have been in consultation with members of this group for guidance on promotion and recruitment plans, pertinent questions for both phases of data collection, refining analysis and commenting on final drafts of outputs. They are a critical part of our work, and we acknowledge their significant contributions to ensuring the success of this project.

2.2 Survey design

The *Pride and Pandemic* survey was designed in consultation with the *Pride and Pandemic* Community Advisory Board. The survey utilised standardised instruments where possible to allow for comparisons to the general population in Australia, and also used items consistent with those used in the *Private Lives 3* survey so as to allow for comparisons with Australian LGBTQ+ adult data collected prior to the pandemic. Additional items were added to capture experiences unique to the pandemic, such as financial and employment changes including JobKeeper payments introduced during the pandemic, experiences of lockdown and social distancing particularly with regard to changes in social interactions and support, and experiences with the introduction of telehealth and COVID-19-related healthcare. Furthermore, many questions asked specifically about time frames relating to the pandemic. Where in previous surveys such as *Private Lives 3* we have asked about lifetime and past 12 months'

experiences, in *Pride and Pandemic* we frequently ask about experiences occurring prior to or during the pandemic ('i.e. since March 2020' or 'prior to March 2020'). As a quantitative data collection method, the survey involved predominantly fixed response questions.

2.3 Focus group design

The *Pride and Pandemic* focus group questions were similarly designed in consultation with the *Pride and Pandemic* Community Advisory Board. The questions differed slightly between specific focus groups and aimed to elicit further rich detail about the mental health circumstances and coping strategies used by LGBTQ+ people during the pandemic. Focus group questions were broad and designed to guide discussions among focus group participants. The focus group discussions were conducted online via Zoom with a minimum of four and maximum of eight participants in each group. These discussions ran for approximately one and a half to 2 hours.

2.4 Advertising and recruitment

2.4.1 Online survey

The *Pride and Pandemic* survey was launched in November 2021 and closed in February 2022. The survey was promoted via LGBTQ+ community organisations as well as paid advertising through Facebook and Instagram. The survey was hosted by REDCap to be completed online. It was presented in English, and eligible participants were LGBTQ+-identifying people aged over 18 years old who were living in Australia at the time of completing the survey and had been in Australia for most of the pandemic, so as to be able to reflect on an Australian experience of the pandemic and associated restrictions.

2.4.2 Focus groups

The focus groups were conducted in January 2022. Focus group participants were drawn from the survey sample. On completion of the online survey, participants were asked if they were interested in participating in a follow-up focus group discussion to further discuss their experiences during the pandemic. Those who expressed interest were then asked to complete a short additional survey to provide basic demographic details, contact details and indicate their best availability to participate in the groups. On receiving expressions of interest from approximately 380 survey participants for the focus groups, the focus group expression of interest survey was closed. A selection of participants who expressed interest in the focus group and who met the relevant inclusion criteria were then invited via email to participate in the focus group. As with the survey participants, focus group participants were aged over 18, had been living in Australia during the pandemic and identified as LGBTQ+, while also meeting the criteria of any one of the four specific intersections chosen for the focus groups: aged 18 to 24, trans or gender diverse, from a multicultural background (other than an Anglo-Celtic background), or a parent or carer of young children (rainbow families). In addition to these inclusion criteria, focus group participants were purposefully

selected to represent diverse age ranges and sexual and gender identities as well as to ensure the inclusion of participants with disability.

2.5 Time frame of the survey

Given the rapidly changing environment brought about by the COVID-19 pandemic, it is important to note the time frame within which *Pride and Pandemic* was conducted, and the landscape of the pandemic and associated public health measures across the country at the time. The Pride and Pandemic survey was launched in November 2021 and remained open to responses through to February 2022. At the time that the survey opened, Australia was on the tail end of the COVID-19 Delta wave, which had seen a large surge in COVID-19 cases and strict lockdowns in both Melbourne and Sydney. Both Melbourne and Sydney experienced the end of lockdowns in October 2021, followed by progressive easing of restrictions. However, in December 2021 Australia reported its first cases of the fast-spreading COVID-19 Omicron variant. While this did not lead to additional lockdowns, stricter social distancing restrictions were implemented again. These changes in the spread of the virus and the public health response may have impacted the mental wellbeing and responses of participants depending on when they completed the survey. For example, the Kessler Psychological Distress Scale (K10), detailed in section 5.2, asks participants to respond to items relating to experiences of mental wellbeing over the previous 4 weeks. For a participant responding in November 2021 when restrictions were easing, these responses may differ from a participant responding in January 2022 when Omicron cases led to the reinstatement of social distancing restrictions. In addition, the state of vaccinations also varied over the country during the survey time frame, with increasing mandates across the country to receive two doses of the vaccine toward the end of 2021, and the rollout of a third booster vaccine beginning in 2022. Vaccines are discussed in more detail in section 9.1.1.

2.6 Data analysis

Survey data were analysed using Stata 16.1. the report includes predominantly descriptive analyses including comparisons with national data from *Private Lives 3* and national general population data such as from the ABS as well as other sources where appropriate. Where relevant, large tables of descriptive statistics are provided that include breakdowns of key variables by intersectional characteristics that were identified as likely to be impacted in particular ways by the pandemic. These include age, gender, sexual orientation, multicultural background, disability, residential location and state or territory (note that the Northern Territory and Tasmania were combined due to small sample sizes). Variables were broken down by state/territory to assess the impact of different COVID-19 restrictions. Multivariable logistic regression analyses were also conducted to explore the association between pandemic experiences, coping strategies and mental health outcomes. These analyses additionally controlled for a number of sociodemographic characteristics including age, gender identity, sexual orientation, rurality and state or territory. Where relevant, outcomes from regression analyses are reported as adjusted odds ratios (AOR), 95% confidence intervals (CI) and significance values (P). The multivariable logistic regression analyses allow us to determine, for example, if mental health is likely to be worse among people who spent less time

dedicated to hobbies during the pandemic, while taking into consideration (controlling) differences that occur due to sociodemographic traits.

The data collected in the focus group were analysed using inductive thematic analysis (10), insights gained from this analysis and relevant quotes from participants are presented through the report. In the quotes, participants were given a pseudonym to protect their anonymity.

2.7 Study limitations

While it is a very large and robust study of LGBTQ+ communities, our study is not without its limitations. An absence of LGBTQ+ inclusion in the census of Australia means it is not possible to establish a representative sample of this population. However, the characteristics of our sample mirror those of other studies conducted over the past 5 years and – across many characteristics – reflect those of the broader populations of Australia.

We acknowledge that as the survey was conducted largely online, without means to support administration of more equitable participation for those with specific accessibility needs (such as those with intellectual disability), it may be the case that findings do not speak to the diversity of experience for all those with disability. The methodology itself in quantitative surveys of this kind falls short in facilitating meaningful engagement of people with intellectual disability, as this requires participatory methods and co-design to ensure survey research participation accessibility and comprehension and may require development of nuanced questions and lines of enquiry that are specific to their experiences.

We also acknowledge that the surveys were only available in English, which may limit engagement from LGBTQ+ people whose first language is not English. Future surveys of this population should, ideally, be adequately resourced to include translated versions in commonly used non-English languages.



3 Demographics

This report presents the results from 3,135 participants who were living in Australia for the most part of the pandemic and at the time of completing the *Pride and Pandemic* survey.

3.1 Distribution/residence

Table 1: State or territory where participants resided for most of the pandemic (n = 3,135)

State	n	%
Victoria	1,115	35.6
New South Wales	907	28.9
Queensland	491	15.7
Western Australia	204	6.5
South Australia	201	6.4
Australian Capital Territory	120	3.8
Tasmania	82	2.6
Northern Territory	15	0.5

A small number of participants (2.0%; n = 64) moved state or territory during the pandemic and had spent most of the pandemic in a state or territory other than the state or territory of residence at the time of completing the survey. The distribution of *Pride and Pandemic* participants during the pandemic is comparable to that of the general population (11). The higher than expected sample size in Victoria, relative to state population size, may arise from the state having a larger network of LGBTIQ+ organisations, many of which helped to promote the survey.

The majority of participants reported living in capital cities, 44.9% (n = 1,401) living in inner-suburban areas and 27.7% (n = 864) in outer-suburban areas, followed by 22.2% (n = 694) living in a regional city or town, and 5.3% (n = 64) living in a rural or remote area.

3.2 Age of participants

Table 2: Distribution of participants by age (n = 3,135)

Age	n	%
18	865	27.6
25	879	28.0
35	560	17.9
45	426	13.6
55	290	9.3
65+	115	3.7

The mean age of participants was 35.7 years (SD = 14.2) and ranged from 18 to 85 years. More than one-quarter were aged between 18 and 24 years (27.6%; n = 865), 28.0% (n = 879) between 25 and 34 years, 17.9% (n = 560) between 35 and 44 years, 13.6% (n = 426) between 45 and 54 years, and 13.0% (n = 405) aged over 55 years. The proportion of participants in each age group reflects that of participants in *Private Lives 3*. While weighted towards younger people, there is still a large and viable sample of those aged 55 and over (n = 405) to enable disaggregation of data in later chapters.

3.3 Gender identity and sexual orientation

Table 3: Gender identity (n = 2,977)

Gender identity	n	%
Cisgender woman	1,137	38.2
Cisgender man	1,066	35.8
Trans woman	128	4.3
Trans man	170	5.7
Non-binary	476	16.0

Participants were able to choose from a wide range of gender identities; however, for the purpose of analyses these responses were then categorised into five broad gender categories. This approach is described in section 1.2.1. More than one-third (38.2%; n = 1,137) of participants were categorised as cisgender women, 35.8% (n = 1,066) as cisgender men, 4.3% (n = 128) as trans women, 5.7% (n = 170), and 16.0% (n = 476) as non-binary. In total, 774 (26.0%) of the sample were categorised as trans or gender diverse, which is a comparatively large sample of trans and gender diverse people for a national survey in Australia.

Table 4: Sexual orientation (n = 3,038)

Sexual orientation	n	%
Lesbian	642	21.1
Gay	948	31.2
Bisexual	516	17.0
Pansexual	244	8.0
Queer	438	14.4
Asexual	115	3.8
Something else	135	4.4

When asked to identify their sexual orientation, small proportions of participants selected 'homosexual,' 'prefer not to have a label' or 'something different.' For the purpose of analyses, these were combined together into a 'something else' category. Additionally, the small number participants with an intersex variation/s and trans and gender diverse participants who selected 'heterosexual' were categorised in the 'something else' category. Participants who selected 'prefer not to answer' were coded as missing. The responses from these participants are included in the overall proportions in the sections that follow but are not included in breakdowns by sexual orientation. This approach to categorising sexual orientations reflects that used for the *Private Lives 3* project.

Approximately half (52.3%; n = 1,590) of participants identified as lesbian or gay. One-quarter (25.0%; n = 763) of participants of participants identified as multi-gender attracted (bisexual = 17.0%; pansexual = 8.0%). Approximately one in seven participants identified as queer (14.4%; n = 438), 3.8% (n = 115) identified as asexual, and 4.4% (n = 135) identified as something else.

3.4 People with an intersex variation/s

Thirty-six (1.2%) participants indicated that they had an intersex variation/s. Approximately three-quarters (75.9%; n = 22) of participants who indicated that they had an intersex variation/s were trans or non-binary. As explained in detail in section 1.3, this is an insufficient sample size to enable disaggregation of data for people with an intersex variation and for us to speak with confidence about COVID-19-related impacts for this group. It is for this reason that we use the acronym 'LGBTQ+' throughout this report.

3.5 Aboriginal and Torres Strait Islander descent

In total, 131 (4.2%) participants indicated that they were of Aboriginal or Torres Strait Islander origin or heritage. This is a similar proportion to the general population in Australia (3.3%; 12).

3.6 Ethnicity and visa status

Participants were asked to indicate their cultural background by selecting as many ethnicities as apply from a list of 13 ethnicities, with the additional option to select 'other' and provide a text response. Participants were also asked if they were born in Australia or overseas, and those who were born overseas were asked to provide a text response of the country they were born in. Finally, participants were asked if they identify as a person of colour, with response options including 'yes', 'no' and 'prefer not to answer'.

The majority of participants were born in Australia (84.0%, n = 2,620), with 10.3% (n = 321) born overseas in another English-speaking country, and 5.7% (n = 178) born in a non-English-speaking country. Almost one in ten participants (9.0%; n = 272) identified as a person of colour.

A small proportion of participants did not hold an Australian citizenship; 4.4% (n = 136) were permanent residents, 1.3% (n = 40) were on a temporary, working or student visa, and 0.89% (n = 28) reported another kind of visa status.

Table 5: Ethnicity of participants (n = 3,017)

Ethnicity	n	%
Anglo-Celtic	2,263	75.01
Other European	375	12.43
Southern European	232	7.69
Eastern European	210	6.96
Aboriginal/Torres Strait Islander	132	4.38
Chinese	87	2.88
Southeast Asian	65	2.15
Middle Eastern	52	1.72
Māori/Pacific Islander	45	1.49
Other Asian	36	1.19
Indian	34	1.13
Latin American	31	1.03
African	13	0.43
Different ethnicity	193	6.4

3.7 Education

Table 6: Educational qualification (n = 3,108)

Education	n	%
Secondary or below	790	25.4
Non-university tertiary	676	21.8
University	922	29.7
University	720	23.2

Approximately three-quarters (74.7%; n = 2,318) of participants reported receiving tertiary-level education (non-university tertiary = 21.8%; university – undergraduate = 29.7%; university – postgraduate = 23.2%).

3.8 Religious or spiritual identity

Table 7: Religious or spiritual identity (n = 3,126)

Religion	n	%
No religion	2331	74.6
Catholic	167	5.3
Anglican (Church of England)	88	2.8
Buddhism	58	1.9
Uniting Church	46	1.5
Judaism	49	1.6
Islam	12	0.4
Greek Orthodox	13	0.4
Presbyterian	21	0.7
Aboriginal and Torres Strait Islander spirituality	21	0.7
Hinduism	5	0.2
Sikhism	1	0.0
Other	314	10.0

Approximately three-quarters of participants (74.6%; n = 2,331) reported having no religion, in keeping with the proportion of participants reporting no religion in *Private Lives 3* (74.2%). Of participants reporting a religious or spiritual identity, 5.3% were Catholic, 2.8% Anglican and 1.9% Buddhist. As with *Private Lives 3*, the proportion of participants reporting no religious or spiritual affiliation was much higher in this sample than is reported in the general population (30%; 13).

3.9 Disability

To assess disability, participants were asked, 'Do you identify as having a disability, being neurodiverse/autistic, or having a long-term physical or mental health condition? Long-term health conditions could include things like epilepsy, mental health conditions, speech or sensory impairments. A disability could include things like the loss of – or difficulty using – a body part, or difficulty managing everyday activities.' Responses included 'yes', 'no', 'don't know' and 'prefer not to say.' Participants who answered 'yes' to this question were then asked to identify the type of disability. Response options included:

- Physical (your body and/or mobility)
- Intellectual (difficulty communicating, making decisions, engaging with others, or learning or retaining information)
- Mental illness (your emotional state and/or behaviours)
- Sensory (sight, hearing, smell, touch, taste, or spatial awareness)
- Neurodiversity/autism (ADHD, dyslexia, Tourette syndrome, dyspraxia etc.)
- Acquired brain injury (ABI, TBI, dementia)
- Something else

Participants who identified more than one type of disability were further asked to select, from a list of the same options, the disability that is their primary disability.

Approximately half of the sample (51%; n = 1,516) reported having a disability. Types of disability reported by participants are presented in Table 8 below.

Table 8: Type of disability or long-term health condition (n = 1,498)

Disability/long-term health condition	n	%
Mental	726	48.5
Neurodiversity/autism	426	28.4
Physical	215	14.4
Sensory	38	2.5
Intellectual	16	1.1
Acquired brain injury	7	0.5
Something else	70	4.7

Almost half (48.5%; n = 726) of participants who reported having a disability or long-term health condition identified mental health as their sole or primary disability, and more than one-quarter (28.4; n = 426) reported neurodiversity or autism as their primary disability; the next largest proportion reported a physical disability (14.4%; n = 215). Smaller proportions of participants reported having a sensory (2.5%) or intellectual (1.1%) disability, acquired brain injury (0.5%), or something else (4.7%).

3.10 Household, relationships and families

3.10.1 Household structure

Table 9: Who lives with you (n = 3,127)

Household	n	%
Partner/s	1,103	35.3
Parent or carer	782	25.0
I live alone	694	22.2
Siblings	496	15.9
Housemate/s	381	12.1
My child/children that I care for	286	9.2
Friend/s	219	7.0
Other	66	2.1
Grandparents	44	1.4
Co-parent	32	1.0
Someone else	53	1.7

At the time of completing the survey, 35.3% (n = 1,103) of participants lived with their partner or partners, slightly lower than the proportions in *Private Lives 3* who lived with their partner or partners. A slightly greater proportion of *Pride and Pandemic* participants lived with a parent or carer (25.0%; n



= 782) than was found in *Private Lives 3* (21.6%). Additionally, more participants in *Pride and Pandemic* reported living alone (22.2%; $n = 694$) compared to *Private Lives 3* (17.1%). These differences in proportions may reflect impacts of the pandemic on financial and housing security, as well as social distancing regulations.

3.10.2 Current relationship status

Approximately half of participants (51.3%, $n = 1,607$) were in a committed relationship at the time of completing the survey. Of those who were in a committed relationship, 70.0% ($n = 1,122$) lived with their partner/s, and another 3.2% ($n = 52$) had an alternative cohabiting arrangement with their partner/s, such as part-time living together.

3.10.3 Children and dependents

At the time of completing the survey, less than 10% (8.8%; $n = 276$) of participants were the primary carer of any children including those of a partner. The ages of participants' children are presented in Table 10 below.

Table 10: Age range of children ($n = 274$)

Child/ren age range	n	%
0-5 years old	96	35.04
6-12 years old	132	48.18
13-18 years old	111	40.51
19 years or older	45	16.42

Note: Multiple responses were available as participants may have had more than one child, thus percentages do not add up to 100.

The greatest proportion of participants with children reported having children of school age (6-12 years old: 48.2%; 13-18 years old: 40.5%). Over one-third (35.0%; $n = 96$) reported children who were infants or of preschool age (0-5 years old), and 16.4% ($n = 45$) reported having adult children (19 years or older).

3.11 Focus group participants

The focus groups consisted of discussions with four sub-groups of participants (young people aged 18 to 24, trans and gender diverse people, people from multicultural backgrounds, and people caring for young children/rainbow families). Overall, 23 people took part in the focus groups. Seven participated in the group discussion for young people aged 18 to 24; seven in the trans and gender group; four in the group with people from a multicultural background (i.e. background other than Anglo-Celtic, which in this group included one participant who identified as Chinese and three as Chinese/Southeast Asian); and five as rainbow families. Potential focus group participants were asked to provide a selection of demographic characteristics when registering interest to participate, and these are detailed below. The demographic characteristics of the 23 participants are reported as a whole, rather than divided by group. This follows our analytical approach that sought to explore in-depth a multiplicity of overlapping and/or diverging issues among the wider LGBTQ+ community rather than for each of these groups only. These groups were chosen to facilitate diverse discussions among groups that may have been particularly affected by the pandemic. In order to achieve more nuances, we sought to select diverse focus group participants across the four groups, including by age, gender identity and disability.

Table 11: Focus group sample characteristics (n = 23)

	n
Age	
18	10
25	5
35	4
45	1
55	2
Gender identity	
Cisgender woman	5
Cisgender man	3
Trans woman	5
Trans man	8
Non-binary	5
Sexual orientation	
Lesbian	4
Gay	3
Bisexual	9
Pansexual	1
Queer	0
Asexual	2
Something else	4
Ethnicity	
Anglo-Celtic only	8
Anglo-Celtic and other European	3
Aboriginal/Torres Strait Islander and Anglo-Celtic	3
Eastern European and Anglo-Celtic	1
Eastern and Southern European	1
Other European	1
Chinese	1
Chinese and Southeast Asian	3
Different ethnicity	1
Residential location	
Capital	16
Regional or remote	7
State or territory	
Victoria	12
New South Wales	6
Queensland	2

	n
Western Australia	1
South Australia	0
Australian Capital Territory	2
Tasmania	0
Northern Territory	0

3.11.1 Disability among focus group participants

A majority of focus group participants (n = 17) indicated having a disability or being unsure about whether they had one. While details about its nature were not asked in the recruitment form, some participants shared their experiences within the focus group discussions about how the pandemic impacted on them in particular ways due to their disability.

3.12 Summary

While not a truly representative sample (which is impossible to achieve in the absence of census-level data that are inclusive of LGBTIQ+ people), the diversity and distribution of the *Pride and Pandemic* sample broadly aligns with the population demographics of Australia. The proportion of participants is comparable to *Private Lives 3*, the largest and most diverse sample of LGBTIQ+ people in Australia. The diversity of participants enables us to examine the experiences of key intersectional groups in later chapters.

The findings from the focus groups are qualitative in nature and do not aim to be representative of the LGBTIQ+ community as a whole but rather offer an opportunity to understand in more detail the experiences of certain groups that we have reason to believe may have been disproportionately impacted by COVID-19.



4 Financial and housing security

Public health measures implemented during the pandemic to limit the spread of COVID-19 in Australia led to changes in work for many people in Australia, including loss of employment, reduced hours and reduced pay (14).

LGBTQ+ communities may have been disproportionately impacted as many LGBTQ+ people are employed in industries that were heavily impacted by the pandemic, lockdowns and social distancing, such as hospitality and entertainment (14,15). Research during COVID-19 in countries outside of Australia has found the pandemic has resulted in significant unemployment and underemployment among LGBTQ communities (16). Furthermore, LGBTQ+ people may face additional barriers to accessing welfare and support, such as discrimination and harassment. Discrimination was, for instance, reported as linked to homelessness by one in ten *Private Lives 3* participants (6).

4.1 Income and employment

Pride and Pandemic participants were asked to indicate their level of concern for financial, employment and housing security. Three-quarters (75.7% n = 2,293) of participants expressed at least some concern about the impact of the pandemic on their financial situation; 71.4% (n = 2,020) were concerned about the impact of the pandemic on their employment; and 54.9% (n = 1,628) were concerned about the impact of the pandemic on their housing stability.

4.1.1 Current income

Table 12: Total weekly income before tax of all wages/ salaries, government benefits, pensions, allowances and other income (n = 3,096)

Income	n	%
Nil income	208	6.7
\$1 – \$399	616	19.9
\$400 – \$999	795	25.7
\$1,000 – \$1,999	950	30.7
\$2,000+	527	17.0

At the time of the survey, 6.7% (n = 208) of participants reported earning no income, similar to *Private Lives 3* (6.9%), and 19.9% (n = 616) reported earning less than \$400 per week (below the Australian poverty line of \$581 per week for a single person with no dependents; 9).

Almost one-quarter (23.4%; n = 685) of participants reported that they were not able to live comfortably on their income during the pandemic.

4.1.2 Current employment

Table 13: Employment (n = 3,068)

Employment	n	%
Employed full-time	1,266	41.3
Employed casually	604	19.7
Employed part-time	488	15.9
Unemployed or not working	415	13.5
Self-employed	245	8.0
Retired	147	4.8
Sick leave or medically retired	79	2.6
Other	105	3.4

At the time of the survey, 77.4% (n = 2,417) of participants were engaged in some form of paid employment, a rate similar to that found by *Private Lives 3* (73.5%). Approximately one in ten (13.5%; n = 415) participants were unemployed or unable to work, which is more than three times higher than the rate of unemployment in the general population (4.2%).

4.1.3 Change to income or employment status during the pandemic

The pandemic and associated public health measures had a large impact on employment for many in Australia. Table 14 details experiences of changed employment circumstances during the pandemic for the *Pride and Pandemic* sample.

Table 14: Employment and income stability during the pandemic (n = 3,042)

Employment	n	%
Working reduced hours	921	30.3
Unemployed or struggling to find work	857	28.2
Working inconsistent or unreliable hours	821	27.0
Received reduced pay	574	18.9
Temporarily stood down	448	14.7
Permanently stood down	254	8.4
None of the above	1,386	45.6

Note: Multiple responses were available, thus percentages do not add up to 100.

More than half (54.4%; n = 1,656) of the participants experienced some form of change to their employment circumstance during the pandemic. One-fifth (20.1%; n = 612) of participants had been either temporarily or permanently stood down during the pandemic, and one-third (33.0%; n = 1,003) had worked reduced hours or received reduced pay.

More than one in ten (16.9%; n = 513) participants received JobKeeper Payment and a similar number (17.0%; n = 515) received JobSeeker Payment at some point during the pandemic.

4.2 Housing and homelessness

Participants were asked to respond to several questions regarding their housing situation, including where they were living at the time and whether or not they had experienced any homelessness prior to or during the pandemic.

4.2.1 Current living situation

Table 15: Current living situation (n = 3,120)

Current living situation	n	%
Private rental	1,351	43.3
Home	933	29.9
At home with family	738	23.7
Rooming house	79	2.5
Public housing	63	2.0
Couch surfing	24	0.8
Supported accommodation (14	0.5
Transitional housing	17	0.5
Caravan park	8	0.3
Crisis/emergency accommodation	8	0.3
Youth foyer	3	0.1
Street/abandoned property/squatting	4	0.1
Somewhere else	44	1.4

More than four in ten (43.3%; n = 1,351) participants reported living in a private rental property, and three in ten (29.9%; n = 933) in a home they own, which is similar to findings from *Private Lives 3* (44.1% and 29.2% respectively). In the general Australian population, a higher proportion of people (66%) live in a home they own and a lower proportion (32%) live in a private rental property (Australian Bureau of Statistics). Almost one-quarter (23.7%; n = 738) of participants lived in the family home.

4.2.2 Experiences of homelessness

Participants were asked if they had ever experienced homelessness and if these experiences were prior to the pandemic, during the pandemic or both. More than one in ten (14.3%; n = 446) had ever experienced homelessness. In total, 3.4% (n = 107) of participants experienced homelessness during the pandemic, with 1.2% of participants experiencing homelessness for the first time during the pandemic.

4.3 Financial and housing security across intersections

To illustrate the role of intersectionality in the financial and housing impacts of the pandemic, Table 16 below provides additional data on concerns about financial, employment and housing stability as well as experiences of homelessness during the pandemic across various intersections of the survey population. The table reports data from intersections of the population believed to be most likely to have been impacted in unique ways during the pandemic. These include age, gender, ethnicity, disability and residential location and state or territory.

Table 16: Financial, employment and housing stability during the pandemic across age, gender, ethnicity, disability, residential location and state or territory

	Some concern about the impact of the pandemic on:			Homelessness	
	Financial situation (%)	Employment (%)	Housing stability (%)	Experienced prior and during the pandemic (%)	Experienced for the first time during the pandemic (%)
Age					
18-24 years	83.7	81.2	62.4	2.2	3.5
25-34 years	78.2	74.1	62.0	1.5	1.8
35-44 years	75.0	68.2	53.6	1.1	0.9
45-54 years	69.0	64.4	46.9	0.2	2.4
55-64 years	63.3	56.2	34.6	1.1	1.1
65+ years	54.8	35.7	20.7	0.0	0.9
Gender					
Cisgender woman	77.9	72.6	55.6	1.4	1.8
Cisgender man	67.0	63.6	45.1	0.4	1.1
Trans woman	77.0	71.9	61.2	1.6	1.6
Trans man	86.9	81.6	74.1	3.5	2.4

Table 16 continued:

	Some concern about the impact of the pandemic on:			Homelessness	
	Financial situation (%)	Employment (%)	Housing stability (%)	Experienced prior and during the pandemic (%)	Experienced for the first time during the pandemic (%)
Non-binary	82.6	80.0	65.1	1.7	5.1
Sexual orientation					
Gay or lesbian	70.6	66.7	47.2	0.9	1.1
Bisexual or pansexual	82.6	77.0	64.1	1.2	3.7
Queer	82.7	79.9	61.4	2.5	3.0
Asexual	81.2	79.4	63.6	1.8	2.6
Something else	75.0	64.1	62.4	2.2	1.5
Ethnicity*					
Anglo-Celtic only	74.3	69.8	53.0	0.7	2.0
Multicultural background	77.8	74.0	57.3	2.0	2.1
Person of colour	73.8	71.7	58.3	1.5	2.6
Disability/long-term health condition**					
No disability	68.4	64.9	43.7	0.4	1.1
Physical	79.0	76.3	53.6	3.3	1.9
Mental illness	84.9	79.1	68.2	1.9	2.5
Sensory	73.0	79.4	55.3	5.3	2.6
Neurodiversity/autism	82.1	74.9	65.9	1.9	3.3
Something else	74.3	72.7	66.2	2.9	4.3
Residential location					
Capital city, inner suburban	74.4	71.5	55.0	1.0	1.6
Capital city, outer suburban	78.3	73.6	55.4	1.2	2.3
Regional city or town	76.0	69.1	53.6	2.2	2.7
Rural or remote area	72.2	66.7	56.2	1.9	1.9
State or territory					
Victoria	76.2	72.3	54.0	0.8	1.5
New South Wales	73.3	68.6	50.7	1.0	1.8
Queensland	77.9	70.7	61.4	1.6	2.9
Western Australia	76.5	78.4	58.1	2.9	2.5
South Australia	82.1	76.0	60.1	2.5	2.0
Australian Capital Territory	75.2	74.5	56.5	2.5	1.7
Northern Territory and Tasmania	67.4	61.9	51.1	2.1	7.3

* Participants who only indicated an Anglo-Celtic ethnic background were categorised as 'Anglo-Celtic only'; participants who were not only Anglo-Celtic were categorised as 'multicultural background'. 'Person of colour' includes all participants who additionally identified as a person of colour. Refer to section 3.6 for detail on how ethnicity was assessed.

** Sample sizes for intellectual disability and acquired brain injury were too small to allow disaggregation of the data and are not included in the table

I don't think it's subsidised enough [...] And if it's a choice between fixing my mental health or, you know, putting petrol in my car or buying food, obviously [...] you're just going to put your mental health aside

(DAN, TRANS MAN, PANSEXUAL, 30)

4.4 Focus group insights

Several participants spoke of how they and their peers were affected by financial and housing (in)security during the pandemic. A few young people (aged 18 to 24) related having to move back into their parents' home following job loss and how this posed challenges to their ability to express their gender and sexuality while being in lockdown with non-supportive parents.

There's been a lot of us losing jobs and having to go move back in with their parents, [it] is like a rehashing of features that they were supposed to move on from, but then they've had to be pushed back into that.
(Ian, non-binary, bisexual, 23)

Focus group participants in the multicultural focus group spoke of the specific challenges for LGBTQ+ migrants having to move back to families whom they are not out to, or worse, due to lack of sufficient funds or job security to keep their visas, having to move back to countries where their sexuality is outlawed. Participants also mentioned that migrant LGBTQ+ people (alongside all migrants) were impacted by financial insecurity in further ways. For instance, those without permanent residency could not access most government support schemes and experienced severe delays in getting visas. These were described as increasing stress and possibly impacting on their mental health. One migrant bisexual cisgender man spoke about the difficulty of being separated from his husband for much of the pandemic as the latter did not yet have an Australian visa and was stuck in their home country (where homosexuality is illegal). He also added that he was lucky to have the means to engage very expensive immigration lawyers but felt for those who did not have such means.

So what do we do [...] Because government says one thing, then something happens the next day and they panic, they shut borders [...] there's no way to plan your life [...] I mean, even in the best of times, it's so difficult to find a life around, you know, the regular visa process, right? Where you don't get a visa in 2 years and don't know what's going to happen, they can reject you for no reason [...] I think it might be crippling [...] I'm very fortunate to be in a place where money is no object, so I could throw cash at agents and lawyers [in a way that] for people with no means [would have been] impossible.
(Kim, cisgender man, bisexual, 34)

The pandemic was also seen by participants in all four groups as exacerbating existing financial barriers to accessing LGBTQ+-specific or LGBTQ+-friendly private therapists, which would preclude enjoying high-quality mental health support for many in the community.

I don't think it's subsidised enough [...] And if it's a choice between fixing my mental health or, you know, putting petrol in my car or buying food, obviously [...] you're just going to put your mental health aside.
(Dan, trans man, pansexual, 30)

4.5 Summary

Our findings show that worries around financial and housing insecurity during the pandemic were common among LGBTQ+ communities. LGBTQ+ people generally have been found to have worse financial and housing stability than the general population (6). Findings from the current study indicate that this was made harder by the pandemic. For instance, self-reported rates of unemployment during the pandemic were 28.2%, as compared to 16.1% in *Private Lives 3* – conducted at the end of 2019. In a comparable manner to *Private Lives 3*, trans and non-binary participants had lower rates of full-time employment and higher concerns over financial and housing (in)stability than cisgender people, while cisgender men had the least concerns over housing and the highest financial stability of all other gender groups. Younger people (aged 18 to 24) had considerably more concerns over housing and financial stability than other age groups.

Financial and housing insecurity during the pandemic were understood as negatively impacting on LGBTQ+ people's mental health by focus group participants. In particular, for young people (aged 18 to 24) in our focus groups, insecure housing and finances were linked to having to return to their parents' home and potentially face unsupportive environments towards one's gender identity or sexuality. Migrant LGBTQ+ people without financial means risked having to return to culturally unaccepting environments or even countries where their sexuality is outlawed. Finally, increased financial constraints were linked to having poor access to good quality mental health support for some during the pandemic.



5 Mental health and wellbeing

Previous research suggests that LGBTQ+ people are at greater risk of poor mental health outcomes, including higher rates of depression and anxiety diagnoses than the general population (18,19), as well as higher rates of psychological distress, suicide and self-harm (6).

The toll of the pandemic on physical health, social connections and financial security are all likely to have further impacted the mental health and wellbeing of LGBTQ+ people (5). Recent international research suggests declines in mental health and wellbeing across LGBTQ+ populations (2-4), and in Australia, gay and bisexual men were found to report increased depression and anxiety (20). *Pride and Pandemic* consequently explored mental health outcomes both during and prior to the

pandemic, where relevant, and included self-reflection on the impact of the pandemic on health and mental wellbeing.

The impact of discrimination on the mental health of marginalised populations', including LGBTQ+ people, has been increasingly studied. Recent research found associations between LGBQ and LGB people's experiences of discrimination and their experience of suicidal ideation and suicidality (21,22).

5.1 Self-reported impact of the pandemic on health

All participants, regardless of mental health status or prior diagnoses, were asked to report whether they felt that their physical health and fitness or mental wellbeing had got better, worse or had not changed since the pandemic and asked to respond on a 5-point scale from 'much worse' to 'much better'. Responses were then categorised to indicate whether there was no change or if participants reported that their health or wellbeing had got worse or better.

5.1.1 Impact on physical health and fitness

More than half (54.7%; $n = 1,706$) of participants felt that their physical health and fitness had got worse since the beginning of the pandemic, while 21.5% ($n = 669$) felt that their physical health and fitness had got better.

5.1.2 Impact on mental wellbeing

Almost two-thirds (63.8%; $n = 1,982$) of participants felt that their mental wellbeing had got worse since the beginning of the pandemic, while 14.1% ($n = 438$) felt that mental wellbeing had improved.

5.2 Psychological distress

The Kessler Psychological Distress Scale (K10) is a 10-item standard scale designed to measure psychological distress. The 10 items refer to experiences over the past 4 weeks and cover symptoms of depression and anxiety. Total scores can range from 10 to 50, with a higher score indicating higher levels of psychological distress. A score of less than 20 is clinically considered to be low or normal psychological distress (23).

The mean K10 score among *Pride and Pandemic* participants was 25.4 (with a standard deviation of 9.6), similar to *Private Lives 3* where the mean score was 24.3.

The K10 scores were additionally categorised into low, moderate, high or very high psychological distress. These are presented in Figure 1.

Almost two-thirds (62.7%; $n = 1,967$) of participants indicated experiencing high or very high psychological distress in the past 4 weeks. One-fifth (19.3%; $n = 605$) reported moderate and just 18.0% ($n = 563$) reported low psychological distress. The Australian Institute of Health and Welfare provides a snapshot of the experiences of psychological distress of the general population in Australia during the pandemic by detailing findings from survey studies using the K6, a shortened version of the K10 (24). These findings illustrate that in October 2021 (1 month prior to the launch of the *Pride and Pandemic* survey) the Australian population reported its highest levels of psychological distress, with 12.5% of the population indicating severe psychological distress, dropping to 11.0% in January 2022 (24). While reports of psychological distress appear to reflect the impacts of the pandemic for the general population, it is evident that psychological distress among LGBTQ+ communities remained considerably worse than the general population.

5.3 Mental health diagnoses

Participants were asked if they had been diagnosed with one or more mental health conditions either prior to the pandemic or during the pandemic (i.e. since March 2020). Table 17 presents proportions of mental health diagnoses.

Nearly two-thirds (63.4%; $n = 1,934$) of participants had ever been diagnosed with a mental health condition. More than half (57.6%; $n = 1,756$) of participants had received a mental health diagnosis prior to the pandemic, and an additional 5.8% ($n = 178$) received a diagnosis during the pandemic. The most commonly diagnosed mental health conditions during the pandemic were generalised anxiety disorder (6.6%; $n = 203$) and depression (6.3%; $n = 192$).

Of participants who received a diagnosis prior to the pandemic, 71.0% ($n = 1,245$) felt that their condition had got worse as a result of the pandemic, 5.6% ($n = 98$) felt that their condition had improved, and 23.4% ($n = 410$) felt that the pandemic had no impact on their mental health condition.

Figure 1: Rates of low, moderate, high or very high psychological distress

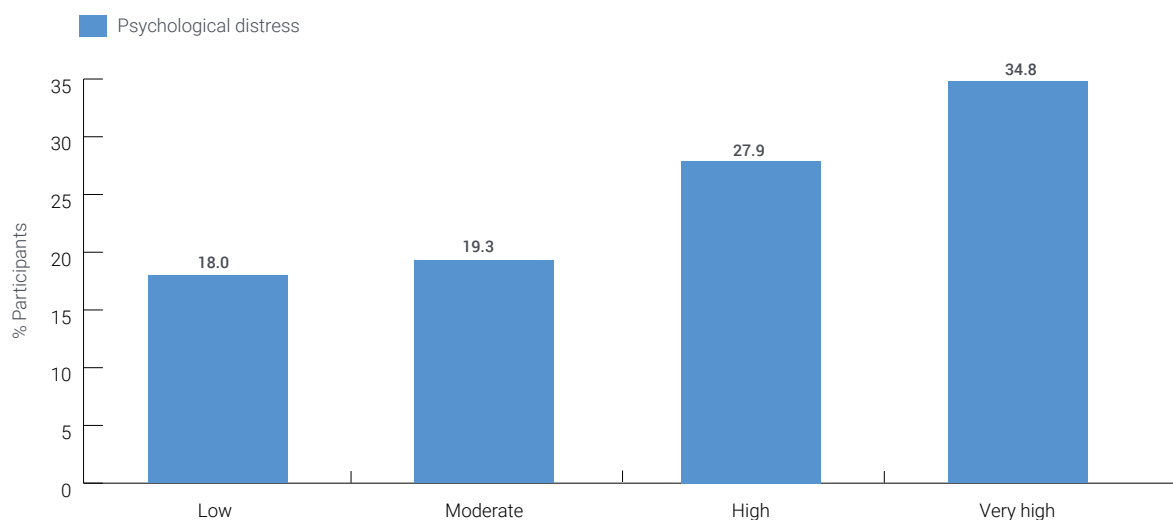


Table 17: Diagnoses of mental health condition prior to or during the pandemic

Condition	Diagnosed prior to the pandemic		Diagnosed during the pandemic	
	n	%	n	%
Depression	1,437	46.9	192	6.3
Generalised anxiety disorder	1,299	42.4	203	6.6
Post-traumatic stress disorder (PTSD)	512	16.7	109	3.6
Bipolar disorder	108	3.5	26	0.8
Panic disorder	240	7.8	41	1.3
Social phobia	254	8.3	36	1.2
Agoraphobia	75	2.4	19	0.6
Obsessive-compulsive disorder (OCD)	175	5.7	44	1.4
Schizophrenia	20	0.7	6	0.2
Eating disorder	271	8.8	81	2.6
Other mental health challenge	185	6.0	98	3.2
Any of the above	1,756	57.6	178	5.8

Note: Multiple responses were available, thus percentages do not add up to 100.

5.4 Suicidal ideation, suicide attempt and self-harm

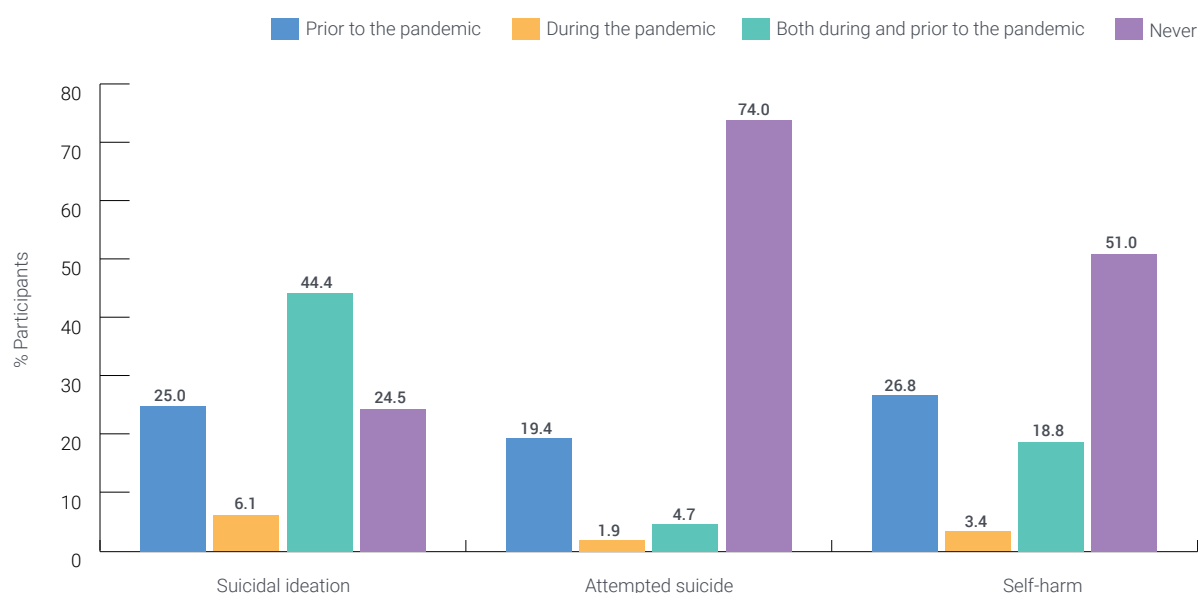
Pride and Pandemic asked participants about suicidal ideation, 'Have you experienced thoughts about suicide, wanting to die or about ending your life?'; suicide attempts, 'Have you attempted suicide or to end your life'; and self-harm, 'Have you injured or harmed yourself on purpose?'

While asking people about suicide has been found not to increase suicide risk (25), as a precaution, online and telephone resources were provided to participants prior to

suicide and self-harm questions appearing in the survey. Participants were also provided with an option to skip the survey items relating to suicide and self-harm by selecting 'I prefer not to answer these questions'. Participants who chose to respond to these questions were also provided with the option to select 'prefer not to answer' for each item.

Three-quarters (75.5%; n = 2,184) of participants reported having ever experienced suicidal ideation in their lifetime, with half (50.5%; n = 1,460) of participants experiencing suicidal ideation during the pandemic, and 6.1% (n = 176) experiencing suicidal ideation for the first time during the pandemic.

Figure 2: Rates of suicidal ideation, suicide attempt and self-harm prior to and during the pandemic



More than one-quarter (26.0%; n = 744) of participants reported having ever attempted suicide in their lifetime, with 6.6% (n = 189) attempting suicide during the pandemic, and 1.9% (n = 55) attempting suicide for the first time during the pandemic.

Approximately half (49.0%; n = 1,412) of participants reported having ever self-harmed in their lifetime, with more than one-fifth (22.2%; n = 639) self-harming during the pandemic, and 3.4% (n = 98) self-harming for the first time during the pandemic.

5.5 Concerns about experiencing discrimination as a result of the pandemic

Given prior experiences or knowledge of the discrimination, harassment and mistreatment of sexual minority people during the HIV epidemic (26), LGBTQ+ people may have been more conscious of how the broader community may respond during the COVID-19 pandemic. Moreover, in the early phases of the pandemic, Australia saw an increase in racism and violence toward ethnic minorities, in particular those from Southeast Asian backgrounds (27,28). Consequently, we were interested to explore if and how LGBTQ+ people, and in particular those from a multicultural background, may have been affected by discrimination and racism during this time.

Participants were asked to respond to several items regarding their concerns for the safety and wellbeing of themselves and others during the pandemic, including concerns around experiences of discrimination. Response options ranged from 'not at all concerned' to 'very concerned', with the option to select 'not applicable'.

Almost half (49.5%; n = 1,514) of participants expressed at least some concern that they would experience LGBTQ+

discrimination against them during the pandemic.

Additionally, approximately one-quarter (28.8%; n = 321) of participants from a multicultural background and almost two-thirds (66.7%; n = 174) of those who identified as a person of colour expressed at least some concern that they would experience discrimination against them based on their cultural or ethnic background during the pandemic.

5.6 Mental health and wellbeing across intersections

To illustrate the role of intersectionality in mental health outcomes during the pandemic, Table 18 below provides additional data on self-reported impact of the pandemic on physical health and mental wellbeing as well as mental health outcomes including psychological distress and experiences of suicide during the pandemic across various intersections of the survey population. The table reports data from intersections of the population believed to be most likely to have been impacted in unique ways during the pandemic. These include age, gender, ethnicity, disability and residential location and state or territory.

Table 18: Mental health outcomes across age, gender, ethnicity, disability, residential location and state or territory

	Pandemic had a negative impact on:		Psychological distress			
	Physical health and fitness (%)	Mental wellbeing (%)	Low (%)	Moderate (%)	High (%)	Very high (%)
Age						
18-24 years	55.6	70.0	6.2	15.5	27.6	50.6
25-34 years	53.3	63.2	12.3	19.3	30.8	37.5
35-44 years	58.3	66.0	20.4	22.0	31.6	26.1
45-54 years	57.8	60.0	29.1	21.1	27.5	22.3
55-64 years	50.0	56.6	36.2	24.8	21.4	17.6
65+ years	41.1	39.6	50.4	13.9	8.7	27.0
Gender						
Cisgender woman	57.6	68.1	13.4	19.8	30.3	36.5
Cisgender man	48.5	56.8	31.5	22.0	24.6	21.9
Trans woman	53.1	54.3	14.1	16.4	30.5	39.1
Trans man	59.2	66.5	7.1	18.2	28.2	46.5
Non-binary	61.2	69.0	5.3	15.1	28.8	50.8

Table 18 continued

	Pandemic had a negative impact on:		Psychological distress			
	Physical health and fitness (%)	Mental wellbeing (%)	Low (%)	Moderate (%)	High (%)	Very high (%)
Sexual orientation						
Gay or lesbian	51.5	60.5	25.3	20.7	26.4	27.6
Bisexual or pansexual	57.1	68.0	9.6	17.5	30.3	42.6
Queer	63.9	69.9	8.7	18.3	31.1	42.0
Asexual	51.3	60.2	8.7	20.9	30.4	40.0
Something else	50.0	65.4	16.3	19.3	22.2	42.2
Ethnicity*						
Anglo-Celtic only	55.3	62.4	20.2	20.1	27.8	31.9
Multicultural background	53.2	65.2	15.2	18.3	28.3	38.2
Person of colour	48.5	64.3	14.7	20.2	25.4	39.7
Disability/long-term health condition**						
No disability	48.5	58.6	30.7	24.8	24.1	20.5
Physical	66.0	66.8	11.6	12.1	37.7	38.6
Mental illness	61.9	74.4	3.7	12.8	29.5	54.0
Sensory	52.6	61.1	18.4	28.9	31.6	21.1
Neurodiversity/autism	59.0	64.4	4.5	16.0	33.6	46.0
Something else	56.5	50.7	12.9	20.0	27.1	40.0
Residential location						
Capital city, inner suburban	54.3	62.1	20.3	22.5	29.0	28.2
Capital city, outer suburban	57.4	67.1	14.9	16.0	29.2	39.9
Regional city or town	52.4	63.6	17.6	17.1	25.2	40.1
Rural or remote area	53.0	60.5	16.5	17.7	24.4	41.5
State or territory						
Victoria	59.9	67.5	16.9	21.2	30.0	32.0
New South Wales	52.3	64.5	21.1	19.6	25.0	34.3
Queensland	49.7	59.9	17.3	14.5	26.7	41.5
Western Australia	50.7	54.2	14.2	22.5	27.0	36.3
South Australia	51.7	60.5	17.4	12.9	31.8	37.8
Australian Capital Territory	60.0	66.4	10.8	20.0	35.0	34.2
Northern Territory and Tasmania	50.0	56.4	22.7	24.7	23.7	28.9

* Participants who only indicated an Anglo-Celtic ethnic background were categorised as 'Anglo-Celtic only'; participants who were not only Anglo-Celtic were categorised as 'multicultural background'. 'Person of colour' includes all participants who additionally identified as a person of colour. Refer to section 3.6 for detail on how ethnicity was assessed.

** Sample sizes for intellectual and sensory disability and acquired brain injury were too small to allow disaggregation of the data and are not included in the table

Table 18 continued

	Suicidal ideation		Suicide attempt		Self-harm	
	During the pandemic for the first time (%)	Both during and prior to the pandemic (%)	During the pandemic for the first time (%)	Both during and prior to the pandemic (%)	During the pandemic for the first time (%)	Both during and prior to the pandemic (%)
Age						
18-24 years	6.4	61.5	3.8	11.5	6.2	38.2
25-34 years	5.7	47.5	1.1	3.1	3.4	19.8
35-44 years	6.7	37.2	1.7	2.3	2.7	9.5
45-54 years	7.2	28.8	1.1	1.1	1.0	4.6
55-64 years	4.3	27.5	1.2	0.8	1.2	2.3
65+ years	3.9	23.5	0.0	1.0	0.0	1.0
Gender						
Cisgender woman	6.5	43.4	1.8	3.6	3.7	19.4
Cisgender man	6.1	28.5	1.3	1.6	1.6	3.5
Trans woman	6.8	54.7	3.6	7.1	6.8	23.1
Trans man	5.1	68.4	4.5	16.8	2.5	41.4
Non-binary	5.8	64.8	2.8	8.5	5.4	37.7
Sexual orientation						
Gay or lesbian	6.3	35.1	1.7	3.0	2.3	11.1
Bisexual or pansexual	5.6	54.7	2.4	7.2	5.4	28.1
Queer	5.4	54.4	1.5	6.0	3.0	26.2
Asexual	10.0	49.1	3.7	2.8	6.4	29.1
Something else	6.3	50.4	1.6	7.3	1.6	15.9
Ethnicity*						
Anglo-Celtic only	5.3	41.4	1.4	3.3	2.4	16.5
Multicultural background	7.2	48.7	2.7	6.5	4.5	21.7
Person of colour	5.3	46.9	2.8	6.1	4.4	19.2
Disability/long-term health condition**						
No disability	7.0	26.6	1.0	1.3	2.3	5.4
Physical	5.0	50.5	1.5	2.5	3.5	19.5
Mental illness	4.4	65.5	3.0	9.8	4.3	35.8
Neurodiversity/autism	6.5	61.5	2.8	6.6	6.5	31.5
Something else	1.6	50.0	3.5	7.0	0.0	21.7
Residential location						
Capital city, inner suburban	6.4	39.1	1.7	3.7	2.9	14.8
Capital city, outer suburban	5.1	49.4	2.1	5.2	3.5	21.2
Regional city or town	6.4	48.6	2.0	6.1	3.7	23.4
Rural or remote area	7.2	46.7	2.0	5.4	5.4	22.1

Table 18 continued

	Suicidal ideation		Suicide attempt		Self-harm	
	During the pandemic for the first time (%)	Both during and prior to the pandemic (%)	During the pandemic for the first time (%)	Both during and prior to the pandemic (%)	During the pandemic for the first time (%)	Both during and prior to the pandemic (%)
State or territory						
Victoria	6.2	43.6	1.9	3.3	3.7	18.2
New South Wales	5.7	40.4	2.0	4.3	2.5	16.1
Queensland	6.9	47.7	2.5	6.5	2.9	21.8
Western Australia	5.7	45.8	1.0	6.7	2.6	21.9
South Australia	5.2	56.8	2.7	6.9	6.4	22.9
Australian Capital Territory	4.6	45.4	1.0	3.8	5.5	18.3
Northern Territory and Tasmania	8.2	42.4	1.2	7.1	3.5	19.8

* Participants who only indicated an Anglo-Celtic ethnic background were categorised as 'Anglo-Celtic only'; participants who were not only Anglo-Celtic were categorised as 'multicultural background'. 'Person of colour' includes all participants who additionally identified as a person of colour. Refer to section 3.6 for detail on how ethnicity was assessed.

** Sample sizes for intellectual and sensory disability and acquired brain injury were too small to allow disaggregation of the data and are not included in the table

5.7 Focus group insights

The extent to which the pandemic impacted on the mental health and wellbeing of the LGBTQ+ community in Australia is indicated by the above survey results, which suggest that the pandemic had a negative impact on the mental health of a considerable proportion of LGBTQ+ people, in particular younger (aged 18 to 24), trans and gender diverse, and people living with disabilities. The focus groups sought to reflect on the how and why the pandemic impacted on the mental health of specific sections of the LGBTQ+ communities, or how they sought to mitigate mental health impacts, rather than on the focus group participants' own mental health and wellbeing. We will report below insights relative to the experiences of discrimination by focus group participants. Further focus group reflections are described in the other sections of the report.

5.7.1 Experiences of discrimination

During our focus group discussions, participants were asked about experiences of discrimination for being LGBTQ+, and/or people of colour during the pandemic. Most did not feel that discrimination had occurred more than usual, with some exceptions. A small number of trans and gender diverse focus group participants mentioned problems while navigating vaccine certificates, MyGov and other agencies, which misgendered them and used dead names on official documents. Others reported the negative impact of delays imposed on gender affirming surgeries, which were considered to be 'selective' and therefore halted during parts of the pandemic to free-up hospital facilities and staff. Delays in receiving hormonal medications were also experienced as extremely stressful by some trans participants.

Participants in the multicultural group spoke of having witnessed racism against Asian-looking people during the pandemic. One

lesbian cisgender woman reported facing anti-Asian, racist attitudes herself and feeling that she 'did not belong':

When COVID came out, there was a lot of media attention towards Chinese people [...] And that's when I noticed the racist attacks [...] So, I'm born in Australia, but my parents weren't. And I grew up with that kind of loss of identity because I didn't quite belong where my family came from. But I didn't belong here as well, because people just saw me as not one of them [...] all of a sudden, I'm in a quiet [...] white-dominated neighbourhood. I was noticing glares and looks every time I was walking by. And even going to the supermarket and making sure I didn't cough, because as soon as someone [Asian] coughs, sometimes I'd hear comments here and they're saying, 'Oh my God, they've got Corona; they're going to give it to me' [...] that's what we definitely face that's unique to LGBTQ+ people with multicultural backgrounds. I definitely noticed that in the queer community, because I was part of a Facebook group [...] specifically for queer Asians [...] And we were kind of making posts saying, you know, there have been attacks on people of Asian descent recently, because of COVID. (Rebecca, cisgender woman, lesbian, 27)

Experiences of racist attitudes were seen and experienced as common to people from multicultural backgrounds in general, rather than specific to LGBTQ+ people of colour only. None of the multicultural participants reported experiencing or witnessing racist attacks against non-white LGBTQ+ people linked to the pandemic within majority-white queer communities.

[I wish] that people with disabilities particularly weren't kind of being viewed as the collateral damage while we all push the COVID normal.

(KEN, NON-BINARY, 37)

The same participant quoted above also shared an important insight on the perceived changes around mental health stigma within her cultural community due to the pandemic, which was met with agreement by other multicultural focus group participants:

I still feel [...] that stigma between culture and mental health. I kind of grew up with the notion of, well, if you're thinking depressing thoughts, then you're considered weak, or there's something not right with you or that it's not normal. And going to therapy was kind of shunned, I guess, and you lose that family face. And I thought about growing up with my sister who had depression and anxiety, and turns out, it came from Mum, she has depression and anxiety and Dad had PTSD. But they [were] just never diagnosed or considered that this was kind of something that you can look into. Thankfully, the pandemic actually helped us become more familiar [...] It's kind of normalised that everyone has a bit of anxiety, everybody could probably get a bit of depression over time. And it might be through traumatic experiences, or it might just [...] happen.
(Rebecca, cisgender woman, lesbian, 27)

One participant living with disability described what she felt to be a painful public discourse by media and governments that presented older people and people with co-occurring medical conditions as 'collateral damage':

When people get really sick or die in the news, and governments like to say, 'Oh, well, it's only people that have co-occurring or other additional health needs that are really getting really ill.' That's me, and that's the people that I love [...] [I wish] that people with disabilities particularly weren't kind of being viewed as the collateral damage while we all push the COVID normal.
(Ken, non-binary, something else, 37)

Importantly, focus group participants insisted that they had found queer communities to be particularly sensitive and careful about protecting the most vulnerable within their

communities during the pandemic. However, one participant felt that LGBTQ+ people who chose not to get a COVID-19 vaccine were excluded from LGBTQ+ community events and sources of support and felt discriminated against within their own community for this reason.

5.8 Summary

Previous research has identified very high rates of psychological distress and suicidality among LGBTQ+ communities in Australia (6,7) which, appear considerably higher in comparison to rates among the general population of Australia according to the best available data sources. It is important to hold in mind then that many within the LGBTIQ community entered the COVID-19 pandemic in already challenging mental health circumstances.

Data from this survey suggest that the pandemic further exacerbated this situation and that COVID-19 and associated restrictions had a considerable impact on the mental health of the LGBTQ+ community in Australia. A similar proportion of participants to that in *Private Lives 3* reported ever having experienced suicide ideation. A slightly higher proportion of *Pride and Pandemic* participants experienced suicide ideation during the pandemic than in the previous 12 months in *Private Lives 3* (50.5% compared to 41.9%). The negative impact of the pandemic on mental wellbeing of LGBTQ+ people was more frequently reported by the following groups than other sections of the LGBTQ+ community: younger people (18 to 24 years); those who identified as queer, bisexual or pansexual; trans and gender diverse people; and people living with disability.

Concerns about experiencing LGBTQ+ discrimination during the pandemic were reported by almost half (49.5%) of survey participants. About one-quarter (28.8%) of those from a multicultural background and almost two-thirds (66.7%) of those who identified as a person of colour expressed at least some concern that they would experience discrimination against them based on their cultural or ethnic background during the pandemic. Focus groups discussions highlighted how some trans and gender diverse people may have been impacted by delays in and suspensions of gender affirming surgeries categorised as 'elective', as well as by misgendering in vaccination and other documents during the pandemic. Focus group participants from (Chinese or Southeast Asian) multicultural backgrounds shared experiences of racism in the wider community, which for some intensified feelings of not fully belonging to either their cultures of origin or majority-white cultures. Discrimination was strongly experienced by participants with disability and/or co-occurring health conditions, who shared their feelings about being portrayed as what they described as 'collateral damage' by media when reporting COVID-19-related deaths.



6 Social interactions and informal support

As a consequence of social distancing public health recommendations and mandates as well as individual measures taken to avoid contracting and preventing the spread of COVID-19, most people in Australia would likely have experienced a degree of decreased social interactions and isolation from others.

Social isolation and less opportunity for receiving support from others are likely to have exacerbated poor mental health and wellbeing outcomes for many during the pandemic (29,30). The pandemic may have further restricted the social networks and affirming social support of LGBTQ+ people due to adapted living situations that may have required concealment of their LGBTQ+ identity. LGBTQ+ communities may therefore be disproportionately impacted by the decrease in social interactions and supports, as has been evidenced

by an early pandemic study in the US (31). Importantly, research also suggests that social interactions and perceived support from others may protect mental wellbeing (32,33), with a recent Australian study suggesting the importance of online social interactions for mitigating the impacts of health anxiety during times of pandemic related isolation (34). These previous findings illustrate the important role that adapted, socially distanced interactions and support from others may play for LGBTQ+ people during the pandemic.

6.1 Living situation during lockdowns

6.1.1 Household members during periods of lockdown

While not all regions of Australia experienced extensive lockdowns, particularly those areas outside of Melbourne and Sydney, almost all participants (98.1%; n = 3,051) indicated that they had experienced some periods of lockdown during the pandemic. Participants who had experienced lockdowns were asked to provide details of who else was resident in their household during times of lockdown.

Table 19: Household members during lockdowns (n = 3,051)

Household members during lockdowns	n	%
I was on my own	613	20.1
One or more family members	992	32.5
Relationship partner(s)	1,165	38.2
Children that I care for	249	8.2
One or more friends/roommates/housemates	527	17.3
Someone else	32	1.1

Note: Multiple responses were available, thus percentages do not add up to 100.

While a large number of participants lived on their own during lockdowns (20.1%; n = 613), most (79.9%; n = 2,438) participants were in a household with at least one other person, with the highest proportions of participants living with a relationship partner or partners (38.2%; n = 1,165) or with one or more family members (32.5%; n = 992), followed by participants who lived with one or more friends or roommates or housemates (17.3%; n = 527).

6.1.2 Children learning at home

As shown above in Table 19, 8.2% (n = 249) of participants lived in a household with children that they cared for during lockdown and of these participants, 73.9% (n = 184) cared for children who required support for learning at home.

6.2 Change in social interactions with others

Change in the frequency of social interaction during the pandemic, in person and online, was assessed by asking participants to reflect and self-report whether they felt that these interactions had changed during the pandemic as compared to prior to the pandemic, ranging from 'much less than before the pandemic' to 'much more than before the pandemic'.

6.2.1 Social interactions with family, friends and partners

More participants reported less interaction with family of origin (48.7%; n = 1,413) and chosen family (51.5%; n = 1,400) than reported no change or more interaction during the pandemic. This difference was even more pronounced for interaction with friends, with three-quarters (75.0%; n = 2,317) reporting less interaction during the pandemic. These proportions are to be expected given stay-at-home orders and a higher frequency of participants living in a household with family during lockdown than with friends.

Additionally, 62.5% (n = 300) of participants with a partner or partners reported that they experienced challenges visiting their partner or partners whom they did not live with during the pandemic.

6.2.2 Online social interactions

Given the decrease in social interaction as a result of public health recommendations and mandates to socially distance and isolate, it was expected that people would compensate for the lack of in-person interactions with remote or online interactions. Accordingly, approximately three-quarters (75.8%; n = 2,329) of participants reported an increase in the frequency of their use of social media, with just 6.3% (n = 195) suggesting that they used social media less than before the pandemic.

Additionally, more than two-fifths (45.8%; n = 1,308) of participants reported more online participation in social or learning activities for fun compared to prior to the pandemic, with 18.2% (n = 521) reporting less participation in online social or learning activities.

6.3 Support from others during the pandemic

Participants were asked how much support or assistance they received during the pandemic from others in comparison to prior to the pandemic, with responses ranging from 'much less than before the pandemic' to 'much more than before the pandemic'.

Table 20: Frequency of interaction with friends and family during the pandemic as compared to prior to the pandemic

	Much less/slightly less than before the pandemic		Same as before the pandemic		Slightly more/much more than before the pandemic	
	Number	%	Number	%	Number	%
Interaction with friends and family						
Birth or childhood family (i.e. family of origin)	1,413	48.7	791	27.3	698	24.1
Chosen family	1,400	51.5	778	28.6	539	19.8
Friends	2,317	75.0	414	13.4	358	11.6

I'm used to speaking to my friends online. But a lot of liberating experiences [...] only really come from being in [physical] shared spaces that are, you know, LGBT-friendly [...]

(ANTHONY, TRANS MAN, BISEXUAL, 22)

Table 21: How much support participants received from others during the pandemic

	Much less/less than before the pandemic		Same as before the pandemic		More/much more than before the pandemic	
How much support or assistance did you receive during the pandemic from:	n	%	n	%	n	%
Family	564	19.0	1,694	57.0	715	24.0
Friends	868	28.5	1,330	43.7	844	27.7
Neighbours	402	17.1	1,478	62.8	473	20.1
Work colleagues	505	21.2	1,026	43.1	848	35.6
An LGBTIQ+ support group or organisation	300	22.5	761	57.0	273	20.5
Religious group or community	218	32.7	367	55.0	82	12.3
Other type of support	130	24.5	284	53.5	117	22.0

For the greatest proportion of participants, support or assistance received from others remained the same during the pandemic as compared to prior to the pandemic. However, for many, support or assistance decreased, with the greatest proportion among participants who reported reduced support (32.7%; n = 218) reporting less support from a religious group or community, followed by those reporting less support from friends (28.5%; n = 868). Conversely, participants also reported receiving increased support or assistance from some sources; in particular, more than one-third (35.6%; n = 848) of participants reported receiving more support during the pandemic from work colleagues.

6.4 Working and studying remotely

Many people living in Australia were asked or required to work or study remotely during the pandemic. Of the *Pride and Pandemic* participants, 36.1% (n = 1,128) had worked or studied remotely throughout the course of the pandemic and a further 31.3% (n = 980) had worked or studied remotely during times of lockdown or workplace restrictions during the pandemic. Participants who had spent any time working or studying remotely were asked to respond to a number of questions regarding this experience, and how they feel about it moving forward.

Table 22: Experience of working or studying remotely during the pandemic (n = 2,108)

Experience of remote work or study	n	%
Happy to be working or studying remotely	1,306	62.6
Working/studying remotely improved accessibility	1,003	50.2
Happy to return to in-person working/studying	1,293	66.7
Felt able to balance work/study with personal life while working/studying from home	1,105	53.7
Would like to continue working/studying remotely after the pandemic (this includes preference for either part-time or full-time hours working remotely)	1,208	58.8

While participants generally felt that remote work or study was a positive thing, with more than three-fifths (62.6%; n = 1,306) reporting that they were happy with working or studying remotely, many were also happy to return to in-person work or study (66.7%; n = 1,293). Half (50.2%; n = 1,003) of participants working or studying remotely felt that remote options improved accessibility, and approximately half (53.7%; n = 1,105) felt that they were able to balance their work or study with their personal life. More than half (58.8%; n = 1,208) expressed a desire to continue working or studying remotely to some degree beyond the pandemic.

6.5 Social interactions across intersections

To illustrate the role of intersectionality in social interactions and support from friends and family during the pandemic, Table 23 below provides additional data on changes in social interactions with family and friends as well as change in

support from family and friends across various intersections of the survey population. The table reports data from intersections of the population believed to be most likely to have been impacted in unique ways during the pandemic. These include age, gender, ethnicity, disability and residential location and state or territory.

Table 23: Changes in social interactions and support from friends and family across age, gender, ethnicity, disability, residential location and state or territory

	Less interaction during the pandemic with:		Less support during the pandemic from:	
	Family of origin (%)	Friends (%)	Family of origin (%)	Friends (%)
Age				
18-24 years	39.6	72.7	14.1	27.7
25-34 years	49.5	72.5	18.9	26.4
35-44 years	53.3	78.3	20.7	32.8
45-54 years	52.7	80.0	25.9	28.5
55-64 years	58.5	79.6	21.7	31.5
65+ years	51.5	65.8	16.2	22.9
Gender				
Cisgender woman	50.7	76.9	19.1	28.9
Cisgender man	45.9	72.1	16.1	24.0
Trans woman	40.9	67.5	23.7	32.5
Trans man	50.6	76.2	20.9	32.5
Non-binary	51.0	77.8	21.3	31.7
Sexual orientation				
Gay or lesbian	49.6	74.5	17.4	25.9
Bisexual or pansexual	46.4	75.4	20.7	34.5
Queer	51.1	80.7	22.2	31.1
Asexual	50.9	75.2	17.8	22.1
Something else	41.2	66.7	17.7	25.0
Ethnicity*				
Anglo-Celtic only	48.4	75.5	18.1	28.2
Multicultural background	48.4	74.2	19.8	29.1
Person of colour	42.7	67.7	19.9	29.4
Disability/long-term health condition**				
No disability	46.5	73.9	16.0	23.0
Physical	52.1	81.4	26.7	37.4
Mental illness	51.9	76.8	20.9	36.0
Sensory	65.7	81.6	8.6	34.2

Table 23 continued

	Less interaction during the pandemic with:		Less support during the pandemic from:	
	Family of origin (%)	Friends (%)	Family of origin (%)	Friends (%)
Neurodiversity/autism	50.4	74.6	19.8	28.1
Something else	41.7	73.1	23.8	29.9
Residential location				
Capital city, inner suburban	50.6	76.3	19.2	27.8
Capital city, outer suburban	46.8	75.5	17.5	28.5
Regional city or town	46.4	72.3	19.9	29.6
Rural or remote area	51.3	73.3	20.4	28.4
State or territory				
Victoria	54.0	80.6	21.4	30.2
New South Wales	46.9	77.5	20.0	31.0
Queensland	42.9	68.5	14.9	26.9
Western Australia	37.3	59.7	14.0	20.2
South Australia	50.3	69.0	18.0	24.1
Australian Capital Territory	57.5	79.8	19.8	28.4
Northern Territory and Tasmania	43.0	58.3	13.0	20.8

* Participants who only indicated an Anglo-Celtic ethnic background were categorised as 'Anglo-Celtic only'; participants who were not only Anglo-Celtic were categorised as 'multicultural background'. 'Person of colour' includes all participants who additionally identified as a person of colour. Refer to section 3.6 for detail on how ethnicity was assessed.

** Sample sizes for intellectual disability and acquired brain injury were too small to allow disaggregation of the data and are not included in the table

6.6 The association between social supports and mental health

Decreased social interactions and opportunities for support from others are likely to have resulted in poorer mental health outcomes. To explore associations between changes in social interaction and support and mental health outcomes during the pandemic, a series of multivariable logistic regression analyses were conducted using psychological distress (as assessed using the K10) and suicide ideation or suicide attempt during the pandemic as outcome variables. Demographic variables were controlled for in the model, including age, sexual orientation, gender, residential location and state or territory. These analyses are further detailed in section 2.6.

Less interaction with friends during the pandemic was associated with:

- A greater likelihood of reporting high or very high psychological distress (AOR = 1.40, CI = 1.04-1.90, $p = 0.029$)
- A greater likelihood of reporting that mental wellbeing got worse during the pandemic (AOR = 1.82, CI = 1.36-2.43, $p < 0.001$)

Less interaction with chosen family during the pandemic was associated with:

- A greater likelihood to report that mental wellbeing got worse during the pandemic (AOR = 1.37, CI = 1.07-1.76, $p = 0.012$)

More interaction with family of origin during the pandemic was associated with:

- A lower likelihood of having attempted suicide during the pandemic (AOR = 0.53, CI = 0.30-0.91, $p = 0.022$)

Reporting any change in the amount of support received during the pandemic from family, whether less or more, was associated with:

- A greater likelihood of reporting high or very high psychological distress (less support: AOR = 1.53, CI = 1.15-2.04, $p = 0.003$; more support: AOR = 1.30, CI = 1.02-1.67, $p = 0.036$)
- A greater likelihood of experiencing suicidal ideation during the pandemic (less support: AOR = 1.87, CI = 1.43-2.45, $p < 0.001$; more support: AOR = 1.44, CI = 1.13-1.84, $p = 0.003$)

Reporting less support from family was associated with:

- A greater likelihood of attempting suicide (AOR = 2.51, CI = 1.53-4.12, $p < 0.001$)
- A greater likelihood of reporting that mental wellbeing had got worse during the pandemic (AOR = 1.60, CI = 1.20-2.12, $p = 0.001$)

Reporting any change in the amount of support received during the pandemic from friends, whether less or more, was associated with:

- A greater likelihood of reporting high or very high psychological distress (less support: AOR = 2.17, CI = 1.68-2.81, $p < 0.001$; more support: AOR = 1.32, CI = 1.05-1.67, $p = 0.019$)
- A greater likelihood of reporting that mental wellbeing had got worse during the pandemic (less support: AOR = 1.75, CI = 1.37-2.24, $p < 0.001$; more support: AOR = 1.72, CI = 1.36-2.18, $p < 0.001$)

Additionally, reporting less support from friends was associated with:

- A greater likelihood of experiencing suicidal ideation (AOR = 1.43, CI = 1.12-1.82, $p = 0.005$)

Evidently, less social interaction and less support received from others was associated with poorer mental health outcomes during the pandemic. In some cases, increased support from family and friends was also associated with poorer mental health outcomes. These findings may reflect the negative impacts of the pandemic on mental health resulting in LGBTQ+ individuals seeking out more support from their friends and family.

6.7 Focus group insights

6.7.1 Shift from physical to online modes of interaction

Changes in sociality and interaction with friends and family during the pandemic were central themes of discussion in all focus groups, in which participants spoke of both negative and positive aspects of such changes. The severely limited access to physical contact with friends was experienced as taxing and isolating by most participants, particularly those who were younger, and/or trans and gender diverse:

I'm certainly very aware of myself and many of my LGBT+s friends that were inclined towards feeling isolated anyway. And feeling outside of the norm and feeling, you know, safety and security with each other [...] I think that there is a predisposition to isolation and loneliness. And that's been the case for everyone, of course, but it's been really strong for LGBT young people [...] So, isolation is a key word from my point of view [...] [Physical isolation] has been challenging. I'm used to speaking to my friends online. And I think that's fairly common for LGBT young people. But a lot of liberating experiences and a sense of freedom and a sense of comfort [...] only really comes from being in [physical] shared spaces that are, you know, LGBT-friendly, where everyone is. (Anthony, trans man, bisexual, 22)

Some of my friends who are a bit younger, these are the years where they actually go out and make more friends and meet new people and sort of learn more about

themselves at a very young age [...] They haven't really got that opportunity [...] [I] feel like all the experiences they're meant to gain have been lost or it's been lagged [...] So that's another thing that I think is quite unique for our community. (Fran, trans woman, something else, 24)

Younger focus group participants shared further concerns about being required to stay at home with birth families who were not accepting of their LGBTQ+ identities, and about being isolated from their LGBTQ+ friends. Conversely, some also expressed concerns for LGBTQ+ people who had moved to other cities or interstate away from accepting and supportive families, and may have felt more isolated by being physically separated from them during the pandemic:

Most of my friends who are LGBTI+ moved to Melbourne from somewhere else in Australia, in Victoria or other states. And so, going through the lockdowns, they felt even more isolated, because their family is in a completely different part of Australia, if they're still in contact or on good terms with their family. (Nathan, cisgender man, gay, 23)

Participants from multicultural backgrounds felt that physical isolation during lockdowns would come as an added layer to a pre-existing condition of isolation already common among their peers:

I think [isolation] is not unique to COVID periods; it's, I guess, a constant feature of people from multicultural backgrounds. First of all, we tend to be strangers within our own cultures [...] we tend to be more isolated than the average person out there [...] So, all they're really adding here is the very visually isolating aspect of being in lockdown, and all that. And I guess [this would be] even more important [in affecting us], because so many families from multicultural backgrounds are not accepting [LGBTQ+ identities]. (Kim, cisgender man, bisexual, 34)

Rainbow families spoke at length of missing physical contact with their friends (particularly other rainbow families), who were seen as crucial support to navigate the possible isolation linked to being non-heteronormative families. For some, online connection was particularly difficult to maintain as a family, as young children were less likely to engage in online environments than they were in person.

On a different note, not having to enter spaces often experienced as cis-heteronormative, such as school drop-offs or other mixed parent events, was a relief to one participant in the rainbow families focus group. Their remark was endorsed by many others in the group and is both an indication of how LGBTQ+ people may experience pandemic-related restrictions in specific ways and a reminder of how physical cis-heteronormative spaces may still not be felt as welcoming and inclusive by members of the LGBTQ+ community.

The impact of isolation and lack of socialisation was acutely felt by one trans participant living in a rural area. She recalled having been mostly isolated for 2 years, speaking to hardly anyone and, crucially, not being able to use antidepressants or anxiety medication, as these were not compatible with her gender-affirming hormone therapies:

When you're only going here once every fortnight to get your medication and food, and the only other company you've got is a dog, and that continuous amount of time of being alone is frustrating, when you've got no-one else you

[...] It's been one of the hardest 2 years that I've come across, not being able to socialise and [not] having that wellbeing. We have always been able to [...] get out and do what you want, and all of a sudden that's gone. There's no socialisation [...] You're talking to yourself. And it is draining on your mental health.

(MARIA, TRANS WOMAN, 62)

can actually talk to [...] it is a strain on your mental health [...] It's been one of the hardest 2 years that I've come across, not being able to socialise and [not] having that wellbeing. We have always been able to [...] get out and do what you want, and all of a sudden that's gone. There's no socialisation [...] You're talking to yourself. And it is draining on your mental health. And because of some of the HRT medication, they can't give you anything for depression and anxiety. The drugs don't mix. And it only gets worse. (Maria, trans woman, something else, 62)

Another insight on the potential negative consequences of lack of in-person relations specific to LGBTQ+ people in general was raised by a non-binary participant who felt the downside of remote work culture in the way they could not connect with possibly supportive queer colleagues in the same manner online as in person:

The workplace I'm employed at definitely has a lot of queer employees. But because I don't share a physical space with them [...] I don't necessarily get to recognise them and feel a community with them and become friends with them. [...] It takes way too long to find that out. And you don't know who your friends and allies are, necessarily [...] It's such a weird dynamic. People I spend, you know, hours with, and I don't, I can't feel their welcoming presence as much. (Ian, non-binary, 23)

Nevertheless, focus group participants found the possibility of maintaining contact and support from friends and families online as crucial to their wellbeing. Particularly for participants who live or whose friends live with disability or co-occurring medical conditions, being connected online was not only seen as of great help during the pandemic but also as an asset for the time to come:

[What] really helped was having queer chosen family and having folks that we felt really connected to, and that we could catch up with via Zoom. And having regular connection points with them. I would say after heading into year three of this, I feel the connection points [will be] still mostly online, because a lot of my friends have co-occurring health conditions and [we are] super careful about when we see each other and that kind of stuff. (Ken, non-binary, something else, 37)

6.8 Summary

Half of the participants reported that they were concerned about experiencing discrimination against them during the pandemic. This was particularly true for LGBTQ+ people who identified as a person of colour, two-thirds of whom were concerned that they would experience discrimination against them during the pandemic based on their cultural or ethnic background.

Less social interaction and decreased support and assistance from friends and family were reported by most survey participants. Having less interaction and support from friends and family was associated with worse mental health outcomes. Conversely, a considerable number of participants who indicated poorer mental health during the pandemic also reported increased support from friends, suggesting these individuals may have been actively seeking more interactions and support because of feeling emotionally unwell during the pandemic.

Insights from our focus groups emphasised the potential negative consequences of isolation and the lack of physical interaction with friends and chosen family for younger and multicultural LGBTQ+ people and rainbow families, who may have already been even more isolated than other groups. The lack of physical contact and interaction with friends and chosen or supportive families was experienced as an overwhelmingly negative experience. However, online and phone communication was viewed as essential and as having allowed increased access and frequency of social interactions during the pandemic. Some participants felt confident that such improvements would remain.



7 Family violence

People with diverse sexual and gender identities have previously been found to experience the same, if not higher, rates of family violence compared to cisgender and/or heterosexual people (32-34), while further facing barriers to receiving support for these experiences (38,39).

According to the WHO (40), occurrences of family violence increased globally during the pandemic. This chapter highlights how, among LGBTQ+ people in Australia, financial insecurity and stay-at-home orders implemented during the pandemic to prevent the spread of COVID-19 may have resulted in many LGBTQ+ people having to spend more time in unfavourable home environments, and potentially

being required to isolate among family members who reject their identity or perpetrate violence toward them based on their LGBTQ+ identity. Additional intersecting identities – including an individual's gender or sexual orientation, cultural background or disability – may have further exacerbated these experiences during the pandemic.

7.1 Experiences of violence from an intimate partner or family member

Given the dominant, gendered framing of family violence as a presumptively cisgender man enacting violence against a cisgender woman, some LGBTQ+ people may have trouble directly identifying experiences of family violence (6,41). It is, therefore, important to ask about these experiences in a nuanced manner that can reflect LGBTIQ experiences, as was done in *Private Lives 3*. Participants of *Pride and Pandemic* were asked to respond two family violence-related questions: 'Have you experienced any of the following from family members? (Choose as many as apply)'; and 'Have you experienced any of the following from an intimate partner? (Choose as many as apply)'. Response options included 10 forms of violence as detailed in Figure 3 below, with an additional option for participants to indicate that they had not experienced any of these forms of violence. Participants who indicated that they had experienced any of these forms of violence were categorised as having experienced family violence.

- Almost one-fifth (17.2%; n = 494) of participants had experienced violence from an intimate partner during the pandemic
- More than one-quarter (28.9%; n = 852) of participants had experienced violence from a family member during the pandemic.

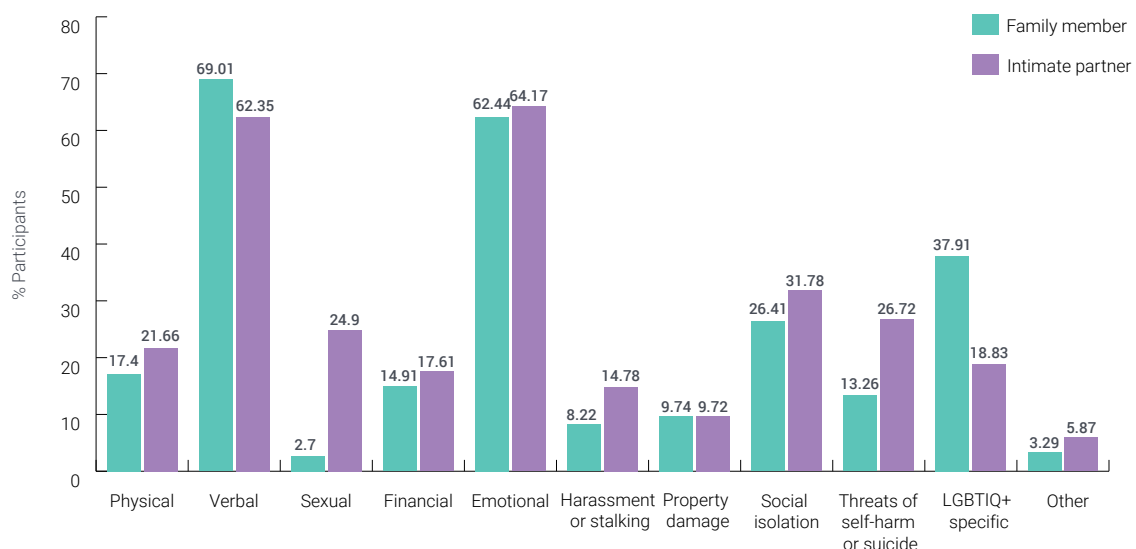
Participants who indicated having ever experienced violence from a family member were then asked to select 'the relation the family member/s had to you at the most recent time this occurred'. The highest proportion, more than three-quarters (77.9%; n = 637), reported that the violence was perpetrated by a parent, carer or guardian, followed by those who reported violence from a younger sibling (17.2%; n = 141), older sibling (16.0%; n = 131) or extended family member (12.1%; n = 99). A small proportion of participants reported the perpetrator to be a child or grandchild (3.8%; n = 31), in-laws (3.3%; n = 27) or other family members (1.7%; n = 14).

7.2 Forms of violence experienced from an intimate partner or family member

The same item as described above was also used to break down the types of violence experienced by participants. Figure 3 shows the type of violence experienced, as perpetrated by an intimate partner or family member. Forms of violence included:

- Physical violence (e.g. hitting, throwing heavy objects or using threats and physical intimidation, regardless of whether an injury resulted)
- Verbal abuse (e.g. using regular criticism, insults or demeaning language)
- Sexual assault (e.g. enacting undesired sexual behaviour through force or other means)
- Financial abuse (e.g. stealing or controlling access to money, preventing you from working or studying, or accruing debts in your name)
- Emotional abuse (e.g. regularly manipulating or humiliating you in front of others, gaslighting, bullying, or blaming you for abuse) harassment or stalking (e.g. monitoring your movements, coercing you into a relationship commitment or religious practice, forcing you to stop practising your own religious or spiritual practices)
- Property damage (e.g. destroying or threatening to destroy possessions or property, including pets)
- Social isolation (e.g. making it difficult to see friends, family or community)
- Threats of self-harm or suicide (e.g. partner or family member threatening self-harm or suicide)
- LGBTQ-related abuse (e.g. shaming you about being LGBTQ, threatening to 'out' you or your HIV status, withholding hormones or medication)
- Additional options of 'other' and 'I have not experienced any of these from an intimate partner'

Figure 3: Forms of violence experienced from an intimate partner or family member during the pandemic



Many of my friends who are not in a position where they can take control of their lives, I see them withdrawing into themselves. They are effectively going back into the closet, right? Because they're isolated from their usual support group where they can be open and be themselves and they can be out.

(KIM, CISGENDER MAN, BISEXUAL, 34)

Participants from *Pride and Pandemic* reported a wide range of violence experienced during the pandemic. However, the types of violence most frequently reported from family members and intimate partners were emotional (family member: 62.4%; n = 532; intimate partner: 64.2% n = 317) and verbal abuse (family member: 69.0%; n = 588; intimate partner: 62.4% n = 308). Also frequently reported from both family members and intimate partners were social isolation (family member: 26.4%; n = 225; intimate partner: 31.8% n = 157) and LGBTQ+-specific violence (family member: 37.9%; n = 323; intimate partner: 18.8% n = 93). Violence from an intimate partner also more regularly involved threats of self-harm or suicide (26.7%; n = 132) and sexual violence (24.9; n = 123). Approximately one-fifth of participants experienced physical violence from a family member (17.1%; n = 146) or intimate partner (21.7%; n = 107).

7.3 Impact of the pandemic on experiences of family violence

Participants who reported having experienced family violence during the pandemic were additionally asked if there was a change in frequency in the violence that they experienced during the pandemic. Responses included if there was no change, if it was less or more frequent, and if violence was experienced for the first time during the pandemic.

Table 24: Change in frequency of violence during the pandemic (n = 836)

Frequency of family violence during the pandemic	n	%
No change from prior to March 2020	438	52.4
Violence occurred less frequently than prior to March 2020	94	11.2
Violence occurred more frequently than prior to March 2020	210	25.1
Experienced violence for the first time during the pandemic	94	11.2

More than one-third (36.3%; n = 304) of participants who had experienced family violence during the pandemic indicated that this violence was more frequent during the pandemic as compared to the violence experienced prior to the pandemic, or that they had experienced violence for the first time during the pandemic. A much smaller proportion (11.2%; n = 94) reported that violence had occurred less frequently during the pandemic. While we cannot ascertain from the data how or why the frequency of violence changed during the pandemic, we may assume that increased stressors, combined with changed living situations in which people have been forced to remain in a household with an abusive family member or intimate partner during lockdowns and isolation, are likely contributors to increased frequency of violence.

7.4 Experiences of family violence across intersections

To illustrate the role of intersectionality in experiences of family violence during the pandemic, Table 25 provides additional data on experiences and frequency of violence from a family member or intimate partner during the pandemic across various intersections of the survey population. The table reports data from intersections of the population believed to be most likely to have been impacted in unique ways during the pandemic. These include age, gender, ethnicity, disability and residential location and state or territory.

7.5 Focus group insights

While no focus group participant shared experiencing family violence themselves (groups were not directly asked this for reasons of anonymity), many expressed concerns for their peers, in particular younger LGBTQ+ people who may have been compelled to live and isolate with families of origin who may not be supportive of their gender diversity or sexuality.

I've got friends who are at home still and have parents, or families even, that aren't overly accepting or supportive. [It] would be really hard [...] having to isolate and stay at home for months on end with unsupportive parents or siblings, or anyone. (Felicia, cisgender woman, lesbian, 21)

Table 25: Experiences of family violence during the pandemic across age, gender, ethnicity, disability, residential location and state or territory

	Experience any family violence during the pandemic		Frequency of violence from a family member during the pandemic			Frequency of violence from an intimate partner during the pandemic		
	From an intimate partner (%)	From a family member (%)	Violence occurred less frequently (%)	Violence occurred more frequently (%)	Violence occurred for the first time (%)	Violence occurred less frequently (%)	Violence occurred more frequently (%)	Violence occurred for the first time (%)
Age*								
18-24 years	17.1	49.5	14.5	27.5	7.8	11.9	24.6	36.6
25-34 years	17.4	27.2	9.9	24.8	10.8	6.6	29.2	21.9
35-44 years	18.7	17.8	5.5	27.5	14.3	13.5	24.7	23.6
45-54 years	18.2	16.9	9.2	18.5	12.3	4.6	29.2	18.5
55-64 years	15.1	15.7	5.3	13.2	28.9	14.3	25.7	17.1
Gender								
Cisgender woman	18.3	29.3	12.2	24.4	9.0	10.8	29.7	24.9
Cisgender man	15.0	14.8	5.0	20.0	22.1	8.8	26.5	25.7
Trans woman	21.9	39.8	2.2	30.4	21.7	12.5	4.2	37.5
Trans man	20.8	50.6	13.3	26.5	7.2	0.0	34.4	25.0
Non-binary	17.5	44.8	13.8	28.6	8.9	11.3	23.9	26.8
Sexual orientation								
Gay or lesbian	16.3	20.9	7.3	20.9	18.5	10.8	26.0	24.7
Bisexual or pansexual	19.7	41.1	12.7	26.4	6.5	9.0	29.9	26.9
Queer	15.5	29.7	11.9	28.6	7.1	5.2	25.9	27.6
Asexual	11.4	44.1	8.3	29.2	12.5	0.0	16.7	25.0
Something else	19.5	26.9	27.3	27.3	9.1	13.0	26.1	26.1
Ethnicity**								
Anglo-Celtic only	15.4	24.9	8.1	24.7	13.1	6.4	26.0	28.1
Multicultural background	19.5	34.5	14.7	25.4	9.0	13.0	28.4	22.8
Person of colour	22.0	40.8	17.1	21.9	11.4	7.7	34.6	30.8
Disability/long-term health condition*								
No disability	15.2	16.4	5.5	20.2	16.5	8.0	26.7	26.7
Physical	14.9	28.4	12.7	30.9	12.7	14.8	22.2	14.8
Mental illness	20.9	39.0	12.4	30.8	8.3	10.8	27.3	29.5
Neurodiversity/autism	18.0	47.8	13.0	24.9	9.3	7.5	22.4	26.9
Something else	14.1	39.4	15.4	19.2	3.8	22.2	33.3	0.0
Residential location								
Capital city, inner suburban	15.0	23.0	8.5	20.3	13.2	9.8	29.5	25.7
Capital city, outer suburban	18.5	33.7	12.8	32.2	10.3	9.2	25.5	25.5
Regional city or town	19.1	33.7	13.0	22.7	10.2	11.5	23.9	23.9
Rural or remote area	21.6	33.3	12.0	26.0	8.0	6.5	29.0	35.5

Table 25 continued

	Experience any family violence during the pandemic		Frequency of violence from a family member during the pandemic			Frequency of violence from an intimate partner during the pandemic		
	From an intimate partner (%)	From a family member (%)	Violence occurred less frequently (%)	Violence occurred more frequently (%)	Violence occurred for the first time (%)	Violence occurred less frequently (%)	Violence occurred more frequently (%)	Violence occurred for the first time (%)
State or territory*								
Victoria	15.4	27.6	12.3	24.6	11.6	4.1	28.8	25.3
New South Wales	17.7	26.5	9.5	26.8	10.5	9.2	27.0	30.5
Queensland	19.2	32.5	12.8	25.5	10.1	19.3	18.1	22.9
Western Australia	16.3	30.3	6.9	17.2	17.2	6.9	37.9	24.1
South Australia	21.6	37.0	13.2	27.9	11.8	12.8	28.2	25.6
Australian Capital Territory	15.2	29.2	9.1	21.2	3.0	13.3	46.7	6.7

* Sample sizes for those aged 65+ years, for those with intellectual and sensory disability and acquired brain injury; and for those in the Northern Territory or Tasmania were too small to allow disaggregation of the data and are not included in the table

** Participants who only indicated an Anglo-Celtic ethnic background were categorised as 'Anglo-Celtic only'; participants who were not only Anglo-Celtic were categorised as 'multicultural background'. 'Person of colour' includes all participants who additionally identified as a person of colour. Refer to section 3.6 for detail on how ethnicity was assessed.

Participants in the multicultural group further expressed a concern for LGBTQ+ people of cultural backgrounds whose families may hold values that may be unaccepting of sexual or gender diversity.

Many families from multicultural backgrounds are not accepting [of sexual and gender diversity] [...] Many of my friends who are not in a position where they can take control of their lives, I see them withdrawing into themselves. They are effectively going back into the closet, right? Because they're isolated from their usual support group where they can be open and be themselves and they can be out. (Kim, cisgender man, bisexual, 34)

One participant from the multicultural group expressed relief to be living in a location away from their family and some concerns about what would happen once restrictions would be lifted, and their parents would be able to travel to see them:

A lot of us are sort of separated from our families, right, like physically, because of this pandemic, because a lot of people can't visit. And interestingly, that's kind of been a source of more freedom for me, to explore things and meet new people [...] I'm personally a bit worried about what will happen when all these restrictions are lifted, and my parents will come over in person, and then I'll have to go back to getting used to hiding all this stuff again. (Henry, non-binary, asexual, 23)

7.6 Summary

Overall, this survey found very high rates of family violence among its LGBTQ+ participants. Over one-third of participants reported experiencing violence from a family member or intimate partner during the pandemic. Family violence was experienced more frequently or for the first time during the pandemic for over one-third of participants who reported it. A small proportion mentioned experiencing less violence during the pandemic. The nature of the violence from both intimate partners or family members was primarily verbal and emotional, while one-fifth experienced physical family violence.

Younger participants (18 to 24 years) were most likely to report family violence. Concerns for the wellbeing of younger LGBTQ+ people during the pandemic emerged repeatedly within our focus group discussions. Participants in the multicultural focus group raised concerns and shared experiences of having to spend lockdowns with families who were unaccepting of gender and sexual diversity. Within our survey, people of colour and those from multicultural backgrounds were also more likely to report family violence from a family member than was the case for participants from an Anglo-Celtic background.

Further differences in the experience of family violence emerged in relation to gender identity and sexuality: participants who identified their sexual orientation as other than gay and lesbian, and those who identified as trans and gender diverse were both more likely than participants belonging to other groups to report violence from a family member. Similarly, these groups were more likely to report intimate partner violence.

Finally, a greater proportion of people with disability than those without disability reported an increase in frequency of violence from family members during the pandemic.



8 Alcohol and other drugs

Changes in tobacco, alcohol and other drug consumption during the pandemic have been illustrated by a number of studies nationally and globally (39-41).

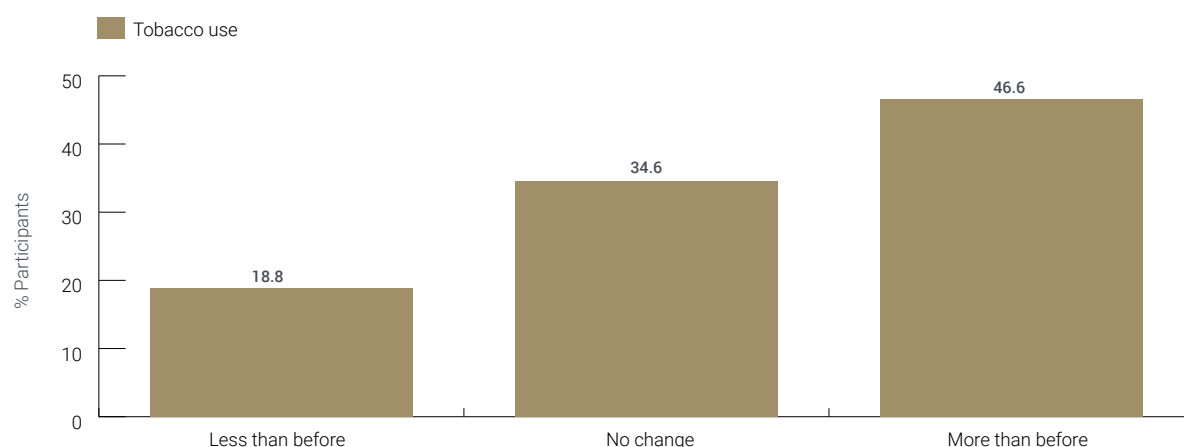
One study assessing samples from wastewater plants around Australia found evidence in the early pandemic national lockdown of decreases in the use of drugs such as methamphetamine, MDMA and cocaine, an increase in the use of cannabis and, in general, a return to pre-pandemic rates of use for most substances as the pandemic progressed (45).

Increases in alcohol consumption have been reported among people who consumed high amounts prior to the pandemic (43), and among those who experienced mental health concerns such as depression or anxiety during the pandemic among both cisgender heterosexual and sexual minority populations (42,43,46,47). Many studies attribute observed increases in alcohol and other drug consumption to increased stressors

experienced during the pandemic, and illustrate associations between increased consumption and stay-at-home orders, caring for children in lockdown, and income loss(42,43).

LGBTQ+ people have been found previously to consume tobacco, alcohol and other drugs at higher rates than the general population (48,49). Coupled with additional stressors and exacerbated mental health outcomes among LGBTQ+ populations during the pandemic, LGBTQ+ people's consumption of tobacco, alcohol and other drugs may be disproportionately impacted by the pandemic. In addition, barriers already faced by the community in accessing healthcare and support in relation to consumption may have further been limited by the impacts of the pandemic.

Figure 4: Frequency of tobacco consumption during the pandemic as compared to prior to the pandemic



8.1 Tobacco

8.1.1 Change in frequency of tobacco consumption during the pandemic

Under one-third (30.4%; $n = 940$) of participants consumed tobacco. Those who did were asked to report any change in frequency of their tobacco use during the pandemic. Figure 4 presents these data.

Reflecting the increased stress brought about by the pandemic, of those who consumed tobacco, almost half (46.6%; $n = 438$) reported consuming more tobacco during the pandemic, while just 18.8% ($n = 177$) reported consuming less, and 34.6% reported no change ($n = 325$).

8.2 Alcohol

8.2.1 Change in frequency of alcohol consumption during the pandemic

Most participants (83.5%; $n = 2,602$) consumed alcohol. Those who did were asked to report any change in frequency of their alcohol use during the pandemic. Figure 5 presents these data.

Among those who reported alcohol consumption, almost half (46.0%; $n = 1,198$) reported consuming alcohol more frequently during the pandemic, while one-quarter (25.1%; $n = 654$) reported consuming it less, and 28.8% ($n = 750$) reported no change. While pandemic public health measures and social distancing would have decreased the consumption of alcohol in social spaces (e.g. due to the closure of bars and pubs), increases in alcohol consumption likely reflect the heightened stress brought about by the pandemic.

8.2.2 Alcohol-related concern

Participants who consumed any alcohol during the pandemic were asked if, since the pandemic began, they had experienced a time where they struggled to manage their alcohol use, or where it had negatively impacted their everyday life, or whether a friend or family member had expressed concern about their alcohol use. Just under one-fifth (17.5%; $n = 455$) self-reported struggling to manage their alcohol use during the pandemic and approximately one in ten (12.1%; $n =$

316) reported that a friend or family member had expressed concern about their alcohol use during the pandemic

8.2.3 Professional support for alcohol consumption

Participants who reported any concern regarding their alcohol consumption, whether their own concern or concern from others, were additionally asked if they sought any support for their alcohol consumption during the pandemic, along with the type of service they engaged.

Table 26: Alcohol support service engagement during the pandemic ($n = 534$)

Alcohol support service	n	%
Did not seek support	448	83.9
Support from a mainstream service that is that is not known to be LGBTQ+ inclusive	56	10.5
Support from a mainstream service that is known to be LGBTQ+ inclusive	25	4.7
Support from a service that only caters to LGBTQ+ people	11	2.1

Under one-fifth (17.3%; $n = 92$) of participants who indicated some concern with their alcohol consumption, from themselves or others, during the pandemic engaged an alcohol support service. The type of service engaged by the highest proportion of participants was a mainstream support service that is not known to be LGBTQ+ inclusive (10.5%; $n = 56$), followed by a mainstream support service that is known to be LGBTQ+ inclusive (4.7%; $n = 25$), and a support service that only caters to LGBTQ+ people (2.1%; $n = 11$).

8.2.4 Non-professional support for alcohol consumption

Participants who indicated concern about their alcohol consumption during the pandemic were additionally asked if they had sought any non-professional support and where they sought support from.

One of the biggest things [...] was to stay away from the bottle. With the depression and anxiety at its peak with a lot of people, it wouldn't have taken much to have those few extra drops to put you over the limit and really have a big loud crash with the alcohol. And especially when you are living alone, because there's nothing else to do.

(MARIA, TRANS WOMAN, 62)

Figure 5: Frequency of alcohol consumption during the pandemic as compared to prior to the pandemic

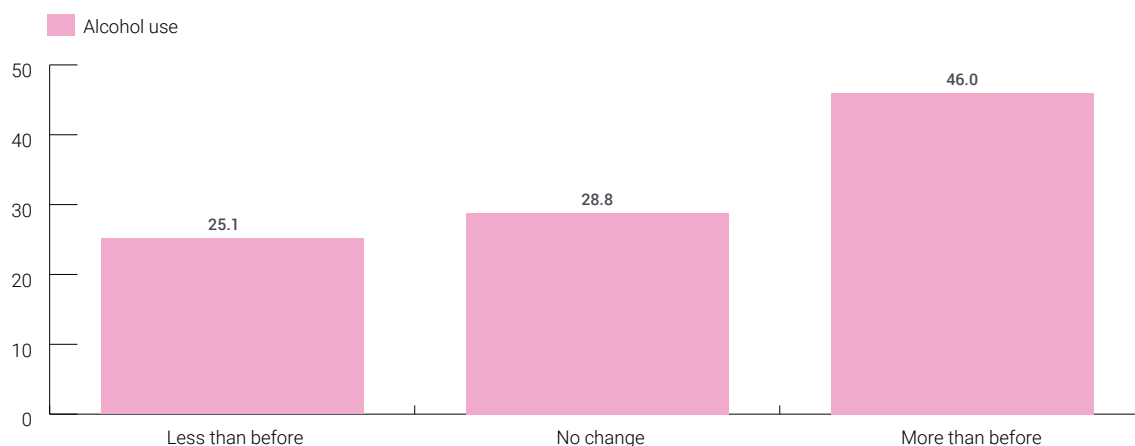


Table 27: Non-professional support for alcohol consumption during the pandemic (n = 532)

Non-professional support for alcohol consumption	n	%
Did not seek support	196	36.8
Support from friends	113	21.2
Support from family	48	9.0
Doing my own research (e.g. online research)	139	26.1
Trying different strategies (trial and error)	253	47.6
Other strategies	26	4.9

Note: Multiple responses were available, thus percentages do not add up to 100.

Almost two-thirds (63.2; n = 336) of participants who had indicated some concern, from themselves or others, about their alcohol consumption during the pandemic had sought non-professional support. Most frequently participants tried

different strategies (trial and error) to manage their alcohol consumption (47.6%; n = 253) or did their own research (26.1%; n = 139). Many participants also sought support from friends (21.2%; n = 113) or family (9.0%; n = 48).

8.3 Illicit drug use

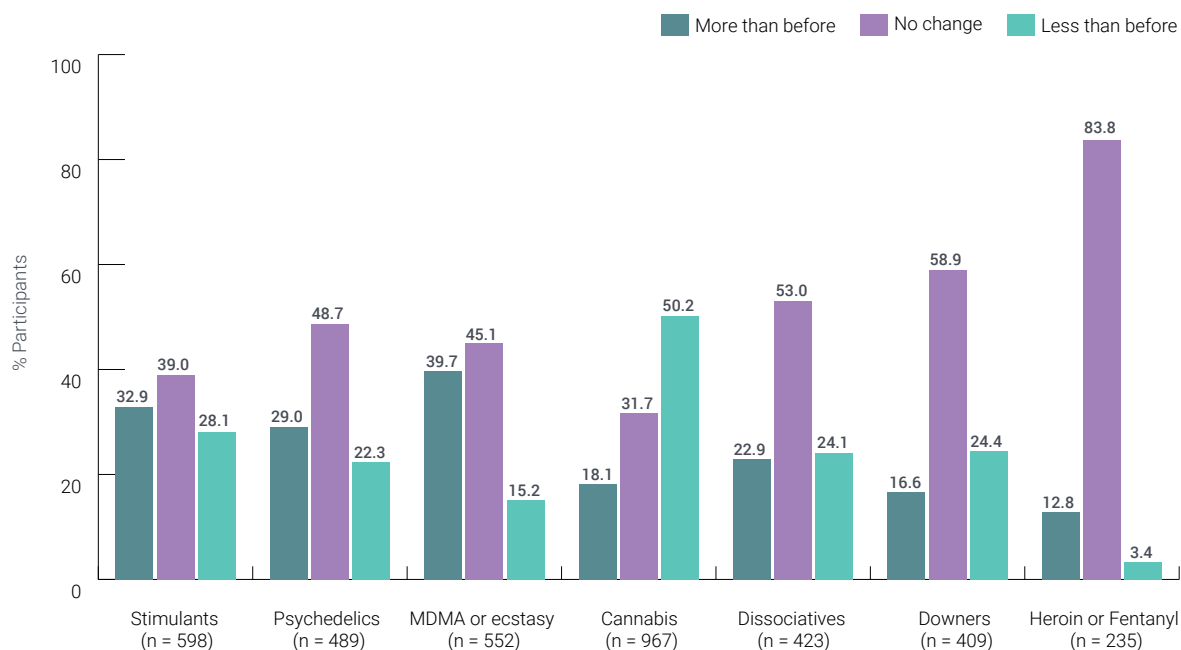
8.3.1 Change in frequency of drug use during the pandemic

Participants were asked to report any change in frequency of illicit drug consumption, and provided a response for several drug categories:

- Stimulants (e.g. methamphetamine, cocaine)
- Psychedelics (e.g. LSD, magic mushrooms)
- MDMA or ecstasy
- Dissociatives (e.g. nitrous oxide, ketamine)
- Downers (e.g. benzos, GHB/GBL)
- Heroin or fentanyl

Figure 6 reports any change in frequency of consumption during the pandemic for those participants who reported consuming these drugs.

Figure 6: Frequency of illicit drug use during the pandemic as compared to prior to the pandemic



Across most drug categories, participants most frequently reported that their consumption did not change during the pandemic, with smaller proportions of participants who consumed these drugs reporting some decreased or increased consumption. However, similarly as with alcohol and tobacco consumption, of the participants who consumed cannabis (31.4%; n = 967), approximately half (50.2%; n = 485) reported an increase in use during the pandemic, while just 18.1% (n = 175) reported less consumption, and 31.7% (n = 307) reported no change in consumption.

8.3.2 Concerns relating to drug use

Participants who consumed any drugs during the pandemic were asked if, since the pandemic began, they had experienced a time where they struggled to manage their drug use or where it had negatively impacted their everyday life, or whether a friend or family member had expressed concern about their drug use. Of those participants who consumed illicit drugs during the pandemic, 17.2% (n = 208) self-reported struggling to manage their drug use during the pandemic, and approximately one in ten (11.6%; n = 140) indicated that a friend or family member had expressed concern about their drug use during the pandemic.

8.3.3 Professional support for drug use

Participants who reported any concern regarding their drug consumption, whether their own concern or concern from others, were additionally asked if they sought any support for their drug consumption during the pandemic, along with the type of service they engaged.

Table 28: Engagement with drug use support services during the pandemic (n = 236)

Drug use support service	n	%
Did not seek support	180	76.3
Support from a mainstream service that is that is not known to be LGBTQ+ inclusive	33	14.0
Support from a mainstream service that is known to be LGBTQ+ inclusive	24	10.2
Support from a service that only caters to LGBTQ+ people	3	1.3

Approximately one-quarter (25.5%; n = 60) of participants engaged with a professional support service for drug consumption. Of those, the highest proportion engaged a mainstream service that was not known to be LGBTQ+ inclusive, and only a few engaged a support service that catered specifically to LGBTQ+ people (1.3%; n = 3).

8.3.4 Non-professional support for drug use

Participants who indicated concern about their drug consumption during the pandemic were additionally asked if they had sought any non-professional support for their drug use as well as where they sought support from.

Table 29: Non-professional support for drug use during the pandemic (n = 232)

Non-professional support	n	%
Did not seek support	63	27.2
Support from friends	75	32.3
Support from family	30	12.9
Doing my own research (e.g. online research)	85	36.6
Trying different strategies (trial and error)	128	55.2
Other strategies	19	8.2

Note: Multiple responses were available, thus percentages do not add up to 100.

Almost three-quarters (72.8; n = 169) of participants who had indicated concern about their drug consumption during the pandemic had sought non-professional support. Most frequently participants tried different strategies (trial and error) to manage their drug consumption (55.2%; n = 128) or did their own research (36.6%; n = 85). Many participants also sought support from friends (32.3%; n = 75) or family (12.9%; n = 30).

8.4 Tobacco, alcohol and other drug use during the pandemic across intersections

To illustrate the role of intersectionality in alcohol and other drug consumption during the pandemic, Table 30 below provides additional data on increased consumption of tobacco and alcohol, as well as reported struggles with alcohol or other drug consumption during the pandemic across various intersections of the survey population. The table reports data from intersections of the population believed to be most likely to have been impacted in unique ways during the pandemic. These include age, gender, ethnicity, disability and residential location and state or territory.

Table 30: Tobacco, alcohol and other drug consumption during the pandemic across age, gender, ethnicity, disability, residential location and state or territory

	Consumed more during the pandemic		Struggled with alcohol consumption during the pandemic		Struggled with drug use during the pandemic	
	Tobacco (%)	Alcohol (%)	Self-reported (%)	Family/friends expressed concern (%)	Self-reported (%)	Family/friends expressed concern (%)
Age						
18-24 years	16.4	40.9	14.7	13.1	17.1	13.7
25-34 years	15.5	38.7	17.3	10.9	19.8	13.5
35-44 years	12.8	41.1	19.8	13.7	16.3	9.1
45-54 years	13.4	36.2	23.2	14.4	15.5	9.7
55-64 years	11.0	36.2	16.9	8.5	12.3	6.2
65+ years	4.6	17.9	9.8	8.8	12.5	4.2
Gender						
Cisgender woman	14.4	36.7	17.0	11.5	15.1	10.9
Cisgender man	13.1	40.8	17.0	12.0	13.3	10.4
Trans woman	7.9	33.6	17.0	14.3	22.0	9.5
Trans man	19.5	39.6	20.9	17.9	23.9	12.7
Non-binary	15.7	40.4	18.0	11.5	24.3	15.6
Sexual orientation						
Gay or lesbian	13.8	40.4	18.6	12.0	16.1	10.7
Bisexual or pansexual	17.0	38.2	16.0	12.8	16.1	14.8
Queer	13.4	36.7	18.5	12.6	22.3	11.3
Asexual	7.1	27.8	8.2	6.8	9.5	4.8
Something else	9.8	37.8	19.3	16.5	21.1	15.8

Table 30 continued

	Consumed more during the pandemic		Struggled with alcohol consumption during the pandemic		Struggled with drug use during the pandemic	
	Tobacco (%)	Alcohol (%)	Self-reported (%)	Family/friends expressed concern (%)	Self-reported (%)	Family/friends expressed concern (%)
Ethnicity*						
Anglo-Celtic only	13.3	39.8	17.4	11.4	16.5	9.1
Multicultural background	15.3	36.6	17.8	13.0	18.2	15.2
Person of colour	12.6	31.4	15.9	11.9	22.2	20.4
Disability/long-term health condition**						
No disability	12.4	40.7	15.8	10.6	11.1	9.2
Physical	10.4	28.5	17.3	9.3	16.9	11.8
Mental illness	21.7	39.8	22.5	16.7	24.3	14.8
Neurodiversity/autism	12.2	36.0	15.4	10.9	22.5	11.3
Something else	14.3	33.3	19.6	13.7	16.7	8.3
Residential location						
Capital city, inner suburban	14.3	40.5	19.7	13.6	19.5	13.2
Capital city, outer suburban	12.1	35.8	13.0	10.5	11.6	9.5
Regional city or town	15.7	37.0	18.1	11.0	19.7	10.8
Rural or remote area	17.4	42.2	18.2	13.0	9.8	7.8
State or territory						
Victoria	14.4	39.6	17.9	11.8	17.2	11.2
New South Wales	12.8	39.3	19.6	12.2	14.6	8.4
Queensland	16.2	36.1	15.6	12.0	21.8	15.0
Western Australia	12.4	30.5	16.1	10.6	18.4	13.5
Australian Capital Territory	11.0	38.3	14.1	19.2	13.6	13.6
South Australia	16.8	36.4	12.3	11.0	14.5	14.3
Northern Territory and Tasmania	17.0	49.5	21.0	13.6	27.3	21.2

* Participants who only indicated an Anglo-Celtic ethnic background were categorised as 'Anglo-Celtic only'; participants who were not only Anglo-Celtic were categorised as 'multicultural background'. 'Person of colour' includes all participants who additionally identified as a person of colour. Refer to section 3.6 for detail on how ethnicity was assessed.

** Sample sizes for intellectual and sensory disability and acquired brain injury were too small to allow disaggregation of the data and are not included in the table

8.5 Focus group insights

Focus group participants largely did not speak of alcohol, tobacco or illicit drug use, with a few exceptions. One trans woman explicitly mentioned that staying away from alcohol and tobacco had been her main way to keep emotionally well, as she recognised the potential dangers in how the pandemic may have made it easier to compensate loneliness and depression with 'the bottle':

One of the biggest things [...] was to stay away from the bottle. With the depression and anxiety at its peak with a lot of people, it wouldn't have taken much to have those few extra drops to put you over the limit and really have a big loud crash with the alcohol. And especially when you are living alone, because there's nothing else to do. You're tied up, you're stuck with the same four walls, you've got nowhere to go. So, for example, I gave up smoking, stopped drinking. I couldn't drink. Because I knew once I started, I couldn't stop. And in that time, when would I stop? And what other damage [could occur]? Could I take up smoking again? And then you've got to wonder, how far would a person go? If they didn't have that self-control over their wellbeing? (Maria, trans woman, something else, 62)

One non-binary participant in the rainbow families focus group mentioned a helpful coping strategy for them and their family during lockdowns was to finish work at 4pm, allowing them to share a glass of wine with their partner and their child to watch television.

8.6 Summary

Many participants who consumed alcohol or tobacco reported increasing their use during the pandemic. This was also the case in relation to cannabis use, whereas for participants who reported consumption of other illicit drugs, there were less notable changes in frequency of use. About one-fifth of participants who reported any alcohol consumption and about one-fifth of those who reported any drug consumption expressed concerns about their use.

The vast majority of those who had been concerned about their alcohol and/or drug use had not sought professional support. Among the those who looked for professional support, a majority sought support from mainstream alcohol and other drugs support services, and a minority from LGBTQ+-inclusive or LGBTQ+-specific services. This likely reflects the limited availability of such LGBTQ+-affirming services in Australia.

There was limited variation between participants in intersectional groups, although those aged over 65 were much less likely to report alcohol, tobacco or illicit drug use. Trans women reported much lower rates of tobacco use than cisgender women or men or trans men. In our focus groups, one participant expressed concern as to how alcohol and other drug use might be used during the pandemic to mitigate anxiety, depression and loneliness, although this was not a commonplace discussion within the focus groups and warrants further investigation.



9 Health service engagement and support

Research conducted prior to the pandemic noted how LGBTQ+ people often face barriers to accessing physical and mental health care.

These barriers relate to experiences of discrimination and a lack of providers who are inclusive, affirming and knowledgeable of LGBTQ+ needs (47-49). The pandemic led to further barriers to accessing both physical and mental health care, including an overburdened healthcare system and social distancing mandates leading to difficulties physically

accessing services. At the same time, the introduction of remote technologies and telehealth services likely led to increased accessibility of certain services. This may be particularly true for individuals with disability and those living outside of city centres who may otherwise have had difficulty accessing physically located services.

Figure 7: Rate of vaccination among the study sample (n = 3,130)

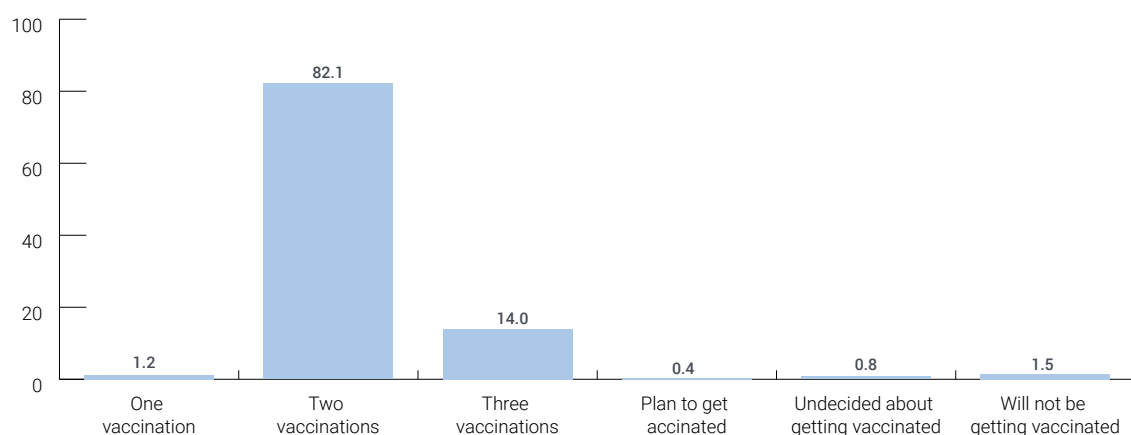
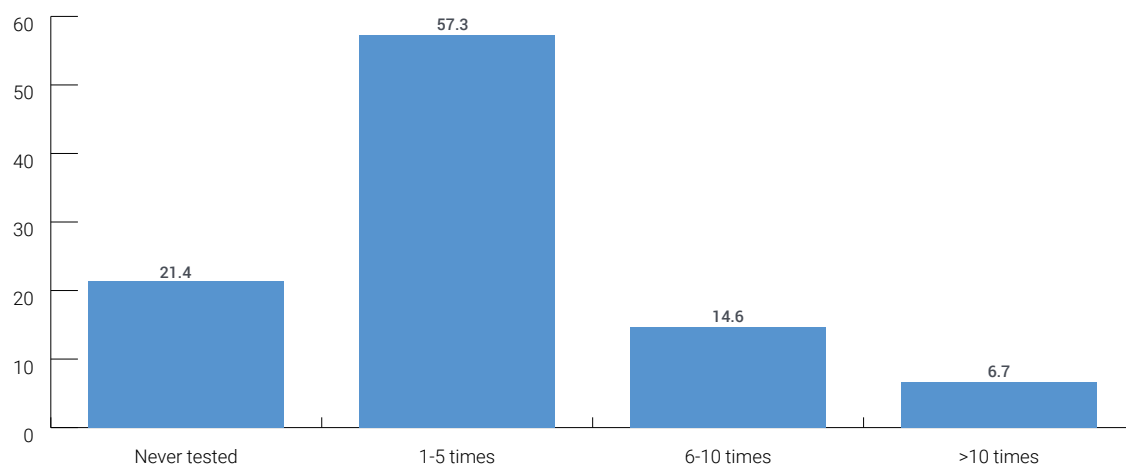


Figure 8: Number of COVID-19 tests taken (n = 3,135)



9.1 COVID-19-related healthcare

9.1.1 COVID-19 vaccination

Rates of vaccination among the *Pride and Pandemic* participants was high, with 96.1% of participants reporting that they had had at least two doses of the vaccine as of 4 February 2022 (the date the survey closed for completion). To compare these rates to the general population, it is important to take into consideration the time frame of the survey. At the time when data collection for *Pride and Pandemic* began, in November 2021, approximately 87% of the Australian population 16 years or older were fully vaccinated (with two doses of a COVID-19 vaccine), and by the time data collection had concluded, in February 2022, approximately 94% of the Australian population 16 years or older were fully vaccinated (with at least two doses of a COVID-19 vaccine).

Table 31: Vaccination service accessed (n = 3,031)

Vaccination service	Number	%
State-run vaccine centre (e.g. convention centre, recreation centre, town hall)	1,983	65.4
GP clinic	1,135	37.5
Pharmacist	275	9.1
LGBTIQ+ specific service	18	0.6

Note: Multiple responses were available, thus percentages do not add up to 100.

While most (65.4%; n = 1,983) participants accessed vaccinations via a state-run vaccine centre, followed by a GP clinic (37.5%; n = 1,135), and a very small proportion (0.6%; n = 18) of participants accessed their vaccine via a LGBTIQ+ specific service (reflecting the small number of such services resourced to provide vaccinations), the vast majority (93.6%; n = 2,438) felt that they were treated with dignity and respect throughout the vaccination process.

9.1.2 COVID-19 testing

More than three-quarters (78.6%; n = 2,464) of participants had been tested for COVID-19 at least once, and the vast majority (92.4%; n = 2,240) of those tested, felt that they were treated with dignity and respect throughout the testing process.

Given the time frame of data collection and the introduction of RATs (rapid antigen tests) in early 2022, rates of testing may have increased toward the end of data collection and this testing may have been self-collected at home, without the need for interaction with a healthcare provider or testing service.

9.1.3 COVID-19 treatment and contact tracing

A small proportion (5.7%; n = 139) of participants reported testing positive for COVID-19, and of those, less than two-thirds (61.2%; n = 85) felt that they were treated with dignity or respect throughout the contact tracing process. Of those who tested positive, 11.6% (n = 16) required medical treatment or hospitalisation.

9.2 Disability support

Of the 1,516 *Pride and Pandemic* participants who reported having a disability or long-term health condition, a small proportion (7.0%; n = 105) were receiving NDIS support and 14.1% (n = 213) were receiving non-NDIS support. Those receiving support were asked to indicate whether there was any change in the supports they received during the pandemic, including whether they received more or less support, whether they received different support or whether the support they received had stayed the same as prior to the pandemic.

I think [...] there is a very strong association, among the queer people that I hang out with [...] with queer history and the fact that we did lose so many to the HIV epidemic [...] this understanding that vaccines are essential and crucial and life-saving.

(TOM, TRANS MAN, BISEXUAL, 35)

Table 32: Change in NDIS and non-NDIS supports received during the pandemic

	NDIS support		Non-NDIS support	
	n	%	n	%
Received less support	34	32.7	45	21.8
Supports stayed the same	29	27.9	80	38.8
Received different supports	13	12.5	22	10.7
Received more support	11	10.6	37	18.0
Unsure	17	16.4	22	10.7

Almost half (45.2%; n = 47) of participants who were receiving NDIS supports reported that they received less support or different support during the pandemic, with under two-fifths (38.5%; n = 40) reporting that the support they received had either remained the same or increased during the pandemic.

Changes in non-NDIS supports were not reported as frequently among participants with disability. More than half (56.8%; n = 117) of participants receiving non-NDIS support reported that this support had either stayed the same or

increased during the pandemic, while approximately one-third (32.5%; n = 67) indicated that they had received less or different non-NDIS support during the pandemic.

9.3 Mental health care

More than half (56.1%; n = 1,738) of participants sought professional support for their mental health during the pandemic.

9.3.1 Accessing mental health care

Participants who accessed professional support for their mental health were additionally asked to report where they received this support from and whether it was in person, via telephone or online.

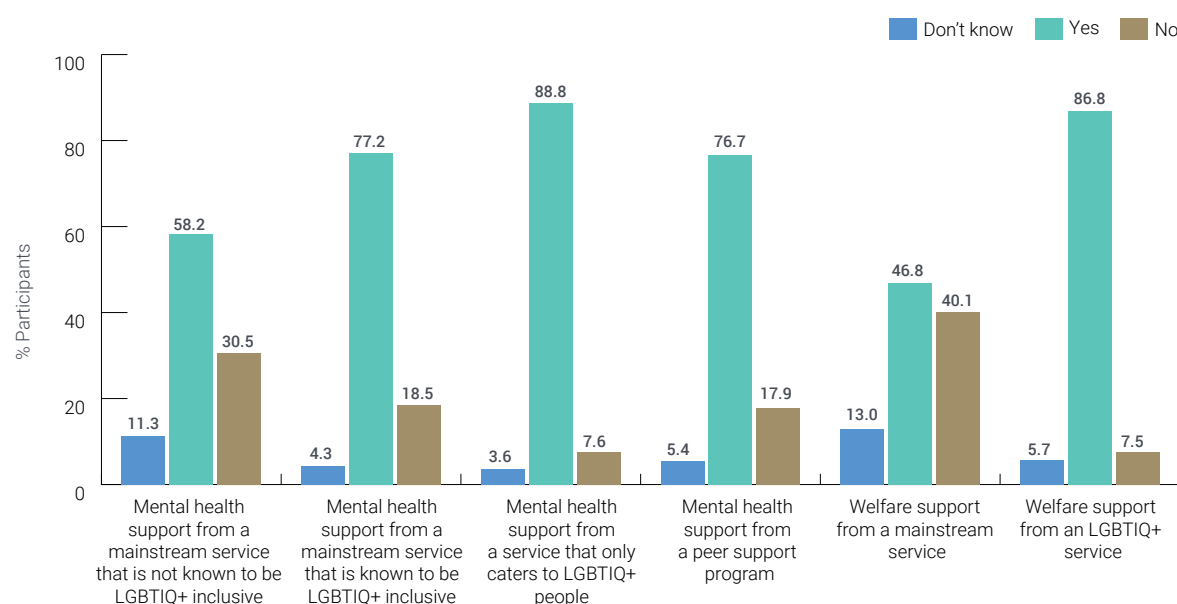
Of participants who accessed professional support for their mental health, almost two-fifths had accessed a mainstream service that is not known to be LGBTIQ+ inclusive (39.0%; n = 672), and almost two-thirds (63.6%; n = 1,102) had accessed a mainstream service that is known to be LGBTIQ+ inclusive. Approximately one in ten (11.6%; n = 200) had accessed mental health support through a service that only caters to LGBTIQ+ people, and 12.9% (n = 223) from a peer support program, 16.7% (n = 288) through a mainstream welfare support service, and 3.1% (n = 54) through a LGBTIQ+ welfare support service.

The mode (in person, via telephone or online) by which participants accessed these services is detailed in Table 33 below.

Table 33: Mental health service accessed in person, via telephone or online (n = 1,580)

Mental health service	In person		Via telephone		Online	
	n	%	n	%	n	%
Mental health support from a mainstream service that is not known to be LGBTIQ+ inclusive	433	27.4	250	15.8	200	12.7
Mental health support from a mainstream service that is known to be LGBTIQ+ inclusive	643	40.7	468	29.6	433	27.4
Mental health support from a service that only caters to LGBTIQ+ people	58	3.7	99	6.3	112	7.1
Mental health support from a peer support program	85	5.4	59	3.7	116	7.3
Welfare support from a mainstream service	127	8.0	105	6.7	127	8.0
Welfare support from an LGBTIQ+ service	22	1.4	19	1.2	32	2.0

Figure 9: Felt LGBTIQ+ identity was respected when accessing mental health care, by service provider



As shown in Table 33 above, mainstream mental health services, whether they were known to be inclusive of LGBTIQ+ people or not, were most frequently accessed in person (40.7%; n = 643 and 27.4%; n = 433, respectively), followed by telephone access (29.6%; n = 468 and 15.8%; n = 250, respectively) and online access (27.4%; n = 433 and 12.7%; n = 200, respectively). Conversely, participants who accessed mental health support from an LGBTIQ+-specific service most frequently did so via online access (7.1%; n = 112), followed by telephone (6.3%; n = 99), and least frequently in person (3.7%; n = 58), likely reflecting the limited resources of mental health services available that cater specifically to LGBTIQ+ people. Similarly, peer support programs were predominantly accessed online (7.3%; n = 116), followed by in person (5.4%; n = 85) and telephone access (3.7%; n = 59).

Participants who accessed professional support for their mental health were further asked if they felt that their LGBTIQ+ identity was respected when accessing these services. Response options included 'yes', 'no' and 'don't know'. These data are presented in Figure 9 below.

Among participants who accessed a mental health care service, they most frequently felt respected when this was accessed through a service that only catered to LGBTIQ+ communities (88.8%; n = 175), and least frequently felt supported when they accessed a mainstream mental health service that was not known to be LGBTIQ+ inclusive (58.2%; n = 387). These outcomes are similar to those of *Private Lives 3* in which participants, particularly those who were trans or gender diverse, more frequently reported feeling respected in inclusive or LGBTIQ+-only services, as compared to mainstream services that are not known to be inclusive.

Similarly, participants more frequently reported feeling respected when accessing support from a peer support program (76.7%; n = 171) or when receiving welfare support from an LGBTIQ+ service (86.8%; n = 46), with less than half feeling respected when accessing welfare support from a mainstream service (46.8%; n = 133).

9.3.2 Barriers to accessing mental health care during the pandemic

Participants who accessed professional support for their mental health during the pandemic were asked to identify barriers to accessing this care, with a list of barriers to choose from as detailed in Table 34 below.

Table 34: Barriers to accessing mental health care during the pandemic (n = 1,653)

Barrier to mental health care access	n	%
Cost of service	738	44.7
Preferred service unavailable or not taking new clients	594	35.9
Stay-at-home orders	584	35.3
Did not experience any barriers	440	26.6
Difficulty accessing LGBTIQ+-inclusive or LGBTIQ+-specific services	314	19.0
Other barrier	204	12.3
Challenge accessing remote technology (e.g. telephone or internet connectivity required for telehealth services)	144	8.7

Note: Multiple responses were available, thus percentages do not add up to 100.

Almost three-quarters (73.4%; n = 1,213) of participants reported some form of barrier to accessing mental health care during the pandemic. The mental health care system during the pandemic became overburdened nationally with increases in mental health concerns due to the stressors brought about by the pandemic, as well as many people experiencing financial hardship as a result of public health efforts to prevent or slow the spread of

COVID-19. Accordingly, participants most frequently identified the cost of services as a barrier to accessing healthcare (44.7%; n = 738), followed by lack of availability of their preferred service (35.9%; n = 594) and stay-at-home orders (35.3%; n = 584). Less frequently reported barriers were challenges accessing remote technologies required for remote services (8.7%; n = 144) and other barriers not specified (12.3%; n = 204).

9.3.3 Telehealth for mental health care

The vast majority (90.9%; n = 1,523) of participants who had accessed mental health care services during the pandemic had accessed at least some of this care via telehealth. These participants were further asked to indicate the extent to which they agreed that telehealth had made mental health care appointments more accessible; they felt comfortable accessing mental health care through telehealth; and they felt safer accessing mental health care via telehealth. Response options ranged from 'strongly disagree' to 'strongly agree'. Table 35 presents the proportions of participants who somewhat or strongly agreed.

Table 35: Experiences accessing mental health care via telehealth

Experience with telehealth for mental health care	Somewhat/ strongly agree	
	n	%
Telehealth has made mental health care appointments more accessible	1,117	76.6
I felt comfortable accessing mental health care through telehealth	884	58.5
I felt safer accessing mental health care through telehealth	483	31.2

Participants indicated positive experiences accessing mental health care via telehealth during the pandemic. Approximately three-quarters (76.6%; n = 1,117) felt that telehealth had made mental health care appointments more accessible, more than half (58.5%; n = 884) felt comfortable accessing mental health care in this way, and 31.2% (n = 483) felt safer accessing mental health care via telehealth.

9.3.4 Preference for mental health care service provider

All participants, regardless of whether or not they reported a mental health condition or had ever accessed professional mental health support, were asked if they had a preference for a type of mental health care service provider for during the pandemic and beyond the pandemic. Response options included a mainstream service, a mainstream service that is known to be LGBTIQ+ inclusive, a service that only caters to LGBTIQ+ people, no preference or unsure.

Almost two-fifths of participants (39.5%; n = 1,232) did not have a preference for a type of mental health service provider. A small proportion (7.3%; n = 229) expressed a preference for a mainstream service that is not known to be LGBTQ inclusive, while the highest proportion of participants (40.4%; n = 1,261) expressed a preference for a mainstream service that is known to be LGBTQ inclusive, followed by a preference for a service that caters only to LGBTQ people (12.8%; n = 400).

9.4 Engaging with GPs

Most (72.2%; n = 2,274) *Pride and Pandemic* participants reported having a regular GP, and 60.5% (n = 1,715) reported that their regular GP or health clinic knew about their sexual or gender identity.

9.4.1 Frequency of GP consultations during the pandemic

Participants were asked how frequently they saw a GP during the pandemic, including telehealth consultations. A small proportion (7.0%; n = 217) of participants did not access a GP during the pandemic, while 11.9% (n = 371) had a consultation with a GP once per year, 35.6% (n = 1,111) had a consultation two to three times per year, 36.9% (n = 1,151) had a consultation four to 11 times per year, and 8.6% (n = 269) reported having a consultation 12 or more times per year during the pandemic.

9.4.2 Telehealth for GP consultations

Most (81.3%; n = 2,365) participants had accessed a GP via telehealth during the pandemic. These participants were further asked to indicate the extent to which they agreed that telehealth had made GP appointments more accessible, they felt comfortable accessing a GP through telehealth, and they felt safer accessing a GP via telehealth. Response options ranged from 'strongly disagree' to 'strongly agree'. Table 36 presents the proportions of participants who somewhat or strongly agreed.

Table 36: Experiences accessing a GP via telehealth

Experience with telehealth for mental health	n	
	n	%
Telehealth has made GP appointments more accessible	1,754	74.2
Felt comfortable accessing a GP through telehealth	1,624	66.0
Felt safer accessing a GP through telehealth	729	29.8

Participants reflected positively on accessing a GP via telehealth during the pandemic. Almost three-quarters (74.2%; n = 1,754) felt that telehealth had made GP appointments more accessible, two-thirds (66.0%; n = 1,624) felt comfortable accessing a GP through telehealth, and 29.8% (n = 729) felt safer accessing a GP via telehealth.

9.5 Mental health care and GP access across intersections

To illustrate the role of intersectionality in healthcare engagement, Table 37 below provides additional data on experiences of telehealth provision of mental health care and GP appointments, and preferences for type of mental health care provider across various intersections of the survey population. The table reports data from intersections of the population believed to be most likely to have been impacted in unique ways during the pandemic. These include age, gender, ethnicity, disability and residential location and state or territory.

Table 37: Healthcare engagement during the pandemic across age, gender, ethnicity, disability, residential location and state or territory

	Experience of telehealth provision of mental health			Preference for mental health		
	Felt it was more accessible (%)	Felt comfortable accessing through telehealth (%)	Felt safer accessing through telehealth (%)	Mainstream mental health care service that is known to be LGBTIQ+ inclusive (%)	Mental health care service that only caters to LGBTIQ+ people (%)	No preference/unsure (%)
Age						
18-24 years	71.9	45.9	26.3	44.1	10.7	39.6
25-34 years	82.8	64.0	37.1	42.5	15.4	35.8
35-44 years	77.9	70.5	32.0	37.2	12.9	41.3
45-54 years	71.1	57.5	31.0	36.1	12.7	40.6
55-64 years	79.7	58.7	23.2	39.8	11.8	40.5
65+ years	42.9	42.9	20.0	29.2	11.5	51.3
Gender						
Cisgender woman	77.1	58.0	31.9	42.0	8.6	41.8
Cisgender man	74.9	60.1	28.8	35.4	10.2	44.8
Trans woman	76.0	67.1	24.7	43.0	25.8	25.0
Trans man	76.3	54.7	31.6	47.0	24.4	25.0
Non-binary	79.0	57.4	35.9	46.9	19.8	29.9
Sexual orientation						
Gay or lesbian	75.9	59.0	31.0	39.0	11.2	41.3
Bisexual or pansexual	74.6	56.2	30.9	43.1	11.0	39.2
Queer	80.0	62.3	33.1	45.5	23.1	28.4
Asexual	71.9	55.7	23.7	34.5	15.0	41.6
Something else	83.7	63.0	36.4	34.8	8.9	51.9
Ethnicity*						
Anglo-Celtic only	78.7	60.3	29.4	42.1	12.5	37.7
Multicultural background	73.5	56.7	33.8	38.9	13.5	40.8
Person of colour	76.3	68.8	44.8	38.1	12.6	41.1
Disability/long-term health condition**						
No disability	79.2	61.0	29.7	38.6	10.5	42.0
Physical	84.4	64.1	39.7	37.1	16.0	37.6
Mental illness	75.1	54.4	28.9	42.8	13.5	37.3
Sensory	73.3	75.0	56.2	31.6	15.8	42.1
Neurodiversity/autism	72.5	59.7	34.0	46.5	17.7	31.8
Something else	88.6	62.2	38.5	39.1	13.0	43.5

Table 37 Continued

	Experience of telehealth provision of mental health			Preference for mental health		
	Felt it was more accessible (%)	Felt comfortable accessing through telehealth (%)	Felt safer accessing through telehealth (%)	Mainstream mental health care service that is known to be LGBTIQ+ inclusive (%)	Mental health care service that only caters to LGBTIQ+ people (%)	No preference/unsure (%)
Residential location						
Capital city, inner suburban	79.3	64.5	31.0	42.1	14.4	36.5
Capital city, outer suburban	75.1	53.6	29.6	42.2	10.9	39.3
Regional city or town	73.7	51.8	33.5	37.4	10.8	44.2
Rural or remote area	69.2	58.6	34.7	29.0	16.0	46.3
State or territory						
Victoria	79.1	62.5	33.6	41.9	16.2	35.2
New South Wales	78.8	59.1	33.1	38.1	9.7	45.3
Queensland	73.6	55.5	29.3	36.6	11.2	42.5
Western Australia	70.8	46.8	22.2	47.5	12.7	32.8
South Australia	69.8	47.8	22.6	35.2	12.1	44.2
Australian Capital Territory	70.6	60.3	33.8	52.9	9.2	31.1
Northern Territory and Tasmania	67.5	51.2	19.5	43.3	16.5	33.0

My instinct is certainly to go for LGBT-specific services, both [for] physical and mental health.[...] it's been a positive experience anyway, but sometimes they've just gone, 'You need to see someone who has more experience in this' [...] So, my instinct is always LGBT only. But in practice, it hasn't worked for me to follow that instinct.

(ANTHONY, TRANS MAN, BISEXUAL, 22)

Table 37 Continued

	GP		Experience of GP telehealth provision		
	Have a regular GP (%)	Saw a GP at least once during the pandemic (%)	Felt it was more accessible (%)	Felt comfortable accessing through telehealth (%)	Felt safer accessing through telehealth (%)
Age					
18-24 years	65.4	90.7	68.5	54.6	27.5
25-34 years	70.3	91.7	79.7	70.3	36.1
35-44 years	74.0	94.0	78.1	72.7	30.7
45-54 years	76.9	93.9	73.8	69.5	24.4
55-64 years	84.5	98.6	70.6	66.8	25.8
65+ years	94.8	99.1	59.3	59.3	25.6
Gender					
Cisgender woman	74.4	94.8	75.8	68.2	28.7
Cisgender man	71.1	90.6	72.0	67.5	27.9
Trans woman	78.9	93.8	78.1	69.3	32.0
Trans man	78.8	98.2	78.8	63.2	36.3
Non-binary	70.0	92.8	72.1	58.8	34.4
Sexual orientation					
Gay or lesbian	73.7	93.2	73.2	67.4	29.0
Bisexual or pansexual	73.1	92.1	75.0	64.4	31.2
Queer	72.1	95.2	77.8	69.8	31.7
Asexual	57.4	92.1	75.0	60.2	31.7
Something else	71.1	91.9	71.9	57.3	30.2
Ethnicity*					
Anglo-Celtic only	74.2	93.8	75.7	67.5	28.7
Multicultural background	71.0	92.2	72.3	64.4	30.7
Person of colour	71.5	87.5	78.3	71.7	39.0
Disability/long-term health condition**					
No disability	70.4	91.0	73.0	68.7	26.7
Physical	85.5	98.6	80.9	68.2	33.9
Mental illness	76.1	96.5	75.5	65.2	31.0
Sensory	84.2	97.3	82.4	71.4	48.6
Neurodiversity/autism	72.2	93.2	73.5	59.3	31.9
Something else	75.7	100.0	75.4	66.7	34.9
Residential location					
Capital city, inner suburban	73.7	93.6	78.8	72.5	30.6
Capital city, outer suburban	73.5	92.8	72.6	62.0	29.3

Table 37 Continued

	GP		Experience of GP telehealth provision		
	Have a regular GP (%)	Saw a GP at least once during the pandemic (%)	Felt it was more accessible (%)	Felt comfortable accessing through telehealth (%)	Felt safer accessing through telehealth (%)
Regional city or town	70.0	92.9	65.7	58.0	29.5
Rural or remote area	69.9	90.1	75.5	61.5	27.4
State					
Victoria	74.1	94.1	79.5	73.1	31.5
New South Wales	71.3	92.1	70.4	64.9	29.0
Queensland	75.5	92.8	71.9	60.6	30.9
Western Australia	70.1	93.1	70.0	58.6	23.1
Australian Capital Territory	65.0	92.5	77.4	63.7	29.7
South Australia	74.5	92.4	66.9	49.4	28.9
Northern Territory and Tasmania	67.0	91.7	69.7	62.9	25.0

* Participants who only indicated an Anglo-Celtic ethnic background were categorised as 'Anglo-Celtic only'; participants who were not only Anglo-Celtic were categorised as 'multicultural background'. 'Person of colour' includes all participants who additionally identified as a person of colour. Refer to section 3.6 for detail on how ethnicity was assessed.

** Sample sizes for intellectual disability and acquired brain injury were too small to allow disaggregation of the data and are not included in the table

9.6 Focus group insights

9.6.1 Vaccines and community care

Participants across the four groups highlighted the very strong levels of care within their own and the wider community shown by the vast majority of LGBTQ+ people in their networks. LGBTQ+ people's readiness to get vaccinated and to adopt safety measures to protect each other and those more at risk were repeatedly stressed in the four discussion groups. Several participants shared how they felt this sense of community responsibility was a legacy of the HIV epidemic.

I think [...] there is a very strong association, among the queer people that I hang out with and socialise with, with queer history and the fact that we did lose so many to the HIV epidemic. And this understanding that vaccines are essential and crucial and life-saving. I found that overall, more so than the general population, the queer population [...] tend to be more pro vaccine. (Tom, trans man, bisexual, 35)

One bisexual cisgender man did describe how the requirement to socially distance challenged opportunities to engage in sex with other men. While he reported seeing some men in online environments who appeared to still be seeking sex, despite the restrictions, such behaviour was met with censure within his close social networks.

The results of our survey and our focus group discussions both indicate a strong adherence to vaccines and a solid sense of responsibility towards members of the LGBTQ+ community thought to be in greatest need. We do note,

however, one trans participant who shared a concern that a minority of LGBTQ+ people who chose not to get vaccinated, like him, were being silenced and excluded from the LGBTQ+ community and faced heightened challenges to their mental health and to accessing community support.

Conversely, a participant living with a disability shared how their mental health would have benefited from a more efficient vaccine rollout that had prioritised people with disabilities or co-occurring medical conditions and made sure staff at vaccination centres were trained to be accepting and affirming of gender and sexual diversity:

I think, a vaccine rollout that was actually prioritised by the government and effective would have really helped my mental health; to know that myself and my family and the people that I love [who have co-occurring medical conditions] could be vaccinated sooner, way sooner than they were. And if you're having trouble accessing a vaccination point, [that] they could find supportive people in their health system to assist them to do that, and that those people were going to be affirming of gender identity and sexuality when you walk up into those places. (Ken, non-binary, something else, 37)

9.6.2 Engagement with mainstream and community health services

Access to, and engagement with, health services during the pandemic were discussed at length in all our focus groups. In terms of access to mental health support, participants largely appreciated the increased allowance for psychology sessions from 10 to 20 hours per year under Medicare's mental health care plan. However, some felt that such increase was insufficient, given the high demand and the limited availability of mental health professionals who would bulk-bill. Some remarked that it was hard for LGBTQ+ individuals to find a practitioner who was knowledgeable of LGBTQ+ issues and who was available and affordable. With this in mind, one trans woman participant suggested that it would have been better to increase the amount of rebate a patient would get from Medicare per session, rather than just extending the number of sessions included per year within the mental health care plan.

A trans man who shared living on a low income and having faced economic hardship during the pandemic expressed the beneficial effect of finally finding a therapist who specialised in transgender issues after a long search, yet finding it 'very expensive':

I have been seeing psychologists for a very long time, but it's only during the pandemic that I saw this new psychologist [...]. I'd been pretty frustrated with having other psychologists really not understanding it [...]. It took me a long time to find one that actually specialised in gender diverse and trans people. And it is very expensive. But I found that's been really helpful.
(Dan, trans man, pansexual, 30)

When asked whether they would rather go to a mainstream, LGBTQ+-friendly provider or to an LGBTQ+-specific service, several participants clarified that while they would ideally prefer a community-specific service, for a number of reasons, they would likely choose a mainstream, LGBTQ+-friendly service instead. This was despite the fact that many felt the label 'LGBTQ+ friendly' was often misused by professionals who were actually judgemental and/or not at all knowledgeable about LGBTQ+ issues. The principal reason given for this choice was the limited availability of LGBTQ+-specific services in their locality. One trans woman participant elaborated, saying that trans and gender diverse people would often not engage with community-specific services, knowing these have limited availability and that there may be other members of the community in greater need, thus risking downplaying the seriousness of the problems they were personally facing:

I know for certain that I and quite a few other people who would make use of [LGBTQ+-specific services] would rather try and gauge how affecting what they're trying to get treated exactly is. Because typically at LGBT-friendly [i.e. LGBTQ+-specific] places, bookings are completely packed. And there's a lot of personal guilt that can come up when you feel you're maybe wasting resources [...]. Basically, it's pretty common to downplay anxiety and depression or dysphoria that might otherwise be affecting you. It's just like normal feelings that you can just handle at a regular place, you don't have to take up all the very, very precious booking slots at a trans-specific place, it's much easier to just try and find somewhere that won't misgender you. But that's usually a grab bag anyway.
(Iliana, trans woman, lesbian, 31)

Several other participants said that they would choose mainstream services when they felt their health needs (either mental or physical) were not linked to their gender identity or their sexuality. One trans man explained that instinctively he would go to an LGBTQ+-specific provider, but practical needs, which include living with a number of medical conditions, led him to choose different specialists in areas other than gender and sexuality:

My instinct is certainly to go for LGBT-specific services, both [for] physical and mental health. But my experience has been that's not necessarily the most productive. And just because I think that a lot of queer-specific services can have quite narrow focuses, and will be superb when it comes to sexual health, physical gender transition, maybe some family-related issues and unipolar depression. But as soon as it's like, I've got a really complex physical health picture. My mental illnesses are married and intersecting. Those are things that are not necessarily what a queer service has prepared for, or if they have, I certainly haven't experienced that. And, you know, most of the time, it's been a positive experience anyway, but they've just gone, 'You need to see someone who has more experience in this' [...]. So, my instinct is always LGBT only. But in practice, it hasn't worked for me to follow that instinct. (Anthony, trans man, bisexual, 22)

One trans woman shared choosing mainstream services as she envisions a world without discrimination where LGBTQ+ people should be able to attend any service, not be classed as 'different' and not feel the need to attend community-specific services.

The vast majority of participants were very appreciative of LGBTQ+-specific services and of their work and wished to see them expand. Multicultural participants said they were not aware of any service or program catering specifically to LGBTQ+ people of colour, migrants, refugees or people from multicultural backgrounds but that they wished they existed. One participant reported actively looking for them and not being able to find any:

I personally haven't found any targeted resources. So everything's quite an umbrella approach. And that's completely fine, because it's quite an inclusive community. But if you're going to target, I guess, multicultural backgrounds, it's maybe something to add on to a project where you do target the services – you might link it to something like a multicultural group or access group. Because I was going down that rabbit hole, I found that there's not really anything that's related to the fact that I'm from a multicultural background or migrant background, and there wasn't a lot around, for example, refugees who are also queer. (Rebecca, cisgender woman, lesbian, 27)

An indication of the need to develop specific, culturally sensitive services for multicultural LGBTQ+ people was given by another multicultural participant, who shared her frustration with what she felt was a readiness by white LGBTQ+ psychologists to suggest cutting ties from one's birth family, which she saw as inappropriate for people who are financially depending on their families or generally needing the connection to their culture through their birth family:

It's like a classic trope, when [...] white therapists, [are] like, 'Cut off your family. They're so toxic, they're awful for you; just cut them out'. And you're like, 'Yes, thank you, unhelpful'. For, whether it's because of financial reasons – some people are just financially dependent on their parents; whether it's cultural reasons – for some people, the only way they can connect to their culture is via their

family and losing that is incredibly traumatic; or even just for the simple reason of, like, I like these people outside of that, and I want them in my life.
(Brenda, cisgender woman, bisexual, 22)

One non-binary participant, who identified as living with a disability, shared their plea to incentivise gender-affirming mental health support and peer-based support:

I think ongoing mental health supports that are clear, affirming, and gender affirming [are needed]. And continuing to put money into that. And also having lived experience positions in a number of our big LGBTIQ health services to get more people who are part of our communities into those places, running programs for and by the communities, which they're serving, to do some of that kind of peer connection and peer support. Because I don't always think it's [just about] going to a counsellor or psychologist, although they are great, but sometimes it's about finding that other person who shares some of your identity and being able to feel like they really understand and get you, and they have navigated some of this stuff and they can put you in contact with people.
(Ken, non-binary, something else, 37)

9.6.3 Experience with telehealth

Telehealth was viewed by focus group participants as an important and helpful method to allow access to both physical and mental health care both during and beyond the pandemic. Most appreciated the way telehealth had made access to support safer, and some even found the safer distance provided by the phone or screen helpful. This was true in particular for participants with disabilities:

I'd say telehealth has been really amazing. And I'm glad that they extended it and I wish that they'll continue it beyond whatever this pandemic evolves into, because I think it's super important for people with disabilities to be able to access supports when you find it difficult to get to a doctor. I'd also say that in some ways, I've found it easier to chat over the phone, and do the massive check there, than being in a room with somebody [...] Sometimes when you're going through stuff, it's just easier to have a bit of that distance and articulate myself, verbally.
(Ken, non-binary, something else, 37)

Some participants were glad to have continued during lockdowns being supported by their psychologists whom they had previously seen in person and established rapport with. A non-binary participant remarked how telehealth allowed them to keep being supported by a practitioner they trusted even after they had moved away.

I am comfortable doing psychology over telehealth, but that's because there was a period of time in which I got to meet my psychologist face to face and so I feel like I got enough of those meetings in there. I don't need to see her face to face anymore. And that's, I'm really, really happy about that, because I moved to the other side of the city, and [being able to do telehealth sessions] was amazing.
(Ian, non-binary, bisexual, 23)

Being able to keep working with trusted practitioners may be particularly relevant for LGBTQ+ people, who, as seen above, may take a long time to find medical staff who are knowledgeable and non-judgemental of sexual and gender diversity.

9.7 Summary

LGBTQ+ survey participants displayed very high vaccination rates, higher than the general population. Focus group participants shared insights that help to contextualise such findings: several conveyed that they saw a strong sense of community responsibility and trust in vaccines as a means to protect each other among LGBTQ+ individuals, and they understood this to be partly stem from the experience of the HIV epidemic.

The cost of services was commonly described as a barrier to accessing high-quality mental health care during the pandemic, followed by lack of availability of the participant's preferred service, and stay-at-home orders. Higher proportions of survey participants across intersections engaged with mainstream support services known to be LGBTQ+ friendly than LGBTQ-specific support services. Yet, participants more frequently reported feeling respected by LGBTQ-specific or LGBTQ-inclusive services. This suggests a need for more LGBTQ-specific services during the pandemic and future crises, as well as ensuring mainstream mental health providers are able to provide culturally safe services to this population. Moreover, survey participants mostly accessed mainstream services in person and mostly accessed LGBTQ-specific services online.

Within focus group discussions, LGBTQ-specific services were widely perceived as crucial and as the ideal first choice for many participants, but also as having limited availability, and they were seen as being in very high demand. Some consciously chose not to access LGBTQ-specific services in order not to take up places for those perceived to be in greater need. Others felt that LGBTQ-specific services were good in matters relevant to sexuality and gender but may be unable to aid in other, more complex and specific health matters, both physical and mental, given limited resources. Focus group participants wished for more community and intersectional peer-based support services, including for LGBTQ migrants and LGBTQ people from multicultural backgrounds, and LGBTQ people living with disabilities.

Telehealth was seen by a majority of survey participants as having greatly improved accessibility to healthcare. Focus group discussions centred on the particular value of telehealth for LGBTQ people with disability and those living far from metropolitan centres. While focus group participants maintained that in-person psychological support was preferable for building rapport with a therapist, they appreciated the opportunity to keep being supported by trusted professionals remotely.



10 Community connection and participation

Participation within, or a sense of connection to, the LGBTQ+ community is often a source of support, companionship and resilience for many LGBTQ+-identifying people (53,54).

Social distancing measures and fear of contracting the virus during the pandemic have impacted access to community events and services provided by community organisations, including the mode through which these connections are made, with the introduction of remote access options.

This chapter explores experiences of community connection among *Pride and Pandemic* participants and the role that these experiences may have played in mental health outcomes during the pandemic.

10.1 Community belonging

Participants were presented with the following statement, 'The following questions are about LGBTIQ communities. By LGBTIQ communities, we do not mean any particular neighbourhood or social group, but in general, groups of gay men, bisexual men and women, lesbians, transgender and intersex individuals.'

Participants were then asked to indicate the extent to which they felt that they were a part of the Australian LGBTIQ+ community and the extent to which participating in the Australian LGBTIQ+ community was a positive thing for them. Participants responded on a 5-point scale ranging from 'strongly disagree' to 'strongly agree'.

More than six in ten (60.2%; n = 1,883) participants agreed or strongly agreed that they felt they were a part of the Australian LGBTIQ+ community, marginally more than participants from *Private Lives 3* (56.1%; n = 3,824) who agreed or strongly agreed that they felt a part of the community.

Almost two-thirds (63.8%; n = 1,995) of participants agreed or strongly agreed that participation in the Australian LGBTIQ+ community was a positive thing for them, again marginally higher than participants from *Private Lives 3* (61.8%; n = 4,207) who agreed or strongly agreed that participation in the community was a positive thing for them.

10.2 Participation in mainstream or LGBTIQ+ events and media

Participants were asked to respond to a number of items regarding a change in the frequency of which they participated in mainstream or LGBTIQ+ community events as well as access to LGBTIQ+ print, broadcast, social or other online media during the pandemic. Response options ranged on a 5-point scale from 'a lot less frequently' to 'a lot more frequently', with an additional option of 'not applicable'. Rates of responses to these items are presented in Figure 10 below.

Many participants reported less participation in community and social events, including 42.7% (n = 1,333) of participants who reported less participation in mainstream community events and 35.7% (n = 1,112) who reported less participation in LGBTIQ+ community or social events. This appears to have been compensated for by a rise in accessing LGBTIQ+ social media, with two-fifths of participants (42.4%; n = 1,320) reporting increased use of LGBTIQ+ social media.

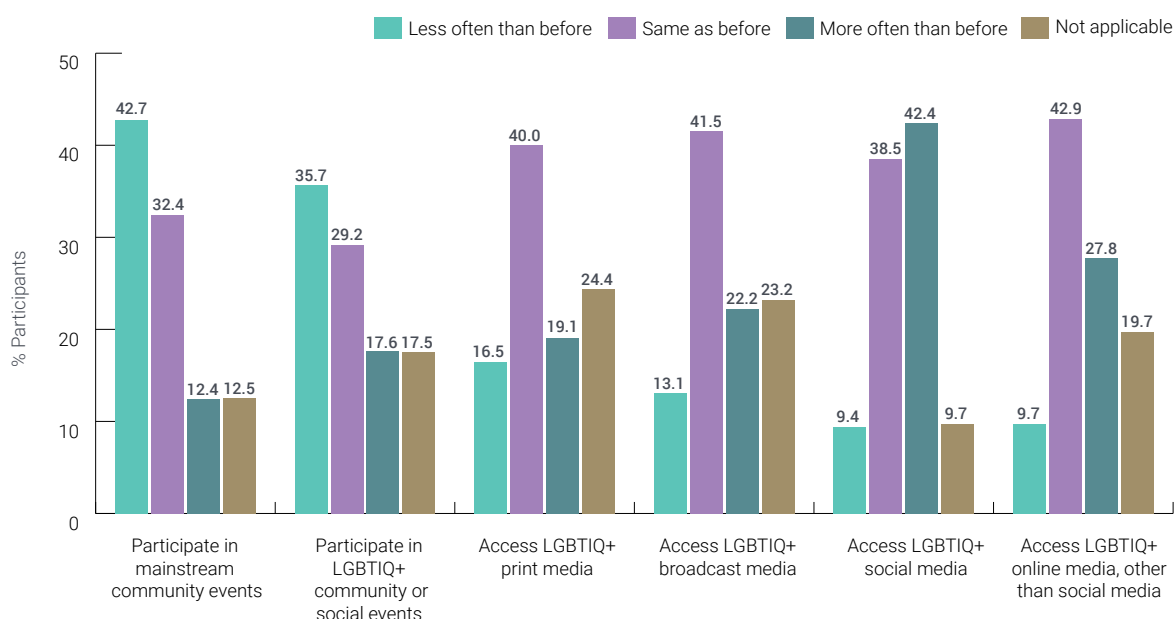
10.3 Remote technologies and access to LGBTIQ+ organisations

Participants were asked if remote access options introduced during the pandemic (such as video conferences or online social spaces) impacted their ability to access services provided by LGBTIQ+ organisations and whether remote access options had resulted in more frequent access, accessing services for the first time, or less frequent access. These responses are provided in Table 38 below.

Table 38: Impact of remote access to services provided by LGBTIQ+ organisations during the pandemic (n = 3,110)

Remote access to services provided by LGBTIQ+ organisations	n	%
No impact on access to services provided by LGBTIQ+ organisations	1,593	51.2
Unsure	773	24.9
Yes, accessed services provided by LGBTIQ+ organisations more frequently	342	11.0
Yes, accessed services provided by LGBTIQ+ organisations for the first time	258	8.3
Yes, accessed services provided by LGBTIQ+ organisations less frequently	144	4.6

Figure 10: Participation in mainstream and LGBTIQ+ community events and access to LGBTIQ+ media during the pandemic



While most participants did not feel or were unsure if remote access options had changed their frequency in accessing services provided by LGBTIQ+ organisations, one in ten participants (11.0%; n = 342) indicated that remote access option had led to them accessing these services more frequently, and a further 8.3% (n = 258) suggested that the remote access option led to them accessing services provided by LGBTIQ+ organisations for the first time.

10.4 Community connection and access to services provided by LGBTIQ+ organisations across intersections

To illustrate the role of intersectionality in community connection and engagement with LGBTIQ+ organisations, Table 39 below provides additional data on the rates of feeling a part of the Australian LGBTIQ+ community and the perceived impact of remote access options on accessing services provided by LGBTIQ+ organisations across various intersections of the survey population. The table reports data from intersections of the population believed to be most likely to have been impacted in unique ways during the pandemic. These include age, gender, ethnicity, disability, and residential location.

Table 39: Community connection and access to services provided by LGBTIQ+ organisations across age, gender, ethnicity, disability and residential location

		Impact of remote access options on access to services provided by LGBTIQ+ organisations			
		Felt a part of the Australian LGBTIQ+ community (%)	No/unsure (%)	Accessed more frequently (%)	Accessed for the first time (%)
Age					
18-24 years	69.7	75.6	9.1	11.2	4.1
25-34 years	60.0	74.2	11.8	9.3	4.7
35-44 years	54.0	78.6	10.4	5.9	5.0
45-54 years	54.0	76.2	12.5	5.9	5.4
55-64 years	53.3	76.7	12.5	6.3	4.5
65+ years	60.0	80.0	12.2	4.3	3.5
Gender					
Cisgender woman	59.5	77.0	10.9	8.8	3.4
Cisgender man	53.4	82.2	8.0	4.8	5.0
Trans woman	65.6	65.4	11.0	14.2	9.4
Trans man	70.0	65.7	13.6	13.0	7.7
Non-binary	70.4	65.2	17.0	13.4	4.5
Sexual orientation					
Gay or lesbian	59.7	80.4	9.1	6.1	4.4
Bisexual or pansexual	58.8	72.5	12.2	11.4	4.0
Queer	72.8	64.4	19.1	9.5	7.0
Asexual	47.8	72.8	8.8	14.0	4.4
Something else	52.2	78.5	5.2	10.4	5.9
Ethnicity*					
Anglo-Celtic only	59.7	76.4	10.6	8.8	4.2
Multicultural background	61.1	75.4	11.3	7.8	5.5
Person of colour	57.7	69.3	14.8	10.0	5.9

Table 39 continued

		Impact of remote access options on access to services provided by LGBTIQ+ organisations			
		Felt a part of the Australian LGBTIQ+ community (%)	No/unsure (%)	Accessed more frequently (%)	Accessed for the first time (%)
Disability/long-term health condition**					
No disability	58.0	80.1	10.0	6.3	3.6
Physical	55.3	70.1	13.1	9.8	7.0
Mental	61.6	75.1	11.0	8.9	5.0
Sensory	50.0	75.7	8.1	10.8	5.4
Neurodiversity/autism	68.2	68.5	14.7	10.7	6.2
Something else	61.4	73.9	7.2	14.5	4.3
Residential location					
Capital city, inner suburban	64.0	75.5	11.4	7.6	5.5
Capital city, outer suburban	57.7	76.3	10.5	9.1	4.1
Regional city or town	57.7	77.0	10.3	8.4	4.3
Rural or remote area	51.5	77.4	13.4	7.3	1.8
State or territory					
Victoria	61.8	70.6	14.2	9.3	5.9
New South Wales	61.9	77.2	10.2	7.6	5.0
Queensland	55.5	83.2	6.6	8.0	2.3
Western Australia	61.1	80.1	8.5	8.0	3.5
Australian Capital Territory	70.0	69.7	15.1	12.6	2.5
South Australia	48.3	82.5	7.0	4.5	6.0
Northern Territory and Tasmania	59.8	78.4	12.4	8.2	1.0

* Participants who only indicated an Anglo-Celtic ethnic background were categorised as 'Anglo-Celtic only'; participants who were not only Anglo-Celtic were categorised as 'multicultural background'. 'Person of colour' includes all participants who additionally identified as a person of colour. Refer to section 3.6 for detail on how ethnicity was assessed.

** Sample sizes for intellectual disability and acquired brain injury were too small to allow disaggregation of the data and are not included in the table

10.5 The association between community connection and mental health

Previous research suggests a protective role of the LGBTQ+ community for the mental health and wellbeing of LGBTQ+ people (53,54). To explore the relationship between feeling connected to the Australian LGBTIQ+ community and mental health outcomes during the pandemic, a series of multivariable logistic regression analyses were conducted using psychological distress (as assessed using the K10) and suicide ideation or suicide attempt during the pandemic as outcome variables. Demographic variables were controlled for in the model, including age, sexual orientation, gender, residential location and state or territory. These analyses are further detailed in section 2.6.

Outcomes of these analyses suggest an association between feeling a part of the Australian LGBTIQ+ community and mental health. Participants who felt they were a part of the Australian LGBTIQ+ community were:

- Almost 40% less likely to have reported high/very high psychological distress in the previous four weeks (AOR = 0.6, CI = 0.5-0.7, $p < 0.001$)
- Almost 20% less likely to have experienced suicidal ideation during the pandemic (AOR = 0.8, CI = 0.7-1.0, $p = 0.031$)
- Although there was no association shown between feeling a part of the LGBTIQ+ community and suicide attempts during the pandemic, the results of these analyses suggest the importance of feeling a part of the LGBTIQ+ community for the mental wellbeing of LGBTQ+ people.

10.6 Focus group insights

10.6.1 Community belonging and lack of access to physical communities

Many focus group participants indicated feeling strongly connected to the LGBTQ+ community. A minority shared having mostly friends who were LGBTQ+ but being unsure whether that meant they were part of the LGBTIQ+ community, reflecting varied ways in which people understand the notion of an LGBTQ+ community.

Isolation and lack of access to the physical LGBTIQ+ community were commonly seen as major negative consequences of the pandemic by participants across the four groups. Yet, it was felt this would be most taxing for younger LGBTQ+ people, who may be new to coming out or may have had to move back and/or isolate with potentially unsupportive families, or families whom they were not out to.

The importance of physical affection and 'touch' with peers was mentioned by a number of participants across the four groups. Touch was understood as central means of peer support, healing and self-affirmation for the LGBTQ+ community:

There is value in being in a space with each other and being able to touch each other [...] I think queer communities are very injured. In general, I think we're quite affectionate with each other. And there's a lot of sort of puritan standards about how people engage with each other in non-LGBT society, like touch is something that's really sexualised, being able to hug someone and not be sexual, hold someone's hand, sit on someone's lap. Those things are really closely associated with queer spaces. And it's just, yeah, not possible anymore. (Anthony, trans man, bisexual, 22)

Similarly, one single mother spoke of how she missed physical touch with other rainbow families during lockdown, and how this lack was the hardest thing for her:

For me, the physicality of being in a queer community is something I've missed a lot [...] I don't think I realised until we went into lockdown that I was actually a touchy-feely person within the queer communities that I had built [...] a hand on your arm when you're talking to someone or, you know, a hug or something like that. And that was much more prevalent within those family communities, particularly like our rainbow families that I caught up with, but suddenly all disappeared [...] That, for me, was probably my biggest struggle. (Fleur, cisgender woman, lesbian, 42)

LGBTQ+ sociality and culture were not experienced by all participants in the same manner. For instance, one participant in the multicultural focus group indicated having a mode of sociality that was different from dominant white queer culture:

[There] is a very specific type of queerness that I don't necessarily relate to [...] there's a different type of censorship when it comes to queerness [...] White queerness is very much, at least for me, centred on aesthetics [...] It's also very sex fluid, which is, again, chill, but that's not necessarily the experience of every queer person, and especially [not] for people from different cultural backgrounds. (Brenda, cisgender woman, bisexual, 22)

10.6.2 Engagement with community online

Social interactions with and support from the LGBTQ+ community through phone, internet and social media were often seen as crucial to wellbeing by focus group participants, regardless of their location. Most were indeed able to connect with community online through community events and social media and felt this helped their mental health during the pandemic. One participant from a rural area told us that 'Community Zoom meetings stopped me from ending up in the funny farm' (Maria, trans woman, 62), while a participant in the multicultural group described the value she found in online communities:

I guess what I found helpful [...] especially in the LGBTIQ+ community of multicultural background is that there were little pockets of communities popping up on social media. A lot of people were just saying to me, 'I think this group might be good for you'. Or, 'If you reach out to this group, it might actually help you', because I have friends who are counsellors, thankfully, and they said, 'I discovered this site or this, here, try it out'. (Rebecca, cisgender woman, lesbian, 27)

Shifting to social interactions exclusively or mostly online also brought about some downsides for a number of participants. Some regretted being less able to meet new people and becoming isolated from the wider community. Others shared anxieties about their ability to readapt to the physical community after months of lockdown, more so if having chosen to express their gender identity differently during the pandemic:

As lockdown has continued, my social skills just continued to decline [...] So for context, I'm a trans man, and I went from, pre-COVID, I was still being read as a butch woman, people would just interpret me as female, pretty much all the time. And during the pandemic, I have started to pass.

For me, the physicality of being in a queer community is something I've missed a lot [...] a hand on your arm when you're talking to someone or, you know, a hug or something like that [...] but suddenly all disappeared [...] That, for me, was probably my biggest struggle.

(FLEUR, CISGENDER WOMAN, LESBIAN, 42)

So I've changed a lot [...] I really don't know how to interact with other people in person anymore. It's like, every time that there's been a brief reprieve from lockdown [...] it's like I'm relearning. Not just how to be interacting with people in person and exercising social skills. But I don't know this body in the way it is now, and how this voice relates to other people, whether they are LGBT or not. And that's been quite scary. (Anthony, trans man, bisexual, 22)

Another younger participant recalled finding the strength to come out as trans during lockdown and socialising within a supportive online community. The prospect of having to face the physical wider community was a concern as he feared not being able to read potentially unsafe situations:

[During lockdown] my mama [was like] 'You're changing your name? All of a sudden?' And I was like, 'Actually, no, it's just taken years.' And then, I got out of lockdown, and I was like, 'Oh crap, I have to actually talk to people now and tell them I changed my name'. It was [scary] [...] Because you're just so used to talking to people like you. You're just so used to seeing a queer person and going, 'Oh, what's up, beautiful, sexy person?', and then going outside, and someone's just, 'What are you doing, queer?' and you're kind of, 'Oh, shit, I forgot. I'm in real life. I forgot, I'm not on a computer' [...] you can't tell who is safe to talk to. Because it's kind of like having a bad gaydar. (Max, trans man, something else, 20)

and reflections. Crucially, participants felt that access to community online was a critical factor in maintaining their mental health during the pandemic. However, lack of access to a physical community was felt as particularly hard for people new to the LGBTQ+ community, such as those who had recently affirmed their gender. Moreover, physical interactions, including touch, were seen by some as inherent part of queer culture and as being particularly missed in times of lockdown. Others felt that accessing community exclusively online had made them unlearn some social skills, had narrowed their social circles and precluded the chance of getting to know different perspectives, or had made them live in a bubble of queer acceptance online that they were unsure to find in the physical 'real world' once restrictions were lifted. Belonging to the LGBTQ+ community was not understood by all in the same way, and some participants in the multicultural group shared feeling censored within majority-white queer modes of presenting or interacting.

10.7 Summary

Feeling part of the LGBTQ+ community was reported by over a half of survey participants, across all intersectional groups. About one-third of participants reported less engagement with LGBTQ+ community events during the pandemic, and this was likely compensated for by access to LGBTQ+ social media, which increased for two-fifths of participants. One in ten reported more access to services provided by the LGBTQ+ community and 8.3% reported they accessed them for the first time in this period. These results suggest the shielding effect of online access to community during the pandemic. Indeed, LGBTQ+ participants who indicated feeling part of the LGBTQ+ community were more likely to have better mental health outcomes and less suicide ideation than those who did not.

The importance of accessing community for diverse LGBTQ+ people's mental health was highlighted in our focus groups, whose participants raised a number of concerns



11 Other coping strategies

A number of coping strategies to mitigate the impacts of the pandemic on mental health, beyond social supports and professional healthcare, have been documented in the current literature (55,56).

The *Pride and Pandemic* study asked participants about additional coping strategies they may have utilised during the pandemic, including exercise, time spent outdoors, hobbies and relationship with pets. In addition, focus group participants were asked to identify any additional coping strategies that they used during the pandemic to look after their mental wellbeing.

11.1 Positive activities

Participants were asked to indicate any change in frequency of the time they spent during the pandemic on several activities, including time dedicated to physical exercise, time spent outdoors, and time spent on hobbies. Response options ranged from 'much less than before' to 'much more than before'.

Table 40: Time spent engaging in positive activities during the pandemic as compared to prior to the pandemic

	Much less/slightly less than before the pandemic		Same as before the pandemic		Slightly more/much more than before the pandemic	
	n	%	n	%	n	%
Time dedicated to physical exercise	1,473	48.0	777	25.3	820	26.7
Time spent outdoors	1,615	52.2	622	20.1	859	27.7
Time spent on hobbies	1,027	33.5	857	27.9	1,183	38.6

Many participants reported spending less time during the pandemic dedicated to physical exercise (48.0%; n = 1,473), time outdoors (52.2%; n = 1,615) or hobbies (33.5%; n = 1,027). However, there was also a considerable number who spent more time on these activities (26.7%; n = 820, 27.7%; n = 859 and 38.6%; n = 1,183, respectively). Given the enforced restrictions of the pandemic, these activities may have been made more difficult or impossible to engage with in the same capacity as before the pandemic. Conversely, for some people the lockdowns and change in working arrangements may have allowed for more time to spend on these activities, and others may have made a concerted effort to protect their wellbeing

For our family, I think it was actually a real silver lining that I was working from home [...] So I think that for us, having both of us around all the time, really sort of helped mitigate the impact of the pandemic [...] I know, for my partner, having been able to bounce off me really helped.

(MAURICE, TRANS MAN, BISEXUAL, 32)

by increasing these activities. These outcomes are likely to be highly dependent on how someone partakes in these activities and how they were impacted by the pandemic and related public health measures. For example, a person who attends a gym for their physical exercise would have faced more challenges maintaining this activity during lockdown than someone who jogs in their local area.

11.2 Pet ownership

Participants were asked if they owned any pets and whether the pet or pets were a dog, cat, both or another type of pet. Pet owners were then asked if they felt that their pet or pets had provided them with valuable companionship during the pandemic.

Table 41: Proportion of participants who owned a pet (n = 3,124)

Pets	n	%
One or more cats	1,043	33.39
One or more dogs	1,131	36.2
One or more other pets	417	13.35
No pets	1,150	36.81

Most participants (63.2%; n = 1,974) owned at least one pet. Moreover, the vast majority of pet owners (98.0%; n = 1,907) felt that their pet or pets had provided them with valuable companionship throughout the pandemic. A little over one-fifth (22.5%; n = 437) felt that their pet or pets provided some valuable companionship, while three-quarters (75.5%; n = 1,470) felt that their pets provided a lot of valuable companionship.

11.3 The association between coping strategies used and mental health outcomes

Physical exercise, time spent outdoors and time spent on hobbies are positive behaviours that may contribute to better mental health outcomes during challenging times like the pandemic. To explore the potential for these behaviours to have protected mental health during the pandemic, a series of multivariable logistic regression analyses were conducted using psychological distress (as assessed using the K10) and suicide ideation or suicide attempt during the pandemic as outcome variables. Demographic variables were controlled for in the model, including age, sexual orientation, gender, residential location and state or territory. These analyses are further detailed in section 2.6.

Spending less time dedicated to physical exercise during the pandemic, as compared to prior to the pandemic, was associated with:

- A greater likelihood to report high or very high psychological distress (AOR = 1.51, CI = 1.23-1.85, $p < 0.001$)
- A greater likelihood to have experienced suicidal ideation during the pandemic (AOR = 1.35, CI = 1.1-1.66, $p = 0.005$)
- A greater likelihood to report that mental wellbeing got worse during the pandemic (AOR = 2.21, CI = 1.82-2.7, $p < 0.001$)

Spending less time outdoors during the pandemic, compared to prior to the pandemic, was associated with:

- A greater likelihood to report high or very high psychological distress (AOR = 2.08, CI = 1.68-2.58, $p < 0.001$)
- A greater likelihood to report experiences of suicidal ideation during the pandemic (AOR = 1.41, CI = 1.13-1.76, $p = 0.002$)
- A greater likelihood to report that their mental wellbeing got worse during the pandemic (AOR = 2.21, CI = 1.79-2.72, $p < 0.001$)

Spending less time on hobbies during the pandemic, as compared to prior to the pandemic, was associated with:

- A greater likelihood to report high or very high psychological distress (AOR = 2.28, CI = 1.84-2.82, $p < 0.001$)
- A greater likelihood to report experiences of suicidal ideation during the pandemic (AOR = 1.61, CI = 1.3-1.99, $p < 0.001$)
- A greater likelihood of attempting suicide during the pandemic (AOR = 1.85, CI = 1.17-2.94, $p = 0.009$)
- A greater likelihood to report that mental wellbeing had got worse during the pandemic (AOR = 3.06, CI = 2.46-3.81, $p < 0.001$)

Interestingly, participants who spent more time outdoors and more time on hobbies compared to prior to the pandemic were also more likely to report high or very high psychological distress (more time outdoors: AOR = 1.36, CI = 1.07-1.72, $p = 0.010$; more time on hobbies: AOR = 1.27, CI = 1.04-1.54, $p = 0.020$). While unexpected, these findings may reflect the unforeseen increase in 'free time' that many may have experienced during the pandemic due to lockdowns and loss of work hours.

The findings illustrate that participants who reported spending less time dedicated to positive behaviours, including physical exercise, time spent outdoors, and time spent on hobbies during the pandemic, as compared to before the pandemic, were more likely to report worse mental health outcomes than those whose behaviours had not changed. Spending more time than prior to the pandemic dedicated to these behaviours was not associated with positive mental health outcomes, and in fact, more time outdoors and spent on hobbies was associated with poorer mental health outcomes. These findings suggest the importance of being able to maintain positive behaviours during challenging times.

11.4 Other strategies for maintaining mental health and wellbeing

The last question of the *Pride and Pandemic* survey gave participants an opportunity to tell us more, in their own words, about how they managed their mental health during

the pandemic, with an open text response. Participants were asked: 'What were some of the things that you did or are doing to maintain your mental health and wellbeing throughout the pandemic?' In total, 1,978 of the survey participants provided a response to this question.

The responses both confirmed and expanded the quantitative survey data. Owning pets, engaging in physical activities outdoors, and dedicating time to one's hobbies were often part of the open answers given. The open-ended answers also often specified which hobbies had been particularly helpful. Beyond specific sports, other hobbies mentioned were gardening, listening to or making music, reading, watching films, playing videogames, and building Lego.

There were several further indications of coping strategies that warrant attention as they confirm and clarify other findings of our research. First, many mentioned being part of peer support groups and attending community online events as being of great help, which confirms what was suggested in Chapter 10 in relation to the importance of feeling a part of LGBTQ+ community for LGBTQ+ people's mental health.

Several participants wrote about the help they found in psychologists, in having regular online sessions with them, or in being diagnosed with a specific mental health condition or neurodiversity, confirming the importance of access and engagement with high-quality mental health care as detailed in Chapter 9. Meditation and mindfulness were also often mentioned as crucial to self-care and mental wellbeing.

Participants often referred to the importance of support from friends and family, as seen in Chapter 6, and several specified further the importance of strengthening and cherishing the relationship with their intimate partners, which can be seen as the counterpart to the negative impact of family violence reported in Chapter 7.

Self-care in the form of cooking and eating well, sleeping enough and reducing or quitting alcohol and tobacco use also frequently featured in the answers given. However, several participants specified that 'a healthy relationship' with alcohol helped them cope. This is an important aspect that further contextualises the increase in alcohol and tobacco consumption among LGBTQ+ people during the pandemic discussed in Chapter 8: increased consumption of alcohol is not necessarily experienced as a failure of self-care. When perceived as well managed, alcohol was described as a positive coping mechanism and an opportunity to facilitate enjoyment.

Financial stability, the help provided by JobSeeker Payment and other types of government support, and changing or starting work, as well as volunteering were also mentioned in the answers to this open-ended question. This also confirms the crucial role of financial stability for one's mental health, as highlighted in Chapter 4. Another coping strategy that was mentioned as linked to one's work was learning how to set boundaries and separate work from private life while working from home.

Two further interesting and diametrically opposed answers were given by a similar number of participants: that is, keeping informed and up to date with the news or avoiding it fully – in either case with the intention of maintaining mental wellbeing. Finally, a few participants mentioned having been able to live or move to areas with without COVID-19-related restrictions, such as South Australia or Western Australia, as the obvious reason for being able to safeguard their mental wellbeing.

11.5 Focus group insights

Extended time was spent in the focus groups discussing coping strategies adopted during the pandemic. While an overwhelming majority of the strategies mentioned in the focus groups are included among those mentioned above, there are a few in relation to belonging to a specific subgroup that are worth exploring more in depth.

Rainbow families found spending more time with their children and partners because of working remotely of great help:

For our family, I think it was actually a real silver lining that I was working from home. Because previously I worked full-time, I was usually out from 6:30 to 7 o'clock at night, which is not terrible hours, relative to some people I know, but also made it really difficult to see the little one very much, especially during winter. So I think that for us, having both of us around all the time, really sort of helped mitigate the impact [of the pandemic] [...] I know, for my partner, having been able to bounce off me [...] really helped. (Maurice, trans man, bisexual, 32)

Several other younger participants, however, mentioned being able to move out from their childhood family homes pre-pandemic as what helped them the most during the pandemic. One multicultural focus group participant raised two important points relative to the lifting of mental health stigma during the pandemic and the way employees and students were encouraged to access mental health support and given disability support for mental health-related issues:

I found out working in Australia, you still have that stigma against mental health, that you can't talk about your feelings or that you [...] have to be professional all the time. So, I found that when the pandemic happened, they put that stress on mental health and wellbeing [...] [and] said, 'We've got these services here for you. You can call EAP, which is an employee assistance program, and they've got counsellors for you that you can access'. And with university, they did the same thing, they said, 'Let's have a mental health care plan for you. Your GP can set that up for you, and [...] if you felt you couldn't finish off an assignment or something, you can have access to disability support', because mental health finally came under that category. (Rebecca, cisgender woman, lesbian, 27)

11.6 Summary

The *Pride and Pandemic* survey reveals how several key coping strategies helped LGBTQ+ people to maintain mental wellbeing during the pandemic. Key behaviours noted were engaging in physical exercise, spending time outdoors, and dedicating time to one's hobbies. Analyses demonstrated an association between maintaining these behaviours during the pandemic and better mental health outcomes among survey participants. Spending the same amount of time as prior to the pandemic dedicated to physical exercise, being outdoors and engaged with hobbies was associated with better mental health outcomes, illustrating the importance of being able to maintain levels of engagement with healthy habits through challenging times.

To deepen our understanding of what helped LGBTQ+ people cope with the pandemic, extra data were collected from 1,978 participants who answered an open-ended question on this matter. These responses confirmed the buffering role of

exercise and outdoor activities, dedicating time to hobbies and caring for pets. They also highlighted the protective role of accessing online LGBTQ+ communities, nourishing intimate partner connection, regular and high-quality professional mental health support, as well as self-care, meditation and reduced as well as well-managed alcohol consumption. One important factor mentioned by a few participants was the crucial role of setting boundaries between work and personal life and achieving financial stability thanks to government support schemes. A few acknowledged the benefit of being in states with hardly any COVID-19-related restrictions, while different participants mentioned keeping up to date with the news or avoiding the news entirely as helpful strategies to maintain mental wellbeing.

Focus group participants spoke of several coping strategies already mentioned above, and also added further reflections. Rainbow families spoke of the importance of enjoying and providing increased family support and presence due to home-office arrangements, while younger LGBTQ+ people who managed to move out from toxic or unsupportive childhood homes saw this as having saved them. Other focus group participants deeply valued the way the pandemic had helped in destigmatising and mainstreaming mental health both in the workplace as well as at schools and universities, leading to an increase in access to mental health support within these institutions.



12 Summary of intersectional experiences

The mental health of LGBTQ+ communities in Australia was heavily impacted by the COVID-19 pandemic, as was the mental health of the wider community.

Among the objectives of *Pride and Pandemic* was to identify the scale and the specific ways in which diverse LGBTQ+ people were affected; the kinds of services and support they accessed, and their experiences with these; their needs in matters of mental health support; and what they felt mitigated the negative impact of the pandemic on their mental health.

Identities and experiences intersect in multiple ways within the LGBTQ+ community, given its diversity. With this in mind, we

have summarised findings from the study for intersectional communities who we have reason to believe may have been disproportionately impacted by the pandemic. These are LGBTQ+ young people, trans and gender diverse people, LGBTQ+ people from multicultural backgrounds, and LGBTQ+ people with disabilities. We do, of course, acknowledge that these groups are not mutually exclusive and that some experiences may intersect in complex ways.

12.1 LGBTQ+ young people (18 to 24 years)

The mental health of LGBTQ+ young people (18 to 24 years old) appeared to have been heavily impacted during the pandemic. Half indicated experiencing high or very high levels of psychological distress (50.6%); more than half (61.5%) reporting suicide ideation both prior and during the pandemic; and one in ten (11.5%) reported suicide attempts both prior and during the pandemic. Younger people were also the age group who most frequently reported financial insecurity, with 83.7% indicating concerns about their financial situation during the pandemic and 81.2% about their employment. Homelessness was experienced for the first time during the pandemic by 3.8% of young people. Concerningly, nearly half of all younger participants (49.5%) reported experiencing violence from a family member during the pandemic and more than a quarter (27.5%) indicated such violence occurred more frequently than before the pandemic.

Several younger focus group participants shared their negative experiences and mental distress linked to living with unsupportive families during lockdowns. Many participants across the four groups discussed feeling worried for their younger peers who were forced to live with families who were not supportive of them, including younger multicultural LGBTQ+ who described how their cultures may sometimes be less accepting of gender diversity and sexuality. Conversely, younger multicultural participants who spent lockdowns away from their birth families felt that the pandemic kept them at a safe distance and allowed them to be themselves. It was generally understood as harder for younger LGBTQ+ people not to have a physical community to go out with, meet new friends and find oneself, more so if they had come out during the pandemic.

There were no notable differences in survey responses regarding the proportion of younger LGBTQ+ participants engaged with professional psychological support. However, younger focus group participants shared important insights on the difficulty of accessing psychological support while living with their families, due to struggling with finances and shared their unease at having to do Zoom psychology sessions in the family home.

12.2 Trans and gender diverse people

Trans and gender diverse participants reported higher rates of poor mental health outcomes compared to cisgender participants. Trans men and non-binary people reported particularly high rates of poor mental health, with nearly half (46.5%) and just over a half (50.8%) respectively reporting high or very high psychological distress. In comparison, 39.1% of trans women, 36.5% of cisgender women and 21.9% of cisgender men reported high psychological distress.

Higher proportions of trans men (4.5%), trans women (3.6%) and non-binary people (2.8%) reported attempting suicide for the first time during the pandemic than was the case for cisgender women (1.8%) and cisgender men (1.3%). Trans and gender diverse people were also more likely to report intimate partner and family violence during the pandemic than were cisgender members of the LGBTQ+ community. Data from focus groups gave us further insight into the specific ways in which trans and gender diverse people may have been affected by the pandemic. They spoke about the negative impact of having their gender affirming surgeries delayed by the halt to elective surgeries; frustrations about being misgendered in vaccination certificates and other documents; and the negative consequences of delays in

receiving hormonal medication as well as not being able to take antidepressants or anxiety medication due to their incompatibility with gender-affirming hormone therapies.

Lack of access to physical trans and gender diverse communities was described as impacting individuals who had transitioned or come out as gender diverse during the pandemic. Some participants shared feeling particularly isolated due to the difficulty of finding their place in a community new to them that they could not physically access. Other trans participants shared their anxieties about having to relearn social skills and dealing with the wider, potentially not queer-friendly community after lockdowns, with transformed bodies or newly affirmed gender identities.

There was a lot of discussion within the trans and gender diverse focus group about access to and availability of trans and gender diverse-specific services and specialised psychologists. Most participants stressed the need for more trans and gender diverse-specific services and for more financial support to be able to enable access specialised private therapists who were trans-affirming and knowledgeable of the key challenges faced by this community.

12.3 LGBTQ+ people from multicultural backgrounds

LGBTQ+ survey participants identifying as coming from multicultural backgrounds or as people of colour demonstrated some differing experiences during the pandemic from those of participants who identified as Anglo-Celtic.

Approximately one-quarter (28.8%) of participants from a multicultural background and almost two-thirds (66.7%) of those who identified as a person of colour expressed concern that they would experience discrimination against them based on their cultural or ethnic background during the pandemic. The insights shared by our multicultural focus group participants (all of whom were of either Chinese or Southeast Asian backgrounds) confirmed such concerns. They described both experiencing and witnessing anti-Asian racism in the wider community. One lesbian cisgender woman whose parents migrated to Australia expressed feeling triggered by experiencing anti-Asian racism during the pandemic and reminded of the way she never really felt she fully belonged to either Australia or the culture of her family of origin.

While no-one mentioned feeling discriminated against within majority-white LGBTQ+ communities, one bisexual cisgender woman in the multicultural focus group talked about feeling 'censored' when staying with her birth family to whom she is not out, as well as within majority-white queer culture, as she felt the latter was centred on 'aesthetics' and sex positivity in a way that may not be shared by diverse LGBTQ+ people, particularly those from multicultural backgrounds. This same participant had to spend part of lockdowns in her childhood home and reported feeling distressed by having to remain in the closet to her parents during this time. However, she also felt 'censored' after she managed to move in with majority-white queer flatmates, highlighting how pandemic restrictions may have intensified feelings of lack of belonging for LGBTQ+ people with multicultural backgrounds by hindering their physical movement in between different communities.

The survey data also illustrate greater proportions of participants who identified as a person of colour (40.8%) or as being from a multicultural background (34.5%) reporting experiences of violence from a family member during the

I personally haven't found any targeted resources. So everything's quite an umbrella approach [...] I found that there's not really anything that's related to the fact that I'm from a multicultural background or migrant background, and there wasn't a lot around, for example, refugees who are also queer.

(REBECCA, CISGENDER WOMAN, LESBIAN, 27)

pandemic, as compared to Anglo-Celtic participants (24.9%). Accordingly, some multicultural focus group participants spoke of the difficulties they faced or feared others would face during the pandemic when stuck with unsupportive families who belong to cultures that are unaccepting of gender and sexual diversity. Conversely, one non-binary participant from a multicultural background felt glad to have been separated from their birth family during the pandemic as this allowed them to explore their identity and make new friends, which they feared having to hide again upon being reunited with their parents.

Multicultural focus group participants also shared concerns about the situation of migrant LGBTQ+ people, including international students, who risked returning or had to return to unsupportive families and/or particularly homophobic or transphobic countries, where their sexuality or gender identities may be outlawed. Others mentioned the lack of financial support for migrants without permanent residency, and the high costs of immigration procedures and lawyers required to be able to reunite with partners stuck abroad or to stay in Australia during the pandemic.

On a positive note, one participant shared feeling that the pandemic had brought about a shift in awareness about mental health problems within migrant cultures where mental health stigma was generally particularly strong, as well as in majority-white Australian workplaces.

12.4 LGBTQ+ people with disability

In the *Pride and Pandemic* survey, participants were asked to report whether they identified as having a disability or long-term health condition, whether existing at birth or acquired later in life. Over half of the sample (51%) reported having a disability, a long-term health condition or a neurodiversity. Among the most frequent reported disabilities/conditions were mental illness (48.5%); neurodiversity/autism (28.4%); physical disability (28.4%); intellectual disability (1.1%); acquired brain injury (0.5%); and something else (4.7%). Over one-third (38.6%) of participants identifying as having a physical disability and over a half (54%) of those identifying as having a mental disability reported high psychological distress during the pandemic. Concerningly, over one-third (39%) of survey participants identifying as having a mental disability and nearly a half of those identifying as having a neurodiversity (47.8%) reported experiencing violence from a family member during the pandemic.

Almost half (45.2%; n = 47) of participants who were receiving NDIS supports reported that they received less support or different support during the pandemic, with under two-fifths (38.5%) reporting that the support they received had either remained the same or increased during the pandemic. Changes in non-NDIS supports were not reported as frequently among participants with disability. More than half (56.8) of participants receiving non-NDIS support reported that this support had either stayed the same or increased during the pandemic, while approximately one-third (32.5%) indicated that they had received less or different non-NDIS support during the pandemic.

While no specific focus group was run with people with disability, 17 participants across the four groups identified and shared living with disability or neurodiversity. Some shared important insights on the ways the pandemic and its related restrictions, changes in service provision, social interactions and supports impacted on their health. Crucially, focus group participants living with disability or co-occurring health conditions shared strong negative feelings about being portrayed as 'collateral damage' of a pandemic whose victims would be described by media as 'only' older people or people with co-occurring medical conditions.

In general, focus group participants with disability described telehealth, online service provision and social events as incredibly helpful and having allowed them access to professional and social support in better ways. However, participants criticised the COVID-19 vaccine rollout for not having prioritised people with disability and wished for staff at vaccination hubs to be trained to be affirming of disability and gender and sexual diversity. Incentivising peer-based support for LGBTQ+ people living with disability was also specifically wished for within focus group discussions.



13 Summary and recommendations

LGBTQ+ people entered the pandemic under already challenging circumstances, with disproportionately poor mental health, high rates of family violence, and high rates of stigma, discrimination and abuse relating to their gender identity or sexuality (6).

The results from *Pride and Pandemic* further illustrate the disparities between LGBTQ+ health and wellbeing and that of the general population. Additionally, the results demonstrate the detrimental impacts of the pandemic on mental health and loss of access to supports and community connections that ordinarily serve to protect mental health. Some of the more concerning outcomes include high rates of suicidality and experiences of family violence during the pandemic. However, the findings also highlight the resilience of the LGBTQ+ community, a desire to support one another and look after the broader community, and the strategies used by LGBTQ+ people to cope during the pandemic. These strengths can be harnessed now and into the future.

We start this chapter by summarising key health and wellbeing concerns identified in the data and outline recommendations that need to be taken in the short and medium term to address them. We then outline recommendations for consideration in the context of future pandemics or other potential crisis situations. All of these recommendations should be considered by governments at local, state/territory and federal level and can help to inform the practices of LGBTIQ community organisations and the mainstream organisations that also work to further the wellbeing of LGBTIQ people across Australia.

I think ongoing mental health supports that are clear, affirming, and gender affirming [are needed]. And continuing to put money into that. And also having lived experience positions in a number of our big LGBTIQ health services to get more people who are part of our communities into those places, running programs for and by the communities, which they're serving, to do some of that kind of peer connection and peer support.

(KEN, NON-BINARY, 37)

13.1 Health and wellbeing

The findings presented in this report are concerning, highlighting poor health and wellbeing outcomes among LGBTIQ+ people during the pandemic. While poor health and wellbeing outcomes were found across the full *Pride and Pandemic* sample, the findings also revealed priority populations and key issues that require specific initiatives for LGBTIQ+ people during and beyond the pandemic, and in face of future crises that pose similar challenges.

13.1.1 Mental health

Almost two-thirds (63.8%) of participants felt that their mental wellbeing had been negatively impacted during the pandemic, and this was expressed most among participants of younger age (18 to 24 years), trans and gender diverse participants and participants with disability. Additionally, most participants who had received a diagnosis prior to the pandemic reported that their condition had got worse during the pandemic. The findings from the survey also suggest alarmingly high rates of suicide attempt (6.6%) during the pandemic.

Compounding the poor mental health outcomes observed among LGBTIQ+ people, the pandemic posed additional challenges for managing mental health, with many *Pride and Pandemic* participants reporting less support from others during the pandemic as well as additional barriers to accessing mental health care that is knowledgeable and inclusive of their needs.

While many participants noted cost as a barrier to accessing mental health care and focus group participants expressed the value of additional funding to access mental health appointments, little of the mental health funding during the pandemic was directed toward LGBTIQ+ organisations. As has been noted in previous national reports including *Private Lives 3*, the outcomes of *Pride and Pandemic* further shone a spotlight on the need for better resourcing of LGBTIQ+ community controlled organisations as the trusted sources of knowledgeable support and mental health care for LGBTIQ+ communities. At the same time, many participants expressed a preference for access to mainstream services that are inclusive of LGBTIQ+ people.

Recommendation 1. Resourcing of LGBTIQ+ community organisations to meet extensive mental health need.

Such services were valued by participants and perceived as being experts in the experiences and needs of LGBTIQ+ people. A lack of accessibility or a concern about their resource capacity dissuaded some from seeking help when they needed it, a situation that could be addressed with greater investment.

Recommendation 2. Ensuring the provision of culturally safe and affirming practices in mainstream mental health services.

LGBTIQ+ communities have a right to access healthcare services where they are treated with dignity and where their identity and lived experience of their gender or sexual orientation is respected and affirmed. Resourcing is essential to ensure that mainstream services have the support and training required to provide the services that LGBTIQ+ people need at the scale that is required.

13.1.2 Family violence

Stay-at-home orders implemented during the pandemic as well as potential financial strain may have resulted in many LGBTIQ+ individuals needing to spend more time in unfavourable home environments. Focus group participants expressed a great concern for young people who may have been forced into these situations, and this was a further concern for those from multicultural backgrounds where families may be less affirming of LGBTIQ+ identities. The survey results reflect these concerns with very high rates of violence from family members (28.9%) and intimate partners (17.2%) reported by participants. Rates of violence from family members were particularly high for young participants (aged 18 to 24 years), trans and gender diverse participants, people with disability, and those from a multicultural background or identifying as a person of colour. Notably, many participants who had experienced violence from a family member reported that the violence was more frequent during the pandemic or had occurred for the first time.



Recommendation 3: Enhancing access to LGBTIQ+-affirming family violence services.

LGBTIQ+ people who experience family violence need access to high-quality, culturally safe services when subject to family violence. Resourcing is required for both LGBTIQ+-controlled organisations to establish or expand their capacity to meet demand as well as mainstream services that currently lack the capacity or skills to meet the family violence support needs of LGBTIQ+ communities.

Recommendation 4: Development and promotion of family of origin violence prevention interventions.

Efforts must be made to support LGBTIQ+ young people who are not safe in their homes. Such interventions should be designed in collaboration with LGBTIQ+ and youth organisations and must ensure involvement of people with disability and those from multicultural backgrounds. They could include, but not be limited to, interventions through educational settings to promote sources of support to young people who may not be safe at home, as well as increased support for families of trans and gender diverse young people.

13.1.3 Alcohol and other drug use

Changes in patterns of tobacco, alcohol and other drug consumption were observed during the pandemic among *Pride and Pandemic* participants. In particular, almost half of the participants who consumed tobacco (46.6%) or alcohol (46.0%) reported an increase in use during the pandemic, likely as a response to increased stressors presented by the pandemic. Similarly, use of cannabis for many increased, while use of other illicit drugs more associated with parties and social use, such as MDMA, decreased.

There is nothing inherently problematic with the use of such substances, particularly if they assist in maintaining mental health or providing a means of relaxation during particularly stressful times. What is worthy of attention, however, is that some participants expressed concern with their consumption of alcohol and other drugs during the pandemic and felt it was having a negative impact on their everyday life. In the vast majority of cases, these participants did not seek any professional support. Of those who did seek professional support, few sought support from LGBTIQ+-inclusive or LGBTIQ+-specific services, reflecting the limited availability of such LGBTIQ+-affirming services in Australia.

Recommendation 5: Resourcing of LGBTIQ+ organisations for the provision of drug and alcohol support services.

Due to the trust in such organisations that was reflected in focus group discussions, there is a need to ensure these services are available and accessible to meet the needs of those who find themselves in more difficult circumstances. These organisations may also be well placed to assist in LGBTIQ+-affirming capacity development in mainstream drug and alcohol services.

Recommendation 6: Promotion of LGBTIQ+-affirming support services for drug and alcohol use.

Pending the development of capacity recommended above, it is essential that LGBTIQ+ communities are appraised of the services available to them in times of need. Such promotional work should also seek to disestablish any stigma that may exist regarding drug and alcohol-related concerns and facilitate open discussion of problems if they develop.

13.2 Recommendations for crisis preparedness

The findings from *Pride and Pandemic* highlight ongoing challenges faced by the LGBTQ community in Australia including poor mental health outcomes, systemic discrimination, and barriers to equitable and affirming healthcare. For the LGBTQ community, the data collected in this study would suggest that the pandemic made an already challenging situation worse. The ramifications of this crisis are likely to be long-lasting within the community and recovery may be slow. Immediate action is required to reduce health disparities and ensure that the wellbeing of LGBTQ communities does not deteriorate further. These actions cannot wait for the next crisis.

While the pandemic was far-reaching, impacting people across the country, Australia frequently faces additional crises such as bushfires and floods. These disasters may be localised, but they have a huge impact on affected communities, including LGBTIQ+ people within these communities. Moreover, due to the climate crisis, Australia is likely to experience increasing occurrences of these disasters in the future. In face of future crises, whether global or local, and in light of the ongoing disparities experienced by this population, it is essential that resources are available to



support LGBTQ+ communities through such challenging times. The findings from *Pride and Pandemic* highlight key services and supports that were required to assist LGBTQ+ people through the pandemic and need to be made available in face of future crises. Specifically, we recommend:

Recommendation 7: Funding of LGBTQ+-community mental health services

to provide dedicated support for LGBTQ+ people during times of crisis. Data from the survey replicate findings from other research that showed some LGBTQ+ people do not feel adequately supported or respected in mainstream mental health services and thus LGBTQ+ community organisations can play a crucial role in addressing acute mental health need.

Recommendation 8: Resourcing of LGBTQ+ organisations to facilitate accessible peer support groups

where access may be challenging and enable community interaction in crisis affected areas. This may involve providing online or remote access to peer support groups as well as the facilitation of in-person peer support groups in affected areas where needed, such as in bushfire-affected or flood-affected communities.

Recommendation 9: Continued resourcing of and access to telehealth services

across all health services including medical and mental health care, with emphasis given to those organisations that have demonstrated themselves to be providing LGBTQ+ culturally safe practice.

13.3 Recommendations for future research

This report presented findings from a national survey of LGBTQ+ people in Australia during the pandemic. While reporting on the health experiences and impacts of a large sample of people, no one project can ever hope to reflect all of the experiences and needs of this population, and additional research is needed to further our knowledge of the experiences of LGBTQ+ people during a crisis, particularly for those from intersectional communities. While further funding is needed for community participatory research to attend to the diversity and heterogeneity of LGBTQ+ people more broadly in Australia, there is a particular need for:

Recommendation 10: Undertaking of focussed research on the experiences of people with an intersex variation.

This research must involve community consultation throughout all phases of its development and would likely need to be specifically targeted only to people with an intersex variation/s to ensure maximum engagement.

Recommendation 11: Undertaking of research that focuses on a broader diversity of gender and sexual identities.

Non-binary identities are rapidly evolving, and non-binary participants frequently reported poorer health and wellbeing outcomes during the pandemic when compared with other participants. Additionally, people who identify as queer, bisexual or pansexual similarly reported poorer health outcomes compared to participants who identify as lesbian or gay. Qualitative research with these groups would help to ensure a richer body of knowledge to plan interventions for now and in the context of future crisis events that may be experienced.

Recommendation 12: Undertaking of focussed research among First Nations LGBTQ+ people.

To attain an understanding of experiences of First Nations LGBTQ+ people during times of crisis requires specific, culturally situated research to explore their experiences relating to health and wellbeing. This research should be led by First Nations researchers and organisations.

Recommendation 13: Monitoring of LGBTQ+ inclusion in future crisis responses.

Research is required to observe (and enable responses to) LGBTQ+ health and wellbeing during and in the aftermath of future crises, whether these are local (e.g. bushfires and flooding) or global. This research must include nuanced explorations of the experiences and needs of LGBTQ+ communities as they cope both during the disaster and while the community recovers, including the strengths and resources they bring as well as the unique recovery needs they may have.

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La Trobe University proudly acknowledges the Traditional Custodians of the lands where its campuses are located in Victoria and New South Wales. We recognise that Indigenous Australians have an ongoing connection to the land and value their unique contribution, both to the University and the wider Australian society.

La Trobe University is committed to providing opportunities for Aboriginal and Torres Strait Islander people, both as individuals and communities, through teaching and learning, research and community partnerships across all of our campuses.

The wedge-tailed eagle (*Aquila audax*) is one of the world's largest.

The Wurundjeri people – traditional owners of the land where ARCSHS is located and where our work is conducted – know the wedge-tailed eagle as Bunjil, the creator spirit of the Kulin Nations.

There is a special synergy between Bunjil and the La Trobe logo of an eagle. The symbolism and significance for both La Trobe and for Aboriginal people challenges us all to 'gamagoen yarrbat' – to soar.

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