

# Health priorities and perceived health determinants among Western Australians attending the 2011 LGBTI Perth Pride Fairday Festival

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## Abstract

**Issue addressed:** Although data exist demonstrating poorer health indicators on a range of health outcomes for lesbian, gay, bisexual, transsexual and intersex (LGBTI) people, there is little information as to how this group perceives the relative importance of different health issues or what the underlying reasons behind poorer health may be.

**Method:** A self-completed survey was administered to people attending the October 2011 LGBTI Perth Pride Fairday Festival. Three hundred and fifty-one people completed the survey, resulting in a total of 335 useable surveys. One hundred and seventy-eight participants identified as female, 145 as male, four as transgender and eight as other genders.

**Results:** Depression, anxiety, excessive worry or panic attacks and problems in family relationships were reported as the most important individual health issues, whereas depression, suicide and HIV/AIDS were seen as the most important health issues affecting the LGBTI community. Discrimination was rated the most important social factor impacting on the health and well being of this community.

**Conclusions:** When members of the LGBTI community were asked to rank health issues of importance both individually and as a community, the results indicate that mental health issues are of prime concern. Discrimination and the stress of living as part of this minority group were seen as contributing to this. Health promotion and public health need to be responsive to these issues if real gains are to be made in reducing the health inequities affecting this group.

**So what?** This research highlights the link between social justice, social inclusion and health outcomes. The health of LGBTI people is rarely considered by mainstream agencies, despite poorer health outcomes. Sensitive and targeted public health interventions that resonate with the community and that acknowledge the impact of being part of this marginalised group are required.

**Key words:** gender identity, sexual orientation, lesbian, gay, bisexual, transsexual and intersex (LGBTI), health priorities, determinants of health.

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## Introduction

The inequity of the health status of lesbian, gay, bisexual, transsexual and intersex (LGBTI<sup>1</sup>) people has been widely reported.<sup>2,3</sup> Such reports highlight that LGBTI populations are at higher risk of various mental health issues, hate crime, sexually transmitted infections, including HIV/AIDS, assorted cancers and alcohol and/or drug use issues.<sup>3</sup> The Private Lives LGBTI health and well being study in 2006 reported high levels of depressive disorders, with 73.7% of respondents reporting they had ever been depressed and a third of respondents feeling depressed on more than half the days in the past 2 years.<sup>4</sup> Half (50.1%) of the Private Lives respondents reported they had seen a counsellor or psychiatrist in the past 5 years.<sup>4</sup>

The 2010 National Drug Strategy Household Survey reports a higher prevalence of both licit and illicit drug use in the LGBTI than broader population, with 34.2% of homosexual and/or bisexual people reporting being current smokers compared with a prevalence of 17.5% for all Australians.<sup>5</sup> That study also reported a higher prevalence of illicit drug use in the homosexual and/or bisexual population (35.7%) than the national level (13.9%), as well as a higher prevalence of risky alcohol consumption by homosexual and bisexual people (26.5%) than by the heterosexual population (15.8%).<sup>5</sup>

Among the determinants that contribute to the inequality of LGBTI health, social factors merit emphasis: continual negative societal attitudes within the community, including from health service

providers and discrimination under the law.<sup>6</sup> The present study replicates research undertaken in South Australia<sup>1</sup> and sought to ask members of the LGBTI community to rank health issues of importance to themselves personally and to their community. In so doing, the present study reveals the areas of health concern for this minority group and provides direction for preventive health strategies in key areas where there is likely to be community support for such interventions.

## Methods

### Ethics approval

Ethics approval for this research was obtained through Curtin University (approval no. SPH-34-2011). Eligibility criteria specified an age of 18 years or older, residence in Western Australia and same-sex attraction identification and/or behaviour. No incentives were provided for participation.

### Questionnaire

Rogers<sup>1</sup> undertook a community-needs assessment of a South Australian LGBTI sample. (Note, the acronym LGBTI refers to lesbian, gay, bisexual, transgender and intersex individuals. There is much debate on terminology for this group, and other terms are also used, including gay, GLBT (gay, lesbian, bisexual, trans), sexual minority groups, and sexual and gender diverse. In the present study, LGBTI will be used as a general term to include people who are not exclusively heterosexual in identity, attraction and/or behaviour, both male and female.) The questionnaire and protocol used by Rogers<sup>1</sup> have been replicated in the present study in Perth, Western Australia, with the permission of the author. The self-completed paper and pencil questionnaire comprised a single A4 sheet back and front, taking approximately 5–10 min to complete. The questionnaire required participants to disclose information regarding gender and sexual identity, as well as sociodemographic characteristics (including age, cultural background, employment status and postcode of residence).

Participants were asked to nominate, in order of importance, three 'health issues' that were 'most important in the lives of lesbian, gay, bisexual, transgender and intersex (LGBTI) Western Australians' first in a personal context and then, second, in a general context. Provision was made for participants to nominate a health issue not included in the list of 23 already appointed issues. A preferential selection methodology was used for these questions, asking participants to rank (in order of importance) the top three health issues. The 23 health issues listed in the questionnaire were not explained further in either the survey or by recruiters. Therefore, preferential selection was based on each respondent's interpretation of the health issue.

Participants were also asked questions about the use, access to and experience of health services. An opportunity to report on any negative interactions with health services was provided, which was used as qualitative data.

Finally, participants were asked to appoint, in order of importance, three social factors (as taken from Rogers<sup>1</sup>) that they believed had the 'greatest effect on the health and well being of lesbian, gay, bisexual, transgender and intersex Western Australians'. This question also allowed participants to include other social factors they may deem important from experience, not listed in the already appointed 14 factors, among their three nominations. Preferential selection methodology was again used for this question.

### Recruitment

A non-probability convenience sample was recruited at the 2011 October Perth Pride Fairday Festival. This 1-day event is a large community fair and picnic that is held as part of the annual LGBTI Pride Festival and attracts approximately 4000 people who identify with, are attached to or support the LGBTI community.<sup>7</sup>

The research was conducted by the Western Australian Centre for Health Promotion Research and used Curtin University health promotion students to undertake recruitment. All recruiters were briefed on the research methodology and the protocol to use. Recruiters approached prospective participants at random. Before any questionnaires were completed, participants were provided with a written information sheet. Agreement by participants to complete the survey was considered as providing consent. All questionnaires were completed at the time of dispatch and returned to recruiters immediately after completion into a sealed holding satchel to guarantee anonymity. Participants could also complete the survey at a survey stall, which was used in the coordination of the survey.

### Analysis

Quantitative and qualitative data were entered into SPSS Statistics 19.<sup>8</sup> Transfer fidelity was verified through re-examination of a 10% random sample of surveys.

For the preferential selection questions, three points were allotted for a first preference, two points for a second and one point for a third. The points accordingly allotted by participants were then summed for each category to formulate a range of relative priority, supported by the total number of points awarded. Thematic analysis was used for qualitative data.

## Results

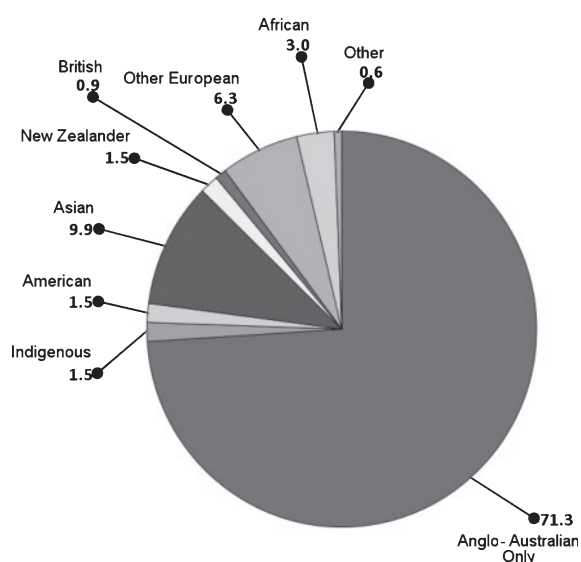
### Participants

The gender and sexual identities of the 335 participants are given in Table 1. Overall, 70% of participants identified as lesbian, gay or homosexual. The median age of participants who identified as male (26 years; range 18–76 years) was slightly lower than that of participants who identified as female (30 years; range 18–64 years). The four transgender participants had a median age of 38 years (range 18–76 years).

Sixty-three per cent of participants who identified as female, 46% of participants who identified as male and one of the four transgender participants reported being in a regular relationship at the time

**Table 1. Gender and sexual identities of participants**  
Data show the number of participants in each group, with percentages in parentheses

	Lesbian, gay, homosexual	Bisexual	Sexual orientation		Something else	Total
			Straight or heterosexual	Queer		
Gender						
Female	119 (67%)	22 (12%)	26 (15%)	7 (4%)	4 (2%)	178 (100%)
Male	114 (79%)	12 (8%)	8 (6%)	9 (6%)	4 (1%)	145 (100%)
Transgender	3 (75%)	0 (0%)	0 (0%)	1 (25%)	0 (0%)	4 (100%)
Something else	0 (0%)	0 (0%)	0 (0%)	8 (100%)	0 (0%)	8 (100%)
Total	236 (70%)	34 (10%)	34 (10%)	25 (8%)	6 (2%)	335 (100%)



**Fig. 1.** Cultural background reported by participants (%).

the questionnaire was completed. The median duration of the relationship did not differ significantly between the two largest gender categories (median 3 years (range <1 to 42 years) for males; median 3 years (range <1 to 26 years) for females). Ninety per cent of participants reported residing in the City of Perth, 3% in Inner Regional Perth, and 2% in Outer Regional Perth localities. Substantially more participants who identified as female reported having dependent children than participants who identified as male (17% vs 3%, respectively;  $P < 0.01$ , Fisher's exact test).

Seventy-one per cent of participants reported having an Anglo-Australian only cultural background, with the remaining participants reporting various cultural identifications, as shown in Fig. 1; 3.6% of participants did not answer this question.

### Health priorities

Figure 2 provides data on participants' rankings of listed health issues of importance to them both personally and generally as applied to the Western Australian LGBTI community as a whole. There is considerable congruence with issues listed as important at both a personal and community level. The leading health issues that

emerged both individually and for the community were depression, suicide, HIV/AIDS and anxiety, excessive worry or panic attacks. When the top three ranked mental health-related issues are grouped together with other mental health issues, including problems in relationships with a partner and problems in relationships with family, they account for 53% of all weighted responses. At a personal level, depression was listed as the highest ranked issue (489 points). As a community identified issue, this was still the highest ranked (385 points). This represents a total of 165 participants, or 49%, who listed depression personally as one of the top three health issues. Almost double the number (99) of participants who identified as female listed depression personally as one of their top three health issues, compared with 58 participants who identified as male.

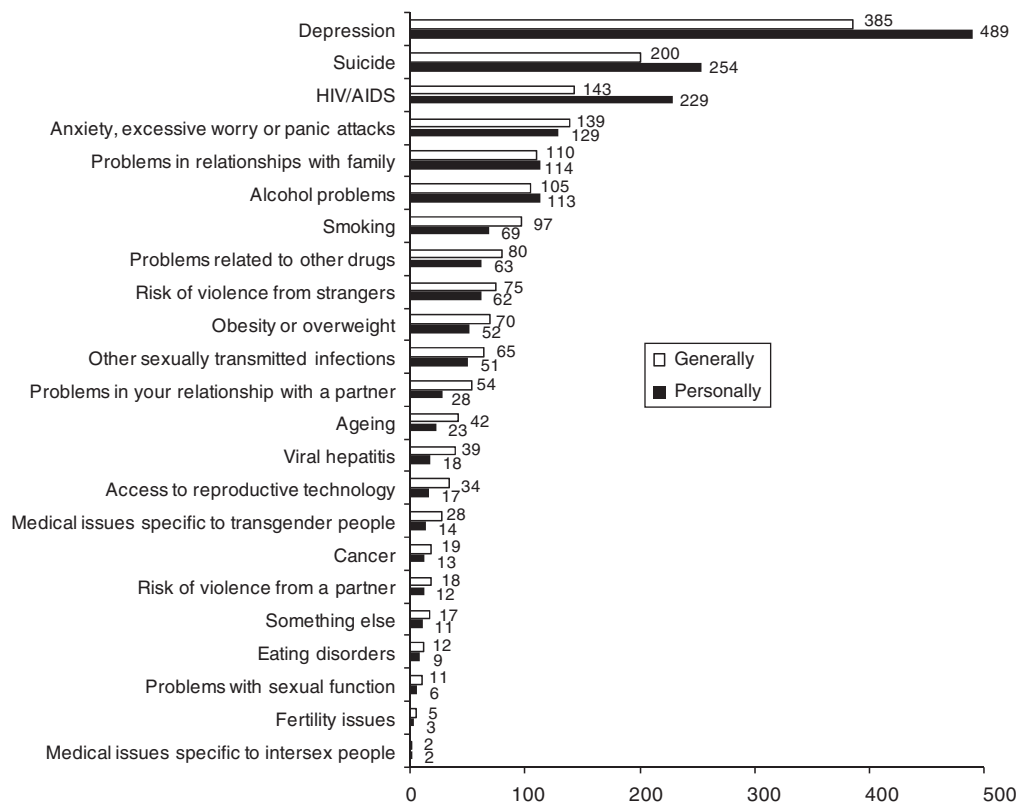
### Perceived health determinants

Figure 3 shows the ranked social factors, as nominated by participants, that affect health and well being of LGBTI Western Australians. Discrimination in daily life, discrimination under the law and hearing homophobic comments in person emerged as the leading categories reported in answer to this question. Overall, more participants who identified as female allocated a ranking to either of the leading social factors listed above, although none of these were statistically significant. Fifty-three per cent of participants who identified as female allocated a ranking to discrimination in daily life compared with 46% participants who identified as male; 40% of participants who identified as female allocated a ranking to discrimination under the law compared with 26% of participants who identified as male; and 23% of participants who identified as female allocated a ranking to hearing homophobic comments in person compared with 26% of participants who identified as male.

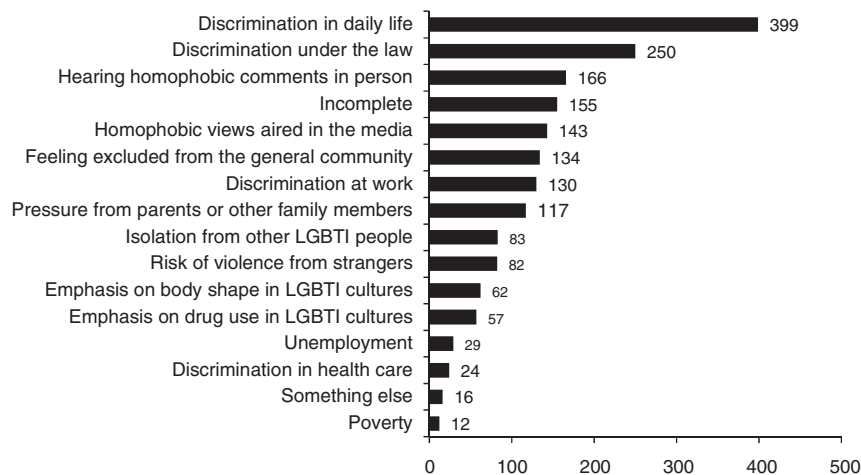
Nine participants listed additional social factors that they believed had an effect on the health and well being of LGBTI Western Australians. These included internal homophobia, homelessness, marriage equality, marriage discrimination, acceptance of children, schooling and everyday challenges faced by minority communities.

### Discussion

The present study provides insights into how members of the Western Australian LGBTI community perceive health priority



**Fig. 2.** Participant's ratings of importance of health issues personally and generally for lesbian, gay, bisexual, transsexual and intersex (LGBTI) Western Australians by points allocated. Note, incomplete responses where the question was not completed correctly were not included.



**Fig. 3.** Participant ratings of the social factors that have the greatest effect on the health and well being of lesbian, gay, bisexual, transsexual and intersex (LGBTI) Western Australians by points allocated. Note, incomplete responses refer to those participants who did not complete the question correctly. This means participants marked boxes without ranking them, partially ranked some boxes or did not complete the question in any way. All responses classified as incomplete were included in the analysis because all data provided were deemed significant.

issues both at a personal level and for the LGBTI community as a whole. Data were also collected on what were considered to be social factors that contributed to the poorer health of this community. One

strength of the present research is that in replicating an earlier study undertaken in South Australia,<sup>1</sup> a tested survey instrument and protocol were used.

There are several limitations to the present study, including the use of a convenience sample. The sample of LGBTI people recruited to the present study at some level identifies with the community and is likely to be somewhat comfortable with their minority sexual identity or, in contrast, be actively seeking out connection with this community in order to develop such an identity. Therefore, the study may not have recorded results from members who are not well connected to this community or who are struggling to reach acceptance or disclose their sexual orientation. Much has been written about the difficulties of sampling a sexual minority population.<sup>9–11</sup> There are numerous challenges linked with undertaking health research with LGBTI populations: (1) people's sexual behaviour, identity or attraction may reflect LGBTI status, however they may not identify as such; (2) LGBTI groups are stigmatised and may be reluctant to disclose information about their same-sex sexual behaviour or gender nonconformity; and (3) when sampling a statistically small minority group, it is usually labour intensive and costly to recruit a large enough sample for meaningful analysis.<sup>12,13</sup>

LGBTI populations are exposed to the same health issues the population at large experiences; however, there are additional unique and poorly understood health factors.<sup>12</sup> LGBTI people are at increased risk of suicide, depression, harassment and victimisation compared with their heterosexual counterparts.<sup>12,14</sup> They also exhibit a higher prevalence of substance abuse, overweight and obesity and tobacco use.<sup>3,15–17</sup>

Mental health issues are not innate to belonging to a sexual minority or gendered group; however, they may manifest as a consequence of social marginalisation or stress due to protecting or hiding LGBTI identity or enduring verbal, emotional or physical abuse from disapproving community and family members.<sup>18,19</sup> The data revealed a clear picture that depression followed by suicide are the top two health issues of importance both individually and to the LGBTI community in general. This finding is similar to that reported by Rogers,<sup>1</sup> with the South Australian sample reporting depression, HIV and suicide as the three top ranked health issues of importance. The results are also supported by literature reporting significant levels of LGBTI people experiencing mental health disorders, predominantly diagnoses of depression and anxiety.<sup>20</sup> An Australian-wide survey in 2006 reported that 20.2% of all LGBTI participants had been diagnosed with anxiety and 33% had been diagnosed with depression.<sup>4</sup> Results from the Sex In Australia study revealed same-sex attracted people experienced increased levels of psychosocial distress.<sup>21</sup> Similar results have been reported in the US, where 43% of LGBTI people had been diagnosed with a mental disorder and almost 30% had attempted suicide.<sup>22</sup>

Issues of homophobia and discrimination emerged as the key social factors contributing to poorer health within the group. Discrimination in daily life was listed as the highest ranked factor, followed by discrimination under the law. Rogers' research reported these as the top two factors, but in reverse order.<sup>1</sup> This may reflect progress in Australia towards addressing legal inequalities and

an increasing acceptance of same-sex attraction. The absence of same-sex marriage is one area of discrimination against LGBTI people that continues in Australian legislation.<sup>23</sup>

Although reporting on subjective ranking of listed issues, the data contribute to the notion that LGBTI identity and behaviour can be considered a social determinant of health, as proposed by others.<sup>24,25</sup>

Public health services provided to LGBTI people are negatively affected by practitioners' lack of knowledge and/or sensitivity about sexual or gender orientation, which can result in less than adequate care.<sup>3</sup> It is therefore important that all public health service providers have good knowledge and understanding of LGBTI health issues. LGBTI cultural competency training is one option to assist in achieving this to improve public health services for LGBTI people.

Creating a public health environment that is more accessible and services that are appropriate for LGBTI individuals is essential to the health and well being of this population. In order to attain this, LGBTI people should be included in public health research, interventions and policy development. This holds true particularly for mental health care. Working with LGBTI people to identify suitable approaches that could be taken to improve mental health services is imperative if depression and mental health issues are to be addressed appropriately.

LGBTI individuals seeking mental health services are regularly confronted with barriers and challenges in finding supportive service providers.<sup>17</sup> Noteworthy correlations connecting mental health disorders and medical mistrust indicate that LGBTI people may shun health services due to underlying negative expectations.<sup>17</sup> Future research on LGBTI people's access to and utilisation of mental health services, barriers to use and perceptions of availability of 'gay-friendly' services is required using larger, more diverse LGBTI samples.<sup>14,17</sup> In addition, further research is necessary to progress and assess LGBTI public health interventions developed to confront the health inequities between LGBTI populations and their heterosexual counterparts.<sup>12</sup>

The results from the present study and those of Rogers<sup>1</sup> clearly identify what the perceived priority health issues are within this community and for LGBTI individuals personally. However, these health issues are only 'perceived priority' issues. It would be valuable to have access to more comprehensive research data that report on the health status of LGBTI populations to determine which health issues, in reality, are of most concern.

## Conclusions

The data collected in the present study support results from previously conducted research. Although the present study is small in scale, the data provide an insight into the LGBTI community of Perth, Western Australia, and lead the way for similar studies to be conducted in communities across Australia and beyond. It is hoped that the data presented will help assist in identifying strategies to improve the health of LGBTI individuals. Continued efforts to develop

public policy on sexual and gender minority health, advocacy for LGBTI culturally sensitive health care and the eradication of health inequities LGBTI people endure must be reinforced by substantial research if health inequality is to be taken seriously.

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