GP Supervisor Guide

LGBTQIA+ Health and Inclusive Healthcare in General Practice

An Introduction to Teaching and Learning

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GENERAL PRACTICE SUPERVISION AUSTRALIA

About the **Authors**

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Asiel's writing has appeared in Cordite Poetry Review, Rabbit Poetry, Archer Magazine, Voiceworks Magazine, and Australian Multilingual Writing Project, among others. Their first poetry collection, *m//otherland*, is published through Revarena Ediciones.

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Photo by Mark Dickson

Morgan Carpenter is a bioethicist, executive director of Intersex Human Rights Australia, and creator of the intersex flag. He plays an active role in systemic advocacy on legislative, regulatory and clinical reform. A signatory of the Yogyakarta Principles plus 10 and a participant in the first UN expert meeting on ending human rights violations against intersex persons in 2015, he has acted as a consultant to the UN Office of the High Commissioner for Human Rights, World Health Organisation, Australian Capital Territory and Victorian governments, and an advisory group member for the Australian Human Rights Commission, Australian Bureau of Statistics, New South Wales Health, and the EU Intersex: New Interdisciplinary Approaches research network. He is a member of the Australasian Association of Bioethics and Health Law.

Mark Hughes is Professor of Social Work in the Faculty of Health, Southern Cross University, NSW. His research and practice interests centre on ageing and aged care services. Since 2002 he has published widely on LGBTIQ+ ageing, which has included a focus on sexuality, healthy ageing and service use. His research on LGBTIQ+ older people's experiences has examined health disparities, caregiving networks, loneliness, end-of-life care, and sexual identity expression in aged care. Mark is a former Dean of Arts and Social Sciences at SCU and a former editor of the journal, Australian Social Work.

About this Guide

This guide aims to support GP supervisors in their teaching and supervision of registrars who are providing medical services to lesbian, gay, bisexual, trans and non-binary, queer, intersex, asexual and other (LGBTQIA+) patients in general practice.

It is designed as a brief introduction to the key health and healthcare issues for the wide spectrum of patients under the LGBTQIA+ acronym. References are provided for readers wanting a deeper understanding of certain sub-groups. Links to resources for LGBTQIA+ patients, including peer support groups around Australia, are also included.

The guide is structured to first explain the LGBTQIA+ group, including definitions and terminology, and underpinning issues of discrimination and marginalisation that lead to major health disparities.

The social context of LGBTQIA+ lives is detailed, including family relationships, and coming out, is followed by an outline of strategies to create LGBTQIA+ inclusive primary care, then a summary of LGBQTIA+ health priorities.

The physical health section is divided into men's, women's, trans, and intersex issues; clearly, however, these issues overlap.

A whole section is devoted to mental health as this is one of the major points of difference needing more detailed GP support. Ageing and aged care also has unique issues.

The guide ends with an extensive resource list incorporating links for LGBTQIA+ patients, including peer support groups around Australia, and resources for health professionals on LGBTQIA+ health.

The length of this resource reflects the importance and often challenging nature of the topic.

Supervisors and their registrars are therefore encouraged to digest it over the term or even multiple terms as it seems appropriate (e.g. reviewing the healthy aging section prior to a nursing home visit or doing the mental health section around the time mental health skills training is being completed for Medicare item numbers).

Importantly, the authors acknowledge that GP supervisors and registrars reading this guide will be on a broad spectrum of knowledge development when it comes to this topic. This is a sensitive topic, and it is "ok to get it wrong", as long as you approach your own personal and professional development from a position of open-mindedness and respect.

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Contents

LGBTQIA+ **Key Terms and Definitions**

Diverse sexual orientation, gender identity and sex characteristics are all included in the LGBTQIA+ acronym. The terms and language that individuals use to describe these attributes are constantly evolving, and it can be difficult to remain current.

A Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables has been produced by the Australian Bureau of Statistics (ABS) in 2020 and provides a useful starting point of terms for clinicians to gain an understanding of the appropriate terminology[1].

Image from: The Gender Spectrum Collection

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FIGURE 1: CURRENT TERMINOLOGY AS PER THE ABS STANDARD 2020[1]

Sex characteristics refer to chromosomal, hormonal and reproductive characteristics, including secondary characteristics arising from puberty.

Innate variations of sex characteristics, also termed intersex variations or 'differences/disorders of sex development', refer to traits that are perceived to vary from medical or social norms for female or male bodies.

Sex is based on sex characteristics observed and recorded at birth or in infancy. Registered sex may change over a lifetime.

- female
- male
- another term, such as non-binary, dependent on jurisdiction

Gender is about social and cultural differences in identity, expression and experience.

- *gender identity* is about who a person feels themselves to be
  - woman
  - man
  - non-binary
  - other (*including gender queer, gender diverse, agender)
- *gender expression* is the way a person expresses their gender. A person's gender expression may also vary depending on the context, for instance expressing different genders at work and home
- *gender experience* describes a person's alignment with the sex recorded for them at birth
  - cis experience (same as the assigned gender at birth)
  - trans experience (different to the assigned gender at birth)

Sexual Orientation is an umbrella concept incorporating:

- *Sexual identity* (how a person thinks of their sexuality and the terms they identify with)
  - straight or heterosexual
  - gay, lesbian or homosexual
  - bisexual
  - pansexual*
  - queer*
  - asexual
  - other
- *attraction* (romantic or sexual interest in another person)
- *sexual behaviour*

*not in the ABS standard

The Victorian Government LGBTQIA+ Inclusive Language Guide[2] (figure 2) expands on the definitions provided in Figure 1:

FIGURE 2: EXTENDED DEFINITIONS

Queer	An umbrella term that can apply to diverse genders of sexualities. Can be used to indicate fluid or flexible genders or sexualities.
Lesbian or gay	Romantically and/or sexually attracted to people of the same sex and/or gender as themselves, some women use the term gay, but many prefer the term lesbian.
Non-binary gender	Their gender is not exclusively female or male.
Bisexual	Romantically and/or sexually attracted to people of their own gender and other genders.
Agender	They do not identify as any gender.
Asexual	Does not experience sexual attraction, but may experience romantic attraction to others.
Pansexual	Romantically and/or sexually attracted to people of all genders, binary or non-binary.

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Glossary

TABLE 1: LGBTQIA+ GLOSSARY[3]

Affirming Gender	The process a trans or gender diverse person undertakes to live as their true gender. This may include medical treatment (surgery, hormone therapy and other treatments), a change of name, using a different pronoun, and changing sex on identification documentation such as a birth certificate, passport or drivers licence. This process is also referred to as Gender Affirmation or Gender Transition.
Asexual	A person who does not experience sexual attraction to others.
Biphobia	The fear, hatred or intolerance of people who are bisexual, or perceived to be bisexual, that often leads to discriminatory behaviour or abuse.
Bisexual/Bi	A person who is sexually and/or emotionally attracted to people of more than one sex. Often this term is shortened to 'bi'. Related terms include pansexual, and hetero/homoflexible.
Cis/Cisgender	Cisgender describes a person whose gender conforms to the dominant social expectations of the sex they were assigned at birth.
Cisgenderism	Cisgenderism describes beliefs and practices that privilege cisgender people at the expense of people whose gender does not conform to the dominant social expectations of the sex they were assigned at birth. Cisgenderism devalues people whose experience of their embodied gender does not fit within a binary model of sex and gender.
Discrimination	Discrimination is when you treat, or propose to treat, a person unfavourably because of a personal attribute or characteristic. Under Commonwealth legislation it is illegal to discriminate against someone on the basis of their sexual orientation, gender identity or intersex status.
Gay	A person whose primary emotional and sexual attraction is toward people of the same sex. The term is most commonly applied to men, although some women use this term.
Gender Diverse	A broad term that encompasses a diversity of gender identities and gender expressions including: bigender, trans, transgender, genderqueer, gender fluid, gender questioning, gender diverse, agender and non-binary. Gender diverse refers to identities and expressions that reject the belief that gender is determined by the sex someone is assigned at birth.
Gender Dysphoria/Gender Identity Disorder	Gender Dysphoria or Gender Identity Disorder is a medical diagnosis given to trans and other gender diverse people who are experiencing discontent and distress resulting from 'gender identity issues'. The term is seen as pathologising by many because it implies that trans and gender diverse people are 'disordered'.

Gender Expression (Gender Conforming and Non-conforming)	The way someone chooses to publicly express their gender, through name, pronoun, clothing, haircut, mannerisms etc. Gender conforming refers to behaviour and modes of presentation that match the dominant social expectations of the sex someone was assigned at birth. Gender non-conforming involves behaviour and modes of presentation that do not match the dominant social expectations of the sex someone was assigned at birth.
Gender identity	Gender identity has a specific meaning under State and Commonwealth Equal Opportunity and anti-discrimination legislation. In broad terms, however, it refers to a person's deeply felt sense of being a man or a woman, both, neither, or in between. For example, an individual who has no gender identity or a gender identity that is neutral may refer to themselves as agender or gender free. Some people's gender identity may vary according to where they are and who they are with.
Genderqueer	A person whose gender identity is not limited to or by the binary categories of male or female. Genderqueer people may identify as masculine, feminine, bigendered or partially male or female. Some genderqueer people may be third-gendered or reject gender roles altogether (see Gender Diverse above).
Gender Reassignment Surgery (GRS)	A surgical procedure where an individual's body or sexed anatomy is aligned with their gender identity. Also known as sex reassignment surgery (SRS) or genital confirmation surgery (GCS).
Heteronormativity and Heterosexism	Heteronormativity is the belief that everyone is, or should be, heterosexual and that other sexualities are unhealthy, unnatural and a threat to society. Heterosexism describes a social system built on heteronormative beliefs, values and practices in which non-heteronormative sexualities are subject to systemic discrimination and abuse.
Homophobia	Fear, hatred or intolerance of people who are same-sex attracted or are perceived to be same sex attracted, including lesbians, gay men and bisexuals, that often leads to discriminatory behaviour or abuse.
Internalised Biphobia/ Homophobia/ Transphobia	The internalisation by LGBT people of heterosexist beliefs, values and practices that can lead to feelings of reduced self-worth, shame and sadness.
Intersectionality	Intersectionality understands that identity, a person's sense of 'who they are', is not singular but rather an effect of multiple, intersecting social categories. These categories are effects of complex socio-historical processes and reflect deeply entrenched relations of power and inequality. For example, many LGBTI people also identity as Aboriginal, religious, having a disability, and more. For any individual, these categories are not discrete but mutually constitutive. For some people, they are mutually reinforcing; for others, there may be tensions or contradictions between different categories that leads to a fractured or dissonant sense of identity.
Intersex and Intersex Status	Intersex status has a specific meaning under State and Commonwealth Equal Opportunity and anti-discrimination legislation. Intersex, however, refers to a person who is born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies.

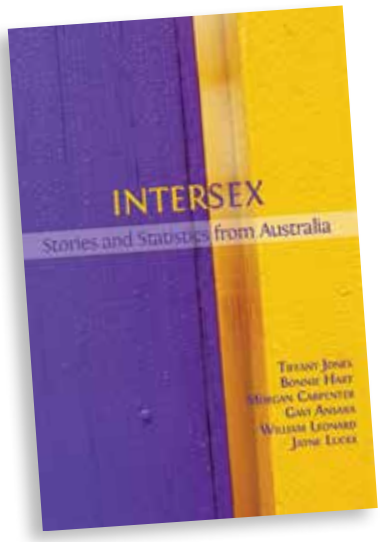
Lesbian	A woman whose primary emotional and sexual attraction is toward other women.
Misgendering	Describing or addressing someone using language that does not match that person's gender identity or expression. For people with intersex variations, this may include a presumption that they have a non-binary gender identity, or that they identify exclusively as a man, or a woman.
Non-Binary	People who are non-binary may express their gender in ways that do not match the dominant social expectations of the sex they were assigned at birth, and are not exclusively male or female.
Pansexual	Pansexual describes someone who is sexually and emotionally attracted to other people regardless of their sex, gender or gender identity.
Polyamory	Polyamory is the practice of, or desire for, intimate relationships involving more than two people with the knowledge and consent of everyone involved. Sometimes referred to as multiple ethical relationships.
Pronouns	Gender pronouns are words that people use to refer to others without using their names such as He/His, She/Her, They/Them. Using a person's correct pronouns fosters an inclusive environment and affirms a person's gender identity.
Queer	Queer is often used as an umbrella term that includes non-heteronormative gender identities and sexual orientations. The term has also been used as a critique of identity categories that some people experience as restrictive and limiting. For some older LGBTI people the term is tied to a history of abuse and may be offensive.
Same-Sex Attraction Attracted	Sexual and/or emotional attraction toward people of one's own sex. This includes lesbian, gay and bisexual people and people who may be questioning their sexuality, or do not want to label themselves. The term has also been used to describe young people whose sense of sexual identity is not fixed and experience sexual feelings toward people of their own sex. Others prefer the term same gender attracted.
Sex/Sex Characteristics	A person's physical characteristics relating to sex, including genitalia, chromosomes or hormones and also secondary sex characteristics that emerge at puberty.
Sexual Orientation	Describes a person's sexual or emotional attraction to another person based on that other person's sex and/or gender. The term is restricted in law to sex only and refers to attraction to persons of: the same sex (gay and lesbian); different sex (heterosexual); or persons of both the same and different sex (bisexual).
Trans/Transgender	A person whose gender identity or expression is different from that assigned at birth or those who sit outside the gender binary. The terms male-to-female or trans woman and female-to-male or trans man may be used to refer to individuals who are undergoing or have undergone a process of gender affirmation. Transgender and trans* are older terms and may now be seen as less inclusive than trans and gender diverse.
Transphobia	A fear, hatred or intolerance of people of who are transgender, or perceived to be transgender, that often leads to discriminatory behaviour or abuse.

"…language is meaningfully associated with the construction and maintenance of attitudes toward gender roles and categories[4]"

Adoption of this changing language in the LGBTQIA+ space is key to breaking down barriers and promoting inclusion[4]. Pronouns and titles are increasingly accepted as expanding from he/him and she/her to include they/them. Similarly, gender identity and expression is helping the narrative evolve from generalised assumptions to the individual and their needs and preferences[2].

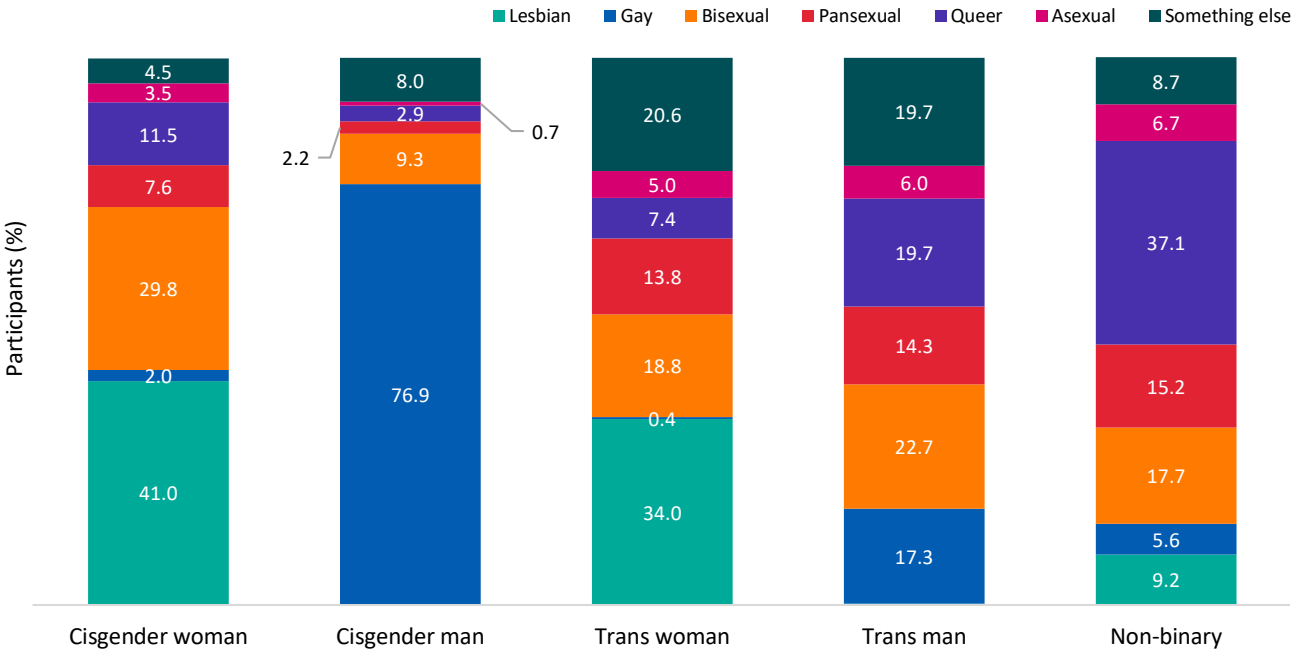
Common terms to describe a person's birth assigned gender are 'assigned male at birth' (AMAB), and 'assigned female at birth' (AFAB). These can be useful when needing to know about anatomical body parts of the patient or a sexual partner.

Any of these attributes can be fluid within an individual, in that they can change during their lifetime. Also, once you know about one attribute, it is important not to make any assumptions about any of the others. For example, a person may disclose to you that they are trans female, and they may have any sexual orientation, and a variety of possible sex characteristics.



Equally, a person who is bisexual may have any gender identity, sex characteristics and sexual behaviour. This is demonstrated in the intersecting identities seen in a large survey of LGBTI Australians in Figure 3[5]. This study did not receive an adequate number of responses from people with intersex variations and overall data therefore reflect an LGBTQA+ population.

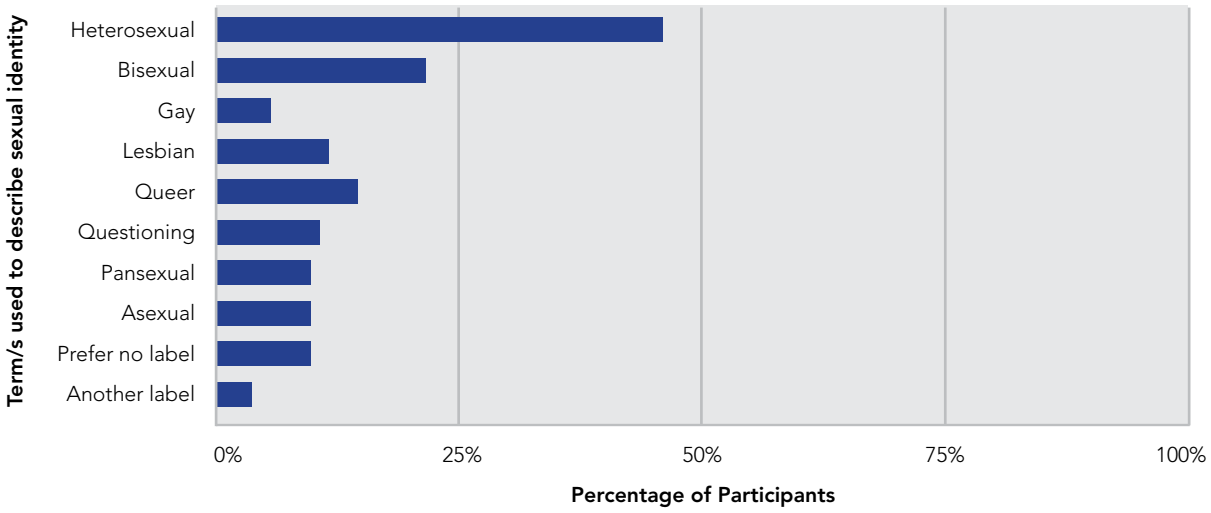
FIGURE 3: PRIVATE LIVES 3, 2019 INTERSECTION OF GENDER AND SEXUAL ORIENTATION (N = 6,765)



A survey sample of 272 Australian people born with atypical sex characteristics (intersex variations) showed that 8% or 23 respondents identified as transgender[6]. A higher proportion had changed their sex marker from that assigned at birth to another marker, however most of these people did not identify as being transgender. The majority of participants were women, while around a quarter were men, and another quarter had other or undisclosed genders.

The sexual orientation of the people in this intersex sample is seen in Figure 4, with 48% heterosexual, 22% bisexual, 18% lesbian or gay, 15% queer, 11% questioning, 10% pansexual and 10% asexual.

FIGURE 4: SEXUAL ORIENTATION TERM(S) USED BY PEOPLE WITH INTERSEX VARIATIONS (N = 176)



Rather than considering these LGBTQIA+ attributes as separate, it is more useful to think about them as intersecting within individuals. Intersections also occur with other important personal identities including those that are cultural, faith-based, or indigenous. Terminology can differ within these other identities. For example, an Aboriginal person who is a trans woman may identify as a sistergirl, and a trans man may identify as a brotherboy. A trans person from Samoa might use the term Fa'afafine.

LGBTQIA+ community connections also vary in that some people connect very strongly with sub-sections of these communities and others do not. Many people with intersex variations grow up to be cisgender and heterosexual, and do not necessarily feel any connection with LGBTQIA+ communities.

Why Teach **LGBTQIA+ Inclusive Healthcare**?

The LGBTQIA+ community, like many marginal groups, are vulnerable to significant health disparities when compared with the heterosexual community. While some patients will confidently self-identify with their GP, many will not offer this information willingly unless they feel safe and comfortable to do so.

A registrar's ability to deliver clinically relevant and appropriate care is informed by the patient history they are able to elicit.

A sound understanding of appropriate and inclusive language, prevalence and common health challenges provides confidence and competence in their ability to deliver appropriate care.

Simultaneously, LGBTQIA+ inclusive healthcare literacy puts vulnerable patients at ease and enables important patient history disclosure and the possibility of delivering better health outcomes for this patient cohort.

From a teaching and learning perspective using an LGBTQIA+ Inclusive lens will also support the development of core competency domains on which a registrar will be assessed in their fellowship exams across all five domains of general practice.

Prevalence

We now have excellent data on the prevalence of sexual identities.

TABLE 2: PREVALENCE OF SEXUAL IDENTITIES

Sexual Identity Proportions As Identified In Victorian Population Health Survey 2017[7]	
Heterosexual	88.1% (n=30,615)
Gay/Lesbian	1.8% (n=458)
Bisexual	2.8% (n=564)
Pansexual	0.1% (n=31)
Asexual	0.1% (n=32)
Queer	0.1% (n=21)
Other	0.1% (n=96)

Unfortunately, there are currently no population-based data on trans prevalence. Current estimates are that 1-2% of the population are binary trans, and up to 4% non-binary. People with intersex variations may comprise up to 1-2% of the population.

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TEACHING ACTIVITY 1: COLLECTING LGBTQIA+ DATA

TEACHING ACTIVITY

- Ask your registrar to review the ways in which your clinic collects LGBTQIA+ data in the medical record. They may need to look at the new patient intake form, the receptionists' process for recording patient demographics, and the medical software capacity for capturing LGBTQIA+ status.
- Then discuss together how this process may enhance or impede the documentation of LGBTQIA+ people at the clinic. Consider, as a new doctor to the practice, how would they ascertain this status for existing patients. Plan any possible improvements.

Health disparities for LGBTQIA+ people

There are two major reasons for making the effort to know about an individual patient's LGBTQIA+ status in clinical practice:

1. It provides a more holistic context about the life of that person, which is often desired by patients.
2. There are major health disparities for LGBTQIA+ people that require our attention and care.

Areas Of Heightened Risk	Link To Location In Guide
Depression, anxiety, suicidality	Mental health issues
Smoking, alcohol and drug use	LGBTQIA+ Health Priorities
	Women's Health
	Men's Health
	Trans Health
Poorer sexual health	LGBTQIA+ Health Priorities
	Women's Health
	Men's Health
	Trans Health
Increased instances of abuse	Women's Health
STIs	LGBTQIA+ Health Priorities
	Women's Health
	Men's Health
	Trans Health
Reduced screening practices	LGBTQIA+ Health Priorities
	Women's Health
	Men's Health
	Trans Health

These health disparities are related to a much higher likelihood of experiencing discrimination, marginalisation, abuse, and violence. This is thought to be a result of 'minority stress'[8] and 'structural stigma', defined as community norms and institutional policies that embed heteronormative and homophobic, biphobic, transphobic or anti-intersex prejudices in everyday practice[9].

Further, structural stigma is found to reduce primary care visits for sexual minorities in Australia despite their higher healthcare needs[10]. The negative attitudes towards diverse sex characteristics, gender identity and sexual orientation can be much worse in some rural and outer urban areas, and amongst more conservative cultural and faith groups. In recent years, despite attitudes improving towards lesbian and gay people, negativity is stubbornly persistent against gender diversity, bisexual, queer, and pansexual people.

The Private Lives 3 national survey showed major differences in self-rated general health among LGBTQA+ people, with 30.9% of the sample (n=6,792) rating their health as fair or poor, compared with 14.7% of the general population[5]. Just 31.2% rated their health as very good or excellent compared with 56.4% of the general population. These differences were even more marked amongst the groups that experience more negative social attitudes (Figure 5, Figure 6)

FIGURE 5: PRIVATE LIVES 3, 2019 "VERY GOOD/ EXCELLENT" GENERAL HEALTH BY GENDER (N = 6,739)

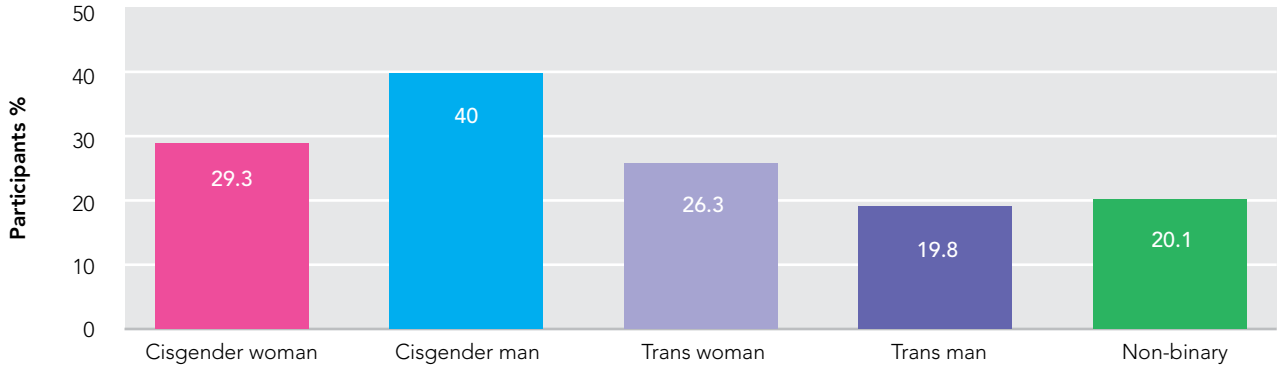
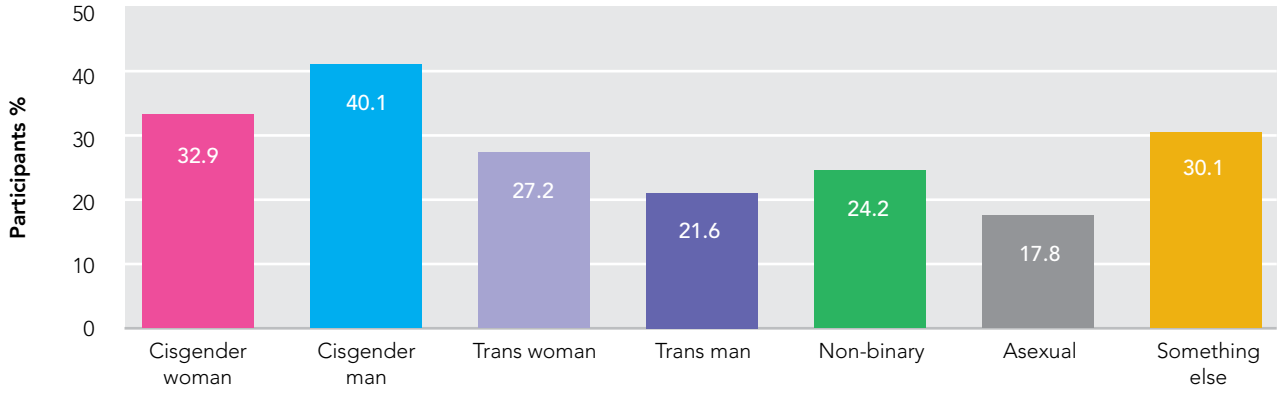


FIGURE 6: PRIVATE LIVES 3, 2019 "VERY GOOD/EXCELLENT" GENERAL HEALTH BY SEXUAL ORIENTATION (N = 6,772)



"Disclosing LGBTQIA+ status to a regular GP is found to improve disclosure of other stigmatised issues such as drug and alcohol use and improve screening rates[11]"

In view of these significant health disparities, access to affirming and inclusive primary health care is crucial. Disclosing LGBTQIA+ status to a regular GP is found to improve disclosure of other stigmatised issues such as drug and alcohol use and improve screening rates[11]. It should be noted that disclosure may be unavoidable for some populations – such as people with intersex variations – due to physical differences and experiences of, for example, gonadectomies necessitating lifelong aftercare, but forms of disclosure (for example, using diagnostic language) can be regarded as an attempt to mitigate risks of stigmatisation in medical settings.

There are emerging resilience factors for LGBTQIA+ people, which include community connectedness, both mainstream and LGBTQIA+ community; family support, both from families of origin and families of choice; and forming intimate relationships and parenting. GPs can support many of these factors through referral, advocacy, and family advocacy. In addition, there is a strong culture of activism, volunteering and advocacy within the LGBTQIA+ communities.

Social issues

GPs are adept at engaging with our patients about their social context and social influences on their health. This is a very good way to introduce our willingness to discuss and understand diversity in sexuality, sex characteristics and gender. We can support our LGBTQIA+ patients to question and identify where they sit within this umbrella, exploring their family life, and encouraging social engagement.

Questioning, identifying, and coming out

A GP or practice nurse may be the first person someone talks to about their emerging diverse sexual orientation or gender identity, and this could happen at any age.

Coming out to self is an important milestone in a LGBTQIA+ person's life, and may be hindered by negative social attitudes, and/or by internalised feelings of negativity, often termed internalised homophobia, biphobia, or transphobia. Some people delay this process for many years until they are in a more accepting or resilient place in their lives.

Having a health professional who affirms their identity can be very therapeutic. Equally, we may also talk with parents, siblings, children, or close friends of an LGBTQIA+ person to help them understand the identity and how to support the person. For example, some trans or non-binary people come out as trans once their own children leave home, and this can have major repercussions for their partner and children.

On the other hand, people with intersex variations may have a very different experience of discovering their intersex status, as many have a history of having this information concealed from them as children. A GP may be able to explain the physical implications of the intersex variation and provide reassurance about social implications or may even diagnose it in situations of previously unexplained infertility or childhood surgery.

For any LGBTQIA+ people exploring their identity, referral to identity-appropriate peer support is an important role for GPs. We have included a list of peer support groups in this Guide. Some people may also require referral for more formal counselling to work through their issues.

Families and relationships

Understanding how a person defines their family and the people in that family is important for GPs so that we are aware of who is supporting the person, and who is their legal next of kin. Families involving LGBTQIA+ people can be very diverse, ranging from biological kin relationships to chosen friends. Intimate relationships may be monogamous, or polyamorous.

SPECIFIC STRESSORS IDENTIFIED BY VICTORIAN STUDY OF THE TRANSITION TO PARENTHOOD FOR LGBTQIA+ PEOPLE[12]	
Navigating heteronormative attitudes and discrimination at several levels	• Societal – stereotypes about family structures. • Institutional – such as difficulty accessing surrogacy for trans people. • Community – rigid constructs of gender and sexuality. • Individual – gendered role assumptions including division of labour.
Challenges and stress related to family formation	• Decisions about the method of family formation. • Access to and cost of fertility services. • Finding sperm or egg donors. • Dealing with negative or unpredictable attitudes.
Social isolation	• Estrangement from family of origin members. • LGBTQIA+ community not embracing families. • Moving to outer suburbs or rural areas with fewer LGBTQIA+ connections.
Past experiences of abuse or other trauma	

Countering the identified stressors, there are increasingly visible stories of resilience and acceptance for LGBTQIA+ relationships. Good examples form part of the Respect Victoria campaign Pride, Respect, Equality, which is producing stories of strong and supportive family relationships[13].

Tips from the Drummond Street Services Transition to Parenthood project are in Teaching Activity 2[12].

TEACHING ACTIVITY 2: INCLUSIVE PRACTICE FOR LGBTQIA+ FAMILIES AND INTIMATE PARTNERS

TEACHING ACTIVITY

Reflect on commonly held ideas about parenting and families embedded through community attitudes and behaviour. Consider how these ideas impact on LGBTQIA+ parents and find ways to challenge these beliefs in yourself and your wider community. Some tips on inclusive practice for LGBTQIA+ families and intimate partners:

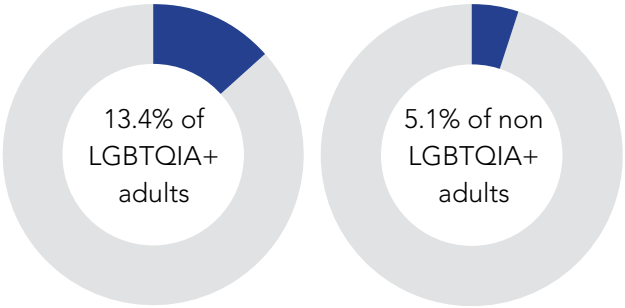
- Unlearn assumptions about families being formed with two parents – a mother and a father – and celebrate the diversity of all families across our society, including LGBTQIA+ parented families.
- Reject ideas around children needing 'female' and 'male' role models in their families.
- Challenge ideas that preference 'biological' relationships. Instead, celebrate the legitimacy of all parents in LGBTQIA+ parented families.
- Avoid assumptions about the role of donors – some play a parenting role, some are like another family member or friend, some are not involved at all in a child's life.

Intimate partner and family violence

The Victorian Population Health Survey 2017 data showed that 13.4% of LGBTQIA+ adults had experienced family violence in the past 2 years compared with 5.1% of non LGBTQIA+ adults[7]. All types of family violence listed were significantly higher, with emotional/ psychological abuse being most prevalent at 12.7% LGBTQIA+ compared with 4.3% of non-LGBTQIA+ respondents. Some groups experience even higher rates of intimate partner violence including bisexual women[14], and trans and gender diverse people compared to cisgender people[15]. There is limited research into the family violence experiences of people with intersex variations, but anecdotal evidence exists not only of abuse on grounds of physical sex characteristics, but also of assumptions that people with intersex variations have LGBT identities[16].

Many LGBTQIA+ people experience violence and abuse within their biological family or 'family of origin', and this is clearly also a form of family violence. GPs have a strong role in identifying and naming family violence experiences amongst our LGBTQIA+ patients and supporting them to find affirming and knowledgeable counselling support.

FAMILY VIOLENCE EXPERIENCE IN THE PAST 2 YEARS[7]



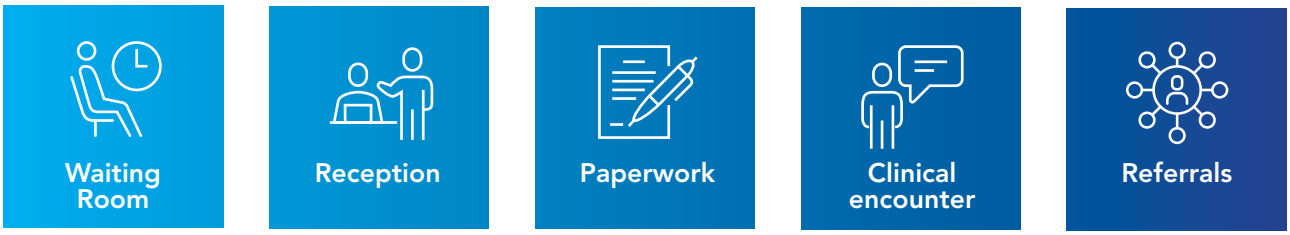
LGBTQIA+ data collection for medical records

The Victorian Family Violence Data Collection Framework[19] provides a comprehensive guide to the data that should be included in medical records. Currently, many medical software programs do not yet uphold these standards. Practices need to use work-around solutions to include LGBTQIA+ characteristics in their records.

What Is LGBTQIA+ **Inclusive Healthcare**?

LGBTQIA+ inclusive care requires a whole of practice approach, so that the person's journey through the clinic is safe.

FIGURE 7: LEVELS OF THE LGBTQIA+ INCLUSIVE JOURNEY THROUGH THE CLINIC



Waiting room and reception - Creating a LGBTQIA+ inclusive environment

Encouraging disclosure of LGBTQIA+ identities starts at the front door, as they need to feel they will be acknowledged and supported. This is particularly important for LGBTQIA+ patients who may have experienced negative attitudes from healthcare providers in the past.

There are readily available Australian tools to assist practices become more LGBTQIA+ inclusive. One example is the Rainbow Tick[3], an accreditation program and framework for planning and implementing organisational change to facilitate LGBTQIA+ inclusive services. Another is the Pride in Health online benchmarking[17]. Intersex community organisations offer the 'Yellow Tick' to improve understanding of the health needs of people with intersex variations[18].

Beyond putting up a poster practices might consider making toilet signs unisex than gendered male and or female specific toilets.

Download a copy of this resource
https://zbgc.org.au/resources/zbgc-resources/posters/

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PRACTICE TIPS FOR GPs:

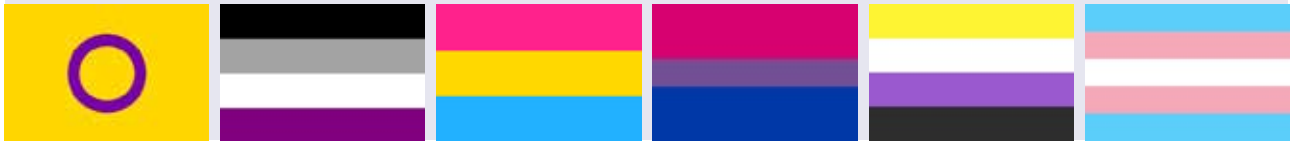
Helping reception staff understand how to greet LGBTQIA+ patients:

- Using appropriate language.
- Making no assumptions about sex, sex characteristics, gender, or sexual identities.

Ensuring that new patient intake forms include LGBTQIA+ information:

- Gender identity markers female, male, transgender, other- non-binary.
- Relationship status rather than marital status.
- Sexual identity markers lesbian, gay, bisexual, heterosexual.
- Including a space to specify any variations of sex characteristics.

Displaying materials and imagery in the waiting room that represents LGBTQIA+ people are important signs that the practice is safe and inclusive. One easily accessible set of imagery are the various 'flags' used to represent sub-sections of LGBTQIA+ communities. The rainbow flag generally represents the whole LGBTQIA+ community.



Intersex | Asexual | Pansexual | Bisexual | Non-binary | Trans

Pronouns and titles

- These should be clarified with all patients and documented. This might be on intake forms and/or in the consultation.
- Individuals may use she/her, he/his, they/them or another set of pronouns.
- Titles such as Mr, Ms and Mrs are generally not necessary on letters or referrals and software can be modified so that these are left blank. Where a title is required on documentation it is best to provide the option of Mx, which is used by some non-binary people.

ABS standard for gender identity, sex characteristics and sexual orientation[1]

This provides the appropriate terminology to include in an intake form and in the medical record itself. This is outlined in the introduction to this guide.

How should I use pronouns?

Pronouns are one way people refer to each other and themselves. Most but not all men (including trans men) use the pronoun 'he'. Likewise, most but not all women (including trans women) use the pronoun 'she'. Some people use a gender neutral pronoun such as 'they' (e.g., "Pip drives their car to work. They don't like walking because it takes them too long").

If you're unsure what someone's pronoun is, you can ask them respectfully, and preferably privately. Use a question like "Can I ask what pronoun you use?". Do not ask "What pronoun do you prefer?". A person's pronoun and identity are not a preference. Instead, just ask what pronoun they use.

Some people's pronouns may be context-specific. For example, someone might not use their pronoun in a particular environment or around particular people because they do not feel safe or comfortable to do so.

Source: Victorian LGBTIQ Inclusive Language Guide[2]

The clinical encounter and referrals

An important first step in the clinical encounter is to encourage disclosure of diverse sex characteristics, gender, and sexual identities. Even if clinic paperwork offers these options, individuals may choose not to disclose until they are talking with a clinician.

TABLE 3: *EXAMPLES OF GENDER-NEUTRAL WORDS FOR BODY PARTS

GENDERED REFERENCE	GENDER-NEUTRAL TERMINOLOGY
Breast or Chest	Upper body
Ovaries	Internal gonads
Female reproductive organs	Internal reproductive organs
Vagina	Internal genitals/ genitals
Vulva	External genital area

FACILITATION OF DISCLOSURE

- Using inclusive language for gender, sexual orientation, and sex characteristics.
- Asking about pronouns and name, that may differ from the Medicare listed name.
- Making no assumptions.
- Using the patient's terms for their own body and identities.
- Asking directly about relationships and family
  - Number of intimate partners.
  - Genders of intimate partners.
  - Living arrangements.
  - Family definitions – biological and/or chosen family.
  - Children - both biological and non-biological.

TEACHING ACTIVITY 3: UNDERSTANDING LGBTQIA+ COMMUNITIES AND ORGANISATIONS

TEACHING ACTIVITY

Ask your registrar to identify local LGBTQIA+ peer support groups and peak organisations and add them to your clinical software address book. Discuss whether they could inform the rest of the clinical staff about these services.

Picking up cues related to possible experiences of LGBTQIA+ based discrimination, abuse, or violence[20] is also an important part of some consultations.

- Asking about general experiences of homophobia, biphobia, or transphobia and how these may be affecting health and wellbeing.
- Intersex people may experience body shaming, ableism and also homophobia and transphobia, with impacts on health and wellbeing.
- Asking about other potentially marginalising issues such as:
  - Disability.
  - Culture and/or faith.
  - Indigenous identity.
- Clarifying preferred community connections and whether these are LGBTQIA+ or not.
- Understanding help seeking already used and preferred.
- Referring to LGBTQIA+ inclusive providers.

LGBTQIA+ **Health Priorities**

Click on these buttons to lead you to specific information for each topic.

WOMEN'S HEALTH | MEN'S HEALTH | TRANS HEALTH

There are a number of health issues that are particular to LGBTQIA+ people including contraception, fertility, and pregnancy; sexual health and STI prevention and management; smoking, alcohol, and drug use patterns; and cancer screening.

Contraception, fertility, and pregnancy

WOMEN'S HEALTH | MEN'S HEALTH | TRANS HEALTH

Children can become part of LGBTQIA+ families using multiple strategies, including assisted reproductive technologies, surrogacy, adoption, fostering, co-parenting, being a known sperm or egg donor and sexual intercourse.

Australian data show that between 2-20% of LGBTQA+ people currently have children (see Figure 8). In the Private Lives 3 study[5], 28% of surveyed participants wanted to have children in the future, and 25% were not sure. Trans and non-binary people may have had children within a heterosexual relationship before affirming their gender, and were increasingly seeking to have children after gender affirmation. This might be trans men using their own eggs and uterus, or trans women using their own sperm (often stored before gender affirmation treatments).

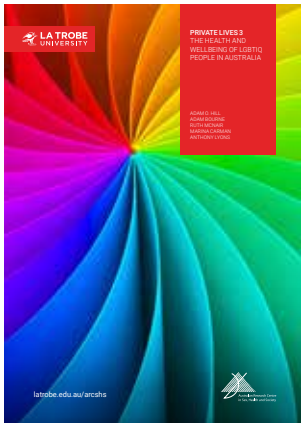
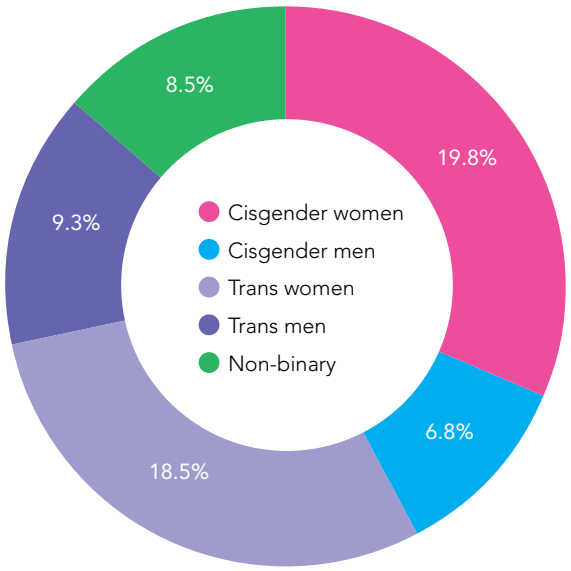


Image source: La Trobe University [5]
https://bit.ly/2Zy8ilf

FIGURE 8: PRIVATE LIVES 3, 2019, PERCENTAGE OF PEOPLE WITH CHILDREN ACCORDING TO GENDER IDENTITY[5]



Sexual health

WOMEN'S HEALTH | MEN'S HEALTH | TRANS HEALTH

Registrars should be comfortable asking questions related to sexual behaviour in a safe and appropriate manner. The Australasian Sexual Health Alliance (ASHA) has collated a wide range of resources to help with this[21].

It is important to have a non-judgemental, open approach when discussing sexual health.

For patients who are trans and gender diverse, and when asking about the gender of partners, using the terms "assigned male at birth" or "assigned female at birth" can be a useful way of asking about sexual practices and knowing the relevant anatomy while respecting the gender identity of all concerned.

STIs

WOMEN'S HEALTH | MEN'S HEALTH | TRANS HEALTH

STI prevention and management is covered in the relevant sections (links above).

Smoking, alcohol, and drug use

WOMEN'S HEALTH | MEN'S HEALTH | TRANS HEALTH

LGBTQIA+ people are much more likely than the general population to smoke, drink potentially risky levels of alcohol and use illicit drugs. The National Household Drug surveys held every 3 years have included sexual identity questions since 2010 and clearly indicate higher levels of use for LGB people[22]. Unfortunately, it still does not include gender identity or intersex questions. Across time, daily smoking and alcohol intake has slowly reduced, however the use of any illicit drug has remained static.

The usage patterns vary considerably between different identity groups. The Private Lives 3 survey[5] is the best current measure comparing these data. Bisexual, pansexual, and queer people were generally more likely to smoke or use illicit drugs. Cis men and gay men were more likely to be daily smokers, drink heavily, or use cocaine or meth. Non-binary people were more likely then trans people to use any illicit drug. There are no reliable data yet on AOD use or smoking for people with intersex variations.

Reducing smoking, alcohol and drug use involves addressing an individual's mental health, underlying issues, and setting up adequate supports. It is important to know services that are LGBTQIA+ friendly where individuals can get support if they are struggling with alcohol and other drugs. Facilitating connection to the LGBTQIA+ community outside of contexts involving alcohol and drug use can be a powerful protective factor for gay and bisexual men. Likewise, affirming an individual's identity and recognising the impact of stigma, marginalisation and homophobia can facilitate care and recovery.

TABLE 4: DATA FROM THE NATIONAL HOUSEHOLD DRUG SURVEY

In 2019, LGB Compared to heterosexual people were:

1.5 times more likely to:	9 times more likely to:	3.9 times more likely to:	2.6 times more likely to:
			
Smoke daily or to drink at harmful levels	Use inhalants	Use methamphetamines	Use Ecstasy

There are multi-factorial reasons for the levels of usage suggested in Table 4, including a strong normalisation of use in the LGBT communities, and using as self-medication for experiences of discrimination, violence, or marginalisation. For example, LBQ women are found to start drinking at a much younger age than heterosexual women, and this may be related to seeking out LBQ social venues where drinking is common. Higher prevalence of depression, anxiety and PTSD are also inter-connected with drug and alcohol use and smoking.

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CONSULTATION TIPS FOR GPs:

Assisting with disclosure of AOD use or smoking

- GPs are pivotal in assisting with disclosure of AOD use or smoking.
- We know that many patients do not disclose these issues unless directly asked, and this can be even more difficult if patients have not disclosed their sexual orientation or gender identity.
- GPs are also usually the first port of call for initiating management, so need to be aware of LGBTQIA+ inclusive AOD services and counsellors for referrals.

Cancer screening

WOMEN'S HEALTH | MEN'S HEALTH | TRANS HEALTH

Early detection of cancer is covered in the relevant sections (links above).

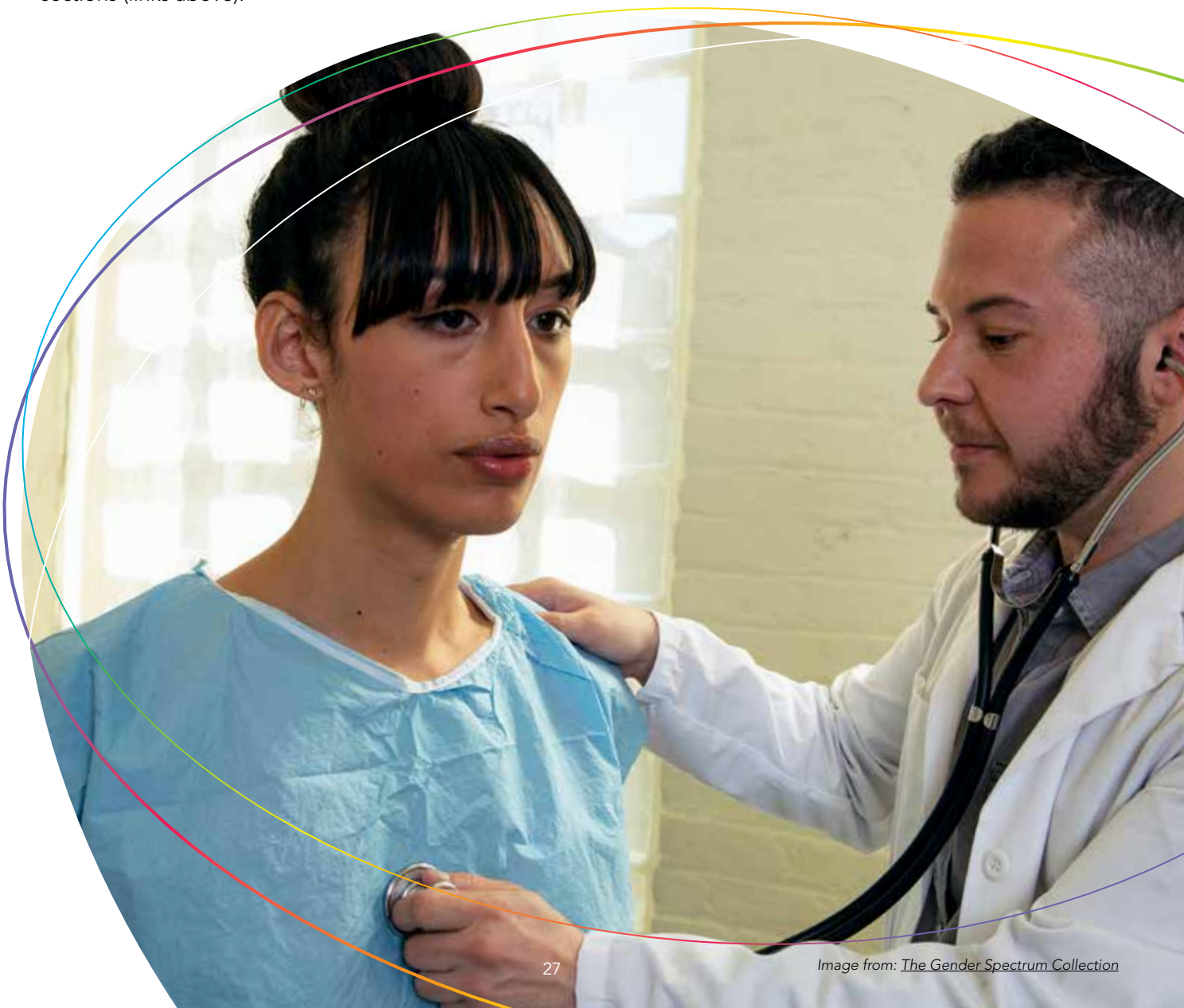


Image from: The Gender Spectrum Collection

Lesbian and Bi Women's Health

Expanding on the previous chapter, this section will focus on the health issues particular to lesbian, bisexual, queer (LBQ) and same-sex attracted women.

Contraception, fertility, and pregnancy

LBQ and same-sex attracted women may need contraceptive advice if they are having sex with men or trans people who were assigned male at birth. This is important to clarify during a careful sexual history. Sexual behaviour can vary and cannot necessarily be assumed based on a person's sexual identity. Many LBQ women are interested in having children and may come to their GP seeking advice (Box 2) about the various options for family formation.

Some women have concerns about the wellbeing of prospective or current children, and discussion of the social issues can be very helpful. There is excellent evidence now that the wellbeing of children raised by LBQ women and couples is equivalent to that of children in heterosexual-parented families[24]. The main specific issues that LGBTQIA+ families deal with are the potential for peer bullying regarding parental LGBTQIA+ status, and children to feel stigma related to negative social attitudes in the local community or families of origin. Referral to LGBTQIA+ inclusive counsellors may be needed for support about these issues.

HEIGHTENED RISK FACTORS FOR WOMEN IDENTIFYING AS LBQ[23]

- Smoking.
- Alcohol intake.
- Lack of child-bearing.
- Depression.
- Physical abuse.
- Intimate partner violence.

BOX 2: THE ROLES THE GP CAN PLAY IN LBQ CONTRACEPTION. FERTILITY, AND PREGNANCY

CONSULTATION TIPS FOR GPs:

The roles the GP can play in LBQ contraception, fertility, and pregnancy

- Discussing options such as home insemination, clinic-based insemination, IVF, fostering, adoption, surrogacy within a same sex couple.
- Safety planning if a known sperm donor is involved including STI, genetic and sperm testing for the donor.
- Usual pre-conception care.
- Referral to LGBTQIA+ inclusive fertility services if IUI or IVF and/or clinic-recruited sperm donor are needed.
- Pregnancy care and referral to LGBTQIA+ inclusive obstetric services.
- Caring for the children and family over the long term.
- Discussing options such as home insemination, clinic-based insemination, IVF, fostering, adoption, surrogacy within a same sex couple.

IMAGE 1: #SMOKEFREESTILLFIERCE CAMPAIGN

Image source courtesy ACON

Smoking, alcohol, and drug use

For LBQ women, current priorities are to create health promotion initiatives that are specifically tailored to their needs, as general population messaging does not resonate with many of them. There are good recent examples of health promotion such as the SmokeFreeStillFierce campaign run by ACON in NSW[25] and the ReThink the Drink for rural LBQ women in Victoria.[26]

While this section focuses on the health of cisgender LBQ women, the health of transgender women is explored in the relevant section.

IMAGE 2: RETHINK THE DRINK FOR RURAL LBQ WOMEN IN VICTORIA

Image source: The first iteration of Thorne Harbour Health's ReThink the Drink project rethinkthedrink.org.au

Sexual health

Women who have sex with women (WSW) use a variety of sexual behaviours including genital rubbing, vaginal fingering or fisting, cunnilingus, and vaginal sex toys. Less common activities include anal rimming and anal sex toys, and sadomasochism. Some WSW are also sex workers.

STIs

Rates of sexually transmissible infections (STIs) between WSW are similar to heterosexual women. In the second Australian Study of Health and Relationships (2014), STIs rates were considered according to sexual identity, and were the highest for bisexual women (see Table 5)[27].

TABLE 5: PROPORTION OF STI DIAGNOSES AMONGST WOMEN ACCORDING TO SEXUAL IDENTITY IN THE SECOND AUSTRALIAN STUDY OF HEALTH AND RELATIONSHIPS (2014)

%	HETEROSEXUAL	HOMOSEXUAL	BISEXUAL
Had an STI past year	2.8	2.7	7.3*
Had an STI ever	20.4	18.4	27.7*
Tested for an STI past year	16.4	20.8	51.5*
Tested for HIV ever	36.6	49.8*	49.6*

**Significance p <.001*

Advocating for safe sex

Advice about safer sex is important, which includes changing fingers or sex toys between sites; and having short fingernails, removing jewellery, and using plenty of lubrication to avoid mucosal damage. Avoiding oral sex during herpes episodes or menstruation is also advised. The use of latex barriers such as condoms on sex toys (or penises!), gloves, or dams during oral sex is also possible, although these methods have limited utility and are not popular.

WSW also need regular cervical screening and subgroups are known to be under-screened including older lesbians and gender diverse or trans masculine people. LGBTQIA+ people are now a specific target group and listed as 'high risk' in the National Cervical Screening Program[28] and specific health promotion campaigns have been developed such as the 'Public Cervix Announcement' campaign[29].

It can be very helpful to offer these groups self-collection, particularly people who find vaginal examinations very uncomfortable.

Image Source: Cancer Council Victoria and Thorne Harbour Health's 2018 campaign 'Public Cervix Announcement'

"Sex positive messages from GPs are helpful, including asking non-judgementally about preferred behaviours and checking in regarding sexual pleasure and a lack of coercion."

CONSULTATION TIPS FOR GPs:

To enable cervical screening and other vaginal examinations for LGBT people[30]

- Acknowledge barriers including discomfort, gender dysphoria, past trauma.
- Invite them to bring a support person.
- Use person-centred language such as gender-neutral words for body parts with gender diverse and trans masculine people.
- Enable greater control by explaining a stop signal, having the patient insert the speculum, offering a mirror.
- Offer vaginal oestrogen therapy for 2 weeks prior to the examination for post-menopausal women and people on testosterone.

What to test

The types of STIs amongst WSW depend on transmission method. Common types transmitted from skin to skin or oral sex contact include human papilloma virus (HPV) and herpes simplex virus (HSV). Transmission of bacterial vaginosis (BV) and candida also occurs via vaginal or anal penetration with fingers or sex toys, and less commonly chlamydia. Rarely, blood play - a form of kink sexual activity that involves cutting the skin and then sucking or licking off the blood[31] - may cause transmission of blood borne viruses including HIV or Hepatitis B/C.

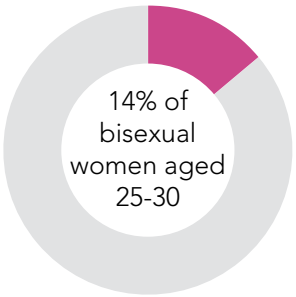
Early detection of cancer

Cancer screening rates among LBQ women tend to be lower than heterosexual women. This is partly due to a lack of awareness of risk, inadequate targeted health promotion initiatives, and women not accessing regular primary health care[32].

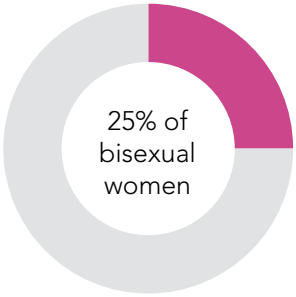
"We know that having a regular GP and being able to disclose sexual orientation safely in primary care improves the screening rates and early detection of cancers. This creates an excellent incentive for GPs to encourage disclosure… "

Sexual abuse

A higher proportion of LBQ women than heterosexual women have experienced sexual violence either as children or adults[33], so sensitive exploration of this history may be important. For example, in the Australian longitudinal women's health study, 14% of women aged 25-30 who were bisexual reported a lifetime history of sexual abuse, compared with 3% of lesbian and 2% of heterosexual women. Intimate partner violence was also more common for LBQ women, experienced by 25% of bisexual and 15% of lesbian women, compared with 10% heterosexual women. These experiences were correlated with much higher stress, anxiety, and depression.



Experience of lifetime history of sexual abuse



Experience of intimate partner violence

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Gay and Bi Men's Health

Parenting, being a sperm donor, surrogacy

Same-sex families are becoming increasingly common, with a broad range of parenting arrangements within each family. There are several ways that male same-sex couples can form a family, including:

- Adoption.
- Assisted reproductive therapy through surrogacy.
- Donor insemination through surrogacy.

For male same-sex couples looking at sperm donation, a full STI screen should be considered, in addition to avoiding sexual health risks during the period of insemination.

It is important to become familiar with legislation surrounding same-sex families in your home state, as this can vary from state to state:

- All states allow for same-sex couples to adopt.
- Most states allow single LGBTQIA+ people to adopt, except the Northern Territory.
- Assisted reproductive therapy for surrogates of male same-sex couples is available in most states, except Western Australia and Northern Territory.
- Regarding surrogacy, most states require that the egg donor is not the gestational surrogate woman, to reduce the small risk of the surrogate woman changing her mind and not relinquishing the child after birth.
- Legislation varies as to gamete donors and requirements for counselling, identity release and registration.

Legislation can affect referral options and pathways for same-sex couples to start a family. As a result, clinicians must be familiar with their local services available to best support same-sex couples in starting a family. Finding an egg donor can be very challenging and often relies on finding a personal contact. There is a World Egg Bank that includes Australian egg donors and complies with Australian legislation[34].

Smoking, alcohol, and drug use

Cisgender gay and bisexual men are at increased risk of smoking and potentially problematic alcohol and drug use. The reasons behind this are multifaceted, ranging from minority stress – chronic levels of stress faced by members of stigmatised communities – to greater acceptance of alcohol and other drugs in the community, as well as their use to enhance sexual experiences.

While it is important not to overly-pathologise gay and bisexual men, keeping an open-minded, non-judgemental approach can help identify at-risk behaviours. Particular care should be taken with individuals who face other vulnerabilities for alcohol and substance abuse disorders, such as patients with previous mental health disorders, intravenous drug use and patients from marginalised communities.

Sexual Health

Sexual health is an important component of men's health. According to the latest Annual Surveillance Report from the Kirby Institute in Australia, men who have sex with men (MSM) are overrepresented in transmission of both HIV and sexually transmitted infections[35]. Focusing only on sexual identity can miss a proportion of men who have sex with men (MSM) who are at risk of sexual transmitted infections, HIV, and other blood-borne viruses, since not all MSM identify as part of the LGBTQIA+ community.

CONSULTATION TIPS FOR GPs:

What to ask in a routine sexual health consult.

- The gender of the patient's sexual partners, without making assumptions.
- The number of partners over the last 3 months and over the last 12 months.
- Sexual practices, including any instances of unprotected anal sex.
- Use of Pre-Exposure Prophylaxis (PrEP).
- Partners from overseas and their country of origin.
- Use of recreational drugs during sex, in particular intravenous drug use (IVDU).
- Record any previous vaccination record if available.

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STIs

WHO TO TEST

Asymptomatic men who have sex with men and transgender women should routinely screen for STIs. The most up to date guidelines for what to test in the standard asymptomatic check-up are available on the AHSA website[36]. Other tests should be considered depending on individual risks, such as those outlined in (Table 6).

TABLE 6: HEPATITIS TESTING RECOMMENDATIONS

Pathogen	Test	Recommendation
Hepatitis A	Antibody	Test if no record of vaccination. Offer vaccination if antibody negative.
Hepatitis B	Surface antigen, core antibody, surface antibody	Test if no record of vaccination. Offer vaccination if antibody negative. Consider full vaccination course if no history or documentation of previous full course.
Hepatitis C	Antibody	Consider yearly testing in people living with HIV, on PrEP or other relevant risk factors such as IVDU.

How often to offer STI screening

A thorough sexual health history can guide how often testing should occur. Men who have sex with men and transgender and gender diverse people with relevant risk factors should be offered a routine 3-monthly screen if they have been sexually active in the last 3 months.

For individuals in a monogamous relationship or those who have not been sexually active in the last 3 months, screening can occur less frequently. Overall, all individuals at risk should be offered routine screening at least annually[21].

HIV Pre-Exposure Prophylaxis (PrEP)

PrEP should be actively offered to men who have sex with men, trans and gender diverse people, and people who inject drugs who are at risk of HIV transmission. Similarly, PrEP can be commenced at patient request or if there is potential risk of HIV exposure in the future. As of 2021, PrEP is on the general PBS schedule and can be prescribed by any general practitioner.

PrEP is a single combined tablet of tenofovir 300mg and emtricitabine 200mg. Most people take a PrEP tablet daily to prevent HIV infection. Some people elect to take PrEP "on demand", particularly if their sexual practices are infrequent. This involves taking 2 tablets 2-24 hours before a potential HIV exposure, then one tablet 24 hours after the first dose, and another 48 hours after the first dose.

FIGURE 9: EXAMPLE OF ON-DEMAND PREP WHEN THERE ARE MORE THAN 7 DAYS BETWEEN THE NEXT EXPOSURE AND THE LAST TABLET*

Start 2-24 hours before

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1	2	3	4	5 💊💊 19:00 - 24 hours before	6 💊⭐ 19:00
7 💊 19:00	8	9	10	11	12	13
14	15	16	17	18 💊💊⭐ 20:00 - 2 hours before	19 💊 20:00	20 💊 20:00
21	22	23	24	25	26	27
28	29 💊💊⭐ 11:00 - 10 hours before	30 💊 11:00	31 💊 11:00			

💊 = PrEP ⭐ = HIV risk exposure

*Detailed guidelines for commencing PrEP can be found at https://prepguidelines.com.au/ [37]

HIV Post-exposure Prophylaxis (PEP)

PEP is initiated as soon as possible within 72 hours of an HIV exposure and taken for 28 days to prevent infection. It is given as either a 2-drug regime or a 3-drug regime in higher risk exposures, and is available from GPs who have s100 prescribing rights or from sexual health clinics, and can be obtained after hours at Emergency Departments.

A follow-up testing schedule is recommended in the Australian National Guidelines of Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV[38]. Detailed guidelines can be found at https://www.ashm.org.au/HIV/hiv-management/PEP/ [39].

TABLE 7: LABORATORY EVALUATION OF INDIVIDUALS PRESCRIBED PEP

Timeframe	Tests
Baseline	Blood borne virus serology, STI screen, LFT and EUC, pregnancy test as needed.
Week 2	STI screen – urine, throat, anal.
Week 4-6	HIV serology, syphilis serology, LFT EUC, pregnancy test.
Month 3	All BBV serology and STI screen.

TEACHING ACTIVITY 4: CLINICAL DECISION-MAKING AROUND ENCOURAGING PREP

TEACHING ACTIVITY

Clinical decision-making: encouraging PrEP for men who have sex with men and for other patients engaging in potentially HIV exposing activities.

Some key questions for your registrar to consider:

- Do they have any ethical or moral concerns regarding PrEP?
- Are there any absolute contraindications to PrEP?
- When would they recommend PrEP on demand?
- How often would they want to review someone on PrEP?
- What would they do at the regular review?
- What other preventive care could they offer?

Early detection of cancer

Cisgender men who have sex with men should be routinely educated about cancer and encouraged to undergo screening where appropriate, following the guidelines for the general population in the RACGP Red Book[40] with respect to:

- Prostate cancer.
- Colorectal cancer.
- Skin cancer.
- Testicular cancer.

Ano-rectal cancer

Men who have sex with men (MSM) and transgender people may be at risk of ano-rectal Human Papilloma Virus (HPV) infection through anal sex. This is the same type of virus that causes cervical cancer.

While routine screening for ano-rectal HPV is not recommended, there are special considerations in people living with HIV. Detailed guidelines can be found at: https://www.ashm.org.au/HIV/hiv-management/anal-cancer/[41].

Routine screening requires digital ano-rectal examination (Table 8). Findings suspicious for cancer should be promptly referred to a colorectal surgeon.

TABLE 8: SIGNS TO WATCH FOR IN DIGITAL ANO-RECTAL EXAMINATION

SIGNS TO WATCH FOR IN DIGITAL ANO-RECTAL EXAMINATION	
• Firm lump >5 mm.	• Friable mass.
• Indurated ulcer.	• Painful mass.
• Plaque.	• Associated inguinal lymphadenopathy.
• Bleeding.	

"MSM living with HIV aged 50 and above should have a digital ano-rectal examination annually as part of their routine HIV care."

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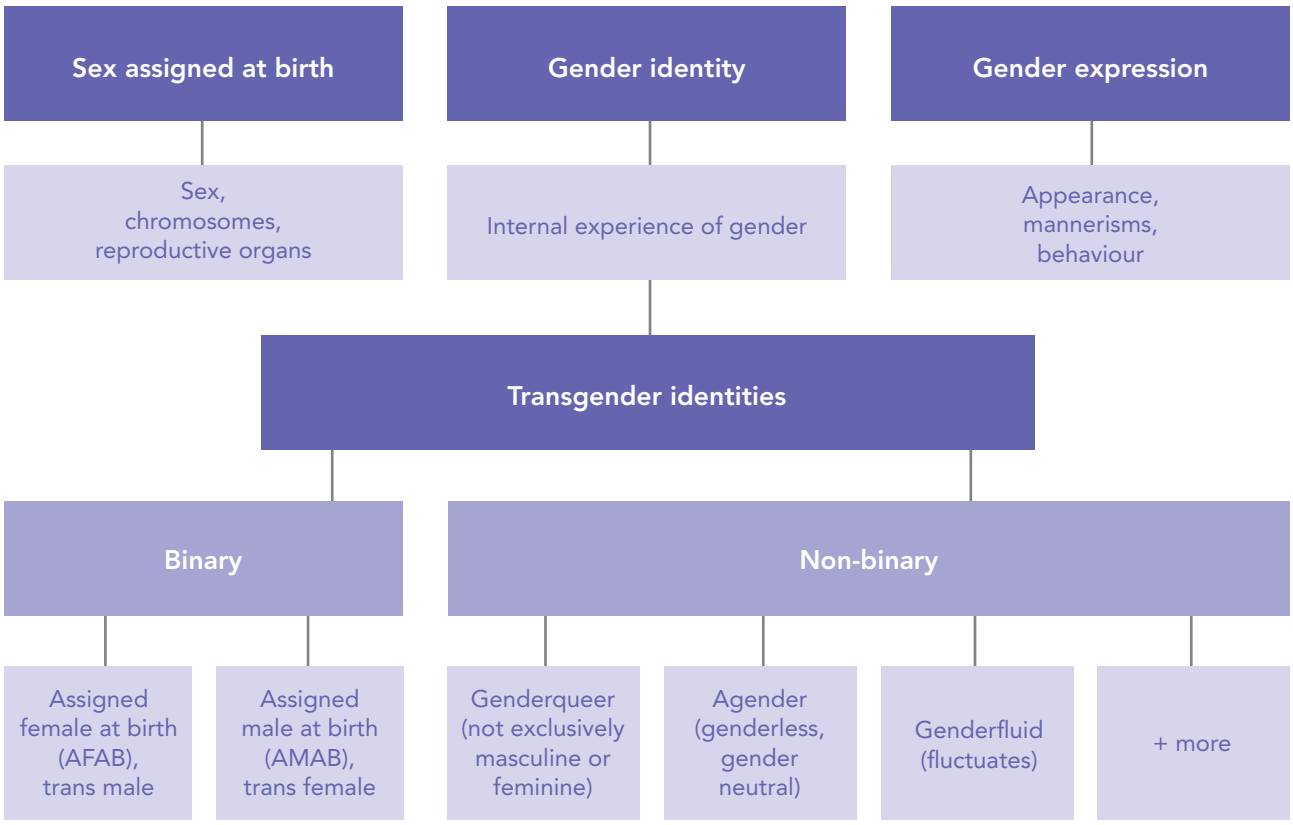
Trans, Non Binary and Gender Diverse People

Gender identity and expression

The terminology used for diverse gender identities and expression can be very confusing, as it is constantly changing. A useful way to categorise gender diversity is seen in Figure 10, dividing people roughly by whether they identify as binary or non-binary trans. Beyond this, it is important to clarify gender identity, expression, and preferred terms with each individual patient.

FIGURE 10: GENDER IDENTITY TERMS[42]



Designed by TGD community member and graphic artist Jake Kidson-Purry.

CASE EXAMPLE 1: WHEN ANATOMY MATTERS

A trans man on regular testosterone treatment is seeing you for a general check-up. He mentions that he has a new sexual partner. You sensitively ask about the gender of their partner by asking whether their partner was assigned male or female at birth. He tells you they were assigned male at birth but identifies as non-binary. You then need to know what body parts your patient has – that is whether they have had a hysterectomy for gender affirmation (they have not), and what terms they use for their vagina (they use 'front hole'). You discuss whether they have penetrative sex together and whether your patient might need cervical screening, an STI check, or contraception.

Anatomy and gender identity

Looking at things from a medical practitioner's perspective, it can seem obvious that anatomy and genetics are major determinants of health outcomes. Therefore, medical practitioners may want to approach someone's health needs from the medical perspective based on their anatomy and birth assigned gender and recommend preventative health strategies and treatments from that perspective. However, this can be come across as delegitimising to a gender-diverse person and can trigger intense feelings of rejection and dysphoria. Discussions about a patient's health needs based on their birth gender and anatomy therefore need to be handled very sensitively.

A discussion could start with an affirmation of the patient's preferred gender and an explanation for the intervention proposed by the medical practitioner. How much further to then proceed should depend on the patient's response and whether they feel happy to proceed down the path proposed by the medical practitioner.

Ultimately, every person has the right to make decisions about their own healthcare and any approach to someone's healthcare is going to be a lot more successful if we can involve the patient in decision-making about their healthcare and have their active consent at every step of the process.

Recording of birth gender and affirmed gender in medical software is currently challenging. It is important to record birth gender because of the health implications of particular anatomy and physiology. However, in some software, the birth gender is the gender marker used to populate the gender field on

forms and pronoun fields in correspondence. This can cause considerable distress for patients when the birth gender does not match their affirmed gender. Unfortunately, our medical software companies have not sorted out this problem so this is something we just have to be particularly cognisant of and explain the reason, for example, that birth gender may be listed on a pathology form. It may be necessary to free text the affirmed gender within the social history section and to manually alter letters and forms as needed.

Medical gender affirmation care, social affirmation, and voice therapy

By the time a gender diverse person sees a doctor, they would have gone through months if not years of self-questioning. What they therefore need is a supportive and understanding voice. These patients do not expect you to be an expert in transgender healthcare and a lot of them will have already done a lot of research and will be very knowledgeable about their healthcare needs. They just need you to be non-judgmental, willing to listen, open-minded, and willing to learn.

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"Each State and Territory will have different rules relating to change of gender on the birth certificate, available at the relevant Births Deaths and Marriages website."

Assisting a gender diverse person on their life-changing journey can be a very rewarding and educational experience. However, if you feel that this is a journey you can't undertake with your patient, then you do have a responsibility to find a service that can assist your patient. If they are a young person under 18 years, they may need referral to a gender specialist service. In several jurisdictions in Australia, there are now laws against conversion therapy that make it an offence to try to change a person's sense of gender identity.

You would start by listening to the person's story.

CONSULTATION TIPS FOR GPS:

Key points to cover in the consult

- Check their affirmed name, gender and pronouns and make sure this is visible somewhere in their medical records.
- Ask about the history of their gender incongruence and what their experience of gender affirmation has been. Who have they talked to, who is supporting them, what treatment have they had already and the effects of that treatment?
- Ask what they know about and expect from medical affirmation treatment.
- If they are seeking hormone treatment, order some baseline blood tests and other investigations[43].
- If they are a young person under 18, they will need referral to a gender specialist service. There are Australian treatment guidelines for the care of gender diverse children and adolescents[44].

Image from: The Gender Spectrum Collection

Social affirmation is the process by which a person assumes a new gender role in society. This can be a daunting process and family, the workplace and/or educational institution may need to be involved. Your patient may need psychological support from you and/or their psychologist or counsellor to negotiate this process. There is good community-based guidance through local trans peer support groups and online advice[45].

You can also help with the process of gender change officially by:

- Providing a letter for Medicare and Centrelink stating that you are their treating GP and support their change of name and gender.
- Completing forms for change of name and gender on the birth certificate and/or passport[46, 47].

Voice therapy is something that some transgender people use to reduce their dysphoria around their voice and to reduce the risk of social misgendering. This can assist trans women to learn to raise the pitch of their voice. Most trans men on testosterone develop a deeper voice but can benefit from seeing a speech pathologist to reduce vocal fatigue. AusPATH has list of gender-affirming providers in different parts of the country[47] or you can try asking your local speech pathologist. There are also lots of videos on YouTube that your patient can look at.

Feminising or masculinising hormone therapy

For adults seeking hormone therapy, traditionally we have referred the patient for a formal mental health review with a trans specialist psychiatrist or clinical psychologist. After confirmation of gender dysphoria, we then can refer to an endocrinologist specialising in trans care. This can be expensive, can result in long waiting times, and can be pathologising for many people.

Alternatively, you can use an informed consent model of care. This is based on the idea of a cooperation between you and your patient and involves the patient giving informed consent to hormone treatment as they would to any other medical intervention. It requires 2 to 3 consultations to explore their gender journey, do a mental health review, and exclude significant contraindications[49]. Exceptions to informed consent that require specialist referral include current active psychosis, possible dissociative identity disorder, other severe mental health problems needing stabilisation, or major medical contraindications to hormones such as recent hormone dependent tumours or liver disease. Clear guidelines are available to support GPs to use informed consent[43].

For a person assigned male at birth who wants to be feminised, hormonal treatment involves the use of oestrogens and anti-androgens. The benefit of progesterone for this purpose is unclear and its use is debated. For a person who is assigned female at birth who wants to be masculinised, we would use testosterone.

Guidelines to refer to for prescribing are included in the Resources section of this Guide.

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TEACHING ACTIVITY 5: HORMONE TREATMENT FOR GENDER AFFIRMATION

TEACHING ACTIVITY

Consider a trans or non-binary patient who is requesting hormone treatment for gender affirmation. Discuss with your registrar the pros and cons of prescribing hormones using the informed consent model. This is a very personal decision based on willingness to upskill, and to work with the individual patient. However, it is well within the scope of general practice.

PROS:	CONS:
• Providing ready access to this important medical treatment, particularly in rural and regional areas without specialist access. • Holistic care through managing all of the patient's needs. • Transferring a known skill set such as prescription of MHT during menopause to a new population group. • Access to excellent guidelines.	• Theoretical medico-legal risk as this is a fairly new process in Australia. • Possible destabilisation of the patient's mental or physical health. • Difficulty dealing with doses and side effects. • The need for specialist referral to enable access to testosterone prescriptions on the PBS.

Surgery

You may come across references to "top" and "bottom" surgery for transgender people. For a trans woman, top surgery would refer to breast implant surgery and bottom surgery would usually refer to a penectomy and bilateral orchidectomy, often with a vaginoplasty or labiaplasty. For a trans man, top surgery would mean a bilateral mastectomy (better termed chest reconstruction) and bottom surgery would mean a metoidioplasty (clitoral lengthening) or phalloplasty. What a person may choose to do is an individual choice and some individuals may choose not to have any surgery at all. Most Australian surgeons follow the WPATH guidelines for assessing suitability for surgery[50]. For bottom surgery, surgeons require supporting documentation from two psychiatrists and/or clinical psychologists of the patient's suitability for surgical intervention, including a formal gender dysphoria diagnosis. For top surgery, just one mental health specialist review is required.

Other surgery that transgender patients may request include facial feminisation surgery, thyroid cartilage surgery, voice surgery in trans women patients and a radical hysterectomy in trans men patients. Most of this surgery is done in the private system, which is very expensive. There is some activism around allowing the surgery in the public system, which may be possible in the future.

Trans contraception and fertility

Most transgender women opt to have very low levels of serum testosterone when they go on hormonal treatment. However, levels of serum testosterone can be very variable in transgender women and there are reports in the scientific literature of transgender women producing viable sperm while on hormonal treatment. If transgender women who have not had genital affirmative surgery are having sexual activity with female partners of reproductive age, it may be appropriate to discuss contraception.

For transgender men, testosterone treatment usually results in the cessation of menses, but this doesn't always mean anovulation. There are case reports in the literature of transgender men who have fallen pregnant while on testosterone treatment. It is therefore important to discuss contraception if transgender men are having sexual activity that could result in pregnancy.

A transgender woman who has had genital affirmation surgery would suffer permanent loss of fertility as would a transgender man who has had surgery to remove their reproductive organs. Testosterone therapy usually stops ovulation; however, this often returns on hormones cessation. Oestrogen therapy, on the other hand, usually stops spermatogenesis, but cessation of hormones often does not result in sperm production. It is also unclear what the effect of long-term use of gonadotrophin releasing hormone analogues (usually called puberty blockers), followed by the use of gender affirming hormone treatment, would have on the development and maturation of gonadal tissue in our younger transgender patients.

Discussion about fertility should therefore be part of the initial consultation process for all gender-diverse people before embarking on treatment that could affect their fertility. For transgender women, fertility preservation could involve sperm cryopreservation or testicular tissue biopsy for pre-pubertal trans girls. For transgender men, this could involve oocyte or embryo cryopreservation or surgical removal of ovarian tissue or immature oocytes; the latter two can be applicable to pre-pubertal trans boys[51]. Unfortunately, none of these procedures are available without charge in Australia.

Image from: The Gender Spectrum Collection

Smoking, alcohol, and drug use

The few studies looking at cigarette smoking give conflicting results as to whether gender diverse populations have higher rates of smoking than the cisgender population. The small number of studies looking at alcohol and other drug use amongst gender diverse populations show higher rates of alcohol and other drug use in these populations[52]. There is a section in this Guide on mental health in gender diverse populations. As there are much higher rates of mental health comorbidities in this population, it is not surprising that alcohol and other drug use also tends to be more common.

"It is important to let our gender diverse patients know that hormonal medication can affect their risk of cardiovascular disease although the evidence on this is still unclear and results from studies are conflicting. Nevertheless, it is good practice to discuss measures to maximise health as part of gender affirmation treatment."

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Sexual Health

As people start to explore their affirmed gender identities, this can also mean an exploration of their sexual identities. An earlier section in this document has already discussed the difference between sex, sexuality, and gender identity. Medical practitioners should therefore make no assumptions about the sexual identities and sexual behaviour of their patients but ask about this sensitively. Any consultation that involves sexual history taking is an opportunity to provide safe sex education and this is no exception. Depending on the sexual activity that your patient is engaging in and your assessment of risk, it may also be appropriate to discuss HIV pre-exposure prophylaxis.

An Australian study* of trans sexual health[53] found that, compared with their cis gender peers, trans and gender diverse (TGD) young people:

- Were more likely to be sexually active.
- Were more likely to have sex with adults.
- Were less likely to be receiving adequate targeted sex education.
- Were more likely to have had an STI.
- Had higher rates of sexual violence and coercion, and unwanted sex (For example, 53.2% had experienced sexual violence, compared with 13.3% of the general population).
- Non-binary people were much more likely than binary trans people to have sex with other non-binary people.

*This study also showed that almost 87% of participants accessed their sexual health care through general practice[54]. Over two thirds had experienced gender insensitivity in sexual health care, and this was associated with a reluctance to seek care in the future.

STIs

For some people, exploring their new sexual identities can involve unfamiliar sexual behaviour and this could expose them to new STI risks. If this is happening with your patient, it may be important to sensitively discuss risk and to offer regular STI testing.

Early detection of cancer

Per the current guidelines for ciswomen in Australia[55], cervical screening tests should be offered to all trans people who:

Have been sexually active

+

Still have a cervix

+

Are aged 24 years and 9 months to 75 years

Trans people would still attract a Medicare rebate for their cervical screening test even if they have changed their gender with Medicare. However, it may be worthwhile letting your pathology service know so that there is no confusion about the test.

A lot of trans men find a speculum examination very confronting and it is very worthwhile offering the option of a self-collected cervical screening[56].

For transgender men who have not had top surgery (bilateral mastectomy) or still have some breast tissue left after surgery, the screening guidelines are the same as for cisgender women, ie breast cancer screening every 2 years from the age of 50 to 74 years[57]. Please note that some transgender people prefer to use the term chest instead of breast.

For transgender women, the current advice is to have breast cancer screening as per a cisgender woman of their age range once they have been on feminising hormones for more than 5 years. All transgender men and women should be able to access free breast cancer screening at their local breast screen clinics.

Some guidelines both in Australia and overseas recommend prostate cancer screening for transgender women[58]. There are only a small number of reports of prostate cancer in the scientific literature[59]. This is something you can explore further with your trans women patients.

A recent French study has suggested an association between the use of higher doses of cyproterone acetate, a medication that is used to reduce testosterone levels in transgender women, and the risk of meningioma. It has therefore recommended that the lowest effective dose of cyproterone acetate be used, and monitoring be done for the symptoms of a meningioma in trans women who are taking higher doses of cyproterone acetate[60].

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People with Intersex Variations

Understanding intersex variations

Intersex is a term for a range of innate variations of sex characteristics that do not fit medical norms for female or male bodies, including genetic, chromosomal, hormonal, or genital characteristics. Multiple terms exist to describe intersex variations including 'disorders or differences of sex development' (DSD), 'innate variations of sex characteristics', and a range of specific diagnostic terms.

TABLE 9: RELEVANT DIAGNOSES

RELEVANT DIAGNOSES

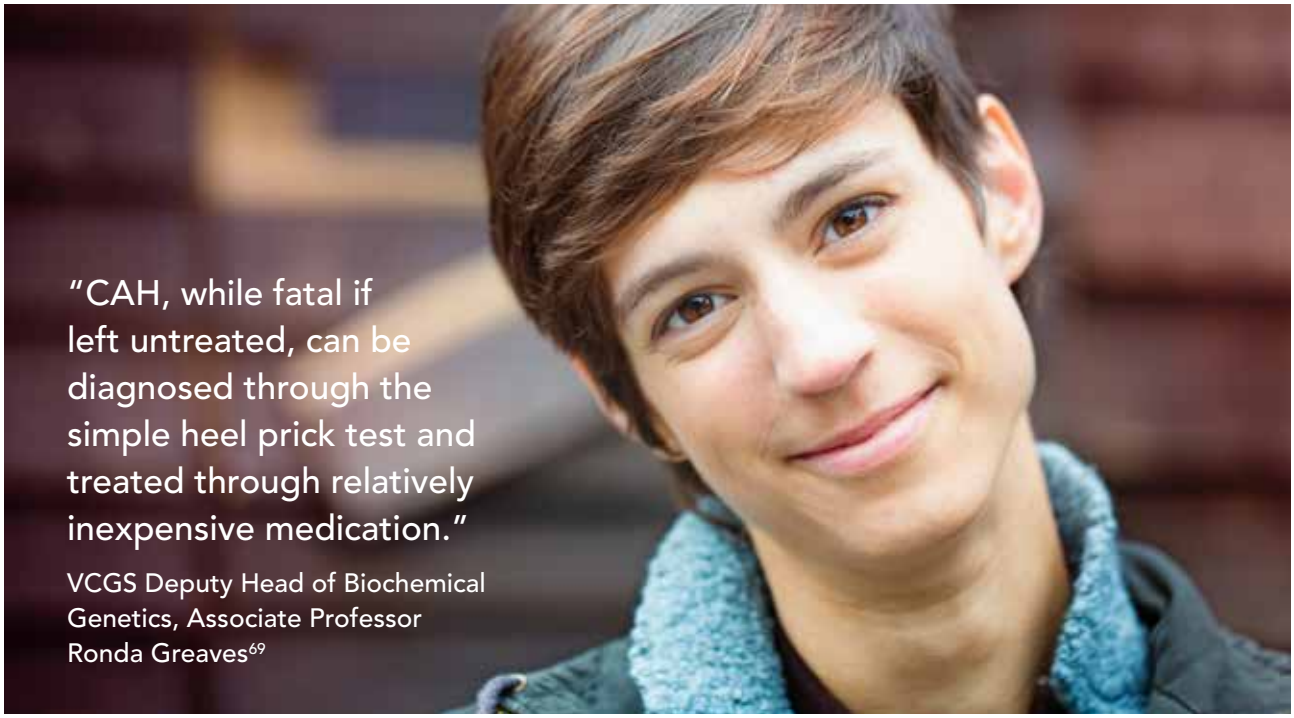
- Androgen insensitivity.
- Congenital adrenal hyperplasia (CAH) with XX or mosaic sex chromosomes.
- 5α reductase deficiency.
- 17ß hydroxysteroid dehydrogenase 3 deficiency.
- Gonadal dysgenesis.
- Micropenis.
- Many sex chromosome variations such as
  - Klinefelter - 47XXY.
  - Turner - monosomy X, 45X.

"People with intersex variations do not necessarily understand or use the term intersex, and many do not associate with the LGBTQIA+ community."

Irrespective of diagnosis, people with intersex variations are a very diverse population, and do not share any universal experience of sex, gender, or sexual orientation. People with innate sex characteristics that do not fit medical and social norms for female or male bodies often experience stigma or discrimination. Also, many have experienced harmful surgical and hormonal interventions that occurred before they could personally give informed consent[61, 62, 63]. Associating intersex traits with non-binary gender identities or third sex categories can be stigmatising for girls, boys, women, and men with intersex variations.

People with intersex variations do not necessarily understand or use the term intersex, and many do not associate with the LGBTQIA+ community.

The 'I' is often included in the LGBTQIA+ acronym in Australia due to various overlapping issues including experiences of stigma and discrimination due to normative conceptions of sex and gender. Of course, some people with intersex variations grow up to express LGBTQ identities.



Medical diagnosis

Intersex traits may be diagnosed prenatally, at birth or in the neonatal period, or they might be determined during puberty or adolescence, or later in life, such as when attempting to conceive a child.

Prenatal diagnosis of some traits, particularly sex chromosome variations, is possible, for example using non-invasive prenatal testing, amniocentesis, or screening during IVF. Some institutions are reporting concern about high rates of pregnancy terminations for some sex chromosome variations, and these are not commensurate with the realities of life with an intersex variation. Prenatal treatment to modify genital appearance in congenital adrenal hyperplasia (CAH) - which entails the administration of dexamethasone from very early in the at-risk person's pregnancy[64, 65] - prioritises appearance over established cognitive development risks[66]. Most intersex traits are not candidates for pre-conception screening because the adverse impacts of having intersex variations are not intrinsic but are instead associated with stigma and social norms[67].

It is essential not to emphasise unlikely negative outcomes to the prospective parents, but rather to provide referrals to affirmative support[68]. With love and support, people with intersex variations can live happy and fulfilling lives.

Diagnosis in the neonatal period can occur either due to a visible difference that complicates sex assignment, or due to adrenal insufficiency.

If left untreated, adrenal insufficiency can be fatal. As outlined in the Newborn Bloodspot Screening Resources on the Department of Health website[70], neonatal screening is now becoming available in most jurisdictions in Australia.

Some intersex traits become evident due to physical changes at puberty (such as virilisation or under-virilisation), or an absence of physical changes at puberty (such as amenorrhea or delayed puberty). Other traits, including sex chromosome variations like 47XXY (Klinefelter syndrome), are known to have relatively low rates of diagnosis[68].

Neurodiverse and related developmental issues may be present in some cases (notably with sex chromosome variations), and renal or other issues may also be features (for example, of Mullerian agenesis). Each of these may require referral to specialists.

Diagnosis and/or disclosure of medical information to an adolescent can be very challenging for patients. Open and early disclosure is critical to maximise the choices that individuals have over their bodies, and also reduce the risks of snap decisions. Contact with peers can help individuals and parents to make better informed choices. Support from a psychologist, counsellor or social worker can also be helpful in some cases.

Surgical and hormonal interventions

Some medical interventions on infants and young children are urgent and necessary for physical health, for example:

- Where there is a high risk of gonadal tumours.
- Managing an inability to urinate.
- Managing salt wasting associated with congenital adrenal hyperplasia.

Some traits are associated with other medical issues requiring management at any life-stage such as neurodiverse issues (including ADHD), developmental delay, or renal issues. Individuals old enough to consent may also need or wish to undergo medical interventions including genital surgery, gonadal and fertility-related interventions. Support is needed to ensure these choices are informed, supported by evidence of efficacy, and in line with the individual's preferences and values.

Infants and children with intersex variations in Australia are still routinely subjected to feminising or masculinising surgeries, hormonal treatments, and associated medical examinations or dilation. They often take place on the grounds of gender stereotypes, parental distress, or other psychosocial rationales[61, 71]. Sadly, parents may not be providing fully informed consent on behalf of their children, and many may experience regret[72, 73]. Despite calls for more research dating back to 1995[74], global clinical statements report a lack of evidence in support of early 'normalising' medical interventions, and a lack of clinical consensus about timing, necessity and procedures[75].

In response to these concerns and evidence of continuing harm in medical settings, the Australian Human Rights Commission has called for reform of the criminal law to end medical interventions grounded in psychosocial rationales, implement independent oversight and national guidelines and promote better research. ACT and Victoria have made public commitments to reform[63, 77, 105, 106].

These issues may arise in relation to children in your care if they are proposed to undergo medical interventions to satisfy ideas about the genital or other physical appearance of girls or boys, or ideas that associate functionality with the idea that boys need to be able to stand to urinate. You need to be aware that these are regarded as human rights abuses and institutions may become culpable for such practices.

Stock photo. Posed by model.

Psychosocial context

Like other sexual and gender minorities, people with intersex bodies are stigmatised and individuals can experience high levels of distress and trauma[79]. This distress may persist into adulthood and relate to:

- A history of deliberate non-disclosure of medical histories and diagnostic information. This persists in some areas and can impact individuals' ability to manage their health as well as their engagement with health services.[80, 81]
- Stigmatisation of intersex variations and bodies.
- Infertility – this may be related to their underlying intersex variation, or to surgery during childhood that removed gonads.
- Multiple surgical procedures during childhood.
- Family conflict relating to non-disclosure, sibling abuse or discrimination.

Affirmative, open, and age-appropriate disclosure can counter risks and experiences of shame and secrecy. Like all children, those with intersex variations most need the unconditional love and support of their parents. Decisions regarding medical treatments including hormones or surgery can and should be made once children reach an age at which they can consent themselves, with the support of their families.

Affirming care for people with intersex variations

The common trauma experiences amongst people with intersex variations mean that they might prefer not to be in your clinic. Compassionate, trauma-informed care is essential, ensuring that your patient consents, is engaged, and in control.

Community connectedness and access to a GP are important protective factors, mitigating risks of suicidal ideation, anxiety, and depression[5, 80]. GPs can play a key role in promoting open communication, including in situations where youth may experience communication obstacles in hospital and home settings, an absence of affirmative information in education settings, and suffer the prevalence of popular misconceptions[82].

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TABLE 10: STRATEGIES FOR AFFIRMING CARE

CONSULTATION TIPS FOR GPS:

Specific strategies for affirming care

- Respect the language choices of patients and their families, which will contribute to their wellbeing. Language in this area is contested. Often debates about what makes someone intersex turn on a presumed sense of gender identification, sexual orientation, an experience of sex assignment, or uncertainty about sex[83]; it is best never to rely on these potentially harmful presumptions. Using terms that the person and their family are comfortable with is essential.
- Clinicians have a key role in educating individuals and parents about nomenclature regarding intersex variations, countering misconceptions and allaying fears and negative connotations that may be associated with linked LGBT identities and experiences.
- Align your data collection with the ABS Standard on sex, gender, variations of sex characteristics, and sexual orientation[1]; rather than falling into the trap of treating the term intersex as if it refers to a non-binary sex or gender category. Third or non-binary categories on intake forms are better termed 'non-binary'.
- Respect the human rights and identities of infants, children, adolescents, and adults with intersex variations. This includes delaying treatment whenever possible, ensuring full informed consent is gained from the patient for any medical or surgical treatment that may impact the genital appearance, the gonads or fertility.
- Do not assume that intersex traits need to be 'fixed' for people with intersex variations to be 'real' or valid girls or boys, women, or men.
- Refer for peer support to independent community organisations.

TEACHING ACTIVITY 6: DISCUSSING CURRENT ETHICAL STANDARDS FOR TREATMENT OF CHILDREN WITH INTERSEX CHARACTERISTICS

TEACHING ACTIVITY

Read the article https://bit.ly/3GpRnbt: A Principled Ethical Approach to Intersex Paediatric Surgeries[84]

- Discuss with your registrar the relatively common scenario of seeing an adolescent or adult with intersex characteristics who had unwarranted genital surgery as infants that has left them infertile and understandably mistrusting of the medical system.
- How would they support this patient into the future?

  This may include the strategies for affirmation listed in Table 10, as well as appropriate specialist referral, information giving about current ethical standards, and referral to peer support groups.

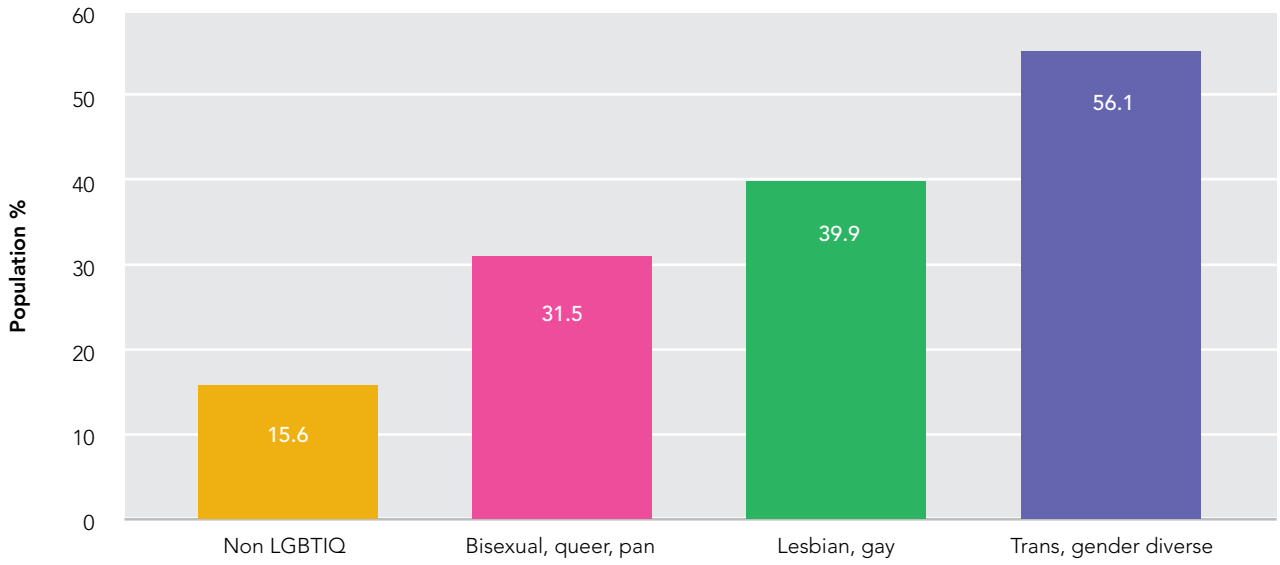
Mental Health Issues

One of the main health inequalities facing LGBTQIA+ people relates to their mental health. LGBTQIA+ people are much more likely than non-LGBTQIA+ people to experience depression, anxiety, and suicidality. This stems from often repeated experiences of trauma, discrimination, and marginalisation due to their minority sexual orientation, sex characteristics or gender identity, which is often termed minority stress. These experiences also differ within the subgroups and are much more likely for trans or non-binary people, and pansexual, bisexual, or queer people.

Impact of homophobic, biphobic or transphobic attitudes

Australian attitudes towards LGBTQIA+ people have gradually become more accepting in recent years. However, negative attitudes persist in many families, schools, socially and religiously conservative groups and workplaces. For example, in Victoria in 2017, LGBTQIA+ people were more likely to experience discrimination in the past year than non-LGBTQIA+ people:

EXPERIENCING DISCRIMINATION VICTORIAN POPULATION HEALTH SURVEY 2017



These experiences of discrimination can be associated with violence and abuse from family members, school or work peers, or strangers. They are directly associated with the higher rates of depression, anxiety and suicidality seen in the LGBTQIA+ populations, as well as higher rates of PTSD.

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FEELING THAT LIFE IS WORTHWHILE

22.1%

of LQBTIQ+ adults rated what they did in life was worthwhile as low to medium (score of 0–6)

16.5%

of heterosexual, non-LQBTIQ+ adults rated what they did in life was worthwhile as low to medium (score of 0–6)

PSYCHOLOGICAL DISTRESS

24.4%

of LGBTIQ+ adults had high or very high levels of psychological distress

14.5%

of heterosexual, non-LGBTIQ+ adults had high or very high levels of psychological distress

DEPRESSION OR ANXIETY

44.8%

of LGBTIQ+ adults had ever been diagnosed with anxiety or depression by a doctor

26.7%

of heterosexual, non-LGBTIQ+ adults had ever been diagnosed with anxiety or depression by a doctor

EXPERIENCE OF FAMILY VIOLENCE

13.4%

of LGBTIQ+ adults had experienced family violence in the past 2 years

5.1%

of heterosexual, non-LGBTIQ+ adults had experienced family violence in the past 2 years

Image Source: *The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex and queer population in Victoria Findings from the Victorian Population Health Survey 2017, Victorian Agency for Health Information, 2020.*

Image from: The Gender Spectrum Collection

The risk of suicide amongst LGBTQIA+ people in Australia is particularly concerning. The national LGBTQIA+ survey found that 30.3% of the respondents had suicidal thoughts over their lifetime, and 5.2% in the past 12 months, compared with 3.2% and 0.4% of the general population. Understanding the underlying associations of suicidality is very important to providing primary and secondary prevention for these groups. Particular risk factors include lacking family acceptance, and histories of physical and sexual abuse[85].

On an individual patient level, it is helpful to tease out some of these potential risk factors. You can use the social determinants framework, as the risk factors can be present at a number of levels.

SOCIAL DETERMINANTS	VIGNETTES
Individual level risks • Identity questioning of confusion. • Internalised homophobia, biphobia, transphobia, intersex-phobia.	A young man is same-sex attracted. He has understood from his Muslim faith that this is a sin and feels a burden of guilt and shame. He is unable to talk about this with anyone for fear of bringing shame to his family. He turns to self-harming. A girl with an intersex variation feels that she needs to consent to surgery to construct a vagina, because who heard of a girl without one?
Family/friend level risks • Rejection or fear of rejection, can lead to homelessness. • Peer bullying, abuse and violence – in families of origin, within intimate relationships. • Isolation.	A non-binary adolescent comes out to their family and is told they cannot live in the family home if they persist with this 'phase'. They experience transphobic abuse at school and some cyber bullying. They chose to leave home but have nowhere to live.
Community level risks • Marginalisation from social groups. • Discrimination within schools, workplaces. • Abuse and violence.	A pansexual trans woman in her 30s has experienced repeated episodes of abuse in public settings. She is also not been supported at work as a mechanic and does not feel able to be authentic at work in her affirmed gender. She is becoming increasingly depressed.
Societal level risks • Lack of inclusion in services including healthcare, social services, legal. • Lack of inclusion, or active exclusion from policies and legislation.	A bisexual woman has had a child with her same sex partner. She is the non-birth parent, and her name is not on the child's birth certificate. The couple separate and she finds she is not recognised as the parent at her child's school or GP. She also cannot find LGBT aware legal advice and is feeling highly anxious. She starts drinking heavily.

These vignettes highlight one of the common consequences of isolation or marginalisation and not fitting in, which is various risk-taking behaviours including sexual risks, or alcohol and drug taking, or self-harm. This is often the point at which LGBTQIA+ people present to a GP. Our role is not only to provide mental health care, but also to tease out and understand the complex background to these behaviours. We also need to be prepared to link people in to relevant and LGBTQIA+ specific community-based supports.

Multiple identities and mental health

The vignettes also touch on another challenge, that of having multiple identities (intersectionality). GPs understand the impact of multiple marginalised identities on mental health. We frequently see people who come from religious minorities, perhaps a refugee background, or those that face added challenges living with a disability. In the LGBTQIA+ field these identities can add a further burden on mental health. For example, some LGBTQIA+ people from religious communities have been subject to conversion practices that attempt to make them adopt heterosexual, cisgender identities. These are known to be extremely damaging to mental health and are increasingly banned under Australian legislation.

LGBTQIA+ refugees and people seeking asylum

This is one of the most marginalised groups in Australia. They often seek asylum due to sexuality or gender-based discrimination in their home countries and can also face high levels of violence in refugee camps and detention. They can have great difficulty proving their refugee claim here as they have often been living in stealth in their home country for safety reasons[87]. Their expression of gender identity or sexual orientation, or their understanding of their body, can also be culturally very different to common experiences in Australia, making it harder to find peer support here.

LGBTQIA+ people living with a disability

This group of LGBTQIA+ people are found to face heightened mental health risks when compared with LGBTQIA+ without disability[86] including:

- Higher rates of abuse and violence, including family violence.
- Higher rates of discrimination within both LGBTQIA+ and disability communities.
- Lower levels of social connection within both LGBTQIA+ and disability communities.
- Restriction of expression of sexuality and gender, particularly for people with intellectual disability.

Note that some people with intersex variations, particularly those with traits that require significant support such as salt wasting congenital adrenal hyperplasia or sex chromosome variations, may have an affinity with conceptions of disability.

Complex trauma for LGBTQIA+ people

Clearly, LGBTQIA+ people are more likely than others to have experienced trauma, often repeated episodes throughout their lifetimes[33]. So, it is not surprising to find a higher proportion of this group have PTSD and/or borderline personality disorder. Certain subgroups are more likely to suffer complex PTSD including trans and non-binary people, and this has implications for the GPs role in not only understanding the background issues for suicidality and poor mental health, but also advocating for better family and social support[88]. Affirming the person's identity and supporting their self-esteem and identity stability can be a helpful brief intervention.

Neurodiversity and gender diversity

There is some evidence that neurodiversity such as autism spectrum disorder (ASD) and ADHD is more common amongst trans and non-binary people. For example, in one study around 20% of gender identity clinic-assessed individuals reported features of ASD[89]. These authors highlighted that there is no agreement on aetiological factors, nor on diagnosis and treatment of co-occurring gender diversity and ASD, so research is needed to help our understanding of the phenomenon and to provide evidence for optimal care in this unique population. In general practice, the most important issue is to understand these issues can co-exist, and that being neurodiverse does not preclude the possibility that the person is also trans or non-binary.

Mental health care and accessing services

There are many barriers for LGBTQIA+ people in accessing services for mental health care. These often result in delayed presentations or even avoiding care. They include:

- Lack of readiness to seek help.
- Lack of perceived need for help.
- Fear of discrimination or lack of understanding in healthcare.
- Lack of choice of LGBTQIA+ inclusive services, particularly in rural and regional areas.
- Homelessness.
- Poverty, lack of availability of public and low cost LGBTQIA+ inclusive counselling.
- Negative experiences in healthcare:
  - Breaches of confidentiality.
  - Rejection.
  - Excessive focus on LGBTQIA+ status including pathologisation.

LGBTQIA+ Health Australia has focused on mental health and training for healthcare professionals for many years. They have several resources including fact sheets, guides and webinars[90] that support more inclusive and knowledgeable practice. Key points in their advice are to focus on resilience and the importance of finding community support. Other tips include the importance of overtly valuing diversity and having LGBITQIA+ inclusive referral networks.

Resilience

Resilience is an important determinant of positive mental health and recovery and is a new area of study in LGBT health[91].

CONSULTATION TIPS FOR GPS:

Supporting LGBTQIA+ patients with their resilience-building strategies.

- Social connectedness, both to LGBTQIA+ and mainstream communities, as preferred.
- Self-care.
- Self-advocacy.
- LGBTQIA+ inclusive professional help.
- Disclosing LGBTQIA+ status in supportive environments.

LGBTQIA+ Peer Support

Peer support is increasingly important in mental healthcare and recovery. This can be very important for many LGBTQIA+ people as it enables sharing of information, finding like-minded peers, and improving self-worth. It has been shown to reduce suicidality and improve access to mental health services[92]. Peer support may take the form of face-to-face support groups such as groups for trans people (e.g. The Shed) or young people (e.g. Minus 18), online support groups (e.g. Wingmen) or peer-led counselling services (e.g. QLife). Many of these peer support groups also take on an advocacy role.

However, some LGBTQIA+ people do not need or want peer support as they prefer more mainstream or professional services. Some LGBTQIA+ people are so distrustful of professional services that they might rely entirely on peer support groups. This creates an added burden on the peer support facilitators who can be faced with people with complex needs[93].

TEACHING ACTIVITY 7: LGBTQIA+ MENTAL HEALTH AND APPROPRIATE REFERRALS

TEACHING ACTIVITY

Discuss the scenario of a LGBTQIA+ person with significant trauma and discrimination in their life, which is adversely affecting their self-esteem and mental health.

How would the registrar navigate finding appropriate support for this patient?

- Social support.
- Family of origin and/or chosen family.
- Referral to peer support groups – identity specific.
- Professional support.
- General psychological care.
- LGBTQIA+ specific psychological care.
- Role of psychiatric referral for 291 assessment or ongoing involvement.

Healthy **Ageing**

The social context of healthy ageing for LGBTQIA+ older people

Healthy ageing for LGBTQIA+ people, like all people, starts well before older age. Social, cultural, and economic factors influence people's susceptibility to and experience of age-related illnesses, such as cardiovascular disease, diabetes, and dementia. They also determine the resources and supports available to promote healthy ageing and independent living.

For many LGBTQIA+ older people, discrimination, violence, and stigma across the life course have had long-lasting effects on their physical and mental health. For most of their lifetime, they lived in a society where homosexuality was both criminalised and considered a psychiatric illness, where transgender people were categorised as suffering gender identity disorder, and where 'surgical options' continue to be a factor in determining the sex of intersex people.

The resulting health disparities are particularly noticeable in relation to mental health, where psychological distress, depression, anxiety, loneliness, and suicidality are higher among LGBTQIA+ older people than non-LGBTQIA+ older people[95]. There has been less research on intersex older people, although there is some evidence of educational and employment disparities affecting social inclusion, and there are likely to be considerable long-term physical and mental health effects of unwanted medical interventions.

Despite these challenges, many LGBTQIA+ people report good health in later life. For example, in the ARCSHS Private Lives 2 study[96], around 50% of LGBT respondents aged 65 and over said their health was very good or excellent. This study also reported that

"I used to see a GP who was gay, but he stopped bulk billing, so I stopped going to him. Now I see a bulk-billing GP, but he is very rushed with his appointment times and you are in the door and out again before you know it. He may or may not be good with LGBT issues, but I chose not to disclose my sexuality in case he doesn't get it."

(Older gay man)[94]

"As a gay ageing woman, I would like myself and my partner to receive care at home when we eventually need it. But such care would need to be provided by staff trained to understand and be sensitive to LGBTI people."

(Older lesbian woman)[94]

"I was self-medicating hormones for 18 months before having the courage (and good sense) to approach my GP. I thought he would be angry/disgusted/dismissive/judgmental etc. He was just the opposite: non-judgmental and supportive. All the fears were inside my head."

(Older transgender woman)[94]

"Good old-fashioned homophobia and discrimination is alive and well so I think it will continue to be an issue. Ageing presents the same problems to trans people as the general community due to the visual nature and society's obsession with looks."

(Older transgender woman)[94]

psychological distress was lower, and resilience was higher, among the older respondents compared to the younger ones.

Many LGBTQIA+ older people are also actively engaged in their communities with research in the United States indicating that LGBT people are more likely to be caregivers than non-LGBT people[97]. While some have become estranged from biological family members, many stay connected to family and some have repaired relationships in later life. The significance of chosen families continues in later life with friends featuring prominently as both providers and receivers of support by LGBTQIA+ older people.

What does aged care look like for LGBTQIA+ older people?

LGBTQIA+ people are now recognised as a 'special needs' group under the Aged Care Act and sensitivity training has been delivered to some aged care providers to improve their engagement with LGBTQIA+ clients and communities. Despite this, many LGBTQIA+ older people report being concerned about accessing aged care services and, in particular, are fearful of discrimination and having to return to the 'closet' if they need to enter residential care.

And there is evidence of actual discrimination against LGBTQIA+ older people occurring in both community and residential aged care. Examples include inappropriate use of restraints, abuse, and misgendering transgender people. Past experiences of discrimination accessing health and social services can also lead people to be fearful of future discrimination and to avoid accessing services when they need to in later life[98].

LGBTQIA+ older people have a diversity of views about accessing services designed especially for their needs. Some prefer to access LGBTQIA+ specific services, some gender-specific services, and others mainstream services that are welcoming of LGBTQIA+ people[99, 100].

Aged care service providers and health professionals play a key role in creating an inclusive and welcoming environment. Positive messages can be conveyed by ensuring one's language is not exclusionary – for example, not assuming the gender of a person's partner or spouse. Giving people the option to disclose their identity, relationships, or variations of sex characteristics on a form or in conversation is also important.

Many of these strategies do not need to take more time or resources. They involve thinking and talking more openly about diverse identities, relationships, and personal characteristics. Encouraging people to talk about what's important in their life, as it relates to the professional encounter, can be key.

How do LGBTQIA+ people experience dementia?

Like most people, dementia ranks high among LGBTQIA+ people's concerns about ageing and there is evidence that lesbian, gay and bisexual people, due to other health disparities, face greater risk of cognitive impairment in later life than heterosexual people[101].

A key concern for many is how dementia may put them at risk of poor-quality care. Loss of inhibition in relation to sexuality can make lesbian, gay and bisexual people vulnerable to discrimination. Tensions may arise when a person's previous way of presenting their gender identity or sexual orientation changes due to memory loss. Transgender people may feel confronted by others needing to be more involved in their intimate care than they had previously experienced[102].

CONSULTATION TIPS FOR GPS:

Inclusive practice strategies important to older LGBTQIA+ patients

- Checking in with people about the terms they prefer to use to describe their sexual orientation, gender diversity or intersex status. For example, while the term 'queer' is commonly used by young people, some older lesbian, gay or bisexual people still feel it is offensive and don't use it to describe themselves.
- Discussing both their challenges and strengths. Each individual will have their own history and pattern of health behaviour across the life course that will affect how they experience later life and the supports and resources available to them.
- Honouring a person's identity and life history are central to best practice dementia care and are especially critical when providing care to LGBTQIA+ people with dementia.
- While individuals' identities, relationships and community connections are important to recognise, so too is their privacy when they wish to not make these aspects of their life known publicly.

How can GPs promote the rights of LGBTQIA+ older people with reduced decision making?

A concern for many LGBTQIA+ older people is what will happen if they are unable to make their own decisions about their health treatment or finances, for example, due to dementia or being comatose. For those estranged from family members, there can be a real fear that these people will make decisions on their behalf and the views of partners or other members of their chosen family may be ignored.

Advance care plans, enduring guardianships and enduring powers of attorney can be promoted by GPs as important legal mechanisms for LGBTQIA+ older people to clearly state their views about what they would like to happen if their decision making is impaired and who they would like to act on their behalf. Lack of awareness and not knowing how to complete the documents are the main reasons why there is a low take-up of these options among LGBTQIA+ communities[103].

It is also important for health practitioners to convey current health policy regarding who is authorised to make decisions on an incapacitated person's behalf even where there is no advance directive in place. In New South Wales, for example, the 'person responsible' is the guardian, spouse or partner, carer, or relative or friend (in order), regardless of any assumptions about who is 'next of kin'.

> "For those estranged from family members, there can be a real fear that these people will make decisions on their behalf and the views of partners or other members of their chosen family may be ignored"

TEACHING ACTIVITY 8: END OF LIFE PLANNING FOR LGBTQIA+ PATIENTS

TEACHING ACTIVITY

Read https://bit.ly/316Rt7K: 'Safeguarding the End of the Rainbow: A guide to helping LGBTI people to plan an end of life of their choice'[104]

- Encourage your registrar to schedule a specific session with older LGBTQIA+ patients to talk though:
  - Developing an advance care plan.
  - The various end of life medical decisions that may be needed on a person's behalf if they have reduced decision making.

Source: COTA Victoria and Transgender Victoria Inc. This guide should be read in conjunction with qualified legal advice for your state.

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Resources

Resources for LGBTQIA+ people

LGBTQIA+ Health Australia https://bit.ly/3mmDgM2	The national peak health organisation in Australia for organisations and individuals that provide health-related programs, services and research focused on lesbian, gay, bisexual, transgender, and intersex people (LGBTI) and other sexuality, gender, and bodily diverse people andLGBTQIA+ communities.
Previously known as the AIDS Councils based in each State and Territory, these organisations are gradually refocusing on the broader health needs of LGBTQIA+ communities, although some are still mostly providing HIV and sexual health services. They typically provide health promotion information about sexual health, and general health issues, counselling for mental health and alcohol and drug issues, and advocacy.	ACON - NSW https://www.acon.org.au
	Thorne Harbour Health (THH) – Victoria https://bit.ly/311cOzg
	SAMESH – supported by THH – SA (mostly sexual health) https://samesh.org.au/
	Queensland Council for LGBTI Health (formerly QuAC) https://www.qc.org.au/
	NT AIDS and Hepatitis Council (NTAHC) https://bit.ly/3jLDxql
	Meridian - Canberra, ACT https://bit.ly/2ZxudPf
	WA AIDS Council (Mostly HIV) https://waaids.com/
	Tas Council on AIDS Hepatitis & Related Diseases (Mostly HIV) https://bit.ly/3BoDh6k
Beyond Blue https://bit.ly/3IHvRPS	Support for LGBTI people with specific resources for the various groups.
Diversity Australia https://bit.ly/3vTPK12	Diversity Australia work on strategies to improve legislation for diversity and inclusion in Australian workplaces.
My Aged Care https://bit.ly/3blbDwF	Healthy Ageing.
Pride https://bit.ly/3C0Rd6Z	Website for information about supporting people who are questioning their sexuality.
Pride Foundation Australia https://bit.ly/3bhN57D	The Pride Foundation supports charitable activities for LGBTQIA people by advancing equity.
QLife https://bit.ly/3jFsFKf	A nationally-oriented counselling and referral service - phone (1800 184 527) and online peer support for mental health. It supports state and territory-based organisations such as Switchboard (Vic).
Working It Out https://bit.ly/3blCOY4	The Tasmanian LGBTQIA+ health and wellbeing organisation.

Resources and Peer Support Groups

LESBIAN AND BISEXUAL WOMEN	
ALMA https://bit.ly/3mnZflX	The Australian Lesbian Medical Association (ALMA) was founded in 1999 for lesbian doctors, lesbian medical students, and their partners. ALMA provides a supportive network to its members through advocacy, mentoring and social activities.
DocLIST https://bit.ly/3BnhEnd	DocLIST is an online list of doctors and mental health professionals recommended by lesbian and bisexual women . It is a national resource administered by the Australian Lesbian Medical Association. Lesbian and bisexual women can go to the DocLIST to find or recommend a doctor or mental health professional. The new Links section is a table of over 600 national and state-based organisations which may be of interest to lesbian, bisexual and queer women.
Queensland Women's Health Network https://bit.ly/3ukkckj	The Queensland Women's Health Network have a page dedicated to information for lesbian and bisexual women.
GAY AND BISEXUAL MEN'S HEALTH	
Gay Men's Health Australia https://bit.ly/3vYEAYH	Gay Men's Health Australia is a website devoted to healthy lifestyle information, tips and tricks for gay men, bisexual men and other men who have sex with men.

TRANS HEALTH	
ACON https://bit.ly/3CmmaDL	"A Blueprint For Improving The Health & Wellbeing of the Trans & Gender Diverse Community in NSW" (2019) AIDS Council of New South Wales.
Trans Health Australia https://bit.ly/3Gsk9bw	Trans Health Australia was founded in April 2012 and is the fastest growing Advocacy & Support Network in the nation focused on social justice, human rights and healthcare services for Trans and Gender Diverse Australians. The organisation advocates for policy and legislation changes, provides education about the issues that affect the trans community, and referral and peer support for medical and surgical services.
Trans Hub https://bit.ly/3CmYTl9	A digital information and resource platform for all trans and gender diverse (TGD) people in NSW, our loved ones, allies and health providers.
PEOPLE WITH INTERSEX VARIATIONS	
Head to Health: Intersex People https://bit.ly/3U4znKA	Provided by the Australian Department of Health, Head to Health brings together apps, online programs, online forums, and phone services, as well as a range of digital information resources.
Intersex Human Rights Australia https://ihra.org.au	Providing independent affirmative support for individuals, parents, and families: resources, policy guidance and community development.
Intersex Human Rights Australia https://bit.ly/2ZDGEtt	Lum, Steph. 2021. 'Youth.'
Intersex Peer Support Australia https://isupport.org.au	The Androgen Insensitivity Syndrome Support Group Australia: provides support for individuals and family members irrespective of diagnosis.
LGBTQIA+ Healthcare. Health Needs of People with Intersex Variations https://bit.ly/3mo0guh	Written by Morgan Carpenter 2021.
PARENTS AND FAMILIES	
Intersex Human Rights Australia https://ihra.org.au/parents/	Intersex for Parents'. 18 May 2013.
Rainbow Families https://bit.ly/2ZwhsVQ	Australian charity "Rainbow Families" offers a range of resources such as their 'Trans and gender diverse parents guide' to provide support for LGBTQI+ parents and their cchildren.
Rainbow Fertility https://bit.ly/3vPa4Ax	"Rainbow Fertility", a fertility and IVF service provider dedicated to the LGBTQI+ patients, lists a number of links and fact sheets to empower the community.
ReachOut Parents https://bit.ly/3H3aubC	'Supporting an Intersex Teenager'. 2019.
PEOPLE WHO IDENTIFY AS ASEXUAL	
Medical News Today https://bit.ly/3BnDgQj	What does it meant to be asexual?
Trevor Project https://bit.ly/3EpDQyG	Offering a great range of resources and education tools for suicide prevention in LGBTQI youth.

Resources for health professionals on LGBTQIA+ health

A Guide to LGB Sensitive Care in General Practice, by Ruth McNair https://bit.ly/2XPuE78	Designed to assist GPs, practice nurses and practice staff to be inclusive of and sensitive to lesbian, gay and bisexual (LGB) people.
A Systematic Review of Guidelines for the Care of Lesbian, Gay and Bisexual People in Primary Care Settings, by Ruth McNair and Kelsey Hegarty https://bit.ly/3BgyT9C	Exploring current (and lacking) guidelines for the primary care of lesbian, gay, and bisexual (LGB) people and their utility for primary care clinicians.
AusPATH https://bit.ly/3nEODP3	AusPATH actively promotes communication and collaboration among professionals and community members involved in the health, rights and wellbeing of trans, gender diverse and non-binary people. It also provides a list of trans-specialist health providers in each state and territory, for referral purposes.
Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents https://bit.ly/3kkbLkM	Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents.
Australian STI Guidelines https://bit.ly/3nEDkX1	Management guidelines for use in primary care.
Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline https://bit.ly/3BlED1Y	Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline.
EndingHIV https://bit.ly/3qLidWj	Ending HIV initiative has focused on educating, informing and supporting gay, bisexual and other men who have sex with men (GBMSM) to reduce HIV transmissions in NSW by 80% by 2020.
Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People https://bit.ly/2XQqhJ1	These guidelines aim to equip primary care providers and health systems with tools and knowledge to meet the health care needs of transgender and gender nonconforming patients.
Health.Vic https://bit.ly/3mVK9nJ	Health Pathways – several Primary Health Networks in Australia have LGBTQIA+ specific Health Pathways, such as NWMPHN
Hormone Therapy for Trans and Gender Diverse Patients in the General Practice Setting https://bit.ly/3pLicBa	(The aim of this article is to provide GPs working in Australia with a practical guide to prescribe gender affirming hormone therapy to TGDNB patients.
Lesbian, Bisexual and Queer Women's Health: A Guide for GPs, by Ruth McNair https://bit.ly/3qlchmv	Includes a range of questions for CPD points.
PivotPoint (about substance use) https://bit.ly/3Hiwjnw	Provides guidance, tips, advice, and where to get help for yourself or your loved ones.
Position Statement on the Hormonal Management of Adult Transgender and Gender Diverse Individuals https://bit.ly/3D5XPm4	Position statement on the hormonal management of adult transgender and gender diverse individuals.

Post-exposure Prophylaxis for HIV: Australian National Guidelines https://bit.ly/3jEDnkr	Outlines the management, treatment and prevention of HIV transmission in non-occupational and occupational settings using PEP.
Pre-exposure Prophylaxis (PrEP) https://bit.ly/3vRahmE	For clinicians involved in HIV, who may be consulted about HIV Pre-Exposure Prophylaxis (PrEP). It assumes an understanding of HIV prophylaxis.
RACGP https://bit.ly/3H7Pf8v	Silver Book 2019 – Chapter Care of Older LGBT people.
RACGP https://bit.ly/3JmILTE	White Book 2021 - Chapter LGBTIQ+ Family abuse and violence.
Say It Out Loud (about relationships) https://bit.ly/3qwQRCQ	Information for professionals around how to better understand and support LGBTQ+ people experiencing sexual, family and intimate partner violence.
WPATH: Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People https://bit.ly/3QSU5uh	Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People
TRAINING IN LGBTQIA+ INCLUSIVE PRACTICE	
Inclusive Practice: Understanding Experiences of Violence -1800RESPECT https://bit.ly/3H4qytJ	Supporting people who identify as LGBTI.
Introduction to LGBTIQ-Inclusive Practice – Rainbow Health https://bit.ly/3nDWrjM	This online module provides and introductory understanding of LGBTIQ people's identities, their health and wellbeing, and unique needs service needs.
Index and Benchmarking: Health and Wellbeing Equality Index - Pride in Health and Wellbeing https://bit.ly/31L06oQ	Designed to assess and benchmark LGBTQ-inclusive service provision amongst health, wellbeing and human service providers.
LGBTIQ Support – PHN North Western Melbourne bit.ly/3yG30cL	Several online training modules and other resources for GPs, designed to enable better care for LGBTIQ people.
MindOut https://bit.ly/3mm6TNr	Training and community of practice re LGBTI mental health.
INTERSEX INCLUSIVE PRACTICE	
Intersex Human Rights Australia - Healthcare Pathways https://bit.ly/3pSg8ae	Provides a comprehensive suite of resources practitioners can use to ensure they are knowledgeable and competent to treat and support intersex patients
Intersex Human Rights Australia - Inclusive Practice https://bit.ly/3pliyrY	These resources are aimed at making services intersex friendly.
Yellow Tick Training https://bit.ly/3Bm8c3k	The Yellow Tick is a community led initiative that assists groups develop intersex inclusive and affirmative practices for programs, clients, and staff.

References

1. Australian Bureau of Statistics (ABS). Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables. Updated January 14, 2021. Accessed September 21, 2021. https://www.abs.gov.au/statistics/standards/standard-sex-gender-variations-sex-characteristics-and-sexual-orientation-variables/latest-release
2. Victorian Government. LGBTIQ+ Inclusive Language Guide. Updated August, 2021. Accessed September 21, 2021. https://www.vic.gov.au/inclusive-language-guide
3. Rainbow Tick. Rainbow Health Victoria. Accessed September 21, 2021. https://www.rainbowhealthvic.org.au/rainbow-tick
4. Tavits M, Pérez EO. Language influences mass opinion toward gender and LGBT equality. *Proc Natl Acad Sci USA*. 2019;116(34):16781-16786. doi:10.1073/pnas.1908156116
5. Hill AO, Bourne A, McNair R, Carman M, Lyons A. Private Lives 3: The health and wellbeing of LGBTQ people in Victoria: Victoria summary report. ARCSHS Monograph Series No. 130. La Trobe University, Australian Research Centre in Sex, Health and Society; 2021. https://www.latrobe.edu.au/__data/assets/pdf_file/0005/1229468/Private-Lives-3-The-health-and-wellbeing-of-LGBTQ-people-in-Victoria.pdf
6. Jones T, Hart B, Carpenter M, Ansara G, Leonard W, Lucke J. *Intersex: stories and statistics from Australia. Cambridge*: Open Book Publishers; 2016. doi:10.11647/OBP.0089
7. Victorian Agency for Health Information. The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex and queer population in Victoria. Findings from the Victorian Population Health Survey 2017. Updated November, 2020. Accessed September 21, 2021. https://www.bettersafercare.vic.gov.au/sites/default/files/2020-09/The-health-and-wellbeing-of-the-LGBTIQ-population-in-Victoria.pdf
8. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull.* 2003;129(5):674-697. doi:10.1037/0033-2909.129.5.674
9. Hatzenbuehler ML, Link BG. Introduction to the special issue on structural stigma and health. *Soc Sci Med.* 2014;103:1-6. doi:10.1016/j.socscimed.2013.12.017
10. Saxby K, de New SC, Petrie D. Structural stigma and sexual orientation disparities in healthcare use: Evidence from Australian Census-linked-administrative data. *Soc Sci Med.* 2020;255:113027. doi:10.1016/j.socscimed.2020.113027
11. McNair R, Hegarty K, Taft A. Disclosure for same-sex attracted women enhancing the quality of the patient-doctor relationship in general practice. *Aust Fam Physician*. 2015;44(8):573-578.
12. Centre for Family Research and Evaluation. New parents, new possibilities. Updated July, 2021. Accessed September 21, 2021. https://cfre.org.au/new-parents-new-possibilities/#Overview_and_Final_Report
13. Victorian Government. Pride, Respect, Equality. Updated March 24, 2021. Accessed September 21, 2021. https://www.respectvictoria.vic.gov.au/campaigns/pride-respect-equality
14. Barrett B, St Pierre M. Intimate partner violence reported by lesbian-, gay-, and bisexual-identified individuals living in Canada: An exploration of within-group variations. *J Gay Lesbian Soc Serv*. 2013; 25(1):1-23. doi:10.1080/10538720.2013.751887
15. Peitzmeier SM, Malik M, Kattari S, et al. Intimate Partner Violence in Transgender Populations: Systematic Review and Meta-analysis of Prevalence and Correlates. *Am J Public Health*. 2020;110(9):e1-e14. doi:10.2105/AJPH.2020.305774
16. Carpenter, M. Domestic and family violence. Intersex Human Rights Australia. Updated July 6, 2021. Accessed September 21, 2021. https://ihra.org.au/familyviolence/
17. Index and Benchmarking: Health + Wellbeing Index. Pride in Health and Wellbeing. Accessed September 21, 2021. https://www.prideinhealth.com.au/index-benchmarking/
18. The Yellow Tick. Darlington Statement. Published November, 2020. Accessed September 21, 2021. https://darlington.org.au/yellowtick/
19. Department of Premier and Cabinet. Victorian Government Family Violence Data Collection Framework. Victorian Government. Updated January, 2020. Accessed September 21, 2021. https://www.vic.gov.au/victorian-family-violence-data-collection-framework

20. ACON. A Blueprint For Improving The Health & Wellbeing of the Trans & Gender Diverse Community in NSW. AIDS Council of New South Wales. 2019. Accessed September 21, 2021. https://www.acon.org.au/wp-content/uploads/2019/04/ACON-TGD-Health-Blueprint-Booklet.pdf
21. Australasian Sexual Health Alliance. Australian STI Management Guidelines for use in Primary care. Updated February 10, 2020. Accessed September 21, 2021. http://www.sti.guidelines.org.au/populations-and-situations/msm
22. Commonwealth of Australia. National Drug Strategy Household Survey 2019. Australian Institute of Health and Welfare. Updated March 24, 2021. Accessed September 21, 2021. https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/contents/summary
23. Brown R, McNair R, Szalacha L, Livingston PM, Hughes T. Cancer Risk Factors, Diagnosis and Sexual Identity in the Australian Longitudinal Study of Women's Health. *Women's Health Issues.* 2015. 25(5):509-16. doi:10.1016/j.whi.2015.04.001
24. Dempsey D. Same-sex parented families in Australia. Australian Institute of Family Studies; CFCA Paper No.18 2013. Accessed September 21, 2021. https://aifs.gov.au/cfca/sites/default/files/cfca/pubs/papers/a145197/cfca18.pdf
25. ACON. Smoke free still fierce. Accessed September 21, 2021. https://www.acon.org.au/who-we-are-here-for/women/smoke-free-still-fierce-project/
26. ReThink The Drink. Couldn't have done that with a hangover! Accessed September 21, 2021. https://rethinkthedrink.org.au/
27. Grulich AE, de Visser RO, Badcock PB, et al. Knowledge about and experience of sexually transmissible infections in a representative sample of adults: the Second Australian Study of Health and Relationships. *Sex Health.* 2014;11(5):481-94. doi:10.1071/SH14121
28. Commonwealth of Australia. Who should get a cervical screening test. Department of Health. Updated November 25, 2020. Accessed September 21, 2021. https://www.health.gov.au/initiatives-and-programs/national-cervical-screening-program/getting-a-cervical-screening-test/who-should-get-a-cervical-screening-test
29. Cancer Council Victoria. Public Cervix Announcement new campaign highlights safe inclusive cervical screening for LGBTIQ people. November, 2019. Accessed September 21, 2021. https://www.cancervic.org.au/about/media-releases/2019-media-releases/november-2019/public-cervix-announcement-new-campaign-highlights-safe-inclusive-cervical-screening-f.html
30. The Inner Circle. Accessed September 21, 2021. https://www.theinnercircle.org.au/
31. Holland K, Brito J (medical reviewer). 16 Things to Know About Hematolagnia, or Blood Play. Healthline. June 26, 2019. Accessed 29 September 2021. https://www.healthline.com/health/bloodplay
32. Drysdale K, Cama E, Botfield J, Bear B, Cerio R, Newman CE. Targeting cancer prevention and screening interventions to LGBTQ communities: A scoping review. *Health Soc Care Community.* 2021;29(5):1233-48. doi:10.1111/hsc.13257
33. Szalacha LA, Hughes TL, McNair R, Loxton D. Mental health, sexual identity, and interpersonal violence: Findings from the Australian longitudinal Women's health study. *BMC Womens Health.* 2017;17(1):94. doi:10.1186/s12905-017-0452-5
34. The World Egg Bank. Australian Recipients. Accessed September 21, 2021. https://www.theworldeggbank.com/intended-parent/getting-started/australian-recipients/
35. The Kirby Institute. HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2018. Accessed September 21, 2021 https://kirby.unsw.edu.au/report/hiv-viral-hepatitis-and-sexually-transmissible-infections-australia-annual-surveillance
36. Australian Sexual Health Alliance. Standard Asymptomatic Check-Up. Updated February, 2020. Accessed September 21, 2021. http://www.sti.guidelines.org.au/standard-asymptomatic-check-up
37. Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM). PrEP. Accessed September 21, 2021. https://prepguidelines.com.au/

38. Australasian Sexual Health Alliance. Australian National Guidelines of Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV, Australian National Guidelines (second edition): Laboratory assessment and follow-up. Accessed September 21, 2021. http://www.pep.guidelines.org.au/index.php/management-of-an-individual/laboratory-assessment-and-follow-up
39. Australasian Sexual Health Alliance. Post-Exposure Prophylaxis (PEP). Accessed September 21, 2021. https://www.ashm.org.au/HIV/hiv-management/PEP/
40. The Royal Australian College of General Practitioners. Early detection of cancers. In: Guidelines for preventive activities in general practice. 9th ed. East Melbourne, Vic: RACGP, 2016:104-21. Accessed September 21, 2021. https://www.racgp.org.au/download/Documents/Guidelines/Redbook9/17048-Red-Book-9th-Edition.pdf
41. Australasian Sexual Health Alliance. Anal cancer in men living with HIV. Accessed September 21, 2021. https://www.ashm.org.au/HIV/hiv-management/anal-cancer/
42. Cheung AS, Wynne K, Erasmus J, Murray S, Zajac JD. Position statement on the hormonal management of adult transgender and gender diverse individuals. *Med J Aust.* 2019;211(3):127-133. doi:10.5694/mja2.50259
43. Cundill P, Brownhill A, Locke P. Protocols for the initiation of hormone therapy for trans and gender diverse patients Version 2.0. Equinox Gender Diverse Health Centre. June, 2020. Accessed September 21, 2021. https://equinoxdotorgdotau.files.wordpress.com/2020/08/protocol-for-the-initiation-of-hormone-therapy-v2-aug-2020.pdf
44. Telfer MM, Tollit MA, Pace CC, Pang KC. Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents Version 1.3. The Royal Children's Hospital. 2020. Accessed September 21, 2021. https://www.rch.org.au/uploadedFiles/Main/Content/adolescent-medicine/australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and-adolescents.pdf
45. Social affirmation. Trans Hub. Accessed Sept. 2021. https://www.transhub.org.au/social
46. Updating your gender details with us. Services Australia. Updated May 27, 2021. Accessed September 21, 2021. https://www.servicesaustralia.gov.au/updating-your-gender-details-with-us?context=21826
47. Australian Passport Office. Sex and gender diverse passport applicants. Department of Foreign Affairs and Trade. Accessed September 21, 2021. https://www.passports.gov.au/getting-passport-how-it-works/documents-you-need/sex-and-gender-diverse-passport-applicants
48. Service Providers. Aus Path. Accessed September 21, 2021. https://auspath.org/providers/
49. Informed consent. Trans Hub. Accessed September 21, 2021 https://www.transhub.org.au/clinicians/informed-consent
50. The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. Version 7.0. 2011. Accessed September 21, 2021. https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf
51. Ainsworth AJ, Allyse M, Khan Z. Fertility preservation for transgender individuals: A review. *Mayo Clin Proc.* 2020;95(4):784-92. doi:10.1016/j.mayocp.2019.10.040
52. Substance use. Trans Hub. Accessed September 21, 2021. https://www.transhub.org.au/substance-use
53. Callander D, Wiggins J, Rosenberg S, et al. The 2018 Australian Trans and Gender Diverse Sexual Health Survey: Report of Findings. The Kirby Institute. 2019. Accessed September 21, 2021. https://kirby.unsw.edu.au/sites/default/files/kirby/report/ATGD-Sexual-Health-Survey-Report_2018.pdf
54. Rosenberg S, Callander D, Holt M, et al. Cisgenderism and transphobia in sexual health care and associations with testing for HIV and other sexually transmitted infections: Findings from the Australian Trans & Gender Diverse Sexual Health Survey. *PLoS One.* 2021;16(7):e0253589. doi:10.1371/journal.pone.0253589
55. Who should get a Cervical Screening Test. Department of Health. Updated November 25, 2020. Accessed September 21, 2021. https://www.health.gov.au/initiatives-and-programs/national-cervical-screening-program/getting-a-cervical-screening-test/who-should-get-a-cervical-screening-test
56. National Cervical Screening Program – Self-collection and the cervical screening test. Department of Health. Updated September 16, 2021. Accessed September 21, 2021. https://www.health.gov.au/resources/publications/national-cervical-screening-program-self-collection-and-the-cervical-screening-test
57. Breast/chest screening. Trans Hub. Accessed September 21, 2021. https://www.transhub.org.au/breast-chest-screening?rq=breast%20cancer
58. Prostate cancer diagnosis in trans women. Prostate Cancer UK. Updated October, 2020. Accessed September 21, 2021. https://prostatecanceruk.org/prostate-information/prostate-tests/prostate-cancer-diagnosis-in-trans-women

59. Deebel NA, Morin JP, Autorino R, Vince R, Grob B, Hampton LJ. Prostate Cancer in Transgender Women: Incidence, Etiopathogenesis, and Management Challenges. *Urology.* 2017;110:166-171. doi:10.1016/j.urology.2017.08.032

60. Restrictions in use of cyproterone due to meningioma risk. ESMO. February 19, 2020. Accessed September 21, 2021. https://www.esmo.org/oncology-news/restrictions-in-use-of-cyproterone-due-to-meningioma-risk

61. Carpenter, M. Intersex Variations, Human Rights, and the International Classification of Diseases. *Health Hum Rights.* 2018;20(2):205–14

62. Background Note on Human Rights Violations against Intersex People. Office of the High Commissioner for Human Rights. 2019. Accessed September 21, 2021. https://www.ohchr.org/sites/default/files/Documents/Issues/Discrimination/LGBT/BackgroundNoteHumanRightsViolationsagainstIntersexPeople.pdf

63. Second Report: Involuntary or Coerced Sterilisation of Intersex People in Australia. Senate of Australia Community Affairs References Committee. October 23, 2013. Accessed September 21, 2021. http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Involuntary_Sterilisation/Sec_Report/index

64. Miller WL, Witchel SF. Prenatal treatment of congenital adrenal hyperplasia: risks outweigh benefits. *Am J Obstet Gynecol.* 2013;208(5):354-9. doi:10.1016/j.ajog.2012.10.885

65. Hughes, I. Prenatal treatment of congenital adrenal hyperplasia: do we have enough evidence? *Treat Endocrinol.* 2006;(5):1–6. doi:10.2165/00024677-200605010-00001

66. Dreger A, Feder EK, Tamar-Mattis A. Prenatal Dexamethasone for Congenital Adrenal Hyperplasia, An Ethics Canary in the Modern Medical Mine. *J Bioeth Inq.* 2012;9(3):277-94. doi:10.1007/s11673-012-9384-9

67. Kirk EP, Ong R, Boggs K. et al. Gene selection for the Australian Reproductive Genetic Carrier Screening Project ("Mackenzie's Mission"). *Eur J Hum Genet.* 2021;(29):79–87. doi:10.1038/s41431-020-0685-x

68. Jones T, Leonard W, Rostant J (ed). Health and wellbeing of people with intersex variations: information and resource paper. Victorian Department of Health and Human Services. Department of Health and Human Services 2016–2018 Intersex Expert Advisory Group. Available at Health of people with intersex variations, Health.Vic. Accessed September 21, 2021. https://www2.health.vic.gov.au/about/publications/policiesandguidelines/health-wellbeing-people-with-intersex-variations-information-resource-paper

69. Genetic condition that affects the adrenal glands added to newborn screening test. VCGS. August 14, 2021. Accessed September 21, 2021. https://www.vcgs.org.au/news/genetic-condition-affects-adrenal-glands-added-newborn-screening-test

70. Newborn bloodspot screening resources. Department of Health. Updated November 10, 2020. Accessed September 21, 2021. https://www.health.gov.au/resources/collections/newborn-bloodspot-screening-resources

71. Vora KA, Hanna CA, Neville KA, et al. Role of cross-campus multidisciplinary team meetings in decision-making for children and adolescents with differences of sex development/intersex. *J Paediatr Child Health.* 2021;57(9):1402-7. doi:10.1111/jpc.15474

72. Timmermans S, Yang A, Gardner M, et al. does patient-centered care change genital surgery decisions? The strategic use of clinical uncertainty in disorders of sex development clinics. *J Health Soc Behav.* 2018;59(4):520-535. doi:10.1177/0022146518802460

73. Vavilov S, Smith G, Starkey M, et al. Parental decision regret in childhood hypospadias surgery: a systematic review. *J Paediatr Child Health.* 2020;56(10):1514-1520. doi:10.1111/jpc.15075

74. Sandberg D. A Call for Clinical Research. In Hermaphrodites with Attitude. 1995:8–9. http://www.isna.org/files/hwa/winter1996.pdf

75. Vora KA, Srinivasan S. A guide to differences/disorders of sex development/intersex in children and adolescents. *Aust J Gen Pract.* 2020;49(7):417–22. doi:10.31128/AJGP-03-20-5266.

76. AIS Support Group Australia, Intersex Trust Aotearoa New Zealand, Organisation Intersex International Australia, et al. Darlington Statement. March, 2017. Accessed September 21, 2021. https://darlington.org.au/statement

77. Protecting the human rights of people born with variations in sex characteristics in the context of medical interventions: Consultation Paper. Australian Human Rights Commission. July, 2018. Accessed October 18, 2021. https://humanrights.gov.au/sites/default/files/AHRC_Consultation%20paper_2018_2.pdf.

78. The Office of LGBTIQ+ Affairs. Chief Minister, Treasury and Economic Development Directorate ACT. Accessed September 21, 2021. https://www.cmtedd.act.gov.au/policystrategic/the-office-of-lgbtiq-affairs
79. Machado PS, Costa AB, Nardi HC, Fontanari AMV, Araujo IR, Knauth DR. Follow-up of psychological outcomes of interventions in patients diagnosed with disorders of sexual development: a systematic review. *J Health Psychol.* 2016;21(10). doi:10.1177/1359105315572454.
80. Lee PA, Nordenström A, Houk CP, et al. Global disorders of sex development update since 2006: Perceptions, approach and care. *Horm Res Paediatr.* 2016;85(3):158–80. doi:10.1159/000442975
81. Blackwood, V. Handling health information of intersex individuals. Privacy Commissioner (NZ). March 2, 2018. Accessed September 21, 2021. https://www.privacy.org.nz/blog/handling-health-information-of-intersex-individuals
82. Callens N, Kreukels BPC, van de Grift TC. Young voices: sexual health and transition care needs in adolescents with intersex/differences of sex development—A pilot study. *J Pediatr Adol Gynec.* 2021;34(2):176-189.e2. doi:10.1016/j.jpag.2020.11.001.
83. González R, Ludwikowski BM. Should CAH in females be classified as DSD? *Front Pediatr.* 2016;4:48. doi:10.3389/fped.2016.00048
84. Behrens KG. a principled ethical approach to intersex paediatric surgeries. BMC Med Ethics. 2020;21(1):108. https://doi.org/10.1186/s12910-020-00550-x
85. Skerrett DM, Kolves K, De Leo D. Factors related to suicide in LGBT populations: A psychological autopsy case-control study in Australia. *Crisis.* 2016;37(5):361-9. doi:10.1027/0227-5910/a000423
86. Leonard W, Mann R. The everyday experience of lesbian, gay, bisexual, transgender and intersex (LGBTI) people living with disablity. No. 111. GLHV@ARCSHS, La Trobe University: Melbourne. 2018. Accessed September 21, 2021. https://www.rainbowhealthvic.org.au/media/pages/research-resources/the-everyday-experiences-of-lesbian-gay-bisexual-transgender-and-intersex-lgbti-people-living-with-disability/1242611313-1605661766/the-everyday-experiences-of-lesbian-gay-bisexual-transgender-and-intersex-lgbti-people-living-with-disability.pdf
87. Hopkinson RA, Keatley E, Glaeser E, Erickson-Schroth L, Fattal O, Nicholson Sullivan M. Persecution experiences and mental health of LGBT asylum seekers. *J Homosex.* 2017;64(12):1650-66. doi:10.1080/00918369.2016.1253392.
88. Strauss P, Cook A, Winter S, Watson V, Wright Toussaint D, Lin A. mental health issues and complex experiences of abuse among trans and gender diverse young people: Findings from trans pathways. *LGBT Health.* 2020;7(3):128-136. doi:10.1089/lgbt.2019.0232
89. Van Der Miesen AI, Hurley H, De Vries AL. Gender dysphoria and autism spectrum disorder: A narrative review. *Int Rev Psychiatry.* 2016;28(1):70-80. doi:10.3109/09540261.2015.1111199
90. MindOut: Mental Health and Suicide Prevention. LGBTIQ+ Health Australia. Accessed September 21, 2021. https://www.lgbtiqhealth.org.au/mindout
91. Kwon P. Resilience in lesbian, gay, and bisexual individuals. *Pers Soc Psychol Rev.* 2013;17(4):371-383. doi:10.1177/1088868313490248
92. Kia H, MacKinnon KR, Abramovich A, Bonato S. Peer support as a protective factor against suicide in trans populations: A scoping review. *Soc Sci Med.* 2021;279:114026. doi:10.1016/j.socscimed.2021.114026
93. McNair RP, Bush R. Mental health help seeking patterns and associations among Australian same sex attracted women, trans and gender diverse people: a survey-based study. *BMC Psychiatry.* 2016;16:209. doi:10.1186/s12888-016-0916-4
94. Hughes M. Health and well being of lesbian, gay, bisexual, transgender and intersex people aged 50 years and over. *Aust Health Rev.* 2018;42(2):146-151. doi:10.1071/AH16200
95. The 2021 update: Snapshot of mental health and suicide prevention statistics for LGBTIQ+ people. LGBTIQ+ Health Australia. May 13, 2021. Accessed September 21, 2021. https://www.lgbtiqhealth.org.au/statistics#_Toc68881011
96. Leonard W, Pitts M, Mitchell A, et al. Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians. ARCSHS Monograph Series No. 86. La Trobe University, Australian Research Centre in Sex, Health and Society; 2012. Accessed September 21, 2021. https://www.acon.org.au/wp-content/uploads/2015/04/PrivateLives2-report-2012.pdf

97. National Alliance for Caregiving, AARP Public Policy Institute. Caregiving in the United States 2015. AARP Public Policy Institute. June 4, 2015. Accessed September 21, 2021. https://www.aarp.org/ppi/info-2015/caregiving-in-the-united-states-2015.html

98. Barrett C, Whyte C, Leonard W, Comfort J. no need to straighten up: discrimination, depression, anxiety and older lesbian, gay, bisexual, transgender and intersex Australians. La Trobe University, Australian Research Centre in Sex, Health and Society. 2015. Accessed September 21, 2021. https://www.opalinstitute.org/uploads/1/5/3/9/15399992/nntsu_-_full_report_-_print_read.pdf

99. Alba B, Lyons A, Waling A, et al. Older lesbian and gay adults' perceptions of barriers and facilitators to accessing health and aged care services in Australia. *Health Soc Care Community.* 2021;29(4):918-927. doi:10.1111/hsc.13125

100. Hughes M. Older lesbians and gays accessing health and aged care services. Aust Soc Work. 2007;60(2):197-209. doi:10.1080/03124070701323824

101. Hsieh N, Liu H, Lai WH. Elevated risk of cognitive impairment among older sexual minorities: do health conditions, health behaviors, and social connections matter? *Gerontologist.* 2021;61(3):352-362. doi:10.1093/geront/gnaa136

102. Cousins E, de Vries K, Dening K. LGBTQ+ people living with dementia: an under-served population. *BJHCA.* 2021;15(1):26-35. doi:10.12968/bjha.2021.15.1.26

103. Hughes M, Cartwright C. Lesbian, gay, bisexual and transgender people's attitudes to end-of-life decision-making and advance care planning. *Australas J Ageing.* 2015;34 Suppl 2:39-43. doi:10.1111/ajag.12268

104. Safeguarding the End of the Rainbow: A guide to help LGBTI people to plan an end of life of their choice. COTA Victoria. March, 2018. Accessed September 21, 2021. https://d3n8a8pro7vhmx.cloudfront.net/lgbtihealth/pages/668/attachments/original/1585530052/Safeguarding-the-End-of-the-Rainbow-Booklet-V1.pdf?1585530052

105. Chief Minister, Treasury and Economic Development Directorate. Prohibition of deferrable medical interventions on intersex people: listening report on submissions received. April, 2021. Accessed October 18, 2021. https://www.cmtedd.act.gov.au/__data/assets/pdf_file/0008/1745837/Intersex-Project-Listening-Report-final-v.2.pdf.

106. 106. Department of Health and Human Services. (i) Am Equal. Health.vic. May, 2021. Accessed October 19, 2021. https://www2.health.vic.gov.au/about/publications/factsheets/i-am-equal.

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