RESEARCH

BUILDING THE EVIDENCE BASE OF RISK AND PROTECTIVE FACTORS FOR DEPRESSION AND ANXIETY WITHIN THE LGBQ COMMUNITY

Centre for FAMILY RESEARCH and EVALUATION

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Project Title: Building the evidence base of risk and protective factors for depression and anxiety within the LGBQ Community.

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BRIEF DESCRIPTION OF THE PROJECT

International and Australian research shows high prevalence rates of depression, anxiety and other mental health issues within Lesbian, Gay, Bisexual and Transgender, Intersex and (Sexual Identity) Questioning/Queer (LGBTIQ) communities as compared to the general population[1]. While a substantial body of research identifying risk and protective factors for mental health and illness for general populations in Australia and other Western societies has been conducted, we cannot assume findings from general risk and protective research applies to specific groups such as sex, gender and sexuality diverse people.

Much of the literature addressing disparities in mental health across sex, gender and sexuality argues homophobia and transphobia are the social forces responsible for poorer outcomes in LGBTIQ communities[2], however, research is only starting to explore the specific pathways to mental health and illness for same-sex attracted and sex and/or gender diverse groups, and to provide evidence for exposure to homophobia or transphobia being related to higher rates of mental illness[3].

This research project therefore sought to: 1) undertake qualitative research to identify risk and protective factors present within the LGBTIQ (specifically LGBQ) clients attending for counselling in a 'mainstream' but well known queer-friendly, family service agency in inner Melbourne, within a three year period; and 2) to explore the relationship of these risk and protective factors to the presence or absence of depression and anxiety diagnosis. In addition to making a contribution to the existing knowledge base in this area, The project, in addition to making a contribution to the existing knowledge base in this area, also intended to inform practical interventions, such as the development of future community public health initiatives, targeted at reducing the rates of anxiety and depression for sex, gender and sexuality diverse people.

drummond street services (**drummond street**), a 125+ year-old organisation, in the inner Melbourne suburb of Carlton, is uniquely placed to contribute to this knowledge base. This family service agency, which has for the past 40+ years built its reputation within the Melbourne LGBTIQ ('Queer') community, for providing valuable queer-specific counselling services, by both queer-friendly and queer-identified counsellors, and within a queer-affirmative agency, is well connected within the broader LGBTIQ community and service system and a well-respected advocate of the needs of this diverse group. **drummond street** has conducted Queer research previously, for example, community consultation undertaken at LGBTIQ community events and festivals and focus groups, and via online surveys, and provision of a policy paper in relation to Australian LGBTI separated families to the federal government's Child Support Program. This initial work formed the basis for this project's in-depth and systematic exploration of the risk and protective factors present in LGBTIQ community members presenting for counselling at **drummond street**'s family service agency.

Over the past eight years, **drummond street** has obtained written consent for use of clinical files for research, and undertaken substantial data collection in relation to presenting clients. Data available includes demographic and presenting needs information (according to given categories) at the point of intake to the agency and recorded in an electronic client information system (See **Appendix 1** for **drummond street**'s 'Client Intake Form'), as well as client files which include assessment information, content and process notes regarding counselling sessions attended, and information pertaining to the conclusion of service, including needs addressed.

A large body of data therefore, is available for analysis in regards to LGBQ community members presenting for supportive counselling services at this agency over a lengthy period of time. For this research project, non-heterosexual clients 18 years and over, and attending the service within a three year period, from July 1 2008 to June 30 2011, were targeted, and in-depth clinical file audits were undertaken in relation to risk and protective factors which may relate to mental illness and mental health, within this sample. We were not able to conduct in-depth clinical file audits on the heterosexual comparative sample at this time.

The original title of this project was "Building the evidence base of risk and protective factors for depression and anxiety within the LGBTI Community", however the preliminary analysis outlined in this report addresses only the needs of clients based on sexuality (i.e. gay, lesbian, bisexual and questioning) but not sex and/or gender diversity (T) or intersexuality (I). A limitation of this preliminary analysis had been relying on the categories used at the intake screening process, which captured sexuality but not whether someone identifies under the T or I of the LGBTI umbrella, although this was explored within the file audits. Therefore, we were not confident if the sample included people who identified as intersex and the project was refocused and names to reflect the research's sample. Based on the data of case file notes there were at least 20 clients who identified as transgender, transsexual, genderqueer or as exploring their gendered identities, and we intend to conduct further analysis on the experiences of this sex and/or gender diverse group of clients in the future.

There are clear and significant limitations to this current study, however this is the first research of this nature undertaken that we are aware of, and our data and analyses provides very interesting preliminary findings, and specific directions for further analysis and validation, as well as directions for policy and practice.

1) AIMS AND OBJECTIVES

The research project therefore aimed to:

(a) Identify and model the key risk and protective factors for depression and anxiety;

(b) Determine pathways to mental health issues and illness;

(c) Identify factors which build resilience, and support treatment and recovery and the specific needs of sub-groups within the community;

(d) Develop a screening and outcome measure able to accurately identify common mental health problems together with risk and protective factors which can be used in routine clinical practice specifically with reference to the LGBTIQ community.

It was anticipated that this research would also provide invaluable early evidence to support the development of a comprehensive public health approach to responding to depression and anxiety within the LGBTIQ communities.

2) METHODS

It was initially estimated that the project would conduct data mining on over 600 client files, however, the provision of over 600 'episodes of care' within a three year period, to non-heterosexual community members, translated to 299 individual clients who attended the service during this time, and for which comprehensive client files with appropriate level of data was available for analysis. The initial specified audit period of June 30 2008 to April 30 2011 was extended to 30th June 2011, given this data was now available. All cases open within this timeframe (i.e. commencing before or during this period, and completing during or after this period) were targeted for analysis. During this period, 2908 episodes of care were provided for heterosexual clients at this service, and 814 episodes of care were provided for non-hetero-sexual clients, the latter of which accounts for 27.9% of clients attending for counselling within this three year period. Of these 814 clients, 34 episodes involved undertaking the agency 'intake' process only, and not proceeding to a counselling service with this agency, for a variety of reasons, often relating to waiting list times, or identification of a more suitable service.

During the period of the project, **drummond street** has undertaken five focus groups with local same-sex-attracted women, and collected a further 141 online surveys in relation to pathways to health and illness within the local and broader Australian queer community, which are able to be combined with the findings of our earlier GLBTI community health perceptions surveys collected at the GLBTI Midsumma Festivals of March 2010 (n=135) and 2012 (n=130). (A copy of the Queer Bill of Health Online Survey is available in **Appendix 2**). We are currently in the process of seeking further funding to analyse these results in the context of the findings of this research project.

As intended, this audit included analyses regarding demographic information, presenting issues, and risk and protective factors relating to the individual, their family, school/work/peers, local community and society, as identified in client files and in the literature, as associated with the development of mental health issues and illness. For example, risk and protective factors identified and analysed related to individual cognitive and coping styles, physical health, and health risk behaviours family of origin, current relationship and parenting, experience of stressful life events, school/work factors, social connection within queer and mainstream communities, and queer-specific relationship and risk factors including exposure to homophobia and current identity transition (for example currently 'questioning' sexuality). A complete list of risk and protective factors identified and audited within files, is provided in **Appendix 3**.

The following are explorations which have not been the focus of the present study on mental health risk and protective factors within the LGBTIQ community: Age; other than considering clients who are in the transition stage of 'Questioning', analyses have not yet been completed specifically regarding issues relating development of sexual identity; other than association of experience of child sexual abuse to experience of mental illness, analyses have not yet been completed in relation to other specific experiences within the family of origin; in-depth file audits in relation to heterosexual clients attending the same service during the same timeframe, have not been completed at this time, yet would provide invaluable comparison information regarding distinguishing the nature and frequencies of risk and protective factors across heterosexual and non-heterosexual groups; the current analyses provide some initial data in relation to sex, gender and sexuality diverse subgroups, however further analyses are required to distinguish risk and protective factors across these groups,

and possibly factors unique for the latter two groups in particular; and while information regarding past and current service use has been collected, however has not been analysed at this time.

Some of the limitations of this study are following. The project undertook retrospective analyses regarding risk and protective factors present in existing client counselling files. Documentation was created for the purpose of recording a summary of the counselling session discussion content and process, and not for the purpose of research, or risk and protective factor 'collection'. Limitations exist in this method, particularly in terms of records being an incomplete record of discussions and of risk issues that may be present within a client's life. Counselling discussions focus on those issues the client and the counsellor identify as pertinent or as having meaning, at that time, and case records may also be biased towards counsellor theoretical frameworks and perspectives.

On this basis, factors identified and frequencies reported are acknowledged to be conservative estimates, as well as containing possible biases in terms of what is actually discussed or documented in the file notes. The data available pertains to LGBTQ clients presenting at one particular family service agency, within inner Melbourne, with LGBTQ and mental health specialties, and well known to the local LGBTIQ community. Causal relationships cannot be assumed from the current research, merely associations. Qualitative data is available for future exploration of the nature of the link between the identified risk and protective factors and the clients' mental health.

While this research is limited given the funding, timeline and possible scope of the project, this has been the first step in identifying possible risk and protective factors, and their prevalence and associations, within this sample and has been invaluable in developing the thinking and methodology for a larger trial. A 'Screening and Outcomes Tool' (able to identify mental health status, together with risk and protective factors) for possible use in routine LGBTIQ clinical practice has been drafted as an outcome of the current research project. It has been beyond the capacity of the current project to undertake prospective data collection with new or current clients attending the service to further validate the current results and to trial this measure, however the tool is now available for a larger study in order to validate the measures and to provide pre and post intervention client outcome data. As evidenced, **drummond street's** services are well attended by the local and broader Melbourne Queer community and **drummond street** has a well-developed community engagement capacity, which is able to be garnered for this future work. Additional Queer Affirmative services could also be identified to trial the tool.

As anticipated, a purpose designed survey/audit instrument was developed which included items able to be identified by a researcher revising the content of a client file, for qualitative analysis, and a manual was provided to enable reliable audit completion by different staff (**Appendix 3**). Quantitative data analysis regarding the key risk and protective factors for depression and anxiety in LGBTQ communities was undertaken using multivariate modelling techniques. While there were additional intentions at the outset, the following are the key objectives which directed data analyses for the current report (with findings presented further below). Key objectives of data analyses were as follows:

1. Using inductive and deductive reasoning processes, identify a comprehensive list of risk and protective factors for file audit

2. Identify risk and protective factors most frequently present/identified within this sample
3. Identify via Chi Square analysis, presence (or otherwise) of correlation between the most frequent risk and protective factors and presence or absence of mental illness as follows:
    a. Depression diagnosis only
    b. Anxiety diagnosis only
    c. Both depression and anxiety diagnosis
    d. Other mental illness diagnosis
    e. Any mental illness diagnosis (c and d)
    f. No mental illness diagnosis
4. Identify via Chi Square analysis, presence (or otherwise) of correlation between risk factors commonly identified within mainstream literature to relate to depression and anxiety diagnosis (for example, employment and cognitive factors) and presence or absence of mental illness as above.
5. Explore differences in mental illness diagnosis for the subtypes of Gay, Lesbian, Bisexual, Transgender, and for those Questioning sexuality.
6. Explore the relationship between exposure to homophobia, and depression and anxiety diagnoses.

Prior to any information being extracted from client files, approval for the research was received from the Human Research Ethics Committee at Deakin University (DUHREC). The process of data audit and mining of clinical files was guided by practice-based research strategies outlined by Epstein (2002) and Giles et al. (2011)[4]. The development of the list of risk and protective factors began with an initial reading and qualitative content analysis of session notes, to extract data from 40 clinical files. 'Inductive' reasoning was used initially whereby themes and categories (also referred to as variables, factors or codes) emerged from the data through the researcher's careful examination and constant comparison. 'Deductive' reasoning was then employed to generate additional potential variables based on the current queer literature and clinical experience.

The list of potential codes, their definitions and examples was compiled into a coding manual, and consultation with queer-identified counsellors at **drummond street** was undertaken to ensure the correct wording was used for each code and to determine the ease of understanding of the codes' definitions, in order to further validate or amend the draft list of factors. Five coders (including both Queer-identified and Queer-friendly/not-identified Counsellors) were asked to complete coding of a sample session note, individually. Results were compared and further revisions were made to the coding manual and the data extraction form. Thirteen counsellors were recruited as coders and they were given a coding manual and data extraction forms, and allocated client files to audit. After all coding response sheets were received from coders, data was entered into a database and merged with another database containing clients' electronic Client Information System data regarding demographics, presenting needs, needs addressed, and dates and number of sessions attended, for analyses to be undertaken.

Six categories of mutually exclusive 'mental health status' were created using codes that asked whether clients had a past/present diagnosis of depression, or of anxiety, or both, or other mental illness, or any mental illness (depression,

anxiety or other), or no mental illness. The presence or otherwise of mental ill-health **symptoms**, as distinguished from diagnosis, while collected within the file audits, has not been the focus of the present study. It should be noted that many people with mental ill-health symptoms meeting diagnostic criteria do not seek support. Therefore, our record of frequency of 'past' or 'present' 'symptoms' likely includes clients who may previously or currently qualify for a clinical diagnosis. Our prevalence of mental health diagnoses within this sample both past and present therefore likely underestimates the rates of mental health disorders in this sample.

drummond Street implemented a fixed-time use of client counselling outcome measures from 2008 for two years, when the General Health Questionnaire (28 item) was used to measure mental health status pre and post counselling. This measure is able to indicate whether or not a client is likely to meet psychiatric diagnostic criteria and is therefore a measure of mental ill-health severity or likelihood of diagnosis. The period of client outcome measurement collection coincided roughly with the timelines of client attendance at **drummond street** for the current study, the integration of the data and analyses relating the two datasets could be analysed if further funding is secured in future.

Information pertaining to past or present diagnosis was used in the present study as the most accurate measure for mental health status available. Associations between mental illness status and other risk and protective variables were then examined. Due to an exhaustive list of risk and protective factors being generated (220), only a selected number of risk and protective factors were chosen to examine their associations with the five mental health categories. Key demographics and key factors or variables known to relate to mental illness within the literature and nineteen risk and ten protective factors that had the highest frequencies, were selected for analyses[1]. Chi square tests were used to explore the bivariate associations between these factors and the six mental health categories.

3) KEY FINDINGS

The results of our study are consistent with the literature on depression in terms of high prevalence rates of mental illness within same-sex-attracted populations, which may be expected within this sample seeking help. Our findings also indicate that risk and protective factors for mental illness, common to the mainstream community, are also present at high levels (while likely being an underestimate) within this sample as compared to the broader population. The current sample contains additional risk and protective factors unique to LGBTQ people. These results support the validity of the data collected, and the analyses conducted.

Table 1 below presents demographic information including sexual orientation, education level, employment status, income level, and factors associated with mental health in the literature, such sexual abuse in the family context, experiences of homophobia, and experiences of other trauma. Rates of depression, anxiety, comorbid depression and anxiety as well as rates of other mental health diagnoses are also presented.

1 'Strengthening relationships' presenting need was a high frequency factor identified, however this may be interpreted to be a risk or a protective factor, and further may relate more to the nature of the service being sought than the nature of the relationship, and therefore this factor was removed from the current analyses, hence 19 not 20 risk factors were examined.

TABLE 1.
SAMPLE CHARACTERISTICS REGARDING KEY DEMOGRAPHIC AND RISK FACTORS, AND MENTAL ILLNESS STATUS

Key Demographic & Risk Factors & Mental Illness Status	Percentage of clients (N=299)
Sexual identity	
Lesbian	49.5%
Gay	28.4%
Bi-sexual	15.1%
Questioning & unknown	6.4%
Education	
Up to Year 12	23.7%
Tertiary – degree	60.9%
Tertiary – post graduate	13.0%
Employed – including self-employed	77.9%
Unemployed – actively looking for a job	6.0%
Student / Not in the labour force (e.g. stay at home parent, volunteer, not looking for a job etc.)	15.1%
Income	
Low	50.4%
Middle	39.7%
High	9.9%
Sexual abuse in FOO – Yes	**9.7%**
Homophobia – Yes	**15.7%**
Trauma – Yes	**14.7%**
Mental health status categories	
Depression diagnosis past or present	**33.8%**
Anxiety diagnosis past or present	**23.4%**
Co-morbid depression and anxiety diagnoses	**9.7%**
Depression diagnosis at present	13.0%
Anxiety diagnosis at present	8.4%
Other mental illness diagnosis past or present	8.0%
No prior mental illness diagnosis past or present	68.2%

In relation to sample characteristics, the majority of the sample identified as female (68.2%), were born in Australia (75.3%), and speak English as their first language (96%). Almost half of the audited files were lesbian identified clients (49.5%), and although over half of the sample had completed university degrees (60.9%) and were employed (77.9%), 50.4% reported to have low income. Other variables associated with mental health risk were present in a sizable number of cases, such as sexual abuse in the family context (9.7%), experiences of homophobia (15.7%) and experiences of other trauma (14.7%), and higher than in the general population. A large proportion (41.8%) specifically requested to see a queer-identified counsellor, which suggests the availability of queer-specific services is important in enhancing the accessibility of mental health care for GLBTQ people.

Of the 299 people in our sample, 33.4% reported having been diagnosed with depression (as compared to a general lifetime prevalence of depression of 1 in 7 or ~14.3%) for the Australian population[5]. This is even higher than the finding of the ABS National Survey of Mental Health and Wellbeing (2007)[6] that 19.2% of same sex attracted respondents experienced affective disorders compared to the general population rate of 6.2%, which may be expected in a sample seeking help.

Of our sample, 13% reported a current diagnosis of depression at the time they attending counselling at **drummond street**, which compares to research indicating the national rate of people meeting criteria for an affective disorder in any 12-month period is 6.2% (ABS, 2007)[7]. We interpret results as likely significantly underestimating the actual rates of mental illness of the clients in our sample.

SEX AND/OR GENDER DIVERSITY

Of note, file audits revealed 20 clients could be considered to fall under the umbrella of sex and/or gender diverse, as distinct from being same-sex attracted or questioning sexuality. Results for these clients have been included within the broader results as organised based on sexuality, and qualitative and quantitative analyses are yet to be completed in relation to sex and/or gender diversity. On this basis, the current sample may be best described as same-sex attracted or questioning (LGBQ) clients, and our findings are not able to highlight specific issues for the 'T' in the LGBT umbrella in this initial phase of analysis. As noted earlier, we are not aware whether any of the clients in the sample identified as intersex (I), and while we acknowledge the importance (and lack) of research addressing the needs of intersex people this is beyond the scope of the present study.

RELATIONSHIPS OF RISK AND PROTECTIVE FACTORS TO MENTAL HEALTH

Along with identification of factors within files, analysis of relationships between risk and protective factors and mental health was approached both deductively and inductively: as predicted from the literature, and; as indicated by factors in the data with the highest frequencies. Analysis of relationships between key demographic and risk factors (as indicated from the literature) and mental health status (using categories from Table 1.) was conducted using Chi square tests to explore bivariate associations. Table 2, provided in **Appendix 5** presents the bivariate associations between these key demographic and risk factors, and the five mental health categories. Results relating to each mental health category are presented in that table. Findings indicated significant relationships between mental health status and the demographic factors of sexual identity and socioeconomic status, as well as risk factors of sexual abuse in family of origin (FOO) (which may in fact be higher than in the broader population), experience of homophobia, and other traumatic experiences.

Analysis of the relationships between the most frequently occurring risk and protective factors in the data, and mental health status was also conducted. The nineteen risk factors found in the highest frequencies, and the ten protective factors found in highest frequencies within the files, are presented below in Tables 3 and 4, respectively.

TABLE 2.
RISK FACTORS FOUND TO HAVE THE HIGHEST FREQUENCIES WITHIN FILES (N=299)

Risk Factors	Percentage of clients (%)
1. Challenge of sustaining a healthy relationship	51.2
2. Client finds it a challenge to believe in themselves and their own worth and value	40.2
3. Coping style at odds	35.5
4. Dependent/not able to assert needs/passive/ avoidant/victim role/avoids conflict	35.1
5. Emotional abuse (verbal) in intimate relationship	34.2
6. Rumination, difficulty solving problems, overwhelmed, procrastinating	33.4
7. Sexual issues in intimate relationship	32.5
8. Difficulty with emotional regulation	31.8
9. Values at odds	30.4
10. Internalise/blame self for problems	30.1
11. Has one or more children	28.4
12. Work/school stress	28.1
13. Distraction / avoidance	26.1
14. One or both clearly thinking about leaving/one or both not motivated to do work on relationship	26.1
15. Difficult relationship with father(s)	24.4
16. Significant life transitions	23.4
17. Sleep issues	22.7
18. General feelings of isolation	22.4
19. Difficult personality/inflexible/rigid/controlling personality traits/aggressive/ambivalent attachment style/perpetrator role/conflictual style	21.0

TABLE 3.
PROTECTIVE FACTORS FOUND TO HAVE THE HIGHEST FREQUENCIES WITHIN FILES (N=299)

Protective Factors	Percentage of clients (%)
1. Relationship strengthening	52.5
2. Supportive friends	44.1
3. Feeling connected with the wider community	28.7
4. Action orientation, focus on problem solving	28.1
5. Talking to a friend/trusted other	27.4
6. Involved in queer community – socialise with people who are queer	25.7
7. Supportive/close/positive relationship with mother(s)	25.0
8. Positive experiences with friends re: sexuality	25.0
9. Framing challenging experience as learning/growth experience	19.1
10. Positive experiences with family re: sexuality	18.0

Chi square tests were used to explore the bivariate associations between these frequent risk and protective factors and six 'mental health status' categories of 'depression diagnosis only', 'anxiety diagnosis only', 'comorbid anxiety and depression diagnoses', 'other mental health diagnosis', 'depression, anxiety and other mental health diagnoses', and finally 'no mental health diagnosis'. The bivariate associations between risk and protective factors and these mental health categories are presented in Tables 5 and 6, respectively, in **Appendix 5**. Chi Square results indicated ten out of the twenty risk factors were significantly related to at least one mental health category. Results are discussed further below.

HOMOPHOBIA AND MENTAL HEALTH

Four codes were used to conduct analysis of clients' experience of homophobia. These codes included: clients' experience of religious homophobia; internalised homophobia[2]; fear of experiencing homophobia; whether they had experienced homophobia identity shame, and/or social exclusion and judgment within the queer community itself. As can be seen in Table 2, homophobia was significantly related to all mental health categories except "depression only". A higher percentage of clients who had experienced homophobia reported having a diagnosis in the "anxiety only" (25.5%), "both depression and anxiety" (19.2%), and "other mental illnesses" (21.3%) categories. Clients whose files had no record of experiences of homophobia were more likely to have reported having no mental illness diagnosis (71%).

2 Our reasoning for including clients coded as experiencing internalised homophobia, regardless of whether there was a direct reference in the case file of these clients facing homophobia externally from others, was the assumption the conditions for internalised homophobia are some exposure to external homophobia.

As noted earlier, many studies have found higher rates of poor mental health outcomes for LGBTIQ, and it is generally asserted by researchers and policy makers that this higher level of risk is a consequence of the homophobia and heterosexism these people experience, while the evidence for this is still limited. Our findings provide further evidence for such an assertion. Associations between clients talking about experiences of homophobia in counselling and mental health outcomes in our data is as indicating those in our sample who experienced homophobia were more likely to develop a mental health issue.

However, here we also acknowledge a limitation in the data we were working with: we cannot assume a client whose file does not contain a record of them talking about homophobia in sessions had not ever experienced homophobia. Clients may have referred to homophobic incidents and the counsellor simply did not record this in the case notes. Alternatively, homophobic experience may not have been a core presenting issue for the client and therefore not a significant part of the therapeutic focus. Further, while we would expect **drummond street** counsellors to have a high degree of queer cultural competence, we cannot rule out the potential for counsellors to not recognize the importance of clients' disclosing experiences of homophobia and failing to record them in client notes.

In relation to homophobia and protective factors, it is possible, that those who have protective factors such as supportive family of origin, feel connected rather than isolated, and have good self-esteem and therefore identity cohesion, may not be impacted as much by homophobia as those who lack such protective factors. If this is the case, clients who had been exposed to homophobic bullying at work or school, for example, may not feel the need to bring this up in counselling if it did not impact them or was not the reason for their presentation. One final point in relation to homophobia has been highlighted in other LGBT research **drummond street** is currently conducting (The Queer Bill of Health), which indicates ignorance rather than intentional discrimination is at times responsible for unhelpful and possibly unhealthy health service responses, for example, ignorance about the need for lesbian women to undertake regular pap smears. These experiences may not be perceived as homophobia, although they may impact on wellbeing, and warrant further investigation.

The context in which people experience homophobia or affirmation for their sexuality may be significant. Supportive friendships where people have opportunities for positive experiences regarding their sexuality may be a particularly important protective factor for LGBTQ people. Positive experiences with friends was something people talked about more than any of the other contexts, which suggests these experiences are salient for clients and part of their personal narratives. Similarly, negative experiences with family regarding sexuality may be particularly impactful; negative experiences in family of origin was the most talked about social context in relation to negative experience in relation to sexuality, which indicates this is the most salient for clients in general.

SOCIO-ECONOMIC STATUS AND MENTAL HEALTH

Several indicators of socio-economic status were significantly related to at least three mental health categories. Level of education was significantly related to all five mental health categories. Clients who had completed education up to Year 12 were more likely to report having diagnosis of depression (35.2%), anxiety (18.3%), both depression and anxiety (13.1%), and other mental illnesses (15.5%),

compared to university graduates and post-graduates. A high proportion of post-graduates (87.2%) reported not having been diagnosed with any mental illnesses previously. Clients who were employed were least likely to have reported having diagnosis of depression or anxiety or both of these diagnoses, compared to clients who were unemployed and not in the labour force. A higher proportion of employed clients (71.1%) also reported having no mental illness in the past or present. Level of income was also found to be significantly related to the "depression only" and "other mental illnesses" diagnoses. A high percentage of clients who were high income earners reported not having had any mental illness diagnosis before (88.9%).

TRAUMA AND MENTAL HEALTH

Trauma was constructed using three codes regarding clients' experiences: sexual assault not in FOO; physical assault not in FOO; and accidents. A greater number of clients who had experienced traumatic experiences, compared to those who had not, reported having been diagnosed with depression only (36.4% vs. 21.9%), both depression and anxiety (20.5% vs. 7.8%), and other mental illnesses (20.5% vs. 5.9%). Again comparison with whole of population data indicates higher prevalence of trauma, and in particular child sexual assault, in this clinical LGBTQ sample. Other LGBTIQ research has also shown higher rates of trauma experiences within this population, particularly in lesbian women regarding childhood sexual abuse, but also in gay males regarding exposure to trauma as adults (McNair, 2005)[8]. There is a real tendency within the LGBT community to downplay possible higher rates of experience of trauma, and the effects of trauma, such as child sexual abuse, on the development of sexual identity. This, out of concern for experience of trauma being seen as a cause for divergent sexual identity. These trauma prevalence rates and their interplay with sexual identity development, and mental illness development, however warrant further research attention.

As sexual abuse in FOO is known to impact people so profoundly, it is not surprising in our sample this factor was significantly related to all five mental health categories. In particular, a higher percentage of clients who were sexually abused in the family context, compared to those who were not, reported having a diagnosis in the "depression only" (41.4% vs. 22.2%), "anxiety only" (31% vs. 11.9%), "both depression and anxiety" (27.6% vs. 7.8%), and "other mental illnesses" (24.1% vs. 6.3%) categories. Clients who had not experienced sexual abuse in FOO were more likely to report not having been diagnosed with any mental illnesses (70%).

SEXUALITY AND MENTAL HEALTH – 'COMING OUT' AS A RISK PERIOD

The results indicate those in a process of questioning their sexual identity may be at increased risk of poor mental health outcomes. Sexual identity was significantly related to each of the mental health categories, except the "anxiety only" category, with a higher percentage of clients who were questioning their sexual identities reported having been diagnosed with depression only (36.8%), both depression and anxiety (21.1%), or other mental illnesses (15.8%), compared to clients who self-identified as lesbian, gay, and bisexual.

These higher rates of mental health issues for questioning clients is consistent with previous research indicating identity cohesion in terms of sexuality is protective [9]and literature which highlights 'coming out' as a risk period, for example, Sorensen and Roberts (1997)[10] findings that attempts of suicide decreased considerably after adolescence and **"**coming out**".** Further, a high proportion of questioning clients attributed anxiety and depression symptoms to homophobia (around 15%, which is more than half of those with current symptoms), which may indicate increased vulnerability to the impact of homophobia on the mental health of those questioning their sexuality.

Looking at presenting issues of clients, isolation came up much more often for questioning clients (21.1% of 19 cases) than those who were categorised as gay (7.1%), lesbian (6.1%) or bisexual (2.2%) at intake. This is a finding of interest given social isolation is a risk factor for mental health in the literature on the general population, and this may be an important part of the picture of mental health for people questioning their sexuality. Interventions could target enhancing the social connectedness of people questioning their sexuality.

Higher proportions of lesbian, gay and bisexual clients sought counselling for issues around enhancing relationships (38.5, 35.3% and 31.1% respectively) than questioning clients (10.5%), however the proportion of each group presenting with issues around relationship breakdown was fairly similar (lesbian 22.3%; gay 35.3%; bisexual 24.4%; questioning 21.1%). Coming back to the proposal that during periods of 'coming out' and making sense of sexual identity is one of increased risk for mental health issues, it follows that seeking counselling for relationship strengthening may be a lower priority for many questioning clients, who perhaps are more concerned with identity and mental health issues unless one of their significant relationships is in crisis.

Our focus here is on 'questioning sexuality' as a risk period, rather than making generalisations about specific identities, as we are mindful such reporting with a lack of context can inadvertently feed into stereotyping. We consider bisexual clients as a subgroup briefly, however we have limited this preliminary analysis and intend to consider differences between gay and lesbian and other sexuality groups, as well as sex and/or gender diverse clients, in future work on this project.

SEXUALITY AND MENTAL HEALTH – BISEXUAL PEOPLE

Our findings are consistent with previous studies indicating bisexual people face a higher risk of developing mental health issues than both gay and lesbian identified populations as well as general populations[11]. In our sample:

- 37.8 % of bisexual people had received a diagnosis of depression (15.6% comorbid with anxiety or other mental health diagnosis)
- 20% had received a diagnosis of anxiety (15.6% comorbid with depression or other mental health diagnosis).

RISK AND PROTECTIVE FACTORS FOR DEPRESSION

Factors associated with depression were consistent with much of the general literature on risk and protective factors for depression (Department of Health and Aging, n.d.)[12], with themes around interpersonal and psychological factors.

Over 30% of clients who had a diagnosis of depression only reported having the following risk factors: finds it a challenge to believe in themselves and their own worth and value; rumination; difficulty with emotional regulation; internalise/blame self for problems; difficult relationship with father; sleep issues; and general feelings of isolation. Risk factors associated with both anxiety and depression diagnoses were somewhat similar: finds it a challenge to believe in themselves and their own worth and value; difficulty with emotional regulation; distraction/avoidance; internalise/blame self for problems; difficult relationship with father; sleep issues; and general feelings of isolation.

While the absence of certain protective factors (supportive friends; talking to a friend/trusted other; and having positive experiences with friends regarding their sexuality) was significantly related to the depression only outcome category, the presence of these same factors was significantly related to no record of any mental disorder diagnoses in client files.

These findings suggest the validity of interventions on both psychological and social/interpersonal areas. On the level of individual counselling, this would include interventions such as cognitive behaviour therapy to develop healthier thinking and coping styles, as well as things like social skills training. Wellbeing of individuals exists in a social context and so interventions on a community level would also be indicated.

RISK FACTORS FOR ANXIETY AND OTHER MENTAL HEALTH DIAGNOSES

For the "anxiety only" category, nine risk factors were found to have significant associations: finds it a challenge to believe in themselves and their own worth and value; dependent/ not able to assert needs etc.; rumination; difficulty with emotional regulation; distraction/avoidance; internalise/blame self for problems; difficult personality/inflexible/rigid/controlling; sleep issues; and general feelings of isolation.

Difficult personality, difficult relationship with father, and general feelings of isolation were significantly related to the "other mental illnesses" category. Furthermore, nine risk factors were not found in over 70% of clients who reported **having no mental illness diagnosis**: finds it a challenge to believe in themselves and their own worth and value; rumination; difficulty with emotional regulation; distraction; internalise/blame self for problems; difficult personality; difficult relationship with father; sleep issues; and general feelings of isolation.

RELATIONSHIPS, ISOLATION AND CONNECTEDNESS

As touched on in the previous sections on homophobia and depression, themes around relationships, isolation and connectedness emerged from the data. These were on the level of friendships with peers as well as sense of connectedness or isolation from queer and wider communities.

Two protective factors found to be significantly related to the "anxiety only" and "both depression and anxiety" categories socialising with people who are queer, and having positive experiences with friends regarding their sexuality, both of which involve the social aspects of people's lives. Similarly, three protective factors significantly related to the "other mental illnesses" category were: talking to a friend/trusted other; socialising with people who are queer; and having positive experiences with friends regarding their sexuality.

CONCLUSIONS

Our findings suggest that current evidence-based treatments, which address cognitive factors relating to depression and anxiety, as well as social connections is relevant and important for LGBTIQ clients as well, and that social and economic wellbeing is likewise important.

Findings further suggest however that unique risk factors such as sexual identity questioning, exposure to homophobia and elements of social isolation/ alienation are unique to this population, and require special attention. In particular, our findings provide further support for the significant role that exposure to homophobia has in mental health, and further analysis in relation to the types of homophobia experienced, and protective factors which build resilience in the face of homophobia, are warranted, (as well of course as ongoing social and health promotion campaigns to address stigma and discrimination within the broader community and within young people in particular).

In addition, the timing of services and support appears to be important, especially when individuals maybe in the process of 'coming out' or questioning their sexual identities. It follows therefore, that social connections to family, supportive friends and the broader queer community could provide vital protective roles in ensuring resilience at this time. Families in particular have a key support role to play, and there is a distinct lack of appropriate services and responses to support families through this process.

If living in a homophobic, heterosexist society is the reason LGBTIQ people experience higher rates of mental health issues, we might expect presenting issues to reflect this, however, risk and protective factors don't appear to work in such a straightforward way. Previous studies have indicated same sex attracted people usually seek counselling and other mental health support services to address concerns not directly related to their sexuality or experiences of homophobia[13], and our sample was consistent with this, such as, for example, a high proportion of clients presenting for relationship issues. The concerns of same sex attracted clients may be quite similar to the general population, however, as with all clients, they occur against the backdrop of the various intersecting aspects of their identities.

LIMITATIONS

The sample is not representative of same sex attracted and sex and/or gender diverse populations more broadly, as these are people who have accessed counselling (either to address self-identified relationship, identity, or mental health issues). These are people who may be more likely to experience mental health issues, and are willing to seek support through mental health services such as *drummond street*. Similarly, that this sample consists of people who presented for counselling does not mean this sample is representative of those same sex attracted and sex and/or gender diverse people with 'poor mental health status". While many people who experience mental health issues do attend counselling, there are significant barriers for many people who live with mental health issues to access services, with an Australian study in 2001 indicating only 35% of people with mental health issues consulted a mental health professional in the previous year[14]. Also, seeking counselling can actually be a sign of psychological wellness and the presence of internal resources to seek support during difficult times, such as during grief for example. Further, many people, often referred to somewhat

pejoratively as the 'worried well', seek counselling to enhance their wellbeing and their relationships rather than to address mental health problems, that is, as a preventive or early intervention, rather than as a clinical treatment intervention as such.

A core limitation of the present study is the data was not gathered for the purpose of this research project and there is much variability in the level of detail given in case files. Apart from the number of sessions varying widely, the note taking styles of therapists were not uniform. Some counsellors provided detailed session notes and quotes from clients while others employed a more minimalist style with brief lists of topics covered. These differences do not reflect the quality of therapy, as therapists rely on their memories to differing degrees and may use case notes for case conceptualisation or do this elsewhere such as in other notes and/or in supervision. All this reflects the purpose of case notes in counselling: to document information relevant to the processes of therapy rather than documenting an exhaustive list of demographic and case history information. Indeed, care must be taken where clients are asked for such information on intake forms and by therapists when it is not relevant to presenting issues, in order that this not be experienced as alienating or hinder the development of strong therapeutic relationships.

As mentioned earlier, all frequencies are conservative and a limitation is that they likely underestimate the actual frequency of factors present in the sample. Also mentioned earlier, a limitation of these preliminary analyses has been relying on categories from the intake screening process, which captures sexuality but not whether someone falls under the T or I of the LGBTIQ umbrella. We are not aware if the sample does include people who identify as intersex and found no evidence in session notes in this regard. From data of case file notes there are at least 20 clients who identified as transgender, transsexual, genderqueer or as exploring their gendered identities, and we intend to conduct further analysis on the experiences of this sex and/or gender diverse group of clients in the future. We need to acknowledge the categorization for research of people along the lines of sexuality is also problematic. As much as quantitative methods require neat categories, real life, particularly in the area of identity, without always clear boundaries. There were also a number of clients whose 'categorization' at intake was not consistent with session note data and we intend to address this further in future work.

4) PRACTICAL OUTCOMES

THE NEED FOR A JOINT FOCUS ON COMMON AND LGBTIQ UNIQUE RISK FACTORS

Our findings, which indicate that some risk and protective factors are unique to LGBQ populations (such as homophobia, questioning sexual identity, having positive experiences with friends regarding their sexuality, and socialising with queer people) while others appear to be common to the general population but may have added complexity (such as sexual abuse in family of origin, other traumatic experiences, and socioeconomic status), have implications for service interventions relevant to the mental health of LGBQ clients. The results suggest the need for awareness and specialist skills when working with LGBQ clients. This involves understanding both the common and unique risk and protective

factors for same sex attracted mental health, while balancing such an awareness with specific needs and perceptions of each individual client so as to avoid an over- or under-focus on sexuality (taking a stance of 'educated not-knowing'). The consequence of over-focusing on sexuality may be inadvertent pathologisation of 'difference'. Alternatively, under-focusing may involve ignoring the role that stigma can play and contributing to invisibility; ignoring it may be the result of counsellors' own discomfort in discussing it, or by not understanding its implications and relevance for the client. This is consistent with cross cultural counselling literature regarding same-sex attracted clients.

THE NEED FOR COMPETENT MAINSTREAM AND LGBTIQ SPECIFIC HEALTH/MENTAL HEALTH/FAMILY SERVICES

The importance of building the capacity of the non-LGBTIQ or mainstream services and professionals in working appropriately and effectively with the LGBTIQ community is well documented. The current study supports this and also highlights the need for queer-specific services with professionals who are culturally competent in working with same-sex attracted clients to meet the needs of some LGBQ clients who may not find generalist services accessible or for the may who have already had negative experiences of health services and help seeking. As indicated, a high proportion of clients seek queer-identified counsellors within **drummond street**. This is an agency known to be able to provide this, and other research conducted by **drummond street** further highlights patterns of help-seeking and access to services, and highlights to need for both building the capacity of the mainstream health services, while also providing queer-specific services as a known and available option for LGBTIQ communities.

USE OF A 'LGBTIQ SCREENING AND OUTCOME TOOL'

Queer affirmative mental health clinicians would be greatly assisted with the use of a specialist 'LGBTIQ Screening and Outcomes' tool. This would incorporate screening across risk and protective factors to enable further validation of the factors identified (research purpose), as well as to inform assessment and clinical intervention (clinical purpose) and to incorporate pre and post intervention client outcomes measures (research purpose).

THE NEED FOR A TRAUMA-INFORMED APPROACH

Specialist trauma-informed assessment and counselling intervention, with specific reference to and awareness of, the link and effects of trauma on the development of sexual identity has also been highlighted as important.

DATA COLLECTION IN RELATION TO SEX, GENDER AND SEXUAL IDENTITY DIVERSITY

The current project has highlighted the need for improved data collection by **drummond street** and other services, in relation to sex and/or gender diversity, and greater clarity in relation to sexual identification, at the point of intake, and recorded within the electronic Client Information System, for future research purposes.

CONTINUED FOCUS ON HOMOPHOBIA

Experience of homophobia clearly plays a role in mental health and illness, however there seems to be other variables at play which may reduce or enhance the impacts for individuals and groups, and this warrants further exploration within interventions and research.

FAMILY-FOCUSSED INTERVENTIONS

Findings highlight the need for support to be available for families who have a child/loved one who is questioning their sexuality/gender and for families who are having difficulties in supporting or accepting that loved one. This support may be targeting mental health prevention, early intervention and clinical interventions, and it is noted that there is currently little such support available for families.

Early parenting education and support which encourages parents to respect and value their children's individuality and autonomy of identity (which may be at odds with their own values or beliefs or which may concern parents in terms of the risk this may pose the child to, for example, bullying) and supports and strengthens the child's resilience and capacity to deal with disapproval of others is likely to support a child's 'coming out'. Likewise, support for parents of primary school aged parents in relation to their children becoming sexual beings, potentially with diverse gender or sexual orientations, is likely to support questioning transition and 'coming out'.

KEY FINDINGS, ACHIEVEMENTS AND ACTIVITIES (INCLUDING THE DEVELOPMENT OF RESOURCES AND/OR TRAINING MATERIALS) ARISING FROM THE PROJECT

This project satisfied its key aims of: 1) contributing to the knowledge-base by identifying risk and protective factors present within the LGBQ community (specifically those attending a mainstream but well known queer-friendly family service agency in inner Melbourne); and 2) exploring the relationship of risk and protective factors to presence or absence of Depression or Anxiety diagnosis. Findings provide directions for practical interventions to be further trialled (outlined in d), below), and provides some early evidence towards the development of a comprehensive public health initiative to respond to Depression and Anxiety which may reduce prevalence, onset and severity of mental health issues within the LGBTIQ community. Further directions for research were also highlighted (and are provided below).

The current study involved in-depth qualitative file audit of 299 non-heterosexual counselling clients who attended **drummond street** (within a 3 year period from 2008-2011), with 220 risk and protective factors identified via inductive and deductive reasoning methods (qualitative content analysis of 40 initial files, and additional factors incorporated from mainstream and LGBTIQ research and clinical experience, respectively). Additional steps were taken to verify validity and reliability of factors identified. Factors identified related to individual (cognitive and coping styles, physical health and health risk behaviours), family of origin, couple relationship and parenting, stressful life events, school and work factors, social connection to mainstream and queer communities, and queer specific factors (such as exposure to Homophobia and being currently in a 'questioning' stage regarding sexual identity formation). Frequency analysis indicated a higher prevalence of mental illness within the sample as compared to the general population. Bivariate data analyses on limited factors indicated both risk and protective factors were found to be significantly correlated with diagnosis of Depression or Anxiety, or both, or neither.

The present study did not identify intersex clients within the sample, and while 20 sex and/or gender diverse clients were identified, specific qualitative and quantitative analysis in relation to this group are yet to be undertaken. The project does however provide some illuminating findings in relation to risk and protective factors specific to Lesbian, Gay, Bisexual and Questioning clients, and the nature of factors' mediating roles in mental health and illness.

Key findings include:

- the presence of high frequencies of risk and protective factors common to the mainstream community (for example, level of education, employment and income, experience of childhood sexual abuse and trauma in adulthood) (and possibly at higher rates to the general population), as well as presence of factors unique to the LGBQ community (for example experience of Homophobia and 'questioning' transition), and the need to attend to both within mental health interventions
- the importance of the 'coming out' /questioning period in terms of vulnerability to mental ill-health
- being Bisexual was also placing individuals at greater risk of mental ill-health than being Gay or Lesbian, and was also associated with increased feelings of isolation from the broader, as well as the queer communities

- the importance of negative family of origin experiences including lack of support for sexual identity, in increasing mental health risk
- the importance of positive friendships and connection to the queer community as protective factors for mental health
- the importance of experience of homophobia in mental illness, as per the literature, and the additional indication of the possible protective role of other mediating variables to reduce its impacts, for example, identity cohesion and sense of connection to the queer or broader community.

A 'LGBTQ Screening and Outcome Tool' has been drafted based on our file audit tool (including a manual with definitions and examples), and incorporating mental health status measure (the General Health Questionnaire – 28 items – used previously by **drummond street**), to be used for both research purpose (validation of current identified factors) and clinical purpose of informing assessment (and intervention) and serving as a pre and post mental health intervention client outcome measure. It is hoped that this tool may be incorporated into a larger trial to further validate risk and protective factors and explore pathways to mental health and illness, as well as to trial and evaluate developed LGBTQ mental health interventions.

COMMUNICATION AND DISSEMINATION STRATEGIES RELATING TO:

1) POLICY, INCLUDING ANY RECOMMENDATIONS FOR POLICYMAKERS AND RELEVANT STAKEHOLDERS:

Dissemination of findings and implications to government policy makers and funders, including recommendations as follows:

In recognition of the high prevalence rates and impacts on vulnerable groups and the specialist needs of specific sub-populations, funders including governments at all levels in policy and service funding would be well placed to set key targets and outcomes to "close these gaps". It is common practice for tender responses and contract requirements with community providers to enshrine requirements to ensure the appropriate knowledge, competency, engagement and servicing of vulnerable groups. Two examples include Indigenous Australians and our culturally and linguistically diverse communities. This could very easily be expanded within policy to include the LGBTIQ community in, for example:

1. The collection and reporting of service data as a measure of ability to engage with and provide services to this community.
2. Tender and service agreements which ensure all staff have Queer Affirmative training and all aspects of provider operations are Queer sensitive.

While we have seen some efforts to support mainstream organisations through training and the use of QA type processes, they may well be too cumbersome for organisations – it needs to be incremental and achievable or organisations will opt out.

This research calls for a recognition and commitment to fund specialist evidence-based or informed public health responses for this community beyond the many important initiatives to reduce homophobia. It needs to be understood that it will take substantial time for these efforts to achieve population level outcomes,

however, that there are a number of urgent efforts which, if funded, could make considerable ground to reduce prevalence rates, and assist in early identification and intervention, therefore lessening the disabling effects of depression and anxiety. These efforts could include:

1. Additional funding of research to expand our knowledge of the relationship between these risk and protective factors such as a trial of the 'LGBTIQ Screening and Outcome Tool'.
2. Trial of clinical interventions which are able to address both common and unique risk and protective factors for mental health within this community
3. Funding for specialist parenting and family support services
4. Expansion of existing fledgling peer support models within clinical interventions to address increased social isolation and support network, and connection to other queer identified or questioning individuals

2) TRANSLATION OF THE FINDINGS INTO PRACTICE, INCLUDING ANY PRACTICE AND SERVICE RECOMMENDATIONS AND PLANS TO IMPLEMENT THE RESEARCH FINDINGS – CONSUMERS AND CARERS:

In terms of implications for practice and services, the current study raised the following issues:

- the importance of family of origin connection and support for 'coming out'/ questioning transition and sexual identity more generally, and the need for further specialist Family Support Services (e.g. for families who have a child/ young person or other loved one who is questioning their gender/sexual identity, and families coming to terms with their family members' difference, as well as upstream parenting education in relation to supporting children's resilience capacity prior to 'coming out').
- current evidence-based treatments which address cognitive factors regarding Depression and social connection appear important, with appreciation for added complexities, along with the development of additional LGBTIQ unique interventions.
- the importance of Queer Cultural Competency (for queer-identified and queer-friendly practitioners and queer-affirmative services) to ensure LGBTIQ unique factors are attended to, while recognising LGBTIQ clients may present with concerns similar to the general population and common risk factors, therefore the need for mental health and other practitioners to attend to both common/ mainstream and 'LGBTIQ unique' risk and protective factors.
- further social campaigns to address stigma and discrimination, particularly within young people, as well as ignorance and discrimination within health, mental health and family services and professionals working in these fields.
- the need for greater social support as vital protective factors during the 'coming out' transition, including further investigation in relation to protective factors and psychological interventions which support the process of transition in relation to sexual identity.
- data collection regarding sex, gender and sexual identity diversity requires expanding and clarifying at the point of recording.

- the importance of specialist trauma-informed assessment and interventions which take into account the effects of trauma on development of gender and sexual identities.

drummond street will seek future funding to enable the development of a larger trial of the screening tool and trial of specific mental health interventions, as well as development of a training package and the next steps in research required to progress this work.

Specific directions for other continued research are indicated as follows:

- prospective screening of new clients in relation to risk and protective factors, using the 'LGBTIQ Screening and Outcomes Tool', as part of a larger trial, and including other queer affirmative services.
- LGBTIQ mental health intervention development and trial based on findings, incorporating client outcome measures.
- a comparison study of client data including in-depth file audits of heterosexual clients attending **drummond street** within the same three year timeframe.
- analysis in relation to sex and gender diverse subgroups, and their unique risk and protective factors for mental health.
- analyses in relation to age, gender and sexual identity development and 'coming out', and the interplay of risk and protective factors with this transition, for example, further analyses in relation to the role of trauma, and experience of homophobia on gender and sexuality development, and on mental ill-health.
- bivariate analyses undertaken in relation to a broader list of risk and protective factors and their association to mental health status.
- qualitative data analysis in relation to the nature of the association between key risk and protective factors and mental illness.
- analyses of risk and protective factors for mental ill-health (symptoms) in comparison to mental illness diagnosis.
- matching and integration of **drummond street**'s client counselling pre and post outcome measure data with the current risk and protective factor profiles for individual clients, to enable analyses in relation to mental health status and risk and protective factors present.
- further analysis of data available regarding protective factors and coping strategies and interventions to promote mental health and wellbeing and to intervene in relation to mental ill-health to promote recovery and to build resilience.
- analysis in relation to help-seeking and service access and use patterns.
- integration with **drummond street**'s other recent LGBTIQ research data available from online surveys and focus groups.

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APPENDICES

APPENDIX 1: CLIENT INTAKE FORM

drummond street services
wellbeing for life

APPENDIX 1

CLIENT INTAKE FORM

Date	Time	Worker	Action Taken

Service initially requested: Individual Couple Family/Children Group
Referral Source: ..... New/Previous client
Search for previous appointment summary has been completed Y / N

Client 1: Personal Details				
Title:	**First Name:**	**Surname:**	**Gender:**	**D.O.B:**

Address:		**Family Membership:**	
		Marital Status:	
Suburb:	**Postcode:**	**Email:**	
Mobile #:		**Ancestry:**	
Home #:		**Country of birth:**	**Year of Arrival:**
Work #:			
SMS/VM : Yes No		**First Language:**	**ATSI:** No TSI ABG Both
Sexuality: Bisexual Gay Heterosexual Lesbian Questioning Unknown Other		**English Ability (If ESL):** Not at all Not well Very well Well	
Highest Education Level:		**Interpreter:** Yes No	
Employment Status:		**Annual Income:**	

Client 2: Personal Details				
Title:	**First Name:**	**Surname:**	**Gender:**	**D.O.B:**

Address:		**Family Membership:**	
		Marital Status:	
Suburb:	**Postcode:**	**Email:**	
Mobile #:		**Ancestry:**	
Home #:		**Country of birth:**	**Year of Arrival:**
Work #:			
SMS/VM : Yes No		**First Language:**	**ATSI:** No TSI ABG Both
Sexuality: Bisexual Gay Heterosexual Lesbian Questioning Unknown Other		**English Ability (If ESL):** Not at all Not well Very well Well	
Highest Education Level:		**Interpreter:** Yes No	
Employment Status:		**Annual Income:**	
Health Care Card: Yes No		**Agreed Fee:**	

Relationship	First Name	Surname	Gender	D.O.B	Strengths/Concerns	Lives with	To attend Y / N

Prior counselling: Yes No	**Comments:**
Medical Health Details:	**Issue(s):** **Current / Previous** **Severity: High Medium Low**
Mental Health Details:	**Issue(s):** **Current / Previous** **Severity: High Medium Low**
Violence Details:	**Type(s):** **Frequency:** **By whom:** **Current / Previous** **Severity: High Medium Low**
Child Concerns:	**At Risk/Safety Issues/Abuse Concerns**

AOD or Gambling Details:	**Issue(s):** **Current / Previous** **Severity: High Medium Low**

Legal Concerns: Yes No	**Court Order:** Yes No	**Asked to bring it to first session:** Yes No
FDR Experience: Yes No	**Resolution:** Yes No	**Certificate:** Yes No

Legal details:	**Comments:**
Financial or Accommodation Concerns:	**Comments:**
Formal Supports:	**Service Type:** **Agency/worker details:** **Length/type of involvement:**
Informal Supports:	

Priority:	HIGH	MEDIUM	LOW
At-risk Youth	Suicide		Mental ill-health
Child Protection	Physical Health		At-risk Child/ren
Drug and/or Alcohol	Gambling		Carer
Family Violence	Mental Illness		Post-Separation
Homeless/financial	Case Management		

Can client come at short notice: Yes No

Counsellor preference:
Male Female No preference

Queer friendly Queer identified

Childcare Needed: Yes No	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Day:					
After 5pm:					

Reason for calling:

Allocation Comments:	**Counsellor:**	**Date/Time:**

Coordinators Initial:
FARS / FMHSS / JUST FAMILIES / HOPE / Assessment / Stepfamilies

Presenting Needs:					
Accommodation issues		Drug/alcohol		Parents	
Adult physical/emotional abuse		Eating related difficulties		Physical health	
Adult sexual abuse		Employment issues		Post separation parenting	
Anger		Childhood neglect		Pre-marriage	
Anxiety		Enhancing a relationship		Property	
Behavioural		Establishing a relationship		Refugee	
Breach of post-sep agreement		Family formation		Relationship breakdown	
Bullying		Family maintenance		Re-partnering	
Carer's		Family separation		School	
Child protection issues		Family violence		Self-harm	
Child support payment		Family violence order		Separation of parents	
Childhood neglect		Financial difficulty		Siblings	
C/H physical/emotional abuse		Fly in/fly out		Step-parents	
C/H sexual abuse		Gambling		Step-parenting	
Communication issues		Grand parents		Stress	
Conflict		Mental health issues		Succession planning	
Criminal charges		Migrant		Suicide ideation	
Cultural		Other		Trauma	
Dealing with r/ship difficulties		Other legal issues		Client on wait-list for:	
Depression		Parent order plan			
Diagnosed mental illness		Parenting		Client needs an assessment appointment: Yes No	
Disability		Parenting plan			

Sub-Programs:		
FDR	Men's behaviour program	Single Session
JF 1	Open Place	Specialist Assessment
JF 2	Queer Programs	Stepfamilies

Client has been referred to (external services):	Client has been given information about (internal/external):

APPENDIX 2: QBOH ONLINE SURVEY

COMPLETING THE QBOH SURVEY

The following survey aims to build our knowledge about what contributes to the health and wellbeing of individuals within our Australian Lesbian Gay Bisexual Transgender Intersex Queer (LGBTIQ) community, a very diverse community, which we will refer to in our survey as 'our Queer community'.

If you live in Australia identify as GLBTI or Q, we are interested in your views regardless of whether or not you are 'out', and regardless of whether or not you are involved with the Queer community in any way.

The survey is really trying to build our knowledge about:

- The health and wellbeing of our queer community, including our mental health and our health risk behaviours
- Experiences in our lives which have contributed to our personal difficulties, as well as those which have contributed to our health and wellbeing, and
- Things which help us to use healthy behaviours and things which support our health and wellbeing. Here you have a chance to share your ideas about health promotion strategies we may trial, to support individuals and our Queer community as a whole, to be healthy and well.

We hope to gather over 500 responses to this survey, the results will be accessed and analysed by members of the 'Queer Research Team' at drummond street services and the overall aim of the research is:

To help our Queer community 'take our health back in our own hands'

The survey is anonymous and will take about 30 minutes to complete, and we can't thank you enough for taking the time to help us with this!

Queer Bill of Health Project Staff

APPENDIX 3: AUDIT RECORD FORM

DS QUEER FILE AUDIT 2013 – RECORD SHEET

Case number: _____

Client name: _____

RISK and PROTECTIVE FACTORS	TICK	COMMENTS
Factors are grouped into 7 areas: 1. Intake demographics and service use 2. Individual factors 3. Family of origin factors 4. Intimate relationships and parenting 5. Mental and physical health 6. Social and Community 7. Coming out/questioning/ homophobia	Please tick in this column if factor is present in client file	Evidence of a link having been made in the file between the factor and the mental health and wellbeing of the client. This factor will have been identified as significant and discussed/worked on in counselling, versus just having been mentioned. For these significant factors please provide details in this column. **Note:** — You can see examples of what we're looking for underlined in the coding manual. — Not all factors mentioned in files will have this evidence of the link, other factors will just be listed/mentioned, and for those factors, simply tick that the issue was present in the column left, and do not provide further detail in this column. — Some comments boxes include directions and requests for specific information.

1. INTAKE DEMOGRAPHICS AND SERVICE USE INFORMATION

1.1. DSS		
Request for Queer counsellor		Please specify wording in file
Prior counselling at DS		
1.2. Sex and Gender Diversity		
SGD (Sex and/or Gender Diverse) client; issues raised related to sex/gender – If this is ticked please pass case on to Nat for further coding		
1.3. Intake sexuality tick-box		
Client's identity/narrative about their sexuality not captured in DS intake categories [gay; lesbian; bisexual; questioning] – please specify		If ticked, please give details

1.4. Therapy / healthcare system		
Orientation to counselling and psychotherapy		If ticked, please specify positive/negative/neutral orientation
experiences with queer specific psychological service (counselling, psychotherapy, psychiatry)		If ticked, please specify positive/negative/neutral experience and which service if info present in file
experiences with general psychological services		"
experiences with other health care system		"
Has used Medicare Better Access scheme to see a psychologist		Please specify details in file

2. INDIVIDUAL

2.1. Individual - emotional regulation/coping strategies		
difficulty with emotional regulation		
self-medication		If ticked, also see factors in AOD sections 5.8 and 5.9
talking to a friend/trusted other		
exercise		If ticked, specify any info on whether this is constructive or maladaptive/obsessive
distraction/avoidance		If ticked, specify any info on whether this is constructive or maladaptive
self-harm		
action orientation, focus on problem solving		
risk taking		
comfort eating		
seeking sex for comfort		
2.2. Individual – internalise/externalise		
externalise/blame others for problems		
internalise/blame self for probl ems		
2.3. Individual – thinking styles		
Rumination, difficulty solving problems, overwhelmed, procrastinating		
protective – frame challenging experience as learning/growth experience		

2.4. Individual – personality/ traits		
openness/flexibility/assertiveness/rescuer-educator role		
difficult personality/ inflexible/rigid/ controlling personality traits/aggressive/ ambivalent attachment style/ perpetrator role/conflictual style		
dependent/ not able to assert needs/ passive/ avoidant/ victim role/avoids conflict		
2.5. Self-esteem		
Client finds it a challenge to believe in themselves and their own worth and value		
Client has a solid sense of their self-worth		

3. FAMILY OF ORIGIN

3.1. Family of origin – family when growing up (can be more than one)		
queer family		Please give details
biological nuclear family		
parents separated, raised mainly by single parent		
parents separated, co-parenting arrangement		
extended family		
step/blended family		
foster family		
Residential care/ 'resi unit'/group home/ youth homelessness/left home at a young age		If ticked, please specify details such as age and reason for leaving FOO, whether there was DHS involvement
Poverty as issue		
3.2. Parents		
Education level of parents		If mentioned please specify
3.3. Family of origin - nature of relationships		
supportive/close/positive relationship with mother(s)		
supportive/close/positive relationship with father(s)		
supportive/close/positive relationship with sibling(s)		
close-knit family		

difficult relationship with mother(s)		If ticked, please specify if related to client sexuality
difficult relationship with father(s)		"
problematic sibling relationship(s)		"
as child, client experienced parental mental health issue		
as child, client experienced parental chronic health issue		
client carer for parent (mental illness)		
client carer for parent (physical illness)		
poverty an issue growing up		
loss of primary attachment figure during childhood/adolescence [due to death/ separation/abandonment]		
loss of other significant relationship in family		
3.4. Family of origin – DV/abuse		
witnessed physical violence in family context		If ticked, please specify who this was between
witnessed sexual abuse in family context		"
witnessed emotional abuse in family context		"
experienced sexual abuse in family context		If ticked, please specify relationship to perpetrator
experienced physical abuse in family context		Please specify if homophobic violence If ticked, please specify relationship to perpetrator
experienced emotional abuse		Please specify if homophobic abuse If ticked, please specify relationship to perpetrator
experienced neglect		

4. INTIMATE RELATIONSHIPS AND PARENTING

4.1 Intimate relationships		
healing from/grieving past intimate relationship		
challenge of finding a partner/forming a relationship		
Challenge of sustaining a healthy relationship		
relationship strengthening		
one or both clearly thinking about leaving/ one or both not motivated to do work on relationship		

separated and wanting to maintain friendship afterwards/one partner wanting to reunite		
values at odds		
sexual issues in intimate relationship		
cultural difference		
coping style at odds		
significant life transitions		
transition to separation		
carer for partner		
Client is carer for other and this is impacting their partner relationship		Please specify who they are a carer for and the impact
4.2 Style of relationships		
Monogamous; non-monogomous; polyamorous; is not interested in intimate relationships		Please specify
4.3 Queer-specific relationship issues		
hiding relationship for fear of homophobia		
issues with acceptance of relationship by each partner's extended family		
visibility issues for couple that passes as straight in society		
issues related to client's partner being straight		
4.4 Parenting		
has one or more children		
challenge of forming a 'family life' with children		
pregnancy issues		
step-parenting issues		
different parenting styles		
separated and working on co-parenting relationship		
postnatal depression impacting relationship		
donor/surrogate issues		
DHS involvement with children of client		
child with a chronic illness		

4.5. Intimate relationships – abuse		
physical abuse in relationship		Specify past/present and whether client is survivor/perpetrator or both
sexual abuse in relationship		"
emotional abuse (verbal)		"
financial abuse		"
social abuse (social isolation)		"

5. MENTAL AND PHYSICAL HEALTH

5.1. depression		
previous diagnosis (please specify)		
previous symptoms but not diagnosed		
previous treatment received		
current diagnosis (please specify)		
currently receiving treatment (therapy)		
currently receiving treatment (medication)		
current symptoms (please specify if counsellor suggests diagnosis)		
symptoms linked to perceived/experienced homophobia		
5.2. anxiety		
previous diagnosis (please specify)		
previous symptoms but not diagnosed		
previous treatment received		
current diagnosis (please specify)		
currently receiving treatment (therapy)		
currently receiving treatment (medication)		
current symptoms (please specify if counsellor suggests diagnosis)		
symptoms linked to homophobia		
5.3. other mental health conditions		
previous diagnosis (please specify)		
previous symptoms but not diagnosed		
previous treatment received		
previous diagnosis (please specify)		

currently receiving treatment (therapy)		
currently receiving treatment (medication)		
current symptoms (please specify if counsellor suggests diagnosis)		
symptoms linked to homophobia		
5.4. sleep issues		
sleep issues		
5.5. suicidality		
suicidal ideation: past and not frequent		
suicidal ideation: past and frequent		
suicidal ideation: current and not frequent		
suicidal ideation: current and frequent		
suicide attempts		
suicide ideation linked to homophobia (internalised or external)		
significant figure in the client's life suicided		
5.6. trauma		
survivor of sexual assault not FOO or partner; or context not specified		
physical assault not FOO or partner; or context not specified		
accident		
5.7. body image		
Concerns with body image and attractiveness		
5.8. alcohol		
Impacting area of health		
Impacting area of mental health		
Impacting area of relationships		
financial impact		
legal impact		
Impact on work/study		
treatment		

5.9. other drugs		
drug(s) used		
Impacting area of health		
Impacting area of mental health		
Impacting area of relationships		
financial impact		
legal impact		
Impact on work/study		
treatment		
5.10. gambling		
please specify		
5.11. physical health		
Physical illness		
Cancer		
HIV/AIDs		
STIs		
smoking		
weight gain due to medication		
obesity		

6. SOCIAL AND COMMUNITY

6.1. Involvement with Queer community		
Read Queer communication and media such as blogs, websites, newspapers		
Communicate with the Queer community via online forums		
Attend Queer events such as movies, festivals and shows		
Visit Queer venues such as bars and clubs		
Socialize with people who are queer		
6.2. Social and community – feeling connected		
queer/trans communities		
wider community		
ethnic/religious communities		

intersection support/social group ethnic/ religious and queer/trans		
other (please specify)		
6.3. Social and community – feeling disconnected		
queer/trans communities		
wider community		
ethnic/religious communities		
intersection support/social group ethnic/ religious and queer/trans		
other (please specify)		
6.4. Social and community – seeking connection		
queer/trans communities		
wider community		
ethnic/religious communities		
intersection support/social group ethnic/ religious and queer/trans		
other (please specify)		
6.5. Social and community – isolation		
general feelings of isolation		
link isolation and internalised/externalised homophobia		
6.6. Social and community – work/school		
work/school stress		
engaged in work/school community/culture		
time management issues		
School education type		
6.7. Social and community – cultural/religious identity		
cultural/religious identity specified/ mentioned		
tension between sexuality and cultural/ religious identity		
6.8. Social and community – friends		
supportive friends		
friends enable unhealthy coping strategies such as alcohol and other drug use		

7. COMING OUT/QUESTIONING/HOMOPHOBIA

Coming out/questioning sexuality a current issue for the client		
Internal stress feeling different from the mainstream community		
Experience of not being able to be fully open about myself and my life to others (e.g. keeping secrets)		
Experience of having to 'come out' each day and in each new social setting		
Experience of homophobia, identity shame, and/or social exclusion and judgment within the queer community, by queer community members themselves. E.g. Bi-phobia		
Feeling labeled, pigeonholed or stereotyped rather than feeling free to just be fully who they are		
positive experiences with family re: sexuality		
positive experiences with school (peers) re: sexuality		
positive experiences with school (teachers) re: sexuality		
positive experiences with workplace re: sexuality		
positive experiences with friends re: sexuality		
positive experience with media re: sexuality		
negative experiences with family re: sexuality		
negative experiences with school (peers) re: sexuality		
negative experiences with school (teachers/ system) re: sexuality		
negative experiences with workplace re: sexuality		
negative experiences with friends re: sexuality		
negative experiences with media re: sexuality		
seeking to leave homophobic environment		
significant figure standing up against homophobia		
significant figure being silent against homophobia		

significant figure expressing homophobic attitudes		
empathy but not taking on board responsibility for significant other struggling with client's sexuality		
taking on board responsibility for significant other struggling with client's sexuality		
resentment at significant other struggling with client's sexuality		
internalised homophobia		
fear of experiencing homophobia		
religious homophobia		
belief same sex attraction is an illness		
belief same sex attraction is a choice, is undesirable, and can be changed		
belief that sexuality and/or gender is fluid and socially constructed		
coming out related to increased anxiety		
coming out related to reduced anxiety		
coming out related to increased depressive symptoms		
coming out related to decreased depressive symptoms		
coming out related to increased other MH symptoms		
coming out related to decreased other MH symptoms		
Client reports expressing homophobic attitudes outside the therapy space		
pressure to conform to gender norms		Please specify

APPENDIX 4: METHOD

DETAIL REGARDING DATA MINING METHODOLGY UNDERTAKEN IN THE CURRENT PROJECT

The process of data audit and mining of clinical files was guided by practice-based research strategies outlined by Epstein (2002) and Giles et al. (2011). Clinical data-mining involves the conceptualisation, extraction, analysis, and interpretation of available clinical data for practice knowledge-building, clinical decision-making, and practitioner reflection. The following research steps were therefore utilised to identify risk and protective factors, among LGBTIQ clients who accessed counselling services, which may relate to their mental health status.

1. Determine the kinds of information that are available. A typical client file at drummond street, includes intake information provided by the prospective counselling client over the phone, including demographics, family characteristics, health risks present, and the presenting needs. Each client file also contains session notes recorded by the allocated counsellor.
2. Assess the accessibility, credibility, and legibility of the information. Counselling session notes were mostly hand-written for files prior to July 1, 2010, before counsellors were asked to record their notes on the electronic Client Information System. Efforts were made to include all files with any readable hand-written, as well as typed, session notes.
3. Determine the unit of analysis, time-frame, potential staging of information. 'Qualitative content analysis' was used to extract data from session notes and the unit of analysis was individual theme (see details of content analysis below in Step 5). All clients whose first counselling session started between July 1, 2008 and June 30, 2011 were included in the study. Clinical files that were excluded from the study were those which upon closer qualitative examination, had not been excluded by electronic data sorting, including those clients, 1) for whom their self-reported sexuality was, in fact, heterosexual (not LGBTIQ); and 2) who were under the age of 18 at the time of the first counselling session. The latter decision was made on the basis that there is a shorter timeframe within which to experience the factors, and the absence of or lower frequency of a factor may be more a function of age than of its relationship to mental health and illness.
4. Conduct a literature review to conceptualise study possibilities and develop research questions. This was completed previously by drummond street.
5. Conduct a detailed inventory of potential variables. A list of potential variables was developed by three research assistants with post-graduate qualifications in psychology and public health research. The development of this list of variables began with an initial reading and qualitative content analysis of session notes in 40 clinical files. Qualitative content analysis involves a process designed to condense raw data into categories or themes based on valid inference and interpretation (Zhang & Wildemuth, 2009). 'Inductive' reasoning was used in the process whereby themes and categories (these were also referred to as variables, factors or codes) emerged from the data through the researcher's careful examination and constant comparison. In addition, 'deductive' reasoning was employed to generate additional potential variables based on the current queer literature and clinical experience. These variables or codes were worded according to the language used by counsellors. This list of codes was examined by Clinical research assistants to ensure they had face validity, and were as mutually exclusive as possible. Examples and definitions for each

code were developed through content analysis. The list of potential codes, their definitions and examples was compiled into a coding manual and consultation with LGBTIQ-identified counsellors at drummond street was undertaken to ensure the correct wording was used for each code and to determine the ease of understanding the codes' definition, as well as to further validate or amend the draft list of factors. The decision to consult with LGBTIQ-identified counsellors at the outset was intentional as it was seen that their own personal, as well as their level of clinical practice experience of working with LGBTIQ clients, would contribute to the accuracy of the audit tool. Revisions were made accordingly to incorporate suggestions from LGBTIQ Counsellors.

6. Develop preliminary forms for data extraction. Paper and electronic versions of the preliminary data extraction tool was developed based on the coding manual created in Step 5.

7. Conduct sample studies to assess validity, reliability, accuracy and completeness of codes. A sample session note of a Lesbian couple Counselling session was used to test the coding manual and the preliminary data extraction forms. Five coders (including both Queer-identified and Queer-friendly/not-identified Counsellors) were asked to complete the coding of the sample session note, individually. Results were compared and further revisions were made to the coding manual and the data extraction form. In additional, two workshops were held to recruit and train Queer-friendly and non-identified counsellors as coders. Coders were asked provide feedback on the ease of use of the audit tool, and suggestions for improvements were considered by the research team and incorporated accordingly.

8. Construct data extraction forms and extract data from clinical files. Paper and electronic versions of the data extraction form (also referred to as 'Coding Record Form') were made available to coders. Thirteen counsellors were recruited as coders and they were given a coding manual and data extraction forms, and allocated client files to audit. Counsellors were asked to prioritise coding of files for their own prior clients. This was an intentional decision on the basis that counsellors would be more familiar with the material to be audited and therefore more efficient. Counsellors then completed coding of client files associated with another Counsellor where required.

9. Create a database, enter data and run frequencies to determine which variables are suitable for descriptive and multivariate analysis. After all coding response sheets were received from coders, data was entered into a database with coding responses only. Another database contained clients' electronic Client Information System data regarding demographics, presenting needs, needs addressed, and dates and number of sessions attended. The information from these two databases were matched and then merged into a master file containing all relevant data prior to frequency analyses being run.

10. Conceptualise and conduct studies based on available data. Five categories of mutually exclusive 'mental health status' were created using five codes that asked whether clients had a past or present diagnosis of depression, anxiety, or other mental illnesses (Each category was coded as "1" to indicate the presence of the diagnosis and "0" to indicate its absence). Associations between mental illness status and other risk and protective variables were then examined. Mental illness status categories were as follows: 1) "Depression only" was created when clients reported having been diagnosed for depression in the

past and present and had not been diagnosed for any other mental illnesses; 2) Similarly, “Anxiety only” was created when clients reported having been diagnosed for anxiety in the past and present and had not been diagnosed for any other mental illnesses; 3) “Both depression and anxiety” was created by recoding a “1” to indicate the presence of both depression and anxiety diagnoses; 4) . “Other mental illness” was created when clients reported having been diagnosed for any mental illness other than depression or anxiety, in the past and present; and 5) “No mental illness” was created by recoding “1” as absence of any of the above-mentioned categories and “0” as presence of any mental illness diagnoses.

Due to an exhaustive list of risk and protective factors being generated (220), only a selected number of risk and protective factors were chosen to examine their associations with the five mental health categories. Twenty risk and ten protective factors that had the highest frequencies were selected. In addition, demographics and key variables known to relate to mental illness within the literature, were also examined. Chi square tests were used to explore the bivariate associations between these factors and the five mental health categories.

APPENDIX 5: RESULTS

DETAIL REGARDING RESULTS

TABLE 2.
BIVARIATE RESULTS FROM CHI-SQUARE ANALYSES FOR DEMOGRAPHICS AND KEY VARIABLES THAT ARE KNOWN TO ASSOCIATE WITH MENTAL ILLNESS

	Depression only		Anxiety only		Both Depression & Anxiety		Other mental illness diagnosis		No mental illness diagnosis	
Demographics/ key variables that relate to mental illness	%	chi-square value	%	chi-square value	%	chi-square value	%	chi-square value	%	chi-square value
Gender		0.25		3.19		1.75		**0.039*[a]**		2.55
Male	22.3		8.5		6.4		3.2		74.5	
Female	25		16.2		11.3		10.3		65.2	
Sexual identity		**9.87***		6.49		**0.039*[a]**		**0.037*[a]**		**12.60***
Lesbian	23.7		14.9		10.8		8.8		68.9	
Gay	15.3		7.1		3.5		2.4		78.8	
Bi-sexual	37.8		17.8		13.3		13.3		51.1	
Questioning & not identified	36.8		26.3		21.1		15.8		52.6	
Country of birth		0.39		0.78		0.59		0.61[a]		0.001
Australia	23.1		14.7		10.7		8.9		68.4	
Outside Australia	26.9		10.5		7.5		5.9		68.7	
Language		3.7		0.147[a]		0.06[a]		0.19[a]		1.54
English	23.3		13.2		9.1		7.7		68.6	
Non-English	50		30		30		20		50	
Education		**0.011*[a]**		**0.047*[a]**		**0.019*[a]**		**0.01*[a]**		**10.99***
up to year 12	35.2		18.3		15.5		15.5		56.3	
university degree	23.6		14.8		9.9		6.6		68.1	
post-graduate	10.3		2.6		0		0		87.2	
Employment		**15.28****		**6.49***		**12.50***		0.10[a]		**7.03***
Employed	19.7		12		7.7		7.3		71.2	
Unemployed	55.6		33.3		33.3		22.2		44.4	
Student / not in labour force	35.6		15.6		11.1		6.7		60	

Income		**0.009*[a]**		0.104[a]		0.072[a]		**0.027*[a]**		**0.001**[a]**
low	30.7		18.3		13.1		12.4		59.1	
middle	18.5		12		8.3		4.6		75	
high	7.4		3.7		0		0		88.9	
No	24.3		13.3		9.8		8.3		67.8	
Request queer counsellor		0.06		**3.99***		1.29		**6.63***		3.36
Yes	24.8		18.4		12		12.8		62.4	
No	23.6		10.3		8.1		4.6		72.4	
Sexual abuse in FOO		**5.26***		**8.14***		**11.73***		**11.29***		**4.03***
Yes	41.4		31		27.6		24.1		51.7	
No	22.2		11.9		7.8		6.3		70	
Homophobia		3.03		**6.58***		**5.69***		**13.26****		**5.82***
Yes	34		25.5		19.2		21.3		53.2	
No	22.2		11.5		7.9		5.6		71	
Trauma		**4.26***		3.54		**6.81***		**10.97***		3.1
Yes	36.4		22.7		20.5		20.5		56.8	
No	21.9		12.1		7.8		5.9		70.2	

Significant p-values are highlighted in bold

[a] Fisher's exact test * $p<0.05$ ** $p\leq0.001$

TABLE 5.
BIVARIATE RESULTS FROM CHI-SQUARE ANALYSES FOR RISK FACTORS

	Depression only		Anxiety only		Both Depression & Anxiety		Other mental illness diagnosis		No mental illness diagnosis	
Risk factors	%	chi-square value	%	chi-square value	%	chi-square value	%	chi-square value	%	chi-square value
Client finds it a challenge to believe in themselves and their own worth and value		**7.77***		**8.59***		**6.43***		2.14		**9.05***
Yes	32.5		20.8		15		10.8		58.3	
No	18.4		8.9		6.2		6.2		74.9	

dependent/ not able to assert needs/passive/ avoidant/ victim role/ avoids conflict		0.59		**3.89***		1.32		0.41		1.46
Yes	26.7		19.1		12.4		6.7		63.8	
No	22.7		10.8		8.3		8.8		70.6	
Rumination, difficulty solving problems, overwhelmed, procrastinating		**6.54***		**6.74***		3.17		1.8		**8.74***
Yes	33		21		14		11		57	
No	19.6		10.1		7.5		6.5		73.9	
difficulty with emotional regulation		**5.57***		**18.69****		**5.90***		2.38		**11.69****
Yes	32.6		26.3		15.8		11.9		54.7	
No	20.1		7.8		6.9		6.4		74.5	
distraction / avoidance		1.69		**5.82***		**3.90***		0.71		2.18
Yes	29.5		21.8		15.4		10.3		61.5	
No	22.2		10.9		7.7		7.2		70.6	
internalise/blame self for problems		**11.16****		**7.88***		**7.14***		1.66		**11.28****
Yes	36.7		22.2		16.7		11.1		54.4	
No	18.7		10.1		6.7		6.7		74.2	
difficult personality / inflexible etc		0.88		**6.88***		1.92		**6.66***		**4.52***
Yes	28.6		23.8		14.3		15.9		57.2	
No	22.9		11		8.5		5.9		71.2	
difficult relationship with father(s)		**8.80***		2.44		**7.25***		**4.21***		**6.48***
Yes	37		19.2		17.8		13.7		56.2	
No	19.9		12		7.1		6.2		72.1	
sleep issues		**9.65***		**5.18***		**6.35***		1.67		**7.75***
Yes	38.2		22.1		17.7		11.8		54.4	
No	19.9		11.3		7.4		6.9		72.3	
general feelings of isolation		**12.42****		**9.92***		**12.36****		**5.57***		**14.34****
Yes	40.3		25.4		20.9		14.9		49.3	
No	19.4		10.3		6.5		6		73.7	

Significant p-values are highlighted in bold

*p<0.05 **p≤0.001

TABLE 6.
BIVARIATE RESULTS FROM CHI-SQUARE ANALYSES FOR PROTECTIVE FACTORS

	Depression only		Anxiety only		Both Depression & Anxiety		Other mental illness diagnosis		No mental illness diagnosis	
Protective factors	%	chi-square value	%	chi-square value	%	chi-square value	%	chi-square value	%	chi-square value
supportive friends		**11.07****		2.75		2.73		2.13		**12.37****
Yes	33.3		17.4		12.9		10.6		57.6	
No	16.8		10.8		7.2		6		76.7	
talking to a friend/trusted other		1.66		0.44		0.21		**4.44***		3.74
Yes	29.3		15.9		11		13.4		59.8	
No	22.1		12.9		9.2		6		71.4	
involve in queer community – Socialise with people who are queer		**5.32***		**13.18****		**11.33****		**5.50***		**7.34***
Yes	33.8		26		19.5		14.3		55.8	
No	20.7		9.5		6.3		5.9		72.5	
positive experiences with friends re: sexuality		**6.14***		**11.43****		**9.17***		**5.98***		**8.49***
Yes	34.7		25.3		18.7		14.7		54.7	
No	20.5		9.8		6.7		5.8		72.8	

Significant p-values are highlighted in bold

*p<0.05 **p≤0.001

Please contact **drummond street services** on **(03) 9663 6733** or at **enquiries@ds.org.au** with any questions about this research

www.ds.org.au/queerspace