

## **Report of the Survey of the Health and Wellbeing of Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Older People in NSW, 2013-2014**

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Most importantly we are very thankful for the contribution made by the LGBTI respondents to this survey. The information gained from the survey has already been made use of in the development of health promotion programs, and we hope that this report will also be a useful document for the development of new initiatives to improve the health and wellbeing of LGBTI seniors.

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## Executive summary

This survey sought to investigate the health and wellbeing of LGBTI seniors in New South Wales, including the health issues they are most concerned about, activities they would like to be involved in, and who they would like to connect with in engaging in these activities.

The survey comprised qualitative and quantitative components and was delivered in online and paper form between March and December 2013. Standardised instruments included the SF-12 measure of health-related quality of life, the Kessler 10 questionnaire on psychological distress, and the 3-item Loneliness Scale. Other variables were measured through closed- and open-ended questions.

312 people aged 50 and over completed the survey. The average age was 59.87, with the oldest participant being 84. The majority of participants identified their current gender as female (48.6%); 46.5% identified as male, and 4.5% identified as transgender male to female. 43.9% of respondents identified as a gay man, 42.9% as lesbian, and 5.8% as bisexual. 57.4% of respondents were in a relationship, the average length of which was 17.35 years. 14.7% of respondents reported that they were caring for another person, while 2.9% said they were receiving care.

Nearly 60% of respondents were from metropolitan Sydney, 16.1% from a regional city, 15.2% from a regional town, and 9.7% from a rural area. 61.5% lived in a house, while 33.7% lived in a flat or unit. The majority of respondents (46.2%) lived with their partner, and 40.4% lived on their own.

The average score on the 3-item Loneliness Scale (ranging from a low of 3 to a high of 9) was 4.877, which was higher than that recorded in general aged population studies. Those living alone and those who were not in a relationship were significantly more likely to score higher on the Loneliness Scale.

The majority of respondents (57.8%) had positive things to say about their biological family members, while for 12.5% the experience was mixed, 12.1% were estranged from biological family, and 17.6% reported being distant from family members due to other factors (such as geographical location, and relatives having severe disability).

Consistently more respondents said they had non-LGBTI friends than LGBTI friends that they could rely on in a crisis. For example, 70.8% said that they had non-LGBTI friends in their region that they could rely on, while 68.9% said they had LGBTI friends in the same situation. Similarly, respondents were engaged in both LGBTI-specific and non-LGBTI-specific community activities.

Respondents were active users of internet-based technologies, with 97.8% having an internet connection at home, 89.7% using email and 51.0% using social media. Confidence levels were high for using mobile phones, email, and internet searching, although less high for using Twitter and Blogging. Respondents reported accessing a wide range of media, including both LGBTI-targeted, but also, and more commonly, mainstream media.

The average physical health composite score (measured by the SF-12) of 47.365 was lower than that expected of national populations (which would be 50), however this is to be

expected for a sample of people aged 50 and over. The average mental health summary score of 49.373 was very close to the expected score of 50 for a national population, although it was lower than that typically expected of a population aged 50 and over. The degree of psychological distress reported in this study (as measured by the Kessler 10 instrument) was higher than that reported in samples of the general adult population, even though about 60% of respondents experienced low or non-existent psychological distress.

Only one significant relationship was identified between physical health and other characteristics of the sample: those identifying as female were more likely to report lower levels of physical health than others. This may reflect research findings demonstrating that lesbians experience some health issues, such as obesity and alcohol use, at a greater rate than the general population.

In terms of mental health issues and psychological distress, these were significantly more likely to be experienced by those not in a relationship, those living alone, those reporting greater loneliness, and by carers. In line with other research findings, those in the upper age groups of the sample reported lower levels of psychological distress and better mental health than those in the lower age groups.

Commonly reported health concerns included lack of exercise, memory loss and dementia, dental health, heart disease, loneliness, and anxiety and depression. For the older group in the sample (those aged 65+) physical activity was more a concern than for the younger group (those aged 50-54), whereas the reverse was the case for anxiety and depression. Reflecting other findings, those not in a relationship were more likely to report concerns about loneliness and anxiety and depression than those who were. People who scored higher on the Loneliness Scale were also more likely to have concerns about a wide range of health issues, including mental health issues, dental health, heart disease, obesity, mobility, and pain.

Most people (84.3%) said they had a regular General Practitioner, and 74.7% reported having disclosed their sexuality or gender identity to their GP. Other frequently accessed health services included dentists (68.6% saw one in the past year), optometrists or ophthalmologists (58.3%), physiotherapists or chiropractors (35.9%), and counsellors (27.9%). Of those born female, 34.3% had had a pap smear in the past year, and of those born male 38.9% had had a prostate check.

Barriers to accessing health services included the fear and actual experience of discrimination or abuse, concerns about the quality of services provided, and the cost of services. However, about half of respondents said that they experienced no barrier to health service use, and some reported very positive experiences.

With respect to the activities people are involved in to promote or maintain their health and wellbeing, fitness and exercise were nominated by 66.4% of respondents as what they are doing now to achieve this, and by 46.1% as what they would like to be doing in the future to achieve this goal. Healthy eating and losing weight figured strongly as strategies people are currently pursuing and would like to pursue more in the future, as did socialising with friends and family. Some of the barriers to taking up health promoting activities included time and work commitments, lack of motivation, the impact of health issues, and social isolation.

Respondents were presented with a selection of activities for promoting health and wellbeing and were asked to indicate how likely would they be to participate in each. The most popular

were fitness groups, walking groups, swimming, and meditation. The younger members of the sample were more likely to want to be involved in a walking group than older members, those not in a relationship were more interested in yoga, and those identifying as female were more interested in swimming and walking groups. People who experienced more psychological distress were more interested in weight loss groups, and those who experienced more loneliness were more interested in craft/arts groups as well as being involved in an LGBTI ageing action group.

The majority (52.7%) of those identifying as female wanted to be involved in women-only activities, while 33.1% of those identifying as male wanted to be involved in men-only activities. Nearly half the participants wanted to be involved in activities with other LGBTI people. Just over 43% said they didn't mind who they participated with. 28.5% said they preferred to participate alone. Wanting to participate with other LGBTI people was much more common among those not in a relationship, those reporting higher levels of psychological distress and those who were more lonely. More of those who wanted to participate with other people aged 50 and over were not in a relationship, living in metropolitan areas, and experiencing greater psychological distress.

Respondents were given the opportunity to comment on anything else they wished to about the topics of the survey. Many people highlighted the need for safe environments for LGBTI people to live and receive services. Some noted the need for LGBTI-friendly residential care facilities and retirement villages. Concerns were expressed about heteronormativity – the assumption that all people are heterosexual – as well as the likelihood of discrimination and the need for staff training. Some reflected on the treatment of older people in LGBTI communities, while others were concerned about the financial future and housing options. Some advocated voluntary euthanasia and a number reported feeling positive about growing older. Many highlighted the need for LGBTI ageing and LGBTI seniors to be better acknowledged within society.



## Background

The survey reported on in this paper comprised part of a wider project carried out by Evergreen Life Care and funded by the Department of Health. The key objectives of the project were:

1. Improve the health and wellbeing outcomes of LGBTI elders, across a range of healthy ageing indicators relating to physical, social and mental health.
2. Sustain independent, active and healthy lives, including social/family connectedness, informed access, and engagement with aged care providers.
3. Improve the skills and awareness of aged care providers regarding the health and wellbeing needs of LGBTI elders, leading to improved quality of care for LGBTI elders.

In formulating the project plan and how it should be operationalised, the project needed to determine responses to two major questions. Firstly, what are the major challenges that LGBTI older people in Australia face in improving their health and wellbeing, and sustaining independent, active and healthy lives? Secondly, how are we to locate, communicate with, and engage with LGBTI older Australians?

A review of the literature suggested several areas in which the health and wellbeing of LGBTI seniors is likely to be worse than that of their non-LGBTI counterparts. These include (but are not limited to) higher rates of:

- the use of Alcohol, Tobacco and Other Drugs (ATODs) (Boehmer et al., 2012)
- HIV/AIDS, including AIDS-related dementia (Mallit et al., 2012)
- cancers, including breast and gynaecological cancers (Zaritsky & Dibble, 2010)
- risk factors for hypertension and heart disease (Fredriksen-Goldsen et al., 2013)
- mental health, including depression, anxiety, self-harm and suicide (Carman et al., 2012; Lewis, 2009)
- being overweight and obesity (Boehmer et al., 2012)
- social isolation (Fokkema & Kuyper, 2009; Wallace et al., 2011)

However, in thinking about health promotion for this group, we came to the conclusion that there would be a better chance of engagement and participation if we were able to examine the experiences and views of the actual people (i.e., LGBTI seniors in NSW). This includes their health-related concerns, and what kind of activities they would actually be interested in participating in.

Consequently a partnership was established with Associate Professor Mark Hughes and Southern Cross University, and a survey developed in consultation with academics and other experts in LGBTI ageing and aged care around the country. The survey was designed to find out about ageing from the point of view of older LGBTI people in New South Wales, asking:

- What is your experience of health and wellbeing?
- What are the health issues that most concern you?
- What information do you need?
- What activities would you like to be involved in?
- How would you like to connect with other people like you?

## **Methodology**

### **Research design**

The survey comprised both quantitative and qualitative components and was delivered between March and December 2013. It sought to examine the health and wellbeing of people aged 50 and over in New South Wales. This would provide evidence underpinning the development and implementation of health promotion activities in five regions of New South Wales. The survey was delivered online through Qualtrics and was also available as a hard copy questionnaire. Ethics approval for the survey was provided by Southern Cross University and subsequently by ACON.

### **Sampling and recruitment**

One challenge in conducting research involving older LGBTI people is recruitment of participants (Hays et al., 1997), and this was also the case for this project. The cost and difficulty of generating a probability sample (e.g., random sample) meant that a non-probability convenience sample was necessary. Recruitment involved an email and social media campaign targeting LGBTI community organisations, aged care providers and other community agencies. Both the academic literature and anecdotal evidence point to the widespread isolation of LGBTI older people, especially in areas outside concentrations of visible LGBTI community. Although the initial response to the release of the survey was encouraging, it came almost exclusively from the Sydney metropolitan area. Two outreach trips in the Far North Coast and Hunter regions helped boost participation, but required that the survey remain open for longer than originally envisaged.

### **Instrument**

In order to engage the maximum possible number of LGBTI elders in health promotion activities, a range of questions was asked in the survey. These included a series of demographic questions relating to such characteristics as gender and sexual identity, ethnicity, housing circumstances, and personal and social relationships. Loneliness was measured by the 3-item Loneliness Scale (based on the UCLA loneliness scale), which has a demonstrated alpha coefficient of reliability of .72 (Hughes et al., 2004).

Health and wellbeing were examined through the use of two standardised instruments. The SF-12 was used to measure health-related quality of life. The SF-12 comprises 12 items that produce two composite scores: one for physical health (PCS) and one for mental health (MCS). It has well-established validity and reliability, including high level correlation with the respective components of the larger SF-36, on which it was based (Ware et al., 1996). The instrument has proved robust across diverse populations, including people with severe mental illness (Salyers et al., 2000). The second instrument used was the Kessler 10, a widely-used

measure of psychological distress, which has an alpha coefficient of reliability of .93 (Kessler et al., 2003).

To examine specific health concerns and preferred activities, the survey included two closed questions, and three open-ended questions. In this way we hoped to establish what kinds of health promotion activities people would be interested in, who they would like to do them with, and what the barriers to participation might be. The survey was pilot tested with a small number of LGBTI people prior to delivery. [Appendix B, Survey Instrument]

## **Data analysis**

Hard copy survey responses were entered into Qualtrics survey software. Data were then exported into IBM SPSS Statistics version 19. Data were analysed using descriptive statistics, including univariate statistics and bivariate statistics (such as chi-square and correlation), as well as inferential statistics. Given the relatively low number of people from non-English speaking backgrounds and people identifying as intersex and transgender, it was not possible to include these variables in bivariate analysis. The alpha was set at 0.05. The limitations of using inferential statistics for a non-probability sample are acknowledged.

Qualitative responses to the open-ended questions were analysed thematically, as well as being treated as categorical data and presented via frequencies and percentages. Please note that when percentages are used they are proportions of the people who answered that specific question (presented as n= within tables) rather than as a proportion of the whole sample (presented as N= in table titles). Word clouds are used to provide a brief snapshot of the 75 most common words used by respondents to answer some of the qualitative questions. The more frequently the words were used, the larger the word in the word cloud. One question at the end of the survey asked respondents to if there was anything else they would like to say. In addition, to providing a summary of responses to this question, quotations from these responses are included elsewhere in the report (as box quotations).

## **Limitations**

There were a number of limitations to this study. As noted, the non-probability sample means that attempts should not be made to generalise the findings to a wider population. The length of the survey may have been off-putting to some respondents, and it is noted that some questions were not answered by all respondents. Nonetheless, some participants highlighted areas where the survey could have been more comprehensive, such as in the exploration of culture and language use. It would have been preferable to gain a better representation of people in the upper age groups, those living in rural areas, as well as transgender and intersex people. The one intersex person who completed the survey noted areas where we could have better phrased questions, and ensured that the survey was more inclusive.

# Results

## 1. Demographics

### 1.1. Age

In total, 312 people completed this survey. The average age was 59.87 (SD=7.186, n=301). The oldest person to participate was aged 84. A much greater proportion of those aged 50 to 54 participated in the survey than any other age group.

Approximately 24.6% of people aged 65 or over participated, while only 2.0% of respondents were aged 75 or over (Table 1).

At 84 I am very healthy and active, but who knows what is around the corner. Would like to see voluntary euthanasia legalised.

### 1.2. Sex / gender

Participants were asked about their sex as identified at birth. More participants reported that they were born male (53.5%) than female (45.8%), while one participant reported that she was born intersex female (Table 1).

In terms of current gender identity, the majority of participants reported identifying as female (48.1%). 46.5% identified as male, and 4.5% as transgender male to female. Approximately 2.9% reported identifying as gender queer. Other responses to this question included: androgynous, gender resister, and intersex woman (Table 1).

### 1.3. Sexuality

So much work has been done to advance GLBT issues over the past 30 or so years. I still long for the day when sexuality is something that I NEVER need to worry about. I still am very careful about who I disclose my sexuality to.

Approximately 43.9% of the sample identified as being a gay man, while 42.9% reported being lesbian (Table 1). Relatively small proportions identified as bisexual (5.8%), queer (3.5%), asexual (2.2%), or heterosexual (1.6%). Other sexualities reported by participants included: pansexual, questioning, and not sure.

### 1.4. Ethnicity

Six people (1.9%) identified as being of Aboriginal or Torres Strait Islander descent, and five people (1.6%) said that English was not the main language they speak at home (Table 1). The majority of participants identified their ancestry as English (56.7%), while other reported ancestries included: Australian (35.9%), Irish (27.9%), Scottish (25.3%) and German (7.4%). Other European, Asian, North American, South American and African ancestries were reported.

### 1.5. Relationship status

Approximately 57.4% of respondents reported that they were in a relationship at the time of the survey (Table 1). In only 20 cases (6.4%) was this not a same-sex relationship. Of the 163

people in a relationship who answered the question, the average length of the relationship was 17.35 years (SD=12.923; median=15.00 years). The longest a respondent reported being in a relationship was 50 years.

**Table 1: Demographic characteristics (N=312)**

Characteristic	N	%
<b>Age (n=301)</b>		
50 – 54	90	29.9
55 – 59	62	20.6
60 – 64	75	24.9
65 – 69	39	13.0
70 – 74	29	9.6
75 +	6	2.0
<b>Sex at birth (n=312)</b>		
Female	143	45.8
Male	167	53.5
Intersex female	1	0.3
Intersex male	0	0.0
<b>Current gender (n=312)*</b>		
Female	150	48.1
Male	145	46.5
Trans female to male	0	0.0
Trans male to female	14	4.5
Gender queer	9	2.9
Other	4	1.3
<b>Sexuality (n=312)*</b>		
Asexual	7	2.2
Bisexual	18	5.8
Gay man	137	43.9
Lesbian	134	42.9
Heterosexual	5	1.6
Queer	11	3.5
Other	11	3.5
<b>Aboriginal or Torres Strait Islander (n=310)</b>		
Yes	6	1.9
No	304	98.1
<b>Main language spoken at home (n=309)</b>		
English	304	98.4
Other, inc. Indian, French	5	1.6
<b>Relationship status (n=311)</b>		
In a relationship	179	57.7
Not in a relationship	132	42.3

Note. \* respondents were able to select multiple options

## 2. Care arrangements

### 2.1. Providing care

Respondents were asked if they provide care to another person. Forty-six people (14.7%) indicated that they do; the majority of whom (84.8%; n=46) were providing care to a partner, family member or friend (Table 2). The average number of hours per week providing care was 23.84 (SD=30.739), while the median number of hours was 15.50.

### 2.2. Receiving care

With respect to receiving care, nine participants (2.9%) indicated that they were receiving care from another person (Table 2). Of these, five were receiving this care from a partner, family member or friend, and three were receiving it from a service provider or paid employee. The average number of hours respondents reported receiving care was 8.38 (SD=8.601) and the median number of hours was 4.50.

**Table 2: Care arrangements (N=312)**

Care arrangement	N	%
<b>Providing care to another person (n=312)</b>		
Yes	46	14.7
No	266	85.3
<b>Types of care provision relationships (n=46)</b>		
Service provider or paid employee	5	10.9
Partner, family member or friend	39	84.8
Other	2	4.3
<b>Receiving care from another person (n=312)</b>		
Yes	9	2.9
No	303	97.1
<b>Type of care receiving relationship (n=9)</b>		
Service provider or paid employee	3	33.3
Partner, family member or friend	5	55.6
Other	1	11.1

## 3. Home, Family, Community

### 3.1. Home

#### 3.1.1. Location

I and my partner live very happily in this regional/rural situation. It is a strange thing - we are more accepted in this community than we were in greater Sydney.

This project sought to include LGBTI people from a diversity of areas across New South Wales. As noted in the methodology section, particular strategies were implemented in order to recruit participants from regional and rural areas. Nonetheless nearly 60% of respondents were from metropolitan Sydney, with 16.1% from a regional city, 15.2% from a regional town,

and 9.7% from a rural area (Table 3). Identification of location was cross-checked with the postcode of main residence.

### 3.1.2. Dwelling

Most respondents lived in a house (61.5%), while about one third (33.7%) lived in a unit (Table 3). Four people (1.3%) lived in a retirement village. Other dwellings including a permanent caravan site and temporary or mobile accommodation, as well a boat, warehouse, and studio.

My accommodation is sub-standard but if I rented something better it would chew up all of my income. I am concerned as I grow older that accommodation options will become less and less affordable and it might mean moving into a boarding house or similar. That scenario is really depressing.

### 3.1.3. Cohabitation living arrangements

A large proportion of people (46.2%) in this study reported living with their partner (Table 3). Others reported living with their children (6.7%), friends (4.2%), parents (1.3%), and housemates/residents who are not their friends (1.0%). Other types of cohabitants included grandchild, former partner, nephew, and sister. Notably a large proportion of people – 126 respondents or 40.4% – reported that they live alone.

**Table 3: Home circumstances (N=312)**

Home circumstances	N	%
<b>Location (n=310)</b>		
Metropolitan Sydney	183	59.3
Regional city	50	16.1
Regional town	47	15.2
Rural area	30	9.7
<b>Dwelling (n=312)</b>		
House	192	61.5
Unit	105	33.7
Retirement village	4	1.3
Permanent caravan site	1	0.3
Temporary/mobile accommodation	1	0.3
Other	9	2.9
<b>Cohabitation (n=312)*</b>		
Living alone	126	40.4
Living with partner	144	46.2
Living with children	21	6.7
Living with parents	4	1.3
Living with friends	13	4.2
Living with housemates/residents	3	1.0
Other	26	8.3

Note. \* respondents were able to select multiple options



I would not like to be left alone as it has been a very lonely journey to this point. I am lucky as I have Veterans Affairs to help me but being a closeted gay man in the armed forces has taken its toll.

As might be expected, living alone was significantly associated with loneliness with the score on the 3-item Loneliness Scale 5.443 for those who live alone and 4.488 for those who live with others  $F(1, 275) = 18.738, p \leq .001$ . Similarly, those who were not in a relationship scored much higher on the Loneliness Scale (5.815) than those who were in a relationship (4.166)  $F(1, 274) = 65.403, p \leq .001$ . In terms of the individual items of the scale, the average score was greatest for feeling isolated from others, then feeling that you lack companionship, and then that you feel left out (Table 4).

Loneliness: How often do you feel ...	Hardly ever N (%)	Some of the time N (%)	Often N (%)	Mean (SD)
That you lack companionship	163 (52.2)	101 (32.4)	48 (15.4)	1.63 (.736)
Left out	158 (50.8)	122 (39.2)	31 (10.0)	1.59 (.665)
Isolated from others	147 (47.3)	117 (37.6)	47 (15.1)	1.68 (.723)

### 3.2.1. Biological kin

[illegible]

### Figure 1

lifestyle and my partner. Their partners and family are also supportive and include my partner and I in family events. Other than my children I have no immediate relatives. My partner has siblings and they also are supportive of our relationship. I can't think of anyone in my family group who would not be there for us in a crisis.

Some noted that they may be the ones providing the support or at least there would be a degree of mutuality in the relationship:

I have one son and extended family. I would see myself as offering more support than I receive, except for my sister, where there is a give and take balance.

Some respondents provided specific detail about situations where biological family members had supported them in a crisis:

I have a good relationship with my son who lives in Sydney and a very close relationship with my sister who I talk to and text regularly. She has been very supportive during my breakup with partner last few months.

In contrast, 12.1% indicated that they were completely estranged from all their biological family members, and would not be able to turn to them for support. For some this related to their sexuality:

I have an elderly Father and a brother and sister, but being gay I was isolated from them from my early adulthood. I therefore receive no support from them.

My two living brothers are both homophobic and have excluded me from their lives and the lives of their families. I never see them. They would certainly not be there for me in a crisis.

For some transgender people, family members were struggling to adjust to their transition:

My wife is struggling with my desire to transition. My adult children are more likely to support her than me. There is a big question as to whether any of them will come with me if I press on with my journey.

For others, there were other issues that led to estrangement:

My immediate family are estranged from me, not because of my sexuality but because alcohol and mental health have precluded a strong relationship. I am a proud single woman who is looking for companionship but believe I will be doing things on my own for the rest of my life.

For 17.6% of the 289 people who provided responses to this question, the distance between them and biological family members was not due to estrangement, but to other issues, including geographical distance:

I have one half brother plus his family in South Australia, all other surviving relatives live in England and so being here in a crisis would be marginally practical only for the SA half-brother.

For others, death, ill health and disablement have impacted on their relationships with biological family members and the availability of support. For example:

Only child. Mother deceased. Father has advanced dementia. Unlikely to receive much support from cousins.

For some, changes in people's lives (e.g., work commitments and family responsibilities) means that the support that once would have been there is no longer available:

That is a hard one! I have three married children who are all very busy with their partners and children, so I come way down the line. I know they love me but they have very busy lives and little time left over for me. As for friends, most of my close friends are dead, those who are not live a long way from me, so we don't catch up very often.

About 12.5% of respondents noted considerable variation in the degree to which they might expect support from biological family members. For some, support is available from some kin, but not others:

I have only one sister, and we have not communicated in 9 years. She does not know about my same sex relationship and I know she would disapprove. I have no children. My partner's 2 sons, her sisters and parents, plus extended family are all supportive of our relationship.

I have a medium size family. Most are fine about my sexuality and love my partner. I have two daughters 33 and 31yrs. The younger one is homophobic and pretty cruel to me. She drains me of the support I receive. UMM

Some respondents were not sure family members would be there for them in a crisis:

Parents deceased..... No siblings.... Lovers deceased.....One son living OS [overseas]. .....One son in Sydney. ....I think they would be there in a crisis situation, but you never know.....

Some had fought estrangement:

I'm an only child. My parents are now both deceased. For many years I was estranged from them due to my sexuality. It was only due to my determination, love and concern for them that any contact was maintained. My partner's family are very supportive of us and would be there in a crisis.

And others reflected on changing attitudes over time:

Son and daughter-in-law, totally accepting, would be there for me. Daughter and son-in-law were totally accepting and supportive UNTIL I started talking about top surgery. Now my gender identity is not discussed. Grandson who adores me, but he's only 6. Parents deceased. Aunt in Perth, cousin in WA - totally accepting and supportive. Brother and nephew in Sydney - completely useless.

### **3.2.2. Friends**

Respondents were asked about their friends and who would be there for them in a crisis. We were interested to see if people felt they would have both LGBTI and non-LGBTI friends available to provide support. The findings demonstrated that for most people this was the case. Nearly 71% of respondents indicated that they have non-LGBTI friends in the same region available to support them, while nearly 69% indicated that they had LGBTI friends in the same region (Table 5). Indeed consistently more people said that they had non-LGBTI friends available to provide them with support – this was most marked for friends living interstate (36.9% had non-LGBTI friends compared to 26.3% for LGBTI friends).

The survey also asked respondents what they felt about the following statement: My friends are more important to me than my biological family. The majority of respondents (51.3%) neither agreed nor disagreed with the statement, while 31.0% agreed with the statement, and 17.6% disagreed with it.

**Table 5: Supportive friends (N=312)**

Who would be supportive of you in a crisis?	N	%
LGBTI friends in the same region	215	68.9
Non-LGBTI friends in the same region	221	70.8
LGBTI friends elsewhere in NSW	122	39.1
Non-LGBTI friends elsewhere in NSW	125	40.1
LGBTI friends interstate	82	26.3
Non-LGBTI friends interstate	115	36.9
LGBTI friends overseas	76	24.4
Non-LGBTI friends overseas	90	28.8

*Note.* respondents were able to select multiple options

### 3.3. Community

The survey asked people to consider the different types of groups they were involved in in their local community and whether or not these were LGBTI-specific groups (Table 6). For some types of activities more people attended non-LGBTI groups than LGBTI-specific groups: arts and culture (26.3% attended general groups versus 15.4% attended LGBTI groups); church, religious or spiritual groups (13.5% versus 6.4%); clubs or pubs (17.9% versus 13.1%); and sports and fitness groups (22.8% versus 7.7%).

Examples of LGBTI-specific arts and crafts groups included Sydney Gay and Lesbian Choir and LGBTI theatre group, while non-LGBTI groups included theatre groups, art galleries, bridge clubs, classical music groups, knitting groups, gardening clubs, drumming group and pottery group. Examples of LGBTI-specific religious activities included attending the Metropolitan Community Church and participating in LGBTI-meditation groups. Non-LGBTI-specific activities included church attendance, involvement in meditation groups, participating in Buddhist groups, and Wicca groups. Some people attended LGBTI clubs and pubs, such as LGBTI venues and dance parties, Sydney Sunboys (a nudist group), Tropical Fruits and Feathers Women's Social Club. Non-LGBTI clubs attended included RSL clubs, local pubs, Masonic clubs, and rugby league clubs. LGBTI-specific sports and fitness groups included walking groups, cycling groups and ten-pin bowling group. General sports and fitness groups included gym groups, cycling groups, table tennis club, walking groups, swimming groups, dragon boat club, lawn bowls, golf, and sailing groups.

**Table 6: Participation in community groups (N=312)**

Group activities	LGBTI-specific N (%)	Non-LGBTI specific N (%)
Arts & Culture	48 (15.4%)	82 (26.3%)
Church, religious or spiritual	20 (6.4%)	42 (13.5%)
Clubs or pubs	41 (13.1%)	56 (17.9%)
Community organisations	50 (16.0%)	38 (12.2%)
Social or support groups	76 (24.4%)	16 (5.1%)
Sports & fitness groups	24 (7.7%)	71 (22.8%)

With respect to participation in community organisations (e.g., volunteering) and involvement in social or support groups, more people identified belonging to LGBTI-specific rather than general groups (Table 6). Of the total sample, 16.0% of respondents said that they were involved in LGBTI community groups, while 12.2% said they were involved in general community organisations. 24.4% of respondents said they were involved in LGBTI-specific social or support groups, while 5.1% were involved in similar non-LGBTI groups.

LGBTI community organisations that people participated in included ACON, Mardi Gras, Gay and Lesbian Counselling Service, Pride History Group, Gay and Lesbian Rights Lobby, Australian Lesbian Medical Association, National LGBTI Health Alliance, and Mature Age Gays. Non-LGBTI-specific groups included political parties, local community services agencies, Apex, Lions Club, Parents and Friends Associations, aged care services, neighbourhood centres, Older Women's Network, Rural Fire Service, Surf Lifesaving, SES, Landcare, Cancer Council, International Women's Day Committee, and Legacy. LGBTI support and social groups included Ten Forty Matrix, Harbour City Bears, Tropical Fruits, Coastout, Rainbow Coffs, Coastal Castaways, Websisters, A Gender Agenda, Fruits in Suits, Long Yang Club, Mature Age Gays, and Lesbians in Shoalhaven. Non-LGBTI social or supported groups attended included retirement group, and a community women's group.

## 4. Communication and technology

### 4.1. Methods of communication

Engaging with people in relation to health promotion activities requires an understanding of participants' preferred method of communication, as well as their degree of comfort with different communication technologies. Respondents were asked whether or not they have an internet connection at home. Of the 302 people who answered this question, 285 (97.8%) indicated that they do. Use of the internet also figured strongly when asked about the main ways in which they keep in touch with friends and family: nearly 90% of respondents indicated that they used email, and a further 51.0% that they used social media (Table 7). Nearly 87% said that they used a mobile phone for this purpose, and nearly 60% a landline phone. Only 25% said that they used the regular post to stay in touch with friends and family. Other ways included LinkedIn and Skype and through face to face contact.

**Table 7: Main ways of keeping in touch (N=312)**

Main ways of keeping in touch with friends and family	N	%
Landline phone	186	59.6
Mobile phone	271	86.9
Email	280	89.7
Social media	159	51.0
Post	78	25.0
Other	37	11.9

*Note.* respondents were able to select multiple options

The high use of internet-based technology suggests a degree of comfort with these tools. When asked how confident they felt using email, 81.1% said they felt extremely confident, while 77.9% said they felt extremely confident conducting an internet search (Table 8). Fewer people reported such a high degree of confidence using social media tools such as Facebook (54.3%), Youtube (47.3%), Twitter (21.1%) and Blogging (19.2%). Indeed the latter two recorded the highest proportion of people feeling not at all confident using them: 50.8% for Twitter and 45.5% for blogging. High proportions of respondents also felt extremely confident using mobile phones (72.0%) and smart phones (60.8%).

**Table 8: Confidence using technology**

Technology	Not at all confident N (%)	Confident N (%)	Extremely confident N (%)
Mobile phone (n=300)	7 (2.3)	77 (25.7)	216 (72.0)
Smart phone (n=240)	24 (10.0)	70 (29.2)	146 (60.8)
PC/Laptop (n=300)	7 (2.3)	83 (27.7)	210 (70.0)
Tablet (n=197)	29 (14.7)	50 (25.4)	118 (59.9)
Blogging (n=156)	71 (45.5)	55 (35.3)	30 (19.2)
Email (n=312)	2 (0.6)	57 (18.3)	253 (81.1)
Facebook (n=223)	25 (11.2)	77 (34.5)	121 (54.3)
Internet search (n=308)	3 (1.0)	65 (21.1)	240 (77.9)
Twitter (n=128)	65 (50.8)	36 (28.1)	27 (21.1)
Youtube (n=256)	36 (14.1)	99 (38.7)	121 (47.3)

## 4.2. Media use

Targeted health promotion activities rely on understanding the media through which LGBTI people access information. In terms of LGBTI media, the publication most people accessed was Star Observer (34.6% in print, and 20.2% online) (Table 9), although this may not be surprising given that nearly 60% of respondents resided in metropolitan Sydney. The next most frequently accessed publication was SX/Gay News Network (23.1% in print, 12.2% online), followed by Lesbians on the Loose (18.3% in print, 7.7% online).

Non-LGBTI media was accessed regularly by a much greater number of respondents. Nearly 47% regularly access the local free newspaper in print (9.6% online), while nearly 45% listen to the local radio station live to air (8.3% online). Other reported media sources included national newspapers, ABC Radio National, television news programs, and national magazines.

**Table 9: Media used regularly (N=312)**

Media	Print / live to air N (%)	Online N (%)
<b>LGBTI media</b>		
AXN	13 (4.2)	6 (1.9)
Cherrie	3 (1.0)	2 (0.6)
DNA	13 (4.2)	4 (1.3)
FUSE	2 (0.6)	6 (1.9)
JOY 94.9FM	5 (1.6)	7 (2.2)
Lesbians on the Loose (LOTL)	57 (18.3)	24 (7.7)
Polare	7 (2.2)	8 (2.6)
QPride	5 (1.6)	4 (1.3)
QNews	10 (3.2)	5 (1.6)
Star Observer	108 (34.6)	63 (20.2)
SX/Gay News Network	72 (23.1)	38 (12.2)
<b>Non-LGBTI media</b>		
Local free newspaper	146 (46.8)	30 (9.6)
Local radio station	139 (44.6)	26 (8.3)
Ageing-related publication	36 (11.5)	15 (4.8)
Other	64 (20.5)	38 (12.2)

*Note.* respondents were able to select multiple options

## 5. Health and wellbeing

### 5.1. Health-related quality of life

As noted in the Methodology section, health-related quality of life was measured using the SF-12 instrument, which provides composite scores for physical health and mental health. Both scores can range from 0 to 100, with higher the score indicating the higher level of self-reported health. In large national surveys of the adult population in the United States the means for both composite scores have been established as 50, with standard deviations (SD) of 10. Convention has established scores of 40-49 as representing mild disability, 30-39 as moderate disability, and below 30 as severe disability (Andrews, 2002).

In terms of physical health the average composite score for the sample (N=312) was 47.365 (SD=10.2067). The median physical health composite score was 50.4, with the scores ranging from 17.61 to 64.28. This compares favourably with other studies of the general population. For example in a study of 1570 people aged 50 and over in the United States, the mean physical health summary score was 45.6 (SD=11.1) (Der-Martirosian et al., 2010).

The average composite score for mental health was 49.373 (SD=10.844), with the median score being 57.73, ranging from 18.0 to 64.23. In contrast with the score for physical health, the mean mental health summary score is much lower than that of studies of the general population. In the Der Martirosian et al. (2010) study, the mean mental health summary score was 53.9 (SD=8.0).



With respect to the general health item, nearly 51% of respondents said that their health was excellent or very good, while only 3.5% said their health was poor (Table 10). This compares favourably with the results from the 2011-13 Australian Health Survey which established that in that sample of adults aged 15+ about 4% of respondents identified their health as poor (ABS, 2012).

**Table 10: General health item (SF-12) (N=310)**

In general, would you say your health is	N	%
Excellent	48	15.5
Very good	110	35.5
Good	94	30.3
Fair	47	15.2
Poor	11	3.5
Mean = 2.56 (SD=1.037); Median = 2.00		

## 5.2. Psychological distress

In addition to the mental health composite score in the SF-12, mental health was also measured through the well-established Kessler 10, which examines psychological distress. In contrast to the SF-12 (where lower scores indicate a greater degree of ill health), the higher the score on the Kessler 10, the higher the degree of psychological distress. The overall summary score for the Kessler 10 can vary between 10 and 50. Following the categorisation in the 2011-13 Australian Health Survey, scores ranging from 10 to 15 represent low levels of psychological distress; 16 to 21 moderate levels; 22 to 29 high levels; and 30 and above very high levels (ABS, 2012).

For this sample of LGBTI people aged 50 or over, the average summary score was 15.749 (SD=5.439). The median was 14, and the scores for the sample ranged from 10 to 34. Of the 263 people who responded to this question, 60.1% scored within the low level of psychological distress band, 24.7% within the moderate band, 12.2% in the high level band, and 3.0% in the very high band.

This represents a higher level of psychological distress than that evidenced in the Australian adult (18+) population as reported in the Australian Health Survey (ABS, 2012). In that survey, about 70% of people were scored in the low band, about 20% in the moderate band, and 10% in the high and very high bands combined (compared to just over 15% in these two bands in our study). It is also higher in this sample than that recorded in the 45 and Up study (Phongsavan et al., 2013), which surveyed 236,490 Australians aged 45 and over. In that survey, 92.3% of respondents were classified as experiencing low/medium psychological distress (10-21 on the Kessler 10), compared to 84.8% in our study. In the 45 and up study, 7.6% reported high or very high psychological distress (22 and over on the Kessler 10), while in our study 15.2% reported this high or very high level.



With regard to the individual items in the Kessler 10 instrument, the item with the highest mean score was “tired out for no good reason”, where nearly 38% said that they felt this way at least some of the time (Table 11).

**Table 11: Psychological distress (Kessler 10) items**

In the last 4 weeks, how often did you feel:	None of the time N (%)	A little of the time N (%)	Some of the time N (%)	Most of the time N (%)	All of the time	Mean (SD)
Tired out for no good reason (n=312)	90 (28.8)	104 (33.3)	88 (28.2)	26 (8.3)	4 (1.3)	2.20 (.991)
Nervous (n=310)	136 (43.9)	101 (32.6)	60 (19.4)	10 (3.2)	3 (1.0)	1.85 (.910)
So nervous that nothing could calm you down (n=308)	265 (86.0)	30 (9.7)	13 (4.2)	0	0	1.18 (.484)
Hopeless (n=311)	212 (67.9)	67 (21.5)	26 (8.4)	5 (1.6)	1 (0.3)	1.44 (.742)
Restless or fidgety (n=309)	149 (48.2)	109 (35.3)	42 (13.6)	9 (2.9)	0	1.71 (.809)
So restless or fidgety that you could not sit still (n=309)	263 (85.1)	34 (11.0)	9 (2.9)	2 (0.6)	1 (0.3)	1.20 (.545)
Depressed (n=311)	148 (47.6)	90 (28.9)	51 (16.4)	19 (6.1)	3 (1.0)	1.84 (.974)
That everything was an effort (n=308)	147 (47.7)	96 (31.2)	47 (15.3)	15 (4.8)	3 (1.0)	1.80 (.936)
So sad that nothing could cheer you up (n=308)	237 (76.9)	45 (14.6)	22 (7.1)	4 (1.3)	0	1.33 (.665)
Worthless (n=311)	225 (72.3)	58 (18.6)	20 (6.4)	7 (2.3)	1 (0.3)	1.40 (.737)

### 5.3. Relationship between health status and other factors

In addition to understanding the health characteristics of the whole sample, we were also interested in looking to see if there were any significant differences across different groups in the sample. With regard to respondents’ age, no relationship was identified between this variable and the physical health composite score. However, a significant difference was identified in relation to the mental health composite score on the SF-12: specifically that people in the older age groups (60-64 and 65+) reported better mental health than people in the younger age groups (50-54 and 55-59)  $F(3, 287) = 2.765, p \leq .05$ . This reflects well-established prevalence data demonstrating that the prevalence of mental disorders in the general population decreases with age (Slade et al., 2009).

My concern is for my partner. He had a cancer in the late eighties, which was cured by severe surgery and radiation but with serious and ongoing side effects. Due to these and other aging health problems his health has been declining for the last five years.

With respect to relationship status, mental health (as measured by the SF-12) was significantly better for people with a partner (51.867) than those without (46.058)  $F(2, 299) = 11.879, p \leq .001$ . This finding was reinforced by identification that people in a relationship reported less psychological

distress on the Kessler 10 instrument (14.658) compared to those who were not in a relationship (17.236)  $F(2, 260) = 7.623, p \leq .001$ . No significant relationships were identified between relationship status and physical health. The better mental health state of people in relationships is reflective of well-established findings in the general population that those people who are married or in marriage-like relationships report better mental health than those who aren't (Wight et al., 2013). Questions remain about whether formally-recognised marriages prove more beneficial in terms of mental health to LGBTI people than non-recognised relationships, with initial evidence suggesting they are (Wight et al., 2013).

In terms of current gender identity, those identifying as female reported significantly lower levels of physical health (45.702) than others in the sample (48.841)  $F(1, 300) = 7.261, p \leq .01$ . As might be expected given this finding, males reported significantly higher levels of physical health (48.727) than others (46.140)  $F(1, 300) = 4.900, p \leq .05$ . No significant differences were identified between mental health and gender identity. Given the majority of those identifying as female were lesbians, this finding reflects, perhaps, the wider literature on lesbians' health which points to key physical health issues such as higher levels of obesity, alcohol use and smoking than the general population (Boehmer et al., 2012).

Deteriorating physical health (eye sight, arthritis etc) can lead to an increase in fear and anxiety - I am somewhat worried about this in my own ageing process.

While it was not possible to identify any relationships in relation to receiving care and health status (due to the small number of people receiving care), it was possible to examine the relationship between providing care (being a caregiver) and health as measured by the SF-12. Notably people who were providing care reported significantly lower mental health (45.744) than those who were not providing care to another person (49.992)  $F(1, 300) = 5.862, p \leq .05$ . This reflects findings from the Australian National Mental Health Survey that the prevalence of mental health disorders is greater among carers than the general population (Slade et al., 2009).

With respect to people living alone, no significant relationships were identified between this factor and physical health or mental health as measured by the SF-12. However, people who lived alone did score significantly higher on the Kessler 10 measure of psychological distress (16.604 compared to 15.172)  $F(1, 261) = 4.442, p \leq .05$ . This was a very similar finding to that of Winefield et al. (2009) who identified, in a sample of 1933 people from the general

population aged 18+, a mean score of 16.3 for those living alone, compared to 15.1 for those living with one other person and 15.5 for those living with three or more people.

My primary concern about ageing is loneliness and social isolation. I sometimes see advertisements for activities I would like to be involved in, but because I am alone and have no-one to go with me, I end up not attending, primarily because of the embarrassment and awkwardness involved in walking into a strange venue for the first time, where no-one knows you. Fear of rejection can be extremely debilitating.

Correlations were also identified between loneliness, as measured by the 3-item Loneliness Scale, and lower levels of mental health [ $r(268) = -.519, p \leq .05$ ] and higher levels of psychological distress [ $r(260) = .630, p \leq .001$ ]. The relationship between loneliness and higher prevalence of mental disorder is

well established in both the general population (Hawkey & Cacioppo, 2010) and among LGBTI people (Fokkema & Kuyper, 2009).

No relationships were identified between physical or mental health and the region in which the respondent lived. It was not possible to examine relationships between language and health status due to the small number of people in the sample who did not speak English as their main language at home.

#### 5.4. Health issues

Respondents were asked what health issues they thought were most important for them. The greatest proportion of people (44.9%) identified exercise as very important (Table 12). Other

health issues most commonly rated as very important included memory loss (26.4%) and dementia (23.7%).

Approximately 29% of respondents identified dental health as very important, while 27.7% identified heart disease.

Loneliness was also reported as very important by 27.7% of respondents, and anxiety or depression was identified by 25.8% as very important.

Vascular disease runs through my mother's side of the family and so I work hard to stay fit to try and stave off my genetic legacy. In that regard, since her sister dropped dead of a stroke at age 46 and my mother herself started dementing when she was only 53, I am geared toward living well.

#### 5.5. Relationship between health issues and other factors

Further analysis was conducted to see if there were any associations between key demographic variables and self-reported health issues. Reflecting findings reported earlier, people in the upper age groups were significantly less likely to report anxiety and/or depression as very important to them (18.3% of people aged 65+ compared to 30.6% of those aged 50-54)  $\chi^2 (6, N = 288) = 19.381, p \leq 0.01$ . The older portion of the sample also felt that lack of exercise or physical activity was a very important issue to them (53.4% of those aged 65+) compared to the younger members of the sample (35.3% of those aged 50 to 54)  $\chi^2 (6, N = 290) = 13.360, p \leq 0.05$ .

Again, similar to previously reported findings, those who were not in a relationship were significantly more likely to report anxiety and/or depression as being very important to them (33.3%) than those who were partnered (19.5%)  $\chi^2 (2, N = 298) = 14.231, p \leq 0.001$ . They were more likely to identify other mental health problems (not anxiety/depression) as very important (18.5% compared to 9.6%)  $\chi^2 (2, N = 291) = 6.413, p \leq 0.05$ . And finally, those not in a relationship were more likely to think that loneliness or social isolation was a very important issue for them (44.2%) compared to those who were in a relationship (15.3%)  $\chi^2 (2, N = 299) = 32.418, p \leq 0.001$ .

I think loneliness and dementia are my greatest worries. The latter moreso. To lose one's mental powers would be just the absolutely most devastating thing to happen in my opinion.

**Table 12: Health issues (N=312)**

Which of these health issues are most important to you?	Not at all important N (%)	Somewhat important N (%)	Very important N (%)
Alcohol use (n=302)	178 (58.9)	95 (31.5)	29 (9.6)
Anxiety and/or depression (n=299)	105 (35.1)	117 (39.1)	77 (25.8)
Cancer (n=300)	119 (39.7)	127 (42.3)	54 (18.0)
Dementia (n=300)	101 (33.7)	128 (42.7)	71 (23.7)
Dental (n=297)	78 (26.3)	132 (44.4)	87 (29.3)
Diabetes (n=296)	175 (59.1)	76 (25.7)	45 (15.2)
Drug use (n=295)	233 (79.0)	43 (14.6)	19 (6.4)
Exercise (n=301)	48 (15.9)	118 (39.2)	135 (44.9)
Heart disease (n=296)	89 (30.1)	125 (42.2)	82 (27.7)
Loneliness (n=300)	108 (36.0)	109 (36.3)	83 (27.7)
Melanoma (n=295)	122 (41.4)	116 (39.3)	57 (19.3)
Memory loss (n=299)	84 (28.1)	136 (45.5)	79 (26.4)
Mental health (not anxiety/depression) (n=292)	167 (57.2)	86 (29.5)	39 (13.4)
Mobility (n=295)	152 (51.5)	89 (30.2)	54 (18.3)
Overweight (n=299)	124 (41.5)	119 (39.8)	56 (18.7)
Pain (n=296)	147 (49.7)	102 (34.5)	47 (15.9)
Prostate (n=294)	207 (70.4)	63 (21.4)	24 (8.2)
Sexual health (n=295)	208 (70.5)	52 (17.6)	35 (11.9)
Smoking (n=294)	233 (79.3)	34 (11.6)	27 (9.2)
Urine problems (n=295)	167 (56.6)	95 (32.2)	10.6 (11.2)
Violence/abuse (n=295)	221 (74.9)	52 (17.6)	22 (7.5)
Vision loss (n=297)	119 (40.1)	126 (42.4)	52 (17.5)

With respect to gender, those identifying as female were significantly less likely to think that melanoma was a very important issue to them (14.9%) than the rest of the sample (23.4%)  $\chi^2$  (2,  $N = 295$ ) = 8.253,  $p \leq 0.05$ . Mental health problems (other than anxiety or depression) were also less likely to be reported as very important to them by those identifying as female (8.5% compared to 17.9%)  $\chi^2$  (2,  $N = 292$ ) = 9.879,  $p \leq 0.01$ . Sexual health issues were much less likely to be identified as very important to people identifying as female (1.4% compared to 21.6%)  $\chi^2$  (2,  $N = 295$ ) = 67.140,  $p \leq 0.001$ . Those identifying as male were also significantly less likely to think that lack of exercise or physical activity was very important to them (37.9% compared to 50.9%)  $\chi^2$  (2,  $N = 301$ ) = 7.211,  $p \leq 0.05$ .

In relation to geographical location, some important differences were noted which suggest that people in non-metropolitan areas were concerned about some key health issues more than those in metropolitan areas. These included:

- alcohol use (12.7% versus 7.4%)  $\chi^2$  (2,  $N = 302$ ) = 5.904,  $p \leq 0.05$
- anxiety and/or depression (32.3% versus 21.1%)  $\chi^2$  (2,  $N = 299$ ) = 6.757,  $p \leq 0.05$
- diabetes (20.0% versus 11.7%)  $\chi^2$  (2,  $N = 296$ ) = 7.357,  $p \leq 0.05$ .
- smoking (13.8% compared to 5.8%)  $\chi^2$  (2,  $N = 294$ ) = 9.646,  $p \leq 0.01$

For people living alone, they were significantly more likely to identify loneliness and social isolation as very important to them (35.0% compared to 22.6%)  $\chi^2 (2, N = 300) = 6.144, p \leq 0.05$ . For carers, a key concern was dental health, where 31.8% of carers reported this as very important to them compared to 14.3% of non-carers  $\chi^2 (2, N = 297) = 7.229, p \leq 0.05$ .

People who reported a higher degree of loneliness (as measured on the 3-item Loneliness Scale) were more likely than those less affected by loneliness to say that a range of health issues were very important:

- anxiety and/or depression (41.4% versus 10.6%)  $\chi^2 (2, N = 265) = 51.935, p \leq 0.001$ .
- other mental health issues (18.9% versus 8.6%)  $\chi^2 (2, N = 260) = 8.900, p \leq 0.05$ .
- dental health (36.8% versus 21.5%)  $\chi^2 (2, N = 263) = 7.610, p \leq 0.05$ .
- heart disease (33.3% versus 21.4%)  $\chi^2 (2, N = 290) = 6.761, p \leq 0.05$ .
- mobility issues (24.2% versus 12.3%)  $\chi^2 (2, N = 262) = 7.491, p \leq 0.05$ .
- being overweight/obesity (21.8% versus 13.5%)  $\chi^2 (2, N = 266) = 7.324, p \leq 0.05$ .
- pain (20.7% versus 10.2%)  $\chi^2 (2, N = 263) = 8.887, p \leq 0.05$ .

Similarly, those who reported higher degrees of psychological distress were also more likely to report a series of health issues as very important (in addition to depression/anxiety and other mental health issues):

- heart disease (44.4% versus 24.2%)  $\chi^2 (2, N = 251) = 7.665, p \leq 0.05$ .
- loneliness and social isolation (64.9% versus 19.7%)  $\chi^2 (2, N = 255) = 38.593, p \leq 0.001$ .
- being overweight/obesity (33.3% versus 15.6%)  $\chi^2 (2, N = 254) = 7.607, p \leq 0.05$ .
- pain (23.7% versus 13.6%)  $\chi^2 (2, N = 251) = 6.341, p \leq 0.05$ .

## 5.6. Health services

Of those who answered the question (n=305), 84.3% indicated that they have a regular General Practitioner who they visit. Further, 74.7% stated that they have disclosed their sexual and/or gender identity to their General Practitioner. Disclosure was positively associated with having a regular GP – of those who reported having a regular GP, 80.2% said they had disclosed their sexual and/or gender identity to them, while only 56.4% of those who did not have a regular GP had disclosed this  $\chi^2 (1, N = 302) = 10.930, p \leq 0.001$ .

Respondents were also asked about their health service use in the past 12 months and in the past 5 years (Table 13). As indicated by the previous findings, a large proportion (88.5%) reported that they had contact with a General Practitioner in the past year (Table 12). Other services reported by most people as having been accessed in the last 12 months included: dentist (68.6%), optometrist/optamologist (58.3%) and physiotherapist/chiropractor (35.9%). For males (at birth) 38.9% had had a prostate check in the last 12 months, and for females (at birth) 34.3% had had a pap smear during the past year.

**Table 13: Health service use (N=312)**

Which health services have you used?	In the past 12 months N (%)	In the past 5 years N (%)
Counsellor/psychiatrist/psychologist	87 (27.9)	80 (25.6)
Dentist	214 (68.6)	74 (23.7)
Dietician/nutritionist	32 (10.3)	37 (11.9)
General Practitioner	276 (88.5)	21 (6.7)
Hormone test	46 (14.7)	29 (9.3)
Mammogram	56 (17.9)	45 (11.9)
Naturopath/alternative health practitioner	69 (22.1)	37 (11.9)
Occupational Therapist	16 (5.1)	25 (8.0)
Optometrist/Ophthalmologist	182 (58.3)	61 (19.6)
Pap smear	49 (15.7) (34.3% female sex at birth)	33 (10.6) (23.1% female sex at birth)
Physiotherapist/chiropractor	112 (35.9)	51 (16.3)
Podiatrist	59 (18.9)	36 (11.5)
Prostate check	65 (20.8) (38.9% male sex at birth)	24 (7.7) (14.4% male sex at birth)
Sexual health check	75 (24.0)	35 (11.2)

### 5.7. Barriers to access

Survey respondents were given the opportunity to identify any factors that prevented them from accessing health services. Only 115 people answered this question and, of those, 49.6% said that nothing prevented them from accessing services. Some commented favourably on their treatment by health providers:

No issues at all, quite the contrary, without exception all medical professionals I see are exactly that - professional.  
I expect proper treatment and I get it.

Some people noted their satisfaction of receiving services from LGBTI staff or by those who were clearly friendly towards LGBTI people.

No, my doctor is also lesbian. Love it!

One person noted that her fears of discrimination were unfounded:

Not now but I was self-medicating hormones for 18 months before having the courage (and good sense) to approach my GP. I thought he would be angry/disgusted/dismissive/judgmental/etc.. He was just the opposite, non-judgmental and supportive, all my fears were inside my head.

Some barriers to accessing services were identified though and these did include, for 4.3% of respondents, as suggested above, the fear of discrimination or abuse:



Fear of discrimination, expecting the health service will not understand my situation.

Still have some fear from previous abuse in hospital.

Direct experiences of discrimination, homophobia or ageism were reported by 4.3% of respondents:

On one occasion when admitted to hospital for emergency surgery one attending [doctor] appeared scared of me when she discovered I was a gay woman and had a partner. Also she then failed to complete some administrative forms, which led directly to some problems we had to go and sort out later (Not happy Jan). On one occasion a wardsmen made quite rude remarks about gay people and the Mardi Gras and I told him I am sure he would "get over it" but on reflection I should have complained to his superiors.

I find doctors assume you are stupid when you are old. I keep looking for a doctor that can see me as a person not just grey hair. My friends say I'm stupid to keep looking. Just resign yourself to it. I am unconventional and do not want to put up with their stereotypes.

GP is hard to get an appointment to see. Also not very approachable and sort of judgemental. I don't really like him much, so one tends to avoid going until way later than should have.

The most commonly reported reason (by 18.3% of respondents) for people feeling that they cannot access health services was a general concern about the quality of services. For example:

Fear of infection if admitted to hospital. I have already cancelled a procedure because I am afraid I will not be well looked after.

Can't stand the waiting time. Haven't found a GP I like, so just go to the medical centre, but don't feel comfortable disclosing personal issues there.

Would like a gay or gay friendly doctor but too many GPs on the (Oxford Street) strip are too jaded, too burnt out. I've had really scary experiences arguing with them that I am actually in a closed, monogamous relationship. Those guys should get some therapy to shake off their misbelief that all gay men sleep around and are thus HIV+.

For other respondents, cost of services (including lack of bulk billing practices) were felt to impact on their ability to access resources:

Cost, it is very hard to find anyone who bulk bills when you do not have a health care card.

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

I can't afford dental services although my dental problems are not chronic.

Other respondents noted work/time pressures kept them from accessing services (3.5%), while others reported a lack of services in the local area (2.6%) and the distance to travel to services (1.7%).

Respondents were asked:

- ### 5.8.1. Current activities

Maintaining my excellent health at 68 years of age is my highest priority. I walk to shops located in local areas rather than drive. If I do drive to shops, or any venue really, (during daylight hours) I park in a street approx 1 mile from my destination AND WALK there. I play regular full on squash every week (one to two days), & 2 hours of bushwalking every Wednesday. Before bed every night I do BALANCE EXERCISES (standing on one leg, etc.) and weights.

### Eating healthily (fresh fruit and vegetable)

## Taking responsibility for correct eating

### Eating a healthy diet - I am vegetarian

Socialising with friends (e.g., dining out) was also reported by a large proportion of people: 24.6%:

Lots of social interaction / Go out for dinner twice a week with partner and family / friends



### Figure 2

## Outrageous Ageing Survey Report



some, maintaining or improving health and wellbeing related to maintaining a positive attitude towards life (8.0%). For example:

I keep a positive outlook on life and maintain a happy outlook.

Trying not to be so hard on myself.

Paying attention to what gives me energy and doing more of that. Limit my time with people who zap my energy.

Other activities included playing with pets (3.2%), enjoying nature (3.0%), studying (3.0%), playing music or singing (2.7%), listening to music (2.0%), and retiring from work (1.3%).

### 5.8.2. Future activities

Survey respondents were also asked what they would like to do in the future to improve or maintain health and wellbeing. See Figure 3 for a word cloud representing the most common 75 terms used to describe this. Nearly half (46.1%) of those who responded to this question (n=269) said that they would like to be taking up more exercise than they currently do. As before, this included more walking, swimming, and gym activity:

I would like somewhere affordable to get strengthening exercise and an exercise leader who is knowledgeable about strengthening weak areas in older people, particularly when some disability is present.

I live on a National Park and would like to do a lot more bushwalking, as I would be on edge bushwalking on my own.

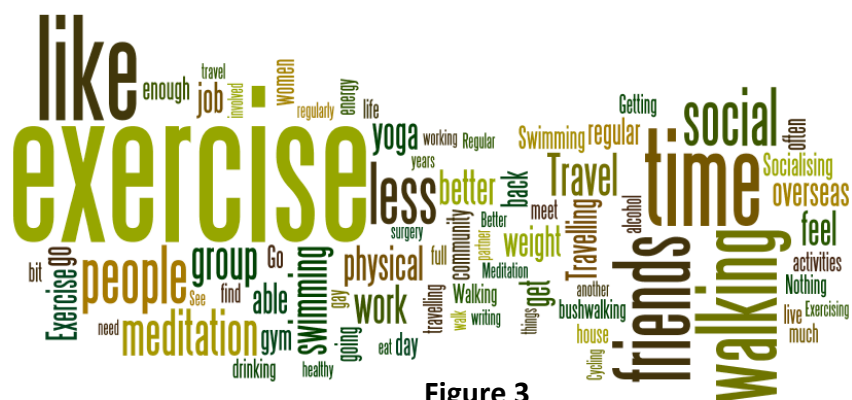


Figure 3

Do more to improve my physical fitness, for snow skiing and in preparation for GRS [gender reassignment] surgery.

Socialising – both with current friends and by making new friends – was reported by 17.1% of respondents as something they would like to participate in more. For example:

Would like to be out making some friends I could share a coffee or meal with or movie. Feeling isolated after returning to Sydney 2 years ago to care for mother after 36 years abroad, friends all abroad.

Many people (12.3%) reported that they would like to take the opportunity to take more holidays or go travelling:

Travel interstate and overseas to sightsee and see friends.

Travelling in Australia, i.e., to Darwin and Broome

For about 10.0% of respondents, losing weight and eating better was a priority:

Losing more weight (have dropped 20kg over past 12 years but need to lose another 10kg)

Learn about nutrition and how to cook healthy meals

Other strategies people identified included more spiritual engagement, including taking up meditation (8.9%), taking up a new job or occupation (5.6%), getting involved in more creative activities (5.9%), better management of physical health (5.2%), being involved in music or dancing (4.5%), retiring from or reducing work (4.1%), reducing alcohol intake (4.1%), having less stress and more quiet time (3.3%), taking up study (3.3%), moving house or location (2.6%), and giving up smoking (1.9%). Some people (4.5%) highlighted the importance of establishing a permanent intimate relationship, while others (2.2%) felt that their current relationship needed improving to facilitate future health and wellbeing. About 5.2% of respondents felt that they wanted to be more a part of the LGBTI community. And for 7.4% they felt that there was nothing additional that they could be doing to improve or maintain health and wellbeing.

### 5.8.3. Barriers to taking up activities

The third question asked respondents what they thought was preventing them from taking up the activities they would like to be involved in to maintain and increase their health and wellbeing. Figure 4 highlights 75 of the key words used by the 249 participants who responded to this question. The reason most people cited for not taking up these preferred activities – by 67 people or 26.9% – was time (i.e., being too busy), a further 13.3% cited work commitments.

Too much to do (uni, partner wants sex, kids to look after, business to run, community giving back - school and soccer expects help)

Busy work schedule and very long days owing to both work and travel to the city.

Time Father Time

Others (23.7%) cited their own lack of motivation – sometimes presenting this as laziness or lack of willpower. For example:

Laziness! I'd always prefer to stay in bed with a book.

Laziness and procrastination.

For 22.1% of those who answered the question, physical health issues were impacting on the ability to take up these activities.

Torn tendons in both shoulders arthritis in both knees hips and lower back

I get back aches and have a bit of arthritis and a medical problem that has to be

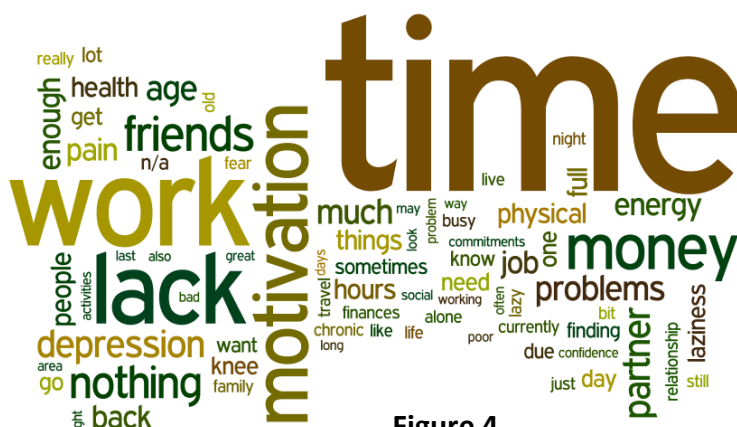


Figure 4

managed. I'm not forty anymore and my body lets me know.

Others (9.2%) highlighted the impact of mental health issues:

Just taking one day at a time - I have made massive adjustments over the last 6 months - I can not emotionally, physically etc do any more at the moment with out a strong possibility of failure and possible return to where I was 1 year ago - unhappy, very depressed with poor health.

#### DEPRESSIVE ILLNESS

Grief and loss since relationship ended a few months ago

More practical factors were of concern to other respondents. 14.1% reported lack of money to be the main reason why they could not participate in these activities, while 4.4% said it was due to a lack of resources/facilities in their area, and 1.6% said they were limited due to transport difficulties. Approximately 4.8% said that they were not able to participate in the activities because they did not know how to contact the relevant groups or the right people:

I cannot find any way to find or contact these groups, or anyway of connecting with men of similar age. The only mature aged groups seem to be old men who dress in drag and drink heavily pretending they are still 20 something.

For 7.2% of respondents social isolation or loneliness was a key factor. For example:

I don't know where they are or how to make contact with people who are safe. I also have to admit that I am not open with my sexuality and I am still trying to find my own feet with it ..... on my own ..... and this is quite limiting and a lonely place to be.

Sometimes I don't bother going to events because I stop and think, if I go then I will chat to lots of people - but they would not miss me if I wasn't there. It's a bit sad really to think that you would not be missed. Social isolation is a big problem and it affects your motivation and enthusiasm for life.

For 4.8% fear, anxiety or a lack of confidence was the main factor:

The main thing preventing me from meeting someone, is the fact that I am way too shy and lacking in confidence to go to a venue or a Gay Function on my own.

fear fear fear

Approximately 2.8% of respondents said that prior experiences of prejudice (including ageism and homophobia) had meant that they were unlikely to seek out the activities they were interested in:

Not being able to get employment - mainly due to ageism (I know because it has been indicated subtly to me).

Not being fully accepted in straight venues.

And for 5.6% of respondents – 14 people – their caring responsibilities prevented them from taking up the activities they believed would maintain or improve their health and wellbeing.

Having to look after both elderly infirm parents

Depression, finances, caring duties, anxiety.

## 6. Specific health promoting activities

### 6.1. Preferred activities

Respondents were presented with a list of possible activities and were asked to indicate how likely they would be to be involved in them personally (Table 14). They also had the option to identify if a particular activity was not applicable to them. The most popular activities reported were fitness group (29.5% said they would definitely want to be involved in this), walking group (28.8%), swimming (28.5%) and meditation (26.3%). The least popular activities were Alcoholics Anonymous or similar 12 step program (4.2% said they definitely would want to be involved in this) and computer skills workshops (13.5%). Other less popular activities included weight loss group (16.3%) and crafts/art group (18.9%).

**Table 14: Preferred activities**

How likely would you be involved personally in:	Definitely not N (%)	Maybe N (%)	Definitely would N (%)	Not applicable N (%)
Alcoholics Anonymous or other 12 step program	77 (24.7)	21 (6.7)	13 (4.2)	201 (64.4)
Attending a talk on issues for older people	19 (6.1)	164 (52.6)	73 (23.4)	56 (17.9)
Computer skills workshops	56 (17.9)	90 (28.8)	42 (13.5)	124 (39.7)
Crafts / Art	63 (20.2)	123 (39.4)	59 (18.9)	67 (21.5)
Fitness group	31 (9.9)	147 (47.1)	92 (29.5)	42 (13.5)
Healthy eating workshops/cooking classes	55 (17.6)	115 (36.9)	72 (23.1)	70 (22.4)
LGBTI Ageing Action Group	30 (9.6)	161 (51.6)	73 (23.4)	48 (15.4)
Meditation	56 (17.9)	114 (36.5)	82 (26.3)	60 (19.2)
Swimming	53 (17.0)	116 (37.2)	89 (28.5)	54 (17.3)
Visiting older LGBTI people	30 (9.6)	151 (48.4)	81 (26.0)	50 (16.0)
Walking group	33 (10.6)	138 (44.2)	90 (28.8)	51 (16.3)
Weight loss group	71 (22.8)	85 (27.2)	51 (16.3)	105 (33.7)
Yoga	57 (18.3)	114 (36.5)	74 (23.7)	67 (21.5)

### 6.2. Relationship between preferred activities and other factors

Respondents' age did not appear to be associated with their interest in participating in different activities with the exception of a walking group. In this sample, more younger people reported being interested in this activity than the older people (41.7% of those aged 50-54 compared to 22.2% for those aged 65+)  $\chi^2 (6, N = 252) = 13.912, p \leq 0.05$ . Similarly, relationship status did not appear related to interest in the activities, with the exception of yoga, in which more single people were interested (37.3% compared to 21.8% said they would definitely want to be involved in this)  $\chi^2 (2, N = 244) = 8.713, p \leq 0.05$ .

I'd like an LGBTI walking or social group get together where I live, probably in my age group, which isn't predicated on having a meal (since I'm a vegetarian). I'd prefer a mixed group i.e., not just a gay women's group. I am a gay woman who likes gay men!

With respect to gender, those identifying as female were significantly more likely than others to say they would definitely be involved with swimming (42.5% versus 25.8%)  $\chi^2 (2, N = 258) = 10.897, p \leq 0.01$ . Walking groups were also more likely to be something those identifying as female would definitely want to be involved in (42.3% compared to 26.7%)  $\chi^2 (2, N = 261) = 7.053, p \leq 0.05$ . Again, the opposite was the case for those identifying as males.

No significant differences were identified between people's location (metropolitan/non-metropolitan), their carer status or whether they lived alone or not and their interest in the different activities.

More people who scored highest on the Kessler 10 (i.e. had greater psychological distress) were interested in being involved in a weight loss group (43.3%) than those who scored lower (21.1%)  $\chi^2 (2, N = 177) = 7.295, p \leq 0.05$ . People who

I 'retired' three years ago after a major stroke. I am now relatively well. Transition from 'well' to retired has meant the slow dilution of my gay friendship networks and their slow replacement by different sorts of networks based on common interests. I would be interested in facilitating social networking based on shared interests, and on LGBTI organised healthy activities (walking group etc.).

scored high on the Loneliness Scale were significantly more likely to definitely want to be in crafts/arts than those who reported being less lonely (31.6% compared to 15.5%)  $\chi^2 (2, N = 217) = 12.669, p \leq 0.01$ . Further, people who reported higher levels of loneliness were also more likely to definitely want to be involved in an LGBTI ageing action group (33.9% versus 20.5%)  $\chi^2 (2, N = 236) = 5.913, p \leq 0.05$ .

### 6.3. Preferred co-participants

We were also interested in who respondents preferred to be involved in these activities with. Of the 150 women (current gender identity) in the sample, 52.7% said that they preferred to participate in health promoting activities only with other women (Table 15). In contrast, 33.1% of the 145 men said that they would only want to participate with other men. Of the whole sample (N=312), 48.7% said that they would prefer to participate in activities with friends, 49.7% said that they preferred to participate with LGBTI people. Just over 43% said they didn't mind who they participated with, and 28.5% said they preferred to participate alone.

**Table 15: Preferred co-participants in health promoting activities (N=312)**

How would you prefer to be involved in activities?	N	%
Alone	89	28.5
With friends	152	48.7
With women only (n=150)	79	52.7
With men only (n=145)	48	33.1
With other LGBTI people	155	49.7
With other Trans people	28	9.0
With other intersex people	21	6.7
With people aged 50 or over only	75	24.0
With anyone	135	43.3

*Note.* respondents were able to select multiple options

Age did not appear to be a factor in determining who people wanted to participate in activities with. People not in a relationship were significantly more likely (57.6%) than those in a relationship (43.6%) to want to participate in activities with LGBTI people  $\chi^2 (1, N = 311) = 5.957, p \leq 0.05$ . Similarly people not in a relationship were more interested in participating only with people aged 50 and over (31.1% versus 18.4%)  $\chi^2 (2, N = 311) = 6.678, p \leq 0.05$ . People living in metropolitan areas were more likely to want to participate with people aged 50 and over (29.8%) than those in non-metropolitan areas (17.9%)  $\chi^2 (1, N = 278) = 5.112, p \leq 0.05$ . This was also the case for those who lived alone (32.5% compared to 18.3%)  $\chi^2 (1, N = 312) = 8.365, p \leq 0.01$ .

I live in a relatively small country area, and while I know there are other lesbians here, I do not know how to make contact / find them without broadcasting my sexuality publicly. So I am alone and lonely, and am afraid I will be like that for the rest of my life. My children are supportive but of course they have their own lives to live too.

People reporting higher levels of psychological distress (as measured by the Kessler 10 scale) were more likely than others to want to participate in activities with other LGBTI people (65.0% compared to 48.0%)  $\chi^2 (1, N = 263) = 3.930, p \leq 0.05$ . They were also more likely to want to participate only with people aged 50 and over (37.5% compared to 22.4%)  $\chi^2 (1, N = 263) = 4.144, p \leq 0.05$ . People who were more lonely were significantly more likely to want to participate in activities with other LGBTI people (63.1%) than people who were less lonely (38.2%)  $\chi^2 (1, N = 277) = 17.154, p \leq 0.001$ .

These findings highlight some important factors when developing health promotion activities targeting those experiencing higher levels of psychological distress and loneliness. Specifically that for these people involving them in activities with other LGBTI people and other seniors is much more preferred.

Respondents were asked at the end of the survey if they had any thing else that they would like to say. Figure 5 is a word cloud of the 75 most common terms used by the 204 participants who responded to this question. The most frequently commented on issue – by 58 or 28.4% of respondents who answered the question – was the need for safe environments for older LGBTI people to live and receive services. The need for LGBTI-friendly and even LGBTI specific aged care facilities and retirement villages was frequently noted. For example:



### Figure 5

Want to be treated with respect if



there was a chance that I could be in a nursing home.

We need to get specialised LGBTI institutions going. I don't want to have to go back into the closet at the end of my life.

I have my doubts about being able to freely be an out and proud gay man if I were forced to enter some kind of nursing home. I am aware of discrimination against gay people in certain of these later-stage-of-life care situations. I'd prefer to be putting up with some physical isolation at home rather than have to be defending my sexuality on a daily basis with people who could have a degree of control over my physical and emotional comfort.

Concerns were expressed specifically about heteronormativity – the assumption all people are heterosexual – in residential aged care and the need for training and education of staff to ensure they are providing services in a way that is appropriate for LGBTI people. Some respondents (6.4%) highlighted ongoing concerns about discrimination and homophobia in the delivery of services:

My concerns about ageing relate to the discrimination that I will probably experience in terms of accessing services, particularly those that have a religious base and are funded through taxpayer money. Services are needed that will not be able to discriminate against people based on their sexuality. Legislation needs to reflect this.

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

For some participants (3.9%) it was the treatment of LGBTI older people within their own communities that is a concern.

Ageism and discrimination from younger gay people. Something I've encountered.

I've always had some difficulty identifying with the gay community, despite having made many friends and having enjoyed many gay activities, but in recent years I have been finding it harder and harder to feel that I have anything in common with the "community" as represented by the free gay press.

Many people (16.7%) reported concerns about deteriorating health – physical, mental and cognitive health – and what that will mean for their independence. Some stressed the importance of being able to stay in their own homes and ensuring that there are appropriate services to facilitate this.

I would be most concerned with losing my independence.

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

I want LGBTI friendly services to enable me to remain in my own home until the end of my life.

For others (12.3%) they were worried about their financial or work situation into the future, and the need to ensure that services are affordable.

I am very concerned about the number of LGBTI folk who are likely to be living in poverty into their old age. Many women in particular have very little super, less likely to own their own homes etc. I already see this happening with

some of my friends. Poverty has a huge impact on health and well being - it impacts access to health care, recreational activities, holidays, good food and much much more. Poverty for me is the number one issue.

Others were concerned about housing options:

My accommodation is sub-standard but if I rented something better it would chew up all of my income. I am concerned as I grow older that accommodation options will become less and less affordable and it might mean moving into a boarding house or similar. That scenario is really depressing.

Approximately 15.7% of the sample who answered this question said they were particularly fearful of loneliness and isolation in later life:

I face the real prospect of facing old age lonely and isolated. My health has significantly deteriorated in the past year and I have experienced the frightful isolation and lack of support of living alone and without a support network.

I have been a single mother of a daughter with chronic health problems for the past 23 years, now I find myself on my own with little connection to LGBT community and with little to no confidence on how to connect. I envision living out the rest of my life alone if I can't connect to others this saddens me deeply.

Although one person said:

I enjoy living alone; many people assume it must be lonely but I am a solitary person by conscious choice.

Five people (2.5% of those who responded to this question) said that they support voluntary euthanasia:

I would like voluntary euthanasia to be one of the legal options available to us as we age.

Six people (2.9%) reported that they felt positive about growing older:

I feel very blessed being Gay, as I am forever the optimist ! ! ! With the power of positive thinking. What's the bloody alternative?

I am very fortunate to have a long lasting relationship (more than 12 years), own our own house and travel extensively. I do not worry about aging. People don't grow old, they become old! I keep myself active, have two wonderful dogs who are our children and enjoy life.

Some participants (3.4%) highlighted the need and value of LGBTI people themselves organising services and building resources, and suggested they could help. For example:

I would be interested in facilitating social networking based on shared interests, and on LGBTI organised healthy activities (walking group etc.).

I am very interested in creating support systems for the elderly to stay in their homes and work together as a gay community but also as a neighbourhood.

I tend to think it is much more preferable that we do this for ourselves than have programs set up for us, particularly if the model for straight people are used and adapted.

The conclusion for some participants (5.9%) was the need for more respect given to LGBTI seniors within society, and for acknowledging their needs and concerns.



We are a special people who have endured lots (at least some of us have) and deserve to be supported and loved in our later years - we shouldn't have to feel that our whole lives have been a battle, one of unacceptance, no support, fairly loveless - give something to LGBT in their later years as some compensation for what they have endured to survive to that royal age of maturity.

I am interested in anything that raises awareness of the issues facing ageing LGBTI people and the need to challenge discrimination and ignorance at all levels of society and government.

## Conclusion

In total, 312 people aged 50 and over from across New South Wales completed the questionnaire. The mean age of respondents was just under 60, with the oldest participant being 84. Approximately 25% of respondents were aged 65 or over. The challenges in recruiting older LGBTI research participants have been well documented in the academic literature and are also reflected in service providers' difficulties accessing this group. While we would have liked more people in the upper age groups to have participated in the study, the inclusion of the 'young old' was very valuable given the project aims were to improve health and wellbeing and sustain independent, active and healthy lives. Thus, we believe that engaging this younger cohort is a valuable, proactive investment in future outcomes for LGBTI people as they age.

There were limitations in the size and distribution of the sample that need to be borne in mind when drawing conclusions from this study. More research studies – with larger samples – are needed into the health and wellbeing of LGBTI seniors in Australia. An example of such a study is that conducted by Fredriksen-Goldsen et al. (2014) which involved a cross-sectional survey of over 2500 LGBT people aged 50 and over in the United States. Other limitations included the small number of transgender people involved in the study – including the fact that no person identified as transgender female to male. Another key limitation was the inclusion of only one intersex person. Future research in this area will need to develop more targeted sample recruitment activities and perhaps set quotas to ensure adequate representation from across LGBTI communities and identities.

In terms of health and wellbeing, many of the findings from this study reflected what might be expected in a sample of people in the same age range from the general population. For example, mental health and psychological distress were better for those in the upper age groups (i.e., 65+) than those in the lower age groups (i.e., 50-55). The overall physical health-related quality of life of the sample was close to that expected in the general population of adults aged 50+. And many of the health concerns reflected what one might ordinarily expect, such as concerns about lack of exercise, memory loss and dementia, dental health, heart disease, and loneliness. Unfortunately, as reflected in the general population, carers in this study were significantly more likely to experience lower mental health than non-carers.

Despite these commonalities, there were nonetheless some findings that were different from those of general population studies. In this sample, experiences of psychological distress and loneliness were higher than might otherwise be expected in a sample from the general population, including the sample of 45 and Up Study (Phongsavan et al., 2013). As in other research (Coyle & Dugan, 2012), loneliness and psychological distress were found to be significantly associated. They were also associated with a number of other factors, such as living alone and not being in a relationship. Those who reported higher levels of loneliness also reported much higher levels of concern about a range of health issues, including mental health, heart disease, obesity, dental health, mobility and pain. Importantly for planning health and wellbeing activities, people who reported higher levels of loneliness and psychological distress were more likely than others in the sample to want to participate in health promoting activities with other LGBTI people and other people aged 50 and over.

As has been evidenced in other studies of health and wellbeing of lesbians, women in this study were on average more likely to report a lower physical health status than the rest of the

sample. Women were more likely to want to participate in certain health activities, such as swimming and walking groups. Notably, women were also much more likely to want to want to participate in health promoting activities only with other women, than men were only with other men.

The survey yielded rich and very practical data on which to base development of appropriate health promotion programs for LGBTI older people. Respondents highlighted their health concerns, what activities they would like to be involved in to improve their health and wellbeing, and who they would like to participate in these activities with. There are some important groups within this study that require particular attention. What was striking for us was the group of people who identified as being lonely – more work is needed to understand this group of LGBTI people, and to develop effective social and health promotion activities to improve their health and wellbeing.

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## Appendices

### Appendix A – Glossary

**Anxiety:** feelings of worry, nervousness and fear, which may reflect a clinical disorder. In this study, respondents were not provided with a definition of anxiety to respond to, rather they provided responses based on their own lay understanding of the term.

**Depression:** includes persistent feelings of sadness, hopelessness and loss of interest, which may be caused by a clinical disorder. As with anxiety, in this study respondents relied on their own lay understanding of this term when responding to questions about depression.

**Gay:** typically used to describe same-sex attracted people, in this study the term was used in conjunction with male (i.e., gay male) to distinguish between gay women and men. Respondents self-identified as gay male based on their own understanding of this term.

**Health-related quality of life:** an individual's perceived health and wellbeing, which incorporates physical health and mental health, and focuses on the impact of health on the quality of life. Measured in this study by the SF-12 (Short Form 12), which itself is based on the SF-36.

**Heteronormativity:** the assumption that everyone is heterosexual and that gender identity is simply male or female.

**Intersex:** where a person's biological sexual or reproductive anatomy does not match traditional definitions of male or female.

**Lesbian:** typically used to describe women who are sexually attracted to other women. Respondents self-identified as lesbian in this study based on their own understanding of this term.

**LGBTI:** Lesbian, gay, bisexual, transgender and intersex.

**Loneliness:** an unpleasant emotional response to social isolation and lack of support from others. Measured in this study by the 3-item Loneliness Scale, based on the longer UCLA Loneliness Scale.

**Psychological distress:** emotional responses which can impact on everyday living. Measured in this study by the Kessler Psychological Distress Scale, which comprises 10 questions about negative emotional states.

**Social media:** the use of the internet and related technologies to facilitate online networking and social participation. Common tools include Facebook, Youtube, Twitter, Blogging.

**Transgender:** refers to the experience of living or wanting to live as a member of the gender which is opposite to that ascribed at birth.



### Default Question Block

## Survey of the Health and Wellbeing of Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) Older People in New South Wales

***If you identify as lesbian, gay, bisexual, trans or intersex (LGBTI) AND you are aged 50 years or over AND you live in New South Wales, then you are invited to complete this survey.***

*The survey is designed to find out about ageing, health and wellbeing from **your** point of view.*

*All questions are **optional** – if you don't want to answer any part, just skip it.*

*For privacy, all your information is **confidential**. None of your personal information will be shared with anyone else, including government departments or people who want to sell you stuff.*

***Remember there are no right or wrong answers – we just want to find out about how things are for you – no blame, no shame! So be honest – you're among friends!***

### Participant Information Sheet and List of Support Services

Please refer to the attached [info sheet](#)

This project has been approved by the Human Research Ethics Committee of Southern Cross University (Ref: **ECN-12-303**).

If any of the topics covered in this survey causes you distress you may contact a  
Mental Health and Wellbeing Counsellor at ACON.

Phone: 02 9206 2000; Freecall: 1800 063 060; Hearing Impaired: 02 9238 2088

Daily between 11:00am and 1:00pm.

(This service is provided free of charge).

Additional information about support and counselling services can be found in the attached list of [Support services](#)

Would you like to receive feedback on the project's findings?

If so, please [complete the form](#) giving us your contact details.

This information will be kept separate from the other information you submit in this survey.

I confirm that I have been given clear information about this survey and I consent to voluntarily complete the survey

Yes

☐

No

☐

### Block 3

## About You

**Remember, any information you give us is confidential and will not be shared with anyone else. We need it to design a health and wellbeing program that best meets the needs of LGBTI seniors. Just skip any questions you don't want to answer.**

How old were you on your last birthday?

What sex were you assigned at birth? Please select one box only.

- ☐ Female
- ☐ Male
- ☐ Intersex (male)
- ☐ Intersex (female)

What is your current gender? Please indicate all that apply.

- ☐ Female
- ☐ Male
- ☐ Trans female to male
- ☐ Trans male to female
- ☐ Genderqueer
- ☐ Other

How do you describe your sexuality? Indicate all that apply.

- ☐ Asexual
- ☐ Bisexual
- ☐ Gay man / homosexual man
- ☐ Gay woman / lesbian / dyke / homosexual woman
- ☐ Heterosexual / straight
- ☐ Queer
- ☐ Other

Do you identify as an Aboriginal or Torres Strait Islander Person?

- ☐ Yes
- ☐ No

Is English the main language you speak at home?

- ☐ Yes
- ☐ No, please indicate which is your main language

What is your ancestry? (You may select multiple items)

(Note: examples of 'other' may include Greek, Vietnamese, Dutch, Kurdish, Maori)

- ☐ English
- ☐ Irish
- ☐ Italian

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- ☐ German
- ☐ Chinese
- ☐ Scottish
- ☐ Australian
- ☐ Other, please specify
- 

Do you have a partner?

- ☐ Yes
- ☐ No

Is this a same-sex relationship?

- ☐ Yes
- ☐ No

How many years have you been together?

#### Care Arrangements

Do you provide care to someone else?

- ☐ Yes
- ☐ No

Approximately how many hours per week would you spend providing care?

In providing this care, are you best described as:

- ☐ A service provider or paid employee
- ☐ A partner, family member or friend
- ☐ Other

Do you receive care from someone else?

- ☐ Yes
- ☐ No

Approximately how many hours per week do you receive care?

Who is this care provided by?

- ☐ A service provider or paid employee
- ☐ A partner, family member or friend
- ☐ Other



Block 1

Home, Family, Community

What is the postcode of your usual place of residence?

What best describes the area in which you live?

Metropolitan Sydney  
☐

Regional City  
☐

Regional Town  
☐

Rural Area  
☐

**Your dwelling:** Which of the following best describes where you usually live?

- ☐ House
- ☐ Unit
- ☐ Boarding House or Hostel
- ☐ Retirement Village
- ☐ Nursing Home or other supported living facility
- ☐ Caravan on a permanent site
- ☐ Temporary or mobile accommodation (e.g. shelter, caravan)
- ☐ Homeless
- ☐ Other

**Living arrangements:** Please indicate who you currently live with in your usual place of residence. (Please indicate all that apply)

- ☐ No one
- ☐ Partner
- ☐ Children
- ☐ Parents
- ☐ Friends
- ☐ Residents/house mates who are not friends
- ☐ Other

These questions are about how you feel about different aspects of your life. For each one, indicate how often you feel that way.

	Hardly ever	Some of the time	Often
How often do you feel that you lack companionship?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do you feel left out?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do you feel isolated from others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Family:** Please say something about your biological family.

We know that family relationships can have their ups and downs. Just let us know whether you have family members, such as parents, sisters and brothers, kids, or other biological kin who are supportive of you (including in-laws and step-children/parents). Would they be there for you in a crisis?

--

**Friends:** Indicate all that apply.

Are there other people in your life who are supportive, who would be there for you in a crisis?

	LGBTI	Non-LGBTI
In your region	<input type="checkbox"/>	<input type="checkbox"/>
Elsewhere in New South Wales	<input type="checkbox"/>	<input type="checkbox"/>
Interstate	<input type="checkbox"/>	<input type="checkbox"/>
Overseas	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate if you agree or disagree with the following statement:

My friends are more important to me than my biological family.

Agree  
☐

Neither Agree nor Disagree  
☐

Disagree  
☐

**Community:** Do you participate in any of the following group activities in your local community? Please do not include online groups unless they also meet locally. You can give details if you like.

	LGBTI	Non-LGBTI
Arts & Culture, e.g. book club, band or orchestra, theatre group, arts and crafts group	<input type="text"/>	<input type="text"/>
Church, religious or spiritual group, including meditation, 12 step group, Wicca etc.	<input type="text"/>	<input type="text"/>
Clubs or pubs e.g. RSL, local pub, nightclub, dance party, etc.	<input type="text"/>	<input type="text"/>
Community organisations, e.g. ACON, Lions	<input type="text"/>	<input type="text"/>
Social or support groups, e.g. Tropical Fruits, MAG, TenForty	<input type="text"/>	<input type="text"/>
Sports & fitness, e.g. bowls, tennis, walking group	<input type="text"/>	<input type="text"/>

**Communication and Technology:** What are the main ways you keep in touch with friends and family? Indicate all that apply.

☐ Phone - landline

☐ Phone - mobile (including SMS/text message)

☐

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Email

- ☐ Social media (e.g. Facebook)
- ☐ Traditional post (e.g. letters, cards)
- ☐ Other

Do you have an internet connection at home?

Yes

☐

No

☐

Please indicate how comfortable you are in using the following:

	Not at all confident	Confident	Extremely confident	Not applicable(e.g. don't have or never use)
Mobile phone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smart phone (e.g. iPhone, Blackberry)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PC/Laptop/Notebook	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tablet (e.g. iPad, Samsung Galaxy Tab)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blogging	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Email	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Facebook	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Internet search engine (e.g. Google, Yahoo, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Twitter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
YouTube	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

LGBTI Community Media: Which of the following media do you view/listen to regularly?

	Print/Live to air	Online
AXN	<input type="checkbox"/>	<input type="checkbox"/>
Cherrie	<input type="checkbox"/>	<input type="checkbox"/>
DNA	<input type="checkbox"/>	<input type="checkbox"/>
FUSE	<input type="checkbox"/>	<input type="checkbox"/>
Joy94.9FM	<input type="checkbox"/>	<input type="checkbox"/>
Lesbians on the Loose (LOTL)	<input type="checkbox"/>	<input type="checkbox"/>
Polare	<input type="checkbox"/>	<input type="checkbox"/>
Queensland Pride	<input type="checkbox"/>	<input type="checkbox"/>
QNews	<input type="checkbox"/>	<input type="checkbox"/>
Star Observer	<input type="checkbox"/>	<input type="checkbox"/>
SX/Gay News Network	<input type="checkbox"/>	<input type="checkbox"/>

Other media: Which of the following media do you view/listen to regularly?

	Print/Live to air	Online
Local free newspaper	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>		
Local radio station	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>		
Ageing-related publication	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>		
Other <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Block 2

## Your health

The following questions ask about how you have been feeling in the **last four weeks**.

For each question, indicate the option that best describes the amount of time you felt that way. In the last four weeks, how often did you feel:

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
tired out for no good reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
so nervous that nothing could calm you down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
restless or fidgety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
so restless or fidgety that you could not sit still?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
that everything was an effort?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
so sad that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
worthless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Does YOUR HEALTH NOW LIMIT YOU in the following activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing SEVERAL flights of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

	Yes	No
ACCOMPLISHED LESS than you would like	<input type="radio"/>	<input type="radio"/>
Were limited in the KIND of work or other activities	<input type="radio"/>	<input type="radio"/>

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

	Yes	No
ACCOMPLISHED LESS than you would like	<input type="radio"/>	<input type="radio"/>
Didn't do work or other activities as CAREFULLY as usual	<input type="radio"/>	<input type="radio"/>

During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?

Not at all      A little bit      Moderately      Quite a bit      Extremely

☐      ☐      ☐      ☐      ☐

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS:

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt downhearted and blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time      Most of the time      A good bit of the time      Some of the time      A little of the time      None of the time

☐      ☐      ☐      ☐      ☐      ☐

What are one to three things that you are doing now to improve or maintain your health and wellbeing, whether physical, emotional, mental or spiritual?

What are one to three things that you would like to be doing to improve or maintain your health and wellbeing, whether physical, emotional, mental or spiritual?

What main things are preventing you from doing those things?

Which of the following health issues are most important to you personally.

This means you don't necessarily have to have the condition, only that it is extremely important to you, maybe you worry about it, or there's a family history that concerns you.

	Not at all important	Somewhat important	Very important
Alcohol use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety and/or Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dementia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dental (teeth and gums)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug use (may be illicit or prescription drugs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Exercise / physical activity (lack of)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart disease / high blood pressure / high cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loneliness / social isolation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Melanoma (skin cancer)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Memory loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health problems (other than anxiety or depression)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mobility - difficulty getting around inside and/or outside home, including fear of falls	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overweight / obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain, that is ongoing and not responding to treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prostate problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual health (sexually transmitted infections, including HIV/AIDS)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smoking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urine problems (such as not making to the toilet in time, leaking, frequency)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Violence / abuse (such as domestic / family violence, violence at work, in the streets)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vision loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Which health services have you used?

	In the past 12 months	In the past 5 years
Counsellor / Psychiatrist / Psychologist	<input type="radio"/>	<input type="radio"/>
Dentist (oral care)	<input type="radio"/>	<input type="radio"/>
Dietician/Nutritionist	<input type="radio"/>	<input type="radio"/>
GP (General Practitioner / Family Doctor)	<input type="radio"/>	<input type="radio"/>
Hormone Test	<input type="radio"/>	<input type="radio"/>
Mammogram (screening for breast cancer)	<input type="radio"/>	<input type="radio"/>
Naturopath / Other Alternative Health Practitioner	<input type="radio"/>	<input type="radio"/>
Occupational Therapist	<input type="radio"/>	<input type="radio"/>
Optometrist / Ophthalmologist (eye test)	<input type="radio"/>	<input type="radio"/>
Pap Smear (screening for cervical cancer)	<input type="radio"/>	<input type="radio"/>
Physiotherapist / Chiropractor	<input type="radio"/>	<input type="radio"/>
Podiatrist (cares for feet)	<input type="radio"/>	<input type="radio"/>
Prostate Check	<input type="radio"/>	<input type="radio"/>
Sexual Health Check (e.g. testing for HIV, other STIs)	<input type="radio"/>	<input type="radio"/>
Other <input type="text"/>	<input type="radio"/>	<input type="radio"/>

Do you have a GP / family doctor that you see regularly?

Yes  
☐No  
☐

Have you disclosed your sexuality and/or gender identity to your GP?

Yes  
☐

No  
☐

Is there anything that prevents you from accessing health services? (e.g. fear of discrimination, expecting the health service will not understand you and your situation, etc.) If so, please describe.

#### Activities to enhance your health and wellbeing

Please rate the following activities by how likely you personally would be to get involved. If they are not relevant to you personally (e.g. you don't need to lose weight or your computer skills are fine), please indicate the item is not applicable.

	Definitely <i>would not be</i> involved	May be involved	Definitely <i>would be</i> involved	Not applicable
Alcoholics Anonymous or other 12 step program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attending a talk about issues for older people (e.g. government services)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Computer skills workshops	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crafts / Art	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fitness group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Healthy eating workshops / cooking classes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LGBTI Ageing Action Group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meditation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Swimming / Aqua aerobics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Visiting older LGBTI people in their homes or in residential facilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight loss group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yoga (easy Yoga for older people)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thinking about the activities in the previous questions, would you prefer to be involved with them ...? Indicate all that apply.

- ☐ Alone
- ☐ With friends
- ☐ With women only
- ☐ With men only
- ☐ With other LGBTI people
- ☐ With other Trans people
- ☐ With other Intersex people
- ☐ With people aged 50 or over only
- ☐ With anyone (no particular preference)
- ☐ Other

## Have your say!

(This is the most important part!)

*Is there anything else you want to tell us about what ageing as an LGBTI person means to you? What are your concerns about ageing? What information or services do you need? What kind of activities or programs would you like to see to help you sustain and even improve your health as you get older? Here's your chance!*



Thank you for participating in this project.

If any of the topics covered in this survey causes you distress you may contact a  
Mental Health and Wellbeing Counsellor at ACON.  
Phone: 02 9206 2000; Freecall: 1800 063 060; Hearing Impaired: 02 9238 2088.  
(This service is provided free of charge).

Additional information about support and counselling services can be found in the attached Support Services list: [Support services](#)



## About the Authors

Mark Hughes is an Associate Professor in social work at Southern Cross University. He has been involved in a series of research projects on LGBTI ageing, including studies on health and wellbeing, LGBTI people's use of aged care services, and their end-of-life care. He is widely published on this topic, as well as on social work practice and education. Mark is currently editor of the journal *Australian Social Work*.

Sujay Kentlyn was the Lesbian, Gay, Bisexual, Transgender and Intersex Elders' Wellbeing Project Officer for Evergreen Life Care in New South Wales. A sociologist, Sujay has taught and researched at the University of Queensland, conducting training in sexuality, sex, and gender, and provision of inclusive services for health care workers. Sujay identifies as genderqueer and prefers gender neutral pronouns, zie and hir.