SAFER OPTIONS

Building the Capacity of Primary Care Providers to Support LGBTIQA+ Individuals Experiencing or at Risk of Intimate Partner Violence

RESEARCH REPORT

December 2023

CERIPH

Curtin University

We acknowledge the First Nations peoples as the true and traditional custodians of the land contemporarily known as Australia, and recognise that these lands have always been places of learning for Aboriginal and Torres Strait Islander peoples.

We pay our deepest respects to all First Nations peoples past and present, and acknowledge the important role of Aboriginal and Torres Strait Islander voices and their ongoing leadership.

Safer Options was conducted on the traditional lands of the Whadjuk-Noongar, Kaurna, Nharangga, Larrakia, and Wudjari nations. Sovereignty was never ceded.

Always was, always will be, First Nations land.

Thank You

We express our gratitude to all the LGBTIQA+ people who participated in this research study. Your input and feedback were vital for collecting the wealth of information that we have received. We acknowledge that many of our participants have experienced intimate partner violence, and we thank them for their vulnerability, emotional labour, and time to make this project possible. We recognise that within Western Australia's LGBTIQA+ community there are many diverse experiences, histories, and identities. In this report, we have attempted to convey your stories and voices as accurately as possible.

We give further thanks to those who were part of the initial community consultation groups that helped shape Safer Options; people who provided feedback on our initial survey; and employees from the LGBTIQA+ and IPV sector who generously gave their time and expertise. Your input was crucial to the success of this project.

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The CERIPH research team has expertise in the development, implementation, and evaluation of formative and longitudinal intervention research in early childhood health and nutrition; physical activity and nutrition; alcohol and other drug use; seniors' health; mental health; and HIV and sexual health.

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6. Building sustained partnerships and collaborations with vulnerable and most at-risk communities, and relevant community, government, and private sector organisations.

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Executive Summary

Safer Options (formerly the *SOFA - Safer Options from Aggression Project*) was a 12-month research project that commenced in September 2022. Funding for Safer Options was provided by the *WA Primary Health Alliance (WAPHA)* awarded jointly to *WAAC* (formerly the *WA AIDS Council*) and *Curtin University*. Safer Options was also supported by *Womens Health and Family Services (WHFS)*.

Safer Options was coordinated by a team of researchers in the Curtin School of Population Health at *Curtin University*: Chief Investigator Dr Roanna Lobo and Co-Investigators Dr Jack Farrugia, Dr Bronwyn Milkins, Danny Della Vedova, Professor Sharyn Burns, Dr Peta Dzidic, and Dr Jacqui Hendriks.

The primary aim of Safer Options was to strengthen the capacity of primary care providers in Western Australia (WA) to deliver accessible primary care services to LGBTIQA+ individuals experiencing intimate partner violence (IPV). This was to be achieved by investigating:

1. Primary care providers' ability to recognise and respond to IPV in LGBTIQA+ relationships.
2. Primary care services' inclusiveness of LGBTIQA+ individuals.
3. LGBTIQA+ individuals' capacity to recognise and seek professional assistance for IPV.

There were two key deliverables for Safer Options. The first was the generation of recommendations concerning how recognition and responsiveness to IPV in the LGBTIQA+ community could be enhanced among primary care services and providers. The second was the co-design of hard-copy and online resources intended to improve recognition of and responsiveness to IPV among primary care services, providers, and LGBTIQA+ individuals.

Extensive consultation was undertaken with LGBTIQA+ individuals and WA metropolitan primary care providers. Methods used included an online survey, semi-structured interviews with LGBTIQA+ individuals and primary care providers, focus groups with LGBTIQA+ individuals, consumer navigator activities, and co-design activities with LGBTIQA+ individuals and primary care providers. Quantitative data were analysed using descriptive statistics and qualitative data were analysed using simple thematic analysis.

Data revealed that IPV appears to be highly prevalent among LGBTIQA+ individuals in WA, with one in two LGBTIQA+ individuals in the research sample reporting ever having experienced one or more forms of abuse in their intimate relationships. Additionally, apart from individuals already engaged in a trusting relationship with their psychologist or GP, LGBTIQA+ individuals who have experienced IPV reported difficulty accessing inclusive primary care services due to fear of judgement from providers. WA primary care providers revealed a lack of confidence to recognise IPV in LGBTIQA+ clients and have difficulty identifying and finding suitable primary care services to refer to. Across the consultations, both primary care providers and LGBTIQA+ individuals emphasised the need to increase awareness and knowledge of how IPV can present in LGBTIQA+ relationships.

Consultations presented the need for educational and awareness-raising resources tailored towards LGBTIQA+ individuals experiencing IPV and primary care providers in the WA context. It was suggested that these resources include information about IPV and how it may present in LGBTIQA+ relationships, tools to recognise unhealthy and healthy relationships, an LGBTIQA+ inclusive primary care service directory with emergency contacts, and information for how primary care providers can modify their service provision to be more inclusive of LGBTIQA+ individuals experiencing IPV. Through a series of co-design activities, we developed a website, two brochures, and a suite of posters to aid in the education and recognition of IPV among LGBTIQA+ individuals and primary care providers. Furthermore, primary care providers expressed a desire to better support LGBTIQA+ individuals experiencing IPV through training in the use of a screening and referral tool for IPV in LGBTIQA+ patients, and access to high-quality professional development on inclusive practice for LGBTIQA+ patients.

Overall, Safer Options revealed a high level of need among WA LGBTIQA+ individuals for accessible and inclusive supports from primary care services, and a strong willingness among primary care providers to acquire further skills to better support LGBTIQA+ individuals. Additional investment is required to ensure the Safer Options resources can be maintained and to co-design additional resources for specific sub-populations. Ongoing investment is also required to ensure that specific workforce training can be provided and to monitor the prevalence of IPV in LGBTIQA+ communities and develop and evaluate targeted solutions to respond to specific needs.

List of Terms

Cisgendered and Heterosexual Normativity

The assumption that cisgender and heterosexual identities are the norm and the privileging of these identities over other forms of sexual orientation and gender identity. Cisgendered and heterosexual normative assumptions are reinforced through socio-cultural beliefs and practices, and perpetuate has prejudice, stigma, and violence against LGBTIQA+ individuals.

Intimate Partner Violence (IPV)

IPV refers to a pattern of abusive, coercive, or controlling behaviour within an intimate relationship that results in physical, psychological, spiritual, or sexual harm to those in that relationship.

Intimate Relationship

A non-familial relationship (more than one interaction) between two or more partners that involves sexual or emotional intimacy.

LGBTIQA+

'LGBTIQA+' is an evolving acronym that stands for lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and other diverse gender, and sexual identities.

Primary Care Service

A primary care service refers to the first point-of-contact for medical, emotional, and/or social support in relation to personal experiences of IPV. These services are provided in community settings and can be face-to-face or online/phone-based, such as a general practice, community health centre, phone line, or shelter.

Primary Care Provider

Primary care providers include General Practitioners (GP's), nurses, case workers, social workers, counsellors, alcohol and drug counsellors, youth workers, and peer-support workers.

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Background

Intimate partner violence (IPV) presents a significant health burden to individuals, their families, and the wider community, and is receiving increasing attention as a public health issue (1,2). IPV refers to a pattern of abusive, coercive, or controlling behaviours within an intimate relationship that causes harm, including but not exclusively, physical, psychological, emotional, or sexual harm, and is also known as domestic violence or spousal abuse (3). LGBTIQA+ individuals have unique experiences of IPV (4). Some examples of IPV within LGBTIQA+ relationships include threatening to reveal a partner's LGBTIQA+ identity to friends or family, and employing homophobia, transphobia, biphobia, or heterosexism to exert coercive control or abuse over their partner (5), intentionally exposing one's partner to HIV and STIs, and exerting control over or threatening to withhold access to HIV medication or gender-affirming hormones. Identifying these specific forms of IPV can be challenging for those experiencing them.

Most research studies on IPV have primarily focused on the experiences of cisgender heterosexual women (6). These studies have played a significant role in shaping the general understanding of IPV in contemporary times but may not provide a suitable basis for comparing the experiences of LGBTIQA+ individuals (6,7). For instance, the Personal Safety Survey collected data from approximately 21,250 people living across Australia and found that 17% of women and 6% of men had experienced physical and/or sexual violence from a partner, but these data were limited to cohabiting partners and did not account for less formal relationships common among LGBTIQA+ individuals (8).

Since the onset of the COVID-19 pandemic in 2020, organisations like WAAC (formerly the WA AIDS Council) and Women's Health and Family Services (WHFS) have observed an increase in LGBTIQA+ clients seeking support for IPV. Prevalence of issues such as IPV has been reported to escalate during disasters and pandemic situations (9). Both WAAC and WHFS have endeavoured to address this demand by enhancing support structures within their existing resources, revealing the challenges LGBTIQA+ clients encounter when seeking inclusive assistance due to limited resources.

In Australia, the attitudes of primary care providers towards LGBTIQA+ individuals experiencing IPV can vary widely, from being inclusive and welcoming to heteronormative and exclusionary, making it challenging for LGBTIQA+ individuals to identify safe options for support (10–12). Research that aims to enhance LGBTIQA+ inclusivity in relation to IPV within policy and service provision contexts is limited. It is necessary that these attempts are shaped by the perspectives of LGBTIQA+ people they aim to support, as they are often absent from these discussions (13). Medical and allied health practitioners such as general practitioners (GPs), psychologists and social workers are well-positioned to identify those at risk and connect them with specialised services.

The Safer Options research explored the perspectives of LGBTIQA+ individuals with lived experience of IPV to better understand their needs and experiences of accessing primary care services in WA, as well as the capacity and LGBTIQA+ inclusivity of primary care services in WA to support LGBTIQA+ individuals experiencing or at risk of IPV. The project identified preferences for support services, obstacles to accessing appropriate help, and effective pathways for assistance. This information will help guide the development of services, interventions, and resources that facilitate early help-seeking, recognise individuals in crisis situations, enhance psychosocial well-being, and mitigate the various health repercussions of IPV.

Research Aim and Design

Research Aim

The aim of the Safer Options research was to strengthen the capacity of primary care providers in Western Australia (WA) to deliver accessible primary care services to LGBTIQA+ individuals experiencing intimate partner violence (IPV).

Research Design

The research used a multi-method approach comprising six phases conducted between September 2022 to September 2023. Please see Table 1 for a summary of and sample size for each of the research activities.

Phase One | Grounding the Project

To guide research activities to ensure language, priorities, and processes were safe, inclusive, and relevant for LGBTIQA+ community and key stakeholders, two drop-in spaces and several interviews were held.

Phase Two | Scoping Review

A scoping review was conducted to identify facilitators and barriers in the current literature to both LGBTIQA+ individuals experiencing IPV and primary care providers who support them, as well as to identify existing interventions aimed at improving primary care service inclusivity.

Phase Three | Survey

A state-wide survey was implemented in WA to assess the needs and preferences of LGBTIQA+ individuals regarding the support they receive from primary care services when experiencing or at risk of IPV, and the barriers that LGBTIQA+ individuals encounter when seeking and engaging with primary care services.

Phase Four | Consultations with LGBTIQA+ Individuals

Semi-structured interviews, focus groups, and a consumer navigator activity were employed with LGBTIQA+ individuals to understand their experiences, needs, and preferences when seeking and accessing support for IPV in WA.

Phase Five | Consultations with Primary Care Providers

Semi-structured interviews were conducted with primary care providers who have supported LGBTIQA+ individuals experiencing IPV to explore their confidence in supporting LGBTIQA+ individuals experiencing or at risk of IPV, and the resources they need at an individual and organisational level to enhance their responsiveness to this population.

Phase Six | Co-design of Resources

LGBTIQA+ individuals and primary care providers were consulted in multiple co-design workshops and interviews to co-design resources that aim to enhance the ability of primary care providers to respond effectively to the needs of LGBTIQA+ individuals experiencing IPV, to promote awareness of IPV within the LGBTIQA+ community, and to encourage LGBTIQA+ individuals to seek support.

Findings from all phases of the project were synthesised to develop a policy brief outlining a primary care service approach to meet the needs and expectations of the LGBTIQA+ community.

Research Participation

Table 1. List and sample size of research activities, excluding scoping review.

Activity	Study Phase	Participants
Grounding group discussions	One	8
Individual stakeholder consultation	One	7
State-wide online survey of IPV	Three	523
Focus groups with LGBTIQA+ individuals	Four	4
Community navigator groups	Four	3
Individual interviews with LGBTIQA+ individuals	Four	11
Individual interviews with primary care providers	Five	8
Co-design activities	Six	16
	Total	**580**

Who Participated in Research Activities?

Excluding participants who completed the state-wide online survey of IPV, 29 unique individuals participated in individual interviews, focus groups, community navigator groups, and co-design groups. Some participants participated in multiple activities. Demographic data of the survey respondents are presented separated in Table 2.

Table 2. Demographics of participants in Safer Options research activities, excluding online survey

		n	%
Sample		29	
Age	M = 32, SD = 10, range = 20-68		
Gender	Non-binary	7	24%
	Man or male	7	24%
	Woman or female	14	48%
	Demiboy	1	3%
Sex Assigned at Birth	Female	22	76%
	Male	7	24%
Intersex	No	28	97%
	Don't know	1	3%
Sexual Orientation	Bisexual	7	24%
	Lesbian	6	21%
	Gay	4	14%
	Pansexual	4	14%
	Queer	4	14%
	Heterosexual	3	10%
	Asexual	1	3%
Disability/Neurodivergence	No	15	52%
	Yes	12	41%
	Prefer not to say	1	3%
	Don't know	1	3%
Country of Birth	Australia	18	62%
	Other	11	38%
Cultural Identity	Australian	15	52%
	Southern and Central Asian	3	10%
	South-East Asian	3	10%
	Anglo-European	2	6%
	North-East Asian	2	6%
	Other	6	18%
Main Language Spoken	English	25	86%
	Other	4	14%
Highest Level of Education	Postgraduate or professional degree	13	45%
	Bachelor's degree	11	38%
	Some university but no degree	2	7%
	Secondary	3	10%
West Australian (WA) Residence	Metropolitan	25	86%
	Regional WA – South	3	10%
	Regional WA – North	1	3%

Phase One | Grounding the Project

What We Did

To ground Safer Options in the perspectives of key stakeholders, two drop in spaces and several meetings were held to provide a foundational understanding of IPV and LGBTIQA+ individuals within the WA context, and to guide the future phases of the project to ensure it addresses the needs of LGBTIQA+ individuals and primary care providers.

Informal meetings were held with employees from WA or national organisations active in the LGBTIQA+ space and/or IPV space. These meetings focused on understanding organisational perspectives, challenges, and suggestions for improving primary care responsiveness towards LGBTIQA+ individuals experiencing or at risk of IPV. Key primary care providers were invited to partake, and seven employees from Sexual Health Quarters, Rainbow Community House, ACON (formerly the AIDS Council of NSW), Rainbow Gate Project, Freedom Centre, Safe to Tell Project, and Living Proud participated.

Community conversations were conducted through two separate drop-in spaces. Participants were recruited via Curtin University's Ally network. The aim was to foster an inclusive, open dialogue where members of the LGBTIQA+ community and allies could share their perspectives on IPV, what they thought the project should focus on, and what they hoped the research outcomes would be. During these conversations, participants were encouraged to voice their thoughts on the project's research plan, share personal perspectives that the researchers should be mindful of, and offer feedback on desired research outcomes. In total, eight participants participated in these conversations.

What We Found

Challenges in Primary Care Services

The consultations revealed that primary care services in WA encounter several challenges when addressing the needs of LGBTIQA+ individuals who are experiencing or at risk of IPV, for example:

Referral challenges are significant, as it can be difficult to locate suitable and inclusive primary care services that are appropriate for the LGBTIQA+ community.

- Limited capacity due to funding constraints hampers efforts to create LGBTIQA+ inclusive IPV support.
- Workforce limitations, including staffing shortages and high turnover rates, hinder effective support provision.
- Some primary care services, while inclusive, may not openly advertise their LGBTIQA+ inclusivity.
- Competing priorities, like crisis management and administrative tasks, pose challenges in allocating sufficient resources for comprehensive support for LGBTIQA+ individuals.

Strategies for Enhanced Responsiveness

The following strategies were recommended to address these challenges and enhance the responsiveness of primary care services for LGBTIQA+ individuals experiencing or at risk IPV:

- It is essential for every employee within a primary care service to genuinely engage with LGBTIQA+ individuals, as just one non-affirming worker can undermine the service's credibility and lead to an adverse experience for an individual seeking support. Ensuring consistency in engagement across the service builds trust and safety.
- Seeking Rainbow Tick accreditation demonstrates the commitment of the primary care service to inclusivity and understanding the unique needs of the LGBTIQA+ community and allows for active integration of culturally appropriate policy and principles.
- Active involvement of the LGBTIQA+ community in shaping primary care service delivery is crucial. By engaging with the community, primary care services can gain valuable insights into the specific needs and concerns of this population and shape their service provision accordingly.

Beneficial Resources for Primary Care Services

Participants recommended developing tailored resources to create a more inclusive environment for LGBTIQA+ individuals experiencing IPV, including:

- Clear guidance for primary care services on addressing IPV as experienced by LGBTIQA+ individuals.
- Adapting existing resources on IPV for cisgender and heterosexual individuals to cater to the LGBTIQA+ community.
- A screening tool to recognise IPV as experienced by LGBTIQA+ individuals, together with a clinical decision-tree.
- A HealthPathways [1] page focused on effective IPV screening and response for LGBTIQA+ individuals can improve accessibility for primary care providers and improve patient pathways.
- Establishing an updated referral primary care service directory may guide in building pathways for LGBTIQA+ individuals who require support for IPV.
- Implementing comprehensive educational training for all service staff to create a safe and inclusive primary care service.
- Developing educational brochures addressing concerns such as IPV disclosure and unique challenges related to cultural and LGBTIQA+ identity factors.

[1] HealthPathways is an online portal funded by the WA State Government and WAPHA that offers locally agreed information on a wide range of health concerns brought to primary care providers, to assist them in making the right decisions together with patients at the point of care. The pathways are designed for general practitioners, specialists, allied health professionals, and other health professionals in WA.

Phase Two | Scoping Review

What We Did

A scoping review was conducted to provide an empirical grounding for Safer Options and to better understand the facilitators and barriers of LGBTIQA+ engagement with primary care services for IPV support.

Two research questions guided the scoping review:

1. What are the facilitators and barriers to seeking help for IPV among LGBTIQA+ individuals?
2. What are the facilitators and barriers to delivering inclusive primary care services to LGBTIQA+ individuals for concerns about IPV among primary care providers?

The search strategy aimed to locate both published studies and unpublished grey literature, and 3,213 records were identified. The titles and abstracts of all records were screened by two members of the research team (JF and BM), resulting in 73 articles. The full text of these articles was subsequently screened by BM against the inclusion criteria. 43 records were retained for analysis (see Appendix A); seven studies were conducted in Australia and one study recruited West Australian participants. Data on participants, concepts, context, study methods and key findings relevant to the review questions were extracted.

The themes as they pertain to each review topic are summarised on the next page.

What We Found

Barriers to Providing Inclusive Care

Three key themes emerged related to barriers experienced by primary care providers:

1. Heteronormative assumptions around IPV in primary care services cause LGBTIQA+ individuals to conceal their identities, due to fears of exclusion or discrimination.

2. Knowledge gaps due to insufficient training and education about IPV in LGBTIQA+ contexts, leads to ineffective service provision and potential misidentification of IPV in these relationships.

3. Greater inclusion of LGBTIQA+ experiences are needed to improve service provision, to address gaps in treatment options, and to improve outreach to the LGBTIQA+ community.

There is also a need for stronger collaboration between researchers and practitioners, as well as empirically validated screening tools for LGBTIQA+ experiences of IPV.

Barriers to Accessing IPV Primary Care Services

Four key themes emerged highlighting the challenges faced by LGBTIQA+ individuals in accessing support for IPV:

1. The complexity of identifying IPV reflects why LGBTIQA+ individuals struggle to recognise and acknowledge abuse, influenced by underestimations of the severity of abuse, the belief it needs to be solved privately, and messages about how and where to seek help are less visible to LGBTIQA+ communities.

2. Stigma and believability reveal how anticipated discrimination and social norms are a barrier for LGBTIQA+ individuals wanting to disclose abuse and seek help, particularly if an individual has multiple intersectionalities.

3. Service barriers underscore a variety of obstacles, including inadequate representation and fears around mandatory reporting, that hinder the LGBTIQA+ community from seeking support.

4. Logistical challenges focus on practical barriers like financial constraints and scheduling issues, further deterring LGBTIQA+ people from obtaining necessary assistance.

Interventions and Programs for Inclusive Primary Care Services

Two main themes emerged in relation to existing pilot interventions and programs for inclusive primary care services. First, the necessity of training and education highlights the critical need for staff to gain competency in LGBTIQA+ topics, including gender identity and culturally sensitive care, to better serve this community. Second, a theme emerged around inclusive care which outlines multiple approaches to achieving more accessible and sensitive services. This includes updating administrative systems and forms, fostering stronger collaborations between researchers and practitioners, and implementing effective screening processes and trans-competent care to improve primary care service provision and inclusivity.

Phase Three | Survey

What We Did

To examine WA-based LGBTIQA+ individuals' awareness of IPV, support needs and preferences, and experiences of IPV, an online survey was designed and distributed within WA. It was anticipated that the resulting knowledge would enhance understanding of the prevalence of IPV in the WA LGBTIQA+ community and inform the development of recommendations to WA primary care services to enhance their capacity to meet the needs of LGBTIQA+ individuals experiencing IPV.

We sought to recruit individuals aged 18 and over who identified as LGBTIQA+ and currently resided in WA to participate in a 20-minute online survey examining their understanding of, and experiences of IPV, including their experiences of accessing support services. Individuals did not have to have experienced IPV to participate. Participants were recruited via social media, LGBTIQA+ organisations in WA, radio, and word-of-mouth. Participation was voluntary.

The survey comprised four conceptual domains:

1. Knowledge of what constitutes abusive behaviours in relationships
2. Experiences of IPV
3. Awareness of support services
4. Preferences for types of support services.

Articles included in the scoping review informed the generation of items for each domain (14–16), and items were either taken verbatim from these sources or adapted for the context of the present survey.

To assess face validity of the survey, eight members of the LGBTIQA+ community reviewed and provided feedback on a preliminary version of the survey. Specifically, individuals were asked to provide honest feedback on the appropriateness of wording used in the survey, whether they believed any items were irrelevant or that other items should be included, length of the survey, and ease of understanding and completing the survey. These individuals received a small honorarium in exchange for their participation. Participants' feedback was subsequently integrated into the final version of the survey. The final survey was distributed via Qualtrics software.

In total, 523 individuals completed the survey. The average age of participants was 28 years old (SD = 9.5, range = 18-71). Respondents were diverse in several aspects including sex, gender, cultural identity, type of neurodivergence or disability, level of education and place of residence in WA.

These demographic statistics are reported in Table 3 on the next page.

Table 3. Demographics of survey respondents

		n	%
Total Sample		523	
Gender	Woman/female	242	46%
	Man/male	147	28%
	Non-binary [1]	125	24%
	Transgender	7	1%
	Prefer not to say	2	0.4%
Sex Assigned at Birth	Female	367	70%
	Male	154	29%
	Undetermined	1	0.2%
	Prefer not to say	1	0.2%
Intersex	No	522	99.8%
	Yes	1	0.2%
Sexual Orientation	Bisexual	158	30%
	Lesbian	142	27%
	Gay	120	23%
	Pansexual	70	13%
	Queer [2]	57	11%
	Asexual	42	8%
	Demisexual	8	2%
	Heterosexual [3]	6	1%
	Aromantic	2	0.2%
	Questioning	2	0.2%
Disability/Neurodivergence	No	269	51%
	Yes	252	48%
	Prefer not to say	2	0.4%
Type of Disability /Neurodivergence [4]	Other [5]	173	33%
	ADHD	154	29%
	Autism	84	16%
Country of Birth	Australia	407	78%
	Other	116	22%
Cultural Identity	Australian	375	72%
	Anglo-European	133	25%
	South-East Asian	32	6%
	North-West European	22	4%
	New Zealander	19	4%
	South and Central American	14	3%
	Aboriginal and/or Torres Strait Islander	12	2%
	South-East European	9	2%
	North or Sub-Saharan African	8	2%
	Southern and Central Asian	7	1%
	Other	22	6%
	Prefer not to answer	4	1%

Table 3. Demographics of survey respondents (cont.)

		n	%
Total Sample		523	
Australian Residency Status	Permanent	487	93%
	Temporary	22	4%
	Prefer not to say	14	3%
Main Language Spoken	English	505	97%
	Other [6]	18	3%
Highest Level of Education	Postgraduate or professional degree	82	16%
	Bachelor's degree	166	32%
	Some university but no degree	145	28%
	Vocational qualification or similar	48	9%
	Secondary	60	11%
	Some secondary	21	4%
	Prefer not to say	1	0.2%
West Australian (WA) Residence	Metropolitan	482	92%
	Regional WA – South	29	6%
	Regional WA – North	7	1%
	Regional WA – East	5	1%

What We Found

Prevalence of IPV Experienced

Overall, 260 (51%) participants reported having ever experienced IPV, 121 (24%) reported having experienced IPV in more than one relationship, and 209 (41%) reported that they had never experienced IPV. However, when asked if they had ever experienced abusive behaviours from an intimate partner, 346 (68%) participants reported experiencing a type of abuse. Therefore, it is possible that the prevalence or recognition of IPV may be underreported due to a lack of education or self-awareness about IPV and its association with abusive behaviours. Table 4 shows the types of abuse reported by participants.

Table 4. Types of abuse participants reported ever having experienced (n = 508)
Participants were able to select multiple options.

	n	%
Emotional abuse	269	53%
Verbal abuse	200	39%
Sexual abuse	197	39%
Physical abuse	136	27%
Social abuse	124	24%
Stalking	96	19%
Technological abuse	70	14%
LGBTIQA+ related abuse	70	14%
Financial abuse	63	12%
Spiritual abuse	35	7%
Other abuse [7]	3	2%
I have not experienced any of these from an intimate partner	162	32%

Amongst survey participants there was a perception that risk of IPV among members of the LGBTIQA+ community was highest for transgender (n = 331, 66%), bisexual (n = 78, 16%) and gay (n = 54, 11%) individuals. However, cisgender women (n = 122, 47%) and those who identified as bisexual (n = 78, 30%) had the highest incidence of IPV, followed by individuals who were non-binary (n = 71, 27%), lesbian (n = 65, 25%), cisgendered men (n = 65, 25%), and gay (n = 54, 21%). Additional data have been summarised in Appendix B, Tables 12, 13, and 14.

Survey participants who had experienced IPV reported on the gender and sexual orientation of the perpetrator of abuse in their most recent intimate relationship. The most frequently reported perpetrators were cisgendered men (n = 211, 62%), heterosexual (n = 125, 37%), and cisgendered women (n = 111, 33%). Additional data are reported in Appendix B, Tables 15 and 16.

Time since respondents' last experience of IPV ranged from 0-2 years ago (n = 106, 31%), 2-5 years ago (n = 11, 32%), 5-10 years ago (n = 72, 21%), and more than 10 years ago (n = 43, 13%). Eight participants (2%) preferred not to say. Amongst LGBTIQA+ people who had experienced IPV, 40 (12%) participants believed they were targeted for abuse because of their sexual orientation, gender, gender expression, or intersex variation.

Knowledge of Healthy, Unhealthy, and Abusive Behaviours in Intimate Relationships

To assess participants' awareness of abusive behaviour in the context of intimate relationships, and their ability to discriminate between healthy, unhealthy, and abusive behaviours in intimate relationships, we generated an item that presented participants with 32 behaviours and instructed them to categorise each behaviour according to whether they believed it was Healthy, Unhealthy, or Abusive in the context of an intimate relationship. Each behaviour could only be placed into one category. The items assigned as healthy, unhealthy, and abusive were selected from previous research studies (15,17) and public educational initiatives on healthy relationships (18–20). The final behaviours retained for this item are listed below in Table 5.

Table 5. Items used in healthy-unhealthy-abusive categorisation question

Category	Qty	Items
Healthy	10	Respect | Good communication | Trust | Honesty | Fairness | Safety | Making choices together | Financial partners | Accountability | Support
Unhealthy	10	Not communicating appropriately | Disrespectful behaviour | Not trusting | Dishonest | Trying to take control | Only spending time together | Pressuring partner into activities | Making financial decisions that favour one partner over the other | Refuses to see how their actions can hurt the other partner | Inconsiderate behaviour
Abusive	12	Physically hurt you or your possessions | Prevent you from seeing your family or friends | Force you to do something sexually | Call you names | Threaten to disclose your LGBTIQA+ identity | Demand access to your mobile or email | Refuse to use protection during sex | Disrespect LGBTIQA+ identity | Demand you take on their beliefs | Totally control finances | Excessive phone calls or texts or emails | Prevent you from accessing gender affirming care or services

Most participants were able to correctly identify the 10 healthy behaviours (n = 484, 93%). However, some participants incorrectly categorised "Demanding access to your phone or email" (n = 7, 2%), "Receiving excessive phone calls or text messages or emails from your partner" (n = 14, 3%), "Feeling like they should only spend time with their partner" (n = 15, 3%), and "Pressuring your partner into activities" (n = 10, 2%) as healthy behaviours. Fewer participants could correctly identify the 10 unhealthy behaviours (n = 92, 18%) and the 12 abusive behaviours (n = 137, 26%).

Some participants incorrectly categorised abusive behaviours as unhealthy behaviours, including "Name-calling" (n = 129, 25%), "Demanding access to your phone or email" (n = 198, 38%), "Refusing to use protection during sex" (n = 151, 29%), "Disrespecting LGBTIQA+ identity" (n = 168, 32%), "Demanding you take on their beliefs" (n = 200, 38%), and "Sending excessive calls, texts, emails" (n = 450, 86%). These results indicate that some participants had difficulty discerning Unhealthy from Abusive' behaviours in intimate relationships. Conversely, 202 (39%) participants incorrectly categorised 'Pressuring your partner into activities' as abusive instead of unhealthy.

Attitudes Towards Sexual Abuse

Almost all participants (n = 501, 99%) agreed or strongly agreed that sexual abuse is a problem in society. Most participants (n = 480, 92%) also agreed or strongly agreed that IPV is a problem for members of the LGBTIQA+ community. About 1 in 3 participants (n = 158, 30%) agreed or strongly agreed that most people in the local LGBTIQA+ community have healthy sexual encounters.

Most participants (n = 484, 92%) agreed or strongly agreed that they know how to establish consent for sexual activities, and most participants (n = 462, 88%) agreed or strongly agreed that they establish consent with each sexual encounter.

Nearly all participants (n = 508, 97%) agreed or strongly agreed that alcohol or other drugs affects the capacity for consent in sexual situations and 252 (48%) participants agreed or strongly agreed that alcohol and other drugs are often used within the LGBTIQA+ community to intentionally lower another person's boundaries during sexual activity.

Disclosure of IPV

Table 6 shows the professional and non-professional supports participants disclosed their IPV experiences to.

Table 6. Supports who participants disclosed experiences of IPV to (n= 338)

	n	%
I did not disclose	90	27%
Friends	210	62%
Someone who identifies as LGBTIQA+	189	56%
A later partner	181	54%
Family	87	26%
Psychologist/counsellor	33	10%
Work colleagues	34	10%
Police	6	2%
GP/psychiatrist/hospital staff	5	1%
Someone else	5	1%
Telephone helpline	3	1%
Lawyer	1	1%

Use of IPV Support Services

Overall, 346 (68%) participants reported experiencing an abuse behaviour from an intimate partner, but 165 (48%) of these participants did not seek professional support. Participants who had ever experienced IPV sought professional support from the support services listed in Table 7.

Table 7. Support services that participants who have experienced IPV sought professional assistance from (n = 482) Participants were able to select multiple options.

	n	%
Psychological/counselling service	151	44%
GP, hospital	26	8%
Police (including LGBTIQA+ liaison officer)	23	7%
Lawyer, legal service, court system	17	5%
Telephone helpline	16	5%
IPV/FDV service	13	4%
Sexual assault service	9	1%
LGBTIQA+ organisation	6	1%
Religious organisation or spiritual elder	2	1%
Teacher or educational institution	5	1%
Employer	3	1%
Other [8]	6	1%
I did not seek professional support	165	48%

Participants reported that they learned about the service they engaged with from a variety of sources. Table 8 lists these sources.

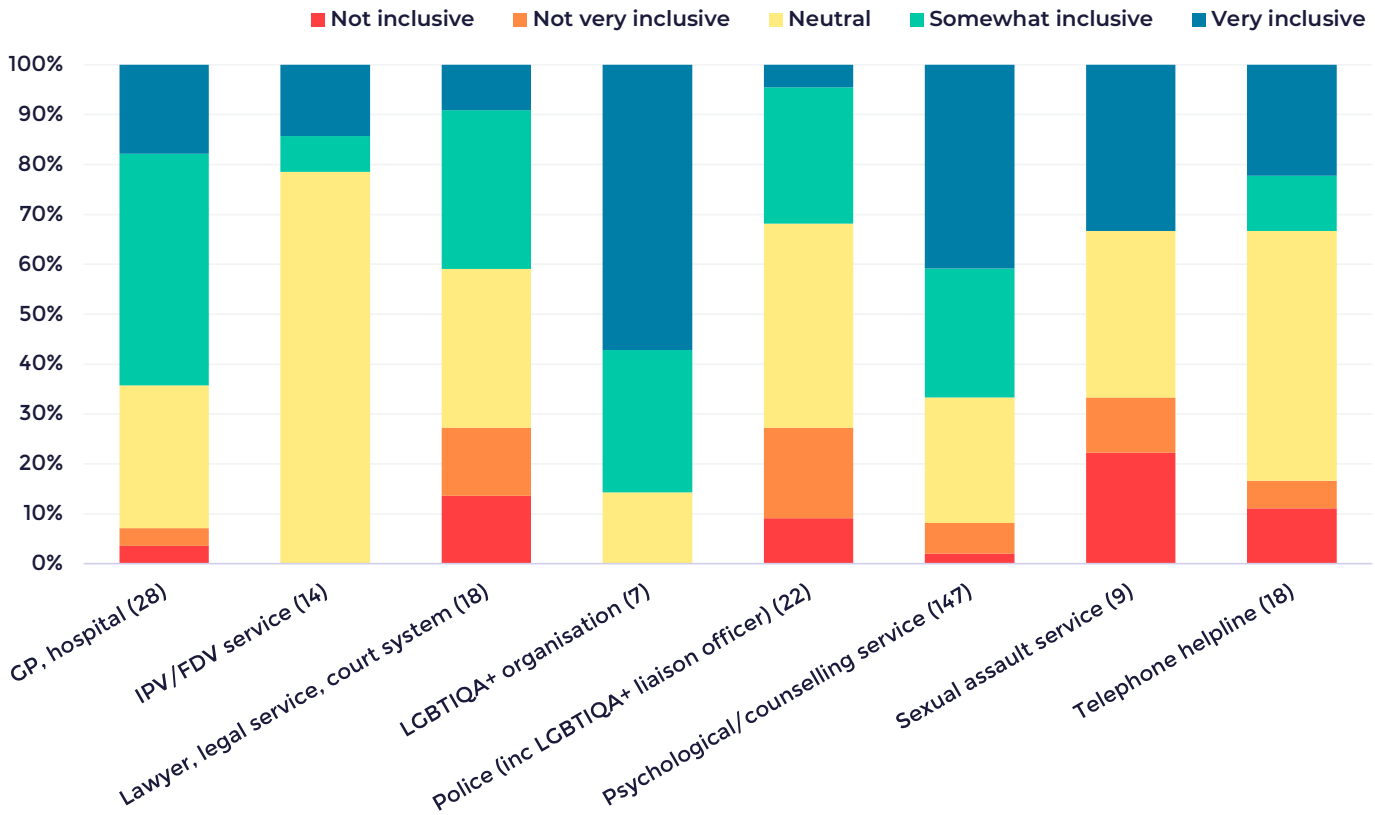
Table 8. How participants heard about the services they accessed for IPV support (n = 161) Participants were able to select multiple options.

	n	%
Referred by another service [9]	41	25%
Search engine	40	25%
Recommended by family member	31	19%
Social media	25	16%
Recommended by friend/colleague	12	7%
Employer	2	1%
Other	31	19%
- Was already a patient of the service	18	11%
- Word of mouth	2	1%
- University/school	3	2%
- Recommended by partner	1	1%

Inclusivity of IPV Support Services

Participants who accessed support services for IPV were asked to rate how inclusive they found the service. Seven participants rated 'other' services including "friends", which were rated "Very inclusive", and "mental health nurse", which was rated "Neutral". Other ratings are shown in Figure 1.

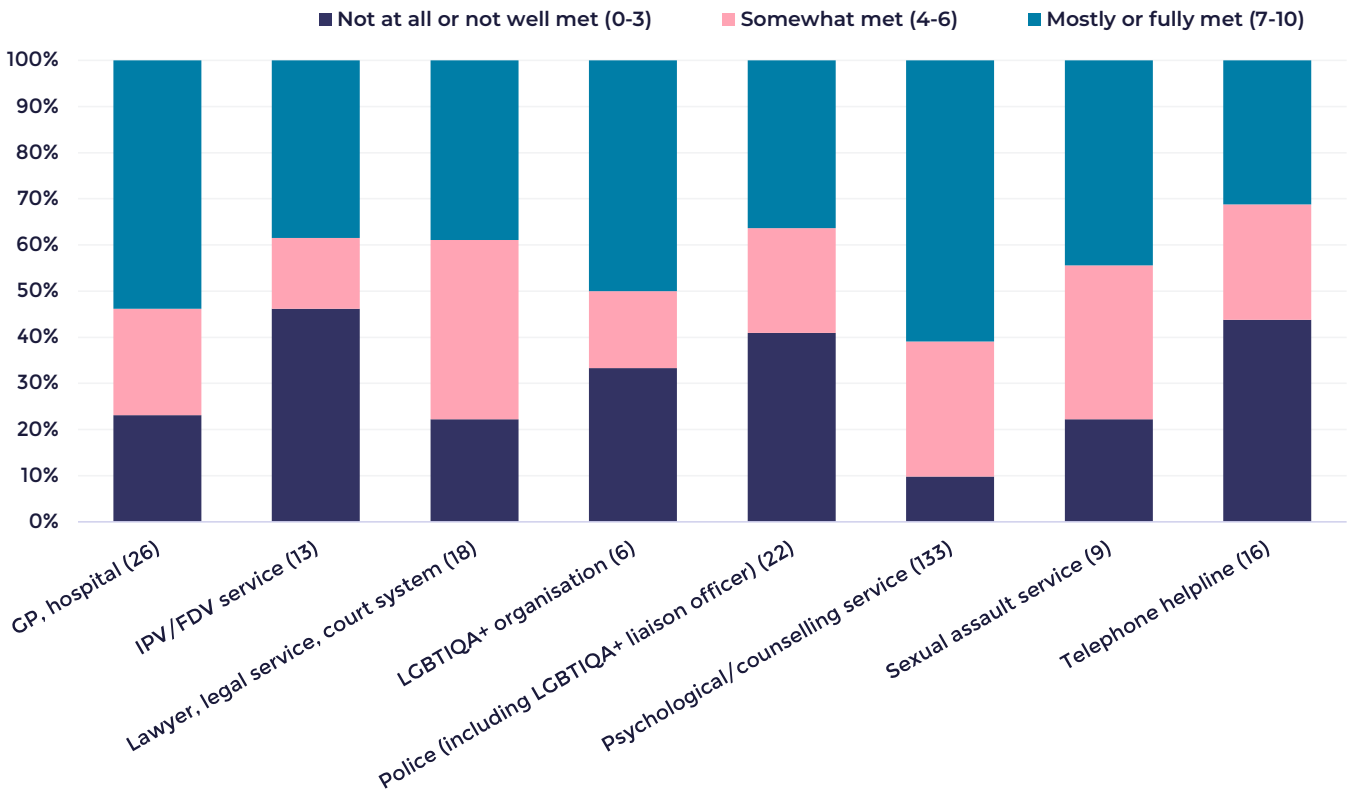
Figure 1. Inclusivity of services accessed for IPV support
(n = 160) Participants were able to select multiple options.
*Options with less than 5 responses were excluded. See full data in **Table 21, Appendix B** (Page 52).



Extent to Which IPV Support Services Met Participants' Needs

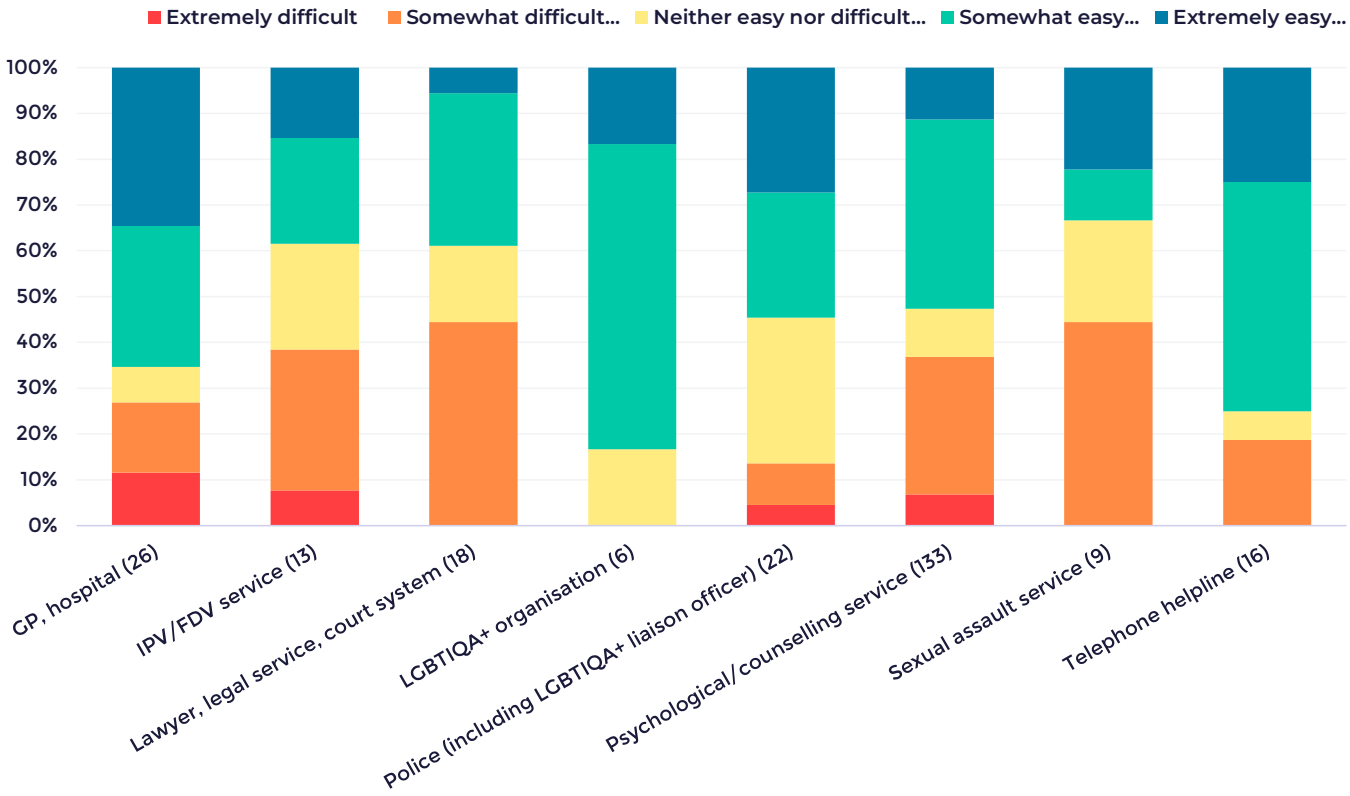
Participants who sought professional support for IPV varied in how much they believed the support service met their needs. Seven participants rated 'other' services including "friends", which were rated "Did meet my needs", and "mental health nurse", which was rated "Somewhat met my needs". Other ratings are shown in Figure 2.

Figure 2. Perceived extent to which professional support services met participants' support needs
(n = 146) Participants rated the support service on a 10-point scale, from 0 (Did not meet my needs) to 10 (Did meet my needs). Participants were able to rate multiple support services.
Options with less than 5 responses were excluded. See full data in **Table 22, Appendix B** (Page 53).



LGBTIQA+ individuals who had experienced IPV varied in how difficult it was to access professional support services. Six participants rated "friends" as "extremely easy" to access, and 1 participant rated "mental health nurse" as "extremely easy" to access. Other ratings are shown in Figure 3.

Figure 3. Perceived ease of accessing the service that participants sought support from for IPV (n = 146) Participants were able to rate multiple support service options.
*Options with less than 5 responses were excluded. See full data in **Table 23, Appendix B** (Page 53).



Ease of Accessing IPV Support Services

There can be barriers when LGBTIQA+ attempt to access professional support services for IPV. A list of barriers generated from the scoping review was created, and participants were asked to select which they perceived as barriers to accepting professional help. Most participants (n = 128, 88%) experienced one or more barriers when they attempted to access professional support services for IPV. These barriers are listed in Table 9.

Table 9. Perceived barriers to accessing services for IPV support (n = 145)
Participants were able to select multiple options.

	n	%
Not knowing what LGBTIQA+ safe supports are available	63	43%
Believing the service will fail to recognise or not take your experience of IPV seriously because you are LGBTIQA+	56	39%
Lack of LGBTIQA+ specific or inclusive services	56	39%
Not knowing what LGBTIQA+ safe supports are available due to lack of visibility	54	37%
Having to fit into gender binary service access criteria	37	26%
The dismissal by professionals of a victims' experience of IPV as mutual	36	25%
Another barrier/s not listed [10]	32	22%
Being misgendered and therefore receiving inappropriate referrals or being disrespected	21	14%
I did not experience any barriers	18	12%

IPV Support Service Preferences

Participants were asked several questions regarding their preferences were they to seek support for IPV in the future.

Almost all participants would prefer to access psychological/counselling services for IPV support (n = 395, 90%), followed by LGBTIQA+ organisations (n = 302, 69%), sexual assault services (n = 291, 67%), IPV services (n = 289, 66%), police (n = 258, 59%), and telephone helplines (n = 250, 57%). Participants indicated that they would prefer that these IPV services serviced LGBTIQA+ individuals only (n = 169, 39%) or serviced all individuals but were visibly committed to LGBTIQA+ inclusivity (n = 162, 37%).

Almost all participants would prefer that their IPV primary care service is LGBTIQA+ inclusive (n = 412, 92%). Participants were polarised in whether they would prefer an IPV primary care provider that was an LGBTIQA+ peer, with 43% (n = 189) of participants stating that they would prefer an LGBTIQA+ peer and 35% (n = 151) of participants stating that it did not matter whether the IPV primary care provider was an LGBTIQA+ peer. Similarly, some participants stated a preference for an IPV primary care provider with the same sexual orientation (n = 161, 37%), while other participants indicated that this did not matter (n = 267, 61%). These data indicate that support services should seek to employ staff with diverse attributes to better the needs of LGBTIQA+ individuals seeking support for IPV. Additional data are provided in Appendix B, Tables 17, 18, and 19.

Lastly, participants were asked to indicate how they would prefer to access IPV support services in the future. Most participants (n = 345, 79%) reported a preference for meeting face-to-face with a primary care provider, followed by accessing a 24/7 telephone helpline (n = 232, 53%), and face-to-face with a LGBTIQA+ peer (n = 206, 47%). One-fifth of participants indicated a preference for accessing support online via a chatbot (n = 111, 25%). Additional data are provided in Appendix B, Table 20.

Footnotes

[1] 'Non-binary' was considered an umbrella gender identity. Identities subsumed within non-binary were Agender, Autigender, Bigender, Demiboy, Demigirl, Gender Outlaw, Genderfluid, and Girlboy.

[2] 'Queer' was considered an umbrella sexual orientation. Orientations subsumed within queer were Trans for trans, Pomosexual, Sapphic, and Aromantic.

[3] Of the 6 participants who identified as heterosexual, all responded 'yes' to the screening question, 'Do you identify as LGBTIQA+?'. Two of the six participants reported gender identities that differed to their sex assigned at birth (i.e., could be said to be transgender).

[4] Participants with more than one reported disability/neurodivergence were reported again across the separate categories. Autism and ADHD were reported separately in the table as these were the most prevalent form of disability/neurodivergence.

[5] Disability/neurodivergence with n = 1 were neurodegenerative disease, amputation, Crohn's disease, irritable bowel syndrome, sleep apnea, long COVID-19, gastroparesis, intestinal failure, multiple sclerosis, Neurofibromatosis, Tourette's syndrome, Cancer, Diabetes mellitus, Acquired brain injury, Dissociative identity disorder, Osteoporosis, Schizoaffective disorder, Retinitis pigmentosa.

[6] Other main languages spoken at home included Afrikaans, Auslan, Cantonese, Chinese, Croatian, Dari, Dutch, Farsi, French, German, Greek, Gujarati, Hindi, Indonesian, Irish, Italian, Japanese, Macedonian, Malay, Mandarin, Persian, Sinhalese, Spanish, Swahili, Tagalog, Turkish, Urdu, and Vietnamese.

[7] Image-based abuse (1), False imprisonment (1), Abuse targeted towards victims' disability/health status (1)

[8] 'Other' included mental health nurse (1) and men's health service (1).

[9] Participants were referred by various services/providers for IPV support, including their GP, Freedom Centre, Headspace, Domestic Violence Advocacy Support service, Life 360, QLife, WA Police, Psychologist, Support worker, Trans Folk WA, Share and Care Community Services, Workskil, and Workplace Counselling Service.

[10] Barriers referenced by participants included: Length of time for a psychological appointment (2), Dismissal of IPV due to 1) the perpetrator being a transgender man 2) the perception of heterosexuality in a relationship with a heterosexual cisgendered male 3) being of a certain sexual orientation, Lack of accommodations as an ADHD person (taken off waitlists due to difficulty remembering to return calls), concerns about safety (accessing the service without the perpetrator knowing), self-stigma/internalised shame regarding IPV or queer identity (2), geographical isolation (1), and cost (6).

[11] Thirteen (13) responses. Other services listed by participants were: Open community discussions/educative workshops aimed at preventing and identifying IPV (2), mental health peer support worker services (2), Housing/accommodation services (4) including a dedicated LGBTIQA+ refuge/shelter (1), Sexual health clinic (2), Financial support services (3), Drug and alcohol counselling (1), text-based chat counselling services (1), and an independent LGBTIQA+ advocacy program to support LGBTIQA+ individuals seeking medical or legal support for IPV.

[12] Other preferences reported by participants included: LGBTIQA+ youth-focused service that is affordable with short wait times, existing psychologist, family/extended family, a service not accessible by one's partner, a private provider, mainstream LGBTIQA+ inclusive service with only either lived experience providers or queer providers.

[13] Other modality preferences reported by participants included: SMS with a real person, online text-based chat with a real person.

Phase Four | Consultations with LGBTIQA+ Individuals

Consultations were conducted with LGBTIQA+ individuals to understand their experiences, needs, and preferences when seeking and accessing support for IPV in WA. Semi-structured interviews, focus groups, and consumer navigator activities were used.

Interviews and Focus Groups

What We Did

The aim of the interviews and focus groups was to understand the experience of LGBTIQA+ individuals seeking support for IPV from primary care services. Participants were required to be over 18 years of age, live in WA, and have either experienced IPV, attempted to access primary care services, or supported someone from the LGBTIQA+ community who had experienced IPV. In total, 15 people participated, four in focus groups and 11 in interviews.

What We Found

Across the interviews and focus groups, four themes were identified that captured the experiences of LGBTIQA+ individuals when seeking support for IPV in WA. Theme One explores the difficulties some LGBTIQA+ individuals experience in recognising abusive behaviours within relationships which hinder subsequent help-seeking. Theme Two explores the strategies recommended by participants to encourage help-seeking, including the importance of positive reputation of services, safe service spaces, and community engagement by services. Theme Three addresses the struggles of seeking support within cisgendered and heteronormative systems and the need for inclusive services. Theme Four explores what LGBTIQA+ individuals need from these primary care services, highlighting the importance of comprehensive and integrated education in practice. A summary of the findings are presented in Table 10.

Table 10: Summary of the qualitative findings from interviews and focus groups with LGBTIQA+ individuals

Theme One | Can't Recognise, Can't Seek

Explores the challenges that arise for LGBTIQA+ individuals when seeking support for IPV.

Theme Aspect	Supporting Quote
Participants highlighted the complexity of recognising abusive behaviours within their relationships due to IPV often being characterised by cis-gendered and heteronormative stereotypes, often leading to delayed realisations and heightened distress. Specifically, an assumption that only cis-gender woman experience IPV and cis-gender man uses physical violence was discussed as significant barrier to LGBTIQA+ individuals being able to accurately recognise IPV.	*I think also it makes it really hard for people to even recognise that maybe they are the victim. I've had so many conversations with people where whether they identify as a male or as the more masculine partner, it's been quite a journey for them to go, oh wait, yes, something terrible has been happening to me, or it is possible for me to be the one being abused. And I've definitely found that, I've seen the concept of intimate partner as a term, to be one of the biggest barriers to people who even thinking that this is something they need to or want to seek help about. Because there's a lot of different words that we might use. There's all different types of relationships that we might have. And I don't know that very many of us would ever consider it an intimate partner, like your friends with benefits or your hookup that you happen to have multiple encounters with.* **- Non-binary, Queer, 28**
The lack of LGBTIQA+-tailored primary care services were discussed as creating hurdles in accessing support once IPV was recognised in their situations. Participants called for specialised and inclusive support and resources for IPV tailored towards LGBTIQA+ individuals.	*I really didn't think there was anything wrong with the relationship until later on, like, "Hey, that's actually abuse," which is hard as well. And then not having access or not knowing that there was someone that I can go to.* **- Non-binary, Pansexual, 22**
Participants also emphasised the importance of greater education and awareness about IPV among the LGBTIQA+ community, particularly that IPV is not just physical violence, to facilitate better self-recognition and subsequent support seeking. Participants expressed the need to address the stigma associated with IPV among within the LGBTIQA+ community for open discussions and community engagement to normalise seeking help.	*There's such little awareness on what domestic violence and IPV actually is, because when we hear domestic violence, we think, "Oh, well, they were beaten by their partner." Not, "They were verbally abused," or, "They were forced to feel less than what they are from their partner." We still see DV and IPV as physical abuse or sexual abuse, not as verbal abuse.* **- Non-binary, Pansexual, 22**

Table 10: Summary of the qualitative findings from interviews and focus groups with LGBTIQA+ individuals (cont.)

Participants raised the challenges of accessing identifiable and suitable primary care services and expressed the need for clear guidelines for where to seek help during crisis situations.	*Yeah, I think clear access or just really if you're in that situation, you can know pretty much straight away where you need to go. When you're so overwhelmed and you can't take in a lot of information, it's really difficult to go seek help. If it's really clear where you can go similar to say, Lifeline, you always know you can go there. Yeah. I think that would be really valuable.* - Cisgender Woman, Pansexual, 23
Theme Two | Encouraging Help Seeking **Explores how primary care services can effectively encourage LGBTIQA+ individuals to seek help for IPV. Participants emphasised key strategies that primary care services can employ, including building a positive reputation, leveraging word of mouth, creating safe spaces that recognise and validate LGBTIQA+ identities and experiences in practice, and engaging with the LGBTIQA+ community.**	
Theme Aspect	**Supporting Quote**
The significance of establishing a strong reputation within the LGBTIQA+ community was discussed, with a focus on proactive communication of LGBTIQA+ inclusivity. Word-of-mouth recommendations from other LGBTIQA+ peers were identified as influential motivators for seeking help.	*Having someone be able to tell you "Yes, I went and accessed this service, and yes, they were really inclusive, and I had a really good experience with them."* - Non-binary, Queer, 28
Participants stressed the need for explicit LGBTIQA+ inclusivity in primary care services, highlighting the importance of safe physical and online spaces. Visible symbols like rainbow stickers were noted for their role in creating a welcoming environment.	*Just having a tiny little rainbow sticker makes a world of difference to know that the business or an individual is LGBTIQA+ friendly and are thinking about that proactively, rather than if they're asked, then they'll say, oh yes.* - Cisgender Woman, Gay, 22
Engaging with the LGBTIQA+ community, such as through attending community events or formal partnerships, before crises emerged as a beneficial approach, simplifying the help-seeking process through relationship-building. These efforts foster trust and accessibility, ultimately facilitating timely support-seeking behaviours.	*I think building relationships with the community is really important as well, building relationships, even before there is an occurrence of violence. If people in the general community are aware of the service, they're aware that it's there and it's going to be a high quality inclusive service, then it takes a little bit of the labour away of having to go and find that when you're in a crisis.* - Non-Binary, Lesbian, 35

Table 10: Summary of the qualitative findings from interviews and focus groups with LGBTIQA+ individuals (cont.)

Theme Three | "We're Not For You"

Captures the experience of LGBTIQA+ individuals being excluded when seeking or receiving support for IPV from primary care providers.

Theme Aspect	Supporting Quote
Participants shared instances where their gender identities and relationship structures did not align with heterosexual and cisgender norms which caused barriers seeking support within the current IPV support systems that overlooks the unique experiences of LGBTIQA+ individuals experiencing IPV.	*I did try and call up one place, it was a very brief call that stopped me from trying to call other places that, from my voice alone, they went, "We're not for you." And they immediately dismissed without understanding the context and whatnot. So, it was quite frustrating because on paper, my partner at the time was a trans woman and I'm a trans man, so technically by all the paperwork, we're a hetero couple. But it was very, very weird trying to navigate that space.* - Transgender Man, Bisexual, 26
Existing primary care services were found lacking by participants and were considered to be focused on supporting cisgender heterosexual women experiencing IPV with the assumption that it had typically been a male who had caused harm, thereby excluding diverse LGBTIQA+ experiences and dismissing those who need support.	*There really isn't any services that feel equipped to support LGBTQA+ people because the system is really built around this idea that it's gender-based violence and it's a man harming a woman. And if it's not, doesn't fit neatly into that binary, then it is really hard for people to know how to respond appropriately.* - Non-binary, Queer, 27
Participants discussed the pressure to fit into these problematic systems, leading some to conceal their identities to access support, revealing the need for primary care services that embrace LGBTIQA+ diversity.	*It's just making sure that there are places there that everyone can go and that they know that they're going to be welcomed there and not judged, not spoken over, not misgendered or forced to identify a way that they don't so that they can access the service.* - Non-binary, Queer, 27

Table 10: Summary of the qualitative findings from interviews and focus groups with LGBTIQA+ individuals (cont.)

Theme Four | Recommendations for Primary Care Services

Encompasses recommendations made by LGBTIQA+ individuals to address what is missing, and what they need from primary care services to appropriately support LGBTIQA+ individuals seeking support for IPV. Overall, participants emphasised creating safe, empathetic environments for validation and support when seeking support for IPV.

Theme Aspect	Supporting Quote
Notably, participants highlighted the limited LGBTIQA+ knowledge among primary care providers and called for comprehensive education about IPV within LGBTIQA+ relationships.	*I guess the dream scenario would be you'd have an LGBT person who is experiencing IPV, and they know that they can go to a primary healthcare provider. And they know that, one, they'll be taken seriously. Two, they'll be respected. Three, they'll be understood. That should be the goal and that should be the bare minimum.* - Cisgender Woman, Lesbian, 68
Acknowledging intersectionality within the community was cited as necessary, expanding primary care services to various cultures, abilities, and age groups.	*I think across the intersectionality, so the fact that the lesbians exist, and they might also be Aboriginal, and they might also have a disability, and they might also be 60 years old. So, I think so much of what's in the media, positive and negative ways, is very focused on young LGBTI people. And what we tend to miss out on seeing as basically this is just as normal as everything else, is that intersection between cultures, through disability and through age across our whole community.* - Cisgender Woman, Lesbian, 20
Participants also recommended that primary care providers are well-informed about foundational LGBTIQA+ topics to relieve individuals of the responsibility to educate primary care providers, addressing the emotional effort required in these situations.	*You have to go through the emotional labour of educating a practitioner about issues that seem to be extremely basic LGBTIQA+ issues when you live in this kind of LGBTIQA+ bubble. I've come here for a service and now I'm being treated like I'm some kind of novelty specimen that is just fascinating because the things I'm saying have probably never been said in this office before.* - Non-Binary, Lesbian, 35

Consumer Navigator Activity

What We Did

The consumer navigator activity comprised three components designed to understand IPV help-seeking process and to assess the perceived inclusivity and accessibility of IPV primary care services in WA. Three participants from the LGBTIQA+ community took part in this exploration.

What We Found

Part One

To provide context for participants' responses on the following tasks, participants were asked to complete an open-text questionnaire examining their level of familiarity with IPV primary care services in WA, and their personal experiences of IPV. All participants had experienced IPV, and all were familiar with at least one IPV primary care service in WA. Two participants had extensive knowledge of IPV services in WA, while one participant had less familiarity.

Part Two

Participants were asked to search online for four primary care services that advertise themselves as supporting LGBTIQA+ individuals experiencing IPV in WA, and to critically evaluate these services. The findings from this part of the consumer navigator activity raises several considerations concerning current primary care services available in WA for individuals within the LGBTIQA+ community who experience IPV.

A summary of the findings is provided below:

1. For the search process, participants entered terms such as 'LGBT', 'FDV', 'DFV', 'queer DV', or 'abuse' into Google search, and most participants reported that it was easy to find relevant services.

2. In terms of perception of inclusivity, across the 11 services identified, participants reported a range of inclusivity from unclear to extremely inclusive. Overall, participants noted a lack of transparency from services regarding how their IPV support services were inclusive of LGBTIQA+ individuals. Specifically, participants reported that some services did not provide enough information to determine how inclusive services, while other services lacked written statements concerning their allyship with the LGBTIQA+ community and/or lacked visible indicators of allyship.

3. Rainbow Tick visibility ranged from obvious, unclear, to not present. For organisations with a positive reputation, it was less important if the Rainbow Tick was visible.

4. The reputation of the service and employees of the service in the LGBTIQA+ community is important for choosing whether to engage with a service. Participants mentioned that word of mouth was sometimes more important than the demonstrated inclusivity of a website when choosing a service to engage.

5. It was important to participants that the information on websites was current, that the design of the website did not appear out-of-date, and that the website made it obvious whether the service was WA-based on available nationally. Some participants experienced confusion when trying to determine whether the service was local or national.

Part Three

Lastly, to understand the challenges that participants faced as they searched for services and evaluated them, participants engaged in a discussion with the researchers. Participants highlighted a few key points about their experience of searching online for services which are summarised below:

1. The information and imagery on the websites of some of the identified services did not make it clear whether these services were suitable and appropriate for LGBTIQA+ individuals experiencing IPV. For example, some websites lacked inclusive language and did not have visual representations of relationships beyond those that are cisgendered and heterosexual, which led to participants' feeling that their LGBTIQA+ experiences of IPV would not be understood by service providers

2. Participants expressed the need for services to be about their capacity to provide LGBTIQA+ inclusive support and to explicitly acknowledge intersectionality. For example, if a service has obtained Rainbow Tick accreditation, participants believed that a visual indicator of this accreditation should be prominently displayed on the website.

3. Participants called for services to ensure that any indication of inclusivity on the website is backed by genuine and authentic instances of inclusivity in real-world interactions with the service.

Together, the points made by participants emphasise that it is important for WA IPV primary care services to enhance the inclusivity of service provision to better meet the needs of LGBTIQA+ individuals experiencing IPV.

Phase Five | Primary Care Provider Interviews

What We Did

Semi-structured interviews were held to explore primary care providers' confidence in supporting LGBTIQA+ individuals experiencing or at risk of IPV, and the resources they need at an individual and organisational level to enhance their responsiveness to this population. Interviews were 30 minutes in length and conducted in person, by phone or online. Primary care providers were eligible to participate if they had provided services to LGBTIQA+ individuals experiencing IPV or had an interest in supporting this population. Eight primary care providers (3x General Practitioners, 3 x Clinical Psychologists, 1x Counsellor, 1x Registered Nurse) based in metropolitan WA participated.

What We Found

The themes explore primary care providers' experiences in supporting LGBTIQA+ individuals experiencing IPV. In the first theme, the focus is on the varying confidence levels of primary care providers, shaped by experience and training. The second theme addresses the barriers primary care providers face, including time constraints and unconscious biases that hinder appropriate support. The third theme explores effective strategies for inclusive service provision, highlighting the significance of creating a nonjudgmental environment and visible signs of inclusivity. Finally, the fourth theme comprises the essential requirements for achieving comprehensive and inclusive support, including ongoing education, tailored resources, and structured assessment tools. A summary of the findings are presented in Table 11

Table 11: Summary of the qualitative findings from interviews with primary care providers

Theme One | Varied Capacity to Support LGBTIQA+ Individuals Experiencing IPV

Primary care providers expressed varying degrees of comfort and confidence in supporting LGBTIQA+ individuals experiencing IPV.

Theme Aspect	Supporting Quote
One participant felt confident due to their experience and familiarity with available support and resources, allowing them to offer appropriate guidance to their clients.	*So, I am very confident in recommending primary care services to people experiencing violence because I've worked a lot in that area and I'm aware of some of the things that are available.* - Cisgender Woman, Heterosexual, 42
Conversely, participants noted the lack of available training to address IPV within the LGBTIQA+ community which resulted in diminished confidence. This deficit in training was discussed to hinder needed conversations of sensitive topics with their clients and the use of appropriate language for relationships.	*I think as well, a lot of people who haven't done ally training or any training specifically with working with LGBTIQA+ people is not knowing how to talk about things or having the language to talk about relationships safely and stuff like that.* - Cisgender Women, Bisexual and Heterosexual, 28
Participants discussed the challenge of finding resources inclusive of LGBTIQA+ individuals and referral options suitable for LGBTIQA+ individuals, a problem exacerbated by the prevalence of heteronormative systems in IPV service provision. This lack of awareness regarding suitable resources and referral options further compounded the difficulty in providing effective support, highlighting the need for enhanced LGBTIQA+ inclusivity training and accessible resources to strengthen confidence and deliver meaningful support.	*Yeah, I think not knowing what support is appropriate or what other organisations or resources are even available is another one, because if I did identify it in someone I was working with, I wouldn't really know where to refer them to or what services are appropriate or resources helpful.* - Cisgender Women, Bisexual and Heterosexual, 28

Table 11: Summary of the qualitative findings from interviews with primary care providers (cont.)

Theme Two | Barriers to Provision of Needed Support

Encompasses the barriers encountered by primary care providers when offering support to LGBTIQA+ individuals experiencing IPV.

Theme Aspect	Supporting Quote
A common barrier highlighted is the constraint of time during consultations, often leaving limited space to address IPV when it arises amidst other health discussions.	*Time, it is always a big barrier, I guess because often violence is something that comes up as a... It's not the reason that someone's come to that consult. They've come to the consult for other reasons and violence is something that comes up, and it's a little bit like opening a can of worms. So, time is always an issue.* - Cisgender Woman, Heterosexual, 42
Participants recognised that unconscious biases and assumptions about the LGBTIQA+ community are present among primary care providers, possibly leading to missed opportunities for support. For example, a common assumption was that IPV primarily manifests in heterosexual relations hips where males are most likely to be perpetrators, which could result in overlooking IPV in LGBTIQA+ relationships. Such assumptions were recognised to hinder appropriate support provision and the necessity for increased awareness and sensitivity among primary care providers to diverse relationship contexts was emphasised.	*Because intimate partner violence is so commonly seen in the general population as male to female and the statistics show that that's usually the way it is that I think there's a risk of missing intimate partner violence when you might be seeing two women, for example, because with the assumption that there's no coercive control or there's no violence because they don't fit the stereotype. So, I think that's a barrier is clinician's assumptions.* - Cisgender Woman, Heterosexual, 42
The harmful consequences of these assumptions were discussed, as illustrated by a participant describing how another's clinician's lack of understanding or dismissal of non-binary identity led to a breakdown in a therapeutic relationship and hindering further support-seeking.	*If you tell your psychologist that you are non-binary, whatever, and they're like, 'What does that mean?' Then, nope, I'm not coming back here.... Clinicians aren't comfortable discussing some things, especially around sex and gender. Some people just really feeling shut down and dismissed, like a client who tried telling their psychologist that they were non-binary. And the psychologist just being like, 'Oh, you just don't want a label.' And then also stuff pathologising it or reading their gender or sexuality as the root of all their problems, or assuming that someone's gender identity must be linked to their past of sexual trauma.* - Cisgender Woman, Pansexual, 41

Table 11: Summary of the qualitative findings from interviews with primary care providers (cont.)

Theme Three | Effective Strategies to Achieve Inclusive Service Provision

Encompasses the strategies and approaches that can promote inclusive service provision for LGBTIQA+ individuals experiencing IPV. Overall, participants emphasised the importance of creating a nonjudgmental and inclusive environment to encourage disclosure and support-seeking.

Theme Aspect	Supporting Quote
Recommendations were made to display visible signs of inclusivity, such as rainbow flags and pronoun usage, which can effectively establish a sense of safety and trust. Assuring patients that the service is a safe and nonjudgmental space was seen as pivotal, with promotion of an LGBTIQA+ friendly environment encouraging patients to seek support without fear of discrimination.	*A big one just off the top of my head, is use of pronouns. And encouraging patients to disclose pronouns and disclose gender identities. And making sure that we acknowledge that and support them in what they're disclosing with us.* - Cisgender Man, Heterosexual, 23
Participants recognised the value of being open to learning from patients and being aware of unconscious biases, which enhances communication and fosters a supportive atmosphere. The willingness to learn from patients was acknowledged as a pathway to better understanding and promoting patients' well-being.	*I'm very happy to be educated by my patients. I make that very well known. I want it to be a comfortable space for them to be able to express how they're feeling and things. I've learned a lot from my patients. I'm very happy to be corrected and learn from them.* - Cisgender Woman, Bisexual, 34
Challenges individuals face in seeking psychological support were also discussed, with some patients choosing not disclosing their gender and sexual identity and subsequent relationship dynamics when seeking support, which hinders capacity to provide the needed appropriate support.	*I see some people who've seen multiple psychologists in the past who they couldn't vibe with for some of these reasons, and I'm quite impressed that they've tried again and come to me. But I know there's plenty more people out there who have bad experiences with a psychologist and like, "That's not for me. I'm not doing that again." Obviously, that can be quite dangerous then. But also, people talked about gatekeeping themselves in therapy, feeling like there was parts of themselves they couldn't share. It was like, "Okay, I'm just going to go and focus on this one thing, and I can't let this person know all this stuff about me because that might change how they can help me and reduce..." They might still go to the psychologist but not disclose things that might be important.* - Non-binary, Queer, 30

Table 11: Summary of the qualitative findings from interviews with primary care providers (cont.)

Theme Four | What is Needed to Achieve Inclusive Service Provision

Captures the requirements for primary care providers to establish a comprehensive and inclusive approach in supporting LGBTIQA+ individuals experiencing IPV.

Theme Aspect	Supporting Quote
Participants stressed the necessity of ongoing education and professional development to recognise and address both LGBTIQA+ topics and IPV within the community. The concept of a certification or training program specifically focused on IPV within the LGBTIQA+ context emerged, aiming to enhance primary care providers' capacity to offer suitable support.	*Have a certification or training thing where if people have done a PD, which is specifically for IPV in the LGBTIQA+ community, then they could display that somehow on a website. Or there could be a register of practitioners who have completed that training so that if someone is experiencing that, they can look it up and then know that that person is a safe person to go to.* - Cisgender Women, Bisexual and Heterosexual, 28
This idea included the potential for a register of trained practitioner and primary care services, safe accommodation options, and crisis helplines to guide primary care providers in building referral pathways and addressing the current lack of familiarity with available resources.	*I think if someone was to disclose now, I'm not as familiar with the services for intimate partner violence in the context of LGBT people rather than 1800RESPECT or all those kind of... So that's why I'm not really aware of. I'm sure there are some that'll be frantically googling but I'm not really aware of where I'd suggest that next steps are for them.* - Cisgender Woman, Heterosexual, 35
The importance of a structured screening tool and risk assessment guidelines for IPV cases was emphasised, aiming to ensure appropriate support and confidentiality while navigating the unique challenges faced by LGBTIQA+ individuals who experience IPV.	*I think having a screening tool would be really useful. Having some sort of maybe guideline for risk assessment and recommended course of action, or levels of escalation or if they disclose this, this would be an appropriate course of action. If they disclose this, then this.* - Cisgender Man, Queer, 29
Financial barriers to accessing primary care services were also discussed as something that impacts the broader population including LGBTIQA+ individuals, with participants acknowledging the significant obstacles posed by limited financial accessibility.	*Financial barriers as well are huge. We're ostensibly a private billing practice. I bulk bill most of my trans and gender diverse patients but that is not sustainable. I have to have my other work as well so that I can live. It's really tricky to offer affordable primary healthcare in this day and age. If you don't bulk bill, a lot of them won't come. I think they can't afford it and it's devastating. It ends up being a decision like, do I bulk bill them and then they come or do I not? And of course, you bulk bill them because you want them to come and see you and be safe.* - Cisgender Woman, Bisexual, 34

Phase Six | Co-Design Resources

What We Did

A key deliverable of Safer Options was to co-design a set of hard-copy and online resources intended to improve recognition and responsiveness to IPV among primary care services and LGBTIQA+ individuals. Across the consultations, the need for primary care providers and LGBTIQA+ individuals to be educated on what IPV can look like in LGBTIQA+ relationships were emphasised. Out of the recommended resources raised, it was determined the following would be most effective and possible within the time-scope of the project.

A website tailored towards LGBTIQA+ individuals experiencing IPV and primary care providers in the WA context was recommended across the consultations. This website included details of what IPV is in LGBTIQA+ relationships, tools to recognise unhealthy and healthy relationships, an LGBTIQA+ inclusive service directory with emergency contacts, and information for how primary care services can modify their service provision to be more inclusive of LGBTIQA+ individuals experiencing IPV.

Two sets of brochures were developed. The first brochure contains information to educate readers on IPV in LGBTIQA+ relationships, including signs of unhealthy relationships, forms of IPV, and encouraging those in need to learn more and seek support through the Safer Options website. The second brochure is an abbreviated version of the content provided on the Safer Options website detailing practical strategies that primary care services can use to be inclusive of LGBTIQA+ individuals. The brochure directs readers to the Safer Options website to learn more.

A suite of five posters was developed to raise awareness of IPV among LGBTIQA+ individuals as a significant public health issue and to assist LGBTIQA+ individuals in recognising IPV and seeking support if needed. The posters direct viewers to the Safer Options website to learn more about IPV and utilise the support through the service directory.

To ensure these resources were meeting the needs of the target population, LGBTIQA+ individuals and primary care providers were consulted in multiple co-design workshops and interviews between February and September 2023. The co-design approach was based on principles of participatory problem-solving and aimed to challenge power imbalances between professionals and people they support, leading to higher quality and more inclusive primary care services. The first two co-design workshops were conducted to receive feedback on the draft set of resources. The objectives were to enhance the resources to best aid self-identification of abuse and help-seeking behaviours among LGBTIQA+ individuals, and improve primary care providers' capacity to recognise, respond to, and refer these patients to appropriate primary care services. The two workshops contained five primary care providers and five LGBTIQA+ community members and were held separately. An additional co-design workshop with five LGBTIQA+ individuals also was held to gain further insight on a more advanced and developed version of the website, ensuring that the website in its development stage was meeting the needs of the target populations. Three interviews were also conducted with two primary care providers and one LGBTIQA+ individual who could not attend the workshop.

What We Found

Brochures

To refine the brochures' content, participants requested for the information to:

- Be guided by and consistent with the Rainbow Tick Standards to ensure the information is consistent with reputable sources
- Highlight the differing experiences of IPV across LGBTIQA+ sub-communities to honour diversity and intersectionality.
- Be clearly understood with a glossary and definitions for clarity.
- Include practical advice that can be implemented immediately.

Regarding the design of the brochures, participants requested for:

- The brochures must be visually appealing, sleek, professional, and clear that it focuses on LGBTIQA+ through use of iconography.
- The information to logically ordered.
- Practical tips to be highlighted without being reliant on large amounts of text.

Posters

To refine the posters' content, participants requested:

- For positive language to be used that encourages help-seeking for IPV.
- Clear definitions around what IPV is and what is considered an unhealthy relationship.
- For various types of violence (i.e., financial, emotional, technological) to be included to raise awareness that IPV is not just physical.
- For the content to be phrased as questions around how a person feels, to promote self-reflection on their situation and if they are experiencing IPV.
- For impactful statistics and quote to be used that may relate to common experiences of IPV.

Regarding the design of the posters, participants requested:

- That the posters are eye catching but also sensitive to those who experience IPV.
- Ensure that information can be understood at a quick glance to not require people to stop and read the poster and potentially 'outing' them or placing them in a vulnerable situation.

Website

To refine the website's content, participants requested:

- For key concepts such as 'unhealthy relationships' and the difference between sex, gender identity, gender expression, and sexuality to be defined.
- For practical steps for primary care providers providing support and LGBTIQA+ seeking support to be presented prominently.
- An acknowledgement of country on the front page.
- Quotes and stories of LGBTIQA+ individuals who have experienced IPV are integrated throughout.
- Language and terminology to achieve a balance between positivity and seriousness given the sensitive nature of the content.

Regarding the design of the website, participants requested:

- The website be made clearer on the landing/home page, with the most relevant resources and information readily accessible without needing to navigate to other pages.
- Greater simplicity with less text and more use of bullet points and drop-down boxes. Clear categorisation and labelling of the information in the tabs were requested, so it is clear what content is for LGBTIQA+ individuals and primary care providers.
- Translation in multiple languages.
- The 'quick exit' button displayed always on the site and accompanied with emergency contact information so that people in crisis can seek help immediately when entering the website.
- For pictures and imagery to capture the diversity among the LGBTIQA+ community.
- For the branding and aesthetic to be consistent with LGBTIQA+ iconography, yet professional and not too reliant on 'rainbow' colours.
- Larger text and higher contrast to improve readability.
- The carousel on the front page to be manual rather than automatic for accessibility reasons.

Conclusion

IPV is a significant public health concern that disproportionately impacts LGBTIQA+ individuals, families, and communities. The aim of Safer Options was to strengthen the capacity of primary care providers in WA to deliver accessible services to LGBTIQA+ individuals experiencing IPV. In this research, WA primary care providers revealed a lack of confidence to recognise IPV in LGBTIQA+ clients and have difficulty identifying and finding suitable primary care services to refer to. Furthermore, IPV was highly prevalent among LGBTIQA+ individuals we surveyed in WA, with one in two respondents having experienced one or more forms of abuse in their intimate relationships. LGBTIQA+ individuals who have experienced IPV also reported difficulty in appropriately recognising these behaviours due to a general lack of awareness surrounding this issue. When attempting to seek support, LGBTIQA+ individuals reported a fear of judgement from primary care providers alongside other challenges that made it difficult for them to find inclusive and affirming primary care services.

Two key recommendations from Safer Options are proposed:

1. Primary care providers receive ongoing education about IPV within the context of LGBTIQA+ relationships and integrate these learnings to increase inclusivity of services.

2. LGBTIQA+ individuals have access to information to assist them in recognising IPV in their relationships and to seek support.

If LGBTIQA+ individuals have greater awareness of IPV and are being encouraged to seek support from primary care providers, primary care settings must be capable of responding in a culturally inclusive and appropriate way, to avoid further compounding harm to individuals in crisis.

Informed by the research findings, Safer Options has commenced development of multiple educational resources that will increase awareness of IPV among LGBTIQA+ individuals and increase confidence and capacity of primary care providers to support LGBTIQA+ individuals experiencing IPV in an inclusive and informed way. Please see **www.saferoptions.org.au** for more information. To supplement these interventions, high-quality training on inclusive practice for LGBTIQA+ individuals experiencing IPV, and a screening and referral tool appropriate for LGBTIQA+ individuals experiencing IPV are urgently needed.

Overall, findings from Safer Options indicate opportunities to increase responsiveness of WA primary care settings to support individuals experiencing or at risk of IPV. Current responses from primary care providers are grounded in cisgendered and heterosexual normative understandings of IPV. By committing to inclusive service provision, primary care providers are well-placed to substantially improve the lives of LGBTIQA+ individuals experiencing IPV.

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References

1. Stubbs A, Szoeke C. The Effect of Intimate Partner Violence on the Physical Health and Health-Related Behaviors of Women: A Systematic Review of the Literature. Trauma Violence Abuse. 2022 Oct 5;23(4):1157–72.
2. Peterson C, Kearns MC, McIntosh WL, Estefan LF, Nicolaidis C, McCollister KE, et al. Lifetime Economic Burden of Intimate Partner Violence Among U.S. Adults. Am J Prev Med. 2018 Oct;55(4):433–44.
3. Garcia-Moreno C, Guedes A, Knerr W. Intimate partner violence [Internet]. 2012 [cited 2023 Sep 25]. Available from: https://iris.who.int/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf
4. Walters ML, Lippy C. Intimate Partner Violence in LGBT Communities. In: The Wiley Handbook on the Psychology of Violence. Wiley; 2016. p. 695–714.
5. Workman A, Kruger E, Micheal S, Dune T. LGBTIQ CALD People's Experiences of Intimate Partner Violence: A Systematic Literature Review. Int J Environ Res Public Health [Internet]. 2022 Nov 28;19(23):15843. Available from: https://www.mdpi.com/1660-4601/19/23/15843
6. Messinger AM. Marking 35 Years of Research on Same-Sex Intimate Partner Violence: Lessons and New Directions. In: Handbook of LGBT Communities, Crime, and Justice. New York, NY: Springer New York; 2014. p. 65–85.
7. Bourne A, Amos N, Donovan C, Carman M, Parsons M, Lusby S, et al. Naming and Recognition of Intimate Partner Violence and Family of Origin Violence Among LGBTQ Communities in Australia. J Interpers Violence. 2023 Mar 29;38(5–6):4589–615.
8. Australian Bureau of Statistics. Personal Safety, Australia [Internet]. Canberra; 2016 [cited 2023 Sep 25]. Available from: https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/2016
9. Ravi KE, Rai A, Schrag RV. Survivors' Experiences of Intimate Partner Violence and Shelter Utilization During COVID-19. J Fam Violence. 2022 Aug 30;37(6):979–90.
10. Lim G, Lusby S, Carman M, Bourne A. LGBTQ Victim-Survivors' Experiences and Negotiations of Service Worker and Service System Discrimination. J Fam Violence [Internet]. 2023 Jul 6; Available from: https://link.springer.com/10.1007/s10896-023-00554-2
11. Du Mont J, Kosa SD, Solomon S, Macdonald S. Assessment of nurses' competence to care for sexually assaulted trans persons: a survey of Ontario's Sexual Assault/Domestic Violence Treatment Centres. BMJ Open [Internet]. 2019 May 27;9(5):e023880. Available from: https://bmjopen.bmj.com/lookup/doi/10.1136/bmjopen-2018-023880
12. Du Mont J, Kosa SD, Abavi R, Kia H, Macdonald S. Toward Affirming Care: An Initial Evaluation of a Sexual Violence Treatment Network's Capacity for Addressing the Needs of Trans Sexual Assault Survivors. J Interpers Violence [Internet]. 2021 Nov 2;36(21–22):NP12436–55. Available from: http://journals.sagepub.com/doi/10.1177/0886260519889943
13. Amos N, Hill A, Donovan C, Carman M, Parsons M, McNair R, et al. Family Violence Within LGBTQ Communities in Australia: Intersectional Experiences and Associations with Mental Health Outcomes. Sexuality Research and Social Policy [Internet]. 2023 May 9; Available from: https://link.springer.com/10.1007/s13178-023-00822-2
14. Ovenden G, Salter M, Ullman J, Denson N, Robinson K, Noonan K, et al. Gay, Bisexual, Transgender, Intersex and Queer Men's Attitudes and Experiences of Intimate Partner Violence and Sexual Assault, Sexualities and Genders Research. Sydney; 2019.
15. Hill AO, Bourne A, Mcnair R, Carman M, Lyons A. Private Lives 3: The health and wellbeing of LGBTIQ people in Australia. Melbourne, Australia; 2020.
16. Turell SC. Seeking Help for Same-Sex Relationship Abuses. J Gay Lesbian Soc Serv [Internet]. 1999 Oct 22;10(2):35–49. Available from: https://www.tandfonline.com/doi/full/10.1300/J041v10n02_02
17. Hill B, Uink B, Dodd J, Bonson D, Eades A, Bennett S. Breaking the Silence: Insights into the Lived Experiences of WA Aboriginal/LGBTIQ+ People, Community Summary Report. Kurongkurl Katitjin; 2021.
18. ACON (Say it Out Loud). Healthy relationship quiz [Internet]. 2023 [cited 2023 Sep 28]. Available from: https://sayitoutloud.org.au/healthy-relationships/quiz/?state=all
19. Domestic Abuse Intervention Programs. Wheel library: Power and control wheel (the Deluth model) [Internet]. 2023 [cited 2023 Sep 28]. Available from: https://www.theduluthmodel.org/wheel-gallery/
20. National Domestic Violence Hotline (Love is Respect). Relationship spectrum [Internet]. 2023 [cited 2023 Sep 28]. Available from: https://www.loveisrespect.org/everyone-deserves-a-healthy-relationship/relationship-spectrum/

Appendix A | Articles Included in Scoping Review

1. Australia's National Research Organisation for Women's Safety. Developing LGBTQ programs for perpetrators and victims/survivors of domestic and family violence (Research to policy and practice, 10/2020). Sydney; 2020.
2. Bacchus LJ, Buller AM, Ferrari G, Peters T, Devries K, Sethi G, et al. Domestic violence and abuse in gay and bisexual men attending a sexual health clinic: pilot testing of an educational support intervention for sexual health practitioners. The Lancet [Internet]. 2015 Nov;386:S20. Available from: https://linkinghub.elsevier.com/retrieve/pii/S0140673615008582
3. Battista S Di, Paolini D, Pivetti M, Biondi P, Balsamo M, Carlucci L, et al. Emotional abuse among Lesbian Italian women: Relationship consequences, help-seeking and disclosure behaviors. J Gay Lesbian Ment Health [Internet]. 2021 Apr 3;25(2):175–207. Available from: https://www.tandfonline.com/doi/full/10.1080/19359705.2020.1843582
4. Bermea AM, VanBergen AM. The Potential for Restorative Justice Practice for Addressing Intimate Partner Violence with Queer Couples. J Couple Relatsh Ther [Internet]. 2022 Jan 2;21(1):3–26. Available from: https://www.tandfonline.com/doi/full/10.1080/15332691.2021.1902445
5. Bornstein DR, Fawcett J, Sullivan M, Senturia KD, Shiu-Thornton S. Understanding the Experiences of Lesbian, Bisexual and Trans Survivors of Domestic Violence. J Homosex [Internet]. 2006 Sep 25;51(1):159–81. Available from: http://www.tandfonline.com/doi/abs/10.1300/J082v51n01_08
6. Callan A, Corbally M, McElvaney R. A commentary on the challenges for nurses in identifying and responding to intimate partner violence amongst gay and bisexual men. J Adv Nurs [Internet]. 2023 Apr 31;79(4):e21–9. Available from: https://onlinelibrary.wiley.com/doi/10.1111/jan.15392
7. Calton JM, Cattaneo LB, Gebhard KT. Barriers to Help Seeking for Lesbian, Gay, Bisexual, Transgender, and Queer Survivors of Intimate Partner Violence. Trauma Violence Abuse [Internet]. 2016 Dec 23;17(5):585–600. Available from: http://journals.sagepub.com/doi/10.1177/1524838015585318
8. Cannon CEB. What Services Exist for LGBTQ Perpetrators of Intimate Partner Violence in Batterer Intervention Programs Across North America? A Qualitative Study. Partner Abuse [Internet]. 2019 Apr 1;10(2):222–42. Available from: http://connect.springerpub.com/lookup/doi/10.1891/1946-6560.10.2.222
9. Das KJH, Peitzmeier S, Berrahou IK, Potter J. Intimate Partner Violence (IPV) Screening and Referral Outcomes among Transgender Patients in a Primary Care Setting. J Interpers Violence [Internet]. 2022 Jul 25;37(13–14):NP11720–42. Available from: http://journals.sagepub.com/doi/10.1177/0886260521997460
10. Donne MD, DeLuca J, Pleskach P, Bromson C, Mosley MP, Perez ET, et al. Barriers to and Facilitators of Help-Seeking Behavior Among Men Who Experience Sexual Violence. Am J Mens Health [Internet]. 2018 Mar 22;12(2):189–201. Available from: http://journals.sagepub.com/doi/10.1177/1557988317740665
11. Donovan C, Barnes R. Help-seeking among lesbian, gay, bisexual and/or transgender victims/survivors of domestic violence and abuse: The impacts of cisgendered heteronormativity and invisibility. Journal of Sociology [Internet]. 2020 Dec 11;56(4):554–70. Available from: http://journals.sagepub.com/doi/10.1177/1440783319882088
12. Du Mont J, Kosa SD, Abavi R, Kia H, Macdonald S. Toward Affirming Care: An Initial Evaluation of a Sexual Violence Treatment Network's Capacity for Addressing the Needs of Trans Sexual Assault Survivors. J Interpers Violence [Internet]. 2021 Nov 2;36(21–22):NP12436–55. Available from: http://journals.sagepub.com/doi/10.1177/0886260519889943
13. Du Mont J, Kosa SD, Solomon S, Macdonald S. Assessment of nurses' competence to care for sexually assaulted trans persons: a survey of Ontario's Sexual Assault/Domestic Violence Treatment Centres. BMJ Open [Internet]. 2019 May 27;9(5):e023880. Available from: https://bmjopen.bmj.com/lookup/doi/10.1136/bmjopen-2018-023880
14. Ford CL, Slavin T, Hilton KL, Holt SL. Intimate Partner Violence Prevention Services and Resources in Los Angeles. Health Promot Pract [Internet]. 2013 Nov 5;14(6):841–9. Available from: http://journals.sagepub.com/doi/10.1177/1524839912467645
15. Furman E, Barata P, Wilson C, Fante-Coleman T. "It's a gap in awareness": Exploring service provision for LGBTQ2S survivors of intimate partner violence in Ontario, Canada. J Gay Lesbian Soc Serv [Internet]. 2017 Oct 2;29(4):362–77. Available from: https://www.tandfonline.com/doi/full/10.1080/10538720.2017.1365672
16. Gibson M, Kassisieh G, Lloyd A, McCann B. There's No Safe Place at Home: Domestic and family violence affecting LGBTIQ+ people. Sydney and Melbourne; 2020.
17. Guadalupe-Diaz XL, Jasinski J. "I Wasn't a Priority, I Wasn't a Victim." Violence Against Women [Internet]. 2017 May 9;23(6):772–92. Available from: http://journals.sagepub.com/doi/10.1177/1077801216650288

18. Hancock R, McAuliffe G, Levingston K. Factors Impacting Counselor Competency with Sexual Minority Intimate Partner Violence Victims. J LGBT Issues Couns [Internet]. 2014 Jan 3;8(1):74–94. Available from: http://www.tandfonline.com/doi/abs/10.1080/15538605.2014.853640

19. Hardesty JL, Oswald RF, Khaw L, Fonseca C. Lesbian/Bisexual Mothers and Intimate Partner Violence: Help Seeking in the Context of Social and Legal Vulnerability. Violence Against Women [Internet]. 2011 Jan 22;17(1):28–46. Available from: http://journals.sagepub.com/doi/10.1177/1077801209347636

20. Helfrich CA, Simpson EK. Improving Services for Lesbian Clients: What Do Domestic Violence Agencies Need to Do? Health Care Women Int [Internet]. 2006 May 1;27(4):344–61. Available from: http://www.tandfonline.com/doi/abs/10.1080/07399330500511725

21. Hill AO, Bourne A, Mcnair R, Carman M, Lyons A. Private Lives 3: The health and wellbeing of LGBTIQ people in Australia. Melbourne, Australia; 2020.

22. Hill B, Uink B, Dodd J, Bonson D, Eades A, Bennett S. Breaking the Silence: Insights into the Lived Experiences of WA Aboriginal/LGBTIQ+ People, Community Summary Report. Kurongkurl Katitjin; 2021.

23. Kurdyla V, Messinger AM, Ramirez M. Transgender Intimate Partner Violence and Help-Seeking Patterns. J Interpers Violence. 2021 Oct 1;36(19–20):NP11046–69.

24. Lippy C, Jumarali SN, Nnawulezi NA, Williams EP, Burk C. The Impact of Mandatory Reporting Laws on Survivors of Intimate Partner Violence: Intersectionality, Help-Seeking and the Need for Change. J Fam Violence [Internet]. 2020 Apr 3;35(3):255–67. Available from: http://link.springer.com/10.1007/s10896-019-00103-w

25. Martin TE, Gover AR, Langton L. The Relationship Between Formal Help-Seeking and Sexual Orientation Among Victims of Domestic Violence. J Interpers Violence [Internet]. 2023 Jan 26;38(1–2):156–82. Available from: http://journals.sagepub.com/doi/10.1177/08862605221080150

26. Merrill GS, Wolfe VA. Battered Gay Men. J Homosex [Internet]. 2000 Jul 10;39(2):1–30. Available from: http://www.tandfonline.com/doi/abs/10.1300/J082v39n02_01

27. Messinger AM, Kurdyla V, Guadalupe-Diaz XL. Intimate Partner Violence Help-Seeking in the U.S. Transgender Survey. J Homosex [Internet]. 2022 May 12;69(6):1042–65. Available from: https://www.tandfonline.com/doi/full/10.1080/00918369.2021.1901506

28. Ovenden G, Salter M, Ullman J, Denson N, Robinson K, Noonan K, et al. Gay, Bisexual, Transgender, Intersex and Queer Men's Attitudes and Experiences of Intimate Partner Violence and Sexual Assault, Sexualities and Genders Research. Sydney; 2019.

29. Palmer JE, Williams E, Mennicke A. Interpersonal Violence Experiences and Disclosure Patterns for Lesbian, Gay, Bisexual, Queer+, and Heterosexual University Students. J Fam Violence [Internet]. 2022 Apr 8;37(3):505–19. Available from: https://link.springer.com/10.1007/s10896-021-00268-3

30. Parry MM, O'Neal EN. Help-Seeking Behavior among Same-Sex Intimate Partner Violence Victims: An Intersectional Argument. Criminology, Criminal Justice Law & Society [Internet]. 2015;16:51–67. Available from: https://scholasticahq.com/criminology-criminal-justice-law-society/

31. Richardson HB, Armstrong JL, Hines DA, Reed KMP. Sexual Violence and Help-Seeking Among LGBQ and Heterosexual College Students. Partner Abuse [Internet]. 2015;6(1):29–46. Available from: http://connect.springerpub.com/lookup/doi/10.1891/1946-6560.6.1.29

32. Riggs DW, Fraser H, Taylor N, Signal T, Donovan C. Domestic Violence Service Providers' Capacity for Supporting Transgender Women: Findings from an Australian Workshop. Br J Soc Work [Internet]. 2016 Dec 1;46(8):2374–92. Available from: https://academic.oup.com/bjsw/article-lookup/doi/10.1093/bjsw/bcw110

33. Rogers M. Breaking down barriers: exploring the potential for social care practice with trans survivors of domestic abuse. Health Soc Care Community [Internet]. 2016 Jan 1;24(1):68–76. Available from: https://onlinelibrary.wiley.com/doi/10.1111/hsc.12193

34. Santoniccolo F, Trombetta T, Rollè L. The Help-Seeking Process in Same-Sex Intimate Partner Violence: a Systematic Review. Sexuality Research and Social Policy [Internet]. 2021 Mar 15;20(1):391–411. Available from: https://link.springer.com/10.1007/s13178-021-00629-z

35. Scheer JR, Baams L. Help-Seeking Patterns Among LGBTQ Young Adults Exposed to Intimate Partner Violence Victimization. J Interpers Violence [Internet]. 2021 Sep 14;36(17–18):8050–69. Available from: http://journals.sagepub.com/doi/10.1177/0886260519848785

36. Scherzer T. Domestic Violence in Lesbian Relationships. J Lesbian Stud [Internet]. 1998 Mar 22;2(1):29–47. Available from: http://www.tandfonline.com/doi/abs/10.1300/J155v02n01_03

37. Schulze C, Perkins W. Awareness of Sexual Violence Services Among LGBQ-Identified College Students. J Sch Violence [Internet]. 2017 Apr 3;16(2):148–59. Available from: https://www.tandfonline.com/doi/full/10.1080/15388220.2017.1284481

38. Sechrist SM, Laplace DT, Smith PH. North Carolina LGBTQ Domestic Violence Response Initiative: Building Capacity to Provide Safe, Affirming Services. Health Education & Behavior [Internet]. 2022 Dec 19;49(6):949–59. Available from: http://journals.sagepub.com/doi/10.1177/10901981211067167

39. Simpson EK, Helfrich CA. Lesbian Survivors of Intimate Partner Violence. J Gay Lesbian Soc Serv [Internet]. 2005 Jun 4;18(2):39–59. Available from: https://www.tandfonline.com/doi/full/10.1300/J041v18n02_03

40. The Australian Centre for Social Innovation. Mapping the journeys of LGBTIQ people experiencing family violence: Early insights from people with lived experience [Internet]. Victoria; 2018 [cited 2023 Sep 25]. Available from: https://rainbowhealthaustralia.org.au/media/pages/queer-family-violence-sector-network/201603160-1650953507/research-lgbti-fv-pathways-mapping-project-early-insights-from-people-with-lived-experience.pdf

41. Turell S, Herrmann M, Hollander G, Galletly C. Lesbian, Gay, Bisexual, and Transgender Communities' Readiness for Intimate Partner Violence Prevention. J Gay Lesbian Soc Serv [Internet]. 2012 Jul;24(3):289–310. Available from: http://www.tandfonline.com/doi/abs/10.1080/10538720.2012.697797

42. Turell SC, Cornell-Swanson LV. Not All Alike. J Gay Lesbian Soc Serv [Internet]. 2005 Jan 4;18(1):71–88. Available from: https://www.tandfonline.com/doi/full/10.1300/J041v18n01_06

43. Turell SC. Seeking Help for Same-Sex Relationship Abuses. J Gay Lesbian Soc Serv [Internet]. 1999 Oct 22;10(2):35–49. Available from: https://www.tandfonline.com/doi/full/10.1300/J041v10n02_02

Appendix B | Additional Tables of Survey Results

Table 12. Within the LGBTIQA+ community, who is perceived to be the most at risk of experiencing IPV? (n = 501) Participants were able to provide multiple answers.
BIPOC = Black, indigenous, and other people of colour.

Category	n	%
Transgender	331	66%
Bisexual	78	16%
Gay	54	11%
Asexual	26	5%
Younger	25	5%
Lesbian	21	4%
Non-Binary People	20	4%
BIPOC	19	4%
Queer	14	3%
Disability	12	3%
Neurodiverse	10	2%
Disconnected from family	8	2%
Pansexual	7	2%
Closeted	6	1%
Inexperienced	5	1%
Financially reliant	3	1%
Homeless	3	1%
Mental health challenge	3	1%
Intersex	1	1%
Additional categories	16	0%

Table 13. Gender of participants who have experienced IPV (n = 260)

Gender	n	%
Cisgender woman	122	47%
Non-binary	71	27%
Cisgender man	65	25%
Transgender	2	1%

Table 14. Sexual orientation of participants who have experienced IPV (n = 260)

Sexual Orientation	n	%
Bisexual	78	30%
Lesbian	65	25%
Gay	54	21%
Pansexual	28	11%
Queer	21	8%
Asexual	9	3%
Demisexual	2	1%
Heterosexual	2	1%
Questioning	1	0%

Table 15. Gender of perpetrator in most recent relationship involving IPV (n = 339)
20 participants provided more than one gender.

Gender	n	%
Cisgender man	211	62%
Cisgender woman	111	33%
Non-binary	13	4%
Transgender man	10	3%
Transgender woman	6	2%
Unsure	4	1%
Prefer not to say	3	1%

Table 16. Sexual orientation of perpetrator in most recent intimate relationship (n = 339)

Sexual Orientation	n	%
Heterosexual	125	37%
Bisexual	64	19%
Gay	60	18%
Lesbian	53	16%
Pansexual	15	4%
Queer	10	3%
Questioning	6	2%
Asexual	3	1%
Prefer not to say	3	1%

Table 17. Support services that participants believe are needed by LGBTIQA+ individuals experiencing IPV (n = 437) Participants were able to select multiple options.

Support Service	n	%
Psychological/counselling service	395	90%
LGBTIQA+ organisation	302	69%
Sexual assault service	291	67%
IPV/FDV service	289	66%
Police (including LGBTIQA+ liaison officer)	258	59%
Telephone helpline	250	57%
Lawyer, legal service, court system	219	50%
GP, hospital	206	47%
Employer	116	27%
Teacher or educational institution	111	25%
Religious organisation or spiritual elder	69	16%
Another service not listed	17	4%
None of these services	2	0%

Table 18. Participant preferences regarding IPV support services (n = 437)

Preference	Yes	No	Doesn't Matter
LGBTIQA+ inclusive	412 (94%)	4 (1%)	21 (5%)
Same gender	248 (57%)	23 (5%)	166 (38%)
LGBTIQA+ peer	189 (43%)	97 (22%)	151 (35%)
Similar age group	165 (38%)	20 (5%)	252 (58%)
Same sexual orientation	161 (37%)	9 (2%)	267 (61%)
Same ethnic origin	51 (12%)	13 (3%)	373 (85%)

Table 19. Support service type preferences (n = 437)

Sexual Orientation	n	%
IPV service for LGBTIQA+ only	169	39%
Mainstream IPV service that is LGBTIQA+ inclusive	162	37%
Unsure	55	13%
No preference	30	7%
Mainstream IPV service that is not visibly LGBTIQA+ inclusive	11	3%
None of the above	10	2%

Table 20. Participant preferences for how they would access IPV support services in the future
(n = 436) Participants were able to select multiple options.

Preference	n	%
Face to face - professional	345	79%
24/7 telephone helpline	232	53%
Face to face - peer	206	47%
Online - Website	135	31%
Online - chatbot	111	25%
Online - Video	91	21%
Printed pamphlet	19	4%
Something else	11	3%
No preference	10	2%

Table 21. Inclusivity of services accessed for IPV support
(n = 160) Participants were able to select multiple options. "FDV" stands for Family and domestic violence.

Professional support service (n)	Not inclusive	Not very inclusive	Neutral	Somewhat inclusive	Very inclusive
GP / hospital (28)	1 (4%)	1 (4%)	8 (29%)	13 (46%)	5 (18%)
Employer (3)	1 (33%)	-	-	2 (66%)	-
IPV / FDV service (14)	-	-	11 (79%)	1 (7%)	2 (14%)
Lawyer / legal service / court system (18)	3 (17%)	3 (17%)	7 (39%)	3 (17%)	2 (11%)
LGBTIQA+ organisation (7)	-	-	1 (14%)	2 (29%)	4 (57%)
Police / LGBTIQA+ liaison officer (22)	2 (9%)	4 (18%)	9 (41%)	6 (27%)	1 (5%)
Psychological / counselling service (147)	3 (2%)	9 (6%)	37 (25%)	38 (26%)	60 (41%)
Religious organisation / spiritual elder (3)	1 (33%)	-	1 (33%)	-	1 (33%)
Sexual assault service (9)	2 (22%)	1 (11%)	3 (33%)	-	3 (33%)
Teacher / educational institution (5)	-	2 (40%)	1 (20%)	2 (40%)	-
Telephone helpline (18)	2 (11%)	1 (6%)	9 (50%)	2 (11%)	4 (22%)
Other (7) [14]	-	1 (14%)	3 (43%)	-	3 (43%)

[14] When asked to name the service they were referring to, 5 responses were blank, 1 response named "friends" (rated "Very inclusive"), and 1 response named "mental health nurse" (rated "Neutral").

Table 22. Perceived extent to which professional support services met participants' support needs (n = 146) Participants rated the support service on a 10-point scale, from 0 (Did not meet my needs) to 10 (Did meet my needs). Participants were able to rate multiple support services.

Professional support service (n)	Not at all or not well met (0-3)	Somewhat met (4-6)	Mostly or fully met (7-10)
GP / hospital (26)	6 (23%)	6 (23%)	14 (54%)
Employer (3)	1 (33%)	1 (33%)	1 (33%)
IPV / FDV service (13)	6 (46%)	2 (15%)	5 (38%)
Lawyer / legal service / court system (18)	4 (22%)	7 (39%)	7 (39%)
LGBTIQA+ organisation (6)	2 (33%)	1 (17%)	3 (50%)
Police / LGBTIQA+ liaison officer (22)	9 (41%)	5 (23%)	8 (36%)
Psychological / counselling service (133)	13 (10%)	39 (29%)	81 (61%)
Religious organisation / spiritual elder (3)	1 (33%)	-	2 (67%)
Sexual assault service (9)	2 (22%)	3 (33%)	4 (44%)
Teacher / educational institution (4)	1 (35%)	1 (25%)	2 (50%)
Telephone helpline (16)	7 (44%)	4 (25%)	5 (31%)
Other (7) [15]	-	3 (43%)	4 (57%)

[15] When asked to name the service they were referring to, 5 responses were blank, 1 response named "friends" (rated "10"; Did meet my needs), and 1 response named "mental health nurse" (rated 4; Somewhat met my needs).

Table 23. Perceived ease of accessing the service that participants sought support from for IPV (n = 146) Participants were able to rate multiple support service options.

Professional support service (n)	Extremely difficult	Somewhat difficult	Neither easy nor difficult	Somewhat easy	Extremely easy
GP / hospital (26)	3 (12%)	4 (15%)	2 (8%)	8 (31%)	9 (35%)
Employer (3)	-	-	-	1 (33%)	2 (67%)
IPV / FDV service (13)	1 (8%)	4 (31%)	3 (23%)	3 (23%)	2 (15%)
Lawyer / legal service / court system (18)	-	8 (44%)	3 (17%)	6 (33%)	1 (6%)
LGBTIQA+ organisation (6)	-	-	1 (17%)	4 (67%)	1 (17%)
Police / LGBTIQA+ liaison officer (22)	1 (5%)	2 (9%)	7 (32%)	6 (27%)	6 (27%)
Psychological / counselling service (133)	9 (7%)	40 (30%)	14 (11%)	55 (41%)	15 (11%)
Religious organisation / spiritual elder (3)	-	-	-	2 (67%)	1 (33%)
Sexual assault service (9)	-	4 (44%)	2 (22%)	1 (11%)	2 (22%)
Teacher / educational institution (4)	-	1 (25%)	1 (25%)	2 (50%)	-
Telephone helpline (16)	-	3 (19%)	1 (6%)	8 (50%)	4 (25%)
Other (7) [16]	1 (14%)	-	2 (29%)	1 (14%)	3 (43%)

[16] When asked to name the service they were referring to, 5 responses were blank, 1 response named "friends" (rated "extremely easy" to access), and 1 response named "mental health nurse" (rated "extremely easy" to access).

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