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NARRATIVE REVIEW

Seen, Safe and Respected

How LGBTQIA+ young people experience the consulting room, and what inclusive practice can change about whether they come back.

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What happens in the few minutes after a young person sits down in a consulting room can shape whether they ever return. For lesbian, gay, bisexual, trans, queer, intersex, asexual and other gender and sexuality diverse (LGBTQIA+) young people, those minutes often carry an extra question that other patients do not have to ask: is it safe to be honest here? This report asks how LGBTQIA+ young people experience general practice and sexual healthcare, and what the evidence says about practices that make those rooms safer.

This report synthesises 20 academic and grey literature sources, drawing on major Australian surveys led by La Trobe University's Australian Research Centre in Sex, Health and Society (ARCSHS) and international studies. Its findings are organised into three themes: **Invisible by Default** (disclosure and assumptions of heterosexuality), **When Care Becomes a Risk** (misgendering, discrimination and avoidance) and **Building Rooms Worth Returning To** (the evidence on inclusive practice). The report deliberately focuses on access, respect and engagement in everyday general and sexual healthcare, rather than on debates about specific clinical treatments.

AT A GLANCE

- 20 academic and grey-literature sources
- For young people, families, clinicians, practice managers and policymakers

THEMES

- Invisible by Default
- When Care Becomes a Risk
- Building Rooms Worth Returning To

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BACKGROUND

Why the Consulting Room Matters

LGBTQIA+ young people in Australia carry a heavy health burden, yet the services designed to help them are often the places where they feel least accepted. The four points below explain why the experience of a single appointment deserves close attention.

A disproportionate burden of distress

Writing Themselves In 4, the largest national survey of LGBTQA+ young people in Australia, gathered 6,418 responses from people aged 14 to 21 (Hill et al., 2021). Among 16- and 17-year-old participants, 83.3% reported high or very high psychological distress, compared with 27.3% of the same age group in the general population. These young people need accessible, trustworthy care more than most, which makes any barrier to that care especially costly.

RESEARCH

Among 16–17-year-old LGBTQA+ participants, 83.3% reported high or very high psychological distress, compared with 27.3% of the general population of that age.

Hill et al., 2021

Health services lag behind other settings

Private Lives 3 surveyed 6,835 LGBTIQ adults aged 18 and over, almost a third of whom (31.3%) were aged 18 to 24 (Hill et al., 2020). Only 43.4% of participants felt accepted when accessing health or support services, a lower level of acceptance than participants reported at work, in education or within their families. In other words, the health system, which should be a place of safety, is one of the settings where LGBTIQ people feel least welcome.

RESEARCH

Only 43.4% of LGBTIQ adults felt accepted when accessing a health or support service.

Hill et al., 2020

Stress that comes from stigma, not identity

The minority stress model explains that the higher rates of distress in sexuality and gender diverse people are not caused by their identities, but by the extra stress of living with prejudice (Meyer, 2003). Meyer describes "distal" stressors, such as discrimination and harassment, and "proximal" stressors, such as expecting rejection and hiding one's identity. Hendricks and Testa (2012) adapted this model for trans and gender diverse people, adding stressors such as non-affirmation of gender identity. Both versions help explain why a consulting room can feel risky even before a clinician speaks.

TERM

Minority stress

The extra, ongoing stress that people from stigmatised groups experience because of prejudice, discrimination, and the effort of anticipating or hiding from it.

Young people are still learning to navigate care

Young people are often new to managing their own healthcare. They may still attend a family GP, may have a parent in the room, and may be seeking sexual healthcare for the first time. Fuzzell et al. (2016) found that adolescents described conversations about sexuality with doctors as infrequent, and identified confidentiality, comfort and inclusive language as key concerns. When the first experiences of care feel unsafe, young people may carry that expectation into adulthood.

TERM

Heteronormativity

The assumption that everyone is heterosexual and cisgender unless they say otherwise, built into language, forms and routines.

DIAGRAM

The Disclosure Loop

The Disclosure Loop describes how small cues in a health setting feed into a young person's decision about whether to be open, and how the outcome of that decision shapes their future help-seeking. It draws on the minority stress model (Meyer, 2003) and on reviews of disclosure barriers (Brooks et al., 2018). The loop can turn in either direction: affirming cues build trust and openness over time, while assumptions and misgendering reinforce silence and avoidance. Because most barriers to disclosure are modifiable, each stage is also a point where services can intervene.

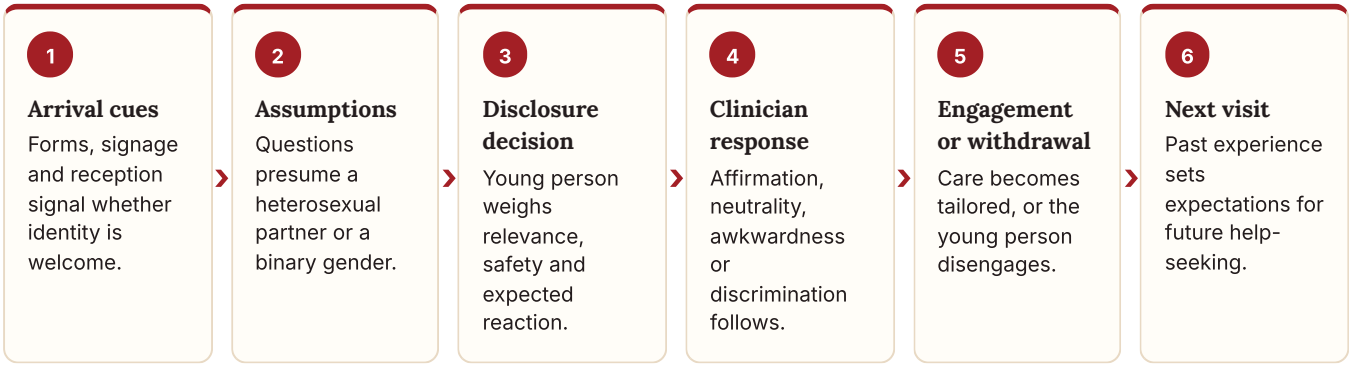

Figure – conceptual model developed from the literature reviewed in this report.

THEME 1

Invisible by Default

Many LGBTQIA+ young people leave appointments without their sexuality or gender ever being acknowledged. This theme examines why disclosure so often does not happen, and what is lost when care is built on assumptions.

Finding 1.1 – Most non-disclosure happens because nobody asks

SILENT CONSULTS

In a study of 206 LGBTQ young adults aged 18 to 27 in the United States, 63% had disclosed their identity to a healthcare provider, leaving around a third who had not (Rossman et al., 2017). The most common reason for not disclosing was simply that providers never raised the topic. Other young adults wanted privacy, feared stigma, or did not see their identity as relevant to their health. A study of rural LGBT adults similarly found that 37% were not out to their main healthcare provider (Whitehead et al., 2016).

A systematic review of 31 studies identified the perceived relevance of sexual orientation, the clinician's communication skills and language, and fear of a poor reaction as the most prominent influences on disclosure (Brooks et al., 2018). Importantly, the authors concluded that most of these barriers are modifiable. This suggests that silence in the consulting room is not inevitable; it is often a product of how the conversation is set up.

RESEARCH

"The doctor said I didn't look gay"

Rossman et al., 2017

TERM

Disclosure

Choosing to tell someone, such as a doctor, about one's sexual orientation, gender identity or intersex variation.

Finding 1.2 – Clinicians overestimate how uncomfortable patients are with being asked

MISPLACED HESITATION

Health professionals sometimes avoid asking about sexuality and gender because they fear patients will be offended. The EQUALITY study tested this belief in emergency departments (Haider et al., 2017). Of 429 clinicians, 77.8% thought patients would refuse to provide their sexual orientation. Yet of 1,516 patients surveyed, only 10.3% said they would refuse.

Young people describe the same gap from the other side. Adolescents interviewed by Fuzzell et al. (2016) said they wanted doctors to raise sexual health more often and to do it in inclusive language, rather than leaving the young person to bring it up. When clinicians stay silent to avoid discomfort, they may unintentionally communicate that the topic is unwelcome.

RESEARCH

Of emergency clinicians, 77.8% expected patients to refuse sexual orientation questions; only 10.3% of patients said they would.

Haider et al., 2017

RESEARCH

"I just think that doctors need to ask more questions"

Fuzzell et al., 2016

Finding 1.3 – Assumptions of heterosexuality distort sexual healthcare

ASSUMED STRAIGHT

When a clinician assumes a young person's partner is of a different gender, sexual health advice can become irrelevant or incomplete. Rossman et al. (2017) found that while some providers had knowledge of sexual health for gay and lesbian patients, knowledge about trans patients' health was more limited. Young people in Fuzzell et al. (2016) identified language, including gendered assumptions about partners, as a key place where clinicians either signal inclusion or shut the conversation down.

Australian evidence points to the same pattern. Among 2,707 lesbian, bisexual and queer cisgender women in Private Lives 3, 58.3% of those with a regular GP believed their GP knew their sexual orientation, with bisexual women much less likely, and women aged 45–54 much more likely, to be known (Buckingham et al., 2024). In a survey of young adults attending general practices in Western Sydney, members of priority populations were less likely to seek sexual healthcare from GPs, which was associated with fear or perceived judgement, although that subgroup was small (Coleman et al., 2019).

RESEARCH

Only 58.3% of LBQ+ women with a regular GP believed their GP knew their sexual orientation; bisexual women were least likely to be known.

Buckingham et al., 2024

PROPOSED SOLUTIONS

Ask, and ask well

- **Routine, normalised questions**
  Ask every patient about sexuality, gender and pronouns so no one feels singled out.
- **Neutral partner language**
  Use "partner" or "the people you have sex with" rather than gendered assumptions.
- **Explain the relevance**
  Tell young people why the information helps their care, and that it is confidential.

Redesign the paperwork

- **Inclusive intake forms**
  Offer open options for gender, pronouns, name used and sexual orientation, including "prefer not to say".
- **Consistent records**
  Make sure a name and pronouns recorded once appear on every screen and letter.

THEME 2

When Care Becomes a Risk

For some LGBTQIA+ young people, a health appointment is not only a place where they go unseen, but a place where they are actively hurt. This theme examines misgendering, discrimination and the avoidance of care that follows.

Finding 2.1 – Misgendering is a common, repeated harm

NON-AFFIRMATION

Writing Themselves In 4 found that 86.8% of trans and gender diverse participants had been misgendered by others in the past 12 months (Hill et al., 2021). While this figure covers all settings, not only healthcare, it shows how routine this experience is and how likely it is that a clinic will add to it. Hendricks and Testa (2012) identify non-affirmation of gender identity as a distinct minority stressor, separate from overt discrimination.

The reverse also holds. In a United States cohort of 129 transgender young people, being able to use a chosen name in more settings was associated with lower depressive symptoms, suicidal ideation and suicidal behaviour, even after accounting for social support (Russell et al., 2018). Using the right name and pronouns costs a clinic almost nothing, yet it is linked with better mental health.

RESEARCH

86.8% of trans and gender diverse young people had been misgendered in the past 12 months.

Hill et al., 2021

TERM

Misgendering

Referring to someone with a name, pronoun or gendered term that does not match their gender identity.

Finding 2.2 – Respect in mainstream clinics is far lower than in inclusive ones

RESPECT GAP

Private Lives 3 asked participants how respected they felt in different kinds of services (Hill et al., 2020). In mainstream medical clinics, 58.6% felt their sexual orientation was very or extremely respected, and only 37.7% felt this about their gender identity. In mainstream clinics known to be LGBTIQ-inclusive, these figures rose to 90.9% and 81.9%. Mainstream services are where most people go, with 82% of participants accessing them (Carman et al., 2020).

Young trans people in the Trans Pathways study described the burden of having to educate the professionals who were meant to help them (Strauss et al., 2017). For First Nations LGBTIQSB+ young people, interviews revealed concern about the combined effects of heteronormativity and racism, both implicit and explicit, within services meant to support them (Spurway et al., 2023). For young people facing more than one form of exclusion, respect can be even harder to find.

RESEARCH

Respect for gender identity was felt by 37.7% in mainstream clinics, versus 81.9% in clinics known to be inclusive.

Hill et al., 2020

RESEARCH

"I have spent more time educating health professionals than receiving services from them."

Strauss et al., 2017

Finding 2.3 – Expecting discrimination keeps people away from care

ANTICIPATED STIGMA

Minority stress theory predicts that people who expect rejection will try to avoid it (Meyer, 2003). In a large United States survey of 19,157 trans adults aged 25 to 64, 22.8% had avoided healthcare because they anticipated discrimination (Kcomt et al., 2020). Comparable data specifically for young Australians are limited, but warning signs are clear. In Trans Pathways, 24.2% of trans young people with a current depression diagnosis were not receiving professional treatment (Strauss et al., 2017).

Qualitative research with 27 LGBTQA+ young Australians who had experienced suicidal thoughts found that concerns about LGBTQA+-inclusive practice were reported more often as barriers than general access issues (Paciente et al., 2024). When young people cannot tell in advance whether a service is safe, staying away can feel like the safer option, even when they need help.

RESEARCH

Nearly one in four trans adults (22.8%) avoided healthcare because they expected discrimination.

Kcomt et al., 2020

COMPOSITE CASE

Composite case — the sexual health check

This composite is based on themes in the reviewed literature and does not describe a real person. Jordan, 19, books a sexual health check. The receptionist reads out a legal name Jordan no longer uses, in a full waiting room. In the consult, the doctor asks about "your girlfriend" and does not ask about other partners. Jordan answers the questions asked, leaves without the tests they actually needed, and decides not to come back.

PROPOSED SOLUTIONS

Get names and pronouns right

- **Name used on every screen**
  Flag a young person's name and pronouns so reception and clinicians use them consistently.
- **Quiet call-outs**
  Call patients by first name used or by number, not by legal name in public.
- **Repair, don't dwell**
  If misgendering happens, correct it briefly, apologise and move on.

Lower the cost of trying

- **Visible signals**
  Display inclusion statements on websites and in waiting rooms so young people can judge safety before booking.
- **Intersectional cultural safety**
  Pair LGBTQIA+ inclusion with anti-racism and culturally safe practice, including for First Nations young people.

THEME 3

Building Rooms Worth Returning To

Evidence shows that inclusive services are experienced as more respectful, but less is known about which specific changes produce better engagement. This theme looks at what young people want, what inclusive practice involves, and where the evidence is still weak.

Finding 3.1 – Young people want respect more than a matching identity

WHAT YOUTH VALUE

In a survey of 733 LGBTQ young people aged 13 to 21 in the United States and Canada, the provider qualities ranked most important were being respectful, honest, a good listener and non-judgemental, and treating LGBTQ youth the same as other youth (Hoffman et al., 2009). Having a provider of the same sexual orientation ranked last among provider qualities. This is encouraging: young people are not asking for specialist clinicians in every clinic, but for respectful, competent ones.

Australian data point the same way. In Writing Themselves In 4, 63.2% of young people who had used an LGBTIQA+-specific service said it made things better, compared with 50.2% for in-person counselling generally (Hill et al., 2021). In Private Lives 3, 75.3% of participants said they would be more likely to use a service accredited as LGBTIQ-inclusive (Hill et al., 2020).

RESEARCH

75.3% of LGBTIQ adults would be more likely to use a service accredited as LGBTIQ-inclusive.

Hill et al., 2020

Service type	Felt sexual orientation respected	Felt gender identity respected
Mainstream medical clinic	58.6%	37.7%
Mainstream clinic known to be LGBTIQ-inclusive	90.9%	81.9%
Clinic serving only LGBTI people	94.9%	90.2%

Source: Private Lives 3 (Hill et al., 2020); "very" or "extremely" respected.

Finding 3.2 – Inclusive practice is a whole-of-organisation task

ACCREDITATION

Rainbow Tick is an Australian accreditation framework that assesses organisations against six standards: organisational capability, workforce development, consumer participation, a welcoming and accessible organisation, disclosure and documentation, and culturally safe and acceptable services (GLHV@ARCSHS, 2016). It asks services to make intake and care-planning processes LGBTI-inclusive, to have clear policies on when and how sexuality and gender information is collected, and to recognise people's identities through their chosen names and pronouns.

This approach matches what young people describe. Paciente et al. (2024) found that visible inclusive practice was a key facilitator of service access, and Fuzzell et al. (2016) highlighted signage, physical space and staff training as ways to signal safety. Buckingham et al. (2024) found that LBQ+ women whose GP knew their sexual orientation had greater odds of using LGBTIQA+-inclusive or specific mental health services, suggesting that being known by a GP can open doors to further care.

TERM

Rainbow Tick

An Australian accreditation showing that an organisation has met six standards for LGBTIQ-inclusive and culturally safe practice.

RESEARCH

Visible LGBTQA+-inclusive practice was described by young people as a key facilitator of service access.

Paciente et al., 2024

Finding 3.3 – The evidence on what works is still thin

EVIDENCE GAP

Training is the most common way services try to become more inclusive. A systematic review of 13 studies found that LGBTQ-related training for medical, nursing and dental students and providers generally improved knowledge and comfort, but effects on attitudes were inconsistent (Morris et al., 2019). Crucially, none of the studies measured changes in how clinicians actually behaved toward patients, and none assessed patient outcomes or satisfaction.

Similarly, while young people and adults clearly say they would prefer accredited services (Hill et al., 2020), this review did not identify published studies that measured whether Rainbow Tick accreditation changes engagement or health outcomes for young people. This does not mean inclusive practice is ineffective; it means the evidence has not yet caught up with what young people are reporting. Future research should be co-designed with LGBTQIA+ young people and should measure what matters to them, such as feeling respected, disclosing safely and returning for care.

RESEARCH

None of the 13 training studies reviewed measured changes in clinician behaviour or patient outcomes.

Morris et al., 2019

PROPOSED SOLUTIONS

Make inclusion structural

- **Pursue accreditation**
  Use Rainbow Tick standards as a roadmap, even before formal accreditation.
- **Youth on the inside**
  Involve LGBTQIA+ young people in consumer participation and service design.

Train for behaviour, not just knowledge

- **Practise the conversation**
  Include role-play and practice interviewing, not only lectures.
- **Measure what changes**
  Evaluate training by observing practice and asking patients, not only by testing knowledge.

Fill the evidence gap

- **Track engagement**
  Services should record, with consent, whether LGBTQIA+ young people return and how respected they felt.
- **Fund youth-led research**
  Support studies that test whether inclusive forms, pronoun practices and accreditation improve engagement.

SUMMARY

Key Findings of Report

1 **Invisibility is common and often unintended**

Around a third or more of LGBTQ young people and adults in the reviewed studies had not disclosed their identity to a health provider. The most common reason was that nobody asked, and most barriers to disclosure are modifiable.

2 **Clinicians underestimate young people's willingness to talk**

Most clinicians expect patients to refuse questions about sexuality, but only around one in ten patients say they would. Young people want doctors to raise sexual health more often, in inclusive language.

3 **Assumptions undermine sexual healthcare**

When clinicians assume a heterosexual partner or a binary gender, advice can be incomplete or irrelevant. In Australian data, bisexual women were less likely to have a GP who knew their sexual orientation.

4 Misgendering and disrespect are routine harms

Most trans and gender diverse young people have recently been misgendered, and respect for gender identity is especially low in mainstream clinics. Using chosen names is associated with better mental health.

5 Anticipated discrimination drives avoidance

Consistent with minority stress theory, expecting mistreatment leads people to delay or avoid care. Young people say visible inclusive practice is what helps them decide a service is safe.

6 Inclusive practice is valued but under-evaluated

Inclusive services are rated as far more respectful, and most LGBTIQ people would prefer an accredited service. However, few studies measure whether training or accreditation changes clinician behaviour or young people's engagement.

WHERE TO GET HELP

QLife
Free, anonymous LGBTIQ+ peer support and referral by phone or webchat, 3pm to 9pm every day
1800 184 527 / qlife.org.au

Lifeline
24-hour crisis support and suicide prevention
13 11 14 / lifeline.org.au

Kids Helpline
Free, confidential counselling for young people aged 5 to 25, 24 hours a day
1800 55 1800 / kidshelpline.com.au

headspace
Youth mental health services and online support for young people aged 12 to 25
headspace.org.au

In an emergency, call 000. This report is health education, not medical advice.

METHOD

Research Method

This report is a narrative literature review of peer-reviewed literature and grey literature, including national survey reports and guidance from Australian research centres and health organisations. Sources were identified through searches of PubMed, Google Scholar and the publications of La Trobe University's Australian Research Centre in Sex, Health and Society and Rainbow Health Australia, using terms related to LGBTQIA+ young people, disclosure, discrimination, misgendering, sexual healthcare, healthcare avoidance, minority stress and inclusive practice. The review focused on English-language Australian and international research relevant to young people aged approximately 10 to 24, supplemented by studies of young adults and broader LGBTQIA+ populations where youth-specific evidence was limited. Debates about specific clinical treatments were outside its scope.

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