



Friday, 20 August 2021

Medical Specialist Services Section & Medical Benefits Division
MBS Policy and Specialist Services Branch
Medical Benefits Division
Commonwealth Department of Health

Emails: Role email: s47E(d) @health.gov.au
s22 : s22 @health.gov.au
s22 : s22 @health.gov.au
s22 : s22 @health.gov.au
s22 : s22 @health.gov.au

Dear s22 and s22

Thank you for approaching ASPS for information on what item numbers are currently in use for gender affirmation surgery. We understand that this is in part in response to members of the community calling for gender affirmation surgery to be available via Medicare, as evidenced by a Commonwealth Parliamentary petition – [Petition EN3307: Gender affirming surgery should be covered by Medicare](#).

The ASPS Therapeutic Procedures Committee, along with our MBS Specialist Officer, has spent several months trying to obtain and collate information on item number usage, separately to the approach from the Department, and mainly for the benefit of our members, who feel concerned about the ambiguity around whether it is legitimate for them to use Medicare item numbers for gender affirmation surgery. The genuine fear around “doing the wrong thing” makes many members feel vulnerable, and as a result, even reluctant to enter into this field of surgical practice, although there is clearly a significant need in the community. This has come to light over the period of consultation that we have had. As it stands, ASPS has been told that the Department has “no position” on the use of MBS items for gender affirmation procedures, but clearly this tacit consent for their use, rather than specific explicit consent is *not* satisfactory gives little surety to patients or providers.

ASPS is committed to advocating for equity of access to services for all in the community and has an intention to mount an MSAC application for dedicated item numbers for gender affirmation surgery, as a proper solution to this deficiency. However, given the multidisciplinary nature of such surgery, this application will be complex and will need co-ordination with multiple specialty groups. Due to the number of different surgical specialties involved in gender affirmation surgery, ASPS will be proposing that there is a specific section of the Schedule for such surgery, rather than having it hosted within the Plastic and Reconstructive Surgery Section or any other section of the Schedule.

The information in the attached Guide on the use of MBS item numbers for gender affirming surgeries is offered as information in the interim. The items in the table have been collated from

ASPS members with experience in this area and reviewed by the ASPS Therapeutic Procedures Committee (TPC) in order to form some consensus amongst the specialty. It has been beyond our means to ask what other specialty groups use at this stage. As stated above, after discussion with relevant parties, the TPC has reached the conclusion that the existing item numbers are wholly inadequate for provision of gender affirmation surgery and new, gender-affirming surgery specific item numbers are urgently required. It would be helpful, in the short term, if the Department could confirm that the usage of items as described in the table is legitimate.

The impact of the MBS Review Taskforce on the usage of these item numbers for this purpose is pertinent. One of the principles of the MBS Review Taskforce was to "tighten up" the wording of item descriptors to prevent potential misuse, and the resultant reduction in the vagueness of some item descriptors will mean that many of these item numbers will cease to be at all applicable once the Plastic Surgery Item Section of the MBS Review is implemented in November 2022. This will mean that the item number situation for gender affirmation surgeries will essentially go from bad to worse.

ASPS looks forward to working with stakeholders to put forward an MSAC application for a suite of item numbers and will hope for further dialogue with the Department of Health in the lead up to submission.

Yours Sincerely,

s37(1)(c)



s37(1)(c)



s37(1)(c)






Compilation of existing item numbers used for gender affirming surgeries

November 2021

Procedure name (including synonyms)	Item Number	Item Descriptor	Proposed new item descriptor from MBS Review Taskforce (PRS or other)	TPC Commentary	Reasons this item is not ideal
TOP SURGERIES: Breast and chest					
Bilateral subcutaneous mastectomy / bilateral mastectomy with nipple pedicle	31524 x 2	BREAST, subcutaneous mastectomy	<ol style="list-style-type: none"> 1. Breast, nipple sparing mastectomy (unilateral), 2. Breast, nipple sparing mastectomy (bilateral) 3. Breast, skin sparing mastectomy (unilateral), 4. Breast, skin sparing mastectomy (bilateral) 	Item 31524 will become 4 new separate item numbers: 2 nipple sparing mastectomy and 2 skin sparing mastectomy.	The term "mastectomy" means removal of all breast tissue, and in some trans masculine surgery, it is appropriate to leave some breast tissue behind.
Mastectomy with nipple grafting	31519 x 2	BREAST, total mastectomy	<ol style="list-style-type: none"> 1. Breast, total mastectomy (unilateral) 2. Breast, total mastectomy (bilateral) 	TPC suggests this procedure is more likely to be used for patients with a larger breast size where a skin sparing / nipple	The term "mastectomy" means removal of all breast tissue, and in some trans masculine surgery, it is appropriate to leave



				sparing approach is not feasible	some breast tissue behind.
	45545 x 2	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique	No change	TPC interprets the descriptor of 45545 to mean that item 45451 is not usually claimed if 45545 is being claimed.	This item was designed for use when there is no nipple or areola present at all and not when there is a remodeling of an existing Nipple areolar complex
	45451 x 2	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness	<i>Full thickness skin graft to 1 defect with an average diameter of 5 mm or more</i>	TPC interprets the descriptor of 45545 to mean that this item is not usually claimed if 45545 is being claimed.	
Keyhole top surgery / periareolar top surgery	31525 x 2	BREAST, mastectomy for gynecomastia, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies	<i>1. Breast, mastectomy for gynecomastia (unilateral), with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies, and is not applicable when breast enlargement is due to obesity and is proportionate to body habitus. Sufficient photographic evidence demonstrating the clinical need for this service</i>	TPC notes that this item will become 2 separate items on 1 November 2022: 1 x unilateral; 1 x bilateral. TPC recommends using the bilateral item number in place of 2 x 31525, once the changes are implemented.	



			<p>must be included in patient notes (Anaes.) (Assist.).</p> <p>2. Breast, mastectomy for gynaecomastia (bilateral), with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies, and is not applicable when breast enlargement is due to obesity and is proportionate to body habitus. Sufficient photographic evidence demonstrating the clinical need for this service must be included in patient notes (Anaes.) (Assist.).</p>		
Second surgery if required	45545 x 2	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique	No change	TPC recommend use if native nipple areolar complex was not retained at the time of mastectomy	
	45240	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by liposuction, not being a service to which item 45239, 45497, 45498 or 45499 applies	Direct, indirect, free or local flap, revision of, by incision and suture and/or liposuction, applicable once per flap	With the implementation of the MBS Review (PRS) 45240 and 45239 are to be consolidated into one item.	There may often be a need to revise the chest of gender affirmation surgery patients but there is no item designed for this.



				TPC recommends it is not appropriate to use these items as no formal flap has been performed.	
45239	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by incision and suture, not being a service to which item 45240 applies	<i>Direct, indirect, free or local flap, revision of, by incision and suture and/or liposuction, applicable once per flap</i>	With the implementation of the MBS Review (PRS) 45240 and 45239 are to be consolidated into one item. TPC recommends it is not appropriate to use these items as no formal flap has been performed.	There may often be a need to revise the chest of gender affirmation surgery patients but there is no item designed for this.	
45206	Single stage local flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376	Not mentioned. This item was changed as a result of the Skin Services Review in 2016 so was not within the scope of the MBS Review Taskforce.	TPC does not recommend using this item.	This is not designed for use in the breast / chest area.	



BOTTOM SURGERIES: Genital Reconfiguration Surgeries (GRS)

Vaginoplasty	37405	PENIS, complete or radical amputation of	<u>Urology Report:</u> No change	TPC agrees that this item is appropriate	
	37342	URETHROPLASTY single stage operation	<u>Urology Report:</u> No change	TPC agrees that this item is appropriate	
	35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus	<u>Gynaecology Report:</u> No change	TPC believes this is not an ideal descriptor for this indication, but can be viewed as appropriate	Those born with an absent vagina, but otherwise a female phenotype, are very different from adults requiring gender affirmation and it is not ideal to code them as the same surgeries or for the same population
	30642 X2	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach , with insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643, 30644 or 45051 applies	<u>Urology Report:</u> The urology changes were already implemented on 1 November 2020. Taskforce inserted 'for tumour, inguinal approach' into item descriptor.	TPC notes that historically this was an appropriate item but the current descriptor is no longer appropriate due to the insertion of 'for tumour' effective from 1 November 2020.	This item is no longer available for this patient group as a consequence of the Taskforce changes effective 1 November 2020. In its original, pre-1 November 2020 form it was appropriately claimed



					for radical removal of the testes as it included relevant components to the procedure. In genital reconfiguration surgery, it is not just a 'simple' orchidectomy, since dissection up to the external inguinal ring, puts at risk those structures in the vicinity of that anatomical location.
	3064I	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis		TPC originally suggested this be used in place of item 3064I which is no longer available to this patient group. However, for reasons outline to the right, it is not suitable as it does not include all components required for the procedure.	Being a simple orchidectomy only, item 3064I does not include the dissection and division of the spermatic cord. This is an essential component of the procedure in order to prevent the development of neuromas within the labia majora, if the cords are left and the



					testicle is simply removed.
	30630	Insertion of testicular prosthesis, at least 6 months following orchidectomy	Not mentioned	TPC recommends to use this item as required.	
	45451 (if doing free graft)	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness	Full thickness skin graft to 1 defect with an average diameter of 5 mm or more	TPC agrees this item may be appropriate	
Clitoroplasty / creation of the clitoris	45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness	Neurovascular island flap for restoration of essential sensation in the digits or sole of the foot, including direct repair of secondary cutaneous defect if performed. Requires formal dissection of the neurovascular pedicle. Not to be used for simple V-Y flaps or other standard flaps, such as rotation or keystone. Not to be claimed with skin excision items 31200 to 31376	TPC notes that the option to use this item for vaginoplasty will disappear on 1 Nov 2022.	After 1 November 2022 there will be no MBS item number suitable for this procedure. If the proposed descriptor were to have '...the digits, sole of the foot, or for genital reconstruction...' inserted, this item may continue to be claimed for clitoroplasty and



					other GRS it is currently being used for. However, it would be preferable to have a separate item for that purpose
Labiaplasty, no vaginal cavity / 'vulvoplasty'	45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness	<i>Neurovascular island flap for restoration of essential sensation in the digits or sole of the foot, including direct repair of secondary cutaneous defect if performed. Requires formal dissection of the neurovascular pedicle. Not to be used for simple V-Y flaps or other standard flaps, such as rotation or keystone. Not to be claimed with skin excision items 31200 to 31376</i>	TPC notes this item will change on 1 Nov 2022, rendering it inappropriate for use for gender affirming surgeries.	After 1 November 2022 there will be no MBS item number suitable for this procedure. If the proposed descriptor were to have '...the digits, sole of the foot, or for genital reconstruction... ' inserted, this item may continue to be claimed for clitoroplasty and other GRS it is currently being used for. However, it would be preferable to have a separate item for that purpose
	37405	PENIS, complete or radical amputation of	<u>Urology Report:</u> No change	TPC agrees this is appropriate	
	37342	URETHROPLASTY single stage operation	<u>Urology Report:</u> No change	TPC agrees this is appropriate	



Australian Society of Plastic Surgeons

	30642 x 2	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach , with insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643, 30644 or 45051 applies	<u>Urology Report:</u> The urology changes were already implemented on 1 November 2020. Taskforce inserted 'for tumour, inguinal approach' into item descriptor.	TPC notes that historically this was an appropriate item but the current descriptor is no longer appropriate due to insertion of 'for tumour' = effective from 1 November 2020.	This item is no longer available for this patient group as a consequence of the Taskforce changes effective 1 November 2020. In its original, pre-1 November 2020 form it was appropriately claimed for radical removal of the testes as it included relevant components to the procedure. In genital reconfiguration surgery, it is not just a 'simple' orchidectomy, since dissection up to the external inguinal ring, puts at risk those structures in the vicinity of that anatomical location.
	30641	ORCHIDECTOMY, simple or subcapsular, unilateral with or without insertion of testicular prosthesis		TPC originally suggested this be used in place of item 30641 which is no longer available to	Being a simple orchidectomy only, item 30641 does not include the dissection and division of the



				this patient group. However, for reasons outline to the right, it is not suitable as it does not include all components required for the procedure.	spermatic cord. This is an essential component of the procedure in order to prevent the development of neuromas within the labia majora, if the cords are left and the testicle is simply removed.
	45206 x 2	Single stage local flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376	Not mentioned	TPC recommends to use this item as required.	
Standalone Bilateral Orchidectomy	30642 x 2	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach , with insertion of testicular prosthesis, other than a service associated with a service to which item 30631,	<u>Urology Report:</u> The urology changes were already implemented on 1 November 2020. Taskforce inserted 'for tumour, inguinal approach' into item descriptor.	TPC notes that historically this was an appropriate item but the current descriptor is no longer appropriate due to insertion of 'for tumour' =	This item is no longer available for this patient group as a consequence of the Taskforce changes effective 1 November 2020. In its original, pre-1 November 2020 form it was



		30635, 30641, 30643, 30644 or 45051 applies		effective from 1 November 2020.	appropriately claimed for radical removal of the testes as it included relevant components to the procedure. In genital reconfiguration surgery, it is not just a 'simple' orchidectomy, since dissection up to the external inguinal ring, puts at risk those structures in the vicinity of that anatomical location.
	30641 x 2	ORCHIDECTOMY, simple or subcapsular, unilateral with or without insertion of testicular prosthesis		TPC originally suggested this be used in place of item 30641 which is no longer available to this patient group. However, for reasons outline to the right, it is not suitable as it does not include all components required for the procedure.	Being a simple orchidectomy only, item 30641 does not include the dissection and division of the spermatic cord. This is an essential component of the procedure in order to prevent the development of neuromas within the labia majora, if the cords are left and the



					testicle is simply removed.
Reconstruction of testes	30630	Insertion of testicular prosthesis, at least 6 months following orchidectomy			
Phalloplasty – radial forearm free flap (RFF) or anterior lateral thigh flap (ALT)	Free flap items: 45562, 45504, 45505, 45564, 45565.	Refer to MBS Online	1. Items 45504 and 45505: Consolidate these two items into two new items in line with the complete medical service concept. Change the item descriptors to exclude claiming in the context of breast reconstruction. 2. Item 45562: Change the item descriptor to better describe the service and exclude claiming in the context of breast reconstruction. Delete	Phalloplasty may be performed by plastic surgeons, urologists or a combination of the two. Use free flap item numbers as appropriate, noting various changes due 1 November 2022 as a result of the PRS Taskforce. For further detail about new free flap	



			reference to male pattern baldness 3. Items 45564 and 45565: Change the item descriptors to exclude claiming in the context of breast reconstruction.	items not listed here, see Section 4.7: Microvascular procedures of the PRS Taskforce Report .	
Metoidioplasty (formation of penis from clitoral tissue)	45206	Single stage local flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376	Not mentioned. This item was changed as a result of the Skin Services Review in 2016 so was not within the scope of the MBS Review Taskforce.	TPC recommends use as required	
<p style="text-align: center;">Non-breast/non-genital surgeries</p> <p style="text-align: center;">These procedures will generally be performed by surgeons other than plastic surgeons</p>					
Rhinoplasty	45632 – 45644, and 45650 All here		Not mentioned in PRS, ENT, Head and Neck Committees	TPC cannot recommend as gender affirming surgery, as this indication is not consistent with	No item number for this purpose



				current item descriptors	
Browlift	None			Currently no items	No item number for this purpose
Cheek enhancement	None			Currently no items	No item number for this purpose
Facial feminisation: may include forehead reduction	40600	Cranioplasty, reconstructive, other than a service associated with a service to which item 39113, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39710, 39712, 39715, 39801, 39803 or 40703 applies	<u>Neurosurgery and Neurology Report:</u> already implemented.	TPC agrees this may meet the indication in the descriptor for some cases	No item number for this purpose
Lip lift and reshaping				Currently no items	No item number for this purpose
Scalp advancement				Currently no items	No item number for this purpose
Tracheal shave (chondrolaryngoplasty)	ENT			TPC agrees this procedure is outside the scope of Plastic and Reconstructive Surgery	



Genioplasty (chin)	45761	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site	<i>Genioplasty, where the deformity is secondary to congenital absence of tissue or has arisen from trauma, (other than from previous cosmetic surgery), or a diagnosed pathological process or is required for maintaining lip competency. Sufficient photographic evidence demonstrating the clinical need for this service must be included in patient notes</i>	Could be interpreted as being applicable	No real item for this indication
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Other Specialties' Procedures for Gender Affirming Surgeries

Procedure	Specialty	
Hysterectomy	Ob/Gyn	
Oophorectomy	Ob/Gyn	
Phalloplasty	Urologist	
Facial feminisation or masculinisation	Craniomaxillofacial	
Tracheal shave (chondrolaryngoplasty)	ENT	
Fertility preservation (sub-spec obs)	Fertility Specialists	



Other		
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BY THE DEPARTMENT OF HEALTH AND AGED CARE

From: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Sent: Tuesday, 26 October 2021 2:14 PM
To: s22
Cc: s22 s22 s37(1)(c)
Subject: RE: List of MBS items billed for gender confirmation surgery FW: s22
 [SEC=OFFICIAL]

REMINDER: Think before you click! This email originated from outside our organisation. Only click links or open attachments if you recognise the sender and know the content is safe.

Dear s22

Sincerest apologies but s37(1)(c) has been held up in theatre today so we have to reschedule our meeting to finalise the MBS list which means I won't be able to get it to you this afternoon. As you can imagine it is difficult to arrange practicing surgeons and their busy schedules so at this stage its looking like next week. s37(1)(c) sends her apologies.

I also want to apologise for the extended time to finish this as I know the Department are getting a lot of queries. ASPS do not think it would be responsible or appropriate to send even a draft list of MBS items until we have had the list finalised, as the risk of misinterpretation if there is no commentary alongside each item could result in unintended misuse. As we discussed over the phone there are a lot of issues at play so unfortunately it not as simple as generating a numerical list of items. I hope you can understand this and apologise for the delay!

Warm regards,

s37(1)(c)

s37(1)(c) | s37(1)(c) | (Tues/Fri AM)

Australian Society of Plastic Surgeons

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A: Suite G01, Ground Floor, 69 Christie Street, St Leonards, NSW 2065

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We are pleased to be able to assist you on this occasion. Positive feedback really helps to encourage the public to visit our website and use our content to educate themselves before beginning their plastic surgery journey. If you wouldn't mind leaving a review, it would be much appreciated." [Google Review](#)

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From: s22 [mailto:s22@health.gov.au]
Sent: Friday, October 22, 2021 11:56 AM
To: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Cc: s22 <s22@health.gov.au>; s22 <s22@health.gov.au>
Subject: FW: List of MBS items billed for gender confirmation surgery FW: s22
 [SEC=OFFICIAL]

Hi s37(1)(c)

I've just tried called your work number but understand you are working from home today. Due to an increasing number of enquiries regarding items billed for gender confirmation surgery we would be really grateful for a draft version of the list ASPS is developing if possible, with the understanding that it will not be the final list.

Kind regards

s22

Medical Specialist Services Section
 MBS Policy and Specialist Services Branch
 Medical Benefits Division
 P: (02) 6289 s22

From: s22
Sent: Friday, 8 October 2021 11:13 AM
To: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Subject: RE: List of MBS items billed for gender confirmation surgery FW: s22
[SEC=OFFICIAL]

Thank you s37(1)(c) much appreciated.
s22

From: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Sent: Friday, 8 October 2021 10:44 AM
To: s22 a s22 @health.gov.au>
Cc: s22 <s22@health.gov.au>; s37(1)(c) <s37(1)(c)@gmail.com>
Subject: RE: List of MBS items billed for gender confirmation surgery FW: s22
[SEC=OFFICIAL]

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Hi s22
Thanks for touching base. We are still finalizing this list before sending to members and yourselves. But as soon as it is completed we will send it through.

Best
s37(1)(c)
s37(1)(c) | s37(1)(c) | (Tues/Fri AM)

Australian Society of Plastic Surgeons

T: +61 2 9437 9200
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From: s22 [mailto:s22@health.gov.au]

Sent: Wednesday, October 6, 2021 2:54 PM

To: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Cc: s22 <s22@health.gov.au>

Subject: List of MBS items billed for gender confirmation surgery FW: s22
[SEC=OFFICIAL]

Hi s37(1)(c)
We have received some further questions from the public regarding MBS items that are generally billed for gender confirmation surgery procedures. To inform our advice I would be very grateful for the list you discussed with s22 below.

Kind regards
s22

Medical Specialist Services Section
MBS Policy and Specialist Services Branch
Medical Benefits Division
P: (02) 6289 s22

From: s22 <s22@health.gov.au>
Sent: Wednesday, 6 October 2021 2:26 PM
To: s22 <s22@health.gov.au>
Subject: FW: s22 [SEC=OFFICIAL]

From: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Sent: Friday, 17 September 2021 10:39 AM

To: s22 <s22@health.gov.au>

Subject: RE: s22 [SEC=OFFICIAL]

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Thank you so much, s22

Also wondering if there's an indication of the breast AFG item descriptors? As I'm sure you can imagine, the majority of queries are about the breast items.

And re the gender affirming surgeries list, I have sent it for final review today so should be able to forward to you next week....hopefully before you leave!

Best

s37(1)(c)

s37(1)(c) | s37(1)(c) | (Tues/Fri AM)

Australian Society of Plastic Surgeons

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From: s22 [mailto:s22@health.gov.au]

Sent: Thursday, September 16, 2021 1:17 PM

To: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>

Subject: s22 [SEC=OFFICIAL]

Hi s37(1)

s22

Additionally, with regards to gender confirmation surgery, at the last CIC meeting we spoke about ASPS providing a list MBS item numbers which may be used for confirmation surgeries. I was wondering whether such a list was available yet? One of my colleagues was enquiring what MBS services may be claimed for these surgeries.

s22

Regards

s22

Medical Specialist Services Section

MBS Policy & Specialist Services Branch | Medical Benefits Division

Australian Government Department of Health

T: 02 6289 s22 | E: s22 @health.gov.au

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s22

From: s22
Sent: Friday, 20 October 2023 1:35 PM
To: s37(1)(c)
Cc: s22; MSAC PASC_Secretariat; s37(1)(c); s37(1)(c); MSAC PASC_Secretariat; s22
Subject: FW: Invitation to ASPS Gender Roundtable [SEC=UNOFFICIAL]

Hi s37(1)(c)

Thank you for this invitation it won't be possible for a Department member to attend the roundtable, however we would welcome the report from the meeting.

Kind regards

s22

Medical Specialist Services Section
 MBS Policy and Specialist Services Program
 Medicare Benefits and Digital Health Division
 P: (02) 6289 s22

From: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Sent: Thursday, 19 October 2023 10:07 AM
To: s22 <s22@health.gov.au>
Cc: s22 <s22@Health.gov.au>; MSAC PASC_Secretariat <MSAC.PASC.Secretariat@health.gov.au>; s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>; s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Subject: Invitation to ASPS Gender Roundtable

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Dear s22

As discussed in the pre-PASC meeting, here is the invitation for the ASPS Gender Roundtable for distribution to the HTA group.

We would be delighted of course if any member of your division were interested in attending too.

Please let me know

Kind regards,
 s37(1)(c)

s37(1)(c) | s37(1)(c)
My working days are Thursday & Friday.
Australian Society of Plastic Surgeons

T: +61 2 9437 9200
E: s37(1)(c)@plasticsurgery.org.au
A: Suite G01, Ground Floor, 69 Christie Street, St Leonards, NSW 2065
W: www.plasticsurgery.org.au

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s 22

From: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Sent: Thursday, 26 October 2023 10:43 AM
To: SurgicalServices
Subject: RE: Invitation to ASPS Gender Roundtable [SEC=UNOFFICIAL]

Thanks s 22 I appreciate you passing it on and thanks for letting us know.

s37(1)(c) s37(1)(c)

My working days are Thursday & Friday.

Australian Society of Plastic Surgeons

T: +61 2 9437 9200

E: s37(1)(c)@plasticsurgery.org.au

A: Suite G01, Ground Floor, 69 Christie Street, St Leonards, NSW 2065

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From: SurgicalServices <s47E(d)@health.gov.au>
Sent: Tuesday, October 24, 2023 2:59 PM
To: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Cc: MSAC PASC_Secretariat <MSAC.PASC.Secretariat@health.gov.au>; s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>; s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>; s 22 <s 22@Health.gov.au>; s 22 <s 22@health.gov.au>; SurgicalServices <s47E(d)@health.gov.au>
Subject: FW: Invitation to ASPS Gender Roundtable [SEC=UNOFFICIAL]

Hi s37(1)(c)

The assessment group has advised that whilst they are grateful for the invitation to the roundtable they will decline it on this occasion as they consider it best to avoid any perceived or actual conflicts of interest in relation to attendance at the event, as interactions between the applicant and assessment group need to be facilitated through the Department whilst the application is active.

The assessment group would also be grateful for the outcomes from the meeting. We would be happy pass those on to the assessment group when they are available.

Kind regards

s 22

Medical Specialist Services Section
 MBS Policy and Specialist Services Program
 Medicare Benefits and Digital Health Division
 P: (02) 6289 s22

From: s 22
Sent: Friday, 20 October 2023 1:35 PM
To: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Cc: s 22 <s 22@health.gov.au>; MSAC PASC_Secretariat <MSAC.PASC.Secretariat@health.gov.au>; s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>; s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>; MSAC PASC_Secretariat <MSAC.PASC.Secretariat@health.gov.au>; s 22 <s 22@health.gov.au>
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 MBS Policy and Specialist Services Program
 Medicare Benefits and Digital Health Division
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Sent: Thursday, 19 October 2023 10:07 AM
To: s 22 <s 22@health.gov.au>
Cc: s 22 <s 22@Health.gov.au>; MSAC PASC_Secretariat <MSAC.PASC.Secretariat@health.gov.au>; s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>; s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Subject: Invitation to ASPS Gender Roundtable

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Please let me know

Kind regards,
 s37(1)(c)

s37(1)(c) | s37(1)(c)
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s22

From: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Sent: Tuesday, 13 February 2024 1:40 PM
To: s22
Subject: TRIM: ASPS FINAL GAS Report
Attachments: The Australian Roundtable on Gender Affirming Surgery_FINAL.pdf; LetterNDAH.pdf

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Dear s22

Please see letter and report attached for your attention.

Kind regards,

s37(1)(c) | s37(1)(c) | (Mon-Wed, Fri)
Australian Society of Plastic Surgeons

T: +61 2 9437 9200
E: s37(1)(c)@plasticsurgery.org.au
A: Suite G01, Ground Floor, 69 Christie Street, St Leonards, NSW 2065
W: www.plasticsurgery.org.au

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13 February 2024

Dear s22

Please find attached the Report of the Australian Roundtable on Gender Affirming Surgery 2023. I understand that it was not possible for you or other Department members to make it to the event, but know you were interested in hearing about the outcome.

I hope you find the report interesting. As you know, we are now in the midst of preparing the ADAR, as the next stage towards MSAC and look forward to seeing you again in due course.

Thank you for your interest in ASPS' work in the field of gender affirming care.

Kind regards

s37(1)(c)

s37(1)(c)

ASPS

s22

From: s22
Sent: Monday, 22 April 2024 9:12 AM
To: s37(1)(c); s37(1)(c); s37(1)(c); s47F (s47F)
Cc: s22; s22; s22; s22; s22; s22
 s22; s22; s22; s47E(d)
Subject: Multidisciplinary support considerations for Application 1754 [SEC=UNOFFICIAL]
Attachments: PICO proposed clinical algorithm and existing item groups 18424.DOCX; PICO proposed clinical algorithm stages and existing MBS items.XLSX; MSAC 1754 Ratified PICO to applicant.DOCX

Dear s37(1)(c)

Thank you for this advice, I trust you and s47F and team are well. I apologise for the delay in response but we have been considering an approach to facilitate ongoing discussion between yourselves and relevant policy teams regarding MBS item supports (including multidisciplinary) for patients accessing the proposed surgical MBS items.

To this email I have attached:

1. A high level proposed clinical algorithm (taken from the PASC ratified PICO) mapped to the existing MBS item groups.
2. A spreadsheet detailing clinical services within each stage of the clinical algorithm alongside the existing MBS items.

We consider that these documents will assist in providing reassurance of access to MBS items for the proposed patient group as the application progresses to the ESC and MSAC committees.

As the next stage in this work we would be grateful if you could include any clinical services (in line with current and developing clinical guidelines) that we have not included under the individual stages of worksheet 'Clinical services and MBS items' (i.e. under 'Diagnosis of patient with gender incongruence that is marked and sustained'), we also welcome your comments throughout this worksheet.

For your convenience the other worksheets in the spreadsheet provide the full item descriptors of each item referenced in the 'Clinical services and MBS items' worksheet. I note there may be unrelated amendments to these items over time through legislative changes, MBS online is always a current source of the item descriptors.

Following receipt of your comments in the spreadsheet I consider that we would organise a meeting between yourselves and policy areas to discuss any concerns and suggestions raised.

We look forward to working with you throughout the year.

Kind regards

s22

Medical Specialist Services Section
 MBS Policy and Specialist Services Program
 Medicare Benefits and Digital Health Division
 P: (02) 6289 s22

From: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Sent: Wednesday, December 13, 2023 6:31 PM
To: s22 <s22@health.gov.au>; s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>; s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>

Cc: s47F <s47F>

Subject: Consultations etc. for s22

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Dear s22,

Thankyou again for your time in the meeting yesterday. In regards to consultation etc. items that are very relevant to the area of Gender Incongruence and its surgical management, we have previously highlighted the importance of careful assessment and the need for working as a multidisciplinary team. MSAC Executive have also emphasised the need to demonstrate this within this field. We have had mixed messages about the appetite for developing special consultation items. I understand the concerns about expansion of items, but if MSAC Executive have expressed a desire for this to be especially safeguarded this is clearly a direction that should be considered. There are several important areas

1. **Assessment for a possible diagnosis of gender incongruence.** This is clearly a crucial assessment of a vulnerable population. We have argued that gender incongruence could be a condition warranting an Assessment item. It would be helpful if this could be reconsidered. My understanding is that this would not mean a new item number, but an inclusion of this as an eligible condition. Regardless of whether or not you feel it is appropriate to devise an assessment item, I thought it would be useful to understand what the process typically is for coming to a diagnosis of gender incongruence. The attached Word document gives some information on this. The key "home" for gender incongruence diagnosis is Sexual Health Medicine and the Australian Society of Sexual Health Medicine may produce a document on this shortly. However, it is important to note that Specialist General Practitioners and Endocrinologists also have capacity to diagnose gender incongruence. There are a number of courses via AusPATH GPs can undertake. As you can see formulating a diagnosis normally requires multiple consultations. So from an item number perspective there may be an initial long and complex consultation plus communication with other health disciplines, and then perhaps two shorter consultations.
2. There must be an ability for **specialists to have a case conference** about a patient. This is key for good multidisciplinary care. This may sometimes involve a GP as well and sometimes not. There should be provision for face to face or virtual.
3. A Nurse practitioner consultation for discussion of surgical care is useful.
4. An ability to hold not only a multidisciplinary case conference, but also to allow for a multidisciplinary consultation (ie in a clinic with the patient present)

Many patients will require psychology and allied health inputs. My understanding is that this would be outside of your remit.

MSAC Executive, as well as us as surgeons are keen to have robust and appropriate items for assessment of gender incongruence and multidisciplinary care, so it is crucial that this is addressed in parallel to the application for the surgical items.

Thankyou for looking into this and getting back to us,

Kind regards

s37(1)(c)

s37(1)(c)

| s37(1)(c)

(she/her)

Australian Society of Plastic Surgeons

T: +61 2 9437 9200

E: s37(1) @plasticsurgery.org.au

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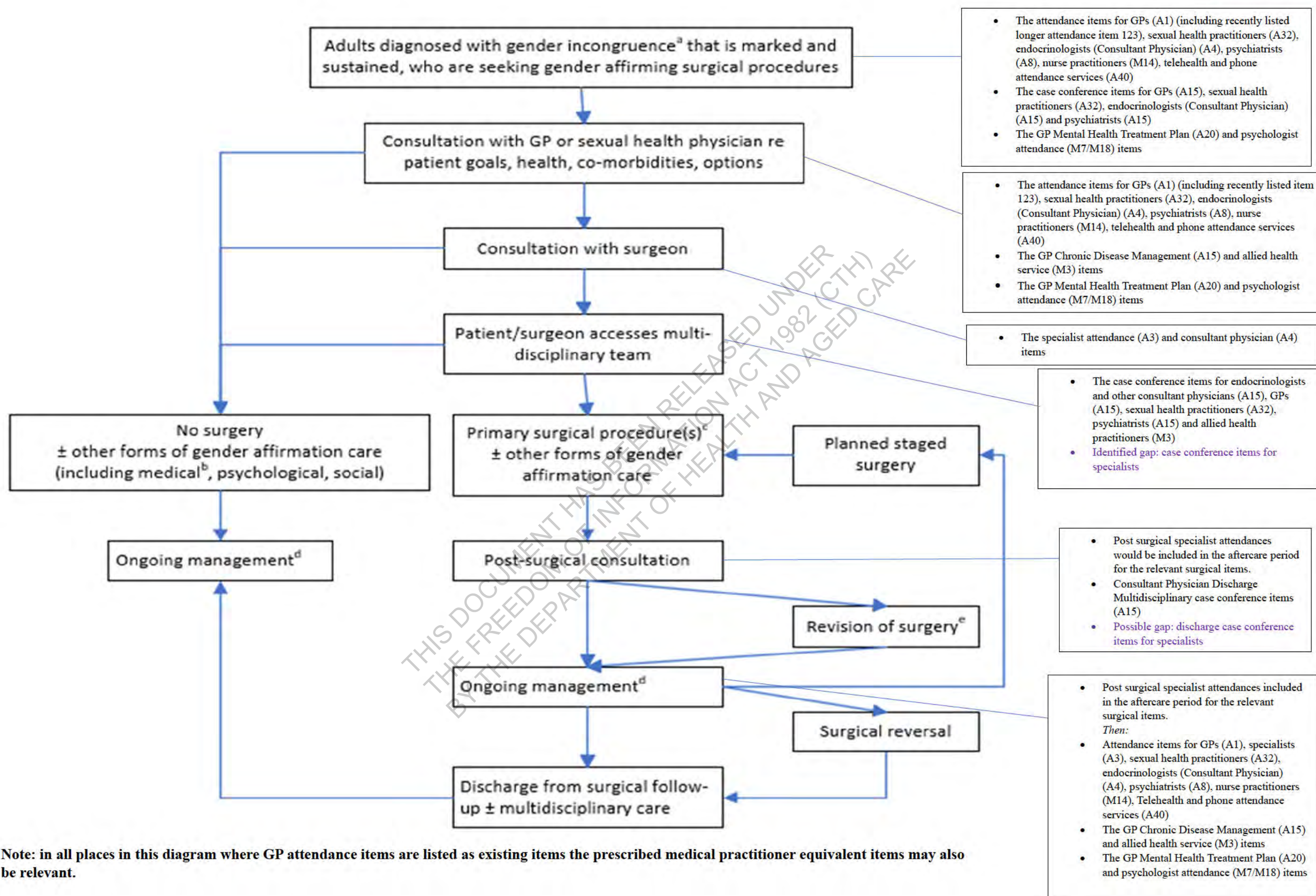


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Consultation stages from proposed clinical algorithm in PICO (page 21)	Existing items	Policy team comments	ASPS comments
Diagnosis of patient with gender incongruence that is marked and sustained			
<p>Clinical services:</p> <p>The diagnosing clinician will need to rule out other causes of apparent gender incongruence which may occur as part of an acute psychotic episode, or cases where surgery is sought for reasons other than the alleviation of gender incongruence.</p> <p>There may be an initial long and complex consultation plus communication with other health disciplines, and then perhaps two shorter consultations.</p> <p>Applicant advised suitably qualified health professionals, such as practice nurses or Aboriginal and Torres Strait Islander health practitioners, employed and or otherwise engaged by a medical practice or health service, may assist medical practitioners in performing gender incongruence assessments. This may include activities associated with information collection and providing patients with information about recommended interventions at the direction of the medical practitioner.</p> <p>Assessment for a possible diagnosis of gender incongruence, includes</p> <p>information collection, including taking a patient gender history and undertaking or arranging investigations as required by guidelines</p> <p>making an overall assessment of the patient including assessment of mental health</p> <p>recommending appropriate interventions</p> <p>keeping a record of the assessment, and offering the patient a written report about the assessment, with recommendations about matters covered by the assessment</p>	<p>GP attendance items (link to full item descriptors)</p> <p>Item 23 (and telehealth 91800) Professional attendance by a general practitioner lasting less than 20 minutes</p> <p>Item 36 (and telehealth 91801, phone 91900) Professional attendance by a general practitioner lasting at least 20 minutes</p> <p>Item 44 (and telehealth 91802, phone 91910) Professional attendance by a general practitioner lasting at least 40 minutes</p> <p>Item 123 (and telehealth 91920) Professional attendance by a general practitioner lasting at least 60 minutes (listed 1 November 2023)</p> <p>Item 91891 Phone attendance by a general practitioner lasting at least 6 minutes</p> <p>Item 92715 Telehealth attendance (and phone 92731) for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of not more than 5 minutes</p> <p>Item 92718 Telehealth attendance (and phone 92734) for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 5 minutes in duration but not more than 20 minutes</p> <p>Item 92721 Telehealth attendance (and phone 92737) for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 20 minutes in duration but not more than 40 minutes</p> <p>92724 Telehealth attendance (and phone 92740) for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner lasting at least 40 minutes in duration</p> <p>Sexual health practitioner attendance items</p> <p>Item 6051 Professional attendance by a sexual health medicine specialist - initial</p> <p>Item 6052 Professional attendance by a sexual health medicine specialist -subsequent</p> <p>Item 6057 Professional attendance by a sexual health medicine specialist of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities</p> <p>Item 6058 Professional attendance by a sexual health medicine specialist of at least 20 minutes after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities</p> <p>Endocrinologist (Consultant Physician) attendance items</p> <p>110 Professional attendance by a consultant physician -initial attendance in a single course of treatment.</p> <p>116 Professional attendance by a consultant physician — an attendance (other than a service to which item 119 applies) after the initial attendance in a single course of treatment</p> <p>132 Professional attendance by a consultant physician lasting at least 45 minutes for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders)</p> <p>133 Professional attendance by a consultant physician lasting at least 20 minutes after the initial attendance in a single course of treatment for a review of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders)</p> <p>Psychiatrist attendance items</p> <p>291 Professional attendance of more than 45 minutes in duration following referral of the patient to the consultant for an assessment and written management plan for GP</p> <p>293 Professional attendance of more than 30 minutes but not more than 45 minutes - review of management plan (291)</p> <p>296 Professional attendance of more than 45 minutes in duration - new patient or not seen in preceding 24 months</p> <p>300 Professional attendance of not more than 15 minutes in duration at consulting rooms</p> <p>304 Professional attendance of more than 30 minutes, but not more than 45 minutes</p> <p>306 Professional attendance of more than 45 minutes, but not more than 75 minutes</p> <p>GP case conference items</p>	<p>Policy team notes in all places in this spreadsheet where GP attendance items are listed as existing items the prescribed medical practitioner equivalent items may also be relevant, this also applies to all face to face attendance items that have equivalent telehealth and phone items.</p> <p>Policy team considers that the range of existing attendance and case conference items for diagnosing physicians support the patient diagnosis process.</p> <p>Policy team considers that the existing case conference items would support physicians to diagnose patients within a multidisciplinary care setting, and notes that case conference items provide for face to face or teleconference meetings.</p>	

<p>GP has organised and coordinated case conference</p> <p>735 conference lasts for at least 15 minutes</p> <p>739 conference lasts for at least 20 minutes, but for less than 40 minutes</p> <p>743 conference lasts for at least 40 minutes</p> <p>GP has attended case conference</p> <p>747 conference lasts for at least 15 minutes, but for less than 20 minutes</p> <p>750 conference lasts for at least 20 minutes, but for less than 40 minutes</p> <p>758 conference lasts for at least 40 minutes</p>
Sexual health practitioner case conference items
<p>Sexual Health practitioner has organised and coordinated case conference</p> <p>Item 6064 conference less than 15 minutes</p> <p>Item 6065 conference at least 15 minutes but less than 30 minutes</p> <p>Item 6067 conference at least 30 minutes but less than 45 minutes</p> <p>Item 6068 conference at least 45 minutes</p> <p>Sexual Health practitioner has attended case conference</p> <p>Item 6071 conference less than 15 minutes</p> <p>Item 6072 conference at least 15 minutes but less than 30 minutes</p> <p>Item 6074 conference at least 30 minutes but less than 45 minutes</p> <p>Item 6075 conference at least 45 minutes</p>
Endocrinologist (Consultant Physician items) case conference items
<p>Consultant Physician has organised and coordinated case conference</p> <p>820 conference of at least 15 minutes but less than 30 minutes</p> <p>822 conference of at least 30 minutes but less than 45 minutes</p> <p>823 conference of at least 45 minutes</p> <p>Consultant Physician has attended case conference</p> <p>825 conference of at least 15 minutes but less than 30 minutes</p> <p>826 conference of at least 30 minutes but less than 45 minutes</p> <p>828 conference of at least 45 minutes</p>
Psychiatrist case conference items
<p>Psychiatrist has organised and coordinated case conference</p> <p>855 conference of at least 15 minutes but less than 30 minutes</p> <p>857 conference of at least 30 minutes but less than 45 minutes</p> <p>858 conference of at least 45 minutes</p> <p>Psychiatrist has attended case conference</p> <p>825 conference at least 15 minutes but less than 30 minutes</p> <p>826 conference of at least 30 minutes but less than 45 minutes</p> <p>828 conference of at least 45 minutes</p>
GP Mental Health Treatment Plan, Review and Consultation items
<p>Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare either through item 2700, 2701, 2715, 2717, 92112, 92113, 92116 or 92117 a patient is eligible to be referred for up to 10 Medicare rebateable mental health services per calendar year for psychological therapy or focussed psychological strategy (FPS) services.</p>
Psychological services
<p>80100, 80105, 80110 and 80115 for provision of FPS services by a psychologist;</p> <p>91169, 91170, 91183 and 91184 for provision of video conference and phone FPS services by a psychologist;</p> <p>80125, 80130, 80135 and 80140 for provision of FPS services by an occupational therapist;</p> <p>91172, 91173, 91185 and 91186 for provision of video conference and phone FPS services by an occupational therapist;</p> <p>80150, 80155, 80160 and 80165 for provision of FPS services by a social worker; and</p> <p>91175, 91176, 91187 and 91188 for provision of video conference and phone FPS services by a social worker.</p>
Nurse Practitioner attendance items
<p>82200 - attendance by nurse practitioner straight forward in nature</p> <p>82205 - attendance by nurse practitioner less than 20 minutes</p> <p>82210 - attendance by nurse practitioner at least 20 minutes</p> <p>82215 - attendance by nurse practitioner at least 40 minutes</p>

Consultation with GP or sexual health physician regarding patient goals, health, co-morbidities, options			
<p>Clinical services:</p> <p>initiating/management medical therapy</p> <p>counselling and psychological therapies</p> <p>referral to relevant specialist services (eg plastic, gynaecology, urology, sexual health)</p> <p>care coordination</p>	<p>GP attendance items</p> <p>Item 23 (and telehealth 91800) Professional attendance by a general practitioner lasting less than 20 minutes</p> <p>Item 36 (and telehealth 91801, phone 91900) Professional attendance by a general practitioner lasting at least 20 minutes</p> <p>Item 44 (and telehealth 91802, phone 91910) Professional attendance by a general practitioner lasting at least 40 minutes</p> <p>Item 123 (and telehealth 91920) Professional attendance by a general practitioner lasting at least 60 minutes (listed 1 November 2023)</p> <p>Item 91891 Phone attendance by a general practitioner lasting at least 6 minutes</p> <p>Item 92715 Telehealth attendance (and phone 92731) for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of not more than 5 minutes</p> <p>Item 92718 Telehealth attendance (and phone 92734) for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 5 minutes in duration but not more than 20 minutes</p> <p>Item 92721 Telehealth attendance (and phone 92737) for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 20 minutes in duration but not more than 40 minutes</p> <p>92724 Telehealth attendance (and phone 92740) for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner lasting at least 40 minutes in duration</p> <p>Sexual health practitioner attendance items</p> <p>Item 6051 Professional attendance by a sexual health medicine specialist - initial</p> <p>Item 6052 Professional attendance by a sexual health medicine specialist -subsequent</p> <p>Item 6057 Professional attendance by a sexual health medicine specialist of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities</p> <p>Item 6058 Professional attendance by a sexual health medicine specialist of at least 20 minutes after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities</p> <p>Chronic Disease Management items</p> <p>GPs may refer patients to MBS subsidised allied health services under a GP Management Plan (item 721) and Team Care Arrangement (item 723). GPs can refer patients for up to five MBS rebated allied health services per calendar year. In addition, patients with a GP Management Plan and/or Team Care Arrangement can also access up to five services with a practice nurse or Aboriginal and Torres Strait Islander Health Practitioner that are provided on behalf of a medical practitioner each calendar year.</p> <p>Item 721 (and telehealth 92024) Preparation of a GP Management Plan</p> <p>Item 723 (and telehealth 92025) Coordination of Team Care Arrangements</p> <p>Item 732 (and telehealth 92028) Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements</p> <p>Allied health services</p> <p>MBS rebated allied health services include items 10950 Aboriginal or Torres Strait Islander health service, 10951 Diabetes education health service, 10952 Audiology, 10953 Exercise Physiology, 10954 Dietetics services, 10956 Mental Health service, 10958 Occupational therapy, 10960 Physiotherapy, 10962 podiatry, 10964 Chiropractic service, 10966 Osteopathy, 10968 Psychology, 10970 Speech pathology</p> <p>Item 10955, 10957, and 10959 provide for attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team.</p> <p>10955 - at least 15 minutes, but for less than 20 minutes</p> <p>10957 - at least 20 minutes, but for less than 40 minutes</p> <p>10959 - at least 40 minutes</p> <p>GP Mental Health Treatment Plan, Review and Consultation items</p> <p>Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare either through item 2700, 2701, 2715, 2717, 92112, 92113, 92116 or 92117 a patient is eligible to be referred for up to 10 Medicare rebateable mental health services per calendar year for psychological therapy or focussed psychological strategy (FPS) services.</p> <p>Psychological services</p>	<p>Policy team considers that the listed existing items may support patients for health assessment and treatment planning.</p> <p>Policy team notes that the patient group are currently eligible to access the chronic disease management items when considered clinically appropriate by the treating practitioner. It is not standard practice to specifically name eligible patient groups for these items, and not the preferred option of the policy team in this instance.</p> <p>Policy team notes that the health assessment items are not available for this group specifically unless they come under one of the eligible cohorts. The health assessment items are currently under review.</p>	

	<p>80100, 80105, 80110 and 80115 for provision of FPS services by a psychologist; 91169, 91170, 91183 and 91184 for provision of video conference and phone FPS services by a psychologist; 80125, 80130, 80135 and 80140 for provision of FPS services by an occupational therapist; 91172, 91173, 91185 and 91186 for provision of video conference and phone FPS services by an occupational therapist; 80150, 80155, 80160 and 80165 for provision of FPS services by a social worker; and 91175, 91176, 91187 and 91188 for provision of video conference and phone FPS services by a social worker.</p> <p>Psychiatrist attendance items</p> <p>291 Professional attendance of more than 45 minutes in duration following referral of the patient to the consultant for an assessment and written management plan for GP 293 Professional attendance of more than 30 minutes but not more than 45 minutes - review of management plan (291) 296 Professional attendance of more than 45 minutes in duration - new patient or not seen in preceding 24 months 300 Professional attendance of not more than 15 minutes in duration at consulting rooms 304 Professional attendance of more than 30 minutes, but not more than 45 minutes 306 Professional attendance of more than 45 minutes, but not more than 75 minutes</p> <p>Nurse Practitioner attendance items</p> <p>82200 - attendance by nurse practitioner straight forward in nature 82205 - attendance by nurse practitioner less than 20 minutes 82210 - attendance by nurse practitioner at least 20 minutes 82215 - attendance by nurse practitioner at least 40 minutes</p>		
Consultation with surgeon			
<p>Clinical services: consultations to take further specific history and examinations with specialist plastic surgeons, specialist urologists, specialist obstetricians +/- specialist liaison psychiatrists</p>	<p>Specialist attendance items</p> <p>104 Professional attendance by a specialist at consulting rooms or hospital - initial 105 Professional attendance by a specialist at consulting rooms or hospital - subsequent</p> <p>Consultant Physician attendance items</p> <p>110 Professional attendance by a consultant physician -initial attendance in a single course of treatment.</p> <p>116 Professional attendance by a consultant physician — an attendance (other than a service to which item 119 applies) after the initial attendance in a single course of treatment</p> <p>132 Professional attendance by a consultant physician lasting at least 45 minutes for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders)</p> <p>133 Professional attendance by a consultant physician lasting at least 20 minutes after the initial attendance in a single course of treatment for a review of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders)</p>	<p>Policy team considers that the existing specialist items would support patient consultations with surgeons.</p>	
Patient/surgeon accesses multi-disciplinary team			
<p>Clinical services: After patient consultations with surgeons, and prior to undergoing surgery, assessment by a multi-disciplinary team</p> <p>Identifying and planning the treatment and services that will be provided by each member of the multidisciplinary team, explaining the expected outcomes and risks of the treatment plan to the patient and preparing a written record of the patients care plan.</p> <p>Team make-up will vary but may include sexual health physicians, endocrinologists, members of surgical team (plastic surgeon, urologist, ENT surgeon, gynaecologist, anaesthetist, surgical nurses), GPs, psychiatrists, other mental health workers, psychologists, peer workers, speech pathologists and social workers.</p>	<p>Endocrinologist/consultant physician case conference items</p> <p>Consultant Physician has organised and coordinated case conference 820 conference of at least 15 minutes but less than 30 minutes 822 conference of at least 30 minutes but less than 45 minutes 823 conference of at least 45 minutes</p> <p>Consultant Physician has attended case conference 825 conference of at least 15 minutes but less than 30 minutes 826 conference of at least 30 minutes but less than 45 minutes 828 conference of at least 45 minutes</p> <p>GP case conference items</p>	<p>Policy team considers that case conference items for specialists may need to be considered, other relevant disciplines have access to existing case conference items.</p> <p>Policy team considers that the existing case conference items with the addition of case conference items for specialists may support multidisciplinary treatment planning.</p>	

<p>GP has organised and coordinated case conference</p> <p>735 conference lasts for at least 15 minutes</p> <p>739 conference lasts for at least 20 minutes, but for less than 40 minutes</p> <p>743 conference lasts for at least 40 minutes</p> <p>GP has attended case conference</p> <p>747 conference lasts for at least 15 minutes, but for less than 20 minutes</p> <p>750 conference lasts for at least 20 minutes, but for less than 40 minutes</p> <p>758 conference lasts for at least 40 minutes</p>	
<p>Psychiatrist case conference items</p>	
<p>Psychiatrist has organised and coordinated case conference</p> <p>855 conference of at least 15 minutes but less than 30 minutes</p> <p>857 conference of at least 30 minutes but less than 45 minutes</p> <p>858 conference of at least 45 minutes</p> <p>Psychiatrist has attended case conference</p> <p>825 conference at least 15 minutes but less than 30 minutes</p> <p>826 conference of at least 30 minutes but less than 45 minutes</p> <p>828 conference of at least 45 minutes</p>	
<p>Sexual health practitioner case conference items</p>	
<p>Sexual Health practitioner has organised and coordinated case conference</p> <p>Item 6064 conference less than 15 minutes</p> <p>Item 6065 conference at least 15 minutes but less than 30 minutes</p> <p>Item 6067 conference at least 30 minutes but less than 45 minutes</p> <p>Item 6068 conference at least 45 minutes</p> <p>Sexual Health practitioner has attended case conference</p> <p>Item 6071 conference less than 15 minutes</p> <p>Item 6072 conference at least 15 minutes but less than 30 minutes</p> <p>Item 6074 conference at least 30 minutes but less than 45 minutes</p> <p>Item 6075 conference at least 45 minutes</p>	
<p>Allied health practitioner case conference items</p>	
<p>Item 10955, 10957, and 10959 provide for attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team.</p> <p>10955 - at least 15 minutes, but for less than 20 minutes</p> <p>10957 - at least 20 minutes, but for less than 40 minutes</p> <p>10959 - at least 40 minutes</p>	

Post surgical consultation

Clinical services:

Post operative surgical assessment

Monitoring for surgery-related adverse events and complications

Nurse practitioner consultation for discussion of surgical care

Mental health support

MBS services (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient (referred to as "aftercare").

Aftercare is deemed to include all post-operative treatment rendered by medical specialists and consultant physicians, and includes all attendances until recovery from the operation.

[Specialist attendance items](#)

104 Professional attendance by a specialist at consulting rooms or hospital - initial

105 Professional attendance by a specialist at consulting rooms or hospital - subsequent

[Consultant Physician attendance items](#)

110 Professional attendance by a consultant physician -initial attendance in a single course of treatment.

116 Professional attendance by a consultant physician — an attendance (other than a service to which item 119 applies) after the initial attendance in a single course of treatment

[Consultant Physician Discharge Multidisciplinary case conference items](#)

Post surgical attendances are covered under aftercare for surgical surgery items. Surgical nurse care is currently not covered under Medicare.

Policy team notes consultant physicians and GPs have access to patient discharge case conference items, consideration of specialist access to discharge case conference items may be relevant to support multidisciplinary post discharge treatment planning.

At the completion of the aftercare period for a surgical procedure the existing specialist and consultant physician attendance items may be relevant to the patient's care.

	<p>Consultant Physician has organised and coordinated discharge case conference</p> <p>830 - at least 15 minutes but less than 30 minutes 832 - at least 30 minutes but less than 45 minutes 834 - at least 45 minutes</p> <p>Consultant Physician has attended discharge case conference</p> <p>835 - at least 15 minutes but less than 30 minutes 837 - at least 30 minutes but less than 45 minutes 838 - at least 45 minutes</p>		
Ongoing management			
<p>Clinical services:</p> <p>Once the surgery is completed, an individual should continue to be monitored, but this may be performed by the GP, rather than the surgeon or multi-disciplinary team.</p>	<p>MBS services (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient (referred to as "aftercare").</p> <p>Aftercare is deemed to include all post-operative treatment rendered by medical specialists and consultant physicians, and includes all attendances until recovery from the operation.</p> <p>Under Medicare General practitioners providing post-operative treatment to a patient during an aftercare period for surgery are eligible for Medicare benefits under the relevant item if they did not perform the initial procedure requiring post-operative treatment.</p> <p>GP attendance items</p> <p>Item 23 (and telehealth 91800) Professional attendance by a general practitioner lasting less than 20 minutes Item 36 (and telehealth 91801, phone 91900) Professional attendance by a general practitioner lasting at least 20 minutes Item 44 (and telehealth 91802, phone 91910) Professional attendance by a general practitioner lasting at least 40 minutes Item 123 (and telehealth 91920) Professional attendance by a general practitioner lasting at least 60 minutes (listed 1 November 2023) Item 91891 Phone attendance by a general practitioner lasting at least 6 minutes Item 92715 Telehealth attendance (and phone 92731) for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of not more than 5 minutes Item 92718 Telehealth attendance (and phone 92734) for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 5 minutes in duration but not more than 20 minutes Item 92721 Telehealth attendance (and phone 92737) for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 20 minutes in duration but not more than 40 minutes 92724 Telehealth attendance (and phone 92740) for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner lasting at least 40 minutes in duration</p> <p>Sexual health practitioner attendance items</p> <p>Item 6051 Professional attendance by a sexual health medicine specialist - initial Item 6052 Professional attendance by a sexual health medicine specialist -subsequent Item 6057 Professional attendance by a sexual health medicine specialist of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities Item 6058 Professional attendance by a sexual health medicine specialist of at least 20 minutes after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities</p> <p>Endocrinologist (Consultant Physician) attendance items</p>	<p>Policy team consider that generally the Medicare "aftercare" arrangements are adequate for post surgery management. At the completion of the aftercare period there are a range of attendance items for ongoing management and support of patients.</p>	

110 Professional attendance by a consultant physician -initial attendance in a single course of treatment.
116 Professional attendance by a consultant physician — an attendance (other than a service to which item 119 applies) after the initial attendance in a single course of treatment
132 Professional attendance by a consultant physician lasting at least 45 minutes for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders)
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82200 - attendance by nurse practitioner straight forward in nature
82205 - attendance by nurse practitioner less than 20 minutes
82210 - attendance by nurse practitioner at least 20 minutes
82215 - attendance by nurse practitioner at least 40 minutes
Chronic Disease Management items
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Item 721 (and telehealth 92024) Preparation of a GP Management Plan
Item 723 (and telehealth 92025) Coordination of Team Care Arrangements
Item 732 (and telehealth 92028) Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements
Allied health services
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Psychological services

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91172, 91173, 91185 and 91186 for provision of video conference and phone FPS services by an occupational therapist;
80150, 80155, 80160 and 80165 for provision of FPS services by a social worker; and
91175, 91176, 91187 and 91188 for provision of video conference and phone FPS services by a social worker.

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s22

From: s37(1)(c) <s37(1)(c)@plasticsurgery.org.au>
Sent: Tuesday, 9 November 2021 2:22 PM
To: SurgicalServices; s22
Cc: s37(1)(c)
Subject: Letter and list re gender affirming surgeries
Attachments: ASPS Letter to DoH - using MBS for Gender Affirming Surgeries_9 Nov 2021.pdf;
 ASPS Gender affirmation surgeries existing MBS Items_Nov 2021.pdf

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Dear s22 and s22
 Please find attached letter from s37(1)(c) on ASPS interim list of MBS item numbers which can be used for gender affirming surgeries. Also attached is the list as requested.

s22

Thank you for your patience with this. Given the complexity in this area of surgery it has taken longer than originally anticipated to ensure accurate information is conveyed.

Kind regards,

s37(1)(c)

s37(1)(c) | s37(1)(c) | (Tues/Fri AM)

Australian Society of Plastic Surgeons

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A: Suite G01, Ground Floor, 69 Christie Street, St Leonards, NSW 2065

W: www.plasticsurgery.org.au

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We acknowledge the Aboriginal people as the First Australians and pay respect to Elders past and present.

We are pleased to be able to assist you on this occasion. Positive feedback really helps to encourage the public to visit our website and use our content to educate themselves before beginning their plastic surgery journey. If you wouldn't mind leaving a review, it would be much appreciated." [Google Review](#)

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RESEARCH TRANSLATION PAPER

LGBTQ+ People and Mental Health Services Research

Prepared for
Commonwealth Department of Health and Aged Care

By
University of Technology Sydney
and research partners

December 2023

Acknowledgements

The University of Technology Sydney acknowledges the Eora Nation and the Dharug Nation, upon whose ancestral lands our university stands. We would also like to pay respect to the Elders both past and present, acknowledging them as the traditional custodians of knowledge for these lands.

We would like to sincerely thanks staff in the Commonwealth Department of Health and Aged Care for their input, advice, and support throughout the project, and to various peer reviewers, whose combined comments greatly assisted the finalisation of the project end-products.

About the authors

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- Edwina Deakin (Project Manager), Clara Mills, and Cindy Yin from [UTS Institute for Public Policy and Governance](#)
- Associate Professor Jo River, [UTS Faculty of Health](#), and Northern Sydney Local Health District. Professor Deborah Parker, Dr. Daniel Demant, Dr. Sophie Isobel, Holly Kemp, Katie Thorburn, Saskia Zhethoven, Nayonika Bhattacharya, and Nash Wall from [UTS Faculty of Health](#).

The UTS Faculty of Health team includes members of the Rainbow Embassy and associates, who are LGBTQ+ people with a lived experience of life interrupting mental health challenges, and/or suicidality, and of accessing mental health and suicide prevention services.

- Dr Priya Vaughan, University of New South Wales, Black Dog Institute, and the Knowledge Translation Strategic Platform, Maridulu Budyari Gumal SPHERE
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Glossary

ABS	Australian Bureau of Statistics
APA	American Psychiatric Association
APS	Australian Psychological Society
Asexual	The term asexual specifically refers to people who experience little to no sexual attraction or desire for sexual contact. However, the term asexual is also used to describe people across a spectrum with varied experiences, levels, and consistency of sexual attraction. This includes 'gray-sexual' people and demi-sexual people, among others.
CALD	Culturally and linguistically diverse
CBT	Cognitive behavioural therapy
Department	Commonwealth Department of Health and Aged Care
DSM	Diagnostic Statistical Manual
GP	General Practitioner
GSS	General Social Survey
People with innate variations of sex characteristics	A term used to describe a people with a variety of bodies with genetic, chromosomal, hormonal, and physical variations outside the binary norms of male and female bodies. Commonly referred to as intersex people, the literature also uses a variety of other terms including diverse sex development.
IPV	Intimate partner violence
KRQ	Key Research Questions
LGBTQ+	<p>LGBTQ+ is an umbrella term used to refer to people of diverse genders and sexual orientations, including, but not limited to, people who identify as lesbian, gay, bisexual, trans, and gender diverse, queer, and pansexual.</p> <p><u>Note:</u> In this report the LGBTQ+ abbreviation is used when broadly referring to specialist policies and services, some of which may include a different range of groups. However, alternative abbreviations are used to indicate the precise groups covered by a specific service, policy, or research study.</p>
LGBTQ+SB	LGBTQ+ people including Sistergirl (S) and Brotherboy (B). SB is the preferred term used in some Aboriginal and Torres Islander communities.
LHD	Local Health District

Lived experience	Unless qualified, in this paper, references to lived experience refers to a) people with a lived experience of mental health challenges and/or suicidality, and/or b) mental health and suicide prevention service use.
Life-interrupting mental health challenges	In this paper, this term is used instead of severe and persistent mental health challenges that have significantly impacted on a person's life and service use.
MBS	Medicare Benefits Scheme
Mental health challenges	Refers to diverse experiences of social, emotional, and mental distress, and a range of suicidal thoughts and behaviours, which may be experienced by an individual or group. This definition includes, though is not limited to, those who might have received a clinical mental health diagnosis.
Mental health condition	Refers to conditions classified in medical diagnostic manuals, such as the Diagnostic Statistical Manual or the International Classification of Diseases.
NDIS	National Disability Insurance Scheme
NMHC	National Mental Health Commission
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RMHC	Residential Mental Health Care
SLR	Systematic Literature Review
UTS	University of Technology Sydney
VPC	Victorian Pride Centre

Executive Summary

About the Research

In June 2023, the Department of Health and Aged Care contracted a University of Technology Sydney (UTS) led research team to undertake an applied systematic literature review (SLR) to inform the preparation of a 10-Year National Action Plan for the Health and Wellbeing of Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, plus other people with diverse genders and sexual orientations (LGBTQIA+).

Based on the in-scope literature, and the specific research parameters (*see below*), the brief was later amended to focus on LGBTQ+ people, with the expectation that other options will be explored to attend to the specific needs of asexual people and people with innate variations of sex characteristics (commonly shortened to intersex people). The Australian Government is aware of the unique health and wellbeing needs and challenges faced by people with innate variations of sex characteristics. Options to further support this group, including exploring further research, will be considered as part of the development and ongoing consultation to support the *10-Year National Action Plan for the Health and Wellbeing of LGBTQIA+ people*.

The targeted UTS-led research was to address three key research questions (KRQ):

1. For LGBTQ+ people:
 - a. What are the key causes of distress experienced that impact on their mental health or wellbeing, and/or increase their risk of suicidal behaviours?
 - b. What are the key issues and barriers when accessing services for their mental health and/or suicide prevention services?
2. In respect to accessing services for mental health and suicide prevention, and based on a Departmental literature search of peer reviewed literature on mental health and/or suicide prevention services for LGBTQ+ people in Australia and a comparator international context (UK).
 - a. What services are available and provided to LGBTQ+ people?
 - b. What services were found to be effective?
 - c. What service gaps or barriers were identified, and what were their details?
3. What evidence-based insights can be drawn from the UK and Australian literature for Australia, to help inform policy development for the *10 Year National Action Plan for the Health and Wellbeing of LGBTQIA+ people*?

To address these, three papers were prepared for the Department:

- **Applied SLR** addressing KRQ 2 based on the 56 peer reviewed articles identified by the Department. This report included interpretation of review data with members of the UTS Rainbow Embassy and associates, comprised of LGBTQ+ people with lived

experience of mental health challenges¹ and/or suicidality, and of accessing mental health and suicide prevention services (intersecting lived experience).²

- **Research Translation Paper** (this paper) answering all three KRQ, including a summary of the Applied SLR.
- **A plain English summary** of the above.

Background

What do we know about Australia's LGBTQ+ community?

While there are substantive gaps and limitations to the available data, estimates from the Victorian Agency for Health suggest that upwards of 5.7% of the population identify as Gay/Lesbian (1.8%), Bisexual/Queer/Pansexual (3.0%), Transgender or gender diverse (0.2%), Intersex (0.2%), and Asexual/Other (0.4%).³ Many researchers however argue that actual figures are higher still.

The data that is available indicates that LGBTQ+ people experience higher rates of mental health challenges and suicidality than the general population.⁴ For example, the National Study of Mental Health and Wellbeing 2022 found that more than half of GLB+ respondents reported having a diagnosis of any mental health condition in the past 12 months (59%), compared to only 20% of heterosexual respondents. Further, 33% of transgender respondents had a diagnosis in the 12 months preceding the survey, compared to 21% of cisgender respondents.⁵ Emerging evidence also suggests that LGBTQ+ people with intersecting identities and experiences (e.g. LGBTQ+ people with disability) are at even greater risk of poor mental health and suicide outcomes.

What do we know about the mental health policy and service landscape in Australia?

There is a diverse range and distribution of services to LGBTQ+ people in Australia who need support related to mental health, wellbeing, and suicide prevention. Reflecting the broader health system, these services are administered, funded, and delivered through a mix of Commonwealth, state/territory, private, not-for-profit, and community-controlled mechanisms.

¹ We also use the terms mental health challenges or mental distress as they are broader non-pathologising terms that can encompass those people without a mental health diagnosis who experience distress.

² Collectively, Rainbow Embassy members also have experience and expertise in mental health advocacy, research and education, and peer work in in-patient and community mental health services and LGBTIQ+ specific services providing mental health support, and include First Nations LGBTQSB+ people, and LGBTQ+ people from culturally and linguistically diverse backgrounds, people with disability, and people from rural areas.

³ Victorian Department of Health, *Proportion of population who identify as LGBTIQ+*, Last modified 16 November 2023 <https://www.health.vic.gov.au/your-health-report-of-the-chief-health-officer-victoria-2018/health-inequalities/lgbtiq-victorians>

⁴ Rainbow Health Victoria, "Research Matters: How many people are LGBTIQ?", Accessed August 2023. <https://www.rainbowhealthvic.org.au/media/pages/research-resources/research-matters-how-many-people-are-lgbtiq/4170611962-1612761890/researchmatters-numbers-lgbtiq.pdf>

⁵ Australian Bureau of Statistics, "National Study of Mental Health and Wellbeing 2022 – 2023", Released: 5 October 2023, <https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release>

While most of the services available are designed for the general community, there is also a patchwork of services which are designed specifically for LGBTQ+ people (referred to as LGBTQ+ specific services). However, these specialised services are limited, with only a small number of services providing state-wide or national coverage. Evidence suggests that many mainstream mental health services are not well equipped to provide best practice care for LGBTQ+ people and can be experienced as discriminatory, pathologising, and traumatising.

There are various policies, strategies, and other mechanisms already in place at the Commonwealth and state/territory levels which are seeking to improve outcomes and services for LGBTQ+ people. This includes dedicated LGBTQ+ health or whole-of-government strategies in at least five state and territories, as well as ongoing lived experience input provided through permanent advisory infrastructure. Various community organisations, education providers, and industry bodies are also promoting new strategies, best practice guides, and other resources to support mental health and suicide prevention for LGBTQ+ people, including, for example, LGBTIQ+ Health Australia's 2021-26 Strategy).⁶

KRQ 1: Causes of Distress

The research indicates that there is no single or uniform set of factors which determine mental health, wellbeing, and suicide prevention outcomes for Australia's LGBTQ+ population. As with the general population, the causes of distress (referred to as 'stressors') are complex and include a diversity of structural, psychosocial, and biological factors.

Researchers have, however, identified specific external stressors which LGBTQ+ people have a heightened or, in some cases, unique risk of experiencing. As described in Meyer (2003)'s Minority Stress Model, exposure to external stressors can drive internal stressors such as internalised stigma, the anticipation of rejection and fear of harm. These external and internal stressors can also directly and indirectly undermine access to protective factors which support resilience and positive mental health, such as access to social support and structural resources (e.g., employment, housing, and healthcare).

For the purposes of this research, the specific stressors which can be generalised to the broader LGBTQIA+ community are categorised as:

- **Stigmatisation, discrimination, and marginalisation** at structural, institutional, and interpersonal levels. These exist in both overt and covert forms, and, among various other issues, include pathologisation and stigmatisation by health service providers.
- **Victimisation, bullying, and violence:** while data indicates that LGBTQ+ people are exposed to these issues at higher rates, the research also suggests that incidents which are explicitly driven by stigma pose an even greater risk to health and wellbeing.
- **Rejection, isolation, and loneliness** from both family and peers. While distressing in itself, these experiences can also undermine access to crucial internal, social, and

⁶ LGBTIQ+ Health Australia, *Beyond Urgent: National LGBTIQ+ Mental Health and Suicide Prevention Strategy*, Published: 1 November 2021.

structural resources (e.g., self-esteem, group-level coping support and, in the case of family, economic necessities such as housing).

- **Factors related to LGBTQ+ specific milestones:** researchers have developed competing theories regarding both the legitimacy of 'milestone' models and the impacts of the processes they describe (i.e., discovering, accepting, and disclosing identity) on mental health and wellbeing.

While the stressors outlined above can be generalised to the whole LGBTQ+ community, they vary at the level of the individual and sub-group, and with respect to intersecting experiences and sociopolitical context. The literature has also identified additional stressors related to specific LGBTQ+ subgroups (e.g., transgender people) and at the intersection of different minority statuses (e.g., LGBTQ+ people of colour).

KRQ 2: Mental health and suicide prevention services effectiveness

A definitive answer regarding the effectiveness of services could not be provided based on the literature included within the applied SLR research scope. However, findings of the review provide important insights into the current state of service provision as summarised below:

a) *What services are available and provided to LGBTQ+ people?*

None of the screened studies (56) provided a comprehensive map of the mental health services provided to LGBTQ+ people in Australia, nor the UK. A few studies, however, surveyed the mental health services that LGBTQ+ participants had accessed, which indicated that they used services across the range of different care and provider types.

In addition to a gap in general service mapping, the SLR pointed to a lack of dedicated research regarding the provision of care to some sub-groups of the LGBTQ+ population (e.g., non-binary people, gender fluid, and/or pansexual people), as well as LGBTQ+ people with intersecting identities (e.g., LGBTQ+ people from CALD backgrounds).

b) *What services were found to be effective?*

The SLR analysed the review data in respect to the six domains of health care quality put forward by the Institute of Medicine Committee.⁷ This provides a comprehensive framework to analyse evidence on the quality and performance of mental health services, including assessment of timeliness, person-centredness, effectiveness, equity, safety, and efficiency.⁸

Most of the studies examined a mix of mental health service providers, making it difficult to distinguish the perceived quality and performance of specific providers or service types – for example, between services offering diagnosis and medication, compared to those offering therapeutic or behavioural support options.

⁷ Institute of Medicine Committee on Crossing the Quality Chasm, *Adaption to mental health and addictive disorder: Improving the quality of health care for mental and substance use conditions*. (Washington, DC: Institute of Medicine, National Academies Press, 2006)

⁸ Levesque, J. F., & Sutherland, K., "Combining patient, clinical and system perspectives in assessing performance in healthcare: an integrated measurement framework", *BMC health services research*, no. 20, (2020): 1-14.

Overall, there were mixed findings regarding the quality and performance of mental health and suicide prevention services. While some LGBTQ+ people received mental health and suicide prevention services that were accessible, affirming, safe, and effective for promoting personal recovery⁹, many studies indicated difficulties related to timely access to person-centred, recovery-oriented, equitable, and safe services. Commonly identified issues with service quality and performance included:

- **Knowledge deficits** among healthcare providers and reliance on those seeking care to educate the provider about the needs of LGBTQ+ people, which could be emotionally exhausting and financially costly in terms of therapy time.
- **Microaggressions** including hetero/cis normativity, misgendering, invalidation and pathologisation of sexual orientation, gender, or sex identity. These issues were linked to increased distress and discouragement of future help seeking.
- **Difficulty accessing affirming mental health services, particularly during a crisis.** This related to timely access to recovery-oriented services that are safe, affirming, and effective. It also related to timely access to appropriate referrals.
- **Inequitable and unsafe care in inpatient and emergency services.** This included low acceptance and affirmation of sexual orientation and gender identity, and inequitable and unsafe care that could be coercive, restrictive, disempowering, and traumatising for some LGBTQ+ people, serving to reinforce rather than alleviate minority stress.

Further, the research indicated that LGBTQ+ people with intersecting identities and experiences, and some sub-populations of LGBTQ+ people (e.g., trans and gender diverse youth, women who have sex with women), are more likely to encounter stigmatising, or traumatising care situations.

Positive care experiences were more often reported in LGBTQ+ specific services, including knowledgeable, equitable and safe care, as well as appropriate referrals to affirming providers. However, these services were reported to be less equipped to support more marginalised LGBTQ+ subgroups (e.g., nonbinary people, bisexual people), or those with intersecting identities. Further, they may be insufficiently resourced to support LGBTQ+ people with intersecting experiences, specifically related to life-interrupting mental health challenges and suicidality.

c) What service gaps or barriers were identified, and what were their details?

The SLR identified numerous gaps and barriers in the mental health and suicide prevention services available to LGBTQ+ people. As the literature tended to assess a mix of services, it is hard to discern how these gaps and barriers vary with types of services or providers – however, at a high-level they can be summarised as:

⁹ Personal recovery is a key focus of Australian mental health services and challenges a narrow focus on clinical definitions and measures of recovery, emphasising instead the importance of meaning, connection, hope, empowerment and identity to promote wellbeing for people with lived experience whether or not they have clinical symptom reduction (Leamy et al., 2011).

- **Provider shortages**, long waitlists and limited operating hours, particularly with respect to accessing LGBTQ+ specific services. Limited affirming care options were particularly evident in relation to access to knowledgeable, affirming, and affordable mental health care providers, and timely referrals by mental health professionals to gender-affirming medical care.
- **Lack of lived experience involvement**, including in service development and research undertaken in partnership with LGBTQ+ people with an intersecting lived experience of mental health challenges and suicidality, and also encompassing with LGBTQ+ youth and people from diverse social backgrounds with an intersecting experience of severe and life-interrupting mental distress and suicidality.^{10,11}

There were also some gaps and barriers noted which, although applicable to the general population, could be considered a greater risk to LGBTQ+ people, due to the difficulty of finding providers that are affirming in terms of both experiences of mental distress and being LGBTQ+. These can be summarised as:

- **Inconsistencies in quality of care**, including inconsistencies between care providers and services, particularly in relation to the provision of equitable, person-centred care. For example, while many General Practitioners were perceived positively, others were “visibly uncomfortable with dealing with mental health” issues.
- **Lack of linkage** between different mental health services – including between crisis services and long-term care, and between alcohol services and mental health services.
- **Limited options** for services able to attend to intersectional needs, including limited access to equitable and safe care in a crisis or for those experiencing severe and life-interrupting mental distress and suicidality.
- **Financial costs** related to gap fees and limitations to the number of Medicare-subsidised sessions an individual can claim within a year, and to publicly available mental health services, or to the National Disability Insurance Scheme (NDIS).

In addition, gaps in evidence were also noted in the included literature, including in particular:

- Research on the care needs of those experiencing intersectional issues, especially those impacting First Nations LGBTQ+SB (plus Sistergirl and Brotherboy) populations; people from CALD backgrounds; people living in rural and remote areas, and people from low socioeconomic backgrounds.

¹⁰ Jones, Timothy W., Power, Jennifer, & Jones, Tiffany M., Religious trauma and moral injury from LGBTQ+ conversion practices. *Social Science & Medicine*, 305, (2020a): 115040–115040.

¹¹ Bellingham, Brett, Elder, Emma, Foxlewin, Bradley, Gale, Nyree, Rose, Dr. Grenville, Sam, Katy, Thorburn, Kath & River, Jo, *Co-design Kickstarter*. Community Mental Health Drug and Alcohol Research Network, 2023.

- Research related to specific subgroups of LGBTQ+ people, and specifically people with innate variations of sex characteristics, nonbinary, and asexual identifying people.
- Research on topics including: the effectiveness of services for promoting personal recovery; LGBTQ+ people receiving involuntary treatment in inpatient and community settings; and responses to mental health professionals engaging in harmful conversion practices.

KRQ 3: Research insights to help inform 10 Year National Action Plan

Notwithstanding the targeted nature of the UTS-led research, and the gaps in peer reviewed literature on current mental health and suicidal prevention services for LGBTQ+ people, the research did provide various insights that could help frame or inform future Government policies and services. This involved distilling a set of eight overarching principles, defining six priority policy directions, each supported by a set of possible actions arising (included in an attachment).

Overarching principles

The following principles, distilled from the included literature, could inform the approach, measures, and implementation of the National Action Plan:

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1] Intersecting Lived Experience

- At all levels mental health services should be guided by LGBTQ+ people with intersecting lived experience of mental health challenges (including life-interrupting challenges) and engagement with mental health services.

2] No one size fits all

- Research and service planning needs to be responsive to the diversity of needs under the LGBTQ+ umbrella: including at the individual and subgroup level, and with relation to intersectional experiences and severity of distress.

3] Focus on Service Quality

- Services should be planned, implemented and assessed against quality principles including timeliness, effectiveness, person-centredness, equity, safety, and efficiency.

4] Focus on the spectrum of needs

- Services need to be equipped to provide a continuum of care: supporting people experiencing mild distress through to life-interrupting challenges and suicidality. Focus also needs to be provided to personal recovery from a life-span perspective.

5] More than a health and service matter

- It is essential to address the factors which mediate or act as the 'social determinants' of mental health and wellbeing: including education, housing, work, family and social relations, plus disability and aging. As much as possible, a focus should be given to early intervention and prevention activities in these spaces.

6] Language matters

- The language used to describe and communicate on issues related to mental health, and LGBTQ+ people can have profound impacts. It is important to ensure that language choice is inclusive, mirrors the preferences of people with lived experience, avoids pathological framings, and evolves in line with recommendations by the community.

7] Moving with the evidence base

- As evident in this paper, the research evidence is incomplete, with significant gaps in available data. It is, therefore, essential that governments adapt and respond to the emerging evidence.

8] Ongoing monitoring, evaluation and learning

- Building on principle 4 and 7, it is essential that future policies, strategies and action plans are closely monitored and updated, informed by the lived experience of LGBTQ+ people.

Key Policy Directions

Building from the above overarching principles, the UTS-led researchers identified the following six core policy directions, with specific options arising included as an Attachment.



Options Arising

Directions	Options Arising from the Research
(1) Build on this research and leverage existing initiatives	<ol style="list-style-type: none"> 1) Undertake further research and consultations to refine, validate, and build upon the findings of the UTS-led research incorporating unpublished and grey literature, with a focus on identified gaps in evidence. 2) Consider the release of a 10-year National 'Strategy', supported by successive two- to three-year 'Action Plans', capitalising on new evidence and identified needs. 3) Collaborate with relevant Commonwealth, state, and territory governments to harmonise and strengthen evidence-based reforms and initiatives. 4) Building on the Expert Advisory Group model, establish an ongoing LGBTQ+ mental health 'Council' of individuals with intersecting lived experience of mental health to oversee the finalisation of the National 'Strategy' and provide ongoing monitoring and advice on its development and implementation.
(2) Invest in targeted research and	<ol style="list-style-type: none"> 5) Research to further understand the needs and experiences of diverse LGBTIQ+ people experiencing mental distress and/or suicidality, including tailored research to better understand the policy implementations for groups such as people with innate variations of sex characteristics, asexual people, and those impacted by intersectional issues.

improved data	<p>6) Better map the Australian mental health service system, including mainstream and LGBTQ+ specific services potentially used by LGBTQ+ people, noting unmet needs and service gaps by groups of potential users.</p> <p>7) Following from Option 6), establish methods to continuously evaluate mainstream and LGBTQ+ specific mental health services, including consideration of their access, inclusion, service quality, and overall performance for LGBTQ+ people.</p> <p>8) Research, pilot, and evaluate initiatives to reduce stressors experienced by LGBTQ+ people in the first instance, within both mainstream and LGBTQ+ specific mental health service systems. (Also see Option 21-23 regarding primary prevention initiatives.)</p>
(3) Expand LGBTQ+ specific and intersectional service offerings	<p>9) Investigate funding a diversity of additional LGBTQ+ specific mental health service options, providers, and models designed to deliver quality outcomes, with a specific focus on addressing unmet needs.</p> <p>10) Commit resources to train, recruit, and retain staff in LGBTQ+ specific services to optimally manage the spectrum of mental health care needs, with a focus on trauma-informed, personal recovery.</p> <p>11) Establish a mechanism for First Nation peoples and organisations to oversee the design, development, and implementation of First Nations LGBTQ+SB specific mental health and suicide prevention services.</p> <p>12) Expand evidence-based services for young LGBTQ+ people within and outside of mental health services, including mental health early intervention and prevention options in schools and other community settings.</p> <p>13) Action ways to better accommodate intersecting identities and sub-group needs within LGBTQ+ services.</p>
(4) Address stigmatisation, discrimination, and capabilities within mainstream health services	<p>14) Build the capacity, skills, knowledge, and understanding of mainstream health staff to ensure the provision of affirming and culturally safe services for LGBTQ+ people.</p> <p>15) Embed LGBTQ+ people with intersecting lived experience within health settings and provide meaningful opportunities for them to influence every stage of the service's development, culture, and practices.</p> <p>16) Actively support LGBTQ+ people, and particularly those with intersecting lived experience, to work in health settings, and to take up service provider roles at all levels of seniority.</p> <p>17) Update and streamline processes and referral pathways to connect LGBTQ+ people with inclusive mainstream and LGBTQ+ specific mental health providers that are able to optimally support their personal recovery.</p> <p>18) Develop and widely promote a trauma-informed, recovery-oriented, equitable, and safe care framework for Australian mental health services, which addresses minority stressors known to drive mental distress and suicidality, and which prevents traumatisation or re-traumatisation.</p>

	19) Collaborate to action current recommendations designed to overcome stigmatisation in relation to mental health and LGBTQ+ people in other health, aged care, and disability care services.
	20) Investigate and find practical options to embed multiple explanatory frameworks for understanding mental distress and service provision for LGBTQ+ people experiencing mental health distress or suicidality that incorporate understandings of minority stress and trauma.
(5) Collaborate across sectors to build connection and promote inclusion	21) Initiate a major whole-of-government and cross-sectoral health and wellbeing inclusion strategy to promote social inclusion and address sources of stigma impacting LGBTQ+ people and communities.
	22) Work with relevant Commonwealth, state, and territory agencies to promote inclusion amongst young people, in order to improve understanding and connections, and to reduce stigma and discrimination against LGBTQ+ people.
	23) Develop and promote educational resources to build the capacity of family and community to affirm LGBTQ+ people in their lives.
(6) Adopt and promote the consistent use of inclusive and affirming language	24) Update and standardise the inclusivity of language and terminology used in all mainstream health, mental health, and wellbeing services, including services provided by religious organisations. (Also see Principle 6)
The report also posed two options on reducing barriers to accessing gender affirming care, albeit noting that the applied SLR literature did not provide a comprehensive perspective on this issue.	

Conclusion

The evidence reviewed as part of this research indicated the need for significant investments to ensure that Australia's mental health service system and accompanying sectors are able to support the diversity of LGBTQ+ health and wellbeing needs. This includes both improvements to the design and delivery of services, as well as consideration to strategies to address causes of distress (e.g., discrimination and violence).

In addition, the research highlighted significant gaps in the available data and research to inform LGBTQ+ health and wellbeing policy. As such, while the authors sought to answer the KRQs, a complete and definitive answer to any of the questions was not possible within the scope of the available evidence and will require significant investments in future research, with a particular focus on gaps in the evidence identified through this, and other, research.

1 Introduction

This report provides a background to drivers of mental health challenges and suicidality amongst people who are lesbian, gay, bisexual, trans and gender diverse, queer, and other sexual orientations and diverse gender identities (LGBTQ+). It also presents findings from a systematic literature review (SLR) of mental health and suicide prevention services provision to LGBTQ+ people, and related implications for mental health and suicide prevention services and research in Australia.

The research was conducted by a University of Technology Sydney (UTS) led research team for the Commonwealth Department for Health and Aged Care (the Department).

1.1 Purpose of the Research

In May 2023, the Department sought expressions of interest from independent research institutes to undertake an independent SLR to help inform the development of the mental health and wellbeing component of Australia's first *10-Year National Action Plan for the Health and Wellbeing of LGBTIQ+ people*.

The SLR built on the initial research design and literature search conducted by the Department and reviewed published, peer-reviewed research on mental health and/or suicide prevention services for LGBTIQ+ people in Australia and a comparator international context (UK).

Based on the in-scope literature, the research parameters (see Sections 1.2 – 1.4) and feedback received from sector experts, the brief was later amended to cover only LGBTQ+ people, with the expectation that other options will be explored to attend to the specific needs of asexual people and people with innate variations of sex characteristics (commonly shortened to intersex people).

In June 2023, a UTS-led project team was commissioned to undertake the background and SLR project. The team included senior researchers from:

- [UTS Faculty of Health](#)
- [UTS Institute for Public Policy and Governance](#)
- [University of New South Wales, Black Dog Institute](#)
- [University of Sydney, Faculty of Medicine and Health](#)

The research interpretation was informed by advice from members of the UTS Rainbow Embassy and associates, comprised of LGBTQ+SB (plus Sistergirl/ Brotherboy) people with a lived experience of life-interrupting mental health challenges and/or suicidality, and of accessing mental health and suicide prevention services (intersecting lived experience)¹².

¹² Collectively, Rainbow Embassy members also have experience and expertise in mental health advocacy, research and education, and peer work in in-patient and community mental health services and LGBTIQ+ specific services providing mental health support.

1.2 Research Focus

1.2.1 Key Research Questions

The Department and the UTS-led research team co-developed the following Key Research Questions (KRQ) to guide the overall research:

4. For LGBTQ+ people:
 - a. What are the key causes of distress experienced that impact on their mental health or wellbeing, and/or increase their risk of suicidal behaviours?
 - b. What are the key issues and barriers when accessing services for their mental health and/or suicide prevention services?
5. In respect to accessing services for mental health and suicide prevention, and based on peer-reviewed literature:
 - a. What services are available and provided to LGBTQ+ peoples?
 - b. What services were found to be effective?
 - c. What service gaps or barriers were identified, and what were their details?
6. What evidence-based insights can be drawn from the UK and Australian literature for Australia, to help inform policy development for the *10 Year National Action Plan for the Health and Wellbeing of LGBTIQ+ people*?

1.2.2 Definitions

Unless otherwise stated, the following definitions have been adopted for this research:

- **LGBTQ+** is an umbrella term used to refer to people of diverse genders and sexual orientations, including but not limited to people who identify as lesbian, gay, bisexual, trans and gender diverse, queer, and pansexual.
Note: In this report the LGBTQ+ abbreviation is used when broadly referring to specialist policies and services, some of which may include a different range of groups. However, alternative abbreviations are used to indicate the precise groups covered by a specific service, policy, or research study.
- **LGBTQ+SB** when referring to the Aboriginal and Torres Strait Islander LGBTQ+ community, as some trans and gender diverse people use the terms Sistergirl (S) and Brotherboy (B).
- **Intersecting lived experience** refers to people with a lived experience of being LGBTQ+ with experience of mental health challenges, suicidality and/or mental health and suicide prevention service use.
- **Mental health challenges and suicidality** refers to diverse experiences of social, emotional, and mental distress, and a range of suicidal thoughts and behaviours, which may be experienced by an individual or group. This definition includes, though is not limited to, those who might have received a clinical mental health diagnosis.

- **Services for mental health and suicide prevention** (as expanded upon in Section 3.4) comprise:
 - Primary health services – predominately general practices, community health centres, and Primary Health Network (PHN) services, often serving as an entry level to the health system, though can continue in some instances as the prime provider of mental health advice and support.
 - Specialist mental health and suicide prevention services (public or private), which may be in-patient, or community based. These are delivered by mental health practitioners, including: psychologists, psychiatrists, mental health nurses, allied health workers, therapists and counsellors, and peer workers.
 - LGBTQ+ specific services delivered by an LGBTQ+ organisation offering mental health and suicide prevention services and support provided by mental health practitioners (see above).
- **Stressors** refers to internal and external factors or determinants which can impact mental health and wellbeing.

Other key terms and acronyms used are listed in the Glossary at the front of the report.

1.2.3 Project Deliverables

To deliver on all KRQ, it was agreed that three separate documents would be prepared for the Department:

Deliverable 1: Research Translation Report (this paper)

This paper contains a summary of the evidence base and advice arising from this commissioned research:

- Section 2: Provides a profile of Australia's LGBTQ+ community and available prevalence rates regarding mental health challenges.
- Section 3: Contains an overview of the mental health, wellbeing, and suicide prevention services in Australia, plus a summary of the current policy landscape.
- Section 4: Addresses KRQ 1, providing an overview of the *key causes of distress experienced by the LGBTQ+ community that impact on their mental health or wellbeing, and/or increase their risk of suicidal behaviours. This section draws from a cross section of peer-reviewed and grey literature.*
- Section 5: Contains a summary of the second deliverable – the Applied SLR (see details below) – and addresses KRQ 2.
- Section 6: Presents the synthesis of all research conducted, answering KRQ 3 – *What evidence-based insights can be drawn from the UK and Australian literature for Australia, to help inform policy development for the 10 Year National Action Plan for the Health and Wellbeing of LGBTIQ+ people?*

Deliverable 2: An applied SLR of peer-reviewed literature

In the first half of 2023, the Department identified 1895 potential abstracts drawn from peer-reviewed literature in Australia and the UK between February 2013 and February 2023.

As illustrated in the updated PRISMA diagram at Figure 1, the Department then selected 369 research papers for potential inclusion in the SLR.

The UTS-led research team screened each abstract and, excluding duplicates, were left with 352 texts. The full texts of each of these were then screened against the following exclusion criteria:

- 1) The paper is not peer-reviewed and published.
- 2) The paper is not about LGBTQ+ people.
- 3) The paper is not about accessing services for mental health challenges or suicidality.
- 4) The paper is not a primary study (for example, a protocols or case study).
- 5) The paper is not Australia or United Kingdom focused.
- 6) The paper is not published between February 2013 and February 2023.
- 7) The paper is solely about people with an innate variation of sex characteristics or who were asexual.*

* The 7th exclusion criteria was applied retrospectively following feedback from sector experts that the literature included in the SLR omitted key literature on these target groups. As this could not be corrected within the timeframe restrictions of the present research, the brief was later amended to cover only LGBTQ+ people, with the expectation that other options will be explored to attend to the specific needs of asexual people and people with innate variations of sex characteristics.

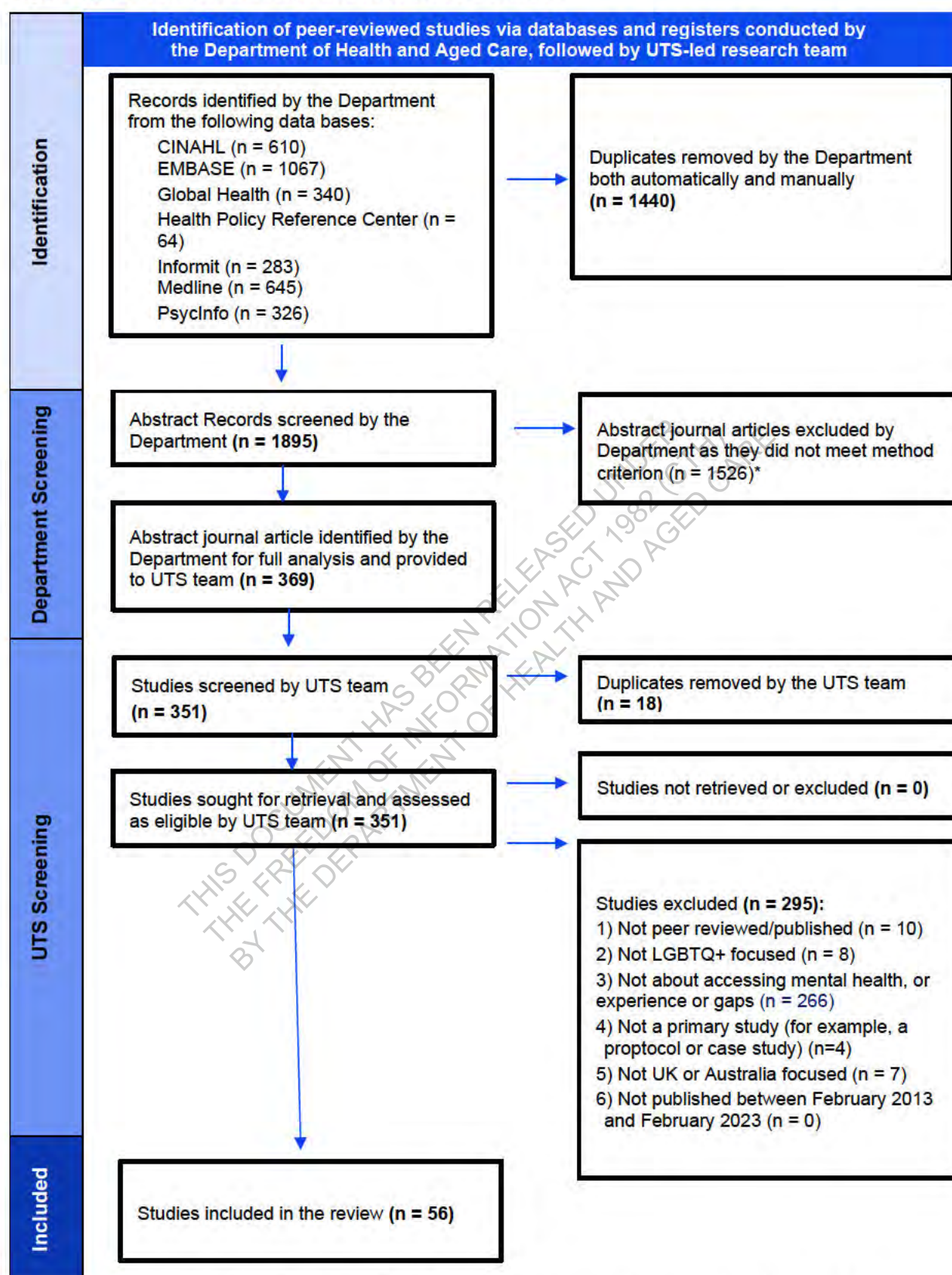
This process left a total of 56 texts that were the subject of the systematic literature review focused on addressing KRQ 2: *In respect to accessing services for mental health and suicide prevention, and based on peer reviewed literature:*

- a. *What services are available and provided to LGBTQ+ peoples?*
- b. *What services were found to be effective?*
- c. *What service gaps or barriers were identified, and what were their details?*

Further information about the SLR is included at Attachment 1. A summary of its key findings is included at Section 5 of this report.

Deliverable 3: Summary Paper of the other two deliverables, written in plain English.

Figure 1: PRISMA flow diagram of included studies



Source: Department of Health and Aged Care and UTS-led research team, using Covidence and PRISMA software, October 2023. *Records were excluded by a human. Adapted from Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71.

1.3 Methodology

As documented above, this paper draws on a mixed methodology including:

- Targeted desktop review of:
 - Peer-reviewed and grey literature, including government policy papers, LGBTQ+ advocacy papers, and other publications, with a specific focus on Australia sources. These are included at Reference List A.
 - Targeted United Kingdom and Australian peer-reviewed literature used in the SLR. These are included at Reference List B.

It should be noted that due to the commissioned project scope and timing, this should not be considered a comprehensive review of all available literature.

- Feedback and insights drawn from:
 - Subject matter experts on the UTS-led research team (see inside cover of this report).
 - Rainbow Embassy and associates, with interpretation of SLR literature undertaken at three timepoints, during the week beginning 18 September, 5 October, and 16 October 2023.
 - Departmental feedback and advice on draft papers and provided during fortnightly work-in-progress meetings held from July and November 2023.

1.4 Research qualifications and limitations

As with all research, there were a number of limitations that should be noted when reading this Report. These limitations are not designed to undermine the findings that follow, but rather are to: a) acknowledge the research is not a definitive review of all available evidence; and b) the in-scope texts were solely interrogated to answer the specified KRQ as part of this commissioned and time-limited research project.

As such, the research hereafter should be considered with respect to the following qualifications and limitations:

- **Constraints posed by the short research timeframe and available resources** to ensure the final research products met the Department's policy development timelines and budget requirements.
- **Limitations to the publicly available data, research, and information.** These limitations relate to:
 - Publicly available data on LGBTQ+ populations in Australia, including breakdowns on sub-groups therein.
 - Research related to LGBTQ+ people with intersecting lived experience of mental health challenges and/or suicidality, including subgroups of people covered in the LGBTQ+ abbreviation and intersectional experiences. While this is an issue for all listed groups, the authors noted that available research and data was particularly thin for non-binary and gender fluid people, and pansexual people, among others, as

expanded upon in other parts of this report. For this reason, caution should be taken in inferring that all findings relate to these groups, each of which comprises a unique set of health, wellbeing, and general service needs and aspirations.

- **Reliance on English language sources** due to the timeframes, budget, and language skills of the researchers, thereby limiting learnings and perspectives that could be drawn from other language sources and countries.
- **Limited lived experience input.** While the co-interpretation of the research findings was immensely valuable (see above), members of the Rainbow Embassy and associates were not involved in research design, nor should their involvement be construed as a consultative process, involving gathering insights from a representative sample of Australians with lived experience.

Further, while Rainbow Embassy members do include intersectional perspectives, they do not speak for all LGBTQ+ people.

This said, the UTS-led research team understands, and strongly supports, that the Department is undertaking a robust consultation process in addition to this research. This is essential to ensure lived experience perspectives are overlayed onto what is predominately desktop research.

In addition, and as noted in the companion applied SLR report, there are a number of other research limitations associated with the SLR methodology and exclusion criteria. While the findings nonetheless provide an important contribution to knowledge on LGBTQ+ mental health and wellbeing in the Australian context, future research should be undertaken to provide a comprehensive analysis of existing literature and to address identified research gaps.

The SLR limitations include:

- **Reliance on the Department's initial literature searches** undertaken in early 2023. As per the research contract and timeframe, UTS-led researchers were not in a position to undertake a normal academic review process, such as searches for missing literature, or cross-checks for research bias, omissions, or other reliability issues. As such the listed SLR articles should be taken at face value.
- **Restrictions of the literature search to solely Australia and the UK**, as determined by the Department. As such, the SLR lacks findings and insights that could have been drawn from other jurisdictions, which should be addressed in future research.
- **Restrictions of the publication timeframes**, solely to those published between February 2013 and February 2023. As a result, any key studies published before or after these dates are not covered in the SLR.
- **Restrictions to solely peer-reviewed, academic literature.** While there are long established benefits of relying on peer-reviewed and vetted texts, this excluded the option to gather evidence and insights found in grey literature, including policy documentation, service reviews, or advocacy papers, available from credible sources including government agencies, research institutes or not-for-profit and/or peak body organisations, such as LGBTIQ+ Health Australia (LHA).

- **Limitations related to the search terms used.** Reviews undertaken by industry experts noted that limitations to the search terms used led to the unintended omission of key studies from the research. In particular, the present research did not search for literature under the term “innate variations in sex characteristics”. Future research should consult with lived experience advisors and a wider array of sector experts to ensure the search terms used are fully inclusive of the target populations.

Notwithstanding these limitations, the UTS-led research team has prepared a robust Research Translation Report, and its members are proud to stand behind their evidence-based findings, analysis, and conclusions.

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2 Australia's LGBTQ+ community

This section provides an overview of the available evidence on Australia's LGBTQ+ community, and the prevalence of their mental health challenges and suicidality. It provides the background and context against which other sections of this report should be read.

Further information about method and focus can be found at Section 1.2.

2.1 About this Section and Data Availability

The UTS-led research team wish to note that there are gaps in available data on Australia's LGBTQ+ community, which should be noted prior to reading the profiling content summarised in this section. These gaps are driven by a number of factors, as summarised below:

1. **National and state-level data collection instruments are still in the process of being refined to capture meaningful information on sexual orientation and gender diversity.** A notable example of this issue can be seen in the formal complaint brought against the Australian Bureau of Statistics (ABS) in 2022 alleging unlawful discrimination against LGBTIQ+ people in the 2021 Census for failing to ask appropriate questions on sexual orientation, gender identity, and innate variations in sex characteristics. While the ABS has since committed to re-evaluating its approach for the 2026 Census with the support of a LGBTIQ+ Expert Advisory Committee¹³, in the interim Australia lacks significant data to support evidence-based policy making and service provision to LGBTIQ+ people.¹⁴
2. While the evolution of terminology to describe sexual orientation and gender diversity empowers communities to redefine and refine their understanding of themselves and each other over time, **changing and overlapping terminologies can also create various difficulties related to data collection and analysis.** Inconsistencies in the terminology used across instruments, therefore, complicate the processes of estimating population size, tracing population changes over time, and making useful comparisons across jurisdictions¹⁵.

¹³ Australian Bureau of Statistics, "Statement of Regret - 2021 Census," accessed August 2023, <https://www.abs.gov.au/media-centre/media-statements/statement-regret-2021-census>.

¹⁴ Equality Australia, "ABS Admits New Recommendations Required to Count LGBTIQ+ People Properly in Census," accessed August 2023, <https://equalityaustralia.org.au/abs-admits-new-recommendations-required-to-count-lgbtqi-people-properly-in-census/>.

¹⁵ For example, in consultation with the community, La Trobe University has adjusted and expanded the terminology used in their *Writing Themselves in* surveys, which focuses on the experiences of LGBTQIA+ youth. The terminology used to capture data on gender diverse youth has expanded from a single 'gender-questioning' option in 2010, to include 19 gender identity options in 2021. (Hill AO, Lyons A, Jones J, McGowan I, Carman M, Parsons M, Power J, Bourne A 2021, *Writing Themselves*

3. **Data collection instruments can only capture information on individuals willing to identify as LGBTQ+.** Willingness to disclose sexual orientation and gender diversity in a survey or other instrument can be influenced by various factors, such as the broader social and legal environment, how people understand and define their sexual orientation and gender identity, and their confidence that survey responses will remain confidential.¹⁶ It is, therefore, possible that current data only captures a portion of the LGBTQ+ population in Australia.

While the research team notes that a number of state and territory governments have committed to improving their data collection practices (see Section 2.3.2), these limitations in data should be further considered by Governments at all levels.¹⁷

All figures in this section have been rounded to the nearest whole numbers. Researchers are referred to the source documents for more accurate numbers and percentages.

2.2 Demographic Overview

As outlined above, Australia currently lacks a comprehensive source of data on LGBTQ+ people and, as a result, the demographic data below only provides a partial picture of the communities. Significantly, there is an absence of Australian population-level data on people of diverse genders. Further, in many cases, the limited publicly available data artificially groups communities and provides limited information regarding intersections with other demographic characteristics – making it difficult to highlight differences within and between groups.

With these limitations in mind, Australian researchers currently use the following broad population estimations for LGBTQ+ people¹⁸:

- According to the 2020 ABS General Social Survey (GSS), approximately 4% (or 773,000) of the Australian population identify as gay, lesbian, bisexual, or another term to describe their sexual orientation (shortened in this section when referring to this survey as GLB+). This marks a 1% total increase and roughly 33% proportional increase to self-reported GLB+ compared to 2019 (3%) and is consistent with estimates from other Australian population studies.¹⁹ Neither this, nor any other existing Australian population survey, appears to provide specific data on other sexual orientations, such as 'queer' or 'pansexual'.

In 4: The health and wellbeing of LGBTQ+ young people in Australia, National report, monograph series number 124. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University p. 26).

¹⁶ Rainbow Health Victoria, "Research Matters: How Many People Are LGBTQI?"

¹⁷ It should also be noted that organisations such as LHA have been campaigning to improve the way LGBTQ+ data is collected across Australia. Among other actions, this has included campaigning and the development of submissions to support the proposed inclusion of *gender, sexual orientation, and variations of sex characteristics* as new topics in the 2026 Census.

¹⁸ Rainbow Health Victoria, "Research Matters: How many people are LGBTQI?"

¹⁹ Rainbow Health Victoria, "Research Matters: How many people are LGBTQI?"

- The Second Australian Study of Health and Relationships (ASHR2) found that a higher proportion of Australians reported attraction or sexual interaction with people of the same gender – approximately 19% of women and 9% of men.²⁰
- In the absence of Australian data, roughly 1% of people participating in international research have reported identifying as 'transgender'. The studies available reportedly do not capture data on broader gender diverse identities or expressions.²¹

Limited Australian population studies have also provided more detailed demographic data on gay, lesbian, bisexual, and other sexual orientations (GLB+). For example, the GSS indicated that Australia's GLB+ population has a relatively young age profile compared to the general population. As outlined in Figure 2, over three-quarters (78%) GLB+ respondents were under 40 years of age, while only 40% of respondents who identified as heterosexual were under 40 years of age.²²

Figure 1: Age profile of sexually diverse people in Australia

	15-24 years	25-39 years	40-54 years	55+ years	Totals
Gay, Lesbian, Bisexual and Other (as defined by ABS)	29%	49%	13%	12%	100%
Heterosexual	14%	26%	24%	35%	100%

Source: ABS, General Social Survey 2014, 2019 and 2020 (Canberra: ABS, 2021); Parliamentary Library calculations.

The GSS also found that there were no notable differences between the GLB+ and heterosexual respondents in terms of family composition. However, a much lower proportion of GLB+ reported being in a registered marriage (over 11%, compared to nearly 51%), and a much higher proportion reported being in a de facto relationship (30%, compared to 11%).

A higher proportion of GLB+ respondents (64%) were fully engaged in either employment or study compared to heterosexual respondents (50%). Conversely, a slightly lower proportion of GLB+ respondents reported acting as a carer (8.8%) for a person with either a disability, long-term health condition or old age compared to heterosexual respondents (8.8%).

The 2021 ABS Census also captured information on living arrangements. While the survey did not explicitly ask sexual orientation questions concurrent with cohabitation and relationship status, cross analysis with other variables allows some inferences to be drawn. For example, the 2021 Census counted 78,425 same-sex couples (identifying as de facto or married) living together in Australia.

²⁰ Rainbow Health Victoria, "Research Matters: How many people are LGBTIQ?"

²¹ Rainbow Health Victoria, "Research Matters: How many people are LGBTIQ?"

²² Australian Bureau of Statistics. "General Social Survey 2020: Summary Results Australia – Table 5.3." Accessed August 2023. <https://www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/latest-release>.

The geographic distribution of same-sex couples living together was not dissimilar to the distribution of couples living together in the general population. NSW and Victoria both accounted for the majority of same-sex couples living together, at 61% of the total. Further, same sex couples were most likely to live in capital cities compared to all couples.

Overall, the number of same-sex couples across all jurisdictions has increased since 2011.

2.3 Mental health and wellbeing in the LGBTQ+ community

While Australia lacks comprehensive data on LGBTQ+ communities, the data that is available suggests that such communities more commonly experience poor mental health and suicide outcomes than the general population.

The sections below provide a broad summary of data on LGBTQ+ mental health and wellbeing, compared to the general population. A detailed breakdown of available evidence by sub-groups and different mental health conditions can be found in LHA's 2021 [*Snapshot of Mental Health and Suicide Prevention Statistics*](#).

2.3.1 Mental Health Conditions²³

Although many LGBTQ+ people live happy and health lives, evidence indicates that compared to the general population they have higher rates of mental distress and are more likely to be diagnosed with a mental health condition.²⁴ For example, the *National Study of Mental Health and Wellbeing 2022* (NSMHW 2022) found that more than half of GLB+ respondents reported having a diagnosis of a mental health disorder in the past 12 months (59%), compared to only 20% of heterosexual respondents. Almost one third (33%) of transgender respondents had a diagnosis in the 12 months preceding the survey, compared to 21% of cisgender respondents.²⁵

The data available suggest that, on average, LGBTQ+ score higher on the Kessler Psychological Distress Scale (K10) than their peers, indicating higher levels of psychological distress. In one study, LGBTIQ people over 18 reported a mean score of 24.3 on the K10 scale, indicating high levels of psychological distress.²⁶ In comparison, a separate study reported a mean score of 14.5 on the K10 for the general population aged 16 and over, indicating lower levels of psychological distress.²⁷

²³ The literature that the present research is based on generally uses the term mental health condition to mean a condition classified in internationally recognised diagnostic manuals (e.g., the Diagnostic Statistical Manual or the International Classification of Diseases).

²⁴ LGBTIQ+ Health Australia, *Snapshot of Mental Health and Suicide Prevention Statistics*, October 2021 p.8.

²⁵ Australian Bureau of Statistics, *National Study of Mental Health and Wellbeing 2022 – 2023*, Released: 5 October 2023

²⁶ Adam Hill, Adam Bourne, Ruth McNair, Marina Carman and Anthony Lyons, *Private Lives 3: The health and wellbeing of LGBTIQ people in Australia*. ARCSHS monograph series number 122. Melbourne: Australia, Australian Research Centre in Sex, Health and Society, La Trobe University, 2020.

²⁷ Tim Slade, Rachel Grove and Philip Burgess, "Kessler psychological distress scale: Normative data from the 2007 Australian national survey of mental health and wellbeing", *Australian and New Zealand Journal of Psychiatry*, vol. 45 (2011): 308-316

2.3.2 Suicidality

Compared to the general population, research indicates that LGBTQ+ people are at a higher risk of suicidal thoughts and behaviours.

Data highlighted in LHA's 2021 Snapshot reports that LGBTQ+ people are more likely to attempt suicide, compared to the general population. For example, across separate research studies, 30.3% of LGBTI people aged 18 and over²⁸, and 48% of transgender and gender diverse people aged 14 to 25, reported that they had attempted suicide in their lifetime.²⁹ In comparison, in the NSMHW 2022, 4.9% of all persons reported that they had attempted suicide in their lifetime.³⁰

The available data also indicates that LGBTQ+ people are more likely to have experienced suicidal ideation. For example, one study found that 74.8% of LGBTI people aged 18 and over had considered attempting suicide at some point during t

heir lives.³¹ In comparison, in the NSMHW 2022, 16.7% of the general population reported having suicidal thoughts at some stage in their lifetime.³²

There is also emerging evidence to suggest that LGBTQ+ people with intersecting issues or minority status – such as from diverse cultural backgrounds or those with a disability – are at even greater risk of poor mental health and suicide outcomes. For example, the Disability Royal Commission's 2023 Final Report indicated that approximately nine in ten LGBTQA+ adults with disability reported experiencing suicidal ideation at some stage in their lifetime (88%), compared to one-in-ten of the general population (13%).³³

Taken together, these statistics, while noting their limitations, indicate a pressing need for a targeted response to address mental health distress and suicide risk in Australia.

²⁸ Hill et al., 2020

²⁹ Penelop Strauss, Angus Cook, Sam Winter, Vanessa Watson, Dani Toussaint and Ashleigh Lin, "Trans Pathways: The Mental Health Experiences and Care Pathways of Trans Young People. Summary of Results." Perth: Telethon Kids Institute, 2017.

³⁰ Australian Bureau of Statistics, National Study of Mental Health and Wellbeing 2022 – 2023, Released: 5 October 2023

³¹ Hill et al., 2020

³² Australian Bureau of Statistics, National Study of Mental Health and Wellbeing 2022 – 2023, Released: 5 October 2023

³³ Commonwealth of Australia, *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability – Volume 3: Nature and extent of violence, abuse, neglect and exploitation*, September 2023 p. 155

3 Overview Australia's policy and service landscape

This section outlines the current state of policy and service provision related to mental health, wellbeing, and suicide prevention for LGBTQ+ people in Australia. It provides the background and context against which other sections of this report should be read.

Further information about method and focus can be found at Section 1.2.

3.1 Introduction to this Section

There is a diverse range and distribution of services for LGBTQ+ people in Australia who need support related to mental health, wellbeing, and suicide prevention. Reflecting the broader health system, these services are administered, funded, and delivered through a mix of Commonwealth, state/territory, private, and not-for-profit mechanisms.

Most of the mental health, wellbeing, and suicide prevention services available are designed for the general community (referred to as 'mainstream services', see Section 3.4.2). However, there is also a patchwork of services which are specifically designed for, and often delivered by, LGBTQ+ people (referred to as 'LGBTQ+ specialist services', see Section 3.4.3).

It appears, however, that LGBTQ+ specialist services are often only available in limited locations – with only a few examples of services with either state-wide or national coverage. Evidence also indicates that mainstream services are, in some cases, not equipped to provide best practice care for LGBTQ+ people, and can expose LGBTQ+ people to stigmatising and harmful experiences (see Section 5). As such, LGBTQ+ peak bodies have called for improvements to mainstream services and the availability of LGBTQ+ specialist services to ensure an adequate continuum of safe and affirming mental health, wellbeing, and suicide prevention care in all locations.³⁴

Accompanying the various policy instruments supporting improvements to the wider mental health system, there are some policies, strategies, and other mechanisms already in place at the Commonwealth (see Section 3.3.1), and the state/territory (see Section 3.3.2) levels, which are seeking to improve outcomes for, and the services available to, LGBTQ+ people. Among other instruments, this includes dedicated LGBTQ+ health or whole-of-government strategies in at least five state and territories (see Section 3.3.2.1), as well as ongoing lived experience input provided through permanent advisory infrastructure (see Section 3.3.2.2). Community organisations, education providers, and industry bodies have also invested in the development of strategies, best practice guides, and other resources to support

³⁴ LGTBIQ+ Health Australia, *Beyond Urgent: National LGBTIQ+ Mental Health and Suicide Prevention Strategy 2021 – 2026*, November 2021

improvements for LGBTQ+ people in Australia (see Section 3.4), which continue to provide invaluable information and direction to those developed by governments.

Note: The information that follows is primarily drawn from the source documents referenced. The section does not include any evaluation of the initiative's merits or impacts. It is included solely to describe the mental health landscape in Australia, and highlight the complexity of players, policies, and activities that may impact the future mental health and wellbeing of LGBTQ+ people across Australia.

3.2 Relevant Laws and Regulations

Across Australia, different jurisdictions have in place a range of laws, regulatory instruments, and complaints bodies designed to protect and uphold the rights of LGBTQ+ citizens, some with direct relevance to their rights within health settings. Some of the key instruments are summarised below.

Although most laws affecting LGBTQ+ people on a day-to-day basis are made by Australia's states and territories, there are federal laws in place which apply across all of Australia. For example, the national [Sex Discrimination Act 1984](#) prohibits discrimination on the basis of an individual's sex, gender identity, sexual orientation, marital or relationship status, family responsibilities, or because they are pregnant or might become pregnant. There are however some religious exemptions.

The federal body responsible for administering this Act, and also investigating complaints related to it, is the [Australian Human Rights Commission](#).

The Commonwealth is also responsible for marriage and family law in Australia. The amendment of the [Marriage Act 1961](#) in December 2017, following the national plebiscite, meant that marriage was no longer determined by sex or gender, giving same-sex couples the same right to marry as heterosexual couples.

Included in Attachment 2 is a summary of related bodies and legislations related to LGBTQ+ rights in each of the states and territories.

3.3 Overview of the Australian policy landscape

There is a complex interplay of national and state/territory policy, strategies, and other mechanisms coordinating improvements to mental health and wellbeing services, and mental health and wellbeing outcomes, for LGBTQ+ people across Australia. These are supported, and often influenced by, the development of strategies, resources, and other instruments by community organisations, peak and industry bodies, and education providers.

Some of the key instruments informing mental health policy and specific improvements for LGBTQ+ people are summarised in the sections below. Further info on relevant Commonwealth, state, and territory initiatives are summarised in Attachment 2.

3.3.1 Australian Government Policy

While mental health and suicide prevention is primarily the responsibility of state and territory governments, the Commonwealth Government plays a substantive role in priority setting and regulation, as well as in the funding, administration, and delivery of some services.

The shared approach of Commonwealth and state/territory governments toward mental health and suicide prevention is set out in the 2022 [National Mental Health and Suicide Prevention Agreement](#). The National Agreement is underpinned by seven Bilateral Agreements signed with each state and territory, which outline jurisdictional priorities and funding allocation.³⁵ Under the National Agreement, the Commonwealth, state, and territory governments have committed to:

“collaborate on systemic, whole-of-government reform to deliver a comprehensive, coordinated, consumer focused and compassionate mental health and suicide prevention system to benefit all Australians”.³⁶

The Agreement lists LGBTQIA+SB people as second of 15 priority population groups (after Aboriginal and Torres Strait Islander peoples³⁷), and commits all governments to “work together to close the gap, improve mental health and wellbeing outcomes and reduce suicide”.³⁸

The Commonwealth Government’s priorities and reform agenda is also influenced by various policy papers and reports. Perhaps most notably, the Productivity Commission’s 2020 [Mental Health Report](#) and the [National Suicide Prevention Adviser and Taskforce’s 2021 Final Report](#). These and other key Commonwealth policy initiatives are summarised in Attachment 3.

As evident by this commissioned research, the Commonwealth Government intends to build upon its existing commitments to LGBTQIA+ mental health and wellbeing through the development of a new National Action Plan for the Health and Wellbeing of LGBTQIA+ People (Action Plan). The Action Plan, announced on 1 March 2023 at the WorldPride 2023 Human Rights Conference, will provide a national framework for how Australia addresses health disparities and makes improvements across the health system, including the mental health system.³⁹

The announcement was accompanied by a \$26 million investment in grant funding through the Medical Research Future Fund. The grants will support projects seeking to improve care

³⁵ Commonwealth of Australia, *National Mental Health and Suicide Prevention Agreement* (2022). p.1

³⁶ *National Mental Health and Suicide Prevention Agreement* (2022) p.4

³⁷ *National Mental Health and Suicide Prevention Agreement* (2022) p.25

³⁸ *National Mental Health and Suicide Prevention Agreement* (2022) p.7

³⁹ Department of Health and Aged Care, “Pathway to better health for LGBTQIA+ communities”, Date published: 1 March 2023, [Pathway to better health for LGBTQIA+ communities | Health Portfolio Ministers | Australian Government Department of Health and Aged Care](#)

and treatment for LGBTIQ+ people, with objectives to develop more sustainable models of care after evaluation of the effectiveness and acceptability of health care.⁴⁰

3.3.2 Overview of State and Territory Government Policy and Strategies

As noted above, state and territory governments have the primary responsibility for the delivery of health services, including mental health services.

In addition to commitments made in broader mental health policies and strategies (see Attachment 3), many state and territory governments have developed dedicated LGBTQ+ health or whole-of-government strategies to coordinate improvements to outcomes and services for LGBTQ+ people. In some instances, lived experience advisory infrastructure has also been developed to enable the government to access ongoing advice on issues impacting LGBTQ+ people.

3.3.2.1 LGBTQ+ health strategies

Five state and territory governments have already developed or implemented a dedicated strategy focused on improving outcomes for LGBTQ+ people, either in the form of a specific health strategy, or incorporating health within a whole-of-government strategy. In addition to commitments aimed at directly improving mental health and wellbeing outcomes for LGBTQ+ people, many of these strategies also include commitments to improve data collection practices to support future evidence-based decision-making.

While these developments have been generally welcomed, some LGBTQ+ peak bodies have raised concerns regarding the efficacy of some of these initiatives and the progress they are making toward improving outcomes for LGBTQ+ people.

While assessing the status or effectiveness of these strategies was outside the scope of this research, an overview of existing dedicated state strategies is provided in Table 1 below. For those governments who do not have a dedicated strategy, commitments made through other policy instruments and frameworks are highlighted in the table. Additional detail regarding other relevant state and territory policy initiatives which relate to LGBTQ+ mental health and wellbeing is also provided in Attachment 3.

3.3.2.2 LGBTQ+ lived experience advisory infrastructure.

At least four state and territory governments have also established what appear to be permanent pieces of LGBTQ+ lived experience advisory infrastructure to provide ongoing advice to government on issues impacting LGBTQ+ people, including mental health and wellbeing.

These advisory bodies vary in their membership structure and responsibilities, with some enjoying a wide remit to undertake consultation with, and receive submissions from, the community. While assessing the status or effectiveness of these bodies was outside the

⁴⁰ GrantConnect 2023, *GO6063 Models of Care for Sexuality & Gender Diverse People & People with Innate Variations of Sex Characteristics*, Published: 1 March 2023, [Models of Care for Sexuality & Gender Diverse People & People with Innate Variations of Sex Characteristics](#).

scope of this research, a high-level summary of the four permanent advisory bodies identified is provided in Table 3.

While this section describes permanent bodies, it should be noted that other states and territories have also established short-term advisory bodies to support the development of specific initiatives. For example, the Northern Territory established a 'NT Health Advisory Group for People with Diverse Sexualities and Gender Identities' to support the development of their Inclusive Health Strategy.

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Figure 3: Key Australian state and territory LGBTQ+ health strategies

Jurisdiction	Title	Description
ACT	Capital of Equality Strategy	<p>The whole-of-government strategy sets out the ACT's commitment for Canberra to be the most LGBTQ+ welcoming and inclusive city in Australia.⁴¹ In addition to commitments to reduce discrimination and other forms of inequality, the Strategy includes a variety of actions to improve the delivery of inclusive and accessible services. This, for example, includes:</p> <ul style="list-style-type: none"> • Providing training to mainstream service providers • Improving the provision of targeted, peer-led services <p>The Strategy's Second Action Plan outlines further commitments to improve access to mental health support for LGBTQ+ Canberrans: this includes ongoing funding to Meridian and A Gender Agenda; removing barriers to gender affirmation surgeries and procedures; as well as implementation of several mental health recommendations from the LGBTQ+ Health Scoping Study.⁴²</p>
New South Wales	NSW LGBTQ+ Health Strategy 2022-2027	<p>The Strategy commits the NSW Government to delivering high quality, safe, inclusive, and responsive healthcare – including mental healthcare – to LGBTQ+ people across the state. It proposes to do so through numerous interlinked measures, including:</p> <ul style="list-style-type: none"> • Providing training to mental health professionals and support staff in mainstream services • Developing and distributing LGBTQ+ resources to providers • Ensuring co-design is embedded in the development of LGBTQ+ specific initiatives • Consulting with communities to identify service gaps

⁴¹ ACT Government, "Capital of Equality Strategy – ACT Government LGBTQ+ Strategy", [Capital of Equality – ACT Government LGBTQ+ Strategy](#).

⁴² ACT Government 2022, [Capital of Equality Strategy Second Action Plan \(2022-2023\)](#).

		The strategy also includes specific initiatives for gender diverse people; people with innate variations of sex characteristic; and to improve data collection instruments to capture information on sexual orientation and gender diversity. ⁴³
Northern Territory	NT Health Inclusion Strategy Plan of Actions 2019-2022 : Respecting people with diverse sexualities and gender identities	<p>The NT Inclusion Strategy Plan aimed to support health and wellbeing for the territory's LGBTQ+ people through a variety of interlinked goals and actions. For example:</p> <ul style="list-style-type: none"> • Ensuring physical spaces, services and, promotions materials are inclusive • Updating and providing staff training on awareness, language, and unconscious bias • Investing in research on LGBTQ+ health issues • Working with LGBTQ+ communities to address stigma <p>It is unclear whether this strategy has been fully implemented, or if an updated strategy is in development.</p>
Queensland	N/A	<p>Queensland does not appear to have a dedicated LGBTQ+ health or whole-of-government strategy, however, their broader mental health and suicide prevention plans include commitments to:</p> <ul style="list-style-type: none"> • Co-design and implement initiatives aimed at improving inclusivity and community attitudes⁴⁴ • Explore and expand service models to address health inequity for LGBTQ+ people⁴⁵
South Australia	N/A	<p>While South Australia does not have a dedicated LGBTQ+ health strategy, specific commitments are made to improving services to LGBTI people in the state's <i>Mental Health Services Plan 2020–2025</i>⁴⁶, including:</p> <ul style="list-style-type: none"> • Providing staff training • Developing an LGBTI clinical standards document • Consulting with LGBTI people about service priorities

⁴³ NSW Government, "[NSW LGBTIQ+ Health Strategy 2022-2027](#)" (2022),

⁴⁴ Queensland Government, "[Every Life: the Queensland Suicide Prevention Plan 2019 – 2029: Phase One](#)" (2019), p. 17

⁴⁵ Queensland Government, "[Shifting minds: the Queensland mental health, alcohol and other drugs, and suicide prevention strategic plan 2023- 2028](#)" (2023), p. 34

⁴⁶ Government of South Australia, "[Mental Health Services Plan 2020 – 2025](#)" (2020) p. 29 & 86

		<ul style="list-style-type: none"> Scoping an anti-stigma initiative inclusive of all people “known to face inequality in service access across health services”, including LGBTI people
Tasmania	N/A	<p>While Tasmania does not have a dedicated LGBTQ+ Health Strategy, the Whole-of-Government Framework for LGBTI Tasmanians sets out various principles related to the delivery of services to LGBTI people in the state including:</p> <ul style="list-style-type: none"> Diverse characteristics and experiences are both recognised and respected All Tasmanians have equal rights to access government services and be involved in their design and delivery All services (non-government included) are expected to coordinate and collaborate efforts to develop evidence-based, innovative service delivery <p>Tasmania’s broader mental health and suicide prevention plan Rethink 2020 also identifies LGBTQIA+ people as a priority population under their 7th Reform Direction ‘Responding to the needs of specific population groups’, which includes specific commitments to:</p> <ul style="list-style-type: none"> Developing a concept model for a LGBTQIA+ specific mental health and alcohol/other drugs service Embedding LGBTQIA+ inclusive practice online training modules for all DOH staff Developing and implementing a LGBTQ+ inclusive audit tool⁴⁷
Victoria	Pride in our future: Victoria’s LGBTIQ+ strategy 2022-32	<p>The Victorian Government’s Pride in our future: Victoria’s LGBTIQ+ strategy 2022–32 is a 10-year, whole-of-government strategy, setting up the state’s:</p> <p><i>“vision and plan to drive equality and inclusion for Victoria’s diverse lesbian, gay, bisexual, trans and gender diverse, intersex and queer (LGBTIQ+) communities within all aspects of government work over the next decade”.</i>⁴⁸</p> <p>The strategy includes a range of priorities across sectors. Among others, some notable actions related to mental health and wellbeing include:</p> <ul style="list-style-type: none"> Reducing discrimination and harmful practices against LGBTIQ+ people (e.g., conversion therapies) Improving data collection

⁴⁷ Tasmanian Government, [“Rethink 2020: a state plan for mental health in Tasmania 2020 – 2025: 2023 – 24 Rethink 2020 Implementation Plan”](#) (2023) p. 13

⁴⁸ Victorian Government, [“Pride in our future: Victoria’s LGBTIQ+ strategy 2022-32”](#) (2022)

		<ul style="list-style-type: none"> Ensuring all government services are equitable, inclusive, and accessible <p>Among other actions, the strategy proposes to provide training to both LGBTIQ+ specialist and mainstream service providers; foster social programs; and embed lived experiences voices in the development of relevant frameworks, governance models, and services.⁴⁹</p>
Western Australia	Western Australian LGBTI Health Strategy 2019–2024	<p>Western Australia's 5-year strategy outlined 6 priorities to develop an "equitable, accessible, culturally safe and inclusive WA health system and health services" which are responsive to LGBTI health and wellbeing needs. Among other actions, the Strategy committed to improving data collection; undertaking research; providing training to mainstream service staff; including LGBTI voices in service planning; and improving access to LGBTI specialist health services.</p>

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⁴⁹ Victorian Government, "[Pride in our future: Victoria's LGBTIQ+ strategy 2022-32](#)" (2022). 6 – 7

Table 1: State and Territory lived experience advisory infrastructure

Jurisdiction	Name	Structure	Responsibilities
ACT	LGBTIQ+ Ministerial Advisory Council	<ul style="list-style-type: none"> • Reports directly to the Chief Minister. • Currently has 14 members, selected for their expertise and experience in LGBTIQ+ rights and care. • Appointments up to 3 years, with no members able to serve more than two terms. 	<ul style="list-style-type: none"> • Multiple policy portfolios with a strong focus on non-discrimination, aged care, education, and health delivery. • Provides advice on issues referred by the Chief Minister, the Office of LGBTIQ+ Affairs or raised by the community. • Undertakes consultation with the LGBTIQ+ community and relevant organisations. • The Council additionally has an open submission email welcoming input from the community.
Queensland	LGBTIQ+ Roundtable	<ul style="list-style-type: none"> • Administered by the Department of Communities, Housing and Digital Economy. • Currently comprised of 15 members, including: <ul style="list-style-type: none"> – individuals and network/organisational representatives – representatives from various government departments. • Appointments are for 2 year-terms. 	<ul style="list-style-type: none"> • Aims to provide an “engagement mechanism for the LGBTIQ+ community to highlight opportunities to strengthen community outcomes”. • Members provide feedback through quarterly meetings and through out-of-session channels (e.g., providing feedback on strategies).
South Australia	LGBTIQA+ Minister's Advisory Council	<ul style="list-style-type: none"> • Provides advice to the Minister for Human Services. 	<ul style="list-style-type: none"> • Broad remit to provide advice on issues affecting LGBTIQA+ people.

Jurisdiction	Name	Structure	Responsibilities
		<ul style="list-style-type: none"> Currently comprised of 13 members 	<ul style="list-style-type: none"> Members provide feedback in quarterly meetings
Victoria	LGBTIQ+ Taskforce	<ul style="list-style-type: none"> Convened by the Minister for Equality and works closely with the Commissioner for LGBTIQ+ communities. Comprised of 9 community members, with Deputy secretaries from relevant departments acting as “ex-officio” members. Appointments are for 2 year-terms. Supported by two dedicated working groups, which comprise additional members and SMEs: <ul style="list-style-type: none"> The Health and Wellbeing Working Group, which covers mental health policy among other health areas. The Justice Working Group. 	<ul style="list-style-type: none"> Aims to ensure that government equality initiatives are “underpinned by genuine community consultation”. Sits across multiple policy portfolios, with targeted advice provided through Working Groups and Expert Advisory Panels.

3.3.3 Other policy and advocacy documents

Peak bodies, community organisations, education providers and industry bodies have also invested in a range of policy, research, advocacy and education options related to LGBTQ+ mental health and suicide prevention. A number of well-known examples include:

- **LHA** released its second [National LGBTQ+ Mental Health and Suicide Prevention Strategy](#) in 2021: in addition to setting out the actions LHA will take, the Strategy sets out priorities for coordinated action among all relevant stakeholders, including government, service delivery organisations, and community organisations, as well as research and data collection bodies.⁵⁰
- **LHA** has also released a synthesis of [Current Evidence for Good Practice in Suicide Prevention for LGBTQ+ People](#): this report provides an overview of the evidence for good practice from 2010 to 2020, with a focus on peer-reviewed literature released after 2018.⁵¹
- **Transcultural Mental Health Centre's** [LGBTIQ+ People from CALD Communities and Mental Health](#) resources, including links to terminology, organisations and service, translated resources, related articles and resources, and more.
- **La Trobe University's Rainbow Health Australia Program**, including [Rainbow Tick](#) quality framework and accreditation system for LGBTQ inclusive service provision in the health and human services sector, along with other resources and training programs.
- **Mental Health Coordinating Council's** Mental Health Rights Manual including a section on [LGBTIQ+ and mental health conditions](#) (2021), plus its 2022 [Recovery Oriented Language Guide](#), which outlines language and communication principles, and best practice related to mental health and suicide prevention, including a dedicated section on LGBTQ+ people.⁵²

3.4 Australia's Mental Health Services Landscape

Similar to the legal and policy landscape that exists across Australia (see above), the mental health service system that LGBTQ+ people interface with on a daily basis is complex. There are numerous pathways, types of professionals and support options that any one individual or group might intersect with, ranging from the mainstream public health system, through to private clinical or community support options.

Most of the mental health, wellbeing, and suicide prevention services available are designed for the general community (referred to as 'mainstream services'). However, there is also a

⁵⁰ LGTBIQ+ Health Australia, *Beyond Urgent: National LGBTQ+ Mental Health and Suicide Prevention Strategy 2021 – 2026* (2022) p.8

⁵¹ LGBTQ+ Health Australia, *Current Evidence for Good Practice in Suicide Prevention for LGBTQ+ People*, Published 30 October 2020.

⁵² Mental Health Coordinating Council, *Recovery Oriented Language Guide: Third Edition* (Sydney, Australia, 2022).

patchwork of services which are specifically designed for, and often delivered by, LGBTQ+ people (referred to as 'LGBTQ+ specialist services').

This section provides a general overview of the funding and administration of mental health services in Australia (Section 3.4.1), and the mainstream mental health services that LGBTQ+ interface with (Section 3.4.2), before summarising the variety of LGBTQ+ specific services available (Section 3.4.3).

It should be noted that some of what follows may not fully align with recent policy initiatives outlined above, as they are still in the process of being implemented.

3.4.1 Service Funding and Administration

Although Australia is increasingly taking a "cross-portfolio approach" to supporting mental health, responsibility for the funding and administration of mental health-specific services currently sits primarily with the Commonwealth Department of Health and Aged Care and its counterparts within state and territory governments.⁵³ Funding for services that target specific consumer groups are in some cases administered by their relevant agency: for example, the Department of Veteran's Affairs administers funding for mental health services and prescription medications for veterans, though this funding is provided by the Department of Health and Aged Care.⁵⁴

While different levels of government provide funding for different mental health and related services, it is currently estimated that spending from state and territory governments account for roughly two-thirds of Australia's annual expenditure on mental health.⁵⁵ Much of this funding is linked to the National Mental Health Bi-Lateral Agreements described in Section 2.1.4, with current allocations listed in Attachment 3.

Further, state and territory governments generally have responsibility for funding residential mental health care and some community-based mental health services, as well as specific initiatives.⁵⁶

The Commonwealth Government is primarily responsible for subsidising mental health treatment through the Medicare Benefits Scheme (MBS), the Pharmaceutical Benefits Scheme (PBS), and the Repatriation Pharmaceutical Benefits Scheme (RPBS). The Commonwealth Government additionally funds mental health-related services, such as the National Psychosocial Support Measure, through Primary Health Networks (PHN) and through specific initiatives, such as Headspace.

In addition, a number of services receive joint Commonwealth-State funding, such as: mental health services provided through public hospital, crisis support services (e.g., Lifeline

⁵³ National Mental Health Commission, *Monitoring mental health and suicide prevention reform: National Report 2020*, p. 13.

⁵⁴ Commonwealth Department of Health, *Annual Report 2019-20*, Published: 1 December 2020 p. 129.

⁵⁵ Australian Productivity Commission, *Mental Health Inquiry Report*, Published: 16 November 2020 p. 154.

⁵⁶ Australian Institute of Health and Welfare, [Mental Health Services in Australia](#), Last Updated: 31 October 2023.

and Beyond Blue), and psychosocial support services provided through the NDIS.⁵⁷ Further, Commonwealth, state, and territory governments are jointly responsible for the accreditation and registration of mental health professionals through the Australian Health Practitioner Regulation Agency.

Non-government organisations and private providers are also often contracted by government bodies to deliver various services, such as psychosocial support programs, in addition to their independent service delivery, research and advocacy work.

3.4.2 Mainstream mental health services

The majority of mainstream (i.e., not LGBTQ+ specific) mental health services in Australia can be categorised as follows:

- Primary health care
- Crisis services
- Specialist mental health services
- Prevention and early intervention services

3.4.2.1 Primary Health Care

Primary health care is generally accessed as a first port of call when a person is unwell, requiring a diagnosis, and/or needing treatment for health conditions. In some instances, this includes long-term care for chronic conditions, such as some forms of mental health conditions.

The most common types of primary care are provided by:

- General Practitioners or private medical practices in the community
- Community health centres funded or other publicly funded services such as Aboriginal Community Controlled Health Organisations
- Public or privately funded allied health professionals including psychologists, plus nurses, and pharmacists (also see Section 2.5.3.2)

Access to the vast majority of these service options is subsidised or free under the Commonwealth Government MBS. Specifically, the Better Access initiative gives Medicare rebates to help people access mental health professionals and care, regardless of where they live.

Primary care services can also facilitate access to prescription medication and to mental health treatment plans, which can help individuals claim up to 10 individual or 10 group sessions with a mental health professional, each calendar year.⁵⁸

⁵⁷ Australian Institute of Health and Welfare, *Mental Health Services – in brief 2019*, Published: 2020 p. 21.

⁵⁸ Service Australia, [Mental health Care and Medicare](#). Accessed October 2023.

The Commonwealth Government also funds the Better Access initiative, which gives Medicare rebates to help people access mental health professionals and care, regardless of where they live.

3.4.2.2 Crisis mental health services

Historically, mental health crisis services have primarily been managed by public and private hospitals, in part due to the presentation of individuals in crisis to hospital emergency departments. However, in recent years the availability of alternative crisis services has been expanded through dedicated helplines, digital gateways, and adult mental health centres, as well as suicide aftercare and postvention services. More detail on these services is provided below.

- **Hospital-based care:** crisis services are provided in public and private hospitals through emergency department presentations and through same-day or overnight hospitalisation in acute general and psychiatric wards. Various forms of care and treatment are provided within these settings, depending on distress type, severity and duration, and complicating factors (e.g., co-occurring drug and alcohol issues). Service provision often includes peer support, mental health nursing, allied health, and psychological care, as well as medical and psychiatric care, including pharmaceutical medication, electroconvulsive therapy, or cerebral anaesthesia.⁵⁹ Emergency departments still act as the initial access point to the mental health care system for many Australians living with a mental health challenge.
- **Adult mental health centres:** these services are designed to reduce the number of mental health-related emergency department presentations,⁶⁰ by providing immediate treatment and care, as well as referrals to longer-term medical and social support services. These newly launched centres are funded by the Australian Government, in partnership with state and territory governments.⁶¹
- **Crisis helplines and online supports:** across Australia, a number of telephone services and online sites have been established to provide immediate support and information to individuals in crisis, often operating 24/7. The most high-profile crisis helplines are Lifeline and Beyond Blue, with other dedicated helplines available to specific populations including:
 - 13YARN and Brother to Brother Support Line for Aboriginal and Torres Strait Islanders
 - Kids Helpline for consumers aged 5 to 25
 - Defence Family Helpline for veterans and their families.⁶²

⁵⁹ AIHW, *Mental Health Services – in brief 2019, 2020* p. 16.

⁶⁰ Commonwealth Department of Health, *Prioritising Mental Health – Adult Mental Health Centres*, Published: 2019.

⁶¹ At the time of writing, there are 18 of these (11 centres and 7 satellites) so coverage is limited. Commonwealth Department of Treasury, *Budget 2021 – 22: Budget Paper No. 1 - Budget Overview (2021)* p. 22.

⁶² National Mental Health Commission, *Get Help*.

- **Suicide Aftercare and Postvention services** are also available in select locations to provide recovery support to individuals who have engaged in suicidal behaviour or who have been impacted by suicide.

Aftercare services provide dedicated support to individuals in the months following a suicide attempt, when they are most at-risk of re-attempting, e.g., the *Way Back Support Service*.

The Department additionally funds two dedicated suicide postvention services to support individuals and communities impacted by suicide, including families, witnesses, first responders, and service providers. The *Suicide Call Back Service* and *Stand by Support After Suicide Program* both provide 24-hour telephone, face-to-face, and online counselling services.⁶³

3.4.2.3 Specialist mental health services

Dedicated, and promoted specialist mental health services are offered in a range of settings, including as part of hospitals or other public or private health facilities, as well as in community health settings. These have been traditionally divided into 'inpatient' services that are residential in nature, and where the individual temporarily resides in the facility or service, and 'outpatient' services where the individual seeks assistance through an appointment or drop-in option. These are briefly expanded upon below:

- **Residential Mental Health Care:** Residential Mental Health Care (RMHC) services are non-acute services provided, often including rehabilitation or long-term care,⁶⁴ and are either hospital-based or provided in the community by government and non-government agencies, in locked hospital units or unlocked "domestic living" type units. The most recent data from 2020–21 shows that 7,180 residents received 9,051 episodes of residential care: 58% completed RMHC episodes of 2 weeks or less, whilst 2.7% of RMHC episodes lasted a year or more. Approximately 17% of admissions to RMHC were involuntary.⁶⁵

RMHC services are primarily used for people with lived experience who are perceived to have more complex support needs, such as those living with a diagnosis of schizophrenia, and are often provided as a "step up" from outpatient care when a person's mental health challenge worsens, or an intermediary "step down" from acute inpatient care after a person's mental health challenges improve.⁶⁶

- **Outpatient services:** most frequently accessed through hospitals and other public health facilities, but including community-based services, consulting rooms, home visits, and telehealth, these clinical care services are delivered by a mix of professional health staff including mental health nurses, psychologists, psychiatrists, general practitioners, and/or peer workers. Individuals receiving care often can receive assistance from allied

⁶³ StandBy Support After Suicide, n.d., [What we do](#).

⁶⁴ Australian Institute of Health and Welfare, *Mental Health Services – in brief 2019* (2020) p. 18

⁶⁵ Australian Institute of Health and Welfare, *Mental health services in Australia* (2022)

⁶⁶ Australian Productivity Commission, *Mental Health Inquiry Report* (2020), p. 593-594.

health professionals, such as social workers and occupational therapists.⁶⁷ Although mental health care is primarily funded by the MBS, some services for specific consumer groups are funded through other streams, such as the NDIS and the Department of Veterans Affairs.

- **Community-based mental health wellbeing programs:** There is a wide array of community-based mental health, wellbeing, and support programs available across Australia, which target the unique needs of different consumer groups. These programs are funded through various mechanisms and are often delivered through non-government organisations as well as Primary Health Networks (PHN).

For example, the New South Wales's Community Living Supports program provides support to individuals with severe mental illness to "live and recover in the community in the way they want to". These services are usually provided by support workers from community organisations, or clinicians from a local mental health service, and may include support with mental and physical health appointments, medication management, daily living skills, accessing education or employment, learning new skills, and participation in social, leisure, or sporting activities.⁶⁸

3.4.2.4 Prevention and Early Intervention Services

Increasingly, health investments are being made to develop and improve the availability of prevention and early intervention services, and to embed these services into workplaces, schools, and social services.⁶⁹

Some examples of existing prevention and early intervention services include:

- **Mental health screening tools:** these are used to detect early warning signs of mental health challenges in various settings, with the aim of supporting people to access effective care and treatment before distress becomes more severe and life-interrupting. Various tools have been developed and are being promoted, such as the Initial Assessment and Referral tool used by General Practitioners.
- **Digital gateways:** these online platforms are being developed to "break down various access barriers" and increase the number of consumers receiving effective treatment. For example, the *Head to Health* website collates hundreds of digital mental health resources available from government and non-government providers, including online programs and apps, online forums, email and telephone services, and other dedicated websites.⁷⁰ Digital gateways for specific consumer groups have also been developed such as *Headspace*⁷¹, which aims to support younger people, and *Wellmob*, which

⁶⁷ Australian Institute of Health and Wellbeing, *Mental Health Services – in brief 2019* (2020) p. 8.

⁶⁸ NSW Health, "Community Living Supports", Last updated: 12 April 2023

⁶⁹ National Mental Health Commission, *National Report 2020* (2020) p. 14.

⁷⁰ Head to Health n.d. *About Us*.

⁷¹ Please note that *headspace* also provides services at physical locations across Australia.

provides social and emotional wellbeing online resources that are culturally relevant and accessible for Aboriginal and Torres Strait Islander People.⁷²

3.4.3 LGBTQ+ specialist services

In addition to the general mental health, wellbeing, and suicide prevention services described above, there is a complex variety and distribution of services which specifically cater to people in the LGBTQ+ community. These targeted services are promoted as delivering an affirmative and supportive service option, thereby reducing barriers to care and support (see Section 5), and supporting LGBTQ+ people to access care tailored to the specific needs related to their experiences as an LGBTQ+ person (see Section 4).

These services vary in terms of their models of funding and delivery, as well as the types of care provided. Many services are delivered by community-controlled organisations which are governed by and operated for affected communities, enabling them to deliver trusted and culturally appropriate services. There are also a number of services delivered directly through publicly funded services and local health districts (LHD), as well as by private providers. In addition, formal and informal mental health and peer support services are provided to LGBTQ+ people in a variety of other settings, including through local councils, education providers, and through online platforms.

Many LGBTQ+ specialist service options have been established by the community in response to local need and, in some cases, upscaled with government funding. There is, therefore, a patchwork of LGBTQ+ specialist services available in Australia, with only a few examples of services with either state-wide or national coverage (e.g., Q Life). As such, the availability of different types of LGBTQ+ specific mental health care services varies substantially by location. LGBTQ+ advocacy groups have called for improvements to the specialist services available, to ensure an adequate continuum of safe and affirming mental health care in all locations.⁷³

The discussion below outlines the major types of mental health services available, categorised as follows:

- Dedicated LGBTQ+ service hubs
- Specialist LGBTQ+ services in PHNs
- Private Options
- Digital gateways, helplines, and webchat platforms
- Digital resource platforms and wellbeing apps
- Social programs which aim to provide preventative mental health care by reducing social isolation and loneliness for LGTBQ+ people.

Each of these are expanded upon below.

Wellmob n.d. *About*

⁷³ LGTBIQ+ Health Australia, *Beyond Urgent* (2022)

3.4.3.1 Dedicated Service Hubs

There are a number of organisations operating in Australia that offer a broad arrange of services, supports, and activities, specifically for the LGBTQ+ community. Included amongst these are heath, mental health, and wellbeing services and supports, designed to suit different needs and individual preferences.

These dedicated LGBTQ+ hubs offer a range of options, from counselling through to peer support, case management, and general life support, as well as the creation of safe spaces and opportunities to socialise with LGBTQ+ peers. Below are short descriptions of the two largest of these, noting that equivalent broad-based centres operate in most other states and territories.

- [ACON](#): a NSW-based community controlled organisation, ACON provides a range of services to LGTBQ+ people, including short-term PRIDE counselling, as well as care coordination and peer support targeted to a range of different issues (e.g., depression and anxiety, substance use, domestic and family violence, suicide prevention and HIV diagnosis).⁷⁴ These services are offered via telehealth across NSW, and in-person through ACON offices in Surry Hills and Newcastle. ACON funds their services through income generated through fees, as well as Medicare rebates, and targeted funding from the NSW Government. For example, ACON's suicide prevention services were established through funding from the NSW Government's Suicide Prevention Fund.⁷⁵
- [Thorne Harbour Health](#): a Victorian community-controlled organisation which provides mental health counselling, AOD individual and group-based therapeutic interventions, as well as family violence services (both victim-survivors and perpetrators), housing and homelessness support, and sexual health testing and treatment.⁷⁶

There are also a number of LGBTQ+ general service and support options that specifically cater to sub-groups within the LGBTQ+ community, most specifically young people and Aboriginal and Torres Strait Islander peoples. Some examples of these services include:

- [Twenty10](#): this NSW based youth service provides a broad range of free, accessible mental health and psychosocial support programs, as well as creative and digital programs, events, safe spaces, and delivering specialist capacity building training all over NSW to continue building a world where NSW LGBTIQ+ people are secure, connected, and celebrated. Specifically, it offers young people information and referral services, housing and case management, counselling options, plus social support programs.⁷⁷

⁷⁴ ACON, "LGBTQ+ Counselling and Support", [Mental Health -ACON – We are New South Wales' leading HIV and LGBTQ+ health organisation.](#)

⁷⁵ NSW Health, "NSW opens first LGBTQ+ suicide prevention service", Published: 15 April 2022, [NSW opens first LGBTQ+ suicide prevention service - News](#)

⁷⁶ Thorne Harbour Health, "Our Services", <https://thorneharbour.org/services/>

⁷⁷ Twenty10, "Youth Services", [Youth Services - Twenty10 incorporating GLCS NSW](#)

- [The Freedom Centre](#): a Perth-based youth centre supporting LGBTIQ+ people aged 12 to 25, run by the not-for-profit organisation WAAC with funding from the Mental Health Commission. The Centre provides free counselling services, peer support and informal safe social spaces, as well as wellbeing and training workshops.⁷⁸
- [Open Doors Youth Services](#): this Queensland community organisation provides various services to young LGBTIQAP+SB people aged 12 to 24. This includes care coordination and general counselling, case management and external referrals, social groups, and assistance securing ongoing access to structures resources (e.g., housing, employment, and education) as well as necessities (e.g., food, toiletries, and clothing). However, the ODYS website makes it clear that their “services can complement and work alongside other support, however, is not a replacement for acute mental health services” and is not fit for addressing crisis care, or severe and complex mental health care.⁷⁹
- [BlaQ Aboriginal Corporation](#): BlaQ is a NSW peak organisation for First Nations LGBTQ+SB peoples in NSW. While BlaQ does not offer formal mental health counselling, it does provide support through case management in areas such as referrals, life administration, support letters, provide community networking and relationship building, essential crisis support, as well as housing assistance. They are also involved in numerous research and training projects.⁸⁰

3.4.3.2 Specialist services in PHN

Some PHN have also established or funded dedicated services, or communities-of-practice, focused on providing safe and affirming care for LGBTQ+ people. For example: the [Supporting Minds service](#), funded by the Gold Coast PHN and delivered by Wesley Mission Queensland, includes a dedicated stream targeted to people aged 12–65 who identify as LGBTQ+. It provides short term clinical and non-clinical services to people with mild to moderate support needs.⁸¹

The Western Victoria PHN also supports a [community-of-practice group](#), comprised of primary health professionals who care for people identifying as trans and gender diverse. The group meets monthly and aims to improve the practice of providers through a range of actions: for example, providing a multi-disciplinary forum where health professionals collaborate and communicate new research, providing peer-to-peer support, and delivering continuing professional development. The group also explores opportunities to develop new, and/or enhanced, services, and to expand access to support the affirmative healthcare needs of trans and gender diverse people.⁸²

⁷⁸ WAAC, “Freedom Centre”, <https://www.waac.com.au/what-we-do/freedom-centre/>

⁷⁹ Open Doors Youth Service inc, “LGBTIQAP+ Individual Support Services”, <https://www.opendoors.net.au/lgbtiqap-individual-support/>

⁸⁰ BLAQ Aboriginal Corporation, *Case Management*.

⁸¹ Wesley Mission Queensland, “LGBTIQAP+ flyer”, [Gold Coast Short-term Mental Health Services | Supporting Minds WMQ](#)

⁸² Western Victoria Primary Health Network, “LGBTQIA+”, [LGBTQIA+ | Western Victoria Primary Health Network \(westvicphn.com.au\)](#)

3.4.3.3 Private Options

Within the mental health care services described in Section 3.4.2 above, there are a number of private mental health professionals, including clinical psychologists, who have dedicated teams within services, and dedicated services, which specialise in providing care to LGBTQ+ clients. Some examples include:

- [Q Psychology](#): an LGBTQIAP+ owned and operated service providing dedicated care across Victoria.⁸³
- [Here Completely](#): a Sydney-based organisation which provides dedicated LGBTQI+ Counselling Psychology & Relationship Counselling services through a team of approximately 10 dedicated LGBTQI-affirming therapists, in addition to services to the general population.⁸⁴
- [Someone Health](#): an Australia-wide clinical telehealth provider which has a dedicated page for accessing LGBTQ friendly psychologists.⁸⁵

In addition, when accessing health services such as gender affirming care through dedicated LGBTQ+ services, specialist psychological support is often provided to the trans and gender diverse people, as well as to their families.⁸⁶ For example, Melbourne's Monash Health [Gender Clinic](#) – currently operating out of the Victorian Pride Centre – includes the provision of psychological support as one of its core services.⁸⁷

3.4.3.4 Digital gateways, helplines and chat options

There are also a number of organisations which provide remote support through call, text, and webchat lines staffed by mental health professionals and/or LGBTQ+ peers. These services tend to provide a wider geographic coverage – facilitating the provision of specialist LGBTQ+ services at a state-wide or nation-wide level. Examples include:

- [QLife](#): a service delivered by LHA, relying on a mix of Australian Government funding and community donations to provide free teleweb peer support for LGBTQ+ people or their networks who want to talk about sexual orientation, identity, gender, bodies, feelings, or relationships.⁸⁸ The peer support text, and call-lines, as well as web-chat options, are made available across Australia through its various state partners including [Living Proud](#) (Western Australia), [Diverse Voices](#) (Queensland), [Twenty 10](#) (NSW) and [Switchboard](#) (Victoria).

⁸³ Victorian Pride Centre, "Q Psychology", [Q Psychology - Victorian Pride Centre](#)

⁸⁴ Here Completely, "Sydney Queer & LGBTQI Counselling, Psychology & Relationship Counselling", <https://www.herecompletely.com.au/lgbtq>

⁸⁵ Someone.health, "LGBTQ Friendly Psychologists", [LGBTQ Friendly Psychologists | someone.health - Medicare bulk-billed counselling](#)

⁸⁶ Telfer, Associate Professor Michelle, Tollit, Dr Michelle, Pace, Dr Carmen, & Pang, Associate Professor Ken C, *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescent Version 1.3*, (Melbourne, The Royal Children's Hospital: 2020) p. 9 & 11

⁸⁷ Monash Health, "Gender Clinic – Frequently Asked Questions", Last Updated: 4 August 2023, <https://monashhealth.org/services/gender-clinic/questions/>

⁸⁸ QLife, "Get Help", [Get Help \(qlife.org.au\)](#)

- [qheadspace](#): a part of the national youth mental health digital gateway headspace, administered by the Australian government, providing a dedicated platform for LGBTIQ+ young people to access peer support and other mental health resources. Through the platform, users can also access phone and webchat support from trained mental health professionals.⁸⁹

3.4.3.5 Resource platforms and wellbeing apps

A number of digital resource platforms and wellbeing apps have also been developed to enable LGTBQ+ to access specialised mental health resources individually, at their own pace. Some examples include:

- [HERE](#): a digital suicide prevention hub for LGBTQ+ people, their networks, and service providers.⁹⁰
- [TransHub](#): a digital information and resource platform for trans and gender diverse people in NSW, including providing accessible and clear information about gender affirmation and gender related health and social support.⁹¹ TransHub is an initiative from ACON, which receives funding from the NSW Government.⁹²
- [Voda](#): a recently launched LGBTQIA+ mental wellness app which is developing on-demand programmes based on mindfulness, Cognitive Behavioural Therapy (CBT), and Acceptance Commitment Therapy. The app was seeded by DigitalHealth.London Launchpad and is still in the process of being fully developed. It began by sharing a series of digital mental health support resources for the trans and non-binary community, called "Coping with Gender Dysphoria". While the app was developed in the UK, it is available in Australia.

3.4.3.6 Social programs

There are also various examples across Australia of social programs which aim to promote wellbeing and prevent mental distress by reducing social isolation and loneliness for LGBTQ+ people. These are often delivered by community organisations, as well as local councils and education providers. Some examples include:

- The [Queer Sisterhood Project](#): delivered by the Forcibly Displaced People Network, this peer-run support group aims to provide a safe space for self-identifying women who also identify as queer (homosexual, bisexual, lesbian, same-sex attracted, pansexual) and have sought asylum in Australia on the ground of stigma-driven persecution.⁹³
- [Out and About](#): aims to reduce isolation and loneliness among LGBTI+ seniors in Victoria by coordinating fortnightly visits from peer volunteers. This service is delivered

⁸⁹ Headspace, "Out-spoken", <https://headspace.org.au/our-impact/campaigns/lgbtiqaplus/>

⁹⁰ HERE, "HERE for LGBTQ+ communities", <https://here.org.au/>

⁹¹ TransHub, "Mental Health", <https://www.transhub.org.au/mental-health>

⁹² ACON, "About ACON", <https://www.acon.org.au/about-acon/>

⁹³ Forcibly Displaced People Network, "Queer Sisterhood Project", <https://fdpn.org.au/queer-sisterhood/>

by Switchboard Victoria (a partner of Q life) with funding from the Federal Department of Health and Aged Care, under the Aged Care Volunteer Visitors Scheme.⁹⁴

- [Albany Pride](#): a volunteer-run community organisation in Western Australia which organises various social events for Albany and its surrounds, including for specific communities (e.g., Transverse, for trans, nonbinary and gender diverse people, and Spectrum, for LGBTIQ+ people under 25), as well as to provide a “safe and affirming place” for LGBTIQ+ people with disabilities, neurodivergence, or mental health challenges, such as depression or anxiety.⁹⁵

As summarised in the above Section, the Australian policy, funding, and services landscape related to mental health is complex and involves a highly diverse range of service types, as well as health professionals and other staff. These all need to be factored into any reforms designed to better support the mental wellbeing of the LGBTQ+ peoples nationally.

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⁹⁴ Switchboard Victoria, “Out and About”, <https://www.switchboard.org.au/lgbtiolderpeople>

⁹⁵ Albany Pride, “Events”, <https://albanypride.com.au/events/>

4 Stressors, risks, and protective factors

This section addresses KRQ 1, namely:

What are the key causes of distress experienced by LGBTQ+ people that impact on their mental health or wellbeing, and/or increase their risk of suicidal behaviours?

This section also covers various social determinants which impact mental health and wellbeing.

Further information about method and focus can be found at Section 1.2.

4.1 About this Section

Many LGBTQ+ people in Australia live healthy and fulfilling lives, often bolstered by the love and support of the LGBTQ+ people, and allies, that form their family (biological and chosen), friends, extended kinship networks, and community. However, as outlined in Section 2, the available data suggest that a significant proportion of those in the community also experience mental distress and suicidality, at a higher rate than the general population.

The research indicates that there is no single or uniform set of factors which determine mental health, wellbeing, and suicide prevention outcomes for Australia's LGBTQ+ population, nor for any of the specific subgroups which comprise this population. Similarly to the general population, the causes of mental distress and suicidality are complex and include a diversity of structural, social, cultural, psychosocial, and biological factors or determinants.

Researchers have, however, identified specific stressors impacting mental health and wellbeing which LGBTQ+ people have a heightened or, in some cases, unique risk of experiencing. Key stressors, for example include various forms of stigma, discrimination, plus rejection and alienation in social structures and institutions.⁹⁶ These stressors – described in Meyer's Minority Stress Model (2003) as 'distal' LGBT-specific 'minority stressors' – can create an excess burden of risk in terms of poor mental health outcomes and suicidality.⁹⁷

According to Meyer, exposure to external or 'distal' stressors can drive internal or 'proximal' stressors (such as internalised stigma, the anticipation of rejection, fear of harm, and identity concealment), which further exacerbate the risk of poor mental health outcomes.⁹⁸ These external and internal stressors can also directly and indirectly undermine access to

⁹⁶ David Frost and Ilan Meyer, "Minority stress theory: Application, critique and continued relevance," *Current Opinion in Psychology* 51, no. 101579 (2023), <https://doi.org/10.1016/j.copsyc.2023.101579>.

⁹⁷ Frost and Meyer, "Minority stress theory".

⁹⁸ Frost and Meyer, "Minority stress theory".

protective factors which support resilience and positive mental health, such as coping skills, access to social support and safe, affirming environments, and structural resources (e.g., access to employment, housing, and healthcare).

This section of the report will first provide an overview of the unique external and internal stressors or risks impacting mental health and wellbeing for LGBTQ+ people (see Section 4.2). It will then highlight evidence related to stressors experienced by specific subgroups in the LGBTQ+ community (see Section 4.3). Finally, it will address the unique mental health and wellbeing needs of LGBTQ+ people who have multiple, intersecting minority identities (see Section 4.4 – 4.5).

It should be noted, however, that what follows should not be considered exhaustive nor comprehensive, but rather an overview of the research evidence analysed within the limits of the research window. Further, the majority of the stressors outlined are complex and overlapping, significantly limiting options to identify and recommend clear options and solutions.

Despite these qualifications, this section offers a structured way to approach mental health and suicide related stressors, risks, and protective factors that are currently evident in the Australian LGBTQ+ population.

4.2 Stressors impacting LGBTQ+ people

The external and internal stressors which LGBTQ+ people have a heightened or unique risk of experiencing have been described and categorised in various ways in the literature.⁹⁹ For the purposes of this report, these risk factors or stressors are grouped under the following four headings:

1. Stigmatisation, discrimination, and marginalisation
2. Victimisation, bullying, and violence
3. Rejection, isolation, and loneliness
4. Factors related to LGBTQ+ specific milestones

4.2.1 Stigmatisation, discrimination, and marginalisation

Both the experience and anticipation of stigmatisation, discrimination, and marginalisation, have consistently been linked to increased risk of social, emotional, and mental distress, and poor mental health and suicide outcomes.¹⁰⁰ As noted above, these experiences can also

⁹⁹ Matthew Rivas-Koehl, Dane Rivas-Koehl, and Sharde Smith, "The temporal intersectional minority stress model: Reimagining minority stress theory," *Journal of Family Theory & Review*, (2023): 1-21.

¹⁰⁰ Miriam Moagi, Anna van Der Wath, Priscilla Jiyane, and Richard Rikhotso, "Mental health challenges of lesbian, gay, bisexual and transgender people: an integrated literature review," *SA Gesondheid* 26, no. 1487 (2021): 8.
<https://doi.org/10.4102/hsag.v26i0.1487>

Also Sav Zwickl, Alex Wong, Eden Dowers, Shalem Leemaqz, Ingrid Bretherton, Teddy Cook, Jeffrey Zajac, Paul Yip, and Ada Cheung, "Factors Associated with Suicide Attempts among Australian Transgender Adults," *BMC Psychiatry* 21, no. 81 (2021): 1-10.

undermine access to essential structural resources (e.g., healthcare and employment), as well as the development of coping resources, and social and community supports, which act as protective factors supporting mental health and wellbeing.¹⁰¹

While there is limited research data, the available evidence suggests that both people who have diverse sexual orientations¹⁰² and gender identities¹⁰³ continue to experience alarming rates of stigmatisation, discrimination, and marginalisation at structural, institutional, and interpersonal levels.

4.2.1.1 Structural and institutional discrimination and marginalisation

Although there are various legal protections against discrimination in Australia, evidence indicates that forms of overt discrimination and marginalisation still exist in law, institutions, and broader society. For example, while commitments have been made to improve data collection instruments, previous failures to meaningfully include LGBTQ+ populations have resulted in an absence of data in many settings, which undermines the provision of appropriate services, including mental healthcare.¹⁰⁴

The extent of legal protections provided to LGBTQ+ people by anti-discrimination laws (see Section 3.2) also varies at the state level. Legal exemptions still exist in many Australian jurisdictions, which make it lawful to discriminate against LGBTQ+ people in some instances. In Queensland, for example, it is lawful to prevent people from working with children on the basis of their sexual activity or gender identity if “the discrimination is reasonably necessary to protect the physical, psychological or emotional wellbeing of minors”.¹⁰⁵ A number of states also retain religious exemptions which expose LGBTQ+ populations to discrimination when attempting to access health, mental health, and aged care services operated by religious organisations.¹⁰⁶ It should, however, be noted that protections against religious exemptions are currently undergoing review at the federal level¹⁰⁷ and in various states. In addition, definitions covering sexual orientation and gender diversity in anti-discrimination legislation are inconsistent and, in many cases, incomplete.

These overt structural and institutional forms of marginalisation and discrimination can “facilitate a culture of intolerance” which contributes to interpersonal discrimination,

¹⁰¹ Moagi, van Der Wath, Jiyane, and Rikhotso, “Mental health challenges of lesbian, gay, bisexual and transgender people,” 8.

¹⁰² ABS, “General Social Survey: Summary Results Australia – Table 5.3”.

¹⁰³ LGBTIQ+ Health Australia, “Factsheet: Understanding suicide amongst transgender and gender diverse people,” accessed August 2023, https://www.lgbtiqhealth.org.au/understanding_suicide_among_tgd.

¹⁰⁴ Australian Human Rights Commission, “Commission welcomes resolution in Census inclusion complaint,” accessed 15 August 2023, <https://humanrights.gov.au/about/news/media-releases/commission-welcomes-resolution-census-inclusion-complaint>.

¹⁰⁵ Queensland Government, *Anti-Discrimination Act 1991*, s. 28.

¹⁰⁶ Australian Human Rights Commission, “Resilient Individuals: Sexual Orientation, Gender Identity & Intersex Rights – National Consultant Report,” (2015), 15, accessed August 2023, https://humanrights.gov.au/sites/default/files/document/publication/SOGII%20Rights%20Report%202015_Web_Version.pdf.

¹⁰⁷ Dreyfus, Mark, “Australian Law Reform Commission review of religious exemptions for educational institutions extended,” 20 April 2023, accessed August 2023, <https://ministers.ag.gov.au/media-centre/australian-law-reform-commission-review-religious-exemptions-educational-institutions-extended-20-04-2023>.

stigmatisation, harassment and violence, and increased mental health and wellbeing risks.¹⁰⁸ This has been clearly demonstrated in the Australian context through research on the national plebiscite on same-sex marriage, held in late 2017, which was characterised as a “pervasive and predominantly negative event” and a “highly stressful, socially fracturing process” for LGBTQ+ Australians. Research indicates that it more than doubled the reported rates of physical and verbal assaults on LGBTQ+ people, increased risk of mental distress, and damaged relationships with self, others, workplaces, and country.¹⁰⁹ Participants in a 2019 study on the plebiscite’s impacts described “feeling betrayed by the government, country and Church”, as negative messages about the LGBTQ+ community “were given legitimacy in the process of public debate”.¹¹⁰

A 2018 Australian study (drawing on the same sex plebiscite debates and data) found a correlation between low community levels of support for same-sex marriage and poorer life satisfaction, mental health, and overall health of LGBTQ+ people.¹¹¹ The impact of low-level community support was also found to be 2–4 times greater than the estimated impact of other general risk factors, such as being unemployed.¹¹² Predicted differences in health outcomes between LGB and heterosexual populations also increasingly diverged as levels of community support decreased.¹¹³ The study’s authors concluded that this indicated that social support provided or withheld by the general community has a substantive impact on psychological distress, independent to the availability of LGBTQ+ community support.

4.2.1.2 Interpersonal discrimination and microaggressions

Many LGBTQ+ people are known to experience commonplace forms of discrimination or inappropriate or offensive interpersonal exchanges, sometimes referred to as ‘microaggressions’.¹¹⁴ These are behaviours and attitudes towards LGBTQ+ people that may be intentional or unintentional, and/or within or outside of conscious awareness. In addition to various negative internal impacts (e.g., internalised stigma), when enacted by people in positions of authority, these forms of discrimination can also inhibit LGBTQ+ people’s access to employment, housing, education, and community activities or undermine the quality of the services they receive.

For example, research has indicated that when accessing healthcare, some LGBTQ+ patients reported that health issues were ‘overlooked’ by providers who held stereotypical

¹⁰⁸ Australian Human Rights Commission, “Resilient Individuals,” 14.

¹⁰⁹ Saan, Ecker, Sharon Rostosky, Ellen Riggie, Elizabeth Riley, and Joanne Byrnes, “The Australian Marriage Equality Debate: A Qualitative Analysis of the Self-Reported Lived Experience of Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGTBIQ) People,” *International Perspectives in Psychology: Research, Practice, Consultation* 8, no. 4 (2019): 212.

¹¹⁰ Ecker, Rostosky, Riggie, Riley, and Byrnes, 2019, “The Australian Marriage Equality Debate,” 212 and 223.

¹¹¹ Francisco Perales and Anna Todd, “Structural Stigma and the Health and Wellbeing of Australian LGB Populations: Exploiting Geographic Variation in the Results of the 2017 Same-Sex Marriage Plebiscite,” *Social Science & Medicine* 208 (2018): 196.

¹¹² Perales and Todd, “Structural Stigma,” 197.

¹¹³ Perales and Todd, “Structural Stigma,” 197.

¹¹⁴ Sue Derald Wing, Christina Capodilupo, Kevin Nadal, and Gina Torino. *Microaggressions in Everyday Life*, 2nd edition. John Wiley & Sons: Hoboken, NJ, 2020.

ideas about the expected health concerns of LGBTQ+ people.¹¹⁵ The interactions were also impaired by personnel making overt or covert assumptions that all people are heterosexual and cis-normative, thereby privileging heterosexual and cisgender identities within the health setting or wider institutions.¹¹⁶

The internalised anticipation of discrimination or hetero- and cis-normativity has also been linked to mental distress, and the experience of “threat” to the identities of LGBTQ+ people, particularly in relation to accessing services such as healthcare.¹¹⁷ For example, recent research has demonstrated that this can lead to poorer service outcomes associated with the non-disclosure of relevant information¹¹⁸, delays in help-seeking and treatment, and even avoidance of formal healthcare settings altogether.¹¹⁹ This can compromise both the access to, and the quality of, health and social services, including mental health, aged care, and other community supports.

4.2.2 Victimisation, bullying and violence

The personal experience, as well as the anticipation of victimisation, bullying, and violence, has been consistently linked to increased risks of mental distress and suicidal thoughts and behaviours in both the general and LGBTQ+ populations.

While there are substantial gaps in available data, the evidence does suggest that Australia’s LGBTQ+ populations are subjected to overt victimisation, bullying, and violence, at significantly higher rates than the general population.¹²⁰ For example, the 2020 ABS GSS found that Australia’s GLB+ populations were more than twice as likely to report being threatened with, or experiencing, an assault in the 12 months preceding the survey (8.6%), compared to the general population (4%).

Similarly, a 2023 national survey focused on transphobic victimisation and violence found that approximately one in six (16%) of the sample of transgender participants reported experiencing “anti-trans” violence in the 12 months preceding the survey. This included physical and sexual assault in various forms, with some instances so severe that the study’s authors concluded they “may have amounted to attempted murder”.¹²¹ In addition, almost

¹¹⁵ Moagi, van Der Wath, Jiyane, and Rikhotso, “Mental health challenges of lesbian, gay, bisexual and transgender people,” 9.

¹¹⁶ Meredith Worthen, ““Hetero-cis-normativity and the gendering of transphobia,” *International Journal of Transgenderism* 41, no 17 (2016): 31-57.

¹¹⁷ Moagi, van Der Wath, Jiyane, and Rikhotso, “Mental health challenges of lesbian, gay, bisexual and transgender people,” 8.

¹¹⁸ Moagi, van Der Wath, Jiyane, and Rikhotso, “Mental health challenges of lesbian, gay, bisexual and transgender people,” 8.

¹¹⁹ Dylan Kneale, Josie Henley, James Thomas, and Robert French, “Inequalities in Older LGBT People’s Health and Care Needs in the United Kingdom: A Systematic Scoping Review,” *Ageing and Society* 41 (2021): 501.

¹²⁰ Michael Skerrett, Kairi Kolves, and Diego De Leo, “Factors Related to Suicide in LGBT Populations - A Psychological Autopsy Case-Control Study in Australia,” *Crisis* 37, no. 5 (2016): 364.

Madi Day, Bronwyn Carlson, Dameyon Bonson, and Terri Farrelly, *Aboriginal and Torres Strait Islander LGBTQI+ People and Mental Health and Wellbeing*, Catalogue number IMH 15 (Australian Institute for Health and Welfare, Australian Government, 2023).

¹²¹ Hiero Badge, Jackie Turner, Austin Fabry-Jenkins, and Nevena Sirovska, “Fuelling Hate: Abuse, Harassment, Vilification and Violence Against Trans People in Australia,” Trans Justice Project and Victorian Pride Lobby, 19.

half (47.9%) of the transgender respondents to the survey reported experiencing “anti-trans abuse, harassment or vilification in-person” in the 12 months preceding.¹²²

Research also indicates that the risks to mental health and wellbeing posed by victimisation, bullying, and violence, are heightened in cases where an individual is explicitly targeted due to their sexual orientation and/or gender identity.¹²³ Some researchers have theorised that this may be due to an increased likelihood that stigma-driven victimisation and violence will fuel internal stressors, such as internalised stigma (sometimes referred to as internalised homophobia, transphobia, etc.).¹²⁴

In addition, LGBTQ+ populations are at unique risk of being coerced or threatened with the revelation of their sexual orientation or gender identity.¹²⁵ For example, research has indicated that perpetrators of Intimate Partner Violence (IPV) use the threat of ‘outing’ and revealing a person’s sexual orientation or gender identity as a tactic to isolate LGBTQ+ people from their family, friends, work colleagues, and community.¹²⁶ The threat of being outed can also complicate the ability of victimised LGBTQ+ people to seek help, safety, and assistance from services which are affirming, without exposing their identity. Evidence suggests that LGBTQ+ people who are ‘out’ may also hesitate to seek formal avenues of support when experiencing IPV, due to fear of experiencing or further contributing to the stigmatisation of LGBTQ+ people.¹²⁷

4.2.3 Rejection, isolation, and loneliness

Rejection and isolation from family and peers – particularly when explicitly related to LGBTQ+ identification – has been associated with significant mental distress and increased risks of poor mental health and suicide outcomes. These experiences can additionally undermine access to crucial social and internal coping resources which act as protective factors when navigating general life stressors, as well as the specific external stressors of being a part of the LGBTQ+ community such as stigma, discrimination, and victimisation, described above.

¹²² Badge, Turner, Fabry-Jenkins, and Sirovska, *Fuelling Hate*, 19.

¹²³ Sav Zwickl, Alex Wong, Eden Dowers, Shalem Leemaqz, Ingrid Bretherton, Teddy Cook, Jeffrey Zajac, Paul Yip, and Ada Cheung, "Factors Associated with Suicide Attempts among Australian Transgender Adults," *BMC Psychiatry* 21, no. 81 (2021): 6.

¹²⁴ Francesca Mongelli, Daniela Perrone, Jessica Balducci, Andrea Sacchetti, Silvia Ferrari, Giorgio Mettai, and Gian Galeazzi, "Minority Stress and Mental Health Among LGBT Populations: An Update on the Evidence," *Minerva Psichiatrica* 60, no. 1 (2019): 37.

¹²⁵ Mayumi Benavides, Obianuju Berry, and Molly Mangus, "Treating LGBTQ Patients Who Have Experienced Intimate Partner Violence," American Psychiatric Association, April 2019, 1-2.

¹²⁶ Benavides, Berry, and Mangus, "Treating LGBTQ Patients," 1-2.

¹²⁷ Benavides, Berry, and Mangus, "Treating LGBTQ Patients," 1-2.

4.2.3.1 Social isolation and rejection

While social connection acts as a significant protective factor for all people, research has found that, for LGBTQ+ people, socialisation with LGBTQ+ peers is particularly important for promoting positive internal processes which support mental health and wellbeing.

Studies have demonstrated that LGBTQ+ populations have an increased risk of social isolation, loneliness, and resulting mental distress when they do not have access to opportunities to connect with other members of the LGBTQ+ community. Those with access only to hetero- and cis-normative social spaces have reported “difficulty finding common ground”. They have also reported limitations to the social resources available to navigate life transitions and stressors unique to LGBTQ+ people.¹²⁸

Research also shows that social connections are instrumental in the development of “positive in-group identity” and self-acceptance, as well as in providing access to social and community support and “group-level coping”.¹²⁹ For example, research has shown that where there is an absence of tailored mental health services, having access to social supports from LGBT peers has been integral to their health and wellbeing, with many LGBT people reporting that they rely on informal peer support in times of distress.¹³⁰ Interestingly the research also found that access to this form of informal peer support often encouraged and supported individuals to seek help from formal mental health services.¹³¹

While efforts to develop targeted spaces for LGBTQ+ people have been shown to have substantive positive impacts, research has also noted discrimination and rejection from within the LGBTQ+ community towards subgroups, including transgender and bisexual people, as well as older LGBTQ+ community members (see Sections 3.3 and 3.4).¹³² This has been described as a “double discrimination” and has been linked to an increased risk of poor mental health outcomes among these affected cohorts.¹³³

¹²⁸ Dylan Kneale, Josie Henley, James Thomas, and Robert French, “Inequalities in Older LGBT People’s Health and Care Needs in the United Kingdom: A Systematic Scoping Review,” *Ageing and Society* 41 (2021): 503.

¹²⁹ Emily Bariola, Anthony Lyons, William Leonard, Marian Pitts, Paul Badcock, and Murray Couch, “Demographic and Psychosocial Factors Associated with Psychological Distress and Resilience among Transgender Individuals,” *Health Discrimination and Disparities* 105, no. 10 (2015): 2110.

¹³⁰ Shane Worrell, Andrea Waling, Joel Anderson, Anthony Lyons, Jackson Fairchild, and Adam Bourne, “Coping with the Stress of Providing Mental Health-Related Informal Support to Peers in an LGBTQ Context,” *Culture, Health & Sexuality* 25, no. 8 (2023): 991-1006.

¹³¹ Shane Worrell, Andrea Waling, Joel Anderson, Anthony Lyons, Jackson Fairchild, and Adam Bourne, “Coping with the Stress of Providing Mental Health-Related Informal Support to Peers in an LGBTQ Context,” *Culture, Health & Sexuality* 25, no. 8 (2023): 991-1006.

¹³² Francesca Mongelli, Daniela Perrone, Jessica Balducci, Andrea Sacchetti, Silvia Ferrari, Giorgio Mettai, and Gian Galeazzi, “Minority Stress and Mental Health Among LGBT Populations: An Update on the Evidence,” *Minerva Psichiatrica* 60, no. 1 (2019): 31.

¹³³ Mongelli, Perrone, Balducci, Sacchetti, Ferrari, Mettai, and Galeazzi, “Minority Stress and Mental Health Among LGBT Populations,” 31.

4.2.3.2 Familial isolation and rejection

Family connection and support has been shown to have a more significant influence on mental health and wellbeing outcomes than community and social support¹³⁴, particularly in terms of impacts on early stages of self-identification and expression.¹³⁵

The importance of family support is attributed to the “differing potency of ascribed relationships (family) compared with achieved relationships (friends or partners)”¹³⁶, such that social support from peers often cannot compensate for low family support.¹³⁷ In addition, family support facilitates access to structural resources, particularly in the early stages of life. As such, in some cases family rejection has been found to inhibit access to social and economic necessities, such as housing.¹³⁸

Rejection by, and isolation from, family has also been associated with a range of poor mental health and suicidal outcomes. For example, Skerret et al (2016)’s autopsy of LGBT suicide cases in Australia found that LGBT people who had died by suicide were significantly less likely to have been accepted by their father (25%) and their mother (46.2%), compared to those who had not (60.5% and 70.4% respectively).¹³⁹

Various studies have also indicated that the negative impacts of familial rejection and isolation can be mediated by cultural background and poses an even greater risk to the mental health and wellbeing of individuals with larger kinship networks and strong family bonds.¹⁴⁰

In the inverse, for LGBT populations, research has found that explicit expressions of approval and the capacity to have “open discussions” regarding identity with parents and family act as potent protective factors supporting mental health and wellbeing, when compared to instances of only implicit support.¹⁴¹

¹³⁴ Samskruthi Madireddy and Sahithi Madireddy, "Supportive Model for the Improvement of Mental Health and Prevention of Suicide Among LGBTQ+ Youth," *International Journal of Adolescence and Youth* 27, no. 1 (2022): 85-101.

¹³⁵ Nicole Aqsuith, Anneke Collison, Lisa Lewis, Kai Noonan, Eloise Layard, Guneet Kaur, Fernanda Bellei, and Erdem Yigiter, "Home Is Where Our Story Begins: CALD LGBTIQ+ People's Relationships to Family," *Current Issues in Criminal Justice* 31, no. 3 (2019): 315.

¹³⁶ Emily Bariola, Anthony Lyons, William Leonard, Marian Pitts, Paul Badcock, and Murray Couch, "Demographic and Psychosocial Factors Associated with Psychological Distress and Resilience among Transgender Individuals," *Health Discrimination and Disparities* 105, no. 10 (2015): 2112.

¹³⁷ Robert Eres, Natasha Postolovski, Monica Thielking, and Michelle Lim, "Loneliness, Mental Health and Social Health Indicators in LGBTQIA+ Australians," *American Journal of Orthopsychiatry* 91, no. 3 (2021): 363.

¹³⁸ Aqsuith, Collison, Lewis, Noonan, Layard, Kaur, Bellei, and Yigiter, "Home Is Where Our Story Begins," 327.

¹³⁹ Michael Skerrett, Kairi Kolves, and Diego De Leo, "Factors Related to Suicide in LGBT Populations - A Psychological Autopsy Case-Control Study in Australia," *Crisis* 37, no. 5 (2016): 365.

¹⁴⁰ Kari McDonald, "Social Support and Mental Health in LGBTQ Adolescents: A Review of Literature," *Issues in Mental Health Nursing* 39, no. 1 (2018): 16-29.

¹⁴¹ Mongelli, Perrone, Balducci, Sacchetti, Ferrari, Mettai, and Galeazzi, "Minority Stress and Mental Health Among LGBT Populations," 32.

4.2.4 Factors related to LGBTQ+-specific development milestones

The development of LGBTQ+ identities has been described in various staged milestone models which assume that LGBTQ+ people commonly undergo a linear development process: this can be summarised as questioning, discovering, understanding, accepting, and then disclosing their identity or 'coming out'. Researchers have competing theories regarding both the legitimacy of these types of linear milestone models (elaborated on further below), and the impacts that these development processes have on some people's mental health and wellbeing.¹⁴²

Some studies have indicated that the processes of navigating LGBTQ+ specific milestones can have substantive positive impacts on mental health and wellbeing. For example, researchers have suggested they can foster "a sense of personal empowerment" and self-acceptance and support intra- and interpersonal growth.¹⁴³ Conversely, the concealment of LGBTQ+ identity has been associated with stress, self-isolation, lowered self-esteem, and various other negative mental health and suicide outcomes.¹⁴⁴

Conversely, the staged 'coming out' model has received criticism for creating a narrative of progression which applies pressure on LGBTQ+ people to move through these stages in a coherent way, and then reveal their identity as a rite of passage or moral obligation.¹⁴⁵ However, for some people it is not safe to come out, or by coming out they risk losing valued family and community resources which support mental health and wellbeing. For others, coming out is not considered an imperative.¹⁴⁶

The stage model has additionally been criticised for being too rigid and not providing an accurate reflection of the dynamic and non-linear processes that many LGBTQ+ people navigate in relation to their identity. For example, many LGBTQ+ people must continuously navigate and re-negotiate their identity in different social contexts, in relation to varied social structures and intersecting experiences. For some, sexual orientation and gender identity are fluid, or more nuanced, due to intersectional understandings of identity. For this reason, the coming out narrative, with its assumption of a final and coherent self that can be made intelligible to others, does not reflect the lived experience or personal situations of all LGBTQ+ people.¹⁴⁷

¹⁴² Kate Klein, Alix Holtby, Katie Cook and Robb Travers, "Complicating the Coming Out Narrative: Becoming Oneself in a Heterosexist and Cissexist World," *Journal of Homosexuality* 62, no. 3 (2015): 297-326.

¹⁴³ Emily Bariola, Anthony Lyons, and Jayne Lucke, "Flourishing Among Sexual Minority Individuals: Application of the Dual Continuum Model of Mental Health in a Sample of Lesbians and Gay Men", *Psychology of Sexual Orientation and Gender Diversity* 4, no. 1 (2017): 50.

¹⁴⁴ Moagi, van Der Wath, Jiyane, and Rikhotso, "Mental health challenges of lesbian, gay, bisexual and transgender people," 8; Michael Skerrett, Kairi Kolves, and Diego De Leo, "Factors Related to Suicide in LGBT Populations - A Psychological Autopsy Case-Control Study in Australia," *Crisis* 37, no. 5 (2016): 365.

¹⁴⁵ Klein, Holtby, Cook and Travers, "Complicating the Coming Out Narrative," 297-326.

¹⁴⁶ Mary Lou Rasmussen, "The Problem of Coming Out," *Theory into Practice* 43 (2004): 144-150.

¹⁴⁷ Guilzar Raisa Charania, "Regulated Narratives in Anti-Homophobia Education: Complications in Coming Out Stories," *Canadian Woman Studies* 24 (2005): 31-37.

Further, research has shown that coming out is not just about internal processes of discovery and self-acceptance, but also linked to an individual's sense of safety and their access to information and resources. Access to resources such as counselling can support LGBTQ+ people to explore their sexual orientation or gender identity. For example, the lack of widespread understanding of bisexuality can limit a person's ability to discover and disclose identity in the absence of resources and support.¹⁴⁸

Recognising critiques of stage frameworks, research has nonetheless explored how social and contextual factors can mediate the mental health and wellbeing impacts of navigating LGBTQ+ milestones. In particular, the literature identifies age and life stages as two core factors:

- **Age:** there is no consensus amongst researchers regarding the impacts of age when navigating sexual orientation and gender identity, with different studies noting both positive and negative impacts to mental health and wellbeing. For example, research has both associated the early experience of 'coming out' as LGBT with "positive psychosocial adjustment" and, conversely, negative impacts to identity formation and self-esteem.¹⁴⁹ Researchers have linked these negative impacts to exposure to minority stressors at a more vulnerable age.¹⁵⁰ In addition, studies have indicated that receiving gender-affirming care during adolescence can have substantive positive impacts on lifelong mental health and suicide prevention outcomes.¹⁵¹ It has, therefore, been suggested that the impact of age is mediated by other factors, such as an individual's environment, and the support received from their family and community, including formal support.
- **Life stage:** research has indicated that the life stage when LGBTQ+ people engage in identity negotiation can have a significant impact on their mental health. For example, navigating sexual orientation and gender identity within hetero- and cis-normative family units can carry additional complications as people must also negotiate the potential impacts on intimate relationships, co-parenting arrangements, and children.¹⁵² This can exacerbate the risks of internal and external stressors, such as losing a partner or children through relationship breakup, divorce, family separation, or formal custody battles. However, as noted above, these factors are themselves also mediated by other contextual factors, such as generation or geographical location; intersectional identity; or

¹⁴⁸ Kirsten McLean, "Hiding in the Closet? Bisexuals, Coming Out, and the Disclosure Imperative," *Journal of Sexuality* 43: 151-166.

¹⁴⁹ Skerrett, Michael., Kolves, Kairi., and De Leo, Diego. "Factors Related to Suicide in LGBT Populations" p. 366.

¹⁵⁰ Skerrett, Michael., Kolves, Kairi., and De Leo, Diego. "Factors Related to Suicide in LGBT Populations" p. 366.

¹⁵¹ Jack Turban, "The Evidence for Trans Youth Gender-Affirming Medical Care: Research Suggests Gender-Affirming Medical Care Results in Better Mental Health." *Psychology Today*, January 24, 2022.
<https://www.psychologytoday.com/us/blog/political-minds/202201/the-evidence-trans-youth-gender-affirming-medical-care>.

¹⁵² Rosie Charter, Jane Ussher, Janette Perz, and Kerry Robinson, "Transgender Parents: Negotiating 'Coming Out' and Gender Affirmation with Children and Co-Parents," *Journal of Homosexuality* 70, no. 7 (2022): 1292.

intelligibility of gender or sexual orientation, each of which can alter community acceptance and the sociopolitical context in which these experiences occur.¹⁵³

Taken together, these factors highlight the need to not assume a one-size-fits-all approach with regard to the mental health and wellbeing of LGBTQ+ people across Australia.

4.3 Supplementary stressors experienced by some communities

While the mental health and wellbeing stressors outlined above can be generalised across the broader LGBTQ+ community, there are various additional issues or risk factors that can impact subgroups within the community, or that are compounded by intersectional issues.

These are summarised below, commencing with, transgender and gender diverse people and bisexual people (Section 3.3), followed by First Nations peoples (3.4), and ending with various stressors related to intersectionality (3.5).

4.3.1 Transgender and gender diverse people

Trans and gender diverse people face a number of additional stressors when compared to the broader LGBTQ+ community, as well as to the general population. Most research has, unfortunately, tended to treat gender diverse people as a single group or has focused primarily on differences in assigned gender at birth, rather than differences in individual identity.¹⁵⁴ There are, therefore, limited studies that consider specific risk factors for more marginalised gender diverse identities, such as non-binary and gender fluid individuals.

For the purposes of this overview, we have summarised the major additional risk factors applicable to all gender diverse people as:

- **Erasure:** trans and gender diverse people can face near complete erasure in the provision of facilities, as well as the documentation and language used by many institutions. This has been linked to both reduced access to inclusive, affirming, and safe services, as well as poor mental health and suicide outcomes. Erasure has, for example, been demonstrated with regard to cisnormativity in perinatal care: among other issues, in the organisation of the physical space by binary gender (e.g., mother's rooms and women's toilets); language of the service (e.g., references exclusively to

¹⁵³ Matthew Rivas-Koehl, Dane Rivas-Koehl, and Sharde Smith, "The temporal intersectional minority stress model: Reimagining minority stress theory," *Journal of Family Theory & Review*, (2023): 6.

Kate Klein, Alix Holtby, Katie Cook and Robb Travers, "Complicating the Coming Out Narrative: Becoming Oneself in a Heterosexist and Cissexist World." *Journal of Homosexuality* 62, no. 3 (2015): 297-326.

¹⁵⁴ Rainbow Health Australia, "Research Matters: Trans and Gender Diverse Health and Wellbeing," accessed August 25, 2023. <https://rainbowhealthaustralia.org.au/media/pages/research-resources/research-matters-trans-and-gender-diverse-health-and-wellbeing/80199998-1655786493/research-matters-trans-and-gender-diverse-health-and-wellbeing.pdf>.

'breast feeding'); and exclusion of non-gestational parents.¹⁵⁵ This study indicated that self-advocacy and making the trans or non-binary self visible again, is costly and exhausting for people, particularly as they navigate pregnancy, birth, and parenting, and this can exacerbate or create poor post-natal mental health outcomes. On a broader scale, in many instances, gender diverse people are not provided adequate options to update their identified gender in official documentation. For example, in NSW, the legal gender marker on a birth certificate can only be updated in instances where an individual has undergone a surgical, sex affirmation procedure involving altering a "person's reproductive organs" to align with the gender binary.¹⁵⁶ This erases a wide range of gender diverse people whose identities do not align with any binary, or who do not want to, choose not to, or cannot access surgical affirming care.

- **Pathologisation:** the historical and contemporary pathologisation of gender diverse identities has been deemed a globally "damaging approach".¹⁵⁷ Research has indicated that pathologisation has legitimised exposure to "harmful and coercive conversion practices" – including by mental health service providers – and contributed to stigmatisation and discrimination.¹⁵⁸

While pathologisation is relevant to all LGBTQ+ people, there are particular considerations for trans and gender diverse people. Although homosexuality was removed from the World Health Organisation's International Classification of Disease (ICD) in 1992, categorisation of gender diversity as a medical disorder was not removed until the 11th version, in January 2022.¹⁵⁹ Previously in 2013, the 5th edition of the Diagnostic Statistical Manual (DSM) replaced 'gender identity disorder' with 'gender dysphoria', with the aim of refocusing diagnosis to related stress, rather than the identity itself.¹⁶⁰ However, as the American Psychiatric Association (APA) and trans advocates have emphasised, the move to using gender dysphoria as a diagnostic category in the DSM has not necessarily mitigated pathologisation.¹⁶¹ Although it is argued that the diagnostic category facilitates access to gender-affirming care options, this new category has been criticised for perpetuating stigmatisation by positioning gender

¹⁵⁵ George Parker, Alex Ker, Sally Baddock, Elizabeth Kerekere, Jaimie Veale, and Suzanne Miller, "It's Total Erasure: Trans and Nonbinary Peoples' Experiences of Cisnormativity within Perinatal Care Services in Aotearoa New Zealand," *Women's Reproductive Health* (2022).

¹⁵⁶ *Births, Deaths, and Marriages Registration Act 1995* (NSW) No 62, s 32A.

¹⁵⁷ Carl Horton, "Depathologising Diversity: Trans Children and Families' Experiences of Pathologisation in the UK," *Children & Society* 37 (2023): 754.

¹⁵⁸ Horton, "Depathologising Diversity," 754.

¹⁵⁹ Horton, "Depathologising Diversity," 754.

¹⁶⁰ American Psychiatric Association, "Gender Dysphoria Diagnosis: A Guide for Working with Transgender and Gender Nonconforming Patients," accessed August 2023, <https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis>.

¹⁶¹ American Psychiatric Association, "Gender Dysphoria Diagnosis: A Guide for Working with Transgender and Gender Nonconforming Patients," accessed August 2023, <https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis>.

related distress as mental illness, and continuing to expose trans and gender non-conforming people to potentially harmful psychiatric intervention.¹⁶²

The injustices and impacts of historic, and ongoing, inappropriate mental health interventions for trans and gender diverse people still need to be understood and addressed. In the Australian context, the Australian Psychological Society's (APS) 'Panel on assessment, support and therapeutic approaches to transgender and gender diverse people' (established in July 2022) is yet to deliver a position statement regarding this, indicating that it will now be delivered in late 2023.¹⁶³

- **Stigmatisation, discrimination, and exclusion from public spaces:** while experiences of stigmatisation and discrimination are widespread amongst the general LGBTQ+ community (see Section 3.2.1), in recent years, trans and gender diverse peoples' access to dedicated healthcare services, safe use of public utilities (such as bathrooms), and participation in various social spaces (such as education and sport), has become the subject of ongoing and heated political debate both in Australia and globally.¹⁶⁴ As discussed in Section 3.2.1, research on Australia's same-sex marriage plebiscite has demonstrated the mental health impacts of being centred as the object of public debate, particularly when it is legitimised by governing institutions. It not only fuels internal stressors such as internalised stigma and transphobia, but it can also exacerbate external risks related to experiences of discrimination and victimisation.¹⁶⁵ As discussed in Section 3.3.1, this can also inhibit access to protective structural factors, such as healthcare and education. In the Australian context, discrimination is evident in the higher incidence of unemployment among trans people (19%), which occurs at more than three times the rate of the general population (5.5%).¹⁶⁶

In addition to the above, major risk factors have been identified which are more specific to transgender people. These can be summarised as:

- **Barriers to accessing gender-affirming care:** while research and regulation is still evolving globally¹⁶⁷, access to gender affirming care (e.g., hormones, surgery) has been repeatedly identified as a significant protective factor against mental distress and

¹⁶² American Psychiatric Association, "Gender Dysphoria Diagnosis: A Guide for Working with Transgender and Gender Nonconforming Patients," accessed [insert date], <https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis>.

¹⁶³ Australian Psychological Society, "Lesbian, Gay, Bisexual, Transgender and Intersex Issues," <https://psychology.org.au/community/advocacy-social-issues/lesbian-gay-bisexual-transgender-intersex>.

¹⁶⁴ Sav Zwickl and Ada Cheung, "Challenging Five Years of Transphobia: The Real-World Impact of the 'Transgender Debate' Is Unrelenting on Australia's Trans Community, However, Small but Visible Acts of Allyship Can Go a Long Way," *Pursuit*, University of Melbourne, May 16, 2022, <https://pursuit.unimelb.edu.au/articles/challenging-five-years-of-transphobia>.

¹⁶⁵ Saan Ecker, Sharon Rostosky, Ellen Riggle, Elizabeth Riley, and Joanne Byrnes, "The Australian Marriage Equality Debate: A Qualitative Analysis of the Self-Reported Lived Experience of Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGTBIQ) People," *International Perspectives in Psychology: Research, Practice, Consultation* 8, no. 4 (2019): 212-223.

¹⁶⁶ Sav Zwickl, Alex Wong, Eden Dowers, Shalem Leemaqz, Ingrid Bretherton, Teddy Cook, Jeffrey Zajac, Paul Yip, and Ada Cheung, "Factors Associated with Suicide Attempts among Australian Transgender Adults," *BMC Psychiatry* 21, no. 81 (2021): 7.

¹⁶⁷ The NHS England Cass Review, for example, is still underway. See: <https://cass.independent-review.uk/publications/interim-report/>

suicidality in the trans population.⁴⁴ Research has also shown that barriers to accessing care, such as lack of availability, affordability, or denial or delay of service access, can have “profound” impacts, and have been consistently correlated with increased risk of self-harm and suicide.⁴⁵ Access barriers can also further complicate the processes of identity formation and of disclosing identity to family and peers – for example, research on trans and gender diverse youth indicates that they are more likely to be exposed to cis-normative assumptions, due to a lack of access to gender affirming care.¹⁶⁸ A lack of explicit support from family members can also lead an individual to delay accessing gender-affirming care, which they would otherwise have sought. Charter et al (2017), for example, found that many transgender parents delay accessing gender affirming care due to concerns about the potential impacts to their children.⁴⁶

- **Passing/not passing and the fear of being ‘outed’:** although trans people can seek to pass as cisgender for safety reasons, not all trans or gender diverse people seek to pass, or can pass, as cisgendered. However, passing or not passing can have implications related to family and community violence.¹⁶⁹ Passing can also pose new threats to mental health and wellbeing, including risks to self-esteem and self-acceptance related to concealing or loss of identity¹⁷⁰, as well as risks of accidental or intentional discovery or disclosure of identity by others, and related exposure to rejection, stigmatisation, and discrimination on the basis of gender identity.¹⁷¹

4.3.2 Bisexual people and other marginalised sexual orientations

Research has shown that monosexism – or the belief that people can only be heterosexual, lesbian, or gay – is a well-established stressor for people who are bisexual and pansexual.¹⁷² The associated denial or belittling of bisexual and pansexual identities can exacerbate the risks of various external and internal stressors which impact on mental health and wellbeing. For example, research suggests that this increases the risks of:

- **Lower self-acceptance of sexual orientation and higher incidence of identity concealment** compared to others in the LGBTQ+ community, which have been linked to poorer mental health outcomes,¹⁷³ and barriers to help seeking. For example, bisexual adults referred to psychological services in the UK expressed unique concerns about

¹⁶⁸ Damien Riggs, Gavriel Ansara and Gareth Treharne, “An Evidence-Based Model for Understanding the Mental Health Experiences of Transgender Australians,” *Australian Psychologist* 50, no. 1 (2015): 32-39.

¹⁶⁹ Eduardo Mesquita Peixoto, Virginia Maria de Azevedo Oliveira Knupp, Jesilaine Resende Teixeira Soares, Davi Gomes Depret, Cleo de Oliveira Souza, Maria Eduarda Dantas Messina, and Luciana de Souza Velasque, “Interpersonal Violence and Passing: Results from a Brazilian Trans-Specific Cross-Sectional Study,” *Journal of Interpersonal Violence* 37, no. 15-16 (2022): NP14397-NP14410.

¹⁷⁰ Isaac Blythe, “Passing Notion: The Experience of Four Trans Identified Students and the Violence of Assimilation.” Honors thesis, 2016.

¹⁷¹ Rosie Charter, Jane Ussher, Janette Perz, and Kerry Robinson, “Transgender Parents: Negotiating ‘Coming Out’ and Gender Affirmation with Children and Co-Parents,” *Journal of Homosexuality* 70, no. 7 (2022): 1298.

¹⁷² Sarah Noble, “Mental Health Facts on Bisexual Populations,” January 2020, American Psychological Association.

¹⁷³ Jake Camp, Silia Vitoratou, and Katharine Rimes, “LGBTQ+ Self-Acceptance and Its Relationship with Minority Stressors and Mental Health: A Systematic Literature Review,” *Archives of Sexual Behavior* 49 (2020): 2353.

disclosing their sexual orientation when receiving mental health care. Because bisexuality is poorly understood, participants were concerned that practitioners would “brand them as confused, attention-seeking or hypersexual”.¹⁷⁴ Discomfort and fear around disclosure of sexual orientation can also deter people who are bisexual from seeking help from formal health services.¹⁷⁵

- **Rejection, erasure, and social isolation in LGBTQ+ spaces** and resulting impacts to social support. As such, opportunities to participate in specific bi- and pan-community events have been identified as a significant protective factor for bisexual and pansexual people.¹⁷⁶

There is limited research investigating the mental health and wellbeing of pansexual people, particularly where they differ from bisexual people. One Australian study conducted in 2023, found that their pansexual participants were more open about their sexual orientation and reported feeling more connected to the LGBTQ+ community than their bisexual peers.¹⁷⁷ However, the study also found that pansexual identification was indirectly linked to increased psychological distress due to an elevated awareness of stigmatising views related to their identity.¹⁷⁸

4.4 First Nations LGBTQ+SB people

Australia’s First Nations community is comprised of hundreds of different nations, languages, and traditions,¹⁷⁹ which inform a diversity of experiences and risk factors relevant to each LGBTQ+SB First Nations person and community. However, there has been limited research addressing the specific needs of Australia’s First Nations LGBTQ+SB (including Sistergirl and Brotherboy) population overall, let alone the diversity of needs within this population.

The experiences and needs of First Nations LGBTQ+SB people must also be contextualised within the varied historical and contemporary impacts of colonisation and discrimination,

¹⁷⁴ Daniel Morris, Vanessa Fernandes, and Katharine Rimes, "Sexual Minority Service User Perspectives on Mental Health Treatment Barriers to Care and Service Improvements," *International Review of Psychiatry* 34, no. 3-4 (2022): 230-239.

¹⁷⁵ Taylor, Julia., Power, Jennifer., Smith, Elizabeth., and Rathbone, Mark. "Bisexuals' Experiences of Mental Health Services: Findings from the Who I Am Study," *Sexuality Research and Social Policy* 18, no. 1 (2021): 27-38.

¹⁷⁶ Francesca Mongelli, Daniela Perrone, Jessica Balducci, Andrea Sacchetti, Silvia Ferrari, Giorgio Mettai, and Gian Galeazzi, "Minority Stress and Mental Health Among LGBT Populations: An Update on the Evidence," *Minerva Psichiatrica* 60, no. 1 (2019): 32.

¹⁷⁷ James Morandini., Jessica Strudwick, Rachel Menzies, and Ilan Dar-Nimrod, "Differences between Australian Bisexual and Pansexual Women: An Assessment of Minority Stressors and Psychological Outcomes," *Psychology & Sexuality* 14, no. 1 (2023): 233.

¹⁷⁸ Morandini, Strudwick, Menzies, & Dar-Nimrod, 2023, "Differences between Australian bisexual and pansexual women," p. 233.

¹⁷⁹ "Aboriginal Diversity – Why One Size Does Not Fit All," Evolve Communities, accessed 2023, <https://www.evolve.com.au/aboriginal-diversity/>.

which have been strongly and repeatedly linked to worse health, mental health, and wellbeing outcomes.¹⁸⁰

Notwithstanding the above, the available literature has identified distinct stressors which impact the mental health and wellbeing of LGBTQ+SB First Nations people. In addition to stressors related to being a First Nations person¹⁸¹, some stressors related to the intersecting experiences of being First Nations and LGBTQ+SB include (though are not limited to):

- **Erasure:** research involving LGBTQ+SB First Nations people points to the interconnection between colonialism and the imposition of patriarchal, hetero and cis-normative values, which have denied and erased Aboriginal people with diverse sexual orientations and genders from public consciousness¹⁸² and from Australian institutions.¹⁸³ As Baylis (2015) notes: "the lived realities of colonisation have constructed a silencing force that mutes Queer-Aboriginality".¹⁸⁴ This is despite pre-colonial, colonial, and post-colonial evidence of sexual and gender diverse peoples in First Nations communities.¹⁸⁵ Research has indicated that First Nations LGBTQ+SB representation in media, policy, and community can have substantive impacts on supporting self-understanding and confidence integrating LGBTQ+SB identity within community and culture, as well as reducing the burden of educating others.¹⁸⁶
- **Social isolation and disconnection from country:** while social inclusion measures have been critiqued by First Nations researchers for failing to capture the complexities of First Nations peoples' social systems and values, research has also indicated that many LGBTQ+SB people are impacted by difficulty finding social spaces in which they can be "simultaneously queer and Aboriginal".¹⁸⁷ First Nations LGBTQ+SB people have reported experiencing racist discrimination within LGBTQ+ spaces, as well as

¹⁸⁰ Pat Dudgeon, Lobna Rouhani, Leilani Darwin, and Maddie Boe, *Indigenous Lived Experience of Suicide: Literature Review* (Western Australia: The University of Western Australia, 2018), 16.

¹⁸¹ See: Australian Institute for Health and Welfare 2022, *Protective and risk factors for suicide among Indigenous Australians*, Published: 25 March 2022, <https://www.indigenoussmhspc.gov.au/publications/protective-and-risk-factors>

¹⁸² Oscar Monaghan, "Dual Imperatives: Decolonising the Queer and Queering the Decolonial," in *Colouring the Rainbow: Blak Queer and Trans Perspectives*, ed. Dino Hodge (Wakefield Press, 2015).

¹⁸³ Bep Uink, Jennifer Dodd, Sian Bennett, Dameyon Bonson, Anne-Marie Eades, and Braden Hill, "Confidence, Practices, and Training Needs of People Working with Aboriginal and Torres Strait Islander LGBTQ+ Clients," *Culture, Health & Sexuality* 25, no. 2 (2023): 206-222.

¹⁸⁴ Troy-Anthony Baylis, "Introduction: Looking Into the Mirror," in *Colouring the Rainbow: Blak Queer and Trans Perspectives*, ed. Dino Hodge (Wakefield Press, 2015).

¹⁸⁵ Braden Hill, Jennifer Dodd, Bep Uink, Dameyon Bonson, Sian Bennett, and Anne-Marie Eades, "Aboriginal and Queer Identity/ies in Western Australia: When There is a Need to Know in Therapeutic Settings," *Qualitative Health Research* 32, no. 5 (2022): 755-770.

Nicole Anae, "Embracing what is rightfully ours": representing Australian Aboriginal Brotherboy identities", in *European Journal of English Studies*, vol. 24 (2020) p. 76 – 88.

¹⁸⁶ Shakara Liddel-Hunt, Ashleigh Lin, James Hector, Laurent Hill, Kate Daglas, Braden Hill, Yael Perry, Mirella Wilson and Bep Uink, "Conceptualising Wellbeing for Australian Aboriginal LGBTQ+ Young People", in *Youth 2023*, vol. 3 (2023) p. 83

¹⁸⁷ Liddel-Hunt et al., "Conceptualising Wellbeing for Australian Aboriginal LGBTQ+ Young People" p. 75

“queerphobia” within First Nations community spaces.¹⁸⁸ This is particularly complicated for individuals who have not been brought up on country or amongst their community, due to the impacts of colonisation and ‘Stolen Generation’ policies. For some LGBTQ+SB, reliance on older relatives and elders who may have discriminatory views towards LGBTQ+SB people to reconnect with community and culture can reportedly make the process “difficult and nerve-racking”.¹⁸⁹ While experiences varied substantially and many report feeling that their LGBTQ+SB identity is accepted by their community, some participants in recent research undertaken in Western Australia reported experiencing overt rejection, violence or feeling that they had to hide their LGBTQ+SB self in order to participate in their community.¹⁹⁰ In addition to driving internal stressors, such as self-stigma, these experiences could also make it difficult to maintain connection to community, country, and First Nations identity, and, in some cases, “arrested the process of healing from the impacts of colonisation”.¹⁹¹ For some LGBTQ+SB people, distress was exacerbated by the association of discriminatory attitudes towards LGBTQ+ with the historical trauma of missions, where patriarchal, hetero and cis-normative values teachings were enforced on older community members.¹⁹² Further, some LGBTQ+SB people have reported that the racialized hardships and traumas experienced by their families and communities can make it difficult for them to provide support for hardships related to being LGBTQ+, which, in some cases, was seen as minor in comparison.¹⁹³

- **Marginalisation:** even less attention has been given to determining appropriate ways to support the unique needs of First Nations LGBTQ+SB people. The existing research indicates that First Nations LGBTQ+SB people experience complex, intersecting issues in family and society that exacerbate distress and impact on community connection. However, they may be hesitant to access services such as mental health care, due to: historical pathologisation of First Nations people; limited availability of culturally safe services; and the absence of services that can attend to intersecting experiences related to race, ethnicity, culture, gender and sexual orientation.¹⁹⁴ Research has found that LGBTQ+SB First Nations people have developed communities of care through alternative avenues, such as social media, in lieu of formal help-seeking.¹⁹⁵ In addition, the terminology used by many First Nations communities to describe transgender individuals – ‘Sistergirl’ and ‘Brotherboy’ – is often absent from national dialogue on

¹⁸⁸ Day, Carlson, Bonson, & Farrelly, *Aboriginal and Torres Strait Islander LGBTQIASB+ People and Mental Health and Wellbeing*, 8.

¹⁸⁹ Liddel-Hunt et al., “Conceptualising Wellbeing for Australian Aboriginal LGBTQIA+ Young People” p. 76

¹⁹⁰ Liddel-Hunt et al., “Conceptualising Wellbeing for Australian Aboriginal LGBTQIA+ Young People” p. 80

¹⁹¹ Liddel-Hunt et al., “Conceptualising Wellbeing for Australian Aboriginal LGBTQIA+ Young People” p. 76

¹⁹² Liddel-Hunt et al., “Conceptualising Wellbeing for Australian Aboriginal LGBTQIA+ Young People” p. 80

¹⁹³ Liddel-Hunt et al., “Conceptualising Wellbeing for Australian Aboriginal LGBTQIA+ Young People” p. 76

¹⁹⁴ Day, Carlson, Bonson, & Farrelly, *Aboriginal and Torres Strait Islander LGBTQIASB+ People and Mental Health and Wellbeing*, 15.

¹⁹⁵ Day, Carlson, Bonson, & Farrelly, *Aboriginal and Torres Strait Islander LGBTQIASB+ People and Mental Health and Wellbeing*, 2.

LGBTQ+SB people.¹⁹⁶ While researchers have emphasised the need to treat First Nations LGBTQ+SB people as a priority group in research and policy development, they have also stressed that First Nations LGBTQ+SB people are at risk of being treated as “objects of anthropological interest”, and that it is imperative that research and policy development in this area is “responsible, ethical and community-owned”.¹⁹⁷

4.5 Stressors related to intersectional identities

LGBTQ+ people with multiple intersecting identities related to race, ethnicity, culture, disability, and social class, also face further risks to their mental health and wellbeing.

Research indicates that people with intersecting identities do not experience additive or “multiple minority stress”¹⁹⁸ (i.e., additional risk factors related to multiple, separate identities), but rather that they experience unique stressors at the intersection of their minority identities, which can “interact and conflict with each other”.¹⁹⁹ An individual with intersecting identities may, for example, experience a stigmatising event through the lens of multiple minority identities, simultaneously. They can also experience stigma about one facet of their identity even while another aspect is affirmed: for example, racial discrimination within an LGBTQ+ inclusive setting. In addition, the internal processes related to accepting and negotiating one identity may be complicated by the lens of their other identity. The ways these identities interact, overlap, and conflict, is also likely to fluctuate over life course and in relation to contextual factors, such as location and geography, and access to coping resources.²⁰⁰

In addition to intersectional experiences of First Nations LGBTQ+SB people (see Section 3.4), research has demonstrated intersectional stressors that impact on mental health and wellbeing of other groups within the LGBTQ+ community, including older adults, culturally and linguistically diverse people, and people with disability. These intersectional experiences are complex, and a comprehensive review is beyond the scope of this report. However, the information below intends to provide an overview of some stressors that are specific to these communities.

4.5.1 Age

In addition to experiencing separate issues related to age, in various contexts, research has identified various stressors which LGBTQ+ people are likely to experience with relation to their identity at different ages and life stages. While intersecting experiences related to age

¹⁹⁶ Day, Carlson, Bonson, & Farrelly, *Aboriginal and Torres Strait Islander LGBTQI+ People and Mental Health and Wellbeing*, 2.

¹⁹⁷ Liddel-Hunt et al., “Conceptualising Wellbeing for Australian Aboriginal LGBTQ+ Young People” p.90

¹⁹⁸ Matthew Rivas-Koehl, Dane Rivas-Koehl, and Sharde Smith, “The temporal intersectional minority stress model: Reimagining minority stress theory,” *Journal of Family Theory & Review*, (2023): 6.

¹⁹⁹ Rivas-Koehl, Rivas-Koehl, & Smith, “The temporal intersectional minority stress model: Reimagining minority stress theory,” 7.

²⁰⁰ Rivas-Koehl, Rivas-Koehl, & Smith, “The temporal intersectional minority stress model,” 7.

and being LGBTQ+ vary across the various subgroups which comprise the community, as well as by other demographic factors, a high-level summary of some notable stressors is provided below.

For older LGBTQ+ people, some unique stressors identified in the literature include:

- **Marginalisation and discrimination within some LGBTQ+ spaces** due to an “emphasis on youth”. This has been associated with multiplicative internalised stigma, and overall poorer mental health and wellbeing outcomes.²⁰¹ Various studies have found that many older gay men, in particular, report that many LGBTQ+ spaces can feel “actively ageist”²⁰² and contribute to an experience of dual discrimination for both being gay and being older.²⁰³
- **Exposure to stigma and discrimination in aged care:** research indicates that healthy aging and aged care services and organisations can be hetero- or cis-normative in their service and care offerings, forcing older adults to go back into the closet to access them, or to simply avoid them altogether.²⁰⁴

For young LGBTQ+ people – particularly those under the age of 18 – unique stressors largely arise from the reduced legal or financial autonomy this cohort often has to choose the environments in which they live, are educated and socialise, as well as the service providers from which they access health and wellbeing support. These constraints to autonomy can increase the likelihood that LGBTQ+ young people face:

- **Exposure to experiences of stigmatisation, discrimination, bullying, and social isolation** in various contexts. The 2019 *Writing Themselves in 4* national survey, for example, found that almost two-thirds (60.2%) of LGBTQ+ young people reported feeling unsafe or uncomfortable in the prior 12 months, while in secondary school settings, compared to two-fifths of participants at full-time work (40.3%), and roughly one-third of participants at a TAFE (29.2%) or university (29.2%).²⁰⁵
- **Constraints on their avenues for seeking mental health support** due to the limitations of services offered by educational providers, in combination with financial or family barriers faced by the general population of young people. The 2021 *Australian Youth Barometer* survey, for example, found that LGBTQ+ respondents were 71% more likely to have sought but not received mental health support, when compared with their

²⁰¹ Anthony Lyons, Beatrice Alba, Andrea Waling, Victor Minichiello, Mark Hughes, Catherine Barrett, Karen Fredriksen-Goldsen, Teresa Savage, and Samantha Edmonds, "Assessing the Combined Effect of Ageism and Sexuality-Related Stigma on the Mental Health and Wellbeing of Older Lesbian and Gay Adults," *Ageing & Mental Health* 26, no. 7 (2022): 1460-1469.

²⁰² Kneale, Dylan., Henley, Josie., Thomas, James., and French, Robert. "Inequalities in Older LGBT People's Health and Care Needs in the United Kingdom: A Systematic Scoping Review." *Ageing and Society* 41 (2021): 504.

²⁰³ Francesca Mongelli, Daniela Perrone, Jessica Balducci, Andrea Sacchetti, Silvia Ferrari, Giorgio Mettai, and Gian Galeazzi, "Minority Stress and Mental Health Among LGBT Populations: An Update on the Evidence," *Minerva Psichiatrica* 60, no. 1 (2019): 31.

²⁰⁴ Ruby Grant and Briohny Walker, "Older Lesbians' Experiences of Ageing in Place in Rural Tasmania, Australia: An Exploratory Qualitative Investigation," *Health Soc Care Community* 28, no. 6 (2020): 2199-2207.

²⁰⁵ Adam Hill, Anthony Lyons, Jami Jones, Ivy McGowan, Marina Carman, Matthew Parsons, Jennifer Power, and Adam Bourne, *Writing Themselves in 4: The Health and Wellbeing of LGBTQ+ Young People in Australia* (February 2021), 15.

peers.²⁰⁶ They were also 27% less likely than their peers to be satisfied with health and mental health support provided by their education institutions, and less likely to seek support in their immediate home environment.²⁰⁷

4.5.2 LGBTQ+ people from CALD backgrounds

The term culturally and linguistically diverse (CALD) captures hundreds of cultural, religious, ethnic, linguistic, and national communities within Australia. The term does not distinguish between the different communities which fall under it, nor the different depths of connection an individual or their family may have with the varied features comprising their background.²⁰⁸ It should be noted, therefore, that the experiences of LGBTQ+ people from CALD backgrounds varies substantially at the individual, family, and community levels.

While these factors are in no way consistent across, or within, different CALD groups, the limited research that has been undertaken into Australia's LGBTQ+ population from CALD backgrounds has highlighted the following additional and intersecting risk factors to mental health and wellbeing:

- **Pressure to suppress or conceal identity:** in some CALD communities and families, cultural or religious beliefs can create additional internal and external pressures to hide or suppress diversity in sexual orientation and gender. This has been noted as a particular pressure in tight-knit communities with extensive family and kinship networks, who may interpret the divergence of one individual from the community as bringing shame on the collective.²⁰⁹ Diverse conceptions of gender and sexual orientation have existed across various international contexts and it is estimated that there are roughly 500 different terms for sexual orientation and gender identity, "many of which do not align with the normative Western frame".²¹⁰ However, research indicates that the processes of 'coming out' and developing community identity can, in some instances, be complicated by the perception of sexual orientation and gender diversity as a "Western concept".²¹¹ These pressures have been associated with an increased likelihood of self-isolation from LGBTQ+ peers by those from some CALD backgrounds, and disruptions to internal processes of self-acceptance and identity formation.²¹²
- **Additional risks related to community victimisation and violence:** in response to coming out to family, some LGBTQ+ people from CALD backgrounds have reported

²⁰⁶ Blake Cutler, Beatriz Cordoba, Lucas Walsh, Masha Mikola, and Catherine Waite, *Queer Young People in Australia: Insights from the 2021 Australian Youth Barometer* (May 2022).

²⁰⁷ Cutler, Cordoba, Walsh, Mikola, and Waite, *Queer Young People in Australia*.

²⁰⁸ Nicole Aqsuith, Anneke Collison, Lisa Lewis, Kai Noonan, Eloise Layard, Guneet Kaur, Fernanda Bellei, and Erdem Yigiter. "Home is where our story begins: CALD LGBTIQ+ people's relationships to family." *Current Issues in Criminal Justice* 31, no. 3 (2019): 312.

²⁰⁹ Aqsuith, Collison, Lewis, Noonan, Layard, Kaur, Bellei, and Yigiter. "Home is where our story begins," 315.

²¹⁰ Aqsuith, Collison, Lewis, Noonan, Layard, Kaur, Bellei, and Yigiter. "Home is where our story begins," 313

²¹¹ Aqsuith, Collison, Lewis, Noonan, Layard, Kaur, Bellei, and Yigiter. "Home is where our story begins," 315.

²¹² Aqsuith, Collison, Lewis, Noonan, Layard, Kaur, Bellei, and Yigiter. "Home is where our story begins," 315.

additional risks related to forced or pressured marriage, 'honour-based violence', and deportation to country of origin, in cases where visa or citizenship rights are insecure.²¹³ Further, evidence suggests that LGBTQ+ people from some CALD backgrounds experiencing domestic and IPV have their avenues of help-seeking dually complicated by concern regarding experiencing or contributing to stigmatising views regarding both LGBTQ+ people and CALD people.²¹⁴

- **Marginalisation:** similarly to First Nations LGBTQ+SB+ people, the existing marginalisation of CALD people, and individual CALD communities, in policy dialogue and service provision is exacerbated at the intersection of CALD and LGBTQ+ identities²¹⁵. Research has found that some LGBTQ+ people from CALD backgrounds feel "silenced" in LGBTQ+ communities. For example, during the 2017 Marriage Equality plebiscite, LGBTQ+ people from CALD backgrounds living in Western Sydney reported feeling forgotten by services which targeted areas with denser or more open LGBTQ+ populations, or where the vote was expected to be on the fence.²¹⁶

4.5.3 LGBTQ+ people with a disability

There is still a need for substantial research to be undertaken into sexual orientation and gender diversity among people with disability²¹⁷, and the ways in which these intersectional identities interact with mental health and wellbeing risk.²¹⁸ However, the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, and accompanying research reports²¹⁹, have recently shed light upon some of the compounding and intersecting external and internal stressors faced by LGBTQ+ people with disability in Australia.

Research also indicates that these stressors vary substantially by severity and type of disability (e.g., psychological, intellectual, sensory impairment or physical disability), as well as in relation to various other demographic and contextual factors (e.g., location and cultural background).

For the purposes of this overview, these stressors have been summarised at a high level as follows:

²¹³ Aqsuith, Collison, Lewis, Noonan, Layard, Kaur, Bellei, and Yigiter. "Home is where our story begins," 317.

²¹⁴ Aqsuith, Collison, Lewis, Noonan, Layard, Kaur, Bellei, and Yigiter. "Home is where our story begins," 312.

²¹⁵ Aqsuith, Collison, Lewis, Noonan, Layard, Kaur, Bellei, and Yigiter. "Home is where our story begins," 317.

²¹⁶ Aqsuith, Collison, Lewis, Noonan, Layard, Kaur, Bellei, and Yigiter. "Home is where our story begins," 312.

²¹⁷ Genee Marks, Amie O'Shea, Keith McVilly, Patsie Frawley, and Nathan Despott. "Where's the Human Dignity in That?: LGBTQIA+ People with Intellectual Disability Exploring Sexual Lives and Respectful Relationships." *Journal of Gay & Lesbian Social Services* 32, no. 3 (2020): 354-376.

²¹⁸ Adam Hill, Natalie Amos, Adam Bourne, Matthew Parsons, Christine Bigby, Marina Carman, and Anthony Lyons, *Violence, Abuse, Neglect and Exploitation of LGBTQIA+ People with Disability: A Secondary Analysis of Data from Two National Surveys* (Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University, 2022), 12.

²¹⁹ Hill, Amos, Bourne, Parsons, Bigby, Carman, and Lyons, *Violence, Abuse, Neglect and Exploitation of LGBTQIA+ People with Disability: A Secondary Analysis of Data from Two National Surveys*

- **Compounding risks related to harassment, abuse, and violence:** evidence indicates that LGBTQ+ people with disability are at an increased risk of harassment, abuse, and violence, compared to both LGBTQ+ people without disability, and heterosexual or cisgender-identifying people with disability. The Royal Commission, for example, reported that LGB+ people with disability are more than twice as likely to report being threatened with, or experiencing, violence, compared to heterosexual people with a disability.²²⁰ The national survey *Private Lives 3*, conducted in 2019, also found that LGBTIQ people with disability were more likely to experience verbal abuse and harassment directed at their sexual orientation or gender identity than their peers without disability, which increased with severity of disability. For example, stigma-driven verbal abuse in public places in the 12 months leading up to the survey was most commonly reported by LGBTIQ people categorised as having severe disability (58.1%), compared to LGBTIQ people with moderate (41.6%) and mild (34.8%) disability, and LGBTIQ people without disability (31.7%).²²¹
- **Compounding exposure to stigmatisation and discrimination in disability and health services:** in addition to the documented risk of neglect and exploitation experienced by the general population accessing disability services²²², LGBTQ+ people with disability have an increased likelihood of being exposed to stigmatising or discriminatory behaviour in health and disability services based on hetero- or cis-normative beliefs.²²³ The *Private Lives 3* national survey found that only one third (34.5%) of the sample of LGBTIQ adults with disability reported feeling accepted when accessing a health or support service.²²⁴ Similarly, the 2019 *Writing Themselves in 4* national survey found that less than one-quarter (21.5%) of young (aged 14–21) LGBTQA+ people with disability felt their LGBTQA+ identity was supported by the NDIS or disability support services.²²⁵ The Royal Commission also reported that submissions received from some gender diverse people with disability indicated that they had been refused “lifesaving” affirming care on the basis of their disability.²²⁶
- **Erasure:** research suggests that LGBTQ+ people feel marginalised in dialogue surrounding both disability issues and LGBTQ+ issues.²²⁷ The *Writing Themselves in 4* survey, for example, found that less than one-third (27.2%) of young LGBTQA+ people (aged 14–21) with disabilities felt that their voices were heard and understood.

²²⁰ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Final Report*. (2023), 49.

²²¹ Hill, Amos, Bourne, Parsons, Bigby, Carman, and Lyons, *Violence, Abuse, Neglect and Exploitation of LGBTQA+ People with Disability*, 4.

²²² Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability: *Final Report* p. 50

²²³ Marks, O'Shea, McVilly, Frawley, and Despott. "Where's the Human Dignity in That?," 355.

²²⁴ Hill, Amos, Bourne, Parsons, Bigby, Carman, and Lyons, *Violence, Abuse, Neglect and Exploitation of LGBTQA+ People with Disability*, 3.

²²⁵ Hill, Amos, Bourne, Parsons, Bigby, Carman, and Lyons, *Violence, Abuse, Neglect and Exploitation of LGBTQA+ People with Disability*, 5.

²²⁶ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability: *Final Report* p. 153- 154

²²⁷ Marks, O'Shea, McVilly, Frawley, and Despott. "Where's the Human Dignity in That?," 354 – 376.

- **Barriers to accessing services and social spaces:** evidence also indicates that accessibility issues create additional barriers for LGBTQ+ people when trying to use services and engage with social spaces, including those targeting LGBTQ+ people. The *Writing Themselves In 4* survey found that less than half of young LGBTQA+ people with disability indicated that it was “easy or very easy” to access LGBTQA+ social/community venues (44.2%) or services/support groups (47.6%) in their local area.²²⁸ Young LGBTQA+ people with an intellectual disability were slightly less likely to feel it was easy to access social/community venues (38%), compared to those with a physical or sensory disability (44.6%). Similarly, the *Private Lives 3* survey found that more than one-third of LGBTIQ adults with disability did *not* report feeling accepted at an LGBTIQ event/venue (41.5%). While more than half did *not* report feeling accepted in other settings, including work (54.1%), at an education institution (53.8%) and with family members (56.8%).²²⁹ There was limited variation by disability type regarding feelings of acceptance in the LGBTQ+ community amongst adults.

4.6 Other Lived Experiences and Complexities

Finally, it is important to note that some LGBTQ+ people also have lived experience of structural disadvantage and interactions with other institutional, social, or service systems which can increase their risk of poor mental health, wellbeing, or suicide prevention outcomes.

While this paper is unable to do justice to the research in any one area, the authors have emphasised some of the important evidence relevant to the following areas:

- Employment and housing
- Substance use
- Criminal justice system
- Out-of-home care
- Mental health diagnosis and treatment

4.6.1 Employment and housing

Insecure or poor-quality employment and housing have been consistently linked to mental distress and poor mental health, wellbeing, and suicide prevention outcomes.²³⁰ While employment and housing are intrinsically interlinked, research has also demonstrated that the relationship between these structural factors and mental health are multi-directional and

²²⁸ Hill, Amos, Bourne, Parsons, Bigby, Carman, and Lyons, *Violence, Abuse, Neglect and Exploitation of LGBTQA+ People with Disability*, 133.

²²⁹ Hill, Amos, Bourne, Parsons, Bigby, Carman, and Lyons, *Violence, Abuse, Neglect and Exploitation of LGBTQA+ People with Disability*, 3

²³⁰ Australian Institute of Health and Welfare, “[Social determinants of health](#)”, Published: 7 July 2022

cyclical – meaning poor mental health, and/or diagnosis with a mental health condition, can also negatively impact access to employment and housing (see Section 4.6.4 below).

As outlined in Section 4.2 above, LGBTQ+ people are at increased risk of experiencing the cyclical impacts of unemployment and homelessness to mental health and wellbeing, due to the impacts of other external stressors (e.g., stigma, discrimination, family and social rejection, victimisation, and violence). This is evidenced in available Australian data, indicating higher rates of unemployment and homelessness among LGBTQ+ communities. For example, the 2020 GSS found that GLB+ respondents were almost three times as likely to report being unemployed (9.3%) compared to heterosexual respondents (3.9%). The 2017 GSS also indicated that bisexual respondents were more likely to have at least five repeated experiences of homelessness, while lesbian and gay people were twice as likely to stay in crisis accommodation or sleep rough compared to heterosexual people.²³¹

In addition, evidence indicates that experiences of misgendering, discrimination, harassment, and violence, create barriers to accessing homelessness services for LGBTQ+ people. For example, trans and gender diverse people have reported issues accessing accommodation, which is often separated by gender and requiring the use of identity documents that may be in the wrong name or gender.²³² It should be noted that LHA, in collaboration with other organisations, has developed an [LGBTIQ+ Inclusive Practice Guide for Homelessness and Housing Sectors in Australia](#), which includes clear actions for service providers and staff.

4.6.2 Substance use

Substance misuse has been repeatedly linked to poor mental health and wellbeing outcomes, with evidence of multi-directional impacts.²³³ While there is a lack of comprehensive publicly available data, the existing evidence indicates that LGBTQ+ people use alcohol and other drugs at a higher rate than the general population. For example, estimates from the 2019 National Drug Strategy Household Survey indicate that lifetime alcohol risk among GLB+ people was at 24.6%, compared to 16.9% for heterosexual people. Likewise, GLB+ people were more than twice as likely to report using any illicit drug (36%) than their heterosexual peers (16.1%).²³⁴

Research has linked these increased risks related to alcohol and drug use among LGBTQ+ individuals to a combination of factors, including increased exposure to external stressors

²³¹ Pride Foundation, *Federal Parliamentary Inquiry into Homelessness*, 2020, <https://pridefoundation.org.au/wp-content/uploads/2020/07/Pride-Foundation-Australia-Submission-Federal-Parliamentary-Inquiry-into-Homelessness-2020-final.pdf>

²³² Ruth McNair, Cal Andrews, Sharon Parkinson, and Deborah Dempsey, *Stage 1 Report LGBTI Homelessness: Preliminary findings on risks, services needs and use*, (Lord Mayors Charitable Foundation, Assia Altman Fund of the Australian Communities Foundation, Launch Housing and Gay and Lesbian Foundation of Australia, 2017).

²³³ US National Institute on Drug Abuse 2021, *Why is there comorbidity between substance use disorders and mental illnesses?*, April 13 2021 <https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/why-there-comorbidity-between-substance-use-disorders-mental-illnesses>

²³⁴ Australian Institute of Health and Welfare, "[Alcohol, tobacco & other drugs in Australia](#)", accessed October 2023.

such as discrimination, victimisation, and violence.²³⁵ In this context, substance use is generally considered to be a coping mechanism. The physical manifestation of LGBTQ+ safe spaces in licensed venues, such as bars, clubs, discos, and pubs, has also been linked to increased substance use.²³⁶

Advocates have, therefore, called for tailored substance misuse treatment services and the creation of more LGBT safe spaces which are not linked to alcohol and other drug use.²³⁷

4.6.3 Criminal Justice System

Both Australian and international evidence indicates that LGBTQ+ people are at increased risk of coming into contact with the criminal justice system due to a variety of factors, including their increased risk of experiencing mental health challenges, violence, homelessness, and substance use.²³⁸

Research also indicates that LGBTQ+ people are more likely to have negative experiences in the criminal justice system, ranging from marginalisation and discrimination to harassment and violence. For example, GLB+ identification has been repeatedly linked to increased risk of verbal, sexual, and physical assault in prison.²³⁹ Research investigating the experiences of trans and gender diverse people in Victoria's criminal justice system has also found that interactions with police were generally negative, with participants reporting discomfort disclosing their identity, misgendering, and stigmatisation.²⁴⁰ In addition, trans and gender diverse people were inconsistently placed in prison facilities which aligned with their gender identity: exposing them to physical and sexual harassment from both fellow prisoners and prison staff.²⁴¹

The impact of these experiences is evidenced in increased self-harm and suicidal behaviours among incarcerated GLB+ people. Research investigating a sample of incarcerated adults in Queensland and Western Australia found that GLB+ people were more than twice as likely to report having self-harmed (37%), compared to their heterosexual

²³⁵ Daniel Demant, Leanne Hides, Katherine White, and David Kavanagh, "LGBT Communities and Substance Use in Queensland, Australia: Perceptions of Young People and Community Stakeholders," *PLoS One* 13, no. 9 (2018).

²³⁶ Demant, Hides, White, and Kavanagh, "LGBT Communities and Substance Use in Queensland."

²³⁷ Demant, Hides, White, and Kavanagh, "LGBT Communities and Substance Use in Queensland."

²³⁸ Paul Simpson, Danika Hardiman and Tony Butler, "Understanding the over-representation of lesbian or bisexual women in the Australian prisoner population", in *Current Issues in Criminal Justice*, vol. 31, no. 3 (2019); Jane Hereth, *Overrepresentation of people who identify as LGBTQ+ in the criminal legal system* (2022), Supported by the John D. and Catherine T. MacArthur Foundation.

²³⁹ Katie Hail-Jares, Craig Cumming, Jesse Young, Rohan Borschmann, Nick Lennox, and Stuart Kinner, "Self-harm and suicide attempts among incarcerated lesbian, gay and bisexual people in Australia," *Australian & New Zealand Journal of Psychiatry* 57, no. 4 (2023), 567, <https://doi.org/10.1177/00048674221104744>.

²⁴⁰ Matthew Mitchell, Adrien McCrory, Isabelle Skaburskis, and Brenda Appleton, "Criminalising Gender Diversity: Trans and Gender Diverse People's Experiences with the Victorian Criminal Legal System," *International Journal for Crime, Justice and Social Democracy* 11, no. 4 (2022), <https://doi.org/10.5204/ijcsd.2225>.

²⁴¹ Mitchell, McCrory, Skaburskis, and Appleton, "Criminalising Gender Diversity: Trans and Gender Diverse People's Experiences with the Victorian Criminal Legal System"

peers (14%).²⁴² Similarly, GLB+ participants were more than twice as likely to report having attempted suicide at least once (49%), compared to their heterosexual peers (23%).

4.6.4 Out-of-home care

International research indicates that LGBTQ+ children and youth are roughly 2.5 times more likely to be in contact with the child welfare system, when compared to their cisgender and heterosexual peers.²⁴³ This has been linked to increased risks of family rejection and violence (see Sections 4.2.2 and 4.2.3).

While out-of-home care has been associated with poor mental health, wellbeing, and suicide prevention outcomes among all children²⁴⁴, evidence indicates that young LGBTQ+ people experience worse outcomes than their peers. This disparity in outcomes has been linked to a variety of factors, including:

- Exposure to stigma and discrimination, and increased rates of victimisation and violence from care professionals and peers.²⁴⁵ Research has variously linked these factors to higher rates of absconding, ejection from care, and disengagement from services intended to promote the development of life skills.
- Reduced access to resources and support regarding sexual orientation and gender diversity, and related care needs. This has been linked to hetero/cisnormativity and stigmatising views of carers, discomfort of carers with discussing these matters with young people, and the increased likelihood that care placements are disrupted for young LGBTQ+ people (see below). Exposure to previous negative experiences related to their identity have also been linked to non-disclosure by young LGBTQ+ people in care.²⁴⁶
- Increased likelihood of having disrupted care placements, being placed in a group home or in a residential care setting. Research has indicated that this can be driven by the stigmatising views of prospective foster parents. While disrupted placements increase risk of distress and poor outcomes for all young people, this can disproportionately curb access to affirming care for trans and gender diverse youth.²⁴⁷
- Increased likelihood of ageing out of care – disrupting access to ongoing social and structural support provided by the family unit. Research has linked this to a reduced

²⁴² Katie Hail-Jares, Craig Cumming, Jesse Young, Rohan Borschmann, Nick Lennox, and Stuart Kinner, "Self-harm and suicide attempts among incarcerated lesbian, gay and bisexual people in Australia," *Australian & New Zealand Journal of Psychiatry* 57, no. 4 (2023), <https://doi.org/10.1177/00048674221104744>.

²⁴³ Rodrigo Gonzalez Alvarez, Luis Armando Parra, Mijntje ten Brummelaar, Lucy Avraamidou, and Monica Lopez, "Resilience among LGBTQIA+ youth in out-of-home care: A scoping review," *Child Abuse & Neglect* 129 (2022), <https://doi.org/10.1016/j.chiabu.2022.105660>.

²⁴⁴ Katherine Monson, Kristen Moeller-Saxone, Cathy Humphreys, Carol Harvey, and Helen Herrman, "Promoting Mental Health in Out of Home Care in Australia," *Health Promotion International*, vol. 35, no. 5 (2020): 1026-1036.

²⁴⁵ Alvarez, Parra, ten Brummelaar, Avraamidou, and Lopez, "Resilience among LGBTQIA+ youth in out-of-home care."

²⁴⁶ Alvarez, Parra, ten Brummelaar, Avraamidou, and Lopez, "Resilience among LGBTQIA+ youth in out-of-home care."

²⁴⁷ Centre for Excellence in Therapeutic Care, *The Needs of LGBTIQ Young People in Out of Home Care*, Australian Childhood Foundation and Southern Cross University, 2019. <https://www.cetc.org.au/the-needs-of-lgbtqi-young-people-in-out-of-home-care-research-brief/>

emphasis on achieving family reunification in cases of rejection and violence, and stigmatising views of prospective adoptive parents.²⁴⁸

It should be noted that Australia's [Centre for Excellence in Therapeutic Care](#) has released a report with a series of recommendations related to addressing these issues and improving the experiences of young LGBTQ+ people in out-of-home care.

Mental health challenges, diagnosis, and treatment LGBTQ+ children and youth are 2.5 times more likely to be in contact with the child welfare system, when compared to their cisgender and heterosexual peers. Research indicates that they often do not feel safe and affirmed in their out-of-home care experiences, where there is exposure to harassment, violence, bullying, discrimination, lack of acceptance, and abuse from their peers and/or care professionals.²⁴⁹ This has been linked to mental distress and an exacerbated risk of poor mental health, wellbeing, and suicide prevention outcomes.²⁵⁰

4.6.4.1 Mental health diagnosis and treatment

It is also important to consider that a lived experience of mental health diagnosis, life-interrupting mental health challenges or inappropriate mental health treatment can, in themselves, act as stressors which can have ongoing negative impacts on mental health and wellbeing. This intersection is particularly significant due to the impacts of past and current pathologisation of gender and sexual orientation in medical settings, as well as the stigmatisation of mental health issues.²⁵¹

For example, the stigma associated with diagnosis of a mental health condition can impact access to structural resources such as employment, housing, and education.²⁵² Thus, mental health diagnosis – whether or not related to the person's gender or sexual orientation – can exacerbate the existing risks to protective mental health and wellbeing factors for LGBTQ+ people. To counteract these issues, the National Mental Health Commission is currently in the process of developing a national strategy to reduce mental health-related stigma and discrimination.²⁵³

In addition, mental health professionals, influenced by pathologising discourses from psychiatry, psychology, and other mental health disciplines, can hold stigmatising views toward LGBTQ+ people, which have been shown to compromise the quality of care provided. Research has shown that LGBTQ+ people with lived experience of mental health challenges, and of seeking mental health treatment, often report having symptoms of mental distress viewed as intrinsically linked to factors associated with sexual orientation or gender

²⁴⁸ Centre for Excellence in Therapeutic Care, *The Needs of LGBTIQ Young People in Out of Home Care*, Australian Childhood Foundation and Southern Cross University, 2019. <https://www.cetc.org.au/the-needs-of-lgbtq-young-people-in-out-of-home-care-research-brief/>

²⁴⁹ Alvarez, Parra, ten Brummelaar, Avraamidou, and Lopez, "Resilience among LGBTQIA+ youth in out-of-home care."

²⁵⁰ Alvarez, Parra, ten Brummelaar, Avraamidou, and Lopez, "Resilience among LGBTQIA+ youth in out-of-home care."

²⁵³ National Mental Health Commission 2023, *National Stigma and Discrimination Reduction Strategy*, <https://www.mentalhealthcommission.gov.au/Projects/stigma-and-discrimination-reduction-strategy>

identity.²⁵⁴ This can lead to other issues being overlooked and left untreated, potentially exacerbating the risk of poor mental health outcomes and exposing LGBTQ+ people to further, complicated interactions with the mental health service system.

The above section has highlighted a wide range of stressors, risks, and barriers impacting on the mental health and wellbeing of LGBTQ+ people in Australia. The breadth of these issues, as well as the compounding impacts when taken together, need to be carefully considered in the development of future strategies to support LGBTQ+ mental health and wellbeing.

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5 Summary Applied SLR Findings

This section presents a summary of the companion Applied SLR report focused on accessing services for mental health and suicide prevention, and based on peer reviewed literature as described at Section 1.2 and Attachment 2.

Specifically it addresses KRQ 2 namely:

- a) What services are available and provided to LGBTQ+ peoples?*
 - b) What services were found to be effective?*
 - c) What service gaps or barriers were identified, and what were their details?*
-

5.1 Overall Applied SLR findings

As documented in Section 1.2, the companion report presenting the Applied SLR focused on 56 articles identified by the Department, published between 2013 and 2023, which focused on provision of mental health and suicide prevention services to LGBTQ+ people in Australia and the UK. The SLR report also included a lived Experience interpretation provided by the Rainbow Embassy, summarised below at Section 5.1.4.

While no definitive answer regarding the effectiveness of services could be provided based on the in-scope literature, a number of key findings nonetheless were drawn from the review as summarised below:

5.1.1 What services are available and provided to LGBTQ+ peoples?

None of the screened studies (56) reviewed provided a comprehensive map of mental health services provided to LGBTQ+ people in Australia, nor the UK. Additionally, the SLR pointed to a lack of dedicated research regarding the provision of care to some sub-groups of the LGBTQ+ population (e.g., non-binary people, gender fluid, and/or pansexual people), as well as LGBTQ+ people with intersecting identities and experiences (e.g., LGBTQ+ people from CALD backgrounds). Importantly, no studies included in the SLR examined experiences of people with innate variations in sex characteristics or asexual people, meaning that the findings only pertain to LGBTQ+ people.

Nonetheless, the SLR literature provided insight into services available and provided to LGBTQ+ people. Like the general population, most LGBTQ+ people access mental health services via a GP and prefer to be referred to a psychologist for mental health concerns.²⁵⁵ Only a small portion of LGBTQ+ were reported to access LGBTIQ+ specific services (e.g.,

²⁵⁵ Julia Taylor, Jennifer Power, & Elizabeth Smith, "Bisexuals' Experiences of Mental Health Services: Findings from the Who I Am Study", *Sexuality Research & Social Policy*, vol. 18 (2021) 27–38.

12%)²⁵⁶, a trend that has been noted previously.²⁵⁷ Given that this review, and previous research^{258,259}, indicates a clear preference among LGBTQ+ people in Australia for LGBTIQ+ specific services, this finding likely reflects a lack of available services and may also indicate limited capacity within these organisations to address mental health concerns. SLR findings also indicate that LGBTIQ+ specific services may not fully meet the needs of LGBTQ+ sub-populations, including trans and bisexual people.^{260,261,262}

The studies also indicate that LGBTIQ+ specific services, as well as mainstream and Aboriginal Community Controlled Health Organisations, may not adequately address the care needs of First Nations LGBTQ+SB (plus Sistergirl and Brotherboy) people.²⁶³ The research gap on First Nations people echoes a broader lack of sustained examination of the experiences and needs of LGBTQ+ people from diverse CALD backgrounds, or LGBTQ+ people with other kinds of intersectional identities and experiences, e.g., related to disability.

5.1.2 What services were found to be effective?

The Applied SLR analysed the review data in respect to the six domains of health care quality put forward by the Institute of Medicine Committee. This provides a comprehensive framework to analyse evidence on the quality and performance of mental health services, including assessment of timeliness, person-centredness, effectiveness, equity, safety, and efficiency.

The available research detailed findings relevant to five domains, with no data available on service efficiency, and provides insights on the quality and performance of mental health and suicide prevention services, including effectiveness of services, as well as gaps, shortfalls, and areas which could be enhanced to provide timely, equitable, and safer mental health service provision.

Most of the studies examined a mix of mental health service providers, making it difficult to distinguish the perceived quality and performance of specific providers or service types. Nonetheless, the SLR evidence indicates that person-centred, welcoming, empathic, and caring mental health services that prioritise listening, and respect is the minimal standard of

²⁵⁶ Ruth McNair & Rachel Bush, "Mental health help seeking patterns and associations among Australian same sex attracted women, trans and gender diverse people: a survey-based study", *BMC Psychiatry*, vol. 16 (2016) 209–209.

²⁵⁷ Hill et al., 2021,

²⁵⁸ Collective Action (2023). The role of LGBTIQ+ peer-led services in meeting the health needs of LGBTIQ+ people in Australia. Meridian

²⁵⁹ Hill et al., 2021,

²⁶⁰ Brener, L., Broady, T., Cama, E., & Treloar, C, "The impact of sources of stigma on health care avoidance among gay and bisexual men in Australia". *AIDS Care*, vol. 35 (2023) p. 663–671

²⁶¹ Jaco Erasmus, Harjit Baggam and Fintan Harte, "Assessing patient satisfaction with a multidisciplinary gender dysphoria clinic in Melbourne", *Australasian Psychiatry: Bulletin of the Royal Australian and New Zealand College of Psychiatrists* vol. 3 (2015)

²⁶² Michelle A., Tollit, Tamara May, Tiba Maloof, Michelle M. Telfer, Denise Chew, Melanie Engel, & Ken Pang, "The clinical profile of patients attending a large, Australian pediatric gender service: A 10-year review", *International Journal of Transgender Health*, vol. 24 (2023)

²⁶³ Bep Uink, Jenny Dodd, Sian Bennett, Dameyon Bonson, Anne-Marie Eades, and Braden Hill, "Confidence, practices and training needs of people working with Aboriginal and Torres Strait Islander LGBTIQ+ clients", *Culture, Health & Sexuality*, vol. 25 (2023)

care required for anyone accessing mental health services.^{264,265,266,267,268} However, overall, there were mixed findings regarding the quality and performance of mental health and suicide prevention services.

While some LGBTQ+ people received mental health and suicide prevention services that were accessible, affirming, safe and effective for promoting personal recovery, many studies indicated difficulties related to timely access to person-centred, recovery-oriented, equitable and safe services. Commonly identified issues with service quality and performance included:

- **Knowledge deficits** among healthcare providers and reliance on those seeking care to educate the provider about the needs of LGBTQ+ people, which could be emotionally exhausting and financially costly in terms of therapy time.^{269,270,271,272}
- **Microaggressions** including hetero/cis normativity, misgendering, invalidation and pathologisation of sexual orientation or gender identity. These issues were linked to increased distress and discouragement of future help seeking.^{273,274,275}

²⁶⁴ Rosie Charter, Jane Ussher, Janette Perz and Kerry Robinson, "Negotiating mental health amongst transgender parents in Australia", *International Journal of Transgender Health*, vol. 23 (2022)

²⁶⁵ Erasmus et al., 2015

²⁶⁶ Gene Lim, Andrea Waling, Anthony Lyons, Christopher Pepping, Anna Brooks, and Adam Bourne, "Trans and Gender-Diverse people's experiences of crisis helpline services", in *Health & Social Care in the Community*, vol. 29 (2021)

²⁶⁷ Jennifer Martin, Meredith Butler, Anne Mudlowney and Gabriel Aleksandrs, "Impacts of regulatory processes on the experiences of carers of people in LGBTQ communities living with mental illness or experiencing a mental health crisis", *Social Science & Medicine*, vol. 230 (2019b)

²⁶⁸ Robert Elliott, Arthur Bohart, Jeanne Watson, and David Murphy 2018, "Therapist Empathy and Client Outcome: an Updated Meta-analysis", *Psychotherapy*, vol. 55 (2018).

²⁶⁹ Bridget Haire, Eloise Brook, Rohanna Stoddart and Pault Simpson, "Trans and gender diverse people's experiences of healthcare access in Australia: a qualitative study in people with complex needs", in *PloS One*, vol. 16 (2021)

²⁷⁰ Annie Pullen Sansfaçon, Denise Medico, Damien Riggs, Anna Carlile and Frank Suerich-Gulick, "Growing up trans in Canada, Switzerland, England and Australia: access to and impacts of gender-affirming medical care", in *Journal of LGBT Youth*, vol. 23 (2023).

²⁷¹ Damien Riggs and Clare Bartholomaeus, "Australian mental health nurses and transgender clients: attitudes and knowledge", in *Journal of Research in Nursing*, vol. 21 (2016b)

²⁷² Damien Riggs and Clare Bartholomaeus, "Australian mental health professionals' competencies for working with trans clients: a comparative study", *Psychology & Sexuality*, vol. 7 (2016).

²⁷³ Geraldine McNamara and Charlotte Wilson, "Lesbian, gay and bisexual individuals experience of mental health services-a systematic review", *The Journal of Mental Health Training, Education and Practice*, vol. 15 (2020): 59 – 70.

²⁷⁴ Tiffany O'Shaughnessy and Zachary Speir, "The state of LGBTQ affirmative therapy clinical research: a mixed-methods systematic synthesis", *Psychology of Sexual Orientation and Gender Diversity*, vol. 5 (2018): 82 – 98.

²⁷⁵ Annie Snow, Julie Cerel and Laura Frey, "A safe bet? Transgender and gender diverse experiences with inclusive therapists", *American Journal of Orthopsychiatry*, vol. 92 (2022): 154.

- **Difficulty accessing affirming mental health services, particularly during a crisis.** This related to timely access to recovery-oriented services that are safe, affirming, and effective. It also related to timely access to appropriate referrals.^{276,277}
- **Inequitable and unsafe care in inpatient and emergency services.** This included low acceptance and affirmation of sexual orientation and gender identity and inequitable and unsafe care that could be coercive, restrictive, disempowering and traumatising for some LGBTQ+ people, serving to reinforce rather than alleviate minority stress.

Further to this, some sub-populations of LGBTQ+ people (e.g., trans and gender diverse youth, women who have sex with women) and LGBTQ+ people with intersecting identities and experiences (e.g., LGBTQ+ people from CALD backgrounds) are more likely to encounter stigmatising, or traumatising care situations.²⁷⁸

- **Positive care experiences were more often reported in LGBTIQ+ specific services.** This includes knowledgeable, equitable and safe care, as well as appropriate referrals to affirming providers.

However, as noted previously, these services were reported to be less equipped to support more marginalised LGBTQ+ subgroups (e.g., non-binary people, bisexual people), or those with intersecting identities and experiences (e.g., LGBTQ+ people from CALD backgrounds). Further, they may be insufficiently skilled and resourced to support LGBTQ+ people with intersecting experiences related to life-interrupting mental health challenges²⁷⁹ and suicidality.

Other SLR findings on effective service types include:

- Online mental health services and crisis helplines, could increase mental health service access, particularly in rural areas.^{280,281} Online services could also provide an anonymous and safe environment for LGBTQ+ people to access support.²⁸²

²⁷⁶ Martin et al., 2019a;

²⁷⁷ Lim et al., 2021

²⁷⁸ Jennie Robertson, Helen Pote, Angela Byrne and Francisco Frasquilho, "The Experiences of Lesbian and Gay Adults on Acute Mental Health Wards: Intimate Relationship Needs and Recovery", *Journal of Gay & Lesbian Mental Health*, vol. 19 (2015) 261–284.

²⁷⁹ 'Life-interrupting' mental health challenges is used as an alternative to severe and persistent mental illness as it describes more severe, persistent, and enduring mental health challenges, and related life impacts, without reference to medicalising or pathologising frameworks.

²⁸⁰ Sarah Bowman, Brona Nic Giolla Easpaig and Rachael Fox, "Virtually caring: a qualitative study of internet-based mental health services for LGBT young adults in rural Australia", *Rural and Remote Health*, vol. 20 (2020): 5448–5448

²⁸¹ Lim et al., 2021

²⁸² McNair & Bush, 2016

- Game-based therapeutic interventions, that are contemporary and acknowledge the unique experiences of LGBTQ+ people, could be effective and acceptable to youth.²⁸³
- Supporting access to gender-affirming mental health care promoted wellbeing and decreased suicidality in trans and gender diverse people.^{284,285,286,287}, a finding that is consistently reported in the wider literature.²⁸⁸

5.1.3 What service gaps or barriers were identified and what were their details?

At a high-level, the service gaps and barriers identified in the applied SLR were:

- **Provider shortages**, long waitlists and limited operating hours, particularly with respect to accessing LGBTIQ+ specific services. Limited affirming care options were particularly evident in relation to access to knowledgeable, affirming, and affordable mental health care providers, and timely referrals by mental health professionals to gender-affirming medical care.^{289,290,291}
- **Inconsistencies in quality of care**, including inconsistencies between care providers and services particularly in relation to the provision of equitable, person-centred care. For example, while many General Practitioners were perceived positively, others were “visibly uncomfortable with dealing with mental health” issues. Research also indicated that inpatient services were understaffed, lacking in privacy, restrictive, and inpatient and emergency services were disempowering for patients and lacking in choice and opportunities for collaboration with health care providers.^{292,293,294}

²⁸³ Mathijs Lucassen, Rajvinder Samra, Ionna Lacovides, Theresa Fleming, Matthew Shepherd, Karolina Stasiak and Louise Wallace, “Virtually caring: a qualitative study of internet-based mental health services for LGBT young adults in rural Australia”, *Rural and Remote Health*, vol. 20 (2018): 5448–5448.

²⁸⁴ Louis Bailey, Sonja Ellis, and Jay McNeil, “Suicide risk in the UK trans population and the role of gender transition in decreasing suicidal ideation and suicide attempt”, *Mental Health Review Journal*, (2014): 1361 – 9322.

²⁸⁵ Rosie Charter, Jane Ussher, Janette Perz and Kerry Robinson, “Negotiating mental health amongst transgender parents in Australia”, *International Journal of Transgender Health*, vol. 23 (2021): 308 – 320.

²⁸⁶ Nicola Harrison, Lisa Jacobs and Adrian Parke, “Understanding the Lived Experiences of Transitioning Adults with Gender Dysphoria in the United Kingdom: An Interpretative Phenomenological Analysis”, *Journal of LGBT Issues in Counselling*, vol. 14 (2020): 38 – 55.

²⁸⁷ Pullen Sansfaçon et al., 2023

²⁸⁸ Diana Tordoff, Jonathon Wanta, Arin Collin, Casalie Stepney, David Inwards-Breland and Kym Ahrens, “Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care”, *JAMA Network Open*, vol. 5 (2022) e220978-e220978.

²⁸⁹ Bailey et al., 2014; 3;

²⁹⁰ Pullen Sansfaçon et al., 2023

²⁹¹ Strauss et al., 2021b

²⁹² McNair & Bush, 2016

²⁹³ Riggs et al., 2014

²⁹⁴ Taylor et al., 2021

- **Lack of linkage** between different mental health services – including between crisis services and long-term care, and between alcohol services and mental health services.²⁹⁵
- **Limited options** for services able to attend to intersectional needs, including limited access to equitable and safe care in a crisis or for those experiencing severe and life-interrupting mental distress and suicidality.^{296,297}
- **Financial costs** related to gap fees and limitations to the number of Medicare - subsidised sessions an individual can claim within a year, and to publicly available mental health services, or to the National Disability Insurance Scheme (NDIS).^{298,299,300}
- **Lack of lived experience involvement**, including in service development and research undertaken in partnership with LGBTQ+ people with an intersecting lived experience of mental health challenges and suicidality, including with LGBTQ+ youth and people from diverse social backgrounds with an intersecting experience of severe and life-interrupting mental distress and suicidality.^{301,302}
- **Gaps in evidence** were also noted in the included literature, including in particular:
 - research on the care needs of those experiencing intersectional issues, especially those impacting First Nations LGBTQ+SB populations; LGBTQ+ people from CALD backgrounds; LGBTQ+ people living in rural and remote areas, and LGBTQ+ people from low socioeconomic backgrounds.
 - research related to specific subgroups of LGBTQ+ people, including people with innate variations in sex characteristics and asexual people, and nonbinary people.
 - research on specific mental health service issues, including: the effectiveness of services for promoting personal recovery; LGBTQ+ people receiving involuntary treatment in inpatient and community settings; and responses to mental health professionals engaging in harmful conversion practices.

²⁹⁵ Elena Dimova, Rosaleen O'Brien, Lawrie Elliott, Jamie Frankis, and Carol Emslie, "Exploring the experiences of alcohol service use among LGBTQ+ people in Scotland", *International Journal of Drug Policy*, vol. 109 (2022): 103859.

²⁹⁶ Uink et al 2023

²⁹⁷ Hill et al., 2022

²⁹⁸ Timothy Cronin, Christopher Pepping, Kim Halford and Anthony Lyons, "Mental health help-seeking and barriers to service access among lesbian, gay, and bisexual Australians", *Australian Psychologist*, vol. 56 (2021): 46-60.

²⁹⁹ Bretherton et al., 2020;

³⁰⁰ Martin et al., 2019b

³⁰¹ Jones et al, 2022

³⁰² Bellingham et al., 2023

5.1.4 Lived experience interpretation

A response statement was developed in collaboration with the Rainbow Embassy to ensure that the interpretations of LGBTQ+ people, including LGBTQ+SB people, with lived experience were considered as part of the SLR. The statement reaffirms that LGBTQ+ people collectively are experiencing mental distress and suicidality at higher rates due to the oppression they experience within a hetero- and cis-normative, patriarchal society. As confirmed in the companion Research Translation Paper, the challenges for LGBTQ+ people are both external and internal, with the risks of bullying and to family and community connections profound. The harms of First Nations LGBTQ+SB people, and CALD people of colour were further compounded by the effects of colonisation and racism. The statement notes that accessing mental health services is particularly fraught for LGBTQ+ people, and that many people with lived experience have limited access to LGBTIQ+ specific services. In regard to mainstream mental health services, this was attributed to a lack of staff skills and organisational resources, with the prospects of trauma being reinforced when care is inequitable and unsafe.

Overall, the Rainbow Embassy noted the limited research involvement of LGBTQA+ people with an intersecting lived experience of mental health challenges and mental health service use (6 of the included 56 SLR studies). There was also concern that researchers have not sufficiently engaged with critiques from consumer/survivor movements, including insufficient interrogation of dominant models of psychiatric treatment and service provision, and seclusion and restraint practices in mental health services. Mental health challenges experienced by LGBTQ+ people need to be understood in the context of minority stress, but also as an intersecting experience that can include exposure to new stressors, including sanism (prejudicial attitudes towards people with a lived experience of mental health challenges) and trauma in the community and mental health services.

There is a need for collaborative mental health services that meaningfully embed trauma informed and personal recovery-oriented frameworks, and that consider other explanatory frameworks for distress (e.g., socio-political or trauma frameworks), and prioritise choice in service provision, including non-medicalised options. Timely access to gender-affirming care for trans and gender diverse people, including youth, is also critical to promote wellbeing and prevent suicide. Overall, the response emphasises the need for services to be safe from the perspective of LGBTQ+ people with a lived experience. Positive experiences reported in LGBTIQ+ specific services were noted, however evaluating these services is important to gain a fuller picture of service equity and quality for all subgroups of the LGBTQ+ population, and for people with intersecting identities and experiences, as previously noted.

5.2 SLR findings by categories

To assist policy makers in applying these frameworks and concepts, the researchers sorted the findings by service type, LGBTQ+ population sub-groups, and gaps in research on LGBTQ+ mental health and suicide prevention services. A summary of the findings by category is provided below.

5.2.1 Service type (mainstream and specific service type)

Overall, there is a clear indication for mental health services to be affirming of LGBTQ+ people, culturally safe, person-centred, recovery-oriented, trauma informed, and to meet the specific needs of sexuality and gender diverse people. Mental health challenges need to be understood as an intersecting experience, and that people who face life-interrupting mental health challenges may also face sanism and trauma in the community and mental health services.

- **Affirming and culturally safe service provision:** Equitable, affirming, and culturally safe services are required for LGBTQ+ people with interesting lived experience of mental health challenges, including youth. Affirming services are core to supporting positive mental wellbeing and preventing suicide (rather than being conceptualised as a 'luxury'). Where possible, services should be designed with LGBTQ+ people with an intersecting lived experience of mental health challenges and service use, with an emphasis on designing with sub-populations whose needs are less likely to be addressed.
 - **What we know works:** The literature found a number of factors that work including Improving health care worker confidence and communication skills, valuing First Nations LGBTQ+SB people's perspectives on wellbeing, mental health providers who are proactive in learning about LGBTQ+ people's needs and community concerns (including specialist training), peer support, visual cues, inclusive language, and access to diverse health care professionals who have shared sexuality or gender or intersectional experiences.
 - **Key areas of improvement:** There is a clear need for service provision from knowledgeable and affirming mental health workers. Training in LGBTQ+ mental health is required for all mental health workers and clinicians, including in undergraduate, postgraduate curriculum, and within health services. There is also need for Aboriginal and Torres Strait Islander LGBTQ+SB specific services, including services specifically tailored for youth. Further research and service provision for LGBTQ+ people from CALD backgrounds, neurodiverse LGBTQ+ people, LGBTQ+ people with disability, LGBTQ+ people on low incomes, and LGBTQ+ people living in rural areas was also highlighted.
- **Person-centred and recovery-oriented service provision:**
 - **What we know works:** Mental health services can be perceived positively if they are welcoming, affirming, respectful, empathic, supportive, and caring. Therapeutic interventions designed for, and delivered to, people of diverse sexualities can promote mental wellbeing. A focus on community and peer connection can increase social support, promote mental health seeking, and improve LGBTQ+ peoples' mental health outcomes. Online adjuncts to therapeutic interventions could also enhance community and peer connection.
 - **Key areas of improvement:** There is a need for care that is personal-recovery oriented. This means moving beyond tokenistic, *in-name-only approaches*, and embracing tangible and measurable approaches to

recovery-oriented care. Measures of care should focus on personal-recovery indicators that promote wellbeing, including connection, hope, identity, meaning, and empowerment of LGBTQ+ people with an intersecting lived experience of mental health challenges. A key gap highlighted by the Rainbow Embassy, is the need for service providers (and researchers) to engage with multiple explanatory frameworks for mental distress (e.g., trauma, minority stress) and prioritise choice in service provision, including non-medicalised options. There is also a need for integration of services, including linkage between substance use services, and coordination of care for LGBTQ+ people with complex mental health needs.

- **Trauma informed service provision:**

- **What we know works:** Timely access to affirming providers is a powerful and protective factor for LGBTQ+ people.
- **Key areas of improvement:** There is a need for consistent, affirming service provision to all LGBTQ+ people, including through community organisations. Mental health services need to ensure an end to pathologisation of sexuality and gender, and ensure mental health staff are trained in recognising pathologising practices. Safe and trauma-informed care need to be provided consistently to LGBTQ+ people. To achieve this, actions such as ending highly restrictive practices, homophobia, transphobia, racism, stigma and discrimination, and abuse and violence in mental health settings, and conversion practices needs to occur.

Overall, there is a lack of data on specific service types, with most research examining multiple types of service providers. However, information was provided in the SLR on aspects of service provision that are working and could be extended, as well as key areas for improvement relevant to the service type.

- **Online services:** The evidence suggests internet and online resources and services are of value and of interest to youth, particularly if they can be used to garner information and support. Online services can be perceived as more accessible and safer for LGBTQ+ youth and young adults, and gamified e-therapeutic content could be acceptable. Many online services however appear to be nascent, and need to be tailored, via lived experience collaboration, to the needs of diverse subgroups of the LGBTQ+ community.
- **Primary care and therapeutic services:** GPs, psychologists, and allied health practitioners are often rated positively by LGBTQ+ people. GP care and care with therapists can however be inconsistent. Care from private therapists is also reported to be expensive and out of reach for many people, with expensive gap payments and limited access via Medicare.
- **Crisis helpline services:** Crisis helplines can be more accessible to LGBTQ+ people in a crisis, including people in rural areas. Crisis helplines can be effective if helpline staff are non-judgemental and indicate acceptance towards LGBTQ+ people. However, crisis helplines are often not sufficiently oriented to the needs of LGBTQ+ people and crisis helpline staff may not have the sufficient knowledge. LGBTQ+

people have reported negative experiences (including microaggressions and misgendering), and referral processes to long-term mental health care can be poor.

- **Emergency and inpatient services:** Mental health providers, including emergency staff and inpatient service healthcare workers and clinicians can be knowledgeable, empathic, and caring towards LGBTQ+ people and inclusive of carers. However, while individual interactions can be positive, service provision is highly inconsistent, unsafe and traumatising, with LGBTQ+ people and carers reporting the highest level of dissatisfaction with these services. Emergency and inpatient services need to be trauma-informed, and designed and evaluated with LGBTQ+ people with an intersecting lived experience and carers, including those who have experienced involuntary treatment.
- **LGBTQIA+ services:** Positive experiences are more consistently reported in LGBTQIA+ specific services (including trans and gender-specific services). There is a need for more LGBTQIA+ specific mental health services accessible in Australia, with existing LGBTQIA+ specific services also requiring better resourcing to meet the needs of people with life-interrupting mental distress and those from diverse backgrounds (e.g., LGBTQ+ people from CALD backgrounds).

5.2.2 LGBTQIA+ population sub-groups

This SLR did not include evidence related to the mental health services needs of people with innate variations in sex characteristics, and an independent review of evidence is recommended to inform the action plan. Insufficient evidence was found in the review to comment on the mental health service needs of asexual people, people of other diverse gender and sexualities (e.g., nonbinary people, pansexual people), and people with intersectional experiences, and a wider scoping of international literature and grey literature is recommended.

- **Services to Sexuality diverse people:** Sexuality diverse people report positive and supportive engagements with health care professionals. However, many reported microaggressions and pathologisation, particularly in inpatient services. Sexuality diverse youth need information on mental health services, including online and face-to-face services. There is a lack of awareness among sexuality diverse youth about existing services. Service providers also need a better understanding of patterns of disclosure among sexuality diverse people to improve provision of care to this population.
- **Services to Trans and Gender diverse people:** Trans and gender diverse people were more likely to report inequity in service provision, including misgendering and pathologisation. Access to gender-affirming care, including gender dysphoria clinics, hormone treatment, surgery and puberty blockers supports trans and gender diverse people's mental health, including decreasing distress, depression, self-harm and suicidal thoughts and behaviour, and increasing safety in the community for trans and gender diverse people. A trusted GP facilitates referrals to mental health support, while school psychologists create safe and affirming therapeutic environments for trans and gender diverse youth. However, in many instances access to gender affirming care was delayed or denied by clinicians. Also, many

health professionals (including school psychologists) have knowledge deficits and require training in the specific mental health needs of trans and gender diverse people. Crisis services, including helplines, emergency services and support for parents and families, also need to be made more accessible, and should be designed and evaluated with trans and gender diverse people with an intersecting lived experience of mental health challenges.

5.2.3 Gaps in research on LGBTQ+ mental health and suicide prevention services

The SLR found gaps in research knowledge that limit our understanding of mental health and suicide prevention service provision to LGBTQ+ people. Based on the SLR findings, we outline some priority areas for research, with the caveat that research agenda be co-designed with LGBTQIA+ people with an intersecting lived experience of mental health challenges and suicidality as well as sector experts. The research gaps noted include:

- **Comprehensive review of evidence:** This review was not able to comment on the needs of intersex people or asexual people. A more comprehensive review of both the international and Australian peer-reviewed and 'grey' literature would be recommended to gain a clearer and more accurate picture of service provision, quality and performance and gaps in research evidence.
- **Safety in services:** A clear priority for research should be a focus on safe service provision, as mental health services, as a minimum, should do no harm. Further research is required to investigate safety issues (e.g. rates of seclusion and restraints for LGBTQ+ people), the extent to which pathologisation, conversion practices, abuse, and violence occur in mental health services, and how therapeutic, and faith needs, of survivors of conversion practices can best be met.
- **Specific services and interventions:** Research should focus on specific service or intervention type, and ideally evaluation should be undertaken in collaboration with LGBTQ+ people with an intersecting lived experiences. Of particular interest would be the experiences of LGBTQ+ people in inpatient mental health services and emergency departments, LGBTQIA+ specific services, trauma specific therapeutic interventions, youth mental health, peer-led services or services with employed peer workers, and collaborative care planning and decision-making. Little is also currently understood about the relationship between microaggressions, service type, intervention, and quality.
- **Involvement of people with lived experience in research:** Only a small portion of the SLR research involved LGBTQ+ people with an intersecting lived experience of mental health challenges. Involvement of LGBTQ+ people is an imperative in mental health research. Further research could look into co-design of research with LGBTQ+ people with lived experience of mental health challenges through all stages of the research process. LGBTQ+ researchers should also consider consumer/survivor perspectives, and what can be learnt from these, to inform LGBTQ+ advocacy and research.
- **Research equity for First Nations LGBTQ+SB people:** The SLR indicates that there is little data on the needs and expectations of Aboriginal and Torres Strait

Islander LGBTQ+SB people in mental health services. Research should be designed and led by First Nations LGBTQ+SB people.

- **Research equity for LGBTQ+ people with intersectional identities and experiences:** The SLR included little research on the needs, stressors, or service experiences of people with intersectional identities and experiences. In the first instance, a broader review of the evidence base is required to understand the specific needs, and to determine gaps in evidence, in regard to LGBTQ+ people including people of colour, people with CALD backgrounds, people with disability, people who are neurodiverse, youth, older adults, people from rural and remote areas, and people from a low-socioeconomic backgrounds.
- **Efficiency:** None of the literature included in this review focused on efficiency, which is a key indicator of quality and performance, questioning how well resources were used. However, reviews or research considering efficiency should not be privileged over other domains of services quality and performance, and should also attend to timeliness, effectiveness, person-centredness, equity, and safety. research considering efficiency also needs to consider the financial cost of services to LGBTQ+ people and how this impacts service access for people on low incomes.

5.3 SLR Conclusions and limitations

The SLR showed that in the Australian context (and beyond), there are many health services and broader health workers that provide positive and supportive care for LGBTQ+ people. However, there also remain significant barriers, service-gaps, and unsafe practices that are detrimental to the mental health and wellbeing of LGBTQ+ people. While there are encouraging signs that services and service providers are willing to learn about, and accommodate, the care needs of LGBTQ+ people, it is clear that individual training or upskilling is not, on its own, enough to address gaps, barriers, and unsafe practices.

To the researchers' knowledge, this is one of the few systematic reviews that has involved LGBTQ+ people with an intersecting lived experience of mental health challenges and suicidality in interpretation of review findings. As Oliver et al. (2014) have argued, there is an urgent need to involve people with lived experience in research, and particularly in systematic reviews, given the influence of these on policy and service decision-making. A particular strength of the review is the involvement of people with life-interrupting mental health challenges from diverse backgrounds, including First Nations LGBTQ+SB people, LGBTQ+ people from CALD backgrounds, LGBTQ+ people with disability, and LGBTQ+ people from rural areas and/or low socio-economic backgrounds.

While this SLR commenced with a focus on published, peer-reviewed research literature from Australia and the UK, to gain a broader picture of the needs of LGBTQ+ people, future reviews should include international and Australian contexts as well as 'grey' literature that is not peer-reviewed or published. Additionally, although research gaps have been identified, any future research agenda should be co-designed with LGBTQ+ people with intersecting lived experience of mental health challenges and suicidality, community experts and advocates, and mental health providers.

6 Conclusion and Research Insights

Drawing on the evidence presented earlier in this report, this section addressed KRQ 3 namely:

What evidence-based insights can be drawn to help inform policy development for the Commonwealth Governments 10 Year National Action Plan for the Health and Wellbeing of LGBTQIA+ people?

6.1 About this Section

Drawing on the evidence gathered through the applied SLR (interpreted in collaboration with the Rainbow Embassy and associates), the desktop review of the Australian landscape and of risks and protective factors for LGBTQ+ presented in this report, various research insights can be identified that are relevant to the Government's *National Action Plan for the Health and Wellbeing of LGBTQIA+ people*.

These insights have been grouped into 3 sections:

- **Overarching Principles**, that can be used to frame the action plan (Section 6.2)
- **Key Policy Directions and Options Arising** to help inform the policy development (Section 6.3)
- **Other issues and considerations**, that while adjacent to the KRQ, nonetheless, emerged from the literature and interpretation provided by the Rainbow Embassy and associates (Section 6.4)

6.2 Overarching Principles

The research revealed a number of higher level or overarching principles seen as useful to shaping the approach, measures, and implementation of the mental health component of the *National Action Plan*. Many of these echo and complement other contemporary policy and advocacy documents, including those promoted by LHA.

The principles are summarised in Figure 3 and expanded upon below.

1] Importance of Intersecting Lived Experience

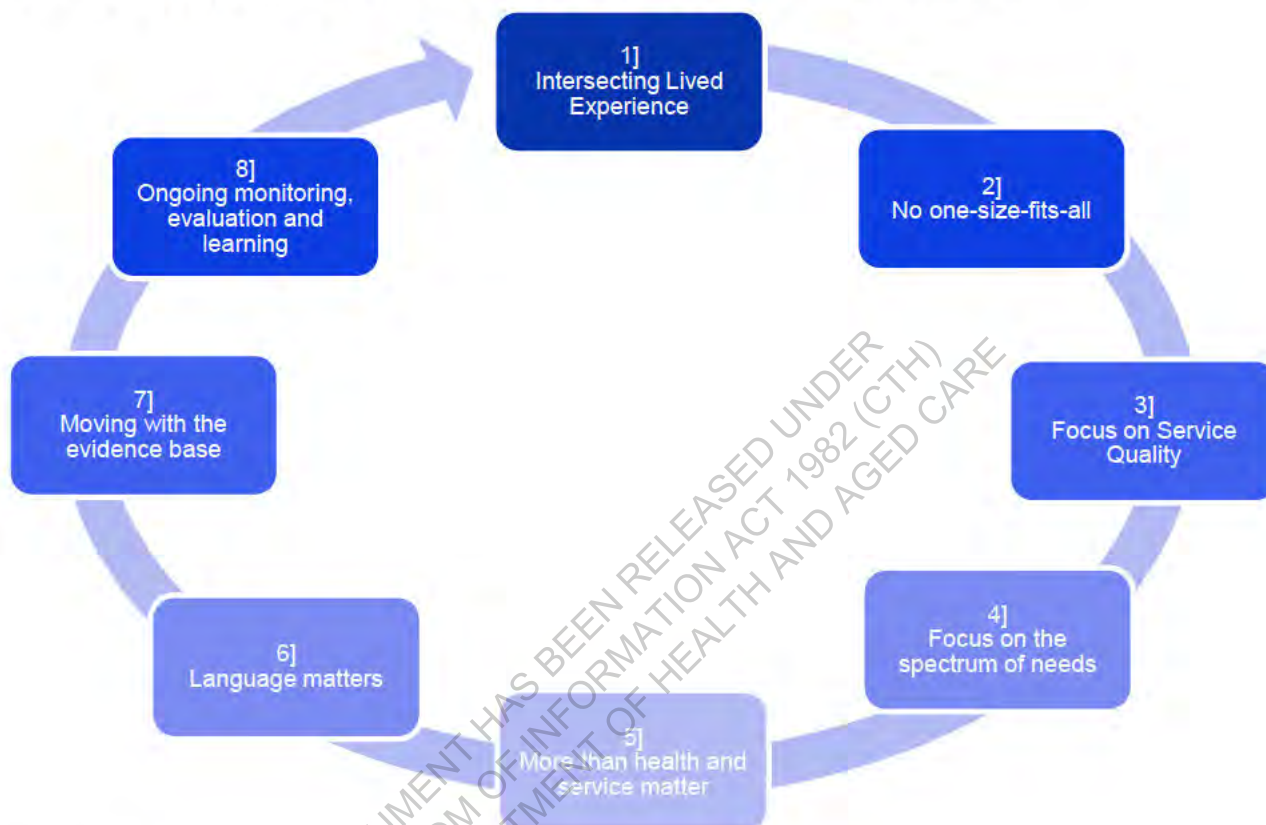
A strong theme to emerge from the research was the importance of ensuring future actions for the LGBTQ+ community are built on the lived experience of LGBTQ+ people who have an intersecting experience of living with



mental health challenges and suicidality (including life-interrupting mental distress), and who have experience of using mental health and suicide prevention services.

Hereon, references to lived experience inclusive of these three dimensions is referred to as “intersecting lived experience”.

Figure 3: Overarching principles to help inform the National Action Plan



Source: UTS-led researchers, October 2023.

As summarised in Figure 3, insights from people offering this combination of perspectives and experiences are vital for future policies and services to be fully effective and to meet the needs of LGBTQ+ people with intersecting lived experience.

This three-aspect approach to lived experience should underpin any future bodies or advisory structures used by the Department.

2] No one-size-fits-all

While the Government’s commitment to responding to the mental health needs of LGBTQ+ people through a national action plan is a positive initiative, it is important not to lose sight of the diverse needs of sub-populations under the LGBTQ+ umbrella. Further, intersectional experiences of LGBTQ+ people (associated with culture, age, socio-economic status, geographic location, disability, etc.) must also be acknowledged. All this means that there can be no one-size-fits all solutions.

This perspective has a number of dimensions:

Firstly, it underlines the importance of consistently adopting and promoting personal, recovery-oriented, and trauma-informed responses that are affirming of specific sub-populations. This includes promoting personal recovery – connection, hope, identity, meaning, and empowerment for LGBTQ+ people – rather than an exclusive focus on clinical recovery, as well as ensuring that care recognises and responds to minority stress and is affirming of LGBTQ+ people with diverse identities.

Secondly, it highlights the importance of not assuming people within LGBTQ+ sub-groups all have the same service needs or wish to access services via the same pathways. For example, some LGBTQ+ people will prefer to remain within mainstream services while others will seek specialist options.

Thirdly, the action plan should recognise the unique needs of specific sub-populations. For example, trans and gender diverse people often seek and need distinct approaches to service provision related to their intersecting lived experience. To this end, policies and services for these groups should be developed with these communities and be strongly based in their lived experiences and service needs.

Finally, it highlights the need for culturally safe and trauma-informed care for LGBTQ+ people who have intersectional identities, including Aboriginal and Torres Strait Islander people, those with CALD backgrounds, or living in rural and remote parts of Australia, who have intersecting lived experiences, perspectives, and needs, including unique experiences of oppression or marginalisation, that need to be recognised and responded to in service settings.

3] Focus on Service Quality

As noted in this research, mental health and suicide prevention services for the LGBTQ+ communities should be founded on common quality and performance indicators, such as those promoted by Crossing the Quality Chasm Framework (Institute of Medicine Committee, 2006), and specifically related to mental health services.

To this end, all future initiatives should be planned, implemented, and assessed against an agreed set of outcomes, such as:

- **Timeliness:** Were services delivered on time, including timely access and/or delays in service provision?
- **Effectiveness:** Did interventions produce positive health outcomes and meet the intended purpose?
- **Person centredness:** Was care experienced as respectful and responsive to the preferences and needs of service users? Did people have control over healthcare decisions, and was care coordinated, continuous, supportive, and inclusive of carers and family?
- **Equity:** Did services vary in quality, based on the characteristics of service users such as sexual orientation, gender, ethnicity, disability, geographic location, and/or socioeconomic status, etc?
- **Safety:** Did services intending to help, actually cause harm, including psychological and medical harms?

- **Efficiency:** How well were resources used? This includes examination of financial and human inputs, management processes, and services provided.

4] Focus on Spectrum of Needs

Like all communities, the mental health challenges experienced by LGBTQ+ people occur across a spectrum which may shift overtime, or be long-term and enduring. Therefore, policy and service responses need to focus on provision of services to address the full spectrum of needs, from mild to moderate distress, to crisis (including severe mental distress and suicidality), through to those with enduring and life-interrupting mental health challenges.

Policy and services must also be formulated to reflect needs across a person's lifespan, and from a continuum of care perspective. It also involves attending to the needs of LGBTQ+ people in education, community and workplace settings, as well as in specialist and mainstream services including crisis support, in-patient and community settings, LGBTQ+ specific services.

In short, there are many temporal and conceptual dimensions to addressing LGBTQ+ needs.

5] More than a health matter

The literature highlights the importance of considering the social determinants of health when addressing mental health and suicide prevention for LGBTQ+ people. This means that health responses need to be considered alongside other critical factors, including: socioeconomic status; family relationships; housing and homelessness; education, employment, and work; and social inclusion and exclusion.

This strongly points to the need to consider early intervention and prevention measures that reduce or eliminate known mental health stressors.

At another level, it is also important for any approaches and deliverables arising from the mental health component of the LGBTQ+ Action Plan to be fed into not only the full spectrum of health policies and services, but also other key parts of the service system, including education, housing, business and industry, community and family services, disability and aged care services, and law and order, etc. These interlinked issues are well articulated in other key policy and advocacy documents including LHA's [Beyond Urgent: National LGBTIQ+ Mental Health and Suicide Prevention Strategy 2021-2026](#).

6] Language Matters

As illustrated in the literature, how we use language and communicate can profoundly impact the people we engage with. Inappropriate language can be a symptom of overt and covert discrimination, hetero-normative assumptions, and microaggressions, each of which can do serious harm to those on the receiving end. It is, therefore, essential that all policies and services, forms and signage, and written and oral communications involving LGBTQ+ people with mental health challenges, use inclusive language and terminology.

Additionally, the focus should be on:

- Language preferred by people with lived experience. For example, using non-gendered pronouns such as *they*, *them*, *their*; and using gender and relationship neutral terms such as *partners* over wife or boyfriend.

- De-emphasising medical diagnoses and pathological framings. For example, using *mental distress* or *mental health challenges* in place of mental illness; and using *life-interrupting mental health challenges* and *suicidality* in place of severe mental illness.
- Utilising other trauma-informed and inclusive vocabulary, as recommended in publications such as [MHCC Mental Health Rights Manual](#) (2021).

This said, it is also important to acknowledge that language is continuously evolving, and preferences and understandings regarding specific terminology are influenced by a variety of personal, cultural, and other contextual factors. One size does not fit all, and engaging with people with intersecting lived experience to determine appropriate language can be a practical way to negotiate language use.

In short, a major focus should be on the consistent use of contemporary language and communications that is inclusive, safe, and affirming.

7] Moving with the evidence base

As is evident throughout this paper, and the applied SLR, the research related to LGBTQ+ people and their interface with mental health services is dynamic and changing.

For this reason, it is important for all Government policies, strategies, and action plans, to be informed by, and contribute to, the emerging evidence base; refreshing terminology and knowledge about the mental health needs of LGBTQ+ people, adding new models or approaches to high-quality service provision, and utilising proven approaches established in research and good practice from across Australia and in other parts of the world.

8] Ongoing monitoring, evaluation, and learning

Building from Principle 4 and Principle 7, it is essential that any future policies, strategies, and action plans be closely monitored, including in collaboration with LGBTQ+ people with intersecting lived experience.

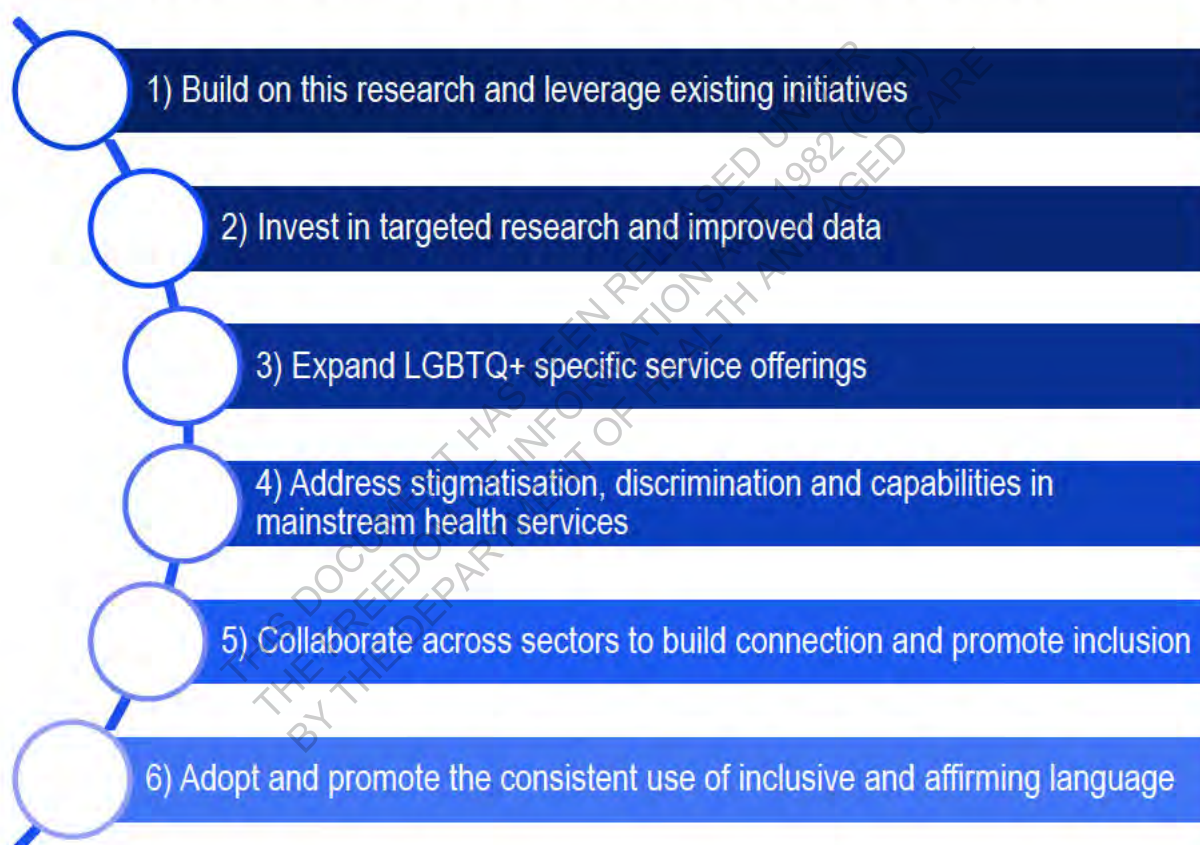
There should also be formal evaluations, learning, and reflections involving key sector and advocacy groups, plus policy makers at Commonwealth, state, and territory levels to ensure synergies of effort and opportunities to continuously improve outcomes for LGBTQ+ peoples across Australia.

6.3 Key Policy Directions and Options Arising

Building from the above overarching principles, the SLR and this supporting Research Translation Paper, the UTS-led researchers identified six core policy directions as summarised in Figure 4, with specific options arising under each following.

While each of these reflect the findings and results of the targeted, and time-limited research undertaken for the Department, they should not be interpreted as definitive, or the sole 'source of truth' in future policy formation. On the contrary, all options should be thoroughly tested through consultation processes with LGBTQ+ people with intersecting lived experience, service providers, advocacy groups, and peak bodies, and through supplementary research beyond the defined scope of the UTS commissioned research.

Figure 4: Key Considerations for the development of the National Action Plan



Source: UTS-led research team, October 2023.

1] Build on this research and leverage existing initiatives

The research highlighted various reforms and initiatives that are in progress which may have substantial impacts on LGBTQ+ health, mental health, and wellbeing, in the near future. As outlined in Sections 2, 3 and 4. These include:

- Targeted state and territory LGBTQ+ health strategies and lived experience advisory infrastructure, as outlined in Section 3.3. Many of these strategies align to the options below. For example, actions to improve data collection, training, and enhance inclusivity

in mainstream health services. However, as noted in Section 3.3.2, some LGBTQ+ peak bodies have queried the efficacy of some of these initiatives, and their progress towards improving outcomes for LGBTQ+ people.

- Ongoing policy reforms and submissions to government driven by LGBTQ+ peak bodies and industry organisations, drawing from people with lived experience.
- Planned improvements to data collection by national, state, and territory bodies. Significantly, it is hoped that the 2026 Census will make a substantive contribution to the availability of meaningful data on LGBTQ+ people.

There are also changes occurring in sectors which either directly impact LGBTQ+ health and wellbeing, and/or address similar mental health stressors. To provide a single example: the Final Report of the Disability Royal Commission includes recommendations to reduce stigma, discrimination, and violence directed toward people with disability. In addition, the Royal Commission recommends measures to improve data collection on LGBTQ+ people with disability, and their experiences accessing disability services.

Noting these related initiatives, a number of opportunities arise to support the development of the National Action Plan:

1. Undertake further research and consultations to refine, validate, and build upon the findings of the UTS-led and other existing research. This could include activities and research involving:

- a. A wider scope, and inclusion of an expanded pool of Australian and international literature about LGBTQ+ people and mental health and suicide prevention, including grey literature developed by LGBTQ+ bodies.
- b. Structured input and co-design with a diversity of LGBTQ+ people with lived experience as outlined above. This should include engagement with people with intersecting lived experience of mental distress and suicidality, including life-interrupting mental health challenges.
- c. Co-interpretation of the research findings and their policy implications by LGBTQ+ people with an intersecting lived experience and by service providers, building upon the Rainbow Embassy model used in this research.

2. Consider the release of a 10-year National 'Strategy', supported by successive two- to three-year 'Action Plans'³⁰³ to fully capitalise on the dynamic policy environment and emerging research evidence.

For example, this will allow the Government to utilise upcoming improvements to available LGBTQ+ data, including in particular hoped improvements to the 2026 Census.

³⁰³ For example, the ACT Government has adopted such a model for their [Capital of Equality Strategy](#), which is underpinned by biennial Action Plans.

3. **Collaborate with relevant Commonwealth, state, and territory governments to harmonise and strengthen evidence-based reforms and initiatives.** This should build upon existing policy levers and capitalise on available datasets or sector consultative processes. It could also serve to minimise duplication and reduce unproductive impacts on individuals involved in multiple policy initiatives. Collaborations might include:
 - a. Units and agencies across the Commonwealth Government tasked with delivering on relevant reforms, for example in other areas of health and aged care, disability, and law reform.
 - b. State and territory-level agencies undertaking work to improve LGBTQ+ health and wellbeing, as well as relevant PHN and LHD active in this services area.
 - c. Relevant state, regional, or local advisory bodies and infrastructure for example the [Victoria Government's LGBTIQ+ Taskforce](#) and [Queensland Government LGBTIQ+ Round Table](#).

4. **Establish an ongoing LGBTQ+ mental health 'Council' of individuals with intersecting lived experience of mental health challenges** to oversee the finalisation of the National 'Strategy' and provide ongoing monitoring and advice on its development and implementation.

Consideration could be given to building upon the representation on the Department's current Expert Advisory Group. Consideration could also be given to collaborating with existing community-controlled lived experience networks, such as the Rainbow Mental Health Lived Experience Network.

2] Invest in targeted research and improved data

The UTS-led research highlighted significant gaps in the evidence available to inform the development of effective strategies and services to support the diversity of mental health and wellbeing needs in the LGBTQ+ population. Notably, the current research landscape, combined with the evidence available through the applied SLR, could not deliver definitive answers to the KRQ, as documented at Section 1.4.

Further, the research highlighted the need to work with LGBTQ+ people with lived experience, including people from diverse backgrounds, to better address evidence gaps.³⁰⁴ It is also important to ensure research includes people with lived experience of severe life-interrupting mental health challenges (including suicide attempts), as well as those with mild and moderate mental health challenges. Further, the inclusion of First Nations LGBTQ+SB people, and people with other intersectoral profiles (e.g., LGBTQ+ people from CALD backgrounds, LGBTQ+ people with disability), is vital. In addition, collaboration with

³⁰⁴ This is consistent with the Government's commitment to support lived experience, collaboration and leadership in mental health research under the 2022 [National Mental Health Research Strategy](#)

researchers with lived experience also improves the quality and depth of research findings, and the prospects of robust knowledge translation.³⁰⁵

Informed by interpretations from the Rainbow Embassy, the UTS-led team have identified four areas for future research investment:

5. Research to further understand the needs and experiences of diverse LGBTQ+ people experiencing mental distress and/or suicidality, and to interrogate the implications of existing evidence for Australian policy.

This should include investigation of the impacts of different contextual, personal, cultural, and institutional factors. More specifically, the research should aim to fill identified research gaps regarding mental health and suicide prevention related to:

- a. Marginalised gender identities, including non-binary people.
- b. Marginalised sexual orientations, including bisexual and pansexual people
- c. First Nations LGBTQ+SB people³⁰⁶, noting that any research in this space should acknowledge and attend to the diversity within, and between, the different groups which comprise Australia's First Nations population.³⁰⁷
- d. LGBTQ+ people with intersectoral identities, including, though not limited to:
 - i. LGBTQ+ people from CALD backgrounds, living in rural and remote areas, those from low socioeconomic backgrounds, or living with disability.
 - ii. LGBTQ+ people with significant lived experience of other service systems or with compounding or co-occurring issues, including those related to alcohol and drug use, homelessness, the criminal justice system, and out-of-home care, among others.

6. Better map the Australian mental health service system, including mainstream and LGBTQ+ specific services potentially used by LGBTQ+ people, noting unmet needs and service gaps by different groups or potential users.

As noted in this research, none of the studies included in the SLR adequately mapped the services available in Australia. While Section 3 sought to provide a broad outline of the service system, comprehensively mapping the services was outside of the scope of this research.

Further, while many studies in the applied SLR surveyed service access among participants, this did not provide a nationally representative picture. In addition, these studies frequently did not distinguish between different service types, or service

³⁰⁵ Jo Brett, Sophie Staniszewska, Carole Mockford, Sandra Herron-Marx, John Hughes, Colin Tysall and Rashida Suleman, Mapping the impact of patient and public involvement on health and social care research: A systematic review. *Health Expectations*, vol. 17 (2012): 637–650.

³⁰⁶ Uink et al 2020

³⁰⁷ Evolve Communities, *Aboriginal Diversity – Why one size does not fit all*, <https://www.evolve.com.au/aboriginal-diversity/>

interactions available with any one service setting, nor between specific user groups included under the LGBTQ+ abbreviation.

The mapping be continuously updated to maintain usability for different groups (e.g., service users, GPs) and should include documenting continuity of care pathways and post-intervention recovery options.

7. **Following from Option 6), establish methods to continuously evaluate access, inclusion, service quality, and service outcomes delivered by mainstream and LGBTQ+ specific mental health services and programs** to support continuous improvement, as well as necessary major reforms across some services, sectors, or professional practice.

The evaluations should be undertaken in collaboration with LGBTQ+ people with lived experience and capture data on personal recovery measures in line with the national, whole-of-person approach to mental health and wellbeing.³⁰⁸

Included at Attachment 4 are some specific issues that the SLR highlighted as requiring targeted evaluation research.

8. **Research, pilot and evaluate initiatives designed to reduce mental health stressors experienced by LGBTQ+ people, in the first instance within both mainstream and LGBTQ+ specific mental health service systems.**

In particular, this should include practical options to address stigma, discrimination, microaggressions, pathologisation, abuse, and other exclusions impacting access to quality care and support.

See Options 21–23 regarding primary prevention initiatives.

3] **Expand LGBTQ+ specific service offerings**

The research evidence suggests that while LGBTQ+ specific services can reduce barriers to accessing care and support, they are not widely or consistently available across Australia. For example, the only nationwide options identified were online and telephone services. While these modes were found to have merits, they are not accessible to, or accessed by, all potential users within the LGBTQ+ community.

Further, the research found that some LGBTQ+ specific service offerings are not equipped to support people with severe or life-interrupting mental health challenges and suicidality, or to meet the full diversity of LGBTQ+ sub-populations. In addition, research highlighted that

³⁰⁸ See for example the Australian National Mental Health Commission, *Contributing Lives, Thriving Communities*, <https://www.mentalhealthcommission.gov.au/lived-experience/contributing-lives,-thriving-communities>

members of the LGBTQ+ community find some services impersonal and difficult to use, and lacking in continuity of care options.³⁰⁹

Drawing on these findings, and research interpretations from the Rainbow Embassy, the UTS-led researchers identified opportunities to expand the LGBTQ+ specific service offerings across life stages and intensity levels available across Australia.

9. Investigate funding a diversity of additional LGBTQ+ specific mental health service options, providers, and models designed to deliver quality outcomes, including those specifically addressing unmet needs in respect to:

- a. Supporting severe and life-interrupting mental distress and suicidality for specific sub-populations of the LGBTQ+ community
- b. Continuum of care and recovery pathways
- c. Supporting greater user choice
- d. Improved access in general, not unduly restricted by an individual's specific mental health need, geography, age, income, or personal capabilities

10. Commit resources to train, recruit and retain staff in LGBTQ+ specific services to optimally manage the spectrum of mental health care needs.

The research indicates that LGBTQ+ specific services often lack the training and resources to adequately respond to suicidality and severe and life-interrupting mental health challenges, co-occurring substance use issues, and other intersectional issues.

11. Establish a mechanism for First Nations peoples and organisations to oversee the design, development, and implementation of First Nations LGBTQ+SB specific mental health and suicide prevention services.

The evidence suggests that mainstream, LGBTQ+ specific, and First Nations health services, often fail to accommodate the intersectional experiences and needs of Aboriginal and Torres Strait Islander clients who are also LGBTQ+SB.³¹⁰ The provision of additional services, created by and for First Nations LGBTQ+SB people with lived experience, is essential to address this significant service gap.

12. Expand evidence-based services for young LGBTQ+ people within and outside of mental health services, including mental health early intervention and prevention options in schools and other community settings.

The research indicates that young LGBTQ+ people benefit from school counselling, family-based approaches, and online mental health services provided by well-trained, well-informed, and respectful staff. However, evidence also indicates that youth can also experience stigma and exclusion from school counsellors, and telephone crisis

³⁰⁹ Bowman et al., 2020

³¹⁰ Uink et al 2022

helpline staff, with online services found to be at times impersonal, complex, and with limited follow up. This suggests a need to develop a clear strategy with LGBTQ+ youth with a lived experience to ensure easy access to affirming mental support services through a variety of different modes, with online services as an adjunct to face-to-face service provision rather than a mainstay of care.

13. Action ways to better accommodate intersectional and sub-group needs within LGBTQ+ specific services, including stronger pathways to accessing quality mental health care and support for diverse populations and for those with severe mental health distress and suicidality, or co-occurring health issues.

Further research and investment are required to ensure that LGBTQ+ specific services can address the intersecting needs, experiences, and preferences of diverse LGBTQ+ communities. While some social programs addressing intersectional needs were identified through the research, these were limited.

4] Address stigmatisation, discrimination, and capabilities within mainstream health services

This research highlights that stigmatisation, pathologisation, and hetero-normativity in mainstream, and some faith-based health and wellbeing services, pose significant barriers which can discourage LGBTQ+ people from accessing health services, undermine the quality of the services they receive, and contribute to further harm and mental distress. The SLR found that in-patient and emergency services were most commonly reported to expose LGBTQ+ people to these issues.

The UTS-led researchers understand that numerous states and territories are already undertaking actions to reduce these issues in health care services (see Section 3.3). In addition, organisations such as [Rainbow Health Australia](#) have developed frameworks and assessment tools – among other resources and training programs – to support services to become safe, welcoming, and inclusive for LGBTQ+ people and staff.

While training was identified as a major area for further action, the evidence also suggests that training alone is not sufficient to change practice, and other initiatives will need to be implemented to support education. This includes, but is not limited to:

- Zero tolerance for stigmatising, pathologizing, or exclusionary practices
- Benchmarks and accountability for affirming and culturally safe practice, including performance management for non-attainment at all levels of organisations
- Community-of-practice initiatives to foster best practice
- Leadership and mentoring strategies³¹¹

³¹¹ Priddle, T., Crawford, T., & Power, T. 2023, "The inclusion and representation of LGBTIQ+ content in undergraduate nurse education: A scoping review", *Nurse Education Today*, vol. 124, p. 105771-105771.

14. Build the capacity, skills, knowledge, and understanding of mainstream health staff to ensure the provision of affirming and culturally-safe practice for LGBTQ+ people experiencing mental health challenge or suicidality.

Affirming and culturally safe care has been consistently identified as a requirement for ensuring services are safe, inclusive, and affirming. They have also been directly linked to reducing additional strain placed on LGBTQ+ individuals to educate those who are providing care to them.³¹² The SLR also identified that many providers and practitioners have expressed an appetite for capacity building in this area.

There is also evidence that relatively non-intensive training can have good outcomes. For example, purposefully developed eLearning for mental health practitioners has been demonstrated to increase knowledge, confidence, and comfort working with non-binary people.³¹³ However, it is also critical to ensure that training materials are co-designed to communicate the diversity of needs and experiences encompassed under the umbrella of LGBTQ+, including intersectional experience.

LGBTQ+ specific content should also be included in undergraduate curricula for mental health and other health professionals to improve knowledge, attitudes, comfort, and preparedness for working with LGBTQ+ people in health services. This should also include strategies to evaluate in collaboration with LGBTQ+ people to ensure that curricula is affirming, culturally safe, and does not further pathologise or stigmatise LGBTQ+ people.

15. Embed LGBTQ+ people with intersecting lived experience within health settings and provide meaningful opportunities for them to influence every stage of the service's development, culture, and practices.

This approach aligns with the National Mental Health Commission's [Vision 2030](#) goal that "communities are the centre of identifying people's needs, designing responses and delivering care".³¹⁴ Nonetheless, the SLR did not find evidence that services were co-designed.

16. Actively support LGBTQ+ people, and particularly those with intersecting lived experience, to work in health settings, and to take up service provider roles at all levels of seniority. This should include, though not be limited to, peer worker roles, lived experience advocacy, and researcher roles, as well as managerial roles.

The provision of services by LGBTQ+ people, and LGBTQ+ people with intersecting lived experience, can support a sense of inclusion and safety for service users. It is

³¹² Tamara Reynish, Ha Hoang, Heather Bridgman and Brona Nic Giolla Easpaig, "Psychological Distress, Resilience and Help-Seeking Experiences of LGBTIQ+ People in Rural Australia", in *International Journal of Environmental research and Public Health*, vol. 20 (2023): 2842.

³¹³ Damian M. Vann, Damien W. Riggs & Heather J., "Implementing a brief E-training opportunity for mental health practitioners working with non-binary clients", *Australian Psychologist*, vol. 56 (2021): 299-310.

³¹⁴ National Mental Health Commission, *Vision 2030* p. 12

also particularly important to support workers and practitioners who represent intersectional experiences, such as LGBTQ+ people from CALD backgrounds.

17. Update and streamline processes and referral pathways to connect LGBTQ+ people with inclusive mainstream and LGBTQ+ specific mental health providers that are able to optimally support their recovery.

Numerous SLR studies highlighted that the process of navigating to LGBTQ+ inclusive providers in Australia was complicated by the rigidity of mental health referral processes.³¹⁵ While coordinated care is ideal, streamlined referral mechanisms are required in the interim.

18. Develop and widely promote a trauma-informed, recovery-oriented, equitable and safe framework of Australian mental health services that addresses minority stressors known to drive mental distress and suicidality. The Framework should provide practical advice on how to eliminate the traumatising impacts that unsafe, poor-quality service provision can have on LGBTQ+ people.

The UTS-led research team notes that trauma-informed care is captured within the National Mental Health Commission's understanding of recovery-oriented care, and efforts should be furthered to ensure that this is meaningfully incorporated in practice.³¹⁶ In addition, some Australian states have developed trauma-informed frameworks for their mental health services – for example, in August 2023 the NSW Government published a trauma-informed framework and self-assessment tool for mental health services across NSW.³¹⁷

19. Collaborate to action current recommendations designed to overcome stigmatisation in relation to mental health and LGBTQ+ people in other health, aged care, and disability care services.

The researchers note that work undertaken through the Disability Royal Commission which focused on the experiences of LGBTQ+ people, led to the development of a series of recommendations for structural, service, and community-level interventions.³¹⁸

20. Investigate and find practical options to embed multiple explanatory frameworks for distress and service provision for LGBTQ+ people experiencing mental health distress or suicidality.

³¹⁵ Jones, 2016; Amos et al., 2023

³¹⁶ National Mental Health Commission 2019, *Vision 2030* p.34

³¹⁷ NSW Government Agency for Clinical Innovation, *Trauma-informed care and practice in mental health services* (2023) <https://aci.health.nsw.gov.au/networks/mental-health/trauma-informed-care>

³¹⁸ See: Hill et al., 2022

To provide safe and affirming care that aligns with the needs of LGBTQ+ people, service providers need to embed a multiple explanatory framework for mental distress and suicidality in health services. This includes recognition of the impacts of minority distress, discrimination, and trauma of LGBTQ+ people in the community, and a de-emphasis of pathologising and illness models of mental health that can be experienced as “dehumanising”. When well designed, these frameworks also provide practice options that emphasise recovery-oriented and trauma-informed approaches to care.

It should be noted that the Rainbow Embassy emphasised that “the care solution must fit the problem” and provide trauma-informed and recovery-oriented choices which are therapeutic and non-medical, as well as medication options.

5] Collaborate across sectors to build connection and promote inclusion

The research consistently linked the health, mental health, and wellbeing outcomes of LGBTQ+ people with social, institutional, and structural factors. The literature also demonstrated that these factors could either risk or protect mental health and wellbeing. For example, explicit parental support and involvement in helping manage mental health distress was identified as a potent protective factor, while parental rejection was linked with grave mental health and suicide prevention outcomes. Similarly, support provided or withheld by the general community was found to have a substantive impact on psychological distress of LGBTQ+ people, independent to the availability of support from the LGBTQ+ community.³¹⁹

There is, therefore, significant opportunity to oversee interventions to foster the protective potential of these factors and reduce the risks they pose in the community at large. This requires seeking out multiple opportunities to collaborate across sectors to build connection and promote inclusion within workplaces, schools, and sports, as well as within families and community structures more broadly:

21. Initiate a major whole-of-government and cross-sectoral health and wellbeing inclusion strategy to promote social inclusion and address sources of stigma impacting LGBTQ+ people and communities.

The research highlighted a pressing need to reduce stigma and discrimination in, and beyond, the sphere of health and mental health, in order to support better mental health and wellbeing outcomes for LGBTQ+ people.

The UTS-led researchers note that some initiatives to promote social inclusion have been integrated into existing strategies at both national and state-levels (see Section 3 and 4.6). For example, the National Mental Health Commission is finalising a National Stigma and Discrimination Reduction Strategy focused on promoting social inclusion

³¹⁹ Perales & Todd., 2018

for people with lived experience of mental health challenges.³²⁰ This amongst other documents could be looked to as a model for a similar strategy promoting social inclusion for LGBTQ+ people.

In addition, among other recommendations designed to reduce discrimination, the Disability Royal Commission called for the creation of a “positive duty” to promote disability equality and inclusion either attached to a new or current Commonwealth entity.³²¹

Clearly, the content and optimal method for actioning the above initiative will need to be undertaken in conjunction with LGBTQ+ people with lived experience, together with other relevant Commonwealth and state entities, including the Australian Human Rights Commission.

22. Work with relevant Commonwealth, state, and territory agencies to promote inclusion amongst young people, in order to improve understanding, connections, and reduce stigma and discrimination against LGBTQ+ people.

The research indicated that early intervention and prevention measures are powerful tools in reducing mental health distress and suicidality. For example, it has been shown that school experiences can profoundly impact the mental health and wellbeing of not just the children and young people attending, but also adults as they move through their lives. Further, the research shows that while the inclusivity of school cultures differs across Australia, it can be significantly influenced by the curriculum and by the examples set by school staff. Reducing the prevalence of stressors in young LGBTQ+ people, may have significant and profound long-term benefits.

23. Develop and promote educational resources to build parents, carers, family, and community awareness, skills, and capacity to affirm LGBTQ+ people within their lives.

The UTS-led research suggested that stressors could be reduced through designing and implementing interventions at the family³²², and direct community-level, in respect to LGBTQ+ people. Further, evidence has demonstrated that family and community education interventions can be effective and effectively scaled in the form of online programs. For example, an online programme aimed at increasing affirming behaviour

³²⁰ National Mental Health Commission, *National Stigma and Discrimination Reduction Strategy*, <https://www.mentalhealthcommission.gov.au/projects/stigma-and-discrimination-reduction-strategy>.

³²¹ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability: Final Report p. 198.

³²² Bariola, Emily, Lyons, Anthony, Leonard, William, Pitts, Marian, Badcock, Paul, and Couch, Murray 2015, “Demographic and Psychosocial Factors Associated with Psychological Distress and Resilience among Transgender Individuals”, *Health Discrimination and Disparities*, vol. 105, no. 10 p. 2112.

among the parents of transgender youth – such as through the ‘Parent Support Program’ – has been piloted in California and found to be “highly acceptable”.³²³

6] Adopt and promote the consistent use of inclusive and affirming language

A tangible means of reducing minority stressors linked to LGBTQ+ people experiencing mental health challenges and suicidality is through consistently adopting inclusive and affirming language, terminology, and communications. As expanded upon at Principle 7, this includes the use of updated terms preferred by LGBTQ+ people with lived experience.

This principle also has a practical application in terms of mental health and suicide prevention services:

24. Update and standardised the inclusivity of language and terminology used in all mainstream health, mental health, and wellbeing services, including services provided by religious organisations.

For example, ensure that in-take forms accommodate and acknowledge diverse genders and sexual orientations. This can simultaneously improve data capture and grow the evidence base to support future policy development.

6.4 Other Options and Considerations

While evident in the research, though somewhat adjacent to the KRQ commissioned by the Department, the UTS-led research team identified a number of other options related to:

5. Reducing barriers to accessing gender affirming care

For example, the applied SLR found that mental health service providers were often involved in facilitating access to gender affirming care options including puberty blockers, hormone treatments, and various forms of surgery. Further, the literature noted that this was regularly linked to improved mental health, wellbeing, and suicide prevention outcomes for trans and gender diverse people.³²⁴ Among other factors, the positive impacts of gender affirming care were linked to reductions in exposure to minority stressors such as stigmatisation, discrimination, and violence.³²⁵

However, the research also indicated that many trans and gender diverse people experienced barriers to accessing treatment, including a shortage of appropriate providers,

³²³ Mutsuno, E., & Israel, T. (2021). The parent support program: Development and acceptability of an online intervention aimed at increasing supportive behaviours among parents of trans youth. *Journal of GLBT Family Studies*. Advance online publication. doi:10.1080/1550428X.2020.1868369

³²⁴ See SLR

³²⁵ See SLR

requirements for multiple assessments (referred to as “professional gatekeeping”), requirements for parental consent in the case of young people, plus costs.³²⁶

Further, the research indicated that long wait lists, a lack of appropriate providers, and out-of-pocket costs commonly acted as barriers to timely access to gender affirming care. These could be counteracted through improvements to resourcing and Medicare rebates.³²⁷

Taken together this suggests value in the National Action Plan also giving consideration to the following:

25. Conduct additional research to investigate options (including potential pilot projects) to streamline, coordinate, and improve access to gender affirming care in order to reduce mental health distress and suicidality, including for young people.

The research indicated that substantial work was needed to improve the coordination of care and referral pathways across the health sector more broadly, specifically in relation to gender affirming care. Consistent with good practice, these should be investigated and developed in collaboration with trans and gender diverse people, advocates, and service providers.

As an interim option, however, the research indicated that the prescription of hormonal treatments by GPs was a “practical and acceptable solution” to reducing certain access hurdles and was preferable to assessment by a mental health clinician.³²⁸ Clearly, additional research is needed to further review these types of options and pathways.

26. Conduct additional research to investigate options (including potential pilot projects) to overcome barriers to gender-affirming care in order to reduce mental health distress and suicidality, including for young people. These options should consider mechanisms to:

- a. Improve provider availability
- b. Reduce cost³²⁹

³²⁶ See SLR

³²⁷ While Medicare does provide rebates for some gender affirming treatment options, the UTS-led research team notes that an application has been submitted to the Department by the Australian Society of Plastic Surgeons (ASPS), in collaboration with trans organisations and other health professionals, to list specific gender-affirming procedures on Medicare. ASPS has argued that, in addition to reducing out-of-pocket costs, this inclusion could incentivise more surgeons to train in providing gender affirming procedures. (Barraclough, Ashleigh 2023, “Transgender Australians waiting years for gender affirming surgery, as Medicare bid looms”, ABC News, updated Fri 25 August 2023 at 9:10am, <https://www.abc.net.au/news/2023-08-25/transgender-affirming-surgery-barriers-waiting-lists-costs/102473890>).

³²⁸ See SLR

³²⁹ See SLR

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Attachments

Attachment 1: About the SLR Methodology

The SLR research focused on texts published between February 2013 and February 2023, as identified by the Department, (n=1895) drawing from seven databases:

- CINAHL database
- EMBASE database
- Global Health database
- Medline
- PsycInfo
- Health Policy Reference
- Informit.

Only those research papers included in the Department's initial selection process (n=369) will be in scope.

Before proceeding to full text analysis, duplicates were removed, with each remaining abstract subjected to a double-blind review, using the following exclusion criteria:

1. Not peer reviewed/published (n = 10)
2. Not LGBTQ+ focused (n = 8)
3. Not about accessing mental health, or experience or gaps (n = 266)
4. Not a primary study (for example, a proptocol or case study) (n=4)
5. Not UK or Australia focused (n = 7)
6. Not published between February 2013 and February 2023 (n = 0)

A second round of literature screening was conducted, based on identification and inclusion criteria finalised in the Stage 1 co-design process with the Department. This was informed by the Department's existing methodology and suite of source documents. The Joanna Briggs Institute (JBI) Systematic Review methodology was utilised.³³⁰

³³⁰ Aromataris E, Munn Z (Editors). JBI Manual for Evidence Synthesis. JBI, 2020. Available from <https://synthesismanual.jbi.global>. <https://doi.org/10.46658/JBIMES-20-01>

Attachment 2: State and Territory Legislation and Bodies with responsibility for protecting the rights of LGBTQIA+ people

- **ACT Government**

LGBTIQ+ rights are protected in the ACT under the *Discrimination Act 1991* (ACT), which includes sex, sexual orientation, intersex status, gender identity, and HIV/AIDS status as prescribed attributes. It is also one of only three jurisdictions that possess specific provisions protecting the rights of intersex people, which includes children with intersex variations and the protection from surgeries without their consent.

In the ACT, transgender and intersex people can also change the sex listed on their birth certificate under the Births, Deaths and Marriages Registration Amendment Act 2014. The ACT is yet to pass the Bill aimed at protecting LGBTIQ rights by outlawing conversion therapy.³³¹

The body responsible for protecting these rights and managing complaints is the [ACT Human Rights Commission](#).

- **New South Wales**

The *Anti-Discrimination Act of 1977* (NSW) prohibits discrimination on the basis of a person's sexual orientation in workplaces, education, and in the provision of goods and services. The Act also prohibits discrimination against transgender individuals. The NSW Government allows a person to change their sex on their birth certificate and driver's license. However, this can only be done after sex affirmation surgery and does not accommodate the wishes of transgender individuals who have been unable or unwilling to undergo surgery. Conversion practices have also not yet been outlawed in New South Wales.

The body responsible for protecting these NSW rights and managing complaints is the [Anti-Discrimination Board of NSW](#).

- **Northern Territory**

Under the *Anti-Discrimination Act 1996* (NT), the rights of non-heterosexual individuals are protected in most areas of the Northern Territory law. However, the NT Anti-Discrimination Act does not comprehensively protect individuals from discrimination on the basis of gender identity. The NT also does not have legislation prohibiting vilification on the basis of sexual orientation, gender identity, or other attributes.

The body responsible for protecting these rights and managing complaints is the [Northern Territory Anti-Discrimination Commission](#).

- **Queensland**

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Under the *Anti-Discrimination Act 1991* (Qld), it is unlawful to incite hatred towards LGBTIQ+ people on the grounds of their sexuality or gender identity. Intersex people in Queensland do not currently have the right to have their intersex status recognised on their birth certificate.

The body responsible for protecting these rights and managing complaints is the [Queensland Human Rights Commission](#).

- [South Australia](#)

The *Equal Opportunity Act 1984* (SA) prohibits discrimination based on sex, sexual orientation, or gender identity, with the latter terms replacing outdated terms of 'chosen gender' and 'sexuality' in the Act's 2016 amendment. Intersex protections were added to the Equal Opportunity Act in 2017. In 2016, South Australia became the first state to allow individuals to change their sex on their birth certificate without having undergone sex affirmation surgery. South Australia has not yet passed laws outlawing conversion therapy.

The body responsible for protecting these rights and managing complaints is [Equal Opportunity SA](#).

- [Tasmania](#)

The *Anti-Discrimination Act 1998* (TAS) prohibits discrimination on the basis of a person's sex, sexual orientation, gender identity, and intersex variations. Tasmania's *Marriage Gender Amendments Act 2019* permits individuals to change their name and gender information on a birth certificate, and also removes the requirement for a person wishing to change their gender to have undergone sexual reassignment surgery.

The body responsible for protecting these rights and managing complaints is [Equal Opportunity Tasmania](#).

- [Victoria](#)

Following amendment to the *Equal Opportunity Act 2010* (Vic), it is unlawful in Victoria to discriminate against an individual on the basis of their intersex characteristics, gender identity, or sexual orientation. Since 2019, trans and gender diverse Victorians no longer need to undergo sex affirmation surgery to alter the sex recorded on their birth certificate. In addition, conversion therapy practices were banned in 2021 by the Victorian Government.

The body responsible for protecting these rights and managing complaints is the [Victorian Equal Opportunity and Human Rights Commission](#).

- [Western Australia](#)

The *Equal Opportunity Act 1984* (WA) prohibits discrimination on the basis of an individual's sexual orientation. These laws do not protect transgender people unless they have been reassigned gender under the *Gender Reassignment Act 2000* (WA), in which discrimination is prohibited on the basis of gender history and not gender. In addition, discrimination against intersex people is not prohibited.

The body responsible for protecting these rights and managing complaints is the [Equal Opportunity Commission Western Australia](#).

Attachment 3: Additional Commonwealth, state and territory policies and strategies

The table below provides a broad summary of additional Commonwealth, state, and territory policies and strategies with relevance to LGBTQIA+ mental health and wellbeing identified in the course of this research not covered in the main text.

Name	Summary Description
Commonwealth	
<u>National Mental Health Workforce Strategy 2022-2032</u>	The Strategy is a high-level vision with aims to building a sustainable workforce that is skilled, well-distributed, and supported to deliver mental health treatment, care, and support that meets the current and future population needs. Goals are to attract, train, support, and retain a skilled, motivated, and coordinated mental health workforce.
ACT	
<u>ACT-Commonwealth Bilateral Mental Health Agreement</u>	Signed in 2022, this agreement commits to supporting improved mental health and suicide prevention outcomes for all people in the ACT, through collaborative efforts to address gaps in the mental health and suicide prevention system. More than \$38 million will be invested into mental health and suicide prevention support and services in the ACT over the next five years. The funding includes \$9 million to enhance the existing headspace centre, \$8 million to continue Head to Health adult mental health services, among other funding.
Northern Territory	
<u>NT-Commonwealth Bilateral Mental Health Agreement</u>	Following the signing of a bilateral agreement between the Commonwealth and Northern Territory governments in 2022, more than \$43 million will be invested into mental health and suicide prevention support and services. This includes \$15 million for two new Head to Health adult mental health clinics, \$9 million to establish universal aftercare services, and \$9 million for a new Head to Health Kids Hub.
<u>Northern Territory Suicide Prevention Strategy 2018-2023</u>	A commitment funded by the NT Department of Health to halve suicide rates by 2026. Outcomes specifically relating to LGBTIQ+ individuals include targeted training for healthcare staff, especially those in primary healthcare services in supporting vulnerable people. Organisations funded in line with the Strategy are Indigenist, Rainbow Territory, The Gap, Headspace, NT AIDS and Hepatitis Council, and Tiwi Strong Women: Watering the Tree of Life.

Name	Summary Description
Northern Territory Gender Equality Action Plan 2022-25	This plan funded by the NT Department of Territory Families, Housing and Communities has aims of establishing an LGBTIQ+ consumer sub-committee, including Pride flags in hospital foyers and other public spaces, promoting, and supporting Quality Innovation Performance Rainbow Tick Accreditation for departments in the NT Public Service, as well as the implementation of the silver Rainbow Program for NT Aged Care Services.
New South Wales	
NSW-Commonwealth Bilateral Mental Health Agreement	Following the signing of a bilateral agreement between the Commonwealth and New South Wales governments in 2022, more than \$383 million will be invested into mental health and suicide prevention support and services. This includes \$106 million for headspace to expand and enhance services, \$121 million to establish universal aftercare services, and \$84 million to establish 14 adult new Head to Health treatment centres.
Queensland	
Qld-Commonwealth Bilateral Mental Health Agreement	Following the signing of a bilateral agreement between the Commonwealth and Queensland governments in 2022, more than \$260 million will be invested into mental health and suicide prevention support and services. This includes \$50 million for five new Head to Health adult mental health clinics with seven satellites, \$78 million to expand universal aftercare services, and \$21 million for two new Head to Health Kids Hub.
Shifting Minds and Every Life	The Shifting Minds plan funded by the Queensland Mental Health Commission aims to increase early intervention responses to address diverse needs and experiences. Another objective for LGBTIQ+ individuals is to build inclusive, resilient, and mentally healthy communities.
Queensland public sector LGBTIQ+ inclusion strategy 2017-2022	A 5-year LGBTIQ+ strategy funded by the Queensland Department of Health, focused on building the capability of allies, leaders, and the broader workforce so they can actively champion inclusion, provide supportive workplace cultures as well as implement inclusive policy and practice.

South Australia	
SA-Commonwealth Bilateral Mental Health Agreement	Following the signing of a bilateral agreement between the Commonwealth and South Australian governments in 2022, more than \$127 million will be invested into mental health and suicide prevention support and services. This includes \$101 million for a network of new Head to Health adult mental health centres with two additional satellites, \$15 million to establish one new headspace centre, and \$10 million to establish a new Aboriginal Mental Health and Wellbeing Centre.
Mental Health Services Plan 2020-2025	A 5-year plan funded by the SA Department of Health promoting fairness, inclusion, tolerance, and equity in all interactions, to be achieved through an anti-stigma campaign targeting stigma and discrimination experienced by LGBTIQ+ people facing inequalities.
Tasmania	
TAS-Commonwealth Bilateral Mental Health Agreement	Following the signing of a bilateral agreement between the Commonwealth and Tasmanian governments in 2022, more than \$55 million will be invested into mental health and suicide prevention support and services. This includes \$24 million for new Head to Health adult mental health clinics with three satellites, \$4 million to establish a new headspace centre, and \$5 million for universal aftercare services to support individuals discharged from hospitals following a suicide attempt.
Whole of Government Framework for LGBTI Tasmanians	<p>Under this framework, LGBTI Tasmanians are provided with equal access to government programs and services and are treated with dignity and respect. Some principles include:</p> <ul style="list-style-type: none"> • Diverse characteristics and experiences are both recognised and respected. • All Tasmanians have equal rights to access government services and be involved in their design and delivery. • All services (non-government included) are expected to coordinate and collaborate efforts to develop evidence-based, innovative service delivery. • The Tas Government will actively recognise and promote the achievements of organisations in relation to the LGBTI community. • Every Tasmanian, regardless of their sexuality, gender identity or intersex characteristics, is supported to participate and contribute to the social, political, economic, and cultural life of Tasmania.

Victoria	
<u>Vic-Commonwealth Bilateral Mental Health Agreement</u>	Following the signing of a bilateral agreement between the Commonwealth and Victorian governments in 2022, more than \$248 million will be invested into mental health and suicide prevention support and services. This includes \$125 million to continue operation of the 14 existing Head to Health adult mental health clinics, \$45 million to enhance headspace services and establish two new centres, and \$5 million for postvention support services.
Western Australia	
<u>WA-Commonwealth Bilateral Mental Health Agreement</u>	Following the signing of a bilateral agreement between the Commonwealth and Western Australia governments in 2022, more than \$61 million will be invested into mental health and suicide prevention support and services. This funding will be directed to a child health and wellbeing hub, statewide aftercare services, and eating disorder services in the East Metropolitan Health Service.
<u>LGBTQIA+ Advisory Group and the LGBTQIA+ Plan 2021- 2024</u>	This 3-year plan funded by the City of Perth targets seven key areas including safety, education, homelessness, healthcare, organisational capability, welcoming and accessible services, and visibility. The plan includes details of their expected timeframe, success measure, and related action areas (e.g., providing all-gender bathrooms and change facilities).

Source: Various including Department of Health and Aged Care unpublished fact sheet, plus online sources listed as at October 2023.

Attachment 4: Subjects for further targeted research

As highlighted in the companion SLR, the current peer-reviewed literature in Australia and the United Kingdom is weak on the following issues, strongly suggesting the need for supplementary research:

1. The experiences of diverse LGTBQIA+ people accessing LGBTQIA+ specific services, including the extent to which these services are meeting the unique needs of sub-populations (e.g., intersex people), the needs of diverse populations with intersecting experiences (e.g., people from CALD backgrounds), as well as people with severe life-interrupting mental distress and suicidality.
2. The experiences of, and outcomes for, LGBTQIA+ people receiving specific services and therapeutic approaches, including trauma-specific therapeutic interventions.
3. The experiences and service needs of LGBTQIA+ people with intersecting identities, with a focus on provision of safe, dignified, and effective services for First Nations people and people from CALD backgrounds, that recognises and responds to intersecting experience, across specialised and mainstream services.
4. The experiences of LGBTQIA+ people in in-patient and emergency services, particularly where care is involuntary.
5. The experiences of LGBTQIA+ people receiving involuntary treatment in the community, such as through Community Treatment Orders
6. The safety of services, including with reference to:
 - a. The use of coercive and traumatising practices, including seclusion and restraint, etc. The UTS-led research team notes that the Disability Royal Commission recommended that a longitudinal study on the use of restrictive practices in disability, health, education, and justice sectors be commissioned by the National Disability Research Partnership.³³² It should be ensured that research on the use of restrictive practices, as well as efforts to reduce and eliminate these, are extended to LGBTQIA+ people accessing mental health services with psychosocial disability or acute life-interrupting mental distress and suicidality.
 - b. The extent to which forms of conversion practice are still practiced by some health professionals; how regulatory bodies can act to prevent these practices; and best practice for therapeutic care for survivors of conversion practice.
7. Approaches to care for LGBTQIA+ people that aim to maximise choice and collaboration, including collaborative care planning, choice of treatments and therapies, and collaborative decision-making.

³³² *Executive Summary, Our vision for an inclusive Australia and Recommendations p. 237*

8. The experiences of LGBTQIA+ people who are experiencing mental health challenges and suicidality and receiving care from peer workers, in peer-led services, or services with employed peer workers.
9. The experiences of LGBTQIA+ people accessing general medicine and/ or mental health services within Primary Health Networks and Local Area Health services.
10. The experiences of young LGBTQIA+ people with mental health challenges in schools, including those who are access school counselling. These should be informed by the perspectives of young people with a lived experience.

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Public Policy
and Governance

APPLIED SYSTEMATIC LITERATURE REVIEW LGBTQ+ People and Mental Health Services Research

An applied systematic review
and lived experience informed synthesis of
mental health and suicide prevention services
for LGBTQ+ people

Prepared for
Commonwealth Department of Health and Aged Care

By
University of Technology Sydney
and research partners

December 2023

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The UTS Faculty of Health team includes content experts and members of the Rainbow Embassy and associates, who are LGBTQ+SB people with a lived experience of life-interrupting mental health challenges and/or suicidality, and of accessing mental health and suicide prevention services.

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Executive Summary

About the Research

In June 2023, the Department of Health and Aged Care contracted a University of Technology Sydney (UTS) led research team to undertake an applied systematic literature review (SLR) to inform the preparation of a 10-Year National Action Plan for the Health and Wellbeing of Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual, plus other people with diverse genders and sexual orientations (LGBTQIA+).

Based on the in-scope literature, and the specific research parameters (*see below*), the brief was later amended to focus on LGBTQ+ people, with the expectation that other options will be explored to attend to the specific needs of asexual people and people with innate variations of sex characteristics (commonly shortened to intersex people). Future search strategies would ideally be conducted with experts in the field to ensure inclusion of relevant literature.

The targeted UTS-led research was to address three key research questions (KRQ):

1. For LGBTQ+ people:
 - a. What are the key causes of distress experienced that impact on their mental health or wellbeing, and/or increase their risk of suicidal behaviours?
 - b. What are the key issues and barriers when accessing services for their mental health and/or suicide prevention services?
2. In respect to accessing services for mental health and suicide prevention, and based on a Departmental literature search of peer reviewed literature on mental health and/or suicide prevention services for LGBTQ+ people in Australia and a comparator international context (UK)¹:
 - a. What services are available and provided to LGBTQ+ peoples?
 - b. What services were found to be effective?
 - c. What service gaps or barriers were identified and what were their details?
3. What evidence-based insights can be drawn from the UK and Australian literature for Australia, to help inform policy development for the 10 Year National Action Plan for the Health and Wellbeing of LGBTQ+ people?

To address these, three papers were prepared for the Department:

- **Applied SLR** (this paper) addressing KRQ 2 based on the 56 peer reviewed articles identified by the Department.
- **Research Translation Paper** answering all three KRQ, including a summary of the Applied SLR.

¹ The UTS-led research team inherited an initial literature search undertaken by the Department. As such, the team did not search for missing literature, or cross-check for reliability issues. For this reason, the listed SLR articles should be taken at face value.

- A plain English summary of the above.

The design, conduct, and reporting of this applied SLR was undertaken according to the Joanna Briggs Institute (JBI) critical appraisal tools, using a narrative synthesis framework, incorporating the Institute of Medicine Committee on Crossing the Quality Chasm Framework, plus the concepts of (i) personal recovery and (ii) trauma informed care and practice, both of which are central to contemporary Australian approaches to mental health service provision.

The applied SLR also included interpretation of review data with members of the UTS Rainbow Embassy and Associates, comprised of LGBTQ+ people, including people who identify as Aboriginal and Torres Strait Islander and from Cultural and Linguistically Diverse backgrounds, who have an intersecting lived experience of life-interrupting mental health challenges and/or suicidality, and of accessing mental health and suicide prevention services (referred to as intersecting lived experience).

Results and key findings

The 56 peer reviewed studies included in the UTS-led applied SLR comprised the following research methodologies: 23 quantitative studies; 18 qualitative; 14 mixed-methods; plus one Delphi study. All papers were published between February 2013 and February 2023. Forty were conducted in Australia, 15 in the UK, and one across multiple jurisdictions, including Australia and the UK.

While a definitive answer regarding the effectiveness of services could not be provided based on the literature included within the research scope, nonetheless the findings of the review provide important insights into the current state of service provision as summarised below:

a. *What services are available and provided to LGBTQ+ peoples?*

None of the studies provided a comprehensive map of mental health services provided to LGBTQ+ people in Australia or the UK. Further, the SLR pointed to a lack of dedicated research regarding the provision of care to some sub-groups of the LGBTQ+ population (e.g. non-binary people, gender fluid, and/or pansexual people), as well as LGBTQ+ people with intersecting identities (e.g. LGBTQ+ people from CALD backgrounds). Importantly, no included studies examined experiences of people with innate variations in sex characteristics or asexual people, meaning that the findings only pertain to LGBTQ+ people.

The literature did provide insight into services available and provided to LGBTQ+ people. Like the general population, most LGBTQ+ people access mental health services via a GP and prefer to be referred to a psychologist for mental health concerns.² Only a small portion of LGBTQ+ were reported to access LGBTQ+ specific services (e.g. 12%)³, a trend that has been noted previously.⁴ Given that this review, and previous research^{5,6}, indicates a clear preference among LGBTQ+ people in Australia for LGBTQ+ specific services, this finding

² Taylor et al., 2021

³ McNair & Bush, 2016

⁴ Hill et al., 2021

⁵ Collective Action, 2023

⁶ Hill et al., 2021

likely reflects a lack of available services. It may also indicate limited capacity within these services to address specific mental health concerns.

The SLR findings also indicate that LGBTQ+ specific services may not fully meet the needs of LGBTQ+ sub-populations, including trans and bisexual people.^{7,8,9} Additionally, LGBTQ+ specific services, as well as mainstream and Aboriginal Community Controlled Health Organisations, may not adequately address the care needs of First Nations LGBTQ+SB (plus Sistergirl and Brotherboy) people.¹⁰

b. What services were found to be effective?

The majority of the studies examined a mix of mental health service providers, making it difficult to distinguish the perceived quality and performance of specific providers or service types.

Overall, there were mixed findings regarding the quality and performance of mental health and suicide prevention services. While some LGBTQ+ people received mental health and suicide prevention services that were accessible, affirming, safe and effective for promoting personal recovery, many studies indicated difficulties related to timely access to person-centred, recovery-oriented, equitable and safe services.

Commonly identified issues with service quality and performance included knowledge deficits among healthcare providers; macroaggressions linked to increased distress and discouragement of future help seeking; and difficulty accessing affirming mental health services, particularly during a crisis.

Inpatient and emergency services were found to be particularly problematic for LGBTQ+ people. These were criticised for providing inequitable and unsafe care that could be coercive, restrictive, de-humanising, disempowering and traumatising for LGBTQ+ people, serving to reinforce rather than alleviate minority stress. Further, the research indicated that LGBTQ+ people with intersecting identities and experiences, and some sub-populations of LGBTQ+ people (e.g. trans and gender diverse youth, women who have sex with women), are more likely to encounter stigmatising, or traumatising care situations.

The research highlighted that positive care experiences were more often reported in LGBTQ+ specific services, including knowledgeable, equitable and safe care, as well as appropriate referrals to affirming providers. However, as noted previously, these services were reported to be less equipped to support more marginalised LGBTQ+ subgroups or those with intersecting identities and experiences. Further, they may be insufficiently skilled and resourced to support LGBTQ+ people with intersecting lived experience of mental health challenges, specifically related to life-interrupting mental health challenges and suicidality.

c. What service gaps or barriers were identified and what were their details?

At a high-level, the service gaps and barriers identified in the applied SLR were: provider shortages; inconsistencies in quality of care; lack of linkage between different mental health services; limited options for services able to attend to intersectional needs; financial costs of

⁷ Brener et al., 2023

⁸ Erasmus et al., 2015

⁹ Tollit et al., 2023

¹⁰ Uink et al., 2023

services; and a lack involvement and partnerships with LGBTQ+ people with an intersecting lived experience of mental health challenges in service development and research.

Gaps in evidence were also noted in relation to the mental health care needs of those with intersectional identities and experiences (e.g. First Nations LGBTQ+SB populations and people from CALD backgrounds); research related to specific subgroups of LGBTQ+ people (e.g. nonbinary and asexual identifying people); and research on topics such as the effectiveness of services for promoting personal recovery (e.g. connection, hope, identity, meaning and empowerment). There were also research gaps related to LGBTQ+ people with other kinds of intersectional identities and experiences, for example people with disability.

Lived experience interpretation

A response statement developed in collaboration with the Rainbow Embassy to ensure that the interpretations of LGBTQ+ people, including LGBTQ+SB people, with lived experience were considered as part of the SLR. The statement reaffirms that LGBTQ+ people collectively are experiencing mental distress and suicidality at higher rates due to the oppression they experience within a hetero- and cis-normative, patriarchal society. As confirmed in the companion Research Translation Paper, the challenges for LGBTQ+ people are both external and internal, with the risks of bullying and to family and community connections profound. The harms of First Nations LGBTQ+SB people, and CALD people of colour were further compounded by the effects of colonisation and racism. The statement notes that accessing mental health services are particularly fraught for LGBTQ+ people, and that many people with lived experience have limited access to LGBTQ+ specific services. In regard to mainstream mental health services, this was attributed to shortcomings in staff skills and organisational resources, with the prospects of trauma being reinforced when care is inequitable and unsafe.

Overall, the Rainbow Embassy noted limited research involvement of LGBTQ+ people with an intersecting lived experience of mental health challenges and mental health service use (6 of the included 56 SLR studies). There was also concern that researchers have not sufficiently engaged with critiques from consumer/survivor movements, including insufficient interrogation of dominant models of psychiatric treatment and service provision, and seclusion and restraint practices in mental health services. Mental health challenges experienced by LGBTQ+ people need to be understood in the context of minority stress, but also as an intersecting experience that can include exposure to new stressors, including sanism (prejudicial attitudes towards people with a lived experience of mental health challenges) and trauma in the community and mental health services.

There is a need for collaborative mental health services that meaningfully embed trauma informed and personal recovery-oriented frameworks; consider other explanatory frameworks for distress (e.g., socio-political or trauma frameworks), and prioritise choice in service provision, including non-medicalised options. Timely access to gender-affirming care for trans and gender diverse people, including youth, is also critical to promote wellbeing and prevent suicide. Overall, the response emphasises the need for services to be safe from the perspective of LGBTQ+ people with a lived experience. The positive experiences reported in LGBTQ+ specific services were noted, however evaluating these services is important to gain a fuller picture of service equity and quality for all subgroups of the LGBTQ+ population, and for people with intersecting identities and experiences, as previously noted.

The full response statement by the Rainbow Embassy can be found in **Section 4** of this report.

Conclusion

In addition to the key findings above, the Applied SLR sorted findings using a number of filters: a) service type, b) LGBTQ+ population sub-groups (for example by sexuality and gender where data is available), and c) gaps in research on LGBTQ+ mental health and suicide prevention services. Readers are referred to **Appendix 3** which highlights:

- *what we know works* (and could be applied more broadly in health services for various populations)
- *key areas for improvement*
- *gaps in knowledge.*

Overall, the Applied SLR showed that in the Australian context (and beyond), there are many health services, and health workers, that provide positive and supportive care for LGBTQ+ people. However, there also remain significant barriers, service-gaps, inequities and unsafe practices that are detrimental to the mental health and wellbeing of LGBTQ+ people. While there are encouraging signs that services and service providers are willing to learn about, and accommodate, the care needs of LGBTQ+ people, it is clear that individual training or upskilling is not, on its own, enough to address gaps, barriers, inequitable care and unsafe practices. Systemic issues must be identified and addressed via meaningful and extended collaboration with LGBTQ+ people with lived experience of life-interrupting mental health challenges and suicidality.

Readers are referred to the companion UTS-led Research Translation Paper for the findings and insights related to all three KRQ.

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1 Introduction

This paper contains the results of an applied systematic literature review (SLR) undertaken for the Commonwealth Department of Health and Aged Care (the Department) by a University of Technology Sydney (UTS) led research team. The focus of the SLR is specifically on mental health and suicide prevention services for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) people, due a lack of studies included in the Department search on intersex and asexual people.

While the SLR used rigorous research methods, it was adapted to the parameters set by the Department, and specifically to help inform the development of a *10-Year National Action Plan for the Health and Wellbeing of LGBTIQ+ people*. The SLR is, therefore, best understood as 'applied research' that provides evidence on mental health and suicide prevention services for LGBTQ+ people to inform the broader policy context, as future explained in the companion UTS Research Translation Paper on the same topic, also commissioned by the Department.

While a version of this paper may, in time, be prepared for publication, it is noted that the paper's current structure, length, discussion, and conclusion sections have been drafted to address the prescribed research questions detailed below. As such, it is not fully consistent with standard academic publication requirements.

1.1 About the research

In May 2023, the Department sought expressions of interest from independent research institutes to undertake an independent SLR to help inform the development of the mental health and wellbeing component of Australia's first *10-Year National Action Plan for the Health and Wellbeing of LGBTIQ+ people*.

The SLR built on the initial research design and literature search conducted by the Department and reviewed published, peer-reviewed research on mental health and/or suicide prevention services for LGBTQ+ people in Australia and a comparator international context (UK).

Based on the in-scope literature, and the research parameters (see below), the brief was later amended to cover only LGBTQ+ people, with the expectation that other options will be explored to attend to the specific needs of asexual people and people with innate variations of sex characteristics (commonly shortened to intersex people).

In June 2023, a UTS-led project team was commissioned to undertake the background and SLR project. The team included senior researchers from:

- [UTS Faculty of Health](#)
- [UTS Institute for Public Policy and Governance](#)
- [University of New South Wales, Black Dog Institute](#)
- [University of Sydney, Faculty of Medicine and Health](#)

The SLR literature was interpreted with members of the UTS Rainbow Embassy and associates, comprised of LGBTQ+ people with an intersecting lived experience of life-interrupting mental health challenges¹¹ and/or suicidality, and of accessing mental health and suicide prevention services (LGBTQ+ people with a lived experience), including First Nations LGBTQ+SB¹² people with a lived experience.

1.1.1 Key Research Questions

The following Key Research Questions (KRQ) were determined by the Department to guide the research:

- 1) For LGBTQ+ people:
 - a) What are the key causes of distress experienced that impact on their mental health or wellbeing, and/or increase their risk of suicidal behaviours?
 - b) What are the key issues and barriers when accessing services for their mental health and/or suicide prevention services?
- 2) In respect to accessing services for mental health and suicide prevention, and based on peer reviewed literature:
 - a) What services are available and provided to LGBTQ+ peoples?
 - b) What services were found to be effective?
 - c) What service gaps or barriers were identified, and what were their details?
- 3) What evidence-based insights can be drawn from the UK and Australian literature for Australia, to help inform policy development for the *10 Year National Action Plan for the Health and Wellbeing of LGBTIQ+ people*?

1.1.2 Project Deliverables

The research commenced in late June and concluded in November 2023. There were three end products:

- 1) **Research Translation Paper** addressing all three KRQs, including a summary of this applied SLR
- 2) **Applied SLR Report** addressing only KRQ 2 (*this paper*)
- 3) **Plain English Summary** of the UTS-led research overall.

For further background information about the UTS led research, and its overall conclusions and insights, readers are referred to two companion documents.

¹¹ The term 'life-interrupting' mental health challenges is used by the Rainbow Embassy as a non-medicalising or pathologising term to describe severe and persistent mental health challenges and associated life impacts

¹² 'S' and 'B' refers to Sistergirl and Brotherboy respectively, which are terms used by some First Nations trans people.

2 Methodology

2.1 SLR Research Questions

The SLR following was focused on mental health and suicide prevention service provision, specifically to address the three questions posed under KRQ 2:

- a. What services are available and provided to LGBTQA+ peoples?
- b. What services were found to be effective?
- c. What service gaps or barriers were identified, and what were their details?

The design, conduct, and reporting of the SLR was undertaken according to the Joanna Briggs Institute (JBI) critical appraisal tools¹³, using literature solely searched and identified by the Department.

2.2 Search Strategy

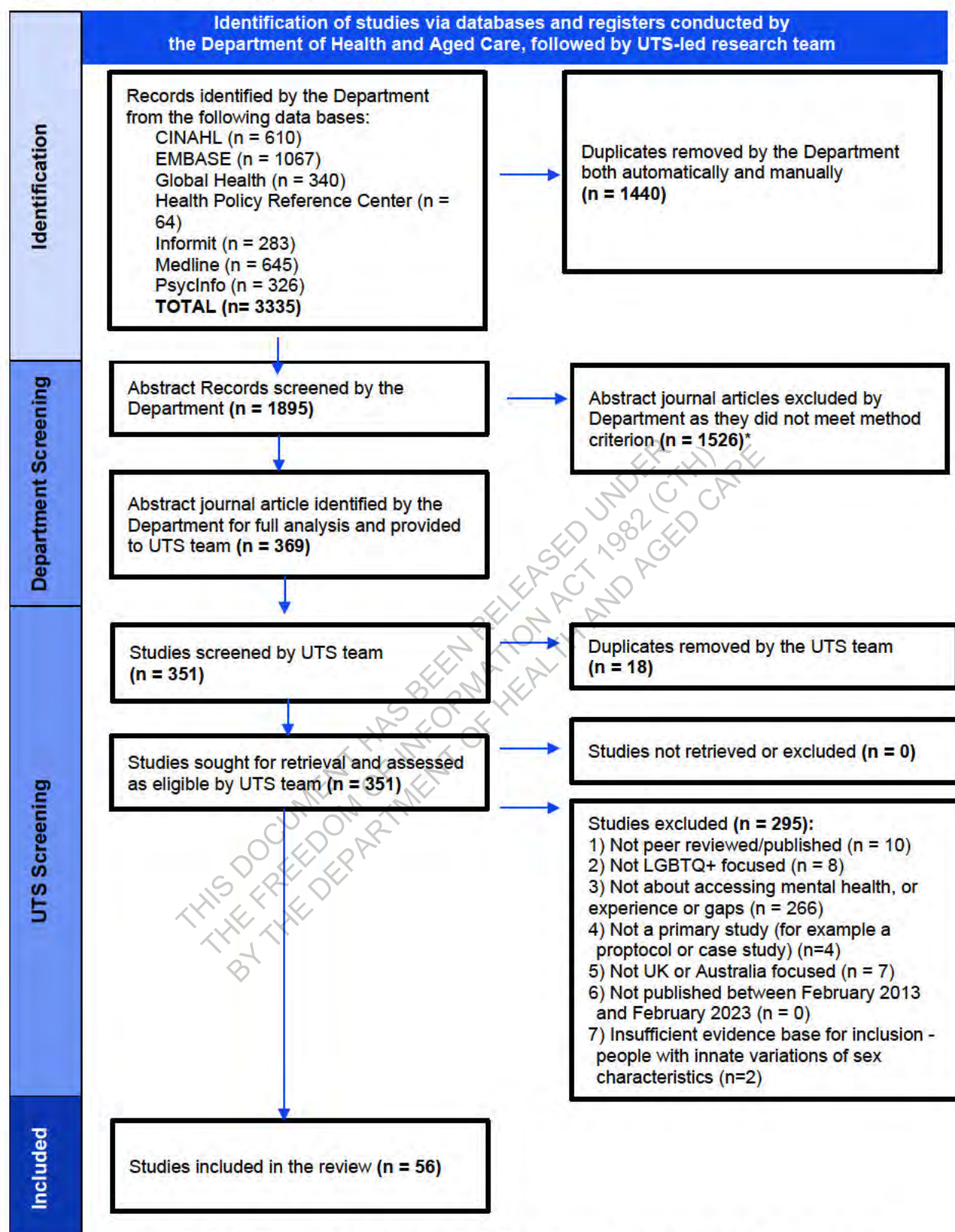
In early 2023, the Department undertook searches across various key scientific international databases, namely Medline, Embase, PsychInfo, CINAHL, Global Health, Health Policy Reference Centre, and Informit Health Collection. The search terms included two conceptual categories: 'mental health', and 'suicide and suicide prevention', with the search limited to studies in Australia and the UK, which was considered to have a comparable health system to Australia. The full search strategy is represented in [Appendix 1: Search strategy undertaken by the Department.](#)

A total of 1,895 articles were initially identified. Following screening of the abstracts, the Department nominated 369 for inclusion in the SLR, as documented in the PRISMA diagram at Figure 1.

The UTS-led team used the Covidence systematic review management software to support all screening and paper selection. All abstracts and resulting in-scope full texts were double-blind screened based on the criteria below. Discrepancies between two reviewers were resolved by a third reviewer.

¹³ Joanna Briggs Institute. (2017). *Checklist for systematic reviews and research syntheses*. <https://bi.global/critical-appraisal-tools>.

Figure 1: PRISMA flow diagram of included studies



Source: Department of Health and Aged Care and UTS-led research team, using Covidence and PRISMA software, October 2023*

*Records were excluded by a human. Adapted from Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71.

2.3 Eligibility criteria and study selection

As documented in the PRISMA diagram, the UTS-led team undertook a preliminary review of these abstracts and excluded a further 18 as duplicates. The remaining 351 were then subject to the following Departmental-agreed exclusion criteria:

- 1) The paper is not peer reviewed and published
- 2) The paper is not about LGBTQ+ people
- 3) The paper is not about accessing services for mental health challenges or suicidality
- 4) The paper is not a primary study (for example is a protocols or case study)
- 5) The paper is not Australia or United Kingdom focused
- 6) The paper is not published between February 2013 and February 2023
- 7) The paper is solely about people with innate variations of sex characteristics or who were asexual.*

* The 7th exclusion criteria was applied retrospectively following feedback from sector experts that the literature included in the SLR omitted key literature on these target groups. As this could not be corrected within the timeframe restrictions of the present research, the brief was later amended to cover only LGBTQ+ people, with the expectation that other options will be explored to attend to the specific needs of asexual people and people with innate variations of sex characteristics.

Although gender-affirming medical services (e.g., hormones, puberty blockers, surgery) are not the focus of this review, mental health professionals and providers frequently assess and provide access to gender-affirming medical care, and access to gender-affirming care is highly protective for mental health. Therefore, studies that examined issues related to mental health providers involved in, or supporting, access to gender affirming care were included in this review.

With a further 295 excluded on these grounds (see Figure 1 for details), 58 texts were deemed eligible for inclusion. Only two papers included in the Department search examined the mental health service needs of people with innate variations in sex characteristics, which were not considered inadequate to represent the needs of this population. Therefore, on the advice of expert reviewers, a decision was made to exclude the two papers and recommend the Department undertake a separate review for this population. A total of 56 texts were included in the final review.

2.3.1 Language considerations

None of the 56 studies included in the SLR focused specifically on people with innate variations in sex characteristics or asexual people. Therefore, the findings detailed in the SLR pertain to LGBTQ+ people only, and for this reason we do not use the full LGBTIQ+ acronym in the SLR report, including in reference to specific services or initiatives that may publicly be promoted as LGBTIQ+-specific.

Terms used across studies to describe LGBTQ+ people and mental health were not consistent, and some terms are currently contested. Duplication of terms in this review is not an indication of endorsement.

Where possible, we use LGBTQ+ people to refer to all subgroups of people with diverse sexualities and genders. We also refer to a particular sub-group (e.g., trans and gender diverse people) or specific population (e.g., gay men, men who have sex with men) when findings specifically pertained to these subgroups or populations.

We also use the terms mental health challenges or mental distress or life-interrupting mental health challenges, rather than mental illness or mental disorder or severe and persistent mental illness. Mental health challenges and mental distress are broader terms that can encompass those people without a mental health diagnosis who experience distress. 'Life-interrupting' mental health challenges is used as an alternative to severe and persistent mental illness as it describes more severe, persistent, and enduring mental health challenges, and related life impacts, without reference to medicalising or pathologising frameworks, and allows for other explanatory frameworks for distress, including (but not limited to) trauma-informed frameworks (Sweeney et al., 2018).

2.4 Data extraction, analysis, and synthesis

To best address the SLR research questions, the review adopted two frameworks:

- 1) A narrative synthesis framework (Popay et al., 2006), as heterogeneity of data across the studies precluded a meta-analysis.
- 2) The Institute of Medicine Committee on Crossing the Quality Chasm Framework (Institute of Medicine Committee, 2006) specifically for analysing and reporting quality and performance indicators in mental health services. This was considered valuable given the need to evaluate services and to assess their relevance to policy makers (Proctor, 2011).

The Institute of Medicine Committee (2006) Framework comprises six domains for service analysis, reporting, and quality improvement. They are also relevant from a service user experience and service outcomes perspective. The six domains and related questions for analysis are outlined in Table 1. These, or similar, indicators are commonly used across various contemporary frameworks (Levesque & Sutherland, 2020).

Table 1: Institute of Medicine Committee six domains for analysis of service quality

Timeliness	Were services delivered on time, including timely access and/or delays in service provision?
Effectiveness	Did interventions produce positive health outcomes and meet the intended purpose?

Person-centredness ¹⁴	Was care experienced as respectful and responsive to the preferences and needs of service users? Did people have control over healthcare decisions, and was care coordinated, continuous, supportive, and inclusive of carers and family?
Equity	Did services vary in quality based on the characteristics of service users such as sexuality, gender, ethnicity, disability, geographic location, and/or socioeconomic status etc?
Safety	Did services intending to help, cause harm, including psychological and medical harms?
Efficiency	How well were resources used? This includes examination of financial and human inputs, management processes, and services provided.

The researchers applied two further concepts to interpretation of the SLR that are central to contemporary Australian approaches to mental health service provision:

- **Personal recovery¹⁵** as a key focus of Australian mental health services that emphasises meaning, connection, hope, empowerment, and identity, rather than clinical symptom reduction.
- **Trauma informed care and practice**, providing an additional dimension to the concept of safety outlined above¹⁶.

Together, these frameworks and concepts have been used to extract, synthesise, and present the SLR findings (see Section 3 - Results and Section 4 - Discussion).

In addition, to assist policy makers in applying these frameworks and concepts the researchers also sort findings by:

- a) Service type (mainstream and specific service type)
- b) LGBTQ+ population sub-groups (for example by sexuality and gender where data is available)
- c) Gaps in research on LGBTQ+ mental health and suicide prevention services

This synthesis highlights SLR findings, including: *what we know works* (and could be applied more broadly in health services for various populations), and *key areas for improvement*, and *gaps in knowledge*.

¹⁴ For this research, the term person-centred has been substituted for Institute's 'Patient-centredness' term as person-centredness captures the needs of a patient as a whole person and moves beyond functional improvements to centre a person's goals, including to live a meaningful life (Hakansson Eklund et al., 2019)

¹⁵ This is a key focus of Australian mental health services and challenges a narrow focus on clinical definitions and measures of recovery, emphasising instead the importance of meaning, connection, hope, empowerment and identity to promote wellbeing for people with lived experience whether or not they have clinical symptom reduction (Leamy et al., 2011).

¹⁶ This concept recognising that many people with lived experience of mental health challenges have a history of psychological and intergenerational trauma – incorporates psychological and cultural safety as well as physical safety (NSW Agency of Clinical Innovation, 2019).

2.5 Lived experience involvement in the SLR

The UTS-led researcher team included LGBTQ+SB people with, and intersecting, lived experience and expertise, who are members of the UTS Rainbow Embassy and associates (hereafter referred to as the Rainbow Embassy). In addition to applying the above academic data analysis and syntheses approaches, five members of the Rainbow Embassy were employed to interpret and respond to the SLR findings.

Oliver et al. (2014) state that there is an ethical imperative to involve people with lived and living experience in systematic reviews, particularly given the influence of these on policy and service planning. Involvement of people with lived experience in the analytical process can also enhance the quality of research interpretation, highlight the relevance of findings to people with lived experience, and identify gaps that need to be addressed (Brett et al., 2012).

In the context of research on the provision of mental health and suicide prevention services to LGBTQ+ people, lived experience refers to an intersecting experience of being LGBTQ+ and having a lived or living experience of mental health challenges and/or suicidality, and of accessing mental health and/or suicide prevention services.

2.5.1 About the Rainbow Embassy

The Rainbow Embassy was formed in 2020 to examine provision of care to LGBTQ+SB people with lived experience of mental health challenges and of accessing mental health services. In 2023 membership of the Rainbow Embassy was opened to associates.

The Rainbow Embassy is comprised of people with a lived experience of life-interrupting mental health challenges and/or suicidality, and of accessing mental health and suicide prevention services. Collectively, they also have experience and expertise in mental health advocacy, research, and education, and peer work in inpatient and community mental health services and LGBTQ+ specific services providing mental health support. The Rainbow Embassy members are from diverse social and cultural backgrounds and include people of diverse genders and sexualities, First Nations people, people of colour from non-English speaking backgrounds, people with disability, people from low socioeconomic backgrounds, and people living in metropolitan and rural locations¹⁷. No members had innate variations in sex characteristics or identified as asexual.

The Rainbow Embassy does not claim to be representative of the LGBTQ+ population, and their involvement is intended to provide a lived experience perspective on the SLR findings at the point of interpretation to inform the research translations report prior to wider consultation with LGBTQ+ communities, as expanded upon in the companion Research translation Paper. Members of the Rainbow Embassy who chose to be named are listed as authors of this report.

¹⁷ The Rainbow Embassy does not include people with innate variations in sex characteristics.

2.5.2 Engagement methods

A deliberative dialogue approach was used for interpretation of the SLR findings in collaboration with the Rainbow Embassy. Deliberative dialogue is a group process that aims to bring key stakeholders together to exchange, interpret, and integrate empirical and contextual data, and has been used previously in research, policy, and service development (Boyko et al., 2014). This process allowed the Rainbow Embassy to engage in a rich dialogue with 'conventional' academics to interpret the data on mental health service provision to LGBTQ+ populations, and to develop a response statement as well as recommendations for future research and service provision. Co-interpretation of systematic review findings and response statements have been used previously in mental health research (Bone et al., 2019).

Associate Professor Jo River, has experience and expertise in participatory research and convened the interpretive dialogue with the Rainbow Embassy members. Dialogues were recorded and informed interpretation of findings and were the basis for the Rainbow Embassy response statement.

2.6 Research limitations

As with all research, there were a number of limitations that should be noted when reading this paper. These limitations are not designed to undermine the findings that follow, but rather are to: a) acknowledge the research is not a definitive review of all available evidence; and b) the in-scope texts were solely interrogated to answer the specified KRQ as part of this commissioned and time-limited research project.

As such, the research hereafter should be considered with respect to the following qualifications and limitations:

- **Constraints posed by the short research timeframe and available resources** to ensure the final research products met the Department's policy development timelines and budget requirements.
- **Limitations of available peer reviewed research** related to LGBTQ+ people accessing mental health services. As noted throughout this paper, this creates gaps in evidence that constrains the findings that can be made, including for different sub-groups within the LGBTQ+ community. The implications from these limitations are addressed in the recommendations.

Given this, the findings presented should be viewed as an important contribution towards answering the KRQ, based on the available evidence, rather than be positioned as definitive research on the topics. As noted in **4 - Discussion Section**, significantly more research and analysis clearly remains to be done.

- **Reliance on English language sources** due to the timeframes, budget, and language skills of the researchers, thereby limiting learnings and perspectives that could be drawn from other language sources and countries.

In addition, there are a number of other research limitations associated with the SLR search methodology and exclusion criteria, including:

- **Reliance on the Department's initial literature searches** undertaken in early 2023. As per the research contract, UTS-led researchers were not able to independently assess the studies identified as in-scope, nor check for any research bias, omissions, or other reliability issues.
- **Restrictions of the literature search to solely Australia and the UK**, as determined by the Department. As such, the SLR does not include research that could have been drawn from other jurisdictions. The priority of this research was to solely look at the Australia context with comparable insights from a similar jurisdiction such as the UK. Future research should draw on policy and service insights from other jurisdictions.
- **Restrictions to solely peer-reviewed literature.** Determined by the Department, this excluded the option to gather evidence and insights found in grey literature, including policy documentation, service reviews or advocacy papers, available from credible sources including government agencies, research institutes or not-for-profit organisations, such as LGBTIQ+ Health Australia.
- **Restrictions of the publication timeframes**, solely to those published between February 2013 and February 2023. As a result, any key studies published before or after these dates are not covered in the SLR.
- **Limitations related to the search terms used.** Reviews undertaken by industry experts noted that limitations to the search terms used led to the unintended omission of key studies from the research. In particular, the present research did not search for literature under the term "innate variations in sex characteristics". Future research should consult with lived experience advisors and a wider array of sector experts to ensure the search terms used are fully inclusive of the target populations.

Notwithstanding these limitations, and noting the other introductory comments above, the UTS-led research team have prepared a robust SLR based on the available search and present the evidence-based findings, analysis and conclusions that follow.

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