UTS Institute for 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

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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):

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?

1. 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?

2. 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

[7] Brener et al., 2023

[8] Erasmus et al., 2015

[9] Tollit et al., 2023

[10] Uink et al., 2023

services; limited options for services able to attend to intersectional needs; financial costs of 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 LGBTIQ+ 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 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; 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.

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 LGBTIQA+ 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 LGBTIQA+ 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 challenges[11] and/or suicidality, and of accessing mental health and suicide prevention services (LGBTQ+ people with a lived experience), including First Nations LGBTQ+SB[12] 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 LGBTIQA+ 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

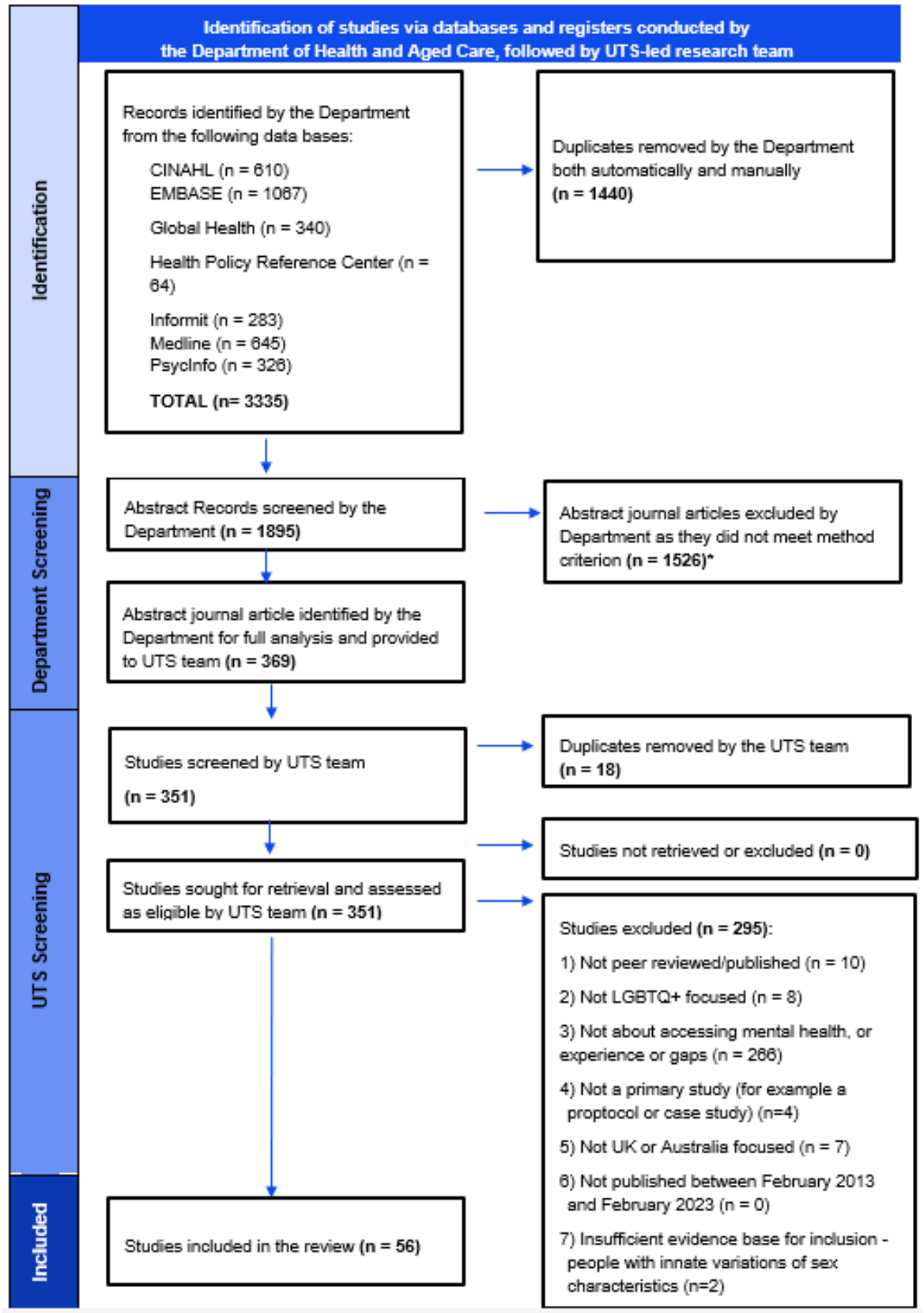
In early 2023, the Department undertook searches across various key scientific international databases, namely Medline, Embase, PsychInfo, CINAHL, Global Health, Health Policy Reference Centre, and Informit Health Collection. The search terms included two conceptual categories: 'mental health', and 'suicide 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://jbi.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:

a) The paper is not peer reviewed and published

b) The paper is not about LGBTQ+ people

c) The paper is not about accessing services for mental health challenges or suicidality

d) The paper is not a primary study (for example is a protocols or case study)

e) The paper is not Australia or United Kingdom focused

f) The paper is not published between February 2013 and February 2023

g) 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 LGBTIQA+ acronym in the SLR report, including in reference to specific services or initiatives that may publicly be promoted as LGBTIQA+-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?

[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)

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 recovery**[15] 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 above[16].

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.

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

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).

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 locations[17]. 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 LGBTQA+ 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.

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).

[17] The Rainbow Embassy does not include people with innate variations in sex characteristics.

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.

3 Results

3.1 Study Characteristics

Fifty-six studies were included in this systematic review comprised a range of methodologies and populations studies, are documented in The Departmental searches were performed on 30 March 2023.

The databases used were:

1. CINAHL (Platform: EBSCOHost) 610 articles retrieved
2. EMBASE (Platform: Ovid) 1067 articles retrieved
3. Global Health (Platform: EBSCOHost) 340 articles retrieved
4. Health Policy Reference Center (Platform: EBSCOHost) 64 articles retrieved
5. Informit databases: Health Collection, ATSIHEALTH, FAMILY, APAIS, MAIS and RURAL (Platform: Informit) 283 articles retrieved
6. Medline (Platform: Ovid) 645 articles retrieved
7. APA PsycInfo (Platform: Ovid) 326 articles retrieved

CINAHL

#	Search Statement	Results
S1	(MH "Psychiatry+") OR TI psychiatr* OR AB psychiatr*	100,551
S2	(MH "Depression+") OR TI (depressed OR depressive OR depression) OR AB (depressed OR depressive OR depression)	210,848
S3	(MH "Panic Disorder") OR TI panic* OR AB panic*	5,888
S4	(MH "Agoraphobia") OR TI agrophobia* OR AB agrophobia*	483
S5	(MH "Social Behavior Disorders+")	110,277
S6	(MM "Social Anxiety Disorders") OR TI "social phobia*" OR AB "social phobia*"	1,991
S7	(MH "Anxiety+") OR TI anxiety OR AB anxiety	121,463
S8	(MH "Obsessive-Compulsive Disorder+") OR TI "obsessive compulsive disorder*" OR AB "obsessive compulsive disorder*" OR TI OCD OR AB OCD	8,776
S9	(MH "Stress Disorders, Post-Traumatic+") OR TI "post traumatic stress disorder*" OR AB "post traumatic stress disorder*"	28,831
S10	(MH "Dysthymic Disorder") OR TI dysthymi* OR AB dysthymi*	1,075
S11	(MH "Bipolar Disorder+") OR TI "bipolar disorder*" OR AB "bipolar disorder*" OR TI "bi polar disorder*" OR AB "bi polar disorder*"	16,735
S12	(MH "Gender Dysphoria") OR TI "gender dysphoria" OR AB "gender dysphoria"	982
S13	(MH "Anorexia") OR (MH "Anorexia Nervosa") OR TI anorexia* OR AB anorexia*	11,017

S14	(MH "Eating Disorders+") OR TI "eating disorder*" OR AB "eating disorder*"	24,325
S15	(MH "Stigma") OR TI stigma OR AB stigma	30,030
S16	(MH "Alcoholism") OR (MH "Alcohol-Induced Disorders, Nervous System") OR (MH "Alcohol-Related Disorders+") OR (MH "Alcohol Drinking+") OR TI alcohol* OR AB alcohol*	118,561
S17	(MH "Substance Abuse+") OR "Drug abus*" OR "drug depend*" OR "substance abus*" OR "substance depend*"	104,327
S18	(MM "Mental Disorders+") OR TI "mental* ill*" OR AB "mental* ill*" OR TI "mental* disorder*" OR AB "mental* disorder*"	500,646
S19	(MH "Mental Health") OR TI "mental* health" OR AB "mental* health"	157,639
S20	(MH "Suicide+") OR (MH "Suicidal Ideation") OR (MH "Suicide, Attempted") OR (MH "Suicide Risk (Saba CCC)") OR TI suicid* OR AB suicid*	50,293
S21	(MH "Injuries, Self-Inflicted") OR TI "self harm*" OR AB "self harm*"	6,886
S22	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21	990,936
S23	(MH "LGBTQ+ Persons+") OR (MH "Gay Persons+") OR (MH "Homosexuality") OR (MH "Sexual and Gender Minorities+") OR TI LGB* OR AB LGB* OR TI lesbian* OR AB lesbian* OR TI gay OR AB gay OR TI ("bi-sexual" or bisexual) OR AB ("bi-sexual" or bisexual) OR TI transgender OR AB transgender OR TI queer OR AB queer OR TI intersex OR AB intersex OR TI asexual OR AB asexual OR TI homosexual* OR AB homosexual* OR TI "sexual minor*" OR AB "sexual minor*" OR TI "gender minor*" OR AB "gender minor*" OR TI "cis gender" OR AB "cis gender" OR TI "gender non conforming" OR AB "gender non conforming"	33,666
S24	(MH "Australia+") OR TI Australia* OR AB Australia* OR TI "New South Wales*" OR AB "New South Wales*" OR TI Sydney OR AB Sydney OR TI Newcastle OR AB Newcastle OR TI "South Australia*" OR AB "South Australia*" OR TI Adelaide OR AB Adelaide OR TI Victoria* OR AB Victoria* OR TI Melbourne OR AB Melbourne OR TI "Western Australia*" OR AB "Western Australia*" OR TI Perth OR AB Perth OR TI Queensland* OR AB Queensland* OR TI Brisbane OR AB Brisbane OR TI "Australian Capital Territory" OR AB "Australian Capital Territory" OR TI Canberra* OR AB Canberra* OR TI "northern teritor*" OR AB "northern teritor*" OR TI Darwin OR AB Darwin OR TI Tasmania* OR AB Tasmania* OR TI Hobart OR AB Hobart	172,128
S25	(MH "United Kingdom+") OR TI "United Kingdom" OR AB "United Kingdom" OR TI England OR AB England	358,205
S26	S22 AND S23 AND S24	434
S27	S22 AND S23 AND S24 Limiters - Published Date: 20130101-20231231	313
S28	S22 AND S23 AND S24 Limiters - Published Date: 20130101-20231231	313
S29	S22 AND S23 AND S25	494
S30	S22 AND S23 AND S25 Limiters - Published Date: 20130101-20231231	312

S31	S22 AND S23 AND S25 Limiters - Published Date: 20130101-20231231	312
S32	S28 OR S31	610

Embase

#	Search Statement	Results
1	exp Psychiatry/	143836
2	psychiatr*.ti,ab.	385401
3	1 or 2	457541
4	exp Depression/	602427
5	depressed.mp.	129742
6	depressive.mp.	207609
7	depression.mp.	836335
8	4 or 5 or 6 or 7	967198
9	exp Panic/	26281
10	panic*.mp.	41412
11	9 or 10	41412
12	exp Agoraphobia/	6839
13	agrophobia*.mp.	6
14	exp Social Phobia/	14045
15	social phobia*.mp.	15795
16	exp Anxiety/	282743
17	exp Anxiety Disorder/	310932
18	anxiety.mp.	483123
19	anxiety.ti,ab.	359804

#	Search Statement	Results
20	anxiety disorder*.mp.	125124
21	16 or 17 or 18 or 19 or 20	628247
22	17 or 20	322718
23	exp obsessive compulsive disorder/	47489
24	obsessive compulsive disorder*.mp.	35498
25	OCD.mp.	17547
26	23 or 24 or 25	52810
27	exp posttraumatic stress disorder/	78414
28	(post traumatic stress disorder* or posttraumatic stress disorder*).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	84448
29	PTSD.mp.	43830
30	27 or 28 or 29	86385
31	exp dysthymia/	11710
32	dysthymi*.mp.	10494
33	31 or 32	12962
34	exp Bipolar Disorder/	76941
35	((bipolar or bi polar) adj3 disorder*).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	84562
36	34 or 35	87795
37	exp Gender Dysphoria/	6688
38	gender dysphoria.mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	3580

#	Search Statement	Results
39	37 or 38	7243
40	exp Anorexia Nervosa/ or exp Anorexia/	93414
41	anorexia*.mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	103761
42	40 or 41	103761
43	exp eating disorder/	63105
44	eating disorder*.mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	46944
45	43 or 44	67604
46	exp alcohol intoxication/	13520
47	exp alcohol consumption/	160595
48	exp alcohol abuse/	48328
49	alcohol*.mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	780646
50	46 or 47 or 48 or 49	782751
51	exp drug abuse/	138259
52	((drug or substance) adj2 (disorder* or abus* or depend*)).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	230559
53	51 or 52	291342
54	exp mental disease/	2598583
55	exp Mental Health/	227268
56	mental* ill*.ti,ab.	59072

#	Search Statement	Results
57	mental* disorder*.ti,ab.	62012
58	mental* health.ti,ab.	255039
59	54 or 55 or 56 or 57 or 58	2768963
60	exp suicidal behavior/	124521
61	suicid*.mp.	158689
62	60 or 61	159746
63	exp automutilation/	23773
64	self harm*.mp.	11674
65	63 or 64	27622
66	exp Social Stigma/	14241
67	stigma.ti,ab.	41786
68	66 or 67	46991
69	exp "sexual and gender minority"/ or exp transgender/ or exp LGBTQIA+ people/ or exp bisexuality/ or exp homosexuality/	63453
70	LGBTQ*.ti,ab.	2528
71	lesbian*.ti,ab.	9269
72	gay.ti,ab.	15638
73	(bi-sexual or bisexual).ti,ab.	12712
74	transgender.ti,ab.	13493
75	trans*.ti,ab.	7701285
76	queer.ti,ab.	2461
77	intersex.ti,ab.	2219

#	Search Statement	Results
78	asexual.ti,ab.	9857
79	homosexual*.ti,ab.	14990
80	"sexual minor*".ti,ab.	4658
81	"gender minor*".ti,ab.	1919
82	"cis gender".ti,ab.	203
83	"gender non conforming".ti,ab.	270
84	69 or 70 or 71 or 72 or 73 or 74 or 76 or 77 or 78 or 79 or 80 or 81 or 82 or 83	86147
85	(Australia* or "New South Wales*" or Sydney* or Newcastle* or "South Australia*" or Adelaide* or Victoria* or Melbourne* or "Western Australia*" or Perth* or Queensland* or Brisbane* or "Australian Capital Territory*" or Canberra* or "Northern Territory*" or Darwin* or Tasmania* or Hobart*).ab,cp,ti.	559029
86	exp Australia/	194848
87	85 or 86	582290
88	84 and 87	3301
89	limit 88 to yr="2013 -Current"	2099
90	limit 89 to english language	2096
91	3 and 90	37
92	8 and 90	132
93	11 and 90	4
94	12 or 13	6842
95	14 or 15	15795
96	90 and 94	1
97	90 and 95	3

#	Search Statement	Results
98	21 and 90	149
99	26 and 90	4
100	30 and 90	14
101	33 and 90	1
102	36 and 90	6
103	39 and 90	55
104	42 and 90	2
105	45 and 90	13
106	50 and 90	124
107	53 and 90	100
108	59 and 90	396
109	exp *Mental Disorders/	1574329
110	108 and 109	128
111	55 and 90	137
112	56 and 90	22
113	57 and 90	15
114	58 and 90	190
115	62 and 90	76
116	65 and 90	27
117	68 and 90	144
118	91 or 92 or 93 or 96 or 97 or 98 or 99 or 100 or 101 or 102 or 103 or 104 or 105 or 106 or 107 or 110 or 111 or 112 or 113 or 114 or 115 or 116 or 117	621

#	Search Statement	Results
119	exp United Kingdom/	460064
120	(United Kingdom or England).ti,ab.	137206
121	119 or 120	504345
122	3 or 8 or 11 or 21 or 26 or 30 or 33 or 36 or 39 or 42 or 45 or 50 or 53 or 55 or 56 or 57 or 58 or 62 or 65 or 68 or 94 or 95 or 109	3514282
123	84 and 121 and 122	721
124	limit 123 to (english language and yr="2013 -Current")	465
125	118 or 124	1067

Global Health

#	Search Statement	Results
S1	(DE "psychiatry") OR TI psychiatr* OR AB psychiatr*	17,707
S2	(DE "depression") OR TI (depressed OR depressive OR depression) OR AB (depressed OR depressive OR depression)	59,681
S3	TI panic* OR AB panic*	4,402
S4	TI agrophobia* OR AB agrophobia*	0
S5	TI "social phobia*" OR AB "social phobia*"	258
S6	(DE "anxiety") OR TI anxiety OR AB anxiety	29,502
S7	TI "obsessive compulsive disorder*" OR AB "obsessive compulsive disorder*" OR TI OCD OR AB OCD	764
S8	(DE "post-traumatic stress disorder") OR TI "post traumatic stress disorder*" OR AB "post traumatic stress disorder*"	4,126
S9	TI dysthymi* OR AB dysthymi*	233
S10	(DE "bipolar disorder") OR TI "bipolar disorder*" OR AB "bipolar disorder*" OR TI "bi polar disorder*" OR AB "bi polar disorder*"	2,070
S11	TI "gender dysphoria" OR AB "gender dysphoria"	76
S12	(DE "anorexia" OR DE "anorexia nervosa") OR TI anorexia* OR AB anorexia*	13,398
S13	(DE "appetite disorders" OR DE "bulimia" OR DE "compulsive eating" OR DE "hyperphagia" OR DE "pica" OR DE "anorexia") OR TI "eating disorder*" OR AB "eating disorder*"	20,226

#	Search Statement	Results
S14	(DE "social stigma") OR TI stigma OR AB stigma	11,883
S15	(DE "alcoholism") OR TI alcohol* OR AB alcohol*	102,410
S16	(DE "drug abuse") OR (DE "drug addiction") OR "Drug abus*" OR "drug depend*" OR "substance abus*" OR "substance depend*"	43,169
S17	(DE "mental disorders") OR TI "mental* ill*" OR AB "mental* ill*" OR TI "mental* disorder*" OR AB "mental* disorder*"	65,009
S18	(DE "mental health") OR TI "mental* health" OR AB "mental* health"	48,037
S19	(DE "suicide") OR TI suicid* OR AB suicid*	13,166
S20	TI "self harm*" OR AB "self harm*"	1,408
S21	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20	283,369
S22	(DE "homosexuality") OR (DE "intersexuality")) OR (DE "bisexuality") OR TI LGB* OR AB LGB* OR TI lesbian* OR AB lesbian* OR TI gay OR AB gay OR TI ("bi-sexual" or bisexual) OR AB ("bi-sexual" or bisexual) OR TI transgender OR AB transgender OR TI queer OR AB queer OR TI intersex OR AB intersex OR TI asexual OR AB asexual OR TI homosexual* OR AB homosexual* OR TI "sexual minor*" OR AB "sexual minor*" OR TI "gender minor*" OR AB "gender minor*" OR TI "cis gender" OR AB "cis gender" OR TI "gender non conforming" OR AB "gender non conforming"	23,615
S23	(DE "Australia" OR DE "Australian Capital Territory" OR DE "New South Wales" OR DE "Northern Territory" OR DE "Queensland" OR DE "South Australia" OR DE "Tasmania" OR DE "Victoria" OR DE "Western Australia") OR TI Australia* OR AB Australia* OR TI "New South Wales*" OR AB "New South Wales*" OR TI Sydney OR AB Sydney OR TI Newcastle OR AB Newcastle OR TI "South Australia*" OR AB "South Australia*" OR TI Adelaide OR AB Adelaide OR TI Victoria* OR AB Victoria* OR TI Melbourne OR AB Melbourne OR TI "Western Australia*" OR AB "Western Australia*" OR TI Perth OR AB Perth OR TI Queensland* OR AB Queensland* OR TI Brisbane OR AB Brisbane OR TI "Australian Capital Territory" OR AB "Australian Capital Territory" OR TI Canberra* OR AB Canberra* OR TI "northern teritor*" OR AB "northern teritor*" OR TI Darwin OR AB Darwin OR TI Tasmania* OR AB Tasmania* OR TI Hobart OR AB Hobart	70,350
S24	(DE "UK" OR DE "Channel Islands" OR DE "Great Britain" OR DE "Isle of Man" OR DE "Northern Ireland") OR TI "United Kingdom" OR AB "United Kingdom" OR TI England OR AB England	90,282
S25	S21 AND S22 AND S23	293
S26	S21 AND S22 AND S23 Limiters - Publication Year: 20130101-20221231	181
S27	S21 AND S22 AND S23 Limiters - Publication Year: 20130101-20221231	181
S28	S21 AND S22 AND S24	321
S29	S21 AND S22 AND S24 Limiters - Publication Year: 20130101-20231231	164

#	Search Statement	Results
S30	S21 AND S22 AND S24 Limiters - Publication Year: 20130101-20231231	164
S31	S27 OR S30	340

Health Policy Reference Center

#	Search Statement	Results
S1	DE "PSYCHIATRY" OR TI psychiatr* OR AB psychiatr*	9,720
S2	(DE "MENTAL depression") OR TI (depressed OR depressive OR depression) OR AB (depressed OR depressive OR depression)	17,699
S3	(DE "PANIC disorders" OR DE "PANIC attacks") OR TI panic* OR AB panic*	506
S4	DE "AGORAPHOBIA" OR TI agrophobia* OR AB agrophobia*	19
S5	(DE "SOCIAL phobia" OR DE "COMMUNICATION apprehension" OR DE "PARURESIS" OR DE "SPEECH anxiety") OR TI "social phobia*" OR AB "social phobia*"	66
S6	(DE "ANXIETY") OR TI anxiety OR AB anxiety	8,601
S7	(DE "OBSESSIVE-compulsive disorder" OR DE "BIBLIOMANIA" OR DE "COMPULSIVE hair pulling" OR DE "COMPULSIVE skin picking" OR DE "COMPULSIVE washing") OR TI "obsessive compulsive disorder*" OR AB "obsessive compulsive disorder*" OR TI OCD OR AB OCD	205
S8	TI "post traumatic stress disorder*" OR AB "post traumatic stress disorder*"	828
S9	(DE "DYSTHYMIC disorder") OR TI dysthymi* OR AB dysthymi*	67
S10	(DE "BIPOLAR disorder" OR DE "CYCLOTHYMIA") OR TI "bipolar disorder*" OR AB "bipolar disorder*" OR TI "bi polar disorder*" OR AB "bi polar disorder*"	674
S11	(DE "GENDER dysphoria" OR DE "GENDER dysphoria in adolescence" OR DE "GENDER dysphoria in children") OR TI "gender dysphoria" OR AB "gender dysphoria"	121
S12	(DE "ANOREXIA nervosa") OR TI anorexia* OR AB anorexia*	513
S13	(DE "EATING disorders" OR DE "ANOREXIA nervosa" OR DE "BINGE-eating disorder" OR DE "BULIMIA" OR DE "COMPULSIVE eating" OR DE "COPROPHAGIA" OR DE "EATING disorders in women" OR DE "HYPERPHAGIA" OR DE "ORTHOREXIA nervosa" OR DE "PICA (Pathology)") OR TI "eating disorder*" OR AB "eating disorder*"	939
S14	(DE "SOCIAL stigma") OR TI stigma OR AB stigma	5,668
S15	DE "ALCOHOL" OR DE "ALCOHOL & sex" OR DE "AVERTIN" OR DE "FUSEL oil" OR DE "METHOXYETHANOL" OR DE "PHYSIOLOGICAL effects of alcohol" OR DE "ALCOHOL & LGBTQ people" OR DE "ALCOHOL drinking" OR DE "ALCOHOL & LGBTQ+ people" OR DE "ALCOHOL & authors" OR DE "ALCOHOL drinking in college" OR DE "ALCOHOL use of people with drug addiction" OR DE "ATTITUDES toward drinking of alcoholic beverages" OR DE "BINGE drinking" OR DE	15,381

#	Search Statement	Results
	"CONTROLLED drinking" OR DE "DRINKING on aircraft" OR DE "STUDENTS -- Alcohol use" OR DE "ALCOHOLISM" OR DE "ALCOHOL testing of employees" OR DE "ALCOHOLISM & crime" OR DE "ALCOHOLISM in sports" OR DE "ASTROLOGY & alcoholism" OR DE "YOUTH & alcohol" OR DE "ALCOHOL drinking" OR DE "ALCOHOL & LGBTQ+ people" OR DE "ALCOHOL & authors" OR DE "ALCOHOL drinking in college" OR DE "ALCOHOL use of people with drug addiction" OR DE "ATTITUDES toward drinking of alcoholic beverages" OR DE "BINGE drinking" OR DE "CONTROLLED drinking" OR DE "DRINKING on aircraft" OR DE "STUDENTS -- Alcohol use" OR TI alcohol* OR AB alcohol*	
S16	(DE "DRUG abuse" OR DE "AMPHETAMINE abuse" OR DE "COCAINE abuse" OR DE "DRUG abuse in sports" OR DE "DRUG addiction" OR DE "DRUGS & authors" OR DE "DRUGS & mass media" OR DE "DRUGS & sex" OR DE "HEROIN abuse" OR DE "INTRAVENOUS drug abuse" OR DE "MARIJUANA abuse" OR DE "MEDICATION abuse" OR DE "METHADONE abuse" OR DE "MORPHINE abuse" OR DE "OPIUM abuse" OR DE "PHENCYCLIDINE abuse" OR DE "SEDATIVE abuse") OR "Drug abus*" OR "drug depend*" OR "substance abus*" OR "substance depend*"	32,336
S17	(DE "MENTAL illness" OR DE "ART & mental illness" OR DE "DUAL diagnosis" OR DE "GENDER dysphoria" OR DE "GENIUS & mental illness" OR DE "INSANITY (Law)" OR DE "LITERATURE & mental illness" OR DE "PARAPHILIAS" OR DE "REACTIVE attachment disorder" OR DE "SCHIZOPHRENIA") OR TI "mental* ill*" OR AB "mental* ill*" OR TI "mental* disorder*" OR AB "mental* disorder*"	9,910
S18	(DE "mental health") OR TI "mental* health" OR AB "mental* health"	27,600
S19	DE "SUICIDE" OR DE "ATTEMPTED suicide" OR DE "SELF-immolation" OR DE "SELF-poisoning" OR TI suicid* OR AB suicid*	7,071
S20	TI "self harm*" OR AB "self harm*"	537
S21	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20	94,456
S22	DE "LGBTQ people" OR DE "HOMOSEXUALITY" OR DE "LESBIANISM" OR DE "MALE homosexuality" OR (DE "BISEXUALS" OR DE "BISEXUAL men" OR DE "BISEXUAL women" OR (DE "homosexuality") OR (DE "intersexuality")) OR (DE "bisexuality") OR TI LGB* OR AB LGB* OR TI lesbian* OR AB lesbian* OR TI gay OR AB gay OR TI ("bi-sexual" or bisexual) OR AB ("bi-sexual" or bisexual) OR TI transgender OR AB transgender OR TI queer OR AB queer OR TI intersex OR AB intersex OR TI asexual OR AB asexual OR TI homosexual* OR AB homosexual* OR TI "sexual minor*" OR AB "sexual minor*" OR TI "gender minor*" OR AB "gender minor*" OR TI "cis gender" OR AB "cis gender" OR TI "gender non conforming" OR AB "gender non conforming"	5,435
S23	TI Australia* OR AB Australia* OR TI "New South Wales*" OR AB "New South Wales*" OR TI Sydney OR AB Sydney OR TI Newcastle OR AB Newcastle OR TI "South Australia*" OR AB "South Australia*" OR TI Adelaide OR AB Adelaide OR TI Victoria* OR AB Victoria* OR TI Melbourne OR AB Melbourne OR TI "Western Australia*" OR AB "Western Australia*" OR TI Perth OR AB Perth OR TI Queensland*	20,308

#	Search Statement	Results
	OR AB Queensland* OR TI Brisbane OR AB Brisbane OR TI "Australian Capital Territory" OR AB "Australian Capital Territory" OR TI Canberra* OR AB Canberra* OR TI "northern teritor*" OR AB "northern teritor*" OR TI Darwin OR AB Darwin OR TI Tasmania* OR AB Tasmania* OR TI Hobart OR AB Hobart	
S24	TI "United Kingdom" OR AB "United Kingdom" OR TI England OR AB England	21,127
S25	S21 AND S22 AND S23	71
S26	S21 AND S22 AND S23 Limiters - Publication Date: 20130101-20231231	44
S27	S21 AND S22 AND S23 Limiters - Publication Date: 20130101-20231231	44
S28	S21 AND S22 AND S24	28
S29	S21 AND S22 AND S24 Limiters - Publication Date: 20130101-20221231	21
S30	S21 AND S22 AND S24 Limiters - Publication Date: 20130101-20221231	21
S31	S27 OR S30	64

Informit

#	Search Statement	Results
1	All Fields:psychiatr* OR All Fields:depressed OR All Fields:depressive OR All Fields:depression OR All Fields:panic* OR All Fields:agrophobia* OR All Fields:"social phobia*" OR All Fields:anxiety OR All Fields:"obsessive compulsive disorder*" OR All Fields:OCD OR All Fields:"post traumatic stress disorder*" OR All Fields:dysthymi* OR All Fields:"bipolar disorder*" OR All Fields:"gender dysphoria" OR All Fields:anorexia* OR All Fields:"eating disorder*" OR All Fields:stigma OR All Fields:alcohol* OR All Fields:"Drug abus*" OR All Fields:"drug depend*" OR All Fields:"substance abus*" OR All Fields:"substance depend*" OR All Fields:"mental* ill*" OR All Fields:"mental* disorder*" OR All Fields:"mental* health" OR All Fields:suicid* OR All Fields:"self harm*"	88669
2	All Fields:LGB* OR All Fields:lesbian* OR All Fields:gay OR All Fields:"bi-sexual" OR All Fields:bisexual OR All Fields:transgender OR All Fields:queer OR All Fields:intersex OR All Fields:asexual OR All Fields:homosexual* OR All Fields:"sexual minor*" OR All Fields:"gender minor*" OR All Fields:"cis gender" OR All Fields:"gender non conforming"	9751
3	[All Fields:psychiatr* OR All Fields:depressed OR All Fields:depressive OR All Fields:depression OR All Fields:panic* OR All Fields:agrophobia* OR All Fields:"social phobia*" OR All Fields:anxiety OR All Fields:"obsessive compulsive disorder*" OR All Fields:OCD OR All Fields:"post traumatic stress disorder*" OR All Fields:dysthymi* OR All Fields:"bipolar disorder*" OR All Fields:"gender dysphoria" OR All Fields:anorexia* OR All Fields:"eating disorder*" OR All Fields:stigma OR All Fields:alcohol* OR All Fields:"Drug abus*" OR All Fields:"drug depend*" OR All Fields:"substance abus*" OR All Fields:"substance depend*" OR All Fields:"mental* ill*" OR All Fields:"mental* disorder*" OR All Fields:"mental* health" OR All Fields:suicid* OR All Fields:"self harm*"] AND [All Fields:LGB* OR All Fields:lesbian* OR All Fields:gay OR All Fields:"bi-sexual" OR All Fields:bisexual OR All	951

#	Search Statement	Results
	Fields:transgender OR All Fields:queer OR All Fields:intersex OR All Fields:asexual OR All Fields:homosexual* OR All Fields:"sexual minor*" OR All Fields:"gender minor*" OR All Fields:"cis gender" OR All Fields:"gender non conforming"]	
4	[All Fields:psychiatr* OR All Fields:depressed OR All Fields:depressive OR All Fields:depression OR All Fields:panic* OR All Fields:agrophobia* OR All Fields:"social phobia*" OR All Fields:anxiety OR All Fields:"obsessive compulsive disorder*" OR All Fields:OCD OR All Fields:"post traumatic stress disorder*" OR All Fields:dysthymi* OR All Fields:"bipolar disorder*" OR All Fields:"gender dysphoria" OR All Fields:anorexia* OR All Fields:"eating disorder*" OR All Fields:stigma OR All Fields:alcohol* OR All Fields:"Drug abus*" OR All Fields:"drug depend*" OR All Fields:"substance abus*" OR All Fields:"substance depend*" OR All Fields:"mental* ill*" OR All Fields:"mental* disorder*" OR All Fields:"mental* health" OR All Fields:suicid* OR All Fields:"self harm*"] AND [All Fields:LGB* OR All Fields:lesbian* OR All Fields:gay OR All Fields:"bi-sexual" OR All Fields:bisexual OR All Fields:transgender OR All Fields:queer OR All Fields:intersex OR All Fields:asexual OR All Fields:homosexual* OR All Fields:"sexual minor*" OR All Fields:"gender minor*" OR All Fields:"cis gender" OR All Fields:"gender non conforming"] AND Publication Date: (01/01/2013 TO 31/12/2023)	283

Medline

#	Search Statement	Results
1	exp Psychiatry/	110159
2	psychiatr*.ti,ab.	274617
3	1 or 2	340711
4	exp Depressive Disorder/ or exp Depressive Disorder, Major/ or exp Depression/	253718
5	depressed.mp.	100473
6	depressive.mp.	210834
7	depression.mp.	484518
8	4 or 5 or 6 or 7	600955
9	exp Panic Disorder/	7267
10	panic*.mp.	25615
11	9 or 10	25615
12	exp Agoraphobia/	2670
13	agrophobia*.mp.	1
14	exp Phobia, Social/	1182
15	social phobia*.mp.	4344
16	exp Anxiety/	109599

#	Search Statement	Results
17	exp Anxiety Disorders/	89487
18	anxiety.mp.	302921
19	anxiety.ti,ab.	250971
20	anxiety disorder*.mp.	64017
21	16 or 17 or 18 or 19 or 20	340466
22	17 or 20	109277
23	exp Obsessive-Compulsive Disorder/	16568
24	obsessive compulsive disorder*.mp.	21988
25	OCD.mp.	11721
26	23 or 24 or 25	24031
27	exp Stress Disorders, Post-Traumatic/	40592
28	(post traumatic stress disorder* or posttraumatic stress disorder*).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	38801
29	PTSD.mp.	32805
30	27 or 28 or 29	56625
31	exp Dysthymic Disorder/	1172
32	dysthymi*.mp.	3765
33	31 or 32	3765
34	exp Bipolar Disorder/	44845
35	((bipolar or bi polar) adj3 disorder*).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	58870
36	34 or 35	58870
37	exp Gender Dysphoria/	886
38	gender dysphoria.mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare	1995

#	Search Statement	Results
	disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	
39	37 or 38	1995
40	exp Anorexia Nervosa/ or exp Anorexia/	19608
41	anorexia*.mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	38772
42	40 or 41	38772
43	exp "Feeding and Eating Disorders"/	35791
44	eating disorder*.mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	33446
45	43 or 44	44266
46	exp Alcoholism/	79874
47	exp Alcohol-Related Disorders/	120936
48	exp Alcohol Drinking/	77463
49	alcohol*.mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	487562
50	46 or 47 or 48 or 49	488985
51	exp Substance-Related Disorders/	308471
52	((drug or substance) adj2 (disorder* or abus* or depend*)).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	176567
53	51 or 52	352415
54	exp Mental Disorders/	1419387
55	exp Mental Health/	59451
56	mental* ill*.ti,ab.	45766

#	Search Statement	Results
57	mental* disorder*.ti,ab.	48387
58	mental* health.ti,ab.	202923
59	54 or 55 or 56 or 57 or 58	1576407
60	exp suicide/ or exp suicidal ideation/ or exp suicide prevention/ or exp suicide, assisted/ or exp suicide, attempted/ or exp suicide, completed/	73761
61	suicid*.mp.	112463
62	60 or 61	112463
63	exp Self-Injurious Behavior/	82592
64	self harm*.mp.	8542
65	63 or 64	86060
66	exp Social Stigma/	12514
67	stigma.ti,ab.	33233
68	66 or 67	35822
69	exp "Sexual and Gender Minorities"/	15425
70	LGBTQ*.ti,ab.	2002
71	lesbian*.ti,ab.	8405
72	gay.ti,ab.	13657
73	(bi-sexual or bisexual).ti,ab.	11175
74	transgender.ti,ab.	10178
75	trans*.ti,ab.	6302202
76	queer.ti,ab.	2266
77	intersex.ti,ab.	2028
78	asexual.ti,ab.	9703
79	homosexual*.ti,ab.	13892
80	"sexual minor*".ti,ab.	4188
81	"gender minor*".ti,ab.	1686
82	"cis gender".ti,ab.	94
83	"gender non conforming".ti,ab.	176
84	69 or 70 or 71 or 72 or 73 or 74 or 76 or 77 or 78 or 79 or 80 or 81 or 82 or 83	56728

#	Search Statement	Results
85	(Australia* or "New South Wales*" or Sydney* or Newcastle* or "South Australia*" or Adelaide* or Victoria* or Melbourne* or "Western Australia*" or Perth* or Queensland* or Brisbane* or "Australian Capital Territory*" or Canberra* or "Northern Territory*" or Darwin* or Tasmania* or Hobart*).ab,cp,ti.	484656
86	exp Australia/	168459
87	85 or 86	510050
88	84 and 87	2120
89	limit 88 to yr="2013 -Current"	1237
90	limit 89 to english language	1236
91	3 and 90	19
92	8 and 90	76
93	11 and 90	1
94	12 or 13	2670
95	14 or 15	5267
96	90 and 94	0
97	90 and 95	0
98	21 and 90	61
99	26 and 90	1
100	30 and 90	6
101	33 and 90	0
102	36 and 90	0
103	39 and 90	36
104	42 and 90	0
105	45 and 90	8
106	50 and 90	69
107	53 and 90	104
108	59 and 90	274
109	exp *Mental Disorders/	1203785
110	108 and 109	135
111	55 and 90	48

#	Search Statement	Results
112	56 and 90	17
113	57 and 90	8
114	58 and 90	157
115	62 and 90	56
116	65 and 90	37
117	68 and 90	104
118	91 or 92 or 93 or 96 or 97 or 98 or 99 or 100 or 101 or 102 or 103 or 104 or 105 or 106 or 107 or 110 or 111 or 112 or 113 or 114 or 115 or 116 or 117	435
119	exp United Kingdom/	388948
120	(United Kingdom or England).ti,ab.	102286
121	119 or 120	435199
122	3 or 8 or 11 or 21 or 26 or 30 or 33 or 36 or 39 or 42 or 45 or 50 or 53 or 55 or 56 or 57 or 58 or 62 or 65 or 68 or 94 or 95 or 109	2520356
123	84 and 121 and 122	416
124	limit 123 to (english language and yr="2013 -Current")	225
125	118 or 124	645

PsycInfo

#	Search Statement	Results
1	exp Psychiatry/	56389
2	psychiatr*.ti,ab.	274422
3	1 or 2	287033
4	exp major depression/ or exp "Depression (Emotion)"/	181431
5	depressed.mp.	53971
6	depressive.mp.	161240
7	depression.mp.	379978
8	4 or 5 or 6 or 7	416976
9	exp Panic Disorder/	7950
10	panic*.mp.	19452
11	9 or 10	19452
12	exp Agoraphobia/	2961

#	Search Statement	Results
13	agrophobia*.mp.	3
14	exp Social Phobia/	5155
15	social phobia*.mp.	8923
16	exp Anxiety/	87959
17	exp Anxiety Disorders/	42252
18	anxiety.mp.	281262
19	anxiety.ti,ab.	222991
20	anxiety disorder*.mp.	62341
21	16 or 17 or 18 or 19 or 20	289416
22	17 or 20	76134
23	exp Obsessive-Compulsive Disorder/	18049
24	obsessive compulsive disorder*.mp.	22313
25	OCD.mp.	12456
26	23 or 24 or 25	24823
27	exp Posttraumatic Stress Disorder/	39340
28	(post traumatic stress disorder* or posttraumatic stress disorder*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	51515
29	PTSD.mp.	44105
30	27 or 28 or 29	57230
31	exp Dysthymic Disorder/	1523
32	dysthymi*.mp.	4422
33	31 or 32	4422
34	exp Bipolar Disorder/	34012
35	((bipolar or bi polar) adj3 disorder*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	46941
36	34 or 35	48560
37	exp Gender Dysphoria/	1227
38	gender dysphoria.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	2013
39	37 or 38	2013

#	Search Statement	Results
40	exp Anorexia Nervosa/ or exp Anorexia/	12335
41	anorexia*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	19000
42	40 or 41	19000
43	exp Eating Disorders/	34881
44	eating disorder*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	35849
45	43 or 44	44450
46	exp Alcohol Abuse/	51287
47	exp alcoholism/	31845
48	exp alcoholism/	31845
49	alcohol*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	160129
50	46 or 47 or 48 or 49	160696
51	exp Drug Abuse/	50444
52	((drug or substance) adj2 (disorder* or abus* or depend*)).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	126620
53	51 or 52	127044
54	exp Mental Disorders/	1014403
55	exp Mental Health/	86590
56	mental* ill*.ti,ab.	56838
57	mental* disorder*.ti,ab.	55225
58	mental* health.ti,ab.	218718
59	54 or 55 or 56 or 57 or 58	1185944
60	exp Attempted Suicide/ or exp Suicide/ or exp Suicidal Ideation/	45113
61	suicid*.mp.	80722
62	60 or 61	80722
63	exp Nonsuicidal Self-Injury/	7592
64	self harm*.mp.	8157
65	63 or 64	12615

#	Search Statement	Results
66	exp Social Stigma/	17322
67	stigma.ti,ab.	29643
68	66 or 67	32864
69	exp Lesbianism/ or exp Homosexuality/ or exp Bisexuality/ or exp Male Homosexuality/ or exp LGBTQ/	39281
70	LGBTQ*.ti,ab.	3237
71	lesbian*.ti,ab.	18104
72	gay.ti,ab.	23808
73	(bi-sexual or bisexual).ti,ab.	13608
74	transgender.ti,ab.	9903
75	trans*.ti,ab.	607522
76	queer.ti,ab.	5982
77	intersex.ti,ab.	763
78	asexual.ti,ab.	659
79	homosexual*.ti,ab.	14201
80	"sexual minor*".ti,ab.	5822
81	"gender minor*".ti,ab.	1543
82	"cis gender".ti,ab.	66
83	"gender non conforming".ti,ab.	224
84	69 or 70 or 71 or 72 or 73 or 74 or 76 or 77 or 78 or 79 or 80 or 81 or 82 or 83	57212
85	(Australia* or "New South Wales*" or Sydney* or Newcastle* or "South Australia*" or Adelaide* or Victoria* or Melbourne* or "Western Australia*" or Perth* or Queensland* or Brisbane* or "Australian Capital Territory*" or Canberra* or "Northern Territory*" or Darwin* or Tasmania* or Hobart*).ab,cp,ti.	79176
86	12 or 13	2962
87	14 or 15	8923
88	exp *Mental Disorders/	869838
89	(United Kingdom or England).ti,ab,cp.	35983
90	84 and 85	1276
91	limit 90 to (english language and yr="2013 -Current")	631
92	3 and 91	19

#	Search Statement	Results
93	8 and 91	67
94	11 and 91	2
95	21 and 91	58
96	26 and 91	1
97	30 and 91	2
98	33 and 91	0
99	36 and 91	0
100	39 and 91	13
101	42 and 91	0
102	45 and 91	8
103	50 and 91	41
104	53 and 91	47
105	59 and 88 and 91	74
106	55 and 91	68
107	56 and 91	11
108	57 and 91	4
109	62 and 91	43
110	65 and 91	18
111	68 and 91	56
112	86 and 91	0
113	87 and 91	0
114	92 or 93 or 94 or 95 or 96 or 97 or 98 or 99 or 100 or 101 or 102 or 103 or 104 or 105 or 106 or 107 or 108 or 109 or 110 or 111 or 112 or 113	245
115	3 or 8 or 11 or 21 or 26 or 30 or 33 or 36 or 39 or 42 or 45 or 50 or 53 or 55 or 56 or 57 or 62 or 65 or 68 or 86 or 87 or 88	1500855
116	84 and 89 and 115	152
117	limit 116 to (english language and yr="2013 -Current")	89
118	114 or 117	326

Appendix 2:Characteristics of included SLR studies (n=56). The in-scope studies included:

- 23 quantitative studies
- 18 qualitative
- 14 mixed-methods studies
- 1 Delphi study.

All studies were published between February 2013 and February 2023, with forty conducted in Australia, 15 in the UK, and one across multiple jurisdictions, including Australia and the UK.

Eleven studies examined experiences of LGBTQ+ people of mental health and suicide prevention service provision, 21 examined experiences of trans and gender-diverse people, and 15 of sexuality diverse people.

Nine papers examined mental health professionals' perspective of services to LGBTQ+ people, and 3 examined the experiences of carers of LGBTQ+ people. (Note: totals do not add up to 56 as some studies examined multiple groups).

Quality appraisal of included studies using the Mixed Methods Appraisal Tool (MMAT), (Pluye et al., 2009) indicated that studies were of moderate-high quality.

3.1.1 Service provider types

Most studies (n=27) examined a mix of public and/or private, mainstream and LGBTQ+ specific mental health services and/or a mix of mental health practitioners, including:

- primary health services, including general practitioners (GPs)
- crisis and emergency services, including emergency departments
- inpatient and outpatient mental health services, including outreach services
- community mental health services
- individual and group therapy services (e.g., counsellor, psychologist, psychotherapist, social worker)
- individual and group mental health care (e.g., from a peer worker, mental health nurse, allied health, medical specialist, or psychiatrist)
- public and private child and youth mental health services
- youth specific online services
- LGBTQ+ specific services, including gender affirming clinics and services
- health services to First Nations LGBTQ+SB people, including mental health services; and sexual health and drug and alcohol services providing mental health care.

For example, Martin et al. (2019b) reported on a variety of mental health services, including helplines, primary health (GP) services, community based mental health services, allied health services, crisis and emergency department services, and inpatient mental health services.

The remaining studies focused on a specific service, intervention, or provider type, including: gender-affirming clinics or service (n=7); psychology or counselling services (including individual and group therapy) (n=6); online mental health services, including e-therapy (n=2); crisis helplines (n=2); GPs (n=2); child and youth mental health services (n=2); conversion practices (n=2); mental health first-aid (n=1); wellbeing workshops (n=1); school counselling

(n=1); primary care clinic (n=1); mental health nurses (n=1); and inpatient mental health services (n=1).

3.1.2 Lived experience involvement

Most studies (n=32) did not include an explicit statement regarding lived experience involvement.

Twenty-four studies stated that they involved LGBTQ+ people and/or LGBTQ+ people with an intersecting lived experience of mental health challenges in the design or conduct of the study. Of these:

- 15 involved LGBTQ+ people
- 6 involved LGBTQ+ people with an intersecting lived experience of mental health challenges
- 1 involved First Nations LGBTQ+SB people
- 1 involved people with lived experience of mental health challenges (not specified if the person was LGBTQ+)
- 1 involved First Nations people (not identified as LGBTQ+).

Of the studies involving LGBTQ+ or LGBTQ+ people with an intersecting lived experience, they were involved as advisors (n=13) or co-researchers (n=9).

3.2 Services provided to LGBTQ+ people

The SLR literature did not provide a comprehensive overview of mental health and suicide prevention services for LGBTQ+ people in Australia and the UK, with no included studies mapping mental health service provision in these countries[18], as well as a lack of included studies examining mental health services to people with innate variations in sex characteristics and asexual people (see 2.3 Eligibility criteria and study selection).

Included survey studies indicated that 50-91% of LGBTQ+ respondents in Australia had accessed a mental health service provider (McNair et al., 2018; Reynish et al., 2023). Mental health services were provided by a range of mental health practitioners, including peer workers, nurses (including mental health nurses), psychologists, counsellors, allied health (including social workers and paramedics), medical doctors (including GPs), and psychiatrists. Data show that LGBTQ+ people were most likely to access a psychologist or counsellor (44-78%), GP (22-45%), psychiatrist (14-41%), allied health professional (23%), or telephone counsellor (10%) (Reynish et al., 2023; McNair & Bush, 2016). One study found that only 12% of LGBTQ+ people reported having attended LGBTQ+ specific services (McNair & Bush, 2016).

Further, studies indicated that GPs were a common, and often preferred, provider for LGBTQ+ people (McNair & Bush, 2016; Riggs et al., 2014; Taylor et al., 2021). For example, bisexual people most frequently nominated GPs and psychologists as their preferred

[18] Australian surveys exist that were not included in this review (due to not meeting inclusion criteria e.g., not peer reviewed) and provide a more detailed understanding of mental health service engagement for LGBTIQA+ people. Examples include, but are not limited to, Hill et al.'s (2021) *Private Lives 3* and Liddelow-Hunt et al.'s (2023) *Walkern Katatdjin Phase 2*, which detail mental health service use in LGBTIQ+ populations. Additionally, LGBTQ+ youth mental health services have been mapped in the UK (e.g., Pattinson et al., 2021).

providers (Taylor et al., 2021), and same-sex attracted women, including trans women, reported that GP support was the most accessed form of professional care (McNair & Bush, 2016). However, GPs were reported to be an access point for mental health services, rather than a source of ongoing mental health care (McNair & Bush, 2016; McNair et al., 2018). Indeed, the most frequently endorsed enabler for mental health help-seeking among same-sex attracted women was “having a trustworthy GP” who was supportive of their sexual orientation (see 3.3.4 Equity). For women with concurrent mental health and alcohol related issues, “having a regular GP was also strongly correlated with alcohol and mental health treatment utilisation” (McNair et al., 2018).

GPs were also an important access point to services for trans and gender diverse people. In a survey of 180 trans people in Australia, Riggs et al. (2014) found that 70% of trans people had accessed a psychiatrist and 80% had accessed a primary care provider e.g., GP. Strauss et al. (2021b) also found that trans and gender diverse people tended to access mental health services at younger ages, with 59.4% being below 18 years. As Haire et al. (2021) and Strauss et al. (2021b) reported, trans and gender diverse people in Australia commonly accessed mental health supports for gender and non-gender related needs, including: to gain access to gender-affirming medical care; for support with gender dysphoria; for support with distress related to minority stress (e.g., stigma, discrimination); and/or for support with mental distress that was not related to gender identity. While gender-affirming medical care (e.g., puberty blockers, hormones, surgery) was not a focus of this review, experiences with mental health professionals were of interest.

One study in this review examined provision of services to First Nations LGBTQ+SB people and indicated that a small number of dedicated and specific mental health services/organisations are available and provided to this population. However, due to limited availability of these services, findings indicated that the majority of Aboriginal and Torres Strait Islander LGBTQ+SB people must seek mental health support from Aboriginal Community Controlled Health Organisations (ACCHOs), or mainstream (non-Aboriginal specific) services, or LGBTQ+ specific services (Uink et al., 2023).

3.3 Service quality and performance

This review uses the Institute of Medicine Committee (2006) framework for assessing quality and performance in mental health services, which allows for a more robust analysis of services quality and performance. Each study was mapped to the Institute of Medicine (2006) six domains, which include: timeliness, effectiveness, patient-centredness, equity, safety, and efficiency, and are detailed in Table 2.

As discussed in further detail in the discussion section, there were no available data across studies on service efficiency.

Table 1:	Study findings across the six Institute of Medicine Committee domains					
Author Year	**Timeliness**	**Effective-ness**	**Person-centredness**	**Equity**	**Safety**	**Efficiency**
Bailey 2014	✓				✓	
Bishop 2022				✓		
Bond 2017				✓		
Bowman 2020	✓		✓	✓		
Brenner 2023				✓	✓	
Bretherton 2021				✓	✓	
Charter 2022	✓		✓	✓	✓	
Cheung 2020				✓		
Cronin 2021				✓		
Davies 2013			✓			
del pozo de Bolger 2014			✓	✓		
Dimova 2022			✓			
Erasmus 2015	✓	✓	✓	✓		
Haire 2021	✓		✓	✓		
Author Year	**Timeliness**	**Effective-ness**	**Person-centredness**	**Equity**	**Safety**	**Efficiency**
Harrison 2020	✓		✓			
Hawkey 2021	✓		✓	✓		
Hill 2022				✓		
Ho 2017			✓			
Hughes 2018				✓		
Jones 2022a					✓	
Jones 2022b					✓	

Table 1:	Study findings across the six Institute of Medicine Committee domains					
Author Year	**Timeliness**	**Effective-ness**	**Person-centredness**	**Equity**	**Safety**	**Efficiency**
Kilicaslan 2019				✓		
Lefrancois 2013				✓	✓	
Lim 2022	✓			✓	✓	
Lim 2021	✓		✓	✓	✓	
Lucassen 2018				✓		
Lyons 2022				✓	✓	
Mackie 2023			✓	✓		
Martin 2019a	✓		✓	✓	✓	
Martin 2019b			✓	✓	✓	
McNair 2016		✓		✓	✓	
McNair 2018		✓	✓	✓		
Morris 2022		✓		✓	✓	
Pennay 2018				✓		
Platell 2021		✓				
Pullen Sansfaçon 2023	✓			✓	✓	
Reynish 2023			✓	✓		
Riggs 2016a				✓		
Riggs 2016b				✓		
Riggs 2015				✓		
Riggs 2014	✓			✓	✓	
Author Year	**Timeliness**	**Effective-ness**	**Person-centredness**	**Equity**	**Safety**	**Efficiency**
Rimes 2018		✓				

Table 1:	Study findings across the six Institute of Medicine Committee domains					
Author Year	Timeliness	Effective-ness	Person-centredness	Equity	Safety	Efficiency
Rimes 2019		✓				
Rivers 2018		✓		✓		
Robertson 2015		✓	✓	✓	✓	
Roberts 2018	✓			✓		
Saunders 2023			✓			
Spanos 2021	✓					
Strauss 2021a				✓		
Strauss 2021b	✓			✓	✓	
Taylor 2021				✓		
Tollit 2023				✓		
Uink 2023				✓		
Williamson 2022		✓		✓		
Witcomb 2018		✓				
Yang 2021				✓		

Main findings related to each of the five domains of the Institute of Medicine Committee (2006) are reported in detail below, including timeliness, effectiveness, person-centredness, equity, and safety.

3.3.1 Timeliness

Timeliness considers whether LGBTQ+ people had timely access to services, and whether there were delays in service referral or provision. Fifteen of the included papers examined

timeliness of service delivery. Key themes include *access to services* and *delays in service provision*.[19]

Table 3:	timeliness
Access to services	**Access in rural areas.** Three studies reported findings on access in rural areas. Roberts et al.'s (2018) survey of 531 youth (13-18 years) found that these same-sex attracted adolescents did not experience greater barriers to accessing mental health support in rural South Australia compared to the general adolescent population (U = 4120; p = 0.21). Survey studies by Lim et al. (2021, 2022) of sexuality and gender diverse adults also found that Australian crisis helplines were perceived as extending access to mental health services in rural areas. Additionally, a small qualitative study of LGBT young adults (n=9) indicated that online services were perceived as improving access in rural areas, and accessibility was related to the impersonal and anonymous nature of online interactions, which were less likely to trigger social anxiety (Bowman et al., 2020). **Access can be challenging.** Despite the range of services and health providers noted across studies (see 3.1 Services for LGBTQ+ people), access to mental health services was frequently described as challenging for LGBTQ+ people in qualitative data. For example, a small qualitative study of trans and gender diverse adults (n=12) in Australia, reported that access to health services was like a "wild goose chase" due to the difficulty of having to juggle coordination of mental health and gender-affirming health providers, and expressed a wish to have a simpler process whereby they could access health services via a GP (Haire et al., 2021). In the same study, it was also reported that access could be complicated by intersecting health issues such as HIV diagnosis or physical health conditions (Haire et al., 2021). **Challenges of accessing services during a crisis.** Three studies indicated difficulties accessing support during a crisis including via emergency services and crisis helplines (Martin et al., 2019a; Lim et al., 2021). Only 30% of lesbian, gay, and bisexual adults, and 33% of trans and gender diverse people used helpline services in a crisis (Lim et al., 2021, 2022). Non-use appeared to be associated with equity issues in both populations and is explored in more detail below (3.3.4.1 Equity). Referral processes to longer-term mental health care were also reported to be poor from gender-affirming services and crisis helplines (Harrison et al., 2020; Lim et al., 2021).

[19] LGBTQ+ people also experience various barriers to accessing mental health care directly related to stigma, prejudice or lack of competency/appropriate services connected to the needs of those with diverse genders and sexuality. The community also report barriers to access that are common within the majority population. For example, Cronin et al (2021) surveyed 591 lesbian, gay, and bisexual individuals and found that although minority stressors were a barrier to access, the most cited barrier was the cost of services. Specific equity issues are examined in more detail under *3.3.4 Equity*, including issues of cost.

Table 3:	timeliness
	Challenges accessing gender-affirming care. Seven studies discussed access to gender-affirming care via a mental health professional (e.g., access to puberty blockers, hormone treatment, surgery). Pullen Sansfaçon et al. (2023) noted that recent elimination of requirements for court approval had improved access to gender-affirming care in Australia. Findings across four studies indicated that timely access to supportive and gender-affirming care promoted wellbeing and decreased suicidal thoughts and self-harm in trans youth and adults (Bailey et al. 2014; Charter et al., 2021; Harrison et al., 2020; Pullen Sansfaçon et al., 2023). For example, a UK study of 889 trans adults reported that access to gender-affirming medical care had a significant impact on suicidality, with 67% of trans people reporting suicidal thoughts pre-transition to only 3% reporting suicidal thoughts post transition (Bailey et al., 2014). An Australian qualitative study by Hawkey et al. (2021) also reported that timely access to gender-affirming care was also perceived by trans women of colour as protective from exposure to violence in the community. A retrospective audit of trans and gender diverse adults (n=589) presenting at primary care clinics found that GPs could also provide a practical and acceptable solution to reduce wait times for gender-affirming hormonal treatment and facilitated referral to mental health support (Spanos et al., 2021). Five studies discussed 'gatekeeping' or denial of gender affirming care. Spanos et al. (2021) found that, trans adults were less satisfied with mental health assessments for gender-affirming care. Indeed, "Gatekeeping", or unnecessary and unreasonable barriers imposed by psychiatrists or other mental health professionals were commonly reported (Bailey et al., 2014; Haire et al., 2021; Pullen Sansfaçon et al., 2023; Riggs et al., 2014), including in a large survey of gender diverse people (n=188) in Australia. Qualitative findings also indicated that trans youth in Australia could be denied access to gender-affirming care by one parent (Haire et al., 2021). However, some trans youth over 16 years, who no longer lived with a parent, reported mental health professionals blocking access to gender-affirming care due to them not having a parent who could provide consent (Haire et al., 2021).
Delays in service provision	**Reasonable wait times.** An Australian mixed-methods study of 895 trans and gender diverse adolescents and young adults (14-25 years) found that most (76.8%) had relatively short wait times (one month or less) for an appointment with a therapist (Strauss et al., 2021b). In the same study, trans and gender diverse youth and young adults (44%) reported that they could access a psychiatrist within a month, and 30% were able to access a psychiatrist within 2-3 months. However, data were likely skewed as some youths were prioritised for services due to suicide attempts, thoughts, or behaviours (Strauss et al., 2021b).

Table 3:	timeliness
	Extended delays for 'trans-friendly' psychiatrists. Two studies reported extended delays in accessing psychiatrists who were trans-friendly, indicating that these providers were in short supply (Strauss et al., 2021b). Finding an affirming provider outside of public speciality clinic was reported to be particularly challenging, and in qualitative interviews was described as a "trial and error" process by trans and gender diverse people and their families (Pullen Sasfaco et al., 2023, p.63). **LGBTQ+ specific service delays.** Although LGBTQ+ specific services were reported to provide high-quality care, data indicate they were also difficult to access due to long wait times and limited hours of operation (Bailey et al., 2014; Davies et al., 2013; Haire et al., 2021; Harrison et al., 2020; Pullen Sansfaçon et al., 2023). Even in studies that did not directly ask about timeliness, waiting times for appointments were still discussed in open comment sections by participants as one of the main issues in accessing care (Erasmus et al. 2015). **Delays in access to gender-affirming care.** Delays in access to gender-affirming care were reported across four studies (Haire et al., 2021; Harrison et al., 2020; Pullen Sansfaçon et al., 2023). Reasons included the requirements of multiple assessments; long waiting lists; parental conflict (one parent withholding of consent); and difficulty finding a supportive healthcare provider – particularly if they were reliant on public mental health services (Pullen Sansfaçon et al., 2023). Healthcare providers could also disregard decisions of supportive parents, and deny or delay access to gender-affirming care (Pullen Sansfaçon et al., 2023). For trans youth, this often led to delays in access until they reached adulthood: *"[services] refused me help at age 16 and forced me to wait until I was in my twenties before I could get help! At that point I became increasingly angry, depressed, and suicidal – which was completely unnecessary if I had just been allowed to access hormone replacement therapy at the age of 16 – I could have avoided several years of hell."* (Bailey et al., 2014, p.215) **Access to gender affirming care via private providers.** Harrison et al. (2020) found that access to gender-affirming care via private mental health providers was viewed more favourably (by those who could afford it) due to abbreviated wait-times and quicker treatment, particularly among trans and gender diverse people seeking access to gender-affirming care.

3.3.2 Effectiveness

Effectiveness examines whether interventions produce positive health outcomes and meet the intended purpose. Eleven of the included papers examined effectiveness of service

delivery. Key themes related to clinical recovery (reduction of clinical symptoms) or those that aligned more with conceptions of personal recovery.20

Table 4 :	effectiveness
Clinical recovery	**Six studies examined clinical recovery outcomes** (Erasmus et al., 2015; Platell et al. 2020 ; Rimes et al., 2018; Rimes et al., 2019; Rivers et al., 2018; Witcomb et al., 2018). **Benefits of diagnosis and treatment.** Data from a qualitative study suggest that a mental health diagnosis and treatment can support LGBTQ+ youth to make sense of distress (including suicidal distress) and reduce self-blame (Rivers et al., 2018). A cross-sectional survey of LGBTQ+ youth, who were a subset of the study population (43% of 106 respondents), showed higher levels of agreement than non-LGBTQ+ youth that services would be beneficial for mental health symptoms (Platell et al., 2021). However, this finding was related to the perception of improved clinical outcomes rather than actual improvements in mental health symptoms (Platell et al., 2020). **Treatment did not necessarily translate into improved clinical outcomes.** Although Rimes et al. (2018) found reductions in clinical symptoms of anxiety and depression in sexuality diverse adults receiving psychological services in the UK, they also found that the majority of all clients (regardless of sexual orientation) did not experience any clinical recovery. After adjusting for several variables, bisexual women were also less likely than their heterosexual counterparts to experience clinically recovery (Odds Ratio = 1.88, 95% I: 1.35-2.60), $p < 0.0005$), and less likely to have a sustained clinical recovery (Odds Ratio = 1.83, 95% CI 1.32-2.54, $p < 0.0005$) (Rimes et al., 2018). However, no such differences were identified between male sub-groups or for lesbian women (Rimes et al., 2018). In another study by Rimes et al. (2019), the researchers found disparities based on sexual orientation in treatment outcomes in 85,831 heterosexual, lesbian, gay, and bisexual clients attending psychological treatment services in the UK. In contrast to heterosexual women, lesbian and bisexual women had elevated levels of depression, anxiety, and functional impairment in their final sessions (Rimes et al., 2019). These women also had increased likelihood of not having sustained clinical recovery, including for depression/anxiety or functioning (adjusted odds ratios [aORs] 1.3–1.4), or reliable improvement in depression/anxiety or functioning (aORs 1.2–1.3) (Rimes et al., 2019). Similarly, in comparison to heterosexual men, bisexual

[20] Unlike clinical recovery, which has a narrow focus on symptom management and/or reduction, personal recovery emphasises the value of promoting meaning, connection, hope, empowerment, and identity for people with lived experience of mental health challenges, whether or not they are experiencing mental health symptoms (Leamy et al.,2011).

Table 4 :	effectiveness
	men demonstrated greater final-session severity for depression, anxiety, and functioning, and an elevated chance of no clinical recovery, including for depression/anxiety or functioning (aORs 1.5–1.7), nor for sustained improvement in depression/anxiety or functioning (aORs 1.3–1.4) (Rimes et al., 2019). **Clinical recovery among trans and gender diverse people.** Positive findings were reported in two studies, although they only appear to pertain to trans and gender diverse people. For example, a cross-sectional survey study of 127 trans and gender diverse people, which assessed patient satisfaction with a gender dysphoria clinics in Melbourne, reported a significant reduction in perceived distress among participants ($t(124)= -12.845$; $p < .001$) (Erasmus et al., 2015). Although not described in detail, Erasmus et al. (2015) also reported that, after attending the clinic, 70.1% of participants felt satisfied with their ability to handle the issues that had required them to attend the clinic in the first place. However, it should be noted that the design of the study does not allow for a direct attribution of these effects to the operations of the health service (Erasmus et al, 2015). Another study by Witcomb et al. (2018) examined the impact of masculinising or feminising hormone treatment on mental health outcomes in a sample of 913 transgender clients of a national transgender health service in the UK. Witcomb et al. found that clients receiving hormone therapy had significantly, and clinically meaningful, lower levels of clinical depression (depressive disorder), with 47.6% (n = 304) of those not receiving hormone therapy showing signs of a possible or probable clinical depression compared to 35.2% (n = 92) in those with access to hormone therapy (X^2 =11,556, $p < 0.001$). This effect was seen in both trans women (X^2 = 6709, $p < 0.05$) and trans men (X^2 = 4535, $p < 0.05$) (Witcomb et al., 2018). However, these findings should be treated with caution as they may be related to other factors such as those on hormone therapy being longer in treatment.
Personal recovery	Five **studies examined impacts of care on personal recovery or indicators** that align with personal recovery (McNair et al., 2018; McNair & Bush, 2016; Morris et al., 2022; Robertson et al., 2015; Williamson et al., 2022). Lack of personal recovery focus in mental health services. A qualitative study of lesbian and gay people reported a lack of personal recovery focus in inpatient mental health services (Robertson et al., 2015). Practice within these environments was described as detrimental to personal recovery due to devaluing and negative attitudes towards people with lived experience; a lack of choice; and a lack of opportunities to connect with friends and family (Robertson et al., 2015). Robertson et al. (2015) also reported that the focus on clinical recovery in inpatient settings, with the emphasis on pathology and medical treatments, was experienced as dehumanising and for

Table 4 :	effectiveness
	sexuality diverse people echoed other experiences of dehumanisation and oppression in the community. As one lesbian woman stated: *"They are just looking at things from, some psychiatrists not all, from a biochemical viewpoint and that your brain is broken, we'll fix your brain with some medication and there, you know, there is no, you know, [consideration for] your social and personal life."* (Robertson et al. 2015, p.275) Promoting connection and identity. Four studies examined personal recovery indicators. One study focused on connection and identity (Williamson et al., 2022) and three studies focused on social and peer connection (McNair et al., 2018; McNair & Bush, 2016; Morris et al., 2022). In the UK, Williamson et al. (2022) describe The Quest intervention, which sought to promote community connection and wellbeing via a therapeutic workshop for gay, queer, and bisexual men from British Black, Asian, and Minority Ethic ('BAME') communities. The Quest uses group-based cognitive-behavioural and shame-resilience models to instil a sense of community and self-worth and increase social capital, while supporting participants to identify and discard limiting self-beliefs or maladaptive coping strategies (Willamson et al., 2022). A pre- and post-evaluation revealed that participants experienced rapid improvements in self-esteem ($t = 2.30$, $p = .02$, $d = 0.37$), self-efficacy ($t = 2.73$, $p = .01$, $d = 0.44$), psychological well-being ($t = 1.95$, $p = .03$, $d = 0.44$), and reduced internalised homophobia ($t = 1.75$, $p = .05$, $d = 0.36$) (Williams et al., 2022). However, this study does not report on whether interactions increased social capital, and, while statistically significant, reported improvements were overall modest with low to moderate effect sizes. Long term outcomes, and associated behaviour changes, were also not assessed (Williamson et al., 2022). In a mixed-methods study of help-seeking by 1628 same-sex attracted women, including trans women, McNair and Bush (2016) found that formal peer support groups were an important source of support and connection and furnished help-seekers with information about LGBTQ+ specific or affirming services. However, McNair and Bush (2016) note that key stakeholders in the LGBTQ+ community articulated limitations linked to formalised peer support groups – namely that they are often underfunded and were not necessarily inclusive of LGBTQ+ people with intersecting identities, and may be led by people without formal training (McNair & Bush, 2016). These aspects are discussed further in 3.3.4 Equity. In a later study focusing on 521 same-sex attracted Australian women experiencing alcohol and mental health issues, McNair et al (2018) also note that connectedness to peers within the community was "associated with greater treatment utilisation". However, contrary to previous research, they found that social support was negatively

Table 4 :	effectiveness
	associated with utilisation of health services. They speculated that participants “with good social support” may seek help through social networks rather than health services (McNair et al., 2018). A qualitative study of 26 sexuality diverse adults with a referral for psychological services in the UK, also found that the integration of technological adjuncts that promoted connection, e.g., online support groups, video testimonies from sexuality diverse peoples, or a mobile phone application with online groups/forums and other resources, could enhance participants’ experience of face-to-face mental health services (Morris et al., 2022).

3.3.3 Person-centredness

Person-centredness explores how services are experienced, and whether they are respectful and responsive to the preferences and needs of service users. It also explores to what extent people have control over healthcare decisions, and whether care is coordinated, continuous, supportive, and inclusive of carers and family.

Eighteen studies reported on an aspect of *person-centredness of services*. Although *satisfaction with services* is not necessarily an indicator of person-centredness, it can point to positive or negative responses to care by service users and is included in this section.

Table 5:	person-centeredness
Person-centredness of services	**Positive experiences of mental health services**. It was noted across studies that many LGBTQ+ people had positive experiences in services, indicating that service providers were knowledgeable, welcoming, empathic and caring (Charter et al., 2022; Erasmus et al., 2015; Haire et al., 2021; Lim et al., 2021; Mackie et al. 2023; Saunders et al., 2023), supportive (del pozo de Bolger et al., 2014), compassionate and non-judgemental (Lim et al., 2021; Martin et al., 2019a). Data indicate that health professionals could also be perceived positively, including doctors (Haire et al., 2021; Harrison et al., 2020; Hawkey et al., 2021), nurses (Hawkey et al., 2021), counsellors, psychologists, and psychiatrists (Charter et al., 2022; Hawkey et al., 2021; Saunders et al., 2023). For example, trans and gender diverse people, who were a subset of a UK study population (6,333 of 840,691 survey respondents) reported generally positive experiences with accessing a GP (80%) or making an appointment (71.4%), although they were more likely to report very good or very poor experiences in these services (Saunders et al., 2023). Some carers of LGBTQ+ people also reported positive care experiences, which were often the result of people with lived experience of mental health challenges being treated empathetically and respectfully by mental health staff (Martin et al., 2019a). In another study by Martin et al. (2019b) carers rated allied mental health services, GPs, and paramedic services as the most helpful. **Inconsistent and poor-quality care experiences.** Data indicated that experiences with service providers were often inconsistent and of poor quality. For example, although GPs were perceived positively, they could be “visibly uncomfortable with dealing with mental health” issues (Reynish et al., 2023); and despite positive experiences with some health professionals, carers of LGBTQ+ people reported a lack of information and choice in mental health services, and a lack of opportunity to collaborate in mental health care decisions (Martin et al., 2019b). Experiences with online mental health services was also inconsistent. Although they could be perceived as more accessible for young LGBTQ+ people, they were also described as complex, and concerns were expressed that they were used to replace face-to-face services (Bowman et al., 2020). **Poor perception of inpatient mental health services.** Inpatient mental health services perceived by service users, who in qualitative interviews described them as understaffed, dirty, and lacking in privacy, with highly restricted measures such as limits on phones, visiting hours, and internet use (Robertson et al., 2015). Additionally, LGBTQ+ people with lived experience reported that they or their family/carer was not included in decision-making, which was experienced as profoundly disempowering and damaging to relationships with service providers (Robertson et al., 2015).

Table 5:	person-centeredness
	A lack of referral pathways and service integration. Two studies reported poor referral pathways and integration of services. For example, a qualitative UK study of LGBTQ+ adults using alcohol treatment services reported a lack of linkage between alcohol and mental health services, and a desire for integration of services to attend to their complex and interconnected health and wellbeing needs (Dimova et al 2022). People with co-occurring mental health, drug, and alcohol issues also noted a heightened fear of judgement. For example, McNair et al (2018) found that the most reported barrier to service use for same-sex attracted women engaging with mental health and/or alcohol-related health services was the concern about being judged about their mental health or alcohol use.
Satisfaction with services	**Six studies reported on satisfaction with services.** Lim et al., (2021) reported that trans and gender diverse youth in Australia were slightly satisfied (21%), moderately satisfied (14%), very satisfied (25%), or extremely satisfied (7%) with crisis helpline counsellor interactions. However, studies more often reported mixed and sub-optimal levels of satisfaction with mental healthcare providers (Charter et al., 2022; Davies et al., 2013; Haire et al., 2021; Lim et al., 2021; Saunders et al., 2023). For example, although sexuality diverse people reported positive experiences with crisis helpline counsellors (Lim et al. 2022), trans and gender diverse people were less likely to use crisis helplines, and those who did commonly reported negative experiences and were not satisfied with service provision (Lim et al., 2021). Unexpectedly, while high levels of dissatisfaction with both mental health practitioners and Standards of Care were found in an Australian study of 161 trans people, these did not appear to have impacted on mental health care experiences (Ho & Mussap, 2017). However, it should be noted this pattern was not reported in any other study included in this review.

3.3.4 Equity

Equity examines whether services vary in quality based on the characteristics of service users. This domain is particularly pertinent to LGBTQ+ people, who may experience inequity based on sexuality and gender in health service contexts. This domain also draws attention to equity for LGBTQ+ people with intersectional experiences.[21]

Forty-three studies reported on equity issues for LGBTQ+ people in mental health and suicide prevention services. In the following section themes related to equity issues for all LGBTQ+ people are presented, including: *inconsistent service provision; knowledge and*

[21] Intersectionality theory has been used to draw attention to the heterogeneity of LGBTQ+ populations and the dynamic and abrasive character of oppression at the intersection of sexuality, gender and other social structures, including race, culture, disability, age, geographic location and social class etc. (Rivas-Koehl et al. 2023).

knowledge deficits; *microaggressions*[22] (hetero- and cis-normativity, misgendering and invalidation); *pathologising LGBTQ+ people*; *promoting equity*; *equity in LGBTQ+ specific services*. *Intersectionality and equity* are also presented for youth, First Nations people, culturally and linguistically diverse people, people from low-socioeconomic backgrounds, and people living in rural locations.

3.3.4.1 Service inconsistency, knowledge, microaggressions and pathologisation

Table 6:	service inconsistency, knowledge, microaggressions and pathologisation
Inconsistent service provision	**Positive experiences**. Australian mental health services were described by some LGBTQ+ people as welcoming and connected to LGBTQ+ communities (Haire et al., 2021). A number of studies reported that health professionals were perceived positively by many trans and gender diverse people. Examples in Australia studies include crisis helpline staff described as non-judgemental (Lim et al., 2021); medical doctors perceived as "on the ball" and able to provide accurate and helpful information on gender-affirming care (Haire et al., 2021); therapists experienced as being knowledgeable, present, and empathic, and as a "lifesaver" for trans people (Charter et al., 2022, p.314). As a trans person stated: *"I felt that (my Mental health provider) really listened to me and to what I needed from him and I respected that."* (Charter et al., 2022, p.314). Although experiences with crisis helplines varied, Lim et al. (2021) found that they could be a useful resource to trans and gender diverse people if helpline staff indicated acceptance towards gender identity, even if they lacked knowledge of trans and gender diverse specific mental health concerns (e.g., gender dysphoria). Value of safe disclosure of sexual orientation. Safe disclosure of sexual orientation to a GP was strongly associated with use of mental health or alcohol services, and could engender trust of health services more broadly (McNair et al., 2018). A study of 2,657 bisexual people in Australia, also found that bisexual adults were more likely to feel comfortable disclosing their sexual orientation to a health care provider if they had previously had a positive experience making such a disclosure to a health professional (Taylor et al., 2021). This is significant, as fears around disclosure of sexuality can deter bisexual people from attempting to access health services. Mixed and poor experiences. Even when positive findings were reported, most studies reported negative findings, including staff knowledge deficits,

[22] Microaggressions have been described as commonplace, 'everyday', intentional, and unintentional interactions that communicate bias toward, or exclude, people who are historically marginalised (Sue & Spanierman, 2020, p.7).

Table 6:	service inconsistency, knowledge, microaggressions and pathologisation
	experiences of micro-aggressions and pathologisation, and other equity issues, which are described in detail below. Many studies described mixed experiences in services related to equity. For example, Charter et al. (2022) reported that 80% of trans and gender diverse people (n=66) in their study who accessed mental health supports had mixed experiences, with 10% reporting only positive or only negative experiences (Charter et al., 2022). Strauss et al (2021a), who investigated the experiences of young gender diverse people in Australia also found that overall, most participants (n = 404; 60%) felt isolated from mental health services; although no differences in feeling isolated from services were found between participants with and without a diagnosis of an autism spectrum disorder (Odds Ratio = 1.143 [95%CI: 0.784 - 1.667), p = 0.486). As detailed below (microaggressions, pathologisation) particularly poor experiences were reported in emergency and inpatient mental health services (Martin et al., 2019b; Robertson et al. 2015).
Knowledge and knowledge deficits	**Knowledgeable therapists.** Positive interactions with therapists with training in trans health, or who made efforts to educate themselves about trans and gender diverse people, were reported in an Australian study of parents who are transgender (Charter et al., 2022). Two further studies showed that health professionals who had received training, and had clinical experience working with trans people, were more likely to hold positive attitudes towards trans and gender diverse people and provide competent care (Riggs & Bartholomeaus, 2016a, 2016b). In a qualitative study, one trans person explained the value of health professionals taking responsibility for learning about trans mental health: *"My therapist was great. She went away after our sessions and did lots of research… any time I introduced something new she worked it out herself and it took a lot of the pressure off me. I really appreciated that*." (Charter et al., 2022, p.314) Martin et al. (2019a) reported that mental health professionals were also viewed more positively if they demonstrated awareness of LGBTQ+ communities and how community connection can shape recovery processes. Knowledge deficits. Knowledge deficits among mental health professionals were reported across 13 studies, including a lack of knowledge of: sexuality and gender diversity; the life experiences of LGBTQ+ people, including experiences of gender dysphoria; and family and kinship networks in LGBT communities. It was frequently reported that Australian LGBTQ+ people had difficulty finding knowledgeable and inclusive health professionals (e.g., Haire et al., 2021; Pullen Sansfaçon et al., 2023). A lack of knowledge about diverse

Table 6:	service inconsistency, knowledge, microaggressions and pathologisation

sexualities was perceived as a barrier to effective care, including a lack of knowledge about appropriate terminologies or heterogeneity of sexualities, and a lack of understanding of the social experience of being a person with a diverse sexuality (Morris et al. 2022; Lim et al. 2022; Taylor et al., 2021). For example, Taylor et al (2021) report that while half of the bisexual research participants who disclosed their sexuality to practitioners found the experience positive, 67% felt that health professionals generally were not at all, not very, or some are and some are not, knowledgeable about bisexuality. In Australian studies by Riggs and Bartholameaus (2016a, 2016b), psychiatrists and mental health nurses had the lowest reported levels of knowledge compared to other mental health practitioners (e.g., counsellors, psychologists, social workers).

Lack of knowledge of gender diversity. Mental health professionals often lacked knowledge about trans and gender diverse people, including their mental health needs (del pozo de Bolger et al., 2014; Charter et al., 2022; Lim et al., 2021; Pullen Sansfaçon et al., 2023; Riggs et al., 2014; Riggs & Bartholameaus, 2016a, 2016b, Taylor et al. 2021). Gender diverse participants found it particularly difficult to find health professionals who were adequately trained in trans and gender diverse people's health outside of gender-affirming clinics (Pullen Sansfaçon et al., 2023), such as a lack of knowledge about gender dysphoria (Lim et al., 2021). Trans and gender diverse people reported negative experiences with mental health providers in emergency departments (Pullen Sansfaçon et al., 2023), as well as "having to educate" health professionals about trans people (del pozo de Bolger et al., 2014, p.400).

Lack of knowledge of LGBTQ+ family and kinship networks. One study found that providers may also have limited understanding of LGBTQ+ family and kinship networks. Martin et al. (2019b) found that carers of LGBTQ+ people believed that their caring role was often devalued, and they were not notified of the person's diagnosis, or that they could not be registered as a nominated person or carer. Carers were left unsure of the willingness of health professionals to work with LGBTQ+ clients and families (Martin et al., 2019b).

Burden of reliance on LGBTQ+ people for education. In lieu of training, Australian research indicated that health professionals in mainstream services often relied on LGBTQ+ people for information and education (Charter et al., 2022; del pozo de Bolger et al., 2014; Haire et al., 2021; Mackie et al., 2023; Riggs et al., 2014). As one school psychologist stated:

> *"They [*trans *and gender diverse youth] teach you a huge amount. […] there's things like deadnaming [use of pre-gender transition name] that I had no idea about"* (Mackie et al., 2023)

While learning from LGBTQ+ service users was commonplace, three studies reported that it was experienced as burdensome to trans people

Table 6:	service inconsistency, knowledge, microaggressions and pathologisation
	(Charter et al., 2022; Haire et al., 2021; Lim et al., 2021). In a qualitative study, a trans person expressed frustration and concerns that health professionals did not wish to learn, stating: *"I've seen some who just don't seem to understand (being trans), and don't seem to want to... You feel like you have to educate them about* absolutely *bloody everything."* (Charter et al., 2022, p.314) **Impacts of knowledge on service use.** The perception that healthcare providers lacked appropriate knowledge could also influence choices about whether to engage with mental health services, and whether to disclose sexuality with practitioners (Taylor et al., 2021). In a study of 592 same-sex attracted bisexual and queer men and women, Cronin et al (2021) found that 64.4% of participants reported that "a lack of professionals competent to work with LGB people [lesbian, gay, and bisexual]" was a barrier to their mental health help seeking, and 53.8% reported "at least some concern about being treated unkindly or unfairly". This study also found that declining to care for lesbian, gay and bisexual people was perceived as a "slight problem" among health professionals by 32.4% of participants, with 8.9% indicating it was a "major problem" (Cronin et al., 2021).
Micro-aggressions *Hetero- cis-normativity*	Ten studies in in this review examined issues related to micro-aggressions, including hetero- and cis-normativity, misgendering, and invalidation. **Hetero- and cis-normativity was commonplace.** Hetero- and cis-normativity refers to the privileging of heterosexual and cisgender identities in social institutions, and the mistaken assumption that all people are heterosexual and cisgendered (Kurdyla, 2022), as well as the rendering of LGBTQ+ people as 'other' or 'abnormal' (LeFrancois, 2013). It was reported across 10 studies that LGBTQ+ people were exposed to hetero- and cis-normative assumptions in mental health services (Charter et al., 2022; del pozo de Bolger et al., 2014; Haire et al., 2021; LeFrancois, 2013; Lim et al., 2021; Martin et al., 2019b; Morris et al., 2022; Pullen Sansfaçon et al, 2023; Rivers et al., 2018; Robertson et al., 2015). Multiple studies indicated that health providers routinely assumed people were heterosexual or cisgender (Charter et al., 2022; del pozo de Bolger et al., 2014; Haire et al., 2021; LeFrancois, 2013; Lim et al., 2021; Martin et al., 2019b; Morris et al., 2022; Pullen Sansfaçon et al , 2023; Rivers et al., 2018). For example, Rivers et al.'s (2018) qualitative study found that family therapy was experienced as frustrating to a young gay man who was struggling with distress and alienation related to sexuality but when assumed to be heterosexual by the therapist, did not feel safe to disclose

Table 6:	service inconsistency, knowledge, microaggressions and pathologisation
	his sexual orientation (Rivers et al., 2018). In a detailed ethnographic study, LeFrancois (2013) found that sexual orientation was closely monitored in inpatient youth mental health settings, and it was consistently relayed to young people that heterosexuality was the norm and that same-sex relationships were to be avoided.
	Hetero-normativity was a barrier to service access. Sexuality diverse adults referred to psychological services in the UK indicated, in a qualitative study, that assumptions of heterosexuality were a barrier to effective relationships with their mental health care providers, as was anticipation of "discrimination, unconscious bias, or stereotyping" (Morris et al., 2022). One participant explained that these fears arose because people with diverse sexualities have "been judged previously, and it's that fear of that happening again" (Morris et al., 2022). Further, bisexual participants expressed unique anxieties about responses to their sexuality, worrying that "practitioners would brand them as confused, attention-seeking or hypersexual" (Morris et al., 2022). In cases where there was not fear about disclosing sexuality, participants still expressed apprehension about discussing topics relating to their sexuality (such as physical or romantic intimacy) due to anxiety about not being understood (Morris et al., 2022). **Routine misgendering.** Data from seven studies indicated that trans and gender diverse people were routinely misgendered in mental health services, which included misuse of names, titles, and pronouns (Charter et al., 2022; del pozo de Bolger et al., 2014; Haire et al., 2021; Lim et al., 2021; Morris et al., 2022; Pullen Sansfaçon et al , 2023; Robertson et al., 2015). Studies also reported incidents of health professionals referring to them by their old name (sometimes referred to as 'deadnaming') (Charter et al., 2022; Haire et al., 2021). Importantly, misgendering was not necessarily a one-off occurrence, and could be persistent and repetitive, and continue despite efforts by the person to stop this behaviour (Charter et al., 222). As one trans person explained:
Micro-aggressions *Misgendering and invalidation*	*"He (the mental health professional) kept saying things like, "when you used to be a woman this or when you used to be a woman that" even though I had repeatedly explained to him that I didn't like him doing this… I would tell him' "listen, I have always been trans ok? I was never a* woman*". But he just couldn't understand… it made sessions very uncomfortable for me."* (Charter et al., 2022, p.314-315) **Misgendering detracted from therapeutic benefits.** Misgendering was reported to detract from the therapeutic benefits of, and undermine confidence in, services, and promoted fears of encountering transphobia

Table 6:	service inconsistency, knowledge, microaggressions and pathologisation
	(Lim et al., 2021). A trans person in Charter et al. (2022) summed up how common these kinds of experiences were: *"I have honestly had very few positive experiences with [mental health professionals], and I've seen quite a few over the years."* (p.314) **Low acceptance of gender diversity in inpatient settings.** Inpatient settings may have the lowest acceptance of gender diversity. In an analysis of data from the Trans Pathways study, Strauss et al. (2021b) reported on 'gender acceptance' in services (i.e., level of respectful engagement with the person's gender identity). They rated higher gender acceptance in therapy and counselling services (71.9%, n = 279) and psychiatric services (64.0%, n = 162) than inpatient mental health services, which received the lowest rating (rated as respectful or mostly respectful by only 34.0%, n = 18) (Strauss et al., 2021b). **Invisibility and invalidation of LGBTQ+ identities or relationships.** Four studies discussed invalidation or denial of sexual orientation or gender identity (del pozo de Bolger et al., 2014; Haire et al., 2021; Pullen Sansfaçon et al., 2023), or LGBTQ+ relationships (Martin et al., 2019b). For example, Pullen Sansfaçon et al. (2023) qualitatively report on a young trans man who was told that his interest in ballet meant that he could not be trans and must be a "type of lesbian" (p.65). Robertson et al. (2015) described how lesbian and gay adults on acute inpatient mental health wards, not only reported that their sexuality became invisible when health care providers failed to ask about their partners or intimate relationships, but also that discussion about same-sex relationships could be met with embarrassment or silence.
Pathologising LGBTQ+ people	Pathologisation of sexual orientation or gender identity in mental health services was reported across 10 studies, particularly within qualitative data. **Fixating on sexuality or gender as the cause of distress** Pathologisation, as an assumption that gender was the cause of distress was reported across five studies (Charter et al., 2022; Haire et al., 2021; Lim et al., 2021; Morris et al., 2022; Pullman Sansfaçon et al., 2022). For example, one trans person noted that: *"My mother died about a couple of years ago and it was a very, very difficult time… The grief was very overwhelming… I was very distracted with (caring for my children). My GP put me in touch with a counsellor and it was a mess (laughs)… They were just so fixated on my transition (which had occurred many years previously) and, you know, my being trans I suppose. It totally overshadowed the way they approached and talked to me. Like*

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> *actually, I am not just my gender (laughs). I have a whole life going on."* (Charter et al., 2022, p.315)

Sexuality diverse adults with experience of a psychological referral in the UK also reported pathologisation, which took the form of practitioners assuming their presenting mental health issues were related to their sexual orientation, indicating that "sexuality was perceived as inherently pathological and that their mental healthcare needs were subsumed in their sexuality" (Morris et al., 2022). Practitioner insistence on a link between sexuality and mental health, even when clients refuted this, was experienced as detrimental to recovery (Morris et al., 2022).

Explicitly pathologising sexual orientation and gender identity. Pathologisation also included explicit linking of sexual orientation or gender identity to mental illness (Mackie et al., 2023; Morris et al., 2022; Robertson et al., 2015; Strauss et al., 2021b). For example, two studies reported that some individuals had experienced mental health professionals pathologising their sexual orientation (Morris et al., 2022; Robertson et al. 2015). As one lesbian woman receiving care in an inpatient unit stated:

> *"The psychiatrist said] that my, my, my problems were emotional and* that *being lesbian or gay was, was a contributory factor to my, to my mental health."* (Robertson et al., 2015, p.272)

Inpatient services and pathologisation. Qualitative research undertaken with lesbian and gay adults in acute, inpatient mental health services found that all participants had experienced negative attitudes about their sexuality including pathologisation (Robertson et al., 2015). Strauss et al. (2021b) also reported that trans and gender diverse youth in inpatient services were openly told that they were delusional and that their gender identity did not exist.

As Robertson et al. (2015) state, for LGBTQ+ people this could exacerbate their sense of stigmatisation, which was experienced as detrimental to recovery (Robertson et al. 2015).

Pathologisation of LGBTQ+ people and sanism. LeFrancois (2013) was the only study to examine intersectional experiences of LGBTQ+ people with mental health challenges, exploring the link between pathologisation of sexual orientation, and sanism. Sanism refers to prejudicial attitudes towards people with a lived experience of mental health challenges and suicidality (Perlin, 2003). LeFrancois (2013) provide a thought-provoking analysis of inpatient mental health settings, arguing that entrenched sanist attitudes towards people with lived experience led to "normative conceptualisations" of mind and emotions that intersect with hetero-normativity and create hostile environments for people of diverse sexualities, and heterosexual people who express same-sex affection. In

Table 6:	service inconsistency, knowledge, microaggressions and pathologisation
	this context, diverse sexualities came to be depicted as “abnormal”, “immoral”, and in need of reform (LeFrancois, 2013).
Promoting equity	Findings from seven studies related to how mental health services might attend to equity issues. **Modification of services.** Two studies examined ways to modify services to meet the specific needs of LGBTQ+ people. Bond et al (2017), reported on a Delphi study undertaken with 75 mental health professions providing services to LGBTIQ+ people, which aimed to develop guidelines for the delivery of LGBTQ+ specific mental health first aid. The recommendations for LGBTQ+-specific mental health first aid highlight the common assumptions health providers make, and proposes specific actions to support LGBTQ+ people. Importantly, the study highlights how the diversity of the LGBTQ+ community can be harnessed to develop an accessible, culturally appropriate, and inclusive mental health intervention. A study by Cheung et al. (2020) also indicated that services need to be extended to particular population sub-groups. By analysing the characteristics of 895 trans and gender diverse clients attending clinical settings in Melbourne, Cheung et al. found that an increasing proportion of clients identified as nonbinary and this requires further tailoring of services for this population, particularly in view of the high prevalence of depression, anxiety, and drug use among nonbinary people. **Community recommendations for improvement.** Three studies examined community recommendations for improvement of services (Bishop et al. 2022; Morris et al., 2022; Pennay et al. 2018). Morris et al. (2022) interviewed 26 lesbian, gay, bisexual, queer, and non-heterosexual adults with experience of referrals via the Improving Access to Psychological Therapies or primary care counselling services in the UK; and Pennay et al. (2018), interviewed 25 lesbian, bisexual, and queer women about their experiences of mental health and alcohol and other drug (AOD) services. Areas for service improvement from both studies centred specifically on the provision of affirming support, including: inclusive language and related terminology (Morris et al., 2022; Pennay et al., 2018); understanding the challenges associated with belonging to a sexual minority group including experiences of discrimination, and the process of coming out; explicit acknowledgement of sexuality in care contexts (Pennay et al., 2018), and use of visual signs to signal inclusivity in health services (e.g., displaying posters and pamphlets regarding sexual minority specific services that provided information about practitioner training/knowledge about diverse

Table 6:	service inconsistency, knowledge, microaggressions and pathologisation
	sexualities) (Morris et al., 2022); and access to practitioners with diverse sexualities or with lived experiences of discrimination (Morris et al, 2022). Importantly, the authors acknowledge that participants held different views about these key messages, demonstrating that a one-size-fits all approach for sexually diverse clients is not appropriate (Pennay et al. 2018). For example, not all participants expressed a preference for treatment from health care professionals with shared sexual identities or experiences, although many respondents believed that this would help ensure they were understood, and were not discriminated against when they sought care (Morris et al., 2022). **Importance of inclusivity.** A mixed-methods study undertaken with 274 sexuality diverse adults measured the importance of inclusivity practices in mental health settings – as articulated in a modified version of the Gay Affirming Practices Scale – to determine LGBTQ+ community support for inclusivity practices (Bishop et al. 2022). Specific practices that were listed for endorsement align with those put forward by Morris et al. (2022) and Pennay et al. (2018), including visual cues in waiting rooms, explicit acknowledgement, and development of knowledge and skills in health providers. Additionally, Bishop et al. (2022) found endorsement for: assisting sexuality diverse people to develop supportive networks; challenging misinformation; helping clients develop positive identities; learning about issues affecting sexual minority couples; addressing discrimination in treatment; assisting clients in reducing shame; and learning about support resources for sexuality diverse people. All items received positive endorsement, with approximately 80% of participants indicating they agreed or strongly agreed with all items. **Appetite for inclusive practice.** Kilicaslan and Petrakis (2019) report on outcomes related to the 'HOW2 Program', which indicates an appetite among health care professionals to improve provision of equitable care. The HOW2 Program is a professional development program delivered to a mainstream mental health service in metropolitan Victoria. Kilicaslan and Petrakis (2019) found that the majority of the 125 mental health professionals who had completed the program (61%) reported having 'some knowledge' of LGBTQ+ issues, and when asked if they wanted to learn more, the overwhelming majority (93%) responded in the affirmative.

3.3.4.2 Equity in LGBTQ+ specific services

Table 7:	Equity in LGBTQ+ specific services
Equity in LGBTQ+ specific services	**Equitable provision of services**. Positive equity experiences were more consistently reported in studies of LGBTQ+ or gender-specific mental health providers and services (Charter et al., 2022; Erasmus et al., 2015; Haire et al., 2021; Hawkey et al., 2021; Lim et al., 2021). This is an important finding and indicates that LGBTQ+ and gender-specific services are often more acceptable to LGBTQ+ people than mainstream services. For example, Trans and gender diverse people in Australia reported that these services had a better understanding of the needs of trans and gender diverse people (Charter et al., 2022; Haire et al., 2021; Hawkey et al., 2021) and were able to provide appropriate referrals that met the needs of First Nations trans and gender diverse people and LGBTQ+ people of colour (Haire et al., 2021; Hawkey et al., 2021). Meeting the needs of sub-populations. Some studies highlighted the need for LGBTQ+ specific services to be adapted sufficiently to provide relevant and high-quality offerings to different subsections of LGBTQ+ communities. For example, studies indicated that stigma and discrimination in service provision can be heightened for individuals who are not cis-gender, gay, or lesbian identified (e.g., queer, bisexual etc) (Brener et al., 2023; Lyons et al. 2022; McNair & Bush 2016; McNair et al. 2018). Erasmus et al. (2015) discuss feedback from clients that demonstrated that satisfaction with service offerings was good overall, but that there was a lack of offerings for particular groups such as adult trans men. Similarly, a study by Tollit et al., (2023) analysing retrospective clinical data of 395 gender diverse youth attending a paediatric gender service, highlighted the need for more tailored care that meets the complex needs of trans and gender diverse children and adolescents. Taylor et al., (2021) found that just over half of the bisexual people who participated in the Who I Am study stated that they would like increased access to health services which specialise in the provision of care for bisexual people (Taylor et al., 2021). This was most common amongst trans and gender-diverse bisexual people (67%), although 55% of cisgender women and 42% of cisgender men also reported a need for increased access to services (Taylor et al., 2021). Finally, McNair and Bush (2016) found strong support for the provision of strengths-based, targeted, psycho-social mental health promotion for same-sex attracted women, that shares knowledge about “specific issues” affecting their mental health including “marginalisation both from mainstream and LGBTI communities”. **Adapting interventions**. Data also indicate a need for the provision of mental health and other health services which have specifically been

Table 7:	Equity in LGBTQ+ specific services
	developed for, and are intended to service, sexuality diverse people seeking mental health support. For example, sexuality diverse adults with experience of referrals to Improving Access to Psychological Therapies or primary care counselling services in the UK, identified tailored support as a key area for mental health service development (Morris et al., 2022). They noted that such services would facilitate sexually diverse people to seek support earlier, reduce fears about prejudice and discrimination in mental health services, and reduce pressure on mainstream services (Morris et al., 2022).

3.3.4.3 Intersectionality and equity

Rivas-Koehl et al. (2023) have drawn attention to the heterogeneity of LGBTQ+ populations, and the dynamic and abrasive character of oppression at the intersection of sexuality, gender, culture, race, social class, or due to age or geographic location. As LeFrancois (2013) states, it is not possible to pull these aspects of self apart and *"whenever we are speaking about sexuality, gender and class, we are always speaking about race, including the enveloping realm of whiteness".* LeFrancois (2013) also makes the point that gender, sexuality, and mental distress ***comprise an intersectional experience*** that leads to a specific form of experience, including of stigma and discrimination in health services. This is explored in relation to sexuality diverse youth below.

In the following section, studies that examined intersecting experiences are highlighted, including *age* (LGBTQ+ youth), *First Nations LGBTQ+SB people*, *LGBTQ+ people from CALD backgrounds*, *LGBTQ+ people with low income*, *and LGBTQ+ people in rural areas.*

Table 8:	intersectionality and equity
Age *Sexuality diverse youth and young adults*	Nine studies reported on service delivery to sexuality diverse youth, including examining mental health service access, and service and care approaches. **Mental health service access.** Evidence suggests that sexuality diverse youth experience higher levels of mental distress, and greater stresses than opposite-sex attracted peers. For example, Roberts et al. (2018) show that same-sex attracted adolescents in rural Australia have an increased likelihood of mental health challenges and higher stressors than their heterosexual peers. Same-sex attracted youth participants also reported increased experience of stressors associated with interpersonal relationships (e.g., family members, teachers, school peers) and due to "bullying at home and physical assault". However, Roberts et al. (2018) found that these same-sex attracted adolescents did not experience greater barriers to accessing mental health support in rural South Australia ($U = 4120$; $p = 0.21$), nor did they report being less comfortable help-seeking than heterosexual participants ($U = 4536$; $p = 0.80$). The authors speculate that this may suggest that services in rural South Australia have good competencies in supporting sexuality diverse clients, and may also reflect wider public acceptance of sexuality diverse people. However, the Roberts et al. (2018) note that same-sex attracted youth reported 'other' (undefined) barriers to help seeking at higher rates than heterosexual peers, and suggest that qualitative research investigating these additional barriers is required to fully understand help seeking experiences for rural youth. A cross-sectional survey study by Hughes et al. (2018) among mental health staff from three National Health Service trusts in England, may shed some light on these issues. Researchers found high levels of reported awareness among 113 mental health care staff concerning distress in LGBTQ+ youth, with very few participants dismissing distress or self-harming behaviour in this cohort (Hughes et al., 2018). However, participants identified a range of barriers that prevent LGBTQ+ youth from engaging with mental health services, with the main barrier being a lack of awareness of existing services, followed by fear of not being understood by workers, as well as the stigma associated with receiving a mental health diagnosis (each higher than 90%) (Hughes et al., 2018). Additionally, factors directly associated with service providers were rated highly, with agreement around 90%, including: fear of judgement or not being taken seriously, and potential lack of knowledge among staff regarding LGBTQ+ issues (Hughes et al., 2018). Rivers et al.'s (2018) qualitative study supports this finding, suggesting that a lack of awareness and training around LGBTQ+ youth issues hindered provision of care to this group (Rivers et al., 2018).

Table 8:	intersectionality and equity
	Difficulty disclosing sexual orientation. Youth and young adults may also be less comfortable disclosing sexual orientation. Taylor et al (2020) report on research undertaken with bisexual adults (18+), which found that participants who were younger in age were significantly less comfortable disclosing their sexuality to their health providers, than those who were older. They note that, "understanding patterns of non-disclosure of sexual orientation among bisexual people is a necessary step towards improving the mental health of this population with previous research revealing that non-disclosure in itself is a significant predictor of future mental health" outcomes (Taylor et al 2020). Similarly, LeFrancois (2013) highlights the highly heteronormative character of inpatient youth mental health services, and how this can impact on disclosure of sexual orientation. **Need for specialized services.** Research suggests that youth require specialised services to support effective treatment. For example, Yang et al (2021) reported on outcomes for the first year of delivery for the Comprehensive Assessment Service for Psychosis and At-risk (CASPAR) Service. This community-based service provides assessment and a short-term early intervention in youth (12-25 years) with "emerging mental health issues" (Yang et al., 2021). Although Yang et al. (2021) did not distinguish between sexuality and gender in their study, they found that under 25% (n=21) of participants who reported on their sexuality, identified as lesbian, gay, bisexual and/or trans. Participants who disengaged from treatment at study follow up were also most likely to be those who identified as sexuality or gender diverse (P=.025), with no additional clinical or demographic differences evident between participants who were engaged or disengaged (Yang et al., 2021). The authors conclude that, although lesbian, gay, bisexual, and transgender clients initially utilised CASPAR, "tailored efforts to ensure their continued engagement are needed, possibly through enhanced collaboration with LGBT+ specific community services" (Yang et al., 2021). **Value of online services.** There are indications that the internet broadly, and e-therapies specifically, may have potential to enhance LGBTQ+ youth's mental health. Lucassen et al (2018) found that LGBTQ+ youth use the internet to support their mental health including via information gathering and to gain support. Further, they found that gamified e-therapeutic content was acceptable to young people and produced positive effects, but cautioned that content should be carefully developed and tailored, and that safety and privacy considerations from users should be paramount (Lucassen et al., 2018). Bowman et al. (2020), also present a small qualitative study assessing how lesbian, gay, bisexual, and transgender youth in rural Australia experience online mental health services. The authors found that internet-

Table 8:	intersectionality and equity
	based mental health care has potential, but issues around "availability, anonymity, privacy and connectedness" need to be considered. They concluded that providers need to work with LGBTQ+ youth in rural areas to design services to ensure they met the complex needs of these communities.
Age *Trans and gender diverse youth*	Seven studies reported on service provision to trans and gender diverse youth. Data suggests that trans and gender diverse youth accessed mental health services for support with multiple mental health issues, including general mental health concerns (depression, anxiety, and suicidal thoughts and behaviours) and gender-related mental health issues (gender dysphoria, gender transition), as well as for non-specific issues e.g., "to get help", and to gain access to gender transition-related services (hormones, surgery, legal gender affirmation) (Strauss et al., 2021b). **Mixed experiences in mental health services.** Most youth reported mixed experiences in mental health services, and often saw multiple providers before finding an affirming professional who could respond to their needs (Strauss et al., 2021b). Private psychologists, public mental health services, *headspace* (youth focused mental health services), school psychologists and counsellors were mostly reported by trans and gender diverse youth as "respectful or mostly respectful" of the person's gender (71.9%), with most young trans and gender diverse people reporting satisfaction with services (60%), and relatively short wait times (one month or less) (76.8%) (Strauss et al., 2021b). **Factors in positive experiences.** Strauss et al. (2021b) found that favourable experiences were more likely if services were respectful and staff were well informed and provided consistent support, including support to access gender-affirming medical care. Data indicated that positive interactions with a knowledgeable, competent, and gender-affirming therapists could support parents and transgender and gender diverse youth to navigate the transition process (Pullen Sansfaçon et al., 2023), and played a "crucial role" in boosting parental confidence in supporting their trans or gender-diverse child (Pullen Sansfaçon et al., 2023, p.67). As noted previously, access to puberty blockers for trans and gender diverse youth was also reported to have a positive impact on mental health (Pullen Sansfaçon et al., 2023). **Equity and school counselling.** Psychologists acting as school counsellors in Australia were reported to create a safe, non-judgemental, and affirming environment for trans and gender diverse youth to explore their identities, and in many cases may provide one of the few places where youth could "safely express themselves" (Mackie et al., 2023). School psychologists also engaged in staff education and developed plans and policies in collaboration with trans and gender diverse youth as a

Table 8:	intersectionality and equity

means of affirming agency and changing the school environment (e.g., uniforms, toilets, physical education) (Mackie et al., 2023). The finding that school psychologists engaged in system change in collaboration with trans and gender diverse youth is important, and may have repercussions beyond the therapy room. As one school psychologist noted:

> *"We realised just how gendered a lot of our procedures and policies and networks are [. . .] and so having to go through with a fine-tooth comb to try and make sure we're minimising that [. . .] trying to have more conversations about respect and gender diversity and tolerance at all different levels and in different shapes and forms so that we can actually have a policy that is reflected, so that we know at each level there's some discussion around these kinds of key topics."* (Mackie et al., 2023)

However, Mackie et al.'s (2023) qualitative study is small (n=7), and while reports by psychologists are positive, it does not examine the experiences of trans and gender diverse youth accessing these school counselling services. Indeed, school psychologists reported low levels of understanding of trans youth issues and needs and had unmet needs for training in trans mental health, including how to manage suicidal youth, and how to link youth with trans-inclusive medical providers, mental health professionals and LGBTIQA+-specialised services (Mackie et al., 2023). One psychologist is quoted as stating that,

> *"I really don't know what I'm doing" (*Mackie et al. 2023).

Mackie et al. (2023) also found that school psychologists could pathologize trans youth, assuming they were mentally unwell and complicated, and could be surprised to meet trans youth who were calm, had social support, and who could benefit from "small changes", such as a haircut or finding a new friend (Mackie et al., 2023). School psychologists also reported feeling pushed by transphobic parents to "hunt" for "weak points" in a trans youth's reasoning about their gender identity (Mackie et al., 2023). As such, this could make it difficult for school psychologists to meet the needs of trans and gender diverse youth and address concerns of parents, with supportive parents creating a more helpful therapy context (Mackie et al., 2022). As a school psychologist stated:

> *"For students whose families aren't supportive, that can have a huge knock-on effect regarding the ease of the counselling process."* (Mackie et al., 2022)

Negative interactions. Other studies indicated that negative interactions with mental health providers were common (Pullen Sansfaçon et al., 2023; Strauss et al., 2021b). Negative interactions often related to misgendering, disrespect, invasive questioning, invalidation of concerns about gender (Pullen Sansfaçon et al., 2023; Strauss et al., 2021b), and "outdated" understandings about gender diversity, as well as unpleasant

Table 8:	intersectionality and equity

environments (Strauss et al., 2021b). Data also show that mental health professionals often had a lack of knowledge about the needs of trans youth (Mackie et al., 2023; Strauss et al., 2021b).

For example, although psychiatrists reported high confidence in caring for trans people (Riggs & Barholameaus, 2016b), studies demonstrate that trans youth have low levels of satisfaction in their interactions with psychiatrists (Riggs et al. 2015; Strauss et al., 2021b).

Gatekeeping in psychiatric services. Dissatisfaction with psychiatric services was linked to gatekeeping of gender-affirming treatments (Strauss et al., 2021b). For young people, prohibiting access to treatment and documentation could create a sense of losing autonomy over their own bodies and lives (Strauss et al., 2021b). As one youth was reported, psychiatrists' gatekeeping practices could also be perceived as implying deviance:

> *"The psychiatrist I visited was extremely arrogant and condescending and had a very strong 'gatekeeper' approach to trans healthcare. I felt like I had to prove that I was 'really' trans' (whatever the heck that means), despite living full time as female and having been on feminizing hormone therapy for over a year at that point. I strongly objected to this kind of treatment, since it started from the assumption that I was somehow lying or deluded about my gender."* (Strauss et al., 2021b, p.396)

Intersection of age and cisnormativity. As Riggs et al. (2015) note, it is likely that implications of deviance arise from cis-normativity, which is more likely to be imposed on youths who, due to their age and reduced less access to gender-affirming medical care. As stated previously (3.3.1 Timeliness), trans and gender diverse youth frequently reported difficulties and delays in accessing gender affirming care (Haire et al., 2021; Pullen Sansfaçon et al., 2023; Strauss et al., 2021a, 2021b).

Duress to 'prove' gender. Australian healthcare providers could also put young people under duress to "prove" they were trans, including pressure to adopt stereotypical gender behaviours (Pullen Sansfaçon et al., 2023; Strauss et al., 2021b).

For example, Pullen Sansfaçon et al. (2023) reported that nonbinary youth found it difficult to access affirming services, and felt under pressure to "prove" they were trans by adopting stereotypical binary trans narratives. Strauss et al. (2021b) also reported that for nonbinary youth, pressure from psychiatrists to conform to a binary transgender identity meant that they hid their true gender to gain access to services. As one nonbinary person cited in Strauss et al. (2021b) stated:

> *"I lied and said I was a binary trans man to gain access to the services I needed. The psych was very focused on gender norms and binary identities, and I felt judged and 'not trans enough'*

Table 8:	intersectionality and equity
	because of my hobbies are traditionally 'feminine' things." (Strauss et al., 2021b, p.396). **Invalidation of gender identity.** Qualitative data indicate that psychiatrists could also express the opinion that "nonbinary genders aren't real" (Strauss et al., 2021b, p.397). Additionally, trans and gender diverse youths' family members reported that mental health professionals refused to discuss issues related to gender in the context of therapeutic interventions, which would exacerbate distress for trans youth (Pullen Sansfaçon et al., 2023). **The intersection of age, gender, and neurodiversity.** Strauss et al. (2021a), who investigated the prevalence of autism among trans youth and young adults, as well as the mental health care needs of autistic young people, demonstrated that a significant portion of the Australian trans and gender diverse population are autistic and identify as nonbinary, and that this population report higher rates of mental health challenges, as well as more barriers to accessing gender-affirming care. This finding suggests that neurodiverse LGBTQ+ youth may be even more disadvantaged in mental health services than other LGBTQ+ youth. **Inpatient settings.** Inpatient mental health services were often reported to be the most unsatisfactory mental health service setting, with trans and gender diverse youth indicating that they were "very" or "somewhat" unsatisfied with inpatient services (43.7%). Over one-third (36.9%) of youth found these services were "not respectful or mostly not respectful" of gender identity, and could be reported to be unsafe (Strauss et al., 2021b).
First Nations LGBTQ+SB people	**Limited findings.** Only two studies included in this SLR examined mental health service provision for Aboriginal and Torres Strait Islander LGBTQ+SB people (Hill et al., 2022; Uink et al., 2023). Uink et al (2023) report troubling inequities in terms of access to care and health services for Aboriginal and Torres Strait Islander LGBTQ+SB peoples, which were associated with "elevated risk for suicide, serious assault, homelessness and psychological distress". In addition, they note that there is a dearth of research about the population's needs and preferences for care and service provision, compounding access inequities (Uink et al 2023). **Few dedicated support or care organisations.** Few dedicated services exist for Aboriginal and Torres Strait Islander LGBTQ+SB people meaning many seek support from the following types of services: 1) Aboriginal specific organisations such as Aboriginal Community Controlled Health Organisations (ACCHOs), 2) LGBTQ+ specific services, or 3) non-Aboriginal specific, generalist services (Uink et al 2023). There is no data showing ACCHOs efficacy in support of LGBTQ+SB specific needs. Further, Uink et al. caution that LGBTQ+ specific and generalist services may not be able to address the care needs of people with intersectional needs, including Aboriginal and Torres Strait Islander clients. Research is

Table 8:	intersectionality and equity
	required to understand experiences and outcomes associated with accessing these services (Uink et al 2023). **Service barriers.** In a survey of the scant literature on Aboriginal and Torres Strait Islander LGBTQ+SB experiences of health and social services, Uink et al (2023) note that there are various barriers to accessing "appropriate care". These include; being misgendered by providers, having to educate practitioners about LGBTQ+ issues, and low access to services for trans people. Enablers for care included "external symbols of inclusion and embedding inclusive approaches to service and care" (Uink et al., 2023). As outlined above, these are barriers and enablers also reported by the wider LGBTQ+ community. Research focusing on Aboriginal and Torres Strait Islander service experiences broadly (beyond mental health services) indicate that "clinician confidence and communication" is an "essential enabler of effective care with Aboriginal and Torres Strait Islander individuals", as is having Aboriginal and Torres Strait Islanders staff, valuing Aboriginal perspectives on wellbeing, and representation of Aboriginal and Torres Strait Islander people in services (Uink et al 2023). This suggests that cultural competencies could address barriers to care. **Cultural safety in services.** Two papers (Uink et al., 2023 and Hill et al., 2022) report on research into service provision knowledge regarding Aboriginal LGBTQ+SB client needs. Uink et al (2023) focus on mental health service provision in Western Australia, while Hill et al (2022) engaged broadly with health and social services in Western Australia (2023). Both studies report that service providers acknowledge the importance of accommodating Aboriginal LGBTQ+SB clients. Despite this, both studies also found practitioner and service limitations in terms of cultural competency and readiness to support Aboriginal people. Further, both studies noted that providers who are guided by a person-centric care model (Hill et al 2022), or who strive to treat *everyone equally* (Uink et al 2023), often assume that the needs of First Nations LGBTQ+SB people will automatically be met due to this approach, and that additional accommodations need not be made. As Hill et al. (2022) observe, not only does this thinking fail to acknowledge and accommodate intersectional experiences and needs, but a focus on "treating everyone equally" can result in the erasure of difference (and different care needs), which means some LGBTQ+ people do not receive appropriate care, or may even receive "unsafe care" (2022). **Appetite for cultural safety.** Both studies conclude that there is a willingness from services and practitioners to "get it right" with First Nations LGBTQ+SB clients (Uink et al 2023). However, further education and training is required to ensure effective service provision (Uink et al

Table 8:	intersectionality and equity
	(2023), Hill et al (2022)). This would also help to address provider non-engagement with LGBTQ+SB identity, due to provider fears about being "disrespectful" or making mistakes when canvassing the issue (Uink 2023).
LGBTQ+ people from CALD backgrounds	**Limited findings.** Four studies examined delivery of mental health services/interventions to LGBTQ+ people from culturally and linguistically diverse (CALD) backgrounds (Hawkey et al., 2021; McNair & Bush, 2016; Robertson et al 2015; Williams et al. 2022), with two of these studies presenting limited findings on this topic. Most findings on LGBTQ+ people from CALD backgrounds relate to people of colour from culturally and linguistically diverse backgrounds. **Effectiveness of recovery-oriented approaches.** As described above (3.3.2 Effectiveness), Williams et al. (2022) report on The Quest intervention, which was designed for gay, queer, and bisexual men of colour (described as Black, Asian and Minority Ethic [BAME]), and delivered in the UK. This study demonstrates the importance of dedicated translational research that specifically aims to benefit culturally diverse populations. **Safety and inclusivity.** Hawkey et al. (2021) reported that, in Australia, access to gender-affirming care was perceived by trans women of colour participants as increasing safety, as they were less likely to be exposed to violence. McNair and Bush (2016), who present minimal information on CALD populations, reported that key stakeholders within the LGBTQ+ community emphasised the importance of inclusive mainstream services for minority same-sex attracted women who may not access LGBTQ+ specific services, including for older adults, people who are from CALD backgrounds, First Nations people, and people in rural and remote areas (McNair & Bush, 2016). **Racism in inpatient settings.** Robertson et al (2015) also qualitatively explored experiences of culturally diverse lesbian and gay adults on acute mental health wards. They report that some participants experienced racism and that this compounded "a sense of 'intolerance' on the ward that was threatening for participants and dissuaded partners from visiting" (Robertson et al., 2015).
LGBTQ+ people with low income	**Limited findings.** Six studies reported on equity issues related to the cost of mental health care. Findings are limited and indicate that further research around the costs of mental health care, and the impacts on LGBTQ+ populations from low socio-economic groups, may be warranted. **Cost of services.** Cronin et al. (2021) found that the most cited barrier to mental health services was the cost of services. Overall, these barriers more frequently affected participants living in non-urban areas (t(490) =

Table 8:	intersectionality and equity
	2.89, p = 0.004), as well as young participants compared to their older counterparts (F(2) = 5.92, p = 0.003) (Cronin et al., 2021). Strauss et al. (2021b) also found that psychiatric care was commonly reported as costly, and Haire et al. (2021) reported that trans and gender diverse people struggled to meet basic needs due to the costs of mental health care, particularly as they often had to access private providers, or make co-payments or full payment for medications. As one transgender study participant stated: *"My psychiatrist, he's sort of got me on a medication with a bipolar... you know, I've gotta pay full price. But, you know, what do you do sort of for those things, you know? It's 20 bucks instead of six dollars, so it's one thing but... and there is one other medication that I take, that he won't give me PBS [subsidised prescription] but the doctor will."* (Haire et al., 2021) Bretherton et al. (2020) reported that a meaningful proportion of Australian trans and gender diverse people experience difficulties in accessing hormone treatment for a variety of reasons, including not being able to find a doctor for a prescription (16%, n = 148), financial costs for doctor appointments (17%, n= 156) or the medications themselves (14%, n = 124), as well as experiencing the general pathway to access as too difficult (31%, n = 284). **Access to NDIS.** One study noted that people with lived experience of enduring mental health challenges also had limited access to the National Disability Insurance Scheme (NDIS) funding for psychosocial disability (Martin et al., 2019b)
LGBTQ+ people in rural areas	Seven studies reported on equity issues in relation to people living in rural locations. **Access in rural areas.** As noted above (3.3.1 Timeliness, and 3.3.4.2 Age), Roberts et al.'s (2018) found that these same-sex attracted adolescents did not experience greater barriers to accessing mental health support in rural South Australia. However, Cronin et al. (2021) found that lesbian, gay, and bisexual Australians in non-urban locations experience a higher number of general barriers to mental health care than those in urban areas (e.g., costs, long distances, shortage of health care professional, etc.), as well as greater minority-stress barriers to help-seeking then those in urban areas (e.g., social stigma, professionals not adequately trained to care for, or declined to care for, sexuality diverse people), although these were reported with a small effect size difference. However, contrary to previous research, no significant difference in mental health service use was found between urban and non-urban residents (Cronin et al., 2021). Reynish et al. (2023) also show that most LGBTQ+ people in rural areas were able to access a mental health professional that they did not need to educate about gender or sexuality diversity or sex

Table 8:	intersectionality and equity
	variations; and (as noted in 3.3.1 Timeliness) Lim et al. (2021, 2022) found that Australian crisis helpline services were perceived as extending access in rural areas for LGBTQ+ people. **Long wait times, limited mental health providers, and confidentiality issues.** In contrast, data indicated that it was still challenging for transgender people to access mental health services in rural areas, when compared to cisgender people, due to long wait times and a limited number of mental health professionals (Reynish et al., 2023). Charter et al., (2022) interviewed a number of Australian participants who lived outside major regional and rural areas. They noted that, for these participants, referrals to mental health services were particularly problematic. Importantly, this not only related to availability of services but also to issues of confidentiality. As one trans person stated: *"Confidentiality is my primary concern, for my family's safety. I don't feel like I can get that (in rural town). There's only one counsellor (in the area), that I'm aware of…* I *sometimes see a psychologist when I go to Melbourne but it's very few and far between… it's made things very difficult at times."* (Charter et al., 2022) LGBTQ+ specific service can be difficult to access generally, but these restrictions are heightened in rural contexts (McNair and Bush, 2016).

3.3.5 Safety

Safety examines whether services intended to help actually lead to harm. As noted earlier, this includes psychological and cultural, as well as physical harms. Safety issues related to mental health service provision were reported across eighteen studies. Key themes include: Safety and timely access; safety and inequity; traumatising mental health services; trauma and conversion practices; and safety and future access.

Table 9:	Safety
Safety and timely access	Safety issues were highlighted in relation to access to timely mental health care in four studies (Bailey et al., 2014; Martin et al., 2019a, 2019b; Pullen Sansfaçon et al., 2023). **Timely access to crisis support and gender affirming care.** Martin et al., (2019a, 2019b) noted that difficulty accessing mental health services during a crisis could leave people with lived experience without necessary supports, including being denied access to a service or discharged when a person was highly distressed or threatening to suicide. Timely access to gender-affirming care was described as a "powerful" and protective factor for mental health of trans and gender diverse people (Charter et al., 2022, p.313), and linked to reducing suicidality (Bailey et al., 2014). For example, access to puberty blockers for trans youth was

Table 9:	Safety
	reported to have a "tangible positive impact" on wellbeing (Pullen Sansfaçon et al., 2023, p.66). However, as noted previously (3.3.1 Timeliness and 3.3.4 Equity and Trans and gender diverse youth), gatekeeping by mental health professionals, and the delays or denial of access to gender-affirming medical care, particularly for youth, was commonly reported by trans and gender diverse people (e.g., Bailey et al., 2014; Haire et al., 2021; Pullen Sansfaçon et al., 2023; Strauss et al., 2021b). Trans and gender diverse youth could also find that mental health professionals "refused to discuss" gender in therapeutic interventions (Pullen Sansfaçon et al., 2023). Denial, delay, or refusal to discuss gender-related concerns could lead to significant psychological harms, including exacerbation of gender dysphoria, self-harm (Pullen Sansfaçon et al., 2023), and mental distress, despair, depression, and suicidality (Bailey et al., 2014; Pullen Sansfaçon et al., 2023). Pullen S Sansfaçon et al. (2023) hypothesise that lack of access to gender affirming care, can lead to a loss of hope and inclination to self-harm" as a way of "externalizing, mourning and soothing suffering" (p.66).
Safety and inequity	Safety issues were also raised in relation to inequity in mental health service provision. Safety and access to affirming mental health care. Having to educate mental health professionals about LGBTQ+ people, and experiences of microaggressions and pathologisation, could be a cause of psychological harm. For example, trans and gender diverse people who accessed Australian crisis helplines noted that a lack of expertise in affirming care, not only reduced the benefits of the services, but could also exacerbate distress (Lim et al., 2021). As one genderqueer and trans man noted, while this may be unintentional, the possibility of harm could outweigh the risk of using crisis helplines: > "Getting assigned a random call centre operator is a gamble I am not able to risk when I'm already in a heightened state of distress. The chance that I could be matched with someone who is well-meaning but ignorant is high, and even a small misstep or misunderstanding on their part will cut deeply." (Lim et al., 2021, p.678) As Lim et al., (2021) state, "slights" (e.g., misgendering), which might ordinarily be "unremarkable", were magnified when a caller was in a state of distress, particularly as it came from a mental health care provider. Experiencing exclusion from health services had serious consequences. For example, Lyons et al (2022) found that Lesbian, gay, bisexual, and queer people who did not feel accepted while accessing a health service, were more likely to experience suicidal ideation. Further, LeFrancois (2013), who noted that it was consistently relayed to young people that heterosexuality was the norm in inpatient settings, indicated that this

Table 9:	Safety
	impacted on young people's feeling of safety and comfort in discussing sexuality, and may exacerbate distress and suicidality. Pathologisation of sexuality in mental health services was perceived as harmful (Morris et al., 2022). Pathologisation of sexuality was commonplace, and reported as detrimental to wellbeing (Morris et al., 2022; Robertson et al., 2015; Strauss et al., 2021b). For example, a study of lesbian and gay adults on an acute inpatient mental health ward found that all research participants had experienced stigmatisation of their sexuality identity, including pathologisation, and this was experienced as 'alienating' and undermined recovery (Robertson et al., 2015). As one sexuality diverse participant stated; "...it is literally, you know, walking into a field full of landmines... you don't know who is safe to talk to on your ward." (Robertson et al 2015). Intrusive questioning. Four studies also reported that trans people were forced to undergo intrusive and offensive questioning about gender identity, which could be distressing (Haire et al., 2021; Pullen Sansfaçon et al., 2023; Riggs et al., 2014; Strauss et al., 2021b).
Traumatising mental health services	Some experiences in mental health services were described by LGBTQ+ people as traumatising (Martin et al., 2019a, 2019b; Robertson et al., 2015), distressing (Pullen Sansfaçon et al., 2023), homophobic (Robertson et al., 2015), disrespectful and transphobic (Hawkey et al., 2021; Strauss et al., 2021b), with one study describing verbal and physical abuse occurring (Robertson et al., 2015). **Conflict and distress.** Martin et al (2019a) found that, for LGBTQ+ people (and their carers), engagements with mental health services were "characterised by conflict" (Martin et al., 2019a). Emergency departments and inpatient services were perceived as the most harmful and were described as "traumatising" for LGBTQ+ people with lived experience and their carers (Martin et al., 2018a, 2019b; Robertson et al., 2015), as well as a "source of distress" and an "obstacle to care" (Pullen Sansfaçon et al., 2023). It was reported that interactions in emergency settings could trigger depression and anxiety in LGBTQ+ people (Martin et al., 2019a, 2019b). Particularly traumatising experiences included compulsory treatment and coercive practices, such as restraint and forced injections (Martin et al., 2019a, 2019b; Robertson et al., 2015). These practices, and other experiences (e.g., not being involved in decision-making) were experienced as profoundly disempowering and reminiscent of other disempowering phenomena experienced as a sexuality diverse person in other contexts (Robertson et al., 2015). **Dehumanising experiences.** A sense of being stripped of rights and identity was also exacerbated by an exclusive focus on illness and biomedical treatments (Martin et al., 2019a, 2019b; Robertson et al., 2015). A sexuality diverse person stated that mental health inpatient services were

Table 9:	Safety
	worse than prison due to the possibility of indefinite detention under the mental health act: *"In a way going to prison can be better than, than if you're on a section because . . . um . . . you're given a, a, a sentence and you know what the maximum's going to be . . . whereas if you're on a section you, yeah, each section has a time limit but then that section can be changed you know . . . so in a way it's better to go to prison than to go to . . . the nuthouse (speaks quietly)."* (Robertson et al., 2015) **Exacerbation of minority stress.** Traumatising experiences were compounded by previous negative experiences in mental health inpatient services and society. As one carer of an LGBTQ+ person stated: *"Poor access, long waits, snowball effect; management of physical injury, pain, medication/addiction/abuse, mental health issues, financial issues, etc. The cycle continues. Then throw in extras like trauma, abuse and LGBTIQ factors and what hope does anyone have?"* (Martin et al., 2019b) **Physical safety issues.** LGBTQ+ people could also be placed in unsafe environments during treatment. Martin et al. (2019a) noted unsafe practices in inpatient settings included putting LGBTQ+ women with a previous history of sexual assault on male units. As a carer stated: *"They put her in the male corridor knowing that she had a history of sexual abuse. On top of that, there was no buzzer in the room, so she couldn't communicate with staff. The toilet had no lock. … I was beside myself, worrying about her having to be there. She'd been sectioned at the time, so I couldn't get her out. But she was terrified to leave her room. Understandably. That's just unacceptable, in my book."* (Martin et al.,2019a) Robertson et al. (2015) also reported that for gay and lesbian people, mental health inpatient units could feel particularly "dangerous" due to the risk of being outed (p.271). People not only feared a homophobic assault, they also reported incidences of this occurring and of no action taken by staff to provide protection. For example, a sexuality diverse woman reported that: *". . . he [other patient on the ward] pushed me against the wall and felt me up basically, um… and I forget what he said, something, I kind of blanked it out a little bit, I think he said something along the lines of, "That's what you're missing" or something and I actually reported that to the nurse… and nothing happened."* (Roberson et al., 2015, p.272)

Table 9:	Safety
	Homophobia and transphobia. Not only did staff fail to intervene, data indicate that they could participate in homophobic attacks. As one gay man on an inpatient ward stated some staff were: *"…rampantly homophobic […] I mean, they'd be telling me and another guy who were gay, and another couple of lesbians, that we were going to he-hell, and we'd, we'd burn for all eternity, and this was why we'd got mental health problems."* (Robertson et al., 2015, p.273) Strauss et al. (2021b) also reported that trans youth in Australia reported that inpatient services were "harmful", and they could be exposed to transphobic mental health practitioners, who intentionally misgendered and openly pathologised them. This included a reported incident of a psychiatrist stating that it was "delusional" to transition gender and, despite significant research evidence to the contrary, that "everyone regrets transitioning" (Strauss et al., 2021b, p.397).
Trauma and conversion practices	**Experience of conversion practices.** In one Australian study, LGBTQ+ people reported exposure to conversion practices, including by mental health providers (conversion practice refers to efforts made to change a person's sexuality or gender identity) (Jones et al., 2022a). Forty-four qualitative study participants indicated that they had experienced conversion practices in Australia, including from psychologists and counsellors. They also reported incidents of being "tricked" into undergoing spiritual exorcisms by Christian counsellors (Jones et al., 2022a). However, studies of conversion practices did not distinguish between experiences with spiritual groups and with qualified therapists, so it is hard to determine the extent of types of conversion practices conducted by health professionals, with more research required. **Therapeutic care for survivors of conversion practices.** Although an Australian study also indicated that an affirming psychologist could be instrumental in healing from conversion practices, and reconciling sexuality and faith (Jones et al., 2022b), LGBTQ+ people noted that it was hard to find a mental health practitioner that did not conflate conversion practices with religion, with mental health professionals frequently assuming that the person would wish to abandon religion after being exposed to conversion practices, and becoming confused when they did not (Jones et al., 2022b). One participant indicated an experience with a psychiatrist who argued that "being religious was delusional" (Jones et al., 2022b, p.365). Survivors of conversion practices also indicated that judgemental therapists, and efforts to change the person to a new, and potentially more accepting, religion were unhelpful as they overlooked the person's connection to their own faith (Jones et al., 2022b). Jones et al. (2022b) recommend that psychologists train in LGBTQ+ issues, and the impact of conversion practices, as it can be re-traumatising and even shaming for

Table 9:	Safety
	people to have to explain these events, including having to explain that some LGBTQ+ people chose to go through harmful conversion practices (Jones et al., 2022b)
Safety and future access	This review found that unsafe and harmful experience in services could impact future access to mental health services (Berner et al., 2023; Bretherton et al., 2020; McNair & Bush, 2016; Lim et al., 2022; Morris et al., 2022). **Barrier to help-seeking.** A major barrier to help-seeking and access to effective and safe mental health care, is anticipation or actual experience of stigma and discrimination from health care services and providers. As an LGBTQ+ research participant reflected; *"I think the prospect of being hated... it's so scary that I would say that that's the biggest inhibition to seeking help – it's just that fear... of judgement – negative judgement"* (Morris et al. 2022). Research undertaken with same-sex attracted women and trans and gender diverse people, identified experiences of discrimination and judgment as the most common barrier to seeking mental health support, particularly for gender diverse, pansexual, or queer participants (McNair & Bush, 2016). This is supported by findings from a cross-sectional online survey (Bretherton et al., 2020) among trans and gender diverse people in Australia, which found that more than a quarter of respondents indicated experiences with discrimination when accessing healthcare services (26%, n = 244). Research with key stakeholders from the LGBTQ+ community reported a pattern whereby negative experiences with health care professionals perpetuates broader mistrust of mainstream services. (McNair & Bush 2016). **Low uptake of crisis helplines.** Lim et al (2022) found that, despite the effectiveness of mental health helplines for many groups, only 30% of sexuality diverse participants in Australia had accessed a helpline service during a crisis. With this low uptake primarily being attributed to fears about stigma or a lack of understanding around sexuality diverse people's concerns (Lim et al., 2022). **Avoidance of mental health services.** Brener et al (2023) also found that gay and bisexual men who have experienced stigma from a specific health care service, are more likely to avoid that type of health service; however, this appears to only apply to a small proportion, with 80% never avoiding GP services, 84% never avoiding specialist services, and 85% never avoiding sexual health services. Nonetheless, stigmatising experiences were reported by 22% for specialists, 12% by nurses, 11% for GPs and receptionists, 10% from pharmacists and 7% from sexual health services.

4 Lived experience interpretation

This section provides a lived experience interpretation by LGBTQ+SB people with an intersecting lived experience of mental health challenges and/or suicidality, and of accessing mental health or suicide prevention services. The Rainbow Embassy interpretation influenced the presentation of findings, including the focus on personal recovery and safety.

A response statement, detailed below, was also developed in collaboration with the Rainbow Embassy to ensure that the perspectives of LGBTQ+ people with lived experience were highlighted. As noted in the methodology (2.5 Lived experience involvement), a deliberative dialogue approach was used, which is a group process that involves interpretation and integration of empirical and contextual data in a dialogical exchange aiming to build understanding of a phenomena, and ensure lived experience engagement in interpretation of data, to better inform service, policy and research development (Boyko et al., 2014). Co-interpretation of systematic review findings and response statements have been used previously in mental health research (Bone et al., 2019).

4.1 Rainbow Embassy response statement

We agree that, although some individuals are doing well, 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. We note that, every institution in society is set up to privilege and protect heterosexual and cisgendered people, and that this falls onto queer and trans in damaging ways. LGBTQ+ people can experience exclusion, abuse, and violence in families, schools, the workplace, and the community. They may not even be able to go a teacher or the police for help because it is not safe, or it does not feel safe. LGBTQ+ people are also constantly denied access to simple things that would mean they would have better ‘crack’ at life.

We would also agree that challenges for LGBTQ+ people are not only external, they can be internal. Our society is so hetero- and cis-normative, and it can be hard for LGBTQ+ people to figure out who they are and become comfortable with their identity. Also, there is often an emphasis on coming out, but there is an assumption that LGBTQ+ people want to come out or can come out. However, the risks – including risks of bullying or risks to family and community connections – can be profound. For example, First Nations people and people of colour who migrated to Australia (e.g., from Polynesia or India) have historically had more diverse conceptualisations of gender and sexuality – including Sistergirl and Brotherboy. However, communities impacted by colonisation have had dominant cultural ideas about gender, sexuality, and sex imposed on them, often violently. This can mean that, when coming out, First Nations LGBTQ+SB people, and culturally and linguistically diverse people of colour, may face rejection from communities navigating the harms of colonization, in addition to alienation from the dominant culture.

Thinking from a personal-recovery and strengths-based approach, we note that distress for LGBTQ+ people is not only about the harms of society, but also about how our society is not ‘fabulous’ enough, and does not promote connection, hope, meaning, or empowerment for people with diverse identities. For example, there are few places where it is possible for LGBTQ+ people to connect, and it can be hard to engage with our own communities. This means that it is difficult to access those community resources that would be supportive or protective in a crisis. We would also emphasise that, distress and a lack of access to

protective resources, are compounded in complex ways for people with intersectional identities, who face exclusions, microaggressions, and violence based on intersecting experiences related to race, culture, disability, etc., as well as gender and sexuality diversity.

We would like to point out that mental health services are particularly fraught for LGBTQ+ people. It was not that long ago that homosexuality and gender identity were listed as illnesses in the Diagnostic and Statistical Manual of Mental Disorders (DSM), and LGBTQ+ people were held in mental institutions and subjected to conversion practices. It is not as though those histories are forgotten, and it is disturbing (although not surprising) to see in the literature that conversion practices are continuing in Australia, even among registered health professionals. While we applaud de-pathologisation of gender and sexuality diversity – and the removal of homosexuality and gender identity disorder from the DSM – we are concerned that the focus on 'rescuing' queer and trans people from the DSM categories, may have inadvertently reinforced ideas of 'normalcy' and deficiency, and thereby reinforced sanism. By sanism, we mean stigmatisation and discrimination towards people with a lived experience of mental health challenges. As such, we believe that our community has not fully grappled with the needs of LGBTQ+ people experiencing life-interrupting mental distress and suicidality. In our lives and work with LGBTQ+ organisations, we have seen people with lived experience being denied access to LGBTQ+ specific services due to this stigma and discrimination, or people with lived experience being referred to mental health services that fail to meet the needs of community members, and in many instances reinforce trauma. We resist this division, which goes against queer and trans people's commitments to recognising diversity and supporting the needs of the most marginalised people in our community.

We are also concerned that researchers have not sufficiently interrogated dominant biomedical paradigms of mental health, and dominant models of psychiatric treatment and service provision. We notice that the findings across the included studies examine inequity from a queer and trans perspective, but there appears to be less engagement across studies with perspectives from consumer/survivor movements. Consumer/survivor movements and lived experience communities have highlighted human rights violations in mental health services and dissatisfaction with psychiatric 'illness' models and treatments. They have also consistently called for collaborative mental health services that are trauma informed and personal recovery-oriented; provide a choice of services; and consider other explanatory frameworks for distress (e.g., socio-political or trauma frameworks).

It is also the case that there is little evidence provided across studies of lived experience involvement in research. By lived experience, we mean LGBTQ+ people with an intersecting lived experience of life-interrupting mental health challenges and/or suicidality, who have used mental health and/or suicide prevention services, and not only researchers who identify as LGBTQ+. In terms of involvement, we mean LGBTQ+ people with a lived experience not only being consulted, but being employed as partners in co-designed research, or leading research, who are engaged in all stages of the research process (co-planning, co-design, co-conducting, and co-dissemination). Of course, we would also like to see support, including funding and resources, for LGBTQ+ people with lived experience of mental health challenges to collaborate on, or lead, research.

We would also like to state that, if we are going to match causes of distress (e.g., minority stress) with responses to distress, then policy makers need to think more broadly about the kinds of services LGBTQ+ people need. We note that LGBTQ+ people, in a state of distress,

are often trying to access mental health or suicide prevention services that are not designed for them. For example, if LGBTQ+ people are presenting with trauma related to systemic discrimination, then a response that is individualised and medicalised, is not going to meet their needs. Also, much of the research is not specific about the kind of support that is being provided, but there is a big difference between services offering a diagnosis and medication, or individualised cognitive behavioural therapy, and services that use family systems therapy or trauma healing. For LGBTQ+ people who have experienced adverse events in families, schools, the workplace, and/or the community, we note that they would need to be able to access a choice of diverse modalities to support them to navigate those traumas. We would like to ask researchers and service providers, if services are biomedically focused, or where trauma is not even acknowledged in the therapeutic modality, how can they attend to these issues for LGBTQ+ people?

However, we cannot expect a therapist to fix systemic discrimination, and we need to think at a population level – at ways of changing structural discrimination and attending to the social determinants of mental health, including within families, workplaces, and the community. For example, what workplace accommodations are offered to LGBTQ+ people with a lived experience, who want to work but may struggle to maintain employment in ableist workplaces? The findings from this review indicate that we also need to consider the specific needs of youth. This is often the time when distress starts. Families and schools are rigidly hetero and cis-normative and can impose behaviours and segregations that are painful and harmful for sexuality diverse, and trans and gender diverse youth. As the findings indicate, LGBTQ+ youth, under the authority of their parents, schools, and healthcare practitioners, are not only denied access to gender-affirming care or referral to mental health support, but they are also frequently subjected to stigma and control over their identity. We understand the pain and consequences of this kind of stigma and of having every aspect of your identity controlled by adults, including clothes, hair, and ways of moving.

Timely access to gender-affirming care for trans and gender diverse people, including youth, is mental health care and suicide prevention. It promotes mental wellbeing for trans and gender diverse people, and can also create safety for trans people who might otherwise be targeted in the community. However, it is clear from the findings that gatekeeping by mental health professionals, and psychiatrists in particular, continues. We would recommend that this gatekeeping model of access to gender-affirming care is ended. It is simply not required, and not only adds to trauma for trans and gender diverse people – who are exposed to unknowledgeable, pathologising, and/or transphobic health professionals who can block access and exacerbate distress – but also creates an extra financial and time burden to trans and gender diverse people who often have little choice but to sit on lengthy wait lists or pay for expensive healthcare providers to access gender-affirming services.

We did not find anything particularly surprising about the mental health services LGBTQ+ people were accessing. All people would have to go through a GP to get a referral, and most referrals will be to a psychologist. However, we would recommend that positive findings about youth access to mental health services in rural areas are read with caution, and the specific context is examined as it may not translate to all LGBTQ+ youth in all rural areas. We also recommended that researchers interested in these contexts go to the place and connect with the local community, as people answering online surveys may have more resources to access online mental health services.

Likewise, many of the positive findings about service provision, such as timeliness and person-centredness, are not particularly startling. LGBTQ+ people would expect to be seen in a timely way, met with compassion, listened to, and respected when they are in a state of distress. That would be a minimum expected standard of care. However, we are concerned by findings that indicate that services were often inequitable. To attend to this, it is not just about displaying rainbow stickers and wearing rainbow lanyards. Although that is important, it cannot just stop there, and services need to actively deal with the inequities, including providing access to affordable services that are sexuality and gender-affirming; ensuring a knowledgeable workforce who understand diverse genders and sexualities; providing care that is inclusive rather than hetero- and cis-normative; and ending practices of misgendering, pathologisation, and conversion. In building the workforce, mental health services must also stop relying on LGBTQ+ people with lived experience (including youth), who are already in distress, to educate them about diversity.

Above all else, we would like to emphasise the need for services to be safe. By safe, we mean safe from the perspective of LGBTQ+ people with a lived experience. The findings indicate that it can be exceedingly difficult for many LGBTQ+ people to find an affirming and affordable mental health provider, and negative experiences with mental health professionals can exacerbate distress and suicidality. Although research on emergency and inpatient service experiences is limited, they point to a disturbing lack of safety for LGBTQ+ people with lived experience in these settings, including exposure to discrimination, restrictive and coercive practices, abuse, and violence. This aligns with our own experiences. Members of the Rainbow Embassy have also found that emergency and inpatient services can be deeply traumatising, and there is a clear need for more research in these contexts to understand what is happening and what would work better. When considering quality of services, we should always be asking, not only are they effective, equitable, and acceptable, but also are they safe, or did they exacerbate or cause psychological or physical harm?

For First Nations LGBTQ+SB people and people of colour, safety concerns in mental health services are heightened. For example, if a First Nations LGBTQ+SB person accesses a crisis service, they may be concerned about the increased chance of involuntary treatment or coercive practices if they reveal their gender or sexuality identity, as their intersecting experiences may be pathologised, and they may be viewed as having a more complex mental health issue. Members of the Rainbow Embassy know from experience that we, or other people of colour, have not been treated well in emergency and inpatient services, including encountering lack of understanding of intersectional identity, being invalidated and exposed to abuse from other people and staff. However, in this review there is a distinct lack of research on First Nations people or culturally and linguistically diverse people, including people of colour. Nonetheless, we would like to emphasise that, these communities do not need more research on what is wrong, but rather research that is focused on how to provide dignified and culturally safe mental health services.

We also note that the review findings often cover a range of services and a continuum of mental distress – from mild to moderate distress, to acute crises and life-interrupting mental health challenges. However, there is a need to examine the distinct service experiences and needs of LGBTQ+ people who have an acute crisis or live with life-interrupting mental health challenges, who may have little choice over service provision. We would like to draw particular attention to the lack of research on the experiences of LGBTQ+ people in

emergency and inpatient services who are involuntarily detained (e.g., scheduled under the Mental health Act), as well as the experiences of those receiving involuntary treatment in the community (e.g., on community treatment orders). LGBTQ+ people receiving involuntary treatment have little choice over service provider or treatment, yet research indicates that inpatient mental health services are of poor-quality and can be experienced as particularly unsafe. Therefore, this population should be a priority for future research and service reform.

We note that positive experiences were more often reported in LGBTQ+ specific services. However, it was interesting that only a small percentage of LGBTQ+ people appear to be accessing these services. This finding may suggest that there are not sufficient LGBTQ+ specific services that are accessible to LGBTQ+ people. The idea that services are being rationed is abhorrent to the Rainbow Embassy members, particularly when there is such a clear and urgent need, and LGBTQ+ people are living in a world that is often hostile and traumatising. Although private providers who are LGBTQ+ identified or knowledgeable about LGBTQ+ people, may be currently filling this gap in service provision, private providers are out of reach for many LGBTQ+ people. Even referrals from a GP to a private provider, although covered by Medicare, often allow for only a limited number of consultations, and do not reimburse the full costs of the session. While we acknowledge that some LGBTQ+ specific services are doing amazing work to support people, we would like to emphasise that many LGBTQ+ specific services lack the necessary resources or skills to support a person is in a crisis or with life-interrupting mental distress and suicidality, and will refer them to mainstream mental health services which may be struggling with the basics of equitable, safe, and trauma informed service delivery to LGBTQ+ people.

We would also add that, not all LGBTQ+ services are equal, and some are more welcoming to trans and gender diverse people or people who are sexuality diverse but not lesbian or gay identified (e.g., pansexual people). We would also like to state that many of the providers in LGBTQ+ specific services, like most mental health services, are oriented towards the needs of the dominant Anglo-Australian population. Providers often do not understand the specific needs of LGBTQ+ people with intersectional experiences. Indeed, members of the Rainbow Embassy noted that in some cases they preferred to be met by a person of colour, rather than by an LGBTQ+ white person, as they would have more understanding of the oppression they face in society and services. We would therefore like to emphasise that, the high rates of satisfaction reported in LGBTQ+ specific services, while important and noteworthy, may not be indicative of high-quality service to all LGBTQ+ people, particularly those experiencing a life-interrupting mental health crisis and those with intersectional experiences. When evaluating LGBTQ+ specific services, it is important for researchers and service providers to interact with these communities to gain a fuller picture or service equity and quality.

5 Discussion

5.1 About this Section

Commissioned by the Department, this SLR provides a narrative synthesis of 56 articles, published between 2013 and 2023, which report on LGBTQ+ people's use of mental health and suicide prevention services across Australia and the UK. Specifically, this review sought to address 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?

The following discussion addresses each of these Department's research questions, as well as contributing to the final 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 LGBTIQA+ people?*

The discussion content draws both from the results presented at Section 3, incorporating evidence drawn from the peer reviewed literature, and interpretation from the Rainbow Embassy statement (see Section 4.1). When addressing these questions, we again apply the Institute of Medicine (2006) six domains of quality and performance (see Section 2.4):

- Timeliness
- Effectiveness
- Person/ (Patient) centredness
- Equity, plus intersectionality and equity issues
- Safety
- Efficiency

The discussion summarises the evidence across each domain, as well as gaps and barriers identified, and recommendations arising for future mental health and suicide prevention services (where relevant).

While the researchers note the overall organisation of the Discussion Section does create some overlaps, it nonetheless is designed to offer a logical way to access a wide range of research insights, structured under topics of interest to specific reader groups and policy makers alike.

In addition, in Appendix 3: Highlights from SLR findings, to assist policy makers in applying these frameworks and concepts, the researchers sort the 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

5.2 What services are available and provided to LGBTQ+people?

The literature included in this SLR does not give a comprehensive understanding of services that are available and provided to LGBTQ+ people in Australia and the UK. 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. Additionally, no studies mapped service provision in these countries[23].

Additionally, most studies included in the review examined a mix of mental health services (e.g., inpatient, community, private or public providers) as well as a mix of mental health practitioners. This makes it difficult to distinguish exactly what kind of services were provided, or the perceived quality and performance of a specific service type. As noted by members of the Rainbow Embassy, there is a considerable difference between services offering diagnosis, medication, or behavioural therapies, and those that are offering trauma or family therapy, and it is not possible to distinguish these differences in many of the available studies.

Nonetheless, the SLR literature does 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 (Taylor et al., 2021). Also, trans and gender diverse people tend to access GPs and psychiatrists more frequently as they require access for gender and non-gender related care (e.g., to gain access to gender-affirming care and for mental health care). Only a small portion of LGBTQ+ were reported to access LGBTQ+ specific services (e.g., 12% - McNair & Bush, 2016), a trend that has been noted previously (Hill et al., 2021). Given that this review, and previous research (e.g., Collective Action, 2023; Hill et al., 2021), indicates a clear preference among LGBTQ+ people in Australia for LGBTQ+ 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 LGBTQ+ specific services may not fully meet the needs of LGBTQ+ sub-populations, including trans and bisexual people (e.g., Brener et al., 2023; Erasmus et al., 2015; Tollit et al., 2023).

Two studies included in the SLR examined service provision to First Nations LGBTQ+SB people (Uink et al., 2023; Hill et al., 2022). These studies indicate that LGBTQ+ specific services, as well as mainstream and Aboriginal Community Controlled Health Organisations, currently do not adequately address the care needs of First Nations LGBTQ+SB people (Uink et al., 2023). Only a small number of dedicated organisations exist for First Nations people LGBTQ+SB people. As Day et al. (2023) suggest, First Nations people must often choose between care that attends to their needs as an Indigenous person, or care that caters to them as LGBTQ+SB person – and rarely both.

However, as Uink et al (2020) suggest, intersectionality-informed research is required to gain a better understanding of the specific service use experiences of First Nations LGBTQ+SB people. This suggestion has also been put forward by First Nations LGBTIQA+SB advocacy group, *Black Rainbow* (2022), who recommend that research is community-led and takes an

[23] While some Australian surveys do exist, they were not part of this review. Examples include, but are not limited to, Hill et al.'s (2021) *Private Lives 3* and Liddelow-Hunt et al.'s (2023) *Walkern Katatdjin Phase 2*, which detail mental health service use in LGBTIQ+ populations. Additionally, LGBTQ+ youth mental health services have been mapped in the UK (e.g., Pattinson et al., 2021).

intersectional lens that recognises LGBTIQA+SB people as a distinct community with unique experiences and needs. There is a particularly urgent need for research regarding the mental health stressors, service needs and experiences of First Nations LGBTQ+SB youth, as the needs of this population “remains largely unknown”, with the scant existing literature focused on adult experiences (Uink et al. 2020). 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 experiences, e.g., related to disability. Only four studies in the SLR examined mental health service provision to people with lived experience from CALD backgrounds, with two studies from Australia providing only minimal data (McNair & Bush, 2016; Robertson et al., 2015).

However, as noted earlier, some existing studies were not picked up in the SLR search, and a broader search incorporating international published, and unpublished ‘grey literature’ is warranted. For example, Amos et al. (2022) explored the experiences of LGBTQA+ people with disability who experience abuse, and findings may have implications for LGBTQA+ people accessing mental health services. If research gaps are found to exist, as the Rainbow Embassy suggest, the focus of should be on research that identifies and implements solutions that promote the provision of dignified, accessible, and culturally safe mental health and suicide prevention services.

5.3 What services were found to be effective and what gaps and barriers were evident?

This review used the Institute of Medicine Committee (2006) framework to assess the quality of mental health and suicide prevention services across the available published Australian and UK research. This framework addresses six domains (timeliness, effectiveness, person-centredness, equity, safety, and efficiency) to assess quality and performance so as to inform policy and development (Proctor, 2011). No data was available across the 56 studies on service efficiency. However, the available research did detail findings relevant to the other five domains, 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 support better, more inclusive, and safer mental health service provision. A discussion of findings across each domain of quality and performance are provided below, with a specific focus on evidence for effectiveness, and gaps and barriers in service delivery. Although not comprising an exhaustive list, research gaps are also noted throughout.

5.3.1 Timely access to services

5.3.1.1 Evidence for timeliness

SLR findings indicated that online mental health services and crisis helplines, could increase mental health service access, particularly in rural areas (Bowman et al., 2020; Lim et al., 2021). Online services could also provide an anonymous and safe environment for LGBTQ+ people to access support (Bowman et al., 2020; McNair & Bush, 2016). The value of online forums and crisis helplines for providing psychosocial support for mental health has been noted previously (Mathieu et al., 2021; McDermott et al., 2016), with preferences noted for online services among youth (McDermott et al., 2016). This review found that game-based

therapeutic interventions, that are contemporary and acknowledge the unique experiences of LGBTQ+ people, were effective and acceptable to youth (Lucassen et al., 2018).

Although the SLR does not focus on gender-affirming medical care (e.g., puberty blockers, hormone treatment, surgery), mental health service practitioners are frequently involved in assessing trans and gender diverse people and providing access to these services. This review found that supporting access to gender-affirming mental health care promoted wellbeing and decreased suicidality in trans and gender diverse people (Bailey et al., 2014; Charter et al., 2021; Harrison et al., 2020; Pullen Sansfaçon et al., 2023), a finding that is consistently reported in the wider literature (Tordoff et al., 2022). One study in this review indicated that GP services enhanced timely access to gender-affirming hormonal treatment for trans and gender diverse people, as well as referrals to mental health support, and were preferable to assessments by mental health clinicians (Spanos et al., 2021). This is an important finding and may warrant further investigation in the Australian context. Internationally, researchers have also found that multi-disciplinary clinics for trans and gender diverse people can improve access and coordination of care (Sotiros et al., 2021).

5.3.1.2 Evident gaps and barriers

SLR data indicated that access to mental health services was often challenging for LGBTQ+ people, particularly during a crisis (Harrison et al., 2020; Martin et al., 2019a; Lim et al., 2021), and that they lacked appropriate referral processes (Harrison et al., 2020; Lim et al., 2021). LGBTQ+ specific services, while providing high-quality and affirming care, were also reported to be difficult to access, due to long wait times and limited hours of operation, or lack of availability (Bailey et al., 2014; Erasmus et al., 2015; Davies et al., 2013; McNair & Bush, 2016). This reflects international research, which suggests that LGBTQ+ specific services are perceived to be of high quality but are difficult to access due to high demand from the LGBTQ+ community (Crockett et al., 2022).

SLR evidence shows that access to gender-affirming services was frequently challenging for trans and gender diverse people, and often stalled by mental health providers due requirements for multiple assessments, gatekeeping by psychiatrists and other mental health professionals, and long wait lists (Bailey et al., 2014; Pullen Sansfaçon et al., 2023; Strauss et al., 2021b). While private providers offered an alternative and preferable route to access gender-affirming care, due to abbreviated wait-times (Harrison et al (2020), it was reported to be difficult to find affirming care providers outside of gender clinics (Pullen Sansfaçon et al., 2023). Trans and gender diverse people also reported difficulties in coordinating complex mental health care needs (Haire et al., 2021). Delays in access to gender-affirming care are particularly concerning given the clear mental health benefits to trans and gender diverse people. SLR evidence suggests that, rather than advancing mental health and gender-affirming supports, in many instances, mental health professionals (including psychiatrists and psychologists) are delaying and denying access, including by imposing unreasonable demands on trans and gender diverse people to perform stereotypical and binary gender identities (Strauss et al., 2021b). These findings reflect Canadian research, which shows that trans and gender diverse people often struggle to access gender-affirming services, and may feel they have to hide their actual gender identity in order to gain referrals to gender-affirming services (MacKinnon et al., 2020).

5.3.2 Service effectiveness

5.3.2.1 Evidence for effectiveness

Few studies examined the effectiveness of interventions on clinical recovery outcomes. Positive findings were mostly reported in relation to trans and gender diverse people, including those who received hormone therapy and had clinically meaningful reductions in depressive symptoms (Witcomb et al., 2018), and those accessing gender dysphoria clinics in Melbourne, who had a reported reduction in perceived distress (Erasmus et al., 2015).

More evidence was found for the effectiveness of interventions for promoting outcomes aligned with personal recovery (e.g., McNair et al., 2018; Morris et al., 2022; Williamson et al., 2022). As noted previously, personal recovery emphasises connection, hope, identity, meaning, and empowerment over clinical recovery outcomes (Leamy et al.,2011). Studies included in this review were predominantly focused on supporting and facilitating social connection, with one focused on promoting connection and identity (Williamson et al., 2022). The value of social connection as a protective factor in mental health has been noted previously in the literature (e.g., Bauer et al., 2015). Findings in this review indicate that interventions aimed at promoting community connection could improve self-esteem and psychological well-being, reduce internalised homophobia (Williamson et al., 2022), and promote help seeking and service utilisation (McNair et al., 2018).

5.3.2.2 Evident gaps and barriers

Review findings indicate a lack of improvement in clinical recovery outcomes for sexuality diverse people receiving psychological interventions (Rimes et al., 2018; 2019). However, due to limited data this finding must be read with caution, and further research to understand the specific value of psychological therapies is required. Indeed, qualitative data within this study indicates that LGBTQ+ people had many positive experiences in psychology and counselling services, with some interactions described as being a “lifesaver” (Charter et al., 2022).

Data from this review does suggest that an exclusive focus on clinical recovery may be problematic. Robertson et al. (2015) found that, in mental health services, the privileging of medical treatments and clinical recovery outcomes over personal recovery could be experienced as dehumanising for sexuality diverse people, and reinforced other experiences of dehumanisation and oppression. Robertson et al.’s findings align with international research, which indicates that public mental health services are often overly reliant on medical interventions, and that mental health practitioners struggle to provide recovery-oriented care (Waldemar et al., 2016).

Findings related to the effectiveness of some interventions for promoting personal recovery are promising, e.g., via community connection. However, there are evident gaps in this research area, with no mention of family connection despite evidence that this is highly protective for youth mental health (Bauer et al., 2015), and little mention is made across studies of other personal recovery indicators, e.g., hope, identity, meaning, and empowerment. Further research, including a review of the international literature, may yield important insights into successful approaches to promoting personal recovery for LGBTQ+ people. For example, research indicates that family therapy can support sexuality diverse youth and their parents to work though negative thoughts about sexual orientation and

maintain connection (Levy et al., 2016). Online educational programs can also promote acceptance in parents of trans and gender diverse youth (Mutsuno & Israel, 2021). However, as this review found, family-based approaches that were imbued with heteronormative assumptions could be experienced as alienating and invalidating for LGBTQ+ youth (Rivers et al. 2018), and interventions to promote family connection need to be developed in collaboration with LGBTQ+ people with lived experience, to ensure that they meet the needs of this community (Mutsano & Isreal, 2021), particularly for those communities that have different conceptions of family and kinship groups (Black Rainbow, 2022).

A focus on personal recovery in future research endeavours may also meet the call articulated by the Rainbow Embassy to engage with perspectives from consumer/survivor movements. Indeed, the push for recovery-oriented care in health reform policy, as well as the expansion of peer support roles in mental health services, has been directly linked to the increasing strength of consumer/survivor movements (Adame & Leitner, 2008; Repper & Carter, 2011). The consumer/survivor movement first appeared in the 1960s, at a time of radical restructuring and de-institutionalisation of the mental health system, and grew from the lived experience of people with mental health challenges and suicidality, particularly from calls for recognition of human rights violations in mental health services and dissatisfaction with psychiatric treatments (Chamberlin, 1978, 1990; Tomes, 2006). Over the past fifty years, the Australian consumer/survivor movement has had a powerful impact on mental health policy, legislation, and service provision, and on how mental health challenges are understood and approached.

As noted by the Rainbow Embassy, most studies in this review do not appear to explicitly engage with critiques from consumer/survivor movements related to the experiences and needs of people with a lived experience of mental health challenges. Yet, LGBTQ+ researchers and advocates share many concerns articulated by consumer/survivor movements, with consumer/survivors having a stated agenda to end coercive practices and an over-reliance on medical treatments, and to promote choice of recovery-oriented and peer-led service options (Chamberlin, 1978, 1990; Repper & Carter, 2011). There are examples of international researchers seeking to apply consumer/survivor perspectives to LGBTQ+ research on mental health distress and mental health service provision that may provide a model for future research. For example, Pilling (2014, 2022) explores LGBTQ+ people's experiences of mental distress, applying critiques from consumer/survivor movements to make sense of these experiences and the impacts of mental health care. Pilling (2014, 2022) also advocates for responses to people that are non-coercive, non-pathologising and promote autonomy and choice.

5.3.3 Person-centredness and services

5.3.3.1 Evidence for person-centredness

The SLR evidence indicates that some mental health service providers can be perceived as person-centred, welcoming, empathic, caring, and compassionate (e.g., Charter et al., 2022; Erasmus et al., 2015; Haire et al., 2021; Lim et al., 2021; Martin et al., 2019a, 2019b). Although this is encouraging to read, as the value of empathic and welcoming mental health service provision is well documented (Elliott et al., 2018), as the Rainbow Embassy state, to be met with compassion, to be listened to, and to be respected, is the minimal standard of care required for anyone accessing mental health services.

5.3.3.2 Evident gaps and barriers

Despite positive reports, experiences within services, and with healthcare practitioners, were frequently reported to be inconsistent and sub-optimal. For example, although GPs were positively perceived (Haire et al., 2021; Harrison et al., 2020), they could also be uncomfortable with providing support for mental health concerns (Reynish et al., 2023), and although online mental health services were perceived as accessible and safe for young LGBTQ+ people, they could also be experienced as complex, unfamiliar, and impersonal (Bowman et al., 2020). The SLR studies also indicated a lack of linkage between services, including between crisis services and long-term care (Lim et al., 2021), and between alcohol services and mental health services (Dimova et al., 2022; McNair et al., 2018). Inconsistencies and a lack of continuity in provision of care have been noted previously in the international literature (e.g., Gaspar et al., 2021; Holt et al., 2023; McCann & Brown, 2020), including a lack of linkage between mental health and drug and alcohol services (Gaspar et al., 2021; Holt et al., 2023).

Person-centredness of services also examines how services were experienced, and whether they were respectful and responsive to the preferences and needs of service users (Institute of Medicine, 2006). In this review, reports of experiences in emergency and inpatient mental health services were particularly poor. Research indicated that inpatient services were understaffed, lacking in privacy, restrictive (Robertson et al., 2015); unpleasant and dirty (Robertson et al., 2015; Strauss et al. 2021b); and inpatient and emergency services were disempowering for patients and lacking in choice and opportunities for collaboration with health care providers (Martin et al., 2019a, 2019b; Robertson et al., 2015). This echoes international research, which has found that LGBTQ+ people have particularly negative experiences in inpatient mental health services, which have been described as objectifying, directive, and focused on sedation and containment with limited treatment options (McCann & Brown, 2020; McCann & Sharek, 2014).

5.3.4 Service equity

5.3.4.1 Evidence of service equity

Equity in mental health and suicide prevention services was the most common measure of service quality and performance and was discussed across most studies. The SLR found that equity across services was inconsistent. Some studies were perceived as welcoming and affirming for people of diverse LGBTQ+ people (see 3.3.4 Equity). Interactions were often reported to be more positive with providers who educated themselves about the experiences and needs of LGBTQ+ people, and demonstrated acceptance and awareness of community needs (Charter et al., 2022; Lim et al., 2021; Martin et al., 2019a).

Positive experiences were also more likely to be reported in LGBTQ+ specific services, including knowledge of community needs and appropriate referrals to affirming service providers for people with intersecting identities (Charter et al., 2022; Erasmus et al., 2015; Haire et al., 2021; Hawkey et al., 2021; Lim et al., 2021). The findings point to the value of knowledgeable providers and specialised service provision. This has been noted previously in the literature – particularly the value of LGBTQ+ specific services in providing comprehensive and integrated services (Matsuzaka et al., 2021; Sotiros et al., 2021).

Positive interactions with mental health providers were also reported among LGBTQ+ youth, specifically with regards to respectful and well-informed health professionals who took seriously the distress experiences of sexuality diverse youth (Hughes et al., 2018; Strauss et al., 2021b). SLR findings indicate that school counsellors may play a particularly important role in supporting trans and gender diverse youth to explore and affirm their identity, as well as in educating school staff, and supporting students to shift school culture and policy (Mackie et al., 2023). However, further research on the value of school counselling from the perspective of LGBTQ+ youth is required.

5.3.4.2 Evident gaps and barriers

Most studies reported mixed experiences with mental health service providers related to equitable provision of health care, with negative findings related to equity frequently reported. Findings indicate that prejudice towards, and exclusion of, LGBTQ+ people underpins both LGBTQ+ people's engagement with, and perceptions of, mental health and suicide prevention services, as well as service provision practices and approaches. As powerfully articulated by the Rainbow Embassy, systemic prejudice, and discrimination towards LGBTQ+ people can be compounded or replicated in the context of contemporary mental health service provision. For example, findings show that the default-assumption that a client is heterosexual or cisgender can be a barrier to accessing mental health care, as can non-engagement with (or avoidance of) a client's sexuality or gender identity (Brener et al. 2023; Roberts et al., 2018; Cronin et al. 2021; Lyons et al. 2022).

Multiple equity issues for LGBTQ+ people were raised across studies and are discussed below, including: knowledge deficits; micro-aggressions; pathologisation; and specific forms of inequity related to intersectional identities.

5.3.4.3 Knowledge deficits.

This review found that staff knowledge deficits about LGBTQ+ people were commonly reported across studies, and that this was a barrier to affective and affirming care, particularly for trans and gender diverse people (Haire et al., 2021; Lim et al., 2021). This finding is reflected in international research, which demonstrates that mental health providers often lack knowledge about LGBTQ+ people, including terminology, identity, culture, and the impacts of discrimination, minority stress, and intersecting identities (Ellis, 2015; Goldberg et al., 2019), with knowledge of trans and gender diverse people's identities and needs reported to be particularly poor (Stroumsa et al., 2019).

In lieu of training, findings indicate that health professionals often relied on LGBTQ+ people for information and education, including relying on youth, a point noted in the international literature (Snow et al., 2020). This review indicates that educating mental health professionals about LGBTQ+ issues is burdensome to LGBTQ+ people who are seeking knowledgeable providers to support them (Charter et al., 2022). Research also suggests that educating health professionals is not only emotionally exhausting, but it is also financially costly in terms of therapy time (Snow et al., 2020). There may be particular impacts on youth that have yet to be understood in terms of mental health outcomes.

5.3.4.4 Microaggressions and pathologisation

Data indicate that, in mental health settings LGBTQ+ people were frequently exposed to microaggressions, including to hetero- and cis-normativity, misgendering, invalidation of their sexuality or gender (and of their family relationships), and pathologisation. Pathologisation included assumptions that sexuality or gender was the primary cause of distress or a "contributory factor" to mental illness (Robertson et al., 2015, p.272). The findings related to microaggressions and pathologisation are supported by international research, which shows that LGBTQ+ people are routinely medicalised, misgendered, and misunderstood in mental health services (e.g., & Rees et al., 2020; McNamara & Wilson, 2019; O'Shaughnessy & Speir, 2018; Snow et al., 2019). However, as this SLR shows, these kinds of experiences are damaging to therapeutic relationships and personal recovery (Robertson et al., 2015), and also impact on future mental health help seeking among LGBTQ+ people (Brener et al., 2023; McNair & Bush, 2016).

Ongoing pathologisation of LGBTQ+ people in mental health services is concerning. Social-prejudice and stigma towards people with diverse genders and sexualities has historically informed clinical conceptions and treatments, with reports of LGBTQ+ people being systemically pathologised in psychiatry, psychology, and other mental health disciplines, despite de-pathologisation efforts and changes to the DSM (Khul, 2019). As Davy and Toze (2018) note, there is also no indication that the removal of gender identity as a disorder from DSM-5, and the inclusion of 'gender dysphoria',[24] has reduced pathologisation of transgender people. Indeed, researchers have suggested that retaining gender dysphoria in the DSM has only maintained the power of mental health professionals to regulate and control trans and gender diverse people, including their access to gender-affirming care (Davy & Toze, 2018).

However, as the Rainbow Embassy members, and international researchers such as Pilling (2014, 2022) argue, an exclusive focus on efforts to de-pathologise LGBTQ+ identities may have inadvertently emphasised notions of normalcy and deviance that promote sanism towards LGBTQ+ people with lived experience. Sanism has been defined as prejudicial attitudes towards, and treatment of, people with a lived experience of mental health challenges and suicidality (Perlin, 2003). As Perlin (2003) states:

> *"Sanism is as insidious as other 'isms' and is, in some ways, even more troubling, because it is largely invisible, to a considerable degree socially acceptable, and frequently practiced (consciously and unconsciously) by individuals who ordinarily take "liberal" or "progressive" positions decrying similar biases and prejudices involving gender, race, ethnicity and/or sexual orientation. […] Like other 'isms', sanism is based largely upon stereotype, myth, superstition and de-individualization." (Perlin, 2003, p.286)*

Although sanism has been linked to pathologisation of LGBTQ+ people in mental health services (LeFrancois, 2013; Pilling 2014, 2022), researchers, health providers, and policy makers have largely remained "silent" on sanism in mental health systems and settings (Perlin, 2003). Indeed, only one study in this review referred to sanism. LeFrancois (2013) found that, in inpatient mental health settings, entrenched sanist attitudes towards people with lived experience intersect with hetero-normativity, create hostile environments for

[24] Diagnostic And Statistical Manual of Mental Disorders, 5th Edition

LGBTQ+ people, and are linked to pathologisation. However, the intersections between sanism, homophobia, and transphobia were not fully explored within the included SLR literature, and this requires further research to fully understand.

5.3.4.5 Intersectionality and equity

In addressing system inequities, it is important to acknowledge that systemic factors that contribute to distress may be heightened for LGBTQ+ people with intersectional experiences. For example, intergenerational trauma resulting from colonisation, and the continued existence of racism, discrimination, and institutional and public erasure of Aboriginal and Torres Strait Islander LGBTQ+SB people, must be acknowledged as significant stressors for First Nations LGBTQ+SB people (Dudgeon et al., 2018). These not only negatively impact wellbeing, they also act as a barrier to help-seeking and shape mental health service provision (Day et al., 2023). Indeed, as Day et al. (2023) discuss, First Nations LGBTQ+SB people may be reluctant to access mainstream mental health services due to previous traumatic experiences in these services, as well as historical discrimination perpetuated by psychiatry and psychology disciplines. However, this review found that First Nations LGBTQ+SB people may also encounter homophobia and transphobia within some Aboriginal and Torres Strait Islander-specific services (Uink et al 2023, Hill et al 2022).

Findings indicate that service barriers to LGBTQ+ people from CALD backgrounds, including people of colour, also need to be addressed. Inequities exist not only in service provision, but also in the research base, with minimal data available in the SLR on the experiences of First Nations LGBTQ+SB people and LGBTQ+ people from CALD backgrounds. However, it is apparent that experiences of racism can compound experiences of hetero- and cis-normativity in mental health settings (Robertson et al., 2015). This echoes international literature, which has found that trans women of colour face unique challenges in mental health services due to the racialized nature of cisnormativity (Lyons et al., 2015; Moore et al., 2020; Snow et al., 2022). As Moore et al. (2020) have explained, healthcare professionals can be “less accepting” of trans women of colour as they do not fit their stereotypes about gender and race (p.31). The Rainbow Embassy suggest that people of colour may have to choose between a healthcare provider who understands sexuality and gender diversity, or a person who understands the nuances and impacts of systemic racism. This also echoes broader literature indicating that people of colour may choose a provider who is a person of colour over an LGBTQ+ provider, due to their having a greater understanding of their community and health service experience (Dangerfield et al., 2021).

Also emphasised by the Rainbow Embassy, youth have specific mental health care needs due to the intersecting and compounding impacts of age, sexual orientation, and gender identity, and high exposure to hetero- and cis-normativity in families and schools. As this SLR shows, LGBTQ+ youth also report negative experiences in mental health services, with gatekeeping by mental health professionals and delays in accessing gender-affirming care being particularly problematic for youth (Strauss et al., 2021b). LGBTQ+ youth were also more likely to disengage from mental health assessment services (Yang et al., 2021). A clear strategy to support LGBTQ+ youth is required, particularly in regard to accessing gender-affirming care, but also in navigating family and school dynamics.

Equity for LGBTQ+ people with low incomes is also a key consideration. Findings point to the issue of high costs of accessing mental health services and medicine prescriptions for LGBTQ+ people, and their limited access to public mental health services and NDIS

supports (Bretherton et al., 2020; Martin et al., 2019b). As Ross et al. (2018) have previously indicated, private mental health care is costly and often beyond the means of LGBTQ+ people, many of whom are on lower incomes due to discrimination in employment practices. Costs to LGBTQ+ people may be particularly high, given the higher rates of mental distress and suicidality in this population, and may lead to a greater reliance on public mental health services. However, gaining access to public mental health services is not only challenging (Ross et al., 2018), it can also be risky, with findings showing that LGBTQ+ people and their carers are exposed to inconsistent care, conflict, and harmful experiences in emergency and inpatient settings (Martin et al., 2019a, 2019b).

The SLR findings briefly touch on access in rural and remote areas. In South Australian, access to mental health services may have improved for some (Roberts et al., 2018). However, as the Rainbow Embassy emphasise, positive findings must be treated with caution as they may not apply broadly to all LGBTQ+ people or across all rural areas of Australia. Indeed, this review suggests that trans and gender diverse people can find it challenging to access mental health services in rural areas, and confidentiality issues are a concern (Charter et al., 2022; Lim et al., 2021). The wider literature also indicates that LGBTQ+ people have less access to inclusive services in rural areas (e.g., Hill et al., 2021).

5.3.4.6 LGBTQ+ specific services

Although LGBTQ+ specific services were reported to provide more consistently equitable care, SLR findings indicate that these services need to consider the specific needs of subgroups of the LGBTQ+ populations, including First Nations people (Uink et al., 2023), CALD people (McNair & Bush, 2016), and LGBTQ+ sub-populations, including trans, nonbinary, and bisexual people, (Brener et al., 2023; Tollit et al., 2023). Additionally, as emphasised by the Rainbow Embassy, LGBTQ+ specific service providers may lack skills and resources to meet the needs of those with intersecting lived experience of mental health challenges that are more severe and life-interrupting. This reflects international research, which finds that LGBTQ+ specific service providers tend to be oriented towards people with lower mental health needs and have insufficient skills and training to support people with severe mental distress and suicidality (Kidd et al., 2016).

Recommendations for improving equity in mental health services were put forward across studies and included: training for health providers; affirming cues and language; acknowledgement of LGBTQ+ people and verbalisation of respect in service contexts, access to practitioners with diverse identities; support for diverse families; and linking LGBTQ+ people to community (Bishop et al., 2022; Morris et al., 2022; Pennay et al., 2018). However, as the Rainbow Embassy state, in efforts to reform services, it is important to avoid tokenism, and services need to proactively deal with inequities and ensure a knowledgeable and affirming workforce.

Furthermore, we cannot expect mental health services to fix systemic discrimination enacted beyond the health space, and a systemic approach to improving mental health for LGBTQ+ people is required. Although beyond the scope of this review, health promotion efforts to build wellbeing (rather than only treating distress) and attend to the social determinants of mental health would be a key strategy to improve mental health outcomes (de Leeuw, 2020). These strategies are highly relevant to LGBTQ+ people, who experience marginalisation and discrimination in society, and would necessarily include improving the everyday settings where LGBTQ+ people live, including families, schools, communities, and workplaces

(World Health Organization, 1986). As Marmot (2015) states, we cannot simply treat people, and "then send them back to the conditions that made them sick".

Policy makers must also take seriously the impacts on mental health of legislation that explicitly works against the needs of LGBTQ+ people. For example, despite high suicide rates in trans and gender diverse youth, and clear benefits of affirming identity and changing school cultures (Mackie et al., 2023), the Education Legislation Amendment (Parental Rights) Bill, supported by the NSW Liberal parliamentary secretary for education, sought to prevent school staff from teaching about gender diversity, using gender congruent pronouns, or providing support to trans and gender diverse students (Parliament of New South Wales, 2020).

5.3.5 Service safety

Doing no harm, and maintaining safety, including psychological and physical safety, is a priority for mental health services (National Mental Health Commission, 2019). Notably, safety issues were raised across 17 studies in this review.

5.3.5.1 Evidence of service safety

Positive findings about service safety were not reported across included studies. This may be due, in part, to conflation of equity issues with safety in health services research. However, where *equity* refers to variation in service provision based on characterises of service users, *safety* examines whether services intended to help actually lead to harm, including psychological and cultural, as well as physical harms (Institute of Medicine Committee, 2006).

5.3.5.2 Gaps and barriers in service safety

Safety issues raised across SLR studies related to difficulties accessing crisis services (Martin et al., 2019a), delays and denial of gender-affirming care (Bailey et al., 2014), a lack of access to affirming care (Lim et al., 2021), and exposure to pathologisation of sexuality or gender identity (Robertson et al., 2015; Strauss et al., 2021b). Findings also suggest that LGBTQ+ people can be subjected to traumatising experiences in mental health services, including exposure to homophobia and transphobia (Robertson et al., 2015; Strauss et al., 2021b), conversion practices (Jones et al., 2022a), and abuse and violence (Robertson et al., 2015). Coercive practices, including involuntary treatments and physical restraints, were also experienced as traumatising and profoundly disempowering (Martine et al., 2019a, 2019b).

Harmful experiences, and a lack of safety in mental health settings for LGBTQ+ people have been reported previously in the international literature (Braine, 2014; Crockett et al., 2022; Kidd et al., 2016; Ross et al., 2018). Findings suggest that, rather than supporting LGBTQ+ people to navigate the unique traumas and stressors associated with minority stress, mental health services can create "surplus suffering" for LGBTQ+ people (James & Clarke, 2001). Surplus suffering has been defined as suffering that is created, in addition to the original suffering, as a result of seeking healthcare (James & Clarke, 2001). This aligns with study findings, with unsafe experiences in mental health services evidently exacerbating mental distress for LGBTQ+ people (Bailey et al., 2014; Haire et al., 2021; Lim et al., 2021; Pullen Sansfaçon et al., 2023), and were implicated in increased self-harm and suicidality in

LGBTQ+ people (Baile et al., 2014; Pullen Sansfaçon et al., 2023). Exacerbation of suicidal distress and self-harm, due to mental health service provision to LGBTQ+ people, has also been reported in the broader international literature (e.g., Delaney & McCann, 2020; Snow et al., 2022), and indicates an urgent need for service reform.

A systems-level assessment of the attitudes, policies and practices which inform mental health services is required to address fundamental inequities in service provision, and build consistent safety within these systems. However, as the Rainbow Embassy observe, considerations of safety must be formulated in direct response to the specific needs of LGBTQ+ people with intersecting lived experience of mental health challenges. In mental health services, "safety is often synonymous with risk", and can lead to risk adverse approaches that are experienced as unsafe and restrictive by people with lived experience (Cutler et al., 2020), and can be detrimental to personal recovery (Perkins & Repper, 2016). As Cutler et al. (2020) found, safety is enhanced not by more risk-adverse and restrictive practices, but by therapeutic engagement and recovery-oriented practice. The concept of safety is also a core component of trauma informed care and practice, and necessarily involves recognising that people with lived experience of mental health challenges and suicidality often have a history of trauma and require provision of psychologically and culturally safe care, as well as maintenance of physical safety (NSW Agency of Clinical Innovation, 2019).

It is notable that more traumatising experiences were reported in emergency and inpatient services (Martin et al., 2019b; Robertson et al., 2015; Strauss et al., 2021b). The broader literature also indicates that inpatient mental health services can be particularly harmful and traumatising. For example, mental health inpatient services have been described as "locations with the most serious prejudice" exhibited towards sexuality and gender diverse people (Braine, 2014; p.206), and Welch et al. (2000) found that 42% of lesbian women in their study perceived inpatient hospital settings to be "anti-lesbian". This review also found reported incidences where mental health professionals in inpatient settings not only failed to protect LGBTQ+ people in their care from abuse and violence (Braine, 2014; Lyons et al., 2015), but were actually abusive towards LGBTQ+ people (Robertson et al., 2015).

As the Rainbow Embassy highlight, most studies in this review report on a variety of mental health settings, with only one study focusing exclusively on inpatient services (Robertson et al., 2015). This may skew results towards a more favourable evaluation of mental health services overall. As Strauss et al., (2019b) found, inpatient mental health services are rated far lower in terms of providing respectful care (34%), compared to counselling (71.9%), and psychiatric services (64%). Additionally, little is known about the specific experiences of LGBTQ+ people held involuntarily in inpatient services or treated involuntarily in the community, where risk of coercive practice would be higher. These contexts require careful investigation to determine the extent of unsafe practice and the requirements to build consistent safety within these settings.

Conversion practices also require further investigation and serve as a disturbing example of how LGBTQ+ people can experience very specific kinds of harms in mental health services, as well as in community and religious organisations. One study in this review suggests that mental health professionals continue to be engaged in conversion practices (Jones et al., 2022a). As Kuhl (2019) has noted, unscientific and harmful conversion practices have occurred even after removal of homosexuality and gender identity disorder from the DSM. International research also shows that mental health professionals continue to express the

view that sexual orientation and gender identity can be corrected (e.g., Goldberg et al., 2019; Gaspar et al., 2021), and health practitioners have engaged in practices aimed at converting sexuality or gender (Kuhl, 2019; McCann & Brown, 2020; Penn et al., 2013). Of particular interest in this review, is the lack of research on registered health professionals who are still engaged in these kinds of conversion practices, or research on the policies and actions of regulatory bodies to prevent these practices in mental health services. While the study by Jones et al. (2022b) provides valuable information about how health professionals can practice in trauma-informed ways to support LGBTQ+ people who have been exposed to conversion practices, it is the case that conversion practices are profoundly harmful and legislating against these should be a key strategy of policy makers seeking to improve mental health outcomes for LGBTQ+ people.

5.4 Final Limitations and Opportunities

To our 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 LGBTQSB+ 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 LGBTQA+ people with intersecting lived experience of mental health challenges and suicidality, community experts and advocates, and mental health providers.

6 Conclusion

This report has shown 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. In particular, people with intersectional identities, experiences, and health needs, are likely to encounter ineffective, stigmatising, or traumatising care situations.

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. As the Rainbow Embassy note, the majority of health services (and care approaches) can be understood as systemically cis- and hetero-normative, and therefore, a systems-level approach is required to ensure inclusive and safe care for all.

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. The considered, and constructive interpretation of review data by the Rainbow Embassy illustrates why there is both a pragmatic and ethical imperative, for researchers, service providers, and policy makers, to collaborate with the LGBTQ+ community to ensure mental health services are safe, inclusive, and fit for purpose.

Taken together the evidence presented in this report offers important signposts and options to help inform the Government's proposed LGBTIQA+ Mental Health Action Plan.

Readers are referred to the companion Research Translation Paper to see the combined insights and conclusions drawn from across the UTS led research.

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8 Appendices

8.1 Appendix 1:Search strategy undertaken by the Department

The Departmental searches were performed on 30 March 2023.

The databases used were:

8. CINAHL (Platform: EBSCOHost) 610 articles retrieved
9. EMBASE (Platform: Ovid) 1067 articles retrieved
10. Global Health (Platform: EBSCOHost) 340 articles retrieved
11. Health Policy Reference Center (Platform: EBSCOHost) 64 articles retrieved
12. Informit databases: Health Collection, ATSIHEALTH, FAMILY, APAIS, MAIS and RURAL (Platform: Informit) 283 articles retrieved
13. Medline (Platform: Ovid) 645 articles retrieved
14. APA PsycInfo (Platform: Ovid) 326 articles retrieved

1. CINAHL

#	Search Statement	Results
S1	(MH "Psychiatry+") OR TI psychiatr* OR AB psychiatr*	100,551
S2	(MH "Depression+") OR TI (depressed OR depressive OR depression) OR AB (depressed OR depressive OR depression)	210,848
S3	(MH "Panic Disorder") OR TI panic* OR AB panic*	5,888
S4	(MH "Agoraphobia") OR TI agrophobia* OR AB agrophobia*	483
S5	(MH "Social Behavior Disorders+")	110,277
S6	(MM "Social Anxiety Disorders") OR TI "social phobia*" OR AB "social phobia*"	1,991
S7	(MH "Anxiety+") OR TI anxiety OR AB anxiety	121,463
S8	(MH "Obsessive-Compulsive Disorder+") OR TI "obsessive compulsive disorder*" OR AB "obsessive compulsive disorder*" OR TI OCD OR AB OCD	8,776
S9	(MH "Stress Disorders, Post-Traumatic+") OR TI "post traumatic stress disorder*" OR AB "post traumatic stress disorder*"	28,831
S10	(MH "Dysthymic Disorder") OR TI dysthymi* OR AB dysthymi*	1,075
S11	(MH "Bipolar Disorder+") OR TI "bipolar disorder*" OR AB "bipolar disorder*" OR TI "bi polar disorder*" OR AB "bi polar disorder*"	16,735
S12	(MH "Gender Dysphoria") OR TI "gender dysphoria" OR AB "gender dysphoria"	982
S13	(MH "Anorexia") OR (MH "Anorexia Nervosa") OR TI anorexia* OR AB anorexia*	11,017

#	Search Statement	Results
S14	(MH "Eating Disorders+") OR TI "eating disorder*" OR AB "eating disorder*"	24,325
S15	(MH "Stigma") OR TI stigma OR AB stigma	30,030
S16	(MH "Alcoholism") OR (MH "Alcohol-Induced Disorders, Nervous System") OR (MH "Alcohol-Related Disorders+") OR (MH "Alcohol Drinking+") OR TI alcohol* OR AB alcohol*	118,561
S17	(MH "Substance Abuse+") OR "Drug abus*" OR "drug depend*" OR "substance abus*" OR "substance depend*"	104,327
S18	(MM "Mental Disorders+") OR TI "mental* ill*" OR AB "mental* ill*" OR TI "mental* disorder*" OR AB "mental* disorder*"	500,646
S19	(MH "Mental Health") OR TI "mental* health" OR AB "mental* health"	157,639
S20	(MH "Suicide+") OR (MH "Suicidal Ideation") OR (MH "Suicide, Attempted") OR (MH "Suicide Risk (Saba CCC)") OR TI suicid* OR AB suicid*	50,293
S21	(MH "Injuries, Self-Inflicted") OR TI "self harm*" OR AB "self harm*"	6,886
S22	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21	990,936
S23	(MH "LGBTQ+ Persons+") OR (MH "Gay Persons+") OR (MH "Homosexuality") OR (MH "Sexual and Gender Minorities+") OR TI LGB* OR AB LGB* OR TI lesbian* OR AB lesbian* OR TI gay OR AB gay OR TI ("bi-sexual" or bisexual) OR AB ("bi-sexual" or bisexual) OR TI transgender OR AB transgender OR TI queer OR AB queer OR TI intersex OR AB intersex OR TI asexual OR AB asexual OR TI homosexual* OR AB homosexual* OR TI "sexual minor*" OR AB "sexual minor*" OR TI "gender minor*" OR AB "gender minor*" OR TI "cis gender" OR AB "cis gender" OR TI "gender non conforming" OR AB "gender non conforming"	33,666
S24	(MH "Australia+") OR TI Australia* OR AB Australia* OR TI "New South Wales*" OR AB "New South Wales*" OR TI Sydney OR AB Sydney OR TI Newcastle OR AB Newcastle OR TI "South Australia*" OR AB "South Australia*" OR TI Adelaide OR AB Adelaide OR TI Victoria* OR AB Victoria* OR TI Melbourne OR AB Melbourne OR TI "Western Australia*" OR AB "Western Australia*" OR TI Perth OR AB Perth OR TI Queensland* OR AB Queensland* OR TI Brisbane OR AB Brisbane OR TI "Australian Capital Territory" OR AB "Australian Capital Territory" OR TI Canberra* OR AB Canberra* OR TI "northern teritor*" OR AB "northern teritor*" OR TI Darwin OR AB Darwin OR TI Tasmania* OR AB Tasmania* OR TI Hobart OR AB Hobart	172,128
S25	(MH "United Kingdom+") OR TI "United Kingdom" OR AB "United Kingdom" OR TI England OR AB England	358,205
S26	S22 AND S23 AND S24	434

#	Search Statement	Results
S27	S22 AND S23 AND S24 Limiters - Published Date: 20130101-20231231	313
S28	S22 AND S23 AND S24 Limiters - Published Date: 20130101-20231231	313
S29	S22 AND S23 AND S25	494
S30	S22 AND S23 AND S25 Limiters - Published Date: 20130101-20231231	312
S31	S22 AND S23 AND S25 Limiters - Published Date: 20130101-20231231	312
S32	S28 OR S31	610

2. Embase

#	Search Statement	Results
1	exp Psychiatry/	143836
2	psychiatr*.ti,ab.	385401
3	1 or 2	457541
4	exp Depression/	602427
5	depressed.mp.	129742
6	depressive.mp.	207609
7	depression.mp.	836335
8	4 or 5 or 6 or 7	967198
9	exp Panic/	26281
10	panic*.mp.	41412
11	9 or 10	41412
12	exp Agoraphobia/	6839
13	agrophobia*.mp.	6
14	exp Social Phobia/	14045
15	social phobia*.mp.	15795

#	Search Statement	Results
16	exp Anxiety/	282743
17	exp Anxiety Disorder/	310932
18	anxiety.mp.	483123
19	anxiety.ti,ab.	359804
20	anxiety disorder*.mp.	125124
21	16 or 17 or 18 or 19 or 20	628247
22	17 or 20	322718
23	exp obsessive compulsive disorder/	47489
24	obsessive compulsive disorder*.mp.	35498
25	OCD.mp.	17547
26	23 or 24 or 25	52810
27	exp posttraumatic stress disorder/	78414
28	(post traumatic stress disorder* or posttraumatic stress disorder*).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	84448
29	PTSD.mp.	43830
30	27 or 28 or 29	86385
31	exp dysthymia/	11710
32	dysthymi*.mp.	10494
33	31 or 32	12962
34	exp Bipolar Disorder/	76941
35	((bipolar or bi polar) adj3 disorder*).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	84562

#	Search Statement	Results
36	34 or 35	87795
37	exp Gender Dysphoria/	6688
38	gender dysphoria.mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	3580
39	37 or 38	7243
40	exp Anorexia Nervosa/ or exp Anorexia/	93414
41	anorexia*.mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	103761
42	40 or 41	103761
43	exp eating disorder/	63105
44	eating disorder*.mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	46944
45	43 or 44	67604
46	exp alcohol intoxication/	13520
47	exp alcohol consumption/	160595
48	exp alcohol abuse/	48328
49	alcohol*.mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	780646
50	46 or 47 or 48 or 49	782751
51	exp drug abuse/	138259
52	((drug or substance) adj2 (disorder* or abus* or depend*)).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword heading word, floating subheading word, candidate term word]	230559
53	51 or 52	291342

#	Search Statement	Results
54	exp mental disease/	2598583
55	exp Mental Health/	227268
56	mental* ill*.ti,ab.	59072
57	mental* disorder*.ti,ab.	62012
58	mental* health.ti,ab.	255039
59	54 or 55 or 56 or 57 or 58	2768963
60	exp suicidal behavior/	124521
61	suicid*.mp.	158689
62	60 or 61	159746
63	exp automutilation/	23773
64	self harm*.mp.	11674
65	63 or 64	27622
66	exp Social Stigma/	14241
67	stigma.ti,ab.	41786
68	66 or 67	46991
69	exp "sexual and gender minority"/ or exp transgender/ or exp LGBTQIA+ people/ or exp bisexuality/ or exp homosexuality/	63453
70	LGBTQ*.ti,ab.	2528
71	lesbian*.ti,ab.	9269
72	gay.ti,ab.	15638
73	(bi-sexual or bisexual).ti,ab.	12712
74	transgender.ti,ab.	13493

#	Search Statement	Results
75	trans*.ti,ab.	7701285
76	queer.ti,ab.	2461
77	intersex.ti,ab.	2219
78	asexual.ti,ab.	9857
79	homosexual*.ti,ab.	14990
80	"sexual minor*".ti,ab.	4658
81	"gender minor*".ti,ab.	1919
82	"cis gender".ti,ab.	203
83	"gender non conforming".ti,ab.	270
84	69 or 70 or 71 or 72 or 73 or 74 or 76 or 77 or 78 or 79 or 80 or 81 or 82 or 83	86147
85	(Australia* or "New South Wales*" or Sydney* or Newcastle* or "South Australia*" or Adelaide* or Victoria* or Melbourne* or "Western Australia*" or Perth* or Queensland* or Brisbane* or "Australian Capital Territory*" or Canberra* or "Northern Territory*" or Darwin* or Tasmania* or Hobart*).ab,cp,ti.	559029
86	exp Australia/	194848
87	85 or 86	582290
88	84 and 87	3301
89	limit 88 to yr="2013 -Current"	2099
90	limit 89 to english language	2096
91	3 and 90	37
92	8 and 90	132
93	11 and 90	4
94	12 or 13	6842

#	Search Statement	Results
95	14 or 15	15795
96	90 and 94	1
97	90 and 95	3
98	21 and 90	149
99	26 and 90	4
100	30 and 90	14
101	33 and 90	1
102	36 and 90	6
103	39 and 90	55
104	42 and 90	2
105	45 and 90	13
106	50 and 90	124
107	53 and 90	100
108	59 and 90	396
109	exp *Mental Disorders/	1574329
110	108 and 109	128
111	55 and 90	137
112	56 and 90	22
113	57 and 90	15
114	58 and 90	190
115	62 and 90	76

#	Search Statement	Results
116	65 and 90	27
117	68 and 90	144
118	91 or 92 or 93 or 96 or 97 or 98 or 99 or 100 or 101 or 102 or 103 or 104 or 105 or 106 or 107 or 110 or 111 or 112 or 113 or 114 or 115 or 116 or 117	621
119	exp United Kingdom/	460064
120	(United Kingdom or England).ti,ab.	137206
121	119 or 120	504345
122	3 or 8 or 11 or 21 or 26 or 30 or 33 or 36 or 39 or 42 or 45 or 50 or 53 or 55 or 56 or 57 or 58 or 62 or 65 or 68 or 94 or 95 or 109	3514282
123	84 and 121 and 122	721
124	limit 123 to (english language and yr="2013 -Current")	465
125	118 or 124	1067

3. Global Health

#	Search Statement	Results
S1	(DE "psychiatry") OR TI psychiatr* OR AB psychiatr*	17,707
S2	(DE "depression") OR TI (depressed OR depressive OR depression) OR AB (depressed OR depressive OR depression)	59,681
S3	TI panic* OR AB panic*	4,402
S4	TI agrophobia* OR AB agrophobia*	0
S5	TI "social phobia*" OR AB "social phobia*"	258
S6	(DE "anxiety") OR TI anxiety OR AB anxiety	29,502
S7	TI "obsessive compulsive disorder*" OR AB "obsessive compulsive disorder*" OR TI OCD OR AB OCD	764
S8	(DE "post-traumatic stress disorder") OR TI "post traumatic stress disorder*" OR AB "post traumatic stress disorder*"	4,126
S9	TI dysthymi* OR AB dysthymi*	233

#	Search Statement	Results
S10	(DE "bipolar disorder") OR TI "bipolar disorder*" OR AB "bipolar disorder*" OR TI "bi polar disorder*" OR AB "bi polar disorder*"	2,070
S11	TI "gender dysphoria" OR AB "gender dysphoria"	76
S12	(DE "anorexia" OR DE "anorexia nervosa") OR TI anorexia* OR AB anorexia*	13,398
S13	(DE "appetite disorders" OR DE "bulimia" OR DE "compulsive eating" OR DE "hyperphagia" OR DE "pica" OR DE "anorexia") OR TI "eating disorder*" OR AB "eating disorder*"	20,226
S14	(DE "social stigma") OR TI stigma OR AB stigma	11,883
S15	(DE "alcoholism") OR TI alcohol* OR AB alcohol*	102,410
S16	(DE "drug abuse") OR (DE "drug addiction") OR "Drug abus*" OR "drug depend*" OR "substance abus*" OR "substance depend*"	43,169
S17	(DE "mental disorders") OR TI "mental* ill*" OR AB "mental* ill*" OR TI "mental* disorder*" OR AB "mental* disorder*"	65,009
S18	(DE "mental health") OR TI "mental* health" OR AB "mental* health"	48,037
S19	(DE "suicide") OR TI suicid* OR AB suicid*	13,166
S20	TI "self harm*" OR AB "self harm*"	1,408
S21	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20	283,369
S22	(DE "homosexuality") OR (DE "intersexuality")) OR (DE "bisexuality") OR TI LGB* OR AB LGB* OR TI lesbian* OR AB lesbian* OR TI gay OR AB gay OR TI ("bi-sexual" or bisexual) OR AB ("bi-sexual" or bisexual) OR TI transgender OR AB transgender OR TI queer OR AB queer OR TI intersex OR AB intersex OR TI asexual OR AB asexual OR TI homosexual* OR AB homosexual* OR TI "sexual minor*" OR AB "sexual minor*" OR TI "gender minor*" OR AB "gender minor*" OR TI "cis gender" OR AB "cis gender" OR TI "gender non conforming" OR AB "gender non conforming"	23,615
S23	(DE "Australia" OR DE "Australian Capital Territory" OR DE "New South Wales" OR DE "Northern Territory" OR DE "Queensland" OR DE "South Australia" OR DE "Tasmania" OR DE "Victoria" OR DE "Western Australia") OR TI Australia* OR AB Australia* OR TI "New South Wales*" OR AB "New South Wales*" OR TI Sydney OR AB Sydney OR TI Newcastle OR AB Newcastle OR TI "South Australia*" OR AB "South Australia*" OR TI Adelaide OR AB Adelaide OR TI Victoria* OR AB Victoria* OR TI Melbourne OR AB Melbourne OR TI "Western Australia*" OR AB "Western Australia*" OR TI Perth OR AB Perth OR TI Queensland* OR AB Queensland* OR TI Brisbane OR AB Brisbane OR TI "Australian Capital Territory" OR AB "Australian	70,350

#	Search Statement	Results
	Capital Territory" OR TI Canberra* OR AB Canberra* OR TI "northern teritor*" OR AB "northern teritor*" OR TI Darwin OR AB Darwin OR TI Tasmania* OR AB Tasmania* OR TI Hobart OR AB Hobart	
S24	(DE "UK" OR DE "Channel Islands" OR DE "Great Britain" OR DE "Isle of Man" OR DE "Northern Ireland") OR TI "United Kingdom" OR AB "United Kingdom" OR TI England OR AB England	90,282
S25	S21 AND S22 AND S23	293
S26	S21 AND S22 AND S23 Limiters - Publication Year: 20130101-20221231	181
S27	S21 AND S22 AND S23 Limiters - Publication Year: 20130101-20221231	181
S28	S21 AND S22 AND S24	321
S29	S21 AND S22 AND S24 Limiters - Publication Year: 20130101-20231231	164
S30	S21 AND S22 AND S24 Limiters - Publication Year: 20130101-20231231	164
S31	S27 OR S30	340

4. Health Policy Reference Center

#	Search Statement	Results
S1	DE "PSYCHIATRY" OR TI psychiatr* OR AB psychiatr*	9,720
S2	(DE "MENTAL depression") OR TI (depressed OR depressive OR depression) OR AB (depressed OR depressive OR depression)	17,699
S3	(DE "PANIC disorders" OR DE "PANIC attacks") OR TI panic* OR AB panic*	506
S4	DE "AGORAPHOBIA" OR TI agrophobia* OR AB agrophobia*	19
S5	(DE "SOCIAL phobia" OR DE "COMMUNICATION apprehension" OR DE "PARURESIS" OR DE "SPEECH anxiety") OR TI "social phobia*" OR AB "social phobia*"	66
S6	(DE "ANXIETY") OR TI anxiety OR AB anxiety	8,601
S7	(DE "OBSESSIVE-compulsive disorder" OR DE "BIBLIOMANIA" OR DE "COMPULSIVE hair pulling" OR DE "COMPULSIVE skin picking" OR DE "COMPULSIVE washing") OR TI "obsessive compulsive disorder*" OR AB "obsessive compulsive disorder*" OR TI OCD OR AB OCD	205
S8	TI "post traumatic stress disorder*" OR AB "post traumatic stress disorder*"	828
S9	(DE "DYSTHYMIC disorder") OR TI dysthymi* OR AB dysthymi*	67

#	Search Statement	Results
S10	(DE "BIPOLAR disorder" OR DE "CYCLOTHYMIA") OR TI "bipolar disorder*" OR AB "bipolar disorder*" OR TI "bi polar disorder*" OR AB "bi polar disorder*"	674
S11	(DE "GENDER dysphoria" OR DE "GENDER dysphoria in adolescence" OR DE "GENDER dysphoria in children") OR TI "gender dysphoria" OR AB "gender dysphoria"	121
S12	(DE "ANOREXIA nervosa") OR TI anorexia* OR AB anorexia*	513
S13	(DE "EATING disorders" OR DE "ANOREXIA nervosa" OR DE "BINGE-eating disorder" OR DE "BULIMIA" OR DE "COMPULSIVE eating" OR DE "COPROPHAGIA" OR DE "EATING disorders in women" OR DE "HYPERPHAGIA" OR DE "ORTHOREXIA nervosa" OR DE "PICA (Pathology)") OR TI "eating disorder*" OR AB "eating disorder*"	939
S14	(DE "SOCIAL stigma") OR TI stigma OR AB stigma	5,668
S15	DE "ALCOHOL" OR DE "ALCOHOL & sex" OR DE "AVERTIN" OR DE "FUSEL oil" OR DE "METHOXYETHANOL" OR DE "PHYSIOLOGICAL effects of alcohol" OR DE "ALCOHOL & LGBTQ people" OR DE "ALCOHOL drinking" OR DE "ALCOHOL & LGBTQ+ people" OR DE "ALCOHOL & authors" OR DE "ALCOHOL drinking in college" OR DE "ALCOHOL use of people with drug addiction" OR DE "ATTITUDES toward drinking of alcoholic beverages" OR DE "BINGE drinking" OR DE "CONTROLLED drinking" OR DE "DRINKING on aircraft" OR DE "STUDENTS -- Alcohol use" OR DE "ALCOHOLISM" OR DE "ALCOHOL testing of employees" OR DE "ALCOHOLISM & crime" OR DE "ALCOHOLISM in sports" OR DE "ASTROLOGY & alcoholism" OR DE "YOUTH & alcohol" OR DE "ALCOHOL drinking" OR DE "ALCOHOL & LGBTQ+ people" OR DE "ALCOHOL & authors" OR DE "ALCOHOL drinking in college" OR DE "ALCOHOL use of people with drug addiction" OR DE "ATTITUDES toward drinking of alcoholic beverages" OR DE "BINGE drinking" OR DE "CONTROLLED drinking" OR DE "DRINKING on aircraft" OR DE "STUDENTS -- Alcohol use" OR TI alcohol* OR AB alcohol*	15,381
S16	(DE "DRUG abuse" OR DE "AMPHETAMINE abuse" OR DE "COCAINE abuse" OR DE "DRUG abuse in sports" OR DE "DRUG addiction" OR DE "DRUGS & authors" OR DE "DRUGS & mass media" OR DE "DRUGS & sex" OR DE "HEROIN abuse" OR DE "INTRAVENOUS drug abuse" OR DE "MARIJUANA abuse" OR DE "MEDICATION abuse" OR DE "METHADONE abuse" OR DE "MORPHINE abuse" OR DE "OPIUM abuse" OR DE "PHENCYCLIDINE abuse" OR DE "SEDATIVE abuse") OR "Drug abus*" OR "drug depend*" OR "substance abus*" OR "substance depend*"	32,336
S17	(DE "MENTAL illness" OR DE "ART & mental illness" OR DE "DUAL diagnosis" OR DE "GENDER dysphoria" OR DE "GENIUS & mental illness" OR DE "INSANITY (Law)" OR DE "LITERATURE & mental illness" OR DE "PARAPHILIAS" OR DE "REACTIVE attachment disorder" OR DE	9,910

#	Search Statement	Results
	"SCHIZOPHRENIA") OR TI "mental* ill*" OR AB "mental* ill*" OR TI "mental* disorder*" OR AB "mental* disorder*"	
S18	(DE "mental health") OR TI "mental* health" OR AB "mental* health"	27,600
S19	DE "SUICIDE" OR DE "ATTEMPTED suicide" OR DE "SELF-immolation" OR DE "SELF-poisoning" OR TI suicid* OR AB suicid*	7,071
S20	TI "self harm*" OR AB "self harm*"	537
S21	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20	94,456
S22	DE "LGBTQ people" OR DE "HOMOSEXUALITY" OR DE "LESBIANISM" OR DE "MALE homosexuality" OR (DE "BISEXUALS" OR DE "BISEXUAL men" OR DE "BISEXUAL women" OR (DE "homosexuality") OR (DE "intersexuality")) OR (DE "bisexuality") OR TI LGB* OR AB LGB* OR TI lesbian* OR AB lesbian* OR TI gay OR AB gay OR TI ("bi-sexual" or bisexual) OR AB ("bi-sexual" or bisexual) OR TI transgender OR AB transgender OR TI queer OR AB queer OR TI intersex OR AB intersex OR TI asexual OR AB asexual OR TI homosexual* OR AB homosexual* OR TI "sexual minor*" OR AB "sexual minor*" OR TI "gender minor*" OR AB "gender minor*" OR TI "cis gender" OR AB "cis gender" OR TI "gender non conforming" OR AB "gender non conforming"	5,435
S23	TI Australia* OR AB Australia* OR TI "New South Wales*" OR AB "New South Wales*" OR TI Sydney OR AB Sydney OR TI Newcastle OR AB Newcastle OR TI "South Australia*" OR AB "South Australia*" OR TI Adelaide OR AB Adelaide OR TI Victoria* OR AB Victoria* OR TI Melbourne OR AB Melbourne OR TI "Western Australia*" OR AB "Western Australia*" OR TI Perth OR AB Perth OR TI Queensland* OR AB Queensland* OR TI Brisbane OR AB Brisbane OR TI "Australian Capital Territory" OR AB "Australian Capital Territory" OR TI Canberra* OR AB Canberra* OR TI "northern teritor*" OR AB "northern teritor*" OR TI Darwin OR AB Darwin OR TI Tasmania* OR AB Tasmania* OR TI Hobart OR AB Hobart	20,308
S24	TI "United Kingdom" OR AB "United Kingdom" OR TI England OR AB England	21,127
S25	S21 AND S22 AND S23	71
S26	S21 AND S22 AND S23 Limiters - Publication Date: 20130101-20231231	44
S27	S21 AND S22 AND S23 Limiters - Publication Date: 20130101-20231231	44
S28	S21 AND S22 AND S24	28

#	Search Statement	Results
S29	S21 AND S22 AND S24 Limiters - Publication Date: 20130101-20221231	21
S30	S21 AND S22 AND S24 Limiters - Publication Date: 20130101-20221231	21
S31	S27 OR S30	64

5. Informit

#	Search Statement	Results
1	All Fields:psychiatr* OR All Fields:depressed OR All Fields:depressive OR All Fields:depression OR All Fields:panic* OR All Fields:agrophobia* OR All Fields:"social phobia*" OR All Fields:anxiety OR All Fields:"obsessive compulsive disorder*" OR All Fields:OCD OR All Fields:"post traumatic stress disorder*" OR All Fields:dysthymi* OR All Fields:"bipolar disorder*" OR All Fields:"gender dysphoria" OR All Fields:anorexia* OR All Fields:"eating disorder*" OR All Fields:stigma OR All Fields:alcohol* OR All Fields:"Drug abus*" OR All Fields:"drug depend*" OR All Fields:"substance abus*" OR All Fields:"substance depend*" OR All Fields:"mental* ill*" OR All Fields:"mental* disorder*" OR All Fields:"mental* health" OR All Fields:suicid* OR All Fields:"self harm*"	88669
2	All Fields:LGB* OR All Fields:lesbian* OR All Fields:gay OR All Fields:"bi-sexual" OR All Fields:bisexual OR All Fields:transgender OR All Fields:queer OR All Fields:intersex OR All Fields:asexual OR All Fields:homosexual* OR All Fields:"sexual minor*" OR All Fields:"gender minor*" OR All Fields:"cis gender" OR All Fields:"gender non conforming"	9751
3	[All Fields:psychiatr* OR All Fields:depressed OR All Fields:depressive OR All Fields:depression OR All Fields:panic* OR All Fields:agrophobia* OR All Fields:"social phobia*" OR All Fields:anxiety OR All Fields:"obsessive compulsive disorder*" OR All Fields:OCD OR All Fields:"post traumatic stress disorder*" OR All Fields:dysthymi* OR All Fields:"bipolar disorder*" OR All Fields:"gender dysphoria" OR All Fields:anorexia* OR All Fields:"eating disorder*" OR All Fields:stigma OR All Fields:alcohol* OR All Fields:"Drug abus*" OR All Fields:"drug depend*" OR All Fields:"substance abus*" OR All Fields:"substance depend*" OR All Fields:"mental* ill*" OR All Fields:"mental* disorder*" OR All Fields:"mental* health" OR All Fields:suicid* OR All Fields:"self harm*"] AND [All Fields:LGB* OR All Fields:lesbian* OR All Fields:gay OR All Fields:"bi-sexual" OR All Fields:bisexual OR All Fields:transgender OR All Fields:queer OR All Fields:intersex OR All Fields:asexual OR All Fields:homosexual* OR All Fields:"sexual minor*" OR All Fields:"gender minor*" OR All Fields:"cis gender" OR All Fields:"gender non conforming"]	951
4	[All Fields:psychiatr* OR All Fields:depressed OR All Fields:depressive OR All Fields:depression OR All Fields:panic* OR All Fields:agrophobia* OR All Fields:"social phobia*" OR All Fields:anxiety OR All Fields:"obsessive compulsive disorder*" OR All Fields:OCD OR All Fields:"post traumatic stress disorder*" OR All Fields:dysthymi* OR All Fields:"bipolar disorder*" OR All Fields:"gender dysphoria" OR All Fields:anorexia* OR All Fields:"eating disorder*" OR All Fields:stigma OR All Fields:alcohol* OR All Fields:"Drug abus*" OR All Fields:"drug depend*" OR All Fields:"substance abus*" OR All Fields:"substance depend*" OR All Fields:"mental* ill*" OR All Fields:"mental* disorder*" OR All Fields:"mental* health" OR All	283

#	Search Statement	Results
	Fields:suicid* OR All Fields:"self harm*"] AND [All Fields:LGB* OR All Fields:lesbian* OR All Fields:gay OR All Fields:"bi-sexual" OR All Fields:bisexual OR All Fields:transgender OR All Fields:queer OR All Fields:intersex OR All Fields:asexual OR All Fields:homosexual* OR All Fields:"sexual minor*" OR All Fields:"gender minor*" OR All Fields:"cis gender" OR All Fields:"gender non conforming"] AND Publication Date: (01/01/2013 TO 31/12/2023)	

6. Medline

#	Search Statement	Results
1	exp Psychiatry/	110159
2	psychiatr*.ti,ab.	274617
3	1 or 2	340711
4	exp Depressive Disorder/ or exp Depressive Disorder, Major/ or exp Depression/	253718
5	depressed.mp.	100473
6	depressive.mp.	210834
7	depression.mp.	484518
8	4 or 5 or 6 or 7	600955
9	exp Panic Disorder/	7267
10	panic*.mp.	25615
11	9 or 10	25615
12	exp Agoraphobia/	2670
13	agrophobia*.mp.	1
14	exp Phobia, Social/	1182
15	social phobia*.mp.	4344
16	exp Anxiety/	109599
17	exp Anxiety Disorders/	89487
18	anxiety.mp.	302921
19	anxiety.ti,ab.	250971
20	anxiety disorder*.mp.	64017
21	16 or 17 or 18 or 19 or 20	340466
22	17 or 20	109277
23	exp Obsessive-Compulsive Disorder/	16568

#	Search Statement	Results
24	obsessive compulsive disorder*.mp.	21988
25	OCD.mp.	11721
26	23 or 24 or 25	24031
27	exp Stress Disorders, Post-Traumatic/	40592
28	(post traumatic stress disorder* or posttraumatic stress disorder*).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	38801
29	PTSD.mp.	32805
30	27 or 28 or 29	56625
31	exp Dysthymic Disorder/	1172
32	dysthymi*.mp.	3765
33	31 or 32	3765
34	exp Bipolar Disorder/	44845
35	((bipolar or bi polar) adj3 disorder*).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	58870
36	34 or 35	58870
37	exp Gender Dysphoria/	886
38	gender dysphoria.mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	1995
39	37 or 38	1995
40	exp Anorexia Nervosa/ or exp Anorexia/	19608
41	anorexia*.mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	38772
42	40 or 41	38772

#	Search Statement	Results
43	exp "Feeding and Eating Disorders"/	35791
44	eating disorder*.mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	33446
45	43 or 44	44266
46	exp Alcoholism/	79874
47	exp Alcohol-Related Disorders/	120936
48	exp Alcohol Drinking/	77463
49	alcohol*.mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	487562
50	46 or 47 or 48 or 49	488985
51	exp Substance-Related Disorders/	308471
52	((drug or substance) adj2 (disorder* or abus* or depend*)).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	176567
53	51 or 52	352415
54	exp Mental Disorders/	1419387
55	exp Mental Health/	59451
56	mental* ill*.ti,ab.	45766
57	mental* disorder*.ti,ab.	48387
58	mental* health.ti,ab.	202923
59	54 or 55 or 56 or 57 or 58	1576407
60	exp suicide/ or exp suicidal ideation/ or exp suicide prevention/ or exp suicide, assisted/ or exp suicide, attempted/ or exp suicide, completed/	73761
61	suicid*.mp.	112463
62	60 or 61	112463
63	exp Self-Injurious Behavior/	82592

#	Search Statement	Results
64	self harm*.mp.	8542
65	63 or 64	86060
66	exp Social Stigma/	12514
67	stigma.ti,ab.	33233
68	66 or 67	35822
69	exp "Sexual and Gender Minorities"/	15425
70	LGBTQ*.ti,ab.	2002
71	lesbian*.ti,ab.	8405
72	gay.ti,ab.	13657
73	(bi-sexual or bisexual).ti,ab.	11175
74	transgender.ti,ab.	10178
75	trans*.ti,ab.	6302202
76	queer.ti,ab.	2266
77	intersex.ti,ab.	2028
78	asexual.ti,ab.	9703
79	homosexual*.ti,ab.	13892
80	"sexual minor*".ti,ab.	4188
81	"gender minor*".ti,ab.	1686
82	"cis gender".ti,ab.	94
83	"gender non conforming".ti,ab.	176
84	69 or 70 or 71 or 72 or 73 or 74 or 76 or 77 or 78 or 79 or 80 or 81 or 82 or 83	56728
85	(Australia* or "New South Wales*" or Sydney* or Newcastle* or "South Australia*" or Adelaide* or Victoria* or Melbourne* or "Western Australia*" or Perth* or Queensland* or Brisbane* or "Australian Capital Territory*" or Canberra* or "Northern Territory*" or Darwin* or Tasmania* or Hobart*).ab,cp,ti.	484656
86	exp Australia/	168459
87	85 or 86	510050
88	84 and 87	2120
89	limit 88 to yr="2013 -Current"	1237
90	limit 89 to english language	1236

#	Search Statement	Results
91	3 and 90	19
92	8 and 90	76
93	11 and 90	1
94	12 or 13	2670
95	14 or 15	5267
96	90 and 94	0
97	90 and 95	0
98	21 and 90	61
99	26 and 90	1
100	30 and 90	6
101	33 and 90	0
102	36 and 90	0
103	39 and 90	36
104	42 and 90	0
105	45 and 90	8
106	50 and 90	69
107	53 and 90	104
108	59 and 90	274
109	exp *Mental Disorders/	1203785
110	108 and 109	135
111	55 and 90	48
112	56 and 90	17
113	57 and 90	8
114	58 and 90	157
115	62 and 90	56
116	65 and 90	37
117	68 and 90	104
118	91 or 92 or 93 or 96 or 97 or 98 or 99 or 100 or 101 or 102 or 103 or 104 or 105 or 106 or 107 or 110 or 111 or 112 or 113 or 114 or 115 or 116 or 117	435
119	exp United Kingdom/	388948

#	Search Statement	Results
120	(United Kingdom or England).ti,ab.	102286
121	119 or 120	435199
122	3 or 8 or 11 or 21 or 26 or 30 or 33 or 36 or 39 or 42 or 45 or 50 or 53 or 55 or 56 or 57 or 58 or 62 or 65 or 68 or 94 or 95 or 109	2520356
123	84 and 121 and 122	416
124	limit 123 to (english language and yr="2013 -Current")	225
125	118 or 124	645

7. PsycInfo

#	Search Statement	Results
1	exp Psychiatry/	56389
2	psychiatr*.ti,ab.	274422
3	1 or 2	287033
4	exp major depression/ or exp "Depression (Emotion)"/	181431
5	depressed.mp.	53971
6	depressive.mp.	161240
7	depression.mp.	379978
8	4 or 5 or 6 or 7	416976
9	exp Panic Disorder/	7950
10	panic*.mp.	19452
11	9 or 10	19452
12	exp Agoraphobia/	2961
13	agrophobia*.mp.	3
14	exp Social Phobia/	5155
15	social phobia*.mp.	8923
16	exp Anxiety/	87959
17	exp Anxiety Disorders/	42252
18	anxiety.mp.	281262
19	anxiety.ti,ab.	222991
20	anxiety disorder*.mp.	62341

#	Search Statement	Results
21	16 or 17 or 18 or 19 or 20	289416
22	17 or 20	76134
23	exp Obsessive-Compulsive Disorder/	18049
24	obsessive compulsive disorder*.mp.	22313
25	OCD.mp.	12456
26	23 or 24 or 25	24823
27	exp Posttraumatic Stress Disorder/	39340
28	(post traumatic stress disorder* or posttraumatic stress disorder*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	51515
29	PTSD.mp.	44105
30	27 or 28 or 29	57230
31	exp Dysthymic Disorder/	1523
32	dysthymi*.mp.	4422
33	31 or 32	4422
34	exp Bipolar Disorder/	34012
35	((bipolar or bi polar) adj3 disorder*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	46941
36	34 or 35	48560
37	exp Gender Dysphoria/	1227
38	gender dysphoria.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	2013
39	37 or 38	2013
40	exp Anorexia Nervosa/ or exp Anorexia/	12335
41	anorexia*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	19000
42	40 or 41	19000
43	exp Eating Disorders/	34881
44	eating disorder*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	35849
45	43 or 44	44450
46	exp Alcohol Abuse/	51287

#	Search Statement	Results
47	exp alcoholism/	31845
48	exp alcoholism/	31845
49	alcohol*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	160129
50	46 or 47 or 48 or 49	160696
51	exp Drug Abuse/	50444
52	((drug or substance) adj2 (disorder* or abus* or depend*)).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	126620
53	51 or 52	127044
54	exp Mental Disorders/	1014403
55	exp Mental Health/	86590
56	mental* ill*.ti,ab.	56838
57	mental* disorder*.ti,ab.	55225
58	mental* health.ti,ab.	218718
59	54 or 55 or 56 or 57 or 58	1185944
60	exp Attempted Suicide/ or exp Suicide/ or exp Suicidal Ideation/	45113
61	suicid*.mp.	80722
62	60 or 61	80722
63	exp Nonsuicidal Self-Injury/	7592
64	self harm*.mp.	8157
65	63 or 64	12615
66	exp Social Stigma/	17322
67	stigma.ti,ab.	29643
68	66 or 67	32864
69	exp Lesbianism/ or exp Homosexuality/ or exp Bisexuality/ or exp Male Homosexuality/ or exp LGBTQ/	39281
70	LGBTQ*.ti,ab.	3237
71	lesbian*.ti,ab.	18104
72	gay.ti,ab.	23808
73	(bi-sexual or bisexual).ti,ab.	13608

#	Search Statement	Results
74	transgender.ti,ab.	9903
75	trans*.ti,ab.	607522
76	queer.ti,ab.	5982
77	intersex.ti,ab.	763
78	asexual.ti,ab.	659
79	homosexual*.ti,ab.	14201
80	"sexual minor*".ti,ab.	5822
81	"gender minor*".ti,ab.	1543
82	"cis gender".ti,ab.	66
83	"gender non conforming".ti,ab.	224
84	69 or 70 or 71 or 72 or 73 or 74 or 76 or 77 or 78 or 79 or 80 or 81 or 82 or 83	57212
85	(Australia* or "New South Wales*" or Sydney* or Newcastle* or "South Australia*" or Adelaide* or Victoria* or Melbourne* or "Western Australia*" or Perth* or Queensland* or Brisbane* or "Australian Capital Territory*" or Canberra* or "Northern Territory*" or Darwin* or Tasmania* or Hobart*).ab,cp,ti.	79176
86	12 or 13	2962
87	14 or 15	8923
88	exp *Mental Disorders/	869838
89	(United Kingdom or England).ti,ab,cp.	35983
90	84 and 85	1276
91	limit 90 to (english language and yr="2013 -Current")	631
92	3 and 91	19
93	8 and 91	67
94	11 and 91	2
95	21 and 91	58
96	26 and 91	1
97	30 and 91	2
98	33 and 91	0
99	36 and 91	0
100	39 and 91	13

#	Search Statement	Results
101	42 and 91	0
102	45 and 91	8
103	50 and 91	41
104	53 and 91	47
105	59 and 88 and 91	74
106	55 and 91	68
107	56 and 91	11
108	57 and 91	4
109	62 and 91	43
110	65 and 91	18
111	68 and 91	56
112	86 and 91	0
113	87 and 91	0
114	92 or 93 or 94 or 95 or 96 or 97 or 98 or 99 or 100 or 101 or 102 or 103 or 104 or 105 or 106 or 107 or 108 or 109 or 110 or 111 or 112 or 113	245
115	3 or 8 or 11 or 21 or 26 or 30 or 33 or 36 or 39 or 42 or 45 or 50 or 53 or 55 or 56 or 57 or 62 or 65 or 68 or 86 or 87 or 88	1500855
116	84 and 89 and 115	152
117	limit 116 to (english language and yr="2013 -Current")	89
118	114 or 117	326

8.2 Appendix 2: Characteristics of included SLR studies (n=56)

Author Year	Country	Aims	Method	Participants	Service type
Bailey 2014	UK	Explores trans mental health including suicidal ideation and attempts and the impact of gender dysphoria, minority stress and medical delay	Qualitative – A narrative analysis of qualitative sections of a survey with open and closed questions	889 trans adults	Mixed – mental health services, including access to gender affirming care
Bishop 2022	Australia	Investigate perspectives on culturally competent counselling and psychology services	Mixed methods – Quantitative measure of cultural competence (Gay Affirming Practice Scale) and open-ended qualitative responses	274 sexuality diverse (LGBQ) adults	Counselling and psychology services
Bond 2017	Australia	Develop guidelines on mental health first aid to LGBTIQ people	Delphi survey – A systematic literature search was the basis for a questionnaire containing items about the knowledge, skills, and actions needed to assist LGBTIQ mental health. Items were rated by an expert panel and qualitative feedback	75 mental health professionals	Mental health first aid
Bowman 2020	Australia	Promote understanding about the provision of internet-based mental health services for LGBT young adults in rural areas	Qualitative - Semi-structured interviews exploring perspectives of both LGBT young adults and internet based mental health service providers	15 participants – 9 LGBT young adults (18-25 years) living in rural or regional areas, and 6 service providers	Online mental health services

Author Year	Country	Aims	Method	Participants	Service type
Brenner 2023	Australia	Assess the association between sources of stigma and health care avoidance amongst gay and bisexual men	Quantitative – online survey	1116 gay and bisexual men	Mixed - GPs, specialists, nurses, pharmacists, sexual health services
Bretherton 2021	Australia	Examine the health status and needs of Australian trans people to guide health and well-being programs	Quantitative – cross-sectional online survey using nonprobability snowball sampling. Descriptive demographic data on access to health care, health burden, access to health resources, and priorities for transgender health	928 Transgender, nonbinary, and gender diverse adults	Mixed – GP, psychologist, psychiatrist, medical, nurse, allied health, gender clinic
Charter 2022	Australia	Explore mental health issues for transgender parents and their experiences of formal and informal support	Qualitative – online open-ended survey data and one-on-one interviews	66 transgender adult parents completed the survey, 38 consented to being interviewed	Counselling from a mental health professional, including those specialising in trans health
Cheung 2020	Australia	Understand the mental health characteristics of nonbinary people compared with trans men and women	Quantitative –Retrospective study of electronic medical records of new consultations for gender dysphoria across three clinical settings	895 trans and nonbinary youth and adults	Gender dysphoria consultations in gender centre, endocrine specialist clinic, and paediatric gender clinic

Author Year	Country	Aims	Method	Participants	Service type
Cronin 2021	Australia	Examine predictors of mental health service use among LGB Australians	Quantitative – online questionnaire	592 same-sex attracted men and women (bisexual, queer)	Mental health counsellors, including psychologists and social workers
Davies 2013	UK	Understand levels of satisfaction with gender service provision at two gender identity clinics	Quantitative – patient satisfaction questionnaire	330 gender diverse people	Gender identity clinic services
del pozo de Bolger 2014	Australia	To understand the experiences, developmental trajectories, and mental health status of Australian trans men	Quantitative – online data collection	279 trans men	Mixed – mental health (unspecified)
Dimova 2022	UK	Explores experiences of LGBTQ+ people who have used alcohol services	Qualitative – semi-structured interviews	14 LGBTQ+ adults, who used alcohol treatment services	Mixed – Alcohol service focused, including peer support groups, with some comment of co-occurring conditions and mental health service needs
Erasmus 2015	Australia	Assess patients' subjective evaluation of the healthcare services they received through gender dysphoria clinical services	Quantitative and qualitative – cross-sectional survey	127 trans and gender diverse adults	Gender dysphoria clinic, including social workers and psychologists
Haire 2021	Australia	Explore the experiences of healthcare access in a diverse sample of trans and gender diverse people with complex health needs	Qualitative – semi- structured interviews	12 trans and gender diverse adults	Mixed – general health, mental health, and sexual health services

Author Year	Country	Aims	Method	Participants	Service type
Harrison 2020	UK	Understand the lived experiences of adults with gender dysphoria seeking treatment in gender identity clinics	Qualitative – semi-structured interviews, phenomenology	8 trans adults who had or were seeking gender affirming surgery	Gender identity clinic
Hawkey 2021	Australia	Explore support needs of trans women exposed to sexual violence	Qualitative – in-depth interviews and photovoice	31 trans women of colour	Mixed – accessing support from GP, nurse, physiotherapist, psychiatrist, police, or LGBTQ+ community support workers
Hill 2022	Australia	Document and measure the extent to which the social, health, emotional well-being, and other support needs of Aboriginal and/or Torres Strait Islander LGBTQIA+ people are currently met by health, education, and social support organisations	Mixed methods – focus group and written response, primarily qualitative	54 health workers	Mixed – including Aboriginal-specific services
Ho 2017	Australia	Evaluate the satisfaction with gender transition support and mental health services	Quantitative – satisfaction survey	161 trans adults	Mixed – GP, psychologist, psychiatrist, medical
Hughes 2018	UK	Examine perceptions and practice related to working with LGBTQ youth who engage in suicide, self-harm, and help-seeking in mental healthcare settings	Quantitative – cross-sectional survey, part of a larger mixed method study of LGBTQ youth suicide and self-harm	113 mental health staff perspective on working with LGBTQ people	Mixed – mental health practitioners

Author Year	Country	Aims	Method	Participants	Service type
Jones 2022a	Australia	Explore the experiences and support needs of survivors of conversion practices or SOGIECE (sexual orientation and gender identity expression change efforts)	Qualitative – focus groups and interviews	35 LGBTQA+ adult survivors of conversion practices	Conversion practices – mixed mental health settings and health practitioners, including psychologists
Jones 2022b	Australia	Explore experiences of harm, including spiritual harms, of conversion practices	Qualitative – three sets of interviews, including life-history interviews and group interviews	42 LGBTQ+ adult survivors of conversion practices	Exposure to conversion practices, including by mental health practitioners
Kilicaslan 2019	Australia	Examine perceived knowledge and confidence of mental health staff to deliver responsive care to LGBTIQ+ people, and the perceived organisational culture and level of support for LGBTIQ+ inclusive service delivery	Quantitative – online survey with some open-ended responses	125 mental health staff	Mixed – public mental health services, including community mental health clinics, residential services, acute mental health inpatient services, service development, and research departments
Lefrancois 2013	UK	Explore heteronormativity and intersection with classism, sanism, and “adultism” within child and youth mental health services	Qualitative – ethnography using interviews, observation, and patient files	3 youth (12-17 years), and health professionals (numbers not specified)	Child and youth mental health services
Lim 2022	Australia	Determine experiences of sexuality diverse people accessing crisis helplines, including equitable delivery	Mixed methods –quantitative and qualitative survey	248 sexuality diverse adults	Mental health crisis helplines

Author Year	Country	Aims	Method	Participants	Service type
Lim 2021	Australia	Examine experiences of trans and gender diverse people accessing crisis helplines	Mixed methods – survey	134 trans and gender diverse adults	Mental health crisis helplines
Lucassen 2018	UK	This study aimed to explore how and why LGBT+ young people use the internet to support their mental health, and their views about e-therapies	Qualitative – focus groups and semi-structured interviews	21 LGBT+ youth (15-22 years), and 6 online service providers of mental health content	e-therapy for depression in LGBT+ youth
Lyons 2022	Australia	Examine demographic and psychosocial correlates of suicidal ideation and suicide attempts among a large cross-section of sexual orientation populations	Quantitative – cross-sectional survey. Sample drawn from Private Lives survey	5,174 LGBQ people suicidal ideation and attempts	Mixed – focus on suicide prevention, mixed mental health services
Mackie 2023	Australia	Explore the experiences of psychologists working with transgender young people in a school counselling contexts	Qualitative – semi-structured interviews	7 school psychologists	School counselling
Martin 2019a	Australia	Examine experiences of carers of LGBTQ people experiences of safety in interactions with mental health providers	Qualitative – online survey with open questions	18 adult carers of LGBTQ+ people accessing mental health crisis services	Mixed – mental health crisis services

Author Year	Country	Aims	Method	Participants	Service type
Martin 2019b	Australia	Examine mental health and community services experiences of carers of adult people from LGBTIQ communities living with mental health challenges, or experiencing a mental health crisis	Mixed methods – online survey and in-depth qualitative interviews	18 adult carers of LGBTQ+ people	Mixed – including community mental health providers, outreach services, crisis services, including emergency department doctors, inpatient mental health services, NDIS services, GP, allied health
McNair 2016	Australia	To examine “the range of professional and social help seeking by same-sex attracted women, and patterns according to sexual orientation and gender identity”	Mixed methods – qualitative stakeholder interviews, online survey	1628 Australian same-sex attracted women (including: cisgender, trans, and “other” women)	Mixed – mental health care (not specified)
McNair 2018	Australia	To investigate the impact of mental health of health service usage on mental health and alcohol problems for same-sex attracted women	Quantitative – online survey	521 same-sex attracted women (including cisgender, trans, genderfluid, and gender queer people)	Mixed – including mental health, alcohol treatment services, and GPs
Morris 2022	UK	Investigate experiences of sexual minority service users accessing mental health services for common mental health problems	Qualitative – interviews	26 sexual minority adults with mild to moderate mental health problems	Counselling services for mild to moderate mental health issues

Author Year	Country	Aims	Method	Participants	Service type
Pennay 2018	Australia	Explores how sexuality shapes experiences and needs in mental health and alcohol treatment	Qualitative – grounded theory study	25 same-sex attracted women who were light-heavy drinkers (including cisgender, trans, and gender queer people)	Alcohol counselling, including 12-step programs, residential rehabilitation. Included interactions with mental health counsellors, psychologists, psychiatrists, and GPs
Platell 2021	Australia	Identify the perceived benefit of mental health service use for two adolescent populations: (i) those who had considered getting help from a mental health service but had not yet done so, and (ii) those who had previously contacted or accessed a mental health service but not continued with care	Quantitative – Cross- sectional online survey	106 youth (14-18 years) living in Perth, Western Australia - 43% of participants identified as LGBTIQ	Mixed – mental health services
Pullen Sansfaçon 2023	Australia, Canada Switzer-land, UK	Compare the experiences of trans and non-binary youth accessing gender affirming care	Qualitative – interviews, grounded theory, and thematic analysis	68 dyads of trans and non-binary youth, and their parents (total 138 participants)	Gender affirming care
Reynish 2023	Australia	Explore mental health and help-seeking experiences of LGBTIQA+ people in rural Australia	Mixed methods – survey and qualitative interviews	66 LGBTIQA+ adults completed a survey, and 30 participated in interviews	Mixed – Consultations with a GP and/or mental health professional – mostly in rural Tasmania

Author Year	Country	Aims	Method	Participants	Service type
Riggs 2016a	Australia	Assess clinical knowledge, comfort, and confidence of mental health professionals when working with trans clients	Quantitative – online survey	304 mental health professionals	Mixed – mental health professionals, including councillors, mental health nurses, psychiatrists, psychologists, and social workers from diverse mental health services
Riggs 2016b	Australia	To explore the experience, knowledge, and attitudes of a sample of Australian mental health nurses with regards to working with transgender people	Mixed methods – online survey	96 mental health nurses	Mental health nurses from diverse mental health services
Riggs 2015	Australia	To present an evidence-based model for understanding mental health experiences for transgender Australians	Quantitative – secondary analysis of data	Number of trans participants originally recruited not stated, secondary data presented	Mixed – mental health and gender-affirming care, including surgery
Riggs 2014	Australia	To explore health care experiences of gender diverse Australians	Mixed methods – online survey	188 gender diverse adults	Mixed – mental health professionals, including psychiatrists, GPs, and surgeons from diverse mental health services

Author Year	Country	Aims	Method	Participants	Service type
Rimes 2018	UK	Comparison of sociodemographic and clinical characteristics, and treatment outcomes for adults accessing primary care psychological interventions via Improving Access to Psychological Therapies (IAPT)	Quantitative – clinical outcome data used to compare baseline psychosocial characteristics, and changes between initial and final sessions across "sexual orientation groups"	188 lesbian women, 222 bisexual women, 6637 heterosexual women, 645 gay men, 75 bisexual men, and 3024 heterosexual men	Psychological services
Rimes 2019	UK	To identify if sexual minority patients have poorer mental health outcomes in comparison to heterosexual patients in Improving Access to Psychological Therapies (IAPT) services	Quantitative – clinical data accessed and analysed for a cohort who had attended at least 2 treatment sessions	85,831 women (83,482 heterosexual, 1,285 lesbian, and 1,064 bisexual women) 47,092 men (44,969 heterosexual, 1,734 gay, 389 bisexual men	Psychological services
Rivers 2018	UK	To understand participant perceptions of risk and of protective elements to "explain suicide in youth"	Qualitative – interviews using Goffman-informed thematic analysis	17 LGBT+ adults who had attempted suicide	Mixed – mental health professionals and mental health services
Robertson 2015	UK	To explore lesbian and gay service users' experiences of psychiatric inpatient care, with respect to their "intimate relationships needs" impact on recovery	Qualitative interviews, interpretive phenomenological analysis	6 gay and lesbian adult participants	Inpatient mental health services

Author Year	Country	Aims	Method	Participants	Service type
Roberts 2018	Australia	Examination of mental health experiences and outcomes, and of barriers to help seeking for same-sex attracted rural youth	Quantitative – measures and scales-based questionnaire	531 youth (13-18 years), 31 identified as same-sex attracted	Mixed – mental health services
Saunders 2023	UK	Examine the demographic characteristics, health conditions and healthcare experiences of trans and non-binary adults in the UK	Quantitative – Cross-sectional secondary data analysis of nationally representative GP Patient Survey	840,691 survey respondents including 6,333 trans and non-binary adults	GP services
Spanos 2021	Australia	To describe proportion and characteristics of patients referred to mental health practitioners for secondary consultation at a primary care clinic utilising the informed consent model for gender affirming care. To also ascertain patient satisfaction	Retrospective audit of new trans and gender diverse patients presenting to a primary care clinic in Melbourne, and survey assessing patient satisfaction	589 new patients – 39% identified as female, transfemale, or trans feminine; 31% as male, trans- male, or transmasculine; 27% identified as non-binary or genderqueer identity; and 3% unassigned	Primary care clinic, including GP services
Strauss 2021a	Australia	To investigate the prevalence of autism spectrum disorder amongst trans young people. To understand their mental health, and experiences accessing gender affirming care	Mixed methods – cross-sectional survey	859 trans youth (14-25 years)	Mixed – mental health general

Author Year	Country	Aims	Method	Participants	Service type
Strauss 2021b	Australia	Investigate the experiences of trans and gender diverse young people who have sought mental health support from therapists, counsellors, psychiatrists, and/or inpatient care providers	Mixed methods – online questionnaire	895 trans and gender diverse youth (14-25 years)	Mixed – mental health general
Taylor 2021	Australia	To measure experiences of mental health service use amongst bisexual Australians who completed the Who I Am study	Quantitative – cross-sectional, online survey	2657 bisexual adults	Mixed – mental health services
Tollit 2023	Australia	To understand the clinical profile of patients attending a large Australian paediatric gender service	Quantitative – retrospective clinical audit	395 gender diverse youth	Gender service in children's hospital
Uink 2023	Australia	To investigate the confidence, training needs, and levels of inclusive practices of providers working with Aboriginal and Torres Strait Islander LGBTIQ+ clients	Mixed methods – survey, focus groups, interviews	197 survey respondents, 49 focus group participants, 5 interviews – Service Providers working with Aboriginal and Torres Strait Islander LGBTIQ+ Clients	Mixed – health services, including mental health

Author Year	Country	Aims	Method	Participants	Service type
Williamson 2022	UK	To evaluate “The Quest” therapeutic intervention	Mixed methods – quantitative data (pre and post intervention), qualitative data (post-intervention)	26 gay or bisexual men from British, Black, Asian, and Minority Ethnic (BAME) communities	Workshop based intervention
Witcomb 2018	UK	Examine depression rates in large sample of trans people and compare with matched cohort of the general population	Quantitative – multiple measures and scales, including depression scale	913 trans adults	Transgender health services
Yang 2021	Australia	To report on outcomes for the first year of delivery for the CASPAR (Comprehensive Assessment Service for Psychosis and At-risk) Service – a community-based service providing assessment and a short-term early intervention in youth (12-25 years) with “emerging mental health issues”	Mixed methods: demographic and clinical data	92 youth (12-25 years), 25% of whom identified as LGBT+	Comprehensive Assessment Service for Psychosis and At-risk Service (CASPAR)

8.3 Appendix 3: Highlights from SLR findings

Drawing on the discussion in Section 5, key data is synthesised by service type and LGBTQ+ population sub-group (sexuality diversity and gender diversity). This synthesis aims to assist policy makers in research translation efforts and highlights – based on findings from the SLR – what we know works (and could be applied more broadly in health services for various populations), and key areas for improvement.

These highlights come with the caveat that a more comprehensive review of international peer-reviewed literature and grey literature is required to ensure that an accurate picture of mental health and suicide prevention services to LGBTQ+ people is obtained, and unnecessary replication is avoided. Additionally, that specific mental health needs of people with innate variations in sex characteristics, asexual people, and people with more marginalised sexualities and genders are ascertained in order to determine what works for LGBTQ+ people and key areas for improvement.

8.3.1 A) Patterns by service type

8.3.1.1 General service provision

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.

Table 10: Affirming and Culturally Safe service provision
Equitable, affirming, and culturally safe services are required for trans and gender diverse people, 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 a lived experience, with emphasis on designing with sub-populations whose needs are less likely to be addressed.

What we know works:
• Provision of mental health care by a knowledgeable, affirming, and culturally competent provider improves mental health service experience for LGBTQ+ people and is protective for mental health.
• Improving health care worker confidence and communication skills, as well as value for First Nations people's perspectives on wellbeing, can enable effective care for Aboriginal and Torres Strait Islander LGBTQ+SB people.
• Mental health providers who are proactive in learning about LGBTQ+ people's needs and community concerns are more confident and are perceived more positively by LGBTQ+ people:
  ○ Mental health providers who undertake specialist training in LGBTQ+ health have improved attitudes towards, and confidence in meeting the needs of, LGBTQ+ people, including understanding of referral care pathways for trans and gender diverse people.
  ○ Mental health care providers are keen to 'get it right' with LGBTQ+ people (including with people with intersectional experiences such as Aboriginal and

Table 10: Affirming and Culturally Safe service provision

Torres Strait Islander peoples). This suggests that there would be positive engagement and uptake of any training or skill-building in this area.

- Specific mental health interventions that are adapted to meet the needs of LGBTQ+ people. Design undertaken in collaboration with LGBTQ+ people with lived experience will enhance likelihood of acceptability.
- Peer support, and LGBTQ+ specific services are perceived as more affirming and culturally competent.
- Visual cues that signal inclusivity, including indication of health professional training in LGBTQ+ health, are informative and welcoming to LGBTQ+ people, but need to be backed up by affirming service provision.
- Inclusive language, and verbalisation of respect for LGBTQ+ people, can make services more accessible and welcoming.
- Access to diverse health care professionals who have shared sexuality or gender or intersectional experiences, can support LGBTQ+ people – including people from diverse cultural backgrounds – to feel understood and welcome in a service.

Key areas for improvement:

Service providers, including health workers, and clinicians, lack competency and knowledge regarding LGBTQ+ people (including in relation to gender and sexuality, health needs, social stressors, stigma and discrimination, relationships with family, kin, friends, community, and carers). Findings indicate that mental health services and support groups may not be inclusive of sub-populations of the LGBTQ+ community, but dedicated research is required to affirm this.

- There is a clear need for service provision from knowledgeable and affirming mental health workers and clinicians.
    - Mental health services provide inequitable service delivery, and health professionals engage in practices such as microaggressions, misgendering and invalidation of identity, and pathologisation.
    - There is a lack of safety in many services, preventing disclosure of LGBTQ+ identity to health professionals. This impacts service delivery and recovery.
    - Poor service delivery and inequity are linked to creating surplus suffering for LGBTQ+ people, and can undermine any intended therapeutic benefits of the service, and can create a hostile and unsafe environment that can exacerbate mental distress and suicidality.
- Training in LGBTQ+ mental health is required for all mental health professionals, including in undergraduate, postgraduate curriculum, and within health services.
    - LGBTQ+ training in health services is often optional, meaning the burden of educating providers is often passed on to LGBTQ+ people, in terms of costs of care and emotional labour.
    - Training and service delivery must be inclusive of all sub-populations of LGBTQ+ people, must include training on the challenges faced by people in the community, and should be delivered pre- and post-registration to health practitioners.
- There is a need for Aboriginal and Torres Strait Islander LGBTQ+SB specific services, including services specifically tailored for youth.

Table 10: Affirming and Culturally Safe service provision

  - First Nations people are often reliant on Aboriginal specific organisations, LGBTQ+ specific organisations, and mainstream organisations that may not meet their care needs.
  - As indicated by members of the Rainbow Embassy, mainstream services are perceived as particularly unsafe for First Nations LGBTQ+SB people, and LGBTQ+ people from CALD backgrounds, as they are more likely to be perceived to be complex and exposed to restrictive treatment practices.
  - Person-focused approaches are, on their own, inadequate to meet the needs of First Nations LGBTQ+SB people. A person-focused approach can erase intersectional experiences and reduce access to cultural and social supports, and lead to unsafe care.
  - Services to LGBTQ+SB need to be designed by communities to ensure they meet the needs of First Nations people.
- There appears to be minimal research on the needs of LGBTQ+ people from CALD backgrounds, but findings indicate a lack of culturally safe service provision options, and experiences of racism that require immediate attention:
  - Culturally safe service options need to be developed and evaluated in collaboration with LGBTQ+ people from CALD communities.
  - Experiences of racism must be addressed (see discussion of trauma informed service provision, 5.3.5 Service safety).
- There is a need for provision of LGBTQ+ youth services, including access to affirming and knowledgeable mental health professionals in schools. There is also a lack of youth-oriented, gender-affirming care.
  - Training needs to be provided to mental health professionals on the unique needs and experiences of LGBTQ+ youth.
- Neurodiverse LGBTQ+ people may experience more disadvantage in mental health services due to a lack of understanding of this population.
  - Affirming service options need to be developed and evaluated in collaboration with neurodiverse LGBTQ+ people.
- This SLR provided little understanding of the needs of LGBTQ+ people with disability in the Australian context. To attend to this, review of the international literature is required. Additionally, mental health services should be designed and evaluated with this population to ensure needs are addressed.
- There is a need for access to affordable mental health services for LGBTQ+ people on low incomes.
  - LGBTQ+ people on low incomes struggle to access adequate mental health support due to the cost of private providers, costs of prescription medication, and lack of access to NDIS for people with life-interrupting mental health challenges.
- There is a need to improve access to mental health services in rural areas.
  - Findings related to LGBTQ+ people living in rural areas are mixed, with some reports of positive experience. However, barriers to mental health care noted related to costs of services, long distance to services, shortage of mental health professionals (including knowledgeable mental health professionals),

Table 10: Affirming and Culturally Safe service provision

and difficulties maintaining confidentiality, as well as less inclusivity of LGBTQ+ people.

Table 11: Person-centred and Recovery-oriented service provision

What we know works:

- Mental health services can be perceived positively if they are welcoming, respectful, empathic, supportive, and caring.
- Therapeutic interventions designed for, and delivered to, people of diverse sexualities can promote mental wellbeing.
    - Few studies were identified, but recovery-oriented approaches that attend to social connection and identity show promising results.
- 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 enhance community and peer connection.

Key areas for 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 lived experience.
- A key gap highlighted by the Rainbow Embassy, is the need for service providers (and researchers) to engage with multiple explanatory frameworks for service provision. While bio-medical frameworks are useful, a sole focus on these can be experienced as dehumanising, can make socio-economic stressors invisible, and can preclude opportunities for provider engagement with personal recovery or trauma frameworks. As the Rainbow Embassy noted, the care solution must fit the problem. This can be addressed by providing:
    - Choice and engagement in collaborative care planning in mental health services with people with lived experience (and carers, where permission is given). Choice should include access to trauma informed, and recovery oriented therapeutic options, as well as to medication options.
    - Therapeutic interventions should be designed and evaluated with LGBTQ+ people with lived experience, including people with a lived experience of life-interrupting mental health challenges and suicidality.

Table 11: Person-centred and Recovery-oriented service provision

  - There is a need for the provision of non-medical support mechanisms and services for LGBTQ+ youth in school and community spaces to enable social inclusion, address social- (and self-) stigma, and facilitate access to peer support and information and resources (to dismantle barriers to help-seeking).
- There is a need for integration of services, including linkage between substance use services, and coordination of care for LGBTQ+ people with complex mental health needs.

Table 12: Trauma informed service provision

What we know works:

- Timely access to affirming providers is a powerful and protective factor for LGBTQ+ people.

Key areas for improvement:

- There is a need for consistent, affirming service provision to all LGBTQ+ people, including through community organisations.
  - A lack of access to affirming services can lead to a sense of hopelessness and exacerbation of distress.
  - The impacts of being exposed to microaggressions can be amplified in a crisis and exacerbate distress and suicidality.
  - Hetero and cis-normativity in services can lead to a lack of safety for LGBTQ+ people, including feeling unsafe to discuss sexuality or gender identity.
  - Pathologisation of sexuality and gender is perceived as harmful to LGBTQ+ people, and detrimental to wellbeing.
- 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. This would include:
  - Measurable actions taken to end these practices, and reporting of breaches to regulatory and professional bodies.
  - Training in, and recognition of, pathologisation practices for mental health professionals, including:
    - Education regarding how pathologisation is linked to historical practices in mental health of pathologising gender and sexuality, as well as to sanism towards people with lived experience in the community and mental health services.
    - Recognition that homophobia, transphobia, and sanism comprise a unique intersectional experience for LGBTQ+ people with lived experience of mental health challenges and suicidality, which is often invisible in services and research.

Table 12: Trauma informed service provision

- Training in, and recognition of, intersectional experiences related to culture, ethnicity, disability, etc., and how this may lead to pathologisation of First Nations LGBTQ+SB and LGBTQ+ people from CALD backgrounds.

- Safe and trauma-informed care need to be provided consistently to LGBTQ+ people. To achieve this, the following must be addressed:
  - Ending highly restrictive practices, including coercion, seclusion, and restraint in mental health settings. These practices exacerbate distress in LGBTQ+ people and carers, and reiterate trauma experienced in society. Restraint practices include use of physical, mechanical, chemical, and environmental restraints.
  - An end to homophobia, transphobia, racism, stigma and discrimination, and abuse and violence in mental health settings, and potentially other settings including within faith-based organisations. Mental health professionals and managers must take measurable action to ensure the safety of LGBTQ+ people. This includes management of other people in mental health settings who may pose a threat to LGBTQ+ people, and staff who engage in unsafe practices. Any breach by staff should be reported to regulatory and professional registration bodies.
  - An end to conversion practices by health practitioners, including mandatory reporting of these practices to professional registration bodies.
  - Recognition of the harm caused by past practices in mental health services, and commitment to recognition and reform.

8.3.1.2 Specific service types

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

Table 13: Online services

What we know works:

- 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.
- Online services can be a valuable means of accessing social support.
- Online support groups, video testimonies, and mobile phone applications can enhance face-to-face mental health supports.

Table 13: Online services

Key areas for improvement:

- Many online services appear to be nascent, and need to be tailored, via lived experience collaboration, to the needs of diverse subgroups of the LGBTQ+ community.
- Online services can be perceived as complex and unfamiliar, with little information on the diverse platforms available.
- Online services can be perceived as impersonal, and should not replace face-to-face services, but be used as an adjunct, particularly given the value of peer support.
- Online services need to be developed with LGBTQ+ people, to ensure they are safe, accessible, and offer privacy and confidentiality.
- Attention must be paid to barriers that inhibit access to online services (including issues of, and concerns regarding, privacy, and a lack of access to internet services in rural and remote locales).
- Online services should not replace face-to-face care that involves family and community, including school communities, as these are core in the promotion of protective factors.

Table 14: Primary care and therapeutic services

What we know works:

- GPs, psychologists, and allied health practitioners are often rated positively by LGBTQ+ people.
- GP services can be instrumental in providing care, making referrals to mental health providers and gender-affirming care services.
- Therapists, including peer workers, psychologists, counsellors, and other mental health professionals in primary care settings, can be knowledgeable about the needs of LGBTQ+ people, and skilled in therapeutic approaches that are beneficial to them.
- Primary healthcare providers who take steps to educate themselves, are perceived positively and can provide affirming and supportive care to LGBTQ+ people

Key areas for improvement:

- GP care is inconsistent, with some GPs being uncomfortable with LGBTQ+ people and their health needs.
- Care from therapists, including psychologists and counsellors, can be inconsistent, with many LGBTQ+ people reporting mixed experiences, and LGBTQ+ people having difficulty finding a knowledgeable and affirming providers, as well as experiencing inequitable care.
- Care from private therapists is reported to be expensive and out of reach for many people, with expensive gap payments and limited access via Medicare.

Table 15: Crisis helpline services
What we know works: • 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.
Key areas for service improvements: • Most crisis helplines are not sufficiently oriented to the needs of LGBTQ+ people, and many people do not access them in a crisis. • Crisis helpline staff are not sufficiently knowledgeable about LGBTQ+ people, or trans and gender diverse people's mental health needs. • LGBTQ+ people report negative experiences and dissatisfaction with crisis helpline services, including experiencing microaggressions and misgendering. • Referral processes to long-term mental health care for LGBTQ+ people are poor or not occurring in some crisis services.

Table 16: Emergency and inpatient services
What we know works: • Mental health providers, including emergency staff and inpatient service staff 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 and can be unsafe and traumatising, with LGBTQ+ people and carers reporting the highest level of dissatisfaction with these services.

Key areas for service improvement:
• Emergency and impatient services need to be trauma-informed, and designed and evaluated with LGBTQ+ people with lived experience and carers, including those who have experienced involuntary treatment:
  ○ Services are described as being 'characterised by conflict', with a distinct lack of information, choice, and collaboration with LGBTQ+ people with lived experience and their carers consistently occurring.
  ○ Medicalisation of mental distress, and a lack of focus on personal recovery, can be experienced as dehumanising and oppressive, and echoes feelings of oppression related to being LGBTQ+.
  ○ Highly restrictive and disempowering environments are reported – including limits on phones, visiting hours, and internet use, understaffed wards that were described as unhygienic, and lacking in privacy.

Table 16: Emergency and inpatient services

- Negative attitudes towards LGBTQ+ people with lived experience and their families are reported, including:
  - Microaggressions, invalidation, and pathologisation of sexuality and gender identity that is undermining for recovery.
  - Intrusive and offensive questioning about gender identity that is distressing.

- Emergency and inpatient services need to be safe. Exposure to unsafe and traumatising environments is reported, including;
  - Experiences of homophobia, transphobia, and verbal and physical abuse, including from both peers and staff.
  - Exposure to conversion practices, and judgement and pressure on conversion survivors to abandon their religion.

Table 17: LGBTQ+ specific services

What we know works:

- Positive experiences are more consistently reported in LGBTQ+ specific services (including trans and gender-specific services). These services have:
  - A better understanding of the needs of trans and gender diverse people.
  - Can provide appropriate referrals to trans and gender diverse people, including in some cases to First Nations and people from CALD backgrounds.

Key areas for improvement:

- There is a need for more LGBTQ+ specific mental health services accessible in Australia
  - Only a minority of LGBTQ+ people are able to access specialist services.
  - Access is currently limited by long wait times and limited hours of operation, as well as geographic location.
- Existing LGBTQ+ specific services (including trans and gender-specific services) need to be developed, resourced, and sustained.
  - LGBTQ+ specific services appear to be under-resourced and do not accommodate the heterogenous needs of LGBTQ+ people. Services need to be funded, designed, and evaluated with LGBTQ+ people with an intersecting lived experience, including:
    - Aboriginal and Torres Strait Islander LGBTQ+SB people, LGBTQ+ people with a CALD background
    - LGBTQ+ people experiencing life-interrupting mental distress and suicidality.
    - LGBTQ+ sub-populations including (but not limited to) trans, nonbinary, LGBTQ+ youth, and bisexual people.
    - LGBTQ+ people with complex health needs (e.g., disability) or co-occurring substance use issues (e.g., Alcohol use).

Table 17: LGBTQ+ specific services
○ Training and resources should be provided to all staff within LGBTQ+ specific services on the needs of people with life-interrupting mental health challenges and suicidality, as well as those with intersectional experiences. This would necessarily include recognition of intersectional experiences of people with lived experience and the impacts of sanism.

8.3.2 B) Services to specific populations

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. Additionally, it did not include sufficient evidence 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.

Table 18: Services to Sexuality diverse people
What we know works: • Sexuality diverse people report positive and supportive engagements from health care professionals. • Same-sex attracted youth in South Australia in rural areas have poorer mental health but did not experience greater barriers to accessing mental health support. However, as the Rainbow Embassy highlight, this finding should be read with caution as it may not apply to all LGBTQ+ people in all rural areas across Australia..
Key areas for service improvement: • 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 need a better understanding of patterns of disclosure among sexuality diverse people to improve provision of care to this population. ○ Sexuality diverse youth report fearing stigma related to identity and mental health diagnoses. • Mental health staff require training in sexuality diversity, including: ○ Understanding sexuality diversity, and the needs of sub-populations, particularly bisexual people, who can experience a lack of knowledgeable and affirming health provision. ○ Recognising and responding to heteronormative practices. Mental health services are highly heteronormative, with mental health staff conveying negative attitudes towards same-sex relationships that impact on sexuality diverse people.

Table 18: Services to Sexuality diverse people
• Comprehensive assessment services need to be developed in collaboration with LGBTQ+ people, as sexuality diverse youth are more likely to disengage from comprehensive assessment services for psychosis.

Table 19: Services to Trans and Gender diverse people
What we know works: • 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. • GPs promote timely access to gender-affirming hormonal treatment for trans and gender diverse people, and this may be a practical and acceptable solution to reduce wait times for gender affirming care. • GP referral to gender-affirming care is preferable to assessment by mental health clinicians. • A trusted GP facilitates referrals to mental health support. • School psychologists create safe and affirming therapeutic environments for trans and gender diverse youth. • School psychologists provide important information and education to school staff and parents.

Key areas for service improvement:
• Training for mental health professionals in the mental health needs of trans and gender diverse people:
  ○ Mental health professionals have low levels of knowledge about the mental health needs of trans and gender diverse people, including nonbinary people.
  ○ It is difficult for trans and gender diverse people to find a knowledgeable and affirming mental health care providers outside of gender-affirming services.
  ○ Mental health service providers can put trans and gender diverse people under duress to prove they are trans, including pressure to adopt stereotypical gender behaviours and conform to binary gender identities.
  ○ Training should be strengths-focused to mitigate against the pathologisation of trans and gender diverse people, and needs to recognise the skills and strengths of this population.
• Crisis services, including helplines and emergency services, need to be made more accessible, and should be designed and evaluated with trans and gender diverse people:
  ○ Trans and gender diverse people struggle to access crisis services that are affirming of their gender identity, and frequently experience repeated episodes of misgendering, use of incorrect names and titles, invalidation, and pathologisation.

Table 19: Services to Trans and Gender diverse people

- These kinds of experiences have detracted from therapeutic benefits, and undermined confidence, in mental health services.

- School psychologists need further training to meet the needs of trans and gender diverse youth.
  - School psychologists can lack sufficient education regarding the mental health needs and strengths of trans and gender diverse students.
  - School psychologists may have a lack of understanding of how to manage suicidal youth and how to link with trans inclusive providers.
  - School psychologists may assume that trans and gender diverse youth are complex, and may overlook strengths and needs of this population.
- Support for parents of trans and gender diverse youth is required, including family therapy and online supports. Family based therapies and online supports should be designed in collaboration with LGBTQ+ youth and family.
  - Parents can struggle to accept trans and gender diverse youth, and can apply pressure on school psychologists to deny gender identity, impacting on therapeutic relationships.
- Trans and gender diverse youth experience particular barriers to access that need to be addressed, including issues related to health professional gatekeeping and parental consent.
  - The mental health assessment and gatekeeping model of access to gender-affirming care needs to be revised, as it frequently leads to delays and denial of care. Delays in access were related to:
    - Multiple assessments by mental health professionals.
    - Long wait lists.
    - Parental conflict and withholding of consent. Approaches to navigating parental consent need to be designed in collaboration with trans and gender diverse people and families.
    - Lack of affirmative providers available.
- Services need to be linked and coordinated to reduce barriers to access, particularly for trans and gender diverse people with complex mental and physical health needs

8.3.2.1 Population level interventions

Although not a focus of this review, population level interventions would be part of an overall strategy for improving mental health outcomes for LGBTQ+ people. As outlined previously, high rates of mental distress in LGBTQ+ populations are linked to minority stress related to stigma and discrimination in society, and to reduced access to resources that support mental health. Therefore, population-level approaches to reducing discrimination towards LGBTQ+ people, and improving access resources for mental wellbeing is required. Population level approaches include (but are not limited to):

- Efforts to reduce stigma and discrimination within the community, including (but not limited to) educational strategies, including working with families and schools, and improving workplaces for LGBTQ+ people; media communication strategies (Donovan, 2004); and building healthy settings (Dooris, 2004; Newman et al., 2015) – creating and maintaining healthy living conditions, including healthy leisure spaces and workplaces.

- Building healthy public policy that is protective for mental health. Policy and population level approaches should also promote personal recovery, including connection, hope, meaning, and empowerment for LGBTQ+ communities.
- Building community for LGBTQ+ people:

  This would necessarily include developing places where LGBTQ+ people can connect and engage. While a therapeutic focus is important for LGBTQ+ people to connect with peers, a health promotion focus should also focus on promoting wellbeing and solidarity, and on celebrating strengths of the community, as well as taking actions for health and rights of LGBTQ+ people.

8.3.3 C) Research gaps

As has been noted throughout the discussion, and highlighted by the Rainbow Embassy, 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 LGBTQ+ people with lived experience of mental health challenges and suicidality as well as sector experts.

8.3.3.1 Comprehensive review of evidence

This review was not able to comment on the needs of intersex people or asexual people. It also provided limited data on current mental health service provision to LGBTQ+ people in Australia, particularly those with diverse intersectional experiences. Therefore, as a first action, we **would recommend a more comprehensive review** of both the international and Australian peer-reviewed and 'grey' literature (research reports, not peer reviewed) to gain a clearer and more accurate picture of service provision, quality and performance and gaps in research evidence.

8.3.3.2 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. For example:
  - What are the rates of seclusion and restraints for LGBTQ+ people within emergency and inpatient contexts? And what are the impacts of these practices on people with lived experience and carers?
  - What are the experiences of LGBTQ+ people who are involuntarily treated in services and the community? What are the impacts?
  - What other models of care, e.g., peer led models, or collaborative models, might provider safer services to LGBTQ+ people with lived experience?
- There is also a need for greater understanding of the extent to which pathologisation, conversion practices, abuse, and violence occur in mental health services; how regulatory bodies are engaging with this issue; and what actions can be taken to end these practices.
- Additional research should also investigate how therapeutic, and faith needs, of survivors of conversion practices can best be met.

8.3.3.3 Specific services and interventions

Most studies in this review focused on a mix of service types, providing a range of interventions. This makes it hard to decipher the specific impacts of these services on the experiences and mental health outcomes of LGBTQ+ people.

- Research should focus on specific service or intervention type, and ideally evaluation should be undertaken in collaboration with LGBTQ+ people with a lived experience.
    - Of particular interest would be:
    - The experiences of LGBTQ+ people in inpatient mental health services and emergency departments, as well as community settings, where treatment is involuntary and LGBTQ+ people may have limited choice and access to an affirming care provider.
    - Experiences of diverse LGBTQ+ people in LGBTQ+ specific services.
    - Experiences of LGBTQ+ people receiving trauma specific therapeutic interventions.
    - Experiences of LGBTQ+ youth and parents in interventions aimed at improving and maintaining family connection, which could be highly protective for youth mental health.
    - Experiences of LGBTQ+ people receiving care from LGBTQ+ peer workers with an intersecting lived experience of mental health challenges, including in peer-led services or services with employed peer workers.
    - Evaluation of approaches to care for LGBTQ+ people that aim to maximise choice and collaboration, including collaborative care planning, choice of treatments and therapies, and collaborative decision-making.
- Little is currently understood about the relationship between microaggressions, service type, intervention, and quality. Further research in this area is required.

8.3.3.4 Involvement of people with lived experience in research

As the Rainbow Embassy has highlighted, 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. In Australia, and internationally, government agencies and research institutions have recommended inclusion of people with lived experience throughout all stages of the research process (e.g., National Institute for Health Research [NIHR] 2015; National Health and Medical Research Council [NHMRC] 2018; Black Dog Institute, 2020) for pragmatic and justice-based reasons.

As noted previously, lived experience participation is associated with improving the relevance of research priorities and outcomes, and raising the quality of research interpretation and knowledge translation (Brett et al. 2012). LeBlanc and Kinsella (2016) and others (e.g., Jones, 2022) have also argued that partnership with people with lived experience can also rectify historic “epistemic disparities” related to the exclusion of people with lived experience from research, and will likely become the “new normal” in research-informed services and policy (Jones, 2022, p.125).

Of particular interest would be:

- Co-design research with LGBTQ+ people with lived experience, which involves embedding lived experience researchers as partners throughout all stages of research process. For further details on co-design of research with people with lived experience,

see the 'Co-design Kickstarter' produced by the Mental Health Coordinating Council (Bellingham et al., 2023).

- As highlighted by the Rainbow Embassy, LGBTQ+ researchers need to consider lived experience and consumer/survivor perspectives, and what can be learnt from these, to inform LGBTQ+ advocacy and research. This may lead to new questions asked in the research, including:
    - What are the links between sanism, hetero- and cis-normativity and pathologisation, and how does this impact specifically on the experiences of LGBTQ+ people in the community and mental health services?
    - How can personal recovery, as articulated by consumer movements and people with lived experience, inform our understanding of mental health service provision to LGBTQ+ people?
    - What can the experience of consumer/survivor movements tell us about how safety and equity might be improved in mental health services for LGBTQ+ people with lived experience?

8.3.3.5 Research equity for First Nations LGBTQ+SB people

This 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.

- A broader review of the literature is required to ascertain any potential studies not included in this review, including studies that are not published or peer reviewed.
- Researchers should focus on designing and evaluating services that aim to provide culturally safe and competent care.
    - There is only scant research on the needs and experiences of Aboriginal and Torres Strait Islander people, and none appear to examine the needs of youth. This is urgently required to establish services guided by best-evidence and lived experience needs.

8.3.3.6 Research equity for LGBTQ+ people with intersectional identities

This SLR included little research on the needs, stressors, or service experiences of people with intersectional experiences or needs. 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
- people from a low-socioeconomic backgrounds.

8.3.3.7 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. This includes examination of financial and human inputs, management processes, and services provided. 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.

Additionally, research considering efficiency also needs to consider the financial cost of services to LGBTQA+ people and how this impacts service access for people on low incomes

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