

LGBTQ+ People and Mental Health Services Research

Conducted by a UTS-led research team for

Commonwealth Department of Health and Aged Care

About the Research

In June 2023, the Department of Health and Aged Care contracted a University of Technology Sydney (UTS) led research team¹ 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 LGBTIQ+ People (the Action Plan).

Based on the in-scope literature (*see details on page 2*), the specific research parameters (*see below*) and feedback provided through independent review by sector experts, the brief was later amended to focus on Lesbian, Gay, Bisexual, Transgender and gender diverse, and Queer (LGBTQ+²) people with the expectation that other options will be explored to attend to the specific needs of asexual people and people with innate variations of sex characteristics (commonly shortened to intersex people). The Australian Government is aware of the unique health and wellbeing needs, and challenges faced by these groups and will other options to further support this group, including exploring further research, will be considered as part of the development and ongoing consultation to support the Action Plan.

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

1. For LGBTQ+ people:
 - a) What are the key causes of distress experienced that impact on their mental health or wellbeing, and/or increase their risk of suicidal behaviours?
 - b) What are the key issues and barriers when accessing services for their mental health and/or suicide prevention services?
2. In respect to accessing services for mental health and suicide prevention, and based on a Departmental literature search of peer reviewed literature on mental health and/or suicide prevention services for LGBTQ+ people in Australia and a comparator international context (UK)³.
 - a) What services are available and provided to LGBTQ+ peoples?
 - b) What services were found to be effective?
 - c) What service gaps or barriers were identified and what were their details?

3. What evidence-based insights can be drawn from the UK and Australian literature for Australia, to help inform policy development for the 10 Year National Action Plan for the Health and Wellbeing of LGBTIQ+ people?

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

- **Applied SLR** addressing KRQ 2 based on the 56 peer reviewed articles identified by the Department. This report included interpretation of review data with members of the UTS Rainbow Embassy and associates, comprised of LGBTQ+ people with lived experience of mental health challenges⁴ and/or suicidality, and of accessing mental health and suicide prevention services (intersecting lived experience).⁵
- **Research Translation Paper** answering all three KRQ, including a summary of the Applied SLR
- **A plain English** summary of the above (this paper).

Background

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

While there are substantive gaps and limitations to the available data⁶, estimates from the Victorian Agency for Health suggest that upwards of 5.7% of the population identify as Gay/Lesbian (1.8%), Bisexual/Queer/Pansexual (3.0%), Transgender or gender diverse (0.2%), Intersex (0.2%) and Asexual/Other (0.4%).⁷ Many researchers however argue that actual figures are higher still.⁸

The data that is available indicates that LGBTQ+ people experience higher rates of mental health challenges and suicidality than the general population.⁹ For example, the *National Study of Mental Health and Wellbeing 2022* found that more than half of GLB+ respondents reported having a diagnosis of any mental health condition in the past 12 months (59%), compared to only 20% of heterosexual respondents. Further, 33% of transgender respondents had a diagnosis in the 12 months preceding the survey, compared to 21% of cisgender respondents.¹⁰ Emerging evidence also suggests that LGBTQ+ people with intersecting identities and experiences (e.g. LGBTQ+ people with disability) are at even greater risk of poor mental health and suicide outcomes.

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

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

While most of the services available are designed for the general community¹¹, there is also a patchwork of services which are designed specifically for LGBTQ+ people (referred to as LGBTQ+ specific services).¹² However, these specialised services are limited, with only a small number of services providing state-wide or national coverage. Evidence suggests that many mainstream mental health services are not well equipped to provide best practice care for LGBTQ+ people and can be experienced as discriminatory, pathologising, and traumatising.

There are various policies, strategies, and other mechanisms already in place at the Commonwealth and state/territory levels which are seeking to improve outcomes and services for LGBTQ+ people. This includes dedicated LGBTQ+ health or whole-of-government strategies in at least five state and territories, as well as ongoing lived experience input provided through permanent advisory infrastructure. Various community organisations, education providers and industry bodies are also promoting new strategies, best practice guides and other resources to support mental health and suicide prevention for LGBTQ+ people (e.g., LGBTIQ+ Health Australia's *2021-26 Strategy*)¹³.

KRQ 1: Causes of Distress

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

Researchers have, however, identified specific external stressors that LGBTQ+ can experience, including, though not limited to:

- Stigmatisation, discrimination, and marginalisation
- Victimisation, bullying and violence
- Rejection, isolation, and loneliness from both family and peers.

As described by Meyer (2003)'s Minority Stress Theory¹⁴, exposure to external stressors can drive internal stressors such as internalised stigma, anticipation of rejection, and fear of harm. These stressors can also erode protective factors which support resilience and positive mental health, such as access to social support and structural resources, including employment, housing, and healthcare.

While all LGBTQ+ people have the potential to be exposed to the external and internal stressors outlined above, exposure varies with respect to individual, subgroup, as well as sociopolitical factors. For example, research has identified additional and specific stressors related to LGBTQ+ subgroups (e.g., transgender people) and those with intersecting identities (e.g., LGBTQ+ from culturally and linguistically diverse [CALD] backgrounds).

KRQ 2: Mental health and suicide prevention services effectiveness

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

a. What services are available and provided to LGBTQ+ peoples?

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

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

b. What services were found to be effective?

The SLR analysed the review data in respect to the six domains of health care quality put forward by the Institute of Medicine Committee.¹⁵ This provides a comprehensive framework to analyse evidence on the quality and performance of mental health services, including assessment of timeliness, person-centredness, effectiveness, equity, safety, and efficiency.¹⁶

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

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 recovery¹⁷, many studies indicated difficulties related to timely access to person-centred, recovery-oriented, equitable, and safe services. Commonly identified issues with service quality and performance included:

- **Knowledge deficits** among healthcare providers and reliance on those seeking care to educate the provider about the needs of LGBTQ+ people, which could be emotionally exhausting and financially costly in terms of therapy time.¹⁸
- **Microaggressions** including hetero/cis normativity, misgendering, invalidation and pathologisation of sexual orientation, gender, or sex identity. These issues were linked to increased distress and discouragement of future help seeking.
- **Difficulty accessing affirming mental health services, particularly during a crisis.** This related to timely access to recovery-oriented services that are safe, affirming, and effective. It also related to timely access to appropriate referrals.
- **Inequitable and unsafe care in inpatient and emergency services.** This included low acceptance and affirmation of sexual orientation and gender identity, and inequitable and unsafe care that could be coercive, restrictive, disempowering, and traumatising for some LGBTQ+ people, serving to reinforce rather than alleviate minority stress.

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

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

intersecting experiences, specifically related to life-interrupting mental health challenges and suicidality.

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

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

- **Provider shortages**, long waitlists and limited operating hours, particularly with respect to accessing LGBTQ+-specific services¹⁹. Limited affirming care options were particularly evident in relation to access to knowledgeable, affirming, and affordable mental health care providers, and timely referrals by mental health professionals to gender-affirming medical care.²⁰
- **Lack of lived experience involvement**, including in service development and research undertaken in collaboration with LGBTQ+ people with a lived experience of mental health challenges and suicidality, including with LGBTQIA people and youth with severe and life-interrupting distress, and people from diverse social backgrounds.

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

- **Inconsistencies in quality of care**, including inconsistencies between care providers and services particularly in relation to the provision of equitable, person-centred care.²¹ For example, while many General Practitioners were perceived positively, others were “visibly uncomfortable with dealing with mental health” issues.²²
- **Lack of linkage** between different mental health services – including between crisis services and long-term care²³, and between alcohol services and mental health services.²⁴
- **Limited options** for services able to attend to intersectional needs, including limited access to equitable and safe care in a crisis or for those experiencing severe and life-interrupting mental distress and suicidality.
- **Financial costs** related to gap fees and limitations to the number of Medicare -subsidised sessions an individual can claim within a year, and to publicly available mental health services, or to the National Disability Insurance Scheme (NDIS).²⁵

In addition, gaps** in evidence were also noted in included papers, including in particular:

- research on the care needs of those experiencing intersectional issues, especially those impacting First Nations LGBTQ+ and Sistergirl and Brotherboy populations; people from CALD backgrounds; people living in rural and remote areas, and people from low socioeconomic backgrounds.
- research related to specific subgroups of LGBTQ+ people, and specifically people with innate variations of sex characteristics, nonbinary and asexual identifying people.

- research on topics including: the effectiveness of services for promoting personal recovery; LGBTQ+ people receiving involuntary treatment in inpatient and community settings; and responses to mental health professionals engaging in harmful conversion practices.

*** note some gaps in evidence noted in the papers are due to the specific search terms used in the initial methodology for the Systematic Literature Review.*

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

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

Overarching principles

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

1] Intersecting Lived Experience

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

2] No one-size-fits-all

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

3] Focus on Service Quality

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

4] Focus on the spectrum of needs

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

5] More than a health and service matter

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

6] Language matters

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

7] Moving with the evidence base

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

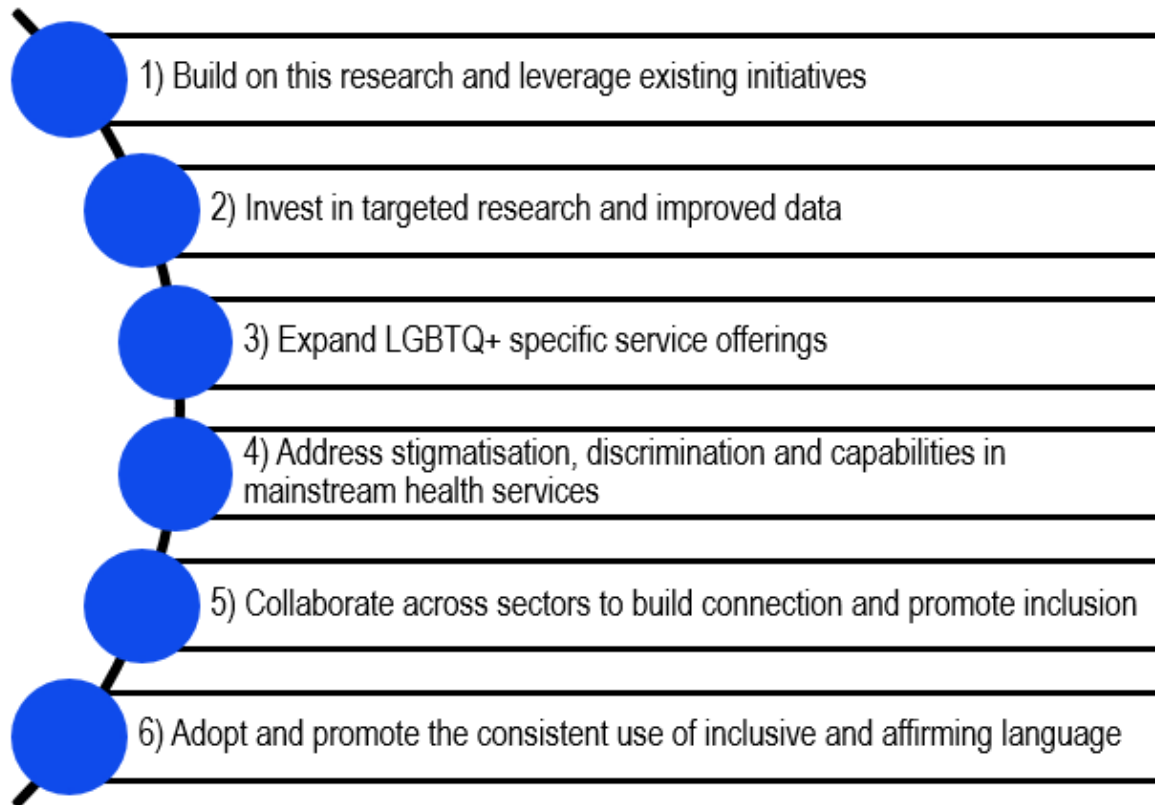
8] Ongoing monitoring, evaluation and learning

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

Key Policy Directions

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

Figure 1: Key Considerations for the development of the National Action Plan



Source: UTS-led research team, October 2023.

Conclusion

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

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

Attachment – Options Arising

Directions	Options Arising from the Research
(1) Build on this research and leverage existing initiatives	1) Undertake further research and consultations to refine, validate, and build upon the findings of the UTS-led research incorporating unpublished and grey literature, with a focus on identified gaps in evidence.
	2) Consider the release of a 10-year National ‘Strategy’, supported by successive two- to three-year ‘Action Plans’, capitalising on new evidence and identified needs.
	3) Collaborate with relevant Commonwealth, state, and territory governments to harmonise and strengthen evidence-based reforms and initiatives.
	4) Building on the Expert Advisory Group model, establish an ongoing LGBTQ+ mental health ‘Council’ of individuals with intersecting lived experience of mental health to oversee the finalisation of the National ‘Strategy’ and provide ongoing monitoring and advice on its development and implementation.
(2) Invest in targeted research and improved data	5) Research to further understand the needs and experiences of diverse LGBTQ+ people experiencing mental distress and/or suicidality, including tailored research to better understand the policy implementations for groups such as people with innate variations of sex characteristics, asexual people, and those impacted by intersectional issues.
	6) Better map the Australian mental health service system, including mainstream and LGBTQ+ specific services potentially used by LGBTQ+ people, noting unmet needs and service gaps by groups of potential users.
	7) Following from Option 6), establish methods to continuously evaluate mainstream and LGBTQ+ specific mental health services, including consideration of their access, inclusion, service quality, and overall performance for LGBTQ+ people.
	8) Research, pilot, and evaluate initiatives to reduce stressors experienced by LGBTQ+ people in the first instance, within both mainstream and LGBTQ+ specific mental health service systems. (Also see Option 21-23 regarding primary prevention initiatives.)
(3) Expand LGBTQ+ specific and intersectional service offerings	9) Investigate funding a diversity of additional LGBTQ+ specific mental health service options, providers, and models designed to deliver quality outcomes, with a specific focus on addressing unmet needs.
	10) Commit resources to train, recruit, and retain staff in LGBTQ+ specific services to optimally manage the spectrum of mental health care needs, with a focus on trauma-informed, personal recovery.
	11) Establish a mechanism for First Nation peoples and organisations to oversee the design, development, and implementation of First Nations LGBTQ+SB specific mental health and suicide prevention services.
	12) Expand evidence-based services for young LGBTQ+ people within and outside of mental health services, including mental health early intervention and prevention options in schools and other community settings.

Directions	Options Arising from the Research
	13) Action ways to better accommodate intersecting identities and sub-group needs within LGBTQ+ services.
(4) Address stigmatisation, discrimination, and capabilities within mainstream health services	14) Build the capacity, skills, knowledge, and understanding of mainstream health staff to ensure the provision of affirming and culturally safe services for LGBTQ+ people.
	15) Embed LGBTQ+ people with intersecting lived experience within health settings and provide meaningful opportunities for them to influence every stage of the service's development, culture, and practices.
	16) Actively support LGBTQ+ people, and particularly those with intersecting lived experience, to work in health settings, and to take up service provider roles at all levels of seniority.
	17) Update and streamline processes and referral pathways to connect LGBTQ+ people with inclusive mainstream and LGBTQ+ specific mental health providers that are able to optimally support their personal recovery.
	18) Develop and widely promote a trauma-informed, recovery-oriented, equitable, and safe care framework for Australian mental health services, which addresses minority stressors known to drive mental distress and suicidality, and which prevents traumatisation or re-traumatisation.
	19) Collaborate to action current recommendations designed to overcome stigmatisation in relation to mental health and LGBTQ+ people in other health, aged care, and disability care services.
(5) Collaborate across sectors to build connection and promote inclusion	20) Investigate and find practical options to embed multiple explanatory frameworks for understanding mental distress and service provision for LGBTQ+ people experiencing mental health distress or suicidality that incorporate understandings of minority stress and trauma.
	21) Initiate a major whole-of-government and cross-sectoral health and wellbeing inclusion strategy to promote social inclusion and address sources of stigma impacting LGBTQ+ people and communities.
	22) Work with relevant Commonwealth, state, and territory agencies to promote inclusion amongst young people, in order to improve understanding and connections, and to reduce stigma and discrimination against LGBTQ+ people.
(6) Adopt and promote the consistent use of inclusive and affirming language	23) Develop and promote educational resources to build the capacity of family and community to affirm LGBTQ+ people in their lives.
	24) Update and standardise the inclusivity of language and terminology used in all mainstream health, mental health, and wellbeing services, including services provided by religious organisations. (Also see Principle 6)

Directions	Options Arising from the Research
<p>The report also posed two options on reducing barriers to accessing gender affirming care, albeit noting that the applied SLR literature did not provide a comprehensive perspective on this issue.</p>	

End Notes:

¹ The team included senior researchers from:

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

² The plus sign indicates the diverse terms used to describe diverse sexualities and genders that are not covered by LGBTQ+.

³ The UTS-led research team inherited an initial literature search undertaken by the Department and, as per the research contract, were not in a position to undertake normal academic review processes (e.g., searches for missing literature, or cross-checking for reliability issues). As such the listed SLR articles should be taken at face value.

⁴ We also use the terms mental health challenges or mental distress as they are broader non-pathologising terms that can encompass those people without a mental health diagnosis who experience distress.

⁵ Collectively, Rainbow Embassy members also have experience and expertise in mental health advocacy, research and education, and peer work in in-patient and community mental health services and LGBTIQ+ specific services providing mental health support, and include First Nations LGBTQSB+ people, and LGBTQ+ people from culturally and linguistically diverse backgrounds, people with disability, and people from rural areas.

⁶ See section 2.1 of the Research Translation Paper for further detail

⁷ Victorian Department of Health 2017, *Proportion of population who identify as LGBTIQ+*, <https://www.health.vic.gov.au/your-health-report-of-the-chief-health-officer-victoria-2018/health-inequalities/lgbtiq-victorians>

⁸ Rainbow Health Victoria, “*Research Matters: How many people are LGBTIQ?*”

⁹ See Section 2.3 of the Research Translation Paper for further detail

¹⁰ Australian Bureau of Statistics 2023, National Study of Mental Health and Wellbeing 2022 – 2023, Released: 5 October 2023.

¹¹ See Section 3.4.2 of the Research Translation Paper

¹² See Section 3.4.3 of the Research Translation Paper

¹³ LGBTIQ+ Health Australia (2021), *Beyond Urgent: National LGBTIQ+ Mental Health and Suicide Prevention Strategy*, Published: 1 November 2021.

¹⁴ David Frost and Ilan Meyer, “Minority stress theory: Application, critique and continued relevance,” *Current Opinion in Psychology* 51, no. 101579 (2023), <https://doi.org/10.1016/j.copsyc.2023.101579>.

¹⁵ Institute of Medicine Committee on Crossing the Quality Chasm 2006, *Adaption to mental health and addictive disorder: Improving the quality of health care for mental and substance use conditions*. Washington, DC: Institute of Medicine, National Academies Press.

¹⁶ Levesque, J. F., & Sutherland, K. (2020). Combining patient, clinical and system perspectives in assessing performance in healthcare: an integrated measurement framework. *BMC health services research*, 20(1), 1-14.

¹⁷ Personal recovery is a key focus of Australian mental health services and challenges a narrow focus on clinical definitions and measures of recovery, emphasising instead the importance of meaning, connection, hope, empowerment and identity to promote wellbeing for people with lived experience whether or not they have clinical symptom reduction (Leamy et al., 2011).

¹⁸ Amos, N., Hart, B., Hill, A. O., Melendez-Torres, G. J., McNair, R., Carman, M., Lyons, A., & Bourne, A. (2023). Health intervention experiences and associated mental health outcomes in a sample of LGBTQ people with intersex variations in Australia. *Culture, Health & Sexuality*, 25(7), 833–846.; Haire, B. G., Brook, E., Stoddart, R., & Simpson, P. (2021). Trans and gender diverse people's experiences of healthcare access in Australia: A qualitative study in people with complex needs. *PloS One*, 16(1), e0245889–e0245889.; Lim, G., Waling, A., Lyons, A., Pepping, C. A., Brooks, A., & Bourne, A. (2021). Trans and Gender-Diverse peoples' experiences of crisis helpline services. *Health & Social Care in the Community*, 29(3), 672–684; Jones, T. (2016). The needs of students with intersex variations. *Sex Education*, 16(6), 602–618.

¹⁹ Bailey, L., J. Ellis, S., & McNeil, J. (2014). Suicide risk in the UK trans population and the role of gender transition in decreasing suicidal ideation and suicide attempt. *Mental Health Review Journal*, 19(4), 209–220; Erasmus, J., Bagga, H., & Harte, F. (2015). Assessing patient satisfaction with a multidisciplinary gender dysphoria clinic in Melbourne. *Australasian Psychiatry: Bulletin of the Royal Australian and New Zealand College of Psychiatrists*, 23(2), 158–162; Davies, A., Bouman, W.P., Richards, C., Barrett, J., Ahmad, S., Baker, K., Lenihan, P., Lorimer, S., Murjan, S., Mephram, N., Robbins-Cherry, S., Seal, L., Stradins, L. (2013). Patient satisfaction with gender identity clinic services in the United Kingdom. *Sexual and Relationship Therapy*, 28(4), 400–418; McNair & Bush, 2016

²⁰ Bailey et al., 2014; Pullen Sansfaçon, A., Medico, D., Riggs, D., Carlile, A., & Suerich-Gulick, F. (2023). Growing up trans in Canada, Switzerland, England, and Australia: access to and impacts of gender-affirming medical care. *Journal of LGBT Youth*, 20(1), 55–73; Strauss, P., Lin, A., Winter, S., Waters, Z., Watson, V., Wright Toussaint, D., & Cook, A. (2021). Options and realities

for trans and gender diverse young people receiving care in Australia's mental health system: findings from Trans Pathways. *Australian and New Zealand Journal of Psychiatry*, 55(4), 391–399

²¹ Martin, J., Butler, M., Muldowney, A., & Aleksanders, G. (2019). Carers of people from LGBTQ communities interactions with mental health service providers: Conflict and safety. *International Journal of Mental Health Nursing*, 28(3), 766–775 Martin et al. 2019b;

²² Reynish, T., Hoang, H., Bridgman, H., & Nic Giolla Easpaig, B. (2023). Psychological Distress, Resilience, and Help-Seeking Experiences of LGBTIQ+ People in Rural Australia. *International Journal of Environmental Research and Public Health*, 20(4), 2842

²³ Lim et al., 2021

²⁴ Gasper et al., 2021; Holt et al., 2023; Pennay, A., McNair, R., Hughes, T. L., Leonard, W., Brown, R., & Lubman, D. I. (2018). Improving alcohol and mental health treatment for lesbian, bisexual and queer women: Identity matters. *Australian and New Zealand Journal of Public Health*, 42(1), 35–42

²⁵ Bretherton, I., Thrower, E., Zwickl, S., Wong, A., Chetcuti, D., Grossmann, M., Zajac, J. D., & Cheung, A. S. (2021). The Health and Well-Being of Transgender Australians: A National Community Survey. *LGBT Health*, 8(1), 42–49; Cronin, T.J., Pepping, C.A., Halford, W.K., Lyons, A. (2021). Mental health help-seeking and barriers to service access among lesbian, gay, and bisexual Australians. *Australian Psychologist*, 56(1), 46-60; Haire et al., 2021; Martin et al., 2019b, Strauss et al., 2021b.