Out & Online: Evaluation of a tailored online same-sex attracted youth-focused trans-diagnostic mental health and wellbeing program

Final report to beyondblue – May 2015

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When the grant was awarded the Chief Investigator on the project was Prof Britt Klein who conceptualised the program, trial design and eScreener, with contributions from Prof Suzanne McLaren, Assoc Prof David Austin, Dr Jo Abbott, Dr Mari Molloy and Assoc Prof Denny Meyer.

The Out & Online program content was developed by Dr Jo Abbott, Prof Britt Klein and research assistants by adapting existing program content on the Anxiety Online platform (now on the Mental Health Online platform) and the content was reviewed by Prof Suzanne McLaren, Assoc Prof David Austin and Dr Mari Molloy.

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Abbreviations

CBT  Cognitive Behaviour Therapy
LGBTIQ  Lesbian, gay bisexual, trans, intersex, and queer
PTSD  Post-Traumatic Stress Disorder
RCT  Randomised Controlled Trial
SAD  Social Anxiety Disorder
SSAYA  Same-sex attracted young adults
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1. Main messages

• This project resulted in the development of the Out & Online program, one of the first online interventions specifically designed to be relevant for same-sex attracted individuals.

• The Out & Online program is unique and sophisticated, not only in targeting the mental health needs of same-sex attracted young adults (SSAYA) but in tailoring program content to gender and enabling the simultaneous treatment of multiple mental health problems within one program; this streamlines healthcare for the young person as well as provides inherent acknowledgement of the uniqueness of each user.

• Out & Online was made relevant for SSAYA by using inclusive language and content (e.g., videos and pictures of people in same-sex relationships), providing examples of stressors, unhelpful thoughts and behaviours unique to challenges associated with being same-sex attracted (e.g., “coming out”, feeling accepted by heterosexual peers), providing information on support services specialising in supporting same-sex attracted individuals and by helping SSAYA to enhance their self-esteem and self-acceptance despite stigma towards non-heterosexual sexual/gender orientations.

• SSAYA who used Out & Online reported that the program was enjoyable, convenient and easy to use, easy to understand and provided much needed practical help for mental health problems. They felt that the program was unique in specifically reaching out to a same-sex attracted audience.

• Further work is needed to make the program more engaging, interactive and more compatible with portable devices so that SSAYA feel motivated to seek help for mental health problems.

• The Out & Online program has the potential to improve access to specialist same-sex attracted relevant mental health services for young adults and to facilitate wellbeing outcomes for these individuals.

• Recommendations for further development of online programs inclusive of gender and sexual diversity are provided, including using gender inclusive language but not making mental health programs all about sexual orientation; making programs interactive and fun, accessible and portable; and including opportunities for peer interaction and encouragement to use the programs.
2. Executive summary

Same-sex attracted young adults (SSAYA) have been found to be at greater risk of mental health problems than their heterosexual peers. Despite an increased need for help for mental health problems SSAYA experience greater barriers to accessing mental health care services. SSAYA have reported feeling as though mental health services marginalise them by assuming heterosexuality and do not adequately help them to address challenges unique to being same-sex attracted, such as coming out and homonegativity.

The internet has the potential to make mental health services more accessible to SSAYA but existing online programs have not been designed to be relevant to the needs of same-sex attracted individuals.

In this project, Out & Online, one of the first online programs designed specifically for same-sex attracted individuals, was developed. Out & Online is also unique in tailoring treatment content to gender and symptom profile so that young people receive a customised program that recognises their individuality. The program contains eight brief modules containing mental health and wellbeing information and exercises based on Cognitive Behaviour Therapy principles.

Out & Online was developed based on feedback obtained in focus groups with SSAYA, adapting the content of existing online mental health programs on the Anxiety Online service (now known as Mental Health Online), expert review and usability testing with SSAYA.

Feedback obtained from SSAYA in focus groups supported previous research in that the young people felt as though they were marginalised (e.g., by using language suggesting heterosexuality) by existing mental health services, which they did not feel were gay- or lesbian-friendly. Their feedback highlighted the need for an online resource that used gender inclusive language but which did not imply that any mental health problems SSAYA were experiencing were because of their sexual orientation.

Out & Online was evaluated by seeking feedback from SSAYA who used the program. These young people endorsed the program as enjoyable, convenient and easy to use, easy to understand, and providing much needed practical help for mental health problems.

Further work is needed to make the program more engaging, interactive and more compatible with portable devices so that SSAYA feel motivated to seek help for mental health problems.

This project is a starting point in helping to make mental health services more inclusive of gender and sexual diversity.
3. Detailed report

3.1 Context

The major aim of this project was to improve the mental health and wellbeing outcomes for same-sex attracted young adults (SSAYA, ages 18-25 years) by developing an online program that is relevant to SSAYA and provides integrated and tailored treatment based on gender and mental health symptom profile.

3.1.1 Background

Mental health needs of same-sex attracted young adults (SSAYA)

SSAYA have been found to experience higher rates of mental health problems\(^1\)\(^-\)\(^12\) and greater barriers to accessing specialist mental health care services compared to their heterosexual peers.

SSAYA are twice as likely to attempt suicide as heterosexual peers,\(^1\)\(^-\)\(^4\) 3-5 times more likely to engage in self-harm and 5 times more likely to report having had recent thoughts about suicide than their heterosexual peers.\(^5\) SSAYA also experience more depressive symptoms than heterosexual youth.\(^3\),\(^6\)\(^-\)\(^10\) About 9% of SSAYA also experience Post-Traumatic Stress Disorder (PTSD). They are also at risk of experiencing social anxiety because they may learn to fear and avoid social situations.\(^12\)

In addition, the experience of homonegative attitudes in the community has been found to lead same-sex attracted individuals to feel isolated and alienated, which in turn can trigger mental health problems such as depression, PTSD, social anxiety and thoughts of suicide.\(^13\)\(^-\)\(^14\) Same-sex attracted individuals who internalise society’s negative perceptions of same-sex attraction (internalised homonegativity or self-stigma) may experience reduced self-esteem,\(^15\) which can also lead to mental health problems.\(^16\)\(^-\)\(^18\)

Access to mental health services

SSAYA also experience more difficulties getting help for mental health problems, such as feeling as though mental health services marginalise them by assuming heterosexuality and do not adequately assist them to address challenges unique to being same-sex attracted such as coming out and stigma.\(^19\)

Getting help is even more challenging for SSAYA living in rural or regional areas as they have less access to relevant information, resources, support and services than their city peers. Rural SSAYA attempt suicide six times more often than the population average\(^20\) and experience higher levels of homonegativity than their city peers.\(^21\) Research with same-sex
attracted adults living in rural areas has found that most do not disclose their sexual orientation, which exacerbates social isolation, and makes them more vulnerable to homonegative responses from workers in the health care system.22

The role of the internet in assisting SSAYA

Internet-based interventions, compared to those delivered face-to-face, have the potential to be more engaging and more accessible to young adults, who are early adopters of new technology.23-24 For SSAYA the internet may be especially helpful in making treatment more accessible given difficulties accessing relevant help and stigma concerns.25 The internet has been found to help make treatment more flexible and accessible and preserve anonymity.26-27

Numerous internet-based mental health interventions targeting young people have been developed e.g.,28-32 and found to be effective for a number of psychological symptoms, including anxiety and depression.26 However, existing internet-based interventions are rarely inclusive of or relevant for same-sex attracted individuals.19, 33 In a review of 24 web- and mobile phone-based interventions Rozbrojet al.19 found that these interventions seldom addressed stressors faced by same-sex attracted individuals and contained content suggesting users were heterosexual.

3.1.2 Research aims

Given the need for online interventions relevant to SSAYA, this project aimed to develop an online cognitive behaviour therapy (CBT) intervention (the Out & Online program) designed to reduce anxiety and depressive symptoms and enhance wellbeing in SSAYA aged 18-25 years. The intention was to develop a customised program tailored to individuals’ gender and symptom profile and designed to be relevant to SSAYA.

The project aimed to evaluate the effectiveness of the Out & Online program for reducing anxiety and depressive symptoms and improving wellbeing. It was anticipated that additional benefits participants might gain from the program would include reduced internalised homonegativity, more positive attitudes towards seeking help, greater sense of control over their health and greater satisfaction with their lives.
3.2 Approach

3.2.1 Project design

This project was conducted over two phases.

Phase 1: Intervention development

The intervention development phase involved the following steps:

1. Conducting focus groups with SSAYA;
2. Adapting the content of existing online mental health programs on the Anxiety Online platform (now known as Mental Health Online);
3. Expert review of the program content;
4. Usability testing of the program with SSAYA.

Phase 2: Evaluation of the Out & Online program

The intention was to evaluate the Out & Online program using a randomised controlled trial (RCT) design but difficulties with recruitment and problems with the usability of the trial entry process on the website meant this needed to be modified to an open trial design with online surveys completed pre- and post-program and telephone interviews conducted at post-program.

3.2.2 Methods

Phase 1: Intervention development

Focus groups

To inform the development of the program, focus groups were conducted with SSAYA (aged 18 to 25 years) who discussed their experiences regarding their sexual orientation, their mental health needs and their preferences for support services.

Development of the program

The feedback from the focus groups, along with expert review, informed the modification of existing online prevention and treatment programs on the Anxiety Online platform (now known as Mental Health Online) of the National eTherapy Centre at Swinburne University of Technology.
The program content was adapted so that it would deliver both general mental health information and symptom relevant material across up to three different types of mental health difficulties (out of generalised anxiety, social anxiety, post-traumatic stress, obsessions and/or compulsions, panic, specific fear and depressive symptoms). Some program content was also tailored for gender.

In addition, content was personalised for SSAYA by using inclusive language and content (for example, pictures and videos of people in same-sex attracted relationships), providing examples of stressors, unhelpful thoughts and beliefs and unhelpful behaviours unique to challenges associated with being same-sex attracted (e.g., “coming out”, feeling accepted by heterosexual peers), providing information on support services specialising in supporting same-sex attracted individuals and enhancing self-esteem and self-acceptance in the face of homonegativity and internalised homonegativity.

The resulting program was designed to provide individuals with a customised mental health early intervention that respects their individuality, and acknowledges the reality and frequency of the experience of multiple symptoms.

**Expert review**

The program content was reviewed by experts in clinical and research work with LGBTIQ communities, e-mental health and/or suicide prevention.

**Usability testing**

Further refinement of the program was made following usability testing, whereby SSAYA reviewed specific modules within the program and made recommendations for amendment to content. This feedback was incorporated where possible within project funding and timelines.

**Phase 2: Evaluation of the Out & Online program**

The evaluation phase of the project commenced as an RCT design with the following inclusion criteria:

- Australian resident;
- Aged between 18 and 25 years;
- Same-sex attracted (self-identify as gay, lesbian or bisexual);
- Access to the internet;
- Mild to moderate distress (Kessler-10 score between 16 and 21);
- Having depressive and/or anxiety symptoms (being eligible to receive tailored content for at least one anxiety or depressive symptom);

However, in response to recruitment and website design challenges (discussed in section 3.3) the RCT design was modified to an open trial design where everybody who met the following inclusion criteria was given access to the program:

- Australian resident;
- Aged between 18 and 25 years;
- Self-identify as same-sex attracted (gay, lesbian or bisexual) or non-heterosexual but happy to provide feedback about how the program could be made more relevant to other sexual and gender diversities (e.g., the program was not specifically designed for young people who identify as transgender or transsexual but these individuals were not excluded from participating in this revised trial);
- Mild to moderate distress; or low distress but happy to provide feedback on the program; or high distress but after discussion with researcher mutually agreed the program was suitable for them.

3.3 Results

Phase 1: Intervention development

Focus groups

Focus groups were conducted with 17 SSAYA (aged 18 to 25 years) from regional and metropolitan areas. Focus group participants discussed their experiences regarding their sexual orientation, their mental health needs and their preferences for support services. Themes emerging from the focus group feedback were analysed and are discussed below. This feedback informed the development of the program.

Sexual orientation and mental health

Focus group participants discussed the possible relationship between sexual orientation and mental health. They felt that it was assumed that every problem they had was because they were gay or lesbian. They were not given good information to be able to understand if there was a link between their sexual orientation and their mental health.
Experiences with mental health professionals

The participants also discussed their experiences seeing mental health professionals (MHP). They felt that the MHPs they had seen were not gay or lesbian friendly. They tended to go to MHPs that other SSAYA had reported having good experiences seeing.

Social support

The young people taking part in the focus groups said that they did not like to go to their family for mental health support, who in some cases were still coming to terms with their having come out to them. They felt that their peers assumed that they only wanted to mix in LGBTIQ circles.

Documentation

In the focus groups a dislike was voiced for the language used in existing documentation within mental health services. This tended to assume heterosexuality by assuming an opposite sex partner.

Preferences for mental health support

The focus group participants discussed their preferences for mental health support. They wanted mental health services to use gender inclusive and relevant language. They also did not want everything to be linked to their sexual orientation. That is, they did not want the mental health service to give the impression that any mental health problems they were experiencing were because of their sexual orientation.

Expert review

The program content was reviewed by all members of the research team which included researchers and mental health professionals with considerable experience in clinical and research work with LGBTIQ communities and/or in online mental health. The suicide prevention content was reviewed by the crisis intervention service Lifeline Australia.

Usability testing

Four SSAYA were recruited for usability testing of the online program. Based on their feedback the language used to refer to sexual/gender orientation was changed from “same-sex” to “same-gender” and additional support service details were provided.

The Out & Online program

The Out & Online program was developed as a standalone resource that should complement face-to-face therapy, but does not require the involvement of a health professional. The program contains eight brief modules containing mental health and wellbeing information and exercises based on CBT principles (see Table 1). The modules contain generic information
and information and exercises specific for the symptoms participants endorse in an online assessment at pre-intervention, which screens for generalised anxiety, obsessions and compulsions, post-traumatic stress, specific fear, social anxiety and depressive symptoms. Some program content is also tailored for gender. It is recommended to participants that they spend an hour a week over eight weeks reading through the online modules and practising offline exercises. The eighth module, on prevention and help for suicide thoughts, is accessible to all participants at all times.

Table 1.

Content contained within the modules of the Out & Online program

<table>
<thead>
<tr>
<th>Module</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Program introduction</td>
<td>• Overview of and introduction to the program</td>
</tr>
<tr>
<td>2. Main symptoms</td>
<td>• Psycho-education about common mental health problems, including anxiety, depressive symptoms, addiction and thoughts of suicide</td>
</tr>
<tr>
<td></td>
<td>• Introduction to Cognitive Behaviour Therapy</td>
</tr>
<tr>
<td></td>
<td>• Making the most of the program</td>
</tr>
<tr>
<td>3. Your physical health</td>
<td>• Relaxation and breathing training</td>
</tr>
<tr>
<td>4. Your thoughts</td>
<td>• Identifying and challenging unhelpful thoughts</td>
</tr>
<tr>
<td>5. Your behaviours</td>
<td>• Activity planning (if depressive symptoms)</td>
</tr>
<tr>
<td></td>
<td>• Exposure therapy (if anxiety symptoms)</td>
</tr>
<tr>
<td>6. Useful tools</td>
<td>• Self-esteem and self-acceptance</td>
</tr>
<tr>
<td></td>
<td>• Sleep</td>
</tr>
<tr>
<td></td>
<td>• Nutrition and comfort eating</td>
</tr>
<tr>
<td></td>
<td>• Physical activity</td>
</tr>
<tr>
<td></td>
<td>• Drugs and alcohol</td>
</tr>
<tr>
<td></td>
<td>• Reducing social isolation</td>
</tr>
<tr>
<td>7. Keeping on track</td>
<td>• Maintaining gains</td>
</tr>
<tr>
<td></td>
<td>• Managing setbacks</td>
</tr>
<tr>
<td></td>
<td>• Plan for staying healthy</td>
</tr>
<tr>
<td>8. Prevention and help for suicide thoughts</td>
<td>• Warning signs of suicide</td>
</tr>
<tr>
<td></td>
<td>• Keeping yourself safe</td>
</tr>
<tr>
<td></td>
<td>• Keeping someone else safe</td>
</tr>
<tr>
<td></td>
<td>• Getting help</td>
</tr>
</tbody>
</table>
Module 1. Introduction

In the video below Dr Matt Malloy, clinical psychologist from Federation University (formerly University of Ballarat), welcomes you to the Out & Online program.

Download Introduction to the Out & Online program video transcript

Click on the icon to the right to download a printable version of the Introduction to the Out & Online program video transcript in PDF format.

Breathing depth check

Depth of breathing

Also important for learning to control your breathing is to consider your depth of breathing.

Often when we are scared or stressed we get into the habit of taking shallow breaths or even holding our breath. This can make us feel physically uncomfortable and on edge. Your breathing rate may be in the normal range (8-10 breaths per minute) but you may be taking shallow breaths.

The diagram below shows you the differences between shallow and deep breathing.

Examples of Shallow and Deep Breathing

INSTRUCTION
Click the start button above the body on the left to see an example of shallow breathing. Click the start button above the body on the right to see an example of deep breathing.

Figure 1. Screenshots of the Out & Online program
Figure 1 (continued). Screenshots of the Out & Online program
Phase 2: Evaluation of the Out & Online program

*Randomised controlled trial (RCT)*

Recruitment activities for the RCT commenced on 23 July 2014. Participants were recruited through Australian organisations that work with SSAYA, mental health organisations, advertising via social, online and news media, and information sessions held for community groups (including support groups for SSAYA, health professionals that work with SSAYA).

Extensive efforts were made by the research team to promote the *Out & Online* program and research trial. Considerable interest in the program was received from LGBTIQ communities, mental health organisations, media and from the research team’s universities.

Promotional videos were developed to explain the research trial and program and were made available via the *Out & Online* website (www.outandonline.org.au) and YouTube (https://www.youtube.com/user/OutandOnline/videos). We developed electronic and print postcards, with nine versions of the print postcards available to incorporate diversity in the images of young people. These postcards were very popular and helped to create awareness of the program.

Promotion efforts also involved running a Facebook page (https://www.facebook.com/outandonline) to supplement the website. This page aimed to provide young adults from LGBTIQ communities with links to additional resources and services as well as further information about the *Out & Online* program.

Promotion efforts also partly focused on building relationships with services that provide specialised support to LGBTIQ communities. Some services provided us with feedback to help us improve the website, some of which we have addressed already (e.g., expanding the diversity of images of young people used) and some we will address in the future pending further funding (e.g., making the home page appear more engaging for young LGBTIQ adults and adding content tailored for adults who identify as bisexual, transgender or gender questioning).

The universities involved in the project also embraced the program. For example, at Swinburne University of Technology the program was promoted to staff and students through e-newsletters, participation by *Out & Online* project researchers in events for Wear it Purple Day and Pride @ Swinburne day, and promotion of the program through the Swinburne Queer Department, Swinburne ALLY network, Swinburne Psychology Clinic and Swinburne Health Service.

In total 105 individuals registered on the *Out & Online* website. Of these individuals, 78 (74%) did not start the pre-intervention surveys, 8 started but did not complete the surveys
and 19 participants completed the surveys. Of the participants who completed the surveys 2 people were ineligible because of low distress, 6 people were ineligible because of high distress and 11 people were offered the program. Only 4 out of the 11 participants offered the program proceeded to the next step, which was randomisation and all 4 participants were randomised to the waitlist control group.

Of the people who did not start the surveys three people formerly opted out of the trial and completed a departure questionnaire, with their responses indicating a preference for face-to-face services. Two people opted out by contacting the research team; one person stated not wanting to participate in a research trial and the second person stated that the first survey did not provide enough options to indicate sexual orientation. Another six people opted out of the trial for unknown reasons.

Several attempts were made to contact people who had not formerly opted out of the project, including sending them a welcome email with a link to a video overview of the research trial, offering them a $20 gift card as a thank you for taking part in a telephone interview about the trial registration process and then offering them a $50 gift card as a thank you for taking part in a much simplified version of the trial.

**Telephone interviews based on original RCT design**

Only two people took part in the first round of telephone interviews based on the original RCT design. The first person interviewed did not continue with the trial because he was outside the eligible age range. He thought the program was “an incredibly important initiative” but had not been clear on what the program involved (thought it might have been a chat-style forum), had not been aware of the promotional videos about the program and research trial and thought that the 8 week time frame of the program might be overwhelming for many people. The second person interviewed was also not sure what to expect of the program, but thought it might involve online chat with a counsellor. She completed the surveys but had not gone further because she was not clear on what the next step was. She thought that the length of the program was appropriate but would have liked more financial incentives to take part and while she did not mind completing the questionnaires, this took her 45 minutes. This participant was assisted to progress to the next step of the trial which resulted in her being randomised to the waitlist control group.

Despite extensive efforts to promote the program and efforts to seek feedback from people about barriers to continuing their participation in the research trial we were unable to complete the RCT within the remaining time frame and project budget. No participants had got to the stage of being randomised into the program (and only 4 participants had been randomised into the waitlist control group). Though few people stated reasons for not
continuing with the trial it was felt that the barriers were with the process of taking part in the trial rather than the program itself. Some of the possible barriers may have been:

- We were capturing a small demographic: 18-25 year old same-sex attracted individuals with at least one symptom of anxiety or depression and mild to moderate psychological distress (a score between 16-29 on the Kessler-10 scale\textsuperscript{34-35}; persons with low or high distress were ineligible to continue with the trial but were provided with referral advice);
- The website home page was a modified version of the Mental Health Online website, the larger online mental health service that the \textit{Out \& Online} program is part of. In the context of the demographic in the current project, anecdotal feedback obtained during project promotion activities suggested that the home page was too corporate looking and did not look like a place relevant for gender-diverse young adults;
- There were too many steps involved before randomisation took place and the steps needed to be more clear;
- Participants were initially asked to agree to the terms and conditions of the Mental Health Online website, as the \textit{Out \& Online} program is part of that larger service; however, it was not clear to participants what the connection with Mental Health Online was;
- There were too many surveys to complete;
- The benefits of doing the program and participating in the research trial were not made clear enough to participants;
- Participants did not feel motivated enough to respond to the research team’s attempts to contact them, perhaps having already lost interest;
- The website was not fully compatible with tablets and mobile phones.

It was considered critical to seek feedback on the actual program content so that these barriers to getting into the program did not overshadow what could still be a valuable mental health resource for SSAYA. Hence, a revised trial was conducted in order to obtain feedback about the program.

\textit{Revised open trial}

The revised trial involved the following:

1. Interested consumers were directed to a separate online survey website (Opinio) to provide their consent and to complete a shorter online survey (4 surveys, about 15 minutes);
2. Program suitability assessed: a researcher manually assessed suitability for the program and gave participants a demonstration login (that did not identify them).
tailored to only 2 types of symptoms (generalised anxiety and/or depressive symptoms) in order to shorten the surveys and program entry process. Persons with low or high distress were not deemed ineligible but for those with high distress the researcher discussed with them their current support and the suitability of the program;

3. Participants accessed the program for up to 4 weeks;

4. Participants completed a second survey and a telephone interview about their views on the program.

The revised trial was promoted by emailing all people who had registered for the RCT other than those who had formerly opted out and the trial was promoted through social media. There were 26 people who started the pre-program survey, 19 of whom completed it. Of the 19 participants, 1 was ineligible because he was outside the age range for the project, 5 people who reported high distress did not respond to a request to telephone them to discuss the suitability of the program for them and 1 person did not continue because the researcher and participant discussed his involvement and determined the program would not be suitable given current high levels of distress. The remaining 12 people were given access to the program and asked to look at it over the next 4 weeks. Eight people took part in post-program telephone interviews and 7 people completed the post-program online survey.

Demographic and background information about the 8 people who took part in the telephone interviews are shown in Table 2. The interviewees had spent between 1 to 8 hours using the program over the previous four weeks. Their psychological distress levels, as measured by the Kessler-1033-34 scale showed a trend of reducing from pre- to post-program, though this did not reach statistical significance in a paired-samples t-test ($t (6) = 2.33, p = .059$). However, it was a small sample and the interviewees had not had access to the program for the recommended time period (8 weeks).
<table>
<thead>
<tr>
<th>Participant number</th>
<th>Sexual orientation</th>
<th>Gender</th>
<th>Age</th>
<th>Pre-program - general distress (Kessler-10\textsuperscript{34-35}, range 10-50) (10-15 = low distress, 16-29 = mild-mod distress, 30-50 = high distress)</th>
<th>Pre-program - depression (DEP) symptoms (PHQ-9\textsuperscript{36}, range 0-17) (4+ eligible for program content for depression symptoms 15+ eligible but additional face-to-face (F2F) support recommended)</th>
<th>Pre-program Generalised anxiety (GA) symptoms (GAD-7\textsuperscript{37}, range 0-21) (4+ eligible for program content for generalised anxiety symptoms 15+ eligible but additional face-to-face support recommended)</th>
<th>Current support</th>
<th>Time accessing program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lesbian</td>
<td>Female</td>
<td>20</td>
<td>Pre-program; 17 = mild to mod distress 18= mild to mod distress Post-program; unknown</td>
<td>Pre-program; 7 (DEP tailoring) Post-program; 4 (DEP tailoring)</td>
<td>Pre-program; 8 (GA tailoring) Post-program; unknown</td>
<td>Social worker/counsellor for anxiety disorder</td>
<td>7-8 hours (got up to Module 5)</td>
</tr>
<tr>
<td>2</td>
<td>Gay</td>
<td>Male</td>
<td>25</td>
<td>Pre-program; 21 = mild to mod distress unknown Post-program; unknown</td>
<td>Pre-program; 8 (DEP tailoring) Post-program; unknown</td>
<td>Pre-program; 4 (GA tailoring) Post-program; unknown</td>
<td>None</td>
<td>1-2 hours (half way through Module 2)</td>
</tr>
<tr>
<td>3</td>
<td>Lesbian</td>
<td>Female</td>
<td>22</td>
<td>Pre-program; 37 = high distress Post-program; 27 = mild to mod distress Post-program; unknown</td>
<td>Pre-program; 18 (DEP tailoring, F2F support recommended) Post-program; 15 (DEP, F2F support recommended)</td>
<td>Pre-program; 11 (GA tailoring) Post-program; 9 (GA tailoring)</td>
<td>Psychiatrist, psychologist, medical doctor for anxiety disorder, depression</td>
<td>3-4 hours</td>
</tr>
<tr>
<td>4</td>
<td>Lesbian</td>
<td>Female</td>
<td>18</td>
<td>Pre-program; 20 = mild to mod distress Post-program; 15 = low distress</td>
<td>Pre-program; 7 (DEP tailoring) Post-program; 6 (DEP)</td>
<td>Pre-program; 4 (GA tailoring) Post-program; 4 (GA tailoring)</td>
<td>None</td>
<td>1-2 hours (half way through Module 3)</td>
</tr>
</tbody>
</table>
## Table 2 (continued). Demographic and background characteristics of participants from revised open trial who took part in telephone interviews

<table>
<thead>
<tr>
<th>Participant number</th>
<th>Sexual orientation</th>
<th>Gender</th>
<th>Age</th>
<th>Pre-program general distress (Kessler-10, range 10-50)</th>
<th>Pre-program depression (DEP) symptoms (PHQ-9, range 0-17)</th>
<th>Pre-program Generalised anxiety (GA) symptoms (GAD-7, range 0-21)</th>
<th>Current support</th>
<th>Time accessing program</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Gay</td>
<td>Male</td>
<td>20</td>
<td>Pre-program; 10 = low distress Post-program; 10 = low distress</td>
<td>Pre-program; 0 (no DEP tailoring) Post-program; 0 (no DEP tailoring)</td>
<td>Pre-program; 0 (no GA tailoring) Post-program; 0 (no GA tailoring)</td>
<td>None</td>
<td>1-2 hours (some of the modules)</td>
</tr>
<tr>
<td>6</td>
<td>Bi-sexual</td>
<td>Female</td>
<td>18</td>
<td>Pre-program; 28 = mild to mod distress Post-program; 23 = mild to mod distress</td>
<td>Pre-program; 16 (DEP tailoring, F2F support recommended) Post-program; 14 (DEP)</td>
<td>Pre-program; 12 (GA tailoring) Post-program; 14 (GA tailoring)</td>
<td>Psychiatrist, psychologist, counsellor for anxiety, depression.</td>
<td>5-6 hours (6 modules)</td>
</tr>
<tr>
<td>7</td>
<td>Gay</td>
<td>Male</td>
<td>19</td>
<td>Pre-program; 40 = high distress Post-program; 38 = high distress</td>
<td>Pre-program; 19 (DEP tailoring, F2F support recommended) Post-program; 19 (DEP, F2F support recommended)</td>
<td>Pre-program; 17 (GA tailoring, F2f support recommended) Post-program; 15 (GA, F2F support recommended)</td>
<td>Psychologist, doctor, online service, self-help book for anxiety, depression, sleeping problems</td>
<td>5 hours (most except Module 2)</td>
</tr>
<tr>
<td>8</td>
<td>Gay</td>
<td>Male</td>
<td>19</td>
<td>Pre-program; 18 = mild to mod distress Post-program; 16 = mild to mod distress</td>
<td>Pre-program; 7 (DEP tailoring) Post-program; 8 (DEP tailoring)</td>
<td>Pre-program; 9 (GA tailoring) Post-program; 4 (GA tailoring)</td>
<td>None</td>
<td>1-2 hours (Modules 1-3)</td>
</tr>
</tbody>
</table>
Feedback from interviews with SSAYA

Program overall

The response to the program by the eight interviewees was overwhelmingly very positive, with Out & Online seen as unique in specifically reaching out to a same-sex attracted audience, very easy to use and navigate, appropriate in tone, and very beneficial in terms of generalist practical help leading to medium- to long-term benefit for those with mild to moderate symptoms, or for those with severe but well managed/supported symptoms.

All interviewees endorsed the program for a generalist use and said they would recommend it, with some specific reference made to the usefulness of the program for younger people or friends who may be experiencing difficulties associated with coming out.

Sexuality

Most interviewees endorsed the program specifically for same-sex attracted individuals, and four noted that they had never seen a program of that sort specifically targeted at that market before. Interviewees appreciated the overt inclusion of terminology with which they identified, e.g., “this is specific with the names and stuff, same-gender, I thought that was really good, and it was kind of calming and reaffirming.”

However, while “inclusivity” and normalisation were noted as positives, interviewees most commonly expressed praise for an absence of (“in your face”) hetero-normative assumptions, and the inclusion of terminology (same-gender) with which the interviewees identified, rather than any specific presence of program content specific to gay/lesbian/bisexual individuals. One interviewee specifically noted that it “could be for anyone.” Another interviewee commented that the general look of the program also meant young people could look at the program without fear of a parent finding out they were gay or lesbian if they walked in on them when they were using the program:

“Because it’s not so overt [in being for same-sex attracted individuals] that also makes it possible that people in situations where they don’t feel comfortable with their sexuality due to religion or parents or anything like that could access these resources and not feel that they’re going to get slammed if their parents accidentally walk in and they see this information and there’s no huge big rainbow flag or anything like that which could make them feel uncomfortable…”

Where the sexuality-specific content was endorsed, it was seen as probably most useful for those who were beginning their “journey” (of coming out), rather than people who were
already out, as assistance for that was perceived to be either not needed or already available (especially gay/lesbian sexual health).

One interviewee specifically asked for more information pertaining to coming out and other such issues that are relevant for same-gender-attracted people but which are not necessarily mental health issues.

*Psycho-educational information*

Interviewees were overall very positive about the quantity and quality of the psycho-educational material provided by the program, with one person expressing pleasant surprise at how in-depth the information was. Typically, those who scored low- (or no-) to mild-severity of symptoms/distress stated that some of the information was either not new to them, or not especially relevant. However, some with mild to moderate distress indicated that while there was material they had already encountered, there was also a lot of new information, and that is was useful to go over “old” material anyhow.

All interviewees endorsed the content, including psycho-educational and therapeutic exercises, for others who might be experiencing greater difficulties than themselves. It was also indicated by interviewees that they, or others, might like to refer back to the information in the future on an as-needed basis; to have it on-hand.

For those with higher levels of distress and/or symptoms that may not have been currently well managed, the volume of information was experienced as too great. For example, one interviewee who scored high distress levels / symptom severity felt the information was of good quality and an appropriate amount, but that they found it to be quite overwhelming. This participant drew attention to the fact that they were probably not in the target market due to the nature of their mental health difficulties (as discussed with interviewer).

*Content / Exercises*

Participants were enthused most about the practical applicability of the exercises. They appreciated learning “techniques” that would enable them to find “solutions” to daily problems.

The relaxation exercises and unhelpful thought-pattern exercises were the most commonly endorsed (but most interviewees only completed up to modules 2-5, thus did not try out all the exercises).
One interviewee suggested that the program would be useful as a structured component in a school curriculum, and as something available for family and friends.

**Motivation and engagement**

Interviewees who expressed a high level of motivation to engage with the program, and who felt the volume, quality, structure and practicability of content was very beneficial, were mostly those whose distress/symptom ratings were mild to moderate, or even high, *but who were already receiving support* from a psychotherapist and/or other help, and who appeared to be managing their symptoms well.

The interviewees who were less motivated to engage, and/or who saw the program as less helpful/relevant to them, were typically in one of two groups:

- Those for whom distress severity / symptom ratings were moderate to high *and they were either not* receiving support, *or* their symptoms were not presently well managed;
- Those whose distress severity / symptom ratings were low.

All those who showed low motivation for engagement with the program, or who struggled with it, still endorsed the program for use by others.

Most interviewees noted the difficulty of fitting the program in around their schedules (e.g., university studies), but their range of success/difficulty in completing the modules alongside study or work differed, according to their distress severity / symptom ratings, presence or absence of external support, and other unknown variables.

**Structure and tone**

Interviewees were all very positive about the navigation and flow of the material. The fact that the text was broken up with images and text boxes was regarded as useful and appropriate, and the content of the text boxes useful. The text boxes and summary pages were positively likened to learning models used at university or school.

The tone and wording were overwhelmingly seen as positive, with an absence of jargon while still retaining an appropriate level of detailed information.

**Support**
All interviewees thought that the nature of support (self-help with links to other services given within the program) provided within the program was optimal. However, some made suggestions for variations, pertaining to their circumstances.

Most of the interviewees, especially those who were younger and/or had moderate to severe difficulty ratings, were very positive about the external links to further resources, with some expressing that this gave them a sense of security/options for further support if they needed it.

Some interviewees who scored moderate distress levels / symptom severity felt that if they did not already have external psychotherapeutic and other support, they might have difficulty with the program; that it was good as a supplemental option for face-to-face support, or perhaps as a stepping stone to face-to-face support.

One interviewee, who scored high distress levels / symptom severity, and explained that motivation was a problem for them, stated that it might be helpful to receive support via phone or video chat as a "crutch."

Interviewees endorsed adding in a weekly email reminder to use the program.

Integration of symptom treatment

All interviewees endorsed the integration of treatment for multiple mental health symptoms. Reasons given included the experience of being able to see an "overall picture" and how these symptoms relate to each other while also being able to differentiate and target specific problems as needed, and, similarly, that "a combined approach is ideal because those [symptoms] are usually … related." An integrated approach was also seen as "convenient" compared with accessing multiple programs.

Two interviewees were interested in receiving even more symptom-specific content [though these participants did not complete all modules].

Online availability

The online availability of the program was seen as overwhelmingly positive, especially because it is:

- "Convenient" (fitting in with busy schedules, especially university);
- Less "daunting" (in terms of dealing with both clinical bureaucracy and the psychotherapeutic process);
- "Anonymous" (don't have to worry about "being judged");
• Helpful if experiencing ambivalence/anxiety ("you get feelings of doubt, and all that sort of thing and everything just sort of bubbles up and goes crazy.") [whereas online you can go at your own pace];
• A stepping stone to face-to-face treatment.

Concerns about online delivery included:

• The possibility the user might “miss out” on getting a “better perspective”, which can come with face-to-face treatment;
• Concern that online delivery might mean losing some specificity of treatment;
• Concern about encountering emotional difficulties but not having guidance (“You don’t always know exactly what you are feeling kind of thing. When you are face to face someone can help you get that out. Whereas on the internet you are kind of doing everything for yourself.”);
• Concern that there is a lack of “emotion behind the text,”;
• Concern about the risk of avoiding facing “permanent feelings,” i.e. that the online model might only mean a superficial treatment.

Technical aspects / platform

Most interviewees expressed a desire for the program to be more compatible with a tablet or mobile. Reasons for this included:

• Being able to do it [the program] at uni / out of the house;
• Laptop is associated with work / project, and therefore it is more likely the program would be forgotten due to conflict/ associations with other priorities/activities;
• Being able to access the program easily especially before bed, or at times away from a desk would make it more likely to be used.

One interviewee recommended something like the Smiling Mind app.¹

Half of the interviewees expressed difficulties with downloading PDFs and exercise work sheets. It was felt this used up bandwidth, and also that it was messy and not streamlined. There was one technical problem with PDF use on a tablet.

Look and feel, media content

¹An age-specific mindfulness meditation app with a colourful interface, including information as well as formal and informal guided practices.
Overall it was felt that the look and feel of the program were completely appropriate and not at all deleterious or offensive, but that interviewees felt it “looks a bit basic,” “feels a bit clinical,” and they would prefer a more “dynamic” and “colourful” interface.

One interviewee stated that it was “not as visually engaging as Headspace and ReachOut.”

Another interviewee referred to the Smiling Mind app, as above, for structure/platform, but also for visual aesthetics.

It was also noted by one interviewee that the level of colour/dynamism etc. was appropriate and functional.

Most interviewees liked the videos, aside from one interviewee who wanted them to be more engaging.

_Timeframe_

All endorsed the 8-week time frame, and the volume of information and activities for each week. One interviewee specifically noted that the weekly pacing assisted in integrating the program into their life as part of “a routine.” However, it was overwhelmingly felt that the flexibility provided within the program of being able to go at one’s own pace and to move back and forth if needed was essential.

One interviewee negatively likened the 8-week time frame to a university course, but stated that this was nevertheless probably appropriate for medium to long-term benefits.

_Suggestions_

Two interviewees stated that they would like to see a forum associated with the program, for example where they could connect with others facing similar challenges or to ask questions and receive feedback, possibly from a moderator.

As noted above, one interviewee suggested that the program would be useful as a structured component in a school curriculum, and as something available for family and friends.

_Feedback from online survey_

Seven participants responded to the online post-program survey. They had spent between 1 and 8 hours looking at the program; with 3 people having looked at it for 1-2 hours, 2 people for 3-4 hours, 1 person for 5-6 hours and 1 person for 7-8 hours.
Participants all reported enjoying the program and they were all moderately to very highly satisfied with the Out & Online program. Reasons for using the program included being curious \((n = 5)\), the program being a convenient way to receive help \((n = 4)\), concerns about social shyness \((n = 3)\) and a preference for anonymity \((n = 2)\). Reasons endorsed by only one respondent included there being nothing else available, financial constraints, concerns about possible stigma and something to complement face-to-face assistance. Participants were asked about any features that would have helped them engage more with the program (see Table 3). The most common suggestions were more online activities \((n=4)\) SMS reminders to use the program \((n = 3)\) and more use of video \((n = 3)\).

Participants’ feedback about the program in the online survey supported what they had said in their telephone interviews. The program was seen as easy to understand and the participants liked being able to access further information if they chose to.

For example:

“I like that the program goes into further depth than a lot of counsellors do. For example, whereas counsellors tell you to ‘focus on your breathing’ and to ‘breathe deeply’ (from my experience anyway), Out & Online tells you HOW to breathe deeply.”

“The information was concise and easy to understand making the whole process streamlined”

“It was very convenient and easy to work through at my own pace.”
Table 3.

Participants’ responses to the question “Please select any of the following features that would have engaged you more with the online program”.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Number of people selecting</th>
</tr>
</thead>
<tbody>
<tr>
<td>More online activities</td>
<td>4</td>
</tr>
<tr>
<td>More use of video</td>
<td>3</td>
</tr>
<tr>
<td>SMS reminders</td>
<td>3</td>
</tr>
<tr>
<td>Email therapist</td>
<td>2</td>
</tr>
<tr>
<td>Chat room for peer support</td>
<td>2</td>
</tr>
<tr>
<td>More use of audio</td>
<td>2</td>
</tr>
<tr>
<td>Phone/Skype audio only therapist</td>
<td>1</td>
</tr>
<tr>
<td>Web cam/ video therapist</td>
<td>1</td>
</tr>
<tr>
<td>Bulletin board</td>
<td>1</td>
</tr>
<tr>
<td>Face-to-face therapist</td>
<td>0</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td>Better use of video</td>
<td>1</td>
</tr>
<tr>
<td>Mobile app</td>
<td>1</td>
</tr>
</tbody>
</table>

Suggestions for improving the program were to include more videos, include more online activities such as games, make the program more compatible with tablets and containing all the information in the program rather than providing downloadable fact sheets.

3.4 Implications

The project has resulted in the development of one of the first online interventions designed to be relevant for same-sex attracted individuals. The Out & Online program is unique in not only being designed to be relevant for SSAYA but in tailoring program content to gender and
symptom profile. Feedback from SSAYA who used the program endorsed the program as 
easy and convenient to use, easy to understand, enjoyable, practical, and providing much 
needed assistance for mental health problems.

However, the difficulties in recruiting participants into the research trial and the website 
usability issues highlighted the critical need for programs to be easy to access and carefully 
marketed so that same-sex attracted individuals feel motivated to seek help for mental health 
difficulties. These challenges plus feedback from focus groups were consistent with previous 
research that suggests that while same-sex attracted individuals are more prone to mental 
health problems compared to their heterosexual peers, they are also more likely to feel 
existing mental health services will not be relevant for them. It is thus crucial to create 
programs that same-sex attracted young people will feel enthused about using and believe 
will be of benefit to them.

While the program content was informed by feedback from SSAYA in focus groups and 
through usability testing more work with SSAYA is needed to understand how to make online 
programs appealing to them.

This research was focused on developing a program relevant to SSAYA but it is 
acknowledged that this is just a starting point to helping to make mental health services more 
inclusive of gender and sexual diversity. Further work is needed to develop mental health 
interventions that are relevant for sexually and gender diverse individuals, including those 
outside the 18-25 year age range targeted in this study and those of sexual/gender 
orientations other than gay or lesbian.

### 3.4.1 A new online mental health resource for same-sex attracted young adults

The Out & Online program ([www.outandonline.org.au](http://www.outandonline.org.au)) is now publicly available via the 
Mental Health Online service at Swinburne University of Technology. The program is 
available without the need to take part in a research trial and with a shorter set of surveys for 
the purpose of tailoring program content to the individual. However, further work is needed to 
make the website more appealing to the demographic so that they feel motivated to use the 
program. Further research is also needed to determine the effectiveness of the program for 
reducing anxiety and depressive symptoms and improving wellbeing in SSAYA. Separate 
avenues of conducting further research will be sought, such as through postgraduate student 
research projects and submission of funding applications in collaboration with an advisory 
group of SSAYA.
The program is unique and sophisticated, not only in targeting the mental health needs of SSAYA, but in tailoring the program content to gender and symptom profile. The personalisation of this program and online nature may help to make it more attractive and engaging for young people than traditional face-to-face alternatives. The integrated nature of the intervention also enables the simultaneous treatment of multiple mental health problems in one program, streamlining health care for the young person, as well as acknowledging the uniqueness of each user.

Feedback obtained from SSAYA about Out & Online endorsed the program as very easy to use and navigate, enjoyable, convenient and providing much needed practical help for mental health problems that they could work through at their own pace and refer back to later.

3.4.2 Implications for online program development

In our efforts to promote our research trial of Out & Online, feedback we obtained from health professionals and SSAYA highlighted the need for online programs such as Out & Online that are relevant to LGBTIQ individuals. This was also highlighted in a recent review paper on the applicability of existing eTherapies to gay men and lesbian women.19

During the project, promotion activities feedback obtained highlighted the need for further research and service provision aimed at making mental health services more inclusive of gender and sexual diversity, including services that are tailored to the needs of people who identify as transgender, bisexual or by other gender and sexual orientations besides same-sex attracted or opposite-sex attracted, as well as gender-questioning young people and services for gender diverse individuals outside the 18-25 age range of the current project.

Learnings from this project, while focused on SSAYA, may have implications for the development of other programs for gender- and sexually-diverse young adults. These learnings are discussed below.

Make programs relevant to gender and sexually diverse individuals

Feedback obtained from SSAYA in the current study from focus groups highlighted the need for programs that do not assume heterosexuality. The use of gender inclusive and relevant language was considered important in order for participants to feel the program was accepting of them.
Don’t make programs all about sexual orientation or gender

The SSAYA we spoke to in focus groups also highlighted that they did not want to feel that it was assumed that any mental health problems were because of their sexual/gender orientation. However, they also expressed a need for better information about any link between sexual orientation and mental health. This need could be met by providing information about homonegativity and internalised homonegativity as well as strategies for coping with this stigma and for developing self-acceptance in spite of this stigma.

SSAYA in the focus groups and who provided feedback on Out & Online during telephone interviews liked the idea of a generalist mental health program that was largely relevant for anybody but that used gender inclusive language and content. However, there was a need for some content specific to the challenges unique to diverse gender/sexual orientations (e.g., coming out, dealing with homonegativity and internalised homonegativity). This is how Out & Online was designed, but additional sexuality specific content could be developed such as more about coping with decisions about coming out.

Make programs interactive and fun

The young adults who provided feedback about Out & Online, while very positive about the program, wanted it to be more interactive, by including more online activities, games and videos and less text. They wanted information easily accessible within the program, without the need to download further information.

Make programs accessible and portable

At the time of carrying out this project the Out & Online program was not specifically designed to be compatible with mobile and tablet devices. However, the feedback from the young people we spoke to highlighted the need to make it as easy as possible for people to feel motivated to use the program. Making it easy to use and engage with on portable devices is imperative for a group that are already hesitant about how helpful mental health services will be for them. Web development work has almost been completed to make all programs available through the Mental Health Online service more compatible with portable devices.

Add additional forms of support options

While the self-help nature of Out & Online was appealing for the SSAYA we spoke to due to concerns about anonymity and social shyness or a preference for self-managing mild mental health difficulties, they were also open to additional support options. The idea of an optional moderated online peer forum and email or SMS reminders to use the program were seen as
appealing. Adding in opportunities for peer interaction may be a way of reducing isolation among SSAYA.

These learnings are consistent with recommendations developed by Lyons and colleagues for developing tailored web and mobile phone-based depression and anxiety interventions that are relevant for gay men and lesbian women.

3.5 Conclusion

In summary, SSAYA are at greater risk of poor mental health outcomes compared to their heterosexual peers. The provision of a preventive online mental health and wellbeing program, tailored to the gender and symptoms of the participant, may provide a cost-effective, anonymous and flexible medium for improving mental health outcomes for these individuals. This project is a starting point in helping to make online mental health programs more inclusive of gender and sexual diversity, and further research and program development is needed to ensure gender and sexually diverse adults feel motivated to use such programs.

3.6 References

social relationships, psychosocial functioning, and school performance in early adolescence. *Developmental Psychology, 44*, 59-68.


