
Project Title:

Rainbow Women’s Help Seeking Behaviour Research

This research project was funded by beyondblue: the national depression and anxiety initiative.

Ref CLT: 7195

Investigators:

Associate Professor Ruth McNair

Mrs Rachel Bush

The Department of General Practice, The University of Melbourne
## 1 CONTENTS

2 Executive summary ........................................................................................................................................... 3

2.1 PROJECT OBJECTIVES ................................................................................................................................. 3

2.2 PROJECT METHODS AND PARTICIPANTS ....................................................................................................... 3

2.3 KEY FINDINGS .................................................................................................................................................. 3

2.4 RECOMMENDATIONS ...................................................................................................................................... 8

3 Report .................................................................................................................................................................. 10

3.1 Context – literature review ............................................................................................................................... 10

3.2 Framework of help seeking ............................................................................................................................ 15

3.3 Methods ........................................................................................................................................................... 16

3.3.1 Survey Design ............................................................................................................................................ 16

3.3.2 Advertising and Recruitment .................................................................................................................. 16

3.3.3 Survey Measures .................................................................................................................................... 17

3.3.4 Analysis .................................................................................................................................................... 19

3.4 Findings ............................................................................................................................................................ 20

3.4.1 The participants ........................................................................................................................................ 20

3.4.2 The profile of rainbow women in the survey sample .............................................................................. 21

3.4.3 Mental health and physical health of RW in the sample ....................................................................... 25

3.4.4 Perceived need for mental or physical health help .................................................................................. 31

3.4.5 Help seeking intentions, attitudes and behaviour .................................................................................. 34

3.4.6 Types of support ....................................................................................................................................... 40

3.4.7 Barriers and enablers of help seeking .................................................................................................... 48

3.4.8 Priority subgroups according to health care need and access ............................................................... 53

3.4.9 Messages – content and delivery platforms .......................................................................................... 57

3.5 Future research ................................................................................................................................................ 63

3.6 References ....................................................................................................................................................... 65
EXECUTIVE SUMMARY

beyondblue commissioned this study to better understand the preferences and methods of help seeking by ‘rainbow women’ in order to target their mental health promotion efforts more effectively. Rainbow women in this study include any person identifying as lesbian, bisexual, queer or other diverse sexual orientations, same-sex attracted, and/or trans, gender queer, intersex or other diverse gender identities.

2.1 PROJECT OBJECTIVES
a) Improve knowledge on help-seeking behaviour of rainbow women (RW) and identify the most appropriate communication methods and language;

b) Identify priorities for developing targeted messaging to RW, thereby contributing to RW having increased awareness of depression/anxiety and the actions to take, and decreasing stigma; and

c) Summarise the knowledge that will guide the development of medium term project proposals for the population of RW.

2.2 PROJECT METHODS AND PARTICIPANTS
The project included four methods of collecting information about help seeking:

a) Literature review

b) Key informant interviews n = 8
   Eight people representing various LGBT health organisations around Australia were interviewed.

c) Online survey n = 1628
   An online survey was undertaken targeting women who identified as lesbian, bisexual, transgender, intersex, queer or same-sex attracted women, who were aged 18 years and over, and were currently living in Australia. In all 1706 Australian people participated, of whom 1628 completed all sections of the survey used for analysis.

d) Focus groups n = 12
   Three focus groups of four people were conducted, each with a different age cohort, ‘young’ aged under 30, ‘mid-life’ aged 30-50, and ‘older’ over 50 years of age.

2.3 KEY FINDINGS

The profile of rainbow women in the sample

The participants to the online survey were a very diverse group of people, with an age range of 18 to 81 years. Women who identified as lesbian, bisexual, queer and pansexual were well represented. A wide range of gender identities were also well represented including female, gender queer, and trans female. We extended the reach to include people who did not identify as female or ‘women’ with a small number identifying as ‘other’ genders, intersex and trans male. We were also interested in community connections of participants, both within LGBTI subgroups and subgroups based on general interests.

RW from all states and territories participated and one fifth of the sample lived in regional or rural areas. Typical of LGBTI convenience samples and population-based studies, ethnicity was largely Anglo-Saxon,
and education level was high with over half of the sample having a University or higher degree. Two thirds of the sample were partnered and 28% had children.

**Mental health and physical health of rainbow women in the sample**

The burden of mental illness was high in the sample overall, with people in all subgroups of sexual orientation, gender identity and intersex status having high rates of stress, distress, depression and anxiety. In general, the participants’ perceived level of mental health problems matched the actual level measured on their completed mental health measures. Lesbian identified women were least likely to have mental health problems, as were female-identified people. The groups that had the highest levels of problems including stress, distress, depression and anxiety were those identifying as asexual, ‘other’, pansexual, bisexual, intersex, gender queer, agender and trans male.

The women who identified as female and/or lesbian and/or were connected with lesbian community also reported the highest rating of their own general health and the best physical health. The gender diverse and trans people reported lower general health, as did the intersex people, and those connected with the trans, disability and religious communities. Lower general health mirrored higher levels of mental ill health, chronic illness and higher physical health problems.

Resilience levels were relatively low (means ranged from 1.81 to 3.16) when compared with mainstream samples (higher means of 3.5-4.0 are common, see Smith, 2008). The most resilient identity subgroups were the female identified, lesbian and bisexual women, and also those connecting with gardening/environment, sport/fitness, parenting, or political activism groups. The least resilient were those identifying as pansexual, trans male, trans female, gender queer and asexual. Resilience according to subgroup connections were very similar, with lower levels for pansexual, asexual and kink connected women; and particularly low for religion and disability connected women and geeks. There was a strong correlation between lower resilience and higher levels of all mental health issues.

**Community connections**

Overall, LGBTI connectedness was higher than mainstream connectedness, although connection to both was generally high. Greater connection to mainstream community was related to having higher resilience, but connection to LGBTI community was not. The lack of relationship between resilience and LGBTI community connection was unexpected. Factors leading to resilience requires more exploration.

LGBTI community connectedness had a small but significant positive influence on intentions to seek help, informal help seeking and to a lesser extent professional help seeking. This probably related to the strong preference for peer support and for attending services that had been recommended by like-minded peers. Mainstream community connectedness was not related to help seeking.

**Perceived need for help**

A very high proportion of the participants perceived the need for help with emotional/mental health problems (80%), or physical health problems (73%). Younger participants perceived the highest need for mental health help, while older participants perceived the highest need for physical health help. The perception of need closely matched their actual help seeking behaviour, both for professional services and informal supports.
Attitudes towards professional help seeking did not differ according to sexual orientation, gender identity or intersex status amongst participants. The only differences were that people with a regular GP and those that had disclosed their sexual orientation to their GP had slightly more positive attitudes towards seeking help.

Help seeking behaviour - types and frequency of support

Formal (professional) help seeking was more common than informal (peer/social) help seeking, but they were inter-related. There was a high level of professional help seeking over the past 12 months, with 74.4% of people seeing a GP at least once, and 44.3% seeing a psychologist/counsellor. Only 6.8% had not accessed any professional support. The majority of the sample had sought informal help (peer support) from family and/or friends (74.7%), and from the internet (55.2%). Only 6.3% of participants had not accessed any informal support. Alternative/complementary health care was used much less than mainstream professional or peer support. A higher level of mental health problems was associated with a higher level of formal help seeking.

There were important differences in the levels of help seeking behaviour according to sexual orientation, gender identity and intersex status. These mostly matched the higher levels of need amongst certain subgroups including trans, queer, other sexual orientations, pansexual, intersex and gender queer people. Lower levels of help seeking occurred amongst those unsure of their sexual orientation, asexual, bisexual, heterosexual, agender and female identified people. Notable exceptions were that trans women tended to report higher help seeking relative to need; asexual, bisexual and pansexual women reported lower formal help seeking; and trans men and agender people reported lower informal help seeking relative to need.

Peer support groups were a crucial element of support with many people turning to this type of help first before they sought professional help. However, there were several concerns reported by participants about the reliance on peer support groups, including that they are not funded/sustainable, can be difficult to find, can tend to exclude certain subgroups, and are often facilitated by people with no training in group management including conflict resolution and confidentiality.

Only 12.2% of survey participants had accessed LGBTI specific services. Key stakeholders and focus group participants identified that these services can be extremely valuable for many RW, although some prefer mainstream services. Despite the appeal of LGBTI specific services major limitations limited their access including that there are very few available, they are generally urban based, and often poorly funded. Also, they can lack a focus on women and on marginalised groups including trans and gender diverse.

General Practice services: Overall, 75.2% of the sample had a regular GP, and 34.8% had seen their GP at least four times over the past 12 months. Over half (56.8%) believed that their GP knew about their sexual orientation, 18.8% were not sure, and 24.4% believed their GP did not know. Lesbian, heterosexual and ‘other’ identified people, trans women and intersex people were most likely to have a regular GP. Having a regular GP was associated with higher perceived need for physical care but not for mental health care, higher formal help seeking behaviour, but no difference in informal help seeking.
Cultures of help seeking

Overall, many RW believed in and encouraged peer support, which was felt to be a strongly gendered phenomenon. This peer support was particularly encouraged amongst sub-groups of like-minded women. There were some experiences of gendered attitudes that reduced help seeking. These included values of self-sufficiency or toughness that prevented help seeking particularly amongst some trans women due to being socialised as men, or women with more masculine (butch) identities. Also several sub-groups were identified that cannot utilise peer-support within the LGBTI community due to a lack of connection (e.g. some older women, bisexual women) or fear of rejection including religious minority RW, and women who don’t identify with any identity label. Also, preferences for family or community care over RW peer support were seen amongst indigenous RW and ethnic minority women.

Participants clearly recognised the need for professional help and accessed it at levels that seemed to match their perceived need. However, negative experiences with mainstream care generated a lack of trust in many health professionals, and a pattern of a reliance on untrained peer-support rather than professional support for some people.

Barriers to and facilitators of help seeking

Experiencing discrimination or judgement were consistently reported as the most common barriers, followed by a lack of LGBTI sensitivity of services. Lack of readiness or self-reliance were common barriers, and around one third of survey participants were concerned about lack of confidentiality.

The most common enabler was having a trustworthy GP, selected by 62.4% followed by encouragement to get help by a friend or partner 44.6%. Having a choice of provider was an enabler for up to one third of participants.

There was a high level of agreement in the importance of access to LGBTI sensitive mainstream services across all subgroups, but particularly amongst trans women, gender queer, queer and pansexual women. Key stakeholders and focus group participants also agreed that this was especially important for

- Subgroups that cannot or prefer not to access LGBTI specific services:
  - older women, remote/rural, cultural minorities, indigenous women
- Services with a high case load or seeing issues with a high degree of sensitivity:
  - general practice, fertility/ gynaecology, emergency departments, women’s refuges and domestic violence, homelessness, and mental health – particularly acute services

Priority subgroups and underlying reasons for inequities

There were consistent subgroups with better general health and higher resilience, which included lesbians, female identifying people, and those connected with sport, parenting, environmental, political and volunteering interests.

Conversely, there was an important hierarchy of need amongst identified subgroups related to a confluence of low general health (both emotional and physical), low resilience, high need for services, and high barriers to seeking help. Marginalisation is likely to be a unifying factor for many of these subgroups. Key stakeholders identified two themes that result in marginalisation: identity policing and social isolation. This would explain some of the differences in health and wellbeing in our sample for participants with identities or behaviours that don’t necessarily fit within current peer support networks.
such as intersex people, people with ‘other’ sexual orientations or gender identities, asexual women, and to some extent trans men. Geek and gaming connected people also fall into this group perhaps due to their lack of face-to-face social connection.

We suggest that there is a second underlying factor related to having multiple minority identities that compound experiences of discrimination. This would apply to people who appear to be well connected, yet with high need such as those connected with pansexual, kink, disability or religious communities.

We have suggested a priority list of subgroups with a greater level of need for health promotion, health care and policy attention (see recommendations below). However, we need to acknowledge that all subgroups of rainbow women have a higher burden of mental health problems than the general community, so should be included in targeted messaging, policy and health care services.

**Content of mental health promotion messages for RW**

There was strong support for the need to have targeted mental health promotion for rainbow women that highlights the specific issues affecting their mental health including discrimination, marginalisation both from mainstream and LGBTI communities, and the compounding effects of multiple identities.

The key stakeholders and focus group participants encouraged the use of a strengths-based perspective with three major themes:

- Building self-esteem, normalising, finding positive points of difference
- Encouraging help seeking, including practical messages about where to find LGBTI sensitive mainstream services or LGBTI specific services
- Embracing diversity within LGBTI communities to overcome marginalisation, which involves inclusion of a wide range of RW in the messaging and stories of diversity

**The platform for delivery of mental health promotion to RW**

The development and delivery of mental health promotion must have strong involvement of LGBTI communities to be trustworthy.

Internet-based sources were the most preferred methods including mainstream mental health websites, LGBTI media and social media. The majority of people of any age preferred online platforms, however there was a need for alternative platforms for some subgroups including the use of peer support groups and local community networks. Adding specific reference to RW in existing mainstream health promotion platforms was also suggested.
2.4 RECOMMENDATIONS

1. Recommendations to enable help seeking

   a) Encourage help seeking amongst all RW by
      i. disseminating information about peer support groups – this could be facilitated by creating a national registry of support groups, particularly including those with trained peer-facilitators
      ii. disseminating information about LGBTI sensitive health care services (e.g. through existing channels such as the DocList for lesbian and bisexual women)
      iii. encouraging RW to have a regular GP, as this facilitates access to other formal care and is associated with more positive attitudes to help seeking
      iv. challenging tendencies to avoid care or to care for others before themselves

   b) Enable high quality peer support through
      i. diversifying the membership to include ‘other’ identified people, ethnic minorities, bisexual women and other marginalised subgroups
      ii. creating guidelines for the successful running of LGBTI peer support groups including having a rights and responsibility charter
      iii. creating peer support group facilitator training, in areas of inclusion, mental health first aid, group management including conflict resolution, and ensuring confidentiality

   c) Facilitate an integrated approach between peer support and professional support including encouraging inter-referral mechanisms where needed.

   d) Expand the focus of existing LGBTI specific services to include specific focus on rainbow women and identify how to engage subgroups that feel excluded.

2. Recommendations to improve the LGBTI sensitivity of mainstream health services

   a) Training for mainstream health care providers
      i. raise awareness of the need for improved LGBTI sensitivity
      ii. prioritise training for services that are the first contact point, particularly general practice, emergency departments, women’s health services, crisis, primary mental health and substance use services (training has been prioritised and funded to date for the aged care sector nationally via the LGBTI Aged Care Strategy and the mental health sector via the MindOut project)
      iii. consider a broad range of platforms for health care provider training including online training modules, brief guidelines, webinars and workshops.

   b) Create high level support for engaging with LGBTI health within mainstream agencies, including integrating LGBTI issues into policies and procedures – i.e. system wide and comprehensive sensitivity and inclusion that is sustainable via training such as the Rainbow Tick program.
c) Encourage a partnership approach between LGBTI specific services and mainstream agencies to assist in awareness raising, training and inter-referral.

d) Health care policy that includes RW as a target group in women’s health, general practice and other primary health care services

3. Recommendation on priority subgroups for health promotion and policy attention

While all RW deserve attention, the following subgroups should be particularly prioritised for mental health promotion campaigns, improved access to health services including sensitive GPs, and further research to understand the basis of their inequalities:

a) Gender identities and intersex status:
   - gender queer people
   - trans men
   - intersex people
   - people with ‘other’ genders
   - agender people
   - trans women

b) Sexual orientations:
   - women with ‘other’ sexual orientations including asexual women
   - pansexual women
   - queer women
   - women who are unsure of the sexual orientation
   - bisexual women

c) Women connected with the following communities should also be prioritised:
   - religion
   - disability
   - geek
   - kink/polyamory
3 REPORT

3.1 CONTEXT — LITERATURE REVIEW

3.1.1. Depression and Anxiety Amongst Rainbow Women

Research has consistently identified depression and anxiety to be the main mental health issues that rainbow women seek help for. For example, in the Australian National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2008), homosexual/bisexual participants most commonly reported experiencing anxiety disorders (31.5%) and affective disorders (19.2%) in the preceding 12 months. These rates are much higher than the heterosexual sample (14.1% and 6.0%).

Significant differences have also been observed within different sub-groups of rainbow women. In Australian population level data, bisexual women reported the highest levels of perceived stress, depression symptoms, anxiety symptoms, and the lowest scores on the mental health index and the social support scale (T. Hughes, Szalacha, & McNair, 2010). Suicidal thoughts also varied in this study, with 4.9% heterosexual women thinking life was not worth living, compared with 9.2% lesbians, 14.0% mainly heterosexuals and 16.2% of the bisexual women. Bisexual women also had the highest scores on psychological distress than any other group in the Private Lives 2 data, and this was less likely to improve with age (Leonard, Lyons, & Bariola, 2015). ‘Mainly heterosexual’ women also had higher levels of depression and anxiety than lesbian women in the Australian longitudinal study of women’s health, however it is very difficult to ascertain who these women actually are (T. Hughes et al., 2010). They are likely to be a mixed group of women with varying levels of same-sex attraction, male and/or female partners, un-partnered, and un-identified women.

Hyde et al. (Hyde et al., 2014) explored Australian trans mental health in a sample of 482 trans women and 232 trans men. Trans people were found to experience very high levels of mental health problems. Most notably, 43.7% of the sample were experiencing clinical levels of depressive symptoms at the time of the survey with 28.8% meeting the criteria for major depressive syndrome. Furthermore, 57.2% had been diagnosed with depression in their lifetimes and 54.2% of these participants had been diagnosed in the last 12 months. While 18.3% met the criteria for a panic syndrome and 16.9% for another anxiety disorder, 39.9% had previously been diagnosed with an anxiety disorder with 62.1% being diagnosed in the last 12 months. Finally, in the 2 weeks preceding the survey, 20.9% reported thoughts of suicide ideation or self-harm on at least half of the days.

The higher rates of mental health problems amongst rainbow women compared with heterosexual women is consistently found in population based samples from other Western countries. Rates of depression have been found to range between 50-85% and rates of anxiety between 31-79% (Bradford, Ryan, & Rothblum, 1994; McCann & Sharek, 2014; Roberts, Grindel, Patsdaughter, Reardon, & Tarmina, 2005; Rogers, Emanuel, & Bradford, 2002).

3.1.2. Protective Factors Against Mental Illness

The level of social support and community connectedness have been associated with mental health. For example, in a sample of 178 lesbians, McLaren (2009) found that an increased sense of belonging to
both the general and lesbian communities were associated with decreased levels of depression. Similarly, in the Private Lives 2 data, participation in LGBT community events was associated with increased resilience amongst lesbian, bisexual and trans women (Leonard et al., 2015).

A Canadian study using a sample of 117 lesbians examined the relationship between perceived social support from family, perceived social support from friends, relationship involvement, and sexual orientation disclosure and depression and also explored the extent to which these four variables predicted depression (Ayala & Coleman, 2000). Each of the four variables were significantly related to depression which implies that lower levels of depression are associated with higher levels of social support from friends and family, sexual orientation disclosure, and being in a relationship. Furthermore, each of these variables were able to predict 38% (36% adjusted) of the variability in level of depression.

Increased social support and community connectedness has similarly been associated with lower levels of depression amongst Latino lesbians (Zea, Reisen, & Poppen, 1999); lesbian, gay, and bisexual (LGB) adults, aged 60 and over (Grossman, D’Augelli, & Hershberger, 2000); and LGB youth, with family connectedness being of particular importance to this age demographic (Detrie & Lease, 2007). Conversely, depression has been linked to smaller social networks and a feeling of dissatisfaction with perceived availability of social support (Robinson & Garber, 1995).

There have been mixed findings on whether self-disclosure of sexual orientation affects depression. Oetjen and Rothblum (2000) examined four of the risk factors consistently cited in the women and depression literature to determine their ability to predict depression among a sample of 167 lesbians. A significant correlation between depression and self-disclosure was not found in any context. Conversely, Jordan and Deluty (1998) explored the correlation between disclosure of sexual orientation and “positive affectivity” among a sample of 499 lesbians. Positive affectivity was defined as “a mood state that encompasses happiness and satisfaction”. The researchers found that broader disclosure of sexual orientation was significantly correlated with more positive affectivity. It was also noted that greater self-disclosure was associated with receiving more social support.

Researchers have also investigated the role of self-disclosure on levels of anxiety. Jordan and Deluty (1998) found that women who disclosed their sexual orientation were significantly less anxious than those who did not. Driscoll, Kelley, and Fassinger (1996) explored self-disclosure and workplace stress in a sample of 123 employed lesbians. Although the sample was found to have low disclosure scores it was not significantly correlated with workplace stress. However, a negative correlation was found between length of time in a relationship and workplace stress. Meaning, the longer a woman had been in a relationship, the less workplace stress she experienced.

3.1.3. Service Use

Studies have typically found a higher utilisation of mental health services by lesbian and bisexual women than heterosexual women. In terms of formal professional help, counsellors, psychiatrists, psychologists, GPs and hospitals are commonly accessed (Barrett & Pierre, 2011; Bradford et al., 1994; Koh, Kang, & Usherwood, 2014; McCann & Sharek, 2014; Welch, Collings, & Howden-Chapman, 2000). Research has found women to concurrently access informal help from friends, family, peers and support groups (Barrett & Pierre, 2011; Bradford et al., 1994; Welch et al., 2000). E-therapies and online self-help were
utilised particularly by LGB youth perhaps because they offer anonymity and do not require parental help to attend or pay for appointments (McDermott, 2014).

3.1.4. Barriers to Help Seeking

The barriers to effective help seeking for rainbow women can be divided into factors that are either external or internal. External barriers refer to perceived inadequacies with the services, often classified a lack of cultural competence. Internal barriers refer to factors such as fear of mistreatment or lack of readiness. A key indicator of inadequate cultural competence is that while lesbian and bisexual women have been found to access mental health services at high levels, research has consistently shown that they are less satisfied with mental health treatment than their heterosexual counterparts (Avery, Hellman, & Sudderth, 2001; T. L. Hughes, 2011; Lucksted, 2004; McNair, Szalacha, & Hughes, 2011). For example, studies continue to find that between 40-60% of rainbow women report negative or mixed reactions from mental health service providers towards their sexual orientation (Carr, 2010).

Koh, Kang and Usherwood (2014) explored experiences of accessing primary health care amongst LGBT Australians. The authors found the most common barriers were concerns about discrimination (e.g. being spoken to as if they are heterosexual), blaming mental health issues on sexual orientation, receiving heterosexist advice, and difficulty finding a health care provider who will care for them due to their sexual orientation. Similar reports were found in a New Zealand study (Welch et al., 2000) in which 29% of women who had accessed mental health support reported that they had used a lesbian unfriendly service. The most common types of discriminatory treatment included ignoring the effects of living within an anti-lesbian society (80.8%), not taking sexuality seriously (72.3%), using only heterosexual examples (69.5%), and ascribing client’s problems to sexuality (48.2%). Evidence of heterosexism was also found an Ireland-based study (McCann & Sharek, 2014) with about two-thirds reporting the mental health service assumed they were heterosexual and nearly 30% had received a negative reaction when they disclosed that they were LGBT. Further, 10-26% reported comments that their LGBT identity was the result of a childhood trauma, that it was a phase or not normal.

St Pierre and Senn (2010) explored barriers to help-seeking among 280 gay, lesbian, and/or queer Canadian victims of intimate partner abuse. Accessibility of services and outness were commonly cited barriers to help seeking. Many were concerned that service providers wouldn’t take their concerns seriously given their sexual orientation. Others were sceptical that mainstream services would be equipped with the resources and information to help same-sex clients.

3.1.5. Enablers of Help Seeking

Enablers were again partly external, such as recommendations by peers, trust in the cultural competence of services, and finding female or lesbian providers; and partly internal, including education level, level of mental health need, and concordance between sexual behaviour and sexual identity. The ALICE study on alcohol use amongst Australian LBQUT women found that two significant enablers to the use of mental health services were having a regular GP (odds ratio=3.02,95% CI:1.84-4.96), and disclosure of sexual orientation to the GP (OR=2.421, 95% CI: 1.445-4.057). LGBT community connectedness was also associated with service use for mental health (Odds ratio 1.12), indicating a level of encouragement or acceptance of the need for mental health care within parts of the LGBT community.
A study by Razzano and colleagues (2006) explored predictors of accessing mental health services in a community sample of 120 lesbians (60%) and heterosexual (40%) women. The researchers found that being a lesbian in itself was an enabler of seeking mental health support given that lesbians were found to be 3½ times as likely to report using a mental health service than were heterosexual women. This finding was interpreted to suggest that due to their sexual orientation, lesbians confront additional factors to the traditional predictors of mental health service use which cause them to seek treatment. This is consistent with Welch and colleagues (2000) who discovered lesbian culture encourages use of mental health professionals and places importance in acknowledging one’s emotional suffering and the difficulties that may be inherent in developing a mature identity. This study found that a large proportion (51%) of participants used mental health services that were recommended by friends or they found through women’s networks. McDermott (2014) similarly found a significant proportion of LGBT youth made recommendations to each other to seek help from clinical services, schools, friends and ‘trusted’ adults.

Kerker, Mostashari and Thorpe (2006) explored health care access amongst a total of 19,349 women who have sex with women. The authors found that women whose sexual behaviour and identity were concordant were more likely to access health care than those whose behaviour and identity were not concordant. This outcome is similar to that found by Bostwick and colleagues (2010) in that women who had only had sex with women had better health outcomes than bisexual women. Also, in a sample of 396 self-identified LGB adults, Kertzner and colleagues (2009) found that bisexuality and young age were associated with decreased social well-being (the fit between individuals and their social worlds).

Finally, preferences for female or lesbian/bisexual therapists are common and enabling. For example, Roberts and colleagues (2005) found the majority of people who had accessed mental health support had worked with female therapists (range = 78% for first to 89% for fourth therapy sessions). The percentage of reported homosexual therapists increased from first therapy (29%) to the fourth therapy (40%). Liddle (1997) similarly found lesbian participants more often reported a preference for lesbian/bisexual women therapists or a female therapist if sexual orientation was not known.

3.1.6. Patterns of Help Seeking

In the ALICE study, the use of health services varied according to sexual orientation. More lesbians had a regular GP (78.8%), than bisexual women (68.5%), queer/pansexual (63.6%) and those selecting ‘other’ sexual orientation (46.7%). Bisexual women were most likely to use services for mental health (57.3%), compared with 56.6% queer/pansexual women, 50% other, and 46.5% lesbians. Similarly, the Private Lives 2 data set indicates that rates of mental health service use varied according to sexual orientation and gender identity, and were highest among trans females (67.2%), trans males (59.6%) and bisexual women (52.5%).

Patterns of help seeking outside of formal mainstream professional services are emerging, with evidence that rainbow women are more likely than heterosexual women to access complementary and alternative medicine (CAM). Specifically, sexual orientation has been found to be an independent predictor of CAM use and that more lesbians than heterosexual women are accessing it (Bowen, Anderson, White, Powers, & Greenlee, 2002; Dillworth, Kaysen, Montoya, & Larimer, 2009; Matthews, Hughes, Osterman, & Kodl, 2005; H. A. Smith et al., 2010); identification with mainstream culture has been found to have a mediating effect on the relationship between sexual identity and likelihood to access alternative treatments (Dillworth et al., 2009); and positive correlations have been found
between interest in alternative providers and anxiety and trust in alternative providers, whereas a negative correlation was found between trust in traditional providers and interest (Bowen et al., 2002).

3.1.7 Limitations and gaps in the literature

There are several gaps in the research that the current study will aim to address. Firstly, previous studies have not adequately examined help seeking behaviour and service use across the various categories of support, namely formal (professional) services, CAM, informal services (including social support), and self-help. Second, there has been a lack of clarity regarding what are formal and informal services. It is suggested that a clear definition of what is formal and informal is provided to allow researchers to directly compare and evaluate findings. Third, a framework for help seeking is rarely outlined within the reported studies. This has also been a criticism of studies exploring help seeking in mainstream populations (Rickwood, Thomas, & Bradford, 2012). Rickwood (2012) recommends using a framework that not only examines the source of assistance, but also attitudes to help seeking, behavioural intentions and observable behaviour. Fourth, few studies have examined patterns of help seeking among sexual minority subgroups. The majority of previous research has broadly compared heterosexuals versus LGB people. Furthermore, lesbian and bisexual women are often grouped together. This is problematic because sexual minority subgroups are very diverse and the issues faced by each group are not comparable. Questions of whether women are encouraged or discouraged from help seeking within particular subgroups are missing.

Finally, we have not found any literature that identifies the most effective targeted health promotion messages for diverse groups of rainbow women. Emerging literature recommends the development of health promotion campaigns and messages to reduce harmful effects of substance abuse and other mental health risk factors that are tailored to specific population subgroups (Cochran, Grella, & Mays, 2012). This approach can also be justified for rainbow women because there are many contextual, cultural, and socio-emotional differences between the experiences of heterosexual and rainbow women that impact on mental health. These include minority stress, marginalisation, and sexual orientation-based discrimination, and these are not recognised within existing mainstream programs. LGBT-specific issues could be identified and addressed in treatment programs and health promotion initiatives by encouraging disclosure of sexual orientation and discussion of specific behavioural influences on health (Durso & Meyer, 2013).

The current research therefore addresses these limitations by exploring help seeking across the various subgroups. Furthermore, ambiguity surrounding formal and informal services is addressed and all the categories of support are included. Finally, the research explores the preferred mental health promotion messages and platforms for specific subgroups of rainbow women.
3.2 FRAMEWORK OF HELP SEEKING

We have chosen to use the following definition of help seeking proposed by one of the key stakeholders:

“an individual’s ability to recognise that they need assistance or guidance and then to actively seek support by approaching organisations, services, support groups or friends to get help.”

This is similar to the definition proposed by Rickwood (2012)

“in the context of mental health, help seeking is an adaptive coping process involving attempts to obtain external assistance to deal with the mental health concerns.”

Rickwood has critiqued the help seeking literature as being quite un-focused, and lacking a framework. She recommends the use of the following framework, which we have followed.

1. Concern
   a. The problem in need of help – general distress or a specific condition such as distress, depression, anxiety, stress (substance use, suicidal thoughts, self-harm not included)

2. Process of help seeking
   a. Attitudes to help seeking
      Mainstream or LGBTI specific, professional or informal
   b. Behavioural intentions
   c. Observable behaviour

3. Source of Assistance
   a. Professional – formal health provider
   b. Informal – social support, including from friends (LGBTI, or mainstream), family, peers, partners, social networks, religious network, cultural network
   c. Self-help - including online resources, and self-help groups

4. Type of assistance
   a. Information and understanding
   b. Advice
   c. General support
   d. Treatment

5. Timeframe
   a. Past 12 months
   b. Ever
3.3 METHODS

3.3.1 Survey Design
The RWHSS survey was designed by the authors using a combination of established psychometrically sound scales and author developed questions. The measures that were included in the survey are discussed in more detail below. The survey was piloted amongst several LGBT researchers and people without knowledge of LGBTI issues or mental health.

3.3.2 Advertising and Recruitment
Ethics approval was obtained from the University of Melbourne Human Research Ethics Committee on 20 April 2015 (ethics ID number 1543831). The Rainbow Women Help Seeking Study (RWHSS) survey was publicised through LGBTI websites and publications, email groups, social network groups, and through mainstream websites such as beyondblue and the University of Melbourne. The survey was administered online between 21st April and 17th June, 2015 and was hosted by www.surveymonkey.com.

Figure 1 – Pattern of survey responses

Key informants were approached around Australia representing a range of leadership positions within the LGBTI communities. Ten people were invited and eight agreed to be interviewed.

A list of Victorian participants to the online survey that had agreed to be contacted was generated, and then purposively sampled to invite a diverse range of women in three age groups to attend face-to-face focus groups. Fifteen women were recruited to participate in one of three focus groups arranged according to age: Under 30, between 31 and 50, and aged 51 or older, and twelve attended.
3.3.3 Survey Measures

3.3.3.1 Demographics
Demographic information collected included age, country currently living in, state or territory currently living in, homelessness, indigeneity, ethnicity, level of education, income, gender identity, intersex status, sexual orientation, relationship status, preferred gender of partner, parenting status, and subgroup connectedness.

3.3.3.2 Community Connectedness
The Connectedness to the LGBT Community Scale (Frost & Meyer, 2011) was used to twice: once to measure connectedness to the LGBTI community, and a second modified version connectedness to the mainstream community. The LGBTI version was also modified to exclude specific reference to the LGBTI community in New York. Good reliability and validity has been found with Cronbach’s alpha ranging from .78-.81 (Frost & Meyer, 2011). The current sample obtained an alpha of .84 for the LGBTI version and .75 for the mainstream version thus demonstrating the reliability of both modified versions. The scales asked participants to answer seven questions about perceived closeness to the community, how positive these connections were, and whether they believed these connections were rewarding and could help them solve problems. Items were answered on a four-point Likert-type scale ranging from 1 (strongly disagree) to 4 (strongly agree) with high scores indicating greater connectedness.

3.3.3.3 Perceived Need for Help
Participants were asked to indicate whether in the past 12 months they believed they needed help for either emotional or mental health problems, or for physical health problems.

3.3.3.4 Help Seeking Intentions
The General Help-Seeking Questionnaire (Wilson, Deane, Ciarrochi, & Rickwood, 2007) is a ten-item questionnaire. Satisfactory reliability and validity was found in a sample of 218 high school students. Questions asked participants about their beliefs about help seeking and their intentions to seek help if they needed it, using a four-point Likert-type scale ranging from 0 (disagree) to 3 (agree) where higher scores indicate greater intentions.

3.3.3.5 Previous Help Seeking Behaviour
Participants were asked to select which health professionals, informal and self-help services, and complementary or alternative health professionals they had accessed in the previous 12 months. The items were based on those used on the Australian National Survey of Mental Health and Wellbeing. They also had the option to list any services that were not included in the questionnaire. Each service accessed was allocated one point and the sum of these was used to produce a total score for each of the three categories to indicate the degree of help seeking.

Participants were also asked whether they had accessed any LGBTI specific services in the previous 12 months, whether they had a regular GP, the frequency of visits to their GP, and whether their GP was aware of their sexual orientation.

3.3.3.6 LGBTI Sensitivity
An author developed four-item questionnaire was used to assess how important it was for health care services to be sensitive and affirming, knowledgeable, skilled, and LGBTI specific. Questions were answered on a five-point Likert-type scale ranging from 1 (not important) to 5 (very important). Strong
reliability was found with a Cronbach’s alpha of .81. Participants were also asked to indicate how important it is for health information to be specifically tailored to LGBTI people on scale ranging from 1 (not important) to 5 (very important).

3.3.3.7 Help Seeking Attitudes
The Attitudes toward Seeking Professional Help Scale (Fischer & Farina, 1995) was used to measure willingness to seek help for mental health issues. Participants were asked 10 questions (e.g. “I would want to get psychological help if I were worried or upset for a long period of time”) which were answered in four-point Likert-type scale ranging from 0 (disagree) to 3 (agree) with items 2, 4, 8, 9 and 10 reverse scored. Higher scores indicated more willingness to seek help. The current sample had a very low Cronbach’s alpha of .26, therefore had a low reliability with this population group.

3.3.3.8 Barriers and Enablers of Help Seeking
Participants were asked to select which of the nine common barriers had stopped them from seeking help and which of the eight common enablers had encouraged them to seek help. The lists of barriers and enablers were developed from those commonly found in the literature. Barriers included lack of readiness and fear of discrimination; enablers included encouragement from family and friends, and having an LGBTI sensitive and knowledgeable practitioner.

3.3.3.9 Health Messages
Preferred health messages was measured using a questionnaire adapted from the beyondblue shOUT OUT! survey for gay, bisexual, trans and intersex men. Participants were asked about message content, images, desire for LGBTI specific messages, and recognition of discrimination, using a six-point Likert-type scale ranging from 0 (unsure) to 5 (very important).

Methods of health message communication were also assessed with a list of communication platforms adapted from the shOUT OUT! survey. These included various online avenues such as websites and Facebook, print media, billboards, LGBTI events, and other ads.

3.3.3.10 Health and Wellbeing
Several validated and reliable scales were used to measure health:

General health was measured with a simple ranking from excellent (1) to poor (5), lower mean scores indicating better general health. Participants were also asked to indicate whether they had a chronic illness or disability.

Stress: The Perceived Stress Questionnaire for Younger Women (PSQYW) was developed by Bell and Lee (2002) for the ALSWH. Reliability and validity was demonstrated using a sample of 14,779 young Australian women. Participants were asked 11 questions about how stressed they have felt over the last 12 months. Areas of possible stress related to own or other’s health, work and study, relationships, parenthood, and money. Responses were on a six-point Likert-type scale that ranged from 1 (not applicable) to 6 (extremely), with higher scores indicating higher levels of perceived stress. Cronbach’s alpha for the current sample was .72.

Distress: The Kessler Psychological Distress Scale (K10; Andrews & Slade, 2001) was used to measure distress over the past four weeks. This 10 item scale asked how often participants felt, for example,
tried, nervous, hopeless, or fidgety. Items were asked on five-point Likert-type scale ranging from 1 (none of the time) to 5 (all of the time) with higher scores indicating more distress. Cronbach’s alpha in the current sample was .94.

**Depression:** The 10-item Center for Epidemiologic Studies Depression Scale (CES-D10; Andresen, Malmgren, Carter, & Patrick, 1994) was used to measure depression. The CES-D is widely used to assess depressive symptoms in non-clinical individuals, however, the shorter 10 item scale was used in this study. Participants were given 10 statements (e.g. “I felt depressed” and “I was happy”) and were asked to indicate how often they felt or behaved that way in the past week using a four-point scale ranging from 0 (rarely or none of the time) to 3 (all of the time) with items 5 and 8 reverse scored and a higher score indicating higher levels of depressive symptoms. Andresen and colleagues (1994) demonstrated a Cronbach’s alpha of .80. In the current sample, Cronbach’s alpha was .89.

**Anxiety:** The Hospital Anxiety and Depression Scale (HADS) was developed by Zigmond and Snaith (1983) to measure anxiety and depression among non-psychiatric hospital populations. In the current study, only the seven-item anxiety subscale was used which has been demonstrated to have good reliability and validity (Olssøn, Mykletun, & Dahl, 2005). Participants ranked statements about how often they had felt, for example, “tense or wound up” or restless, over the past week on a four point Likert-type scale ranging from 0 (not at all) to 3 (definitely) where a high score indicated greater anxiety. Cronbach’s alpha for the current sample was .77.

**Resilience:** The Brief Resilience Scale (B. W. Smith et al., 2008) was used to measure the ability to recover from stress. Strong reliability and validity has been demonstrated in four diverse samples with Cronbach’s alpha ranging from .80-.91 (B. W. Smith et al., 2008). This six item scale was answered on a five-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree) with items 2, 4, and 6 reverse scored. In the current sample, Cronbach’s alpha was .89.

### 3.3.4 Analysis
Survey analyses were completed using the Statistical Package for the Social Sciences (SPSS) Version 22. Descriptive statistics were gathered to observe trends in the data; the relationship between community connectedness and resilience was explored using Pearson correlations; and multiple regression was used to assess the ability of mental health measures to predict resilience. Future analysis is planned to complete papers for submission to peer reviewed journals including further significance testing, controlling for age, income, education and other key demographics. Comparisons with population based data will also be made.

Key informant interviews were audiotaped and analysed according to key themes relating to experiences of the diversity amongst rainbow women, the help seeking attitudes and observed behaviour of RW, sources of assistance, and preferred health promotion messages for RW. Focus groups were audiotaped after appropriate consent, and transcribed verbatim. Transcripts were analysed for key themes in the areas of help seeking preferences, culture of help seeking, barriers and enablers, peer support, preferred communication platforms and preferred health promotion messages.

All findings were then integrated into the main report. De-identified individual outputs from the three data sources have been supplied to beyondblue separately.
3.4 FINDINGS

3.4.1 The participants

There were three groups of participants: those completing the online survey, key informants who participated in an interview, and focus group participants.

Survey participants

A total of 1,883 people accessed the survey. Of those, 177 people were ineligible as they did not consent to participate, were under the age of 18, did not live in Australia, or were cis male. This left a total of 1,706 participants who were eligible, of whom 1,628 completed all sections for analysis. The profile of the study sample is discussed in greater detail below.

Key informants

Eight key informants were interviewed.

- Interviews: 2 in person and 6 by phone, interviews lasted between 30 and 70 minutes.
- Gender identity: 5 women, 1 man, 1 trans man and 1 gender queer person (sexual identity was not asked of the stakeholders).
- Cultural identity: one identified as Aboriginal
- Age range: early 30s to late 60s (estimate)
- Location: 3 NSW (all Sydney), 2 Queensland (both regional centres), 1 Vic, 1 Tas, 1 WA (all 3 capital cities)
- Organisations: Three AIDS Council CEOs; one LGBTI mental health organisation coordinator; one LGBTI ageing organisation president; National LGBTI Health Alliance CEO and one manager; one LGBTI youth service coordinator
- Other past roles amongst interviewees: domestic violence services (generic), homelessness services (generic), lesbian health group, LGBTI youth work, alcohol and drug services (generic), running a LGBTI network for a local area health network.
- Research: one person had done a Masters in lesbians and coming out, another a PhD on trans issues. Several had also done considerable voluntary work and advocacy within the LGBTI communities.

Focus group participants

Twelve women participated in one of three focus groups arranged according to age: Under 30, between 31 and 50, and aged 51 or older (four women in each group).

- Each group lasted between 60 and 90 minutes.
- Gender identity: (under 30) 2 female, 1 cisgender female, 1 trans female; (31-50) 1 trans female, 2 female, 1 gender queer; (51+) 2 female, 2 trans female.
- Sexual orientation: (under 30) 1 lesbian, 1 “largely gay”, 1 bisexual, 1 queer; (31-50) 1 pansexual, 2 lesbian, 1 queer; (51+) 2 lesbian, 2 pansexual.
- Cultural identity: (under 30) all Anglo-Australian; (31-50) 1 Maori, 1 Celtic, 2 Anglo-Australian; (51+) 3 Anglo-Australian, 1 Celtic/Eastern European.
- Living location: (under 30) 2 outer urban, 1 inner urban, 1 rural; (31-50) 3 outer urban, 1 did not say; (51) 2 outer urban, 1 inner urban, 1 rural area.
3.4.2 The profile of rainbow women in the survey sample

The participants to the online survey were a very diverse group of people, with an age range of 18 to 81 years (Table 1). The research was particularly focused on comparing the health and help seeking behaviour of rainbow women based on their sexual orientation, gender identity and intersex status, as well as on the groups with whom they felt comfortable connecting. Therefore, most of the findings will be presented comparing these subgroups. We extended the scope to include people who did not identify as female or ‘women’ including gender queer, intersex and trans male people. This was particularly because they had chosen to complete a survey for ‘rainbow women’, but also assuming that many of these people may have been socialised as female during their early lives. We also retained the heterosexual people as they were either gender diverse or intersex. There were enough people in most subgroups to make meaningful comparisons. Caution must be applied to the groups containing less than 30 people: intersex, trans male, agender, heterosexual, asexual and unsure people, for whom we cannot make any definitive conclusions.

<table>
<thead>
<tr>
<th>Table 1 – Age of identity and connection subgroups of the survey sample</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n</strong></td>
</tr>
<tr>
<td>Total sample</td>
</tr>
<tr>
<td><strong>Gender Identity &amp; Intersex status</strong></td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Gender queer</td>
</tr>
<tr>
<td>Trans (identifying as female)</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Intersex</td>
</tr>
<tr>
<td>Agender</td>
</tr>
<tr>
<td>Trans (identifying as male)</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
</tr>
<tr>
<td>Lesbian</td>
</tr>
<tr>
<td>Bisexual</td>
</tr>
<tr>
<td>Queer</td>
</tr>
<tr>
<td>Pansexual</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Not sure or undecided</td>
</tr>
<tr>
<td>Heterosexual/straight</td>
</tr>
<tr>
<td>Asexual</td>
</tr>
<tr>
<td><strong>Sexual/Gender Subgroups</strong></td>
</tr>
<tr>
<td>Lesbian</td>
</tr>
<tr>
<td>Queer</td>
</tr>
<tr>
<td>Bisexual</td>
</tr>
<tr>
<td>Femme / lipstick</td>
</tr>
<tr>
<td>Pansexual</td>
</tr>
<tr>
<td>Gender queer</td>
</tr>
</tbody>
</table>
The largest sexual orientation groups were lesbian, then bisexual and queer, and almost 10% being pansexual. The sample was gender diverse, with 15.5% identifying as trans, gender queer, intersex or other.

The subgroups were listed by women according to which groups women ‘connected with’ socially. Importantly, many more women connected with lesbian, bisexual, queer, pansexual and gender queer groups than actually self-identified with these subgroups, indicating that socialisation was much more flexible or open than identification. An exception to this was the intersex identified women as only one quarter of these connected with intersex community. Each of the subgroups based on sexual orientation, gender identity or intersex status, and general interests contained women from the full age spectrum, apart from intersex who were 43-68 years old, and asexual women who were under 58. The majority of women connected with general interest groups, particularly related to the arts, and/or to sport and fitness. A large minority also connected with parenting, ethnic/cultural and/or disability groups.
Table 2 – Demographics of the survey sample

<table>
<thead>
<tr>
<th>State, ( n=1628 )</th>
<th>South Australia</th>
<th>8.4</th>
<th>Gender Identity/intersex, ( n=1645 )</th>
<th>Female</th>
<th>84.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tasmania</td>
<td>6.4</td>
<td></td>
<td>Trans (identifying as male)</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>New South Wales</td>
<td>19.3</td>
<td></td>
<td>Trans (identifying as female)</td>
<td>5.1</td>
<td></td>
</tr>
<tr>
<td>Victoria</td>
<td>40.5</td>
<td></td>
<td>Gender queer</td>
<td>5.5</td>
<td></td>
</tr>
<tr>
<td>Western Australia</td>
<td>6.4</td>
<td></td>
<td>Intersex</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Queensland</td>
<td>14.4</td>
<td></td>
<td>Agender</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Northern Territory</td>
<td>1.4</td>
<td></td>
<td>Other</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>3.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sexual Orientation, ( n=1632 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inner urban</td>
<td>38.0</td>
<td></td>
<td>Queer</td>
<td>14.5</td>
<td></td>
</tr>
<tr>
<td>Outer urban</td>
<td>40.9</td>
<td></td>
<td>Bisexual</td>
<td>17.6</td>
<td></td>
</tr>
<tr>
<td>Regional centre</td>
<td>9.1</td>
<td></td>
<td>Pansexual</td>
<td>9.1</td>
<td></td>
</tr>
<tr>
<td>Rural area 1*</td>
<td>8.9</td>
<td></td>
<td>Asexual</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>Rural area 2**</td>
<td>3.1</td>
<td></td>
<td>Heterosexual/straight</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not sure or undecided</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td>Homelessness</td>
<td>Sleeping rough/squatting, ( n=1606 )</td>
<td></td>
<td>Other</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>87.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anytime in the past</td>
<td>11.9</td>
<td></td>
<td>Relationship, ( n=1632 )</td>
<td>34.3</td>
<td></td>
</tr>
<tr>
<td>Now</td>
<td>0.4</td>
<td></td>
<td>Yes, with one person</td>
<td>61.8</td>
<td></td>
</tr>
<tr>
<td>Emergency accommodation, ( n=1625 )</td>
<td></td>
<td></td>
<td>Yes, with more than one person</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>71.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anytime in the past</td>
<td>26.8</td>
<td></td>
<td>Gender of Partner, ( n=1006 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Now</td>
<td>2.0</td>
<td></td>
<td>A woman</td>
<td>79.9</td>
<td></td>
</tr>
<tr>
<td>A trans woman</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boarding house, caravan park, hostel, hotel, motel, ( n=1597 )</td>
<td></td>
<td></td>
<td>A trans man</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>84.5</td>
<td></td>
<td>Gender queer</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>Anytime in the past</td>
<td>14.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Now</td>
<td></td>
<td>Intersex</td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----</td>
<td>------</td>
<td>----------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>Indigeneity, $n=1639$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not wish to say</td>
<td>0.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal/Torres Strait Islander</td>
<td>2.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children, $n=1626$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity, $n=1623$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anglo-Australian</td>
<td>76.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anglo-European</td>
<td>14.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ</td>
<td>1.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>0.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese, Vietnamese, Indian, Sri-Lankan</td>
<td>1.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income, $n=1640$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0-$24,999</td>
<td>36.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$25,000-$49,999</td>
<td>19.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$50,000-$74,999</td>
<td>18.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$75,000-$99,999</td>
<td>14.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$100,000-$124,999</td>
<td>5.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$125,000-$149,999</td>
<td>2.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$150,000-$174,999</td>
<td>1.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education, $n=1641$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Still at high school</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$175,000-$199,999</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School before year 12</td>
<td>5.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed high school to end of year 12</td>
<td>20.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed a trade apprenticeship or traineeship</td>
<td>5.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed a diploma</td>
<td>11.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed a university degree</td>
<td>34.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed a higher degree (e.g. Masters / Doctorate)</td>
<td>21.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The ethnic diversity of the sample was limited, with just under 10% being non-Anglo background and 2.4% being Aboriginal or Torres-Strait Islander. Almost 56% of the sample had a University degree or higher degree, although only 25.7% had incomes over $75,000 per annum.

Almost 29% of the women had been homeless at some point in their lives, and 3.1% were currently homeless.
3.4.3 Mental health and physical health of RW in the sample

The burden of mental illness was high in the sample overall, with all categories of sexual orientation, gender identity and intersex status having high mean scores for stress, distress, depression and anxiety. In general, the women accurately perceived their high level of mental health problems.

Mental health differed according to gender identity and intersex status (Figure 2) and sexual orientation (Figure 3). The particular at risk groups for all measures including stress, distress, depression and anxiety were those identifying as intersex, gender queer, agender, and trans male, in that order. Trans women were slightly more at risk than female-identified women, who had the best mental health. Regarding sexual orientation, those identifying as asexual, ‘other’, pansexual, bisexual then queer women in that order being most at risk. Lesbian identified women were least likely to have any of the measured mental health issues.

Figure 2 – Mental health indicators by gender identity and intersex status

<table>
<thead>
<tr>
<th>Gender identity and intersex status</th>
<th>Mean</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trans female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intersex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trans male</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PSQYW – higher scores indicate higher stress over the past 12 months, K10 – scores over 20 indicate distress past 4 weeks, CES-D – scores over 9 indicate depression past 4 weeks, HADS-A – scores over 10 indicate current moderate to severe anxiety
**Figure 3 – Mental health indicators by sexual orientation**

![Graph showing mental health indicators by sexual orientation.](image)

**Figure 4 – Mental health indicators by sexual/gender connection subgroups**

![Graph showing mental health indicators by sexual/gender connection subgroups.](image)
There were some differences in mental health according to sexual orientation/gender identity subgroup connections (Figure 4), with lesbian connected women being consistently least likely to have mental health problems. Pansexual, bisexual, gender queer and trans connected women were more at risk. A clear pattern also emerged for associations between mental health and general interest connections (Figure 5). Those connecting with environment, parenting, political activism or sport/fitness were least likely to have mental health problems. Those connecting with religious, disability and geek/gaming subgroups were the most likely to be at risk. Those women with no connections with sexual orientation/gender identity or general interest subgroups were not in the highest risk groups for mental health problems, suggesting that sub-group connection is not a pre-requisite for positive mental health.

3.4.3.1 **General health**

General health ratings tended to mirror both mental health indicators (as above) and physical health indicators (that is perceived physical health problems, and actual chronic illness/disability). Just the general health ratings are presented here.
The general and physical health varied according to identity and largely matched the mental health (Figure 6). The female identified, lesbian identified and lesbian connected women provided the highest rating of their own health and the best physical health. The gender diverse and trans people had lower general health, as did the intersex people, and those connected with trans, disability and religious groups.
Lower general health mirrored higher levels of chronic illness and higher physical health problems. Importantly, those with a chronic illness or disability rated both their perceived physical and mental health needs much higher than those without, indicating the close associations between physical and mental health. For example, need for mental health care was 89.1% for those with disability versus 74.5% for those without. Need for physical health care was 85.9% for those with disability versus 65.1% for those without.

3.4.3.2 Resilience and Community connectedness

Resilience is defined as the ability to bounce back from stress, with concepts including recovery, resistance, adaptation, and thriving being used in the Brief Resilience Scale (B. W. Smith et al., 2008). Previous research indicates that reduced resilience is strongly correlated with stress, anxiety and depression. We tested these associations in our sample relative to sexual orientation (Figure 7) and gender identity and intersex status (Figure 8), as well as testing previous findings that social support and connection is associated with better resilience.

Resilience mean levels were relatively low (means ranged from 1.81 to 3.16) when compared with mainstream samples (means of 3.5–4.0 are common – Smith 2008). The most resilient identity subgroups were the female identified, lesbian and bisexual women. The least resilient were those identifying as pansexual, trans male, trans female, gender queer and asexual. Resilience according to subgroup connections were very similar, with lower resilience amongst pansexual, asexual and kink connected women; and even lower for religion and disability connected women and geeks.

Figure 7 – Resilience and community connectedness by sexual orientation
Regarding community connectedness, LGBTI connectedness was more common than mainstream connectedness, although connection to both was generally high, with ratings ranging from 17.69 (gender queer identified people with mainstream) to 22.78 (agender identified people with LGBTI), where the scale is from 7 to 28.

LGBTI community connectedness varied very little according to identity subgroups or general interest subgroups. The most connected people with LGBTI community were gender diverse, agender, then lesbian, queer, pansexual and trans connected people. The most mainstream connected were heterosexual identified, parenting, volunteer and politically connected women.

Resilience was mildly correlated with mainstream community connectedness, but not at all correlated with LGBT community connectedness (Table 3).

Table 3 – Correlations between community connectedness and resilience

<table>
<thead>
<tr>
<th>Variables</th>
<th>1. LGBT Community Connectedness</th>
<th>2. Mainstream Connectedness</th>
<th>3. Resilience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. LGBT Community Connectedness</td>
<td><em>r</em></td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>n</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Mainstream Community Connectedness</td>
<td><em>r</em> = .21***</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td><em>n</em> = 1565</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Resilience</td>
<td><em>r</em> = .04</td>
<td><em>r</em> = .22***</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td><em>n</em> = 1364</td>
<td><em>n</em> = 1363</td>
<td></td>
</tr>
</tbody>
</table>

Note: two-tailed *p < .05, **p < .01, ***p < .001.

The lack of relationship between resilience and LGBTI community connection is unexpected. This may indicate that people connect with the community for a range of reasons, and have a wide range of...
health and resilience levels from high to low. So, connection is not just about seeking help, but rather maintaining health and wellbeing.

3.4.3.3 Summary of the health problems of the sample
The online survey sample is a very diverse group of rainbow women with relatively high levels of physical and mental health problems. Their level of community connectedness is high with both LGBTI and mainstream communities. Resilience is relatively low, and is marginally associated with mainstream connections but not with LGBTI connections.

The women with highest levels of depression, anxiety, stress, and distress; and the lowest levels of resilience, are those who are pansexual, bisexual, gender queer and trans, intersex, other or questioning, religious, disability, gaming or kink connected. Those with consistently highest levels of mental health and resilience were lesbian identified, lesbian connected, and those connecting with gardening/environment, sport/fitness, parenting, or political activism.

3.4.4 Perceived need for mental or physical health help
A very high proportion of the participants perceived the need for help with their own emotional/mental health problems (80%, n=1,199), or physical health problems (73%, n=1,089). There were several demographic associations with greater perceived need for mental health care, and these generally matched perceived need for physical health care. These were:

- Lower age was associated with greater perceived mental health need (however greater age was associated with physical health need) – see Figure 9
- Living in smaller rural area
- Being homeless now or in the past
- Lower educational level – this was a linear relationship
- Lower income – this was a linear relationship
- Being in a polyamorous relationships or not being in a relationship
- Not having children
- Having a chronic illness
- Having a lower perceived general health (in a linear relationship) – see Figure 9

Figure 9 – Perceived need for mental and physical health care past 12 months
The percentage of women who perceived that they needed help for mental health problems was similar to those with actual problems. Overall, at least 75% of the sample felt they had needed mental health help over the past 12 months.

There were several differences in perceived need according to sexual orientation (Figure 10). There was higher perceived mental health need for women with pansexual, asexual, queer, other and unsure sexual identities, and lowest for lesbian identified women. This mirrors the measured mental health differences seen above, and indicates that the more marginal the identity, the lower the mental health, and the greater the need for help. Physical health need was consistently lower than mental health need with similar trends, apart from lesbians who had relatively higher need, and unsure women with relatively lower.

There were also differences according to gender identity and intersex status (Figure 11). Gender queer, intersex, other (gender) and trans women had the greater perceived mental health needs. Trans men were the least likely to have a perceived need, despite having one of the highest levels of mental health problems.

Figure 10 - Perceived health care need compared with sexual orientation
We compared participants’ general health ratings with their perceived need and actual help seeking over the past 12 months (Figure 12). These factors closely matched, with perceived need increasing as the self-rated general health deteriorated. Regarding help seeking behaviour over the past 12 months, professional help seeking increased as general health reduced. Informal help seeking also increased, but not as much. However, alternative health care seeking was not reflective of actual need, in that it was more often used by women with good to very good health, rather than poor health. This may be
because alternative health care, and to a lesser extent informal support, was utilised more to maintain health and wellbeing, whereas professional help was sought to manage ill health.

3.4.5 Help seeking intentions, attitudes and behaviour

We compared help seeking at three levels – attitudes towards help seeking, intentions to seek help, and actual self-reported behaviour over the past 12 months.

3.4.5.1 Attitudes towards seeking professional help

Results from the survey indicated that the attitudes toward seeking professional help were positive, with the overall mean attitudes score of 22.31 (range 0-30). Attitudes did not seem to be affected by any of the demographic variables, including sexual orientation, gender identity and intersex status, apart from a slight trend for more negative attitudes amongst indigenous women and asexual women. The only differences were that women with a regular GP and those that had disclosed to their GP had slightly more positive attitudes.

The key stakeholders discussed attitudes that they had observed or experienced. They were asked to comment on whether they had observed a culture of help seeking amongst RW. There was generally a belief that RW believe in and encourage peer support, which was felt to be a strongly gendered phenomenon. This peer support is particularly encouraged in sub-groups of like-minded/similar women. While there is a generally positive attitude, there were concerns that peer-support could backfire if the group of people was struggling or not well equipped with strategies for peer support. Concerns were raised that trans women were a possible exception to this pattern due to not being socialised as women, therefore less familiar/engaged with peer support. Several sub-groups were identified that cannot utilise peer-support within the LGBTI community due to a lack of connection (particularly some older women) or fear of rejection including religious or ethnic minority RW, and women who don’t identify with any identity label. Also, preferences for family or community care over RW peer support were seen amongst some indigenous RW and ethnic minority women.

Self-help ‘literacy’ was seen to be low. There was a sense that RW, as women, are socialised to look after others before themselves. Also, one stakeholder suggested that amongst butch lesbians, there may be a reluctance to seek help as they feel they must appear to be self-sufficient. A lack of mental health literacy was also identified, as evidenced by a tendency not to raise mental health as an issue of concern. Conversely, the oldest key stakeholder identified that RW take more pride in self-care as they get older.

Attitudes towards professional help seeking were felt to be generally negative or discouraging. This was largely generated by a lack of trust of many health professionals, leading to a reliance on untrained peer-support. One stakeholder felt that this distrust was passed from one generation to another amongst RW, so that younger women have not necessarily had bad experiences but still may tend to avoid professional help. Avoiding medicalisation was also thought to result in reduced professional help seeking. Seeking alternative therapies was part of this trend. Certain sub-groups were listed as being particularly likely to avoid professional help due to a fear of discrimination or stigmatisation. This
included trans people (especially in terms of hospital care), and polyamorous and bisexual women (especially regarding sexual health care).

**Focus group** participants were also asked about attitudes or a ‘culture’ of help seeking. There was general agreement that LGBTI is not a community as such, there are too many diverse identities, so it is difficult to speak of one particular culture of help seeking. The younger group did not feel that there was discouragement to seek help, apart from advice to avoid negative providers to protect each other from having negative experiences. All groups discussed attitudes to professional help seeking that were pragmatic, in that women realised there was a need. Most women had experience of peer support, and help seeking within peer networks. The mid aged group believed that women tend to share their emotions more readily than men, which can be helpful or problematic when it gets out of hand. They highlighted that there are many marginalised groups including bisexuals, who do not feel comfortable accessing peer support. The older group discussed gender, both as a driver of inequality, in that there is ongoing misogyny within the LGBTI community; and as a driver of health behaviours and beliefs. Some had experienced not wanting to seek help through a need to display toughness, both amongst themselves before transition, and amongst some lesbian friends.

“Seeking help, from my perspective the biggest problem to overcome personally has been getting over the boy factor, I’m tough, I can pull myself up by my own bootstraps and I’m not going to ask anyone for help, ever.” (trans woman, older group)

“Anecdotally some of my lesbian friends would be in the category of being pretty tough, not butch but stoic and philosophically they would not be help seekers and askers.” (trans woman, older group)

### 3.4.5.2 Intentions to seek help

Overall, intentions to seek help were relatively high and did not vary amongst most of the sexual or gender identities. There were just a few demographic features in the survey that were related to lower intentions to seek help:

- Living in rural areas (likely to relate to reduced access)
- Current homelessness (likely to relate to reduced access)
- Slight reduction as income increased (this may be related to reduced need)
- Trans men (likely to relate to reduced perceived need)
- Asexual, heterosexual and queer sexual identities

### 3.4.5.3 Help seeking behaviour over the past 12 months

Overall, formal help seeking was more common than informal help seeking, but were inter-related (see the correlations Table 4 below). This suggests that the concern by key stakeholders that RW were less likely to attend professional than peer support was incorrect. Alternative care help seeking was universally much less common. Formal and informal help seeking were both lower for certain subgroups according to their demographics, and this tended to reflect those demographics with higher levels of mental and physical health, so reduced need for services:
- living in rural areas
- informal help seeking reduced as women aged, but not formal help seeking
- never been homeless
- not indigenous
- higher education levels related to lower formal help seeking but not informal
- higher income related to lower informal help seeking but not formal help seeking

There was no difference in formal or informal help seeking behaviour related to relationship status or parenting status.

There were important differences in help seeking behaviour according to sexual orientation (Figure 13) and gender identity and intersex status (Figure 14). In general, there was a linear relationship between worse general health (i.e. higher general health scores) and more help seeking behaviour. Notable exceptions were a trend towards lower formal help seeking amongst asexual, bisexual and pansexual women relative to need, and lower informal help seeking for trans males and agender people.

Therefore, these people may be under-utilising help seeking when they need support. Conversely, trans women showed higher formal and informal help seeking relative to need, indicating that they may be over-utilising services. Alternative/complimentary help seeking behaviour was most likely amongst lesbian, queer, female, gender queer and other gender identities.

Figure 13 - Help seeking behaviour and general health according to sexual orientation

General health score range = 1-5, with 1 being excellent and 5 being poor. Higher score indicates poorer health.
We conducted correlation analysis to determine relationships between mental health, help seeking and perceived need (Table 4). All four mental health variables (stress, distress, depression and anxiety) were strongly correlated with each other, which is to be expected. Further, there was a strong correlation between lower resilience and all mental health variables.

Regarding help seeking behaviour, there was a strong relationship between formal and informal help seeking, indicating that women generally chose to seek help in both ways rather than one replacing the other; and a medium relationship between alternative help seeking and formal/informal. There were medium correlations between all mental health variables and seeking formal help, and weaker relationships with seeking informal help, confirming that higher mental health care need was associated more with formal help seeking. This was also reflected in medium correlations with perceived mental health problems, and less so for perceived physical health problems.

Help seeking intentions weakly correlated with higher stress and anxiety and lower resilience. Intentions were most strongly related to informal help seeking, perhaps indicating that this was the most accessible or easiest way to realise the intention to seek help.

Help seeking attitudes were very weakly related to formal and informal help seeking behaviour, indicating that while a positive attitude is helpful, there are many more factors that encourage actual help seeking, particularly the actual need.

Figure 14 – Help seeking behaviour and general health according to gender identity and intersex status
Table 4 – Correlations between mental health variables and previous help seeking behaviour, help seeking intentions, perceptions of help seeking, and perceived need for help

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PSQYW(^a) Stress</td>
<td>r</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. K10(^b) Distress</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. CES-D10(^c) Depression</td>
<td>r</td>
<td>.59***</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. HADS-A(^d) Anxiety</td>
<td>n</td>
<td>1381</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. BRS(^e) Resilience</td>
<td>r</td>
<td>-.41***</td>
<td>-.55***</td>
<td>-.56***</td>
<td>-.43***</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Health Professionals</td>
<td>n</td>
<td>1399</td>
<td>1381</td>
<td>1373</td>
<td>1370</td>
<td>1369</td>
<td></td>
<td></td>
<td></td>
<td>1364</td>
<td>1373</td>
<td>1370</td>
</tr>
<tr>
<td>7. Informal/ Self-help</td>
<td>r</td>
<td>.24***</td>
<td>.20***</td>
<td>.17***</td>
<td>.16***</td>
<td>-.19***</td>
<td>.57***</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Comp./ Alt. Help</td>
<td>n</td>
<td>1399</td>
<td>1381</td>
<td>1373</td>
<td>1370</td>
<td>1364</td>
<td></td>
<td>1366</td>
<td>1370</td>
<td>1364</td>
<td>1370</td>
<td>1370</td>
</tr>
<tr>
<td>9. GHSQ(^f) intentions</td>
<td>r</td>
<td>.16***</td>
<td>.06*</td>
<td>.027</td>
<td>.10***</td>
<td>-.11***</td>
<td>.12***</td>
<td>.34***</td>
<td>.07*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. ATSPHS(^g) Attitudes</td>
<td>n</td>
<td>1397</td>
<td>1381</td>
<td>1373</td>
<td>1370</td>
<td>1364</td>
<td></td>
<td>1364</td>
<td>1465</td>
<td>1346</td>
<td>1365</td>
<td>1465</td>
</tr>
<tr>
<td>11. Mental Health Problems(^h)</td>
<td>r</td>
<td>.34***</td>
<td>.41***</td>
<td>.39***</td>
<td>.32***</td>
<td>-.35***</td>
<td>.22***</td>
<td>.20***</td>
<td>.03</td>
<td>.06*</td>
<td>.02</td>
<td></td>
</tr>
<tr>
<td>12. Physical Health Problems(^i)</td>
<td>n</td>
<td>1390</td>
<td>1372</td>
<td>1364</td>
<td>1361</td>
<td>1355</td>
<td></td>
<td>1355</td>
<td>1510</td>
<td>1510</td>
<td>1510</td>
<td>1456</td>
</tr>
</tbody>
</table>

Note: two-tailed * \(p < .05\), ** \(p < .01\), *** \(p < .001\). \(^a\)PSQYW = The Perceived Stress Questionnaire for Younger Women. \(^b\)K10 = The Kessler Psychological Distress Scale. \(^c\)CES-D10 = The Center for Epidemiologic Studies Short Depression Scale. \(^d\)HADS = Hospital Anxiety and Depression Scale, Anxiety Subscale. \(^e\)BRS = Brief Resilience Scale. \(^f\)GHSQ = General Help Seeking Questionnaire (ie intentions). \(^g\)ATSPHS = Attitudes Toward Seeking Professional Help Scale. \(^h\)Emotional/Mental health problems: \(0 = \) no, \(1 = \) yes. \(^i\)Physical health problems: \(0 = \) no, \(1 = \) yes.

Correlations of > 0.50 are strong and generally highly significant, correlations of 0.30-0.50 are medium, and those 0.10-0.30 are weak but still significant. Negative numbers indicate a reverse correlation.

3.4.5.4 Social connections and help seeking

We also examined whether being more socially connected to LGBTI and/or mainstream communities was related to help seeking behaviour, intentions or attitudes (Table 5 correlations). LGBTI community connection was related to mainstream connection, so that the more a person was involved with one, the more they would be involved in the other. It had a weak positive association with professional and informal help seeking, and with intentions to seek help.
Mainstream community connection seemed to be slightly associated with reduced professional help seeking, and had no relationship with informal help seeking. It was weakly connected with intentions and attitudes.

**Table 5** – Correlations between LGBTI and mainstream community connectedness, and previous help seeking behaviour, help seeking intentions, perceptions of help seeking, and perceived health problems

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. LGBTI Connection(a)</td>
<td>r</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Mainstream Connection(b)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Health Professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Informal/Self-help</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Comp./Alt. Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. GHSQ(^{c}) Intentions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. ATSPHS(^{d}) Attitudes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Mental Health Problems(^{e})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Physical Health Problems(^{f})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: two-tailed \(^{a}\) p < .05, \(^{b}\) p < .01, \(^{c}\) p < .001. \(^{d}\) LGBTI = LGBTI community connectedness. \(^{e}\) Mainstream community connectedness. \(^{f}\) GHSQ = General Help Seeking Questionnaire. \(^{g}\) ATSPHS = Attitudes Toward Seeking Professional Help Scale. \(^{h}\) Mental health problems: 0 = no, 1 = yes. \(^{i}\) Physical health problems: 0 = no, 1 = yes.

Perceived health problems were not related to community connection, apart from being slightly less likely to connect with mainstream community when mental health problems were higher.

Therefore, it appears that LGBTI community connectedness had a small but significant positive influence on intentions to seek help, informal help seeking and to a lesser extent professional help seeking.

The focus group findings shed some light onto the help seeking behaviour. The need for trust and safety within formal and informal services was high, particularly for younger people and more stigmatised groups, who reported relying heavily on recommendations from LGBTI peers. Connection to LGBTI communities certainly facilitated access to informal peer support through knowing what was available and how to connect with it. Trusted connections were also used to seek recommendations for LGBTI sensitive professional health services.
“When you find someone you’re comfortable with, and sometimes that can be - for me, although I found them on my own, I found them through a GLBT resource. I think it was Zoe Belle Centre. On their website there were a list of resources and I found someone. You kind of feel comfortable knowing in advance that you’re going to this person, that someone has already put them up and said, hey, in this space it’s a safe place to go. I think that helps a lot.” (trans woman, mid aged)

3.4.6 Types of support

The types of health support accessed were divided into professional (i.e. formal) help seeking (Figure 15), informal help seeking (Figure 16), and alternative or complementary services (Figure 17).

**Figure 15 – Use of health professionals in past 12 months**

There was a high level of professional help seeking over the past 12 months, with 74.4% of people seeing a GP at least once, and 44.3% seeing a psychologist/counsellor. Just 6.8% had not accessed any professional support. The open ended responses under “other” typically included dentist (n = 8); online counselling (n = 5); in-patient hospital care (n = 5); and an IVF specialist (n = 3).

The majority of the sample had sought help from family and/or friends (74.7%). Self-help was very important too, with the internet being the most important source. Only 6.3% of participants had not accessed any informal support. Under “other” the most common open ended responses were books and apps (n = 14); assistance programs or community courses (n = 4); and Facebook groups (n = 3).
Almost half of the participants (44.4%) had not accessed any complementary therapies over the past 12 months. The “other” complementary therapies most commonly included a kinesiologist (n = 16); meditation (n = 9); reiki (n = 6); and hypnotherapist (n = 3).

3.4.6.1 The role of peer support

The benefits and drawbacks of peer support for RW were outlined by key stakeholders and focus group participants.
**Benefits of peer support**

All of the key stakeholders discussed the important role of peer support groups for RW. These were felt to be important as they provide potentially safe and culturally appropriate spaces and avoid medicalisation of RW’s problems. They also fill gaps that RW perceive to exist in professional services around LGBTI sensitivity. They spoke of a history of volunteer-led groups being developed within AIDS Councils for sub-groups that fell outside of the funding streams. For example, in Queensland this included lesbian and bisexual women, trans women and indigenous people.

Women in the focus groups reiterated the essential role of peer support at certain life stages. For many it was felt to be the first level of help seeking, partly due to a mistrust of professional support.

“I think that's something that has really brought me and my friends, and friends in the community together is our ability to help each other in different situations. I think that's not necessarily because we want to be like capital queer in everything that we do. Just because there's a lot of people, such as my friends, who have been denied access to a service, or have had an awkward or unpleasant experience. So I think that help-seeking behaviours have become a big part of our friendship and ways of helping each other. ..Often, that'll be the first way that we get ourselves through something, rather than looking on health websites, or even asking about doctors... Now I think about it, a lot of my friends and especially a lot of my trans and gender queer friends do that amongst themselves as well... they've started up Facebook groups for helping each other. Queer-friendly doctor lists in Melbourne, or queer ride share, or things that become part of that community... That's really, in my experience, helped to build up my friendship networks, my sense of community, my sense of being part of a group that cares for each other.” (lesbian woman, young group)

For some younger women, it was also peer support that replaced the family support that other young people may have accessed:

“There's an approach from friends instead of family. Like, I mean, a lot of us, we can't turn towards our family for support and help seeking. I mean, even if they would help, often they won't understand or get it.” (trans woman, young group)

Of course, some people did not use peer support groups:

“I've sought no other outside help from groups of any description; I don't belong to any group other than dipping into a couple of online chatty things. I've got no intention of joining any group whatsoever, don't need to.” (trans woman, older)

**Drawbacks of peer support**

The key stakeholders raised major concerns about the capacity of peer support groups to fully meet the needs and expectations of participants. Sustainability is often limited due to lack of funding. Group participants can share problems that are of high prevalence amongst RW including mental health issues, substance misuse or self-harm, with little ability to help each other through these difficult issues. Group dynamics can also be problematic, either due to identity policing and exclusion of certain sub-groups, or negative behaviours such as abuse.
Negative experiences were also discussed by people in each of the focus groups. These included burn out of the carer/facilitator, dominance of certain subgroups or agendas, exclusion of certain people based on their identity or lack of acceptance.

“groups can be very clicky and it’s about trying to work out a way that you can be comfortably involved and express yourself. How you’re accepted makes a big difference.” (lesbian mid aged)

A key point from key stakeholders and focus groups was that peer-facilitators are rarely trained or skilled in knowing how to handle these issues. As one focus group participant said:

“You kind of feel your friends understand you, especially within the community. But they don’t have the skills. Then you worry the professionals who do have the skills, don’t have the understanding.” (trans woman, mid aged)

And another:

“I think the downside of having to use the community… is that people trust each other more than the health professionals.... Then you have this situation where people are trying to support each other while doing all this emotional labour and unpaid support that seems to be... completely untrained, and they're like well I’m going to do my best to help my friend. So then I feel like I’ve been in a situation where I’ve supported some of my friends with some really tough mental health issues because there has been no-one else or because they've been rejected by the health profession so many times. Which you know is horrible, but ...what are you going to do?” (lesbian woman, young)

There were several suggestions from the stakeholders of methods to improve the effectiveness of peer support, and many of these had been put into practice by the one particular LGBTI youth service:

- Peer support group facilitator training could be developed, ideally online, in issues of conflict resolution, mental health first aid, group management, rights and responsibilities of groups
- Having a national registry of support groups, particularly including those with trained peer-facilitators
- Group members could read and sign a rights and responsibility charter
- Groups could encourage social responsibility as a welcoming open group
- Engagement of external mediator if needed

**Online support**

Online support was also raised by key stakeholders – there was consensus that this is increasingly being used by young RW, and also trans people and those in rural locations. There was some concern that for older women, this does not replace the need for face-to-face connection. They pointed to good evidence for its popularity amongst women under 26 as they are common users of QLife, the new national LGBTI specific online counselling and referral service. One stakeholder mentioned that generic online mental health support is not targeted enough to be useful for RW, although we understand that eHeadspace is heavily used by LGBTI young people.
Amongst the focus group participants, while the young group accepted social media as an essential part of their peer support, the mid aged and older groups had concerns.

“It’s interesting you mention the whole thing about social media… I think social media has made it a lot worse [loss of face-to-face connection. But I do remember pre-Facebook. You know what? It really wasn’t any better… I think now it’s maybe just changed location. Maybe that’s why lesbians aren’t as visible now, because they can meet a certain amount of their needs sitting at home on the internet.” (lesbian, mid aged)

The lack of safeguards was of particular concern, which can also be the case within any peer support group without trained facilitation as discussed in the mid-aged focus group:

Lesbian 1: That’s social media too though, I think. Being on Facebook and people just saying whatever they want to say.
Lesbian 2: Well seeing something in a certain way, and having an emotional, quick reaction without maybe thinking that through.
Lesbian 1: Maybe I shouldn’t post that.
Trans woman: The sense of anonymity. Combined with the speed at which you can - blah, blah, send.
Lesbian 1: Also, it’s writing it down. It’s not like you have to say it to the person. It’s easier to hide behind.
Lesbian 2: Or say something really passive aggressive. Next thing you know, someone has screen shot that, sent it to 20 million people and it’s a big huge explosion. Certainly parts of that made me a bit timid about communicating in those ways.

3.4.6.2 LGBTI specific health service access
Just 12.2% (n = 179) of the participants had accessed any LGBTI specific services over the past 12 months. Table 6 below lists the services that were accessed by more than one respondent.

Table 6 – LGBTI specific health services accessed by participants

<table>
<thead>
<tr>
<th>Service</th>
<th>No.</th>
<th>Service</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGBTI friendly GP/clinic</td>
<td>18</td>
<td>QuAC (AIDS Council Qld)</td>
<td>4</td>
</tr>
<tr>
<td>Northside Clinic (a LGBTI friendly GP clinic, Vic)</td>
<td>16</td>
<td>A Gender Agenda (ACT)</td>
<td>4</td>
</tr>
<tr>
<td>University based LGBTI group</td>
<td>15</td>
<td>VAC (AIDS Council, Vic)</td>
<td>3</td>
</tr>
<tr>
<td>Support groups (online, Face-to-face)</td>
<td>15</td>
<td>Twenty10 (Youth, NSW)</td>
<td>3</td>
</tr>
<tr>
<td>LGBTI friendly psychologist or other therapist</td>
<td>13</td>
<td>Shine SA (Family Planning, SA)</td>
<td>3</td>
</tr>
<tr>
<td>Social groups/networks</td>
<td>10</td>
<td>QLife (National phone/web support)</td>
<td>3</td>
</tr>
<tr>
<td>ACON (AIDS Council NSW)</td>
<td>9</td>
<td>Monash Gender Clinic (Hospital, Vic)</td>
<td>3</td>
</tr>
<tr>
<td>The Gender Centre (NSW)</td>
<td>7</td>
<td>Ygender (Vic)</td>
<td>2</td>
</tr>
<tr>
<td>Trans* support/community group</td>
<td>6</td>
<td>Prospective Lesbian Parenting Group (Vic)</td>
<td>2</td>
</tr>
<tr>
<td>Legal service e.g. Donor Parenting Legal Talk</td>
<td>6</td>
<td>Aids Action Council (ACT)</td>
<td>2</td>
</tr>
<tr>
<td>Playgroups (e.g. Playgroups with Pride)</td>
<td>5</td>
<td>Headspace (National)</td>
<td>2</td>
</tr>
<tr>
<td>Working It Out (Tas)</td>
<td>4</td>
<td>PFLAG (National)</td>
<td>2</td>
</tr>
<tr>
<td>Sexual Health Centre/Service</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Several of the **key stakeholders** discussed the place of LGBTI specific services such as the AIDS Councils. They had observed an identifiable need for specific services amongst many RW. They stated that LGBTI specific services fill a gap in theoretically providing care that is sensitive to the needs to RW and where RW can fully disclose. However there are major limitations, including the tendency for such services to be only in urban or large regional centres, and also that they can be perceived as having little focus on women within the ‘LGBTI’ agenda. This is dictated largely by funding streams that prioritise HIV and STI prevention. The lack of funding specifically for RW was a major ongoing concern. Examples were given of some AIDS Councils that have creatively extended their programs under the HIV/STI funding to RW specific initiatives. Other are intending to do so, but are having trouble attracting significant numbers of RW to their services. Further, LGBTI-specific services can be seen as less welcoming to ethnic minorities.

**Focus group** participants had mixed experiences, some having never used LGBTI specific services and others being devotees. A bisexual woman in the young group had never found an LGBTI specific service, she feels that is partly because she feels she has to be ‘straight acting’ at health services.

“I've always felt that pressure to act like I'm straight in things like that. So I've just gone normal [mainstream] places...I tend to just jump from place to place ... if I say something to them and then they're weird about it, I just won't go back. I'll just go somewhere else again. I just wing it normally.” (bisexual woman, young)

Whereas the trans woman in the group had a very different perspective:

“These community organisations [AIDS Council, LGBTI-specific general practice] are very important to me, because I think perhaps they bridge the gap a little bit, and allow that kind of intimacy with a stranger. But you know that you're going to be able to trust this person even though maybe you don't have a personal relationship with them... I can't say that I've had any negative experiences with specifically queer-friendly services. It's more when you mention you're queer to a not queer-friendly service, or maybe someone who advertises themselves as queer-friendly, but they don't really deal with that. Then it can end up being stereotyping or not worth it.” (Trans woman, young)

The mid aged group generally believed that the AIDS councils mostly catered for men, apart from known alcohol and drug counselling and a few other services. They identified that women would not ‘automatically know’ that they could go there. The older group raised the issue that trans people don’t necessarily feel comfortable accessing a G&L labelled service. For example, one woman had worked as a volunteer with G&L Switchboard for 3 years and not taken any calls from trans people. Another woman believed there should be a specific crisis phone line for trans people because the issues are so different from LBG issues. Under-funding was another problem, which contributed to LGBTI support groups and services being hard to find:

“Switchboard is just so underfunded. They can’t afford to advertise themselves. When they do advertise themselves, it’s on websites that probably haven’t been updated since 2009, and that’s unfortunate.” (lesbian mid aged)
3.4.6.3 General practice usage and relationships with health

We asked specific questions about GP visits including whether women had a regular GP, how often they visited and whether the GP knew about their sexual orientation.

Overall, 75.2% of the sample had a regular GP, and 34.8% had seen their GP at least four times over the past 12 months. Over half (56.8%) believed that their GP knew about their sexual orientation, 18.8% were not sure, and 24.4% believed their GP did not know.

There were differences according to sexual orientation, gender identity and intersex status (Table 7). Lesbian and heterosexually and ‘other’ identified people were most likely to have a regular GP, as were trans women and intersex people. Asexual, agender and trans men were least likely to have a regular GP. The highest usage occurred amongst intersex people, trans women and men, pansexuals and other sexual orientations. GPs were most likely to know about sexual orientation for lesbian women and trans women, and least likely for asexual, unsure sexual orientation, pansexual and bisexual women.

Table 7. Frequency of GP access and GP awareness by gender identity, intersex status and sexual orientation

<table>
<thead>
<tr>
<th></th>
<th>Regular GP (yes)</th>
<th>High GP use past 12 months (&gt;= 4 visits)</th>
<th>GP knows sexual orientation (yes)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td><strong>Gender Identity and Intersex status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1255</td>
<td>75.30</td>
<td>1256</td>
</tr>
<tr>
<td>Gender queer</td>
<td>83</td>
<td>71.10</td>
<td>83</td>
</tr>
<tr>
<td>Trans female</td>
<td>79</td>
<td>86.10</td>
<td>79</td>
</tr>
<tr>
<td>Other</td>
<td>36</td>
<td>66.70</td>
<td>35</td>
</tr>
<tr>
<td>Intersex</td>
<td>22</td>
<td>81.80</td>
<td>23</td>
</tr>
<tr>
<td>Agender</td>
<td>8</td>
<td>62.50</td>
<td>8</td>
</tr>
<tr>
<td>Trans male</td>
<td>7</td>
<td>57.10</td>
<td>7</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesbian</td>
<td>781</td>
<td>79.00</td>
<td>780</td>
</tr>
<tr>
<td>Bisexual</td>
<td>260</td>
<td>70.40</td>
<td>262</td>
</tr>
<tr>
<td>Queer</td>
<td>219</td>
<td>73.50</td>
<td>219</td>
</tr>
<tr>
<td>Pansexual</td>
<td>134</td>
<td>70.10</td>
<td>134</td>
</tr>
<tr>
<td>Other</td>
<td>35</td>
<td>77.10</td>
<td>35</td>
</tr>
<tr>
<td>Unsure</td>
<td>23</td>
<td>65.22</td>
<td>23</td>
</tr>
<tr>
<td>Asexual</td>
<td>21</td>
<td>47.60</td>
<td>21</td>
</tr>
<tr>
<td>Heterosexual/straight</td>
<td>18</td>
<td>88.89</td>
<td>18</td>
</tr>
</tbody>
</table>

We analysed relationships between GP care, help seeking in general and perceived need (Figure 18). Those with perceived physical health needs were more likely to have a regular GP than those without. Perceived mental health need did not influence having a regular GP. Those with a perceived physical health need were more likely to have told a GP about their sexual orientation, whereas those with perceived mental health need were less likely to have told. This is likely to indicate that those with mental health issues were more vulnerable and had less resilience, therefore were less likely to risk a disclosure.
Formal help seeking behaviour was very connected with having a regular GP, confirming one of the roles of GPs as conduits into other parts of the health care system (or that people willing to have a regular GP were also more likely to attend other formal services). Formal help seeking was also more likely if the GP was aware of the sexual orientation. Coming out to the GP may be more likely amongst people who are more autonomous and likely to seek help elsewhere. An alternative explanation is that when the GP understands the sexual orientation, they can more fully uncover the person’s health needs and refer appropriately.

Informal help seeking varied little whether a person had a regular GP or not. It was slightly higher for those who were not out to their GP. This may indicate that GPs were not assisting people to find appropriate peer support, also that being unable to disclose to GPs led people to seek help elsewhere within informal networks. Attitudes towards help seeking and intentions to seek help did not vary, regardless of whether people had a regular GP or had told their GP.

Figure 18 – General practice care compared with help seeking behaviour, intentions, attitudes and perceived need

Women in the focus groups described various negative experiences with GPs. The young women had had many experiences of being stereotyped by GPs, for example:

- Bisexual woman has had to have an STI test every time she attends the GP because she is bisexual – she finds this difficult
- Lesbian woman has asked for an STI test and been told she doesn’t need one as she is not having ‘real’ sex.
- Trans woman felt that all her mental health problems are blamed on her being trans
There was also an example of poor clinical systems, that do not accommodate trans patients:

“I get a letter from my GP’s office this week. I laughed when I opened it. They said, you’re due for a pap smear. Yeah, no. There’s just no need for that. It becomes interesting that when these medical issues aren’t relevant, it’s kind of... I’ve heard of people who just break down when they get that. I just laughed. It’s like, it’s great that your system only has M and F on the thing, but at the same time, why don’t you have T, you know? What if for a person it was an issue?... My partner, she actually took a different view. Because she’s had friends who have had hysterectomies in their 20’s, and for them, when they got this letter it was just devastating.”

(Trans woman, mid aged)

Lack of knowledge about trans issues was frequently raised:

“I was a little bit surprised that my GP had almost zero experience and knowledge within [gender] transitions. I more or less had to tell him who I wanted to see and he was fine, he was really good about it; he’s a lovely man but had zero knowledge.” (trans woman, older)

3.4.7 Barriers and enablers of help seeking

3.4.7.1 Barriers to help seeking

In the survey, we listed nine common barriers to help seeking, and only around 10% of participants felt that none of these applied to them. Experiencing discrimination or judgement were consistently the most common barriers, followed by a lack of LGBTI sensitivity. Lack of readiness or self-reliance were common, and around one third were concerned about a lack of confidentiality.

Figure 19 – Barriers to help seeking by gender identity and intersex status

Note: Discrimination/judgement includes concerns about being judged, fear of discrimination, prior experiences of discrimination and experiences of heterosexism. Lack of LGBTI knowledge includes experiences of excessive focus on LGBTI status when not relevant and concerns that service providers will not be LGBTI knowledgeable and skilled.
Discrimination was most problematic for gender queer, other gender identity, queer and pansexual people; and these same groups were also most affected by a lack of LGBTI sensitivity (Figures 19 and 20). Heterosexuals and trans men were least affected by discrimination, while trans, asexual and heterosexual women were least affected by a lack of sensitivity. Most affected by a lack of readiness or self-reliance were gender queer, agender and asexual people.

**Figure 20** – Barriers to help seeking by sexual orientation

The **Key informants** identified similar barriers including a lack of sensitive services and not knowing where to find sensitive services, stigma and discrimination. Importantly, failure to meet expectations in services that promote themselves as LGBTI sensitive is a major problem. This included the LGBTI status being problematised, or conversely ignored. Fears that confidentiality would not be guaranteed was a barrier, particularly in smaller communities. Finally inherent issues including poor mental health (or substance use) affecting the ability to seek help, and a lack of health literacy were barriers.

The **focus group** participants shared several barriers that they had experienced that matched those in the survey. It was clear that experiences of discrimination and poor knowledge often led to disempowerment, with women commonly not expressing their concern or not returning to the service:

“I have had so many doctors be explicitly queer phobic once I have said that I'm queer. They sexualise me in a super creepy way...I'd like to think that at 27, and confident in who I am now, if that shit was to go down again, I would report it. But in the past, if I've seen for example a homophobic doctor at Uni... I'm not going to see that guy again. I don't actually do anything about it except knock [them] back. I would love, in the future, to actually report or do something about it so that doesn't happen again...Also really uneducated health professionals. Like one
time I told a doctor I was bisexual, and they asked me – ‘oh, so you want to change your gender’. I’m like, that’s not what I’m saying.” (bisexual woman, young)

These experiences can be subtle or well-meaning yet damaging:

“I think it can just take one thing that someone says. Like if you go and see a counsellor and it’s really inappropriate, it can really put you off from wanting to go back, even though they might not have meant it, it’s just that they’re ignorant, or whatever it is. It can just destroy that whole...But not everyone thinks that they have choices or options. Especially with young people, I think. They think that if they go see a counsellor that they have to see that counsellor. That they don’t have the option to go somewhere else.” (lesbian, mid aged)

Lack of trust was another common outcome of these negative experiences:

“I think there's a lot of... resentment and also mistrust by queer people towards health professionals in general. I think most of the time that's really justified, and - but it does discourage you from help seeking behaviours. I've had experiences, especially mental health services, acute mental health services can be really difficult.” (trans woman, young)

The participants also raised the following barriers

- Difficulty being able to predict attitudes before attendance
  “I mean - you can’t tell. You might think that someone is going to be accepting and they’re not, or vice versa.” (lesbian, mid aged group)
- Providers being overly focused on LGBTI status, perhaps to the point of pathologising:
  “I had seen the counsellor and then I had to go to the GP and get more appointments. He’s asking me questions, and because I had suffered a traumatic relationship, he felt the need to write traumatic lesbian relationship. I’m thinking, is that necessary? I mean, I already knew the counsellor. I was like, what was the point of that? Was that really necessary? It was a traumatic relationship. Not a traumatic lesbian relationship. (lesbian, mid aged group)
- Having to educate providers:
  “There's no easy way to do it, because the thing is, the second you speak out, you know that you’re going to have to give them a lesson as well. You’re going to have to be the teacher, the complainer and do all the work, and to be honest, I don't have that energy most of the time. I have to save my energy for when I know it's actually going to be worthwhile.” (trans women, young group)

3.4.7.2 Enablers to help seeking
Four common enablers were listed, and only around 11% of participants selected that none of these applied. The most commonly selected enabler was having a trustworthy GP by 62.4% (n = 918), followed by encouragement to get help by a friend or partner 44.6% (n = 638). Having a choice of provider was an enabler for up to one third of participants.
Figure 21 – Enablers of help seeking by gender identity and intersex status

Note: LGBTI sensitive and knowledgeable includes having trustworthy and sensitive GP, and knowing that a provider or service is LGBTI sensitive through personal recommendation, prior experience or because it is run by an LGBTI agency or group. Awareness and acceptance by provider includes being out to the health care provider and being able to involve one’s domestic partner in health care.

Figure 22 – Enablers of help seeking by sexual orientation

Notable differences by gender identity were that trans men did not select encouragement by friends at all, and were unlikely to select choice of provider as an enabler (Figure 21). Trans women and agender people were most likely to find sensitivity and knowledge enabling. According to sexual orientation
(Figure 22), queer and other orientations found sensitivity most enabling, and choice of provider was least enabling for asexuals, heterosexuals and those who were unsure about their sexual orientation.

The key stakeholders identified many of these enablers. They felt that a key enabler was being able to predict, or have experienced a service as being safe and culturally sensitive. Social connection was another enabler, either with mainstream or LGBTI community, from parents, or at an individual level through peer mentoring.

In addition, focus group participants identified that having services that are run by LGBTI people is an enabler:

“When people see that there are services that are run by people who are not heterosexual... then the engagement happens. Because it’s like, all right, that’s got to be an okay place”.
(lesbian woman, mid aged group)

3.4.7.3 Preferences for LGBTI sensitivity or tailoring

We asked two questions about preferences for LGBTI sensitivity and tailoring of services.

There was strong agreement that access to LGBTI sensitive, knowledgeable and skilled services is important. Less people felt that LGBTI specific services were important, which may reflect either a pragmatic approach in the knowledge that there are very few such services, or a preference for attending sensitive mainstream services.

Figure 23 – Importance of LGBTI sensitive and tailored health care by gender identity, intersex status and sexual orientation

Note: LGBTI Sensitive: Importance for health care provider to have LGBTI sensitivity, knowledge, skills, and specificity; high score = very important. LGBTI Tailored: Importance for health information to be specifically tailored to LGBTI people; high score = very important.
Based on gender identity, trans women, agender and gender queer people rated LGBTI sensitivity of highest importance. Based on sexual orientation, the queer and pansexual women rated this the highest. Bisexual women rated sensitivity lowest. These differences in perceived importance of LGBTI sensitivity might indicate how much these difference subgroups need or prefer to be out to their health providers. Tailored services were most favoured by the same groups that favoured sensitivity.

**Key stakeholders** also had observed that some RW prefer to use mainstream professional services, or they access mainstream services because they could not access LGBTI specific services. Whereas other RW prefer LGBTI specific or women specific professional services. They felt this was dictated largely by the level of comfort in the service and attempts to avoid discriminatory treatment, as well as accessibility.

Having sensitive mainstream services was seen to be very important for RW, particularly subgroups who cannot or prefer not to access LGBTI services: older women, remote/rural, cultural minorities, indigenous women. Services particularly highlighted were those in general practice, fertility/gynaecology, emergency, women’s refuges and domestic violence, homelessness, and mental health – particularly acute services. Perceived discrimination and lack of LGBTI sensitivity were common experiences of RW attending mainstream services. Several stakeholders discussed a lack of LGBTI focus within women’s health services, and that there has been a notable shift away from a RW focus as services focus more on ethnic minority and other diverse communities. RW are not seen as core business for women’s health, whereas in the past some women’s health services did have such a focus.

Stakeholders discussed how to improve LGBTI sensitivity in mainstream services and the discussion pointed to no easy solution. They identified several helpful steps including raising awareness of the need for sensitivity, having high level support within agencies (including at times LGBTI personnel), training in specific issues and appropriate language, then integrating this into service policies and procedures. This was advocated as a comprehensive, system wide approach that is sustainable and effective, rather than the piecemeal approach that tends to happen currently, if at all. A further model was a partnership approach described by one stakeholder, in which LGBTI specific services assist in training of mainstream agencies in order to refer their clients to these agencies.

### 3.4.8 Priority subgroups according to health care need and access

According to the survey data, there is a consistent group of women with better general health and higher resilience, which includes lesbians, female identifying women, and those connected with sport, parenting, environment, political and volunteering interests.

Conversely, there is an important hierarchy of need amongst identified subgroups related to a confluence of low general health (both emotional and physical), low resilience, high need for services, and high barriers to seeking help. We have attempted to represent this hierarchy of need in table 8, with the people with highest need nearer the top. We have done this by creating some arbitrary levels to indicate health inequalities relative to the rest of the sample.
Table 8 – Hierarchy of need according to subgroups

<table>
<thead>
<tr>
<th>Poor general health Mean &gt;3.4</th>
<th>Poor mental health K10 &gt;25</th>
<th>Reduced resilience Score &lt;2.8</th>
<th>High MH* need &gt;80%</th>
<th>High PH* need &gt;75%</th>
<th>Discrimination as a barrier &gt;70%</th>
<th>Lack readiness as barrier &gt;60%</th>
<th>Lack HP knowledge as barrier &gt;60%</th>
<th>Confidentiality as a barrier &gt;30%</th>
<th>Lack of reg. GP &lt;70%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender queer</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>‘Other’ SO</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Trans men</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Asexual</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Pan-sexual</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Queer</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Intersex</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Religion</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Disability</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Geek</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>‘other’ gender</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Unsure SO</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Agender</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Bisexual</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Trans women</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Kink/ Polyam.</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

*MH = mental health, PH = physical health

We asked the key stakeholders to discuss key subgroups of RW they were familiar with and emerging trends. They particularly mentioned the following subgroups that they felt were emerging in the LGBTI communities:
women who don’t necessarily identify with a label. It’s more about their attraction and behaviour. This applies at both age extremes- young and old. Both can tend to be invisible in the LGBTI community
• trans and intersex people
• ethnic minorities and indigenous people
• women who are partnered with a gender queer person – they can find it difficult to know what language should be used, what to call themselves, although pansexual is an emerging term
• queer people
• bisexual women, particularly amongst younger age groups
• kink and/or polyamorous women

These experiences were certainly reflected in the survey with several women identifying as ‘other’ sexual orientation or gender identities, trans, gender queer, pansexual or queer sexual orientation.

The key stakeholders provided an insight into one likely factor that connects many of the high priority women, being marginalisation. Two connecting themes that contribute to marginalisation emerged from the interviews: identity policing, and social isolation.

a) Identity issues
- Identity defining and policing is common, for example against trans women in lesbian spaces, queer women in lesbian spaces, bisexual women anywhere. However, there was a feeling that some younger RW are starting to challenge these norms and assumptions, by not adopting labels. They are encouraging more individuality.
- Care is needed when using the term queer as there is a lack of clarity around how to define queer. It was felt to be currently incorrectly used as an umbrella term. Some older women do not like to use the term “queer” as it has negative connotations for them.
- The definition of bisexual is contested – the politics amongst older women suggest that bisexual identity is not a valid label. Another view was that they might select the label lesbian despite being bisexual as it won’t offend their partner or lesbian friends.

b) Social isolation
- There are some subgroups that tend to be insular, with little connection outside of their group. One example was some groups of older rural lesbians. They may not access mainstream or LGBTI health messages, and may have increased health issues. Conversely, this should not be applied to subgroups universally, for example some older lesbians are very good at organising women only events to attend and are very outward looking.
- Similarly, the virtual connections favoured particularly by young rainbow women can be isolating as they may not have face-to-face connections. There are less face-to-face social groups available now specifically for young RW, who are tending to socialise in mixed groups.
- RW identifying closely with their religion, particularly marginalised religions such as Islam or Judaism, can feel excluded from LGBTI organisations. For some, their religious identity can outweigh their gender or sexual identity. This equally applies to minority cultural groups.
Trans women - can be difficult for them to access women’s spaces, also heterosexual trans women may not feel comfortable connecting with lesbian women and groups
- Trans men – who can lose their connection with their previous women’s community, and find it difficult to find a new community to feel comfortable in.
- BDSM/kink/polyamorous are very marginalised and stigmatised – due to their perceived promiscuity. Also, damaging behaviours within their own group have been observed.

This would explain some of the differences in health and wellbeing in our sample for participants with identities or behaviours that don’t necessarily fit with current peer support networks such as intersex, people with ‘other’ sexual orientations or gender identities, asexuals, to some extent trans men. Geek and gaming connected people also fall into this group perhaps due to their lack of face-to-face social connection. This extends the emerging literature showing that reduced concordance between sexual identity and behaviour was related to reduced mental health.

We suggest that there is a second underlying factor related to having multiple minority identities that compound experiences of discrimination. This would apply to people who appear to be well connected, yet with high need such as pansexuals, kink, disability or religion connected people.

While we have set a priority list, we need to acknowledge that all subgroups of rainbow women have a higher burden of mental health problems than the general community, so should be included in targeted messaging, policy and health care services. However, we suggest that the following groups should be particularly prioritised for mental health promotion campaigns, improved access to health services including sensitive GPs, and further research to understand the basis of their inequalities:

Gender identities and intersex status:
- gender queer people
- trans men
- intersex people
- people with ‘other’ genders
- agender people
- trans women

Sexual orientations:
- women with ‘other’ sexual orientations
- asexual women
- pansexual women
- queer women
- women who are unsure of the sexual orientation
- bisexual women

Women connected with the following communities should also be prioritised:
- religion
- disability
- geek
- kink/polyamory
3.4.9 Messages – content and delivery platforms

3.4.9.1 Determining the target audience
One woman in the mid aged focus group suggested two important targets:

“Well who’s your target audience? Are you trying to educate people who are making the stereotypes or are you trying to empower people who have been stereotyped, because there’s two very different questions there.” (Lesbian, mid aged)

Given the remit of the RW project, we have chosen to focus on the consumers, however this is important ongoing work for the future regarding community attitudes and health provider education. One key stakeholder felt that beyondblue should focus on both consumers and providers. She was concerned that it is difficult to encourage help seeking when there are so few LGBTI sensitive services.

There were mixed views on whether LGBTI targeting of messages was helpful amongst key stakeholders. One stakeholder was concerned that sub-groups should not be targeted as this can be stigmatising, but rather specific issues should be targeted. Alternatively targeting subgroups through imagery rather than words e.g. Quit recently ran an ad that targeted the Indigenous community by using Indigenous people in the ad which was identifiable by people within the community but otherwise appeared to be a mainstream ad.

Another stakeholder preferred that messages should be around behaviour and attraction rather than specific identity labels so that people aren’t excluded. ‘beyondblue needs to put more focus on the margins so everyone feels welcome’.

The majority of stakeholders felt that it is important to target more at-risk or marginalised sub-groups, particularly to engage them. Specific groups mentioned:

- youth – they often aren’t given a voice and are overlooked
- ethnic minorities – about how they can exist within both identities
- bisexual women – often overlooked or ostracised by the lesbian community
- pansexual women - ditto
- trans women
- lesbians with a trans partner who may not identify with an identity label
- women with multiple identities, which tend to lead to ‘layers of invisibility’

Two stakeholders stated that targeting messages raises awareness of LBQT issues in the general community. This can educate the broader community and reduce stigma.

Focus group members suggested that the most important element of any campaign for it to be trustworthy is that it is developed with strong involvement of the LGBTI communities.

3.4.9.2 Content of health promotion messages
Survey participants were asked the following question about the most appropriate health messages for rainbow women:
‘In developing a mental health information campaign aimed at lesbian, gay, bisexual, trans or intersex women, how important would the following points be to guide the content?’ with responses using a 5-point scale from not at all to very important (responses in Table 9).

**Table 9 – Preferred key messages**

<table>
<thead>
<tr>
<th>Messages</th>
<th>Mean (Range 0-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include referral information for LGBTI specific/friendly services</td>
<td>4.28</td>
</tr>
<tr>
<td>Include images/stories that reflect the diversity of LGBTI women</td>
<td>4.22</td>
</tr>
<tr>
<td>Recognise the impact of discrimination on mental health/well-being</td>
<td>4.21</td>
</tr>
<tr>
<td>Include images/stories from LGBTI women from different ethnic/social backgrounds</td>
<td>4.14</td>
</tr>
<tr>
<td>Include stories from LGBTI women about living with depression/anxiety</td>
<td>4.14</td>
</tr>
<tr>
<td>LGBTI women should feature in the campaign</td>
<td>4.12</td>
</tr>
<tr>
<td>There are messages that are relevant to LGBTI women</td>
<td>3.92</td>
</tr>
<tr>
<td>The accuracy of the information is more important than being LGBTI specific</td>
<td>3.87</td>
</tr>
<tr>
<td>LGBTI women need their own campaign on depression/anxiety</td>
<td>3.38</td>
</tr>
<tr>
<td>Causes of depression/anxiety are different to those for non-LGBTI women</td>
<td>3.34</td>
</tr>
</tbody>
</table>

There was a high level of agreement with all of the messages provided, although the messages scoring means over 4 were the most popular. There were no clear differences according to sexual orientation, gender identity, intersex status or connections in the ratings provided.

**Key stakeholders** and **focus group** participants were also asked about the key messages they would like delivered. These fell into three themes: the need to convey the importance of building self-esteem amongst RW, encouraging help-seeking, and embracing diversity within RW.

**Theme 1: Building self-esteem, self-worth**

Several stakeholders suggested messages about the importance of looking after yourself and your mental health. Convey that despite all the negativity that can surround RW in many areas of their lives, it is important that they understand they have worth and value as a person. That there is nothing wrong with you, therefore normalising messages, because a key issue is internalised homophobia, biphobia and transphobia. Also their gender and sexuality is what makes them special because they have an added dimension. One stakeholder emphasised that RW women are socialised differently to men, they want
and need safe and supportive messages that are not sexualised. Finally, that it is possible to live with multiple identities, rather than have to choose one.

“In the perspective of beyondblue wanting to know how best to offer their assistance... the starting point [could] be that they view the particular cohort we’re discussing as normal ...with a particular issue which in a sense is no different to any other issue that might be out there. We’re starting from a point of commonality in terms of our common humanity and they are charged with the task of helping that humanity by actually identifying what the issue might be but treating whoever it is that they’re dealing with as essentially normal.” (trans woman, older group)

Theme 2: Encouraging help seeking

An important message is that it is alright to talk to someone about the thoughts you are having. Remind people they aren’t alone and that there is help out there. One stakeholder felt this is a better message than ‘It gets better’, because young people can’t necessarily see past their problems to a bright future. While women are good at supporting each other, they may not be good at supporting and encouraging each other to get mental health support.

“if this is about developing help seeking resources, part of it is training the professionals to be more understanding, and then giving information to the people seeking help of things you should consider. You can pick and choose [your service]. You can go, actually no, this doesn’t work, and it’s good to do that” (trans woman, mid aged).

Encouraging intergenerational support was also important e.g. Q connect project providing online and face to face connection between older and younger LGBTI, although younger have been much easier to recruit. The older focus group discussed the need for families and friends of trans people to find support:

“In relation to some sort of help for the families of the trans individuals. I certainly feel that would be enormously helpful to each of those family members but also enormously helpful to that trans individual. I’m not aware whether there is something like that out there. I would certainly be inclined from a personal perspective to put that at the top of the tree.” (trans woman, older group)

Further thoughts on encouraging help seeking from the focus groups:

“Maybe that it’s good for people to know that they don’t have to come out, as well. People feel that they have to again and again. But really, that’s fine, if that’s what you want to do.” (lesbian, mid age)

“They need from a health promotion point of view to convince those that fall within that, let's call it trans community, that they can go to [services] for help and be rewarded with support, understanding, acceptance. They don’t come in on the first step of the ladder, they come in on the fourth or fifth step of the ladder because they’re already aware of what's going to happen.” (trans woman, older group)
“I think that community connection is really important, particularly me speaking as someone who's new to an area who doesn't really know all the connections out there... But even just some sort of campaign to say what's out there, because I've tried looking, and it's really hard to find things on the internet. If you don't have friends to ask” (bisexual woman, young).

**Theme 3: Embracing diversity within the LGBTI community**

“Well something I would say is that there's more than one way to be anything. More than one way to be a female. There’s more than one way to be a lesbian. There’s more than one way to be bi. There’s more than one way to be straight.” (lesbian, mid aged group)

Education is needed for the LGBTI community regarding different cultures and backgrounds within the community, to counteract the prevalent racism within this community and also ableism. It could also educate cultural minority groups about how to engage with LGBTI communities.

The difficulty for newcomers to the LGBTI scene to understand sub-cultural norms and hidden rules within subgroups and support groups was raised as an area for education. Need to have support groups that develop a social responsibility as a welcoming open group.

Messaging should not focus on difference between, say, lesbians and gay men, but instead look at ways to support one another, and especially support women within LGBTI community spaces. Care must be taken not to label specific identities in the messaging.

“actual representation from all parts of LGBTIQs, and the diversity within that. I would say, explicitly name all groups. They'll just be like, rainbow, yay. What does that mean? It actually just means gay, for example, which often happens.” (lesbian woman, young group)

“I think diversity is one of the best things that we have going for us. It's being able to meet people who you have something in common with, but they’re also leading vastly different lives from you. I think that's a really cool thing. But yeah, if you go for an image of conformity and everyone looks the same, it can be really disheartening.” (trans woman, young)

**3.4.9.3 Preferred delivery platforms for health promotion**

Survey participants were asked ‘Which of the following media or communication methods would you find most effective?’ (Responses in Figure 24).

Online media including mental health websites, LGBTI online media and social media were the most popular methods. Over half also chose mainstream media as a helpful platform.

There were no clear differences with regard to sexual orientation, gender identity or intersex status, however there were a few differences according to age (table 10). Any form of online media were still the most popular across all age groups, although mainstream media and LGBTI print media increased in popularity amongst older women. Apps were more popular amongst young women, while community forums were more favoured by older women.
Figure 24 – Preferred platform for health message delivery

Table 10 – Preferred platform for health message delivery by age groups

<table>
<thead>
<tr>
<th></th>
<th>Age &lt;30 (%)</th>
<th>Age 30-50 (%)</th>
<th>Age 51+ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Websites</td>
<td>62.70</td>
<td>62.40</td>
<td>54.90</td>
</tr>
<tr>
<td>LGBTI Online Media</td>
<td>61.20</td>
<td>59.80</td>
<td>58.50</td>
</tr>
<tr>
<td>LGBTI Social Media</td>
<td>59.70</td>
<td>55.90</td>
<td>50.80</td>
</tr>
<tr>
<td>Mainstream Media</td>
<td>53.20</td>
<td>55.80</td>
<td>59.00</td>
</tr>
<tr>
<td>Community Pride Events</td>
<td>46.20</td>
<td>46.00</td>
<td>49.70</td>
</tr>
<tr>
<td>Apps</td>
<td>43.50</td>
<td>37.50</td>
<td>32.30</td>
</tr>
<tr>
<td>Public Transport Ads</td>
<td>37.40</td>
<td>32.90</td>
<td>31.30</td>
</tr>
<tr>
<td>LGBTI Print Media</td>
<td>27.80</td>
<td>35.50</td>
<td>37.40</td>
</tr>
<tr>
<td>Community Forums</td>
<td>25.00</td>
<td>28.40</td>
<td>40.00</td>
</tr>
<tr>
<td>Cinema Ads</td>
<td>22.40</td>
<td>20.10</td>
<td>20.50</td>
</tr>
<tr>
<td>Billboards</td>
<td>18.90</td>
<td>17.30</td>
<td>17.90</td>
</tr>
<tr>
<td>Dating Websites</td>
<td>14.10</td>
<td>16.40</td>
<td>14.90</td>
</tr>
</tbody>
</table>
Amongst the three focus groups, there was some age-related variation in preferences. The young group all agreed that the internet was their primary preference:

“I think definitely the internet is the way that people are finding things out. I mean, that's my first port of call. Straight to the internet.” (bisexual woman, young)

Both other groups also agreed with the internet, however with more reservations, understanding that there are subgroups that do not have access.

The mid aged group raised the use of LGBTI role models to show the LGBTI and wider community successful, well integrated people, leading ‘normal’ lives. One of the older group raised this too:

“I suppose as a teen what I would have really appreciated was some role models I suppose or some successful trans people... Whereas if you're a straight kid you've got hundreds and hundreds of role models who you can choose from... I know beyondblue is for example recording some little videos, I was involved in one where they just put them up on their website or whoever and people can find them.” (woman, older group)

One woman in the older age focus group suggested that a roadshow be conducted to enable local LGBTI people and their families to attend, as long as it was presented as a generic show about mental health for minorities rather than specifically about LGBTI people.

Various methods were suggested by key stakeholders for particular subgroups:

- Social media - Particularly for younger RW, while recognising that some rural and isolated RW do not access social media.
- RW support groups - Especially focusing on specific messages for the group, and find a core person in the group to influence
- Local community - to access RW who are not connected with LGBTI community
- Via existing health promotion for women - Such as Breastscreen, Pap screen, bowel screen
- Via primary care - Primary Health Networks, substance use and mental health sectors

They were concerned that LGBTI print and radio media could be less useful as it tends to be more targeted to men. They were similarly concerned that messaging through the AIDS Councils may again be seen as male-focused in most states (notable exceptions are ACON and QUAC), despite recent efforts by some to target women.

The imagery to use was discussed by two stakeholders, who warned against heterosexist images, and felt it was very important to find images that were relatable for different groups of women.
3.5 FUTURE RESEARCH

Future projects in the area of help seeking and rainbow women, particularly in the context of depression and anxiety are suggested here.

beyondblue has recently set their agenda to work within the following four domains: Places (community infrastructure, workplace, education, home), Interventions (prevention, early intervention, active intervention, recovery), Platform to reach people (broadcast, print, digital), and Influences (self, relationships, communities, society). We suggest that the project ideas arising from the current project fall best into the fourth domain, although we have also recommended one intervention study.

**Domain 2: Interventions**

- **Early intervention**
  1. Research that examines the impact of high LGBTI sensitivity in mainstream health services (particularly general practice and other primary care services) on the mental health and wellbeing of rainbow women. This may include formal evaluations of services that have systematically received training such as Headspaces, and aged care services.
    
    *Rationale* - although LGBTI sensitivity is clearly an enabler of access to mainstream health care and a preference amongst most rainbow women, there is little existing evidence regarding the actual effect on the outcomes in terms of continuity of care, earlier presentation of illness, or improved health outcomes.

**Domain 4: Influences (the context in which the intervention works)**

- **Self (changing personal behaviour, targeting biological and personal history factors)**

  2. Research that explores the relationship between gender and help seeking in relation to people with diverse genders that intersect with diverse expressions of sexual orientation. A question could be
    
    - How do diverse expressions of gender or gender transition influence gendered help seeking behaviours including self-care, caring for others, seeking informal and formal support?

  3. Research to understand resilience for rainbow women, particularly what it looks like and how it is developed. A question could be
    
    - What are the modifiable factors that contribute to resilience for rainbow women in the face of discrimination?
- **Relationships (changing behaviour of person’s closest social circle)**

4. Enhancing peer support amongst rainbow women – a project that evaluates the effectiveness in terms of improved health and wellbeing of participants attending peer support groups. Questions include
   - Does peer group facilitator training improve the effectiveness of a peer support group?
   - What is the role of peer group rule setting in improving group functioning?
   - What are sustainable funding models for peer support groups in the LGBTI communities?

- **Communities (seeking to challenge community social and cultural norms and the way individuals in a community behave)**

5. Methods to embrace diversity within rainbow women communities, a concept that could be termed diversity literacy. This would be a community-led project exploring how to increase engagement of marginalised rainbow women and reduce identity policing with LGBTI community groups and settings.

- **Society (social advocacy, natural environments etc.)**

6. Ongoing evaluated campaigns to influence general social attitudes (and specifically health provider attitudes) about rainbow women.
3.6 REFERENCES


