Author/s:
Gonçalves, CC;Lin, A;Hill, AO;Bourne, A;McNair, R;Amos, N;Lekamlage, DH;Haddad, PM;Williams, LJ;Yung, AR

Title:
Health service experiences of LGBTQA+ adults in Australia with psychotic disorders, common mental disorders and physical health conditions: Findings from the Private Lives 3 national survey

Date:
2025-01-01

Citation:
Gonçalves, C. C., Lin, A., Hill, A. O., Bourne, A., McNair, R., Amos, N., Lekamlage, D. H., Haddad, P. M., Williams, L. J. & Yung, A. R. (2025). Health service experiences of LGBTQA+ adults in Australia with psychotic disorders, common mental disorders and physical health conditions: Findings from the Private Lives 3 national survey. Australian and New Zealand Journal of Psychiatry, 60 (2), pp.148-159. https://doi.org/10.1177/00048674251387877.

Persistent Link:
https://hdl.handle.net/11343/368203

ANZJP

Australian & New Zealand Journal of Psychiatry
2026, Vol. 60(2) 148–159
DOI: 10.1177/00048674251387877

Health service experiences of LGBTQA+ adults in Australia with psychotic disorders, common mental disorders and physical health conditions: Findings from the *Private Lives 3* national survey

Cláudia C Gonçalves[1], Ashleigh Lin[2], Adam O Hill[3,4], Adam Bourne[3,5], Ruth McNair[6], Natalie Amos[3], Dulari Hakamuwa Lekamlage[1], Peter M Haddad[1], Lana J Williams[1] and Alison R Yung[1,7]

Abstract

Background: Lesbian, gay, bisexual, transgender, queer or questioning, asexual or aromantic and more (LGBTQA+) populations face disparities in health outcomes, which are particularly pronounced in relation to mental health. While psychotic disorders are associated with added barriers to treatment, they are rarely included in conversations around improving healthcare for LGBTQA+ individuals. The present study compared the healthcare experiences reported by LGBTQA+ individuals with psychotic disorders, common mental disorders (anxiety and depressive disorders) and physical health conditions.

Methods: A large online cross-sectional survey of LGBTQA+ adults in Australia was completed by 6835 individuals: 84 diagnosed with psychotic disorders, 521 diagnosed only with common mental disorders and 318 diagnosed only with common physical health conditions. Logistic regression analyses were used to investigate the association between diagnostic groups and health service access, service satisfaction and perceived respect for identity, and the importance of service LGBTQA+ inclusivity.

Results: Compared to those with psychotic disorders and common mental disorders, participants with physical health conditions were more likely to access mainstream clinics that are not explicitly LGBTQA+ inclusive and demonstrated a trend towards lower importance of service LGBTQA+ inclusivity. Participants with psychosis reported lower levels of respect for gender identity in LGBTQA+ inclusive services than those with common mental disorders.

Discussion: Differences in healthcare experiences between LGBTQA+ participants with physical health conditions, common mental disorders and psychotic disorders are present but not marked. Findings highlight a need for improved LGBTQA+ competencies in mainstream services and resource allocation to community-led services. Further research is needed to explore the factors contributing to worsened healthcare experiences for individuals with psychosis.

Keywords

LGBT, mental health, health disparities, inclusive healthcare, psychotic disorders

Background

The Australian Government recently released the National Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025–2035 (Department of Health and Aged Care, 2024), which acknowledges there are significant discrepancies in health outcomes and healthcare access for people in Australia who are LGBTQA+ (lesbian, gay, bisexual,

transgender, queer or questioning, asexual or aromantic and more). Indeed, although epidemiological findings are often conflicting, there is some evidence for a range of poor physical health outcomes in LGBTQA+ populations worldwide compared to their peers. These include poorer self-reported general health (Lick et al., 2013; Smith-Johnson, 2024), higher prevalence of asthma (Landers et al., 2011), chronic obstructive pulmonary disease (COPD) (Maniar and Drummond, 2024), cardiovascular disease (Caceres et al., 2020), diabetes (Beach et al., 2018), fibromyalgia (Driban et al., 2024) and various cancer diagnoses (Quinn et al., 2015), as well as higher adjusted all-cause mortality (Wallace and Santacruz, 2017). Despite the increased visibility and mainstream acceptance of LGBTQA+ identities, disparities across many health outcomes do not seem to be abating (Liu and Reczek, 2021; Reback et al., 2018; Russell and Fish, 2019).

Health disparities appear especially pronounced when it comes to the mental health of LGBTQA+ populations (Hill et al., 2020; Mongelli et al., 2019; Russell and Fish, 2016). There is strong evidence for disproportionate levels of psychological distress and rates of psychiatric diagnoses in non-heterosexual (Chakraborty et al., 2011; Cochran et al., 2003) and trans or gender-diverse individuals (Wang et al., 2024; Zimmerman et al., 2022). Most existing literature on diagnostic prevalence has focused on common mental disorders, finding increased rates of anxiety and depression across the LGBTQA+ community (Bostwick et al., 2010; Gmelin et al., 2022; King et al., 2008; Pinna et al., 2022; Plöderl and Tremblay, 2015; Ross et al., 2018; Strauss et al., 2020). However, there is growing evidence that discrepancies in illness prevalence extend to, and may be larger in, psychotic disorders such as schizophrenia (Kidd et al., 2016; Peta, 2020; Wanta et al., 2019). This is especially marked for trans and gender-diverse individuals, with a large literature review finding they are 2.46–49.7 times more likely than their cisgender peers to receive a diagnosis of a psychotic disorder (Barr et al., 2021). Diagnostic rates may also be higher for sexual minority individuals compared to heterosexual people, as the prevalence of psychotic-like experiences (PLEs) appears disproportionate in this group (Chakraborty et al., 2011; Gevonden et al., 2014; Jacob et al., 2021; Sageot et al., 2025).

The worsened health outcomes found in LGBTQA+ individuals may be partly explained by minority stress theory (Meyer, 1995). This framework proposes that continuous experiences of personal and systemic victimisation can lead to heightened vigilance, the internalisation of stigma, expectations of rejection and pressure to conceal one's identity, which can then contribute to chronic stress and worsened health (Frost and Meyer, 2023). This is supported by research in LGBTQA+ communities which points to minority stress as a predictor for poor outcomes in physical (Lick et al., 2013) and mental health (Mongelli et al., 2019). Notably, there is evidence that the increased hypervigilance and chronic stress arising from experiences of discrimination may increase the risk of psychosis, with this potentially being a dose–response relationship (Pearce et al., 2019). Minority stress factors such as stigma and discrimination are also associated with delays in access to healthcare (Ayhan et al., 2020; Correll-King et al., 2024; Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011; Romanelli and Hudson, 2017), which can then further promote poor health outcomes (Seelman et al., 2017).

It is likely that barriers to accessing mental health services are larger than those for accessing physical healthcare given the complicated history between psychiatry and LGBTQA+ identities. Homosexuality featured in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1973 and some conditions related to same-sex attraction were not removed until 1987 (Russell and Fish, 2016); asexual identities are still often medicalised through diagnoses of hypoactive sexual desire disorder (Van Dyk, 2023); diagnoses of 'transsexualism' were included until 1994 and gender identity disorder until 2013, with gender dysphoria still featuring as a required diagnosis for many to access gender-affirming care (Russell and Fish, 2016). This is compounded by the fact that mental health professionals can pathologise the gender expression of trans individuals, with gender dysphoria historically being seen as evidence of delusional thinking (Barr et al., 2021).

It is therefore unsurprising that LGBTQA+ individuals are more likely than their cisgender heterosexual peers to avoid help-seeking and report unmet needs for mental

[1]Institute for Mental and Physical Health and Clinical Translation, School of Medicine, Deakin University, Geelong, VIC, Australia
[2]School of Population and Global Health, The University of Western Australia, Perth, WA, Australia
[3]Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University, Melbourne, VIC, Australia
[4]Department of Global and Community Health, School of Nursing, Nagoya City University, Nagoya, Japan
[5]Kirby Institute, UNSW Sydney, Sydney, NSW, Australia
[6]Department of General Practice and Primary Care, The University of Melbourne, Melbourne, VIC, Australia
[7]School of Health Sciences, The University of Manchester, Manchester, UK

Current affiliation: **Ashleigh Lin** is now affiliated with Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University, Melbourne, VIC, Australia.

Corresponding author:
Cláudia C Gonçalves, Institute for Mental and Physical Health and Clinical Translation, Deakin University, Level 2, Health, Education and Research Building (HERB), 299 Ryrie Street, 3220 Geelong, VIC, Australia.
Email: c.goncalves@research.deakin.edu.au

healthcare (Peta, 2020; Steele et al., 2016). Even when accessing support, LGBTQA+ individuals often face stigma from providers (Ayhan et al., 2020; Clark et al., 2025) and have to experiment with multiple mental health services to find culturally competent care (Simeonov et al., 2015). This extends to Australia, with most trans and gender-diverse adults not feeling their gender identity was respected in mainstream medical services (Hill et al., 2023). Barriers to accessing appropriate support are further amplified for LGBTQA+ people with psychosis (Gonçalves et al., 2025), who are likely to experience intersecting stigma for both their identity and mental illness (O'Connor et al., 2018) and report low levels of service satisfaction overall (Kidd et al., 2016). However, differences in satisfaction between LGBTQA+ individuals and their peers appear to be mitigated in psychiatric services that have good LGBTQA+ competencies (Plöderl et al., 2022; Schuller and Crawford, 2022; Simeonov et al., 2015). This points to the importance of explicit and intentional LGBTQA+ inclusivity in health services.

Overall, LGBTQA+ individuals experience barriers to timely access to healthcare, report lower levels of satisfaction with services and are often not met with respect for their identities. This seems especially prevalent in mental health services, particularly for individuals experiencing psychosis, but mitigated in services known to be LGBTQA+ inclusive, for example, those in Australia following the Rainbow Tick framework (Jones et al., 2020). While efforts are being made to improve access of LGBTQA+ populations to physical and mental health services (Charles et al., 2015; Department of Health and Aged Care, 2024; Furness et al., 2020; Russell and Fish, 2016), psychotic disorders are rarely included in the conversation despite being associated with the highest stigmatisation of mental illnesses and significant barriers to care (Mannarini et al., 2022). There are a limited number of LGBTQA+ community-led services in Australia which target mental health (with their focus mostly including wellbeing and suicide prevention), alcohol and other drug use, sexual health and trans-specific healthcare. However, we are not aware of any LGBTQA+-specific services targeting severe mental illness. It is therefore necessary to explore differences in health service experience outcomes across diagnostic groups to determine whether individuals with psychosis are receiving comparable levels of care. Furthermore, it is important to understand which types of services are being accessed by LGBTQA+ people for various health issues and whether the care provided is aligned with their expectations of LGBTQA+ inclusivity. Thus, the present study aims to compare three groups of LGBTQA+ individuals, namely those with psychosis, common mental disorders and common physical health conditions, in terms of their access to and experiences with different types of health services.

Methods

Sample and procedure

This study uses secondary data from the *Private Lives 3* national survey (Hill et al., 2020), which was conducted between July and October 2019 and included responses from 6835 lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual or aromantic, and more (LGBTQIA+) adults. Participants were recruited across all Australian states and territories via social media advertisement and promotion through LGBTQIA+ community organisations. The present study includes data from a subsample of 923 participants, comprising 84 individuals who reported lifetime diagnoses of psychotic disorders (schizophrenia, schizoaffective disorder and/or unspecified psychosis), 521 who reported only lifetime diagnoses of common mental disorders (depression and/or generalised anxiety disorder) and 318 who reported only diagnoses of common physical health conditions (diabetes, osteoarthritis, rheumatoid arthritis, other arthritis, heart disease, stroke, asthma, emphysema and/or cancer). To ensure groups were independent, participants were excluded from the latter two groups if they reported any other health diagnoses. The *Private Lives 3* survey received ethics approval from the La Trobe University Human Research Ethics Committee (HEC19108).

Measures

Demographics. To determine sexual orientation, participants were asked to select an identity term that best described them from a list of options. Participants were categorised based on their responses as 'lesbian', 'gay', 'bisexual', 'pansexual', 'queer', 'asexual' or 'something else'. For gender identity, participants were asked to indicate the sex on their original birth certificate and to select a gender term that most closely described them from a list of options. Participants were then categorised as 'cisgender man', 'cisgender woman', 'trans man', 'trans woman' or 'non-binary'. Additional participant demographics collected included age, residential location, highest level of education completed, country of birth and Aboriginal or Torres Strait Islander ancestry.

Mental health. Participants were asked, 'Have you ever been diagnosed with any of the following?', with options including depression, generalised anxiety disorder, post-traumatic stress disorder (PTSD), bipolar disorder, panic disorder, social phobia, agoraphobia, obsessive-compulsive disorder (OCD), schizophrenia, eating disorder or other mental health challenges (with open text). Schizophrenia and relevant open-text responses (including schizoaffective disorder and unspecified psychosis) were combined into a 'psychosis' variable. Depression and generalised anxiety disorder were combined into a

comparison 'common mental disorders' variable which excluded participants with any other mental health disorders or physical health disorders.

Physical health. Participants were asked, 'In the past 12 months, have you been diagnosed with or treated for the following conditions?', with options including diabetes, impaired glucose tolerance, osteoarthritis, rheumatoid arthritis, other arthritis, heart disease, thrombosis, hypertension, stroke, low iron level, asthma, emphysema, osteoporosis/osteopenia, cancer, Chronic Fatigue Syndrome/myalgic encephalomyelitis, sexually transmitted infection (not including HIV), viral hepatitis A or B, viral hepatitis C, HIV or other major illness (open text). To ensure that only common physical health conditions were included in the comparison group, a new variable was created to identify participants who reported one or more of the physical health conditions covered in the latest Australian census (Australian Bureau of Statistics (ABS), 2022). These were diabetes, osteoarthritis, rheumatoid arthritis, other arthritis, heart disease, stroke, asthma, emphysema and cancer, and excluded any mental health conditions.

Service access. Participants were asked to indicate which services they had used in the past 12 months from a list of options. The services included in analyses were mainstream medical clinic, mainstream medical clinic that is known to be lesbian, gay, bisexual, transgender, intersex, queer or questioning (LGBTIQ)-inclusive, medical clinic that only caters to LGBTIQ people, mainstream mental health service, mainstream mental health service that is known to be LGBTIQ-inclusive, and mental health service that only caters to LGBTIQ people. Participants were able to choose more than one option if applicable. Binary yes/no variables were created to capture whether participants had accessed any relevant services (i.e. any mental health service for the psychosis and common mental disorders groups and any physical health service for the physical health group) and specific service types (i.e. relevant mainstream, LGBTIQ-inclusive mainstream and LGBTIQ-specific services).

Satisfaction with mental health services. Participants who sought professional mental health treatment in the past 12 months from a mainstream service, a mainstream service that is known to be LGBTIQ-inclusive and/or a service that only caters to LGBTIQ people were asked to rate their satisfaction which each relevant type of service. Responses were recorded on a 5-point Likert-type scale ranging from 'very dissatisfied' to 'very satisfied'. For the purposes of statistical analyses, responses were dichotomised into satisfied ('very satisfied' or 'somewhat satisfied') and not satisfied ('neutral', 'somewhat dissatisfied' or 'very dissatisfied'). This approach has been used in other studies using this data set (e.g. Grant et al., 2024; Lim et al., 2024).

Respect for sexual orientation and gender identity. Help-seeking participants coded as non-heterosexual were asked, 'In the past 12 months to what extent did you feel your sexual orientation was respected when seeking or receiving care from these services?' In addition, help-seeking participants coded as gender diverse were asked, 'In the past 12 months to what extent did you feel your gender identity was respected when seeking or receiving care?' For each question, participants were asked to rate each relevant service type on a 5-point Likert-type scale ranging from 'not at all respected' to 'extremely respected'. Responses were dichotomised into very respected ('extremely respected' or 'very respected') and not very respected ('somewhat respected', 'a little respected' or 'not at all respected').

Importance of LGBTIQ inclusivity in services. Participants were asked the question, 'How important is it to you that a health service or support service you use is known to be LGBTIQ-inclusive?' Responses were recorded on a 5-point Likert-type scale from 'not at all important' to 'extremely important'. These were then dichotomised into very important ('extremely important' or 'very important') and not very important ('somewhat important', 'a little important' or 'not at all important').

Statistical analyses

Statistical analyses were conducted using STATA (Version 18 SE; StataCorp, 2023) and R (R Core Team, 2025). Descriptive statistics were used to describe the sociodemographic characteristics of the study participants. Participants were grouped according to whether they reported (1) a lifetime diagnosis of a psychotic disorder ('psychosis' group), (2) a lifetime diagnosis of depression and/or generalised anxiety disorder and no other mental health or physical health conditions ('common mental disorders' group) or (3) a recent diagnosis of a common physical health condition and no mental health conditions ('physical health conditions' group). Chi-square tests for independence were conducted to examine the associations between diagnostic groups and demographic characteristics. Univariable (unadjusted) and multivariable (adjusted) logistic regression analyses were performed to test the association between reported diagnoses and health service experience outcomes. All sociodemographic variables reported were included as confounders in the adjusted models. Outcome variables included (1) access to any relevant services (i.e. mental health services for the psychosis and common mental disorders groups, and physical health services for the physical health group), (2) access to different service types, (3) satisfaction with each service type, (4) perceived respect for sexual orientation and gender identity in each service type and (5) importance given to LGBTIQ inclusivity in services. Analyses for outcomes (1) and (5) were conducted

with all participants, and all others were conducted with help-seeking participants only (i.e. those reporting access to any relevant services). Unadjusted odds ratios (ORs) and adjusted odds ratios (AORs) are reported using the physical health group for all-group comparisons, and the common mental disorders group for comparisons with the psychosis group on service satisfaction. Marginal effects were calculated using the marginal effects R package (Arel-Bundock et al., 2024) to estimate marginally adjusted risk ratios (RRs). Across analyses, 95% confidence intervals (CIs) and $p < 0.05$ were used to assess statistical significance. Missing values were not inferred.

Results

Demographics

A total of 923 LGBTQA+ individuals were included in the study sample. Detailed sample characteristics are presented in Table 1. These are stratified by diagnostic group and include chi-square p-values for differences between groups. Demographic information for the entire *Private Lives 3* sample of 6835 participants has been described elsewhere (Hill et al., 2020). The participants in the present study sub-sample ranged in age from 18 to 85 years, with a mean age of 36.36 (SD = 15.31). The majority were born in Australia (84.3%), lived in a capital city (66.3%), had completed a form of tertiary education (73.7%) and did not have Aboriginal or Torres Strait Islander ancestry (98.0%). There was wide variety in sexual orientation, with most participants being coded as lesbian (21.6%), gay (30.1%) or bisexual (19.7%). For gender, most participants were coded as cisgender (77.5%), with 22.5% coded as gender diverse (i.e. trans or non-binary).

Access to services

Table 2 presents the results of the logistic regression analyses exploring associations between diagnostic groups and access to services. Compared to participants with recent physical health diagnoses, those with lifetime psychosis and common mental disorders were less likely to choose a mainstream service or access any service in the last 12 months. There were no significant differences in service access between the psychosis and common mental disorders groups.

Satisfaction with mental health services

Table 3 presents the results of the logistic regression analyses exploring associations between mental health diagnosis and satisfaction with each service type accessed. Participants with psychosis reported a lower percentage of high satisfaction than those with common mental disorders across all service types, but differences between the groups were not statistically significant.

Respect for sexual orientation and gender identity in services accessed

Table 4 presents the results of the logistic regression analyses exploring associations between diagnostic groups and reported respect for sexual orientation and gender identity in each service type accessed. Participants with lifetime common mental disorders were more likely than those with recent physical health diagnoses to report high levels of respect in mainstream services for both their sexual orientation and gender identity when controlling for confounders. In addition, unadjusted analyses suggested that participants with lifetime psychosis were marginally less likely than the physical health group to report high respect for sexual orientation and gender identity in LGBTIQ-inclusive services. However, neither of these comparisons was significant when controlling for confounders.

When directly comparing participants with common mental disorders to those with psychosis, the latter reported lower levels of respect for gender identity in LGBTIQ-inclusive services (RR = 0.65, CI = [0.43, 0.99]; ARR = 0.65, CI = [0.47, 0.91]). In addition, unadjusted analyses suggested that participants with psychosis reported lower levels of respect for sexual orientation than those with common mental disorders in mainstream services (RR = 0.77, CI = [0.61, 0.97]) and LGBTIQ-inclusive services (RR = 0.82, CI = [0.66, 0.97]), though differences were no longer significant when controlling for confounders.

Importance of LGBTQA+ inclusivity

Table 5 presents the results of the logistic regression analyses exploring associations between diagnostic groups and the importance given to LGBTQA+ inclusivity in health services. Participants with lifetime psychosis and common mental disorders were more likely to place high importance on LGBTQA+ inclusivity in services than those with recent physical health diagnoses. While there was a higher percentage of participants with psychosis than those with common mental disorders reporting inclusivity as very important, this difference was not statistically significant.

Discussion

Drawing from a sample of 923 LGBTQA+ adults in Australia, this study found that individuals with lifetime psychotic disorders report similar or worse experiences with healthcare to those with lifetime common mental disorders and recent physical health diagnoses. In addition, LGBTQA+ inclusivity in healthcare seems to be more

Table 1. Sample characteristics, stratified by diagnostic groups.

	Physical health conditions	Common mental disorders	Psychosis	Chi-square	Total
N (%)	318 (34.5%)	521 (56.4%)	84 (9.1%)	p	923 (100.0%)
Sexual orientation				<0.001	
Lesbian	84 (26.6%)	97 (18.6%)	18 (21.4%)		199 (21.6%)
Gay	137 (43.4%)	131 (25.1%)	9 (10.7%)		277 (30.1%)
Bisexual	43 (13.6%)	123 (23.6%)	15 (17.9%)		181 (19.7%)
Pansexual	10 (3.2%)	49 (9.4%)	6 (7.1%)		65 (7.1%)
Queer	13 (4.1%)	68 (13.1%)	16 (19.0%)		97 (10.5%)
Asexual	6 (1.9%)	17 (3.3%)	6 (7.1%)		29 (3.1%)
Something else	23 (7.3%)	36 (6.9%)	14 (16.7%)		73 (7.9%)
Gender[a]				<0.001	
Cisgender man	164 (51.7%)	164 (31.6%)	15 (18.3%)		343 (37.4%)
Cisgender woman	117 (36.9%)	223 (43.0%)	28 (34.1%)		368 (40.1%)
Trans man	5 (1.6%)	23 (4.4%)	6 (7.3%)		34 (3.7%)
Trans woman	11 (3.5%)	33 (6.4%)	8 (9.8%)		52 (5.7%)
Non-binary	20 (6.3%)	76 (14.6%)	25 (30.5%)		121 (13.1%)
Age				<0.001	
18-24	51 (16.0%)	169 (32.4%)	43 (51.2%)		263 (28.5%)
25-34	51 (16.0%)	177 (34.0%)	21 (25.0%)		249 (27.0%)
35-44	45 (14.2%)	87 (16.7%)	9 (10.7%)		141 (15.3%)
45-54	69 (21.7%)	59 (11.3%)	5 (6.0%)		133 (14.4%)
55-64	55 (17.3%)	25 (4.8%)	4 (4.8%)		84 (9.1%)
65+	47 (14.8%)	4 (0.8%)	2 (2.4%)		53 (5.7%)
Residential location[a]				.104	
Capital city, inner suburban	139 (44.1%)	213 (41.2%)	29 (34.5%)		381 (41.6%)
Capital city, outer suburban	70 (22.2%)	152 (29.4%)	32 (38.1%)		254 (27.7%)
Regional city or town	80 (25.4%)	119 (23.0%)	18 (21.4%)		217 (23.7%)
Rural/remote	26 (8.3%)	33 (6.4%)	5 (6.0%)		64 (7.0%)
Highest education-level report				<0.001	
Secondary or below	62 (19.5%)	147 (28.2%)	34 (40.5%)		243 (26.3%)
Non-university tertiary	63 (19.8%)	117 (22.5%)	24 (28.6%)		204 (22.1%)
University-undergraduate	83 (26.1%)	147 (28.2%)	16 (19.0%)		246 (26.7%)
University-postgraduate	110 (34.6%)	110 (21.1%)	10 (11.9%)		230 (24.9%)
Country of birth[a]				0.001	
Australia	249 (78.5%)	449 (86.3%)	78 (92.9%)		776 (84.3%)
Overseas	68 (21.5%)	71 (13.7%)	6 (7.1%)		145 (15.7%)
Any Aboriginal or Torres Strait Islander ancestry[a]				0.005	
No	311 (97.8%)	512 (98.7%)	80 (95.2%)		903 (98.0%)
Yes	7 (2.2%)	7 (1.3%)	4 (4.8%)		18 (2.0%)

[a]Data do not add up to the total for each group due to missing values.

important for individuals seeking help for lifetime mental health disorders than those with recent physical health diagnoses.

The finding that participants with physical health conditions had the highest percentage of access to services in the previous 12 months is unsurprising given every participant

Table 2. Associations between diagnostic groups and access to relevant service types in the past 12 months.

		Unadjusted univariable	Adjusted multivariable[b]
	N (%)[a]	RR (95% CI)	ARR (95% CI)
Access to any relevant services			
Physical health conditions	307 (96.5%)	Ref	Ref
Common mental disorders	459 (88.1%)	0.91 (0.88-0.95)	0.90 (0.86-0.94)
Psychosis	73 (86.9%)	0.90 (0.83-0.98)	0.91 (0.83-0.99)
Access to mainstream services			
Physical health conditions	260 (84.7%)	Ref	Ref
Common mental disorders	342 (74.5%)	0.88 (0.82-0.95)	0.87 (0.80-0.94)
Psychosis	54 (74.0%)	0.87 (0.76-1.01)	0.83 (0.71-0.98)
Access to LGBTIQ-inclusive mainstream services			
Physical health conditions	87 (28.3%)	Ref	Ref
Common mental disorders	141 (30.7%)	1.08 (0.87-1.36)	1.09 (0.85-1.40)
Psychosis	27 (37.0%)	1.31 (0.92-1.85)	1.32 (0.91-1.92)
Access to LGBTIQ-specific services			
Physical health conditions	15 (4.9%)	Ref	Ref
Common mental disorders	28 (6.1%)	1.25 (0.68-2.30)	1.18 (0.61-2.29)
Psychosis	4 (5.5%)	1.12 (0.38-3.28)	1.19 (0.39-3.64)

RR: risk ratio; CI: confidence interval; ARR: adjusted risk ratio; Ref: reference category.
[a]Percentage of participants in each diagnostic group who accessed any services and percentage of help-seekers in each diagnostic group who accessed the specified service type.
[b]Adjusted for differences in sexual orientation, gender, age, residential location, highest education level reported, country of birth and Aboriginal or Torres Strait Islander ancestry.

Table 3. Associations between mental health diagnosis and satisfaction with mental health services.

		Unadjusted univariable	Adjusted multivariable[b]
	N (%)[a]	RR (95% CI)	ARR (95% CI)
Satisfied with mainstream services			
Common mental disorders	232 (67.8%)	Ref	Ref
Psychosis	34 (63.0%)	0.93 (0.75-1.15)	0.98 (0.80-1.20)
Satisfied with LGBTIQ-inclusive mainstream services			
Common mental disorders	130 (92.2%)	Ref	Ref
Psychosis	22 (81.5%)	0.88 (0.73-1.06)	0.95 (0.82-1.10)
Satisfied with LGBTIQ-specific services[c]			
Common mental disorders	26 (92.9%)	Ref	Ref
Psychosis	2 (50.0%)	0.54 (0.20-1.44)	-

RR: risk ratio; CI: confidence interval; ARR: adjusted risk ratio; Ref: reference category.
[a]Percentage of participants in each diagnostic group who reported that they were 'very satisfied' or 'somewhat satisfied' with the specified service type.
[b]Adjusted for differences in sexual orientation, gender, age, residential location, highest education level reported, country of birth and Aboriginal or Torres Strait Islander ancestry.
[c]Adjusted multivariable model was not fitted due to lack of observations;

in this group received a diagnosis during that period. However, participants with lifetime diagnoses of common mental disorders were equally, if not more, likely to access mental health services as those with lifetime psychotic disorders. This is perhaps surprising given psychotic disorders are often chronic and may require sustained treatment (Keks and Hope, 2007). In addition, participants with psychosis were significantly younger, meaning that diagnoses were likely more recent. Subsequently, the similar rates of service access between the two groups may reflect the high

Table 4. Associations between diagnoses and respect for sexual orientation and gender identity in services.

		Unadjusted univariable	Adjusted multivariable[b]
	N (%)[a]	RR (95% CI)	ARR (95% CI)
Sexual orientation very respected			
In mainstream services			
Physical health conditions	173 (68.1%)	Ref	Ref
Common mental disorders	180 (77.9%)	1.14 (1.03-1.28)	1.31 (1.16-1.47)
Psychosis	31 (59.6%)	0.88 (0.69-1.11)	1.16 (0.95-1.40)
In LGBTIQ-inclusive mainstream services			
Physical health conditions	82 (95.3%)	Ref	Ref
Common mental disorders	117 (93.6%)	0.98 (0.92-1.05)	1.10 (0.94-1.27)
Psychosis	20 (76.9%)	0.81 (0.65-1.00)	1.03 (0.83-1.27)
In LGBTIQ-specific services[c]			
Physical health conditions	11 (84.6%)	Ref	Ref
Common mental disorders	19 (95.0%)	1.21 (0.90-1.62)	-
Psychosis	4 (80.0%)	1.02 (0.61-1.71)	-
Gender identity very respected			
In mainstream services			
Physical health conditions	22 (61.1%)	Ref	Ref
Common mental disorders	39 (66.1%)	1.08 (0.79-1.49)	1.50 (1.04-2.18)
Psychosis	10 (47.6%)	0.78 (0.46-1.31)	1.28 (0.80-2.05)
In LGBTIQ-inclusive mainstream services			
Physical health conditions	12 (92.3%)	Ref	Ref
Common mental disorders	48 (92.3%)	1.00 (0.84-1.19)	1.05 (0.76-1.46)
Psychosis	9 (60.0%)	0.65 (0.42-1.01)	0.69 (0.45-1.05)
In LGBTIQ-specific services[c]			
Physical health conditions	2 (66.7%)	Ref	Ref
Common mental disorders	12 (92.3%)	1.38 (0.61-3.13)	-
Psychosis	3 (75.0%)	1.12 (0.42-3.00)	-

RR: risk ratio; CI: confidence interval; ARR: adjusted risk ratio; Ref: reference category.
[a]Percentage of participants in each diagnostic group who reported that their identity was 'extremely respected' or 'very respected'.
[b]Adjusted for differences in sexual orientation, gender, age, residential location, highest education level reported, country of birth and Aboriginal or Torres Strait Islander ancestry.
[c]Adjusted multivariable model was not fitted due to lack of observations.

Table 5. Associations between diagnoses and importance given to LGBTQA+ inclusivity in health services.

		Unadjusted univariable	Adjusted multivariable[b]
	N (%)[a]	RR (95% CI)	ARR (95% CI)
LGBTQA+ inclusivity very important			
Physical health conditions	184 (57.9%)	Ref	Ref
Common mental disorders	349 (67.1%)	1.16 (1.04-1.30)	1.11 (0.98-1.24)
Psychosis	61 (72.6%)	1.26 (1.07-1.47)	1.20 (1.01-1.42)

RR: risk ratio; CI: confidence interval; ARR: adjusted risk ratio; Ref: reference category; LGBTQA: lesbian, gay, bisexual, transgender, queer or questioning, asexual or aromantic and more.
[a]Percentage of participants in each diagnostic group who reported that it was 'extremely important' or 'very important' to them that a health service they use is LGBTIQ-inclusive.
[b]Adjusted for differences in sexual orientation, gender, age, residential location, highest education level reported, country of birth and Aboriginal or Torres Strait Islander ancestry.

rates of treatment disengagement and barriers to sustained care found in those with psychosis (Gonçalves et al., 2025; Kane et al., 2013).

In terms of service type, participants in the physical health group were more likely than both other groups to access mainstream health services. While this difference could be due to higher rates of health service access overall, it did not extend to services that are LGBTIQ-inclusive/specific. Relatedly, individuals with physical health conditions reported the lowest importance for health services being LGBTQA+ inclusive. LGBTQA+ identity may not be relevant in many physical health settings, whereas it is generally an important factor for mental health help-seeking (Rees et al., 2021; Schuller and Crawford, 2022). Identity not coming up may also explain why participants in this group were less likely than those with common mental disorders to report feeling that their identity was 'very' or 'extremely' respected in mainstream services. However, the choice of mainstream services may also reflect a paucity of physical healthcare that is explicitly LGBTQA+ inclusive.

While group differences were not large enough to reach statistical significance, there was a slight gradient in relation to the percentage of participants accessing LGBTIQ-inclusive mainstream services, with participants with lifetime psychotic disorders at the highest end of access and those with recent physical health diagnoses at the lowest. This suggests individuals with psychosis may be more likely to seek LGBTQA+ affirming care, in line with this group having the highest percentage rating LGBTQA+ inclusivity in services as very important. However, there were very low numbers of participants accessing LGBTIQ-specific services across all health groups, suggesting these are not an option for most Australians. Overall, these findings illustrate an unmet need for access to LGBTQA+ community-led health services. This likely disproportionately affects people with psychosis, for whom inclusivity is a higher priority despite often being excluded from community spaces due to illness complexity and intersectional stigma (Kidd et al., 2011; Pilling et al., 2017).

In line with the literature, we also observed a trend towards people with psychosis reporting lower perceived respect for sexual orientation and gender identity across service types (Ayhan et al., 2020; Clark et al., 2025). In mainstream services, just over half report high levels of respect for their sexual orientation, and less than half felt their gender identity was very respected. In addition, while differences were not significant, there was a lower percentage of participants with psychosis reporting high satisfaction across services. These findings highlight an unmet need for inclusivity and respect in health services for LGBTQA+ people with psychosis, which likely contributes to greater disparities for this group (Gonçalves et al., 2025; Kidd et al., 2016; Peta, 2020). For disparities to be reduced, a focus is needed on getting LGBTQA+ people with psychosis to feel welcomed to access and stay engaged with services. Considering the low rates of access to LGBTIQ-specific services paired with the high importance placed on inclusivity, a potential avenue would be to increase investment in community-led services that explicitly include people with psychotic disorders.

Limitations

The main limitation of this study is that for participants to have received health diagnoses, they had inevitably accessed relevant services in their lifetime. This may have skewed treatment access rates, as many participants were likely being followed up for health conditions and thus more likely to access services in the past 12 months. In addition, it means the survey did not capture people who have avoided accessing services when facing health difficulties, which is often the case for LGBTQA+ individuals in need of mental health support (Peta, 2020; Savill et al., 2022; Simeonov et al., 2015). However, service use outcomes being limited to the past 12 months may also have provided an insufficient timeframe to adequately capture long-term service engagement for individuals with chronic conditions. Another limitation is the fact that participants were not asked about the number of services accessed in the past 12 months. LGBTQA+ individuals often have to investigate multiple health services before accessing adequate treatment, particularly for their mental health (Simeonov et al., 2015). This means that participants who accessed numerous services of the same type to find one they were satisfied with may not have reported initial negative experiences. Similarly, the survey did not capture disengagement with services, which is known to be an issue for LGBTQA+ individuals with psychotic diagnoses (Gonçalves et al., 2025; Yang et al., 2021). Finally, this study employed a cross-sectional convenience sampling method. While this is commonly used in research for stigmatised and hard-to-reach populations including sexual minorities (Balakrishnan et al., 2022; Smith et al., 2016), the relatively small proportion of participants with psychotic disorders limited statistical power to unveil significant differences between groups.

Conclusion

While this study demonstrated that most LGBTQA+ survey responders with various health diagnoses are able to access care in Australia, there are differences in service access and experiences between LGBTQA+ adults with psychotic disorders, common mental disorders and physical health conditions. Overall, this study highlights the need for further research that specifically explores healthcare outcomes for LGBTQA+ people who experience psychosis, as there appears to be a discrepancy between their expectations for LGBTQA+ inclusivity and the reality of

their care. In terms of practice, LGBTQA+ competencies must be improved in mainstream health services to ensure respect for diverse identities, particularly in services providing mental healthcare. Recommendations have previously been made (Gonçalves et al., 2025) and include a shift towards holistic and affirming healthcare. Finally, there is a need for improved access to community-led mental health services that provide LGBTQA+ specific care across the spectrum of mental disorders. This highlights the necessity for increased availability of these services across a range of geographic areas and greater allocation of resources to LGBTQA+ health.

Acknowledgements

We wish to thank members of the *Private Lives 3* Expert Advisory Group and Gender Advisory Board, who supported this research and gave valuable support, advice and feedback at various stages of this study, as well as the many other individuals and organisations who gave assistance at different stages. We would also like to thank Marina Carman and Anthony Lyons for their contributions to *Private Lives 3*.

Author contributions

Cláudia C Gonçalves: Writing – review and editing; Writing – original draft; Visualisation; Project administration; Methodology; Formal analysis; Data curation; Conceptualisation.
Adam O Hill, Adam Bourne, Ruth McNair and Natalie Amos: Writing – review and editing; Investigation; Data curation.
Dulari K Jayarathna: Visualisation; Methodology; Formal analysis.
Peter M Haddad: Writing – review and editing.
Ashleigh Lin, Lana J Williams and Alison R Yung: Writing – review and editing; Supervision.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship and/or publication of this article: *Private Lives 3* was funded by the Victorian Government Department of Health and Human Services and the Victorian Government Department of Premier and Cabinet. C.C.G. is funded by a Deakin University Postgraduate Research (DUPR) Scholarship. A.L. is supported by a National Health and Medical Research Council (NHMRC) Emerging Leaders Fellowship (2010063). L.J.W. is supported by an NHMRC Emerging Leaders Fellowship (1174060). A.R.Y. is supported by an NHMRC Leaders Fellowship (2026339). The funding providers had no role in the design and conduct of the study or in the preparation, review or approval of this manuscript.

Ethical considerations

The *Private Lives 3* survey received ethics approval from the La Trobe University Human Research Ethics Committee (HEC19108).

Consent to participate

Not applicable.

Consent for publication

Not applicable.

ORCID iDs

Cláudia C Gonçalves https://orcid.org/0000-0001-6767-0920
Alison R Yung https://orcid.org/0000-0002-0401-9791

Data availability statement

The data that support the findings of this study are available upon reasonable request from the corresponding author. The data are not publicly available due to the sensitive nature of the survey and resulting privacy and ethical restrictions.

References

Arel-Bundock V, Greifer N and Heiss A (2024) How to interpret statistical models using marginal effects for R and Python. *Journal of Statistical Software* 111: 1–32.

Australian Bureau of Statistics (ABS) (2022) *Long-Term Health Conditions*. Available at: www.abs.gov.au/articles/long-term-health-conditions (accessed 19 August 2025).

Ayhan CHB, Bilgin H, Uluman OT, et al. (2020) A systematic review of the discrimination against sexual and gender minority in health care settings. *International Journal of Health Services: Planning, Administration, Evaluation* 50: 44–61.

Balakrishnan K, Haregu T, Hill AO, et al. (2022) Discrimination experienced by sexual minority males in Australia: Associations with suicidal ideation and depressive symptoms. *Journal of Affective Disorders* 305: 173–178.

Barr SM, Roberts D and Thakkar KN (2021) Psychosis in transgender and gender non-conforming individuals: A review of the literature and a call for more research. *Psychiatry Research* 306: 114272.

Beach LB, Elasy TA and Gonzales G (2018) Prevalence of self-reported diabetes by sexual orientation: Results from the 2014 behavioral risk factor surveillance system. *LGBT Health* 5: 121–130.

Bostwick WB, Boyd CJ, Hughes TL, et al. (2010) Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American Journal of Public Health* 100: 468–475.

Caceres BA, Streed CG, Corliss HL, et al. (2020) Assessing and addressing cardiovascular health in LGBTQ adults: A scientific statement from the American Heart Association. *Circulation* 142: e321–e332.

Chakraborty A, McManus S, Brugha TS, et al. (2011) Mental health of the non-heterosexual population of England. *The British Journal of Psychiatry: The Journal of Mental Science* 198: 143–148.

Charles C, Haaland M, Kulkarni A, et al. (2015) *Improving Healthcare for LGBTQ Populations*. Ottawa, ON, Canada: Canadian Federation of Medical Students (CFMS).

Clark KD, Jewell J, Sherman ADF, et al. (2025) Lesbian, gay, bisexual, transgender and queer people's experiences of stigma across the spectrum of inpatient psychiatric care: A systematic review. *International Journal of Mental Health Nursing* 34: e13455.

Cochran SD, Mays VM and Sullivan JG (2003) Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology* 71: 53–61.

Correll-King WM, Dusic EJ, Suen D, et al. (2024) Healthcare avoidance and delay among trans adults: Associations with mental and behavioral health outcomes. *American Journal of Preventive Medicine* 68: 726–734.

Department of Health and Aged Care (2024) *National Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025–2035*. Canberra, ACT, Australia: Department of Health and Aged Care, Australian Government.

Driban JB, Jesdale BM and McAlindon TE (2024) Embracing diversity: The imperative to represent the LGBTQIA+ community in rheumatology research. *The Journal of Rheumatology* 51: 112–113.

Frost DM and Meyer IH (2023) Minority stress theory: Application, critique, and continued relevance. *Current Opinion in Psychology* 51: 101579.

Furness BW, Goldhammer H, Montalvo W, et al. (2020) Transforming primary care for lesbian, gay, bisexual, and transgender people: A collaborative quality improvement initiative. *Annals of Family Medicine* 18: 292–302.

Gevonden MJ, Selten JP, Myin-Germeys I, et al. (2014) Sexual minority status and psychotic symptoms: Findings from the Netherlands Mental Health Survey and Incidence Studies (NEMESIS). *Psychological Medicine* 44: 421–433.

Gmelin J-OH, De Vries YA, Baams L , et al. (2022) Increased risks for mental disorders among LGB individuals: Cross-national evidence from the World Mental Health Surveys. *Social Psychiatry and Psychiatric Epidemiology* 57: 2319–2332.

Gonçalves CC, Waters Z, Quirk SE, et al. (2025) Barriers and facilitators to mental health care access and engagement for LGBTQA+ people with psychosis: A scoping review. *Psychiatry Research* 343: 116281.

Grant R, Amos N, Lyons A, et al. (2024) Out in Suburbia: Associations between residential location, mental health, and community connectedness among LGBTQ Australians. *Social & Cultural Geography* 25: 1272–1290.

Hill AO, Adam B, Ruth M, et al. (2020) *Private Lives 3: The Health and Wellbeing of LGBTIQ People in Australia*. Melbourne, VIC, Australia: Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University.

Hill AO, Cook T, McNair R, et al. (2023) Demographic and psychosocial factors associated with recent suicidal ideation and suicide attempts among trans and gender diverse people in Australia. *Suicide & Life-Threatening Behavior* 53: 320–333.

Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities (2011) *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (The National Academies Collection, Reports funded by National Institutes of Health). Washington, DC: National Academies Press.

Jacob L, Smith L, McDermott D, et al. (2021) Relationship between sexual orientation and psychotic experiences in the general population in England. *Psychological Medicine* 51: 138–146.

Jones J, Fairchild J, Carman M, et al. (2020) *Rainbow Tick Standards: A Framework for LGBTIQ Cultural Safety*. Bundoora, VIC, Australia: Rainbow Health Victoria, La Trobe University.

Kane JM, Kishimoto T and Correll CU (2013) Non-adherence to medication in patients with psychotic disorders: Epidemiology, contributing factors and management strategies. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)* 12: 216–226.

Keks NA and Hope J (2007) Long-term management of people with psychotic disorders in the community. *Australian Prescriber* 30: 44–46.

Kidd SA, Howison M, Pilling M, et al. (2016) Severe mental illness among LGBT populations: A scoping review. *Psychiatric Services* 67: 779–783.

Kidd SA, Veltman A, Gately C, et al. (2011) Lesbian, gay, and transgender persons with severe mental illness: Negotiating wellness in the context of multiple sources of stigma. *American Journal of Psychiatric Rehabilitation* 14: 13–39.

King M, Semlyen J, Tai SS, et al. (2008) A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry* 8: 70.

Landers SJ, Mimiaga MJ and Conron KJ (2011) Sexual orientation differences in asthma correlates in a population-based sample of adults. *American Journal of Public Health* 101: 2238–2241.

Lick DJ, Durso LE and Johnson KL (2013) Minority stress and physical health among sexual minorities. *Perspectives on Psychological Science: A Journal of the Association for Psychological Science* 8: 521–548.

Lim G, Bourne A, Hill A, et al. (2024) Community connection is associated with lower psychological distress for sexual minority women who view community connection positively. *Culture, Health & Sexuality* 26: 513–530.

Liu H and Reczek R (2021) Birth cohort trends in health disparities by sexual orientation. *Demography* 58: 1445–1472.

Maniar NT and Drummond MB (2024) From invisibility to inclusion: A call to action to address COPD disparities in the lesbian, gay, bisexual, transgender, and queer+ community. *Chronic Obstructive Pulmonary Diseases* 11: 326–330.

Mannarini S, Taccini F, Sato I, et al. (2022) Understanding stigma toward schizophrenia. *Psychiatry Research* 318: 114970.

Meyer IH (1995) Minority stress and mental health in gay men. *Journal of Health and Social Behavior* 36: 38–56.

Mongelli F, Perrone D, Balducci J, et al. (2019) *Minority Stress and Mental Health among LGBT Populations: An Update on the Evidence*. Torino: Edizioni Minerva Medica, pp. 27–50.

O'Connor LK, Pleskach P and Yanos P (2018) The experience of dual stigma and self-stigma among LGBTQ individuals with severe mental illness. *American Journal of Psychiatric Rehabilitation* 21: 167–187.

Pearce J, Rafiq S, Simpson J, et al. (2019) Perceived discrimination and psychosis: A systematic review of the literature. *Social Psychiatry and Psychiatric Epidemiology* 54: 1023–1044.

Peta JL (2020) Schizophrenia spectrum and other psychotic disorders among sexual and gender minority populations.In: Rothblum ED (ed.) *The Oxford Handbook of Sexual and Gender Minority Mental Health*. Oxford: Oxford University Press, pp. 125–134.

Pilling M, Howison M, Frederick T, et al. (2017) Fragmented inclusion: Community participation and lesbian, gay, bisexual, trans, and queer people with diagnoses of schizophrenia and bipolar disorder. *The American Journal of Orthopsychiatry* 87: 606–613.

Pinna F, Paribello P, Somaini G, et al. (2022) Mental health in transgender individuals: A systematic review. *International Review of Psychiatry* 34: 292–359.

Plöderl M and Tremblay P (2015) Mental health of sexual minorities. A systematic review. *International Review of Psychiatry* 27: 367–385.

Plöderl M, Mestel R and Fartacek C (2022) Differences by sexual orientation in treatment outcome and satisfaction with treatment among inpatients of a German psychiatric clinic. *PLoS One* 17: e0262928.

Quinn GP, Sanchez JA, Sutton SK, et al. (2015) Cancer and lesbian, gay, bisexual, transgender/transsexual, and queer/questioning populations (LGBTQ). *CA: A Cancer Journal for Clinicians* 65: 384–400.

R Core Team (2025) *R: A Language and Environment for Statistical Computing* (version 4.4.1). Vienna: R Foundation for Statistical Computing.

Reback CJ, Clark K, Holloway IW, et al. (2018) Health disparities, risk behaviors and healthcare utilization among transgender women in Los Angeles county: A comparison from 1998–1999 to 2015–2016. *AIDS and Behavior* 22: 2524–2533.

Rees SN, Crowe M and Harris S (2021) The lesbian, gay, bisexual and transgender communities' mental health care needs and experiences of mental health services: An integrative review of qualitative studies. *Journal of Psychiatric and Mental Health Nursing* 28: 578–589.

Romanelli M and Hudson KD (2017) Individual and systemic barriers to health care: Perspectives of lesbian, gay, bisexual, and transgender adults. *The American Journal of Orthopsychiatry* 87: 714–728.

Ross LE, Salway T, Tarasoff LA, et al. (2018) Prevalence of depression and anxiety among bisexual people compared to gay, lesbian, and

heterosexual individuals: A systematic review and meta-analysis. *Journal of Sex Research* 55: 435–456.

Russell ST and Fish JN (2016) Mental health in Lesbian, Gay, Bisexual, and Transgender (LGBT) youth. *Annual Review of Clinical Psychology* 12: 465–487.

Russell ST and Fish JN (2019) Sexual minority youth, social change, and health: A developmental collision. *Research in Human Development* 16: 5–20.

Sageot M, Myin-Germeys I, Achterhof R, et al. (2025) Examining psychosis risk in sexual minority youth: Increased exposure to and differential impact of the social envirome in early adolescence. *Schizophrenia Bulletin*. Epub ahead of print 2 January. DOI: 10.1093/schbul/sbae216.

Savill M, Nguyen T, Shim RS, et al. (2022) Online psychosis screening: Characterizing an underexamined population to improve access and equity. *Psychiatric Services* 73: 1005–1012.

Schuller KA and Crawford RP (2022) Impact of interpersonal client-provider relationship on satisfaction with mental healthcare among the LGBTQ+ population. *Journal of Mental Health* 31: 634–641.

Seelman KL, Colón-Diaz MJP, LeCroix RH, et al. (2017) Transgender noninclusive healthcare and delaying care because of fear: Connections to general health and mental health among transgender adults. *Transgender Health* 2: 17–28.

Simeonov D, Steele LS, Anderson S, et al. (2015) Perceived satisfaction with mental health services in the lesbian, gay, bisexual, transgender, and transsexual communities in Ontario, Canada: An internet-based survey. *Canadian Journal of Community Mental Health* 34: 31–44.

Smith BC, Armelie AP, Boarts JM, et al. (2016) PTSD, depression, and substance use in relation to suicidality risk among traumatized minority lesbian, gay, and bisexual youth. *Archives of Suicide Research: Official Journal of the International Academy for Suicide Research* 20: 80–93.

Smith-Johnson M (2024) Gender differences in self-assessed measures of health: How does the structure of self-rated health compare across transgender and cisgender groups? *Demography* 61: 2147–2175.

StataCorp (2023) *Stata Statistical Software: Release 18*. College Station, TX: StataCorp LLC.

Steele LS, Daley A, Curling D, et al. (2016) LGBT identity, untreated depression, and unmet need for mental health services by sexual minority women and trans-identified people. *Journal of Women's Health* 26: 116–127.

Strauss P, Cook A, Winter S, et al. (2020) Mental health issues and complex experiences of abuse among trans and gender diverse young people: Findings from trans pathways. *LGBT Health* 7: 128–136.

Van Dyk IS (2023) The 'A' is not for ally: The continued pathologization of asexual people in modern mental health practice. *The Behavior Therapist* 46: 337–342.

Wallace BC and Santacruz E (2017) Health disparities and LGBT populations. In: Ruth R and Santacruz E (eds) *LGBT Psychology and Mental Health: Emerging Research and Advances*. Santa Barbara, CA: Praeger/ABC-CLIO, pp. 177–195.

Wang YC, Hoatson T, Stamoulis C, et al. (2024) Psychological distress and suicidality among transgender young adults in the United States. *The Journal of Adolescent Health* 74: 1095–1105.

Wanta JW, Niforatos JD, Durbak E, et al. (2019) Mental health diagnoses among transgender patients in the clinical setting: An all-payer electronic health record study. *Transgender Health* 4: 313–315.

Yang R, Curtis J, Jensen C, et al. (2021) Detection and intervention in emerging youth mental health issues: Outcomes from the first year of the CASPAR service. *Early Intervention in Psychiatry* 15: 167–173.

Zimmerman M, Benjamin I and Seijas-Rodriguez C (2022) Psychiatric diagnoses among transgender and gender diverse patients compared to cisgender patients. *Journal of Clinical Psychiatry* 83: 21m14062.