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The Mental Health Experiences of LGBTIQA+ People, Kink-Oriented People, and Sex Workers in Rural and Remote Tasmania

By

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Declaration of Originality

I, Tamara Reynish, am the author of the thesis entitled The Mental Health Experiences of LGBTIQ+ People, Kink-Oriented People, and Sex Workers in Rural and Remote Tasmania, submitted for the degree of Doctorate of Philosophy. I declare that the material is original, and to the best of my knowledge and belief, contains no material previously published or written by another person, except where due acknowledgement is made in the text of the thesis, nor does the thesis contain any material that infringes copyright. The thesis contains no material which has been accepted for a degree or diploma by the University or any other institution.

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Date 20 April 2022

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Statement of Ethical Conduct

The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, the guidelines by the Australian Government's Office of the Gene Technology Regulator and the rulings of the Safety, Ethics and Institutional Biosafety Committees of the University. Tasmanian Social Sciences Human Research Ethics Committee Reference #: H0018041.

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Abstract

From penitentials to the medical model, sex, sexual, gender, and erotic difference has long been pathologised resulting in scientific righteousness, criminalisation, and pervasive systemic stigma and discrimination. Over the last two decades, society has become increasingly mutable as people and lexicon evolve. As a result, research into mental health includes lesbian, gay, bisexual, transgender, intersex, queer/questioning, and asexual (LGBTIQA) people, and people with other sexual orientations and gender identities (+). The inclusion of kink-oriented people and sex workers in research into mental health, however, has been a little slower. The foci on whether or not kink is a psychopathology and if sex work is a public health concern were a bit more entrenched, thus, scholarship has been slower to progress. Current research into the mental health of people who are LGBTIQA+, sex workers, and/or kink-oriented is more comprehensive, yet no research could be found that examines these populations in combination, despite their shared, compromised access to the human right of bodily autonomy. Furthermore, no research could be found that examines these populations' mental health or service use in rural or remote areas. Investigations into the mental health status and related service experiences of LGBTIQA+ people, sex workers, and/or kink-oriented people in rural or remote Australia is absent from national health research and policy. In light of the well-documented impacts of minority stress, social exclusion, stigma, and discrimination, and the health disparities of rural populations, this gap is glaring.

The aim of this research was to investigate the mental health of LGBTIQA+ people, kink-oriented people, and sex workers with preexisting mental health issues in rural or remote Tasmania as it pertains to psychological support. The aim was explored via five research questions relating to the target populations: 1) mental health status; 2) risk and protective factors; 3) mental health service uptake; 4) barriers to help seeking; and 5) factors that facilitate uptake. Inclusion criteria required that participants be current or former sex workers, and/or LGBTIQA+, and/or kink-oriented; be 18 years of age or older; be current or past residents of rural or remote Tasmania; have experiences with mental health issues; have used related formal or

informal support; have functional English literacy; and have access to a telephone, and/or smart device or computer.

A mixed-methods research approach consisting of a triangulation design-convergence model was used. Two systematic literature reviews were conducted to identify existing research. Semi-structured interviews and a survey were conducted concurrently. Recruitment was multipronged, consisted of purposive, convenience, and snowball sampling, and was conducted via emails, Facebook, a poster, telephone calls, in-person discussions, third-parties, and self-selection. Interviews ($N = 33$) were held in person or via telephone and consisted of 26 questions. The online survey ($N = 78$) contained 174 questions, including 10 for the Kessler Psychological Distress Scale (K10) and 6 for the Brief Resilience Scale (BRS). Due to technical error, $n = 65$ survey participants completed the K10 and the BRS. Three papers resulted from the dataset: a qualitative sex worker paper and mixed methods LGBTIQ+ and kink papers. NVivo software was used to transcribe and manage all interview data. Qualitative data was analysed thematically via line-by-line coding, code refinement, collation, aggregation, and revision to produce a descriptive narrative summary. For the LGBTIQ+ paper, quantitative survey data were analysed via descriptive statistics to establish demographic and psychosocial profiles, help-seeking experiences, and factors associated with psychological distress and resilience. Bivariate correlations were performed for all variables against K10 and BRS scores to determine those significantly associated with each measure. Descriptive statistics were used to analyse quantitative data in the kink paper, which facilitated pattern and trend identification.

Across both measures, mental health status was gauged via issues reported, comorbidity, and suicidality. K10 and BRS survey findings also informed mental health status. Of the 23 total reported diagnoses, anxiety and depression were the most prevalent: anxiety was highest in heterosexual participants ($n = 17$; 88.2%) and depression was highest in transgender participants ($n = 29$; 93.1%). Comorbidities were rampant among all participants, with sex workers ($n = 12$) reporting the most (100%). Suicidality was highest in transgender participants (72.4%) and lowest in sex workers (25.0%). With a mean score of 31.9/50 or very high, distress was highest in transgender, kink-oriented ($n = 52$), gay ($n = 11$), and asexual ($n = 11$)

participants. Distress was associated with lacking social support, younger age, outsidership, and violence. With an average BRS score of 2.96/5.00 (SD = 1.02), our participants had low resilience overall. Low resilience was associated with outsidership and lacking social support. Normal resilience, which 52.3% scored, was correlated with social support, self-pride, community belonging, and having a kink orientation. Across both measures, risk factors included social exclusion, stigma, isolation, forced secrecy, identity concealment, and discrimination. Resilience, self-awareness, self-care, and social inclusion were protective factors for both interview and survey participants and encouraged help seeking. Almost all (98.7%) survey participants and $N = 33$ interviewees consulted a mental health professional (MHP) at some point. Six interviewees reported not having seen an MHP in rural or remote Tasmania. Interviewees had more negative than positive formal help seeking experiences. A negative formative experience with an MHP, ineffective or ignorant MHP, a lack of tailored or culturally competent support, faith-based services, stigma, cost, an absence of services, waitlists, or too few MHP were barriers to care cited across both measures. Self-awareness, duty to others, social acceptance, culturally competent MHP, less-than-full-fare services, and proximal services facilitated help seeking for interviewees and survey participants.

Although having a preexisting mental health issue was an inclusion requirement, our participants' mental health existed on a continuum. Results from this research suggests that sex work, a kink orientation, and being LGBTIQ+ generally improved our participants' mental health, but exogenous oppressions worsened it. Specialised curricula and services could help reduce disparities, but could also be minoritising in that they could indicate that knowledge about sexual orientation, gender identity, and/or sexual difference in mental health services is only important for some. Universalising curricula, services, and public education campaigns and decriminalising sex work could start to ameliorate harmful stigma against and treatment of people with sex, sexual, gender, and erotic difference. Endemic rural constraints such as reduced proximity to services, social conservatism, discrimination, stigma, and identity concealment can isolate people who are marginalised from vital social support and communities, worsen mental health, and breed help-seeking avoidance. Acceptance, access and proximity to care, and MHP

cultural competence would greatly benefit rural and remote Tasmanian LGBTIQ+ peoples', sex workers', and kink-oriented peoples' mental health.

ACHIEVEMENTS FROM THE WORK PRESENTED IN THIS THESIS

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1. INTRODUCTION

1.1 Preface

This chapter provides an overview of the entire study. First, the background is presented, which identifies and describes the history and nature of the research, putting it into context. Secondly, an outline of the research aims and the methodological framework are presented. Lastly, the thesis structure is outlined.

1.1.1 Researcher Reflexivity

The right to the highest attainable standard of physical and mental health is a fundamental human right indispensable for the exercise of other human rights (General Assembly, United Nations, 2017).

[Ubuntu embraces the belief that] a person is a person through other persons, that my humanity is caught up, bound up, inextricably, with yours. When I dehumanize you, I inexorably dehumanize myself. The solitary human being is a contradiction in terms and therefore you seek to work for the common good because your humanity comes into its own in belonging (Archbishop Desmond Tutu in Wallis, 2008, p. 72).

The topic of fundamental human rights and the notion that when one person hurts, we all hurt and, thus, we have a duty to work toward addressing wrongs stem from the candidate's diverse background. Before embarking upon this PhD, the candidate grew up in West Germany and Canada, completed a Bachelor of Arts (History and Russian Studies) and a Master of Arts (Polish Intellectual History), and held a variety of professional and philanthropic posts as a writer, editor, teacher, translator, fund developer, and more. Before moving to Australia, she worked extensively in rural areas via non-profit, community-based organisations with a range of people. Throughout her work, she was repeatedly exposed to the impact that compromised human rights had on people's mental health and general wellbeing.

Subsequently, in 2014, the candidate decided to formalise her desire to strive for the common good in the area of mental health in a full-time capacity. Her previous, but part-time experience and diploma and certificate-based training as a mental health professional was harnessed via the commencement of a Diploma of Applied Ethics and a Master of Counselling Psychology degree at Memorial University of Newfoundland. A move to Tasmania, Australia, curtailed this study, thus, the candidate completed of a Master of Social Work at UTAS in 2017 and began this Doctorate in March 2018.

Working in Tasmania as a counsellor for a sexual assault support service, an LGBTIQA+ support service, a large public hospital, two private counselling firms, as well as a researcher on a Centre for Rural Health (CRH) project, the candidate witnessed firsthand the discrimination and other oppressions people were subjected to solely because of their differences (See Reynish et al., 2019 for additional information on how the candidate's clinical practice lead to this doctoral research). The initial plan for this thesis was to explore mental health and related service usage among people who are marginalised in rural and remote Tasmania with a focus on people from Culturally and Linguistically Diverse (CALD) backgrounds and LGBTIQA+ people. After an initial scoping and due to the range of diversity and experiences, the candidate chose to alter her focus. People with alternate ways of living, working, and being involving sex and eroticism, namely sex workers and kink-oriented people were paired with LGBTIQA+ people. Investigation revealed similarities in the experiences of all three target populations, which were not unique to rural Tasmania.

How a person copes with exogenous oppressions, how risk and protective factors impact a person, and what motivates (or disinclines) a person from help seeking are complex and multifaceted. Personal resilience can help people cope, what is perceived to be a risk factor can actually be a protective factor, and barriers and facilitators to care often overlap.

1.2 Research Background and Study Rationale

1.2.1 Theoretical Background

The primary concepts that underpin this research span the personal and the professional and include human rights and individual capabilities. These concepts will be explored here and complement the theoretical framework that follows.

1.2.1.1 Social justice

Social justice is a primary concept that underpins this research and is the view that all people deserve equal and fair rights and opportunities. A lack of social justice occurs when inequitable policies, procedures, customs, or beliefs unduly punish some people (and reward others). People who are marginalised are specifically disadvantaged by social injustice individually, socially, and structurally. Instead of equality (treatment, access, and opportunity without difference) and equity (resource distribution based on need), people are denied access, participation, and rights (Given, 2008).

1.2.1.2 Bodily autonomy and integrity

Bodily integrity is the human right not to be interfered with physically without consent. Bodily autonomy is the right to govern one's body based on one's own rationale without discrimination or coercion (Herring & Wall, 2017). Integrity includes the right to autonomy and self-determination, however, as the term, bodily autonomy is used more commonly in existing literature, it has been adopted for use in this study (Action Canada for Sexual Health & Rights, 2019; Carpenter, 2014 & 2019; Hill et al., 2020).

The only part of the conduct of anyone, for which [they are] amenable to society, is that which concerns others. In the part which merely concerns [themselves], [their] independence is, of right, absolute. Over [themselves], over [their] own body and mind, the individual is sovereign (John Stuart Mill, 1859).

This quotation is part of what came to be known as Mill's harm principle, which is based on the belief 'that no one should be forcibly prevented from acting in any way

[they choose] provided their acts are not invasive of the free acts of others' (Hamowy, 2008). In other words, only those non-consensual acts that harm others (without consent) should be regulated or judged; in all other matters, a person's power over their body is absolute. Mill's principle evolved into the human right of bodily autonomy, which is the right to choose what happens to and with one's body based on one's own rationale (Herring & Wall, 2017). People who have concealable stigmatised identities and who are marginalised are denied bodily autonomy. Instead of being able to work freely in a job of their choosing, sex work is criminalised (*Sex Industry Offences Act 2005 Tas*). Instead of the ability to be, act, or dress in public as desired, LGBTIQ+ people experience violence and abuse from loved-ones and strangers alike (Bennett, 2013; Croome, 2017). Instead of acceptance, kink has been dubbed perverse (American Psychiatric Association, 2013). One reason behind this denied access could be due to patriarchal and kyriarchal domination and moralising criticism, which view society and power relations as a hierarchy and behaviour and being as a matter for public judgement and reproach (Dawthorne, 2019; Rubin, 2007).

Mill's harm principle and bodily autonomy are entwined and the individual sovereignty inherent in bodily autonomy 'merits coercive protection against intentional invasion' (Ripstein, 2004, p. 26). For, '[a]gainst the choices of others, the individual's sovereignty is, as Mills says, absolute' (Ripstein, 2004, p. 30). This coercive protection should extend to a non-interference by society or laws regarding person's way of being, doing, and living. A person's identity and (obviously consensual) conduct does not and need not affect, nor be judged by others (Parchomovsky & Stein, 2019).

1.2.1.3 The capabilities approach

Nussbaum's (2000) capabilities approach sees all people as autonomous and deserving of individual human dignity to achieve their potential. Nussbaum describes central human functioning capabilities that represent freedoms without obstacles. The capabilities that directly apply to this research's target populations are:

- Bodily health: 'being able to have good health ...' (Nussbaum, 2000, p. 78)

- Bodily integrity: ‘... having one’s bodily boundaries treated as sovereign, i.e. being able to be secure against assault...having opportunities for sexual satisfaction ...’ (Ibid).
- Emotions: ‘Being able to have attachments to things and people outside ourselves; love those who love and care for us Not having one’s emotional development blighted by overwhelming fear and anxiety, or by traumatic events of abuse or neglect’ (Nussbaum, 2000, p. 79).
- Affiliation: ‘... to engage in various forms of social interaction; [h]aving the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others. (This entails ... protections against discrimination on the basis of ... sex [i.e. gender], sexual orientation ...’ (Ibid).

1.2.2 Theoretical Framework

The theoretical framework used in this study represents its structure and is an explicit statement of assumptions relating to how the topic was chosen, how research questions were developed, how literature reviews were conceptualised, how the research design was approached, and how the data was collected and analysed (Grant & Osanloo, 2014). This theoretical framework strengthened this study by allowing critical evaluation, connecting to existing knowledge, forming a basis for a hypothesis and research methods choices, addressing reasons for phenomena, facilitating generalisation about phenomena, identifying limits to phenomena, and examining deviations and differences (Grant & Osanloo, 2014). The theoretical framework for this study comprises intersectional feminist, queer, and sexual configurations theories.

1.2.2.1 Intersectional Feminism

Feminism began as advocacy for women’s rights on the basis of gender equality. Starting in the late 19th and early 20th centuries, it consists of a range of movements, ideologies, and theories rooted in the social, political, economic, and personal, which has evolved over time (Clarke et al., 2010). This evolution has placed feminism firmly in the bedrock of inclusion as intersectional feminism,

which is equal rights, representation, and opportunities for transgender women, sex workers, and all genders regardless of their gender, sex, race, culture, ethnicity, class, sexuality, caste, or ability (Alexander 2018; Nussbaum, 1999; Retta, 2020; Sweetman, 2018).

Intersectional feminism acknowledges that due to the lack of equity and equality, people face myriad issues: sexual, physical, emotional, cultural, and psychological violence; lack of financial, educational, and employment equity; mental, physical, and sexual health issues and access disparities; compromised human rights and human capabilities for people who are minoritised due to the sex, sexual, erotic, and gender differences; and more. The theory of intersectional feminism became practice in this research via the following principles adapted from Dominelli (2002): 1) Recognise people's diversity; 2) Value people's strengths; 3) Acknowledge and, where possible, address privilege to address unequal power relations; 4) Honour people's agency; 5) Acknowledge connections between (and among) the individual and relevant collective entities; 6) Provide people the opportunity to tell their stories, voice their needs, and determine solutions; 7) Acknowledge that the personal is political; individual experiences are connected to broader social and systemic structures; 8) See people as whole human beings and address needs accordingly; 9) Realise that all people are connected; what one person experiences has implications for everyone; 10) Realise that personal problems have social and systemic causes; 11) Seek collective solutions to individual issues; and 12) Recognise the power dynamics at play regarding gendered roles, responsibilities, norms, expectations, and behaviours.

1.2.2.2 Queer theory

Queer theory has its origins in Germany in the 1890s with a social and academic movement to advance the rights and understanding of transgender, intersex, lesbian, gay, and bisexual people (Clarke et al., 2010). Queer theory, as it is currently known, emerged in the early 1990s and is academic theory and political action that challenges the notion that heterosexuality and cisgenderism are 'normal' and everything else is deviant (Halperin, 1995; Warner, 1991). Queer theory explores the ways in which heteronormativity and cisnormativity are oppressive, emphasises the

fluidities of genders and sexualities, and challenges related dualistic binaries (Clarke et al., 2010; Sedgwick, 1990).

Several people progressed queer theory and contributed to the field. A short summary of their seminal works and contributions follow: Michel Foucault's 'The History of Sexuality' (1978; 1986; 1990; 2018) was a seminal four-volume study of sexuality that introduced the notion that sex and sexuality originate in society, not biology, and are constantly evolving (Rubin, 2007). Gayle Rubin aligned sexual oppression with gender oppression in 'Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality' (1984) and essentially founded sexuality studies. In 'Gender Trouble: Feminism and Subversion of Identity' (1990), Judith Butler criticised outdated, restrictive notions of a gender binary, stating that gender is a presentation (is performative) based on cultural and social assumption (Nagoshi & Brzuzy, 2010). Eve Kosofsky Sedgwick also explored gender and sexuality as a social construct in the critical work, 'The Epistemology of the Closet' (1990). The influence of this book also extends to its rejection of the homosexuality-based and heterosexuality-based binaries (Sedgwick, 1990). (Please see also Lauren Berlant [1998; 2011], David Halperin [1995; 2003], and Michael Warner [1991, 1999] for additional contributions to queer theory).

The methodology of doing queer research is not clear; it is experimental, deconstructive, and facilitates a reinterpretation of the present (McCann, 2016). To align with its core tenets, queer theory was transformed into practice within this study via an adaptation of Nagoshi & Brzuzy's (2010) conceptualisation of transgender theoretical applications in practice, as follows: 1) Recognise the tension between the binaries and the fluidities of genders and sexualities; 2) Challenge the binaries; 3) Understand how lived experience and its influences shape identity; 4) Understand that a person may have multiple, intersecting identities; 5) Acknowledge that differences can shape and empower a person; 6) Understand that a self-constructed identity can aid in resisting oppression; 7) Avoid using gendered language; use inclusive language or language shared by others; 8) Acknowledge the prejudice, discrimination, and stigma that lesbian, gay, bisexual, transgender, intersex, queer/questioning, and asexual (LGBTIQA) people, and people with other sexual orientations and gender identities (+) (LGBTIQA+) encounter and their

impact on all aspects of a person's life; 9) Acknowledge and challenge the pathologisation of LGBTIQ+ people; 10) Acknowledge the confines and harms of sex, sexual, erotic, and gender binaries; 11) Allow a person to find their own identity and solutions, providing a safe, inclusive space in which this can occur; and 12) Ensure all forms and documents reflect a range of diversities.

1.2.2.3 Sexual Configurations Theory

With roots in feminist and queer theory, sexual configurations theory addresses and incorporates many interpretations of sexuality. It seeks to integrate the diversity of gender, sex, and sexuality (and their differences) in research and clinical practice (van Anders, 2015). It consists of three domains in which people's identities, orientations, statuses, and experiences fit: 1) gender/sex sexuality, 2) partner-number sexuality, and 3) individual gender/sex. The practical applications of sexual configurations theory used in this study were its acknowledgement (and appreciation) of fluidity and change regarding a person's gender, sex, sexuality, and that of their partner(s); its rejection of heteronormative and monosexual assumptions; its rejection of homogeneity and static labels; its acknowledgement of the difficulty of seeing past felt-alignment (use of fixed, static labels) and their power in identity formation; its inclusion of all sexualities and genders under the LGBTIQ+ acronym, as well as sex workers, and kink-oriented people in its exploration of sex, gender, eroticism, and sexuality; its awareness of the influence of cultural, social, physical, and or spiritual norms on a person's sexual configurations (and its request to attempt to see past them so as to find an identity that is ours to choose) (van Anders, 2015).

Each theory has its own perspective, position, and features that inform its ontology and epistemology. There is no one interpretation or category of application for these theories that can be synthesised definitively (McCann, 2016; Ramos, 2021). What these theories have in common, however, is that they are – independently and/or collectively – critical theories; concerned with eradicating othering, marginalisation, the suppression of women, and the yokes of the patriarchy, heteronormativity, cisnormativity, mononormativity, and homonormativity (Doucet, Letourneau, & Stoppard, 2010; Gedro & Mizzi, 2014; Heinekamp, 2015).

Combining these theories is not without complication. That is, a framework that includes queer theory (and, by association, sexual configurations theory) alongside feminism can be considered problematic in that the former seeks to disrupt and deconstruct categories and stances (or the subject), which is the primary focus of the latter (McCann, 2016). Also, there is the view that feminism sees only the binary and women's subjugated role therein, which queer theorists consider outdated in that women are not a homogenous group or a binary dichotomy tied to expired epistemological assumptions (McCann, 2016). Justification for their combination exists in their similarities. First, they are all critical theories – they critique society and the outmoded structures it is built upon and offer dialectical and dialogical suggestions for change (Carpiano & Daley, 2006). Secondly, all theories value lived experience by placing it at the core of the research (McCann, 2016). Thirdly, the intentionality of both feminist and queer theory (and sexual configurations theory, by extension) are ideologically connected to the ongoing processes of being aware, accountable, and questioning, which gives accountability to the framework (Heinekamp, 2015). Fourthly, these theories reject assumptions regarding identity categories, social biases, and gender and/or sexuality-based presumptions (Gedro & Mizzi, 2014). Lastly, rationale for the combination of these theories lies in the support feminism brings to queer (and sexual configurations) theory. As Lambert stated (2006):

...queer theory tends to ignore the more material experiences of 'queers' in favour of asserting affirmative politics which seek to rupture normative discourses. Whilst there is little doubt that dismantling the discursive force of heteronormativity is the primary aim of such research, this is sometimes at the expense of those for whom having an identity, and perhaps even desiring to be 'normal' is an important aspect of their 'sense of self'. I take on this paradox by engaging with strongly empirical work in feminist [theory]... in an attempt to find a theoretical middle ground capable of working with the complex data collected, and of suitably making an account of both the discursive and 'real' matters attached to sexual [gender, and erotic] identity (p. v).

1.2.3 Contextual Background

1.2.3.1 Mental health

According to the World Health Organisation (2014), mental health is ‘a state of well-being in which every individual realises [their] own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community’. Mental illness is the inverse of this and can occur due to genetics, stress, abuse, or a traumatic event. Diagnosable mental illnesses or conditions – mental health disorders – are among the most common causes of disability worldwide (Office of Disease Prevention and Health Promotion, 2021). Roughly one quarter of the world’s population will experience mental health disorders at some point in their life and prevalence is increasing (United Nations, n.d.). Between 2007 to 2017, there was a 13% increase in mental health disorders worldwide and a 71% increase in psychological distress in the United States (Twenge et al., 2019; World Health Organisation, 2021a). Between 2011 and 2018, the number of Australians with mental illnesses jumped from 3.0 to 4.8 million (Australian Bureau of Statistics 2015, 2018c). Roughly ‘1 in 2 (46%) Australians aged 16–85 [have] experienced a mental disorder during their lifetime’ (Australian Institute for Health and Welfare, 2020). Predictions indicate that depression will be the leading cause of disability in the world by 2030 (World Health Organisation, 2011).

1.2.3.2 Marginalisation and mental health

People are marginalised based on race, age, ability, sexual orientation and identity, gender identity and expression, and because of any other presumed cause or reason for unequal power relationships (Cruwys et al., 2010). People who are marginalised are under-resourced and experience disparities in resources and opportunities as well as mutually reinforcing disadvantage, discrimination, stigma, and other exogenous oppressions. People who are marginalised also have worse mental health than those who are not disadvantaged (Cruwys et al., 2010).

Marginalisation can produce stigma, which ‘is the devaluation of a person based upon their perceived departure from social norms’ (Reynish et al., 2021, p. 1). Kink-oriented people are not only presumed to depart from social norms and stigmatised,

but have also been pathologised in psychological and legal contexts (Reynish et al., 2022). The negative psychological impacts of stigma on mental health are well documented (Jiao & Bungay 2019; Quinn & Chaudoir, 2009; Rayson & Alba, 2019). Perceived, anticipated, or actual stigma that some kink-oriented people experience following disclosure, for example, are predictors of psychological issues (Reynish et al., 2022). People with concealable stigmatised identities (identities that can be hidden, devalued, or stereotyped) such as sex workers, LGBTIQ+ people, and kink-oriented people also experience greater psychological distress (Quinn & Chaudoir, 2009). This distress can also be accompanied by the psychological burdens of oppression and ostracisation that can accompany concealment, which can be dire. Accumulatively, these factors can result in minority stress, which is the psychological strain that people in a stigmatised group experience based on exogenous oppressions (Meyer, 2003). For example, kink-oriented people with pronounced minority stress have higher suicide rates than non-kinky people (Hughes & Hammack, 2019). There is a high prevalence of mental health issues and suicidality among transgender sex workers (Sanders et al., 2017). There is a heightened risk of mental health diagnosis, psychological distress, self-harm, and suicidality in LGBTIQ+ people (National LGBTI Health Alliance, 2016).

1.2.3.3 Mental health in Australia

Australia's expenditure on mental ill health grew from an estimated \$56.7 billion in 2014 to \$60 billion in 2016 (Parliament of Australia, 2019), yet poor mental health is among the leading causes of disability in the country (Australian Human Rights Commission, 2014b).

Evidence suggests that the adverse impact of mental ill health may be exacerbated in rural or remote regions of Australia, where issues of isolation and access to services and treatment are more salient (Australian Institute of Health and Welfare, 2012; Jackson et al., 2007; Marel et al., 2016; Strong et al., 1998). However, Australian national mental health research is predominately conducted by urban organisations based in urban areas with little-to-no mention of people with alternate sex, sexualities, genders, erotic identities, or sex-work status (Australian Institute of Health and Welfare, 1998; Australian Psychological Society, 2015; National Mental Health Commission, 2019; Victoria Institute of Strategic Economic Studies, 2016).

National studies that do include LGBTIQ+ people tend to have also been conducted by urban organisations based in urban areas and incorporate rural Tasmanian data into all other data, rendering it less representative (Hill et al., 2020; Jacobs & Morris, 2016). This unbalanced approach is problematic due its lack of inclusion and other disparities discussed in the following two sections.

1.2.3.4 Rural disparities

Geography is a main consideration in health, wellbeing, and related disparities. People in rural or remote areas generally have lower education, employment, and income levels than people living in major cities (Australian Health Ministers' Advisory Council, 2012). Rural dwellers also have poorer health outcomes and more hospitalisations and injury, shorter lifespans, but higher life satisfaction than people in urban regions (Australian Institute of Health and Welfare, 2019). Notably, differences also exist between people who live in rural areas versus those in remote regions, who experience even more disparities (Kölves et al., 2012). Access to services is one area where there is marked difference for urban, rural, and remote people; people in metropolitan areas have access to more infrastructure and can avail of a wider range of services and supports (Australian Institute of Health and Welfare, 2019).

1.2.3.5 Rural mental health disparities

Some studies have found similar prevalence of mental illness in the general populations of rural or remote and urban centres (Australian Bureau of Statistics, 2011; Caldwell, Jorm, & Dear, 2004; National Rural Health Alliance, 2017). People in rural and remote regions, however, face greater challenges that can impact mental health. That is, rural and remote dwellers experience isolation and lack access to mental health supports, including services tailored to their specific needs. In the face of a lack of services, rural and remote dwellers have been found to rely on alcohol and other drugs to manage mental health issues (Marel et al., 2016). Self-harm and suicide rates also increase with remoteness (Caldwell et al., 2004; National Rural Health Alliance, 2009 & 2017; Suicide Prevention Australia, 2010). One study found that in comparison to urban areas, suicide rates are 33% higher in rural areas and 189% higher in very remote areas (Suicide Prevention Australia, 2010).

Notably, while self-harm and suicide are not mental illnesses, they are causally linked; that is, the rate of suicide in those with mental illness is around seven times higher than in those without a mental illness, and self-harm is often a response to a mental illness or trauma-related distress (SANE, 2018).

Marginalised sex and sexually diverse, gender diverse, erotically diverse people, and sex workers who live in rural or remote areas are more likely to have very high levels of general psychological distress and to attempt and complete suicide or self-harm than those living in metropolitan regions (Australian Human Rights Commission, 2011; Chudakov et al., 2002; Hillier et al., 2010; McCann & Sharek, 201[6]; Patel et al., 2015; Riggs, Coleman, & Due, 2014; Rosenstreich, 2013; Rössler et al., 2010; Sanders et al., 2017; Strauss et al., 2017). In 2016, Hottes et al., published a systematic review comprising data from 30 studies that included more than 21,000 sexual minority (SM) adults. The review found that SM are more likely to attempt suicide; 20% of their participants had already attempted suicide (versus roughly 4% of the general public) (Hottes et al., 2016). A second systematic review examined 199 studies regarding the mental health of SM compared to heterosexual people and found that 89% of the lesbian, gay, and bisexual adults included in their study experience depression; that 97% of homosexual and bisexual youth experience depression; and that 98% lesbian, gay, bisexual, and questioning people are at an increased risk of suicide (Plöderl & Tremblay, 2015). That review also found that anxiety disorder and substance use and misuse findings were also higher in SM than in heterosexuals (Plöderl & Tremblay, 2015). The Australian Department of Health (2011a) found that Australian lesbian and bisexual women have higher rates of depression, anxiety, and stress than non-SM women, citing stigma, discrimination, and a lack of social support as explanations. Note that this study did not identify if the women were cisgender or transgender; that is, if they identified with the sex they were assigned at birth, or did not. The Department also cited the following additional barriers for SM women in rural areas: less access to mental health-based specialised services; embarrassment; lack of confidentiality; and heterosexist attitudes among health professionals (2011b).

Sex and sexually diverse, gender diverse, erotically diverse people, and sex workers also experience adverse effects of mental ill-health due to a variety of similar

barriers and risks, including: peer rejection; bullying; discrimination; lack of social/family support; accommodation issues; homelessness; lack of knowledge or bias among health providers; transphobia/homophobia among service providers; lack of services and service providers, including ally services; isolation; exposure to violence and trauma; social disadvantage; minority stress; stigma; and poor mental health literacy among individuals affected, treatment providers, and the public (Australian Human Rights Commission, 2011; Canadian Alliance for Sex Work Law Reform, 2017; Jackson et al., 2007; Kovandzic et al., 2010; Rosenstreich, 2013; Sanders et al., 2017; Strauss et al., 2017; Tasmania Medicare Local Limited, 2012).

Evidence suggests that marginalisation also impacts the mental health of people who live in rural or remote areas (Lyons, Hosking, & Rozbroj, 2014; Willging et al., 2018). Rurality impacts the mental health of under-resourced people with concealable stigmatised identities, for example, due to increased isolation, homophobia, identity concealment, social conservatism, and limited community belonging (Barefoot Smalley, & Warren, 2015; Hughes & Hammack, 2019; Lyons et al., 2015; Willging et al., 2017). Rurality impacts mental health help seeking due to limited (or no) service access, shortages of mental health professionals (MHP), and lacking cultural competency among rural MHP (Barefoot et al., 2015; Lyons et al., 2015). The research into rural and remote LGBTIQ+ people, sex workers, and kink-oriented people is scarce; research regarding these populations in Tasmania is non-existent.

Addressing and improving mental health was a priority of the Australian Government's previous administration, but is not cited as a priority for the current administration (Department of the Prime Minister and Cabinet, n.d.; Turnbull, 2018). Relatedly, the literature on the mental health of people who are marginalised in rural or remote Tasmania, including sex and sexually diverse, gender diverse, erotically diverse, and sex workers is greatly limited. The intersectionality of the oppressions of marginalisation and rurality render the target populations some of the most vulnerable in the nation (Australian Broadcasting Corporation, 2018; Pease, 2010; United Nations, 2012). A better understanding of people in rural or remote Tasmania's experiences with mental health and with help seeking, as well as the

barriers they face and their impact, and the facilitators to care would lead to improvements in the lives of this population.

1.3 Research Aims and Questions

The overarching aim of this research was to investigate the mental health of LGBTIQ+ people, kink-identified people, and sex workers in rural or remote Tasmania as it pertains to the impact of compromised access to bodily autonomy on mental health as well as psychological care and support. The following research questions (RQ) were posited to achieve the study's aim:

RQ1: What is the mental health status of LGBTIQ+ people, sex workers, and kink-oriented people with preexisting mental health issues in rural or remote Tasmania?

Lexiconically, 'preexisting mental health issues' included clinical diagnoses, diagnosable conditions, as well as a situational or reactive issues such as to a traumatic event, (death of a loved one or problems with school, work, or relationships). Issues were included in this study as they can result in stress that impacts daily life and can become clinical conditions. Thus, 'preexisting mental health issues' are also referred to herein as 'chronic mental health', 'experiences with mental health issues', or 'experience with a mental health issue in their lifetime'.

RQ2: What risk and protective factors impact the mental health of LGBTIQ+ people, kink-identified people, and sex workers?

RQ3: What is the uptake of mental health services of LGBTIQ+ people, kink-identified people, and sex workers in rural or remote Tasmania?

RQ4: What barriers to mental health help seeking do LGBTIQ+ people, kink-identified people, and sex workers encounter in rural or remote Tasmania?

RQ5: What factors facilitate uptake of mental health care for LGBTIQ+ people, kink-identified people, and sex workers in rural or remote Tasmania?

1.4 Target populations

This research included participants who were LGBTIQA+, sex workers, and/or kink oriented, and who self-identified as any or all of these identities either independently or in combination. There are many combinations of intersecting identities possible from these individual identities. For example, a person could be pansexual and kink-oriented (and may, or may not, be a sex worker). To clarify, all identities included in this review are unique and not part of a broader group. Specifically, the identities contained within the LGBTIQA+ acronym and unique, sex worker is a unique identity and kink is as well. Researchers have also examined kink in so far as it extends beyond the practice of libidinal gratification and into identity and have concluded that for some, kink is a sexual orientation (Moser, 2016; Savin-Williams, 2014; Sprott & Williams, 2019). Traditional interpretations of sexual orientation that exclude kink are challenged due to: 1) the fluidity and diversity of sexuality and identity; 2) the evolution of the construct of sexual orientation; 3) the shared experiences of discrimination and pathologisation and; 4) the socio-political importance of all people with diverse sexual orientation, gender identity/expression, and sex characteristics (SOGIESC) (Pitagora, 2016; van Anders, 2015).

The rationale behind the combination of including these three identities in this research is nuanced. The populations are, firstly, unified by their compromised access to bodily autonomy. Due to their variations from traditional, social, cultural, or physiological expectations regarding sex (birth-based assignments and coitus), sexuality, and gender, the target populations have shared experiences of discrimination, stigma, pathologisation, heteronormativity, and/or binary gender nonconformity (Adams, Dickinson, & Asiasiga 2013; Mayer et al., 2008; Sexual and Gender Minority Research Office, 2018). Intersex people have even been subjected to non-consensual medical procedures in attempts to eliminate their diversity (Gore, 2017; QLIFE 2017). The target populations' ways of being and doing are also socio-politically important. That is, simply by being and doing, the target populations are subjected to legislative regulation, public policies, and social opinion (Pitagora, 2016; van Anders, 2015). The target populations have also been subject to legal and psychological reprisal. Punishment has been meted out via criminal charges for sex work, kink, being same-sex attracted and/or being transgender, and via violence and

abuse from loved-ones and strangers alike (Bennett, 2013; Croome, 2017; International Committee on the Rights of Sex Workers in Europe, 2017). Also, homosexuality, transgenderism, sex work, and kink have long been pathologised as mental illnesses, including in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2006 & 2013; Andrieu, Lahuerta, & Luy, 2019; Drescher, 2015; Mottier & Duschinsky, 2015).

The target populations possessed identities referred to herein as 'sexual', 'gender', and 'erotic'; whereby 'sexual' was used to represent sex workers and sexuality in general; 'gender' was used to represent people who are transgender, gender diverse, or cisgender; and 'erotic' was used to represent participants' sexuality regardless of whether or not they were sex workers or LGBTIQA+, but was added as a specific, distinct reference to those participants with a kink curiosity or orientation.

This research also assumed that, like many of the sexualities included under the LGBTIQA+ acronym, kink is also, for some, a sexual orientation. Researchers have also examined kink in so far as it extends beyond the practice of libidinal gratification and into identity and have concluded that for some, kink is a sexual orientation (Moser, 2016; Savin-Williams, 2014; Sprott & Williams, 2019). Traditional interpretations of sexual orientation that exclude kink are challenged due to: 1) the fluidity and diversity of sexuality and identity; 2) the evolution of the construct of sexual orientation; 3) the shared experiences of discrimination and pathologisation and; 4) the socio-political importance of all people with diverse sexual orientation, gender identity/expression, and sex characteristics (SOGIESC) (Pitagora, 2016, van Anders, 2015).

Each main grouping is diverse within itself and not all identities within the many subgroupings within these populations have the same experiences with mental health, service access, service use, or risk or protective factors, or any of the other topics presented in this research. The combination of these three identities in this research is not intended to conceptualising each of three populations as monolith blocks of identity. Specific definitions of each of these populations follow.

1.4.1 LGBTIQA+

Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual, and a variety of other identities are included under this acronym. The plus (+) symbol represents additional, diverse sexual orientations (bicurious, pansexual) and gender identities (agender, bigender, demigirl, gender diverse, gender fluid, non-binary, polygender). Transgender is an umbrella term for people who are gender-fluid, nonbinary, and gender nonconforming. Intersex is the status of being born with atypical genitals or physical sex characteristics that do not conform to male-female binary. In other research, LGBTIQA+ people have been referred to as people with diverse sexual orientation, gender identity/expression, and sex characteristics (SOGIESC) (van Lisdonk et al., 2018); ‘sex and gender minorities’ (SGM) (LeBreton, 2013, p. 1); and ‘sexual minorities’ (SM) (Platt, Wolf, & Scheitle, 2018, p. 135). In an effort to use person-centred language, ‘minority people’ has been used herein instead.

1.4.2 Sex worker

A sex worker is a person who is 18 or older who frequently or sporadically accepts money or goods in exchange for consensual sexual services or acts, with the seller and the buyer agreeing on terms (Amnesty International, 2016a). Sex work can occur in commercial establishments, underground operations, as street-based trade, as internet-managed businesses, as an informal sex trade, and/or by people who live in a place year-round, or who travel for sex work (Safe Harbour Outreach Project, personal communication, 15 May 2018; The Tasmanian Sex Worker Project-Project of Scarlet Alliance, personal communication, 15 May 2018). It can be conducted in strip clubs; brothels; private homes; sensual massage parlours; escort agencies; bondage, discipline, domination, submission, sadism, and masochism (BDSM)/kink venues or parties; and swingers’ clubs, and can include porn film acting, webcamming, and phone sex (Selvey et al., 2017; Wong, 2009).

Sex work occurs between consenting adults – it is not exploitation, sexual assault, nor sex trafficking as these are explicitly non-consensual (Canadian Alliance for Sex Work Law Reform, 2017). Sex workers have diverse socioeconomic, cultural, and racial backgrounds and represent a spectrum of age, education, gender identities, and sexual orientations (Chabot, 2012). Sex workers possess a range of legal residency

statuses (citizens, immigrants, and migrants). Some work full-time and others part-time; some enjoy the work and others do not (Puri et al., 2017).

Nota bene: The label ‘prostitute’ is not used in this research due to its stigmatising and derogatory connotations; instead, the terms ‘sex work’ and ‘sex worker’ are used.

1.4.3 Kink

Kink is a broad term for any consensual non-traditional sexual activity; it is any sex act that could include non-traditional desires or fantasies, other than penetration-based coitus between two partners. Kink may or may not involve penetrative sex and can incorporate role playing, costumes, and fantasy. BDSM is a form of kink that typically involves power or pain exchange. Kink can also extend to polyamory, fetishism, swinging, sensation play, temperature play, and/or the use of certain objects or materials (e.g. silk, fur, rubber, latex, shoes) (Damm, Dentato, & Busch, 2017; Pitagora, 2016). People who explore kink have a variety of backgrounds, preferences, genders, and sexual orientations (Damm et al., 2018). Kink can be an identity, an interest, a behaviour, a curiosity, or an orientation (Moser, 2016). While these terms are not synonymous, the term ‘kink-oriented’ is used in this research for simplicity.

1.5 Population Distribution

The population of the Tasmanian, Australian, or even the world’s population of people who are LGBTIQ+, sex workers, or kink oriented is unknown. Due to flawed and inconsistent data gathering tools that produce inaccurate and unrepresentative estimates, population sizes for the target populations are not provided in this research.

While the 2016 Australian Bureau of Statistics census, for example, counted sexually or gender diverse people in Australia, they also state:

This count is not considered to be an accurate count, due to limitations around the special procedures and willingness or opportunity to report as sex and/or gender diverse. People who have been treated with

disrespect, abuse and discrimination because of their sex or gender may be unwilling to reveal their sex [i.e. gender] in an official document (Australian Bureau of Statistics, 2018d).

In 2014, the Australian Human Rights Commission admitted that there is a lack of comprehensive data on gender or sexually diverse people, making estimations difficult (Australian Human Rights Commission, 2014a). Population percentages on LGBTIQ+ people from the Australian Research Centre in Sex, Health and Society (ARCSHS), the national body for sexuality and gender research and education, are also unclear for reasons of skewed data collection due to homophobia, discrimination, stigma, and the fluidity of sexuality (ARCSHS, personal communication, 16 May 2018).

Estimates of kink-oriented Tasmanians are also inaccurate and incomprehensive due to nonrepresentative samples, survey avoidance out of a desire to remain hidden, and the sex survey volunteer effect (survey non-participants are likely more conservative than participants) (Richters et al., 2008). Terminology and frequency also impede accurate number gathering regarding percentages of kink-oriented people. As Webster and Ivanov (2020) stated, ‘Estimating the size of the population of practitioners would be difficult or impossible to do, since many who practice things that are considered “kink” may not consider it “kink” nor necessarily do it regularly’ (p. 19).

The percentage of Australian or Tasmanian sex workers is also unknown. The variability lies in the diversity of the locations for sex work, in stigma, in the seasonal difference, and in the mobile and sporadic nature of sex work. Stigma and legalities surrounding sex work and where it occurs complicates accurate number gathering, but so too does the fact that the number of people engaged in sex work changes throughout the year, the fact that some sex workers do not consistently work from one region, and some do not work year-round or might turn to sex work sporadically for additional income (Cool, 2004).

1.6 Study Setting

This study occurred in Tasmania, Australia. Tasmania is a remote, mostly rural island state. Tasmania has an approximate population of 540,000 people, with roughly 40% living in the Greater Hobart area (Australian Bureau of Statistics, 2020 & 2021). According to the Australian Bureau of Statistics Australian Statistics Geography Standard-Remoteness Areas (ASGS-RA) Section of State Range, Hobart is the only Major Urban area in Tasmania (Australian Bureau of Statistics, 2017a). Based on the ASGS-RA classification, the remainder of the Tasmanian population, 56%, live in 'rural or remote' areas (Australian Bureau of Statistics 2016c, 2017a). Primary Health Tasmania (2018a) found that Tasmania has the highest percentage of socio-economically disadvantaged people in all of Australia, with disadvantage more common in rural or remote areas. Relative to other rural parts of the country, Tasmania has greater socioeconomic and family disadvantage, more people receiving rent assistance, more people without transport, a higher unemployment rate, lower education attainment rate, and lower community participation (Ahmed et al., 2017). Furthermore, rural Tasmanians have worse health risk factors than their urban counterparts and Tasmania has the highest mortality rates in the country (caused, in part, by cancer, diabetes, heart disease, suicide, and an aging population) (Ahmed et al., 2017).

1.6.1 Mental Illness in Tasmania

On par with national approximations, roughly 20% of Tasmanians are said to have mental health disorders ranging from mild to severe (Ahmed et al., 2017; Australian Institute of Health and Welfare, 2015a). Anxiety and depression are the most common diagnoses. Instances of anxiety are increasing; in 2009, 21.4% of Tasmanians had anxiety and in 2016, instances increased to 30.0% (Ahmed et al., 2017). Additional statistics regarding mental illness in the state follow. Rates of high/very high psychological distress in the general population are increasing and are worst and worsening in 18-34-year-old people, in women, and in the north and south of the state (Long & Hippel, 2020). Depression, anxiety, and sleep disorders accounted for 59% of mental health-related issues in 2013 (Ahmed et al., 2017). Tasmanians access mental health medications more than anywhere else in the country. One third of Tasmanians receiving a disability pension are doing so for

psychological diagnoses (Ahmed et al., 2017). Dispensing rates for antidepressants and anxiolytics in Tasmania are the highest nationally (Ahmed et al., 2017). Finally, the state has the second highest national suicide rate, with suicide rates increasing faster than anywhere else in the country (Ahmed et al., 2017).

1.6.2 Mental healthcare in Tasmania

Mental healthcare in the state consists of a blend of public and private support. Public services are government funded, typically provided free-of-charge, and offer dedicated support (e.g. in-patient hospital care and community-based support). Private services consist of clinics or offices and require payment for services (Ahmed et al., 2017). Payment to private MHP can be government-subsidised (via Medicare, the national healthcare scheme) (Services Australia, n.d.a., n.d.b.) or paid out-of-pocket. MHP can set their own fees and offer fee reduction to clients at their own discretion. The current Australian Psychological Society (2021b) recommended fee is \$267 Australian Dollar (AUD) for a 45-60-minute consultation and the Australian Association of Social Workers' (2016) recommended hourly fee for an accredited social worker in private practice is \$240AUD.

Research into opinions on and experiences with healthcare in Tasmania is limited; however, existing surveys share mixed results. Roughly 5% of hospital admissions in the state are for mental health issues (Primary Health Tasmania, 2018c). A 2019 health survey reported that 77.8% of Tasmanians are satisfied with hospital services and 12.1% are not; dissatisfaction increased from 8.5% in 2016 and is higher in people aged 18 to 64 (Long & Hippel, 2020). Notably, the survey did not indicate whether these hospital services were accessed for physical or mental health issues. Thus, the high satisfaction rate is only assumed to pertain to physical health-related hospital experiences. A 2021 *Guardian Australia* poll found that all participants ($N = \sim 700$) experienced issues in accessing mental health care with those who are 'too unwell for primary care but not unwell enough for state-based services' experiencing the brunt of a system deemed 'inadequate' (Davey, 2021; Touma & May, 2021). Although the latter is not a formal survey and includes bias, it does illustrate the lack of robust evidence as well as provide insight into Tasmanians' opinions on mental healthcare in the state.

Recent efforts to improve mental health care in Tasmania involve integrated-services approaches for immediate (crisis), medium-, and long-term care as demonstrated in 10-year government plans (Primary Health Tasmania et al., 2020) and a trial of adult mental health centres in each state and territory (including in Launceston, Tasmania) (Primary Health Tasmania, 2021).

1.6.2.1 Uptake of mental health services in Tasmania

Less than half of people with mental health issues in Tasmania access support (Primary Health Tasmania, n.d.). Tasmanians with low intensity or mild mental health issues also tend to disengage with care due to access issues (Davey, 2021). Since 2009, an increasing number of Tasmanians are seeking formal mental health support (Ahmed et al., 2017). Uptake data for low-intensity, public services that support people with mild mental illnesses is limited (Primary Health Tasmania, 2018b). There is also limited data regarding uptake of private services. However, more data exists regarding uptake by people with serious or complex mental illnesses who access public supports. A 2015 report concluded that Tasmanians use residential mental healthcare services more than any other Australians; have the second highest national usage of specialised homelessness services for people with mental health issues; and have the lowest usage nationally of community mental health services and psychiatric inpatient admissions (Australian Institute of Health and Welfare, 2015a). Uptake of hospital emergency departments for mental health issues is also increasing (Primary Health Tasmania, 2018c).

1.6.2.2 Barriers and facilitators to help seeking in Tasmania

The general population of the state experience barriers and facilitators to help seeking. Data on those factors that encourage or impede help seeking in private services could not be found. Table 1.1 presents data regarding the barriers and facilitators that people with mild to severe mental health issues have encountered from government-funded public services. The candidate created Table 1.1 based on data published in O'Donnell et al., 2020 and Primary Health Tasmania, 2018b & c.

Table 1. 1 Barriers and facilitators to help seeking from public services in Tasmania

Barriers	Facilitators
<i>Access</i>	<i>Access</i>
Lack of MHP (i.e. workforce shortages)*	e-mental health services*
Lack of services*^	Online support*
Lack of full-time MHP*	Smartphone applications*
Waitlists*	Community-based programs/support*
Delays in care*	Advertising of services/service offerings^
Poor/no referral pathways*	Supports tailored to specific regions*
Lack of information/advertisement on available supports*^	Range of care-delivery formats (e.g. individual, group, phone, video-based)* *
Limited range of services*	Low cost*
No follow-up/ongoing support after hospitalisation^	Self-referral/elimination of need for GP or MHP referrals*
	Support tailored to clients' needs^
	Varied sites/locations for clinical support^
	Low MHP turnover^
<i>Systemic</i>	<i>Systemic</i>
Lack of coordinated care*	Support of clients in other areas of their lives (e.g. housing, transport, errands)^
Rigid requirements for government support of MH disability funding for individuals*	Effective case management in general and across services^
Red tape and effort of having to secure mental health treatment plans for reduced-fee support*	
Heavy state-encouraged reliance on cognitive behaviour therapy when other modalities might be more appropriate*	
Heavy administrative workload for government-funded services and MHP, which limits MHP availability for clinical work*	
Heavy concentration of services in Hobart*	
<i>Individual MHP</i>	<i>Individual MHP</i>
Lack of skilled/credentialled MHP*	Qualified MHP^
Lack of MHP literacy in other languages (re working with people from CALD backgrounds)^	High-quality care (e.g. accountable, accessible, appropriate, equitable, efficient, effective)*
Poor practitioner-client relationship^	Awareness of the impact of stigma and discrimination*
	Avoidance of medical model^
	Use of a psychosocial treatment approach^
	Listening to client^
	Person-centred, tailored approaches to care*
	Lack of MHP judgement or discrimination^
<i>Individual clients</i>	
Participants lacking motivation^	
Participants' shame re MH issues resulting in poor engagement with care^	
* Primary Health Tasmania, 2018b & c	
^ O'Donnell et al., 2020	

1.6.3 Mental healthcare funding in Tasmania

Tasmania has among the highest state government per capita expenditure on mental health (Australian Broadcasting Corporation, 2018; Black Dog Institute, 2017; Primary Health Tasmania, 2016). Most (85.0%) of the current mental health funding

in the state is allocated to public services, including hospitals and general practitioner (GP) practices, which address crisis, triage, or episodic care; not preventative care (Australian Broadcasting Corporation, 2018; Burns, Liacos, & Green, 2014; Kenny, 2011; Rajkumar & Hoolahan, 2004). The Australian Health Care Reform Alliance (2018) stated that despite the millions in public expenditure in Tasmania, approaches to mental health care ‘fall short of the changes we need’ (see also Australian Broadcasting Corporation, 2018).

There are other issues with the government funding of mental healthcare in Tasmania. First, funds are not administered regionally, thus, services have been duplicated. Secondly, as most government funding schemes require annual reapplication, services are experiencing heavy administrative burdens, inability to deliver long-term support to clients, job insecurity and turnover for MHP, inability to attract MHP, and impeded ability to provide client-directed services offerings. Thirdly, funds do not match cost of living needs and expected rural compensation rates, which also impairs attracting MHP to the state. Of the MHP who do work in the state, many are on locums from interstate, which hinders long-term practitioner-client relationship development (Commonwealth of Australia, 2018).

1.6.4 Mental health professionals in Tasmania

A range of health professionals provide support in Tasmania, where workforce shortages are a significant issue (Department of Health and Human Services, 2015). The state has the fewest mental health professionals in the nation (Ahmed et al., 2017). In 2018, Tasmania had the third lowest number of psychiatrists and mental health nurses (Australian Capital Territory and Northern Territory [NT] had the least) and the second lowest number of psychologists after the Northern Territories (Australian Institute of Health and Welfare, 2022). At 30 June 2021, there were 583 psychologists in the state registered with the Psychology Board of Australia (second lowest in the country next to NT) (Psychology Board of Australia, 2021). Of the government-subsidised MHP, Tasmania has the lowest number of community mental healthcare service contacts in Australia (Ahmed et al., 2017). Tasmanian MHP are also among the lowest paid in the country (Commonwealth of Australia, 2018).

GP are often the first and only point of service for people with mental health issues in rural or remote areas (Stallman, 2008). Tasmania has the highest percentage of mental-health-based GP consultations (Ahmed et al., 2017). GP consultations can be problematic, however, due to a lack of education: in 2016, only 34% of GPs considered their practices adequate to manage mental health problems (Primary Health Tasmania, 2016). Stated another way, 66% of GPs were not adequately able to manage mental health issues. Furthermore, a 2012 report concluded that 37.7% of mental health treatment plans in Tasmania are prepared by GPs who have not had mental health training (Tasmania Medicare Local Limited, 2012). Tasmanian GP are less likely to use Mental Health Treatment Plans – they have the lowest national average plan administration rate (Ahmed et al., 2017).

1.7 Methodology Overview

A mixed-methods research approach consisting of a triangulation design-convergence model was used in this study. Two systematic literature reviews were conducted to identify existing research and knowledge. Subsequently, semi-structured interviews and a survey were conducted (Appendices 1 and 2). The study took place in areas determined to be rural and remote based on the Australian Statistical Geographical Classification; that is, the major city of Hobart (the state capital) and surrounding areas were excluded based on their relative access to services.

Inclusion criteria required that participants be 18+ years of age, possess functional English literacy, live in rural or remote Tasmania (or have lived there within the last 2 years), have had mental health issues at some point in their life, have mental health help-seeking experiences (formal or informal), and be either LGBTIQ+, a current or former sex worker, and/or kink-oriented. Recruitment was multipronged, consisted of purposive, convenience, and snowball sampling, and was conducted via emails, Facebook, poster, telephone calls, in-person discussions, third-parties, and self-selection.

The interview guide and the survey were developed based on knowledge gleaned in the candidate's clinical practice that was refined via systematic literature reviews, existing research, and piloting by members of the target populations (Appendices 1

and 2). Interviews were conducted and the survey was live between November 2019 and March 2020. Interviews were held in person or via telephone and consisted of 26 questions. Interview data were analysed using thematic analysis; both latent and semantic themes were identified following the analysis.

Surveys were conducted online and contained 174 questions that were designed to be completed by either all participants, and/or those who were LGBTIQ+, and/or those who were sex workers, and/or those who were kink oriented. Data were analysed in Statistical Package for the Social Sciences (SPSS) using descriptive and inferential statistics. Data elicited from these methods facilitated the corroboration of both quantitative and qualitative data while offsetting the restrictions inherent in each, allowed for comparisons, and revealed contrasts to validate findings (Bryman, 2006; Creswell & Plano Clark, 2011).

1.8 Thesis Structure

The remainder of this thesis is organised as follows:

Chapter 2 – Literature Reviews: Two systematic literature reviews:

1. ‘Barriers and Enablers to Sex Workers’ Uptake of Mental Healthcare: a Systematic Literature Review’, which was published in *Sexuality Research and Social Policy* and which is reproduced with permission from Springer Nature.
2. ‘Barriers and Enablers to Mental Health Help Seeking of Sexual, Gender, and Erotic Minorities: A Systematic Literature Review’, which was published in *The Journal of Gay & Lesbian Mental Health*.

Chapter 3 – Contextualisation of Systematic Literature Reviews: The systematic literature review findings (presented in the previous chapter) are put into context in this short chapter to facilitate their integration within the thesis.

Chapter 4 – Research Methodology: The chosen methodology, including the rationale behind specific selections; data collection and data analysis are presented.

Chapter 5 – Results: This chapter includes the three papers that were written based on collected data, which are as follows:

1. “Mental health and related service use by sex workers in rural and remote Australia: ‘There’s a lot of stigma in society’, which was published in *Culture, Health and Sexuality*.
2. ‘Kink-oriented people and exogenous oppressions: understanding mental health and related service use in a rural context’, which was published in *The Journal of Homosexuality*
3. ‘Psychological distress, resilience, and help-seeking experiences of LGBTIQ+ people in rural Australia: a mixed-methods study’, which will be submitted to a journal for publication.

Chapter 6 – Discussion: This chapter includes a discussion of the study’s research findings presented as they relate to the study’s five research questions.

Chapter 7 – Conclusion: The final chapter consists of achievements of the research, as well as recommendations, limitations, and areas for future research.

1.9 Conclusion

The research was contextualised in this chapter via a background on the target populations, mental health in Australia and Tasmania, the underlying concepts and rationale, and the research’s significance and aims, and a methodological overview. Tasmania’s mental health profile, demonstrable rurality issues, and inimitably inclusive legislation makes it a compelling place to explore the psychological impacts of marginalisation on people with concealable, stigmatised identities. It is the candidate’s hope that the outcomes of this research can be used to inform service provision and government policy, and identify gaps and solutions in mental health

care, with the aim of improved psychological functioning and social acceptance in the people it represents.

2. LITERATURE REVIEWS

2.1 Preface

An introduction to the study was presented in the previous chapter, which included the study's theoretical and contextual background, aim and research questions, and thesis structure. This chapter presents two systematic literature reviews on sex workers' and sex, gender, and erotic minority peoples' usages of and experiences with mental health care in Organization for Economic Co-operation and Development (OECD) countries.

The systematic literature reviews contained in this chapter have been published. The first review has been published as, **Reynish, T., Hoang, H., Bridgman, H., Nic Giolla Easpaig, B. (2020). Barriers and Enablers to Sex Workers' Uptake of Mental Healthcare: A Systematic Literature Review. Sexuality Research and Social Policy, 18(1), 184–201. <https://doi.org/10.1007/s13178-020-00448-8>. This has been reproduced with permission from Springer Nature.**

2.1.1 Barriers and Enablers to Sex Workers' Uptake of Mental Healthcare: A Systematic Literature Review

2.1.1.1 Abstract

Introduction. Sex workers face many barriers to accessing the inalienable human right of mental health. The aim of this review was to synthesize the evidence on the barriers to mental healthcare for sex workers and the factors that facilitate uptake.

Methods. A search conducted in 2018 of peer-reviewed and grey literature produced between 2008 and 2018 in OECD countries resulted in 32 documents eligible for inclusion.

Results. The literature revealed that the barriers of stigma, discrimination, violence, pathologisation, and criminalisation exacerbate the psychological distress of sex workers while impeding uptake of mental healthcare. Personal resilience, protective factors, agency, and social inclusion offset these barriers.

Conclusions. Despite the risk of pervasive mental illness among sex workers due to, primarily, external factors, few studies present comprehensive examinations of sex workers' mental health and fewer still explore sex workers with gender identities and sexual orientations that are not cisgender, heterosexual, or female.

Policy Implications. Although timely, equitable treatment of sex workers in mental healthcare is currently atypical, the findings of this review suggest that inclusive, respectful psychological care is possible. Future research on holistic approaches to the mental health of sex workers could support the creation of much-needed, inclusive services and policies that improve sex workers' quality of life.

Keywords: Mental Health, Sex Work, Uptake, Barriers, Enablers

Health, including mental health, is a fundamental, equitable, and inalienable human right without distinction or discrimination (United Nations, 1948; World Health Organization, 2006). Inclusive mental health support is the fulfilment of this human right. Mental health is not merely the absence of mental illness (or disorder) where one who has mental health is flourishing, one who lacks it is languishing, and one who is moderate is neither (Keyes, 2014 and 2002). Mental health is a variable, internal balance in which a person has cognitive and social skills, emotional regulation, coping, and functioning capabilities, and a congruous mind-body relationship (Galderisi et al., 2015). Inclusive care ensures every person's right to impartial, respectful psychological care that is free from discrimination irrespective of gender, sexuality, race, personal circumstance, or career (Ratts et al., 2016; Robinson-Wood, 2017). Many sex workers, however, predominantly experience exclusionary mental healthcare (Benoit et al., 2016; Socías et al., 2016).

A sex worker is a person who is 18 or older who sells or exchanges sexual services (Canadian Alliance for Sex Work Law Reform, 2017). To clarify, sex work occurs between consenting adults and, therefore, is not exploitation and excludes children and people under the age of 18. Sex work is not sexual assault or sex trafficking, which are explicitly non-consensual (Canadian Alliance for Sex Work Law Reform, 2017). The terms sex work and sex worker will be used throughout this review as they lack the stigmatising and derogatory connotations associated with the label

‘prostitute’. The sex industry includes individual workers and occurs in a variety of settings such as street-based work and indoor work conducted in strip clubs; brothels; private homes; sensual massage parlours; escort agencies; bondage, discipline, dominance, submission, sadism, masochism (BDSM)/kink venues; swingers’ clubs; and can include porn film acting, webcamming and phone sex (Selvey et al., 2017; Wong, 2009). Sex workers hail from many socioeconomic, cultural, and racial backgrounds and represent a spectrum of age, education, and gender identities including cisgender (cis), transgender (trans), male, female, and gender-non conforming (GNC) or gender fluid/neutral (Chabot, 2012). Cis is having a gender identity that aligns with the sex assigned at birth and trans is an umbrella term for those people who do not accept or identify with the sex assigned at birth or the related cultural expectations of said gender (Amnesty International, 2016a). Sex workers represent an array of sexual orientations, such as opposite-sex attracted, same-sex attracted (lesbian, gay, bisexual, queer), or sexual attraction to people of any sex or gender (pansexual, polysexual) (Chabot, 2012). Sex workers possess a range of legal residency statuses (citizens, immigrants, and migrants). Some work full-time and others part-time; some enjoy the work and others do not (Puri et al., 2017). There is a lack of data on the number of sex workers worldwide, therefore, the population size is unknown (Balfour & Allen, 2014). In 2003, Kofman estimated that there was between 200,000 and 500,000 sex workers working illegally in the European Union (EU). For that same period, however, HIV prevalence data indicates that there were 978,118 female sex workers in the EU (Adair & Nezhyvenko, 2016). The large gap between 200,000 and 978,118 also excludes legal, male, or trans, and other sex workers. Population data for other Organization for Economic Co-operation and Development (OECD) countries is also problematic. UNAIDS numbers for sex worker population sizes for 2013/2014 was 20,500 in Australia, 13,000 in the Czech Republic, and 237,798 in Mexico; however, these numbers do not include sex workers who do not have HIV. Stigma, legalities, diverse work locations, the mobile and sporadic nature of sex work, and the conflation of sex work with human trafficking all complicate accurate data gathering (Cool, 2004).

The literature has identified that stigma, discrimination, pathologisation, or lack of knowledge in society and mental health professionals alike underlie the exclusionary

treatment of sex workers (Healthwatch Hackney, 2016; Puri et al., 2017; Wong, 2009). This exclusion can exacerbate or trigger preexisting psychological distress or mental illnesses, cause new symptoms, induce worry, shame or discomfort, and inspire disinclination to seek support (Lilienfeld, 2007; Robinson-Wood, 2017). A lack of appropriate mental healthcare is egregious considering that despite differences, which are based largely on place of work, sex workers are at risk for worse mental health than non-sex workers (Platt et al., 2018). Notably, sex work itself is not causally linked to mental illness (International Committee on the Rights of Sex Workers in Europe, 2017). Rather, it is external factors such as violence, stigma, and discrimination that affect sex workers' mental health (International Committee on the Rights of Sex Workers in Europe, 2017; Socías et al., 2016).

Despite the increased risk of mental illness, studies on the mental health of sex workers are limited (Rössler et al., 2010). Instead, sex worker studies primarily focus on physical or sexual health and related public health concerns (International Committee on the Rights of Sex Workers in Europe, 2017). Systematic literature reviews on the mental health of sex workers are equally uncommon. Some couch mental health among explorations of addiction, physical/sexual health, and violence (Love, 2015). Other reviews cover mental health along with additional topics, including factors that purportedly impact entry into sex work, physical/sexual health, and social exclusion (Balfour & Allen, 2014); sexual/physical health service barriers and enablers (Ma et al., 2017); and legal and physical/sexual health associations (Platt et al., 2018).

Given the lack of a consolidated knowledge base and the strong association between those external factors and an increased risk of psychological distress, a systematic literature review that attempts to provide a balanced, inclusive examination into the mental health of sex workers is necessary. The aim of this review, then, is to synthesize the evidence on the barriers to mental healthcare among sex workers and those factors that enable the uptake of care.

2.1.1.2 Methods

Review Questions

1. What is the uptake of mental healthcare among sex workers?
2. What barriers influence sex workers' access to mental healthcare?
3. What strategies or enablers promote sex workers' uptake of mental healthcare?

Search Strategies

A systematic search of peer-reviewed literature (traditional academic publications) and grey resources (documents produced outside academia) was conducted (Tyndall, 2008). Grey literature was included as it offers current, complementary insight often underrepresented in peer-reviewed literature from the fields of physical or mental health (Paez, 2017; Royal Roads University, 2018). PubMed, CINAHL, and Scopus were searched for peer-reviewed articles. These databases were selected for use as they are common public health databases. Google was searched for grey literature and was selected due to its robustness and the breadth of results it produces from Google Scholar as well as a range of fields and industries (Bandara et al., 2015). Snowballing techniques were then applied to those grey documents that met the inclusion criteria; the references within the retrieved articles were then searched for other relevant citations. The following MeSH (Medical Subject Headings) terms/keywords were used in the searches: mental health, access, uptake, barrier, sex work, sex workers, sex industry, prostitute, marginalised, and enabler. British and American English spelling, plural forms, and Boolean operators were used. The search was conducted by the first author (TR). After removing duplicates, titles were screened and irrelevant studies excluded. All authors cross-checked the abstracts and full text of the remaining studies.

Selection Criteria

Table [2-1] shows the inclusion and exclusion criteria.

Table 2. 1 Inclusion and exclusion criteria

Criteria	Inclusion	Exclusion
Time period	2008-2018	Before 2008
Language	English	Non-English
Participants	Sex workers	People who are not sex workers
Age	18 years of age and older	Children (younger than 18 years)
Location	OECD countries	Non-OECD countries
Topic foci	<ul style="list-style-type: none">• mental health• chronic mental illnesses	<ul style="list-style-type: none">• social, physical, sexual, or reproductive health• acute mental health crises

Data Extraction and Synthesis

Data extracted from the reviewed articles included country, participant details, study design, description of the findings, and relevant conclusions relating to the three review questions. Extracted data from the confirmed documents was summarised, examined thematically, and integrated systematically. Key themes and associations from the entire dataset were identified and higher-order categories created. To capture the comprehensiveness of data, findings were integrated and synthesised (Whittemore, 2005). The first author (TR) conducted the data extraction, identification, categorisation, and synthesis, which the other authors reviewed and confirmed or rejected in teams of two. Differences were resolved through discussion or with the third author.

Assessment of Methodological Quality

Grey and peer-reviewed literature were assessed to appraise for quality and relevance to this review. The first author (TR) assessed the grey literature using the Authority, Accuracy, Coverage Objectivity, Date, and Significance (AACODS)

checklist and all other authors reviewed findings, confirming them all (Tyndall, 2010) (Table [2.2]). AACODS was selected as it was designed specifically to evaluate grey literature and is a widely used tool (Georgetown University, 2019; University of South Australia, 2019). The methodological quality of the peer-reviewed literature was assessed and scored by three of the authors (HH, HB, BNGE) using the Mixed Methods Appraisal Tool (MMAT) (Pluye et al., 2011[b]) (Appendix 4). The MMAT was selected because it can efficiently and reliably be used to appraise qualitative, quantitative, and mixed-methods research and it is regularly updated based on user feedback (Pluye et al., 2011[a]). One study received an overall MMAT quality score of 50%, fourteen received 75%, and seven received a score of 100% (Pluye et al., 2011[a & b]). From a pool of 644 articles and documents, 32 met the inclusion criteria (Fig.[2.1]1) [(Moher et al., 2009)].

2.1.1.3 Results

Eight of the documents included in this review (n = 32) originate in the United States (US), seven from Canada, four from the UK (England, specifically), two each from Switzerland and Australia, and one each from Mexico and Portugal. The remaining focus on Europe, Central Asia, North America, Ireland, and the US or are international in scope. The OECD countries not given specific coverage are Japan, Chile, Israel, Korea, and New Zealand. Roughly 71% of the included documents originate from countries with English as the official language. Eleven of the peer-reviewed studies (n = 22) employed qualitative methods, 10 used quantitative, and 1 used a mixed-methods approach. [The table in Appendix 4] presents the characteristics and main findings of the peer-reviewed literature.

Characteristics and Mental Health of Sex Workers in the Included Literature

Only 53% of the included literature discussed the mental health status of sex workers, presenting degrees of severity based on dissimilar assessment measures. Of those studies, 76.4% cited languishing to severely languishing mental health and 23.6% indicated a varying mental health status that is worse in sex workers who are street-based, non-European, and sex and gender minority people (Koken & Bimbi, 2014; Puri et al., 2017; Rössler et al., 2010). Depression and anxiety disorders were the most commonly assessed conditions. Seven (23%) included sex workers who

work in a variety of settings while all but one of the remainder focused on street-based sex workers. In total, 3,651 sex workers were represented, with 64.7% working in variety of settings and 35.3% street based; the workplace of 850 is unknown/not stated. Of the 17 documents that discussed mental health, 15 were urban-based samples and two did not specify locale (International Committee on the Rights of Sex Workers in Europe, 2017; Koken & Bimbi, 2014); none were rural-based studies. The chief factors that impact sex workers' mental health include violence, assault, stigma, social exclusion, pathologisation, criminalisation, marginalisation, homophobia/transphobia, and service or practitioner barriers. Common factors with positive affect include agency, non-judgemental and culturally competent service providers, professionalising sex work, coping, and social inclusion.

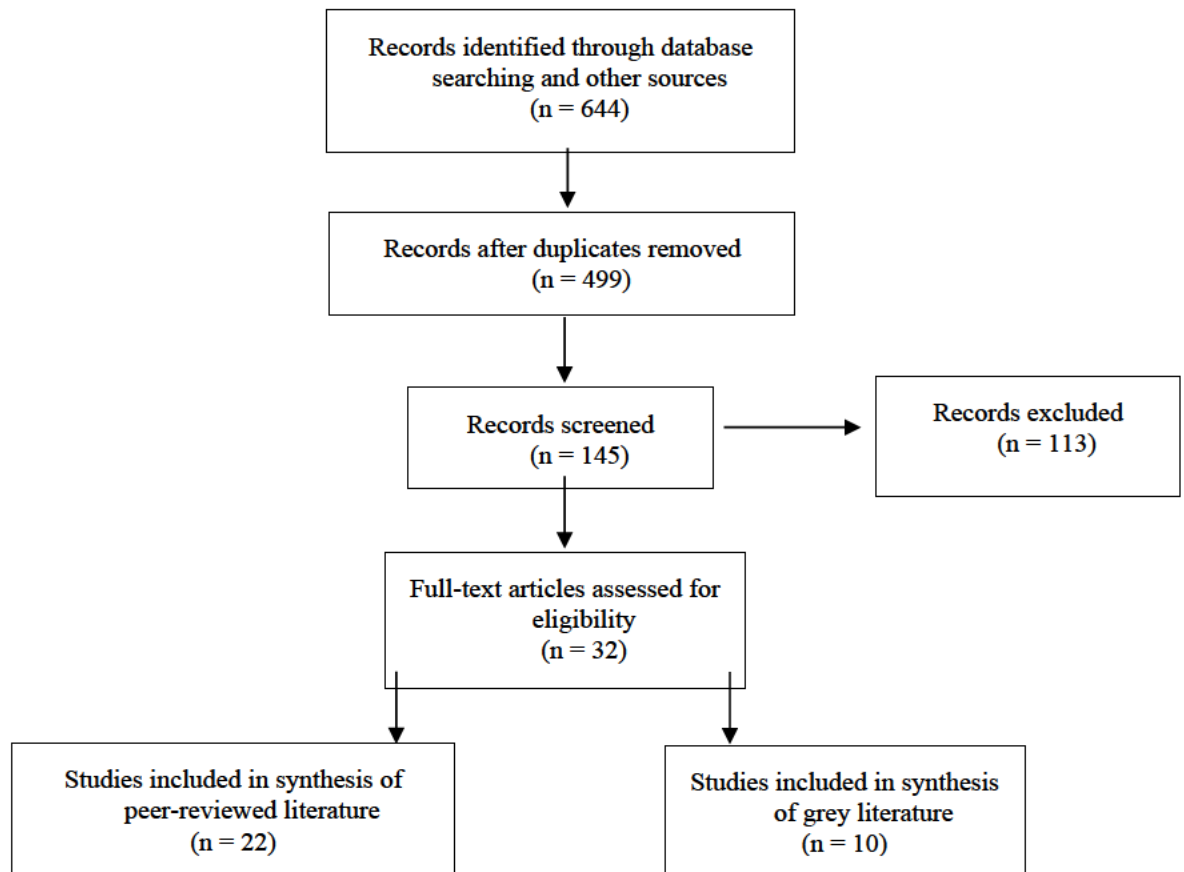


Figure 2. 1 Sex Worker SLR PRISMA Flow Diagram

Table 2. 2 AACODS Checklist Results for All Grey Literature (n = 10)

Author and Setting	Document type	Authority	Accuracy	Coverage	Objectivity	Date	Significance
Amnesty International (2016b), Switzerland	Policy on state obligations	✓	✓	✓	✓	✓	✓
Church (2017), United States	Webpage on counselling for SW	✗	✓	✗	✓	✓	✓
Healthwatch Hackney (2016), England	Report on borough's SW	✓	✓	✓	✓	✓	✓
International Committee on the Rights of Sex Workers in Europe (2017), Netherlands	Briefing paper on impact of criminalisation and violence	✓	✓	✓	✓	✓	✓
Koken and Bimbi (2014), United States	Book chapter	✓	✓	✓	✓	✓	✓
Ley (2017), United States	Webpage on counselling SW	✓	✓	✓	✓	✓	✓
McKeen (2018), Canada	Newspaper article on impacts of a law	✓	✓	✓	✓	✓	✓
Palmisano (2018), United States	Webpage on impacts of a law	✓	✓	✓	✓	✓	✓
Selvey et al. (2017), Australia	Summary report on a study	✓	✓	✓	✓	✓	✓
Wong (2009), United States	Master of Social Work thesis	✓	✓	✓	✓	✓	✓

Uptake of Mental Health Services

The first research question that this systematic literature review sought to explore pertained to the uptake of mental health services among sex workers. Uptake of the non-sex worker population in some OECD countries in 2010 ranged from roughly 6% for people with moderate mental health disorders in the United Kingdom to 35% for people with severe disorders in Denmark (OECD, 2012). Of the 32 included studies, only 14 referred to uptake, indicating a gap in the knowledge about how sex workers avail of mental healthcare. Those 14 revealed that, generally, sex workers' uptake of mental healthcare is poor. For example, the American cohort of an Ireland-US male, sex work study had 'little contact with social services' (McCabe et al., 2014, p. 99). Among a group of 235 trans female sex workers, the desire for mental health support was strong; however, barriers were many, including a lack of services (Nemoto et al., 2015).

Uptake of mental healthcare, however, is not entirely poor. While only 14% of respondents from a Western Australian study accessed counselling and only 11% accessed mental healthcare (Selvey et al., 2017), some sex workers in Canada, America, Portugal, and Dublin availed of support. A Canadian study of 338 trans and cis sex workers found that 80.8% of participants had undergone counselling (Puri et al., 2017). And, 72.4% of participants (cis and trans women) in an American study sought mental health support (Wong, 2009). Teixeira and Oliveira (2017) found that while 55.8% of their Portuguese cohort were diagnosed with mental illness, only 70% received support and only 37.9% had subsequent appointments. Cis male sex workers in Dublin had seen a counsellor, with that contact occurring via methadone clinics (McCabe et al., 2014). Mental healthcare with outreach programs also reported positive uptake (Bodkin et al., 2015; Healthwatch Hackney, 2016). It should be noted, however, that trans people wishing to undergo gender-affirming medical procedures and people accessing methadone are required to see mental health practitioners, thus, likely increasing related uptake results (Benson, 2013; Marel et al., 2016).

Barriers to Mental Healthcare

Twenty-six of the included studies explored the second research question, which pertained to the barriers that impede sex workers' access to mental healthcare. The literature reveals that barriers to care are a reality for sex workers. In a Canadian study of female sex workers, for example, 70% of participants reported barriers, roughly three-times more than the general population (Sociás et al., 2016).

Specifically, sex workers encounter the barriers of stigma, discrimination, pathologisation, criminalisation, and violence that originate with service providers, services, and systems. Barriers can also manifest for some sex workers on an individual level.

Barriers Imposed by Service Providers and Services

Barriers to care that sex workers face include stigma, discrimination, pathologisation, mistrust of mental health service providers, and service logistics. Whether enacted or perceived, stigma is correlated with languishing mental health in sex workers and is a barrier to care (Bowen & Bungay, 2016; Gunn et al., 2016; Ley, 2017; Sociás et al., 2016; Wong, 2009). The included studies show that mental healthcare providers commonly demonstrate stigma toward sex workers, such as provider disdain, blame for destroying families, spreading sexually transmitted infections/human immunodeficiency virus (STI/HIV), and increasing crime (Burnes et al., 2018; McCabe et al., 2014; Mellor & Lovell, 2012; Prince, 2013). The included literature also mentions fear of practitioner judgement or bias – a common facet of stigma – as a barrier, with some authors citing it as the primary cause for sex workers avoiding care seeking (Benoit et al., 2016; Mellor & Lovell, 2012; Prince, 2013; Selvey et al., 2017; Wong, 2009).

The comprehensive nature of stigma affects sex workers on multiple strata; that is, not only are sex workers subjected to whorephobia (fear of or derision for people who exchange sex for money/goods; Burnes et al., 2018), but people of colour, of various gender expressions and sexual identities, of lower socio-economic levels, or those with disabilities also experience racism, transphobia, homophobia, classism, and ableism. These prejudices worsen mental health and breed care-seeking

avoidance (Amnesty International, 2016a; Bith-Melander et al., 2010; International Committee on the Rights of Sex Workers in Europe, 2017; Puri et al., 2017; Rodriguez et al., 2018; Teixeira & Oliveira, 2017).

Discrimination, the manifestation of stigma, is unjust or prejudicial treatment and is a barrier to care for which some mental health professionals are culpable (Mullner, 2009). Discrimination, like stigma, impacts a person's mental health and can result in help-seeking avoidance (Bith-Melander et al., 2010; Rodriguez et al., 2018). Sex workers, including those who use substances, are sex and gender minority people, are street-based sex workers, are First-Nations people, or have a mental health diagnosis that is gender-related have experienced discrimination in the form of refusal of, or inadequate care (Bodkin et al., 2015; Rodriguez et al., 2018; Socías et al., 2016).

Pathologisation is a barrier to uptake in that it vilifies sex work and the people engaged in it while denying the workers' agency (International Committee on the Rights of Sex Workers in Europe, 2017; Koken & Bimbi, 2014). Pathologisation is represented in the included studies as the medicalisation of sex workers where non-medical aspects are rendered medical, and, as such, seeks to determine aetiology, treatment, and cure (Clabough, 2017). In the literature, aetiology presents as an examination of factors that lead to sex workers entering the trade, treatment focuses on identifying and combatting the health risks of being in the trade, and cure assumes that exiting or leaving the trade is the sole solution.

Determining aetiology is an intrinsic quality of the medicalisation of sex work, which seeks to explore why people enter the trade. The causes that receive particular attention in the literature are child physical or sexual abuse, languishing mental health, substance use, leaving home at a young age, poverty, homelessness, and a lack of education (Burnes et al., 2018; Gunn et al., 2016; Koken & Bimbi, 2014; McCabe et al., 2014; Mellor & Lovell, 2012; Prince, 2013; Seib et al., 2009; Teixeira & Oliveira, 2017). Indeed, some sex workers have had these experiences, but so too have many other people.

Pathologising views of sex work also explore the treatment of those public health concerns regularly attributed to sex workers, namely STI/HIV and substance use (International Committee on the Rights of Sex Workers in Europe, 2017; Rössler et al., 2010). Although articles that concentrated solely on STI/HIV and substance use were excluded from this review, many of the included documents made these an essential part of demographic data collection and reporting (Choudhury, 2010; Darling et al., 2013; Fraser et al., 2002; Gunn et al., 2016; Jackson et al., 2009; McCabe et al., 2014; Nemoto et al., 2015; Rodriguez et al., 2018; Socías et al., 2016; Teixeira & Oliveira, 2017). Puri et al. (2017) and Socías et al. (2016) even made HIV/STI and Hepatitis C testing an aspect of study participation. While some sex workers have HIV/STI, prevalence varies; thus, a generalised focus on these health conditions without exploration of violence, stigma, and criminalisation, those additional factors that increase risk, is pathologising (International Committee on the Rights of Sex Workers in Europe, 2017).

The literature also demonstrates that the desired treatment outcome of some mental health practitioners who work with sex workers is to have them exit the trade, regardless of the clients' own, often contradictory, aims (Burnes et al., 2018; Gorry et al., 2010; Healthwatch Hackney, 2016; Palmisano, 2018; Wong, 2009). Exiting is also seen as the panacea as sex work is often conflated with human trafficking, which is inaccurate, lacks nuance, and distracts from the issues that actually enable trafficking (Amnesty International, 2016a; McKeen, 2018; Palmisano, 2018).

Sex workers' mistrust of mental health practitioners includes confidentiality, another barrier to care. Confidentiality, indicated by 47.2% of participants in an Australian study, was one of the reasons given for attending a specific health service (Selvey et al., 2017). Confidentiality was cited by 45.5% of participants in an American study as the reason for non-disclosure (Wong, 2009). The scope and exceptions to confidentiality vary worldwide. Thus, disclosure of a job in the sex industry to a mental health professional could lead to criminal charges, loss of parental rights, or financial hardship due to a loss of government support benefits. To allay these risks, many sex workers do not disclose their labour activity to mental health practitioners (International Committee on the Rights of Sex Workers in Europe, 2017; Mastrocola et al., 2015; Mellor & Lovell, 2012; Selvey et al., 2017; Wong, 2009). While not

disclosing their work is a person's right, non-disclosure can hinder the therapeutic process or be a barrier to care (Mastrocola et al., 2015; Prince, 2013).

Mental healthcare services also erect logistical barriers to care, including too few staff and a lack of or failure to enforcement an anti-discrimination policy (Rodriguez, et al. 2018; Socías et al., 2016). Other service-based barriers to care are limited, inconvenient hours, poor location, wait lists, charging fees for service, and requiring scheduled appointments instead of offering a drop-in service (Bodkin et al., 2015; Darling et al., 2013; Gorry et al., 2010; Gunn et al., 2016; Mastrocola et al., 2015).

Systemic Barriers

Systemic barriers derive from policies that discriminate or prevent participation. Much of the reviewed literature cited criminalisation as one such barrier that profoundly impacts sex workers' mental health and uptake. Legislation pertaining to sex work differs throughout OECD countries. Generally, they can be categorised as full or partial criminalisation, legalisation, and decriminalisation. For brevity, only criminalisation and decriminalisation will be discussed here. Decriminalisation is linked to better health and makes it possible for sex workers' human rights to be upheld and protected (Chabot, 2012). Criminalisation, however, impedes sex workers' access to mental healthcare and encumbers general mental health through precarity. That is, the precarity of sex work due to criminalisation causes anxiety in sex workers about being arrested (Chabot, 2012). Regarding mental healthcare access, this anxiety prevents sex workers from help seeking or encourages profession concealment (International Committee on the Rights of Sex Workers in Europe, 2017).

Institutional 'trans-erasure', which is the propensity to discount, reject, or diminish the existence of trans people, is another systemic barrier (Benoit et al., 2016). Others are the requirement of a residence permit or health insurance to access care, a lack of universal healthcare, and a lack of services (Bith-Melander et al., 2010; Darling et al., 2013; Ley, 2017). Service unavailability is another barrier, particularly in rural

or remote areas where there are few if any supports, including those that are specialised or offer a holistic range of care (Socias et al., 2016).

These barriers hinder uptake of mental health services and manifest in sex workers avoiding care seeking or relying on hospital emergency departments for psychological support (Bodkin et al., 2015; Darling et al., 2013; Mastrocola et al., 2015; Prince, 2013). Hospitals' triage-approach to mental health, however, disallows vital, ongoing support and is often ineffective in addressing lingering complaints.

Individual Factors as Barriers to Mental Healthcare

Factors unique to an individual sex worker, which can manifest for a variety of reasons, including due to stigma and discrimination, can also be barriers to mental healthcare seeking. Some sex workers only seek help when the matter becomes more advanced or urgent (Bodkin et al., 2015; Mastrocola et al., 2015; Prince, 2013). Care is not prioritised due to an inability to pay, out of fear of stigma-based recrimination, a lack of knowledge about available services (due to literacy issues, poor advertising by the services, or language issues), and a lack of services (Darling et al., 2013; Nemoto et al., 2015; Rössler et al., 2010; Wong, 2009).

The literature cited several additional examples of this type of barrier: hectic schedules; substance use; lack of transportation; judgement from other public-transport travellers; limited understanding of conditions; voluntary withdrawal due to fear of being judged, humiliated, and discriminated against; housing issues; inability to afford or difficulty finding childcare; and lack of a medical card or identification (ID) (Benoit et al., 2016; Bith-Melander et al., 2010; Gunn et al., 2016; Healthwatch Hackney, 2016; Mastrocola et al., 2015; Mellor & Lovell 2012; Prince, 2013; Socias et al., 2016).

Violence, a personal reality for many sex workers, is another, significant barrier to mental health care seeking reported in the included literature. This minority or gender-based oppression against sex workers occurs in the form of rape and physical assault by clients against sex workers regardless of where they work, though violence is much more prevalent among those who are street based (Amnesty International, 2016a; International Committee on the Rights of Sex Workers in

Europe, 2017; McKeen, 2018; Seib et al., 2009; Selvey et al., 2017; Socías et al., 2016). Other perpetrators of violence against sex workers are the general public, business owners, and romantic partners (Healthwatch Hackney, 2016; Koken & Bimbi, 2014; Socías et al., 2016). There is a direct connection between criminalisation and violence against sex workers (Bodkin et al., 2015; Bowen & Bungay, 2016; Choudhury, 2010; Darling et al., 2013; Gorry et al., 2010; Healthwatch Hackney, 2016; International Committee on the Rights of Sex Workers in Europe, 2017; Jackson et al., 2009; Mastrocola et al., 2015; Nemoto et al., 2015; Palmisano, 2018; Seib et al., 2009). Police are also known to be perpetrators of harassment, violence, and even brutality against sex workers (International Committee on the Rights of Sex Workers in Europe, 2017; McCabe et al., 2014; Palmisano, 2018; Puri et al., 2017).

Given how it interferes with a person's physical, cognitive, emotional, or social wellbeing, violence undeniably contributes to sex workers' ill mental health (Burnes, et al. 2018; International Committee on the Rights of Sex Workers in Europe, 2017). Countless sex workers throughout Europe and Central Asia cite violence is their principle health worry (International Committee on the Rights of Sex Workers in Europe, 2017). Gender-based violence is a recognised structural determinant of numerous negative health outcomes (Socías et al., 2016). The physical oppression of cis female sex workers can dehumanize, indicating that the perpetrators view them as expendable and that the abuse is warranted (Gorry et al., 2010; Jackson et al., 2009). This can also be said for trans sex workers who are subjected to hate crimes, including violence and murder (Rodriguez et al., 2018). Of the 2,982 trans people murdered in the world from January 2008 to September 2018, 62% were sex workers (Berredo, 2018).

Enablers to Mental Healthcare

The third research question focused on the enablers that promote sex workers' uptake of mental health support and services, which 27 of the included studies covered directly or indirectly. Specifically, enablers are factors that facilitate access to support. Generally, enablers are elements that assist with or contribute to mental health. The reviewed documents cited many enablers that are the inverse of the

barriers; those are not repeated here. Enablers can be counterpoints to barriers, but, ideally, are more nuanced and address the complex, interconnecting factors that impact mental health. It is those holistic enablers that arose most predominantly in the included literature, which are presented in this section as they pertain to service providers, professional development, services, systemic factors, and the personal realities of social inclusion and resilience. Table 2.3 demonstrates that the grey literature indicated more barriers and enablers and, thus, is considered more inclusive, holistic, and solution-focused than the peer-reviewed literature.

Table 2. 3 Predominant barriers and enablers (%) in the included peer-reviewed (PR) (n = 22) and grey literature (n = 10)

Barrier	PR	Grey	Enabler	PR	Grey
Judgement	55	80	Lack of judgement	45	50
Stigma	91	90	Acceptance	36	60
Pathologising	72	80	Not pathologising	22	60
Criminalisation	50	90	Decriminalisation	32	80
Homophobia, transphobia, misogyny, whorephobia, racism	45	90	Allyship, inclusivity	9	40
Providers lacking knowledge and experience	63	50	Educated, experienced providers	63	70
Providers lacking cultural competency	50	80	Cultural competence	55	80
Lack of services, esp. specialised ones	59	70	Services, incl. specialised ones	68	80
Lack of trust of mental health service providers	50	60	Mental health service providers building, maintaining trust	22	40

Service Providers

The literature listed many ways in which service providers can facilitate sex workers' uptake of mental health support as well as enhance mental health. Valuing the person and having a desire to help (Bodkin et al., 2015), being empathetic

(Gorry, et al. 2010; Healthwatch Hackney, 2016; Mellor & Lovell, 2012), and working to develop trust with clients were cited as important (Gorry et al., 2010). Having experience working with marginalised populations also received significant attention. The facets of this included working with sex workers as well as in the areas of inclusion regarding sex and gender minority people and people who practice kink; sexual assault; people of culturally and linguistically diverse backgrounds; substance use; trauma-informed care; community-based care; suicide intervention and prevention; empowerment; sensitivity training; and homelessness (Benoit et al., 2016; Bodkin et al., 2015; Church, 2017; Gunn et al., 2016; Healthwatch Hackney, 2016; Puri et al., 2017). Another enabler cited in the included literature is service providers who advocate for mental health for sex workers by viewing their clients' lives holistically and providing an integrated team or multidisciplinary approach to care (Bodkin et al., 2015). These advocates also work to combat structural inequalities that impact mental health, including stigma, discrimination, and criminalisation (International Committee on the Rights of Sex Workers in Europe, 2017).

Professional development

The literature recommends that mental health practitioners and all healthcare providers adopt an ongoing commitment to professional development, including emergency department staff, due to the high uptake of that service by sex workers (Prince 2013). Suggestions for how requisite skills could be acquired included universities and colleges incorporating training early in academic programs and requiring practitioners to undertake experiential learning via community work (Prince, 2013; Rodriguez et al., 2018; Socías et al., 2016).

The literature recommended the following training topics: exploring anti-sex work and whorephobia biases and how intersectionality can intensify these biases (Burnes et al., 2018; Wong, 2009); cultural competence (Choudhury, 2010; Prince, 2013; Rodriguez et al., 2018; Wong, 2009); working non-judgementally (Gunn et al., 2016; Wong, 2009); and compassion and social exclusion (Prince, 2013). Practitioners should complete this training themselves, and not rely on clients to educate them (Wong, 2009). Finally, in addition to enhancing learning to improve

the mental health of sex workers, it was recommended that practitioners engage in self-reflection, address their inhibitions regarding sex and sex work, become sex-work friendly, sex positive, and make suitable referrals (Ley, 2017; Wong, 2009).

Services

Mental healthcare services can enable uptake via partnerships to provide coordinated, integrated support (Healthwatch Hackney, 2016; Priebe et al., 2013; Prince, 2013). An open-access or barrier-reduced service was another suggested enabler, which would eliminate exclusion criteria, wait lists, proof of ID or age-based access; accept self-referrals; and offer unscheduled or drop-in appointments and ongoing care with no cap on appointments (Bith-Melander et al., 2010; Mastrocola et al., 2015; Priebe et al., 2013). Providing a mix of crisis-based, ongoing, and transition-related care, including prevention were also cited as enablers (Nemoto et al., 2015; Prince, 2013; Puri et al., 2017). Finally, service offerings outside clinical settings, such as mobile units and outreach support, were indicated to be enablers to care (Gunn et al., 2016; Healthwatch Hackney, 2016; Priebe et al., 2013; Prince, 2013; Puri et al., 2017). Outreach can offset barriers associated with formal settings, engage underserved populations in care, and give providers an opportunity to advertise their services (Selvey et al., 2017; Wong, 2009). Tailored, accessible services were identified as filling gaps in service provision while also recognising and validating the people who use them (Nemoto et al., 2015).

Systemic Enablers

Systemic enablers that arose pertain to policies or practices that address disadvantage while making mental healthcare attainable. Funding would be required to ensure an enabling form of care (Nemoto et al., 2015). Proportionate universalism healthcare was cited as an enabler to care, reducing the need for private health insurance and related fees or citizenship qualifications (Bith-Melander et al., 2010; Socías et al., 2016). Gender-specific programming is another suggested systemic enabler to care for sex workers (Socías et al., 2016).

Individual Factors

The two primary enablers that are unique to the individual and which positively influence sex worker mental health and service uptake referenced in the literature are social inclusion and resilience. Social inclusion is perceived support from a significant other, family, friends, community, peers, or society (Jackson et al., 2009). Inclusion is an enabler that leads to increased service uptake via its contributions to an individual's self-worth, which, in turn, inspires healthier behaviours, such as seeking mental health support (Bowen & Bungay, 2016; Mellor & Lovell, 2012). Social support is also a protective factor that reduces the likelihood or severity of mental ill health and suicidal ideation (Jackson et al., 2009; Mellor & Lovell, 2012; Nemoto et al., 2015; Rössler et al., 2010; Teixeira & Oliveira, 2017).

Sex workers' experience with social inclusion varies. Family and community acceptance were cited as lacking in large degree in studies from the US and Mexico (Burnes et al., 2018; Gunn et al., 2016); however, a Dublin-based cohort of sex workers indicated having family support (McCabe et al., 2014). Family support was also affirmed by 77.7% of participants in a Swiss study (Rössler et al., 2010). Trans community support also varied. In a study that compared two cities in California, the cohort in one felt more acceptance than the other (Nemoto et al., 2015). For trans sex workers, social inclusion means support not only for their occupation, but also for their gender.

Social inclusion in the form of peer support also varies. While there was evidence of connection with and assistance from peers (Burnes et al., 2018; Koken & Bimbi, 2014), sex work was also seen as isolating and an impediment to peer connection (Seib et al., 2009). Allies (Palmisano, 2018) and significant others (Jackson et al., 2009; Teixeira & Oliveira, 2017) can also contribute to social inclusion, while the criminalisation of sex work (Church, 2017) and substance use (Teixeira & Oliveira, 2017) were cited as detractors. Itinerant or immigrant sex workers were cited as lacking social inclusion (Rössler et al., 2010). While some people require social support, others do not due to other protective factors, including a positive sense of identity, ability to regulate emotions, and good coping skills or resilience (Selvey et al., 2017). In the absence of additional protective factors, however, being accepted

influences a person's investment in their mental health and, to that end, their engagement with support services.

Resilience is another enabler to sex workers' mental health that reflects personal strength and can counter stigma, pathologisation, and marginalisation as well as increase uptake. Communicated as coping skills, strength, and agency in the literature, sex workers demonstrate resilience as emotional management; establishing and maintaining sexual boundaries (condom use, included and excluded sex acts); and resourcefulness (Bith-Melander et al., 2010; Burnes et al., 2018; McCabe et al., 2014; Wong, 2009). Agency is exemplified as sex workers being active contributors to the planning and implementation of peer-based counselling programs (Bowen & Bungay, 2016; Burnes et al., 2018; Choudhury, 2010; International Committee on the Rights of Sex Workers in Europe, 2017; Puri et al., 2017; Selvey et al., 2017; Wong, 2009). Self- and co-worker-affirmations, self-confidence, promoting one's own mental health, behavioural adaptation, and enjoying sex were other examples of resilience (Burnes et al., 2018; Choudhury, 2010; Mellor & Lovell, 2012). Self-preservation is also an aspect of resilience and was demonstrated as cognitive reframing, injecting comedy, and even positive and negative coping mechanisms (Gorry et al., 2010). Resilience not only enables uptake of mental healthcare and is indicative of mental health, but its consideration facilitates a holistic and ultimately more representational view of sex workers (Bowen & Bungay, 2016).

2.1.1.4 Discussion

The aim of this review was to synthesize the evidence on the barriers to mental healthcare among sex workers and the factors that enable the uptake of care. While uptake is generally poor and barriers are many, factors exist to enable the uptake of mental health support services. This review found that the mental health of sex workers varies from flourishing to languishing. This difference is due to the fact that studies tend to concentrate on or combine mental health with physical health (Benoit et al., 2016; Bodkin et al., 2015; Choudhury, 2010; Darling et al., 2013). The lack of one universal standard for determining the severity of mental illness also contributes to the divide. In the absence of a universal standard, either practitioners or the person affected can gauge presenting symptoms and their severity. Additional

aspects that can be included in severity determination are comorbidity, self-management capacity, duration of presentation, quality of life impact, life satisfaction, or impact on wellbeing (Griffiths, 2017). There is evidence that generally, the mental health of some sex workers is similar to that of women in the general population (Seib et al., 2009). Mental illness in the general population ranges from mild (mild depression or anxiety disorder) to severe (where medication or counselling are necessary) and presents in 13-17% of people (ABS, 2012; Kessler, 2002; Mental Health Foundation, 2016). However, 68% of cis female sex workers convicted for work-based crimes meet the criteria for post-traumatic stress disorder (PTSD), which is the same percentage for combat veterans and people who have been tortured (Mastrocola et al., 2015).

Sex worker uptake of mental healthcare varies. Those affiliated with specific services or who can avail of outreach support tend to access counselling. Those who encounter barriers to care, however, avoid seeking support. Sex workers experience almost triple the barriers that the general population encounter, 40.4% vs. 14.9% (Benoit et al., 2016). Barriers to care for sex workers relate directly to service providers, services, systems, and complicated personal realities. Mental health service providers erect barriers that primarily manifest as stigma, discrimination, and pathologisation. Help seeking for mental health issues has the potential to be enabled by practitioners who possess relevant, adequate training, by services that offer tailored, barrier-free or -reduced support, and by systems that do not criminalize, but that provide inclusive universal healthcare. The protective factors of social inclusion and resilience as demonstrated through agency, self-confidence, emotional management, and boundary setting are also enablers to improved mental health support seeking.

Of the 68% of the peer-reviewed studies that did not receive a full methodological quality score, many failed the MMAT qualitative criteria 1.4., which required that appropriate consideration being given to how findings relate to researchers' influence, for example, through their interactions with participants. Specifically, this suggests that reflexivity may have been lacking in the peer-reviewed literature and could indicate a potential research bias stemming from a lack of assumptions and preconceptions exploration during the research process (Pluye et al., 2011[a & b]).

The included peer-reviewed literature largely perpetuates stigma through a lack of diversity by featuring a majority (54.5%) of cis female sex workers. Indeed, Amnesty International asserts that the majority of sex workers globally are women (Amnesty International, 2016b). This prevalence of cis women, however, discounts people with a multitude of gender expressions and sexual identities who work in the industry, including cis males, trans people, gender non-conforming people, and lesbian, gay, and bisexual people (Amnesty International, 2016b). The exclusion of diversity aligns extreme sexual behaviour with women (Burnes et al., 2018) and contributes to the rendering of male sex workers, for example, as invisible (Chabot, 2012). Of the literature that met the inclusion criteria, only two focus exclusively on male sex workers (Koken & Bimbi, 2014; McCabe et al., 2014). This disproportional representation also positions cis men as reasonable and competent and cis women as defenceless, irrational victims (Koken & Bimbi, 2014). A lack of diversity represented in the peer-reviewed studies also extends to place of work; that is, 35.3% focus on street-based sex workers, yet those who are street based comprise as little as 5% of the trade (Australian Institute of Criminology, 2017; Chabot, 2012). Place of work factors heavily into sex workers' mental illness as those who are street based, for example, encounter more violence and are less likely to engage in care than their indoor counterparts (Mastrocola et al., 2015). Of all sex workers, those who work on street tend to be more significantly disadvantaged, have languishing mental health, greater substance use and misuse issues, and face the most violence. A heavy focus on the negatives inherent in this place of work not only perpetuates the associated stigmas, but implies this data is generalizable to all sex workers. Studies that explore a variety of settings for sex work present a broader picture of where sex workers work, and a more thorough depiction of the realities of sex workers' lives and mental health. Homogenous samples oversimplify the realities and diversity of sex workers and their mental health. When one portion of a population is standardised to represent the entire population, bias results.

A range of factors impel a person's entry into sex work: financial, job flexibility or satisfaction, personal empowerment, the ability to help others, and limited or no alternate opportunities, including for migrants or in places with high unemployment (Amnesty International, 2016a; Church, 2017; International Committee on the Rights of Sex Workers in Europe, 2017; Ley, 2017; Rössler et al., 2010; Selvey et

al., 2017; Wong, 2009). Notably, these factors are quite common reasons to begin any other job, and like any other job, sex work has positive and negative elements (Palmisano, 2018).

The social and structural inequalities that afflict sex workers are borne out of patriarchal and kyriarchal domination and moralising criticism, which view society and power relations as a hierarchy and behaviour as a matter for public judgement and reproach (Rubin, 2007; Dawthorne, 2019). What results from this is the objectification of sex workers, the disallowing of sex workers' agency, and the criminalisation of sex work (Quadara, 2008; Global Network of Sex Work Projects, 2017). Many global organisations and researchers call for the worldwide decriminalisation of sex work due to the pervasive and deleterious impacts it has on sex workers (Amnesty International, 2016a; International Committee on the Rights of Sex Workers in Europe, 2017; McKeen, 2018; Palmisano, 2018; Puri et al., 2017; Rössler et al., 2010; Selvey et al., 2017; Socías et al., 2016; World Health Organization, 2012).

Criminalisation protects the buyers, not the sellers of sex making them more vulnerable to violence, reporting by clients, and limited sexual control (McKeen, 2018; Palmisano, 2018). Criminalisation hinders sex workers' ability or desire to avail of police support (Amnesty International, 2016a; Bowen & Bungay, 2016; Healthwatch Hackney, 2016; McKeen, 2018; Selvey et al., 2017). Decriminalisation normalises and destigmatises sex work (Selvey et al., 2017). Decriminalisation offers sex workers police protection, making it possible to punish the abusers instead of the abused (McKeen, 2018; Puri et al., 2017; Socías et al., 2016). Lastly, decriminalisation of sex work is associated with improving sex worker mental health for the significant impact of criminalisation on uptake and the impact of the violence that occurs due to criminalisation on the mental health of sex workers cannot be overstated (Bodkin et al., 2015; Bowen & Bungay, 2016; Chabot, 2012; Choudhury, 2010; Healthwatch Hackney, 2016; International Committee on the Rights of Sex Workers in Europe, 2017; Jackson et al., 2009; Mastrocola et al., 2015; Mellor & Lovell, 2012; Nemoto et al., 2015; Palmisano, 2018; Prince, 2013; Rössler et al., 2010; Seib et al., 2009; Socías et al., 2016; Teixeira & Oliveira, 2017).

There is emerging literature that views sex workers' mental health holistically not pathologically, but it is sparse. Politically or ideologically focused research further alienates sex workers through approaches that lessen them to mere acts of commercial sex. Extensive focus on substance use, HIV/STI, and childhood abuse in sex worker populations perpetuates the pathologisation of the work. Legislation that ignores the complexities and diversities of sex workers through criminalisation exacerbates already dire marginalisation while denying legal and regulatory protection. This oppression pervades the lives of sex workers, encourages and excuses violence, and causes psychological distress. It also hinders mental healthcare seeking, erects and maintains barriers to support, and diminishes vital enablers.

Social and Public Policy Implications

The findings of this systematic literature review could inform public and social policy pertaining to sex work and sex workers. Generally, policy makers could parlay the findings of this review into the design and creation of new initiatives such as decriminalisation of sex work or the creation of a union for sex workers, for example, that result in improved, targeted outcomes for sex workers in all wellness dimensions. Such potential benefits have practical and translational implications for multidimensional wellness that could extend to the families, friends, loved ones, and clients of sex workers. Specifically, these initiatives could act to optimize the mental health treatment that sex workers receive as social and public policy declarations shape professional practice as well as research directions.

Implications for Mental Health Professionals and Researchers

Mental health professionals and researchers who work with sex workers are uniquely placed to address personal and systemic deficiencies. Counsellors, therapists, psychologists, and psychiatrists can reject the dominating medical model of mental health service provision and enact a holistic, inclusive, person-centred, trauma-informed, anti-oppressive approach to practice (Mellor & Lovell, 2012). Continuous learning on a multitude of topics such as issues facing sex workers, sensitivity, or inclusivity, for example, can facilitate this approach and content

designed or delivered by sex workers can enhance it (International Committee on the Rights of Sex Workers in Europe, 2017; Palmisano, 2018; Rodriguez et al., 2018; Socías et al., 2016; Wong, 2009).

Researchers can eschew the pathologisation of sex workers through positioning authenticity at the core of their investigations, conducting reliable, balanced explorations of a cohort's lived experience and the broader consequences of the research (Given, 2008). Working from an intersectional framework enables understanding of the complex, cumulative oppressions that sex workers face, and attempts to counter interlaced inequities.

Implications for Future Work

Future research could explore sex worker mental health with an inclusive and holistic approach that is entirely separate from physical or sexual health. Explorations that recognize sex workers as experts in their own lives and incorporate this expertise in research design and implementation are rare and provide an excellent opportunity for academics. Future research could also focus on rural and regional populations, which is overwhelmingly absent at present. Outcomes can then be applied systemically to inform policy, legislation, and education.

Limitations

The content and findings of this paper are limited by the inclusion and exclusion criteria and the databases that were searched. Although search parameters are a necessary component of any systematic literature review, they do create the risk of excluding relevant literature. Limiting the geographic location of the study to OECD countries was necessary to establish boundaries and provided an opportunity to explore comparable services within countries that have shared economic and social aims. This restriction rendered the data not easily generalizable to non-OECD countries, but provides an opportunity for subsequent literature reviews. As this was a paper on mental health service usage, the databases selected for peer-review literature searches largely focus on the fields of medicine and health. Searches of other databases from other fields, including the social sciences, for example, may have yielded different findings. This review did not include non-English studies,

which may have provided alternate findings. Finally, the included grey literature, which more so incorporated the perspectives and lived experience or were authored by sex workers than the peer-reviewed literature, was given proxy to serve as best practice. While this attempt to incorporate a holistic, agency-honouring view of sex workers mental health is inclusive, it may represent an imperfect approach to academic research.

2.1.1.5 Conclusions

Balanced, unbiased evidence that sex work itself causes mental ill health is non-existent (International Committee on the Rights of Sex Workers in Europe, 2017). Generally, however, the mental health of some sex workers is languishing and is significantly exacerbated by stigma, discrimination, violence, and criminalisation. When these oppressions coalesce, psychological distress and the need for inclusive support can increase exponentially. In reality, sex workers have low uptake of mental healthcare and encounter significant barriers to access, including those disseminated by practitioners, services, and society.

Understanding the impact of these often mutually reinforcing oppressions and their preventability could contribute to the discontinuation of their perpetuation while improving sex worker mental health. It is corroborated that inclusive psychological care can fulfil every person's right to impartial, respectful support irrespective of gender, sexuality, race, personal circumstance, or career. Honouring the vast array of identities of the people engaged in sex work, including trans and gender fluid/neutral people will offset trans erasure while serving to counter the deeply engrained whorephobia that all sex workers face. More scholarly work that eschews stigma is needed, particularly after many years of discourse that pathologizes, discriminates, and fails to honour sex workers' basic human rights.

The second literature review completed for this study has been published as Reynish, T., Hoang, H., Bridgman, H., Nic Giolla Easpaig, B. (2022) ‘Barriers and Enablers to Mental Health Help Seeking of Sexual, Gender, and Erotic Minorities: A Systematic Literature Review. *Journal of Gay & Lesbian Mental Health*. doi: 10.1080/19359705.2022.2036666

2.1.2 Barriers and Enablers to Mental Health Help Seeking of Sexual, Gender, and Erotic Minorities: A Systematic Literature Review

2.1.2.1 Abstract

Introduction: Sexual, gender, and erotic minority people experience oppressions that psychologically harm and impact help seeking. The aim of this review was to integrate available evidence on the uptake, barriers, and facilitators of mental health help seeking in sexual, gender, and erotic minority people.

Method: Systematic searches were conducted in CINAHL, Medline, and Scopus for peer-reviewed articles and in Google for grey literature using Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines. Studies published in English in Organisation for Economic Co-operation and Development countries between 2008 and 2018 regarding sexual, gender, and erotic minority people older than 18 years were eligible. Quality assessments were conducted and extracted data were analysed thematically.

Result: Ninety documents were included in the review. Uptake is generally greater among sexual, gender, and erotic minority people than cisgender, heterosexual people, but worse in those who experience intersecting oppressions. Barriers to care manifest systemically, in services, and in individual mental health professionals (MHP) and contribute to psychological distress and impede help seeking. Protective factors (resilience, inclusion) and trained MHP counter these barriers.

Conclusion: Despite the general prevalence and risk of mental illness among sexual, gender, and erotic minority people due to external, modifiable oppressions, opportunities for inclusive psychological care exist.

Keywords: gender identity; sexual orientation; mental health care; kink

2.1.2.2 Introduction

This systematic literature review aimed to consolidate the available evidence on the barriers and facilitators to mental health help seeking of sexual, gender, and erotic minority people via an exploration of review questions focused on determining: 1) the uptake of mental health care, 2) barriers to care, and 3) facilitators that promote care uptake. Sexual, gender, and erotic minority people can experience prejudice and oppression that can cause psychological harm and impact mental health help seeking (Hunt, 2014; Lilienfeld, 2007; Robinson-Wood, 2017). Sexual and gender minority people include people who are Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual, and a variety of other identities (LGBTIQA+). Erotic minority people are people with identities, interests, or orientations toward any consensual non-traditional sexual activity, which can include kink, bondage, discipline, domination, submission, sadism, and masochism (BDSM), polyamory, fetishism, exhibitionism, role play, sexual asphyxiation, and many other diverse, intimate, and sexual relationships (Moser, 2016; Pitagora, 2016; Damm et al., 2018).

The research on erotic minority people is relative sparse in comparison to that regarding sexual and gender minority people, yet all experience oppressions including discrimination, stigma, exclusion, violence, homophobia, biphobia, and transphobia from a range of sources (Faircloth, 2014; Qureshi et al., 2018; Riggs et al., 2014; Williams et al., 2017). Indeed, much research has been conducted on the difficulty that sexual, gender, and erotic minority people have accessing culturally competent, inclusive care (Romanelli & Hudson, 2017; Addis et al., 2009; Barmaky & Lee, 2017; Kolmes & Weitzman, 2010; Rees et al., 2021).

Existing studies also explore the mental health of sexual, gender, and erotic minority people alone or as part of a larger literature review or needs assessment (Scott et al., 2016; Jackman et al., 2016; Marshall et al., 2016; Banks, 2003; Cornell University, 2019; McCann & Sharek, 2016; Adams et al., 2012; Chandler et al., 2005; Jenkins Morales et al., 2014; Lee & Kanji, 2017; Rodriguez, 2016; Trevor & Boddy, 2013). Some studies explore mental health services use of sexual, gender, and erotic minority people (Hunt, 2014; Lee & Kanji, 2017). Overall, these studies conclude that their respective sexual, gender, and erotic minority populations had higher rates of depression, self-harm, alcohol and drug use and misuse, suicide, and other mental

health issues than their heterosexual, cisgender, or non-erotic counterparts (Adams et al., 2012; Banks, 2003; Jackman et al., 2016; Lee & Kanji, 2017; Marshall et al., 2016; Scott et al., 2016). Due to a lack of consistency in measurement tools, rates across the studies range widely: prevalence of depression ranges from 11% to 71.4% (Banks, 2003) while prevalence of self-harm spans 15.4% to 47.2% (Jackman et al., 2016). These studies also found that sexual, gender, and erotic minority people experience more barriers to care than cisgender, heterosexual people, including real or perceived discrimination from health professionals (Hunt, 2014; Chandler et al., 2005; Jenkins Morales et al., 2014; Lee & Kanji, 2017; Trevor & Boddy, 2013).

There are no systematic reviews that explore the barriers to mental health care and those factors that facilitate the uptake of care among a broader group of sexual, gender, and erotic minority people. Given the association between preventable, modifiable external factors, and the risk of mental illness, a systematic literature review that explores mental health service use for sexual, gender, and erotic minority people is needed.

2.1.2.3 Materials and Methods

Search Strategies

The selection criteria for this review included peer-reviewed and grey literature published in Organisation for Economic Co-operation and Development (OECD) countries between 2008-2018 in English with topic foci of mental health and related service use of sexual, gender, and erotic minority people who are 18 years of age or older. Grey or non-academic literature was included due to the contemporary, alternate insights it provides into viewpoints often underrepresented in academic sources (Paez, 2017). OECD countries were chosen as they provide an opportunity to explore comparable services within countries that have shared economic and social aims. CINAHL, Medline via PubMed, and Scopus were searched for peer-reviewed articles. These databases were selected for use as they are common public health databases. Google was searched for grey literature. Snowballing was used to search for additional citations from among those grey documents that met the inclusion criteria. The following Medical Subject Headings (MeSH) terms were searched: mental health; access; uptake; barrier; sex and gender minorities; lesbian,

gay, bisexual, transgender, queer (LGBTQ); intersex; sadism, masochism, sadomasochism, bondage, domination (BDSM); kink; gender identity; sexual orientation; marginalised; and enabler. British and American English spelling, plural forms, and Boolean operators were used. The first author conducted the search, removing irrelevant studies and duplicates. All authors substantiated the abstracts and full text of the remaining studies.

Assessment of Methodological Quality

Peer-reviewed and grey literature were appraised for quality and relevance. The first author used the Authority, Accuracy, Coverage Objectivity, Date, and Significance (AACODS) checklist to assess the methodological quality of grey literature (Tyndall, 2010; Table [2.4]).

Table 2. 4 Grey Literature That Did Not Meet All AACODS Checklist Criteria

Author & Setting	Authority	Accuracy	Coverage	Objectivity	Date	Significance	Type
Barbara et al. (2018), CA	✓	✓	✓	✓	✗	✓	talk to LGBTQ+ clients manual
Herek (2012), US	✓	✓	✓	✓	✗	✓	homosexuality & MH facts webpage
Mental Health First Aid (2016), AU	✓	✓	✓	✓	✗	✓	guidelines on working with LGBTQ+
National Alliance on Mental Illness (2020), US	✓	✓	✓	✓	✗	✓	LGBTQ & MH factors & finding inclusive MHP webpage
Oxfam International (2016), UK	✓	✓	✓	✓	✗	✓	LGBTI human rights policy
Ross (2013), CA	✓	✓	✓	✓	✗	✓	LGBTQ women & MH webinar
Royal College of Psychiatrists (2018), UK	✓	✓	✓	✓	✗	✓	psychiatry & LGB webpage
Sanders (2016), US	✗	✓	✓	✓	✓	✓	kink-informed MH provider webpage
Winn (n.d.), US	✓	✓	✓	✓	✗	✓	BDSM & kink webpage

Your psychology clinic (2015), AU	✗	✓	✓	✓	✗	✓	sexual & gender issues webpage
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The remaining authors reviewed and confirmed findings. AACODS was chosen due to its specific purpose to evaluate grey literature (Tyndall, 2008). Three of the authors (HH, HB, BNGE) used the Mixed Methods Appraisal Tool (MMAT) to assess and score the peer-reviewed literature (Hong et al., 2018; [Please see Appendix 5]). The MMAT scoring system concomitantly critiques the methodological quality and appraisal procedures of qualitative, quantitative, and mixed-methods studies. The MMAT was selected as it is an efficient, reliable tool with which to appraise studies that use different research methods (Pluye et al., 2011[a & b]).

Data Analysis

The included literature was analysed thematically (Braun & Clarke, 2006). Multiple readthroughs of the included documents produced initial systematic coding. Recurring themes and connections from the dataset were identified and combined into higher-order groupings. Groupings produced themes that were reviewed repeatedly for clarity and connection and then refined. Resulting themes were summarised and integrated systematically under the three review questions. Thematic analysis was chosen because it facilitates summarisation of the main elements of a large data set; emphasizes similarities and differences across a data set; and can produce unexpected viewpoints (Braun & Clarke, 2006). The first author conducted the data identification, categorisation, and synthesis, which the remaining authors reviewed, confirmed, or rejected in teams of two. Disagreements were resolved via discussion or by the author not in the team of two.

2.1.2.4 Results

From a pool of 6,147 articles and documents, 90 met the inclusion criteria (Figure [2.1]). Of the 90 documents, 67 (74.4%) focused primarily on people who are same-sex attracted and/or gender diverse. The remainder were on kink-identified individuals ($n = 10$, 11%), transgender, gender diverse, or two-spirit people ($n = 9$,

10%), and intersex people ($n = 4$, 4.4%). There were many types of grey literature ($n = 41$) with the most prominent being informational webpages or articles ($n = 12$, 29.3%). Thirty-one grey literature documents met all ACCODS criteria. Table [2.4] shows the ACCODS scoring for the remaining 10 grey documents that did not meet all criteria, with most (90%) only failing the Date criterion (Tyndall, 2010).

Of the included peer-reviewed articles ($n = 49$), 36 received an MMAT quality top score of 5, seven received a 4, and six received a score of 3 (Hong et al., 2018). The population sample sizes ranged from 1 to 6,106. These studies were conducted in the United States ($n = 32$), Canada ($n = 5$), Australia ($n = 4$), and Ireland ($n = 3$). The remaining were conducted in New Zealand, Sweden, and Israel ($n = 1$ each) and two spanned multiple countries.

A variety of outcome measures were used in the included peer-reviewed documents to assess the mental health-related topics discussed in this review, including mental health conditions and statuses, contributing factors, and treatments ([Appendix 5]). Self-reported was the most common measure used (69.4%). Of the formal measurement tools, Kessler Psychological Distress Scale (K6 or K10) was used five times (Cochran et al., 2017; Dunbar et al., 2017; Lyons et al., 2015; Platt et al., 2018; Stanley & Duong, 2015) and the Patient Health Questionnaire (2 or 9) was used four (Jenkins Morales et al., 2014; Steele et al., 2017; Williams et al., 2017; Parent et al., 2018). [Appendix 5] presents the relevant characteristics, outcome measures, and findings of the peer-reviewed literature.

Two main themes and five subthemes emerged from analysis of the 90 included documents: prevalence (mental health status and service use) and factors or barriers and facilitators affecting help seeking (systemic, service-based, and individual).

Prevalence

The mental state and related service use of sexual, gender, and erotic minority people were common topics in the included literature. Mental health status was discussed in 87.4% of the peer-reviewed literature and in 90.6% of the grey. Of the sexual, gender, and erotic minority people included in this review, the literature overwhelmingly indicated that same-sex attracted, intersex, and gender diverse

people have worse mental health than heterosexual, cisgender people (people who accept the sex they were assigned at birth), which was highest in people of colour (Graham et al., 2009; Hahm et al., 2016); younger people (Greene et al., 2016; Royal Australia & New Zealand College of Psychiatrists [RANZCP], 2019b; Stanley & Duong, 2015); transgender people (Mental Health First Aid [MHFA], 2016; New South Wales Mental Health Commission [NSWMHC], 2014; Riggs et al., 2014; Victoria State Government, 2014 & 2018); rural dwellers (Lyons et al., 2015; Stotzer et al., 2014; Walinsky & Whitcomb, 2010; Willging et al., 2018); bisexual people (MHFA, 2016; National Alliance on Mental Illness, 2020; Pennay et al., 2018; Rosenstreich, 2013); religious people (Zeidner & Zevulun 2018); and intersex people who have experienced non-consensual, ‘corrective’ surgeries (Australian Government Department of Health [AGDOH], 2013a & 2013b; Gore, 2017; MHFA, 2016; QLIFE, 2017; RANZCP, 2019b; Rosenstreich, 2013; Stevens, 2013). The literature also found that sexual, gender, and erotic minority people who have additional, intersecting marginalised identities are at risk for mental health issues (Drummond & Brotman, 2014; Elm et al., 2016; Greene et al., 2016; Harrow Council London, 2011; Mann, 2016; Nadal et al., 2011a; Rodriguez, 2016; Ross, 2013; Salkas et al., 2018). With one exception, all included literature on erotic minority people found that their mental health status is the same as or better than non-kink people (Faircloth, 2014; Gemberling et al., 2015a; Roberts et al., 2015; Yamanouchi, 2015). Winn (n.d.) found that submissives reported the lowest mental health scores among all erotic minority people, but scores were still higher than non-kink minority people. Comparatively, however, sexual, gender, and erotic minority people all experience oppressions that contribute to mental illness, which increases the risk of psychological distress (Gemberling et al., 2015b).

Service Use

Generally, sexual, gender, and erotic minority people are reported to have greater uptake of mental health services than heterosexual, cisgender, non-kink people (Bränström, 2017; Cochran et al., 2017; Dunbar et al., 2017; Graham et al., 2009; Hahm et al., 2016; Jacobsen & Wright, 2014; Parent et al., 2018; Pennay et al., 2018; Stanley & Duong, 2015). An American study on sexual minority people found

that their sample's uptake was two to four times higher than that of heterosexual people (Platt et al., 2018).

When compared with white, younger, cisgender, heterosexual people, uptake was reported to be worse among sexual, gender, and erotic minority people who are people of colour (Parent et al., 2018), older (Jenkins Morales et al., 2014; Parent et al., 2018), and transgender (Steele et al., 2017). Dunbar et al. (2017) reported that 61% of their participants in 'serious psychological distress' did not seek mental health support (p. 294). Service use is worse for sexual, gender, and erotic minority people residing in rural areas compared with urban dwellers (AGDOH, 2011; Lyons et al., 2015).

Factors affecting help seeking

Factors affecting help seeking present as barriers and facilitators to care. Generally, barriers were discussed in 83.7% (41/49) of the peer reviewed documents and in 80.5% (33/41) of the grey. The literature reveals that all sexual, gender, and erotic minority people experience a variety of similar barriers with the most common being discrimination, stigma, exclusion, violence, and homophobia, biphobia, and transphobia (Table [2.5]) (Faircloth, 2014; Gemberling et al., 2015b; Harris, 2017; Roberts et al., 2015; Yamanouchi, 2015).

*Table 2. 5 Most Prominent Modifiable Factors that Impede Service Uptake and Mental Health**

	Peer Reviewed		Grey	
Factor	N/41	%	N/33	%
Discrimination	38	92.7	31	94.0
Exclusion	28	68.3	16	48.5
Gender binarism	14	34.1	4	12.1
Heterosexism/heteronormativity	26	63.4	7	21.2
Homo/bi/transphobia	24	58.5	16	48.5
Identity concealment	24	58.5	7	21.2
Internalised homo/bi/transphobia	19	46.3	8	24.2

Marginalisation	25	61.0	8	24.2
Minority stress	24	58.5	9	27.3
Provider bias/discrimination/ignorance	23	56.1	8	24.2
Prejudice	17	41.5	12	36.4
Stigma	30	73.2	22	66.7
Structural/systemic barriers	22	53.7	1	3.0
Violence/abuse/victimisation	28	68.3	13	39.4
* As cited in 1/3 or more of the included literature				

Facilitators to help seeking were explored directly or indirectly in 93.9% (46/49) of the peer reviewed documents and in 82.9% (34/41) of the grey. Examples of social and demographic facilitators included being LGBTQA+ (Cochrane et al., 2017; Parent et al., 2017); having insurance (Stotzer et al., 2014); and being a woman or living in an urban area (AGDOH, 2011). Help seeking also occurs in response to the psychological impact of minority stress and stigma (Stanley & Duong, 2015; Platt et al., 2018). Other factors affecting help seeking are systemic, service-based, and individual which are explored below.

Systemic Factors.

Systemic factors are system-based or social policies or practices that can either impede or encourage help seeking. In the included literature, poverty was a commonly cited systemic barrier (Adams et al., 2013; Benson, 2013; Hsieh & Ruther, 2017; Jenkins Morales et al., 2014). Relatedly, a lack of publicly funded services and a lack of insurance were also cited as barriers (Adams et al., 2013; Hsieh & Ruther, 2017; Kattari & Hasche, 2016; Ross, 2013). Significantly, same-sex attracted and gender diverse people were found to be more likely uninsured (Jenkins Morales et al., 2014; Stotzer et al., 2014).

Other prevalent systemic barriers to help seeking were attitudinal in nature, which were more prevalent in rural areas (Lyons et al., 2015). Attitudinal barriers are negative biases or assumptions. Racism, homophobia, and other forms of discrimination against sexual, gender, and erotic minority people delay help seeking and increase expectations of a poorer level of care (Bastos et al., 2018; Roberts,

2015). The lack of inclusive policies and failure to enforce anti-discrimination legislation compounds attitudinal barriers (Adams et al., 2013; McCann et al., 2013; McCann & Sharek, 2014a; Przedworski et al., 2015; Rodriguez et al., 2018; Jacobs & Morris, 2016; Stanley & Duong, 2015; Stevens, 2013; Williams et al., 2017).

Pathologisation, another attitudinal systemic barrier, was cited in 24.2% of the grey literature and in 31.7% of the peer reviewed. Pathologisation sees sexual, gender, and erotic minority people being medicalised by some MHP and assumed to require remedying, which leads to ineffective or even harmful care (Stevens, 2013; your psychology clinic, 2015). Conversion therapy, one attempt to ‘remedy’ diversity, was cited as a barrier in 21.2% of grey literature and in 2.4% of the peer reviewed. This barrier can result in further psychological harm and termination of help seeking, including subsequent treatment (Australian Psychological Society [APS], 2021a; Jacobsen & Wright, 2014). As such, many principal psychological organisations oppose it; for example, ‘the Australian Psychological Society strongly opposes any form of mental health practice that tries to change or suppress someone’s sexual orientation or gender’ (APS, 2021b).

The included literature recommended changes to policies and laws, which are systemic enablers and which can improve mental health and increase help seeking. First, policies and laws that address systemic oppressions could be enacted. This could include implementing plans to eradicate conversion therapy, systemic discrimination, prejudice, heterosexism, and enforcing anti-discrimination policies (Drummond & Brotman, 2014; Leonard & Metcalf, 2014; McCann & Sharek, 2014a; Nadal et al., 2011b; Orel, 2014; Royal College of Psychiatrists, 2018; RANZCP, 2019a). Secondly, insurance companies could update plans to ensure support and protection of transgender people, for example, via the banning of gender identity-based discrimination (Romanelli & Hudson, 2017). Thirdly, the promotion of access and inclusion to mental health care and to gender-affirming surgery are other systemic enablers that would offset disparities while encouraging uptake (Oxfam International, 2016; Steele et al., 2017). Fourthly, the implementation of social protection is another systemic enabler cited in the included literature (Oxfam International, 2016). Social protection enhances a person’s rights through the facilitation of equitable access to service (Oxfam International, 2018). Finally, the

inclusion of sexual, gender, and erotic minority people in policy, resource, and research planning and implementation could have an insulating factor against mental illness and potentially prevent substandard or absent care (Herek, 2012; NSWMHC, 2014; Williams et al., 2017).

Service-based factors.

The complete absence of mental health services, including affirming services, was a barrier to support seeking cited in the literature (Adams et al., 2013; Pilling et al., 2017). A lack of services is associated with higher levels of mental illness in sexual, gender, and erotic minority people living in rural areas than those living in urban (QLIFE, 2018). Transgender people in particular felt this gap (Romanelli & Hudson, 2017).

Existing mental health services create barriers by not being inclusive and failing to meet needs (Adams et al., 2013; McCann & Sharek, 2014a; NSWMHC, 2014; Pennay et al., 2018; Romanelli & Hudson, 2017; Rosenstreich, 2013; Ross, 2013; Walinsky & Whitcomb, 2010). Mental health services failed to meet needs in 76% of respondents in an Irish study (McCann & Sharek, 2014b). Services also bar or impede access via discrimination or a lack of cultural competency within the service (Kidd et al., 2011; Roberts et al., 2015; Dahlhamer et al., 2016; Rosenstreich, 2013; Sanders, 2016; Stotzer et al., 2014). On-campus, student services were shown to reduce help seeking via unclear eligibility requirements, lack of confidentiality, cost, and inconvenient hours (Dunbar et al., 2017).

Alternately, services that are affordable, responsive, specialised, and affirmative enable uptake and improve help seeking (Barbara et al., 2018; McCann & Sharek, 2014a; NSWMHC, 2014; Pennay et al., 2018; Romanelli & Hudson, 2017; Stanley & Duong, 2015). Specialisation can extend to program offerings and treatment approaches. Specialisation can also be tailored to sexual, gender, and erotic minority people, and people who are Aboriginal, First Nations, two-spirit, and older (Barbara et al., 2018; Romanelli & Hudson, 2017; Stevens, 2013; Stotzer et al., 2014). Services can encourage uptake via offering group and individual counselling (Jacobsen & Wright, 2014).

Service identifiability is another facilitator to help seeking. Achieved with outreach, community visibility, or advertising, services can address service gaps and encourage uptake (Dunbar et al., 2017; Romanelli & Hudson, 2017). Similarly, services can also facilitate help seeking through implementing effective service delivery partnerships, mental health promotion campaigns, and advocacy (NSWMHC, 2014). Finally, services could offer peer-advocacy programs, which were found to increase inclusion and help seeking (Willging et al., 2016).

Individual factors.

MHP and sexual, gender, and erotic minority people comprise the specific individuals at the core of this factor. Many of the individual-specific barriers cited in the included literature originate with MHP, are attitudinal and educational in nature, prevent help seeking, and can cause mental distress (Stotzer et al., 2014) (see Table [2.5]). Heterosexist, cissexist MHP, including those who demonstrate stigma against sexual, gender, and erotic minority people, were found to impede help seeking (AGDOH, 2011; Kidd et al., 2011; Faircloth, 2014; Fredriksen-Goldsen et al., 2013; Mental Health America, 2020; Stotzer et al., 2014).

MHP who demonstrate a lack of cultural competence, discrimination, and bias were other individual-specific barriers noted in the literature (Bith-Melander et al., 2010; Fredriksen-Goldsen et al., 2013; Hahm et al., 2016; Kidd et al., 2011; Stotzer et al., 2014). Another barrier was MHP's lack of confidentiality around disclosure of a client's personal information. Whether real or perceived, these breaches of confidentiality prevent help seeking (AGDOH, 2011; Hahm et al., 2016; Rosenstreich, 2013).

Some MHP were found to also push their religious biases or personal beliefs onto clients, including seeking aetiology for the diversity in sexual, gender, and erotic minority people such as child sexual abuse (even when inaccurate) or viewing identity as a choice (Jacobsen & Wright, 2017; Yamanouchi, 2015). MHP demonstrated these attitudinal barriers in the form of 'embarrassment, anxiety, inappropriate reactions, rejection of the patient, hostility, suspicion, pity, condescension, ostracism, [and] avoidance of physical contact ...' (McCann et al.,

2014a, p. 526; McCann et al., 2014b). Refusal of treatment was another way in which MHP demonstrated attitudinal barriers (McCann et al., 2014a; McCann et al., 2014b; Williams et al., 2017).

Individual facilitators to help seeking of sexual, gender, and erotic minority people in the included literature centred largely around protective factors, or those elements that reduce the likelihood of developing a mental illness and promote psychological health and help seeking (Commonwealth Department of Health and Aged Care, 2000). Resilience – the ability to recover from adversity and negative experiences – was one such facilitator (Damm et al., 2018; Elm et al., 2016; Leonard & Metcalf, 2014; McCann et al., 2013; Nadal et al., 2011b; Watson et al., 2018).

Inclusion is real or perceived support from social groups, family, friends, or community and is another protective factor and facilitator to help seeking cited in the included literature (Adams et al., 2012; Bränström, 2017). Inclusion improves mental health, identity development, and mediates the impacts of external and internalised oppressions (Centers for Disease Control and Prevention, 2016; Graham et al., 2009; Roberts et al., 2015; Rodriguez, 2016). Inclusion also contributes to self-worth and acceptance, which promote help seeking (Bränström, 2017; Elm et al., 2016; Kolmes & Weitzman, 2010). Examples of inclusion in the included literature are families embracing transgender identity disclosure and community involvement and belonging (Faircloth, 2014; Fredriksen-Goldsen et al., 2013; Roberts et al., 2015; Watson et al., 2018). Often in the absence of holistic, specific public or civic supports, the need for inclusion is more urgent in rural areas (Leonard & Metcalf, 2014; Lyons et al., 2015; Willging et al., 2018).

2.1.2.5 Discussion

This literature review provides a novel synthesis of research regarding the mental health status, the barriers to mental healthcare, and the factors that facilitate uptake among a broader group of sexual, gender, and erotic minority people. The findings of this review are informative to policy and practice and can advance sexual, gender, and erotic minority peoples' wellbeing by presenting opportunities for growth in research, in MHP training, in service delivery, and via representation in OECD countries.

Help seeking varies and many systemic, service-based, and individual barriers exist, however, there are enabling factors that improve uptake and mental health. Similar to previous literature, this study suggests that overall, sexual, gender, and erotic minority people have greater uptake than non-minority people (Bränström, 2017; Jacobsen & Wright, 2014; Parent et al., 2018; Stanley & Duong, 2015). Reasons given for this high uptake include mental distress (Pennay et al., 2018), victimisation and threats (Bränström, 2017), and to cope with minority stress and stigma (Bränström, 2017; Meyer, 2003; Platt et al., 2018; Stanley & Duong, 2015).

Sexual, gender, and erotic minority people experience more barriers to mental health care than heterosexual, non-kink, cisgender people (Dahlhamer et al., 2016; Salkas et al., 2018). These barriers represent institutional failure and result in unmet mental health care need, delays, or avoidance of help seeking (Hsieh & Ruther, 2017; Platt et al., 2009; Smith & Freyd, 2014).

The literature suggested that MHP undergo training to address barriers and improve sexual, gender, and erotic minority peoples' mental health and help seeking (Dunbar et al., 2017; Kattari et al., 2016; Kench, 2013; Stotzer et al., 2014). Some of the included studies found that MHP lacked even the most basic of training on sexual, gender, and erotic minority people and recommended mandatory training (Jenkins Morales et al., 2014; Kidd et al., 2011; Oxfam International, 2016; Pennay et al., 2018; Kench, 2013; Romanelli & Hudson, 2017). Training could be incorporated into tertiary curricula, conducted at local community organisations, or as continuing education (Kattari et al., 2016; Qureshi et al., 2018; Ross, 2013). Training would remove the burden from clients of having to educate MHP (Benson, 2013; Kidd et al., 2011). Upskilling by both urban and rural MHP could increase comfort in working with diverse people, enable the adoption of advocacy roles, and improve MHP's ability to make appropriate referrals (Drummond & Brotman, 2014; Walinsky & Whitcomb, 2010). Recommended training topics included gender-affirming surgery (Riggs et al., 2014); transgender issues (Benson, 2013); cultural competency (Adams et al., 2012; Nadal et al., 2011a); kink-awareness (Kolmes & Weitzman, 2010); sexuality, disability, and other areas of intersectional, marginalised identities (Drummond & Brotman, 2014; Rodriguez, 2016); and intersexuality (Thyen et al., 2014).

Despite barriers, sexual, gender, and erotic minority people generally have a favourable view of help seeking (Parent et al., 2018; Stanley & Duong, 2015). Factors that promote this include resilience and inclusion, equitable access to services, and educated MHP. In fact, given the prevalence of discussion in the included literature around the enabling role of MHP who offer quality, inclusive care for all without discrimination or distinction, they can be a significant facilitator to help seeking.

The included literature suggests that uptake of help seeking does not match the prevalence rates or risk of mental illness. Oppressions against sexual, gender, and erotic minority people continue and have spurred an overrepresentation of negative mental health indicators. External oppressions place sexual, gender, and erotic minority people at risk of higher prevalence of mental illness than non-minority people (Cochran et al., 2017; Graham et al., 2009; Roberts et al., 2015; Yamanouchi, 2015). Studies have shown that identity and orientation in itself does not create or contribute to psychological distress, but that external, modifiable oppressions perpetuate mental illness in sexual, gender, and erotic minority people (Meyer, 2003; Roberts et al., 2015; Ross, 2013; Stevens, 2013). Many MHP governing bodies in OECD countries indicate that cultural competence is a core requirement (APS, 2012, National Association of Social Workers, 2015). Yet, sexual, gender, and erotic minority people still encounter MHP who pathologize them (Faircloth, 2014; Kidd et al., 2011; Rosenstreich, 2013; Yamanouchi, 2015). Whether systemic, service-based, or individual, barriers exacerbate psychological distress and result in distrust of mental health support, limiting uptake (Ross, 2013; McCann & Sharek, 2014a).

Limitations

The generalizability of this review is limited by the geographic, age and English language restrictions; therefore, these findings may not apply to non-OECD countries, populations younger than 18, or non-English studies. Generalisation is also limited by the rigidity with which sexual, gender, and erotic minority people have been historically viewed. It is unknown if the sample populations in the included literature are representative of their minority people. The selected databases

largely focus on the fields of medicine and health, which fit this review's aim of mental health service use exploration. Other databases, for example, may have yielded different results. The largely urbancentric focus of the included studies indicate gaps in rural population-based studies. Despite incorporation of several distinct identities under the banner of sexual, gender, and erotic minority people, this is not a singular category representing unified experiences of mental health. This focus served exploration purposes as findings across the groups generally synched due to shared risk of psychological distress, warranting their combination. This focus also reduced deeper examination of all populations represented in this review, thus potentially altering the findings. These limitations provide an opportunity for subsequent reviews and future work, which may explore alternate factors and contexts.

2.1.2.6 Conclusion

This systematic literature review novelly explored barriers and facilitators to mental health care among a broader group of sexual and gender minority people that included erotic minority people. A synthesis of 90 grey and peer reviewed documents revealed the shared experience of a range of barriers that both impede service uptake and impact mental health. Discrimination, stigma, exclusion, violence, homophobia, biphobia, and transphobia from society, services, and MHP were the most common barriers uncovered in this review. These findings indicate the need for tailored, intersectional mental healthcare; mandatory, inclusive curricula for current and future MHP; and the creation and enforcement of anti-discrimination policies. Given the association between external risk factors and mental illness and their systemic, service-based, and individual implications, this systematic literature review is an important resource for advocates, policy makers, and practitioners.

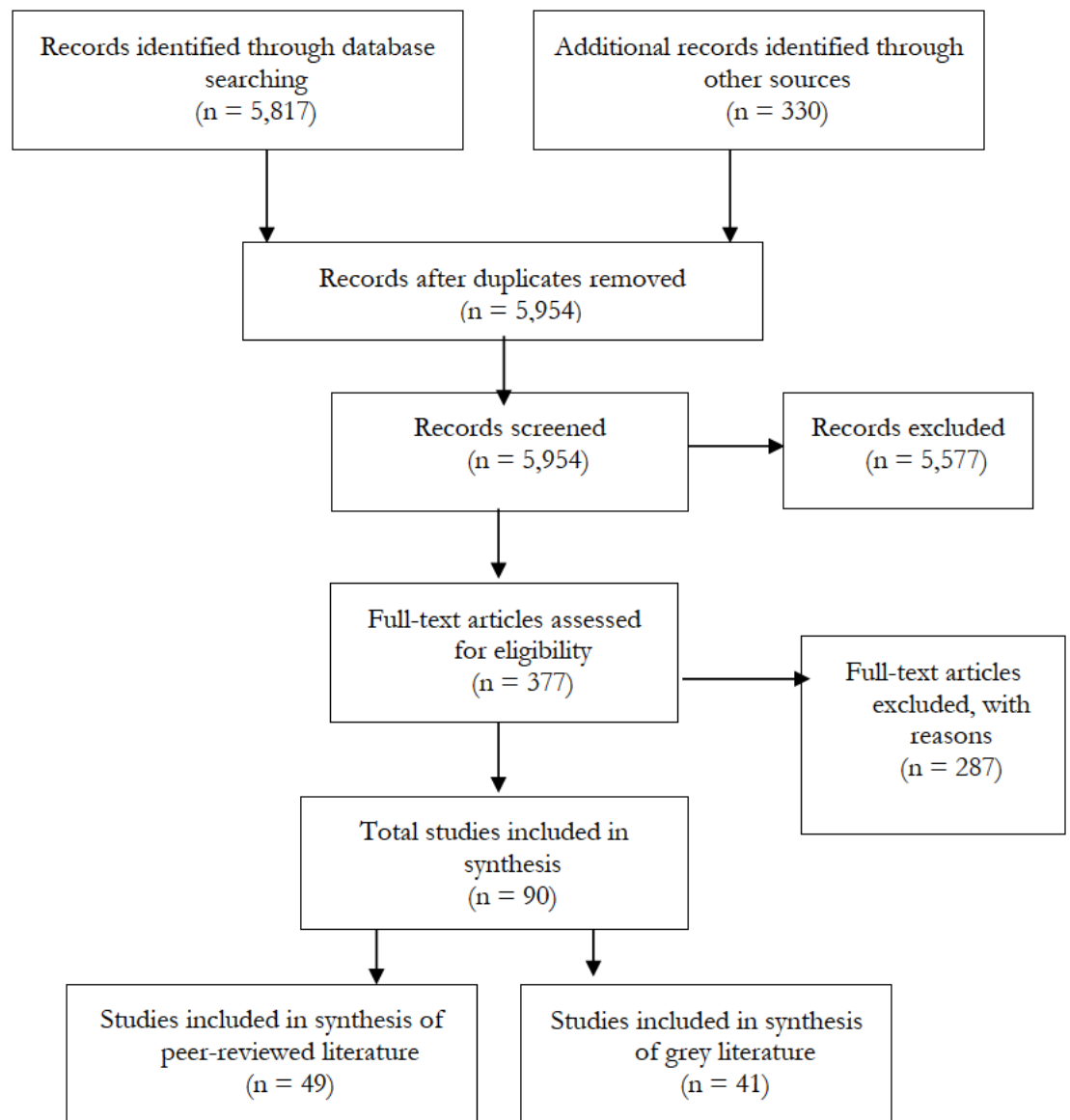


Figure 2. 2 SGM SLR PRISMA 2009 Flow Diagram

3. CONTEXTUALISATION OF SYSTEMATIC LITERATURE REVIEWS

3.1 Introduction

This aim of this chapter is to contextualise the systematic literature review findings (presented in the previous chapter) for the purposes of integrating these systematic reviews within the thesis.

3.1.1 Purpose and Overview of Systematic Literature Reviews

This study's inclusion and exclusion criteria and the research questions guided all work that followed, including the systematic literature reviews. The systematic literature reviews were conducted to identify existing research, to establish gaps in existing research, and to establish a foundation and a justification for this inquiry.

From the outset of the candidate's doctoral journey in 2018, the intent was to conduct hands-on qualitative and quantitative research in Tasmania, Australia.

Therefore, literature reviews that achieved the aforementioned purpose that were based on literature from Tasmania or Australia would have been ideal.

Unfortunately, there was no existing literature based on this study's target populations in the state. Thus, for that reason, as well as to contextualise the survey and interview data, systematic literature reviews based on outputs from Organisation for Economic Co-operation and Development (OECD) countries was performed.

Limiting the geographic location of the study to OECD countries was conducted to establish boundaries and provided an opportunity to explore comparable services within countries that have shared economic and social aims.

Due to the volume of documents found during the search for literature and journals' page restriction guidelines, two systematic literature reviews were performed. The review on people who were LGBTIQ+ and kink-oriented is based on the following research questions: (1) the uptake of mental health care, (2) barriers to care, and (3) facilitators that promote care uptake. The literature review on sex workers is structured around the following research questions: 1) What is the uptake of mental

health services of sex workers? 2) What barriers impede sex workers' access to mental health care? 3) What enablers promote sex workers' uptake of mental health services and support? The impacts of the barriers and enablers to care are also explored.

3.1.2 Systematic Literature Reviews Findings

The systematic literature review on sex workers was conducted based on this study's research questions. The findings conclude that generally, the mental health of some sex workers is extremely poor (RQ1) and is significantly exacerbated by stigma, discrimination, violence, and criminalisation (RQ2). Sex workers also have low uptake of mental health services (RQ3) and encounter many barriers to accessing care, including those erected or perpetuated by practitioners, services, and society (RQ4). The findings also conclude that researchers who view sex workers' mental health holistically as opposed to pathologically is sparse (RQ4 & 5). Research that focuses on sex workers in rural and remote areas is also extremely scarce and related research pertaining to non-urban Tasmanian sex workers is non-existent; thus, highlighting the need for the research that follows – the methodology for this research is described in Chapter 4 and the results, which were written as separate papers, are presented in Chapter 5.

The systematic literature review on LGBTIQ+ people and kink-oriented people was also conducted based on the overarching research questions. The findings conclude that the mental health status of same sex attracted, intersex, and gender diverse people is worse than heterosexual, cisgender people with mental health issues most prevalent in people of colour, younger people, people who are transgender, people who live in rural areas, people who are bisexual, religious people, and intersex people who have experienced non-consensual 'corrective' surgeries (RQ1). Essentially, people with multiple intersecting identities are at risk for more mental health issues (RQ1 & 2). This literature review found that the mental health status of kink-oriented people is generally comparable to people not into kink (RQ1). This review's uptake findings are mixed: LGBTIQ+ people were found to have greater uptake of mental health care than heterosexual, cisgender, non-kink people; however LGBTIQ+ people of colour, older, transgender, with serious psychological issues, or rural have poor uptake (RQ3). This literature review

also found that LGBTIQ+ people and kink-oriented people experience more barriers to care than had our sexual, non-kink, cisgender people (RQ4). Despite these barriers, these populations generally have a favourable view of help seeking due to the protective factor of resilience (RQ2), as well as other facilitators, including equitable access to services and educated, inclusive mental health professionals (RQ5).

The systematic literature reviews demonstrate that prevalence of more mental health concerns and overrepresentation of negative mental health indicators as well as risk factors among these populations are due to exogenous oppressions of stigma, discrimination, and victimisation, which, for some, resulted in high uptake prevalence. Due to systemic and personal shortcomings and strengths, these populations experienced many barriers and facilitators to care.

These literature reviews enabled the candidate to identify what research existed and what gaps there were, which then lead to her own research; the methodology for which is presented in the next chapter.

4. RESEARCH METHODOLOGY

4.1 Introduction

This chapter describes the methodological framework used in the design and conduct of this research. The chosen approach – and the rationale behind specific selections – regarding what data was collected and from whom, the data collection itself, and data analysis will be presented.

4.1.1 Aim and Research Questions

The overall aim of this research was to investigate the mental health of LGBTIQ+ people, kink-oriented people, and sex workers in rural or remote Tasmania with preexisting mental health issues and diagnoses that presented at some point and as it pertained to related psychological care and support. This study's research questions (RQ) were as follows:

RQ1: What is the mental health status of LGBTIQ+ people, sex workers, and kink-oriented people with preexisting mental health issues in rural or remote Tasmania?

RQ2: What risk and protective factors impact the mental health of LGBTIQ+ people, kink-identified people, and sex workers?

RQ3: What is the uptake of mental health services of LGBTIQ+ people, kink-identified people, and sex workers in rural or remote Tasmania?

RQ4: What barriers to mental health help seeking do LGBTIQ+ people, kink-identified people, and sex workers encounter in rural or remote Tasmania?

RQ5: What factors facilitate uptake of mental health care for LGBTIQ+ people, kink-identified people, and sex workers in rural or remote Tasmania?

4.2 Research Design

Research designs are overarching approaches within a study for data collection, analysis, interpretation, and reporting (Creswell & Plano Clark, 2011). They are also important in determining underlying epistemological and theoretical assumptions, how research is conceptualised and conducted, as well as what type of contribution is made to the field of knowledge (Given, 2008). A good research design is mindful of how values and power shape and inform analysis and outcomes. The three most common approaches are qualitative, quantitative, and mixed methods. To link the aim and theoretical framework, the research design chosen for this study had to be based on user experiences to reflect multiple aspects of identity and false universalisations; strive for equality of sexes, genders, and sexualities; address disadvantages and disparities in mental health and healthcare; and be informed by participants and be in their own words to counter power imbalances and systemic issues. Justification for the selection of the specific approach that was used in this study follows.

Placing participants' own words and stories at the fore, qualitative research aims to gain a depth of understanding of human experience in textual form through observation, interviews, or focus groups (Creswell, 2014). Equally rigorous and exploratory, this method is typically inductive, whereby meaning-making occurs based on the collected data and builds from specific to general. This inductive analysis facilitates ongoing interpretation of the data (Creswell, 2014). As such, qualitative research can allow new theories, conceptual frameworks, or hypotheses to develop or expand. Governed by principles of validity, reliability, objectivity, generalisability, credibility, dependability, transferability, and reflexivity, it is a method commonly used in mental health research (Palinkas, 2014). The qualitative approach to research, however, is not without debate. Questions regarding the standardisation of measures used in the assessment of quality have been met with guidelines to 'strengthen rigour if they are used in concordance with a broader understanding of qualitative research design, data collection and analysis' (Kitto, Chesters, & Grbich, 2008).

Complementing the depth of qualitative research, quantitative provides the breadth. Quantitative research tests theories through analysis of variable correlations (Creswell, 2014). It involves converting collected data into numerical form for statistical analysis and is driven by the principles of credibility, dependability, and transferability (Palinkas, 2014). Validity of qualitative data is insured through data saturation, which is the point in data collection when no new themes or subthemes are emerging (Guest, Namey, & Chen, 2020). Following deductive logic, quantitative research tests hypotheses via objectivity.

A mixed-methods research design uses techniques, methods, and procedures from both qualitative and quantitative research data. With mixed-methods, the topics under investigation can be identical or different; data collection can be concurrent or sequential; and weighting can be equal or not (Greene, Caracelli, & Graham, 1989). A mixed-methods approach is not without disadvantages. First, the questions within the measures within may not align, for example, questions in the qualitative research tool may not match those in the quantitative. Secondly, redundancy could occur where some data fails to address the research questions and is of little use (Bryman, 2006). Also, this approach is time consuming, challenging, and requires expertise in multiple areas (Creswell, 2014).

There are, however, advantages to a mixed-methods approach. This approach produces a result that is more comprehensive than either qualitative or quantitative alone. Furthermore, the qualitative data validates, explains, expands upon, improves, or enhances the quantitative, and vice versa, to produce beneficial results while coalescing their diversity (Creswell, 2014; Greene et al., 1989). Based on its advantages and the fact that it allowed for a rigorous examination of the mental health and related service use of LGBTIQ+ people, sex workers, and kink-identified people through the lens of this study's theoretical framework, the mixed-method approach was selected for use in this study.

There are four main types of mixed-method design. The first is embedded mixed-methods design. In this design, one form of data is nested or embedded within another; whereby the embedded data is secondary to the primary, host data and neither design is sufficient for independent usage. This design, in which one data

type is supplemental to another (qualitative to quantitative, or vice versa), is used when research questions each require distinct data types (Creswell & Plano Clark, 2011). As that was not the case with this study, an embedded approach was not used.

The second type of mixed-methods design is explanatory. This design is two-phased where quantitative data is collected first and dominates the qualitative data; where the qualitative data is used to explain or expand upon the quantitative. In an explanatory design, data is collected sequentially and the data types are delineated clearly (McKim, 2015). The nature of this study did not lend itself to a quantitative-dominant approach, as it involved a small sample size and a large narrative component for capturing participants' experiences due to the sensitivity around the topic, thus, this method was not used.

The third type is exploratory, which is the inverse of explanatory. It is similarly two-phased and sequential, however, the qualitative data is collected first, tends to be of greater importance, and is enhanced by the quantitative data. Results of qualitative data analysis are used to construct the quantitative research tools. As its name implies, this design is beneficial when tools or framework do not pre-exist or variables are unknown (Creswell, 2014). This approach was not used as a framework did pre-exist and variables were known.

Triangulation is the last type of mixed-methods design. Triangulation consists of data collection and analysis that occurs via multiple methods, which enhances reliability and validity (Creswell, 2014). Triangulation facilitates the corroboration of quantitative and qualitative data while offsetting the restrictions inherent in each (Bryman, 2006). This design allows for comparisons while revealing contrasts to validate findings (Creswell & Plano Clark, 2011). Triangulation design-convergence model was selected for use in this study. Data collection using both research tools occurred concurrently and the weighting was equal; the two sets of findings were converged during interpretation of the data (Creswell & Plano Clark, 2011). Figure 4.1 illustrates an overview of the design used in this study.

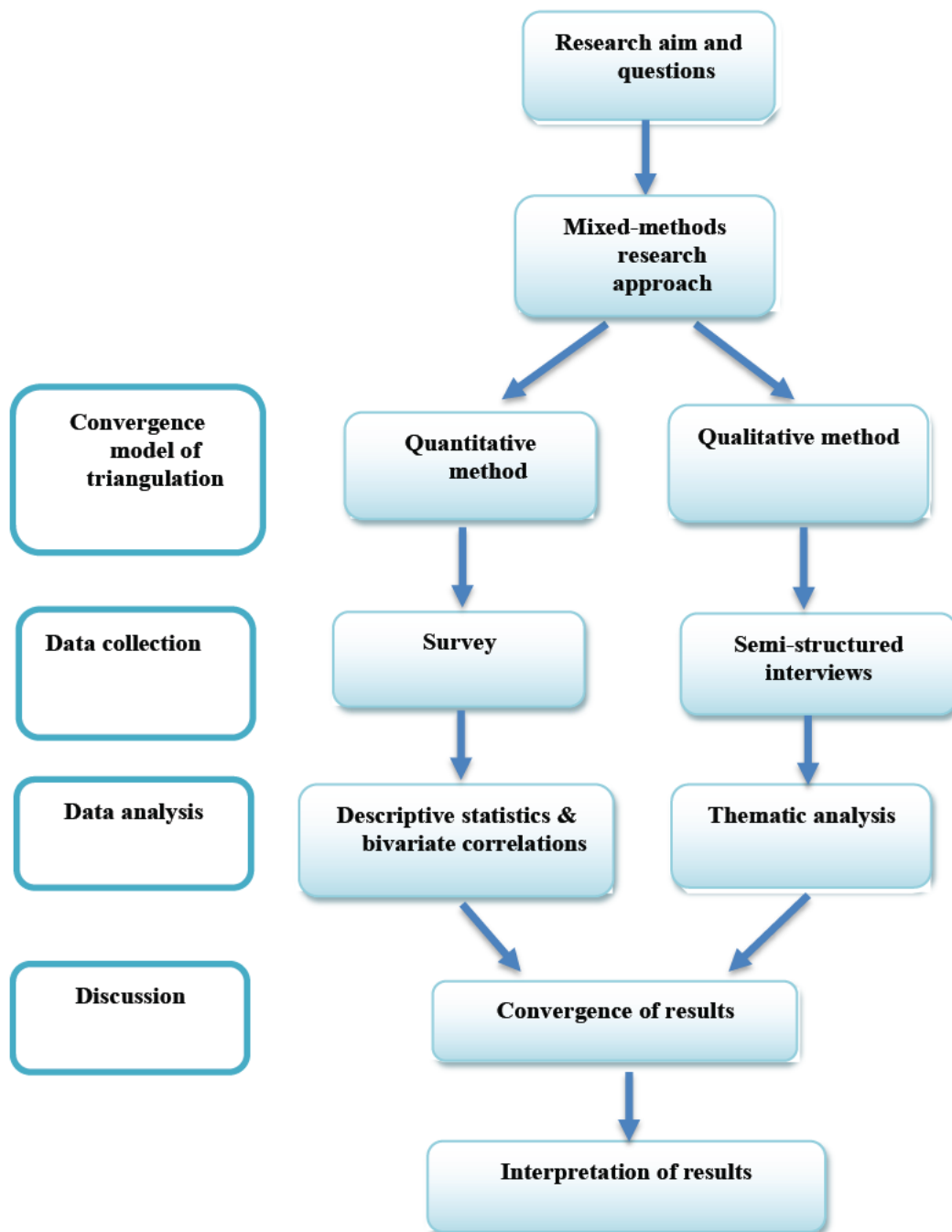


Figure 4. 1 Triangulation design-convergence model used in this research

4.2.1 Qualitative research method

The qualitative portion of this mixed-methods research approach includes interviews, inclusion and exclusion criteria, sample size and sampling methods, recruitment, data collection processes, data analysis, and validity and reliability, which are discussed in the following sections. Figure 4.2 illustrates an overview of the qualitative approach used in this study.

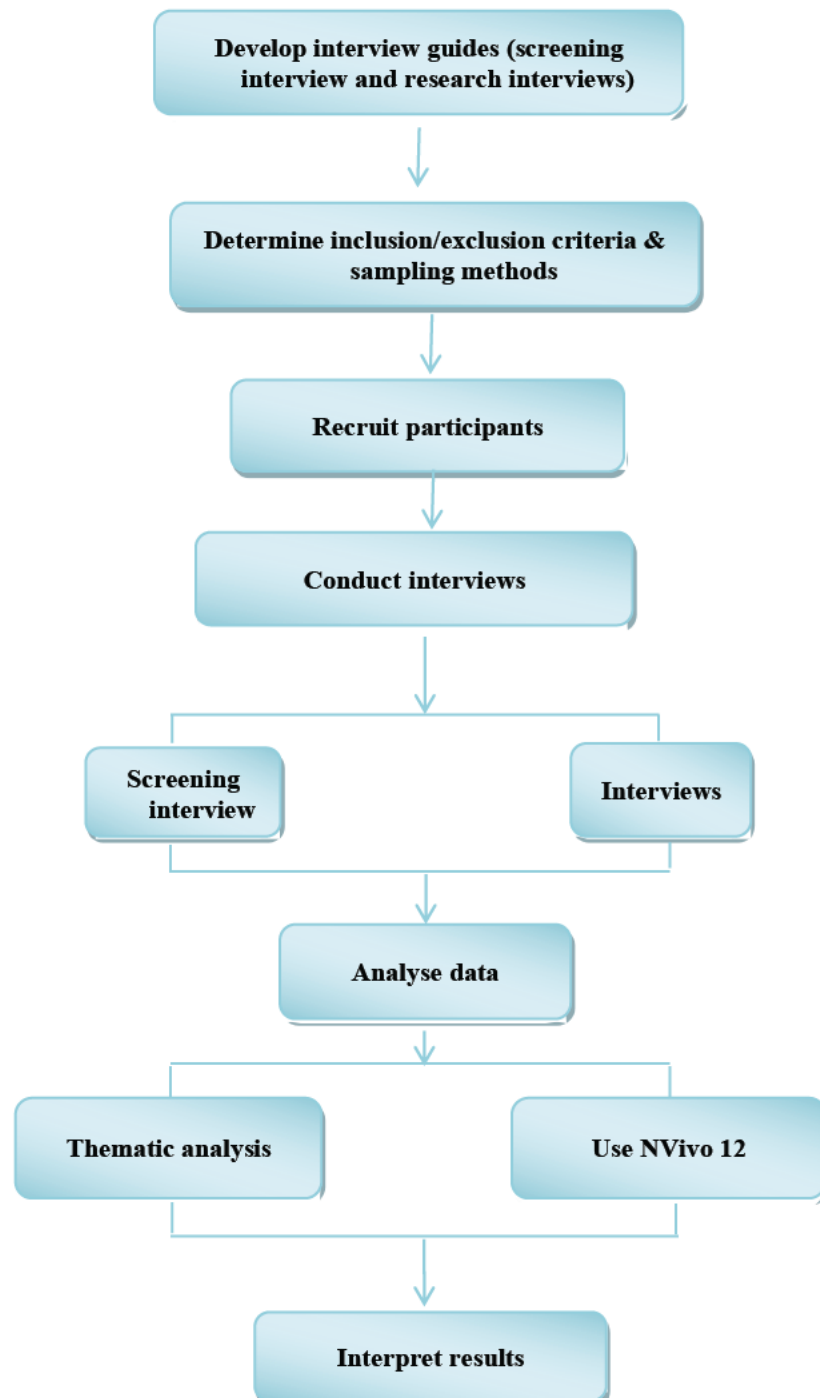


Figure 4. 2 The qualitative approach used in this study.

4.2.1.1 Semi-structured interviews

Semi-structured interviews were used in this study as they are the most used method of qualitative data collection and feature an interview guide of often open-ended questions so some structure is maintained (Willig, 2008). Semi-structured interviews allow for discussion and follow-up questions and they tend to put participants at ease because of their conversational style, which was of particular importance due to the sensitive nature of the topics under investigation. This interview type also generates a large amount of detail and data for analysis. There are issues with semi-structured interviews: their flexibility may reduce the reliability of the data and responses to open-ended questions may not be consistent as each participant will respond differently, thus potentially impeding their interpretation (Creswell, 2014). Also, the interview's meaning and semantics may differ for interviewees and interviewers (Willig, 2008). These issues can impact assessments of quality such as its rigour, credibility, and relevance (Kitto et al., 2008). The candidate felt that the strengths outweighed the weaknesses; to put this decision into context, the two other types of qualitative interviews are explained.

The first other type is unstructured interviews, which are similar to a conversation, but focus on a research topic. Unstructured interviews are intended to build trust with a participant and are guided by a few, open-ended questions designed to probe participants to elicit rich, detailed information. As all desired detail may not be obtained during one interview due to the lack of structure, follow-up interviews tend to be required for this interview type (Creswell, 2014). Time constraints and a desire to gain specific information and insights rendered this type of interview unreasonable for this study.

The second type is structured interviews, which follow a strict set of questions and, as such, limit or exclude the opportunity for follow-up or exploratory questions or discussion. With this type of interview, a researcher will get responses to their interview questions, but structured interviews can be unpleasant for participants as they tend to be clinical (Creswell, 2014). As a clinical approach was not desired, the interviews were not structured.

4.2.1.2 Development of Interview Guides

To preclude any current preexisting acute distress or safety concerns, all interview registrants were required to pass a telephone screening interview prior to participation in a research interview. A structured interview approach was used for the screening interviews, which consisted of strict questions designed to preclude psychological distress in interview participants. The screening interview and research interview guides were developed concurrently and are described below.

4.2.1.2.1 Screening Interview Development

Due to the potentially sensitive nature of the topics under investigation, but particularly due to the fact that all participants had preexisting mental health issues, risks relating to emotional distress needed to be addressed. A screening tool to gauge the potential for adverse emotional reactions that could result from participation in this study was developed based on a tool created by Burke Drauker, Martsolf, and Poole (2009). The screening tool consisted of eligibility questions, participants' self-assessment of current mental state, a confidentiality statement, and four main screening questions (with 18 possible follow-up questions). The three eligibility confirming questions were:

1. Do you now or have you ever lived in rural Tasmania, so not Hobart and area?
2. In what city, town or area do you currently live?
3. Are you either LGBTIQA+, or a current or former sex worker, or into BDSM/kink, or alternate sexual practices?

Participants' self-assessment of current mental state section involved the candidate informing participants about the rationale behind the screening interview and soliciting consent to proceed. The confidentiality statement informed participants that their information was to be kept confidential and not shared with anyone other than the candidate and her supervisors. The four main screening questions were:

1. Are you experiencing a high level of stress or emotional distress?
2. Are you currently having thoughts of harming yourself?
3. Are you currently having thoughts about harming someone else?
4. Can you think of any reason why you should not participate in an interview?

All participants passed their screening interviews and research interviews were scheduled; however, should another outcome have resulted, alternate plans were in place. If responses had indicated acute distress but not imminent danger, an interview was not scheduled, and the participant was referred to a mental health professional. If participants' responses had indicated that they posed imminent danger to themselves or someone else, the authorities were to be contacted and the candidate would follow-up with them the following day.

4.2.1.2.2 Research Interview Guide Development

The topic guide for the research interviews were based on observations from the candidate's clinical practice, findings from the literature reviews (please see Chapter 2) the research aims, and the concurrent survey. Interviews were semi structured, conversational in nature, and contained 26 questions divided into 10 sections. The breakdown of the questions as well as their connection to the literature reviews and the research question are as follows:

Section 1 (questions 1-7), Demographics and confirming inclusion: Informing interview participants about the concurrent survey, questioning what makes them eligible, sexual orientation question, sex assigned at birth question, gender question, what pronouns they use, and what city/town/area they live in. This section confirmed eligibility, explored participants' demographic characteristics that aided in determinations about the representativeness of the sample. As people who were sex workers, LGBTIQA+, and/or kink-oriented were the target populations, these questions were included to determine eligibility that also formed the basis for the research questions. These target populations matched the cohorts that were included in the literature reviews.

Section 2, (questions 8-9) mental health status and risk and protective factors: Participants were asked to describe their overall mental health; what hinders their mental health; and what helps their mental health. The intent of this section was to gain insight into mental health issues and diagnoses and any risk and protective factors. These questions addressed the study's research questions 1 and 2. Mental health status was also included in the systematic literature reviews.

Section 3, (questions 10-12) help seeking experiences: Question regarding help-seeking for mental health issues in rural Tasmania; kinds of help sought; and places where help has been sought. The intent of this section was to explore uptake. Uptake was the primary topic of research question 3 and was featured as a main topic of exploration in both systematic literature reviews.

Section 4, (questions 13-14) personal facilitators and barriers to help seeking: Questions regarding what encourages and what gets in the way of help seeking. The intent of this section was to determine those factors that impeded or encouraged help-seeking. These questions relate to research questions 4 and 5; barriers to care and uptake of care were also explored in both systematic literature reviews.

Section 5, (questions 15-16) GP consultations for mental health: Questions regarding prevalence of and experiences with seeing a GP for a mental health issues. This section was intended to explore the role that physical health providers play in participants help-seeking, as well as the quality of that role. These questions related to research questions 3, 4, and 5. People in rural areas often consult their physical health professional on mental health matters when mental health professionals or services do not exist. These GP consultations can be facilitators to care or barriers to care depending upon the GP's skill and knowledge. GP consultations regarding mental health matters were not included in either systematic literature review.

Section 6 (questions 17-20) MHP and service-based barriers and facilitators to help seeking: Questions regarding positive and negative attributes of MHP that encouraged or impeded help seeking; positive and negative attributes of services that encouraged or impeded help seeking. This section was intended to explore what participants found helpful or hurtful from MHP and services. These questions also related to research questions 3, 4, and 5 and were explored in both systematic literature reviews.

Section 7 (questions 21-22) Opinions on MHP treatment: Questions regarding how MHP treat participants; and different treatment from MHP due to diversity. This section was intended to gauge the existence of and nature of discrimination and stigma that participants experienced because they were LGBTIQ+, sex workers,

and/or kink oriented. These questions were asked in relation to research questions 4 and 5 and were explored in both systematic literature reviews.

Section 8 (questions 23-24) Suggestions and recommendations: MHP areas for improvement and elements missing from services. This section gave participants the opportunity to make suggestions regarding the type of care they wanted to see that would best serve their needs. These questions related to research question 2 in that participants could relay actual or potential risk and/or protective factors.

Section 9 (questions 25-28) External risk and protective factors: Things that help or hurt mental health from family, friends, society/the public, the government. This section explored exogenous risk and protective factors. These questions were included to explore research question 2.

Section 10 (question 29) Additional comments: anything to add. This section gave participants the option to share anything else they wanted to.

Please see Appendix 1 for the research interview question guide.

To ensure cultural and contextual safety, both the screening interviews and the research interviews were conducted with a postmodern approach, which involved the candidate disclosing her own sexual orientation and gender identity; offering a range of in-depth, discourse-based, culturally informed questions; being ‘reflexive and reflective...decentered [*sic*], deconstructed, and self-aware’ research (Kong, Mahoney, & Plummer, 2001, p. 241). The postmodern approach also demands an ethical basis and awareness of the ‘personal, cultural, academic, intellectual, historical’ contexts of the research (Semp, 2011, p. 74). The postmodern approach is also known as ‘queering the interview’.

4.2.1.3 Inclusion and exclusion criteria

Anyone who had been denied or had compromised access to the human right of bodily autonomy was eligible for participation in this study, specifically, this included current or former sex workers, LGBTIQ+ people, and/or kink-oriented people. Additional exclusion and inclusion criteria are outlined in the following table.

Table 4. 1 Inclusion and Exclusion Criteria for Interview Participants

Criteria	Inclusion	Exclusion
Language	Functional English literacy	Non-functional English literacy
Age	18 years of age and older	Children (younger than 18 years)
Location	People who lived or have lived in rural or remote Tasmania	People who lived in Hobart and the surrounding areas without previously having lived in rural or remote Tasmania
Equipment	Access to phone (for screening interviews and for research interviewees who chose not to complete an in-person research interview)	No access to phone
Topic foci	Mental health; chronic mental illnesses; mental health help-seeking experiences (formal or informal)	Social, physical, sexual, or reproductive health; acute mental health crises

This study's location was based on the Australian Statistical Geography Standard (ASGS) Remoteness Structure (Australian Bureau of Statistics, 2018a), which provides a holistic view of the classification of urban and rural used in this research. Introduced in 2011, the ASGS was created based on the Accessibility and Remoteness Index of Australia (Australian Institute of Health and Welfare, 2019). The ASGS divides Australia into five remoteness areas (RA) based on relative access to services: Major cities (RA1); Inner regional (RA2); Outer regional (RA3); Remote (RA4); and Very remote (RA5) (Australian Bureau of Statistics, n.d.). Accordingly, Hobart is the only Major city in Tasmania and the remainder of the Tasmanian population, 56%, live in "rural or remote" areas (Australian Bureau of Statistics, 2016a, 2016b, 2017a). People residing in Greater Hobart, comprising the cities of Hobart, Glenorchy, and Clarence and the municipalities of Kingsborough and Brighton, who had not lived in RA2-5, were excluded.

4.2.1.4 Sampling methods

Sampling methods for qualitative, quantitative, and mixed-methods research include probability and non-probability methods. Probability techniques give all members of a population a fixed, equal selection opportunity; non-probability, selection opportunities are arbitrary, not specified, and unknown. Non-probability sampling is used with exploratory research where a population size is unknown, such as with this study; thus, non-probability sampling methods were used (Eitkan & Bala, 2017). There are four non-probability sampling methods, which were considered for use.

Quota sampling involves a researcher selecting a representative sample from a certain population based on their having specific identities or characteristics. This findings of this type of sampling are generalisable, however, the participants within the representative sample must be mutually exhaustive, have equal weightage, and be proportional (Eitkan & Bala, 2017; Koerber & McMichael, 2008). Ensuring these factors was not possible due to the hidden and unknown size of the target populations; therefore, quota sampling was not used in this study.

Purposive sampling is used when the research purpose is known and a certain population subset is desired due to their identities or characteristics and ability to respond to specific questions or comment on specific topics. Via purposive sampling, people who lack specific identities or characteristics are excluded. With purposive sampling, the sample may not be representative, but results can be generalisable (Koerber & McMichael, 2008). As this study had specific purposes and specific target populations in mind, purposive sampling was used.

Convenience sampling is used when a researcher knows or can gain access to possible participants; they are convenient. With convenience sampling, the representativeness of the sample cannot be determined, rendering results ungeneralisable (Koerber & McMichael, 2008). The candidate counsels people from the target populations and has developed professional and personal networks with services, organisations, businesses, and societies in rural and remote Tasmania that are connected with, serve, or are used by the target populations; thus, convenience sampling was used in the research.

With snowball sampling, people from the target populations who have participated in the study recruit other participants with similar identities or characteristics. Snowball sampling is useful when working with underserved or hidden populations. This sampling technique was also used in this study (Eitkan & Bala, 2017). Notably, regarding the ethics of recruitment, participants were asked to contact other possible participants from their networks directly and not to share the identity of these possible participants with the candidate. This approach protected possible participants' anonymity and indirectly opened the research to closed groups that the

candidate was not privy to/connected with (e.g. BDSM/kink clubs and online forums, transgender-only groups).

4.2.1.5 Sample size

In qualitative research, sample size should be determined ‘definitely before, occasionally during, and sometimes after’ a study (Jones, Carley, & Harrison, 2003, p. 455). Methods for sample-size determination can be based on: a fraction of a population (Creswell, 2014; Creswell & Plano Clark, 2011); sample sizes used in past studies (Creswell, 2014); a tolerable margin of error (Creswell, 2014); incorporation of each segment of the population under review (Boddy, 2016); a size that is not too large so as to prevent in-depth analysis (Sandelowski, 1995); a size that is not too small so as to prevent exploration of differences, comparisons, or generalisability (Given, 2008); multiples of 12 (Boddy, 2016); or data saturation (Boddy, 2016; Given, 2008).

This study used data saturation to determine sample size, which occurs during data analysis when no new information is forthcoming (Guest, Namey, & Chen, 2020). This method involves collecting a base size or minimum number of interviews to determine information gained; determining the number of interviews needed to gain new information or themes; and stopping when interviews contain either less than 5% or no (0%) new information. Ultimately, the sample size needs to enable inferences to be made about and be representative of either the population/topic under review (Boddy, 2016) or the essence of the study (Given, 2008).

Data saturation offers limited guidance in predicting sample size, however, to conform with Tasmanian Social Sciences Human Research Ethics Committee application requirements, the candidate and her supervisors (the research team) determined that $\sim N = 10\text{-}20$ would suffice for the research interviews. To enable the usage of data saturation as a sample-size method in addition to generating these estimated sample sizes, data collection and data analysis occurred concurrently.

4.2.1.6 Participant Recruitment

Recruiting an optimal number of participants is key to the success of a research study. When target populations are comprised of people who are hidden or

underserved by mental health services as in this study, recruitment becomes even more important. Study participants were recruited between November 2019 and March 2020 using emails, Facebook, a poster, in-person, telephone, a community event, third parties, and self-selection.

Nota bene: To eliminate bias and the possibility of feelings of coercion, the study was not advertised at the candidate's place of work, nor advertised or mentioned to her counselling clients.

An email about the study was sent to roughly two dozen people in the target population from the candidate's personal and professional networks. The email contained information about the study (including a link to the survey and contact information to register for an interview). The email asked people to participate and to forward the email to anyone they thought might be eligible to participate.

A Facebook page advertising the study was created in November 2019. Weekly posts were added to the page for the duration of recruitment, the link to the page was included in all recruitment-based correspondence, and the candidate asked her Facebook contacts and third-parties to share the page. Facebook ads were not purchased for the study. While ads would have increased the visibility of the page and the study, they would have also increased the likelihood of discriminating posts to the page and emails to the candidate. In an attempt to make the page a safe space for the target population, the candidate decided to try and avoid instances of homophobia, transphobia, whorephobia, and other related attacks being posted to the page, which would likely come with Facebook advertising.

A professional graphic designer (from one of the target populations) was hired to design a poster that advertised the study. The poster was attached to email correspondence and used on the Facebook page. Anyone who was sent the poster was also asked to print and post it or to forward onto other possible participants or recruiters, where possible.

Throughout the recruitment period and where appropriate, the candidate discussed the study in her various circles in the attempts to recruit additional participants. Telephone calls were made and texts were also sent to people who expressed an

interest in learning more about the study. These recruitment approaches gave the candidate the ability to promote the study and gave participants the opportunity to ask questions. The script for the approach solicited consent to discuss the study, gave background on the study and the reasons for it, directed interested parties to the Facebook page, and informed people about the remuneration offered for participation. That is, each person interviewed was offered a \$30AUD Coles Myer gift card.

On 24 November 2019, the candidate had a table amongst a range of community organisations and service providers at Out in the Park, the sixth annual Ulverstone Pride event. The event was an offshoot of state-wide Tasmanian Pride or TasPride and was organised by Connect4Life Tasmania. The event featured food vans, live music, speeches, and tables for community organisations and service providers. The candidate's table featured a large rainbow flag and a Centre for Rural Health banner. She discussed the study with people who approached the table and gave a 5-minute speech about the study to all attendees.

Third parties, including non-government organisations, government services, and businesses from the candidate's personal and professional networks were asked to assist with recruitment as follows: by displaying the poster that advertised the study in public areas of their organisation; directing potential participants to the poster; inviting possible participants from their member list; circulating information about the study through their online newsletters and bulletins; verbally sharing information about the study; posting about the study on their website or social media accounts (including sharing the Facebook page the candidate created for the study); or forwarding potential participants the email preamble they received from the candidate. The candidate contacted roughly 150 third parties to assist with recruitment and approximately 30 agreed, including the state's sex worker association, sexologists, an LGBTIQ+ support service, and mental health professionals.

With information about the study posted online and the various other ways in which it was advertised, people could choose to participate in either an interview, the survey, or both. Interviewees were asked if they were aware of the existence of an

online survey and at the end of the survey, participants were invited to register for an interview. Naturally, while people were recruited to the study via various approaches, self-selection bias was a factor. That is, people who choose to participate versus those who chose not to participate in the study may have differed significantly. Assumed reasons for non-participation were a lack of motivation, a lack of relevancy, a lack of access to the time or tools required to participate (phone, tablet, or computer), a lack of transport to one of the sites in which interviews occurred, or a lack of literacy.

4.2.1.7 Qualitative data collection

Qualitative data was collected via screening interviews and research interviews. Screening interviews occurred at a date and time of the participants' choosing and were conducted via telephone. Following confirmation of the person's identity and a brief introduction, the candidate read a pre-written (and Tasmanian Social Sciences Human Research Ethics Committee approved) script to the possible participant, which included some background on the study, the purpose of the call, and a confidentiality statement. The candidate then went through four main questions and, if needed, 18 additional follow-up questions to determine acute emotional distress, safety concern, or imminent danger. Finally, research interviews were scheduled.

Screening interviews were conducted with 37 people; all passed the screening interview. However, only data from 33 were retained: two people chose not to proceed to the research interview stage (due to their cessation of contact for which reasons are unknown to the candidate); one withdrew their data following their research interview and; one person's research interview did not record due to a technical malfunction.

When the date and time for the research interview was confirmed, the candidate emailed participants an information sheet, a consent form, a request for PDF of publications arising from participation, and the list of questions (the topic guide, consent forms and, where appropriate, requests for PDF of publications arising from participation, were returned to the candidate via email).

Research interviews occurred on a date and at a time of the participants' choosing and were held in-person or via telephone. Table 4.2 demonstrates the number of participants per locale. Prior to the audio recorder activation, the candidate confirmed the person's identity; confirmed receipt of consent form; responded to any questions; and confirmed consent for audio recording. Following audio recorder activation, the candidate confirmed consent for audio recording; reviewed forms and requested consent of receipt; discussed confidentiality and anonymity (including reciprocal confidentiality) and confirmed participant's informed understanding of same; responded to any questions; and posed the semi-structured interview questions (Appendix 1).

Of the 35 research interviews that were conducted, one participant withdrew their data and there was a technical issue with the recording device in an interview with another person and, as such, the interview did not record. This person chose not to redo the interview; thus, 33 interviews were included for transcription.

Table 4. 2 Locale for interviews and participants (N = 35)

Locale	<i>n</i>
Telephone	15
Newnham Campus, UTAS	3
Burnie Campus, UTAS	2
Inveresk Campus, UTAS	4
Sandy Bay Campus, UTAS	3
Working It Out	4
Private residence	4
Total	35

Interviews were conducted between November 2019 and March 2020 and lasted between 45 minutes and 127 minutes. Audio recordings were made with a Zoom Corporation H4n Handy Recorder. The candidate aimed to establish a conversational tone with the interviewees, which was aided by the open-ended nature of the interview questions as well as her counselling experience. To reinforce this tone, the candidate decided not to take notes during the in-person interviews so as not to distract participants. Each interview participant was offered a \$30AUD Coles Myers gift voucher; *n* = 34 accepted. Vouchers were mailed to telephone participants.

Following the interviews, the H4n files were transferred to a UTAS-issued laptop that is backed up on the university server. The candidate used NVivo Transcription (QSR International Pty Ltd., 2020) to transcribe the interviews. NVivo Transcription is an automated, cloud-based service and was chosen due to its affordability over manual transcription. To confirm quality, transcriptions were verified and corrected by listening to recording and reading Microsoft Word outputs concurrently and were cross-checked by the candidate's three supervisors.

4.2.1.8 Qualitative Data management

Data, as well as any accompanying information, requires good organisation and storage to ensure safekeeping, optimal retrieval, accuracy, verifiability, and productivity (National Health and Medical Research Council et al., 2018). The digital qualitative data that required management for this study included screening and research interviewees' contact information; research interviewees' assigned codes; screening interview results; consent forms; requests for PDF of publications arising from participation; audio recordings of research interviews; and research interview transcripts. The print qualitative data that required management consisted of consent forms and requests for PDF of publications arising from participation.

Digital data is being stored as Microsoft Word, Microsoft Excel, NVivo, mp3, and PDF files on a secure UTAS-issued laptop that is password-protected and backed up on the university server. UTAS maintains licenses for the software on its laptops and new versions of the various software for each data format are installed regularly. Master copies and all versions of all digital data have been retained and are version controlled. File names include the date and version. Print data is being stored in a locked filing cabinet and access to all data is restricted to the candidate and her supervisors.

4.2.1.9 Qualitative data analysis

The coding of data is the process of transforming information or observations into a set of meaningful and cohesive themes, descriptions, and patterns. This study's data were explored inductively and deductively and coded using NVivo 12, computer software used for organising and managing qualitative data (QSR International Pty Ltd., 2021). Via the inductive approach, codes were derived from the data. The

deductive approach began with a set of predetermined codes based on research questions or previous findings and continued with the location of examples from within the data that matched. (Palinkas, 2014).

Data coding for this study involved the following steps: 1) Deductive codes were developed based on the study's research questions and the interview questions, which were based on the systematic literature review findings; 2) During initial data analysis, broad, inductive codes were developed and findings that matched the deductive codes were captured; 3) Line-by-line coding sessions followed in which inductive and deductive codes were added; 4) Codes were then reorganised and refined into categories; 5) Codes were verified by a supervisory team member, which involved reviewing assigned codes, assigning new codes, removing or combining codes, and discussing and resolving differences; 5) Vertical and horizontal integration were then used to cross reference and reveal similarities and differences; 6) Categories were created and refined to ensure that all relevant data was included, nothing was missing, there was no overlap; 7) Categorisation produced themes and subthemes, which were refined until salient themes emerged.

Data analysis resulted in the identification of both latent and semantic themes whereby explicit meanings as well as underlying themes were captured. This approach increased the trustworthiness of the analysis and findings (Given, 2008; Palinkas, 2014). Data analysis is grounded in measuring and meaning-making, which can be achieved via a variety of approaches that can be used alone or in combination. Thematic analysis was adopted for use in this study. To provide context as well as demonstrate why the chosen approaches were selected, an overview of four alternate approaches is first explored.

Content analysis is a systematic way to examine a range of text, render it into a reducible amount, and expose patterns. This form of data analysis is useful for capturing both latent (implied but undeveloped) and semantic (explicit) themes and meaning (Given, 2008). Content analysis' reducibility renders data down to smaller chunks that can be explored either qualitatively or quantitatively. Content analysis was not selected for use, however, due to its reducibility and tendency to be frequency-oriented (Braun & Clark, 2006).

Discourse analysis studies language's role in social interactions. This form of textual analysis focusses on larger units of information (interviews, conversations, speeches) and their relationships with and between social contexts or a participant's environment (Given, 2008). Discourse analysis was not selected for use as it is primarily a qualitative approach and because of its heavy reliance on sampling; inferences that discourse analysis would produce may not be holistically representative of the entire dataset (Aydin-Düzgit & Rumelili, 2018).

Grounded theory seeks to explore the phenomena grounded in the data (Braun & Clarke, 2006). Rooted in induction, grounded theory involves clear, systemic procedures, which require ongoing assessment such as to produce results that represent the essence of the data under review. This theory has the potential to produce a deeper analysis of the research questions as well as the researcher. In spite of its procedural approach, application of this method can be innovative; however, the theory can also be too rigid if followed narrowly (Charmaz, 2008). This approach was not selected for use as it relies on theoretical sampling and saturation, which discounts data representative of alternate, divergent perspectives (Given, 2008).

Narrative analysis is used to analyse data from a variety of sources including stories, biographies, and other documents that are not based on research questions. It seeks to explore stories that, in turn, are connected to and, thus, provide insight into identities and experiences (Given, 2008). There is no one approach for this form of analysis, however, it can consist of stories that are structured or unstructured, historical or current, linear or tangential, detailed or sparse – all of which contribute to understanding the context from which the story derives as well as the narrator (Wong & Breheny, 2018). As the data collected are not stories and are based on research question, this approach was not chosen for use in this study (Wong & Breheny, 2018).

4.2.1.10 Thematic analysis

A common form of analysis employed in mental health research, thematic analysis seeks to provide insight into narratives that are more exploratory in form (Nowell et al., 2017). Considered a foundational approach to understanding qualitative data,

thematic analysis is a flexible method to discover, explore, and extrapolate patterns from across (as opposed to from within) a dataset to produce a rich result (Terry et al., 2017). An established theoretical framework need not be in place to use thematic analysis (Braun & Clark, 2013); however, one needs to be clarified as the analysis ensues to anchor selected themes. Thematic analysis can also produce a rich description of a dataset or a deep exploration of one facet. With the former, depth may be compromised, but a vital snapshot can result. Rich descriptions are recommended for insufficiently researched topics. The latter is useful in fleshing out an aspect of the data (such as a research question, or a particular theme) (Braun & Clark, 2006). Thematic analysis can be inductive or deductive/theoretical; themes are based on the data or on a preformulated theory or hypothesis (Given, 2008).

Disadvantages of thematic analysis exist. It can be used without thorough analysis (heavy reliance on research or interview questions); it can be so flexible as to lack structure or refinement; it requires a theoretical framework to adequately explore and anchor themes; and it can be considered an approach lacking in rigour ascribed to other methods (Nowell et al., 2017). The advantages of thematic analysis were considered to outweigh its disadvantages; thus, thematic analysis was chosen for use in this study because it is established, flexible, is suited to a range of theoretical frameworks, produces rich descriptions, and facilitates pattern identification (Clarke & Braun, n.d.).

A theme is identified when it encapsulates an aspect of the data as it relates to the research question and the dataset as a whole. Themes can be selected due to their proportion/prevalence or significance; that is, they can represent a majority opinion/finding or they represent a vital aspect of the research topic (Terry et al., 2017). Themes can also be latent (interpretive) or semantic (explicit). Themes can originate with research questions or, for example, from the questions posed in interviews; however, further refinement of themes is required to find those that expose the meaning at the core of the dataset (Braun & Clark, 2006; Given, 2008).

Braun and Clark (2006 & 2013) defined a procedure for thematic analysis as well as a quality checklist, which were used in this study and have been combined in Table 4.3.

Table 4. 3 Thematic analysis phases based on Braun and Clark

Phase		Process
1	Data familiarisation	Transcribe data (if required); verify transcripts; read and re-read data; record initial impressions
2	Initial code generation	Give each item equal attention; code interesting features of the entire dataset systematically; collate data relevant to each code
3	Search for themes	Gather all data relevant to each potential theme; collate codes into potential themes inclusively, & comprehensively
4	Review themes	Confirm that themes work in relation to the codes and the entire data set; confirm these are coherent, consistent, & distinctive
5	Define & label themes	Conduct ongoing analysis to refine themes and overall story of the analysis to generate clear definitions and names for each theme
6	Produce manuscript	Select vivid, compelling extract examples; analyse selected extracts; organise content; refer to the research question(s) and literature; produce a scholarly report of the analysis in which assumptions & approaches are explained & then carried out

4.2.1.11 Evaluating the quality of qualitative data

Much existing research presents criteria to assess qualitative data to achieve the rigour embedded in standardised quantitative data evaluations (Anderson, 2010; Northcote, 2012; Sandelowski, 2015; Tracey & Hinrichs, 2017). With more than 100 criteria identified and with terms often used interchangeably or assigned to different criteria, selection can be difficult (Northcote, 2012). For brevity, three common criteria that were adopted for use in this research are validity, credibility, and trustworthiness (Sandelowski, 2015).

4.2.1.11.1 Validity

Demonstrating validity is important in qualitative research due to its subjective nature (Yardley, 2017). Validity can determine the effectiveness and meaning of the research and research findings can ‘empower or educate those involved’ (Lub, 2015, p. 2). One way to strive for validity is through data saturation; when no additional codes are created and themes (and subthemes) have been completely expounded, data collection can cease (Palinkas, 2014). Data saturation was achieved in this study. Another way to achieve validity is to highlight themes or evidence that do not match or that represent exceptions (Lub, 2015; Palinkas, 2014). This presentation of contrasting or disconfirming evidence can help to ensure that one perspective is not elevated as representative (Lub, 2015). Disconfirming evidence was also presented

in this study. A third way to aim for validity is via collaboration or analysis by multiple research team members to achieve consensus (Given, 2008; Lub, 2015). In this research, the supervisory team verified a random sample of transcriptions for accuracy.

4.2.1.11.2 Credibility

Lincoln and Guba (1985) posited that the following were needed to establish credibility in qualitative research: negative case (or outliers) selection, peer debriefing, prolonged field engagement and observation, documented decision making, and member checks. In recent years, this was simplified to thick description, triangulation, and member checking (Tracey & Hinrichs, 2017). In this research, thick description was achieved via complementing qualitative research with quantitative (Palinkas, 2014) and a triangulation design-convergence model was used.

Member checking or participant validation occurs when study participants are asked to confirm the data they have provided (Creswell & Plano Clark, 2011; Lub, 2015). Member checking enables the researcher to compare their interpretation of the data with the participants' (Palinkas, 2014). In this research, member checking occurred when during both the screening and the research interviews, the candidate restated or summarised participants' replies or statements and then asked the participant to determine accuracy.

Another use of member checking used in this research pertained to interview transcripts; that is, on the interview consent form, participants could indicate a preference to review a copy of their transcript and provide any changes thereto to the candidate within two weeks (17 of 34 requested a copy). Thus, following quality control, transcriptions were emailed to those participants who requested a copy; two requested changes: one clarified words misheard by the candidate, and one asked to have several comments redacted lest the participant be identified. This participant verification enhanced authenticity, the integrity of the findings, and trustworthiness.

4.2.1.11.3 *Trustworthiness*

To increase likelihood that the qualitative data receives positive attention and results in action, it must also be trustworthy (Lincoln & Guba, 1985; Sandelowski, 2015). Trustworthiness is based on how consistent it is across different means and measures and the soundness of the research methods and the findings. To achieve this, analysis methods must be consistent and transparent; biases must be declared; reflection and debriefing must occur; the findings must be representative; the research process must be articulated clearly; themes must be discussed and agreed upon by the research team; and findings must be linkable to the theoretical framework and other findings (Noble & Smith, 2015). Several of these strategies were adopted in this study: A research plan and an analysis plan were created by the candidate and approved by the supervisory team; the research and analysis proceeded as planned and was verified within the various phases of this study and with each publication; the candidate was the only interviewer, which ensured consistency in transcript interpretation; self-reflection occurred regularly via critical deconstruction and reconstruction of discourses and biases (Fook, 2002); reflexivity was practiced during the course of this study, in which the candidate explored her beliefs, judgements, bias, and practices and their impact on the research; records were meticulously kept, demonstrating approaches and decisions and ensuring consistent and transparent interpretations of findings; existing research with similar and different findings were represented; participants were invited to verify their transcripts; publications generated from the research contained verbatim descriptions and accounts of participants' verified narratives; data was triangulated through the use of a triangulation design-convergence model.

4.3 Quantitative Research Method

Figure 4.3 presents the quantitative approach used in this study, which included survey development and piloting, participant recruitment, data collection and analysis, and interpretation of results. These steps are described in detail in the sections that follow.

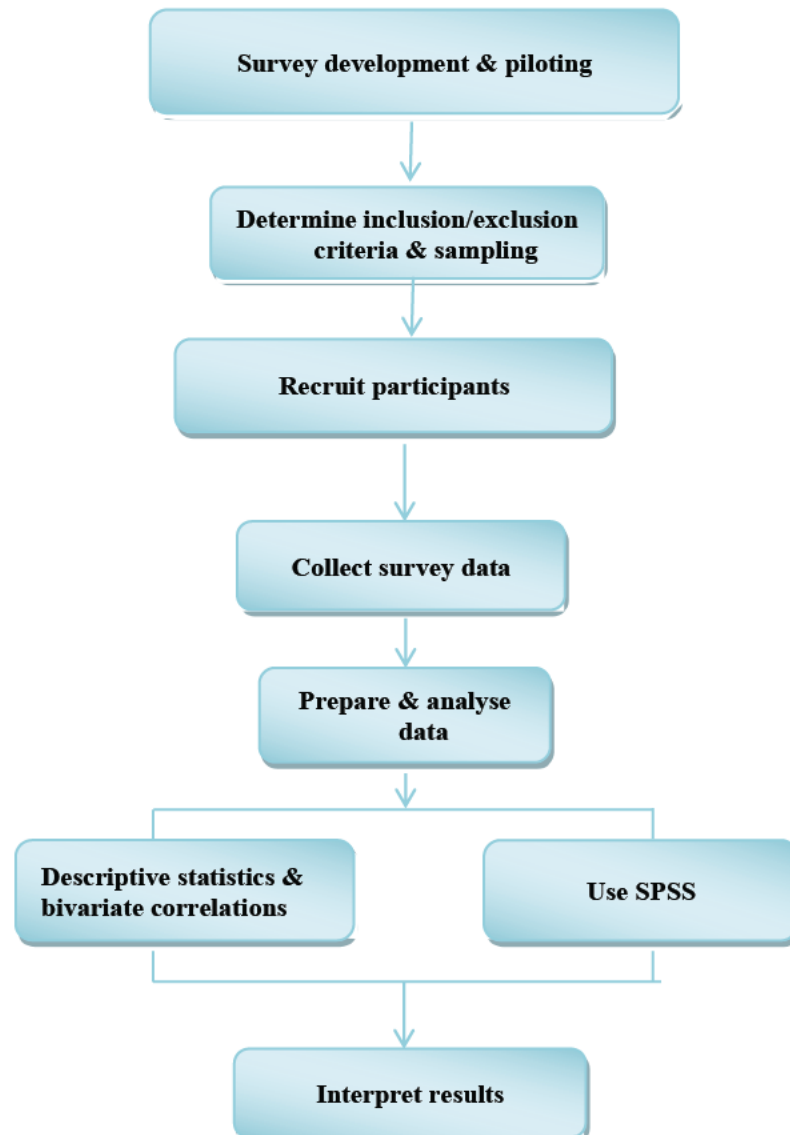


Figure 4. 3 The quantitative approach used in this study

4.3.1 Survey

A survey was chosen for use in this study as surveys provide many advantages, are standardised, provide a snapshot of specific groups, and allow for the collection of a large amount of data in a short time (Kelley et al., 2003). Surveys are flexible; that is, they can be completed at a time and place of participants' choosing, when they deem themselves able to participate. They can also be paused via saving a draft and returned to at a convenient time. The anonymity of the survey provided added ease in that participants are inclined to respond to sensitive questions online rather than in person. To ensure the survey was accessible regarding its lexicon and content, it was

assessed using the Flesch-Kincaid Grade Level readability tool in Microsoft Word; it scored a 7.3 Grade Level, which was deemed appropriate for the subject matter.

Surveys are fairly affordable for both the organisers and respondents (Kelley et al., 2003). Creating and maintaining surveys for research students and staff is part of the Centre for Rural Health's existing infrastructure. Respondent numbers were relatively low, which kept costs down. Respondents had to have personal internet access and a device on which to complete the survey. Our survey was not optimised for small screen, mobile devices. Participants could complete the survey on a mobile phone, but smaller screens did not provide the best user experience. Thus, participants, ideally, needed to have a tablet or computer to participate. Roughly 86% of Australian households have internet access and, of them, 91% have computers and mobile phones and 66% have tablets (Australian Bureau of Statistics, 2018b).

Surveys are relatively easy to administer. The ease of administration of online surveys is increased when they contain mostly close-ended questions (like the one used in this research). A survey's efficacy is increased due to the large geographical area they can cover and their popularity with hidden or underserved populations (Kelley et al., 2003). Surveys can be administered in a variety of ways, each with various pros and cons, which were considered in the design of this research. Surveys can be completed by post, in-person, by telephone, or online.

Postal surveys involve the printing and mailing of surveys to many people in a large area, typically without contact between possible participants and the researcher. Postal surveys are known for nonresponse errors, tend to have a low response rate, and require a large sample to ensure generalisability and a sizeable dataset (Kelley et al., 2003). Administration and postage costs precluded this approach. Mostly, however, this approach was rejected as the identity (and, thus, personal mailing addresses) of the target populations was unknown.

In-person surveys tend to consist of a researcher approaching people randomly in public in the hopes of finding participants who have the time to participate and meet the inclusion criteria. In-person surveys tend to have higher response rates as the

researcher has the advantages of social niceties; people are less likely to reject someone in-person (than over the phone), which gives the research the opportunity to be more persuasive with potential participants (Kelley et al., 2003). Administering the survey used in this study in person, however, was discounted for the following reasons: randomly asking people if they are either LGBTIQA+, kink-oriented, and/or a sex worker, and if they had experience with a mental health issue in their lifetime (based on the inclusion criteria) in public is ethically unsound. If the researcher was able to identify possible participants in another manner and then invite them to an indoor area where the survey could take place, the potential for boredom or frustration in participants due to the survey's length was too high. In-person surveys are too time consuming. Finally, the costs of travelling around rural and remote Tasmania as well as booking interview rooms was prohibitive.

Telephone-based surveys are more economical and have higher response rate and higher refusal rates than postal surveys; the social niceties advantage is less profound over a telephone (Kelley et al., 2003). Administration of telephone surveys would also require that the researcher know the identity and phone numbers of the target population, which was not the case; thus, they were not used in this study.

Online surveys tend to have lower associated financial and time costs; they are more environmentally sound due to the lack of paper, envelopes, and postage; they can be edited or modified easily; they can reach possible participants throughout the world where there are no internet and computer/tablet/phone access issues; they are suitable to a variety of study types; and the technology with which to administer online surveys is tested and relatively easy to use (Nayak & Narayan, 2019). The University of Tasmania has a LimeSurvey licence; LimeSurvey is a popular survey service-platform that is used to prepare, run, and evaluate an online survey (LimeSurvey, 2021). Also, the Centre for Rural Health at University of Tasmania has a dedicated web technology and development officer; part of whose job it is to assist staff, candidates, and students with online surveys. The ethical issue of informed consent was addressed via the inclusion of a clear description and preamble at the beginning of (and separate from) the survey about the nature and purpose of the study and its outputs and how confidentiality and anonymity are dealt

with (Appendix 2) (Nayak & Narayan, 2019). Due to these benefits, online surveys were selected to be a suitable research tool for this study.

Surveys also have inherent confidentiality rendering participants unidentifiable. To prevent or minimise possible implications or consequences to participants due to the potentially sensitive nature of the survey data collected, the following steps were taken to ensure anonymity in this study:

- In the survey preamble, participants were informed of the anonymity of the survey itself, the anonymity of the \$100AUD Coles Myer gift card draw, and the deidentification of any participants in resulting publications
- At the end of the survey, participants were invited to participate in a draw for a \$100AUD Coles Myer gift card. If they clicked a link to participate, another, separate webpage opened where they entered their name and postal address. This new page was not linked to survey responses. The winner of the draw was selected by a computer-generated random sequence that was administered by the Administrative Support Officer, Centre for Rural Health. The Administrative Support Officer mailed the winner the gift card.

Surveys have some disadvantages, including biases, issues, and errors. Nonresponse bias occurs when there is a lack of responses to a survey and when there are systematic differences between those who respond and those who do not. To ensure a representative sample, response rates must be high. Nonresponses impact survey results (Creswell, 2014). Nonresponse error occurs when people do not participate in a survey because they are unable, unavailable, or unwilling. Nonresponse was tempered in this study with advance notification and having the survey open for a long period (Harrison, 2006). An active social media presence in which the survey is advertised often so as to remain front of mind in possible participants also aided in addressing nonresponse in this study.

Survey length is a vital consideration. The number of questions asked and the granularity of the included topics require much forethought. Research shows that the average completion time should be 10 minutes and the maximum should be 20, for, with longer surveys, participants generally spend less time per question and abandon

rates increase. This was tempered somewhat with our survey in that it was academic (academically affiliated surveys have lower abandonment rates), participants appreciated the fact that our study was occurring, and we assured anonymity (Chudoba, n.d.; Revilla & Ochoa, 2017).

Another disadvantage to surveys is information bias, which is bias that occurs in study measurement approaches that impact research validity. Information bias includes self-reporting bias, measurement error bias, confirmation bias, coverage error, sampling error, and nonresponse error (Althubaiti, 2016; Harrison, 2006). All were relevant to this research. Self-reporting bias is a split between what a participant reported and the true value of the measure. Deviations can occur due to a misreporting of the severity of an issue or behaviour influenced by social desirability. Social desirability bias was offset in this study by research-measure validation, which occurred via comparison with other similar research tools and with review by external parties (Althubaiti, 2016). Measurement-error bias occurs when the research tool has limited or not-applicable response options or poorly written questions that lead to participants' misunderstanding. This type of bias was overcome in this study via basing the research tool on existing, similar tools and piloting the tool for comprehension (Althubaiti, 2016). Confirmation bias is interpreting or favouring data that confirms the researcher's beliefs or values, dismissing or downplaying contradictory data, and is more likely to occur when judgement is involved in a study. This bias was overcome in this study with feedback or confirmation of findings from other researchers, acknowledgement of its possibility, critical and objective evaluation, consideration of alternate interpretation, awareness of the potential of external pressure, and creating and adhering to research protocols (Althubaiti, 2016).

Coverage error is the exclusion of possible participants from the target population(s) from the survey frame or sample. An online survey, for example, excludes participation from people who are illiterate or without a computer, tablet, mobile phone, or internet access (or access to same). Coverage can also be over or under: under coverage is the failure to include all members of the target population and over coverage refers to the overrepresentation of some target population members. Over- or under coverage can result in bias if, for example, findings for a specific

topic, variable, or characteristic are inflated or deflated due to its coverage (Harrison, 2006). Coverage error was addressed in this study via offering people an opportunity to participate in a survey or an interview and by recruiting broadly so as to include all members of the target populations.

Sampling error occurs when the sample size is too small, over represented, or under represented to adequately generalise survey findings. It occurs when sample participants' characteristics are not proportional to those in the target population(s) and reliable, representative inferences cannot be made (Harrison, 2006). Probability sampling involves random sampling, whereas nonprobability does not; the former is perceived to be more precise, whereas with the latter, participants are chosen based on availability and convenience (Creswell, 2014). The latter is also useful when the population number of possible participants is not consistent or known. Sampling error was offset in this study by increasing sample size, via follow ups with possible participants and people aiding in recruitment, and the inclusion of two research tools. Purposive nonprobability sampling (based on a clear purpose[s]) and snowball sampling (the recruitment of new participants by existing ones) were used in this study, are common in studies with hidden or underserved populations, and can increase sample size (Kelley et al, 2003; US Institute of Medicine, 2011).

4.3.2 Survey Development

The survey was developed based on the candidate's clinical practice as a mental health counsellor, the systematic literature reviews (Chapter 2), previous research (Reynish et al., 2020, 2019), the 2007 National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2008), and the Australian Psychological Society Stress and Wellbeing in Australian Survey (Australian Psychological Society, 2015). The 2007 national survey explored lifetime and one-year prevalence of mental disorders (Australian Bureau of Statistics, 2008). The 2015 national survey explored mental health and wellness across six domains (physical, social, emotional, spiritual, intellectual, and vocational) as well as risk and protective factors (Australian Psychological Society, 2015).

4.3.2.1 Survey structure

The survey consisted of 174 questions on demographics, psychosocial variables, help-seeking experiences, the Kessler Psychological Distress Scale (K10), and the Brief Resilience Scale (Kessler et al., 2002; Smith et al., 2008). The K10 is a widely used 10-question, five-point Likert-scale measure of mental distress experienced in the last 4 weeks. Questions include, ‘How often did you feel hopeless?’ and ‘How often did you feel worthless?’ Calculated responses were grouped as low (10-15), moderate (16-21), high (22-29), and very high (30-50) psychological distress. The K10 had excellent internal reliability and validity (Cronbach’s alpha = 0.92 Kessler et al., 2002).

The Brief Resilience Scale (BRS) is a 6-question assessment of a person’s ability to recover from stress. Questions include, ‘I tend to bounce back quickly after hard times’ and ‘I tend to take a long time to get over setbacks in my life.’ Likert-response options range from 1 = strongly disagree to 5 = strongly agree (Smith et al., 2008). Unlike other measures, the BRS focuses not on external characteristics or resources, but on the essence of personal resilience itself. A focus on the former may indicate a person’s ability to adapt; thus, potentially skewing the results. The superior psychometric properties, internal consistency, and retest reliability of the BRS have been demonstrated (Cronbach’s alpha = 0.93) (Salisu & Hashim, 2017; Smith et al, 2008; Windle, Bennett, & Noyes, 2011). The suitability of the BRS for use with LGBTIQ+ populations has also been demonstrated (Bariola et al., 2015; Lyons, Hosking, & Rozbroj, 2015; McNair & Bush, 2016); an inference was, therefore, made that the scale would also be suitable for other people with diverse approaches to sex and sexuality – sex workers and kink-oriented people. For these reasons, the BRS was chosen for use in this study.

The survey was divided into 18 sections, as follows:

Section 1 (questions 1-17), Demographics and background: Confirmation of inclusion criteria regarding existence of mental health issues, opinion on stigma regarding mental health issues and help seeking, and demographic questions about the participants such as age; postcode; gender; sex assigned at birth; sexual orientation; intersex status; relationship status; educational attainment; sex work

experience; kink orientation; income source; experience with homelessness; drug use prevalence, frequency, and type. This section of close-ended questions explored participants' background characteristics that aided in the representativeness of the sample. All participants were required to complete this section.

Section 2 (questions 18-21), Mental health: Diagnoses and suicidality in the past year and lifetime as well as the risk/protective factor of social support. The intent of this section was to gain information about mental status and support prevalence using close-ended questions. All participants were required to complete this section.

Section 3 (questions 22-43), Mental health service use and barriers/facilitators: Prevalence of mental health professional (MHP) consultation; types of MHP consulted; services used; wait times for MHP consultations; travel time to MHP; payment for appointments; affordability of appointments; experiences using emergency departments for mental health support; prevalence of general practitioner (GP) consultations for mental health issues; assessment of GP skill level; local, specialised services; sufficient MHP staff in local area; quality of support; waitlists; cost; appointment keeping; public transport; healthcare insurance; and trust for MHP. This section inquired about specific rural or remote service use and barriers/facilitators to help seeking using close-ended questions. All participants were required to complete this section.

Section 4 (questions 44-53), Kessler Psychological Distress Scale (K10): Gauged participants experiences in the last 4 weeks with tiredness, nervousness, unrecoverable nervousness, hopelessness, restlessness, unrecoverable restlessness, depression, effort, unrecoverable sadness, and worthlessness. This section of close-ended questions was included to determine psychological distress prevalence in participants. All participants were required to complete this section.

Section 5 (questions 54-59), Brief Resilience Scale (BRS): Gauged participants' ability to bounce back from stressful events quickly, difficulty with stressful events, in a moderate amount of time, difficulty recovering, limited issues following setbacks, and difficulty recovering from setbacks. This section of close-ended

questions was included to explore participants resilience. All participants were required to complete this section.

Section 6 (questions 60-70), LGBTIQA+ risk and protective factors:

Friends/family awareness of diversity; public acceptance in past 5 years; unfairness of Australian Postal Survey on Marriage Equality; identification representativeness (regarding name and gender); friends' and family's correct pronoun and name usage; ability to dress or act in public as desired; family rejection following disclosure; public toilet usage; need to educate people; mislabelling, misgendering, cisgender-normative, heteronormative assumptions; and age participant knew they were LGBTIQA+. This section of close-ended questions gathered information regarding possible risk and protective factors that harmed or helped participants' mental health. Only LGBTIQA+ participants completed this section.

Section 7 (questions 71-76), LGBTIQA+ mental health: Mental health issues due to being LGBTIQA+; experiences with discrimination due to being LBGTIQA+; pride in being LBGTIQA+; feelings of outsidersness; shame regarding being LBGTIQA+; and LBGTIQA+ community belonging and participants' mental health. This section collected data on risk and protective factors that impacted LGBTIQA+ participants' mental health via close-ended questions. Only LGBTIQA+ participants completed this section.

Section 8 (questions 77-93), Experiences with health professionals (mental and physical) and services: MHP consultation for LGBTIQA+-related mental health issues; skill level of MHP regarding LGBTIQA+ mental health issues; disclosure to MHP; MHP required teaching about LGBTIQA+; GP consultation for LGBTIQA+-related mental health issues; assessment of skill level of GP regarding LGBTIQA+-related mental health issues; MHP sex positivity or kink awareness; MHP insensitivity or rudeness; 'advice' from MHP to stop being LGBTIQA+; MHP saying that being LGBTIQA+ was a phase; MHP recommendation for conversion therapy; MHP who was homophobic, transphobic, racist, classist, ableist, and/or whorephobic; knowledgeable MHP experienced working with LGBTIQA+ people; MHP refusal of care due to being LGBTIQA+; MHP focus on being LGBTIQA+ when participant presented for another issue; friendly, polite, and welcoming MHP;

and MHP or staff breached confidentiality. This section collected data via close-ended questions on barriers and facilitators to care and was only completed by LGBTIQ+ participants.

Section 9 (question 94), Additional comments: anything to add. This section gave participants the option to share anything else they wanted to via an open-ended question and was only completed by LGBTIQ+ participants.

Section 10, (questions 95-104), Demographics regarding sex workers and sex work: Current or former sex worker; duration doing sex work; location of work; age commenced sex work; reasons for becoming a sex worker; hours per week worked; relationship status; partner(s) awareness about sex work; partner(s) support of job; and reasons for partner(s) support. This section of close-ended questions collected background information as well as risk and protective factors. Only sex workers completed this section.

Section 11 (questions 105-108) Thoughts on sex work: Sex work is work; public acceptance of sex work increasing in last 5 years; sex workers' entitlement to human rights; and sex workers' entitlement to workplace health and safety supports. This section of close-ended questions explored risk and protective factors and were only completed by sex workers.

Section 12 (questions 109-125) Sex work and mental health: Mental health issues due to sex work; experiences with client and police violence or aggression; sex work improves mental health; job has been mostly positive; proud of job; friends and family awareness of job; stigma and discrimination because of job cause anxiety or stress; feelings of outsidership; love of job; secrecy about job; decriminalisation would improve safety and mental health; feel in control on-the-job; fear on-the-job violence; and self-esteem due to job. These close-ended questions explored risk and protective factors and were only completed by sex workers.

Section 13 (questions 126-142) Experiences with health professionals (mental and physical) and services: MHP consultation for sex work-related mental health issues; disclosure to MHP; assessment of skill level of MHP regarding sex work-based mental health issues; MHP required teaching about sex work; MHP advocated

exiting; GP consultation for sex work-related mental health issues; skill level of GP regarding sex work-related mental health issues; MHP sex positivity or kink awareness; MHP insensitivity or rudeness; MHP questions about child abuse; ‘advice’ from MHP to stop being a sex worker; knowledgeable MHP experienced working with sex workers; MHP refusal of care due to participant’s job; MHP focus on sex work when participant presented for another issue; friendly, polite, and welcoming MHP; MHP who was homophobic, transphobic, racist, classist, ableist, and/or whorephobic; and MHP or staff breached confidentiality. This section collected data via close-ended questions on barriers and facilitators to care and was only completed by sex workers.

Section 14 (question 143), Additional comments: anything to add. This section gave participants the option to share anything else they wanted to via an open-ended question and was only completed by participants who were sex workers.

Section 15 (questions 144-151), Demographics and information regarding kink: Kink power dynamics role; duration of kink practice; duration of interest in kink; kink partners; friends’ or family knowledge about kink orientation; safe, sane, consensual and/or risk-aware kink; public acceptance of kink in last 5 years; and kink is part of a healthy sexuality. This section of close-ended questions collected background information regarding kink-oriented participants and risk and protective factors. Only kink-oriented participants completed this section.

Section 16 (questions 151-156), Kink and mental health: Mental health issues due to kink; discrimination, abuse, harassment due to kink orientation; proud of kink orientation; feelings of outsidersness; kink community involvement improves mental health; and kink improves mental health. These close-ended questions explored risk and protective factors and were only completed by kink-oriented participants.

Section 17 (questions 157-173), Experiences with health professionals (mental and physical) and services: MHP consultation for kink-related mental health issues; disclosure to MHP; skill level of MHP regarding kink-based mental health issues; MHP required teaching about kink; GP consultation for kink-related mental health issues; assessment of skill level of GP regarding kink-related mental health

issues; MHP sex positivity or kink awareness; MHP insensitivity or rudeness; MHP questions about child abuse; ‘advice’ from MHP to stop kink; knowledgeable MHP experienced working with kink-oriented people; MHP refusal of care due to kink; MHP focus on kink when participant presented for another issue; friendly, polite, and welcoming MHP; MHP who was homophobic, transphobic, racist, classist, ableist, and/or whorephobic; and MHP or staff breached confidentiality. This section collected data via close-ended questions on barriers and facilitators to care and was only completed by kink-oriented participants.

Section 18 (question 174), Additional comments: Anything to add. This section gave participants the option to share anything else they wanted to via an open-ended question and was only completed by kink-oriented participants.

4.3.2.2 Piloting

Research tools are tested prior to release (piloted) with a few possible participants to confirm the tool’s feasibility for a larger sample. The survey used in this study was pilot tested to determine suitability and comprehension of questions and instructions, to uniform understanding of the questions, to aid in determining gaps in survey questions, and to ensure optimal functionality (Creswell & Plano Clark, 2011; Kelley et al., 2003).

4.3.2.2.1 Expert review

The survey was pre-tested by experts in research and by a representative sample of community members from the target populations who had expertise via their lived experience with the identities and topics under investigation. Community members were included in the development of the survey to help the candidate produce a research tool that more inclusively and accurately reflected lived experience and made participants active parts of the research (Bauer et al., 2019; Jeffreys, 2009). The candidate asked 12 people (via email) to pilot the survey; 10 agreed: a Senior Lecturer with the School of Health Sciences (UTAS) with extensive mixed-methods research experience working with populations that are marginalised and people who lived in rural or remote areas; a Lecturer in rural mental health from an Australian university with extensive qualitative research experience; a Senior Research Fellow from a university in England who has research interests in the mental health of

LGBTIQA+ people; a software engineer with web development experience; six people from the LGBTIQA+ community, including two pansexual people, one transgender person, one bisexual person, one gay person, one queer person, two who were kink-oriented, and one who was a current sex worker. The candidate's supervisors also reviewed the study. Experts were emailed a brief outline of the study and the URL link to the survey. They were asked to take the survey three to five times selecting different responses each time, take notes regarding errors, issues, concerns, and impressions, and reply to the candidate with their notes within 2 weeks.

The experts confirmed the 20-minute completion time and provided extensive feedback: change response options for certain questions from yes/no to Likert scale (or the inverse); include definitions for 'counsellor' in the preamble; eliminate repetition; combine all demographic questions into one section; fix navigation and technical issues; clarify syntax and logic issues; add clarity to certain questions; and add additional questions for deeper representation. All suggestions were addressed, specifically for example, additional questions regarding sex workers' personal romantic relationships due to the impact that partnerships have on mental health were added; the preamble was simplified and shortened; and the small movements in the progress bar at the bottom of each page of the survey was considered daunting, so it was removed. Experts also shared comments on the survey and the research as a whole, for example, 'It is a good survey!'; 'It's going to be super helpful info to have — so glad you're doing this research here ...'; 'I feel like it is a really inclusive survey ...' and 'I thought it has a great range of questions, there isn't any question that I would say, is missing at all.'

4.3.2.2.2. Final draft of survey

The post-pilot, final draft of the survey consisted of 174 questions that were organised according to topic and identity. The topics were demographics, mental health prevalence, Kessler Psychological Scale, risk factors, protective factors, Brief Resilience Scale, uptake of services, and barriers and facilitators to care. Topics were organised generally, as they pertained to all participants, and specifically, as they pertained to participants who were LGBTIQA+, sex workers, and kink-oriented. Table 4.4 provides a summary of the survey.

Table 4. 4 Summary of Survey

TOPIC (PARTICIPANTS)	SUMMARY OF QUESTION/STATEMENT
DEMOGRAPHICS/BACKGROUND (ALL)	Age
	Postcode
	Gender
	Sex assigned at birth
	Sexual orientation
	Intersex status
	Relationship status
	Education level
	Sex worker status
	Kink-/BSDM-orientation status
	Income source
DEMOGRAPHICS/BACKGROUND (LGBTIQA+)	Age of self-discovery of SGD
DEMOGRAPHICS/BACKGROUND (SEX WORKERS)	Current or former sex worker
	Duration of time in job
	Location of work
	Age started sex work
	Reasons for selecting sex work
	Hours worked per week
	Relationship status
	Disclosure to partner(s)
	Partner(s) level of support with job
	Reasons for partner(s)' support
DEMOGRAPHICS/BACKGROUND (KINK PARTICIPANTS)	Kink role
	Duration of kink orientation/practice
	Duration of kink interest
	People with whom kink is practiced
	Frequency of engagement in sane, safe, consensual, risk-aware kink
MENTAL HEALTH PREVALENCE (ALL)	Experience with mental health (MH) issues
	Types of MH issues/diagnoses
	Suicidality (past year)
	Suicidality (lifetime)
	MH issues due to being LGBTIQA+/a sex worker/kink-oriented
KESSLER PSYCHOLOGICAL DISTRESS SCALE (K10) (ALL)	K10 – 10 questions regarding psychological distress
RISK/PROTECTIVE FACTORS (ALL)	Stigma regarding help seeking
	Stigma regarding having MH issues
	Experience with homelessness
	Alcohol and other drug (AOD) usage
	Types of AOD used and frequency
	Social support
	Disclosure to friends/family
	Increasing public acceptance of sex, sexual, or gender diversity (SGD), sex work, or kink in past 5 years
	Experiences with victimisation
	Proud to be LGBTIQA+/sex worker/kink-oriented
	Feelings of outsidership due to LGBTIQA+/sex work/kink
RISK/PROTECTIVE FACTORS (LGBTIQA+)	Fairness of Australian Postal Survey on Marriage Equality
	ID all correct regarding name and gender
	Friends'/family's usage of correct name/pronouns
	Fearful of dressing or acting as desired in public

	Family rejection following disclosure
	Fear of using public toilets
	Need to educate people on SGD
	Experiences with cisgenderism/heteronormativity
	Ashamed to be LGBTIQ+
RISK/PROTECTIVE FACTORS (SEX WORKERS)	Sex work is real work
	Belief in entitlement to human rights
	Belief in entitlement to workplace health and safety supports
	Belief that sex work improves MH
	Job has been mostly positive
	Discrimination against me because of my job causes stress/anxiety
	Sex work improves self-esteem
	Love of job
	Secrecy about job
	Decriminalisation is vital to improving sex worker safety
	Decriminalisation is vital to improving sex worker MH
	Sex work provides a sense of control
	Fear of workplace violence
RISK/PROTECTIVE FACTORS (KINK PARTICIPANTS)	Kink is part of healthy sexuality
	Kink improves participant's MH
RISK/PROTECTIVE FACTORS (LGBTIQ+ & KINK-ORIENTED PARTICIPANTS)	Community belonging improves MH
BRIEF RESILIENCE SCALE (BRS) (ALL)	BRS – 6 questions regarding resilience
UPTAKE (ALL)	Formal mental health professional (MHP) support-seeking prevalence
	Consulted MHP for LGBTIQ+/sex work/kink-based MH support
	Use of hospital emergency department for MH issues
	Consulted general practitioner (GP) for general MH support
	Consulted GP for LGBTIQ+/-sex work-/kink-based MH issue
	Type(s) of MHP consulted
	Type(s) of service(s) accessed
BARRIERS/FACILITATORS (ALL)	Disclosure to MHP
	Ability to see MHP ASAP
	MHP/service nearby
	Travel time to MHP/service
	Paid for appointments
	Affordability of appointments
	Perceived skill level of GP for general MH issue
	Lack of services near, especially specialised ones
	Limited operating hours
	MHP/Service provides exactly the right kind of support
	Wait lists
	Difficulty keeping appointments
	A lack of public transport
	No private healthcare
	Lack of trust for MHP
	Perceived skill level of MHP regarding LGBTIQ+/-sex work-/kink-based MH issue

	Perceived skill level of GP regarding LGBTIQ+/-sex work-/kink-based MH issue
	Needed to educate MHP on LGBTIQ+/-sex work/kink
	MHP was sex positive or kink aware
	MHP was insensitive or rude
	MHP gave “advice” to stop being LGBTIQ+/a sex worker/being kink-oriented
	MHP was homophobic, transphobic, racist, classist, ableist, and/or whorephobic
	MHP was knowledgeable and experienced working with LGBTIQ+ people, sex workers, and kink-oriented people
	MHP refused support due to participant’s orientation/job
	MHP focused on LGBTIQ+/-sex work/kink instead of topic participant wanted
	MHP was friendly, polite, and welcoming
	MHP/Service breached confidentiality
	MHP said being LGBTIQ+ was a phase
	MHP recommended conversion therapy
BARRIERS/FACILITATORS (LGBTIQ+)	
BARRIERS/FACILITATORS (SEX WORKERS & KINK PARTICIPANTS)	MHP blamed aetiology of sex work/kink-orientation on child sexual abuse
ADDITIONAL COMMENTS (ALL)	Anything to add

4.3.3 Survey inclusion and exclusion criteria

Table 4.5 presents the selection criteria for the survey.

Table 4. 5 Inclusion and Exclusion Criteria for Survey Participants

Criteria	Inclusion	Exclusion
Language	Functional English literacy	Non-functional English literacy
Age	18 years of age and older	Children (younger than 18 years)
Location	People who lived or have lived in rural or remote Tasmania	People who lived in Hobart and the surrounding areas without previously having lived in rural or remote Tasmania
Equipment	Access to computer, tablet, and/or mobile phone	No access to computer, tablet, and/or mobile phone
Topic foci	Mental health; chronic mental illnesses; mental health help-seeking experiences (formal or informal)	Social, physical, sexual, or reproductive health; acute mental health crises; absence of formal or informal help-seeking experiences

4.3.4 Sampling methods and sample size

The population sizes of LGBTIQ+ people, sex workers, and kink-oriented people in rural or remote Tasmania are not consistent or known. For this reason, and for time and resource constraints, snowball, purposive, and convenience sampling were used in this study. Predicting sample size was difficult, however, the candidate and her supervisors estimated a sample size of $\sim N = 70$ for the online surveys. Please

see sections entitled Sampling methods and Sample size for detailed descriptions of the excluded and included sampling methods as well as the rationale for decisions made.

4.3.5 Recruitment

Please see Section entitled Participant Recruitment for a detailed description of the recruitment approaches used in this study.

4.3.6 Quantitative data management

Quantitative data was collected via an online survey that was open between November 2019 and March 2020. The survey data was the only quantitative data that required management in this study and involved data entry, coding, validation, and cleaning.

4.3.6.1 Data Entry

The web technology and development officer at the Centre for Rural Health, UTAS, built the survey using LimeSurvey and maintained it throughout the data collection period. He compiled three sets of data: one with all the completed surveys, one with the names and contact information for people who registered to participate in an interview, and the final was a list of all survey participants who had entered into the draw to win the \$100AUD gift voucher. Each week, he would send the candidate a password protected Excel spreadsheet with the names and contact information for people who registered to participate in an interview so she could follow up. He emailed the candidate password protected master comma-separated values (CSV) and SPSS files of the survey data at the conclusion of data collection. At the end of data collection, he rendered the draw list into chits containing all entrants' names, placed them in a hat, and gave them to the administrative support officer, Centre for Rural Health, who then drew the winning chit and contacted the person informing them of their successful entry.

4.3.6.2 Data Cleaning

Data cleaning involved finding errors. Data was cleaned in two ways: contingency cleaning, which involved confirming 'that only those cases that should have data on

a particular variable do in fact have such data’ and possible-code cleaning, which involved confirming ‘that only those codes assigned to particular attributes appear in the data’ (Baxter & Babbie, 2003, p. 268). In IBM SPSS Statistics (IBM, 2019), data cleaning occurred via consistency checks, which is using descriptive statistics to produce a summary of data distribution (e.g. mean, standard deviation, minimum, maximum) of each variable. Another approach to data cleaning performed in SPSS was the systematic search for and removal of missing responses.

The raw, master SPSS file contained 125 total survey attempts, of which the web technology and development officer at the Centre for Rural Health removed 36 incomplete entries that did not proceed beyond the qualifying questions. He sent the candidate a file containing 89 surveys consisting of 283 variables. Data cleaning consisted of renaming variables, assigning correct variable type (e.g. numeric, string), assigning correct measure (scale, nominal, ordinal), flagging any incomplete surveys and either removing any empty fields or incorrectly completed fields to reduce the chances of inaccurate results. Following data cleaning, a further 11 surveys were excluded, producing a final $N = 78$.

4.3.6.3 Data Coding

Data coding was performed to allow for summarisation and analysis. The UTAS web technology and development officer built the survey such that all close-ended response options were changed from ordinal (as presented) to numerical (as coded); for example, in response to the question, ‘What is your gender?’ the officer defined cisgender female as 1, cisgender male as 2, transgender woman as 3, and so on. In response to ‘There is stigma around getting help for mental health issues’, the officer defined Strongly disagree as 1, Disagree as 2, and so on. When the candidate received the final version of the completed survey, she created an ordinal, nomenclature coding list based on the original Microsoft Word version of the survey and recoded numerical data back into words, for example, 1/0 were recoded as yes/no and so on. Other numerical data, age for example, was recoded into the following manageable groups: 18-24, 25-34, 35-44, 45-54, and 55+.

4.3.6.4 Data Validation

LimeSurvey data and SPSS data were checked and re-checked by the candidate and her primary supervisor to ensure that they matched and contained no errors.

Following this repeated review, duplicate codes were removed or combined and new codes were created. Also, a review for internal consistency was conducted whereby the correlations between related questions were verified to ensure consistent responses. Survey data was revised and refined thoroughly prior to analysis.

4.3.7 Quantitative data analysis

Data analysis is the process of running statistical tests and procedures systematically to examine a dataset, reveal its insights, and provide population descriptions (Bannon, 2013). The quantitative data analysis steps undertaken in this study follow. Quantitative data analysis occurred in SPSS via descriptive statistics and inferential statistics. Descriptive statistics included frequencies (summary measures of variables) and crosstabs. Cross tabulation was used to identify patterns, trends, and correlations. Bivariate correlations were conducted using Spearman correlation coefficient. Statistical significance aided in ruling out random chance and Spearman correlation facilitated the evaluation of nonlinear relationships (Gravetter & Wallnau, 2014). A significance level of less than .05 was set for all analyses. Data was also altered via compute variable and recoded into different variables to create scale measures that combine several variables into one to produce groupings and to recategorize variables. Data recategorisation does not overwrite the original variable, but produces a copy with a new name.

For the LGBTIQ+ paper that was written based on collected data (Chapter 5), descriptive statistics were used to establish participants' demographic and psychosocial profiles, help-seeking experiences, and factors associated with psychological distress and resilience. Bivariate correlations were performed for all variables against K10 and BRS scores to determine those significantly associated with each measure. For the kink paper written based on collected data (Chapter 5), descriptive statistics provided insight into the data and facilitated pattern and trend identification. This methodology revealed participants' perspectives while highlighting the underlying factors (e.g., individual, service-based, systemic) and addressing the research questions (Braun & Clark, 2006).

4.4 Ethics

An extensive application for the Tasmanian Social Sciences Human Research Ethics Committee (HREC) was prepared and submitted to the Head, School of Health Sciences and submitted on 5 April 2019. This study collected data from a relatively small, rural population that had the potential to be sensitive: mental health; suicidality; sex, sexual, and gender identity; sexual behaviour and orientation; alcohol and other drug use; discrimination; and other topics. Steps were taken to prevent or minimise possible consequences to participants (Table 4.6).

Table 4. 6 Excerpted Ethical Considerations and Management for HREC Application

Ethical Consideration	Risk	Consideration Management
Informed consent	Linguistic or semantic ambiguities/issues	Functional English literacy and proficiency were participation requirements; used the Flesch-Kinkaid Grade Level readability tool in Microsoft Word on survey (scored a 7.3 Grade Level, which was deemed appropriate for the subject matter); used synonyms and explanations in interviews, as needed
	Age-inappropriateness	Only people 18+ could participate
Risks of participation	Discomfort due to discussing mental health	Shared that research indicates that post-participation discomfort is rare; conducted screening interviews; used counselling skills to take care to minimise participants' distress; monitored participants' emotional reactions during screening and research interviews; provided list of help sources
Obligation	Change of mind regarding participation	Participants were informed at outset of survey and interview that they could discontinue their participation during its course; interview participants were also informed they could withdraw participation within 2 weeks of interview date.
Confidentiality	Qualitative data	Confidentiality and reciprocal confidentiality was discussed with each screening interview and research interview participant; all participants were assigned a code (POSSPART 01, POSSPART 02, etc., for screening interviews and Participant 01, Participant 02, etc., for research interviews); identifiable interview content was deidentified and reported in aggregate in publications
	Quantitative data	Online surveys were anonymous, of which participants were informed on the 1 st page of the survey; pages on which to enter draw or register interest in a survey were not linked to LimeSurvey survey responses
Participants' information storage	Qualitative and quantitative data	Data are stored securely either on a password-protected computer or in a locked

		filling cabinet; access to identifiable information was restricted to the candidate and supervisors; quantitative data is being stored separate from qualitative data; codes were kept secure in a password protected file; the candidate maintained a separate password-protected file that identifies participant details with their codes; all data will be shredded or destroyed five years after the PhD is finished
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HREC sent three sets of comments and the candidate and her supervisors attended a meeting with a member of the committee (See Table 4.7 for timeline).

Table 4. 7 Timeline of HREC Comments and Queries and Research Teams' Replies

Item	Date received from HREC	Date replied
Set 1 of HREC Comments	27 May 2019	2 June 2019
Set 2 of HREC Comments	21 June 2019	28 June 2019
Meeting invitation	29 July 2010	30 July 2019 (meeting held)
Set 3 of HREC Comments	28 August 2019	30 August 2019

Please see Table 4.8 for a sampling of the HREC comments and the research teams' replies.

Table 4. 8 Excerpted Sample of HREC Comments and Teams' Proposed Solutions

Set	Comment	Solution
1	Definition and references for 'rural and remote' and 'illegal activities' requested	Definition and references provided
	Safety of research team queried	Candidate's interview schedule was shared; interviews held in occupied premises/buildings
	Privacy of research team queried	Candidate used a UTAS-issued mobile phone; the teams' contact information was not shared with participants – only the candidate's was shared (as per HREC guidelines)
	Candidate's conflict of interest regarding her dual role (a counsellor and a researcher — current or former counselling clients wanting to participate in the study)	Candidate proposed: to seek informed consent; establish clear boundaries; held no expectations or penalties to clients re participation (or not); planned not to waitlist participants who are clients
	Justification requested for amount of gift voucher (\$100) for draw for survey participants	To increase response rates and to also thank participants for their time
2	Regarding candidate's dual role: confirming prioritisation of participants who are clients of the candidates' mental health over research outcome	Participants who are clients of the candidate offered a choice to continue as a client of the candidate or be supported with a referral to another mental health professional
	Questioned why participants would not be waitlisted for 4 weeks	Participants who are clients of the candidate offered a next available follow-up counselling appointment after interview participation
	Query regarding how the process for those people who do not fit the inclusion criteria will be managed	People who do not fit inclusion criteria will be thanked for their time and invited to contact the

		candidate should they wish a copy of the research findings
	Questioning of collection of participants' post code	Post code information important for capturing level of ruralness and remoteness; entering post code voluntary; post code information to be presented in aggregate
3	Candidate's dual role not adequately addressed re: current clients and suggestion that another research team member conduct the interviews with this cohort of participants, then de-identify data before handing over to the candidate for their analysis to ensure participant confidentiality	Suggestion adopted.
	Query regarding specifics of deidentification of possible identifiable data	Participants' names will be replaced by a code to protect privacy; all participants will be assigned a numerical code such as Participant 01, Participant 02, etc.

On 2 September 2019, the Tasmanian Social Sciences Human Research Ethics Committee approved the study (Reference #: H0018041) (Appendix 3).

4.5 Conclusion

This chapter described the research methodology of this study. Qualitative and quantitative data collection, management, and analysis techniques were presented and discussions regarding their strengths and weaknesses and explicated the rationale behind the choices. A mixed-methods approach was undertaken to explore a complex and uninvestigated topic and produced insightful and meaningful findings, which will be presented in Chapter 5, Results and discussed in Chapter 6.

5. RESULTS

5.1 Preface

This chapter addresses the research questions via an exploration of the mental health and service use of sex workers, kink-oriented people, and LGBTIQ+ people in rural and remote Tasmania. The content included in this chapter has been published or will be submitted for publication.

The papers included in this results chapter represent the breadth and depth of knowledge, experiences, and information gathered from the surveys and the research interviews. In an attempt to represent the target populations specifically rather than generally, the first paper included herein is based on data regarding the study's sex worker participants, the second paper is based on the study's kink oriented people, and the third manuscript is based on findings regarding the LGBTIQ+ participants.

5.1.1 Mental health and related service use by sex workers in rural and remote Australia: 'There's a lot of stigma in society'

All of the research contained within this paper has been published as Reynish, T. D., Hoang, H., Bridgman, H., Nic Giolla Easpaig, B. (2021). Mental health and Related Service Use by Sex Workers in Rural and Remote Australia: "There's a lot of stigma in society". *Culture, Health & Sexuality*, <https://doi.org/10.1080/13691058.2021.1985616>

5.1.1.1 Abstract

Sex workers experience risk and protective factors that affect their psychological wellbeing, yet little is known about sex workers' mental health and their experiences with related services in rural and remote Tasmania, Australia. Semi-structured interviews were conducted with six current or former sex workers with preexisting mental health problems. Thematic analysis was used to identify their experiences with mental health and related care. Generally, sex work does not contribute to participants' mental health concerns; rather, social exclusion and systemic issues cause psychological harm. Ineffective mental health professionals and a lack of

tailored or culturally competent support serve as barriers to care. Significant, widespread stigma was both a risk factor to participants' mental health and a barrier to help seeking and resulted in isolation and identity concealment. Resilience, self-awareness, and social inclusion reduce the psychological impacts of exogenous oppression and encourage help seeking. The decriminalisation of sex work could improve sex worker mental health and reduce stigma by normalising sex work.

Keywords: mental health, sex worker, Tasmania, barriers, social inclusion/exclusion, stigma

5.1.1.2 Introduction

Stigma is the devaluation of a person based upon their perceived departure from social norms and can manifest in the form of discrimination, shame, and condemnation. Stigma can result in psychological distress and impact help seeking (Rayson & Alba, 2019). Sex workers experience considerable stigma. They face public stigma when society endorses prejudices against them that manifest in the form of discrimination, such as impeded access to healthcare, housing and justice (Platt et al., 2018). Sex workers experience perceived stigma when they believe that others view them negatively. They experience whore stigma in the form of derision towards people who combine sex with gain (Jiao & Bungay, 2019). Mental health professional stigma is also a reality for many sex workers and occurs when a practitioner's attitudinal bias diminishes client care (Grappone, 2018). Sex workers experience systemic stigma, which occurs when legislation or social processes limit access to rights and opportunities (Grappone, 2018). Together, these different forms of stigma isolate sex workers and can result in identity concealment to guard against stigma's negative impacts (Meyer, 2003). Together, stigma and identity concealment can contribute to psychological distress and may impede or prevent help seeking (Jiao & Bungay, 2019; Rayson & Alba, 2019).

According to the World Health Organization (2018, para. 2), mental health is: 'a state of well-being in which every individual realises [their] own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community'. Poor mental health is the inverse of this; it affects a person's ability to modulate their emotions and internal equilibrium and

can result in mental health issues. Sex workers face many, often intersecting forms of oppression that are predictors of mental health problems and issues (Reynish et al., 2021). Lesbian, gay, bisexual, transgender, intersex, queer/questioning and asexual (LGBTIQA+) sex workers, for example, may experience homophobia or transphobia in addition to whore stigma (Jiao & Bungay, 2019). Rural people tend to have worse mental health indicators than their urban counterparts, which can be due to poorer physical health, higher unemployment, reduced access to care, and restrictive social norms (National Rural Health Alliance, 2017). Rural sex workers can experience these indicators as well as stigma-based oppression, which can impact their mental health. While some Australian sex workers experience poorer mental health than non-sex workers, variation between them exists (Graham et al., 2017). Harris, Nilan, and Kirby (2011) found high rates of mental health issues among urban female sex workers in New South Wales, Australia, while Seib, Fischer, and Najman (2009) found that job satisfaction was associated with improved mental health in their Queensland-based participants. Both found that poor working conditions, exposure to violence, preexisting mental health issues, and stigma contribute to psychological distress (Harris, Nilan, & Kirby, 2011; Seib, Fischer, & Najman, 2009).

The rural, island state of Tasmania has an estimated population of 540,000 (Australian Bureau of Statistics, [ABS] 2021). Relative to other rural Australian regions, Tasmania has higher socioeconomic disadvantage, higher unemployment and lower education attainment (Ahmed et al., 2017). An estimated 21% of Tasmanians have mental health problems, yet the state has the fewest mental health professionals nationwide (Ahmed et al., 2017; Department of Health [DOH], 2018b). Sex work is only legal in Tasmania if the person works alone or with one other sex worker in either a residence or hotel. Brothels, escort agencies, businesses with more than two sex workers, street-based, and public sex work are illegal in the state (*Sex Industry Offences Act* 2005 [Tas]). The *Act (2005)* also requires that workers are older than 18 and consent to the work.

Sex workers' mental health help seeking varies from the occasional (Treloar et al., 2021) to the frequent (Rayson & Alba, 2019). Reasons for help seeking cited in existing literature include increased mental health problems, ability to advocate for

oneself (Rayson & Alba, 2019), and the need to manage the psychological impact of stigma (Treloar et al., 2021).

Much existing research focuses on the sexual or physical health of sex workers and assumed public health concerns (Platt et al., 2018). The near total absence of HIV and low rates of other sexually transmitted infections among sex workers in Australia adds to increasing evidence that these concerns lack salience (Jeffreys et al., 2011; DOH, 2018a). Research into sex workers mental health and service usage prevalence, barriers and facilitators, however, is limited, especially in rural Australia. The prevalence of stigma and intersecting forms of oppression encourages an exploration into rural sex workers' mental health and related service use. This study aimed, therefore, to explore the mental health, barriers and facilitators to help seeking, and help-seeking experiences of a sub-sample of sex workers in rural Tasmania, Australia.

5.1.1.3 Materials and methods

Data for this study derive from a larger mixed-methods research project that explored the mental health and related service use of populations with compromised access to bodily autonomy (including sex, sexual, and gender diverse or LGBTIQ+ people, sex workers, people who are intersex, and kink-oriented people) in rural or remote Tasmania.

Sexual configurations theory and intersectional feminism grounded in the human right of bodily autonomy comprise the study's theoretical basis. Sexual configurations theory seeks to integrate the diversity of gender, sex, and sexuality in research and clinical practice (van Anders, 2015). Intersectional feminism examines the myriad of oppressions that people face based on race, gender, class, and sexuality (Cho, Williams Crenshaw, & McCall, 2013). Bodily autonomy is the right to self-governance without restriction or discrimination (Wicks, 2016). These theories provided the basis on which current knowledge and assumptions about sex, sexuality, and gender were explored through the lenses of participants' various and intersecting identities and experiences.

In an attempt to ensure the larger study and any resulting papers reflect the work's core tenets, ten people including researchers, people with compromised access to bodily autonomy, and sex workers were involved in the design and development of research tools and study piloting (Kelley et al., 2003; Jeffreys, 2009). Suggestions regarding syntactical and logic issues and additional clarity and representation from the pilot study were incorporated in the final version of the research tools.

This study was based on a subset of data involving interview participants who were current or former sex workers. The purpose of the study was not to gather data on illegal activity; all participants reported solely on legal sex work. Semi-structured interviews enabled exploration of praxis-derived assumptions and facilitated probing of participants' responses for additional information (Austin & Sutton, 2014).

Recruitment and sample

Recruitment took place through social media, snowball sampling, and third-party organisations from the primary author's networks across the state. Contacted organisations included the state's sex worker association, sexologists, an LGBTIQA+ support service, and mental health professionals; all agreed to assist and were emailed a description of the study and a digital poster to disseminate or hang. Interview participants received a \$30 Australian dollar gift voucher as compensation. As sex workers are a hidden population, non-proportional quota sampling was used. This method subsumed population diversity into two sample categories: current or historical mental health issues and sex work experience. Eligibility required that participants were aged 18 years or older, currently or formerly employed as sex workers, living (or had lived) in rural or remote Tasmania, had experienced mental health problems, and had sufficient English comprehension skills to provide informed consent. The Tasmanian Social Sciences Human Research Ethics Committee approved the research protocol in September 2019.

Interviews

Participants completed two interviews. To preclude preexisting acute distress or safety concerns, all interview registrants were required to pass a screening interview prior to participation (Burke Draucker, Martsof, & Poole, 2009), which the first

author conducted via telephone. All registrants passed their screening and main interviews were booked. The main interview consisted of 24 questions: 6 eligibility-confirming and demographic questions and 18 open-ended questions (a copy of the schedule may be obtained from the corresponding author on request). Main interviews were conducted in-person or via telephone between November 2019 and March 2020, lasted between 45 and 70 minutes, and were audio recorded. NVivo Transcription (QSR International Pty Ltd. 2020) was used by the first author to transcribe the main interviews. The remaining authors verified a random sample of transcriptions for accuracy.

Analysis

Inductive and theoretical thematic analysis were used to analyse the interview data (Braun & Clarke, 2006). The first author used line-by-line coding in NVivo to generate themes, which were latent (contained contextual meanings) and semantic (contained explicit meanings) in nature. Using vertical (question-to-phenomenon) and horizontal integration (question-to-question) cross referencing, the primary author identified similarities, differences, patterns and commonalities, which provided contextual meaning and aided in data synthesis (Given, 2008). The remaining authors verified and confirmed themes and cross-referenced results.

Researcher reflexivity

The primary author has worked for 25 years with the populations in the larger study as a mental health counsellor, researcher, and community activist. The secondary authors have experience in mental health counselling, mental health service evaluation, and research with othered and rural populations. As recruitment occurred primarily via the primary author's networks, she had previously met four of this study's six participants. Overlapping relationships are not uncommon in rural areas and can be key to establishing the trust required for hidden populations to engage in research (Schank & Skovholt, 1997; Dewane, 2010). To mitigate possible risk, however, no clients of the primary author's counselling practice participated in the study; all authors contributed to defining the study's ethical parameters; all authors had access to data throughout the study; the primary author engaged in ongoing

critical reflection; and clear expectations, boundaries, and reciprocal levels of confidentiality were established and maintained with participants (Fook & Gardner, 2007; Tracy & Hinrichs, 2017).

5.1.1.4 Results

Six cisgender people participated in this study: four women and two men ranging in age from 24 to 61 years. Two were current sex workers; the remainder were former sex workers. One was straight and one was bisexual; other participants were bisexual and either gay, queer or ‘somewhere between straight and bi’. Three resided in inner regional Tasmania, two in outer regional, and one in a remote area of the state. Two did not have children. All used the pronouns historically associated with the sexes they were assigned at birth and worked indoors. Two participants were kink-oriented.

Following data analysis, two themes and six subthemes were developed: Theme 1 (mental state) offers an overview of self-assessed mental status and diagnoses and includes the subthemes of risk factors and protective factors; Theme 2 (mental healthcare) explores participants’ service usage and includes the subthemes of types of care, help-seeking experiences, and barriers and facilitators to care.

Mental state

Having a preexisting mental health problem was an inclusion requirement; thus, all participants reported experiencing psychological distress at some point in their lives. Participants presented with a range of current or historical, mostly comorbid diagnoses (Table [5.1]).

Table 5. 1 Mental health disorders reported by study participants (n = 6)

Diagnoses	No.*
Mood Disorders	Major Depressive Disorder
	Grief
	Bipolar Disorder 1
	Postnatal Depression
Anxiety Disorders	General Anxiety
Personality Disorders	Borderline Personality Disorder
Psychotic Disorders	Schizoaffective Disorder
Trauma & Stressor-Related Disorders	Post-Traumatic Stress Disorder
	Unspecified Trauma Disorder
Dissociative Disorders	Unspecified Disassociation
* n≠6 as all participants had comorbid disorders.	

The most common comorbidity was anxiety and depression. Participants also self-reported situational crises (loss of a job, assault, sudden death of a loved one) and adverse childhood experiences. No participants presented with suicidality.

Participants primarily described their mental health as varying degrees of good; two indicated that it fluctuated.

I think that relatively speaking, I have really good mental health.
(straight-bi woman, former sex worker)

I'll go through waves throughout the week of my mental [ill] health
being more severe [on] some days than others. (queer woman, current
sex worker)

Risk and protective factors

Risk and protective factors are behaviours, influences, or conditions that impact psychological outcomes (Rickwood & Thomas, 2019). Following thematic analysis, risk and protective factors were grouped as follows: 1) individual (regarding a particular person, e.g. participants and mental health professionals); 2) social (adverse societal conditions or factors); and 3) systemic (ingrained issues that are fundamental to society or politics).

Individual risk and protective factors. Participants described a range of factors that affected their mental health. The risk factor stress exacerbated mental illness in all participants. Sources of stress included personal financial concerns and issues with children, friends and family. Two participants discussed the individual risk factor of alcohol use; dependency was a factor for one. Low self-esteem and insecurity, other risk factors, were a reality for some participants:

I have a lot of fear around abandonment or like not being heard, not being seen. And yeah like not being wanted. ... little things will happen and they will just make me quite insecure. (queer woman, current sex worker)

Sex work itself was viewed somewhat of an individual risk factor by one participant in that, along with other factors, it contributed to her mental health problems. Conversely, involvement in sex work was an individual protective factor for most participants:

[Sex work] is extremely empowering on good days. It's helped me ... in my life outside of work. Talking to men and you know to stand up for myself. Yeah, it's helped me learn a lot about consent ... I have so much more confidence now. (queer woman, current sex worker)

I started doing [sex work] in response after a bad relationship breakup ... and it was my way of asserting confidence and dominance again. (straight woman, former sex worker)

The benefits of the job demonstrated in these quotations – boundary setting, negotiation skills, confidence and self-management – are common benefits of sex work (Treloar et al., 2021). They can also be interpreted as examples of resilience and self-esteem that serve to resist whore stigma, which one participant demonstrated passionately:

I love it. I really like what I do. I choose my clients. If you're too much work or you don't have any respect for me, you can f*#k right off. (bisexual woman, current sex worker)

All participants demonstrated the individual protective factors of self-care and self-awareness, which improved their mental health. For these participants, self-care was multifaceted and included engagement in physical activity, eating well, and getting enough sleep. The individual financial protective factor of having sufficient resources was also cited.

Social risk and protective factors. Social interactions both helped and harmed participants' mental health. Most participants experienced the social risk factor of violence, a correlate of mental illness. This violence, however, was not exclusively job-related. Indeed, previous estimates of on-the-job violence for sex workers are inexact, ranging from 35–94% (Seib, Fischer, & Najman 2009). Only two

participants had experienced sex-work-related violence. Some participants shared that they did not feel unsafe while working as a sex worker:

I think there's an assumption that all sex work is really dangerous ... and yeah, and that's a reasonable thing. You know, there is violence at work for sex workers, but not the way I worked. I didn't ever feel ... in danger. (straight-bi woman, former sex worker)

Family and friends caused psychological distress to all participants either directly or indirectly. The indirect interactions included participants' inability to disclose their jobs with their family due to anticipated stigma:

I really would like to tell my family [that I'm a sex worker] but I'm currently not ready ... I'm a bit worried about telling them because ... it would really hurt my mental health if there was negative words to me outing myself. (bisexual woman, current sex worker)

I've never told [my family] about this work because they will not understand. So yeah. It's really hard ... having a job that I really find empowering. I really love, and ... It has to be a secret. (queer woman, current sex worker)

The burden of secret keeping required vigilance and was emotionally and psychologically difficult to carry (Treloar et al., 2021). Disclosing, however, was also difficult. Some participants met with whore stigma that manifested as rejection and verbal abuse after disclosing to their families.

[When I told my family that I was doing sex work] that didn't work out well ... because my sister has called me a slut and a prostitute [laughter] and my mother wasn't too bad, but she thought it was horrible. So, I didn't discuss it again. (straight woman, former sex worker)

Regarding relationships, most participants were single. An absence of intimate or romantic partnerships for sex workers is associated with poor mental health as personal support in the private domain can offer shelter from the negativity that can

occur in public (Jackson et al., 2009). Lacking or negative social relationships with friends also affected participants' psychological wellbeing. Participants' friends failed to be present when needed and disclosure to friends could be met with oppression.

Eventually, I did tell my closest friends and that, that was nice to be able to talk about it, but it was still ... even from the people I loved most and who loved me most, there was judgement and stigma. (straight-bi woman, former sex worker)

This same participant also spoke of friends perpetrating whore phobia by making assumptions about sex work fuelled by misinformation, which tainted her disclosure experience and harmed her mental health. Peer friendships with other sex workers are also important as they provide safe spaces for debriefing and sharing among equals (Treloar et al., 2021). No participants in this study described having such relationships.

Alternately, all participants benefitted psychologically from a myriad of social protective factors. Participants experienced positive familial relations with their children and partners. All participants praised friend-based social inclusion for contributing positively to their mental health. Inclusion is a powerful protective factor in that it contributes to self-worth, reduces severity of mental health issues, and inspires help seeking (Reynish et al., 2020). Having a four-legged friend was also a boon for one participant:

The thing that help [my mental health is] having my dog. I think that's probably 70% of my mental wellbeing. My dog ... is good for me. (bi-gay man, former sex worker)

Systemic risk and protective factors. Systemic stigma from patriarchy and the government represented risk factors that harmed participants' mental health. Patriarchy is a form of structural oppression in which men govern, exploit, and oppress women (Given, 2008). Patriarchal ideologies perpetuate the polarised view of women as either Madonna (most desirable) or whore (least desirable) (Kahalon et al., 2019). Such perspectives places sex workers at the least desirable end of the

spectrum (Brewis & Linstead, 2000). Sadly, some women – and some feminists – internalise and endorse this misogyny. Participants in particular felt harmed by feminists who responded with whore stigma.

[I'm] a lifelong feminist. There's a section of ... the feminist community who are very anti-sex work. And that was also challenging to me [regarding my mental health]. (straight-bi woman, former sex worker)

I think it's an old school paradigm that women aren't allowed to have sexual freedom ... I'd say that women perpetuate that ... negative attitude, as much as men. When I've ... been ... called a slut, it's actually usually women that do it, not men. ... I think that it's a sad thing that women, in response to patriarchy, if they feel threatened by somebody like me who is confident and in charge of my own sexual freedom ... they will compete with you by taking you down and call you a slut. (straight woman, former sex worker)

Participants shared the ways in which the public's acceptance of these harmful, views of sex and sex work impact their mental health.

... in our society, being an IV drug user is about the bottom of the heap; it's as low as you can go. And I think a lot of people feel like that about sex workers too. It's like you don't have any rights. You don't [have] the right to be respected because you're the scum of the earth ... Made me mad let me tell you. (straight-bi woman, former sex worker)

[W]e all feel a bit embarrassed talking about sex and ... I think people feel people do sex work because they're desperate and they don't understand that it's empowering. (queer woman, current sex worker)

Participants also discussed government-perpetuated systemic stigma deriving from existing legislation in Tasmania and the people who created it.

I mean [the government is] very male orientated ... it feels like the laws are mainly for men and ... I don't feel like that should be something that

a man should have to decide about what women can do with their bodies.
(queer woman, current sex worker)

Only one participant was able to describe a systemic protective factor; he lauded the existence of government-funded mental health organisations, including those for service veterans and men, as well as employee assistance counselling programmes. He was encouraged by these attempts to address the stigma around help seeking and normalising discussion regarding mental health issues.

Men had to suck it up. We have to be tough. So [with these programmes] actually allowing you to feel like you can get help these days, I think that's really, really like encouraging. (bi-gay man, former sex worker)

Mental health care

Participants' shared specifics regarding their attempts to address their mental health problems. This theme includes the subthemes of types of care sought; help-seeking experiences; and barriers and facilitators to help seeking, which were individual, service-based, and systemic.

Types of care

Regarding uptake, most participants engaged with a mix of private and public formal mental health professionals, including counsellors, social workers, psychologists, hospital-based crisis teams, psychiatrists, and work-funded employee assistance counsellors. All participants reported seeking informal support.

I try to work on things on my own or with my partner ... and ... I've got a ... couple of good friends [and] we have helpful talks. (straight-bi woman, former sex worker)

Help-seeking experiences

Agreeing with another Australian study reporting negative help-seeking experiences (Treloar et al., 2021), participants in this study described mostly negative

interactions with formal care, with only one exception, who stated ‘for the most part [my help-seeking experience] has been very positive’.

Other participants described their help seeking as not ‘helpful’ and not ‘successful’. Many factors informed these assessments, including mental health professionals’ responses to disclosure. Disclosure can inform the therapeutic approach and thus, impact whether or not the help received is beneficial. Most participants had disclosed to a mental health professional and only one had a positive experience. Reasons for not disclosing were multifactorial and included fear of judgement and internalised stigma, factors also cited in existing literature (Jiao & Bungay, 2019).

[I didn’t disclose because] ... for me it’s a myth around sex workers are being exploited is so present in everyone’s mind that it would have been very hard for [the mental health professional] – that is an assumption I made; I didn’t test it because I didn’t trust them to test it. I feel like that will be [a] really hard ideology for them to move away from. They’d be coming at it from a thinking that I’m a victim of something, which I’m absolutely not; doing sex work was my choice, my decision, and I always did it ... a 100% from free will. (straight-bi woman, former sex worker)

The barriers and facilitators to care that participants experienced also shaped their assessments.

Barriers and facilitators to care

Participants were asked to share what encouraged or prevented them from help seeking. A variety of individual, service-based, and systemic factors affected participants’ formal and informal help-seeking experiences.

Individual barriers and facilitators. Participants’ personal circumstances created individual barriers and facilitators to help seeking. Participants’ self-awareness was a facilitator of access to formal care; they monitored their thoughts and behaviours and sought help when an issue arose. Participants also sought help out of a desire to

be present for others. Help seeking for this reason, however, included complicated emotions.

... I often feel really ashamed how my mental health manifests. Especially ... when I know how much it affects my family ... I'm definitely driven more ... to seek help and deal with it more than I would if I was alone [because of that]. (queer woman, current sex worker)

For all participants, facilitators of informal care involved acceptance and support from friends, family or partners. A lack of judgement, advice and open-mindedness were other protecting facets of informal support. Participants identified a few barriers to informal help seeking: there were times, for example, when friends failed to listen or were struggling with their own mental health problems.

Individual mental health professionals were responsible for many barriers. Participants feared negativity or perceived stigma from mental health professionals, for example, which prevented help seeking. Of the five participants who had received formal support, all cited mental health professionals' shortcomings as a barrier to care. Participants also commented on attitudinal bias or stigma from mental health professionals, which manifested as patronisation and derision and diminished the quality of their care.

[When I said I was gay and a former sex worker] one actually made a comment out loud and they said, 'Oh, that's a new one on me. That changes how I think about things.' Didn't quantify more what that meant, so I can only read between the lines ... I felt like a leper ... And don't get me wrong ... I don't expect to walk into a counsellor and for them to know much about sex work ... but I never expected to be treated like a leper. (bi-gay man, former sex worker)

Participants also described several characteristics of mental health professionals' approach to therapy that contributed to their wellbeing and facilitated help seeking. Participants appreciated an openminded, objective approach to care. Participants were grateful to have a mental health professional who was culturally competent or who was willing to self-educate. Connection was also a plus for participants.

I found one really great mental health social worker and she was just terrific. ... mostly that was because she and I could have been friends outside of it. You know we had an instant rapport and you can't make that happen; just has to happen. (straight-bi woman, former sex worker)

Service-based barriers and facilitators. Service-based barriers and facilitators are factors relating to organisations or businesses, which impact uptake. Services being free of charge was the only service-based facilitator to care indicated. All participants, however, had experienced service-based barriers to mental healthcare, which included the existence of too few or no services, long waitlists, and lack of waiting room anonymity. Participants felt that those barriers existed primarily due to a lack of funding for mental health service provision in the state.

Church-based services were a source of perceived stigma for sex workers due to their long history of stigmatisation (Bowen & Bungay, 2016). This stigma was particularly prevalent in areas of high religious conservatism, such as rural Tasmania (Grant, 2018). Faith-based services were a barrier for half of our participants.

I would absolutely never go to a faith-based service of any kind ... And I think it's incredibly problematic that we have so many faith-based services funded to give services to vulnerable people. It's just wrong. And for me – absolute turn off, even if, even if they said that they are pro-choice or whatever – it is going to get a pass from me and that would be a complete no deal. (straight-bi woman, former sex worker)

Systemic barriers and facilitators. Systemic barriers and facilitators are ingrained factors fundamental to society or politics, which impact help seeking. Participants did not identify any systemic facilitators to care, however, all discussed the systemic barrier of stigma. Both a risk factor to participants' mental health and a barrier to help seeking, participants reported experiencing whore and public stigma from strangers which manifested as discrimination against sex workers and LGBTIQ+ people and harmed mental health.

In not being accepting of sex work and ... making judgements ... about the kind of person a sex worker is. ... the whole sex negative way we

are in society definitely harms sex workers' mental health and mine ...
(straight-bi woman, former sex worker)

I still think there's a lot of stigma in society. ... I'm not ashamed to let people know I'm LGBTQI and I'm quite happy to let people in society know, people I work with know. But the sex worker component I'm more reluctant to [disclose]; more so for the problems that could pose.
(bi-gay man, former sex worker)

The identity concealment and isolation that resulted from stigma contributed to psychological distress for all participants. Active hiding a part of one's self from fear of devaluation is often accompanied by stress. The impacts of this stigma are worse the more central and salient the identity is (Quinn & Chaudoir, 2009).

Being discriminated against as a sex worker. Being told what I can and can't do with my body ... has been impeding on my mental health lately Yeah, and the isolation involved in that. (bisexual woman, current sex worker)

When I was doing sex work, ... the most difficult part was not being able to discuss what was going on in my life with my family and friends. Yeah, it's such a ... stigmatised thing and ... the isolation of that work was the most damaging part of it. (straight-bi woman, former sex worker)

5.1.1.5 Discussion

This glimpse into the mental health and related service use of six sex workers with preexisting mental health problems in rural and remote Tasmania demonstrates the prevalence of many different forms of stigma. For our participants, public stigma manifested as shunning, violence, or negative treatment from friends, family, and strangers. Perceived stigma came from mental health professionals and family following disclosure. Whore stigma, including assumptions of desperation and derision of sex work, came from families, friends, and even feminists. Mental health professionals' stigma manifested in attitudinal biases and negative treatment.

Systemic stigma's prevalence occurred via the perpetuation of the Madonna-whore dichotomy, which polices women's bodies through misogyny (overt and internalised) and controlling laws.

Anticipated stigma also presented. An understandable response to the other stigmas, particularly when viewed within the Tasmanian context, participants expected (and feared) judgement by loved ones and mental health services, especially faith-based ones. Tasmanians have the lowest level of religious affiliation nationally in Australia (ABS, 2017b, para. 7) but are considered to be religiously conservative and parochial (Grant, 2018, pp. 16 & 170). Tasmania's rurality compounds the stigma that result from these outlooks. As is common in rural areas, Tasmania has a general lack of services, including the smallest mental health workforce in the country (Ahmed et al., 2017) and only one sex worker organisation (with one staff member, based in the capital).

The deleterious effects of stigma on sex workers' mental health are well documented (Bowen & Bungay, 2016; Treloar et al., 2021). Sex workers are exposed to a variety of exogenous stressors that affect identity, relationships and psychological wellbeing, which can be likened to minority stress (Meyer, 2003). As with other sexual minority people, sex workers experience identity concealment, rejection (real and perceived), and struggle to manage the resulting stressors, which impacts mental health. Findings reported elsewhere indicate that Australian sex workers have mixed mental health outcomes (Seib, Fischer, & Najman, 2009; Graham et al., 2017). The mental health of this study's participants existed on a continuum. That sex work itself generally had a positive impact on our participants' mental health is a rejection of the patriarchy's attempt to shame people who engage in sexual contractive work.

Findings reported elsewhere indicate that stigma can limit or prevent sex workers from help seeking (Rayson & Alba, 2019; Jiao & Bungay, 2019). With one exception, which occurred because there was no mental health service available in her remote town, all participants in this study had sought formal mental health support. Participants', however, reported mostly negative experiences of formal care. Beyond stigma, participants' failing assessments stemmed from shortcomings

in mental health professionals' skillsets and treatment approach and a lack of cultural competence.

In the face of stigma, poor mental health (due to exogenous factors), and mental health professionals' shortcomings, participants made several recommendations for change. Mental health professionals could, for example, offer culturally competent care by assuming agency in their clients, avoiding the perpetuation of shame, and working from a whole-person and collaborative approach. Culturally competent care for sex workers could include sex worker affirmative therapy that acknowledges the impact of stigma, requires mental health professionals to remain client-centred (put aside internal bias) and use strength-based care (focus on a person's strengths and resilience) (Bloomquist & Sprankle, 2019). The state government could fund a dedicated sex worker counselling service that is tailored to sex workers (flexible operating hours, staffed by peers). It could also better support mental health services, including ones staffed by culturally competent mental health professionals that offer outreach support and anonymity.

What participants most desired however was the full decriminalisation of sex work. Sex work is legalised in Tasmania and, as such, has stringent industry regulations. While partial decriminalisation does not prohibit the sale of sex, it does perpetuate degrading assumptions about sex work via its legislative monitoring, thus, denying sex workers' basic human rights to be free from violence and discrimination and have free choice of employment. Legalisation of sex work also exposes sex workers to needless risks. Echoing sex workers internationally, decriminalisation in Tasmania would contribute to enhancing workplace health and safety; improving mental health and wellbeing; improving access to physical health care; and contribute to attitudinal shifts and public acceptance by normalising sex work (Daniel, 2010).

While mental health professionals and state government adoption of these recommendations would decrease the stigma surrounding sex work, change could also come about via a shift of narrative. Community-based research such as this, which involves sex workers is a form of collective action that encourages social and political change and could usefully be expanded (Treloar et al., 2021). Funding and

advocacy for peer support services that challenge the status quo while creating awareness and capacity among mental health professionals and fostering reform and legislative protections could also take place (Treloar et al., 2021).

Limitations

Several limitations should be considered. A goal of the present study was to actively engage sex workers and contribute to improved sex worker research. Due to recruitment methods, the small sample obtained is not representative and findings cannot be generalised to the larger population of sex workers in Tasmania.

Importantly, this study did not include transgender or migrant sex workers.

Transgender sex workers face additional stigma and discrimination regarding their gender identity. Migrant sex workers face racism, language barriers to care, and threats of deportation. The lack of these perspectives points to an area for future research. For ethical reasons, our study also excluded people with preexisting acute psychological distress; they may have reported different experiences due to increased vulnerability. The former sex workers who participated in this study may have had different experiences and perspectives than the current ones. Former sex workers' ability to distance themselves from a past form of stigma, for example, may have influenced the responses given.

Despite these limitations and the small sample size, the rich data from this study offers a starting point to address significant gaps in the literature. Future research could explore mental health issues and problems among different subgroups of sex workers including those who are exclusively either current or former sex workers, those who work illegally, and those who are not cisgender. Future research could – and should – also examine the experiences of sex workers in other rural and remote regions.

5.1.1.6 Conclusion

This study adds to the limited available research on rural sex workers, stigma, mental health, and related service use. Sex work itself was not the cause of mental ill health for participants in this study, but, rather, contributed positively to their psychological wellbeing. Exogenous, widespread stigma, on the other hand, harmed

sex worker mental health, posed a barrier to quality care, and resulted in identity concealment. Taken together, findings demonstrate some of the ways in which friends, family, mental health professionals, and the government can support sex workers by beginning to reduce, or ameliorate, the impacts of stigma.

Disclosure statement

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5.1.2 Kink-Oriented People and Exogenous Oppressions: Understanding Mental Health and Related Service Use in a Rural Context

The paper that follows represents data collected via surveys and interviews from this study's kink-oriented participants. While the cohorts in this paper differ from those in the previous paper, the findings in both papers are based on the same overarching research questions.

All of the research contained within the paper that follows has been published as Reynish, T. D., Hoang, H., Bridgman, H., Nic Giolla Easpaig, B. (2022). Kink-Oriented People and Exogenous Oppressions: Understanding Mental Health and Related Service Use in a Rural Context. *Journal of Homosexuality*. doi: 10.1080/00918369.2022.2036531

5.1.2.1 Abstract

Rural, kink-oriented people experience much exogenous oppression and yet related research is scarce. This study examined the risk and protective factors of kink-oriented rural Tasmanian Australians with preexisting mental health conditions and help-seeking barriers and facilitators. Participants completed either an online survey ($n = 42$), an interview ($n = 10$), or both. Thematic analysis and descriptive statistics were used to analyse the qualitative and quantitative data, respectively. Participants

aged 18 to 61 were gender and sexually diverse and better educated but had more lifetime suicide attempts than the general public. Despite the increasing normalisation of kink, 90.5% of participants have never seen a kink-aware mental health professional (MHP) and nearly 83.0% did not disclose to an MHP for fear of stigma or discrimination. Self-awareness, resilience, social support and kink improved participants' mental health. Tailored support from trained MHP is vital to improve the mental health of kink-oriented people in rural areas.

Keywords: mental health; kink; rural; mental health services; service barriers; Tasmania; Australia; BDSM

5.1.2.2 Introduction

Although kink is becoming more mainstream, the mental health needs of kink-oriented people living in rural areas are insufficiently researched and often missing from traditional mental health training or care provision. Kink-oriented individuals engage in alternate, non-vanilla, non-heteronormative, or non-mononormative sexual interactions as their primary forms of sexual expression. Vanilla is conventional sex that conforms to basic cultural expectations or people who engage in it. Kink can be synonymous with bondage, discipline, domination, submission, sadism, and masochism (BDSM) and can include an array of activities including power or pain exchange, role play, polyamory, or fetishism (Damm et al., 2018; Pitagora, 2016). Consensual non-monogamy is associated with kink, but is not an inherent feature of kink (Pitagora, 2016). Researchers have increasingly focused on the nature and prevalence of kink (Damm et al., 2018; Gemberling et al., 2015; Graham et al., 2016; Hughes & Hammack, 2019; Richters et al., 2008; Waldura et al., 2016). With almost half of their participants interested in kink and roughly one-third having experience with kink, Joyal and Carpentier (2017) concluded that kink was more normophilic than paraphilic in their sample ($N = 1,040$), or less anomalous and more mainstream than previously thought. Speciale and Khambatta (2020) found that kink had therapeutic benefit and yet all of their participants experienced a lack of affirmative care.

Researchers have also examined kink in so far as it extends beyond the practice of libidinal gratification and into identity and have concluded that for some, kink is a

sexual orientation (Moser, 2016; Savin-Williams, 2014; Sprott & Williams, 2019). Traditional interpretations of sexual orientation that exclude kink are challenged due to: 1) the fluidity and diversity of sexuality and identity; 2) the evolution of the construct of sexual orientation; 3) the shared experiences of discrimination and pathologisation and; 4) the socio-political importance of all people with diverse sexual orientation, gender identity/expression, and sex characteristics (SOGIESC) (Pitagora, 2016; van Anders, 2015).

Estimations of kink-oriented people range substantially. Richters et al., (2008) found that 1.8% of straight Australians engaged in kink in the past year. Holvoet et al., (2017) concluded that 7.6% of the general Belgian population are BDSM practitioners while Strassberg and Lockerd (1998) reported that 64.0% of their American, undergraduate, female participants were interested in kink. Flawed or varied data collection tools and a history of pathologisation impede accurate number gathering (Joyal & Carpentier, 2017). Previously, the Diagnostic and Statistical Manual of Mental Disorders (DSM) considered all forms of kink a ‘paraphilic disorder’; however, in DSM-5, they differentiate between mainstream kink and criminal offenses (American Psychiatric Association, 2013; De Neef, 2019, p. 135). Yet, society and mental health professionals (MHP) alike still pathologize a kinky sexual orientation (Hughes & Hammack, 2019).

The psychological impact of pathologisation and the accompanying judgement can force people who are into kink to remain hidden (Wright, 2006). This forced secrecy as well as the perceived, anticipated, or real stigma and discrimination that can result from disclosure are strong predictors of psychological issues (Meyer, 2003; Roberts et al., 2015). In the face of this marginalisation and psychological burden, however, research has found that the mental health of kink-oriented people is generally the same as or better than people who are vanilla (Gemberling et al., 2015; Nichols, 2006; Roberts et al., 2015). A systematic scoping review found that while kink-oriented people generally experience lower depression scores than vanilla people, they experience comparable rates of anxiety and more posttraumatic symptoms (Brown, Barker, & Rahman, 2020). Specifically, however, submissives experience worse mental health scores than dominants or switches, but their mental health was better than vanilla peoples’ (Wismeijer & van Assen, 2013). All kink-oriented

people with comorbid diagnoses (Brown et al., 2020) or pronounced minority stress (Hughes & Hammack, 2019) had higher rates of suicidality than people who are vanilla.

Global mental health research is increasingly exploring the disparities that populations that are marginalised experience. Subsequently, there have been calls to decrease the barriers to psychological care of stigma, discrimination, and inadequate professionals and services (Wainberg et al., 2017). Despite the prevalence of the topic of kink in academic circles, explorations of rural kink-oriented people's mental health and service usage, barriers, and facilitators to psychological care remain limited. Related explorations in the Tasmanian context are, to our knowledge, hitherto non-existent. Therefore, this study aims to explore research questions regarding personal experiences with mental health help seeking; uptake prevalence and barriers and facilitators to help seeking; and participant-determined best practices for care.

5.1.2.3 Materials and Methods

Study Location

Tasmania is a remote, rural island state in Australia, with an approximate population of 540,000 people; roughly 40.0% of whom reside in and around the capital (Hobart) (Australian Bureau of Statistics [ABS], 2020). Relative to other rural parts of the country, Tasmania has greater socioeconomic and family disadvantage, a higher unemployment rate, and lower education attainment rate (Ahmed et al., 2017; Department of Health [DOH], 2018b). An estimated 21.0% of Tasmanian's have mental health disorders (DOH, 2018b). Tasmania has the fewest MHP in the nation with 65 psychologists per 100,000 (versus 86 nationally) and 9 psychiatrists per 100,000 (versus 13 nationally) (Ahmed et al., 2017). The state also has the highest suicide rate in the country (Primary Health Tasmania, 2019d).

Theoretical Approach

Intersectional feminism and sexual configurations theory rooted in promoting bodily autonomy underpin this study, which employed a mixed-methods approach

consisting of online survey and semi-structured interviews. Intersectional feminism explores the various, overlapping ways in which people are oppressed (Cho et al., 2013). Sexual configurations theory seeks to integrate the diversity of gender, sex, and sexuality in research and clinical practice (van Anders, 2015). The human right of bodily autonomy includes the right to integrity and self-determination without discrimination (Wicks, 2016).

This study examined risk and protective factors and barriers and facilitators to help seeking in a sample of kink-oriented, rural Tasmanians with preexisting mental health conditions. Data for this study were drawn from a larger mixed-methods research project consisting of an online survey ($N = 78$) and semi-structured interviews ($N = 33$). The larger project explored the mental health and related service use of populations with compromised access to bodily autonomy (including sex, sexual, and gender diverse people, sex workers, people who are intersex, and kink-oriented people) in rural or remote Tasmania. The current study reports results from a subset of 42 online survey respondents and 10 interview participants who had self-reported involvement in kink or BDSM. Given this is not a study of the general population, but, rather was focused on a specific group and the intent was to capture their experiences, this is a rich sample within this research area. Note that due to inherent confidentiality built into the research instruments, participants cannot be identified across each measure (Internet Protocol addresses and personal data were not tracked); thus, it is unknown if $N = 52$ are unique or distinct. That said, however, as 80.7% of the total ($N = 52$) completed the survey and $n = 10$ completed interviews, the total number of kink-oriented participants that will be used herein is $N = 52$ as they are considered unique in so far as each respective research measure is concerned.

Instruments

The survey consisted of 174 questions informed by the principal author's clinical practice as a mental health counsellor and previous findings (ABS, 2008; Australian Psychological Society, 2015; Reynish et al., 2020, 2019). Consisting primarily of closed-ended questions with three open-ended ones, survey questions were organised according to identity (LGBTIQA+, sex worker, kink-oriented) and topic,

including demographics; mental health; experiences with services and MHP; barriers and facilitators; and risk and protective factors. To determine suitability, comprehension, gaps, and to ensure optimal functionality, researchers ($n = 4$) and community-based SOGIESC volunteers ($n = 6$) piloted the online survey (Creswell & Plano Clark, 2011; Kelley et al., 2003). Recommendations included resolving repetition and ambiguities, improving functionality, and adding questions for clarity; all were followed.

To determine preexisting acute psychological distress or safety concerns, interview registrants had to complete a telephone-screening interview, which the primary author performed (Burke Draucker et al., 2009). All registrants passed their screening and interviews were scheduled at a time of their choosing. Interviews were completed in-person or via telephone and featured 26 questions, of which 7 were eligibility-confirming and demographic questions. The remainder expanded on the research questions and some survey questions and explored mental health status; risk and protective factors; help seeking experiences, barriers, and facilitators; and recommendations for improvement.

Recruitment and sample

Recruitment occurred via email, phone, in-person contact, third-party organisations, snowball sampling, and Facebook. Survey participants were compensated via an invitation to enter a draw for a \$100 Australian dollar gift voucher. Interview participants received a \$30 Australian dollar gift voucher. The Tasmanian Social Sciences Human Research Ethics Committee approved the study (H0018041).

Random probabilistic sampling tends to underrepresent identities that are predominately hidden, such as kink, thus, potentially introducing bias as the data may demonstrated the overrepresented non-hidden identities (Braun & Clark, 2006). To offset this, nonproportional quota sampling was used in this study. Nonproportional quota sampling subsumes the diversity within the kink population into two overarching sampling categories and assumes the diversity is represented in the overall sample. The two sample categories were preexisting mental health issues and involvement in kink/BDSM. Inclusion criteria were: being 18 years or older,

currently or formerly residing in rural or remote Tasmania, having a preexisting mental health issue, and being able to read and write in English. Informed consent was required for participation.

Analysis

Qualitative interview data and the open-ended questions from the survey were explored via inductive, deductive, and theoretical thematic analysis (Braun & Clark, 2006; Creswell & Plano Clark, 2011). Theme identification was performed in NVivo (QSR International Pty Ltd., 2012) and coding consisted of the following steps as performed by the first and/or second author: 1) develop deductive codes based on the research and interview questions; 2) develop broad, inductive codes and capture findings matching deductive codes; 3) Conduct line-by-line coding sessions adding inductive and deductive codes; 4) reorganize and refine codes into categories; 5) review codes and remove, combine, or assign new ones; 6) integrate codes vertically and horizontally to cross reference and reveal similarities and differences; 7) create and refine categories to ensure the inclusion of all relevant data; 8) refine resulting themes and subthemes, until salient themes emerged (Given, 2008).

Quantitative data analysis occurred in SPSS via descriptive statistics, including frequencies and crosstabs analyses. Data was also altered via compute variable and recoded into different variables to create scale measures that combined several variables into one to produce groupings and to recategorize variables. This approach provided insight into the data, facilitated pattern and trend identification, and revealed participants' perspectives while highlighting the underlying factors (e.g., individual, service-based, systemic) and addressing the research questions (Braun & Clark, 2006).

Two main themes and eight subthemes emerged from the qualitative data (Table [5.2]). These themes (and subthemes) expand upon this study's research questions and provide the basis for this paper's organisational structure, in which the quantitative data is presented with the qualitative themes for enhancement.

Table 5. 2 Themes and subthemes

Theme	Subtheme
Mental state	Self-assessed mental status
	Mental health conditions
	Suicidality
	Risk and protective factors (individual factors, social factors, and systemic factors)
Mental healthcare	Uptake prevalence
	Help providers
	Help-seeking experiences
	Barriers and facilitators to access (individual barriers and facilitators, service-based barriers and facilitators, systemic barriers and facilitators)

Population demographics

Participants ranged in age from 18 to 61 (Mean = 35.8, standard deviation [SD] = 11.58) and represented eight gender identities: cisgender woman (46.2%), cisgender man (25.0%), nonbinary (11.5%), gender questioning (5.8%), transgender woman (5.8%), transgender man (5.8%), brotherboy (1.9%), and demigirl (1.9%).

Participants spanned 10 sexual orientations within the umbrellas of bisexual (35.3%), straight (27.5%), asexual (9.8%), gay (7.8%), pansexual (7.8%), lesbian (5.9%), and queer (5.9%). One person (1.9%) was unsure of their intersex status and 11.5% were current or former sex workers.

Most participants (57.4%) have been kink-oriented for more than five years with 42.6% reaching eight-plus years, including two interview participants who reported a more than 20-year affiliation with kink. Regardless of frequency or involvement, 64.3% of participants have been interested in kink for eight-plus years. Participants who adopted a power exchange role did so as switches (49.0%), submissives (32.7%), and dominants (18.4%). Participants primarily engaged in kink with their partners (75.0%). See Table [5.3] for additional demographic data.

Table 5. 3 Participants' relationship status, educational attainment, employment status, and location (remoteness class): kink-oriented individuals (n = 52) in rural or remote Tasmania

Characteristic	Survey (N = 42); n (%)	Interviews (N = 10); n (%)
Relationship status		
Divorced/Separated	4 (9.5)	1 (10.0)
Married/In a relationship	22 (52.3)	2 (20.0)
Consensual non-monogamist	4 (9.5)	3 (30.0)
Single	12 (28.6)	4 (40.0)
Education^a		
Year 12 (high school) or less	12 (28.6)	----
Vocational school (TAFE)	15 (35.7)	----
Undergraduate degree	9 (21.4)	4 (40.0)
Postgraduate degree	6 (14.3)	1 (10.0)
Employment status^b		
Full-time job	12 (28.6)	5 (50.0)
Part-time job	10 (23.8)	0 (0.0)
Don't work/Receiving Government benefits	15 (40.1)	2 (20.0)
Don't work/home duties	2 (4.8)	0 (0.0)
Student	3 (7.1)	2 (20.0)
Australian Statistical Geography Standard (ASGA) remoteness class^c		
Inner regional (RA2)	19 (45.2)	5 (5.0)
Outer regional (RA3)	17 (40.5)	5 (5.0)
^a Optional question; n = 47 ^b Optional question; n = 51 ^c Optional question; n = 46 ---- Topic not included/broached		

5.1.2.4 Results

Theme 1: Mental State

Mental state is a person's psychological functioning at a certain point in time that provides a snapshot of their general mental health. This theme included four subthemes: mental status, conditions, suicidality, and risk and protective factors.

Mental status, conditions, and suicidality

Having a preexisting mental health condition was a participation requirement; thus, all participants experienced mental health issues at some point in their lives. Interviewees' self-assessed mental status ranged from 'quite good' to it is 'a struggle' with most describing it as fluctuating. Anxiety was the most commonly indicated mental health condition among all participants, at a total self-reported rate of 86.3%, followed by depression at 82.4% (Table [5.4]).

Table 5. 4 Sexual orientation and self-reported mental illnesses from survey and interview data (n = 51^a)

	LGBTIQA+ n = 37 (%)	Straight n = 14 (%)
Self-reported mental illnesses		
Anxiety	31 (83.8)	13 (92.8)
Depression	30 (81.0)	12 (85.7)
Post-Traumatic Stress Disorder	10 (27.0)	3 (21.4)
Non-suicidal self-injury	7 (18.9)	4 (28.6)
Eating Disorders	9 (24.3)	1 (7.1)
Bipolar Disorder	6 (16.2)	3 (21.4)
Disassociation	7 (18.9)	2 (14.3)
Borderline Personality Disorder	4 (10.8)	2 (14.3)
Obsessive-Compulsive Disorder	5 (13.5)	1 (7.1)
Paranoia	2 (5.4)	1 (7.1)
Psychosis	0 (0.0)	1 (7.1)
Schizophrenia	0 (0.0)	1 (7.1)

^a Sexual orientation data is missing for one participant

Interview participants revealed some conditions and developmental disorders that survey participants did not, including Schizoaffective Disorder, Postnatal Depression, Autism Spectrum Disorder, and Attention Deficit Hyperactive Disorder. Also, 27.0% of LGBTIQA+ participants and 14.2% of straight participants reported experiencing gender dysphoria across both research instruments. Gender dysphoria is not a mental illness, but remains a psychiatric diagnostic criteria (World Health Organization, 2016). In this study, 56.8% of LGBTIQA+ and 35.7% of straight participants attempted suicide in their lifetime. Of our 32.7% transgender and gender diverse participants, 70.6% reported lifetime suicide attempts. Risk or protective factors exacerbate or assuage suicidality.

Risk and protective factors

Risk and protective factors was the fourth subtheme of Theme 1, Mental State, and are behaviours, influences, or conditions associated with negative or positive psychological outcomes, which worsen or improve a person's ability to cope with difficulty or oppression (VicHealth, 2019). Thematic analysis revealed reciprocity between the individual and their environment; thus, the uncovered risk and protective factors are explored on individual, social, and systemic levels.

Individual Factors. Individual risk factors are biological or psychological characteristics within a person that can influence their psychological outcome

(Substance Abuse and Mental Health Services Administration, 2019). The risk factors uncovered in this research were use of alcohol and other drugs (AOD), physical health issues, and stress. Roughly one quarter of survey participants reported AOD use, with marijuana, alcohol, and tobacco the most common. Interview participants reported having physical health problems including a spinal condition, a heart condition, and obesity. All interview participants indicated experiencing current or historical stress.

Conversely, interview participants reported having individual protective factors. When asked about factors that helped their mental health, responses spanned self-care, positive self-regard, resilience, self-awareness, and positive views about their identities; examples of which are evident in these quotations:

I ... take stock of where I'm at and what my emotions are doing ... I'm aware of my emotions ... in the past I'd put them aside a lot more. Now, I embrace them (#2, kink-identified, straight, cisgender man).

When I decided to [take the government-contracted job network] to court, I was lying in bed, couldn't sleep, ruminating hideously, and it was the tumble dryer of thoughts going around in my head. But then, there was a clear thought, ... it was my voice in my own head saying, 'I am better than this'. ... I've been basically punching back since then (#15, kink-identified, straight, cisgender man).

Kink orientation and involvement was another individual protective factor: 45.2% of survey participants are proud to be into kink and 81.0% indicated that BDSM and kink are part of a healthy sexuality. While 64.3% of survey participants declared that kink improves their mental health, 83.3% of survey participants and seven interview participants felt that their involvement in kink was not the cause of their mental ill health. The interplay between an individual and their environment demands that social and systemic risk and protective factors also be explored.

Social Factors. Social risk and protective factors impact individuals, but arise from deeds or words by people in community, environment, and society and can negatively or positively influence a person's identity and mental health. Participants

experienced the social risk and protective factors of stigma, discrimination, violence, and the absence and presence of social support. Stigma is negative judgement or shame from others. Discrimination is the manifestation of stigma and occurs as unjust or prejudicial treatment. Stigma and discrimination can also be internalised. When asked if there was stigma around having mental health issues, 92.9% of survey participants agreed or strongly agreed. Participants also experienced stigma based on their kink orientation and their profession: 21.4% of survey respondents experienced discrimination due to their kink orientation, of whom, 44.4% reported disclosing their orientation to their friends or family, a common source of prejudice. The kink-oriented participants who were also sex workers reported that stigma and discrimination based on their job as a sex worker were sources of anxiety or stress.

Violence, a social risk factor, is a correlate of mental illness. Survey participants who were also sex workers experienced violence or abuse from clients and/or police. When asked about risk factors or things that harmed their mental health, interview participants shared that they had experienced violence, including in the form of child sexual assault and intimate partner violence, as these quotations demonstrate:

When I was a child, I was sexually abused. That wasn't very good for me. My grandfather ... was also the paedophile in the family. So that was never good for me (#23, straight cisgender woman, former sex worker, former dominatrix).

... the put downs [by my ex] and the humiliating me in front of family and also ... telling her friends ... intimate things that I told her I'd like in the bedroom and all that is just utterly, utterly humiliating (#25, kink-identified, bicurious, cisgender man).

Interview participants also experienced psychological abuse from employers, disparaging homophobic slurs from family members and strangers, and lateral violence, which is displaced violence directed at peers rather than adversaries. Lateral violence can manifest either blatantly as physical or sexual violence or subtly, as prejudice, minimisation, or delegitimation (Undercurrent Vic, 2012). Our participants experienced this violence as bullying from other kink-oriented

people, humiliation and fat shaming from other gay men, and erasure of specific kinks or sexualities by kink-oriented people and other members of the LGBTIQ+ community, with some participants experiencing this misdirected violence in multiple ways.

Social support is psychological or material support from others; it enhances quality of life and buffers against adverse events (Cohen & Wills, 1985; Hostinar, Sullivan & Gunnar, 2014). The absence of social support is a risk factor that can contribute to mental health problems (Reynish et al., 2020). All interview participants and nearly a quarter of survey respondents (23.8%) reported lacking or deficient social support. The following quotations illustrate ways in which family and friends failed to provide social support:

... I don't want to use that metaphor of the ... black sheep in the family, but ... when one person [in a family] gets diagnosed with a mental health issue, it gives everybody the permission to never be critical towards themselves and always point the finger at you. ... I'd never discuss my mental health with my family now (#23, straight cisgender woman, former sex worker, former dominatrix).

... I don't have very many friends at all anymore ... I haven't managed to maintain my friendships because [of] my mental health; because no one wants to be friends with someone who has six months where they just completely drop off the radar ... (#30, kink-curious, bisexual, cisgender woman).

Inadequate social support can result in isolation and feelings of not belonging or outsidership (Cohen & Wills, 1985; Hughes & Hammack, 2019). Isolation was a risk factor for psychological distress for most interview participants and 50.0% of survey participants reported feeling like an outsider because of their kink identity. Survey and interview participants also reported the opposite of this and benefitted from the protective factor of social support.

All interviewees and 76.2% of survey participants reported having good social support. Involvement in a kink community helped the mental health of 75.0% of

participants across both measures. Of our survey participants: 50.0% reported not feeling like an outsider because of their kink orientation; 50.0% agreed that kink has become more accepted in the last 5 years; and 45.2% reported that their friends or family know about their kink orientation. Participants reported that having social support improved their mental health; the ability to be open with the people in their lives and the resulting acceptance and inclusion were particularly important, as this quotation demonstrates:

... you get some pretty unusual beating marks ... And, I have had a workmate see bruises on my leg ... They responded perfectly because, at first, they went. 'Aww'! And they went, 'Ohhh'! [They] didn't know what to say. Ruffled my hair, and then later on, they sent me a text message say[ing], 'I'm sorry. I hope that wasn't too intrusive.' And I just went, 'No, it was fine'. ... that was a good ... response to it. They didn't judge at all (#2, kink-identified, straight, cisgender man).

Systemic factors. Systemic risk or protective factors can hurt or help a person's mental health and derive from fundamental faults or merits in society that present as norms, policies, or laws that can discriminate, impede participation and access, generate inequality, or provide opportunity for inclusion and access (Reynish et al., 2020, 2021). Across both measures, participants indicated several systemic risk factors, which caused psychological harm; most of which pertained to the presence or absence of legislation, processes, and resources.

Regarding legislation, all but one kink participants who were sex workers strongly agreed that decriminalising sex work is vital to improving physical safety and mental health. As this interviewee indicated, current legislation impacts a range of factors:

I think that the legislation must change because I don't like paying all this tax and [as a sex worker] I do not have the same access to services [such as workplace health and safety or unions] that other people do. I think it's really unfair ... change legislation for our mental and physical

health ... (#1, kink-identified, bisexual, cisgender woman, current sex worker).

Regarding processes, half of our interviewees struggled with government bureaucracy, which impacted their mental health:

... as someone with disabilities, it's always difficult dealing with [government agency that delivers social security payments] and all of that kind of thing. ... I don't think living should have to be stressful (#16, kink-identified, pansexual, polyamorous, cisgender woman).

Access to resources was another systemic risk factor for survey participants: 70.0% could not secure an appointment with an MHP as soon as they needed support due to workforce shortages. This lack of access to care increases vulnerability, burden, and risk. Also, 69.0% lacked the financial resources to pay for mental health support, which is a risk due to the strong causal relationship between poverty and psychological distress (Australian Psychological Society, 2015). The national average of adults with mental health issues who have experienced homelessness is 32.3% (ABS, 2016d); 29.5% of our participants experienced homelessness at some point in their lives. While mental illness can impede the ability to retain a stable home, not having one increases the risk of developing a mental illness (ABS, 2016d).

Survey participants reported systemic protective factors relating to access; that is, 75.0% had MHP located in their town and 78.6% could access public transport to get to an MHP. The only systemic protective factor indicated in the interviews related to the government's facilitation of toll-free mental health lines:

The government aren't mind readers, not yet. You know, if you've got problems ... I know there are numbers, phone numbers out there ... but I don't know how much more you can ask [of] the government (#25, kink-identified, bicurious, cisgender man).

Interview participants also discussed difficulties related to living in a rural, rather than an urban, region. They cited the constraints of identity concealment, isolation, and stigma, which are endemic to rural areas as well as systemic risk factors:

So, unfortunately my family, most of them moved to the mainland, which is one of those things that happens in Tasmania; isolates you in its own way (#2, kink-identified, straight, cisgender man).

... there are some societal views [in rural Tasmania] around sexuality and, and sexual behaviours that are rigid and they're definitely deleterious for my mental health because ... they're not necessarily consistent with how I feel or how I behave (#30, kink-curious, bisexual, cisgender woman).

Corresponding to the small towns in which our interview participants lived, came small kink scenes.

I still don't quite fit in society; I feel [the kink scene in Tasmania is] a small, very small community. And that does make you feel lonely sometimes (#2, kink-identified, straight, cisgender man).

FetLife [social network for the BDSM, fetish, and kinky community] is an interesting place to be on because there's a lot of dramas that happen, especially in a small community scene. There's a lot of people [who] are threatened by being outed to their friends and families. A lot of them live in small towns where everyone knows each other. And so that's, that's quite difficult for people (#15, kink-identified, straight, cisgender man).

Theme 2: Mental healthcare

The second theme explores the apparatus that is mental healthcare including its components and subthemes of uptake prevalence; help providers; and help-seeking experiences. In the face of the mental health burden described in Theme 1, all participants sought either formal or informal support. Almost all survey (95.2%) and all interview participants reported seeing at least one formal MHP, of which

psychologists (82.0%), counsellors (68.0%), and social workers (44.0%) were the most common. Participants also saw psychiatrists (34.0%), hospital emergency department staff (27.5%), and religious or community leaders (12.5%) for help with their mental health. Only 7.1% of survey respondents saw an MHP for issues relating to kink.

All interview participants sought and benefitted from informal care, such as that provided by partners, as indicated in this quotation:

If I'm [mentally] unwell..., my husband, he doesn't say anything about it ... He picks up my jobs for me when I can't do them ... and he gets on with it. And the kids have learned that that's how to roll with it. And ... that's exactly what I need. And it's the reason why I haven't had to be hospitalised (#30, kink-curious, bisexual, cisgender woman).

Interview participants' experiences with formal mental health support ranged from 'very positive' to 'it's been a bit of a nightmare'. A variety of factors influenced these assessments, which comprised barriers and facilitators to care. Notably, barriers and facilitators to help seeking is a subtheme of the second theme of this study. This subtheme is organised as individual, service-based, and systemic barriers and facilitators.

Individual Barriers and Facilitators

Participants' own personal, individual circumstances blocked and fostered help seeking, for example, having mental health issues was an individual barrier for interview participants:

I have a lot of anxiety that I struggle with. So when I'm feeling stressed out or overwhelmed by the world, it's really hard for me to make the phone call and book an appointment and follow through with it (#16, kink-identified, pansexual, polyamorous, cisgender woman).

Generally, when I'm in more of a depressive state, there's overwhelming lethargy, I just don't want to get out of bed ... and ... don't ... really

want to go into the world, it's too loud, it's too bright. And that's generally what'll keep me from [seeking mental healthcare] (#22, kink-identified, straight, gender diverse demigirl).

Interview participants indicated that their desire to not burden others was a barrier to formal and informal help seeking. Interview participants' individual-based facilitators to help seeking also varied. Participants sought care out of a duty to others or a need to do so for oneself. Reasons for self-motivated help seeking included not wanting to die by suicide, not functioning, and a desperation to be well.

All participants across both measures reported on a variety of individual MHP-based barriers and facilitators to care. A bad formative experience with an MHP was one barrier that can have lingering effects:

I had a lot of issues with anxiety as I was growing up so my mum would take me to see different ... counsellors, but none of them really listened to me. I was quite young at the time, so they probably have their reasons, but it's kind of put me off the idea of going to talk to anyone because I feel like they won't respect my autonomy, my decisions (#16, kink-identified, pansexual, polyamorous, cisgender woman).

I think for me it's a lot with past experiences [that get in the way of me getting support], yeah having especially the older [female MHP]; I think it's a generational thing because a lot of the [negative] comments I've had from [MHP] have been from like the 50 to 60 age group ... So I think she was the worst one, she yeah kind of set me back with a lot of things, not just the sexuality [and] gender topics that I was trying to bring up with her And having someone to tell you just to ignore like a major part of your identity was really bad (#32, kink-identified, biromantic, asexual, gender questioning woman).

Reception to the 19.0% of participants across both measures who disclosed their kink identity to an MHP was less than entirely positive. Of the survey participants who did disclose, two-thirds reported that the MHP needed the participant to educate them. Interview participants who disclosed felt dismissed:

And, yeah both psychologists ... I'd mentioned my little side and everything to, and ... they sort of put it in a basket almost like it's a too hard basket ... It still feels like it's just pushed aside (#2, kink-identified, straight, cisgender man).

And in terms of the kink stuff ... I probably only really shared that very minimally with one ... And they ... were ... visibly uncomfortable. I mean, I didn't say very much at all. And yes, [they] just quickly move[d] onto the next topic basically ... I never would have shared that stuff if I didn't want to talk about it. And so hearing it and then quickly moving on and shutting down any conversation around it was not ... in any way kind of helpful ... (#30, kink-curious, bisexual, cisgender woman).

The 81.0% of participants who did not disclose provided a variety of reasons for not doing so, including fear of judgement:

And I don't really know how I would be able to start talking [to an MHP if I were to see one] about all these touchy issues such as BDSM and open relationships ... I don't really know how much understanding they would have ... mostly that they wouldn't have the experience and that, I guess they might be a bit confused or ... if they were more traditional they might ... I don't want to feel judged ... (#16, kink-identified, pansexual, polyamorous, cisgender woman).

... especially with kink, it sort of feels like ... this is a just-me thing. But, I see how it could probably factor into different aspects of my mental health. But ... it does feel like something that is definitely out of the norm and would probably raise quite a few eyebrows so I don't feel entirely comfortable in disclosing that (#22, kink-identified, straight, gender diverse demigirl).

When asked what would lead to the cessation of contact with an MHP, interview participants discussed inadequate cultural competency and education:

If [an MHP] is quite kind of small minded and just doesn't ... understand my life and lifestyle. If people aren't very open minded ... which happens in rural communities probably more than other places, I tend to just sort of switch off and think, 'Oh, I don't think they're going to quite understand what I'm talking about'. And so I move on (#30, kink-curious, bisexual, cisgender woman).

... you kind of go in thinking this is a safe space, you can talk about whatever issue is going on in your life at the moment and they are going to be there to support you and help you through it. Whereas that's not necessarily what you get all the time, which is pretty awful ... and it makes it harder to try and actually go to another one because you're just like, 'Ah, it's just going to be the same. You know, I'm just really feeling even worse' (#32, kink-identified, biromantic, asexual, gender questioning woman).

[When] talking to a psychologist, I find I do sort of like educating them on [my kink], but at the same time, I probably perhaps would like them to go away and do their homework on it to and learn about it and then maybe; it would just make me feel better (#2, kink-identified, straight, cisgender man).

Conversely, although not many, some individual MHP demonstrated attitudes or behaviours that facilitated help seeking. Participants continued to engage in care because their MHP was: kink aware (26.2% of survey participants); had therapeutic experience with kink-oriented people (9.5% of survey participants; $n = 7$ interviewees); friendly and welcoming ($n = 4$ interviewees; 23.8% survey participants); offered bulk billing or reduced rates ($n = 5$ interviewees); offered appointments longer than one-hour ($n = 3$ interviewees); made them feel heard ($n = 5$ interviewees); and established rapport ($n = 4$ interviewees).

Service-based barriers and facilitators

Survey participants used both private and public mental health services and reported many barriers (Table 5[.5]). Interview participants also used a mix of service types

and reported that failure to provide a welcoming service ($n = 5$) or online booking or appointment options ($n = 3$) were barriers to care.

Table 5. 5 Service-based access barriers reported as a percentage by survey participants (n = 42)

Barrier category	Barrier	No. (%)
Financial	Too expensive	23 (54.8)
	No private healthcare insurance	15 (35.7)
Proximal	No MHP/service near where I live	10 (25.0)*
	Lack of MHP in my area	15 (35.7)
	Lack of services in my area	20 (47.6)
	MHP/service too far from my home	6 (14.3)
	Not able to see MHP ASAP	28 (70.0)*
	Travel time to MHP/service 30 to 60+ minutes	9 (22.5)*
Logistical	Service with limited hours	18 (42.9)
	Long waitlists	28 (66.7)
* data missing for 2		

Participants were also asked what drew them to a service or made them want to use it. Participants reported experiencing a range of service-specific facilitators to help seeking:

... another time I went to see a counsellor ... at the university ... they had everything from, even little fluffy, you know, like huggable toys ... and a little sandpit even ... They didn't know anything about my little side either, but ... I remarked about how it was nice to move about. ... they also had ... stress balls and stuff like that. ... And they were just brighter environments. It just felt more cheerful (#2, kink-identified, straight, cisgender man).

Generally, they are set up to be very comfortable and calming spaces. Yeah, they're generally quite welcoming and relaxing and the colour schemes and décor and all that sort of is arranged in a way that does feel nice (#22, kink-identified, straight, gender diverse demigirl).

Systemic Barriers and Facilitators. Systemic elements are factors ingrained within the overall system that become commonplace and transform culture. Stigma was the biggest systemic barrier to help seeking reported in the study; 76.2% of survey participants either agreed or strongly agreed that there is stigma around getting help

for mental health issues. Interview participants also remarked on stigma and its impacts:

... a lot of people are talking about kink-friendly counsellors [on FetLife], because then it goes that there's a stigma around that if you're seeing a counsellor and you're opening up about your fetish or, or your sexual practices (#15, kink-identified, straight, cisgender man).

And I know [stigma against mental ill health is] getting a bit better but, it's still not great to be in therapy or in counselling or whatever. And even though I try not to let that bother me, it still kind of does because people do make comments even though it's not really their place to (#32, kink-identified, biromantic, asexual, gender questioning woman).

Interview participants did not identify any systemic facilitators to help seeking; however, some of their comments could be interpreted as expressed preferences to destigmatize kink, potentially increasing uptake, and improving wellbeing:

I think my little side has probably had the most impact on my mental health and possibly in a negative way. Or, most likely in a negative way ... because I just feel like I don't fit in – that's the big part of it ... or I'm not accepted; that sort of feeds into it (#2, kink-identified, straight, cisgender man).

I suppose there's a lack of understanding or there's a bit of discrimination ... which ... definitely affects my mental health that I internalize. ... For example, I've, at times, I've been non-monogamous in our, in my relation with my husband – negotiated, like he knows. ... I've been with women and, I ... feel like we have such a kind of concentration on monogamy and things in our society that I have a lot of guilt about that even though he's OK with it ... we definitely have a heteronormative society But I mean, it's not necessarily easy to live within the confines of that ... (#30, kink-curious, bisexual, cisgender woman).

Ideologically speaking, participants craved the openness, diversity, acceptance, and change that systemic stigma seeks to stem. Taking steps to curb stigma could increase service use as well as improve mental health.

5.1.2.5 Discussion

This snapshot of the lives of kink-oriented people with preexisting mental health conditions in rural Tasmania reveals a gender and sexually diverse, relatively educated sample with lower employment rates and higher rates of lifetime suicide attempts than the general population. In the 2016 and 2019 national censuses, less than 1.0% of the Australian population indicated they were gender diverse and 2.7% had a sexual orientation other than straight (ABS, 2018 & 2019). However, 32.7% and 72.5% of our participants were gender or sexually diverse, respectively; only 27.5% were straight. This finding is consistent with other research – people with diverse SOGIESC are more inclined to be kink oriented than straight (Damm et al., 2018; Meltsner, 2017; Richters et al., 2008).

Findings reported elsewhere indicate that kink-oriented people tend to be more educated than the general public (Brown et al., 2020; Wismeijer & van Assen, 2013). Concurrently, 74.4% of our participants had either vocational school or university education. In comparison, only 41.4% of the general Tasmanian population have education beyond high school. Only 52.9% of our participants were currently employed, however, 88.1% of Tasmanians work either full- or part-time (ABS, 2017c).

The estimated risk of suicide in people with preexisting mental health conditions such as depression and anxiety ranges from 5.0 to 61.0% (Brådvik, 2018; de Beurs et al., 2019). Almost half (46.25%) of our participants attempted suicide in their lifetime with LGBTIQ+ participants reporting higher instances than straight (56.8% and 35.7%). Researchers have found that transgender people have lifetime suicide attempts of roughly 50.0% (Rosenstreich, 2013). Our transgender and gender diverse participants reported suicide attempt rates of 70.6%. Ruralness, social conservatism, and intersecting exogenous oppressions could account for our high rates.

Contradicting findings reported elsewhere, the straight people in our study reported slightly higher incidences of both anxiety and depression than LGBTIQ+ participants (Table [5.4]) (Lyons et al., 2015; Stanley & Duong, 2015). Two reasons may explain these contradictory findings. First, research demonstrates that straight men tend to prefer submissive power-exchange roles (Brown et al., 2020; De Neef et al., 2019). More than 57.0% of our straight participants were cisgender men; of those who reported their power-exchange role, 62.5% were submissives or switches. This shift from the dominant male role that is expected in hypermasculine, rural society could compound the existing psychological burden (Carrington & Scott, 2008; Wismeijer & van Assen, 2013). Secondly, identity could explain the contradiction. Some LGBTIQ+ people tend to embrace their kink orientation later in life (De Neef et al., 2019). Our LGBTIQ+ participants could have explored their sexuality or gender before finding kink. If so, this initial identity-development experience could have resulted in improved adjustment and positive self-affirmation of their kink orientations, which could explain their slightly lower Axis I disorder presentations.

Despite intent, therapy has the potential to cause harm due to a lack of cultural validity, restricted use of psychological interventions, and adverse MHP behaviours or attitudes (Curran et al., 2019). This study found that 90.5% of participants had never worked with an MHP who was knowledgeable about or had experience working therapeutically with someone with a kink orientation. Furthermore, almost half of our interview participants reported having only negative formal help-seeking experiences.

Other research has concluded that less than 40.0% of their kink-oriented participants disclosed their sexual orientation to healthcare professionals (Waldura et al., 2016). More than 80.0% of our participants did not disclose their sexual orientation to MHP. Non-disclosure was partially due to the fact that some of our participants felt their kink orientation was unrelated to the reasons for entering therapy. Mostly, however, non-disclosure occurred out of fear of stigma or discrimination from MHP. The burden of real or perceived discrimination and identity concealment on mental health should not be ignored due to their association with psychological distress and suicidality (Hughes & Hammack, 2019; Roberts et al., 2015).

The absence of a complete picture of a client's identity places MHP at a disadvantage (Kolmes et al., 2006). More importantly, however, MHP must be aware of the risk inherent in stigma, for non-disclosure of kink-orientation also often extends to friends or family, placing clients at greater risk for social isolation. Reduced proximity to services, social conservatism, discrimination, stigma, and identity concealment can be endemic rural constraints (Willging et al., 2018). These constraints can isolate kink-oriented people from vital social support and communities, worsen mental health, and breed help-seeking avoidance. MHP must avoid contributing to these constraints by eliminating help-seeking barriers and following participant-determined best practices for care (Figure [5.]1). Training in these areas is also recommended. The lack of training that MHP receive (or seek out) on diverse sexualities, including kink, has the potential to exacerbate psychological distress (Dunkley & Brotto, 2018; Shahbaz & Chirinos, 2017). Training would reduce stigma, increase cultural competence, contribute to ethical compliance, and improve clinical practice (Kink Clinical Practice Guidelines Project, 2019).

Participants revealed endogenous and exogenous factors that improved their psychological state and encouraged help seeking. Consistent with other research on kink-oriented people, our participants generally had good self-awareness, practiced self-care, demonstrated resilience, and had social support – all of which improve mental health (Roberts et al., 2015; Wismeijer & van Assen, 2013). Kink has been shown to improve mental wellbeing (Damm et al., 2018). Our study validates those findings: almost 65.0% declared that kink improves their mental health. These empowering protective factors insulate against exogenous oppressions and can be harnessed to reduce the high rates of anxiety, depression, and suicide attempts that our participants reported.

Specifically regarding the context of the present study, the Government of Tasmania is uniquely placed to decrease societal stigma and discrimination and expand existing MHP education and mental healthcare provision. To address erasure and resulting disparity, curricula for all mental (and physical) healthcare students could be updated to include in-depth instruction on topics unique to people with diverse, non-vanilla, non-heteronormative, or non-mononormative sexual interactions.

Finally, complementary to existing public-services funding, which primarily addresses triage, crisis, or episodic care, focus could also include a prioritisation of preventative and tailored mental health support.

Tips for mental health professionals working with kink-oriented people
<ul style="list-style-type: none"> • Consider how your self-awareness, biases, and assumptions might be improved • Work to understand and develop competencies to support all clients • Create a safe space for openness • Commit to ongoing professional development to address clients' unique needs • Adopt strengths-based, client-focused, and trauma-informed interventions • Reconsider your use of the medical model of client care • Solicit and incorporate client feedback and input on care strategies • Promote quality, informal help seeking • Support resilience building • Foster quality social support

Figure 5. 1 Participant-determined best practices for mental health professionals working with kink-oriented people

Limitations

This study had limitations. The small survey sample size may have been due to the population of rural Tasmania and the study's focus on kink-oriented people with preexisting mental health conditions. The recruitment strategies of snowballing and drawing from the principal author's own networks may have excluded or biased people and reduced the number of respondents, therefore, generalisability is limited. However, the interview sample provided a rich data set from which to triangulate and confirm findings. These exploratory findings offer valuable insight and an impetus to further explore and improve the mental health and related service use of kink-oriented people in Tasmania as well as in other rural and remote areas.

5.1.2.6 Conclusions

Kink has become increasingly normalised and, yet, this study is the first of its kind in Tasmania. As acceptance for this alternate sexual orientation grows, psychological support for this stigmatised group must evolve to match. The mental health and related care of kink-oriented people in rural Tasmania involve a complex mix of factors. This study did not find a causal link between a kink orientation and mental ill health. Rather, exogenous prejudicial factors, attitudes, and behaviours impede identity development and uptake of mental healthcare and are much more evidenced as causes for any mental ill health in our participants. If harnessed, these findings can contribute to the development of competent, tailored support for kink-oriented people that reduces risk factors, increases protective factors, and improves mental health. In the meantime, MHP and government alike can challenge the stigma and discrimination they perpetuate through reflection, training, and addressing systemic issues.

5.1.3 Psychological distress, resilience, and help-seeking experiences of LGBTIQA+ people in rural Australia: a mixed-methods study

As with the previous two papers, this final manuscript also represents the results of this study's survey and interviews. This manuscript presents findings that stem from the research questions regarding mental health status, risk and protective factors, service use uptake, and barriers and facilitators to care. All of the research contained within the following manuscript will be submitted for publication to a journal as Reynish, T., Hoang, H., Bridgman, H., Nic Giolla Easpaig, B. (2021). Psychological distress, resilience, and help-seeking experiences of LGBTIQA+ people in rural Australia: a mixed-methods study.

5.1.3.1 Abstract

Objective: This study aimed to explore the mental health, the aspects associated with psychological distress and resilience, and the help-seeking experiences of LGBTIQA+ people.

Design: This is a mixed-method study that used a survey and semi-structured interviews.

Setting: The study was conducted in rural and remote Tasmania, Australia.

Participants: 66 participants completed the survey and 30 participated in interviews.

Results: Depression (79.2%) and anxiety (74.0%) were the most common among both survey and interview participants. Almost half (46.9%) of all participants had attempted suicide in their lifetime and 20.8% had self-harmed.

Survey results: Two-thirds of the sample (66.2%) had high/very high psychological distress and 50.8% had normal resilience. Lacking social support was associated with increased psychological distress and low resilience. Bivariate correlation analysis showed normal levels of resilience were correlated with social support, self-pride, community belonging, and having a kink orientation. Also, 51.5% of survey participants have seen a Mental Health Provider (MHP) for issues relating to being

LGBTIQA+. The majority (89.4%) of survey respondents reported seeing a general practitioner (GP) for general mental health support.

Interview results: Depression ($n = 24$) and anxiety ($n = 19$) were interviewees' most commonly reported diagnoses. Public acceptance and social support enhanced interviewees' resilience. Interviewees experienced a lack of nearby MHP ($n = 20$), were unimpeded by operating hours ($n = 23$), and trusted MHP ($n = 17$), which impacted help seeking and mental health. Twenty-six interviewees recommended training for MHP, which could offset gaps in knowledge and cultural competence.

Conclusions: The findings indicate that acceptance, access and proximity to care, and MHP cultural competence would benefit rural Tasmanian LGBTIQA+ peoples' mental health. There is need to improve public education, MHP curricula, and provide inclusive and tailored mental health care.

Keywords: psychological distress, resilience, LGBTIQA+, rural, mental health

Strengths and limitations of this study:

- Despite attempts to capture the breadth of LGBTIQA+ peoples' experiences, during development and piloting of the survey some were missed (e.g. intersex-specific experiences); thus, disaggregate studies that explore each population inclusively is an area for future study.
- The study's design resulted in the inability to determine unique or distinct qualitative and quantitative participants.
- The methodology and small sample size hampered the generalizability of the findings.
- The sample size included a broad range of representation.
- The exclusion of people without mental health issues did not facilitate comparison.

5.1.3.2 Introduction

Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual, and people with additional sexual and gender identities, including pansexual, polyamorous, gender nonconforming, and many more (LGBTIQ+) have been found by other researchers to have higher mental illness rates than heterosexual, cisgender people (National LGBTI Health Alliance, 2020). This mental health disparity is due to discrimination, victimisation, exclusion, and other manifestations of minority stress (Meyer, 2003; Rosenstreich, 2013). Disparities can exacerbate psychological distress and impact resilience (Bariola et al., 2015). Resilience is the ability to bounce back from trauma, adversity, or considerable stress (Smith et al., 2008). Resilience is not fixed, however, but dynamic, interactive, and can change overtime both in spite of and due to adversity (Kim-Cohen & Turkewitz, 2012).

Protective factors cited elsewhere associated with resilience include social support, community connection, heterosexuality, and higher income (Bariola et al., 2015). These protective factors affect resilience via their many positive psychological (i.e., optimism, problem solving), biological (sympathetic nervous system), and social (i.e., attachment figures, role models) correlates (Sippel et al., 2015). Homosexuality, younger age, a lack of social support, and victimisation have been linked to psychological distress (Bariola et al., 2015; Cochran et al., 2003). Rurality can also impact LGBTIQ+ peoples' mental health as it tends to coincide with increased homophobia, isolation, identity concealment, and limited community belonging (Barefoot et al., 2015; Lyons et al., 2015).

Researchers have found that LGBTIQ+ people access mental healthcare more than heterosexual people and from a range of mental health professionals (MHP) (McNair & Bush, 2016; Platt et al., 2018). The usage difference is related to disparate mental health needs (McNair & Bush 2015). Due to specialised needs, such as gender-affirming care, mental health needs increase with increased intersecting identities (McNair & Bush 2015). Rurality has been found to impact uptake of mental healthcare by LGBTIQ+ people due to limited service access (including access to gender-affirming care), workforce shortages, and MHP lacking cultural competency (Barefoot et al., 2015; Lyons et al., 2015). Researchers have also found that rural LGBTIQ+ people are more likely to have higher levels of

general psychological distress, suicide rates, and self-harm prevalence than those in metropolitan regions (Rosenstreich, 2013).

The island state of Tasmania, Australia, has characteristics of rurality. Tasmania has the highest socio-economic disadvantage, highest unemployment, and the lowest national education attainment rate (Ahmed et al., 2017). The state has the second highest national suicide rate, yet the fewest MHP (Ahmed et al., 2017; Department of Health, 2018). While general practitioners (GP) are the most commonly consulted health professional for mental health issues, only 34% of Tasmanian GP consider themselves adequately trained to provide psychological support (Ahmed et al., 2017; Primary Health Tasmania, 2016).

This study, therefore, aimed to explore the mental health, the aspects associated with psychological distress and resilience, and the help-seeking experiences of LGBTIQ+ people in rural Tasmania, which can help improve MHP knowledge on minority populations. It was hypothesised that 1) LGBTIQ+ people in rural Tasmania would, generally, have poor mental health; 2) transgender participants would encounter the most barriers to care; 3) that acceptance and support would have a positive direct link to resilience and; 4) that absent social support would have a negative direct link to resilience.

5.1.3.3 Materials and methods

The study design was based on queer theory and sexual configurations theory grounded in the human right of bodily autonomy. Queer theory explores the ways in which heteronormativity and cisnormativity are oppressive, emphasises the fluidities of genders and sexualities, and challenges related dualistic binaries (Clarke et al., 2010; Sedgwick, 1990). Sexual configurations theory integrates the diversity of gender, sex, and sexuality in research and clinical practice (van Anders, 2015). Bodily autonomy is the right to self-determination for everyone, regardless of their sex, sexuality, and gender and without discrimination (Fried & Espinoza, 2019), making it a suitable basis for research into LGBTIQ+ people. Lived experience of mental health and help seeking were explored via a mixed-methods research approach (Hesse-Biber, Rodriguez, & Frost, 2015).

Data in this study represents a subset of a larger project that included a survey ($N = 78$) and interviews ($N = 33$). The larger project explored the mental health and related service use of LGBTIQ+ people, sex workers, and kink-oriented people in rural Tasmania. The current study is focused solely on LGBTIQ+ participants and includes a sample of 66 online survey respondents and 30 interview participants.

Patient and Public Involvement

Six members of the public who fit the inclusion criteria were involved in the study development and design. These six piloted an early draft of the online survey to determine suitability and comprehension of questions and instructions, to uniform understanding of the questions, to aid in determining gaps in survey questions, and to ensure optimal functionality. They provided extensive feedback, which was incorporated. All reported completing a survey and five participated in interviews. Those who self-selected to receive results will be emailed publications arising from their participation.

Survey

The principal author's clinical practice and previous findings informed survey development (Australian Bureau of Statistics, 2008; Australian Psychological Society, 2015; Reynish et al., 2019; Reynish et al., 2020). The survey contained 174 questions that were organised based on identity (e.g. LGBTIQ+) and research topic (demographics, mental health, service-use experiences). Demographics such as gender, sexual orientation, and relationship status were collected via multiple-choice survey questions and an open-ended 'other' option. The survey also contained questions on psychosocial variables (i.e., social support, disclosure, victimisation) and help-seeking experiences (i.e., uptake, barriers, facilitators), which were assessed via Likert scales and/or Yes/No questions. The survey also contained the Kessler Psychological Distress Scale (K10) and Brief Resilience Scale (BRS).

The K10 is a 10-question assessment that uses a five-point Likert scale measure of mental distress experienced in the last 4 weeks (Kessler et al. 2002). Questions included, 'How often did you feel hopeless?' and 'How often did you feel worthless?' Each question is scored from 1 for none of the time to 5 for all of the

time. Scores for the ten questions were totalled, producing a score from 10 to 50. K10 scores were grouped into four levels of psychological distress: low (10-15), moderate (16-21), high (22-29), and very high (30-50) (Australian Bureau of Statistics, 2019). The K10 had excellent internal consistency, reliability, and validity (Cronbach's $\alpha = 0.93$) (Kessler et al., 2002). Cronbach's α for the current study was 0.92.

The BRS is a 6-item assessment of a person's ability to recover from stress with three positively worded statements (e.g. 'I tend to bounce back quickly after hard times') and three negatively worded ones (e.g. 'I have a hard time making it through stressful events.') to minimize response bias (Smith et al., 2008). Likert scale response options ranged from 1=strongly disagree to 5=strongly agree. Totalled scores are mean scores of all answers ranging from 1 to 5. The higher the mean score, the greater the respondent's resilience. Mean scores indicated if participants had low (1.00-2.99), normal (3.00-4.30), or high (4.31-5.00) resilience (Smith et al., 2008). The BRS has good internal consistency and reliability (Cronbach's $\alpha = 0.80-0.91$) (Smith et al., 2008). Cronbach's α from this study's sample was 0.93. The BRS has positive optimism ($r = .69$) and active coping ($r = .38$) correlations and negative anxiety ($r = -.53$), depression ($r = -.50$), and perceived stress ($r = -.61$) correlations, demonstrating convergent and divergent validity (Smith et al., 2008).

Interviews

The primary author conducted two interviews with each interviewee held either in person or via telephone: a telephone-screening interview and a main interview. The screening interview consisted of four questions based on a protocol developed by Burke Draucker, Martzolf, and Poole (2009). The purpose of the screening interview was to preclude current acute psychological distress (which was achieved for all participants). The main interviews ranged between 15–60 minutes. Participants were asked a mix of 24 open- and closed-ended questions on mental health, risk and protective factors, and help seeking. Interviewees provided their demographic information in response to seven questions, including 'What is your sexual orientation?', 'What is your gender?', and 'What pronouns do you use?' Sample interview questions included, 'What hurts your mental health and what improves it?'

and ‘What has been your experience with help seeking for mental health issues in rural Tasmania?’

Recruitment

The primary author recruited participants via convenience sampling across professional and personal networks and via snowball sampling through Facebook and third-party organisations. Thirty organisations assisted with recruitment, including local, state-based, and national support and advocacy services; community groups; not-for-profits; and private and public mental health services. Participants of one research tool were invited to participate in the other. Survey participants could enter a draw for a \$100 Australian Dollar (AUD) gift voucher and interview participants received a \$30 AUD gift voucher. Inclusion criteria required that participants self-identified as LGBTIQ+; were 18 years of age or older; were residents of rural Tasmania within the last 2 years (excluding the capital city and its surrounds); had preexisting mental health issues in their lifetime and used related formal or informal supports; and were proficient in English. Informed consent was required for participation. Interview participant recruitment continued until data saturation was attained in the concurrent data analyses (Guest, Namey, & Chen 2020). The Tasmanian Social Sciences Human Research Ethics Committee approved the study (Reference #: H0018041).

Data analysis

Quantitative data were analysed with IBM SPSS Statistics (IBM, 2019). Univariate analyses were conducted on all variables to generate descriptive statistics and frequencies. Bivariate correlation analyses were conducted with all survey questions against all K10 (low, moderate, high, very high) and BRS (low normal, high) scores to determine those significantly associated with each measure and to test each of the four hypotheses. For example, to test hypothesis 3 (that acceptance and support would have a positive direct link to resilience) the survey question ‘My involvement in a BDSM kink community had a positive impact on my mental health’ was run against the BRS scores as well as the K10 scores. The majority of response categories were too small to be considered statistically appropriate to include. Those

of sufficient size for consideration are included herein. Bivariate correlations were then conducted using Spearman correlation coefficient to determine if the hypotheses were nonsignificant ($p > .05$) and should be removed. The demographic categorical variables were: age, gender, sexual orientation, postal code, K10 and BRS scores, relationship status, educational attainment, and employment status.

Interviews were transcribed in NVivo Transcription (QSR International Pty Ltd., 2022). Transcripts were verified for accuracy. NVivo qualitative data software was used to manage the qualitative data and facilitated analysis (QSR International Pty Ltd., 2022). The identified areas of examination for quantitative analysis (i.e. psychological distress, resilience, and help-seeking experiences) formed a framework for and structured the qualitative analytical inquiry. Across the continuum of inductive- to deductive-oriented approaches, the analysis veered closer to the latter given the *a priori* definition of its focus, scope, and parameters (Joffe, 2011; Terry et al., 2017).

The initial steps common within methods of thematic analysis were used to identify and describe the relevant content (Guest et al., 2012; Nowell et al., 2017). This involved engaging in line-by-line coding of units of text explicitly or implicitly relevant to our framework, and reviewing and refining these initial codes (Guest et al., 2012; Nowell, et al., 2017). Within each identified area, codes were collated, aggregated, and revised to develop a descriptive narrative summary of these data. Qualitative data analysis offered a means to deepen and extend our understanding in relation to the quantitative findings.

5.1.3.4 Results

It cannot be determined if $N = 66$ survey and $N = 30$ interview participants are unique or distinct due to the research instruments' inherent confidentiality (Internet Protocol addresses and personal data were not tracked); thus, the results are presented as overall results, survey results, and interview results.

Overall results

This study included 69.8% cisgender people and 30.2% transgender people.

Transgender herein is an umbrella term for participants who were brotherboy, demigirl, gender questioning, gender nonconforming, or transgender. Participants ranged in age from 18 to 78 (Mean = 36.3, standard deviation = 14.1) and reported many sexual orientations, with bisexual the most common (28.4%) (Table 5.6).

Table 5.6 Participants' demographic characteristics (N = 96)

Characteristic	Survey (N = 66) No. (%)	Interview (N = 30) No. (%)	Total (N = 96) No. (%)
Gender			
Cisgender woman	35 (53.0)	16 (53.3)	51 (53.1)
Cisgender man	9 (13.6)	7 (23.2)	16 (16.7)
Nonbinary	10 (15.2)	2 (6.7)	12 (12.5)
Trans woman	5 (7.6)	2 (6.7)	7 (7.3)
Trans man	6 (9.1)	---	6 (6.3)
Additional genders	1 (1.5)	3 (10.0)	3 (3.1)
Intersex status			
Yes	2 (3.0)	---	2 (2.1)
Unsure/Prefer not to say	1 (1.5)	1 (3.3)	2 (2.1)
Sexual orientation^b			
Bisexual	20 (30.8)	7 (23.3)	27 (28.4)
Lesbian	13 (20.0)	3 (10.0)	16 (16.8)
Gay	8 (12.3)	2 (6.7)	10 (10.5)
Pansexual	7 (10.8)	3 (10.0)	10 (10.5)
Queer	7 (10.8)	3 (10.0)	10 (10.5)
Asexual	6 (9.2)	1 (3.3)	7 (7.4)
Additional sexualities	4 (6.2)	11 (36.7)	15 (15.8)
Kink/BDSM			
Kink oriented	33 (50.0)	6 (20.0)	39 (40.6)
Kink curious	---	1 (3.3)	1 (1.0)
Educational attainment^c			
Not university educated	35 (53.0)	8 (47.0)	43 (51.8)
University educated	31 (47.0)	9 (53.0)	40 (48.2)
Employment status^b			
Employed	33 (50.0)	22 (75.9)	55 (57.9)
Not employed	33 (50.0)	7 (24.1)	40 (42.1)
Relationship status^a			
Single	34 (51.5)	9 (40.9)	43 (48.9)
In a relationship	28 (42.4)	7 (31.8)	35 (39.8)
Polyamorous	4 (6.1)	4 (18.2)	8 (9.1)
Open relationship	---	2 (9.1)	2 (2.3)
Sex work experience			
Current or former	4 (5.1)	6 (18.2)	10 (10.4)
Australian Statistical Geography Standard (ASGA) remoteness class^a			
Inner regional (RA2)	28 (48.3)	17 (56.7)	45 (51.1)
Outer regional (RA3)	28 (48.3)	12 (40.0)	40 (45.5)
Remote (RA4)	2 (3.4)	1 (3.3)	3 (3.4)
a. Question optional, <i>n</i> = 88 b. Question optional, <i>n</i> = 95 c. Question optional, <i>n</i> = 83			

All participants presented with a total of 31 current or historical issues; depression (79.2%) and anxiety (74.0%) were the most common. Almost half (46.9%) of all participants had attempted suicide in their lifetime and 20.8% had self-harmed. All participants experienced barriers and facilitators to help seeking.

Survey results

Psychological distress

Sixty-five survey participants completed the K10 and scored an average of 26.1 (standard deviation = 8.6), indicating high levels of psychological distress (as hypothesised). A score of 22 or more or high and very high (H/VH) scores was considered clinically significant (requiring treatment to reduce severity). More than one-third (34.8%) of participants had high and 30.3% had very high levels of distress; 66.2% had H/VH levels.

Mental health. Comorbid mental health diagnoses were reported by 86.4% of survey participants. Of the 19 issues reported by survey participants, depression (84.8%) and anxiety (81.8%) were the most common. Almost half (48.5%) of survey participants reported lifetime prevalence of suicidality, with 6.1% reporting suicide attempts in the previous year.

Resilience. Of the 65 survey participants who completed the BRS, 46.2% scored low resilience, 50.8% scored normal, and 3.1% scored high. The average BRS score was 2.96 (standard deviation = 1.02), indicating low resilience. Depression and anxiety are also negatively associated with resilience (Smith et al., 2008). Of those 46.2% with low resilience, 80.0% had depression and 83.3% had anxiety. Of participants with normal resilience (50.8%), 87.9% had depression and 75.8% had anxiety. Bivariate correlation analysis demonstrated correlations between ordinal variables that represented community, acceptance, support, and normal resilience and confirmed hypothesis 3 (that acceptance and support would have a positive direct link to resilience). Of the 17 people who responded to the survey question, 'My involvement in a BDSM kink community had a positive impact on my mental health', 15 agreed, and of that 15, 75.0% scored normal resilience ($r = .620$ where p

< .01, 2-tailed, $p = .000$). Table 5.7 demonstrates those survey questions that were significantly associated with normal resilience. Findings are as hypothesised.

Table 5. 7 Factors Significantly Associated with Normal Resilience Among LGBTIQ+ Survey Participants in Rural Tasmania[^]

Survey question	<i>N</i>	<i>n</i>	Normal BRS score %	<i>r</i>	<i>p</i>
I have good social support from a significant other, family, friends, community or peers	51	28	54.9	.277*	.026
I am proud of being sex, sexually, or gender diverse	34	33	63.6	-.299*	.016
Sex, sexual, or gender diversity has become more accepted over the past 5 years	65	60	56.7	.314*	.011
BDSM/kink improves my mental health	20	19	73.4	.579**	.001
I am proud of my kink orientation	16	14	63.4	.447*	.010
My involvement in a BDSM/kink community has a positive impact on my mental health	17	15	75.0	.620**	.000
<i>N</i> Total number of respondents who answered this survey question <i>n</i> Total number of respondents who answered this survey question in the affirmative [^] No survey question responses were found to be significantly correlated with high resilience. * $p < .05$, 2-tailed ** $p < .01$, 2-tailed					

Help-seeking experiences. Uptake. More than half (51.5%) of survey participants have seen an MHP for issues relating to being LGBTIQ+. Of this 51.5%, 70.6% have H/VH psychological distress and 52.9% have low resilience. Regarding formal support, survey participants consulted private psychologists (78.1%), counsellors (67.2%), and psychiatrists (40.6%). Furthermore, the majority (89.4%) of survey respondents reported seeing a general practitioner (GP) for general mental health support. Nearly 45% reported seeing a GP for LGBTIQ+-related mental health issues.

Barriers and facilitators. Data representing barriers and facilitators were explored to test hypotheses. As hypothesised, cisgender participants experienced fewer barriers than transgender participants; that is, 76.7% of cisgender participants had an MHP located nearby (only 23.3% of transgender participants reported having local MHP) and 35.7% of cisgender participants lacked public transport (whereby 64.3% of transgender participants lacked public transportation). Also, 84.8% of participants saw MHP who did not indicate that their diversity was a ‘phase.’ Trusting MHP was not an issue for 71.2% of survey participants and 58.8% saw an MHP who did not

need to be educated about sex, sexual, or gender diversity (being LGBTIQ+). (Table 5.8).

Table 5. 8 Gender and formal help-seeking variables from survey data (n = 66)

	Cis woman (n = 35)	Cis man (n = 9)	Trans woman (n = 5)	Trans man (n = 7)	Nonbinary (n = 10)	TOTAL %
EXTERNAL ASPECTS						
<i>MHP said diversity a 'phase'</i>	3 (8.6)	1 (11.1)	1 (20.0)	1 (14.3)	4 (40.0)	15.2
Proximity						
<i>MHP too far from home</i>	5 (14.3)	1 (11.1)	0 (0.0)	4 (57.1)	4 (40.0)	21.2
Access						
<i>Lack of MHP in my town</i>	5 (14.3)	4 (44.4)	2 (40.0)	4 (57.1)	5 (50.0)	30.3
<i>Limited operating hours</i>	7 (20.0)	3 (33.3)	2 (40.0)	4 (57.1)	5 (50.0)	31.8
<i>Lack of public transport</i>	4 (11.4)	1 (11.1)	0 (0.0)	5 (71.4)	4 (40.0)	21.2
INTERNAL ASPECT						
<i>No trust for MHP</i>	6 (17.1)	2 (22.2)	2 (40.0)	3 (42.9)	6 (60.0)	28.8

Interview results

Mental health and contributing aspects. Depression ($n = 24$) and anxiety ($n = 19$) were interviewees' most commonly reported diagnoses. Depression findings were comparable for cisgender ($n = 17/23$) and transgender ($n = 5/7$) interviewees; however, more transgender interviewees experienced anxiety than cisgender ($n = 6/7$ and $n = 13/23$). Ten of the 30 interview participants reported lifetime suicide attempts: $n = 4/9$ transgender and $n = 6/9$ cisgender. Also, $n = 22/30$ reported comorbid diagnoses and three of the remainder ($n = 8/30$) did not report a current diagnosis, but all ($N = 30$) experienced situational issues or contributing aspects (e.g. grief, financial difficulties, discrimination, stigma).

Interviewees both had and lacked social support and community belonging. As hypothesised, their presence conferred a protective benefit against psychological harm and contributed to participants' wellbeing; their absence harmed interviewees mental health and resulted in isolation and loneliness.

[I]t was many years before I met somebody else that identified similarly to me, which is really hard in terms of your ... mental health because [when] there's no one around like you, how do you work out that you

don't come from bloody Mars ... ? ... So that really impacts on your mental health and ... suicidality...

Despite diagnoses and stressors, interviewees possessed the ability to recover from stress and bounce back via resilience.

Resilience. Interviewees demonstrated resilience in many ways: they believed in their ability to cope, stayed connected with supports, talked about their issues, helped others (humans and animals), and sought positivity and affirmations. Public acceptance and social support enhanced interviewees' resilience. More than half benefitted from being seen positively via, for example, pro-LGBTIQA+ media coverage, legislative recognition of sex and gender diversity (*Births, Deaths and Marriages Registration Act* amendment), and rainbow flags on businesses. Public acceptance was described as, '[When] ... a human [is] being seen in the world – truly seen – ... that's a gift.' Almost all interviewees had friends, partners, LGBTIQA+ community members, or family that offered love, aid, or advice.

Help-seeking experiences. *Uptake.* Twenty-five interviewees consulted an MHP in rural Tasmania; four of the remainder reported previously seeing MHP in other parts of the country. Only one interviewee reported never having consulted an MHP. All interviewees relied on informal support from friends and loved ones. Faith-based services received the most backlash; one-third of interviewees expressly indicated they would not use them. Twenty interviewees consulted a GP in rural Tasmania for mental health issues, seeking support, medication, or referral to an MHP; 14 had negative experiences ranging from the GP was 'visibly uncomfortable dealing with mental health' to 'he basically labelled me as a slut.'

The high prevalence of formal service usage enabled participants to assess its calibre. Interviewees encountered dozens of aspects that informed their service use/disuse; only those related to survey findings are reported on here.

Barriers and facilitators. Interview and survey data findings coalesced regarding barriers and facilitators. Specifically, interviewees experienced a lack of nearby MHP ($n = 20$), were unimpeded by operating hours ($n = 23$), and trusted MHP ($n = 17$), which impacted help seeking and mental health. Ability to get help from a

trusted professional at convenient times encouraged help seeking, however, having to travel for care and take time off work to do so impeded uptake.

I feel just that living, living in rural areas, you either see one of the few people [MHP] who are close by, in which case your ability to get help is somewhat limited by the professional's time. Or you go to a larger area where it's limited by your ability to travel that distance [so access to services and care is compromised].

Unmet needs represented absent, insufficient, or inadequate care, which increased risk:

Outside of rural areas, I've found government services for mental health quite encouraging as a whole. But within them [in rural areas] ... I've not really found much help ... the harm, as always, comes from the interminable waiting.

... funds for mental health services are limited in [rural Tasmania]. And there is a lot of pressure on the people delivering these services to keep up with the demand... And sometimes that means [a person] misses out [on getting psychological care]. ... that makes me a bit reluctant to go to these services for fear of not being able to get what I need...

Interviewees offered recommendations to address these gaps. Regarding the lack of MHP, they recommended additional government funding for existing services and new, specialised ones. Rural services' adoption of community support, outreach support, and peer-support to enhance existing offerings was also endorsed. The incorporation of lived experience within a service would add community expertise and knowledge, thereby enhancing competency and capacity for all involved.

Twenty-six interviewees recommended training for MHP, which could offset gaps in knowledge and cultural competence. Suggested training topics included empathy, diversity, body positivity, trauma, polyamory, inclusivity, and inclusive language. Basic training on gender and sexuality was also recommended.

5.1.3.5 Discussion

This examination of LGBTIQ+ people with preexisting mental health issues in rural Australia revealed high rates of depression, anxiety, and psychological distress. Participants also possessed resilience and embraced protective factors. Together, these findings indicate that overall, our participants have poor mental health; thus, supporting the first hypothesis. Indeed, inclusion criteria required that participants had preexisting experiences with situational and/or clinical mental health issues. Of the 96 participants in this study, only three interviewees did not have a diagnosis (they experienced situational stress). Other researchers have found that LGBTIQ+ people have been found to have higher mental illness rates than heterosexual, cisgender people (National LGBTI Health Alliance, 2020). Yet, related aspects of the findings of this study were unexpected.

National studies have revealed higher distress in people with mental disorders (Slade et al., 2011). National studies into rural LGBTIQ+ people report psychological distress ranges of 22.8% to 57.2% (Hill et al., 2020; National LGBTI Health Alliance, 2020). Notably, 66.2% of our participants had H/VH psychological distress. National LGBTIQ+ studies also reported diagnoses of depression that range from 43.9% to 60.5% (Hill et al., 2020; National LGBTI Health Alliance, 2020). Overall, 79.2% of our participants experienced depression. National anxiety rates for LGBTIQ+ people range from 47.2% to 52.0%; 74.0% of our participants had anxiety. Marginality and minority stress accompany rurality and predilections for distress, depression, and anxiety in LGBTIQ+ people are well known (Cochran and Mays, 2009; Lyons et al., 2015; Meyer, 2003). Yet national mental health strategies for LGBTIQ+ people fail to be implemented adequately, particularly in rural areas. Perhaps the urbancentric focus of these strategies is contributing to their poor implementation.

While majority percentages indicate that the included aspects could be interpreted as facilitators to help seeking, the inverse of these majorities represent barriers. Our transgender participants experienced the most barriers to care, supporting hypothesis 2. Indeed, other research has concluded that gender diverse people experience more barriers than cisgender people (McNair & Bush, 2015; Romanelli & Hudson, 2017).

Considering the high rates of depression, anxiety, and distress in our transgender participants, these barriers are compelling.

Barriers to care also included 41.2% of participants who had to educate MHP on LGBTIQ+ matters. A US study found that 48.8% of physical health providers received no formal education on transgender healthcare during their training – citing transphobia as the reason for this gap (Stroumsa et al., 2019). Similar Tasmanian findings are unknown, however, given the high percentage of our participants who had to educate rural MHP, one possible explanation is that transgender curricula content is equally sparse and transphobia is equally prevalent. This barrier places greater burden on a population already experiencing disparities.

Hypotheses 3 and 4 were supported. Acceptance and support presented herein as direct social support from loved ones and community belonging; indirect support presented as a belief in increased public acceptance; and self-acceptance was evident in participants' self-pride. The absence of support presented as lacking social support. While the majority of our survey participants (50.8%) scored normal resilience, 46.2% scored low. When viewed against the high prevalence of distress, depression, and anxiety in our participants, the resilience scores and the ameliorative impact of a majority normal-resilience score are important. Complex self-identity could provide explanation; that is, the identity and self-concept development inherent in diverse populations can buffer against stress and distress (Meyer, 2003). That more than 40.0% of participants were also kink-oriented could add to the complexity of the self-identity, thus adding to the buffering effect. The majority normal-resilience score could also hinge on acceptance, which is a cornerstone to wellbeing, a fundamental human need, and the metonymy of social support, public acceptance, community belonging, inclusion, and self-pride.

Previous research has confirmed the importance of acceptance to LGBTIQ+ mental health (McNair & Bush, 2015; Rosenstreich, 2013). The rural context of this study emphasises the need for the cultivation of acceptance on micro, meso, and macro levels due to increased isolation, prejudice, exclusion, and the harm caused by a lack of acceptance (Lyons et al., 2015; QLIFE, 2018; Wesselmann et al., 2012). These findings suggest that approaches to building resilience and reducing distress

may need to become integral facets of rural care delivery. Furthermore, given how acceptance, support, and community connection enhance a person's resilience, perhaps pathways for support outside of mental health services – as provided via peer support groups, for example – may be an option for exploration.

LGBTIQA+ Tasmanians experience chronic exclusion and erasure from mental health curricula, research, and policy. The impacts of this erasure have dire, but preventable psychological implications. The present study has revealed unique findings regarding ways in which acceptance, access and proximity to care, and MHP cultural competence are vital for rural LGBTIQA+ people. Implementation of these findings could ease distress, increase resilience, encourage help seeking, and optimise support offerings.

6. DISCUSSION

6.1 Introduction

This chapter presents a discussion of the entire study's research findings, which are presented herein as they relate to the study's research questions.

6.2 Research Aim

The aim of this thesis was to investigate the mental health and service use of LGBTIQ+ people, kink-identified people, and sex workers in rural or remote Tasmania using the lenses of social justice, bodily autonomy, intersectional feminist theory, queer theory, and sexual configurations theory. The intent of this aim was to determine the impact of participants' compromised access to bodily autonomy on their mental health and the nature of their experiences with psychological support. The purpose of this study was to identify, and, ideally, contribute to improvement. The findings are discussed below within the context of the study's research questions (RQ).

6.3 RQ 1 (Finding 1)

RQ 1: What is the mental health status of LGBTIQ+ people, sex workers, and kink-oriented people with preexisting mental health issues in rural or remote Tasmania?

This RQ was asked, in part, to address inequities in literature and in the state's existing mental health system, as seen in the candidate's clinical practice. Concurring with this study's two systematic literature reviews and existing literature, participants' mental health status was mixed. As having a mental health issue was an inclusion requirement, all participants reported either situational and/or clinical mental health issues.

6.3.1 Comorbidity and Diagnoses

Despite the fact that participants had preexisting mental health issues, the pervasiveness of comorbidity was unexpected and noteworthy. Comorbidity is associated with worse or compounded outcomes and it has more complex implications in rural and remote areas due to cooccurrence with the lack of (or lacking) resources and other inherent rurality issues (Rajkumar & Hoolahan, 2004). Yet, how widespread comorbidity was, was unexpected.

Concurring with other research into common mental disorders worldwide, anxiety and depression were the most commonly reported diagnoses in this study (Yang et al., 2021; World Health Organization, 2021b). Kink-oriented people are said to experience less depression than vanilla people, but similar (Brown, Barker, & Rahman, 2020) or lower (Gemberling et al., 2015) rates of anxiety. However, anxiety and depression rates were high among the kinky participants, with most reporting both diagnoses. The reason our data does not concur with others' findings could be related to the fact that 62.5% were fully or occasionally submissive. Instead of being dominant and hypermasculine as expected and even valorised in rural areas, most of this study's kinky participants contradicted rural social expectations (Carrington & Scott, 2008). Butler (1990) posits that hypermasculinity occurs as a response to forbidden same-sex desire, stating '... disavowed male homosexuality culminates in a heightened or consolidated masculinity ...' (p. 69). This forbidden desire could be transposed to disavowed passive masculinity, which could have contributed to the high depression and anxiety comorbidity. Mental illnesses result from a range of causal factors, however, the expectations placed on rural cisgender men (those responsible for hypermasculinity) to maintain and defend the status quo while not being overtly free to explore their identity (regardless of whether or not one is homosexual), could be related. Another reason for the difference between this research's findings and previous research may also be due to this study's inclusion criteria; that is, all participants had to have experienced a mental health issue, which could account for the high rates of both anxiety and depression.

Depression was also common in our transgender participants: 89.7% reported depression compared with 76.8% of cisgender participants, which is much higher than found in a national LGBTIQ+ study of 53.0% and 34.2%, respectively (Hill et

al., 2021). The presence of a preexisting mental health issues was not an inclusion requirement of this national study, however, the prevalence of depression and anxiety in LGBTIQ+ people are well known (Cochran & Mays 2009; Lyons et al., 2015; Meyer, 2003). The prevalence of depression and anxiety in transgender people are also known to exceed that of cisgender people (McNair & Bush, 2016). Depression in transgender people has been partially attributed to victimisation and lacking social support, which concurs with our findings (Dhejne et al., 2016).

Nota bene: identification of psychological issues were self-reported; no formal syndrome categorisation was used. Self-diagnoses are valid representations of a person's symptoms as they rely on a person being an expert in their own lives, thus, proof of diagnoses was neither requested nor required. This information is informative with regard to subjective wellbeing. Surveys and research often rely on self-identification, as demonstrated in the 'Outcome measure (Relevant condition/topic; tool' column of Appendix 5; thus, as such, are comparable to formal measures.

6.1.2 Suicide

Suicide ideation and attempts were researched for four reasons: 1) Tasmania has the second highest national suicide rate (Ahmed et al., 2017); 2) rates in the state are increasing the fastest in the country; 3) rates increase with remoteness (Suicide Prevention Australia, 2010); and 4) suicidality is around seven times higher in those with mental illness than in those without (SANE, 2018). Almost three quarters (72.4%) of our transgender participants reported having attempted suicide. A review of 27 mortality studies found that suicidality in people with preexisting mental health conditions ranges between 4.0 to 7.0% (Inskip, Harris, & Barraclough, 1998 in Brådvik, 2018). A Netherlands-based study found a 47.8% suicidality prevalence in people with depression and a 16.6% prevalence in those with anxiety (de Beurs et al., 2019). Overall, 45.0% of our participants experienced suicidality.

Roughly 50.0% of Australian transgender people have lifetime suicide attempts (Hill et al., 2020; Rosenstreich, 2013). Note that the presence of a preexisting mental health issues were not inclusion requirements of these Australian studies, but

transgender people have been demonstrated to have high lifetime suicide attempt rates (Stroumsa et al., 2019), thus comparison can be made. Other research indicates that suicidality in transgender people is associated with depression (Zwickl et al., 2021); 89.7% of this study's transgender participants were depressed. A lack of gender affirming surgery is also associated with suicidality (Zwickl et al., 2021) and could be a factor in our transgender participants' suicidality – medical gender affirmation procedures are not covered by Medicare (the national public health scheme), thus, participants have to pay for their own procedures. Reconstructive chest surgery, for example, can cost roughly \$18,000 (Trans Hub, 2021). Tasmania has the fewest providers of gender affirming surgery in the country, which means people may have to travel for care and, which demonstrates inequities in the state's health system (Australian Professional Association for Trans Health, 2022).

6.3.3 Self-harm

Self-harm is often a response to a mental illness (SANE, 2018); the prevalence of mental illness in our participants has been established. Self-harm increases with remoteness (National Rural Health Alliance, 2017). Of our participants who self-harmed, 45.0% lived in Inner Regional Tasmania, 45.0% lived in Outer Regional Tasmania, and 10.0% lived in Remote Tasmania, thus, our findings may concur that self-harm increases with remoteness (a future study that compares urban and rural prevalence may further confirm these findings). Concurring with findings reported elsewhere, our transgender participants had a slightly higher prevalence of self-harm than our cisgender people; that is, transgender people are 14.8 times more likely to engage in self-harm than people who are LGB (Jackman, Honig, & Bockting, 2016). Dysphoria has been found to contribute substantially to self-harm prevalence in people with diverse genders (Jackman et al., 2018; Morris & Paz, 2019). Relatedly, 79.3% of our transgender participants had gender dysphoria. Unresolved dysphoria is compounded by the state's aforementioned barriers to gender affirmation.

6.3.4 Psychological Distress

The factors that impacted this study's participants' distress were neither simple nor direct. There is a correlation between people with preexisting mental health issues and high distress (Slade et al. 2011), which could partially explain the K10 scores.

Participants also experienced a variety of factors that caused distress: outsidership, victimisation, isolation, poverty, identity concealment, and fear of stigma. What these factors have in common is that they represent a lack of personal agency: ‘... a strong sense of personal agency is important for negotiating adversity’ (Windle et al., 2011, p. 14). Participants did not have control over violence or the isolation inherent in small kink communities, for example, which, in turn, could have worsened their distress. Alternately, participants also had social support: family and friends as well as community involvement, public acceptance, and inclusion, which eased distress.

Cultural stigma could also have contributed to participants’ low K10 scores. Cultural stigma is the stigma that stems from community, which devalues certain identities. The more one is devalued (or believes they are), the higher their psychological distress – this distress is compounded the more intersectional identities a person possesses. In other words, community – and not the individual person – can determine a person’s value, themselves, thereby diminishing personal agency (Quinn & Chaudoir, 2009). A community that is more socially conservative could be assumed to enact more cultural stigma, thus further reducing agency and increasing distress. Rural Tasmania’s social conservatism, which manifested as what Carrington and Scott (2008) saw as hypermasculinity and a belief in imagined rural gender order, could be transposed to include gender in general. More than two-thirds (77.3%) of our transgender participants reported H/VH distress (versus 60.5% cisgender). Distress increases with ‘stigma and/or internalised shame based on societal judgement’ (Speciale & Khambatta, 2020, p. 341). Societal judgement is cultural stigma; 77.3% of our transgender survey participants indicated they feel stigma and discrimination due to their identity (versus 46.5% of cisgender survey participants).

6.3.5 Brief Resilience

Stress, psychological distress, depression, and anxiety are associated with lower resilience (Bariola et al., 2015; Leonard & Metcalf, 2014; Lyons, Hosking, & Rozbroj, 2015; McNair & Bush, 2016). Our findings concur regarding these associations and could explain participants’ average score of low resilience. However, resilience can be a countermeasure to distress and can offset the impact of

mental health issues (Bariola et al., 2015; Liu, 2015). As the papers in the previous chapter demonstrated, social support and positive feelings (self-pride, self-worth, self-confidence), are deemed fundamental to resilience (Bariola et al., 2015; Liu, 2015; McNair & Bush, 2015). These attributes undoubtedly contributed to the sizeable normal resilience score. Family and community and the resources they bring (i.e. self-esteem, problem solving, interpersonal connections, peer support) are important for negotiating adversity and building resilience (Windle et al., 2011). That so few participants scored high resilience was noticeable, but not surprising given the inclusion requirement of having a preexisting mental health issue. Still, the sizeable normal resilience score and the existence of some participants with high resilience are positive outcomes. Like many other aspects relating to mental health status, resilience – and the factors that impact it – are not fixed. Resilience is dynamic, interactive, and can change overtime both in spite of and due to adversity (Kim-Cohen & Turkewitz, 2012).

These findings indicate that clinically, when all factors are considered, our participants had poor mental health. Indeed, minority stress and an intersectional framework could explain this, for stigmatised minority groups experience distress due to the marginalisation of their identity and the more diverse someone is, the more marginalisation they face, thus, the more distressed they are (Meyer, 2003). The candidate has been careful not to problematise sex, sexual, gender, and erotic difference as reasoning for this negative mental health status, as difference, and mental health in general, are not homogenous, but rather, are nuanced. Causally, mental health, wellness, and illness are multifactoral and determined by a variety of biological, psychological, social, and systemic factors that are often mutable or in flux. While the biological factors are beyond the purview of this research, the other three will be discussed via the remaining research questions.

6.4 RQ 2 (Finding 2)

RQ2: What risk and protective factors impact the mental health of LGBTIQ+ people, kink-identified people, and sex workers?

6.4.1 Risk Factors

Across the dataset, our participants experienced many risk factors. Human rights and the government comprise two overarching areas that represented multiple risk factors for participants.

6.4.1.1 Human rights

Highlighting inequity and inequality, the human rights of this study's participants were compromised or absent. For example, the 1948 *Declaration of Human Rights* states that all people are free and equal in dignity, freedom, security, and rights (United Nations, 1948, 1976). More than half (56.9%) of LGBTIQ+ participants, 66.7% of sex workers, and 21.4% of kink-oriented participants reported being discriminated against solely because of their diversity.

The Declaration also states that people shall have access to medical care, including mental healthcare (United Nations, 1948, 1976). However, many participants could not see a MHP as soon as they needed help and some did not have counsellors in their area. Delayed care or not accessing care due to impeded access can worsen or lead to distress or death. As the aforementioned comorbidity and suicidality rates of the target populations indicate, this requires attention.

The Declaration indicates that people shall have the rights to work, to free choice of employment, and to community culture without distinction, or inhumane or degrading treatment, or interference or attacks or limitations (United Nations, 1948, 1976). Instead of being able to choose their job, our sex worker participants are criminalised due to patriarchal and kyriarchal domination and are subjected to moralising criticism and public judgement (Rubin 2007; Dawthorne 2019). Instead of a right to be free from inhumane or degrading treatment, our participants experienced many types of violence: verbal abuse from employers; homophobic slurs from strangers; domestic violence; sexual assault; violence from police officers and sex work clients; fat shaming from a GP and from a MHP; identity erasure from friends and other members of the LGBTIQ+ community (lateral violence); and fear of and threat of violence. These human rights abuses represent compromised bodily autonomy: participants were interfered with physically without consent,

denied the right to govern their bodies based on their own rationale without discrimination or coercion, and denied self-determination (Herring & Wall, 2017).

6.4.1.2 Government

To determine risk factors, participants were asked:

‘What things do your family, friends, society, the public or the government do that help or hurt your mental health?’ Responses that pertained specifically to participants’ sex, sexual, gender, or erotic diversity are presented in two categories: religion and money.

6.4.1.2.1 Religion.

Religion – and people acting in its name – have not always been kind to our target populations. As one participant stated:

Well, unfortunately, we’ve had thousands of years of religion going against most of the people in the world; things, horrible things being done out of religion. And so their personal opinion on us is, it has too much negative history for, for most people to be comfortable with (cisgender, bisexual-gay male, former sex worker).

The jurisprudential concept of the separation of church and state provides some indication that all people (including those with diversities) will be legislatively protected from faith-based judgement and persecution. According to a now Associate Professor of Constitutional Law at Monash University, the wording of the separation in the Australian Constitution lacks rigour and, as such, has been blurred by many recent prime ministers (Beck, 2008). Honorary Professor of Politics at Macquarie University, Maddox (2021) finds the theology of the current [now former] Prime Minister problematic, who has even said that he had a ‘divine calling’ to the office. The overlapping of church and state has impacted the mental health of this study’s participants. First, one third of interviewees queried the continued, generous funding to the many church-based community organisations in rural and remote Tasmania in light of their historical persecution of people with sex, sexual, gender, and erotic diversity. Findings suggest that the lack of church-state separation

was the rationale for the funding. The continued existence of so many faith-based organisations in rural and remote Tasmania is problematic as they are often the only places that provide free mental health support.

Secondly, the lack of church-state separation also impacted our participants via public morals. Public morals are principles enforced via laws, police, religion, or social expectations or pressure that often pertain to matters of sex (e.g. vice, coitus, conduct, identity, profession) sexuality, and gender (George, 2000). Smaller societies, like Tasmania, have less evolved, more rigid morals and are more modest (Barrett et al., 2016). While religion continues to inform and determine legislation, census data indicates that the percentage of Australians who have ‘no religion’ has been accelerating (30% in 2016). Tasmania has the lowest religious affiliation in the country (Australian Bureau of Statistics, 2017). Yet our participants experienced public morality-based stigma and discrimination.

Finally, 12 interview participants indicated that they were afraid of Religious Discrimination Bills. Starting in 2018 (and continuing to 21 March 2022), despite objection from the attorney general, anti-discrimination commissions, and human rights groups, the government has been considering legislation that privileges religion over – and to the detriment of – other rights; this legislation would also legalise hate speech and discrimination against LGBTIQ+ people (as well as people with disabilities, women, people who are culturally and linguistically diverse) on the basis of religion (Attorney General’s Department, 2019, 2020, & 2021; Karp, 2019a & b; Martin, 2019; TasCOSS, 2021).

6.4.1.2.2 *Money*

Thirty interview participants commented on government funding for mental health services in general as well as for specialised, outreach, and/or peer support-based services. Indeed, public expenditure on mental health is suboptimal. In 2019, only 69% of Australia’s public funding went on health, as compared with 79% of the United Kingdom’s (Organisation for Economic Co-operation and Development, n.d.). In 2019-20, 7.6% of Australia’s total health funding went to mental health (Australian Institute of Health and Welfare, 2022). Despite growing global attention to mental health and the fact that one in two Australians experience mental health

issues in their lifetime, mental health funding has not increased significantly in years (Australian Institute for Health and Welfare, 2020; Organisation for Economic Co-operation and Development, 2021).

Undoubtedly, these risk factors are nuanced and alone were not responsible for the generally poor mental health status of our participants. Still, they did contribute to some degree. And yet, sex, sexual, gender, or erotic difference is not a trope of risk and psychological damage. Rather, our participants revealed many things that contributed to and represented wellbeing.

6.4.2 Protective factors

Across both measures, our participants revealed an array of factors that insulated them against poor psychological outcomes and improved their mental health as well as their ability to cope with difficulty or oppression. These findings were consistent with those indicated in the two systematic literature reviews conducted for this study. Protective factors are compelling protection against mental illness and can indicate the presence of positive mental health and wellbeing (Jahoda, 1958).

A healthy sense of self, for example, is a protective factor as well as an important aspect of mental health (Peterson, 2018; Jahoda, 1958). Consistent with the systematic literature reviews, our participants demonstrated their sense of self across both measures, through self-acceptance, self-awareness, self-esteem, and self-pride. For example, sex workers demonstrated self-acceptance via their belief that sex work is empowering. Despite pervasive exogenous oppressions to the contrary (such as stigma and criminalisation), these participants all accepted and all but one were aided by the sex worker aspect of their identity.

Self-pride is the recognition of a positive quality in one's self (self-esteem). It is also deriving satisfaction from said quality. As demonstrated in the previous chapter, the pride that some participants felt regarding their identity or their job was a protective factor or was significantly correlated with normal resilience. Participants' pride demonstrates the nuanced nature of mental health and discredits discrimination and stigma against being LGBTIQ+, a sex worker, or kinky.

A healthy sense of self also includes appreciation for being part of something larger, external to one's self (Peterson, 2018). Survey participants agreed that their respective orientation/identity has become more publicly accepted in past 5 years and that being part of a sex/sexually/gender/erotically diverse community has a positive impact on their mental health. Public acceptance enhanced participants' resilience and improved their mental health.

The discussions pertaining to RQ1 and RQ2 demonstrate the juxtaposition of participants' internal selves and external worlds. The exploration of the individual in relation to the external continues with the remaining research questions, which pertain to help seeking and service use.

6.5 RQ 3 (Finding 3)

RQ3: What is the uptake of mental health services of LGBTIQ+ people, kink-identified people, and sex workers in rural or remote Tasmania?

Other research has found that rurality impacts uptake (Barefoot et al. 2015; Lyons et al. 2015). This study also supported that finding. Participants did use mental health services, but their uptake was mostly historical. At the close of data collection, 75.6% of survey participants and $n = 29$ interviewees (out of 33) were not currently seeing a mental health professional. That is, the vast majority of our participants were not accessing support.

In the absence of mental health services or due to a need for afterhours care, research indicates that people access hospital emergency departments (ED) for mental health support (Cohran, Sullivan, & Mays, 2003; Darling et al., 2013; Duggan et al., 2020). In Tasmania, these ED presentations for mental health support are increasing (Primary Health Tasmania, 2018c). More than one quarter of kinky survey participants (27.5%) reported accessing an ED for mental health support. ED MHP focus on triage and crisis; they are not equipped to offer ongoing or preventative care.

People also consult GP for mental health care when other options do not exist; in fact, Tasmania has the highest rate of GP consultations per capita (Ahmed et al., 2017). Relatedly, 89.4% of LGBTIQ+ survey participants reported seeing a GP for help with general mental health issues. Only, 57.1% found that the GP knew how to help them (meaning 42.9% did not). Twenty interviewees reported seeing a GP for help with general mental health issues; 14 had negative experiences. Primary Health Tasmania (2016) found that 66% of Tasmanian GP did not consider themselves adequately trained in mental health. The lack of training regarding mental health that ED staff and GP have is problematic in that it can impact subsequent help seeking and can worsen or cause mental health issues (Mastrocola, Taylor, & Chew-Graham, 2015).

Telephone helplines are often suggested as a solution to offset service-based limitations of rural areas (e.g. such as MHP workforce shortages or the lack of services) (Davidson, Bruer, & Cannell, 2017). Primary Health Tasmania promotes helplines (2022b; 2022c). The Government of Australia spends millions funding helplines (Australian Institute of Family Studies, 2022a; 2022b). Of the 31 national helplines and 3 Tasmania-based ones, only 1 national line is dedicated to LGBTIQ+ people (none are directly tailored to sex workers or kink-oriented people; Australian Institute of Family Studies, 2022a; 2022b). Helpline usage by LBGTIQ+ Australians with mental health issues ranges from 10.4% (McNair & Bush, 2016) to 30.0% (Lim et al., 2021). Roughly, 14.4% of our participants reported using phone helplines (15.4% of survey participants and four interviewees). Fear of discrimination or cultural incompetence from helpline staff are given as reasons in an Australian study for low uptake, which could explain our participants' low overall engagement (Lim et al., 2021). Helplines may be a solution for the general population in rural areas, however, they do not appear to be one for people who are sex, sexually, gender, and erotically diverse.

6.6 RQ 4 (Finding 4)

RQ4: What barriers to mental health help seeking do LGBTIQ+ people, kink-identified people, and sex workers encounter in rural or remote Tasmania?

Barriers were discussed extensively in the two publications and manuscript that arose from the dataset as well as in the two systematic literature reviews. Stigma, and its many ramifications, was a widespread barrier to care. When asked if, ‘There is stigma or negative attitudes around getting help for mental health issues’ – 80.8% of survey participants agreed/strongly agreed. Stigma is not exclusive to this study’s target populations; it is widely studied in literature globally (Bowen & Bungay, 2016; Grappone, 2018; Jiao & Bungay, 2019; Lyons, Hosking, & Rozbroj, 2015; Meyer, 2003; Quinn & Chaudoir, 2009; Rayson & Alba, 2019; Treloar et al., 2021; Reynish et al., 2020). Roughly 75.0% of all people with mental health issues in the country experience stigma. It is even a direct, organisational focus of the state government-funded Mental Health Council of Tasmania (2020). There were only 61 anti-stigma initiatives operating nationally in 2021, of which, six (9.8%) were occurring in Tasmania (Morgan, Wright, & Reavley, 2021). Of those six, three were ongoing and organised by Tasmanian organisations; the remainder were short-term campaigns (e.g. 1-day, 1-week) or run by national organisations (Morgan, Wright, & Reavley, 2021). Since 1998, the urbancentricity and urbanisation of mental health care funding and access in Australia has been criticised (Cheers, 1998). Still, it continues, even with anti-stigma initiatives.

MHP-based barriers were reported across both measures. Ignorance (lack of knowledge more so than rudeness) and dismissing participants were two primary shortcomings. Mental (and physical) health professionals’ shortcomings could stem from paternalism and classism, which can manifest as a reluctance to associate with (or learn about) people who differ from them (Hansen, 2019). A European summary of studies of MHP concluded that MHP are prejudiced against people with mental health issues, stating, ‘the more a person identifies the clinical picture of psychiatric illness presented to him or her [sic], the more they [the MHP] stigmatize persons with these illnesses’ (Rössler, 2016, p. 1252). These shortcomings have negative therapeutic consequences. MHP ignorance can reinforce participants’ internalised stigma and self-shaming. It also can render any therapeutic intervention ineffective as MHP ignorance will channel the client’s focus away from the reason they presented for support and redirect it onto the MHP ignorance. This ignorance then creates labour – instead of getting help for their issue within a therapeutic session, clients feel an obligation to educate MHP or expend emotional/mental energy

wishing the MHP was already upskilled or feeling that their diversity is not worth knowing about (Gavriel Ansara, 2019).

MHP dismissing or ignoring participants' identity was another barrier. What participants perceived as MHP ignoring their identity could be an example of the MHP adopting a neutral approach to all client-broached topics and not overtly focussing on anyone (Gavriel Ansara, 2019). Neutrality is presumed to give clients control over the focus (foci) of the session, but can also be unhelpful in that it can appear to be judgemental, rude, lacking in empathy, or as if the MHP is inexperienced. In the words of an interview participant who felt their sexuality was dismissed outright by a psychologist:

I never would have shared that stuff if I didn't want to talk about it. And so hearing it and then quickly moving on and shutting down any conversation around it was ... not in any way ... helpful or that was just purely, I think a lack of experience on their part (bisexual, kink-curious, cisgender woman).

Dismissal of a person's sexuality could indicate MHP judgement and discrimination (i.e., racism, sexism, homophobia, transphobia ...) which can re-traumatise; dismissals cause greater psychological harm when they come from a person in a position of trust (Open Counselling, 2022).

When inverted, barriers could be perceived as suggestions for improvement. These suggestions, however, could be seen as blaming MHP/services for issues that are actually systemic failures. These suggestions could minoritize the target populations in that they assume homogeneity (Semp, 2011). Education alone may not improve MHP competence. The internalised bias of transphobia is a learning barrier for MHP (Stroumsa et al., 2019). MHP who discount their professional competency regarding kink, have demonstrated attitudinal bias against the erotically diverse (Ansara, 2019; Kelsey et al., 2013). Assuming this bias also presents in MHP regarding this study's target populations, it could be posited that the MHP (and even the physical and sexual health professionals) our participants saw, were oblivious to the potential that they were harming their client/patients due to the hidden nature of their ignorance

and bias. Suggestions also assume that knowledge regarding sexual orientation, gender identity, and/or sexual difference in mental health services only pertains to a small percentage of the population (Semp, 2011). Instead, universalising services (and society and curricula) could ameliorate current views of and treatment of people with sex, sexual, gender, and erotic difference while avoiding minoritising and othering (Semp, 2011). The entrenchment of the medical model would make this difficult, but not impossible.

The eradication of barriers to help seeking is not simple, however, that most barriers our participants cited are modifiable and preventable, and that society is becoming increasingly mutable as people and lexicon are evolving, perhaps the hope that the mental health care industry and government will follow is not too farfetched. That our participants shared many factors that encouraged uptake could indicate this.

6.7 RQ 5 (Finding 5)

RQ5: What factors facilitate uptake of mental health care for LGBTIQ+ people, kink-identified people, and sex workers in rural or remote Tasmania?

Although uptake was historically, rather than currently high at the close of data collection, our participants had sought and used care. The inverse of barriers presented in the papers in the previous chapter (as well as in the literature reviews) could be facilitators, for example, while 42.9% of kink participants felt standard operating hours were a barrier, 57.1% did not. Also, 22.5% had to travel more than 30 to 120 minutes to get to an MHP/counselling service, however, travel for the remainder took less than 30 minutes. This demonstrates the complexity and ambiguity of help seeking and usage. For while people who are LGBTIQ+, sex workers and kink oriented are ‘underserved and often ill-served’ in mental health services, including in rural and remote Tasmania, they also engage with care (Romanelli & Hudson, 2017, p. 714).

Interviewee-specific individual factors that encouraged help seeking were a conscious decision to get care, a sense of duty to others, a desire to not die by

suicide, a desperation to be well, and a healthy sense of self. Combined, these factors indicate self-awareness – an ability to see one’s self objectively, to determine if their actions/thoughts align with their internal standards. Self-awareness indicates identity development (Kaufman & Johnson, 2004) and is vital to mental health as it lessens distress and improves functioning (Sutton, 2016). Participants’ own resources encouraged help seeking. While economic status is a systemic issue, participants who had money did access care more than those who did not. Direct social support was another facilitator. Support and encouragement from partners, family, and friends drew interviewees to counselling via gentle as well as not gentle ‘prodding’.

Interviewees cited MHP-based factors that encouraged them to seek care and/or made the help seeking experience a positive one. A staple of intersectional feminism, sex positivity is the rejection of patriarchal repression and oppression. Sex positivity is an important aspect of cultural competence, particularly as it pertains to working with this study’s target populations. A sex positive MHP is also seen to reject judgement, stigmatisation, and homonormativity and respect all sexualities. More than acceptance, sex positivity represents an inalienable belief in the right of bodily autonomy (Comte, 2014). Sex positivity helps people relate more effectively with their MHP (Moser, 2019). Participants positive therapeutic experiences represented a degree of ethical clinical practice and beneficial therapeutic outcomes. Effective MHP improved participants’ mental health and quality of life and lessened health disparities.

Services also encouraged help seeking. The primary way in which they did so was by existing. Lack of access is a sizeable barrier; thus, simply by existing, services encouraged uptake.

Candidate: Was there anything about a particular service that that drew you to it, that made you want to go there, made you want to use it?

Participant: No, it was just a matter of what was available. Really ... in the North West there’s very little to choose from. So no, it was just a matter of they are available ...

Surpassing this bare minimum, services retained clients and/or encouraged new ones. Services with a (complete or partial) framework rooted in equity that respected diversity improved target participants' uptake and contributed to their mental wellbeing. Of the 22 services that participants used, one service was uniformly praised by all interviewees who used it: the state's only LGBTIQA+ service. Participants found this service to be inclusive: staff asked for and used people's pronouns and names (despite what was indicated on forms); offered social support groups and drop ins, counselling groups, and one-on-one counselling; gave participants information and advice; and made referrals to psychiatrists for support with transitioning. Of the 96 LGBTIQA+ participants in this study who were the target audience of this service, only 4 participants accessed it. Participants' reasoning was its urbancentricity; 12 of the service's 14 staff members are based in Hobart, which explained its low uptake in rural and remote Tasmania and which participants found detrimental to their wellbeing.

Mental health services and service provision have been examined nationally and locally (Mental Health Council of Tasmania, 2021d; Wright, 2013). The need for improvement is obvious, however, as demonstrated, rural mental health services also possess strengths that benefitted our participants.

Systemic facilitators. The systemic facilitators to help seeking that participants cited in the survey and interviews corresponded with those presented in the literature reviews. Australia is a prosperous OECD country with the highest minimum wage in the world (Andreas, 2022). Except for those who reside in Outer Regional or Remote areas, its citizens can avail of public transportation and a hybrid public health system (in which public services are free or offered at a lower cost and which offers subsidies on therapy). These resources facilitated uptake. These resources also provide an excellent platform for improvements to the existing mental health system.

Stigma is one area where improvements are possible. Rössler (2016) states, 'Structural discrimination of the mentally ill is still pervasive, whether in legislation or in rehabilitation efforts'. However, structural discrimination (the manifestation of stigma) is improving (Morgan et al., 2021). The recently created National Stigma

and Discrimination Reduction Strategy gives hope. The Strategy aims to reduce self-stigma and public stigma, and begin attempts to eliminate structural stigma and discrimination against people with mental health issues in the mental health, physical health, education, social services and other settings (National Mental Health Commission, 2022). Roughly one quarter (23.8%) of kinky survey participants disagreed/strongly disagreed that there is stigma around seeking mental health support. In other words, approximately 25% of kinky participants possibly, believe positively in help seeking. Perhaps The Strategy will succeed and this optimism will spread.

Many factors had capacity to impact help seeking. Positive therapeutic experiences begot positive therapeutic experiences – when participants benefitted from help seeking, they tended to continue help seeking. The pervasiveness of informal help seeking demonstrates how successful help seeking can be when participants were accepted and supported. Positive support can have additional profound beneficial consequences: standardisation of difference; improved mental health; reduction of psychological distress; and reduction of isolation.

In summary, this research represents mental health and related service use scaffolded against mental health disparities based solely on difference. This research featured people who flourished, maintained, and languished; who were resilient and who also endured. Their mental health status indicates that generally, most participants were struggling, yet most opted not to engage in clinical care. The lack of engagement could be indicative of a fragmented clinical care system in rural and remote Tasmania for populations that are sex, sexually, erotically, and/or gender diverse. The lack of engagement also indicates endurance; while resilience is a response to a difficulty, endurance is carrying on regardless of whether or not there are difficulties.

This study acknowledged the inequity and inequalities and addressed the absence of literature regarding the research questions, thereby, attempting to increase representation in the literature of this study's target populations. This study challenged the notion of 'normal' and emphasised the fluidity of people's gender, sexuality, and erotic nature. This study integrated the diversity of gender, sex, and

sexuality (and their differences) in research and clinical practice. In part, this study represented a social causation approach via its examination of those factors that helped and harmed mental health. It also represented a multi-level analysis in that it included analysis of many factors of mental health and mental illness (Pugliesi, 1992). Together, these approaches emphasised the impact of systemic and relational realities on our participants' lives and wellbeing. Sources of distress can become resources. Risk factors can become protective factors; barriers can become facilitators; protective factors, resilience, and endurance can be harnessed. Our participants' identities are important to them and some have many identities that give them meaning and buffer them against the issues that are tied to particular roles and that are exogenous in origin. The mental healthcare system is not protecting our participants from being unwell, rather, they seemed to have been doing that for themselves. Then again, the mental healthcare system is still evolving; still embracing what was once (and sometimes still is) pathologised.

7. CONCLUSION

7.1 Introduction

Societies have been pathologising sex as vice, coitus, conduct, identity, or profession, and sexuality and gender diversities for centuries (Frances, 2017; Holler, 2009; Prunas, 2019; De Block & Adriaens, 2013). Maintaining one's mental health can be complex, and is further complicated when this public, pervasive scrutiny and pathologisation is coupled with rurality and compromised bodily autonomy. Sexual configurations theory, queer theory, and intersectional feminism grounded in bodily autonomy and social justice comprised this study's theoretical basis. This framework has enabled the candidate to render visible the ways in which sex, sexual, erotic, and gender diverse peoples' mental illnesses have been mediated through and unsuitable mental health systems and a socially conservative society. Throughout the study, the impacts of homonormative, hetero-patriarchal biases have been demonstrated, but so too have the benefits of salient identities, community belonging, and self-acceptance. The remainder of this final chapter includes achievements of the research, as well as recommendations, limitations, and areas for future research.

7.2 Achievements of the study

The study achieved its aim of gaining insight into the mental health and service use experiences of the target populations in a local context. The intent of this mixed-method study was to generate preliminary data about the target populations in the state, acknowledging that the findings would not exclusively be positivistic. The purpose was to glean *a posteriori* knowledge about the candidate's *a priori* clinical experience. The systematic literature reviews (Chapter 2) revealed several gaps in the literature regarding the mental health of sex workers, LGBTIQ+ people, and kink-oriented people despite their shared increased risks of mental illness and compromised access to bodily autonomy. The literature reviews also revealed that these populations have mixed mental health statuses, worsened by many exogenous oppressions. The reviews concluded that uptake is also mixed. Uptake increased with affordability and access – when there were services located in participants'

towns and when there was culturally competent, educated MHP of which to avail. Uptake decreased due to stigma, homophobia, transphobia, whorephobia, pathologisation, and unmet need. The reviews demonstrated that there are whole-system issues with mental healthcare of people with diversities that impact mental health and help-seeking.

Preexisting mental health issues and service-usage experience were inclusion requirements, which were demonstrated in the three papers that resulted from this study (Chapter 4). The degree to which participants' mental health status was as generally poor as it was, was an alarming finding. The low current usage rates of services were somewhat surprising, particularly in light of the high mental illness rates. Also surprising was the amount of barriers that participants reported (which, perhaps *ipso facto* explained the low uptake). The findings regarding the benefits of resilience, positive self-attitude, inclusion, and acceptance were uplifting. That these positive attributes improved participants' mental health, and possibly, to some degree, diminished the need for therapeutic support and arose out of the poor quality of support received was interesting. The more diverse a participant was, the worse their mental health, the lower their protective factors and resilience, and yet, there was also much capacity to embrace social and informal support. When dealt with a mental health system that, for the most part, did not work for people who predominately had H/VH psychological distress and comorbidities, informal social support and personal strength were fundamental.

7.2.1 Significance of the Research

This work suggests a new narrative of mental health that positions the people with the issues/diagnoses – and not MHP – as the experts. This study indicates that perhaps mental illnesses have become a common, accepted part of the target populations' lives and that mental health is not merely something people have or do not have. This subsummation of mental health issues as a reality demonstrates the presence and importance of superior psychosocial functioning, and reveals significant implications for service delivery. The study also had theoretical and contextual application and significance.

7.2.1.1 Theoretical Application

There were many practical applications of this study's theoretical framework. Simply by existing and via the publications and (adopted and implied) opportunities for knowledge transfer, this study advances social justice, advocates for people's human rights, and facilitates a reinterpretation of the present. It represents an attempt to bring fairness for people with diversities into research, policy, society, and systems. While working with populations that are marginalised, the candidate employed tenets at the heart of queer theory: reciprocity, participant safety, participatory approach to research, and 'homopositiv[ity]' (Semp, 2011, p. 74). That is, members of the target populations helped shape the research tools; the participant employed a queer sensitivity by sharing her pronouns and pansexual orientation with interviewees; and it was clearly stated on the survey and at the outset of interviews that the data was going to be used to promote social action and improve service delivery, thus demonstrating homo/trans/poly/sex positivity (Semp, 2011). A feminist approach manifested practically via addressing power differentials and establishing trust in navigating the researcher-participant relationship. For example, participants were given the option to receive a PDF of publications arising from their participation as research findings can 'empower or educate those involved' (Lub, 2015, p.2). Comments the candidate has received from participants to date regarding the PDF include:

You have done such amazing work for the sex industry and other minority groups. It will benefit us and the next generation to come (regarding Reynish et al., 2021)

A well-worded and presented publication that does open up further lines of investigation while also offering those seeking help the possibility of better outcomes. You are a champion! (regarding Reynish et al., 2022)

Practical examples of feminism employed in this research include the fact that people were provided the opportunity to tell their stories, voice their needs, and via a request for recommendations, seek collective solutions to individual issues.

7.2.1.2 Theoretical Significance

This study may be the first to realise Sexual Configurations Theory (SCT; van Anders, 2015); no other research could be found that integrates gender, sex, and erotic diversity/sexualities as outlined by SCT. This study incorporated multiple interpretations of sex and sexuality by openly exploring its participants' many orientations, thereby integrating the diversity of gender, sex, sexuality (and their differences). This manifestation and advancement of SCT demonstrated that sexual identity, orientation, and status are related, but distinct and crucial to meaning making (regarding mental health) due the variety of factors involved (van Anders, 2015).

This study advances equity and equality in unique ways. It challenges the harmful heteronormative and cisnormative status quo; it honours the fluidities of genders and sexualities; and it challenges the binary (Clarke et al., 2010; Sedgwick, 1990).

Throughout society, including in the mental health system, there is what Rubin (2007) calls, a 'moral hierarchy of sexual activities' (p. 151). This hierarchy accords the highest status to vanilla, monogamous, married heterosexuals; lesbian and gay couples that emulate this are next, and so on, to the lowest status, which is reserved for people who are transgender, kink-oriented, or sex workers. This study rejects the fact that some sexualities (and people) are elevated and legitimised over others. This study affords equal representation to all participants. This study demonstrates that aleatory or discretionary inclusion/exclusion discounts the diversity of human identity and harms mental health. Shedding light on the way in which intersecting oppressions affect the target populations, this study illuminates the sometimes oppressive realities of service delivery as it is currently, and represents a starting point for change.

7.2.1.3 Contextual Significance

This study is empirically significant for mental health, rural, feminist, queer, sexual configurations, ethics, human rights, identity, public health, physical health, and sexual health scholarship to varying degrees because offsets the dearth of Australian-based and Tasmania-based research. This study provides insight into the mental health service usage, experiences, and impressions of LGBTIQ+, sex worker, and kink-oriented rural and remote Tasmanians and the mental health issues

that brought them there (or kept them away). The target populations were explored with rigour and the findings offer a multifaceted look into the impacts of and possible solutions for modifiable, exogenous oppressions. No research could be found that combines people who are LGBTIQ+, sex worker, and kink-oriented on the basis of compromised access to bodily autonomy. Limited research exists that advances kink as a sexual orientation. No research could be found that merges kink with LGBTIQ+ people for reasons relating to the fluidity and diversity of sexuality and identity; the evolution of the construct of sexual orientation; the shared experiences of discrimination and pathologisation; and/or the socio-political importance of all diverse people. Increasing understanding of LGBTIQ+ people's, sex workers', and kink-oriented people's mental health and related services experiences will progress scholarship on gender, sex, sexuality, identity, and psychology, counter their erasure from theory and practice, improve health service, improve practice, inform government policy, and identify gaps and solutions in mental health care for marginalised populations. This study demonstrated how a lack of acceptance regarding diversity can exacerbate mental health and how inclusion can improve it. It showed how internal resources such as resilience, endurance, and a healthy sense of self can benefit mental health and how important these internal resources are in the face of exogenous oppressions and absent or poor mental health services.

Furthermore, this study makes significant contribution as the first study of Tasmanian LGBTIQ+ people, sex workers, or kink-oriented people given the gaps in national and state-based documentation. That is, national mental health research tends to exclude Tasmanian LGBTIQ+ people, sex workers, or kink-oriented people altogether or combine the Tasmanian data with other findings (Australian Institute of Health and Welfare, 2012, 2015, 2019, 2022; Boza & Perry, 2014; del pozo de Bolger et al., 2014; Graham et al., 2017; Harris, Nilan, & Kirby, 2011; Hill et al., 2020; LGBTIQ+ Health Australia, 2021; Leonard & Metcalf, 2014; Leonard et al., 2012; Lyons, Hosking, & Rozbroj, 2015; McNair & Bush, 2016; National LGBTI Health Alliance, 2020; Rayson & Alba, 2019; Rosenstreich, 2013; Sprod, Hocking, Tomnay, 2020). In fact, a national study on Australians who are marginalised excluded our target populations (Cruwys et al., 2011). The state-based documentation regarding any of our target populations or their mental health is

equally sparse or non-existent (Department of Health, 2018; Department of Health and Human Services, 2009 & 2015; Mental Health Council of Tasmania, 2018, 2021a, 2021b, 2021c; Primary Health Tasmania, 2022a, 2021d, 2019a, 2019b, 2019c, 2019d, 2018a, 2018b, 2018c, 2016).

The significance of this study's contribution also extends to its rural context. This research at least partially addresses requests for a fuller understanding of rural LGBTIQ+ experience that have been shared in academia since 1995 (Bell & Valentine, 1995; Grant & Nash, 2020). This research may inform clinical practice, which may partially dilute the criticised urbancentricity and urbanisation of mental health care funding and access (Cheers, 1998). In light of the fact that urban mental health approaches are said to not work in rural areas (Commonwealth of Australia, 2018), this study may contribute to laying the groundwork for diluting the 92% of the mental health funding that urban Australia receives versus the 8% that remote Australia receives (Wright, 2013). This study may also aid to the development of some localised approaches to care. The first of its kind, this study has important implications for LGBTIQ+ people's, sex workers', and kink-oriented people's mental health throughout Australia as well as in other rural and remote areas worldwide.

7.2.2 Knowledge transfer

Starting in September 2018, the ideas, findings, and outputs of this study have been shared with academics, the general public, community organisations staff, employees of government health department, and more. From three annual research symposia to two national conferences, the candidate's knowledge as represented via this study was shared with faculty and staff from UTAS as well as other universities, most of whom with research areas much different than that represented in this study. Via two interviews on a local ABC Radio show, the candidate was able to share aspects of the research with the general public. A presentation to fellow mental health professionals also occurred. The candidate also presented to the target populations involved in the research at three community forums and at National Coming Out Day. Presentations to employees and volunteers of community-based organisations who work with and serve the target populations also occurred at a pride event. Finally, a presentation to Public Health Services, Department of Health,

Tasmanian Government, was attended by staff and management as well as public health practitioners from throughout the state. At all events, knowledge about the unique and important topics represented in this study moved between the candidate and the people affected and represented, as well as to potential users of the knowledge (Please see the section entitled Achievements from the Work Presented in this Thesis for citations).

7.3 Recommendations

The theories that are underpinned in this study prioritise a commitment to advancing social justice through research. Acknowledging the existing inequities regarding rights and opportunities, interview participants hoped that sharing their narratives could impact social, political, and structural change. The low service consumption and surplus of exogenous oppressions that were demonstrated in this study highlight the need for more inclusive and meaningful engagement with people with diversities. This study's implications for government policy and service delivery follow.

The key recommendation, which encompasses the majority of recommendations, is the universalisation of the mental healthcare system; that is, mental health policy, procedures, curricula, services, and MHP should become more universal (Sedgwick, 1990; Semp, 2011). The mental healthcare system should be one in which all people have 'determinative importance' (Sedgwick, 1990). Universalisation would begin to unentrench heteronormativity, cisnormativity, whorephobia, and pathologisation and demonstrate adherence to human rights, professional codes of conduct, and ethical requirements.

First, universal mental health policies that include sex, sexuality, gender, and erotic difference should become standard (Semp, 2011). Holistic and inclusive policies would begin to ameliorate current views of and treatment of people with difference, improving mental health. Approaches stemming from urban mental health policies are demonstrated to not work in rural areas (Commonwealth of Australia, 2018); thus, urbancentric policies should be replaced with rural centric ones. Initiatives

implemented in other, comparable rural areas could be adopted for use in rural Tasmania (Commonwealth of Australia, 2018).

Secondly, procedures relating to mental health funding, research, and the work of MHP should also be universalised. It is well documented that people with sex, sexuality, gender, and erotic difference who reside in rural areas have worse mental health than their urban counterparts (Lyons et al., 2015; Stotzer et al., 2014; Walinsky & Whitcomb, 2010; Willging et al., 2018). It is also known that the impacts of rurality (increased homophobia, isolation, identity concealment, and limited community belonging) affect mental health (Barefoot et al. 2015; Lyons et al. 2015). It is also known that rates of suicide and self-harm increase with remoteness (National Rural Health Alliance, 2017). Yet, remote Australia gets 8% of the mental health funding that urban Australia receives (Wright, 2013). Equitable funding would be a start to reducing these disparities.

Planning and implementing a universalised approach to mental healthcare in rural and remote Tasmania will take time. In the interim, government could adequately fund existing and new mental health services, including ones that provide free support or have staff dedicated to diverse people. It could fund outreach services, the hiring of additional MHP to address waitlists and restrictive operating hours, and the training and hiring of peer support workers.

Research procedures, as managed by the National Health and Medical Research Council, could adopt a universal approach. For example, they could institute a community-based requirement such that the populations under review (particularly people who are hidden, underserved, or marginalised) are engaged in the research. This type of research is a form of collective action that encourages social and political change (Treloar et al., 2021). Universities could also institute such an approach.

MHP could universalise their work by offering culturally competent care; assuming agency in their clients; avoiding the perpetuation of shame; working from a whole-person and collaborative approach; employing sex worker affirmative therapy that acknowledges the impact of stigma; remaining client-centred (put aside internal

bias); using strength-based and trauma-informed care; and taking direction from their clients. MHP could make it standard practice to share their pronouns and sexual orientation to tackle heteronormative assumptions (Semp & Read, 2015).

The universalisation of curricula for all MHP would facilitate the provision of care that is responsive to the needs of people who are sexual, gender, and erotic minority people and offset gaps in knowledge and cultural competence. Advancements made elsewhere in the area of queer curriculum could be adopted locally (Couto & Pocahy, 2017; Shortall, 2017; Hillock & Mulé, 2017). Community education could become a requirement of curricula to contextualise the curriculum and lighten the issues that arise from paternalism and classism. Curricula could include the following topics: gender and sexuality training, empathy, diversity, body positivity, self-awareness, polyamory, critical reflection, inclusivity, and inclusive language.

Services could also become universalised and demonstrate a commitment to barrier reduction. Services could diversify offerings via flexible operating hours and ‘free/reduced-cost counselling; after-hours appointments; all-ages counselling; client-determined settings for service; and outreach support’ (Reynish et al., 2019, p. 1). Services could actively commit to diversity hiring and ensuring staff are proven allies. Inclusive language could be mandated throughout services ‘from the filling out of forms to the comfortability of a consultation’ (National LGBTI Health Alliance, 2013; Nic Giolla Easpaig, 2015, p. 37).

Other recommendations include the enforcement of Anti-discrimination legislation and the decriminalisation of sex work. These additions would enhance competency and capacity for all involved. Without improvement in rural and remote care delivery, mental illness and suicidality rates are likely to continue to increase.

7.4 Study Limitations

In addition to those limitations outlined in the systematic literature reviews and the papers in the previous chapter, this study had other limitations. As an enfranchised, educated, White, middle-class, cisgender woman who is a MHP, the candidate has

many privileges that include inherent bias, which likely skewed the viewpoints and findings of this study. While the candidate attempted to be demonstrably rigorous in her analysis and understanding of participants' meaning, distortion could have occurred. At 174 questions, the survey was too long and was repetitive for participants with multiple identities. This resulted in nonresponse and diminished participant experience. Some items in the survey combined different dimensions in the one question, which may have skewed results. The survey was not optimised for completion on a mobile phone; this may have disadvantaged people who most often use a mobile phone to access the internet or who did not own a tablet or computer and may have impacted recruitment and the final sample size. Blocks of survey questions were not randomised to minimise order effects, which is a limitation of the design. Some survey and interview questions were direct. While this facilitated data gathering and simplified the survey, it also unitised participants. For example, when asked about sexual orientation, survey participants were presented with a list (multiple responses were possible); interviewees were asked, 'What is your sexual orientation?' This question assumes the participant only has one. The alternate phrasing, 'How do you describe your sexual orientation?' would have been more appropriate to glean a deeper understanding given that people could have multiple orientations that could differ based on preference or context (Semp, 2011). The homogeneity of the interview participants who were mostly rural (not remote), White, and middle-class was another limitation. The intersecting privilege of whiteness and class skewed this study's findings and reduced their generalisability. The combination of the three target populations was also a limitation in that they do not all experience the same level of mental health issues, the same access issues, or the same risk factors; for example, within the LGBTIQ+ community, some populations are more likely to experience discrimination and marginalisation (or at a higher rate) than others, leading to different outcomes in regards to mental health. Although the unifying rationale of their compromised access to bodily autonomy stands as an overarching justification, combining all groups together into one thesis resulted in a partial exclusion of their differences. The lack of control populations in this research impacts the conclusions that were drawn. Future work that includes control populations would improve the validity of the findings. The study also contains the following quantitative analysis limitations: the use of unstandardised measures (the psychometric properties of the developed survey were not tested); the

use of a convenience sample size (as opposed to one determined by a power analysis); and the number of single item analyses that were conducted. The small sample size reflected the nature of the rural population that it was recruited from, with large heterogeneity within the sample. This precluded attempting predictive analysis due to small subgroups. Notwithstanding the limited power of the sample, the outcomes were supported by the qualitative findings, bolstering the rigour of the conclusions. Finally, this study's sample size would also be considered a limitation if representation and generalisability were the purpose of the study. These limitations highlighted many possibilities for future research.

7.5 Future Research

While this study was the first of its kind in the state, its completion exposed several research gaps (in addition to those included in chapters 2 and 5). Suicidality and mental health status require further research based on specific identities and intersectionalities as well as with control groups. The mental health of the specific sub-identities of the target populations could be examined independently and in a more in-depth manner to as to draw conclusions unique to each orientation/identity and this state. Transgender people's experiences with psychological assessments causing harm and specifics regarding the ignorance of MHP could also be explored. The specific impact of our participants' sexual orientation and/or rurality on their mental health was not directly explored. Adding to the small amount of research on the impacts of poor therapy, a measure of the actual numbers of diverse people who have encountered an injurious MHP could lead to systemic improvements in care provision.

7.6 Conclusions

This research is the first-ever study to investigate the mental health and related service use of kink-oriented people, sex workers, and LGBTIQ+ people in rural and remote Tasmania. It is also the first-ever study to combine kink-oriented people,

sex workers, and LGBTIQ+ people in one study under a compromised bodily autonomy lens. This study adds to the body of knowledge regarding barriers and enablers to uptake and mental health status of the target populations by providing a comprehensive exploration into risk and protective factors and experiences with care. The mental health of the target populations must continue to be studied due to the continued pathologisation and exogenous oppression that have led to higher rates of mental illness and psychological distress than their of vanilla, non-sex working, heterosexual, cisgender, mononormative peers.

This study has made a significant contribution to the body of knowledge of Tasmanian people with sex, sexual, erotic, and gender diversities because of the profound impacts of rurality that participants experienced. Arguably, the findings of this study have implications to other rural areas given research shortages and similar experiences. As with any pioneering work, the findings of this study indicate many opportunities for future research. The publications that arose from this study provide the foundation for an evidence base regarding the mental health and service usage of diverse populations in rural and remote areas. Finally, this thesis provides an in-depth, feminist, queer, sexual configurations-based psychological account of the mental health of LGBTIQ+ people, sex workers, and kink-oriented people in rural Australia and how they navigate mental healthcare services, manage exogenous oppressions, and – most importantly – thrive due to resilience, self-worth, endurance, and social support.

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Appendix 1 Interview Topic Guide

- a) Are you aware there is a survey you are eligible to complete as well?
- b) What makes you eligible to participate in this study?
- c) What is your sexual orientation?
- d) What sex were you assigned at birth?
- e) What is your gender now?
- f) What pronouns do you use?
- g) In what city or town do you live now? OR In what city or town in rural Tasmania did/do you live?
- 5. Please describe your overall mental health.
- 6. What hinders your mental health and what improves it?
- 7. What has been your experience with seeking help with mental health issues in rural Tasmania?
- 8. What kind of help have you sought?
- 9. Where have you gone for help?
- 10. Can you tell me about anything that encourages you to seek help when you need it?
- 11. Can you tell me about those things that get in the way of you seeking support?
- 12. Have you ever seen a GP for a mental health issue?
- 13. If yes, how was that – what were they like?
- 14. What is it about a counsellor that makes you see them for help?
- 15. What is it about a particular service that makes you go there for help?
- 16. What things in a counsellor make you not want to use or avoid them?
- 17. What things will make you stay away from a service?
- 18. Generally, what are your thoughts on how well counsellors serve and treat you?
- 19. Do you think counsellors treat you differently because you are [sex, sexually, or gender diverse or a sex worker], and if so, how?
- 20. What could counsellors improve regarding what you want in a mental health care provider?
- 21. What is missing from counselling services regarding how you want to be supported with your mental health?

22. What things do your family, friends, society, the public or the government do that help or hurt your mental health?
23. Is there anything else you want to add?

Appendix 2 Online Research Survey

Invitation

This study is exploring the mental health of sex, sexually, and gender diverse people in rural or remote Tasmania (which we define as anywhere in Tasmania outside of Hobart). The research team consists of Tamara Reynish (PhD Candidate), Dr Ha Hoang, and Dr Heather Bridgman from the Centre for Rural Health, UTAS, and Dr Bróna Nic Giolla Easpaig from Macquarie University. We are exploring mental health and those things that either keep or help people to get mental health support. We would also like to learn about what things you'd like in a counsellor/psychologist or a mental health service.

Purpose of the study

The main purpose of the study is to look at: 1) the uptake of mental health services among sex workers and sex and gender minority people in rural or remote Tasmania, and 2) the barriers and enablers influencing sex workers and sex and gender minority people access to mental health services and their impacts on their mental health.

We are also interested in seeing how people who do not have bodily autonomy or the right to use their body (sex, sexuality or gender) the way they choose manage their mental health in rural or remote Tasmania. This study is the first of its kind in the state and has important implications for policy, legislation, mental health care, and advocacy for sex, sexually, and gender diverse people and sex workers.

What is being asked of you

You are being asked to complete an anonymous survey (which starts on the next page) about your experiences with mental health care in rural or remote Tasmania. The survey will take about 20 minutes to complete.

After completing the survey, you will be asked if you want to volunteer to participate in an interview with a researcher. The interview will run for 60-90 minutes and we will talk more about your mental health and your use of related services. All people who are interviewed will get a \$30 Coles Myer gift card.

Possible benefits of participating in this study

Your involvement will help deepen our understanding of mental health and related service use among sex, sexually, and gender diverse people and sex workers in Tasmania. It may also give you some relief, empowerment, and a feeling of pride in being able to help us. Everyone who finishes the survey can enter into a draw to win one \$100 Coles Myer gift card. Everyone who participates in an interview will get a \$30 Coles Myer gift card. Contact information for the draw will be separate and *not* connected to the survey.

Possible risks of participating in this study

It is possible that you may experience discomfort as a result of talking about your mental health and related experiences. Research demonstrates that discomfort or distress after research participation is rare, and that participation can actually have a positive reaction.

If you are experiencing distress or want to stop the survey at any time, simply close the browser window.

If you need support, please seek help. Here are some places you can contact for support:

Qlife: 1 800 184 527 (3:00 pm-midnight daily) or <https://qlife.org.au/>

Lifeline: 13 11 14 or <https://www.lifeline.org.au/>

Beyondblue: 1 300 224 636 or www.beyondblue.org.au/

Rural, Alive and Well: 1 300 4357 6283 or <http://www.rawtas.com.au/>

The Suicide Crisis Text Line: 0477 131 114 - National text line, operating daily from 6-10pm

Change of mind

Participation in this study is voluntary. If you change your mind during this online survey portion of the study you can withdraw at any time and no explanation will be required. To withdraw, all you need to do is close the browser window.

The study results

Papers written based on this research will be published in academic journals and used in presentations at conferences and public forums. Participants will be de-identified so as to ensure anonymity - your name will *not* be used.

Questions or copy of study results

If you would like a copy of the study results or if you have any questions or comments about this study, please contact PhD Candidate, Tamara Reynish: Tamara.Reynish@utas.edu.au or 04

Concerns

This research has been approved by the Human Research Ethics Committee (HREC) (Tasmania) Network. If you have any concerns about this survey, feel free to contact the HREC: (03) 6226 7479 or email ss.ethics@utas.edu.au. Quote Ethics Reference Number H0018041.

Language

Except where stated, the word “counsellor” will be used in the survey to represent all mental health professionals and service providers including therapists, psychologists, psychiatrists, social workers, religious leaders or clergy, and community leaders or elders.

Questions about you

1. How old are you? (Please enter your age)
2. What is your postcode? (Please enter your postcode in the box below. This study is about and designed for people who live in rural or remote Tasmania or areas outside of Hobart or have in the last 12 months. If you do not wish to include your postcode, leave the box blank and proceed to the next question).
3. Have you experienced mental health issues or concerns at some point in your life? (Yes/No)
4. What is your gender? ([Cis] Female, [Cis] Male, Trans female, Trans male, Sistergirl, Brotherboy, Non-binary (gender fluid, gender neutral, bigender, gender non-conforming), Another gender)
5. What gender were you assigned at birth? (Male, Female, Not on the list? Type here)
6. Are you? (Lesbian, Gay, Straight/heterosexual, Bisexual, Asexual, Pansexual, Queer, Gay for pay, Not on the list? Type here)
7. Are you intersex? (Intersex people are born with physical sex characteristics that don't fit medical and social norms for female or male bodies) (Yes/No/Unsure/prefer not to say)
8. Are you: (Single, In a relationship, Married, Polyamorous, Separated, Divorced, Widowed, Not on the list? Type here)
9. What's your highest level of education? (Year 9 or under, Year 10, Year 12, TAFE, University undergraduate degree, University postgraduate degree, Not on the list? Type here)
10. Are you or have you ever been a sex worker? (Do/Have you regularly accepted goods or money in exchange for consensual sexual services or acts?) (Yes/No)

11. Are you into kink or bondage, discipline, domination, submission, sadism, and masochism (BDSM) or role play, impact play, temperature play, sharp play...? (Yes/No)
12. What is your main source of income? (Full-time job, Part-time/casual job, Centrelink or another type of government benefit, Student, Don't work/Home duties)
13. There is stigma or negative attitudes around getting help for mental health issues (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
14. There is stigma or negative attitudes around having mental health issues (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
15. I am/have been homeless/lived rough/couchsurf (Yes/No)
16. What drugs do you use and how often? (Marijuana, Amphetamines [speed, uppers], Methamphetamines, [crystal meth, ice], MDMA, Ecstasy, Cocaine, Heroin, Methadone, Alcohol, LSC, Mushrooms, Ketamine [Special K, ket], Nitrous oxide [nitro, whippet], Benzodiazepines [benzos, downers, xannies], Tobacco, Not on the list? Type here, Daily, Weekly, Monthly, In the last 6 months, In the last 12 months, No, if you selected 'Not on the list?' above, please specify).
17. What mental health issues do/have you had? (check all that apply) (Anxiety, Bipolar, Depression, Gender dysphoria, Disassociation, Eating disorders, Compulsion [OCD], Paranoia, Post-traumatic stress disorder [PTSD], Psychosis [delusions, hallucinations], Schizophrenia, Substance use, Self-harm [Non-suicidal self-injury] Not on the list? Type here)
18. In the past year, I have tried to die by suicide (Yes/No)
19. In my lifetime, I have tried to die by suicide
20. I have good social support from a significant other, family, friends, community, or peers (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
21. I have seen a counsellor for issues with my mental health at some point in my life (Yes/No)
22. What kind of counsellor have you seen? (therapist, psychologist, counsellor, psychiatrist, social worker, religious leader or clergy, community leader, elder, unsure what their role was, Not on the list? Type here)
23. Where are you accessing a counsellor? (Please know your responses will be coded and you will not be identifiable. If you do not wish to reply, leave the box blank and proceed to the next question) (Anglicare, Private psychologist, Private psychiatrist, Headspace, Relationships Australia, Laurel House, Rural, Alive and Well [RAW], Youth, Family, Community Connections [YFCC], Wellways/My Fellowship, Private social worker/counsellor/therapist, Parkside Community Mental Health team, Missiondale, Telephone helpline [Qlife, Lifeline, Beyondblue], In-patient/Community mental health team, Aboriginal health service, Not on the list? Type here)
24. I am able to see a counsellor as soon as I need support or help (Yes/No)
25. There is a counsellor/counselling service near where I live (Yes/No)
26. My travel to a counsellor/counselling service takes me (less than 30 minutes, 30-60 minutes, 60-90 minutes, 90-120 minutes, more than 120 minutes)
27. I have paid for mental health support appointments (Yes/No)
28. I can afford to pay for mental health support appointments (Yes/No)
29. I have used the hospital emergency department for mental health issues (Yes/No)
30. I have seen a general practitioner (GP/doctor) for issues with my general mental health (Yes/No)
31. The general practitioner (GP/doctor) knew how to help me with my general mental health issues (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
32. Have you experienced? Any of the following (please check all that apply) (A lack of mental health services in my area, especially ones that are specialised or tailored to my needs, A lack of counsellors in my town/area, A mental health service with

limited operating hours, A mental health service/counsellor is located too far from my home, A service/counsellor that provides exactly the kind of support I need, Long wait lists, Too expensive, Appointments are hard to keep, A lack of public transport to get to mental health service, No private healthcare, A lack of trust in counsellor).

Questions about your mental health and resilience

1. During the *last 4 weeks*, about how often did you feel tired for no good reason? (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
2. During the *last 4 weeks*, about how often did you feel nervous? (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
3. During the *last 4 weeks*, about how often did you feel so nervous that nothing could calm you down? (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
4. About how often did you feel hopeless during the *last 4 weeks*? (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
5. About how often did you feel restless or fidgety during the *last 4 weeks*? (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
6. During the *last 4 weeks*, about how often did you feel so restless that you could not sit still? (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
7. During the *last 4 weeks*, about how often did you feel depressed? (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
8. During the *last 4 weeks*, about how often did you feel that everything was an effort? (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
9. About how often during the *last 4 weeks*, did you feel so sad that nothing could cheer you up? (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
10. About how often during the *last 4 weeks* did you feel worthless? (None of the time, A little of the time, Some of the time, Most of the time, All of the time)

In these next 6 questions, please indicate the degree to which you agree with each of the following statements:

1. I tend to bounce back quickly after hard times (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
2. I have a hard time making it through stressful events (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
3. It does not take me long to recover from a stressful event (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
4. It is hard for me to snap back when something bad happens (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
5. I usually come through difficult times with little trouble (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
6. I tend to take a long time to get over setbacks in my life (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)

Questions about sex, sexually, and gender diversity demographics and attitudes

1. Do any of your friends or family know that you are sex, sexually or gender diverse? Yes/No/Unsure/prefer not to say)

2. Sex, sexually or gender diversity has become more accepted over the past 5 years (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
3. The Australian Postal Survey on Marriage Equality was unfair (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
4. All of my IDs (driver's permit/license passport, birth certificate) have my correct name and gender on them (Yes/No)
5. Most of my friends and family use my correct name and pronouns (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
6. I am afraid to dress and act in public in a way that honours my true [sic] sex, sexual, or gender identity (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
7. My family kicked me out/rejected me when they found out I am sex, sexual, or gender diverse (Yes/No)
8. I avoid using public toilets because I am afraid of confrontations or problems that may arise because I am sex, sexual, or gender diverse (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
9. I have to educate people on what it is to be sex, sexual, or gender diverse (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
10. I experience mislabelling, misgendering, and other cis or heteronormative assumptions (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
11. How old were you when you knew you were sex, sexual, or gender diverse?

Questions about sex, sexually, and gender diversity and your mental health

1. Most of my mental health problems have to do with my being sex, sexually, or gender diverse (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
2. I have been discriminated against/abused/harassed because I am sex, sexually, or gender diverse (Yes/No)
3. I am proud of being sex, sexually, or gender diverse (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
4. I feel like an outsider because I am sex, sexually, or gender diverse (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
5. I am ashamed of being sex, sexually, or gender diverse (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
6. Being part of a sex, sexually, or gender diverse community has a positive impact on my mental health (None of the time, A little of the time, Some of the time, Most of the time, All of the time)

Experiences with mental health services and service providers

1. I have seen a counsellor for issues with my mental health relating to my sex, sexual, or gender diversity (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
2. The counsellor knew how to help me with my mental health issue relating to my sex, sexual, or gender diversity (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
3. I was completely open with the counsellor about my sex, sexual, or gender diversity (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
4. The counsellor needed me to teach them about sex, sexual, or gender diversity (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
5. I have seen a general practitioner (GP/doctor) for issues with my mental health relating to my sex, sexual, or gender diversity (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)

7. The general practitioner (GP/doctor) knew how to help me with my mental health issue relating to my sex, sexual, or gender diversity (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
8. I have experienced the following *from a counsellor* or while seeking mental health care and support because I am sex, sexual, or gender diverse (please check all that apply) (Sex positivity or kink awareness, Insensitivity or rudeness, 'Advice' from a counsellor to stop being sex, sexual, or gender diverse, A counsellor telling me that my sex, sexual, or gender diversity was 'a phase', Recommendation from a counsellor to undergo conversion therapy or 'treatment' to make me no longer be sex, sexual, or gender diverse, Homophobia, transphobia, racism, classism, ableism, whorephobia from a counsellor, A knowledgeable counsellor who has experience working with people who are sex, sexual, or gender diverse, A counsellor who refused to give me mental health support because I am sex, sexual, or gender diverse, A focus on my sex, sexual, or gender diversity when I wanted to talk about another issue/problem, A counsellor who is friendly, polite and welcoming, Breaches of my confidentiality by a counsellor or service staff)
9. Is there anything else you would like to add?

Questions about SEX WORKER demographics

1. Are you currently a sex worker? (Yes/No)
2. How long have you been/were you a sex worker? (Less than 1 year, 1-2 years, 3-4 years, 5-7 years, More than 8 years, Not on the list? Type here)
3. Where do you work (Check all that apply)? (Street, Park, Car, Another outdoor place, Private home, Brothel, Sensual massage parlour, Escort agency, BDSM/kink parties/club/venues, Swingers' parties/club/venues, Webcamming, Phone, Porn agency [video or photography], Strip club, Not on the list? Type here)
4. How old were you when you became a sex worker?
5. Why did you become a sex worker (check all that apply)? (I needed an income, I needed money to pay for something extra/specific, Job flexibility, Job satisfaction, Personal empowerment, No other jobs available, Because of or to build body confidence, Seemed exciting, Because I was forced to by someone else, To help my clients, No reason, Not on the list? Type here).
6. How many hours a week on average do you work as a sex worker?
7. Are you currently in a romantic relationship? (Yes/No)
8. Does your partner know you are a sex worker? (Yes/No)
9. Does your partner support your job as a sex worker? (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
10. Why do you think they are supportive of your job as a sex worker? (Money, It turns them on, Improved sex life, Deeper intimacy, I'm more confident, Trust and support, Not on the list? Type here)

Thoughts on sex work.

1. Sex work is real work and an honest way to make a living (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
2. Sex work has become more accepted by public opinion in the last 5 years (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
3. Sex workers are entitled to the same human rights as anyone with any other job (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
4. Sex workers are entitled to the same workplace health and safety supports as anyone with any other job (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)

SEX WORK and your mental health

1. Most of my problems with my mental health have to do with my job as a sex worker (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
2. I have experienced aggression or violence from clients because I am a sex worker (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
3. Sex work improves my mental health (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
4. My job as a sex worker has been mostly positive (Yes/No)
5. I am proud of my job as a sex worker (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
6. Do any of your friends know about your job as a sex worker? (Yes/No/Unsure)
7. Does any member of your family know about your job as a sex worker? (Yes/No/Unsure)
8. Stigma and discrimination against me because of my job as a sex worker are a source of anxiety or stress (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
9. I have been abused/harassed by police because of my job as a sex worker (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
10. I feel like an outsider because I am a sex worker (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
11. I like/love my job as a sex worker (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
12. I often keep my work a secret or only tell a select few people about my job as a sex worker (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
13. Decriminalising sex work is vital to making sex workers safer (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
14. Decriminalising sex work is vital to improving the mental health of sex workers (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
15. I feel in control when I am working as a sex worker (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
16. I fear violence when I am working as a sex worker (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
17. My self-esteem has increased since began working as a sex worker (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)

SEX WORK and your mental health service use

1. I have seen a counsellor for issues with my mental health since I started working as a sex worker (Yes/No)
2. I have told a counsellor about my job as a sex worker (Yes/No)
3. The counsellor knew how to help me with my mental health issue as it related to my job as a sex worker (Yes/No)
4. The counsellor needed me to teach them about sex work (Yes/No)
5. The counsellor told me I should stop or exit sex work (Yes/No)
6. I have seen a general practitioner (GP/doctor) for issues with my mental health that relates to my job as a sex worker (Yes/No)
7. The general practitioner (GP/doctor) knew how to help me my mental health relating to my job as a sex worker (Yes/No)
10. I have experienced the following because I am a sex worker *from a counsellor* or while seeking mental health support (please check all that apply) (Sex positivity or kink awareness, Insensitivity or rudeness, Questions from a counsellor about physical/sexual child abuse/assault to explain why I became a sex worker, 'Advice' from a counsellor to stop being a sex worker, A knowledgeable counsellor who has experience working with sex workers, A counsellor who refused to give me mental

health support because I am a sex worker, A focus on sex worker when I wanted to talk about another issue/problem, A counsellor who is friendly, polite and welcoming, Homophobia, transphobia, racism, classism, ableism, whorephobia from a counsellor Breaches of my confidentiality by a counsellor or service staff)

11. Is there anything else you would like to add?

Questions about BDSM/Kink demographics, taste, and attitudes

1. Which role do you normally take on in BDSM/kink play? (Dom, Sub, Switch)
2. How long have you practiced kink/BDSM? (Less than 1 year, 1-2 years, 3-4 years, 5-7 years, More than 8 years)
3. How long have you been interested in kink/BDSM (regardless of frequency or involvement)? (Less than 1 year, 1-2 years, 3-4 years, 5-7 years, More than 8 years)
4. With whom do you practice kink/BDSM? (Partner(s)/Spouse(s), Sex workers, Other members of my group/club, People I meet online, Not on the list? Type here)
5. Do any of your friends or family know about your involvement in kink/BDSM? (Yes, No, Unsure)
6. I always engage in safe, sane, consensual or risk-aware consensual kink/BDSM (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
7. BDSM/kink has become more accepted or normalised over the past five years (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
8. BDSM/kink are a part of a healthy sexuality (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)

BDSM/Kink and your mental health

1. Most of my problems with my mental health have to do with my involvement in BDSM/kink play (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
2. I have been discriminated against/abused/harassed because I practice BDSM/kink (Yes, No)
3. I am proud of my desire for/involvement in BDSM/kink (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
4. I feel like an outsider because I practice BDSM/kink (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
5. My involvement in a BDSM/kink community has a positive impact on my mental health (None of the time, A little of the time, Some of the time, Most of the time, All of the time)
6. BDSM/kink play improves my mental health. (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)

BDSM/Kink and your mental health service use

1. I have seen a counsellor for issues with my mental health relating to my BDSM/kink play (Yes, No)
2. The counsellor knew how to help me with my mental health issue relating to my BDSM/kink play (Yes, No)
3. I disclosed my involvement in BDSM/kink to a counsellor (Yes, No)
4. The counsellor needed me to teach them about BDSM/kink (Strongly disagree, Disagree, No opinion, Agree, Strongly agree)
5. I have seen a general practitioner (GP/doctor) for issues with my mental health relating to my involvement in BDSM/kink (Yes, No)
6. The general practitioner (GP/doctor) knew how to help me with my mental health issue relating to my involvement in BDSM/kink (Yes, No)

7. I have experienced the following because of my practice of BDSM/kink *from a counsellor* or while seeking mental health care and support (Sex positivity or kink awareness, Insensitivity or rudeness, Questions from a counsellor about physical/sexual child abuse/assault to explain why I practice BDSM/kink, ‘Advice’ from a counsellor to stop practicing BDSM/kink, A counsellor who is knowledgeable, and has experience working with people who practice BDSM/kink, A counsellor who refused to give me mental health support because I practice BDSM/kink, A counsellor who focused on BDSM/kink when I wanted to talk about another issue/problem, A counsellor who is friendly, polite and welcoming, Homophobia, transphobia, racism, classism, ableism, whorephobia from a counsellor, Breaches of my confidentiality by a counsellor or service staff)
8. Is there anything else you would like to add?

Appendix 3 Human Research Ethics Committee Approval Letter



02 September 2019

Dr Ha Hoang
C/- University of Tasmania

Sent via email

Dear Dr Hoang

REF NO: H0018041
TITLE: Mental Health Care Among Marginalised People in Rural and Remote Tasmania

We are pleased to advise that the Tasmania Social Sciences Human Research Ethics Committee approved the above project on 02 September 2019

Please ensure that all investigators involved with this project have cited the approved versions of the documents listed within this letter and use only these versions in conducting this research project

This approval constitutes ethical clearance by the Tasmania Social Sciences HREC. The decision and authority to commence the associated research may be dependent on factors beyond the remit of the ethics review process. For example, your research may need ethics clearance from other organisations or review by your research governance coordinator or Head of Department. It is your responsibility to find out if the approvals of other bodies or authorities are required. It is recommended that the proposed research should not commence until you have satisfied these requirements.

In accordance with the National Statement on Ethical Conduct in Human Research, it is the responsibility of institutions and researchers to be aware of both general and specific legal requirements, wherever relevant. If researchers are uncertain they should seek legal advice to confirm that their proposed research is in compliance with the relevant laws. University of Tasmania researchers may seek legal advice from Legal Services at the University.

All committees operating under the Human Research Ethics Committee (Tasmania) Network are registered and required to comply with the *National Statement on the Ethical Conduct in Human Research* (NHMRC 2007 updated 2018).

Therefore, the Chief Investigator's responsibility is to ensure that

- (1) All investigators are aware of the terms of approval and that the research is conducted in compliance with the HREC approved protocol or project description
- (2) Modifications to the protocol do not proceed until **approval** is obtained in writing from the HREC. This includes, but is not limited to, amendments that
 - (i) are proposed or undertaken in order to eliminate immediate risks to participants

Human Research Ethics Committee (Tasmania) Network Research Ethics and Integrity Unit Office of Research Services	Private Bag 1 Hobart Tasmania 7001 Australia	T +61 3 6226 2975 E ethics@utas.edu.au ABN 30 764 374 782 /CRICOS 00586B utas.edu.au
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- (ii) may increase the risks to participants;
- (iii) significantly affect the conduct of the research; or
- (iv) involve changes to investigator involvement with the project.

Please note that all requests for changes to approved documents must include a version number and date when submitted for review by the HREC.

(3) Reports are provided to the HREC on the progress of the research and any safety reports or monitoring requirements as indicated in NHMRC guidance. Researchers should notify the HREC immediately of any serious or unexpected adverse effects on participants.

(4) The HREC is informed as soon as possible of any new safety information, from other published or unpublished research, that may have an impact on the continued ethical acceptability of the research or that may indicate the need for modification of the project.

(5) All research participants must be provided with the current Participant Information Sheet and Consent Form, unless otherwise approved by the Committee.

(6) This study has approval for four years contingent upon annual review. A *Progress Report* is to be provided on the anniversary date of your approval. Your first report is due 02 September 2020, and you will be sent a courtesy reminder closer to this due date. Ethical approval for this project will lapse if a Progress Report is not submitted in the time frame provided

(7) A *Final Report* and a copy of the published material, either in full or abstract, must be provided at the end of the project.

(8) The HREC is advised of any complaints received or ethical issues that arise during the course of the project.

(9) The HREC is advised promptly of the emergence of circumstances where a court, law enforcement agency or regulator seeks to compel the release of findings or results. Researchers must develop a strategy for addressing this and seek advice from the HREC.

Should you have any queries please do not hesitate to contact me on (03) 6226 2975 or via email ss.ethics@utas.edu.au.

Yours sincerely

Jude Vienna-Hallam
Executive Officer | Social Sciences

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Appendix 4 Peer-Reviewed Literature Findings and MMAT Score, from Sex Worker Literature Review

Authors and setting	Sample	Design	Measurement/ Method	Results/Relevant findings
Benoit et al. (2016), CA	209 M, F, and trans sex workers (SW), 19+ years, VOS and 499,900 non-SW	Qualitative	Interviews and a survey	SW perceived notably worse MH, poorer social health determinants (except income) and nearly triple unmet healthcare needs compared to CCHS respondents (40.4 vs. 14.9%).
Bith-Melander et al. (2010), US	20 youth and 23 adult trans SW of colour, VOS	Qualitative	Interviews and focus groups	Trans people of colour make decisions out of necessity; daily needs the most important. Unmet needs force trans people to use what is available, demonstrating remarkable creativity, resilience, and social support. Need for practical and emotional support great.
Bodkin et al. (2015), CA	14 F, current/former SB SW, 23-49 years, and 3 health and law workers	Qualitative	Semi-structured interviews	Participants represent a vulnerable population with increased safety concerns and health needs.
Bowen and Bungay (2016), CA	1 M and 7 F cis former offstreet SW, advocates, service providers, 35-49 years	Qualitative	Open-ended interviews	All SW experienced stigma, public rejection, humiliation, disowned by family, mistreatment, harassment and denial of agency. Learning to live with, respond to, and resist stigma informed capacity building with other SWs.
Burnes et al. (2018), NA	31 cis and 4 trans F SW, 18+ years, VOS	Qualitative	Demographic questionnaire and semi-structured interviews	4 themes emerged that demonstrated resilience and indicated SW MH needs: (1) validating SW and eliminating whorephobia; (2) safety and mobility within practice environments; (3) sexual boundary setting; and (4) social support
Choudhury (2010), MEX	20 F, establishment-based SW, early 20s-mid-50s	Qualitative	Interviews	Extreme stress and depression were MH consequences of the work. Professionals need to learn that F SW have agency and a desire to control their health and bodies. SW are not victims incapable of making changes to promote own health.
Darling et al. (2013), CH	50 cis and trans F SB SW of any age, from red light district	Quantitative	Cross-sectional questionnaire (full, abridged) and interviews	SB SW are a heterogeneous, mobile and vulnerable group: 96% migrants, 56% no insurance, 70% unaware of available services resulting in use of emergency services. In 60% of healthcare visits, SW did not disclose their work.

Gorry et al. (2010), UK	7 SB SW, 18+ years from drop-in clinic and 5 health professionals	Qualitative	Interviews	4 main impacts of SW on wellbeing: 1) Emotional impact of selling sex; 2) Self-preservation and coping; 3) Barriers to change; and 4) Moving on. Emotional impact affected sense of worth and caused feelings of stigmatisation, shame and degradation.
Gunn et al. (2016), US	24 F SW, 18+ years	Quantitative	Digital diary and semi-structured interviews	SW have disproportional MH comorbidities and face substantial barriers. Participatory research has unanticipated MH benefits, possibly due to positive interactions and discussing experiences.
Jackson et al. (2009), CA	16 F SW, 20-39 years, VOS and 7 of their M partners	Qualitative	Interviews and focus groups	Intimate relationships provide inclusion and safety, positive forces in general health and wellbeing. Stigma-fuelled exclusion can harm intimate relationships, harming wellbeing and emotional health.
Mastrocola et al. (2015), UK	16 SB F SW, 18+ years	Qualitative	Semi-structured interviews	Women were living with difficult to manage ill health that impacted their work. Women reported poor access to care and viewed primary care consultations as unsatisfactory.
McCabe et al. (2014), IRE and US	23 M, SB SW: 11 in San Fran, mean age (MA); 25.36 years and 12 in Dublin, MA 29.42 years	Mixed methods	Semi-structured interviews; psychometric tests	In both cities, the principal factor for entry into SW was drug addiction, with childhood abuse and early school leaving contributing factors. Dublin had higher levels of depression.
Mellor and Lovell (2012), UK	9 SB F SW from Harm Reduction Service, 32-40 years	Qualitative	Semi-structured interviews	SW have considerable life-circumstance complexity, with violence, drugs, alcohol and housing compounding exclusion. Practitioners lack awareness, training and skills to work effectively with SW.
Nemoto et al. (2015), US	235 African-American trans 18+ years SW: San Fran: 112 and Oakland: 123	Quantitative	Interviews using a structured questionnaire	All participants reported unmet needs; Oakland had more re: basic assistance, MH treatment, and healthcare services. Oakland reported less trans-community ID but more support.
Priebe et al. (2013), EU	297 generic/219 specific MH services for SB SW and homeless, asylum seekers, refugees, migrants, unemployed	Quantitative	Face-to-face/phone interviews using structured questionnaire	In 8 European capitals, many services provide MH care to marginalised groups. Group-specific services widely established, but no overlaps with generic services and differences unclear re: staff qualifications or programmes offered.
Prince (2013), US	11 SB F African-American SW from residential facility for exiting the trade, 24-51 years	Qualitative	Semi-structured interviews	Lack of access to affordable culturally sensitive health clinics, individual MH counselling, and healthy nutrition were unmet needs.

Puri et al. (2017), CA	692 cis and trans F SW, VOS, 28-42 years	Quantitative	Semi-annual questionnaire	Women with MH diagnoses (48.8%) were more likely to identify as SGM, to use no injection drugs, to have experienced childhood physical/sexual trauma, and work in informal indoor or street/public spaces
Rodriguez et al. (2018), US	6106 18+ years, trans and GNC ppl, 591 of whom are SW	Quantitative	National survey	Rejected by families and communities due to gender identity, trans ppl are often socially marginalised. Being a SW or recognised trans had significant effect on perceived discrimination in healthcare.
Rössler et al. (2010), CH	193 F SW, VOS, 18-63 years	Quantitative	Interviews (structured questionnaire)	SW had high rates of mental disorders related to violence and perceived burden of SW. Work setting and nationality impacted MH. SW are frequently exposed to much violence, a vital correlate of mental disorders.
Seib et al. (2009), AU	247 SW: legal private=103, licensed brothel=102, illegal=42, 18-57 years	Quantitative	Self-completed or interviewer-administered structured questionnaires	Illegal (mostly SB) SW were 4X more likely to report poor MH; some difference attributable to social background. Increased levels of poor MH among illegal SW was associated with more negative experiences before and subsequent to entering the trade.
Socias et al. (2016), CA	723 self-identified F SW, VOS, 14+ years	Quantitative	Questionnaire	Even with universal health coverage (UHC) SW experience systematic, institutionally ingrained barriers. Call to remove all criminal sanctions re: SW to fulfil SW health and human rights.
Teixeira and Oliveira (2017), PT	52 SB F SW, 18-63 years	Quantitative	Questionnaire and interviews	46.15% reported high suicidal ideation and 44.2% had made at least one suicide attempt. Most had a MH diagnosis – 88.2% had depression. Social support and suicidal ideation moderately negatively correlated.

Appendix 5 Peer-Reviewed Literature Findings and MMAT Score, from Sexual, Gender, and Erotic Minorities: A Systematic Literature Review

Authors & setting	Relevant sample	Method & design	Outcome measure (Relevant condition/topic; tool)	Relevant findings
Adams et al. (2013), NZ	N=124 LGBTI; R/E: NZ, Māori, other; AGE: n=9 <20 & n=122 >21	Qualitative; qualitative surveys & interviews	Service use, issues, & gaps; self-reported	LGBTI people have worse MH than heterosexual; minimal MH policies, services & programs; stigma, homophobia, transphobia, & social rejection harm MH; MHP poorly trained
Bastos et al. (2018), AU	N=371 LGB+; AGE: mean=37	Quantitative; survey	Discrimination, barriers to & need for care; self-reported	LGB+ much more likely to experience barriers to MH services & discrimination than non; MHP are poorly informed or educated on trans issues
Benson (2013), US	N=7 trans people; R/E: white, Latino(a); AGE: 24-57	Qualitative; interviews	Care seeking, ill-informed MHP, recommended MHP, affirmative care; self-reported	Participants sought MH support for many issues, including gender identity & transphobia; prejudice & stigma harm MH
Bith-Melander et al. (2010), US	N=43 trans people; R/E: Black, Latina, Asian/Pacific Islander; AGE: 20s-50s	Qualitative; interviews & focus groups	Gender identity, group membership, MH, services, & supports; self-reported	Daily needs are most important for trans POC; resilience & social support strong; high need for support due to vulnerability
Bränström (2017), SE	N=742 LGB; AGE: >18	Quantitative; questionnaire & health registry data	MH determinants & treatment; self-reported & registry-based International Classification of Diseases-10 data	4% of lesbian & gay & 6% of bi experienced victimisation (versus 2% of heterosexual); 6% of LG & 10% of bi experienced threat of assault (vs 3% of heterosexual); LGB have less social support than heterosexual people
Cochran et al. (2017), US	N=1,664 LGB; AGE: >18	Mixed methods; surveys & interviews	MH diagnoses indicators, & frequency; self-reported, Kessler Psychological Distress Scale	LGB have worse MH & greater uptake than heterosexual; MH issues interfere with life more in LGB than in heterosexual; LGB have diverse MH needs; gay & bi men have greater MH & substance use

			(K6) & Likert scales	abuse correlation than lesbian, bi women
Dahlhamer et al. (2016), US	N=736 LGB; AGE: 18-64	Mixed methods; survey & interviews	Barriers to care; self-reported	LGB experience more barriers than heterosexual; cost is a higher barrier for LGB than for heterosexual; bi women experience the most barriers & delay care seeking
Damm et al. (2018), US, CA, EU, UK, NZ	N=41 BGQ+ (& heterosexual n=22); R/E: white, Black, Hispanic, other; AGE: 19-63	Mixed methods; mixed methods survey	Intersecting identities, disclosure of BDSM identity, shame, empowerment, & resilience; self-reported	Confidence/comfort to disclose BDSM identity improves MH; queer people have better disclosure experiences than heterosexual; being closeted causes compartmentalisation & shame; shame decreases disclosure; BDSM empowers 59% of study participants
Drummond & Brotman (2014), CA	N=1 GNC, queer femme (with chronic illness & physical disability); AGE: 27	Qualitative; interviews	Identity; sexual expression, response from other to sexual self; self-reported	Chronic pain, illness, gender identity crises, & social exclusion (incl. from queer people) worsen MH; agency, social support, & experimenting with sexuality & gender improve MH
Dunbar et al. (2017), US	n=2,377 LGBQ; R/E: white, Latino(a), Asian, Black, other; AGE: "college age"	Quantitative; survey	MH service use, barriers & diagnoses; self-reported, Kessler Psychological Distress Scale (K6) & Likert scales	LGBQ people have higher rates of psychological distress than heterosexual, better uptake & more unmet needs; discrimination, harassment, & unsupportive campus climate impede MH
Elm et al. (2016), US	N=11 two-spirit women; AGE: 20s-50s	Qualitative; interviews	MH issues, trauma, resilience & protective factors; self-reported	Minority stress & trauma impede MH; personal & cultural resilience, social support & acceptance, & traditional practices improve MH
Fredriksen-Goldsen et al. (2013), US	N=2201 LGBT; R/E: white, Native, Black, other; AGE: >50	Quantitative; survey	Depressive symptomatology, perceived stress, risk & protective factors; Center for Epidemiological Studies Depression Scale, Perceived Stress Scale, & modified Homosexual Stigma, Lifetime Victimization, & Outness Inventory scales, Social Support Instrument; & self-reported	Trans older adults are highly marginalised, have significantly worse MH, more lifetime victimisation & less social support than non-trans; stigma, discrimination, & gender identity concealment impede MH

Graham et al. (2009), US	N=21 GBT men; R/E: Black, multiracial; AGE: 18-50	Qualitative; focus groups	MH status, social support, masculinity, cultural “roles,” societal attitudes, identity development; self-reported	Black, gay men have worse MH than white gay or heterosexual people; homophobia, hypermasculinity, discrimination (racism, classism), early intro to s & child sexual assault impede MH sense of self & social support improve MH
Greene et al. (2016), US	N=525 LGBTQ; R/E: white, Hispanic, other; AGE: >50	Quantitative; survey	Mental status, risk factors; Health Status Questionnaire-12, Body Shame subscale, Financial Anxiety Scale, Adult Self-Transcendence Inventory, UCLA Loneliness Scale-3, Self-Compassion Scale–Short Form	Lack of self-compassion & self-transcendence caused by minority stress; marginalisation, discrimination & oppression impede MH
Hahm et al. (2016), US	N=129 LB, single women; R/E: Asian American, multiracial; AGE: 18-35	Quantitative; computer-assisted self-interviews	MH care uptake & assessment; self-reported	LB have better uptake, less adequate care, & higher unmet ne than heterosexual (31% vs 23%); intersecting oppressions impede uptake
Hsieh & Ruther (2017), US	N=2,346 LGB; R/E: white, Black, Hispanic; AGE: >18	Quantitative; survey	No insurance, emergency department care, cost as a barrier, poor access, access barriers, reduced satisfaction with care; Likert scales, self-reported	Despite insurance, LGB have poorer access to good care; LGB have more unmet needs, care delays, & worse uptake than heterosexual; people who experience intersecting oppression face many barriers
Jacobsen & Wright (2014), US	N=23 LBQ women; R/E: white, other; AGE: 20-56, mean 37	Qualitative; semi-structured interviews	Mood disorders and anxiety, self-worth, suicidality, treatment attempts, social support, & MH recovery; self-reported	Religiousness & same-sex attraction conflict; cooccurrence of religiousness & same-sex attraction, heteronormativity, conversion therapy, rejection, fundamentalist religions, & minority stress impede MH; family & social support improve MH
Jenkins Morales et al. (2014), US	n=151 LGBTQ+; R/E: white, Black, Asian, multiracial; AGE: 50-79	Quantitative; survey	Barriers, disclosure, experiences of violence & victimisation, & MH; Patient Health Questionnaire-2, Revised UCLA	55.2% of 50-64yo felt there was lack of trained, informed MHP; homophobia, violence, & victimisation impede MH & increase loneliness; disclosure can improve community safety & MH older LGBTQ+ have poor uptake

			Loneliness Scale, Likert scales, self-reported	
Kattari & Hasche (2016), US	N=5,823 LGBTQA+ & GNC; R/E: white, POC; AGE: >18	Quantitative; survey	Discrimination, harassment, & victimisation, insurance status, passing, time since transition; Likert scales, self-reported	>1 in 5 trans & GNC people reported discrimination or victimisation - worse in 18-35, POC, & trans, queer, & asexual, including in MH facilities; people with private insurance felt less discrimination & more harassment
Kattari et al. (2016), US	N=417 trans & gender diverse; R/E: white, POC; AGE: 18-75	Quantitative; survey	MH provider inclusivity, MH status (depression, anxiety, suicidality) & outcomes; self-reported	Trans-inclusive, culturally competent MHP improve MH & increase uptake; exclusive, phobic MHP impede MH
Kidd et al. (2011), CA	N=11 LGT; R/E: white, Caribbean descent, Aboriginal descent, multiracial; AGE: 15-54, mean 41	Qualitative; interviews	Stigma, discrimination, social support, disclosure, MH status & service use, marginalisation; Likert scales, self-reported	Exclusion, stigma, discrimination, identity concealment, & marginalisation impede MH; inclusive MHP improve MH & enable uptake; all (n=11) experienced provider discrimination, worse after disclosure
Lyons et al. (2015), AU	N=1,034 gay men; R/E: white, POC, other; AGE: 18-39, mean 26.8	Quantitative; survey	Psychological distress, self-esteem, life satisfaction, resilience, discrimination, stigma, & social support; Kessler Psychological Distress Scale (K10), Rosenberg Self-Esteem Scale, Satisfaction with Life Scale, & Brief Resilience Scale, LGB Identity Scale, Interpersonal Support Evaluation Checklist-12	Rural gay men have much worse MH, internalised stigma, less inclusion/support, & more sexual identity concealment & discrimination than urban
McCann & Sharek (2014a), IRE	N=20 LGBT; AGE: 18-64, mean 34.1	Qualitative; interviews	MH service access, barriers & experiences, treatments, stigma, discrimination,	Cost is a barrier; biased MHP, minority stress, stigma, intersectional oppressions, exclusion, & discrimination impact MH; inclusive services, especially,

			social support; self-reported	for trans people are lacking; inclusion & support improve MH
McCann & Sharek (2014b), IRE	N=125 LGBT+; R/E: white, other; AGE: 18-64	Mixed methods; survey & interviews	Treatment, service use, experiences with MHP, recommendations to improve services; self-reported	76% said MH service did not meet needs; 37% said service lacked LGBT competence; 40% found M staff did not speak inclusively; 40% did not trust staff
McCann et al. (2013), IRE	N=180 LGBT+; AGE: >55, mean 60	Mixed methods; survey & interviews	Service experiences, MH status, suicidality, self-harm, AOD, violence, grief, & loss; self-reported	Violence & rejection impair MH; coping & resilience improves MH (most had “good” MH); older LGBT+ experience more violence than general population
Nadal et al. (2011a), US	N=26 LGB; R/E: white, Latino(a), Black, multiracial, Asian American; AGE: 18-55, mean 25.7	Qualitative; focus groups	Experiences & coping with microaggressions and sources of, mental health; self-reported	Overt, subtle, & systemic discrimination, minority stress, criminalisation, rejection, intersectional oppressions, & violence impede MH; coping skill & resilience improve MH
Nadal et al. (2011b), US	N=26 LGB; R/E: white, Latino(a), Black, multiracial, Asian American; AGE: 18-55	Qualitative; focus groups	Microaggressions, homophobia, heteronormativity, exoticisation, erasure, discrimination, pathologisation, threats & assault; self-reported	Subtle & overt discrimination, heterosexism, heteronormativity, homophobia impede MH & encourage sexual identity concealment
Orel (2014), US	Focus groups: N=26 LGB, AGE: 65-84; Survey: n=1,150 LGB, AGE: 64-88; Interviews a): N=38 LG, AGE 43-75; Interviews b): n=11 gay men, AGE 40-79; R/E: Black, white, Asian American, Latino(a), other	Mixed methods; focus groups, survey, & interviews	MH, disclosure, social support, stigma, discrimination, ageism, heterosexism; self-reported, LGBT Elders Needs Assessment Scale, modified Burdon’s Openness Scale	Discrimination, homophobia, heterosexism, erasure, ageism, & intersecting oppressions impede MH; coping strategies, safety to disclose, social support, & acceptance improve MH
Parent et al. (2018), US	N=227 GB+ men; R/E: white, Black, Mexican American; AGE: 20-59	Quantitative; surveys	Help seeking, depression; Patient Health Questionnaire–9; Likert scales, self-reported	Gay, white, single, older men, & men with higher instances of psychological distress have better uptake than heterosexual, men of color
Pennay et al. (2018), AU	N=25 LGQTI+ women; AGE: 19-71, mean 40.1	Mixed methods; survey & interviews	Alcohol, MH, treatment, & recommendations; self-reported	Participants had more negative than positive experiences with MHP exhibiting heteronormativity,

				discrimination, & promoting sexual identity concealment
Pilling et al. (2017), CA	N=16 LGBTIQ+, two-spirit, gender diverse; R/E: white, East & West Indian, Caribbean, multiracial	Qualitative; interviews	Participation in communities, MH, ways in which community & MH are interconnected & siloed; self-reported	Communities are vital for inclusion & support to combat discrimination; a lack of intersectional inclusion impedes access & uptake; structural homophobia & transphobia impact MH & treatment
Platt et al. (2018), US	N=3,188; LGBTQ+; R/E: white, Black, Alaskan Native, Asian, Hispanic, multiracial; AGE: >17	Quantitative; survey	Uptake of MH services, MH status & limitations; Kessler Psychological Distress (K6) Scale & self-reported	White LGBTQ+ have higher uptake than heterosexual (2-4x more), unlike heterosexual, LGBTQ+ uptake equal between men & women; minority stress & stigma may explain high uptake; LGBTQ+ POC have lower uptake than heterosexual
Przedworski et al. (2015), US	N=2,517 LGBTQ+; R/E: white, "non-white"; AGE: 18-98	Quantitative; survey	MH diagnoses, frequency, stressful life events, service use; self-reported	LGBTQ+ have worse than "crisis" level MH than heterosexual, worse in bi women; minority stress, stigma (external & internal), discrimination (systemic & interpersonal), heterosexism, sexual identity concealment, & exclusion impede MH
Qureshi et al. (2018), US	N=438 LGBT+; R/E: white, Black, Hispanic, Latino, Asian, multiracial; AGE: >18	Quantitative; survey	MH needs, service use, barriers; self-reported	No insurance & transport are barriers; stigma, & discrimination lead to sexual identity concealment; 47.6% felt lack of culturally competent MHP is a barrier; LGBT+ have worse MH than heterosexual; LB have best uptake; violence & concealment impede MH; trans people & Asian Americans face most barriers
Riggs et al. (2018), AU	N=188 gender diverse, trans; R/E: white, Indigenous, Asian, Middle Eastern; AGE: 30-58	Mixed methods; survey	Experiences with MHP, MH status; Likert scales, self-reported	Respectful, knowledgeable GP, MHP, & gender-affirming surgery improve MH; discrimination & biased/transphobic medical & MH impede MH
Roberts et al. (2015), US	N=59 furries; AGE: 18-41	Qualitative; focus groups	Social support, identity exploration & formation, social skills development, stigma, ostracism, discrimination; self-reported	Stigma, fear of judgement, discrimination, violence, & rejection impede disclosure; concealment impedes MH; support & inclusion improve MH & identity development; furries' MH similar to general population despite much stigma

Rodriguez et al. (2018), US	N=6,106 LGBTQA+; R/E: white, Black, Native Alaskan, Hispanic, Latino(a), multiracial; AGE: 18-55+	Quantitative; survey	Discrimination in mental healthcare setting; Likert scales, self-reported	Discrimination impedes MH; participants experienced the worst discrimination from MH services, worse in people recognizable as trans, sex workers, people who use drugs, people with gender-related MH diagnoses, & trans POC
Romanelli & Hudson (2017), US	N=29 LGBT+; R/E: Black, Latino(a), Native American, white, multiracial; AGE: >18	Qualitative; questionnaire & interview	MH care access prevalence, issues with & barriers to access, how barriers impact MH; self-reported	Exclusion, erasure, stigma, pathologisation, lack of services, competent & discriminatory MH & insurance are common systemic barriers that produce individual barriers & impede MH
Salkas et al. (2018), US	N=77 trans people; R/E: white, POC	Quantitative; survey	Barriers to MH care, experiences with MHP; Likert scales, self-reported	Having a competent MHP means fewer barriers; trans men experience more barriers than trans women
Stanley & Duong (2015), US	N=209 LGB; R/E: white, other; AGE: >50	Quantitative; survey	MH service use, psychological distress & mental status, alcohol use; Likert scales, Kessler Psychological Distress (K6) Scale, self-reported	LGB have better uptake than heterosexual & are 2x more likely to have had counselling; reasons maybe to cope with stigma & minority stress & due to a normalised view of MH care among LGB people
Steele et al. (2017), CA	N=704 LBTQ+ women; R/E: white, First Nations, Black, Southeast Asian, other; AGE: 19-77	Quantitative; survey	Depression, social support, discrimination, barriers to MH care; Social Provisions Scale-24, Perceived Discrimination Scale, Patient Health Questionnaire-9, self-reported	Trans & gender diverse people have 2.4x & bi/pan have 1.8x unmet need & worse MH than cis heterosexual women due to discrimination & social & systemic exclusion, which reduce uptake; 68.3% had unmet MH need in last year
Stotzer et al. (2014), US	N=710 LGBT+; R/E: white, Native Hawaiian, Japanese, multiracial, other; AGE: 18-83	Mixed methods; survey	Barriers to & discrimination in MH care, delaying care, mental status; self-reported,	Rural dwellers delay MH care due to fear of how MHP will manage sexual or gender identity; LGBT+ less likely to be insured than heterosexual
Thyen et al. (2014), DE	N=110 intersex people; AGE: 17-63, mean 28.4	Mixed methods; interviews & questionnaires	Satisfaction with care, quality of life, mental status, care access & experiences; Client Satisfaction Questionnaire-8,	27% had unmet need for MH support; secrecy, inferior communication, lack of access to MH care, unmet need, lack of good health care, & lack of social support impair MH

			Short Form Survey-36, Brief Symptom Inventory; self-reported	
Walinsky & Whitcomb (2010), US	N=7 trans (BQA, heterosexual); R/E: white; AGE: 25-61	Qualitative; focus group & interview	Wellbeing, gender identity, acceptance, coming out; self-reported	Rural MHP need to advocate for their clients regarding work & disclosure to counter discrimination & increase empowerment
Watson et al. (2018), US	N=304 BQT+ women; R/E: white, multiracial, Black, Hispanic/Latinx, Asian American, Native American; AGE: >18	Quantitative; survey	Bisexual discrimination, sexism, psychological distress & wellbeing, resilience, belonging; Anti-Bisexual Experiences Scale-17; Schedule of Sexist Events, Hopkins Symptoms Checklist-21, Psychological Wellbeing Scale-18, Brief Resilience Scale, Involvement in Feminist Activities Scale-17, modified Involvement in Feminist Activities Scale	Biphobia, discrimination, heterosexism, & sexism considerably impair MH; resilience & community involvement & activity improve MH
Willging et al. (2018), US	N=47 LGBT+; R/E: Native American, Black, Asian, white, Hispanic; AGE: 18-61	Mixed methods; questionnaires & interviews	Mental status, AOD use, social support, advocacy, MH & AOD treatment; Brief Symptom Inventory; self-reported, Social Support Survey Instrument; modified Psychosocial Treatments Interview, M.I.N.I. International Neuropsychiatric Interview; self-reported	Peer advocates offered social support, reduced social isolation, strengthened social networks, & increased participant MH care uptake; high AOD use in participants may be due to minority stress and endemic rural realities (discrimination, lack of services & supports, identity concealment, social conservatism)

Willing et al. (2016), US	N=65 LGBTQ; R/E: multiracial, white, Native American; AGE: 18-50s	Qualitative; interviews	Peer advocate coaching, skills development & work, addressing personal biases, rural constraints, systemic issues; self-reported	LGBTQ peer advocates can offer valuable, community-based support with adequate supervision from trained MHP
Williams et al. (2017), CA	N=704 LBT; R/E: white, POC; AGE: >18	Quantitative; survey & questionnaires	Mental status, service use including unmet need, discrimination; modified Everyday Discrimination Scale, Patient Health Questionnaire-9	Discrimination & intersecting oppressions impair MH & cause more unmet needs; LBT women & women with lower income have high unmet MH needs; the most marginalised people experience the most discrimination
Zeidner & Zevulun (2018), IL	N=144 gay men; R/E: Israeli; AGE: >18	Quantitative; survey	Dual-identity conflict, coping, mental status; Religious/spiritual-Sexual Identity Conflict Scale; Coping Inventory for Stressful Situation Questionnaire, State Anxiety measure; Center for Epidemiologic Studies Depression Scale, UCLA Loneliness Scale	Gay people have worse MH than heterosexual; having a partner reduces sexual identity & dual identity conflict & coping; sexual identity & dual identity conflict, religiosity, & passive coping strategies impair MH & promote isolation
<p>Note. A=asexual. AOD=alcohol & other drugs. B or Bi=bisexual. BDSM=bondage/discipline, dominance/submission. cis=cisgender. G=gay. GNC=gender non-conforming. I=intersex. L=lesbian. MH=mental health. MHP=mental health professional. +=another sexual/gender orientation. POC=people of color. ppl=people. Q=queer and/or questioning. R/E=race/ethnicity. UCLA=University of California, Los Angeles</p> <p>NB: Entries in bold in this legend are combined in the table to represent the variety of study participants' sexual/gender identities</p>				