A School of Population Health

A Qualitative Exploration of Satisfaction with Mental Health Services in Western Australia Among Sexuality and Gender Diverse Youth

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university. The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2023). The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number # HRE2022-0214.

Signature:

Date: 02/03/24

Acknowledgement of Country

We acknowledge that Curtin University is based on the Country of the Wadjuk Noongar people, works across hundreds of traditional lands and custodial groups in Australia, and with First Nations people around the globe. We wish to pay our deepest respects to their ancestors, Elders and members of their communities, past, present, and to their emerging leaders.

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List of Abbreviations

ABS	Australian Bureau of Statistics
DID	Dissociative identity disorder
GP	General practitioner
LGBTIQASB+	Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual, sistergirl, brotherboy, and other terms denoting non cis-heteronormative sexuality or gender
RTA	Reflexive thematic analysis
SDT	Self-determination theory
SGD	Sexuality and/or gender diverse
WA	Western Australia

Glossary

Aromantic is a term used to label a person who experiences low or no romantic attraction to or desire for others (Tessler & Winer, 2023).

Asexual is a term used to describe a person who experiences low or no sexual attraction to or desire for others (Tessler & Winer, 2023).

Bisexual is a term used to describe a person who experiences sexual and/or romantic attraction to a plurality of sexes and/or genders (Farquhar & Dau, 2020).

Brotherboy is a term used by some Aboriginal and Torres Strait Islander communities to refer to First Nations persons in Australia who are assigned female at birth with a male gender identity (Davies et al., 2021).

Cisgender is a gender category applicable to persons whose gender identity and expression aligns with their sex assigned at birth (Davies et al., 2021).

Cis-heteronormative refers simultaneously to cis-normative and heteronormative assumptions (McDermott et al., 2021).

Cis-normative assumptions position cisgender persons as normal, and gender diverse persons as abnormal (Davies et al., 2021).

Demigirl is term used to describe a person who identifies partially with a female gender identity (Colangeli, 2024; Dictionary.com, 2018).

Demisexual refers to a person who experiences sexual attraction to another person only after an emotional bond has been established (Tessler & Winer, 2023).

Distal stressors are minority stressors arising from systemic or interpersonal sources and may manifest as chronic or acute major events, microaggressions, or as the non-occurrence of expected positive events (Meyer, 2003).

Exosystem refers to formal and informal social structures (e.g., policies and norms) governing society (Bronfennbrenner, 1977).

Gay is a term that describes persons who are romantically and/or sexually attracted to persons of the same gender. The term is often associated with persons identifying with a male gender identity and may be used by persons identifying as non-binary (Davies et al., 2021).

Gender is a social construction used to categorise a person based on characteristics (e.g., roles, behaviours, physical attributes) associated with that person, that are usually regarded by culture as masculine or feminine (Davies et al., 2021).

Gender binary refers to a dualistic conception of gender that accommodates only male and female (Davies et al., 2021).

Gender diversity is represented by persons whose gender identity differs from their sex and/or gender assigned at birth (Diamond & Alley, 2022).

Gender identity refers to the gender/s that align with a person's innermost view of themselves (Davies et al., 2021).

Heteronormative assumptions position heterosexuals as normal, and sexuality diverse persons as abnormal (Davies et al., 2021).

Heterosexual is a term used to describe the sexual orientation of a person who identifies with a binary gender and is sexually and/or romantically attracted to persons of the other binary gender (Dictionary.com, 2024).

Intersex is a term used to describe persons possessing innate variations of sex characteristics that do not align with medical or social norms for male and female bodies (Intersex Human Rights Australia, 2021a).

Lesbian is a term used to refer to persons who identify with a female gender identity, or as non-binary, who are romantically and/or sexually attracted to persons identifying with a female gender (Davies et al., 2021).

Macrosystem refers to cultural beliefs and ideologies pervading society (Bronfenbrenner, 1977).

Mesosystem refers to interactions between the immediate settings that an individual is part of, that impact upon the individual's development (Bronfenbrenner, 1977).

Microaggressions are a type of minority stressor that may appear to be minor and tend to occur frequently (Meyer, 2003).

Microsystem refers to the immediate settings that an individual is part of, in which the individual engages in specific roles and activities (Bronfenbrenner, 1977).

Minority stressors when considered in the context of sexuality and/or gender diversity, are manifestations of the stigmatisation of this diversity. These stressors contribute to the greater levels of mental distress experienced by queer persons relative to the dominant cisgender heterosexual population (Meyer, 2003).

Non-binary is a term that may be used to describe a gender identity that cannot be defined by a binary gender (Davies et al., 2021).

Pansexual is a label used to describe a person whose sexual and/or romantic attraction to others is not confined to any specific sex, gender, or gender identity (Davies et al., 2021).

Polyamorous refers to behaviours or a set of circumstances involving a person engaging in intimate relationships concurrently with two or more persons, and where all parties consent to this arrangement (Cardoso et al., 2021).

Proximal stressors are a type of minority stressor that are experienced by persons internally, and in response to, distal stressors. These stressors include internalised stigma, vigilance from fear of encountering distal stressors, and concealment of one's sexuality and/or gender diversity status (Meyer, 2003).

Queer is a term that was historically used as a slur in the 1800s to refer to people of non-heterosexual identity but has since been reclaimed as an empowering term to refer to persons representing sexuality and/or gender diversity. (Davies et al., 2021).

Questioning is a term that may be used to describe an individual who is exploring their sexuality and/or gender identity, and who has not committed to a specific sexual and/or gender identity (Messih, 2020)

Service access involves consumers' healthcare-system navigation to identify and engage services, and opportunity and ability to use services and benefit from this use (Robards et al., 2019).

Sexuality diversity is represented by persons whose sexual orientation is other than heterosexual (Davies et al., 2021).

Sexual orientation refers to a person's sexual identity, sexual and/or romantic attraction, and sexual and/or romantic expression (Davies et al., 2021).

Sistergirl is a term used by some Aboriginal and Torres Strait Islander communities to refer to First Nations persons in Australia who are assigned male at birth with a female gender identity. (Davies et al., 2021).

Transfeminine is a gender identity that is more female than male, adopted by a person assigned male at birth (Dictionary.com, 2024b; Messih, 2020).

Transgender is a term used to describe someone whose gender assigned at birth and gender identity are not aligned (Davies et al., 2021).

Transmasculine is a gender identity that is more male than female, adopted by a person assigned female at birth (Dictionary.com, 2024c; Messih, 2020).

Trixic is a term used to refer to a non-binary person who experiences attraction to women and/or femininity (Jennings, 2023).

Youth refers to a human life stage occurring between 12 and 25 years-of-age, involving significant neurological (Wilson & Cariola, 2020), cognitive, and identity development (Brown et al., 2016).

A Note on Terminology

Language and terminology in the field of sex, sexuality, and gender diversity changes and evolves over time but is deemed appropriate for the contemporary social context at the time this thesis was published. Queer is a term that was historically used as a slur in the 1800s to refer to people of non-heterosexual identity but has since been reclaimed as an empowering term to refer to persons representing sexuality and/or gender diversity. (Davies et al., 2021). Use of the queer label throughout this thesis is intended to draw upon this latter connotation of the term. The term intersex refers to persons who possess innate variations of biological sex characteristics that do not align with medical or social norms for female and male bodies (Intersex Human Rights Association, 2021a). Intersex persons represent sex diversity, which is distinct from, but may intersect with sexuality and/or gender diversity (Intersex Human Rights Association, 2021a). During the recruitment phase of this project, the target population encompassed sex, sexuality, and gender diverse individuals. Twelve sexuality and/or gender diverse youth participated in the current research project, in addition to one intersex youth. This young person focussed on gender diversity issues during their interview and was thus referred to as gender diverse. Studies featuring samples consisting of sex, sexuality, and gender diverse persons are cited throughout this paper, but only for the purpose of drawing on findings relevant to sexuality and/or gender diverse youth, due to the nature of our sample.

The geographical locations of youth who participated in this project were categorised using the Australian Statistical Geography Standard (Australian Bureau of Statistics, 2023a). Ranked by descending population size and decreased proximity to services, categories of this classification system include major city, inner regional,

outer regional, remote, and very remote areas. Throughout this thesis, major city areas are referred to as urban, and the term non-urban is used to encompass all other categories of geographical location. The term rural, commonly used in extant literature to refer to geographical locations resembling inner and/or outer regional areas, is substituted with regional in this thesis (Hill et al., 2021; Leung et al., 2022; Lewis et al., 2020; McQueen et al., 2022; Robards et al., 2019; Roberts et al., 2018; Robinson et al., 2014). The terms counsellor and therapist were used interchangeably by participants and are used generically by the authors to refer to mental health professionals qualified to provide mental health counselling support.

Abstract

Sexuality and/or gender diversity is reflected by persons whose sexual orientation and/or gender identity subverts cis-heteronormative assumptions. These cultural assumptions lend to systemic and interpersonal discrimination for sexuality and/or gender diverse (SGD) youth. This discrimination contributes to the greater prevalence of mental distress among SGD youth relative to youth overall, and inadequate mental healthcare access faced by SGD youth. Mental health need among SGD youth is heightened in non-urban communities where cis-heteronormativity is commonly entrenched, and because mental health services are skewed toward urban areas. In Western Australia (WA), the largest most isolated Australian state with the lowest population density, SGD youth may face notable challenges accessing appropriate mental healthcare.

Within a social constructionist paradigm, this research explored perspectives of 13 SGD youth residing across WA, aged between 15 and 24 years, regarding what they need and want in order to experience satisfaction with mental health services to facilitate access. Eligible participants had accessed professional mental health counselling in WA in the last year. Participants engaged in semi-structured interviews via video-conference, phone call, SMS, or email, and reflexive thematic analysis was inductively applied to participants' verbatim interview data. In Study 1, a convenience sample of seven urban-based SGD youth, including one youth with regional experience, was recruited via a university student participant pool, community organisations, and service providers catering to SGD youth in WA. In Study 2, six additional SGD youth with regional experience were recruited via community organisations and service providers supporting the wellbeing of non-urban SGD youth, and social media advertisements. Verbatim interview data from

both studies were combined for Study 2. Themes focussed predominantly upon aspects shaping satisfaction among SGD youth during their navigation of the healthcare-system to access mental healthcare (Study 1), and aspects encountered by SGD youth during service engagement that shaped satisfaction with client-therapist interactions (Study 2).

Findings indicated that support for a sense of autonomy, competence, and relatedness among SGD youth during the process of mental healthcare access, may facilitate their access to, and satisfaction with, mental healthcare. Policies and practices fostering these needs may enable SGD youth to experience their access journeys as personally meaningful and thus self-determined. Supporting certainty of social safety among SGD youth may prevent or diminish their experience of minority stress during service engagements, fostering the personal meaningfulness of these engagements, while encouraging the authentic expression of these young people. In WA, regional SGD youth may have inequitable access to socially safe spaces to engage with therapists in-person or online. Among our sample, this inequity stemmed from factors including immersion in tightly knit cis-heteronormative contexts, inadequate availability of regional-based mental health services, and restriction of quality internet to public spaces.

The results add to the exiguous corpus providing an in-depth exploration of the perspectives of SGD youth regarding access to professional mental healthcare in WA. These perspectives are vital given that many access barriers faced by SGD youth arise from systems built upon societal norms failing to accommodate their realities. To the author's knowledge, this is the first study to draw upon self-determination and social safety theories to conceptualise satisfaction with mental health services among SGD youth. The results highlight practical implications for

health policies to enhance mental healthcare access for SGD youth in urban and regional WA and similar contexts.

Chapter 1: General Introduction

Sexuality and/or gender diverse (SGD) youth experience disproportionately high levels of mental ill-health relative to youth overall (Hill et al., 2021; Strauss et al., 2021), and inadequate access to professional mental health support (McDermott et al., 2021). The term sexuality and/or gender diversity refers to individuals whose identity is not aligned with cis-heteronormative assumptions (Davies et al., 2021) that pervade Western cultures at the macro level (McDermott et al., 2021). Specifically, that there are only two genders, woman or man; these genders will be cisgender, aligning with the female or male sex respectively; and that romantic and/or sexual attraction inevitably occurs between individuals of different sex (McDermott et al., 2021). Thus, persons identifying with the term lesbian, gay, bisexual, transgender, queer/questioning, asexual, sistergirl, brotherboy, or another term denoting an SGD identity not aligned with cis-heteronormative assumptions (LGBTQASB+) represent sexuality and/or gender diversity (Davies et al., 2021). Throughout this thesis, individuals aged between 12 and 25 are referred to as youth, an age range associated with significant neurological (Wilson & Cariola, 2020), physical, cognitive, and identity development in humans, and where negative impacts of stressors on mental health tend to be exacerbated (Brown et al., 2016;).

Youth tend to be immersed in cis-heteronormative social settings, increasing their chances of exposure to the stigmatisation of sexuality and gender diversity (Wilson & Cariola, 2020). Stigmatisation occurs when human differences are assigned labels that are linked to stereotypes due to cultural assumptions (Link & Phelan, 2001). For example, the assumption that humans are naturally cisgender underpins negative stereotypes conveying gender diverse persons as attention-seekers (Riley, 2017) or mentally ill (Solomon & Kurtz-Costes, 2018). When systems

or persons supporting those assumptions enable or enact discrimination against the labelled persons from a greater position of power, the labelled persons experience marginalisation, and inequities in a range of life domains (Link & Phelan, 2001). For example, in pre-tertiary school settings where sexuality and gender diversity is commonly regarded as abnormal by cisgender heterosexual peers, students with SGD status are often subjected to intense bullying that revolves around this status, contributing to reduced mental health and educational outcomes (Fowler & Buckley, 2022; Wilson & Cariola, 2020).

Meyer (2003) and Frost and Meyer (2023) refer to manifestations of the stigmatisation of sexuality and gender diversity as minority stressors, which are not experienced by the cisgender heterosexual population, a dominant group of society. Distal minority stressors are those that arise from systemic or interpersonal sources and may manifest as chronic or acute major events (e.g., poverty or physical assault due to SGD status), 'minor' yet common occurrences known as microaggressions (e.g., being misgendered), or as the non-occurrence of expected positive events. Proximal minority stressors are experienced internally by persons with SGD status in response to actual or expected distal stressors, and include internalised stigma, vigilance, and concealment. Minority stressors contribute to the greater levels of mental distress experienced by many SGD youth relative to youth overall (Frost & Meyer, 2023; Meyer, 2003), distress that may be exacerbated due to its interaction with the physiological and intrapsychic development that occurs during youth (Wilson & Cariola, 2020).

Minority stressors can impact SGD youth to various degrees, depending on other facets of their social position (Frost & Meyer, 2023; Meyer, 2003). Leung et al. (2022) identified that the effectiveness of programmes designed to support SGD

youth (e.g., gender-sexuality alliances) appeared to be mitigated in schools situated within communities where cis-heteronormativity tends to be particularly entrenched, such as in regional communities. De Pedro et al. (2018) found that the presence of gender-sexuality alliances, and detailed anti-bullying policies, was not associated with an improved sense of safety or lower levels of victimisation among SGD youth at regional schools.

The disproportionately high level of mental health need among SGD youth is amplified due to barriers these young people face when attempting to access mental health services, stemming in part from their SGD and youth status, and geographical location (Lovejoy et al., 2023). Healthcare systems in Western developed countries have been structured around cis-heteronormative assumptions; thus, persons with SGD status are often exposed to minority stressors enabled or enacted by healthcare systems and staff during the process of service access (e.g., therapists unequipped to support the management of SGD issues) (Lovejoy et al., 2023; Robards et al., 2018). In their meta-narrative review of literature focussed on early intervention mental health supports for LGBTQ+ youth, McDermott and colleagues (2021) identified dominant macro-level assumptions seated in Western cultures about youth. Specifically, that youth are passive subjects who are inferior to, and waiting to become, adults, and that their mental distress is either pathological or a phase. Accordingly, youth are prone to paternalistic treatment during the process of accessing mental health services, with young people's agency to direct the support they receive diminished (McDermott et al., 2021). Meanwhile, non-urban youth experience greater challenges than their urban counterparts regarding mental health service access, largely because the locations of these services are skewed toward urban areas (Brown et al., 2016; Lovejoy et al., 2023). In line with an intersectional

perspective (Crenshaw, 1994), access barriers encountered due to SGD status, age, and geographical location then converge, exacerbate one another, and compound health inequities for SGD youth (Lovejoy et al., 2023).

In large developed Western countries such as Australia, equitable distribution of health infrastructure is challenged due to low population densities in non-urban areas, and the large distances between cities, and non-urban towns and communities (World Health Organization, 2018; Kavanagh et al., 2023). While more mental health services are offering telehealth options (Fisher et al., 2020), a shift accelerated by the COVID-19 pandemic (McQueen et al., 2022), internet pricing in Australia is relatively high (Alizadeh et al., 2023). Australia ranks lowest for entry-level broadband affordability compared to all other Organisation for Economic Cooperation and Development countries (Foley et al., 2021). Internet quality also varies notably across Australia, with higher quality more common in urban areas, in part due to better cost efficiency in setting up internet infrastructure in these areas (Alizadeh et al., 2023; Kavanagh et al., 2023).

Australian state and territory governments and corresponding private and community sectors influence the delivery of health services in their jurisdictions (Australian Institute of Health and Welfare, 2023) allowing for differences in service provision between jurisdictions. Salvador-Carulla and colleagues (2022) found that among a selection of Primary Health Networks in Australia, only outpatient mental health services designed to meet the needs of youth aged below 18 were available in non-urban Western Australia. Meanwhile, in non-urban New South Wales, youth-friendly outpatient, residential, and day services were provided.

Of all Australian states, Western Australia is the largest and most isolated, and despite experiencing the fastest population growth nationally between 2006 and

2016, owing largely to its resilient agricultural and mining sectors (van Staden & Haslem-McKenzie 2019), it has the lowest population density, attesting to its large landmass relative to other states and territories (McQueen et al., 2022). Up until December 2021, 99.5% of all COVID-19 cases in Australia occurred outside of Western Australia, despite the state's population making up 11% of the national total, indicative of Western Australia's geographical isolation, capacity to control state borders, and low population density (McQueen et al., 2022). The state is surrounded by ocean on all sides except for its Eastern Border, and Perth is in its southwest corner, at least 2000 kilometres away from any other city (Australian Bureau of Statistics, 2023a; McQueen et al., 2022). The majority of Western Australia's population resides in Perth, with 15% and 6% of the remaining population residing in regional and remote areas, respectively (Australian Bureau of Statistics, 2023a). The Western Australian government implemented a strategy in 2019 to enhance the inclusivity of services of the state's healthcare system by the year 2024, for SGD and intersex populations (Western Australian Department of Health, 2019). Given Western Australia's unique geography and healthcare infrastructure, and priorities to improve mental healthcare access for persons with SGD status, research focussed on Western Australian urban and non-urban SGD youth regarding access to services is warranted.

Such an investigation calls for a qualitative exploration of the perspectives of SGD youth regarding mental health service access, since many of the access barriers SGD youth encounter arise from systems failing to accommodate their needs and preferences (Hankivsky & Christofferson, 2008; Lovejoy et al., 2023). Intense and chronic mental distress experienced during youth can negatively impact physical and social development, academic and employment outcomes (Brown et al., 2016), and

lead to mental disorder that extends into adult life (Wilson & Cariola, 2020). Research that can help to identify how to facilitate access to mental health services for SGD youth is needed to assist in the reduction of health disparities in this population (Robards et al., 2018), and is the overarching aim of the current project.

The project consists of two studies. Study 1 (Chapter 2) and Study 2 (Chapter 3) were guided by a social constructionist approach. Perspectives of 13 SGD youth, aged 15 to 24, residing throughout Western Australia, were explored regarding their experiences with professional mental health services and factors linked to access and satisfaction. All participants had received professional mental health counselling in the last 12 months. Youth satisfaction with mental health services is an indicator of service access (Rickwood et al., 2017; Rickwood et al., 2019), thus the results may help inform service providers on how to facilitate access for SGD youth in similar contexts.

In both studies, participants were recruited via community organisations and service providers that had an interest in the health and wellbeing of SGD youth in Western Australia, a university student participant pool in Study 1, and social media advertisements in Study 2. Due to anticipated challenges accessing a stigmatised population to share information on potentially sensitive issues (Ellard-Gray et al., 2015), and time and resource constraints on recruitment, eligible participants were recruited via a convenience sampling strategy. Participants were engaged in semi-structured interviews via video-conference, phone call, SMS, or email. Reflexive thematic analysis (Braun & Clarke, 2021) was applied inductively to their verbatim interview data.

The results of Study 1 are largely focussed upon experiences that SGD youth had during their navigation of the healthcare system toward mental health

services, that shaped satisfaction with services. While the participant sample in Study 1 (N = 7) consisted of one youth with regional experience, and all youth resided in urban areas, the results corroborated previous research, suggesting that non-urban SGD youth have additional access needs relative to their urban-based counterparts (Hill et al., 2021). Participants' accounts also provided rich data about service aspects encountered during mental healthcare engagement that shaped their satisfaction with client-therapist interactions, inspiring Study 2, that specifically explores these experiences. To further investigate the interplay of these experiences with geographical location, verbatim interview data of the seven participants from Study 1 were analysed along with that provided by another six SGD youth with regional experience recruited for Study 2. Chapter 4 presents a general discussion of the synthesised results from Study 1 and 2, with a particular focus on practical and policy implications.

Chapter 2: An Exploration of Satisfaction with Mental Health Counselling Services in Western Australia Among Sexuality and Gender Diverse Youth

Bruce Lim[1], Elizabeth A. Newnham[1,2], & Roanna Lobo[1,2]

Abstract

Clinically significant psychological distress affects approximately 29.3% of Australian adolescents and 80.6% of sexuality and/or gender diverse (SGD) youth. Often, SGD youth experience inadequate access and lower satisfaction with professional mental health services. Accordingly, exploration of factors affecting mental healthcare access for SGD youth, and their satisfaction with mental health services, is critical. Using a social constructionist lens, we explored factors supporting satisfaction with mental health services for SGD youth, and how these needs are or could be met. Seven LGBTQA+ youth aged 15 to 21 who received counselling in Western Australia in the last year, recruited via a university student participant pool, community organisations, and service providers, participated in semi-structured interviews via video-conference, phone call, or SMS. Reflexive thematic analysis was inductively applied to participants' verbatim accounts. Satisfaction was tied to participants' sense of control over their healthcare-system experiences, shaped by four themes: perception of choice to pursue counselling, resources to guide the search for services, confidence in therapists, and healthcare-system organisation. Practices and policies supporting the self-determination of SGD youth throughout the process of service access, may allow for empowering and personally meaningful therapeutic experiences. Policymakers and developers of initiatives may need to adopt a systems approach to foster the self-determination of SGD youth as they access services.

Keywords: healthcare-system navigation, access to mental healthcare, satisfaction, self-determination, sexuality and/or gender diverse youth, reflexive thematic analysis

Introduction

Clinical psychological distress affects approximately 29.3% of Australian adolescents (Mission Australia, 2022). Sexuality and/or gender diverse (SGD) youth are at greater risk of psychological distress and often experience inadequate access and lower satisfaction with professional mental health support (Cutler et al., 2022). Service access involves users' healthcare-system navigation to identify and engage services, and opportunity and ability to use services and benefit from this use (Robards et al., 2019). The term sexuality and/or gender diversity refers to persons identifying as lesbian, gay, bisexual, transgender, queer/questioning, asexual, sistergirl, brotherboy, or with another term denoting non cis-heteronormative sexuality or gender (LGBTQASB+) (Byron et al., 2017). Research is commonly conducted with combinations of SGD subgroups along with intersex persons who possess innate variations of sex characteristics, represented by the addition of 'I' to the LGBTIQASB+ acronym (Intersex Human Rights Australia, 2021b). However, intersex persons do not necessarily have SGD identities, are subject to unique forms of stigma, and have distinct mental health needs (Intersex Human Rights Australia, 2021b). Studies featuring samples consisting of LGBTIQASB+ persons are cited throughout this paper, but only for the purpose of drawing on findings relevant to SGD youth.

An Australian survey of 6,418 LGBTQA+ youth aged 14 to 21, indicated that 80.6% of the sample had experienced clinically significant psychological distress in the last month and less than half of this subgroup sought counselling in the last year (Hill et al., 2021). The 12-month prevalence of attempted suicide among LGBTQA+ youth aged 16 to 17 years was three times higher compared to a general population of youth in the same age group. These findings are consistent with another survey of

Australian LGBTQA+ youth (*N* = 110), showing that young people who sought mental health support in the last two years were 71% less likely to have received support than cisgender heterosexual counterparts (*N* = 395) (Cutler et al., 2022). Given the high rates of mental health need among SGD youth, exploration of factors affecting their mental healthcare access, and that influence their satisfaction with mental health services is critical.

Hill et al. (2021) found that one-third of LGBTQA+ youth in their study were unsure of, or had no preference, regarding the type of counselling services to access for support. This suggests specific service options are not well communicated to youth, and that SGD youth sometimes lack knowledge to distinguish between mental health services. Similarly, Bowman et al. (2020) found that non-urban LGBT youth (*N* = 9) in Australia found it challenging to discern differences across online mental health services. Another Australian study reported that marginalised youth (*N* = 41) aged 12 to 24, including 20 SGD youth, commonly experienced confusion when initially engaging health services. Young people were unsure of whether they needed to be accessing services, conveying their uncertainty regarding the suitability of services. Such experiences were salient for youth with less experience and autonomy regarding healthcare-system navigation. Also, health services were particularly expensive for youth facing multiple marginalisation. For example, SGD youth experiencing homelessness often lacked family and financial support (Robards et al., 2019).

SGD youth have highlighted the need for shorter wait times to attend suitable mental health services (Hill et al., 2021), with wait times to access gender specialists potentially exceeding one year (Cutler et al., 2022). SGD youth have also indicated that queer-friendly services are not equitably dispersed throughout inner and outer

urban and non-urban Australia (Hill et al., 2021). Poor affordability, timeliness, and proximity of heath service provision have led some marginalised youth to experience ambivalence toward healthcare-system navigation and to delay help seeking (Robards et al., 2019).

While telehealth creates potential for SGD youth to overcome geographical barriers, privacy concerns may hinder access to such services (Bowman et al., 2020; McQueen et al., 2022). In a state-wide survey of 84 youth (31% LGBTIQA+) in Western Australia, one-third reported lacking the privacy to access online counselling (Perry et al., 2021). In non-urban areas, SGD youth may need to access online services in public facilities due to poor internet connections, potentially exacerbating pre-existing privacy concerns (Bowman et al., 2020). Among a regional South Australian sample of same-sex attracted youth (N = 31), 48% reported reluctance to access mental health services in general due to concerns of others finding out (Roberts et al., 2018). For regional SGD youth, such pervasive privacy concerns may stem from the interconnected nature of regional communities, along with salient mental health stigma and entrenched cis-heteronormativity (Lewis, 2020). Tight-knit communities may also create privacy concerns for urban-based SGD youth. For example, First Nations LGBTIQSB+ youth may avoid even culturally sensitive services based in areas frequented by relatives (Spurway et al., 2023).

Inadequate understanding of SGD among mental health therapists creates further engagement barriers with SGD youth (Hill et al., 2021). An Australian study with 13 First Nations LGBTIQSB+ youth, reported that therapists pathologised their SGD identification, assuming this to be the cause of presenting issues (Spurway et al., 2023). Non-urban LGBT youth (N = 9) indicated experiencing fear of such

prejudice even while being able to preserve anonymity (Bowman et al., 2020). Among a sample of 11 transgender students attending Australian high schools, there were common reports of feeling frustrated when engaging with school counsellors who lacked knowledge of transgender issues, evoking closed communication (Mackie et al., 2021). Newman et al. (2021) found that LGBTQ+ youth in Australia ($N = 71$) reported experiences of emotional discomfort when clinicians appeared unsure of how to respond to SGD issues. These youth would often change providers to avoid having to educate and manage clinicians' emotional responses.

Western Australia is the largest and most isolated Australian state, with the lowest population density (Australian Bureau of Statistics, 2018). Mental healthcare delivery in each Australian state and territory is influenced by its own government, and corresponding private and community sectors (Australian Institute of Health and Welfare, 2023). Youth satisfaction with mental health services is an indicator of service access (Rickwood et al., 2017; Rickwood et al., 2019). Based on a critical review on youth perceptions of psychiatric care, Biering (2010) identified three domains of youth satisfaction with mental health services: satisfaction with client-practitioner interactions, therapy outcomes, and service infrastructure. This conceptual structure has been supported by psychometrically validated scales designed to measure youth satisfaction with mental health services (Rickwood et al., 2017; Rickwood et al., 2019). These studies focussed on identifying aspects shaping young people's service satisfaction, with less attention paid to why or how these aspects evoke satisfaction.

We qualitatively explored what SGD youth in Western Australia, aged between 12 and 25, need and want in order to experience satisfaction with mental health counselling services and why. We also explored how these needs are or could

be met. Our results may help inform service providers on how to facilitate mental healthcare access for SGD youth.

Method

Research Design

A social constructionist paradigm guided this research, wherein an individual's interpretation of events informs their reality, with these interpretations shaped by positionality (Boyland, 2019). Semi-structured interviews were used to elicit rich interpretations (Boyland, 2019) among SGD youth about their satisfaction with counselling services in Western Australia. Reflexive thematic analysis (RTA) was applied inductively using the method outlined by Braun and Clarke (2021), allowing participants' interpretations to drive the analysis.

Researcher Reflexivity

The first author designed the study, collected data, and conducted analyses supervised by the second (EN) and third author (RL). EN and RL are cisgender female researchers experienced in research examining barriers and enablers to healthcare access for marginalised populations including rural and SGD youth. The research team worked in consultation with advisors at WAAC, a non-profit organisation delivering services in part to support the mental health of LGBTIQA+ persons in Western Australia. The first author (BL) identifies as gay, experienced incongruence between his sex assigned at birth and gender identity and benefited from access to timely and appropriate mental health support during youth. This position facilitated BL's ability to empathise with participants, encouraging rich accounts. Reflexive journaling was used to foster appreciation for the uniqueness of participants' experiences (Levitt et al., 2017). Journalling involved the researcher

reflecting on personal responses to participants' accounts, followed by an exploration of underpinning assumptions.

Sample

Seven SGD youth who collectively identified as LGBTQA+ participated in this study and are referred to by pseudonyms and pronouns reflecting their gender identities (see Table 1 Participant Demographic Data). All participants were born in Australia, spoke English as a main language, and lived in Western Australia's capital city, Perth, where they accessed counselling services. One participant relocated from regional Western Australia two years prior and attended a regional counselling service. Four participants identified as White or Caucasian, and remaining participants identified as Aboriginal, Anglo-Indian/Caucasian, or Jewish Australian. The sample ranged in age from 15 to 21 years (M = 19.43). Five participants were psychology undergraduates from one university, and another was in high school. Participants were unknown to the research team.

Sampling Process

This study received approval from Curtin University's Human Research Ethics Committee (HRE2022-0214). Inclusion criteria were LGBTIQA+ youth aged between 12 and 25 who received counselling from any mental health service in Western Australia in the past 12 months, living in Western Australia. Organisations affiliated with the target population promoted the study using their social media accounts (Facebook, Instagram, X/Twitter). Participants were also recruited from a university student participant pool, a population at increased risk of psychological distress relative to the general population (Farrer et al., 2021).

Participant recruitment took place between July and September 2022. Of 18 eligible participants who completed the intake survey, 11 did not schedule an

interview. The seven interviews consisted of three online and two phone call interviews ranging from 50 to 117 minutes (M = 80 min) and two mobile text interviews (1,594 and 4,816 words). There was variation among participants regarding SGD status, age, experience living in different geographical regions, and ethnicity.

Table 1

Participant Demographic Data

Pseudonym	Age in years	Ethnicity or race	Disability, neurodiversity/autism, long-term physical or mental health condition	Gender identity	Sex assigned at birth	Sexual orientation	Counselling sessions in the last 12 months [a]
Aiden	20	Aboriginal	Prefer not to say	Man	Female	Bisexual	> 5
Briar	20	White	Prefer not to say	Demi-girl	Female	Asexual	> 5
Clay	19	White	Mental illness, neurodiversity/ autism	Non-binary	Female	Queer, trixic	> 5
Daniella	20	Caucasian	Mental illness	Woman	Female	Lesbian	> 5
El	21	Anglo-Indian/ Caucasian	No	Trans-feminine	Male	Gay	> 5
Gracie	21	Jewish Australian	Physical illness, other	Woman	Female	Pansexual	> 5
Fenn	15	White	Mental illness, other	Man	Female	Bisexual	3-4

[a] Counselling sessions were attended in Perth.

Measures

Intake Survey

Participants' contact and demographic details were obtained via an online survey developed for this study. Data requested were: name; preferred contact details; preferred interview mode; country of birth; main language spoken at home; ethnicity; whether participants identified as having a disability, long-term physical or mental health condition, or neurodiversity/autism; and a description of the disability or long-term condition. Details regarding residential postcode, number of counselling sessions undertaken in the last 12 months, age, gender identity, sex assigned at birth, whether participants were born with a variation of sex characteristics, and sexual

orientation were asked to determine participant eligibility. Questions and wording of the survey and the subsequent interview schedule were formulated in consultation with WAAC advisors. Open-ended response options were offered for questions that could not be answered with a yes or no (excluding questions about interview mode and counselling sessions). The survey stated that all answers were voluntary.

Interview Schedule

The interview schedule was developed for this study. The three domains of youth satisfaction with mental health services identified by Biering (2010) translated to satisfaction/dissatisfaction with counselling sessions, counselling outcomes, and counselling service aspects encountered outside of sessions. Each domain was explored via three core interview questions encouraging youth to describe what shaped their satisfaction (e.g., *Please have a think now about experiences you have had with counselling services outside of counselling sessions. What, if anything has been satisfying/dissatisfying? What changes can the service make outside of counselling sessions to create a satisfying experience for you?*). Interview prompts sought explanations as to why or how these aspects shaped satisfaction (e.g., *In what ways is this satisfying/dissatisfying for you? Could you provide an example?*). The schedule was designed to be read by persons aged eight and above according to the Flesch-Kincaid Grade Level (Gray, 2012), facilitating asynchronous interviews. Prompts were modified or added to facilitate rich interview responses. The sequence and wording of core questions was adapted to be contextually relevant to participants' statements.

Procedure

Participants accessed the study's webpage using a link provided with recruitment material and were directed to complete the intake survey using Qualtrics.

Participants were informed of their eligibility to participate and sent participant information and consent forms within 24 hours of sign-up. Participant information advised all participants of their right to withdraw at any time.

Eligible participants indicating a preference for asynchronous interviews received asynchronous interview guidelines. These stipulated that participants had one week to answer all interview questions, asked sequentially, and that BL would answer responses within the hour where possible between 10 AM and 8 PM weekdays, and 10 AM and 5 PM weekends. These guidelines were adapted from Ratislavová and Ratislav's (2014) procedure. Participants were informed that they were not expected to spend more than 30 minutes in total generating interview responses. Eligible participants indicating preference for synchronous interviews were directed to an online tool to schedule an interview. Participants were encouraged to seek a quiet, distraction-free setting and to discuss any study-related questions with BL. Minors aged below 16 years-of-age were deemed mature minors (Kelly & Halford, 2007) and were asked a series of questions assessing their understanding of participant information (e.g., purpose and benefits of the study, right to withdraw), a procedure adapted from Hildebrand et al. (2015). All questions were answered correctly.

Prior to interview commencement, participants engaging in asynchronous or synchronous interviews provided written or verbal consent respectively. For asynchronous interviews, participants could type yes or no in response to a declaration that they had read the participant information and consent forms and agreed to participate, consistent with Ratislavová and Ratislav's (2014) procedure. All synchronous interview participants consented to being audio recorded.

Notes were taken during interviews, facilitating probing. Post interview, participants were thanked for their time, offered a copy of their interview transcript, and encouraged to contact the research team with any study-related concerns. One participant requested their transcript, no participants contacted the research team with any concerns. Students who accessed the study via the university's research programme were awarded course credit, all other participants were sent a $20 groceries gift card in Australian dollars.

Data Analysis

Webex software was used to record video-conference interviews. Only audio recordings were retained and transcribed verbatim. All transcripts were deidentified and imported into NVivo 13 (2020, R1; Lumivero, 2023) for analysis. All recordings and transcripts were saved to a secure drive and deleted from NVivo after project completion.

Inductive RTA began with two readings of each transcript, during which impressions of participants' healthcare-system experiences were annotated. Next, across two iterations, data were extracted from each transcript that conveyed the participant's perspective on the following topics: What did the participant want or need in order to experience satisfaction with counselling services in Western Australia and why? How had these needs been met or how could they be met? Each extract was labelled with a code; that is, a semantic or latent meaning constructed by the researcher in response to the extract, expressed through language, providing insight into the topics (Braun & Clarke, 2021). The first two transcripts were independently coded by the first and third author, and the first author coded all transcripts. Consistencies and disparities among codes from the first two transcripts were discussed to foster awareness of personal biases shaping the analysis (Levitt et

al., 2017). This practice was not used to establish consensus which reflects a neopositivist approach, inappropriate for RTA (Braun & Clarke, 2021). The interviewer used reflexive journalling to enhance fidelity to the subject matter (Levitt et al., 2017). For example, via this activity, BL developed awareness of normative assumptions about monosexuality (Farquhar & Dau, 2020) taken for granted as someone of monosexual orientation. This subverted the adoption of an ethnocentric lens when analysing data provided by participants attracted to more than one gender.

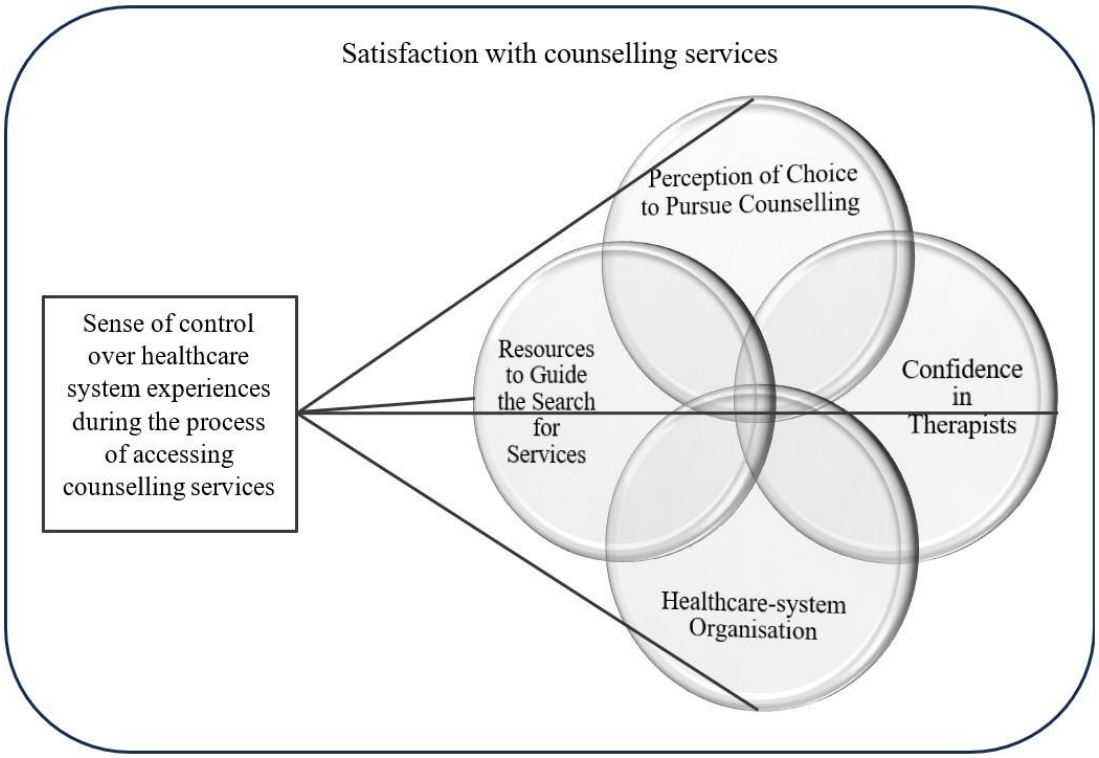
Data extracted from subsequent transcripts were attributed to codes constructed from earlier transcripts. Otherwise, codes were modified or removed, or new codes were generated to accommodate additional extracts (Braun & Clarke, 2021). Related codes were clustered into first-order categories that were then clustered into second-order categories, each labelled with a title conveying a theme underpinning participants' understanding of their satisfaction with counselling services.

Results

The analysis identified that participants' sense of control over their healthcare-system experiences throughout the process of accessing mental healthcare contributed to their satisfaction with services. Four interconnected themes contributed to this perceived control: perception of choice to pursue counselling; resources to guide the search for services; confidence in therapists; and healthcare-system organisation (see Figure 1 for thematic map).

Figure 1

Thematic Map of Satisfaction with Mental Health Counselling Services Among Sexuality and/or Gender Diverse Youth



Perception of Choice to Pursue Counselling

Accounts of multiple youth suggested that their sense of control over their trajectory toward counselling services was linked to qualities of the assistance provided by support persons to facilitate this process.

Person-centred Support During the Service-access Process

Participants who wanted to pursue counselling because they believed counselling would benefit their wellbeing, maintained a sense of control over service access when this process was supported by others with more healthcare-system experience with whom participants had rapport. This support fostered participants' optimism about the appropriateness of services selected or the benefits of counselling. This pattern was salient for youth who conveyed having little

knowledge about mental health services, or who were minors at the time, suggesting that they felt unable to independently access appropriate services.

For example, soon after having their sexual orientation disaffirmed by a high school counsellor, Clay recalled, "… didn't know where to go, I just had no clue what support I could get …". Clay then described that they were "not forced but given very much a nudge" by hospital staff to re-engage in counselling during a hospital stay:

> … staff were very accepting and listened … so when they referred me to a programme based at the hospital, I had that positive association and I was like, 'okay, maybe this is different 'cause they're good, so maybe this process will be a bit better', and they were definitely a lot better.

Recalling how he attended counselling during early adolescence, Fenn stated:

> I didn't want to be on meds [medication] at the time so I wanted counselling, my mum just mentioned to the doctor she'd had a good experience there and the doctor wrote me a referral and mum booked an appointment. I was just glad I'd found a place.

Disregard for the Young Person's Consent

Two participants recounted how they received counselling as minors despite not wishing to do so. In these instances, it appears that caregivers and health professionals wanted these minors to engage in counselling because they doubted the soundness of their choices, demonstrating this doubt by dismissing the young person's consent to access counselling. Resultantly, these youth expected therapists to undermine their decision-making ability, creating a sense of threat during service engagement.

For instance, Gracie indicated that “hooking up with guys” during early adolescence was perceived as “scandalous” in the tight-knit religious community she grew up in. Gracie recalled that when her parents were informed by community members about this behaviour, they felt their trust had been betrayed and grew concerned about her stability. Describing how her parents then propelled her toward counselling, she stated:

> … no reason for me to be there. … parents didn’t like the choices I was making … so they ended up sending me there. … it was quite anxiety inducing. I remember going and feeling uncomfortable in the clinic and in the waiting room, and just especially because it was my parents dropping me there and picking me up, and I knew they didn’t like the choices that I’d made, but then they wanted me to go and talk about them.

Daniella recalled being “put into” a mental health service as part of a mandatory measure after attending a hospital for self-harm as a minor. She then indicated that this service “didn’t feel like a very safe space”, and that this feeling stemmed from a fear of being judged.

Resources to Guide the Search for Services

Access to resources enabling identification of appropriate services shaped participants’ sense of control during healthcare-system navigation.

Mental Health Literacy

Mental health literacy involves understanding mental distress and its treatments, and how to attain and nurture mental wellness (Kutcher et al., 2016). This knowledge provided participants with insight into presenting issues and a sense of competence to identify therapists qualified to provide relevant support. One participant explicitly connected acquisition of this knowledge to tertiary education in

psychology. Describing how she approached her general practitioner (GP) for a referral to a psychologist, Gracie stated:

> I gave [GP] a very specific list of what I wanted, and I knew what I wanted … from my studies, I'm aware of how the system works, so that was something that I had as an advantage on my side … knew I needed someone who had done some form of sexology study because I'm a fuckin' polyamorous pansexual …

Several participants indicated that they developed knowledge about the suitability of mental healthcare services by trialling services.

> … it felt like the first service I received was a fifteen percent fit, my previous counsellor was a fifty percent fit, and my current counsellor is an eighty-five percent fit … (Aiden)

This pathway was sometimes accompanied by uncertainty and distress, and sometimes meant that appropriate support was delayed. Clay reflected upon being referred to a mental health service by hospital staff after a suicide attempt and having to wait 10 months to attend that service. They then recalled what happened during the hiatus:

> I had to trial a lot of different sorts of services, and I didn't know what fit, and as much as that was a distressing thing, I think it gave me a unique perspective … when friends ask, 'ah, I'm struggling with this thing, do you know what would help?' I'm like, 'yes, I know the exact therapist …' I'm very well versed with mental health stuff.

Tangible Information Resources

Access to tangible information resources also appeared to shape participants' sense of control when searching for services. Participants expressed satisfaction with

having access to information in therapists' profiles about their counselling approaches, knowledge and skills, and ties to certain issues, as these attributes assisted them in evaluating therapists' suitability. Daniella shared: "… do my research in terms of the different databases … really appreciate when people have … a description of themselves, and their counselling style, and whatever techniques they use, and their areas of interest". Referring to online profiles, Aiden stated: "I value if a counsellor has a degree or doctorate as a foundation qualification … search through what they specialise in or have an interest in so I can see if they can cater to my needs …".

The quality of information resources designed to assist with service selection was sometimes inadequate. Some participants conveyed that information about the array of mental health services in Western Australia was disparate. They wanted resources that intuitively collated information about a comprehensive range of services to streamline their search process, and reduce the chance of overlooking optimal services:

> … everyone's needs are different and there's different levels of support needs … it's so complex, and that's why there's so many services … needs to be some kind of comprehensive list where everything is collected … I feel like that doesn't exist … (Clay)
>
> … want like a 'how to pick a psych', I want to be able to use a Tinder for psychologists, just swipe left or right … (Briar)

A sentiment supported by most participants' accounts was that the online delivery of information resources was useful in making those resources accessible.

> … being able to find the services … with a quick Google search has been super satisfying, including the websites where they show you what kind of

services they provide … (Aiden)

… should be on the internet, like accessible. (Clay)

Clay also acknowledged that online mediums may be inappropriate for some consumers. Further, that the complexity and amount of information in resources should cater to different audiences' needs, facilitating users' access to meaningful information and ability to make informed choices: "Maybe make a pamphlet of it, a shortened version that's easy to read …".

Confidence in Therapists

The data suggested that participants' confidence to openly express themselves with therapists, and access to therapists who could competently support the management of SGD issues, played a role in participants' sense of control during service access.

Client Confidentiality

Several participants conveyed the importance of confidentiality when appraising the appropriateness of services. Two participants indicated being reluctant to engage with services when they suspected therapists might breach their confidentiality. These concerns appeared to be heightened by tightly knit community contexts, and fears that disclosure would attract stigma to themselves or family. For example, during high school, Briar perceived her access to the few in-person services in her regional area as removed, due to a wariness that therapists at these services would recognise her familial connection to another client to whom they might disclose personal information: "… couldn't go and see a therapist because my [relative] had gone through all of them in that town … Everybody knows everybody". Briar also described being "terrified" of having her asexuality pathologised due to an assumption that she had been sexually assaulted.

Clay recalled having revealed to a counsellor at high school that they were questioning their sexuality, and how the counsellor pressured them to disclose this to their parents who associated sexuality and gender diversity with "evil": "… was scared that she was gonna out me [disclose sexual orientation] to my parents … she'd probably get into a lot of legal trouble for that, but I didn't know … ". Clay's uncertainty regarding the therapist's potential disclosure of SGD status stemmed from limited knowledge of policies enforcing the ethical conduct of mental health professionals, shaping an ambivalence within Clay regarding engagement with the therapist: "I kept seeing her for a while … it just made me quite uncomfortable at school and I would always try and hide from her …". Participants who were certain about their rights to confidentiality advocated counselling as a support option. They viewed counselling as an opportunity to freely express themselves without affecting relationships outside the counselling space.

> I just find it reassuring that legally, any personal discussions that I'm having are just that, they're confidential … (Daniella)
>
> … the fact that they're not attached to anything that's connected to your life. You can just completely be yourself and just like, say whatever you want. (El)

Therapists' Affirmation of Sexuality and/or Gender Diversity

Regardless of region or community support, SGD youth wanted to engage with therapists who embraced sexuality and/or gender diversity, to gain a sense of security to interact authentically with these therapists. Youth wanted services and therapists to provide clear signs that communicated affirmation of sexuality and/or gender diversity.

> … when I was looking for a psychologist, I was like, I do want to see someone who openly identifies themselves, someone who was like, area of interest, LGBTIQ plus … (Daniella)
>
> … it's very vulnerable to share things about gender and sexuality with people and so it would be nice to know more information. Like if counsellors put more effort into flagging like this is a safe space … (Clay)
>
> … for a safety thing, therapists down home … if they're going to be allies or affirming, they have to actively show that a lot more than up here [Perth] because you walk around [regional area] assuming everyone has a negative impression of you. (Briar)

All participants wanted access to therapists who understood concepts, issues, and experiences relevant to their SGD statuses, or who were ready to educate themselves to achieve this competency. Accordingly, therapists may need to elevate above being aware and accepting of sexuality and gender diversity by actively informing themselves about it, to meaningfully affirm SGD youth.

> … in counselling services … I'd like to see a better understanding of LGBTQIA+ concepts like transitioning … (Aiden)
>
> … cis counsellors being more educated on experiences of trans people … (Fenn)
>
> … there's a top of the range gender therapist … [she's] done her masters in gender … she's like the it girl of gender psych [psychology], and I was like, 'oh my God, I really want to see this woman' … (El)

Healthcare-system Organisation

The organisation of mental health services and the healthcare system also shaped participants' sense of control when accessing services.

Service Feasibility

For most participants, the ability to competently navigate their way to the premises of a service impacted their decision to access in-person counselling. For some youth, this sense of competence was supported by the proximity of services to familiar areas. Thinking about satisfying service aspects, Daniella stated:

> … to access a service close by … whether it's to my work or to where I'm living … it minimises stress of the experience because I'm not as worried about how I'm going to get there … or what else I could be doing with that time.

For SGD youth seeking professional mental health support, affordability may take precedence over therapists' knowledge and skills. Describing when she approached her GP for recommendations to therapists who could assist with gender issues, El stated: "… mentioned quite a few but she mentioned two people that were specialised in gender. I think [for] both of them it was really inaccessible 'cause it was just so expensive". Although therapists' fees are often subsidised by Medicare, Australia's national health insurance scheme, policies limit the amount that can be rebated resulting in a failure to adequately account for notable differences in young people's financial support.

Inefficiencies Tied to the Referral Process

Some participants spoke of the importance of GPs building rapport with SGD youth so that those GPs could refer them to services catering to their needs, while allowing SGD youth to feel more certain about the suitability of those services. The data suggested that conditions faced by GPs prompting them to prematurely discontinue their tenure, may impede this rapport-building process. Describing her experience of seeking a service referral from a Perth-based GP, Briar stated: "…

mentioned some people that they had worked with previously, but this was just the one off GP … because I didn't have one. I'm from the country, doctors leave all the time." Briar then added: "… there was no trust there. So I'm like, well why would I take their suggestions?"

Several participants conveyed how referral processes to mental health services were convoluted, creating access barriers. Such processes were perceived as burdensome and inconducive to a sense of agency, exacerbated by the lack of alternative options offered.

> … had to constantly rely on my GP to contact the counsellor first and the counsellor to respond back and then I'd have to do a telehealth phone call to get relayed that one message … went on like that at least twice before I could get sessions officially booked. This was quite tedious and I wished I was contacted alongside my GP via email or a phone call. (Aiden)

Gracie acknowledged that she could circumvent having to pay GP fees to access service referrals by attending subsidised GP services, but that this option came at a cost: "… could go to a bulk billing practice but they've got fifteen minute appointments most of the time so it's very hard to get a healthcare plan done …". Gracie's concern about the impact of time pressures on GPs to create effective care plans and thus offer appropriate service referrals, was echoed by an experience Clay had in hospital: "… [staff] didn't do that [safety plan] until half an hour before I was discharged and it was like five minutes, very rushed. I had no idea what was on there if you asked me". Insufficient time dedicated by hospital staff to the process of having a safety plan generated, reduced its utility. This plan was meant to form a source of support for Clay during their 10-month wait to engage with the mental health service they were referred to. However, the inadequacy of the safety plan

meant that it did not meaningfully support a sense of stability during the hiatus that then exacerbated their dissatisfaction with the wait time: "… wasn't the easiest 10 months, and I was in hospital several more times after ...".

Discussion

In Australia, clinically significant psychological distress is disproportionately more prevalent among SGD youth compared to the general population (Hill et al., 2021). Yet, SGD youth commonly experience inadequate access and lower satisfaction with professional mental health support (Cutler et al., 2022). This research contributes to a descriptive and explanatory understanding of satisfaction with counselling services in Western Australia among SGD youth, to help facilitate access.

Factors that Shaped Satisfaction with Counselling Services

Satisfaction with counselling services among SGD youth appeared to be facilitated by empowering experiences where they willingly participated in, and had a sense of control over, their healthcare-system navigation toward services and service engagement. These experiences involved socio-contextual factors supporting the following three conditions: SGD youth believed that counselling would directly benefit their wellbeing and that engagement in the process of service access was a choice; they perceived themselves as efficacious toward identifying, selecting, or engaging appropriate services; and felt their values were respected and understood by others supporting their service access. Self-determination theory (SDT) offers a potential framework to conceptualise these patterns (Ryan & Deci, 2000). SDT, a theory of motivation, proposes that an individual's psychological need for a sense of autonomy, competence, and relatedness must be supported by socio-contextual factors while the individual performs a behaviour (i.e., accessing counselling

services) to perceive that behaviour as personally meaningful. According to SDT, as the personal meaningfulness of an action increases, the individual perceives their enactment of it as motivated less by external forces toward being self-determined, creating a perception of control over and investment in the behaviour. The experience of self-determination facilitates a sense of empowerment and subjective wellbeing, and when thwarted, psychological distress may arise (Ryan & Deci, 2000).

Accordingly, for SGD youth, a sense of control over counselling service access, and satisfaction with services, appeared to be facilitated by practices and policies enabling them to view counselling as beneficial to their wellbeing and to engage with services under their own volition, supporting a sense of autonomy; to efficaciously identify, select, or engage appropriate services, supporting a sense of competence; and to feel that their values were respected and understood by others involved in their service access, supporting a sense of relatedness. Dissatisfaction arose when any of these conditions went unfulfilled, and was often associated with anxiety, worry, and fear. Here, youth seemed to experience diminished control, characterised by uncertainty or doubt over whether they would access an appropriate service or benefit from counselling. Diminished control was also evident when youth felt forced to endure circumstances or processes that hindered or delayed their ability to benefit from counselling.

How Satisfaction with Counselling Services May Be Enhanced

The results have implications for how policy and practice may enhance the self-determination of SGD youth during the service-access process, to facilitate greater satisfaction with services. Youth who were more confident in their knowledge about mental health and the healthcare system played increasingly active roles in identifying services. This mental health literacy supported young people’s ability to

competently and autonomously identify therapists that they perceived as appropriate. Acquisition of this knowledge was attributed to tertiary education in psychology in one case, and the application of a trial-and-error approach to identify appropriate services that was sometimes associated with uncertainty and distress. These pathways may be impractical for many young people and serve as a deterrent to service access (Robards et al., 2019; Farrer et al., 2016). Education to develop this literacy should be easily accessible; for example, via pre-tertiary curricula when school attendance is compulsory, to reach marginalised youth (Nash et al., 2021; Rickwood et al., 2007).

Such education may also need to inform youth about their rights and limits to client confidentiality when disclosing information to therapists. SGD youth who were wary about whether their information would be disclosed, doubted counselling as a support option. Immersion in highly interconnected contexts such as school settings or regional communities and concerns about stigma due to SGD status (Bowman et al., 2020; Lewis, 2020) may have contributed to this wariness. SGD youth who were certain about their right to confidentiality willingly engaged in counselling, viewing this as an opportunity to express themselves without impacting other life areas. It seems especially important that such education reaches minors, since they will likely be accustomed to having caregivers making decisions on their behalf (Kelly & Halford, 2007).

SGD youth were optimistic about the benefits of counselling and participated in the process of service access when supported by others who could assist with healthcare-system navigation, such as caregivers or health professionals who also respected young people’s mental health needs. Youth resisted engagement with counselling services nominated by support persons who had not developed or

demonstrated respect for the young person's wishes; for example, when the readiness of SGD youth to engage in counselling was discounted. These results reinforce the need for tailored programmes designed to build caregivers' and health professionals' knowledge about person-centred care, and for caregivers in particular, knowledge about healthcare-system navigation (Australian Government Department of Health, 2019; Western Australian Department of Health, 2018).

Health professionals may be challenged to provide person-centred support to SGD youth, due to circumstances limiting time available to develop an understanding of young people's problems (Bellairs-Walsh et al., 2020; Rickwood et al., 2007), creating challenges for SGD youth to efficaciously navigate their way to appropriate mental health services. For instance, SGD youth in our sample conveyed that challenges accessing adequate levels of health professionals' time to have mental health treatment or safety plans competently developed, can and did result in such activities and resources lacking meaning, and the utility to facilitate their access to appropriate services. Meanwhile, GP turnover in regional areas is high (Department of Health, 2023), and our data suggest that regional youth may thus commonly have to access GPs with whom they have had little time to build rapport to obtain service referrals. This predicament may then contribute to an ambivalence for SGD youth regarding whether to engage with services recommended by those GPs. Also, our results indicate that youth may have to engage repeatedly in GP consultations to organise a single service referral. SGD youth conveyed that they perceived these processes as inefficient and inconducive to a sense of agency, while impacting on their time and finances. Robards et al. (2019) indicated that among their sample of marginalised youth, inefficient healthcare-system processes demotivated youth from

wanting to engage with services, giving rise to ambivalence and sometimes leading to termination of engagement.

Echoing our results, extant research suggests that health services could enhance in-person communication with youth during time-limited consultations (Bellairs-Walsh et al., 2020), and streamline young people's healthcare-system navigation (Robards et al., 2019) by employing a greater range of digital solutions. For example, GPs could adopt youth-friendly online mental health screening apps, such as Check Up GP, that allow clients to complete self-administered psychosocial assessments prior to consultations (Bellairs-Walsh et al., 2020; Webb et al., 2017). Check Up GP then automatically flags risk and protective factors, sharing this information digitally with the GP. Findings indicate that this technology may enable GPs to efficiently gain an understanding of clients' problems, prime youth to discuss sensitive topics ahead of consultations, and enhance GPs' ability to provide person-centred support to youth under time pressure (Webb et al., 2017). Among our sample, there was also a desire for health professionals and therapists to include the client in interprofessional discussions using carbon-copy emails, or teleconference, to reduce the number of in-person consultations needed to organise a service referral.

SGD youth indicated that access to effectively designed information resources was necessary to competently search for, and select, appropriate services. They suggested that such resources be made available via a variety of media to reach a broad audience, emphasising web-based delivery. This is consistent with reports from Byron et al.'s (2017) Australian sample of 303 LGBTIQ youth, three-quarters of whom used web-based resources to access mental health information. Participants in our sample advocated the design of a resource that organised information about an extensive range of mental health services in Western Australia that catered to needs at

all levels of complexity. There was a desire for such a resource to operate using software affording intuitive and efficient functionality analogous to popular mobile apps like Tinder (Lapsley et al., 2022) that could streamline the search for appropriate services (Cheng et al., 2021).

The results indicated that information about therapists such as their areas of interest, professional knowledge, and lived experience was sought after and appreciated by SGD youth. Therapists could use their professional profiles as an opportunity to initiate rapport-building with youth (Cheng et al., 2021), for example by using a combination of images, videos, and text to introduce themselves (Pretorius et al., 2020). Most SGD youth in our sample wanted therapists and services to clearly communicate their affirmation of sexuality and/or gender diversity, for example, via the use of visual signs such as flags to demonstrate advocacy, thereby providing them with a sense of security to express themselves authentically with these therapists. Consistent with this finding, extant research suggests that SGD youth commonly look for information online (Byron et al., 2017; Robards et al., 2019), and while attending service premises (Newman et al., 2021; Spurway et al., 2023) to ascertain whether therapists will be affirmative of sexuality and/or gender diversity, that then encourages engagement.

SGD youth expressed a need for better access to therapists who were informed about concepts, issues, and experiences pertinent to subgroups of the LGBTQA+ community to which they belonged, or who were prepared to educate themselves to achieve this. This coheres with national survey responses of LGBTIQ adults who wanted mental health therapists at publicly funded services to transition from mere awareness of sexuality and/or gender diversity to being informed about it

(Hill et al., 2020), and calls for better inclusion of LGBTQA+ therapists at services (Newman et al., 2021).

SGD youth expressed that having services situated close to familiar locations such as their residential suburb or workplace was central to their efficacy in locating and attending in-person services in Perth. This proclivity speaks to the need for the equitable distribution of queer-friendly services (Hill et al., 2021), while highlighting the inequitable service access experienced by SGD youth residing in interconnected cis-heteronormative contexts such as regional communities (Bowman et al., 2020; Lewis, 2020). As our results suggested, such youth may feel unable to attend services situated in or close to familiar locations due to concerns of unwanted disclosure of their SGD status, and consequently attracting stigma. This predicament calls for the development and implementation of initiatives in these contexts, designed to foster positive community attitudes about sexuality and gender diversity (Lewis, 2020).

Strengths and Limitations

This study is one of the few to offer an in-depth exploration of experiences of SGD youth accessing professional mental health support in Western Australia. While based on the accounts of a small sample, the results converge with research focussed on the access of SGD youth to health services nationally. The results highlight potential practices and policies that may enhance satisfaction among SGD youth with counselling services in Western Australia, similar contexts, and possibly across Australia, by supporting their self-determination as they navigate the healthcare system toward services and engage with them. Our results support SDT as a potential theoretical framework to guide an understanding of satisfaction with counselling services among SGD youth, helping to shed light on the concept of youth satisfaction with mental health services, that currently lacks conceptual depth (Biering, 2010;

Rickwood et al, 2019). Future research conducted with diverse groups of youth is needed to further investigate this potential.

Several notable features of the sample may limit the transferability of the results. All SGD youth were tied to circumstances or conditions associated with high psychological distress; specifically, most youth were undergraduates, reported having a mental disorder or a long-term physical health condition, and were counselling service clients at the time of their interviews (Robards et al, 2019). The entire sample had access to internet-enabled digital devices that likely facilitated service access (Byron et al., 2017) and while most SGD youth had engaged in online counselling sessions, the services they attended were primarily in-person oriented, as were the experiences they recounted.

Non-urban experience was limited, and despite the range of ethnicities in the sample, SGD youth did not refer to their ethnic identities in the context of service access. Since participants were regarded as experts of their experience, their understanding of satisfaction with services was of primary interest. SGD youth who belong to more than one minority group may face multiple inequities (Robards et al., 2018), as supported by the current research in terms of the intersection between regional and SGD status. Future research should investigate the intersection of ethnicity and/or non-urban residence among SGD youth and how this contributes to their mental healthcare access and satisfaction (McDermott et al., 2021; Robards et al., 2018).

Conclusion

Supporting a sense of autonomy, competence, and relatedness for SGD youth as they navigate the healthcare system toward counselling services and engage with them, may facilitate their satisfaction with those services. Practices and policies

designed to foster these needs may enable SGD youth to experience a sense of self-determination or control over their service access journeys, allowing for empowering and personally meaningful counselling experiences. Policymakers and developers of initiatives may need to promote action or change at the interpersonal, organisational, and community level to meaningfully foster the self-determination of SGD youth during the process of service access.

Authors' Contributions

BL: conceptualisation (lead); data curation (lead); formal analysis (lead); investigation (lead); methodology (lead); project administration (lead); visualisation (lead); writing – original draft preparation (lead); writing – review and editing (lead). **EN:** supervision (equal); visualisation (supporting); writing – review and editing (equal). **RL:** conceptualisation (supporting); formal analysis (supporting); methodology (supporting); project administration (supporting); supervision (equal); visualisation (supporting); writing – review and editing (equal).

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Chapter 3: Satisfaction with Client-therapist Interactions Among Sexuality and Gender Diverse Youth in Urban and Regional Western Australia

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Abstract

Introduction: Evidence suggests that the prevalence of clinically significant psychological distress among sexuality and/or gender diverse (SGD) youth in Australia is almost triple that of the general population, and greater still for non-urban SGD youth. Further, at least 30% of SGD youth who receive professional mental health support are unsatisfied with this care, discouraging service engagement. This research explored the satisfaction of urban and regional SGD youth regarding client-therapist interactions. **Methods**: Participants were 13 SGD youth aged 15 to 24 from urban and regional areas of Western Australia who received professional mental health support in the last year. Using a social constructionist approach, participants' satisfaction was explored via semi-structured interviews, conducted via video-conference, phone call, SMS, and email. Reflexive thematic analysis was applied inductively to verbatim interview data. **Results**: Satisfaction stemmed from service aspects that fostered confidence among SGD youth to openly express themselves with therapists, organized across three themes: safe therapeutic settings, experiences of inclusive support, and congruency of perspectives. **Conclusion**: Regional SGD youth may experience inequitable access to socially safe in-person and online client-therapist interactions. Service aspects supporting the social safety of SGD youth may encourage their open expression with therapists, enabling self-determined therapeutic experiences.

Keywords: client-therapist interactions, satisfaction, social safety, urban and regional, sexuality and/or gender diverse youth

Introduction

Australian national data suggest that sexuality and/or gender diverse (SGD) youth are more at risk of mental ill-health than youth overall; further, roughly two-thirds of SGD youth receive professional mental healthcare, and at least 30% of these youth are dissatisfied with this support (Hill et al., 2021; Smith et al., 2014; Strauss et al., 2021). Sexuality and/or gender diversity is reflected by persons whose sexual orientation and/or gender identity subverts cis-heteronormativity; that is, persons identifying as lesbian, gay, bisexual, transgender, queer/questioning, asexual, sistergirl, brotherboy, or with other terms denoting a non cis-heteronormative sexual orientation and/or gender identity (LGBTQASB+; Davies et al., 2021). Particular groups of SGD persons are referred to using variations of the LGBTQASB+ acronym.

The prevalence of clinically significant psychological distress, suicidal ideation and attempts among SGD youth in Australia may be almost triple that of the general population, and greater still for regional SGD youth (Hill et al., 2021). Minority Stress Theory (Frost & Meyer, 2023; Meyer, 2003) proposes that persons with SGD status experience more psychological distress than the general population due to stigma experienced on a systemic and interpersonal level. Distal stressors include events that persons with SGD status encounter in external environments that result from this stigma (e.g., unemployment or assault due to SGD status). This may lead to proximal stressors where individuals internalize this stigma and become perpetually vigilant of encountering distal stressors and conceal their SGD statuses. Minority stressors take a mental and emotional toll on persons with SGD status that can evoke intense, chronic psychological distress (Frost & Meyer, 2023; Meyer, 2003).

The confluence of deeply entrenched cis-heteronormativity and the highly interconnected nature characteristic of many non-urban communities, means that distal stressors may be perceived as more encompassing by non-urban SGD youth, intensifying their experience of proximal stressors (Bowman et al., 2020; Robinson et al., 2014). It is vital that urban and non-urban SGD youth have access to mental health therapists that are informed on how to ameliorate the impact of minority stressors (Frost & Meyer, 2023; Hill et al., 2021; Meyer, 2003). Yet, a notable proportion of SGD youth experience low satisfaction with professional mental health support (Hill et al., 2021; Smith et al., 2014; Strauss et al., 2021). Interactions with mental health therapists factor prominently into the appraisals of SGD youth regarding the support they receive (Mackie et al., 2021; Newman et al., 2021). Thus, exploration of aspects shaping satisfaction with client-therapist interactions for SGD youth is needed.

Evidence shows that SGD youth will commonly avoid healthcare professionals after having negative encounters with them (Byron et al., 2017). Among an Australian national sample of 189 gender diverse youth, 53% had negative experiences with a health professional, and 33% avoided health professionals thereafter (Smith et al., 2014). Often, negative encounters are linked to cis-heteronormative practices and inadequate knowledge about sexuality and/or gender diversity that may exacerbate minority stress (Byron et al., 2017; McNair & Bush, 2016; Smith et al., 2014; Strauss et al., 2021). McNair and Bush found that among 1390 same-sex attracted cisgender women, 64.5% hesitated to seek help due to concerns or experiences of having their sexual orientation denigrated. Half the sample reported that having undue emphasis placed on their sexuality, and concerns about health professionals possessing inadequate knowledge and skills to support

queer persons, impeded help seeking. For SGD youth, affective responses to these experiences tend to involve frustration (Mackie et al., 2021), awkwardness (Newman et al., 2021), and anger (Smith et al., 2014) creating aversion to client-therapist interactions.

Reduced agency is linked to dissatisfaction with client-therapist interactions among SGD youth, particularly for gender diverse youth (Hill et al., 2021; Smith et al., 2014; Strauss et al., 2021). Gender diverse youth have reported having to pathologize their gender experiences to access gender-affirming medical interventions at government subsidized rates (Strauss et al., 2021). Gender diverse youth have also reported having their gender identities disclosed by therapists without consent (Hill et al., 2021). Of the 1,188 gender diverse youth in Hill et al.'s study whose gender identity had been disclosed without consent, 3.7% stated that providers had breached confidentiality. SGD youth often hesitate to engage health professionals due to confidentiality concerns (Byron et al., 2017).

These findings indicate that satisfaction among SGD youth with client-therapist interactions notably shapes their appraisals of the support received, impacting the service access of SGD youth. Biering (2010), after performing a critical review of literature on young people's mental health service experiences, also found that satisfaction with client-therapist interactions was a major domain contributing to youth satisfaction with mental health services, alongside domains comprising therapy outcomes, and service infrastructure. This conceptual structure is supported by psychometrically validated scales designed to measure youth satisfaction with in-person (Rickwood et al., 2017) and online (Rickwood et al., 2019) mental health services.

Geographical location may also shape satisfaction with client-therapist interactions among SGD youth. Research suggests that SGD youth in non-urban Australia experience greater challenges accessing quality mental healthcare (Bowman et al., 2020), including non-judgemental and confidential support (Byron et al., 2017). However, literature focussing on the intersection of geographical location with healthcare experiences of SGD youth is modest (Bowman et al., 2020).

Western Australia is distinct from other Australian states, largest in landmass and surrounded by ocean on all sides except for its Eastern border, making it the most isolated state (Australian Bureau of Statistics [ABS], 2023a). Relative to other states, Western Australia has a low population density with 2.85 million people, making up 11% of the national total (ABS, 2023b). Seventy nine percent of the state's population resides in its capital city, Perth, in its southwest corner, with the other 21% residing in non-urban areas (ABS, 2023a). We accessed the perspectives of SGD youth, aged between 12 and 25, residing in these regions, to qualitatively explore aspects encountered during service engagement promoting satisfaction with client-therapist interactions. We also explored how their needs could be met. Our study may help to inform service providers on how SGD status impacts the satisfaction of youth when engaging with mental health professionals, and how these experiences intersect with geographical location, to facilitate the service access of SGD youth.

Method

Research Design

This study was designed using a social constructionist perspective, from which an individual's positionality guides their interpretations of events, shaping their reality (Boyland, 2019). Semi-structured interviews were used to elicit the

interpretations of SGD youth (Boyland, 2019) about their satisfaction experiences as clients of Western Australian mental health services, and how this satisfaction might be enhanced. Following the process outlined by Braun and Clarke (2006, 2021), inductive reflexive thematic analysis (RTA) was applied, allowing the results to be grounded in participants' accounts, while being directed by the researcher's interpretations and thus positionality. Reflexive research requires the researcher to develop a critical understanding of their societal position, and how experiences and knowledge accessed via this position shapes the research process (Braun & Clarke, 2021).

Researcher Reflexivity

Development of the research design, data collection, and analysis were undertaken by the first author (BL) under the supervision of the second and third authors (RL, EN). Both RL and EN identify as cisgender women, and have engaged in research with marginalized youth, including non-urban and SGD youth, to facilitate the healthcare access of these populations. The authors consulted advisors at a not-for-profit organization that includes services to support the wellbeing of Western Australian SGD and intersex communities (representing the 'I' in LGBTIQA+). BL identifies as gay and questioned his gender identity throughout youth, during which he accessed mental health services for support to manage issues arising in part from experiences of stigma. This position enabled BL to access academic, professional, and lived experience to connect with interviewees' narratives using theoretical, empirical, and embodied knowledge to aid in the elicitation and interpretation of rich data. To strengthen an awareness of participants' positions relative to the researcher's own position, reflexive journalling was practiced (Levitt et al., 2017). This practice assisted BL in recognizing the distinct privilege assigned

to him as an urban based cisgender monosexual male; a position distinct to that of all participants who either resided regionally (Hill et al., 2021), had a gender diverse or female gender identity (Hale & Ojeda, 2018), or attraction to more than one gender (Farquhar & Dau, 2020). This recognition enhanced BL's ability to manage taken for granted assumptions of participants' accounts that arose from this position of privilege.

Sample

Thirteen SGD youth participated in this study. They are referred to by pseudonyms and their stated pronouns (see Table 1 Participant Demographic Data). One youth who reported having an innate variation of sex characteristics identified their gender as intersex and spoke primarily about issues pertinent to gender diversity; thus, this youth is referred to as gender diverse in this study. All members of the sample were born in Australia, lived in Western Australia, and were fluent in English. Using the Australian Statistical Geography Standard that categorizes areas of Australia based on their relative proximity to services (ABS, 2023a), eight youth resided in urban areas, three in inner regional areas, and two in outer regional areas. One participant had moved from an outer regional area in Western Australia to Perth two years prior and had accessed mental health services from this regional area, before and after relocating. Another participant resided in an urban location that was 7.5 km away from an inner regional area. Both young people had experiences in common with the five regional participants. Five participants identified as White or Caucasian and another four as Australian. Other participants identified as Aboriginal, Anglo-Indian/Caucasian, or Jewish Australian, with one participant stating, 'not applicable'. The sample's age range was 15 to 24 years (M = 19.07), and the research team had no prior relationship with participants.

Sampling Process

This study was approved by Curtin University's Human Research Ethics Committee (HRE2022-0214). Eligibility criteria stated that participants needed to be persons identifying as LGBTIQA+, aged between 12 and 25 years, living in Western Australia, who had accessed a mental health service in Western Australia for counselling in the past 12 months. A mental health community advisory group was accessed via Curtin University for feedback to enhance the appeal of recruitment materials for the target population.

Recruitment materials were posted on Facebook, Instagram, and X/Twitter accounts of community organizations and service providers connected to the target population, paid ads on Facebook and Instagram, and a university student participant pool. Participants were recruited between July and September 2022, and May and August 2023. Twenty-five eligible youth responded to the intake survey, 12 did not schedule an interview. The 13 interviews included five video-conference and three phone call interviews ranging from 32 to 117 minutes (M = 81.14), and one email and four SMS interviews ranging from 579 to 4,816 words (M = 2413.6). One participant who engaged in an SMS interview responded to two core interview questions and associated prompts, and then stopped responding. As this youth did not request to withdraw from the study, their data have been included in the analysis.

Table 2

Participant Demographic Data

Pseudonym	Age in years	Ethnicity or race	Disability, neurodiversity/autism, long-term physical or mental health condition	Gender identity	Sex assigned at birth	Sexual orientation	Counselling sessions in the last 12 months	Location [a]
Aiden	20	Aboriginal	Prefer not to say	Man	Female	Bisexual	> 5	Major city
Briar	20	White	Prefer not to say	Demi-girl	Female	Asexual	> 5	Major city
Clay	19	White	Mental illness, neurodiversity/ autism	Non-binary	Female	Queer, trixic	> 5	Major city
Daniella	20	Caucasian	Mental illness	Woman	Female	Lesbian	> 5	Major city
El	21	Anglo-Indian/ Caucasian	No	Trans-feminine	Male	Gay	> 5	Major city
Fenn	15	White	Mental illness, other	Man	Female	Bisexual	3-4	Major city
Gracie	21	Jewish Australian	Physical illness, other	Woman	Female	Pansexual	> 5	Major city
Kamryn	16	Australian	Mental illness, neurodiversity/autism, physical	Intersex [b]	Female	Unsure	> 5	Major city
Hart	24	Australian	Mental illness, neurodiversity, intellectual	Trans masculine, non-binary	Female	Pansexual, demisexual, asexual	> 5	Inner regional
Luciana	16	White	Mental illness, sensory, Tourette's syndrome	Female	Female	Lesbian	> 5	Inner regional
Myst	17	White	Neurodiversity/autism	Non-binary	Female	Aromantic asexual	3-4	Inner regional
Isa	20	Australian	Mental illness	Unlabelled	Male	Unlabelled	> 5	Outer regional
Joss	19	Not stated	Neurodiversity/autism, intellectual	Non-binary	Female	Bisexual	> 5	Outer regional

Note. Participants were able to self-describe demographic details featured above. Adapted from "An Exploration of Satisfaction with Mental Health Counseling Services in Western Australia Among Sexuality and Gender Diverse Youth," by B. Lim, E. A. Newnham, and R. Lobo, 2024, *Journal of Homosexuality,* p. 7 (https://doi.org/10.1080/00918369.2024.2360611). Copyright 2024 by the Authors.

[a] Geographical locations were determined using the Australian Statistical Geography Standard (Australian Bureau of Statistics, 2023a).

[b] Also reported being born with a variation of sex characteristics.

Measures

Intake Survey

A 15-item online Qualtrics survey was used to collect participants' contact and demographic details. Questions regarding residential location, age, SGD status, intersex status, and counselling session attendance in the last 12 months were used to assess participant eligibility. Open-ended responses were offered for items requiring more than a yes/no answer. For more detail about the intake survey and interview schedule, see Lim et al. (2024).

Interview Schedule

Interview questions were designed using Biering's (2010) major domains of youth satisfaction with mental health services. Participants' satisfaction with counselling sessions, outcomes, and service aspects were each explored via three core items (e.g., *During counselling sessions, what, if anything has been satisfying/dissatisfying? What else could be done during sessions to create a satisfying experience for you?*). Interview prompts encouraged explanations (e.g., *Could you provide an example? What does this mean to you?*).

Procedure

Youth accessed the Qualtrics intake survey via a hyperlink included with recruitment material. Eligible youth were emailed consent forms and study information outlining their right to withdraw from the study at any time. Youth requesting email or SMS interviews were sent asynchronous interview guidelines, stating they had one week to complete interviews, did not need to spend more than a total of 30 minutes generating interview responses, and that BL would attempt to reply to responses in the hour between 10 AM and 8 PM, and 10 AM and 5 PM on weekdays and weekends (adapted from Ratislavová & Ratislav, 2014).

Participants scheduled synchronous interviews via an online application. Participants were advised to seek a setting that was private and distraction free. Youth aged below 18 were considered mature minors (Kelly & Halford, 2007). Youth aged 15 or below were required to be assessed on their comprehension of the study information (e.g., right to withdraw, study aims) prior to commencement of their interviews (procedure adapted from Hildebrand et al., 2015). One participant needed to complete this assessment, correctly answering all questions.

Before interviews began, participants consented to having their interview responses recorded. During interviews, BL noted details of participants' narratives that required probing. Post interview, BL asked youth if they wanted a transcript of their interview and to contact the research team with any study-related concerns. Three participants requested transcripts; no participants contacted the research team with any concerns. Students recruited through the university research participant pool received course credit; other participants received an AUD$20 grocery voucher.

Data Analysis

Audio interview data were recorded and transcribed verbatim. Disfluencies and repetitions were removed (Cowie & Braun, 2022). Email and SMS interview data were converted to transcripts with spelling errors corrected. All transcripts were deidentified. NVivo 13 (2020, R1; Lumivero, 2023) was used for RTA. After project completion, transcripts were deleted from NVivo.

Following Braun and Clarke's (2006, 2021) procedure, BL inductively applied RTA, consulting with RL and EN. Firstly, the researcher engaged in data familiarization, annotating impressions of participants' experiences during two readings of each transcript. Extracts from the dataset were coded if they conveyed participants' views on the following: During mental health service engagement, what

shaped participants' satisfaction with client-therapist interactions? How could participants' satisfaction with interactions be enhanced? Duplicate codes were removed, and affiliated extracts were assigned to existing codes. Codes were iteratively appraised and modified for fair representation of their corresponding extracts.

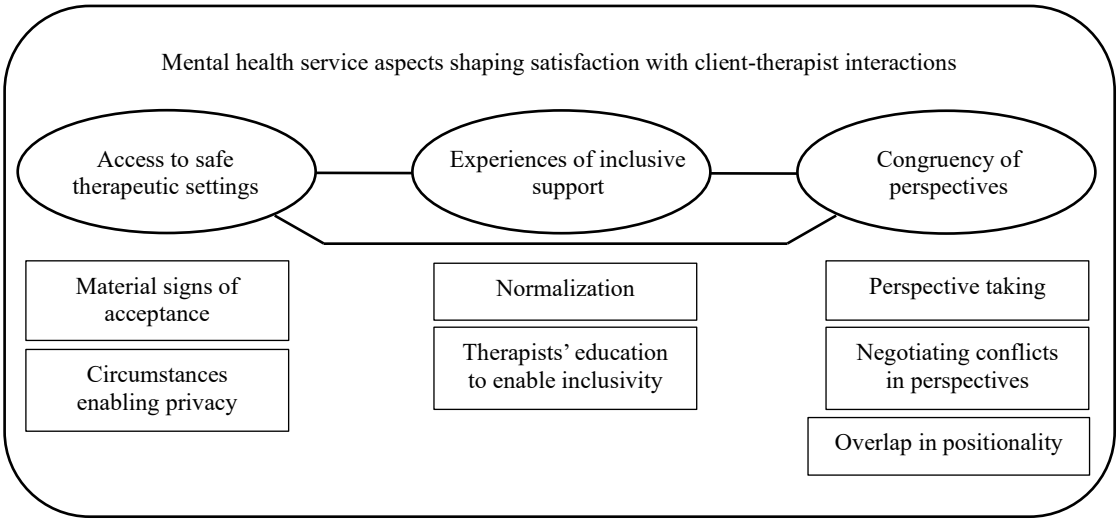
Thematic mapping aided the patterning of codes and generation of conceptual themes to explain links between codes (Braun & Clarke, 2021). When generating themes, analysis was focussed on how SGD status shaped satisfaction of youth located in urban and regional areas, regarding client-therapist interactions. RL and EN, who had reviewed multiple transcripts, engaged BL in reflexive discussions about their impressions of the interview data, codes, and themes. This practice and reflexive journalling supported BL's ability to be critical of the analysis, and to clarify the meaning of codes and themes to articulate the results.

Results

The analysis identified that participants' satisfaction with client-therapist interactions was shaped by mental health service aspects thematically organized across three multifaceted and interconnected themes: access to safe therapeutic settings, experiences of inclusive support, and congruency of perspectives (see Figure 2 for thematic map).

Figure 2

Map of Satisfaction with Client-therapist Interactions Among Sexuality and/or Gender Diverse Youth



Note. Ovals represent themes, rectangles represent subthemes.

Access to Safe Therapeutic Settings

Participants' satisfaction with client-therapist interactions appeared to be shaped by circumstances surrounding those interactions that fostered or diminished young people's confidence to authentically express themselves with therapists.

Material Signs of Acceptance

Participants commonly conveyed that they were wary about drawing attention to their SGD statuses while interacting with therapists when they were uncertain about therapists' attitudes toward sexuality and/or gender diversity. Some participants indicated that services' displays of visual signs to communicate support for this diversity, helped diminish this uncertainty. These signs tended to evoke a strong expectation among SGD youth that therapists would be affirming of their queer identities. This expectation appeared to stem partly from services' prominent displays of these signs, evincing staff at those services as open advocates of sexuality and/or gender diversity. These signs fostered participants' willingness to relax their

defences and express their SGD identities authentically with those therapists upon entering client-therapist relationships.

> … compared to the very behind the times feel of the town … [mental health service is] very open that they are LGBT plus positive, because when you walk through the door … there's a little sticker that says this is an LGBTIQA plus safe space … having that area of freedom and safety for all of us is good ‘cause while I know that people of all kinds are everywhere, it’s hard to tell off of simple looks … (Isa)
>
> … [therapists] could be helpful and are aware and want to help the community, but because they don't have all the ‘you're safe here’ posters and stuff, you don't know, and you might conceal yourself more until you get comfortable … (Hart)

Regardless of location, participants appreciated services’ displays of visual signs to advertise support for sexuality and/or gender diversity. However, accounts of regional-based youth suggested that general community awareness and acceptance of this diversity in these areas was low, especially in outer regional areas, intensifying their wariness about the attitudes of regional therapists. Thus, it seemed that services’ displays of affirmation were especially important in regional contexts.

Other tangible resources serving as signs of therapists’ acceptance of queer identities were administrative forms requesting clients’ details. For Clay, the inclusion of options representing gender diversity on services’ intake forms created an expectation that therapists at those services would appreciate this diversity, contributing to Clay’s sense of security to authentically express their gender identity when initially engaging with those therapists.

> … they would even ask [for preferred pronouns] in the intake form … that made me feel really comfortable ‘cause if they’re asking, obviously they’re going to be fine with it. (Clay)

Circumstances Enabling Privacy

Circumstances that supported or hindered participants’ actual or perceived access to privacy during counselling, shaped willingness among SGD youth to authentically express themselves during client-therapist interactions. Reports from multiple participants suggested that policies designed to protect youth confidentiality played an important role in shaping this willingness. Several young people conveyed that having awareness and confidence in their right to confidentiality contributed to “freeing” experiences when engaging with therapists. This sense of freedom appeared to stem from the understanding that they could openly express themselves with therapists without this affecting their lives outside of sessions against their will.

> … knowing that I can have a conversation, just even in terms of how I’m feeling and not worrying about that impacting any other aspects of my life and relationships with my family or colleagues … there’s the laws, so that’s reassuring. (Daniella)

The data suggested that policies designed to protect youth confidentiality may sometimes be poorly communicated to SGD youth. Further, that this issue may compound any ambivalence that SGD youth may experience regarding their engagement with therapists due to other issues such as wariness of therapists’ attitudes about sexuality and/or gender diversity. It appeared that participants’ uncertainty about their rights to confidentiality discouraged them from speaking openly even when they believed that therapists respected their SGD identification.

For example, Luciana, reflecting on her engagement with a therapist based at her high school, stated:

> … she's way more on the ball with LGBT stuff. She's got lots of gay friends … so its way more open about that kind of thing, but I still haven't got to the comfortability about talking about much deeper things because I guess after the experience at [mental health service], it takes me a lot longer to speak about such things in detail.

Here, the therapist's apparent acceptance and understanding of sexuality and gender diversity appeared to encourage Luciana to discuss topics pertinent to her SGD status. However, "the experience", which involved a previous therapist at a hospital-based mental health service disclosing Luciana's information to her mother without consent, diminished Luciana's confidence about her right to confidentiality, prompting her to limit discussions to relatively superficial concerns.

The results indicated that if therapists inform SGD youth about their rights and limits to client-therapist confidentiality, these young people may perceive those therapists as accountable to abide by the corresponding policies, fostering the client's trust. This process was illustrated by an experience that Luciana had with a different therapist that she had engaged with after the confidentiality breach:

> … I would say some pretty deep things … [the therapist] saying, 'I'm not going to do this [disclose what you say] unless you ask me to'… it had based a lot of trust in the therapist relationship …

The data conveyed that counselling session modality was linked to participants' sense of security to openly express themselves during client-therapist interactions. Among youth who had engaged in sessions via digital communication,

there was a sentiment that these communication channels enabled them to negotiate distance and mobility barriers.

> … living in a rural area means that in-person sessions take up my whole day with hours of travel time … I prefer video … (Myst)
>
> … there were times when I wouldn't be able to get to the place [premises of counselling service] so my parents booked them as online sessions … (Fenn)

However, several participants' reports indicated that the most secure and/or feasible settings available for them to access telehealth were those where privacy may have been compromised. For example, in shared-home settings where youth were concerned about being overheard or interrupted by other house residents, or in public venues with adequate internet quality unavailable from home, particularly in regional areas.

> … [online] sessions with [mental health service], they happen in my room, that's a really comfortable place, but being able to go out somewhere [to access an in-person session] and do what I want, dress how I want, talk how I want … I don't have to worry about being outed randomly by family members … (Isa)
>
> … I would have had to do it [telehealth] at my workplace because of the internet connection, it was the next town over, and it had a better mobile phone tower to actually facilitate that. (Briar)

For some SGD youth, not being able to access telehealth in settings where privacy was assured contributed to their preference for in-person sessions. This preference highlighted the inequitable service access faced by regional youth, who unlike their urban-based counterparts expressed concern about the inadequate number of regional-based in-person services, particularly specialist services.

> … for people that obviously can't travel, we definitely would like to see more [mental health services] down in the Southwest … (Hart)
>
> … having more higher up professionals, like psychiatrists, people who deal with medication, there should be way more people like that in regional areas … if you're seeking medication or diagnoses, you will have to travel. (Luciana)

Experiences of Inclusive Support

Therapists' demonstrations of their attitudes and knowledge about sexuality and/or gender diversity, or lack thereof, was linked to participants' sense of being accepted and supported as persons with SGD status, contributing to participants' satisfaction with client-therapist interactions.

Normalization

Multiple accounts suggested that when therapists demonstrated regard for the client's SGD status or experience as normal, this contributed to the client's sense of being accepted or supported. These experiences fostered a sense of safety for participants to communicate openly about their SGD experiences during client-therapist interactions, based on their trust in therapists to affirm them. Participants' appreciation for this sense of safety seemed to stem from its contrast with their experiences in the community that involved others expressing negative attitudes or a lack of understanding about their SGD identities or experiences.

> … [the therapist] was able to empathize with the more personal sides of gender transition … it feels safe and it's important because a lot of gender diverse youth don't get to experience it. (Kamryn)

According to the data, therapists who conveyed to participants that they viewed their SGD statuses as normal, did so partly by not demonstrating negative attitudes or practices that might have served to stigmatize those statuses.

> … the lack of discrimination or the lack of anything awkward or uncomfortable … those things just make everything feel good and safe for me … My identity is acknowledged and valued and a part of therapy, but it's also not the main focus either cause' I'm not in counselling to talk about my sexuality … (Clay)

Therapists also normalized participants' SGD statuses by evincing awareness of concepts or issues pertinent to those statuses. These actions did not always need to convey a nuanced understanding, but at least a basic appreciation of these concepts or issues. For example, Myst, recalling their therapist's use of their preferred pronouns, stated: "When someone respects my pronouns [they/them] it means they respect my wishes and opinions, even if they don't understand them, and that they are … not judging me for being different to them". In this example, Myst indicated that they did not need their therapist to understand the nuances of their non-binary experience to perceive that their identity was viewed as normal by the therapist. However, the therapist's apparent respect for Myst's preferred pronouns implied that the therapist recognized and appreciated the existence of gender diverse identity.

Two youth described instances of when they had engaged with therapists who appeared to regard concepts or issues pertinent to their SGD statuses as foreign. Despite the absence of any apparent prejudice, therapists' demonstrations of inadequate understanding hindered participants' ability to feel accepted or supported by them. It seems this inadequate understanding created a sense of alienation or isolation for these youth from their therapists. To illustrate this point, Briar recounted

her experience of when she had disclosed her asexuality to her "sex positive" parents, and how they had expressed their struggle to grasp this concept: "… was so confusing in that, 'oh we accept you, but still don't know what the basics mean'." Briar then likened this experience to interactions with her therapist who "didn't know what [asexuality] means", stating: "… it felt very much like, this is happening again." Fenn, recalling how he had talked to his therapist about his non-binary identity and experience of transphobia, stated: "… don't get me wrong, he was[n't] homophobic or anything but it would have been nice if he'd understood the experience somewhat". Fenn added, "… having one of the only people I was being open with not really get it made me feel very alone."

Therapists' Education to Enable Inclusivity

Several participants explained that they sometimes had to educate their therapists about concepts and issues pertinent to their SGD statuses during client-therapist interactions, in some cases, even with therapists employed by services marketed as inclusive of sexuality and gender diversity. These participants conveyed a sense of fatigue from having to educate therapists, with this fatigue seemingly exacerbated for youth who encountered uninformed therapists at inclusive services, contrary to young people's expectations about inclusive support.

> Although the service was inclusive of LGBTQIA+ patients … I felt like I was always explaining terminology like 'dead-name' etc. or things like 'socially vs medically transitioning'. (Aiden)

Some participants conveyed that they would have been more willing to facilitate therapists' education if those therapists had clearly put in the effort to educate themselves once gaps in knowledge had been identified during client-therapist interactions: "If I ask you, 'do you know how polyamory works?' and you

say ‘no’ … do your research, come back, and clarify.” (Gracie) When youth sensed that they were expected by therapists to fulfil the role of educator in the client-therapist relationship, this contributed to participants’ dissatisfaction.

> I told my [psychologist], ‘can you please go and look up what it means so I'm not having to educate you while in session?’, and there was no feedback on that, there was no learnings, that was not implemented … (Briar)

SGD youth communicated that therapists’ demonstrations of inadequate understanding of concepts or issues pertinent to their SGD statuses, conveyed those therapists as lacking the competence to support the management of those issues.

> … it was also obvious it wasn’t really a situation [the therapist] knew how to deal with. (Fenn)

> … I don't think they've done much of their own research. I don’t talk about those aspects as much, I take into account myself how those have impacted the situation. (Gracie)

Congruency of Perspectives

Participants’ observations of therapists’ willingness and ability to understand clients’ experiences from a person-centred perspective, shaped participants’ satisfaction with client-therapist interactions.

Perspective Taking

Several participants recounted moments where therapists appeared to disregard the way they understood or wanted to manage experiences pertinent to their SGD statuses. Here, youth conveyed that their values, beliefs, or feelings had been invalidated, contributing to a sense of being unheard, while reducing young people’s agency to co-direct their support. Youth recalled the aversive states these

experiences elicited, including frustration, discontent, or mistrust, sometimes accompanied by desire for, or actual disengagement from, therapists' support.

> … I felt as though we were only talking about my gender identity and were just stuck in that phase of my therapy, despite me having other issues I wanted to talk about aside from that. I also felt that I couldn't trust them as much because I wasn't entirely present in those sessions … (Aiden)

Joss recalled how a therapist had responded when Joss explained that their rare feelings of attraction were integral to their sexual identity:

> [The therapist] brushed it aside and made some homework on how my feelings don't matter and that I should like others more … I felt a bit disappointed, misunderstood and upset. I felt like I couldn't trust them as much as I did before the discussion and that I should try to seek out somebody that would understand.

Here, the therapist's outwardly dismissive response demonstrated regard for Joss's rare feelings of attraction as trivial and transient, in contrast with Joss's perception of those feelings. Clay recalled how a therapist had pathologized their exploration of gender identity:

> … they were like, 'oh, identity confusion because you're not sure of your pronouns', and they were … saying that was an issue for me when it didn't cause me any issues. I was like, 'hey this thing doesn't cause me any issues … that frustrated me a bit …

These reports convey that therapists' ideas about participants' queer experiences may sometimes stem from assumptions based on societal norms inappropriate for SGD youth, calling for therapists' formal education to oust such assumptions, and to encourage openness to the views of SGD youth.

The data suggested that SGD youth may perceive therapists to be invalidating or disrespectful of how they understand their queer experiences, even when therapists attempt to dissuade these young people from associating those experiences with pathology.

> … ended up stopping counselling as they said she [the therapist] was the only option … when I tried discussing DID [dissociative identity disorder] or gender dysphoria she would reply that she doesn't believe in labels … she was dismissing what I was saying about how it helps me to know and understand more about it. (Kamryn)

The data conveyed that the threat or actual denigration of queer experiences by family, peers, housemates, or strangers evoked distress for SGD youth, that may have been worsened by therapists' invalidation of young people's queer perspectives during counselling. Thus, participants appreciated moments when therapists sought to understand how clients viewed their queer experiences, when clients felt this was relevant to the management of personal issues. Here, participants recalled therapists asking questions that encouraged these youth to articulate and think critically about their thoughts and feelings regarding queer experiences of concern. This guided exploration seemed to be satisfying for SGD youth, as it evidenced therapists' regard for clients' views and encouraged clients to appraise their own perspectives.

> … lets me know they're listening … they ask about the things I say and try to help not only themselves, but also me understanding why I might be feeling like that … (Isa)

> … [gets] me to think about what I'm doing … unpacking things that I've thought for a long time, and just reassessing and being like, 'why do I think

> that?' and that's been helpful in sort of making decisions in my real life that actually benefit me … (El)

Negotiating Conflicts in Perspectives

Some participants expressed hesitance to speak openly with therapists about issues they had with therapists' opinions or support. This hesitance appeared to stem from young people's perceptions of therapists possessing "authority" due to their status as professionals, making it "not socially acceptable" or pointless to offer views that might challenge therapists' competence.

> '… [I told the therapist] my parents generally think that being gay is a choice and they don't really accept trans people and they think it's kind of evil', and then she was like, 'oh well, they wouldn't be wrong, they're kind of telling the truth' … and then I didn't say anything, but in my brain I was like, 'that's not what I was hoping to hear, but cool' … 'if even an official therapist, like psychology person says that to me, then it must be true' … (Clay)

Youth wanted therapists' support to speak openly about perceived conflicts in perspectives. El recalled an occasion where she perceived a conflict in the way her therapist and herself understood sexual orientation, that conveyed how El's confidence to broach the discussion was supported:

> … [they were] open to complaints or disagreeing … they said something that rubbed me the wrong way and I didn't say that it did in session, but then I sent her an email and she emailed back and it was completely cool … she took what I said on board.

The therapist's openness to disagreement was explicit to El who recalled the therapist stating that they were "happy to learn" during the first counselling session. This invitation seemed to imply that therapists' knowledge is not absolute, helping to

redress the power imbalance of the client-therapist relationship, contributing to notable positive consequences for the relationship. El's broaching of the discussion with her therapist revealed that the perceived conflict was a result of "a lapse of wording" that may have otherwise gone unaddressed, and enabled the reconciliation of perceived differences in perspectives, fostering an alliance:

> … glad that I sent that email and had that discussion … You can't expect someone to just show up and have all the answers if you're not openly communicating with them … if I just didn't say that piece about her sexuality … I don't think it would have been as beneficial 'cause we need to be able to see eye to eye.

Several young people reported that communication with therapists during sessions via channels providing less paraverbal information, created barriers to rapport-building:

> … my doctor ended up having COVID, so [we] had to do a phone interview, but I do prefer that face to face interaction more because I like to visually see who I'm talking to." (Hart)

However, the data indicated that young people's ability to communicate asynchronously with their therapists between sessions via email or mobile text, appeared to play a role in supporting their confidence to initiate discussions involving uncomfortable emotions. This affordance of asynchronous communication was illustrated by Daniella as she reflected on the process of making initial contact with therapists:

> … [I] like being able to email, and not having to call … Sometimes it can be really awkward, especially when they're like, 'why, what are your primary concerns?'

Overlap in Positionality

Half the sample linked therapists' understanding of sexuality and/or gender diversity to social groups that therapists belonged to in terms of SGD status, age, and ethnicity.

> … feels like they understand and comprehend what I, as a gender diverse person, am going through because they're LGBTQIA+ themselves … (Kamryn)
>
> … I've had one or two things she said in session, and I was like, 'I don't really agree with that', and I have had the thought that like, 'I think she would have a different perspective if she was queer … (El)

It seemed that these youth believed that queer therapists did, or would have, an empathic understanding of clients' queer experiences due to client-therapist overlaps in societal positions and lived experiences. The data suggested that young people's confidence in a therapist's ability to understand their queer experiences may have been enhanced with even greater alignment in their SGD statuses. For example, when providing suggestions as to how counselling experiences could be made more satisfying, Fenn, who was male-identified and assigned female at birth, stated: "… hiring trans counsellors would be a good step."

Some youth associated age with therapists' understanding of queer experiences:

> … didn't really understand a lot of the LGBT part of my life … That was never really spoken about because she was older, so she didn't quite understand … (Luciana)
>
> … sometimes it's not deliberately derogatory or anything but I think it's a bit of a generational thing … (Daniella)

These reports suggested that SGD youth in our sample may have recognized that public awareness of queer issues has improved with time, but that older therapists may cling to notions about sexuality and gender diversity adopted early in their careers. Thus, therapists who appear to be closer in age to youth may be expected by some SGD youth to be more informed about sexuality and gender diversity.

Young people's assumptions about therapists' understanding of sexuality and/or gender diversity based on therapists' apparent membership to social categories were misleading at times. El explained that she had internalized attitudes about "straight people" and "gay people" that morally exalted the former and denigrated the latter. Thus, when El learned that her therapist identified as heterosexual, she initially interpreted the therapist's responses as "moral judgement" when discussing her sexuality. This interpretative lens began to dissipate as El began to realize that her therapist did not hold these attitudes, partly because the therapist had communicated across sessions that some of the issues El thought of as "gay problems" were also experienced by heterosexuals. Reflecting on the insights shared by her therapist, El stated: "… nice having a straight cis white therapist in that sense …". This account suggested that after El's assumptions about her therapist had been subverted, she was able to appreciate the contrast of the therapist's position with her own position as a gay, transfeminine person of Anglo-Indian heritage. This contrast enabled El to access a perspective that broadened her understanding of her queer experiences, while helping to address internalized homophobia.

Discussion

In Australia, SGD youth are at greater risk of clinically significant psychological distress, self-harm, and suicide relative to the general youth population, with this risk increasing for regional SGD youth (Hill et al., 2021). Based

on verbatim interview data of 13 SGD youth in urban and regional Western Australia, this research explored satisfaction experiences of these young people with client-therapist interactions. Satisfaction among SGD youth appeared to be linked to their trust in therapists to affirm their queer identities, experiences, or views, and certainty that information shared during interactions would remain private. With this trust and certainty, youth indicated that they felt safe, supported, and free to openly express themselves with therapists. When SGD youth felt affirmed by their therapists this fostered a sense of relatedness, and enabled youth to feel heard in the therapeutic relationship allowing for personally meaningful support.

SGD youth conveyed that they experienced diminished satisfaction during client-therapist interactions when they suspected or perceived therapists to possess little understanding, or negative attitudes about their queer identities, experiences, or views. Diminished satisfaction was also apparent when SGD youth suspected their information might be privy to outside parties, or when information was disclosed without consent. When youth anticipated these unwanted events, they often recalled being vigilant during interactions or doubted therapists' support. Youth who experienced these unwanted events conveyed feeling alienated, dismissed, or judged by their therapists, often prompting avoidance of those therapists. Whether youth anticipated or experienced these events, they tended to express an urge to subdue their queer identities or to resist discussing SGD topics.

In line with minority stress theory (Frost & Meyer, 2023; Meyer, 2003), our results suggest that if SGD youth sense that they are protected from distal stressors (externally imposed stigma directed toward sexuality and/or gender diversity) during client-therapist interactions, this may reduce their vigilance or need to conceal their SGD statuses during interactions. However, the objective absence of distal stressors

may be insufficient to instil trust in therapists among SGD youth (Frost & Meyer, 2023; Meyer, 2003). Young people in our study required cues in the physical and relational settings involved in client-therapist interactions to foster a sense of safety to authentically express their queer identities, experiences, and views.

Diamond and Alley's (2022) social safety model offers an explanation when examining the role of safety cues in supporting the confidence of SGD youth to openly connect with others. The model, developed with a focus on SGD populations, defines social safety "as reliable social connection, social belongingness, social inclusion, social recognition, and social protection … essential human needs at all stages of life" (p. 1). Based on human evolution, development, and neurobiological research, Diamond and Alley proposed that humans are innately vigilant, and that detection of social safety cues reduces vigilance more so than the actual or perceived absence of threat cues, since our ancestors learnt that their survival was more likely with human support. If social safety cues are undetected in a setting by persons with SGD status, these persons may refer to past experiences to appraise that setting's safeness. If SGD youth have encountered distal stressors in the past, their vigilance may not abate in that setting even if no distal stressors are objectively present or perceived (Diamond & Alley, 2022).

Accordingly, while SGD youth in our study indicated that the absence of any apparent prejudice or discrimination from therapists contributed to their comfort and willingness to engage with therapists, this non-event was not always enough to foster clients' trust in therapists to support them as queer individuals. Youth who referred to services' use of material signs to communicate inclusivity of sexuality and/or gender diversity, indicated that these signs were prominent in fostering their security to openly express themselves when initially engaging therapists. SGD youth may

even bypass health services that do not explicitly advertise inclusivity of sexuality and/or gender diversity (Newman et al., 2021; Robards et al., 2019; Spurway et al., 2022). Consistent with our results, flags, posters, and intake forms that are inclusive of this diversity, have been shown to be signs guiding choice of therapists among SGD youth (Robards et al., 2019; Spurway et al., 2023).

While SGD youth in urban and regional areas valued material signs, our data suggest that these signs were particularly impactful for regional SGD youth. While most youth spoke of their exposure to distal stressors in specific settings such as their homes, health services, and educational institutions, SGD youth with regional experience tended to consider their communities as generally unaware or unaccepting of sexuality and gender diversity. These results reinforce Australian national data suggesting that regional SGD youth experience greater levels of homophobia, transphobia, and isolation (Robinson et al., 2014) and less safety (Hill et al., 2021) than urban counterparts. Ubiquitous heteronormativity seemed to intensify a wariness of the general community for regional youth in our study, and thus their need for the display of material signs by mental health services to advertise affirmation of sexuality and gender diversity.

An aspect that appeared to signal inclusive support and foster affirmative experiences for SGD youth during client-therapist interactions, were therapists' demonstrations of knowledge about concepts and issues pertinent to clients' SGD statuses, and efforts to independently rectify germane gaps in knowledge. Newman et al. (2021) also found that LGBTQ+ youth in their study viewed health professionals' demonstrations of this knowledge as integral for conveying professionals' competence to offer inclusive support. Further, that this knowledge be gained from training and education systems. Echoing the voices of Mackie et al.'s (2021)

transgender student sample, SGD youth in our study indicated that therapists' demonstrations of recognition, appreciation, and understanding of client's queer identities and experiences were needed to enable a sense of normalization, acceptance, and connection with therapists. These demonstrations of knowledge and of efforts to acquire knowledge without relying on clients to educate therapists, may serve as potent social safety cues for SGD youth.

Our analysis suggests that if SGD youth perceive therapists to contrast with themselves in terms of social categories including SGD status, age, and/or ethnicity, SGD youth may assume that this contrast will lead to a divergence of client-therapist understandings of sexuality and/or gender diversity, and vice versa. As conveyed by our results, SGD youth may therefore interpret perceived contrasts as threat cues, and similarities as safety cues. These patterns mirror the role of positionality in the participant-researcher relationship, where contrasts in social positions may lead the researcher to understand the participant's experience in a way that diverges from, or even conflicts with, the participant's own understanding. Meanwhile, similarities in positionality may enable empathic understanding (Greene, 2014). The accounts of SGD youth who referred to contrasts or similarities between themselves and their therapists regarding SGD status, age, and/or ethnicity, reinforced these notions about positionality. However, SGD youth indicated that therapists who appeared to contrast with themselves in terms of these facets of identity, were not necessarily naïve or denigrating of their queer identities or experiences. Here, client-therapist contrasts in SGD status, age, and ethnicity enabled the client to access a novel perspective that broadened their understanding about their queer identity and experiences.

Therapists' SGD status, age, or ethnicity may not be reliable cues to signal threat or safety for SGD youth. Gay and lesbian clients have reported experiencing

culturally competent care with heterosexual therapists (Liddle, 1996) whether therapists were perceived as younger or older (Bishop et al., 2021). Spurway et al. (2023) found that among 13 First Nations LGBTIQSB+ youth, there were reports of satisfying therapeutic experiences with therapists who were not Indigenous Australians. Thus, therapists may need to initiate discussions with SGD youth about their knowledge of, and experience with sexuality and/or gender diversity early in the client-therapist relationship. This practice could subvert assumptions that SGD youth may have about their therapists based on apparent social positions or demographic characteristics. This point highlights the utility of intake forms in ascertaining the relevance of diversity to clients. Since clients' SGD statuses cannot be confirmed via observation alone, therapists could use intake data to gauge whether to raise discussions about, or focus on, sexuality and/or gender diversity (Bishop et al., 2021). The need for therapists to broach these conversations may be especially important, since some youth in our study were hesitant to speak openly with therapists about matters that they believed might challenge therapists' competence. Consistent with this result, of the 53% of gender diverse youth in Smith et al.'s (2014) sample (N = 189) who had a negative experience with a health professional, 6% made a complaint. Newman et al. (2021) found that LGBTQ+ youth often chose to terminate engagement with health professionals over having awkward discussions with them.

Aligned with Bishop et al.'s (2021) findings, our data indicate that the therapeutic alliance may benefit if therapists explicitly communicate to youth that therapists' knowledge is not absolute, and clearly invite discussions around divergent views. These declarations may serve as social safety cues for SGD youth to openly express their views. Further, therapists may signal openness to the views of SGD

youth by exploring and incorporating the perspectives of these young people into the support provided. Echoing our results, research shows that SGD youth want therapists to explore how clients make sense of their SGD statuses (Bishop et al., 2021) and how it should feature in therapy, if at all (Byron et al., 2017; Newman et al., 2021; Strauss et al., 2021).

The data conveyed that the ability of SGD youth to communicate asynchronously with therapists between sessions (e.g., via email) aided in reducing awkwardness around initiating uncomfortable discussions, seemingly due to the lack of emotional cues. Other SGD youth have also voiced a desire for health services to facilitate communication with clients via digital means, to ease them into in-person discussion (Robards et al., 2019). If therapists inform SGD youth that they can use asynchronous communication channels to broach uncomfortable topics between therapy sessions, this gesture may serve as a social safety cue, evincing therapists' openness to clients' views. Taking feasibility into account, therapists who offer this affordance to clients might need to set clear boundaries around asynchronous communication; for example, by stating that concerns raised via email can be incorporated into the agenda of upcoming sessions, rather than having in-depth discussions asynchronously.

The home setting may not always foster a sense of social protection for SGD youth to engage in online client-therapist interactions (Bowman et al., 2020; McQueen et al., 2022). Several young people in our study were wary of having their SGD status disclosed due to being overheard, or lived with others unaccepting of sexuality and gender diversity. Among youth who felt that their home was relatively safe, some SGD youth with regional experience reported having poor internet availability in their residential areas, prompting the use of public spaces with good

internet availability; a common occurrence in non-urban areas (Bowman et al., 2020; McQueen et al., 2022). Some regional SGD youth from our sample preferred in-person counselling sessions because professional mental health settings better assured them of their privacy. However, regional-based mental health services are notably limited in number (Robards et al., 2019). Regional SGD youth in our study commonly travelled several hours to attend urban services. Mental healthcare providers may enhance service access for SGD youth by providing conveniently located facilities affording adequate internet quality to facilitate online counselling, prioritizing regional areas (McQueen et al., 2022). Designers of these facilities could draw inspiration from privacy cues featured in professional mental health service settings.

Strengths and Limitations

Based on in-depth accounts of urban and regional SGD youth in Western Australia, our study provides guidance to mental health service providers on practices they may employ to signal and support the social safety of SGD youth during service engagement in similar contexts. These practices may simultaneously prevent or diminish the actual or perceived presence of minority distal stressors during service access for SGD youth, enabling these young people to openly communicate with therapists; a process that appears to meaningfully foster satisfaction for SGD youth. Our results suggest that services' efforts to be inclusive, a key element of social safety, do not always equate to inclusive experiences for SGD youth. By exploring the experiences of these young people regarding their satisfaction with client-therapist interactions, we accessed their interpretations of inclusivity.

Several features of our sample shape the transferability of the results. While the results are based on reports of youth collectively identifying as LGBTIQA+, no cisgender gay males participated. The intersex person in the sample focused on gender diversity issues during their interview and was thus referred to as gender diverse in this study. However, many intersex people do not regard their intersex status as a gender identity, or identify as gender diverse (Intersex Human Rights Association, 2021a). Intersex people are subject to unique forms of stigma due to having innate variations of sex characteristics. While having mental health needs that overlap with other populations, intersex people also have distinct mental health needs that future research should explore (Intersex Human Rights Association, 2021b). SGD youth recounted engagements with mainstream, inclusive, and LGBTIQA+ specific services, and online and in-person interactions with community-based counsellors and community- and hospital-based psychologists and psychiatrists. However, most interactions occurred in outpatient settings.

Unique aspects may shape satisfaction with client-therapist interactions among SGD youth in inpatient settings (Biering, 2010). For example, among gender diverse youth, the prevalence of low inpatient service satisfaction appears to be greater than for outpatient services (Strauss et al., 2021). Research could explore service aspects shaping satisfaction with, or a sense of social safety in, inpatient services for SGD youth. Measures of social safety for persons with SGD status are needed (Diamond & Alley, 2022) and our results may help to inform measures relevant to mental health service engagement. However, studies specifically designed to explore perceptions of social safety among SGD youth in mental health service settings are needed to realize this goal.

Conclusion

Confidence among SGD youth to authentically express their queer identities, experiences, and views while interacting with therapists may notably enhance service satisfaction for these young people. Supporting an experience of social safety for SGD youth when engaging with mental health services may be an effective strategy for fostering a sense of relatedness with therapists to enable this confidence, allowing for self-determined therapeutic experiences. In Western Australia, regional SGD youth may have inequitable access to mental health services that support a sense of social safety, relative to urban SGD youth. Among our sample, this inequity stemmed from the inadequate provision of professional mental health services in regional areas and poor internet availability in regional households, hindering access to safe spaces to engage in-person or online with therapists. As with past research, we identified that cis-heteronormativity appears to be more entrenched in some regional communities relative to urban communities. This characteristic may place regional SGD youth at more risk of minority stress, suggesting that their need for access to services supporting a sense of social safety, may be critical.

Authors' Contributions

BL: conceptualisation (lead); data curation (lead); formal analysis (lead); investigation (lead); methodology (lead); project administration (lead); visualisation (lead); writing – original draft preparation (lead); writing – review and editing (lead). **RL:** conceptualisation (supporting); formal analysis (supporting); methodology (supporting); project administration (supporting); supervision (equal); visualisation (supporting); writing – review and editing (equal). **EN:** conceptualisation (supporting); formal analysis (supporting); methodology (supporting); project

administration (supporting); supervision (equal); visualisation (supporting); writing – review and editing (supporting).

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Signed:

Chapter 4: General Discussion

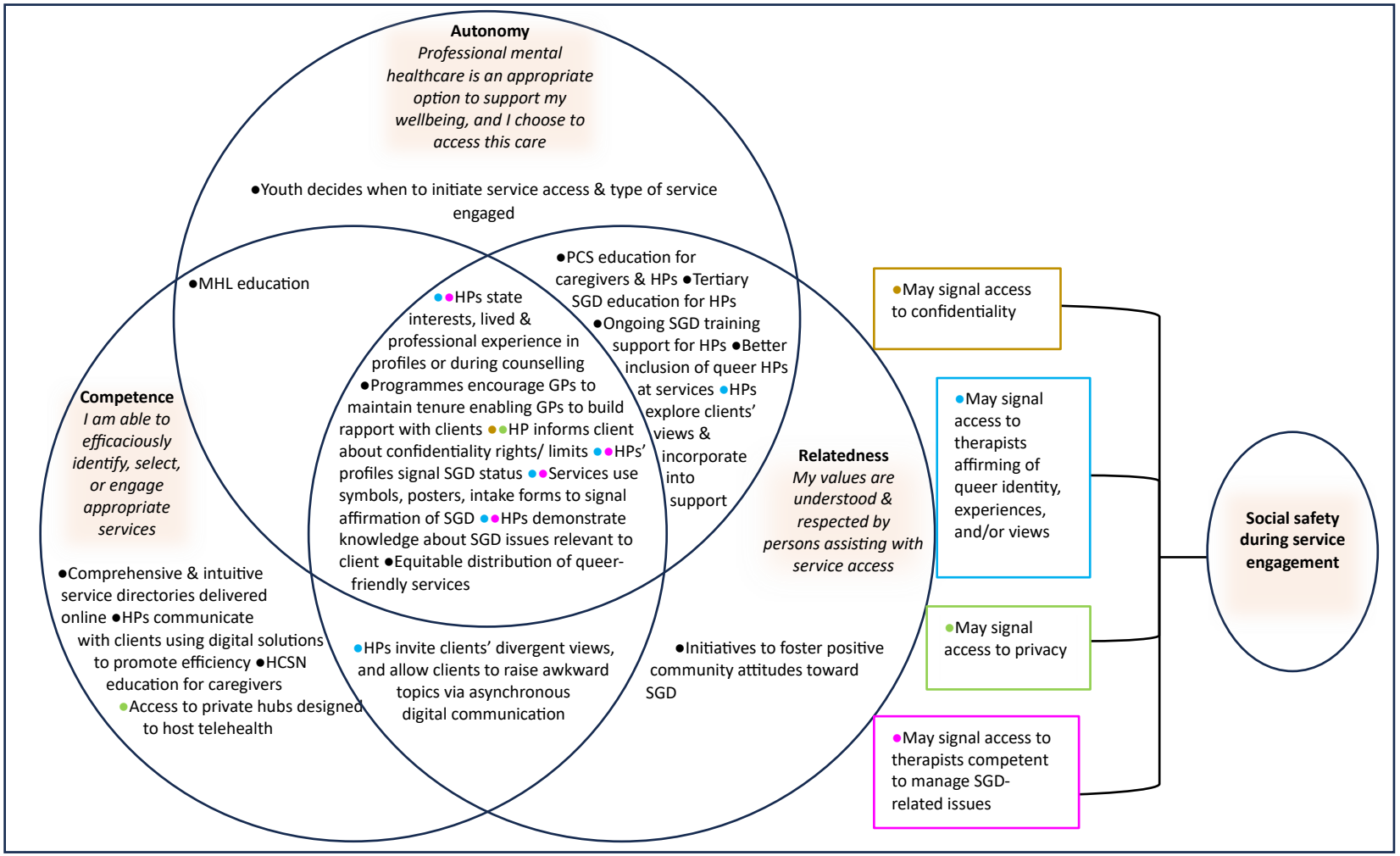
The higher prevalence of clinically significant psychological distress among sexuality and/or gender diverse (SGD) youth relative to youth overall, is compounded by inadequate access to professional mental healthcare faced by this subpopulation (Hill et al., 2021; McDermott et al., 2021). Given the unique geography and healthcare infrastructure of Western Australia (WA), and the state government's aim to improve health service access for SGD populations, this research explored perspectives of urban and regional SGD youth in WA (N = 13; age range = 15 to 24 years), regarding factors linked to mental health service access and satisfaction.

Research Implications

In line with Self-determination theory (Ryan & Deci, 2000), the results of the current research suggest that practices, programmes, and initiatives supporting a sense of autonomy, competence, and relatedness for SGD youth during the process of service access, may facilitate their ability to attain support they deem appropriate. During service engagement, certainty of access to social safety (Diamond & Alley, 2022) as signalled by the presence of cues, may foster these three basic needs for SGD youth allowing for personally meaningful interactions with therapists, characterised and facilitated by these young people's authentic expression and ability to co-direct support. Figure 3 arranges practical recommendations aligned with the findings that may foster a sense of autonomy, competence, and/or relatedness during the service-access process for SGD youth, and indicates which recommendations may act as social safety cues.

Figure 3

Recommendations That may Foster Autonomy, Competence, and/or Relatedness During Service Access for Queer Youth



Note. ● = Practical recommendations that may foster autonomy, competence, and/or relatedness during service access and may enable a sense of social safety during service engagement, but that do not serve as cues to signal this social safety in and of themselves. HCSN = Healthcare-system navigation; HP = Health professional (includes therapists); MHL = Mental health literacy; PCS = Person-centred support; SGD = Sexuality and/or gender diversity.

The Western Australian LGBTI Health Strategy, 2019-2024 (hereinafter 'the Strategy') provides a five-year roadmap to enhance the health and wellbeing of sex, sexuality, and gender diverse persons in WA, by guiding policies and practices to enable their equitable access to an inclusive health system (Western Australian Department of Health, 2019). Practical implications of the current research are discussed below in terms of how they support the implementation of the Strategy and vice versa. Further, based on these practical implications, recommendations are proposed as to how future iterations of the Strategy could be strengthened. In instances where the implications are not accommodated by policies of the Strategy, or when elaboration of the guidance provided by the Strategy is needed, other policy documents that complement the Strategy are drawn upon.

These documents include the Western Australian Youth Health Policy, 2018-2023 (Western Australian Department of Health, 2018), National Action Plan for the Health of Children and Young People, 2020-2030 (Australian Government Department of Health, 2019), and implementation guidelines of the National Standards for Mental Health Services (Australian Government Department of Health and Aged Care, 2010a, 2010b, 2010c). The health consumer bases primarily targeted by the policies in these documents vary (i.e., youth in WA, youth across Australia, and all mental health consumers across Australia, respectively). However, the policies are united and complementary to the Strategy in that they provide guidance to the jurisdictionally relevant health systems and services, to optimise the health and wellbeing of the corresponding consumer bases, recognising the importance of responsiveness to diversity to achieve health equity. Five overarching practical implications arising from our findings relate to this policy guidance as detailed below.

1. Web-based and material information resources can facilitate access to inclusive services for SGD youth. Collectively, SGD youth expressed a desire for access to an intuitive and comprehensive mental health service directory, that would include details about service referral pathways, waitlist times, and therapists' professional and lived experience or interests, to guide their navigation of the healthcare system toward inclusive services. Echoing previous research, SGD youth in our sample were partial to this resource being available online (Byron et al., 2017), and commonly looked for information on service websites and databases to identify therapists who could provide affirming and competent support to SGD populations (Robards et al., 2019).

During service engagement, SGD youth (including persons in our sample) have indicated being mindful of the use or display of material resources at services that convey affirmation of sexuality and/or gender diversity (e.g., intake forms, flags, posters), to gauge the inclusivity of those services (Newman et al., 2021; Spurway et al., 2023). Absence of these signs may result in SGD youth avoiding a service (Newman et al., 2021; Spurway et al., 2023), or as was identified in Study 1 and 2, may evoke reluctance among SGD youth to openly communicate with therapists. These findings suggest that service providers should use these cues in physical service settings, and in online service directories to advertise inclusivity. Multiple youth in our study regarded the lived experience of queer therapists as an asset that could enable the provision of affirmative and competent support for SGD youth. This suggests that queer therapists may facilitate the service selection process for SGD youth by including information in professional profiles to indicate SGD status (e.g., pronouns, flags). These practical suggestions align with the recommendations of Priority 1 of the Strategy: "LGBTI populations' experience of health services is

LGBTI inclusive and meets all physical and mental health and wellbeing needs" (p. 18).

2. *Clients' time and finances can be used more effectively throughout the process of service access if health professionals, including therapists, communicate with clients using digital solutions to promote efficiency*. This implication also aligns with Priority 1 of the Strategy. Echoing our results, Robards et al. (2019) found that inefficient healthcare-system processes may thwart a sense of agency for youth from marginalised groups, evoking ambivalence toward service engagement. Consistent with the preferences of SGD youth from Robards et al.'s study and the current research, the Strategy recommends under Priority 1 that digital technology be used to streamline SGD populations' service access, particularly for non-urban residents.

Our results suggest that a potential extension to the digital solutions recommended under Priority 1 of the Strategy may be useful for future iterations of the policy. For example, the Strategy recommends that telehealth services be especially accessible to non-urban clients but does not account for the poor internet quality that is common to non-urban residential areas, and that hinders access to telehealth from home as indicated by our results and extant research (Alizadeh et al., 2023; Bowman et al., 2020; Cheng et al., 2021; McQueen et al., 2022). Our results support McQueen et al.'s (2022) proposal; specifically, that hubs with good internet quality be provided in non-urban areas to host online consultations, thereby also allowing non-urban clients to save on ancillary internet costs.

The Strategy recommends that "privacy rights of LGBTI populations are widely promoted, marketed and upheld" (p. 28). According to the implementation guidelines of the National Standards for Mental Health Services, Standard 1: Rights and Responsibilities, mental health providers are obligated to uphold the client's

right to privacy by providing physical spaces securing clients' access to privacy when waiting for, and engaging in, consultations (Australian Government Department of Health and Aged Care, 2010a; 2010b; 2010c). Given that privacy issues when engaging in telehealth are amplified for non-urban youth due to the typical restriction of quality internet to public spaces (Bowman et al., 2020; McQueen et al., 2022), these policies could apply to the provision of telehealth, supporting the implementation of these service hubs.

Our results suggest that SGD youth may save time and finances if therapists and health professionals include clients in interprofessional discussions concerning the client's care, for example via carbon-copy email. This affordance might reduce the number of consultations SGD youth need to engage in to be relayed information. GPs could more efficiently gain an understanding of young clients' mental health problems by allowing youth to complete psychosocial assessments on youth-friendly mental health screening apps prior to consultations (Bellairs-Walsh et al., 2020; Cheng et al., 2021). One such app, Check Up GP, digitally notifies the GP of any risk or protective factors based on the client's responses, that can then assist the GP in identifying mental health services well catered to the client's needs, during time-limited consultations (Bellairs-Walsh et al., 2020; Webb et al., 2017). Several SGD youth indicated that asynchronous digital communication with therapists outside of counselling sessions made it easier to broach uncomfortable topics with therapists. Having access to this option may allow SGD youth and therapists to prepare for in-person discussions prior to upcoming counselling sessions, enabling for more efficient and effective navigation of these topics during sessions.

3. *To facilitate their access to appropriate mental healthcare, educational efforts may need to target SGD youth, support persons assisting them with service*

access, and communities that SGD youth are immersed in. Our findings indicate that in typically interconnected cis-heteronormative contexts, for example, regional (Bowman et al., 2020; Lewis, 2020; Robinson et al., 2014) and pre-tertiary educational settings (Fowler & Buckley, 2022), SGD youth may be especially concerned about encountering therapists unaccepting of their SGD status. Aligned with our findings, research suggests that these circumstances may compound worries for SGD youth about therapists breaching client-therapist confidentiality, and attracting prejudice and discrimination from community members as a result (Bowman et al., 2020; Byron et al., 2017). To help remedy this predicament, initiatives designed to foster positive attitudes toward sexuality and gender diversity may need to prioritise such community contexts, in tandem where applicable. As Leung et al. (2022) identified, programmes aiming to destabilise cis-heteronormative school climates appeared to be less effective when situated in wider communities where cis-heteronormativity remained entrenched.

Priority 2 of the Strategy: "The WA health system provides leadership and promotes affirmative practices for the health and wellbeing needs of LGBTI populations" (p. 20), supports initiatives to raise community awareness and acceptance of sexuality and gender diversity, by advocating for better representation of SGD populations in health promotion campaigns. The implementation guidelines of the National Standards of Mental Health Services relevant to Standard 5: Promotion and Prevention, provide further direction as to how these initiatives could be brought to fruition, by recommending that mental health services collaborate with community members and other sectors (e.g., community organisations, local councils, educational institutions) to gather resources and build capacity to promote the mental health of socially diverse groups (Australian Government Department of

Health and Aged Care, 2010a; 2010b; 2010c). Since the link between minority stress and poor mental health among SGD populations is well established (Frost & Meyer, 2023; Meyer, 2003), collaborative efforts to develop and implement these awareness-raising initiatives, particularly in highly cis-heteronormative contexts, is warranted.

Mental health literacy, involving knowledge enabling one to understand mental distress and its treatments (Kutcher et al., 2016), appeared to facilitate participation in, and self-efficacy during, the process of accessing mental healthcare for SGD youth. However, youth in our study sometimes attributed acquisition of this literacy to pathways or sources inaccessible to many marginalised young people; for example, by trialling multiple services (Robards et al., 2019) or via tertiary education (Farrer et al., 2016). To enhance accessibility to mental health literacy education, programmes may need better integration within pre-tertiary curricula when school attendance is compulsory (Nash et al., 2021; Rickwood et al., 2007). These programmes would also provide an opportunity for youth to be informed about their rights and limits to client-therapist confidentiality. This knowledge may be especially useful for minors who will likely be accustomed to having caregivers making decisions on their behalf (Kelly & Halford, 2007).

In line with these recommendations, under Priority 2, the Strategy recommends that the WA health system provides health literacy programmes for LGBTI populations. However, the Strategy does not explicitly acknowledge that health literacy developed during youth, would be particularly effective for preventing ill health among these populations across time (Wilson & Cariola, 2020). The development and implementation of health literacy programmes targeting youth is supported by the Western Australian Youth Health Policy, Priority 1.1: “Young people are equipped with the knowledge, skills, and behaviours to optimise their

health and wellbeing" (p. 14), and Priority 1.2: "Young people are empowered to participate in decisions that affect their health and wellbeing" (p. 17). Based on these priorities, mental health services, GPs, and educational institutions could collaborate to realise these programmes. Further, under Priority 1.2, the policy recommends that health professionals routinely inform youth about their rights and limits to client confidentiality during client-therapist interactions. This recommendation is broadly supported by the Strategy that states: "Confidentiality and privacy rights of LGBTI populations are widely promoted, marketed and upheld" (p. 28). Our results suggest that if health professionals personally inform SGD youth about their rights and limits to client confidentiality, this may foster their trust in therapists to be accountable to respect these boundaries, fostering open communication. Policymakers could consider including this recommendation in future iterations of the Strategy.

Regardless of geographical context or whether services were in or outside educational institutions, there were youth who reported engaging with therapists who demonstrated poor understanding about sexuality and/or gender diversity, and felt forced to educate therapists. Previous research indicates that these experiences are common across a range of healthcare settings for SGD youth (McNair & Bush, 2016; Lovejoy et al., 2023), often prompting disengagement from professional care (Newman et al., 2021; Smith et al., 2014). Education on how to provide affirming and competent care to queer clients may need to be integrated into formal curriculum for health professionals. Further, service providers may need to encourage health professionals and therapists to proactively build upon this knowledge throughout their tenure to meet individual clients' needs, by enabling good access to relevant educational and training programmes. These practical implications are supported by recommendations under Priority 5 of the Strategy: "The Western Australian health

system, health services, and healthcare professionals and support staff are equipped with the knowledge, skills and understanding to meet the health and wellbeing needs of LGBTI populations" (p. 25).

Our results cohere with the findings of Roberts et al.'s (2021) meta-synthesis on factors contributing to adolescents' mental healthcare engagement, in that youth were more willing to engage with services when support persons allowed youth to determine when to initiate engagement and influence the type of service accessed. The accounts of SGD youth in our study also suggested that their ability to access appropriate services was facilitated by support persons' experience with healthcare-system navigation, consistent with the findings of Robards et al. (2019). Thus, the implementation of initiatives designed to build caregivers' knowledge about person-centred support and healthcare-system navigation may serve to facilitate service access for SGD youth.

The Strategy recognises the importance of taking a holistic approach to realise equitable healthcare access for LGBTI populations, stating that the WA health system, LGBTI consumers, and their support networks have roles to fulfil in helping to achieve this goal. However, there are no recommendations in the Strategy that advocate for the capacity-building of caregivers to assist youth with healthcare-system navigation to access health services. Such policy is explicit in the National Action Plan for the Health of Children and Young People, under Priority 2: "Empowering parents and caregivers to maximise healthy development" (p. 15) and could be incorporated into the Strategy going forward.

4. *Person-centred support appears to facilitate multiple stages of the service access journey*. Our data suggested that SGD youth were more willing or able to engage with professional mental health services when they felt support persons

(caregivers, health professionals, therapists) respected the young person's readiness to pursue professional care; understood the mental health needs of the young person and were thus in a position to assist with the selection of appropriate services, or to generate care plans that would provide meaningful support during service wait times; and affirmed clients' views by incorporating these into the support provided during counselling. As mentioned, the Strategy does not acknowledge in its recommendations the role of caregivers providing person-centred help-seeking support to SGD youth to facilitate service access. However, Priority 1 and 5 of the Strategy collectively call for the WA health system to provide training to health professionals that can build their capacity to respond to the needs of LGBTI populations. Based on the convergence of our findings with extant research (Bishop et al., 2021; Byron et al., 2017; Newman et al., 2021; Strauss et al., 2021), highlighting appreciation among SGD youth for health professionals who demonstrate respect for clients' unique perspectives, it seems appropriate that the Strategy also advocate for training that could strengthen the capacity of health professionals to respond to the needs of LGBTI *individuals*. The Western Australian Youth Policy explicitly acknowledges the importance of health professionals and therapists providing person-centred support to youth under Priority 1.2: "Young people are empowered to participate in decisions that affect their health and wellbeing" (p. 17). Recommendations from Priority 1.2 could be integrated into future iterations of the Strategy.

An implication of our results not acknowledged in the Strategy or under Priority 1.2 of the Western Australian Youth Health Policy highlights the importance of GPs' tenure. Person-centred support is facilitated by the client's trust in the health professional (Western Australian Department of Health, 2018) and for SGD youth,

this trust can be slow building (Byron et al., 2017). Due to the high turnover of regional-based GPs (Western Australian Department of Health, 2018), our data suggest that SGD youth from regional areas may commonly seek service referrals from unfamiliar GPs. Due to a lack of rapport, these young people may experience doubt over the appropriateness of services recommended by unfamiliar GPs and may resist engagement with those services. Innovation may be required for the design and implementation of programmes aimed at encouraging GPs to maintain their tenure in non-urban areas (Department of Health, 2023), supported by policy.

5. *Therapists may need to account for the power imbalance of the client-therapist relationship and how this affects young people's communication with them.* Several SGD youth indicated that they viewed therapists as authority figures due to therapists' expert and professional status, and were reluctant to speak openly about topics that may have been construed as a challenge to therapists' competence. Extant research suggests that SGD youth commonly choose to terminate engagement with health professionals over making a complaint or having awkward discussions with them (Newman et al., 2021; Smith et al., 2014). Consistent with the findings of Bishop et al. (2021), our results suggest that therapists may help redress this power dynamic by explicitly communicating to clients that therapists' knowledge is not absolute, and by inviting discussions around divergent views. The Strategy emphasises under one of its major goals that LGBTI persons be empowered to advocate for their wellbeing and co-direct their care. Accordingly, developers of future iterations of the Strategy could consider including the recommendation provided here.

Our findings suggest that SGD youth may make assumptions about therapists' understanding of, and competence to support the management of SGD

issues, based on perceived aspects of therapists' social positions, including SGD status, age, and ethnicity. Consistent with this finding, Bishop et al. (2021) found that LGB persons expected younger and/or queer therapists to be better prepared to support queer clients. To subvert potentially erroneous assumptions, therapists may need to broach discussions about their professional and lived experience with SGD youth early in the client-therapist relationship, since SGD youth may be uncomfortable initiating these discussions themselves. Given that the Strategy acknowledges the importance of health professionals and therapists managing the power imbalance of their relationship with clients, this recommendation could be considered for inclusion in the Strategy going forward.

Strengths and Limitations

This research adds to the exiguous, yet important body of literature focussed upon experiences of SGD youth with mental health services in WA. Tailored supports within healthcare systems have been built upon norms applicable to cisgender heterosexual adults that may marginalise SGD youth (Lovejoy et al., 2023; McDermott et al., 2021). Accessing the perspectives and experiences of SGD youth is vital to realise healthcare systems inclusive of these young people. While based on the accounts of a small sample, the results converge with extant research focussed on the health service access of SGD youth nationally (Bowman et al., 2020; Byron et al., 2017; Hill et al., 2021; Newman et al., 2021; Robards et al., 2019; Spurway et al., 2023). The results highlight considerations for the implementation of current health policies, and future iterations of the Western Australian LGBTI Health Strategy, to enhance mental health service access in WA and similar contexts for this population.

To the author's knowledge, this is the first piece of research to draw upon Self-Determination theory (Ryan & Deci, 2000) and Diamond and Alley's (2022)

conceptualisation of social safety, to understand satisfaction with mental health services among SGD youth. Future studies quantitatively testing the theoretical propositions suggested here could help to consolidate this conceptual understanding. The Youth Service Satisfaction Scale, which measures satisfaction with service aspects of in-person (Rickwood et al., 2017) and online mental healthcare (Rickwood et al., 2019), staff interactions, and outcomes of counselling, could serve to gauge satisfaction among SGD youth both quantitatively and in clinical settings. However, the psychometric properties of these scales are yet to be validated specifically among members of this population. The current research suggests that the content validity of these scales might also be improved by adding items that assess satisfaction with navigation toward services (e.g., satisfaction with referral processes and waitlist times).

Overarching research questions of the current project were aimed at gaining insights into what shapes satisfaction with mental health counselling services (Study 1), and client-therapist interactions (Study 2), among SGD youth in WA. Accordingly, there was a degree of overlap in the results, regarding satisfying and dissatisfying aspects of mental healthcare engagement. However, the studies provide unique and complementary contributions. Specifically, Study 1 identifies how healthcare-system navigation experiences contribute to satisfaction with services among SGD youth. Study 2 provides a broader and more in-depth analysis of service aspects encountered during mental healthcare engagement that shape satisfaction among this population.

Synchronous and asynchronous digital mediums (phone call and video-conference, and email and SMS, respectively) were used to conduct participant interviews to overcome geographical and social distancing barriers that were in effect

to prevent COVID-19 transmission during data collection. It was also anticipated that these options would provide young people with enhanced access to interview locations that afforded adequate internet quality and privacy, and ability to accommodate interviews into their various schedules (Amri et al., 2021; Khan & MacEachen, 2022). All interview mediums were requested by participants, with five interviews conducted via video-conference, four via SMS, three via phone call, and one via email. Thus, inclusion of this range of mediums may enhance participant recruitment rates for future studies involving interview data collection.

Consistency of the interview data appeared to vary across synchronous and asynchronous mediums. Cohering with Ratislavová and Ratislav's (2014) research, young people's SMS and email interview responses tended to be more structured relative to those garnered via synchronous interviews, likely due to participants' greater opportunity to reflect on, and articulate ideas. Nonetheless, data across all interviews conveyed sentiments that contributed meaningfully to the construction of conceptual themes in line with quality RTA (Braun & Clarke, 2021). The lack of paraverbal cues to appraise participants' emotional states during asynchronous interviews did create challenges for the interviewer regarding when to cease probing into issues, consistent with Ratislavová and Ratislav's observations. However, this drawback, encountered to a lesser degree during video-conference and phone call interviews, was compensated for in the current study by the interviewer's enhanced capacity to carefully craft interview prompts to elicit insightful responses (Amri et al., 2021).

In both studies, participants were recruited via community organisations and service providers affiliated with or invested in the wellbeing of the target population, a psychology undergraduate research participant pool in Study 1, and Facebook and

Instagram advertisements in Study 2. Time constraints limited recruitment to a three- and four-month phase (July to September 2022 and May to August 2023). Further, challenges were anticipated regarding recruitment of a stigmatised population to share information about potentially sensitive issues (Ellard-Gray et al., 2015). Resultantly, eligible youth who expressed interest in participating in the research (SGD youth residing anywhere in WA during Phase 1; SGD youth residing in WA with non-urban experience during Phase 2) were recruited via a convenience sampling strategy.

Due to the adoption of this recruitment strategy and challenges accessing members of the target population, in Study 1, one youth with regional experience participated, all youth resided in Perth, and a total of seven participants were recruited. Also, five of the seven youth came from the psychology undergraduate research programme. Accordingly, the findings of Study 1 may be most relevant to urban-based SGD youth, and the relatively high level of mental health literacy likely possessed by most members of the sample should be considered when transferring the findings. Researchers could reproduce Study 1, using purposive sampling strategies to recruit urban and non-urban SGD youth from community organisations and service providers, to further explore similarities and differences in the healthcare-system navigation experiences of these populations.

Differences in the perspectives and accounts of participants with urban and regional experience in Study 2 may have been influenced partly by the fact that most urban-based youth were receiving tertiary education in psychology, while this may not have been the case for their regional counterparts. Also, no SGD youth residing in remote areas participated in either study. This result may have been due in part to the restriction of study promotion to online channels, given internet access is most

limited in remote areas (McQueen et al., 2022). The prevalence of high and very high psychological distress and challenges accessing mental health services are greater among remote SGD youth relative to their urban- and regional-based peers (Hill et al., 2021; McQueen et al., 2022). Researchers aiming to understand the mental healthcare experiences of remote SGD youth could consider distributing promotional hard-copy posters via locally based community organisations, which has been met with some success in recruiting members of this population (Hill et al., 2021).

Conclusion

The current research suggests that what shapes satisfaction with mental health services among SGD youth is their sense of self-determination over the process of service access. This process includes the decision to pursue mental healthcare, navigation of the healthcare system toward mental health services, and client-therapist interactions that SGD youth engage in. The results support Self-determination theory, in that young people's self-determination appeared to stem from the influence of socio-contextual factors supporting their sense of autonomy, competence, and relatedness throughout the service-access process, that allowed for personally meaningful experiences. During service engagement, the experience of social safety may be a key factor contributing to personally meaningful mental healthcare experiences for SGD youth, due to their experience with distal and proximal minority stressors. For SGD youth in our sample, a sense of social safety during service engagement appeared to be facilitated by service aspects contributing to clients' certainty of access to privacy; confidentiality; therapists affirming of clients' queer identities, experiences, and views; and therapists' competency in supporting the management of presenting issues including SGD issues.

Our findings corroborate extant research suggesting that cis-heteronormativity is commonly entrenched in regional areas (Bowman et al., 2020;

Robinson et al., 2014; Leung et al., 2022). For most regional SGD youth in our sample, this characteristic, alongside the interconnected nature of regional contexts, appeared to heighten the risk and impact of minority stress and need for a sense of social safety during service engagement. However, regional locations tended to amplify barriers that hampered certainty of access to socially safe services for SGD youth.

Current health policies have the potential to support the self-determination of SGD youth during the process of service access, and experience of social safety during service engagement in WA. Our results indicate that such policies are those that collectively promote action or change at the level of microsystems (e.g., caregivers' provision of person-centred support), mesosystems (e.g., collaborative efforts of educational institutions, GPs, and therapists), exosystems (e.g., formal education requirements for therapists), and macrosystems (e.g., community attitudes toward sexuality and gender diversity). The implementation of these policies requires a tailored approach that accounts for geographical context in order to enable equitable access to appropriate mental healthcare for urban and regional SGD youth.

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Supplementary Materials

Ethics Approval Letter

Curtin University

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05-May-2022

Name: Roanna Lobo
Department/School: Curtin School of Population Health
Email: Roanna.Lobo@curtin.edu.au

Dear Roanna Lobo

RE: Ethics Office approval
Approval number: HRE2022-0214

Thank you for submitting your application to the Human Research Ethics Office for the project **Freedom Evaluation 2022**.

Your application was reviewed through the Curtin University Low risk review process.

The review outcome is: **Approved**.

Your proposal meets the requirements described in the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007)*.

Approval is granted for a period of one year from **05-May-2022** to **04-May-2023**. Continuation of approval will be granted on an annual basis following submission of an annual report.

Personnel authorised to work on this project:

Name	Role
Tobin, Rochelle	Co-Inv
Lobo, Roanna	CI
Reeves, Karina	Co-Inv
Lim, Bruce	Student

Approved documents:

Document

Standard conditions of approval

1. Research must be conducted according to the approved proposal
2. Report in a timely manner anything that might warrant review of ethical approval of the project including:
   - proposed changes to the approved proposal or conduct of the study
   - unanticipated problems that might affect continued ethical acceptability of the project
   - major deviations from the approved proposal and/or regulatory guidelines
   - serious adverse events
3. Amendments to the proposal must be approved by the Human Research Ethics Office before they are implemented (except where an amendment is undertaken to eliminate an immediate risk to participants)
4. An annual progress report must be submitted to the Human Research Ethics Office on or before the anniversary of approval and a

Participant Information Statement for Counselling Clients – Study 1

PARTICIPANT INFORMATION STATEMENT

HREC Project Number:	*HRE2022-0214-04*
Project Title:	*Freedom Evaluation 2022*
Chief Investigator:	*Roanna Lobo* *School of Population Health, Curtin University, Bentley Campus*
Student researcher:	*Bruce Lim* *School of Population Health, Curtin University, Bentley Campus*
Version Number:	*V4*
Version Date:	*05/08/2022*

What is the Project About?

We aim to support the wellbeing of LGBTIQA+ youth in WA. One way to do this is to inform mental health services on how to meet the needs of LGBTIQA+ youth. We would love to chat with twelve young people who identify with the LGBTIQA+ community about their counselling service experiences. We hope our findings will help mental health services understand what they are doing well, and what needs to change to better support LGBTIQA+ youth.

Who is doing the Research?

Dr Roanna Lobo is from Curtin's School of Population Health and is leading this project. Bruce Lim identifies with the LGBTIQA+ community. He is a psychology student at Curtin and is doing the research as part of his degree.

Why am I being asked to take part and what will I have to do?

We are asking you to take part in this project if you are aged between 12 and 25 years, have used a mental health counselling service in WA the last 12 months, and identify with the LGBTIQA+ community. You must also be living in WA. We will ask you to take part in a 30-minute interview with Bruce. You can choose whether to chat with us via video-chat, phone call, or text (email or SMS). Bruce will ask you about your counselling service experiences. We recommend you find a quiet and private place to do your interview via video-chat, phone call, or text.

If you decide to do your interview via video-chat or phone call, Bruce will make a video/audio recording so he can listen to what you say and not distract himself with notetaking. If you choose to chat with us via text, Bruce will record all text-based answers you provide during the interview. Bruce will make a written copy of all interviews. He will ask you after your interview if you would like to see a written copy of your interview. If so, he will send this to you via your preferred method.

We will send you a $20 Coles grocery e-voucher to thank you for your time. SONA participants will instead earn 3 SONA points for online study participation in Semester 2, 2022.

Are there any benefits to being in the project?
You will be able to share your counselling service experiences. We hope the findings will inform mental health services in WA on how to provide relevant support to LGBTIQA+ youth.

Are there any risks from being in the project?
We have been careful to make sure the interview questions do not cause any distress. If any of the questions make you feel anxious, you do not need to answer. If the questions cause any concerns, we can refer you to a support service.

Apart from your time and cost of travel, there should be no other costs to you by taking part.

Just thinking about counselling experiences can be upsetting. If you feel upset by thinking about taking part in this project, please call Kids Helpline (1800 55 1800) or Lifeline (13 11 14).

SONA participants can contact University Counselling Services on 08 9266 7850 or 1800 651 878 or email: See https://counselling.curtin.edu.au/ (Office hours only).

Who will have access to my information?
The research team and staff from the Office of Research and Development at Curtin are the only people who can access your interview data.

We will remove any information from the written copy of your interview that can identify you. We will replace this information with a code. Only the research team can use the code to match your name so you can withdraw from the project. We will treat all your information as confidential. We will only use your information for this project.

We will keep this re-identifiable data in a digital folder at Curtin. We will protect this folder with a password. We will keep this data for 7 years after we finish the project or until the youngest participant turns 25 years old (whichever is later). We will then destroy all data. We may have the project findings published, but no one will know you took part.

Will you tell me the results of the research?
We will finish this project in November of 2022. If you would like to see the project findings, we can send you a copy. Please email Bruce at bruce.lim@student.curtin.edu.au.

Do I have to take part in the project?
It is your choice to take part or not. You do not have to agree if you do not want to. It will not affect your relationship with Curtin University or any organisation that informed you of the project. If you decide to take part and then change your mind, that is okay. You are free to withdraw from the study at any time before we finish the project. To withdraw, please email Bruce at bruce.lim@student.curtin.edu.au.

What happens next and who can I contact about the research?
If you decide to take part in an interview, we will ask you to provide your verbal or written consent just before the interview begins. This tells us that you understand what you have

read (or had read to you) in this information sheet and that you agree to be in the research project and have your information used as described.

Please take your time before you decide what to do. Please ask us any questions you have about the project. You can email Bruce at bruce.lim@student.curtin.edu.au.
You can email Dr Roanna Lobo at roanna.lobo@curtin.edu.au.

Curtin University Human Research Ethics Committee (HREC) has approved this study (HRE2022-0214-04). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Consent Form for Counselling Clients (Synchronous Interviews)

SCRIPT FOR VERBAL CONSENT

HREC Project Number:	*HRE2022-0214*
Project Title:	*Freedom Evaluation 2022*
Chief Investigator:	*Roanna Lobo* *School of Population Health, Curtin University*
Version Number:	*V5 Consent Form Counselling Clients*
Version Date:	*29 July 2022*

I understand:

- The content of the information statement for this project.
- The Human Research Ethics Committee at Curtin have approved this project.
- This project will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007).
- I will receive a copy of an Information Statement.
- I will receive a copy of the Consent Form
- The purpose of taking part in this project.
- The extent of my part in this project.
- The risks of taking part in this project.

- I have had a chance to ask questions. I am satisfied with the answers.

- If you agree to take part in this research, please say YES when asked by the interviewer.

- Your verbal answers will be audio-recorded.

Participant Name	
Verbal consent provided	
Date	

Declaration by researcher:

I have supplied:

- An Information Letter to the counselling client who has provided verbal consent.
- A Consent Form to the counselling client who has provided verbal consent.

Researcher Name	
Researcher Signature	
Date	

Consent Form for Counselling Clients (Asynchronous Interviews)

CONSENT FORM

HREC Project Number:	*HRE2022-0214-04*
Project Title:	*Freedom Evaluation 2022*
Chief Investigator:	*Roanna Lobo* *School of Population Health, Curtin University*
Version Number:	*V4 Consent Form Counselling Clients*
Version Date:	*29 July 2022*

I understand:

- The content of the information statement for this project.
- The Human Research Ethics Committee at Curtin have approved this project.
- This project will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007).
- I will receive a copy of an Information Statement.
- I will receive a copy of the Consent Form
- The purpose of taking part in this project.
- The extent of my part in this project.
- The risks of taking part in this project.

- I have had a chance to ask questions. I am satisfied with the answers.

- I agree to have my text-based responses to the interview questions recorded.

- I agree to take part in this project.

Participant Name	
Participant Signature	
Date	

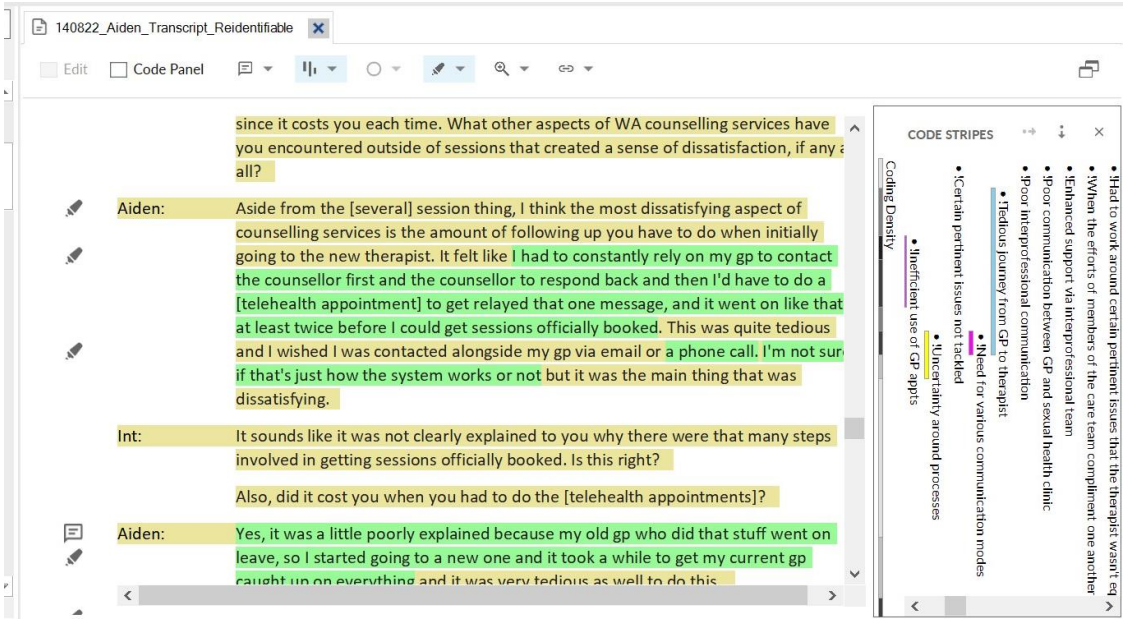
Declaration by researcher

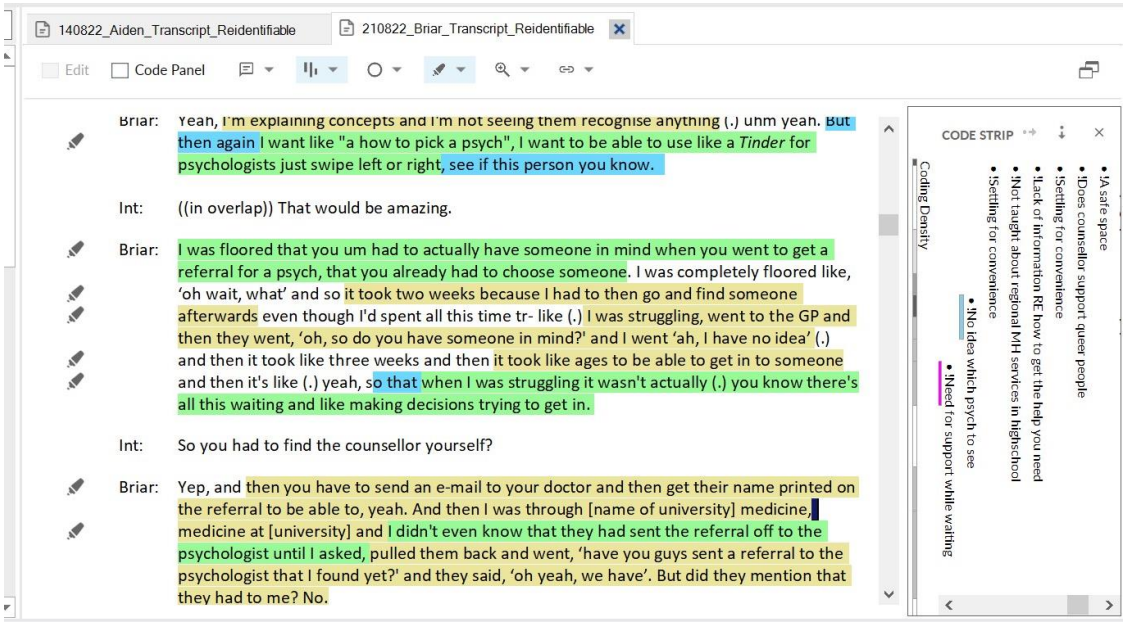
I have supplied:

- An Information Letter to the counselling client who has signed above.
- A Consent Form to the counselling client who has signed above.

Researcher Name	
Researcher Signature	
Date	

Coding Extracts - Study 1





Ethics Approval of Extension Letter

Curtin University

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19-Apr-2023

Name: Roanna Lobo
Department/School: Curtin School of Population Health
Email: Roanna.Lobo@curtin.edu.au

Dear Roanna Lobo

RE: Annual report acknowledgment
Approval number: HRE2022-0214

Thank you for submitting an annual report to the Human Research Ethics Office for the project **Freedom Evaluation 2022**.

The Human Research Ethics Office acknowledges the project is ongoing and approval will remain current until 03-May-2024.

Special Condition of Approval Extension.

It is the responsibility of the Chief Investigator to ensure that any activity undertaken under this project adheres to the latest available advice from the Government or the University regarding COVID-19.

Any special conditions noted in the original approval letter still apply.

Standard conditions of approval

1. Research must be conducted according to the approved proposal
2. Report in a timely manner anything that might warrant review of ethical approval of the project including:
   - proposed changes to the approved proposal or conduct of the study
   - unanticipated problems that might affect continued ethical acceptability of the project
   - major deviations from the HREC approved protocol procedures and/or regulatory guidelines
   - serious adverse events
3. Amendments to the proposal must be approved by the Human Research Ethics Office before they are implemented (except where an amendment is undertaken to eliminate an immediate risk to participants)
4. An annual progress report must be submitted to the Human Research Ethics Office on or before the anniversary of approval and a completion report submitted on completion of the project
5. Personnel working on this project must be adequately qualified by education, training and experience for their role, or supervised
6. Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, that bears on this project
7. Changes to personnel working on this project must be reported to the Human Research Ethics Office
8. Data and primary materials must be retained and stored in accordance with the Western Australian University Sector Disposal Authority (WAUSDA) and the Curtin University Research Data and Primary Materials policy
9. Where practicable, results of the research should be made available to the research participants in a timely and clear manner
10. Unless prohibited by contractual obligations, results of the research should be disseminated in a manner that will allow public scrutiny; the Human Research Ethics Office must be informed of any constraints on publication
11. Ethics approval is dependent upon ongoing compliance of the research with the Australian Code for the Responsible Conduct of Research, the National Statement on Ethical Conduct in Human Research, applicable legal requirements, and with Curtin University policies, procedures and governance requirements
12. The Human Research Ethics Office may conduct audits on a portion of approved projects.

Participant Information Statement for Counselling Clients – Study 2

PARTICIPANT INFORMATION STATEMENT

HREC Project Number:	*HRE2022-0214-04*
Project Title:	*Freedom Evaluation 2022*
Chief Investigator:	*Roanna Lobo* *School of Population Health, Curtin University, Bentley Campus*
Co-supervisor:	*Elizabeth Newnham* *School of Population Health, Curtin University, Bentley Campus*
Co-investigator:	*Bruce Lim* *School of Population Health, Curtin University, Bentley Campus*
Version Number:	*V5*
Version Date:	*01/04/2023*

What is the Project About?

We aim to support the wellbeing of LGBTIQA+ youth in WA. One way to do this is to inform mental health services on how to meet the needs of LGBTIQA+ youth. We would love to chat with young people who identify with the LGBTIQA+ community about their counselling service experiences. We hope our findings will help mental health services understand what they are doing well, and what needs to change to better support LGBTIQA+ youth.

Who is doing the Research?

Dr Roanna Lobo and Dr Elizabeth Newnham are from Curtin's School of Population Health and are supervising this project. Bruce Lim identifies with the LGBTIQA+ community. He is completing his Master of Research in Psychology at Curtin and is doing the research as part of his course.

Why am I being asked to take part and what will I have to do?

We are asking you to take part in this project if you are aged between 12 and 25 years, have used a mental health counselling service while living in regional or remote WA in the last 12 months, and identify with the LGBTIQA+ community. We will ask you to take part in a 30-minute interview with Bruce. You can choose whether to chat with us via video-chat, phone call, or text (email, or SMS). Bruce will ask you about your counselling service experiences. We recommend you find a quiet and private place to do your interview via video-chat, phone call, or text.

If you decide to do your interview via video-chat or phone call, Bruce will make a video/audio recording so he can listen to what you say and not distract himself with notetaking. If you choose to chat with us via text, Bruce will record all text-based answers you provide during the interview. Bruce will make a written copy of all interviews. He will

ask you after your interview if you would like to see a written copy of your interview. If so, he will send this to you via your preferred method.

We will send you a $20 Coles grocery e-voucher to thank you for your time.

Are there any benefits to being in the project?
You will be able to share your counselling service experiences. We hope the findings will inform mental health services in WA on how to provide relevant support to LGBTIQA+ youth.

Are there any risks from being in the project?
We have been careful to make sure the interview questions do not cause any distress. If any of the questions make you feel anxious, you do not need to answer. If the questions cause any concerns, we can refer you to a support service.

Apart from your time and the cost of travel, there should be no other costs to you by taking part.

Just thinking about counselling experiences can be upsetting. If you feel upset by thinking about taking part in this project, please call Kids Helpline (1800 55 1800) or Lifeline (13 11 14).

Who will have access to my information?
The research team and staff from the Office of Research and Development at Curtin are the only people who can access your interview data.

We will remove any information from the written copy of your interview that can identify you. We will replace this information with a code. Only the research team can use the code to match your name so you can withdraw from the project. We will treat all your information as confidential. We will only use your information for this project.

We will keep this re-identifiable data in a digital folder at Curtin. This folder will be protected with a password. We will keep this data for 7 years after we finish the project or until the youngest participant turns 25 years old (whichever is later). We will then destroy all data. We may have the project findings published, but no one will know you took part.

Will you tell me the results of the research?
We will finish this project in January of 2024. If you would like to see the project findings, we can send you a copy. Please email Bruce at bruce.lim@postgrad.curtin.edu.au.

Do I have to take part in the project?
It is your choice to take part or not. You do not have to agree if you do not want to. It will not affect your relationship with Curtin University or any organisation that informed you of the project. If you decide to take part and then change your mind, that is okay. You are free to withdraw from the study at any time before we finish the project. To withdraw, please email Bruce at bruce.lim@postgrad.curtin.edu.au.

What happens next and who can I contact about the research?
If you decide to take part in an interview, we will ask you to provide your verbal or written consent just before the interview begins. This tells us that you understand what you have

read (or had read to you) in this information sheet and that you agree to be in the research project and have your information used as described.

Please take your time before you decide what to do and ask Bruce any questions you have about the project: bruce.lim@postgrad.curtin.edu.au.

Curtin University Human Research Ethics Committee (HREC) has approved this study (HRE2022-0214-04). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Coding Extracts - Study 2