# Providing mental healthcare to LGBTQIA+ people in general practice



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**Background**
Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/aromantic, and other sexuality and gender diverse (LGBTQIA+) individuals in Australia experience poor mental health more often than the general population, largely because of systemic discrimination, minority stress and barriers to inclusive, affirmative healthcare.

**Objective**
The aim of this article is to support general practitioners in their provision of mental healthcare to LGBTQIA+ people by outlining some specific mental health challenges faced by the LGBTQIA+ community, highlighting the importance of culturally competent care and providing strategies for inclusive clinical practice.

**Discussion**
Key recommendations include using affirming language, conducting thorough and respectful risk-assessments, offering adapted evidence-based therapies, and connecting patients with LGBTQIA+-specialised support services where appropriate. The article also highlights systemic barriers such as stigma and financial inaccessibility and emphasises the need for legal and ethical care that respects identity and confidentiality.

**GENERAL PRACTITIONERS (GPS)** are often the first point of contact for individuals seeking mental health support. For lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/aromantic, and other sexuality and gender diverse (LGBTQIA+) people, their relationship with their GP is particularly crucial as LGBTQIA+ individuals often experience higher rates of mental health issues when compared with the general population.[1,2]

## Understanding the mental health needs of LGBTQIA+ individuals

### Minority stress models

The LGBTQIA+ community is diverse, and people's experiences of mental health, mental healthcare and discrimination will reflect this diversity. Some LGBTQIA+ people may not have experienced trauma, rejection, discrimination, stigma, violence and/or abuse, but many will have.[3]

Discrimination may also occur within the LGBTQIA+ community itself.[3]

According to the Australian Bureau of Statistics' 2020–22 National Study of Mental Health and Wellbeing, LGBTQIA+ Australians report higher levels of psychological distress, and are more likely to experience mental health disorders, than their heterosexual and cisgender counterparts.[4]

Having a diverse gender or sexual identity does not cause poor mental health.[3,5] The minority stress model highlights how interacting stressors may explain the disparities in mental health experienced by people who have a diverse sexual identity.[6] Broadly, distal (or external) stressors (which may include workplace discrimination) interact with proximal (or internal) stressors (which might include concealment of identity).[6] The modified gender minority stress model includes the impact of additional stressors – social norms and ideologies – uniquely experienced by transgender and gender diverse (TGD) people.[3,7]

Across the world, growing transphobia, homophobia and discrimination against LGBTQIA+ individuals has been widely reported, contributing to feelings of rejection, worsening mental health outcomes and suicidality within the community.[2–4,8,9] A report by the Australian Human Rights Commission, released in March 2026, found that widespread levels of transphobia persist across our country, with 'consistent and distressing patterns of discrimination across schools and universities, healthcare, workplaces, housing and the justice system'.[9]

### TGD people and mental health disorders

TGD people are more likely to have a diagnosed mental health disorder and are far more likely to experience suicidal thoughts

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or to have attempted suicide than people who do not identify as gender diverse.[5,10,11] Trans Pathways was a large Australian study of TGD youth mental health.[10] It found that three out of four TGD youth had experienced anxiety or depression, four out of five had ever self-harmed, and almost one out of two (48%) had attempted suicide.[10] A more recent Australian study found increased rates of completed suicide among TGD individuals aged 15 years and older, with hazard ratios of 11.73 for those presumed female at birth and 4.02 for those presumed male at birth.[12]

Emerging evidence suggests that TGD people are more likely to identify as autistic, demonstrate autistic traits and/or experience sensory sensitivities than cisgender people.[13,14] TGD individuals have also been observed to have higher rates of attention deficit hyperactivity disorder.[14,15] Some studies have also observed higher rates of bipolar affective disorder, obsessive-compulsive disorder, learning disorders and schizophrenia in TGD people when compared with cisgender individuals.[4,11,13]

A detailed discussion is beyond the scope of this article, but one hypothesis proposes that repeated exposure to minority stress overwhelms a person's coping capacity and increases the risk of psychopathology developing.[15,16]

### LGB+ people and mental health disorders

People who describe their sexuality as lesbian, gay, bisexual or other (LGB+) also often encounter family and societal stigma, rejection and discrimination that may contribute to the higher rates of mental health disorders, self-harm and suicidality observed in this population.[2,4] In Australia, approximately 75% of LGB+ people have been diagnosed with a mental health disorder in comparison to 42% of non-LGB+ people, and 48% of LGB+ people have reported suicidal ideation over their lifetimes, compared with 15% of the non-LGB+ community.[4] A 2024 UK primary care study also found worse overall health among LGB people when compared with people who identify as heterosexual, with bisexual people experiencing the poorest outcomes.[2]

### Non-binary people

Non-binary people (whose chosen gender falls in between or outside of the gender binary of 'man' or 'woman') are often significantly marginalised and may experience poorer mental health than other TGD people.[16] An Australian study found that, when compared with TGD people who have a binary gender identity, non-binary people have a higher prevalence of depression, anxiety and illicit drug use.[16]

### Intersectionality

Some LGBTQIA+ people will have been subjected to intersectional minority stress – for example, someone may have a diverse sexual identity and also experience racial or ethnic discrimination. This combination of minority stress and intersectionality can have profound effects on their resilience, mental health and connection to their community.[3,17]

### Intersex people

Intersex individuals may face medical and surgical interventions without consent and may experience societal stigma. Although literature exploring the mental health of intersex people is limited, some studies report higher rates of depression, anxiety and post-traumatic stress disorder (PTSD) in intersex youth when compared with a general youth population, with high rates of self-harm and suicidal ideation.[4,18]

### Asexual/aromantic people

Asexual and aromantic people may experience invalidation of their identities, contributing to isolation and more frequent symptoms of anxiety and depression when compared with individuals who are not aromantic.[19]

## Creating an inclusive practice environment

Trans Pathways found that 60% of TGD youth in Australia felt isolated from medical and mental health services, and 42% of TGD youth had reached out to a health service provider who did not understand or respect their gender identity.[10] Other Australian studies have shown disparities in healthcare access for LGB people.[20]

## Inclusive language

Using inclusive language is fundamental in making patients feel safe and respected. This includes asking for and using a person's chosen name, pronouns and, when appropriate, chosen terms for their body parts and gender. For example, 'Hello, I'm Dr – and I use he/him pronouns. What name do you use and what are your pronouns?' Responses should be used to update demographic details in the patient's electronic medical health record.[3]

Avoiding assumptions about gender identity, sexuality, family structure or relationships is also an important part of providing inclusive care.[3,5]

## Reflective practice

Reflective practice involves awareness of one's own biases, attitudes and beliefs. Clinicians may have internalised cisnormativity and heteronormativity, assuming that being cisgender and heterosexual is the 'norm'. Acknowledging that people experience and express their gender and sexuality in many ways, all of which are valid, can help clinicians avoid reinforcing traditional expectations, such as commenting on appearance or asking if someone has a husband or wife.[3,5]

Self-reflection should also include consideration of the privileges experienced by cisgender, heterosexual people and the power imbalance inherent in the doctor–patient relationship.[3]

## Trauma-informed care

Trauma-informed care is a strengths-based, person-led model recognising the prevalence and lifelong impacts of trauma in LGBTQIA+ populations.[21] It acknowledges that the effects of trauma on the individual are often lifelong, with potential impacts on their emotions, interpersonal relationships and engagement with support services.[21] It is founded on six core principles: safety, trustworthiness, choice, collaboration, empowerment and respect for diversity.[22] A critical aspect is focusing on what has happened to a person, rather than what is 'wrong' with them.[21,22]

## Cultural safety

Cultural safety occurs when there is 'no assault, abuse, challenge, denial, judgement, or assumptions about LGBTQIA+


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identities and experiences'.[21] Misgendering or failing to challenge discriminatory comments are examples of culturally unsafe practice.[21]

Cultural safety must also consider intersectionality (where someone's culture, religion and sexual or gender identity intersect) and the impact this may have on their connection to the community.[3,17,21]

All practice staff have a professional duty to challenge prejudice and promote diversity and human rights.[9,21] Training programs such as ACON's Pride Inclusion Programs, Rainbow Health Australia and LGBTIQ+ Health Australia can support this work. TransMob and BlaQ offer insights into the experiences of LGBTQIA+ Aboriginal and Torres Strait Islander peoples and can help to provide advocacy.

LGBTQIA+ people may look for indicators of affirmation, inclusion and safety in healthcare services. Visible indicators of inclusivity such as rainbow or trans flags, the Yellow Tick logo (an initiative providing training in affirmative care for intersex people), inclusive posters, pronoun badges and inclusive website statements can help signal cultural safety.[21]

Some LGBTQIA+ individuals may also face financial barriers to accessing healthcare; providing information on billing options and telehealth and linking them to LGBTQIA+ community resources may improve access.

## Conducting inclusive mental health assessments

Aotearoa/New Zealand data show that supportive interactions with GPs are associated with lower psychological distress and reduced suicidality among transgender people.[23] Creating safe, inclusive environments helps to build trust – crucial for a mental health assessment. Asking questions such as 'How would you describe your gender?', 'What is your chosen name?' and 'What pronouns do you use?' can help TGD patients feel respected.[3]

Exploring social supports, including LGBTQIA+ community attachment, can help guide person-centred care. Housing stability is important to assess, as LGBTQIA+ people are more likely to experience homelessness, often due to family rejection.[24] Young LGBTQIA+ people experiencing homelessness are at higher risk of also experiencing poor mental health, trauma, childhood sexual abuse and substance use disorders.[24]

Family support can be a major protective factor for good mental health. Parental closeness has been associated with significantly lower odds of psychological distress, PTSD, depression and suicidality among young transgender women.[25] A large primary care study found that LGBTQ+ adolescents had more depressive symptoms and higher odds of suicidal ideation and attempts than non-LGBTQ+ youth, but parental support was protective.[26] GPs' unique longitudinal knowledge of young people and their families can help them to develop rapport with LGBTQIA+ youth and provide person-centred care.

LGBTQIA+ people are more likely to experience bullying, harassment and discrimination in education and employment settings when compared with non-LGBTQIA+ people.[3,9,27,28] A trauma-informed approach is important when exploring these experiences.[3,22]

Given the higher risk of suicide and self-harm in LGBTQIA+ populations,[4,10,11,12,16] thorough risk assessments using a trauma-informed model of care are essential. This includes exploring self-harm, suicidal ideation, suicidal intent and previous suicide attempts. It may also be appropriate to explore a person's risk of and/or experiences of domestic and family violence, which may include formulating a safety plan and considering the need for any mandatory reporting, such as where there are child protection concerns.

Some data show that TGD and non-binary people are more likely than cisgender people to use illicit drugs and to engage in high-risk alcohol consumption,[16,29] so a non-judgemental approach that explores alcohol and other drug use is also important when taking a mental health history and making a risk assessment.

TGD people may also be at higher risk of experiencing disordered eating when compared with the general population, so screening for eating disorders and exploring eating habits, exercise patterns and body image concerns are important considerations.[30]

It may also be appropriate to screen for any high-risk sexual activities, including sexual activity that an individual does not consent to or that includes coercion. Approaching this with sensitivity and a non-judgemental, reflective approach while explaining to patients why you are asking these questions, and normalising them, is important. Respecting confidentiality in this context, especially, is paramount. Informed consent should be obtained before sharing any relevant information, and limits of confidentiality should be clearly explained. Questions such as 'do you have sex with men or women?' do not include gender diverse people, and it may be more appropriate to ask 'would you mind telling me about the body parts of your partner?' and/or 'are you having sex in a way that means pregnancy is a possibility?'

## Providing affirmative mental healthcare

Evidence-based therapies such as cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT) are effective for treating depression and anxiety in LGBTQIA+ individuals, as in non-LGBTQIA+ individuals, but providers should ensure their care is culturally competent, trauma-informed and affirming. Affirmative CBT incorporates discussions about identity and discrimination, while ACT focuses on accepting one's identity and values.[31]

For TGD people, gender-affirming mental healthcare is vital. Non-affirmative mental healthcare can be associated with heightened distress, disengagement with mental health services and delay in seeking mental healthcare.[23,32] Gender-affirming care recognises that someone's gender is part of their identity – not a disorder – and considers their physical, mental and social health needs while also affirming their chosen gender.[3] It may or may not involve providing gender-affirming hormone therapy (GAHT).

When GAHT is used, it has been associated with better mental health outcomes and reduced use of mental health services.[33,34]

Exercise and sport may be important ways for individuals to improve their mental health and develop connections to peers and their communities. As highlighted in the article 'The longitudinal primary care of transgender and gender diverse people' featured in this issue of *Australian Journal of General*

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*Practice*, LGBTQIA+ people may encounter barriers to engaging in sport and exercise in the community.[35] ACON is developing a list of LGBTQIA+-welcoming sports clubs (https://prideinsport.com.au/resources-and-initiatives/lgbtq-sports-club-directory).

The minority stress model also emphasises the importance of resilience and community support in improving mental health outcomes among LGBTQIA+ people.[6] Peer support may improve community connections and build resilience, making it a key part of providing affirmative mental healthcare.[36] The protective role of family support has already been mentioned.

Although many aspects of providing mental healthcare to LGBTQIA+ people can be managed by the person's usual GP and/or psychologist, it may be appropriate for the person to be referred to mental health professionals with expertise in LGBTQIA+ health, including GPs, psychologists, psychiatrists, gender-affirming clinics and peer support organisations such as The Gender Centre, Transgender Victoria and Open Doors Youth Service. The Australian Professional Association for Trans Health (AusPATH) has a list of such providers (https://auspath.org.au/providers).

## Conclusion

- Providing inclusive, respectful and affirmative mental healthcare to LGBTQIA+ individuals is both a human right and a professional responsibility.
- LGBTQIA+ individuals are more likely to experience mental health disorders and suicidality than non-LGBTQIA+ people.
- Almost one in two TGD youth in Australia have attempted suicide.
- Approximately four out of five TGD youth in Australia have self-harmed.
- When TGD people have supportive relationships with their GPs, lower psychological distress and suicidality are observed.

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### References

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## References


1. General Practice Supervision Australia (GPSA). LGBTQIA+ health and inclusive healthcare in general practice. GPSA, 2025. Available at www.gpsupervisorsaustralia.org.au/wp-content/uploads/2025/01/Guide_LGBITQIA_V13.pdf [Accessed 28 March 2026].
2. Cross H, Bremner S, Meads C, Pollard A, Llewellyn C. Bisexual people experience worse health outcomes in England: Evidence from a cross-sectional survey in primary care. J Sex Res 2024;61(9):1342–50. doi: 10.1080/00224499.2023.2220680.
3. Telethon Kids Institute. Clinical practice point: Gender-affirming mental health care. Orygen Ltd, 2021. Available at www.orygen.org.au/Training/Resources/trans-and-gender-diverse-young-people/Clinical-practice-points/Gender-affirming-mental-health-care/orygen-cpp-gender-affirming-mental-health-care-pdf.aspx?ext [Accessed 3 June 2026].
4. Australian Bureau of Statistics (ABS). Mental health findings for LGBTQ+ Australians. ABS, 2023. Available at www.abs.gov.au/articles/mental-health-findings-lgbtq-australians [Accessed 31 August 2025].
5. Australian Psychological Society (APS). Position statement: Supporting the mental health and wellbeing of transgender and gender diverse people. APS, 2026. Available at https://psychology.org.au/getmedia/39284fb8-5792-4d0a-b874-72e8d67b818e/aps26-ps-transgender-and-gender-diverse-people_final.pdf [Accessed 3 June 2026].
6. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Psychol Bull 2003;129(5):674–97. doi: 10.1037/0033-2909.129.5.674.
7. Riggs DW, Treharne GJ. Decompensation: A novel approach to accounting for stress arising from the effects of ideology and social norms. J Homosex 2017;64(5):592–605. doi: 10.1080/00918369.2016.1194116.
8. Connolly DJ, Meads C, Wurm A, et al. Transphobia in the United Kingdom: A public health crisis. Int J Equity Health 2025;24(1):155. doi: 10.1186/s12939-025-02509-z.
9. Australian Human Rights Commission. New report finds discrimination against trans and gender diverse Australians across schools, healthcare and workplaces. Australian Human Rights Commission, 2026. Available at https://humanrights.gov.au/about-us/media-centre/media-releases/lgbtqia/new-report-finds-discrimination-against-trans-and-gender-diverse-australians-across-schools,-healthcare-and-workplaces [Accessed 15 June 2026].
10. Strauss P, Cook A, Winter S, et al. Trans Pathways: The mental health experiences and care pathways of trans young people. Summary of results. Telethon Kids Institute, 2017. Available at www.thekids.org.au/globalassets/media/documents/brain--behaviour/trans-pathwayreport-web.pdf [Accessed 16 July 2026].
11. Eccles H, Abramovich A, Patte KA, et al. Mental disorders and suicidality in transgender and gender-diverse people. JAMA Netw Open 2024;7(10):e2436883. doi: 10.1001/jamanetworkopen.2024.36883.
12. Saxby K, Bailey S, Petrie D, Nolan BJ. All-cause and cause-specific mortality among transgender and gender diverse people: A nationwide cohort study in Australia. Lancet Reg Health West Pac 2026;67:101813. doi: 10.1016/j.lanwpc.2026.101813.
13. Warrier V, Greenberg DM, Weir E, et al. Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. Nat Commun 2020;11(1):3959. doi: 10.1038/s41467-020-17794-1.
14. Cheung AS, Ooi O, Leemaqz S, et al. Sociodemographic and clinical characteristics of transgender adults in Australia. Transgend Health 2018;3(1):229–38. doi: 10.1089/trgh.2018.0019.
15. Ignatova E, Balasubramanian P, Raney JH, et al. Transgender identity and attention deficit hyperactivity disorder symptoms: Findings from the adolescent brain cognitive development study. J Adolesc Health 2025;76(3):396–400. doi: 10.1016/j.jadohealth.2024.10.015.
16. Cheung AS, Leemaqz SY, Wong JWP, et al. Non-binary and binary gender identity in Australian trans and gender diverse individuals. Arch Sex Behav 2020;49(7):2673–81. doi: 10.1007/s10508-020-01689-9.
17. McConnell EA, Janulis P, Phillips G 2nd, Truong R, Birkett M. Multiple minority stress and LGBT community resilience among sexual minority men. Psychol Sex Orientat Gend Divers 2018;5(1):1–12. doi: 10.1037/sgd0000265.
18. Jones T. The needs of students with intersex variations. Sex Educ 2016;16(6):602–18. doi: 10.1080/14681811.2016.1149808.
19. Yule MA, Brotto LA, Gorzalka BB. Mental health and interpersonal functioning in self-identified asexual men and women. Psychol Sex 2013;4(2):136–51. doi: 10.1080/19419899.2013.774162.
20. Saxby K, de New SC, Petrie D. Structural stigma and sexual orientation disparities in healthcare use: Evidence from Australian Census-linked-administrative data. Soc Sci Med 2020;255:113027. doi: 10.1016/j.socscimed.2020.113027.
21. AIDS Council of New South Wales (ACON). Inclusive and affirming practice guidelines for alcohol, substance use, and mental health services, support, and treatment providers. ACON, 2022. Available at www.acon.org.au/wp-content/uploads/2023/11/22200_AOD-and-MH-Inclusive-Practice-Guidelines-v3a_INTERACTIVE-new.pdf [Accessed 3 June 2026].
22. NSW Government, NSW Health. Integrated trauma-informed care framework: My story, my health, my future. State of New South Wales (NSW Ministry of Health), 2023. Available at www.health.nsw.gov.au/patients/trauma/Publications/itic-framework.pdf [Accessed 3 June 2026].
23. Treharne GJ, Carroll R, Tan KKH, Veale JF. Supportive interactions with primary care doctors are associated with better mental health among transgender people: Results of a nationwide survey in Aotearoa/New Zealand. Fam Pract 2022;39(5):834–42. doi: 10.1093/fampra/cmac005.
24. McNair R, Andrews S, Parkinson S, Dempsey D. GALFA LGBTQ homelessness research project – Final report LGBTQ homelessness: Risks, resilience, and access to services in Victoria. Swinburne, 2017. Report. doi: 10.25916/sut.26248601.v1.
25. Wilson EC, Chen YH, Arayasirikul S, Raymond HF, McFarland W. The impact of discrimination on the mental health of trans*female youth and the protective effect of parental support. AIDS Behav 2016;20(10):2203–11. doi: 10.1007/s10461-016-1409-7.
26. DelFerro J, Whelihan J, Min J, et al. The role of family support in moderating mental health outcomes for LGBTQ+ youth in primary care. JAMA Pediatr 2024;178(9):914–22. doi: 10.1001/jamapediatrics.2024.1956.
27. Cutler B, Cordoba BG, Walsh L, Mikola M, Waite C. Queer young people in Australia: Insights from the 2021 Australian youth barometer. Monash University, 2022. Available at https://bridges.monash.edu/articles/report/Queer_Young_People_in_Australia_Insights_from_the_2021_Australian_Youth_Barometer/19719532?file=35152024 [Accessed 3 June 2026].
28. Sansone D. LGBT students: New evidence on demographics and educational outcomes. Econ Educ Rev2019;73:101933. doi: 10.1016/j.econedurev.2019.101933.
29. Australian Institute of Health and Welfare (AIHW). National Drug Strategy Household Survey 2022–2023: LGBT people's use of alcohol, tobacco, e-cigarettes and other drugs. AIHW, Australian Government, 2024. Available at www.aihw.gov.au/reports/lgbtiq-communities/lgbt-people-alcohol-drugs [Accessed 16 July 2026].
30. Keski-Rahkonen A. Eating disorders in transgender and gender diverse people: Characteristics, assessment, and management. Curr Opin Psychiatry 2023;36(6):412–18. doi: 10.1097/YCO.0000000000000902.
31. Harkness A, Soulliard ZA, Layland EK, et al. Implementing LGBTQ-affirmative cognitive-behavioral therapy: Implementation strategies across five clinical trials. Implement Sci Commun 2024;5(1):124. doi: 10.1186/s43058-024-00657-x.
32. Seelman KL, Colón-Diaz MJP, LeCroix RH, Xavier-Brier M, Kattari L. Transgender noninclusive healthcare and delaying care because of fear: Connections to general health and mental health among transgender adults. Transgend Health 2017;2(1):17–28. doi: 10.1089/trgh.2016.0024.
33. Turban JL, King D, Kobe J, Reisner SL, Keuroghlian AS. Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. PLoS One 2022;17(1):e0261039. doi: 10.1371/journal.pone.0261039.
34. Saxby K, Buchmueller T, Carpenter CS, Coman C, Nolan BJ. Mental health treatment among transgender and gender diverse people following gender affirming hormone therapy: Evidence from whole-of-population Australian administrative data. EClinicalMedicine 2026;92:103765. doi: 10.1016/j.eclinm.2026.103765.
35. Ruhl MJ. The longitudinal primary care of transgender and gender diverse people. Aust J Gen Pract 2026;55(10):667–71. doi: 10.31128/AJGP-03-25-7626.
36. Kia H, Kenney K, MacKinnon KR, et al. "It saves lives": Peer support and resilience in transgender and gender diverse communities. SSM Qual Res Health 2023;3:100264. doi: 10.1016/j.ssmqr.2023.100264.


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