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The influence of care continuity and disclosure of sexual orientation in general practice on lesbian, bi+ and queer cisgender women's engagement with mental health services

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ABSTRACT

Background. Lesbian, bisexual+ and queer (LBQ+) cisgender women have considerable unmet mental health needs. The aims of this study were to examine LBQ+ cisgender women's prior engagement with general practitioners (GPs), and how this relationship shaped their mental health service use. **Method.** Data from 2707 cisgender LBQ+ women were drawn from a national survey of adults who are lesbian, gay, bisexual, trans, intersex, queer or questioning, asexual and other diverse sexuality and gender identities (LGBTIQA+) in Australia. Multivariable logistic regression analyses examined demographic predictors of continuity of care with GPs and GPs' awareness of LBQ+ women's sexual orientation. The relationship between these variables and recent mental health service use was then analysed, comparing LBQ+ women's engagement with services known to be LGBTIQA+ inclusive and those without an inclusive reputation. **Results.** LBQ+ cisgender women with a regular GP had greater odds of having accessed mental health services in the last 12 months. Two-thirds had a regular GP, with the lowest odds among women aged 18–35 years and highest odds among women with a disability. LBQ+ women who did not believe their regular GP knew of their sexuality had lower odds of having accessed LGBTIQA+ inclusive mental health services. These individuals were typically aged below 25 years, bisexual+ or queer identified, had below undergraduate-level education, earned <$2000 AUD per week, or lived in an outer-suburban or regional area. **Conclusion.** GPs may be missing opportunities to promote continuity of care through developing trusting relationships with specific sub-populations of LBQ+ women, which in turn appears to sustain inequitable access to mental health care. To offer appropriate care and referrals for this population, GPs should provide safe and inclusive environments to enable comfortable and supportive discussions about sexual orientation when this is relevant to a person's health care.

Keywords: acceptability of health care, delivery of health care, general practice, health inequities, mental health, primary health care, referral and consultation, sexual minorities, women.

Introduction

While lesbian, bi+ (i.e. bisexual, pansexual and other identities characteristic of attraction to more than one gender) and queer (LBQ+) cisgender women[1] have been found to use mental health services more frequently than heterosexual women and sexual minority men (McNair *et al.* 2011; Cronin *et al.* 2021), they have greater unmet mental health needs (McDermott *et al.* 2018; Grant *et al.* 2020; Carpenter 2021; Cronin *et al.* 2021). A potential explanation for this phenomenon is that many people who are lesbian, gay, bisexual, trans, intersex, queer or questioning, asexual, and other diverse sexuality and gender identities (LGBTIQA+) experience challenges to engaging with the health system and

[1]'Cisgender women' refers to people with a female birth registered sex who identify their gender as women. This study limited inclusion to cisgender women but the authors recognise that discrimination within and beyond the health system contributes to health inequalities among all members of the LGBTIQA+ community, particularly those whose gender identities discord with their birth registered sex.

forego care due to anticipation of discrimination and medical gatekeeping (McDermott *et al.* 2018; Grant *et al.* 2020; Carpenter 2021; Cronin *et al.* 2021). The mental health inequalities observed for LBQ+ cisgender women compared to their heterosexual counterparts (Hughes *et al.* 2010; McNair and Bush 2016) are therefore influenced by the impact of living in a society that discriminates against sexual minorities and the barriers this confers to engaging with health care. One recent study showed that 70% of LGBQ cisgender people indicating clinical levels of distress hadn't accessed mental health care in the past 6 months, and almost one-fifth had never done so despite feeling it would be beneficial (Cronin *et al.* 2021). Similar behaviours have been noted in LBQ+ women populations, in which two-fifths of those participating in a previous study believed they needed mental health or alcohol-related support but had never accessed it (McNair *et al.* 2018).

General practitioners (GPs) provide accessible health promotion, primary physical and mental health care and referral to specialist mental health providers. Continuity of care is a core component of quality general practice care, with studies of the general population showing that people who access multiple GPs report lower levels of preventive health screening, satisfaction with care and confidence in their doctors (Glenister *et al.* 2021). GPs are the most frequently accessed health professionals among LBQ+ cisgender women (McNair and Bush 2016), yet this group still remains less likely than heterosexual cisgender women to report care satisfaction and continuity with their GP (McNair *et al.* 2011)

Importantly, non-disclosure of minoritised sexual orientation in general practice has been associated with poorer care continuity (McNair *et al.* 2015), access to mental health services (McNair and Bush 2016) and psychosocial wellbeing (Durso and Meyer 2013). Yet an Australian study found that around half of LGBT people believed their GPs were unaware of their sexual orientation (McNair and Bush 2016). This has been attributed to pervasive misconceptions about the clinical relevance of sexual orientation within the medical profession and providers' reluctance to discuss sexual orientation in consultations (McGlynn *et al.* 2020). Onus is instead placed on individuals receiving care to 'come out' within a health system that implicitly codes them as heterosexual (attracted to people of the 'opposite' gender) or monosexual (attracted to one gender, e.g. lesbian-identifying women) (Mulligan and Heath 2007; McNair *et al.* 2015; McGlynn *et al.* 2020; Kirubarajan *et al.* 2021).

Further impacts of health care's erasure and stigmatisation of less visible sexual identities have been understood through bi+ and queer individuals' accounts of their healthcare experiences. They have been found to face more discrimination in health care, are less likely to have a regular GP (McNair and Bush 2016; McNair *et al.* 2018; Grant *et al.* 2020) and report experiences of mental health issues at higher rates than lesbian-identifying women (McNair *et al.* 2011; McNair and Bush 2016). Many individuals in these particularly underserved groups report a preference for LGBTQA+ inclusivity, and the accessibility of these services may therefore be a necessary precursor of their engagement with health care. Access to these services is, however, complicated by geographical challenges, given they are inequitably distributed across the country (Grant *et al.* 2020; Cronin *et al.* 2021).

Providers working in services with a reputation for LGBTIQA+ inclusivity may further have limited capacity to adopt transformative care models (Uink *et al.* 2022); for example, to address patriarchal, racist, ableist and other discriminatory systems that historically underpin western medicine. There is recognition among people whose identities encompass multiple marginalised or stigmatised groups that an individual healthcare provider may not have capacity to respond to all of their identities and health concerns holistically (Robards *et al.* 2019; O'Shea *et al.* 2020; Newman *et al.* 2021). They may therefore choose to attend a range of services conducive to their needs at the time, rather than prioritising continuity of care with a single GP (Robards *et al.* 2019). This strategy may also protect multiple-marginalised people from the various forms of discrimination that can lead to foregone care (Robards *et al.* 2019).

Healthcare management is often a multidimensional task for individuals identifying with two or more marginalised or stigmatised groups, when these identity groupings have intrinsic, at times incongruent, value systems or healthcare-related needs (Robards *et al.* 2019; O'Shea *et al.* 2020; Newman *et al.* 2021). For example, LGBTQA+ people with a disability may need to educate providers and have limited opportunity to convey the full range and complexity of their identities, experiences and health concerns (O'Shea *et al.* 2020). Older LBQ+ women are often overlooked in efforts towards LGBTQA+ inclusive practice due to the culmination of patriarchal and ageist structural inequalities and provider biases (Hayman and Wilkes 2016). Race/ethnicity, immigration status, education level and parenting are further experiences found to be associated with lesbian-identifying women's sexuality nondisclosure in health care (Durso and Meyer 2013).

While previous studies have linked GP care engagement with mental health outcomes and service access (McDermott *et al.* 2018; Grant *et al.* 2020; Carpenter 2021; Cronin *et al.* 2021), few have identified how identity-affirming GP practices can shape LBQ+ women's access to LGBTIQA+ inclusive mental health care. The participant sample for this study was drawn from a national survey of 6835 LGBTQA+ people aged 18+ years in Australia. Cautious about limiting inclusion to cisgender women when discrimination within and beyond health care contributes to particularly heightened health inequalities for trans and gender diverse people, we understand challenges to healthcare engagement among these populations are likely to be distinct (Strauss *et al.* 2020), and need to be the subject of specific attention in future research. Additionally, the findings of this study were not

intended to reduce participants' realities according to the discrete demographic categories used; rather, highlight the importance of identity-affirming GP practices in LBQ+ women's mental healthcare engagement, together with inequities that require addressing to improve the health and wellbeing of this population. The two key aims were to identify:

- Demographic predictors of cisgender LBQ+ women reporting they (1) had a regular GP and (2) believed their regular GP was aware of their sexual orientation;
- In the past 12 months, whether those with a regular GP and those who believed their regular GP is aware of their sexual orientation had greater odds of having accessed (1) any mental health service/s and (2) mainstream mental health services with a reputation for LGBTIQA+ inclusivity or services catered specifically for LGBTIQA+ people.

Method

Sample and procedure

The Private Lives 3 survey was developed in collaboration with an expert advisory group of members with expertise in LGBTIQA+ population health in Australia, and open online for responses in July through to October 2019. Participants were recruited through Australian LGBTIQA+ community organisation networks and targeted Facebook and Instagram advertising. Interested individuals followed a link to the project landing page where they viewed the explanatory statement and provided informed consent before being directed to complete the survey. The present sample included 2707 cisgender women (i.e. participants who reported a female birth registered sex and selected only 'woman' as their gender identity) who identified as lesbian, bisexual, pansexual or queer. Ethical approval for the project was obtained from the La Trobe University Human Research Ethics Committee.

Measures

Demographics

Demographic characteristics collected and used for the purpose of this study were age, sexual orientation, gender, area of residence (inner suburban, outer suburban, regional, rural/remote), country of birth (Australia, other English-speaking country, non-English-speaking country), education level, weekly pre-tax income and whether participants lived with a disability or long-term health condition. Participants who indicated they lived with a disability or long-term health condition lasting or anticipated to last 6 months or more completed the Australian Institute of Health and Welfare Standardised Disability Flag Module (SDFM), and these responses were coded to a variable including the SDFM 'mild', 'moderate' or 'severe' activity limitation categories (Australian Institute of Health and Welfare 2016), or 'no disability.' Regarding sexual orientation, participants were first asked to choose all relevant identity labels from 12 options: 'gay', 'lesbian', 'bisexual', 'pansexual', 'queer', 'asexual', 'homosexual', 'heterosexual', 'prefer not to answer', 'prefer not to have a label', 'don't know' and 'something different.' Those who selected more than one sexuality label were then asked to choose the *one* label they identified with the most.

Regular GP and GP awareness of LBQ+ cisgender women's sexual orientation

To explore engagement with a regular GP, participants were asked whether they attend a regular GP and responses were coded to a binary variable with categories 'Yes' and 'No, I don't have a regular GP but I attend the same health centre'/ 'No, I don't have a regular GP, and I attend different health centres.' Participants with a regular GP were further asked if their GP was aware of their sexual orientation and responses were dichotomised to 'Yes' and 'No'/'I don't know.'

Mental health services accessed in the past 12 months

Participants indicated whether they had accessed mental health care in the past 12 months from a mainstream mental health service (e.g. psychologist, counsellor) that is *not* known to be inclusive of LGBTIQA+ people, a mainstream mental health service that *is* known to be inclusive of LGBTIQA+ people or a mental health service catered specifically to LGBTIQA+ populations. Participants could select all relevant services, or alternatively state they had not accessed any services. Two binary variables were generated: one indicating whether participants accessed any mental health services, and another indicating whether participants had only accessed mainstream services *not* known to be inclusive or had accessed either mainstream services that *are* known to be inclusive or services that cater only to LGBTIQA+ populations.

Statistical analysis

Statistical analyses were conducted using STATA (Ver. 16 SE; StataCorp, College Station, TX). Multivariable logistic regression analyses examined sociodemographic factors co-occurring with participants having a regular GP, and having a regular who is aware of their sexual orientation. Multivariable logistic regressions then explored whether having a regular GP and GPs' awareness of participants' sexual orientation influenced odds of having engaged with mental health care in the past 12 months, as well as the type of service accessed, controlling for confounding effects of age, sexual orientation, educational attainment, income, residential location, disability (SDFM) and country of birth. No issues were found in relation to multicollinearity (variance inflation factor < 2). Adjusted odds ratio (AOR) and 95% confidence interval (CI) are reported.

Table 1. Sample characteristics ($n = 2707$).

	n	%
Age		
18–24	940	34.7
25–34	779	28.8
35–44	477	17.6
45–54	285	10.5
55–64	161	5.9
65+	65	2.4
Sexual orientation		
Lesbian	1268	46.8
Bisexual	876	32.4
Pansexual	225	8.3
Queer	338	12.5
Education		
Secondary or below	680	25.1
Non-university tertiary	548	20.2
University-undergraduate	780	28.8
University-postgraduate	699	25.8
Weekly income (pre-tax)		
Nil income	172	6.4
≤$399	678	25.3
$400–$599	317	11.8
$600–$999	391	14.6
$1000–$1999	850	31.7
≥$2000	274	10.2
Country of birth		
Australia	2314	85.7
Other English-speaking country	286	10.6
Non-English-speaking country	100	3.7
Residential location		
Capital city, inner suburban	1109	41.3
Capital city, outer suburban	772	28.8
Regional city or town	617	23.0
Rural/Remote	186	6.9
Disability		
None	1488	57.3
Mild activity limitation	207	8.0
Moderate activity limitation	595	22.9
Severe activity limitation	306	11.8
Regular GP		
No	967	35.8
Yes	1734	64.2
Regular GP aware of participant's sexual orientation[A]		
No	724	41.7
Yes	1010	58.3
Accessed any mental health service/s in the past 12 months		
No	1314	48.7
Yes	1386	51.3
Type of mental health service accessed in the past 12 months[B]		
Mainstream service not known to be inclusive	943	68.0
Inclusive mainstream service[C] or population-specific service[D]	443	32.0

[A]Among those with a regular GP.
[B]Among those who accessed any mental health service.
[C]Mainstream mental health service with a reputation for LGBTIQA+ inclusivity.
[D]Mental health service that caters only to LGBTIQA+ populations.

Ethics approval

Ethical approval for the Private Lives 3 project was obtained from the La Trobe University Human Research Ethics Committee.

Results

Demographic characteristics

Participants were aged between 18 and 80 years (Table 1). The majority identified as lesbian (46.8%), followed by bisexual (32.4%), queer (12.5%) and pansexual (8.3%). Almost half (44%) reported a weekly income of less than $600 AUD – below poverty line estimates (University of Melbourne and Melbourne Institute 2021).

Regular GP and GP awareness of LBQ+ women's sexual orientation

All but 94 women had visited a GP at least once in the past 12 months (96.5%), and 64.2% had a regular GP. Multivariable analyses (Table 2) revealed that odds of having a regular GP increased with age (e.g. compared to 18–24 year-olds: AOR[45–54 years] = 2.26, 95% CI = 1.56–3.26), and SDFM category (e.g. compared to no disability reported: AOR[severe activity limitation] = 2.51, 95% CI = 1.85–3.40).

Among LBQ+ cisgender women with a regular GP, only 58.3% believed their GP was aware of their sexual orientation. GP awareness of their sexual orientation was most frequently reported among women with a weekly income of ≥$2000 compared to nil income (AOR = 2.17, 95% CI = 1.08–4.37); undergraduate (AOR = 1.46, 95% CI = 1.01–2.12) or postgraduate (AOR = 1.68, 95% CI = 1.11–2.54) education compared to secondary school or below; aged 25+ compared to 18–24 years (e.g. AOR[45–54 years] = 5.22, 95% CI = 3.20–8.50); identifying as lesbian compared to other

Table 2. Multivariable logistic regression analyses demonstrating factors co-occurring with LBQ+ cisgender women having a regular GP and believing their regular GP is aware of their sexual orientation.

	Regular GP (*n* = 2539)				GP aware of sexual orientation[A] (*n* = 1645)			
	n	%	AOR (95% CI)	*P*	*n*	%	AOR (95% CI)	*P*
Age								
18–24	520	55.6	REF		139	26.7	REF	
25–34	477	61.3	1.25 (0.97–1.61)	0.089	292	61.2	2.82 (1.96–4.05)	< 0.001
35–44	333	70.0	1.83 (1.35–2.48)	< 0.001	248	74.5	4.08 (2.70–6.17)	< 0.001
45–54	214	75.1	2.26 (1.56–3.26)	< 0.001	177	82.7	5.22 (3.20–8.50)	< 0.001
55–64	132	82.0	3.76 (2.28–6.20)	< 0.001	108	81.8	4.50 (2.58–7.88)	< 0.001
65+	58	89.2	6.07 (2.53–14.52)	< 0.001	46	79.3	4.58 (2.01–10.42)	< 0.001
Sexual orientation								
Lesbian	836	66.1	REF		649	77.6	REF	
Bisexual	544	62.2	1.11 (0.90–1.37)	0.323	174	32.0	0.19 (0.14–0.25)	< 0.001
Pansexual	139	61.8	0.98 (0.71–1.36)	0.912	56	40.3	0.28 (0.18–0.43)	< 0.001
Queer	215	63.6	1.03 (0.79–1.35)	0.831	131	60.9	0.46 (0.32–0.65)	< 0.001
Education								
Secondary or below	393	58.1	REF		126	32.1	REF	
Non-university tertiary	367	67.1	1.12 (0.85–1.47)	0.430	212	57.8	1.36 (0.93–1.99)	0.114
University-undergraduate	485	62.2	0.97 (0.75–1.26)	0.818	299	61.6	1.46 (1.01–2.12)	0.044
University-postgraduate	489	70.1	1.10 (0.81–1.49)	0.556	373	76.3	1.68 (1.11–2.54)	0.013
Weekly income (pre-tax)								
Nil income	101	59.8	REF		32	31.7	REF	
≤$399	405	59.8	0.96 (0.66–1.39)	0.817	157	38.8	1.18 (0.68–2.04)	0.564
$400–$599	201	63.4	0.94 (0.61–1.44)	0.765	102	50.7	0.98 (0.53–1.81)	0.940
$600–$999	251	64.4	1.07 (0.71–1.63)	0.743	132	52.6	0.85 (0.47–1.53)	0.587
$1000–$1999	553	65.1	1.00 (0.66–1.50)	0.984	398	72.0	1.45 (0.81–2.57)	0.209
≥$2000	206	75.5	1.46 (0.88–2.42)	0.139	180	87.4	2.17 (1.08–4.37)	0.029
Country of birth								
Australia born	1479	64.1	REF		840	56.8	REF	
Other English-speaking country	187	65.4	0.86 (0.66–1.13)	0.274	128	68.4	0.74 (0.50–1.08)	0.114
Non-English-speaking country	64	64.6	0.97 (0.61–1.55)	0.899	39	60.9	0.64 (0.30–1.38)	0.256
Residential location								
Capital city, inner suburban	712	64.4	REF		473	66.4	REF	
Capital city, outer suburban	501	65.0	1.20 (0.97–1.48)	0.091	255	50.9	0.65 (0.49–0.87)	0.003
Regional city or town	389	63.3	0.99 (0.79–1.24)	0.945	205	52.7	0.70 (0.51–0.96)	0.028
Rural/Remote	114	61.3	0.83 (0.58–1.17)	0.286	65	57.0	0.62 (0.38–1.02)	0.062
Disability								
None	888	59.9	REF		565	63.6	REF	
Mild	149	72.0	1.83 (1.31–2.55)	<0.001	88	59.1	1.07 (0.70–1.63)	0.760
Moderate	415	69.7	1.74 (1.40–2.16)	<0.001	220	53.0	1.01 (0.75–1.36)	0.961
Severe	231	75.7	2.51 (1.85–3.40)	<0.001	112	48.5	0.84 (0.59–1.21)	0.358

Frequency and percentages refer to the number and proportion of LBQ+ cisgender women in each demographic group who attended a regular GP or who reported that their GP was aware of their sexual orientation.

[A]Among LBQ+ cisgender women with a regular GP.

sexual orientations (e.g. AOR[bisexual] = 0.19, 95% CI = 0.14–0.25); and living in inner suburban or rural areas (compared to inner suburban: AOR[outer suburban] = 0.7, 95% CI = 0.5–0.9; AOR[regional] = 0.7, 95% CI = 0.5–1.0).

Mental health services accessed in the past 12 months

Over half (51.3%) of LBQ+ cisgender women had accessed mental health services in the past 12 months (Table 1). Of those, 68.0% attended a mainstream mental health service that is not known to be LGBTIQA+ inclusive, while 32.0% (16.4% of all women) attended either a LGBTIQA+ inclusive mainstream or exclusively LGBTIQA+ service. Adjusted analyses (Table 3) showed that LBQ+ cisgender women with a regular GP had greater odds of accessing any mental health service (AOR = 1.57, 95% CI = 1.31–1.88) and of accessing LGBTIQA+ inclusive or specific mental health services (AOR = 1.28, 95% CI = 0.97–1.68), although the latter did not meet $P \leq 0.05$ significance. Among participants with a regular GP, GP awareness of their sexual orientation corresponded to greater odds of attendance at mainstream-inclusive or specific LGBTIQA+ mental health services (AOR = 1.81, 95% CI = 1.29–2.54).

Discussion

LBQ+ cisgender women were more likely to report engaging with mental health care in the previous 12 months if they had a regular GP, and inclusive or specific LGBTIQA+ mental health services were accessed primarily by women whose regular GPs knew about their sexual orientation. Discrepancies in identity disclosure for specific sub-populations are particularly noteworthy, given that non-disclosure appears to compromise access to LGBTIQA+ inclusive services, potentially when these services may be preferred. In context with prior documentation of the extent of LBQ+ cisgender women's unmet mental health needs, together with studies linking sexual identity disclosure in general practice with continuity and satisfaction with general practice care and 'met' mental health needs (McNair *et al.* 2011, 2018), GPs are likely missing opportunities to develop trusting relationships with LBQ+ cisgender women through which they may facilitate continuity of care and access to appropriate forms of mental health support.

The two-thirds of participants reporting they had a regular GP is a relatively low proportion compared to studies of the general population. One such study showed that about 80% of adults had a regular GP (Wright *et al.* 2013). Odds of having a regular GP were lowest among women aged <25 years. Compared to older generations, young LGBTQA+ people express a greater desire for clinicians who show 'immediate and visible forms of acceptance,' and are willing to seek new providers when existing ones don't meet these expectations (Newman *et al.* 2021). It appears that non-inclusive practices may interact with age-related structural barriers to consistent GP care and heighten young LBQ+ women's barriers to mental health care. Potentially by virtue of these practices, young LBQ+ women's mental health needs may be particularly underserved relative to the general population, given that people aged 18–25 years in Australia have been shown in population-level data to be the most likely of all age cohorts to access subsidised mental health care (Australian Institute of Health and Welfare 2019).

LBQ+ cisgender women with a disability were more likely to have a regular GP, which has also been shown in general population data (Department of Social Services; Melbourne Institute of Applied Economic and Social Research 2019). Women with disability were however no more likely than other participants to believe their GP was aware of their sexual orientation. LGBTQA+ people with a disability have reported challenges with sexual identity disclosure in health care including provider assumptions of heterosexuality or

Table 3. Relationship between LBQ+ cisgender women's engagement with GPs and mental health service access in the past 12 months.

	Any mental health service (n = 2533)				Mainstream-inclusive/LGBTIQA+ specific mental health service[A] (n = 1319/n = 924)			
	n	%	AOR (95% CI)	*P*	*n*	%	AOR (95% CI)	*P*
Regular GP								
No	420	43.6	REF		119	28.3	REF	
Yes	966	55.8	1.57 (1.31–1.88)	<0.001	324	33.5	1.28 (0.97–1.68)	0.081
Regular GP aware of sexual orientation[B]								
No or unsure	–	–	–	–	108	27.0	REF	
Yes	–	–	–	–	216	38.2	1.81 (1.29–2.54)	0.001

Frequency and percentages refer to the number and proportion of participants who accessed any mental health service in the past 12 months and who accessed either a mainstream mental health service that is known to be LGBTIQA+ inclusive or a service that caters only to LGBTIQA+ populations in the past 12 months.
[A]Comparing the proportion of women who engaged with LGBTIQA+ inclusive/specific mental health services with that who accessed only mainstream mental health services that do not have a reputation for LGBTIQA+ inclusivity.
[B]Among those with a regular GP.

asexuality, gatekeeping of health care by carers and relatives and lack of disability inclusion within LGBTIQA+ spaces (O'Shea *et al.* 2020). In the context of higher rates of mental health concerns among this population (Hill *et al.* 2022), a better understanding of their experiences when accessing inclusive LGBTIQA+ mental health services, and the role of GPs in facilitating access, is needed. It could be argued that disclosure and sensitive referral to inclusive LGBTIQA+ mental health services are even more important for this sub-group, given their multiple marginalised identities and barriers to peer and social support.

Less than one-third of LBQ+ cisgender women who had accessed mental health care had done so via LGBTIQA+ inclusive or specific services, with greater odds observed among participants whose regular GPs were aware of their sexuality. These participants were typically older, highly educated, on high incomes, lesbian-identifying and living in inner suburban or rural areas. Previous research strongly indicates non-disclosure may be a consequence of inadequately inclusive GP practices such that LBQ+ cisgender women do not feel comfortable or safe disclosing their sexual orientation (Mulligan and Heath 2007; Durso and Meyer 2013; Newman *et al.* 2021; Carpenter 2021). Pansexual and queer identifying people in particular are more likely to prefer inclusive over mainstream health services and to report greater reluctance to access mental health care than other sexual minority groups (McNair and Bush 2016; McNair *et al.* 2018; Grant *et al.* 2020). This makes identity-affirming GP relationships pertinent to addressing their mental health needs.

Lower rates of sexuality disclosure to GPs in regional and outer-suburban areas may be due to heightened anticipation of discrimination; for example, it has been found that social attitudes towards LGBTIQA+ people may be more negative in outer-suburban compared to inner-suburban areas of capital cities (Flood and Hamilton 2005). Women living regionally have, however, been found to value and make decisions about health care based primarily on interpersonal rapport with their providers (Ward *et al.* 2015). The lower rates of GP awareness of sexuality among regional participants, but not of having a regular GP, demonstrates a dynamic and non-mutually exclusive relationship between satisfaction with GP care and sexuality nondisclosure. The co-existence of these seemingly discordant factors may occur when one's minoritised sexuality is not a key facet of their holistic sense of identity (McNair *et al.* 2012; Grant and Nash 2020).

While rural LGBTQA+ people also report more barriers and discrimination in health care than their urban counterparts (Nic Giolla Easpaig *et al.* 2022), the emergence of rural queer hubs – offering the social networks, inclusive services and broader awareness and visibility of queer community – could explain the similar rates of sexuality disclosure among inner-suburban and rural participants. The counter-urban movement and cultural consumption practices of predominantly white, middle-class lesbian and gay cisgender women and men have been simultaneously implicated in the urbanisation and gentrification of rural areas (Smith and Holt 2005). These 'gay capitals' are inhabited primarily by elder lesbians and potentially less accessible or catered to young people who are more likely to inhabit plurisexual identities and have considerably less financial security (Grant 2021). Taken together, our findings challenge contested notions of inherent non-inclusion in rural and regional areas but infer potential inequities in access to inclusive GP care and mental health services across identity groupings (e.g. according to age, sexual orientation and class), within and between urban and non-urban communities. This demonstrates the importance of identifying geographically specific research and healthcare priorities.

The findings provide valuable insight into GP care engagement and mental health service access among a large sample of LBQ+ cisgender women. There are, however, some limiting factors. The sample was not nationally representative, and therefore has limited generalisability to specific identity groups. For example, there was no difference in regular GP status and GPs' sexuality awareness according to country of birth, potentially due to the small sample of non-Australian-born participants. Pre- and-post-migration experiences, structural violence and explicit forms of discrimination and abuse (e.g. based on racial, patriarchal and homophobic constructs) in countries of origin and settlement have been found to exacerbate health inequalities for women and LGBTQA+ people (Namer and Razum 2018; Sullivan *et al.* 2020), while a person's visa status in Australia can further limit access to health care. We also recognise that collapsing sexual (and other) identities into discrete categories may erase their hybridity and the range of terms people use to describe their realities. Exploratory research with LGBTIQA+ people, that centres their realities and offers deeper insight into affirming healthcare relationships and mental health management within and beyond health services, is needed.

Conclusion

Honest, open dialogue about sexuality in general practice settings appears to be a necessary precursor to accurate clinical assessment and linkage to mental health services for LBQ+ cisgender women. However, heterosexism and monosexism in primary care are likely reducing their access to mental health services; particularly to LGBTIQA+ inclusive services when these may be preferred. Barriers to identity-affirming GP and mental health services need to be addressed particularly for young LBQ+ cisgender women, those who identify as bi+ or queer, have below undergraduate-level education, lower incomes, or live in outer-suburban or regional areas. GPs need to work to improve their competency in LGBTIQA+ inclusive practice, incorporate sexual orientation in holistic healthcare management, develop trust and rapport with patients and ensure general practice environments are safe and affirming places for people to comfortably

discuss their sexuality when it is relevant to their health care. Rather than eliciting unwanted disclosure, GPs referring to specialist mental health services may consider it appropriate to ask patients whether LGBTIQA+ inclusivity is important to them.

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Data availability. The data that support this study will be shared upon reasonable request to the corresponding author.

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