LGBTQ+ young people's digital peer support for mental health

May 2023

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Contents

Acknowledgements

The author and research team acknowledge that our research was undertaken on stolen lands. We pay our respects to Aboriginal and Torres Strait Elders, past and present, and extend this to all Aboriginal and Torres Strait people who have advised, participated in, or will engage with, this research.

This report would not exist without the intellectual and hands-on work of Sab D'Souza, as research assistant and advisory committee member. It is beyond disappointing that they did not live to see this report and I am indebted to them for our many conversations about LGBTQ+ young people's digital peer support and how and why we should research this.

This study was guided by the wisdom and expertise of project advisory committee members. Many thanks to Cristyn Davies, Félix Delhomme, Andrew Farrell, Alison Guo, Mitch Hibbens, Melissa Kang, Marlene Khouzam, Kochava Lilit, Lisa McDaid, Luke Noverraz, Brady Robards, and Emery Wishart. Additional thanks to Starlady from Zoe Belle Gender Collective for consultation, and to Tommaso Armstrong for proofreading and input.

Most significantly, thanks to the 674 young people who participated in this research. We hope this report adequately represents your experiences, knowledges, and valuable expertise on LGBTQ+ young people's digital peer support.

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Recommended Citation: Byron, P. (2023) LGBTQ+ young people's digital peer support for mental health. University of Technology Sydney. Sydney, Australia.

Executive Summary

This report presents findings from a national survey and interviews with LGBTQ+ young people, aged 16-25 years, about digital peer support for mental health. For this study, digital peer support comprises informal, digital and social media engagement with friends and peers. Findings, drawn from the experiences of 674 young participants, demonstrate how LGBTQ+ young people support each other in ways that families, schools, and health practitioners cannot. This is not to suggest that formal and family-based support is unnecessary, but that informal digital support should be considered alongside these.

Taking a strengths-based approach to LGBTQ+ young people's experiences, this study engages participants as digital peer support experts. Research that centres LGBTQ+ young people's digital cultures can expand current understandings of their support needs and practices and enrich current healthcare practices, strategies, and policies. This report offers insight into what digital peer support means to LGBTQ+ young people and how mental health is negotiated – personally and collectively, through digital media. It offers new knowledge of where and how digital peer support is practiced, who is involved, and the value it adds to participants' lives. These insights can inform future research and practice aiming to improve the mental health of LGBTQ+ communities.

Key findings

- Social media can offer young people easy access to LGBTQ+ communities, knowledge and support, if and when needed.
- Digital and social media provide manifold opportunities for LGBTQ+ young people to provide, access and/or circulate care and support to friends and strangers.
- LGBTQ+ young people can feel supported, and less alone in their struggles, by witnessing, following, and engaging with people who share similar identities and mental health experiences on social media (typically referred to as 'people like me').
- Peer-level knowledge from 'people like me' is not only accessible, rich, and informative, but offers more holistic support than is available from families, schools, health systems, and sometimes friends.
- Witnessing and engaging with digital peer support enhances LGBTQ+ young people's abilities to provide meaningful support to friends and strangers alike.
- Informal digital support for mental health is mostly not about providing counselling or therapeutic support, but more so sharing personal experiences, space, memes, tips, and information, and providing opportunities to share, listen, learn, and feel validation.
- Social media can offer easy connection to LGBTQ+ culture and communities, as well as access to Indigenous communities, POC (people of colour) communities, disability communities, and where these intersect. Participants who were multiply marginalised by social systems (including formal care systems), commonly discussed the difficulties and joys in finding 'people like me'.
- Poor mental health is exacerbated by social and structural forces of racism, colonialism, ableism, classism, and living in rural/regional locations. These complicate affiliation with, and the safety of, LGBTQ+ community spaces and services for many young people. This highlights a need for intersectional approaches to young people's mental health support.
- While digital peer support is not usually LGBTQ+ young people's only source of support, it is often how support is initially found, and can therefore structure how it is experienced, felt and enacted thereafter. This should be kept in mind when developing support services and initiatives for LGBTQ+ young people.

Introduction

For this study, digital peer support refers to informal digital practices of giving and receiving support, as well as the circulation and use of supportive content online. It largely involves social media use and interaction with friends, peers, and strangers, and includes everyday practices of social media scrolling and immersion. Findings from this study should be considered alongside existing knowledge and practices relating to formal support provision for LGBTQ+ young people. Informal digital peer support does not simply 'fill the gaps' of formal health care, but has its own practices, meanings, and values among LGBTQ+ young people. Further knowledge of this can expand our understanding of LGBTQ+ young people's support needs, as well as their expertise and skills in care provision.

This report presents key findings on how, where and when digital peer support for mental health happens, who is involved, and why this is valuable for LGBTQ+ young people. As well as informing practitioners working across health policy, health care, education, social work, community services and academia, this report is for all those who wish to support LGBTQ+ young people's mental health and wellbeing.

Participants of this study comprise 660 LGBTQ+ young people aged 16-25 who completed an online survey in late 2020, and 36 young people who were interviewed in 2021 (most of whom completed the survey). Interview participants mostly feature in this report since they had more opportunity to elaborate on their digital peer support experiences (see Appendix 1 for interview participant details).

Snapshot of 660 survey participants:

- Most (66.5%) were aged 16-17 years.
- Most were female (59.5%), with more participants identifying as non-binary or using other terms (22%) than those who were male (18.5%).
- One third (33.3%) were trans, gender diverse or gender questioning (26.6% indicated a different gender to what was presumed at birth; 6.7% were unsure about this).
- Participants often listed multiple sexual orientations, with bisexuality being most common (44.4%), followed by queer (28.5%), lesbian (23%), pansexual (15.9%), gay (13.9%), questioning (11.7%), and asexual (11.4%).
- Most participants reported mental health conditions (60.5%) and many others (27.5%) were unsure about this.

For more details on methods and participant demographics (including details on age, gender, sexual orientations, cultural background, disability, and living situations), see Appendix 1. Participants quoted in this report are typically interviewees and referred to by pseudonyms. Unnamed quotes are taken from survey responses.

A note on terminology

How participants referred to their mental health, disabilities, and other aspects of identity and selfhood, including Indigeneity and ethnicity, varied, and where possible, participants own terms are used. When reporting on shared experiences of multiple participants, more general descriptors are applied. This includes referring to mental health struggles or conditions, rather than 'mental illness', which does not reflect everyone's experience. I have used the LGBTQ+ acronym throughout to reflect project recruitment and survey materials, and as a commonly recognised acronym in which the '+' signals a wide range of gender and sexuality identities and experiences.

I.

Part 1: LGBTQ+ young people's lives

Part 2: Digital peer support for mental health

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Appendices

This section provides important context to participants' experiences of digital peer support. Here, a summary of participant experiences relating to mental health, families, school, health settings, and friendships helps us to understand the value and necessity of informal digital peer support that will be discussed in Part 2 of this report.

Mental health experiences

While most participants reported experiencing poor mental health, this ranged from lifelong journeys of formal mental health care to more temporary or situational experiences. The following is a snapshot of the mental health conditions and diagnoses of 653 survey participants who disclosed these details. Approximately half of this sample (48.7%) had received a mental health diagnosis from a health professional, with almost one-fifth (19.1%) self-diagnosing a mental health condition[1] (see Table 1). Formal diagnoses by health professionals were mostly for anxiety (42.1% of survey participants) and depression (34%). Most of those participants (N=205) were diagnosed with both anxiety and depression, which equates to almost one third of survey participants (31.4%). Following these, eating disorders (ED), attention deficit hyperactivity disorder (ADHD), and post-traumatic stress disorder (PTSD) were the next most common medical diagnoses.

Table 1: Mental health diagnosis (653 participants)

Diagnoses	***#***	***%***
Yes (medical diagnosis)	318	48.7
Yes (self-diagnosis)	125	19.1
No diagnosis	253	38.4
Medical diagnoses		
Anxiety	275	42.1
Depression	222	34.0
ADHD	50	7.7
PTSD	43	6.9
ED: Anorexia/Bulimia	42	6.4
ED: EDNOS/Binge eating disorder	27	4.1
Complex PTSD	17	2.6
Dissociative identity disorder	11	1.7
Bipolar disorder	9	1.4
Borderline personality disorder	6	0.9
Other	66	10.1

[1] Forty-three participants (6.5%) indicated both medical and self-diagnoses, so are counted twice in the first section of Table 1.

Ten percent of participants reported 'other' medical diagnosis which were mostly autism spectrum disorder (ASD) and obsessive-compulsive disorder (OCD). Of the 125 participants who reported self-diagnoses, these too were mostly for anxiety and depression, with 85 participants (13% of the sample) self-diagnosing either or both. This was followed by self-diagnosis of ADHD (6.1%; N=40).

Early in the survey, respondents were given the option to describe their mental health using their own words, and most did so (83.5%; N=551). Responses ranged from one-word to more detailed descriptions that often emphasised moving towards or away from poor mental health (see Table 2). These responses highlight a diversity of mental health experiences, and how participants were often in the process of negotiating, figuring out, or managing a range of conditions or symptoms.

Table 2: Examples of survey participants describing their mental health

A journey that I have only begun to progress positively in the last 2-3 years. Tend to have suicidal ideation once every 6-12 months. ***(23, cis female, bisexual, white)***

Unpredictable, sometimes like a roller coaster (extreme highs and lows). Incredibly exhausting and takes a huge toll on my life. ***(21, cis female, queer, Indigenous)***

I manage a mental health condition which impacts but doesn't drastically impair my day to day life but requires considerable thought, care and attention. ***(25, cis female, bi/queer, white)***

Not fantastic but others for sure have it worse. ***(19, cis female, bi/pan/queer, white)***

It fluctuates, sometimes i'm fine and sometimes i get really stressed and burst into tears for the littlest things. ***(18, genderfluid, bi/pan/gay/queer, Aboriginal)***

Rocky at times to be honest. I don't believe I have a mental health disorder (I have not been diagnosed with anything) but I do struggle with stress and feelings of anxiety, as well as having gone through times where I have felt depressed. ***(17, female/questioning, gay/lesbian, white)***

I am functioning but my mental health can be fragile. I go through intense periods of depression and anxiety due to Bipolar 2 disorder. ***(21, cis male, gay/queer, white)***

when its bad, its really bad. i struggle with being in the habit of self harm. ***(16, demigirl, gay/lesbian/queer, white)***

I have trauma that is very difficult to live with and am miserable a lot but I am getting help now at least. ***(16, non-binary, asexual, mixed race)***

Confusing and ever-changing. I don't have a medical diagnosis, which just gives me more anxiety about what could actually be happening. ***(17, cis female, pansexual/queer, white)***

cont.

Table 2, cont.

My mental health is a roller coaster, but these past few years it has been a downward plummet. ***(16, questioning, bi/pansexual, white)***

I am able to handle stress and make choices. Although I have been quite overwhelmed recently and have had spikes in bad days, that's just caused by end of high school. Overall, I am a very lucky person who has lots of support. ***(18, cis male, gay, white)***

My mental illnesses along with my adhd impair my life to the extent that they're considered a disability. I'm impacted substantially on a day-to-day basis, but fluctuations are common. Currently I'm managing my symptoms okay. ***(21, cis female, bi/pan/queer, white)***

Family experiences

Most participants lived with their families, who were therefore often involved in their mental health negotiations, including seeking formal support. Survey participants were asked who they were likely to turn to when feeling down or anxious, with most indicating their friends (90%), and approximately half saying that they would or might turn to a family member (50.9%) (see Table 4 in Friendship Experiences section). More context was provided by interview participants who described mixed and complicated family situations, ranging from wholly supportive to unsafe. Many reported having at least one close parent who supported their initiation of formal mental health care as well as their gender/sexual identities. Sometimes a supportive parent did not have good mental health literacy, so their support was mostly practical (i.e. finding a psychologist and driving them to appointments). While it was common for participants' parents to be okay with having gay or lesbian children, trans and gender diverse/questioning participants were less commonly able to disclose their identities to parents, which typically impacted their mental health and access to formal support.

"She's not a bad mum but she doesn't get mental health stuff at all."

Greta, (22, cis female, queer/pansexual, white)

Participants with childhood experiences of poor mental health, including medical interventions, were often more reliant on families to initiate and supervise their mental health care. Among participants who sought formal mental health support from their late teens onwards, many did this independently of families. This was for a variety of reasons, included pre-existing family difficulties, cultural or generational impasses (e.g., parents did not believe in mental health), or parents having their own mental health conditions. Where there was prior experience of poor mental health within families (immediate or extended), this sometimes led to early intervention. Participants with strong family support typically had an easier and quicker journey to finding adequate support, and this sometimes involved non-disclosure of gender/sexual identities. Many reported having homophobic and transphobic parents, despite some parents claiming to be accepting.

"with my family, I've got certain boundaries set up now where I don't – I try not to let them affect my mental health… I only keep it light and really happy, not heavy conversation with [my mother] and only hang out with her a short period of time. Otherwise, it will start to affect my mental health."

June, (20, agender/genderfluid, bisexual, Filipino/Australian)

Some participants were unable to live with their families due to non-acceptance of their gender/sexuality. Many discussed how family relationships changed over the years, whether repairing after time apart, or worsening to the point of no longer speaking. Many participants' parents were trying to be more supportive, and some participants spoke of strategies to accommodate this while also protecting themselves from the negative impacts – for example, June spoke of boundaries for engaging with their mother (see quote). Some recalled feeling safer staying at friends' or siblings' houses as teenagers or finding more support from friends' parents. Extended family members who were part of the LGBTQ+ community (e.g., cousins) were an important source of support and solidarity for some since they understood family dynamics. While many participants had freedom to explore their identities over time, others reported intense family supervision that prevented this, including internet and social media monitoring. Challenging family situations directly impacted participants' mental health, including parental pressure to excel at school.

"When I was 16 I tried to access headspace, but after two appointments, my parents removed me from the service because they did not want me seeing a therapist."

Yarran, (24, trans masc non-binary, queer, Indigenous)

School experiences

As with families, school experiences were mixed. Interview data shows that school support often depended on the culture of the school, school friendships, and the teachers and counsellors. Many participants were active members of school-based LGBTQ+ support clubs or Queer-Straight Alliances (where these existed) that celebrated events like Wear It Purple Day. Many noted that their former schools had since improved in relation to visible LGBTQ+ student support. Personal school experiences were not traumatic for most participants, though one interview participant spoke of being a victim of school violence, and several mentioned instances of bullying and racism. More commonly, peer-experiences of homophobia and transphobia were often described as students being stupid and ill-informed, and making bad jokes rather than being malicious. Some did account for instances where teachers and staff actively hindered LGBTQ+ inclusion, and this was most common in conservative and religious high schools. Many noted that while schools and teachers were not actively homophobic or transphobic, little effort was put into showing visible and active support of LGBTQ+ students. Most LGBTQ+ support initiatives (including alliance clubs) emerged through students lobbying for these.

"They would let me come to school late because I would be coming from the hospital, go to school and then go back to the hospital – and like really flexible. But I don't know what they would be like if I wasn't a very conscientious student."

Leif, (19, non-binary, queer, white)

Some participants felt that students' mental health was adequately supported by their schools, with some able to negotiate their learning needs with teachers and counsellors in a supportive manner. However, the onus on raising issues with teachers and staff was typically on students themselves. This was also true of raising concerns on behalf of other students, with many noting that teachers did not seem to see what they saw in relation to peers with mental health struggles. Some schools went to lengths to highlight the importance of mental health, visibly and in curriculum, but this was uncommon. Many participants reflected on a need for whole-of-school work toward promoting and supporting student mental health, often suggesting changes to curriculum and teacher training. Commonly, teachers were seen as clueless or uneducated about student mental health, and religious schools were particularly highlighted as neglectful. Suicides of fellow students often led to an intensification of mental health discussion and resourcing (such as appointing additional counsellors), but for a limited time. Several such stories highlight that school-based mental health support programs were often a response to such events and not a long-term strategy.

"Students often would intervene and tell staff that things were happening, and then something would happen from there. But perhaps teachers need to be trained in picking up on those things, checking in with students."

Perry, (21, genderqueer, queer, Aboriginal)

Many participants received valuable support from an individual teacher, and this was more common than feeling supported by school counsellors, though many did find that useful. Many described school counsellors as ineffective, being unqualified to deal with serious issues for which they typically referred to headspace services. As such, counsellors were often seen as offering administrative and practical support, or advice that was not particularly useful. Some reported avoiding school counsellors due to negative reviews from other students. Many counsellors were good, however, but only available some days, and many participants saw this as inadequate. Many who went to religious schools avoided chaplain support as they assumed they would be unaccepting of their identities. Overall, schools were seen to be improving with support for LGBTQ+ students, and support for student mental health, but most did not rely on nor expect school-based support. However, schools did provide regular access to friends who were important sources of support.

Engaging with health professionals

Most survey and interview participants had engaged with mental health services and professionals, but experiences of these varied (see Table 3). Of survey respondents, 38.7% (N=223) had not engaged in formal mental health support, which includes 98 who were undecided about doing so.

Table 3: Survey participants' engagements with formal mental health support (N=577)

Q. Which of these best applies to you?	*#*	*%*
I have sought health from a health professional	354	61.4
I have not sought help from a health professional	125	21.7
I am undecided about seeking help from professionals	98	17.0

The 223 participants who had not sought formal support were asked if they had ever wanted to, and most (N=165) had. This highlights that service use reluctance is common among LGBTQ+ young people, which may specifically relate to access barriers due to age, living situation, and potential difficulties involving their parents.

"it's either I see someone who knows a lot about PTSD, I talk to them about being trans and they freak out. Or I go to speak to someone about being trans, I talk to them about my PTSD, and they freak out."

Rubin (18, trans masc non-binary, pan/bi/gay/ace, white)

While most interview participants experienced formal mental health support, some discussed their uncertainty about needing it. For those who engaged with formal support, experiences ranged from temporary engagement during a difficult phase to many years of support – sometimes since childhood. Participants in the latter group had typically moved through a range of practitioners or therapists before they found the 'right fit'. Often, first experiences with health professionals and therapists were less comfortable than in later years, where more suitable care was found. Many older participants spoke of now researching care providers to ensure they were safe and qualified to meet their needs.

A common difficulty in accessing mental health care was the financial cost, including the Medicare rebate gap, especially for participants whose parents were not involved in their mental health care. Other barriers included long wait times to see specialised and LGBTQ+ affiliated professionals; difficulties finding trans-friendly therapists; parents not supporting a need for mental health care; and the limited number of Medicare-supported therapy sessions available per year. A university student who was studying from abroad noted the dilemma of choosing between a free university counsellor who likely spoke English, and a practitioner who could speak their first language but would be costly and less likely queer-friendly. Many noted the difficulties in navigating health care systems, including referrals, Medicare rebates, and the different kinds of professionals (e.g., counsellors vs. clinical psychologists). Some wanted to access inner-city LGBTQ+ counselling services but lived too far away. COVID-19 lockdowns also disrupted regular access to formal care, or preferred modes of care (e.g., face-to-face). Participants also spoke of time costs, noting the extra effort to find trans/queer-friendly services and professionals. Shopping around was a common experience, and many felt fatigued by repeatedly sharing their stories with many health care providers. This was particularly an issue for trans and gender non-conforming participants.

"I know there are a lot of good psychiatrists and you have to see a lot to make sure it's a match but it's a lot of effort and it's a lot of money."

Mei (24, cis female, queer, Chinese)

Participants whose early experiences of formal support were negative sometimes delayed seeking further support. The free youth mental health service, headspace, was the first counselling experience for many, and mixed experiences of this were reported. Many indicated that they were too guarded or concerned about confidentiality in early therapy experiences, particularly with regard to gender/sexuality and fear of their parents finding out. Many took time to trust practitioners, with initial concern that they may

not accept or understand their identities. Some disengaged from formal care because they did not feel ready to speak about gender/sexuality, and some had felt pressured to have those conversations with therapists before they were ready to.

Discussions of gender and sexual orientation with health professionals had been easy for some, but others felt misunderstood or that their gender/sexuality had been either too emphasised or dismissed. Not everyone discussed their gender or sexual orientation in formal care, but most felt it was important. Many spoke about the need to build trust with health practitioners first, and some indicated that they were only comfortable discussing their gender/sexuality with other queer or trans people. The authority of health practitioners overseeing medical transitioning was noted, and one trans participant discussed not disclosing his (queer) sexual orientation for fear of jeopardising this process. While some participants saw therapists or health professionals who were part of the LGBTQ+ community, this could have limited benefits, as per an example of a gay therapist not having much knowledge of gender diversity, and white practitioners being unable to understand the experiences of Indigenous people and POC. Sometimes 'queer-friendly' had too narrow a view of queer and trans people's experiences, making it particularly difficult to find practitioners who validated 'non-traditional' trans experiences.

"I will make the assumption if I go somewhere and everyone is white, and everyone is cis, and everyone is het, that it's not going to be good care for me."

Perry (21, genderqueer, queer, Aboriginal)

Friendship experiences

Among survey and interview participants, support from friends was more common and relied upon than support from families and other sources. When survey participants were asked who they were likely to turn to when feeling down or anxious, most indicated friends, followed by social media (see Table 4).

Table 4: Survey participants' likelihood to use a range of support services (N=648)

Q. When you feel down or anxious, are you likely to turn to the following?	*Yes (%)*	*Maybe (%)*	*No (%)*
Friends	55.6	34.4	10.0
Social media browsing	40.1	34.3	25.6
Friendship group	26.4	33.2	40.4
Health professional	22.2	40.0	37.8
Family member	18.2	32.7	49.1
Online counselling/chat	10.0	28.1	61.9
Online forum	5.9	22.4	71.8
Phone counselling	5.1	14.4	80.6
Offline support group	4.0	16.2	79.8
Facebook group	3.1	7.7	89.2

Throughout interviews and survey responses, participants shared many examples of how they support their friends who experience mental health difficulties. In accounting for friendship support, participants often referred to trust, reliability, honesty, as well as the value of friends knowing you well and having insight into your feelings, needs, and history. Friendships offered space to vent, share, and feel more authentic. In another survey question, participants were asked about the types of friends they engage with when feeling down or anxious, and unsurprisingly this was mostly close friends, followed by friends who talk about their mental health (see Table 5).

"My best friend, I literally talk to him every day... He's also trans... He's my first port of call just to be like, look I need to vent. That's like a mutual agreement that we have that it's okay to do that."

Riley (18, non-binary, no labels, white)

Table 5: Types of friends survey participants turn to for support (N=593)

Q. What type of friends do you engage with when you feel down or anxious?	***#***	***%***
Close friends	526	88.7
Friends who talk about their mental health	348	58.7
Old friends (those you've known a long time)	183	30.9
Friends I only engage with online	131	20.2
New friends (those you haven't known for long)	55	9.3
Other	17	2.9

Mutual support between close friends happened in person and online, in private conversations and group chats. Participants who discussed their mental health with friends mostly did so with those who shared similar experiences, just as they commonly consulted other queer or trans friends on matters relating to gender/sexuality. Many gave accounts of friendship groups and dynamics changing after high school, with trans participants commonly finding more trans friends, often via Instagram. Some interview participants reflected on 'unhealthy' teenage friendship support practices, including Riley's discussion of 'trauma dumping' at high school. Several participants spoke of developing stronger boundaries about how much they shared with friends (as opposed to therapists) and the types of support they were willing to offer to friends. Friendship support ranged from listening and holding space, offering advice (if solicited), doing 'research' for friends, sharing found resources and information, and offering distraction through hanging out or watching something together. For most, close friends were described as well-equipped to know when something was wrong and how best to offer support.

"When I hang with [friends] everything kind of just disappears. There's no stress, no worries, no negativity."

Chris (19, cis male, bisexual, white)

Not everyone found it easy or necessary to discuss mental health with friends, with some suggesting they have few close friendships, some choosing to only discuss mental health with therapists, and some wanting to keep friendships free of mental health talk, or not wanting to be too vulnerable among friends. As Yarran noted, not sharing mental health struggles on social media could also be considered an act of friendship care, since some friends may find this triggering or difficult to negotiate. Some participants had strategies for carefully signaling to friends that they needed support (e.g. through use of Instagram's Close Friend Stories – discussed in the following section). Friendship support tended to be initiated on social media as it was easier to reach friends there, and social media offered a range of private connection points that could be carefully managed. For many, texting friends felt easier than speaking to them, and for some, chat histories were valuable to return to later, to access the care and validation a friend had previously offered.

Friendship communication around mental health support was mostly private and unlikely to take place in public social media posts and comments. Friends, whether privately or in small groups, supported each other with managing a range of difficulties or support pathways, including a sense of what to expect from counselling/therapy. Friends also provided models of care and support that could be taken up by others.

"I'm very lucky. I have so many friends that are such like me… We stay on calls for hours, late night. We talk about our feelings… All of them are queer and most of them are also people of colour."

Amal (18, non-binary, lesbian/questioning, Middle Eastern, Islamic)

"We'll send like $10 to each other if someone needs a McDonalds quickly. That kind of support is good too."

Perry (21, genderqueer, queer, Aboriginal)

II.

Part 1: LGBTQ+ young people's lives

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Appendices

This section of the report explores participants' informal digital peer support practices, defined to survey participants as: ***online interactions that make people feel supported or cared for, which can range from direct to indirect communication (e.g. from private messaging to simply looking at what other people share.)***

Social Media

Many participants challenged common representations of social media as negative, including popular media discussions of how its use contributes to poor mental health. While some interview participants discussed how social media use could negatively impact their mental health, they more often experienced it as supportive. Fifty-nine per cent of survey participants indicated experiencing mental health support through social media. While social media 'addiction' was mentioned, this was rarely framed as a problem and mostly used as a colloquial term for high-use. For many, high-use was justified as a coping strategy – for example, by scrolling social media to ease one's mind, as a way to feel connected to others, or to provide a distraction from current feelings or potential self-harm. Only one interview participant (Parker) disliked social media. Although he wished he did not have to use it, he saw it as necessary to communicate with friends.

"it's nice to be in a space where most of the things you see are queer people like you."

Lucas (18, trans male, pansexual, white)

Discussions of the supportive aspects of social media mostly related to support from friends, but also to finding and sharing support within LGBTQ+ communities, including intersecting communities (e.g. Indigenous, disabled, or POC communities). Feelings of support were also commonly found through browsing particular spaces and engaging with particular types of content, without necessarily interacting with other people. Many participants shared how social media gave them access to communities, including opportunities to witness, learn from, and feel connected to these. Social media allowed participants to find people like themselves who were negotiating similar experiences and identities. Social media also offered access to information about supportive services, resources, and events for LGBTQ+ people.

Regarding negative aspects of social media, there was common reference to toxicity in survey responses – specifically, references to toxic communities, environments, people, behaviour, and content. Shared examples of negative or toxic content and interactions related to all major platforms. Some participants discussed content that romanticised mental illness and self-harm, often associated with Tumblr. For many, Instagram offered unrealistic footage of lives that most people do not have, which was associated with body image issues and low self-esteem. Twitter was described as sometimes toxic for hosting arguments, and Facebook was often seen as a site inhabited by older people likely to share racist and trans/homophobic content. Two cis male participants spoke of Snapchat as toxic for young gay men due to 'overly sexual' content, and trans male/masc participants suggested similar discomfort with Grindr and other dating/hook-up apps, though did not describe these as toxic. One participant described 'bad Reddit' as a toxic side of that platform, reflecting a common recognition that all platforms have 'bad sides' to be avoided.

"Sometimes I find all social media… impact me negatively. I like how I can stay in contact with people but also I can be kind of anxious or it can - I can't really moderate how much I use certain platforms like Instagram and I can be a bit obsessive with them or kind of fixate on different people."

Van (22, cis male, queer, white)

Social media was also described as unsupportive due to cultures of comparing yourself to others, the promotion of unrealistic or harmful body and beauty standards, the presence of triggering content (and lack of trigger warnings), and content seen as fake, unrealistic, and misleading. Interview participants often reflected on their personal strategies for managing, curating, or limiting social media use to enhance their mental health. Many highlighted how they developed skills, over time, to have a better experience of social media. Across all data, participants more commonly discussed social media as supportive.

"People are like, oh social media's so bad for your mental health, social media causes so many issues. But I've never faced any sort of issues from it. If anything, I [found] social media very helpful when I was having really problematic episodes, because it was a way to make my brain shut down."

Rubin (18, trans masc non-binary, pan/bi/gay/ace, white)

Supportive platforms

Survey participants who had experienced mental health support on social media (59%; N=378) were asked "Which, if any, social media platforms have you found to be supportive for mental health?" The multiple-choice question listed all platforms featured in Figure 1, except for Discord, the most common 'other' response. Among this sample, Instagram was most named as supportive (72.5%; N=274), followed by TikTok (51.6%; N=195) and YouTube (50%; N=189) (see Figure 1). Although less common, many participants experienced mental health support on Twitter, Tumblr, Snapchat, Facebook, Reddit, and Discord.

"Usually, most people that are commenting [on Twitter] are making the effort because they're so supportive, or they want to be supportive. But if no one is commenting, it still helps you to get your thoughts out there, so you know how you're feeling. If someone interacts that's just an added bonus."

Bob (24, cis male, bisexual, white)

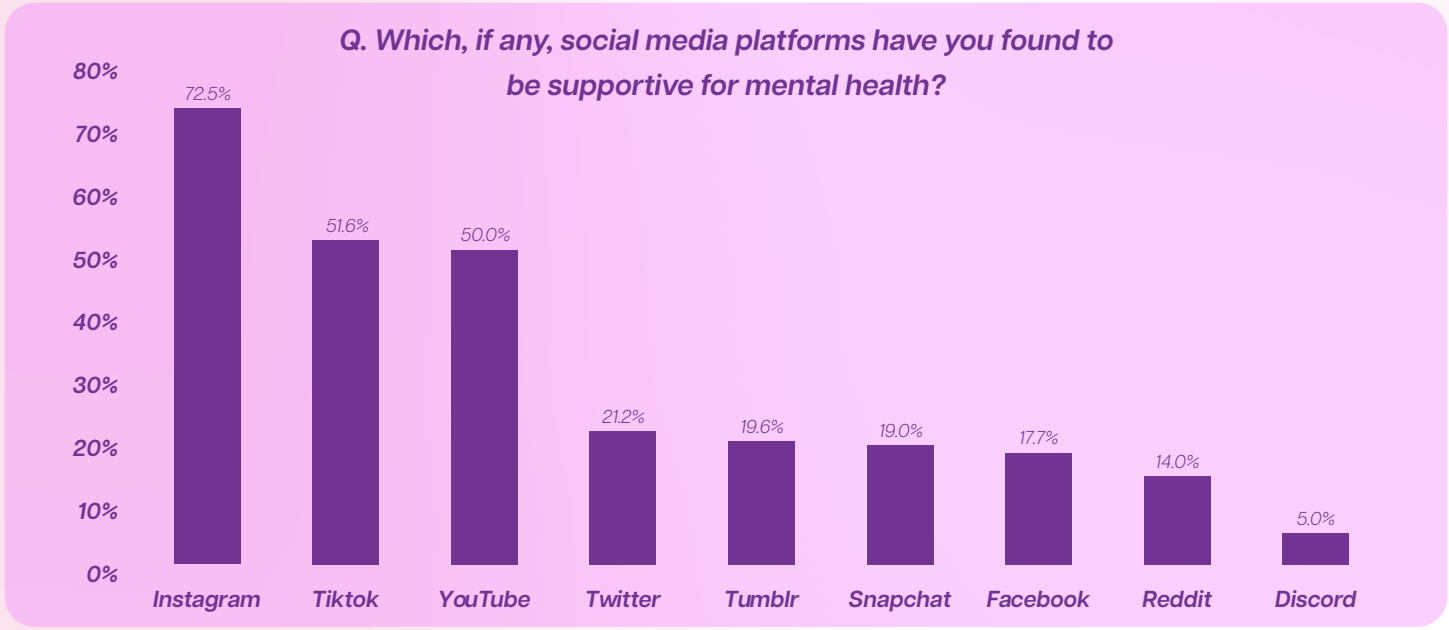
Mental health support is typically experienced across multiple platforms, with respondents naming 2.8 supportive platforms on average. Notably, 'mental health support' was a concept left intentionally open, for participants to decide what this means for them. Platforms had diverse uses, with some commonly oriented to friend-based communication (Instagram; Snapchat; Discord), some affording greater privacy through anonymous use (Tumblr; Reddit; sometimes Twitter), and some more associated with entertainment and education (TikTok; YouTube). Many platforms offered spaces for private interaction with interest or affinity groups – felt by many as safer and more intimate (e.g. Facebook groups; Discord servers). Platforms offering algorithmic suggestion to accounts and content that users may like, based on existing relationships and browsing/liking histories, could further connect LGBTQ+ young people to supportive content.

"I've been finding a lot of [Instagram] accounts that focus on Islamic and people of colour, queer people... it's really weird seeing someone that's similar to you come out, because I thought we don't exist [laughs]"

Amal (18, non-binary, lesbian/questioning, Middle Eastern, Islamic)

Platforms that allowed narrow audience curation (Snapchat; Instagram's Close Friend Stories) were particularly useful for signaling a need for support, as well as offering personalised care. Mental health support was also associated with private chat functions available on most common platforms. It is notable that Instagram – most associated with support – offers multi-layered communication channels. On Instagram, sharing can be private (messaging; group

Figure 1: Platforms indicated to be supportive of mental health, from 378 multiple choice responses



chats); semi-private (Close Friend Stories); temporary (Stories); somewhat permanent (posts); phatic (liking; emoji responses); and responsive to shared content, both publicly (comments on posts and other comments) and privately (responses to Stories). Further, private messages can be in audio, video, or text form. These multiple modes and layers of communication afforded participants different forms of privacy and intimacy, and the ability to adopt modes of communication most suited to a particular friend and discussion topic. This could make it less difficult to share something uncomfortable.

Participants' platform practices changed over time. For many, Instagram was an early place to explore queer and trans content, and witness creators who shared resources and information relating to mental health. At times, Instagram use was deemed unhealthy, such as engaging with 'eating disorder content' and therefore being shown more of this due to the algorithm. Many highlighted the value of the Explore page on Instagram, where you could scan and engage with content from accounts you do not follow without leaving a visible trace of being interested in such content. For many participants, supportive content seemed to find them through what friends and contacts shared, and algorithmic suggestion. Many reflected on algorithms knowing them well and surfacing useful content, particularly in the case of TikTok.

"The thing about Tumblr was that it was proof that there were other people out there. It was a way of finding other people, not necessarily to talk to or make friends with, but to acknowledge their existence, I guess, and find out what was going on in the world."

Sasha (23, non-binary, bisexual, white)

Supportive practices

Participants highlighted a range of digital peer support practices relating to giving, receiving, sharing, and feeling support for mental health. In summary, common support practices on social media were:

- following the right people or accounts – i.e. those providing supportive, affirming content
- sharing or recirculating supportive content to friends and strangers (directly or widely)
- being there for friends when needed, if you have the capacity to support them
- learning from people similar to you who have experienced what you're experiencing
- accessing, participating in, or gaining a sense of LGBTQ+ communities
- curating your social media feeds for a better experience of social media

Interview participants often described early social media use in terms of finding community and people who were not available in their day-to-day life – for many, Tumblr and Twitter were invaluable for this. Participants noted that social media support was often not about seeking help or advice, but scrolling, watching, and learning. Social media also provide anonymous spaces for offering direct or indirect support to strangers – a practice that many participants had benefitted from on platforms like Reddit.

Social media allowed participants to witness and learn from people who have experienced, or are going through, what they are experiencing. Seeking out or following creators who are transitioning, for example, can provide a sense of how to initiate the process for oneself, and what to expect from hormones, surgery, dealing with families, and more. Participants commonly reflected on digital cultures of LGBTQ+ peers sharing and responding to each other's personal struggles, making them feel less alone in those struggles. This is true of recipients of direct support, as well as those who witness the supportive interactions of others.

To gain more knowledge of how common it is for LGBTQ+ young people to support each other through social media, we asked survey participants how often they provided digital support to friends and to people they do not know. Unsurprisingly, 96.4% of respondents

often or sometimes provided digital peer support to friends. Supporting strangers was less common, though almost half of the respondents (49.4%) sometimes or often did so (see Table 6).

Table 6: How often participants provide digital support to friends and strangers (N=470)

How often do you provide digital support to friends? (n=470)	***#***	***%***
Often	282	60.0
Sometimes	171	36.4
Rarely	14	3.0
Never	3	0.6
How often do you provide digital support to people you don't know? (n=470)		
Often	61	13.0
Sometimes	171	36.4
Rarely	145	30.9
Never	93	19.8

Among friends, digital chat about mental health struggles was often said to be easier and quicker than in-person conversations, given that the latter usually involves a slower and more careful movement to heavy topics. Online chat was typically described as an easier way to share personal feelings and concerns which could offset the awkwardness of talking about mental health. Several participants also noted that writing things down can give pause to reflect on what is being said and how to express it better. Further, social media offer spaces for easy sharing and listening, often without being visible to others, which can reflect, but also potentially challenge, the stigma that participants associated with mental health disclosures. As previously mentioned in relation to friendship support, participants discussed concerns of oversharing, with some stating that they would ask friends to consent to mental health discussion ahead of such conversations. Evidently, friendship care extended to not wanting to overshare, burden, or ask too much of friends.

"I don't follow a lot of people [on Instagram]. I follow people that make me feel comfortable and with content that I enjoy."

Timy (17, demigirl, lesbian, white)

Many noted a common friendship practice of joking or hinting about poor mental health to signal a need for support. This did not always work, as per Ruby's experience when her friends did not respond to her mental health jokes during lockdown. Among participants, this signaling strategy mostly occurred through Instagram Close Friend Stories, since this only reached select friends and could indicate a need for support without directly asking. This ensures that friends can decide if they have capacity to offer support or not. This was particularly important for friendship groups where most people faced mental health challenges.

"you can follow [TikTok] creators that you - you know what I mean – you feel like are just kind of like a friend, in a way"

Ruby (20, cis female, bisexual, white)

Where platforms offered a range of communicative means (text; video; voice), these were adapted to suit a range of friendship communication preferences, and different ways to manage difficult disclosures and careful support. Some participants highlighted the value of sending voice or video messages since these felt warmer and like you were physically there. For more casual support, Discord was noted as particularly useful for hanging out and feeling co-present and not alone.

Using Snapchat to support or be supported by friends was particularly common among cis gay and bisexual male interview participants. As a common friendship chat space, Snapchat was more naturally used to disclose mental health struggles. While Jake indicated the added value of disappearing chat messages (ensuring no trace of him being vulnerable), Chris saved supportive chats for later use. Beyond Snapchat, many participants noted the value of keeping a digital record of supportive comments from, or conversations with, friends – an archive of sorts that can be returned to for validation. This was also said of video and audio messages that could be replayed.

Participants noted that digital peer support is often available whenever needed – whether from friends or strangers – since there's a global pool of people who can offer this. Support from strangers was often discussed as different to friend support. Sometimes it was described as less useful because, unlike close friends, online strangers do not know you and your situation intimately. At other

times it was seen as more useful, particularly if friends did not have experiences of negotiating mental health or were not queer or trans. Some noted a preference for support from more dedicated people who position themselves as supporters, who willingly and visibly take on such roles. As many noted, friends sometimes expect more support from each other than they can give. Expectations of what online strangers could offer varied and some participants had felt disappointed with such support. Notably, most drew support from friends and strangers alike, depending on the issue, the kind of support needed, and platforms used. Some articulated their boundaries around offering support (e.g. providing an ear, but not advice), and some participants (usually older) were careful not to expect therapeutic support from friends, only professionals.

Anonymous use of platforms ensured that participants could not only seek support among unknown peers, but also witness, learn from, and feel the warmth of supportive interactions. This was particularly practiced on Reddit, where many noted the value of being in spaces where people were only ever genuinely supportive of each other, particularly on trans subreddits. Support found here was multi-layered, since subreddit users could feel supported and affirmed by what is shared, witness models of support that they can enact elsewhere, and feel a strong sense of solidarity and belonging forged through visible practices of mutual care.

TikTok was commonly discussed as providing valuable insight into how LGBTQ+ people support each other through a range of user practices. Many participants boosted supportive TikToks by liking or commenting on them, with a view to increasing their audience alongside supporting their creators. Many would scroll the comments on mental health TikToks and add comments to support creators, commenters, and audiences alike. Practices of boosting were informed by a sense of algorithms responding to highly-engaged content by elevating this to a wider audience. While practices of TikTok boosting differ from Tumblr reblogging, Twitter retweeting, and Facebook sharing (since TikTok does not offer a home space where users can re-post other people's content), they echo these platformed practices of peer support simultaneously offered to creators and their audiences.

Lastly, many participants discussed practices for controlling and curating their feeds to ensure that social media is not experienced as triggering, stressful, or toxic. Some participants limited their use of particular platforms or were careful not to comment on social media content where this might lead to arguments. Such knowledge was often gained through previous negative experiences or witnessing the dynamics of certain platform spaces. Curating, withdrawing, and limiting content and interactions were common strategies to ensure positive social media experiences that supported participants' mental health.

> **"I think it's actually healthier for young LGBT people to follow predominantly adult LGBT people, because there is the lived experience of going through all that stuff and having come out the other side. So, I do think this, but I don't know if that still counts as peer support as such."**
>
> *Daniel (17, trans male, gay, white)*

Supportive content

As noted, supportive social media content came from friends and strangers alike, and survey data on whom participants engaged with for support gives further context to this. After naming the social media platform they experienced as most supportive, participants were asked who they mostly interacted with there. This was predominantly friends (41.7%), yet almost one-third mostly interacted with strangers (31.1%) on their nominated platform (see Table 7). In these responses, participants mostly interacted with friends on Instagram, Snapchat, Discord, Twitter and Facebook; with strangers on TikTok, Tumblr, and Reddit; and mostly did not interact on YouTube.

Table 7: Who survey participants mostly interact with on the social media platform they named as most supportive of their mental health (N=357)

	#	%
Friends	149	41.7
Strangers	111	31.1
I don't interact	60	16.8
Peers	21	5.9
Family	5	1.4
Other	11	3.1

Participant accounts of seeing 'people like me' on social media (beyond friendships) were frequently discussed as important for mental health support. This often related to peers sharing mental health journeys, or more so, their everyday experiences of navigating being queer or trans. Content of other people sharing trans journeys was useful for participants considering or instigating gender-affirming surgery or hormones. Peer-generated content that was intimate and personable was highly valued, and many discussed platform differences regarding this. For example, TikTokers were commonly seen as more authentic than Instagrammers who were associated with more aspirational or professional posting. Many followed creators because they were queer or trans, more so than whether they posted about being queer or trans. This reflected parallel discussions about the value of representation and visibility, with many participants indicating their efforts to follow more LGBTQ+ people of colour, Indigenous people, and people who were disabled, fat, and/or promoting body diversity – whether or not they shared these aspects.

"there were resources I used on YouTube, like videos, like coming out videos and things like that. Which when I was younger I did watch quite a lot to just affirm who I was and I'm not some weird creep, I'm just a normal person sort of thing. It was quite valuable to me."

Kieran (18, cis male, gay, white)

Many participants named creators whose content they found supportive, while others could not recall creator names, but nonetheless appreciated this content. Holden felt that there were no key creators, but that content came from many sources, and its circulation was collective (see quote). He discussed infographic images circulating on Instagram as an example of this (where their source was often unconsidered), and many others also appreciated learning about and promoting issues through such content. Some participants, however, described these as annoying. Some appreciated inspirational posts that circulated in a similar way, and would re-post these. Content seen as educational was enjoyed by many, and TikTok and YouTube were discussed as key platforms for peer learning. Mental health content was too overwhelming for some participants, in which case it was avoided.

Many participants followed LGBTQ+ advocates and re-posted their content. While activist or advocacy content (including but not limited to LGBTQ+ mental health) was important for many, some spoke of moving away from or limiting this, or coming to avoid this entirely, since it could feel heavy and gave them a negative view of the world. Others noted increasingly sharing and supporting mutual aid projects, or local community activism. 'LGBTQ+ mental health content' comprised a range of material – from creators sharing personal experiences and tips, to the use of humour to discuss living with and managing mental illness, to sharing information for LGBTQ+ people and their allies. For many, it was affirming to see relatable people being open about their mental health struggles. Many appreciated a broader range of content from such creators that did not solely focus on mental health, nor on creators' trans/queer identities. Across examples discussed, a variety of content was appreciated. For many, political and potentially triggering content existed alongside humorous content, memes, cute pet posts, and more. Meme sharing was particularly common among friends, in the context of everyday sharing and chat, and used as shorthand for communicating feelings. Humorous content and cute animal videos were used to distract oneself or a friend from certain feelings or situations.

"a lot of the good content that's shared just comes and goes from different people and it's just everyone, all the different people sharing different content together. It makes up this big pile or mountain of support that you can reach out to."

Holden (16, cis male, gay, Chinese)

As noted, it was uncommon for participants to share their mental health difficulties to wide social media audiences, nor to witness this of friends, given the stigma of mental health discussion commonly referred to. Where public statements were seen, a usual response was a private message or phone call to check-in. Content that explicitly discussed mental health was typically more general and often posted by advocacy figures or groups. While such content

providers were typically not friends, they could feel close. Some participants highlighted the value of being supported by older LGBTQ+ people, and found this easier to foster online. However, this was more difficult on platforms where participants' networks were predominantly comprised of school friends.

A general visibility of 'people like me' was commonly noted as a supportive aspect of social media content. This suggests that support was often felt through immersion in particular content, rather than something sought and delivered in an explicit sense, and this content and its reception varied in relation to the platforms and people involved. This reflects the support of being part of, or having access to, community, and suggests that many participants are not specifically using social media to find or give support, but to exist in supportive environments.

As noted in the previous section, many participants spoke of curating and generating certain feeds that offered more positive content and, therefore, a more positive social media experience. Algorithms were commonly discussed as barriers or enablers of 'good content', and many felt able to work with algorithms to ensure a supportive experience of social media.

"representation really does make a difference with mental health because seeing people like you succeeding is really powerful. Just makes you feel better about things."

Perry (21, genderqueer, queer, Aboriginal)

III.

people's lives

Part 2: Digital peer support for mental health

Part 3: Intersections

Conclusion

Appendices

This section focuses on LGBTQ+ young people who experience multiple forms of marginalisation – in this case, those who are disabled, Indigenous, people of colour, and/or from rural/regional settings. These experiences highlight more nuanced and specific practices of digital peer support that include specific negotiations of safety and wellbeing, including in health and community settings where LGBTQ+ young people are expected to find support.

Regional & rural support

Interview participants discussed in this section had lived in regional or rural settings, and some discussed these as homophobic and negatively impacting their mental health. Only being out to some close friends and family members was common for interview participants in these settings. Several came out at high school, which in some cases negatively impacted their mental health due to increased attention, bullying, and in one case, physical violence. Avery discussed coming out at high school as easy, given their pre-existing minority status of being Aboriginal. As the only 'out person at school', many other students privately disclosed their LGBTQ+ status to Avery thereafter. Chris also came out at school because he felt like he was hiding an important aspect of himself. He found that his mental health worsened after this, due to increased homophobia. He has since relocated (to attend university) and associated this change with improved mental health. Chris knew of three other queer students at his school, one of whom was not out but with whom he found mutual support. One participant had to change schools due to experiencing homophobia. Many regional/rural participants referred to feeling isolated as teenagers, not knowing anybody like themselves, except online.

Some participants referred to subtle expectations and pressures to conform to the norms of their hometowns, and that rather than overt homophobia, it was more often subtle comments and gestures that made them feel unwelcome and cautious. Kieran shared an anecdote about overhearing negative comments from people in town about a friend of his who wore a pride flag during the marriage equality debate – an example of what he refers to as 'subtle pressure' to conform. In terms of mental health, many suggested that there was little to no conversation about this in 'the country'. As Bob notes, his experiences of seeking mental health support inadvertently educated his friends about how they too might reach out for help. Kieran attributed his not seeking professional support to a stubborn form of regional masculinity, where feelings are not discussed. Emerson, also noted a tendency to not discuss mental health with friends. Alongside reluctance to seek formal mental health support in these settings, and although many were able to access a local headspace service, limited access to such support was still an issue.

These discussions suggest that not only can it be more difficult for LGBTQ+ people to come out without becoming targets of harassment or bullying in regional/rural settings, but that mental health is less discussed, due to local cultures of stoicism. As such, mental health literacies are less common, with fewer opportunities to disclose and address mental health experiences, whether among friends or health professionals. Some regional/rural participants noted that mental health conversations would arise in response to local suicides. This context may limit the mental health conversations available, and how they are structured.

"[On growing up in a regional setting] Day to day seeing what everyone else is doing, hearing the comments they make even if they're not directed at you at all, just seeing how everyone else is thinking and acting around you. I think that's where the pressure came from to conform, to try not to stand out."

Kieran (18, cis male, gay, white; formerly regional)

Disability support

Ten per cent of survey participants indicated being disabled, with another 10% being unsure about this. More commonly, these participants had neurological rather than physical disabilities, and many also lived with chronic illness. Most disabled survey participants indicated that their disabilities impacted their mental health (73%), which included feeling restricted from seeing friends, low mood due to lack of sleep or chronic pain, and the impact of other people not understanding or accommodating their needs.

Eight interview participants explicitly indicated being disabled, and many of these discussed experiences of ableism in LGBTQ+ communities. These participants felt that peer support from disabled LGBTQ+ people was critical. Often it was only through digital media that they could access people who were queer/trans

and disabled and who knew what it was like to negotiate ableism in health settings and LGBTQ+ communities alike. Social media were also primary sites for communicating with friends and community/health services. In terms of peer support, Yarran, who is Indigenous and disabled, spoke of narrowing their focus to only seek support from people who understood their experiences.

"it can be really hard to navigate medical systems when you don't have an education in those areas and just like sharing that information to people who don't have access to it, which is such a huge proportion of the population. It makes their lives easier. It made my life easier. Like I didn't have to stress on my own about how I was going to ever have enough money to get a wheelchair because I had people online, on social media, helping me through information sharing about NDIS - the process. That's something that actively contributed to my mental health."

Yarran (24, trans masc non-binary, queer, Indigenous)

Two participants spoke of their physical disabilities with EDS (Ehlers-Danlos syndrome) and highlighted key issues of being visibly or invisibly disabled. Riley spoke of attending the Sydney Mardi Gras parade in a wheelchair and being stared at and dealing with "patronising high-fives." They noted that online spaces were easier for avoiding these encounters as they provide more control over who you engage with and how. Liam spoke of learning to accept his "very invisible" condition after previously being a competitive athlete. Similar experiences were shared about negotiating a range of chronic illnesses. Liam and Riley each discussed how EDS may not seem like a disability to others, including their friends. Liam recently started speaking publicly about his disability after meeting someone else with EDS who has also faced mental health difficulties, saying: "we both hugged and cried 'cause we both know what the struggle was like." Knowing each other's struggles was central to peer support among disabled participants. These struggles included negotiating inaccessible health care systems that did not accommodate intersecting disadvantages, sexual identities, and holistic health needs.

Yarran's negotiations of the disability support sector directly impacted how they engaged with mental health professionals, and they spoke of their fatigue in dealing with such systems. Social media allowed them to find people facing similar struggles. Yarran particularly highlighted the need for peer support that is not simply LGBTQ-oriented but needs to be from (and for) other disabled, Indigenous, and trans people. They spoke of finding vital peer support that helped them to navigate health systems, and they now provide this support to others. Like Yarran, Riley primarily connects with friends and support networks through social media. They are busy on Instagram Stories and described this as their social time, noting how this differs from their friends who are not disabled.

Some participants who were not disabled commented on the difficulties faced by their disabled LGBTQ+ friends, or otherwise spoke of following disabled and queer content creators and learning from them. Such discussions suggest an awareness of intersecting marginalisations among participants who were actively interested in being part of a more diverse and accessible LGBTQ+ community. Similarly, many white participants referred to LGBTQ+ POC as having specific support needs and experiences.

Indigenous & POC support

Survey and interview participants highlighted how peer support often occurred in smaller, safer online spaces. This was especially the case among participants who are Indigenous or POC, where support was often more friend-based or within private Facebook groups or activist/advocacy communities. Perry, for example, worked with an Indigenous and POC collective, which they described as giving them a greater sense of purpose that was useful for managing their depression. They stated: "it's just refreshing to all work together to create spaces for people... going over topics together that are important, that we don't talk about anywhere else." Indigenous and POC participants were also more likely than other participants to speak of contributing to mutual aid, including crowdfunding for peers.

Some also distinguished their social media platform uses from how they imagined white friends to use them. For example, Amal said of their white school friends: "They probably hate Twitter with a

passion. They don't see the good side of it at all." Amal also felt that, unlike them, those friends would not see diverse content on TikTok and Instagram Reels. Many interview participants spoke of a need for greater media representation of LGBTQ+ POC, and some white participants also discussed following Black, Indigenous and POC creators to learn from them.

Social media provided participants with an outlet for sharing experiences of racism or checking in with friends for their understanding of an interaction that felt racist. Amal, for example, shared such content on their Instagram Close Friend Stories, but also framed this as a space to joke about such things. They also commonly sent relatable memes to POC friends who they knew would find them funny.

Several POC interview participants highlighted cultural differences in how mental health was perceived or (not) accepted, with many highlighting parents' hesitance to discuss mental health or help them initiate formal support. Sam spoke of creating boundaries around discussing mental health with their mother, and several others faced ongoing family tensions around this. This highlights a difficult situation for some young LGBTQ+ POC wanting to access formal care. Several POC discussed their preference to see health professionals who were not white, recounting previous bad experiences with such professionals. Perry gave a contrasting account of seeing both white and Aboriginal mental health practitioners, with the latter being far more supportive.

Amal gave examples of dealing with racism at high school but also reflected on believing at the time that racist jokes were normal, until university friends told them otherwise. Mei highlighted that while she is lucky to have family support for being queer, many other LGBTQ+ international students in Australia do not have this, and may also lack support from universities and local LGBTQ+ communities. For Amal, Mei, and many others, university experiences and friendships changed their perspective on, and access to, queerness, including a new language around intersectionality. While these examples do not specifically relate to digital peer support, they are informed by social media content and interactions discussed elsewhere.

Some participants highlighted that they are Indigenous, Black or brown before they are LGBTQ+ affiliated. Avery noted that they were one of few people who came out at their high school but that doing so was not a big deal: "I was already a minority because of my skin tone, so what do I have to lose." Amal similarly notes that people have always noticed their ethnicity before ever considering whether or not they are queer. This highlights that racism is a greater threat than homophobia for many POC and Indigenous people. Koda discussed how being POC and having a diverse sexuality can lead to other people making you a 'figurehead' and calling on you to unwillingly educate them. These discussions of the discomforts of 'LGBTQ+ diversity work' indicate additional burdens put upon Indigenous and POC community members, where they can feel pressured to speak for a wider community. Many of these discussions also highlighted that LGBTQ+ communities in this continent are predominantly white, and that being Black, brown, Indigenous, or Asian (and/or disabled) may marginalise you within that community, creating difficult negotiations of being visibly 'different' yet invisibly queer.

Indigenous and POC participants' use of social media for safe connection to friends and peers included access to fun. All three Indigenous interview participants talked about following a lot of Indigenous creators on social media. Yarran and Avery used TikTok and noted that they are mostly on Blak TikTok, while Perry followed a lot of Bla(c)k content and creators on Instagram, which was used "just to find content that I want to see, like, Bla(c)k fat queer content, that you wouldn't see on TV or whatever." Avery (see quote) engaged with a queer Indigenous hub of TikTok creators, describing this as a fun space for community.

"mainly I watch [TikTok] just because there's been a little hub of other Indigenous people who I follow, like First Nations people I follow on TikTok where they've created a hub of their videos in this community where it's really nice to watch them interact with each other and it's just really fun."

Avery (21, non-binary, bisexual, Aboriginal)

Intersectional support

Several participants – often those who are Indigenous or POC – explicitly highlighted the intersectional aspects of negotiating mental health. For many, it was only through digital and social media that they could access support described as more specific and nuanced than general support and resources provided by health and community services.

As a concept, intersectionality was first used by critical race scholars in the US, coined by legal scholar and Black feminist Kimberlé Crenshaw. Its use has spread through social media advocacy, and many people have criticised its adaption and appropriation beyond its original use and meaning. While important to consider, we can also ask if this term has been popularised out of a need and push for more language that references, speaks to, and asks for systems to be more accommodating of a range of needs. In doing so, this challenges a sense of universal citizenship that is built into social systems (like law, or health) that were arguably constructed by and for white, straight, cisgender, able-bodied, middle-class men. Most participants of this study reflected on systems that do not meet their needs, or that cannot see their identities, cultures, and values – such as in education, health care, and family settings. All LGBTQ+ young people stand to gain from systems of support (formal or otherwise) that are more flexible and able to engage with a range of intersecting needs and experiences.

"I wish there was more mental health discussions in terms of colonisation in Australia and in terms of as a migrant, as me a migrant, how that affects my mental health, but also how I affect First Nations mental health as a migrant."

Sam (22, genderqueer, pan/asexual, Chinese-Cambodian)

For many participants, support that only addressed one aspect of their identity or life experience was unsatisfactory and potentially harmful. Many referred to how Indigeneity, disability, neurodivergence, or cultural and ethnic marginalisations are often not seen nor supported in LGBTQ+ community settings, resulting in the exclusion of many, and a need to source, build, and share safer (and often more private) forms of support through social media. Yarran, for example, spoke of mostly following Indigenous, disabled, and trans people on social media, when discussing their investment in community care and support. This informal care was specific, validating, and built on a shared recognition of social and systemic exclusions. Yarran's friendships offered more holistic care than could be found elsewhere.

"Yeah, and just more intersectionality as well. I want someone that's going to know what it's like to be Bla(c)k, and queer, and to be fat, and to be, I don't know, mentally ill. To be all of it, in combination. It all intersects, and it all affects each thing, so I don't like when doctors, or mental health professionals just try to separate everything. Because it doesn't work like that."

Perry (21, genderqueer, queer, Aboriginal)

Several interview participants reflected on their difficulties in discussing their mental health with their non-white immigrant parents, fostering a need to privately engage with and learn from peers who can understand their situation. For some of these participants, immediate friends also had limited comprehension of their experiences. Similar can be said of disabled participants, as discussed, indicating a more significant need for digital peer support that came from a place of understanding, relatability, and solidarity.

In contrast to the examples of digital peer support discussed above, formal mental health information and resources are less likely to offer an intersectional framework that accommodates the dynamics of negotiating multiple marginalisations. Similarly, health professionals are known (by participants and their peers) as unable to understand one's full situation, nor have the language or capacity to do so, as Perry highlighted (see quote in *Engaging with health professionals)*.

"Intersectionality is always important. That should be the framework of all decisions, consulting all people who are affected, no decisions about us without us. I strongly believe in that."

Liam (17, cis male, gay, Burmese)

IV.

Part 2: Digital peer support for mental health

Part 3: Intersections

Conclusion

Appendices

Conclusion

This report gives an overview of key findings from the research that will be further explored in future publications. LGBTQ+ young people's practical expertise of digital peer support, seen in their statements throughout, offers guidance for a more holistic approach to future mental health research and practice – for this population and potentially others. We hope this report can expand current research and initiatives by encouraging greater attention to digital cultures of informal care and support. For this, more attention must be given to the digital spaces, practices, relationships, and media content involved in LGBTQ+ young people's informal and digital cultures of care.

A notable limitation of these findings is a lack of trans female/femme participants. Trans survey participants were commonly male or non-binary, and despite additional consultation and recruitment attempts, we were unable to interview any trans women. Tailored digital peer support research with trans female/femme communities is necessary, and it is important to read these findings as indicative, not representative, of LGBTQ+ young people's experiences.

Participant accounts of negotiating mental health difficulties/conditions/illnesses were varied, as was the language given to these experiences. It is important to recognise that not all LGBTQ+ young people require mental health support, and that many provide and share support to friends and strangers regardless of their own mental health experiences. These practices signal a communal awareness of the value of digital support, and an everyday collective project of supporting one another. This can extend beyond the confines of a 'queer community' or 'trans community' to broader understandings of social justice endeavours, including attention to intersectionality. Informal digital peer support for mental health is mostly not about providing counselling or therapeutic support, but sharing experiences, spaces, memes, tips, and opportunities for venting, listening, and validation. That almost half the survey participants supported strangers online is an important finding that warrants further consideration when implementing mental health programs and initiatives.

Some participants found it more difficult to articulate their mental health experiences than others, with many being in the process of negotiating their needs. Many highlighted the social aspects of poor mental health and its negotiation, indicating that in addition to its neurological aspects, poor mental health can reflect, and be exacerbated by, a range of intersecting social factors including racism, colonialism, ableism, classism, and rural/regional living. These aspects of many participants' experiences can complicate their affiliations to (and safety within) LGBTQ+ community spaces and services. This situation also orients many LGBTQ+ young people to more specific peers who are mostly available to them through social media. As such, social media provide sites for supportive networks that would otherwise not exist. Participant discussions of intersectional support available to them through social media highlights that a public health focus on universal, population-wide mental health initiatives is insufficient.

While digital peer support was not the only source of support for most participants, it is often how support was initially found, and can therefore structure how it is experienced, felt, and enacted thereafter. This should be kept in mind when developing support services and initiatives for LGBTQ+ young people. As seen throughout this report, LGBTQ+ young people's practices of giving, receiving, circulating, and feeling support through their digital and social media use highlight their diverse needs and skills regarding mental health care. This includes how care is offered, found, and facilitated through digital platforms and networks. Participants reported learning how to forge a more positive experience of social media over time, and this expertise is valuable to professionals, organisations and community members who wish to support young people's mental health – particularly where digital media are involved in this work.

A key lesson in these data, as identified by participants, relates to the art of listening.

> **"I feel like good support is listening to what people need, and going based on that… Yeah, listening is the basis of all good support."**
>
> *Mika (25, agender, queer, Indo-Fijian Australian)*

While Mika is referring to good peer support practices, the same applies to those of us – whether researchers, health practitioners, or community members – who wish to ensure that mental health support is always available to LGBTQ+ young people. Beyond listening to what young people need, we must also listen for their knowledge and expertise within their everyday digital peer support practices, with a view to learn from these. Our goal should not be to replicate nor formalise these practices, which would be impossible, but to recognise these as vital systems of networked support that offer valuable care to many LGBTQ+ young people, alongside (or in the absence of) other forms of support.

Connecting to peers and friends who understand their situations is a key aspect of why digital peer support is invaluable to LGBTQ+ young people. For many participants, digital support was associated with simply existing in queer and trans spaces, being immersed in queer and trans content, and feeling a sense of belonging to a range of queer and trans communities. Participants in this study bring their firsthand knowledge of digital cultures of care, including the complexity of this care, and diverse practices of finding, offering, circulating and feeling support across a range of platforms. While digital peer support is not the full extent of what LGBTQ+ young people need for their mental health, it is a key aspect of how they experience support. We must therefore integrate this into our understanding of mental health care – particularly how this operates in LGBTQ+ young people's everyday lives, and how an ever-shifting social media ecology may continue to offer mental health support to LGBTQ+ young people and their friends and communities.

V.

Part 3: Intersections

Conclusion

Appendices

Appendix 1: Data collection and participant demographics

Data collection

In late 2020, our survey asked LGBTQ+ young people from Australia, aged 16-25, about their experiences of digital peer support for mental health. Most of the 660 respondents found the survey through Instagram ads. The survey link was also available on Twitter and Facebook and shared to LGBTQ+ organisations. The survey, developed in close consultation with the study's Advisory Committee, was designed to generate a detailed snapshot of digital peer support practices, to be followed up with participant interviews. Thirty-six interviews were conducted in late 2021 via Zoom, and two thirds of these participants had completed the survey. Interviews were audio-recorded, transcribed, and coded to extend on survey findings. The first part of interviews asked participants about mental health support they have received, and the second part focused on informal digital peer support, including how participants support others. Most participants quoted in the report are interviewees and are referred to by pseudonyms to ensure confidentiality. Unnamed quotes are taken from survey responses.

Participant demographics

The following table gives an overview of survey participants, including age, gender, sexual orientation, cultural background/ ethnicity, disability, and living situation.

Table 8: Demographic characteristics for survey participants aged 16-25 (N=660)

Demographic details

Age (660 responses)	***#***	***%***
16 years	218	33.0
17 years	221	33.5
18 years	82	12.4
19 years	33	5.0
20 years	19	2.9
21-25 years	87	13.2
Gender (660 responses)		
Female	393	59.5
Male	122	18.5
Non-binary	102	15.5
Other terms used	43	6.5
Gender differs to what was recorded at birth (655 responses)		
Yes	174	26.6
No	437	66.7
Unsure	44	6.7
Sexual Orientation (660 multiple choice responses)		
Bisexual	293	44.4
Queer	188	28.5
Lesbian	152	23.0
Pansexual	105	15.9
Gay	92	13.9
Questioning	77	11.7
Asexual	75	11.4
Straight	10	1.5
Other, not listed above	36	5.5
Cultural background / ethnicity (649 responses)		
White/European	538	82.9
Asian	33	5.1
South Asian	14	2.2
Aboriginal and/or Torres Strait Islander	12	1.8
South American	11	1.7
Middle Eastern	11	1.7
Pacific Islander	10	1.5
Mixed/other	20	3.1
Disability (646 responses)		
Yes	66	10.2
No	514	79.6
Unsure	66	10.2
Living situation (660 responses)		
Living with family	570	86.4
Renting	68	10.3
Other	22	3.3

The following table presents details of interview participants. All names are pseudonyms. Interview participants came from all states and territories except Tasmania and Northern Territory, are a spread of ages, live across urban, regional and rural settings, and represent a range of gender and sexual identities. Unfortunately, we did not interview any trans female/femme participants. Interview participants were more culturally diverse than survey respondents.

Table 9: Demographic characteristics for interview participants aged 16-25 (N=38)

Name	*Age*	*Gender*	*Sexual orientation*	*Cultural background*	*Disability (where stated)*	*Location*
Alex	17	unsure	lesbian	white		regional VIC
Amal	18	non-binary	lesbian, questioning	Middle Eastern, Islamic		Western Sydney, NSW
Avery	21	non-binary	bisexual	Aboriginal		Melbourne, VIC
Bob	24	cis male	bisexual	white		regional NSW
Chris	19	cis male	bisexual	white		regional NSW
Cody	19	non-binary	bisexual	white		Melbourne, VIC
Daniel	17	trans male	gay	white	yes, fibromyalgia, chronic fatigue	Melbourne, VIC
Elise	17	cis female	bisexual	white		rural SA
Emerson	16	bigender	bisexual	white	yes, autism	regional VIC
Greta	22	cis female	queer/pansexual	white		Perth, WA
Holden	16	cis male	gay	Chinese		Sydney, NSW
Jake	19	cis male	gay	white		Brisbane, QLD
June	20	agender/genderfluid	bisexual	Filipino Australian	yes	Perth, WA
Kayla	19	cis female	pansexual	white		Melbourne, VIC
Kieran	18	cis male	gay	white		Canberra, ACT
Koda	16	cis male	bisexual, gay, pansexual, queer, questioning	Sri Lankan/Dutch		Western Sydney, NSW
Leif	19	non-binary	queer	white	yes	Brisbane, QLD
Liam	17	cis male	gay	Burmese	yes, EDS	Perth, WA
Lucas	18	trans male	pansexual	white		regional NSW
Ly	20	cis female	asexual	Vietnamese		Sydney, NSW
Mei	24	cis female	queer	Chinese		Melbourne, VIC
Mika	25	agender	queer	Indo-Fijian		Sydney, NSW
Nyx	24	genderqueer man	queer	white		regional NSW
Odette	23	cis female	bisexual (don't like labels)	white, Jewish		Sydney, NSW
Parker	18	cis male	gay	white, Jewish		Melbourne, VIC
Perry	21	genderqueer	queer	Aboriginal		Sydney, NSW
Pia	17	cis female	bisexual	Indian	yes, MDD & GAD	Perth, WA
Riley	18	non-binary	gay (don't really label)	white	Yes, EDS	Sydney/rural NSW
Rubin	18	trans masc, genderfluid, non-binary	pan/bi/gay/ace	white		Sydney, NSW
Ruby	20	cis female	bisexual	white		Brisbane, QLD
Sadie	19	cis female	bisexual	white		Perth, WA
Sam	22	genderqueer	pansexual/asexual	Chinese/Cambodian	yes	Melbourne, VIC
Sasha	23	non-binary	bisexual	white		Sydney, NSW
Timy	17	demigirl	lesbian	white		Melbourne, VIC
Van	22	cis male	queer	Greek/Anglo		Sydney, NSW
Yarran	24	trans masc non-binary	queer	Indigenous Australian	yes, mobility, fibromyalgia	Sydney, NSW

Appendix 2: Acronyms & abbreviations

ace	Asexual
ADHD	attention deficit hyperactivity disorder
bi	bisexual
cis	cisgender
ED	eating disorder
EDNOS	eating disorder not otherwise specified (i.e. not anorexia or bulimia)
EDS	Ehlers-Danlos syndrome
GAD	generalised anxiety disorder
het	heterosexual
LGBTQ+	lesbian, gay, bisexual, trans, queer and other gender/sexuality diversities
MDD	major depressive disorder
OCD	obsessive-compulsive disorder
NDIS	National Disability Insurance Scheme
pan	pansexual
POC	people of colour
PTSD	post-traumatic stress disorder