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LGBTQ Mental Health Peer Support: A Descriptive Survey

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Abstract

Background Gender and sexual minority adults have significant unmet mental health care needs and are often faced with barriers to accessing appropriate services. In this context, LGBTQ individuals often turn to each other for mental health support.

Methods In a sample of 326 LGBTQ adults (*M* age = 37.64) who were providing mental health support to their LGBTQ peers, we examined the nature of LGBTQ peer support, including who provides peer support, to whom, and for what issues. We also examined the experiences of those providing LGBTQ peer support, and the role of mental health training. Data were collected in 2020.

Results Participants provided support to a range of individuals, including close friends, colleagues, and those who were previously strangers. The types of concerns they supported their peers with varied greatly, though depression, anxiety, suicidality, and coping with discrimination were common concerns. Participants were often managing multiple competing demands, and many appeared to be managing their own mental health concerns. Those who had received at least some mental health training appeared to fare better in their experiences of providing peer support compared to those without such training.

Policy Implications Findings illustrate the importance of increasing access to LGBTQ-affirmative mental health services. We also highlight the importance of developing and disseminating initiatives designed to support those providing LGBTQ peer support, both to increase the effectiveness of peer support and to help manage the impact of providing LGBTQ peer support.

Keywords Help-seeking · LGBTQ · Peer support · Mental health service access

Lesbian, gay, bisexual, and trans and gender-diverse and queer (LGBTQ) individuals are at greater risk of mental ill health compared with non-LGBTQ people (e.g., Hill et al., 2020, 2021; King et al., 2008). For instance, sexual minority individuals are around 1.5 times more likely to be diagnosed with depression, anxiety, or a substance use disorder compared with heterosexual individuals, and are at an almost twofold risk of suicide attempts within the past year (King et al., 2008; Lick et al., 2013; Plöderl & Tremblay, 2015; Semlyen et al., 2016). Similarly, trans, gender-diverse, and non-binary (TGDNB) individuals are at high risk of mental health concerns, including depression, anxiety (Bouman et al., 2017; Leonard et al., 2015; Witcomb et al., 2018), and suicidality (Adams & Vincent, 2019; Dickey & Budge, 2020; Skerrett et al., 2016; Strauss et al., 2020). Testa and colleagues (2017) found that 56.1% of TGDNB adults reported having experienced suicidal ideation within the past year, and almost 80% had seriously considered death by suicide at some point in their lives (Testa et al., 2017).

Minority stress theory outlines how the effects of discrimination, stigma, and prejudice based on sexual orientation and/or gender identity contribute to increased levels of mental distress among LGBTQ people (Meyer et al., 2003; Hatzenbuehler, 2009). Much evidence suggests that discrimination, rejection, and internalized stigma contribute to poorer mental health among LGBTQ individuals (Lea et al., 2014; Newcomb & Mustanski, 2010; Perales & Todd, 2018; Taylor et al., 2020), and undermine well-being by depleting a person's coping resources and by inhibiting help-seeking (Hatzenbuehler, 2009).

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LGBTQ Help-Seeking

Although LGBTQ individuals access mental health services at relatively high rates, they have significant unmet mental health needs and experience a range of barriers to accessing appropriate psychological services (e.g., Cronin et al., 2021a; Mayer et al., 2008; Shipherd et al., 2010; Steele et al., 2017; Williams & Chapman, 2011; Worrell et al., 2022). Barriers to service use include both practical barriers, such as time limitations and financial constraints, as well as minority stress-related barriers, such as fear of potential discrimination or mistreatment from healthcare providers (Bonvicini, 2017; Cronin et al., 2021a, b; Pepping et al., 2017). Even when LGBTQ individuals do seek help, the extent to which this help is affirming and tailored to meet the needs of LGBTQ individuals can be limited (e.g., Higgins et al., 2021; Lim et al., 2021, 2022) as not all mental health professionals have received appropriate training in LGBTQ-affirmative care (Higgins et al., 2021; Klein, 2017). This is unfortunate given that non-affirmative mental health support is associated with reduced effectiveness (Davis et al., 2021). In this context, LGBTQ individuals often turn to each other for mental health-related support (e.g., Worrell et al., 2021).

Mental Health Peer Support

Distinct from formal mental health services, mental health peer support refers to the support provided by peers who do not necessarily hold mental health-related qualifications or training. Peer support workers involved in formal programs often have lived experience with mental health concerns and may draw upon their experience to help another person (Chapman et al., 2018; Hardy et al., 2019). However, mental health support can also be provided in more informal settings that may be entirely separate from mental health or community services. Little is known about peer support in this context (Asad & Chreim, 2016).

Recent qualitative research (Worrell et al., 2021, 2022, 2023a) reported on in-depth interviews with 25 LGBTQ individuals who performed various informal mental health support roles with peers experiencing mental health concerns and other forms of emotional distress. This work described six core peer-support roles that were typically extensions of existing relationships: (1) the *Safe Friend* was a trusted individual a person could turn to for support, and did not necessarily need to be in close physical proximity; (2) the *Help Worker* described those who worked professionally in a helping profession as their main occupation, but who provided informal peer support outside of hours; (3) the *Peer Leader* referred to someone who was considered strong and trustworthy and who was visible in the community, yet not necessarily a friend; (4) the *Housemate* tended to provide support within the home; (5) the *Partner* referred to someone in a romantic relationship with the individual they were providing support to; and (6) the *Friendship Circle Member* who jointly, in collaboration with others, provided support to an individual within the friendship group. Some participants performed multiple roles.

Participants identified several positive impacts of providing support, including a sense of fulfillment and meaning, particularly when helping them to navigate feelings of hopelessness or suicidality (Worrell et al., 2022, 2023b). However, these positive experiences were coupled with a range of challenges and factors that negatively affected well-being. For instance, participants described challenges when support was required over prolonged periods, as well as difficulty managing boundaries, and feeling ill-equipped to provide peer support in some situations (Worrell et al., 2022). Burnout was also a prominent theme, with several participants expressing feelings of exhaustion, stress, anxiety, and cynicism about their ability to effectively help another person, as well as resentment regarding the toll it had taken on their mental health. A number of participants felt that providing peer support long-term may not be sustainable (Worrell et al., 2022a), and there was substantial variability in the extent to which participants felt able to cope with stress effectively (Worrell et al., 2022, 2023a).

The Present Research

Gender and sexual minority individuals are at greater risk of poor mental health and suicide (Hill et al., 2020, 2021; King et al., 2008), face substantial barriers to accessing mental health services (e.g., Cronin et al., 2021a, 2023), and have significant unmet mental health needs (Mayer et al., 2008; Shipherd et al., 2010; Steele et al., 2017; Williams & Chapman). In this context, LGBTQ individuals often turn to each other for mental health-related support, yet the types and forms of support appear to vary greatly, and there are substantial challenges reported by those who provide LGBTQ peer support (Worrell et al., 2021, 2022, 2023a). However, there has been very little research focused on the following: (1) who provides LGBTQ peer support; (2) what issues they provide support for; and (3) their experiences of providing peer support to the LGBTQ community. As the current study was largely exploratory, specific hypotheses were not tested, though the following exploratory research questions were explored in a sample of LGBTQ individuals providing peer support:

1. Who provides peer support? To address this question, we report on demographic characteristics, qualifications, and mental health symptoms among those who provide LGBTQ peer support.
2. Who do they typically support? And for what issues?
3. What is the experience of those providing LGBTQ peer support? How confident are they in their ability to provide help? To what extent do they feel their support is valued? And given evidence of strong interest in learning skills to support LGBTQ peers (Ferlatte et al., 2020), does holding a mental health qualification or having received training influence the experience of providing LGBT peer support?

Method

Participants

Participants were 326 adults living in metropolitan Melbourne, Australia, ranging in age from 18 to 79 ($M = 37.64$, SD = 12.69). As displayed in Table 1, there was diversity in gender identity while approximately two-thirds were cisgender and the remainder were trans or gender diverse. More than half the sample identified with a plurisexual sexual orientation, such as queer, pansexual, or bisexual, and a large proportion were from Anglo-Celtic and/or other European backgrounds. More than 60% had completed a university degree, and about 23% of the sample indicated they were currently studying.

Table 1 Demographic characteristics

Demographic variable	*n*	%
Gender identity		
Man	118	36.2
Woman	136	41.7
Non-binary and/or gender diverse	69	21.2
Gender[a]		
Cisgender	215	66.0
Transgender, gender diverse, and/or non-binary	108	33.1
Sexual identity		
Lesbian	53	16.3
Gay	85	26.1
Homosexual	10	3.1
Bisexual	67	20.6
Pansexual	12	3.7
Queer	79	24.2
Asexual	10	3.1
Prefer not to say	5	1.5
Ethnicity		
Anglo-Celtic	231	70.9
Other European	101	31.0
East Asian and Southeast Asian	20	6.1
Aboriginal and/or Torres Strait Islander	9	2.8
Indian/South Asian	6	1.8
Other ethnicity	22	6.7
Education		
Year 12 or below	37	11.4
Diploma or certificate	55	16.8
University undergraduate degree	109	33.4
Graduate diploma/certificate	24	7.4
University postgraduate degree	97	29.8
Student		
No	250	76.7
Yes	76	23.3
Employment		
Full-time	126	38.7
Part-time or casual	118	36.2
Unemployed	37	11.3
Retired	9	2.8
Unable to work due to disability/illness	23	7.1
Volunteering	43	13.2
Domestic duties	8	2.5
Self-employed	39	12.0

[a]Proportion of participants who were cisgender vs. transgender, non-binary, or gender diverse

Measures

Provision of Peer Support

Participants were asked to indicate who they have provided support to during the last 2 years and were presented with the following options: (1) close friends; (2) colleagues or co-workers; (3) schoolmates; (4) family members; (5) partners; (6) people I didn't know previously (e.g., members of an online support group); and (7) other. Participants were instructed to select all that applied.

Presenting Problem

Participants were asked about the issues that emerged among those they were helping to support and were presented with the following options: (1) anxiety; (2) depression; (3) work-related stress; (4) coping with experienced stigma or discrimination; (5) coping with violence or abuse; (6) concerns about suicidal thoughts; (7) support following an attempt to take their life by suicide; (8) concerns about self-harming; (9) other. Participants were instructed to select all that applied.

Experiences of Providing Peer Support

Participants were asked to indicate the extent to which they agreed or disagreed with the following statements about their experiences of providing peer support: (1) "It has been challenging to have enough time to provide support to LGBTQ peers"; (2) "I feel comfortable offering help to other LGBTQ people"; (3) "I am able to seek advice to support my LGBTQ friends when I need to"; (4) "I don't feel like I have the skills to be good at supporting my LGBTQ friends and peers." They responded on a 5-point scale (1 = *Strongly Disagree* and 5 = *Strongly Agree*) or could decline to answer a question if it was not relevant to their situation.

We asked respondents to indicate the extent to which they felt their skills were valued: (1) by the person they are helping; (2) by professional mental health service providers; and (3) by the LGBTQ community. Participants responded on a 5-point scale (1 = *Not at all;* 5 = *Completely*).

Training and Competence

Participants were asked "Have you received training in the provision of mental health support?" and were asked to select all that applied from the following options: (1) no training; (2) participated in workshops or training programs; (3) formal qualification (e.g., degree, certificate); (4) on-the-job training; (5) other or incomplete. To compare those with and without formal training in the provision of mental health support, we collapsed these categories into two groups: (1) those with either a formal qualification or who had attended workshops or training programs were considered to have had training in mental health service provision; and (2) those who had either not completed any training or qualification, or who had received only informal, on-the-job or training (if they also had not attended workshops/held a qualification) were considered to have not had formal training in the provision of mental health support. Finally, drawing from Ferlatte and colleagues (2020), we asked participants "How interested would you be in learning to recognize someone who is thinking of suicide?" and "How interested would you be in learning how to support someone who is thinking of suicide?" and they responded on a 4-point scale (1 = *Not interested at all;* 4 = *Very interested*). We collapsed the two items to produce an overall rating of training interest ($\alpha = .93$).

Participants were asked "Overall, how would you rate your ability to provide quality care for people you support?" and responded on a 5-point scale (1 = Poor; 5 = Excellent). In addition, they were asked to indicate the extent to which they agreed or disagreed with three statements about their competence in relation to suicide: (1) "I would feel comfortable being someone an LGBTQ friend could talk to if they were thinking of suicide"; (2) "I would know what to say to an LGBTQ friend who brought up that they were thinking of suicide"; (3) "I would know where to refer a LGBTQ friend who brought up that they were thinking of suicide." Participants responded on a 4-point scale (1 = *Strongly Disagree;* 4 = *Strongly Agree*). We collapsed the three items to produce an overall self-rating of suicide competence ($\alpha = .69$).

Mental Health

The 21-item Depression, Anxiety and Stress Scale-21 (DASS-21; Lovibond & Lovibond, 1995) is a widely used self-report measure that assesses symptoms of depression (e.g., "I was unable to become enthusiastic about anything"), anxiety (e.g., "I felt I was close to panic"), and stress (e.g., "I found it difficult to relax"). Internal consistency was high in the present sample for depression ($\alpha = .93$), anxiety ($\alpha = .84$), and stress ($\alpha = .89$).

Procedure

Participants responded to online advertisements distributed via social media, targeted to adults who were gender or sexual minority individuals living in Metropolitan Melbourne, Australia. Participants were required to be aged 18 or older, identify as LGBTQ, live in metropolitan Melbourne, and have experience of providing mental health-related peer support within their LGBTQ communities. Participants were informed that the questionnaire was anonymous and that the aim was to investigate their experience of providing peer support to the LGBTQ communities. No rewards or incentives were given for participating. The study received ethical clearance from the La Trobe University Human Research Ethics Committee.

Analysis

Descriptive statistics are provided for demographic characteristics, and aspects of peer support provision, such as the targets of support and associated presenting problems. To examine experiences of peer support provision, the frequencies of each item response were examined. A series of independent-samples *t*-tests (two-tailed) compared participants who had received mental health training and those who had not. These focused on identifying any significant differences in their experiences of providing peer support as well as their mental health. Finally, we conducted a

series of exploratory analyses to examine potential demographic differences in mental health, training uptake, and peer support experiences on the basis of gender (man vs. woman vs. non-binary/gender diverse), sexual orientation (gay vs. lesbian vs. plurisexual), or gender status (cisgender vs. transgender/non-binary/gender diverse). One-way analysis of variance (ANOVA; two-tailed) was used to test for gender and sexual orientation differences. We used an independent-samples *t*-tests (two-tailed) to test for differences by gender status. Three chi-square tests examined differences in training status (yes vs. no) on the basis of the above demographic characteristics.

Results

Table 2 displays results pertaining to participants' provision of peer support. More than 80% of participants had provided peer support to a close friend, and approximately 40% to a partner. Approximately 30% had provided peer support to a colleague or co-worker, and just under 30% indicated that the person they had provided support to had been previously unknown to them. The most commonly reported issues facing the people they were supporting were depression and anxiety (over 80% each), followed by suicidal thoughts, work-related stress, and coping with stigma or discrimination (50–55% each). Nearly 40% of participants indicated they had supported someone with issues relating to self-harm, and over 35% of people had supported someone to cope with violence or abuse. Just under 20% reported having supported someone due to a suicide attempt, and about 30% reported other reasons, such as trauma or other stressors. Finally, about 40% of the sample had received some form of formal training, including workshops, training courses, or a formal qualification, and about 40% had not completed any formal training.

Table 2 Descriptive data on peer support provision

Variable	*n*	%
Target of support		
Close friends	269	82.5
Partners	134	41.1
Colleagues or co-workers	102	31.3
Previously unknown individuals	94	28.8
Family members	55	16.9
Schoolmates	24	7.4
Other	35	10.7
Presenting problem		
Anxiety	266	81.6
Depression	261	80.1
Suicidal thoughts	182	55.8
Work-related stress	180	55.2
Coping with stigma or discrimination	170	52.1
Self-harm	124	38.0
Coping with violence or abuse	115	35.3
Suicide attempt	65	19.9
Other	98	30.1
Training		
No training	116	35.6
Workshops or training courses	64	19.6
Formal qualification	44	13.5
On-the-job training alone	6	1.8
On-the-job training and workshops	20	6.1
Other or incomplete training/qualification	6	1.8
Any formal training (yes/no)		
Yes	128	39.3
No	128	39.3

We asked participants to indicate the extent to which they agreed or disagreed with four statements pertaining to aspects of their provision of peer support. As displayed in Fig. 1, almost 90% of participants reported feeling comfortable providing peer support to LGBTQ individuals, and about 75% of participants reported feeling able to seek advice to support their LGBTQ friends when needed (i.e., selected "agree" or "strongly agree"). Almost 60% reported finding it challenging to have sufficient time to support their LGBTQ peers (i.e., selected "agree" or "strongly agree"). Finally, just over 20% reported concerns with their skills in relation to supporting their LGBTQ peers (i.e., "agree" or "strongly agree"), whereas over 50% did not report such concerns (i.e., "disagree" or "strongly disagree").

Figure 2 displays the extent to which participants felt valued by (a) the person or people they supported; (b) the LGBTQ community; and (c) professional mental health service providers. Around 90% reported feeling valued by the person or people they were supporting (i.e., "moderately" to "completely"), whereas approximately 60% felt valued by the LGBTQ community. Only approximately 40% felt valued by professional mental health providers, and almost 30% reported feeling "not at all" valued by professionals.

Figure 3 displays the percentage of participants who scored within the various clinical severity ranges for symptoms of depression, anxiety, and stress. Approximately 30% of the sample reported symptoms of depression and anxiety that fell within the *severe* or *extremely severe* range, whereas just over 20% of the sample displayed *severe* or *extremely severe* levels of stress. Only a minority of individuals fell within the normal range (i.e., at or below the population mean) for depression (30.6%), anxiety (41.6%), and stress (46.1%).

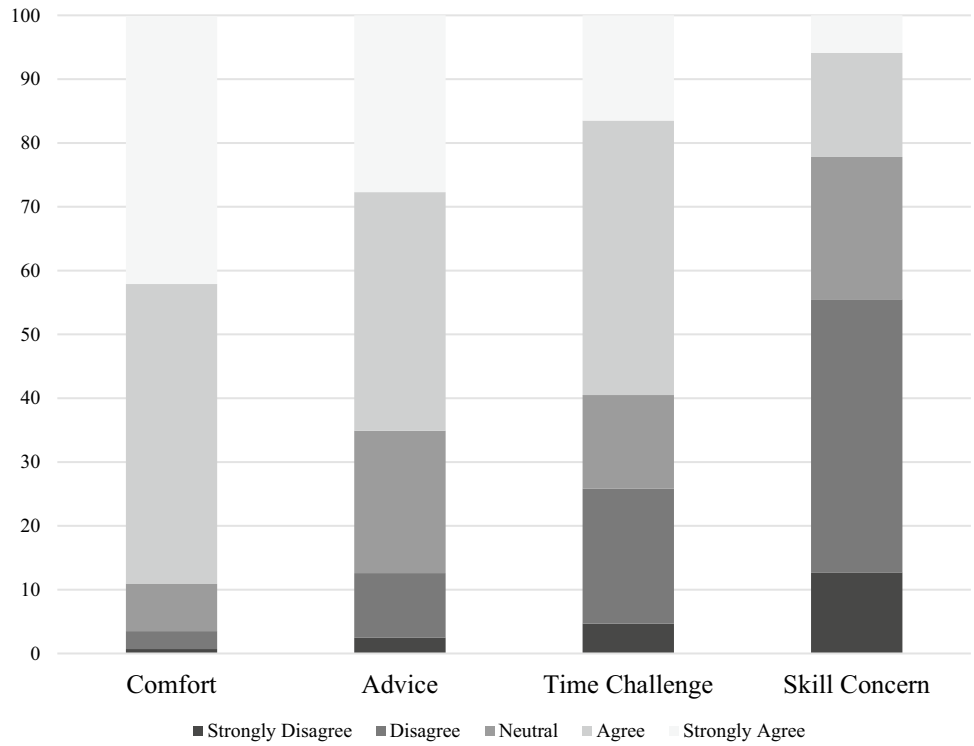

Fig. 1 Experiences of providing support. *Comfort*, the extent to which participants felt comfortable offering help to other LGBTQ people; *Advice*, the extent to which participants felt able to seek advice to support their LGBTQ peers when needed; *Time Challenge*, the extent to which participants experienced challenges having sufficient time to provide support to their LGBTQ peers; *Skill Concern*, the extent to which participants believed they did not have the skills to be good at supporting their LGBTQ peers

Table 3 displays means and standard deviations for the variables of interest in the current study, for both the full sample and split by training status. Results from the independent-samples *t*-tests indicated that those who had received formal training felt more able to seek advice (a small effect size) and reported feeling more valued by the person they were supporting, by the LGBTQ community, and by mental health professionals (medium effect sizes). Those who had not received training reported greater concern about their skills and rated their overall ability to support their peers lower, compared with those who had received training. Further, respondents who had received training were higher in

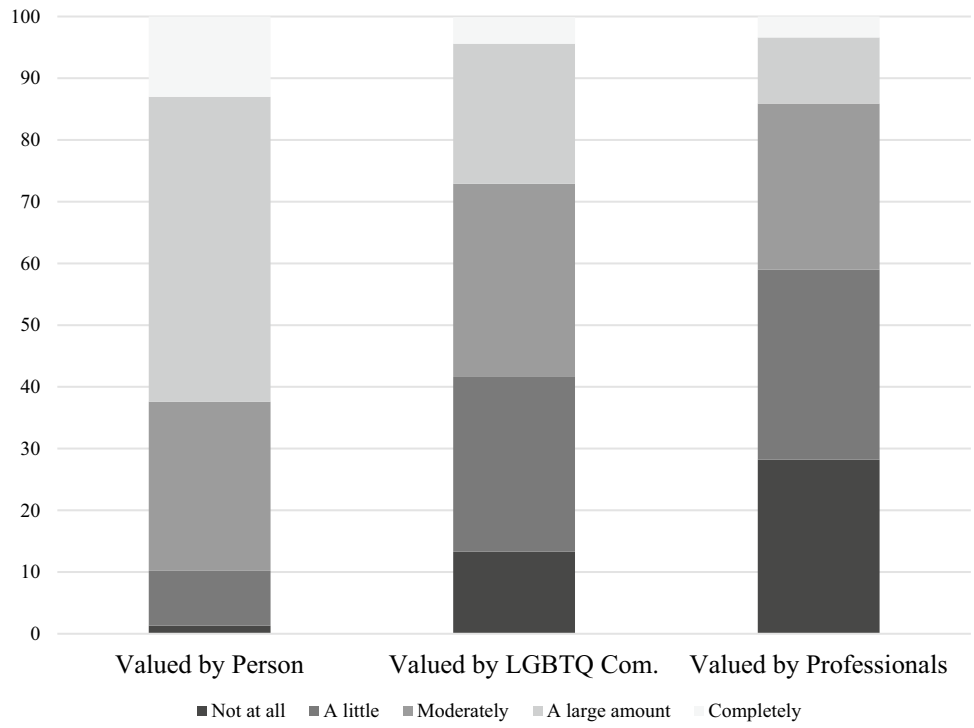

Fig. 2 The extent to which participants felt valued while providing peer support

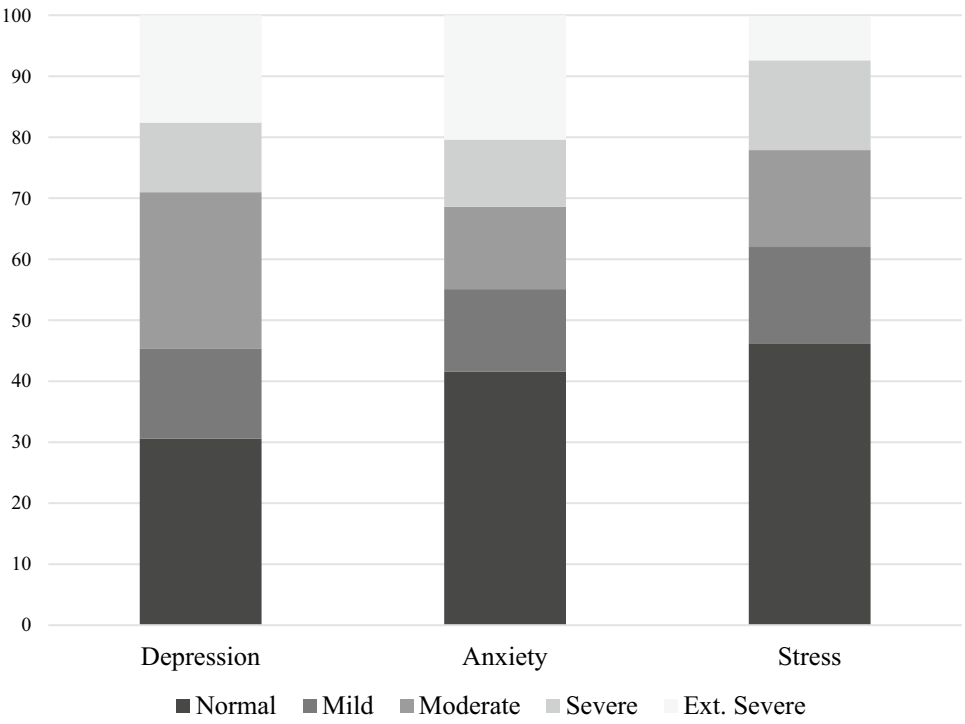

Fig. 3 Clinical severity ranges for depression, anxiety, and stress

self-rated competence when supporting those with suicide-related concerns relative to those who had not received training (large effect size). Individuals without training reported somewhat more interest in receiving training in how to support those with issues relating to suicide, though interest was relatively high in both groups. Finally, those without training reported greater symptoms of anxiety compared with those who had received training (small effect size).

With few exceptions, there were no significant demographic differences in mental health outcomes, experiences of providing peer support, or training status (received vs. not received training). Given we had no specific hypotheses regarding demographic differences, and that only two of the 42 comparisons were significant, these demographic differences are unlikely to be reliable or replicable.

Table 3 Means and standard deviations for continuous variables, and independent-samples *t*-test for group comparisons

	Reference range	Full sample Mean (SD)	No training Mean (SD)	Training Mean (SD)	*df*	*t*	*p*	Cohen's *d*
Time challenge	1–5	3.46 (1.13)	3.41 (1.18)	3.52 (1.14)	233	−.67	.503	−.09
Comfort	1–5	4.27 (.78)	4.24 (.75)	4.33 (.76)	235	−.93	.351	−.12
Seek advice	1–5	3.78 (1.04)	3.61 (1.04)	3.98 (.98)	225.29	−2.73	.007	−.36
Feel valued	1–5	3.64 (.87)	3.42 (.94)	3.85 (.74)	213.94	−3.85	<.001	−.51
Valued by profession	1–5	2.30 (1.10)	1.99 (1.0)	2.59 (1.10)	232	−4.34	<.001	−.57
Valued by LGBTQ	1–5	2.76 (1.08)	2.49 (1.0)	3.02 (1.10)	231	−3.82	<.001	−.50
Skill concern	1–5	2.60 (1.09)	2.89 (1.15)	2.27 (.87)	207.50	4.65	<.001	.61
Overall ability	1–5	3.20 (.91)	2.89 (.94)	3.48 (.79)	234	−5.19	<.001	−.68
Suicide competence	1–4	3.17 (.61)	2.89 (.61)	3.46 (.46)	235.98	−8.29	<.001	−1.04
Interest in training	1–4	3.30 (.73)	3.39 (.67)	3.21 (.77)	254	1.99	.047	.25
Depression	0–21	7.89 (5.51)	8.54 (5.63)	7.27 (5.34)	243	1.81	.071	.23
Anxiety	0–21	5.56 (4.50)	6.33 (4.66)	4.83 (4.22)	243	2.63	.009	.34
Stress	0–21	8.45 (4.95)	8.68 (5.09)	8.22 (4.82)	243	.73	.468	.09

Commonly used benchmarks for small ($d = .20$), medium ($d = .50$), and large ($d = .80$) effect sizes (see Cohen, 1988)

Discussion

The aim of the present research was to examine who provides LGBTQ peer support, to whom, and for what issues. We also sought to understand the experience of those who provide LGBTQ peer support. Participants provided support to a range of people, including close friends, colleagues, partners, and those who were previously unknown. Similarly, the types of concerns participants supported others with varied greatly, though the most frequently cited issues were depression, anxiety, suicidal thoughts, work stress, and coping with discrimination. Although most participants reported feeling valued by the person they were supporting, they also highlighted several challenges. Participants were often managing multiple competing demands, including work or study commitments, and most reported challenges finding time to provide support to their peers. More than half the sample displayed symptoms of depression, anxiety, and/or stress in at least the mild to moderate clinical severity ranges. Finally, those who had received at least some mental health-related training felt more competent, had fewer concerns about their skills, felt more valued, and reported less anxiety, compared to those without such training. In brief, those providing LGBTQ peer support appear to support a range of individuals with varied concerns but are often managing multiple competing demands, and many appear to be coping with their own mental health challenges.

LGBTQ Mental Health Peer Support

The majority of the sample appeared to hold significant responsibilities outside of their peer-support roles. In addition, approximately 7% of the sample reported being unable to work due to disability or illness, and more than half showed symptoms of depression, anxiety, and/or stress in at least the mild to moderate clinical severity range. Again, this suggests that a large proportion of the sample was coping with their own significant challenges at the same time as providing LGBTQ peer support.

In line with recent qualitative evidence (Worrell et al., 2022), participants provided support to a wide range of individuals. They were most likely to have provided support to close friends (more than 80%), partners (approximately 40%), and colleagues (more than 30%). Almost 30% had provided support to people who were previously unknown to them, and many had provided support to more than one person. The types of concerns participants provided support for were broadly consistent with a minority stress perspective (Meyer, 2003), such that the concerns centered around mental health and coping with stigma, discrimination, and abuse. Specifically, anxiety and depression (each approximately 80%) were the most frequently cited concerns, though suicidal thoughts (55.8%) and coping with stigma or discrimination (52.1%) were also prominent concerns. In addition, participants reported having supported peers with work-related stress (55.2%), self-harm (38%), violence or abuse (35.3%), and suicide attempts (19.9%). Thus, the problems participants were helping their peers with were generally serious and often life-threatening.

Almost all of the sample (approximately 90%) reported feeling comfortable (agree or strongly disagree) providing support to the LGBTQ communities, and most (approximately 75%) did not have concerns regarding their ability to provide support. This may reflect that the shared experience of being LGBTQ helps in understanding and feeling comfortable providing support to LGBTQ peers. Sexual minority people receiving therapy report that shared experience and understanding of LGBTQ issues is relevant and helpful (Quiñones et al., 2017), though less is known about how shared experience affects those providing the help. This may be a useful focus for future research.

There were also significant challenges reported by the sample in providing LGBTQ peer support. For instance, in line with recent qualitative research (Worrell et al., 2022, 2023a), about 60% of the sample reported challenges in having time to support LGBTQ peers, and only approximately 65% indicated feeling able to seek advice to support their LGBTQ peers. Although close to 90% felt valued by the person they were providing peer support (moderately to completely), only approximately 60% felt valued by LBGTQ communities. This might reflect that those providing peer support often do so as a trusted confidante; and thus, perhaps few people in the broader LGBTQ communities are aware of a person's role in providing LGBTQ peer support (Worrell et al., 2022, 2023a). Of note, only about 40% felt valued by professionals, and almost 30% reported feeling "not at all" valued by professionals. These findings converge with the broader mental health peer support literature showing that those providing peer support often face challenges establishing a legitimate place within broader mental health care teams responsible for supporting an individual (e.g., Ehrlich et al., 2020).

The sample was evenly split between those who had prior mental health training and those who did not. We examined whether participants' experiences providing peer support differed based on training status (completed mental health-related training vs. no completed training). There were no significant differences between the two groups on ratings of time challenges, comfort providing support to LGBTQ individuals, and depression and stress. However, those who had received mental health-related training felt more confident in their abilities to provide LGBTQ peer support relative to those without such training. This is consistent with evidence highlighting the benefits of training for peer support

workers (Ibrahim et al., 2020). The largest effect size difference between the groups was for competence in supporting someone who is suicidal, which is understandable given this can be a particularly challenging issue, and one that requires specific skills and training (see Rudd et al., 2008). Unsurprisingly, those without training reported more interest in receiving training in how to best support LGBTQ individuals compared with those who had received some form of training, though this effect size was small, and interest in training was high across both groups.

Those without mental health-related training reported greater anxiety compared to those who had received training. This could suggest that providing LGBTQ peer support without adequate training may be associated with greater anxiety and that providing mental health-related training could improve competence and reduce anxiety. Nonetheless, future research is needed to explicitly test this possibility as it might be the case that those who are more anxious simply do not access training. This seems less likely, however, given that individuals high in anxiety are especially likely to take steps (whether helpful or not) to reduce their anxiety (Pittig et al., 2018), which might include accessing training. Finally, those who had received mental health-related training felt more valued by the individual they were supporting, and by professionals and the LGBTQ community more broadly relative to those who had not received such training. Finally, we found little evidence of differences in mental health or experiences of providing peer support based on demographic characteristics. Given that no hypotheses were made regarding demographic characteristics, and that only two of 42 comparisons were significant, these results are unlikely to be reliable or replicable.

Social Policy Implications

Participants in the current study were supporting their LGBTQ peers, and often multiple peers, with a wide range of challenges and concerns. Although participants broadly felt valued by the people they were supporting, they were also faced with significant challenges in providing peer support, and these challenges were more pronounced among those who had not received mental health-related training. Participants were generally providing support outside of formal organizations or support services and are therefore unlikely to have significant scaffolding and support around them when supporting others. About half the sample did not have formal mental health-related training and are thus not qualified to provide support to those with significant mental ill health. However, there are substantial barriers that limit access to mental health services for LGBTQ individuals (e.g., Cronin et al., 2021a), and qualitative research suggests that individuals often feel they have no choice but to provide LGBTQ peer support to fulfil unmet mental health needs (e.g., Worrell et al., 2022). This situation needs addressing and there are at least two areas of focus for social policy that are likely to prove fruitful.

First, efforts to expand the availability of LGBTQ-affirmative mental health services and to reduce barriers to service access are critical to reduce the need for LGBTQ individuals to rely on peer support for their mental health. As Gidugu et al. (2015) argue, peer support should complement but not stand in place of more traditional mental health supports. There is a need for greater focus on training mental health practitioners to be competent in working with LGBTQ individuals, and evidence suggests that such training can effectively enhance affirmative practice (Pepping et al., 2018). Greater investment is needed to ensure that mental health services adequately meet the needs of LGBTQ individuals and address both the systemic barriers to service access, such as financial constraints, as well as minority stress-related barriers to service access (Cronin et al., 2021a).

Second, there is a clear need for initiatives designed to support those providing LGBTQ peer support. As has been suggested before (Rebeiro Gruhl et al., 2016; Worrell et al., 2022), those providing LGBTQ peer support should have access to mental health response training, including knowledge and skills to help them define roles and boundaries, recognize and respond to suicide risk, and refer to appropriate mental health professionals when needed. For instance, mental health first aid courses can increase mental health literacy and foster supportive attitudes and behaviors towards those experiencing mental health challenges (e.g., Hadlaczky et al., 2014), and have been extended to focus on supporting LGBTQ individuals with mental health challenges (Bond et al., 2017). Further, supports should be available to assist in managing the impact of providing LGBTQ peer support, and it is critical that such support is ongoing (Ibrihim et al., 2020). The requirement for either formal supervision or peer supervision is often outlined by professional bodies of mental health practitioners (e.g., Australian Psychological Society, 2007), and within some forms of psychotherapy (e.g., Linehan, 2018). Although it may be impossible to mandate such supervision or support for those providing informal LGBTQ peer support, efforts should be made to enhance the availability of such supports to prevent burnout and to ensure people are providing peer support in a sustainable way. This is especially important given that interest in such training was high in the present sample, as it has been in prior research (e.g., Ferlatte et al., 2020).

Limitations and Future Directions

There are some limitations of the present research that should be acknowledged. First, the cross-sectional nature of the study prevents us from drawing conclusions about

causation, particularly regarding the potential effects of training on experiences of providing peer support. Research is needed to examine the efficacy of providing training and supervision to those providing informal LGBTQ peer support on both the outcomes of support and the experience and impact of providing peer support. Second, although the size of the sample was ample for examining the research questions in the present study, it was not sufficiently large to examine whether experiences of providing peer support differed based on characteristics of the person being supported (e.g., relationship to the person providing support, or the nature of the issue or concern). Although we found little evidence of differences based on demographic characteristics, the size of the sample did not allow for a finer-grained analysis of the influence of intersecting and overlapping identities. This remains an avenue for future research efforts. Similarly, although there was diversity in gender and sexual identities in the present sample, there was less variation in other characteristics, such as ethnicity and educational background. Thus, the extent to which these findings generalize to varied cultural contexts and groups remains less clear.

The present research was focused largely on exploring who provides LGBTQ peer support, to whom, and how this is experienced. Although we explored the role of prior mental health training, research is needed to test a wider range of individual differences and their possible effects on experiences providing LGBTQ peer support. For instance, the extent to which lived experience of mental ill health may be helpful when providing LGBTQ peer support remains to be investigated, as well as the potential challenges arising from lived experience when providing LGBTQ peer support. In summary, those providing LGBTQ peer support appear to support a range of individuals for varied concerns, but are often managing multiple demands and personal challenges. Initiatives designed to support those providing LGBTQ peer support are greatly needed.

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Declarations

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

Conflict of Interest The authors declare no competing interests.

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