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Original Article

Understanding key priority areas of mental health among queer asylum seekers and refugees in Australia through the lens of structural violence: A modified Delphi method study

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Abstract

Queer asylum seekers and refugees (QASaR) are more likely to have poor mental health compared to non-QASaR. This paper examines key priority areas for refugee services to improve mental health outcomes of QASaR in Australia. The key priority areas were identified through a modified Delphi method (DM), comprised of two stages: a scoping review of literature and three rounds of consensus building process. In the second stage, twenty-one participants were involved, including QASaR, health/social care professionals, and people in policy/funding-related roles. Drawing on Farmer's understanding of structural violence, our consensus suggests QASaR's poor mental health is primarily produced by the asylum system, further exacerbated by the lack of safe queer-inclusive refugee services, and can be improved by supporting QASaR-led organizations. Greater investments in QASaR-led organizations and initiatives are needed to improve cultural safety of refugee services and achieve systemic change.

Keywords: LGBTIQ; queer; refugees; asylum seekers; Australia; mental health; Delphi

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1. Introduction

Globally, adult asylum seekers and refugees have high prevalence of post-traumatic stress disorder (31.46%) and depression (31.5%) (Blackmore et al. 2020). However, Queer[1] asylum seekers and refugees (QASaR) are more likely to develop anxiety, depression, post-traumatic stress disorder, and suicidality compared to non-QASaR (Hopkinson et al. 2017; Gottlieb et al. 2020; Bird et al. 2022).

United Nations High Commissioner for Refugees (UNHCR) (2008) defined QASaR as people who flee their home country due to fear of persecution based on sexuality, gender identities and expressions, and sex characteristics. Psychosocial and structural factors shape their asylum process (Berg and Millbank 2009), including Western dominant understanding of queerness (Lopes Heimer 2020; Selim et al. 2022) and heteronormative norms (Rehaag 2009; Andrade et al. 2020; Selim et al. 2022). Meanwhile, many QASaR do not use sexuality, gender, and sex as the basis to claim asylum, as highlighted in the case of Ukrainian refugees (Jaworska 2023). Regardless of their pathways to seek safety, QASaR are vulnerable to homophobia and transphobia from their ethnic and religious communities, in addition to racism within Queer and broader host communities (Alessi et al. 2021a; Held 2023). As such, many QASaR tend to avoid health services due to fear of discrimination (Nematy, Namer, and Razum 2022).

In Australia, asylum claim based on sexual orientation was first granted in 2002 (Millbank 2009). Until present, many QASaR arrive with temporary visas, such as work, student, and tourist visas, before claiming for asylum (Dawson 2017; Cohcrane, Dixson, and Dixson 2023). Some arrive by boat and thus are at risk of being sent to offshore detention centres where persecutions towards Queer people are likely to occur (Dawson 2017). In offshore detention centres, such as Nauru, there have been concerns about immigration officials being allowed to report same-sex sexual acts to the local police (Dawson 2017). In addition, QASaR have reported experiences of being asked sexually explicit and stereotyping questions during their interviews to claim asylum (Dawson 2017).

For QASaR who live in the communities in Australia, their access to mental health support is embedded within a fragmented network of formal and informal refugee services, which consist of settlement services, specialized primary care, trauma-based services, charity organizations, and QASaR-led organizations (Cohcrane, Dixson, and Dixson 2023; Multicultural Youth Advocacy Network 2023; Many Coloured Sky n.d.; Queensland Program Assistance for Survivors of Torture and Trauma n.d.). Some QASaR-led organizations, such as Forcibly Displaced People Network, are also inclusive of those who seek safety by using visas other than protection visa (Cohcrane, Dixson, and Dixson 2023). Most refugee services are funded by Federal and State Governments (Correa-Velez, Gifford, and Bice 2005) and charity grants (see Pride Foundation Australia 2022). They are important because many QASaR do not access mainstream Queer services in Australia (Cohcrane, Dixson, and Dixson 2023), potentially due to ineffective community engagement approaches (Cohcrane, Dixson, and Dixson 2023; Multicultural Youth Advocacy Network 2023). Many refugee services are also perceived to be unsafe and exclusionary for QASaR due to experiences of stigma or anticipated stigma related to gender and sexual identities (Migration Council of Australia and Forcibly Displaced People Network 2020; Multicultural Youth Advocacy Network 2023); however, these services remain among the first institutions they engage with since their arrival in Australia. Efforts to improve their mental health need to involve QASaR and refugee services, especially in informing research and translating existing evidence into practice.

Focusing on Australian refugee services, we aim to identify key priority areas to improve mental health outcomes of QASaR using a modified Delphi method (DM). We engaged with QASaR, health/social care professionals, policy makers, and funding agencies to achieve a consensus on what and how to translate evidence into policy and practice. Our approach of centring on lived

[1] We use 'Queer' to encompass lesbian, gay, bisexual, transgender, intersex, queer, and asexual. See, for example, Walks 2014. 'Queer' also reflects the prominent use of this term in the context of Australian refugee movements (see https://fdpn.org.au/queer-displacements/ and https://thirdqueerculture.com/).

experience while drawing on research and professional expertize is aligned with refugee-led movements (Kara et al. 2022). As such, DM as a systematic approach to build consensus among various experts (Dalkey 1969; Hsu and Sanford 2007; Jorm 2015) is an appropriate method to identify key priority areas of mental health, defined as the most important and urgent recommendations for refugee services.

We draw on the concept of structural violence to understand the key priority areas identified by the participants. Farmer et al. (2006) understood structural violence as social structures that put people in harm's way, increasing their vulnerabilities to diseases while creating barriers to prevention and treatment. Structural violence enacted by the nation states can manifest as inhumane immigration policies and complex visa processes that increase risk of prolonged distress, mental illness, and poor quality of life (Kelly 2005; Guillot-Wright et al. 2022; Hourani et al. 2022). With the addition of having the power to allocate funding for migrant organizations, the nation states maintain their control over migrants' access to resources for health, wellbeing, and treatment of diseases (Pursch et al. 2020; Guillot-Wright et al. 2022). While previous studies on QASaR have used minority stress as a framework to examine their experiences of discrimination based on sexual and gender identities (Di Giuseppe 2020; Fox, Griffin, and Pachankis 2020; Golembe et al. 2021; Yarwood et al. 2022), structural violence in our study has been useful to understand how some of these discriminations occur in the refugee services within wider context of the asylum system.

To explain how structural violence influences the key priority areas, we structure this paper as follows. We begin by describing two stages in our modified DM study: a scoping review of literature and consensus building process. Then, we examine the identified key priority areas through the lens of structural violence, followed with a discussion of the results and our recommendations to dismantle structural violence and achieve systemic change.

2. Method

This study was conducted by three cis-males and a queer person. S.N.I. is a former QASaR (they are now an Australian citizen) and a public health doctoral candidate. Along with E.A.S., who holds a doctoral degree in psychology, they co-facilitate one of the QASaR-led organizations in Australia. A.L. was a gay international student in Australia and now works as a researcher in the area of migration and mental health. Finally, I.C.-V. is a leading expert in refugee health in Australia. As a team, we decided to adapt DM, as outlined by Jorm (2015), and conducted the study in two stages, which took place between September 2022 and January 2024. We obtained ethics approval from Monash University on 1 September 2022 (Project ID: 3331).

2.1 Stage one: a scoping review

Literature review is a common starting point to develop DM questionnaires (Jorm 2015). We conducted a scoping review according to the procedure from Joanna Briggs Institute (Peters et al. 2020) with the aim of addressing the question: *what is the evidence on mental health among QASaR?*

On 23 September 2022, we searched six databases using key terms that indicate the research questions: 'queer', 'asylum seekers', 'refugees', and 'mental health' (see Table 1). We piloted the appropriateness of these terms through an initial search on 15 April 2022.

We stored all the records we found in EndNote 20, a reference management software, and removed the duplicate records. Then, S.N.I. and E.A.S. used Rayyan, a software for literature review (Ouzzani et al. 2016), to conduct title and abstract screenings using a double-blind method. Afterwards, all authors were involved in conducting full-text screening. Any discrepancies were further discussed as a team and agreement was reached by consensus.

Throughout the screening, the criteria for including the studies were: (1) primary data collected from QASaR (as defined by UNHCR'S 2008) and/or health/social care professionals who worked with them; (2) findings focused on or included themes of mental health; and (3) published since 1 January 1994 until the date of the search. The year 1994 was chosen because this

Table 1. Full database search strategy plan.

Databases	PubMed, Scopus, PsycINFO, CINAHL via Ebscohost, Web of Science, and Taylor & Francis Online
Key terms	Population: (queer OR LGB* OR GLB* OR SOGIE* OR gay OR lesbian OR bisexual OR transsex* OR transgend* OR 'trans people' OR non-binary OR intersex OR MSM OR ((sexual OR gender) AND minorit*)) AND (migrant* OR immigrant* OR refugee* OR 'asylum seeker*' OR 'forcibly displace*' OR sojourn* OR overseas-born OR foreigner* OR expatriate*) Mental health: (mental OR trauma OR psych*)

was the year that a country in the world (i.e. USA) first granted asylum on the basis of sexual orientation (UNHCR 2016). Studies that did not meet the inclusion criteria, were not written in English or were not available in full text, were excluded.

Using the same inclusion and exclusion criteria, A.L. conducted grey literature search on 29 September 2022 through eleven sources: ProQuest; Google Scholar; Open Grey; OutRight International, Organization for Refugee, Asylum, and Migration; International Lesbian and Gay Association Europe; UNHCR; International Organization for Migration; World Health Organization; Women's Refugee Commission; Human Rights Watch; and Amnesty International. Similar key terms from the database search were used. After removal of duplicates and sequential screening of title, abstract, and full-text records, included grey literature were saved in the same EndNote library used for peer-reviewed literature.

Figure 1 shows a PRISMA flow diagram based on our search. By January 2023, we screened 6,197 documents and included 42 articles (31 peer-reviewed articles and 11 grey literature). Most studies were conducted in the context of the host countries, with the USA and Canada being the primary settings (Perez-Ramirez 2003; Lee and Brotman 2011; Alessi 2016; Alessi, Kahn, and Chatterji 2016; Human Rights Watch 2016; Logie et al. 2016; Alessi, Kahn, and van der Horn 2017; Cheney et al. 2017; Gowin et al. 2017; Hopkinson et al. 2017; Kahn and Alessi 2017; Kahn et al. 2017, 2018; Piwowarczyk, Fernandez, and Sharma 2017; Nguyen et al. 2019; Fox, Griffin, and Pachankis 2020; Massaquoi 2020; Minero 2020; Najjar 2020; Llewellyn 2021; Mulé 2021; Oren and Gorshkov 2021; Bird et al. 2022; Jain 2022). Other studies were conducted in Europe (Brice 2011; Alessi et al. 2018; Ward 2018; Alessi et al. 2020; Gottlieb et al. 2020; Alessi et al. 2021b; Golembe et al. 2021; Rosati et al. 2021; Cook and Dewaele 2022; Kostenius et al. 2022), Middle East (Millo 2013; Chynoweth 2017; Najjar 2020; Clark et al. 2021), Latin America (Feldman, Freccero, and Seelinger 2013; Millo 2013; Cowper-Smith, Su, and Valiquette 2022), Sub Saharan Africa (Horn and Seelinger 2013; Millo 2013; Marnell, Oliveira, and Khan 2021), and Southeast Asia (Freccero and Seelinger 2013). Figure 1 also provides reasons for excluding some studies throughout the search process, such as studies that did not focus on QASaR, were not based on primary data, were not relevant to mental health, or were not available in full texts.

All authors extracted data from the included articles using a template that included the following information: publication type (peer-reviewed article or grey literature), aim, characteristics (setting, participants, methods), and mental health-related findings. Following the method described by Peters et al. (2020), quality of the studies were not assessed. Based on this process, we extracted primary data from 1,342 QASaR and 265 staff of refugee services.

S.N.I. adapted reflexive thematic analysis process (Braun and Clarke 2019) to synthesize and interpret the data. Reflexive thematic analysis was chosen to use the coding process to develop a list of statements for the DM questionnaires and to categorize the statements into key themes. This process included rereading the extracted data, manually coding the data based on existing systematic reviews on mental health among QASaR (Alessi et al. 2021a; Nematy, Namer, and Razum 2022; Yarwood et al. 2022), and categorizing the codes into statements and themes by

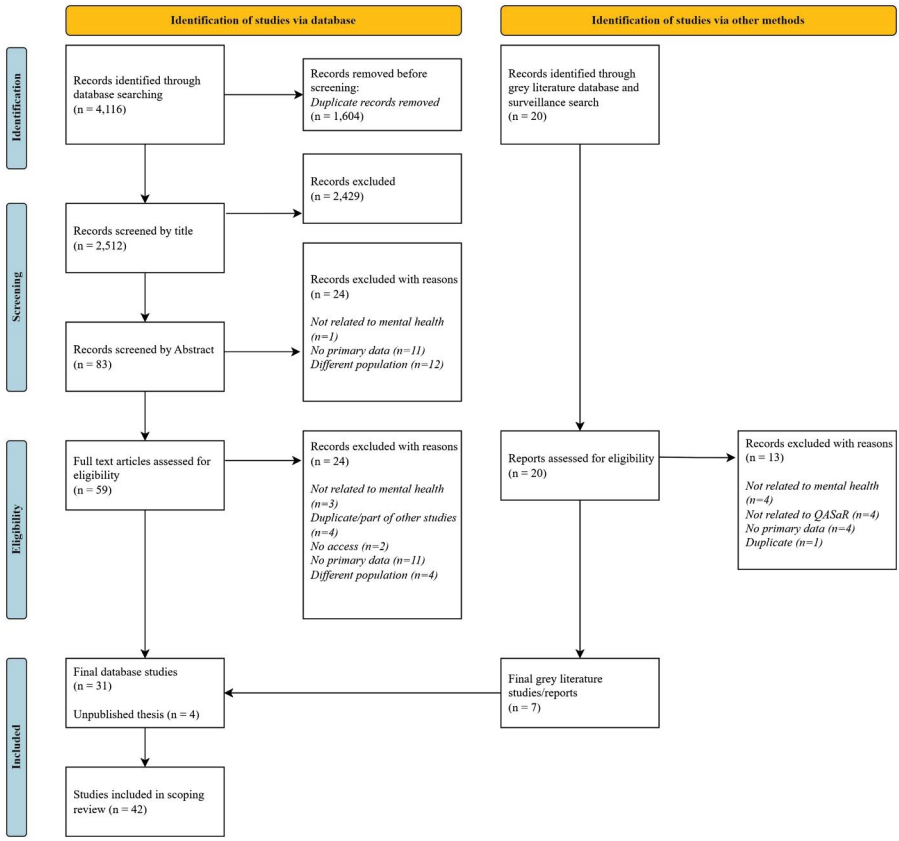

Figure 1. PRISMA flow diagram.

reflecting on S.N.I.'s lived experience and advocacy as a former QASaR. S.N.I. also had discussions with other authors to refine the statements and the themes. The result was 26 statements that were categorized into four key themes: (1) violence, abuse, and trauma across the life course; (2) asylum system; (3) belonging in the context of intersectional stigma and discrimination; and (4) access to queer-inclusive refugee services. The next sub-section discusses the use of these statements in the DM questionnaires.

2.2 Stage two: three rounds of consensus building process

The second stage involved two rounds of questionnaires (including open-ended questions) and a feedback round for this manuscript. The participants were categorized into three groups: (1) QASaR or former QASaR; (2) health/social care professionals working with QASaR in paid or voluntary roles; and/or (3) professionals in policy/funding-related roles that influenced refugee services.

To recruit participants, we held a series of online and in-person presentations to promote the study, including at the Queer Displacement Conference 2023 convened by Forcibly Displaced People Network. Then, we used convenience sampling by sending emails to the Forum of Australian Services for Survivors of Torture and Trauma, Refugee Health Network of Australia, settlement services across the country, Pride Foundation Australia, and QASAR-led organizations. The recruitment for the first round officially began on 9 April 2023, and the data collection

for the third round was completed on 31 January 2024. With no funding, we were not able to remunerate participants for their participation.

In the first round, we asked participants to assess the 26 statements by giving each statement a score between 0 and 100 on Qualtrics (0 = lowest importance and 100 = highest importance). Table 2 provides a complete list of the statements, including the descriptions of the themes that were used to categorize the statements. In addition, we asked open-ended questions for participants to share their reflections on their scoring and to provide potential priority areas that were not identified in the statements. To ensure the questionnaire's appropriateness and ease of access and reading, we piloted it with four people who were potential participants.

For the second round, E.A.S. and A.L. calculated the mean score for each statement. Those that received ≥80 (out of 100) were classified as *key priority areas* while those with a mean score <80 were classified as *least priority areas*. By using both categories, we returned to the participants who completed the first questionnaire to compare their own score for individual statement with its mean score. To help them in this comparison, A.L. gave each participant a confidential and unique ID and a link to an anonymized list of participants' scorings. Then, we asked them to provide a level of agreement with the mean score for each statement by using a Likert scale on Qualtrics (Strongly Disagree, Disagree, Neutral, Agree, and Strongly Agree). In addition, we asked them a few open-ended questions. For the key priority areas, we asked them to identify which statements were the most urgent and why. For the least priority areas, we asked them to identify which statements they found the most surprising and why.

We also shared three key themes based on their qualitative responses in the first round. S.N.I. conducted reflexive thematic analysis by manually collating participants' responses, then coding the data based on the 26 statements from the scoping review. Three themes were generated: (1) asylum system causes direct harms for QASaR's mental health; (2) the lack of safe environments in refugee services for QASaR to foster a sense of belonging; and (3) the centrality of QASaR-led organizations in reducing mental health impacts of systemic challenges. By sharing these themes, we asked the participants which theme(s) resonated the most based on their respective expertize and why.

For the third round, the final key priority areas were identified by choosing the statements that received ≥80 (out of 100) in the first round *and* unanimous 'Agree' and 'Strongly Agree' responses in the second round. We chose this approach because no participant disagreed with the least priority areas, allowing us to focus only on the key priority areas. To understand why these key priority areas emerged as the most important and urgent, S.N.I. conducted further reflexive thematic analysis of all participants' qualitative responses from the first to the second round. This time, S.N.I. and other authors discussed a range of social theories to identify one that was most suitable to explain the relationships between the qualitative responses and the final list of key priority areas.

Finally, we wrote this manuscript and sent it to the participants for their feedback through email. We received four responses, which were generally positive with minor revisions requested. For instance, one of the QASaR participants asked for the key findings to be made clearer in the abstract and we revised the abstract accordingly.

3. Results

3.1 Participants

Table 3 provides the sociodemographic characteristics of the participants and their participation throughout the first and second rounds of DM questionnaires. For the first round, a total of twenty-one participants completed the questionnaire: eight QASaR, twelve health/social care professionals, and three people in policy/funding-related roles (two participants identified with more than one role). Meanwhile, ten out of twenty-one participants completed the second round: five QASaR, five health/social care professionals, and two people in policy/funding-related roles. The attrition rate from the first to the second round was 52.4%.

Table 2. Key themes and statements in the first round of DM questionnaires.

Themes	Descriptions	Statements	
Violence, abuse, and trauma across the life course	Most included studies highlight that QASaR were likely to have experienced violence, abuse, and trauma since their early life. The perpetrators in these incidents tended to be family and community members, but also the authorities. Statements in this theme are potential priority areas to reduce the impacts of violence, abuse, and trauma.	1.1	Support to navigate complex relationships with family as both a source of abuse and trauma but also a source of self-healing and resources.
		1.2	Support to navigate religious faith as both a source of abuse and trauma but also a source of spiritual strength.
		1.3	Provide a safe environment where hiding or concealing sexual orientation and gender identities are not required.
		1.4	Provide counselling and support to recover from past experiences of physical and sexual abuse.
		1.5	Support to access education to gain stability, independence, and self-confidence.
Asylum system (defined as a set of institutions, policies, and pathways that determine the process of claiming refugee status)	Many included studies highlight numerous issues regarding the process of claiming asylum based on sexual orientation and gender identities while identifying other issues related to broader asylum system. Statements in this theme are potential priority areas to advocate for change in the asylum system.	2.1	Advocate for full time work rights during the process of claiming refugee status.
		2.2	Support to report discrimination based on race, gender, and sexuality by immigration officials.
		2.3	Provide information and education about the process of claiming refugee status based on sexual orientation and gender identities.
		2.4	Support to address re-traumatization because of sharing past trauma and pressures to share intimate details of sexual attraction and encounters
		2.5	Change in refugee claims assessment to avoid claimants feeling pressured to conform to Western concepts of gender and sexuality (e.g. lesbian, gay, transgender, bisexual).
		2.6	Reduce processing time for refugee category visas.
		2.7	Closure of detention centres.
		2.8	Ban on holding queer asylum seekers in detention centres, especially those who identify as transgender.
Belonging in the context of intersectional stigma and discrimination	QASaR remained connected to various communities in the home and host countries. However, maintaining relationships with these communities can be	3.1	Provide financial, practical, and strategic support for QASaR in their advocacy and peer support groups.
		3.2	Support to navigate racism within queer communities in order to

(continued)

Table 2. (continued)

Themes	Descriptions	Statements
	challenging due to specific social and cultural norms that stigmatize and discriminate them. Statements in this theme are potential priority areas to help QASaR to foster a sense of belonging.	find diverse, inclusive, and safe queer groups. 3.3 Collaborate with LGBTIQA+ organizations to reduce racism in queer communities. 3.4 Support to navigate homophobia and transphobia within ethnic communities in order to maintain cultural connections. 3.5 Collaborate with ethnic organizations to reduce homophobia and transphobia. 3.6 Support to navigate homophobia and transphobia within religion- and faith-based communities in order to maintain spiritual connections. 3.7 Collaborate with religion- and faith-based organizations to reduce homophobia and transphobia.
Access to queer inclusive refugee services	Mental health of QASaR was at risk of further deterioration when the refugee services were not inclusive and responsive to their needs and aspirations. These barriers could exist at multiple levels from individual staff to sector-wide issues. Statements in this theme are potential priority areas to improve refugee services for QASaR.	4.1 Address homophobia and transphobia that contribute to refugee services' hesitancy in supporting QASaR. 4.2 Develop and sustain queer refugee-led organizations and programmes. 4.3 Develop interagency collaboration across queer refugee groups, queer organizations, settlement services (including housing), legal services, employment, and health services (including mental health, gender services, and sexual health). 4.4 Provide free or low-cost legal services to navigate asylum system and other legal challenges specific to QASaR. 4.5 Provide workshops and trainings for improving employability of queer asylum seekers and refugees. 4.6 Improve LGBTIQA+ cultural safety in refugee services through mandatory training, supervision, feedback and complaint process, and queer refugee led initiatives.

3.2 Structural violence and mental health of QASaR in Australia

To improve mental health of QASaR, participants agreed on eleven key priority areas for refugee services (see Table 4). Drawing on Farmer's (2006) understanding of structural violence, their qualitative responses on the key priority areas suggest QASaR's poor mental health post

Table 3. Sociodemographic characteristics and participation in DM questionnaires.

ID	Round involvement	Region of birth	Age group	Gender[a]	Intersex	Sexual orientation[a]	Lived experience of claiming asylum	Claim for asylum based on being a queer individual	Refugee status as a result of asylum claim	Roles[b]	Total years of working with QASaR
A1	1, 2	Southeast Asia	18-30	Cis male	No	Gay	No	N/A[c]	N/A[c]	2	2
B2	1	Oceania	31-45	Male	No	Heterosexual	No	N/A[c]	N/A[c]	2	4
C3	1	Oceania	31-45	Female	No	Heterosexual	No	N/A[c]	N/A[c]	3	3
D4	1	Northwest Europe	31-45	Female	No	Heterosexual	No	N/A[c]	N/A[c]	2	3
E5	1	Sub Saharan Africa	31-45	Female	No	Female	No	N/A[c]	N/A[c]	2	2
F6	1	Oceania	18-30	Female	No	Heterosexual	No	N/A[c]	N/A[c]	2	1
G7	1, 2	Sub Saharan Africa	31-45	Male	No	Straight	Yes	No	No	2	2
H8	1, 2	Oceania	31-45	Female	No	Heterosexual	No	N/A[c]	N/A[c]	2	2
I9	1, 2	Oceania	46-60	Female	No	Lesbian	No	N/A[c]	N/A[c]	2	2
J10	1	Oceania	31-45	Male	No	Heterosexual	No	N/A[c]	N/A[c]	2	2
K11	1	Oceania	>60	Female	No	Heterosexual	No	N/A[c]	N/A[c]	2	4
L12	1	Oceania	18-30	Female	No	Heterosexual	No	N/A[c]	N/A[c]	2	2
M13	1	Southeast Asia	31-45	Man	No	Gay	Yes	Yes	No	1	N/A[c]
N14	1, 2	Southeast Asia	18-30	Male	No	Gay	Yes	Yes	No	1	N/A[c]
O15	1, 2	Middle East	31-45	Woman	No	Lesbian or queer	Yes	Yes	Yes	1	N/A[c]
P16	1, 2	Middle East	31-45	Male	No	Gay Queer	No	N/A[c]	N/A[c]	1	N/A[c]
Q17	1, 2	Northeast Asia	31-45	Male	No	Homosexual	Yes	Yes	No	1	N/A[c]
R18	1	Middle East	18-30	Female	No	Straight	Yes	Yes	Yes	1	N/A[c]
S19	1, 2	Oceania	31-45	Prefer not to say	No	Queer	No	N/A[c]	N/A[c]	2, 3	5
T20	1	Southeast Asia	31-45	Transgender	Yes	Attracted to men	No	N/A[c]	N/A[c]	1	N/A[c]
U21	1, 2	Eastern Europe	31-45	Woman	No	Queer	Yes	Yes	Yes	1, 3	3

a Data on gender and sexual orientation were collected through open-ended questions and presented as participants reported.
b Roles: 1 = QASaR; 2 = a health/social care professional; 3 = a professional working in policy or funding-related roles.
c N/A = not applicable.

Table 4. Key priority areas to improve mental health of QASaR in Australia.

Statement number	Key priority areas	Mean score	Rate of 'Agree' responses[a]	Rate of 'Strongly Agree' responses[a]
Improving asylum system as the primary source of structural violence				
2.3	Provide information and education about the process of claiming refugee status based on sexual orientation and gender identities.	83.62	5/10	5/10
2.8	Ban on holding queer asylum seekers in detention centres, especially those who identify as transgender.	81.95	4/10	6/10
2.4	Support to address re-traumatization because of sharing past trauma and pressures to share intimate details of sexual attraction and encounters.	80.76	6/10	4/10
2.7	Closure of detention centres.	80.43	2/10	8/10
Creating safe queer-inclusive refugee services				
4.6	Improve LGBTIQA+ cultural safety in refugee services through mandatory training, supervision, feedback and complaint process, and queer-refugee led initiatives.	91.38	1/10	9/10
1.4	Provide counselling and support to recover from past experiences of physical and sexual abuse.	84.81	4/10	6/10
1.5	Support to access education to gain stability, independence, and self-confidence.	84.18	3/10	7/10
4.4	Provide free or low-cost legal services to navigate asylum system and other legal challenges specific to queer asylum seekers and refugees.	83.86	2/10	8/10
4.1	Address homophobia and transphobia that contribute to refugee services' hesitancy in supporting queer asylum seekers and refugees.	82.52	2/10	8/10
Supporting QASaR-led organizations				
4.2	Develop and sustain queer refugee-led organizations and programmes.	87.29	4/10	6/10
3.3	Collaborate with LGBTIQA+ organizations to reduce racism in queer communities.	85.67	4/10	6/10

a Rate is calculated based on *n* per total number of respondents in the second round of Delphi questionnaire ($N = 10$).

migration are primarily caused by the asylum system, exacerbated by the lack of safe queer-inclusive refugee services, and can be improved by supporting QASaR-led organizations. We discuss each theme in the following sub-sections.

3.2.1 *Primary factor: asylum system as the source of structural violence*

QASaR participants often experienced (re)traumatization when navigating the asylum system, causing direct harms to their mental health. Majority perceived the asylum system as a hostile environment for asylum seekers and refugees generally, and QASaR more specifically. Many mentioned the lengthy duration of asylum process as a primary example of this hostility. O15 mentioned being in a visa limbo was the main cause of her deteriorating mental health post migration despite her efforts to take control over her own life. Further, she viewed the contemporary dehumanization of asylum seekers and refugees as a continuation of the colonial history of Australian immigration policies.

> *I have been on a visa limbo for over 10 years. I have had visa valid from 3 months to 5 years … Even though I have secured employment, built a supportive community around me, and am working to create change for others, my mental health has not improved … Having been here for a decade as an asylum seeker and working on settlements, employment, and mental health, the unresolved issue in this country is colonialism. Colonialism is inherently discriminatory and racist, which hinders good policies.* (O15, QASaR)

Besides the complex and lengthy process to claim asylum, the interviews process with the immigration officers also retraumatized QASaR. For instance, QASaR Q17 reported that the officers asked '*very homophobic questions*' even though they did not provide any examples of such questions. Meanwhile, S19, a health/social care professional, said the officers '*are not great at recognising when someone is being re-traumatised or offering support*'. These responses indicate Australian asylum system can be discriminatory towards QASaR and offers limited support during the asylum process. As a result, '[the asylum] *system does not work and often increases harm*' (D4, health/social care professional).

Table 4 shows four key priority areas to improve the asylum system as the primary source of structural violence. Providing comprehensive information about the process to claim asylum based on sexuality, gender, and sex appears to be an essential strategy. Equally important is providing support when QASaR are experiencing re-traumatization through the asylum process. Participants also viewed the use of detention centres within the asylum system as inhumane and recommended it to be abolished. QASaR should also not be placed in detention centres to prevent significant harms related to gender and sexual orientation-based violence.

3.2.2 *Exacerbating factor: the lack of safe queer-inclusive refugee services*

Mental health of QASaR is at risk of further deterioration when refugee services are not safe and inclusive. The notion of safety or the '*freedom to be oneself without judgement*' (D4, health or social care professional) was viewed as a critical starting point for QASaR to begin '*the process of healing*' from past violence, trauma, and abuse (J10, health/social care professional). Creating safe and inclusive refugee services for QASaR, however, is complex due to the fragmented funding for formal and informal organizations that compose these services. As J10 elaborated: '*often there are systemic gaps where services are very specific, and the clients do not fit under these umbrellas*'. Another health/social care professional, I9, also mentioned that '*services and systems can be ignorant to subtle and less visible forms of abuse, intimidation, and violence*', suggesting that refugee services can cause harms and discrimination towards QASaR who access their services. Overall, the lack of safe queer-inclusive refugee services tends to exacerbate poor mental health among QASaR.

Five key priority areas in Table 4 provide strategies to create safe queer-inclusive refugee services. They indicate the need for systemic and cultural change and specific interventions tailored for QASaR. The highest priority is to provide mandatory training for their staff to support QASaR, additional supervision for those working with QASaR, and a safe feedback and complaint process for QASaR to raise issues about services. Specific interventions, such as free or low-cost

legal services for Queer asylum seekers, support to access education, and QASaR-informed counselling services, are also important. These interventions contribute to develop a sense of self-worth and independence in one's life, thus they can mediate some of the negative influences from the asylum system.

3.2.3 Protective factor: supporting QASaR-led organizations

U21, a QASaR who was also in a policy/funding-related role, emphasized that '*funding and support for LGBTIQ+ refugee-led organisations* [is essential] *as we hold necessary expertise to offer solutions*'. The call for other refugee services to support QASaR-led organizations is important because '*there is no healing without a community*' (O15, QASaR). This emergence of QASaR-led organizations as a key priority area was due to multiple intersecting stigma and discrimination that QASaR faced across Queer, ethnic, and faith-based communities.

Supporting QASaR-led organizations and initiatives, however, is not without its challenges. Considering their significant mental health vulnerabilities, strategies to support QASaR-led organizations need to ensure QASaR are '*not overburdened or traumatised*', and '*are adequately paid for their expertise*' (D4, health/social care professional). These factors are important to avoid shifting the '*burden of change to people with lived experience*' (S19, health/social care professional). This tension between creating a specialized service led by people lived experience and supporting a system to be more inclusive was mentioned by a few other participants. As S19 elaborated, '*both need to happen and maybe this will be the case for some time*'.

Table 4 contains two key strategies to support QASaR-led organizations in leading the development of mental health interventions and organizational changes in other refugee services. In addition, QASaR-led organizations can also function as an advisor for mainstream Queer services to improve their community engagement methods and reduce racism within Queer communities. As QASaR O15 mentioned: '*… all LGBTIQ+ services need to have an advisory board or bicultural workers to bridge this gap*.'

4. Discussion

Our study generates eleven key priority areas to improve QASaR's mental health based on the consensus among the participants. Through the lens of structural violence, these key priority areas suggest QASaR's mental health vulnerabilities are shaped by dehumanizing asylum system and the constraints and gaps in refugee services. Collective actions to develop interventions and systemic advocacy are key to reduce the negative impacts of structural violence. For example, QASaR-led organizations need support to navigate asylum and legal systems, including the policy-making process. Capacity-building interventions in collaboration with community-based legal aid programmes, such as those for asylum seekers and Queer communities, can support QASaR-led organizations in their systemic advocacy efforts while providing legal information and individualized support for QASaR. In Australian context, organizations like Refugee Advice and Casework Service (n.d.) have begun to deliver specialized immigration support for Queer asylum seekers living in the communities in recent years. Ultimately, supporting QASaR-led organizations alongside improving the safety of QASaR in accessing other refugee services are of high priority.

Forcibly Displaced People Network have identified similar priorities from their recent national survey (Cohcrane, Dixson, and Dixson 2023). They also recently launched a free online training on QASaR settlement in Australia for health and social care professionals (Forcibly Displaced People Network, n.d.). As previously described, this type of training is crucial to achieve systemic and cultural change across diverse refugee services. Last but not least, they also recently partnered with a community sponsorship pilot programme to offer better integration support for QASaR (Forcibly Displaced People Network 2024). These examples align with the existing evidence suggesting investment in refugee-led organizations can lead to better impacts and outcomes (Kara et al. 2022). As previous need assessment studies on QASaR in USA and Australia

have highlighted, there are often few or no formal organizations represent and deliver services for them at the local level (Chávez 2011; Noto, Leonard, and Mitchell 2014), further pushing the need for QASaR-led organizations. Considering that participating in support groups for QASaR is already beneficial for their mental health (Reading and Rubin 2011; Logie et al. 2016; Pelters et al. 2022), formalizing the groups into QASaR-led organizations can further deliver a wider range of collective and strategic benefits as suggested in this paper. These benefits include providing alternative yet essential mode of belonging outside of the dominant pressures to assimilate into white-dominated Queer communities (Pelters et al. 2022; Held 2023). In short, QASaR-led organizations are key to dismantle structural violence.

Compared to existing studies that use minority stress framework to understand experiences of poor mental health among Queer migrants and refugees (Di Giuseppe 2020; Fox, Griffin, and Pachankis 2020; Golembe et al. 2021; Yarwood et al. 2022), this study has taken a step further by examining urgent and actionable recommendations for refugee services. This examination was conducted through modified DM, which foregrounded lived experience while drawing from professional and research expertize in synthesizing evidence to inform policy and practice. As such, this study is a significant depart in scientific knowledge production and translation compared to existing literature reviews on QASaR's mental health (Alessi et al. 2021a; Burgess, Potocky, and Aless 2021; Nematy, Namer, and Razum 2022; Yarwood et al. 2022; Rodríguez 2023).

Yet our study also has its limitations. We tried to recruit diverse panels, but the proportion of the sample was over-represented by individuals who were health and social care professionals and born in Australia. Therefore, some parts of our findings were obtained through their experiences of working with QASaR (between 1 and 5 years of working with them—see Table 3). In addition, recruitment was conducted by contacting individuals who showed strong interest in the study when we presented it at organizational meetings and conferences. It is likely that the voices and experiences conveyed in our findings do not entirely capture the complexity of seeking safety in Australia. For example, severely traumatized individuals might not participate in this study to avoid re-traumatization. Some QASaR, particularly those who recently arrived, might also prioritize housing and employment (Chávez 2011) rather than participating in a study where there was lack of remuneration due to the absence of funding. A recent scoping review of DM studies on refugees' social participation in health also report a significant range of sample sizes between 16 and 138 (Larsen, Eriksson, and Hägg Martinell 2021), affirming their participation in research is dependent on uncertainties and insecurities linked to socio-economic conditions. The representativeness of our small sample size can also be difficult to determine because there are no publicly available statistical data on QASaR in Australia.

The attrition rate for the DM questionnaires was also high (52.4%) because of the amount of labour and time needed to participate in this study. Although high attrition rate is not uncommon in health-related DM studies (ranging from 0% to 92%), we acknowledge the use of Internet-based DM and the lack of remuneration might contribute to this attrition rate (Shang 2023). For many participants, the digital process of participating in our study may be too complex. However, participants' genuine and critical qualitative responses still provided nuanced, contextual understanding of the key priority areas. Future DM studies can implement a paper-and-pen follow-up with return envelopes to increase participation (Shang 2023).

5. Conclusion

QASaR are more likely to develop poor mental health outcomes compared to non-QASaR. In Australia, their vulnerability to poor mental health is caused by systemic dehumanization, constraints, and gaps, with the asylum system playing a major role as a source of structural violence affecting their mental health. We, the authors and the participants in this study, call for greater investments in QASaR-led organizations to support their initiatives, improve cultural safety of refugee services, and achieve systemic change.

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Conflict of interest

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