MY LGBTI+ VOICE MATTERS

A Mixed Methods Exploration of the Views and Experiences of **LGBTI+ Mental Health Service Users**

Mental Health Reform
Promoting Improved Mental Health Services

LGBT IRELAND
For Inclusion
For Equality
For Everyone

HSE
Seirbhís Sláinte Níos Fearr á Forbairt
Building a Better Health Service

Mental Health Reform,
Coleraine House,
Coleraine Street,
Dublin 7,
D07 E8XF

Telephone: (01) 8749468
Email: info@mentalhealthreform.ie
Facebook: mentalhealthreform
Twitter: @MHReform
Instagram: @mhreform

CHY: 19958
COMPANY NO: 506850
RCN: 20078737

LGBT Ireland,
80 Dame Street,
Dublin 2,
D02 RH42

Telephone: (01) 6859280
Email: info@lgbt.ie
Website: LGBT.ie
Twitter: @LGBT_ie
Instagram: @lgbtireland_ie

CHY: 22036
COMPANY NO: 605384
RCN: 20159672

Mental Health Reform
Promoting Improved Mental Health Services

LGBT IRELAND
For Inclusion
For Equality
For Everyone

HSE
Seirbhís Sláinte Níos Fearr á Forbairt
Building a Better Health Service

TABLE OF CONTENTS

LIST OF TABLES

Main Report:

LIST OF FIGURES

Executive Summary:

Main Report:

LIST OF ABBREVIATIONS

AVFC ..... A Vision for Change

CPI ..... College of Psychiatrists of Ireland

GLEN ..... Gay and Lesbian Equality Network

HSE ..... Health Service Executive

ICGP ..... Irish College of General Practitioners

IIMHN ..... Irish Institute of Mental Health Nursing

LGBT ..... Lesbian, Gay, Bisexual, Transgender

LGBTI+ ..... Lesbian, Gay, Bisexual, Transgender, Intersex, plus

MHC ..... Mental Health Commission

OECD ..... Organisation for Economic Development and Cooperation

PSP ..... Psychological Society of Ireland

PTSD ..... Post-traumatic Stress Disorder

STV ..... Sharing the Vision

TENI ..... Transgender Equality Network Ireland

UK ..... United Kingdom

UN ..... United Nations

UNCRPDTENI ..... United Nations Convention on the Rights of Persons with Disabilities

FOREWORD

Michele Kerrigan,
Chairperson
Mental Health Reform

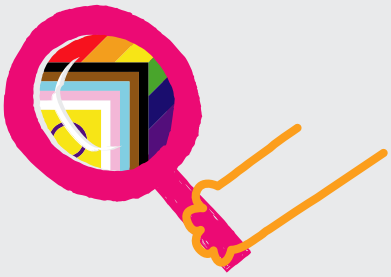
As Chair of Mental Health Reform (MHR), I am delighted to present this important research piece. The voice of people accessing mental health services and supports is central to the work of our members and the work of the coalition. Mental Health Reform (MHR) partnered with LGBT Ireland for this research. The aim was to bring together people from the LGBTI+ community and to research their experiences of mental health services in Ireland. Our objective also is to bring forward clear, concise and achievable recommendations for policy makers and state agencies. MHR is especially delighted to publish this research during Pride month, June 2022.

Ensuring that mental health services and supports are inclusive to the needs of marginalised groups is a policy priority for Mental Health Reform. As part of our My Voice Matters research, published in 2019, it became evident that there was a need for a more in-depth analysis of the experience of people in the LGBTI+ community and mental health services. Mental Health Reform would like to acknowledge the contribution of those who took part in the research, our work is richer with real voices and experiences. We would also like to acknowledge the support of the Health Service Executive (HSE), in particular the Mental Health Engagement and Recovery (MHER) Office.

Members of the LGBTI+ community are recognised as a priority group regarding mental health needs in our National Strategy to Reduce Suicide, Connecting for Life. Therefore, that priority focus has continued to be referenced in our national policy on mental health, Sharing the Vision. We sincerely hope that this research will be used to help inform the changes needed in policy, provision and planning.

Sincerely,

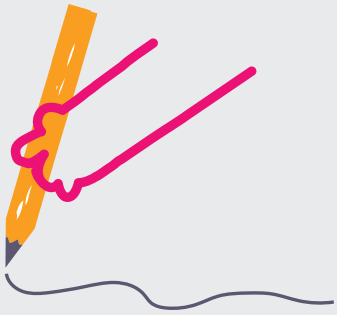
Michèle Kerrigan



..there was a need for a more in-depth analysis of the experience of people in the LGBTI+ community and mental health services..

ACKNOWLEDGEMENTS

Mental Health Reform and LGBT Ireland would like to thank each person who took part in the My Voice Matters and My LGBTI+ Voice Matters projects. We aim to ensure that the findings from this project not only inform the work of our organisations, but also help to inform the provision and improvement of these services so that they better meet the needs of the LGBTI+ community and the diverse groups therein. We would also like to thank all those who worked and advised on the project. These include the staff of Mental Health Reform, Kevin Cullen, Director of the Work Research Centre and Professor Agnes Higgins, Professor of Mental Health in the School of Nursing, Trinity College Dublin. Thank you to all the individuals and organisations who helped to promote and recruit for the project, particularly Keeva Lilith Ferreyra-Carroll, National Community Development Officer for Transgender Equality Network Ireland (TENI) and the Union of Students in Ireland. Finally, we would like to acknowledge the support on the Health Service Executive (HSE) for this project. Although the project was conducted independent of HSE input, it would not have been possible without the funding provided by HSE Mental Health. The financial support shows a commitment to service improvement informed by lived experience.



ABOUT THE AUTHOR

About the Author: Pádraig Ó Féich, PhD, is the former Research Officer in Mental Health Reform.

Citation: Mental Health Reform. *My LGBTI+ Voice Matters: A mixed methods exploration of the views and experiences of LGBTI+ mental health service users* (Dublin: MHR, 2022). https://www.mentalhealthreform.ie/my-voice-matters/

EXECUTIVE SUMMARY

INTRODUCTION

Listening to and building on feedback from people with lived experience of the mental health services is a key mechanism through which services can be developed and improved. However, there has been relatively little research exploring LGBTI+ people's views and experiences of mental health services in Ireland or internationally. For this reason, Mental Health Reform and LGBT Ireland sought to explore the views and experiences of people who identify as LGBTI+ and use mental health service (hereafter referred to as LGBTI+ mental health service users) in an effort to provide insight into how mental health services and supports can better meet their needs. This is a summary of the report which outlines findings from a mixed methods consultation process with LGBTI+ mental health service users.

LGBTI+ Mental Health and Wellbeing

LGBTI+ people face significant challenges not faced by heterosexual cisgender people that can result in additional psychological stress and reduced wellbeing, including institutionalised prejudice, social exclusion, and LGBTI+ related harassment, bullying, and violence. LGBTI+ people are often recognized as a vulnerable group that are at a higher risk of experiencing mental health difficulties than are heterosexual cisgender people due, in part at least, to these additional psychological stresses they experience.[1,2,3] Reflecting this, research has consistently found that mental health difficulties are more common among LGBTI+ people than among heterosexual cisgender people.[4,5,6,7,8]

LGBTI+ people face significant challenges not faced by hetero-sexual cisgender people that can result in additional psychological stress and reduced wellbeing

1 Amos, R. et al. "Mental health, social adversity, and health-related outcomes in sexual minority adolescents: a contemporary national cohort study," Child and Adolescent Health, 4, no.1 (2020): 36-45. https://doi.org/10.1016/S2352-4642(19)30339-6

2 Higgins, A. et al. The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland (Dublin: GLEN & BeLonG To, 2016), p.30. url: https://www.belongto.org/wp-content/uploads/2019/02/250_LGBTIreland_Report_Key_Findings.pdf

3 Mongelli, F. et al. "Minority stress and mental health among LGBT populations: an update on evidence," *Minerva Psichiatrica*, 60, no.1 (2019): 27-50. https://doi.org/10.1080/016396290931614

4 Bariola, E. et al. "Demographic and psychosocial factors associated with psychological distress and resilience among transgender individuals," *American Journal of Public Health*, 105, no.10 (2015): 2108-2116. https://dx.doi.org/10.2105%2FAJPH.2015.302763

5 Ploderl, M. et al. " Suicide risk and sexual orientation: A critical review," *Archives of Sexual Behavior,* 42, no.5 (2013): 715-727. https://doi.org/10.1007/s10508-012-0056-y

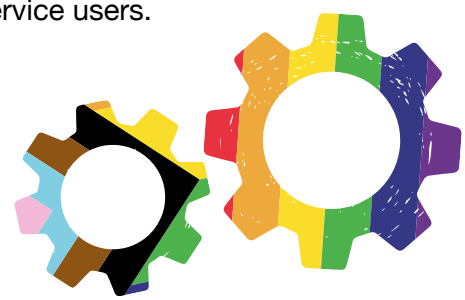
6 Schulman, J.K. & Erickson-Schroth, L. "Mental Health in Sexual Minority and Transgender Women," *The Medical Clinics of North America,* 103, no.4 (2019): 723-733. https://doi.org/10.1016/j.mcna.2019.02.005

7 King, M. et al. "A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people," *BMC Psychiatry*, 8, no.1 (2008): 70. https://doi.org/10.1186/1471-244X-8-70

8 Higgins, *The LGBTIreland Report*

LGBTI+ Mental Health Policy, Strategies and Guidance

Ireland's national mental health policy, *Sharing the Vision* (STV)[9] and its predecessor, *A Vision for Change*,[10] convey a view of modern, inclusive and recovery orientated mental health services that recognise and meet the diverse needs of all service users. Reflecting the heightened risk of mental health difficulties among LGBTI+ people, both documents recognise the LGBTI+ community as an at-risk or priority group, while STV recommends that "the HSE should maximise the delivery of diverse and culturally competent mental health supports throughout all services" (recommendation 61).[11] These policies, are complemented by several important guidance and strategy documents which relate to, and provide guidance on, the delivery of inclusive health and mental health services generally and services that meet the needs of LGBTI+ service users specifically. These include the Mental Health Commission's (MHC) Quality Framework,[12,13] the LGBT Health report,[14] and more recent LGBTI+ national strategies, including the National LGBTI+ Inclusion Strategy 2019-2021[15] and the LGBTI+ National Youth Strategy 2018-2020.[16] Each stress the importance of education, training and guidance for service providers to help them better meet the needs of LGBTI+ people. Reflecting this, several guidance documents for mental health service providers have been produced in recent years, most notably by the Gay and Lesbian Equality Network (GLEN) and the MHC,[17] and by several professional representative bodies representing mental health care providers.[18,19,20,21] Each gives guidance on providing inclusive, welcoming and accessible mental health services and supports that respect the rights, experiences and needs of LGBTI+ service users.



9 Department of Health. *Sharing the Vision: A mental health policy for everyone* (Dublin: Government of Ireland, 2020). url: https://www.gov.ie/en/publication/2e46f-sharing-the-vision-a-mental-health-policy-for-everyone/

10 Department of Health & Children. *A Vision for Change: Report of the expert group on mental health policy* (Dublin: The Stationary Office, 2006). url: https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf

11 Department of Health, *Sharing the Vision,* p.63

12 MHC. *Quality framework: Mental health services in Ireland* (Dublin: MHC, 2007). url: https://www.mhcirl.ie/sites/default/files/2021-01/The%20Quality%20Framework.pdf

13 At the time of writing, the MHC are in the process of updating the Quality Framework with publication due in 2022. It is expected that the updated framework will further strengthen the standards relating to the provision of inclusive mental health services that respect the beliefs, values and experiences of all

14 HSE. *LGBT Health: Towards meeting the health care needs of lesbian, gay, bisexual, and transgender people* (Dublin: HSE, 2009). url: https://www.hse.ie/eng/services/publications/topics/sexual/lgbt-health.pdf

15 Department of Children, Equality, Disability, Integration and Youth, *National LGBTI+ Inclusion*

16 Department of Children and Youth Affairs, *LGBTI+ national youth*

17 GLEN. *Lesbian, gay, bisexual and transgender service users: Guidance for staff working in mental health services* (Dublin: GLEN, 2013). url: https://www.mhcirl.ie/sites/default/files/2021-01/Lesbian,%20Gay,%20Bisexual%20and%20Transgender%20Service%20Users_0.pdf

18 CPI. *Lesbian, gay & bisexual patients: The issues for mental health practice* (Dublin: CPI, 2010). url: https://www.irishpsychiatry.ie/wp-content/uploads/2016/12/Lesbian-Gay-Bisexual-Patients-The-Issues-for-Mental-Health-Practice-Full-doc.pdf

19 PSI. *Guidelines for good practice with lesbian, gay and bisexual clients* (Dublin: PSI, 2015). url: https://www.psychologicalsociety.ie/source/PSI%20Guidelines%20for%20Good%20Practice%20with%20LGB%20Clients_1.pdf

20 IIMHN. *Gay, lesbian & bisexual people: A good practice guide for mental health nurses* (Dublin: IIMGN, 2010). url: https://www.ilga-europe.org/sites/default/files/lesbian_gay_and_bisexual_people_-_a_good_practice_guide_for_mental_health_nurses.pdf

21 ICGP. *Guide for providing care for lesbian, gay and bisexual patients in primary care quick reference guide* (Dublin: ICGP, 2020). url: https://lgbt.ie/wp-content/uploads/2020/11/Guide_for_Providing_Care_for_Lesbian__Gay_and_Bisexual_Patients_in_Primary_Care_Quick_Reference_Guide.pdf

LGBTI+ Mental Health Service User Experiences

There has been relatively little research specifically exploring the views and experiences of LGBTI+ mental health service users. What limited research there has been has found LGBTI+ people are more likely than heterosexual cisgender people to report unfavourable experiences of healthcare generally[22,23] and higher levels of dissatisfaction with mental health services specifically.[24,25,26]

This has been attributed to a variety of factors including health inequalities due to heteronormativity, minority stress, and experiences of bias and discrimination in healthcare settings,[27,28,29] as well as a lack of knowledge about LGBTI+ issues among healthcare professionals.[30,31,32,33] Findings from Irish research, although limited, have been mixed with LGBTI+ participants reporting both positive and negative experiences of mental health care.[34,35,36,37]

.. LGBTI+ people are more likely than heterosexual cisgender people to report unfavourable experiences of healthcare generally..

22 Elliott, M. et al. "Sexual minorities in England have poorer health and worse health care experiences: a national survey," *Journal of General Internal Medicine*, 30 (2015): 9–16. https://dx.doi.org/10.1007%2Fs11606-014-2905-y

23 Thyen, U. et al. "Utilization of health care services and satisfaction with care in adults affected by disorders of sex development (DSD)," *Journal of General Internal Medicine, 29 (2014): 752–759. https://doi.org/10.1007/s11606-014-2917-7*

24 Avery, A. M., Hellman, R.E. & Sudderth, L.K. "Satisfaction with mental health services among sexual minorities with major mental illness," *American Journal of Public Health*, 91, no.6 (2001): 990-991. https://dx.doi.org/10.2105%2Fajph.91.6.990

25 Ellis, S. J., Bailey, L. & McNeil, J. "Trans people's experiences of mental health and gender identity services: A UK study," *Journal of Gay & Lesbian Mental Health*, 19, no.1 (2015): 4-20. https://doi.org/10.1080/19359705.2014.960990

26 Page, E. H. "Mental health services experiences of bisexual women and bisexual men: An empirical study," *Journal of Bisexuality*, 4 (2004): 137-160. https://doi.org/10.1300/J159v04n01_11

27 Thyen, *Utilization of health*

28 Utamsingh, P. et al. "Heteronormativity and practitioner-patient interaction," Health Community, 31 (2016): 566–574. https://doi.org/10.1080/10410236.2014.979975

29 Zeeman, L. et al. "A review of lesbian, gay, bisexual, trans and intersex (LGBTI) health and healthcare inequalities," European Journal of Public Health, 29, no.5 (2019): 974-980. https://doi.org/10.1093/eurpub/cky226

30 Adams, J., McCreanor, T. & Braun, V. "Gay men's explanations of health and how to improve it," *Qualitative Health Research*, 23, no.7 (2013): 887-899. https://doi.org/10.1177%2F1049732313484196

31 Ellis, *Trans people's experiences*

32 McCann, E. & Sharek, D. "Survey of lesbian, gay, bisexual, and transgender people's experiences of mental health services in Ireland," *International Journal of Mental Health Nursing,* 23 (2014): 118-127. doi.org/10.1111/inm.12018

33 Taylor, P. *A survey of LGBT Americans: attitudes, experiences and values in changing times* (Washington, D.C: Pew Research Center, 2013). url: https://www.pewresearch.org/social-trends/2013/06/13/a-survey-of-lgbt-americans/

34 Mayock, P. et al. *Supporting LGBT Lives: The Mental Health and Well-being of Lesbian, Gay, Bisexual and Transgender People in Ireland* (Dublin: GLEN, 2009), p. 110. url: https://www.hse.ie/eng/services/publications/mentalhealth/suporting-lgbt-lives.pdf

35 McCann & Sharek, *Survey of lesbian*

36 McCann, E. & Sharek, D. "Challenges to and opportunities for improving mental health services for lesbian, gay, bisexual, and transgender people in Ireland: A narrative account," *International Journal of Mental Health Nursing*, 23, no.6 (2014): 525-533. https://doi.org/10.1111/inm.12081

37 McNeil, J. et al. *Speaking from the Margins: Trans mental health and wellbeing in Ireland* (Dublin: Transgender Equality Network Ireland, 2013). url: https://lgbt.ie/wp-content/uploads/2018/06/attachment_5bdd0cd5-16b6-4ab6-9ee6-a693b37fdbcf.pdf

My LGBTI+ Voice Matters

Mental Health Reform's My Voice Matters Project[38,39] was the largest and most in-depth consultation with mental health service users and with the family members, friends and carers of mental health service users to be carried out in Ireland to date. Almost 1,200 people with recent experience[40] of accessing secondary or tertiary mental health services in Ireland completed the service user survey. Approximately one in every five participants (19%) identified as members of the LGBTI+ community. This was therefore one of the largest samples of LGBTI+ mental health service users to share their views and experiences of the mental health services in Ireland. Recognising the potential importance of this feedback, HSE Mental Health agreed to fund this My LGBTI+ Voice Matters project, which sought to build on the My Voice Matters survey data by carrying out a series of focus groups with LGBTI+ mental health service users. The My LGBTI+ Voice Matters project aimed to explore the views and experiences of LGBTI+ mental health service users to inform the provision and improvement of services so that they better meet the needs of the LGBTI+ community and the diverse groups therein.

.. Mental Health Reform's My Voice Matters Project was the largest and most in-depth consultation with mental health service users and with the family members, friends and carers of mental health service users to be carried out in Ireland to date..

38 Ó Féich, P. et al. *My voice matters: Report on a national consultation with mental health service users* (Dublin: Mental Health Reform, 2019) url: https://www.mentalhealthreform.ie/wp-content/uploads/2019/03/SU-MAIN-WEB.pdf

39 Ó Féich, P. et al. *My Voice Matters: Report on a national consultation with family, friends and carers/ supporters of mental health service users* (Dublin: MHR, 2019). url: https://www.mentalhealthreform.ie/wp-content/uploads/2019/03/FFCS-MAIN_WEB.pdf

40 Participants were required to have accessed secondary or tertiary mental health services in the two years prior to completing the survey. Survey data were collected between November 2017 and April 2018.

METHODOLOGY

The My LGBTI+ Voice Matters project took a mixed methods approach, using surveys and focus groups. This section gives a brief summary of the methodology used. For more detail, see chapter two of the main report.

Who took part in the Survey?

To take part in the My Voice Matters service user survey, participants were required to be aged 18 years or older and to have had contact with community mental health services, inpatient mental health services, and/or a psychiatrist in the two years prior to completing the survey. 1,188 participants who met the inclusion criteria completed the service user survey. For this project, participants were split into LGBTI+ and non-LGBTI+ participants.

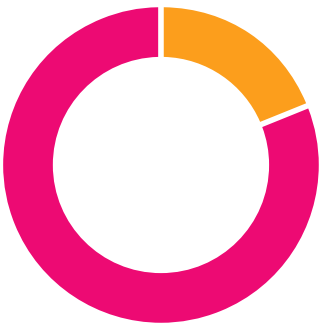
1,127
ALL PARTICIPANTS

215
LGBTI+

912
NON-LGBTI+

What did we do with the Survey Data?

Seven survey items were selected as indicators/proxy indicators of experiential satisfaction with different levels of the mental health services. LGBTI+ participants' responses to these seven items were examined and compared to the responses of non-LGBTI+ participants.



Survey Participant Information ***LGBTI+ PARTICIPANTS***

215
PARTICIPANTS

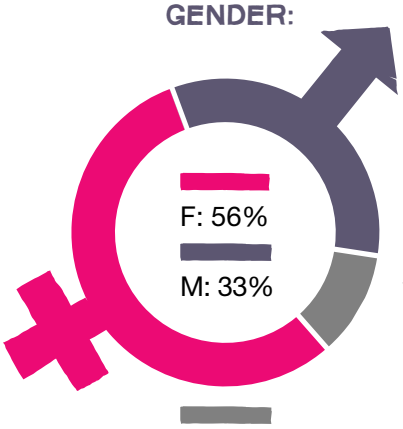
33.1 YRS
AVERAGE AGE

18-68 YRS
AGE RANGE

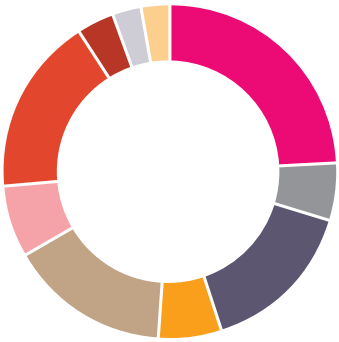
AGE GROUPS:

- 18-25: 37%
- 26-34: 23%
- 35-44: 21%
- 45-54: 14%
- 55-64: 6%
- 65+: 1%

GENDER:



- F: 56%
- M: 33%
- Other: 11%



MAIN DIAGNOSIS OF PERSON BEING SUPPORTED[6]:

- Depression: 27%
- Schizophrenia / Schizoaffective disorder: 6%
- An anxiety disorder: 17%
- Bi-polar disorder: 7%
- Personality disorder: 17%
- 'Other': 8%
- No official diagnosis: 10%
- Post-traumatic stress disorder (PTSD): 4%
- An eating disorder: 3%
- Prefer not to answer: 3%

COMMUNITY HEALTH ORGANISATION (CHO) AREA:

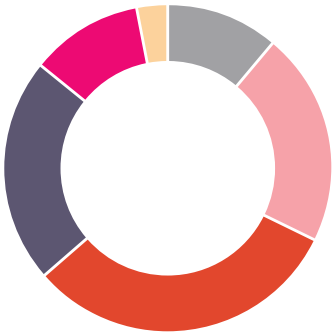
- CHO1: 5%
- CHO2: 12%
- CHO3: 8%
- CHO4: 14%
- CHO5: 8%
- CHO6: 11%
- CHO7: 20%
- CHO8: 6%
- CHO9: 17%

Survey Participant Information NON-LGBTI+ PARTICIPANTS

912
PARTICIPANTS

40.7 YRS
AVERAGE AGE

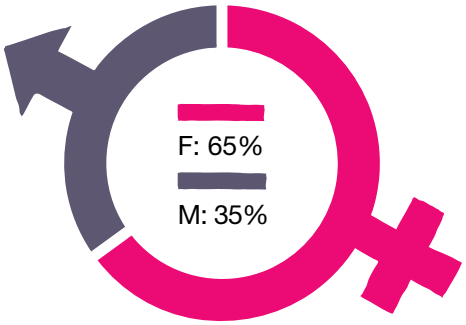
18-76 YRS
AGE RANGE

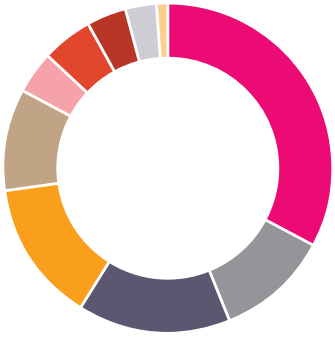


AGE GROUPS:

- 18-25: 11%
- 26-34: 21%
- 35-44: 31%
- 45-54: 22%
- 55-64: 11%
- 65+: 3%

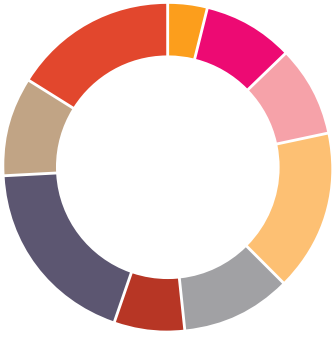
GENDER:





MAIN DIAGNOSIS OF PERSON BEING SUPPORTED[6]:

- Depression: 33%
- Schizophrenia / Schizoaffective disorder: 11%
- Anxiety disorder: 15%
- Bi-polar disorder: 14%
- Personality disorder: 10%
- Other: 4%
- No official diagnosis: 5%
- Post-traumatic stress disorder (PTSD): 4%
- An eating disorder: 3%
- Prefer not to answer: 1%



COMMUNITY HEALTH ORGANISATION (CHO) AREA:

- CHO1: 4%
- CHO2: 9%
- CHO3: 9%
- CHO4: 16%
- CHO5: 11%
- CHO6: 7%
- CHO7: 19%
- CHO8: 10%
- CHO9: 16%

Who took part in the Focus Groups?

People were eligible to participate in the focus groups if they were aged 18 years of age or older, identified as LGBTI+, and had accessed mental health services in Ireland in the last two years. In total 15 people took part in three focus groups: 5 in the first focus group, 6 in the second focus group and 4 in a third transgender specific focus group.

What did we do with the Focus Group Data?

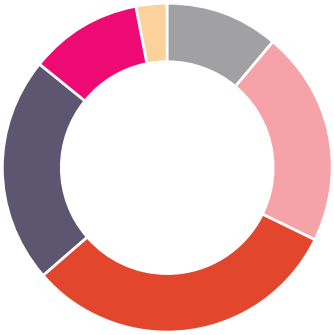
Recordings of the focus groups were transcribed and all identifiable information (e.g. names, place names, etc.) were removed. An exploratory thematic analysis was carried out where the data was closely examined to identify common themes (topics, ideas and patterns of meaning).

Focus Group Participant Information Survey Findings

15
PARTICIPANTS

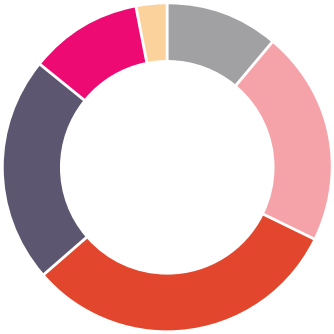
32.9 yrs
AVERAGE AGE

22-46 yrs
AGE RANGE



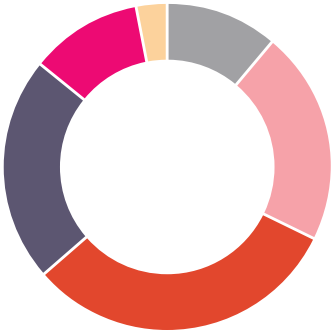
AGE GROUPS:

- 18-25: 20%
- 26-34: 27%
- 35-44: 47%
- 45-54: 7%



GENDER IDENTITY:

- Female: 20%
- Male: 20%
- Cisgender Female: 13%
- Cisgender Male: 13%
- Cisgender: 7%
- Transgender Female: 7%
- Transgender Male: 7%
- Non Binary: 13%



SEXUAL IDENTITY:

- Lesbian: 20%
- Gay: 20%
- Bisexual: 13%
- Queer: 13%
- Asexual: 7%
- Homo-sexual: 7%

SURVEY FINDINGS

LGBTI+ and non-LGBTI+ participant responses were compared graphically and using appropriate statistical procedures. All percentages were rounded to the nearest whole number so may not sum to exactly 100%. Statistically significant findings (p<.05) or findings approaching significance (p<.10) are noted.

Overall satisfaction

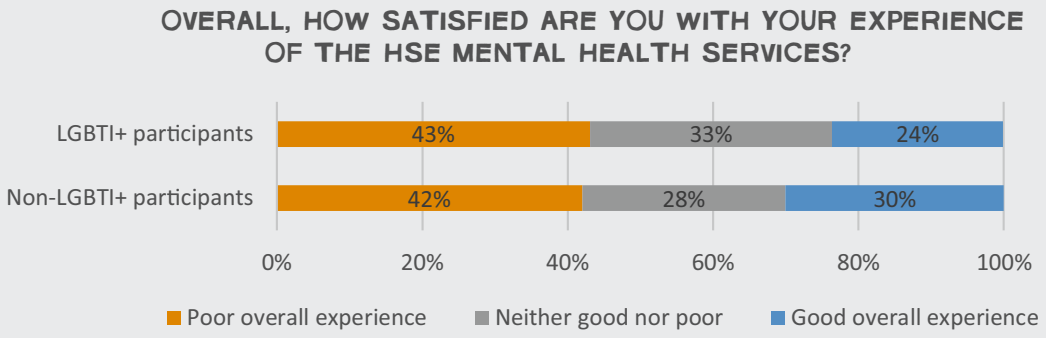


Figure 1: Overall satisfaction compared.

Psychiatry Services

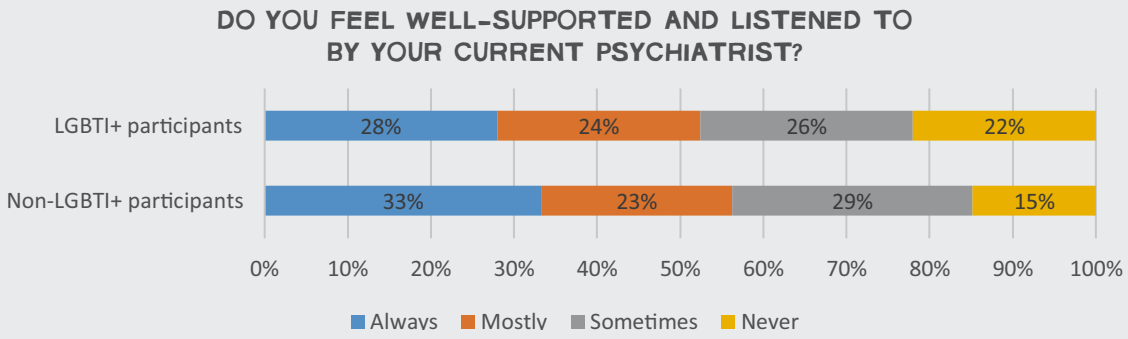
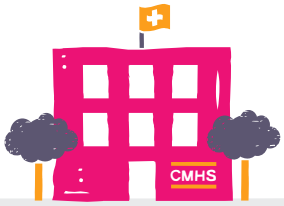


Figure 2: Feeling well-supported and listened to by current psychiatrist compared.[41]

41 This difference approached statistical significance, U=49299.00, z=-1.66, p>.05 (p=0.97).

Community Mental Health Services



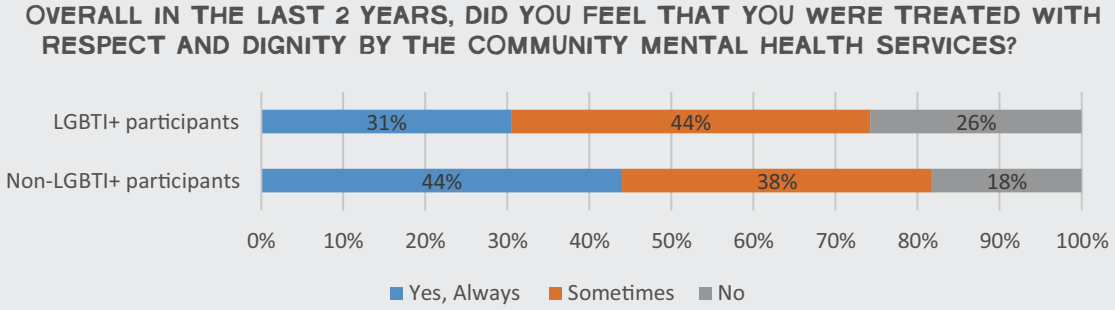


Figure 3: Being treated with respect and dignity by community mental health services compared.[42]

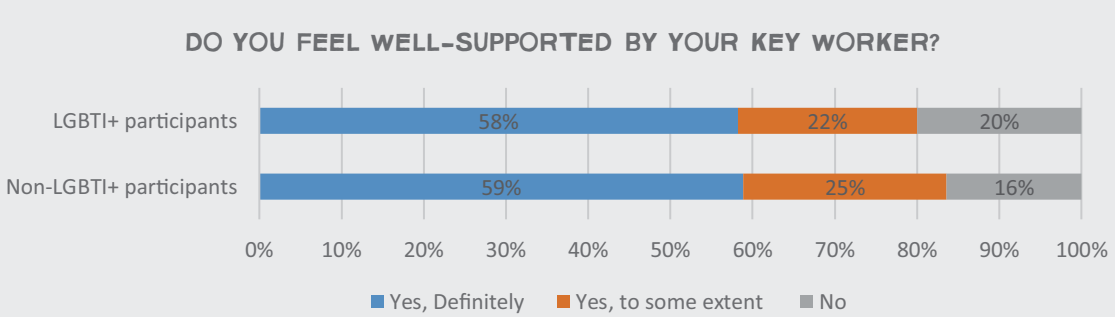
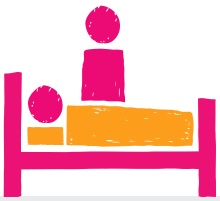


Figure 4: Feeling supported by a key worker compared.

42 This difference was statistically significant, LGBTI+ Mdn: 2.0; Non-LGBTI+ Mdn: 2.0; U=38493.0, z=-3.134, p<.01, r=-.11.

Inpatient Services



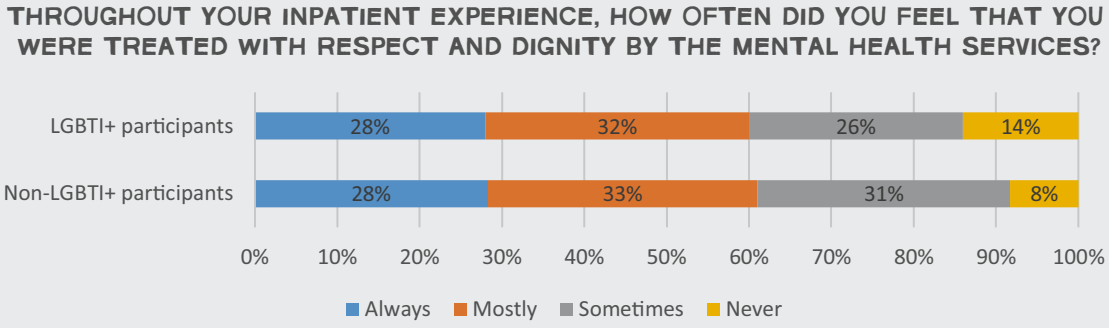
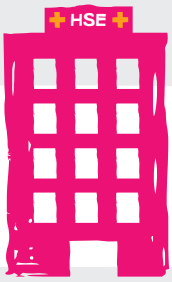


Figure 5: Being treated with respect and dignity by inpatient mental health services compared.



Primary Care

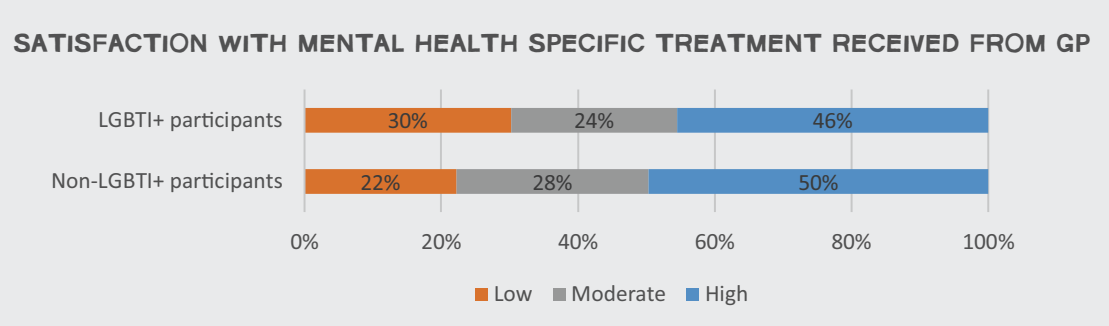


Figure 6: Satisfaction with mental health specific care from GP compared.43

43 This difference approached statistical significance, U=49299.0, z=-1.66, p>.05 (p=0.87).

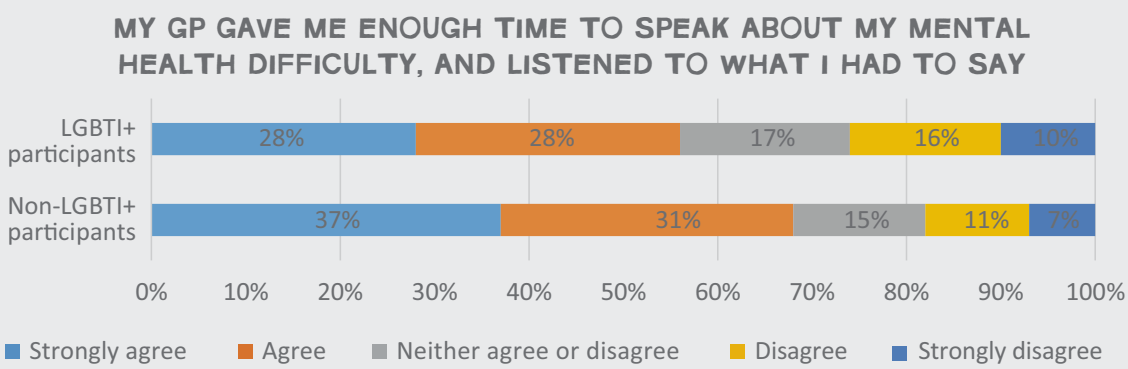


Figure 7: Listened to by GP compared.[44]

44 This difference was statistically significant, LGBTI+ Mdn: 4.0; Non-LGBTI+ Mdn: 4.0; U= 59808.5, z=-3.071, p<.01, r=-.10.

FOCUS GROUP FINDINGS

Five main themes relating to LGBTI+ mental health service users' views and experiences of mental health services were identified. These were as follows: *LGBTI+ Competence and Sensitivity*; *Access; Treatment and Care*; *Transition/Gender Affirmation and the Mental Health Services*; *and Service Improvements*. As indicated in Figure 8 below, all themes related in some way to LGBTI+ competence and sensitivity. Also as indicated in Figure 8, ways to improve services which related to each theme were raised by participants. More detailed findings are available in the main report.

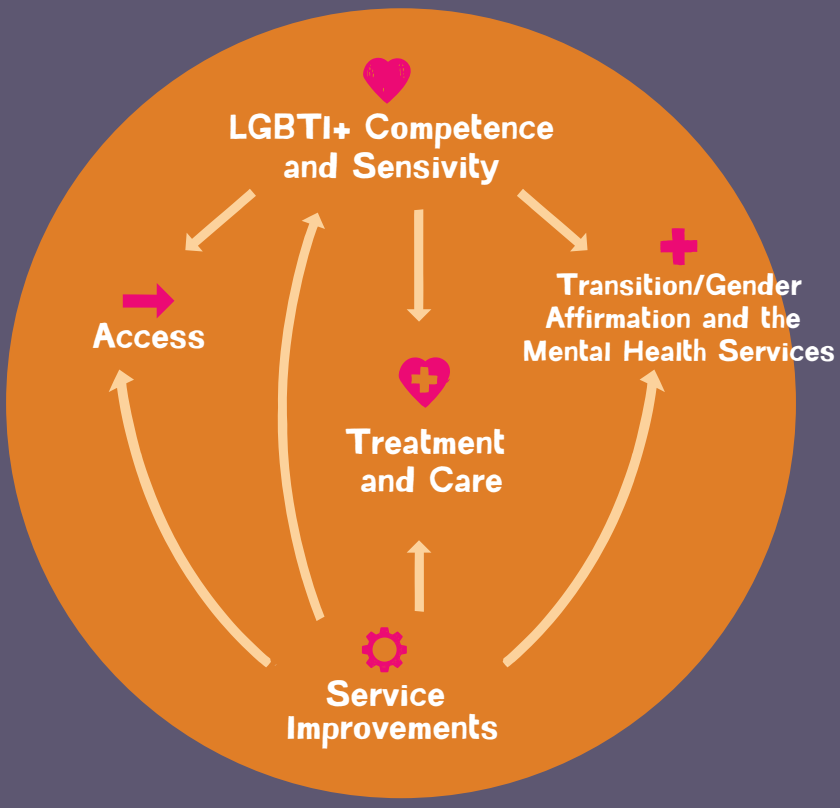


Figure 8: Thematic Map

LGBTI+ Competence and Sensitivity

A major theme identified in this analysis was the importance of LGBTI+ Competence and Sensitivity in mental health service delivery. Two subthemes which provide additional insight were identified. These were as follows: *Need to Explain, Teach and Self-Censor* and *LGBTI+ Competence and Service User Experience.*

Need to Explain, Teach and Self-Censor

Consequences of a lack of LGBTI+ knowledge and competence among some mental health professionals were identified by participants. These included the need to explain their gender and/or sexual identities to mental health professionals, to teach mental health professionals about LGBTI+ issues and terminology, and to self-censor in relation to what and how they share when engaging with mental health professionals and the mental health services more broadly. These placed additional strain on LGBTI+ service users. Many described the need to explain, teach and/or self-censor as time-consuming, tiring and difficult. Participants also described having to teach mental health professionals about their sexual and/or gender identities and other LGBTI+ issues as a common experience. Some participants saw benefits for themselves and/or future LGBTI+ service users. Others saw this as inappropriate and unacceptable.

"the constant explaining yourself, the constant altering and the way that you talk to try and, like, get them to understand you. Like, it just kind of adds to all of the points about the efforts and mental strain that you don't wanna [sic.] be taking on at a time that you are, like, not mentally at your best." **P07 FG2**

"sometimes that being able to teach them is a good thing because that means that at least you can get what you need." **P12 FG3**

"I'm just telling her this so that the next time she comes across an LGBT person, she'll have a better sense of what to do. So certainly, I'm looking out for her potential and hypothetical other patients, um, which is kind of a-a-an-an-a weird position" **P08 FG2**

"I find it completely and utterly unacceptable for the clients to be teaching the mental health professional anything … the expectation that we should take on the emotional work of teaching them is the last thing I want to do. That will make me get up and leave the therapy room if the therapist wants me to teach them anything about transness [sic.]" **P13 FG3**

LGBTI+ Competence and Service User Experience

Participants' experiences of mental health services and supports varied considerably. The LGBTI+ knowledge, competence and sensitivity of mental health professionals appeared to be a significant moderating factor in the quality of experience. Participants who spoke positively of their engagement with the mental health services often praised specific mental health professionals and regularly referenced their level of LGBTI+ knowledge, competence and sensitivity. For some, LGBTI+ knowledge was not essential provided that mental health professionals were open, accepting and willing to learn. By contrast, participants who spoke negatively about their engagement with mental health services regularly referenced the perceived lack of LGBTI+ knowledge, competence and sensitivity. Some spoke about the lack of knowledge displayed by some professionals, while others described inappropriate questions and comments from some mental health professionals. Reflecting the extent to which levels of LGBTI+ competence and sensitivity can influence the quality or nature of experience, many participants spoke of the need to find "the right person" to help them, how difficult this can be and expressed a preference for mental health services and supports recommended to them by LGBTI+ organisations and/or community members.

"she was incredible. She was incredibly understanding. She knew a lot about being LGBT. There was never any kind of, like, anything you said to her didn't surprise her. She was a lifeline. I couldn't say enough about how wonderful she was."
P09 FG2

"the threat [is] *the kind of the lack of mental health professionals that have knowledge on our community because there's a lot of unintended-like, unintended issues that can arise from people making assumptions about a community rather than listening or, you know, being kind of, like, patient-informed."* **P06 FG2**

""she said that people who are non-binary or don't identify within the binary are out of touch, they've had trauma and they're having this dissociative thing with their identity. I just thought, "Jesus." It feels like she got no education in trans or queer matters … she didn't even know some of the basic terms for different transgender things." **P14 FG3**

"when I started my transition … I went to a psychologist in [names Irish county]*, I paid him a fistful of money and it was ridiculous, it was insulting. I was asked things like, 'I see that you're wearing jeans today, do you ever wear skirts or dresses?', 'When you go into the bathroom, do you sit down or do you stand up?' I was just sitting there, I just couldn't wrap my head around this. You're a professional and these are the questions that are going to determine my gender for you?"* **P13 FG3**

"it's made me go more towards services that have been approved by other trans people, or that are somehow connected to TENI [Transgender Equality Network Ireland]*, say, or LGBT Ireland just because I think so many people have had negative experiences that you go for ones that are safe to say or have been approved by others."* **P14 FG3**

Access

Participants spoke of the difficulties they experienced when accessing or attempting to access mental health services and supports. The subthemes *Service-Level Barriers to Access* and *Individual-Level Barriers to Access* were identified.

Service Level Barriers to Access

Participants identified waiting lists as a significant barrier to accessing mental health services. Some linked lengthy waiting lists to what they perceived as insufficient staffing levels in the services, while others spoke of the negative impact and potential dangers of long waiting lists. Participants also shared the difficulties they experienced getting referrals to mental health services. The geographical location of services was also identified as a significant barrier to access. This was particularly challenging for service users from more rural parts of the country and could result in considerable logistical and financial difficulties. Finally, the financial cost of accessing mental health services, both public and private, was raised as a significant barrier by participants.

"waiting lists, the delays in-in getting seen … that's a life, that's-that's-that's a risk to life. That's what that is. And it's not given the, um, seriousness that it needs to be given." **P01 FG1**

"the root of all of that is that there aren't enough, like, doctors or therapists to see everybody who needs to be seen. And if you fixed that, it would be a lot easier to access the services." **P07 FG2**

"part of the problem with the effort of accessing [mental health services] *it is that you need to talk to your GP to get a referral to talk to somebody- to get a referral to talk to somebody who might see you in three to six months. And it's just exhausting to have to keep all of that up."* **P07 FG2**

"the hardest barrier has been both cost and geographic location. Um, for example, when I had a really difficult time with my eating disorder, I was told there was only one psychiatric hospital that deals with that, and it is a private hospital in Dublin … I can't afford this [appointment] *and I can't get to this despite needing it."* **P06 FG2**

Individual-level Barriers to Access

For a number of participants stigma surrounding mental health and/or their LGBTI+ identities was considered a barrier to accessing the mental health services. The former feared being perceived as weak and being judged by others. The latter spoke of their reluctance to openly discuss their sexual and/or gender identities with mental health professionals, while some described feeling apprehensive and even fearful when doing so. Finally, it was noted by some participants that an individual's mental health can exacerbate difficulties accessing or attempting to access mental health services.

"it took me that long to actually step up and look for help … I think it was the fear of being seen to be weak or I-I'm not sure. But like [names participant]*, it was sort of suicidal ideation* [resulted in help seeking]*"* ***P01 FG1***

"I'm always still that bit nervous kind of when you have to come out [to a mental health professional]. *Whether it's you're directly saying it, or whether you're kind of correcting an assumption that someone has made … I'm kind of scared."* **P06 FG2**

"the amount of effort that you have to go through when you're in the position least able to put an effort to do anything. I can't get up off the floor, let alone, call my doctor 10 times … it's mostly been the jumping through hoops, and calling 12,000 times, the effort, um, when I was too depressed to get out of bed." **P08 FG2**

"just because your patient is LGBT doesn't mean that all of their issues is [sic.] *because they are LGBT … it's frustrating."* **P07 FG2**

"this phrase that's called like trans broken arm syndrome, it's a phrase from like the community where no matter what is ailing you, the reason you're having this problem is because you're trans." **P06 FG2**

"I was early on in working out my identity. She [mental health professional] *was very apprehensive. She wasn't encouraging at all. She was very almost conservative at the idea of me coming in terms of being trans. She kept suggesting it was other things like trauma, depression, et cetera."* **P14 FG3**

Treatment and Care

Participants raised issues with the treatment and care they have received from the mental health services generally and from some mental health professionals specifically. Three subthemes were identified: *LGBTI+ Specific Issues*, *Non-LGBTI+ Specific Issues*, and the *Role of Charity and Voluntary Supports*.

LGBTI+ Specific Issues

Many participants raised concerns about the tendency among some mental health professionals to pathologise their LGBTI+ identity by attributing their mental health difficulties to their LGBTI+ identity. A minority of participants spoke about the reverse, where a person's LGBTI+ identity was attributed to their mental health difficulties.

Non-LGBTI+ Specific Issues

Participants raised concerns about the lack of continuity of care. These participants spoke about the excessive staff rotation and the strain this places on service users. Participants also raised concerns about the use of medication as the primary method of treatment and about the lack of long-term talk therapy which encourages a triage approach to therapy.

"There's these different doctors cycling in all the time. You have to go in and explain everything from the very beginning. And one person will be amazing and the next person will tell you to get over it and you're just like, "What?" So you can't even like mentally prepare yourself to go in." **P06 FG2**

"all he wanted was to put me for the medication. And so there was no support necessarily there" **P01 FG1**

"bouts of six sessions [of talk therapy] *that were covered through organisations, or through my work health insurance, or through jigsaw, or through the HSE. And it was very much like, 'How can we fix the immediate problems?' and kind of just glossing over everything else."* **P06 FG2**

Role of Charity and Voluntary Supports

Many participants recognized the role played by charity and voluntary organisations in the sector. Some described how they accessed mental health supports through charity and voluntary organisations when they were experiencing difficulties accessing public or private mental health services. Others emphasized the importance of the work of these organisations in filling gaps in service provision and providing support to those in need.

"I tried to access the same service on those emails and phone in four months because I could feel myself slipping and I'm still waiting on response from that service. And it was a HSE service at the time, or it is a HSE service. So I ended up going through the My Mind service because it was the only way, I knew I was- I was really getting very bad" **P01 FG1**

"charities carry I think so much. They are really the backbone for a lot of us, I think, not everyone, obviously. But it's a huge amount of work that doesn't get recognized by the government … if it goes under, it means it's a service completely lost to a group of people." **P09 FG2**

Transition/Gender Affirmation and the Mental Health Services

Members of the transgender community are required to access mental health services to receive a referral and/or a diagnosis of gender dysphoria to access certain gender affirmation services. This is referred to as the diagnostic model of transition care. For some, accessing gender affirmation services was their sole reason for engaging with mental health services. Those transgender participants who were also engaged with the services due to a mental health difficulty expressed concern that their mental health difficulty could delay access to gender affirmation services. Some participants viewed the diagnostic model of care as problematic. They raised concerns about how difficult the system was to navigate and the potentially detrimental impact this has on the mental health and well-being of those seeking to access gender affirmation services. Others also questioned the validity of gender dysphoria as a diagnosis. Frustration with the diagnostic model was such that participants stressed the need for change.

"I'm on the [Autism] *spectrum, I've heard desperate things about people being denied care because of it and I just have this fear that I'm going to get there after all these years of waiting, and they're going to deny me based on that."* **P15 FG3**

"the fact that the mental health services [are] *part of our transition is the problem, these things are not connected … they're continuing on this outdated model of pathologising our gender identity … psychologists who are put in place standing between us and our autonomy. We have to pay them so that they can decide we're womanly or manly enough."* **P13 FG3**

"We don't run this system, we don't make the rules, you do. We're suffering from them. If you care, change them." **P13 FG3**

Service Improvements

Ways in which the mental health services could be improved were regularly raised and discussed by participants. These actions fell into one of the following two subthemes: *LGBTI+ Focused Actions* and *General Actions*.

LGBTI+ Focused Actions

Almost all participants stressed the need for LGBTI+ training and education for mental health services staff. Participants also recognised that numerous LGBTI+ strategies and policies have been developed but expressed concerns about a lack of implementation. Some participants were of the view that having an advocate, perhaps with self-experience of accessing the mental health services, would be beneficial, as would making the inclusivity of services more visible, e.g. LGBTI+ affirmative posters, badges, etc. Finally, some participants expressed the need to move away from the diagnostic model of transition care and towards an informed consent model.

"the community is incredibly diverse and that there needs to be upkeep and training on this." **P09 FG2**

"There's a lot of, like, great plans and great ideas. And in theory, it's really, really, like, patient-focused service user-focused ... And then the actual implementation … implementing it is incredibly difficult to do." **P09 FG2**

"peer support advocates and it's like a new role in the HSE, so somebody who's gone through the mental health services themselves … if you had someone like that … that they would wear a small LGBT rainbow badge." **P05 FG1**

"I think changing eventually to informed consent, that'll fix a lot of issues … Questioning the old systems and maybe even looking abroad to countries where it is more informed consent, that would definitely help. If it works elsewhere, why not get inspiration from them? I think that would definitely help with the waiting lists problem" **P13 FG3**

General Actions

Although participants raised issues such as a shortage of mental health professionals and lengthy waiting lists, many expressed the view that these issues could be addressed by increasing the financial resources available to the mental health services.

"it would be much more helpful for our service users if we get more psychologists, but that means more budgeting" **P09 FG2**

"I realise this is a simplistic solution of like, let's just throw a shit ton more money at the problem, but we really should be just throwing a shit ton more money at the problem." **P07 FG2**

SUMMARY & CONCLUSION

This project serves to highlight potential disparities between the experiences of LGBTI+ and non-LGBTI+ mental health services users. These disparities are very likely due, in part at least, to the additional issues and challenges faced by LGBTI+ mental health service users, not least a perceived lack of LGBTI+ competence and sensitivity among some mental health service providers. Such findings are consistent with previous research in Ireland[45,46,47,48] and internationally.[49,50,51]

The project also highlights the range and diversity of LGBTI+ people's experiences of the mental health services. Some LGBTI+ mental health service users are experiencing mental health service provision that reflects national mental health policy,[52] national LGBTI+ strategies[53,54] and guidance for mental health service staff working with LGBTI+ service users, produced by the HSE[55], by GLEN and the MHC[56] and by professional representative bodies. [57,58,59,60]

However, many LGBTI+ people are not having wholly positive experiences of the mental health services, and some are having predominantly negative experiences.

45 Higgins, *The LGBTIreland Report*
46 Higgins, A. et al. "LGBT+ young people's perceptions of barriers to accessing mental health services in Ireland," *Journal of Nursing Management*, 29, no.1 (2020): 58-67. https://doi.org/10.1111/jonm.1318
47 Mayock, *Supporting LGBT lives*
48 McNeil, *Speaking from the Margins*
49 Avery, *Satisfaction with mental*
50 Ellis, *Trans people's experiences*
51 Page, *Mental health services*
52 Department of Health, *Sharing the Vision*
53 Department Children, Equality, Disability, Integration and Youth, *National LGBTI+ Inclusion*
54 Department of Children and Youth Affairs, *LGBTI+ national youth*
55 HSE, *LGBT health*
56 GLEN, *Lesbian, gay, bisexual*
57 CPI, *Lesbian, gay & bisexual*
58 ICGP, *Guide for providing care*
59 IIMHN, *Gay, lesbian & bisexual*
60 PSI, *Guidelines for good practice*

.. many LGBTI+ people are not having wholly positive experiences of the mental health services, and some are having predominantly negative experiences.

Positive experiences shared by participants were characterised by LGBTI+ competent and sensitive mental health service provision. In contrast, negative experiences were often characterised by a lack thereof which at best, hindered providers' ability to meet the needs of LGBTI+ service users and at worst manifested as inappropriate questions and comments by some mental health service providers, as well as apprehension and even fear among LGBTI+ service users. Having to explain one's gender and/or sexual identities to mental health service providers, to teach mental health service providers about LGBTI+ issues and terminology, and to self-censor when engaging with mental health service providers were common experiences. Stigma relating to, and pathologising of, LGBTI+ identification were also highlighted as challenges LGBTI+ mental health service users could face. These findings are also consistent with previous research. [61,62,63,64]

61 Higgins, *The LGBTIreland Report*
62 Higgins, *LGBT + young people's*
63 Mayock, *Supporting LGBT lives*
64 McNeil, *Speaking from the Margins*

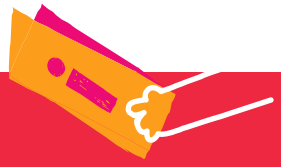
Although the progressive and very welcome policies, strategies and guidance developed in recent years may be having a positive impact for some, the issues and challenges faced by many LGBTI+ mental health service users when accessing or attempting to access mental health services suggest that implementation of these policies, strategies and guidance may be limited and inconsistent.

Taken together, findings not only highlight the considerable scope for improvement so that mental health services in Ireland can better meet the needs of all LGBTI+ people, they also provide guidance to decision makers on how best this can be achieved. This guidance is consistent with national mental health policy, with LGBTI+ National Strategies, and with professional guidance for those working with LGBTI+ service users. There are many steps that can be taken but, at a minimum, building the capacity of mental health service providers through education and training, coupled with regular consultation with LGBTI+ mental health service users to evaluate progress, is key to the delivery of LGBTI+ competent and sensitive mental health services that meet the needs of LGBTI+ people.

**For a more detailed discussion of the findings, see chapter five of the main report.*

.. findings highlight the considerable scope for improvement so that mental health services in Ireland can better meet the needs of all LGBTI+ people..

RECOMMENDATIONS



LGBTI+ Competent and Sensitive Service Provision

1. Review and update policies, procedures, and practice to ensure that services are inclusive of, and responsive to, the needs of LGBTI+ mental health service users.

2. Professional bodies and service providers including the HSE integrate LGBTI+ issues into the curriculum across all training and professional development modules, where possible.

3. Build the LGBTI+ capacity of mental health service providers through accredited education, training and professional development opportunities for existing mental health service providers and LGBTI+ modules for mental health professional providers in training.

4. LGBTI+ educational resources, training and development courses and modules should be developed in consultation with LGBTI+ mental health service users and should at a minimum cover the following:
    a. Sexual orientation, gender identity and LGBTI+ terminology
    b. Research on LGBTI+ mental health and well-being and the relationship between LGBTI+ identification and mental health
    c. The diversity within the LGBTI+ community in terms of identity, experience and need.

5. Review and update professional/good practice guidelines for mental health service providers working with LGBTI+ people. This should be done regularly and in consultation with LGBTI+ mental health service users.

6. Raise awareness of where LGBTI+ competent supports can be accessed. Information should be available on mental health professionals who are experienced in the intersectionality of issues facing people with mental health difficulties.

Treatment and Care

1. HSE Mental Health Services should aim to provide a range of treatment and care options including alternatives to medication where requested.
2. HSE Mental Health Services should ensure that talking therapy is a core component of the service offering and is readily available on an extended basis where necessary.
3. HSE Mental Health Services should provide LGBTI+ friendly reading material, literature and resources, including information on local LGBTI+ services and supports.
4. HSE Mental Health Services should ensure that LGBTI+ mental health service users get the opportunity to develop consistent relationships with mental health professionals that are not subject to frequent change.

Research and Evaluation

1. Given the findings in relation to the model of care, a more in-depth review of the transition model of care should be conducted and should include experiences of service-users.
2. Regular consultations with LGBTI+ mental health service users should be carried out. Where this is part of a larger consultation with mental health service users, an LGBTI+ module should be included in the larger survey. This would facilitate ongoing improvement of services and priority setting by the Minister with responsibility for Mental Health, Department of Health and HSE for annual service plans. This would also be consistent with policies, strategies and guidance outlined in this report and Ireland's obligations under the UNCRPD (see section 1.5).

1. Introduction

1. INTRODUCTION

Listening to and building on feedback from people with lived experience of the mental health services is a key mechanism through which services can be developed and improved. However, there has been relatively little research exploring LGBTI+ people's views and experiences of mental health services in Ireland or internationally. For this reason, Mental Health Reform and LGBT Ireland sought to explore the views and experiences of people who identify as LGBTI+ and use mental health services (hereafter referred to as LGBTI+ mental health service users) in an effort to provide insight into how mental health services and supports can better meet their needs. This report describes findings from a mixed methods consultation process with LGBTI+ mental health service users. Secondary analysis of data from Mental Health Reform's My Voice Matters National Consultation with Mental Health Service Users,[65] coupled with a series of focus groups, were used to explore LGBTI+ people's views and experiences of using primary, secondary and tertiary mental health services in Ireland. This section will provide background for this report by briefly introducing relevant research on LGBTI+ Mental Health, related policy and guidance in Ireland and findings from previous work examining LGBTI+ people's views and experiences of health and mental health services in Ireland.

1.1: Note on Terminology

The acronym LGBTI+ is used throughout this report unless referring to a particular group within this community. Also, in the My Voice Matters survey, LGBTI+ identification was established using a single 'tick all that apply' question that listed gender identifications and sexual orientations. As a result, a number of participants selected multiple LGBTI+ identities, e.g. bisexual and transgender, bisexual and other LGBTI+ identity. This, coupled with the relatively small number of participants in some LGBTI+ groups, meant that the views and experiences of particular LGBTI+ groups could not be explored. However, this report recognises the diversity of the LGBTI+ community, that LGBTI+ people are not one homogenous group and that "the experiences of LGBTI people are very different to one another, not least with respect to their mental health".[66] This report also acknowledges that there are different views on the terms used to describe a person who uses the mental health services. Often terms such as "service user" "the person", "the individual" or "someone who uses the mental health services" are used. In order to be consistent, concise and clear, the term "service user" has been selected for the purposes of this report and is used throughout.

65 Ó Féich, *My Voice Matters* (service user consultation)

66 Higgins, *The LGBTIreland Report,* p.30

1.2: LGBTI+ Mental Health and Well-being

LGBTI+ people face significant challenges not faced by heterosexual cisgender people that can result in additional psychological stress and reduced well-being. These can include difficulties experienced when coming out in a hostile or oppressive environment and minority stress due to direct and indirect discrimination e.g. in the form of institutionalised prejudice, social exclusion, and LGBTI+ related harassment, bullying, and violence.[67, 68, 69, 70, 71, 72] Discrimination, harassment and violence targeting LGBTI+ people is an issue world-wide.[73, 74] However, the prevalence of these challenges varies within this diverse community and can be even more pronounced for LGBTI+ young people as they manage a stigmatized identity, navigate heteronormative education systems and encounter harassment, bullying and violence.[75, 76, 77, 78, 79]

In Ireland, despite considerable progress in the civil and legal rights of LGBTI+ people culminating perhaps most notably in the legalisation of same-sex marriage by public vote in 2015, many LGBTI+ people have faced considerable challenges as a result of direct and indirect discrimination. Higgins et al.'s LGBTIreland study,[80] the largest study to examine the mental health and well-being of LGBTI+ people in Ireland, found that experiences of harassment, bullying and violence were all too common among LGBTI+ people. A large majority of respondents (75%) reported being verbally hurt by others due to being LGBTI+, considerable proportions reported experiencing bullying and harassment at school (48%), college (15%), and at work (17%) because of their LGBTI+ identity, while approximately one in five (21%) reported being physically attacked due to being LGBTI+. Similar findings highlighting the prevalence of these experiences have been reported by previous large scale surveys of LGBTI+ people in Ireland.[81]

Reflecting the diversity of the LGBTI+ community, discrimination, harassment and violence are not homogenously experienced across the different LGBTI+ groups. For example, the LGBTIreland study found that gay male, transgender and intersex participants were more likely to report that they had been hurt verbally (80%, 79% and 79% respectively), threatened with physical violence (42%, 41% and 36% respectively), and physically attacked (29%, 24% and 24% respectively) than were lesbian and bisexual participants.[82] For more detailed information on experiences of harassment and violence by LGBTI groups, see Figure 1.

67 D'Augelli, A. R. "Developmental and Contextual Factors and Mental Health Among Lesbian, Gay, and Bisexual Youths," in *Sexual orientation and mental health: Examining identity and development in lesbian, gay, and bisexual people. Contemporary perspectives on lesbian, gay, and bisexual psychology*, ed. A. R. D'augelli, A. M. Omoto, & H. S. Kurtzman (Eds.), Washington, DC, US: American Psychological Association, 2006.

68 David, S., & Knight, B. G. "Stress and coping among gay men: Age and ethnic differences," *Psychology and Aging, 23*, no.1 (2008): 62–69. doi.org/10.1037/0882-7974.23.1.62

69 Higgins, *The LGBTIreland Report*

70 Kuyper, L. & Fokkema, T. "Minority stress and mental health among Dutch LGBs: examination of differences between sex and sexual orientation," *Journal of Counselling Psychology,* 58, no.2 (2011): 222-233. doi.org/10.1037/a0022688

71 McCann & Sharek. *Survey of lesbian*

72 Mongelli, *Minority stress*

73 Alden, H.L. & Parker, K.F. "Gender Role Ideology, Homophobia And Hate Crime: Linking Attitudes To Macro-Level Anti-Gay And Lesbian Hate Crimes," *Deviant Behaviour*, 26, no.4 (2005): 321-343. https://doi.org/10.1080/016396290931614

74 Rothman, E. F., Exner, D., & Baughman, A. L. "The Prevalence of Sexual Assault Against People Who Identify as Gay, Lesbian, or Bisexual in the United States: A Systematic Review," *Trauma, Violence, & Abuse*, 12, no.2 (2011): 55-66. https://doi.org/10.1177/1524838010390707

75 Hafeez, H. et al. "Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review," *Cureus,* 9, no.4 (2017). https://doi.org/10.7759/cureus.1184

76 Price-Feeney, M., Green, A., & Dorison, S. "Understanding The Mental Health Of Transgender And Nonbinary Youth," *Journal of Adolescent Health*, 66, no.6 (2020): 684–690. https://doi.org/10.1016/j.jadohealth.2019.11.314

77 Rodgers, S. M. "Transitional Age Lesbian, Gay, Bisexual, Transgender, And Questioning Youth: Issues Of Diversity, Integrated Identities, And Mental Health," *Child and Adolescent Psychiatric Clinics of North America*, 26, no.2 (2017): 297–309. https://doi.org/10.1016/j.chc.2016.12.011

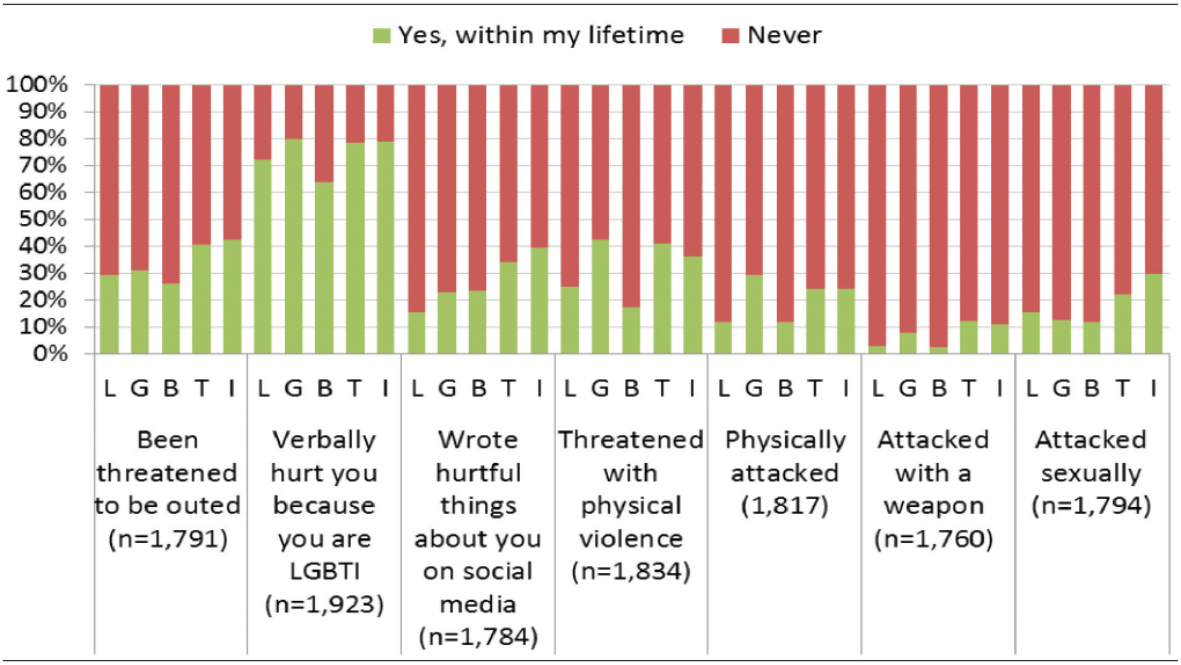
78 Russell, S.T. & Fish, J.N. "Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth," *Annual Review of Clinical Psychology,* 12 (2016):465-487. https://dx.doi.org/10.1146%2Fannurev-clinpsy-021815-093153

79 Wilson, C., & Cariola, L. A. "Lgbtqi+ Youth And Mental Health: A Systematic Review Of Qualitative Research," *Adolescent Research Review*, 5, no.2 (2019): 187–211. https://doi.org/10.1007/s40894-019-00118-w

80 Higgins, *The LGBTIreland Report*

81 Mayock, *Supporting LGBT lives*

82 Higgins, *The LGBTIreland Report*



* Source: LGBTIreland Report (Higgins et al., 2016; p.81)

Figure 1: Experiences of harassment and violence by LGBTI groups

LGBTI+ people are often recognized as a vulnerable group that are at a higher risk of experiencing mental health difficulties than are heterosexual cisgender people due, in part at least, to the additional psychological stresses they experience.[83, 84, 85, 86] In a study of the mental health of LGBTI+ people in England, Chakraborty et al. concluded that discrimination was likely a significant factor affecting mental health for the LGBTI+ population.[87] Similarly, Minority Stress Theory holds that the higher rates of mental health difficulties experienced by LGBTI+ people are due to increased level of social stress, stigma, discrimination, prejudice and victimization.[88] In fact, a recent review of relevant literature concluded that LGBTI+ people face considerable mental health disparities and that mental health outcomes were mediated by levels of minority stressors.[89] Reflecting this, research has consistently found the prevalence of mental health difficulties among LGBTI+ people to be greater than among heterosexual cisgender people.[90, 91, 92, 93] For example, a meta-analysis of findings indicate that depression and anxiety disorders were 1.5 times as prevalent among lesbian, gay and bisexual people, compared to heterosexual cisgender people.[94] International research indicates similar disparities between LGBTI+ and heterosexual cisgender young people. For example, LGBTI+ young people in New Zealand were reported to be three times more likely to express

83 Amos, *Mental health, social adversity*
84 Higgins, *The LGBTIreland Report*
85 Meyer, I. H. "Identity, Stress, And Resilience In Lesbians, Gay Men, And Bisexuals Of Color," *The Counseling Psychologist*, 38, no.3 (2010): 442–454. https://doi.org/10.1177%2F0011000009351601
86 Mongelli, *Minority Stress*
87 Chakraborty, A. et al. "Mental Health Of The Non-Heterosexual Population Of England," *The British Journal of Psychiatry,* 198, no.2 (2010): 143-148. https://doi.org/10.1192/bjp.bp.110.082271
88 Meyer, I.H. "Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence," *Psychological Bulletin,* 129, no.5 (2003): 674-697. https://dx.doi.org/10.1037%2F0033-2909.129.5.674
89 Mongelli, *Minority Stress*
90 Bariola, *Demographic and psychosocial factors*
91 Bolton, S.L. & Sareen, J. "Sexual Orientation And Its Relation To Mental Disorders And Suicide Attempts: Findings From A Nationally Representative Sample," *Canadian Journal of Psychiatry,* 56, no.1 (2011): 35-43. https://doi.org/10.1177/070674371105600107
92 Ploderl, *Suicide risk and sexual orientation*
93 Schulman & Erickson-Schroth, *Mental Health in Sexual minority*
94 King, *A systematic review*

.. intersex participants were found to have the highest mean levels of depression, anxiety and stress, followed in descending order by transgender, bisexual, lesbian/gay female and gay male participants.

symptoms of depression and twice as likely to have self-harmed, compared with their heterosexual cisgender peers.[95] Research by the Mental Health Foundation in the UK found that 40% of LGBTI+ young people reported experiencing mental health difficulties, compared to 25% of heterosexual cisgender young people, with bullying identified as a key factor contributing to their mental health difficulties.[96]

Findings from Irish research are consistent, indicating that LGBTI+ people in Ireland are at a high risk of experiencing mental health difficulties. The Supporting LGBT Lives study[97] from 2009 found that 86% of participants reported experiencing feelings of depression at some point in their life, while two-thirds reported having such feelings in the 12 months prior to completing the survey. More recently, the LGBTIreland study[98] found that almost half (47%) of participants were experiencing some level of depression with one in five (20%) experiencing severe or extremely severe depression, two in every five participants (42%) were experiencing some level of anxiety with almost one in four (23%) experiencing severe or extremely severe anxiety, and a considerable minority (15%) were experiencing severe or extremely severe stress at the time of the survey. In total, the LGBTIreland study found that more than one in three (35%) participants were experiencing severe or very severe depression, anxiety, and/or stress, indicating that mental health difficulties were worryingly prevalent among these LGBTI+ participants.

95 Lucassen, M., Clark, T., Moselen, E., Robinson, E., & The Adolescent Health Research Group. *Youth'12 the health and wellbeing of secondary school students in New Zealand: Results for young people attracted to the same sex or both sexes* (Auckland, New Zealand: The University of Auckland, 2014). url: https://oro.open.ac.uk/43995/1/Same%20Sex%20Report_14NM.pdf

96 Mental Health Foundation. *Mental health in Scotland: fundamental facts* (Mental Health Foundation, 2016). url: https://www.mentalhealth.org.uk/sites/default/files/FF16%20Scotland.pdf

97 Mayock, *Supporting LGBT lives*

98 Higgins, *The LGBTIreland Report*

Differences between LGBTI+ groups in the LGBTIreland study were also evident.[99] For example, intersex participants were found to have the highest mean levels of depression, anxiety and stress, followed in descending order by transgender, bisexual, lesbian/gay female and gay male participants. Reflecting this, the proportion of participants experiencing severe or extremely severe levels of depression, anxiety and stress were highest among intersex participants (depression: 44%; anxiety: 37%; stress: 35%), followed by transgender participants (depression: 33%; anxiety: 35%; stress: 20%) and bisexual participants (depression: 24%; anxiety: 28%; stress: 18%). These findings are in line with international research, which has consistently indicated that mental health difficulties are not experienced homogenously across the LGBTI+ community.[100] For example, bisexual people have been found to be at greater risk of poor mental health compared to lesbian/gay females and gay males,[101, 102] while transgender and non-binary youth were found to be at increased risk of experiencing depressed mood compared to cisgender lesbian, gay, bisexual, queer and questioning young people.[103] These mental health disparities between LGBTI+ groups have been attributed, in part at least, to the unique challenges faced by these different groups, whether it be gender-related stressors such as discrimination, victimization, and exposure to transphobia[104] or 'double discrimination'[105] wherein bisexual people experience discrimination from both the heterosexual population and from within the LGBTI+ population.

Age was also found to be a mediating factor with higher levels of depression experienced by younger cohorts (<35 years). In fact, approximately two-thirds of this age group were found to be experiencing some level of depression (66%) and/or anxiety (69%), with 35% and 43% of 14 to 18-year-old LGBTI+ participants experiencing severe or extremely severe depression and anxiety, respectively.[106] These figures are perhaps more striking when compared with equivalent findings from the most recent wave of the *My World Survey*, the largest and most comprehensive study of the mental health and well-being of young people in Ireland,[107] which found that 15% of adolescent participants (aged 12 to 19 years) were experiencing severe or very severe depression, while 22% were experiencing severe or very severe anxiety. Although not directly comparable, these findings serve to highlight the mental health disparities between LGBTI+ young people and young people in the general population.

99 Higgins, *The LGBTIreland Report*

100 Cochran, S. D. & Mays, V. M. "Burden Of Psychiatric Morbidity Among Lesbian, Gay, And Bisexual Individuals In The California Quality Of Life Survey," *Journal of Abnormal Psychology*, 118, no.3 (2009): 647-658. https://doi.org/10.1037/a0016501

101 Bostwick, W. B., Hughes, T.L. & Everett, B. "Health Behavior, Status, and Outcomes Among a Community-Based Sample of Lesbian and Bisexual Women," *LGBT Health*, 2, no.2 (2015): 121-126. https://dx.doi.org/10.1089%2Flgbt.2014.0074

102 Chan, R.C.H., Operario, D. & Mak, W.W.S. "Bisexual Individuals Are At Greater Risk Of Poor Mental Health Than Lesbians And Gay Men: The Mediating Role Of Sexual Identity Stress At Multiple Levels," *Journal of Affective Disorders,* 260 (2019): 292-301. https://doi.org/10.1016/j.jad.2019.09.020

103 Price-Feeney, *Understanding the mental health*

104 Higgins, *The LGBTIreland Report*

105 Pakula, B. et al. "Life Stress As A Mediator And Community Belonging As A Moderator Of Mood And Anxiety Disorders And Co-Occurring Disorders With Heavy Drinking Of Gay, Lesbian, Bisexual And Heterosexual Canadians," *Social Psychiatry and Psychiatric Epidemiology,* 51, no.8 (2016): 1181-1192. https://doi.org/10.1007/s00127-016-1236-1

106 Higgins, *The LGBTIreland Report*

107 Dooley, B. et al. *My world survey 2: The national study of youth mental health in Ireland* (Dublin: Jigsaw & University College Dublin, 2019). url: http://www.myworldsurvey.ie/content/docs/My_World_Survey_2.pdf

1.3: LGBTI+ Mental Health Policy, Strategies and Guidance

In recent years, there have been significant developments in mental health policy and guidance in Ireland that relates to the provision of mental health services and supports to LGBTI+ mental health service users. Ireland's national mental health policy, *Sharing the Vision* (STV) [108] and its predecessor, *A Vision for Change* (AVFC), [109] convey a view of modern, inclusive and recovery orientated mental health services that recognise and meet the diverse needs of all service users. Reflecting the heightened risk of mental health difficulties among LGBTI+ people, both documents recognise the LGBTI+ community as an at-risk or priority group. AVFC recognised the provision of mental health services for particular groups of people, including LGBTI+ individuals,

"require[s] *specific knowledge and understanding on the part of those delivering mental health services, in terms of their culture and other characteristics …* [and] *require*[s] *professionals who are sensitive to the diversity of human experience and who are able to relate to people from different communities in an open and respectful manner"* [110]

Building on this important step, STV identifies the need for a more developed framework for the implementation of cultural, diversity and gender competency in mental health service delivery and for tailored interventions to meet the needs of priority groups including individuals from the LGBTI+ community. It goes on to recommend that "the HSE should maximise the delivery of diverse and culturally competent mental health supports throughout all services" (recommendation 61).[111]

108 Department of Health, *Sharing the Vision*
109 Department of Health & Children, *A Vision for Change*
110 Department of Health & Children, *A Vision for Change,* p.40
111 Department of Health, *Sharing the Vision,* p.63

These polices are complemented by several important guidance and strategy documents which relate to and provide guidance on the delivery of inclusive health and mental health services generally and services that meet the needs of LGBTI+ service users specifically. These include the Mental Health Commission's (MHC) Quality Framework,[112] the LGBTI+ National Youth Strategy 2018-2020,[113] and the National LGBTI+ Inclusion Strategy 2019-2021,[114] as well as several guidance documents for health and mental health professionals, produced by the Health Service Executive (HSE),[115] the Gay and Lesbian Equality Network (GLEN) in partnership with the MHC[116] and several professional representative bodies.

The MHC's Quality Framework[117] provides guidance to service users, their family, carers and/or supporters, and to service providers on the standards expected in the public mental health services. Published shortly after AVFC, it was stated that both documents "share[d] a common vision for mental health services".[118] Echoing AVFC, several of the quality framework standards emphasise the importance of providing inclusive and respectful mental health services that are accessible to all.[119] For example, Standards 2.1 and 2.1.6 hold that "service users receive services in a manner that respects and acknowledges their specific values, beliefs and experiences"[120] and that service users receive care that complies with equality legislation and prohibits discrimination on the grounds of background and/or characteristics, including gender and sexual orientation.

112 Mental Health Commission, *Quality Framework*
113 Department of Children and Youth Affairs, *LGBTI+ national youth*
114 Department Children, Equality, Disability, Integration and Youth, *National LGBTI+ inclusion*
115 HSE, *LGBT Health*
116 GLEN, *Lesbian, gay, bisexual*
117 MHC, *Quality Framework*
118 MHC, *Quality Framework*, p.74
119 At the time of writing, the MHC is in the process of updating the Quality Framework, with publication due in 2022. It is expected that the updated framework will further strengthen the standards relating to the provision of inclusive mental health services that respect the beliefs, values and experiences of all.
120 MHC, *Quality Framework*, p.26

Similarly, Standard 5.1.1 holds that equality of access to mental health services should be assured regardless of background and/or characteristics, including the service user's gender and sexual orientation. Note that at the time of writing, the MHC is in the process of updating the Quality Framework, with publication expected in 2022.
Several LGBTI+ specific documents and strategies have been published that have implications for the delivery of LGBTI+ sensitive health and mental health services. In 2009, the HSE published its *LGBT Health* report,[121] which gave an overview of health and social service provision and support for LGBT people in Ireland. This report also identified several health issues faced by the LGBTI+ population, including the high incidence of mental health difficulties, and provided good practice guidelines for service providers working with LGBTI+ individuals. Among the 12 recommendations made in this report were the following: develop and implement training and awareness programmes highlighting LGBT issues and the needs of LGBT people for all HSE staff (recommendation 11) and distribute and promote the LGBT Good practice guidelines for Service Providers (recommendation 12).

More recent LGBTI+ national strategies have also stressed the importance of education, training and guidance for service providers. The National LGBTI+ Inclusion Strategy 2019-2021[122] aims to promote the inclusion, equality, health, and safety of LGBTI+ individuals. A key outcome of this strategy is that "healthcare providers and practitioners are trained to understand the identities and needs of their LGBTI+ patients and to avoid making heteronormative assumptions."[123] Similarly, as part of its goal to create a supportive and inclusive environment for LGBTI+ young people, the LGBTI+ National Youth Strategy 2018-2020[124] states that there should be "capacity building measures among service providers to improve their understanding of, and ability to engage with, LGBTI+ young people" (objective 8).[125] Other objectives of this strategy are to respond effectively to the mental health needs of LGBTI+ young people (objective 11), to improve the physical and mental health of transgender young people (objective 13) and to improve the understanding of, and the response to, the physical and mental health needs of intersex young people (objective 14).

As the *LGBT Health* report[126] and national LGBTI+ strategies indicate, building the capacity of mental health service providers through education, training and guidance is central to meeting the mental health needs of all LGBTI+ people who seek support for a mental health difficulty. Reflecting this, several guidance documents for mental health service providers have been produced in recent years, most notably by GLEN and the MHC,[127] as well as several professional representative bodies representing mental health care providers, such as the College of Psychiatrists of Ireland (CPI),[128] the Psychological Society of Ireland (PSI),[129] the Irish Institute of Mental Health Nursing (IIMHN)[130] and the Irish College of General Practitioners (ICGP).[131] Although these documents vary in length, content and intended audience, almost all were produced in partnership with GLEN[132] and share common themes and guidance. A detailed review of these guidance documents is beyond

121 HSE, *LGBT Health*
122 Department Children, Equality, Disability, Integration and Youth, *National LGBTI+ Inclusion*
123 Department Children, Equality, Disability, Integration and Youth, *National LGBTI+ Inclusion*, p.13
124 Department of Children and Youth Affairs, *LGBTI+ national youth*
125 Department of Children and Youth Affairs, *LGBTI+ national youth,* p.18
126 HSE, *LGBT Health*
127 GLEN, *Gay, lesbian, bisexual*
128 CPI, *Lesbian, gay & bisexual*
129 PSI, *Guidelines for good practice*
130 IIMHN, *Gay, lesbian & bisexual*
131 ICGP, *Guide for providing care*
132 While the original ICGP guidance document was produced with GLEN, this has been updated in partnership with LGBT Ireland. The PSI's *Guidelines for Good Practice with Lesbian, Gay and Bisexual Clients* were not produced in partnership with GLEN.

the scope of this report; however, each gives guidance on providing inclusive, welcoming and accessible mental health services and supports that respect the rights of LGBTI+ service users and do not discriminate based on sexual orientation, gender or marital status. Many highlight the importance of creating a safe environment and using language and questions that are LGBTI+ friendly and do not assume heterosexuality or cisgender identification. They stress the need for knowledge of, and training in, LGBTI+ issues and terminology, and the need to consider LGBTI+ specific stresses where appropriate.

.. Many highlight the importance of creating a safe environment and using language and questions that are LGBTI+ friendly.

1.4: LGBTI+ Mental Health Service User Experiences

The policies, strategies and guidance documents introduced in the previous section recognise the importance of better understanding LGBTI+ issues and experiences and how this can contribute to the development of health and mental health services that better meet the needs of LGBTI+ people. Many stress the importance of research and consultation in this process. For example, the LGBT Report[133] recommended that the "HSE undertake regular research on LGBT health and include LGBT people in population health profiling" (recommendation 9). The National LGBTI+ Inclusion Strategy[134] identifies as a key outcome of the strategy the need for better information on the population and needs of LGBTI+ people in Ireland to support the development of effective policy. Similarly, goal three of the LGBTI+ National Youth Strategy 2018-2020 is to "develop the research and data environment to better understand the lives of LGBTI+ young people".[135] In terms of mental health specifically, STV[136] recommends "regular surveys of service users and family members, carers and supporters should be independently conducted" (recommendation 78), while GLEN/MHC guidance for staff working with LGBTI+ people[137] states that LGBTI+ service users should be consulted in the development and evaluation of services.

There have been some significant and insightful studies that explored the mental health and well-being of the LGBTI+ population in Ireland[138,139] and groups therein.[140] In-depth consultation processes have also been carried out, e.g. when developing the LGBTI+ National Youth

133 HSE, *LGBT Health*, p.88
134 Department Children, Equality, Disability, Integration and Youth, *National LGBTI+ Inclusion*
135 Department of Children and Youth Affairs, LGBTI+ national youth, p.30
136 Department of Health, *Sharing the Vision,* p.108
137 GLEN, *Lesbian, gay, bisexual*
138 Higgins, *The LGBTIreland Report*
139 Mayock, *Supporting LGBT lives*
140 McNeil, *Speaking from the Margins*

Strategy 2018-2020.[141] However, there has been relatively little research specifically exploring the views and experiences of LGBTI+ mental health service users internationally or in Ireland. What limited research there has been has found LGBTI+ people are more likely than heterosexual cisgender people to report unfavourable experiences of healthcare generally[142,143] and higher levels of dissatisfaction with mental health services specifically.[144,145,146] This has been attributed to a variety of factors including health inequalities due to heteronormativity, minority stress, and experiences of bias and discrimination in healthcare settings,[147,148,149] as well as a lack of knowledge about LGBTI+ issues among healthcare professionals.[150,151,152,153]

In Ireland, Supporting LGBT Lives[154] found that participants' experiences of healthcare were diverse, with both positive and negative experiences reported. Where positive experiences were reported, participants regularly referred to "feeling comfortable and confident to disclose their sexual identity without the fear of being judged".[155] However, more than three in every four (77%) participants felt that healthcare professionals needed more knowledge of, and sensitivity to, LGBTI+ issues, a minority (40%) felt respected by their healthcare professional for who they were as an LGBTI+ person, and almost one in four (23%) hid their LGBTI+ identity when dealing with healthcare professionals.

141 Department of Children and Youth Affairs. *LGBTI+ national youth strategy: Report of the consultations with young people in Ireland* (Dublin: Government of Ireland, 2017). url: https://www.drugsandalcohol.ie/28323/1/DOCYA_LGBTIConsultationStrategyReport.pdf
142 Elliott, *Sexual minorities in England*
143 Thyen, *Utilization of health*
144 Avery, Hellman, & Sudderth, *Satisfaction with mental*
145 Ellis, Bailey, & McNeil, *Trans people's experiences*
146 Page, *Mental health services experiences*
147 Thyen, *Utilization of health*
148 Utamsingh, *Heteronormativity and practitioner-patient*
149 Zeeman, *A review of lesbian*
150 Adams, McCreanor, & Braun, *Gay men's explanations*
151 Ellis, *Trans people's experiences*
152 McCann & Sharek, *Survey of lesbian*
153 Taylor, *A survey of LGBT*
154 Mayock, *Supporting LGBT lives*
155 Mayock, *Supporting LGBT lives*, p.109

Findings relating to mental health services and supports specifically were also varied. Participants who had attended their GP due to mental health difficulties reportedly "felt strongly that their circumstances and needs were trivialised or ignored by their doctor",[156] while participants who attended counselling for the most part reported more positive experiences, often characterised by the freedom to disclose sexual and/or gender identities, unbiased and LGBTI+ sensitive practices and skilled and knowledgeable practitioners.
A small number of participants interviewed for the Supporting LGBT Lives study had accessed psychiatric services. The experiences shared by these participants were again diverse, with some reporting sensitive and appropriate treatment. However, "most who had direct experience of the mental health service had little confidence in these systems of intervention with some respondents questioning the quality of care they received".[157] This was most often attributed to a lack of understanding of the needs of LGBTI+ issues among healthcare professionals.

A considerable majority (77%) of participants in the LGBTIreland study[158] felt that there were barriers to them accessing mental health services. The most commonly noted were the cost of accessing private services (39%), fear of stigma or being labelled (29%), the perception that the services were not LGBTI+ friendly (19%) and the view that services couldn't help them (18%). Again highlighting the diversity of experience, there were significant differences between LGBTI+ groups in this regard. For example, bisexual and transgender participants were significantly more likely than lesbian/gay female, gay male and intersex participants to report fear of stigma or being labelled, while transgender and intersex participants were more likely than lesbian/gay female, gay male and bisexual participants to report feeling that mental health services

156 Mayock, *Supporting LGBT lives*, p.110
157 Mayock, *Supporting LGBT lives*, p.114
158 Higgins, *The LGBTIreland Report*

were not LGBTI+ friendly. Other barriers were identified through analysis of participants' open ended responses. These included a perceived lack of training, insufficient awareness and understanding of LGBTI+ identities, issues and challenges, and inappropriate use of language and terminology. Many of these barriers have been identified by previous and subsequent research.[159,160,161]

The Supporting LGBT Lives[162] and LGBTIreland studies[163] are without doubt hugely significant and provide detailed insights into the mental health and well-being of the LGBTI+ community and the diverse groups therein. However, neither aimed specifically to explore LGBTI+ service users' views and experiences of the mental health services in Ireland. Studies like this are particularly rare. A notable exception in Ireland is the LGBT Minds study. Some 125 LGBTI+ people with lived experience of accessing the mental health services shared their views and experiences through surveys and interviews. Reflecting previous research, findings were mixed. For example, a majority (60%) felt comfortable using mental health services as an LGBTI+ person and reported that improvements to their mental health due to the mental health services were fair or good (60%).[164] Some participants who were interviewed also shared their positive experiences with practitioners, which were most often characterised by feeling listened to and being treated with dignity and respect.[165] However, approximately two-thirds of participants (63%) did not feel the mental health services responded to their specific needs as an LGBTI+ person and a similar proportion (64%) felt that mental health professionals lack knowledge about LGBTI+ issues,[166] common issues consistently identified by research internationally.

Although the extent to which this project could explore the mental health service experiences of different LGBTI+ groups was limited, it is important to again note the diversity of experience that exists between LGBTI+ groups and individuals. For example, members of the transgender community face unique challenges not just relating to discrimination and transphobia but also as a direct consequence of the steps/process required to transition in Ireland.[167] Specifically, members of the transgender community are required to access the mental health services to receive a referral and/or a diagnosis of gender dysphoria to access certain gender affirmation services. The Speaking from the Margins study,[168] which explored the mental health and well-being of a sample of 164 transgender people in Ireland, gives some insight into these experiences. Among those who shared their experiences of the mental health services, broadly similar proportions were satisfied (37%) and dissatisfied (34%). Approximately half (48%) had not experienced any negative events when availing of mental health services. However, the most common negative events experienced included being asked inappropriate questions about their sexual behaviour (32%), gender identity (22%) and body (21%), having their gender identity treated as a symptom of their mental health difficulty (37%), and being given advice or suggestions by a mental health provider that felt inappropriate. It should be noted that less than half of participants shared their experiences of the mental health services so these findings should be viewed with caution.

159 Mayock, *Supporting LGBT lives*
160 McCann & Sharek, *Challenges to and opportunities*
161 Higgins, *LGBT + young people's*
162 Mayock, *Supporting LGBT lives*
163 Higgins, *The LGBTIreland Report*
164 McCann & Sharek, *Survey of lesbian*
165 McCann & Sharek, *Challenges to and opportunities*
166 McCann & Sharek, *Survey of lesbian*
167 Mental Health Reform and LGBT Ireland welcome the Review of the Equality Acts, being undertaken by the Minister for Children, Equality, Disability, Integration and Youth, which included requests for consultation on the definition of gender as one of the nine equality grounds. Public consultation closed in December 2021 and next steps are awaited
168 McNeil, *Speaking from the Margins*

1.5: My LGBTI+ Voice Matters

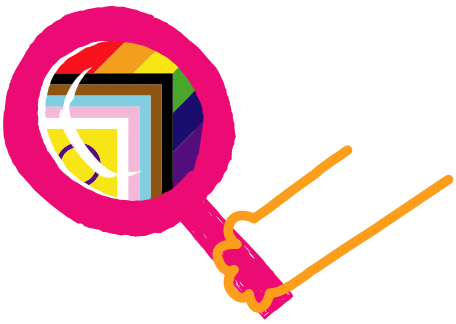
Although research exploring the views and experiences of LGBTI+ mental health service users is rare, consultation processes like these are seen as increasingly important and necessary by national and international bodies.[169,170,171] As noted, listening to and building on feedback from all people with lived experience of the mental health services is a key mechanism through which services can be developed and improved, while article 4.3 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD),[172] which Ireland ratified in 2018, holds that States are obliged to consult disabled persons on issues concerning them, including legislation and policy. People with psychosocial disabilities have rights under the UNCRPD and therefore should be active participants in consultative processes on matters concerning them. Consultations with mental health service users have been conducted in recent years, e.g. as part of the development of AVFC,[173] STV[174] and the MHC's Quality Framework[175] (and as part of the updating of this framework which is ongoing at time of writing), as well as in listening meetings carried out by the HSE Mental Health Division in 2014, However, with some notable exceptions, very little has been published. These exceptions include the Second Opinion report,[176] the MHC's survey on inpatient services[177] and most recently, Mental Health Reform's My Voice Matters National Consultation Project.[178,179]

The My Voice Matters National Consultation Project was the largest and most in-depth consultation with mental health service users and with the family members, friends and carers of mental health service users to be carried out in Ireland to date. Its goal was to assist Government and the HSE in their efforts to improve mental health services in Ireland by providing first hand in-depth feedback from those with lived experience of these services. Reflecting its commitment to listen to the views of people using the mental health services to inform service improvement, the project was fully funded by HSE Mental Health and was carried out independently by Mental Health Reform.

Almost 1,200 people with recent experience[180] of accessing secondary or tertiary mental health services in Ireland took part in the service user consultation survey. Approximately one in every five participants (19%) identified as members of the LGBTI+ community. This was therefore one of the largest samples of LGBTI+ mental health service users to share their views and experiences of the mental health services in Ireland. Recognising the potential importance of this feedback and in line with recommendation 9 of the HSE's LGBT Report[181] for regular research into LGBTI+ health, HSE Mental Health agreed to provide additional funding to Mental Health Reform for the present project.

169 Department of Health, *Sharing the Vision*
170 HSE, *LGBT Health*
171 Organisation for Economic Development and Cooperation (OECD). "Establishing Standards for Assessing Patient-reported Outcomes and Experiences of Mental Health Care in OECD Countries," OECD Health Working Papers, 135 (2022). url: https://www.oecd-ilibrary.org/docserver/e45438b5-en.pdf?expires=1645548810&id=id&accname=guest&checksum=4D5AD718D3202B1AE506912FB6A258AC
172 United Nations General Assembly. *Convention on the rights of persons with disabilities (A/RES/61/106)*. New York: United Nations, 2007. url: http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf
173 Department of Health & Children, *A Vision for Change*
174 Department of Health, *Sharing the Vision*
175 MHC, *Quality Framework*
176 NSUE. *Summary report of the NSUE survey of members on Vision for Change: Have your voice heard... for a change* (Dublin: NSUE, 2011). url: https://www.academia.edu/33944234/Summary_Report_of_the_NSUE_Survey_of_Members_on_Vision_for_Change
177 MHC. *Your views of mental health inpatient services: Inpatient survey 2011* (Dublin: MHC, 2011). url: https://www.lenus.ie/bitstream/handle/10147/313472/YVNISFR11.pdf?sequence=1&isAllowed=y
178 Ó Féich, *My Voice Matters* (service user consultation)
179 Ó Féich, *My Voice Matters* (family member, friend, carer/supporter consultation)
180 Participants were required to have accessed secondary or tertiary mental health services in the two years prior to completing the survey. Survey data were collected between November 2017 and April 2018.
181 HSE, *LGBT Health*

This project sought to build on the data collected from LGBTI+ participants as part of the My Voice Matters project, by supplementing this with a series of focus groups with LGBTI+ mental health service users. The aim of the project was to explore the views and experiences of LGBTI+ mental health service users to inform the provision and improvement of these services so that they better meet the needs of the LGBTI+ community and the diverse groups therein.



.. The aim of the project was to explore the views and experiences of LGBTI+ mental health service users to inform the provision and improvement of these services so that they better meet the needs of the LGBTI+ community and the diverse groups therein.

2. Methodology

2. METHODOLOGY

2.1: Study Design

This project took a mixed methods approach, combining quantitative and qualitative methods. A secondary analysis of selected survey items from the My Voice Matters project was carried out. This was followed by a series of focus groups with LGBTI+ mental health service users to supplement the survey findings and provide more detailed insights into the views and experiences of LGBTI+ mental health service users.

2.2: Quantitative Methodology

This section provides information on the survey sample and data analysis. For detailed methodological information about the My Voice Matters service user survey, e.g. information on survey design, recruitment, data collection, etc., see chapter two of the My Voice Matters Service User Report.[182]

182 Ó Féich, *My Voice Matters* (service user consultation)

2.2.1: Target Population and Sample

To take part in the My Voice Matters service user consultation, participants were required to be aged 18 years or older and to have had contact with community mental health services, inpatient mental health services, and/or a psychiatrist in the two years prior to completing the survey. In total, 1,188 participants who met the inclusion criteria completed the service user survey.

For the purposes of this project, the My Voice Matters service user sample was divided into LGBTI+ and non-LGBTI+ participants as follows: all participants were presented with a list of gender and sexual identities and asked to tick all those identities that applied to them. Participants who chose to self-identify as Lesbian, Gay, Bisexual, Transgender and/or "other" were categorised as LGBTI+ participants. Participants who chose to self-identify only as heterosexual were categorised as non-LGBTI+ participants. Some 61 participants could not be categorised because they reported they would "prefer not to say" or did not respond to these survey questions. These participants were omitted. Table one provides socio-demographic data on these samples.

Some 215 participants were categorised as LGBTI+ participants. This group had a mean age of 33.1 years (SD: 12.0) and ranged in age from 18 to 68. Some 33% of these participants identified as male, 56% identified as female, and 11% identified as "other gender identity".[183] Some 912 participants were categorised as non-LGBTI+ participants. This group had a mean age of 40.7 years (SD: 12.1) and ranged in age from 18 to 76. Some 35% of these participants identified as male and 65% identified as female.

183 'Other' was included as a response option so that individuals did not feel forced to respond within a paradigm that they do not agree with. Other gender identity could include, but is not limited to, trans-male, trans-female, gender non-binary, gender-fluid and intersex.

Table 1: Demographic profile of survey participants.

Samples	%	N
LGBTI+	19	215
Non-LGBTI+	81	912
	LGBTI+	**Non-LGBTI+**
Age Group		
18-25	37%	11%
26-34	23%	21%
35-44	21%	31%
45-54	14%	22%
55-64	6%	11%
65 or older	1%	3%
Gender Identity		
Female	56%	65%
Male	33%	35%
Other gender identity	11%	0%
Educational Attainment		
No formal education/primary education only	1%	4%
Lower secondary	8%	12%
Upper secondary	22%	21%
Third level non-degree	27%	25%
Third level degree	28%	22%
Post graduate qualification	16%	16%
Ethnic/Cultural Background		
Irish	89%	92%
English/Scottish/Northern Irish/Welsh	4%	4%
Any other white background	4%	2%
Other ethnic/cultural background[184]	3%	1%

Participants were also asked a number of questions about their engagement with mental health services. Table 2 outlines participant responses to these questions.

184 Although a variety of different responses were given (e.g. Irish Traveller, African, Indian, etc.), all categories with less than 1.0% were combined with the 'other' category.

Table 2: Mental health related information.

Sample Groups	LGBTI+	Non-LGBTI+
Have you had contact with the following services in the last two years? (tick all that apply)		
Psychiatrist	84%	82%
Community Mental Health Service	78%	72%
Inpatient mental health service	23%	32%
Do you use or have access to private mental health care?[185]		
Yes No	47% 53%	44% 56%
How long have you been in contact with HSE Mental Health Services?		
Less than one year	9%	11%
One to five years	41%	29%
Six to 10 years	17%	15%
More than 10 years	23%	32%
No longer in contact with HSE mental health services	8%	11%
Don't know/can't remember	2%	2%
Please select the closest to your main diagnosis:		
Depression	27%	33%
Anxiety Disorder	17%	15%
Bi-polar disorder	7%	14%
Schizophrenia (including schizoaffective disorder)	6%	11%
Personality disorder	17%	10%
Post-Traumatic Stress Disorder (PTSD)	4%	4%
Eating Disorder	3%	3%
Other	8%	4%
Have not been given a diagnosis	10%	5%
Prefer not to answer	3%	1%
What is your Community Health Organisation catchment area?		
CHO Area 1 (Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan):	5%	4%
CHO Area 2 (Galway, Roscommon, Mayo):	12%	9%
CHO Area 3 (Clare, Limerick, North Tipperary/East Limerick):	8%	9%
CHO Area 4 (Kerry, North Cork, North Lee, South Lee, West Cork):	14%	16%
CHO Area 5 (South Tipperary, Carlow/Kilkenny, Waterford, Wexford):	8%	11%
CHO Area 6 (Wicklow, Dun Laoghaire, Dublin South East):	11%	7%
CHO Area 7 (Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West):	20%	19%
CHO Area 8 (Laois/Offaly, Longford/Westmeath, Louth/Meath):	6%	10%
CHO Area 9 (Dublin North, Dublin North Central, Dublin North West):	17%	16%

185 Participants were asked if they use or have access to any of the following: a private psychiatrist, a private therapist/counsellor, private community mental health services, and private inpatient care. Participants who reported that they had access to one or more of these options were categorised as using or having access to some form of private mental health care.

2.2.2: Data Analysis

A secondary analysis of selected items from the My Voice Matters service user survey was carried out. Seven survey items, deemed to be indicators/proxy indicators of experiential satisfaction with different levels of the mental health services, were selected for inclusion in this analysis (see Table 3). The analysis was descriptive and comparative in nature. Valid percentages[186] have been reported throughout this report and all figures have been rounded to the nearest whole number so may not add to exactly 100%.

Table 3: Survey Items selected for analysis.

Indicators/proxy indicators of satisfaction:	Response Options/Scoring:
Overall, how satisfied are you with your experience of the HSE mental health services?	0 (I had a very poor experience) to 10 (I had a very good experience)
Do you feel well supported and listened to by your current psychiatrist?	1 (never) to 4 (always)
Overall, did you feel that you were treated with dignity and respect by CMHSs?	1 (never) to 3 (always)
Do you feel well-supported by your key worker?	1 (no) to 3 (yes, definitely)
Throughout your inpatient experience, how often did you feel that you were treated with respect and dignity by the mental health services?	1 (never) to 4 (always)
Overall, how satisfied are you with the mental health care you received from your GP?	0 (very dissatisfied) to 10 (very satisfied)
My GP gave me enough time to speak about my mental health difficulties and listened to what I had to say.	1 (strongly disagree) to 5 (strongly agree)

Only participants with relevant experience were asked particular questions. For example, only participants who indicated they had accessed community mental health services in the two years prior to completing the survey were asked questions about their experiences of community mental health services. In these cases, the size of the sample eligible to answer these questions (n) have been reported in footnotes.

186 Valid percent is the percent when all missing responses are excluded from calculations. For example, if 1000 participants answered a question (missing responses =188), the missing cases would be excluded from calculations and the 1000 responses would equal 100%.

2.3: Qualitative Methodology

2.3.1: Designing the Focus Group Schedule

The initial draft of the focus group schedule was developed following a review of research literature into the views and experiences of LGBTI+ mental health service users and was informed by findings from the secondary analysis of the My Voice Matters data described above. This draft schedule was reviewed by LGBT Ireland and changes were made based on the feedback received before being finalised.

2.3.2: Sample and Recruitment

People were eligible to participate in the focus groups if they were aged 18 years of age or older, identified as LGBTI+, and had accessed mental health services in Ireland in the last two years. A multipronged approach to recruitment was taken. A call for participants was made through Mental Health Reform's website, newsletter and social media accounts. LGBT Ireland also brought the project to the attention of their network via their social media accounts and email lists. Other organisations working with members of the LGBTI+ community were contacted and asked to bring the project to the attention of their networks and service users, e.g. community support groups and college societies.

In each case a link was shared that brought potential participants to the Mental Health Reform website, where potential participants could read a detailed information sheet (see appendix A) about the project before deciding to take part. If a person wished to take part, they were asked to contact the Mental Health Reform research team using contact information provided on the information sheet. A member of the Mental Health Reform research team checked whether potential participants met the inclusion criteria before asking those who did to sign a consent form and complete a short demographic survey via Survey Monkey.

Transgender mental health service users were unrepresented in the first two focus groups. Given the difficult and unique challenges faced by transgender mental health service users, the decision was taken to recruit for a transgender specific focus group. Recruitment for this focus group was facilitated by Transgender Equality Network Ireland (TENI), who brought the project to the attention of their network via their social media accounts and email lists.

In total 15 people took part in three focus groups: 5 in the first focus group, 6 in the second focus group and 4 in the third transgender specific focus group. These participants had an average age of 32.9 (SD=8.48) and ranged in age from 22 years to 46 years. See Table 4 for more information.

2.3.3: Procedure

Focus groups took place online via Zoom and were facilitated by a moderator and assistant moderator. The moderator began by giving an overview of the project and what the group were to discuss. Participants were reminded that the focus groups would be recorded, that they had the right to withdraw at any point, that they would not be identified in the report and that only the Mental Health Reform research team would have access to the data. They were asked to abide by Chatham House rules, where participants are free to use the information received, but neither the identity of the speaker(s), nor that of any other participant, may be revealed. Participants were then given the opportunity to ask questions.

Questions started with an icebreaker where each participant was asked to contribute. The moderator proceeded using the focus group schedule as a guide. However, as discussions progressed the questions were no longer asked in a pre-determined order. Instead, questions were asked in accordance with the flow of the discussion. Each focus group lasted for approximately two hours. At the end of each focus group participants were invited to ask any questions they had, before being thanked for their time and contribution to the project.

Table 4: Focus Group participant information.

Age Group	**N**	**%**
18-25	3	20%
26-34	4	27%
35-44	7	47%
45-54	1	7%
55-64	-	-
65 or older	-	-
Gender Identity*	**N**	**%**
Female	3	20%
Male	3	20%
Cisgender Female	2	13%
Cisgender Male	2	13%
Cisgender	1	7%
Transgender Female	1	7%
Transgender Male	1	7%
Non-Binary	2	13%
Sexual Identity*	**N**	**%**
Lesbian	2	13%
Gay	5	33%
Bisexual	5	33%
Queer	2	13%
Asexual	2	13%
Homosexual	1	7%
Educational Attainment	**N**	**%**
No formal education/primary education only	-	-
Lower secondary	-	-
Upper secondary	1	7%
Third level non-degree	6	40%
Third level degree	4	27%
Post graduate qualification	4	27%
Ethnic/Cultural Background*	**N**	**%**
Irish	10	67%
White Irish	2	13%
European Descent	1	7%
White American	1	7%
White	1	7%

Have you had contact with the following services in the last two years? (tick all that apply)	N	%
Psychiatrist	8	53%
Community Mental Health Service	8	53%
Inpatient mental health service	3	20%
Other	5	33%

Participants were free to enter the gender, sexual and ethnic/cultural identities of their choice. Two participants reported multiple sexual identities: Lesbian and Asexual and Bisexual and Queer.

2.3.4: Data Analysis

An exploratory thematic analysis was carried out. Firstly, focus groups were transcribed verbatim. Once de-identified, transcripts were read and re-read to ensure sufficient familiarity with the data. Initial codes were generated and data relevant to these codes were collated. These initial codes were grouped to create potential thematic clusters. All data relevant to these thematic clusters were collated. Data collated under each potential theme were then re-examined to ensure that themes were appropriate and meaningful.

2.4: Ethical Considerations

Ethical Approval for the survey and focus groups with difficult to reach groups of mental health service users was granted by the research ethics committee in Waterford University Hospital as part of the original My Voice Matters project.

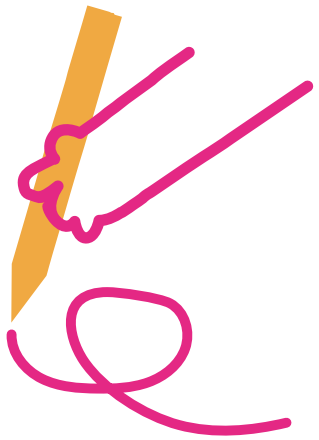
To ensure informed consent, survey participants were required to read detailed information about the project and indicate the following by ticking a box:

* that they understood the purpose of the study
* that they understood that their responses would be confidential
* that they understood that no identifiable information would be collected to ensure their anonymity and
* that they freely consented to take part.

Informed consent from focus group participants was sought on multiple occasions. All potential focus group participants received a detailed information sheet about the project and a consent form. Once they read the information sheet, if they wanted to take part they were asked to sign and return a consent form (see appendix B) by post or email.

Before completing the demographic survey, they were again presented with information about the survey and asked to indicate consent by ticking a box.

Finally, before the beginning of each focus group, the moderator went over the information about the project, gave participants the opportunity to ask any questions they had and asked each participant to provide verbal consent, which was recorded.



3. Quantitative Findings

3. QUANTITATIVE FINDINGS

This section outlines the findings from the descriptive and comparative analysis described in the previous section. Descriptive statistics have been compared graphically and using appropriate non-parametric statistical procedures. Only valid percentages have been reported and all percentages have been rounded to the nearest whole number so may not sum to exactly 100%. Statistically significant findings or findings approaching significance are noted.

3.1: Overall satisfaction

Participants were asked to indicate how satisfied they were with their overall experience of the HSE mental health services on a scale ranging from 0 ('I had a very poor experience') to 10 ('I had a very good experience'). Scores between 0 and 3 were categorised as a poor overall experience, scores between 4 and 6 were categorised as a neither good nor poor experience and scores between 7 and 10 were categorised as a good overall experience. Figure 2 illustrates how LGBTI+ participants compared with non-LGBTI+ participants.

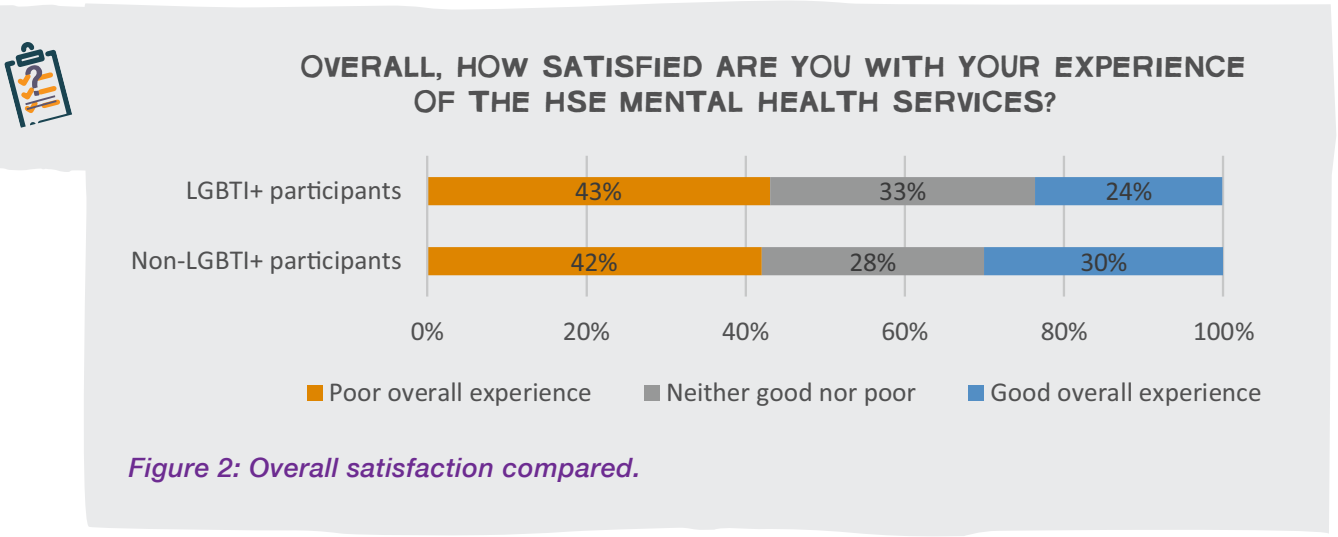
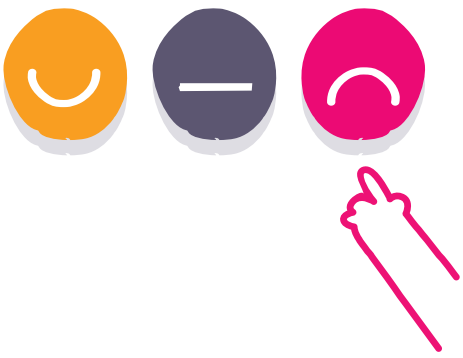


Figure 2: Overall satisfaction compared.



3.2: Psychiatry Services

Participants were asked whether they felt well-supported and listened to by their current psychiatrist.[187] Figure 3 illustrates how the responses of LGBTI+ participants compare with those of non-LGBTI+ participants. Although there was no statistically significant difference between these groups in terms of the extent to which they felt well supported and listened to by their current psychiatrist, it should be noted that this difference did approach significance.[188]

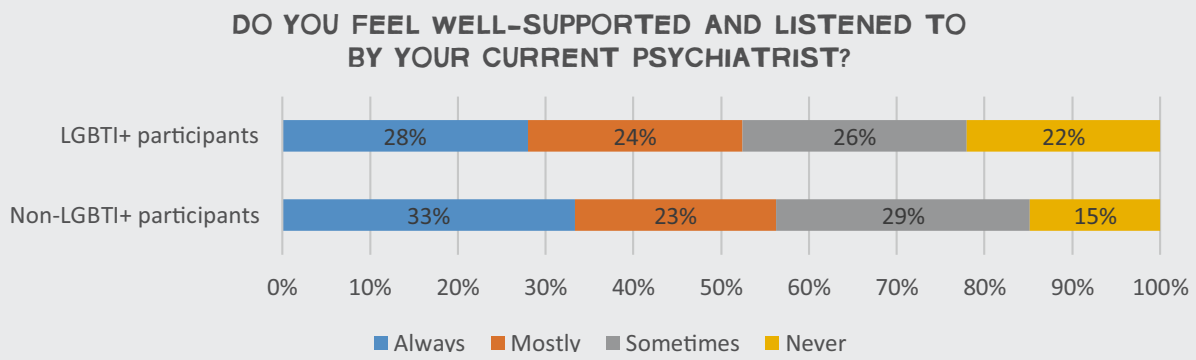


Figure 3: Feeling well-supported and listened to by current psychiatrist compared.

3.3: Community Mental Health Services

Participants were asked "overall in the last two years, did you feel that you were treated with respect and dignity by community mental health services?"[189] Figure 4 illustrates how the responses of LGBTI+ participants compared with those of the non-LGBTI+ participants. The extent to which LGBTI+ participants felt that they were treated with respect and dignity by CMHSs was significantly lower compared to non-LGBTI+ participants.[190]

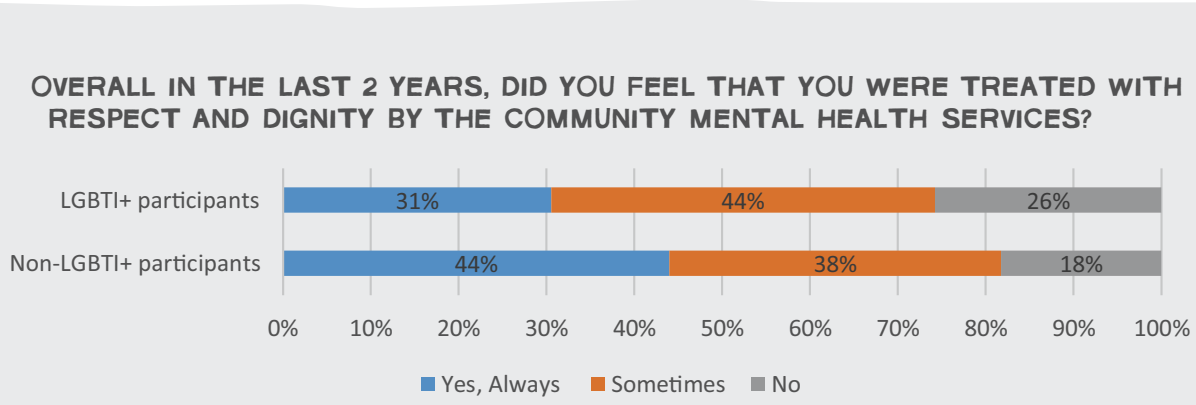


Figure 4: Being treated with respect and dignity by community mental health services compared.

187 Only the responses of participants who indicated that they currently had a psychiatrist (LGBTI+ participants: n=165; non-LGBTI+ participants: n=661) were reported
188 U=49299.00, z=-1.66, p>.05 (p=0.97).
189 Only the responses of participants who indicated they had accessed CMHSs (LGBTI+ participants: n=168; non-LGBTI+ participants: n=657) were reported.
190 LGBTI+ Mdn: 2.0; Non-LGBTI+ Mdn: 2.0; U=38493.0, z=-3.134, p<.01, r=-.11

Participants who reported having contact details for a key worker[191] were asked whether they felt well supported by their key worker. Figure 5 illustrates how the responses of LGBTI+ participants compare with those of the non-LGBTI+ participants on this item.

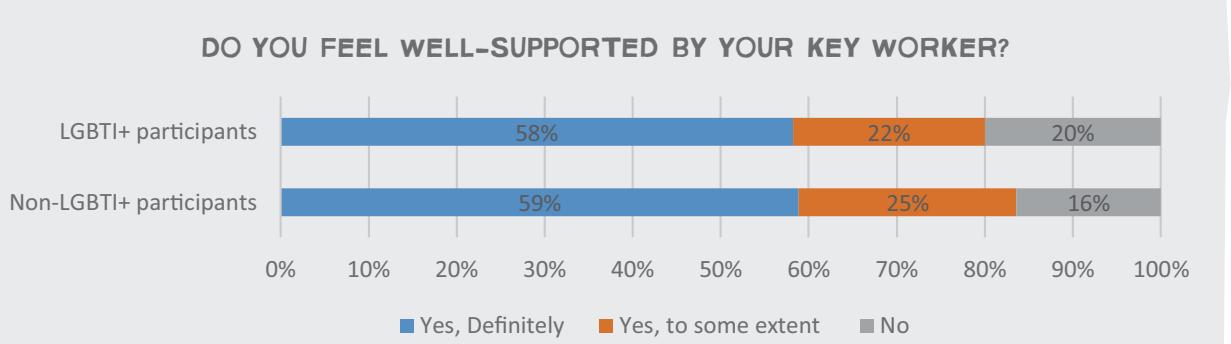


Figure 5: Feeling supported by a key worker compared.

3.4: Inpatient Services

Participants were asked to indicate how often they felt they were treated with dignity and respect by the mental health services during their inpatient experience.[192] Figure 6 illustrates how the responses of LGBTI+ participants compare with those of the non-LGBTI+ participants on this item.

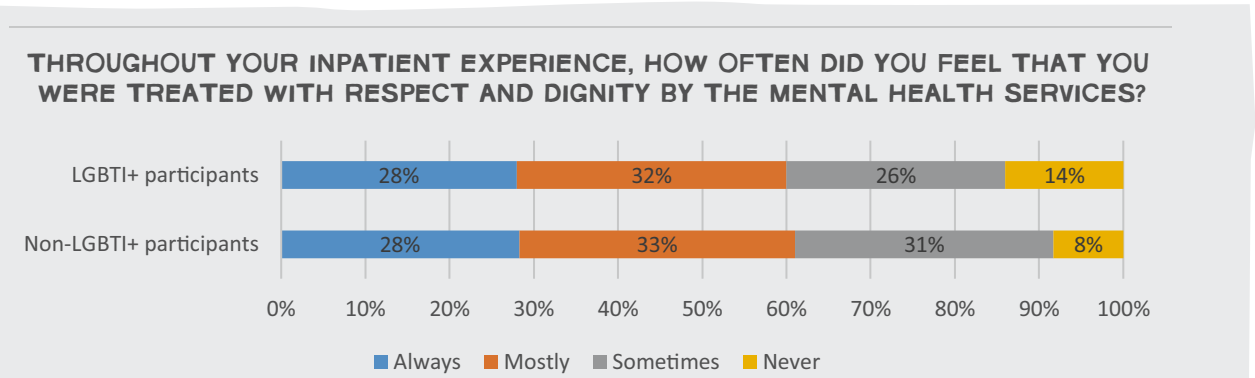


Figure 6: Being treated with respect and dignity by inpatient mental health services compared.

191 LGBTI+ participants: n=57; non-LGBTI+ participants: n=295.
192 Only the responses of participants who indicated they had accessed inpatient mental health services (LGBTI+ participants: n=50; non-LGBTI+ participants: n=295) were reported.

3.5: Primary Care

Participants were asked to indicate how satisfied they were with the mental health care they received from their GP on a scale ranging from 0 (very dissatisfied) to 10 (very satisfied).[193] Scores between 0 and 3 were categorised as low satisfaction, scores between 4 and 6 were categorised as moderate satisfaction and scores between 7 and 10 were categorised as high satisfaction. Figure 7 illustrates how the responses of LGBTI+ participants compare with those of the non-LGBTI+ participants on this item. Although no statistically significant difference between these groups was evident, the difference between the groups did approach significance.[194]

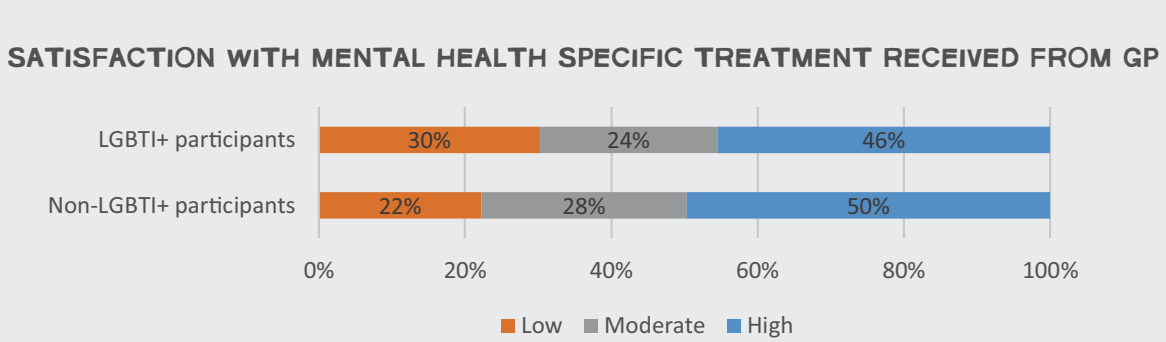


Figure 7: Satisfaction with mental health specific care from GP compared.

Participants were asked to indicate the extent to which they agreed with the following statement: "My GP gave me enough time to speak about my mental health difficulty and listened to what I had to say". Figure 8 illustrates how the responses of LGBTI+ participants compare with those of the non-LGBTI+ participants on this item. Levels of agreement with this statement were significantly lower among LGBTI+ participants compared with non-LGBTI+ participants.[195]

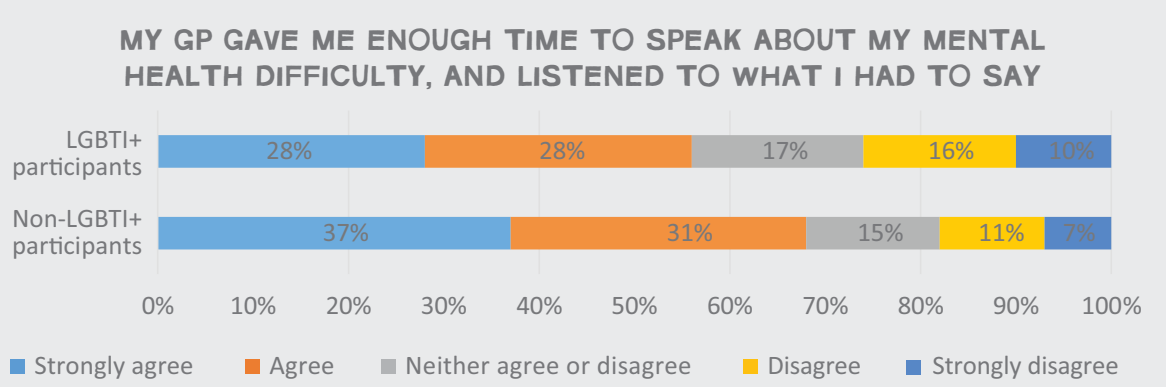


Figure 8: Listened to by GP compared.

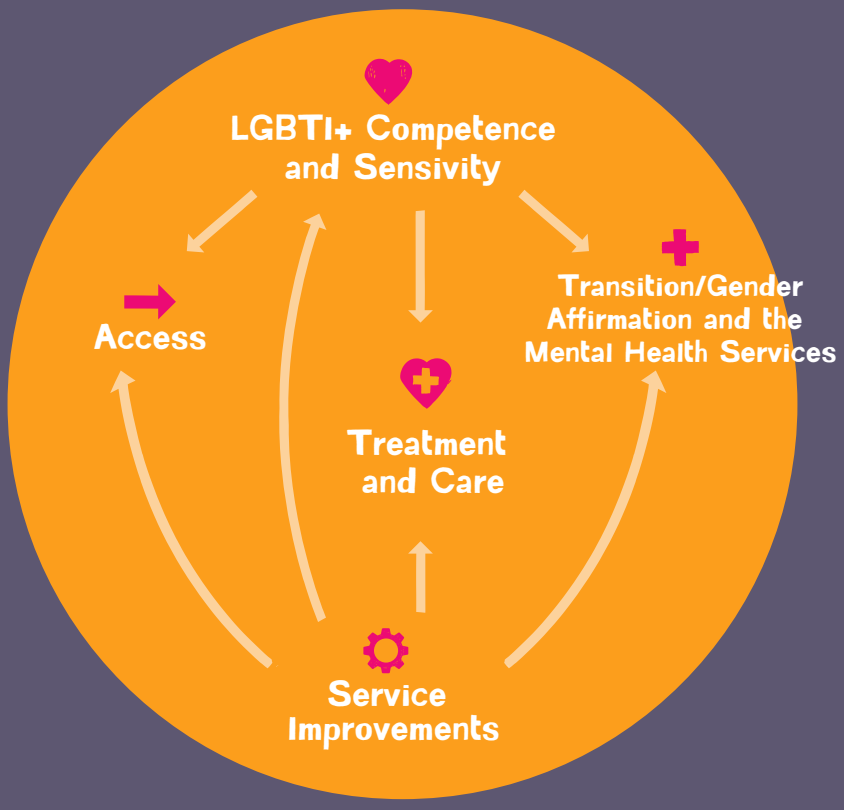
193 Only the responses of participants who indicated they had accessed CMHSs (LGBTI+ participants: n=190; non-LGBTI+ participants: n=739) were reported.
194 U=49299.0, z=-1.66, p>.05 (p=0.87).
195 LGBTI+ Mdn: 4.0; Non-LGBTI+ Mdn: 4.0; U= 59808.5, z=-3.071, p<.01, r=-.10.

4. Qualitative Findings

4. QUALITATIVE FINDINGS

Using inductive thematic analysis, five main themes relating to LGBTI+ mental health service users' views and experiences of mental health services were identified. These were as follows: *LGBTI+ Competence and Sensitivity*; *Access; Treatment and Care*; *Transition/Gender Affirmation and the Mental Health Services*; *and Service Improvements* (see figure 9). As indicated in figure 9 below, all themes related in some way to LGBTI+ competence and sensitivity. Also as indicated, ways to improve services which related to each theme were raised by participants. Note that data not directly related to the stated aims of the project were not reported. Potential themes (e.g. relating to minority stress, suicidal ideation and other challenges faced by the LGBTI+ community that impact negatively on mental health) that emerged spontaneously during the focus groups were not included in this analysis as they were beyond the stated aims of the project.

Figure 9: Thematic Map



4.1: LGBTI+ Competence and Sensitivity

Although all identified themes relate to LGBTI+ sensitive and appropriate mental health services, a major theme identified in this analysis was the importance of LGBTI+ Competence and Sensitivity in mental health service delivery. Participants frequently raised concerns about the perceived lack of LGBTI+ knowledge, competence and sensitivity among some mental health professionals and the consequences of this for LGBTI+ mental health service users. Many also spoke of the importance of learning about and providing LGBTI+ sensitive mental health services and supports.

> *"the threat* [is] *the kind of the lack of mental health professionals that have knowledge on our community because there's a lot of unintended-like, unintended issues that can arise from people making assumptions about a community rather than listening or, you know, being kind of, like, patient-informed."* **P06 FG2**

Two subthemes which provide additional insight were identified. These were as follows: *Need to Explain, Teach and Self-Censor* and *LGBTI+ Competence and Service User Experience.*

4.1.1: Need to Explain, Teach and Self-Censor

Consequences of a lack of LGBTI+ knowledge and competence among some mental health professionals were identified by participants. These included the need to explain their gender and/or sexual identities to mental health professionals, to teach mental health professionals about LGBTI+ issues and terminology, and to self-censor in relation to what and how they share when engaging with mental health professionals and the mental health services more broadly. These could and often did place additional demands and strain on these LGBTI+ service users. Many described the need to explain, teach and/or self-censor as time-consuming, tiring and difficult at a time when they are seeking help with their mental health.

> *"there was a lot of, um, me explaining like me being bisexual and going out with a trans man. And, um, there was a lot of me explaining myself, which I remember at the time was difficult"* **P10 FG2**

> *"it's almost like you have to be the teachable moment for these people. Like, whether it's queer issues, whether it's- you have a couple of different things going on. And it's like, it-it's so exhausting."* **P06 FG2**

> *"having to like work out how people are going to respond to something before you say it. Like, I just want to be able to talk-talk to a therapist without needing to self-censor."* **P07 FG2**

> *"the constant explaining yourself, the constant altering and the way that you talk to try and, like, get them to understand you. Like, it just kind of adds to all of the points about the efforts and mental strain that you don't wanna [sic.] be taking on at a time that you are, like, not mentally at your best."* **P07 FG2**

Many participants described having to teach mental health professionals about their sexual and/or gender identities and other LGBTI+ issues as a common and even expected experience. Despite the strain this added for them, some participants saw benefits for themselves and/or for future LGBTI+ service users. Others saw this as this as inappropriate and unacceptable.

"I think a lot of LGBT people have come across this being the teachable moment. So, my current therapist … I had to spend some time like answering her questions about the LGBT [community] *and discuss just like all things queer, in general."* **P08 FG2**

"sometimes that being able to teach them is a good thing because that means that at least you can get what you need." **P12 FG3**

"it actually shook me 'cause [sic.] *I had just like, grown to accept that this* [explaining/teaching] *was always going to be something I had to deal with. Um, and kind of seeing kind of an outside perspective of, oh wait, no, no, you shouldn't have to do this"* **P06 FG2**

"I'm just telling her this so that the next time she comes across an LGBT person, she'll have a better sense of what to do. So certainly, I'm looking out for her potential and hypothetical other patients, um, which is kind of a-a-an-an-a weird position" **P08 FG2**

"I find it completely and utterly unacceptable for the clients to be teaching the mental health professional anything … the expectation that we should take on the emotional work of teaching them is the last thing I want to do. That will make me get up and leave the therapy room if the therapist wants me to teach them anything about transness [sic.]*"* **P13 FG3**

4.1.2: LGBTI+ Competence and Service User Experience

Participants' experiences of mental health services and supports varied considerably, with many participants sharing both positive and negative experiences. The knowledge, competence and sensitivity of mental health professionals in relation to LGBTI+ identities, issues and terminology appeared to be a significant moderating factor in the quality of experience for many of these LGBTI+ mental health service users.

"you could be going to someone who's really good at this or someone who's really judgmental at us, but they're all mental health professionals but there's no like, there's no consistency about what you can expect they will know or how they'd accept us. And that's really tough." **P05 FG1**

Many participants who spoke positively of their engagement with the mental health services often praised specific mental health professionals who had a positive impact on their mental health journey and regularly referenced their level of LGBTI+ knowledge, competence and sensitivity when doing so.

"we got a new psychiatrist into my region and he's gay, so he's very, very, um, understanding of everything. So I've been very lucky of those who I've dealt with it in the HSE." **P02 FG1**

"a nurse therapist who I came out to, um, as the first person actually I trusted to come out to. And it's from her that I kind of started on my journey of recovery, um, mentally, and then obviously of coming out." **P04 FG1**

"she was incredible. She was incredibly understanding. She knew a lot about being LGBT. There was never any kind of, like, anything you said to her didn't surprise her. She was a lifeline. I couldn't say enough about how wonderful she was." **P09 FG2**

Although important, LGBTI+ knowledge was not essential for some participants, provided that mental health professionals were open, accepting and willing to learn so that they could provide LGBTI+ competent and sensitive care and support.

"Being listened to, being believed, is a big part. I would rather take an ignorant but open and humble professional" **P12 FG3**

"just them admitting, 'I don't know a lot about that. I'm gonna [sic.] *find this out and get back to you,' is, it's such a really small thing, but it's so respectful. And it really makes you think they actually care"* **P06 FG2**

"It was just really nice seeing the actual work put in to understand where I was coming from. And though clearly, it's not something she's a part of, clearly, it's something she spent time investing in … it's still tough teaching sometimes but it's nice to feel that level of respect of just, okay, you're putting in that extra work for me" **P10 FG2**

By contrast, participants who spoke negatively about their engagement with the mental health services regularly referenced the perceived lack of LGBTI+ knowledge, competence and sensitivity. Some spoke about the lack of knowledge some professionals displayed, while others described inappropriate questions they were asked or inappropriate comments made by a mental health professional. Although not limited to transgender and non-binary participants, these experiences appeared more common among this group of participants.

"with my gender, like, I haven't spoken to any of my healthcare people about that. Like, I know how limited the understanding was when I was trying to talk to them about being bisexual … the kind of questions and awkwardness that I got from that, I kinda [sic.] *don't wanna* [sic.] *open that box again."* **P09 FG2**

""she said that people who are non-binary or don't identify within the binary are out of touch, they've had trauma and they're having this dissociative thing with their identity. I just thought, "Jesus." It feels like she got no education in trans or queer matters … she didn't even know some of the basic terms for different transgender things." **P14 FG3**

"when I started my transition … I went to a psychologist in [names Irish county]*, I paid him a fistful of money and it was ridiculous, it was insulting. I was asked things like, 'I see that you're wearing jeans today, do you ever wear skirts or dresses?', 'When you go into the bathroom, do you sit down or do you stand up?' I was just sitting there, I just couldn't wrap my head around this. You're a professional and these are the questions that are going to determine my gender for you?"* **P13 FG3**

"in any other, you know, situation like-like professionals would know that it's-it's expected for them to know what's okay not to ask. And with LGBT issues, it kinda [sic.] *just seems to be a thing* [inappropriate questioning] *that is continuing to be accepted."* **P09 FG2**

Reflecting the extent to which levels of LGBTI+ competence and sensitivity among mental health professionals can influence the quality or nature of experience, many participants spoke of the need to find "the right person" to help them. Some spoke about how difficult this can be and others expressed a preference for mental health services and supports that have been recommended to them by LGBTI+ organisations and/or members of the LGBTI+ community.

"if you don't meet the right person in the beginning, you could be like knocking on doors for years … it is one of those reasons why a lot of us would drift to more towards like queer informed services … especially like if you've got limited energy, um, due to whatever's going on, um, it can be- it can be so much easier to then be able to focus on what you're actually there for rather than having to go ahead and explain yourself the whole time." **P06 FG2**

"it's made me go more towards services that have been approved by other trans people, or that are somehow connected to TENI, say, or LGBT Ireland just because I think so many people have had negative experiences that you go for ones that are safe to say or have been approved by others." **P14 FG3**

4.2: Access

Participants spoke of the difficulties they experienced when accessing or attempting to access mental health services and supports. Several barriers to accessing the mental health services were identified. These included service-level barriers such as lengthy waiting lists, perceived staff shortages, difficulty getting a referral, the geographical location of services, and the financial cost of accessing public and private services. They also included individual-level barriers such as perceived stigma relating to both mental health and LGBTI+ identities and personal mental health.

4.2.1: Service Level Barriers to Access

Participants identified waiting lists as a significant barrier to accessing mental health services. Some linked the lengthy waiting lists to what they perceived as insufficient staffing levels in the services, while others spoke of the negative impact and potential dangers of long waiting lists to access mental health services and supports.

"the waiting lists are awful in the public sector, how they leave you high and dry and with no support, then you might be going through a really difficult period in your life." **P12 FG3**

"waiting lists have just gotten longer and the private sector if you can afford it or if you're lucky enough to be able to go with that route, it still isn't that much better." **P14 FG3**

"the root of all of that is that there aren't enough, like, doctors or therapists to see everybody who needs to be seen. And if you fixed that, it would be a lot easier to access the services." **P07 FG2**

"waiting lists, the delays in-in getting seen … that's a life, that's-that's-that's a risk to life. That's what that is. And it's not given the, um, seriousness that it needs to be given." **P01 FG1**

Participants also shared the difficulties they experienced getting referrals to mental health services and supports. Some described how they found it difficult to "qualify" for a referral, while more spoke about how difficulties getting a referral could be draining and delay access to the services and supports they needed.

"the lack of any kind of pathway to early treatment or intervention … there's a real fine line between you're not mentally ill enough yet to help versus you're now too mentally ill to help. And like if you're not at that exact point on the spectrum, it's really difficult to get into mental health treatment in the first place." **P07 FG2**

"You need to go through GPs [to get a referral] *and all of that there is slowing down the ability to get the help whenever you seriously need it."* **P01 FG1**

"part of the problem with the effort of accessing [mental health services] *it is that you need to talk to your GP to get a referral to talk to somebody- to get a referral to talk to somebody who might see you in three to six months. And it's just exhausting to have to keep all of that up."* **P07 FG2**

The geographical location of services was also identified as a significant barrier to access. This was particularly challenging for service users from more rural parts of the country. Participants noted that having to travel to attend appointments could result in considerable logistical and financial challenges.

"practically all the services are in Dublin. We do have other big cities that still don't get a great amount of resources assigned to them, so that is really bad for people in more rural areas … having to travel hours to get to a 9:00 AM appointment in Dublin or they have to stay at a friend's house the night before, and then go in the morning. That involves booking time off work." **P14 FG3**

"the hardest barrier has been both cost and geographic location. Um, for example, when I had a really difficult time with my eating disorder, I was told there was only one psychiatric hospital that deals with that, and it is a private hospital in Dublin … I can't afford this [appointment] *and I can't get to this despite needing it."* **P06 FG2**

The financial cost of accessing mental health services was raised as a significant barrier by participants. Some participants identified the cost of accessing public mental health services without a medical card as a barrier.

"obviously the cost is a barrier for anyone from a kind of a working-class or struggling kind of background" **P06 FG2**

"it's the cost of, um, accessing services especially if you don't have a medical card" **P08 FG2**

Others spoke about the financial cost of their decision and ability to access a private therapist or counsellor. These participants often expressed concern about their ability to access these services if their financial circumstances changed for the worse.

"I just went straight to private counselling because I'm a bit older now than I was then. I can actually like, afford a therapist … I'm in more secure life circumstances than I was eight years ago when I first thought this and can actually just skip the HSE disaster." **P07 FG2**

"it's a large chunk of my wages. Um, and-and it is a kind of a panic thing to think that if I was sick or I lost my job, that I wouldn't be able to see her … if I was suddenly disenfranchised or suddenly lost my job, I-I would also suddenly lose my support" **P05 FG1**

4.2.2: Individual-level Barriers to Access

For a number of participants stigma surrounding mental health was identified as a barrier to accessing services. These participants feared being perceived as weak, being judged by others, and the implications for different parts of their life. Some delayed seeking help until their mental health had worsened to the point of crisis.

"it took me that long to actually step up and look for help … I think it was the fear of being seen to be weak or I-I'm not sure. But like [names participant], it was sort of suicidal ideation [resulted in help seeking]" ***P01 FG1***

""I definitely wish I spoke up earlier. Like I didn't seek support until 2018, 2018. So it's-it's really recent for me to-to have reached out to the mental [health services] *-- and it was because I attempted to take my life … a barrier for me was I didn't wanna* [sic.] *show or to tell anyone that I was having a problem. … I had an awful lot of internalized shame, like I remember when I did tell my parents I was having a mental health difficulty, they were like, "Well, you can't tell anyone. You can't tell the neighbours".* **P04 FG1**

"outpatient stuff being in like 10 to 4 on weekdays and making it incredibly difficult to have a full-time job and simultaneously manage your mental health … you can't tell your job, "Hey, I need to go to my mental health appointment right now," because you can't be open with your job about your mental health." **P07 FG2**

For some participants, stigma relating to their sexual and/or gender identities was considered a barrier to accessing the mental health services. These participants often felt that their identities made engaging with mental health services more difficult. Many spoke of their reluctance to openly discuss these identities with mental health professionals, while some described feeling apprehensive and even fearful when doing so. This was particularly common among transgender and non-binary participants.

"counselling is difficult enough without having to think to yourself like, "Will this person challenge me or not accept me or whatever?" **P14 FG3**

"I just like to be able to expect that if I go to mental health services, I could at least not be judged." **P05 FG1**

"I'm always still that bit nervous kind of when you have to come out [to a mental health professional]. *Whether it's you're directly saying it, or whether you're kind of correcting an assumption that someone has made … I'm kind of scared."*
P06 FG2

"for our trans and non-binary siblings, there's still a lot, like, oppression and ridicule … I still have a lot of fear about talking about that part of me."
P09 FG2

"It's not safe to just go to anybody … if you just flick through a book and go "um, this one" and you go to a therapist, who knows what kind of abuse you're opening yourself up to? … they're under this person's care for a period of time, and their mental health is actually being negatively affected rather than helped. That's what I mean by not safe."
P13 FG3

It was noted by some participants that an individual's mental health can exacerbate difficulties accessing or attempting to access mental health services. These participants stressed how difficult it can be to overcome the many barriers to access when experiencing mental health difficulties.

"the amount of effort that you have to go through when you're in the position least able to put an effort to do anything. I can't get up off the floor, let alone, call my doctor 10 times … it's mostly been the jumping through hoops, and calling 12,000 times the effort, um, when I was too depressed to get out of bed." **P08 FG2**

4.3: Treatment and Care

Participants raised issues with the treatment and care they have received from the mental health services generally and from some mental health professionals specifically (as partially evidenced in the previous theme, *LGBTI+ Competence and Sensitivity*). These issues were either specific to LGBTI+ mental health service users, e.g. pathologising their LGBTI+ identity, or not specific to LGBTI+ mental health service users, e.g. the lack of continuity of care, the use of medication as the primary method of treatment and care, and the lack of long-term talk therapy. Participants also recognized the role of charity and voluntary organizations in providing mental health care and support. Findings are therefore outlined under the following subthemes: *LGBTI+ specific issues*, *Non-LGBTI+ specific issues*, and *the Role of Charity and Voluntary Supports.*

4.3.1: LGBTI+ specific issues

Many participants raised concerns about the tendency among some mental health professionals to pathologise their LGBTI+ identity by attributing their mental health difficulties to their identity. Participants expressed frustration and described how difficult it can be to separate their mental health status from their LGBTI+ status.

"oversimplifying of things, you know, like, 'Oh, you're LGBT. That's why you're depressed', making it kind of trying to explain away the mental illness because you're part of the LGBT community." **P09 FG2**

"it can be really difficult to get someone who does understand the kind of complexity there, between, Yes, I am queer, no, that is not why I am here."
P06 FG2

"this phrase that's called like trans broken arm syndrome, it's a phrase from like the community where no matter what is ailing you, the reason you're having this problem is because you're trans." **P06 FG2**

"just because your patient is LGBT doesn't mean that all of their issues is [sic.] *because they are LGBT … it's frustrating."* **P07 FG2**

A minority of participants spoke about the reverse, where a person's LGBTI+ identity was attributed to their mental health status or other difficulty.

"I was early on in working out my identity. She [mental health professional] *was very apprehensive. She wasn't encouraging at all. She was very almost conservative at the idea of me coming in terms of being trans. She kept suggesting it was other things like trauma, depression, et cetera."* **P14 FG3**

"the parents … are delighted that these young people have a diagnosis of autism because at least they're not trans." **P01 FG1**

4.3.2: Non-LGBTI+ specific issues

As noted, many participants raised issues relating to their treatment and care that were not specific or unique to LGBTI+ mental health service users. Chief amongst these issues was concern about the lack of continuity of care. These participants spoke about excessive staff rotation and the strain this places on service users.

"you would see a registrar and they change every six months … I guess, well, like, it happens for heterosexuals, as well as LGBT. It's just, they don't know your whole thing and you're starting over again, with each-each time we see the registrar" **P02 FG1**

"I would see new doctors again and again and again. So the way I've been getting care just changes almost every time cause [sic.] *I can see one doctor who is like super, super helpful but the next time I go in, it's a whole new doctor"* **P09 FG2**

"There's these different doctors cycling in all the time. You have to go in and explain everything from the very beginning. And one person will be amazing and the next person will tell you to get over it and you're just like, "What?" So you can't even like mentally prepare yourself to go in." **P06 FG2**

Participants raised concerns about the use of medication as the primary method of treatment and care and the potentially negative consequences of this approach. Participants also spoke about lack of long-term talk therapy which encourages a triage approach to therapy.

"all he wanted was to put me for the medication. And so there was no support necessarily there" **P01 FG1**

"But he put me straight on drugs, and I was on drugs for two or three years. And I was just kind of out of it. Um, I literally kind of just stopped functioning" **P05 FG1**

"with the antidepressants, there's loss of libido and loss of feelings. And, you know, without your feelings, I-I believe, you know, I can't- I can't heal fully, you know, from-from my mental health issues" **P03 FG1**

"you might be going through a really difficult period in your life and they might offer you around 10 sessions of CBT and that's it. Off you go." **P12 FG3**

"bouts of six sessions [of talk therapy] *that were covered through organisations, or through my work health insurance, or through Jigsaw, or through the HSE. And it was very much like, 'How can we fix the immediate problems?' and kind of just glossing over everything else."* **P06 FG2**

4.3.3: Role of Charity and Voluntary Supports

Many participants recognized the role played by charity and voluntary organisations in the sector. Some participants described how they accessed mental health supports through charity and voluntary organisations when they were experiencing difficulties accessing public or private mental health services. Others emphasized the importance of the work of these organisations in filling gaps in service provision and providing support to those in need.

"I tried to access the same service on those emails and phone in four months because I could feel myself slipping and I'm still waiting on response from that service. And it was a HSE service at the time, or it is a HSE service. So I ended up going through the My Mind service because it was the only way, I knew I was- I was really getting very bad" **P01 FG1**

"charities carry I think so much. They are really the backbone for a lot of us, I think, not everyone, obviously. But it's a huge amount of work that doesn't get recognized by the government … if it goes under, it means it's a service completely lost to a group of people." **P09 FG2**

"the only reason that we're, like, scraping by through the current mental health crisis is all of the charities that are being the stopgap. Like be they, like, um, Pieta House, or Let's Get Talking … I feel like that the health service doesn't even see the reality of how tough things are out there because they're not even seeing all of the people" **P06 FG2**

4.4: Transition/Gender Affirmation and the Mental Health Services

The themes outlined up to now can apply to LGBTI+ mental health service users regardless of their sexual and/or gender identities. However, members of the transgender community face unique challenges as a direct consequence of the steps/process required to transition in Ireland. Specifically, members of the transgender community are required to access the mental health services to receive a referral and/or a diagnosis of gender dysphoria to access certain gender affirmation services. This is referred to as the diagnostic model of transition care. Some participants viewed the diagnostic model of care as problematic, while the validity of gender dysphoria as a diagnosis was also questioned.

"I've seen friends, like, have, like, to jump through such hurdles to get any kind of healthcare because-- and especially I think with the mental health services. Because you actually, in this country, have to get diagnosed by a psychologist with, or a psychiatrist, whichever, with gender dysphoria." **P06 FG2**

"I've had to interact with the mental health service because I'm trans and that's the issue for me, because that's no longer acceptable and it's still happening here." **P13 FG3**

"Gender dysphoria is no longer in the DSM. That was my question to the psychologist, what exactly are you diagnosing me with here because your diagnostic model does not actually include me anymore? What is this about? Why am I here? … even if we kept the gender dysphoria in the DSM, that doesn't justify the gatekeeping model [diagnostic model]*"* **P13 FG3**

For some participants, the diagnostic model was their sole reason for engaging with the mental health services. In these cases, engagement with the services was seen as a means to an end. Those transgender participants who were also engaged with the services due to a mental health difficulty expressed concern that their mental health difficulties could complicate and delay their access to gender affirmation services.

"I'm only here because of the gatekeeping scenario. The reason that I'm giving a fistful of money is so that you give me what I need, so I can move on with my life, we're not here to form a relationship or work with each other long term … I had no relationship with this person, the psychologist, this was not me going because I need the psychologist. This is me going solely to get that referral." **P13 FG3**

"if you have mental health issues, and you're then trying to access services, it can either potentially harm the services that you can access, or it can harm, uh, the treatment that you get that you may want to access, um, for like gender-confirming kind of things like, um, hormones or anything else that you might be looking for. So it's- it's really messed up." **P06 FG2**

"I'm on the [Autism] spectrum, I've heard desperate things about people being denied care because of it and I just have this fear that I'm going to get there after all these years of waiting, and they're going to deny me based on that." **P15 FG3**

The diagnostic model and the role of the mental health services therein was described negatively by participants, who perceived it as infringing on their personal autonomy.

"the fact that the mental health services [are] *part of our transition is the problem, these things are not connected … they're continuing on this outdated model of pathologising our gender identity … psychologists who are put in place standing between us and our autonomy. We have to pay them so that they can decide we're womanly or manly enough."* **P13 FG3**

"all this is because of this outdated, awful controlling model that we have" **P12 FG3**

Participants also raised concerns about how difficult the system was to navigate and the potentially detrimental impact this has on the mental health and well-being of those seeking to access gender affirmation services.

"they really want to transition, but it's very difficult because the public system is giving them the run around … They're getting pushed around, they're getting put on years and years, extended wait [lists]*. Everything's not happening for them because they're not able or they don't feel that they're able to go in and get what they need from the system."* **P13 FG3**

"the amounts of minority stress and the amount of anxiety that is created just by accessing a system that is meant to help you combat those things, it's not only counterproductive, but it's actively punishing." **P13 FG3**

Frustration with the diagnostic model was such that participants stressed the need for change, with some advocating alternative actions, e.g. travelling abroad to access gender affirmation services.

"We don't run this system, we don't make the rules, you do. We're suffering from them. If you care, change them."
P13 FG3

"I'm not going to wait three, four years for them to give an appointment and then tell me I'm not trans enough … I decided no, I'm going to start tomorrow because this is my body … At home [another country]*, you don't need a referral to go to a consultant, you just book an appointment. I went to an endocrinologist, paid for the consultation, spent one hour with her just talking about my history. Mainly my gender history, and my medical history but nothing about mental health because that was not relevant."*
P12 FG3

4.5: Service Improvements

Ways in which the mental health services could be improved were regularly raised and discussed by participants. These actions were most often geared towards improving the experiences of LGBTI+ mental health service users. However, some more general actions had the potential to improve the experiences of all mental health service users. These are outlined below under the following subthemes: *LGBTI+ Focused Actions* and *General Actions*.

4.5.1: LGBTI+ Focused Actions

Reflecting the importance of LGBTI+ competent and sensitive mental health service delivery, almost all participants stressed the need for LGBTI+ training and education for mental health services staff. Some expressed the view that this should be mandatory for all mental health professionals, while others highlighted the need for self-guided learning. A minority spoke of the need for caution, raising concerns about the nature, delivery and efficacy of training.

"the community is incredibly diverse and that there needs to be upkeep and training on this." **P09 FG2**

"mandatory training. There should be an expectation that all of our mental health professionals and all of our health professionals just know this"
P08 FG2

"Something has to be organised to teach people just basic understanding of trans issues because people are not teaching themselves. I think it should be on the person's responsibility to look it up, inform themselves, but people just aren't doing that clearly." **P13 FG3**

"they did a training [session] *on queer issues, it was done by basically cis health people or cis gays that had no idea about trans issues, and they were just continuing harmful stereotypes. Sometimes the training is a two-edged sword … It almost end up being worse, yes. It would have to be led by trans and queer people themselves if possible"* **P12 FG3**

"anybody working in the mental health profession needs to prove, whether that's through an exam or an evaluation, their competencies" **P13 FG3**

Participants also recognised that numerous LGBTI+ strategies and policies have been developed. However, these participants expressed concern about the lack of implementation in relation to these strategies and policies.

"I was HSE, and like, even with the promises of, like, new positions and new funding and new models of care coming, none of them are being implemented. Like, they announce a plan, and it just sits in a drawer and gathers dust." **P06 FG2**

"There's a lot of, like, great plans and great ideas. And in theory, it's really, really, like, patient-focused service user-focused ... And then the actual implementation … implementing it is incredibly difficult to do." **P09 FG2**

"They come out with a fabulous LGBT youth strategies and there was another LGBT strategy … But these are just strategies where politicians are getting great recognition in the public eye but when it comes to actually enacting these policies … it's all left to the voluntary sector and we don't have the resources for that." **P01 FG1**

Some participants were of the view that having an advocate, perhaps with self-experience of accessing the mental health services, would be beneficial, as would making the inclusivity of services more visible, e.g. LGBTI+ affirmative posters, badges, etc.

"peer support advocates and it's like a new role in the HSE, so somebody who's gone through the mental health services themselves … if you had someone like that … that they would wear a small LGBT rainbow badge." **P05 FG1**

"an advocate, um, people who spend their time trying to get you into, um, psych-psychiatric or other mental health services, having an advocate" **P08 FG2**

"there needs to be a system where a person going into a psychiatry appointment for something like gender dysphoria, they almost need to have a chaperone who's there as an advocate" **P13 FG3**

Reflecting the negative views participants shared in relation to the diagnostic model of transition care, some expressed the need for change and progression towards an informed consent model of transition care.

"a big change, and I guess this applies a lot to the National Gender Service, not forgetting HRT. I'm trying not to focus too much on that, but I just can't help it. I think changing eventually to informed consent, that'll fix a lot of issues … Questioning the old systems and maybe even looking abroad to countries where it is more informed consent, that would definitely help. If it works elsewhere, why not get inspiration from them? I think that would definitely help with the waiting lists problem" **P13 FG3**

4.5.2: General Actions

Although participants raised issues such as a shortage of mental health professionals and lengthy waiting lists, many expressed the view that these issues could be addressed by increasing the financial resources available to the mental health services.

"it would be much more helpful for our service users if we get more psychologists, but that means more budgeting" **P09 FG2**

"it's more money that's not there. If the money was there, you know, the services would be there" **P10 FG2**

"I realise this is a simplistic solution of like, let's just throw a shit ton more money at the problem, but we really should be just throwing a shit ton more money at the problem." **P07 FG2**

"expand funding and expanding the mental health services of the HSE I think is a huge priority in all of this, because, like, the only reason that we're, like, scraping by through the current mental health crisis is all of the charities that are being the stopgap." **P06 FG2**

5. DISCUSSION

5. DISCUSSION

By examining data collected as part of Mental Health Reform's National Consultation with Mental Health Service Users, My Voice Matters, and through a series of focus groups, this project aimed to explore LGBTI+ mental health service users' views and experiences of the mental health services in order to inform the provision and improvement of these services so that they better meet the needs of the LGBTI+ community and the diverse groups therein.

Findings from the survey were mixed, with some positive findings and others that were less so. For example, six in every 10 LGBTI+ participants felt they were well supported by their key worker and 'always' or 'mostly' treated with dignity and respect by inpatient mental health services. Approximately half of LGBTI+ participants felt that they were 'always' or 'mostly' well supported and listened to by their current psychiatrist. However, less than one in three felt that they were always treated with dignity and respect by community mental health services and less than one in four reported a good overall experience of HSE mental health services. The variation in reported experiences is consistent with previous research examining LGBTI+ people's experiences of healthcare.[196,197,198] Highlighting the potential scope for improving LGBTI+ people's experiences of the mental health services, the survey findings show that some LGBTI+ participants may have had predominantly positive experiences of the services that adequately met their needs; however, a considerable proportion had not.

Although GP/primary care is not part of the specialist mental health services, it is nevertheless often the first port of call for those seeking help for a mental health difficulty and addresses 90% of all mental health need.[199] For this reason, the My Voice Matters survey included items relating to GP/primary care. Survey findings relating to primary care and mental health were predominantly positive. A considerable majority of seven in every 10 LGBTI+ participants reported moderate to high levels of satisfaction with the mental health specific treatment they received from their GP. In contrast with previous research, which reported that participants felt that their circumstances and needs were trivialised or ignored by their GP,[200] a majority of LGBTI+ participants agreed or strongly agreed that their GP gave them enough time to speak about their mental health difficulty and listened to what they had to say. These encouraging findings may indicate an improvement in experiences over time, perhaps due, in part at least, to the engaged approach to LGBTI+ healthcare taken the ICGP, as evidenced by the frequency with which they have reviewed and updated their guidance for members working with LGBTI+ people, which were most recently updated in collaboration with LGBT Ireland in November 2020.[201]

.. 6 in every 10 LGBTI+ participants felt they were well supported by their key worker and 'always' or 'mostly' treated with dignity and respect..

196 Mayock, *Supporting LGBT lives*
197 McNeil, *Speaking from the Margins*
198 McCann & Sharek, *Survey of lesbian*

199 Department of Health & Children, *A Vision for Change*
200 Mayock, *Supporting LGBT lives*
201 ICGP, *Guide for providing care*

The My Voice Matters service user survey was designed for use with all mental health service users. It is therefore somewhat difficult to compare survey findings with those of studies with an LGBTI+ specific focus. However, using data from the My Voice Matters project allowed for the experiences of LGBTI+ and non-LGBTI+ participants to be compared. Findings were indicative of a trend or pattern where LGBTI+ participants were less likely to be satisfied with HSE mental health services generally and with different levels of the services when compared to non-LGBTI+ participants. For example, LGBTI+ participants were less likely to report a good overall experience of HSE mental health services, they were more likely to feel they were never well-supported and listened to by their current psychiatrist, and they were less likely to feel that they were always treated with dignity and respect by community mental health services. They were also more likely to report low levels of satisfaction with the mental health specific treatment received from their GP and less likely to agree that their GP gave them enough time to speak about their mental health difficulty and listened to what they had to say. On four of the seven indicators of experiential satisfaction, the difference between LGBTI+ and non-LGBTI+ participants was either statistically significant or approached significance. These findings are consistent with previous research showing that LGBTI+ people are more likely to report unfavourable experiences of healthcare generally[202,203] and higher levels of dissatisfaction with mental health services specifically.[204,205,206]

Findings from the focus groups with LGBTI+ mental health service users highlighted some potential reasons for these disparities. Supporting the survey findings, diversity of experience among focus group participants was again evident. LGBTI+ competence and sensitivity in mental health service delivery appeared to be a significant moderating factor in the quality of participant experiences. Echoing previous research (e.g. the Supporting LGBT Lives study[207]), positive experiences of the mental health services regularly referenced the LGBTI+ knowledge, competence and openness displayed by mental health professionals and how beneficial this was for participants. In contrast, those who shared negative experiences of the services regularly referenced the lack of LGBTI+ competence and sensitivity displayed by some mental health professionals, as evidenced by inappropriate questions and comments and a lack of knowledge about LGBTI+ issues. A perceived lack of knowledge among mental health service staff to effectively meet the need of LGBTI+ service users is consistent with previous research.[208,209,210,211,212] Although not limited to transgender and non-binary participants, experiences of inappropriate questions and comments appeared more common among these participants, reflecting previous research which found that a considerable proportion of transgender mental health service users who took part in the Speaking from the Margins study were asked inappropriate questions about their gender, sexual behaviour and body by mental health professionals.[213]

202 Elliot, *Sexual minorities in England*
203 Thyen, *Utilization of health*
204 Avery, *Satisfaction with mental*
205 Ellis, *Trans people's experiences*
206 Page, *Mental health services*
207 Mayock, *Supporting LGBT lives*
208 Higgins, *The LGBTIreland Report*
209 Higgins, *LGBT + young people's*
210 Mayock, *Supporting LGBT lives*
211 McCann & Sharek, *Survey of lesbian*
212 McNeil, *Speaking from the Margins*
213 McNeil, *Speaking from the Margins*

Consequences of a lack of LGBTI+ competence and sensitivity alluded to by participants included the need to explain their gender and/or sexual identities to mental health professionals, to teach mental health care providers about LGBTI+ issues and terminology, and to self-censor when engaging with mental health professionals and the mental health services more broadly. This was found to be an additional strain on participants, potentially hindered the development of an effective therapeutic relationship and was likely exacerbated by excessive staff rotation, an issue raised by many participants which required them to begin again with each new mental health professional with whom they engaged. Although the need to explain and educate mental health care providers on LGBTI+ terminology and issues was described as inappropriate by most, others saw benefits for themselves and for future LGBTI+ service users. Similarly, knowledge of LGBTI+ terminology and issues was not deemed essential by all, providing mental health care providers were open, accepting and willing to learn.

.. the need to explain and educate mental health care providers on LGBTI+ terminology and issues was described as inappropriate by most..

Numerous barriers to accessing the mental health services were identified. Most of these barriers could be experienced by anyone, regardless of sexual orientation or gender identity. System-level barriers included lengthy waiting lists, staff shortages, difficulty getting a referral, the financial cost of accessing public and private services, and the geographical location of services, which was particularly pertinent for those in rural areas who faced considerable logistical and financial challenges as a result. Individual-level barriers related to stigma regarding mental health difficulties, which manifested as concerns about being judged and/or perceived as weak, and personal mental health, which could make it more difficult to navigate the system and access services. Reflecting the reluctance of some to disclose their LGBTI+ status in health and mental health settings,[214,215,216] stigma relating to their LGBTI+ identity was also perceived as a barrier to accessing mental health services by some participants, who described feeling apprehension and even fear when discussing their LGBTI+ identity openly with mental health care providers. These findings are consistent with previous research examining perceptions of barriers to accessing health and mental health services among LGBTI+ people[217,218,219] and among mental health service users in the general population.[220]

Many participants also discussed issues relating to the treatment and care they had received from the mental health services. LGBTI+ specific issues raised by participants included a lack of LGBTI+ competence and sensitivity among some staff (discussed above) and concerns that their LGBTI+ identity was being pathologised by some professionals who attributed their mental health difficulties to their LGBTI+ status. The reverse was

214 Mayock, *Supporting LGBT lives*
215 McCann & Sharek, *Survey of lesbian*
216 McNeil, *Speaking from the Margins*
217 Higgins, *The LGBTIreland Report*
218 Higgins, *LGBT+ young people's*
219 Mayock, *Supporting LGBT lives*
220 Ó Féich, *My Voice Matters* (service user consultation)

also alluded to, where LGBTI+ status was attributed to a mental health difficulty. Fear that their LGBTI+ identity would be pathologised if they accessed the mental health services has been identified as a potential barrier to accessing mental health services by LGBTI+ young people,[221] while McNeil et al. found that a considerable minority of the transgender mental health service users who took part in the Speaking from the Margins study felt that their mental health difficulty was attributed to their gender identify or their gender identity was treated as a symptom of their mental health difficulty.[222]

As with the barriers to access discussed above, not all issues relating to treatment and care were LGBTI+ specific. Many could be experienced by all service users and were consistent with findings from previous consultations with mental health service users.[223] For example, continuity of care was an issue raised by many participants, who expressed frustration at what they perceived as excessive staff rotation that required them to regularly begin again with a new mental health professional. Other issues raised by participants were the time-limited nature of talk therapy that encouraged a triage approach to mental health care and a perceived over-reliance on medication. Participants also spoke positively about the role played by charity and voluntary organisations in filling gaps in service provision and providing mental health care and supports to those in need. It should be noted that many of these organisations are at least part funded by HSE Mental Health.

The findings outlined up to now can apply to LGBTI+ mental health service users regardless of their sexual and/or gender identities. However, members of the transgender community face unique challenges as a direct consequence of the steps/process required to transition in Ireland. Specifically, members of the transgender community are required to access the mental health services to receive a referral and/or a diagnosis of gender dysphoria to access certain gender affirmation services. Finding from this project provide some insight into transgender people's views and experiences of this process. The diagnostic approach to transition care was described as problematic by participants and perceived by some to be an infringement on their personal autonomy. Many described the system as difficult to navigate, resulting in delays and long waiting lists. The detrimental impact this can have on the mental health and well-being of those seeking to access gender affirmation services was highlighted. For a small minority of participants, the need to attain a referral and/or diagnosis to access gender affirmation services was the sole reason for engaging with the mental health services. However, those participants who had or were currently experiencing mental health difficulties expressed concern about how these difficulties would impact their access to gender affirmation services. Due to the small number of transgender participants in this study, these findings should be interpreted with caution. More research geared specifically to this topic is required to inform discussions on transition care specifically, and transgender people's views of the mental health services more broadly.

.. members of the trans-gender community face unique challenges as a direct consequence of the steps/process required to transition in Ireland.

221 Higgins, *LGBT+ young people's*
222 McNeil, *Speaking from the Margins*
223 Ó Féich, *My Voice Matters* (service user consultation)

Reflecting the constructive and often solution focused nature of the discussions had during focus groups, when discussing issues and challenges they had experienced when availing of mental health services many participants shared views on how these issues could be addressed. Echoing LGBTI+ orientated policies, national strategies and guidance documents,[224,225,226,227,228,229] participants stressed the importance of, and need for, LGBTI+ competence training and education for mental health service providers. Many expressed the view that such training should be mandatory. Failing this and at a minimum, self-guided learning should be encouraged for all mental health service providers. Some participants recognised the progressive nature of national mental health policy and the national LGBTI+ strategies developed in recent years and spoke of the difficulties with, and importance of, implementing said policies and strategies in full. The benefits of advocates and peer support for LGBTI+ mental health service users were also raised. Transgender participants stressed the need to reconsider the diagnostic model of transition care and encouraged the examination of examples of good practice, e.g. the informed consent approach. This would reflect similar shifts internationally. For example, the latest version of the International Statistical Classification of Diseases and Related Health Problems (ICD-11) no longer includes reference to 'gender identity disorder' and transgender health issues are no longer classified as mental health or behavioural disorders by the World Health Organisation.[230] In some cases, participants proposed solutions to issues and challenges not specific to LGBTI+ mental health service users, e.g. staff shortages and long waiting lists. Participants most often linked these issues to a lack of resources available to the mental health services, with most expressing the view that financial resources were key to addressing many of these issues and improving the mental health services and supports for all who need them.

224 Department Children, Equality, Disability, Integration and Youth, *National LGBTI+ Inclusion*
225 Department of Children and Youth Affairs, *LGBTI+ national youth*
226 HSE, *LGBT health*
227 ICGP, *Guide for providing care*
228 GLEN, *Lesbian, gay, bisexual*
229 PSI, *Guidelines for good practice*
230 World Health Organisation (WHO). *International Classification of Diseases 11th Revision: The global standard for diagnostic health information* (WHO, 2019). url: https://icd.who.int/en

5.1: Methodological Strengths and Limitations

This section outlines the methodological strengths and limitations of this project specifically. For a detailed discussion of the strengths and limitations of the larger My Voice Matters project, see the *My Voice Matters: Report on a National Consultation with Mental Health Service Users*.[231]
The My Voice Matters service user survey was developed through a thorough and collaborative process, which was informed by those with lived experience of the mental health services, by experts in survey design and by previous research. This resulted in a robust and accessible survey instrument. Analysing data gathered using the My Voice Matters survey facilitated a comparison of the views and experiences of LGBTI+ and non-LGBTI+ mental health service users who took part in this project. This was the first comparative study of its kind in the Irish context and was a significant strength of this project. However, the My Voice Matters surveys were not designed specifically for use with LGBTI+ mental health service users and therefore did not include survey items about LGBTI+ specific issues. This limited the depth of insight provided by the survey data and the extent to which findings could be compared with those from previous research with LGBTI+ mental health service users. To address this limitation, survey data were supplemented by carrying out focus groups with LGBTI+

231 Ó Féich, *My Voice Matters* (service user consultation)

mental health service users. This mixed methods approach was another strength of this project. LGBTI+ identification for survey participants was established using a single 'tick all that apply' question with the following limited options: Gay/Lesbian, Bisexual, Transgender, Other. This limited some LGBTI+ participants' ability to accurately express their specific LGBTI+ identity. Future research exploring LGBTI+ service user views and experiences should use an instrument specifically designed for this purpose that includes items used in similar surveys to facilitate comparison. Larger consultation processes aimed at all mental health service users should consider including a specific section aimed at LGBTI+ mental health service users. Such actions would be in line with LGBTI+ national strategies, as well as recommendations made by the HSE, GLEN/MHC, and OECD.[232,233,234,235,236] To avoid limiting participants' ability to accurately express their specific LGBTI+ identity, future research like this should consider including an open ended response option.

Research has shown that people from minority groups, e.g. LGBTI+ people and people experiencing a mental health difficulty, can be less likely to participate in research.[237,238] However, to facilitate recruitment for this and the My Voice Matters project, steps were taken to bring the project to the attention of as many potential participants as possible. Mental Health Reform was able to draw on its extensive networks of member organisations, academic institutions and individuals working with mental health service users to recruit survey participants. Recruitment for the focus groups was facilitated by both LGBT Ireland and TENI, who promoted the project to their network and through social media. The use of online surveys and virtual focus groups was also beneficial in this regard. The former can reduce bias and measurement error as a result of questions relating to stigmatised topics like mental health and can enhance the participation of stigmatised groups like LGBTI+ mental health service users,[239] while the latter facilitated the participation of LGBTI+ mental health service users from around the country.

Despite these steps to facilitate recruitment, it should be noted that the survey and focus group samples were self-selecting and subject to non-response bias, wherein those who chose to take part may be different to those who didn't. For example, participants may have been those who were most motivated to contribute and/or those most engaged with services. This means that the findings cannot be generalised to the population of mental health service users or LGBTI+ mental health service users in Ireland. However, it is important to recognise how difficult it would be to recruit a representative sample of mental health service users when so little reliable data about this population is available. Establishing a mental health information system geared towards collecting important information from service users, e.g. CHO area, diagnosis, etc., would be invaluable to future consultations as it may facilitate the recruitment of a more representative sample. Collecting

232 Department Children, Equality, Disability, Integration and Youth, *National LGBTI+ Inclusion*
233 Department of Children and Youth Affairs, *LGBTI+ national youth*
234 HSE, *LGBT health*
235 GLEN, *Lesbian, gay, bisexual*
236 OECD, *Establishing Standards for*
237 Sheldon, H. et al. *Increasing response rates amongst black and minority ethnic and seldom heard groups: A review of literature relevant to the national acute patients' survey* (Oxford: Picker Institute, 2007). url: https://www.academia.edu/26515283/Increasing_Response_Rates_Amongst_Black_and_Minority_Ethnic_and_Seldom_Heard_Groups
238 UK Care Quality Commission. *Community mental health survey: Quality and methodology report* (London: UK Care Quality Commission, 2017). url: https://www.cqc.org.uk/sites/default/files/20171115_cmh17_qualitymethodology.pdf
239 Trau, R. N., Härtel, C. E., & Härtel, G. F. "Reaching and hearing the invisible: Organizational research on invisible stigmatized groups via web surveys," *British Journal of Management*, 24, no.4 (2013): 532- 541. https://doi.org/10.1111/j.1467-8551.2012.00826.x

information on gender identity and sexual orientation would be equally valuable and would represent progress towards the key goals of carrying out more research on LGBTI+ health,[240] gathering better information and improving the research and data environment to better understand and meet the needs of LGBTI+ people[241,242] and carrying out regular consultations with mental health service users generally[243,244] and LGBTI+ mental health service users specifically.[245]

5.2: Conclusion

This project serves to highlight potential disparities between the experiences of LGBTI+ and non-LGBTI+ mental health services users. These disparities are very likely due, in part at least, to the additional issues and challenges faced by LGBTI+ mental health service users, not least a perceived lack of LGBTI+ competence and sensitivity among some mental health service providers. The project also highlights the range and diversity of LGBTI+ people's experiences of the mental health services. Some LGBTI+ mental health service users are experiencing mental health service provision that reflects national mental health policy, national LGBTI+ strategies and guidance for mental health service staff working with LGBTI+ service users, produced by the HSE, the MHC and professional representative bodies. However, many LGBTI+ people are not having wholly positive experiences of the mental health services, and some are having predominantly negative experiences. Positive experiences shared by participants were characterised by LGBTI+ competent and sensitive mental health service provision. In contrast, negative experiences were often characterised by a lack thereof, which at best hindered providers' ability to meet the needs of LGBTI+ service users and at worst manifested as inappropriate questions and comments by some mental health service providers, as well as apprehension and even fear among LGBTI+ service users. Having to explain one's gender and/or sexual identities to mental health service providers, to teach mental health service providers about LGBTI+ issues and terminology, and to self-censor when engaging with mental health service providers were common experiences. Stigma relating to, and pathologising of, LGBTI+ identification were also identified as challenges LGBTI+ mental health service users could face. Although the progressive and very welcome policies, strategies and guidance developed in recent years may be having a positive impact for some, the issues and challenges faced by many LGBTI+ mental health service users when accessing or attempting to access mental health services suggest that implementation of these policies, strategies and guidance may be limited and inconsistent. Taken together, findings not only highlight the considerable scope for improvement so that mental health services in Ireland can better meet the needs of all LGBTI+ people, they also provide guidance to decision makers on how best this can be achieved, guidance that is consistent with national mental health policy, with LGBTI+ National Strategies, and with professional guidance for those working with LGBTI+ service users. There are many steps that can be taken, but at a minimum, building the capacity of mental health service providers through education and training, coupled with regular consultation with LGBTI+ mental health service users to evaluate progress, is key to the delivery of LGBTI+ competent and sensitive mental health services that meet the needs of LGBTI+ people.

240 HSE, *LGBT health*
241 Department Children, Equality, Disability, Integration and Youth, *National LGBTI+ Inclusion*
242 Department of Children and Youth Affairs, *LGBTI+ national youth*
243 Department of Health, *Sharing the Vision*
244 OECD, *Establishing Standards for*
245 GLEN, *Lesbian, gay, bisexual*

6. Recommendations

6. RECOMMENDATIONS

LGBTI+ Competent and Sensitive Service Provision

1. Review and update policies, procedures, and practice to ensure that services are inclusive of, and responsive to, the needs of LGBTI+ mental health service users.

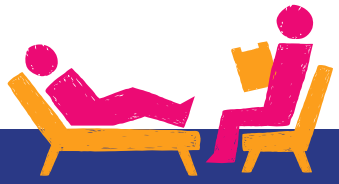
2. Professional bodies and service providers including the HSE integrate LGBTI+ issues into the curriculum across all training and professional development modules, where possible.

3. Build the LGBTI+ capacity of mental health service providers through accredited education, training and professional development opportunities for existing mental health service providers and LGBTI+ modules for mental health professionals providers in training.

4. LGBTI+ educational resources, training and development courses and modules should be developed in consultation with LGBTI+ mental health service users and should at a minimum cover the following:
    a. Sexual orientation, gender identity and LGBTI+ terminology
    b. Research on LGBTI+ mental health and well-being and the relationship between LGBTI+ identification and mental health
    c. The diversity within the LGBTI+ community in terms of identity, experience and need.

5. Review and update professional/good practice guidelines for mental health service providers working with LGBTI+ people. This should be done regularly and in consultation with LGBTI+ mental health service users.

6. Raise awareness of where LGBTI+ competent supports can be accessed. Information should be available on mental health professionals who are experienced in the intersectionality of issues facing people with mental health difficulties.



Treatment and Care

1. HSE Mental Health Services should aim to provide a range of treatment and care options including alternatives to medication where requested.
2. HSE Mental Health Services should ensure that talking therapy is a core component of the service offering and is readily available on an extended basis where necessary.
3. HSE Mental Health Services should provide LGBTI+ friendly reading material, literature and resources, including information on local LGBTI+ services and supports.
4. HSE Mental Health Services should ensure that LGBTI+ mental health service users get the opportunity to develop consistent relationships with mental health professionals that are not subject to frequent change.

Research and Evaluation

1. Given the findings in relation to the model of care, a more in-depth review of the transition model of care should be conducted and should include experiences of service-users.
2. Regular consultations with LGBTI+ mental health service users should be carried out. Where this is part of a larger consultation with mental health service users, an LGBTI+ module should be included in the larger survey. This would facilitate ongoing improvement of services and priority setting by the Minister with responsibility for Mental Health, Department of Health and HSE for annual service plans. This would also be consistent with policies, strategies and guidance outlined in this report and Ireland's obligations under the UNCRPD (see section 1.5).

REFERENCES

Adams, J., McCreanor, T. & Braun, V. “Gay Men’s Explanations Of Health And How To Improve It.” *Qualitative Health Research* 23, no.7 (2013): 887-899. https://doi.org/10.1177%2F1049732313484196

Alden, H.L. & Parker, K.F. “Gender Role Ideology, Homophobia And Hate Crime: Linking Attitudes To Macro-Level Anti-Gay And Lesbian Hate Crimes.” *Deviant Behaviour* 26, no.4 (2005): 321-343. https://doi.org/10.1080/016396290931614

Amos, R., Manalastas, E.J., White, R., Bos, H. & Patalay, P. “Mental Health, Social Adversity, And Health-Related Outcomes In Sexual Minority Adolescents: A Contemporary National Cohort Study.” *Child and Adolescent Health* 4, no.1 (2020): 36-45. https://doi.org/10.1016/S2352-4642(19)30339-6

Avery, A. M., Hellman, R.E. & Sudderth, L.K. “Satisfaction With Mental Health Services Among Sexual Minorities With Major Mental Illness.” *American Journal of Public Health* 91, no.6 (2001): 990-991. https://dx.doi.org/10.2105%2Fajph.91.6.990

Bariola, E., Lyons, A., Leonard, W., Pittts, M., Badcock, P. & Couch, M. “Demographic And Psychosocial Factors Associated With Psychological Distress And Resilience Among Transgender Individuals.” *American Journal of Public Health* 105, no.10 (2015): 2108-2116. https://dx.doi.org/10.2105%2FAJPH.2015.302763

Bolton, S.L. & Sareen, J. “Sexual Orientation And Its Relation To Mental Disorders And Suicide Attempts: Findings From A Nationally Representative Sample.” *Canadian Journal of Psychiatry* 56, no.1 (2011): 35-43. https://doi.org/10.1177/070674371105600107

Bostwick, W. B., Hughes, T.L. & Everett, B. “Health Behavior, Status, and Outcomes Among a Community-Based Sample of Lesbian and Bisexual Women.” *LGBT Health* 2, no.2 (2015): 121-126. https://dx.doi.org/10.1089%2Flgbt.2014.0074

Chakraborty, A., McManus, S. Brugha, T.S., Bebbington, P. & King, M. “Mental Health Of The Non-Heterosexual Population Of England.” *The British Journal of Psychiatry* 198, no.2 (2010): 143-148. https://doi.org/10.1192/bjp.bp.110.082271

Chan, R.C.H., Operario, D. & Mak, W.W.S. “Bisexual Individuals Are At Greater Risk Of Poor Mental Health Than Lesbians And Gay Men: The Mediating Role Of Sexual Identity Stress At Multiple Levels.” *Journal of Affective Disorders* 260 (2019): 292-301. https://doi.org/10.1016/j.jad.2019.09.020

Cochran, S. D. & Mays, V. M. “Burden Of Psychiatric Morbidity Among Lesbian, Gay, And Bisexual Individuals In The California Quality Of Life Survey.” *Journal of Abnormal Psychology* 118, no.3 (2009): 647-658. https://doi.org/10.1037/a0016501

CPI. *Lesbian, gay & bisexual patients: The issues for mental health practice*. Dublin: CPI, 2010. url: https://www.irishpsychiatry.ie/wp-content/uploads/2016/12/Lesbian-Gay-Bisexual-Patients-The-Issues-for-Mental-Health-Practice-Full-doc.pdf

D’Augelli, A. R. “Developmental and Contextual Factors and Mental Health Among Lesbian, Gay, and Bisexual Youths.” In *Sexual orientation and mental health: Examining identity and development in lesbian, gay, and bisexual people. Contemporary perspectives on lesbian, gay, and bisexual psychology*, edited by A. R. D’augelli, A. M. Omoto, & H. S. Kurtzman. Washington, DC, US: American Psychological Association, 2006. https://psycnet.apa.org/doi/10.1037/11261-002

David, S., & Knight, B. G. “Stress And Coping Among Gay Men: Age And Ethnic Differences.” *Psychology and Aging* 23, no.1 (2008): 62–69. doi.org/10.1037/0882-7974.23.1.62

Department Children, Equality, Disability, Integration and Youth. *National LGBTI+ inclusion strategy 2019-2021*. Dublin: Government of Ireland, 2019. url: https://www.justice.ie/en/JELR/LGBTI+Inclusion_Strategy_2019-2021.pdf/Files/LGBTI+Inclusion_Strategy_2019-2021.pdf

Department of Children and Youth Affairs. *LGBTI+ national youth strategy: Report of the consultations with young people in Ireland.* Dublin: Government of Ireland, 2017. url: https://www.drugsandalcohol.ie/28323/1/DOCYA_LGBTIConsultationStrategyReport.pdf

Department of Children and Youth Affairs. *LGBTI+ national youth strategy 2018-2020: LGBTI+ young people: visible, valued and included.* Dublin: Government of Ireland, 2018. url: https://assets.gov.ie/24459/9355b474de34447cb9a55261542a39cf.pdf

Department of Health. *Sharing the Vision: A mental health policy for everyone.* Dublin: Government of Ireland, 2020. url: https://www.gov.ie/en/publication/2e46f-sharing-the-vision-a-mental-health-policy-for-everyone/

Department of Health & Children. *A Vision for Change: Report of the expert group on mental health policy*. Dublin: The Stationary Office, 2006. url: https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf

Dooley, B., O'Conor, C., Fitzgerald, A. & O'Reilly, A. *My world survey 2: The national study of youth mental health in Ireland*. Dublin: Jigsaw & University College Dublin, 2019. url: http://www.myworldsurvey.ie/content/docs/My_World_Survey_2.pdf

Elliott, M., Kanouse, D.E., Burkhart, Q., Abel, G.A., Lyratzopoulos, G., Beckett, M.K, Schuster, M.A. & Roland, M. "Sexual Minorities In England Have Poorer Health And Worse Health Care Experiences: A National Survey." *Journal of General Internal Medicine* 30 (2015): 9–16. https://dx.doi.org/10.1007%2Fs11606-014-2905-y

Ellis, S. J., Bailey, L. & McNeil, J. "Trans People's Experiences Of Mental Health And Gender Identity Services: A Uk Study." *Journal of Gay & Lesbian Mental Health* 19, no.1 (2015): 4-20. https://doi.org/10.1080/19359705.2014.960990

GLEN. *Lesbian, gay, bisexual and transgender service users: Guidance for staff working in mental health services*. Dublin: GLEN, 2013. url: https://www.mhcirl.ie/sites/default/files/2021-01/Lesbian,%20Gay,%20Bisexual%20and%20Transgender%20Service%20Users_0.pdf

Hafeez, H., Zeshan, M., Tahir, M.A., Jahan, N. & Naveed, S. "Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review." *Cureus* 9, no.4 (2017). https://doi.org/10.7759/cureus.1184

Higgins, A., Doyle, L., Downes, C., Murphy, R., Sharek, D., DeVries, J., Begley, T., McCann, E., Sheerin, F. & Smyth, S. *The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland*. Dublin: GLEN & BeLonG To, 2016. url: https://www.belongto.org/wp-content/uploads/2019/02/250_LGBTIreland_Report_Key_Findings.pdf

Higgins, A., Downes, C., Murphy, R., Sharek, D., Begley, T., McCann, E., Sheerin, F., Smyth, S., De Vries, J. & Doyle, L. "Lgbt + Young People's Perceptions Of Barriers To Accessing Mental Health Services In Ireland." *Journal of Nursing Management* 29, no.1 (2020): 58-67. https://doi.org/10.1111/jonm.13186

HSE. *LGBT Health: Towards meeting the health care needs of lesbian, gay, bisexual, and transgender people.* Dublin: HSE, 2009. url: https://www.hse.ie/eng/services/publications/topics/sexual/lgbt-health.pdf

ICGP. *Guide for providing care for lesbian, gay and bisexual patients in primary care quick reference guide*. Dublin: ICGP, 2020. url: https://lgbt.ie/wp-content/uploads/2020/11/Guide_for_Providing_Care_for_Lesbian__Gay_and_Bisexual_Patients_in_Primary_Care_Quick_Reference_Guide.pdf

IIMHN. *Gay, lesbian & bisexual people: A good practice guide for mental health nurses*. Dublin: IIMGN, 2010. url: https://www.ilga-europe.org/sites/default/files/lesbian_gay_and_bisexual_people_-_a_good_practice_guide_for_mental_health_nurses.pdf

King, M. Semlyen, J., Tai, S.S., Killaspy, H., Osborn, D., Popelyuk, D. & Nazareth, I. "A Systematic Review Of Mental Disorder, Suicide, And Deliberate Self Harm In Lesbian, Gay And Bisexual People." *BMC Psychiatry* 8, no.1 (2008): 70. https://doi.org/10.1186/1471-244X-8-70

Kuyper, L. & Fokkema, T. "Minority Stress And Mental Health Among Dutch Lgbs: Examination Of Differences Between Sex And Sexual Orientation." *Journal of Counselling Psychology* 58, no.2 (2011): 222-233. doi.org/10.1037/a0022688

Lucassen, M., Clark, T., Moselen, E., Robinson, E., & The Adolescent Health Research Group. *Youth'12 the health and wellbeing of secondary school students in New Zealand: Results for young people attracted to the same sex or both sexes*. Auckland, New Zealand: The University of Auckland, 2014. url: https://oro.open.ac.uk/43995/1/Same%20Sex%20Report_14NM.pdf

Mayock, P., Bryan, A., Carr, N. & Kitching, K. *Supporting LGBT Lives: The mental health and well-being of lesbian, gay, bisexual and transgender people in Ireland.* Dublin: GLEN, 2009. url: https://www.hse.ie/eng/services/publications/mental-health/suporting-lgbt-lives.pdf

McCann, E. & Sharek, D. "Survey Of Lesbian, Gay, Bisexual, And Transgender People's Experiences Of Mental Health Services In Ireland." *International Journal of Mental Health Nursing* 23 (2014): 118-127. doi.org/10.1111/inm.12018

McCann, E. & Sharek, D. "Challenges To And Opportunities For Improving Mental Health Services For Lesbian, Gay, Bisexual, And Transgender People In Ireland: A Narrative Account." *International Journal of Mental Health Nursing* 23, no.6 (2014): 525-533. https://doi.org/10.1111/inm.12081

McNeil, J. Bailey, L., Ellis, S. & Regan, M. *Speaking from the Margins: Trans mental health and wellbeing in Ireland*. Dublin: Transgender Equality Network Ireland, 2013. url: https://lgbt.ie/wp-content/uploads/2018/06/attachment_5bdd0cd5-16b6-4ab6-9ee6-a693b37fdbcf.pdf

MHC. *Quality framework: Mental health services in Ireland* (Dublin: MHC, 2007). url: https://www.mhcirl.ie/sites/default/files/2021-01/The%20Quality%20Framework.pdf

MHC. *Your views of mental health inpatient services: Inpatient survey 2011*. Dublin: MHC, 2011. url: https://www.lenus.ie/bitstream/handle/10147/313472/YVNISFR11.pdf?sequence=1&isAllowed=y

Mental Health Foundation. *Mental health in Scotland: fundamental facts.* Prestwich: Mental Health Foundation, 2016. url: https://www.mentalhealth.org.uk/sites/default/files/FF16%20Scotland.pdf

Meyer, I.H. "Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence." *Psychological Bulletin* 129, no.5 (2003): 674-697. https://dx.doi.org/10.1037%2F0033-2909.129.5.674

Meyer, I. H. "Identity, Stress, And Resilience In Lesbians, Gay Men, And Bisexuals Of Color." *The Counselling Psychologist* 38, no.3 (2010): 442–454. https://doi.org/10.1177%2F0011000009351601

Mongelli, F., Perrone, D., Balducci, J., Sacchetti, A., Ferrari, Silvia, Mattei, G. & Galeazzi, G.M. "Minority Stress And Mental Health Among Lgbt Populations: An Update On The Evidence." *Minerva Psichiatrica* 60, no.1 (2019): 27-50. https://psycnet.apa.org/doi/10.23736/S0391-1772.18.01995-7

NSUE. *Summary report of the NSUE survey of members on Vision for Change: Have your voice heard... for a change*. Dublin: NSUE, 2011. url: https://www.academia.edu/33944234/Summary_Report_of_the_NSUE_Survey_of_Members_on_Vision_for_Change

Organisation for Economic Development and Cooperation (OECD). "Establishing Standards for Assessing Patient-reported Outcomes and Experiences of Mental Health Care in OECD Countries." *OECD Health Working Papers* 135, 2022. url: https://www.oecd-ilibrary.org/docserver/e45438b5-en.pdf?expires=1645548810&id=id&accname=guest&checksum=4D5AD718D3202B1AE506912FB6A258AC

Ó Féich, P., Mitchell, K., Pérez, S., & McDaid, S. *My Voice Matters: Report on a national consultation with mental health service users*. Dublin: Mental Health Reform, 2019. url: https://www.mentalhealthreform.ie/wp-content/uploads/2019/03/SU-MAIN-WEB.pdf

Ó Féich, P., Mitchell, K., Pérez, S., & McDaid, S. *My Voice Matters: Report on a national consultation with family, friends and carers/supporters of mental health service users*. Dublin: MHR, 2019. url: https://www.mentalhealthreform.ie/wp-content/uploads/2019/03/FFCS-MAIN_WEB.pdf

Page, E. H. "Mental Health Services Experiences Of Bisexual Women And Bisexual Men: An Empirical Study." *Journal of Bisexuality* 4 (2004): 137-160. https://doi.org/10.1300/J159v04n01_11

Pakula, B., Carpiano, ,R.M., Ratner, P.A. & Shoveller, J.A. "Life Stress As A Mediator And Community Belonging As A Moderator Of Mood And Anxiety Disorders And Co-Occurring Disorders With Heavy Drinking Of Gay, Lesbian, Bisexual And Heterosexual Canadians." *Social Psychiatry and Psychiatric Epidemiology* 51, no.8 (2016): 1181-1192. https://doi.org/10.1007/s00127-016-1236-1

Ploderl, M., Wagenmakers, E., Tremblay, P. Ramsey, R. Kralovec, K. Fartacek, C. & Fartacek. R. "Suicide Risk And Sexual Orientation: A Critical Review." *Archives of Sexual Behavior* 42, no.5 (2013): 715-727. https://doi.org/10.1007/s10508-012-0056-y

Price-Feeney, M., Green, A., & Dorison, S. "Understanding The Mental Health Of Transgender And Nonbinary Youth." *Journal of Adolescent Health* 66, no.6 (2020): 684–690. https://doi.org/10.1016/j.jadohealth.2019.11.314

PSI. *Guidelines for good practice with lesbian, gay and bisexual clients*. Dublin: PSI, 2015. url: https://www.psychologicalsociety.ie/source/PSI%20Guidelines%20for%20Good%20Practice%20with%20LGB%20Clients_1.pdf

Rodgers, S. M. "Transitional Age Lesbian, Gay, Bisexual, Transgender, And Questioning Youth: Issues Of Diversity, Integrated Identities, And Mental Health." *Child and Adolescent Psychiatric Clinics of North America* 26, no.2 (2017): 297–309. https://doi.org/10.1016/j.chc.2016.12.011

Rothman, E. F., Exner, D., & Baughman, A. L. "The Prevalence of Sexual Assault Against People Who Identify as Gay, Lesbian, or Bisexual in the United States: A Systematic Review." *Trauma, Violence, & Abuse* 12, no.2 (2011): 55-66. https://doi.org/10.1177/1524838010390707

Russell, S.T. & Fish, J.N. "Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth." *Annual Review of Clinical Psychology* 12 (2016):465-487. https://dx.doi.org/10.1146%2Fannurev-clinpsy-021815-093153

Schulman, J.K. & Erickson-Schroth, L. “Mental Health in Sexual Minority and Transgender Women.” *The Medical Clinics of North America* 103, no.4 (2019): 723-733. https://doi.org/10.1016/j.mcna.2019.02.005

Sheldon, H., Graham, C., Pothecary, N. & Rasul, F. *Increasing response rates amongst black and minority ethnic and seldom heard groups: A review of literature relevant to the national acute patients' survey*. Oxford: Picker Institute, 2007. url: https://www.academia.edu/26515283/Increasing_Response_Rates_Amongst_Black_and_Minority_Ethnic_and_Seldom_Heard_Groups

Taylor, P. *A survey of LGBT Americans: attitudes, experiences and values in changing times*. Washington, D.C: Pew Research Center, 2013. url: https://www.pewresearch.org/social-trends/2013/06/13/a-survey-of-lgbt-americans/

Thyen, U., Lux, A., Jurgensen, M., Hiort, O. & Kohler, B. “Utilization Of Health Care Services And Satisfaction With Care In Adults Affected By Disorders Of Sex Development (Dsd).” *Journal of General Internal Medicine* 29 (2014): 752–759. https://doi.org/10.1007/s11606-014-2917-7

Trau, R. N., Härtel, C. E., & Härtel, G. F. “Reaching And Hearing The Invisible: Organizational Research On Invisible Stigmatized Groups Via Web Surveys.” *British Journal of Management* 24, no.4 (2013): 532- 541. https://doi.org/10.1111/j.1467-8551.2012.00826.x

UK Care Quality Commission. *Community mental health survey: Quality and methodology report*. London: UK Care Quality Commission, 2017. url: https://www.cqc.org.uk/sites/default/files/20171115_cmh17_qualitymethodology.pdf

United Nations General Assembly. *Convention on the Rights of Persons with Disabilities (A/RES/61/106)*. New York: United Nations, 2007. url: http://www.un.org/ disabilities/documents/convention/convoptprot-e.pdf

Utamsingh, P., Richman, L.S., Martin, J.L., Lattanner, M.R. & Chaaikind, J.R. “Heteronormativity And Practitioner-Patient Interaction.” *Health Community* 31 (2016): 566–574. https://doi.org/10.1080/10410236.2014.979975

WHO. *International Classification of Diseases 11th Revision: The global standard for diagnostic health information*. WHO, 2019. url: https://icd.who.int/en

Wilson, C., & Cariola, L. A. “LGBTQI+ Youth And Mental Health: A Systematic Review Of Qualitative Research.” *Adolescent Research Review* 5, no.2 (2019): 187–211. https://doi.org/10.1007/s40894-019-00118-w

Zeeman, L., Sherriff, N., Browne, K., McGlynn, N., Mirandola, M., Gios, L., Davis, R., Sanchez-Lambert, J., Aujean, S., Pinto, N., Farinella, F., Donisi, V., Niedzwiedzka-Stadnik, M., Rosinska, M., Pierson, A., Amaddeo, F. & Health4LGBTI Network. “A Review Of Lesbian, Gay, Bisexual, Trans And Intersex (LGBTI) Health And Healthcare Inequalities.” *European Journal of Public Health* 29, no.5 (2019): 974-980. https://doi.org/10.1093/eurpub/cky226

APPENDICES

APPENDIX A

Information sheet for focus group participants

Introduction
Through this project, Mental Health Reform and LGBT Ireland aim to document and analyse the lived experiences of LGBTI+ people who use mental health services in Ireland. What we learn will be used to explore how mental health services can better meet the needs of LGBTI+ people. This will help to guide both organisations in our campaigning and advocacy work on the subject.

1. Who can take part in this research study?
You must be 18 years of age or older, and must have accessed mental health services in the last 2 years. These services can be public or private, and may include a psychiatrist, community mental health services*, or inpatient services.

2. What will happen if I decide to take part in this research study?
You will talk to us about your views and experiences of using mental health services. This will be done online in a focus group with 4 to 6 other people. Dr Pádraig Ó Féich and I will be there to guide and record the discussion.

3. What are the benefits of taking part in this research study?
You will help us learn more about the experiences of LGBTI+ people who use mental health services. This will help us campaign for better mental health services for the LGBTI+ community. In this way, you could help to change these services for the better.

4. What are the risks of taking part in this research study?
The risks involved are minimal, but some people might get upset or uncomfortable during their focus group. If you feel this way, you can stop, take a break, and decide whether to keep going or not.

5. How will the data/information be used?
We will use what you tell us to find out how the experiences of LGBTI+ people who use mental health services could be improved. What we learn will be used in our campaign and advocacy work for better mental health services. We may also use the data in a later study, for other publications (e.g. articles, book chapters, etc.), or to make presentations. To protect your privacy, we will change or delete details like names and place names, etc.

*HSE community based mental health care involves provision of mental health care for people with severe or complex difficulties in your local area. Community mental health teams should include staff from a range of different disciplines including psychiatrists, psychologists, occupational therapists, social workers, peer support workers, and mental health nurses.

LGBT IRELAND Mental Health Reform

6. How will the data/information be stored?
The audio from focus groups will be recorded and transcribed later. Recordings will be deleted once transcripts are made. Transcripts will be made anonymous by deleting or changing names, place names, and other details that could be used to identify you.

Transcripts will be stored in a password protected folder on an encrypted computer owned by Mental Health Reform. A back-up will be kept on a password protected cloud-based drive. All transcripts will be stored for up to 1 year to allow time for an audit if needed. They will be deleted / destroyed 1 year after the end of the project. Only the Mental Health Reform research team will have access to the data.

7. How will you protect my privacy?
Every effort will be made to ensure the privacy, confidentiality, and anonymity of participants. Anonymising data improves privacy protection and is considered the best protection for personal information/data. Focus group transcripts will be made anonymous as far as is possible. Names, place names, and other potentially identifiable information will be changed and/or deleted.

It should be noted that neither anonymity nor confidentiality can be fully guaranteed with focus groups. The actions of group members after the focus group ends cannot be controlled by the researcher(s). But we will remind the group at the start of the focus group that the discussion is confidential.

Confidentiality is also limited where certain laws apply. For example, if a participant were to say something indicating a risk to themselves or others, the research team would have to act in the best interest of the person(s) at risk.

8. Can I change my mind at any stage and withdraw from the study?
Yes. You can leave the study up to when we change or delete names, place names, etc. from the focus group transcript. After that, it will be impossible to know what information you gave us, so we will not be able remove it then.

9. How will I find out what happens with this project?
Our report will be published on www.mentalhealthreform.ie and www.lgbt.ie. If you are happy for us to store your contact details, we will email you a copy when it is ready to be published. We will also contact you if, for some reason, we do not finish the project or publish the report. We will not use your contact details for any other reason and will delete them once you have been contacted about the report.

If you agree to take part in the research, we will ask you sign a consent form giving us permission to carry out the research as described above.

For questions or to take part, contact:
Paddy (he/his), at 086 0245409 or pofeich@mentalhealthreform.ie

LGBT IRELAND

Mental Health Reform

APPENDIX B

Consent form for focus group participants

Mental Health Reform
Promoting Improved Mental Health Services

Consent Form

DECLARATION:

I have read the information sheet and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time (until either my information has been anonymised or the results have been published) without disadvantage. Also, if I do not want to answer a particular question or questions, I am free to decline.

I agree to this interview/focus group being recorded. I understand that this recording will be transcribed and all identifiable information will be removed.

I understand that my responses will be confidential and that my name will not be identified in any publications resulting from this project. I also understand that only the researchers working on this project will have access to the data. I understand that all data will be retained for one year after completion of the project to facilitate a retrospective audit, if required. All data will be destroyed after this point.

I agree that the anonymised data can be used for the publication of a report, future scientific/academic publications and conference presentations, and for Mental Health Reform's campaign work in the future.

I agree to take part in this research.

Name of Participant (in block letters):_____

Signature:_____

Date:

Mental Health Reform
Promoting Improved Mental Health Services

LGBT IRELAND
For Inclusion
For Equality
For Everyone

HSE
Seirbhís Sláinte Níos Fearr á Forbairt
Building a Better Health Service