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Evidence to Inform the Development of Guidance for Mental Health Service Providers on the Care and Treatment of LGBTQIA+ Service Users

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Glossary of LGBTQIA+ terminology and concepts[1]

Androsexual is a term used to describe someone who experiences attraction to men and/or masculinity and/or male anatomy, regardless of whether the object of one's affection identifies as a man.

Agender is a term used to describe someone who identifies as having no gender, or gender identity, or identifies as non-gendered.

AFAB is an acronym which stands for Assigned Female at Birth and is a term used to describe someone whose sex was assigned as female at birth, typically based on their anatomical and other biological characteristics.

AMAB is an acronym which stands for Assigned Male at Birth and is a term used to describe someone whose sex was assigned as male when born, typically based on their anatomical and other biological characteristics.

Aromantic is a term used to describe someone who experiences little or no romantic attraction to others.

Asexual or Ace is a term used to describe someone who experiences limited or no sexual attraction.

Aroace is short for aromantic asexual and is a term used to describe someone who does not experience romantic or sexual attraction to others.

Bisexual or Bi is a term used to describe someone who is sexually and romantically attracted to multiple genders.

Biphobia is a dislike, fear or hatred of bisexual people.

BIPOC is an acronym which stands for black, indigenous, and other people of colour.

Bi-erasure is ignoring, removing, or re-explaining the evidence of bisexuality.

Cisgender or Cis is a term used to describe an individual's gender when their experiences of their gender correspond to the sex they were assigned at birth.

Coming out is a process that involves developing an awareness of one's LGBTQI+ identity, accepting one's sexual orientation or gender identity, choosing to share the information with others and building a positive LGBTQI+ identity. It not only involves coming out, but staying out and dealing with the potential challenges that one might encounter as an LGBTQI+ person.

Demi-girl is someone who only partially (not wholly) identifies as a girl or woman, whatever their assigned sex at birth.

Deadnaming is the act of referring to a transgender or non-binary person by a name they used prior to transitioning, such as their birth name.

Demisexual is a term used to describe someone who feels sexual attraction only to people with whom they have an emotional bond.

[1] Glossary drawn from the *Being LGBTQI+ in Ireland* study (Higgins et al., 2024) with permission of the authors.

Detransition refers to the stopping or reversal of gender transitioning which could be social (gender presentation, pronouns), medical (hormone therapy), surgical, or legal.

DIY HRT (do-it-yourself hormone replacement therapy) is a phenomenon where transgender people obtain and self-administer hormones as part of their medical transition without the guidance of a licensed medical provider.

Families of choice, or **'friendship families'**, refer to non-familial social networks, which have been highlighted as playing a larger role in the lives of LGBTQI+ people when compared to heterosexual people.

Female-to-Male (FTM) Transgender refers to a person assigned 'female' at birth but who identifies as male.

Gay is a term traditionally used to describe a man who is sexually and romantically attracted to other men. While the term 'lesbian' is typically used to describe women who are attracted to other women, many women with same-sex attractions self-identify as 'gay'.

GBTQ is an acronym for 'gay, bisexual, transgender, queer/questioning.'

Gender fluid refers to a person who does not feel confined by the binary division of male and female.

Gender identity refers to how a person identifies with a gender category. For example, a person may identify as either male or female, or in some cases as neither, both or something else.

Gender identity disorder is a controversial term. Within the medical world it refers to a formal medical diagnosis for the condition in which a person experiences persistent discomfort and disconnect with the biological sex with which they were born. It was included in the Diagnostic and Statistical Manual of Mental Disorder in 1994 as a replacement for the term 'transsexualism'.

Gender non-conforming or gender diverse is an umbrella term for the wide variety of gender identities that exist outside of the binary of man or woman and do not conform to traditional gender roles.

Gender affirming surgery refers to a variety of surgical procedures by which the physical appearance and function of existing sexual characteristics and/or genitalia are altered to resemble the person's gender identity.

Gender critical refers to beliefs about sex being biological and unchanging, while also opposing the idea of gender identity and gender identity-based rights.

Genderqueer is a term used to describe someone who possesses identities that fall outside of the widely accepted gender binary.

Gender-neutral language is language that avoids reference towards a particular sex or gender.

Gynosexual is a term used to describe a person, of any gender or gender non-conforming, which is attracted to femininity, regardless of the gender identity of the femme-presenting person they are attracted to.

Hate speech is any kind of communication that attacks or uses pejorative or discriminatory language with reference to a person or a group based on race, ethnicity, religion, sexual orientation, or similar grounds.

Heteroflexible is a term used to describe someone who primarily identifies as heterosexual, or "straight," but is sometimes attracted to the same sex.

Heteronormative, or the **'heterosexual norm'**, refers to the assumption that heterosexuality is the only sexual orientation. It is closely related to 'heterosexism' (see definition) and can often cause other sexual orientations to be ignored and excluded.

Heterosexual is a term used to describe someone who is sexually and romantically attracted to a person of the opposite sex.

Heterosexism is the assumption that being heterosexual is the typical and 'normal' sexual orientation, with an underlying assumption that it is the superior sexual orientation. This assumption often results in an insensitivity, exclusion or discrimination towards other sexual orientations and identities, including LGBTQI+.

Homophobia is a dislike, fear or hatred of lesbian and gay people.

Internalised homophobia is the homophobia of a lesbian, gay, or bisexual person towards their own sexual orientation. It has been described as the conscious or unconscious incorporation of society's homophobia into the individual. It can be recognised or unrecognised by the individual but has been found to lead to struggle and tension, sometimes severe, for a person when dealing with their sexual orientation and identity.

Internalised stigma occurs when a person cognitively or emotionally absorbs stigmatising assumptions and stereotypes and comes to believe and apply them to themselves.

Intersex is an umbrella term used to describe a variety of conditions in which a person is born with anatomy or physiology that does not fit societal definitions of female or male (e.g. sexual or reproductive anatomy, chromosomes, and/or hormone production).

Lesbian is a term used to describe a woman who is sexually and romantically attracted to other women.

LGB is an acronym for 'lesbian, gay and bisexual'.

LGBT is an acronym for 'lesbian, gay, bisexual and transgender'.

LGBTI is an acronym for 'lesbian, gay, bisexual, transgender and intersex'.

LGBTQI is an acronym for 'lesbian, gay, bisexual, transgender, queer/questioning and intersex'.

LGBTQI+ stands for 'lesbian, gay, bisexual, transgender, queer/questioning and intersex' with the '+' signifying inclusivity to all sexual and gender identities.

LGBTQIA+ stands for 'lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual' with the '+' signifying inclusivity to all sexual and gender identities.

LGBTQI+ bullying*:* Bullying based on prejudice or discrimination towards LGBTQI+ people.

LGBTQI+-friendly refers to services, programmes, groups and activities which recognise, are inclusive of and welcoming to, LGBTQI+ people.

LGBTQI+-specific is a term used to describe services, programmes, groups and activities that are aimed at and cater specifically to LGBTQI+ people.

Male-to-Female (MTF) Transgender refers to a person assigned 'male' at birth but who identifies as female.

Microaggressions are brief and often subtle slights or derogatory acts, that may or may not be intentional but communicate negative viewpoints toward a person, for example, making flippant comments that are rooted in a heteronormative viewpoint.

Minority stress is based on the premise that LGBTQI+ people, like members of any minority group, are subject to chronic psychological stress due to their group's stigmatised and marginalised status. While LGBTQI+ people are not inherently any more prone to mental health problems than other groups in society, coping with the effects of minority stress can be detrimental to LGBTQI+ people's mental health.

Misgendering is the act of using the wrong pronouns or gendered language when talking to or about someone.

MSM is an abbreviation for men who have sex with men.

Neopronouns are a category of new (neo) pronouns that are increasingly used in place of "she," "he," or "they" when referring to a person. Some examples include: xe/xem/xyr, ze/hir/hirs, and ey/em/eir.

Non-binary or **Enby** (plural enbies) is a term used to describe someone whose gender identity is neither exclusively woman or man or is in between or beyond the gender binary.

Omnisexual is a term used to describe someone who is attracted to all genders.

Pansexual is sexual or romantic attraction toward people of any sex or gender identity.

Panromantic is a term used to describe romantic attraction towards persons of every gender(s).

Queer is an umbrella term used to describe people who are not heterosexual and/or are not cisgender. Queer was used as a slur against the LGBTQ+ community for many years and still can be. However, the word has been reclaimed by LGBTQ+ communities and many now embrace the term as one denoting any gender identity or sexuality that does not fit society's traditional ideas about gender or sexuality. Queer may also be used to indicate people's identification with a politically alternative perspective to what some might see as the more assimilationist perspectives of the LGBTQI+ communities.

Questioning is the process of examining one's sexual orientation and/or gender identity.

Sexual identity refers to how a person identifies in terms of sexual or emotional attraction to others. It includes a wide range of identities, with the most typical being gay, lesbian, bisexual and heterosexual. A person's sexual identity may be different than their sexual behaviours and practices.

Sexual and gender minority (SGM) is an umbrella term that encompasses populations included in the acronym "LGBTI" (lesbian, gay, bisexual, transgender and intersex), and those whose sexual orientation or gender identity varies.

Sexual orientation refers to an enduring pattern of emotional, romantic or sexual attraction to others. It includes a wide range of attractions and terms, the most common being gay, lesbian, bisexual and heterosexual.

Stealth is a term used to describe transgender people who have transitioned and are living their gender openly but have not informed the people around them about their transgender status.

Trans Exclusionary Radical Feminism (TERF) or 'TERFs' is a term used to separate feminists who do not support trans people from those who do. TERFs are opposed to the recognition of trans people's genders, particularly trans women as women, opposed to transgender rights, and support the exclusion of trans women from women's spaces. These beliefs are often based on the view that biological sex should determine one's gender.

Transgender is an umbrella term referring to people whose gender identity and/or gender expression differs from conventional expectations based on the sex they were assigned at birth. This can include people who self-identify as trans men, trans women, transsexual, transvestite, cross-dressers, drag performers, genderqueer, and gender variant.

Transmasculine/Transmasc is someone assigned a female sex at birth and who identifies as masculine but may not identify wholly as a man.

Transfeminine is someone assigned a male sex at birth who identifies as feminine but may not identify wholly as a woman.

Transphobia is a dislike, fear or hatred of people who are transgender, transsexual, or people whose gender identity or gender expression differs from the traditional binary categories of 'male' and 'female'.

Transsexual is a controversial and contested term**.** It refers to a person whose gender identity differs from the sex assigned to them at birth. It was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) in 1994 and replaced with gender identity disorder.

Transitioning is the process through which a person takes steps to live openly as their gender. This can include changing appearance, mannerisms, name/pronouns, legal documentation, and other personal, social, and legal changes. This may also include undertaking hormone replacement therapy and/or gender affirming surgery.

Executive Summary

Introduction

A significant body of research has consistently demonstrated that LGBTQIA+ people experience a disproportionate burden of mental health difficulties compared to the general population. In Ireland, the largest study of the mental health of LGBTQI+ people to date, the *Being LGBTQI+ In Ireland* study (Higgins et al., 2024) reported poorer mental health outcomes compared to its prequel study the *LGBTIreland study* (Higgins et al., 2016). These differences were particularly marked in young people under the age of 25 years and in transgender people. While there were a number of positive findings about participants' general healthcare experiences, there were reported gaps in healthcare provider knowledge of LGBTQIA+ identities, and barriers to accessing mental healthcare specifically including resource barriers, stigma, and the fear of pathologisation. Negative encounters centred on engaging with mental health practitioners who were unsure how to react to the person's gender identity or sexual orientation, or were disinterested and not supportive, with participants detailing incidents when they were disregarded, not taken seriously or misgendered. Positive experiences centred on engaging with respectful, sensitive and knowledgeable practitioners.

A 2022 study by Mental Health Reform, the *My LGBTI+ Voice Matters* study focused specifically on the views of LGBTI+ mental health service users who used community mental health services, inpatient mental health services, and/or a psychiatrist in the two years prior to taking part in the study. Compared to non-LGBTI+ participants, a greater proportion of LGBTI+ service users reported 'never' feeling well-supported by their current psychiatrist and fewer LGBTI+ participants reported 'always' being treated with respect and dignity by community mental health services. Participants reported a lack of LGBTI+ competence amongst mental health professionals, needing to self-censor their LGBTI+ identity, getting inappropriate questions and comments, and having their LGBTI+ identity pathologized by attributing their mental health difficulties to their identity.

It is evident that there are a sizeable proportion of people, particularly young people and transgender people who report a significant level of mental distress and unmet mental health needs, and mental health services in Ireland need to be responsive to these needs. The dominant culture in mental health settings and among mental health professionals is generally heteronormative and cis-normative (Rees et al., 2021). This needs to be challenged by practices that are inclusive, respect equality and are LGBTQIA+ affirming. In recent years, LGBTI+ specific policy documents such as *The LGBTI National Youth Strategy 2018-2020* (DCYA, 2018) and the *National LGBTI+ Inclusion Strategy 2019-2021*

(DCEDIY, 2019) have referred to the importance of LGBTI+ inclusive healthcare and LGBTI+ knowledgeable and affirming healthcare staff. In addition to these LGBTI+ specific policies, mainstream mental health policies including *Connecting for Life Ireland's National Strategy to Reduce Suicide 2015- 2024* (DoH, 2015), and the national mental health policy *Sharing the Vision 2020-2030* (DoH, 2020) identify the LGBTQI+ group as a priority group requiring targeted mental health actions. Recommendation 61 of *Sharing the Vision* explicitly states that 'The HSE should maximise the delivery of diverse and culturally competent mental health supports' (DoH, 2020:63). This is supported by the Quality Framework of the Mental Health Commission (Farrelly et al., 2023) which promotes ensuring quality through the provision of equal, socially inclusive, and diverse mental healthcare services. The reviews to follow in this report contribute to the evidence base to inform the development of guidance for mental health service providers on the care and treatment of LGBTQIA+ service users.
The reviews are:

Review 1: A summary of empirical evidence on mental health challenges commonly faced by LGBTQIA+ people (Chapter 3).

Review 2: A summary of empirical evidence on the causation between 'minority stress' and mental health challenges faced by LGBTQIA+ people (Chapter 4).

Review 3: A comprehensive overview of the key challenges faced by LGBTQIA+ people in receiving quality care and treatment from mental health service providers. Highlight strategies and good practice underscored in the literature as key enablers for service providers in mitigating those challenges (Chapter 5).

Review 4: A comprehensive review of current practice and policy on mental health service provision to LGBTQIA+ persons including any strategies/standards/guidance/code of practice published in Ireland or other comparable jurisdictions (Chapter 6).

In addition, this report contains a brief overview of key legislation including rights-based considerations that may impact the treatment and care of LGBTQIA+ people accessing mental health services in Ireland (Chapter 7). The report concludes with some 'Considerations for Ireland' outlining key recommendations based on the reviews conducted which may guide the Mental Health Commission in their development of new guidance for mental health service providers on the care and treatment of LGBTQIA+ service users (Chapter 8).

Methods

A rapid review methodology was utilised based on recommendations issued by the Cochrane Rapid Review Methods Group (Garrity et al., 2021), with some modifications. Consultations with the

commissioners of this review (Mental Health Commission) were held at several timepoints to discuss the parameters of the review, topic refinement, and any emerging issues requiring pragmatic decisions. Search strategies for each review were developed with the assistance of a subject librarian. Within each review, a single reviewer completed title and abstract screening, with two reviewers completing full text review. Data extraction was undertaken by a single reviewer within each review, with a second reviewer carrying out random checking for accuracy in 10% of the data extraction decisions made. Each included paper underwent a critical appraisal by one reviewer with methods appropriate to the study type. A narrative synthesis was conducted with key findings presented thematically.

Key Findings

Review 1: **A summary of empirical evidence on mental health challenges commonly faced by LGBTQIA+ people:**

- Prevalence rates of suicide attempts, suicidal thoughts and behaviours, and non-suicidal self-injury are higher in sexual and gender minorities.

- Rates of anxiety and depression, including perinatal depression, are higher in LGBTQIA+ people.

- Eating disorder behaviours are higher in sexual minority individuals, with higher rates in gay males compared to lesbian females.

Review 2: A summary of empirical evidence on the causation between 'minority stress' and mental health challenges faced by LGBTQIA+ people:

- Proximal and distal stressors related to minority stress negatively impact mental health.

- Proximal stressors identified include expectation of rejection and internalisation of negative attitudes, beliefs, and stereotypes.

- Distal stressors identified include discrimination, rejection, victimisation and harassment.

Review 3: A comprehensive overview of the key challenges faced by LGBTQIA+ people in receiving quality care and treatment from mental health service providers. Highlight strategies and good practice underscored in the literature as key enablers for service providers in mitigating those challenges:

- Access to mental healthcare is a key barrier and includes geographical barriers, resource barriers, impact of stigma and challenges accessing LGBTQIA+ affirming treatment.

- The mental healthcare setting can also be a barrier and includes the attitudes of staff, the knowledge and competence of staff and the prominence of a psychiatry/biomedical model.

- Positive experiences in the mental healthcare setting focused on an accepting and validating environment and the presence of knowledgeable staff within that environment.

Review 4: A comprehensive review of current practice and policy on mental health service provision to LGBTQIA+ persons including any strategies/standards/guidance/code of practice published in Ireland or other comparable jurisdictions:

- Best practice suggests the provision of a welcoming healthcare environment, with affirming and visible organisational policies and practices.

- Training and education are recommended for all staff working with LGBTQIA+ people, with a particular focus on education about trans identities and lives.

- A mental health service that is trauma-informed, considers intersecting identities and is strengths-based and recovery-orientated is recommended.

Recommendations

Grounded in the evidence produced in each of these 4 reviews, and particularly the findings from Chapter 6 (review of best practice guidance/strategies), some key considerations to inform the Mental Health Commission's development of guidance for mental health service providers on the care and treatment of LGBTQIA+ service users in an Irish context are presented here.

<u>Access to mental health services</u>

- Mental health services should ensure there is timely access to a range of supports for LGBTQIA+ people, with increased transparency about how to access these supports.
- Mental health services should ensure there is a range of supports available outside of the traditional structures of in-patient and community services, to include LGBTQIA+ peer supports and digital mental health supports.
- Increased access to psychological therapies is warranted both for service users currently attending the mental health services, and beyond.

<u>LGBTIQIA+ policies and guidelines</u>

- At a mental health organisational and service level, relevant personnel should undertake an impact assessment of each of the existing policies on LGBTQIA+ mental health, ensuring they are inclusive of, and responsive to the needs of LGBTQIA+ service users. Policies should

consider LGBTQIA+ specific issues that may impact on a service user's experience and include antidiscrimination policies, confidentiality policies, visiting policies and policies for trans-affirmative care in the in-patient setting.

- Consider a comprehensive policy of trauma-informed care in mental health services to avoid retraumatising LGBTQIA+ individuals who have experienced minority stress attending the services.
- Policies relating to LGBTQIA+ rights within the mental health setting should be co-designed with members of the LGBTQIA+ community who have experience using mental health services and know from personal experience the issues that impact them in this setting.
- In addition to ensuring existing policies are LGBTQIA+ affirmative, and developing new policies where required, these policies should be available to all service users to view, and the key tenets of them displayed prominently within the service setting.
- Within a broader policy context, LGBTQIA+ individuals should continue to be acknowledged as a high risk group for mental distress and suicidal behaviour within public mental health policy. A significant percentage of transgender individuals experience suicidal ideation and many of these go on to attempt suicide. Transgender individiuals should be prioritised within suicide prevention strategy policies.

8.3 The mental health setting

- The first interaction the LGBTQIA+ service user has with a mental health service can send an instant message of affirmation or dismissal. An inclusive mental health setting needs to show that it is inclusive in the first instance through the means of visual cues. These include prominently displayed rainbow posters/flags that are inclusive of intersecting identities (e.g. the intersectional flag which includes black and brown colours to represent marginalised people of colour, and also includes the transgender flag), rainbow lanyards and name badges and LGBTQIA+ literature in waiting rooms, reading rooms, etc.
- The website of the organisation should also have LGBTQIA+ affirming visual cues (e.g. rainbow logo).
- Visibility of LGBTQIA+ staff in the environment is important to service users, and a recruitment policy that specifically welcomes applications from LGBTQIA+ staff shows that a service is inclusive. However, it is important that if there is a LGBTQIA+ staff member in the mental health setting, they do not become the 'go-to' person to interact with all LGBTQIA+ service users.

- An assessment of clinical documentation, including electronic records, within the mental health care environment should be undertaken to determine how inclusive they are of LGBTQIA+ people and language, particularly in relation to recording of preferred names (vs legal name if different), recording of gender identity and recording of sexual orientation. While there are mixed views in the literature on this, the general consensus is that if asking about gender identity and sexual orientation, it should be asked of all service users and not just those with a LGBTQIA+ identity.
- Mental health organisations/settings could consider using a benchmarking tool to assess how LGBTQIA+ inclusive the service is. A positive score on this, displayed prominently, signals to the LGBTQIA+ service user that the service is inclusive.
- For people who are transgender, there is a requirement for additional protocols to ensure their comfort and safety:

  1. There are additional challenges when in an in-patient setting with regard to the allocation to single sex wards, rooms and bathrooms. The general recommendation in the literature is that the trans person should be assigned to accommodation matching their gender identity. However, authors do note some tensions around this that may need to be considered. Mental health settings should establish a policy for allocation of rooms that is respectful of the trans person and other service users. While single room allocation is seen as a solution by some, this may be an isolating experience for the trans service user.

  2. A conflict may arise between safety (suicide risk) and gender-affirming measures where, for example, trans people may be asked to remove their chest binder as it may pose a ligature risk. Supplying pre-approved safe binders may serve to reduce this risk and still maintain a gender-affirming stance with the person.

8.4 Interpersonal interactions and therapeutic considerations

- Interpersonal interactions with a LGBTQIA+ service user, even brief ones, have the potential to leave a person feeling dismissed and unheard, or affirmed and included. Not making assumptions about a person's identity on first meeting them is important, as is the use of inclusive language.
- Using preferred names and pronouns when they are known is important, as is following the lead of the service user in that regard.

- Asking questions about the person's sexual orientation or gender identity if it is relevant to the clinical encounter may be important and required, however, these questions should not be asked from a curiosity perspective if not related to the clinical encounter.
- There is a balance between not ignoring or dismissing disclosures of LGBTQIA+ identity which can make a service user feel unheard and unseen, and overly focusing on their identity as the 'cause' of their mental health problems when the issues they are experiencing may not be relevant or attributable to their identity.
- Clarifications can be sought from the service user on aspects of their LGBTQIA+ identity if relevant to the clinical encounter, however mental health professionals should not rely on the service user to educate them on broader aspects of LGBTQIA+ identity, culture and language which is information that should be sourced through training.
- LGBTQIA+ individuals can experience high incidences of trauma throughout their lifespan. This may include verbal, physical, or emotional abuse, adverse childhood experiences, or discrimination in relation to sexual and/or gender identity and internalised negativity related to their sexual orientation or gender identity. Given the extent of the trauma and discrimination, clinicians should be especially cognisant of this when carrying out mental health assessments and providing care to this group.
- Working from a trauma-informed, strengths-based perspective is important to ensure that the impact of the negative and damaging attitudes and behaviours LGBTQIA+ people may have experienced are considered, while drawing on the person's own strengths and supports to work through those experiences.
- Bisexual and transgender individuals were shown to have an increased risk for suicidal behaviour including self-harm. It is important that staff are equipped with the necessary skills to identify, assess, and manage risk factors for suicidal behaviour for LGBTQIA+ individuals. Clinicians should receive training on risk assessment and management that is mindful and inclusive of the specific risks that these individuals can face.
- Implementing interventions to address internalised symptoms/feelings in relation to an individual's sexual orientation e.g., thwarted belongingness, biphobia etc. would be beneficial, as these factors appear to have a significant influence on risk for LGBTQIA+ youth.
- Conversion practices, or any practices that are underpinned by the belief that a person's gender identity or sexual orientation can and should be changed should not be used in any form. Mental health professionals engaging in any form of conversion practices should face sanctions within the organisation and reported to their professional body.

- Mental health professionals should ensure that post-discharge supports and referrals are to organisations that are LGBTQIA+ affirmative.

8.5 Training and education

- All staff who have contact of any nature with LGBTQIA+ service users should receive training to ensure they use affirmative approaches with LGBTQIA+ service users and training should include the use of affirmative approaches and inclusive language. Education and training should be grounded within a framework of cultural humility which encourages a consideration of personal biases and heteronormative and cisgender assumptions and the impact of these on LGBTQIA+ service users.
- The negative impact of often cumulative microaggressions on LGBTQIA+ service users, whether intended or not, should be made explicit, with education focusing on how to make microaggressions visible, how to avoid these, and how to respond with humility, and non-defensively if mistakes do happen.
- For mental health professionals working with LGBTQIA+ service users, further education should focus on the disparities in mental health outcomes for the LGBTQIA+ population and the impact of these on the mental health service user, the disbanding of biases that pathologise LGBTQIA+ identities, provision of information to increase understanding of intersectionality and the cumulative impact of multiple minority identities.
- As less is known by staff on issues experienced by transgender people, education and skills training should have a particular focus on this cohort, and the additional challenges they experience in receiving affirming care in the mental health services.
- Key tenets of bystander training should be incorporated for all mental health staff working with LGBTQIA+ service users which will equip them with the skills to 'call out' discriminatory behaviour and attitudes of others (staff and other service users) in the mental health setting.
- Training on LGBTQIA+ issues should be incorporated into the curricula of all mental health professionals and continued professional development should include LGBTQIA+ training for staff who have completed their clinical education. The content of education programmes should be co-produced with members of the LGBTQIA+ community who have used the mental health services and have unique insights to the education needs of those working within them.

1.0 Introduction

It is difficult to quantify the number of people who identify as LGBTQIA+[2] with estimates for those who are 'sexual minorities' suggested at 5% of the population (Bhugra et al., 2022), and the number of transgender or gender diverse adults in the US estimated at 0.5%, and 1.4% of 13–17-year-olds (Herman et al., 2022). A significant body of research internationally, including research from Ireland, has consistently demonstrated that LGBTQIA+ people experience a disproportionate burden of mental health difficulties compared to the general population. A summary of the most recent systematic reviews in the area in Chapter 3 of this report provides an overview of these findings. This introduction will briefly consider the history of pathologisation of LGBTQIA+ identity in the psychiatric field, and changes made therein over the past decades. It will then provide an overview of the key findings relating to mental health in the LGBQTIA+ community, and experiences of accessing mental healthcare and healthcare utilisation as identified in the two largest studies of LGBTQIA+ mental health in Ireland, the *LGBTIreland* study (Higgins et al., 2016) and the *Being LGBTQI+ in Ireland* study (Higgins et al., 2024). These studies were not captured in the rapid review systematic searches as they were published before, and after, the search dates, however they are a key source of evidence of the mental health needs and experiences of LGBTQIA+ people in Ireland. In addition, the review will also outline the key findings of a 2022 study by Mental Health Reform on the views and experiences of LGBTI+ service users accessing and using mental health services in Ireland. While some of these findings have been incorporated into the review on challenges and barriers in Chapter 5, and suggested best practices in Chapter 6, it is important to present on the study as a whole here as it provides key contextual information from an Irish perspective on LGBTI+ peoples' experiences of using mental health services in Ireland.

1.1.1 Brief history of LGBTQIA+ pathologisation

Historically, cultural and social norms have dictated what is viewed as 'normal' and what is viewed as 'deviant' behaviour, and the psychiatric field has been strongly influenced by these norms in determining what is 'normal' and 'abnormal', determining therefore what is or is not mental illness (Bhugra et al., 2022). This is evident in Ireland where works that have considered the history of asylums note the range of 'psychiatric illnesses' of people committed therein over previous decades to include 'Moral Causes' such as 'religious excitement', 'love, jealousy and seduction' and 'pride'

[2] The acronym LGBTQIA+ is used in this report as standard, however when referring to papers /policies the acronym used by the authors is adhered to.

(Brennan, 2014). Similarly, LGBTQIA+ identity has also been medicalised or 'psychiatrised' (Bhugra et al., 2022) and viewed as a psychiatric condition requiring diagnosis and treatment. This medicalisation in the past led to 'treatments' including aversion therapy where patients experienced electric shocks, induced vomiting, hormone treatment to reduce libido, and counselling practices, often from a religious perspective, to change sexual orientation or gender identity (Bhugra et al., 2022). As identified in Chapter 5 of this report, remnants of the latter in the form of conversion practices are still in evidence internationally today.

It is prudent at this stage to separate out sexual minority identity from gender identity as how both were and are dealt with under the Diagnostic and Statistical Manual of Mental Disorders (DSM, APA) and the International Classification of Diseases (ICD, WHO) psychiatric classification systems differ. The DSM-I first listed homosexuality as a mental disorder in 1952 (APA, 1952). Following significant activism and petitioning of the APA, 'Homosexuality' was removed from the DSM-II as a psychiatric diagnosis in December 1973 following a vote of the membership (Drescher, 2015). However, as Drescher (2015) notes this did not end the pathologisation of sexual minority status as it was replaced in the DSM-II (APA, 1968) with the term 'Sexual Orientation Disturbance' (SOD) which captured people with same-sex attractions who found themselves distressed by this and wanted to change, and consequently legitimised conversion therapy practices (Drescher, 2015). However, as Bhugra (2022) highlights, it was not clear whether this distress was internal, or was internalised due to rejecting and discriminatory attitudes and behaviours from families, communities, and society. This diagnosis was subsequently replaced in the DSM-III (APA, 1980) by the term 'Ego Dystonic Homosexuality', to capture a similar concept of someone distressed by their sexual orientation, with the removal of the requirement of a person wanting to change their sexual orientation (Drescher, 2015, Bhugra et al., 2022). However, following critique including that any kind of identity disturbance could be classified as a mental disorder (e.g. a short person unhappy about their height) this was also subsequently removed in DSM-III-R in 1987 (Drescher, 2015; APA, 1987), and subsumed under 'Sexual Disorder Not Otherwise Specified' to include those who experienced 'persistent and marked distress about one's sexual orientation' (Bhugra et al., 2022). This continued in the DSM-IV (APA, 1994) and DSM-IV-R (APA, 2000) before finally being omitted in DSM-5 (APA, 2013) in a landmark decision to remove same-sex experiences from a psychiatric diagnostic system (Bhugra et al., 2022).

Following suit, in 1992 the World Health Organization (WHO, 1992) also removed 'homosexuality' from the International Classification of Diseases (ICD-10), although kept a subcategory of 'ego-dystonic sexual orientation' again where marked distress was present as a result of a person's sexual orientation (Bhugra et al., 2022) but was later removed in ICD-11 (WHO, 2019). The removal of 'disorders' of sexual orientation from both major diagnostic systems moved the debate around sexual

orientation away from the medical and psychiatric field, towards the moral and political realms (Drescher, 2015). The lack of a 'legitimate' diagnostic underpinning to continue discriminatory behaviours, the waning influence of religion in many societies, and the increased activism from human rights perspectives, led to significant advancements in the rights of LGB people culminating in the repeal of laws criminalising homosexuality, and the enactment of laws providing equal rights to LGB citizens in many countries. Within the mental health community, it drove a re-orientation of focus from how people with sexual minority identities can be 'cured' to how their mental health needs can be better recognised and supported (Drescher, 2015).

For those who are trans and gender diverse the path to depathologisation is ongoing. The first classification of trans identity as a mental disorder within diagnostic systems occurred in 1980 when the DSM-III (APA, 1980) listed the disorder of 'Transsexulism', and 'Gender Identity Disorder of Children' (Crocq, 2021). The term Transsexualism was replaced in DSM-IV in 1994 by the term 'Gender Identity Disorder in Adults and Adolescence', with a separate category again of 'Gender Identity Disorder in Children' (APA, 1994), however critics of this label argued that this culminated in the pathologisation and stigmatisation of peoples' identity. In DSM-5 published in 2013 (APA, 2013) gender identity disorder was replaced with the disorder of 'Gender Dysphoria' which moved the focus to gender-identity related disorders that some transgender people may experience, rather than positioning the person's identity itself as a disorder (Crocq, 2021). This is clearly stated in the DSM-5 where is it made explicit that 'gender non-conformity is not in itself a mental disorder' (APA, 2013), and clinically significant distress is required for a diagnosis (Stein et al., 2020). Significant lobbying from LGBTQIA+ advocacy groups has occurred to remove gender dysphoria entirely as a psychiatric classification due to the stigmatising effects of the diagnosis (Stein et al., 2020; Schwend, 2020). The diagnosis however remains in the DSM-5.

Similarly, within the ICD, the disorder of 'Transsexualism' was first listed in the ICD-9 for adults and adolescents while 'Gender Identity Disorder' was listed for Children (WHO, 1992; Stein et al., 2020). In ICD-11 (WHO, 2019) the diagnosis of 'Gender Incongruence' was developed however in a significant change the diagnosis was removed from the chapter on 'Mental and Behavioural Disorders' and instead placed in the Chapter on 'Sexual Health', seen as a move which will serve to reduce the stigmatisation of trans people, while still facilitating access to treatment if required (Stein et al., 2020). The use of the word 'incongruence' highlights the core of the condition which is an incongruence between the person's gender assigned at birth, and their experienced gender identity (Stein et al., 2020).

Although huge advances have been made in the developed world with LGBTQIA+ status having largely been depathologised, and more positive attitudes largely as a result of political and community activism, this is not a universal experience and LGBTQIA+ identity, and particularly the identity of trans and gender diverse people continues to be pathologised and viewed as a condition requiring diagnosis and treatment across some countries and communities (Bhugra et al., 2022). This is evident in Chapter 5 of this report where experiences of being pathologised for their identity are recounted by LGBTQIA+ people. For trans people and activists, there is a desire to move away from the trans healthcare model, from a psychiatric assessment process to an informed consent model (highlighted briefly in Chapter 6) (Schwend, 2020). Key authors in the field support this move, with recommendations made to recognise the trans person as the expert in their own lives, where mental health assessment becomes an option when required rather than a prerequisite to gender-affirming treatment, and health professionals provide a trans person with the benefits and risks of trans-affirming treatment so that they may make an informed decision, rather than gatekeeping access to this treatment (Tan et al., 2022; Coleman et al., 2022; Higgins et al., 2024).

1.1.2 The LGBTIreland study (Higgins et al., 2016)

The *LGBTIreland study* was published in 2016, with data collection occurring in the previous year, just before the Marriage Equality Referendum. A sample of 2,264 people took part in the largest survey at the time of LGBTI mental health. Two-fifths of the sample were gay males (38.6%), just over one quarter were lesbian/gay females (26.5%), 14.4% were bisexual, 12.3% were transgender and 2% were intersex with 6.3% comprising an 'other' category. The age range in the study was 14 (the youngest age permissible to take part) to 71 years, with a mean age of 29 years. The majority of the sample (70%) experienced positive well-being. However, while most of the sample did not report significant levels of distress, there was a significant proportion who did, and this was at a level above that in the general population. Across the LGBTI groups, between 12 to 35% of participants had scores indicating severe or extremely severe depression, anxiety, and stress. This peaked in the youngest participants, those aged 14-18 years, followed by those aged 19-25 years. For the 14–18-year age group, the rates of depression, anxiety and stress were 4 times higher than in the general population of young people in Ireland (Dooley and Fitzgerald, 2012). Mean scores for depression, anxiety, and stress were higher in intersex people, followed by transgender people and bisexual people.

In measures of suicidal behaviour, a lifetime history of self-harm was reported by 34% of the sample, with almost a half reporting they had self-harmed in the last year. Differences were noted when the LGBTI groups were disaggregated with bisexual (54.4%) and transgender (48.8%) participants more likely to have engaged in self-harm. Repeat self-harm was common with over 90% having self-harmed more than once, and 60% self-harmed 6 times or more which is concerning as repeat self-harm is

associated with a poorer prognosis. In total, 60% of the sample thought about taking their own life, with suicidal thoughts more common in those who were intersex (84.2%), transgender (75.6%) and bisexual (65.3%). Just over one-fifth of the sample (21.4%) reported making a previous attempt to take their life and again a hierarchy of risk was evident with those who were intersex (57.9) and transgender (35.1%) more like to have made an attempt on their life. Across the 3 measures of self-harm, suicidal thoughts, and suicide attempts help-seeking was low. Just over 40% of the sample has scores on the AUDIT scale that were indicative of some level of alcohol problem and in a reversal of the previous trends relating to the other mental health outcomes, gay males had the highest mean scores for alcohol use.

Despite the increased levels of mental health problems indicated in the results from this study, participants reported significant barriers in accessing mental health services. Similar barriers were identified as are reported in Chapter 5 of this review and include stigma, lack of available services, fear of being medicated, fear that sexual orientation or gender identity would be pathologised, a lack of skills among staff to work in an LGBTQIA+ affirming way, and knowing someone who had, or having themselves had a previous bad experience with mental health service provision. As with the mental health measures, significant differences were found between groups in relation to barriers to accessing mental health services. A greater proportion of bisexual (37.5%) and transgender (35.1%) participants cited stigma as a barrier, both transgender (35.5%) and intersex (31.4%) participants were more likely to identify that mental health services were not LGBTI-friendly, and intersex (40%), transgender (21.5%) and bisexual (19.4%) participants were more likely to have had a previous negative experience themselves. Negative experiences of a friend were reported more by those who were intersex (24.4%), and transgender (21.5%), and a greater proportion of intersex (35.6%), transgender (22.6%) and bisexual (21.8%) people reported that they did not think the mental health service could help them. It is clear from these findings, that people who are intersex, transgender and bisexual are more likely to experience barriers to accessing mental health services in Ireland than gay men or lesbian/gay women. These findings are replicated in other studies internationally as is outlined in Chapter 5 of this report. An open-ended survey question captured qualitative data on further barriers to accessing mental health care from 193 participants and found systemic barriers and psychosocial barriers which were predominately concerned with the lack of knowledge and training of mental health staff on LGBTI issues and healthcare, negative interactions with staff, the dominance of the medical model of treatment and reliance on pharmacology as a treatment, and fear of receiving inappropriate treatment. Again, many of these issues are also identified in the review in Chapter 5. Participants were also asked in an open-ended question to identify any recommendations for improving mental health services in Ireland and responses were received from 1,037 people.

Responses were focused on redressing systemic barriers by educating mental health professionals in LGBTI issues, encouraging more positive attitudes from mental health professionals reflective of a shift from cisnormative and pathologising attitudes to a more LGBTI-friendly, non-judgemental approach, and the availability of a wider range of mental health supports than currently exists within the mental health services. Again, many of these recommendations are repeated in the reviews in Chapters 5 and 6 of this report.

The results of this landmark study received significant and widespread media attention at the time, coming as it did only a few months after the vote to legalise same sex marriage. The celebratory scenes and media stories around this event were in stark contrast to the reporting of the level of mental distress among a significant cohort of the LGBTI community. One of the recommendations of the *LGBTIreland* study was to repeat the study some years later in a bid to determine if improvements in the mental health of LGBTI people could be identified in light of positive legislative developments, including the passing of the Marriage Equality Act and the Gender Recognition Act in 2015, and a generally more positive attitude towards LGBTI people in Irish society. The *Being LGBTQI+ in Ireland* study was the follow-up study.

1.1.3 The Being LGBTQI+ in Ireland study (Higgins et al., 2024)

The *Being LGBTQI+ in Ireland* study looked to identify changes in mental health for LGBTQI+ people in Ireland in a period which saw two key legislative developments with the Marriage Equality Act (2015) and the Gender Recognition Act (2015), in addition to two significant policy publications The LGBTI National Youth Strategy 2018-2020 (DCYA, 2018) and the National LGBTI+ Inclusion Strategy 2019-2021 (DCEDIY, 2019). A sample of 2,806 LGBTQI+ people took part in the online survey, 70% of whom identified as cisgender, and 30% who identified as trans or gender non-conforming which is a significant increase on the 2016 study. In terms of sexual orientation, 32% identified as gay, 22% as bisexual and 18% as lesbian with the remainder of the sample comprising orientations such as queer, pansexual and asexual. The mean age of the sample was 31 years with 70% aged under 35 and an age range of 14-84 years.

Results from the happiness and self-esteem measures for this sample showed that there was a statistically significant decrease across both measures from the 2016 study when compared to this study. Following adjustments to account for sample differences between the two studies, there was an 11% relative decrease in the prevalence of being happy and a 26% relative decrease in high self-esteem. In relation to specific mental health measures, statistically significant increased levels of severe or extremely severe depression (27%), anxiety (34%), and stress (23%) were found in this study in comparison to the 2016 study. Participants who were transgender had significantly higher levels of depression (44%), anxiety (55%) and stress (35%), as did those who were under 25 years of age (43%,

57% and 35% respectively). For the 14–18-year age group in this study, the rates of severe/extremely depression and anxiety was 3 times higher than in the general population of young people in Ireland as measured in the *My World Survey 2* study (Dooley et al., 2019), and 1.5 times higher in the 19–25-year age group.

Lifetime prevalence of self-harm was 52%, with half engaging in self-harm in the previous year. Lifetime prevalence of suicidal thoughts was 65%, with approximately half (51%) having these thoughts within the last year. Lifetime prevalence of suicide attempt was 26%, with around one quarter (26%) attempting suicide in the previous year. It is evident that the levels of self-harm and suicidality remain high among this cohort although no statistical differences were found between the levels in 2016 and 2024 when differences in sample profile were accounted for. These differences are mostly accounted for by the higher number of trans participants in the overall sample who had a significantly higher level of each of the 3 suicidal behaviour measures – self-harm (75%), suicidal thoughts (82%) and suicide attempt (39%). For younger age groups when comparing again to *My World Survey 2* study, the rates of self-harm, suicidal thoughts, and suicide attempt were significantly higher in both age groups (14-18 years and 19-25 years) in this study.

The potential presence of an eating disorder was assessed in this study having not been assessed in the 2016 study, and findings identified that two fifths (41%) of the sample reached the risk threshold for potentially having an eating disorder while nearly two-fifths (37%) also indicated that they were dissatisfied with their eating patterns and ate in secret. In relation to alcohol use, 42% indicated a risk of hazardous and harmful alcohol use indicative of possible alcohol dependence on the AUDIT test with no significant changes noted since the 2016 study. The impact of the COVID-19 pandemic on participants' mental health was also captured and 48% of the sample reported that their mental health had worsened since the start of COVID-19, with transgender people and young people reporting the most impact.

With regard to healthcare utilisation generally, almost 90% of the sample reported they had used healthcare services in the past 5 years, with almost half reporting that healthcare providers were supportive of their sexual orientation or gender identity. Many positive findings are reported here including that most never had a practitioner tell them that their LGBTQI+ identity could be changed (91.4%), were never discriminated against because of their identity (83%) and were never asked invasive questions about their identity which were unrelated to their reason for visiting (79%). However, fewer positive findings were reported in relation to healthcare providers knowledge of LGBTQI+ identities with one third of the sample reporting educating practitioners about LGBTQI+ identities (34%), with just over one quarter (29%) reporting that healthcare practitioners were 'always'

or ‘most of the time’ knowledgeable about LGBTQI+ identities. Similar issues relating to healthcare provider knowledge in relation to mental health staff particularly are identified in Chapter 5 of this report. This lack of knowledge/awareness of LGBTQI+ identities was also reflected in the number who reported that healthcare practitioners made incorrect assumptions about their LGBTQI+ identity, with around one quarter (25%) stating this ‘sometimes’ happened and around 17% saying this happened ‘most of the time’ or ‘always’. While 44% felt comfortable ‘most of the time’ or ‘always’ disclosing their LGBTQI+ identity, nearly one quarter (23.9%) reported that healthcare practitioners didn’t acknowledge their identity when they disclosed it, again a finding repeated in Chapter 5 of this report. Half of the participants (50%) reported that services didn’t have any posters or information related to LGBTQI+ healthcare and one third ‘sometimes’ had them. This is a ‘best practice’ recommendation identified in Chapter 6 of this report.

Participants who were trans were asked specific questions about their use of healthcare services to support them in medical transitioning. Approximately one-fifth had either received (4%) or were still receiving care (16%) for medical transitioning, with around two-fifths (43%) reporting that they planned to, while just over one third (35%) indicating that they had no intention of using healthcare services to support medical transitioning. Almost one-third of the sample reported that they had self-medicated using hormones, buying them online or getting them from friends. Key barriers to accessing health services to support medical transitioning included waiting times, lack of knowledge among practitioners about transgender healthcare and geographic distance to services. Of those who were medically transitioning, 68.5%, (n=111) indicated that they had used healthcare services outside of Ireland to support this medical transition, with many reporting poor aftercare when they returned.

The majority of the LGBTQI+ sample (60%) had sought professional help for a mental health problem in the past 5 years. Open-ended survey questions elicited further information about these interactions and identified both positive and negative experiences. Timely and affordable access to mental health services was reported a barrier as was stigma, and the fear of pathologisation, and in the case of young people, the need for parental consent to access mental health services. Negative encounters centred on engaging with mental health practitioners that were unsure how to react to the person’s gender identity or sexual orientation, disinterested, or not supportive, with participants detailing incidents when they were disregarded, not taken seriously or misgendered. Positive experiences centred on engaging with respectful, sensitive and knowledgeable practitioners.

Participants made a series of recommendations about improving physical and mental healthcare focusing on increasing service accessibility, proactive signalling that services are LGBTQI+ friendly, and education of healthcare practitioners, each of which are also detailed in Chapter 6 of this report.

Based on the findings of the Being LGBTQI+ in Ireland study as a whole, the research team made a set of recommendations relating to building LGBTQI+ inclusive and affirmative care which are:

- Increase investment in LGBTQI+ inclusive community-based mental health supports and expand supports in educational settings, youth services and community groups.
- Fund and implement a new model of gender-affirming care for young people and adults that complies with national and international human rights and medical standards of care and the principles of self-determination and informed consent.
- Implement interim harm-reduction interventions in primary care for transgender, non-binary and gender non-conforming people who are self-medicating as a result of a lack of access to gender-affirming care or extensive waiting times.
- Build capacity amongst all healthcare personnel currently working with LGBTQI+ individuals by including LGBTQI+ perspectives in ongoing continuing professional development.
- Integrate as an accreditation requirement LGBTQI+ awareness and inclusion in health education curricula for undergraduate and postgraduate healthcare practitioners.

As can be seen in the reviews in Chapters 5 and 6 of this report, these recommendations mirror many of those identified in international literature and best practice guidelines relating to the provision of mental health services to LGBTQI+ people.

1.1.4 My LGBTI+ Voice Matters: A Mixed Methods Exploration of the Views and Experiences of LGBTI+ Mental Health Service Users (Mental Health Reform, 2022)

A sample of 215 LGBTI+ people took part in a wider survey of 1,188 people who used community mental health services, inpatient mental health services, and/or a psychiatrist in the two years prior to completing the survey. For the purpose of this report, the sample was divided into LGBTI+ and non-LGBTI+ participants. Similar findings between the two groups when found for how satisfied participants were with Health Service Executive (HSE) provided mental health services, with a high level of poor overall experiences reported (43% v 42% respectively). More LGBTI+ participants reported 'never' feeling well-supported by their current psychiatrist (22% v 15%), and fewer LGBTI+ participants reported 'always' being treated with respect and dignity by community mental health services (31% v 44%), a difference that was statistically significant. Similar proportions of LGBTI+ (58%) and non-LGBTI+ (59%) participants reported being well-supported by their key worker, and again similar findings were reported between the two groups relating to whether during their inpatient treatment they were treated with dignity and respect, with 28% of both groups reporting they were always treated with dignity and respect. Mental health treatment from GPs was also assessed and here there were again some differences between the groups with more LGBTI+ participants reporting low satisfaction with mental health specific treatment from their GP (30% v 22%), and fewer LGBTI+

participants reporting that their GP provided them with enough time to speak about their mental health difficultly (28% v 37%), a difference that was statistically significant.

Focus groups with LGBTI+ participants elucidated in more detail on some of the findings from the survey and five main themes are outlined; LGBTI+ Competence and Sensitivity; Access; Treatment and Care; Transition/Gender Affirmation and the Mental Health Services; and Service Improvements. Specific findings from these themes are integrated into the review presented in Chapter 5, and similar issues are reported including a lack of LGBTI+ competence amongst mental health professionals resulting in participants needing to teach them about LGBTI+ issues and terminology, needing to self-censor their LGBTI+ identity, getting inappropriate questions and comments, and having their LGBTI+ identity pathologized by attributing their mental health difficulties to their identity. This study highlights that for participants who were transgender they are required to access a mental health service to receive a referral and/or a diagnosis of gender dysphoria to access gender transition services, and for some trans participants in this survey, this was their sole reason for attending a mental health service. This diagnostic model of care was a challenge for some trans participants who questioned what they considered to be the pathologising nature of the model and the impact it had on their autonomy. For those trans participants who also had a mental health difficulty, there were concerns that this might delay access to gender affirming treatment, an issue further discussed in Chapter 6 of this report.

Recommendations from participants to improve mental health service provision included education of mental health professionals on LGBTI+ issues, implementation of existing LGBTI+ policies and strategies, the use of peer advocates within the mental health system, providing visible cues of LGBTI+ friendly mental health services, and moving away from the diagnostic model of trans healthcare towards an informed consent model, a recommendation also made by Higgins et al (2024) in the *Being LGBTQI+ in Ireland* study.

In summing up the findings of these significant studies of LGBTQI+ mental health, it is important to remember that within both cohorts of the *LGBTIreland* study and the *Being LGBTQI+ in Ireland* study, the majority of LGBTQI+ people have a good level of wellbeing and live happy and fulfilling lives. However, there remains a sizeable proportion of people, particularly young people and transgender people who report a significant level of mental distress and unmet mental health needs, and mental health services in Ireland need to be responsive to these needs. These findings are supported by the results of the *My LGBTI+ Voice Matters* study. The dominant culture in mental health settings and among mental health professionals is generally heteronormative and cis-normative (Rees et al., 2021). This needs to be challenged by practices that are inclusive, respect equality and are LGBTQIA+

affirming. In recent years, LGBTI+ specific policy documents such as *The LGBTI National Youth Strategy 2018-2020* (DCYA, 2018) and the *National LGBTI+ Inclusion Strategy 2019-2021* (DCEDIY, 2019) have referred to the importance of LGBTQI+ inclusive healthcare and LGBTQI+ knowledgeable and affirming healthcare staff. In addition to these LGBTI+ specific policies, mainstream mental health policies including *Connecting for Life Ireland's National Strategy to Reduce Suicide 2015- 2024* (DoH, 2015), and the national mental health policy *Sharing the Vision 2020-2030* (DoH, 2020) identify the LGBTQI+ group as a priority group requiring targeted mental health actions. Recommendation 61 of *Sharing the Vision* explicitly states that 'The HSE should maximise the delivery of diverse and culturally competent mental health supports' (DoH, 2020:63). This is supported by the Quality Framework of the Mental Health Commission (Farrelly et al., 2023) which promotes ensuring quality through the provision of equal, socially inclusive, and diverse mental healthcare services. The reviews to follow in this report contribute to the evidence base to inform the development of guidance for mental health service providers on the care and treatment of LGBTQIA+ service users.

The reviews are:

Review 1: A summary of empirical evidence on mental health challenges commonly faced by LGBTQIA+ people (Chapter 3).

Review 2: A summary of empirical evidence on the causation between 'minority stress' and mental health challenges faced by LGBTQIA+ people (Chapter 4).

Review 3: A comprehensive overview of the key challenges faced by LGBTQIA+ people in receiving quality care and treatment from mental health service providers. Highlight strategies and good practice underscored in the literature as key enablers for service providers in mitigating those challenges (Chapter 5).

Review 4: A comprehensive review of current practice and policy on mental health service provision to LGBTQIA+ persons including any strategies/standards/guidance/code of practice published in Ireland or other comparable jurisdictions (Chapter 6).

In addition, the report contains a brief overview of key legislation including rights-based considerations that may impact the treatment and care of LGBTQIA+ people accessing mental health services in Ireland (Chapter 7). The report concludes with some 'Considerations for Ireland' outlining key recommendations based on the reviews conducted which may guide the Mental Health Commission in their development of new guidance for mental health service providers on the care and treatment of LGBTQIA+ service users (Chapter 8).

2.0 Methodology

2.1 Rapid review methodology

Rapid reviews have been identified as a pragmatic alternative to systematic reviews to support good policy development and decisions when findings are required in a shortened time frame (King et al., 2022). Respected international agencies use rapid reviews to inform the development of guidelines for practice using more streamlined processes when compared to systematic reviews (Garrity et al., 2021). The rapid review methods utilised in this review are based on recommendations issued by the Cochrane Rapid Reviews Methods group (Garrity et al., 2021) with some modifications.

King et al. (2022) identify that the most important step for a robust rapid review is for an experienced research team to have early and ongoing engagement with the people who commissioned the review. The research team undertaking this review, which included a subject librarian, are experienced in both review methodology and in the conduct of research in the LGBTQIA+ space with a number of completed projects and associated publications in this field. Important also is the need to make transparent methodological choices informed by stakeholder input. Consultations with the commissioners of this review (Mental Health Commission) were held at several time points throughout the review to discuss the parameters of the review, topic refinement, and any emerging issues requiring pragmatic decisions including the intended use of the review findings.

As the reviews in this report did not focus on assessment of interventions, the PEOS (Participants, Exposure, Outcome and Study Types) format was used to guide each review and details of each of these are reported in the individual reviews to follow.

2.2 Search strategy

The research team, in collaboration with the subject librarian, prepared four detailed search strategies to respond to the nuances of the research questions. Five databases were searched to ensure a comprehensive review of research in the field, these were: CINAHL Ultimate (EBSCO), MEDLINE (EBSCO), PsycINFO (EBSCO), EMBASE(Elsevier), and Web of Science (Clarivate). All databases were searched from 2018 to January 2024, with no limits on language applied. Keywords were determined according to the main concepts identified within the review questions. Additional keywords were included after the initial strategy draft was reviewed by the research team. A three-strand search strategy was developed for each concept, within each strategy, using database index terms and keywords strings. A detailed breakdown of these searches is available in appendices 1, 4, 7 and 10. All searches were completed over a two-week period commencing 19/01/2024. A PRISMA diagram (Page et al., 2021) for each search strategy is available in appendices 2, 5, 8 and 11. Further searches were

conducted for review 4 using Google, OpenGrey and GreyNet to identify standards, codes of practice, legislative and policy documents which may have been published outside of peer review publications.

2.3 Study selection

All recovered sources were uploaded to Covidence[3] to facilitate screening. Initial screening comprised a review of titles and abstracts and was conducted by a single reviewer within each review. While systematic review processes generally require two reviewers to screen title and abstracts, a more streamlined process is evident in many rapid reviews with single reviewer screening occurring in up to 40% of rapid reviews (King et al., 2022). A pragmatic decision to use single reviewer screening at this stage was taken to ensure timely completion of the review, and considering the evidence that the use of a single reviewer who is experienced in the topic area may be sufficient (King et al., 2022). Any sources selected as a 'maybe include', were then screened by a second reviewer for a final decision. Full text screening of included papers was undertaken independently by two reviewers and studies were included or excluded based the criteria for each review guided by PEOS. Any differences in reviewer's decisions were resolved through discussion or by decision of a third reviewer.

2.4 Data Extraction and Quality Review/Risk-of-Bias Assessment

Data extraction from included sources was undertaken by one reviewer, with a second reviewer carrying out independent random checking for accuracy in 10% of the extraction decisions made. An extraction template specific to each review was constructed and data pertinent to the review aims were extracted. Each included paper for data extraction also underwent a critical appraisal conducted by one reviewer per review. For qualitative studies, the CASP (Critical Appraisal Skills Programme) checklist for Qualitative studies was utilised, and for systematic reviews, the CASP checklist for systematic reviews was used. For quantitative cross-sectional studies, the JBI checklist for analytical cross-sectional studies was employed. For opinion papers, the JBI Critical Appraisal checklist for textual evidence: Expert opinion was used. No papers were excluded from the review on the basis of scores in the critical appraisal process, a global comment on the quality of studies is included within each individual review however it is important to note that many of the reviewed papers were qualitative studies employing small sample sizes, or cross-sectional studies with non-random samples.

[3] Online systematic review tool www.covidence.org

2.5 Knowledge synthesis

Due to the disparate nature of the papers included in the four reviews, a narrative synthesis was conducted within each review with the findings presented thematically. Drawing upon the findings presented in each review, recommendations and key considerations for Ireland are presented in Chapter 8.

3.0 Review 1: A summary of empirical evidence on mental health challenges commonly faced by LGBTQIA+ persons.

3.1 Introduction and search strategy

This review focuses on identifying the key mental health challenges experienced by LGBTQIA+ people. A brief scoping of the topic for the review period of 2018 to January 2024 identified a very large number of individual studies reporting on mental health challeges in this community. Considering the timeframe available for this rapid review, and the requirement to provide a summary of these key challenges, a decision was taken by the research team, in consultation with the Mental Health Commission, to conduct a narrative review of systematic reviews in the area thereby bringing a top-level review of key findings.

Embase, Web of Science, Medline, CINAHL and PsychINFO databases were searched (Appendix 1) for papers using the following inclusion criteria:

Population	LGBTQIA+ persons over 5 years old.
Exposure	Mental health problems. Mental illness/disorder/distress.
Outcome	Prevalence of mental health problems. Types of mental health problems.
Study characteristics	Published between 2018 and 2024. Systematic reviews with meta-analysis/meta-synthesis

Table 3.1 PEOS

Titles and abstracts were screened by one reviewer with all full texts screened for inclusion by two reviewers with any conflicts resolved by consensus. Full text papers were appraised for quality using the *CASP Checklist for Systematic Reviews* (Critical Appraisal Skills Programme, 2018) by one reviewer. As per the guidelines, no quality score was calculated, and all papers were included for data extraction and narrative review. Given the aim of the review, the findings focus on the prevalence of mental distress as reported by the included papers.

3.2 Findings

Following the removal of duplicates, 962 titles and abstracts were screened against the inclusion criteria with 803 papers excluded at that point. One hundred and fifty-four (n=154) full text studies were screened for eligibility with five (n=5) not sourced as they were unavailable and required an inter library loan. In total n=134 were excluded following full text review with the reasons for exclusion presented in the PRISMA diagram (Appendix 2). The main reasons for exclusion were that the papers were not focused on the aim of the review (n=23), wrong publication type (discussion papers or not a systematic review, n=82) or papers did not conduct a meta-analysis or meta synthesis (n=23). A total

of 20 papers were appraised for quality with all 20 being included for the final narrative review. A data extraction template was designed and information related to the aim of the review was extracted and a summary table constructed (Appendix 3). The main focus of the included papers were depression, anxiety and suicidal behaviour which were examined from a number of different viewpoints among different LGBTQIA+ subgroups. Two papers explored Post Traumatic Stress Disorder [PTSD] (Marchi et al., 2023; Scheer et al., 2023) and two papers explored eating disorders (Cao et al., 2023; Dotan et al., 2021) with one paper exploring perinatal mental health (Kirubarajan et al., 2022). While most minority sexual orientations and gender identities were explored across all the included papers, two papers specifically focus on the transgender population (Adams & Vincent, 2019; Kohnepoushi et al., 2023) with one paper focusing on the gender non-conforming [GNC] population (Surace et al., 2021). Two papers centre on the experiences of bisexual individuals (Ross et al., 2018; Salway et al., 2019) with one paper looking at the experience of people who are asexual (Xu et al., 2023). Two of the included papers described their sample as men who sleep with men [MSM] (Nouri et al., 2022, 2023). While age was not generally a focus within the papers, five focused specifically on younger populations (Cao et al., 2023; Hatchel et al., 2021; Jonas et al., 2022; Surace et al., 2021; Williams et al., 2021).

3.2.1 Suicide and Self Harm

A considerable proportion of the included studies focused specifically on the prevalence of suicidal behaviours including suicide ideation, suicide attempts and non-suicidal-self-harm across sexual and gender minority populations (Adams & Vincent, 2019; Dunlop et al., 2020; Hatchel et al., 2021; Kohnepoushi et al., 2023; Liu et al., 2019; Marchi et al., 2022; Nouri et al., 2023; Salway et al., 2019; Surace et al., 2021; Williams et al., 2021).

Prevalence rates for suicide attempts were found to be notably higher for sexual and gender minority individuals when compared to non-LGBTQIA+ people (Adams & Vincent, 2019; Hatchel et al., 2021; Kohnepoushi et al., 2023; Marchi et al., 2022; Nouri et al., 2023; Salway et al., 2019; Williams et al., 2021). For example, Marchi et al. (2022) in their meta-analysis, found that LGBTIQ individuals were over four times more likely to attempt suicide when compared to non LGBTIQ controls. Focusing specifically on young people, Hatchel et al. (2021) also found that this population were more likely to experience suicidal thoughts and behaviours especially when accompanied by other mental distress such as depression and anxiety. In addition, it was suggested that internalised symptoms e.g., hopelessness, were strongly linked with sexual minority individuals engaging in self-harm and suicidal behaviours (Hatchel et al., 2021).

Three studies examined suicidal thoughts and behaviours for transgender populations (Adams & Vincent, 2019; Kohnepoushi et al., 2023; Liu et al., 2019). In a meta-synthesis of 64 studies, there was

an average rate of 46.55% for lifetime suicidal ideation and 27.19% for suicide attempts among transgender participants (Adams & Vincent, 2019). These rates echoed those of Kohnepoushi et al. (2023) which showed that the lifetime prevalence of suicidal ideation for transgender individuals was found to be 50% with 29% of transgender individual attempting suicide. This study found that almost half of trans individuals who experience suicidal thoughts then go on to take their own lives (Kohnepoushi et al., 2023). It was suggested that these rates may result from barriers to transitional care, stigma, and discrimination (Adams & Vincent, 2019; Kohnepoushi et al., 2023). These results highlight the impact that these social stressors can place on transgender individuals, leading to a significant increase in suicide risk for this group.

Sexual and gender minority individuals were also found to have elevated rates of non-suicidal self-injury (NSSI) ranging from 30% to 47%. This was noted to be two to three times higher than heterosexual and/or cisgender people (15%) (Liu et al., 2019). Bisexual and transgender individuals were noted to be the most likely groups to engage in NSSI (Dunlop et al., 2020; Liu et al., 2019; Marchi et al., 2022). Dunlop et al. (2020) highlighted that bisexual individuals were 4.5-6 times more likely to engage in self-harming behaviours/NSSI than heterosexuals. It was suggested that these groups may have more risk factors for self-harming behaviours such as anxiety and depression (Liu et al., 2019; Marchi et al., 2022). LGBT individuals may be more vulnerable and at risk of engaging in NSSI due to the increased vulnerabilities they face in relation to their identity, in addition to general issues they face compared to the general population (Liu et al. 2019).

Similar to rates of NSSI, bisexual individuals demonstrated higher incidences of suicidal behaviour than other sexual minorities (Marchi et al., 2022; Salway et al., 2019). In a meta-analysis by Salway et al. (2019), bisexual individuals were shown to experience an increased risk of suicide ideation and attempts in comparison to both heterosexual and lesbian/gay individuals. For example, the OR for lifetime suicide attempt, when compared to heterosexual individuals was 4.44 [95% CI 3.52, 5.60]. There was a significant disparity between the suicide risk of bisexual females (OR range 1.48-1.95) versus bisexual males (OR range 1.00-1.48) (Salway et al., 2019). One meta-analysis that focused on MSM found that 21% of this population experienced suicidal ideation [95% CI 17,26] and 12% attempted suicide [95% CI 8,17] (Nouri et al., 2023).

3.2.2 Depression

Included studies reported that sexual and gender minority individuals experience higher incidences of depression than non-LGBTQIA+ people (Jonas et al., 2022; Kirubarajan et al., 2022; Nouri et al., 2022; Ross et al., 2018; Wittgens et al., 2022; Xu et al., 2023). Wittgens et al. (2022) found that lesbian and gay individuals were almost twice as likely to experience depression (OR = 1.97, 95% [CI = 1.76, 2.19]) when compared to straight individuals. This risk was higher for bisexual individuals with the OR rising

to 2.70 (95% [CI = 2.32, 3.14]) for depression. Asexual individuals were also reported to experience higher rates of depression (Hedges' g = 0.44, 95% CI = [0.61, 0.26], p < .001) (Xu et al., 2023).

Perinatal depression or low mood was more prevalent in lesbian or bisexual cisgender women when compared with their heterosexual cisgender counterparts (Kirubarajan et al., 2022). The rates of depression in men who have sex with men were noted to be more than double the rates for the general population at 35%, with those over 30 being more at risk than those who are younger (Nouri et al., 2022). Jonas et al. (2022) explored the mental health of 26,505 LGBT+ youth who experienced childhood adversities and 36.9% of this sample were found to have depressive symptoms. This highlights the negative impact that adverse childhood experiences can have on LGBT+ youth and the need for clinicians to consider the consequences that trauma can have on this group, a recommendation highlighted in Chapter 6 of this report.

3.2.3 Anxiety

Jonas et al., (2022) found that LGBT+ youth who experienced childhood adversities experienced a higher rate of anxiety than young people generally, with a prevalence rate of approximately 31.5%. Bisexual individuals were also noted to experience higher levels of anxiety than individuals who were gay or lesbian. It was suggested here that this may be due to the increased likelihood for this group experiencing discrimination because of their bisexual identity and internalised bi-negativity (Marchi et al., 2022; Ross et al., 2018). The pooled prevalence of anxiety for gay/lesbian individuals was 0.14 (95% CI: 0.11, 0.17; I2 = 94.8%) in comparison to 0.06 (95% CI: 0.04, 0.09; I2 = 99.8%) for heterosexuals (Ross et al., 2018). Generalised anxiety disorder (GAD) was the only specific anxiety disorder that was examined in Ross et al.'s (2018) meta-analysis which focused on the experience of anxiety in bisexual individuals when compared to gay/lesbian and heterosexual individuals. While the results show that bisexual individual are more likely to experience GAD and had higher rates of GAD when compared to both groups, caution needs to taken when interpreting these results given the low number of studies available for analysis.

Kirubarajan et al. (2022) found that lesbian and bisexual individuals experienced high levels of anxiety when undergoing fertility processes and treatments, which caused worries in relation to ovulation medications, donor insemination and miscarriage. One study included in this meta-analysis found that 28.2% of 117 pregnant lesbian and bisexual individuals had frequent worry and distress in comparison to 9.4% of pregnant heterosexual individuals (P = 0.004). Additionally, two other studies from this meta-analysis concluded that stress and anxiety felt by these individuals was from a lack of control with the fertility process overall.

LGBTQ individuals demonstrated an overall increased risk of PTSD compared to their non-LGBTQ controls (pooled OR: 2.20 [95% CI: 1.85; 2.60). Furthermore, sexual minority women were twice as likely to experience PTSD symptoms than heterosexual women (Scheer et al., 2023). It was highlighted that individuals from sexual minorities report more severe and frequent incidences of both physical and sexual abuse during childhood, which may contribute to these higher rates of PTSD (Marchi et al., 2023; Scheer et al., 2023). Sexual minority women also showed more severe symptoms of PTSD overall than heterosexual women (SMD = 0.43; 95% CI = 0.21–0.65; $p < .001$) (Scheer et al., 2023).

3.2.4 Eating Disorders/Eating Disorder Behaviours

Two studies examined the prevalence of eating disorders/eating disorder behaviours amongst sexual and gender minority individuals (Cao et al., 2023; Dotan et al., 2021). It is worth noting that these studies focused on two very different populations including sexual minority adolescents and adults, which as a result may not provide a fair representation of these groups. Cao et al. (2023) highlighted that gay and lesbian adolescents were significantly more likely to engage in eating disorder behaviours such as dieting, binge eating, purging, and diet pills use than heterosexual individuals. Sexual minority males were noted to be more susceptible to developing eating disorder behaviours than sexual minority females (Cao et al., 2023; Dotan et al., 2021). Gay males were 3 times more likely to engage in binge eating than lesbian females and 2.24 times more likely to purge after meals than lesbian females (Cao et al., 2023). Gay males also experienced higher dieting (OR = 3.10) than lesbians (OR = 1.75). Binge eating behaviours were notably higher in gay men (OR = 7.20) when compared to bisexual males (OR = 4.60) and straight males (OR = 1.00).

Bisexual males were twice as likely to engage in binge eating than bisexual females (Cao et al., 2023). This study highlighted that although bisexual individuals tend to face additional stressors such as sexual objections, internalised biphobia, and bisexual erasure from others (Taylor et al., 2019), they appear to be less likely to engage in eating disorder behaviours than gay males (Cao et al., 2023). Dotan et al. (2021) found in their meta-analysis focusing specifically on sexual minority women, that when compared to lesbians, bisexual females were more likely to report restrictive dieting behaviours and purging.

One meta-synthesis with a sample of 372,356 examined the frequency of eating disorders in sexual minority women and found that there were no major differences in the rates of eating disorders in sexual minority women compared to heterosexual women (Dotan et al., 2021). It should be noted that some studies included in these meta-analyses combined both lesbians and bisexual females together, which may not give representative findings for these groups. This study further concluded that sexual minority women had an increased likelihood of having eating disorder behaviours such as purging, binge eating and using diet pills than heterosexual women (Dotan et al., 2021).

This review highlights that mental health challenges are more common in sexual and gender minorities than in the general population and that within the LGBTQIA+ community, bisexual people tend to be impacted more. The next review identifies some of the key issues impacting the mental health of LGBTQIA+ people within the context of minority stress.

4.0 Review 2: A summary of empirical evidence on the causation between 'minority stress' and mental health challenges faced by LGBTQIA+ people

4.1. Introduction and search strategy

This review outlines a summary of the relationship between minority stress and mental health problems experienced by LGBTQIA+ people. Following assistance from the subject librarian to develop search strings, a detailed search of Embase, Web of Science, PsychInfo, Medline, and CINAHL databases was undertaken in January 2024 (Appendix 4). Key terms relevant to "LGBTQIA+" "Minority Stress" and "Mental Health" linked with 'and' as relevant to each database were used. When searching the databases each set of keywords under the components, were searched using the Boolean operator 'OR' and these were combined using 'AND'.

Population	LGBTQIA+ persons over 5 years old.
Exposure	Mental health problems. Mental illness/disorder/distress.
Outcome	Relationship between minority stress and mental health outcomes
Study characteristics	Published in a peer reviewed journal between 2018 and 2024. English language Primary research

Table 4.1 PEOS

The initial search found 2,542 studies from all databases which were exported to Covidence where 968 duplicates were removed, leaving 1,574 for title and abstract screening (Appendix 5). After initial screening, 1,321 were removed leaving 253 for full text eligibility screening by two people. Two hundred and fourteen (214) were excluded following full text screening for a variety of reasons, the most common being wrong country (n=30) (i.e. not European, North America (USA and Canada), Australian or New Zealand based) and not focussed on the link between minority stress and mental health (n=27), leaving thirty-nine papers included. Findings from studies related to minority stress and its link with mental outcomes were extracted.

Out of these 39 papers, 9 were systematic reviews or metanalysis, 23 were cross sectional studies, 3 were cohort studies. There was also 1 RCT, 1 case control study and 1 correlational study. Only one study used a qualitative methodology. A total of 19 papers had participants that were transgender, non-binary, or gender non-conforming only and another 2 had only lesbian or bisexual participants. The remaining 19 studies included participants described as queer youth (1), LGBTIQ+ people (8),

LGBTQA people (1), LGBT people (1), LGB+ people (1), sexual and gender minority people (5), non-cisgender/ non- heterosexual (1) and lesbian and gay adults (1). See Appendix 6 for details on each study extracted.

4.2 Minority Stress

Minority stress is stress uniquely felt by members of LGBTQIA+ population related to being LGBTQIA+ that is not experienced by the heterosexual or cisgender population. Its origin lies in prejudice and stigma against LGBTQIA+ people. As such LGBTQIA+ people experience population specific distal and proximal stressors that contribute to chronic stress that in turn impacts physical and mental health (Frost & Meyer, 2023). Proximal stressors arise from socialisation experiences in which LGBTQIA+ people develop expectations to be stigmatised, expecting rejection and harassment and may hide or reject their identity as a result. Distal stressors originate from people or institutions that impact the LGBTQIA+ person. These include individual victimisation or discriminatory policies or regulations or everyday experiences (microaggressions) of being treated unfairly because they are LGBTQIA+ (Frost & Meyer, 2023).

4.2.1 Proximal stressors

The proximal stressors identified were common to all studies and all members of the LGBTQIA+ community. Stressors included expectation of rejection, internalisations of negative dominant cultural attitudes, beliefs, stereotypes and values leading to internalised homophobia. Negative expectations led to concealment of LGBTQIA+ status, which is viewed as having a negative impact on mental health outcomes (Helsen et al., 2022; Cascalheira & Choi, 2023). However, Mezza et al. (2024) considers that concealment may not be detrimental to the wellbeing of transgender/ gender diverse people as it can reduce the risk of discrimination. Mezza et al. (2024) suggested that people could live in their preferred gender, receiving affirmation in that gender, without disclosing their gender identity which might reduce the potential for discrimination. This is not a common finding in studies, with the majority instead suggesting that transgender and gender non-conforming people who live freely in their preferred gender, while disclosing their gender identity, have better mental health outcomes. However, for people with non-binary identities they may find that binary-gendered environments can result in greater harassment and discrimination than transgender people (Mezza et al. 2024), as they do not conform to gender expectations. This is supported by Thoma et al. (2021) who report increased verbal victimisation, experiencing more prejudice, and higher expectations of discrimination for gender non-conforming LGB individuals. However, less internalised homonegativity and concealment is reported than in gender non-conforming LGB people who are cisgender or transgender.

4.2.2 Distal Stressors

Discrimination, rejection, victimisation and harassment were reported in all studies. This was not equal among different members of the LGBTQIA+ community in their experiences of discrimination and harassment with non-binary, transgender or bisexual people experiencing more harassment and victimisation than those who were lesbian or gay (Kallstrom et al., 2022; DeVries et al., 2023). Bisexual people reported that not only did they feel victimised by heterosexual people (Scandurra et al., 2020; Ehlke et al., 2020), they also felt victimised by people who were lesbian and gay (Ehlke et al., 2020). Similarly, those who were trans or non-binary reported increased levels of harassment than other members of the LGBTQ+ community (DeVries et al. 2023). These findings are supported by the most recent LGBTIQ+ study by the European Union Agency for Fundamental Rights (FRA) of twenty-seven countries which found that trans people had more experience of harassment and discrimination than LGB people (FRA, 2024) and increased levels of discrimination and hate motivated violence across all countries in the EU.

The harassment described in the studies is in the form of verbal and physical harassment. This can be based on homophobia/ transphobia/ biphobia. A previous EU study (FRA, 2020) reported that 38% of people had experienced harassment due to being LGBTI in the 12 months prior to the survey, 37% of people in Ireland. In addition, in the same study it is reported that based on a previous physical attack, on average 40% of LGBTQI+ people were afraid to go out or visit places. Fear of going out can lead to social isolation, expectation of rejection and increased vigilance when a person does go out. The instance of this is not equal for all groups in the LGBTQI+ minority, with 29% of lesbian woman afraid to go out after a physical attack, but 39% of transgender people reporting that they were afraid to go out. These attacks took place within the previous five years.

Parental and peer rejection is also an important common stressor reported. Personal rejection from people closest to them is a significant stressor for LGBTQIA+ people that impacts mental health outcomes. This was found in the DeVries et al. (2023) Irish study where familial rejection had an impact on participants' mental health. Parental rejection can lead to problems with housing and homelessness, while peer rejection was linked with school-based problems, including consistent name calling, discrimination, failure to provide suitable LGBTQ+ school services and facilities, and physical violence (DeVries et al., 2023). Anti-trans discrimination and victimisation is also evident in school in the only Irish based study in the review, where students reported verbal harassment, physical and sexual assault (DeVries et al., 2023).

Some structural or institutional stigma was also evident with government institutions' management and policies described in some studies as being problematic. These intentionally restrict the opportunities of certain people or groups within the LGBTQIA+ community to avail of suitable services.

Specifically, distal stressors specific to LGBTQIA+ people include stressful and stigmatizing experiences with mental health services which resulted in LGBTQIA+ people not disclosing their LGBTQIA+ status to healthcare providers (DeVries et al., 2023).

4.2.3 Additional Risk Factors

Studies while assessing minority stress and mental health outcomes, have moved beyond measuring individual stressors in the combined LGBTQIA+ community and are now more frequently measuring the exposure to stressors and the number of stressors that a person experiences against mental health outcomes (Puckett et al., 2020; Cogan et al., 202;, deLange et al., 2022; Green et al., 2022; Wilson et al., 2023) or in subgroups of the LGBTIQA+ community. The experiences of people who identify as either a gender or sexual minority in comparison to those who are both a gender and sexual minority has also been explored and compared (Kallstrom et al., 2022; Cisek & Rogowska, 2023). In addition, in recognition of the previous work completed in this area the number of systematic reviews in this subject area is increasing. It has therefore been found that increased numbers of stressors can increase the risks of adverse mental health outcomes. In addition to researching individual stressors, factors that moderate the risk are being studied in subgroups of the LGBTQIA+ community. Studies with transgender and gender diverse participants report greater problems with discrimination and harassment and mental health difficulties than LGB participants. While this review shows that there are an increasing number of studies with transgender and gender diverse participants only, this may be a reflection of the increase of hate speech and an anti-trans agenda in some aspects of society.

Studies reviewed also report that age impacts both minority stress and associated mental health outcomes with younger participants having more minority stress and greater difficulties with mental health than older participants (Tankersley et al., 2021; Branstrom et al., 2022a; Brokjob & Cornelissen, 2022; Koziara et al., 2022; Black et al., 2023; DeVries, et al., 2023). However, while stressors do not decrease as people age, the impact on mental health outcomes is reduced which could signify that resilience that has developed over time. Gender has also been reported to influence minority stress with transgender/ non-conforming people who were assigned female at birth having worse mental health outcomes than males (Hunter et al., 2021; Mezza et al., 2024). Conversely, Black et al. (2023) report that gender did not moderate the effect of minority stress on wellbeing.

Some studies report on intersectionality between sexual and gender minorities and other minorities in particular racial minorities (Green et al., 2022; Merish et al., 2022; Pelicane & Ciesla, 2022; Mezzalira et al., 2023; Ching et al., 2024). Participants describe a combination of heterosexist, transphobic, biphobic and racist experiences, particularly from studies conducted in the USA. In a European study in Sweden, reflecting the changes that have occurred in Europe over the past decade, van der Star et al. (2021) studied the experiences of sexual minority male migrants finding that structural stigma was

associated with internalised homophobia, rejection sensitivity and ultimately poor mental health. The need for a more intersectional approach to mental health service delivery is outlined in Chapter 5 and 6 of this report.

4.2.4 Protective Factors for Minority Stressors

Self-acceptance, openness, and disclosure were common protective factors for mental health outcomes. In addition, peer and parental acceptance, community or social support and school belonging also provide a supportive environment (Ehlke et al., 2020; Mezza et al., 2024; Rogowska & Cisek, 2024). In particular, connection to sexual and gender minority communities, face-to-face or online, is also reported to moderate the effects of minority stress (Ehlke et al., 2020; Hoy-Ellis, 2023).

4.3 Mental Health Outcomes

Lesbian, gay, bisexual, transgender and other sexual and gender minority populations experience mental health disparities in comparison to the cisgender and heterosexual population, which are related to LGBTQI+ minority stressors (Hoy-Ellis 2023). The measures of mental health outcomes reported in the studies varied. Most studies asked participants to self-report on the mental health outcomes using self-report questions or pre validated scales. The elements that were reported most frequently were depression and anxiety with most studies using self-report measures. Participants in all studies were more likely to report symptoms of depression and anxiety and to have received treatment for these conditions compared to heterosexual individuals (Argyriou et al., 2021; Branstrom et al., 2022; Branstrom et al., 2022b; Wilson et al., 2023; Mezza et al., 2024). Increased alcohol and substance misuse were also reported (Puckett et al., 2020; Weeks et al., 2021; Branstrom et al., 2022a; Marchi et al., 2024). Similarly, non-suicidal self-injury, suicide ideation and suicide attempts were reported (Staples et al., 2018; Argyriou et al., 2021; Weeks et al., 2021; Gosling et al., 2022; Drescher et al., 2023; DeVries et al., 2023; Mezza et al., 2024). A minority of studies researched eating disorders in LGBTQIA+ people (Brokjob & Cornelissen, 2022; Mezzalira et al., 2023). Similarly, self-harm while recognised as a mental health outcome for LGBTQ+ people who experience minority stress, was only reported in two studies (Drecher et al., 2023; DeVries et al., 2023). Instances of these mental health outcomes were considered in the previous six or 12 months or if they had ever sought treatment for them.

4.4 Summary and Conclusion

Most studies in this review were cross sectional online survey studies of adults who self-identify as LGBTI+. The majority of studies measured the number of stressors, proximal and distal, and used scales to capture their relationship with self-reported anxiety, depression and suicidal behaviour. In terms of findings of minority stress, greater minority stress and an increased number of stressors were found

to be linked to increased mental health problems. However, some difficulties are still present in accessing inclusive mental health services for LGBTQI+ people. Thus, instead of ameliorating stress this can add to the existing stress for the LGBTI+ person.

Wider mental health policy targeting internalised stigma and discrimination should be considered to develop inclusive care plans and services. Resources are needed to meet the specific needs of LGBTQIA+ people, which can be in the form of supportive programmes designed specifically to engage with LGBTQIA+ people who have experienced minority stress. A warm welcoming physical environment with LGBTQIA+ symbolism and welcoming staff would signify that the LGBTQIA+ person is expected and welcome to the service (Gosling et al., 2022; Camposano et al., 2023). This can reduce discrimination and the stress of seeking mental health services. It is also recommended that mental health professionals should act as advocates to combat the health disparities for LGBTQIA+ people (Staples et al., 2018). This may include undertaking training themselves or educating other professionals and the wider community about the risk factors and wellbeing of LGBTQIA+ people (Hunter et al., 2021).

Trauma-based interventions aimed at reducing suicidal behaviours should also address previous discrimination and the psychosocial impact of this on the person (Kota et al., 2020; deLange et al., 2022; Gosling et al., 2022; Cascalheira & Choi, 2023). Treatment should focus on developing coping skills for minority stress but also include referral to other interdisciplinary colleagues and gender services if required (Tankersley et al., 2021; Brokjob & Carnelissen, 2022). In addition to minority stress, other contributing elements to stress should be considered by mental health practitioners when developing treatment plans. These include but are not limited to race, disability, ethnicity, previous migration, age and gender. Support systems should be assessed and developed if needed for groups or subgroups in the LGBTQIA+ community (Ehlke et al., 2020). These recommendations are also captured in Chapter 6 of this review.

5.0 Review 3: A comprehensive overview of the key challenges faced by LGBTQIA+ people in receiving quality care and treatment from mental health service providers.

5.1 Introduction and Search Strategy

This review identifies the key challenges LGBTQIA+ people have in receiving quality care and treatment from mental health service providers.

Population	LGBTQIA+ persons over 5 years old.
Exposure	Use of, or attempted use, of mental health services
Outcome	Challenges/barriers to accessing mental health care and treatment. Any reporting of good practices.
Study characteristics	Published in between 2018 and 2024. English language Primary research, scoping reviews, systematic reviews, integrative reviews.

Table 5.1 PEOS

In total 3,525 papers were included in a title and abstract search (Appendix 7), with 330 papers included for full-text review. Following full-text review, 290 papers were excluded and primary reasons for exclusion were not being focused on mental health (n=64), not a primary study or review (n=63), not focused on challenges or barriers (n=33), located outside correct country (n=25), not relating to health service providers (n=22), and 'other' reasons (n=83) (e.g. not focused on mainstream mental health service provision). Forty (n=40) papers were included in the review from the systematic search including 5 papers retrieved following a review of the references of key papers (Appendix 8). Of the papers reviewed, 11 were reviews (systematic reviews, scoping reviews, integrative reviews), 11 were qualitative studies, 12 were quantitative studies all using survey methodology, and there were 6 mixed methods papers. The majority of the studies were from the US (n=11) Ireland (n=6) and Australia (n=6), with the remainder from Canada (n=4), New Zealand (n=1) and Nth Macedonia (n=1). The remaining 11 papers were reviews, so the data are drawn from studies located internationally (see Appendix 9 for summary table).

All of the papers in this review are solely from the perspective of the LGBTQIA+ person, apart from one which also included the views of healthcare providers. Where LGBTQIA+ people have identified positive practices within these papers, these are reported on here, however a fuller examination of what best practices should be, and strategies to enable mitigation of identified challenges are captured in the next review. Within this review 17 papers focused on wider LGBTQIA+ population,

with 11 focusing only on trans/gender diverse people, 3 on bisexual people only, 2 on lesbian woman and 1 on sexual minority men.

There were a very limited number of papers that focused on in-patient mental health settings, or community mental health settings exclusively. Rather the majority of the studies/reviews focus on mental health service provision more generally and include within them provision of care by psychologists and counsellors. These were included where the paper was framed as challenges relating to mental health care provision generally. Most of the studies reviewed focus on 'mental health' generally, while a small number focus on specific types of mental health problems e.g. eating disorders (Goetz & Wolk, 2023) and perinatal mental health (Kirubarajan et al., 2022) among the LGBTQIA+ population. Each study/review was appraised for quality. No study was excluded on this basis; however, it is important to note that for qualitative studies the samples were sometimes very small (e.g. Delaney & McCann, (2021) with a sample of 4 participants). The quantitative studies were all cross-sectional survey designs.

5.2 Access to Mental Healthcare

Prior to receiving mental health treatment, a key challenge identified in a number of studies was the ability to gain access to that treatment for LGBTQIA+ people. Here, similar barriers were identified as reported in the literature in general population studies, with some additional barriers from a LGBTQIA+ perspective and focused on geographical barriers, resource barriers and not knowing where to seek LGBTQIA+ affirming treatment from.

5.2.1. Geographical barriers

Barriers to getting access to mental health treatment providers was identified as an issue by LGBTQIA+ people in a number of studies (Higgins et al., 2020; Moore et al., 2020; Cronin et al., 2021; Green et al., 2021; Bettergarcia et al., 2022; Mental Health Reform, 2022; Reisner et al., 2022; Crawford & Schuller, 2023; Reynish et al., 2023). This was exacerbated for people living in more rural or semi-rural communities, and where people did not have their own transport and the providers were located some distance away (Cronin et al., 2021; Bettergarcia et al., 2022; Reisner et al., 2022; Crawford & Schuller, 2023; Nematy et al., 2023; Reynish et al., 2023). For those living in these more remote communities there was also a limited number of LGBTQIA+ providers in the area (Crawford & Schuller, 2023). A physical barrier to gaining entry to buildings where LGBTQIA+ mental health services were located was also identified by people with a disability (McCann & Brown, 2019).

5.2.2 Resource barriers

Financial barriers to accessing mental health treatment were identified in a number of studies, with most reporting an inability to afford the cost of mental health treatment (Ross et al., 2018; Ferlatte, et al., 2019; Higgins, et al., 2020; Moore et al., 2020; Cronin et al., 2021; Gaspar et al., 2021; Green et al., 2021; Bettergarcia et al., 2022; Kirubarajan et al., 2022; Mental Health Reform, 2022; Reisner et al., 2022; Silveri et al., 2022; Stojanovski et al., 2022; Tan et al., 2022; Crawford & Schuller, 2023; Cronin et al., 2023; Nematy, et al., 2023). For studies located in the US and Canada, not having health insurance, or being limited in provider choice by the type of health insurance they did have was a barrier to access to some LGBTQIA+ people (Ferlatte et al., 2019; Moore et al., 2020; Green et al., 2020; Bettergarcia et al., 2022). Participants in the studies by Green et al., (2020) and Bettergarcia et al., (2022) reported that LGBTQIA+ affirming mental health providers did not take the insurance they had and were more expensive than other mental health providers. Crawford & Schuller (2023) in their study predominately located in the US reported that mental health service providers who were trained in LGBTQIA+ issues were in such high demand that they could take private patients paying cash rather than patients using insurance, thereby reducing accessibility to those who were using insurance to cover the cost of care, or who could not afford those private cash payments. While participants in the study by Moore et al. (2020) reported drawbacks with low-cost mental health providers as they saw so many people it was difficult to get quality time with them.

5.2.3 Stigma

As is common in the general mental health help-seeking literature, stigma was also identified in the studies reviewed as a barrier to accessing treatment (McCann & Brown, 2019; White & Fontenot, 2019; Higgins et al., 2020; Moore et al., 2020; Rees et al., 2021; Green et al., 2020; Bettergarcia et al., 2022; Kirubarajan et al., 2022; 2022; Stojanovski et al., 2022; Schuller & Crawford, 2022; Silveri et al., 2022 Crawford & Schuller, 2023; Nematy et al., 2023). Intersecting stigmas were reported where participants identified stigma around the mental health problem, in addition to stigma around LGBTQIA+ identity (Ross et al., 2018; Rees, et al., 2021; Bettergarcia et al., 2022; Kirubarajan et al., 2022; Crawford & Schuller, 2023), with participants fearing being rejected from mental health providers because of their LGBTQIA+ identity (Crawford & Schuller, 2023). Familial, workplace and societal stigma was reported by participants in the studies reviewed (Bettergarcia et al., 2022; Cronin et al., 2023). There were concerns identified in some studies that seeking mental health care would make it difficult to hide their LGBTQIA+ identity from their unaccepting parents (Higgins et al., 2020; Green et al., 2020; Crawford & Schuller, 2023) and this proved to be a barrier to seeking help. In addition to external stigma, there was also evidence of internalised stigma, and poor mental health literacy where LGBTQIA+ people did not want to acknowledge the fact that they were struggling with their mental health or did not believe the problem was significant enough to use up limited mental

health resources, or did not believe that treatment would help with the problem (Kahn et al., 2018; McNair et al., 2018; Higgins et al., 2020; Moore et al., 2020; Green et al., 2020; Kirubarajan et al., 2022; Morris et al., 2022; Nematy, et al., 2023).

5.2.4 Challenges accessing LGBTQIA+ affirming treatment

A number of studies identified LGBTQIA+ peoples' difficulties in knowing how and where to access mental health treatment, and particularly mental health treatment from LGBTQIA+ affirming providers (McNair et al., 2018; Higgins et al., 2020; Moore et al., 2020; Cronin et al., 2021; Gaspar et al., 2021; Green et al., 2020; Bettergarcia et al., 2022; Reisner et al., 2022; Stojanovski et al., 2022) with a shortage of affirming LGBTQIA+ mental health providers identified (Cronin et al., 2021; Tan et al., 2022; Reynish et al., 2023; Roulston et al., 2023). Negotiating the bureaucracies required to access mental health treatment was identified by participants in the study by Crawford & Schuller (2023) as a challenge. Delaney and McCann (2021) report how some participants in their study found it difficult to locate a trans-affirming mental health practitioner within the public system but could access this support instead within the private mental health sector. Participants in the study by Bettergarcia et al., (2022) reported that when they did source mental health providers, some of these providers themselves reported not having the required knowledge and skills to work with them, and this was particularly so for participants with diverse gender identities. Similarly, the study by Ferlatte et al., (2019) reported the lack of a LGBTQIA+ affirming mental healthcare provider was a particular issue for participants who were trans or gender diverse. Previous negative experiences with mental health providers who were not LGBTQIA+ affirming was identified as a barrier to accessing mental health treatment in a number of papers (McNair et al., 2018; Ferlatte et al, 2019; Schuller & Crawford, 2022). For some participants, their search for LGBTQIA+ affirming mental health services was supported by LGBTQIA+ peers who had previously used or were aware of affirming mental health services (Moore et al., 2020).

5.3 Mental Healthcare Providers and the Mental Healthcare Setting

Within this section, key challenges experienced in receiving quality care and treatment from mental health service providers are set out. These predominately focus on the characteristics of the mental health providers that LGBTQIA+ people interacted with, but also reports issues around the poor knowledge of these providers in addition to difficulties with the type of care received within the mental health setting.

5.3.1 Mental Healthcare Provider Characteristics

Affirming healthcare provider attitudes was identified in many studies as important, and the impact of non-affirming or negative attitudes from mental health professionals was a key challenge experienced by LGBTQIA+ people, and particularly by trans and gender diverse people. Participants

across a number of studies reported experiences of both explicit and implicit discrimination from mental health professionals, which fed into a distrust of mental health professionals and a reluctance to seek treatment again (McNamara & Wilson, 2020; Rees et al., 2021; Gaspar et al., 2021; Panchal et al., 2022; Schuller & Crawford 2022; Stojanovski et al., 2022; Goetz & Wolk, 2023). Rees et al's (2021) review identified how participants described being viewed as 'different' or 'not normal' by the mental health professionals they encountered. Mental health providers who seemed uncomfortable or reluctant to discuss sexual orientation or gender identity were seen to be dismissive of the person's identity which negatively impacted the LGBTQIA+ person's healthcare experience (McNamara & Wilson, 2020; Morris et al., 2022), while others reported the experience of being ignored (Panchal et al., 2022; Rees et al., 2021) or made 'invisible' (Silveri et al., 2022) because of their LGBTQIA+ identity. Participants in the study by Morris et al. (2022) suggested this was due to the mental healthcare providers' insecurities about being confidently able to address sexual minority issues. Previous negative experiences were identified which continued to impact on the LGBTQIA+ person. Examples of negatively perceived practices include disclosing LGBTQIA+ identity to the parents of the person (Gaspar et al., 2021), claiming an ability to 'cure' the person of their LGBTQIA+ identity through conversion practices (McCann & Brown, 2019; McNamara & Wilson, 2020; Gaspar et al., 2021; Green et al., 2020; McCann et al., 2021a; Panchal et al., 2022; Stojanovski et al., 2022; Tan et al., 2022), treating a person's LGBTQIA+ identity as a mental illness requiring diagnosis (McCann & Brown, 2020a; McCann & Brown 2020b; Gaspar et al., 2021; Stojanovski et al., 2022), and that treatment of the mental health issue would resolve their LGBTQIA+ identity (McCann & Brown, 2019). While referring on to an alternative service provider is recommended if providers cannot provide LGBTQIA+ inclusive practice (see review to follow), participants in the study by Bettergarcia et al., (2022) reported how this rejection could also have a further negative impact on the person.

5.3.2 Additional challenges for trans people

For participants who were trans or gender diverse there were additional difficulties associated with staffs' poor knowledge, attitudes and practices around gender difference. Acosta et al. (2019) report the experiences of 9 young trans people in relation to inpatient mental health treatment. Almost all (n=8) reported that staff on the unit were aware of their transgender identity but identified that this was because they had independently reported it, often in the context of correcting mistakes with pronouns, rather than it being explicitly asked about and many expressed a preference to be asked their gender identity directly. Healthcare providers, in the same study, reported that when legal names were recorded on medical records, and transferred then to patient armbands, this caused difficulties when patients were then called by their legal name rather than their preferred name (Acosta et al., 2019). Mis-gendering and use of incorrect pronouns and requesting 'dead-names' was also identified

in a number of other studies, with some instances seeming to occur accidentally (Acosta et al., 2019), where in other situations it was not always evident that this occurred accidentally (Delaney & McCann, 2021; Panchal et al., 2022; Bettergarcia et al., 2022; Goetz & Wolk, 2023). Where incorrect pronoun use occurred accidentally, service users did appreciate the effort made by staff to immediately correct these mistakes (Acosta et al., 2019). The impact of incorrect pronoun use and mis-gendering often stayed with service users who reported that it resulted in a breakdown of trust between them and the mental health professional, in addition to compounding their own negative self-perceptions (Delaney & McCann, 2021). Public use of incorrect pronouns was even more damaging as this had the potential to breach a person's privacy and confidentiality around their gender identity and disclosed to others their trans identity at a time when they may not have been ready to do so themselves. Ross et al. (2018) report on the experience of a transwoman, presenting as a woman, but was called in to an office by a doctor using the term 'Mr X', within the earshot of other patients. Similarly, participants in the study by Acosta et al., (2019) reported the distress they experienced when legal names rather than preferred names were utilized in medical records which resulted in them being incorrectly identified in a rollcall for group work (Acosta et al., 2019).

Also reported within the study by Ross et al. (2018) was the issue around allocation of bathroom space in a mental health crisis centre, with trans participants reporting confusion amongst staff about how to manage the situation which impacted on their potential admission to the centre. Similarly in other studies, participants expressed distress or difficulties about sex segregation of in-patient mental health treatment (Goetz & Wolk, 2023) with the review by Panchal et al. (2022) reporting that in studies which dealt with residential or group treatment settings that were not transgender-specific, interactions with non-trans peers were a source of negative or unsafe experiences for participants. These experiences, at a time when participants were in a mental health crisis, served to increase the stressors the person was experiencing and put the focus on the person's gender identity rather than their mental health problem (Ross et al., 2018). Negative attitudes were also experienced by trans participants in the study by Delaney & McCann (2021) when they reported to the mental health professional that they had been self-medicating with hormones which ultimately led to the termination of the service being provided. A questioning of trans identity was also reported in some studies (Delaney & McCann, 2021). These non-affirming experiences resulted in participants seeking to change mental health provider, discharging themselves from in-patient mental health treatment settings, or not seeking care in the future (Delaney & McCann, 2021; Panchal et al., 2022).

Inclusive intentions of mental health professionals was identified in a study by Bishop et al. (2022) as being important to LGBTQIA+ people. Positive, authentic interpersonal interactions where rapport was built were also identified as important to LGBTQIA+ people (Delaney & McCann, 2021). However,

inauthentic interpersonal relationships between the trans person and the mental health provider were sometimes reported when the experience was a transactional one in which the mental health provider was a gatekeeper to gender-affirming and transitioning health services, and the trans person said what needed to be said to access the treatment required (Delaney & McCann, 2021; McCann et al., 2021). The mental health professional's role as a potential 'gatekeeper' to access gender-affirming treatment was also identified in other studies as problematic where again the process was viewed as perfunctory, transactional, and performative, where the trans person had to 'prove' their identity to the mental health professional (Panchal et al., 2022). There was also a recognition that all the power in the interaction was held by the mental health professional.

5.3.3 Mental Health Professionals knowledge and competence

A lack of LGBTQIA+ knowledge, skills and competence was reported by participants in many studies (Acosta et al., 2019; White & Fontenot, 2019; Higgins et al., 2020; McCann & Brown, 2020b; McNamara & Wilson, 2020; Rees et al., 2020; Cronin et al., 2021; Green et al., 2020; Taylor et al., 2021; Bettergarcia et al., 2022; Bishop et al., 2022; Kirubarajan et al., 2022; Mental Health Reform, 2022; Morris et al., 2022; Panchal et al., 2022; Reisner et al., 2022; Silveri et al., 2022; Crawford & Schuller, 2023; Cronin et al., 2023; Goetz & Wolk, 2023; Reynish et al., 2023). This lack of knowledge was reported across the wider LGBTQIA+ group and also in studies focusing specifically on trans people (Acosta et al., 2019; Delaney & McCann, 2021) and bisexual people (McCann & Brown, 2020a; McCann & Brown, 2020b; Taylor et al., 2021). In particular, lack of knowledge and understanding of LGBTQIA+ relationships, norms, terminology and subcultures was reported, as were heteronormative and cisnormative assumptions in the assessment process, and dismissive attitudes around LGBTQIA+ people (McCann & Brown, 2019; McCann & Brown, 2020a; McNamara & Wilson, 2020; Rees et al., 2020; McCann et al., 2021a; McCann et al., 2021b; Bettergarcia et al., 2022; Bishop et al., 2022; Kirubarajan et al., 2022; Morris et al., 2022). There was also a lack of knowledge of intersecting marginalised identities (Bettergarcia et al., 2022; D'souza et al., 2022). Some studies also reported a perceived lack of comfort in mental health professionals when discussing LGBTQIA+ topics, with providers redirecting the conversation away from these areas (McNamara & Wilson, 2020; Rees et al., 2020; Bettergarcia et al., 2022). Some studies reported occasions where mental health providers pathologized their LGBTQIA+ identity, treating it as a symptom of mental illness or as a cause of their mental distress (Ross et al., 2018; Higgins et al., 2020; McCann & Brown 2020b; McNamara & Wilson, 2020; Moore et al., 2020; McCann et al., 2021b; Bishop et al., 2022; Mental Health Reform, 2022; Morris et al., 2022; Panchal et al., 2022; Stojanovski et al., 2022; Tan et al., 2022). Expanding on this, participants in some studies identified that while healthcare provider knowledge about the particular difficulties experienced by LGBTQIA+ people was important, there was a perception that mental health

problems would be, or had been, misattributed to their identity (McCann & Brown 2020a; McCann & Brown 2020b; Moore et al., 2020), and this occurred even when the person clearly stated that they were presenting with issues unrelated to their identity (Morris et al., 2022). Lack of mental healthcare provider knowledge and experience was reported as a particular issue when working with transgender and gender diverse people (Higgins et al., 2020; Bettergarcia et al., 2022; Panchal et al., 2022; Crawford & Schuller, 2023; Cronin et al., 2023), where at times participants found it difficult to source a psychiatrist who was willing to see them as they were 'too complicated' (Higgins et al., 2020). A perceived lack of knowledge among mental health service providers in some instances resulted in LGBTQIA+ service users deciding to censure or withhold information relating to their sexual orientation or gender identity (Moore et al., 2020; Bishop et al., 2022) or to find alternate mental health service providers (Morris et al., 2022).

Service users reported that it was frustrating to have to educate mental health professionals about issues to do with sexual orientation or gender identity within the clinical setting and instead recommended that they source external education and training on this (Acosta et al., 2019; McNamara & Wilson, 2020; Rees et al., 2021; Higgins et al., 2021; McCann et al., 2021a; Bettergarcia et al., 2022; Mental Health Reform, 2022; Panchal et al., 2022). Mental health professionals themselves also reported that they had learned about these issues directly from service users, and frequently asked them questions and used service user interactions as their primary method of learning about diverse identities (Acosta et al., 2019). As identified in the review to follow, this is not recommended best practice. A positive finding reported here however is that participants in the study by Ross et al. (2018) became involved in a group that was responsible for the education of health service providers on LGBTQIA+ issues which provided them with a sense of accomplishment but also provided the healthcare providers with the opportunity to learn directly from the community in a more formal way, a recommendation that is highlighted in the review to follow. A similar scheme was cited by Schuller & Crawford (2022) who reported that having LGBTQIA+ people leading out on competency training for mental health professionals had positive outcomes.

5.3.4 Prominence of Psychiatry/Biomedical Model

LGBTQIA+ participants in a number of studies reported the prominence of the psychiatric/biomedical model of mental health treatment as a challenge to receiving quality care and treatment (Ross et al., 2018; Gaspar et al., 2021). Negative views and experiences about the dominance of psychotropic medication as a first line, and often only, treatment option was reported in some studies, with many reporting a preference for talk therapies and other psychosocial interventions either as an alternative to, or as an adjunct to, pharmacological treatments (McCann & Brown, 2019; McCann & Brown, 2020a; McCann & Brown, 2020b; Higgins et al., 2020; Gaspar et al., 2021; Kirubarajan et al., 2022). However,

in many cases these interventions were not available on public health systems, or where they were, there was a long wait for them (McCann & Brown, 2019; McCann & Brown, 2020a). There was a fear expressed by some that medication would only serve to reduce their autonomy and sense of control over their life choices (Higgins et al., 2020). A lack of opportunity to input into their care was also highlighted with participants identifying a hierarchical approach with psychiatrists perceived as having significant power (McCann & Brown, 2019). Participants in some studies also reported that standard treatments e.g. CBT-E (Cognitive Behavioural Therapy for Eating Disorders) do not meet the needs of the transgender and gender diverse community where issues around body image are inherently more complex (Goetz & Wolk, 2023).

5.3.5 Other issues identified

In some of the studies, having identified poor experiences in receiving quality care and treatment from mental health service providers, participants proffered their preferences for the type of mental health professional they would like to work with. Participants in some studies reported it being easier to discuss mental health issues with LGBTQIA+ providers and therefore identified a preference for LGBTQIA+ providers (White & Fontenot, 2019; Moore et al., 2020; Gaspar et al., 2021; Panchal et al., 2022; Bettergarcia et al., 2022; Bishop et al., 2022; Goetz & Wolk, 2023) as they were more likely to be understood and less likely to be judged. Similarly, some participants expressed a preference for service providers who were younger who were perceived as being more open-minded (McCann & Brown; 2020a; Bishop et al. 2022), and with service providers of the same gender (McCann & Brown, 2020b). A further issue that was identified within this literature was difficulty with follow-up after discharge with participants in some studies reporting a lack of follow-up and wrap-around care following mental health treatment (Bettergarcia et al., 2022). In some cases, participants were referred on for treatment, but nothing ever came of the referral (Higgins et al., 2020). Signposting to sexual minority specialist services and supports was seen as a positive indicator of an LGBTQIA+ affirming healthcare environment (Morris et al., 2022). A lack of integration of psychiatric services with primary care services was also reported in the literature (Reisner et al., 2022).

5.4 Positive experiences of mental health service provision

While the studies within this review report mainly on the challenges and barriers to accessing quality care and treatment from mental health service providers, some studies, even when the focus was on reporting negative experiences, did also report positive experiences and these are identified here. Positive experiences were focused largely on the characteristics of the mental health provider and the organisation they worked in. Acosta et al. (2019) report that the majority of young trans service users in their study reported that there was a generally accepting environment within the mental health setting because of the 'way everyone is'. Organisations and providers that were LGBTQIA+ affirming,

culturally competent, understanding and compassionate were viewed positively by participants (McCann & Brown, 2019; White & Fontenot, 2019; McCann & Brown, 2020b; McNamara & Wilson, 2020; Moore et al., 2020; Delaney & McCann, 2021; McCann et al., 2021a; Panchal et al., 2021; Bettergarcia et al., 2022; Bishop et al., 2022; Mental Health Reform, 2022; Goetz & Wolk, 2023). Mental health providers who were knowledgeable about LGBTQIA+ people and issues were reported as a positive in a number of studies (White & Fontenot, 2019; Moore et al., 2020; Panchal et al., 2022; Bettergarcia et al., 2022; Bishop et al., 2022; Mental Health Reform, 2022), with some reporting that practitioners who had more than surface level knowledge e.g. knowing about different trans identities within the broad trans umbrella, were highly regarded and appreciated (Delaney & McCann, 2021). Even in cases where knowledge was not always good, the acceptance of this knowledge limitation by the mental health professional, and a stance of humility and openness to learn more was important to LGBTQIA+ people (Bettergarcia et al., 2022; Bishop et al., 2022; Mental Health Reform, 2022). Participants in the study by Moore et al., (2020) report how these positive healthcare provider characteristics were more likely to keep them engaged with the mental health services, while White and Fontenot (2019) report that people were more likely to be forthcoming and share more openly when mental health providers were affirming. In a study that reported many incidences of discriminating and invalidating mental health care provision, Stojanovski et al., (2022) did report on some positive experiences and these centered on the provision of a safe and affirming space to talk about sexual and gender identity. Having the ability to include LGBTQIA+ identity in the clinical consultation was important, as was the ability to know when it was not relevant to the mental health difficulties the person was presenting with (Panchal et al., 2022).

Mental health settings that provided visual cues of an LGBTQIA+ affirming service were identified as a positive initiative that signaled to the service user that the potential of experiencing prejudice or discrimination was reduced (Bishop et al., 2022; Morris et al., 2022). Examples of visual cues identified in the literature include rainbow flags, affirmative signage, affirmative statements on the organisation's website, pamphlets about LGBTQIA+ healthcare, identification of staffs' pronouns and inclusive language in intake forms. As identified in the review to follow, these visual indicators of an affirming LGBTQIA+ service are recommended as best practice. A further positive factor experienced by some trans participants was the ability to mix with other trans patients within the mental health setting whether in groups or in less formal interactions (Panchal et al., 2021), with others reporting that allocation of rooms in a residential setting which aligned with their identified gender was affirming (White & Fontenot, 2019). The positive experiences reported in this section are promising and show that affirming, inclusive LGBTIQA+ mental healthcare exists, but it is not the norm (Stojanovski et al., 2022).

5.5 Recommendations from Papers

Within the discussion sections of most of the papers reviewed, authors identified strategies to overcome the barriers and challenges identified in their studies. These are briefly summarized here and as can be seen in more detail in the review to follow, many are components of recommended best practice for provision of mental healthcare for LGBTQIA+ people. Some key aspects of these recommendations are incorporated into the 'Considerations for Ireland' section concluding these reviews in Chapter 8.

Access to mental healthcare: Recommendations were made that mental health providers and insurance providers ensure transparency and ways to increase access to facilitate the sourcing of and access to affirmative LGBTQIA+ mental health services and providers (McCann & Brown, 2020b; Cronin et al., 2021; Bettergarcia et al., 2022). Proposed strategies to increase help-seeking and reduce stigma included the involvement of mental health peer advocates within the LGBTQIA+ community (Bettergarcia et al., 2022; Mental Health Reform, 2022). The use of tele mental health, digital mental health supports, and online support groups was also suggested as an alternative to increase accessibility to mental health service provision, particularly in remote communities (Cronin et al., 2021, 2023; Morris et al., 2022; Reisner et al., 2022; Silveri et al., 2022; Stojanovski et al., 2022; Goetz & Wolk, 2023; Roulston et al., 2023). The expansion of mental health service provision beyond the traditional medical model approach, increased access to psychological therapies, and increasing LGBTQIA+ affirming/specialist services was identified (McCann & Brown, 2020a; McCann & Brown, 2020b; Rees et al., 2021; Gaspar et al., 2021; McCann et al., 2021b; Taylor et al., 2021; Mental Health Reform, 2022; Silveri et al., 2022). Silveri et al., (2022) in their review note that the number of LGBTQIA+ specialist mental health services decreased in the period between 2015 to 2018, but report that it is not clear whether this decrease was due to mainstream mental health services becoming more LGBTQIA+ friendly, thereby negating the requirement for specialist services, or if there is a more negative policy environment around the provision of LGBTQIA+ mental health services. Some authors also suggested the use of mental health literacy education for LGBTQIA+ people to help them understand the need for early intervention for mental health problems and mitigate against self-stigma which may ultimately decrease unmet need within this population (Ferlatte et al., 2019; Gaspar et al., 2021), and reduce the requirement for secondary mental health service provision. For young LGBTQIA+ people, the use of social media to improve mental health literacy and mental health system navigation was recommended (Moore et al., 2020).

Affirming mental healthcare environment and practitioners: Rees et al., (2021) identity that the prevailing culture in mental health settings and among mental health professionals is one of hetero-normativity and cisnormativity which need to be challenged in order to provide an inclusive

environment for LGBTQIA+ service users. Morris et al., (2022) suggest that the mere absence of explicit discrimination or negative attitudes does not equal an affirming mental health setting, and instead it needs to be clear for all to see that the environment and the people working within it are LGBTQIA+ affirming. Mental health professionals and particularly managers within the mental health setting have a role in ensuring that the health care environment, including the policies that operate within it are inclusive, affirming and non-discriminatory (Higgins et al., 2020). Affirming, validating and understanding responses can be modelled by managers working in mental health settings helping to ensure that staff engage in high standards of practice (Delaney & McCann, 2021). Use of, and recording of, preferred names, pronouns and identities (Bettergarcia et al., 2022; Nematy et al., 2023), with documentation that uses gender neutral and inclusive language (McNamara & Wilson, 2020; Kirubarajan et al., 2022; O'Brien et al., 2023) is highlighted frequently throughout the literature. Acknowledging with humility when mistakes happen (Acosta et al., 2019; Bettergarcia et al., 2022) is an important component of affirming practice and indicates a mental health practitioner who is reflective and self-aware which are identified as important traits (Rees et al., 2021; Silveri et al., 2022). A mental health setting that provides visual cues of an affirming LGBTQIA+ stance, including rainbow signs/flags/badges, LGBTQIA+ pamphlets, and LGBTQIA+ symbols on the website was identified as important by a number of authors (White & Fontenot, 2019; McNamara & Wilson, 2020; Moore et al., 2020; Delaney & McCann, 2021; Taylor et al., 2021; Bishop et al., 2022; D'souza et al., 2022; Mental Health Reform, 2022; Morris et al., 2022; Nematy et al., 2023). From a mental health practice perspective, there is a need to ensure that the assessments, interventions and supports provided to trans patients are culturally competent and responsive to their concerns (McCann et al., 2021). Increased involvement of the service user in their own care planning, with the development of coproduced care plans was also recommended (McCann & Brown, 2020b). For trans and gender diverse people, integrated models for gender-affirming care are also recommended (Mental Health Reform, 2022; Reisner et al., 2022). Strategies to make the mental healthcare setting a more affirming one can be developed in partnership with LGBTQIA+ communities and organisations (Higgins et al., 2020; Delaney & McCann, 2021).

Mental healthcare professional education: Most studies reviewed recommended that mental health providers have increased educational content on LGBTQIA+ issues centered particularly around increasing cultural competency and knowledge about LGBTQIA+ needs and issues, and including skills for working in a LGBTQIA+ affirming way (Kahn et al., 2018; McCann & Brown, 2019; Smith et al., 2019; White & Fontenot, 2019; Higgins et al., 2020; McNamara & Wilson, 2020; Moore et al., 2020; McCann et al., 2020a; McCann et al., 2020b; Rees et al., 2021; Cronin et al., 2021; Green et al., 2020; McCann et al., 2021b; Taylor et al., 2021; Bettergarcia et al., 2022; Mental Health Reform, 2022; Morris et al.,

2022; Reisner et al., 2022; Schuller & Crawford, 2022; Silveri et al., 2022; Tan et al., 2022; Crawford & Schuller, 2023; Cronin et al., 2023; Nematy, et al., 2023; Reynish et al., 2023; Roulston et al., 2023). Some authors suggest this training be mandatory (Bishop et al., 2022), or that there should be a mandatory minimum level of training (Cronin et al., 2023). Education around LGBTQIA+ issues should focus on the need for mental health practitioners to be reflexive and aware of their own biases and heteronormative and cisnormative assumptions (Bishop et al., 2022; McCann et al., 2021a; McCann et al., 2021b). For mental health professionals working with trans and gender diverse service users there is also a particular requirement to be familiar with the trans identity and the transition process (Delaney & McCann, 2021) and the often-difficult prior experiences of trans people within the healthcare setting (Kirubarajan et al., 2022) ultimately ensuring that staff are better able to relate to trans and gender diverse people (Frelatte et al., 2019). In cases where sensitive or upsetting questions relating to LGBTQIA+ identity need to be asked, mental health professionals need to have the skills to do this sensitively, while not being overly inquisitive and explaining why this information is clinically relevant (Rees et al., 2021; Kirubarajan et al., 2022). When mental health staff have sufficient knowledge about transgender health, they are more likely to work in an inclusive way with trans people (Tan et al., 2022), however Tan et al. (2022) report that a recent review of the undergraduate curriculum for medical professionals in New Zealand found little to no pre-clinical content focusing on gender diversity suggesting that any training currently taking place, is taking place post-qualification. For mental health professionals working with bisexual people there is a need to be aware of the existence of the specific needs of bisexual people to mitigate the risk of bi-erasure (McCann & Brown, 2020a; McCann & Brown, 2020b; McCann et al., 2021b; Silveri et al., 2022).

There was also a requirement for mental health services and the staff who work within them to be more knowledgeable and understanding of intersecting identities and to practice from an intersectional perspective (Kahn et al., 2018; Ross et al., 2018; White & Fontenot, 2019; Moore et al., 2020; D'souza et al., 2021; Mental Health Reform, 2022; Schuller & Crawford, 2022; Silveri et al, 2022; Stojanovski et al., 2022; Nematy et al., 2023; Roulston et al., 2023). For some, the intersecting identities were in relation to LGBTQIA+ identity and disability (McCann & Brown, 2020b). In particular however, the plight of migrant LGBTQIA+ people seeking mental health support was identified, and the need for mental health professionals to understand that individuals might experience their sexual orientation or gender identity differently than in the Western cultures they migrate to (Kahn et al., 2018; D'souza et al., 2022; Nematy et al., 2023). A culturally and racially sensitive approach which considers the intersectional nature of peoples' identities was recommended for mental health professionals, while the use of interpreters who are educated in LGBTQIA+ issues was also recommended (Kahn et al., 2018; D'souza et al., 2022; Nematy et al., 2023). Recognising the potential

for trauma reactions in migrants, it is recommended that mental health professionals work from a trauma-informed perspective and be prepared for trauma disclosures (D'souza et al., 2022; Nematy et al., 2023). This recommendation for a more trauma-informed perspective was also identified for the wider LGBTQIA+ group (Kirubarajan et al., 2022; Silveri et al.,2022; Goetz & Wolk, 2023; Reynish et al., 2023). Integration of and adherence to guidelines and resources for mental health professionals into standard clinical practice was suggested by some authors (Rees et al., 2021; Delaney & McCann, 2021; Tan et al., 2022; Cronin et al., 2023).

5.6 Conclusion

The review has set out a summary of the evidence published between 2018 and January 2024 identifying key challenges faced by LGBTQIA+ people in receiving quality care and treatment from a mental health service. As seen in the previous two reviews, mental health challenges, often as a result of minority stress, are higher in the LGBTQIA+ population necessitating a greater use of mental health services. However, this review has identified a number of key challenges to receiving quality care and treatment. Difficulties in accessing mental health services in the first instance poses a problem for many LGBTIQA+ people, as it does within the general population with logistical challenges, resource barriers and stigma all impeding access. However, specific to the LGBTQIA+ population is the intersection of stigma relating to having a mental health difficulty, in addition to being LGBTQIA+. Compounding these difficulties then is a lack of LGBTQIA+ affirming mental health services. The characteristics of mental health professionals are identified as an important component in relation to quality of care and treatment with negative attitudes, and poor knowledge, skills and competence identified as a significant barrier to quality care, with these issues being particularly difficult for people who were trans/gender diverse. The dominance of a medical model of treatment with an over-reliance on medications, and lack of opportunity for alternative or adjunct treatment options was also identified as problematic. The review to follow identifies some of the recommended best practice to mitigate some of the challenges identified in this review.

6.0 Review 4: A comprehensive review of current practice and policy on mental health service provision to LGBTQIA+ persons including any strategies/standards/guidance/code of practice published in Ireland or other comparable jurisdictions.

6.1 Introduction and Search Strategy

This review focuses on identifying current practice and policy on mental health service provision to LGBTIQA+ people with a particular focus on identifying best practice as outlined in any available strategies/standards/guidance/code of practice/position statements or papers which provided best practice recommendations. Following a systematic search of databases, 3458 papers were included in a title and abstract search (Appendix 10). Recognising that the type of literature for inclusion in this review was much broader than peer-reviewed empirical studies and reviews, this systematic search of databases was also supplemented with a search for grey literature to identify organisational documents, position statements and similar material that may not be captured in a regular database search with an additional 17 documents included for title and abstract screening with 161 papers included for full-text review. Following full-text review, 122 papers were excluded and primary reasons for exclusion were not being substantially focused on mental health and not identifying best practices or policies (Appendix 11), resulting in 39 documents included in the review.

Population	LGBTQIA+ persons over 5 years old.
Exposure	Mental health problems. Mental illness/disorder/distress.
Outcome	Best practice guidelines/ best practice recommendations/position statements/Standards/codes of practice
Study characteristics	Published between 2018 and 2024. Located in Europe/US/Canada/Australia/New Zealand

Table 6.1 PEOS

Seventeen of the reviewed documents are organisational ones, representing a range of literature including position statements, guidance documents, and standards of care that make recommendations around best practice for working for LGBTQIA+ people relevant to mental health professionals (see Appendix 12a for summary table). Of these 17, 2 were not country specific and related to guidance that was international in nature, 3 were located in the UK (broadly), 1 in Ireland, 1 in Scotland, 1 in mainland Europe, 5 in the US, and 4 from Australia and New Zealand. The remaining 22 documents reviewed consist of a range of papers including scoping reviews, systematic reviews and primary research studies, however most were opinion papers drawing on literature in the area and

were not therefore country specific (see Appendix 12b for summary table). In total, there were 23 documents related to LGBTQ people with 14 focusing exclusively on transgender/gender-diverse/gender non-conforming people and 2 focusing on sexual minorities only.

6.2 The Mental Healthcare Setting

6.2.1 A welcoming environment

Most of the papers reviewed refer to the requirement for a physical environment that is LGBTQIA+ friendly recognising that the physical environment can indicate messages of inclusion or marginalisation (Hudson & Bruce-Miller, 2023; Hope et al., 2022; Hannan et al., 2022; Britt-Thomas et al., 2023; Walton & Baker, 2019). Prominent in the guidance are recommendations for visible displays that convey that the healthcare organisation is LGBTQIA+ welcoming, recognising that LGBTQIA+ people may look for visual indicators of safety and inclusion (Hannan et al., 2022). This can be portrayed in a number of ways and includes the display of affirming posters and signage within the setting, displaying the Rainbow Pride flag, the provision of brochures and magazines that depict LGBTQIA+ lives, the display of LGBTQIA+ art and images, and the use of rainbow lanyards, badges and laces by staff which send an immediate and non-verbal message of welcome (HSE, 2021; Hannan et al., 2022; Bhugra et al., 2022; Felker et al., 2022; Inventor & McIntosh, 2022; Mental Health Reform, 2022; Mental Welfare Commission, 2022; Hudson & Bruce-Miller, 2023; Walton & Bruce-Miller, 2023; van Dyk et al., 2023). In addition to the display of the rainbow flag, recommendations are also made around displaying the trans specific blue, white and pink flag which may send a more overt message of welcome to trans service users (Shipherd et al., 2019).

This welcoming physical environment should also be mirrored in the virtual environment where websites of healthcare organisations should depict LGBTQIA+ inclusion (Hudson & Bruce-Miller, 2023; Hope et al., 2022). Bhurga et al. (2021) in their International Review of Psychiatry Commission Report suggest that the website of healthcare organisations should also profile staff from sexual minorities. The visibility of LGBTQIA+ staff within the healthcare environment is also recommended by a number of other authors/organisations who highlight the potential benefits of services users being able to see themselves reflected in the service providers (Shipherd et al., 2019; Hannan et al., 2022; McNulty et al., 2022; Hudson & Bruce-Miller, 2023). Commitment to LGBTQIA+ equity and inclusion in recruitment can increase the number of staff who can provide valuable insights about working with LGBTQIA+ service users thereby helping LGBTQIA+ service users feel more represented (Hudson & Bruce-Miller, 2023), while also building credibility in the community (Shipherd et al., 2019). Hannan et al. (2022) however caution that LGBTQIA+ staff should not be seen as the default 'go-to' person for working with LGBTQIA+ people. Bhurga et al. (2021) suggest that the LGBTQIA+ staff within mental healthcare

organisations establish workplace networks and support groups of LGBTQIA+ staff, which provide visible evidence of an LGBTQIA+ friendly environment, in addition to the provision of advice and suggestions to management on the provision of LGBTQIA+ welcoming care. Identifying a visible LGBTQIA+ champion within the mental healthcare setting is also recommended as a way to increase visibility and promote a welcoming environment (Hannan et al., 2022), as is partnering with local LGBTQIA+ organisations to promote inclusivity (Hudson & Bruce-Miller, 2023). Walton and Baker (2019) suggest that mental healthcare providers can also look to obtain recognition for offering LGBTQIA+-centred care by using a benchmarking tool (they provide the example of the Healthcare Quality Index, Human Rights Campaign, 2016), and publicise their recognition as a LGBTQIA+ friendly healthcare provider. The Royal Australian and New Zealand College of Psychiatrists (2019) suggest that mental health services should consider service accreditation standards for the provision of culturally appropriate services for LGBTIQ+ communities.

6.2.2 Healthcare documentation

Documentation within the healthcare environment is a key area identified in many of the reviewed papers where organisations are cautioned to be aware of subtle and covert forms of discrimination through the act of omission/erasure. A number of papers make reference to the importance of addressing records including assessment forms, demographic forms and electronic records to ensure they are inclusive of LGBTQIA+ people (American Nurses Association, 2019; Shipherd et al., 2019; Walton & Baker, 2019; Fadus et al., 2020; Britt-Thomas et al., 2023). There is also a requirement to ensure that sexual orientation and gender identity is collected in a sensitive way in records, recognising that it is private information and shared on a need-to-know basis (American Nurses Association, 2019). Practice guidance from the Health Service Executive in Ireland for healthcare professionals working with LGBT service users (HSE, 2021) suggest caution in asking people about their sexual or gender identity if it is not relevant to their healthcare presentation and suggest that service users are only asked about their identity if, as part of an inclusive practice, everyone is asked about their identity. In this vein, van Dyk et al. (2023) recommend that all patients are asked about their identities, as do Hannan et al. (2022) who suggest that it is important to record peoples' sexual or gender identity as this information equips healthcare providers with information about who is using their service, and the specific health needs and outcomes for LGBTQIA+ service users. This call for eliciting and documenting gender and sexual identity is supported by other authors (Mental Welfare Commission, 2022; Britt-Thomas et al., 2023; Hudson & Bruce-Miller, 2023). McNulty et al., (2022) further suggest that there should be transparency around what the personal information collected is used for.

Ensuring that admission forms are not solely binary or heteronormative is an important way to indicate that a setting is LGBTQIA+ friendly (Fadus et al., 2020). A simple way to action this is ensuring a free

space to indicate gender on an admission form, rather than the binary choices of male or female (Felker et al., 2022). Asking people more open-ended questions like 'what are your pronouns?', 'how do you describe your sexual orientation?', and 'how do you describe your gender?' allows people to identify their own gender and sexual identities in a more inclusive way (Hannan et al., 2022; American Psychiatric Association, 2024). For trans and gender non-conforming service users, it is recommended that staff ensure that medical records reflect the person's preferred name and pronoun, in addition to the person's legal name (Shipherd et al., 2019; Fadus et al. 2020; Britt-Thomas et al., 2023), and that room signage, bed rosters, or any other ward display of names reflect the person's preferred name. The Mental Welfare Commission (2022) in Scotland caution against using inverted commas when documenting the person's preferred name. Fadus et al., (2020) suggest some ways in which preferred names and pronouns, in addition to legal names, can be captured in medical notes with the following example: *"The patient has a female legal name but prefers to be addressed as Aiden. The patient will be referred to as Aiden, and male pronouns will be used"*.

Capturing this information early in medical notes is important as incorrect medical records, or mistakes with pronouns follow the service user as mistakes are copied over from one service to another (Fadus et al., 2020; Britt-Thomas et al., 2023).

6.2.3 Organisational policies

Also within the broad theme of mental healthcare environment is the issue of availability of clear organisational policies and guidelines to support mental health professionals when working with LGBTQIA+ people, and to promote cultural safety of LGBTQIA+ people (Hannan et al., 2022; Walton & Baker, 2019; Mental Health Reform, 2022; Mental Welfare Commission, 2022). Policies should consider LGBTQIA+ specific issues that may impact on a service user's experience and include antidiscrimination policies, confidentiality policies, policies for trans-affirmative care in the in-patient setting, and any adjustment to existing policies that may be required (Hudson & Bruce-Miller, 2023; Britt-Thomas et al., 2023; Hannan et al., 2022; Walton & Baker, 2019; Shipherd et al., 2019). Walton and Baker (2019) provide an example of this as an adjustment to ward visitation policies to include visitors not just from families, but also from families of choice, reflecting that some LGBTQIA+ people may have difficult family relationships if their family members are non-affirming. Similarly, the American Nurses Association (2019) advocates for LGBTQIA+ people to have equal rights to visiting privileges and access to loved ones when in hospital, while the British Psychological Society (2019) also recognises the importance of facilitating family members that may not legally be recognised as family members in visiting policies. A number of documents make reference to the need for these policies and guidelines to not only be developed and available to staff, but also to be prominently displayed and visible to service users (Walton & Baker, 2019; Britt-Thomas et al., 2023; Hudson & Bruce-Miller, 2023; Strauss

et al., 2024). Recognising the experiences and expertise of LGBTQIA+ people, and their knowledge of what makes a more inclusive mental health service, these policies should be co-developed with the LGBTQIA+ community (Bhugra et al, 2022; Hannan et al, 2022; McNulty et al., 2022). Hannan et al (2022) on behalf of ACON a government funded LGBTQI+ advocacy organisation in New South Wales Australia, recommends that the inclusion of LGBTQIA+ people in co-design should incorporate people across the range of sexual and gender diversities and include a broad range of ages and people from intersecting minorities. In addition to the availability of these policies, a number of documents make reference to the need for a robust reporting and investigation process for incidences where policies are not upheld (Hannan et al., 2022; Britt-Thomas et al., 2023; Hudson & Bruce-Miller, 2023).

6.2.4 Ward/living space allocation for Trans and Gender Diverse Service Users

For service users who are trans or gender diverse, there are additional issues to consider within the in-patient/residential setting in particular recognising that service users share spaces more intimately in these settings compared to outpatient settings (Walton & Baker, 2019; Britt-Thomas et al., 2023). Primary here are the issues around allocation of bedroom space, and use of bathroom facilities and a smaller number of documents make reference to the challenges inherent in this (Walton & Baker, 2019, Coleman et al., 2022 (WPATH); Felker et al., 2022; Britt-Thomas et al., 2023; Kealy-Bateman et al., 2019; Shipherd et al., 2019; Fadus et al., 2020). Kealy-Bateman et al. (2019) report that allocation to a unit/room is sometimes done without eliciting the views/concerns of the trans person or considering the potential impact on them of allocation to a segregated unit. Some in-patient mental health services remain segregated on the basis of gender which poses difficulties for transgender and gender diverse people if they are assigned to accommodation on the basis of their birth gender rather than their gender identity. However, Kealy-Bateman et al., (2019) and Fadus et al., (2020) identify that allocation to single sex units can also present a clinical challenge which needs to be carefully considered. Firstly, the safety of the trans person themselves is to be considered noting the significantly higher rates of mental distress and suicidal behaviour in trans people, and the potential for this to increase if assigned to single sex accommodation aligned with their birth gender rather than gender identity, which can be seen as discriminatory (Kealy-Bateman et al., 2019). In contrast to this then is consideration of the views of other patients on the unit. Other service users may have religious beliefs or otherwise firm beliefs about gender identity that may come into conflict with that of a transgender person (Kealy-Bateman et al., 2019). They also suggest that considerations around physical and sexual safety may also be put forward as a reason why, for example, a transwoman who has not undergone gender transitioning surgery should not be placed in a female single-sex unit (Kealy-Bateman et al., 2019). This was a point also considered by Walton and Baker (2019), who identified that staff and other service users may have difficulties with this. However, they report that in their 10 years of involvement in a

mental health facility that is trans affirmative, fears around a negative outcome have not materialised and instead patients make positive connections often on the basis of their shared mental health struggles. They suggest that the absence of negative outcomes is also grounded in the positive environment created by the healthcare providers (Walton & Baker, 2019).

Kealy-Bateman et al., (2019) make the point that considering the viewpoints of other service users in the unit is not to deprioritise the transgender person, but rather to anticipate and mitigate potential conflicts. In a bid to meet the needs of the transgender person, while also considering ward dynamics, a number of authors (Kealy-Bateman et al., 2019; Felker et al., 2022; Britt-Thomas et al., (2023) recommend that a thorough assessment be carried out prior to the allocation of living accommodation including a careful clinical history, current risk assessment, mental state examination, diagnosis, review of previous admission experience, consultation with the service user, and consideration of the patient and staff mix. Other organisations are more emphatic in their approach to the allocation of bedrooms and bathrooms. The World Professional Association for Transgender Health (WPATH) who developed the 8th edition of *the Standards of Care for Transgender and Gender Diverse People* are clear in their recommendation that service users be provided access to bathroom and sleeping arrangements that are aligned with the person's gender identity (Coleman et al., 2022). This recommendation is supported by others who also recommend transgender service users are assigned accommodation, bathroom facilities and community spaces according to their self-identified gender (Walton & Baker, 2019; Shipherd et al., 2019; Mental Welfare Commission, 2022; Britt-Thomas et al., 2023).

A potential path to overcoming conflict associated with this issue is to allocate trans people to non-segregated units or single rooms (Britt-Thomas et al., 2023; van Dyk et al., 2023), although Fadus et al. (2020) caution that this might be isolating for the trans person and may also lead to adversarial relationships with peers who must share their rooms with others. Nonetheless, Hudson & Bruce-Miller (2023) suggest the provision of a range of accommodation options including all-gender, gender inclusive, and non-gendered facilities which they suggest indicates a safe space for gender expansive people as well as for those in transition or who feel uncomfortable in any gendered space. Felker et al., (2022) and Walton and Baker (2019) recommend that communication of a non-discrimination policy to other service users prior to their admission can help alleviate tensions that might arise later. Walton and Baker (2019) provide an example of how this is communicated in one female-only veteran mental health service they reviewed:

"*Our program admits women veterans and assigns roommates without regard to race, ethnicity, religious beliefs, sexual orientation, or birth sex. Would you be able to tolerate such differences without becoming unduly distressed or critical of others?"*

Walton and Baker (2019) suggest this fills a number of purposes as it conveys to transgender service users that the service is non-discriminatory, while also providing cisgender service users with the opportunity to make a choice about whether they believe they can be welcoming. Some documents reviewed concluded that this is not an easy issue to resolve within mental health facilities (Fadus et al., 2020) and recommend the development and dissemination of specific guidance within mental healthcare organisations regarding how to manage these complexities and guide decision-making regarding the environment of care (Britt-Thomas et al., 2023; Fadus et al., 2020; Walton & Baker, 2019). It is suggested by some that lack of specific guidance on allocation of trans people to single sex accommodation is a form of institutional erasure (Kealy-Bateman et al., 2019). An additional issue for trans people around the physical mental health care setting identified by van Dyk et al., (2023) is the possibility of deadnames or legal names being used on room nameplates, bulletin boards, meal orders etc. Here, the authors recommend the use of neutral alternatives to nameplates (e.g. naming rooms by colour) to avoid people being deadnamed, or coming out before they are ready (van Dyk et al., 2023).

6.3 Training and education of staff

Prominent in the literature review was the recommendation that staff be educated and trained in skills and practices important to working with LGBTQIA+ people, and that this training is provided by skilled professionals (Hudson & Bruce-Miller, 2023). There is also a recommendation that LGBTQIA+ education be provided to all staff, clinical and non-clinical, as non-clinical staff (receptionists, cleaners, porters etc.,) spend considerable time interacting with the service user (Walton & Baker, 2019; Goldhammer et al., 2019; Fadus et al., 2020; Mental Welfare Commission, 2022; Hudson & Bruce-Miller, 2023; Strauss et al., 2024) and Walton and Baker (2019) identify that it is often staff with the least clinical training that have the most direct contact with service users. Bhugra et al. (2022) and Felker et al. (2022) recommend that this training be mandatory. There were a number of common specific recommendations focused on staff training and education in the literature. One recommendation was that training should help staff to reflect on their own biases and heteronormative and cisnormative assumptions (Rees et al., 2021; American Psychological Association, 2021; O'Brien, et al., 2023; Strauss et al., 2024). Another was that staff should not rely on LGBTQIA+ staff (McNulty et al., 2022) or service users to educate them on LGBTQIA+ issues and healthcare provision (British Psychological Society, 2019; Walton & Baker, 2019; Crapanzano & Mixon, 2022; Hope et al., 2022; Panchal et al., 2022; Hudson & Bruce-Miller, 2023). As seen in the previous

review on 'challenges', one of the barriers for LGBTQIA+ people accessing mental health care was their previous negative experiences, which included having to educate staff who appeared to have little information on LGBTQIA+ issues. Walton & Baker (2019) identify that it is not appropriate for transgender service users to have to educate staff on definitions of transgender specific terms, or to have to tell them about hormone therapy, and recommend instead that staff receive this information from the healthcare provider. In instances where training and expertise is not available from the healthcare provider, they recommend collaborating with the broader community. Most of the documents reviewed did not specify when or where training takes place with the implication in most that this training is provided by the mental health service to staff as a form of Continual Professional Development (CPD) or in-service training. However, some organisations such as the American Nurses Association (2019) identified the importance of early incorporation of issues relevant to LGBTQIA+ people within nursing curricula and also recommend the requirement for regulatory authorities to mandate the inclusion of content and competencies on LGBTQIA+ health. Mental Health Reform (2022) recommend that professional bodies and service providers including the HSE integrate LGBTI+ issues into the curriculum across all training and professional development modules, where possible, in addition to providing continuing education and training opportunities for existing mental health staff. Similarly, the Royal Australian and New Zealand College of Psychiatry (2019, 2023) recommend that training programmes for medical, nursing and other health service staff should include cultural sensitivity training in LGBTIQ+-specific issues.

Many of the authors provide suggestions of content that should be included in training and education programmes. The broad area of 'cultural competency' is one that is identified by many (Shipherd et al; 2019; Green et al., 2020; Bhugra et al., 2022; Hannan et al., 2022; Inventor & McIntosh, 2022; Hudson & Bruce-Miller, 2023). Cultural competency in this context includes the promotion of affirmative approaches and inclusive language, knowledge of LGBTQIA+ health disparities and inequities, barriers to accessing mental health treatment, strategies to increase engagement with mental health services, protective factors for LGBTQIA+ mental health and mechanisms and sources of referrals post-discharge (Hudson & Bruce-Miller, 2023). A particular focus on education on issues relating to trans peoples' mental health was also advocated as less is known about this group of service users. This includes knowledge about transgender issues in society broadly, as well as the unique mental health concerns and needs of transgender people (Goldhammer et al., 2019; Felker et al., 2022; Panchal et al., 2022; Britt-Thomas et al., 2023).

Recommendations for training focusing on identification and management of microaggressions were also identified (Shipherd et al., 2019; Felker et al., 2022). Microaggressions, which are brief verbal or

behavioural actions which can be intentional or unintentional and that communicate discriminatory attitudes or behaviour can occur within the mental health setting and are a feature of minority stress. Training here should focus on making invisible microaggressions visible and educating those who engage in harmful microaggression on how impactful they can be to the LGBTQIA+ service user (Shipherd et al., 2019; Britt-Thomas et al., 2023). van Dyk et al. (2023) suggest training should include role-play with feedback to capture the communication processes required between the mental health professional and the service user. Bystander training, to equip staff with the ability to stand up to discrimination, and to advocate for the LGBTQIA+ person has also been recommended (Shipherd et al., 2019) as have strategies that support staff to address colleagues who use discriminatory language (Strauss et al., 2024).

While cultural competency training was recommended by many as outlined above, there were a small number of papers where authors argued for the need to go further then 'learning about' LGBTQIA+ issues, and to embrace a process of cultural humility (Hudson & Bruce-Miller, 2023). Cultural humility refers to a process of self-reflection, appreciation of service users' lay expertise, and an openness to continually learn from the service user that doesn't serve to 'other' them (Lekas et al., 2020). It also involves the practice of continually examining one's own power and privilege (American Psychological Association, 2021). It is process-orientated rather than content-orientated which enhances healthcare providers capabilities to deliver person-centred care rather than focusing completely on increasing provider knowledge (Lekas et al., 2020). As a focus on cultural humility is increasing in the mental health literature, this approach should be considered when exploring the training and education needs of mental health providers working with LGBTQIA+ people.

6.4 Interpersonal Interactions

A very common area discussed in the reviewed literature, with a number of recommendations made, is around the quality and affirming nature of interpersonal reactions between staff in the mental healthcare setting, and LGBTQIA+ service users. As with the recommendation relating to education and training above, these recommendations apply to all staff who interact with service users, and not just clinical staff (Hudson & Bruce-Miller, 2023). Recommendations focus on the need for all staff to be aware of and to use preferred names and pronouns, and to follow the lead of the service user in this regard, using a process of mirroring (British Psychological Society, 2019; Hudson & Bruce-Miller, 2019; HSE, 2021; American Psychological Association, 2021). When communicating for the first time with a service user it is recommended that staff use inclusive language that does not assume sexual orientation or gender identity (Hudson & Bruce-Miller, 2023). Affirming interpersonal interactions demonstrate an inclusive and respectful organisation to service users, whereas the use of incorrect

language, whether intentionally or unintentionally, can build barriers to care and exacerbate the experience of discrimination for the individual (Hudson & Bruce-Miller, 2023).

Being aware of personal biases and engaging in self-examination is also a common recommendation (Hudson & Bruce-Miller, 2023; American Psychological Association, 2021). A process of cultural humility is recommended (Hudson & Bruce-Miller, 2023; O'Brien et al., 2023; American Psychological Association, 2021;) where mental health professionals engage in constant reflection and self-critique. There is acknowledgement in the literature that even with the best intentions, staff can make mistakes in their communication with service users but how this is dealt with is important with the recommendation being that staff recognise their mistake, apologise for it, and be non-defensive in that apology (Hudson & Bruce-Miller, 2023; Britt-Thomas et al., 2023; Hannan et al., 2022; Hope et al., 2022; Mental Welfare Commission, 2022; HSE, 2021). In addition, a healthcare provider who makes a genuine mistake and offers an authentic apology, must follow this up with a change in behaviour as the apology is meaningless if the behaviour is consistently repeated (HSE, 2021).

6.5 Therapeutic considerations

Most papers reviewed in some way make reference to therapeutic issues and approaches that need to be considered when working with LGBTQIA+ people in a mental health setting. A number of papers remind readers, and make explicit, the fact that being LGBTQIA+ is not a mental disorder (Royal College of Psychiatrists, 2018; British Psychological Society, 2019; American Psychological Association, 2021). Some (Walton & Baker, 2019; Rees et al., 2021; Hope et al., 2022) remind practitioners that although there is a higher level of mental distress within the LGBTQIA+ community, a person's current mental health presentation may not be related to their sexual or gender identity, and the assumption that they are related should not be made. Similarly, Panchal et al., (2022) recommend that mental health professionals have the ability to discuss issues around, in this case, gender identity, but only if it is relevant to the person's presentation. Nonetheless, it is recommended that during intake assessment, attention is also paid to the LGGBTQIA+ specific issues that may be a contributing factor to a person's mental distress (Walton & Baker, 2019; Fadus et al., 2020; Strauss et al., 2024). Some core principles of mental health practice are also identified by some papers including a requirement for a non-judgemental, respectful approach to LGBTQIA+ people (Royal College of Psychiatrists, 2018; American Psychological Association, 2021; HSE, 2021; RANZCP, 2023). The Royal Australian and New Zealand College of Psychiatrists (2019) identify the need for psychiatrists to balance the sometimes divergent views of service users and their family members.

Some reviewed documents report the potential for some mental health staff to grapple with a person's LGBTQIA+ identity when working with people who are very different from themselves (British Psychological Society, 2019). The British Psychological Society (2019) recommend it is the practitioner's

responsibility to learn about different types of diversity, but in situations where they are finding it difficult to act in a positive and affirming way toward the LGBTQIA+ service user, they should refer them to other supports or personnel and seek further training and/or supervision for themselves. Similarly, Lothwell et al. (2020) also advise that mental health clinicians who are not comfortable working with the LGBTQIA+ population should seek supervision and become familiar with clinical alternatives. Ultimately, Rees et al. (2021) and Mental Health Reform (2022) recommend that mental health professionals utilise clinical skills that are grounded in professional ethics, good practice guidelines and standards of care. Some specific therapeutic practices/approaches identified in the literature are outlined below.

6.5.1 Trauma-informed practices

As identified in Chapter 4, many LGBTQIA+ people have experienced minority stress as a result of discriminatory and stigmatising attitudes from others. Consequently, a number of papers in this review make reference to the need to work from a trauma-informed perspective and integrating trauma-informed principles into practice (Shipherd et al; 2019; American Psychological Association, 2021; Hannan et al., 2022; Crapanzano & Mixon, 2022; Britt-Thomas et al., 2023). Trauma-informed practices are increasing within mental health service provision and beyond and require a reorientation of practice that moves from focusing on what is wrong with the person, to what has happened to the person (Sweeney et al., 2018). With specific reference to LGBTQIA+ people, Hannan et al. (2022) recognise that people may have trauma histories which impact significantly on their mental health and on their ability to engage with support services. Taking a trauma-informed approach is to take a strengths-based, recovery-orientated perspective which positions the LGBTQIA+ person as the expert in their own experiences (Hannan et al., 2022).

Focusing specifically on transgender and gender diverse service users, Shipherd et al. (2019) recommend a range of trauma-informed practices including assessing for trauma-related responses such as suicidality, sleep disturbance, hypervigilance, intrusive thoughts and substance misuse, and providing appropriate treatment for Post Traumatic Stress Disorder (PTSD). Shipherd et al. (2019) also recommend assessment of discriminatory experiences using established discrimination measurement scales, and treatment approaches such as Dialectical Behaviour Therapy (DBT).

6.5.2 Intersectionality

A number of papers and some guidance documents make reference to the importance of considering intersectionality (British Psychological Society, 2019; Royal Australian and New Zealand College of Psychiatrists, 2019; Rees et al., 2021; American Psychological Association, 2021; Crapanzano & Mixon, 2022; Hannan et al., 2022; McNulty et al., 2022; Pachankis & Soulliard, 2023). An intersectional approach to mental health practice with LGBTQIA+ people is predicated on the recognition that sexual

orientation and gender identity are just part of a person's identity, and that they intersect with a person's other identities for example race, ethnicity and socio-economic background (Hannan et al., 2022). Mental health professionals working with LGBTQIA+ people need to consider how the cumulative oppression and marginalisation associated with intersecting identities can impact on the mental health of the person and consider clinical interventions that empower service users' multiple minoritized identities (Hannan et al., 2022; Pachankis & Soulliard, 2023). The consideration of intersectionality aligns more with the concept of cultural humility rather than cultural competence as outlined earlier, with Lekas et al (2020) arguing that cultural competency may provide knowledge of only one aspect of a person's life (e.g. in this instance LGBTQIA+ identity) and fails to consider how their other characteristics or identities shape them and their experiences. Hannan et al. (2022) recommend that mental health professionals are cognisant of potential human rights issues involved when a person is culturally or ethnically diverse, or from a migrant or refugee background where being part of the LGBTQIA+ community may be culturally taboo and in some cases criminalised.

6.5.3 Strengths-based, recovery-orientated practices

Mental health services have largely re-orientated to a recovery-focused, strengths-based perspective and a number of papers reviewed made specific reference to the need to harness this approach for LGBTQIA+ people (American Psychological Association, 2021; Crapanzano & Mixon, 2022; Pachankis & Soulliard, 2023). Central to this perspective is the recognition that despite distal and proximal stressors that can impact negatively on mental health, many within the LGBTQIA+ community are thriving, particularly when they are 'out', are surrounded by supportive networks, and have a sense of belonging to the LGBTQIA+ community (American Psychological Association, 2021; Crapanzano & Mixon, 2022). Moving away from a deficits-focused perspective to a strengths-based one that increases wellbeing and resilience is recommended, with mental health professionals having a role to play in affirming strengths and positive relationships at both an individual and community level (American Psychological Association, 2021). Pachankis and Soulliard (2023) similarly suggest that mental health professionals should work in an empowering way with LGBTQIA+ people, helping them to develop the self-efficacy required for coping with the impacts of minority stress through building supportive relationships, community connections and a drawing upon the sense of pride within the LGBTQIA+ community.

6.5.4 Developing and maintaining social supports

In recognition that having affirming social supports is protective of mental health, some of the documentation reviewed made explicit reference to the role of mental health professionals in helping LGBTQIA+ people to develop and maintain social supports (Pachankis & Soilliard, 2023). WPATH Standards of Care, recommend mental health professionals 'encourage, support, and empower transgender and gender diverse people to develop and maintain social support systems, including

peers, friends, and families' (Coleman et al., 2022). Within some of the reviewed literature, there is an understanding that familial relationships may be difficult for some LGBTQIA+ service users who may have experienced rejection and discrimination from their family due to their sexual orientation or gender identity (Hannan et al., 2022; Inventor & McIntosh, 2022). In these cases, partners, friends, and 'families of choice' can be particularly important to the service user and should be included in support planning (American Psychological Association, 2021; Hannan et al., 2022). Developing and maintaining supports within the LGBTQIA+ community was also identified as important in some of the papers reviewed with recommendations that LGBTQIA+ people be encouraged to engage in advocacy and community activism to combat systems of oppression (American Psychological Association, 2021).

6.5.5 Considerations for trans service users and gender-affirming interventions

The 'informed consent' model of care for trans and gender diverse service users was reported on in a number of guidance documents and papers (Crapanzano & Mixon, 2022; Goldhammer et al., 2019; Mental Health Reform, 2022; RANZCP, 2023). Lipshie-Williams (2020) identifies the core foundations of the informed consent model as the provision of detailed information about healthcare interventions from the medical practitioner to the service user, with the service user then having the autonomy to decide on the best course of action for them providing they have the capacity to make those decisions. They set out four key elements that contribute to decision-making capacity; 1. The ability to communicate a choice consistently, 2. An understanding of the fundamentals of the medical care being offered, 3. An ability to appreciate the consequences of accepting or rejecting the intervention, and 4. The ability to manipulate the information rationally. For someone with a mental health problem, is it possible, though not absolute, that the mental health problem may impact on the person's capacity to make an informed consent decision, thereby requiring treatment from mental health providers in a bid to help manage symptoms and improve capacity to consent (Lipshie-Williams, 2020). Crapanzano & Mixon (2022) position the 'Informed Consent' model as a developing approach for providing gender-affirming treatment, the core foundation of which is the recognition that gender diversity is non-pathological and affirming medical care is necessary. As a result, the model seeks to acknowledge and support individuals' personal autonomy relating to gender affirming care without the automatic requirement for external evaluation or therapy from mental health professionals (Crapanzano & Mixon, 2022). Within the informed consent model, a trans or gender non-conforming individual should not have to prove distress around their gender identity or meet diagnostic criteria in order to gain access to gender-affirming treatment. They should however have the cognitive ability to make decisions about their healthcare and understand the risks, benefits and information required to make these decisions (Crapanzano & Mixon, 2022).

Within the broad context of the informed consent model, in papers which discussed the concomitant mental health treatment, and provision of gender-affirming interventions for trans people there are some nuances in terms of consensus for best practice. The Standards of Care by the World Professional Association for Transgender Health (WPATH) (Coleman et al., 2022), recommend that mental health professionals treat mental health symptoms that might interfere with the person's capacity to consent before they commence gender-affirming interventions. They provide psychosis as an example of a mental illness that may impact capacity to consent, while stating that anxiety and depressive symptoms do not impact capacity to consent and should not present as a barrier to obtaining gender-affirming interventions as these interventions may serve to decrease symptoms of depression and anxiety. They do however identify the importance of individual examination of a person's capacity to consent in all cases. Similarly, in the case of people diagnosed with Borderline Personality Disorder (BPD), Goldhammer et al. (2019) report that prioritising either the mental illness or gender-affirming treatment to the exclusion of the other can produce poorer outcomes for the service user. They therefore recommend that BPD be treated in parallel with, rather than prior to, gender-affirming treatment once there is clear capacity to provide informed consent and recommend that clinicians can determine capacity to consent according to the same standards used for all potentially life-saving interventions (Goldhammer et al., 2019). They suggest the overall role of the mental health clinician in the gender-affirmative process is to facilitate gender identity exploration, discovery and affirmation, while also supporting the person's psychosocial adjustment.

WPATH standards also recommend that mental health professionals offer care and treatment to people where mental health symptoms might impact on the person's ability to attend to pre-peri and post-operative requirements of gender affirming surgery. These standards also recommend that it not be compulsory for a person to undergo psychotherapy before the initiation of gender-affirming interventions, although they do also recognise that psychotherapy may be of benefit for some trans and gender diverse people (Coleman et al., 2022). The UK Royal College of Psychiatrists in their 2018 position statement on supporting transgender and gender-diverse people (of which an update is due), recognise that gender-affirming interventions improve the wellbeing and mental health of transgender and gender diverse adults. However, they identify a lack of evidence on the management of pre-pubertal children and therefore until the evidence-base improves, recommend adopting a 'watch and wait' policy regarding whether these children enter treatment, which does not place any pressure on children to live or behave in accordance with their sex assigned at birth, nor to move rapidly to gender transition. Felker et al. (2022) suggest that some young people report changes in gender identity suddenly and unexpectedly and that among younger children gender exploration and fluidity is more common. They therefore caution that in these cases, irreversible medical treatment be considered

thoughtfully, ethically and may be delayed for as long as is clinically appropriate. However, they argue that those youth who have reported their gender identity 'persistently, consistently, and with insistence', should be viewed as having a stable identity.

Recommendations were made about the provision of interdisciplinary care that involves collaboration between mental health professionals and medical personnel who may be supporting a person in their transition process (Walton & Baker, 2019; Crapanzano & Mixon, 2022). Recommendations were also made around facilitating access to hormone therapy (both commencement of, and continued use of,) while in the in-patient mental health setting with WPATH standards (Coleman et al., 2022) recommending that existing hormone treatment be maintained if a person is admitted to a psychiatric in-patient unit unless contraindicated which is a stance supported by others (Felker et al., 2022; Mental Welfare Commission, 2022; Britt-Thomas et al., 2023; van Dyk et al., 2023). Others made recommendations about the provision of items such as binders and packers to trans people while an in-patient (Fadus et al., 2020; Mental Welfare Commission, 2022; van Dyk et al., 2023). The potential issue set out here was that these items may be seen as a suicide risk (either to the person themselves or to others) and therefore may be removed as a suicide prevention intervention by well-meaning staff who view these items as a safety hazard rather than as a vital component of a person's identity (van Dyk et al., 2023). This issue may be overcome by careful consideration of the potential impact on the service user of their removal, and the use of pre-approved safe binders and other gender-affirming devices that could potentially reduce ligature risk.

6.5.6 Conversion practices

Many of the documents referred to 'Conversion practices' 'Reparative therapy' or 'Sexual Orientation Change Efforts' (SOCE), and where they were written about, there was universal agreement that these practices should not be offered to LGBTQIA+ people. There was no validation for conversion practices which were identified as being unscientific and unethical (Royal College of Psychiatrists, 2018), and instead literature made reference to the potentially damaging impact they could have on service users (American Psychological Association, 2021). As can be seen in Appendix 12a almost all of the guidance documents and position statements from representative bodies were explicit in their dismissal of conversion practices as an acceptable therapeutic tool for LGBTQIA+ people (Royal College of Psychiatrists, 2018; American Psychiatric Association, 2018, 2020; British Psychological Society, 2019; HSE, 2021; American Psychological Association, 2021; WPATH - Coleman et al., 2022; International Review of Psychiatry - Bhugra et al., 2022). Bhugra et al. (2022) on behalf of the International Review of Psychiatry group recommend that clinicians offering conversion therapies should be reported to their regulatory body. The European Psychiatric Association in their 2022 position statement on conversion therapies and LGBTQIA+ patients encourage legislation which bans conversion therapy and

similar to Bhugra et al. (2022), recommend that practitioners who engage in these practices should be subject to sanction and penalties. The American Psychiatric Association (2018) also call for legislation which would prohibit the use of conversion therapies. A small number of documents made reference to facilitating a service user's questioning and exploration of their sexual orientation or gender identity, or discussion of feelings of distress at an LGBTQIA+ identity within the therapeutic process (British Psychological Society, 2019), explicitly stating that this is done within the context of accepting the validity of an LGBTQIA+ identity. Affirmative therapeutic practices, which uphold the validity of diverse sexual and gender identity is the recommended alternative to conversion practices (American Psychological Association, 2021).

6.5.7 Discharge and Referral

After-care and provision of support through referral to other services following treatment in the mental health services is an area that is identified in some documents within the reviewed literature, with Fadus et al. (2020) identifying that engagement with outpatient care after discharge reduces the risk of readmission. These documents made reference to the importance of mental health providers knowing what local/regional or national LGBTQIA+ inclusive services are available to service users, and to refer on to these services (Hannan et al., 2022; Fadus et al., 2020; Hope et al., 2022; Inventor & McIntosh, 2022). van Dyk et al. (2023) and Hannan et al. (2022) recommend that mental health professionals referring an LGBTQIA+ person to a new service first speak to staff in that service to ensure that it is LGBTQIA+ inclusive, and after referral follow-up with the service user to ascertain their perceptions of the inclusivity of that service. The Royal Australian and New Zealand College of Psychiatrists (2019) recommend that psychiatrists maintain an up-to-date understanding of appropriate referral pathways should specialist support be required. In the absence of LGBTQIA+ specific/friendly services, service users should be equipped with information on relevant support groups and supports to supplement the healthcare service referred to (van Dyk et al., 2023). For service users who are transgender or gender diverse, discharge planning may need special attention to ensure that services people are being referred to are appropriately skilled to work with transgender service users in an affirmative way (Walton & Baker, 2019; Felker et al., 2022).

6.6 Lifespan Approach

Most of the principles and best guidance recommendations outlined in the reviewed literature are applicable to LGBTQIA+ people across the lifespan, however a small number of documents make particular reference to younger and older LGBTQIA+ service users. The British Psychological Association (2019) caution against mental health service providers treating sexual or gender diversity in young people as 'just a phase' and remind practitioners that for many this is a stable and lasting identity. The

Royal Australian and New Zealand College of Psychiatrists (2019) recommend that mental health services focused on young people should maintain an awareness of the particular stressors faced by LGBTIQ+ young people, including issues to do with 'coming out', and the potentially traumatic experience of puberty for gender diverse young people. In some documents reviewed there were additional considerations including issues regarding confidentiality and consent. The Trevor project in the US, which is the leading suicide prevention and crisis intervention organisation for LGBTQ+ youth in their report on breaking barriers to LGBTQ+ mental healthcare for young people identifies the requirement to seek parental consent as a barrier to accessing mental health treatment and recommend states in the US develop policies that allow mental health providers to provide care to those under 18 who may otherwise not receive care if parental permission was required (Green et al., 2020). They also recommend that mental health service provision be more orientated to LGBTQIA+ youth with the inclusion of tele-mental health and web-based chat and texting option to enquire about appointments and care.

For older LGBTQIA+ people the British Psychological Society (2019) draws attention to the fact that their identity formation occurred in a time when sexual and gender diversity was pathologised, illegal and stigmatised and the consequences of this can be an increased level of internalised stigma, and past experiences of conversion therapy which the mental health professional needs to be mindful of. Similarly, Inventor & McIntosh (2022) identify the potential presence of unique mental health needs among some older LGBTQIA+ people who may have experienced the loss of partners and friends during the HIV/AIDS epidemic in the 1980s, and also may have experienced significant stigmatisation and discrimination due to the HIV/AIDS epidemic which may still resound today. Mental health professionals should capture these unique mental health needs as part of a comprehensive assessment (Inventor & McIntosh, 2022). Older LGBTQIA+ people are also more likely to require formal care supports than younger people and non-LGBTQIA+ people who may be in more of a position to rely on biological family for informal caregiving (Inventor & McIntosh, 2022), and may have concerns about how staff might respond to their identity which should be considered sensitively by mental health professionals (British Psychological Society, 2019). These concerns again highlight the importance of having visible signs of a welcoming and LGBTQIA+ affirming environment in the mental health setting. In addition, the Royal Australian and New Zealand College of Psychiatry (2019) suggests that mental health services for older LGBTQIA+ people should consider issues relating to dementia, end of life decision making and advanced care planning.

6.7 Macro level actions

Some documents refer to the potential role of mental health professionals at the institutional level in informing policy, supporting community groups and engaging in social action (British Psychological Society, 2019; HSE, 2021). Similarly, some documents identify the potential of mental health professionals to become involved in social justice and advocacy (Crapanzano & Mixon, 2022; Hope et al., 2022) and community activism, actively working within the community to repeal harmful policies (Shipherd et al., 2019). Outreach, community engagement and partnership with LGBTQIA+ providers is recommended to demonstrate that mental health providers offer a safe and inclusive environment for LGBTQIA+ service users, and also keep healthcare providers knowledgeable about community supports available (Hudson & Bruce-Miller, 2023). Reference is made in some of the literature to the importance of embedding the needs of LGBTQIA+ people within national frameworks, policies, and strategies (Royal Australian and New Zealand College of Psychiatrists, 2019; Bhugra et al., 2022). Increased funding for research evaluation of services is also recommended to identify current practice and service gaps, and effectiveness of interventions for LGBTQIA+ people in a bid to ensure that services are meeting the needs of LGBTQIA+ service users (Hudson & Bruce-Miller, 2023; Bhugra et al., 2022). The American Psychological Association (2021) and the RANZCP (2019) recognise the importance of research methods which centre the voices and experiences of LGBTQIA+ people including, qualitative, mixed methods, and community participatory approaches. Researchers should be encouraged to use standardised definitions of LGBTQIA+ terms (Bhugra et al., 2022) to ensure consistency across the evidence base. This can be encouraged through the use of the 7th edition of the Publication Manual of the American Psychological Association (APA, 2021) which encourages the use of bias-free language around LGBTQIA+ identity in published research (Noble et al., 2021).

6.8 Conclusion

There is general agreement within the literature, guidance documents and position statements reviewed about best practices when delivering care to LGBTQIA+ people within a mental health setting. Some guidance documents and position statements provide over-arching recommendations e.g. Royal College of Psychiatrists (2018) while others, provide more detail on how a healthcare practitioner or organisation can be more LGBTQIA+ inclusive e.g. Bhugra et al., (2022) on behalf of the International Review of Psychiatry. The remaining body of journal papers focusing on LGBTQIA+ mental health care provision generally provides more detail on the practices and processes through which mental healthcare organisations and providers can be more LGBTQIA+ inclusive in their practices. While many of the documents reviewed here appear to be informed, to some degree, by research and clinical practice, there is a need for further empirical research to support the recommendations made (Britt-Thomas et al., 2023). Nonetheless, consensus is clear on a number of key issues which are hallmarks of best practice in the provision of quality mental health care to

LGBTQIA+ people and include a welcoming mental healthcare environment with knowledgeable, non-judgemental and affirming mental health professionals and wider staff, supported by clear anti-discrimination policies and guidance. Specific considerations for Ireland based on the findings of this review, and the preceding 3 reviews are identified in Chapter 8.

7.0 Brief Overview of Legislative Considerations

This section provides a brief outline of key national legislation, both enacted and proposed, that has, or may have, an impact on the treatment and care of LGBTQIA+ people accessing mental health services in Ireland.

7.1 Gender Recognition Act 2015

The Gender Recognition Act 2015 allows individuals to apply for a Gender Recognition Certificate which entitles them to have their preferred gender recognised by the State of Ireland (Department of Social Protection, 2023). Once the Gender Recognition Certificate has been issued, the individual can choose to order a revised birth certificate with their preferred gender. Legal recognition of a person's preferred gender is not retrospective and only takes hold from the date of recognition. Individuals that wish to apply for a gender recognition certificate must be 18 or above and registered within the: register of births, Adopted Children Register, Register of Intercountry Adoptions, Foreign Births Register or a Foreign Births Entry Book. If applying from outside of Ireland, evidence of birth must be provided. Under current legislation in Ireland, children aged 16 and 17 can apply to the courts to have their gender changed only with parental consent and medical approval. There is no provision for gender recognition for children under 16 years. In November 2019, the Department of Social Protection published a report proposing a simplified path to legal gender recognition for people aged 16 to 17 by introducing an arrangement for self-declaration with parental consent (Department of Employment Affairs and Social Protection, 2019). The report was published after a review of the Gender Recognition Act 2015 however its recommendations have not, as yet, been passed into law.

Since the introduction of the Gender Recognition Act 2015, 1203 gender recognition certificates were issued by 2022 (Department of Social Protection, 2023). At the time of writing, published figures are not yet available for the year 2023. Individuals who are intersex, non-binary, or under 16 years old are still unable to apply for legal gender recognition (Department of Employment Affairs and Social Protection, 2018), despite the recommendations of the Review Group of the Gender Recognition Act (Department of Employment Affairs and Social Protection, 2018).

7.1.1 Impact on treatment and care of LGBTQIA+ people accessing mental health services

In the *Being LGBTQI+ in Ireland* study, 88% of participants reported that legislation like the Gender Recognition Act 2015 had a positive impact on their mental health (Higgins et al., 2024). Therefore, ensuring mental health services and the staff within them are aware of people's rights under these acts is important. As outlined in Chapters 5 and 6, misgendering, deadnaming and using incorrect pronouns can be a distressing experience for a trans service user and its occurrence in the mental health setting is not uncommon. Mental health professionals should ensure they use the correct name

and pronouns for service users and ensure that correct name and pronouns are captured in patient records and in any the documentation within the mental health setting (e.g. names on doors, names on tables etc). Mental health services should have a policy in place for assigning bedroom and bathroom facilities that ensure that trans patients are accommodated with others of their gender identity or have use of single rooms.

7.2 Marriage Equality Act 2015

The Marriage Equality Act 2015 or The Thirty-fourth Amendment of the Constitution authorises the marriage between two individuals of any sex. Prior to this, same sex couples were prohibited from marrying in the Republic of Ireland (legislation permitting civil partnership was introduced in 2010). The Marriage Equality Act 2015 allows both same sex and opposite sex marriages to be recognised as family units, which provides them with Constitutional protection for families.

7.2.1 Impact on treatment and care of LGBTQIA+ people accessing mental health services

Findings from the *Being LGBTQI+ In Ireland* study affirm legislative changes like the Marriage Equality Act 2015 positively impact the mental health and wellbeing of the LGBTQIA+ community, with 94% of the sample reporting a positive impact on mental health (Higgins et al., 2024). As a consequence of this legislation, mental health services must ensure that same sex married couples are afforded the same rights as any married couple. An example is the equal right to ward visiting privileges and access to loved ones when in hospital, a recommendation made in Chapter 6 of this report.

7.3 Employment Equality Acts 1998- 2015

The Employment Equality Acts 1998 to 2015 banned many forms of discrimination within various areas of employment however there was an exemption provided for religious run institutions. The Equality (Miscellaneous Provisions) Bill 2015 prohibited religious-run institutions (e.g. schools, hospitals) from discriminating against workers based on their sexual orientation.

7.3.1 Impact on treatment and care of LGBTQIA+ people accessing mental health services

While not perhaps having a direct impact on people accessing mental health services, this Act ensures that staff within the mental health services cannot be discriminated against due to their LGBTQIA+ identity. An inclusive mental health service also means including staff from diverse background which as identified in Chapters 5 and 6 of this report were recommendations from participants using mental health services, but also recommendations in some best practice guidance.

7.4 Children and Family Relationships Act 2015 and related Acts

The Children and Family Relationships Act 2015 allowed for changes to laws on adoption, guardianship, assisted human reproduction, and various other measures. It legally recognises different and modern types of families, whilst also outlining rights for both biological and non-biological parents and children. The Children and Family Relationships Act 2015 allowed for certain same-sex parents to be

recognised as legal parents. However, there were some omissions in the Act which were subsequently covered in the Children and Family Relationships Amendment Bill 2023, proposed by the Labour party and debated in the Dail in January 2024. This Amendment Bill proposed closing various gaps including where a child has been conceived abroad, outside of a clinical setting or using a known donor before May 4, 2020. It also includes protections for children born outside of Ireland. While this amendment bill is tabled for further discussion in the Dail, some of these gaps were closed by the publication of the Health (Assisted Human Reproduction Act) in June 2024, including the recognition of non-clinical conception of donor conceived children prior to May 4th 2020, and recognition of parentage for children who were conceived using a known donor prior to May 4th 2020. Despite these advancements, gaps remain in the recognition of parental rights for some LGBTQIA+ parents.

7.4.1 Impact on treatment and care of LGBTQIA+ people accessing mental health services

Mental health services and the organisational policies in place within them need to be mindful of the rights of LGBTQIA+ parents conferred under these Acts. This may include LGBTQIA+ parents of child and adolescent service users and the right for both parents to be included in consent decisions for their child. It many also impact LGBTQIA+ service users within the adult services who can, since this act, be recognised as the legal parent of their child.

Within the remit of parenting, the Adoption (Amendment) Act 2017 allowed for both unmarried same-sex and heterosexual couples to adopt a child. This legislation changed various parts of the Adoption Act 2010, which governed how all adoptions in Ireland are carried out. This previously stated that a child could only be adopted by married couples, whereas any couple in a civil partnership or cohabiting relationship are now able to adopt a child. The best interest of the child is outlined as one of the most important considerations for an application for adoption; this amendment outlines these considerations to uphold this. Organisational policies within mental health services should recognise the rights of LGBTQIA+ couples to be the parent of an adopted child.

7.5 Criminal Justice (Hate Offences) Bill 2022

The Criminal Justice (Hate Offences) Bill 2022 was, on 23rd October 2024, passed by all stages of the Oireachtas meaning that it can now be signed in to law. This will create new legislation in relation to hate crimes and expand the current protected characteristics to include gender (identity and expression) and disability. The Bill will also provide for increased prison sentences for certain crimes, where proven to be motivated by hatred, or where hatred is demonstrated. Amendments were removed from the parts of the Bill which deal with incitement to violence or hatred, in order to proceed only with the elements that deal with hate crime. However, the Minister of Justice has acknowledged the importance of proceeding with amendments to existing legislation to deal with incitement to hatred, promising progression on this at the earliest opportunity.

7.5.1 Impact on treatment and care of LGBTQIA+ people accessing mental health services

LGBTQI+ participants in the *Being LGBTQI+ in Ireland* study (Higgins et al., 2024) identified the need for strong hate crime legislation, including passing and enforcement of the hate crime bill, and other hate crime laws. Interestingly, module 2 of this study which reported on the attitudes of the general public towards LGBTQIA+ people reported that a large proportion of the sample (73%) also believed that 'the government should ensure that hate speech and hate crimes against LGBT people are adequately addressed in our law'. A key recommendation from the authors of the study was the introduction of new hate crime and hate speech legislation accompanied by a holistic action plan against hate crimes that includes a reformed Garda response and wrap-around supports for victims. This study highlighted the high levels of hate crime identified by LGBTQIA+ people, and in particular trans people. Chapter 4 of this report also identifies the experience of hate crime by LGBTQIA+ people and the impact it has on their mental health. The passing of the Criminal Justice (Hate Offences) Bill 2022 will enshrine into law protections for LGBTQIA+ people against hate crime. As recommended in the next chapter of this report, mental health services should ensure that there are clear organisational policies on discrimination, including the use of hate speech, and that appropriate reporting mechanisms are in place for contraventions of this policy.

7.6 Draft law on criminalising conversion therapies

Conversion therapy is an umbrella term that describes a range of practices which specifically aim to change or suppress an individual's sexual orientation or gender identity expression (Mendos, 2020). Despite conversion practices being condemned by the United Nations Human Rights Council (2020), professional bodies and survivors, and calls for legislation to prohibit conversion therapy, as of 2022 there are only 14 countries with outright bans on conversion therapy (Stonewall, 2022). Within the European Union, Malta, Germany, France and Greece have banned these practices, with several other member states, including Ireland, engaged in the legislative process to follow suit (DeGroot, 2022; Keogh et al., 2023). In 2023, Iceland and Cyprus also banned conversion therapy. In the United Kingdom, the new Labour government has said it will introduce a Conversion Practices Bill, to ban practices aimed at changing or suppressing someone's gender identity or sexual orientation in England and Wales.

In Ireland, the Prohibition of Conversion Therapies Bill (2018) was drafted and presented to Seanad Éireann. The Bill, which has been at stage three of ten since September 2020, seeks to place an outright ban on conversion therapy in Ireland (Houses of the Oireachtas, 2018). Objective 8(b) of the LGBTI+ National Youth Strategy (Department of Children & Youth Affairs, 2018) outlined the intention to prohibit the promotion or practice of conversion therapy by health professionals in Ireland. In preparation for policy and legislation around conversion therapies in Ireland, and as recommended in

The National LGBTI+ inclusion strategy 2019-2021 (Government of Ireland, 2019), research was commissioned to better understand conversion therapy practices in Ireland and was published in 2023 (Keogh et al., 2023). In January 2024, the Irish government published its Legislation Programme for Spring 2024, listing the bill to ban so-called 'conversion therapy' as a priority for publication. Responses from the Minister of Children, Equality, Disability, Integration and Youth, Roderic O'Gorman, at that time reported that "Intensive work on drafting the General Scheme is ongoing and officials continue to engage with the Office of the Attorney General on the matter. It is planned that legislative proposals will be brought forward shortly." However, there has been a change leadership in government, and with an imminent general election at the time of writing, little progress has been made on progressing this Bill since, with no certainty on when a law will be enacted.

7.6.1 Impact on treatment and care of LGBTQIA+ people accessing mental health services

Chapters 5 and 6 of this report highlight the damaging impacts of conversion therapies and practices on LGBTQIA+ people, and the universal recommendation from 'best practice' guidance and healthcare professional organisations that conversion therapy be banned. The study by Keogh et al. (2023) on the use of conversion practices in Ireland suggests that legislation to ban conversion therapy will also support safety and health of LGBTQIA+ people by ensuring that those who experience distress about their sexual orientation or gender identity because of homophobia or transphobia are unable to access formal conversion practices which have the potential to cause further harm. Raising awareness of the harms associated with conversion practices as well as highlighting the evidence that it is ineffective will also help to prevent it from being advocated as a legitimate course of action for those who experience distress about their sexual orientation or gender identity. Those working with LGBTQIA+ individuals need to be aware that conversion practices are ineffective and harmful and that people who seek out these practices need to be given clear and accurate information about their ineffectiveness and their potential for harm. Interventions that perpetuate stigma, oppression and exclusion and seek to change, suppress or modify sexual orientation or gender identity expression such as the ones described by Keogh et al., (2023) do not correspond with affirmative practices. According to the UN Special Rapporteur on freedom of religion or belief, a person's sexual orientation or gender identity should not be 'treated' using practices that harm. The right to believe religious scripture about the nature of sexuality and gender identity is protected by international human rights legislation. The right to inflict potential harm based on religious teachings to change or suppress sexual orientation and gender identity or for other faith-based reasons is not. Even when consenting adults seek out conversion practices, these practices are inherently debasing as they pathologise and stigmatise LGBTQIA+ individuals promoting the belief that they are somehow inferior to their heterosexual and cisgender counterparts which is tantamount to discrimination (Boulos & González-Cantón, 2022).

Countries, therefore, have an obligation to enact legislation that protects and upholds the full range of human rights for LGBTI+ individuals (Human Rights Council, 2020).

8.0 Key Considerations for Ireland

Grounded in the evidence produced in each of these 4 reviews, and particularly the findings from Chapter 6 (review of best practice guidance/strategies), some key considerations to inform the Mental Health Commission's development of guidance for mental health service providers on the care and treatment of LGBTQIA+ service users in an Irish context are presented here.

8.1 Access to mental health services

- Mental health services should ensure there is timely access to a range of supports for LGBTQIA+ people, with increased transparency about how to access these supports.
- Mental health services should ensure there is a range of supports available outside of the traditional structures of in-patient and community services, to include LGBTQIA+ peer supports and digital mental health supports.
- Increased access to psychological therapies is warranted both for service users currently attending the mental health services, and beyond.

8.2 LGBTIQIA+ policies and guidelines

- At a mental health organisational and service level, relevant personnel should undertake an impact assessment of each of the existing policies on LGBTQIA+ mental health, ensuring they are inclusive of, and responsive to the needs of LGBTQIA+ service users. Policies should consider LGBTQIA+ specific issues that may impact on a service user's experience and include antidiscrimination policies, confidentiality policies, visiting policies and policies for trans-affirmative care in the in-patient setting.
- Consider a comprehensive policy of trauma-informed care in mental health services to avoid retraumatising LGBTQIA+ individuals who have experienced minority stress attending the services.
- Policies relating to LGBTQIA+ rights within the mental health setting should be co-designed with members of the LGBTQIA+ community who have experience using mental health services and know from personal experience the issues that impact them in this setting.
- In addition to ensuring existing policies are LGBTQIA+ affirmative, and developing new policies where required, these policies should be available to all service users to view, and the key tenets of them displayed prominently within the service setting.
- Within a broader policy context, LGBTQIA+ individuals should continue to be acknowledged as a high risk group for mental distress and suicidal behaviour within public mental health policy. A significant percentage of transgender individuals experience suicidal ideation and

many of these go on to attempt suicide. Transgender individiuals should be prioritised within suicide prevention strategy policies.

8.3 The mental health setting

- The first interaction the LGBTQIA+ service user has with a mental health service can send an instant message of affirmation or dismissal. An inclusive mental health setting needs to show that it is inclusive in the first instance through the means of visual cues. These include prominently displayed rainbow posters/flags that are inclusive of intersecting identities (e.g. the intersectional flag which includes black and brown colours to represent marginalised people of colour, and also includes the transgender flag), rainbow lanyards and name badges, and LGBTQIA+ literature in waiting rooms, reading rooms, etc.
- The website of the organisation should also have LGBTQIA+ affirming visual cues (e.g. rainbow logo).
- Visibility of LGBTQIA+ staff in the environment is important to service users, and a recruitment policy that specifically welcomes applications from LGBTQIA+ staff shows that a service is inclusive. However, it is important that if there is a LGBTQIA+ staff member in the mental health setting, they do not become the 'go-to' person to interact with all LGBTQIA+ service users.
- An assessment of clinical documentation, including electronic records, within the mental health care environment should be undertaken to determine how inclusive they are of LGBTQIA+ people and language, particularly in relation to recording of preferred names (vs legal name if different), recording of gender identity and recording of sexual orientation. While there are mixed views in the literature on this, the general consensus is that if asking about gender identity and sexual orientation, it should be asked of all service users and not just those with a LGBTQIA+ identity.
- Mental health organisations/settings could consider using a benchmarking tool to assess how LGBTQIA+ inclusive the service is. A positive score on this, displayed prominently, signals to the LGBTQIA+ service user that the service is inclusive.
- For people who are transgender, there is a requirement for additional protocols to ensure their comfort and safety:

  1. There are additional challenges when in an in-patient setting with regard to the allocation to single sex wards, rooms and bathrooms. The general recommendation in the literature is that the trans person should be assigned to accommodation matching their gender identity. However, authors do note some tensions around this that may need to be considered. Mental

health settings should establish a policy for allocation of rooms that is respectful of the trans person and other service users. While single room allocation is seen as a solution by some, this may be an isolating experience for the trans service user.

2. A conflict may arise between safety (suicide risk) and gender-affirming measures where, for example, trans people may be asked to remove their chest binder as it may pose a ligature risk. Supplying pre-approved safe binders may serve to reduce this risk and still maintain a gender-affirming stance with the person.

8.4 Interpersonal interactions and therapeutic considerations

- Interpersonal interactions with a LGBTQIA+ service user, even brief ones, have the potential to leave a person feeling dismissed and unheard, or affirmed and included. Not making assumptions about a person's identity on first meeting them is important, as is the use of inclusive language.
- Using preferred names and pronouns when they are known is important, as is following the lead of the service user in that regard.
- Asking questions about the person's sexual orientation or gender identity if it is relevant to the clinical encounter may be important and required, however, these questions should not be asked from a curiosity perspective if not related to the clinical encounter.
- There is a balance between not ignoring or dismissing disclosures of LGBTQIA+ identity which can make a service user feel unheard and unseen, and overly focusing on their identity as the 'cause' of their mental health problems when the issues they are experiencing may not be relevant or attributable to their identity.
- Clarifications can be sought from the service user on aspects of their LGBTQIA+ identity if relevant to the clinical encounter, however mental health professionals should not rely on the service user to educate them on broader aspects of LGBTQIA+ identity, culture and language which is information that should be sourced through training.
- LGBTQIA+ individuals can experience high incidences of trauma throughout their lifespan. This may include verbal, physical, or emotional abuse, adverse childhood experiences, or discrimination in relation to sexual identity and/or gender and internalised negativity related to their sexual orientation or gender identity. Given the extent of the trauma and discrimination, clinicians should be especially cognisant of this when carrying out mental health assessments and providing care to this group.
- Working from a trauma-informed, strengths-based perspective is important to ensure that the impact of the negative and damaging attitudes and behaviours LGBTQIA+ people may

have experienced are considered, while drawing on the person's own strengths and supports to work through those experiences.

- Bisexual and transgender individuals were shown to have an increased risk for suicidal behaviour including self-harm. It is important that staff are equipped with the necessary skills to identify, assess, and manage risk factors for suicidal behaviour for LGBTQIA+ individuals. Clinicians should receive training on risk assessment and management that is mindful and inclusive of the specific risks that these individuals can face.
- Implementing interventions to address internalised symptoms/feelings in relation to an individual's sexual orientation e.g., thwarted belongingness, biphobia etc. would be beneficial, as these factors appear to have a significant influence on risk for LGBTQIA+ youth.
- Conversion practices, or any practices that are underpinned by the belief that a person's gender identity or sexual orientation can and should be changed should not be used in any form. Mental health professionals engaging in any form of conversion practices should face sanctions within the organisation and reported to their professional body.
- Mental health professionals should ensure that post-discharge supports and referrals are to organisations that are LGBTQIA+ affirmative.

8.5 Training and Education

- All staff who have contact of any nature with LGBTQIA+ service users should receive training to ensure they use affirmative approaches with LGBTQIA+ service users and training should include the use of affirmative approaches and inclusive language. Education and training should be grounded within a framework of cultural humility which encourages a consideration of personal biases and heteronormative and cisgender assumptions and the impact of these on LGBTQIA+ service users.
- The negative impact of often cumulative microaggressions on LGBTQIA+ service users, whether intended or not, should be made explicit, with education focusing on how to make microaggressions visible, how to avoid these, and how to respond with humility, and non-defensively if mistakes do happen.
- For mental health professionals working with LGBTQIA+ service users, further education should focus on the disparities in mental health outcomes for the LGBTQIA+ population and the impact of these on the mental health service user, the disbanding of biases that pathologise LGBTQIA+ identities, provision of information to increase understanding of intersectionality and the cumulative impact of multiple minority identities.

- As less is known by staff on issues experienced by transgender people, education and skills training should have a particular focus on this cohort, and the additional challenges they experience in receiving affirming care in the mental health services.
- Key tenets of bystander training should be incorporated for all mental health staff working with LGBTQIA+ service users which will equip them with the skills to 'call out' discriminatory behaviour and attitudes of others (staff and other service users) in the mental health setting.
- Training on LGBTQIA+ issues should be incorporated into the curricula of all mental health professionals and continued professional development should include LGBTQIA+ training for staff who have completed their clinical education. The content of education programmes should be co-produced with members of the LGBTQIA+ community who have used the mental health services and have unique insights to the education needs of those working within them.

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World Health Organization (2019). *International Statistical Classification of Diseases (11th rev.).* World Health Organization, Geneva.

Xu, Y., Ma, Y. and Rahman, Q. (2023). Comparing asexual with heterosexual, bisexual, and gay/lesbian individuals in common mental health problems: A multivariate meta-analysis. *Clinical Psychology Review*, 105, pp.102334–102334. doi:https://doi.org/10.1016/j.cpr.2023.102334.

Appendix 1: Search Strategy for Review 1- A narrative review of systematic reviews looking at the mental health challenges faced by LGBTQIA+ people.

Concept 1 Mental Health AND LGBTQAI community
EMBASE: ('mental health'/exp OR 'mental disease'/exp) AND ('LGBTQIA+ people'/exp OR 'transgender and gender nonbinary'/exp OR 'sexual and gender minority'/exp OR 'homosexuality'/exp OR 'gender nonbinary'/exp

Medline ((MH "Mental Health") OR (MH "Mental Disorders+") OR (MH "Trauma and Stressor Related Disorders+") OR (MH "Anxiety Disorders+") OR (MH "Schizophrenia Spectrum and Other Psychotic Disorders")) AND ((MH "Homosexuality, Male") OR (MH "Homosexuality") OR (MH "Transgender Persons") OR (MH "Intersex Persons") OR (MH "Sexual and Gender Minorities+"))

CINAHL: ((MH "LGBTQ+ Persons+") OR (MH "Gay Persons+") OR (MH "Transgender Persons+") OR (MH "Gay Men") OR (MH "Men Who Have Sex With Men") OR (MH "Gender-Nonconforming Persons+") OR (MH "Nonbinary Persons") OR (MH "Sexual and Gender Minorities+")) AND ((MH "Mental Disorders+") OR (MH "Behavioral and Mental Disorders+") OR (MH "Mental Disorders, Chronic") OR (MH "Depression+") OR (MH "Anxiety+") OR (MH "Suicidal Ideation"))

PsycINFO: ((DE "Stress and Trauma Related Disorders" OR DE "Chronic Mental Illness" OR DE "Mental Disorders" OR DE "Affective Disorders" OR DE "Anxiety Disorders" OR DE "Behavior Disorders" OR DE "Bipolar Disorder" OR DE "Dissociative Disorders" OR DE "Gender Dysphoria" OR DE "Neurosis" OR DE "Obsessive Compulsive Disorder" OR DE "Personality Disorders" OR DE "Psychosis" OR DE "Serious Mental Illness")) AND ((DE "LGBTQ" OR DE "Asexuality" OR DE "Bisexuality" OR DE "Homosexuality" OR DE "Intersex" OR DE "Transgender" OR DE "Transsexualism" OR DE "Sexual Minority Groups" OR DE "Transgender" OR DE "Gender Nonbinary"))

WOS: Keywords run on topic

EMBASE Keywords run on title and abstract: ((lgbt* OR glbt* OR 'gay lesbian bisexual transgender*' OR lgbtq* OR 'lesbian gay bisexual transgender*' OR queer* OR 'lesbian-gay-bisexual-transgender queer*' OR queer* OR gay* OR homosexual* OR lesbian* OR bisexual* OR transgender* OR pansexual* OR bigender* OR trigender* OR asexual OR 'men who have sex with men' OR 'women who have sex with women' OR 'gender divers*' OR demisexual* OR bicurious* OR androsexual* OR omnisexual* OR tgd OR nonbinary* OR 'non binary gender*' OR 'non conforming gender*' OR intersex*) NEAR/2 (mental* OR psych* OR trauma* OR ptsd OR mood* OR anxiety OR dissociativ* OR depress* OR impuls* OR schizo* OR behav* OR stress* OR neurot* OR suicid* OR crisis* OR mania* OR depress* OR 'post trauma*')):ab,ti

EBSCO keywords run on title and abstract: ((LGBT* OR GLBT* OR Gay-Lesbian-Bisexual-Transgender* OR LGBTQ* OR Lesbian-Gay-Bisexual-Transgender* OR queer* OR "Lesbian-Gay-Bisexual-Transgender Queer*" OR queer* OR gay* OR homosexual* OR Lesbian* OR bisexual* OR transgender* OR pansexual* OR bigender* OR trigender* OR asexual OR "Men who have sex with

men” OR “Women who have sex with women” OR “gender divers*” OR demisexual* OR bicurious* OR androsexual* OR omnisexual* OR TGD OR nonbinary* OR “non binary gender*” OR “non conforming gender*” OR intersex*)) N2 ((mental* OR psych* OR trauma* OR PTSD OR mood* OR anxiety OR dissociativ* OR depress* OR impuls* OR schizo* OR behav* OR stress* OR neurot* OR suicid* OR crisis* OR mania* OR depress* OR post-trauma*))

WoS keywords: (LGBT* OR GLBT* OR Gay-Lesbian-Bisexual-Transgender* OR LGBTQ* OR Lesbian-Gay-Bisexual-Transgender* OR queer* OR “Lesbian-Gay-Bisexual-Transgender Queer*” OR queer* OR gay* OR homosexual* OR Lesbian* OR bisexual* OR transgender* OR pansexual* OR bigender* OR trigender* OR asexual OR “Men who have sex with men” OR “Women who have sex with women” OR “gender divers*” OR demisexual* OR bicurious* OR androsexual* OR omnisexual* OR TGD OR nonbinary* OR “non binary gender*” OR “non conforming gender*” OR intersex*) NEAR/2 ((mental* OR psych* OR trauma* OR PTSD OR mood* OR anxiety OR dissociativ* OR depress* OR impuls* OR schizo* OR behav* OR stress* OR neurot* OR suicid* OR crisis* OR mania* OR depress* OR post-trauma*)

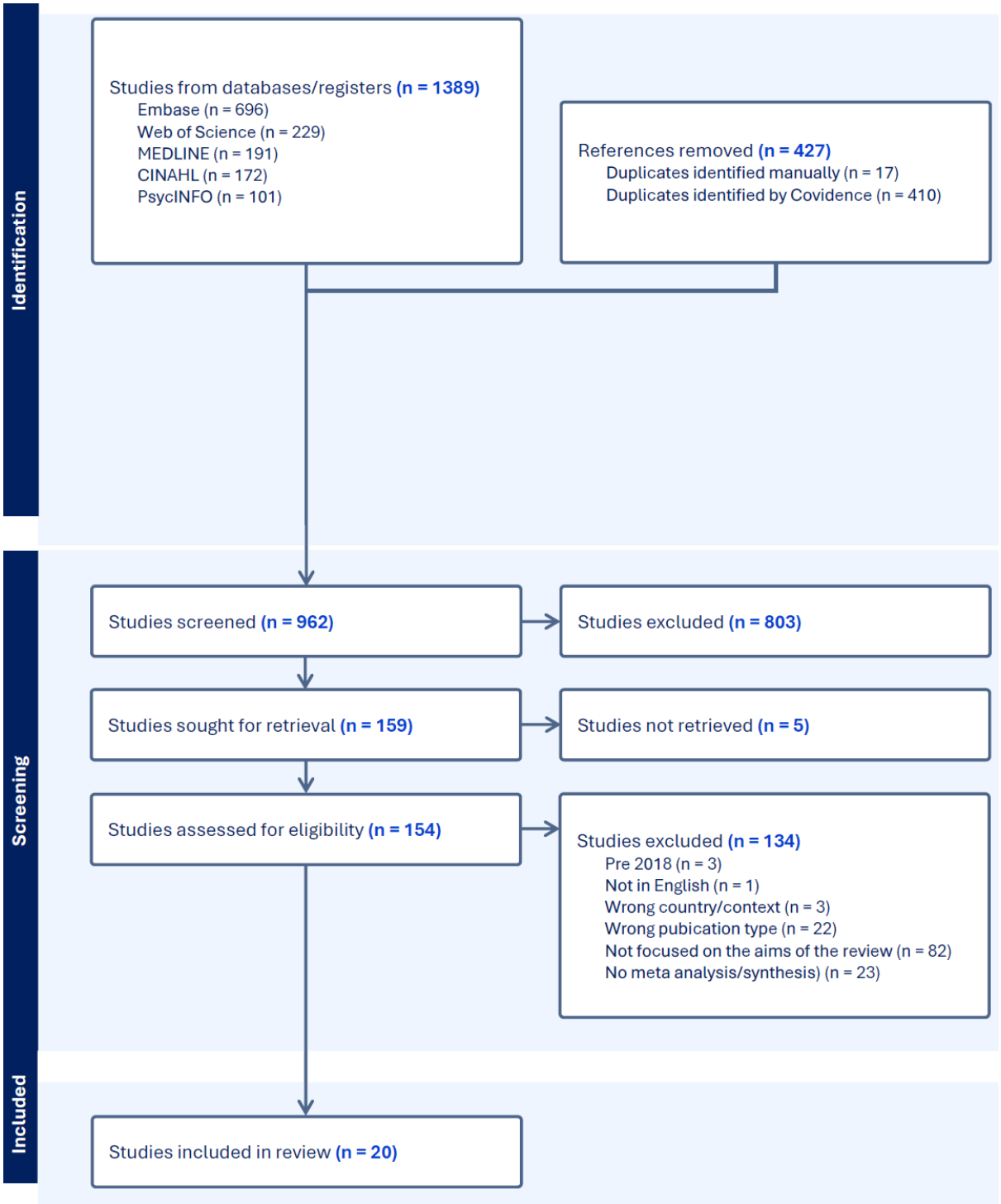
Concept 3: overview - Search strand to narrow to an overview of challenges with mental health
CINAHL: (MH "Systematic Review") OR (MH "Meta Synthesis") OR (MH "Meta Analysis")
Medline: (MH "Systematic Reviews as Topic") OR (MH "Meta-Analysis as Topic+")
EMBASE: 'systematic review (topic)'/exp OR 'systematic review'/exp OR 'meta analysis'/exp
PsycINFO: (DE "Meta Analysis") OR (DE "Systematic Review")
Web of Science: Keyword Search on Topic

Keywords: “systematic review*” OR “meta analys*” OR “meta synthes*” OR metaanalys* OR metasynthes* OR Meta-Analys* OR Meta-synthes*

Search Number	Query Terms	No of Articles
#S1	((MH "Mental Health") OR (MH "Mental Disorders+") OR (MH "Trauma and Stressor Related Disorders+") OR (MH "Anxiety Disorders+") OR (MH "Schizophrenia Spectrum and Other Psychotic Disorders”)) AND ((MH "Homosexuality, Male") OR (MH "Homosexuality") OR (MH "Transgender Persons") OR (MH "Intersex Persons") OR (MH "Sexual and Gender Minorities+"))	8,189
#S2	AB ((LGBT* OR GLBT* OR Gay-Lesbian-Bisexual-Transgender* OR LGBTQ* OR Lesbian-Gay-Bisexual-Transgender* OR queer* OR “Lesbian-Gay-Bisexual-Transgender Queer*” OR queer* OR gay* OR homosexual* OR Lesbian* OR bisexual* OR transgender* OR pansexual* OR bigender* OR trigender* OR asexual OR “Men who have sex with men” OR “Women who have sex with women” OR “gender divers*” OR demisexual* OR bicurious* OR androsexual* OR omnisexual* OR TGD OR nonbinary* OR “non binary gender*” OR “non conforming gender*” OR intersex*) N2 ((mental*	4,674

	OR psych* OR trauma* OR PTSD OR mood* OR anxiety OR dissociativ* OR depress* OR impuls* OR schizo* OR behav* OR stress* OR neurot* OR suicid* OR crisis* OR mania* OR depress* OR post-trauma*)) OR TI ((LGBT* OR GLBT* OR Gay-Lesbian-Bisexual-Transgender* OR LGBTQ* OR Lesbian-Gay-Bisexual-Transgender* OR queer* OR “Lesbian-Gay-Bisexual-Transgender Queer*” OR queer* OR gay* OR homosexual* OR Lesbian* OR bisexual* OR transgender* OR pansexual* OR bigender* OR trigender* OR asexual OR “Men who have sex with men” OR “Women who have sex with women” OR “gender divers*” OR demisexual* OR bicurious* OR androsexual* OR omnisexual* OR TGD OR nonbinary* OR “non binary gender*” OR “non conforming gender*” OR intersex*) N2 ((mental* OR psych* OR trauma* OR PTSD OR mood* OR anxiety OR dissociativ* OR depress* OR impuls* OR schizo* OR behav* OR stress* OR neurot* OR suicid* OR crisis* OR mania* OR depress* OR post-trauma*))	
#S3	S1 OR S2	11,888
#S4	(MH "Systematic Reviews as Topic") OR (MH "Meta-Analysis as Topic+")	36,509
#S5	AB (“systematic review*” OR “meta analys*” OR “meta synthes*” OR metaanalys* OR metasynthes* OR Meta-Analys* OR Meta-synthes*) OR TI (“systematic review*” OR “meta analys*” OR “meta synthes*” OR metaanalys* OR metasynthes* OR Meta-Analys* OR Meta-synthes*)	444,072
#S6	S4 OR S5	453,082
#S7	S3 AND S6	274
#S8	Limiters - Publication Date: 20180101-20241231	191

Appendix 2: PRISMA for Review 1- A narrative review of systematic reviews looking at the mental health challenges faced by LGBTQIA+ people.



Appendix 3: Summary table for Review 1: A narrative review of systematic reviews looking at the challenges faced by LGBTQIA+ people.

Authors and year	Aim of review	Number of papers included	Type of analysis	Sample	Gender	Mean age and Range	Summary of main findings related to aim of the review
Adams & Vincent (2019)	The aim of this systematic review was to assess the impact of race/ethnicity, education, and income on transgender individual's lifetime experience of suicidal thoughts and behaviours (SITB) in grey and published literature between 1997 and 2017	64	Meta-synthesis	Trans	Trans	18 years or older	The average lifetime rate of suicidal ideation for transgender participants was 46.55% and 27.19% for suicide attempts.
Cao et al. (2023)	To explore existing literature identifying if there is an association between sexual orientation and eating disorder-related eating behaviours in adolescents.	10	Meta-analysis	Lesbian; Gay; Bisexual	Male; Female	15.3 years - range of <18 years old	Individuals with a minority sexual orientation, in particular gay men, are at higher risk for eating disorder behaviours such as dieting, binge eating, purging and diet pills use. Gay men were 3 times more likely to engage in binge eating and 2.24 times more likely to purge after meals than lesbians. Bisexual males were twice more likely to engage in binge eating than bisexual females. Female bisexuals were more likely to diet and engage in binge eating behaviours compared to homosexual females.

Dotan et al. (2021)	To examine the association between sexual orientation and disordered eating in women.	21	Meta-analysis	Lesbian; Bisexual	Female	Not stated	Lesbian women were more likely than straight women to engage in binge-eating behaviours [95% CI [0.17, 0.50], p< 0.001]. Bisexual women were more likely to report restrictive eating [95% CI [0.27, 1.42], p 0.004] and purging than lesbian women [95% CI [0.08,1.37], p 0.028].
Dunlop et al. (2020)	To update the estimated risk of non-suicidal self-injury (NSSI) for bisexual people and to examine variables that have been associated with NSSI in this group.	24	Meta-analysis	Lesbian; Gay; Bisexual; Queer; Asexual	Male; Female	Not provided	Bisexual individuals are at an increased risk of engaging in NSSI compared to other minority sexual orientations [OR=1.62]. They were also found to be 4.5-6 times more likely to engage in NSSI in comparison to heterosexual individuals. NSSI was more prevalent in bisexual females than bisexual males.
Hatchel et al. (2020)	To explore and synthesise the current knowledge on suicide among LGBTQ youth.	44	Meta-analysis	Lesbian; Gay; Bisexual; Trans; Queer	Male; Female; Trans	Mean not stated, range of 13-24	LGBTQ youth who experience depression, anxiety, mental distress, trauma, thwarted belongingness, and hopelessness were more likely to experience suicidal thoughts and behaviours (medium effect sizes). Impulsivity, paranoia, oppositional defiance, and psychosis were also noted to be factors that increased suicidal thoughts and behaviours.

Jonas et al (2021)	1) Examining the prevalence of trauma in LGBT youth 2) Establishing the Mental health implications of adverse childhood experiences 3) Comparing the rates of mental health disorders between those exposed to ACEs and those who are not.	18	Meta-analysis	Lesbian; Gay; Bisexual; Trans	Not reported	Mean 16.45	55.2% of the participants experienced ACEs [95% CI [37.8–71.3],p <0.001] with the majority experiencing sexual abuse followed by verbal abuse and then physical abuse. 23.2% experienced mental health problems with depressive symptoms being the most prevalent (36.9%, 95% CI =[26.1–49.1],p<0.001]. LGBT+ youth also experienced a higher rate of anxiety than the general population of young people, with a prevalence rate of approximately 31.5%. [95% CI [25.6–38.2]. p.<0.001].
Kirubarajan et al 2022	To characterise and synthesise the experiences of LGBTQ2S+ childbearing individuals regarding perinatal mental health, including symptomatology, access to care and care-seeking [p1630]	26	Meta-synthesis	Lesbian; Gay; Bisexual; Trans; Queer	Female; Trans; Non-binary	Not reported.	Perinatal depression or low mood was more prevalent in lesbian or bisexual cisgender women when compared with heterosexual counterparts. Anxiety and trauma and stress related experiences were described in 10 studies. PTSD following childbirth was common. Exclusion from traditional perinatal care was common.
Kohnepoushi et al. (2023)	To determine the global prevalence of suicidal thoughts and attempts in the transgender population.	65	Meta-analysis	Transgender	Transgender	Not reported.	The lifetime prevalence of suicidal ideation was found to be 50% for transgender individuals across the world, and 29% of these attempted suicide. The study highlights that almost half of trans individuals who experience suicidal thoughts then go onto take thier own lives.

Liu et al. (2019)	To estimate the prevalence of NSSI among sexual minority and gender minority individuals and heterosexual/cisgender peers and assess the correlates of NSSI in sexual and gender minority groups.	51	Meta-analysis	Lesbian; Gay; Bisexual; Trans; Queer	Male; Female; Trans	Mean not stated, 15-52	Sexual and gender minority individuals were found to have elevated rates of NSSI ranging from 30% to 47%. This was noted to be two to three times higher than heterosexual and/or cisgender people (15%). Bisexual and transgender individuals were found to be the most likely groups to engage in NSSI. Bisexual individuals were found to be more likely to have several risk factors that contribute to individuals engaging in NSSI e.g. having anxiety and depression.
Marchi et al. (2022)	To report a detailed description of research data regarding the risk of attempted suicide, suicide ideation and non-suicidal self-injury behaviours for LGBTIQ people and their subgroups.	50	Meta-analysis	Lesbian; Gay; Bisexual; Trans; Queer; Intersex	Male; Female; Trans M; Trans F	Mean no stated, range of 14-84	There was a greater risk of LGBTIQ individuals attempting suicide (OR:4.36[95%CI:3.32;5.71]), suicidal ideation (OR:3.76[95%CI:3.02;4.69]),and non-suicidal self-injury (OR:4.24[95%CI:3.23;5.55]) when compared with non-LGBTIQ controls. Bisexual individuals were noted to be more at risk of experiencing NSSI, SI and SA (SA, OR:6.71; SI, OR:5.04; NSSI, OR: 5.03).
Marchi et al. (2023)	To summarise data regarding the risk of post-traumatic stress disorder (PTSD) for LGBTQ people and their subgroups.	27	Meta-analysis	Lesbian; Gay; Bisexual; Trans; Queer	Male; Female; Trans	range of 14.7-60	LGBTQ individuals had a greater risk of PTSD than the control group (non LGBTQ people), suggesting a link between minority sexual orientation and exposure to trauma (OR: 2.20 [95% CI: 1.85; 2.60]). Transgender individuals were found to be the most likely group to

							develop PTSD (pooled OR: 2.52 [95% CI: 2.22; 2.87]; I2 = 79%; p < 0.001)followed by bisexuals individuals (pooled OR: 2.44 [95% CI: 1.05; 5.66]).
Nouri et al. (2022)	To determine the global prevalence of depression among men who have sex with men (MSM).	71	Meta-analysis	Men who sleep with men (MSM)	Male	Mean 32, range 20-57.	Rates of depression in MSM were more than double the rates for the general population. 35% of MSM were found to have depression (95% CI 31%–39%, P-value < 0.001). There were higher incidences of depression among MSM that were over 30 years of age. Asian MSM had a higher prevalence of depression, whereas European MSM were less likely to have depression.
Nouri et al. (2023)	To determine the prevalence of suicidal ideation and attempts in men who have sex with men (MSM) worldwide.	38	Meta-analysis	Men who sleep with men (MSM)	Male	mean not stated, 19-44.	The prevalence of suicidal ideation for MSM was 21% (95% CI 17%-26%)while suicide attempts were 12% (95% CI 8%-17%) . These statistics were higher for this group compared to the general population. MSM of all ages were found to be at an increased risk of having suicidal ideation and suicide attempts.

Ross et al. (2018)	To ascertain the prevalence of depression and anxiety among bisexual people when compared to gay, lesbian and heterosexual individuals.	52	Meta-analysis	Lesbian; Gay; Bisexual	Male; Female	Not reported	Depression scores of bisexual people are higher than those of lesbian/gay people by an average of 0.21 standard deviations (95% CI: 0.14, 0.27, OR 1.44 (95% CI: 1.22, 1.70;). Overall, lowest rates of anxiety and depression among heterosexual people while bisexual people have higher or the same rates as lesbian/gay people.
Salway et al. (2019)	To quantify associations between bisexual identity and self-reported suicide ideation and attempt and the moderation of these associations by gender/sex, age, sampling strategy, and measurement of sexuality [p.89].	46	Meta-analysis	Bisexual	Male; Female	Not explicitly stated.	Bisexual individuals were shown to experience an increased risk of suicide in comparison to lesbian/gay individuals. There was a significant disparity between the suicide risk of bisexual males (OR range 1.48-1.95) versus bisexual females.
Scheer et al. (2023)	To provide a comprehensive understanding of PTSD differences between sexual minority women and heterosexual women and among sexual minority women across demographic characteristics.	45	Meta-analysis	Lesbian; Bisexual; Trans	Female	Not reported.	Sexual minority women were more than twice as likely as heterosexual women to meet criteria for probable PTSD. This was particularly relevant for sexual minority women of colour, transgender and bisexual women.

Surace et al. (2021)	To estimate the prevalence of suicidal ideation and suicidal behaviours in gender non-conforming children, adolescents and young adults.	10	Meta-analysis	Trans, GNC	Trans, GNC	Mean not stated, range of 3-25	GNC youths were much more likely to experience suicidal ideation (28%, 95% CI 15-46.3) suicide attempts (14.8%, 95% CI 7.8 - 26.3) and non-suicidal self-injury (28.2% 95% CI 14.8 -47.1) compared to cisgender youths.
Williams et al (2021)	To identify the prevalence of risks associated with self-harm, suicidal ideation or attempts in LGBTQ+ young people who have experiences of being victimized.	40	Meta-analysis	Lesbian; Gay; Bisexual; Trans; Queer	Male; Female; Trans; GNC	Age range 12 - 25, (M =17.7, SD =1.9).	The model calculated a prevalence of mental health difficulties of 0.36 (95% CI: 0.29–0.43) among LGBTQ+ young people who also had experience of self-harm and suicide. A pooled prevalence of 0.36 (95% CI: 0.29–0.43) was indicated for victimisation and 0.39 for mental health difficulties within LGBTQ+ young people with experiences of self-harm or suicide. Odds ratios were calculated which demonstrated particularly high levels of victimisation (3.74) and mental health difficulties (2.67) when compared to cisgender, heterosexual counterparts who also had these experiences.

Wittgens et al., (2022))	To conduct a meta-analysis of population-based studies to quantify the association between sexual minority status (lesbian women, gay men, and bisexual people) and the risk of common mental disorders (depressive disorders, alcohol use disorders (AUD), anxiety disorders, and suicidality).	26	Meta-analysis	Lesbian; Gay; Bisexual	Male; Female	Not reported.	Lesbian/gay people had a higher risk for mental disorders than straight individuals (OR = 2.16; 95% [CI = 1.94,2.41]), with higher risks identified for depression, anxiety disorders, alcohol use disorder, and suicidality. Bisexual people had a higher risk for mental disorders than straight people (OR = 2.78 [CI = 2.34,3.21]) with higher risks identified for depression (OR = 2.70; 95% [CI = 2.32,3.14], k = 18), alcohol use disorder, anxiety disorders, and suicidality.
Xu et al (2023)	We aimed to test whether asexual individuals were at increased risk of higher levels of depressive symptoms, self-harm attempts, and suicide attempts compared with heterosexual, bisexual, or gay/lesbian individuals using multivariate meta-analysis [p1]	23	Meta-analysis	Asexual	Not reported	Not reported	Asexual individuals reported higher levels of depressive symptoms than heterosexual individuals, Hedges' g = 0.39, 95% confidence interval [(CI) = [0.59, 0.18], p < .001.] Both bisexual and gay/lesbian individuals were at greater risk of self-harm and suicide attempts than asexual individuals, with odds ratios ranging from 2.12 to 5.86, all p < .001. The greatest risk of higher levels of depressive symptoms was found in bisexual and asexual individuals. LGB individuals were at significantly greater risk of self-harm and suicide attempts than asexual individuals [OR 2.17 to 5.75, all p < .001]. [p.5]

Appendix 4: Search Strategy for Review 2 – Relationship between minority stress and mental health challenges.

EBSCO Keywords:

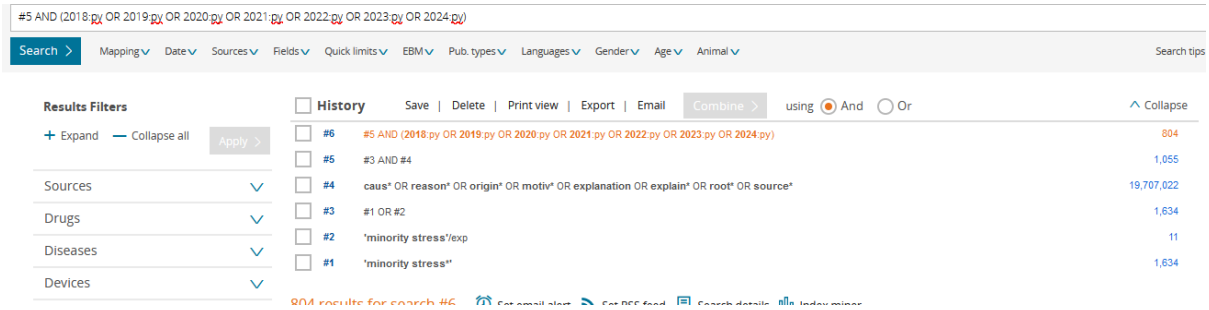
Concept 1:
EMBASE: 'minority stress'/exp
MEDLINE: (MH "Minority Stress")
CINAHL: (MH "Minority Stress")
PsycINFO: DE "Minority Stress"
WOS Keywords only ON TOPIC: "Minority stress*"

Keywords: "Minority stress*"

Concept 2: Causes
Keywords ALL: Caus* OR reason* OR origin* OR motiv* OR explanation OR explain* OR root* OR source*

	Medline	CINAHL	EMBASE	PsycINFO	WoS
	302	277	804	566	595

Embase:



Medline:

#	Query	Limiters/Expanders	Last Run Via	Results
S6	S3 AND S4	Limiters - Publication Date: 20180101-20241231 Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE	302
S5	S3 AND S4	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE	395

S4	Caus* OR reason* OR origin* OR motiv* OR explanation OR explain* OR root* OR source* OR trigger*	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE	6,705,606
S3	S1 OR S2	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE	1,524
S2	"minority stress*"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE	1,524
S1	(MH "Minority Stress")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE	6,759

CINAHL #	Query	Limiters/Expanders	Last Run Via	Results
S6	S3 AND S4	Limiters - Publication Date: 20180101-20241231 Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Ultimate	277
S5	S3 AND S4	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases	383

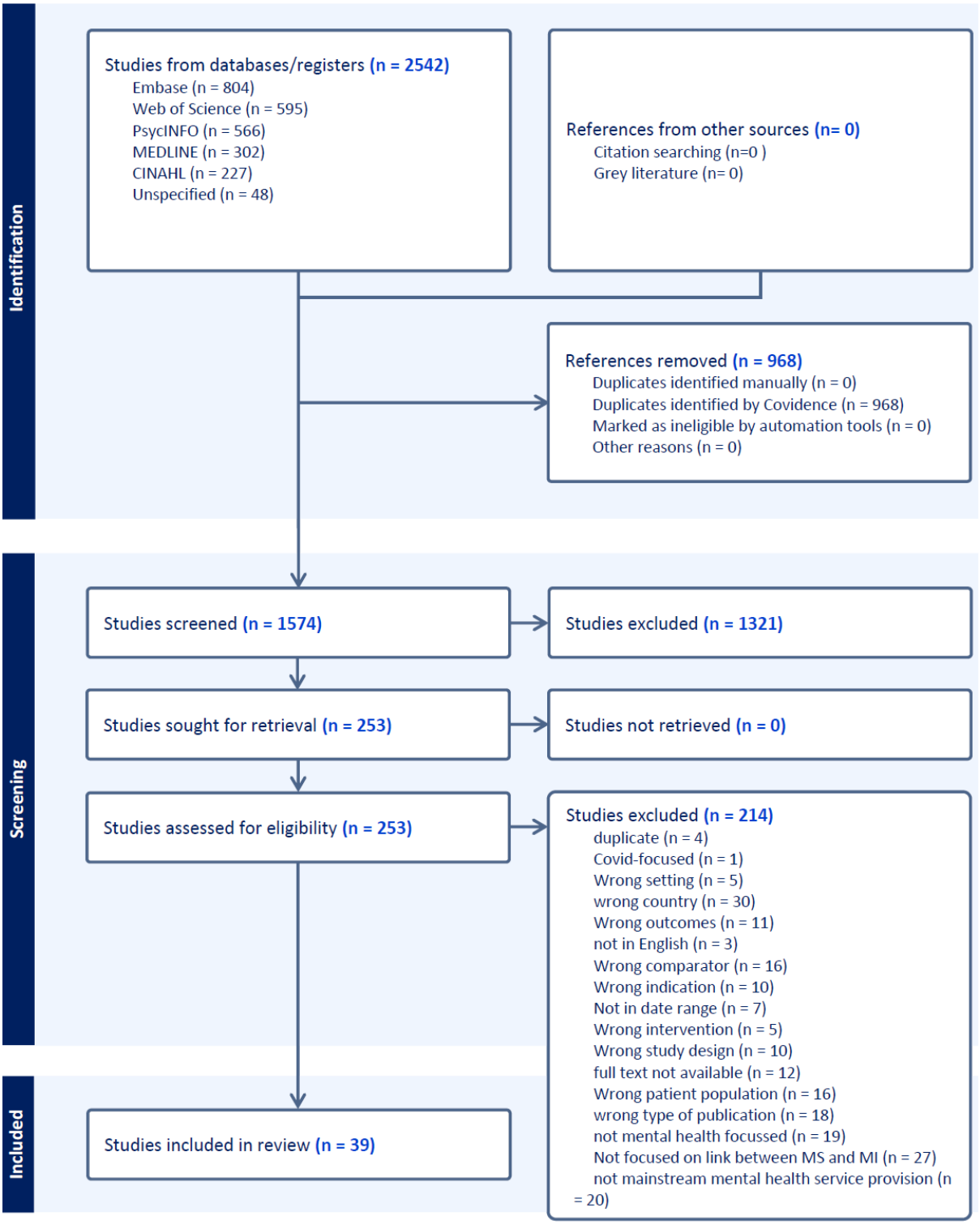
			Search Screen - Advanced Search Database - CINAHL Ultimate	
S4	Caus* OR reason* OR origin* OR motiv* OR explanation OR explain* OR root* OR source* OR trigger*	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Ultimate	1,566,291
S3	S1 OR S2	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Ultimate	1,023
S2	"minority stress*"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Ultimate	1,023
S1	(MH "Minority Stress")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Ultimate	418

PsycINFO:

#	Query	Limiters/Expanders	Last Run Via	Results
S6	S3 AND S4	Limiters - Publication Date: 20180101-20241231 Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	566
S5	S3 AND S4	Expanders - Apply equivalent subjects	Interface - EBSCOhost	799

		Search modes - Boolean/Phrase	Research Databases Search Screen - Advanced Search Database - APA PsycInfo	
S4	Caus* OR reason* OR origin* OR motiv* OR explanation OR explain* OR root* OR source* OR trigger*	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	1,437,217
S3	S1 OR S2	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	2,728
S2	"minority stress*"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	2,728
S1	DE "Minority Stress"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	1,372

Appendix 5: PRISMA for Review 2 – Relationship between minority stress and mental health challenges.



Appendix 6: Summary table for Review 2: Relationship between minority stress and mental health challenges.

Title, date, author, Country	Aim	Design	Population description	Findings	Best Practice/ Significance
Relationships between internalized stigma and depression and suicide risk among queer youth in the United States: a systematic review and meta-analysis Williams et al. (2023) United States	To build upon the findings from prior evidence syntheses examining the relationships between internalized stigma and depression and/or suicide risk in this population.	Systematic review 22 studies included	Queer youth aged 10 to 21 years	Findings on the association between internalized stigma and depression and suicide were mixed. Over 70% of the studies reported a positive association between general internalized queer stigma and depression, while there was a positive association among all studies examining internalized transphobia and biphobia.	Educational and mental health practices often fail to consider the unique intersectional stigmas faced by queer youth who may be also disabled or racial or gender minority. Educational and mental health policy on societal levels must target internalised stigma as part of queer inclusive plans and strategies.
Minority stress, perceived social support, and depression in people diverse in sexual and gender minority status Rogowska & Cisek (2024) Poland	To explain better the mechanism of mutual impact between biopsychosocial factors related to minority stress, depression, and social support in the SGM population.	Cross sectional study	Non-cisgender or non-heterosexual adults over 18 (n=509)	Depression in this study was related positively to all scales of minority stress and negatively to all social support scales. Total social support score and family and friends scales were associated negatively with all minority stress dimensions except vicarious trauma. However, no correlations were found	Family is the most important in the social support network for dual SGM and from friends for single SGM individuals. Among dimensions of minority stress, harassment, and gender exclusion (particularly among dual SGM participants) were the most important, following exclusion from the family, subsequent

				between significant others as a source of social support and minority stress scales, except vicarious trauma (which was related positively).	vigilance (especially in a single SGM people), and victimisation
Coping with discrimination: The insidious effects of gender minority stigma on depression and anxiety in transgender individuals Puckett et al. (2020) United States	To investigate the association between discrimination and mental health in a sample of TGD individuals.	Cross sectional study	TGD individuals aged 16 years and over (n=695)	Over three quarters of participants (76.1%) reported discrimination over the past year. Greater exposure to discrimination was associated with more symptoms of depression and anxiety. The coping responses included detachment/withdrawal coping skills, drug/alcohol use and not positive approaches to coping (education/advocacy and resistance). Thus, when levels of detachment, drug/alcohol use, and internalization were higher, so too were anxiety and depression.	These findings can aid in the development of avenues for interventions to bolster adaptive coping responses for TGD people and highlight that actions to decrease discrimination are urgently needed.
Associations between minority stress, depression, and suicidal ideation and attempts in transgender and gender diverse (TGD) individuals:	The current research meta-analyzed the relationship between minority stress constructs and depression, suicidal	Systematic review 85 studies included	Transgender and gender diverse (TGD) people	Results indicate that distal stress, expectations of rejection, internalized transphobia, and concealment are significantly associated with increased	Moderation analyses suggest that TGD people of color are particularly vulnerable to the effect of multiple minority stressors on mental health outcomes.

Systematic review and meta-analysis Pellicane & Ciesla (2022) United States	ideation, and suicide attempt.			depression, suicidal ideation, and suicide attempt.	
Gender Felt Pressure, Affective Domains, and Mental Health Outcomes among Transgender and Gender Diverse (TGD) Children and Adolescents: A Systematic Review with Developmental and Clinical Implications Mezzalira et al. (2023) Italy	To assess the potential mental health issues that affect the TGD population.	Systematic review 33 studies included	Transgender and Gender Diverse (TGD)	Depression and/or anxiety are the main mental health concerns, followed by other emotional and/or behavioral problems such as ADHD and CD, eating disorders, substance use, sex trading, and even neurodevelopmental disorders such as ASD.	For young TGD individuals to attain a better quality of life, multiple support systems and resources are needed to meet their specific needs. Resilience factors including peer-, family-and community-connectedness can consistently buffer the negative effects that stigma, trauma, and discrimination have on this population's mental outcomes.
Microaggression toward LGBTIQ people and implications for mental health: A systematic review. Marchi et al. (2024) Italy	To systematically review the available literature on microaggression, to provide a quantitative effect estimation of microaggression toward LGBTIQ people.	Systematic review 17 studies included	LGBTIQ people	Microaggressions affect LGBTIQ individuals, particularly transgender ones. The negative impact that microaggression have on mental health, highlight the increased risk of depression, anxiety, suicide attempts, and alcohol abuse.	This evidence may suggest supportive strategies as well as preventive interventions (e.g., supportive programs and destigmatizing efforts) as parts of tailored health-care planning aimed to reduce mental health morbidity

					in this vulnerable population.
It gets better with age: Resilience, stigma, and mental health among lesbian, gay, bisexual, transgender and queer persons from Poland Koziara et al. (2022) Poland	To investigate how exposure to stigma, protective factors and mental health change with age among gender and sexually diverse persons	Cross sectional survey	Lesbian, gay, bisexual, transgender and queer persons (i) sexually diverse cisgender women (n=245) (ii) sexually diverse cisgender men (n=175) (iii) transgender and gender diverse persons (n=98)	The comparison of self-esteem, resilience, exposure to stigma, and depression level across distinguished groups of participants revealed several significant differences. Sexually diverse cisgender women (SDCW) were characterized by significantly higher resilience compared to SDCW (Sexually diverse cisgender women) and TG (Transgender)and GDP (Gender diverse persons).	Age was significantly and positively associated with self-esteem and negatively associated with depression in all groups of participants. The exposure to various minority stressors does not significantly change with age but mental health indicators improve among Gender and sexually diverse (GSD) persons.
Psychosocial mediators of perceived stigma and suicidal ideation among transgender women. Kota et al. (2020) United States	The aim of the study is to measure the prevalence of suicidal ideation and to identify the demographic and psychosocial correlates of suicidal ideation and the potential underlying pathways associated with suicidal ideation among TGW	Cross sectional survey	Transgender women (n=92)	Suicidal ideation was reported by 33% (N = 30) of the study participants. Suicidal ideation was associated with sexual abuse, anxiety, family verbal abuse, stranger verbal abuse and psychosocial impact of gender minority status. Partner support was found to be the protective factor for suicidal ideation.	Interventions that aim to reduce suicidal behaviors among TGW should address stigma, psychosocial impact of gender minority status, and different forms of violence and abuse

Mental health among sexual and gender minorities: A Finnish population-based study of anxiety and depression discrepancies between individuals of diverse sexual orientations and gender minorities and the majority population. Källström et al. (2022) Finland	To examine differences in anxiety and depression within sexual and gender minorities, compared to the heterosexual and cisgender majority in Finland and explore if individuals who belong to both a gender and a sexual minority (double minority) reported higher rates of anxiety and depression than individuals who hold either a gender or a sexual minority status (single minority).	Cross sectional survey	Sexual and gender minorities (n=8,589)	Sexual and gender minority participants reported significantly more depressive and anxiety symptoms than heterosexual participants. Age had a significant negative association with depression indicating that higher age was associated to lower rates of depressive and anxiety.	Sexual and gender minority individuals suffer from higher levels of anxiety and depression overall than the cisgender heterosexual majority. According to our results, bisexual, and nonbinary individuals are especially vulnerable to anxiety and depression.
Mental health in transgender adults: The role of proximal minority stress, community connectedness, and gender nonconformity. Helsen et al. (2022) Belgium	To investigate the association between proximal minority stressors and mental health of transgender adults.	Cross sectional survey	Transgender adults or those with non-binary gender identities (n=143)	People reporting higher levels of internalized transnegativity and/or expectations of rejection reported more mental health difficulties.	The main finding of the study is that about one third of the variance in mental health difficulties of transgender adults was explained by proximal minority stress.
The Role of Distal Minority Stress and Internalized Transnegativity in Suicidal Ideation and Non suicidal Self-Injury Among Transgender Adults.	To investigate the relationship between distal trans stress and Non-Suicidal Self injury (NSSI) and suicide ideation.	Cross sectional survey	Transgender adults (n=247)	Results suggested that internalized transnegativity acts as both a mediator and a moderator in the relationship between distal trans stress and suicidal ideation.	Societal-level policy changes and widely disseminated education about diversity in gender identity, may help to reduce generalized stigma present in the cultural milieu and thus

Staples et al. (2018) United States					help protect trans individuals against internalized transnegativity. Mental health professionals may need to first act as advocates to combat the significant health disparities between trans individuals and the general population.
Risk and Resilience Factors for Mental Health among Transgender and Gender Nonconforming (TGNC) Youth: A Systematic Review. Tankersley et al. (2021) United States	To identify risk and resilience-promoting variables related to mental health among TGNC youth.	Systematic review 44 papers included	TGNC children, adolescents, and young adults under the age of 25	Common risk factors for negative mental health variables included physical and verbal abuse, exposure to discrimination, social isolation, poor peer relations, low self-esteem, weight dissatisfaction, and age. Across studies, older children and adolescents tended to report higher rates of psychological distress. Protective factors for mental health including parent connectedness, social support, school safety and belonging, and the ability to use one's chosen name	Mental health care providers should provide children with coping strategies while also maintaining and advocating for their client's physical and psychological safety. Increasing parent connectedness and support via family-based sessions may be an effective starting point. Mental health professionals are urged to approach treatment in an interdisciplinary manner, coordinating medical doctors, endocrinologists, school counselors, and other care providers in the child's life.

Potentially Traumatic Events and the Association Between Gender Minority Stress and Suicide Risk in a Gender-Diverse Sample. Cogan et al. (2021) United States	To investigate if proximal stressors would mediate the association between distal stressors and suicide risk. It was also considered that higher trauma exposure would influence mediation have stronger evidence of mediation than those who endorsed lower numbers of PTEs.	Cross sectional survey	Transgender and gender diverse individuals (n=155)	Proximal stressors partially mediated the association between distal stressors and suicide risk. The number of potentially traumatic events (PTEs) did not moderate the mediation model that examined proximal stressors as a mediator of the association between distal stressors and suicide risk.	Findings suggest that minority stressors may contribute to suicide risk in a TGD population above and beyond the impact of trauma exposure. Risk reduction efforts for suicide risk may be enhanced by attending to minority stressors in addition to PTEs.
Gender minority stress in trans and gender diverse adolescents and young people. Hunter et al. (2021) UK	The aim of this study was to explore how participants' experience of gender minority stress (GMS) and their heteronormative attitudes and beliefs were associated with psychological distress.	Cross sectional survey	Cisgender n=206) and trans (n=135) and gender diverse (TGD) (n = 106) participants	TGD participants had significantly higher levels of anxiety and depression, and poorer general well-being, than cisgender participants. TGD participants who were assigned male at birth had better wellbeing and less depression and anxiety than those assigned female at birth.	Specialist services could educate other professionals about the role of GMS in the psychological well-being of TGD YP by asking questions about this in assessments and including this as a factor in formulations and interventions. Services should consider how they can actively engage in shifting public attitudes towards TGD adolescents and YP by working with the wider community
Reducing behavioral health symptoms by addressing minority stressors in LGBTQ	To present on a randomized controlled trial conducted at four public schools on the	Randomised control trial	LGBTQ adolescents (n=44)	Moderation analyses showed that the intervention significantly moderated the	Results suggest that Proud & Empowered help reduce mental health symptoms and exposure

adolescents: a randomized controlled trial of Proud & Empowered. Goldbach et al. (2021) United States	west coast of the United States to examine the efficacy of the Proud and Empowered program.		26 were in intervention arm.	relationship between minority stress and PTSD, depression and suicidality symptoms; those in the intervention condition had mitigated relationships between measures of stress and health outcomes compared to those in the control condition.	to minority stressors and build coping strategies
Cumulative minority stress and suicide risk among LGBTQ youth. Green et al. (2022) United States	To examine the association of LGBTQ+ based cumulative minority stress with suicide risk	Cross sectional survey	LGBTQ youth ages 13 to 24 (n=39,126)	Greater minority stress was associated with greater odds of attempting suicide among LGBTQ youth. The number of risk factors was more predictive of suicide risk than any individual risk factor. Marginalized LGBTQ youth had greater adjusted odds of experiencing more minority stress experiences Youth who reported four types of minority stress had nearly 12 times greater odds of attempting suicide compared to those who reported none. Transgender and	Suicide risk is cumulative; therefore, it is important that models for understanding it embodies a cumulative approach. Doing so will provide a more comprehensive understanding of suicide risk among marginalized populations that can push forward policy and practice-based solutions to reducing disparities

				nonbinary youth and American Indian/ Alaskan Native youth had higher odds of reporting three or more minority stress experiences.	
Minority Stress and Suicidal Ideation and Suicide Attempts Among LGBT Adolescents and Young Adults: A Meta-Analysis. deLange et al. (2022) The Netherlands	To synthesize the associations between types of minority stressors and suicidal ideation and suicide attempts among LGBT adolescents and young adults aged 12 to 25 years.	Meta-Analysis 44 studies included	LGBT adolescents and young adults (aged 12 to 25 years)	LGBT bias-based victimization, general victimization, bullying, and negative family treatment were significantly associated with suicidal ideation and/or suicide attempts.	There is a need for prevention and intervention work focused on peer and family victimization and rejection.
Age-Varying Sexual Orientation Disparities in Mental Health, Treatment Utilization, and Social Stress: A Population-Based Study. Bränström et al. (2022a) Sweden	To investigate if depression, anxiety, high-risk alcohol use and treatment seeking for these problems is more prevalent among sexual minority individuals compared with heterosexual individuals across the life course.	Cohort study	Sexual minority individuals Total population (n= 108,641) Those included based on sexual orientation (n= 5,115)	Sexual minority individuals were more likely to report symptoms of depression and anxiety and to have received treatment for these conditions compared with heterosexual individuals, but they were not more likely to report high-risk alcohol use. Age was a factor with elevated risk of depression and anxiety among sexual minority individuals strongest in early ages but the disparity remained significantly elevated among sexual minority	Many studies report a substantial increased risk of mental health problems among sexual minority individuals compared with heterosexual individuals. In a population-based sample, this study highlights a sexual orientation disparity in depression and anxiety.

				individuals until about age.	
Transgender Dehumanization and Mental Health: Microaggressions, Sexual Objectification, and Shame. Cascalheira & Choi (2023) United States	Testing direct and indirect relations between dehumanization (i.e., a higher-order construct from experiences of transgender microaggressions and sexual objectification), internalization processes (i.e., internalized transnegativity, self-objectification), shame, and general mental health	Cross sectional survey	Transgender men and women (n=292)	Internalized transnegativity and shame were significant, negative, direct predictors of mental health measured using Mental Health Inventory (MHI-5). The indirect relations from self-objectification and internalized transnegativity to mental health through shame were significant.	When working with transgender clients, clinicians should target internalization processes and shame to improve mental health. Activists should attend to both microaggressions and objectifying treatment in policy work.
Internalizing Minority Stress: Gender Dysphoria, Minority Stress, and Psychopathology in a Norwegian Transgender Population. Brokjob & Cornelissen (2022) Norway	To further explore the relationships between minority stress, gender dysphoria, and psychopathology and tested a mediation model with minority stress as a predictor variable and gender dysphoria as a mediator on different psychopathologies.	Online survey, nonexperimental correlational design.	Transgender people to include non-binary individuals (n=85)	The study found notable links between minority stress, gender dysphoria, and mental health problems in transgender individuals. Minority stress and gender dysphoria independently linked to anxiety and depression, but minority stress did not link to eating pathology when taking gender dysphoria into account. Minority stress was linked to all measured mental health problems in younger, but not older transgender	This provides a novel insight into mental health problems in transgender individuals and is directly relevant to clinical services for transgender clients.

				individuals when taking gender dysphoria into account.	
Gay vs. straight? Implications of intergroup perceptions on minority stress and the mental health of lesbian and gay people. Camposano et al. (2023) Portugal	To use social identity theorizing to understand if minority stress and Lesbian and Gay (LG) people's perception of the status and boundaries between their ingroup, the LGBTQ+ community vs. the heterosexual outgroup, worsens or improves mental health outcomes	Cross sectional survey	Lesbian and gay adults (n=202) in the UK	LG people with elevated minority stress conveyed worse overall mental health outcomes especially when they perceived the group status between their LGBTQ+ group and heterosexual outgroup as either stable or illegitimate.	Results propose tackling homophobic conditions while also challenging the perceived stability and illegitimacy of the LGBTQ+ community by supporting its spaces and members.
Minority Stress and Mental Health in Italian Bisexual People. Scandurra et al. (2020) Italy	To assess the effects of anti-bisexual discrimination, proximal stressors (i.e., anticipated binegativity, internalized binegativity, and outness), and resilience on psychological distress in Italian bisexuals	Cross sectional survey	Bisexual people (n=381)	The findings suggest that internalized binegativity increases the risk that anti-bisexual discrimination leads to anxiety and depression. Furthermore, the results suggested that internalized binegativity mediated the relationship between anti-bisexual discrimination and mental health problems.	There is a need to ameliorate internalized binegativity to reduce the risk in Italian bisexual people to develop mental health problems.
The impact of transgender minority stress and emotion regulation on suicidality and self-harm.	The current study examined how TGD persons' experiences of gender minority stress were related to self-harm and suicidality through	Cross sectional survey	Transgender and gender diverse (TGD) individuals (n=115)	Individuals who reported a suicide attempt history also endorsed poorer emotion regulation, more self-harm behaviours, and more gender-based	In line with the biosocial model, experiences of gender identity- based victimisation were related to increased suicidality, partially through

Drescher et al. (2023) United States	emotion dysregulation.			rejection and victimisation experiences. A very high percentage of the participants (< 8 out of 10) reported gender identity-based discrimination, rejection, and victimisation, as well as self-harm.	victimisations effects on emotion dysregulation.
Sexual Minority Stress and Social Support Explain the Association between Sexual Identity with Physical and Mental Health Problems among Young Lesbian and Bisexual Women. Ehlke et al. (2020) United States	The current study will test a sequential mediation model to examine if proximal sexual minority stress related to negative identity and social support mediate the association between sexual identity (i.e., lesbian or bisexual women) and physical and mental health problems among young adult SMW.	Cross sectional survey	Young adult lesbian and bisexual women (n=650)	Bisexual women reported more sexual minority stress than lesbian women, which was associated with lower social support, which then was associated with more physical and mental health problems. Compared to lesbian women, bisexual women reported greater identity uncertainty and concealment motivation. Expanding upon prior findings, results from the current study showed that greater sexual minority stress was associated with more physical health problems. Social support reduced sexual minority stress. Thus, those SMW who experience more sexual minority stress may be	Focusing on more effective coping skills for minority stress and enhancing social support networks and interactions may result in positive health outcomes. Cognitive-behavioral therapy focused on affirming GB identities and reducing sexual minority stress processes was linked to improved health outcomes for young adult gay and bisexual men. Negative experiences with medical professionals meant they were reluctant to seek medical care. Creating an online community may provide an outlet for bisexual women to discuss experiences and coping

				more reluctant to seek social support from these individuals due to internal processes and fear of their reactions. Bisexual women who experience more sexual minority stress may have the lowest perceived social support.	strategies while also providing them with a sense of increased social support of a bisexual community. Developing interventions that reduce stigma from heterosexuals, lesbian and gays is also important.
Mediators of the Disparities in Depression Between Sexual Minority and Heterosexual Individuals: A Systematic Review. Argyriou et al. (2021) United States	The aim of the present study is to identify the factors that mediate the relation between sexual minority status and depressive symptoms by systematically reviewing research studies in the literature that use mediational approaches to investigate the disparities among heterosexual and sexual minority individuals.	Systematic review 40 studies included	Sexual Minority and heterosexual individuals	Stressors such as victimization, harassment, abuse, and increased stress, as well as lower social and family support, may contribute to differing depression rates in sexual minority compared to heterosexual individuals. Differences in psychological processes such as self-esteem and rumination may also play a role but have had insufficient research attention so far.	Studies reviewed here reported low social support, increased rumination, low emotional regulation, poor sense of mastery, low resilience, and low self-esteem as factors that can help explain the increased rates of depression in sexual minority individuals.
Lifecourse-varying structural stigma, minority stress reactions and mental health among sexual minority male migrants. van der Star et al. (2021)	To explore the association between structural stigma exposure, minority stress reactions and mental health, as a function of length of exposure to structural stigma among self-	Cross sectional survey	Sexual minority men who had migrated to Sweden (n=247)	Structural stigma experienced by male migrants is associated with rejection sensitivity, internalized homophobia and poor mental health as a function of sexual minority men's length of	This study demonstrates that country-of-origin structural stigma might generate rejection sensitivity and internalized homophobia regardless of country that a person moves to.

Sweden	identified sexual minority men who have changed structural stigma environments.			exposure to structural stigma in their countries of origin.	
The relationship between minority stress factors and suicidal ideation and behaviours amongst transgender and gender non-conforming adults: A systematic review. Gosling et al. (2022) UK	To evaluate recent literature that reports on the association between MS and suicidal ideation and behaviours amongst TGNC adults.	Systematic review 28 papers included	Transgender and Gender Non-Conforming (TGNC) adults	Findings suggested positive associations between external and internal minority stressors and suicidal ideation and behaviour. Dysfunctional individual coping was associated with a greater likelihood of suicide attempts. Community resilience was negatively associated with suicidal outcomes, but did not consistently buffer the effects of minority stress.	Exploring experiences of minority stress could help to inform suicide risk assessments and risk formulations for TGNC clients accessing mental healthcare. Non-inclusive healthcare experiences and suicide outcome were linked highlighting the need for healthcare professionals to be aware of, and sensitive to, the needs of TGNC individuals. Mental healthcare professionals should be encouraged to explore feelings of shame, internalised transphobia, expectations of prejudice (and how the TGNC client manages these expectations) and work with these therapeutically.
Transgender-based disparities in suicidality: A population-based study of key predictions from four theoretical models.	To investigate if transgender individuals are at greater risk of suicidality than cisgender individuals, and if the		Transgender (n=533) and cisgender (n=104,757) individuals	Compared to cisgender individuals, transgender individuals were at a substantially higher risk of reporting both lifetime	Possible explanations for increased risk of suicide, include those derived from clinical, interpersonal, minority

Bränström et al. (2022b) Sweden	increased risk of suicidality among transgender individuals can be partially explained by: (a) more depressive symptoms and substance abuse, (b) lack of social support, (c) greater exposure to discrimination and threat of violence, and (d) barriers to societal integration.			and past 12-month suicidality. Several factors partially mediated the increased risk of suicidality among transgender compared to cisgender individuals, including depressive symptoms, lack of social support, and exposure to discrimination.	stress, and societal integration models of suicide.
The Relationship between Minority Stress and Depressive Symptoms in the LGBTQA Population from Poland. Cisek & Rogowska (2023) Poland	To examine the frequency of depression symptoms and minority stress dimensions related to country context. The study also considers if high minority stress and depression will be presented in dual SGM individuals (bisexual and pansexual people) and women.	Cross sectional survey	LGBTQA people from Poland (n=509)	Among LGBTQA participants, 99.80% declared minority stress at least once during the past year. Vicarious trauma was experienced in 99.80% of participants, vigilance in 95.87%, harassment and discrimination in 80.35%, stress related to the family of origin in 69.16%, and to gender expression in 68.76% of respondents. Depression symptoms were found in 62.50% of respondents. Significantly higher rates of depression and minority stress were presented in dual than single SGM individuals.	The whole SGM population needs professional help focused on mental health issues. The prevention strategies should be implemented in schools and mass media, while intervention programs require a multidisciplinary approach to decrease depression among LGBTQA people. Prevention and intervention programs should be designed for the LGBTQA population focusing on coping with these sources of minority stress, especially among those of dual SGM identity.

The influence of minority stress-related experiences on mental wellbeing for trans/gender-diverse (TGD) and cisgender youth: a comparative longitudinal analysis. Black et al. (2023) UK	To examine gender-related differences in mental wellbeing and minority-related stressors among young people over time.	A hybrid population cohort study design	School pupils aged between 12 and 15 (n=26,042)	TGD and those who preferred not to say their gender had lower wellbeing over the course of the study, than cis-males (CM). TGD adolescents also showed the largest disadvantage (mean difference) compared with CM for minority stressors. Gender was not found to moderate the effect of minority stressors on later wellbeing.	Improving the accessibility and quality of targeted interventions alone is therefore insufficient, and universal intervention is required. This includes work to reduce institutionalized forms of prejudice and discrimination, including policies and institutions that pathologize gender diversity, fail to recognize the value of gender affirmative care and/or create delays in access to healthcare through increased bureaucracy.
Minority stress and mental health in European transgender and gender diverse people: A systematic review of quantitative studies. Mezza et al. (2024) Italy	To systematically review evidence on the relationships between gender minority stress and mental health outcomes among European transgender and gender diverse (TGD) individuals	Systematic review 30 articles included	Transgender and gender diverse (TGD) individuals	Distal stressors were positively associated with various mental health outcomes, including depression, anxiety, and suicidal ideation and attempts. Gendered discrimination was identified as a risk factor for poor mental health providing evidence for the health impact of social inequalities that TGD people generally experience in multiple	Professionals treating TGD people should be familiar with minority stress and that TGD patients are at higher risk for mental health difficulties because of the social stressors imposed by cisnormative societies. Clinical practice should assess the potential impact of distal and proximal stressors on the patient's psychosocial functioning, thus

				domains such as employment, school, and health care. Gender dysporia seems to be associated with psychopathology for older TGD people, who have arguably internalized an increased pressure to conform to stereotypical feminine or masculine appearance. This review seems to support the role of female birth-assigned sex as a risk factor for negative mental health outcomes. The reasons for this widely observed trend remain unclear.	strengthening resilience and coping strategies. Advocacy efforts should be made at a broader level by mental health professionals to encourage inclusive practices within the healthcare system and to improve TGD people's access to social and health resources. Wider sociopolitical change is needed to decrease the stigmatization that TGD individuals experience at a structural level.
Gender Minority Stress and Resilience Measure: A Meta-Analysis of the Associations with Mental Health in Transgender and Gender Diverse Individuals. Wilson et al. (2023) United States	This meta-analysis examined the associations between gender minority stressors and resilience factors, as measured by the Gender Minority Stress and Resilience Measure (GMSR; Testa et al., 2015), and two types of mental health symptoms (i.e., depression and anxiety)	Systematic review 69 studies included	Transgender and gender diverse (TGD) individuals	Depression symptoms were more commonly studied than anxiety symptoms. Inconsistencies in the measurement of suicide-related variables and the small number of studies resulted in the exclusion of that outcome from the analyses. There were positive, statistically significant associations between the four distal stress and three proximal stress	Self-stigma and concerns about the future may be particularly important treatment targets for addressing the mental health needs of TGD populations. Future research should examine these as potential mechanisms of change in evidence-based practices adapted for TGD individuals.

				subscales and depression and anxiety symptoms. Mean effects for the proximal stressors tended to be larger than those for the distal stressors.	
Sexual Minority Stress, Mental Health Symptoms, and Suicidality among LGBTQ Youth Accessing Crisis Services. Fulginiti et al. (2021) USA	To assess if minority stress would be positively associated with suicidal ideation and suicide attempt and if these would be mediated by depressive, PTSD, and hopelessness symptoms.	Cross Sectional	LGBTQ aged between 12 and 24 (n=572)	Minority stress was associated with depressive and PTSD symptoms, which were linked with suicidal ideation and attempt through hopelessness. The findings showed that minority stress would be associated with suicidality not just directly, but also indirectly through multiple mental health symptom pathways	High rates of suicidal experiences among sexual and gender minority youth highlight the importance of identifying pathways to help guide suicide prevention programing in this population. Unfortunately, studies that delineate such pathways have provided an incomplete picture of the minority stress mental health suicide relationship.
An exploration of mental distress in transgender people in Ireland with reference to minority stress and dissonance theory. DeVries et al. 2023 Ireland	The aim of this paper is to focus on participants who self-identified as transgender, their mental health and distress and predictive factors. The findings are contextualized within minority stress and cognitive dissonance theory	Case control study	Transgender individuals (n=279)	Transgender participants reported higher levels of mental distress, self-harm, suicidal ideation and attempts, and lower levels of self-esteem in comparison with the LGB groups, as well as the general population. Mental distress could be predicted from reduced self-esteem, the	Mental health practitioners should focus on enhancing self-esteem and incorporate gender affirming strategies within inclusive care that responds to the specific needs of transgender clients and patients. Secondary schools need to offer more support

				experience of harassment and not belonging in school. Furthermore, mental distress was highest among younger participants, those who were not out, those who had self-harmed and used avoidant coping. There was no significant difference in distress levels among those who had sought mental health support and those who had not	and protection so have an important role to play in the socialization and identity formation of young people who identify as transgender. Transgender affirmative culture and practices within mental health services can be built on this insight. Considering the incidence of reported harassment and violence in this study it is evident that there is an urgent need for policymakers to address these drivers of mental health disparities in gender minority populations.
Subtle and Intersectional Minority Stress and Depressive Symptoms Among Sexual and Gender Minority Adolescents of Color: Mediating Role of Self-Esteem and Sense of Mastery. Mereish et al. (2022) USA	This study examined the associations between subtle and intersectional minority stress (i.e., SGMA of color- specific microaggressions) and depressive symptoms among SGMA of color and tested self-concept factors (i.e., self-esteem and sense of mastery) as mediators of these association	Cross sectional study	A large national US sample of Sexual and Gender Minority adolescents (SGMA) (N=3398; 31.8% transgender; 55.7% plurisexual) ages 13 to 17 years	Nuanced, multiple, and intersectional forms of minority stress were directly associated with elevated depressive symptoms, even after accounting for the effects of overt and acute forms of minority stress (i.e., racist discrimination and SGM-based victimization). These results suggest that subtle and intersectional forms of minority stress	Results were consistent across the aggregate sample of SGMA of color as well as for specific racial/ethnic minority groups in our sample. We also found that self-concept, self-esteem and sense of mastery, mediated the associations between minority stress and depressive symptoms.

				unique to SGMA of color, such as experiencing microaggressions within SGMA and ethnic/racial communities, place SGMA of color at greater risk for depressive symptoms.	
Stigma shapes lesbian, gay, bisexual, transgender, and queer persona mental health and experiences with mental health services in North Macedonia Stojanovski et al. (2022) North Macedonia	To investigate the experiences lesbian, gay, bisexual, transgender, and queer personal mental health and experiences with mental health services in North Macedonia	Qualitative Research	Lesbian gay, bisexual, transgender, and queer (LGBTQ+) (n= 71)	LGBTQ+ participants described living a double-life and explained that minority stressors challenge their mental health and ability to access mental health services. Participants extensively shared unethical experiences with mental health services. Transgender participants and LGBTQ+ persons living in smaller towns described additional stigmatisation that harmed their mental health and hampered use of services. While, safe and affirming mental health services exist, they are not the norm nor readily accessible to all LGBTQ+ persons	Partnering with LGBTQ+ affirming mental health professionals and expanding teletherapy services could significantly improve services. Structural and community-level interventions should also be implemented to address the stigma and discrimination against LGBTQ+ people and support their mental health.

Effects of sexual and gender minority stress on depressive symptoms among adolescents of color in the United States Ching et al. (2024) United States	To assess the effects of sexual and gender minority stress on depressive symptoms among adolescents of colour.	Cross Sectional Study	Transgender adults or those with non-binary gender identities	Internalized transnegativity as well as expectations of rejection but not concealment were significant positive predictors of mental health difficulties. People reporting higher levels of internalized transnegativity and/or expectations of rejection reported more mental health difficulties Community connectedness did not add to the prediction of mental health difficulties on top of proximal minority stress.	The main finding of the present study is that about one third of the variance in mental health difficulties of transgender adults was explained by proximal minority stress
Minority stress as a multidimensional predictor of LGBT+ adolescents mental health outcomes Weeks et al. (2021) United States	To identify whether different levels of minority stress, measured across multiple theoretical levels, affect mental health outcomes in LGB+ adolescents may help inform future research and practice to support LGB+ adolescents.	Cohort study	LGBT adolescents and young adults (aged 12 to 25 years) (n=152)	Multiple regression analyses of LGB+ adolescents found that distal stress predicted substance misuse and suicidality and was a stronger predicter than proximal stress for psychological inflexibility.	This study might contribute to an evidence base that could guide measurement approaches for assessing minority stress and using related results to inform the prediction of and, ultimately, intervention with LGB+ adolescents mental health outcomes.

Appendix 7: Search Strategy for Review 3: Barriers/Challenges to Accessing Quality Mental Healthcare.

Concept 1:
CINAHL: (MH "LGBTQ+ Persons+") OR (MH "Gay Persons+") OR (MH "Transgender Persons+") OR (MH "Gay Men") OR (MH "Men Who Have Sex With Men") OR (MH "Gender-Nonconforming Persons+") OR (MH "Nonbinary Persons") OR (MH "Sexual and Gender Minorities+")

Medline: (MH "Homosexuality, Male") OR (MH "Homosexuality") OR (MH "Transgender Persons") OR (MH "Health Services for Transgender Persons") OR (MH "Intersex Persons") OR (MH "Sexual and Gender Minorities+")

EMBASE: 'LGBTQIA+ people'/exp OR 'transgender and gender nonbinary'/exp OR 'sexual and gender minority'/exp OR 'homosexuality'/exp OR 'gender nonbinary'/exp

PsychINFO: DE "LGBTQ" OR DE "Asexuality" OR DE "Bisexuality" OR DE "Homosexuality" OR DE "Intersex" OR DE "Transgender" OR DE "Transsexualism" OR DE "Sexual Minority Groups" OR DE "Transgender (Attitudes Toward)" OR DE "Transgender" OR DE "Gender Nonbinary" OR DE "LGBTQ Rights")
Web of Science keywords run on topic only

EBSCO & WoS keywords: LGBT* OR GLBT* OR Gay-Lesbian-Bisexual-Transgender* OR LGBTQ* OR Lesbian-Gay-Bisexual-Transgender* OR queer* OR “Lesbian-Gay-Bisexual-Transgender Queer*” OR queer* OR gay* OR homosexual* OR Lesbian* OR bisexual* OR transgender* OR pansexual* OR bigender* OR trigender* OR asexual OR “Men who have sex with men” OR “Women who have sex with women” OR “gender divers*” OR demisexual* OR bicurious* OR androsexual* OR omnisexual* OR TGD OR nonbinary* OR “non binary gender*” OR “non conforming gender*” OR intersex*

EMBASE: 'lgbt*':ab,ti OR glbt*:ab,ti OR 'gay lesbian bisexual transgender*':ab,ti OR lgbtq:ab,ti OR lgbtq+:ab,ti OR 'lesbian gay bisexual transgender*':ab,ti OR 'lesbian-gay-bisexual-transgender queer*':ab,ti OR queer*:ab,ti OR gay*:ab,ti OR homosexual*:ab,ti OR lesbian*:ab,ti OR bisexual*:ab,ti OR transgender*:ab,ti OR pansexual*:ab,ti OR bigender*:ab,ti OR trigender:ab,ti OR asexual:ab,ti OR 'men who have sex with men':ab,ti OR 'women who have sex with women':ab,ti OR 'gender divers*':ab,ti OR demisexual*:ab,ti OR bicurious:ab,ti OR androsexual*:ab,ti OR omnisexual*:ab,ti OR tgd:ab,ti OR nonbinary:ab,ti OR 'non binary gender*':ab,ti OR 'non conforming gender*':ab,ti OR intersex*:ab,ti

Concept 2 Mental Health Services
EMBASE: (('health service'/exp OR 'health care facilities and services'/exp) AND ('mental health'/exp OR 'mental disease'/exp)) OR 'mental health care'/exp OR 'mental health service'/exp

Medline (MH "Mental Health Services+") OR (MH "Mental Health Recovery") OR (MH "Emergency Services, Psychiatric+") OR (MH "Counseling+") OR ((MH "Health Services+") OR (MH "Women's Health Services+") OR (MH "Health Services for the Aged") OR (MH "Preventive Health Services+") OR (MH "Rural Health Services+") AND ((MH "Mental Health") OR (MH "Mental Disorders+"))
CINAHL: (MH "Mental Health Services+") OR (MH "Counseling+") OR ((MH "Health Services+")
PsycINFO: DE "Preventive Mental Health Services" OR DE "Mental Health Services" OR DE "Psychological First Aid" OR DE "School Based Mental Health Services" OR DE "Community Mental Health Services" OR DE "Community Counseling" OR DE "Community Mental Health Centers" OR DE "Mental Health Disparities" OR DE "Mental Health Parity" OR DE "Mental Health Programs" OR DE

"Crisis Intervention Services" OR DE "Deinstitutionalization" OR DE "Hot Line Services" OR DE "Suicide Prevention Centers" OR DE "Psychiatric Hospital Programs" OR DE "Preventive Mental Health Services" OR DE "Behavioral Health Services"
WOS: Keywords run on topic

EMBASE Run title and abstract & WOS Keywords run on topic: (Health* OR care OR nurs* OR medic* OR clinic* OR support* OR service*) NEAR/2 (mental* OR psych* OR wellbeing* OR anxiet* OR depress* OR vulnerab* OR suicid* OR crisis* OR counsel*)
EBSCO Keywords: (Health* OR care OR nurs* OR medic* OR clinic* OR support* OR service*) N2 (mental* OR psych* OR wellbeing* OR anxiet* OR depress* OR vulnerab* OR suicid* OR crisis* OR counsel*))

Concept 3: Barriers
EMBASE: 'health care access'/exp OR 'discrimination against sexual and gender minorities'/exp
Medline: (MH "Health Services Accessibility+") OR (MH "Homophobia")
CINAHL: (MH "Health Services Accessibility+") OR (MH "Access to Primary Care") OR (MH "Attitude to Sexuality+")
PsycINFO: DE "Health Care Access" OR DE "Treatment Barriers" OR DE "Health Service Needs" OR (DE "Homosexuality (Attitudes Toward)")
Wos:

Keywords in title and abstract: (attitud*:ab,ti OR barrier*:ab,ti OR challeng*:ab,ti OR hinder*:ab,ti OR hindr*:ab,ti OR bias*:ab,ti OR discriminat*:ab,ti OR gap*:ab,ti OR inequalit*:ab,ti OR disparit*:ab,ti OR unequal*:ab,ti OR restrict*:ab,ti OR stigma*:ab,ti OR percept*:ab,ti OR exclu*:ab,ti OR fear*:ab,ti OR anxiety*:ab,ti OR homophobi*:ab,ti OR transphobi*:ab,ti OR OR lesbophob*:ab,ti OR transnegativ*:ab,ti OR homonegativ*:ab,ti OR 'sexual prejudice*':ab,ti OR antigay:ab,ti OR stress*:ab,ti OR experien*:ab,ti OR refuse*:ab,ti OR refusal*:ab,ti) NEAR/2 (access*:ab,ti OR use*:ab,ti OR usage*:ab,ti OR utilis*:ab,ti OR utiliz*:ab,ti)

EBSCO Keywords: (attitud* OR barrier* OR challeng* OR hinder* OR hindr* OR bias* OR discriminat* OR gap* OR inequalit* OR disparit* OR unequal* OR restrict* OR stigma* OR percept* OR exclu* OR fear* OR anxiety* OR homophobi* OR transphobi* OR lesbophob* OR transnegativ* OR homonegativ* OR "sexual prejudice*" OR antigay OR stress* OR experien* OR refuse* OR refusal*) N2 (access* OR use* OR usage* OR utilis* OR utiliz*)

WOS keywords: (attitud* OR barrier* OR challeng* OR hinder* OR hindr* OR bias* OR discriminat* OR gap* OR inequalit* OR disparit* OR unequal* OR restrict* OR stigma* OR percept* OR exclu* OR fear* OR anxiety* OR homophobi* OR transphobi* OR lesbophob* OR transnegativ* OR homonegativ* OR "sexual prejudice*" OR antigay OR stress* OR experien* OR refuse* OR refusal*) NEAR/2 (access* OR use* OR usage* OR utilis* OR utiliz*)

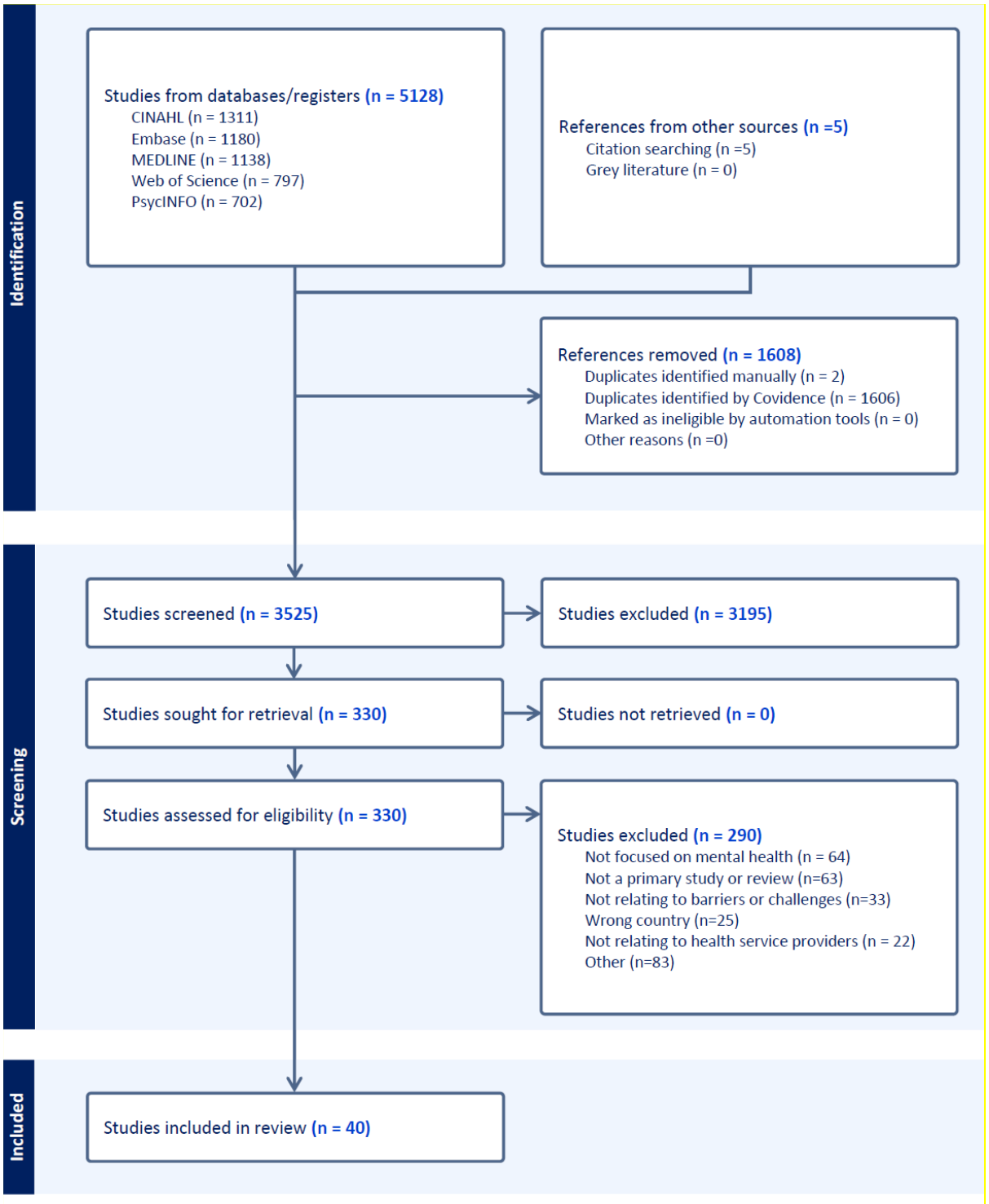
Medline (EBSCO) Friday, January 19, 2024 3:51:22 PM

Search No.	Search Terms	Number of Articles
# S1	AB (LGBT* OR GLBT* OR Gay-Lesbian-Bisexual-Transgender* OR LGBTQ* OR Lesbian-Gay-Bisexual-Transgender* OR queer* OR "Lesbian-Gay-Bisexual-Transgender Queer*" OR queer* OR gay* OR homosexual* OR Lesbian* OR bisexual* OR transgender* OR pansexual* OR bigender* OR trigender* OR asexual OR "Men who have sex with	68,380

	men” OR “Women who have sex with women” OR “gender divers*” OR demisexual* OR bicurious* OR androsexual* OR omnisexual* OR TGD OR nonbinary* OR “non binary gender*” OR “non conforming gender*” OR intersex*) OR TI (LGBT* OR GLBT* OR Gay-Lesbian-Bisexual-Transgender* OR LGBTQ* OR Lesbian-Gay-Bisexual-Transgender* OR queer* OR “Lesbian-Gay-Bisexual-Transgender Queer*” OR queer* OR gay* OR homosexual* OR Lesbian* OR bisexual* OR transgender* OR pansexual* OR bigender* OR trigender* OR asexual OR “Men who have sex with men” OR “Women who have sex with women” OR “gender divers*” OR demisexual* OR bicurious* OR androsexual* OR omnisexual* OR TGD OR nonbinary* OR “non binary gender*” OR “non conforming gender*” OR intersex*)	
# S2	(MH "Transgender Persons") OR (MH "Health Services for Transgender Persons") OR (MH "Intersex Persons") OR (MH "Sexual and Gender Minorities+") OR (MH "Homosexuality, Male") OR (MH "Homosexuality")	45,033
# S3	S1 OR S2	80,162
# S4	(MH "Health Services Accessibility+") OR (MH "Homophobia")	136,618
# S5	TI (attitud* OR barrier* OR challeng* OR hinder* OR hindr* OR bias* OR discriminat* OR gap* OR inequalit* OR disparit* OR unequal* OR restrict* OR stigma* OR percept* OR exclu* OR fear* OR anxiety* OR homophobi* OR transphobi* OR lesbophob* OR transnegativ* OR homonegativ* OR “sexual prejudice*” OR antigay OR stress* OR experien* OR refuse* OR refusal*) N2 (access* OR use* OR usage* OR utilis* OR utiliz*) OR AB (attitud* OR barrier* OR challeng* OR hinder* OR hindr* OR bias* OR discriminat* OR gap* OR inequalit* OR disparit* OR unequal* OR restrict* OR stigma* OR percept* OR exclu* OR fear* OR anxiety* OR homophobi* OR transphobi* OR lesbophob* OR transnegativ* OR homonegativ* OR “sexual prejudice*” OR antigay OR stress* OR experien* OR refuse* OR refusal*) N2 (access* OR use* OR usage* OR utilis* OR utiliz*)	193,015
# S6	S4 OR S5	319,600
# S7	(MH "Mental Health Services+") OR (MH "Mental Health Recovery") OR (MH "Emergency Services, Psychiatric+") OR (MH "Counseling+") OR ((MH "Health Services+") OR (MH "Women's Health Services+") OR (MH "Health Services for the Aged") OR (MH "Preventive Health Services+") OR (MH	2,460,750

	"Rural Health Services+") AND ((MH "Mental Health") OR (MH "Mental Disorders+"))	
# S8	TI (Health* OR care OR nurs* OR medic* OR clinic* OR support* OR service*) N2 (mental* OR psych* OR wellbeing* OR anxiet* OR depress* OR vulnerab* OR suicid* OR crisis* OR counsel*) OR AB (Health* OR care OR nurs* OR medic* OR clinic* OR support* OR service*) N2 (mental* OR psych* OR wellbeing* OR anxiet* OR depress* OR vulnerab* OR suicid* OR crisis* OR counsel*)	469,255
# S9	S7 OR S8	2,800,712
# S10	S3 AND S6 AND S9	1,917
# S11	Limiters - Publication Date: 20180101-20241231	1,138

Appendix 8: PRISMA for Review 3: Barriers/Challenges to Accessing Quality Mental Healthcare.



Appendix 9 Summary Table for Review 3: Barriers/Challenges to Accessing Quality Mental Healthcare.

Author **Date** **Title** **Country** **Study design**	**Aim of study**	Population	**Relevant Findings: Barriers/Challenger** **Best practice / Significance**
Acosta et al. 2019. Identify, Engage, Understand: Supporting Transgender Youth in an Inpatient Psychiatric Hospital. 2019. United States Qualitative	To address the need for better understanding of the experiences of transgender adolescents and psychiatric care providers, to identify areas where existing approaches are both adequately supporting, but also failing to meet the clinical needs of this vulnerable population	Patients, registered nurses, milieu counselors, and social workers.	Inpatient environment was generally considered to be supportive. Barriers included inconsistent identification of trans identity during admission, the presence of birth-assigned name and gender within the system and lack of provider training in transgender cultural competency. Patients found mistakes distressing but most were satisfied when providers acknowledged errors, apologised and corrected themselves. Formal cultural competency education required. System for recording preferred identifier is importance and could convey transgender identity across treatment settings
Bettergarcia et al. 2022. 'There's a stopgap in the conversation': LGBTQ + mental health care and community connection in a semi-rural county. United States Qualitative	To explore mental health experiences, barriers to care, and service needs of LGBTQ+ people in a semi-rural coastal California county.	LGBTQ+ youth and adults living in a semi-rural county in California.	LGBTQ+ people may experience extra barriers to accessing affirming care and building supportive community networks. Participants wanted to give and receive support from other LGBTQ+ people in supportive environments. Participants wanted mental health providers to bridge the gaps in their knowledge that hinder their capacity to adequately serve LGBTQ+ clients.

Bishop et al. 2022. The real and ideal experiences of what culturally competent counselling or psychotherapy service provision means to lesbian, gay and bisexual people. Australia Qualitative	To investigate what culturally competent provision of service means to LGB people through understanding their actual and ideal experience of accessing a counsellor or psychologist	LGB people	Two themes: “creating a safe space” and “modifiable and unmodifiable professional traits”. Modifiable traits: inclusive intention, awareness of heteronormativity, knowledge about issues impacting LGB people and openness to diversity. Unmodifiable traits: service provider age and sexual orientation. LGB people value inclusive, open-minded, knowledgeable and skilful providers. LGB clients may perceive older & heterosexual providers as less culturally competent. Generic cultural competence training is insufficient; mandatory CPD training for counsellors and psychologists is recommended to develop a nuanced and comprehensive understanding of LGB.
Crawford et al. 2023. Functional, communicative, and hybrid barriers to accessing mental health care in LGBTQ+ communities. United States Mixed methods	R1: What are the types and characteristics of different barrier categories that LGBTQ+ participants experienced when pursuing mental health care? R2: How do different barrier categories interact with or compound one another to create care obstructions that are unique to sexual and gender minority communities?	Members of the LGBTQ+ communities	Barriers span a continuum across functional barriers (including finances, time, transport) to communicative barriers (including stigma, trust). Plus is lack of access to trained mental health care professionals providing affirming, appropriate care. Mental health care workforce training in LGBTQ+ specific competencies should be a priority.
Cronin et al., 2021. Mental health help-seeking and barriers to service access among lesbian, gay, and bisexual Australians.	The aim of the present research was to examine: (1) rates of mental health service use among LGB Australians, including rates of use among those endorsing a need to access mental health services (i.e., those experiencing	Lesbian, gay, and bisexual Australians	LGB people have significant unmet mental health needs. Structural barriers include cost, time constraints, and other financial issues.

Australia Survey	clinically significant psychological distress who report that mental health services might be beneficial); (2) barriers to accessing mental health services; (3) whether geographical location (urban vs. non-urban) and barriers to accessing services are associated with rates of service use; and (4) potential gender and age differences in service use and barriers to accessing services		Minority stress barriers included lack of competent professionals, negative treatment, refusal of professionals to work with LGB people. Non-urban participants reported more structural and minority stress barriers. Training for mental health professionals should include use of appropriate language and understanding the differences between sexualities and genders. Mental health professionals should be affirmative.
Cronin et al. 2023. Mental health service use and barriers to accessing services in a cohort of transgender, gender diverse, and non-binary adults in Australia. Australia Survey	To examine mental health service use, satisfaction with services, barriers to accessing services, and desires for tailored interventions in a sample of TGDNB people.	Transgender, Gender Diverse and Non-binary adults in Australia	LGB people experience the same general barriers as others including cost and distance to services. LGB specific barriers include fear of discrimination and perceived lack of appropriately trained practitioners. Women used the services more but also reported more barriers. Barriers to accessing services were negatively associated with mental health service use. Accessibility may be enhanced by specific training for regional and rural practitioners; this can be via accessible methods such as e-learning. Practitioners with experience and knowledge of working with LGB people should advertise and make this more widely known. Where health and mental health care practitioners lack the skills & knowledge to address LGB-related mental health concerns, specific training should be given.
Delaney & McCann 2021.	To explore the personal experiences of transgender people with Irish mental health services	Transgender people living in Ireland	Lack of information and non-affirmative experiences are contributing to poor clinician–patient relationships with transgender populations and impacting attrition.

A phenomenological exploration of transgender people's experiences of mental health services in Ireland. Ireland Qualitative			Services should work collaboratively with trans communities to develop & implement appropriate strategies. Managers & leaders should model respectful and inclusive attitudes. Tangible resources such as gender inclusive literature and forms should be available and visible. Modules including information on the transgender community should be included in nursing curricula and supported by nursing management.
D'souza et al., 2022. The mental health needs of lesbian, gay, bisexual, and transgender (LGBT) refugees: A scoping review. Canada Scoping review	What are the unique mental health challenges and treatment recommendations for LGBT refugee populations?	LGBT refugees	LGBTQ+ refugees may experience their sexual orientation or gender identity differently than Western constructs of LGBT expression. They should be perceived as resilient rather than victims of oppression. LGBT refugees have unique and complex mental health needs LGBT refugees require an affirmative, trauma-informed, intersectional, culturally and racially sensitive approach. It is of key importance to build trust offering safety and stability. Professional interpreters, trained in sexual orientation and gender identity language, can assist in building trust and confidentiality
Ferlatte et al., 2019 Perceived Barriers to Mental Health Services Among Canadian Sexual and Gender Minorities with Depression and at Risk of Suicide. Canada Survey	To examine barriers to mental health services among sexual and gender minorities (SGM) who screened positive for depression and suicide risk.	Sexual or gender minority 18 years+ who screen positive for depression or suicide risk.	Common barriers were structural (cost, access) and internal (wanting to solve on my own, dislike at talking about feelings and emotions) and SGM related (lack of SGM-friendly providers, previous negative experiences with professionals). Transgender, non-binary and queer-identified more frequently reported previous negative experiences and difficulty in finding a SGM or SGM friendly provider.

			Mental healthcare professionals further training SGM sensitivity training. Mental health literacy interventions targeted at SGM individuals may reduce the need for mental health services.
Gaspar et al., 2021. Mental health and structural harm: A qualitative study of sexual minority men's experiences of mental healthcare in Toronto, Canada. Canada Qualitative	A qualitative study of sexual minority men's experiences of mental healthcare	Sexual minority men who had taken part in a larger ENGAGE study	Participants experience both general barriers & sexual minority barriers. General included: financial and logistical obstacles, the prominence of psychiatry and the biomedical model, and unsatisfactory provider encounters. Discussions of general barriers outweighed those of sexual minority barriers. Sexual minority barriers were often rooted in heterosexism and homophobia and included: discrimination & distrust and limited sexual minority affirming options. Effective strategies to address health disparities must take account of both general barriers and sexual minority barriers.
Goetz and Wolk, 2023. Moving toward targeted eating disorder care for transgender, non-binary, and gender expansive patients in the United States. United States Qualitative	To elicit patient and clinician stakeholder needs and preferences regarding TNG-specific ED care (transgender/non-binary/gender expansive people)	TNG people 18+ living in US	Barriers include: inadequate insurance; lack of local providers; clinical gatekeeping; BMI cut-offs for undergoing gender-affirming surgery Also lack of integration between mental health care and gender affirming care. Lack of clinician TNG-competence - clinicians mis-gendering patients, patients fearing discrimination and sex-segregated care. Recommendations include: integration mental health and ED care within interdisciplinary teams. Clinicians should be TNG-competent (or, preferably, TNG), trauma-

			informed, anti-diet/weight-inclusive, anti-racist, and share other pertinent positionalities/identities.
Green et al. 2020. Breaking Barriers to Quality Mental Health Care for LGBTQ Youth The Trevor Project. US	The mission of the Trevor Project is to end suicide among LGBTQ+ young people.	LGBTQ Youth	Financial barriers were the most frequently cited. Other universal barriers included previous negative experiences; transport, location, the need for parental consent; parent refusal of consent; concerns about being outed; concerns about having their LGBTQ identity understood or having too much emphasis placed on their identity and not being able to find a provider who was LGBTQ.
Higgins et al. 2020. LGBTÂ +Â young people's perceptions of barriers to accessing mental health services in Ireland. Ireland Survey	To explore the barriers to mental health care in the Republic of Ireland from the perspectives of young LGBT + people aged 14 to 25	LGBT + people aged 14-25 years	Mental Health System barriers: accessibility & availability of services; previous experiences with services; dominance of medication; lack of cultural competence. Sociocultural barriers: stigma; keeping knowledge of identity from parents; lack of support from family. Individual: perception about the severity of need; belief in ability to cope; lack of confidence. Practices, policies, informational systems and caring environments should be assessed for inclusiveness. All nurses should have cultural competency training. Nurses should promote their service as inclusive and encourage LGBT+ youth to engage with mental health care.
Kahn et al., 2018. Facilitating Mental Health Support for LGBT Forced Migrants: A Qualitative Inquiry.	To understand the facilitators of and barriers to mental health care for LGBT forced migrants in Canada	22 service providers; 7 migrants	Barriers include cultural stigma and shame, mistrust of mental health care and mental health care providers. Participants are unused to talking about mental health symptoms and may hide them. Gatekeepers may hold negative biases, reinforcing internalized stigma and

Canada Qualitative			shame, resulting in missed opportunities for mental health care referrals. Forced LGBT migrants require counsellors working within an intersectional framework taking account of gender, race, ethnicity, culture, class, and migration processes. A multi-pronged approach could incorporate clinic-based treatment and community-based psychosocial support. Community-based groups may decrease isolation and promote mental health.
Kirubarajan et al., 2022. LGBTQ2S+ childbearing individuals and perinatal mental health: A systematic review. Canada Systematic review	To characterise and synthesise the experiences of LGBTQ2S+ childbearing individuals regarding perinatal mental health, including symptomatology, access to care and care-seeking.	Lesbian, gay, bisexual, transgender, queer and Two-Spirit (LGBTQ2S+) individuals [who] choose to conceive, bear and raise children.	Barriers include: stigma and fear of judgement & for employment prospects; fear that children will be taken away. Also finances, waiting lists, transport, childcare, lack of knowledge about postpartum depression; lack of awareness about accessing the system; not prioritising mental health; preference for self-management. Lack of provider knowledge and LGBTQ2S+ exclusion within perinatal mental healthcare. Need to combat heteronormativity and cisnormativity through gender inclusive language. Improved cultural humility of care for LGBTQ2S+ childbearing individuals. Greater information normalising postpartum mental health problems. Specific training.
Mental Health Reform. 2022. A Mixed Methods Exploration of the Views and Experiences of LGBTI+ service users. Ireland	To explore the views and experiences of people who identify as LGBTI and use the mental health services.	LGBTI people	Positive experiences shared by participants were characterised by LGBTI+ competent and sensitive mental health service provision. Negative experiences included: inappropriate questions and comments by some mental health service providers,

Mixed methods			as well as apprehension and even fear among LGBTI+ service users. Also the need 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.
McCann & Brown. 2019. Education and practice developments: Addressing the psychosocial concerns and support needs of LGBT+ people. Ireland Qualitative	The aim of the study was to examine the experiences of people who identify as LGBT+ in relation to their distinct psychosocial support needs.	People who identified as LGBT+ who had experience of mental health services in community and inpatient settings.	There is limited availability of psychological therapies in the public system leading to an over-reliance on medication. Funding a barrier to access therapy in private setting. Need for culturally competent mental health practitioners. LGBTQIA+ education for mental health professionals.
McCann & Brown. 2020a. Psychosocial Needs of Bisexual People: Findings from a Mixed-Methods Research Study. Ireland Mixed methods	To examine the views and experiences of bisexuals in relation to their distinct psychosocial support need	Bisexual people	Patients reported that their sexual or gender identity might be disregarded or dismissed. Alternatively, the mental health problem may be misattributed to the bisexuality. Heteronormativity apparent among some providers MHP need a deeper awareness of specific needs of bisexual people; and should avoid minimizing and dismissing the patient's bisexual identity disclosure. More education about the unique needs of this population.

			More trained therapists with the appropriate knowledge and skills, attitudes and positive values necessary to provide inclusive person-centred assessment, treatment and support relevant to the needs of bisexual people.
McCann & Brown. 2020b. The views and experiences of lesbians regarding their mental health needs and concerns: Qualitative findings from a mixed methods study Ireland Mixed methods	The aim of the study was to identify and present the issues and concerns for lesbians and present recommendations to improve the mental health and wellbeing.	Lesbians	Lesbians have specific psychosocial support and care requiring a culturally competent response from mental healthcare services. Key themes identified were (a) enabling service access, (b) person-centered support, (c) models of care, (d) community presence and participation, and (e) future aspirations for mental health service. Integrating the needs of lesbians and other sexual minority groups within nursing and other health education programmes will contribute to raising the awareness of their distinct needs and concerns within mental health services
McCann et al., 2021a. Experiences and Perceptions of Trans and Gender Non-Binary People Regarding Their Psychosocial Support Needs: A Systematic Review of the Qualitative Research Evidence Ireland Systematic review	To systematically evaluate the best available evidence on the experiences and perceptions of trans and non-binary people regarding their psychosocial needs, and to identify aspects that may influence access to necessary psychosocial interventions and supports	LGB individuals	Some healthcare settings can be oppressive spaces for transgender people Four themes were identified: (i) stigma, discrimination and marginalization (ii) trans affirmative experiences (iii) formal and informal supports, and (iv) healthcare access. Barriers to quality care include stigmatising organisational and institutional cultures. Barriers are a result of lack of knowledge, misinformation and/or experience, bias. There exists a need to ensure that the assessments, interventions and supports provided to trans patients is culturally competent and responsive to their concerns

McCann et al. 2021b. The views and experiences of bisexual people regarding their psychosocial support needs: a qualitative evidence synthesis. Ireland Qualitative evidence synthesis	To synthesize the best available evidence on the views and experiences of bisexual people regarding their psychosocial needs and to establish factors that may support or inhibit access to appropriate psychosocial interventions and supports	Bisexual people	The mental health needs of bisexuals are poorly understood; extant research emanates from North America and Australia and there is none from Europe. Marginalisation & social exclusion compounds poor mental health, however bisexuals are reluctant to disclose their sexual identity fearing discrimination. Mental health professionals should be culturally competent. Personal disclosure should be integrated into assessment & treatment plans and not dismissed or ignored. Treatment options should include psychotherapies and wider networks of support and extend beyond psychopharmacological interventions. Education for primary care and increased access to mental health support are urgently needed
Moore et al., 2020. A Qualitative Investigation of Engagement in Mental Health Services Among Black and Hispanic LGB Young Adults. United States Qualitative	To assess the service use experiences of black and Hispanic lesbian, gay, and bisexual (LGB) young adults to identify factors that promoted or hindered their engagement	Young adults aged 18 to 25, who identified as black-African American or as Hispanic-Latinx and as a sexual minority (including LGB) and reported they had received mental health services within past year.	Engagement with services were influenced by personal, social environment, accessibility, and provider characteristics factors. Other barriers included sigma, availability, cost, lack of support and doubts about treatment efficacy. Recommendations include: targeted outreach in informal settings; peer support; using social media to improve mental health literacy and ability to navigate health systems; matching marginalised youth with provider with similar identity LGB-competent care providers should advertise / list their service. Visual cues that a service is LGB friendly.
Morris et al. 2022.	To assess (1) whether participants had any expectations of stigma or	Sexual minority adults	Fear of disclosure and the perceived lack of understanding and / the omission of discussion around

Sexual minority service user perspectives on mental health treatment barriers to care and service improvements. UK Qualitative	discrimination prior to accessing support, and the extent to which these expectations were borne out; (2) whether their sexuality played a role in their experience of treatment, including: the extent of sexual orientation disclosure, the relevance of their sexuality to their presenting problems and whether therapists asked about such issues; (3) how services could better serve sexual minority people.		sexuality were identified as barriers to effective relationships. User experiences would be enhanced through tailored support, visible cues about inclusivity and by seeing practitioners with shared identities and experiences, and by greater sexual minority training.
McNair et al., 2018. Health service use by same-sex attracted Australian women for alcohol and mental health issues: a cross-sectional study. Australia Survey	To investigate the influences on health service use for alcohol and mental health problems among SSAW	Same-sex attracted women (SSAW)	Barriers to treatment for mental health and alcohol-related issues included: being judged about alcohol use, not feeling ready, unable to access due to transport or costs etc, previous experience; confidentiality fears, lack of relevant information, fear of or experience of discrimination sexual orientation or gender identity. Trusted non-judgemental, inclusive GP care is correlated with improved utilisation of alcohol and mental health treatment for SSAW. Targeted community education may raise awareness and encourage treatment utilisation
McNamara & Wilson, 2020. Lesbian, gay and bisexual individuals experience of mental health services - a systematic review. Ireland	To examine studies which encompass LGB individuals' actual experience of mental health services, specifically in relation to their sexual identity, and to develop themes that represent those experiences.	Lesbian, gay and bisexual individuals	Some practitioners display discomfort or demonstrate poor cultural awareness. Practitioners may be dismissive of sexual identity and show no knowledge or understanding of same. Clients experience discrimination and mental health difficulties were pathologised or linked to sexual identity.

Systematic review			Positive experiences occurred when practitioners were knowledgeable and culturally aware and when they had good counselling skills. Practitioners could advertise, including in waiting rooms that they are LGB affirming. Education and ongoing training essential. Affirming strategies would include asking about sexuality and inquiries about partners using gender neutral language.
Nematy et al. 2022. Lgbtqi + refugees' and asylum seekers' mental health: A qualitative systematic review. Ireland Systematic review	To retrieve, critically appraise, and synthesize the evidence from qualitative data broadly relevant to mental health in the LGBTQI+forced migrants	LGBTQI+ refugees and asylum seekers	LGBTQI+ experience the same challenges as non LGBTQI+ refugees and asylum seekers including language, cultural and financial barriers as well as fear of deportation. Additionally, LGBTQI+ may have to internalized shame or fear of discrimination and may fear that engagement with the health services or use of interpreters would lead to exposure and further stigma. Distance from LGBTQI+friendly service providers and support groups was a further barrier. The needs of people within the LGBT communities should be served by mental health services that challenge heteronormative assumptions and promote self-acceptance and equity.
O' Brien et al. 2023 Experiences of transgender and gender diverse patients in emergency psychiatric settings: A scoping review. 2023 United States	To identify: "What has been published regarding the experiences of TGD individuals in emergency psychiatric settings and what gaps remain in our understanding of this topic?	Transgender and gender diverse (TGD) individuals in emergency psychiatric settings	TGD individuals were younger, more likely to live outside of rural areas, and be vulnerable to other social inequalities. More likely to have diagnosis of mood disorders, personality disorders, or psychotic disorders and have higher rates of NSSI & suicide. TGD individuals experience higher rates of service denial.

Systematic review			Emergency psychiatric settings should be inclusive, non-judgemental, affirmative, therapeutic, confidential.
Panchal et al. 2022. Providing supportive transgender mental health care: A systemized narrative review of patient experiences, preferences, and outcomes. Australia	Aims were to: 1. identify and synthesize current research on mental health care experiences, preferences and outcomes for transgender populations. 2. Provide a preliminary discussion of features of supportive and effective transgender mental health care. 3. Identify gaps in the literature and areas for future research.	Transgender	Identified barriers included: Lack of provider knowledge, awareness or expertise in transgender issues Unsafe or discriminatory care Pathologizing of gender identity Negative gatekeeping Insensitivity/lack of empathy
Rees et al. 2021 The lesbian, gay, bisexual and transgender communities' mental health care needs and experiences of mental health services: An integrative review of qualitative studies. New Zealand Integrative review of qualitative research	To identify the mental health needs of the LGBT communities and their experiences of accessing mental health care	Lesbian, gay, bisexual and transgender people	Mental health services reinforce stigma and demonstrate a lack of understanding of the specific needs of the LGBT community. The needs of people within the LGBT communities should be served by mental health services that challenge heteronormative assumptions and promote self-acceptance and equity. Greater knowledge of LGBT health and psychosocial care is required, and clinical skills must be grounded in professional ethics, guidelines, and standards of care.
Reisner et al. 2022. Gender-Affirming Mental Health Care Access and Utilization Among Rural Transgender and Gender Diverse Adults in Five Northeastern U.S. States.	This study sought to characterize gender-affirming mental health service access and utilization in a sample of TGD adults from predominantly rural areas in the northeastern United States.	Rural Transgender and Gender Diverse Adults	Common barriers to gender-affirming mental health services were lack of trained providers, lack of mental health integration with primary care, financial costs, difficulty scheduling, distances that were too far, and transportation issues.

United States Survey			Factors most important in choosing a mental health care provider were health insurance, gender-affirming care, rapport, and availability. Recommendations included: provision of integrated care; linkages between primary care and psychiatric services; provision of education for MHPs to increase cultural competence; use of tele mental health.
Reynish et al. 2023 Psychological Distress, Resilience, and Help-Seeking Experiences of LGBTIQA+ People in Rural Australia. Australia Mixed methods	To explore the mental health, the aspects associated with psychological distress and resilience, and the help-seeking experiences of LGBTIQA+ people in rural Tasmania, which can help improve MHP knowledge on minority populations.	LGBTIQA+ people	Barriers included lack of local mental health professionals, lack of trusted mental health professionals, restrictive operating times, travel. Acceptance, access and proximity to care, and mental health professionals' cultural competence is required. Also, improvements in public education, mental health professionals' curricula, and provide inclusive and tailored mental health care.
Ross et al. 2018. In spite of the system: A qualitatively-driven mixed methods analysis of the mental health services experiences of LGBTQ people living in poverty in Ontario, Canada. Canada Mixed methods	What are the mental health service experiences of Ontario sexual minority women and/or trans people living in poverty?	Lesbian, gay, bisexual, trans, and/or queer (LGBTQ) people	Despite seeing more mental health professionals, low-income LGBTQ individuals had more unmet needs than all other LGBTQ/income groups. Barriers include intersectional oppressions on the employment and financial levels and meeting basic needs with limited resources; and intersectional oppressions on the employment and financial levels and meeting basic needs with limited resources; and providers' lack of knowledge and unwillingness to address the relevant issues. The focus on individual "disorders" reproduces inequalities.

			The dominant biomedical model is incapable of addressing the fundamental impact of social discrimination. Reform needs to happen at a structural level.
Roulston et al. 2023. Structural Correlates of Mental Health Support Access among Sexual Minority Youth of Color during COVID-19. United States Secondary data analysis	How frequently are SMYoC adolescents 13 to 16 able to access mental health support when they need it during the COVID-19 pandemic? (2) Do SMYoC adolescents living in states characterized by higher anti-Black racism and higher homophobia report less access to mental health support, relative to those living in states with lower levels of anti-Black racism and lower levels of homophobia? (3) Do state-levels of homophobia and anti-Black racism relate to adolescents' perceived access to mental health support over and above local availability of mental healthcare providers and state- level income inequality	Adolescents who (1) self-identified as sexual minority youth of Color (SMYoC), and (2) who endorsed any interest in accessing mental health support since the COVID-19 pandemic began in February 2020	Shortage of state level mental health care providers. Importance of considering diverse structural factors and taking an intersectional approach to the provision of mental health treatment. Recommends the use of digital mental health interventions to increase access
Schuller & Crawford. 2022. Impact of interpersonal client-provider relationship on satisfaction with mental healthcare among the LGBTQ+ population. United States Survey	To determine which aspects of the client / provider relationship affected perceived satisfaction with the quality of mental healthcare received.	LGBTQ+ individuals	LGBTQ+ individuals' care-seeking behaviour is impacted by their perception of the quality of the mental healthcare services. Negative experiences included lack of trust in provider, perception of being negatively judged and dissatisfaction with length of therapeutic encounters. The effects of gender-affirming hormone therapy on mood and their impact the perinatal period among transgender individuals

			Education to increase healthcare professionals' cultural competence including awareness and attitude. More mental health professionals from the sexual / gender minority communities.
Silveri et al. 2022. Barriers in care pathways and unmet mental health needs in LGBTIQ plus communities Italy Narrative review	The aim of this paper was to review the literature around the barriers to pathways of care, and to indicate what the unmet mental health care needs are that may be experienced by LQBTIQ+ populations	Transgender and gender diverse (TGD) individuals in emergency psychiatric settings	Barriers which may limit LGBTQ+'s use of mental health services include: unwelcoming health care environments, discrimination, perceived lack of culturally competent HCPs, limited gender-affirming options, non- affirming health care providers, and institutional practices that inhibit the delivery of gender-affirming care Mental health inequalities will be reduced when LGBTIQ+ people become visible in health care services and such services are friendly and welcoming to LGBTQ+ people
Stojanovski et al. 2022. Stigma shapes lesbian, gay, bisexual, transgender, and queer person's mental health and experiences with mental health services in North Macedonia. United States Qualitative	To identify the mental health needs of Macedonian LGBTQ+ individuals, the factors that shape their mental health needs, and their experiences with mental health services	Lesbian, gay, bisexual, transgender, and queer people	Barriers: societal stigmatisation, institutional discrimination and stigma, transphobia within mental health services, lack of accessibility, and poor quality of services Recommendations include: partnering with LGBTQ+ affirming mental health professionals; expanding teletherapy services; structural and community-level interventions to address the stigma and discrimination against LGBTQ+ people and support their mental health
Smith et al. 2019. Mental Health Care for LGBT Older Adults in Long-Term Care Settings: Competency, Training, and Barriers for Mental Health Providers.	To assess mental health providers' experience with LGBT older adults in long-term care (LTC) settings and perceived barriers to quality care	Mental health providers working on long-term care setting for older people.	Low level of education on LGBTQIA+ issues despite high willingness to receive this education. Barriers to care include: lack of education, stigma, older person not disclosing LGBT identity. More training required on issues relevant to mental and physical health needs of LGBT older adults.

US Survey			LGBT-appropriate mental health practices that are effective in LTC settings should be developed and tested. Visible signage identifying the facility as a safe space and policies assessing all patients' sexual orientation and gender identity are required.
Tan et al. 2022. 'It's how the world around you treats you for being trans': mental health and wellbeing of transgender people in Aotearoa New Zealand. New Zealand Survey	To analyse open-text survey responses from a large nationwide sample of transgender people, with the objective of exploring the mental health needs of transgender people.	Transgender people aged 14 years or older	Key themes included: Pathologising of trans identity. Conversion practices experiences. Lack of trans knowledge among mental health professionals, and a lack of trans affirming care. MHPs need to be knowledgeable about latest guidelines to inform practice. Cultural competency is required. The informed consent model should be considered as an alternative to the DSM.
Taylor et al. 2021. Bisexuals' experiences of mental health services: Findings from the Who I am study. Australia Cross sectional survey	To provide further insights into bisexual peoples' access to, and experiences of, mental health services	Bisexual people	Bisexuals are highly engaged in mental health services but experience barriers in disclosing their sexual orientation. Most want access to services specialising in working with bisexuals. Service providers, specifically GPs and psychologists, require greater education / information about LGBT mental health and barriers to service access. Visual clues indicating that a service provider is be knowledgeable about bisexuality and able to assist bisexual clients with mental health concerns would support clients to feel safe to disclose.

			Services specialising in healthcare for bisexuals should be developed.
White & Fontenot (2019). Transgender and non-conforming persons' mental healthcare experiences: An integrative review. US Integrative review	The purpose of this integrative review is to better understand the firsthand mental healthcare experiences of TGNC persons.	Transgender and gender non-conforming people	Examples of positive practices were provided including affirmative and knowledgeable care from MHPs Negative practices included stigma, lack of knowledge, intersectional insensitivity, Mental healthcare providers and nurses would benefit from interventions to promote TGNC culturally competent care, including in-service training or continuing education for the current work force. TGNC content should be incorporated into pre-licensure educational curricula. A welcoming environment with visible cues of LGBTQIA+ affirming messages should be evident.

Appendix 10: Search Strategy for Review 4- Policies/Best Practice Recommendations

From 2018-2023

Concept 1:
CINAHL: (MH "LGBTQ+ Persons+") OR (MH "Gay Persons+") OR (MH "Transgender Persons+") OR (MH "Gay Men") OR (MH "Men Who Have Sex With Men") OR (MH "Gender-Nonconforming Persons+") OR (MH "Nonbinary Persons") OR (MH "Sexual and Gender Minorities+")

Medline: (MH "Homosexuality, Male") OR (MH "Homosexuality") OR (MH "Transgender Persons") OR (MH "Health Services for Transgender Persons") OR (MH "Intersex Persons") OR (MH "Sexual and Gender Minorities+")

EMBASE: 'LGBTQIA+ people'/exp OR 'transgender and gender nonbinary'/exp OR 'sexual and gender minority'/exp OR 'homosexuality'/exp OR 'gender nonbinary'/exp

PsychINFO: DE "LGBTQ" OR DE "Asexuality" OR DE "Bisexuality" OR DE "Homosexuality" OR DE "Intersex" OR DE "Transgender" OR DE "Transsexualism" OR DE "Sexual Minority Groups" OR DE "Transgender (Attitudes Toward)" OR DE "Transgender" OR DE "Gender Nonbinary"

Web of Science keywords run on topic only

Keywords: LGBT* OR GLBT* OR Gay-Lesbian-Bisexual-Transgender* OR LGBTQ* OR Lesbian-Gay-Bisexual-Transgender* OR queer* OR “Lesbian-Gay-Bisexual-Transgender Queer*” OR queer* OR gay* OR homosexual* OR Lesbian* OR bisexual* OR transgender* OR pansexual* OR bigender* OR trigender* OR asexual OR “Men who have sex with men” OR “Women who have sex with women” OR “gender divers*” OR demisexual* OR bicurious* OR androsexual* OR omnisexual* OR TGD OR nonbinary* OR “non binary gender*” OR “non conforming gender*”

EMBASE: 'lgbt*':ab,ti OR glbt*:ab,ti OR 'gay lesbian bisexual transgender*':ab,ti OR lgbtq:ab,ti OR lgbtq+:ab,ti OR 'lesbian gay bisexual transgender*':ab,ti OR 'lesbian-gay-bisexual-transgender queer*':ab,ti OR queer*:ab,ti OR gay*:ab,ti OR homosexual*:ab,ti OR lesbian*:ab,ti OR bisexual*:ab,ti OR transgender*:ab,ti OR pansexual*:ab,ti OR bigender*:ab,ti OR trigender:ab,ti OR asexual:ab,ti OR 'men who have sex with men':ab,ti OR 'women who have sex with women':ab,ti OR 'gender divers*':ab,ti OR demisexual*:ab,ti OR bicurious:ab,ti OR androsexual*:ab,ti OR omnisexual*:ab,ti OR tgd:ab,ti OR nonbinary:ab,ti OR 'non binary gender*':ab,ti OR 'non conforming gender*':ab,ti

Concept 2 Mental Health Services
EMBASE: (('health service'/exp OR 'health care facilities and services'/exp) AND ('mental health'/exp OR 'mental disease'/exp)) OR 'mental health care'/exp OR 'mental health service'/exp

Medline (MH "Mental Health Services+") OR (MH "Mental Health Recovery") OR (MH "Emergency Services, Psychiatric+") OR (MH "Counseling+") OR ((MH "Health Services+") OR (MH "Women's Health Services+") OR (MH "Health Services for the Aged") OR (MH "Preventive Health Services+") OR (MH "Rural Health Services+")) AND ((MH "Mental Health") OR (MH "Mental Disorders+"))

CINAHL: (MH "Mental Health Services+") OR (MH "Counseling+")

PsycINFO: DE "Preventive Mental Health Services" OR DE "Mental Health Services" OR DE "Psychological First Aid" OR DE "School Based Mental Health Services" OR DE "Community Mental Health Services" OR DE "Community Counseling" OR DE "Community Mental Health Centers" OR DE "Mental Health Disparities" OR DE "Mental Health Parity" OR DE "Mental Health Programs" OR DE "Crisis Intervention Services" OR DE "Deinstitutionalization" OR DE "Hot Line Services" OR DE "Suicide Prevention Centers" OR DE "Psychiatric Hospital Programs" OR DE "Preventive Mental Health Services" OR DE "Behavioral Health Services"

WOS: Keywords run on topic

EMBASE Keywords: (Health* OR care OR nurs* OR medic* OR clinic* OR support* OR service*) NEAR/2 (mental* OR psych* OR wellbeing* OR anxiet* OR depress* OR vulnerab* OR suicid* OR crisis*)

EBSCO Keywords: (Health* OR care OR nurs* OR medic* OR clinic* OR support* OR service* OR counsel*) N2 (mental* OR psych* OR wellbeing* OR anxiet* OR depress* OR vulnerab* OR suicid* OR crisis*)

Concept 3: Policy & Practice
EMBASE: 'policy'/exp OR 'best practice'/exp OR 'framework'/exp OR 'law'/exp

Medline: (MH "Legislation as Topic+") OR (MH "Policy+") OR (MH "Public Policy+") OR (MH "Health Policy+") OR (MH "Policy Making+") OR (MH "International Law") OR (MH "Practice Guidelines as Topic") OR (MH "Guidelines as Topic+")

CINAHL: (MH "Guideline Adherence") OR (MH "Legislation+") OR (MH "Hospital Policies+") OR (MH "Rules and Regulations") OR (MH "Public Policy+") OR (MH "Organizational Policies+") OR (MH "Legislation, Medical+") OR (MH "Legislation, Nursing+") OR (MH "Practice Guidelines") OR (MH "Parliamentary Practice") OR (MH "Guideline Adherence") OR (MH "Professional Regulation") OR (MH "Government Regulations+") OR (MH "Conceptual Framework")

PsycINFO: DE "Laws" OR DE "Abortion Laws" OR DE "Affordable Care Act" OR DE "Discrimination Laws" OR DE "Drug Laws" OR DE "Law (Government)" OR DE "Civil Law" OR DE "Criminal Law" OR DE "Discrimination Laws" OR DE "Best Practices" OR DE "Clinical Practice" OR DE "Professional Boundaries" OR DE "Clinical Governance"
Web of Science: topic search on keywords

EMBASE: 'best practice*':ab,ti OR policy:ab,ti OR policies:ab,ti OR 'service strateg*':ab,ti OR standard*:ab,ti OR guidance*:ab,ti OR guideline*:ab,ti OR 'service* framework*':ab,ti OR 'code* of practice':ab,ti OR pathway:ab,ti OR legislat*:ab,ti OR 'governance*':ab,ti OR 'discriminat* act*':ab,ti OR '**Homosexual** act':ab,ti OR "sexual offences act*" OR decriminal*:ab,ti

EBSCO Keywords title and abstract "best practice*" OR policy OR policies OR "service strateg*" OR standard* OR guidance* OR guideline* OR "service* framework*" OR "code* of practice" OR pathway* OR legislat* OR governance* OR "discriminat* act*" OR "**Homosexual** act*" OR "sexual offences act*" OR decriminal*

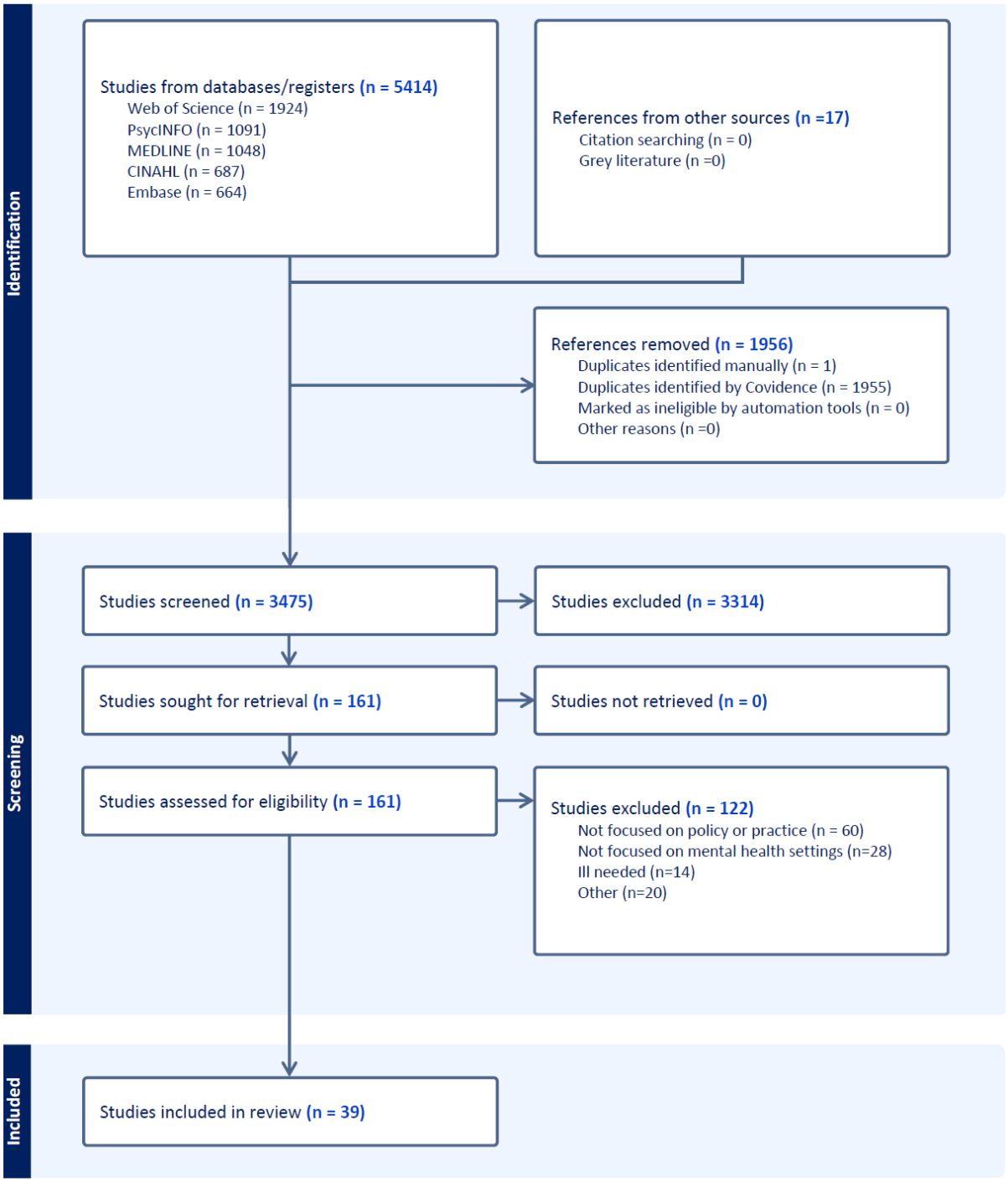
Medline: Friday, January 19 2024.

Search No.	Search Terms	Number of Articles
# S1	AB ("best practice*" OR policy OR policies OR "service strateg*" OR standard* OR guidance* OR guideline* OR "service* framework*" OR "code* of practice" OR pathway* OR	3,950,147

	legislat* OR governance* OR “discriminat* act*” OR “Homosexual act*” OR “sexual offences act*” OR decriminal*) OR TI (“best practice*” OR policy OR policies OR “service strateg*” OR standard* OR guidance* OR guideline* OR “service* framework*” OR “code* of practice” OR pathway* OR legislat* OR governance* OR “discriminat* act*” OR “Homosexual act*” OR “sexual offences act*” OR decriminal*)	
# S2	(MH "Legislation as Topic+") OR (MH "Policy+") OR (MH "Public Policy+") OR (MH "Health Policy+") OR (MH "Policy Making+") OR (MH "International Law") OR (MH "Practice Guidelines as Topic") OR (MH "Guidelines as Topic+")	533,416
# S3	S1 OR S2	4,276,931
# S4	AB ((Health* OR care OR nurs* OR medic* OR clinic* OR support* OR service* OR counsel*) N2 (mental* OR psych* OR wellbeing* OR anxiet* OR depress* OR vulnerab* OR suicid* OR crisis*)) OR TI ((Health* OR care OR nurs* OR medic* OR clinic* OR support* OR service* OR counsel*) N2 (mental* OR psych* OR wellbeing* OR anxiet* OR depress* OR vulnerab* OR suicid* OR crisis*))	452,867
# S5	(MH "Mental Health Services+") OR (MH "Mental Health Recovery") OR (MH "Emergency Services, Psychiatric+") OR (MH "Counseling+") OR ((MH "Health Services+") OR (MH "Women's Health Services+") OR (MH "Health Services for the Aged") OR (MH "Preventive Health Services+") OR (MH "Rural Health Services+")) AND ((MH "Mental Health") OR (MH "Mental Disorders+"))	288,315
# S6	S4 OR S5	663,222
# S7	AB (LGBT* OR GLBT* OR Gay-Lesbian-Bisexual-Transgender* OR LGBTQ* OR Lesbian-Gay-Bisexual-Transgender* OR queer* OR “Lesbian-Gay-Bisexual-Transgender Queer*” OR queer* OR gay* OR homosexual* OR Lesbian* OR bisexual* OR transgender* OR pansexual* OR bigender* OR trigender* OR asexual OR “Men who have sex with men” OR “Women who have sex with women” OR “gender divers*” OR demisexual* OR bicurious* OR androsexual* OR omnisexual* OR TGD OR nonbinary* OR “non binary gender*” OR “non conforming gender*”) OR TI (LGBT* OR GLBT* OR Gay-Lesbian-Bisexual-Transgender* OR LGBTQ* OR Lesbian-Gay-Bisexual-Transgender* OR queer* OR “Lesbian-Gay-Bisexual-Transgender Queer*” OR queer* OR gay* OR homosexual* OR Lesbian* OR bisexual* OR transgender* OR pansexual* OR bigender* OR trigender* OR asexual OR “Men who have sex with men” OR “Women who have sex with women” OR “gender divers*” OR demisexual* OR bicurious* OR androsexual* OR omnisexual* OR TGD OR nonbinary* OR “non binary gender*” OR “non conforming gender*”)	65,219
# S8	(MH "Transgender Persons") OR (MH "Health Services for Transgender Persons") OR (MH "Intersex Persons") OR (MH "Sexual and Gender Minorities+") OR (MH "Homosexuality, Male") OR (MH "Homosexuality")	45,033
# S9	S7 OR S8	77,035

# S10	S3 AND S6 AND S9	1,689
# S11	Limiters - Publication Date: 20180101-20241231	1,048

Appendix 11: PRISMA for Review 4- Policies/Best Practice Recommendations



Appendix 12a: Summary Table for Review 4: organisational policies/guidelines/best practice recommendations on LGBTQI+ mental health service provision.

Author Year Organisation Country	Population	Key recommendations relevant to this review
American Psychiatric Association. 2018. Position Statement on Conversion Therapy and LGBTQ Patients. American Psychiatric Association. US	LGBTQ people	1. APA reaffirms its recommendation that ethical practitioners refrain from attempts to change individuals' sexual orientation. 2. APA recommends that ethical practitioners respect the identities for those with diverse gender expressions. 3. APA encourages psychotherapies which affirm individuals' sexual orientations and gender identities. 4. APA encourages legislation which would prohibit the practice of "reparative" or conversion therapies that are based on the a priori assumption that diverse sexual orientations and gender identities are mentally ill.
American Psychiatric Association. 2020. Position Statement on Issues Related to Sexual Orientation and Gender Minority Status American Psychiatric Association. US	Sexual orientation and gender minorities	1. APA reaffirms that sexual orientation and gender minority status, whether expressed in action, fantasy, or identity, implies no impairment per se in judgment, stability, reliability, or general social or vocational capabilities. 2. APA supports the use of diverse-affirming mental health treatments 3. APA condemns any practice that aims to change one's sexual orientation or gender expression in the form of conversion therapy, or any other similar type of therapy, as ethically and morally wrong. 4. APA opposes discrimination against those with diverse sexual orientations and gender identities whether it be in education, employment, military service, immigration and naturalization status, housing, income, eligibility for government services, retirement benefits, property inheritance, rights of survivorship, spousal rights, family status, access to health services, and legal right to marry, adopt and co-parent.
American Psychiatric Association. Best Practice Highlights: Working with LGBTQ Patients. No year provided – live document	LGBTQ	1. With new patients, create an accepting and affirming environment by not assuming sexual orientation or gender identity. We should be sensitive to patients in transition, and ask both how they'd like to be addressed as well as use the appropriate pronoun. 2. Assess level of openness and self-acceptance.

US		3. Be aware that there is NO basis for so-called “conversion or reparative” therapy which are unscientific attempts to change sexual orientation through shame-based efforts that result in depression, anxiety, and increased suicidality. All major health groups condemn such attempts. 4. Be aware that families can be helped to accept their gay or lesbian children and that in turn leads to greatly reduced suicidality and anxiety in such youth given the risk of suicide, be comfortable to ask about risk and resilience factors.
ANA Ethics Advisory Board. 2019. American Nurses Association Position Statement: Nursing Advocacy for LGBTQ+ Population. American Nurses Association US	LGBTQ+	1. ANA supports efforts to defend and protect the human and civil rights of all members of LGBTQ+ populations. 2. ANA advocates for the rights of all members of LGBTQ+ populations to live, work, study, or serve in the armed services without discrimination or negative activities, such as bullying, violence, incivility, harassment, or bias. 3. ANA affirms the need for nurses in all roles and settings to provide culturally congruent, competent, sensitive, safe, inclusive, and ethical care to members of LGBTQ+ populations, as well as to be informed and educated about the provision of culturally competent care. 4. ANA condemns any discrimination based on sexual orientation, gender identity, and/or gender expression in access to or provision of healthcare. 5. ANA advocates for patients and families in LGBTQ+ populations.
Bhugra et al. 2022. IPR commission: sexual minorities and mental health: global perspectives. International Review of Psychiatry Commission Global	LGB people only	**Policy:** Policymakers should include impact assessment of their policies on LBG mental health. Equity delivered in law and reality to improve outcomes for LGB people. Equitable funding for research, training and delivery of services. All forms of conversion therapies should be banned. **Clinical services and Clinicians:** 1. Therapists should receive training on the impact of self-disclosure, and awareness of prejudices. 2. Psychotherapy training should include teaching on sexual minority identity, development and cultures. 3. All health staff should have training in sexual minority cultural competence including the promotion of affirmative approaches. 4. Services should demonstrate their inclusiveness through visible means and in practice. 5. Workplace network and support groups for staff from sexual minorities in mental health provider organisations should be encouraged. 6. All healthcare employees should be encouraged to become actively involved in ensuring the organisation’s approach to diversity and equality includes sexual minorities. 7. Clinicians offering conversion therapies should be reported to their respective regulatory bodies and appropriate actions should be instigated. 8. National organisations must lead by example.

British Psychological Society (2019) (currently undergoing a mid-way review) Guidelines for psychologists working with gender, sexuality and relationship diversity. British Psychological Society UK	LGBT aged 18 and over	Guidelines for psychologists under the headings of: 1. Psychology and gender, sexuality and relationship diversity. 2. The Socio-political context and attitudes towards gender, sexuality and relationship diversity. 3. Gender, sexual and relationship diverse identities and practices. 4. Families and friends**.** 5. Diversity and intersectionality. 6. Lifespan development. 7. Education, training and personal development.
Coleman et al. 2022. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. World Professional Association for Transgender Health (WPATH) Global	Transgender and Gender Diverse People	**Recommendations for Best Practice in Mental Health Care for Trans people:** Address mental health symptoms that interfere with a person's capacity to consent to gender-affirming treatment before such treatment is initiated. Offer care and support to TGD people to address mental health symptoms that interfere with a person's capacity to participate in essential perioperative care before gender-affirmation surgery. Assess the potential negative impact that significant mental health symptoms or substance abuse may have on outcomes based on the nature of the specific gender-affirming surgical procedure. Existing hormone treatment should be maintained if a transgender and gender diverse individual is admitted to a psychiatric or medical inpatient unit, unless contraindicated. All staff should use the correct name and pronouns (as provided by the patient) and provide access to bathroom and sleeping arrangements that are aligned with the person's gender identity. Transgender and gender diverse people should be support and empowered to develop and maintain social support systems, including peers, friends, and families. Psychotherapy prior to the initiation of gender-affirming treatment should not be mandatory. "Reparative" and "conversion" therapy should not be offered.
European Psychiatric Association. 2022.	LGBTQ people	The EPA encourages legislation which bans conversion therapies.

Conversion therapies and LGBTQ Patients – position statement. European Psychiatric Association Europe.		The EPA condemns so-called conversion ”therapies“ because they constitute violations of human rights and are unjustifiable practices that should be banned and subject to sanctions and penalties. The EPA encourages psychotherapies which affirm individuals' sexual orientations and gender identities and respect the identities for those with diverse gender expressions.
Hannan et al. 2022. LGBTQ+ inclusive & affirming practice guidelines for alcohol, substance use, and mental health services and treatment providers (2nd ed). ACON Health Australia	LGBTQ+ people	4 guiding principles for workers and organisations to be inclusive of all people of diverse genders and sexualities: 1. Trauma-informed recovery-orientated and person led practice. 2. Intersectional lens 3. Community consultation and codesign, co-production, co-implementation and co-evaluation. 4. Family inclusive approach. Guidance on an inclusive and affirming client journey checklist: 1. Organisational and staff development 2. Visibility and cultural safety 3. Disclosure and consent 4. Access, intake, and assessment procedures 5. Data collection 6. Affirmative therapeutic relationship 7. Support planning 8. Building inclusive referral pathways
Health Service Executive. 2021. HSE Rainbow Badge Practice Guide for Healthcare Professionals. HSE Ireland	LGBTQ+	Guidance on inclusion at both service level and clinician level including: How a HSP should respond if a person comes out about their LGBTI+ identity for the first time; how a HSP should respond if a person discloses their LGBTI+ identity. Use of names and pronouns. Unless it is relevant to assisting the person, or if you practice in an inclusive way by asking all people about their identity, do not ask the person if they are LGBTI+. If relevant and you are in doubt about how to talk with the person about their LGBTI+ experience(s), seek permission from the person to ask questions. For a patient who is transitioning, unless it is expressly relevant to the care and treatment planned, a patient should not be asked about their body, genitals, medical history, plans for medical procedures, their previous name, or invasive questioning about their lives prior to questioning.

		When mistakes are made: listen; be accountable; commit to do better. List of Do's and Don'ts
Lipshie-Williams 2020. The peculiar case of the Standards of Care: Ethical ramifications of deviating from informed consent in transgender-specific healthcare. US	Transgender	The authors contrast the Standard of Care model of consent which is widely used for the provision of transgender-specific health care within the US, with the individually provided informed consent model which is the majority model of medical consent. Ethical issues are considered and discussed.
McNulty et al. 2022. What works in early intervention mental health supports for LGBTQ+ young people? Guidance for NHS Commissioners. UK	LGBTQ+	Affirming service Intersectional service Accessible service Knowledgeable staff Strengths-based Staff diversity Co-production
Mental Welfare Commission. 2022. LGBT Inclusive Mental Health Services: Good Practice Guide. Mental Welfare Commission. Scotland.	LGBT	Guidance on 3 key areas: 1. Individual practitioner: avoid assumptions, avoid inappropriate questions, acknowledge LGBT partners and carers 2. Environment. Assess for inclusivity, challenge discrimination – speak up, LGBT awareness training, clear discrimination policies, monitoring sexual orientation and gender identity of service users (to ensure adequate services are in place. 3. Equality and human rights. Everybody, whether they are lesbian, gay, bisexual or heterosexual, is protected from discrimination based on their sexual orientation. Public bodies, such as the NHS, must consider: eliminating discrimination, harassment and victimisation; advancing equality of opportunity and fostering good relations between different groups.
Nakamura et al. 2022. APA Guidelines for Psychological Practices with Sexual Minority Persons. An Executive Summary of 2021 revision. American Psychological Association	LGBTQ	1. Consider intersectionality. Recognise that people can experience oppression and privilege simultaneously. 2. Recognise and challenge own views on the interactions between SO, gender identity and gender expression and assist others in understanding. 3. Refute binegative stereotypes and utilise bisensitive approaches to therapy. 4. Avoidance of SOCE - adopt affirmative principles and practices 5. Understand impact of institutional discrimination and be prepared to address them in therapy. Advocate for inclusive policies in work setting.

USA		6. Consider how distal minority stress increases cumulative burden of stress. Integrate trauma-informed care into practice. 7. Address internalised heterosexism and stigma strive to enhance coping strategies to engage in health promoting strategies. Consider interventions that facilitate authentic decision making about disclosure. 8. Move from a deficit-based model to a strengths-based model. Encourage engagement in advocacy and activism. 9. Consider stigma associated with non-legally recognised family or romantic partners, mixed-orientation relationships, and non-monoganous relationships. 10. Understanding of sexual health as a component of overall health and be aware of best practices in relation to sexual health. 11. Recognise the importance of families of choice - and that some people may choose to keep relationships with families who are less accepting or affirming. 12. Recognise that sexual minority parents are often invisible. 13. Psychologists working in schools target school wide interventions. 14. Assess how sexual minority stressors influence career development and advocate to address oppression in the workplace. 15. Highlight experiences of sexual minority people at training and education events. If psychologists cannot affirm client's sexual minority orientation for religious or other reasons, follow relevant ethical practices. 16. Strive to be aware of the potential influence of covert and overt bias on research involving sexual minority persons.
Royal College of Psychiatrists. 2018. Position statement on supporting transgender and gender diverse people. Royal College of Psychiatrists. UK	TGD people	Specific recommendations: 1. The Royal College of Psychiatrists, as well as medical schools, through their responsibilities for training of doctors and psychiatrists, should promote the need for competence in supporting the wellbeing of transgender and gender diverse people and clarity that gender diversity per se is not a disorder. 2. The Royal College of Psychiatrists should continue to provide professional education events on appropriate care and treatment when patients are transgender or gender-diverse. 3. The National Institute for Health Research and other UK grant funding bodies should commission research to increase our understanding of psychiatry's role in treatments for transgender youth, particularly very young gender-diverse people, to ensure that they fulfil their potential in comfort. 4. The Department of Health and Social Care and the Department for Education should ensure all schools provide appropriate staff training and have clear policies that support transgender children. These include tackling bullying, effective safeguarding, parental concerns, and practical considerations (such as appropriate language, use of toilets and changing rooms, and uniforms). 5. The Royal College of Psychiatrists should work closely with other international organisations in order to improve the wellbeing of transgender and gender diverse people. 6. The College recommends that the ICD and the DSM should de-classify any terms they use to describe transgender as a mental health disorder

Royal Australian and New Zealand College of Psychiatrists. 2019. Recognising and addressing the mental health needs of the LGBTIQ+ population – position statement. Royal Australian and New Zealand College of Psychiatrists Australia and New Zealand	LGBTIQ+ people	Recommendations: 1. The needs of LGBTIQ+ people should be included in all national health frameworks and strategies. 2. Health services should take steps to accommodate the needs and ensure the cultural safety of LGBTIQ+ people. 3. All training programs for medical, nursing and other health service staff should include cultural sensitivity training in LGBTIQ+-specific issues. 4. Consideration should be given to the benefits of health promotion strategies and service accreditation standards for the provision of culturally appropriate services for LGBTIQ+ communities. 5. Psychiatrists should maintain an up-to-date understanding of LGBTIQ+ issues, including appropriate referral pathways, should specialised support be required. 6. Psychiatrists should reflect on their practice to ensure it is inclusive of diverse sexual and gender identities and that their language and approach avoids heteronormative or gender-binary assumptions. 7. Services for children and adolescents should maintain an awareness of the particular stressors faced by LGBTIQ+ young people. 8. Services working with Aboriginal and Torres Strait Islander people, Māori and people from other ethnic minorities who identify as LGBTIQ+ should consider the intersection of LGBTIQ+ identities with issues such as traditional gender roles, community acceptance and the impact of multiple layers of discrimination. 9. LGBTIQ+-specific services, including for LGBTIQ+ people experiencing sexual and family violence should be supported with ongoing funding. 10. Services for older people should consider the intersection of LGBTIQ+ identities with issues such as dementia, end-of-life decision-making and advanced care plans. 11. Psychiatrists and mental health services should recognise and validate intersex identities, with awareness of individuality and complexity. 12. Psychiatrists must have regard to the relevant laws and professional standards in relation to assessing capacity and obtaining consent, including the RANZCP Code of Ethics. 13. Enhanced statistical information and research into LGBTIQ+ mental health is required.
Royal Australian and New Zealand College of Psychiatrists. 2023. The role of psychiatrists in working with Trans and Gender Diverse people. Royal Australian and New Zealand College of Psychiatrists	TGD	1. Psychiatrists should work with TGD people in a way which is person-centred, non-judgmental and is responsive to their mental health needs. 2. People and their families/whānau should be able to access comprehensive assessment and the opportunity to discuss various pathways of care. 3. Health services should take steps to accommodate the needs of and ensure the cultural safety of TGD people. 4. TGD healthcare should be included in training and CPD programs which prepare all health practitioners for practice. 5. Further research should be supported and funded in relation to wellbeing, quality of life, treatment and outcomes, especially for TGD children and adolescents.

Australia and New Zealand		6. Better access to and consistency of care across Australia and New Zealand for TGD children and adolescents is required, including outcomes monitoring. 7. The provision of high-quality information, patient education and informed consent processes are essential for trans healthcare across the lifespan.

Appendix 12b: Summary Table for Review 4: published peer-reviewed research papers/opinion papers on best practices for LGBTQIA+ mental health service provision

Author Date Title Country	Population	Key recommendations relevant to this review
Britt-Thomas, J.Y. et al. 2023. A scoping review of institutional policies and recommendations for trans inpatient mental health care. US	Trans people	Training around issues of sexuality and gender, names pronouns, terminology, confidentiality and reducing stigma. Apologising and acknowledging distress when mistakes are made around pronouns or names. A need for formal policies at both admission and discharge phases. Dismantling of existing policies that perpetuate gender segregation by assigning TGNC individuals to facilities based on their gender identity rather than birth sex. A welcoming environment. Proper assessment of current gender-affirming treatment and access to these treatments while hospitalised. As MH care is team-based, there is a need for constant and accurate communication amongst providers. Utility of trauma-informed care as guiding principles for treating TGNC individuals in inpatient psychiatric settings.
Crapanzano, A. & Mixon, L. 2022. The state of affirmative mental health care for Transgender and Gender Non-Confirming people: an analysis of current	Transgender and Gender Non-Confirming people	MH practices should be culturally relevant and responsive to TGNC clients and their multiple social identities, address the influence of social inequalities, enhance resilience and coping mechanisms, leverage individual strengths, reduce systemic barriers to mental health care, and emphasises client autonomy. Need to establish a collaboration with other professionals involved in care. MHPs should ensure that their assessments, interventions and advocacy are grounded in TGNC-affirming theories.

research, debates, and standards of care. US		Informed consent approach also advocated which at its centre has the principle of respect for a person's right to self-determination. Recommended guidelines for TGNC affirmative practices are: 1. Avoid transnormative narratives about what it means to be transgender - keep an open mind and use active listening. 2. Engage in self-examination - look out for unconscious bias. 3. Do not expect nonbinary people to have to educate the MHP. 4. Understand barriers and be willing to be an advocate. 5. Be mindful of impact of minority stress when conducting assessments and interventions. 6. Encourage engagement of the individual with the trans community as a source of support.
Fadus et al. 2022. Care Considerations for LGBTQ Patients in Acute Psychiatric Settings. US	LGBTQ people	1. Inclusive and affirming communication skills - correct use of names and pronouns. Ensuring correct names and pronouns are recorded in hospital records. 2. Culturally competent history-taking and risk assessment. Asking about risk factors that are known to be elevated amongst LGBT people, including their experience of coming out and reaction of family. Identify sources of support. 3. Culturally competent treatment environments. Segregated according to gender identity, not natal gender, use of chest binder not a ligature risk, using correct names and pronouns. Institutional practices including ensuring admission forms include options outside of the typical gender binary or heteronormative context. Education of clinical and nonclinical staff on topics such as implicit and explicit biases, stigma, minority stress. Complex area of shared patient rooms in a single sex ward when the person is placed in a ward of their natal gender. Needs to be carefully weighed up. 4. LGBTQ specific discharge planning - ensure discharge programmes/supports are inclusive of LGBTQ people.
Felker, P. Redcay, A. & Fritz, L. 2022. Recommendations for Residential Treatment Facilities When Working with Transgender & Gender Expansive Youth. US	Transgender and Gender Expansive Youth	1.Education of staff should encompass terminology and treatment relevant to the Transgender and Gender Expansive (TGE) community. 2. Staff should understand their clients from a “person-in-environment”. 3. Comprehensive knowledge of the treatment guidelines, protocols, and procedures are recommended. 4. The placement decision of a TGE individual should be based on a careful clinical history, current risk assessment, examining his or her mental health, a review of any prior admission experience, and consultation with the consumer.

		10 steps of good trauma practice. 1. Intake - ask correct name/pronoun, explain policy/procedures 2. Paperwork: use identified name and pronoun on all notes, treatment plans etc 3. Discharge paperwork referral: include referrals to TGE supports in discharge planning 4. Treatment groups: ensure groups are not gender specific - but if they are include in a group that matches their gender identity 5. Policy and Procedure: gender affirming policies, define process for addressing discrimination by staff and clients. 6. Milieu: gender neutral bathrooms and social areas, bedrooms that match gender identity 7. Agency environment: affirming spaces, brochures etc 8. Staff Training: regular training on TGE treatment needs and issues 9. TGE Treatment Informed Practice: not pathologising TGE clients, provide training on gender affirmative model 10. TGE Trauma informed practice: provide staff training in intersection between trauma and TGE life cycle - trauma as a result of stigma etc.
Goldhammer et al. 2019. Distinguishing and Addressing Gender Minority Stress and Borderline Personality Symptoms US	Gender minority patients with borderline personality disorder	1. Follow an informed consent model for initiating gender-affirming hormone therapy and surgeries with adult patients. Gender-affirming medical intervention is indicated as long as the patient has the capacity to make a fully informed decision and to consent for treatment. 2. Treat BPD in parallel with, rather than prior to, gender-affirming interventions as long as BPD does not impair capacity to give consent. Clinicians can determine capacity for medical decision making and informed consent according to the same standards used for all potentially life saving interventions. 3. Tailor BPD treatments to address minority stress. 4. Reduce structural stigma such as institutional policies and practices that undermine the efficacy of mental health interventions for minority populations. Training for all staff to use correct names and pronouns, policies to prevent discrimination based on gender identity, offering all-gender restroom facilities.
Hope et al. 2022. Bridging the Gap Between Practice Guidelines and the Therapy Room: Community-Derived Practice Adaptations for Psychological Services With Transgender and Gender Diverse Adults in	Transgender and Gender Diverse (TGD)	A series of 12 Practice Adaptations are recommended under the headings of: Settings; Perceptions of Cultural Messages; Clinician's Experience of Gender; Comfort with various gender identities/Expressions; Managing Marginalisation; Non-defensive stance; Clinicians educate themselves; Share power; Incorporate gender into care conceptualisation; Identify focus of Services; TGD-affirmative referrals;

the Central United States US		Advocacy.
Hudson, K.D. & Bruce-Miller, V. 2022. Nonclinical best practices for creating LGBTQ-inclusive care environments: A scoping review of grey literature. USA	LGBTQ - physical and mental healthcare settings	Identifies 7 domains of nonclinical best practices: 1. Interpersonal quality. 2. Visual cues in the physical environment. 3. Administration environment and facilities. 4. Workplace and Workforce. 5. LBGTQ competency training. 6. Research, assessment & Evaluation. 7. Outreach and engagement.
Inventor et al. 2022. Mental Health of LGBTQ Older Adults. US	Older (65+) LGBTQ adults	Advocate for policies that affirm all sexual orientations and gender identities. Ask patients what pronouns they use. Create a safe and welcoming environment. Conduct an optimal mental health evaluation of LGBTQ older adults. Assess for social determinants of health. Address specific mental health issues, such as social isolation, loneliness, and disenfranchised grief, and health behaviors, such as substance use/misuse, smoking, excessive alcohol consumption, and risky sexual practices. Assess—and reinforce—protective factors for improving mental health, such as resilience, social networks. Develop and use a strong referral network with LGBTQ–affirming providers. Refer to and collaborate with other health care professionals, especially for transgender issues.

Kealy-Bateman et al. 2019. Transgender ward allocation in single-sex mental health wards: contemporary considerations. Australia	Transgender people	Consideration of the needs of the transgender person and their requests for accommodation preferences and consider how allocation to a single sex ward might impact the trans person. The decision to admit to a specific ward should be based on a careful clinical history, current risk assessment, mental state examination, diagnosis, review of previous admission experience, formulation, consultation with the consumer, and consideration of the patient and staff mix.
Green et al. 2020. Breaking Barriers to Quality Mental Health Care for LGBTQ Youth The Trevor Project. US	LGBTQ	Recommendations: 1. Increased funding for mental health care 2. Policy changes to support access to mental health care 3. Improving cultural competencies of mental health providers 4. Ending stigma and reducing fears in asking for help 5. Integrating technology to improve access to mental health care
Lothwell, L.E., Libby, N., & Adelson, S.L. 2020. Mental Health Care for LGBT Youths. US	LGBT Youth	MHPs can help LGBT youth improve social support, coping methods, and problem-solving skills. Clinicians should be mindful regarding issues of confidentiality and disclosure when engaging the patient's support system. Clinician will need to consider specific stressors related to LGBT orientation. Clinicians should be prepared to accept the complexity of a patient's decision to come out. For TGD patients, the MHP can consider helping children and families evaluate their options, weigh risks and benefits, and tolerate uncertainty. MHP can help families navigate and advocate for their child in the school and community and as puberty approaches help pave the way for decision-making about hormonal interventions. MHPs can collaborate with other healthcare professionals involved in their care. Clinicians uncomfortable working with this population should seek supervision and become familiar with clinical alternatives.

Mental Health Reform. 2022. My LGBTQI+ Voice Matters. Ireland	LGBTQI+	Recommendations made under the themes of: LGBTI+ Competent and Sensitive Service Provision; Treatment and Care; and Research and Evaluation.
Noble, N., Bradley, L. & Hendricks, B. 2021. Bias-Free Language: LGBTQ+ Clients and the New APA Manual US	LGBTQ+	Recommends more encompassing language e.g. 'another gender' - gender defined as a social construct and social identity - sex defined as a biological reality. Recommends use of word gender instead of sex when it is more appropriate. The word transsexual is denounced as outdated. Other terms identified as inappropriate include birth sex, natal sex, tranny, transvestite. Recommends use of more specificity when referring to gender e.g. cisgender woman, cis man, trans women etc. Implications for counsellors: Appreciate the impact language has on clients. Be aware of subtle and covert forms of discrimination common in language. Focus on the language used by clients to describe themselves and seek clarification when unfamiliar with new terminology. Seek self-awareness to identify and change language that inadvertently perpetuates oppression. Foster a supportive, caring relationship through fully listening to the lived experiences of clients and grasping the complexity of intersectional identities.
O'Brien et al. 2023. Experiences of transgender and gender diverse patients in emergency psychiatric settings: A scoping review. US	Transgender and Gender Diverse clients in psychiatric EDs	1. Non-judgemental, affirmative and inclusive language 2. Cultural humility in all stages of acute psychiatric care, from history taking to risk assessment and discharge considerations 3. HCPs identifying their own experiences and biases and being conscious of them when caring for this population. 4. Structural change e.g. confidential environments rather than open spaces for assessment, allowing patient to have a support system present throughout assessment 5. Resources discreetly distributed throughout department and identifying an LGBTQIA+ champion in the organisation.
Pachankis, J.E. & Soulliard, Z.A. 2023.	Lesbian, gay, bisexual, queer	LGBQ-Affirmative Principles of the Adaptation Model:

A Model for Adapting Evidence-Based Interventions to Be LGBQ-Affirmative: Putting Minority Stress Principles and Case Conceptualization Into Clinical Research and Practice. US		Principle 1: Highlight how symptoms of depression and anxiety can be normal responses to minority stress. Principle 2: Acknowledge how early and ongoing experiences with minority stress can teach sexual minority individuals powerful, negative lessons about themselves. Principle 3: Empower sexual minority individuals to effectively cope with the unfair consequences of minority stress. Principle 4: Help sexual minority individuals build supportive, authentic relationships. Principle 5: Highlight sexual minority individual's unique strengths. Principle 6: Understand intersecting identities as a source of stress and resilience.
Panchal et al. 2022. Providing supportive transgender mental health care: A systemized narrative review of patient experiences, preferences, and outcomes. Australia	Transgender people	Recommendations: Providers and institutions respect and validate individuals' gender identity. This includes asking about, and using, preferred names and pronouns, as well as taking a flexible approach to gender identity and supporting individuals in defining and expressing their own gender identity. Providers discuss gender identity in care when, and to the extent that, patients are interested in doing so. Providers seek out information and training on transgender issues and do not rely on patients to educate them. This includes knowledge about transgender issues in society broadly, as well as the unique mental health concerns and needs of transgender populations. During psychological evaluations prior to medical transition providers actively seek to understand and address patient questions, goals, and mental health needs.
Rees et al. 2021. The lesbian, gay, bisexual and transgender communities' mental health care needs and experiences of mental health services: An	LGBT	1. Have LGBT friendly services that acknowledge that different mental healthcare is required for these communities- providers should strive to be open, comforting, and non-judgemental; they should ask open-ended questions and not assume the individual seeking care is heterosexual. Access to trans affirmative therapy and treatment that acknowledged gender dysphoria associated with treatment delays or denial. 2. Services that provide informed care that promote self-acceptance. Care that does not pathologise sexuality or assume mental health problems were linked to sexuality. Address experiences of self-blame, address past experiences of harassment. Access to talking therapies that promote self-acceptance and support principles of equity and inclusion. Access to LGBT-friendly therapists. 3 LGBT clinical skills grounded in professional ethics, guidelines and standards of care.

integrative review of qualitative studies. New Zealand		
van Dyk et al. 2023. Affirming LGBTQIA+ Youth in Inpatient Psychiatric Settings. New Zealand	LGBTQIA+	Strategies to overcome barriers (affirming strategies): 1. All patients should be asked about their identities during admission, and all staff should receive culturally informed training on how and when to follow up, how to affirm identities, exploring links between LGBTQIIA+ stressors and psychiatric crises leading to admission. 2. Inpatient services should create protocols for providing gender-affirming care including how youth can access affirming devices and hormonal therapies e.g. pre-approved safe binders. 3. From admission, communicate clearly about the limits of confidentiality - use 'patient' instead of affirmed name if parents are unaware. Use neutral alternative for room nameplates. 4. Provide LGBTQIA+ affirmative badges, encourage staff sharing preferred pronouns, include LGBT artwork, books, movies etc. 5. When discharge planning providers should ask potential providers if they are affirming and can accommodate youth needs. If affirming service providers cannot provide affirming care then referrals should be supplemented with support groups and social resources at local level.
Shipherd et al. 2019. Trauma Recovery in the Transgender and Gender Diverse Community: Extensions of the Minority Stress Model for Treatment Planning. US	Transgender and Gender Diverse	Macro-Level Interventions for MHPs for Trauma-Exposed TGD People (societal level): MHPs may choose to become involved in their communities to participate in the repeal of harmful policies and work to pass inclusive legislation and protections in policies. Mezzo-Level Intervention for Trauma-Exposed TGD people (organisational level): Ensuring policies and protections are in place for TGD people. In addition to non-discrimination policies, a review of systems, intake processes, physical space, and visual cues in the environment. Invest in bystander intervention training. Also inclusive hiring practices. Micro-level interventions: Routine assessment of trauma exposures given almost universal experience of trauma among this population. Assessment of post-trauma and co-occurring symptom assessment (e.g. hypervigilence, sleep problems). Treatment of discrimination experiences, microaggressions and minority stress.
Strauss et al. 2024. Development of best practice guidelines for clinical and community service providers to prevent suicide in LGBTQA+ young people:	LGBTQA+ youth	4 categories of best practice: 1. General principles for creating an affirming and inclusive environment for LGBTQIA+ young people: Creating an affirming and inclusive environment; Communication; Official documentation; Identity disclosure; Training and skills needed for services and providers to work with LGBTQIA+ young people. 2. Assessing suicide risk and working with LGBTQIA+ young people: - Psychosocial risk factors in LGBTQIA+ young people: In addition to a thorough, standard psychosocial assessment, experiences of the following items (past, present and current) should be identified when conducting an assessment with a LGBTQA+

A Delphi expert consensus study. Australia		young person, due to their increased likelihood in this population and/or unique contribution to mental health in this population. 3. Considerations for specific LGBTQIA+ populations including considerations specific to trans young people; considerations specific to neurodivergent LGBTQIA+ young people; considerations specific to Aboriginal and Torres Strait Islander LGBTQIA+ young people (In Ireland, Traveller population may be equivalent?). 4. Advocating for LGBTQIA+ young people.
Ventriglio et al. 2022. Mental Health for LGBTI people: a policies' review. Italy	LGBTI	Review identified a number of reports from psychiatric and psychological associations on LGBTQI mental health: 1. World Psychiatric Association (WPA) Position Statement on Gender Identity and Same-Sex Orientation, Attraction and Behaviours (Bhugra et al. 2016). 2. European Psychiatric Association (EPA) has a position paper in defense of the mental health of LGBT people (2022). 3. APA statement on Conversion Therapies (APA, 2018). 4. APA position statement on Issues Related to Sexual Orientation and Gender Minority Status (APA, 2020). 5. Royal College of Psychiatrists in 2018 (reviewed 2021) has a Position Statement on supporting transgender and gender-diverse people. 6. Canadian Mental Health Association has a webpage dedicated to Lesbian, Gay, Bisexual, Trans & Queer identified People and Mental Health reporting information for readers and health providers. 7. Association of LGBTQ+ Psychiatrists have a number of position statements (AGLP, 2020) 8. APA (2022) proposed a detailed review of documents and information on LGBT health and mental health. 9. Similarly, the Psychological Society of Ireland (PSI,2022) published the Good Practice Guidelines for Lesbian, Gay and Bisexual Clients, in collaboration with GLEN (Gay and Lesbian Equality Network) and the HSE National Office for Suicide Prevention. 10. British Psychological Society (2019) published the Guidelines for psychologists working with gender, sexuality and relationship diversity.
Walton & Baker. 2019. Treating Transgender Individuals in Inpatient and Residential Mental Health Settings.	Transgender people	Creating a welcoming environment: Each setting creates a non-discrimination and inclusiveness policy that includes transgender individuals and publicise that policy. 2. Managing the Milieu: Environment of care: unit or program policies for the treatment of transgender patients should be developed to guide decision-making regarding the environment of care. 3. Content of treatment: Assess for issues known to be prevalent among transgender individuals.

US		4. Interdisciplinary care: Assess need for specialised medical care e.g. hormones. Assess and assist with financial needs. Attend to case management concerns e.g. name change in vital documents, ensuring a discharge plan will be accepting of a trans person. 5. Self-care: Manage expectations - try your best but be forgiving of yourself. Address mistakes - provide a genuine apology, learn from the situation and move on.