



# Queering Mental Health Supports in Canada:

## A Research Report



July 2023



# Land Acknowledgement

We would like to begin by acknowledging that Egale is based on the traditional shared territories of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples. The territory is protected by the Dish With One Spoon Wampum Belt Covenant, an agreement between the Haudenosaunee, Anishinaabe and allied nations to peaceably share and care for the resources around the Great Lakes. The concepts of gender, sexuality, and oppression that we often rely on in 2SLGBTQI advocacy work are largely based in White, Western, colonial systems of thought and do not represent the multitude of understandings of identity that exist outside of this viewpoint. Colonial violence created the foundations for the landscape of gender-based violence that we understand today. Indigenous communities and Two Spirit activists, scholars, writers, and artists have gifted us with ample tools to work with as we move toward the collective liberation of gender and sexuality minority people. We are grateful to carry these with us here and in our work beyond. The violence of colonialism is ongoing. So too are movements toward resisting this violence.

# Acknowledgements

## About Egale

Egale is Canada's national 2SLGBTQI organization. Egale works to improve the lives of 2SLGBTQI people in Canada and to enhance the global response to 2SLGBTQI issues. Egale achieves this by informing public policy, inspiring cultural change, and promoting human rights and inclusion through research, education, awareness, and legal advocacy. Our vision is a Canada, and ultimately a world, without homophobia, biphobia, transphobia and all other forms of oppression so that every person can achieve their full potential, free from hatred and bias.

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# Queering Mental Health Supports in Canada: Project Background

In August 2021, Egale Canada embarked on a multi-year, project called Queering Mental Health Supports in Canada. In the research phase of the project, we sought to better understand the impact of the COVID-19 pandemic on 2SLGBTQI people's mental healthcare needs in Canada, as well as the needs of mental healthcare providers who work with 2SLGBTQI people. This research report summarizes the findings from a national research study and a public consultation.

To learn more about the QMH project and phases, visit our project website [egale.ca/qmh](https://egale.ca/qmh).

## Challenges in Accessing Mental Health Services

A robust evidence base has confirmed the presence of physical and mental health inequalities and inequities among 2SLGBTQI people in Canada (Bettergarcia et al., 2021; Sherman et al., 2020). Despite growing societal awareness and acceptance of 2SLGBTQI people—including among healthcare professionals and administrators (Tam et al., 2022)—there is also evidence of ongoing barriers to mental healthcare and backlash to these gains, including a rise in anti-trans hate (Curlew, 2019) and experiences of gender-based violence among gender-diverse people in Canada (Women and Gender Equality Canada, 2022). Relative to heterosexual and cisgender people, 2SLGBTQI people report higher rates of mental health service utilization, higher levels of dissatisfaction with these services, and more unmet mental health needs (Platt et al., 2018; Steele et al., 2017). Exclusion, discrimination, and a lack of culturally responsive and affirming care in these systems prevent 2SLGBTQI people from accessing the services they need to manage and improve their mental health and well-being (Romanelli & Hudson, 2017). In the shifting sociopolitical

landscape increasingly marred by anti-2SLGBTQI discourse and actions, these barriers to mental health will only become more urgent to address.

In addition, the COVID-19 pandemic is disproportionately impacting 2SLGBTQI people, who are already facing social, economic, and health inequities (Egale Canada & Innovative Research Group, 2020; Jenkins et al., 2021). The pandemic has affected many factors that influence physical and mental health, including access to healthcare, employment, income, food security, housing, education, and social supports (also known as social determinants of health) (Rollston & Galea, 2020). These often-negative impacts have intensified the rates of mental health disorders and concerns among 2SLGBTQI people. For example, mandatory public health measures such as physical distancing and self-isolation have heightened anxiety, stress, loneliness, and other mental health concerns for many 2SLGBTQI people (Phillips et al., 2020). Worries about contracting the virus also create and contribute to mental health concerns (Egale Canada et al., 2020). The pandemic has also intensified many of the barriers 2SLGBTQI people face when trying to access mental healthcare in Canada, such as a lack of available and competent providers (Gonzales et al., 2020).

## Project Guiding Frameworks

### Social Determinants of Mental Health

One of the guiding theoretical frameworks<sup>1</sup> of the Queering Mental Health Supports in Canada project is the Social Determinants of Health (SDH) framework. The SDH approach enables us to understand how one's circumstances impact one's physical and mental health, and how these circumstances drive inequities. We utilize this framework because it investigates the root causes of mental health challenges and how social determinants interact to shape mental health outcomes (Alegría et al., 2018). Understanding the causes of mental health disparities within economic, social, and political contexts is necessary to promote health equity for 2SLGBTQI people. Mental

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<sup>1</sup> A theoretical framework examines why the subject of a given study or project matters, and why the methods the researchers propose to examine it are both appropriate and thorough (Ravitch & Riggan, 2017).

health training should adopt comprehensive approaches involving structural changes to mental healthcare delivery, meaningful and sustained shifts in organizational and service setting cultures, and changes in interpersonal dynamics between service seekers and providers.

Social determinants of health are the conditions in which people “are born, grow, live, work, and age” and are shaped by the multilevel distribution of money, power, and resources (WHO, 2014). Given the unequal distribution of money, power, and resources, these societal circumstances underpin different groups’ risks of poor mental health and well-being. Social determinants of mental health (SDoMH) are largely the same as the social determinants of physical health and can be addressed through policies and programs (Compton & Shim, 2015). SDoMH include:



early childhood  
experiences;



access to housing;



access to food;



employment;



workplace  
'culture';



social norms;



income;



neighborhood/  
community-level  
resources;





education;



healthcare;<sup>2</sup>



degree of  
community  
connections;



access to social  
programs;



access to  
transportation;



exposure to  
violence, conflict,  
and war;



relationship with  
law enforcement  
and other  
institutions;



and environmental  
factors (e.g.,  
pollution, climate  
change) (Compton  
& Shim, 2015).

## Minority Stress Theory

Minority stress theories are central to understanding physical and mental health disparities experienced by 2SLGBTQI people. Minority stress theories have been used to explain the stress caused by conflicts between dominant groups in a given culture or society and various minoritized groups (e.g., racialized groups, individuals with disabilities) (Williams et al., 2003), but is most often used to understand 2SLGBTQI health disparities (Meyer, 2003). 2SLGBTQI minority stress theory posits that 2SLGBTQI mental health disparities are the outcomes of the psychological and emotional strain of confronting discrimination, prejudice, and victimization related to sexual or gender identity, sexual behavior, or gender expression (Brooks, 1981; Meyer, 2003). This theory identifies the social conditions, structures and forces that produce stressors uniquely experienced by 2SLGBTQI people (e.g., internalized stigma) and the individual and group-level factors that help individuals cope with these stressors (e.g., social support) (Hoy-Ellis, 2023).

<sup>2</sup> including public health policies shaping access to/quality of healthcare and access to knowledgeable and affirming healthcare providers.




## Intersectionality and Trauma-Informed Approaches

Intersectionality is a theoretical framework that suggests that people's social identities cannot be separated or simply added together; rather, they interact to produce unique lived experiences due to interlocking systems of privilege and discrimination (Walubita et al., 2022). The term intersectionality was first coined by Kimberlé Crenshaw, an American legal scholar and critical race feminist activist. She uses the term as a metaphor for how intersectional discrimination works in real life:

Consider an analogy for traffic in an intersection, coming and going in all four directions. Discrimination, like traffic through an intersection, may flow in one direction, and it may flow in another. If an accident happened in an intersection, it can be caused by cars travelling from any number of directions and, sometimes, from all of them. (Crenshaw, 1991, p. 63)

An intersectional approach to providing services addresses how people's identities create complex, interlocking social, political, and economic barriers (as well as opportunities) depending on which identities they hold and to which social groups they belong.

Trauma-informed approaches to services recognize that "trauma is not a disorder but a reaction to a kind of wound" (Burstow, 2013, as cited in Wilson, 2013). Trauma-informed approaches also recognize the ways in which trauma impacts interactions with service providers and strive to create a safer experience for people seeking support and services. Trauma-informed approaches involve respecting the continuing impact that trauma has on people's physical, mental, and emotional health. Such approaches are also strengths-based, meaning they recognize and celebrate people's strength and resilience despite enduring trauma, as opposed to deficit-based approaches that often dismiss or over-define people by their trauma. Trauma-informed care for 2SLGBTQI people is rooted in principles of safety, empowerment, peer support, trustworthiness, transparency, and collaboration (Levenson et al., 2023).



Lastly, it is important to note that mental healthcare, especially psychiatry, has a sordid history and ongoing legacy of pathologizing 2SLGBTQI populations as ‘mentally ill’ and subjecting them to dangerous treatments such as “conversion therapy” in institutional settings (Kunzel, 2017; Pilling, 2022). Therefore, provision of culturally competent and affirmative mental health supports that are rooted in trauma-informed and intersectional frameworks can improve mental health by providing care seekers with effective coping mechanisms, resources, and supportive communities (Pilling et al., 2017).

# Methodology

This project involved the use of multiple research methods, including (1) a mixed-methods national survey containing both quantitative and open-ended questions, and (2) qualitative semi-structured focus groups and interviews. All quantitative data was analyzed using R software. Analyses included descriptive statistics, inferential statistics (e.g., t-tests), and graphing using ggplot2. For some items, we generated numerical scores from Likert scales that could be averaged across themed items (e.g., hope and resilience). Qualitative data were analyzed in NVivo software using thematic analysis. Thematic analysis involves assigning codes to transcribed text, and then grouping codes into themes or patterns that appear in all the transcribed focus groups, texts, and open-ended survey responses (see Braun & Clarke, 2014). Lastly, in this multi-phased project, we also analyzed two additional sources of data: (4) the participant feedback responses to Egale's 2SLGBTQI Inclusion for Mental Health and Social Service Providers webinars delivered in 2021 and 2022 to over 1200 service providers, and (5) data collected from a national community consultation event in 2023. The overarching research questions included:

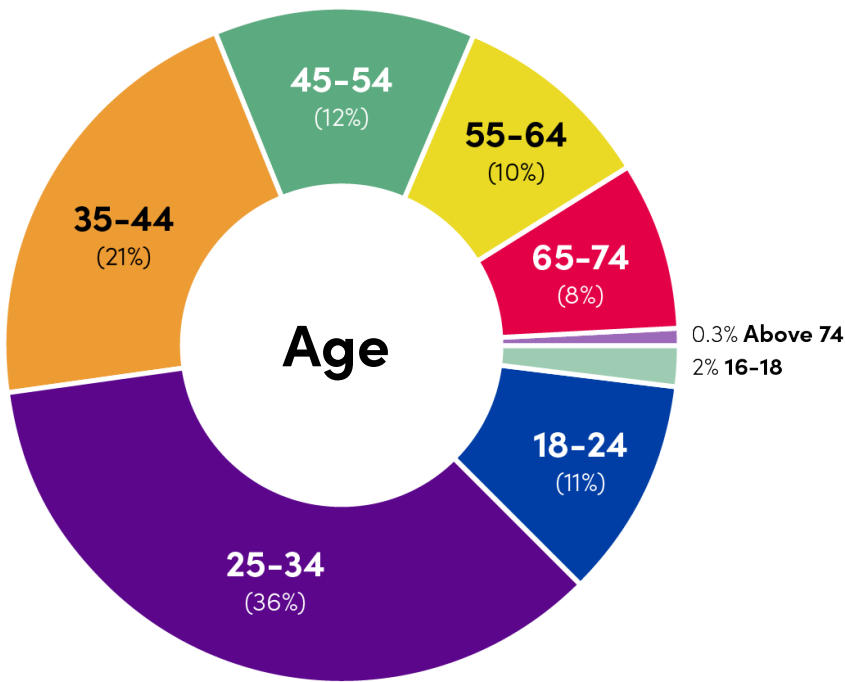
- 1. How has the COVID-19 pandemic impacted the social determinants of mental health among 2SLGBTQI communities in Canada?**
- 2. What gaps and challenges do mental health professionals and social service providers identify and face in delivering inclusive care for 2SLGBTQI people in Canada during the COVID-19 pandemic?**

# Methods and Data Collection

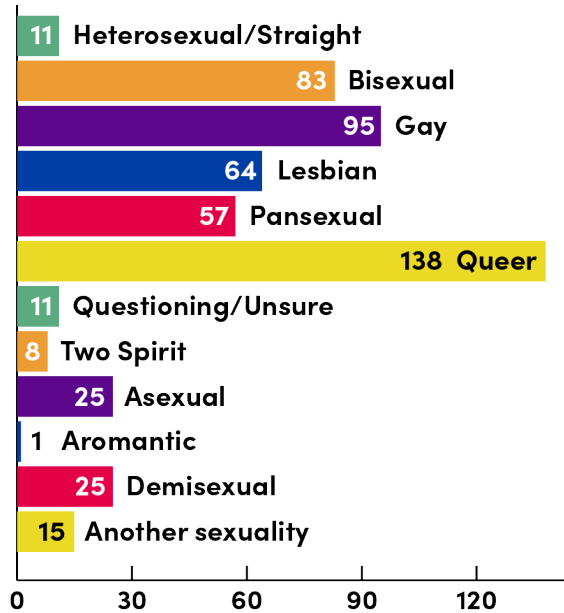
## National Survey

In May 2022, we launched a national survey assessing the impacts of the COVID-19 pandemic on social determinants of health for 2SLGBTQI people in Canada. The survey was live until July 2022, and it included questions on demographics; general mental health; the impacts of the pandemic on specific social determinants of mental health, including access to mental health services and other supports (e.g., peer supports); experiences of and concerns about discrimination and exclusion; coping and resilience; and recommendations on how to improve mental health services. We retained 304 survey participants' responses for analysis based on our eligibility criteria: participants had to be over the age of 16, identify as 2SLGBTQI, live in Canada, have access to the internet or a smartphone, and be capable of providing consent. Of these 304 participants, 214 were service seekers and 90 were service providers who identified as 2SLGBTQI (including 1 allied service provider who self-identified as cisgender and heterosexual). The English survey elicited 274 eligible responses and the French survey elicited 30 eligible responses. The demographics of our survey takers were as follows:

- **36%** of respondents were **25-34** years of age; **21%** were **35-44** years of age; 12% were 45-54 years of age.

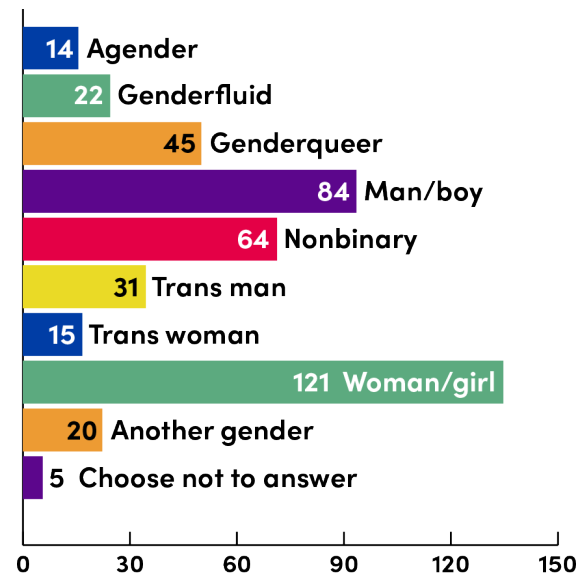


## Attraction



- **44%** identified as **queer**; 28% as gay; 27% as bisexual; 20% as lesbian; 18% as pansexual; <10% identified as various other sexual orientations (e.g., demisexual, Two-Spirit, or questioning).<sup>3</sup>

## Gender Identity



- **39%** indicated their gender identity as **woman/girl**; 27% as man/boy; 20% as nonbinary; 14% as genderqueer; <10% indicated other gender identities.



- **44%** identified as **living with a disability** (includes physical, intellectual, learning, visual, hearing, psychiatric, or neurological disabilities).

<sup>3</sup> Please note that these percentages add up to more than 100%, because people could select more than one response.

- **91%** identified as **white**; 6.2% as Indigenous; 4.3% as Black; 3.6% as East Asian; 3.3% as South Asian; 4.6% identified with another ethno-racial identity.<sup>4</sup>
- **52%** respondents were from **ON**; 16% from QC; 13% from BC; 19% for all other provinces and territories.
- **60% employed full-time**; 15% part-time; 15% indicated another employment status.
- **60% earned 60k or less**; 36% had a personal income of \$60K or more.

## Virtual Focus Groups

From May 2022–August 2022, we conducted virtual focus groups (six in English, two in French) with 61 people. Of these 61 people, 42 were 2SLGBTQI service seekers, 16 were 2SLGBTQI service providers, and three were cisgender-heterosexual allied service providers.

The focus groups with 2SLGBTQI service seekers explored the ways in which the pandemic has impacted their health, well-being, and coping strategies; services that would help them deal with the stress and other impacts of the pandemic; and to get their recommendations on what can be done to improve mental healthcare. The focus groups with service providers explored the challenges they faced in delivering inclusive care, how the pandemic has impacted their service delivery, as well as their recommendations concerning promising practices and training.

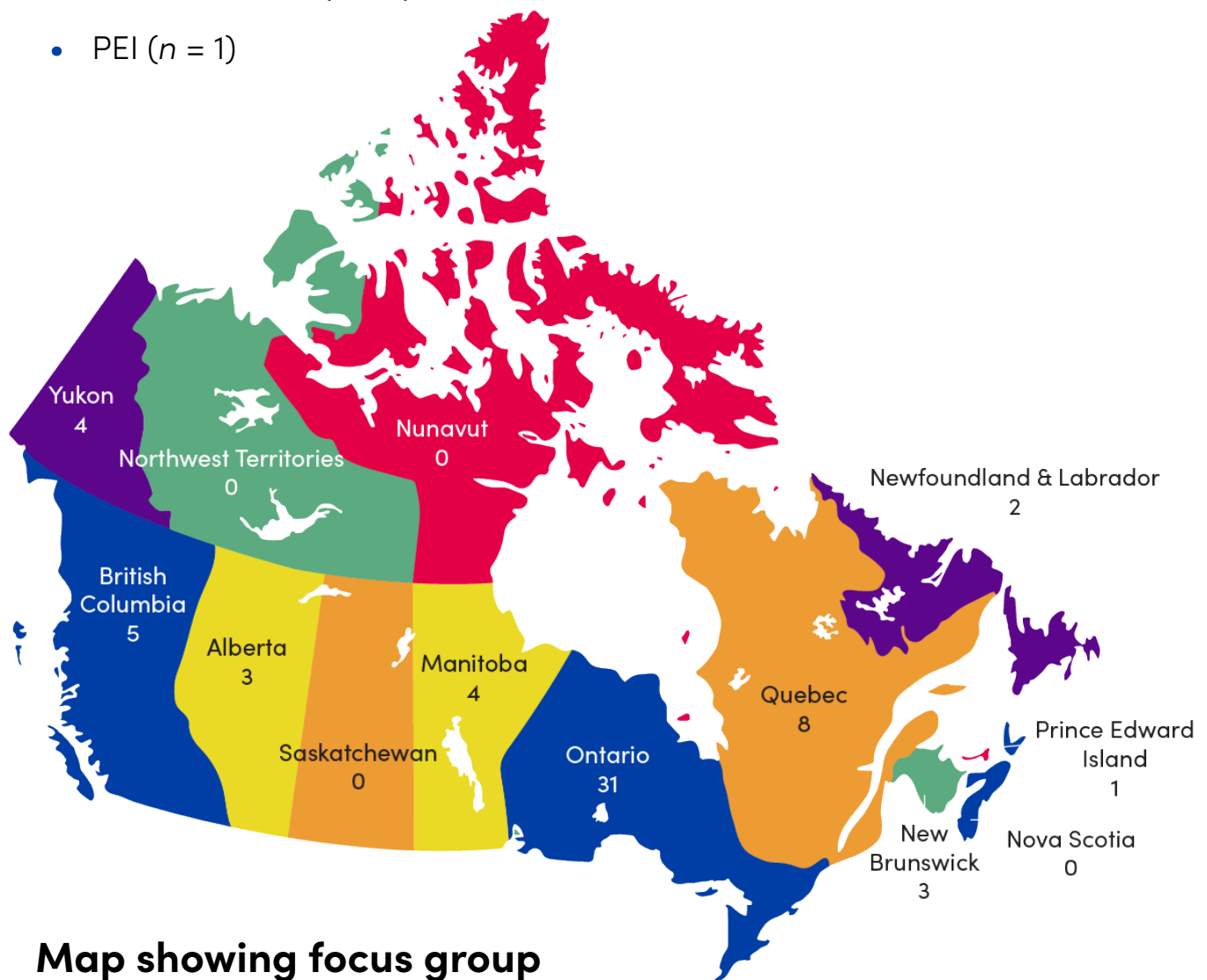
In our sample, five participants were from rural and/or remote areas, and four were from northern areas. The remainder of our sample ( $n = 52$ ) lived in an urban setting. Nearly 28% ( $n = 17$ ) of the focus group participants identified as a person of colour.

---

<sup>4</sup> Please note that these percentages add up to more than 100%, because people could select more than one response.

Participants resided in the following provinces and territories:

- Ontario ( $n = 31$ )
- Quebec ( $n = 8$ )
- Manitoba ( $n = 4$ )
- Yukon ( $n = 4$ )
- British Columbia ( $n = 5$ )
- Alberta ( $n = 3$ )
- New Brunswick ( $n = 3$ )
- Newfoundland ( $n = 2$ )
- PEI ( $n = 1$ )



**Map showing focus group participation across the country**




## **2SLGBTQI Inclusion for Mental Health and Social Service Providers Webinars**

In phase 1 of this project, Egale delivered cultural competency training for service providers who wanted to help 2SLGBTQI people cope with the ongoing pandemic and thrive despite the stressors they face. Egale delivered 24 90-minute 2SLGBTQI Inclusion for Mental Health and Social Service Providers webinars from August 2021 until August 2022 to over 1,200 service providers. These webinars helped service providers build their allyship skills and capacity for culturally competent practices through presentations, first-person scenarios, and interactive exercises. Specific webinar content included a detailed overview of the 2SLGBTQI acronym; the distinctions between gender identity, sexual orientation, gender expression, and sex; and the structural and cultural biases in Canadian mental healthcare and their negative impacts on 2SLGBTQI people. Webinar attendees came from a wide range of healthcare and social service sectors, including psychology, counselling, social work, palliative or long-term care, educational and social services such as housing and employment. Nearly 20% of webinar attendees were social workers, followed by counsellors (6%), psychotherapists (6%) and community workers (6%). Webinar participants represented a wide range of professions and job titles, including nurses, project and program coordinators, peer support workers, physicians, and shelter workers. Webinar attendees completed pre- and post-webinar surveys, relating their prior knowledge, learnings, and remaining gaps in knowledge. The feedback from the pre- and post-surveys informed the research project.

### **Community Consultation Event**

In January 2023, Egale hosted a virtual community consultation event entitled “Changing Hearts and Minds: Integrating lived experiences into 2SLGBTQI affirming mental health and social service approaches.” This online event brought together 34 individuals from across Canada, and we shared preliminary key findings from phase 1 (delivery of 2SLGBTQI Inclusion for Mental Health and Social Service Providers webinars) and phase 2 (national survey, focus groups). At this event, we gathered information about the perspectives and lived experiences of 2SLGBTQI community members, 2SLGBTQI service



providers, and allied service providers working in mental health and social service sectors. The event had several breakout rooms, where participants discussed strategies for implementing culturally responsive practices; addressing distinct and intersectional realities of seeking and accessing mental healthcare (e.g., in non-urban centers); creating trauma-informed training; strategies for service providers to meaningfully connect and serve currently excluded service seekers; strategies for ensuring learning integration and long-term changes in service delivery; ideas regarding partnerships between individuals and organizations to better support 2SLGBTQI service seekers and 2SLGBTQI service providers. The data collected from this consultation event informed the overall project.

# Findings

In this section, we highlight key findings from phases 1 and 2 of the project. As we have multiple data sources, we have used the following system to reference the data: individuals who responded to the survey are identified by “SR” for survey respondent; those who participated in the focus groups are identified by “FGP” for focus group participant; and those who participated in our research activities as service providers are identified by “SP” for service provider. Please note that throughout this report, survey respondents are identified by their sexual orientation(s), gender identity/identities, and locations; focus group participants are identified only by a pseudonym to maintain confidentiality; and service providers are identified by their pseudonym as well as their identity and region of practice, if they consented to share this information.

## Findings from Pre- and Post-Webinar Surveys

Prior to participating in the webinars, registrants were asked about their profession and work setting, their thoughts on what was already being done well with regard to 2SLGBTQI inclusion in their field and in their own work/practice, as well as their concerns about 2SLGBTQI inclusion (or lack thereof) in their field and in their own work/practice.

The most commonly identified strength of attendees’ respective fields and practices was training and educational opportunities. As one intervener working in a community mental health organization noted:

“

There have been more and more opportunities to participate in workshops and conferences to learn more about the 2SLGBTQI community and the challenges they face. The more knowledge, understanding and being informed, the better able we are to serve this and other communities.

”

Although it was not widely cited, a few respondents mentioned specific efforts towards creating more welcoming spaces for 2SLGBTQI people, including:

- Making bathrooms and other spaces gender neutral.
- Making fewer assumptions.
- Using gender-neutral language and correct pronouns.
- Changing intake processes.
- Adding visual markers such as pronoun pins, stickers, and flags to workspaces.
- Creating space for inclusive conversations.
- Creating 2SLGBTQI-specific programming or services.
- Revising hiring processes to increase 2SLGBTQI representation on staff.
- Identifying and addressing bias through critical reflection and self-education.

However, many webinar attendees provided the caveat that 2SLGBTQI inclusion in their workplaces and practices is a “work in progress,” and that “more work needs to be done”. Although “trying one’s best” is a good start, it is not enough to provide 2SLGBTQI-affirmative care, as a therapist working in a non-profit explained:

“

I believe the confidence to work with individuals who identify within the 2SLGBTQIA community can sometimes be challenging for helping professionals who identify as hetero cis-gendered folks. I often feel concerned that individuals in helping professionals often ‘do their best’ and that is sometimes not enough, nor does it translate into competent care. Having more conversations and more training in the 2SLGBTQIA community can help in small steps to develop not only competency but also overall safety for folks receiving services.

”

The most commonly identified concerns relating to respondents' fields or practices were knowledge and competence gaps, as well as training gaps. For instance, a mental health counsellor working in a primary care setting noted that:

“

the issues within the community are ever-evolving, and [I'm] not certain that training and education are keeping up. And there is little training on how to address actual discrimination.


”

Gaps in knowledge and competence are intimately connected with training and educational gaps, leading to provider confusion and discomfort (e.g., being afraid to “say the wrong thing”). This often puts 2SLGBTQI service seekers in the burdensome position of having to teach their providers about their needs.

## Findings from National Survey and Focus Groups

### Access to Mental Healthcare

By far, the social determinant of mental health most widely impacted by the pandemic was access to mental healthcare. Many study participants expressed the need for more affordable and accessible mental healthcare, citing the need for more comprehensive insurance coverage for psychotherapy, medications, and other services, or a desire for more providers offering free or sliding scale services. As one gay genderqueer individual living in urban area of ON (SR) wrote: “I believe that 1-on-1 therapy/talk therapy is one of the best services to process the stress and trauma of the pandemic. That should be offered free of cost to 2SLGBTQI people.” Further, 61.5% of survey respondents noted that an inability to afford care was a reason for delaying their mental healthcare. Focus group participants also cited various reasons for delaying mental healthcare, including cost, a shortage of competent providers, and concerns about “burdening” providers operating within a strained mental healthcare system, as Heather (FGP) noted: “If it’s not an emergency, don’t burden the system.”



The results of the national survey revealed that since the start of the pandemic in early 2020, nearly 66% ( $n = 200$ ) of respondents had seen, talked on the telephone, or otherwise communicated about their emotions or mental health to a mental health professional (i.e., psychologist, psychiatrist, psychiatric nurse, registered counsellor, school counsellor, therapist, or social worker). However, 50.6% ( $n = 153$ ) of survey respondents indicated that they did not receive the mental health supports that they needed since the beginning of the pandemic, while only 28.2% ( $n = 86$ ) indicated that they had received the mental health support they needed despite dire needs. Among survey respondents, 82% ( $n = 249$ ) had felt nervous, anxious, or on edge and 71% ( $n = 216$ ) had felt down, depressed, or hopeless at least several days over the course of the previous two weeks.

Importantly, service providers who identify as 2SLGBTQI described experiences of inaccessible or harmful mental healthcare, feeling isolated, and needing connection to other 2SLGBTQI providers. These providers also discussed the issue of overextending themselves in response to seeing 2SLGBTQI clients or patients struggle in accessing supportive care. This overextension often resulted in burnout, while the provision of ‘pro bono’ or discounted services carried financial burdens. As Chantelle, a queer service provider working in rural Ontario (SP/FGP), explained:

“

I basically take every case as it comes, so some folks that we do every other session pro bono. I have some folks where it's a reduced rate for the whole time, some folks where they'll say to me 'I had to pay for supplies for my top surgery, so I can't see you anymore' and ethically, to me, that's not ok, so then we do all of their appointments for 4 months pro bono, so for me it's been really trying to make it as financially accessible as possible, because I think it's probably obvious to see, I'm in this because my heart's in this. And so, for me, it's not about being capitalist and profiting off of folks. It's about trying to support folks so that they don't die. And that's basically what we're dealing with right now. Specifically in the

pandemic, a lot of folks were at home with really unsafe family members or roommates, so a lot of problem solving around how to stay safe.

”

A shared theme across focus groups with both 2SLGBTQI service seekers and service providers was a concern regarding accessing—or referring clients to—safe, competent service providers. A number of participants noted that service providers may advertise “2SLGBTQI competence” but in reality, they do not have the ability to provide truly responsive and affirming care. Compounding this problem are inflation, increasing privatization of services, and the lack of 2SLGBTQI service providers, especially providers who are Indigenous, Black, or people of colour, as Lindsey, a trans, queer service provider practicing in rural Ontario noted:

“

There is a need for more folks from the community and folks who are Indigenous, Black, or people of colour. I think that’s really important. With the rise of credentialization, what we’re seeing is that a lot of queer and trans service providers [and] a lot of my colleagues have gone private and are charging \$130, \$160 an hour. And so, I really worry about, my focus has always been queer, trans, Two Spirit young folks. And it’s like, just in general with inflation and the cost of living, and that’s even spreading to rural and remote communities. How do we get people, and I have my own issues with the social service sector and publicly funded services. I don’t think that everything is perfect, but I think the increased privatization is a huge issue.

”

Access issues were particularly pronounced for individuals experiencing intersectional marginalization (e.g., identifying as a person living with a disability or as racialized), as Mandy (FGP) explained:



“

For me personally accessing supports that I need, especially the more identities that you hold, the harder it gets to find services that are going to be appropriate for all of you.

”

Specifically, the lack of physical spaces and matched service providers for 2SLGBTQI people who are Indigenous, newcomers, refugees, or from non-westernized cultural backgrounds present access barriers to mental healthcare. Many participants discussed the ‘whitewashing’ of queer mental healthcare, meaning that in their view, there is an over-emphasis on the experiences of white, cisgender queer folks and an over-representation of white, cisgender, heterosexual people in service provision roles.

### **Access to Medical Care**

Access to medical care is a key social determinant of both physical and mental health and is especially important for 2SLGBTQI individuals, as they are significantly more likely to live with a chronic health condition or physical disability (Egale Canada & Innovative Research Group, 2020). Findings reveal the extent to which the pandemic has disrupted and created barriers to accessing medical care: **76%** ( $n = 231$ ) of survey respondents indicated that the pandemic had negatively impacted their access to medical care. These access barriers are particularly pronounced for those seeking gender affirming care, as Sam (FGP) explained:

“

I think the pandemic made me think about my health a bit more and wanting to be proactive [...] but [medical services] are not usually offered in a gender affirming way or they’re not sensitive to folks who might have sensitivities around gender specific care. And on top of that there’s a shortage of family doctors. I can’t get a family doctor, and to be even pickier and say, ‘now I want a gender affirming doctor,’ it’s like virtually unheard of that there’d be availability for that. Unless I’m looking

for specific transition services, which I'm not. **I just need a doctor who understands.** So better healthcare would be it, it would help with my mental health. (Emphasis is the author's)

”

Echoing Sam (FGP), a bisexual/queer genderqueer individual living in urban area of QC (SR) shared the struggle of having to “triage” the health issues they present to providers, given providers’ lack of knowledge regarding 2SLGBTQI health concerns:

“

[I need] access to medical professionals with an understanding of queer issues. I feel like even if I do get to see a doctor, I have to take whatever I get. I'm scared if I open up about my queerness and gender dysphoria it won't be taken seriously. And I feel like I need to triage my health issues, and the neurodivergent stuff has to come first. So if I do get help, the focus will be on that. If I can even get help for that.

”

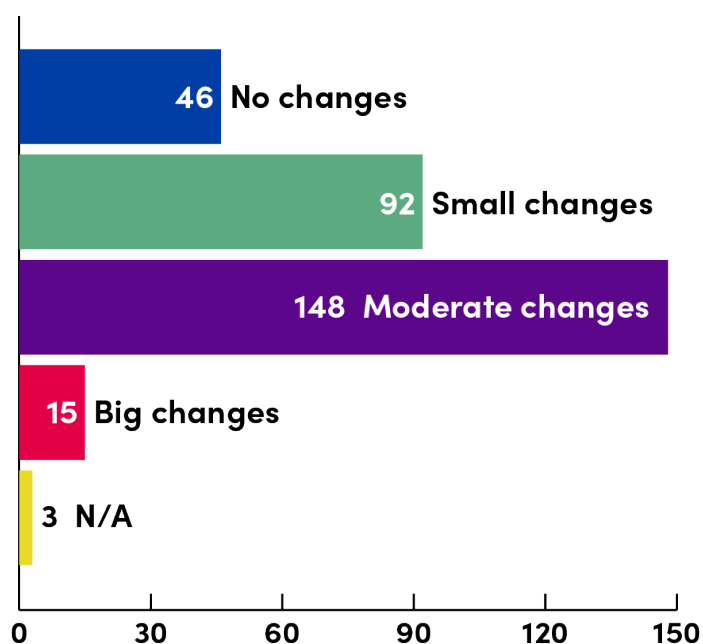
Given doctor shortages across the country, some participants talked about feeling trapped or ‘making do’ with a provider who can provide them with the bare minimum (e.g., filling prescriptions) but is not 2SLGBTQI affirming. This situation creates a significant mental health burden for 2SLGBTQI patients, who must weigh the costs and benefits of going to a provider who may address aspects of their physical health while harming their mental health.

## Social Support

Because social determinants of health influence one another in complex and variable ways, a lot of focus group participants struggled to pinpoint just one or two that had been most impacted by the COVID-19 pandemic. However, one of the most commonly noted social determinants discussed was that of social support and community connections. Negative changes in social support were mentioned by most survey and focus group participants, especially outside of city centers and among trans and gender diverse participants.

Amongst survey participants, over half (54%) ( $n = 163$ ) indicated moderate to severe negative changes (e.g., loss of contact with some family and friends, and loss of contact with all family and friends, respectively), as the chart below shows:

### Changes in social supports since COVID-19



Karina (FGP) shared her own negative severe changes in social support:

“

[M]y whole support system basically folded the day that COVID started. How I survive my mental health issues is a carefully curated social and volunteer life, because I'm retired, so I volunteer at a public school with kids, doing music, and I coordinated a choir, fitness class, all of those things done, in one fell swoop [...] And I became this fragile senior, because I'm over 70, maybe shouldn't ever leave the house.

”

Lack of social support has led to new types of anxieties (e.g., social anxiety) and other mental health concerns like loneliness. The connection between a lack of social support and losing people to suicide or overdose was also noted by multiple participants. Duncan (FGP), for example, talked about these “twin pandemics”:

“

Overdose deaths, and we're talking about mental health, lots of problems, nothing is being done, that is, can't help but bring up social determinants of health that people are dying and there isn't a real response in my community to that unbelievable disaster that's happening daily —everybody, my neighbour—dying, dying, dying.

”

Illustrating the connections between social determinants of mental health, participants like Mandy (FGP) discussed how negative changes to income and other resources resulted in burnout and thus less energy to mutually support fellow community members:

“

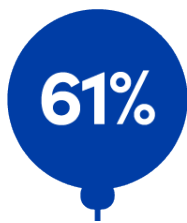
Reduced access to my social support network, I think it's, as a whole, quite a bit less, so capacity is generally lower in my communities. Also, resources that existed pre-pandemic don't exist anymore. A lot of community resources were diverted to pandemic-related things or were stopped when the pandemic happened. And so, spaces that I would go to previously no longer exist or are on pause for an indefinite period of time.

”

Despite pandemic-induced barriers to social support, survey respondents and focus group participants still found ways to access social support, and the survey indicated some potentially promising results. We asked survey respondents a series of questions relating to the types of support they had available to them at the time of taking the survey, with the following results:

65%

(*n* = 198) indicated they had someone to whom they could turn for suggestions about how to deal with a personal problem.



(n = 185) indicated they had someone to love them and make them feel wanted.



(n = 182) indicated they had someone to have a good time with most or all of the time.



(n = 170) indicated they had someone to take them to the doctor if necessary.



(n = 158) indicated they had someone to help them with meal preparation if they were unable to do it themselves most or all of the time.



(n = 146) indicated they had someone to help them if they had to stay in bed.



(n = 140) indicated they had someone to help with daily chores if they were unable to do them most or all of the time.

A few survey participants noted the need for more sober events to foster community connection, providing ideas such as events hosted at local 2SLGBTQI resource centers, art-based healing, mindfulness sessions, and social gatherings centered on an activity rather than at a club or bar. For example, a gay trans man living in a mid-sized ON city (SR) expressed the desire for more casual group activities, noting:

“

It can be hard to make new friends based purely on who you are; having a mutual interest and activity (playing games, for example) can make the process smoother and less intimidating.

”

### *Peer Support*

In addition to general social support, many participants discussed peer support<sup>5</sup> as a form of mental healthcare. Peer support has a number of benefits, including empowerment; social support; increased empathy, acceptance, and hope; and reduced stigma (Repper & Carter, 2011). These benefits are in part because these models are guided by principles such as being peer-led, non-coercive, safe, flexible, non-medical, and de-hierarchized (Abbas, 2022).

When asked about the sources of mental health support they had sought out since the start of the pandemic in 2020, 68 % ( $n = 194$ ) of survey respondents had reached out to friends, and 11% ( $n = 33$ ) had reached out to peer counsellors/navigators as a form of mental health support. Several respondents also indicated a desire for more peer support services such as group meetings, queer advocacy groups, and peer systems navigators to help them deal with pandemic-related stressors.

One focus group participant, Winter, shared the value of peer-based mental healthcare, particularly if one has had negative experiences with mental health professionals:

“

I think that's one of the biggest challenges, especially in the virtual world and during the pandemic, when you're more isolated, just being able to connect with people that are likeminded, have similar experiences, and are willing to talk and share, that to me is more valuable than seeking

---

<sup>5</sup> Peer support can be practiced in many different ways, but generally it has the following unique characteristics: lived experience (those providing and receiving support have similar lived experiences and can relate to one another); authentic support (opportunities for empathy and validation given shared lived experiences); practical advice (peers can offer practical tips and advice of which professionals may be unaware); non-professional vantage point (this can be an important component to building trust and rebuilding one's sense of community and connection) (Mead & MacNeil, 2006).

out care from a mental health professional or a GP, because those experiences are almost always negative, in my experience.

”

Other participants highlighted the silos between formalized mental healthcare and grassroots, peer-based support groups and mutual aid networks. As a result, individuals who are hard to reach or are deemed “hard to serve” do not receive necessary resources, nor do service providers make the effort to reach out to these individuals and groups. This exclusion creates deep levels of distrust among community spaces and networks towards more formalized services (e.g., counselling, social work).

Indeed, the conditions which “push” 2SLGBTQI people towards peer support models are often directly connected to the exclusion they face in other service and practice settings. As Jordaan (FGP) expressed:

“

What are networks and mutual aid networks and peer networks doing right? Contrary to that notion of amateurishness and lack of expertise, peer support groups are well-equipped to deal with not only disaster and imminent crises and also mitigate those with things like social inclusion. That’s the greatest factor of resilience: it’s having community support by you, this is what mutual aid is—it’s connections between people that can be pulled and leveraged when people have needs that cannot be met. The greatest attribute of peer support is lack of regulation, government regulation and credentials around it. I don’t need to be a wealthy enough white woman who did a psych degree at a university institution to be a peer support worker.

”



## Employment

Steady employment is one of the determinants of mental health most directly impacted by the pandemic, with national data revealing a more than twofold increase in the unemployment rate between February 2020 (5.6%) and May 2020 (13.7%) (Statistics Canada, 2020). Although employment-related problems were not widely discussed in the focus groups, nearly 35 % ( $n = 106$ ) of survey respondents indicated that they'd experienced negative changes in their employment as a result of COVID-19. These negative changes had correspondingly negative impacts on mental health: one bisexual/queer/pansexual genderqueer/nonbinary individual living in a small city in ON (SR) wrote "I had to quit my job, move back to my parents, return to school in a different field, and then work in a different field that is harder on my mental health." A gay trans man living in small city in NB (SR) similarly shared the despair accompanying the inability to find employment:

“

I've been unable to find work since the pandemic started [and] unable to find any motivation or desire to run a business like I had planned pre-COVID. It feels hopeless to not hear back from any of these jobs. It just feels like all I can do is sit and wait until I run out of money.

”

Not everyone experienced negative changes to their employment since the start of the pandemic: 26% ( $n = 79$ ) of survey respondents experienced positive changes, leading to better mental health. For example, a queer trans masculine individual in urban area of BC (SR) shared with us the connections between financial stability, social support, and improved mental health:

“

The pandemic ironically ended up accelerating the growth of my consulting business. At first, I was working too much, and the burnout was bad for my mental health, but the resulting income security meant that I could ease off on my workload and take more time to deal with my

mental health (mostly by finally starting my transition) without having to deal with financial anxiety. My work also gives me a sense of purpose and a positive creative outlet that helped ground me when dealing with bad mental health from gender dysphoria and connects me with a supportive professional network where I have many friends.

”

A queer/asexual genderfluid individual living in rural SK (SR) made similar connections between employment, social support, and better mental health:

“

I am working in a much more supportive atmosphere now than prior to the pandemic. My mental health has greatly improved because I feel more valued and that my voice matters. It is not easy being different in some working environments.

”

## Income

The pandemic's impacts on employment have had direct impacts on risks of low income and poverty among 2SLGBQI people (Kia et al., 2021). Participants addressed the pandemic's impact on income alongside rising costs of living. Negative changes to income were indicated by 30% ( $n = 91$ ) of participants, 21% ( $n = 64$ ) noted positive changes in their income, while 40% ( $n = 122$ ) indicated they had not experienced any changes since the start of the pandemic. One survey respondent, a bisexual/greysexual woman living in a mid-sized ON city, who had experienced positive changes, wrote:

“

I think my concerns about money reduced during the pandemic, because I had less expenses as I was working from home [...] this allowed me to make choices for my future, which has reduced my financial worries and I'm now able to justify paying for therapy appointments because I have some savings.

”

Negative changes to income were connected with stress, having to take on a second job or additional shifts, and an array of mental health concerns such as anxiety, rumination, and depression. Numerous survey responses illustrated how the pandemic's impacts on income combine with other social determinants to shape 2SLGBTQI people's mental health. For instance, a queer nonbinary/trans person living in a small BC town (SR) explicitly connected federal and provincial policies, structural economic and sociopolitical problems, and mental distress:

“

Rather than personal services, I need to see an improvement in material circumstances. Universal basic income, rent control, evidence based COVID policies, a political and social climate that is less hostile to trans people. I am very capable of coping with my own mental health struggles; the things causing me significant distress are not personal, they're structural. The primary type of stress I have and cannot easily relieve is a global sort of despair at the rise of fascism, the lack of hope for myself and my friends economically, and fear over being a trans person in public.

”


Another individual, a lesbian woman living in urban area in ON (SR), highlighted the mental health toll of provincial spending cuts for those on disability support:

“

[I need] affordable individual counselling, and I desperately need an increase in ODSP disability payments especially with the current inflation. Never before have I felt so abandoned by the social safety net as I have with Doug Ford's tenure during the pandemic.

”

Participants in the virtual community consultation event echoed the need to closely consider poverty and other barriers and to recognize that poverty can be an outcome of 2SLGBTQI marginalization. Event participants repeatedly noted the importance of outreach to homeless and street persons, refugees and



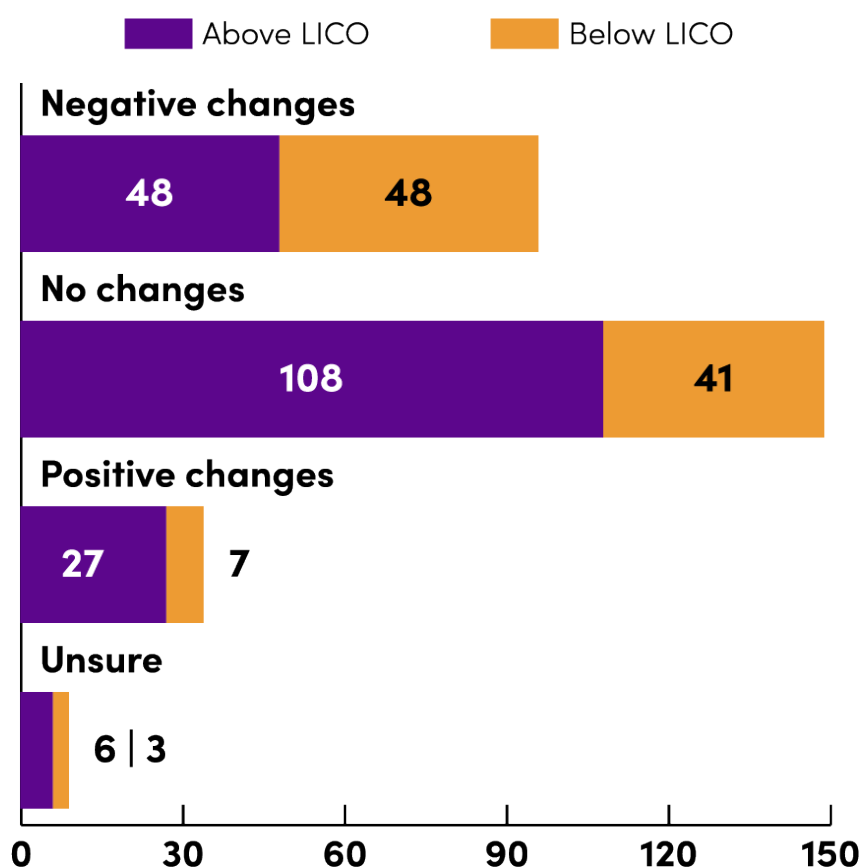
newcomers, those in rural areas, as well as 2SLGBTQI people with disabilities, as these groups are disproportionately more likely to experience poverty (Kia et al., 2020).

## **Food Security**

Another social determinant of mental health that has been impacted by the ongoing pandemic is that of food security. Research has repeatedly shown that food insecurity directly shapes an array of mental health conditions (see Elgar et al., 2021). However, there is a lack of Canadian research addressing the mental health impacts of food insecurity among 2SLGBTQI individuals in the context of the ongoing pandemic. Consequently, our national survey and focus groups emphasized this topic to address this research gap. Our findings regarding healthy food insecurity among 2SLGBTQI people reflects those of a recent national poll, which found that 47% of those identifying as 2SLGBTQI expressing concern about “sufficiently or adequately providing healthy food” to themselves and/or to their families (MHRC, 2023, p. 21).

Our survey found that 32% ( $n = 97$ ) of respondents experienced negative changes to their food security during COVID. The figure below shows that a higher proportion of people living below government-defined low-income cut-offs (LICO)<sup>6</sup> (48%) ( $n = 48$ ) experienced negative changes to their food security during COVID-19 than those above LICO (25%) ( $n = 48$ ).

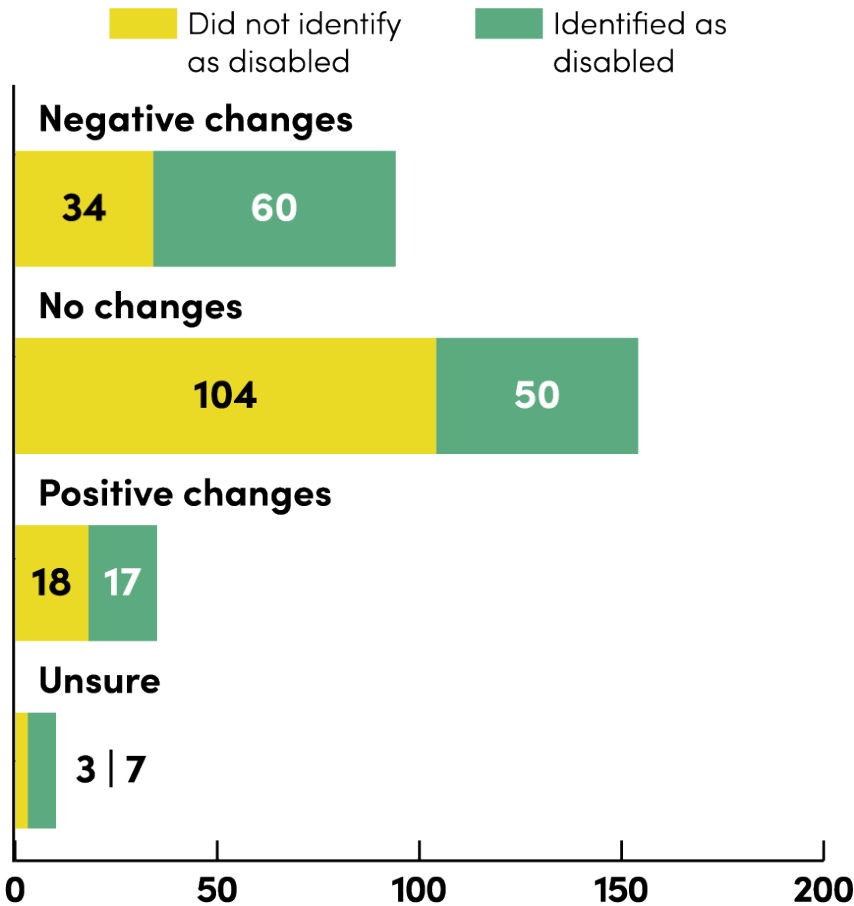
### Food security changes during COVID-19 - LICO



6 LICO is an acronym for "Low Income Cut-Off". Statistics Canada calculates (and adjusts yearly based on inflation) the LICO for 1 person living in a large urban area (population > 500,000) as \$26,620 before taxes in 2020 (<https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1110024101>). Since our demographic question on income banded the range of \$20,000–\$30,000 together, we categorized respondents who selected an income category \$30,000 or less as 'below LICO' and those who selected an income category \$30,000 or more as 'above LICO'. Although this is not a precise estimate, recent spikes in inflation and costs of living, combined with the concern of including all respondents who earn income below current LICO, justify our choice.

Notably, 44% ( $n = 134$ ) of our survey sample identified as someone living with a disability, and the figure below illustrates rates of food insecurity among these respondents. Results show that a higher proportion of people living with a disability had experienced negative changes to their food security (45%) ( $n = 60$ ) than people living without a disability who noted they had experienced negative changes to their food security (21%) ( $n = 34$ ). This difference between disabled and non-disabled respondents was statistically significant ( $p < 0.05$ ).

### Food security changes during COVID-19 - Disability



Survey respondents frequently shared their experiences regarding food insecurity since the pandemic began. A bisexual individual (gender identity not indicated) living in a mid-sized NL city (SR) noted the mutually reinforcing cycle of exhaustion and financial tension caused by rising food prices:

“

“

I have difficulty affording fresh food like vegetables and meats, so I have to buy them sparingly, or frozen. My grocery bill is now \$200 every two weeks, rather than \$150 [...] I also have difficulty preparing food when I get home from work because I'm so tired, so I'm relying on leftovers and prepared meals on those days. I feel ashamed that I'm having a hard time affording food, and if I can, I don't have the strength to prepare it.

”

One gay/queer agender individual in a mid-sized ON city (SR) also indicated the anxiety and stress caused by the inability to pay for food, as well as the role of peers in buffering the impacts of food insecurity:

“

Sometimes, food is insecure, and I am anxious about how I am going to pay for food or how to best stretch the food that we have. Most of the time, my roommates help make sure there is food around and that no one is going hungry [...] less income has made me immensely stressed about how bills and food will get covered for large portions of the pandemic.

”

Rising food prices can combine with other expenses such as transportation to intensify food insecurity, as one bisexual/queer woman living in urban area in BC (SR) explained:

“

In some way I feel very insecure due to the escalating cost of food in [my city]. I also have no car and so there is the added expense of a taxi. I cannot transport the food to my home with my granny cart.

”

Food insecurity is interrelated with other factors such as income and housing, as a queer nonbinary individual living in a small NB town (SR) explained:



“

It has been very, very difficult [...] Both my income and my partners have been reduced, **we recently got a rent increase, and we can't afford it without giving up money for food** or to feed our cat or for medications, but we can't move anywhere else because everywhere else is already more than what we are currently paying. It's a lose-lose situation with housing that makes me depressed and constantly anxious. (Emphasis is the author's)

”

Given increasing rates of food insecurity among 2SLGBTQI people, participants in the virtual consultation event discussed offering food pantries and public fridges as a component of community-based mental health services.

## Housing

Adequate, suitable, and affordable housing is a core determinant of both physical and mental health and well-being, increasing personal safety and decreasing stress (Canadian Mental Health Association, 2021). Among our survey respondents, 35% ( $n = 106$ ) indicated they had not experienced any housing challenges since the start of the COVID-19 pandemic. By contrast, 23% ( $n = 70$ ) of survey respondents noted they had difficulty finding a new place to live, 14% ( $n = 43$ ) borrowed money to pay rent or mortgage, 14% ( $n = 43$ ) needed to move in with family and friends, and 10% ( $n = 30$ ) had to move into a new neighbourhood because housing was not affordable. Participants also highlighted other housing challenges, including feeling unsafe due to others' exposure to COVID (32%,  $n = 97$ ) and due to domestic violence, maltreatment, or harassment (11%,  $n = 33$ ).

Some participants noted dilemmas in which even though they could not afford their current housing, they also could not move anywhere else because everything was as or more expensive. As stated earlier, rent increases also create other dilemmas in which people have to choose between utilities, groceries, medications, and pet care after rent has been paid. A bisexual/queer

woman living in a small Ontario city (SR) expressed the mental health impacts of housing instability:

“

I am furious, disappointed, traumatized, and burnt out over housing instability. My partner and I are masters level professionals with *very good* incomes and we *cannot* afford rent in [my city] where [...] we work and where our chosen and bio family is. We are exhausted, discouraged, and under constant stress. We have moved three times in the pandemic because landlords chose to sell and we are moving again because now that my partner is pregnant, we won't be able to afford our current rent when she goes on leave and only makes 55% of her income. Housing unaffordability and low wages (versus our private professionally practicing peers who make ~\$150/hour) are a feminist issue as mental health workers are primarily women.

”

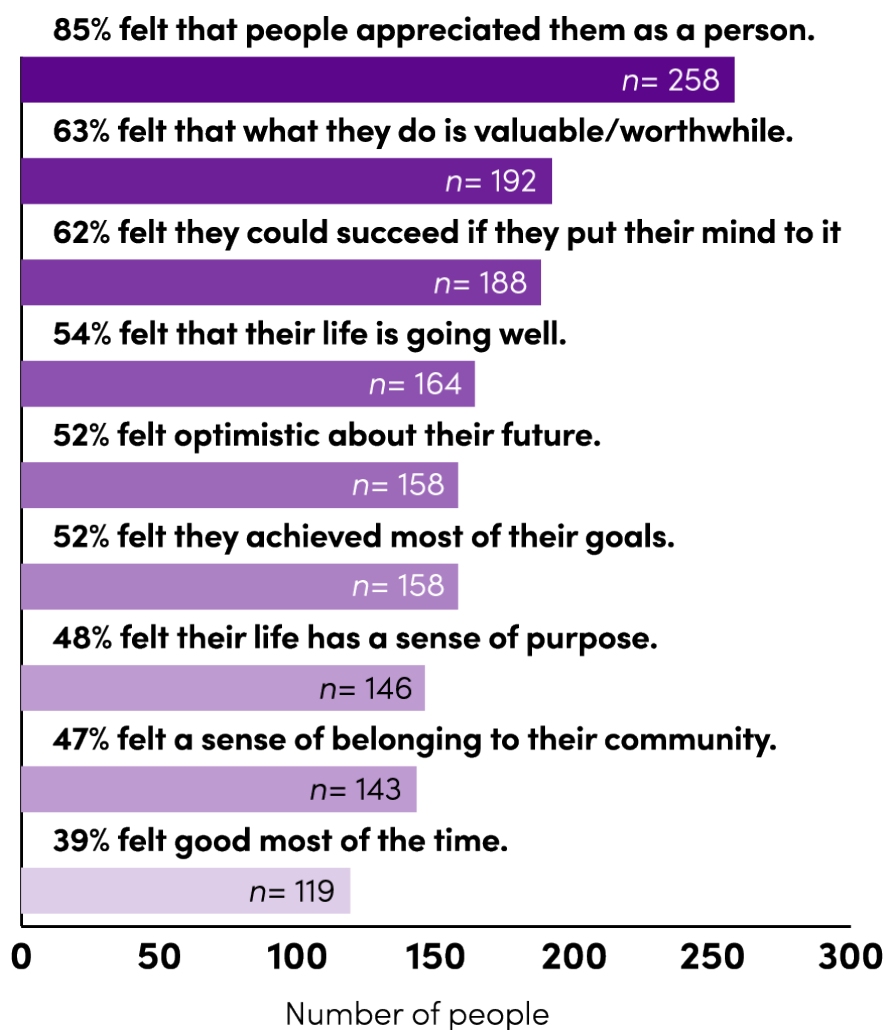
Difficulties finding an apartment or adequate housing due to 2SLGBTQI discrimination were also noted as a future concern by 49% of survey respondents, indicating the importance of addressing housing-related barriers in the context of the ongoing pandemic, rising living costs, and stagnating wages.


### **Hope, Optimism, Coping, and Resilience**

A recent Canadian poll found that 53% of 2SLGBTQI respondents, 54% of racialized respondents, and 40% of respondents with a physical impairment are less likely than the general population to feel hopeful, happy, and interested in life (MHRC, 2023). Although our findings similarly show how the pandemic has created or exacerbated challenges which negatively impact participants' health and well-being, our research also illustrated the coping strategies and resilience of 2SLGBTQI people as they navigate these difficulties. For example, our national survey asked respondents a series of questions gauging their hope and optimism, with these results among those who either somewhat or strongly agreed with the statements below:

- 85% ( $n = 258$ ) felt that people appreciated them as a person.
- 63% ( $n = 192$ ) felt that what they do is valuable/worthwhile.
- 62% ( $n = 188$ ) felt they could succeed if they put their mind to it.
- 54% ( $n = 164$ ) felt that their life is going well.
- 52% ( $n = 158$ ) felt optimistic about their future.
- 52% ( $n = 158$ ) felt they achieved most of their goals.
- 48% ( $n = 146$ ) felt their life has a sense of purpose.
- 47% ( $n = 143$ ) felt a sense of belonging to their community.
- 39% ( $n = 119$ ) felt good most of the time.

## Hope and Optimism – Survey Responses





Importantly, survey respondents who were also service providers received a slightly higher average composite score<sup>7</sup> (out of 5) on hope and optimism measures than respondents who did not identify themselves as service providers (mean scores were 3.71/5 and 3.32/5, respectively). The same held true for resilience measures, with service providers having an average score of 3.48/5 and service seekers having an average score of 3.24/5.

Being hopeful and optimistic may facilitate the use of adaptive coping strategies (i.e., strategies that protect and maintain health and well-being) as well as higher levels of resilience when faced with a range of stressors. Our survey asked respondents questions addressing various aspects of resilience, with these results among those who either selected “often like me” or “very much like me” for these statements:

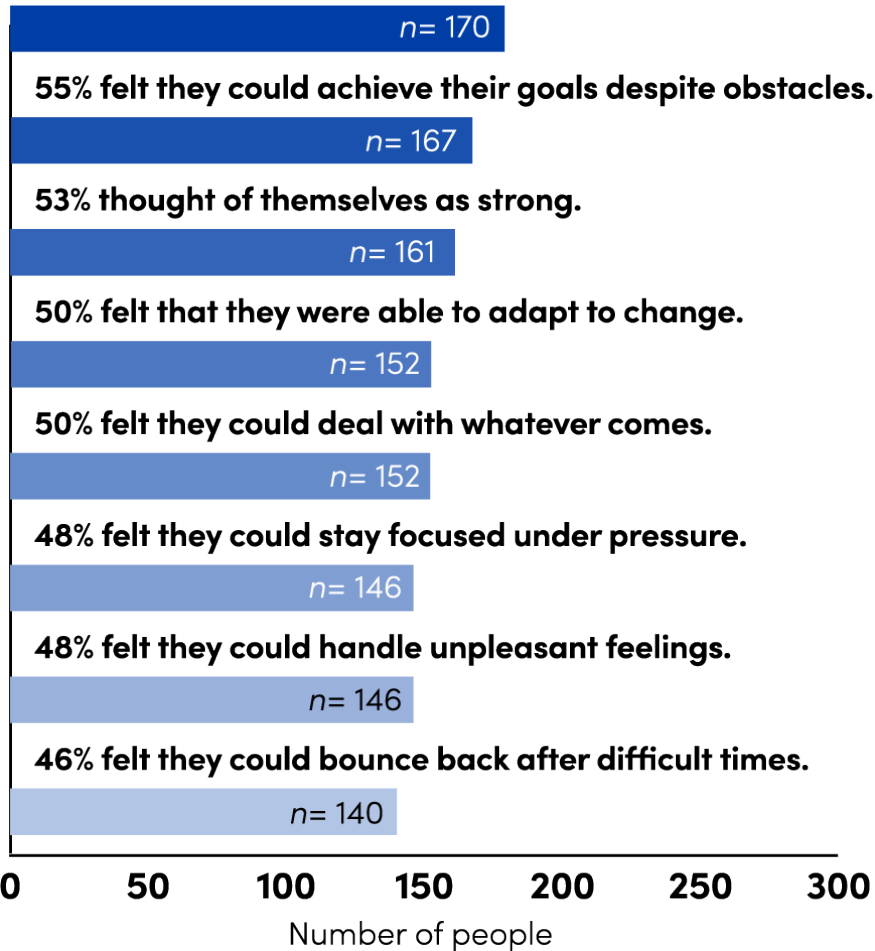
- 56% ( $n = 170$ ) felt they could see the humorous side of problems.
- 55% ( $n = 167$ ) felt they could achieve their goals despite obstacles.
- 53% ( $n = 161$ ) thought of themselves as strong.
- 50% ( $n = 152$ ) felt that they were able to adapt to change.
- 50% ( $n = 152$ ) felt they could deal with whatever comes.
- 48% ( $n = 146$ ) felt they could stay focused under pressure.
- 48% ( $n = 146$ ) felt they could handle unpleasant feelings.
- 46% ( $n = 140$ ) felt they could bounce back after difficult times.

---

<sup>7</sup> Composite scores were calculated based on responses provided on scales by respondents. For example, statements like “My life has a sense of purpose” were followed by scaled responses like “Strongly disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Strongly agree”. Numerical scores were attributed to each possible response: Strongly disagree=1, Somewhat disagree=2, Neither agree nor disagree=3, Somewhat agree=4, Strongly agree=5. Then, averaged scores were calculated over a number of statements related to hope and optimism for each respondent, and the mean was calculated across the sample of survey respondents to have a general idea of how participants were hopeful/optimistic. Higher scores suggest better hope/optimism, and inversely for lower scores.

## Coping and Resilience – Survey Responses

56% felt they could see the humorous side of problems.



Focus group participants highlighted a range of health-protective strategies in which they engaged, including:



Speaking to a mental healthcare provider (e.g., counsellor or therapist);



Doing sports and exercising;



Socializing with friends or getting involved in community-based activities;



Meditating, yoga, and mindfulness;



Pet therapy;



Cooking and trying new recipes;



Gardening;



Volunteering and helping others.

Similarly, over 60% ( $n = 185$ ) of survey respondents indicated that they were going into nature or doing outdoor activities and/or getting emotional support from others to protect their health and well-being. Further, 45% ( $n = 137$ ) of survey respondents indicated they were engaging in at least one of the following strategies to protect their health and well-being: concentrating their efforts on doing something about their situation; getting help and advice from other people; looking for something good in what is happening; getting comfort and understanding from someone; expressing their negative feelings; taking time to do something they really enjoy; eating healthy food; exercising regularly; and participating in online community-building activities or groups.

Duncan (FGP) shared how the pandemic coincided with some intense difficulties and the role that art played in ameliorating some of these difficulties:

“

At the start of the pandemic, I was doing well, I just got out of rehab, sober and clean, and I very clearly went into active addiction, active mental illness. I lost my home, went to jail, became homeless, absolutely fell apart, completely terrible, long story short. Now, I'm pulling out of that, I am back to doing work, creative work—and my latest project is thinking about defining moments, turning points, and what makes those, and looking at turning point in my artistic career, looking at new material, and thinking about “newness” and sort of what are those moments that can turn your life around? Onward and upward. I've gotten some grants and some new projects going so it feels like I am moving away from that awful two and a half years.

”

In addition to participants' engagement in a wide range of health protective strategies, an example of optimism (e.g., reframing a negative situation and/or focusing on a positive element of a situation) that emerged in both our survey and the focus group was the way in which participants talked about the “silver linings” (the positive side) of the pandemic. For example, Sam (FGP) poignantly shared:

“

I found the pandemic, as horrible as it's been, to be this beautiful catalyst for gender exploration without anyone else around to judge or see who I was in a way that I didn't wanna be. And so someone who's more masc of centre but was born into a female body, it was great for me to see 'how do I feel wearing the clothes that feel good on me?' without that fear of judgment or anxiety that comes with other people seeing it [...] I think that was an important shift to understand my discomfort wasn't about being trans, gender nonconforming, or masc, it was with society's judgment of those identity facets.

”

Zack (FGP) also noted a positive shift that coincided with the pandemic:

“

[B]efore the pandemic I didn't think about my mental health too much [...]. I am quite extroverted; I get a lot of my energy from social interactions. As soon as it was taken away, I wouldn't say it was a focus on mental health but a focus on holistic wellness. So, I started doing things like yoga, meditating, and sure the pandemic has been tough, being socially isolated—but I think a big takeaway is that I'm much more comfortable being alone by myself now than I was ever before.

”

A lesbian woman living in urban ON (SR) also mentioned how her mental health had improved during the pandemic, largely due to being out and having access to supportive social relationships:

“

I have heard mental health talked about a lot more since the pandemic began, which I think is great. However, it is also interesting for me because my mental health has been fairly stable and strong throughout the pandemic [...] Now that I am out and feel the support of people in my life for my whole self, and now that I am in a healthy relationship with a supportive partner, I do not feel isolated. My mental health has been much more positive during the pandemic than it was for many years before. This brings home to me how much the social determinants of health matter and how much resources and loving, supportive relationships can positively impact mental health.

”

For some, the pandemic also catalyzed health-supportive behaviours, including preparing more homemade food and reestablishing relationships, as an individual [gender and sexual identities not specified] living in urban ON (SR) noted:



“

I’m eating better and cooking more at home, [rather] than grabbing fast food or eating at restaurants [...] I have become closer to my family and good friends. For example, with friends who had COVID and isolated, we organized the drop off of food. My brother was hospitalized for two weeks with COVID, and I spoke with him and his family, and organized helping them with things in ways that brought us closer.

”

A common silver lining noted by service providers was how the move to virtual, telehealth services made mental healthcare more accessible to many clients. This was particularly true for those working in northern, rural, and remote contexts.

While the resilience, coping, and reframing strategies evidenced by our participants is promising, it bears repeating that the pandemic continues to intensify feelings of exhaustion, burnout, and stress, which compound the minority stressors 2SLGBTQI people already experience.

## Service Provider Experiences

Our research findings revealed that the ongoing pandemic is also presenting healthcare providers—especially providers who are 2SLGBTQI—with a range of challenges in meeting the needs of 2SLGBTQI care and service seekers. These challenges include a lack of resources and navigating the tension of taking on clients whose needs may be out of their scope of practice because of a lack of affirming service providers, as the following quote by Cori, a queer service provider working in Ontario (SP/FGP) illustrates:

“

I feel like I’m on a little island where I’m a support and my client is there with me, but then when we are outside of that, there’s so few resources, especially affirming ones for folks facing multiple experiences of marginalization [...] So many clients on my caseload have experienced trauma from cis therapists in the past and working with that makes

me feel really helpless about the system, because folks don't have the knowledge, there aren't services to refer folks to, and then they'll come to me presenting concerns that are way outside of my scope of what I feel comfortable in. And then I'm like, how much do I respect a client saying, 'I see myself represented in you and that's all I need', versus me saying 'I don't have skills to support this specific concern, but there's nowhere to refer you where you see yourself represented and get that support.' So, I really feel stuck, and **either I'm saying 'sorry I can't' with no referrals, or treating someone outside of my scope, because what other options are there?** (Emphasis is the author's)

”

Other challenges include long wait lists and maintaining personal boundaries in efforts to manage vicarious trauma, as one bisexual/queer/lesbian genderqueer woman living in urban area of QC (SP/SR) wrote:

“

[A]s a mental health professional, I have been burdened by the suffering I have encountered, my clients' difficulties in accessing care (both worrying about them and being called upon more often by clients who don't have access to additional supports), my waiting lists (regretting being simply unable to see many people who approach me for help), and having to manage my time carefully to make sure my practice remains sustainable.

”

Chantelle, a queer-identified counsellor working in rural Ontario (SP/FGP) explained their approach to trauma-informed care, which involves thinking critically about traditional, biomedical approaches to mental healthcare:

“

[S]omething that traditionally I wouldn't be doing with our cis, straight peers [is] depathologizing a lot of the symptoms they're experiencing, because **we're always told we're sort of the problem, we're pathologized, and really helping folks shift their lens to see that a lot of what they're experiencing is symptoms of somebody who's feeling**

**oppressed or is feeling unsafe**. Someone who's experienced trauma. And helping them extrapolate that colonial individualistic pathologizing ways, and really helping them empower themselves outside the traditional medical system, because that is often not where they feel safe [...] That's also something that I've shifted during the pandemic, is finding community and helping them understand, there's a lot of political stuff going on that's been really harmful for trans folks specifically. So, a lot of unpacking the macro level trauma that's happening as well on a policy level. So, a lot of talking about anti-oppressive practice, anti-capitalist stuff, internalized homophobia, so really more of that political talking and depoliticizing of self in session. (Emphasis is the author's)

”

Joelle, a queer therapist working in NL (SP/FGP), discussed the importance of employing a social determinants of health lens when providing mental healthcare:

“

In terms of supporting folks is that in my experience, especially with the trans community, there are so many other concurrent problems that are associated in my mind with injustice and oppression, so more funding for housing, employment services, gift cards to grocery stores. Those kinds of things would help me be a better practitioner for those clients. Because I've worked with people who, just by nature of transitioning, have lost their job, become homeless. And so being able to identify how we can support clients through those other social and systemic injustices I think would be helpful.

”

# Recommendations

Given the surge in demand for mental healthcare services as well as persistent gaps in service delivery and quality of care for 2SLGBTQI people, it is imperative that mental health services and related social services address social determinants of mental health. As such, participants shared several recommendations on how to improve 2SLGBTQI mental healthcare to better meet their diverse needs. We have grouped recommendations into five primary areas: structural changes, accessibility, representation, intersectionality, and accountability.

## Structural Changes

- Address siloed approaches to mental healthcare by connecting mental healthcare services and individual providers to community-based organizations who are already doing great work on the ground.
- Implement structural changes to the mental healthcare system, so that inclusion is not dependent on an individual practitioner and that service providers represent the communities they serve. Suggested structural changes included the following:
  - Increasing the number of psych nurses, social workers, psychologists, psychiatrists, and peer support workers.
  - Addressing structural barriers such as budget cuts or unsupportive administrators or supervisors by involving policymakers and those in leadership decisions in training and educational initiatives.
- Provide more funding for community-based 2SLGBTQI organizations.

## Accessibility

- Offer free or more affordable mental healthcare to help deal with stress caused by ongoing pandemic, discrimination, and other stressors.
- Incentivize more 2SLGBTQI service providers to serve rural, remote, and northern communities.

- Recognize and address the distinct barriers to mental healthcare experienced by 2SLGBTQI people in rural, remote, and northern regions as a result of increased visibility and a lack of resources.
- Highlight and address the need for continuous, long-term access to therapy or counselling, as opposed to single sessions or a limited number of sessions for a specific issue/crisis. This is especially important for mental healthcare services delivered through publicly funded systems.
- Remove federal or provincial taxes for certain types of practitioners in order to decrease the cost of their services and in turn make services more accessible for 2SLGBTQI service seekers.

## **Increasing Representation**

- Hold professional governance bodies accountable for discriminatory practices that prevent marginalized folks from holding these positions (e.g., prohibitive supervision and exam fees).
- Address other barriers and factors that prevent intersectionally marginalized service providers from entering – or that push them out of—their fields of practice:
  - For example, more communication and support from other service providers working with 2SLGBTQI individuals and developing Communities of Practice among 2SLGBTQI service providers would protect against isolation and burnout.

## **Addressing a Wider Range of Needs and Experiences through Intersectional Approaches**

- In training, education, and implementation of learnings into practice, go beyond the basics and unpack the structural, systemwide barriers to care that 2SLGBTQI people face (e.g., transphobia, racism, ableism).
- Approach mental healthcare in an explicitly intersectional, trauma-informed, anti-racist, and anti-oppressive way that actively responds to the harms caused by colonialism and structural racism.

- Address the needs and experiences of Indigenous service seekers and contribute to broader reconciliation efforts by critiquing and dismantling colonial approaches to mental healthcare (This should include—but is not limited to—relationship- and trust-building; working with Indigenous mental health providers to develop meaningful referral pathways; educating oneself on Indigenous understandings of and approaches to mental health concerns, well-being, and healing; and actively dismantling anti-Indigenous racism in mental healthcare settings.)
- In both training and mental healthcare delivery, implement intersectional approaches by addressing how 2SLGBTQI care seekers' needs evolve over the life course and are dependent on a wide range of factors, including gender, sexual orientation, geographical location, ethnicity, income, and disability. (Specifically, use intersectionality theory to understand the complexity of people's identities beyond their sexual and gender identities.)
- Approach both training and mental healthcare delivery from a strengths-based lens in order to combat pathologizing narratives that have historically guided mental health disciplines' approach to 2SLGBTQI people.
- Provide more support for and education about 2SLGBTQI seniors and those living in long-term care.
- Provide mental healthcare support within shelters and abortion services (especially for trans and nonbinary care seekers).

## Accountability

- Make 2SLGBTQI cultural responsiveness training mandatory, since participation in learning opportunities is still dependent on service providers opting in and doing a lot of training on their own time, rather than entire organizations or institutions mandating training or providing a structured set of promising practices as it relates to providing 2SLGBTQI-affirming care.

- Offer continuous and/or prolonged learning for service providers on how to engage respectfully, particularly for providers who have been practicing for a long time.
- In training and educational initiatives; include comprehensive evaluative components that assess what learners have changed in their workplaces, practices, and approaches to service delivery over time.

# Conclusion


This report has provided an overview of what we have heard from 2SLGBTQI people from across Canada about their mental healthcare experiences, needs, and recommendations for improvement in the context of the ongoing pandemic. We have also provided an overview of both 2SLGBTQI and allied mental health service providers' experiences and the challenges they face in supporting 2SLGBTQI people.

Research participants' experiences illustrate the pandemic's wide-ranging impacts on various social determinants of mental health, including access to mental healthcare and medical care, social support, employment, income, food security, and housing. In each of these areas, 2SLGBTQI people experience distinct challenges as a result of both structural- and interpersonal-level homophobia, transphobia, and cisheterosexism. These challenges are particularly pronounced for intersectionally marginalized folks, including 2SLGBTQI people who are racialized, living with a disability, or who are experiencing poverty and economic hardships. Service providers, particularly those who are themselves 2SLGBTQI, are also facing issues such as burnout, vicarious trauma, and financial precarity which require tailored solutions.

The experiences and recommendations detailed in this report point to the pressing need for research, training, educational initiatives, and advocacy rooted in intersectional, holistic, trauma-informed, and anti-oppressive approaches to 2SLGBTQI mental health. Indeed, "queering mental health" requires fundamental shifts in addressing the mental health and healthcare needs of 2SLGBTQI people across Canada. These shifts involve:

- Situating mental health concerns as a social problem rather than an individual issue.
- Recognizing and addressing the harms caused by biomedical, privatized approaches to mental healthcare.



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- Addressing critical training and service delivery gaps by listening to community voices and emergent needs instead of upholding the status quo
  - Dismantling barriers to mental healthcare and other sources of minority stress (e.g., anti-2SLGBTQI stigma and discrimination).
  - Facilitating 2SLGBTQI service seekers' access to individual- and community-level sources of support, resilience, and empowerment.

Implementing these shifts will not only ensure that 2SLGBTQI people receive the affirming and inclusive mental healthcare and related services they need but will also support 2SLGBTQI and allied service providers in their work of addressing the mental health concerns that have been amplified in the wake of the COVID-19 pandemic.

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