# Providing Effective Approaches to Tackle Mental Health Inequality in LGBTQI+ Populations

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## 1 | Introduction

Mental health inequalities between LGBTQI+ populations and non-LGBTQI+ populations have been well documented and are likely attributable to "individual, systemic, and structural factors" (1, 2). Efforts to address these inequalities must be targeted at both individual and population levels. This essay will aim to reflect on the mental health inequalities experienced by this group and consider approaches to tackling them.

## 2 | Health Inequalities

The NHS defines health inequalities as:

> *"...preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs" (3).*

A critical word to highlight is 'preventable' which suggests that LGBTQI+ inequalities can be avoided if appropriate interventions are taken. Addressing inequalities refers back to one of the four main medical ethical principles – justice (4). This is a rights-based argument that refers to all individuals having fair and appropriate access to healthcare.

Importantly, the above definition highlights that inequalities effect an individual's health both before and after sickness suggesting interventions should be targeted at both the prevention and treatment stages. By taking a holistic view, services can prevent undue progression of disease and result in less utilisation of acute and emergency care, leading to a more economical and efficient service for all.

Additionally, the Department of Health and Social Care has a statutory duty to develop policies and deliver services that “eliminate discrimination” and “advance equality” for those with protected characteristics including gender reassignment and sexual orientation (5).

## 3 | LGBTQI+ Population

The term LGBTQI+ encapsulates a group of individuals who identify as lesbian, gay, bisexual, transgender, queer/questioning and intersex with the ‘+’ representing others within the community such as those who identify as aroace or pansexual (6).

The number of individuals within the LGBTQI+ community in the UK is hard to accurately estimate. From the most recent census in 2021 there were 1.5 million people (3.2%) in England and Wales, 32,000 people (2.1%) in Northern Ireland (NI) and 184,000 people (4.0%) in Scotland who identified as “gay or lesbian”, “bisexual” or “other sexual orientation” (7-9).

Looking at gender, 262,000 (0.5%) in England reported that the gender they identified with was different from the sex registered at birth (10). In Scotland, 19,970 people (0.44%) reported they were trans, or had a trans history (8). NI did not collect information on gender in the 2021 census.

Differences in figures may be because of regional sociopolitical factors and individuals choosing not to respond for various reasons such as safety or stigma (11). As such, these figures are almost certainly under representative but do show a number of individuals across the UK that should be afforded equitable healthcare.

## 4 | Approaches to Tackle Mental Health Inequality

Multiple reviews have addressed mental health inequalities considering social determinants like demographic, economic, environmental, and sociocultural factors (12, 13). These factors are key to consider for all individuals, including those in the LGBTQI+ community. There have been four key practical steps identified to address mental health inequalities which will be explored in relation to the LGBTQI+ population throughout this essay.


*Figure 1 - Steps on Commissioning and Delivering Equality in Mental Health Care (14)*

## 5 | Identify: Understanding Inequalities

A crucial first step is to understand the healthcare needs of the LGBTQI+ community, the healthcare services that are currently available and the experiences and outcomes of individuals who use these services.

### 5.1 | Services

Many mental health services for the LGBTQI+ population are in the non-statutory sector, including Pink Therapy, the LGBT Foundation and Switchboard LGBT+ Helpline. It should be noted, services like Pink Therapy are paid for services and so are less available to those with greater levels of socioeconomic deprivation.

Despite the evidence showing the importance of creating LGBTQI+ specific services, there appears to be few specific LGBTQI+ mental health services within the NHS (15). Furthermore, there are few studies evaluating the use of specific LGBTQI+ services against traditional services. One study did find gay and bisexual men had better outcomes in specific LGBT specialised substance misuse services compared to traditional services (16). In addition, since the Cass Review was published in 2024, there have been significant changes to gender identity services for children and young people across the UK.

More information is needed on the uptake and usage of general mental health services by the LGBTQI+ population. This should include information on GP contacts for mental health-related needs, referrals to mental health services, mental health presentations to A&E and mental health hospital admissions specifically in relation to the LGBTQI+ population (14).

### 5.1 | Outcomes

When looking at outcomes, it is important to understand the common mental health presentations in LGBTQI+ individuals. A systematic review and meta-analysis found that lesbian, gay and bisexual individuals were at “higher risk of suicidal behaviour, mental disorder and substance misuse and dependence than heterosexual people” (17). There is less evidence on transgender and intersex populations, but systematic reviews have highlighted poor outcomes including higher rates of psychiatric diagnosis, suicidality and substance use for these individuals (18, 19).

As well as peer reviewed studies, LGBTQI+ charitable organisations have also collected information on mental health inequalities again showing worse outcomes for LGBTQI+ individuals (20, 21). This step of including members and organisations from the LGBTQI+ community is crucial as it enables gaps to be identified that may be ‘hidden’ in the usual forms of data collection.

It is also important to note that the above outcomes are likely to be worsened when considering intersectional factors for example age, ethnicity, and socioeconomic status that also all contribute to health inequalities.

### 5.2 | Experiences

The experiences of LGBTQI+ individuals within mental healthcare services are important to consider. Studies have found that LGBT individuals are more likely to be dissatisfied compared to non-LGBT respondents (22). A report by Stonewall indicated that individuals from the LGBTQI+ community have negative experiences of healthcare services including unequal treatment, inappropriate curiosity, being outed without consent and lack of understanding from staff (20). The National LGBT Survey noted that 28% of respondents found it “not at all easy” to access mental health services within the previous 12 months (23).

The above is multifactorial but demonstrates that there still is significant marginalisation of this group of individuals within services despite the increasing social inclusion. This is played out through “discrimination, stigma, anti-queer and anti-trans policies, bullying/harassment, and other violence occurring at both micro and macro levels (24, 25). This is an example of minority stress and creates a real or perceived

fear for individuals that ‘coming out’ to healthcare staff might be met with animosity and negative experiences.

## 6 | Design: Generating Ideas and Problem Solving

The next stage is formulating steps to address the identified issues. To do this, a thorough review of the evidence base is needed to understand what interventions have successfully been implemented elsewhere. This will help guide the development of ideas and should be done in a co-produced and trauma-informed manner and involve members of the LGBTQI+ community. There are many approaches that could be explored but this essay will aim to focus on two ideas as outlined below.

### 6.1 | Attitudes

With the ICD-11 moving gender incongruence from Chapter 6 (mental, behavioural or neurodevelopmental disorders) to Chapter 17 (conditions related to sexual health), there has been a movement away from the “psychopathological model of transgender people” to one that is “more reflective of current scientific evidence and best practice” (26). This is a similar movement to what was seen with the diagnosis of homosexuality in both the ICD and DSM over the last 50 years (27). This historic pathologising of individuals sexual orientation and gender has created distance between LGBTQI+ individuals and healthcare services, particularly mental health. As such, this is an essential area to tackle if mental health inequalities in LGBTQI+ individuals are to be addressed successfully.

One way to improve this would be provide appropriate cultural competence training to health care staff. This has been shown to improve the following:


*Figure 2 – Positive Outcomes of Cultural Competence Training (28)*

By creating a culturally competent workforce, you are more likely to reduce the issues of staff assuming sexual orientation and gender and staff are more likely to use a person-centred approach. This in turn will lead to greater trust from LGBTQI+ individuals and create a space where they can be openly 'out' without fear of negative repercussions.

### 6.2 | Laws and Policies

Legislation can enact large scale change in services and the attitudes of the general population. Historically, LGBTQI+ individuals have not had equal rights to certain legal processes. For example, same-sex marriage only becoming legal in 2020 across the entirety of the UK and harmful practices like conversion therapy still not being banned across the UK (29, 30).

More recently, the Cass Review on gender identity services and the supreme court ruling on the definition of a 'woman' as per the Equality Act 2010 have fuelled political and societal conversations around the rights of transgender individuals (31, 32). It will take time to further understand the consequences of these decisions, but they will likely have impacts on mental health services.

As with all previous stages, co-production with members of the LGBTQI+ community in the development of policy and law is crucial to ensure they are representative and non-discriminatory (33).

## 7 | Deliver: Tackle and Reduce Inequalities

As demonstrated above, mental health services must have a central focus on gender and sexual orientation affirming care to successfully tackle mental health inequalities. This includes adapting already existing services to be more inclusive of the LGBTQI+ population while also creating and developing specific LGBTQI+ services. A major part to play in this is also the staff education and attitudes as well as wider national laws and local policies that govern LGBTQI+ rights. To do this, the above actions need to be translated into strategy plans and various mitigating factors need to be considered such as resources (e.g. staff and facilities), budget and timeframe (14).

We can see some evidence of this in the government's LGBT Action Plan where it states, "we will take action to improve mental healthcare for LGBT people" (34). This is mirrored in the Mental Health Strategy Northern Ireland which states services should "consider groups disproportionally affected by mental ill health who often struggle to access early intervention services and seek to reduce stigma associated with mental ill health" (35). This is a key step but lack details or clarity on the actions that will need be taken. Nonetheless, it provides civil servants within the Department of Health grounds to research, develop and implement new and innovative ideas.

## 8 | Evaluate: Evaluating and Improving Service

Once the above steps have been completed and new interventions have been implemented, it is crucial to ensure there is "inclusive longitudinal population mental health monitoring" (24). This could include simple measures like capturing gender and sexual orientation data or more specific outcomes such as patient-reported experience or outcome measures. This should be done continuously and data amalgamated to provide an overall picture which in turn can be used to drive further research to improve mental health inequalities. It is also important to provide individuals using and working for LGBTQI+ specific services the opportunity to provide feedback and implement quality improvement measures based on this.

## 9 | Conclusion

In conclusion, this essay has considered the evidence that there are significant mental health inequalities that exist within the LGBTQI+ population. It has highlighted four practical steps that can be used to tackle these inequalities including identifying the

inequalities using existing knowledge as well as formulating, delivering, and evaluating new ideas. This essay emphasizes the importance of using co-production throughout the complete process to ensure voices and opinions of those from the LGBTQI+ community are acted on accordingly.

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