2024

Community informant and mental health provider perspectives on access to mental healthcare for LGBTQIA+ communities in Virginia

Chariz Seijo
Virginia Commonwealth University

Community informant and mental health provider perspectives on access to mental healthcare for LGBTQIA+ communities in Virginia

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science

at Virginia Commonwealth University

By Chariz Seijo, MPH

Committee Members:

Kevin W. Allison, PhD

Shawn C.T. Jones, PhD

Dace Svikis, PhD

Maurice N. Gattis, PhD

Table of Contents

Abstract

The existing literature on mental health disparities for lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) populations suggests members of LGBTQIA+ populations are at greater risk of mental health disorders than cisgender and heterosexual individuals. The COVID-19 pandemic has also exacerbated mental health disparities for many, including LGBTQIA+ populations. Combined with mental health provider shortages and anti-LGBTQIA+ bills across the country, inequities in mental healthcare are a significant concern. This qualitative study was designed to gather unique perspectives of key community informants and mental health providers on their experiences with mental healthcare provision to LGBTQIA+ communities in Virginia. In partnership with Virginia's Department of Behavioral Health and Development Services (DBHDS), 20 community informants (non-profit leadership, educators, etc.) and 14 mental health providers who provided services to LGBTQIA+ populations were interviewed in focus groups and individual interviews from across Virginia during September 2022 to October 2023. Findings supported three broad themes across both informants and providers. These shared themes included the gap in access to LGBTQIA+ mental healthcare, the gap in access to mental healthcare varies across client needs, and the COVID-19 pandemic was a double-edged sword. There was one theme unique to key community informants (community informants find their own solutions to address the gap in care), and one theme unique to mental health providers (the negative impact of anti-LGBTQIA+ politics). These findings can inform future policy and community-led efforts to improve access to mental healthcare for LGBTQIA+ individuals to ultimately reduce LGBTQIA+ mental health disparities.

Vita

Chariz Seijo, MPH, is a doctoral student in the Clinical Psychology program at VCU within the child/adolescent studies concentration. She is a Southern Regional Education Board (SREB) Doctoral Scholar. Her research interests include increasing access to and quality of mental healthcare for minoritized populations. She received her MPH in Health Policy and Management from Columbia University Mailman School of Public Health and completed her undergraduate degree at the University of San Diego. She has previously worked on diverse research projects aimed at improving mental healthcare in school-based, substance use, and primary care settings.

Community informant and mental health provider perspectives on access to mental healthcare for LGBTQIA+ communities in Virginia

Introduction

Despite limited research on lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) health disparities, there is evidence of health inequities between LGBTQIA+ populations and cisgender and heterosexual populations (Cochran et al., 2016; Conron et al., 2010; Operario et al., 2015; Reisner et al., 2016). LGBTQIA+ individuals are at greater risk for substance use disorders (Connolly & Gilchrist, 2020; Kerridge et al., 2017), mental health disorders (Bockting et al., 2013; King et al., 2008; Pinna et al., 2022), and suicidal ideation (E. Marshall et al., 2016; Yıldız, 2018) as compared to the general population. The minority stress model explains how LGTBQ+ individuals face stigma and discrimination and other unique stressors that add excess stress and lead to negative mental health outcomes (Meyer, 2003). This model also suggests how the additive stress from multiple marginalized identities contributes to worse health outcomes (Cyrus, 2017). The COVID-19 pandemic is one stressor that has potentially exacerbated mental health disparities for LGBTQIA+ populations (Salerno et al., 2020), but also increased accessibility to mental healthcare through the widespread use of telehealth (Busch et al., 2021). Another stressor is the escalating anti-LGBTQIA+ political climate affecting the mental health of LGBTQIA+ populations (Gleason et al., 2016; Gonzalez et al., 2018; Tebbe et al., 2022). There are also several barriers to access to mental healthcare, including costs, discriminatory experiences in mental healthcare settings, and a lack of culturally competent mental health providers (Nowaskie, 2020; Shipherd et al., 2010). However, protective factors, including social support and affirming spaces, are critical pathways that may be useful for improving access to mental healthcare (Fernandes et al., 2023; Fuller & Riggs, 2018; Puckett et al., 2019; Valente et al., 2020). The current study seeks to understand, through the perspectives of key community informants and mental health providers, how these and other factors may impact LGBTQIA+ Virginians' access to quality mental healthcare.

Terminology

Members of LGBTQIA+ populations use a wide variety of terminology to express their sexual and gender identities. This proposal will primarily use the umbrella term LGBTQIA+ due to its use to refer to groups of people with various sexual and gender identities other than heterosexual or cisgender (LGBTQIA+ Health Education Center, 2020). These groups include but are not limited to: lesbian (an adjective or noun typically used to describe a woman physically and/or emotionally attracted to other women), gay (an adjective to describe people physically and/or emotionally attracted to the same gender), bisexual (an adjective to describe a person who experiences attraction to more than one gender), transgender (an umbrella term for people whose gender identity does not match their sex assigned at birth), queer (an umbrella term for people who view their sexual orientation or gender identity outside of societal norms), intersex (an adjective for a person with one of a group of congenital conditions in which individuals do not develop according to traditional expectations of female or male), and asexual (an adjective to describe a person who experiences little to no sexual attraction to others; (LGBTQIA+ Health Education Center, 2020).

The "+" (plus) represents identities not explicitly stated under the term. The "+" signifies an ever-evolving community where LGBTQIA+ terminology strives to be more inclusive, reflecting the diversity and range of lived experiences for people who identify under this wide-ranging term (Thelwall et al., 2023). The use of the term LGBTQIA+ conveys a sense of unity and reinforces the idea that individuals share overlapping experiences of stigma and discrimination. However, it is still important to recognize not everyone identifies with this term, and within this heterogeneous group, there are nuances to individual experiences where many have differing concerns and various health needs (Dellar, 2022). Finally, I will be using specific terms when referring to studies addressing different populations within the broader LGBTQIA+ community: LGB for research on lesbian, gay, and bisexual individuals and TGD for research on transgender and gender-diverse individuals.

LGBTQIA+ Health Disparities

In 2011, the Institute of Medicine (IOM) published a report, *The Health of Lesbian, Gay, Bisexual, and Transgender People*, to assess the health status of these populations and identify research gaps (Institute of Medicine et al., 2011). The report pushed for increased interest in research on LGBTQIA+ health, including improved methods and research training in data collection and analysis, to advance our understanding of LGBTQIA+ health needs. Noteworthy research into LGBTQIA+ health inequities suggests that members of LGBTQIA+ populations have an elevated risk of premature mortality compared to their non-LGBTQIA+ counterparts (Cochran et al., 2016; Hughes et al., 2022). Lesbian, gay, and bisexual (LGB) adults also have greater odds of poor physical health and chronic health conditions (Gonzales & Henning-Smith, 2017). Furthermore, data collected from the National Health Interview Surveys also revealed that lesbian and bisexual women were more likely to report multiple chronic health conditions than heterosexual women (Gonzales et al., 2016). In addition to the risk of premature mortality, chronic health conditions can put individuals at risk for poor mental health outcomes (Hoy-Ellis, 2023).

Other research into LGBTQIA+ health disparities has highlighted a greater risk for substance use for LGBTQIA+ populations than non-LGBTQIA+ populations. Data analyzed from the Swedish National Public Health Survey revealed that individuals identifying as homosexual or bisexual were more likely to report high-risk alcohol use, cannabis use, and tobacco use compared to heterosexual individuals (Bränström & Pachankis, 2018). Additional studies provide further evidence of a higher risk for substance use disorders in LGB adults compared to heterosexual adults (Kerridge et al., 2017; King et al., 2008; McCabe et al., 2009). Although there is a dearth of studies on substance use in transgender and gender diverse (TGD) populations, a systematic review of substance use among TGD adults revealed higher reported substance use compared to cisgender adults (Connolly & Gilchrist, 2020). A recent meta-analysis provided further evidence of greater substance use among TGD individuals (Cotaina et al., 2022). However, it is important to note that the study found no difference in the prevalence of substance use disorders in TGD folks when compared to cisgender people providing further evidence that mental healthcare needs may vary across different LGBTQIA+ populations.

High rates of mental health disorders in LGBTQIA+ populations have been well-documented throughout the literature (Bockting et al., 2013; Kerridge et al., 2017; Pinna et al., 2022). These include elevated rates of depression, mood, and anxiety disorders (Bostwick et al., 2010; Cochran et al., 2003; King et al., 2008) as well as posttraumatic stress disorder and psychiatric comorbidities (Hatzenbuehler et al., 2009). Population-based data from the Behavioral Risk Factor Surveillance System indicated that LGB adults reported higher odds of frequent mental distress and depression than heterosexual adults (Gonzales & Henning-Smith, 2017). Study results also indicated variation within the broader LGBTQIA+ population. Comparing transgender adults to non-transgender LGB adults, transgender adults were more likely to report symptoms of depression (Su et al., 2016). Moreover, it is important to examine research with an intersectional lens as some multiple marginalized identities (e.g., LGBTQIA+

people of color, disabled LGBTQIA+ individuals) may result in greater odds of experiencing mental health issues (Robertson et al., 2021). Notably, one study found that Black LGB individuals had a lower prevalence of internalizing disorders compared to White LGB individuals further supporting the need for nuanced approaches to understanding mental health disparities in LGBTQIA+ populations (Rodriguez-Seijas et al., 2019).

Mental health concerns of LGBTQIA+ youth during critical periods of development are also of particular concern. LGBTQIA+ youth have an increased risk for mental health disorders and homelessness compared to non-LGBTQIA+ youth (Hafeez et al., 2017; Rhoades et al., 2018). According to data analyzed from the Youth Risk Behavior Survey, LGB students were more likely to report violent victimization, including feeling unsafe at school, than their heterosexual peers (Johns et al., 2020). Furthermore, it is well-established that the risk of self-harm, suicidal ideation, and suicide attempts is higher among LGBTQIA+ people than heterosexual and cisgender people (King et al., 2008; E. Marshall et al., 2016; Yıldız, 2018). For youth, suicide was the second leading cause of death in youth ages 10-14 and the third-leading cause in those aged 15-24 in 2020 (CDC, 2021), and LGBTQIA+ youth are more than four times as likely to attempt suicide than their peers (Johns et al., 2019, 2020). TGD youth were more than twice as likely to seriously consider suicide than cisgender LGB youth (Price-Feeney et al., 2020). Overall, notable mental and physical health disparities continue to persist across LGBTQIA+ populations with differences across multiple marginalized identities.

Minority Stress Perspective: The Impact of Prejudice and Stigma

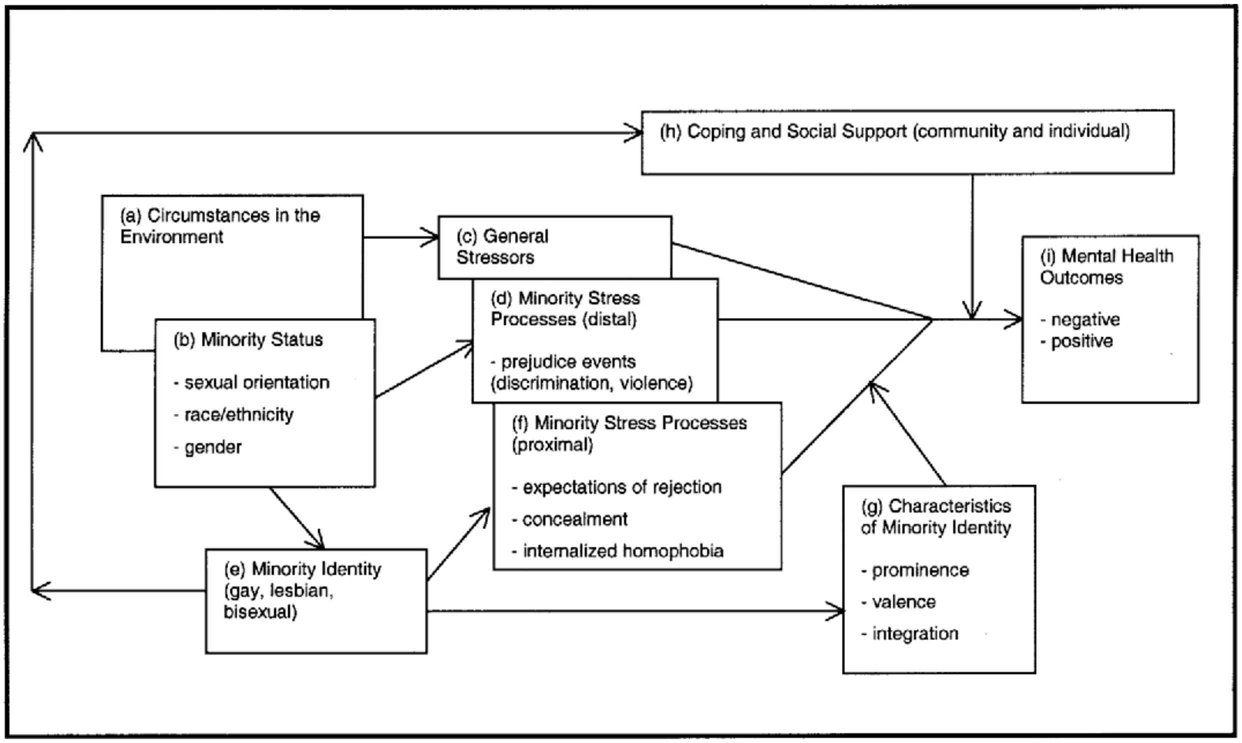
The minority stress model provides a widely accepted explanation for understanding the structural mechanisms driving LGBTQIA+ health disparities (Meyer, 2003). According to this model, both external stressors and internal stressors related to prejudice and stigma contribute to a social environment that can lead to negative health outcomes. The processes that explain how stressors, coping, social support, and identity interact to impact mental health can be seen in Figure 1. Attempting to understand these psychological and structural factors, the model proposes that social status and general circumstances of the environment often shaped by social status (e.g., poverty, education) determine exposure to distal stressors (e.g., discrimination through institutional policies, family rejection) and proximal stressors (e.g., internalized homophobia/transphobia, LGBTQIA+ identity concealment; Meyer, 2003). Excess, and sometimes chronic, exposure to distal stressors may include microaggressions (brief, subtle forms of assault that may be intentional or unintentional) or physical harm, which can in turn bring out proximal stressors, including internalized stigma or fear of rejection (Sue et al., 2007). Personal factors for an individual, including resiliency or social support, may influence how minority stressors impact mental health outcomes (Frost & Meyer, 2023; Hatzenbuehler et al., 2020).

The minority stress model has been applied in numerous contexts, but it was first published focusing on LGB populations (Meyer, 2003). The model published in 2003 focused on mental health outcomes but has since been applied in other contexts to understand the impact of minority stressors on physical health. A systematic review of studies measuring associations between minority stress processes and biological outcomes for LGB individuals found evidence to suggest there is a relationship between these stress processes and physical health (Flentje et al., 2020). Additionally, the minority stress model has since expanded to encompass gender-diverse populations by including experiences of being misgendered and anti-trans stigma (Matsuno et al., 2022; Tebbe & Moradi, 2016). Applications of this model have also moved beyond individual experiences of stress to explore how minority stress is experienced in dyadic relationships. For example, a study investigating minority stressors in same-sex relationships determined that couple-level experiences of stress can have their own unique effect on mental health (LeBlanc & Frost, 2020).

There is noteworthy research suggesting that the unique stressors LGBTQIA+ individuals face are linked to various health disadvantages. Using data from the National Health and Nutrition Examination Surveys, Cochran et al. (2016) demonstrated that elevated risk for early mortality for LGB individuals disappeared when adjusting for health differences, indicating that health disadvantages related to sexual orientation and not sexual orientation itself can account for differences in risk. Yet another study found that structural stigma, defined as community-level prejudice related to homosexuality, was associated with mortality risk for participants reporting same-sex sexual partners (Hatzenbuehler et al., 2020). A systematic review of cardiovascular disease risk concluded that LGB individuals had a greater cardiovascular disease risk related to drug and alcohol use and poor mental health among other factors (Caceres et al., 2017). Additional studies have found an association between drug use and external stressors, and researchers theorize that drug use may be used as a way to cope with traumatic and other experiences linked to LGB identity and community membership (Drabish & Theeke, 2022; Wolford-Clevenger et al., 2021). Further evidence supports this idea: experiences of stigma and discrimination were also associated with a greater risk of mental health problems among LGBTQIA+ populations mediated by drug use (Ngamake et al., 2016).

Figure 1

Minority Stress Model



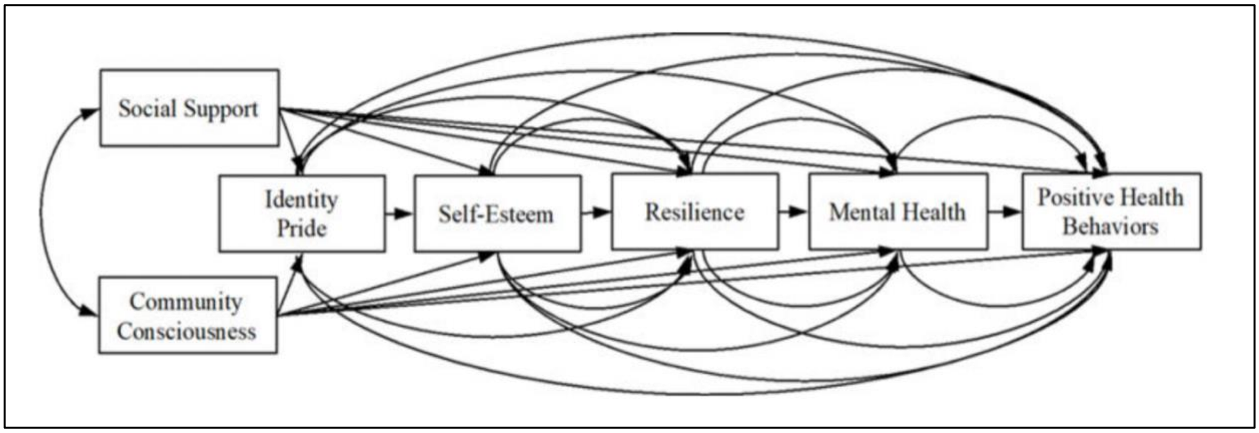
There are additional factors that may further exacerbate the harm experienced from stigmatizing experiences and lead to poor health outcomes. For instance, LGBTQIA+ individuals living in rural communities report higher rates of depressive symptoms and suicidal ideation compared to LGBTQIA+ individuals living in urban communities (Fisher et al., 2014; Irwin et al., 2014). LGBTQIA+ individuals from minoritized racial and ethnic backgrounds often encounter discrimination rooted in both racism and homophobia or transphobia. A study examining intersectional identities and substance use problems found that LGB women were more likely to report lifetime substance use problems than either heterosexual women of color or white LGB women (Mereish & Bradford, 2014). Minority stress theory would suggest that the additive stress from these experiences, including the stress from facing additional barriers to care in rural communities along with discrimination related to LGBTQIA+ identity, would lead to worse physical or mental health outcomes (Cyrus, 2017).

The minority stress model is just one perspective used to understand the health of LGBTQIA+ individuals and how health disparities are developed in these communities. Minority stress emphasizes a shared experience of stigma and discrimination, which is a perspective researchers often apply in conjunction with other theoretical perspectives. For example, the 2011 IOM report on LGBTQIA+ health highlighted three other important perspectives in LGBTQIA+ health research: life-course (a framework for understanding health throughout the life span especially by considering age and cohort differences), intersectional (a framework emphasizing that LGBTQIA+ individuals hold multiple identities worth examining in LGBTQIA+ health research), and social-ecological perspectives (a framework that incorporates influences from the social environment, including family, community, and culture; Institute of Medicine et al., 2011). One such model incorporating these perspectives is the Health Equity Promotion Model, which also emphasizes individual strength and resilience to address disparities (Fredriksen-Goldsen et al., 2014). Other researchers have proposed the importance of social safety (social connection, inclusion, protection, recognition, and acceptance) on LGBTQIA+ health regardless of the presence of stressors (Diamond & Alley, 2022). To reduce LGBTQIA+ health disparities, collaborative approaches incorporating multiple perspectives including the minority stress model are essential.

As one of the most commonly used approaches to understanding LGBTQIA+ mental health disparities, the minority stress model is not without criticism. Much of the criticism of the model suggests it reinforces a deficit-based approach through its focus on stressors and risks to one’s individual mental and physical health (Frost & Meyer, 2023; Perrin et al., 2020). To address this, one model was developed as a strengths-based approach: the minority strengths model. The minority strengths model (figure 2) proposes that a combination of personal and collective strengths can create a causal chain to foster resilience and positive mental and physical health (Perrin et al., 2020). The minority strengths model does not replace the minority stress model but complements it by the inclusion of separate and distinct strength-based factors. It emphasizes the importance of social support and community connectedness in the protection against the impact of minority stressors. Additional research has supported the link between social support and factors identified in the minority strengths model, such as identity pride (Camp et al., 2020), resilience (Puckett et al., 2019), and mental health (McDonald, 2018).

Figure 2

Minority Strengths Model



COVID-19 Impact

It is important to understand and identify stressors for LGBTQIA+ populations within the context of the current global environment. The COVID-19 pandemic has had a profoundly harmful impact on the health and well-being of people across the world. During the first year, the global emergency resulted in governments implementing travel restrictions, school closures, social distancing measures, and quarantine requirements worldwide (Nicola et al., 2020).

Distress related to the global outbreak has been associated with poor mental health outcomes in the general population, especially during the early waves (Manchia et al., 2022). The pandemic has also exacerbated existing health disparities for communities already facing hardship (Andraska et al., 2021). Researchers have theorized that an increase in social isolation, job loss, food and housing insecurity, and related trauma during the pandemic may have had a disproportionately greater impact on the mental health of LGBTQIA+ populations (Salerno et al., 2020). A survey of adults in the U.S. early in the pandemic found that LGBTQIA+ adults rated perceived social support lower than their peers, suggesting that the negative impact of social distancing may be even greater for LGBTQIA+ individuals (Moore et al., 2021). For instance, LGBTQIA+ youth reported having to spend more time in unsupportive and unaccepting home environments during the pandemic (Fish et al., 2020; Gonzales et al., 2020). Multiple studies have provided evidence that LGBTQIA+ individuals experienced worse mental health outcomes, including high levels of depression and anxiety, than heterosexual and cisgender individuals during the pandemic (Firk et al., 2023; Rodriguez-Seijas et al., 2020; Slemon et al., 2022). This evidence suggests that LGBTQIA+ populations may have endured a greater mental health burden from the social isolation and loneliness of the COVID-19 pandemic in addition to the stressors of stigma and discrimination.

However, there is the possibility that some potentially helpful changes have emerged during the pandemic. Lockdown restrictions during the pandemic allowed for an increase in opportunities to expand access to mental healthcare through telehealth, especially for those in vulnerable environments (Busch et al., 2021). The public health emergency led many states to issue emergency rules that temporarily waived licensure requirements for out-of-state providers and expanded telehealth services. Nevertheless, issues of capacity and access persisted. The increase in telehealth availability provided more options for individuals to connect to care, but there were still concerns of limited access related to clinician shortages and the ways in which telehealth could potentially uphold inequities in mental healthcare, especially for people who have limited access to the internet or a deficit in digital literacy (Busch et al., 2021). As the use of telehealth in mental health services continues, it is crucial to consider how its use with LGBTQIA+ populations may be adapted to address concerns of isolation and lack of social support.

Increasing Attacks on LGBTQIA+ Rights

In addition to the mental health concerns exacerbated during the onset of the pandemic, the divisive political atmosphere across the nation has had an impact on the health and well-being of LGBTQIA+ individuals. In 2023, nearly 500 anti-LGBTQIA+ bills were introduced in almost every state legislature (ACLU, 2023a). Over 200 of these bills were related to schools and education, notably laws censoring school curricula, and another 130 bills were related to healthcare, including banning gender-affirming care for transgender youth (ACLU, 2023a). All 12 bills introduced in Virginia's state legislature, primarily in schools and education, were defeated (ACLU, 2023a). Despite this, Virginia Governor Glenn Youngkin's Department of Education released new model policies on the treatment of transgender students in Virginia public schools (ACLU, 2023b; VDOE, 2023). These guidelines included restricting access to restrooms that align with gender identity, forcing teachers and counselors to potentially out students, and denying students opportunities to participate in sports consistent with their identity.

Research suggests that anti-LGBTQ legislation has a negative impact on the mental health of LGBTQIA+ individuals. A study published after the 2016 U.S. presidential election indicated there was an increase in minority stress experiences related to the political climate under the Trump Administration (Gonzalez et al., 2018). In one study of a national sample of TGD individuals, knowledge of anti-trans legislation strengthened the link between transgender discrimination and sense of belonging as well as the link between discrimination and hopelessness, suggesting a potentially negative impact on mental health (Tebbe et al., 2022). Another study investigating the effects of nondiscrimination laws determined that nondiscrimination laws were associated with lower rates of perceived stigma (Gleason et al., 2016). These studies demonstrate how the power of policy can be either harmful or protective. Therefore, policy can be used as an important tool in addressing mental health disparities for LGBTQIA+ individuals.

Access to Mental Healthcare

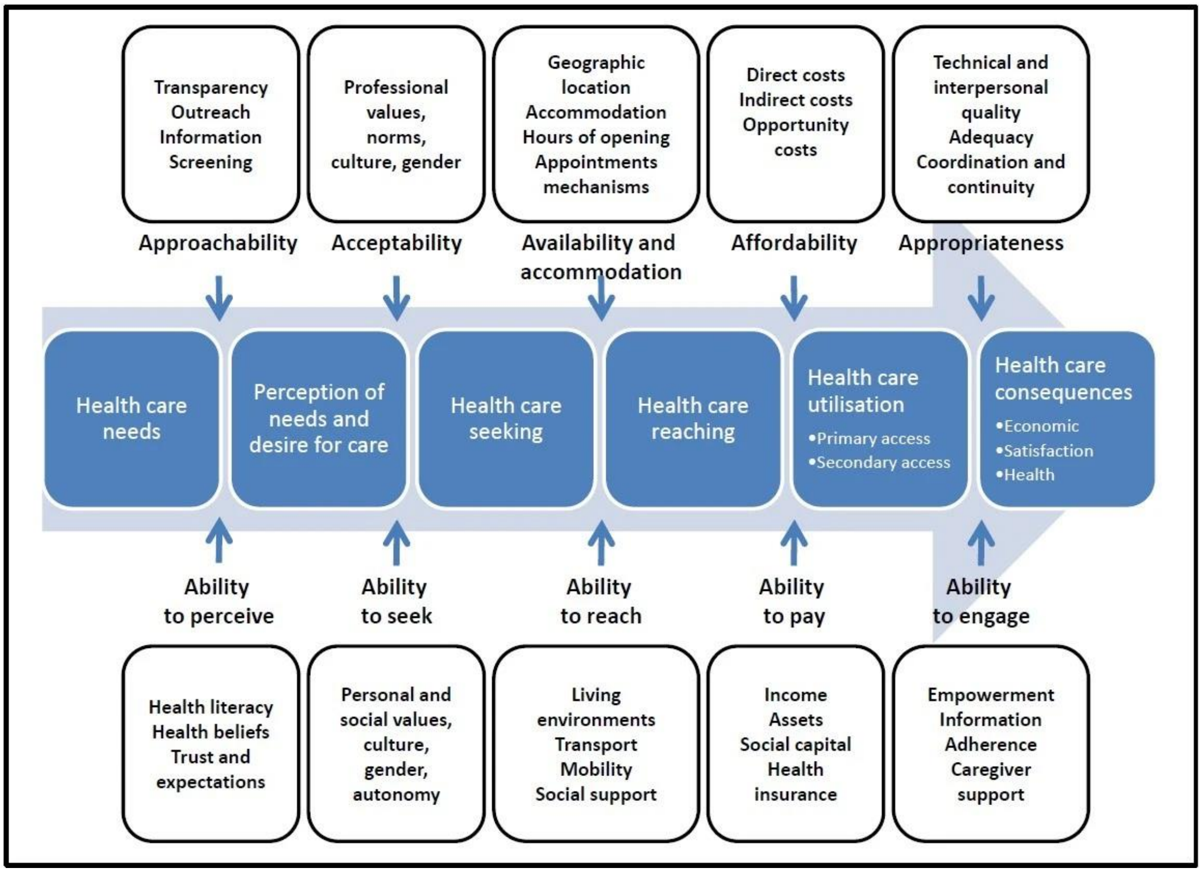
Healthcare accessibility has been conceptualized in various ways. Access has been defined as the use of healthcare depending on the need for care (Waters, 2000). One prominent conceptualization of access is the conceptual framework of access to healthcare (Levesque et al., 2013). Within this framework, access is defined as the opportunity to use health services when there is a perceived need. Levesque's framework focuses on five dimensions of access to healthcare services in the context of health systems (the supply side): (1) approachability, (2) acceptability, (3) availability, (4) affordability, and (5) appropriateness. It also considers patients' perspectives (e.g., the demand side) through corresponding abilities to perceive, seek, reach, pay, and engage in healthcare. The experiences of those accessing care are dependent on the dimensions of the supply and abilities of the demand side. Figure 3 provides brief ideas of these dimensions and how they interact.

Adequate access to mental healthcare is an essential part of providing resources to reduce the risk of mortality for members of LGBTQIA+ populations facing violence and discrimination.

Generally, there remain significant barriers to access to healthcare for LGBTQIA+ populations. According to data collected from the Medical Expenditure Panel Survey, individuals in same-sex couples reported more barriers to care than different-sex couples, including difficulty seeing specialists, delays getting necessary prescriptions, and dissatisfaction with the level of respect from providers (Clift & Kirby, 2012). Aligning with the minority stress model, one commonly reported barrier when engaging with health services is experiences of stigma and discrimination for LGBTQIA+ individuals. LGBTQIA+ populations report especially harmful experiences of discrimination when attempting to access health services (Ayhan et al., 2020). Such experiences include denial of medical services, microaggressions from healthcare providers, and verbal or physical violence (Lambda Legal, 2010; Mitchell et al., 2023; Nadal et al., 2016). In a systematic review of qualitative studies identifying LGB individuals' experiences with health services, themes related to experiences of stigma and discrimination of LGB patients were commonly identified across studies (McNeill et al., 2023). These studies consistently brought up the issues of heteronormative attitudes (i.e., preferences for heterosexual relationships as the norm), negative attitudes, and judgment from health professionals. Discriminatory experiences in healthcare are especially concerning for TGD individuals who risk experiencing invasive questioning or providers incorrectly attributing health issues to gender identity (Mason et al., 2022; Wall et al., 2023). A mixed methods literature review indicated that TGD adults often dealt with non-affirming healthcare providers as well as barriers to and refusal of gender-affirming care (Cicero et al., 2019). Another study identified an association between the denial of care for TGD individuals and attempted suicide (Romanelli et al., 2018).

Figure 3

Levesque's Conceptual Framework of Access to Healthcare



When looking specifically at mental healthcare experiences, client perceptions of mental healthcare indicate that most accessible treatment does not adequately address the unique needs of LGBTQIA+ populations. Qualitative studies investigating the mental healthcare experiences of LGBTQIA+ individuals highlighted two major barriers individuals commonly reported when accessing care: (1) stigma and discrimination when accessing care; and (2) mental healthcare professionals that lacked knowledge of the needs of LGBTQIA+ individuals (Rees et al., 2021). Multiple studies have demonstrated that LGBTQIA+ individuals utilized mental health services at higher rates than cisgender and heterosexual individuals but were more likely to report unmet mental healthcare needs (Burgess et al., 2007; Platt et al., 2018; Silveri et al., 2022). Negative experiences when LGBTQIA+ individuals seek out mental health services, which can range from discomfort with and lack of knowledge of LGBTQIA+ experiences to active discrimination, may explain why LGBTQIA+ report more unmet mental healthcare needs even while engaging in services at higher rates (J. Bishop et al., 2022). When examining the experiences of TGD individuals, over half of the participants in one study indicated a need for mental health treatment but reported having not received mental health services (Shipherd et al., 2010). The lack of satisfaction with mental health services provides further evidence of inadequate access to mental healthcare for LGBTQIA+ populations.

The high cost of services is another one of the most reported barriers to mental health treatment. A study surveying TGD individuals found that costs were the most endorsed barrier to mental health services (Shipherd et al., 2010). LGBTQIA+ individuals were less likely to have access to health insurance compared to heterosexual and cisgender individuals, largely in part to access to employment-based benefits (Buchmueller & Carpenter, 2010; dickey et al., 2016). Health insurance coverage alone is often not enough to ensure access to mental healthcare for LGBTQIA+ populations. A national survey of physicians revealed that psychiatrists were less likely to accept private insurance as well as Medicare and Medicaid than physicians in other specialties (T. F. Bishop et al., 2014). Findings from the 2015 U.S. Transgender Survey found that 25% of respondents reported issues with insurance coverage related to being transgender, including outright denial of routine care (James et al., 2016).

Nationally, there is a shortage of mental health professionals for the general population. About 163 million people in the United States live in a place designated as a mental health professional shortage area by the Health Resources and Services Administration; about two-thirds of these people are also within geographic areas considered rural parts of the country

(HRSA, 2023). LGBTQIA+ populations seeking mental health services face even more barriers when attempting to find mental health providers with knowledge and experience with LGBTQIA+ health. In a national sample of state-approved mental health and substance use treatment facilities, less than one in five substance use treatment facilities, and only one in eight mental health treatment facilities reported LGBTQ-specific programs (Williams & Fish, 2020). These services were also more likely to be offered through for-profit facilities than non-profit or public facilities. When examining mental health resources specific to LGBTQIA+ care, a survey of executives from LGBTQIA+ community centers revealed that most reported offering support groups or individual therapy (Pachankis et al., 2021). However, just over half of these centers reported having more than five mental health staff members suggesting that mental health resources through LGBTQIA+ centers may not be meeting the needs of the community.

In 2003, the American Psychological Association (APA) set forth guidelines to provide mental health professionals with the rationale and support to develop culturally appropriate skills, knowledge of clients' identities, and awareness of their own attitudes and cultural beliefs (American Psychological Association, 2003). This model of cultural competence is foundational to the APA's multicultural guidelines (American Psychological Association, 2017b) and ethics code (American Psychological Association, 2017a). It is also featured prominently in APA guidelines for psychological practice aimed at supporting mental health professionals in understanding LGBTQIA+ health through an affirmative, intersectional lens (American Psychological Association, 2015, 2021). Since then, research in LGBTQIA+ mental healthcare has repeatedly called for improved LGBTQIA+ cultural competency training for mental health professionals primarily due to issues meeting the needs of LGBTQIA+ populations (Boroughs et al., 2015; Fish et al., 2022; Nowaskie, 2020). Qualitative studies of LGBTQIA+ individuals' experiences utilizing mental health services have found that LGBTQIA+ individuals often stated the importance of therapists who understood and affirmed their lived experiences (Moore et al., 2020; Pennay et al., 2018). Additional studies provided evidence that LGBTQIA+ individuals report greater satisfaction with therapists who have had training in LGBTQIA+ cultural competence and demonstrated awareness of LGBTQIA+ identities (Eady et al., 2011; McCann & Sharek, 2014). It is important to note that self-reports of knowledge and experience with LGBTQIA+ mental healthcare by providers may be insufficient. A systematic review of quantitative and qualitative studies analyzing mental health providers' cultural competence when working with LGB clients found that clients reported difficulties working with providers that lacked an understanding of LGBTQIA+ experiences (J. Bishop et al., 2022).

Key Protective Factors

Despite evidence of how the stigma, discrimination, and trauma-related challenges LGBTQIA+ individuals face result in alarming health disparities, there is promising research on cultivating the strength and resilience of LGBTQIA+ populations to overcome these disparities. For example, multiple studies link social support with lower reported symptoms of psychological distress, anxiety, and depression for LGBTQIA+ individuals (Fernandes et al., 2023; Fuller & Riggs, 2018; Puckett et al., 2019; Valente et al., 2020). Research for the development of the minority strengths model found that social support was associated with improved mental health through identity pride, resilience, and self-esteem for LGBTQIA+ adults (Perrin et al., 2020). Family support, especially from parental relationships, may be especially important for protecting LGBTQIA+ youth against negative mental health outcomes (McDonald, 2018). In a study of LGBTQIA+ adults examining connectedness as a moderator between perceived stigma and symptoms of psychopathology, connectedness to the LGBTQIA+ community (a sense of identity and belonging with other people who have LGBTQIA+ identities) was found to be a potential buffer against suicidal behavior (Kaniuka et al., 2019).

Accepting and affirming spaces are especially important for LGBTQIA+ populations. For LGBTQIA+ students, a systematic review of protective factors and positive experiences revealed that extracurricular activities and supportive school policies can be protective against negative outcomes for LGBTQIA+ students (Fernandes et al., 2023). Access to gender-affirming care for TGD youth was associated with lower rates of depression and suicidality (Green et al., 2022). A qualitative study identified strengths of interdependence, resource sharing, and advocacy from the perspectives of LGBTQIA+ populations of color (Hudson & Romanelli, 2020). Understanding protective factors for LGBTQIA+ populations can support the improvement of mental healthcare through the development of services inclusive of affirming support and spaces. Research in this area emphasizes utilizing protective factors to address health inequities, which ultimately requires centering the needs and perspectives of those within and supporting LGBTQIA+ populations.

The Current Study

The limited research available identifies how members of LGBTQIA+ populations are at a greater risk for a range of physical and mental health issues (Flentje et al., 2020; Slemon et al., 2022). Minority stressors potentially contributing to LGBTQIA+ mental health disparities include the effects of an isolating global pandemic and recent increases in anti-LGBTQIA+ legislation. Access to quality mental healthcare is necessary to promote health equity, but significant barriers remain, including high costs and a lack of experienced and knowledgeable mental health providers. Previous qualitative studies have called for further research into understanding the LGBTQIA+ healthcare experience in different social and historical contexts

(Smith & Turell, 2017). A community needs assessment of LGBTQIA+ individuals conducted in Richmond, Virginia, provided supporting evidence of the stigma, discrimination, and inadequate access to care LGBTQIA+ individuals face (Coston & Allison, 2021). Notably, there is a critical need to understand how the COVID-19 pandemic and anti-LGBTQIA+ politics impact how LGBTQIA+ populations access mental health services. The proposed study applies rigorous qualitative methods to understand the intricacies of access to mental healthcare for LGBTQIA+ Virginians within this historical context.

To summarize, LGBTQIA+ health disparities are pervasive and still under-researched. The literature highlights high costs and discrimination as significant barriers to mental healthcare access, pandemic-exacerbated health disparities, and a distressing political environment as primary areas of concern in LGBTQIA+ mental health. The current study seeks to understand how these concerns impact the way LGBTQIA+ Virginians access mental healthcare through the following three aims:

- **Aim 1:** Examine the perspectives on access to mental healthcare of key community informants and mental health providers who work with LGBTQIA+ Virginians.
- **Aim 2:** Identify potential barriers and facilitators LGBTQIA+ individuals may encounter while attempting to access care.
- **Aim 3:** Compare key community informants’ and mental health providers’ perspectives to consider/examine potential differences.

The use of key informants, as experts in the community, is an intentional method of capturing in-depth information from those with extensive knowledge and experience (M.N. Marshall, 1996). The rich details key informants have provided in previous qualitative research on healthcare experiences include opinions from health policy and public health experts as well as cultural, and religious community leaders who are able to provide nuanced details on the strengths and weaknesses of relevant issues, such as the implementation of telehealth or the state of sexual healthcare in a country (Lucksted, 2004; Mgopa et al., 2022; Tönnies et al., 2021). I hypothesize that key informants interviewed in this study, primarily connected leaders in Virginia's LGBTQIA+ communities, will offer detailed insights into the community support and resources available to individuals seeking mental healthcare. As leaders include directors of LGBTQIA+ healthcare organizations and non-profits, their perspectives encompass a range of knowledge and experience on LGBTQIA+ mental health. Likewise, I hypothesize that mental health providers will act as key informants from a healthcare system perspective. Providers can provide insight into the mental health needs of the community by drawing from their personal knowledge, skills, and preparedness to work with LGBTQIA+ populations. Previous qualitative studies collecting provider perspectives on their understanding of mental healthcare gathered details on providers' awareness and use of mental health resources available in their community, their understanding of the needs of their clients, and the resources providers need as well to provide quality care (Albutt et al., 2021; Holt et al., 2020; Schoebel et al., 2021). This study seeks to contribute a deeper understanding of the complexities of the mental healthcare system for LGBTQIA+ populations through the insightful perspectives of key community informants and mental health providers. The information collected is intended to be used to guide further research aimed at improving mental healthcare access for LGBTQIA+ Virginians.

Methods

Procedures

The data presented in this study were collected in collaboration with Virginia's Department of Behavioral Health and Development Services (DBHDS). DBHDS is a public agency that provides services, including emergency, inpatient, outpatient, and case management, services for mental health, intellectual disabilities, and substance use disorders through 41 community service boards and 12 state-operated facilities across Virginia (DBHDS, 2023). DBHDS provides services for developmental disabilities and substance use disorders. The agency has worked to improve community prevention and response capacity by providing training opportunities in adverse childhood experiences, mental health first aid, and suicide prevention as well as expanding services in schools and other integrated settings (DBHDS, 2024). Key informant participants were identified through nominations provided by DBHDS as well as reviews of regional websites of organizations serving the needs of LGBTQIA+ populations. Mental health providers were also identified with the assistance of DBHDS's listserv of public mental health providers as well as nominations from key community informant focus groups and interviews, search of regional websites, and statewide resource lists. All potential participants were contacted through recruitment flyers, emails, or phone calls containing study and contact information. Members of the research team reached out to potential participants through email for a maximum of three outreach attempts.

Virginia Commonwealth University's Survey Evaluation and Research Laboratory (SERL) was contracted by the research team to lead, recruit, conduct, and transcribe focus groups and interviews. The primary goal of data collection was to gather the perspectives of key informants, mental health providers, and LGBTQIA+ individuals who have sought out mental healthcare to inform DBHDS practices. This study represents a secondary analysis of qualitative data due to my inclusion in the original study after research and interview protocol development and core IRB submission. Secondary analysis allows access to a population that may otherwise be difficult to reach given the sensitive topic of LGBTQIA+ mental health research (Long-Sutehall et al., 2011).

The SERL team began conducting the key community informant focus groups and interviews first to leverage the opportunity to recruit potential mental health provider participants from key informant recommendations that could also be used in providing resource lists to participants in the third phase of interviews (i.e., individuals who had sought out mental health services). Participants in both community informant and provider focus groups and interviews were asked the same interview questions, but follow-up questions varied. The focus group protocol is provided in Appendix A. Focus groups and interviews were conducted and recorded via Zoom. Participants were instructed to keep their cameras off. All video recordings were destroyed immediately after the Zoom session ended to maintain confidentiality; only audio recordings were securely stored. Individuals received a $30 gift card as compensation for participation.

A brief REDCap survey of demographic information was distributed through a link shared on Zoom once focus groups and interviews were completed. Demographic information collected included age, race/ethnicity, sexual orientation, gender identity, identification with the LGBTQIA+ community, and percentage of work or clients serving the LGBTQIA+ community (see Appendix B). The overall study was approved by the ethics committee of Virginia Commonwealth University (HM20023124).

Participants

A total of 20 key informants and 14 mental health providers who support LGBTQIA+ Virginians participated in internet-based focus groups or interviews. The focus groups and interviews consisted of individuals serving the entire Commonwealth as well as from each of the five geographic regions of Virginia designated by DBHDS: Northern, Central, Western/Shenandoah Valley, Tidewater/Hampton Roads, and Southside. Key community informants were English-speaking adults who were at least 18 years old, had access to the internet, and worked in a role in which they could serve the LGBTQIA+ community in some capacity. These roles included but were not limited to, non-profit staff and leadership, community advocates, and educators. Mental health providers were individuals who either currently or have previously provided services to LGBTQIA+ populations in roles including social workers, therapists, psychiatrists, psychiatric nurses, prevention staff, and certified peer counselors. Providers were at least 18 years old, had access to the internet, and were willing to share their experiences in English.

Purposive sampling was used to recruit participants from all five DBHDS regions across Virginia. The original study design was to hold one focus group for informants and one for providers per region. However, due to challenges in recruitment and scheduling constraints for participants, both focus groups and interviews were made available for all participants to ensure the inclusion of participants from across the regions. Participants were recruited from September 2022 to January 2023. A total of 20 key community informants participated across four focus groups and one individual interview. Across one focus group and 11 individual interviews, there were a total of 14 mental health providers participating in the study. Community informants and providers represented all five DBHDS regions. Pseudonyms were used for all informant and provider participants to maintain confidentiality. Table 1 provides a breakdown of participants by the regions they served, including two participants serving LGBTQIA+ individuals across Virginia (statewide). There were significant variations in recruitment by region. Regions with fewer participants had multiple rounds of outreach to DBHDS leadership for key community informants and to both leadership and community informants to identify potential participants within each region.

Table 1

Focus Group and Interview Participants by DBHDS Region

	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Statewide**
Key Informant - Focus Group	4	4	2	6	2	1
Key Informant - Interview	0	0	0	0	0	1
Provider - Focus Group	0	0	0	3	0	0
Provider - Interview	5	1	2	2	1	0
Total by region	**9**	**5**	**4**	**11**	**3**	**2**

Out of the 20 total community informants participating, 19 completed the optional demographic survey. All community informant participants from whom we obtained demographic information from identified as part of the LGBTQIA+ community. These participants ranged in age from 23 to 66 years with an average age of 43.3 years (SD = 12.1). Community informant participants included six white American women, four white American men, three African American men, two non-binary white Americans, one non-binary African American, one white Latinx woman, one multiracial woman, and one multiracial man.

Table 2

Participant Demographics

	Key Community Informants (n = 20)		Mental Health Providers (n = 14)	
	N	**%**	**N**	**%**
Gender				
Gender non-conforming, non-binary, genderqueer, or gender variant	3	15	2	14.3
Female/woman	8	40	7	50
Male/man	8	40	2	14.3
No response	1	5	3	21.4
Race/Ethnicity*				
White	15	75	11	78.6
Black/African American	6	30	0	0
American Indian/Alaska Native	1	5	0	0
Hispanic/Latino/a/x	1	5	1	7.1
Multiracial/mixed race	1	5	0	0
No response	1	5	3	21.4
Member of LGBTQIA+				
Yes	19	95	6	42.9
No	0	0	5	35.7
No response	1	5	3	21.4
	M (SD)	**Range**	**M (SD)**	**Range**
Age in years	43.3 (12.1)	23-66	37.4 (8.9)	26-55

Note. 19/20 community informants and 11/14 mental health providers completed the optional demographics survey.
*Participants could select more than one race/ethnicity category.

Of the 14 mental health provider participants, 11 completed the demographic survey. Six out of 11 participants (54.5%) identified as part of the LGBTQIA+ community. Their ages ranged from 26 to 55 years with an average of 37.4 years (SD = 8.9). Out of the 11 providers who shared their demographic information, there were seven white American women, two white American men participating, one non-binary white American, and one non-binary white Latinx American. Table 2 provides a summary of participant demographics for both key community informants and mental health providers.

Data Analysis

Preliminary analysis

Members of the SERL team transcribed all audio recordings. A team of three researchers, including one of the SERL team members who conducted most of the focus groups and interviews, independently reviewed transcripts to become familiar with the data and generate initial ideas for codes. Coders independently coded transcripts to identify potential themes. Coders met weekly to review code development and discuss ideas for initial descriptive themes. The positionality (identities, assumptions, and experiences) of each coder influenced how we related to participants and in turn how codes and themes developed throughout the qualitative research process (Berger, 2015). I am a queer, mixed-race woman of color and have expertise in public health and mental health services research. The second coder is a queer individual who has had personal experiences with Virginia's mental health services. The third coder is an African American gay male trained in clinical psychology. We held discussions on how our identities, perspectives, and training impacted the framing of our research questions as well as the selection of theory and methods. The positionality of all coders demonstrated familiarity and shared experiences with participants, strengthening the credibility of culturally competent qualitative research (Berger, 2015).

Reflexive thematic analysis process

The current analysis applied a reflexive thematic analysis (RTA) approach, a systematic process for developing and interpreting patterns within qualitative data, to identify meaningful patterns that can inform our understanding of how LGBTQIA+ Virginians access mental healthcare (Braun & Clarke, 2006). Building on the prior descriptive coding, a six-phase RTA was undertaken to explore the dataset (Braun & Clarke, 2022). I familiarized myself with the dataset before coding and generated initial themes. I applied Levesque's patient-centered access framework as an informing theory to find patterned meanings in participants' subjective experiences with Virginia's mental healthcare system (Levesque et al., 2013). The choice of Leveque's framework was influenced by my own understanding of the importance of structural factors of mental health. Framing the initial analysis within Levesque's dimensions of healthcare accessibility, I intended for data derived through my analysis to be readily applied to ongoing reform in mental healthcare (Braun & Clarke, 2006; Sandelowski & Leeman, 2012). I also inductively developed themes from the data that did not fit with Levesque's framework. These themes were influenced by the similar experiences of our coding team working in healthcare and academic settings supporting LGBTQIA+ needs. Using an RTA approach addressed the first two aims of the study by not only exploring community informant and mental health provider perspectives but also guiding the identification and analysis of themes regarding potential barriers and facilitators in accessing mental healthcare for LGBTQIA+ Virginians.

I independently recoded, refined, and defined new themes using a contextualist approach guided by the assumption that the nature of language and meaning is dependent on context and that both the participants’ values and practices and my own values and practices will contribute to the knowledge produced (Braun & Clarke, 2022). By applying this approach, I was conscious of the multiple identities I held and experiences I have had that influenced my interpretation of the qualitative data. Throughout theme development, I applied a qualitative health research strategy in which findings were developed into thematic statements that could be easily translated into the language of implementation and dissemination (Sandelowski & Leeman, 2012). RTA’s distinction from qualitative methods that attempt to align with quantitative methods was an influential factor throughout coding and theme development. The flexibility of this approach was particularly suited for a more deductive approach to analysis. To address the third aim, I compared themes between the key community informant and mental health provider groups. By comparing multiple perspectives on the same phenomenon, I was able to refine and develop themes from different viewpoints on mental healthcare access in Virginia (Lindsay, 2019). It was important to subject each group to separate analyses given that community informants and mental health providers had different experiences both engaging with the mental healthcare system in Virginia and with LGBTQIA+ populations, which influenced their understanding of access to care.

To ensure quality in coding through RTA, all transcripts were coded with the same initial codes and guiding themes before comparing these themes within and between groups (Lindsay, 2019). Triangulation was used during data collection through the recruitment of both informants and providers and the development of initial codes with a team. An audit trail consisting of initial codes and definitions, regional summaries, thematic maps, and theme definitions was created as part of theme development to support credibility. The themes presented in this study were first shared with my advisor as initial analytic observations. The resulting themes are presented in overlapping but separate narratives.

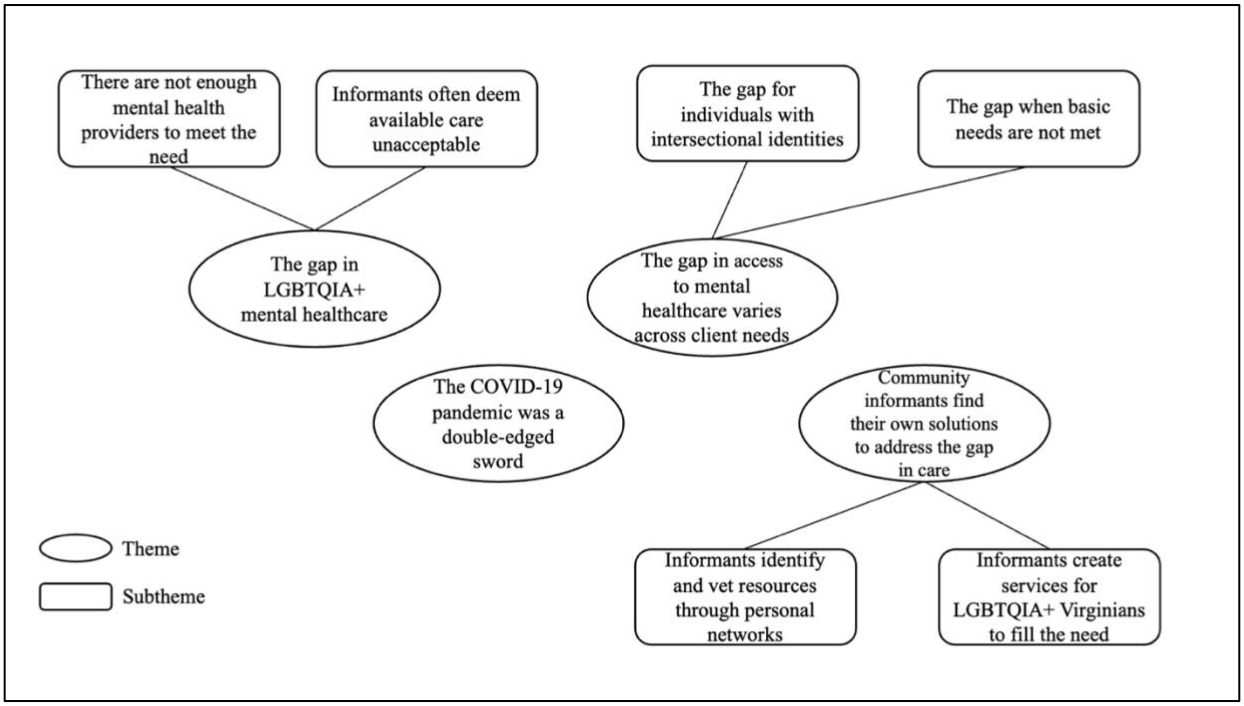
Results

Key Community Informant Themes

Four primary themes were identified across the key community informant focus groups and one interview: (1) the gap in LGBTQIA+ mental healthcare, (2) the gap in access to mental healthcare varies across client needs, (3) the COVID-19 pandemic was a double-edged sword, and (4) community informants find their own solutions to address the gap in care. The community informant themes and subthemes can be found in Figure 4.

Figure 4

Key Community Informant Themes



Theme 1: The gap in LGBTQIA+ mental healthcare.

A commonly reported challenge key informants discussed was the limited availability of appropriate services when LGBTQIA+ individuals attempt to access mental healthcare. These challenges could be divided into two subthemes addressing various needs of LGBTQIA+ Virginians: (1) there are not enough mental health providers to meet the need, and (2) informants often deem available care unacceptable.

Subtheme 1.1: There are not enough mental health providers to meet the need. A common thread across participants was the lack of mental health providers for LGBTQIA+ communities in Virginia. Participants discussed how difficult it was to find therapists who could provide quality, affordable care. One participant in a focus group, Jane, described the discouraging process for individuals seeking out providers when services are limited:

> The demand for providers is exceeding what is available, right. A lot of practices are maintaining waitlists. And for patients that are, clients, whatever word is more appropriate. If you've never been in therapy before, just logging on to Psychology Today or like Googling it and trying to find a good fit, it's overwhelming, it's daunting. Then you find someone who looks like they could meet your needs and would be a good fit. And they are not taking clients, or they don't take your insurance and a lot of mental health providers these days are not accepting insurance and doing a sliding scale model because it gives mental health providers a lot more autonomy in what they treat or how they treat it. (Jane, Group 4)

In another focus group, Chelsea described how the lack of providers made potential participants fearful of losing access to therapy thereby keeping appointments they may not need and limiting access for others:

> And some of the feedback that we've been getting from the community is that people that are in therapy, many of which have worked out past issues… they're scared that if another issue does come up, then they won't be able to book an appointment with their provider. So they just continue to see, keep those mental health appointments even though they don't feel that they need to, but out of fear of not being able to have access to one once they do. (Chelsea, Group 2)

Key informants discussed the ways in which availability could vary by region and reported on LGBTQIA+ individuals traveling outside of their region for care. Participants working with clients in more rural regions often reported the challenge of having to travel significant distances for adequate services. Kris, who was familiar with services in Southwest Virginia, explained this challenge for this more rural area:

> It's very difficult in the Southwest to get those services available unless you get the family who does have the means to send them out of area… at least three hours away unless you want to go out of state. (Kris, Group 1)

Another participant from a rural region, Lee, explained, "I just had someone just come to me last week… There's nothing." (Lee, Group 3). Across focus groups and interviews, community informant participants emphasized how difficult it was to find a provider with any availability. The lack of availability was a significant barrier for individuals seeking out care.

Subtheme 1.2: Informants often deem available care unacceptable. Some community informants acknowledged that the mental healthcare options available were not always affirming and appropriate for LGBTQIA+ individuals. These services often lacked the level of care needed to adequately address the mental health issues of LGBTQIA+ communities. Jane explained how mental health providers lack sufficient knowledge on the scope of LGBTQIA+ health issues despite the best of intentions:

> A lot of it does come down to someone advertising that they're affirming and then it turns out that they actually don't have a lot of competency on this subject, right. Or they, they're really open to working with people who are gay or bisexual or lesbian and actually don't know much about trans folks and that's a problem I see in research to where like, “Oh, we're studying the LGBT community,” but they only focus on sexuality, right… When folks are able to find the right providers who can meet their needs, experiences tend to be really positive. Because of that social isolation, just being seen and feeling understood by somebody can have a monumental change and impact and it's a shame that there's not enough providers who are able to do that. (Jane, Group 4)

In an interview, Mike illustrated how this may play out in interactions within the mental healthcare environment not just with those directly providing care:

> The other thing that’s not helpful is, I'll talk about an example I'm aware of where a transgender individual was referred somewhere and the person who referred them said that the place they were being referred as welcoming to trans individuals, which may have been true, but the person at the front desk misgendered the person. So that was a nonstarter. (Mike, Interview)

In a different focus group, Jen asserted how “mental skill-building places” do not provide quality mental health services:

> You’re charging the insurance and you're providing a service, but you're actually not providing an adequate service because you don't have the necessary training to be able to say, “I have all the resources here and we can refer you out if we don't.” They don't even

> know where to refer. So… yes. There are plenty of services available. No. They don't have the actual training. (Jen, Group 2)

Informants across all focus groups described how there were not enough providers with the knowledge and awareness to meet the mental health needs of LGBTQIA+ communities in Virginia. These informants described how there were training opportunities within Virginia, such as on trauma-informed care and gender and sexuality, that qualified providers to accept insurance to provide LGBTQIA+ mental healthcare. Mav shared one example in which "the whole office went through a gender and sexuality training at orientation" (Mav, Group 2). However, participants suggested that the trainings were ultimately too short and insufficient to appropriately support providers in offering of high-quality LGBTQIA+ mental healthcare.

Theme 2: The gap in access to mental healthcare varies across client needs.

Participants provided nuanced perspectives on the challenging barriers LGBTQIA+ individuals face when accessing mental healthcare. These challenges could be divided into two subthemes: (1) the gap for individuals with intersectional identities, and (2) the gap when basic needs are not met.

Subtheme 2.1: The gap for individuals with intersectional identities. Adding to the discussions on the lack of available and acceptable mental healthcare for LGBTQIA+ populations in Virginia, community informants discussed their understanding of how certain individuals face even more barriers to access. Jane discussed how those with multiple marginalized identities may delay or resist care due to concerns of mistreatment:

> Most of us don't delay going to the dentist when we have a severe toothache or going to the ER if we have a bad injury out of concern of being mistreated or disrespected over who we are… We know that medical racism exists. We know that if English is not your

> primary language, or if you don't speak English at all, or if you have a disability, that your experience in those settings may also be subpar to terrible, right. And that's intersectional. So if you hold multiple of those identities, then that's compounded there too… The type of mistreatment people might experience with regards to their gender is also unique in terms of how it manifests and how it's addressed. (Jane, Group 4).

Informants brought up the challenge of finding services for LGBTQIA+ Virginians due to language or cultural barriers. A community informant who worked primarily with the LGBTQIA+ Latine/x community explained the complexities of these barriers for clients who are Spanish speakers or have limited English proficiency:

> I can say that for individuals who are either solely Spanish speakers or limited English proficiency speakers, that it is virtually impossible and has been for years to find any form of mental health services anywhere, anytime… So even if you could get mental health services, which are few and far between, they would not be able to conduct them in Spanish. So they might have a receptionist or a frontal front desk worker come in and try to interpret. They may ask the patient to bring a family member to interpret. But there really are no services available. And many of the community we serve do not have insurance. (Hal, Group 1)

Another example an informant shared was the challenge of finding a provider that understands the needs of LGBTQIA+ individuals who are also people of color seeking care:

> Particularly people of color may not click or, or have rapport with their mental health provider. And then that's a challenge in this area because there's not a lot of options. And then so what happens when you're in a situation where you are not comfortable enough to disclose the very things that you're trying to work on. (Brian, Group 2)

Several participants emphasized the greater burden for individuals to find mental healthcare when they have other identities.

Subtheme 2.2: The gap when basic needs are not met. Participants discussed the idea that the lack of basic needs is often a priority that must be addressed before mental health needs can be taken care of. A community informant summarized the common top three concerns as, ”finances, health, [and] displacement” (Kelly, Group 2). Finances were the most discussed priority, especially as it relates to securing other basic needs, such as adequate medical care and housing:

> The other thing is financial situations being very, very grim. That was always the main reason as to why there's no ability for a person to get a place to live. We could call that being number one as the most prevalent issue. That's a cause for all of us, you know, finances and a place to live. (Dan, Group 2)

From another focus group, Tine explained how difficult it is to even consider the need for mental healthcare when other pressing needs are not met:

> If your basic survival needs… are not met, like housing and all those kinds of things… The last thing on your mind is that I'm going to go through therapy to address all the trauma that I'm going through because you can't. You don't have a place to stay or, you know, all these things. (Tine, Group 1)

Mike explained how the struggles people face to secure basic needs can be detrimental to their mental health:

> This is just my theory, but I worked in the field of HIV prevention. I think that's closely related to homelessness. Actually, you get, lose your house, you get depressed. Might

> have to do what you have to do to make an income and doing whatever you gotta do while you're high is easier. (Mike, Interview)

Community informants underscored the importance of understanding the importance of securing material resources to address the mental health needs of LGBTQIA+ Virginians.

Theme 3: The COVID-19 pandemic was a double-edged sword.

A final major topic discussed by focus group participants was the impact of the COVID-19 pandemic. Informants discussed how the pandemic worsened mental health and accessibility to services. For example, Will explained:

> I can tell you during the COVID pandemic that we called every available source, every health care provider in Northern Virginia. We called VDH (Virginia Department of Health). We called State, Commonwealth of Virginia crisis hotlines. We called similar in DC… and the federal government, SAMHSA, other hotlines. The only thing that was available were crisis hotlines that were available for one-time crisis intervention. (Will, Group 1)

Jack commented on the lack of connection among LGBTQIA+ individuals during the height of the pandemic, which exacerbated isolation for some:

> I think the pandemic has heightened the gaps between people. And consequently, I think people in the trans community… don't get together as much as we used to… There used to be a monthly circle of transgender and non-binary folks who would get together and have a community circle. (Jack, Group 3)

While acknowledging the harms of the COVID-19 pandemic, participants also spoke of silver linings in the global crisis, many of which were related to telehealth expansion of mental healthcare. Chelsea described how people felt safe to explore their identity in a private setting through telehealth:

> Some people I've talked to have even said that it was a blessing because it was a way for them to, in a more personally secure environment, to experience more of themselves without the fear of having to do it in public... And it also gave them the ability to sense all these online in Zoom… And now they can do all sorts of teletherapy. And that means that they now don't have to go out and see somebody. So it has been to a certain degree, a positive thing. (Chelsea, Group 2)

Another focus group participant, Ryan, discussed how telehealth reduced transportation barriers by creating access to more affirming providers that may be too far to reach in other ways:

> Being able to just log into your computer and not have to travel anywhere. If you don't have a car or your work schedule. It definitely makes it more accessible in that way. And there's a unique, fascinating problem where a lot of people working in telehealth are actually retaining clients more because it makes it more accessible… If they're doing telehealth, it's a good problem to have that people stay in therapy because they want to be there and need to be there… So that's a big positive and we also know there are people in more isolated communities where even if there's some community, the number of informed and affirming mental health providers, they have to drive an hour to see a therapist, right. That adds to the cost in gasoline and car maintenance and time out of your day or away from your family. Or if you're doing it discreetly because you haven't been able to talk to people yet about who you are. (Ryan, Group 4)

Beyond the access to mental healthcare telehealth provided many LGBTQIA+ individuals, some saw the lockdown measures as space and time away from society to prioritize themselves. In another group, Molly shared this benefit for trans folks:

> I think COVID did a lot for trans folks as far as gender identity exploration, a lot of folks that I talked to said that people had a lot of time to see their, see themselves for who they are and not be impacted by the way society views folks. (Molly, Group 1)

Although the pandemic put a serious strain on the mental healthcare system and on individual mental health in general, community informants observed ways in which communities were able to address barriers to access through telehealth and individual exploration.

Theme 4: Community informants find their own solutions to address the gap in care.

When discussing the lack of adequate mental healthcare, informants often discussed the personal work they undertook to address gaps in services to support LGBTQIA+ Virginians. This could be conceptualized into two subthemes: (1) informants identify and vet resources through personal networks, and (2) informants create services for LGBTQIA+ Virginians to fill the need.

Subtheme 4.1: Informants identify and vet resources through personal networks. Participants reflected on the importance of identifying and vetting resources, especially mental health providers, within the community. Participants discussed how it was not only necessary to find providers that understood the unique needs of LGBTQIA+ communities but also to ensure that resources were a safe space for community members. Greg, who maintained a transgender resource list, described the role community members had in creating and sharing resources:

> I definitely try to keep my ear to the ground here. Anytime I hear of other service providers that aren't already on the list, I tried to keep an informal list of those as well

> because I have a lot of people who reach out to me as the person who maintains that list, looking for service providers. So I can pass those names along as people who've been recommended by community members. (Greg, Group 2)

Billie, in a separate focus group, echoed the necessity of vetting resources and explained the process:

> Today, I make those calls and I vet. Because it's so important to vet and know like, "Hey, how many, how many LGBTQIA clients have you actually had experience with or did you just do that 30-minute training?" (Billie, Group 3)

Yet another participant described the creation of different lists for various populations within their organization:

> We have a women's resource center here that has a inclusion counselor, is what they call it, and they have put the work in to collect information from the community about positive and negative providers and have their own list and their own set of resources and it's more community-based… And so it's nice that we have that additional kind of help there for them to be able to refer people to different places. (Ryan, Group 4)

The accumulation of resources was described as an informal process that community informants willingly took responsibility for. Participants explained the importance of these resources for community safety and well-being. They also emphasized how these resources provided vital social support and connection for members of their community.

Subtheme 4.2: Informants create services for LGBTQIA+ Virginians to fill the need. While accumulating resources to share with the community was a widely agreed upon need for LGBTQIA+ communities, informants also highlighted their ability to create services when the need arose. Informants described using their time and resources to fulfill the need for support for

LGBTQIA+ community members. Nic explained how their organization came to fill a gap they observed in the lack of mental healthcare options:

> We had trouble finding [organizations], so we started one. But that's not the same as having mental health providers on staff or having a, a place where we know we can connect somebody to the mental health services they need. So my organization is volunteer-based… We don't have good solutions at this point. We make it work. We find what we have to. And my organization provides support groups and other things so that we can do what we can from a community perspective. (Nic, Group 1)

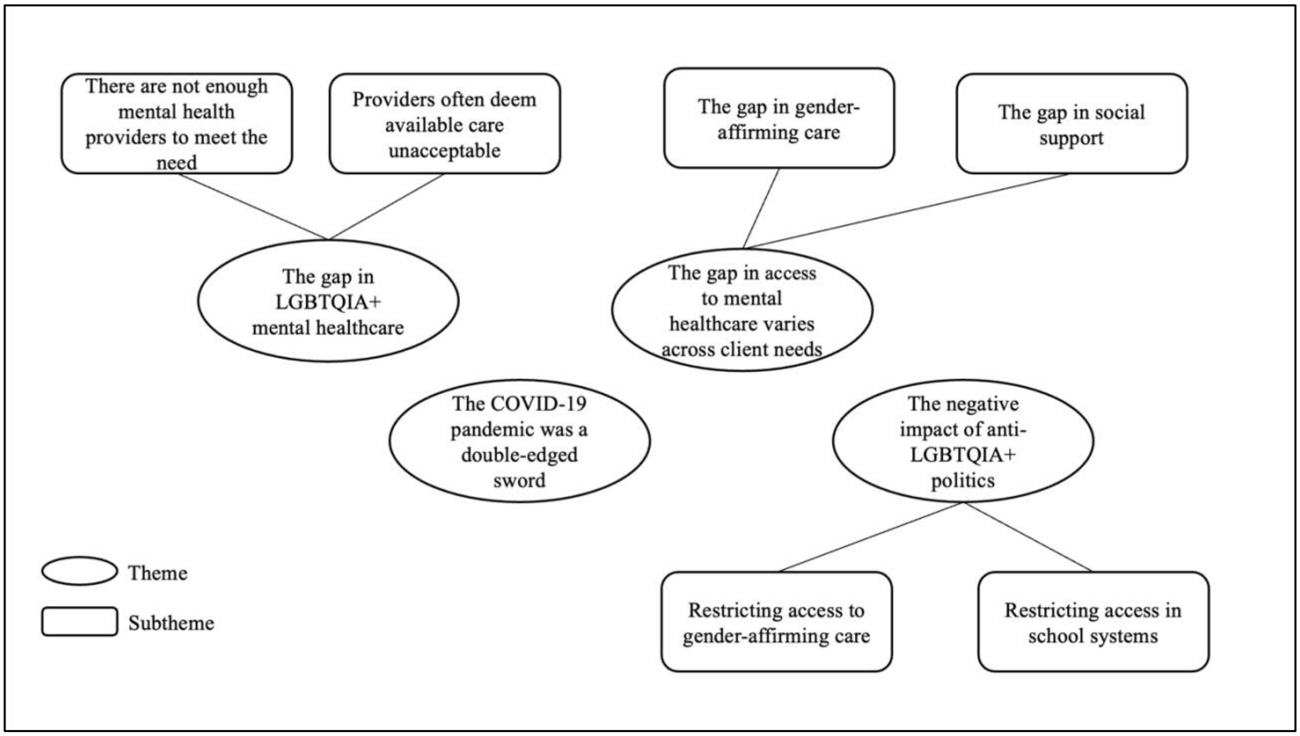
In a separate focus group, a participant discussed how they created a group around healthy cooking after hearing stories during a virtual meeting at an LGBTQIA+ conference:

> But what I realized was once we started meeting, there was more than about food. These guys had eating disorders. These guys were cutting themselves because they didn't like the way their body looks. So I'm sitting here thinking this is beyond me. So what did that do? I picked up the phone and I started calling therapists. I started calling nutritionists… every month there's a different something. (Billie, Group 3)

Community informants address the gaps in mental healthcare through both formal and informal support by collecting resources and creating safe spaces for LGBTQIA+ individuals. Although the limited availability of providers was a prevalent discussion point, participants shared a wide variety of resources, from statewide government to local nonprofit organizations to address the needs of their community.

Figure 5

Mental Health Provider Themes



Mental Health Provider Themes

Mental health providers shared three common primary themes with community informants: (1) the gap in LGBTQIA+ mental healthcare, (2) the gap in access to mental healthcare varies across client needs, and (3) the COVID-19 pandemic was a double-edged sword. One additional and unique theme was discussed among providers: (4) the negative impact of anti-LGBTQIA+ politics. Figure 5 summarizes the themes and subthemes developed from the focus group and interviews with provider participants.

Theme 1: The gap in LGBTQIA+ mental healthcare.

Like community informant participants, mental health providers discussed the lack of available mental healthcare for LGBTQIA+ individuals. These challenges are conceptualized with the same subthemes: (1) there are not enough mental health providers to meet the need and (2) providers often deem available care unacceptable.

Subtheme 1.1: There are not enough mental health providers to meet the need. Provider participants detailed the limited access to mental healthcare in general at their respective agencies with agencies having “a huge vacancy rate and massive waitlists” (Toni). In another interview, Blake described the disappointing waitlist process:

> I've had a number of people say they go through those whole referral lists, and they might get one or two callbacks just to get on a waitlist. (Blake)

One provider explained how the wait for LGBTQIA+-affirming providers could be even worse:

> I think then of course just the demand for services outpaces the supply of providers and I think that true for the general population, but especially true for the LGBTQIA+ community. Because even if you have a number of affirming providers like you do, the odds are good that they'll be at capacity for their practice. (Nate)

Providers discussed how the lack of availability could be felt through their own overwhelmed caseloads. Alex explained:

> Every week I'm getting three or four referrals specifically looking for a queer LGBT therapist. I can't take them. I've been full for months. And that's hard because I want these people to have services, but at the same point, I just don't have the hours in the day to do it. And my list of people who I typically refer to as getting fewer and fewer because they are full as well. (Alex)

Providers’ discussions centered on the demand for mental healthcare and the seemingly endless waitlists for that care. They possessed firsthand knowledge of the limited options of LGBTQIA+ care for their clients.

Subtheme 1.2: Providers often deem available care unacceptable. In addition to the accessibility barrier of limited provider availability, participants provided insight into the lack of affirming care for LGBTQIA+ individuals when seeking out care. Providers often framed this lack of acceptable care as a burden on individuals. From the provider focus group, Sam explained the vulnerability that is required to go through the process of finding mental healthcare:

> Loaded questions like where they feel safe going and how do they know that they're reaching a gender-affirming provider or somebody who's going to provide affirmative care… a lot of people say that they provide gender-affirming care, but that's a subjective reality. So I think a lot of the times when LGBT plus clients are seeking services, there's another layer of vulnerability that they have to they have to put themselves out there and then make the judgment if that's a good fit for them or not. Because a lot of providers advertise themselves, I see as LGBTQ+ affirming. Sometimes that’s just not the case. (Sam)

In the same focus group, Syd explained how difficult it is to find providers with cultural competence in LGBTQIA+ needs, which led to individuals sacrificing provider competence if it meant gaining access to care:

> It depends a lot on what the person is seeking support around and how important competence around particular areas of gender, sexuality may be. For some folks, that may not be as much of a priority, we may be able to seek care in a less affirming environment because the presenting concern is more urgent, and they need to prioritize that need. And I think that unfortunately, that's a reality of negotiating a service field that’s already

> overwhelmed in general where there's just not enough providers… finding trans and non-binary competent providers is much more challenging. (Syd)

Providers also explained how therapists may refer out, to an already limited landscape of options, when learning of their client's queer identity. Jay elaborated on why therapists may refer out due to the fear of treating transgender clients:

> A therapist, even if they have room, is less likely to take on transgender clients. Even if again, these are nice, normal, wonderful therapists, but they don't want to take on these clients because they don't know how to treat them. They're afraid of saying the wrong thing… And so rather than trying to learn to navigate that particular specialty, they just choose to refer outright. (Jay)

Sometimes the burden extends beyond the individual seeking our services. Syd summarized the responsibility it can also place on families to find LGBTQIA+ mental healthcare:

> I think in the context of families, there's so much pressure on families to advocate in a way that is affirming that there's such a focus on they need to figure it out so that I know what to do and I know how to do this… within the context of family, there's so much pressure around how to advocate, how to be accepting, how to create that safe place for people to just exist without having to worry about how this might impact mom's feelings or what was advocated for with the teacher. (Syd)

Providers emphasized how difficult it was to find mental healthcare that LGBTQIA+ individuals can trust is safe and affirming of their needs and identities. Individuals seeking access to care may have to take a careful, cautionary approach and prioritize certain mental health needs over others because of the lack of competent providers in LGBTQIA+ mental healthcare.

Theme 2: The gap in access to mental healthcare varies across client needs.

Community informants and providers both shared insight into how the gap in access may vary across needs in the LGBTQIA+ community, but providers diverged in the areas they emphasized for focus. Both informants and providers observed how access varies based on individual identity. While informants discussed the differences in terms of various intersectional identities, providers highlighted where the gap in access to mental healthcare may be an even greater burden for supporting gender-affirming care. Similarly, while informants drew attention to a lack of economic support, providers commented on the lack of social support for individuals. The views providers shared could be summarized into the following two themes: (1) the gap in gender-affirming care and (2) the gap in social support.

Subtheme 2.1: The gap in gender-affirming care. Mental health providers shared their observations on finding mental healthcare that supports gender-affirming treatment. One provider explained, “Access to gender-affirming care, medical care especially, is at the top of the list of what people are looking for.” (Nate). In another interview, Finn added context to this demand by describing how there were just one of a handful of mental health providers able to referral letters for gender-affirming medical care:

> I personally know a lot of therapists who are open to seeing individuals on that spectrum, the LGBTQIA spectrum. But there are only a handful of us, I would say three of us, that are able to write the gender-affirming referral letters. And so I know who to refer them to in terms of needing referrals for surgery or hormone replacement therapy. (Finn)

Toni provided insight into the subtle ways healthcare may be inaccessible, especially for TGD individuals:

> Gender is so limited or it’s preferred name versus what you're going to see on my driver's license or on my medication or my Medicaid card. I think those can be implied barriers and can also scare people away pretty quickly. Yeah, I think there definitely are probably more subtle barriers to access to resources than really overt, like I don't think there's anybody flashing a sign saying we're only serving people that—But definitely more of the subtle stuff. (Toni)

Providers emphasized the need for mental health support for individuals pursuing gender-affirming care. They also shared how challenging it could be to find that support and the harm individuals faced when pursuing that care.

Subtheme 2.2: The gap in social support. Another important piece restricting access is the disconnect individuals may have from social support systems. Providers shared that LGBTQIA+ are sometimes unable to access care because they do not know where support can be found within a community. Toni explained:

> I think even knowing where to go to for help, particularly the LGBTQ community, I think they've had a lot of doors slammed in their faces. So how much more hesitant are you to go seek help if you have a history of not being able to find the resources. (Toni)

Zane expressed how disconnect from the community may be a loss of connection and support:

> A lack of peer connection. We get a lot of folks that come in, they say, I just don't even know where to find the gay people here. Like I don't know where to go. I don't know where they’re hanging out. I don't know anyone else who's trans. Right? You know, those sorts of experiences. People often have online communities, but the sort of real life in-person, lack of that kind of social support. (Zane)

Youth are especially impacted by the lack of social support. Carey detailed how interactions with peers can be negative for LGBTQIA+ youth:

> We live in a rural area. A lot of my kids struggle with when they are ready to express their identity or explore their sexuality… The peer interactions that they have at school can sometimes not be ideal. They worry about, okay, how is this going to affect me? (Carey)

Providers emphasized how challenging navigating identity exploration and development without support can be, suggesting how it can negatively impact an individual's ability to seek out mental healthcare. Without community support, providers highlighted how LGBTQIA+ individuals may be resistant to accessing resources and seeking out mental healthcare.

Theme 3: The COVID-19 pandemic was a double-edged sword.

Like community informants, mental health providers provided in-depth knowledge of the impact of the COVID-19 pandemic on LGBTQIA+ communities. Providers highlighted the detrimental effect isolation had on LGBTQIA+ individuals. Drew explained the impact of isolation on LGBTQIA+ youth:

> I definitely have seen a huge impact of the feeling of isolation. I mean, it's a rural area, so you have isolation anyway. You have kids who are afraid of coming out so there's isolation, but then [the pandemic] compounding that has made that feeling worse and worse. (Drew)

Jess succinctly stated the ways in which the pandemic hit LGBTQIA+ individuals harder than the general population:

> The pandemic absolutely has decreased access to services in general, but also particularly for a population who might already feel some kind of fearfulness around accessing

> services or stating why they might need to access services. And especially with schools not being in person for almost two years, the isolation was incredibly impactful. Family dynamics that were already challenging became tenfold and really cemented a lot of my clients' beliefs about themselves and about the way that the world works. So that requires a fair amount of, you know, undoing. (Jess)

Providers discussed the impact of the pandemic on LGBTQIA+ mental health, which included an increase in mental health concerns, such as anxiety, depression, and suicidal ideation. Alex described LGBTQIA+ clients coming in with more symptoms of PTSD:

> For a lot of my LGBTQ clients… I've also seen a lot more full-blown PTSD. Thinking about the ways that the pandemic, this global trauma has impacted people, paired with other, either microaggressions or moments of feeling unsafe in their body and their community, in their schools, that I'm having a lot of clients coming in with distress of intrusive memories, flashbacks, very intense, severe nightmares, ongoing symptoms of PTSD, which would make sense kinda given not only the climate we're going through politically and environmentally with the pandemic, but also where people do experience traumas every day and oftentimes aren't naming them as traumas. And we're just starting to kind of connect the dots around, alright, what you're experiencing is PTSD. (Alex)

Despite the serious consequences the pandemic had on mental health, providers were able to highlight a few positive consequences that emerged during this time, particularly telehealth expansion. Blake discussed some of the main benefits of telehealth:

> I can see somebody, an adult that's anywhere in the state of Virginia and do an assessment in a comfortable way and provide more access through telehealth. It's been good for them. (Blake)

In another interview, Carey discussed the positives of telehealth options while noting extra steps needed to ensure the virtual space is still a safe space:

> I think I think it has helped because we have looked at or been able to look at other avenues as far as, are we going to start hosting these peer support groups virtually or even hybrid, you know, having some kiddos coming in office with some signing in virtually. I do feel as though there are a lot of benefits and sometimes you have to outweigh, is this client in a safe space, are we making sure that we are monitoring who's able to sign on to different things to make sure that there isn't ill will or no other plans for the reason why they're joining. (Carey)

Telehealth expansion was not always ideal, but providers were able to adapt to the circumstances. Alex observed an issue with video telehealth sessions for trans clients but found phone sessions to be useful:

> An interesting thing I found was doing telephone sessions only for some clients… especially for our trans clients who have gender dysphoria, seeing a reflection of themselves through a camera or even just the knowledge that someone would see them through a camera could be a barrier to even logging on and accessing services. So I have a lot of my trans young people and young adults who from pretty early on in the pandemic, when we had to go virtually, we went right to phone and it's worked well. (Alex)

Participants in the provider focus groups and interviews observed both the positive and negative impact on their work with LGBTQIA+ clients. Many providers believed the pandemic had devastating effects on the mental health of LGBTQIA+ individuals. However, providers were also able to find ways to connect and support their clients through the shift to telehealth in their practices.

Theme 4: The negative impact of anti-LGBTQIA+ politics.

Providers across the focus group and interviews shared their perspectives on the rise of LGBTQIA+ hate influencing the nation's political climate. Providers elaborated on the ways in which anti-LGBTQIA+ policies restricted access to services. They also provided narratives of the individual impact of "what's happening in the news and nationally movements against folks trying to receive medical care and play sports and live their lives" (Zane). These discussions centered around two subthemes: (1) restricting access to gender-affirming care and (2) restricting access in school systems.

Subtheme 4.1: Restricting access to gender-affirming care. A major concern providers observed was the rise of legislation restricting access to gender-affirming care. Alex detailed the impact of this barrier to access on LGBTQIA+ individuals, especially youth:

> Some of the legislation in Florida and Texas, where parents and medical providers are being charged legally for providing affirming care, even if the young people aren't experiencing it firsthand, that secondary trauma of hearing about it and the fear that grows around well. "If that's happening there, what could happen next to me?" That's really hard. So I think that especially in the last several years, that has been the focus of a lot of the mental health support that I'm providing for my queer and LGBTQ clients, especially younger clients. (Alex)

Many providers discussed the "controversial practice" of referral letters for gender-affirming medical care in this political environment (Nate). Some providers questioned the necessity of such a practice. Jay added:

> The new WPATH criteria is still requiring a letter, which I find just abhorrent. For adults seeking hormone treatment, they shouldn't have to do that. But we do offer that service as well. (Jay)

Based on their experiences with clients, providers emphasized how policy was unhelpful for both providers trying to support their clients' needs and individuals accessing gender-affirming care.

Subtheme 4.2: Restricting access in school systems. Providers had unique insights into how anti-LGBTQIA+ politics in schools and education affected LGBTQIA+ individuals. Finn described how changes in school policy endangered LGBTQIA+ youth:

> I work with kids in schools who were also definitely terrified of what the new governor's school policies were going to be… they have a special plan where if you didn't feel like you were your assigned gender at birth, they could make the teachers with an IEP basically be held accountable to use in your appropriate pronouns, and the school would be obligated to provide a bathroom for that person. But I think the policy changed so that now both of your legal parents had to be involved in the process. And in some cases, I think schools were just upfront saying, like, "we're not going to honor your needs for this kind of stuff." So a lot of the kids are scared like, "well, what's gonna happen now? If I didn't tell my biological dad because he's not in my life. And now I have to have him on board for this meeting with everybody". So I think that was a big fear for the kids at least, like "what's going to happen if I'm already not accepted" or like fears about what's gonna happen with family structure and just coming out in general to people who aren't supportive. (Finn)

Observing the impact in a different region, Nate explained how harmful the political environment could be on a local level, especially for TGD youth:

> We just had a school board election that was particularly inflammatory for the transgender community. We had a candidate who essentially ran on a platform of I think, to be diplomatic as possible, was incredibly dismissive of transgender concerns, especially for transgender youth. And just conveyed sort of remarkable lack of awareness and understanding of the risks that transgender youth face on a day-to-day basis, especially when it comes to being out at school versus being out at home. (Nate)

Providers expressed concerns for how their LGBTQIA+ clients, most notably the effect on youth clients still in school or seeking out gender-affirming care. LGBTQIA+ youth may not feel confident or safe enough to seek out mental healthcare in the current political climate. Anti-Providers believed anti-LGBTQIA+ politics in school systems were a threat to safety and identity.

Discussion

In the current study, I sought to explore how LGBTQIA+ individuals from across the Commonwealth access the mental healthcare system and related supports. I gathered an understanding of mental health outcomes in LGBTQIA+ populations influenced in part by anti-LGBTQIA+ politics and the COVID-19 pandemic. The findings from key community informants and mental health providers revealed a lack of sufficient mental healthcare for LGBTQIA+ individuals and the variability of access within this gap. Notably, LGBTQIA+ Virginians who held multiple marginalized identities or specifically sought out gender-affirming services had limited choices in care or were especially distrustful of the care available. For LGBTQIA+ Virginians, participants observed how challenges meeting basic needs or lack of social support had an impact on the resources and knowledge individuals had to find adequate mental healthcare. Providers and informants observed the mixed experiences of LGBTQIA+

Virginians during the COVID-19 pandemic. Isolation and loneliness limited access to care and were additional burdens to mental health, but LGBTQIA+ individuals also benefited from telehealth expansion. Community informants detailed how they personally addressed the gap in care while providers noted how the anti-LGBTQIA+ political climate contributed to barriers in access for LGBTQIA+ Virginians, especially for those impacted by restrictions in gender-affirming care and school environments.

From the rich discussions of both providers and informants, I identified several themes that aligned with Levesque's patient-centered access framework (Levesque et al., 2013). Participants highlighted barriers in the *availability* of mental healthcare for LGBTQIA+ Virginians. With long waitlists, varying availability by geographic location, and providers at full capacity, there were not enough services to meet the need. These findings correspond with a previous study highlighting the lack of available services as a reason for unmet mental health needs for LGBTQIA+ populations (Simeonov et al., 2015). Additional studies provide further evidence that LGBTQIA+ populations have greater unmet mental health needs than non-LGBTQIA+ populations (Chen et al., 2020; Silveri et al., 2022). Another important dimension both providers and key informants emphasized was the *acceptability* of mental healthcare for LGBTQIA+ individuals. Specifically, participants shared how societal norms (e.g., heteronormativity, gender norms) persisted in mental health spaces, revealing how provider knowledge and clinic practices were unsuitable for LGBTQIA+ populations, especially for TGD needs. There were reported experiences of providers and staff not implementing basic LGBTQIA+ knowledge, such as the use of gender-inclusive pronouns. These issues could be found even with services advertised as safe spaces for LGBTQIA+ populations. The fear of having stigmatizing and discriminatory experiences from inadequate mental healthcare infringed on LGBTQIA+ populations' individual rights and personal autonomy to choose to seek care or in the context of Levesque's model, the *ability to seek* care. Previous qualitative research findings reinforce the underutilization of services due to unacceptable care for LGBTQIA+ mental health needs (Rees et al., 2021).

The findings of this current study suggest that inequities in care are also influenced by the *appropriateness* of the fit of LGBTQIA+ mental healthcare to client needs. Key community informants identified having unmet basic needs (e.g., housing, medical care) and intersectional identities as primary reasons why current mental healthcare options may not be an adequate fit for LGBTQIA+ individuals. These findings align with previous qualitative research examining intersectional identities and unmet basic needs within LGBTQIA+ populations (Matsuzaka et al., 2021; Parmenter et al., 2021). Informants had more exposure to a broad range of services provided to LGBTQIA+ community members, including LGBTQIA+ non-profits and hospitals, compared to providers' experiences as frontline workers in the mental healthcare system. It is possible that this broader awareness of relevant community resources influenced their understanding of LGBTQIA+ needs on community and structural levels. In comparison, mental health providers identified the lack of appropriate mental healthcare for LGBTQIA+ individuals seeking out gender-affirming care or without sufficient social support. These perspectives aligned with previous research on the barriers to access for gender-affirming care (Cicero et al., 2019; Romanelli et al., 2018). Previous research also supports the link between social support and mental health (Fuller & Riggs, 2018; Puckett et al., 2019). Many of the participants' responses to access to care also touched on the *approachability* and *affordability* of LGBTQIA+ mental healthcare. For instance, several participants discussed whether mental healthcare was advertised as affirming. Participants prioritized the need for trust in and safety of care, focusing on interactions with providers and services. Participants also acknowledged the need for affordable care options and financial resources. However, discussions were brief, suggesting an assumption that lack of finances is a universally understood barrier to access.

The current study's findings contribute qualitative data to previous research demonstrating a greater mental health burden in LGBTQIA+ populations compared to non-LGBTQIA+ populations (Chen et al., 2020; Salerno et al., 2020). Findings suggested a silver lining of the pandemic through telehealth expansion for mental healthcare, which aligns with previous research on the importance of online support for LGBTQIA+ communities during the COVID-19 pandemic (Fish et al., 2020). Another study revealed that TGD individuals were more likely to use telehealth for mental healthcare than their cisgender peers, providing further evidence of the importance of online support (Ruprecht et al., 2021). However, the same study found that heterosexual individuals were more likely to use telehealth compared to non-heterosexual individuals, suggesting variability in access may persist.

Mental health providers emphasized another important current event: the anti-LGBTQIA political climate impacting LGBTQIA+ populations. The impact of politics was especially relevant as Virginia Governor Youngkin first drafted a change in policy on the treatment of transgender students in Virginia public schools in September 2022 when data collection began for this study (VDOE, 2023). Previous research has demonstrated the mental health burden that anti-LGBTQIA politics amplifies for LGBTQIA+ populations (Gonzalez et al., 2018). While community informants underscored the stigmatizing and discriminatory experiences of LGBTQIA+ individuals, discussions did not explicitly address the impact of current political events. Instead, community informants provided insight into the ways in which they were able to address barriers to access. As representatives of LGBTQIA+ organizations across Virginia, community informants were able to identify a range of needs but also had limited resources to fill those needs. Their efforts can be examined through the lens of the minority strengths model (Perrin et al., 2020). Informants used their personal and collective strengths to create services for LGBTQIA+ communities in Virginia, increasing social support and community consciousness (i.e., tapping into personal networks and finding experts in identified areas of need). The minority strengths model would suggest that these efforts would have positive cascading effects on mental and physical well-being, through increasing identity pride, resilience, and community connectedness (Perrin et al., 2020).

Participants pinpointed several barriers to mental healthcare access that aligned with constructs in Levesque's framework. They also shared perspectives on how barriers uniquely impacted individuals within LGBTQIA+ populations. Data supports how the lack of social support and challenges meeting basic needs are greater in LGBTQIA+ populations than in the general population and therefore mental health needs are greater (Rhoades et al., 2018; Steele et al., 2017). In the context of the minority stress model, providers and informants emphasized how minority stressors (discrimination, internalized homophobia, etc.) and general stressors compound to influence mental health outcomes (Meyer, 2003). For example, discrimination against LGBTQIA+ individuals in employment can hinder access to health insurance and sufficient housing thereby impacting access to mental healthcare. One of the major takeaways from the interviews and focus groups was the focus on the structural factors impacting access to care. Another way to look at these barriers is through an understanding of the social determinants of mental health (Compton & Shim, 2015). The social determinants of mental health suggest that societal conditions (e.g., economic factors and the physical environment) influence mental health outcomes. Policy and societal norms that stigmatize LGBTQIA+ populations limit access to care.

Combined with a lack of social support and sufficient economic independence, access to mental healthcare and mental health suffers. When considering these factors, the responsibility to improve access to care and reduce mental health disparities falls into the realms of policy and environmental change.

Limitations

There are several limitations to the current study. To protect the confidentiality of our respondents, not all aspects of the identities of participants were captured, which limited my ability to understand how specific intersectional identities impacted the findings. Participants in this study were also recruited through their referrals from DBHDS, LGBTQIA+ organizations, or other participants. The community informants and providers offered detailed and nuanced insight into the mental healthcare access experiences of LGBTQIA+ individuals within these networks. However, their perspectives may not accurately represent the experiences of those less connected to the broader LGBTQIA+ community. Additionally, the current study did not analyze the perspectives of LGBTQIA+ individuals seeking out mental healthcare. Their firsthand experiences navigating mental healthcare systems have the potential to deepen our understanding of the accessibility of LGBTQIA+ mental healthcare.

Another potential limitation is the use of both focus groups and interviews in this study. Focus groups typically allow for further discussion of ideas between group members and can lead to unique data that may not be accessed through individual interviews (Kitzinger, 1995). There are pros and cons to the use of both focus groups and interviews, and the use of both allowed for the inclusion of participants from across Virginia. However, all but one informant participated in a focus group, while only three providers participated in a focus group. There were significant challenges in recruitment, especially of mental health providers and in the

Tidewater/Hampton Roads region. This challenge may reflect greater barriers for these frontline workers to connect with the research because of stressful workplaces (e.g., high caseloads and burnout), or discomfort discussing sensitive information related to their LGBTQIA+ clients. Finally, as this study was a secondary analysis of qualitative data, I was limited in the questions I could ask related to mental healthcare accessibility, especially questions focused on understanding the process of seeking out care and how that may have impacted utilization and individual mental health outcomes.

Implications for Future Research and Practice

Future research should prioritize the safety of participants in recruitment outreach, especially for LGBTQIA+ individuals who distrust mental health providers and related services for LGBTQIA+ needs. Additionally, future research should incorporate the lived experiences of LGBTQIA+ individuals accessing mental healthcare. These perspectives may provide a better understanding of the influence of the demand side of Levesque's framework on LGBTQIA+ mental healthcare accessibility. Further research in LGBTQIA+ mental healthcare should prioritize intersectionality in access; for example, examining the experiences of transgender people of color's access to gender-affirming care or of LGBTQIA+ people with disabilities or chronic illness navigating mental healthcare.

To address disparities in mental healthcare accessibility, the findings suggest a need for a more holistic expansion of services, especially support for more affirming mental healthcare. Such efforts may also include expanding training opportunities to be mandatory and organization-wide in LGBTQIA+ mental health, especially training in gender-affirming care and intersectionality. As evidenced by community informant efforts to address the gap in access to mental healthcare, access to mental healthcare may be improved through collaborations that support the initiatives of other organizations that serve the LGBTQIA+ community's broader needs, such as housing and medical care. Partnering with organizations may also help raise awareness and continue to build networks of affirming and knowledgeable mental health providers, such as through social media campaigns and community events. With an understanding of the social determinants of mental health, efforts must work in parallel to reduce the number of people who need care and improve the quality of care.

Conclusion

This study contributed to our understanding of how LGBTQIA+ Virginians access mental healthcare. Key community informants and mental health providers shed light on the various challenges LGBTQIA+ Virginians face when accessing care. They emphasized the impact of current events, such as the COVID-19 pandemic and a rise in anti-LGTBQIA+ legislation, on LGBTQIA+ mental health and accessibility. Strengthening the mental healthcare workforce to be inclusive, affirming, and knowledgeable is a crucial part of any effort to provide the best mental healthcare for all LGBTQIA+ people.

References

ACLU. (2023a). Mapping Attacks on LGBTQ Rights in U.S. State Legislatures. *American Civil Liberties Union*. https://www.aclu.org/legislative-attacks-on-lgbtq-rights

ACLU. (2023b, July 18). Virginia Department of Education ignores public opposition and greenlights anti-LGBTQ student policies. *ACLU of Virginia*. https://www.acluva.org/en/press-releases/virginia-department-education-ignores-public-opposition-and-greenlights-anti-lgbtq

Albutt, A., Berzins, K., Louch, G., & Baker, J. (2021). Health professionals' perspectives of safety issues in mental health services: A qualitative study. *International Journal of Mental Health Nursing*, *30*(3), 798–810. https://doi.org/10.1111/inm.12838

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for Psychologists. *American Psychologist*, *58*(5), 377–402. https://doi.org/10.1037/0003-066X.58.5.377

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, *70*(9), 832–864. https://doi.org/10.1037/a0039906

American Psychological Association. (2017a). Ethical principles of psychologists and code of conduct. *Https://Www.Apa.Org*. https://www.apa.org/ethics/code

American Psychological Association. (2017b). *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality*. https://doi.org/10.1037/e501962018-001

American Psychological Association. (2021). *Guidelines for Psychological Practice with Sexual Minority Persons*. https://www.apa.org/about/policy/psychological-sexual-minority-persons.pdf

Andraska, E. A., Alabi, O., Dorsey, C., Erben, Y., Velazquez, G., Franco-Mesa, C., & Sachdev, U. (2021). Health care disparities during the COVID-19 pandemic. *Seminars in Vascular Surgery*, *34*(3), 82–88. https://doi.org/10.1053/j.semvascsurg.2021.08.002

Ayhan, C. H. B., Bilgin, H., Uluman, O. T., Sukut, O., Yilmaz, S., & Buzlu, S. (2020). A Systematic Review of the Discrimination Against Sexual and Gender Minority in Health Care Settings. *International Journal of Health Services*, *50*(1), 44–61. https://doi.org/10.1177/0020731419885093

Berger, R. (2015). Now I see it, now I don’t: Researcher’s position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Bishop, J., Crisp, D. A., & Scholz, B. (2022). A systematic review to determine how service provider practises impact effective service provision to lesbian, gay and bisexual consumers in a mental health setting. *Clinical Psychology & Psychotherapy*, *29*(3), 874–894. https://doi.org/10.1002/cpp.2699

Bishop, T. F., Press, M. J., Keyhani, S., & Pincus, H. A. (2014). Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care. *JAMA Psychiatry*, *71*(2), 181. https://doi.org/10.1001/jamapsychiatry.2013.2862

Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, Mental Health, and Resilience in an Online Sample of the US Transgender

Population. *American Journal of Public Health*, *103*(5), 943–951. https://doi.org/10.2105/AJPH.2013.301241

Boroughs, M. S., Bedoya, C. A., O'Cleirigh, C., & Safren, S. A. (2015). Toward defining, measuring, and evaluating LGBT cultural competence for psychologists. *Clinical Psychology: Science and Practice*, *22*(2), 151–171. https://doi.org/10.1111/cpsp.12098

Bostwick, W. B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010). Dimensions of Sexual Orientation and the Prevalence of Mood and Anxiety Disorders in the United States. *American Journal of Public Health*, *100*(3), 468–475. https://doi.org/10.2105/AJPH.2008.152942

Bränström, R., & Pachankis, J. E. (2018). Sexual orientation disparities in the co-occurrence of substance use and psychological distress: A national population-based study (2008–2015). *Social Psychiatry and Psychiatric Epidemiology*, *53*(4), 403–412. https://doi.org/10.1007/s00127-018-1491-4

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.

Buchmueller, T., & Carpenter, C. S. (2010). Disparities in Health Insurance Coverage, Access, and Outcomes for Individuals in Same-Sex Versus Different-Sex Relationships, 2000–2007. *American Journal of Public Health*, *100*(3), 489–495. https://doi.org/10.2105/AJPH.2009.160804

Burgess, D., Lee, R., Tran, A., & van Ryn, M. (2007). Effects of Perceived Discrimination on Mental Health and Mental Health Services Utilization Among Gay, Lesbian, Bisexual and Transgender Persons. *Journal of LGBT Health Research*, *3*(4), 1–14. https://doi.org/10.1080/15574090802226626

Busch, A. B., Sugarman, D. E., Horvitz, L. E., & Greenfield, S. F. (2021). Telemedicine for treating mental health and substance use disorders: Reflections since the pandemic. *Neuropsychopharmacology*, *46*(6), Article 6. https://doi.org/10.1038/s41386-021-00960-4

Caceres, B. A., Brody, A., Luscombe, R. E., Primiano, J. E., Marusca, P., Sitts, E. M., & Chyun, D. (2017). A Systematic Review of Cardiovascular Disease in Sexual Minorities. *American Journal of Public Health*, *107*(4), e13–e21. https://doi.org/10.2105/AJPH.2016.303630

Camp, J., Vitoratou, S., & Rimes, K. A. (2020). LGBQ+ Self-Acceptance and Its Relationship with Minority Stressors and Mental Health: A Systematic Literature Review. *Archives of Sexual Behavior*, *49*(7), 2353–2373. https://doi.org/10.1007/s10508-020-01755-2

CDC. (2021). *10 Leading Causes of Death by Age Group, United States-2020*. https://www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2020-508.pdf

Chen, J. A., Zhang, E., & Liu, C. H. (2020). Potential Impact of COVID-19–Related Racial Discrimination on the Health of Asian Americans. *American Journal of Public Health*, *110*(11), Article 11. https://doi.org/10.2105/AJPH.2020.305858

Cicero, E. C., Reisner, S. L., Silva, S. G., Merwin, E. I., & Humphreys, J. C. (2019). Health Care Experiences of Transgender Adults: An Integrated Mixed Research Literature Review. *Advances in Nursing Science*, *42*(2), 123–138. https://doi.org/10.1097/ANS.0000000000000256

Clift, J. B., & Kirby, J. (2012). Health Care Access and Perceptions of Provider Care Among Individuals in Same-Sex Couples: Findings from the Medical Expenditure Panel Survey (MEPS). *Journal of Homosexuality*, *59*(6), 839–850. https://doi.org/10.1080/00918369.2012.694766

Cochran, S. D., Björkenstam, C., & Mays, V. M. (2016). Sexual Orientation and All-Cause Mortality Among US Adults Aged 18 to 59 Years, 2001–2011. *American Journal of Public Health*, *106*(5), 918–920. https://doi.org/10.2105/AJPH.2016.303052

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology*, *71*(1), 53–61. https://doi.org/10.1037/0022-006X.71.1.53

Compton, M. T., & Shim, R. S. (2015). The Social Determinants of Mental Health. *FOCUS*, *13*(4), 419–425. https://doi.org/10.1176/appi.focus.20150017

Connolly, D., & Gilchrist, G. (2020). Prevalence and correlates of substance use among transgender adults: A systematic review. *Addictive Behaviors*, *111*, 106544. https://doi.org/10.1016/j.addbeh.2020.106544

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A Population-Based Study of Sexual Orientation Identity and Gender Differences in Adult Health. *American Journal of Public Health*, *100*(10), 1953–1960. https://doi.org/10.2105/AJPH.2009.174169

Coston, E., & Allison, K. W. (2021). *Greater Richmond LGBTQ+ Needs & Opportunities Assessment: Final Report to the Richmond Memorial Health Foundation*. https://rmhfoundation.org/wp-content/uploads/2021/10/RMHFLG-Report-V3-1.pdf

Cotaina, M., Peraire, M., Boscá, M., Echeverria, I., Benito, A., & Haro, G. (2022). Substance Use in the Transgender Population: A Meta-Analysis. *Brain Sciences*, *12*(3), Article 3. https://doi.org/10.3390/brainsci12030366

Cyrus, K. (2017). Multiple minorities as multiply marginalized: Applying the minority stress theory to LGBTQ people of color. *Journal of Gay & Lesbian Mental Health*, *21*(3), 194–202. https://doi.org/10.1080/19359705.2017.1320739

DBHDS. (2023). *Virginia Department of Behavioral Health and Developmental Services*. Https://Dbhds.Virginia.Gov/. https://dbhds.virginia.gov/

DBHDS. (2024). *DBHDS Strategic Plan*. Virginia Department of Behavioral Health and Developmental Services. https://dbhds.virginia.gov/about-dbhds/strategic-plans/

Dellar, N. M. (2022). *A Guide to Sexual Orientation and Gender Diversity Terms*. Https://Www.Apa.Org. https://www.apa.org/ed/precollege/psychology-teacher-network/introductory-psychology/diversity-terms

Diamond, L. M., & Alley, J. (2022). Rethinking minority stress: A social safety perspective on the health effects of stigma in sexually-diverse and gender-diverse populations. *Neuroscience & Biobehavioral Reviews*, *138*, 104720. https://doi.org/10.1016/j.neubiorev.2022.104720

dickey, lore m., Budge, S. L., Katz-Wise, S. L., & Garza, M. V. (2016). Health disparities in the transgender community: Exploring differences in insurance coverage. *Psychology of Sexual Orientation and Gender Diversity*, *3*(3), 275–282. https://doi.org/10.1037/sgd0000169

Drabish, K., & Theeke, L. A. (2022). Health Impact of Stigma, Discrimination, Prejudice, and Bias Experienced by Transgender People: A Systematic Review of Quantitative Studies.

Issues in Mental Health Nursing, *43*(2), 111–118. https://doi.org/10.1080/01612840.2021.1961330

Eady, A., Dobinson, C., & Ross, L. E. (2011). Bisexual People's Experiences with Mental Health Services: A Qualitative Investigation. *Community Mental Health Journal*, *47*(4), 378–389. https://doi.org/10.1007/s10597-010-9329-x

Fernandes, T., Alves, B., & Gato, J. (2023). Between Resilience and Agency: A Systematic Review of Protective Factors and Positive Experiences of LGBTQ+ Students. *Healthcare*, *11*(14), Article 14. https://doi.org/10.3390/healthcare11142098

Firk, C., Großheinrich, N., Scherbaum, N., & Deimel, D. (2023). The impact of social connectedness on mental health in LGBTQ + identifying individuals during the COVID-19 pandemic in Germany. *BMC Psychology*, *11*(1), 252. https://doi.org/10.1186/s40359-023-01265-5

Fish, J. N., King-Marshall, E. C., Williams, N. D., Aparicio, E. M., Tralka, H. M., & Boekeloo, B. O. (2022). What motivates community mental and behavioral health organizations to participate in LGBTQ+ cultural competency trainings? *American Journal of Orthopsychiatry*, *92*(6), 647–656. https://doi.org/10.1037/ort0000641

Fish, J. N., McInroy, L. B., Paceley, M. S., Williams, N. D., Henderson, S., Levine, D. S., & Edsall, R. N. (2020). "I'm Kinda Stuck at Home With Unsupportive Parents Right Now": LGBTQ Youths' Experiences With COVID-19 and the Importance of Online Support. *Journal of Adolescent Health*, *67*(3), 450–452. https://doi.org/10.1016/j.jadohealth.2020.06.002

Fisher, C. M., Irwin, J. A., & Coleman, J. D. (2014). LGBT Health in the Midlands: A Rural/Urban Comparison of Basic Health Indicators. *Journal of Homosexuality*, *61*(8), 1062–1090. https://doi.org/10.1080/00918369.2014.872487

Flentje, A., Heck, N. C., Brennan, J. M., & Meyer, I. H. (2020). The relationship between minority stress and biological outcomes: A systematic review. *Journal of Behavioral Medicine*, *43*(5), 673–694. https://doi.org/10.1007/s10865-019-00120-6

Fredriksen-Goldsen, K. I., Simoni, J. M., Kim, H.-J., Lehavot, K., Walters, K. L., Yang, J., Hoy-Ellis, C. P., & Muraco, A. (2014). The health equity promotion model: Reconceptualization of lesbian, gay, bisexual, and transgender (LGBT) health disparities. *American Journal of Orthopsychiatry*, *84*(6), 653. https://doi.org/10.1037/ort0000030

Frost, D. M., & Meyer, I. H. (2023). Minority stress theory: Application, critique, and continued relevance. *Current Opinion in Psychology*, *51*, 101579. https://doi.org/10.1016/j.copsyc.2023.101579

Fuller, K. A., & Riggs, D. W. (2018). Family support and discrimination and their relationship to psychological distress and resilience amongst transgender people. *International Journal of Transgenderism*, *19*(4), 379–388. https://doi.org/10.1080/15532739.2018.1500966

Gleason, H. A., Livingston, N. A., Peters, M. M., Oost, K. M., Reely, E., & Cochran, B. N. (2016). Effects of state nondiscrimination laws on transgender and gender-nonconforming individuals’ perceived community stigma and mental health. *Journal of Gay & Lesbian Mental Health*, *20*(4), 350–362. https://doi.org/10.1080/19359705.2016.1207582

Gonzales, G., & Henning-Smith, C. (2017). Health Disparities by Sexual Orientation: Results and Implications from the Behavioral Risk Factor Surveillance System. *Journal of Community Health*, *42*(6), 1163–1172. https://doi.org/10.1007/s10900-017-0366-z

Gonzales, G., Loret de Mola, E., Gavulic, K. A., McKay, T., & Purcell, C. (2020). Mental Health Needs Among Lesbian, Gay, Bisexual, and Transgender College Students During the COVID-19 Pandemic. *Journal of Adolescent Health*, *67*(5), 645–648. https://doi.org/10.1016/j.jadohealth.2020.08.006

Gonzales, G., Przedworski, J., & Henning-Smith, C. (2016). Comparison of Health and Health Risk Factors Between Lesbian, Gay, and Bisexual Adults and Heterosexual Adults in the United States: Results From the National Health Interview Survey. *JAMA Internal Medicine*, *176*(9), 1344–1351. https://doi.org/10.1001/jamainternmed.2016.3432

Gonzalez, K. A., Ramirez, J. L., & Galupo, M. P. (2018). Increase in GLBTQ Minority Stress Following the 2016 US Presidential Election. *Journal of GLBT Family Studies*, *14*(1–2), 130–151. https://doi.org/10.1080/1550428X.2017.1420849

Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2022). Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *Journal of Adolescent Health*, *70*(4), 643–649. https://doi.org/10.1016/j.jadohealth.2021.10.036

Hafeez, H., Zeshan, M., Tahir, M. A., Jahan, N., & Naveed, S. (2017). Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review. *Cureus*. https://doi.org/10.7759/cureus.1184

Hatzenbuehler, M. L., Keyes, K. M., & Hasin, D. S. (2009). State-Level Policies and Psychiatric Morbidity In Lesbian, Gay, and Bisexual Populations. *American Journal of Public Health*, *99*(12), 2275–2281. https://doi.org/10.2105/AJPH.2008.153510

Hatzenbuehler, M. L., Rutherford, C., McKetta, S., Prins, S. J., & Keyes, K. M. (2020). Structural stigma and all-cause mortality among sexual minorities: Differences by sexual behavior? *Social Science & Medicine*, *244*, 112463. https://doi.org/10.1016/j.socscimed.2019.112463

Holt, N. R., Hope, D. A., Mocarski, R., Meyer, H., King, R., & Woodruff, N. (2020). The provider perspective on behavioral health care for transgender and gender nonconforming individuals in the Central Great Plains: A qualitative study of approaches and needs. *American Journal of Orthopsychiatry*, *90*(1), 136–146. https://doi.org/10.1037/ort0000406

Hoy-Ellis, C. P. (2023). Minority Stress and Mental Health: A Review of the Literature. *Journal of Homosexuality*, *70*(5), 806–830. https://doi.org/10.1080/00918369.2021.2004794

HRSA. (2023). *Health Workforce Shortage Areas*. https://data.hrsa.gov/topics/health-workforce/shortage-areas

Hudson, K. D., & Romanelli, M. (2020). “We Are Powerful People”: Health-Promoting Strengths of LGBTQ Communities of Color. *Qualitative Health Research*, *30*(8), 1156–1170. https://doi.org/10.1177/1049732319837572

Hughes, L. D., King, W. M., Gamarel, K. E., Geronimus, A. T., Panagiotou, O. A., & Hughto, J. M. W. (2022). US Black–White Differences in Mortality Risk Among Transgender and Cisgender People in Private Insurance, 2011–2019. *American Journal of Public Health*, *112*(10), 1507–1514. https://doi.org/10.2105/AJPH.2022.306963

Institute of Medicine, Board on the Health of Select Populations, & Committee on Lesbian, G., Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. National Academies Press. http://ebookcentral.proquest.com/lib/vcu/detail.action?docID=3564220

Irwin, J. A., Coleman, J. D., Fisher, C. M., & Marasco, V. M. (2014). Correlates of Suicide Ideation Among LGBT Nebraskans. *Journal of Homosexuality*, *61*(8), 1172–1191. https://doi.org/10.1080/00918369.2014.872521

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. National Center for Transgender Equality.

Johns, M. M., Lowry, R., Andrzejewski, J., Barrios, L. C., Demissie, Z., McManus, T., Rasberry, C. N., Robin, L., & Underwood, J. M. (2019). Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students—19 States and Large Urban School Districts, 2017. *Morbidity and Mortality Weekly Report*, *68*(3), 67–71. https://doi.org/10.15585/mmwr.mm6803a3

Johns, M. M., Lowry, R., Haderxhanaj, L. T., Rasberry, C. N., Robin, L., Scales, L., Stone, D., & Suarez, N. A. (2020). Trends in Violence Victimization and Suicide Risk by Sexual Identity Among High School Students—Youth Risk Behavior Survey, United States, 2015–2019. *MMWR Supplements*, *69*(1), 19–27. https://doi.org/10.15585/mmwr.su6901a3

Kaniuka, A., Pugh, K. C., Jordan, M., Brooks, B., Dodd, J., Mann, A. K., Williams, S. L., & Hirsch, J. K. (2019). Stigma and suicide risk among the LGBTQ population: Are anxiety and depression to blame and can connectedness to the LGBTQ community help? *Journal* *of Gay & Lesbian Mental Health*, *23*(2), 205–220. https://doi.org/10.1080/19359705.2018.1560385

Kerridge, B. T., Pickering, R. P., Saha, T. D., Ruan, W. J., Chou, S. P., Zhang, H., Jung, J., & Hasin, D. S. (2017). Prevalence, sociodemographic correlates and DSM-5 substance use disorders and other psychiatric disorders among sexual minorities in the United States. *Drug and Alcohol Dependence*, *170*, 82–92. https://doi.org/10.1016/j.drugalcdep.2016.10.038

King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, *8*(1), 70. https://doi.org/10.1186/1471-244X-8-70

Kitzinger, J. (1995). Qualitative Research: Introducing focus groups. *BMJ*, *311*(7000), 299–302. https://doi.org/10.1136/bmj.311.7000.299

Lambda Legal. (2010). *When Health Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV*. https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring_1.pdf

LeBlanc, A. J., & Frost, D. M. (2020). Couple-Level Minority Stress and Mental Health among People in Same-Sex Relationships: Extending Minority Stress Theory. *Society and Mental Health*, *10*(3), 276–290. https://doi.org/10.1177/2156869319884724

Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*(1), 18. https://doi.org/10.1186/1475-9276-12-18

LGBTQIA+ Health Education Center. (2020). *LGBTQIA+ Glossary of Terms for Health Care Teams*. https://www.lgbtqiahealtheducation.org/wp-content/uploads/2020/10/Glossary-2020.08.30.pdf

Lindsay, S. (2019). Five Approaches to Qualitative Comparison Groups in Health Research: A Scoping Review. *Qualitative Health Research*, *29*(3), 455–468. https://doi.org/10.1177/1049732318807208

Long-Sutehall, T., Sque, M., & Addington-Hall, J. (2011). Secondary analysis of qualitative data: A valuable method for exploring sensitive issues with an elusive population? *Journal of Research in Nursing*, *16*(4), 335–344. https://doi.org/10.1177/1744987110381553

Lucksted, A. (2004). Lesbian, Gay, Bisexual, and Transgender People Receiving Services in the Public Mental Health System: Raising Issues. *Journal of Gay & Lesbian Psychotherapy*, *8*(3/4), 25–42.

Manchia, M., Gathier, A. W., Yapici-Eser, H., Schmidt, M. V., de Quervain, D., van Amelsvoort, T., Bisson, J. I., Cryan, J. F., Howes, O. D., Pinto, L., van der Wee, N. J., Domschke, K., Branchi, I., & Vinkers, C. H. (2022). The impact of the prolonged COVID-19 pandemic on stress resilience and mental health: A critical review across waves. *European Neuropsychopharmacology*, *55*, 22–83. https://doi.org/10.1016/j.euroneuro.2021.10.864

Marshall, E., Claes, L., Bouman, W. P., Witcomb, G. L., & Arcelus, J. (2016). Non-suicidal self-injury and suicidality in trans people: A systematic review of the literature. *International Review of Psychiatry*, *28*(1), 58–69. https://doi.org/10.3109/09540261.2015.1073143

Marshall, M. N. (1996). The key informant technique. *Family Practice*, *13*(1), 92–97. https://doi.org/10.1093/fampra/13.1.92

Mason, K. L., Smout, S. A., Wall, C. S. J., Coston, B. E., Perrin, P. B., & Benotsch, E. G. (2022). Exposure to Childhood Healthcare Discrimination and Healthcare Avoidance among Transgender and Gender Independent Adults during a Global Pandemic. *International Journal of Environmental Research and Public Health*, *19*(12), Article 12. https://doi.org/10.3390/ijerph19127440

Matsuno, E., Bricker, N. L., Savarese, E., Mohr, R. Jr., & Balsam, K. F. (2022). “The default is just going to be getting misgendered”: Minority stress experiences among nonbinary adults. *Psychology of Sexual Orientation and Gender Diversity*. https://doi.org/10.1037/sgd0000607

Matsuzaka, S., Romanelli, M., & Hudson, K. D. (2021). “Render a service worthy of me”: A qualitative study of factors influencing access to LGBTQ-specific health services. *SSM - Qualitative Research in Health*, *1*, 100019. https://doi.org/10.1016/j.ssmqr.2021.100019

McCabe, S. E., Hughes, T. L., Bostwick, W. B., West, B. T., & Boyd, C. J. (2009). Sexual orientation, substance use behaviors and substance dependence in the United States. *Addiction*, *104*(8), 1333–1345. https://doi.org/10.1111/j.1360-0443.2009.02596.x

McCann, E., & Sharek, D. (2014). Survey of lesbian, gay, bisexual, and transgender people’s experiences of mental health services in Ireland. *International Journal of Mental Health Nursing*, *23*(2), 118–127. https://doi.org/10.1111/inm.12018

McDonald, K. (2018). Social Support and Mental Health in LGBTQ Adolescents: A review of the literature. *Issues in Mental Health Nursing*, *39*(1), 16–29. https://doi.org/10.1080/01612840.2017.1398283

McNeill, S. G., McAteer, J., & Jepson, R. (2023). Interactions Between Health Professionals and Lesbian, Gay and Bisexual Patients in Healthcare Settings: A Systematic Review. *Journal of Homosexuality*, *70*(2), 250–276. https://doi.org/10.1080/00918369.2021.1945338

Mereish, E. H., & Bradford, J. B. (2014). Intersecting Identities and Substance Use Problems: Sexual Orientation, Gender, Race, and Lifetime Substance Use Problems. *Journal of Studies on Alcohol and Drugs*, *75*(1), 179–188. https://doi.org/10.15288/jsad.2014.75.179

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Mgopa, L. R., Ross, M. W., Lukumay, G. G., Mushy, S. E., Mkony, E., Massae, A. F., Mwakawanga, D. L., Leshabari, S., Mohamed, I., Trent, M., Wadley, J., Bonilla, Z. E., & Rosser, B. R. S. (2022). Perceptions of Sexual Healthcare Provision in Tanzania: A Key Informant Qualitative Study. *Sexuality Research and Social Policy*, *19*(3), 849–859. https://doi.org/10.1007/s13178-021-00607-5

Mitchell, L. A., Jacobs, C., & McEwen, A. (2023). (In)visibility of LGBTQIA+ people and relationships in healthcare: A scoping review. *Patient Education and Counseling*, *114*, 107828. https://doi.org/10.1016/j.pec.2023.107828

Moore, K. L., Lopez, L., Camacho, D., & Munson, M. R. (2020). A Qualitative Investigation of Engagement in Mental Health Services Among Black and Hispanic LGB Young Adults. *Psychiatric Services*, *71*(6), 555–561. https://doi.org/10.1176/appi.ps.201900399

Nadal, K. L., Whitman, C. N., Davis, L. S., Erazo, T., & Davidoff, K. C. (2016). Microaggressions Toward Lesbian, Gay, Bisexual, Transgender, Queer, and Genderqueer

People: A Review of the Literature. *The Journal of Sex Research*, *53*(4–5), 488–508. https://doi.org/10.1080/00224499.2016.1142495

Ngamake, S. T., Walch, S. E., & Raveepatarakul, J. (2016). Discrimination and sexual minority mental health: Mediation and moderation effects of coping. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 213–226. https://doi.org/10.1037/sgd0000163

Nicola, M., Alsafi, Z., Sohrabi, C., Kerwan, A., Al-Jabir, A., Iosifidis, C., Agha, M., & Agha, R. (2020). The socio-economic implications of the coronavirus pandemic (COVID-19): A review. *International Journal of Surgery*, *78*, 185–193. https://doi.org/10.1016/j.ijsu.2020.04.018

Nowaskie, D. (2020). A national survey of U.S. psychiatry residents' LGBT cultural competency: The importance of LGBT patient exposure and formal education. *Journal of Gay & Lesbian Mental Health*, *24*(4), 375–391. https://doi.org/10.1080/19359705.2020.1774848

Operario, D., Gamarel, K. E., Grin, B. M., Lee, J. H., Kahler, C. W., Marshall, B. D. L., van den Berg, J. J., & Zaller, N. D. (2015). Sexual Minority Health Disparities in Adult Men and Women in the United States: National Health and Nutrition Examination Survey, 2001–2010. *American Journal of Public Health*, *105*(10), e27–e34. https://doi.org/10.2105/AJPH.2015.302762

Pachankis, J. E., Clark, K. A., Jackson, S. D., Pereira, K., & Levine, D. (2021). Current Capacity and Future Implementation of Mental Health Services in U.S. LGBTQ Community Centers. *Psychiatric Services*, *72*(6), 669–676. https://doi.org/10.1176/appi.ps.202000575

Parmenter, J. G., Galliher, R. V., Wong, E., & Perez, D. (2021). An intersectional approach to understanding LGBTQ+ people of color's access to LGBTQ+ community resilience:

Journal of Counseling Psychology. *Journal of Counseling Psychology, 68*(6), 629–641. https://doi.org/10.1037/cou0000578

Pennay, A., McNair, R., Hughes, T. L., Leonard, W., Brown, R., & Lubman, D. I. (2018). Improving alcohol and mental health treatment for lesbian, bisexual and queer women: Identity matters. *Australian and New Zealand Journal of Public Health*, *42*(1), 35–42. https://doi.org/10.1111/1753-6405.12739

Perrin, P. B., Sutter, M. E., Trujillo, M. A., Henry, R. S., & Pugh, M. (2020). The Minority Strengths Model: Development and Initial Path Analytic Validation in Racially/Ethnically Diverse LGBTQ Individuals. *Journal of Clinical Psychology*, *76*(1), 118–136. https://doi.org/10.1002/jclp.22850

Pinna, F., Paribello, P., Somaini, G., Corona, A., Ventriglio, A., Corrias, C., Frau, I., Murgia, R., El Kacemi, S., Galeazzi, G. M., Mirandola, M., Amaddeo, F., Crapanzano, A., Converti, M., Piras, P., Suprani, F., Manchia, M., Fiorillo, A., & Carpiniello, B. (2022). Mental health in transgender individuals: A systematic review. *International Review of Psychiatry*, *34*(3–4), 292–359. https://doi.org/10.1080/09540261.2022.2093629

Platt, L. F., Wolf, J. K., & Scheitle, C. P. (2018). Patterns of Mental Health Care Utilization Among Sexual Orientation Minority Groups. *Journal of Homosexuality*, *65*(2), 135–153. https://doi.org/10.1080/00918369.2017.1311552

Price-Feeney, M., Green, A. E., & Dorison, S. (2020). Understanding the Mental Health of Transgender and Nonbinary Youth. *Journal of Adolescent Health*, *66*(6), 684–690. https://doi.org/10.1016/j.jadohealth.2019.11.314

Puckett, J. A., Matsuno, E., Dyar, C., Mustanski, B., & Newcomb, M. E. (2019). Mental health and resilience in transgender individuals: What type of support makes a difference? *Journal of Family Psychology*, *33*(8), 954–964. https://doi.org/10.1037/fam0000561.supp

Rees, S. N., Crowe, M., & Harris, S. (2021). The lesbian, gay, bisexual and transgender communities' mental health care needs and experiences of mental health services: An integrative review of qualitative studies. *Journal of Psychiatric and Mental Health Nursing*, *28*(4), 578–589. https://doi.org/10.1111/jpm.12720

Reisner, S. L., Poteat, T., Keatley, J., Cabral, M., Mothopeng, T., Dunham, E., Holland, C. E., Max, R., & Baral, S. D. (2016). Global health burden and needs of transgender populations: A review. *The Lancet*, *388*(10042), 412–436. https://doi.org/10.1016/S0140-6736(16)00684-X

Rhoades, H., Rusow, J. A., Bond, D., Lanteigne, A., Fulginiti, A., & Goldbach, J. T. (2018). Homelessness, Mental Health and Suicidality Among LGBTQ Youth Accessing Crisis Services. *Child Psychiatry & Human Development*, *49*(4), 643–651. https://doi.org/10.1007/s10578-018-0780-1

Robertson, L., Akré, E.-R., & Gonzales, G. (2021). Mental Health Disparities at the Intersections of Gender Identity, Race, and Ethnicity. *LGBT Health*, *8*(8), 526–535. https://doi.org/10.1089/lgbt.2020.0429

Rodriguez-Seijas, C., Eaton, N. R., & Pachankis, J. E. (2019). Prevalence of psychiatric disorders at the intersection of race and sexual orientation: Results from the National Epidemiologic Survey of Alcohol and Related Conditions-III. *Journal of Consulting and Clinical Psychology*, *87*(4), 321–331. https://doi.org/10.1037/ccp0000377

Rodriguez-Seijas, C., Fields, E. C., Bottary, R., Kark, S. M., Goldstein, M. R., Kensinger, E. A., Payne, J. D., & Cunningham, T. J. (2020). Comparing the Impact of COVID-19-Related Social Distancing on Mood and Psychiatric Indicators in Sexual and Gender Minority (SGM) and Non-SGM Individuals. *Frontiers in Psychiatry*, *11*. https://www.frontiersin.org/articles/10.3389/fpsyt.2020.590318

Romanelli, M., Lu, W., & Lindsey, M. A. (2018). Examining Mechanisms and Moderators of the Relationship Between Discriminatory Health Care Encounters and Attempted Suicide Among U.S. Transgender Help-Seekers. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(6), 831–849. https://doi.org/10.1007/s10488-018-0868-8

Ruprecht, M. M., Wang, X., Johnson, A. K., Xu, J., Felt, D., Ihenacho, S., Stonehouse, P., Curry, C. W., DeBroux, C., Costa, D., & Phillips II, G. (2021). Evidence of Social and Structural COVID-19 Disparities by Sexual Orientation, Gender Identity, and Race/Ethnicity in an Urban Environment. *Journal of Urban Health*, *98*(1), 27–40. https://doi.org/10.1007/s11524-020-00497-9

Salerno, J. P., Williams, N. D., & Gattamorta, K. A. (2020). LGBTQ populations: Psychologically vulnerable communities in the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(S1), S239. https://doi.org/10.1037/tra0000837

Sandelowski, M., & Leeman, J. (2012). Writing Usable Qualitative Health Research Findings. *Qualitative Health Research*, *22*(10), 1404–1413. https://doi.org/10.1177/1049732312450368

Schoebel, V., Wayment, C., Gaiser, M., Page, C., Buche, J., & Beck, A. J. (2021). Telebehavioral Health During the COVID-19 Pandemic: A Qualitative Analysis of Provider Experiences and Perspectives. *Telemedicine and E-Health*, *27*(8), 947–954. https://doi.org/10.1089/tmj.2021.0121

Shipherd, J. C., Green, K. E., & Abramovitz, S. (2010). Transgender Clients: Identifying and Minimizing Barriers to Mental Health Treatment. *Journal of Gay & Lesbian Mental Health*, *14*(2), 94–108. https://doi.org/10.1080/19359701003622875

Silveri, G., Schimmenti, S., Prina, E., Gios, L., Mirandola, M., Converti, M., Fiorillo, A., Pinna, F., Ventriglio, A., Galeazzi, G. M., Sherriff, N., Zeeman, L., & Amaddeo, F. (2022). Barriers in care pathways and unmet mental health needs in LGBTIQ + communities. *International Review of Psychiatry*, *34*(3–4), 215–229. https://doi.org/10.1080/09540261.2022.2075256

Simeonov, D., Steele, L. S., Anderson, S., & Ross, L. E. (2015). Perceived Satisfaction With Mental Health Services in the Lesbian, Gay, Bisexual, Transgender, and Transsexual Communities in Ontario, Canada: An Internet-Based Survey. *Canadian Journal of Community Mental Health*, *34*(1), 31–44. https://doi.org/10.7870/cjcmh-2014-037

Slemon, A., Richardson, C., Goodyear, T., Salway, T., Gadermann, A., Oliffe, J. L., Knight, R., Dhari, S., & Jenkins, E. K. (2022). Widening mental health and substance use inequities among sexual and gender minority populations: Findings from a repeated cross-sectional monitoring survey during the COVID-19 pandemic in Canada. *Psychiatry Research*, *307*, 114327. https://doi.org/10.1016/j.psychres.2021.114327

Smith, S. K., & Turell, S. C. (2017). Perceptions of Healthcare Experiences: Relational and Communicative Competencies to Improve Care for LGBT People. *Journal of Social Issues*, *73*(3), 637–657. https://doi.org/10.1111/josi.12235

Su, D., Irwin, J. A., Fisher, C., Ramos, A., Kelley, M., Mendoza, D. A. R., & Coleman, J. D. (2016). Mental Health Disparities Within the LGBT Population: A Comparison Between Transgender and Nontransgender Individuals. *Transgender Health*, *1*(1), 12–20. https://doi.org/10.1089/trgh.2015.0001

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*(4), 271–286. https://doi.org/10.1037/0003-066X.62.4.271

Tebbe, E. A., & Moradi, B. (2016). Suicide risk in trans populations: An application of minority stress theory. *Journal of Counseling Psychology*, *63*(5), 520–533. https://doi.org/10.1037/cou0000152

Tebbe, E. A., Simone, M., Wilson, E., & Hunsicker, M. (2022). A dangerous visibility: Moderating effects of antitrans legislative efforts on trans and gender-diverse mental health. *Psychology of Sexual Orientation and Gender Diversity*, *9*(3), 259–271. https://doi.org/10.1037/sgd0000481

Thelwall, M., Devonport, T. J., Makita, M., Russell, K., & Ferguson, L. (2023). Academic LGBTQ+ Terminology 1900-2021: Increasing Variety, Increasing Inclusivity? *Journal of Homosexuality*, *70*(11), 2514–2538. https://doi.org/10.1080/00918369.2022.2070446

Tönnies, J., Oeljeklaus, L., Wensing, M., Hartmann, M., Friederich, H.-C., & Haun, M. W. (2021). Health policy experts’ perspectives on implementing mental health specialist video consultations in routine primary care – a qualitative interview study. *BMC Health Services Research*, *21*(1), 713. https://doi.org/10.1186/s12913-021-06676-x

Valente, P. K., Schrimshaw, E. W., Dolezal, C., LeBlanc, A. J., Singh, A. A., & Bockting, W. O. (2020). Stigmatization, Resilience, and Mental Health Among a Diverse Community Sample of Transgender and Gender Nonbinary Individuals in the U.S. *Archives of Sexual Behavior*, *49*(7), 2649–2660. https://doi.org/10.1007/s10508-020-01761-4

VDOE. (2023). *Model Policies on Ensuring Privacy, Dignity, and Respect for All Students and Parents in Virginia's Public Schools* |. Virginia Department of Education. https://www.doe.virginia.gov/parents-students/for-parents/model-policies-on-ensuring-privacy-dignity-and-respect-for-all-students-and-parents-in-virginia-s-public-schools

Wall, C. S. J., Patev, A. J., & Benotsch, E. G. (2023). Trans broken arm syndrome: A mixed-methods exploration of gender-related medical misattribution and invasive questioning. *Social Science & Medicine*, *320*, 115748. https://doi.org/10.1016/j.socscimed.2023.115748

Waters, H. R. (2000). Measuring equity in access to health care. *Social Science & Medicine*, *51*(4), 599–612. https://doi.org/10.1016/S0277-9536(00)00003-4

Williams, N. D., & Fish, J. N. (2020). The availability of LGBT-specific mental health and substance abuse treatment in the United States. *Health Services Research*, *55*(6), 932–943. https://doi.org/10.1111/1475-6773.13559

Wolford-Clevenger, C., Flores, L. Y., Bierma, S., Cropsey, K. L., & Stuart, G. L. (2021). Minority stress and drug use among transgender and gender diverse adults: A daily diary study. *Drug and Alcohol Dependence*, *220*, 108508. https://doi.org/10.1016/j.drugalcdep.2021.108508

Yıldız, E. (2018). Suicide in sexual minority populations: A systematic review of evidence-based studies. *Archives of Psychiatric Nursing*, *32*(4), 650–659. https://doi.org/10.1016/j.apnu.2018.03.003

Appendix A

LGBTQIA+ Individuals Seeking Mental Health Services

Interview and Focus Group Protocols

Key Community Informants

- Identify key LGBTQIA+ community informants (general)
    - Review search of websites
    - Coordinate with SERL/DBHDS
    - Work with Organizations Serving the LGBTQIA+ community in each of the 5 regions to distribute information about the study through their websites and organizational social media posts, as well as making printed flyers available in their sites.
    - Participants will be informed of the purpose of the interviews along with information on confidentiality.
- Focus Group Questions:
    - Describe perspectives on access to mental health services and perspectives on service availability.
        - When LGBTQIA+ individuals in your community have emotional or behavior challenges in their lives that could benefit from a counselor or therapist or other mental health services, where can they go? Could you tell me about their services?
        - If you had a friend or family member in the area who was a member of the LGBTQIA+ community, who would you refer them to for mental health services?
        - What is your perception of the need for mental health resources for members of the LGBTQIA+ community in your area?
        - What issues or problems are you aware of that LGBTQIA+ individuals are seeking support or services to address? (e.g., domestic violence, issues with depression, etc.)
        - What issues or factors do you believe contribute to their need for services? What, if any, preventative measures could be taken to decrease the need for mental health services for this community? What, if any, training do you feel service providers should receive if they are working with the LGBTQIA+ community?
        - Have you ever known someone (from the general community or LGBTQIA+ community?) who has pursued services in the area? Do you have a sense of what their experience was like?
        - Are you aware of any individuals, organizations, programs or other activities that help or support LGBTQIA+ individuals in your community in gaining access to mental health services?
        - Are you aware of factors that serve as barriers or deter LGBTQIA+ individuals in your community from gaining access to services?
        - Do you have a sense if individuals/resources that are providing mental health services to the LGBTQIA+ community are well trained and prepared to meet the needs of this community (or prepared to provide effective services)?

    - What is your perception of the need for mental health resources for members of the LGBTQIA+ community in your area?
    - Who else do you think I should talk with to understand access to mental and behavioral counseling services in your region in relation to the LGBTQIA+ community?
    - If you know of people who have received services or attempted to receive services, would you be willing to share information with them about the study?
    - *Prompts: Do you have a sense that the COVID-19 pandemic has had an impact on your responses? How has the use of technology been relevant to accessing services?*
    - To describe the participants in today's focus groups, we'd like to ask you complete a brief on-line survey about descriptive information like gender, race, age and sexual orientation. We will use this information to describe the individuals participating in the groups. We remind you that all questions are optional and voluntary and you do not have to answer any question that you would prefer not to. We will share the link in the Zoom chat to the survey for you to complete.

Community Mental Health Providers

- Identify Mental Health Providers
  - Review search of websites
  - Coordinate with SERL/DBHDS
  - Work with Organizations Serving the LGBTQIA+ community in each of the 5 regions to distribute information about the study through their websites and organizational social media posts, as well as making printed flyers available in their sites.
  - Input from general Key informant interviews
  - Participants will be informed of the purpose of the interviews along with information on confidentiality.

- Focus Group Questions
  - Describe perspectives on access to mental health services and perspectives on service availability.
    - When LGBTQIA+ individuals in your community have emotional or behavior challenges in their lives that could benefit from a counselor or therapist or other mental health services, where can they go? Could you tell me about their services?
    - If you had a client in the area who was a member of the LGBTQIA+ community, who would you refer them to for mental health services?
    - What is your perception of the need for mental health resources for members of the LGBTQIA+ community in your area?
    - What issues or problems are you aware of that LGBTQIA+ individuals are seeking support or services to address? (e.g., domestic violence, issues with depression, etc.)

- What issues or factors do you believe contribute to their need for services? What, if any, preventative measures could be taken to decrease the need for mental health services for this community? What, if any, training do you feel service providers should receive if they are working with the LGBTQIA community?
- Have you ever known someone (from the general community or LGBTQIA+ community?) who has pursued services in the area? Do you have a sense of what their experience was like?
- Are you aware of any individuals, organizations, programs or other activities that help or support LGBTQIA+ individuals in your community in gaining access to mental health services?
- Do you have a sense if individuals/resources that are providing mental health services to the LGBTQIA+ community are well trained and prepared to meet the needs of this community (or prepared to provide effective services)?
- What is your perception of the need for mental health resources for members of the LGBTQIA+ community in your area?
- Are you aware of factors that serve as barriers or deter LGBTQIA+ individuals in your community from gaining access to services?
- Who else should I talk to understand access to mental and behavioral counseling services in your region?
- If you know of people who have received services or attempted to receive services, would you be willing to share information with them about the study?
- *Prompts: Do you have a sense that the COVID-19 pandemic has had an impact on your responses? How has the use of technology been relevant to accessing services?*
- [From focus groups and work with DBHDS: Develop resource list for regional services]
- To describe the participants in today's focus groups, we'd like to ask you complete a brief on-line survey about descriptive information like gender, race, age and sexual orientation. We will use this information to describe the individuals participating in the groups. We remind you that all questions are optional and voluntary and you do not have to answer any question that you would prefer not to. We will share the link in the Zoom chat to the survey for you to complete.

Appendix B

Demographics

1. What is your race/ethnicity? (Select all that apply)
    a. White
    b. Black or African American
    c. American Indian or Alaska Native
    d. Hispanic or Latino/a/x
    e. Asian or Pacific Islander
    f. Arab or Middle Eastern
    g. Multiracial or mixed race
    h. Other ________

2. What is your current gender identity today?
    a. Male/Man
    b. Female/Woman
    c. Part time as one gender, part time as another
    d. Gender non-conforming, non-binary, gender queer, or gender variant
    e. Other _____

3. Do you identify as a member of the LGBTQIA+ community?
    a. Yes
    b. No
    c. Unsure

4. What percentage of your work/clients/community served are part of the LGBTQIA+ community?

5. What region(s) of Virginia do you or your organization serve?