Community Mental Health Journal (2019) 55:1313–1321
https://doi.org/10.1007/s10597-019-00445-1

ORIGINAL PAPER

Perceived Barriers to Mental Health Services Among Canadian Sexual and Gender Minorities with Depression and at Risk of Suicide

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Received: 19 September 2018 / Accepted: 14 July 2019 / Published online: 20 July 2019
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Abstract

This study examines barriers to mental health services among sexual and gender minorities (SGM) who screened positive for depression and risk of suicide. Data from an online survey of SGM (N = 2778) are analyzed. 37.5% met criteria for depression and 73.6% screened for being at risk of suicide. The most frequently cited barriers to mental health services access were inability to pay (62.3%), insufficient insurance (52.2%), a preference for 'waiting' for the problems to go away (51.5%), discomfort discussing emotions (45.7%), and feeling embarrassed and ashamed about mental health challenges (42.5%). Policy and practices implications of these findings are discussed.

Keywords Sexual and gender minorities · LGBTQ · Mental health · Depression · Suicide

Introduction

Sexual and gender minorities (SGM)[1] experience high rates of societal stigma (Bockting et al. 2013; Hatzenbuehler 2009; Herek 2007; White Hughto et al. 2015) and as such, have elevated rates of mental health disorders (e.g., anxiety and depressive disorders), substance use disorders and suicidality (Hottes et al. 2016; King et al. 2008). For example, sexual minority individuals are two to four times more likely to report depression (King et al. 2008) and two to five times more likely to report a lifetime suicide attempt when compared to heterosexual individuals (Hottes et al. 2016). Research also indicates disproportionate rates of depression and suicidal ideation and attempts among transgender individuals (Budge et al. 2013; Hoffman 2014; Rotondi et al. 2011). A Canadian study found a prevalence of depression of 61.2% among transgender individuals (Rotondi et al. 2011b) while another report revealed that one in ten transgender individuals have attempted suicide in the past year (Bauer et al. 2015).

Reflecting the high burden of mental health disorders among this population, SGM individuals rank mental illness as one of their top health concerns (Grov et al. 2013; Mathieson et al. 2002). Though several research reports suggest that SGM, particularly gay men and lesbian women, are more likely than non-SGM individuals to consult a mental health professional (Grella et al. 2009; Koh and Ross 2006; Tjepkema

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[1] Sexual minorities refer to individuals who do not identify as heterosexual and include but is not limited to gay, lesbian, bisexual, asexual and queer individuals. Gender minorities refer to individuals who do not identify as cisgender, meaning that their gender identity is different from their sex assigned as birth. Gender minorities include individuals who are transgender, gender non-binary, and gender queer.

2008), SGM individuals are also more likely to report barriers to mental health services access and/or to have unmet mental health care needs (Grella et al. 2009; Koh and Ross 2006; McCann and Sharek 2014; Tjepkema 2008; Welch et al. 2000). For example, a survey in Ontario found that 78.2% of transgender women, 72.4% of bisexual women and 67.1% of lesbian women had unmet needs for mental health services and that one in three SGM women had untreated depression (Steele et al. 2017). The large burden of mental health care needs among SGM has been attributed, in part, to the lack of SGM-specific mental health services (Veltman and Chaimowitz 2014) and the general scarcity of mental health services (Bijl et al. 2003; Crabb and Hunsley 2006).

The paradox between high uptake of mental health services and the large burden of unmet mental health needs among SGM suggests important barriers to mental health care for this population. However, research to identifies these barriers is limited. An American study found that gay and bisexual men who were openly out about their sexuality were more likely to have used mental health services, suggesting that concealed SGM identity may be a barrier to accessing mental health care (Currin et al. 2018). While a study looking at mental health service barriers among transgender individuals found that cost was the most cited barrier, followed by hearing reports from others that services were inappropriate for SGM, and a dislike of talking about one's problems (Shipherd et al. 2010). Similarly, a study of gay and bisexual men and women also described cost as the main barrier to timely access to mental health care, while the scarcity of providers (in particular, the lack of SGM providers), and fears of discrimination were also commonly reported (Smalley et al. 2015). The same study also found that bisexual men and women were more likely than gay men and women to report barriers to mental health services (Smalley et al. 2015), suggesting important within-group differences within SGM populations.

The studies above were all conducted in the USA and there is a scarcity of knowledge about the barriers to mental health care of SGM in Canada, which has a distinct public funding mandate for provision of healthcare (Martin et al. 2018). Therefore, the objective of the current study was to identify barriers to mental health services within and across population sub-groups of Canadian SGM who screened positive for depression and suicide risk. Such work may help inform interventions and policies that facilitate timely service access for this underserved population.

Methods

Individuals identified as SGM were recruited to participate in an online study via promotion on social media (Facebook™) and local SGM community groups across Canada. Surveys were completed anonymously in Canada's two official languages (English or French) from November to December 2017. Respondents were eligible to participate if they self-identified as a sexual and/or gender minority, resided in Canada, were 18 years of age or older, and were able to complete the questionnaire in either French or English. All respondents were offered the opportunity to be entered into a draw for a $300 gift card.

Measures

Depression

Depression was screened using the respondents self-reported answers to the Patient Health Questionnaire (PHQ-9) (Kroenke et al. 2001), which is comprised of nine items that correspond to the DSM-5 criteria for major depression (American Psychiatric Association 2013): depressed mood, diminished interest in pleasure, changes in appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feeling of worthlessness, diminished ability to think or concentrate, and thoughts of suicide. For each item, respondents self-reported the occurrence of symptoms in the preceding 2 weeks on a four-point scale: not at all = 0, several days = 1, more than half the days = 2, and nearly every day = 3. Scores for the PHQ-9 range from 0-27. The psychometrics properties of the PHQ-9 are well established (Kroenke et al. 2001) and the current study used the upper score cut-point of 15, established for moderately severe depression (Manea et al. 2012).

Suicide Risk

The Suicidal Behaviours Questionnaire-Revised (SBQ-R) (Osman et al. 2001), a four-item screen for suicide risk, was completed by respondents. The self-reported items included: lifetime suicidal ideation or attempt, past 12-month suicidal ideation, disclosure of suicidal intent or planning, and the likelihood of the respondent making a future suicide attempt. Responses were made on item-specific Likert scales ranging from three to five. The SBQ-R total score ranges from 3 to 18. The present study used the cutoff score of 7, which has been identified as the most useful cutoff score to identify individuals at risk of suicide outside of psychiatric settings (Osman et al. 2001). The psychometric properties of the SBQ-R have been found satisfactory (Aloba et al. 2017).

Barriers

Because there are no specific measures of barriers to mental health services for SGM, the Barriers to Access to Care Evaluation scale (BACE-3), which has been validated among the general population (Clement et al. 2012), was

adapted to the SGM specific contexts for the present study as follows. First, the research team (which has extensive experience in SGM research and mental health services) reviewed the BACE-3 questionnaire to identify items most likely and least likely to apply to SGM. Second, the wording of each item was reviewed for its relevance to SGM. Third, an item specific to SGM was added (Unable to find a Lesbian, gay, bisexual, Transgender, Queer, or Two-spirit (LGBTQTS) or LGBTQTS friendly professional). Fourth, the scale was piloted and adjusted with feedback from 20 SGM respondents. This process resulted in 18 items that were used to measure barriers to professional mental health care for SGM. Each item had four response options; Not at all, a little, quite a lot, and a lot. For the purpose of this article, each barrier was transformed into a binary variable "quite a lot" and "a lot" collapsed together to signify a barrier, and "not at all" and a "little" were collapsed to signify no barrier.

Gender and Sexual Identities

Gender identity was measured using an adaptation of the two-step sex and gender items recommended by Bauer et al. (2017) for identifying gender minorities, including transgender individuals in population health surveys. The first item asked the respondents to report their sex assigned at birth with the options male or female and the second item asked respondents to select what best described their current gender identity from among the following four options: man, woman, non-binary, and other (including open-field response option). Six gender categories were then derived from these two questions: cisgender men (for those who selected male assigned sex at birth and gender-identified as a man), cisgender women (for those who selected female assigned sex at birth and gender-identified as a woman), transgender men (for those who selected female assigned sex at birth and gender-identified as a man), transgender women (for those who selected male assigned sex at birth and gender-identified as a woman), gender non-binary (those who selected non-binary gender identity, regardless of sex assigned at birth) and other (those who selected "other" gender, regardless of sex assigned at birth). The survey asked the respondents to select their sexual identities among the following options: gay/lesbian, bisexual, queer, asexual, pansexual, and other.

Data Analysis

Analyses were restricted to those who scored 15 or higher on the PHQ-9 and/or 7 or higher on the SBQ-R, and thus were classified as currently depressed and/or at risk of suicide. Descriptive statistics and statistical tests (Chi square) were used to identify associations ($p < 0.05$) between endorsement of barriers to mental health care access and gender or sexual identities sub-groups. Because the study was focused on the relationships between genders, sexual identities and barriers to mental health care, the results for those who described their gender or identity as "other" are not presented as they are non-interpretable. All analyses were undertaken using SPSS version 23.

Ethics

The study was approved by the Behavioural Research Ethics Board of the University of British Columbia (#H17-01592).

Results

Overall, 1043 (37.5%) of the respondents met the criteria for probable moderate-to-severe depression according to the PHQ-9, and 2044 (73.6%) were screened for being at risk of suicide based on their responses to the SBQ-R, with a total of 969 (34.9%) identified as having both moderate-to-severe depression and suicide risk. A total of 2118 (76.2%) met the criteria for *either* probable depression or suicide risk and were carried forward for further analyses. A detailed description of the sample is available in Table 1.

A total of 2002 (94.5%) of these respondents reported at least one barrier to accessing mental health services, while 1315 (62.1%) reported five or more barriers. The five barriers that were most often reported by respondents were: "not being able to afford the cost" (62.3%), "not covered or insufficient coverage from insurance" (52.2%), "waiting to solve the problem on my own" (51.5%), "dislike of talking about my feelings, emotions or thoughts" (45.7%), and "feeling embarrassed or ashamed" (42.5%) (Table 2).

For the gender analyses, several statistically significant associations were observed between gender identity and help seeking barriers (Table 2). Similarly, several significant associations between sexual identity and perceived barriers emerged (Table 3). Lack of SGM-friendly provider ranked among the five most frequently reported barriers for non-binary, transgender men, and transgender women, as well as for those who selected queer as their sexual identity. A greater proportion of transgender and non-binary individuals reported previous negative experiences with professional care as a barrier to accessing or continuing care, as compared to cisgender men and women. Similarly, a higher proportion of those who endorsed a queer sexual identity reported previous negative experiences relative to those identifying to other sexual identities.

Table 1 Demographic characteristics and mental health profiles of an online sample of Canadian sexual and gender minorities, 2017, N = 2778

Variables	Total sample n (%)	Depressed and not at risk of suicide n (%)	Not depressed and at risk of suicide n (%)	Depressed and at risk of suicide n (%)
Gender identity				
Cisgender men	623 (22.4)	10 (1.6)	274 (44.1)	103 (16.6)
Cisgender women	1157 (41.6)	34 (2.9)	435 (37.6)	382 (33.0)
Transgender men	209 (7.5)	7 (3.3)	80 (38.3)	97 (46.4)
Transgender women	82 (3.0)	0 (0.0)	37 (45.1)	33 (40.2)
Non-binary	561 (20.2)	19 (3.4)	187 (33.3)	291 (51.9)
Other	146 (5.3)	4 (2.7)	62 (42.5)	63 (43.2)
Sexual orientation				
Gay/lesbian	1032 (37.1)	19 (1.8)	433 (42.0)	245 (23.8)
Bisexual	615 922.1)	17 (2.8)	227 (36.9)	242 (39.3)
Queer	486 (17.5)	17 (3.5)	192 (39.5)	188 (38.7)
Asexual	133 (4.8)	4 (3.0)	31 (23.3)	64 (48.1)
Pansexual	369 (13.3)	13 (3.5)	136 (36.9)	177 (48.0)
Other	143 (5.1)	4 (2.8)	56 (39.2)	53 (37.1)
Age				
18–20	636 (22.9)	15 (2.4)	181 (28.5)	347 (54.6)
20–29	1245 (44.8)	40 (3.2)	480 (38.6)	443 (35.6)
30–39	449 (16.2)	17 (3.8)	200 (44.5)	118 (26.3)
40–49	176 (6.3)	1 (0.6)	83 (47.2)	34 (19.3)
50 +	267 (9.6)	1 (0.4)	131 (49.2)	25 (9.4)
Education				
Some or completed high school	473 (17.0)	12 (2.5)	160 (33.8)	255 (53.9)
Some college or university	1383 (49.8)	41 (3.0)	527 (38.1)	546 (39.5)
University degree	907 (32.6)	21 (2.3)	382 (42.2)	161 (17.8)
Individual income, Canadian dollars				
Under 20,000	1500 (54.0)	44 (2.9)	527 (35.2)	661 (44.1)
20,000–49,999	714 (25.7)	18 (2.5)	332 (46.5)	176 (24.6)
50,000 or more	382 (13.8)	5 91.3)	161 (24.6)	48 (12.6)
Ethnicity				
White	2147 (77.3)	56 (2.6)	829 (38.6)	724 (33.7)
Ethnic minorities	262 (9.4)	8 (3.1)	113 (43.1)	78 (29.8)
Indigenous	283 (10.2)	10 (3.5)	106 (37.5)	133 (47.0)

Depression measured with the Patient Health Questionnaire 9 (PHQ-9) (with score > 15 classified as depressed) and suicide risk with the Suicide Behaviour Questionnaire (SBQ-r) (with score > 7 classified as risk of suicide)

Discussion

This study provides a quantitative profile of the barriers that prevent SGM Canadians with moderate-to-severe depression and/or at risk of suicide from accessing mental health care services. We found that more than one in three SGM scored above the PHQ-9 cut-off for moderate-to-severe major depression, and that three quarters were at risk of suicide based on the SBQ-R threshold. These findings are consistent with Canadian studies that have found high rates of depression and suicidality in SGM communities (Bauer et al. 2015; Ferlatte et al. 2018; Hottes et al. 2015; Pakula et al. 2016b; Rotondi et al. 2011a, b). Early interventions are critical for reducing the burden of mental health disorders in SGM communities, as a delay in the start of treatment can have multiple deleterious consequences, such as risk of developing co-occurring conditions (e.g., substance use disorders) (Conner et al. 2009), developing more severe symptoms, and experiencing greater functional impairment (Ghio et al. 2013). As such, the finding that the vast majority of respondents (94.5%) reported at least one barrier to mental health care access has important implications for mental health professionals and policy-makers, which are outlined below. More so, considering that nearly two-thirds

Table 2 Perceived barriers to mental health care among Canadian sexual and gender minorities disaggregated by gender identity

Issues	Total n=2118 (%)	Cisgender men n=387 (18.3%) (%)	Cisgender women n=851 (40.2%) (%)	Non-Binary n=497 (23.5%) (%)	Transgender men n=184 (8.7%) (%)	Transgender women n=70 (3.3%) (%)	p value
Not being able to afford financial cost involved	62.3	50.9	59.6	73.2	61.4	65.7	.000
Not covered or insufficient coverage from my insurance	52.2	41.9	50.9	59.6	53.8	52.9	.000
Waiting to solve the problem on my own	51.5	43.7	54.6	53.3	51.6	47.1	.013
Dislike of talking about my feelings, emotions or thoughts	45.7	32.3	48.3	51.5	56.0	30.0	.000
Feeling embarrassed or ashamed	42.5	29.7	45.1	44.7	47.8	42.9	.000
Concerns about treatments available (e.g. Medication side effects)	39.0	30.0	41.5	42.9	39.1	31.4	.001
Having had previous bad experiences with professional care for mental health	38.1	20.4	36.4	47.3	47.3	41.4	.000
Unable to find a SGM[a] or SGM[a] friendly professional	34.7	23.8	24.8	50.5	51.6	41.4	.000
Being unsure where to go to get professional help	34.6	22.5	32.2	43.9	41.3	34.3	.001
Difficulty taking time off from work	34.2	29.5	35.0	38.6	28.8	28.6	.033
Concern that I might be seen as weak for having mental health problem	30.9	21.7	33.0	32.0	37.5	25.7	.000
Thinking that professional care probably would not help	27.0	17.6	27.4	27.2	38.0	34.3	.000
Concern about what people at work might think, say or do.	24.7	18.9	27.6	24.7	25.0	21.4	.044
No wanting a mental health problem to be on my medical records	24.5	18.3	25.4	24.9	28.8	28.6	.046
Concern that people I know might find out	20.3	15.0	22.7	20.7	20.1	14.3	.034
Preferring to get help from friends	16.9	16.8	15.5	20.1	16.3	18.6	.364
Preferring to get alternative forms of care	12.7	9.8	13.5	15.1	10.9	8.6	.172
Professionals from ethnic or cultural group not available	8.5	6.5	6.9	9.7	9.2	11.4	.002

[a]Sexual and/or gender minority

of respondents reported at least five barriers, policy, systems and service adjustments are needed.

The most frequently reported barriers across the entire sample, as well as for every sexual and gender identity, were prohibitive costs associated with mental health services and insufficient coverage from insurance. In Canada, only half of medical treatment for mental disorders are provided through the primary care system (World Health Organization 2005), meaning that many Canadians pay out-of-pocket or through private insurance for access to mental health services (Martin et al. 2018). The findings detailed in this article highlight how fee-for-service mental health care and delivery systems ultimately impede access to care for a large proportion of SGM, reflecting significant health inequities along a variety of health indicators (e.g., suicide; depressive disorders). Cost is not a barrier unique to SGM populations and has been reported as a challenge in non-SGM populations as well (Mesidor et al. 2011). However, SGM individuals are about half as likely to be partnered as non-SGM individuals (Operario et al. 2015; Pakula et al. 2016a), and as such may be less likely to access partner's benefits which can provide mental health care coverage. SGM are also more likely to experience poverty (Operario et al. 2015; Pakula et al. 2016a), exacerbating cost-related barriers to mental healthcare access. In the context where the cost and the demand for mental health services has grown increasingly expensive in recent years in Canada (Mental Health Commission of Canada 2017), the number of SGM with depression or at risk of suicide is likely to grow without an expansion of mental health services coverage within the publicly funded Canadian health care system, particularly if outpatient services remain fee for service (e.g., talk-therapy and counselling).

Beyond costs, a barrier that was reported by half of the respondents was "*waiting for problems to resolve on their own*" suggesting that many SGM prefer to rely on themselves rather than to seek professional help. A potential explanation for this is the general health care avoidance of SGM in order to prevent encountering prejudice and negative attitudes about their gender or sexual orientation from health care providers (Simpson et al. 2013; Tracy et al. 2010). This self-reliance may also relate to other frequently reported barriers "*dislike talking about feelings, emotions or thoughts*" and "*feeling embarrassed or ashamed*". These barriers may reflect the persistence of mental illness stigma

Table 3 Perceived barriers to mental health care among Canadian sexual and gender minorities disaggregated by sexual identity

Issues	Total n = 2118	Gay/lesbian n = 697 (32.9%)	Bisexual n = 486 (22.9%)	Queer n = 397 (18.7%)	Asexual n = 99 (4.7%)	Pansexual n = 326 (15.4%)	*p* value
Not being able to afford financial cost involved	62.3	53.9	60.3	76.1	60.6	65.0	.000
Not covered or insufficient coverage from my insurance	52.2	45.6	49.6	65.7	41.4	57.2	.000
Waiting to solve the problem on my own	51.5	46.5	57.6	51.9	60.6	51.5	.002
Dislike of talking about my feelings, emotions or thoughts	45.7	42.2	49.8	46.1	60.6	44.2	.003
Feeling embarrassed or ashamed	42.5	38.6	46.5	41.8	54.5	41.1	.015
Concerns about treatments available (e.g. Medication side effects)	39.0	35.6	42.4	42.6	35.4	40.5	.037
Having had previous bad experiences with professional care for mental health	38.1	29.1	38.3	50.4	39.4	39.0	.000
Unable to find a SGM[a] or SGM[a] friendly professional	34.7	30.1	24.5	50.4	38.4	35.6	.000
Being unsure where to go to get professional help	34.6	28.0	33.5	44.6	32.3	37.1	.000
Difficulty taking time off from work	34.2	32.0	32.5	39.5	27.3	38.0	.036
Concern that I might be seen as weak for having mental health problem	30.9	29.8	33.7	29.0	42.4	29.4	.055
Thinking that professional care probably would not help	27.0	24.2	29.2	28.7	36.4	24.5	.078
Concern about what people at work might think, say or do.	24.7	24.0	25.1	24.7	27.3	24.2	.974
No wanting a mental health problem to be on my medical records	24.5	22.8	29.4	24.4	25.3	20.6	.069
Concern that people I know might find out	20.3	18.5	25.7	14.9	26.3	20.6	.001
Preferring to get help from friends	16.9	14.6	17.7	19.6	16.2	18.4	.334
Preferring to get alternative forms of care	12.7	10.2	13.2	14.4	11.1	15.3	.184
Professionals from ethnic or cultural group not available	8.5	8.2	6.2	11.1	6.1	7.7	.014

[a]Sexual and/or gender minority

and the corresponding barriers to care, which have been reported in non SGM population studies as important barriers to treatment for mental health (Dockery et al. 2015; Gulliver et al. 2012; Thornicroft 2008). As such, these findings suggest that stigma reduction and targeted interventions to increase mental health literacy may be effective in reducing unmet needs for mental health among SGM. Such interventions should focus on SGM most at risk of mental illness and those who face most barriers. Interventions could address knowledge issues such as the importance to start treatment early and treatment options, as well as attitudes towards mental illness, including attitudes toward mental illness treatment.

A concerning trend in the findings was that gender minorities (transgender and non-binary individuals) consistently reported each barrier in greater proportions than cisgender individuals. A similar trend was also seen for those identifying their sexuality as queer in comparison to gay/lesbian and bisexual respondents. Of importance, transgender, non-binary and queer-identified groups reported a greater proportion of negative experiences with professionals and inability to find a SGM (or SGM friendly) professional. While SGM sensitivity training is becoming more frequent for health care professionals (Obedin-Maliver et al. 2011), the findings highlight the need to extend the focus of such training so providers can be trained to better relate to transgender, non-binary, and queer individuals.

Limitations

The following limitations should be kept in mind when interpreting these findings. First, the data were drawn from a non-probability sample via the Internet and social media; as such, it cannot be claimed as representative of the Canadian SGM population. Specifically, the survey's online recruitment strategies (e.g., recruitment through social media and SGM community groups) may have oversampled SGM who are connected to the SGM community, which may have a different profile than those residing outside the SGM community. Second, depression and suicide risk were measured with validated self-report screening tools, which are not equivalent to a clinical interview or diagnosis. Nonetheless, given the more stringent PHQ-9 cut-off of 15 was used to identify caseness, there can be confidence that the present sample were experiencing prominent depressive symptoms. Finally, although the BACE questionnaire was adapted to fit the study population, important barriers faced by SGM individuals may have been missed.

Conclusions

This is the first study to examine reported barriers to mental health services among SGM Canadians experiencing prominent depression and suicide risk. Findings document numerous obstacles to mental health care, in particular cost-related barriers and challenges finding SGM-competent mental health care. Considering the growing body of literature demonstrating the mental health inequities for SGM populations, these results provide important insights that could inform the development of programs and policies to facilitate access to timely and relevant care for these populations. However, more research is needed about the ways in which individuals identifying as SGMs experience and interact with mental health services. Specifically, more work is needed to understand the within-group differences that were detailed in this article, as well as to identify how barriers experienced by SGM differ from non-SGM Canadians. More so, an important focus of future investigation will be to identify the facilitators of mental health help-seeking and care among this population as well as the implementation and formal evaluation of interventions targeted to reducing barriers to mental health care access.

Acknowledgements The authors are extremely grateful to the thousands of SGM that participated in the survey.

Funding This work was supported by an Internal Research Grant from the School of Nursing at the University of British Columbia (UBC) and the Men's Health Research program at UBC. The postdoctoral funding for the first author was provided by Movember Canada (Grant # 11R18296), the Canadian Institutes for Health Research (Grant # 11R06913) and the Michael Smith Foundation for Health Research (Grant # 17945).

Compliance with Ethical Standards

Conflict of interest The authors have no conflict of interest to declare.

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