Perceived Satisfaction With Mental Health Services in the Lesbian, Gay, Bisexual, Transgender, and Transsexual Communities in Ontario, Canada: An Internet-Based Survey

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ABSTRACT

This study compared mental health service experiences of lesbian, gay, or bisexual (LGB), trans-identified, and cisgender (nontrans) heterosexual people in Ontario. An Internet-based survey, derived from the *Canadian community health survey—Mental health and well-being—Cycle 1.2* (Statistics Canada, 2003), was completed by 326 individuals (194 LGB, 71 trans-identified, 61 cisgender heterosexual). Hierarchical logistic regression models were used to examine group differences. All three groups reported high levels of satisfaction and positive experiences with the provider seen most often in the past 12 months. However, substantial proportions of LGB and trans-identified people reported unmet need for mental health services.

Keywords: mental health services, patient satisfaction, sexual orientation, gender identity

RÉSUMÉ

Dans cette étude, nous comparons la façon dont sont offerts les services de santé mentale à trois groupes de personnes et le degré de satisfaction de ces utilisateurs. Ces groupes sont : 1. les lesbiennes, les gais et les personnes bisexuelles (LGB), 2. les personnes transgenres ; et 3. les personnes cisgenres hétérosexuelles. Nos données proviennent d'un sondage fait sur Internet à l'aide d'un questionnaire tiré de l'Enquête sur la santé dans les collectivités canadiennes – Santé mentale et bien-être, Cycle 1.2 (Statistique Canada, 2003) ; 326 personnes y ont répondu (194 personnes LGB, 71 personnes transgenres, 61 personnes cisgenres hétérosexuelles). Nous avons ensuite utilisé des modèles de régression logistique hiérarchique pour analyser les différences entre les trois groupes. Au sujet des prestateurs de services qu'ils avaient vus le plus souvent au cours des 12 mois précédents, les répondants des trois groupes ont rapporté des degrés de satisfaction élevés. Toutefois, une proportion importante des personnes LGB et transgenres ont affirmé que certains de leurs besoins en matière de services de santé mentale ne sont pas comblés.

Mots clés : services de santé mentale, satisfaction des patients, orientation sexuelle, identité sexuelle

BACKGROUND

There is a growing body of evidence demonstrating that lesbian, gay, and bisexual (LGB) people report poorer mental health status than heterosexual people (Meyer, 2003). A meta-analysis of 25 population-based studies found that LGB individuals were 2.5 times more likely to have attempted suicide, and at least 1.5 times more likely to have depression and anxiety disorders than heterosexual people (King, Semlyen, Tai, Killaspy, Osborn, Popelyuk, & Nazareth, 2008). Others have similarly reported poorer health status among LGB people relative to heterosexuals (Bakker, Sandfort, Vanwesenbeeck, van Lindert, & Westert, 2006; Banks, 2003; Cochran, 2001; Cochran, Mays, & Sullivan, 2003; Owens, Riggle, & Rostosky, 2007).

Although less research has focused on examining the mental health status of transgender people, recently the Ontario-wide Trans PULSE project surveyed 433 trans individuals and found that 66.4% of female-to-male and 61.2% of male-to-female transgender Ontarians report symptoms that are consistent with depression (Rotondi, Bauer, Scanlon, Kaay, Travers, & Travers, 2011; Rotondi, Bauer, Travers, Travers, Scanlon, & Kaay, 2011). Further, past-year suicidal thoughts were reported by 36% of trans Ontarians, and 10% of participants had attempted suicide during that time span (Bauer, Pyne, Francino, & Hammond, 2013). Taken together, these data indicate that mental health is a primary concern within lesbian, gay, bisexual, and trans (LGBT) communities.

Canadian population data indicate that LGB people are more likely than heterosexuals to consult mental health professionals (Tjepkema, 2008). These results are consistent with those of U.S. and international

studies (Grella, Greenwell, Mays, & Cochran, 2009; Koh & Ross, 2006; Mays & Cochran, 2001; Weber, 2008), with one identifying that lesbian and bisexual women were approximately twice as likely to seek mental health services as heterosexual women (Grella et al., 2009).

Despite high rates of both mental health problems and mental health service utilization, little research has been conducted on the mental health service experiences of LGBT people, relative to the research that describes mental health disparities among LGBT people. In one New Zealand study, 29.3% of lesbians who completed a postal survey reported experiences of "lesbian-unfriendly" service from their mental health provider (Welch, Collings, & Howden-Chapman, 2000). A Scottish qualitative study examining the mental health service experiences of 17 gay men found that participants had wanted to discuss their feelings of anxiety and stress related to their sexual orientation with their physician but were fearful to, because they thought the physician would treat their homosexuality rather than their emotional needs. Heterosexist language used by physicians, such as assuming individuals have a different-sex partner, was another barrier identified by participants (Robertson, 1998). A recent study conducted in Ireland showed that in a sample of 125 participants, 51% were unsure or felt that they could not discuss their LGBT status with their mental health services provider, and 43% felt that providers were not responsive to their needs (McCann & Sharek, 2014). We could identify only one controlled study which explicitly assessed LGBT peoples' satisfaction with mental health care (Avery, Hellman, & Sudderth, 2001). Avery and colleagues interviewed 67 LGBT individuals with a serious mental illness and compared them to heterosexuals from a previous study also assessing mental health services satisfaction (Avery et al., 2001). A statistically significant and higher percentage of the LGBT group (17.6%) reported dissatisfaction compared to the heterosexual comparison group (8%). However, the study was limited by the noncontemporaneous nature of the control group (Avery et al., 2001).

In order to address this research gap, the current study aims to:

1. Describe patterns of mental health service use and unmet mental health care needs for LGB, trans-identified, and heterosexual people;
2. Compare the likelihood of dropping out of mental health services due to negative experiences related to sexual orientation or gender identity between LGB and trans-identified people;
3. Compare satisfaction with mental health services among LGB, trans-identified, and heterosexual people; and
4. Compare the impact on satisfaction among LGB and trans-identified people of receiving mental health services from a provider with an LGBT-specific mandate versus receiving services without such a provider.

METHODS

This was a cross-sectional, Internet-based survey. Two versions of the survey were made available through two separate Web sites, both hosted by www.surveymonkey.com: 1) a version for cisgender (non-trans) heterosexual people, composed of mental health service utilization questions; and 2) an LGBT version, which included these same questions, plus additional LGBT-specific items. All participants were required to be fluent in English, living in Ontario, and over 16 years of age. The sample was recruited between

October 2008 and January 2009 via announcements on email listservs serving the LGBT communities and advertisements posted in health centres in Toronto, Ontario, and nearby communities. These listservs and communities were identified through the authors' established LGBT networks, as well as with support from community partners, including Rainbow Health Ontario. The announcements invited LGBT people who had previously used (ever, or in the last five years) or were currently using (in the last 12 months) mental health services, and who were interested in completing an on-line survey about their experiences, to visit the Web site. Hard copies of the survey were available upon request to allow participation by those without private access to a computer. Recipients of the original solicitation were encouraged to forward the announcement to additional LGBT contacts.

In order to recruit a cisgender-heterosexual comparison group, we asked LGBT respondents to forward a link to a sibling, friend, or colleague who identified as heterosexual and cisgender. Previous studies have used a variation of this method by recruiting LGB individuals and their siblings as a comparative group (Balsam, Beauchaine, Mickey, & Rothblum, 2005; Rothblum, Balsam, & Mickey, 2004). Additional recruiting using convenience sampling was also undertaken. Informed consent was obtained through the on-line survey. The study was approved by the institutional ethics review board of the Centre for Addiction and Mental Health, Toronto.

Measures

The survey was primarily composed of questions adapted from the *Canadian community health survey* (CCHS)—*Mental health and well-being—Cycle 1.2* (Statistics Canada, 2003) and previously published surveys related to LGBT health (Avery et al., 2001; Stein & Bonuck, 2001; Welch et al., 2000). The survey was developed in consultation with community LGBT partners and experts in the field.

Sexual orientation and gender identity were assessed using the following questions: "I identify as" (lesbian, gay, bisexual, two-spirit, homosexual, queer, heterosexual); or "I identify in another way" with an open probe; and "I identify as" (genderqueer, transgender woman, transsexual woman, woman, two-spirit, transgender man, transsexual man, man—check all that apply); or "I identify in another way" with an open probe. Respondents were divided into three exclusive categories: 1) trans-identified, which included any respondent who chose a response in addition to, or other than, "woman" or "man" on the gender-identity question; 2) LGB, which included respondents who did not identify as heterosexual and did not meet the criterion for trans; and 3) heterosexual (nontrans), which included respondents who identified as heterosexual and did not meet the criterion for trans.

Mental health service utilization was assessed using items derived from CCHS—Cycle 1.2 (Statistics Canada, 2003) exploring sources of care, frequency of use, and payment issues. Mental health services were defined as "any help received for problems with emotions, mental health concerns (e.g., anxiety, depression, stress), relationship issues, or the use of alcohol or drugs" (Statistics Canada, 2008). We further specified that these services may have been received through any type of mental health or social services provider (e.g., counsellor, therapist, psychiatrist, psychologist, support group leader, etc.). Individuals were asked, "Think of the service provider you talked to the most often during the past 12 months. What type of service provider was that?" and, "During the past 12 months, how many times did you see this service provider?" We also inquired whether the provider had an LGBT-specific mandate.

Unmet need for mental health services was determined by the question, "During the past 12 months, was there ever a time when you felt that you needed help for your emotions, mental health concerns, relationship issues, or use of alcohol or drugs, but you didn't receive it?" This item was followed by a list of types of services that the respondent felt he or she needed but did not receive and a list of potential reasons for the unmet need.

Dropping out of mental health care was assessed by asking LGB and trans-identified respondents, "Have you ever stopped using mental health services due to a negative experience related to your sexual orientation or gender identity?"

Statistical Analysis

We reported the demographic characteristics of our respondents by identity group (trans, LGB, or heterosexual (nontrans)) using proportions and 95% confidence intervals. We similarly described patterns of mental health service use, and unmet mental health care needs. We compared the likelihood of dropping out of mental health services due to negative experiences among LGB and trans-identified people, first using a chi-square test and then using hierarchical logistic regression with a forward step conditional test. Demographic variables (age, race, employment, education, reported psychiatric diagnosis, and household income) were entered into block 1 of the regression, and the independent identity variable (LGB or trans) was entered in block 2. We repeated this general approach to compare overall satisfaction with mental health services (including heterosexual (nontrans) respondents) and the impact on satisfaction of receiving services from a provider with an LGBT-specific mandate (excluding heterosexual (nontrans) respondents).

Prior to finalizing our regression models, we assessed our explanatory variables and covariates for the presence of significant collinearity and tested for the presence of interactions among the independent variables. To assess the fit of our models, we examined the Hosmer-Lemeshow Statistic for each model. All data were analyzed using SPSS statistical software, version 17.0, and statistical significance was determined at a two-tailed $p < 0.05$ level.

Results

There were 222 LGB and 90 trans-identified respondents to the LGBT version of the survey and 74 respondents to the heterosexual (nontrans) version. Of these 386 respondents, 60 were excluded because they had insufficient data (in 27 cases more than three-quarters of the survey was unanswered), filled out the heterosexual questionnaire but were not heterosexual (23 cases), or lived outside Ontario (10 cases), yielding a final sample of 326 respondents (194 LGB; 71 trans-identified; 61 heterosexual (nontrans)). Demographic characteristics are presented in Table 1. Within the LGB group, 56 of the sample identified as lesbian, 64 identified as gay, and 33 identified as bisexual. Respondents lived across the province of Ontario, with many living in the Toronto area (86, 46.0% LGB; 39, 57.4% trans; 25, 41.0% heterosexual (nontrans)), some living in another major Ontario city (63, 33.7% LGB; 10, 14.7% trans; 21, 34.4% heterosexual (nontrans)), and some living in a smaller city/town or rural area in Ontario (38, 20.3% LGB; 19, 27.9% trans; 15, 24.6% heterosexual (nontrans)). The groups differed in employment status, household income, and report of psychiatric diagnosis, with respondents in the trans-identified group most likely to be not working, in

Table 1

Participant Demographic Characteristics by Identity Group

	Heterosexual n=61	LGB n=194	Trans n=71
Sexual Orientation			
Lesbian		28.9% (22.5% to 35.3%)	16.9% (8.2% to 25.6%)
Gay		33.0% (26.4% to 39.6%)	5.6% (0.3% to 10.9%)
Bisexual		17.0% (11.7% to 22.3%)	15.5% (7.1% to 23.9%)
Two-spirit		0.5% (0.0% to 1.5%)	9.9% (3.0% to 16.8%)
Homosexual		2.1% (0.1% to 4.1%)	0.0%
Heterosexual	100.0%	0.0%	7.0% (1.1% to 12.9%)
Queer		14.9% (9.9% to 19.9%)	38.0% (26.7% to 49.3%)
Other		3.6% (1.0% to 6.2%)	7.0% (1.1% to 12.9%)
Gender Identity			
Genderqueer			36.6% (25.4% to 47.8%)
Transgender woman			12.7% (5.0% to 20.4%)
Transexual woman			14.1% (6.0% to 22.2%)
Woman	85.2% (76.3% to 94.1%)	58.2% (51.3% to 65.1%)	21.1% (11.6% to 30.6%)
Two-spirit			16.9% (8.2% to 25.6%)
Transgender man			15.5% (7.1% to 23.9%)
Transexual man			11.3% (3.9% to 18.7%)
Man	14.8% (5.9% to 23.7%)	41.8% (34.9% to 48.7%)	8.5% (2.0% to 15.0%)
Age Category			
% 35 years and under	66.7% (54.9% to 78.5%)	50.3% (43.3% to 57.3%)	58.6% (47.1% to 70.1%)
Race/Ethnicity			
Aboriginal	4.9% (0.0% to 10.3%)	0.6% (0.0% to 1.7%)	5.8% (0.4% to 11.2%)
Black	1.6% (0.0% to 4.8%)	1.1% (0.0% to 2.6%)	2.9% (0.0% to 6.8%)
East Asian or South Asian	9.8% (2.3% to 17.3%)	7.9% (4.1% to 11.7%)	4.3% (0.0% to 9.0%)
Latin American	4.9% (0.0% to 10.3%)	1.1% (0.0% to 2.6%)	1.4% (0.0% to 4.1%)
White	77.0% (66.4% to 87.6%)	88.8% (88.4% to 93.2%)	82.6% (73.8% to 91.4%)
Other	1.6% (0.0% to 4.8%)	0.6% (0.0% to 1.7%)	2.9% (0.0% to 6.8%)
Education			
Less than undergrad degree	39.3% (27.0% to 51.6%)	30.1% (23.6% to 36.6%)	44.9% (33.3% to 56.5%)
Undergrad degree	36.1% (24.1% to 48.2%)	30.6% (24.1% to 37.1%)	29.0% (18.4% to 39.6%)
Some postgrad work or degree	24.6% (13.8% to 35.4%)	39.2% (32.3% to 46.1%	26.1% (15.6% to 36.3%)
Employment			
Any paid employment or self-employment	36.1% (24.1% to 48.2%)	39.2% (32.3% to 46.1%)	35.2% (24.1% to 46.3%)
Student, retired, homemaker	55.7% (43.2% to 68.2%)	28.4% (22.1% to 34.7%)	21.1% (11.6% to 30.6%)
Not working	8.2% (1.3% to 15.1%)	32.5% (25.9% to 39.1%	43.7% (32.2% to 55.2%)
Household income			
Up to 39,999	23.7% (13.0% to 34.4%)	34.8% (28.1% to 41.5%)	52.9% (41.3% to 64.5%)
40,000-79,999	30.5% (19.0% to 42.1%)	34.3% (27.6% to 41.0%)	33.8% (22.8% to 44.8%)
80,000+	45.8% (33.3% to 58.3%)	30.9% (24.4% to 37.4%)	13.2% (5.3% to 21.1%)
% Born in Canada	80.0% (70.0% to 83.4%)	83.4% (78.2% to 88.6%)	87.0% (79.2% to 94.8%)
Residency			
Major urban centre	79.7% (69.6% to 89.8%)	75.4% (69.3% to 81.5%)	72.1% (61.7% to 82.5%)
% with a psychiatric diagnosis (excl. GID)	41.0% (28.7% to 53.3%)	66.3% (59.6% to 73.0%)	69.6% (58.9% to 80.3%)

the lowest income bracket, and with the highest rate of psychiatric diagnosis (not including diagnoses of gender identity disorder).

Mental Health Service Utilization

More trans-identified and LGB respondents reported ever using mental health services compared to heterosexual (nontrans) respondents (71,100.0% vs. 175, 90.2% vs. 40, 65.6%), although utilization rates in the past five years (66, 93.0% vs. 152, 86.9% vs. 35, 87.5%) and 12 months were comparable between groups (42, 63.9% vs. 109, 71.7% vs. 21, 60.0%). Respondents visited the provider they saw most often in the last 12 months an average of 15 times (95% CI: 12.8-17.2). Trans-identified respondents were least likely to see a physician for mental health care compared to heterosexual or LGB respondents, but somewhat more likely to see a counsellor or psychotherapist. Trans-identified respondents also had more mental health visits on average and were more likely to have visits that were funded publicly (see Table 2).

Table 2
Mental Health Services Use by Identity Group

	Heterosexual n=20	LGB N=108	Trans n=41
Psychiatrist	20.0% (2.5% to 37.5%)	21.3% (13.6% to 29.0%)	9.8% (0.7% to 18.9%)
Family physician	10.0% (0.0% to 23.1%)	16.7% (9.7% to 23.7%)	7.3% (0.0% to 15.4%)
Psychologist	5.0% (0.0% to 14.6%)	12.0% (5.9% to 18.1%)	9.8% (0.7% to 18.9%)
Nurse	0.0%	0.0%	2.4% (0.0% to 7.1%)
Social worker	20.0% (2.5% to 37.5%)	8.3% (3.1% to 13.5%)	12.2% (2.2% to 22.2%)
Counsellor or psychotherapist	45.0% (23.2% to 66.8%)	35.2% (26.2% to 44.2%)	53.7% (38.4% to 69.0%)
Religious or spiritual advisor	0.0%	1.9% (0.0% to 4.5%)	2.4% (0.0% to 7.1%)
Other	0.0%	3.7% (0.1% to 7.3%)	2.4% (0.0% to 7.1%)
Number of times seen in past 12 months, mean (SD)	8.5 (8.5)	14.5 (13.4)	19.3 (17.2)
LGBT mandate	N/A	26.5% (18.2% to 34.8%)	62.5% (47.7% to 77.3%)
How were services covered?			
Public funding	57.9% (36.3% to 79.5%)	59.4% (50.1% to 68.7%)	67.5% (53.2% to 81.8%)
Private insurance	36.8% (15.7% to 57.9%)	18.9% (11.5% to 26.3%)	15.0% (4.1% to 25.9%)
Out of pocket	5.3% (0.0% to 15.1%)	29.7% (21.1% to 38.3%)	17.5% (5.9% to 29.1%)

Unmet Need for Mental Health Care

At least half of the participants in each group (heterosexual: 30, 50.0%; LGB: 98, 53.8%; trans-identified: 38, 55.1%) reported that in the past 12 months they required mental health care they did not receive. For all three groups, the type of help that was most frequently needed was therapy or counselling (see Table 3). The most common reasons for unmet need were "not getting around to" or "not bothering to" get help (LGB and trans groups) and preferring to manage oneself (heterosexual group). In contrast to the heterosexual participants, substantial portions of both LGB (8, 8.2%) and trans participants (5, 13.2%) noted "professional help not available in the area" as a reason for unmet need. None of the heterosexual (nontrans) respondents cited cost as the reason for not receiving care, while 18, 18.4% of LGB and 5, 13.2% of trans respondents cited not being able to afford to pay as a barrier.

Dropping Out of Mental Health Care

A statistically significant and larger number of trans-identified respondents reported ever having stopped using mental health services due to a negative experience related to sexual or gender identity compared to LGB respondents (LGB: 52, 27.7%; trans: 35, 50.0%; chi-square 11.4, p=.001). After adjustment for previous psychiatric disorder, regression analyses indicated that trans-identified respondents were 2.8 times more likely to have dropped out of mental health services (95% CI: 1.5 to 5.2) relative to LGB respondents. The reasons for dropping out of care are presented in Table 4.

Perceived Satisfaction with Mental Health Services

There were high levels of satisfaction with mental health services received in the previous 12 months, with the majority of respondents being "satisfied" or "very satisfied" with their care (heterosexual: 17, 81.0%; LGB: 88, 81.5%; trans-identified: 36, 87.8%). In regression analyses, only age was statistically significant in predicting satisfaction, with older respondents being significantly more likely to be satisfied.

LGBT-specific Mandate

Seeing a provider with an LGBT-specific mandate was statistically significant and associated with satisfaction for the LGB and trans participants. Nearly all (45, 97.8%) respondents who saw a provider with an LGBT-specific mandate reported being "satisfied" or "very satisfied" compared to 62,73.8% of people who saw a provider without an LGBT-specific mandate (χ^2 =11.8, p=0.001). After adjusting for age and income, the association between an LGBT-specific mandate and satisfaction remained significant (OR: 8.7, 95% CI: 1.8 to 42.8) in the regression analyses.

DISCUSSION

Our research has examined the linkages between sexual orientation, gender identity, and mental health service utilization among LGB, trans-identified, and heterosexual (nontrans) people in Ontario, Canada. We found that LGB, trans, and heterosexual respondents report high levels of satisfaction and predominantly positive experiences with the provider seen most often in the past 12 months. However, substantial proportions of

Table 3

Frequency and Type of Unmet Need for Mental Health Services in the Past 12 Months by Identity Group

	Heterosexual (N=60)	LGB (N=182)	Trans (N=69)
Needed help but did not receive it	50.0% (37.3% to 62.7%)	53.8% (46.6% to 61.0%)	55.1% (43.4% to 66.8%)
Type of help needed	N=30	N=98	N=38
Therapy or counselling	73.3% (57.5% to 89.1%)	69.4% (60.3% to 78.5%)	65.8% (50.7% to 80.9%)
Help with personal relationship(s)	36.7% (19.5% to 53.9%)	42.9% (33.1% to 52.7%)	28.9% (14.5% to 43.3%)
Help with employment status or work situation	10.0% (0.0% to 20.7%)	26.5% (17.8% to 35.2%)	31.6% (16.8% to 46.4%)
Support re: sexual orientation or gender identity	0.0%	23.5% (15.1% to 31.9%)	28.9% (14.5% to 43.3%)
Information on availability of services	20.0% (5.7% to 34.3%)	25.5% (16.9% to 34.1%	21.1% (8.1% to 34.1%)
Help with financial problems	10.0% (0.0% to 20.7%)	21.4% (13.3% to 29.5%)	26.3% (12.3% to 40.3%)
Information about mental illness and treatments	13.3% (1.1% to 25.5%)	23.5% (15.1% to 31.9%)	10.5% (0.8% to 20.2%)
Medication	13.3% (1.1% to 25.5%)	16.3% (9.0% to 23.6%)	13.8% (2.8% to 24.8%)
Help with housing problems	0.0%	7.1% (2.0% to 12.2%)	7.9% (0.0% to 16.5%)
Crisis services/hospitalization	0.0%	1.0% (0.0% to 3.0%)	5.3% (0.0% to 12.4%)
Reason for not receiving help	N=30	N=98	N=38
Didn't get around to it or didn't bother	10.0% (0.0% to 20.7%)	25.5% (16.9% to 34.1%)	23.7% (10.2% to 37.2%)
Didn't know how or where to get help	10.0% (0.0% to 20.7%)	18.4% (10.7% to 26.1%)	18.4% (6.1% to 30.7%)
Couldn't afford to pay	0.0%	18.4% (10.7% to 26.1%)	13.2% (2.4% to 24.0%)
Preferred to manage myself	13.3% (1.1% to 25.5%)	18.4% (10.7% to 26.1%)	10.5% (0.8% to 20.2%)
Afraid to ask for help or of what others would think	3.3% (0.0% to 9.7%)	15.3% (8.2% to 22.4%)	10.5% (0.8% to 20.2%)
Couldn't find help or LGBT-specific help	0.0%	12.2% (5.7% to 18.7%)	15.8% (4.2% to 27.4%)
Waiting time too long	3.3% (0.0% to 9.7%)	12.2% (5.7% to 18.7%)	13.1% (2.4% to 23.8%)
Personal or family responsibilities	3.3% (0.0% to 9.7%)	15.3% (8.2% to 22.4%)	5.5% (0.0% to 12.7%)
Professional help not available at time required	0.0%	12.2% (5.7% to 18.7%)	7.9% (0.0% to 16.5%)
Professional help not available in the area	0.0%	8.2% (2.8% to 13.6%)	13.2% (2.4% to 24.0%)
Didn't think anything more could help	3.3% (0.0% to 9.7%)	10.2% (4.2% to 16.2%)	7.9% (0.0% to 16.5%)
Problems with things like transportation or childcare	3.3% (0.0% to 9.7%)	9.2% (3.5% to 14.9%)	5.3% (0.0% to 12.4%)
Language problems	0.0%	0.0%	2.6% (0.0% to 7.7%)

Table 4
Types of Experiences That Led to Ever Having Stopped Mental Health Care

Types of Experiences Based on Sexual Orientation	LGB=52
Provider didn't ask about stresses related to being LGB	26.9% (14.8% to 39.0%)
Provider assumed that you are heterosexual	38.5% (25.3% to 51.7%)
Provider focused on your sexual orientation when it wasn't the issue	51.9% (38.3% to 65.5%)
Provider focused on your gender identity when it wasn't the issue	5.8% (0.0% to 12.2%)
Provider indicated that your sexual orientation is sick or disordered	23.1% (11.6% to 34.6%)
Provider insisted that your current sexual orientation is "just a phase"	23.1% (11.6% to 34.6%)
Provider suggested that you become heterosexual	17.3% (7.0% to 27.6%)
Provider behaved in a homophobic way	38.5% (25.3% to 51.7%)
Provider failed to acknowledge the importance of partners or family in your life	32.7% (19.9% to 45.5%)
Provider made you feel unsafe	26.9% (14.8% to 39.0%)
Types of Experiences Based on Gender Identity	**Trans=35**
Provider didn't ask about stresses related to being trans-identified	22.9% (9.0% to 36.8%)
Provider focused on your gender identity when it wasn't the issue	22.9% (9.0% to 36.8%)
Provider indicated that your gender identity is sick or disordered	34.3% (18.6% to 50.0%)
Provider insisted that your current gender identity is "just a phase"	11.4% (0.9% to 21.9%)
Provider behaved in a transphobic way	40.0% (23.8% to 56.2%)
Provider made you feel unsafe	31.4% (16.0% to 46.8%)
Provider did not address you with your preferred pronoun	22.9% (9.0% to 36.8%)
Provider suggested that you learn to accept the gender assigned to you at birth	17.1% (4.6% to 29.5%)

LGB and trans-identified people report unmet need for mental health services and having previously dropped out of mental health care due to negative experiences related to sexual orientation or gender identity. With respect to the latter, we find that trans-identified people are more likely than LGB people to report having dropped out of care, with half of the trans people reporting this.

Our finding that most participants, regardless of sexual orientation or gender identity, report satisfaction with services and positive experiences with their providers in the past 12 months contradicts the only other study we know of to investigate this question using a heterosexual comparison group (Avery et al., 2001). The discrepancy could be due to the different social and legal climates for LGBT people in some parts of the United States versus in Canada, or methodological limitations of the study by Avery and colleagues (2001). For example, there have been significant developments across Canada regarding LGBT rights, including the right to same-sex marriage (Andersen & Fetner, 2008). In terms of methods in particular, the study by Avery and colleagues (2001) used data from a 1994 study in which sexual orientation was not measured as a heterosexual control for 2001 LGBT data. Additional research with population-based samples would be helpful to confirm our findings.

Many LGBT participants reported negative experiences with a provider seen sometime in the past. This finding may indicate that, over time, mental health service providers are becoming more competent in serving LGBT individuals. It may also be that, over time, most LGBT people are able to find a provider who meets their needs, though many may encounter providers who are not culturally competent in the process. Based on community feedback, we speculate that many LGBT people are eventually finding service providers through their social networks, and further that within urban centres, many LGBT people are drawing from the same small pool of providers and services who are known to be LGBT-competent.

Although there were no statistically significant group differences in rates of unmet need for mental health care in the past 12 months, the rates were very high in all three identity groups. When asked why needed services were not obtained, unlike comparison respondents, both LGB and trans participants reported that not being able to afford to pay for services was a barrier. This is consistent with our data showing that LGB and trans individuals rarely paid for mental health services using private insurance. In our setting, only psychiatric services and short-term counselling services offered through community health centres or family health teams are typically covered with public funding. It is possible that these services may be less likely than long-term psychotherapy to directly address issues of discrimination, which are thought to contribute to the overrepresentation of mental health problems among LGBT people (Gevonden et al., 2014; Mays & Cochran, 2001; Nuttbrock, Hwahng, Bockting, Rosenblum, Mason, Macri, & Becker, 2010).

Our finding that trans-identified participants were more likely than LGB people to report dropping out of care due to negative experiences is consistent with results of other studies identifying particular barriers to good mental health care for trans people. These are reported to include service providers who are unwilling to treat trans people, or unaware of specific trans health issues (Bauer et al., 2009; Namaste, 2000). This may also reflect the continued pathologization of trans people, in contrast to LGB people, by the psychiatric system in the form of the diagnosis of gender identity disorder. Additional research is needed regarding the implications of including gender identity disorder in the DSM-V for the quality of mental health care received by trans-identified people.

Finally, our data are suggestive of some specific practice and policy recommendations that could decrease negative experiences in care and reduce levels of unmet need for mental health services among LGBT people. First, our data suggest that education of mental health service providers is required to build cultural competency and service capacity for this segment of the population. Basic cultural-competency training regarding the use of gender-neutral language in taking a psychiatric history, and the use of preferred pronouns in the care of trans-identified patients, would address the most common negative experiences reported by participants in this study. Although, to our knowledge, there are no current best practices specifically around mental health care provision for trans-identified people, the World Professional Association for Transgender Health has developed Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People which provide clinical guidance for health professionals (Coleman et al., 2012). Unfortunately, training in LGBT issues is still lacking in the core curricula of many mental health professionals. A recent qualitative study found there is a lack of training on the provision of LGBT-sensitive mental health services and a need for mandatory education in this area (Rutherford, McIntyre, Daley, & Ross, 2012). The study outlines specific recommendations for curricular content (such as terminology and case presentations) and curricular development (such as identifying supportive faculty staff and community resources). A survey

of 132 medical school deans across the United States and Canada further showed that 34 schools (25.8%) found the coverage of LGBT-related content to be "very poor" or "poor," while 58 schools (43.9%) found it to be "fair" (Obedin-Maliver et al., 2011). Addressing this gap in curriculum, as well as ongoing continuing education for practising mental health professionals, will enable providers who are not specialized in the care of LGBT people to avoid making these basic errors.

Our findings reveal that mental health services with an LGBT-specific mandate are statistically significant and associated with satisfaction. Thus, we recommend that practices and providers who are experienced in the care of LGBT people make this information clear and accessible to their patients by establishing mandates and identifying them in service waiting rooms and Web sites. At a policy level, this finding suggests that continued funding of existing specialized services, and establishing new LGBT-specific services in areas where the population is sufficiently large to support them, may be an effective way to address mental health disparities and unmet need for mental health care among LGBT people.

Finally, policy and practice changes are required to ensure that trans-identified people, in particular, have access to supportive mental health care. In Ontario, structuring gender identity disorder as a gateway to sex reassignment surgery and other needed health care has created a relationship between trans communities and the mental health system that is fraught with mistrust and misunderstanding. Many trans people will require mental health care for issues unrelated to sex reassignment, particularly in the context of the extreme marginalization and discrimination experienced by this community (Bauer, Boyce, Coleman, Kaay, Scanlon & Travers, 2010). Policy-makers, service providers, and trans community members will need to partner together to address these important barriers.

Limitations. LGBT respondents to this survey were significantly more likely than heterosexual (non-trans) respondents to be over 25 and to report a psychiatric diagnosis. This occurred because most cisgender heterosexuals who filled out the survey were students recruited through advertising in university listservs and forum postings. Although our sample size did not permit analysis of differences based on geography, this would be an important focus for future research, since there are likely differences in service accessibility depending on where LGBT people live. LGBT individuals in rural areas of the United States report a lack of community, a hostile social climate, and barriers to accessing appropriate services (King & Dabelko-Schoeny, 2009; Oswald & Culton, 2003; Willging, Salvador, & Kano, 2006). Lastly, our sample mostly identified their ethnicity as White/Caucasian. As such, we were unable to address issues of racism and other forms of discrimination that may contribute to experiences with mental health care. Further research addressing the intersectionalities of race, sexual orientation, and gender identity, among other identities associated with oppression and/or privilege, is necessary to elucidate the ways in which various systematic oppressions act in concert to determine mental health service experiences (Veenstra, 2011).

CONCLUSIONS

Overall, our data suggest that although some culturally competent mental health service providers are available to LGBT people in Ontario, LGBT individuals may need to "screen" multiple mental health service providers before they are able to access needed care. This may result in delays to accessing treatment, which in turn may be associated with poorer long-term outcomes. Additional research is required to characterize the

barriers and facilitators to obtaining quality mental health care for LGBT people, in order to ensure timely access to effective mental health services for all individuals, regardless of sexual orientation or gender identity.

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