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"Shared and Collective Stress"
2SLGBTQI and Allied Mental Healthcare Providers' Experiences and Challenges During COVID-19 in Canada
« Stress partagé et collectif »
Les expériences et les défis rencontrés par les fournisseurs de soins de santé mentale aux personnes 2ELGBTQI et alliées pendant la pandémie de COVID-19 au Canada

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Résumé de l'article

En raison de la demande accrue pour des services de santé mentale et de la diminution des ressources à cause de la pandémie de COVID-19, les fournisseurs de soins de santé mentale et de services sociaux ont dû faire face à plusieurs défis. Les fournisseurs de services aux personnes 2ELGBTQI seraient plus durement touchés par les défis liés à la pandémie, tels que la détresse psychologique, le traumatisme transmis par personne interposée et l'épuisement professionnel. Or, on constate qu'on en sait très peu sur les besoins et les expériences des fournisseurs de services aux personnes 2ELGBTQI et alliées dans le contexte de la pandémie de COVID-19 au Canada. Pour remédier à cette situation, nous avons mené un sondage national (N = 304), huit groupes de discussion semi-structurés et cinq entrevues semi-structurées (N = 61) auprès de demandeurs de soins 2ELGBTQI et de fournisseur de services à ces personnes au Canada. Se fondant sur les données recueillies auprès de 106 fournisseurs de services à des personnes 2ELGBTQI et de 3 fournisseurs de services à des alliés qui ont participé à ces activités de recherche, cet article examine les défis rencontrés par les fournisseurs de services lorsqu'ils prodiguent des soins aux personnes 2ELGBTQI, ainsi que les mesures d'adaptation qu'ils ont prises pour relever ces défis. Il est essentiel de comprendre les expériences des fournisseurs de services qui, tout comme leurs clients, ont vécu la discrimination et la marginalisation si l'on veut éliminer les obstacles aux soins de santé mentale axés sur l'affirmation, adapter les services pour répondre aux besoins évolutifs des demandeurs de soins et des fournisseurs, et concevoir des solutions globales en amont pour s'attaquer aux causes des disparités en santé mentale chez les personnes 2ELGBTQI.

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Research

"Shared and Collective Stress": 2SLGBTQI and Allied Mental Healthcare Providers' Experiences and Challenges during COVID-19 in Canada

by Kimberly Seida, Félix Desmeules-Trudel, and Brittany A.E. Jakubiec

Abstract: The confluence of increased demand for mental health services and decreased resources due to the COVID-19 pandemic has created multiple challenges for mental healthcare and social service providers. 2SLGBTQI service providers may be disproportionately impacted by pandemic-related challenges, such as psychological distress, vicarious traumatization, and burnout. However, there are significant knowledge gaps regarding the needs and experiences of 2SLGBTQI and allied service providers in the context of the COVID-19 pandemic in Canada. To address these gaps, we conducted a national survey (N = 304), eight semi-structured focus groups, and five semi-structured interviews (N = 61) with 2SLGBTQI care seekers and service providers across Canada. Based on data from the 106 2SLGBTQI service providers and 3 allied service providers who took part in these research activities, this paper explores the challenges service providers encounter when providing care to 2SLGBTQI individuals as well as their adaptive responses to these challenges. Understanding the experiences of service providers who share lived experiences of discrimination and marginalization with their clients is critical to addressing barriers to affirming mental healthcare, shifting services to meet the evolving needs of both care seekers and providers, and developing upstream, comprehensive solutions to address the causes of 2SLGBTQI mental health disparities.

Keywords: burnout; COVID-19; LGBTQ+; mental healthcare; service providers

Résumé : En raison de la demande accrue pour des services de santé mentale et de la diminution des ressources à cause de la pandémie de COVID-19, les fournisseurs de soins de santé mentale et de services sociaux ont dû faire face à plusieurs défis. Les fournisseurs de services aux personnes 2ELGBTQI seraient plus durement touchés par les défis liés à la pandémie, tels que la détresse psychologique, le traumatisme transmis par personne interposée et l'épuisement professionnel. Or, on constate qu'on en sait très peu sur les besoins et les expériences des fournisseurs de services aux personnes 2ELGBTQI et alliées dans le contexte de la pandémie de COVID-19 au Canada. Pour remédier à cette situation, nous avons mené un sondage national (N = 304), huit groupes de discussion semi-structurés et cinq entrevues semi-structurées (N = 61) auprès de demandeurs de soins 2ELGBTQI et de fournisseur de services à ces personnes au Canada. Se fondant sur les données recueillies auprès de 106 fournisseurs de services à des personnes 2ELGBTQI et de 3 fournisseurs de services à des alliés qui ont participé à ces activités de recherche, cet article examine les défis rencontrés par les fournisseurs de services lorsqu'ils prodiguent des soins aux personnes 2ELGBTQI, ainsi que les mesures d'adaptation qu'ils ont prises pour relever ces défis. Il est essentiel de comprendre les expériences des fournisseurs de services qui, tout comme leurs clients, ont vécu la discrimination et la marginalisation si l'on veut éliminer les obstacles aux soins de santé mentale axés sur

l'affirmation, adapter les services pour répondre aux besoins évolutifs des demandeurs de soins et des fournisseurs, et concevoir des solutions globales en amont pour s'attaquer aux causes des disparités en santé mentale chez les personnes 2ELGBTQI.

Mots clés : épuisement professionnel; COVID-19; LGBTQ+; soins en santé mentale; fournisseurs de services

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Introduction

The COVID-19 pandemic fundamentally altered daily life, population health, and well-being, as well as access to and delivery of healthcare services, including those focused on shoring up the social determinants of mental health (e.g., housing, employment, medical care, and mental healthcare). The pandemic exacerbated rates of mental health disorders (e.g., depression, anxiety, OCD, suicidality, and substance use) among systematically marginalized groups such as Two Spirit, lesbian, gay, bisexual, transgender, queer, and intersex (2SLGBTQI) populations (Brennan et al. 2020; Slemon et al. 2021). Compounding this problem, systemic exclusion, discrimination, and a lack of cultural responsiveness prevent 2SLGBTQI people from accessing the inclusive services and care they need to manage their mental health and well-being. As a result, 2SLGBTQI people are falling through ever-widening gaps in the Canadian mental healthcare system and are bearing the burden of the pandemic's wide-ranging impacts on mental health, well-being, and social supports (Seida, 2023).

Although it is critical for scholarship to examine the pandemic's impacts on 2SLGBTQI communities' mental health, to date it has focused almost entirely on mental healthcare seekers' perspectives, while comparatively few studies have substantially centered provider perspectives (see Canvin, Twist, and Solomons 2021). Pandemic-era research that included service providers as participants has largely focused on their clinical training experience (Stryker et al. 2022), perspectives on and challenges related to 2SLGBTQI cultural competence (Bishop, Crisp and Scholz 2022; Loo et al. 2023), their reflections on treating 2SLGBTQI clients (Kennedy et al. 2022), and navigating disclosure to clients (Beagan et al. 2023). Even less work has addressed the experiences and challenges of mental healthcare and social services providers who are themselves 2SLGBTQI. As a result, there are significant knowledge gaps regarding the needs and experiences of 2SLGBTQI and allied service providers in the Canadian context and as it relates to the COVID-19 pandemic.

Researchers have documented multiple pandemic-related challenges experienced by healthcare providers, including psychological distress, vicarious traumatization, and burnout (De Kock et al. 2021; Greenberg et al. 2020). Based on semi-structured interviews with 15 healthcare providers and administrators in Canada (2SLGBTQI status not disclosed), Kennedy et al. (2022) identified several stressors wrought by pandemic-related changes in service delivery, including reticence about providing virtual mental health supports due to client disengagement and privacy concerns, as well as personal feelings of alienation due to physical distancing. Furthermore, 2SLGBTQI service providers may be disproportionately impacted by changes wrought by the pandemic (Wolfe 2023). For example, 60% of participants in a survey of LGBT healthcare workers in Vancouver reported burnout (Khan et al. 2021). Another survey comparing mental health outcomes between sexual and gender minority (SGM) and non-SGM healthcare workers found that SGM frontline healthcare workers had significantly higher depression, anxiety, and psychological distress (Wojcik et al. 2022).

2SLGBTQI mental health care workers experience particular systemic, interpersonal, and individual barriers and challenges as providers and/or consumers of mental health care. A pre-pandemic qualitative study of eight 2SLGBTQI mental health service providers in Ontario explored systems-level barriers to supportive mental health services for LGBT people (McIntyre et al. 2011). This study found that the medical model's continued influence on both education and care delivery was difficult for 2SLGBTQI providers, who often navigated a binary ('two-gender") and essentialist (as opposed to intersectional) approach to care stemming from implicit assumptions within biomedical frameworks (see also Dickey and Singh 2017). Other systemic barriers to providing quality care noted by 2SLGBTQI providers included long wait times, lack of affirmative mental health services in the public sector, and burnout due to the dearth of funding available for affirmative services (McIntyre et al. 2011). These barriers may be particularly pronounced for racialized 2SLGBTQI service providers, who experience racism and marginalization in both their professional and personal lives (Giwa and Greensmith 2012; Khan et al., 2021), including 2SLGBTQI service settings (Pilling et al. 2017). 2SLGBTQI therapists also face the challenges of heterosexist training environments, navigating disclosure to their peers and to clients, and integrating queer and professional identities (Lykins 2021). Working in heteronormative settings leads to a range of work-related stressors for 2SLGBTQI healthcare providers, including coworkers' lack of knowledge, fears of job loss, and concerns about disclosing to patients, with negative mental health implications (Eliason et al. 2017; Holmberg et al. 2022). Identifying an additional stressor, a recent qualitative study with 2SLGBTQI health professionals from across Canada found that they faced pressure to be "heteroprofessional," entailing demands of appearing and acting heterosexual in professional settings (Bizzeth and Beagan 2023).

The findings presented in this paper are part of a broader initiative, Queering Mental Health Supports in Canada, which is a multi-year, multi-phase project involving research, training, and knowledge mobilization. The impetus behind this project is the rise in mental healthcare needs among 2SLSGBTQI people

amid the COVID-19 pandemic and the troubling lack of affirming and culturally responsive mental healthcare (see Seida, 2023). Exploring the challenges 2SLGTBQI and allied service providers encounter when providing care to 2SLGBTQI individuals is critical to addressing barriers to affirming mental healthcare, shifting services to meet the evolving needs of both care seekers and providers, and developing upstream, comprehensive solutions to address the causes of 2SLGBTQI mental health disparities.

Methods

This project was guided by two research questions:

How has the COVID-19 pandemic impacted the social determinants of mental health among 2SLGBTQI communities in Canada?

What gaps and challenges do 2SLGBTQI and allied mental health professionals and social service providers identify and currently face in delivering inclusive care for 2SLGBTQI people in Canada?

To answer these questions, we conducted several research activities. In Spring 2021, we delivered basic online inclusion training with 1260 service providers from numerous healthcare fields (e.g., psychology, counselling, and social work) across Canada. Along with this training, service providers completed pre- and post-training surveys, the responses of which were analyzed to inform both the current research questions and the next phases of the project (i.e., training development). In 2022, we conducted a mixed-methods national survey in both French and English (N = 304), as well eight semi-structured focus groups (N = 56) with 2SLGBTQI service seekers, 2SLGBTQI service providers, and allied service providers. Each focus group consisted of 5–7 individuals. We also conducted five semi-structured individual interviews with service providers who were unable to participate in the focus groups due to scheduling issues. In total, 106 2SLGBTQI service providers and 3 allied service providers took part in these research activities. Among the survey participants (n = 304), 22 of the 86 service provider participants (26%) identified as BIPOC; among the focus group and interview participants (n = 61), 5 of the 20 service provider participants (25%) identified as BIPOC. This paper focuses on the experiences and challenges of the service providers who participated in at least one of these research activities. All focus group participants have been assigned a pseudonym, while survey participants are described by their job title and service setting. As per participants' requests, we did not note "rural" and "urban" when referring to northern and Atlantic regions in efforts to maximize confidentiality.

Research design

With the input from a community-based advisory committee (see Seida 2023 for more details), and after obtaining ethics approval from the Community Research Ethics Office (approval # 241), we recruited for the survey, focus group, and interview participants through interorganizational listservs, newsletters, social media, and snowball sampling. Our research methodology was guided by critical, participatory approaches: in line with van de Sande and Schwartz's (2017) process of conducting community-based research, we collaborated with the advisory committee to refine the research questions, develop research instruments (e.g., national survey and focus group questions), collect and analyze data, and interpret results. The survey included questions on general mental health, the impacts of the pandemic on social determinants of mental health, experiences of discrimination and exclusion as well as coping and resilience, and recommendations on how to improve mental health services. The focus groups explored the challenges service providers faced in delivering inclusive care, the pandemic's impacts on service delivery, and providers' recommendations concerning promising practices and training to advance 2SLGBTQI-affirming care.

Qualitative analyses of the focus groups, interviews, and open-ended survey questions were guided by a reflexive thematic analysis approach (Joy, Braun, and Clarke 2023). This approach was nested within the guiding frameworks of intersectionality, social determinants of health, and minority stress theories (see Seida (2023) for more details on the frameworks guiding the broader project, entitled "Queering Mental Health Supports in Canada"). All qualitative analyses were conducted in NVivo by the first author, while quantitative analyses of survey data (which are detailed in Seida (2023) were conducted using R by the second author. All research activities and analyses were part of an iterative, community-engaged process reflecting community priorities and the needs of those most impacted. For example, the community-based advisory committee reviewed preliminary thematic overviews and provided insights on further analyses as well as how to translate research findings for various audiences.

Moreover, our work is critical of biomedical, Western approaches which have historically guided mental healthcare in Canada (Sebring 2021) and have pathologized 2SLGBTQI people as "deviant." Perhaps the most blatant example of pathologization was the categorization of "homosexuality" as a mental illness, which justified the development and use of cruel measures such as conversion therapy (Pilling 2022). More recently, medical pathologization of 2SLGBTQI people has taken the form of understanding "gender dysphoria" as a mental illness (see Castro-Peraza et al. 2019). The pathologizing diagnosis of "gender dysphoria" often forces trans people to "rehearse dominant medical narratives reflected in DSM criteria for the sole purpose of convincing clinicians of their legitimacy as trans people" (MacKinnon et al. 2020, 58).

The pitfalls of traditional approaches to mental health, illness, and mental healthcare inform the frameworks and theories used in the Queering Mental Health Supports in Canada project. First, we employed a social determinants of health approach (Alegría et al. 2018), which facilitates an understanding of how one's circumstances impact physical and mental health. This approach also pushes back against neoliberal health narratives that may continue to pathologize 2SLGBTQI mental healthcare seekers by focusing on upstream causes of health and illness rather than individual choices or "deficits." Second, we used intersectionality as a guiding framework. Intersectionality suggests that people's social identities cannot be separated or simply added together; rather, they interact to produce unique lived experiences due to interlocking systems of privilege and discrimination (Walubita et al. 2022). The third framework informing our research was a trauma-informed approach, which is rooted in principles of safety, empowerment, trustworthiness, and collaboration (Levenson, Craig and Austin 2023). Trauma-informed approaches recognize the role of individual and collective trauma in shaping mental health, including traumatic healthcare interactions. Finally, our research design was informed by minority stress theory, which posits that both distal stressors (e.g., experiences of discrimination and rejection) and proximal stressors (e.g., identity concealment) have negative psychological and physiological consequences for stigmatized minority groups (Meyer 2003).

Results

Service providers cited a number of challenges they faced in providing inclusive, 2SLGBTQI-affirming care throughout the COVID-19 pandemic. Analyses of their experiences revealed three main challenges as well as a range of adaptive responses to these challenges.

Training gaps

The most prominent challenge identified by mental healthcare providers as it relates to providing services to 2SLGBTQI people was the lack of training on 2SLGBTQI issues in their formal or continuing education. This finding aligns with previous research, which has shown that many healthcare professionals re-

ceive little to no formal training in providing culturally responsive care to 2SLGBTQI people and therefore feel ill-equipped to adequately address their needs (Gavin 2021; McInroy et al. 2014; Rowe et al. 2017). Expanding on these studies, our participants noted that a key training gap was a lack of nuanced training that went beyond the basics (e.g., definition of terms and key concepts and use of appropriate pronouns). Several service providers talked about how broad and vague the 2SLGBTQI competency training they received was. For example, an addictions counsellor working in a non-profit stated: "I think the training we do receive in this area is extremely surface-level and repetitive. I don't think there's a lot of work on challenging ourselves further than simply listening to someone share basic information." Other providers expressed frustrations with "one size fits all" approaches to 2SLGBTQI training which failed to account for regional or identity-specific needs and experiences.

Training gaps often put pressure on 2SLGBTQI providers to address these gaps in training and workplace settings, knowing that nobody would step up to the plate if they did not do so. Participants reported that this emotional labour was tiring and often led to feelings of isolation, particularly since providers were often the only 2SLGBTQI provider in such spaces. As Sandrine, a cis queer service provider working in Northern Canada explained:

> In some groups I'm in or some training that I'm in that isn't LGBTQ+ related, I feel like I'm the one voice that will bring those issues up, and it's a little bit tiring. So I wish I had networks where I didn't have to be the one bringing up those issues all the time. We could get more in-depth in the conversations, because we're not just staying at the level of "oh it's important to remember that not everyone is straight in our services"; you don't get deeper into your conversations and it's annoying and tiring.

Like Sandrine, Chantelle, a cis queer service provider working in rural Ontario, remarked:

> Med school folks are not really given any training around working with trans or queer folks. Being queer in those spaces, you're the one doing all the emotional labor. You're the one spending all the time saying "oh wait a minute, we're forgetting about these folks" or you're also having to exist in this inherently harmful system that doesn't care about you.

Service providers similarly argued for ongoing training and that competency should be evaluated continuously because terms, concepts, and promising practices evolve. Reflecting on some of their peers who had been in the field for many years, participants stressed the need to receive updated training and education to ensure the provision of affirming and inclusive care.

A third training gap participants identified was specific training on trauma and intersectionality. For instance, Jamie, a cis allied service provider working in Atlantic Canada, noted that trauma-informed approaches were not addressed in her schooling, further noting there was only one mandatory "gender and sexuality" introductory seminar. She linked this gap to the overt transphobia she witnessed amongst her coworkers and in in-patient settings, causing overt harm and further trauma. A therapist working in a public school spoke about the need for training on intersectionality: "I work with many BIPOC youth who are also part of the queer community, I could use more specific training or research/resources that would be relevant to this intersection. Especially Transmasculine Black and Indigenous youth." Chantelle also stressed the need for training to explicitly address the concept of intersectionality and the needs of racialized 2SLGBTQI clients: "Most people seeking services will be living some type of intersectionality, so that concept is one that not even a lot of service providers know or take the time to understand why it's important."

Respondents cited training gaps as the cause of their own and their peers' knowledge gaps regarding intersectionality, minority stress, and the role of trauma in shaping mental healthcare needs and concerns such

as addictions, self-harm, and anxiety. These gaps were often situated in broader discussions of how 2SLGBTQI cultural responsiveness in service settings was "whitewashed."By this, providers meant the Eurocentric focus of existing interventions had failed to account for intersecting forms of discrimination such as racism, colonialism, or classism. Service providers expressed grave concerns about the harmful impacts of this Western, narrow approach for intersectionally marginalized clients. For example, Stephanie, an allied cis service provider working in Northern Canada, noted that a lack of cultural sensitivity for Indigenous clients is a "missing piece in trying to deconstruct some of our very colonial systems". Consequently, service providers widely recommended that training should "dig deeper" (i.e., move beyond the typical focus on terms, definitions, and high-level overviews of health disparities) by employing trauma-informed and intersectional frameworks and tailoring training to specific sectors and types of providers. As Cori, a trans queer BIPOC service provider working in Ontario suggested, "digging deeper" entails "externalizing what's going on for a client rather than internalizing it, so recognizing [mental health struggles] as a product of a system of racism rather than 'my thought process is wrong.'"

Referral and systems navigation challenges

Another common challenge discussed by service providers concerned referrals and systems navigation. Many of these challenges were rooted in systemic issues such as a lack of suitable providers, provider burnout, and a lack of providers offering accessible services. Generally, service providers agreed on the need for not only larger referral networks but also the need to feel more secure in providing referrals to 2SLGBTQI clients. As Joelle, a cis queer therapist working in Atlantic Canada, explained:

> There's a lack of safe referral sources. So wanting to refer people to gender-affirming healthcare, and not really knowing if, when you send that person to a collaborative clinic or something, if that's a safe place to be. So helping clients advocate for themselves and know they can ask questions, like "how are you going to create safety for me?" and expect that that's a reasonable thing for a healthcare provider to have to answer.

Indeed, several service providers expressed concerns about referring clients to potentially unsafe providers, particularly if they did not know the other provider or were unsure about their ability to provide 2SLGBTQI-affirming care. This was particularly challenging for providers in non-urban communities, given the general paucity of mental healthcare providers.

The lack of trans-affirming providers created another challenge for providers seeking to make referrals. For instance, a few participants noted that they and/or their peers were familiar with working with sexual, but not gender, minorities, creating a systemic lack of truly gender-affirming providers. This gap puts significant pressure on service providers who are trans or whose expertise is in trans-related mental health concerns. Logan, a trans queer service provider working in Atlantic Canada, said that they had to take down their advertising because they did not want to spend their time telling clients "sorry, I have a waitlist, I can't take you on." They told us about the wave of people reaching out to them out of sheer desperation and feeling the pressure of not being able to meet the need.

The pressures caused by a confluence of high demand and lack of resources led to an additional challenge: navigating the tension of wanting to meet the ethical obligations of supporting clients while taking on clients whose needs may be out of a provider's scope of practice because of a lack of other affirming providers. The pressure to operate beyond their scope of practice or area of expertise, knowing that clients had nowhere else to turn, was elucidated by Cori, a trans queer service provider working in Ontario:

> So many clients on my caseload have experienced trauma from cis therapists in the past and working with that makes me feel really helpless about the system, because there aren't services to refer folks to, and then they'll come to me presenting concerns that are way outside of my

> scope of what I feel comfortable in. And then how much do I respect a client saying, "I see myself represented in you and that's all I need," versus me saying, "I don't have skills to support this specific concern, but there's nowhere to refer you where you see yourself represented and get that support." So, I really feel stuck, and either I'm saying "sorry I can't" with no referrals, or treating someone outside of my scope, because what other options are there?

Other 2SLGBTQI providers also described how their lived experiences made them acutely aware of the lack of affordable and appropriate mental healthcare for clients with similar identities. In efforts to address these inequities, some providers not only took on more clients but also saw people at steeply reduced rates. However, this had negative impacts on their own financial stability and was identified as a factor contributing to burnout.

Participants reflected on how standards of practice and boundaries of competence for a given role (e.g., psychotherapist), as set out by professional associations, can create silos between different types of service providers. These silos further complicated referral pathways which both care providers and seekers navigated, as Stephanie, an allied cis service provider working in Northern Canada, explained:

> It's like hierarchy and silos, where counselors can't do that, psychologists can do that, I can do this but not that part of it for the government to agree to fund it, so I could do that dysphoria diagnosis but then they have to go see that person for their official assessment to access those other things for affirming surgeries. So there's all these other layers, where you're like no wonder [clients are] just like, "forget about it, I don't want to deal with this stuff."

As Stephanie implied, there are compounding issues arising from different providers not having overlapping scopes of practice that would facilitate referral pathways, patchy government funding for specific forms of care, and gatekeeping access to gender affirming care. Together, these complexities and barriers may lead 2SLGBTQI clients to cease or avoid necessary care and services (see Rimby 2022).

A second upstream cause of gaps in referral chains was related to provider burnout. In line with extant research (see Khan et al. 2021; Wojcik et al. 2022), our participants emphasized the wide-ranging impacts of burnout among their peers. Given the exigencies of the pandemic, the combination of increased mental healthcare needs among 2SLGBTQI care seekers, increased caseloads, and decreased availability of suitable providers created a perfect storm for burnout. Mindy, a cis queer service provider working in British Columbia, described the strategies she invoked to avoid burnout after seeing colleagues get overwhelmed and burn out:

> I've taken a couple of steps back and made sure I'm taking care of myself so that I'm not harming in practice, because that's the worst thing we can do […] I've tried to limit what I do, like a smaller caseload with more intensive one-on-one. I've slowly started to shift to a little larger caseload with less intense services, kind of creating workbooks and stuff to go along with it, so there's still that knowledge and resources.

A final source of referral-related challenges was a lack of providers offering affordable (and thus accessible) services. Lindsey, a trans queer service provider practicing in rural Ontario, explained how many of their peers—especially BIPOC queer and trans providers—were going into private practice to be able to meet their own needs in the context of rising living costs and to avoid the burnout that often accompanies public sector care. This in turn exacerbates a lack of affordable mental healthcare options as well as providers who are themselves members of the communities they are serving (e.g., 2SLGBTQI, Indigenous, racialized, and/or non-urban communities):

> [There's] a need for more folks from the community and folks who are Indigenous, Black, or people of colour. I think that's really important [but] with the rise of credentialization, what

> we're seeing is that a lot of queer and trans service providers have gone private and are charging $130, $160 an hour. And so I really worry about queer, trans, Two Spirit young folks. And with inflation and the cost of living, that's even spreading to rural and remote communities [….] I think increased privatization is a huge issue. I think representation is a huge issue.

Lindsey and other participants bemoaned the impacts of privatization on clients most in need of accessible services (i.e., BIPOC 2SLGBTQI clients as well as clients living in rural or remote regions).

Specific challenges of 2SLGBTQI service providers

Study participants cited several challenges which may be specific to 2SLGBTQI service providers. A first challenge noted by 2SLGBTQI providers was maintaining financial stability while responding to community needs. Multiple queer service providers talked about how they felt there was an onus on them to shift their fee structure or provide pro bono work because they felt that the purpose of their work was not to make money but to help "support folks so that they don't die," as Maria, a cis queer service provider working in Ontario, poignantly stated. Because of their own lived experience, participants were acutely aware of the disproportionate barriers to social determinants of mental health within 2SLGBTQI communities. For instance, Mindy, a cis queer service provider working in British Columbia, stated: "We've been on the other side of things as well, and being a queer person, seeing those gaps in mental health and social services [is] frustrating. So I'm just trying to find ways to support, where I can." These providers were, however, simultaneously cognizant of how providing sliding scale or pro bono services individually and systemically disadvantaged them, relative to their cisgender, heterosexual peers.

Although Logan, a trans queer service provider working in Atlantic Canada, did not cite their choice to do direct billing as causing personal administrative or financial struggles, their sentiment belied an awareness of accessibility barriers created by peers who choose not to do so:

> I try to be very conscientious about people's financial situations. I don't have an official sliding scale [but] I think a lot of service providers are like "oh, direct billing is a pain in the ass so I'm not going to do it," whereas that's something I pride myself on doing. It is much more accessible to people when they're not paying out of pocket and waiting to get reimbursed.

Although direct billing can entail paperwork, wait times for reimbursement, and administrative hurdles for service providers, doing so makes care more accessible for clients. Despite it being more work on their end, Logan's priorities are in making their services more accessible and equitable.

A second challenge providers discussed was having their own needs met, especially given a lack of services for 2SLGBTQI service providers. As Emilie, a cis queer service provider working in Québec, stated: "When you decide to work with LGBTQ+ clients, you have to have an entrepreneurial side because nothing is easy! You need support groups with other workers […] we must help each other because it is difficult to find resources." Jonathan, a cis gay service provider working in Atlantic Canada, shared:

> It's feeling alone and also pressure to volunteer time, to reduce rates, to find space, when I also have to take care of myself. So I think that's a difficult part about being a member of the same community I'm trying to help, I see myself reflected in the struggle, but then I also have to take care of my own family and my own mental health and have boundaries.

Another provider, a bisexual/queer/lesbian genderqueer woman living in Québec, similarly shared the need

to maintain personal boundaries in efforts to manage vicarious trauma resulting from witnessing her clients' hardships:

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

A third challenge noted by service providers, particularly those operating in non-urban settings, was connected to keeping their professional and personal identities siloed. While previous research has identified this challenge in terms of navigating visibility and disclosure of providers' queer identity *within* the therapy relationship (Lykins 2021), our participants described this tension at the social and community level. Cori, a trans queer service provider working in Ontario, mentioned: "If I refer clients to services, then I can never access them […] everyone's my friend or colleague or referral, so it's impossible."

Chelsea, a cis queer service provider working in Atlantic Canada, shared:

> How do I date, and how do I work in this community? And especially when there is that one degree of separation in a small community […] I've had clients whose partners I've met before in other circumstances, and so trying to create that division and also know when it's not appropriate for me to counsel that person.

The small social network of 2SLGBTQI individuals in non-urban areas presents unique challenges for 2SLGBTQI service providers, both in terms of their own access to services and their ability to take on or retain clients.

Service providers' adaptive responses to challenges

Participants described a range of challenges they had been facing since the outset of the pandemic. However, their accounts also illustrate various adaptive responses to these challenges. One adaptive response was to ensure that virtual mental health services remained accessible. Chelsea, a cis queer service provider working in Atlantic Canada, noted her clinic's efforts in making virtual services accessible: "We're doing virtual services and trying to lean into accessibility. For some folks […] who might have hearing impairments, they benefit from the closed captioning on the screen." Second, in response to privacy and safety concerns that came with online services, providers adapted by offering both in-person and virtual services. For example, Adrienne, a cis allied provider working in Northern Canada, told us her workplace "funded transportation for clients who either didn't have a safe space at home to engage in counselling, or it was deemed [that] they would benefit more from in-person counselling." Third, providers integrated approaches focused on upstream causes of mental health disparities and intersectional, person-centered approaches into their practice to address the diverse needs of clients as they navigated the stressors of the pandemic. For example, Chantelle, a cis queer service provider working in rural Ontario, relayed how the pandemic had catalyzed her efforts to better support clients by reframing issues that are often individualized into symptoms of societal failures:

> A lot of [my] time and focus is spent on depathologizing the symptoms clients are experiencing, because we're always told we're the problem, we're pathologized, and really helping folks shift their lens to see that a lot of what they're experiencing is symptoms of somebody who's feeling oppressed, is feeling unsafe, [or] who's experienced trauma. And helping them extrapolate those colonial, individualistic, pathologizing ways, and helping them empower themselves outside the traditional medical system, because that is often not where they feel safe. So

> that's something that I've shifted during the pandemic, is helping them understand there's a lot of political stuff going on that's been really harmful.

Despite experiencing numerous challenges, 2SLGBTQI and allied service providers "queered" mental healthcare by using interpretive lenses that better address the needs of 2SLGBTQI clients and strategically adapting to pandemic-related demands. In practice, this meant self-disclosing and being authentic with clients to push back against "cold, clinical vibes" (so described by Mindy, a cis queer service provider); recognizing the trauma caused by minority stress; and framing mental health concerns as a result of systemic discrimination rather than an individual problem or pathology.

Many of these adaptive responses likely emerge from the lived experiences 2SLGBTQI service providers shared with clients/patients and the critical reflexivity that accompanies operating within a system that often fails to work even for them. As one cis queer provider working in Alberta emphasized: "We [need to] recognize that queer and trans folks are not just clients, they're also service providers and also everywhere. We're not talking about a 'them' or 'other', but rather an 'us.'"

Discussion

Our findings illustrate the various gaps and challenges that 2SLGBTQI and allied mental healthcare service providers are facing in the current context in their efforts to deliver inclusive and affirming care. At the root of many of these concerns are education and training gaps, which in turn lead to knowledge gaps. Without an understanding of the sociopolitical, economic, and cultural factors influencing 2SLGBTQI mental health, it is impossible to know what is required to be a safer practitioner. It is also difficult to situate oneself as an agent of change in dismantling the oppressive systems that shape the mental health and well-being of these populations. Even providers who are well intentioned risk causing serious harm if they cannot recognize the gaps in their own skill set. Our participants recognized this risk of harm and stressed the importance of filling knowledge gaps in order to provide culturally sensitive services, properly support people, and direct clients to appropriate resources.

Another common challenge was related to resource issues, which included a lack of affirming providers and a paucity of accessible services. These resource gaps were intensified by increased service demands wrought by the pandemic, which precipitated burnout among providers who had been trying to meet increased needs. The combination of extant resource gaps and provider burnout created breaks in referral pathways, with negative mental health implications for both 2SLGBTQI providers and clients. Addressing these referral challenges will require an upstream, multi-pronged approach which includes: dismantling entry barriers into mental healthcare professions for 2SLGBTQI individuals (particularly racialized providers); alleviating sources of minority stress (e.g., anti-2SLGBTQI stigma and discrimination) for 2SLGBTQI service providers; and providing comprehensive and accessible resources such as local and regional provider databases.

Finally, the COVID-19 pandemic exacerbated personal and structural resource gaps, which created several issues for 2SLGBTQI service providers. These challenges included maintaining financial stability while trying to address ever-growing client demands and drawing personal boundaries in order to protect their own mental health in this context. Boundary work is especially important, given the lack of services specifically for providers who are themselves 2SLGBTQI.

Structural challenges, such as increased credentialization and privatization throughout and in the wake of the pandemic, are likely to have intensified impacts on racialized service providers, as they are already at a

higher risk of burnout due to the confluence of racism and cisheterosexism within the mental healthcare sector (see Khan et al. 2021). Indeed, therapists' cultural background may influence their vulnerability to professional burnout and vicarious traumatization (Myers and Wee 2002; Miu and Moore 2021). The privatization within the mental healthcare sector also impacts BIPOC clients, who experience intensified access barriers to private services given the racialization of poverty (Daley et al. 2023) as well as racism within the 2SLGBTQI community (Munro et al. 2013). Our analyses of service seekers' experiences (see Seida, 2023) corroborate broader issues of representation of 2SLGBTQI service providers who are also BIPOC, with participants connecting a lack of diversity in service providers informing people's decision to not seek care. It is therefore important that BIPOC clients have access to BIPOC providers who have shared lived experience of these issues, and who can explicitly situate mental health concerns within broader processes of systemic racism and socioeconomic inequities. However, as our findings show, BIPOC 2SLGBTQI providers are struggling to meet their own needs, both as it relates to financial stability and mental well-being.

Many of our participants were critical of biomedical, Western approaches to mental healthcare. Aware of the damaging impacts of the pathologizing narratives that accompany biomedical frameworks, participants implemented intersectional, trauma-informed, and person-centered approaches in their service delivery. Further, service providers ensured that services remained safe and accessible despite the shift to virtual care. Participants' experiences illustrate the importance of unlearning biases and problematic approaches to mental healthcare to become a safer, more affirming service provider when working with 2SLGBTQI service seekers. Indeed, being willing to unlearn and relearn is central to cultural humility and trauma-informed care (Ranjibar et al. 2020), since factors shaping people's mental health and their resulting healthcare needs are always contextual and evolving.

The experiences of the service providers who participated in our project point to the pressing need for research, training, educational initiatives, and advocacy rooted in intersectional, trauma-informed, and upstream approaches to 2SLGBTQI mental health. As it relates to intersectionality, for example, it is important to consider how service providers' multiple social identities (e.g., age, gender identity, sexual orientation, and geographical location) shaped their perceptions and experiences of providing mental healthcare. Intersectional analyses of providers' positionality enabled us to better understand how binary, essentialist, and Western approaches to mental healthcare harm both seekers *and* providers of care. Indeed, "queering" mental health requires fundamental shifts in meeting the mental health and healthcare needs of 2SLGBTQI people—both service seekers and providers—across Canada. These shifts involve repairing the harms caused by biomedical, privatized approaches to mental healthcare by investing in peer-based support and community-centered models of care; situating mental health concerns as a consequence of injustice and oppression rather than individual failings or weaknesses; and supporting the unique needs of 2SLGBTQI service providers by developing local and sector-specific Communities of Practice. Such initiatives would create resources and avenues of social support, particularly for providers in non-urban settings, who require additional support to avoid burnout (Anaraki et al. 2022). It is also critical to address training and service delivery gaps by listening to community voices and emergent needs and by providing more funding to 2SLGBTQI service providers (in both public and private sectors) to ensure they have adequate resources for providing affirming and inclusive care.

Implementing these shifts will not only ensure that 2SLGBTQI people receive the affirming and inclusive mental healthcare and related services they require but will also support 2SLGBTQI and allied service providers in their work of meeting growing mental healthcare needs. The experiences of 2SLGBTQI and allied service providers highlighted in this paper provide a solid base for developing interventions geared to a range of mental health care providers across sectors. More broadly, implementing the aforementioned shifts via policy reform, funding allocation decisions, processual changes, and sociocultural changes within

workplaces, organizations, and governments will ultimately create services that are better equipped to support the mental health needs of 2SLGBTQI people across the country.

Conclusion

This article invites us to consider the ways in which 2SLGBTQI and allied mental healthcare providers' needs and approaches have evolved and continue to evolve in the context of the COVID-19 pandemic. 2SLGBTQI and allied service providers across Canada face a range of challenges, including training and education gaps, a lack of referral pathways, a lack of peers who can provide affirming services, and challenges meeting their personal needs. These challenges are exacerbated by systemic issues such as provider burnout, the continued privatization of mental healthcare, and increased need and demand for affirming and inclusive services.

Identifying critical gaps 2SLGBTQI and allied mental healthcare providers face in delivering affirming care is an important first step. However, robust implementation of recommendations made by participants is necessary to address these gaps and to ensure that the unique mental healthcare and service needs of 2SLGBTQI people—on both sides of the healthcare interaction—are being addressed amid COVID-19 and beyond.

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