



LGBT
IRELAND

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For Equality
For Everyone

HIDDEN BARRIERS

Access to mental health services
for LGBTQI+ people in Ireland

September 2026



Research Team

Mira Fey

*Research Project Lead for EQUICARES,
LGBT Ireland*

*Adjunct lecturer and assistant professor,
University College Dublin*

Adam McBride

*Head of Services and Engagement
Programmes, LGBT Ireland*

Paul D’Alton

*Professor of Psychology, University College
Dublin*

Support

Anne Byrne

CEO, LGBT Ireland

Steven Silke

*Communications and Development
Manager, LGBT Ireland*

Executive Summary

This report aims to provide structured insights into the barriers experienced by LGBTQI+ people trying to access mental health supports in Ireland. The findings can be used by practitioners, policymakers, and community services to reduce barriers, increase equitable access for LGBTQI+ people, and develop mental health supports that meet their needs.

Research design and methods follow a mixed-methods approach, combining: six interviews with Irish mental health and/or LGBTQI+ experts, a quantitative survey with 243 responses by 124 LGBTQI+ and 119 cisgender, heterosexual people living in Ireland, a mixed-method survey with 21 LGBTQI+ respondents living in Dublin, Dún Laoghaire-Rathdown, or Wicklow, two reflective diary entries by LGBTQI+ people living in Dublin, Dún Laoghaire-Rathdown, or Wicklow, and findings from a co-creation workshop with LGBTQI+ people and mental health professionals.

The mixed-method study was carried out between December 2025 and July 2026. It was part of the EQUICARES research project (2025-2028), funded by the European Union.

This report adds to previous research on LGBTQI+ mental health in Ireland by detailing findings structured around The EQUICARES Access Journey, understanding realised, equitable access in a broad and multilayered way consisting of five required characteristics on the service provider side and five abilities on the service user side.

The Findings confirm a high need for competent and inclusive mental health supports among LGBTQI+ people and illustrate a lower mental health status among LGBTQI+ respondents, compared to cisgender, heterosexual respondents. The report details existing access barriers to mental health supports, with three key barriers highlighted here:

1) No openly available, consistent, and easily accessible information exists on LGBTQI+-inclusive and LGBTQI+-competent mental health services and service providers. This means that

LGBTQI+ people navigate a jungle of service offers and rely heavily on word of mouth from within the LGBTQI+ community. LGBTQI+ people who are not, or not yet, part of the community cannot access this information.

2) People's ability to pay for mental health support mediates whether they can access and keep using competent and inclusive mental health supports.

LGBTQI+ participants report that known LGBTQI+-inclusive and -competent services are often private and therefore not free. Our findings show that LGBTQI+ respondents were more affected by direct costs of services as well as by indirect costs such as transportation and loss of income, compared to cisgender, heterosexual respondents. LGBTQI+ participants also reported either not being able to pay for private services in the first place, or not being able to continue paying consistently, leading to discontinuity of much needed care.

3) Trans and non-binary participants are more affected by each of the access barriers, while also reporting the worse

mental health outcomes and the highest unmet need for medical care. Previous negative experiences with and low levels of trust in healthcare providers, broader experiences of Transphobia, Victimisation, and Minority stress, and high levels of financial instability and limited ability to pay for inclusive and competent supports compound. Identifying trans-inclusive and -competent mental health providers and being able to use support as long as needed is reported as very difficult.

We suggest four key areas for recommended action based on the report findings. For more equitable, inclusive, and safe mental health access for LGBTQI+ people, **it is essential that LGBTQI+-competency is ensured within mental health supports and among providers** through standardised, mandatory training.

LGBTQI+ people need **to be able to identify LGBTQI+-competent providers** within mental health supports through easily accessible information and related monitoring. **Mental health pathways need to be easier to understand and navigate for everyone,** including LGBTQI+ people, with a focus on public pathways. Finally, **additional public or low-cost pathways need to be developed,** as current supports are oversubscribed and have long waitlists, and very limited financial support offers are available to people working in low-income roles or who are out of work.

The EQUICARES project is still ongoing, and targeted, actionable recommendations drawing on the upcoming co-development, testing, and evaluation of a LGBTQI+-specific mental health support will follow later.

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Content guidance

Mental health can be a sensitive topic, especially when looking at access barriers. LGBTQI+ people are disproportionately affected by mental health issues, but also by barriers to access, including lack of understanding and training of providers, dual or triple stigma, and direct and indirect costs. If you are an LGBTQI+ person who has experience with struggling to access mental health supports, some of the details in this report might be uncomfortable or distressing. If you need support managing your mental health, please contact the National LGBT Helpline on Freephone 1800 929 539 or through online chat on www.lgbt.ie; further resources for mental health support are available in Appendix 5: List of free mental health crisis support offers in Ireland.

About the author

Dr Mira Fey is the LGBT Ireland Research Lead for EQUICARES and affiliated with UCD as an adjunct lecturer/assistant professor. Mira has been working on LGBTQI+ access to health and social care services through leading and advising on different research projects in Ireland and Switzerland since 2021. Contact Mira for questions, queries, or comments at mira@lgbt.ie.

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List of abbreviations and acronyms

CAMHS	Child and Adolescent Mental Health Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
EUR	Erasmus University Rotterdam
GP	General practitioner, also known as family doctor
HREC	Human Research Ethics Committee
HSE	Health Service Executive
LGBTQI+	Lesbian, gay, bisexual, trans, queer, intersex, and other sexuality and gender-based minorities
NOSP	National Office for Suicide Prevention
SOGI	Sexual orientation and gender identity
TENI	Transgender Equality Network Ireland

Glossary of terms

This glossary presents brief definitions and explanations of terms used in this report. It is not an exhaustive list of all terms linked to LGBTQI+ identities or issues. For additional terms and definitions, you could consult the “[Comprehensive* List of LGBTQ+ Vocabulary Definitions](#)”,¹ “[Alphabet Soup – A collection of LGBTQ+ Terminology](#)”,² and our website (<https://lgbt.ie/get-information/sexuality-and-romantic-identities/>). The definitions and explanations here are either our own words or extracted from the sources referenced.

SOGI-specific terms

LGBTQI+

An umbrella term including sexual orientations and gender identities comprising **lesbian**, **gay**, **bisexual**, **trans(gender)**, **queer**, **intersex**, and others that are not heterosexual and cisgender.

SOGI

An acronym for **s**exual **o**rientation and **g**ender **i**dentify. Everyone has a sexual orientation and a gender identity, not just LGBTQI+ people. Heterosexuality is a sexual orientation, along with being homosexual or bisexual, for instance, and being **cis(gender)** is a gender identity, along with being **trans(gender)** or non-binary.

Cis(gender)

Cis, which is shorthand for cisgender, is the term used to refer to people who do identify with the gender assigned to them at birth (in other words, non-transgender).

Trans(gender)

Trans is shorthand for transgender. A transgender person is someone who does not identify with the gender they were assigned at birth. Trans is an umbrella term, meaning it covers a wide range of gender identities and expressions. We understand trans also as a shorthand to include people

with various gender identities beyond the gender binary, for instance non-binary people.

Gender-affirming care

Gender-affirming care for trans people might include hormonal treatment or surgery, but it starts by greeting trans people with the correct title, pronouns, and name and means not assuming what trans people want for their individual transition journey. Some people might want to take hormones and have surgery to align their gender identity and expression, others might opt for hormones only or no medical interventions at all. As with mental health support, ensuring Person-centred care is most important.

Negative aspects linked to LGBTQI+ identities

Homophobia

“An umbrella term for a range of negative attitudes (e.g., fear, anger, intolerance, resentment, erasure, or discomfort) that one may have toward [LGBTQI+] people.”¹

Heteronormative

“The assumption, in individuals and/or in institutions, that everyone is heterosexual and that heterosexuality is superior to all

other sexualities. Leads to invisibility and stigmatizing of other sexualities: when learning a woman is married, asking her what her husband's name is. Heteronormativity also leads us to assume that only masculine men and feminine women are straight.”¹

Transphobia

“The [...] discrimination against or hatred of trans people, the trans* community, or gender ambiguity. Transphobia can be seen within the queer community, as well as in general society.”¹

Cisnormative

“The assumption, in individuals and in institutions, that everyone is cisgender, and [implicitly or explicitly] that cisgender identities are superior to trans* identities and people. [This] leads to invisibility of non-cisgender identities.”¹

Misgender

“Misgendering means using the incorrect pronouns or honorifics to refer to someone. It can be an honest mistake – like accidentally calling a man “miss” – or an intentional tactic to disrespect someone. Regardless of the intention, when repeated, it can make an individual feel unseen, unwelcome, uncomfortable, or even unsafe [...] and have a significant impact on their mental health.”³

Deadname

“Deadnaming refers to calling someone by a name they no longer use, often their birth name, which can be deeply harmful to their mental health. [It can be] particularly damaging to transgender, gender

nonconforming, and nonbinary individuals, as it invalidates their identity.”⁴

Pathologisation

Historically, LGBTQI+ identities were pathologized and seen as mental illnesses which could be medicalised and treated by psychiatry and religion alike.

Being homosexual was included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as “Sociopathic Personality Disturbance” (1952, DSM-I), “sexual deviance”, along with paedophilia (1968, DSM-II), and “sexual orientation disturbance” (1973, DSM-III). When homosexuality was removed from the DSM in 1987, “a new focus was put on gender, [and] ‘gender identity disorder’ remained in the DSM until the DSM-V (2013), when it became listed as Gender Dysphoria”.⁵ Asexuality is still included in the DSM-V as “Hypoactive Sexual Desire Disorder”.

This history of understanding LGBTQI+ identities as mental illnesses has implications until today, with middle-aged or older LGBTQI+ people as potential victims of such psychiatric treatments. Continuing to require a psychiatric diagnosis of “gender dysphoria” to accept someone's transgender identity is part of the pathologisation, medicalisation, and psychiatrisation of transgender people.

Conversion practices

Conversion practices have been formerly referred to as “conversion therapy” and are also known as Sexual Orientation and Gender Identity and Expression Change Efforts (SOGIEEC).

According to a 2023 study on conversion practices in Ireland, “conversion practices is an umbrella term that describes a range of practices which specifically aim to change or suppress an individual’s sexual orientation or gender identity expression, [and understood to be] rooted in the medicalisation of homosexuality and gender identity, and the belief that being heterosexual and cisgender are the only ‘natural’ or ‘healthy’ expression of [SOGI].”^{6(p9)} Often, conversion practices are associated with religious beliefs or with psychiatric treatments.

Conversion practices have been likened by Amnesty International as methods of torture and inhuman or degrading treatment. They are evidenced as having extremely negative effects on LGBTQI+ people’s mental health.⁷

Internalised stigma

Internalised stigma refers to negative beliefs or biases towards our own identities, for instance a feeling of shame or inadequacy around specific identities. People might experience internalised stigma because they have been taught that their identity is wrong or dangerous, or because they are afraid to embrace their stigmatised identity. This can be harmful and have adverse effects on someone’s mental health.⁸

Minority stress

Minority stress suggests that people who face both negative external experiences (discrimination, victimisation, and rejection) because of their sexual orientation and/or gender identity and suffer from related internalised stigma or

fear of rejection are likely to feel more distressed.⁹

Victimisation

Victimisation in this report refers to people being treated negatively, targeted for hate crimes, or subjected to verbal harassment and/or physical violence because of their LGBTQI+ identity. This might be due to homophobia and/or transphobia.

(Mental) health-related terms

LGBTQI+- competent

In this report, we use LGBTQI+-competent instead of “LGBTQI+-friendly”, based on conversations with LGBTQI+ organisations in the interviews. We do this to capture that mental health providers do not only need to know what being transgender and cisgender is, and what terms to use to avoid misgendering or deadnaming clients. They should also understand societal attitudes, experiences of discrimination, lack of gender care, and overall life experiences to adequately support LGBTQI+ people’s mental health journey. If this is the case, they can be considered LGBTQI+-competent.

Cultural humility

The concept of cultural humility is included as a goal in the current HSE mental health policy. An ongoing project at Dublin City University (DCU) aims to co-produce a model of cultural humility in mental healthcare. The research team highlights that cultural competency is not enough, as related training only enhances short-term knowledge and attitudes, but does not improve mental health experiences for minority populations over longer periods of time. Accordingly, cultural humility “goes

beyond competence by asking us to critically reflect on how our ‘normal’ ways of thinking, acting, and organising care might impact diverse communities differently.”¹⁰ While the CHUMS project at DCU focuses on the experiences of ethnic minority communities, the concept of cultural humility can also be used when describing how to create and sustain adequate, LGBTQI+-competent mental health support.

Person-centred care

A key concept for mental health support, person-centred care refers to support offers and counselling approaches that apply a holistic approach. According to a recent guidance document from the Mental Health Commission, this means that “services place the people using the service at the core of what they do. The needs of each person using the service determine how the service operates”. This includes “promoting people's rights, allowing people to make meaningful choices, supporting them to participate in decisions about their lives, and promoting an individualised service that recognises their will and preferences”.¹¹

Intersectional needs

The concept of intersectionality is used to describe how different types of discrimination might compound when experienced by the same person, for instance, when a Black refugee is trans, the person might experience xenophobia, racism, and transphobia all at the same time, each compounding the other and creating everyday experiences that differ significantly from those of cisgender refugees or Irish trans people. This also means that the mental health needs of someone affected by intersectional forms of discrimination are different and need to be considered through a lens of Cultural humility and LGBTQI+-competent, person-centred care.

Realised, equitable access

In this report, we consider access to mental healthcare and supports realised and equitable when all five dimensions of the EQUICARES access framework are guaranteed and providers cultural humility and LGBTQI+-competent, person-centred care.

Context

LGBTQI+ mental health experiences, help-seeking, and barriers in Ireland

Lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+) people face higher levels of mental health difficulties compared to the general population, both internationally¹² and in Ireland.^{13,14} Previous national studies on LGBTQI+ mental health and wellbeing in Ireland show high rates of self-harm, suicidal thoughts and attempts, substance misuse, and depression, anxiety and stress, with a concerning increase between 2016¹⁵ and 2024.¹⁴ Transgender, non-binary, bisexual and intersex people report the poorest mental health outcomes, the highest risk of experiencing mental health issues, and the worst encounters with mental health providers.¹⁴⁻¹⁷

LGBTQI+ people's mental health is not necessarily worse because of their sexual orientation or gender identity (SOGI), but homophobia, transphobia, and related discrimination can lead to minority stress, adversely impacting people's mental health.

Minority stress occurs when people face negative external experiences (discrimination, victimisation, and rejection) because of their sexual orientation and/or gender identity, as well as internalised stigma and fear of rejection, leading to higher levels of distress, stress and/or anxiety.⁹ In Ireland, research has shown that negative attitudes and behaviours can create oppressive environments which impact the wellbeing of LGBTQI+ youth^{18,19} and the self-esteem and mental health of trans people.¹⁶ Both groups can be said to experience minority stress due to instances of discrimination and internalised stigma based on their sexual orientation and/or gender identity.

This does not necessarily mean they seek out mental health support: help-seeking for mental health challenges remained low among LGBTQI+ people in Ireland, even when experiencing serious distress.^{14,15} One reason for not seeking help for mental health difficulties overall is mental health stigma, where people fear being perceived or treated negatively and/or hold negative internalised perspectives on mental health.²⁰⁻²⁴ For LGBTQI+ people in Ireland, mental health stigma, combined with minority stress, makes support seeking more difficult. LGBTQI+ people who are also part of other discriminated groups such as Travellers,²⁵ refugees and international protection applicants,²⁶ sex workers,²⁷ and people in the criminal justice system²⁸ face even higher burdens due to multilayered stigma. Each layer of stigma becomes an additional challenge when seeking mental health supports.

Even when LGBTQI+ people overcome these challenges and seek mental health support, they often face a variety of access barriers. In Ireland, people with mental health issues can be negatively impacted by the geographic distance of available services, especially for people living outside of cities, the direct costs of being referred to and attending the service, and the

limited resources available.^{29–34} LGBTQI+ people face these barriers and also struggle with previous experiences of discrimination within healthcare settings and beyond, minority stress, and dual or triple stigma, leading to difficulties identifying service providers they can trust. We know from previous studies that LGBTQI+ people who use mental health services in Ireland are more likely to report not feeling supported by their psychiatrist, and less likely to report being consistently treated with dignity and respect in community services.³⁵ Provider attitudes, gaps in staff knowledge and competence, and a largely heteronormative and cisnormative mental health service culture have been identified as additional barriers facing LGBTQI+ people in mental health support.^{13,19} Trans people also report meeting providers who pathologize their transgender identity and misgender or deadname them.³⁶

The intention of this report is to provide further insights into access barriers for LGBTQI+ people in Ireland to help practitioners, policymakers, and community supports develop approaches to reduce barriers and increase equitable access for LGBTQI+ people to mental health supports that meet their needs.

Mental health policy in Ireland

Mental health policy in Ireland is undergoing a period of change, with the new *Mental Health Act 2026* signed into law in May 2026. It replaces the 2001 Act and is built around informed consent and stronger safeguards, extending regulation to community mental health teams and child and adolescent mental health services (CAMHS) for the first time.^{37,38} LGBTQI+ people are not directly mentioned in the new act.

***Sharing the Vision: A Mental Health Policy for Everyone* remains the guiding policy document, with a specific commitment to culturally competent services for LGBTQ+ people**, among other priority groups.^{39(p29)} The current *2025-2027 Sharing the Vision Implementation Plan* “recognises that additional work is needed to promote inclusivity in mental health policy and practice in Ireland”. The document highlights that mental health supports and services are meant to be sensitive to “personal, social, and cultural circumstances” and “reflect cultural humility” to ensure “that each person in Ireland who seeks access to mental health support is treated with respect”.^{40(p9)} Recommendation 61 calls for the HSE to “maximise the delivery of diverse and culturally competent mental health supports throughout all services”.^{40(p51)}

Specifically focused on the LGTBQI+ population, Ireland’s current *National LGBTIQ+ Inclusion Strategy II 2024-2028* recognises the negative mental health outcomes for LGBTQI+ people outlined above and highlights gaps and issues linked to mental healthcare provision. Pillar 2 on Health and Wellbeing has the strategic outcome “LGBTIQ+ people enjoy health and wellbeing outcomes similar to that of the general population and their specific needs are addressed within the health system”. The strategy sets out that this will be achieved through “improved investment in and access to services, particularly in rural areas”, and the

creation of “an inclusive environment [...] for LGBTIQ+ people in health and social care settings”.^{41(p22)}

Gender-affirming care is not mental health care, but its availability and form affect the mental health of trans people. Accessing gender-affirming care, including hormone treatment, can be a crucial factor in improving the wellbeing of trans people,^{42–44} and has been found to reduce depressive symptoms and psychological distress.^{45,46} Not receiving this treatment or being on a waitlist for a significant amount of time can contribute to minority stress and worsen the mental health of trans people.^{47,48} At present, there are significant challenges with access to and the form of gender healthcare provided in Ireland, with Ireland previously ranked by TGEU as one of the worst countries in Europe for trans healthcare,^{49,50} and ILGA Europe highlighting the lack of adequate access.⁵¹ A process is currently underway by the HSE to develop a Model of Care for Gender Healthcare,⁵² which may address barriers and challenges in accessing this care. This new model will hopefully indirectly support mental health outcomes.

While these four different policies, recommendations, and outcomes are commendable, they have not yet been realised. Previous research on the implementation of healthcare policy aimed at improving access in Ireland indicates that translating policy into action is a significant challenge.⁵³ **The gap between what national policy promises and what LGBTIQ+ people encounter at the point of service remains a central problem highlighted in this report.**

The EQUICARES project

This report was developed based on the Irish findings of research conducted 2025 to 2026 as part of the EQUICARES project. EQUICARES is a four-year research project (2025-2028) funded by the EU. The project aims to identify mental health access barriers and to develop corresponding community-led solutions for cohorts of people in vulnerable situations. LGBT Ireland is one of eighteen partner organisations in the EQUICARES consortium. The project applies the EQUICARES access journey,^{54,55} an adaptation of the Levesque framework,^{56,57} to conceptualise access to mental health support through providing person-centred care.

LGBT Ireland, as part of the EQUICARES project, leads on the data collection and the co-creation of community-led mental health solutions for LGBTIQ+ people in Ireland. Due to limited staff capacity and financial resources, most of the project focuses on a specific area in Ireland instead of being rolled out nationally. The catchment area for the project is Dublin, Dún Laoghaire-Rathdown, and Wicklow,¹ but some of the data collection methods used for this report had a national scope.

More information is available on the project website www.equicares-project.eu.

¹ Find more information about the catchment area, including some demographic and socioeconomic insights, on pages 26-50 of the public D3.1 EQUICARES report prepared by White Research, one of the project partners.⁵⁸

Report outline

This report provides an overview of the research design and methods used, highlights the EQUICARES access journey framework, and discusses the findings to date. Findings begin with a spotlight of three key results followed by a detailed description structured along the EQUICARES access journey. The conclusion contextualises the findings and highlights next steps. Appendices include detailed information on the theoretical framework and methods used in this study, and a list of support lines and websites for mental health crisis situations.

Research approach

Research design and methods

This report is based on a mixed-methods study. Methods used include both qualitative, open-ended question types and data collection methods and quantitative, closed question types and data collection methods. Table 1 shows the five different data collection methods. In total, we engaged 299 people through five different methods between December 2025 and July 2026, with most data collection finalised in March 2026. All participants gave informed consent and agreed to the use of the data we collected in an anonymised form.

Table 1 Data collection methods used

Data collection method	Type of method	Timeframe of data collection	Type of participants	Number of participants
Quantitative survey	74 closed, multiple-choice questions based on the access journey, statistical analysis	December 2025 to March 2026	LGBTQI+ and cisgender, heterosexual people living in Ireland	249
Stakeholder interviews	Open-ended questions, following a topic guide based on the access journey, thematic analysis	February 2026	Experts across mental health, public policy, and on LGBTQI+ issues	6
Mixed survey	44 questions, mixed between closed, multiple-choice questions and open-ended questions based on the access journey, mixed-method analysis	January to February 2026	LGBTQI+ people living in the catchment area who have used mental health services before	21
Reflective diary	Open-ended questions based on the access journey, interpretative phenomenological analysis	January to February 2026	LGBTQI+ people living in the catchment area who have used mental health services before	2
Co-creation workshop	Interactive and discussion-focused workshop inviting participants to share experiences and validate findings, thematic analysis	July 2026	LGBTQI+ people interested in mental health, allies with experience working with LGBTQI+ people, mental health professionals	22

Each of the data collection methods provided a different dataset, analysed separately before being brought together by the LGBT Ireland researcher to compare findings on the same aspects through a joint-display approach: findings from all five datasets were mapped side by side against the EQUICARES access journey framework. This joint display analysis approach allowed us to triangulate findings across the different datasets. This means that a pattern showing up in any one dataset, for instance in the interviews, could be checked against the other datasets, say the survey data, the diaries, and the workshop, rather than relying on any one source alone. Data triangulation is used to verify consistency across different datasets and reduce potential bias.^{59–61}

The findings in this report are based on research conducted in 2025 and 2026 as part of the EQUICARES project.² Several other EQUICARES partners, particularly EUR and Jigsaw, were involved in designing the research methods and developing the ethics guidance we used for the ethics review by University College Dublin (UCD). UCD granted final ethics approval for our research team in December 2025. More detailed information about the different partners involved and each of the five methods is included in Appendix 2.

The EQUICARES access journey

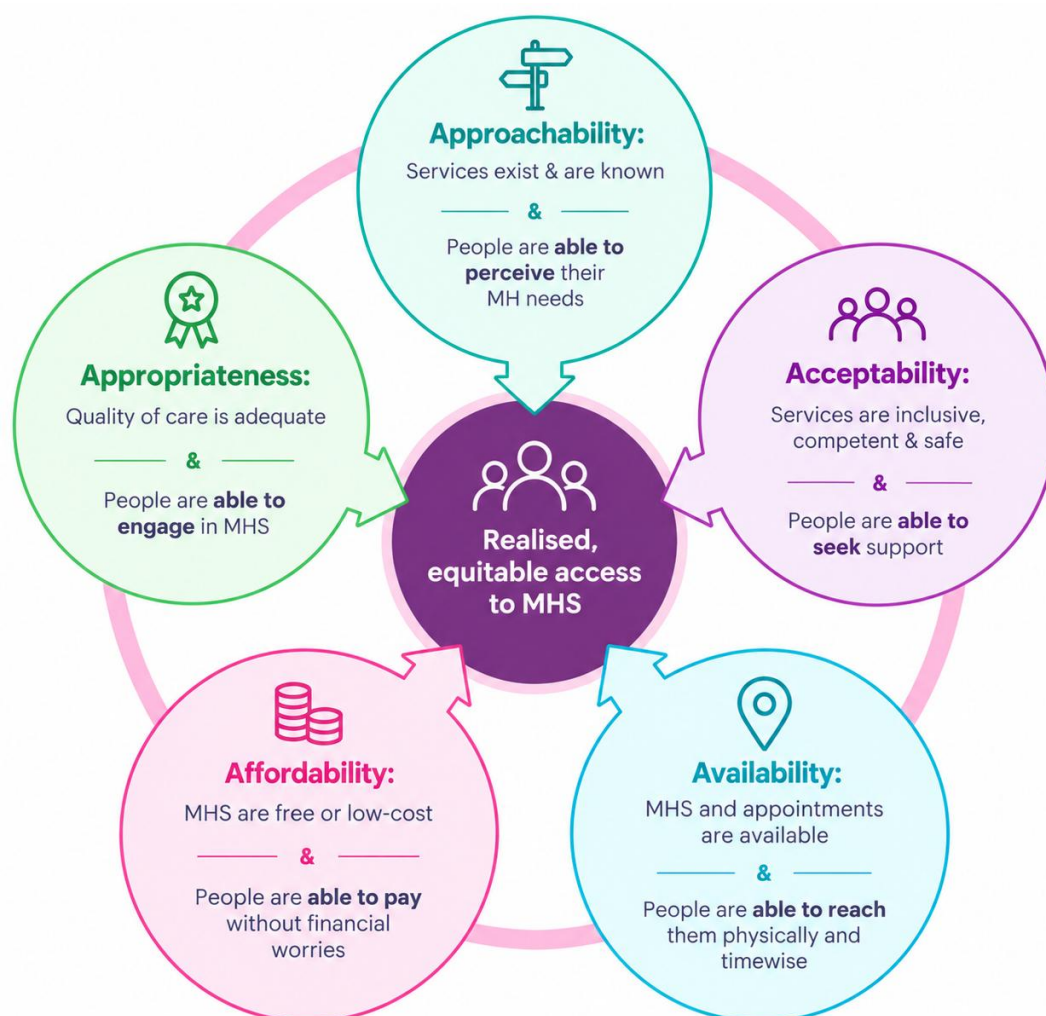
To understand whether access to mental health services is realised for LGBTQI+ people in Ireland, we use the EQUICARES access journey.^{54,55} See Appendix 1 for a more detailed description. It is adapted from the Levesque access to health care framework which combined five service provider-side and user-side factors.^{56,57} Other EQUICARES project partners further developed this framework from a patient-centred process to an interacting, circular system⁵⁴ of the different service provider characteristics and the abilities of potential service users. See Figure 1 below for a simplified illustration of the ideal version of the journey, with realised and equitable access ensured.

Realised, equitable access to mental health supports only exists when both sides of each of the five factors are guaranteed for all people. Realised access to mental health services is not measured by the sheer existence of a service or by how many people use it, but by whether people are able to use should they want to, regardless of if they choose to. This understanding is important to assess how to guarantee equitable access for all people, including those who face the additional barriers of discrimination and stigma.

This framework helps explain why some people can access a service while others, affected by discrimination or stigma, might not be able to. For instance, if information about a service is available online, but only in one language, people who do not understand that language will be unable to identify the service, even if they are willing to seek help. Providing multi-language information can be a solution to this issue. However, if the service is paid and the person does not have the financial means to pay for the service and no access to financial support, they might still not be able to access the service. **When analysing access to mental health support, it is important to consider all five double-sided factors, as they are interconnected and affect each other.**

² For a detailed analysis of the interviews and the quantitative survey conducted in Ireland by LGBT Ireland and in six other countries by seven other pilot partners of the EQUICARES project, please also note the corresponding report by EUR.⁶² For a detailed analysis of the qualitative survey and the reflective diary data collected in Ireland and the six other countries, please note the report by Jigsaw⁵⁵ and the corresponding research protocol.⁶³

Figure 1 Simplified illustration of the circular EQUICARES access journey



Limitations

The findings of this report are based on the data collection conducted as part of the EQUICARES project. While LGBT Ireland was able to comment on and suggest amendments to the data collection tools, these were developed by researchers at EUR and Jigsaw for the overarching EQUICARES project. The data collection tools applied the EQUICARES access journey framework. This grounds the findings in a specific theoretical context which is both helpful and potentially restrictive, as aspects that do not neatly fall into these categories were more difficult to include.

Because the data collection tools were developed by other EQUICARES partners, they were not based on insights and experiences from the Irish context. LGBT Ireland adapted them whenever possible to ensure that they were as relevant and accessible for local participants.

The research team contacted over 70 individuals and organisations in Ireland to support study recruitment both online via social media channels, websites, and emails and offline via

posters and flyers. However, people who do not attend physical services, or follow these organisations on social media/through email newsletters will likely not have found out about the study. This may include older people, people living in more rural areas, or those who are not “out” or are more isolated, but such gaps cannot be stated with precision.

There were several limitations linked to language and digital skills. We only recruited participants through English-speaking material, and the surveys were only available in English. This may have restricted participation opportunities for people who do not speak English or did not feel comfortable participating in English. Moreover, the surveys and the reflective diaries were only available online, although we also specified in the recruitment material that support for people without safe access to a computer or mobile phone was available upon request. It is possible that people could not or did not feel comfortable to reach out to use said support, we only had one person contact us to participate through a conversation instead of filling in the online forms.

Finally, the quantitative survey and the stakeholder interviews were conducted on a national level, but the mixed-method survey and the reflective diary focused on participants living in the catchment area. While some workshop participants came from other parts of Ireland, the views presented in findings show insights that are (at least in part) focused on Dublin, Dún Laoghaire-Rathdown, and Wicklow.

Findings

Key findings at a glance

Three key findings emerged from the research, two linked to the EQUICARES access journey and one cross-cutting finding for a specific group of people within the LGBTQI+ community in Ireland – trans people.



Word of mouth replaces formal information and signposting to help people identify LGBTQI+-competent, trustworthy services. Our findings show that systematic, visible signposting and clear information about which services are LGBTQI+-competent is not available. Instead, LGBTQI+ people in Ireland rely on personal recommendations from within community networks to find safe providers. This works for people with connections to community networks, but LGBTQI+ people who are not, or not yet, part of these networks struggle to navigate the system and identify trustworthy services.



People's ability to pay is a decisive factor influencing realised access to approachable, acceptable, available, and appropriate services. According to our findings, public mental health services are underfunded, staff are often not sufficiently (or consistently) competent on LGBTQI+ issues and cross-cutting challenges, and access, when obtained, can be capped (e.g. at a limited number of sessions). Participants report awareness of private services that are known to be LGBTQI+-inclusive, -competent, and responsive, but only for people who can pay for them. A lack of affordability on the provider side and limited ability to pay on the service user side compound each other.

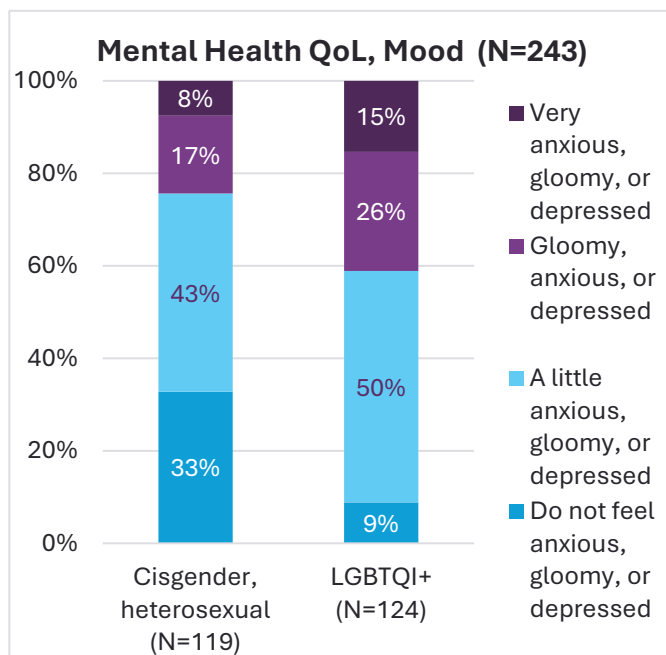


Trans people face increased barriers at every point of the access journey, and also when first thinking about seeking help. Fear of losing existing access or being denied future access to gender-affirming treatment can mean trans people withhold their mental health status and history from clinicians. The long waitlist and negative experiences of gender-affirming healthcare in Ireland are directly worsening the mental health and wellbeing of trans people. When they decide to seek mental health supports, identifying trans-competent and -inclusive services is only possible through word of mouth, and, in most cases, the recommended supports are not free. Moreover, trans people are disproportionately affected by direct and indirect financial barriers, often leading to discontinuity of care. This means that trans people, already facing higher degrees of discrimination and stigma and reporting worse mental health outcomes, are also more affected by barriers throughout their mental health journey, which further exacerbates their mental health.

Adding to previous research on LGBTQI+ mental health in Ireland

Before looking at the five entry points of the EQUICARES access journey, we briefly describe findings on the mental health status and wellbeing of our participants to situate these among previous, similar studies. Overall, across all datasets, we identified a strong need for LGBTQI+-inclusive and -competent mental health supports among our LGBTQI+ participants, validating and updating previous research findings.

Figure 2 Comparison of survey respondents' mental health status



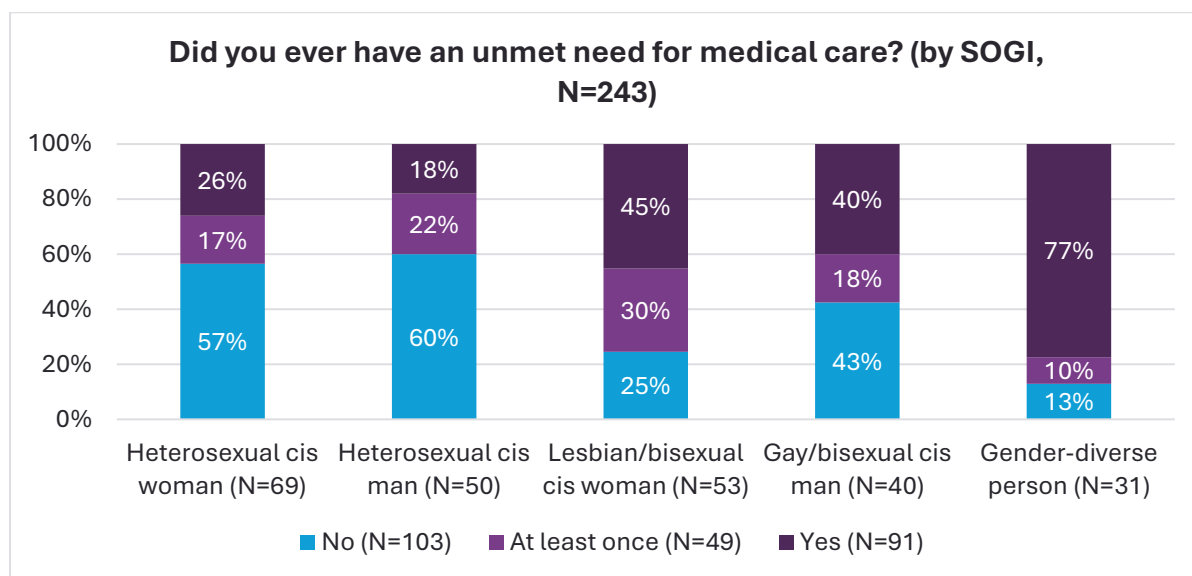
Within the quantitative survey, LGBTQI+ respondents reported higher proportions of moderate, moderately severe, and severe depressive symptoms compared with the cisgender, heterosexual respondents.^{62(p90)} For example, only 9% of LGBTQI+ respondents said they “do not feel anxious, gloomy, or depressed”, compared to 33% of their counterparts. Most LGBTQI+ respondents felt at least “a little anxious, gloomy, or depressed” (see Figure 2). These findings mirror previous studies on LGBTQI+ mental health in Ireland which highlighted high rates of negative mental health outcomes among LGBTQI+ respondents.^{14,15,35}

The LGBTQI+ survey respondents reported higher rates of using mental health supports compared to the cisgender, heterosexual respondents. Roughly 70% of LGBTQI+ respondents in the quantitative survey reported they used mental health care in the last 12 months, while only 38% of the cisgender, heterosexual respondents said they had. Cisgender male, heterosexual respondents report particularly low usage of mental health care, something that aligns with previous findings on mental health stigma affecting cisgender, heterosexual men more than others.^{64,65}

Our LGBTQI+ survey respondents reported higher proportions of fair and bad general health compared to the cisgender, heterosexual respondents and the national average,^{62(p87)} **and a much higher unmet need for healthcare.** Only 27% of LGBTQI+ respondents said they had never had an unmet need for medical care, compared to 58% of their cisgender, heterosexual counterparts. A closer look at the responses separated by sexual orientation and gender identity (SOGI) shows that trans respondents were particularly likely to say they have experienced an unmet need for medical care before (see Figure 3 below). This finding reflects access challenges to gender-affirming care in Ireland. We also see that lesbian

and bisexual cis women respondents are facing high rates of unmet medical needs compared to gay and bisexual cis men and compared to the cisgender, heterosexual respondents. One issue where lesbian and bisexual cis women in Ireland face a medical access gap compared to heterosexual cis women is fertility treatment through public services; while female same-sex couples can access private, paid treatment, they cannot currently access free fertility treatment through the HSE.⁶⁶ Lesbian and bisexual women also experience access gaps in sexual health services and to preventative screenings compared to heterosexual women.⁶⁷

Figure 3 Quantitative survey responses "unmet medical need"



LGBTQI+ and cisgender, heterosexual respondents both listed long waiting lists and high costs as reasons for unmet medical care needs, but LGBTQI+ respondents also highlighted fear and uncertainty about finding “a good provider”. These findings further confirm previous studies in Ireland which highlighted the lack of adequate, inclusive, and culturally competent healthcare providers for LGBTQI+ people.^{68,69} Below, we explore this further in relation to mental healthcare providers. It is important to note that these experiences and attitudes were found regarding general healthcare in Ireland.

Knowing support exists and recognising the need for it

Before someone can seek mental health support, they first have to recognise their own need for it, know support exists and identify which fit their need.

The first point, mental health literacy (knowing one’s needs for mental health support) has changed significantly over the past decades in Ireland according to interview participants. Reasons for this cited by an interviewee include related campaigns and a decrease in mental health stigma. Another interviewee illustrates how mental health has long been perceived in poorer Irish families:

“[When you grow up very poor], mental health was something that you just didn't talk about. You just get on with life because someone's murdered in the family, there's drugs, there's alcoholism, there's domestic violence. You just get on with it because you have to survive. You're in survival mode. You know, you don't have the luxury of thinking, I have to look after my own mental health. We always thought mental health was for middle class people, like honestly, when we were actually the people who needed to access mental health services.”

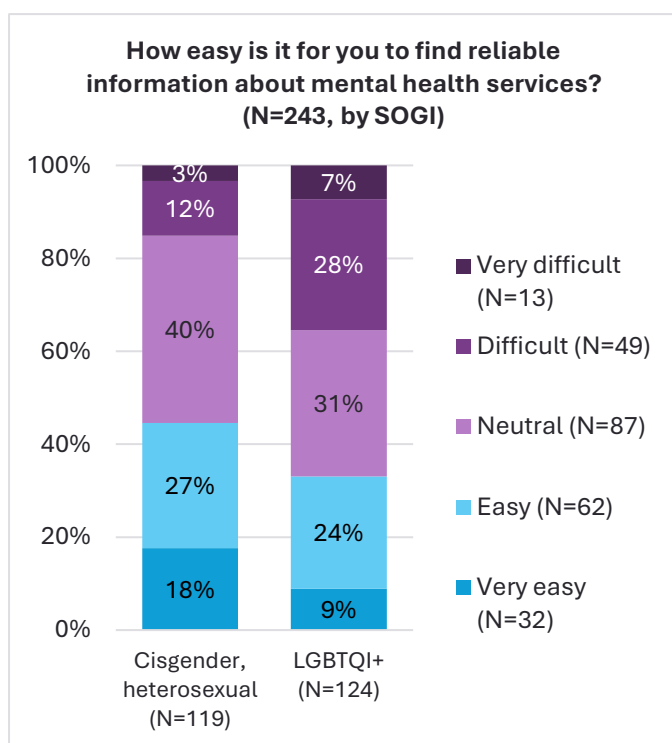
Interviewees, workshop participants and survey respondents describe mental health literacy as relatively high among the LGBTQI+ population in Ireland. Most of the 21 mixed-method survey respondents say they would know they needed mental health support if they recognised feelings of “anxiety, low mood”, “a sense of hopelessness” and when they are “losing motivation and lacking energy to do everyday essentials like personal hygiene, cooking, cleaning, and attending work/school”. The two interviewees representing LGBTQI+ organisations highlighted that they often receive questions about suitable mental health supports by LGBTQI+ people frequenting their organisations, illustrating that service users are aware of mental health needs, but don't know where to find adequate support.

There is no readily available and systematically displayed information about LGBTQI+-adequate, -inclusive, and -competent mental health services. There is no one specific place to look for this information, and signposting is not consistent across healthcare providers. While the HSE-provided webpage www.yourmentalhealth.ie provides information about public and private mental health services in Ireland, LGBTQI+-inclusivity and -competency is not one of the headings or search options.

General practitioners (GPs) are the main entry into mental health support in Ireland and usually refer patients when they disclose mental health difficulties. According to two interviewees, some GPs might be aware of providers who are LGBTQI+-inclusive and LGBTQI+-competent, others might not know any such providers. Based on our findings, mental health providers known to be LGBTQI+-inclusive and -competent are reported to be almost exclusively operating privately (at a cost), not publicly through the HSE, as explored in detail further below. Referrals to these known providers mostly happen through informal professional networks. As one interviewee with a mental health background said, “local GPs have phoned me to say, ‘can you take on this client?’ So, I think it's still at that level where it's ‘who do you know’”.

Workshop participants further highlighted the “**overwhelming jungle of service offers**” when listing access barriers and said that “it is difficult to find information and to find the suitable entry point”.

Figure 4 Finding reliable information by SOGI

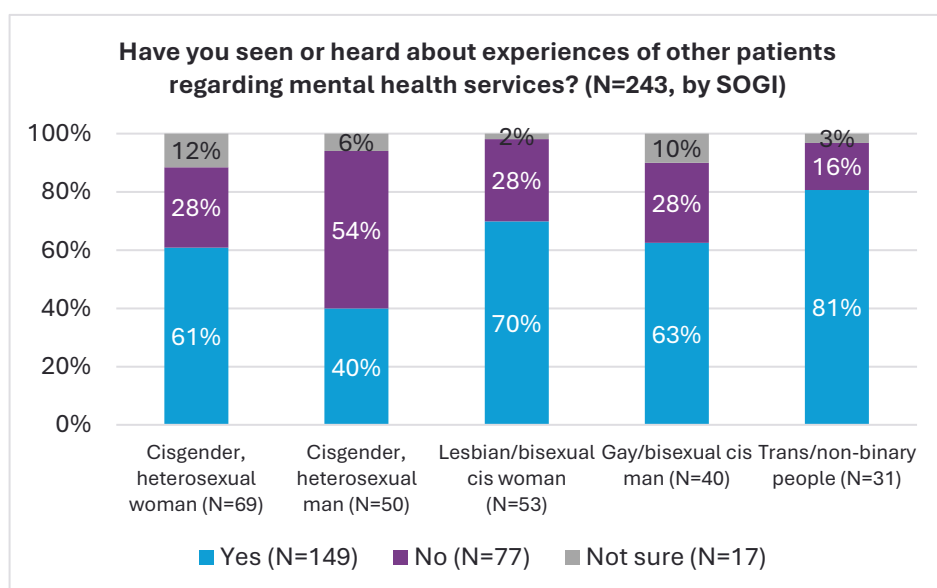


The quantitative survey also highlights one key difference between LGBTQI+ respondents and cisgender, heterosexual respondents when it comes to information about local mental health services among respondents, visualised in Figure 4.

While a similar percentage of the two groups knows where and how to get mental health support in their area (roughly 40% across both groups) and finds understanding this information “very easy” or “easy” (approximately 60% across both groups when combining these response options), significantly more LGBTQI+ respondents reported finding it difficult to find “reliable information”.^{62(p72)}

In the absence of clearly displayed information and consistent signposting, word-of-mouth often fills the gap. The quantitative survey shows that around 70% of LGBTQI+ respondents have previously seen or heard about the experiences of other patients regarding mental health services, compared to around 50% of their cisgender, heterosexual counterparts.

Figure 5 Use of PREMs and PROMs, by SOGI



This can be particularly important for trans people in Ireland. As displayed in Figure 5, more than 80% of trans survey respondents answered “yes” when asked whether they were aware of the mental health experiences of other patients.

An interviewee said “If you don’t know [a suitable provider], where

do you really begin? What do you Google?... [you are] much more likely to ask around and get a recommendation than to Google ‘trans friendly therapist Dublin!... It just feels like it carries

more weight.” Another interviewee confirmed this: “I don't think that anyone necessarily is walking into a service and expecting to get inclusive care. So, I do think word-of-mouth [is important] within the trans community, there would be kind of a back chat, like, ‘this is a good place, that's a good place’.” Asking for recommendations can work well for people already connected to community networks, but much less so for anyone outside them.

Services aren't always trusted but people seek help

Being aware of one's support need and about the existence of services means the person can decide to seek help, but making this decision often involves weighing up whether they deem it safe to do so. On the service provider side, this means that services are acceptable: fit to provide adequate and competent support for LGBTQI+ people. For the people making the decision, it means that they trust the service or the mental health system and are willing to seek support.

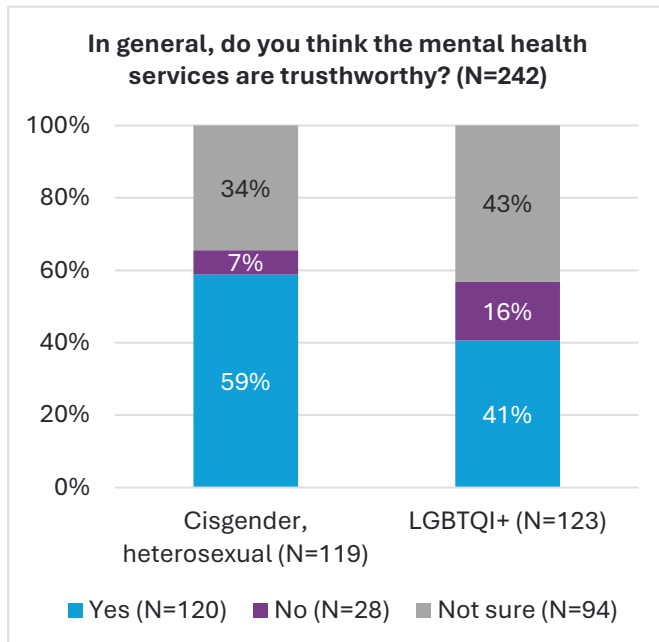
Recommendation 61 of the *Sharing the Vision* mental health policy stresses that HSE services should “maximise the delivery of diverse and culturally competent mental health supports throughout all services”,^{40(p99)} which, if implemented and realised, would guarantee publicly available LGBTQI+-inclusive and competent services across Ireland. However, in reality, it is currently next to impossible for LGBTQI+ people to verify such competence. While hanging up rainbow flags or posters or wearing rainbow pins can signal that services might be LGBTQI+-friendly, they do not show whether providers actually possess the knowledge and capacity required to be LGBTQI+-competent. As an interviewee from an LGBTQI+ organisation highlighted:

“It would be great to have a standard. People need to understand that it goes beyond learning the pronouns and learning what the words mean and knowing that this is a lesbian and that's a gay man, into an understanding of, ‘there's a whole subculture of queerness that exists’, and there are things and experiences that happen within our community that are different to the cisgender and heterosexual community. [Mental health professionals] have to allow a person to fill them in on what their world is without judging it, or trying to apply their own standards to it, which is very difficult for someone who's been raised and socialised and has always been cisgender and heterosexual and do not really have an in depth understanding of how our community operates.”

One interviewee explained that LGBTQI+-competence means that patients will not need to “hand hold their therapist through an [LGBTQI+ 101] information session”. LGBTQI+ people want to be able to access mental health support without having to explain their identities and related experiences of discrimination and stigma first. As one respondent of the mixed-method survey said, “I always try and find professionals who are demonstrably LGBTQI+ inclusive but even then, I worry that I will have to spend a lot of time teaching them about being trans rather than focusing on my mental health needs.” LGBTQI+ people want to be certain to be treated “like everybody else” if they open up about their identity, as an interviewee said.

Trust towards mental health providers is comparatively low among LGBTQI+ participants in our study. The quantitative survey reveals stark differences by sexual orientation and gender identity when comparing responses to the question “In general, do you think mental health services are trustworthy?”, as visualised in Figure 6.

Figure 6 Trust in mental health services, by SOGI



While almost 60% of cisgender, heterosexual respondents consider mental health services generally as trustworthy, only around 40% of LGBTQI+ respondents do. This is even lower among the trans respondents: Only 13% answer “yes” to this question (see Figure 11 in the appendices). This group also reported less certainty when asked whether they believe that their rights would be protected against any mistreatment or abuse while receiving mental health services – only around 30% agreed, compared to 50% of all LGBTQI+ and 60% of all cisgender, heterosexual respondents.

Fear of stigma and discrimination by mental health professionals plays an important role in preventing LGBTQI+ people from deciding to seek support. Several open-ended responses in the mixed-method survey show a fear of “not having my gender identity and sexuality understood and respected by the mental health professional”, of “being misunderstood, misgendered, dismissed, and discriminated against”, and of “engaging with a professional who is transphobic or homophobic”. Often, this is based on previous bad experiences with mental health providers or the healthcare system more broadly, as workshop participants also pointed out. An interviewee details reports of young trans people who “have been discouraged from exploring their gender identity” by a mental health provider, and mental health providers who treated “the trans experience of a young person as a mental health issue”.

Double or triple stigma further compounds these experiences and reduces the likelihood of trust in healthcare professionals, as another interviewee said: “We have double, triple, quadruple stigmas. You know, we could be gay. We could be both, we could be a gay, trans person living with HIV, and we could be non-binary. So, there's loads of different things that we just know healthcare professionals are stigmatising about.” Other participants, including people attending the workshop and interviewees, also mention the obstacles experienced by someone who struggles with their mental health and is LGBTQI+, neurodiverse, and/or misuses substances – it is rare to find services that apply person-centred care and treat the person

holistically, without judgment, and without referring them to separate services for each of these challenges.

The risk of being outed by the act of seeking help itself is a factor that prevents some people reaching out to visibly LGBTQI+ services. Several workshop participants pointed out that while rainbow flags and names including terms associated with the LGBTQI+ community can be welcome symbols for people who are already out and looking for inclusive and supportive services, they can function as a barrier for people who are concealing their LGBTQI+ identity. These might be younger people and/or people from families or cultural backgrounds that are less accepting of LGBTQI+ identities. They might worry that simply being seen entering such a service will disclose their identity to family and friends before they want it to be known to them. It might not be safe for these LGBTQI+ people to come out, especially if living with family who are not LGBTQI+-friendly or supportive. Navigating these cultural differences and fears of diverse forms of stigma and discrimination can be a challenge for mental health providers and LGBTQI+ community services alike.

The experience of gender-affirming care in Ireland is a factor preventing trans people specifically from deciding to seek support for mental health issues. Trans participants shared views that seeking mental health support could be a blocker to accessing gender-affirming care or could result in removal of care. Interviewees shared experiences of “being taken off hormones on the basis of that [accessing mental health support]”. Participants also described experiences where mental health care information was shared with gender healthcare providers without consent, which negatively impacted trust in public mental health services more generally. Based on what interviewees and workshop participants told us, there is a high level of information and knowledge-sharing across the trans community, which means these negative experiences can have considerable impact beyond those who directly experience them. Additionally, the long waitlist for access to public gender-affirming services as well as the process itself, in particular the use of a psychiatric evaluation, was also highlighted as impacting negatively on the mental health of trans people and on the trust trans people place in mental health providers.

Actually getting in the door? Opening times, location, and transport

A person realising they need mental health support and deciding to seek out a service does not yet mean they receive support – one decisive factor is whether local services are available at suitable times in accessible locations that can be reached by the person. As our findings show, especially outside of mental health emergencies and situations of acute need, public mental health services are not easily available to everyone, regardless of their sexual orientation and gender identity. They are often capped at a limited number of sessions

and depend heavily on GP referral.³ An interviewee highlighted that public mental health service provision outside of clinical psychology is thin, and psychotherapy is almost only privately available. This was confirmed by workshop participants.

Support offers are not evenly spread across the country, but heavily concentrated in urban areas. As one interviewee puts it, “it’s a postcode lottery”. Getting to mental health services can also be difficult, especially for people who are depending on public transport options. Survey respondents described these as “unreliable” and “often late”. One person wrote, “the bus service in [county] has gotten so bad, it negatively affects my entire life, mental health, and any appointments”.

Mental health services are also often offered around standard office hours, which is a specific problem for people in precarious or shift work. This can be especially difficult for LGBTQI+ migrants living in Ireland, as an interviewee reports: “they aren’t often stepping into the sort of set, steady jobs, they’re having to work in precarious situations. Many of them are part of the gig economy. They wouldn’t have the time, freedom”. Moreover, waiting times for appointments also differ vastly, ranging from a few days to several months or longer, as indicated by survey respondents (see Figure 12 in the appendices).

Low-cost mental health services outside of public HSE services are not always located in buildings that are accessible for people with mobility restrictions, as an interviewee highlighted.

These factors, amongst others, are why workshop participants and interviewees highlight that LGBTQI+ people in Ireland are pushed to private service providers known to be LGBTQI+-inclusive and -competent. These are heavily concentrated in Dublin, with some available in Cork or Galway, but otherwise mainly online. Due to the limited number of these providers, they often have waitlists, as workshop participants confirmed.

Being able to pay to keep going: the costs of mental health supports

The cost of mental health support that is considered LGBTQI+-inclusive and -competent has appeared consistently throughout this research. As highlighted above, public mental health services in Ireland are not consistently inclusive and competent for LGBTQI+ people, navigating which services might be is almost impossible, LGBTQI+ people often do not trust public services based on continuous stigma and discrimination and previous bad experiences, and getting your foot into a public service that is easily available time- and location-wise can be very difficult.

³ The HSE website includes information about the different pathways into public mental healthcare, including for medical card holders and other specific categories of people, but it is difficult to easily identify information that is suitable to someone’s specific needs. The HSE recommendation is to go through GP referral, meaning it is at discretion of the individual GP to decide whether their patient is sufficiently “in need” of mental health services.

Being able to access mental health support quickly almost always comes at a cost. One interviewee described how cost can become a significant barrier for people in a mental health crisis:

“If you're having an acute mental health issue in a moment, and you're getting in touch [with public mental health services], and you're told, ‘Well, you know, we can't actually set up any kind of regular treatment for you for three months’. If that's not really good enough, and if you don't have the money to download BetterHelp, or, you know, get onto [a private mental health provider], then you're going to end up not getting any help... you have to be pretty focused on things to stick with it for three months [...] that's a huge barrier”.

For people who have not yet been assessed, paying for private assessments can be a quicker, but costlier option to accessing mental health support, including public services.

As a mental health expert said in an interview, “I'd say, ‘Have you got a few bucks? If you have, just to get your assessment done quick as you can, then you'll be able to access the service, because you'll have that assessment’. But that's a terrible thing to have to say, and the discrimination that's there for people who wouldn't have the few bucks to do that.”

The vast majority of survey respondents say they do not have a health insurance covering mental health services fully and they have not been offered financial support or discounts to reduce or cover mental healthcare costs. Interviewees confirm that such subsidies are rare and often a one-off, for instance when describing mutual-aid funds. Benefits such as tax relief only benefit people on a decent salary, as an interviewee points out: “You have to obviously pay tax to get it back, and you have to have private healthcare, [which means] you're certainly not on income support. A medical card does not get you anything.”

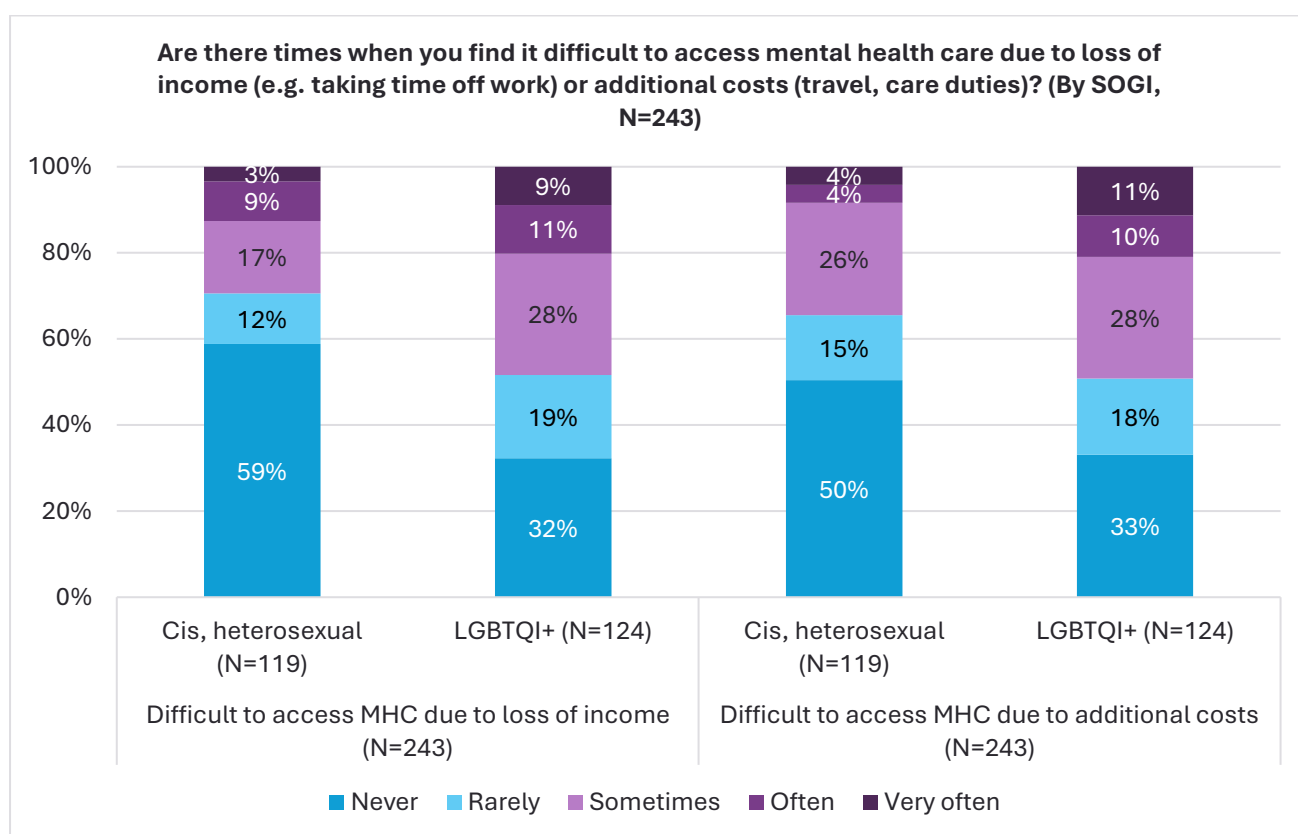
Subsidised options, including sliding-scale fees and low-cost NGO-based counselling, were described as invaluable. One survey respondent said: “The only thing I can afford right now are low-cost options with therapists in training that aren't allowed to prescribe medication or diagnoses, and even that I have secretly not been paying as I should for the past few months, which I feel some shame about.” These low-cost services often have a waiting list, ranging from a few weeks to a couple of months, according to a mental health professional.

Cost is also mentioned frequently in the open-ended answers of the mixed-methods survey, almost always as a reason for interrupting or abandoning care already under way: respondents described cancelling appointments “once a month”, prioritising other essentials over therapy, and pausing therapy entirely “due to a lack of finances”. Financial cost is generally described as a key factor affecting respondents’ ability to keep using mental health services. Similarly, workshop participants noted that being pushed toward unaffordable private care “leads to lower continuity of care”. The quantitative survey further confirms these findings. Almost 50% of LGBTQI+ respondents report they have delayed or avoided mental health care due to cost in the past 12 months, compared to 25% of cisgender, heterosexual respondents.

As Figure 13 in the appendices shows, this disproportionately affects trans respondents, where 65% said they had previously delayed or avoided mental health care for cost-related reasons. This further confirms findings about financial difficulties experienced by the LGBTQI+ population as a whole, with trans people being worst off in Ireland.⁷⁰

Indirect costs such as travel costs or loss of income when having to take time off work to attend therapy also make it more difficult to use mental health supports, especially for LGBTQI+ people. The quantitative survey results show that LGBTQI+ respondents reported increased difficulty in accessing mental health care due to both of these factors. As Figure 7 below shows, almost 50% found it “sometimes”, “often”, or “very often” difficult to access mental health care, compared to only around 30% of cisgender, heterosexual respondents. Interviewees, workshop participants and open-ended survey respondents also confirmed this finding. As a mental health expert said, even if you were able to access free public services, “you have transport costs, you have childcare costs, time off work... the HSE services, they're all free, but accessing them [is not].”

Figure 7 Indirect costs affecting mental health care use, by SOGI



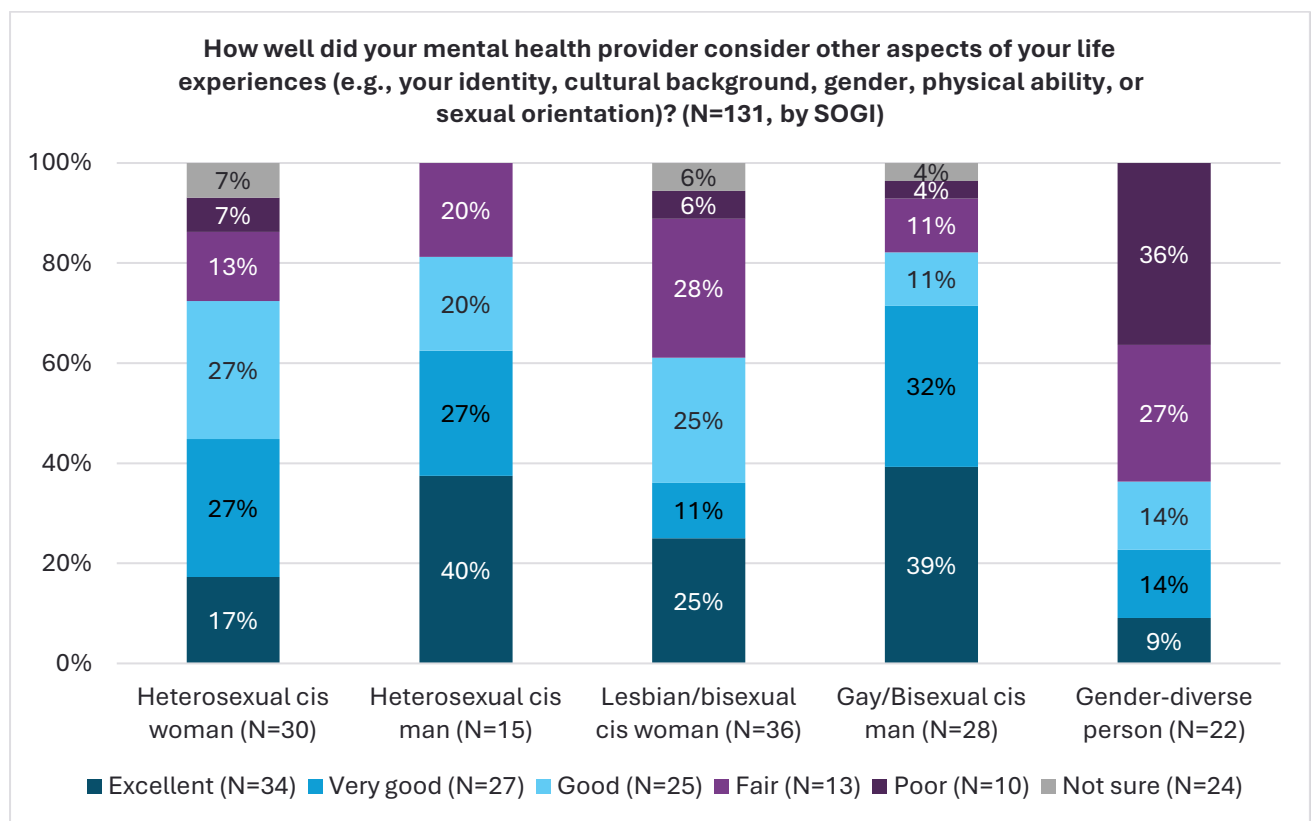
Experiencing LGBTQI+-competent and -inclusive care

For LGBTQI+ people who realised their mental health need, decided to seek out help, identified an available service, and, potentially, were able to pay for it, a remaining question is whether the mental health care they receive will be fully LGBTQI+-inclusive and -competent.

When it comes to the quality-of-care indicators assessed through the quantitative survey, they largely did not reveal a significant difference between LGBTQI+ and cisgender, heterosexual respondents.^{62(pp81-2)} **However, a closer look by sexual orientation and gender identity revealed that the transgender respondents reported the lowest rates of satisfaction**, for instance, under 20% of this group reported “always” being treated with courtesy and respect by their treating mental health professionals, while overall responses range at around 40% (see Figure 14 in the appendices). Trans respondents are also least likely to find their mental health service helpful or relevant, with only around 35% agreeing with this statement “always” or “often”, compared to between 50% to 80% of the other respondents (see Figure 15 in the appendices).

LGBTQI+ respondents overall are slightly less likely to rate providers’ responsiveness to their intersectional needs as “excellent”, “very good”, or “good” when asked how well their mental health provider considers other aspects of their life experiences, including their identity, cultural background, gender, physical ability, or sexual orientation (see Figure 8 below).

Figure 8 Responsiveness to intersectional needs, by SOGI



Trans respondents are less likely than all other groups to rate their provider’s responsiveness positively. Less than 40% of these respondents report these answer options, compared to between 60% and 80% of the other groups, divided by sexual orientation and gender identity. Importantly, 36% of trans respondents explicitly rated their provider’s responsiveness as “poor”, compared to between 0% and 4% of the other groups. Responses to the open-ended

survey further confirm this finding. Trans respondents specifically highlight having to educate their therapist about LGBTQI+ issues, highlighted that therapists had been “homophobic, transphobic, or severely lacking education on non-binary topics”, and describe previous therapists who “had very little understanding of gender and sexuality, and frequently misgendered me, even after I explained my identity multiple times”.

A key reason for the lack of LGBTQI+-competent support experienced by survey respondents might be due to an absence of consistent, standardised training to address gaps in provider knowledge. An interviewee highlighted that to date, there is no standardised or regulated process to train mental health providers in LGBTQI+ needs: “it's self-identified, if you like. So, there's no rigorous process to ascertain [someone is LGBTQI+-friendly] ... it is a kind of self-declaration. I think that's the scary thing about therapy in Ireland, [...] it is still an unregulated area, and the regulations coming in are quite contentious. It's going to be years away.” This is further confirmed by another interviewee talking about LGBTQI+-inclusion training for mental health professionals:

“Where the kind of core training is delivered to mental health professionals, the issues around our community just aren't really spoken about in any great detail, and people then take the little information they may have garnered from the one webinar they do on it, and think, ‘well, now I'm an inclusive practitioner’, with actually no idea of what they're doing, but I do think that needs to be built in. So, if the HSE wants to have an inclusive service, they need to be making sure that they're prioritising training, they need to be allowing people space to do the training and encouraging people to do it and not making it something that's just kind of like an afterthought or something superficial.”

Another suggestion on how mental health providers can help realise the *Sharing the Vision* recommendations was to treat people holistically and “always see a person as an individual, wants and all, [...], and not seeing a person as a set of symptoms – ‘oh, there’s Mary, she’s got depression, she’s gay, she’s this, she’s that... you know, not seeing people as a set of something, but as a person”.

Understanding LGBTQI+ mental health access through the EQUICARES access journey

To better understand LGBTQI+ access to mental health supports in Ireland, this report applied the interdependent, circular structure of the EQUICARES access journey, based on Levesque et al’s access framework.⁵⁶ The short description of the access journey in the previous chapter, Research approach, showed a visual representation of the ideal journey, with each of the five factors positioned to realised equitable access to mental health supports for all. Our findings show that access to mental healthcare is not realised in an equitable way, but rather benefits people with strong connections to LGBTQI+ networks who have the funds to access private services (see Figure 9 below).

People who are dependent on publicly available, free supports, live in isolated areas, and have no pre-existing community links are at a disadvantage. It is less likely that they receive LGBTQI+-inclusive and -competent mental healthcare. Trans people experience particular barriers related to the interplay between access to gender-affirming care and mental health. They are one of the groups most likely to have experienced discrimination and stigma within the general healthcare system and least likely to have trust in healthcare professionals. This can discourage trans people from seeking out mental health support in the first place. Finally, they are also one of the groups within the LGBTQI+ community in Ireland to most likely experience financial hardship and be affected by the ongoing housing crisis,⁷⁰ which may mean that they are disproportionately impacted by direct and indirect costs of mental healthcare.

Figure 9 The findings organised along the EQUICARES access journey



Conclusion

Findings in context

The findings along the EQUICARES access journey describe a mental healthcare system in which people's sexual orientation and gender identity shape access at every angle, but almost always through the mediating factor of money. LGBTQI+ people in Ireland, for the most part, recognise their mental health needs and, as the quantitative survey shows, might even seek support at higher rates than cisgender, heterosexual respondents. Identifying a service that can be trusted to be LGBTQI+-inclusive and -competent, finding such services in the public system and in the locality, and being able to pay to use them often enough and long enough to benefit are the key challenges.

Systematic information and signposting on LGBTQI+-inclusive and -competent services is non-existent. There is no general standard, registry, or consistent referral practice that identifies which services (public or private) are LGBTQI+-competent, so participants rely on recommendations circulating within community networks, and providers rely on informal professional networks of their own. Word of mouth is an effective substitute for people who are already connected to LGBTQI+ community spaces. For those who are not, including people who are not out and people who have recently arrived in Ireland it leaves the search largely to chance. The same mechanism that makes the system navigable for some makes it opaque for others, and it does so along lines that track existing marginalisation.

The lack of a verifiable standard regarding the level of training providers receive to be labelled LGBTQI+-competent also has consequences beyond navigation. Participants consistently distinguished between visible signals of friendliness and demonstrated competence and reported that the burden of closing that gap falls on them, for instance through educating their own providers. LGBTQI+-competency is self-declared. This helps explain the low levels of trust recorded in the quantitative survey, where around 40% of LGBTQI+ respondents considered mental health services trustworthy compared with almost 60% of cisgender, heterosexual respondents, and only 13% of trans respondents. These figures are consistent with the accounts of prior negative experiences reported across the interviews, the open-ended survey responses, and the workshop.

People's ability to pay for mental health supports is a dividing factor. Public provision of mental health services is often capped in the number of sessions, unevenly distributed across the country, largely only available within standard working hours, and centres people with the most severe mental health needs. Where LGBTQI+-competent provision exists publicly, participants have no reliable way of knowing it. This pushes LGBTQI+ people toward private providers, and their ability to pay for these determines whether the access journey is completed, interrupted, or abandoned. Almost 50% of LGBTQI+ respondents reported delaying or avoiding mental healthcare because of cost in the past twelve months, compared to roughly

30% of cisgender, heterosexual respondents, and the open-ended survey questions by LGBTQI+ participants show cost operating as a reason for interrupting or abandoning care.

For trans people, the findings show a worse outlook. Across every indicator, from unmet medical need to cost-related delay to satisfaction with care received, trans participants report the poorest outcomes. In addition, negative experiences of existing public gender-affirming care provision, including the mandatory psychiatric evaluation, works directly against their use of mental health services. Based on personal and community experiences, trans people can fear accessing mental health support. This is of particular concern when the long waiting time to access gender-affirming care in Ireland is itself a source of psychological distress.

The report findings are consistent with earlier research on LGBTQI+ mental health in Ireland, which has repeatedly documented elevated need alongside a shortage of inclusive and culturally competent provision. This study provides a structured account of where in the access journey that shortage becomes decisive: the substitution of informal networks for public information, the absence of any standard against which competence can be assessed, and the particular experiences of trans people. **Each of these is an addressable policy object.**

What we could not cover

This study drew on five data collection methods, with limitations detailed above. Some aspects with more general implications are highlighted here. The survey samples were self-selecting, so the figures describe the people who took part rather than all LGBTQI+ people in Ireland, and the trans responses come from a smaller group (31 out of 243 respondents in the quantitative survey and 7 out of 21 in the mixed-method survey). Many of the participants in the reflective diaries and in the workshop were already connected to LGBTQI+ organisations or community networks, as recruitment was done via our social media channels, flyers and posters in LGBTQI+-friendly spaces, and supported by other LGBTQI+ organisations. This means that people least well-served by word of mouth are also the people we were least likely to reach. What we report about searching for a service without those connections might, in part, come from participants describing others rather than themselves. We also only spoke to a relatively small number of mental health professionals, so what we say about training and provider knowledge reflects how services are experienced, not what most providers themselves might say.

Some experiences within the LGBTQI+ community appear here only at the edges. Intersex people, LGBTQI+ migrants and people in the international protection system, older LGBTQI+ people, Travellers, and disabled and neurodivergent LGBTQI+ people were all described by participants as facing added barriers, but this study was not designed to look at any of them closely. Each deserves dedicated attention.

Where to go next

The gaps in information and in competence are practical problems with actionable solutions. This report indicates that people are not confident or clear in whether providers are LGBTQI+ inclusive, that there are not common standards to provide for this competence or to verify it, and that there are gaps in the availability of information. This challenge leads to multiple solution areas: the need to set and implement a level of LGBTQI+ competent practice; the need to make this competent practice visible and verifiable; and the need to find ways to spread and share information about competent support which is available.

Consistent monitoring and building ongoing understanding of experience is essential. If a standard for LGBTQI+-competent practice is developed it needs to be checked against what people actually experience in the room, not only against whether services have signed up to it. If signposting improves, the test is whether someone with no connection to LGBTQI+ community spaces can find a suitable service. This means that follow-up monitoring and studies focused on these areas are required.

Cost is a significant factor, but additional data is needed. We know that direct and indirect costs interrupt care, but not what LGBTQI+ people in Ireland end up paying over the course of therapy, or what properly resourced public provision would cost against the price of leaving needs unmet. More information on these aspects is needed and would help with assessing where to invest.

Barriers to and enablers of mental health support access go beyond mental health services. Experiences in non-mental health-related healthcare provision can impact mental health support access. Negative experiences generally with healthcare providers can impact LGBTQI+ people's willingness to access and trust in mental healthcare. This is particularly the case for trans people, where challenges with the current public gender affirming care provision are creating knock-on barriers to mental health support: in trust in healthcare services generally, in willingness to use mental health supports, and through mental health distress from waiting times and practice. Recognising these impacts in the design and delivery of other services, such as through the gender model of care currently being developed, is an important opportunity for wider benefit.

Finally, bringing the results to participants, LGBTQI+ organisations and mental health services, and agreeing together which recommendations to work together on first, is the next step and a continuation of the co-production approach the study was built on. This will continue through further stages of this project.

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Appendices

Appendix 1 The theoretical framework: The EQUICARES access journey

To understand whether access to mental health services is realised for LGBTQI+ people in Ireland, we use the EQUICARES access journey concept.^{54,55} It is adapted from the Levesque access to health care framework which combined five supply-side and demand-side factors:^{56,57}

Table 2 The Levesque access to health care framework (2013)

Supply side/service providers are...	Demand side/patients are...
Approachable: Services & related information exist and is known	Able to perceive: Health literacy and trust, knowledge of care needs
Acceptable: Cultural/social fit of the services	Able to seek: Want to autonomously seek out support
Available: Location and opening times are suitable	Able to reach: Can navigate getting there or have adequate support
Affordable: Direct, indirect, and opportunity costs are bearable	Able to pay: Have the financial means to pay or receive support
Appropriate: Quality and adequacy of care, service and need fit	Able to engage: Are empowered and informed to participate

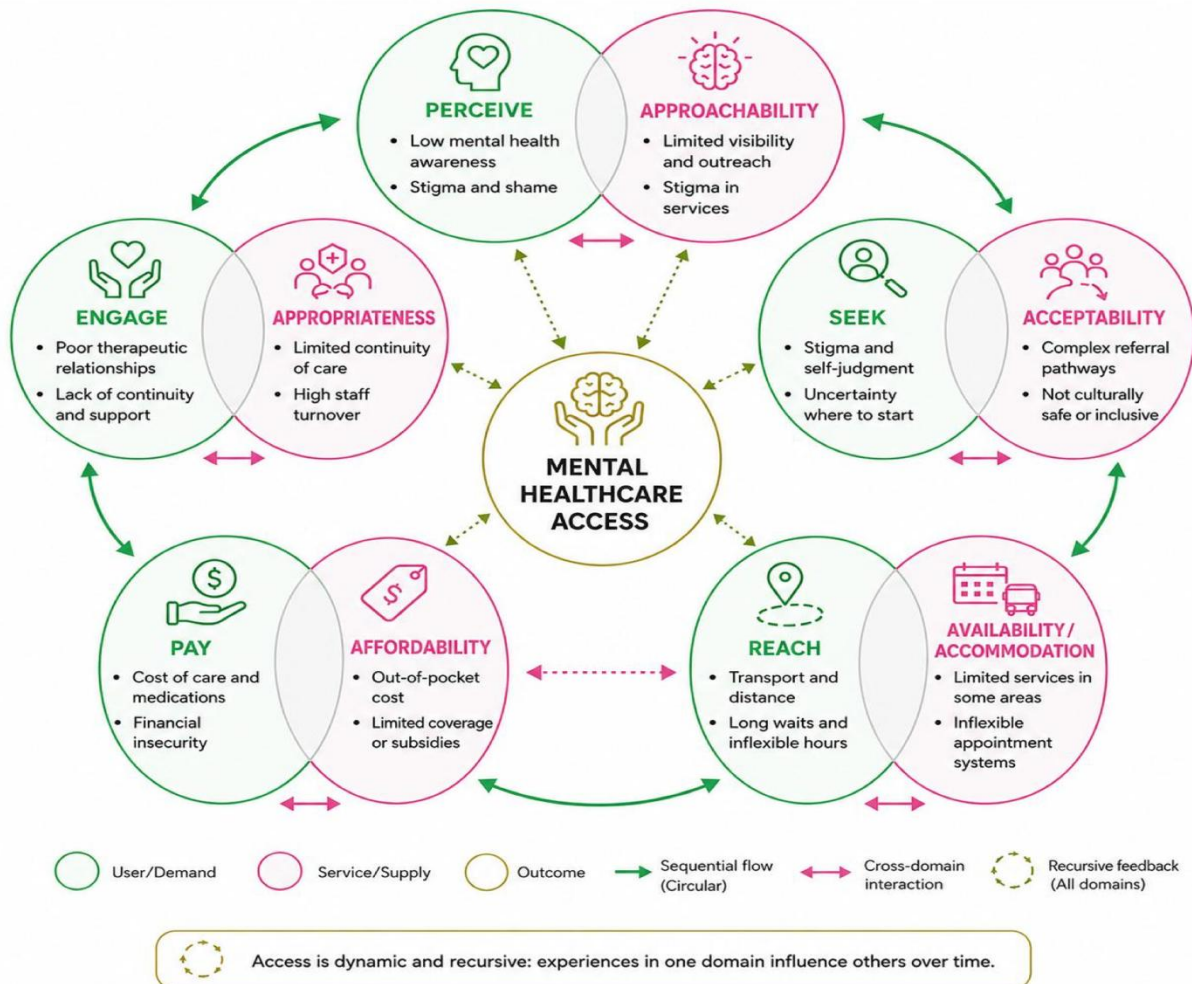
The EQUICARES access journey reframes the Levesque framework from the depicted patient-centred process to a person-centred journey that is co-produced between the person and the system over time. This is needed to include people in vulnerable situations who are not patients yet but might want to become patients. It also helps consider how repeat encounters with the healthcare system shape their access, for instance when experiencing stigma or discrimination.⁵⁴

The EQUICARES access journey also applies Amartya Sen's capability approach^{72,73} to define access as a "capability, a real opportunity, distinct from mere provision and actual use".^{54(p169)} Realised access is not measured by the existence of a service or its usage, but by people's capability to use it, regardless of whether they choose to. This approach helps to understand how different aspects of vulnerability or intersectional forms of discrimination and stigma affect access to a service and to the mental healthcare system as a whole. In the EQUICARES access journey, the Levesque supply-side factors are opportunities that expand or constrain a person's capability, while the demand-side factors are the personal capacities and agency the person uses to convert an opportunity into use. Access only functions when an opportunity exists and the person can convert it into use due to their own capacities and agency.^{54(pp170-1)} This approach helps explain why some people can access a service while others, perhaps in vulnerable situations, might not be able to.

Ensuring equitable access to services for everyone requires services to adjust and compensate for restricted conversion capacity.^{54(p171)} For instance, if information about a service is available online, but only in one language, people who do not understand that language will be unable to identify the service, even if they are willing to seek help. Providing multi-language information can be a solution to this issue. However, this will only compensate for part of potentially missing capacity – if the person does not have the financial

means to pay for the service and no access to support, they might still not be able to access the service. Access is therefore not understood as the linear process above, but as an interacting, circular system of the different supply- and demand-side factors.^{55(p63)} See below for a detailed graphic, designed by Jigsaw for the EQUICARES D1.5 report.

Figure 10 Adapting the Levesque Framework by Jigsaw (Mac Dhonnagáin et al, 2026, p. 63)



Appendix 2 The five data collection and analysis methods

The report is based on findings from five types of data collection methods that created five datasets. Each dataset was analysed separately first and then brought together along the five factors of the EQUICARES access journey. The data collection methods were designed by two different partners within the broader EQUICARES project, Erasmus University Rotterdam (EUR) and Jigsaw. The eight EQUICARES pilot partners, including LGBT Ireland, commented on and validated the different methods. The two research partners first obtained ethics approval by their respective review boards before the eight pilot partners across the seven country contexts adapted the ethics applications to the guidelines of their respective review boards and obtained approval for their specific contexts. LGBT Ireland partnered with Professor Paul D’Alton, School of Psychology, University College Dublin, and obtained ethics approval from the UCD HREC in December 2025 (approval ID: HS-25-97-D’Alton).

Stakeholder interviews

The team at EUR designed the interview guides and related material for the stakeholder interviews, and the researcher at LGBT Ireland was responsible for identifying and contacting stakeholders, scheduling and conducting interviews, and providing anonymised transcripts to EUR via a secure platform.

Between February and March 2026, six semi-structured interviews were conducted by the LGBT Ireland researcher with key experts across four stakeholder categories: mental health services, HSE, LGBTQI+ organisations, and academia.

The interviews were organised along a set of questions following the access journey. Interviewees were identified based on their roles and expertise on healthcare access and LGBTQI+ inclusion and contacted directly by the researcher. Five interviews were conducted using a video chat software (MS Teams) and one was an in-person interview in the office of the interviewee. The interviews ran 45 to 60 minutes and were recorded with the informed consent of the interviewee. Recordings were destroyed after transcription. The transcripts were analysed thematically by the LGBT Ireland researcher. The analysis of all interviews across the eight pilot contexts is available in the broader D4.1 report on the interviews and survey findings published by EUR.⁶²

Quantitative survey

The team at EUR designed the quantitative survey and related material and provided the survey online via the EUR Qualtrics server. The team at LGBT Ireland was responsible for disseminating information about the survey and recruiting participants. Recruitment was carried out digitally via personalised emails to key stakeholders, organisations, and mailing lists, on LGBT Ireland’s social media (Instagram, Facebook, and LinkedIn), with posts being reshared by supporting organisations, and via LGBT Ireland’s website, as well as through using

flyers and posters, distributed in key spaces frequented by LGBTQI+ people in Ireland. By mid-February 2026, the target number of LGBTQI+ participants had been reached, but an insufficient amount of cisgender, heterosexual participants meant that we used an external organisation to assist with the final recruitment of the additional participants needed. These diverging ways of finding out about the survey, one by actively responding to recruitment material targeting LGBTQI+ people in Ireland with previous experiences trying to access mental health supports, and one by being contacted by an organisation to fill in a survey about said experiences, likely means that the LGBTQI+ group and the cisgender, heterosexual group are comparable to a degree.

The quantitative survey with 74 closed multiple choice questions captured respondents' demographic information, standardised measures of general health, mental health, and wellbeing, and their experiences with mental health supports along the different categories of the access journey.

The survey was available online between December 16, 2025, and March 16, 2026. We received 249 complete responses from respondents across the Republic of Ireland, 124 from LGBTQI+ respondents and 119 from cisgender/heterosexual respondents, along with six respondents who did not indicate their sexual orientation and gender identity.⁴ This relatively even split allowed a direct comparison between the LGBTQI+ respondents and their cisgender, heterosexual counterparts on their responses. The Irish data was made available via a secure platform and analysed by the LGBT Ireland researcher using descriptive statistics. An in-depth statistical analysis with significance tests of all survey datasets across the eight pilot contexts is included in the D1.4 report by the EUR team.⁶²

Mixed-method survey

The team at Jigsaw designed the mixed-method survey and related material and provided the survey online via the Jigsaw server. The team at LGBT Ireland was responsible for disseminating information about the survey and recruiting participants.

The mixed-method survey consisted of 44 questions and combined closed multiple-choice questions with open-ended follow-up questions along the five categories of the access journey.

The survey was available online between January and March 2026. Recruitment was targeting LGBTQI+ respondents living in the catchment area of the project (Dublin, Dún Laoghaire-Rathdown, and Wicklow) only. We collected 21 responses from suitable participants. Due to the small sample size, this report only uses data from the open-ended questions which were analysed thematically by the LGBT Ireland researcher. Jigsaw provided an in-depth analysis of all survey responses across the eight pilot contexts in the D1.5 report.^{55,63}

⁴ See Appendix 3 Demographic overview of the quantitative survey participants for more details on the participants.

Reflective diaries

The team at Jigsaw designed the reflective diary questions and related material and provided the diary online via the Jigsaw server. The team at LGBT Ireland was responsible for disseminating information about the diary and recruiting participants.

In February 2026, two participants living in the catchment area completed in-depth reflective diaries covering their mental health care journeys. These were available online via the Jigsaw server or completed as part of a qualitative interview with the LGBT Ireland research. The data was analysed by the Jigsaw research team using Interpretative Phenomenological Analysis (IPA)⁵¹. IPA focuses on small samples to go in-depth into the experiences of some individuals to surface fine-grained, sequential details of interconnected events. These insights into the experiences of two LGBTQI+ people in Ireland are used to complement the survey findings along the access journey. Jigsaw provided an in-depth analysis of all survey responses across the eight pilot contexts in the D1.5 report.

Co-creation workshop

As part of the EQUICARES project, each pilot partner was responsible to organise and facilitate a co-creation workshop with local people who are part of the respective target population as well as mental health experts. The workshop guidelines and related material was prepared by White Research, EQUICARES Project Lead partner, and adapted by each pilot partner to the local contexts.

In July 2026, LGBT Ireland organised and facilitated a co-creation workshop in Dún Laoghaire. 22 LGBTQI+ community members, mental health professionals working with LGBTQI+ people, and representatives of LGBTQI+ and mental health support organisations came together to discuss access barriers at the individual, family, provider, service, system, and societal levels; map existing services across public, private, NGO, and peer/informal provision; identify service gaps; and develop priority areas for future research and support practice. These different insights were documented using post-it notes and posters, photographed and digitised by the LGBT Ireland researcher. The workshop provided community-level insights and validated whether findings emerging from the other four methods were confirmed by LGBTQI+ community members and mental health professionals working with LGBTQI+ people.

Data integration

Rather than reporting on each dataset and the results separately, the findings in this report were organised around the EQUICARES access journey. This allowed us to combine the insights from the different datasets and let them speak to each other directly: for example, long waiting times raised by a diary respondent also appeared, unprompted, in the workshop's priorities areas and in the survey responses. This combination allowed for data triangulation and showed consistency across findings from all five data collection methods.

High-level overviews of the quantitative survey findings were presented to the LGBT Ireland EQUICARES advisory group in May 2026 and at the 5th annual LGBT Ireland Pride Health Conference at Royal College of Surgeons in Ireland (RCSI) in June 2026. A broader overview of the findings along the access journey was presented at the biannual conference of the European Society of Health and Medical Sociology in August 2026. The reactions and discussions were helpful to structure the findings for this report.

Ethics and anonymity

All participants in this study received a detailed briefing about the EQUICARES project, the research protocol, and the ways in which collected data is used, managed and stored. They all provided informed consent to their participation in line with the requirements of the UCD ethics approval process.

All quotations in this report have been reviewed to remove or generalise identifying detail. Locations, service names, and other specifics have been altered or omitted. Interview and diary excerpts are attributed only by broad role of the participant or data collection method rather than by name. This report prioritises anonymity of the research participants to ensure their safety and avoid any risks of identification.

Appendix 3 Demographic overview of the quantitative survey participants

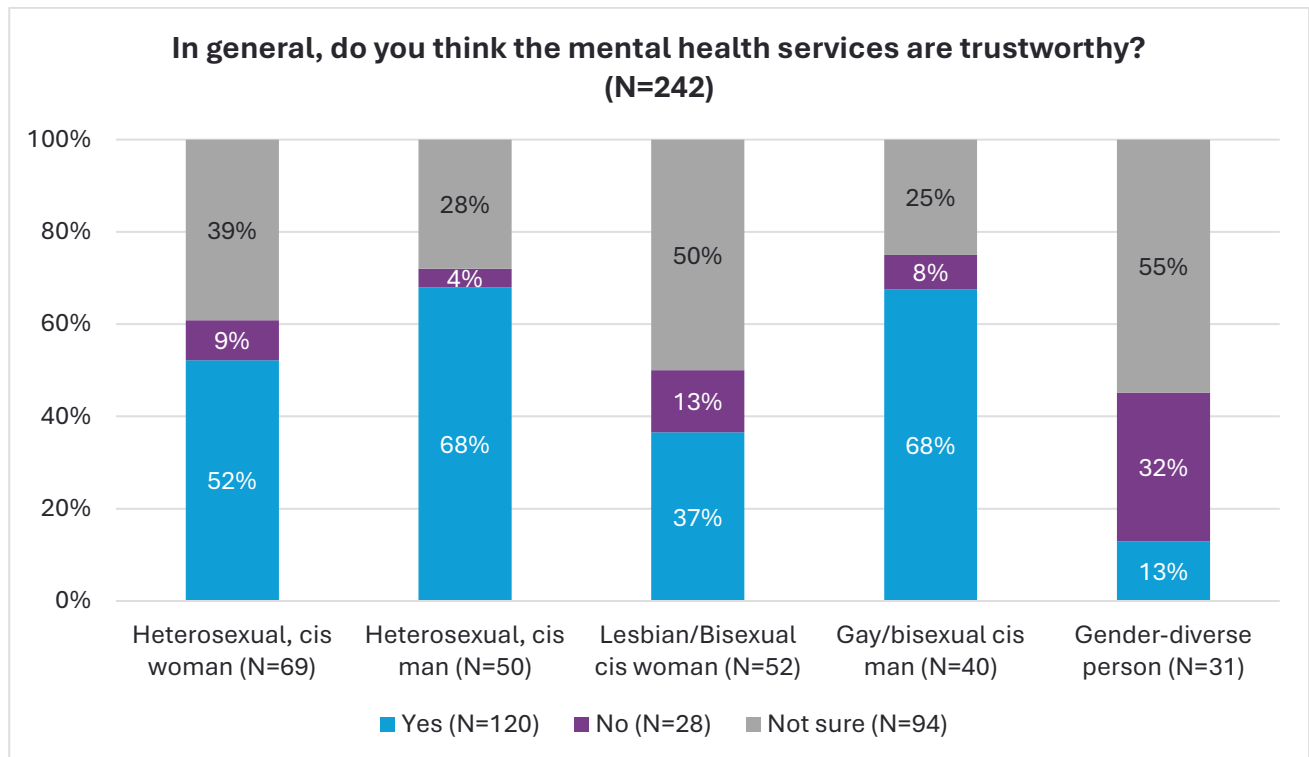
Table 3 Demographic overview of participants, quantitative survey

Demographic overview of the participants (N=249)				
Gender identity and sexual orientation (N=249)		Born in... (N=249)		Citizen of... (N=249)
LGBTQI+	49% (n=124)	Ireland	71% (n=177)	82% (n=204)
Cisgender, L/B woman	21% (n=53)	EU	8% (n=20)	6% (n=15)
Cisgender, G/B man	16% (n=40)	NI/UK	8% (n=20)	2% (n=6)
Trans person	12% (n=31)	Non-EU	13% (n=32)	10% (n=24)
Cisgender, heterosexual	48% (n=119)			
Cisgender hetero woman	28% (n=69)			
Cisgender, hetero man	20% (n=50)			
NA	2% (n=6)			
Age groups	Total (N=249)	LGBTQI+ (N=124)		Cisgender, heterosexual (N=119)
<21	3% (n=8)	5% (n=6)		2% (n=2)
21-29	16% (n=40)	21% (n=26)		12% (n=14)
30-39	28% (n=70)	36% (n=44)		22% (n=26)
40-49	26% (n=65)	25% (n=31)		25% (n=30)
50-59	12% (n=31)	8% (n=10)		16% (n=19)
60-69	9% (n=22)	4% (n=5)		14% (n=17)
70+	5% (n=13)	2% (n=2)		9% (n=11)
Education level	Total (N=248)	LGBTQI+ (N=124)		Cisgender, heterosexual (N=118)
Secondary school	16% (n=39)	7% (n=9)		25% (n=29)
Short certificate/third-level	22% (n=54)	21% (n=26)		21% (n=25)
At least a Bachelor's degree	63% (n=155)	72% (n=89)		54% (n=64)

Appendix 4 Figures

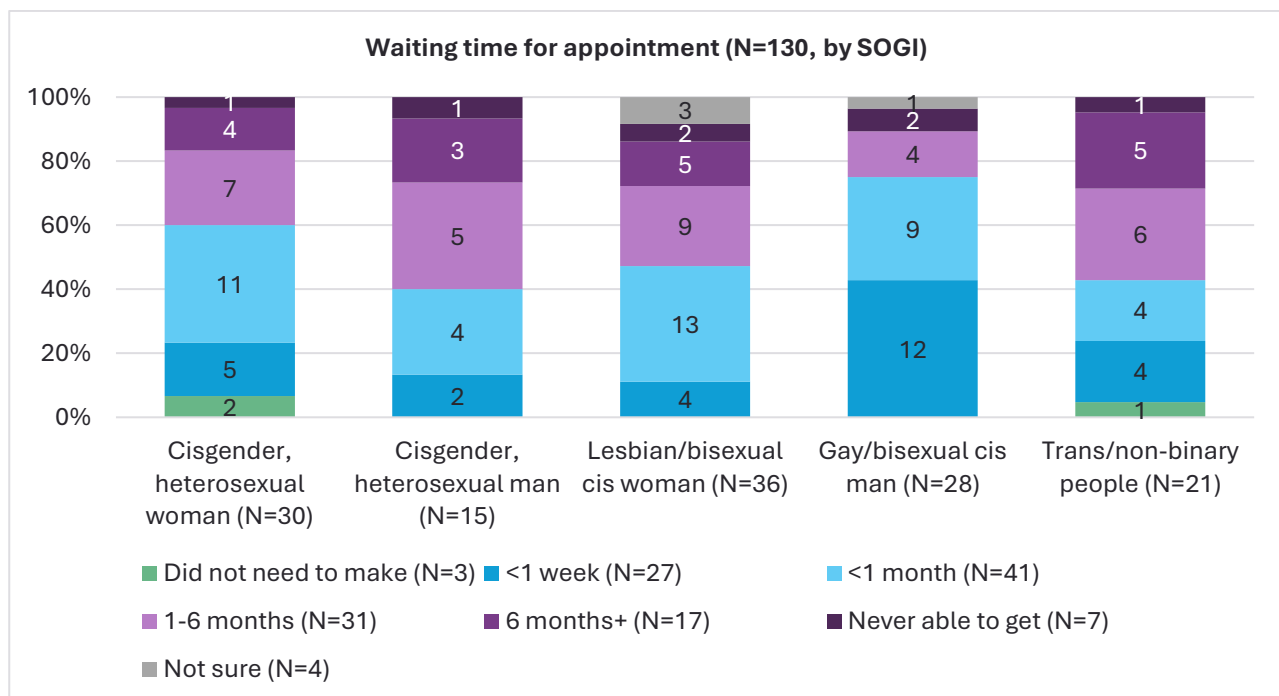
Disaggregated figure trust in mental health services

Figure 11 Trust in mental health services, disaggregated by SOGI



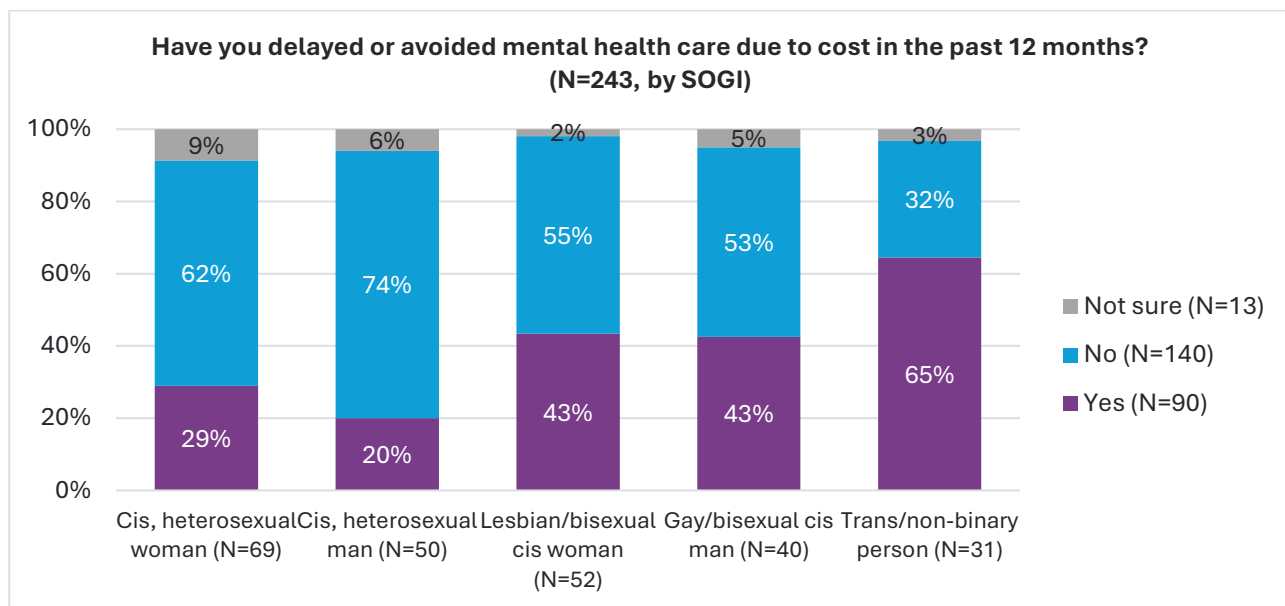
Waiting time for appointment, disaggregated by SOGI

Figure 12 Waiting time for appointment, by SOGI



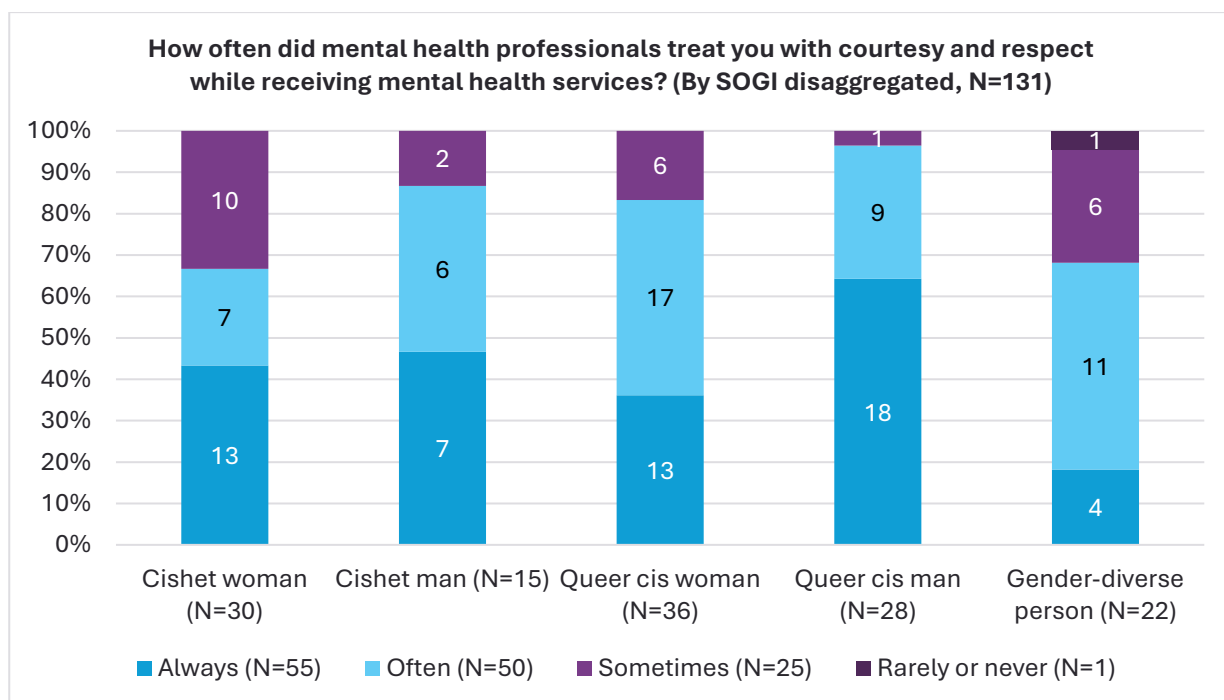
Delayed or avoided mental health care, by SOGI

Figure 13 Delayed or avoided mental health care, by SOGI



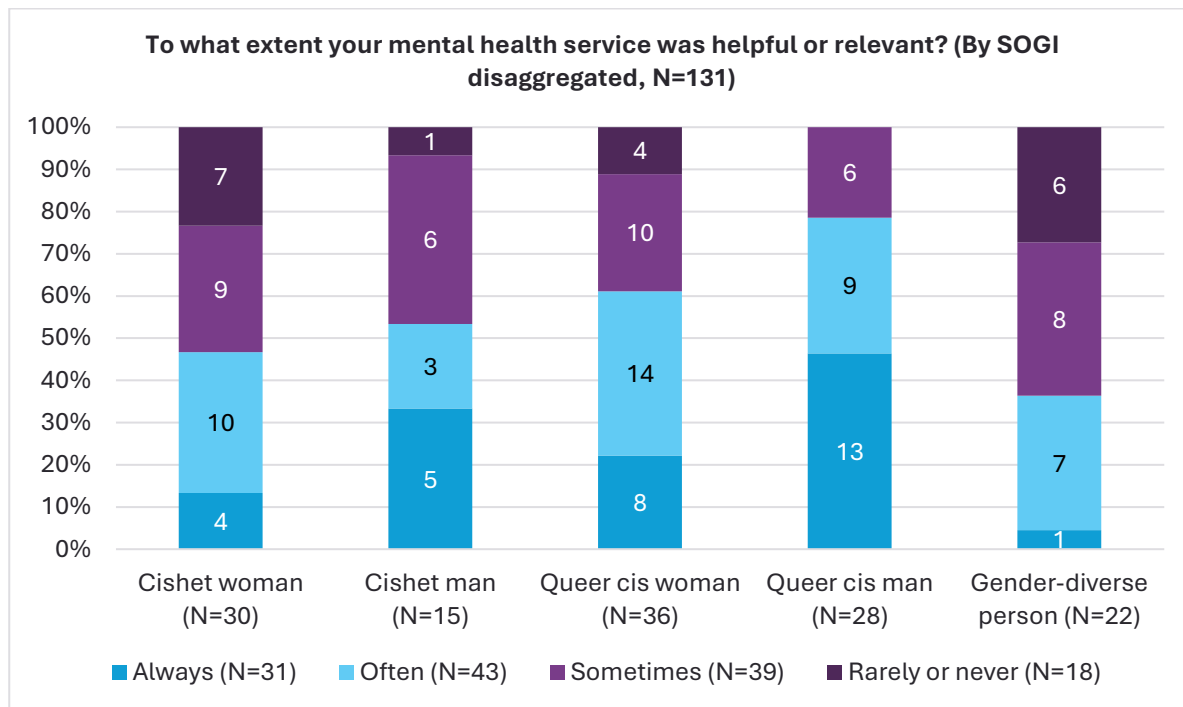
Being treated with courtesy and respect by mental health professionals, by SOGI

Figure 14 Being treated with courtesy and respect, by SOGI



Mental health service helpful or relevant, by SOGI

Figure 15 Mental health service helpful or relevant, by SOGI



Appendix 5: List of free mental health crisis support offers in Ireland

Local Mental Health Support Services

- National LGBT Helpline: Freephone 1800 929 539 or online chat on www.lgbt.ie
- Samaritans on Freephone: 116 123, Email: jo@samaritans.ie, Website: samaritans.ie
- Pieta House (Self-Harm/Suicide Support) Freephone: 1800 247 247, Website: www.pieta.ie
- Childline telephone service, 24/7, Freephone: 1800 66 66 66, Website: www.childline.ie
- Teenline, telephone service, 24/7, Freephone: 1800 833 634, Website: www.teenline.ie
- Aware (Depression) Freephone: 1800 80 48 48, Website: www.aware.ie
- Bereavement Support Line: 1800 80 70 77
- Bodywhys (Eating Disorders): www.bodywhys.ie
- Alcoholics Anonymous, Website: www.alcoholicsanonymous.ie
- Drugs/HIV Helpline telephone service, Freephone: 1800 459 459, Website: www.hse.ie/drugshivhelpline
- Rape Crisis Network Ireland telephone service 24/7, Freephone: 1800 77 88 88, Website: www.rapecrisishelp.ie
- Text About It, free service 24/7, Free text: HELLO to 50808, Website: textaboutit.ie
- Turn2me online support, available 24/7, Website: www.turn2me.ie

Emergency Support (If someone is at immediate risk)

NATIONAL EMERGENCY LINE 112

NOTES

