Queer Finds:
Peer-led Research to Improve Mental Health Support in Lambeth and Southwark

Executive Summary

Queer Finds: Peer-led Research to Improve Mental Health Support in Lambeth and Southwark explores the experiences of LGBTQIA+ residents of Lambeth and Southwark accessing or attempting to access mental health support. It was funded by Impact on Urban Health, delivered through the Health and Social Equity Collective.

Context

LGBTQIA+ individuals experience disproportionately high rates of mental health problems. This is especially pronounced for trans and non-binary people facing widespread transphobia, and Black people and those from other minoritised ethnicities facing racism and anti-LGBTQIA+ discrimination within LGBTQIA+ spaces.

Methodology

This study followed a participatory methodology through which peer researchers ensured the process was rooted in lived experience, employing a mixed-methods approach consisting of peer-led interviews; two focus group discussions (including a dedicated session for Black participants); and a wider online survey.

Key findings

While there are pockets of effective and affirming practice, many participants described persistent transphobia and the invisibility of Black LGBTQIA+ people within services, leading to mistrust, avoidance, and poorer outcomes.

Addressing these harms must be the priority, alongside scaling what works (including, for example, peer-led support, co-designed services and dedicated LGBTQIA+ clinics) framed around active listening, respect for diverse gender identities and sexual orientations, and personalised culturally nuanced care.

Key recommendations

- Include LGBTQIA+ communities directly in policy development and service design, delivery and evaluation. Compensate them for their time.
- Improve structures and functions through trainings requirements for NHS staff; better data collection and use; and enforced policies with clear complaint pathways.
- Improve services and pathways with inclusive practices; targeted trans and culturally-competent support; routes for patients to request LGBTQIA+ practitioners; and safe access to toilets and changing rooms for trans and non-binary people.
- Fund community and grassroots provision (including LGBTQIA+ peer support) and build links and pathways between these services.

Conclusion

We highlight community-driven solutions for improving mental health support for LGBTQIA+ individuals. Our findings show a need to make changes across multiple themes: provider training, data collection and use, policy, service design and delivery, and partnership working. Services should centre lived experience, invest in inclusive practices, and build strong partnerships across statutory and community services.

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Context

Being lesbian, gay, bisexual, transgender, queer, intersex, asexual and/or another minoritised sexuality or gender (LGBTQIA+) does not cause mental health problems, but LGBTQIA+ individuals in the UK face high rates of mental health challenges compared to non-LGBTQIA+ individuals. Mental wellbeing is harmed by the chronic stress of stigma and discrimination[1], social exclusion[2], and shortcomings in health service provision.[3]

Mental health disparities arise within the LGBTQIA+ community, with trans people and/or LGBTQIA+ people from minoritised ethnicities experiencing poor mental health most frequently. 46% of trans people in Britain reported suicidal thoughts in a one-year period. 51% of LGBTQIA+ people from minoritised ethnicities reported racism from other LGBTQIA+ people[4], in addition to potential homophobia or transphobia from other communities. Transgender people of colour are particularly vulnerable.[5]

Barriers to accessing adequate mental health services must be understood to be overcome. 14% of LGBTQIA+ people reported avoiding needed treatment out of fear of discrimination against their sexuality or gender.[6] This fear is rooted in reality: a UK cohort (13%) had experienced unequal treatment from staff because they were LGBTQIA+.[7]

Trans people frequently report feeling unwelcome or unsafe in health settings. 10% of LGBTQIA+ people surveyed said NHS staff had "outed" them without consent, whereas almost three times as many trans people (27%) had had been outed by a professional.[8] 14% of trans respondents in the UK reported being refused GP care because they were trans, and 70% experienced transphobia from their GP.[9] 37% of trans people avoided needed healthcare due to fear of discrimination.[10]

Additionally, mental health care often lacks culturally competent services that understand the needs of LGBTQIA+ people of colour.[11] In some studies LGBTQIA+ individuals from minoritised ethnicities reported that counsellors did not understand the racial aspect of their experiences.[12] A systematic review of queer people of colour's experiences in mental health care found common themes of feeling unseen or stereotyped.[13]

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[1] Hatzenbuehler, M. L., and Pachankis, J. E. (2016). Stigma and minority stress as social determinants of health among LGBT youth: Research evidence and clinical implications. *Pediatric Clinics*, 63(6), 985-997.

[2] Takács, J. (2006). *Social exclusion of young LGBT people in Europe*. Brussels, Belgium: ILGA Europe.

[3] Frost, David M., and Ilan H. Meyer. Minority stress theory: Application, critique, and continued relevance. *Current opinion in psychology* 51 (2023): 101579.

[4] Stonewall. (2018). *LGBT in Britain: Health Report*. London: Stonewall.

[5] Sherman, A. D., et al. (2022). Transgender and gender diverse community connection, help-seeking, and mental health among Black transgender women who have survived violence: A mixed-methods analysis. *Violence against women, 28*(3-4), 890-921.

[6] Government Equalities Office (GEO). (2018). *National LGBT Survey: Summary Report*. UK Government.

[7] Stonewall. (2018). *LGBT in Britain: Health Report*. London: Stonewall.

[8] Ibid.

[9] TransActual. (2021). Trans lives survey 2021. Retrieved from: https://transactual.org.uk/trans-lives-21/

[10] Stonewall. (2018). *LGBT in Britain: Health Report*. London: Stonewall.

[11] Dominguez, M. L. (2017). LGBTQIA people of color: Utilizing the cultural psychology model as a guide for the mental health assessment and treatment of patients with diverse identities. *Journal of Gay & Lesbian Mental Health*, *21*(3), 203-220.

[12] Griffith, T. Y. (2022). *Intersectional Invisibility of Black LGBTQIA+ Client Strategies for Bias and Discrimination Prevention* (Doctoral dissertation, Walden University).

[13] Dawes, H. C., et al. (2023). Experiences of queer people of color in mental health care and substance use treatment: A systematic review. *Journal of the Society for Social Work and Research*, *14*(3), 721-755.

Methodology

Queer Finds: Peer-led Research to Improve Mental Health Support was designed to explore the experiences of LGBTQIA+ individuals living in Lambeth and Southwark who accessed or attempted to access mental health services in the past two years. Research aims included documenting their lived experiences; identifying key barriers; highlighting examples of good practice and community-based solutions; and co-producing practical recommendations to inform improvements to mental health services.

Research Design

A mixed-methods approach, combining qualitative and quantitative tools, was used to allow participants flexibility in how they shared their experiences, to reach a broad cross-section of the community, and to generate in-depth, nuanced data. Central to the methodology was working with peer researchers– LGBTQIA+ individuals with lived experience of mental health challenges, and a working group of relevant professionals.

Sampling and recruitment

Efforts were made to centre the voices of trans, non-binary, and Black LGBTQIA+ people. Recruitment used a mix of word of mouth, social media, local LGBTQIA+ groups, and outreach through local voluntary and community sector partners. Participation was entirely voluntary and participants could withdraw at any stage. Only those who identified as LGBTQIA+, aged 18+, and were residents of Lambeth or Southwark were eligible to participate

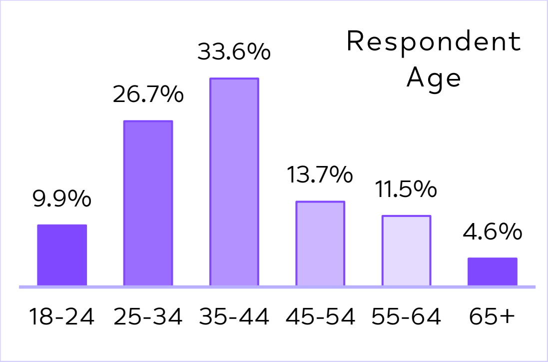
Data collection

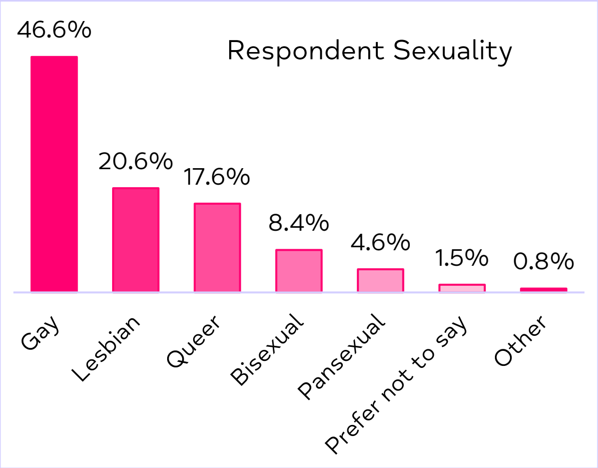
Data collection took place through three key methods:

- One to one interviews: 9 stakeholders and 11 service users were interviewed by two peer researchers.
- Focus group discussions: two-hour group sessions were facilitated by members of the target group. This includes:
  - A Black LGBTQIA+ session with four participants.
  - An open LGBTQIA+ session with three participants.
  - A third, planned, trans and non-binary session was unable to take place. An initial attempt to run the session online was cancelled due to a high number of fraudulent/bot sign-ups. When rescheduled in-person, two people registered but neither attended. To address this gap, insights were gathered from one-to-one interviews and survey responses with trans and non-binary participants.
- Online survey: 131 respondents answered a mix of open and closed questions, allowing participants to describe experiences in their own words while also providing quantitative context.

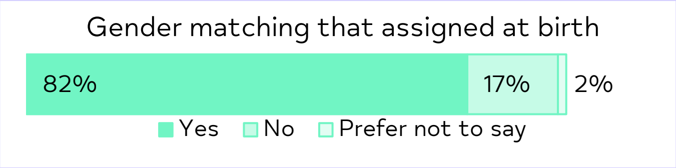
Sample demographics

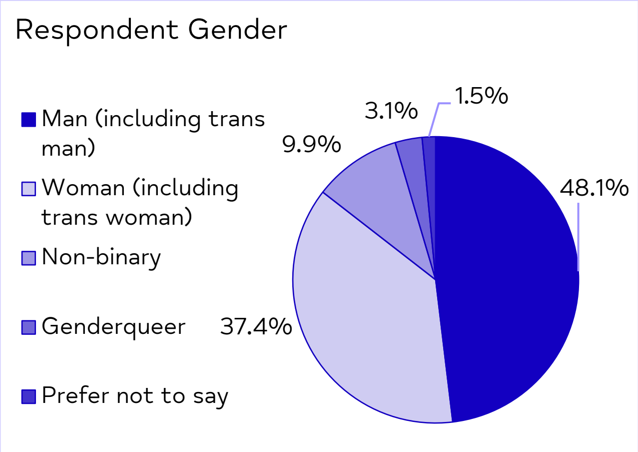
Most survey respondents (>60%) were aged 25–44. The largest group were aged 35–44 (33.59%, n = 44), followed closely by those aged 25–34 (26.72%, n = 35). Younger adults aged 18–24 were least represented (9.92%, n = 13). Those aged 55–64 made up 11.45% (n = 15). The 45–54 age group was modestly represented (13.74%, n = 18).





The most common sexual orientation was Gay (46.56%, n = 61), followed by Lesbian (20.61%, n = 27). Queer people accounted for 17.6% (n=23). Bisexual people made up 8.40% (n = 11), with 4.58% (n = 6) Pansexual respondents. Only 0.76% (n = 1) selected Other, and there were no heterosexuals in the dataset.

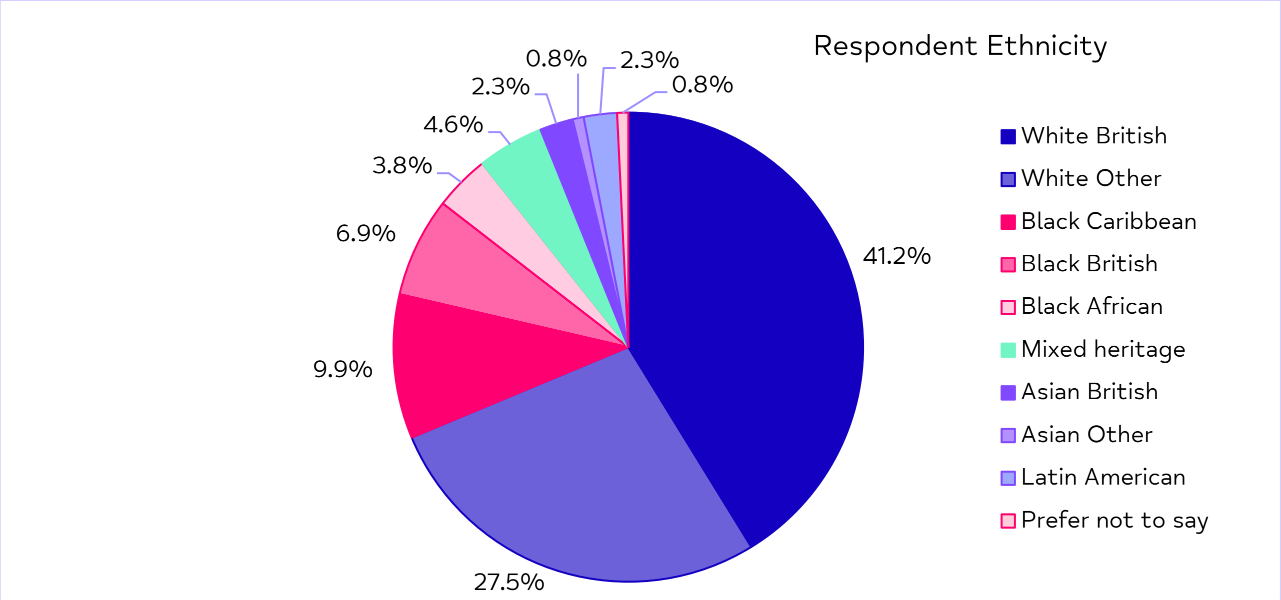




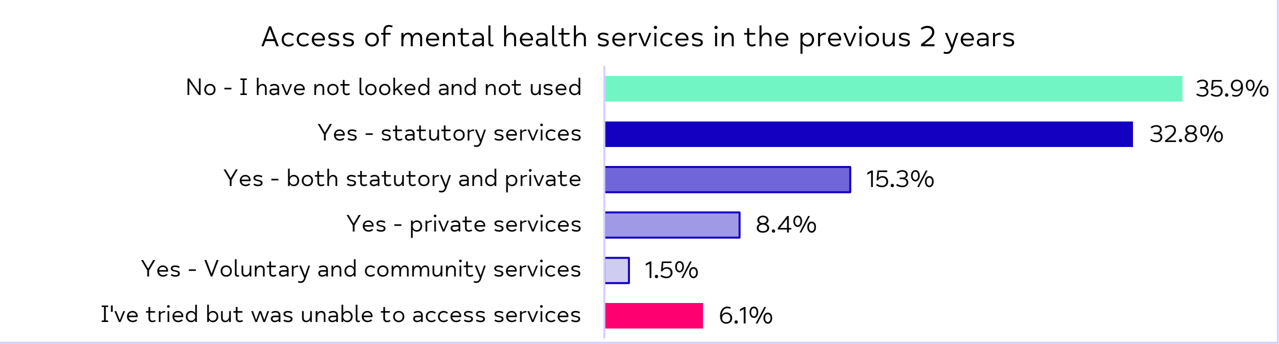
When asked whether their gender identity was the same as the gender they were assigned at birth, a majority of participants (81.68%, n = 107) answered "Yes." A notable minority (16.79%, n = 22) said “no”, and a small group (1.53%, n = 2) preferred not to answer.

Man (inc. trans man) was the most frequently selected gender (48.09%, n = 63), followed by Woman (inc. trans woman) at 37.40% (n = 49). A meaningful proportion identified as Non-binary or Genderqueer (12.97%, n = 17).

The ethnic composition of the sample was heavily White British / White Other (68.68%, n=90). Black Caribbean individuals represented 9.92% (n = 13), and Black British made up 6.87% (n = 9), while Black African respondents were 3.82% (n = 5). Other ethnic categories accounted for smaller proportions individually, none exceeding 3%, apart from mixed heritage participants (4.58%, n = 6).



Most survey respondents (64.13%) indicated that they had interacted with mental health services in the past two years. 32.82% (n = 43) accessed statutory services such as NHS Talking Therapies, and 15.27% (n = 20) used both statutory and private services. A smaller portion (8.40%, n = 11) used private services. Notably, 6.11% (n = 8) attempted accessing support but were unable to do so, indicating systemic or structural barriers. A significant group (35.88%, n = 47) had not looked for or used mental health services.



Sample limitations

The survey primarily engaged working-age adults. Some gender-diverse people responded to the survey but most respondents had binary gender identities. There were no heterosexual respondents. While we cannot say for certain why trans and non-binary people did not engage in a focus group, it is possible that the current hostile climate towards trans people contributed to lower levels of engagement despite outreach through trusted networks.

At 68.7% white, the sample is more heavily white than the general populations of Lambeth (55% white) or Southwark (51% white).[14] Within minoritised ethnicities, the sample is not fully representative of the demographic diversity typically found in Lambeth and Southwark, particularly in terms of Asian and Latin American communities.

Ethics and consent

The project followed robust ethical guidelines to ensure the safety, confidentiality and dignity of all participants. Peer researchers received training in safeguarding, confidentiality, and trauma-informed facilitation. All participants received clear information about the study and gave informed consent before taking part. Participants in one-to-one interviews and focus group discussions received £10 vouchers to compensate them for their time.

Co-production and analysis

The research team worked together to analyse transcripts and survey data thematically. Draft findings and emerging recommendations were sense-checked with all the research participants and the working group of experts, which met once a month, to ensure they would be useful in practice.

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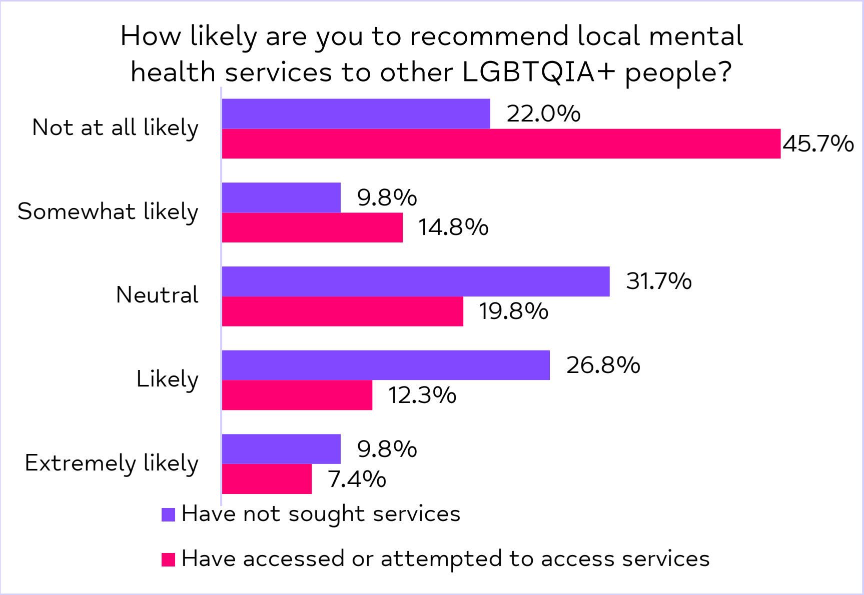
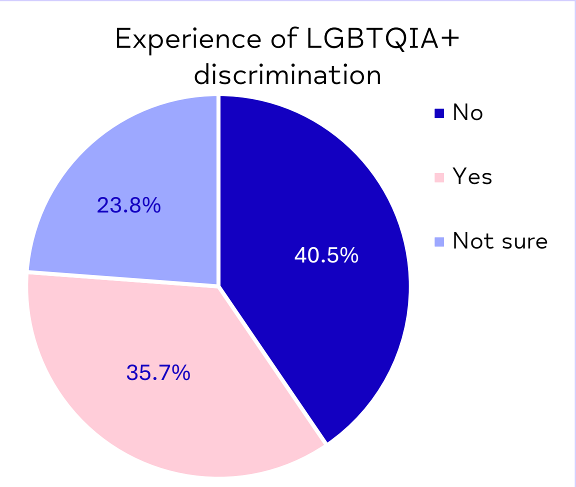
[14] ONS Census (2021)

Recommendations

Participants strongly identified the need for change. When asked how likely they were to recommend local mental health services to other LGBTQIA+ people, there was a clear difference between those who had accessed or attempted to access local mental health services, and those who had not (and so were responding solely based on perception).



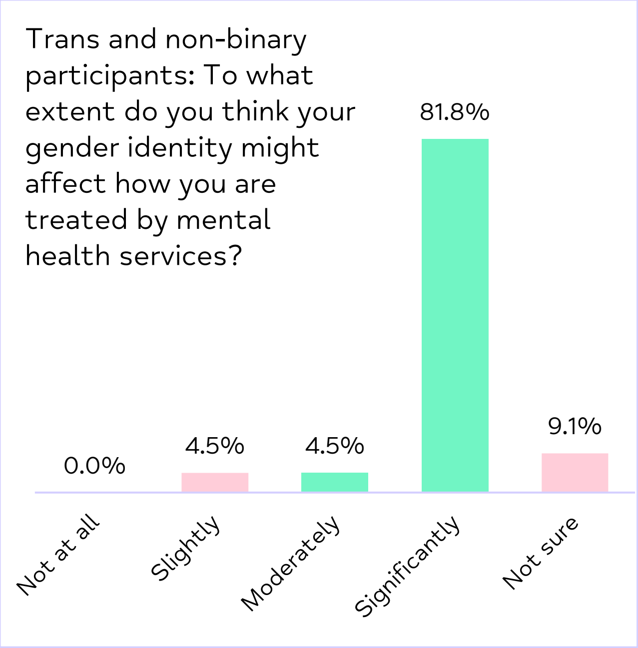
Almost half (45.7%, n=37) of people who interacted with services chose “Not at all likely”. Comparatively, people with no direct experience had a much more positive view, selecting the most negative option at less than half the frequency (22.0%, n=9). They also selected “Likely” more than twice as frequently (26.8%, n=11) as their peers with experience of services (12.3%, n=10).



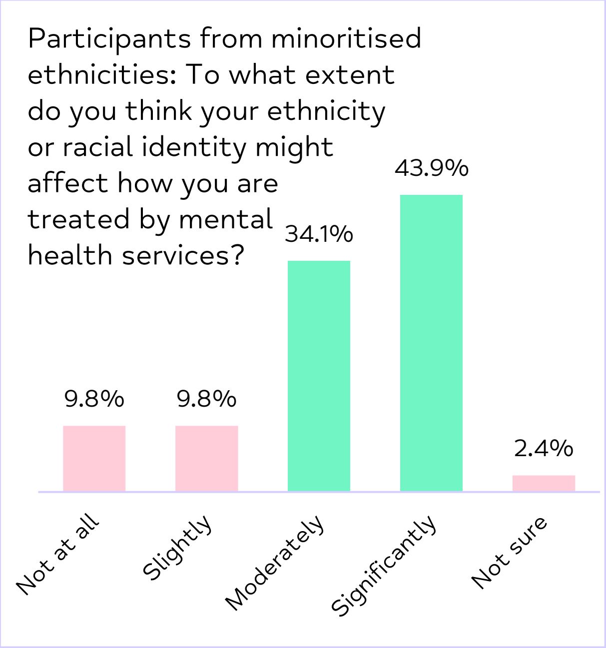
Fewer than half (40.48%, n=34) of respondents said they had not experienced discrimination from mental health providers related to LGBTQIA+ identity, while 35.71% (n = 30) reported that they had. One asked her GP directly whether he was accepting of LGBTQIA+ people, to which *“he said he’ll work with everyone but he doesn’t approve of it.”* Meanwhile, 23.81% (n = 20) were not sure, which may reflect ambiguous experiences and microaggressions.

Marginalised voices within the LGBTQIA+ community had additional barriers. 81.8% of trans and non-binary participants who have accessed or tried to access mental health services (n=18) believed their gender identity “significantly” affected how they are treated. 4.5% (n=1) felt it affected them “moderately”, and another 4.5% (n=1) felt the effect was only slight. A small portion (9.1%) (n=2) were unsure about the impact. No participant indicated that gender identity had no effect at all, a striking finding.

Almost half (43.9%, n=18) of participants from minoritised ethnicities believed their ethnicity or racial identity affected their treatment “significantly”, while 34.1% (n=14) thought it affected them “moderately”. A small minority (9.8%, n=4) felt their identity has no impact at all and an equal amount felt it has only a slight effect. Concerns about gender discrimination, transphobia, cultural misunderstandings, bias, and discrimination were rooted in the reality of people’s experiences.



Trans and non-binary participants: To what extent do you think your gender identity might affect how you are treated by mental health services?



Participants from minoritised ethnicities: To what extent do you think your ethnicity or racial identity might affect how you are treated by mental health services?

Using feedback from interviews, surveys, focus groups and the working group, the following sections identify a set of recommendations for service providers, policymakers, stakeholders and others involved in mental health services.

Training

1. Incorporate intersectional thinking into mandatory staff training curricula with in-depth, role-sensitive sessions.
2. Partner with LGBTQIA+ organisations for training.

Lack of comprehensive, role-sensitive LGBTQIA+ understanding was one of the most consistently raised areas for improvement. Participants called for training that is mandatory, regularly updated, and co-produced with LGBTQIA+ communities. Those working within the mental health systems agreed that there is often no knowledge or understanding at all: *"We desperately need training, LGBTQ+ 101, back to basics... I've been in meetings where people don't understand the difference between sex, gender identity and sexual orientation. That's fairly simple stuff."*

Another said, *"Unless [LGBTQIA+ training] is made a compulsory part, they're not gonna know what they should or shouldn't be doing."* Compulsory training was echoed by the working group. Professionals in the NHS and Public Health services noted that staff often struggle to prioritise 'extra' trainings and agreed that making LGBTQIA+ training part of continued professional development requirements would provide protected learning time to achieve this.

Organisations often devalue trainings that are seen as optional. As an NHS stakeholder explained, *"The trust used to offer trans and non-binary inclusion training... [now] HR would always just say that there's no budget for this."* The persistent de-prioritisation of LGBTQIA+ training means frontline staff continue without essential skills, perpetuating gaps in competent care. Another added, *"Training needs to be targeted and relevant to people's roles."* For example, administrative staff may need to understand inputting pronouns in digital records, while crisis workers may need tools to support LGBTQIA+ people experiencing acute distress.

Participants repeatedly emphasised that LGBTQIA+ identities cannot be understood in isolation from other axes of marginalisation. One respondent was direct: *"Intersectionality needs to be more than just a buzzword so stop using it if you don't know how to 'action' it* *please."* A gay Latino man living with HIV explained that a Spanish-language, culturally specific service *"didn't have the LGBT awareness"*. Conversely, his HIV clinic understood sexuality and HIV but not *"the impact of growing up in a Latin American country."* Other participants echoed a *"lack of understanding of my background"* or *"no knowledge about what it means to be Black and religious [and LGBTQIA+]."* The impact of constantly having to educate practitioners was significant: *"it takes a lot of time, a lot of energy… it becomes quite emotionally draining, especially when it's sensitive topics"*. This then detracts from their support.

Many participants stressed the importance of lived experience, recommending *"training co-designed with us"* and using *"real-life case studies of LGBTQ+ individuals of colour"*. Respondents identified multiple areas where training should be more specific and actionable, including *"trauma-informed care for queer communities,"* understanding *"[trans healthcare] within the NHS,"* and awareness of *"cybersex, the internet and parties"* in the context of queer experiences. General training is not sufficient – clinicians need to engage deeply with the nuances that shape risk, resilience, and help-seeking behaviours for LGBTQIA+ people.

Data

3. Collect, analyse, and act on sexual orientation and gender identity data, using inclusive options.
4. Emphasise confidentiality policies, particularly to youth or those in tight-knit ethnic communities.

Without meaningful data, LGBTQIA+ people remain invisible in systems that rely on metrics to drive change. Inclusive data practices paired with clear accountability mechanisms are essential for identifying disparities, informing interventions, and evaluating progress. One contributor described the current state of data collection bluntly, stating that they had *"90% non-disclosure"* of sexuality / gender identity data. Data must also be disaggregated to expose inequalities. Normalising collecting this information is an inclusive practice that can identify disparities.

A 62-year-old gay man noted, *"I don't think [my sexuality] ever cropped up"*, making him *"feel invisible"* in treatment. Others echoed that services rarely proactively inquire about sexuality or gender identity, and don't use the information when it is collected. A pansexual woman observed that *"no one has ever asked me if I need something LGBTQ+ specific"*. Formal accountability and governance structures are needed, such as regular reviews of LGBTQIA+ data with named leadership responsibility. LGBTQIA+ staff networks or community partners could have access to this data to meaningfully co-produce solutions.

Finally, some participants feared accessing services in case it forced them to disclose their sexual orientation/gender identity when they were not ready (for example, pressure to share pronouns in a group, or worrying about confidentiality when using interpreters from their community). Services can address this by allowing anonymity in initial contacts, clarifying confidentiality policies, and letting service users guide how much personal information is shared and with whom.

Policies

5. Involve LGBTQIA+ communities directly in policy development and compensate them for their time.
6. Develop clear guidelines that allow trans and non-binary service users to safely access gendered services.
7. Show a commitment to implement and enforce policies and training, with robust complaint pathways.

Policies should be explicit, enforceable, and unambiguous in their stance on LGBTQIA+ rights, particularly for trans and non-binary staff and service users. This includes setting clear expectations alongside complaint procedures that incorporate mechanisms for redress and disciplinary processes when those expectations are not met. Strong leadership backing is needed to maintain an organisational culture protecting both staff and service users.

Inclusive policies and guidelines can eliminate structural practices that exclude or stigmatise. One trans man's experience of gender-segregated psychiatric wards was a striking example. On multiple occasions his urgent hospital admissions could not be completed because there were no beds available in the only mixed-sex ward. He explained, *"I will refuse to go to an all-female ward because I'm not a woman, and they won't send me to an all-male ward because that's not in their policy".* He was initially placed on the male corridor under observation, but as soon as he was well enough for observations to end, trust policy required that he move to the female corridor. He felt like he was being punished for getting better, and he feared other patients' reactions to what amounted to outing him: *"other patients didn't have to know I was trans, but then obviously if I move to the female corridor, they're all going 'why is this guy in the female corridor'."*

Organisations must be explicit that hate or harassment are not tolerated, have policies that back this up, and train management on how to handle such issues. One stakeholder recounted a case where a patient attempted to complain about a mental health team's care but abandoned the process due to its complexity: *"The complaint process was so long-winded it discouraged them from pursuing it... even after we advised them to contact the Ombudsman."* A mental health service user noted: *"I have faced blatant religious discrimination... I complained but they hadn't kept any records."* For LGBTQIA+ people, navigating complaint systems can be especially fraught, fearing that complaints might lead to further marginalisation or retribution. Complaints processes are a key part of the policy recommendation and need to include explicit, reasonable timeframes for a response.

Service design

8. Involve LGBTQIA+ communities directly in the design, delivery, and evaluation of services, and compensate them for their time.
9. Allocate dedicated funding and resources for peer support and targeted support for intersectional identities.
10. Provide unisex facilities in mental health clinics and hospitals.
11. Designate or hire specialist clinicians with LGBTQIA+ expertise to whom teams can refer or consult.

Health services should embed community voices in every stage of planning, delivery, and evaluation and ensure this participation is meaningful and properly compensated. Many existing examples of good practice should be examined. One clinician described a service based in GP surgeries developed specifically for trans and non-binary patients, combining clinical expertise and lived experience. It was co-developed in partnership with local trans community leaders and CliniQ, a specialist trans health organisation.

SLAM's Rainbow Allies programme creates peer advocates throughout the NHS by educating and equipping allies who support LGBTQIA+ inclusion work but who are not part of the LGBTQIA+ staff network. This extends the reach of inclusive practice (e.g., an ally in a clinical team can ensure a trans patient's pronouns are respected even if no one in that team is trans).

A queer person of colour cited the "Friendship Bench", a project developed by the London School of Hygiene & Tropical Medicine for Black and Afro-Caribbean communities which uses culturally familiar approaches (matriarchal, informal talk in a familiar setting) to discuss mental health. She noted the absence of an analogous programme for LGBTQIA+ communities, saying *"that... highlights to me that [cultural tailoring] is not really being pushed forward"* for LGBTQIA+ people.

A non-binary participant urged that mental health services could be more accessible to trans people by *"not having single-sex spaces or single-sex wards, or single-sex approaches to treatment in general".* Many participants advocated for gender-inclusive options, for example mixed-gender group therapies and protocols for trans people to be housed at their preference, either in wards according to their gender or in a safe non-gendered area.

One person suggested that mental health teams could benefit from a dedicated LGBTQIA+ liaison or consultant role: *"someone teams could call for advice... for LGBTQ+ or transgender identities".* Access to a professional with expertise could have guided colleagues on appropriate treatment and language, improving his experiences of care.

Service delivery

12. Allow patients to identify what aspects of sexuality and gender are important to their mental health.
13. Allow patients to request a clinician of a certain background (e.g., ethnic group, sexual orientation, gender identity).
14. Implement standard practices to introduce yourself with pronouns.

Personalised, flexible care must start with the person's story and needs. Many people described experiences of assumptions, stereotyping and pathologising, including:

> *"One therapist ... [suggested] that my sexuality might be a contributing factor to my 'emotional conflict',"* and another, *"My therapist kept trying to take the conversation away from anything to do with my sexuality... even when I clearly said how it was linked to my anxiety."*

Trans and non-binary clients expressed wanting knowledgeable care without stereotypes. As one interviewee put it, therapists should create *"a space where [gender identity] can be explored or not explored in whatever way [the client] wants... without having assumptions on what someone's experience might be as a trans person".* Participants responded well to staff who admitted ignorance and showed willingness to learn. One suggested clinicians should *"mirror the language [clients] are using"* about their own experiences.

One example of accessible support came from someone who was initially too anxious to bring up their LGBTQIA+ identity in therapy face-to-face, so they emailed their therapist. The therapist responded in their next meeting saying, *"I want you to know this is a really safe space and we can talk about it whenever you're ready".* They said even though *"I wasn't ready to talk about it, the fact that they said that was really helpful".* Some also discussed the financial and emotional cost of accessing care elsewhere: *"The NHS therapist didn't understand anything about me being gay and Black... I now pay even though it means I have to stop [doing] social activities".*

Representation within services was another recurring theme, and several suggested making available peer-practitioners or practitioners with a shared background. The Black LGBTQIA+ focus group spoke repeatedly about feeling unseen or unheard within mainstream services. One respondent explained that they preferred to search private directories for this reason. Another found it *"profoundly helpful"* that both his current and previous therapist are gay men like himself. With a gay therapist, he did not worry about needing to self-censor or educate on gay subculture; he could mention experiences and *"not [have them be] shocked or thrown off".*

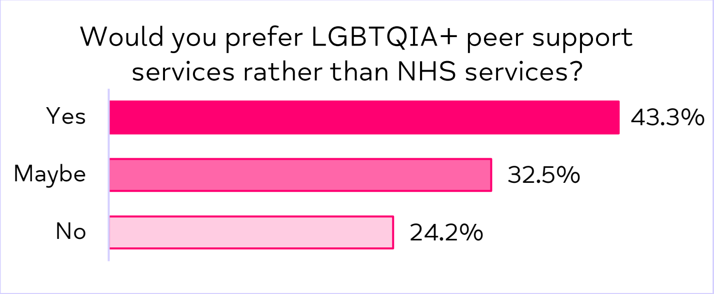
NHS staff in the working group said data protection regulations around staff personal data would not make it possible for the trust to identify LGBTQIA+ practitioners. However, they suggested creating a scheme which staff could opt into, which would enable this choice.

Southwark's Bridge Clinic is a case study in good practice. Diverse recruitment and specialised training create an affirming clinical environment. One member of staff explained, *"Everyone [on staff] is queer, two are gender non-confirming...and we've done further training in diversity so people don't have to explain everything, and we don't make assumptions about people's identities."* Having clinicians who are themselves LGBTQIA+ or who are deeply trained in these issues means patients more easily feel understood, seen and heard.

Participants also asked for normalised pronoun sharing, for example, having pronouns on name badges, or starting meetings with introductions that include pronouns. When cisgender staff and clients routinely introduce themselves with pronouns, it creates an environment where asking and respecting pronouns is the norm, and no one is singled out.

Partnerships

15. Establish grants or funding streams to sustain peer support groups, drop-in spaces, and community events.
16. Build referral pathways to LGBTQIA+ groups, especially organisations serving intersectional demographics.



A significant 43.3% of respondents preferred peer-led mental health provision, and 32.5% (n=39) answered "Maybe," suggesting that they could be swayed by factors such as the availability, quality, and cultural competence of the services. One participant remarked, *"when I have experienced internalised homophobia, being around other queer people has been quite effective"*. Another participant described the local Queer Minds group as *"the most unstigmatised place I've ever stepped foot in"*, where he could talk freely about both his sexuality and his mental health.

Health commissioners should create grant schemes for community LGBTQIA+ mental health projects, with funding streams specifically for underrepresented communities. One participant described that current funding models disadvantage smaller, intersectional initiatives. More widely, there is an ongoing loss or inaccessibility of community-based organisations. One participant observed, *"A lot of community organisations have closed like Opening Doors... There's an organisation called Imaan... [for LGBTQIA+ Muslims] but they are impossible to get hold of."* One interviewee applied to a charity offering LGBTQIA+ therapy, *"but just never got anywhere with that because they're so underfunded"*.

Across mental health services, a common experience was that help often comes too late or only after great persistence. Several participants mentioned never hearing back after initial contact, which results in a loop, *"You are taken back off the list and start again."* For some, this led to withdrawal from services or worsening mental health, with some saying they are *"worn out"*, *"what's the point?"*, and *"I haven't got the fight anymore to help myself."*

Networking and community outreach are needed. One person gave an example of ongoing, bimonthly seminars that are bringing together from "*all the different LGBT staff networks throughout the different hospitals but also independent community organisations"* for seminars and learning.

Expanding the range and location of access points was another key theme to improve access to services. Health providers could host services in trusted venues, offering low-barrier support without referrals. These could be co-hosted with local organisations to blend clinical expertise with community credibility. Health services and community groups are not parallel options but part of a shared ecosystem.

Conclusions

This report demonstrates the urgent need for a mental health system that is responsive to the diverse realities of LGBTQIA+ individuals in Lambeth and Southwark. Current services are not sufficiently equipped to meet the needs of LGBTQIA+ people, with systemic barriers such as discrimination, inadequate cultural competence, and a lack of personalised care creating significant obstacles to accessing support. These challenges are magnified for transgender, non-binary, and LGBTQIA+ individuals who are Black or of other minoritised ethnicities, who face multiple layers of marginalisation.

Key recommendations include the co-production of services with LGBTQIA+ communities, continuous training for all healthcare staff; improved sexual orientation and gender identity data collection and use; and investment in co-designed services, co-delivered services, and community partnerships. These steps are essential for rebuilding trust, ensuring safety, and enabling personalised and identity-affirming care. This requires budgeting for training, dedicated roles, and co-designed initiatives.

True progress will depend on sustained leadership and investment, as well as a shift towards viewing LGBTQIA+ individuals not as passive recipients of care but as active partners in shaping mental health services.