**Appendix A.** TableDescriptive statistics of mean scores of skills subscale, knowledge subscale, and total sexual orientation competency by age group

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **20-24 years old****(*n*=16)** | **25-29 years old****(*n*=38)** | **30-34 years old****(*n*=15)** | **35-39 years old****(*n*=5)** | **40-44 years old****(*n*=5)** | **45+ years old****(*n*=4)** |
| **Measure** | ***M*** | ***Mdn*** | ***SD*** | ***M*** | ***Mdn*** | ***SD*** | ***M*** | ***Mdn*** | ***SD*** | ***M*** | ***Mdn*** | ***SD*** | ***M*** | ***Mdn*** | ***SD*** | ***M*** | ***Mdn*** | ***SD*** |
| **Total Sexual Orientation Competency** | 4.53 | 4.63 | .602 | 4.43 | 4.50 | .816 | 4.05 | 4.00 | .656 | 4.23 | 4.17 | .383 | 4.27 | 3.92 | .891 | 3.15 | 3.17 | .823 |
| **Skills Subscale** | 3.19 | 3.20 | .750 | 2.99 | 2.80 | 1.11 | 3.03 | 3.00 | 1.19 | 3.00 | 3.20 | .583 | 3.44 | 2.80 | 1.48 | 2.30 | 2.00 | 1.39 |
| **Knowledge Subscale** | 5.49 | 5.43 | .796 | 5.46 | 5.64 | 1.10 | 4.79 | 4.71 | .890 | 5.11 | 5.00 | .865 | 4.86 | 4.58 | 1.41 | 3.75 | 3.86 | .768 |

**Appendix B.** Table illustrating descriptive statistics of mean scores of skills subscale, knowledge subscale, and total sexual orientation competency by sexual orientation.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Heterosexual****(*n*=55)** | **Bisexual****(*n*=11)** | **Lesbian/Gay Woman****(*n*=6)** | **Gay Man****(*n*=5)** | **Other\*****(*n*=6)** |
| **Measure** | ***M*** | ***Mdn*** | ***SD*** | ***M*** | ***Mdn*** | ***SD*** | ***M*** | ***Mdn*** | ***SD*** | ***M*** | ***Mdn*** | ***SD*** | ***M*** | ***Mdn*** | ***SD*** |
| **Total Sexual Orientation Competency** | 4.15 | 4.17 | .804 | 4.77 | 4.75 | .678 | 4.63 | 4.33 | .794 | 4.53 | 4.58 | .326 | 4.26 | 4.33 | .640 |
| **Skills Subscale** | 3.13 | 3.20 | 1.08 | 3.07 | 3.20 | 1.16 | 2.77 | 2.70 | 1.21 | 2.44 | 2.60 | .590 | 2.80 | 2.60 | 1.05 |
| **Knowledge Subscale** | 4.88 | 4.86 | 1.06 | 5.97 | 6.14 | .660 | 5.95 | 5.93 | .649 | 6.03 | 6.00 | .710 | 5.31 | 5.07 | 1.03 |

***n.b*.** \*This group included individuals identifying as Queer, Pansexual, and those who preferred not to disclose their sexual identity.

**Appendix C.** Table illustrating descriptive statistics of mean scores of skills subscale, knowledge subscale, and total sexual orientation competency by role of participants

|  |  |  |  |
| --- | --- | --- | --- |
|  | **PWPs****(n=49)** | **HITs****(*n*=21)** | **Other\*****(*n*=13)** |
| **Measure** | ***M*** | ***Mdn*** | ***SD*** | ***M*** | ***Mdn*** | ***SD*** | ***M*** | ***Mdn*** | ***SD*** |
| **Total Sexual Orientation Competency** | 4.40 | 4.50 | .759 | 4.08 | 4.00 | .880 | 4.28 | 4.25 | .645 |
| **Skills Subscale** | 3.08 | 3.00 | 1.11 | 2.87 | 2.80 | 1.06 | 3.12 | 3.00 | .954 |
| **Knowledge Subscale** | 5.34 | 5.29 | .998 | 4.95 | 4.86 | 1.10 | 5.11 | 5.57 | 1.28 |

***n.b.*** \*This group encompassed individuals who previously held roles as CBT Therapists or PWPs but have since moved on to other positions (including Assistant Psychologists, Trainee Clinical Psychologists, Trainee High Intensity CBT Therapists, PWP Lead, and PhD student)

**Appendix D.** Table illustrating descriptive statistics of mean scores of skills subscale, knowledge subscale, and total sexual orientation competency by gender

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Man****(n=11)** | **Woman****(*n*=69)** | **Other\*****(*n*=3)** |
| Measure | *M* | *Mdn* | *SD* | *M* | *Mdn* | *SD* | *M* | *Mdn* | *SD* |
| **Total Sexual Orientation Competency** | 4.46 | 4.50 | .460 | 4.27 | 4.25 | .825 | 4.36 | 4.42 | .668 |
| **Skills Subscale** | 2.85 | 3.00 | .913 | 3.10 | 3.00 | 1.09 | 2.00 | 2.20 | .346 |
| **Knowledge Subscale** | 5.61 | 6.00 | .988 | 5.10 | 5.14 | 1.06 | 6.05 | 6.43 | 1.19 |

***n.b,*** \*This group included individuals identifying as non-binary and genderfluid

**Appendix E.** Table illustrating statistics of mean scores of skills subscale, knowledge subscale, and total sexual orientation competency by years of experience working as a PWP or HIT

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **<1 year****(*n*=27)** | **1 year****(*n*=14)** | **2 years****(n=11)** | **3 years****(n=9)** | **4 years****(n=5)** | **5 years****(n=5)** | **6+ years****(n=12)** |
| Measure | *M* | *Mdn* | *SD* | *M* | *Mdn* | *SD* | *M* | *Mdn* | *SD* | *M* | *Mdn* | *SD* | *M* | *Mdn* | *SD* | *M* | *Mdn* | *SD* | *M* | *Mdn* | *SD* |
| **Total Sexual Orientation Competency** | 4.31 | 4.17 | .859 | 4.70 | 4.79 | .470 | 4.02 | 4.17 | .537 | 4.78 | 4.58 | .515 | 3.97 | 3.92 | .948 | 4.07 | 3.92 | 1.38 | 3.94 | 4.00 | .778 |
| **Skills Subscale** | 3.13 | 3.20 | .847 | 3.14 | 2.80 | 1.24 | 2.69 | 2.60 | 1.02 | 3.09 | 2.80 | 1.39 | 3.16 | 3.20 | 1.57 | 2.92 | 2.40 | 1.58 | 2.93 | 2.90 | 1.07 |
| **Knowledge Subscale** | 5.15 | 5.14 | 1.19 | 5.82 | 5.79 | .671 | 4.96 | 4.71 | .806 | 5.98 | 5.86 | .595 | 4.54 | 4.00 | 1.42 | 4.89 | 4.57 | 1.60 | 4.65 | 4.50 | 1.07 |

**Appendix F.** Table illustrating descriptive statistics of mean scores of skills subscale, knowledge subscale, and total sexual orientation competency by work setting.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **NHS commissioned service****(n=76)** | **Private Provider****(n=5)** | **Other Provider****(n=2)** |
| Measure | *M* | *Mdn* | *SD* | *M* | *Mdn* | *SD* | *M* | *Mdn* | *SD* |
| **Total Sexual Orientation Competency** | 4.31 | 4.38 | .795 | 4.23 | 4.00 | .696 | 4.00 | 4.00 | .354 |
| **Skills Subscale** | 3.06 | 3.00 | 1.09 | 2.88 | 2.40 | .901 | 2.40 | 2.40 | .000 |
| **Knowledge Subscale** | 5.21 | 5.21 | 1.09 | 5.20 | 5.14 | 1.02 | 5.14 | 5.14 | .606 |

**Appendix G.** This appendix presents further relevant quotes according to each theme.

**Theme 1: Training received on sexual minority issues by NHS Talking Therapies clinicians.**

**Delivery of diversity teaching and training (Amount and Specificity)**

***n.b.***A large number of participants reported that they received no training on issues surrounding sexual orientation pre-qualifying and post-qualifying. Therefore, we present further relevant quotes below to give readers an overview of other clinician’s perspectives.

|  |  |
| --- | --- |
| **Pre-qualifying** | **Post-qualifying** |
| *“I honestly can’t remember if we covered this.”* *“We had an opportunity to discuss LGBQ+ issues during one of our lectures which focused on diversity”* *“One lecture on working with LGBT+”* *“We received no specific training on LGBQ+ issues, however we received training on how to assess a client for diverse and individual issues.”**“I didn’t receive any specific training…the topic was briefly mentioned as a protected characteristic in the diversity module but the content of this module was mainly focused on ethnicity, language barrier and disability.”**“None, aside from a lecture which vaguely touched upon "diversity'”**“Very little direct support or guidance the training for LGBQ+ was given as part of the diversity training module”**“It was one section of my diversity and inclusion module at university…however, the IAPT service I trained with barely touched on this area at all”**“1 day session with the apprenticeship team on diversity and protected characteristics- not specifically LGBTQ+”**“I trained at…that provide ZERO training.”**“During my PWP training there was a module on 'cultural competence' this covered all the protected characteristics. In my HI training I would say this was not covered.”**“Received a half-day's lecture on diversity, which included teaching on why LGBTQ+ issues are important to acknowledge”**“As a PWP I had a day on diversity which covered LGBTQ+ issues, and during my CBT training we had a day on LGBTQ+ experiences as well.”**“Made aware of it as a protected characteristic..”**“Minimal, I am currently doing my HIT training and aside from the odd comment there has been no direct training”**“In the whole year of training, we had one lecture on diversity and I don’t recall LGBQ bring mentioned at all”* | *“No discussions on LGBT+ community have occurred in my service yet.”**“We were presented with 30 min power point on the historical oppression of LGBQ+ in our team meeting.”**“We had an organisation providing counselling for the lgtbq+ community come and talk to us”**“I have experienced training within the service as a qualified HI”**“MESMAC training session”**“I have attended two courses hosted by an LGBTQ+ charity organisation”**“Within the services I trained at and ones I have since worked at as a qualified PWP, LGBQ+ training has been informal”**“...I haven’t received any further training as of yet on LGBQ+ issues and there isn’t any training currently coming up”**“Absolutely nothing.”**“I have attended several CPD…had training from London Friend previously”**“I did attend a 3 (+/-) hour workshop run by the BABCP on working with diversity and a lot of the focus for the section I attended (3 consecutive days) was on LGBQ+ issues.”**“In house training course”**“Never had explicit training in any of my jobs.”**“CPD by Pink Therapy”**“I haven’t received a specific training however as a part of my service we regularly discuss issues LGBT+ face and how to work with them in clinical skills”**“None yet, but we have a LGBTQ+ champion and some training coming up”* |

**Theoretical Content**

*“The lecture briefly covered the increased prevalence of mental health issues among LGBTQ+ and what might be the reason behind that.”*

*“Factors that may impact mental health and adjustments that can be made as well as increased awareness.”*

*“...the training touched on potential social and/or psychological issues that the LGBTQ+ community might face”*

*“...​​on the historical oppression of LGBQ+”*

*“...an overview of what some LGBQ+ clients might face when referring to an IAPT service. Such as if a client has not come out to their family yet (and are under the age of 18) they may be less likely to refer themselves due to confidentiality and duty of care the NHS staff have. For example if they score quite high in risk due to coming out, the PWP or CBT Therapist may need to then contact their parents to inform them and if their parents are highly religious and against LGBQ+ it can highly impact the client further”*

*“...it included barriers and social inequality issues LGBTQ+ individuals faced and discussion how our services managed these”*

*“...I learnt about differences in recovery rates within IAPT dependent on sexual identity but that was all.”*

*“Potential differences in the way people may view mental health services…the disproportionate impact covid has had on the community eg young people stuck indoors with abusive family.”*

*“We were taught about some of the reasons that might affect LBTQ+ Individuals‘ mental health…”*

*“barriers to treatment”*

*“It mainly just explained that there are different outcomes/barriers…”*

*“...mainly looked at the history…”*

*“...issues that lgbtq+ people face”*

*“...certain inequalities and barriers faced by this population”*

“...a presentation about LGBTQ+ issues”

“...more general overview of historical and contextual issues (e.g., legislation) and how this may impact clients”

*“...a training highlighting the history, the socio-political context, the current issues, the impact on healthcare, discrimination, and differences in IAPT outcomes across different sexualities/gender identities. We also discussed minority stress…”*

**Practical Content**

“*...adjustments that can be made”*

“...received training on how to assess a client for diverse and individual issues.”

*“looking at adaptations eg asking how we could support and wearing a rainbow lanyard”*

*“Adaptations for treatment”*

*“We looked at things such as empathy statements, normalising to an extent (without invalidating the persons experience) but really being sensitive to their difficulties if they have had their mental health impacted by experiences linked to their sexuality.”*

*“We did consider how it [LGBQ+ issues] would play out in the therapy room and discussed this in the context of the therapeutic alliance.”*

*“...ways to make people feel more comfortable especially at initial assessment due to first impressions. Eg asking about pronouns, title preferences and whether their name on their account is the preferred name (as some people would give their birth name).”*

*“we can facilitate adaptations to treatment if required…”*

*“encourage to use a protected characteristics tree during every assessment to offer space for open conversations”*

*“...appropriate terminology”*

*“...local LGBQ+ support service discussing relevant assessment considerations and support they offer”*

*“Overview of appropriate terminology. Signposting…”*

*“...focus largley on signposting to more specialised charities/services and support lines”*

*“...including weekly consultations and developing an LGBTQ+ adapted Low Intensity Protocol.”*

*“...adaptations to assessment. We will be running an additional training on treatments”*

**Theme 2: Experiences of NHS Talking Therapies clinicians in accessing and receiving sexual minority training**

**Barriers to Learning and Implementation**

*“...not waiting until a case is brought to supervision to discuss the needs of LGBQ+ individuals when they could have been supported before initial assessment/triage*”

*“My supervisor for LGBTQ+ clients is a cis-straight individual with little understanding of the models and theories behind affirmative practice, which limits the usefulness of the space.”*

*“The management teams and supervisors didn't really have a clue”*

*“I was part of the lgbtq+ champion group but it would’ve been better if the champions were listened to. A lot of staff did not put their pronouns in their email signatures and it wasnt spoken about too much within the wider team and trust.”*

*“...more discussion in team meetings and in supervision…”*

*“Training - our IAPT service does not fund additional training for you until you are a year post qualified. Not helpful…My service declined including a question on pronoun preference based on the fact it was time consuming. However I've had transgender patients who still have records depicting their assignment at birth, so entire assessments happen until the end where they feel comfortable informing me of their status. This is not supportive.”*

*“...It hasn’t been bought up in clinical skills, case management, CPD slots…I now routinely ask a person their preferred pronouns…our Team Manager who said it’s a good idea, but it’s not a mandatory/standard part of our assessment and not all therapists do this.”*

*“Queer people in NHS services have to do extra work and deal with constant micro-aggressions to push for LGBTQ+ training and development for no extra pay. It's exhausting.”*

*“ No allocated time and minimal support given…”*

*“...could be opportunities to go deeper in reflective practice.”*

*“More reflection…”*

*“​​safe spaces for clinicians to explore stigmas etc that they may have when working with LGBTQ+ people”*

*“Have supervisors and senior management attend mandatory training to become aware of such issues but also how to support their staff identifying as LGBTQ+ (e.g., because this identity might be seen as an asset and a way to uptrain the service, when that is not their job, minority stress at work).”*

**Clinicians’ perceptions of training**

*“During the training I only had a lecture on LGBQ+ issues. The lecture was very vague and mainly focused homosexuality, but did not look at the issues in wilder terms. It was a poor quality lecture where no new information was given. The lecture briefly covered the increased prevalence of mental health issues among LGBTQ+ and what might be the reason behind that.”*

*“A short day session (run on Teams) by an external individual. She was lovely, but knew less about various identities than many participants (i.e. she had never heard of pansexuality).”*

*“The UCL the training was vague, a question was raised regarding trans women's rights to access DV refuge for women. No clear answers, and uncertainty whether trans women could be referred to a women's safe space. The topic of trans rights verses women's right is a highly controversial matter and it wasn't acknowledged during the training. There was alot of confusion over the difference between a transexual and a transvestite”*

*“One of our uni days was on LGBT however was vague and just involved watching a pre-recorded lecture”*

*“I would be interested in specific training. My knowledge is quite limited so I’m not confident in being able to provide best quality therapy”*

*“Any training to cover LGBT+ identities - I have felt like I have been making it up at times”*

*“The topic was briefly mentioned as a protected characteristic in the diversity module but the content of this module was mainly focused on ethnicity, language barrier and disability.”*

*“...LGBQ+ issues were briefly touched on. I.e. we can facilitate adaptations to treatment if required but the course did not go into specifics around what/how/when when working with LGBQ+ issues”*

*“It was one section of my diversity and inclusion module at university. One of my lecturers was an expert in this feild with lived experiance, so I felt the training in this area through my university was relatively comprehensive. However, the IAPT service I trained with barely touched on this area at all.”*

*“It felt more like just considering LGBTQ for a day, but not actioning anything or doing anything, ironic really that this is what CBT is. But if felt like we were supposed to consider it/understand it, so the University could tick the box that they’ve taught that part of Diversity to us….when really it undermines the importance of learning and working with LGBTQ. Uni didn’t seem to give that much importance. Or any other diverse groups either to be honest. I do know with a 1-year course it is time limited. But we focused 1 whole module on conducting an ATS, and only 1 day on considering different diversities.“*

*“Perhaps have more training than just an afternoon session. I think this is true for many of the ‘diverse’ cases we are trained to work with.”*

*“A short day session (run on Teams) by an external individual. She was lovely, but knew less about various identities than many participants (i.e. she had never heard of pansexuality). Also, the training touched on potential social and/or psychological issues that the LGBTQ+ community might face, but nothing to do with how we might amend our practice in light of these, as she wasn’t a PWP or CBT therapist.”*

**Clinicians’ self-motivation to develop practice and policy**

*“I have received no formal training on LGBTQ+ issues from my service. Therefore, myself and a few other colleagues created our own LGBTQ+ training, we have run two training courses so far, including weekly consultations and developing an LGBTQ+ adapted Low Intensity Protocol. Again, Queer people in NHS services have to do extra work and deal with constant micro-aggressions to push for LGBTQ+ training and development for no extra pay. It's exhausting.”*

*"...I have created training along with other colleagues who were interested in this. No allocated time and minimal support given at the start of our endeavours.”*

*“After qualifying as a PWP myself and a colleague (we both identify as LGBQ+) felt there was a gap at service level and no specific work done to support LGBQ+ clients. We set up a lead area with a focus on training staff and developing queer affirmative adaptations to treatment. Any training I have had in the service I have co-written and facilitated with several colleagues (the LGBQ+ lead areas now has at least 5 therapists involved).”*

*“As a CBT therapist I myself have not attended additional training, but I have facilitated 2 additional trainings to all staff in my IAPT service for LGBTQ+ experiences of IAPT. We did a sensitivity training, then we did a training highlighting the history, the socio-political context, the current issues, the impact on healthcare, discrimination, and differences in IAPT outcomes across different sexualities/gender identities. We also discussed minority stress and adaptations to assessment. We will be running an additional training on treatments. We have also facilitated reflective spaces and a HI skills to discuss LGBTQ+ history month.”*

***Theme 3: Perceived gaps in current sexual minority training and ways to improve training.***

**Clinicians’ views on ways to improve training delivery.**

*“Developing a 'well practice guide' for LGBTQ+ issues - there is extended version for elderly patients and some for perinatal clients too. More CBT. Workshop for LGBTQ+ - by running the workshop I would learn more.”*

*“During training would be great to invite previous patients as testimonials. My cohort had few clients who had stress management treatment and I found that q&a with them very helpful.”*

*“Perhaps input from an lgbq+ service user? Or more input from the lecturers into their experiences and how they have tailored their practice for this group of patients”*

*“Scenarios and role plays maybe even to hear hear research or service users experience of rescuing and receiving support”*

*“Role playing. Having a service user speak on what they would find helpful.”*

*“Roleplays on examples of LGBT specific challenges and issues that can present in sessions”*

*“​​I personally feel very informed about LGBTQ+ specific issues but maybe a speaker who identified as LGBTQ+ to provide insight into some of the challenges faced could be helpful.”*

*“Insight into previous experiences, recent data and research would have been helpful”*

*“Rather than mentioning information (which is still important), to find ways to help practitioners and trainees think on how to use this (e.g., 'we know these experiences were stressful for this cohort and so when someone from this cohort is referred, this would have been their previous experience accessing services', etc.). Have service users involved in teaching/training.”*

*“Perhaps having a speaker who is queer and has accessed MH services would be useful? To make it seem more personable.”*

*“A day of tutorial, a speaker to answer questions.”*

*“I think an additional module or section of module could be given to this as a stand alone item”*

*“I think generally making people feel more comfortable with these conversations would be helpful. My sense is we are still very much in the 'I don't need to know what goes on in your bedroom' stance. Training courses should focus on improving confidence in talking about sexuality and gender.*

*This could include reflective spaces, peer supervision - to allow people to express their concerns or anxieties and reflect on where this may be coming from.”*

**Systemic Issues**.

*“The lecture was very vague and mainly focused homosexuality, but did not look at the issues in wilder terms.”*

*“Psychology as a whole is far too white, cis, hetero centric.”*

*“More of the current psychological/social issues faced by people in the LGBTQ+ community to create a less individualised approach (less onus on individual change and just having an awareness and acknowledging things like discrimination and microaggressions which impact on mental health).”*

*“We had a small section of training that was more focussed on care at an individual level (i.e. how can we adapt this therapy for the individual), rather than training promoting systemic thinking re promoting diversity/inclusion in IAPT.”*

*Further awareness of the demographics and needs of the local population in regards to sexual orientation. Information on available local services that can offer specialist support for issues around sexual orientation and identity.”*

*“Aiming to enhance practitioner understanding of the additional challenges LGBQ+ individuals face to their mental, social and sometimes physical wellbeing due to their sexual identity. I think otherwise it is easy for practitioners to come across dismissive to patients by simply sending them info on other more specialised services.”*

*“There are very few High Intensity staff that are either Queer or have knowledge on LGBTQ+ psychology - this would be a game changer to be able to offer more LGBTQ+ affirmative/targeted work. My supervisor for LGBTQ+ clients is a cis-straight individual with little understanding of the models and theories behind affirmative practice, which limits the usefulness of the space.”*

*“LGBTQ+ inclusive workspaces, if we cannot create an LGBTQ+ affirmative work space how can we think about doing this in our therapy spaces. IAPT spending less time researching LGBTQ+ specific mental health barriers to engagement/recovery/etc, and spending more time working on adapted protocols, and guidelines.”*

*“.…signposting available to local and national services. Specific methods to overcome systemic barriers to accessing services that LGBTQ+ people may experience.”*

*“Furthermore, explaining that treatment can be offered to LGBTQ+ people, even if part of their presenting problem is related to their sexuality. Too often clients are being signposted away to LGBTQ+ specific counselling services as soon as they raise an issue with identity. This does not need to happen.”*

**Theoretical Content**

*“Really anything, it's not something that was focused on. It would have been good to have included some basic sensitivity training so everyone being trained had a basic understanding about appropriate language, why queer clients have more difficulties access services, more queer specific risk factors (chemsex for eg).”*

*“I think further training on prevalent issues for LGBTQ+ would be an appropriate addition to the PWP curriculum”*

*“Common issues/barriers faced by the LGBQ+ community in relation to accessing IAPT services”*

*“Literally anything more than what we received; having some insight into the idiosyncratic issues that people within the LGBTQ community face and the obstacles they may encounter in services would be brill.”*

*“What the issues are and why they exist e.g. the history behind LGBTQ+, culture etc. The types of stressors they face and how it differs among the community. Ways in which challenges can be explored at Step 2”*

*“More information around the impact of sexuality would be helpful for example the impact on childhood, friendships, identity, harassment from others, lack of sex education, etc”*

*“The basics on minority stress theory, the basics on LGBTQ+ identities (particularly trans and nonbinary)...understanding the historical and social context in which Queer people grow up in”*

 *“Really anything, it's not something that was focused on. It would have been good to have included some basic sensitivity training so everyone being trained had a basic understanding about appropriate language, why queer clients have more difficulties access services, more queer specific risk factors (chemsex for eg).”*

**Practical Content**

*“Help with broaching the topic around sexaulity and further ideas on when to signpost to specailair services or not. How to sensitively assess for issues around sexuality.”*

*“Increase engagement with the LGBQ + community in the local area. Support staff to build confidence in discussing LGBQ + issues with clients and offering support for these in a more informed manner. Training to understand the links between LGBQ + issues and mental health and how to include these in treatment plans.”*

*“Less statistics, more time on adapting assessments and treatments, how to ask questions around sexuality and gender”*

*“Not sure this is for the service to do, probably more for a LGBTQIA+ Champion, but I often find I am out of touch with the correct & most respectful terminology & fear unintentionally upsetting someone”*

*“How to conduct assessments for LGBT people - what questions to ask, sensitive questioning, relevant signposting etc”*

*“If courses taught more about how these conversations can be had at step 2/3 within the protocols this would help people feel more confident. The way in which courses are taught is far too rigid and not representative of real life. There should be role plays where a client is LGBTQ+ and they are depressed and disengaged from things and their community. The BA Can then just be adapted by asking more about their identity, what is important to them in connecting with it, can we schedule that in, etc. Problem solve any barriers or safety issues. This is all what we are trained for, people just don't feel confident with it.”*

*“An overview of specific issues, how to incorporate it into assessment, formulation and treatment.”*

*“Also, similar to culturally adapted cbt, I think something similar is needed as I think it would be helpful to have space to explore any discrimination people experience rather than be expected to rush sessions and just tell people that they should try behavioural activation. So it might even be that considerations of additional time in sessions for the lgbtq+ community (if needed) to ensure they feel listened. And then empowered to make practical changes to things in their control.”*

*“what queer-affirmative or queer-sensitive practice looks like”*

*“Instead, offering LGBQ+ individuals the space to explore topics relating to their sexual identity that affect mental wellbeing, as relevant within the CBT and/or IAPT framework, could be really beneficial.”*