

Transgender and Gender Diverse People's Experiences of Acute and Post-Discharge Mental Healthcare in Ontario: A Mixed Methods Study

by

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Institute of Health Policy, Management and Evaluation
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Abstract

Introduction: Transgender (trans) and gender diverse (TGD) people experience significant oppression, which can translate into greater risk of mental disorders and need for acute mental healthcare, i.e. mental health hospitalizations and emergency department (ED) visits. Early post-discharge care can reduce negative health outcomes following acute care presentations. The aim of this study was to understand TGD people's experiences of acute and post-discharge mental healthcare.

Objectives:

- 1) To compare characteristics of TGD and non-TGD individuals accessing acute mental healthcare
- 2) To compare physician visits following discharge from acute psychiatric care (mental health-related ED visits or hospitalizations) between TGD and non-TGD individuals
- 3) To explore the lived experiences of TGD people accessing acute mental healthcare and understand their post-discharge journeys
- 4) To integrate the qualitative and quantitative data to explain the quantitative results

Methods: A sequential explanatory mixed methods study was conducted. First, a retrospective population-based cohort study used linked health administrative data to examine psychiatric patients discharged from an ED visit or hospitalization in Ontario, Canada. TGD individuals were identified and their data linked with health administrative

data. Sociodemographic and clinical factors associated with the TGD ED and hospitalization samples were examined. Multivariable logistic regression analyses examined outpatient mental health physician follow-up within 30 days of discharge. The quantitative results guided the subsequent qualitative study design and data generation plan. TGD people living in Toronto, Ontario, who have experienced acute mental healthcare (n = 15) were recruited for the qualitative study. In-depth individual interviews were conducted, transcribed, and analyzed using constructivist grounded theory. Quantitative and qualitative results were integrated and presented together.

Results: From the retrospective cohort study, TGD individuals presenting for acute psychiatric care had increased measures of socioeconomic marginalization and were more likely to be diagnosed with a mood or personality disorder, and less likely a substance-related disorder. TGD individuals had increased 30-day post-ED follow-up (adjusted OR=1.21), but reduced 30-day follow-up post-hospitalization (aOR=0.81). The quantitative findings informed the qualitative study's semi-structured interview guide and the purposive sampling strategy. A qualitative theory explaining the quantitative findings was co-constructed with the qualitative study participants. Participants described how chronic minority stress (developmental trauma, physical disability, neurodivergence, and marginalization) and inability to access care led to presenting to ED as one of few remaining doors to needed care. Autonomy, safety, and usefulness around the acute care experience influenced their decision post-discharge to 1) engage in care within the formal system, 2) prefer community care, or 3) avoid the system altogether. Participants offered explanations for each quantitative finding that are presented in joint displays with illustrative quotes and themes.

Conclusions: TGD individuals who use acute mental healthcare have experienced greater marginalization and are more likely to follow up with mental healthcare after discharge from the ED but less likely to follow up after hospitalization, which is explained by transphobic experiences during hospitalization. Hospital staff and policies need to prioritize autonomy and address systemic transphobia to support access to care. Integrating TGD-specific community organizations into acute mental health services may help address the needs of TGD individuals more holistically.

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Chapter 1

1 Introduction

1.1 Problem Statement & Research Objectives

Transgender (trans) is an umbrella term used to describe people whose gender identity differs from their sex assigned at birth (1,2). Gender diverse refers to a range of gender identities that are not necessarily male or female, but may be a combination, fall along a spectrum, or be outside of the binary (1,2). Trans and gender diverse (TGD) identities include genderqueer, gender fluid, and non-binary (2). TGD individuals are estimated to be at least 0.5% of the population (3,4), and up to 4% of adolescents and youth may identify as gender diverse (2,5), but there is a paucity of evidence or literature to understand their psychiatric needs, clinical presentations, and mental health service utilization. As a group they have poor mental health outcomes, including, in one cross-sectional study of 433 trans Ontarians, over 60% having active depressive symptoms (6,7) and 43% having attempted suicide in their lifetime (8). Studies suggest that high rates of mental illness and suicidality are related to experiences of marginalization and oppression, including experiences of transphobia, violence, unemployment, and homelessness (4). As such, characteristics of TGD individuals who require acute mental healthcare (mental health hospitalization and/or emergency department care) may be different from cisgender individuals (people whose gender identity is concordant with their sex assigned at birth (2)) accessing acute mental healthcare. Clarifying any differences in demographic, clinical, and prior healthcare utilization characteristics between TGD individuals and cisgender individuals who access acute mental healthcare can inform how to better provide care for TGD individuals.

Several qualitative studies have explored the significant barriers to accessing care that TGD people face (9–13). A review of qualitative studies focusing on mental health needs of TGD individuals found that common barriers include a lack of inclusive and appropriate services, a fear of discrimination and refusal of care, a lack of knowledgeable and non-judgmental providers, and factors related to social determinants of health and

marginalization that make accessing care very challenging (10). Some studies have highlighted how qualitative research with TGD individuals can inform how to improve mental healthcare for this population (9,11–15). One qualitative study focused on TGD teenagers' experiences of mental health hospitalization (14) and another focused on TGD adults' experiences of emergency care but not emergency mental healthcare specifically (15). None of the qualitative studies focused on lived experiences of TGD adults accessing acute mental healthcare (i.e. mental health hospitalizations and emergency department visits), which is an important treatment option for mental health symptoms of higher severity and complexity, with or without safety concerns. No studies have focused on the Canadian context either, which is a different healthcare system than the US and other countries. Since TGD individuals face much higher rates of mental illness and suicidality, the experience of acute mental healthcare is important to understand. Aspects of acute care, such as having to replace gender affirming clothing with a hospital gown, can cause fear and avoidance of care (13). These aspects are important to elicit and explore.

The time following discharge from hospitalization is known to be high risk for negative outcomes including suicide attempts and readmissions (16–19). Accordingly, there is a performance indicator in Ontario that measures post-discharge follow-up within seven days to monitor adequacy of access to care to help mitigate that risk (20,21). The time immediately following suicidal behaviour is also a high-risk period for a repeat attempt. In one study, ten percent of individuals were found to have repeated suicidal behaviour within five days of discharge where the clinical presentation had included suicidal behaviour (22). Early and active follow-up after an emergency department (ED) visit reduced suicide attempts at six months (23), suggesting that mental health support, including physician follow-up, soon after ED discharge can reduce suicidal behaviour. However, there is also evidence that TGD individuals avoid health care. Half of trans Ontarians in one study did not feel comfortable sharing their transition-related health needs with their family doctor (24) while 21% avoided the ED due to concerns that their gender identity would affect the care they receive (25). Twenty-four percent of trans Ontarians who have had ED visits experienced being belittled or ridiculed for being trans in the ED and ten percent had their ED care refused or ended (25). This may translate into some TGD individuals also avoiding post-discharge care. However, there were no

qualitative studies or studies using health administrative data found focusing on access to mental health care after discharge. Understanding access to post-discharge care and the barriers and facilitators of post-discharge care can lead to further research and healthcare delivery changes that improve access to care for this marginalized population and reduce risks of readmission and suicide.

We thus proposed a sequential explanatory mixed methods study to understand characteristics of TGD individuals who have experienced a mental health hospitalization and/or mental health-related ED visit(s) in Ontario, and explore their access to post-discharge mental healthcare. The overall study aim was to clarify what social and clinical factors affect access to acute and post-discharge mental healthcare for TGD people in Ontario. Findings from the two initial quantitative studies would inform the design of the subsequent qualitative study to explain the results of the quantitative studies.

The first quantitative study was a descriptive study using matching on key characteristics to compare TGD and non-TGD individuals who have had a mental health hospitalization (cohort 1) or a mental health-related ED visit (cohort 2). The study question was: *What sociodemographic and clinical factors are associated with TGD individuals presenting for mental health ED visits and hospitalizations in Ontario?* The second quantitative study was a retrospective cohort study designed to answer the research question: *What is the association between TGD status and post-discharge mental health physician follow-up amongst individuals discharged from acute psychiatric care?* This study examined access to an outpatient mental health physician for TGD individuals in the 7 and 30 days (primary outcomes) after a mental health hospitalization (cohort 1) or a mental health-related ED visit (cohort 2) compared to controls.

Results of the quantitative studies then guided the study design and data collection strategies in the qualitative study. Sociodemographic and clinical factors associated with TGD people's acute mental healthcare presentations and findings related to post-discharge outcomes from the first two studies shaped the interview guide and sampling strategy in the subsequent qualitative study. The main research question guiding the qualitative study asked: *How do transgender and gender diverse (TGD) people living in Toronto (Ontario, Canada) with a history of mental health hospitalization(s) and/or emergency department*

(ED) visit(s) understand and experience their acute mental healthcare visits, and journeys after discharge? The study objective was to construct a theory of how life and healthcare experiences impacted TGD people's acute and post-discharge mental healthcare experiences, and thus explaining the prior quantitative findings. Individual semi-structured interviews were conducted, with data analyzed using constructivist grounded theory.

Joint displays were used to integrate quantitative and qualitative results. Qualitative theoretical models were presented alongside the quantitative outcome data they explain. Statistical analyses of specific variables associated with acute and post-discharge mental healthcare were presented with relevant illustrative quotes from the qualitative study. Ultimately, this study aimed to center the experiences of TGD people to create models that can aid healthcare providers and policy makers in understanding their lived experiences of acute and post-discharge mental healthcare, with hopes that this data will lead to building a better mental healthcare system with and for TGD people.

1.2 Theoretical Frameworks

1.2.1 Minority Stress Theory

TGD people have a higher prevalence of mental health conditions than the general population (26). However, it is crucial to consider the potential reasons and contributors to this discrepancy. One guiding theory employed in this thesis is the minority stress theory, which postulates that gender and sexual minority people (i.e., people who identify as 2SLGBTQIA+) have physical and mental health disparities secondary to discrimination, violence, oppression, and marginalization they face in society (27,28). The minority stress theory was initially proposed to explain the excess mental distress and disorders, including suicidality and deliberate self-harm, faced by lesbian, gay, and bisexual (LGB) people (27). Researchers and clinicians challenged the pathologization of LGB identities that was reflected in the American Psychiatric Association's inclusion of homosexuality as a mental disorder in an earlier version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) by explaining that the disproportionate mental health challenges faced by LGB

individuals are due to the stress of a social environment that regularly discriminates against them (27). The minority stress model was later applied to gender minorities as well, describing how distal stress factors such as gender-related victimization and non-affirmation combined with more proximal stress factors including internalized transphobia and expectations of future discriminatory events to produce negative mental and physical health outcomes (28). Minority stress is theorized to cause epigenetic changes and dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis, which lead to inflammation and alterations in immune, cardiovascular, metabolic, and endocrine functions that can produce the excess illness burden in TGD populations (29).

These minority stress experiences are rooted in cisnormativity, which is the automatic and normalized assumption that everyone identifies with their assigned sex at birth and those who do not are considered “abnormal” (30). Cisnormativity forces TGD people to regularly have to come out as TGD. Cisnormativity is perpetuated by society through both institutions and policies, such as the conceptualization of TGD people as experiencing a mental disorder by having diagnoses of gender identity disorder and gender dysphoria in the DSM, as well as through individuals, such as regular misgendering of TGD people and denying TGD people employment and housing (28,30,31). Cisnormativity privileges cisgender people, who do not have to respond to or cope with these stressors that invalidate and pathologize TGD identities (30). The minority stress theory posits that the locus of the excess risk for negative health outcomes lies in cisnormativity and its impacts rather than in TGD people or their identities.

Recent research has suggested that minority stress would benefit from incorporating the concept of social safety, which is defined as individuals having access to reliable social inclusion, connection, belongingness, recognition, and protection (32). Researchers suggest that the regular minority stress faced by TGD individuals disrupts their sense of social safety, so they must face all people with caution and vigilance, and this lack of social safety is a crucial contributor to the health disparities they face (32). They suggest that addressing health inequities experienced by TGD people thus requires both the reduction of minority stressors and the amplification of their sense of social safety (32). The importance of social support and sense of belonging for the mental health of TGD people is

reflected by prior studies illustrating the significant impact of parental support and connectedness on reducing suicidality and deliberate self-harm in TGD youth (33,34). Another recent study demonstrated how the use of TGD youth's chosen name in multiple contexts (i.e., home, school, work, and/or with friends) was associated with reduced depression, suicidal ideation, and suicidal behaviour (35). This literature highlights the importance of not only minimizing prejudicial and discriminatory experiences, but also the importance of having more affirming spaces that facilitate a sense of support, belongingness, and safety for TGD people to have optimal mental health.

1.2.2 Social Determinants of Health

Social determinants of health refer to the non-medical factors and the wider systems of forces that affect the daily conditions in which individuals are born, grow, work, live, and age; which ultimately impact health outcomes and inequities (36,37). These factors have traditionally included childhood development, socioeconomic status, education, employment, access to healthcare, food security, social support and inclusion, housing, access to basic material needs, and the physical environment of neighbourhoods and communities (36–38). Addressing inequities related to social determinants of health requires tackling the inequitable distribution of money, resources, and power globally between countries and locally within countries and regions (38). The World Health Organization outlined how social determinants of health are impacted at a more upstream level by structural determinants of health (or social determinants of health inequities), which are the socioeconomic and political contexts that a person lives in that determines the socioeconomic position of that individual in that particular community and context (37). These socioeconomic and political contexts create mechanisms whereby individuals are stratified and given differential access to power and resources according to factors like gender, race/ethnicity, education, occupation, and income that determine an individual's social status and place in the social hierarchy in that particular context (37).

The social determinants of health theory is important to consider in the present thesis study because it suggests that inequitable health outcomes are downstream effects of more

upstream issues around systems that distribute money, power, and resources inequitably (36–38). Since gender and gender inequity are structural determinants of health (37,38), one might expect that living in a world that privileges cisgender people and marginalizes TGD people would have social determinants of health impacts (26). Unsurprisingly, TGD individuals do in fact face significant social determinants of health challenges, including housing instability, financial strain, employment discrimination, and inequitable access to healthcare; all of which have predictable negative consequences for physical and mental health (39,40). Studies highlight how social determinants of health challenges faced by TGD people are often secondary to stigma and discrimination (39–41). Tying back to minority stress theory, stigma has been construed as a social determinant of health for TGD people because discrimination against TGD people occurs due to socioeconomic and political power dynamics that privilege cisgender people and lead to social determinants of health challenges (such as housing, financial, and employment instability) that have clear health impacts (41). In this way, minority stress can be thought of as a structural determinant of health for TGD people that operates through impacting social determinants of health to produce health inequities.

The stigma that TGD individuals experience can be categorized into individual stigma, which refers to individual responses to stigma and can include internalized transphobia, interpersonal stigma, which refers to discrimination expressed by one person to another such as transphobic violence and microaggressions, and structural stigma, which refers to social conditions and processes such as stigmatizing policies and institutional practices (40,41). Stigma confers risk of poor health outcomes onto TGD people through hypothesized mechanisms that include making individuals ruminate on negative experiences and thoughts, feel isolated and lonely, and be more vigilant to avoid discriminatory encounters; all of which can trigger a chronic stress response through the HPA axis and have long-term health consequences (29,41). The literature suggests that both stigma and social determinants of health should be key priorities in clinical care if the goal is to meaningfully improve the health of TGD communities (39–41). Interventions can target these upstream individual, interpersonal, and structural forms of stigma to shift this structural determinant, which will have downstream impacts on social determinants of health and ultimately improve health inequities (40). Clinicians, researchers, and

policymakers have also advocated for greater inclusion and integration of social determinants of health measures in electronic medical records to be able to identify these important indicators of health and prioritize addressing these more upstream factors in the care of marginalized populations (39,42). Although this thesis focuses on the acute and post-discharge mental healthcare experiences of TGD people, the theories of minority stress and social determinants of health suggest that these upstream factors and life experiences are important to examine to fully appreciate the mental health journeys TGD individuals face and what contributes to their mental health needs and experiences in order to potentially identify targets for intervention that can improve their care.

1.2.3 Paradigmatic Considerations

Philosophical assumptions, or paradigmatic worldviews, underlie all research, shaping the approach and conduct of the inquiry process. In mixed methods research, clarity around the researcher's paradigm or worldview is particularly important, as it impacts how integration of qualitative and quantitative methods are conducted (43,44). A researcher's paradigm is a set of beliefs that includes one's ontology, which are the beliefs about the nature of reality, and epistemology, which are beliefs around the nature of knowledge and how researchers can access or create knowledge (45). Quantitative and qualitative research are often based in different philosophical assumptions about the nature of reality and knowledge, so it is important to consider how and whether it is possible to integrate the two if one is to pursue mixed methods research (43,44).

Before discussing the paradigmatic considerations guiding this mixed methods study, let me first outline the core foundations of each of the qualitative and quantitative components of the study; including the ontology, epistemology, theory, methodology, methods, and analysis of each (46). The quantitative studies are rooted in realist ontology, which posits that there is an external objective reality that can be discovered (45). This flows naturally into an objectivist epistemology, which is the belief that knowledge about reality can be determined through unbiased measurements that would be entirely reproducible by

another researcher following the same methodology (45). As described above, the quantitative studies are guided by the minority stress theory and a matched retrospective cohort study design as its methodology. The methods use health administrative data and the analysis is statistical, using both descriptive statistics and logistic regression modelling.

In contrast, the qualitative study is grounded in a relativist ontology, which is a reality that is dynamic and socially co-constructed by individuals (45). The study embraces interpretivist epistemology, which views knowledge as co-constructed by the researcher(s) and the participant(s) through the research process (45,47). The study is guided by Charmaz's constructivist grounded theory as its methodology (48), and this methodology has roots in the theory of symbolic interaction, where "interaction between people is viewed as symbolic because the interactive processes use the symbols of language, words and interpretation" (p. 664) (49). These symbols interacting co-construct realities and knowledge. The qualitative study's methods consist of individual interviews, and the analysis is guided by constructivist grounded theory. Please see **Figure 1** for a summary of the core foundations of the study components.

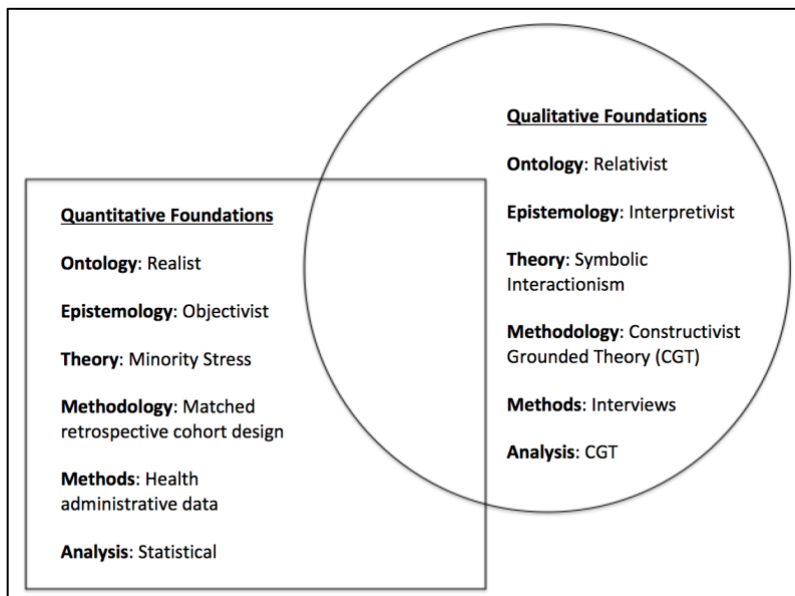


Figure 1. Core foundations of the qualitative and quantitative studies forming the mixed methods research study.

For a mixed methods study like this thesis, four worldviews are well-described in the literature as overarching paradigms to guide the integration of qualitative and quantitative research: dialectics, critical realism, pragmatism, and transformative-emancipation (43,44). Each approach was considered for this study, which is expanded upon below.

Dialectics is an approach that draws attention to the tensions and conflicts that may arise between divergent and dissonant data between qualitative and quantitative methods (44). The dialectical perspective supports different paradigms being used for different aspects of the mixed methods study, with the belief that the contradictions and dialogue between the paradigms should be accepted rather than reconciled (43,44,50). This approach was not appropriate for this study, as the goal was for the qualitative results to explain the quantitative findings, so we were searching more for complementarity and congruence rather than dissonance. Dialectics is also less oriented towards solving social problems with practical solutions compared to other paradigms (44,50). Dialectics may be a more useful approach for mixed methods studies where the purpose is to highlight the limited perspectives of health administrative data and qualitative data each on exploring a research question, or when the findings from the two approaches are hard to reconcile, such that putting the two methodologies and paradigms in conversation and tension with each other can lead to greater insights (50).

Critical realism rests on a realist ontology where reality can exist outside of perception, but a constructivist epistemology where knowledge about the world is co-constructed from individual perspectives (44,51). Critical realists believe that only partial presentations of reality can be known, and the goal is to use research to approximate the underlying structures of reality, such as by understanding what outcomes occur in what specific contexts and through which generative mechanisms (44,51). This paradigm is less useful for the present mixed methods study, as the health administrative data included individuals from multiple cities, while the qualitative data focused on one specific city, so it was not possible or desired to focus on one specific context in this study. Critical realism may be more applicable to mixed methods studies using health administrative data applied to one specific healthcare institution or setting so that the context being studied can be

more clearly delineated. Critical realism is also often focused on uncovering underlying causal mechanisms (44,51), which was not the focus of this study. Critical realism may be more suitable for a convergent mixed methods study design (51).

Transformative-emancipation is a paradigm with the explicit goal of collaborating with marginalized communities to center their voices and advocate for change (44). This approach pays particular attention to issues of power in research and requires the researcher to have a strong connection to and understanding of the community of study (44). This paradigm certainly informs the present study, as the goal of the study is to understand the mental health needs of the TGD community and provide evidence to inform improving care with and for TGD people. The rationale for adding a qualitative study to the quantitative studies was also specifically to create an explanatory sequential mixed methods study so participants' lived experiences of mental healthcare can be highlighted to explain the quantitative findings (44). Researchers involved in this study have also strived to understand the history and lived experiences of the TGD community in Ontario, connect with community, and promote social change outside of this study. Issues of power, oppression, and the need for social change to address health inequities have been considered throughout the study's design and execution (44,52). However, I hesitate to assert that this study is fully able to embrace the transformative-emancipation approach. Although my goal and hope are for this study to lead to improvements in the mental healthcare system with and for TGD people, this social change is not built into the study design as an outcome. Transformative-emancipation would ideally also meaningfully involve more TGD community members from initial forming of research questions and the study design through to data generation and knowledge mobilization (44).

Finally, pragmatism as a paradigm is outcome-oriented, able to engage with different ontologies and epistemologies to practically answer and address specific research questions (43,44,50). It encourages the use of multiple methods from different paradigms as long as they all serve to address the same practical research problems (43,50). This approach to research prioritizes communication and shared meaning-making undergirded by the belief that quantitative and qualitative methods can complement each other's strengths and

weaknesses (44). The pragmatist approach is consistent with this study's aims as the qualitative methods were added in part to address the limitations of the quantitative studies. Both methods are also being mixed to understand and address the practical social problem of inequities in mental healthcare access for TGD people. Pragmatism also uses qualitative and quantitative methods for triangulation of results, finding shared meaning from positivist and constructivist epistemologies (44), which is the approach this study embraces. Pragmatism also often investigates the transferability of research findings to other contexts (44), which this study aims to do by using population-based health administrative data that is representative of the population, while also using qualitative methods in a specific city to determine context-specific findings that will be triangulated with the quantitative data to determine elements of transferability.

Pragmatism has been criticized for being a methodological approach to allow for mixing of methods rather than an overarching worldview that fundamentally guides the entire mixed methods study (44,50). As such, this study's paradigm is most aligned with a combination of transformative-emancipation and pragmatism. Transformative-emancipation underlies the researchers' values and the study's overall goal of improving mental healthcare with and for TGD people by highlighting inequities they face and centering their lived experiences. Simultaneously, the approach of mixing the methods involves a pragmatic approach that focuses on shared meaning-making between the qualitative and quantitative methods to practically address the research problem of what inequities exist in access to mental healthcare for TGD people and what factors explain and contribute to these differences.

1.3 Critical Review of Relevant Literature

1.3.1 Experiences of TGD Individuals in the Emergency Psychiatric Setting

A survey of TGD people in Ontario, Canada found that one-third of the 408 respondents reported a need to present to the ED in the last year, but 29% of the individuals were not able to access needed care (53). Twenty-one percent of the participants reported ever

avoiding ED care related to the belief that their TGD identity would negatively impact their ED presentation (53). More than half (52%) of the participants who presented to the ED in their felt gender reported experiencing negative or discriminatory experiences based on their TGD identity, including being refused care, experiencing hurtful or insulting language, and being told that the provider does not know enough to provide care for them (53). A survey-based study of 4,190 TGD people in the United States found that being unable to access care in healthcare settings including the ED was associated with increased substance use as a coping mechanism, which mediated the relationship between not receiving care and attempted suicide (54,55).

Researchers in the United States conducted surveys and focus groups with TGD patients who had experienced emergency care, and they found that 43.8% avoided the ED when needing acute care; and the reasons included previous negative experiences, fear of discrimination, and the length of the wait (56). The participants described multiple systemic and structural issues related to emergency care, namely that ED care is “not designed for safe and private gender disclosure and fosters disempowerment and mistrust between providers and patients” (pp. 175) (56). ED practices that may be considered routine felt discriminatory and disempowering; such as being asked similar questions repeatedly by different providers, having to share personal information in non-private settings, rooming by sex rather than gender, and requiring disclosure of gender identity to multiple providers in part related to identification bracelets and electronic medical records reflecting sex rather than gender identity (56). The participants also reported lack of reliability of ED staff and clinicians being able to provide competent care for TGD people contributing to ED avoidance (56).

Another qualitative study of survey-based data supported the importance of ED providers and staff having trans care training, as clinicians with specific training on how to provide affirming and inclusive care for TGD people provided positive care experiences for the participants (57). A case example of a trans man’s experience in the ED reflected the above themes around the ED setting sometimes being traumatic, describing how his experience made him feel like “a freak show at the circus”, and he would never return to that facility after that experience (58). These negative experiences in the ED are reminiscent of unmet

care expectations that TGD patients often have in other healthcare settings as well, including experiencing regular misgendering and deadnaming, discrimination and othering by healthcare providers, probing by clinicians that make TGD patients feel like a specimen rather than a person, and gatekeeping of care where there are more barriers to accessing care for TGD people than for cisgender people (59). While experiencing more transphobia predictably leads to greater ED avoidance, having more social support reduced the likelihood of ED avoidance for TGD people (60).

While negative ED experiences and ED avoidance for TGD people are well-documented phenomena, the literature described above largely did not explore the specific experiences of TGD people presenting to the emergency department for mental healthcare. The need for acute mental healthcare is an important focus given the high prevalence of mental health conditions in TGD populations (26,61) combined with evidence that TGD people are more likely than cisgender people to present for ED psychiatric care despite the multiple reasons for ED avoidance described above (62,63). A recent scoping review of TGD patients' experiences of emergency psychiatric settings found that TGD ED patients tended to be younger, present with more suicidality and deliberate self-harm, had more prior mental healthcare utilization, and be more likely to receive a mood disorder diagnosis than cisgender ED patients (55,63,64). Previous studies have recommended care considerations for individual providers providing emergency psychiatric care for TGD patients, including the use of non-judgmental and inclusive language, cultural humility throughout the ED clinical encounter, and reflecting on clinician bias in providing care for TGD people (55). The studies also suggested the need for structural interventions to improve emergency psychiatric care for TGD patients, including the need for confidential spaces, allowing patients to have chosen support people participate in their care experiences, and having TGD-specific resources available in the ED (55).

The majority of the studies included in the scoping review on emergency psychiatric care experiences of TGD people were case reports and opinion articles (55), which while valuable, have limits in their ability to be used to inform evidence-based care and policy changes. Also, most of the included articles were from the United States, with one being from Italy, and only one being from Canada (55). There is thus a lack of understanding of

this topic from the Canadian context, which is relevant because the Canadian healthcare system is different than that of other countries, so data grounded in the Canadian context are best positioned to inform and improve care. The prior studies also did not explore in detail the factors that led to the need for ED psychiatric care for TGD patients, and did not use qualitative methodology (54,55,63,64). Qualitative methodology in particular can examine in-depth the reasons that TGD patients present to the ED for mental healthcare, elucidating potential interventions that can prevent the need for ED care that can be costly and traumatic (53,65). Qualitative methodology can also center the lived experiences of TGD patients in the ED psychiatric setting to understand what specific aspects of this care are experienced as helpful and harmful so that targeted interventions can address this. Such research can also clarify what experiences in the ED lead to subsequent care avoidance so that clinicians and policymakers can leverage this data to improve mental healthcare with and for TGD people.

1.3.2 TGD Individual Experiences of Psychiatric Hospitalization

Several studies have documented the increased need for mental health hospitalization in TGD populations using health administrative data (62,63,66,67). However, these studies have several important limitations, including the use of ICD-9 diagnoses of gender identity disorders and medical transition-based definitions in several studies to identify TGD individuals (63,66). This is not representative of many TGD people without these diagnoses and many who do not seek medical transition (i.e., gender-affirming hormone therapy or surgeries). One United States-based study used a convenience sample of TGD youth from one clinical site, which often confers selection bias (14). The prior studies also did not specifically examine the factors and individual characteristics associated with the increased need for psychiatric hospitalizations.

A United States-based study using health administrative data to examine inpatient clinical encounters for TGD patients (for both physical and mental health) found that TGD inpatients were more likely to be younger, have a lower household income, have no health

insurance coverage, and be treated at an urban teaching hospital than cisgender inpatients (68). A multivariable analysis controlling for demographic and clinical factors found a multifold increase in the odds of psychiatric diagnoses in the TGD inpatient encounters (68). The TGD inpatient encounters with a psychiatric disorder diagnosis were also more likely to have comorbid physical health diagnoses than the TGD inpatient encounters without a psychiatric diagnosis (68). While this study did examine psychiatric hospitalizations in a TGD population, this study did not directly compare TGD inpatient psychiatric encounters with cisgender inpatient psychiatric encounters (68), so it did not allow for isolation of the unique contribution of TGD identity on psychiatric hospitalizations.

A small number of qualitative studies and case studies exist that highlight the lived experiences of TGD people during psychiatric hospitalizations to further understand the impact of that experience and how to improve care in that setting (69–73). One qualitative study focused on TGD youth (age 13–17) in an inpatient psychiatric hospital setting (70). They highlighted several facilitators and barriers to the TGD patients experiencing the inpatient environment as supportive (70). No qualitative studies focused on TGD adults, which is supported by a recent scoping review on TGD inpatient mental healthcare (69), which found only seven articles, with the only qualitative study of patient experiences being the one with TGD youth (70). A qualitative study that focuses on TGD adults' lived experiences of inpatient psychiatric care would facilitate an in-depth understanding of how current inpatient settings impact TGD patients and how institutions and policies could improve.

The scoping review on inpatient psychiatric care for TGD patients highlighted six themes to consider for improving policies to better address the care needs of TGD patients in inpatient settings, including: (1) using chosen name and pronouns, (2) communicating among providers (including through proper documentation and the use of electronic medical record systems), (3) training in TGD healthcare, (4) addressing personal bias among providers, (5) creating formal policies that are inclusive and affirming, and (6) housing segregation by gender rather than sex (69). These clinical recommendations for inpatient psychiatric care for TGD people resonate with the discussion from other case studies and clinical opinion articles on the topic (71–74). The seven studies included in the

scoping review were from the United States, the United Kingdom, and Australia (69). An in-depth qualitative study that examines TGD people's experiences of psychiatric hospitalization in Canada would be potentially fruitful in confirming and extending these care considerations for the Canadian context.

None of the studies described above used mixed methods research to examine the experience of psychiatric hospitalizations for TGD individuals. Mixed methods research combining health administrative data and qualitative research on this topic could uniquely highlight population-based factors associated with psychiatric hospitalizations for TGD people while using qualitative methodology to explain those quantitative results in-depth (43). This could offer findings that use complementary methodology to identify areas of intervention to improve care not only for TGD patients in hospital but also in their mental health journeys prior to presenting for acute care.

1.3.3 Post-Discharge Access to Mental Healthcare

Equity in access to mental healthcare early after discharge from acute psychiatric care has been a focus in the literature (75–81). Outpatient treatment of mental health conditions soon after an ED visit or hospitalization has been associated with reductions in substance use, future ED visits and hospitalizations, number of inpatient days, and even mortality (77,82,83). Physician follow-up after a psychiatric hospitalization is known to differ by diagnosis (78–80), socioeconomic status (76,78), geography (78,80), trauma history (79), racialization (78,81), and other factors. Despite this variability, post-discharge mental health follow-up is poor overall (75,79,80). No study to our knowledge has focused on this quality-of-care measure (84,85) for TGD patients. A recent study of follow-up after post-partum psychiatric ED visits found social-determinants-of-health-based disparities in post-discharge access to care, including reduced likelihood of follow-up in individuals who were younger, immigrants, and/or living in areas with lower neighbourhood income or in smaller communities (76). These studies highlight the value of examining post-discharge access to mental healthcare for marginalized populations, and the potential for health administrative data to highlight health inequities.

No studies have used qualitative research to explain post-discharge outcomes from health administrative data as part of a sequential mixed methods study (43). Using qualitative data to understand the post-discharge mental health journeys of TGD people has the potential to explain the health administrative data by centering the lived experiences of those with firsthand knowledge of the phenomenon being studied and advocate with the community to improve the system (43,44). Many TGD people do not use mental health services even when they need them because of barriers related to income and healthcare costs, geography, mental health status, not believing care would be effective, and not trusting providers to understand their needs and experiences (86). Qualitative research would allow for clarity around whether and how these factors affect post-discharge care; and what specific experiences before, during, and in the early days after discharge from acute psychiatric care impact post-discharge access to mental healthcare for TGD patients.

1.4 Methodology

1.4.1 Mixed Methods Study Design

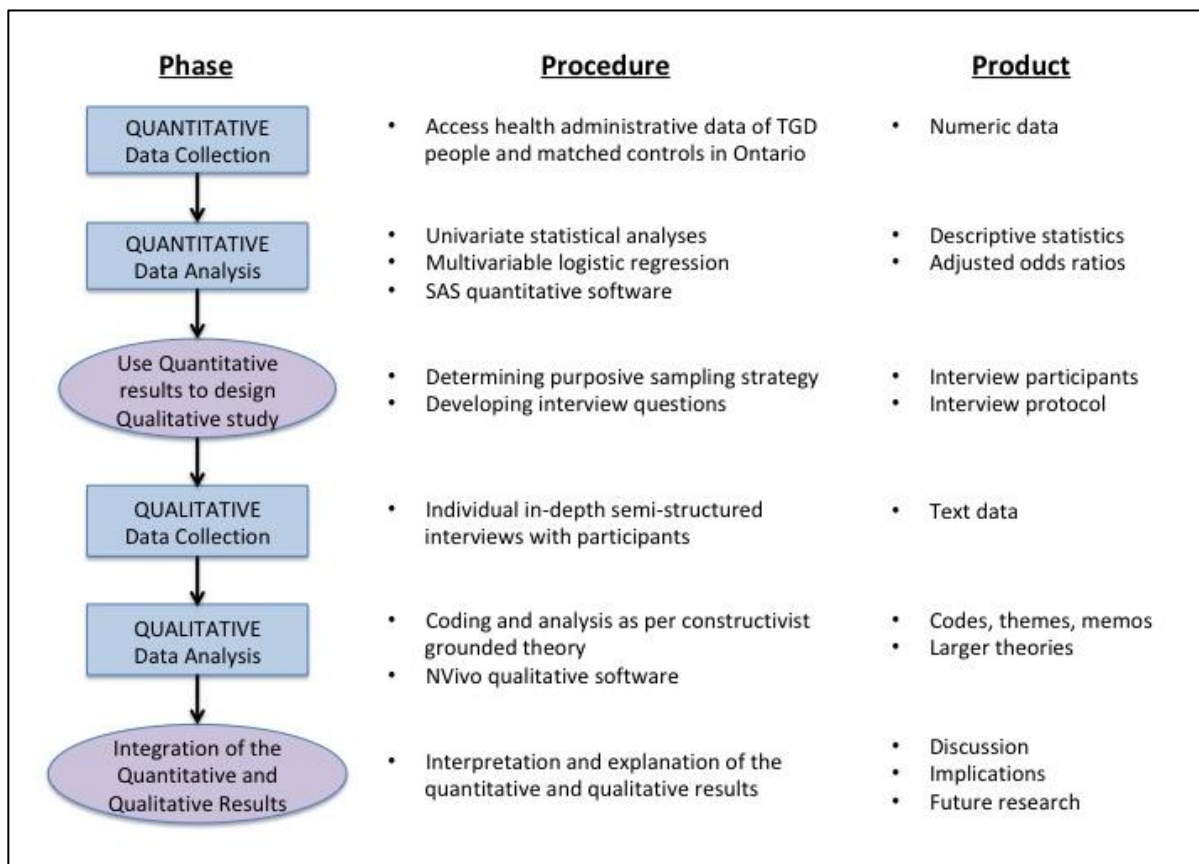
The sequential explanatory mixed methods study design (43) consists of two distinct phases: quantitative followed by qualitative. This design starts with the research collecting and analyzing quantitative data. The qualitative data are then collected and analyzed sequentially second after the quantitative data to help explain or elaborate on the quantitative results from the first phase. The second qualitative phase builds on and connects to the first quantitative phase through an intermediate stage in the study. The rationale for this approach is that the quantitative data and their analysis provide a general understanding of the research problem. The qualitative data and their analysis refine and explain those statistical results by exploring participants' views in more depth.

In this study, the quantitative results guided the refinement of the qualitative study design and the data collection plan in the qualitative study, including guiding the purposive sampling strategy used and the list of sensitizing concepts and interview questions. After all the quantitative and qualitative data were analyzed, the results were interpreted and

integrated together for enhanced understanding, with the qualitative results expanding on and explaining certain quantitative results. We cannot guarantee that the participants in the qualitative study were also participants in the quantitative studies because of the de-identified nature of the health administrative data used in the quantitative studies. However, the inclusion criteria and purposive sampling strategies used ensured that there are similarities in the participants to be able to use the qualitative results to help understand the quantitative results. See **Figure 2** for a diagram of the study design.

Below I describe in detail the methodology guiding each of the three studies that formed this mixed methods research thesis project.

Figure 2. Study design of the mixed methods research. TGD: transgender and gender diverse.



1.4.2 First Paper: Quantitative Study – *Characteristics of Transgender and Gender Diverse Individuals Who Access Mental Health Hospitalization and Emergency Department Visits in Ontario*

Summary

Question: Amongst individuals discharged from a mental health hospitalization or emergency department visit in Ontario, what are the differences in demographic, clinical, and previous health service utilization characteristics between transgender and gender diverse (TGD) individuals and non-TGD individuals?

Population: 1) Individuals discharged from a mental health hospitalization in Ontario.
2) Individuals discharged from a mental health-related emergency department (ED) visit in Ontario.

Exposure: TGD individuals who have been identified as TGD at one of four trans-inclusive health care clinics AND who have been discharged from a mental health hospitalization (sample 1) or discharged from a mental health-related ED visit (sample 2) in Ontario.

Comparison: Non-TGD patients who have been discharged from a mental health hospitalization or a mental health ED visit in Ontario.

Outcome: Descriptive characteristics of the demographic, clinical, and previous health service utilization factors of the individuals.

Study Question

Amongst individuals discharged from a mental health hospitalization or emergency department visit in Ontario, what are the differences in demographic, clinical, and previous health service utilization characteristics between transgender and gender diverse (TGD) individuals and non-TGD individuals?

Study Design and Setting

This was a descriptive study using linked health administrative data to compare TGD individuals who had a mental health hospitalization (sample 1) or a mental health ED visit (sample 2) to individuals from the general population who had a mental health hospitalization or ED visit in Ontario. The accrual window for the index discharge was January 1, 2012 to December 31, 2018. There was a two-year look-back window prior to the index discharge date to obtain data on previous health service utilization.

Data Sources

All the variables described below were captured by health administrative databases in Ontario linked through the Institute for Clinical Evaluative Sciences (ICES). ICES is able to link different health administrative data sources using an encrypted unique identifier for each individual (the IKN). The following are different ICES data sources. The Registered Persons Database (RPDB) includes demographic information such as date of birth and residential neighbourhood. The OHIP database includes physician billing information, including date of visit and diagnosis. The ICES Physician Database (IPDB) contains information about the specialty type of the physician providing services. The National Ambulatory Care Reporting System (NACRS) contains information about Emergency Department (ED) visits. The Ontario Mental Health Reporting System (OMHRS) database includes information from psychiatric admissions starting in 2005. The Hospital Discharge Abstract Database (DAD) captures information from medical hospitalizations in non-mental health hospital beds. The Ontario Marginalization Index (ON-Marg) is an area-based index that shows differences in marginalization between geographic areas and explores four dimensions of marginalization: residential instability, material deprivation, dependency, and ethnic concentration (87). The Transgender Client's Health Information (transgender clients) dataset includes TGD individuals identified from four clinics in Ottawa, Thunder Bay, and Toronto with their data linked by ICES through approved data sharing agreements.

Study Population

All individuals aged 16 and above who were discharged from a mental health hospitalization (sample 1) or mental health-related ED visit (sample 2) in Ontario between January 1, 2012 and December 31, 2018 were eligible to be in the study population. A mental health hospitalization discharge was defined by having a hospitalization in the DAD or OMHRS dataset with a primary discharge diagnosis that is an ICD or DSM psychiatric code. A mental health-related ED discharge was defined by having an ED visit in the NACRS dataset with a primary discharge diagnosis that is an ICD psychiatric code. The discharge psychiatric diagnosis confirms that the hospitalization or ED visit was primarily due to a mental health reason.

The index discharge date was the individual's first discharge within the specified time period. For individuals with a second discharge date within 30 days after the index discharge date, the second discharge date was used as the index discharge date instead. Individuals with a third discharge date within 30 days after the second discharge date were excluded.

Inclusion criteria included participants who: 1) had an index discharge date, 2) had a valid ICES number (IKN number) for data linkage purposes, 3) were Ontario residents, 4) were alive at discharge, and 5) were between the ages of 16 and 105. It is possible for the same individual to be in both the hospitalization (sample 1) and ED visit (sample 2) samples if they met the inclusion criteria for each group.

Exclusion criteria included individuals missing a valid discharge diagnosis, age, LHIN, or sex. A death date preceding a mental health hospitalization or ED visit for an individual suggests data error and was excluded as well.

Exposure

The TGD samples were defined by having TGD identity based on the intersection of individuals who have been discharged from a mental health hospitalization or ED visit between 2012 and 2018 (i.e. part of the study population) AND who identified as TGD in

the transgender clients dataset. The transgender clients dataset is a linked dataset that reliably identified TGD individuals from four clinics in Ottawa, Thunder Bay, and Toronto. The clinics' electronic medical records between 2012 and 2016 accurately captured gender identity data and were used to create the transgender clients dataset. There are approximately two thousand TGD individuals in the dataset. Preliminary analysis suggested that 411 (around 20%) of the TGD individuals have had a mental health hospitalization within the data accrual window.

Comparison Group

Two comparison groups were created, one for each TGD sample to understand the ways in which the TGD population differs from the general Ontario population of acute care users (unmatched) and from a non-TGD population from the same health regions with similar demographics and prior mental healthcare history (matched). In each matched comparison group, four comparison group individuals were found to match with each TGD individual based on shared age, health region of residence, and mental healthcare utilization history. Local health region of residence is a variable capturing which of fourteen Local Health Integration Networks (LHINs) the individual resides in. LHINs were previously the health authorities responsible for regional administration of public healthcare services in Ontario. Individuals were categorized into four categories of mental healthcare utilization history based on their mental health service use in the 24 months prior: 1) having any psychiatric hospitalization history, 2) if not 1, then having any psychiatric ED visit history, 3) if not 1 or 2, then having any outpatient mental health visit history, and 4) having none of the above. This categorization strategy approximates mental illness severity history based on the greater use of acute psychiatric care for patients with greater illness severity (88).

Outcomes

The outcomes were the demographic, clinical, and previous health service utilization factors for the individuals in each sample. Demographic factors included age, LHIN, rurality, neighbourhood income quintile, and Ontario Marginalization Index quintile scores (for

dependency, residential instability, material deprivation, and ethnic concentration). Specific gender identity is not reliably captured in the TGD or non-TGD samples so it was not used in this study (62). Clinical factors included the primary discharge diagnosis in seven categories: 1) mood disorder, 2) anxiety disorders, trauma/stress-related/OCD and related disorders, 3) schizophrenia and psychotic disorders, 4) substance-related disorders, 5) personality disorders, 6) deliberate self-harm, and 7) other mental health diagnoses. Previous mental healthcare utilization factors measured in the two years prior to the discharge date included previous mental health hospitalizations, mental health ED visits, mental health outpatient visits, non-fatal deliberate self-harm, and continuity of mental health care (defined as two or more outpatient mental health visits with the same physician).

Statistical Methods

The quality of the variables was assessed including for the percentage of missing data for each variable. ICES linked databases generally have a low proportion (less than 5%) of missing data. Tables were created to outline the demographic, clinical, and prior mental health service utilization variables for the samples to compare and describe the characteristics of the samples. Univariate analyses were used to assess for statistically significant differences between the samples.

1.4.3 Second Paper: Quantitative Study – *Access to Outpatient Mental Health Care for Transgender and Gender Diverse Individuals After Discharge from Acute Mental Healthcare in Ontario*

Summary

Question: Amongst individuals discharged from a mental health hospitalization or emergency department visit in Ontario, what is the association between transgender and gender diverse (TGD) individuals and post-discharge physician follow-up within 30 days?

Population: 1) Individuals discharged from a mental health hospitalization in Ontario.
2) Individuals discharged from a mental health-related emergency department (ED) visit in Ontario.

Exposure: TGD individuals who have been identified as TGD at one of four trans-inclusive health care clinics AND who have been discharged from a mental health hospitalization (cohort 1) or discharged from a mental health-related ED visit (cohort 2) in Ontario.

Comparison: Non-TGD patients who have been discharged from a mental health hospitalization or a mental health ED visit in Ontario.

Outcome: Post-discharge outpatient mental health physician follow-up in Ontario within 7 days and within 30 days (binary outcome; yes or no).

Study Question

Amongst individuals discharged from a mental health hospitalization or ED visit in Ontario what is the association between TGD identity and post-discharge physician follow-up?

Study Design and Setting

This was a matched retrospective cohort study using linked health administrative data to compare TGD individuals who had a mental health hospitalization (cohort 1) or a mental health ED visit (cohort 2) to individuals from the general population who had a mental health hospitalization or ED visit in Ontario. These cohorts were followed after discharge from the hospitalization or ED visit to assess for an outpatient mental health physician visit in Ontario in the 7 and 30 days after discharge. The accrual window for the index discharge was January 1, 2012 to December 31, 2018. The maximum follow-up date was January 30, 2019. There was a two-year look-back window prior to the index discharge date to obtain data on previous mental healthcare utilization.

Data Sources

All the variables described below were captured by health administrative databases in Ontario linked through the Institute for Clinical Evaluative Sciences (ICES). ICES is able to link different health administrative data sources using an encrypted unique identifier for each individual (the IKN). The following are different ICES data sources. The Registered Persons Database (RPDB) includes demographic information such as date of birth and residential neighbourhood. The OHIP database includes physician billing information, including date of visit and diagnosis. The ICES Physician Database (IPDB) contains information about the specialty type of the physician providing services. The National Ambulatory Care Reporting System (NACRS) contains information about Emergency Department (ED) visits. The Ontario Mental Health Reporting System (OMHRS) database includes information from psychiatric admissions starting in 2005. The Hospital Discharge Abstract Database (DAD) captures information from medical hospitalizations in non-mental health hospital beds. The Ontario Marginalization Index (ON-Marg) is an area-based index that shows differences in marginalization between geographic areas and explores four dimensions of marginalization: residential instability, material deprivation, dependency, and ethnic concentration (87). The Transgender Client's Health Information (transgender clients) dataset includes TGD individuals identified from four clinics in Ottawa, Thunder Bay, and Toronto with their data linked by ICES through approved data sharing agreements.

Study Population

All individuals aged 16 and above who were discharged from a mental health hospitalization (cohort 1) or mental health-related ED visit (cohort 2) in Ontario between January 1, 2012 and December 31, 2018 were eligible to be in the study population. A mental health hospitalization discharge was defined by having a hospitalization in the DAD or OMHRS dataset with a primary discharge diagnosis that is an ICD or DSM psychiatric code. A mental health-related ED discharge was defined by having an ED visit in the NACRS dataset with a primary discharge diagnosis that is an ICD psychiatric code. The discharge

psychiatric diagnosis confirms that the hospitalization or ED visit was primarily due to a mental health reason.

The index discharge date was the individual's first discharge within the specified time period. For individuals with a second discharge date within 30 days after the index discharge date, the second discharge date was used as the index discharge date instead. Individuals with a third discharge date within 30 days after the second discharge date were excluded.

Inclusion criteria included participants who: 1) had an index discharge date, 2) had a valid ICES number (IKN number) for data linkage purposes, 3) were Ontario residents, 4) were alive at discharge, and 5) were between the ages of 16 and 105. It was possible for the same individual to be in both the hospitalization (cohort 1) and ED visit (cohort 2) cohorts if they met the inclusion criteria for each cohort.

Exclusion criteria included individuals missing a valid discharge diagnosis, age, LHIN, or sex. A death date preceding a mental health hospitalization or ED visit for an individual suggests data error and was excluded as well.

Exposure

TGD individuals were identified through data from four outpatient 2SLGBTQIA+ specialty health clinics with the capacity to systematically identify TGD individuals in their clinic electronic medical records (EMR) in three cities (Thunder Bay, Toronto, Ottawa) across Ontario. Questions regarding gender identity were on clinic intake forms, so each patient was asked to describe their gender identity. One of the four clinics was unable to provide specific gender identity information, though they were able to reliably identify a sample of TGD patients. Three of the four clinics provide primary care to their patients. The manager of health information at each clinic identified all TGD patients from 2012-2016 through their EMR. Individuals' Ontario health insurance numbers and date of birth were used to link individuals to administrative databases at ICES. This process has been previously described (62). All TGD individuals were identified from the study population to create the

two TGD cohorts in this study.

Comparison Group

The comparison groups for each TGD cohort included all individuals in the general Ontario population who were discharged from a psychiatric hospitalization (hospitalization cohort) or mental health-related ED visit (ED cohort) in Ontario between January 1, 2012 and December 31, 2018 who were not identified as part of the TGD cohorts. The exposure variable is a binary variable of either being in the TGD cohort or the comparison cohort.

Outcomes

For each cohort, the primary outcomes were whether the individual had any post-discharge mental health-related outpatient physician visit within 7 days (yes or no) and within 30 days (yes or no) of discharge. A mental health-related outpatient physician visit was defined by using billing claims data in the OHIP database as defined by 1) an outpatient psychiatrist visit, 2) an outpatient family physician visit with a psychiatric ICD diagnostic code, or 3) an outpatient pediatrician visit with a psychiatric ICD diagnostic code. The secondary outcomes assessed whether the individual had a post-discharge mental health-related outpatient physician visit within 7 and 30 days of discharge for each of the physician types, including a category for individuals who have had visits with two or more physician types. The primary and secondary outcomes were all binary variables (yes or no).

Potential Confounders

Potential confounders included rurality index of Ontario (RIO), neighbourhood income quintile, psychiatric diagnosis, and previous mental healthcare utilization while potential mediators included experiences of marginalization as measured by the Ontario Marginalization Index (ON-Marg) (87).

Statistical Methods

Analysis of the quantitative study was guided by the early development of a directed acyclic graph (DAG) *a priori* (see **Figure 3**) (89), which was based on the existing literature and the minority stress model (see section 1.2.1 above on *Minority Stress Theory*).

Descriptive and baseline characteristics (frequencies, means) were calculated across cohorts. Differences between samples were explored using χ^2 tests and Student's t-tests as appropriate. Statistical significance comparing samples was set to $p < 0.05$ in two-tailed tests. For the primary and secondary outcomes, we used multivariable binary logistic regression models to examine the effects of each TGD group compared with the reference population, adjusted for age, LHIN, rurality of residence, neighbourhood income quintile, ON-Marg quintiles, psychiatric diagnosis, any previous psychiatric hospitalizations, any previous mental health-related ED visits, number of previous psychiatric outpatient visits, and any previous non-fatal deliberate self-harm. The outcomes were also assessed by diagnostic category. All analyses were performed using SAS version 9.4 (SAS Institute).

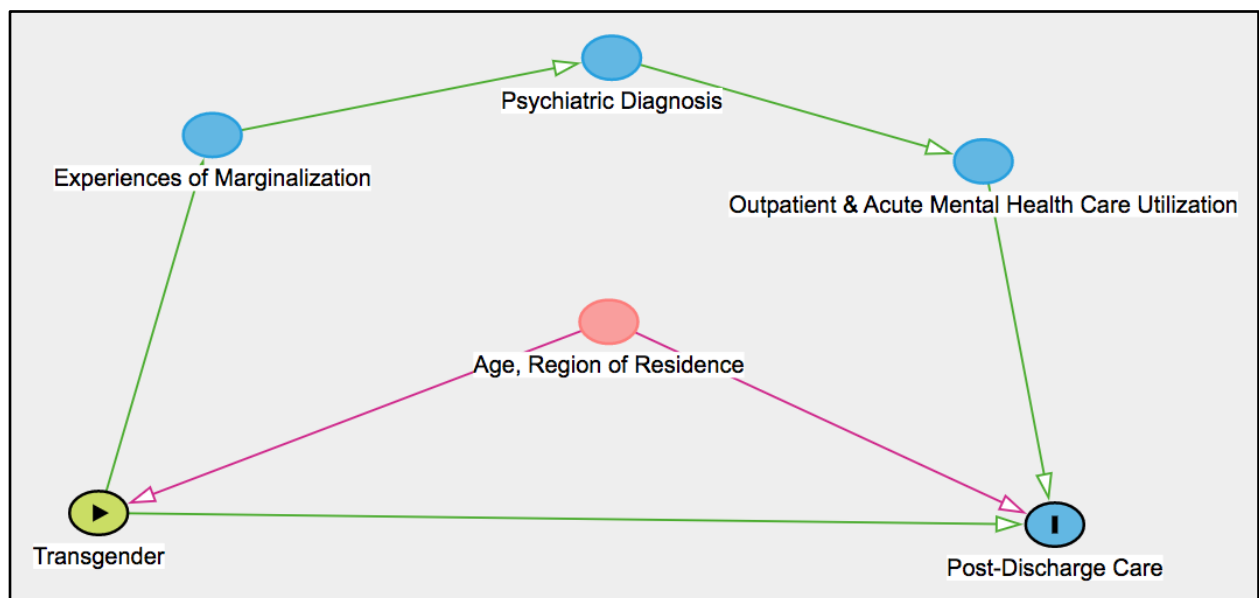


Figure 3. Directed acyclic graph (DAG) guiding the quantitative study.

1.4.4 Third Paper: Qualitative Study – *Exploring Transgender and Gender Diverse Individuals’ Lived Experiences of Acute Mental Health Care and Post-Discharge Journeys*

Study Overview

The main **research question** guiding this study asked, *how do transgender and gender diverse (TGD) individuals living in Toronto, Ontario with a history of mental health hospitalization(s) or emergency department (ED) visit(s) understand and experience their hospitalization(s) and ED visit(s), and their journey after discharge?* The **study objective** was to understand barriers and facilitators to accessing acute mental healthcare and post-discharge care for TGD people to inform further research and policy and service delivery changes. Results from the prior quantitative studies guided this research design and data collection plan, including sensitizing concepts used for interviews and the purposive sampling strategy. An interpretivist life history approach to the study design and analysis was used to leverage lived experience to understand how individual factors interact with systemic and institutional factors to affect access to acute mental healthcare and post-discharge mental healthcare.

Study Aims

This qualitative study had the **specific aims** to:

- 1) Explore the lived experiences of transgender and gender diverse (TGD) individuals leading up to and during a) mental health hospitalization(s) and b) mental health-related emergency department visit(s).
- 2) Understand TGD individuals’ post-discharge access to mental healthcare, and the factors impacting and influencing that experience.

Study Design

Individual semi-structured qualitative interviews and analysis were informed by constructivist grounded theory (48,90), which allows for the exploration of cultural and social determinants that may influence behaviour. Grounded theory is a systematic

qualitative research methodology that emphasizes the generation of theory rooted in data (90). Constructivist grounded theory assumes a relativist approach, acknowledges multiple standpoints and realities, and takes a reflexive stance towards actions, situations, and participants (48). Constructivist grounded theory can inform the examination of social psychological processes, data collection, data analytic approach, and development of abstract theoretical frameworks that explain the studied process (48). Qualitative interviewing can elicit views from the participant's subjective world to guide in-depth exploration of an aspect of life about which the participant has substantial experience (48).

Participants & Recruitment

Self-identified TGD individuals living in the Greater Toronto Area (GTA) with a history of mental health hospitalization(s) or mental health-related emergency department visit(s) in Ontario were recruited from hospitals, shelters, community centres, clinics, other health care and community organizations, and through social media within a two-year period after ethics approval was received. Recruitment purposively occurred both in and out of healthcare institutions to elicit a diversity of perspectives. We used maximum variation sampling to maximize diversity of demographic factors including age, gender identity, ethno-racial status, and prior acute mental healthcare utilization. The specific purposive sampling strategy was guided by the quantitative results from the previous studies. Data saturation was informed by constructivist grounded theory methodology and (48) based on the concept of information power to determine sample sizes in qualitative studies (91). Participants were recruited only from the Greater Toronto Area for feasibility of the study and to facilitate understanding of lived experiences that share a geographical context. Since two of the trans-inclusive clinics in the quantitative study (described above) were in Toronto, this qualitative study focusing on TGD individuals in the Greater Toronto Area has the potential to extend and clarify results from the quantitative study.

Inclusion criteria included individuals who:

- Identified as **transgender and/or gender diverse** (inclusive of non-binary, Two-Spirit, genderqueer, genderfluid, and other gender diverse identities)

- ⦿ Were comfortable conducting an interview in English
- ⦿ Were at least 18 years old
- ⦿ Had at least one mental health hospitalization or mental health-related emergency department visit since age 18

Exclusion criteria included individuals experiencing any of the following at the time of the interview:

- ⦿ Manic symptoms
- ⦿ Active substance intoxication or withdrawal
- ⦿ Significant cognitive impairment affecting ability to consent to study participation

Study Setting

Interviews occurred virtually, with only the interviewer and participant present.

Data Collection and Analysis

The interviewer explained the study, went through the informed consent process, and answered any questions from each participant. Each participant completed a brief structured demographic interview so the sample could be later described. Each participant underwent a semi-structured qualitative interview in English. A semi-structured qualitative interviewing format allows the interviewer and respondent to engage in a one-on-one, informal interview. The interviewer used an interview guide informed by life history exploration as well as sensitizing concepts related to gender, mental health, healthcare access, experiences of care, and recovery. The specific list of sensitizing concepts and interview questions were guided by the quantitative results from the previous studies that the research team wanted to understand further. Participants were remunerated for their time.

Qualitative interviews were taped and transcribed verbatim. Data were entered into NVivo, an electronic text management and analysis software package designed to support a

variety of research methods, including grounded theory. Each transcript was coded. Memos were written after coding and the coding and memos were reviewed and discussed with the research team. Coding was an on-going process during the data collection period, with analysis informing the list of sensitizing concepts in later interviews (92). Analytic memos were written iteratively to capture major issues relevant to each code. Each transcript was coded at least twice to ensure earlier transcripts were examined for themes that developed through the data analysis process. The team met throughout data analysis to explore emergent themes and construct larger theories. Data collection ended when no new codes were generated in data analysis and the identified themes adequately captured and categorized the phenomena, relationships between concepts, and complexity of experiences. This is also known as data saturation (48).

We also recruited individuals who identify as trans and/or gender diverse, who are also clinicians and/or researchers with experience and expertise in trans health, to provide feedback on the qualitative data analysis to improve scientific rigour. An honorarium was provided.

1.5 Ethical Considerations

1.5.1 Ethical Considerations Related to the Quantitative Studies

For the first two quantitative studies using health administrative data, this project was conducted using linked health administrative data held at ICES. ICES is an independent, non-profit research institute whose legal status under Ontario's health information privacy law allows it to collect and analyze healthcare and demographic data, without consent, for the purposes of health system evaluation, planning, and monitoring. The use of data in this project was authorized under section 45 of Ontario's Personal Health Information Protection Act, which does not require review by a Research Ethics Board. The linkage of external data to ICES for this project has been approved by the Research Ethics Board at the University of Toronto (RIS Protocol # 38210). There is a very small risk of loss of privacy for individuals but this risk is minimal because the data used are already de-identified and any publications and presentations will only have summarized results with

any small cells suppressed.

1.5.2 Ethical Considerations Related to the Qualitative Study

The qualitative study protocol and materials were reviewed and approved by the CAMH Research Ethics Board (REB # 132/2021). There were a few potential risks to participants that required consideration and mitigation strategies, which are described below.

Distress

Qualitative interviews may be distressing to participants considering the personal nature of the questions. I attempted to minimize this by 1) using a semi-structured interview that guided participants to describe their own narratives rather than mandate answers to specific questions, 2) encouraging participants to stop the interview or skip any questions they did not feel comfortable with, and 3) ensuring that the interviewer had expertise to identify levels of distress and recognize the potential need for further care (which I had as a psychiatrist). Resources were also readily available for any distressed participants and a list was shared with participants before the interviews.

Exploitation

Interviewees could have felt pressured to participate if they felt their participation affected future access to care. This potential harm was minimized by being clear to the participant throughout the research process about roles and boundaries, stressing that refusal to participate will not affect their care at CAMH or anywhere else in any way. As I am a practicing psychiatrist, I also ensured that I had not had any patient care contact with any of the participants prior to the interviews.

Misrepresentation

Qualitative research is interpretive in nature, and participants may feel misrepresented by the researchers' construction of their lived experiences. This risk was minimized with analysis of the data with multiple researchers who have qualitative research experience. Multiple community advisors who identify as TGD and are also clinicians and/or researchers in trans health were also recruited and provided feedback during the data

analysis to improve scientific rigour and ensure that the results of the data analysis represent lived experiences in the TGD community. Reaching data saturation through the data analysis process and triangulating the qualitative data with both the extant literature and the results from the first two quantitative studies in this project also contributed to minimizing the risk of misrepresentation of participant lived experience.

Identification

Audio recordings and interview transcripts likely contain clues to a person's identity. The storage of recordings and transcripts was therefore secured through locked cabinets and encrypted files on the encrypted internal CAMH server. Names and all other identifying details were removed from transcripts. Great care was taken to ensure no participant can be identified in any publications or presentations. Audio recordings will be deleted within two years of the initial recording. Transcripts will be deleted within two years of completion of the study.

Remuneration

Participants received a \$40 honorarium to compensate them for their time (expected to be 60 minutes to 120 minutes) and participation in the study. This compensation amount is consistent with other study protocols at CAMH and in qualitative research more broadly. Compensation is particularly important as an ethical consideration when interviewing participants from a population that has experienced significant oppression in both healthcare and research settings.

1.6 Reflexivity

Aspects of a researcher's identity are foundational in shaping who we are and how we see the world. Practicing reflexivity around our social identities and positionalities as researchers and human beings, and how that has tangible impact on the research process from beginning to end is of crucial importance to understand power relations with participants and ensure that ethical and rigorous research is conducted (93). While reflexivity is a longstanding tradition in qualitative research (94,95), there is increasing

recognition of the importance of reflexivity in being applied to the entirety of a mixed methods study to ensure high-quality ethical research (96). There are reflexivity tools and existing literature that can guide researchers in engaging in reflexivity and understanding their positionality in relation to their participants and the research study as a whole that is crucial work in practicing rigorous mixed methods research (93–96), especially when working with marginalized populations and for the purpose of equity-oriented research.

I am a queer racialized person of East Asian descent, a Chinese-Canadian, and a practicing psychiatrist working as a clinician and educator in trans health and gender-affirming care. In my social location I have witnessed and experienced realities of oppression that people experience because of aspects of one's identity. I have learned and seen how multiple intersecting systems of oppression and inequity (including transphobia, racism, classism, sexism, homophobia, and ableism) lead to different people having different unearned advantages and disadvantages in society, and how this has real-life impacts on people having inequitable health outcomes and access to care (97). These experiences have shaped this thesis project throughout, including shaping the project's main research questions around access to care for TGD people and how the findings are framed.

I have an interest in quantitative and qualitative research, and particularly in the potential for mixed methods research for health services research. My clinical and academic work is rooted in understandings of intersectionality (52) and minority stress theory (41). As a queer person, I know what it is like to live daily with minority stress, so I know the minority stress theory reflects real lived experiences and is a plausible explanation for many TGD people's inequitable mental health outcomes. The minority stress model is thus a guiding theory that underlies how this thesis project was conceived and designed, how the data were analyzed, and how the results were interpreted.

As both a researcher and a physician, my goal is to leverage scientific knowledge to inform evidence-based care and policy changes that reduce health inequities, especially for 2SLGBTQIA+ communities. That positionality has oriented this work towards framing of the results in ways that hopefully best leverages the data and findings as evidence to drive practice and policy changes to improve care with and for TGD people. I decided it was

important to seek the expertise of multiple advisors during the data analysis process who identify as TGD and are experts in trans health research and/or clinical practice to further ensure that the findings both reflect lived experiences of TGD individuals (recognizing that the experiences and perspectives of TGD people are not monolithic) and are optimally positioned for uptake towards improving care. As our positionalities as researchers drive and guide our work (93–95,98,99), as it has in this study, reflexivity and transparency around our social locations and their impacts on our research are crucial.

1.7 Summary of Dissertation Manuscripts

The following three chapters are three manuscripts from this mixed methods research thesis project. Chapter 2 is a quantitative study that used health administrative data to examine the sociodemographic and clinical characteristics of TGD individuals who presented for mental health ED visits and hospitalizations. Through a matching protocol, we were able to isolate the unique factors associated with TGD identity for individuals presenting for acute mental healthcare in Ontario. Our deliberate inclusion of measures of marginalization allowed us to explore the association between social determinants of health measures and the need for acute mental healthcare in TGD populations. We found that TGD individuals presenting for acute mental healthcare were more likely to live in areas of low income and high residential instability and material deprivation than the general population of acute psychiatric care users. We also found that TGD individuals were presenting for acute mental healthcare with a different diagnostic pattern, namely with a greater likelihood of presenting for mood disorders and personality disorders. We explore the significance of these findings and suggest some potential reasons for these associations, grounded in the extant literature.

Chapter 3 presents data from the second quantitative study using the same health administrative data to understand access to physician-based mental healthcare in Ontario for TGD patients early after discharge from acute mental healthcare. We used multivariable binary logistic regression models to examine the effects of TGD status on post-discharge outcomes, adjusting for variables we had found to differ between groups from the first study and were associated with post-discharge outcomes. We found that TGD individuals

had increased follow-up in the month after discharge from the ED compared to the general population of acute care users, but reduced follow-up after discharge from a psychiatric hospitalization. We examined the post-discharge outcomes by diagnostic category to attempt to understand this discrepancy further. We discuss the clinical implications and the potential reasons for these findings, but we also make a case for the limits of health administrative data in understanding these results, and the importance of qualitative research to center lived experience of TGD people who have had acute mental healthcare experiences to explain these quantitative findings.

Chapter 4 is grounded in the findings of the qualitative study where I interviewed fifteen TGD individuals in the Greater Toronto Area who have lived experience of acute and post-discharge mental healthcare, and analyzed their data using Charmaz's constructivist grounded theory methodology (48). I co-constructed a model of the experiences of TGD patients who end up seeking acute mental healthcare, highlighting how their prior lived experiences and frustrations in accessing care led to presenting to the emergency department as one of few remaining pathways for them to access needed care. Their experiences before, leading up to, and during the acute care visit impacted and influenced how and whether they accessed mental healthcare after discharge. This theory explains the prior quantitative findings from Chapters 2 and 3, and Chapter 4 goes on to present quantitative and qualitative findings together in joint displays, and discusses in detail how the qualitative results explain the prior quantitative findings, consistent with mixed methods research methodology (43).

Finally, Chapter 5 summarizes and make connections between the three studies, discussing the potential substantive, theoretical, and methodological contributions this thesis project offers. Chapter 2 is discussed further in the context of the relationships between minority stress, social determinants of health, and acute mental healthcare presentations for TGD people. I also reflect on both the potential and limitations of health administrative data in exploring the factors related to this acute care need. Chapter 3 is leveraged to further reflect on how health administrative data can be used to highlight health inequities facing marginalized populations, though it is also combined with caution around its challenges and limitations. Chapter 4 is then revisited for its methodological contributions

demonstrating the potential strength of using mixed methods research for equity-oriented health services research. Ways in which the mental health system is not designed to provide inclusive care for TGD people are highlighted, and I discuss the potential clinical and policy implications from the integrated mixed methods findings. Finally, I address the limitations of this thesis project, situate the findings in the broader context of TGD health and mixed methods literature, and suggest future directions that can be considered based on this work.

A final note to clarify that though I am using the pronoun “I” throughout the Introduction and Discussion chapters (Chapters 1 and 5) of this thesis project, I shift to mainly using the pronoun “we” in the core three manuscript chapters of this thesis (Chapters 2, 3, and 4) in recognition of the significant contributions and guidance provided by my thesis committee in facilitating the completion of this project throughout.

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Chapter 2

2 **Characteristics of transgender and gender diverse individuals accessing emergency department visits and hospitalizations for mental health**

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2.1 Abstract

Objective: Transgender (trans) and gender diverse (TGD) individuals experience significant oppression resulting in mental health disparities. Factors associated with their need for acute mental healthcare are unknown. This study compared characteristics of TGD individuals who presented for acute mental healthcare to population-based comparison samples.

Methods: This cross-sectional study examined TGD individuals who had a mental health-related Emergency Department (ED) visit (n=728) or hospitalization (n=454). TGD individuals were identified and their data linked with health administrative data. The TGD ED and hospitalization samples were each compared to two samples: all individuals who had an ED visit or hospitalization (unmatched); and individuals matched on age, local health region of residence, and mental healthcare utilization history. Individuals were compared on sociodemographic and clinical factors.

Results: After matching, TGD individuals in the ED sample remained more likely than comparison group individuals to be in the lowest neighbourhood income

quintile (37% vs. 28%) and the highest residential instability quintile (47% vs. 29%); and diagnosed with a mood (26% vs. 16%) or personality disorder (3.6% vs. 0.7%). TGD individuals in the hospitalization sample remained more likely to be in the lowest neighbourhood income quintile (36% vs. 29%) and the highest residential instability quintile (45% vs. 31%); and diagnosed with a mood (40% vs. 36%) or personality disorder (5.3% vs. 1.8%).

Conclusions: TGD individuals who accessed acute mental healthcare had unique sociodemographic and clinical factors associated with their presentation that persisted after matching. More research into the factors associated with their acute care presentation is warranted, including how experiences of marginalization play a role.

2.2 Highlights

- Indicators of socioeconomic marginalization (living in areas of low income and high residential instability and material deprivation) were associated with the transgender and gender diverse (TGD) samples.
- TGD individuals who presented for a psychiatric Emergency Department visit were more likely diagnosed with a mood or personality disorder, and less likely a substance-related disorder than population-based comparators.
- TGD individuals who had a psychiatric hospitalization were more likely to be admitted for a mood or personality disorder, and less likely a psychotic or substance-related disorder.

2.3 Introduction

Transgender (trans) and gender diverse (TGD) people are individuals whose gender identity differs from their sex assigned at birth (1). They are estimated to represent at least 0.5% of the population (2,3). International studies have found a two to five-fold increase in diagnoses of depression and anxiety compared to cisgender individuals (people whose gender identity are congruent with their assigned sex at birth) (3–5), with ten-fold increases in the rate of suicide attempts (3,6). High rates of mental illness, substance use, and suicidality are related to experiences of marginalization and oppression, including experiences of transphobia, violence, lack of social support, barriers to education, homelessness, and unemployment (3,7–9). The minority stress model posits that those with marginalized identities, including TGD people, face chronically high levels of stress due to discrimination, which leads to increased rates and severity of physical and mental illness (7,8,10,11).

Higher rates of mental illness in TGD individuals likely translate into greater need for acute mental healthcare, which includes Emergency Department (ED) visits and hospitalizations. Health administrative data can be useful to examine patterns of mental healthcare access for populations. Recent studies have explored TGD

patients' use of mental healthcare using health administrative data in the United States (US) and Canada (12–16). Studies have found that TGD individuals were more likely to have had psychiatric outpatient visits, hospitalizations, and ED visits (12–16). However, these studies have had several important limitations. One limitation was the use of ICD-9 diagnoses (Gender Identity Disorders) and medical transition-based definitions in several US studies to identify TGD individuals (12,13). This is not representative of many TGD people without these diagnoses and many who do not seek medical transition (i.e., gender-affirming hormone therapy or surgeries). One US study used a convenience sample from one site, which often confers selection bias (14).

None of the prior studies clarified the factors and individual characteristics associated with the increased need for acute mental healthcare. Examining factors associated with this need can highlight what might be amenable to intervention to improve mental healthcare for TGD people. This study aims to compare characteristics of TGD and population-based comparison individuals who had a psychiatric hospitalization or ED visit in Ontario, Canada, using linked health administrative data.

2.4 Methods

Study Design and Setting

This is a cross-sectional study using linked health administrative data to compare characteristics of TGD and general population individuals who had a psychiatric ED visit (ED sample) or a psychiatric hospitalization (hospitalized sample) in Ontario. This project was conducted using linked health administrative data held at ICES. ICES is an independent, non-profit research institute whose legal status under Ontario's health information privacy law allows it to collect and analyze healthcare and demographic data, without consent, for the purposes of health system evaluation, planning, and monitoring. The use of data in this project was authorized under section 45 of Ontario's Personal Health Information Protection Act, which

does not require review by a Research Ethics Board. The linkage of external data to ICES for this project has been approved by the Research Ethics Board at the University of Toronto (RIS Protocol # 38210).

Data Sources

The ICES data repository includes individual-level longitudinal data on most publicly funded healthcare services for individuals covered by Ontario health insurance. These datasets were linked using unique encoded identifiers and analyzed at ICES. Data resources used in this study included: the Registered Persons Database, which includes demographic information for all individuals in Ontario with a health card number. The Ontario Health Insurance Plan database includes physician-billing information. The National Ambulatory Care Reporting System contains information about ED visits. The Ontario Mental Health Reporting System database includes information from psychiatric hospitalizations in mental health-designated hospital beds. The Hospital Discharge Abstract Database captures information from medical hospitalizations in non-mental health hospital beds. The Ontario Marginalization Index (ON-Marg) is a provincial adaptation of the Canadian Marginalization Index, which uses the smallest census area level data to create validated variables measuring multi-dimensional aspects of marginalization through four dimensions: dependency, residential instability, material deprivation, and ethnic concentration (17).

Study Population

All individuals aged 16 and above who were discharged from a psychiatric hospitalization (hospitalized sample) or mental health-related ED visit (ED sample) in Ontario between January 1, 2012 and December 31, 2018 were eligible to be in the study population. The index discharge date is the individual's first discharge within the time period. Patients were excluded if they were not Ontario residents, did not have a valid health card number for data linkage, or were missing valid data

for discharge diagnosis, age, or their Ontario local health region of residence (i.e., LHIN – Local Health Integration Network) during the study period.

Identifying TGD Individuals

TGD individuals were identified through data obtained from four outpatient health clinics with the capacity to systematically identify TGD individuals in their clinic electronic medical records (EMR) in three cities (Thunder Bay, Ottawa, Toronto) across Ontario. Questions regarding gender identity were on each clinic's intake forms, so each patient was asked to describe their gender identity. The manager of health information at each clinic identified all TGD patients from 2012-2016 through their EMR. Individuals' Ontario health insurance numbers and date of birth were used to link individuals to administrative databases at ICES. This process has been previously described (16). All TGD individuals were identified from the study population to create the two TGD samples in this study.

Comparison Groups

Two comparison groups were created for each TGD sample to understand the ways in which the TGD population differs from the general Ontario population of acute care users (unmatched) and from a non-TGD population from the same regions with similar demographics and prior mental healthcare history (matched). In each matched comparison group, four comparison group individuals were found to match with each TGD individual based on shared age, local health region of residence, and mental healthcare utilization history. Local health region of residence is a variable capturing which of fourteen Local Health Integration Networks (LHINs) the individual resides in. LHINs were the health authorities responsible for regional administration of public healthcare services in Ontario at the time of the study. Individuals were categorized into four categories of mental healthcare utilization history based on their mental health service use in the 24 months prior: 1) having any psychiatric hospitalization history, 2) if not 1, then having any psychiatric ED

visit history, 3) if not 1 or 2, then having any outpatient mental health visit history, and 4) having none of the above. This categorization strategy approximates mental illness severity history based on the greater use of acute psychiatric care for patients with greater illness severity (18).

Variables

The following sociodemographic variables were measured for each group: age, LHIN, rurality (derived from postal code), neighborhood-level income (measured in quintiles at the census tract level), and ON-Marg quintiles. Gender identity was not included because of the high proportion of unknown gender in the TGD samples (16). The clinical diagnosis for the ED visit or hospitalization was captured in one of seven psychiatric diagnostic categories used in previous studies (19). Prior health service use variables captured the number of prior mental health-related ED visits, hospitalizations, outpatient visits, and self-harm-related ED visits or hospitalizations in the 24 months before the index admission date.

Statistical Analysis

Descriptive and baseline characteristics (frequencies, means) were calculated across both samples. Differences between samples were explored using χ^2 tests and Student's t-tests as appropriate. Statistical significance comparing samples was set to $p < 0.05$ in two-tailed tests. All analyses used SAS version 9.4 (SAS Institute).

2.5 Results

TGD ED sample

Comparing the TGD ED sample ($n=728$) with the unmatched general population of ED users ($n=581,708$), the TGD ED sample was younger (age 28.8 ± 11.7 vs. 38.3 ± 18.1 , $t=21.90$, $df=731$, $p < 0.001$) and less rural (2.7% vs. 14%, $\chi^2=79.64$, $N=580,768$, $df=1$, $p < 0.001$). They were more likely to be in the lowest quintile for

neighborhood income (37% vs. 28%, $\chi^2=30.91$, $N=582,436$, $df=5$, $p<0.001$) and dependency (30% vs. 23%, $\chi^2=37.95$, $N=571,637$, $df=4$, $p<0.001$); and the highest quintile for residential instability (47% vs. 29%, $\chi^2=118.47$, $N=571,637$, $df=4$, $p<0.001$), material deprivation (33% vs. 28%, $\chi^2=9.58$, $N=571,637$, $df=4$, $p=0.048$), and ethnic concentration (29% vs. 22%, $\chi^2=78.78$, $N=571,637$, $df=4$, $p<0.001$) (**Table 1**). The TGD ED sample was more likely than the unmatched general population of ED users to be diagnosed with a mood disorder (26% vs. 16%), psychotic disorder (4.9% vs. 3.4%), personality disorder (3.6% vs. 0.7%), and deliberate self-harm (7.4% vs. 5.2%) ($\chi^2=208.83$, $N=582,436$, $df=6$, $p<0.001$) (**Table 2**). They were less likely diagnosed with an anxiety, trauma, or OCD-related disorder (38% vs. 46%) or a substance-related disorder (14% vs. 25%). The TGD ED sample had much greater prior psychiatric service use than the unmatched general population of ED users, including more prior hospitalizations (21% vs. 8.1%, $\chi^2=172.73$, $N=582,436$, $df=1$, $p<0.001$), ED visits (16% vs. 9.9%, $\chi^2=30.27$, $N=582,436$, $df=1$, $p<0.001$), outpatient visits (83% vs. 57%, $\chi^2=198.21$, $N=582,436$, $df=1$, $p<0.001$), and deliberate self-harm (7.3% vs. 2.3%, $\chi^2=81.92$, $N=582,436$, $df=1$, $p<0.001$) (**Table 3**).

Comparing the TGD ED sample with the *matched* comparison sample of ED users ($n=2,912$), no differences persisted in dependency or ethnic concentration quintiles. However, the TGD ED sample remained more likely to be in the lowest neighbourhood income quintile (37% vs. 27%, $\chi^2=31.00$, $N=3,640$, $df=5$, $p<0.001$), highest residential instability quintile (47% vs. 38%, $\chi^2=32.17$, $N=3,574$, $df=4$, $p<0.001$), and highest material deprivation quintile (33% vs. 26%, $\chi^2=19.19$, $N=3,574$, $df=4$, $p<0.001$) than the matched comparison sample of ED users (**Table 1**). The TGD ED sample remained more likely than the matched comparison sample of ED users to be diagnosed with a mood (26% vs. 19%) or personality disorder (3.6% vs. 1.4%), and less likely a substance-related disorder (14% vs. 25%) ($\chi^2=66.33$, $N=3,640$, $df=6$, $p<0.001$) (**Table 2**). The differences in diagnoses of anxiety, trauma, or OCD-related disorders and psychotic disorders did not persist after matching. None of the differences in prior mental health service utilization between the TGD ED sample and the unmatched general population of ED users

persisted after matching except the TGD ED sample still had more prior self-harm (7.3% vs. 5.4%, $\chi^2=3.98$, $N=3,640$, $df=1$, $p=0.046$) (**Table 3**).

TGD hospitalization sample

Comparing the TGD hospitalization sample ($n=454$) with the unmatched general population of hospitalized individuals ($n=217,507$), the TGD hospitalization sample was younger (age 28.3 ± 11.9 vs. 40.9 ± 18.5 , $t=22.30$, $df=458$, $p<0.001$) and less rural (3.7% vs. 12%, $\chi^2=31.07$, $N=217,454$, $df=1$, $p<0.001$). They were more likely to be in the lowest quintile for neighborhood income (36% vs. 29%, $\chi^2=19.10$, $N=217,961$, $df=5$, $p=0.002$) and dependency (30% vs. 22%, $\chi^2=35.07$, $N=214,496$, $df=4$, $p<0.001$); and the highest quintile for residential instability (45% vs. 31%, $\chi^2=50.75$, $N=214,496$, $df=4$, $p<0.001$), and ethnic concentration (31% vs. 22%, $\chi^2=63.07$, $N=214,496$, $df=4$, $p<0.001$) (**Table 1**). The TGD hospitalization sample was more likely than the unmatched general population of hospitalized individuals to be diagnosed with a mood (40% vs. 36%) or personality disorder (5.3% vs. 1.8%) ($\chi^2=74.46$, $N=217,961$, $df=6$, $p<0.001$) (**Table 2**). They were less likely diagnosed with a psychotic (13% vs. 17%) or substance-related disorder (12% vs. 21%). The TGD hospitalization sample had much greater prior psychiatric service use than the unmatched general population of hospitalized individuals, including more prior hospitalizations (16% vs. 12%, $\chi^2=8.11$, $N=217,961$, $df=1$, $p=0.004$), ED visits (47% vs. 33%, $\chi^2=40.66$, $N=217,961$, $df=1$, $p<0.001$), outpatient visits (89% vs. 76%, $\chi^2=44.58$, $N=217,961$, $df=1$, $p<0.001$), and deliberate self-harm (8.1% vs. 5.7%, $\chi^2=5.10$, $N=217,961$, $df=1$, $p=0.024$) (**Table 3**).

Comparing the TGD hospitalization sample with the *matched* comparison sample of hospitalized individuals ($n=1,808$), no differences persisted in the dependency or ethnic concentration quintiles. However, the TGD hospitalization sample remained more likely to be in the lowest neighbourhood income quintile (36% vs. 27%, $\chi^2=27.02$, $N=2,262$, $df=5$, $p<0.001$) and the highest residential instability quintile (45% vs. 35%, $\chi^2=25.48$, $N=2,225$, $df=4$, $p<0.001$) (**Table 1**). The TGD hospitalization sample was more likely to be in the highest material deprivation

quintile than the matched comparison sample of hospitalized individuals (32% vs. 26%, $\chi^2=11.36$, $N=2,225$, $df=4$, $p=0.023$). The TGD hospitalization sample remained more likely than the matched comparison sample of hospitalized individuals to be diagnosed with a mood (40% vs. 35%) or personality disorder (5.3% vs. 2.3%), and less likely a psychotic (13% vs. 19%) or substance-related disorder (12% vs. 18%) ($\chi^2=42.42$, $N=2,262$, $df=6$, $p<0.001$) (**Table 2**). None of the differences in prior mental health service utilization between the TGD hospitalization sample and the unmatched general population of hospitalized individuals persisted after matching (**Table 3**).

2.6 Discussion

Compared to the unmatched comparison group presenting for acute mental healthcare, TGD individuals in our samples were younger, were more likely to experience marginalization, had different diagnostic patterns for their acute mental healthcare presentation, and had more prior mental healthcare utilization (as an outpatient, in the ED, and for hospitalization). Matching was required to isolate the unique contribution of TGD status on sociodemographic and clinical factors not adequately explained by differences in age, local health region of residence, and prior mental healthcare utilization. Even after matching, TGD individuals were more likely to live in lower-income neighbourhoods and areas of greater residential instability and material deprivation. TGD individuals were more likely to be diagnosed with a mood disorder and twice as likely a personality disorder during their acute mental healthcare presentation. They were less likely to be diagnosed with a substance-related disorder and in those hospitalized, less likely with a psychotic disorder. TGD individuals in the ED sample were more likely to have presented to acute care for self-harm even after other mental healthcare use differences disappeared with matching.

The different diagnostic pattern in the TGD samples is consistent with the two- to five-fold higher prevalence of depression in TGD individuals compared to comparison individuals (3-5,14,15). While there are also increased rates of anxiety

and trauma-related disorder diagnoses in TGD individuals (3,14,15,20), this was not reflected in our results. The multi-fold increase in personality disorder found in the TGD samples in this study may be partially explained by the minority stress model (11,21). One theory of borderline personality disorder posits its development in individuals living in emotionally invalidating environments (21). A society that subscribes to a rigid sex-gender binary (22) where TGD individuals are regularly misgendered can be construed as an environment that is constantly emotionally invalidating. However, diagnosis of borderline personality disorder is also prone to healthcare provider bias (23,24) and this may have impacted our results. Furthermore, TGD people are frequently pathologized and those seeking medical transition are required to have a mental health assessment, both of which can lead to psychiatric diagnoses (25).

Our study provides evidence for acute mental healthcare utilization being associated with increased measures of marginalization in the TGD samples. Our study echoes previous US findings of TGD psychiatric inpatients being more likely in the lowest neighbourhood income quintile (15), and extends that same finding to TGD individuals presenting to the ED for mental healthcare. Our study clarifies that residential instability and material deprivation are disproportionately affecting TGD individuals presenting for acute psychiatric care. Residential instability refers to high rates of family or housing instability while material deprivation measures indicators of poverty and difficulty accessing basic material needs (26). These findings being persistent after matching add strength to the possibility that experiences of marginalization are an important contributor to acute mental healthcare utilization for TGD individuals. This is consistent with evidence that high mental illness rates for TGD people are associated with elevated rates of homelessness, unemployment, and poverty (3,7,8,27,28).

2.6.1 Strengths and Limitations

A strength of the study is the use of two comparison samples – one unmatched and one matched on key characteristics. This allowed for an understanding of the ways

TGD individuals differ from general populations who access acute mental healthcare and the unique contributions of TGD status on sociodemographic and clinical factors associated with acute mental healthcare presentation. The large sample of TGD individuals also allowed for adequate power to examine for differences in multiple characteristics associated with psychiatric hospitalizations and ED visits for this population. In total, the unmatched samples are inclusive of nearly every psychiatric hospitalization and ED visit within the study time period in Ontario. Unlike previous studies that have relied on diagnostic and medical transition-based definitions to identify TGD individuals (12,13), this study used self-reported gender identities to identify individuals, which is more representative of the overall TGD population.

This study has several limitations. TGD individuals were identified from clinics in larger cities, which may not be representative of individuals in smaller cities and rural areas. Since the unmatched comparison groups represented all regions in Ontario, geographic variation in psychiatric service availability and utilization may have impacted results. Matching was thus important to control for regional differences. Some of the sociodemographic differences may reflect the specific TGD sample (16) and not specific for those with acute psychiatric care utilization. The samples are also more likely to have had prior outpatient visits than other TGD individuals due to being a clinical population. This may limit generalizability of findings. Prior outpatient visits for TGD individuals can include assessments to facilitate access to medical transition. This may differentially contribute to the number of prior outpatient visits for TGD samples. However, this should have limited impact on other measures of prior mental healthcare. Matching likely did not remove all variation in mental illness severity between TGD and comparison groups, which may have also impacted results. Since TGD status was based on self-report, some individuals may not have disclosed their identity and thus would have been excluded from the TGD sample. The comparison samples will thus include TGD individuals who were not identified to form the TGD samples. However, the vast majority of the comparison samples are likely to consist of cisgender individuals (13,15).

2.7 Conclusion

This study found that transgender and gender diverse (TGD) individuals presenting for acute mental healthcare were more likely to experience marginalization and present to acute care with different diagnostic patterns. More research is warranted into the experiences of TGD individuals presenting for acute mental healthcare and factors associated with their presentation, particularly related to how experiences of marginalization and discrimination may play a role.

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Table 1. Sociodemographic characteristics of TGD and two comparison groups, by discharge category.

(i.)	TGD ED Sample (n=728)		Unmatched Comparison Sample (n=581,708)		P-value	Matched Comparison Sample (n=2,912)		P-value
	n	%	n	%		n	%	
Age at admission (mean±SD)	28.8±11.7		38.3±18.1		p<0.001*	29.0±11.7		p=0.76
Rural residence:					p<0.001*			p<0.001*
Rural (<10,000)	20	2.7	83,604	14.4		247	8.5	
Urban (≥ 10,000)	704	96.7	496,440	85.3		2,653	91.1	
Neighbourhood income quintile:					p<0.001*			p<0.001*
Q1 (poorest)	266	36.5	160,320	27.6		774	26.6	
Q2	139	19.1	123,313	21.2		563	19.3	
Q3	110	15.1	108,753	18.7		518	17.8	
Q4	105	14.4	97,229	16.7		517	17.8	
Q5 (wealthiest)	103	14.1	88,884	15.3		518	17.8	
ON-Marg Dependency quintile:					p<0.001*			p=0.67
Q1 (least dependent)	216	29.7	135,070	23.2		901	30.9	
Q2	167	22.9	113,131	19.4		706	24.2	
Q3	137	18.8	103,316	17.8		508	17.4	
Q4	94	12.9	102,665	17.6		355	12.2	
Q5 (most dependent)	106	14.6	116,735	20.1		384	13.2	
ON-Marg Residential Instability quintile:					p<0.001*			p<0.001*
Q1 (least unstable)	70	9.6	86,013	14.8		405	13.9	
Q2	61	8.4	91,172	15.7		385	13.2	
Q3	110	15.1	101,314	17.4		414	14.2	

Q4	138	19.0	122,734	21.1		556	19.0	
Q5 (most unstable)	341	46.8	169,684	29.2		1,094	37.6	
ON-Marg Material Deprivation quintile:					p=0.05*			p<0.001*
Q1 (least deprived)	108	14.8	89,744	15.4		580	19.9	
Q2	113	15.5	98,194	16.9		466	16.0	
Q3	119	16.3	105,155	18.1		517	17.8	
Q4	141	19.4	117,440	20.2		538	18.5	
Q5 (most deprived)	239	32.8	160,384	27.6		753	25.9	
ON-Marg Ethnic Concentration quintile:					p<0.001*			p=0.78
Q1 (lowest ethnic concentration)	77	10.6	112,499	19.3		336	11.5	
Q2	92	12.6	109,298	18.8		395	13.6	
Q3	145	19.9	106,611	18.3		567	19.5	
Q4	196	26.9	114,077	19.6		775	26.6	
Q5 (highest ethnic concentration)	210	28.8	128,432	22.1		781	26.8	
(ii.)								
	TGD Hospitalized Sample (n=454)		Unmatched Comparison Sample (n=217,507)			Matched Comparison Sample (n=1,808)		
	n	%	n	%		n	%	
Age at admission (mean±SD)	28.3±11.9		40.9±18.5		p<0.001*	28.3±11.9		p=0.97
Rural residence:					p<0.001*			p=0.02*
Rural (<10,000)	17	3.7	26,927	12.4		122	6.7	
Urban (≥ 10,000)	435	95.8	190,075	87.4		1,682	93.0	
Neighbourhood income quintile:					p=0.002*			p<0.001*
Q1 (poorest)	163	35.9	62,642	28.8		481	26.6	

Q2	108	23.8	46,543	21.4		360	19.9	
Q3	71	15.6	39,429	18.1		337	18.6	
Q4	52	11.5	35,325	16.2		284	15.7	
Q5 (wealthiest)	57	12.6	32,509	14.9		331	18.3	
ON-Marg Dependency quintile:					p<0.001*			p=0.18
Q1 (least dependent)	137	30.2	48,244	22.2		567	31.4	
Q2	98	21.6	42,602	19.6		406	22.5	
Q3	95	20.9	39,060	18.0		303	16.8	
Q4	52	11.5	38,522	17.7		258	14.3	
Q5 (most dependent)	66	14.5	45,620	21.0		243	13.4	
ON-Marg Residential Instability quintile:					p<0.001*			p<0.001*
Q1 (least unstable)	47	10.4	30,277	13.9		258	14.3	
Q2	38	8.4	33,062	15.2		249	13.8	
Q3	60	13.2	36,933	17.0		283	15.7	
Q4	97	21.4	45,864	21.1		360	19.9	
Q5 (most unstable)	206	45.4	67,912	31.2		627	34.7	
ON-Marg Material Deprivation quintile:					p=0.34			p=0.02*
Q1 (least deprived)	70	15.4	32,255	14.8		321	17.8	
Q2	64	14.1	35,500	16.3		318	17.6	
Q3	71	15.6	38,705	17.8		321	17.8	
Q4	96	21.1	44,368	20.4		355	19.6	
Q5 (most deprived)	147	32.4	63,220	29.1		462	25.6	
ON-Marg Ethnic Concentration quintile:					p<0.001*			p=0.94
Q1 (lowest ethnic concentration)	42	9.3	41,010	18.9		182	10.1	
Q2	60	13.2	41,801	19.2		245	13.6	

Q3	79	17.4	40,709	18.7		330	18.3	
Q4	125	27.5	42,364	19.5		485	26.8	
Q5 (highest ethnic concentration)	142	31.3	48,164	22.1		535	29.6	

Note: Sociodemographic characteristics above were of the TGD and two comparison samples discharged from (i.) a mental health-related ED visit and (ii.) a psychiatric hospitalization. The two comparison samples used to match the TGD sample include: (a) no matching, and (b) matching 1:4 by age, LHIN, and mental healthcare utilization history. P-values compared to TGD sample (* denotes statistical significance at $\alpha=0.05$). TGD = transgender and gender diverse. ED = emergency department. ON-Marg = Ontario Marginalization Index. SD = standard deviation.

Table 2. Diagnoses of TGD and two comparison groups, by discharge category.

(i.)	TGD ED Sample (n=728)		Unmatched Comparison Sample (n=581,708)		P-value	Matched Comparison Sample (n=2,912)		P-value
	n	%	n	%		n	%	
Mood disorders	191	26.2	90,528	15.6	p<0.001*	566	19.4	p<0.001*
Anxiety, trauma/stressor, and OCD-related disorders	278	38.2	267,868	46.0		1,112	38.2	
Schizophrenia and psychotic disorders	36	4.9	19,874	3.4		148	5.1	
Substance-related disorders	98	13.5	145,610	25.0		729	25.0	
Personality disorders	26	3.6	4,013	0.7		42	1.4	
Deliberate self-harm	54	7.4	30,053	5.2		188	6.5	
Other mental health diagnoses	45	6.2	23,762	4.1		127	4.4	
(ii.)	TGD Hospitalized Sample (n=454)		Unmatched Comparison Sample (n=217,507)		P-value	Matched Comparison Sample (n=1,808)		P-value
	n	%	n	%		n	%	
Mood disorders	182	40.1	77,346	35.6	p<0.001*	626	34.6	p<0.001*
Anxiety, trauma/stressor, and OCD-related disorders	63	13.9	29,779	13.7		273	15.1	
Schizophrenia and psychotic disorders	60	13.2	35,968	16.5		335	18.5	
Substance-related disorders	54	11.9	45,363	20.9		324	17.9	
Personality disorders	24	5.3	3,889	1.8		41	2.3	
Deliberate self-harm	23	5.1	12,962	6.0		107	5.9	

Other mental health diagnoses	48	10.6	12,200	5.6		102	5.6	
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Note: Diagnoses above were for the TGD and two comparison samples discharged from (i.) a mental health-related ED visit and (ii.) a psychiatric hospitalization. The two comparison samples used to match the TGD sample include: (a) no matching, and (b) matching 1:4 by age, LHIN, and mental healthcare utilization history. P-values from χ^2 tests compared to TGD sample (* denotes statistical significance at $\alpha=0.05$). TGD = transgender and gender diverse. ED = emergency department.

Table 3. Prior mental health service use for TGD and two comparison groups, by discharge category.

(i.)	TGD ED Sample (n=728)		Unmatched Comparison Sample (n=581,708)		P-value	Matched Comparison Sample (n=2,912)		P-value
	n	%	n	%		n	%	
Prior MH hospitalizations in last two years:								
Any	156	21.4	47,178	8.1	p<0.001*	624	21.4	p=1.00
Mean±SD	0.4±1.1		0.1±0.6		p<0.001*	0.4±1.0		p=0.27
Prior MH ED visits in last two years:								
Any	116	15.9	57,306	9.9	p<0.001*	425	14.6	p=0.36
Mean±SD	0.3±1.4		0.2±0.9		p=0.001*	0.3±1.0		p=0.19
Prior MH outpatient visits in last two years:								
Any	605	83.1	333,198	57.3	p<0.001*	2,420	83.1	p=1.00
Mean±SD	9.1±12.7		4.9±11.8		p<0.001*	8.3±15.5		p=0.16
Prior non-fatal self-harm in last two years:								
Any	53	7.3	13,216	2.3	p<0.001*	156	5.4	p=0.05*
Mean±SD	0.1±0.6		0.0±0.3		p<0.001*	0.1±0.4		p=0.05
(ii.)	TGD Hospitalized Sample (n=454)		Unmatched Comparison Sample (n=217,507)		P-value	Matched Comparison Sample (n=1,808)		P-value
	n	%	n	%		n	%	
Prior MH hospitalizations in last two years:								

Any	74	16.3	26,009	12.0	p=0.004*	288	15.9	p=0.85
Mean±SD	0.3± 1.0		0.2± 0.7		p=0.02*	0.2± 0.8		p=0.32
Prior MH ED visits in last two years:								
Any	214	47.1	71,871	33.0	p<0.001*	814	45.0	p=0.42
Mean±SD	1.1± 2.2		0.7± 2.3		p<0.001*	0.9± 1.8		p=0.06
Prior MH outpatient visits in last two years:								
Any	406	89.4	165,400	76.0	p<0.001*	1,624	89.8	p=0.80
Mean±SD	10.7± 13.0		8.5± 15.0		p<0.001*	10.1± 15.8		p=0.38
Prior non-fatal self-harm in last two years:								
Any	37	8.1	12,379	5.7	p=0.02	132	7.3	p=0.54
Mean±SD	0.1± 0.5		0.1± 0.4		p=0.05*	0.1± 0.4		p=0.29

Note: Prior mental health service use above were for the TGD and two comparison samples discharged from (i.) a mental health-related ED visit and (ii.) a psychiatric hospitalization. The two comparison samples used to match the TGD sample include: (a) no matching, and (b) matching 1:4 by age, LHIN, and mental healthcare utilization history. P-values compared to TGD sample (* denotes statistical significance at $\alpha=0.05$). TGD = transgender and gender diverse. ED = emergency department. MH = mental health. SD = standard deviation.

Chapter 3

3 **Physician follow-up among transgender and gender diverse individuals after psychiatric emergency department visits and hospitalizations: A retrospective population-based cohort study in Ontario, Canada**

3.1 Abstract

Background: Transgender (trans) and gender diverse (TGD) individuals experience significant oppression, resulting in mental health disparities and greater need for acute mental healthcare. Early access to care after discharge from hospital can improve outcomes but has not been studied for TGD individuals. This study compared physician-based outpatient mental healthcare follow-up between TGD individuals and the general population who had a mental health-related emergency department (ED) visit or hospitalization.

Methods: This retrospective population-based cohort study used linked health administrative data to examine all adult psychiatric patients discharged from an ED visit (ED cohort) or hospitalization (hospitalization cohort) between 2012 and 2018 in Ontario, Canada. TGD individuals were identified and their data linked with health administrative data. The primary outcome was the proportion of individuals with any outpatient mental health physician (psychiatrist, family physician, and/or pediatrician) visit within 7 and 30 days of the index discharge. Multivariable logistic regression analyses examined follow-up outcomes, including by diagnostic category, with adjustment for sociodemographic and clinical factors.

Outcomes: There were 728 TGD and 581,708 general population individuals with a mental health-related ED visit, while 454 TGD and 217,507 general population individuals had a psychiatric hospitalization. TGD individuals had increased 30-day post-ED follow-up (adjusted OR=1.21; 95% CI 1.03-1.42), particularly with a

psychiatrist (aOR=1.28; 95% CI 1.07-1.52) and for those with an anxiety and related disorder diagnosis (aOR=1.63; 95% CI 1.23-2.15). Meanwhile, TGD individuals had reduced 30-day follow-up post-hospitalization (aOR=0.81; 95% CI 0.66-0.99) after adjusting for covariates.

Interpretation: TGD individuals have greater rates of post-ED outpatient mental health follow-up, particularly with a psychiatrist, but lower rates of follow-up after a hospitalization. The increased follow-up after ED visits among TGD individuals likely reflects greater clinical need. Reduced follow-up for TGD individuals after hospitalization is concerning given the risk of adverse outcomes and requires further research.

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3.2 Introduction

Transgender (trans) and gender diverse (TGD) individuals are people whose gender identity differs from their sex assigned at birth (1). TGD individuals are estimated to be at least 0.5% of the population (2–4), and there is a paucity of evidence or literature to understand their psychiatric needs, clinical presentations, and mental health service utilization. Previous research has shown higher rates of poor mental health outcomes among TGD individuals compared to cisgender individuals (people whose gender identity is congruent with their sex assigned at birth), including over 60% having active depressive symptoms cross-sectionally (5,6) and 43% having attempted suicide in their lifetime in one cross-sectional study of 433 TGD Ontarians (7). Studies suggest that high rates of mental illness and suicidality are related to experiences of marginalization and oppression, including experiences of transphobia, violence, unemployment, and homelessness (3). Higher rates of mental illness in TGD individuals have translated into greater need for acute mental healthcare, which includes Emergency Department (ED) visits and hospitalizations (8–12).

The time following discharge from hospitalization is known to be high risk (13–17). Early access to post-hospitalization mental healthcare can reduce negative outcomes, including readmission (16,18) and even mortality (16). Accordingly, post-discharge follow-up within seven days is a performance indicator measuring adequacy of access to care (19,20). The time immediately following suicidal behaviour is also a high-risk period for a repeat attempt. In one study ten percent of individuals were found to have repeated suicidal behaviour within five days of discharge where the clinical presentation had included suicidal behaviour (21). Early and active follow-up after an ED visit reduced suicide attempts at six months (22), suggesting that mental health support, including physician follow-up, soon after ED discharge can reduce suicidal behaviour.

There is evidence that TGD individuals avoid healthcare due to experiences of discrimination. For example, half of TGD Ontarians in one study did not feel comfortable sharing their trans-related health needs with their family doctor (23)

while twenty-one percent avoided the ED due to concerns that their gender identity would affect the care they receive (24). Twenty-four percent of TGD Ontarians who have had ED visits reported being belittled or ridiculed in the ED because of their TGD identity and ten percent had their ED care refused or ended (24). This may result in some TGD individuals also avoiding post-discharge care. The critical post-discharge period and access to mental healthcare for TGD individuals has been understudied. Examining post-discharge access to care for TGD people can highlight any inequities in care and identify potential care needs that can guide healthcare delivery and policy.

This study aims to compare the post-discharge access to outpatient mental health physician visits between TGD and population-based comparison individuals following a psychiatric hospitalization or ED visit in Ontario, Canada, using linked health administrative data.

3.3 Methods

Study Design and Setting

This retrospective cohort study utilized linked health administrative data to compare post-discharge follow-up among TGD and general population individuals who had a psychiatric ED visit (ED cohort) or a psychiatric hospitalization (hospitalization cohort) in Ontario. This project was conducted using linked health administrative data held at ICES. ICES is an independent, non-profit research institute whose legal status under Ontario's health information privacy law allows it to collect and analyze healthcare and demographic data, without consent, for the purposes of health system evaluation, planning, and monitoring. The use of data in this project was authorized under section 45 of Ontario's Personal Health Information Protection Act, which does not require review by a Research Ethics Board. The linkage of external data to ICES for this project has been approved by the Research Ethics Board at the University of Toronto (RIS Protocol # 38210).

Data Sources

The ICES data repository includes individual-level longitudinal data on most publicly funded healthcare services for individuals covered by Ontario health insurance. These datasets were linked using unique encoded identifiers and analyzed at ICES. Data resources used in this study included: the Registered Persons Database, which includes demographic information for all individuals in Ontario with a health card number. The Ontario Marginalization Index (ON-Marg) is a provincial adaptation of the Canadian Marginalization Index, which uses the smallest census area level data to create validated variables measuring multi-dimensional aspects of marginalization through four dimensions: dependency, residential instability, material deprivation, and ethnic concentration (25). These are area-level measures where dependency measures area-level concentrations of people with no income from employment, residential instability refers to high rates of family or housing instability, material deprivation measures indicators of poverty and difficulty accessing basic material needs, and ethnic concentration refers to area-level concentrations of people who are recent immigrants and/or belonging to a visible minority group (25).

The Ontario Health Insurance Plan database includes physician-billing information. The National Ambulatory Care Reporting System contains information about ED visits. The Hospital Discharge Abstract Database captures information from medical hospitalizations in non-mental health hospital beds. The Ontario Mental Health Reporting System database includes information from psychiatric hospitalizations in mental health-designated hospital beds.

Study Population

We examined all individuals aged 16 and above who were discharged from a psychiatric hospitalization (hospitalization cohort) or mental health-related ED visit (ED cohort) in Ontario between January 1, 2012 and December 31, 2018. The index discharge date is the individual's first discharge within the time period. For

individuals with multiple acute care presentations over the study period, we included in our analysis the first presentation, with one exception: when a re-presentation occurred within 30 days of discharge, the second presentation was considered the index presentation, provided all other selection criteria were met. Patients were excluded if they were not Ontario residents, did not have a valid health card number (required for data linkage), or were missing valid data for discharge diagnosis, age, or their Ontario local health region of residence (i.e., LHIN – Local Health Integration Network) during the study period.

Identifying TGD Individuals

TGD individuals were identified through data obtained from four outpatient health clinics with the capacity to systematically identify TGD individuals in their clinic electronic medical records (EMR) in three cities (Thunder Bay, Toronto, Ottawa) across Ontario. Questions regarding gender identity were on each clinic's intake forms, so each patient was asked to describe their gender identity. The manager of health information at each clinic identified all TGD patients from 2012-2016 through their EMR. Individuals' Ontario health insurance numbers and date of birth were used to link their data to administrative databases at ICES. This process has been previously described (26). All TGD individuals were identified from the study population to create the two TGD cohorts in this study.

Comparison Groups

The comparison groups for each TGD cohort included all individuals in the general Ontario population (excluding individuals in the TGD cohorts) who were discharged from a psychiatric hospitalization (hospitalization cohort) or mental health-related ED visit (ED cohort) in Ontario between January 1, 2012 and December 31, 2018.

Sociodemographic/Clinical Characteristics

The following sociodemographic variables were measured for each group: age, LHIN (local health region of residence), rurality (derived from postal code), neighborhood-level income (measured in quintiles at the census tract level), and ON-Marg quintiles. Gender identity was not included because of the high proportion of unknown gender identities in the TGD sample due to one of the four clinics being unable to provide specific gender identity information, though they were able to still identify the individuals as being TGD (26). The clinical diagnosis for the ED visit or hospitalization was captured in one of seven psychiatric diagnostic categories used in previous studies (27). A mood disorder diagnosis includes any depressive disorder and bipolar disorder. Anxiety and related disorders include anxiety, OCD, and trauma-related disorders such as PTSD. Prior health service use variables captured the number of prior mental health-related ED visits, hospitalizations, outpatient visits, and self-harm-related ED visits or hospitalizations in the 24 months before the index presentation date.

Outcomes

The primary outcomes were whether the individual had any post-discharge mental health-related outpatient physician visit within 7 days and within 30 days of discharge. A mental health-related outpatient physician visit is captured by physician billing data as defined by 1) an outpatient psychiatrist visit, 2) an outpatient family physician visit with a psychiatric diagnostic code (28), or 3) an outpatient pediatrician visit with a psychiatric diagnostic code. The secondary outcomes examined whether the individual had a post-discharge mental health-related outpatient physician visit within 7 and 30 days of discharge for each of the physician types, including individuals with visits to two or more physician types.

Statistical Analysis

Descriptive and baseline characteristics (frequencies, means) were calculated across cohorts. Differences between samples were explored using χ^2 tests and Student's t-tests as appropriate. Statistical significance comparing samples was set to $p < 0.05$ in two-tailed tests. For the primary and secondary outcomes, we used multivariable binary logistic regression models to examine the effects of each TGD group compared with the reference population, adjusted for age, LHIN, rurality of residence, neighbourhood income quintile, ON-Marg quintiles, psychiatric diagnosis, any previous psychiatric hospitalizations, any previous mental health-related ED visits, number of previous psychiatric outpatient visits, and any previous non-fatal deliberate self-harm; as these variables differed between groups and were associated with post-discharge outcomes. The outcomes were also assessed by diagnostic category. All analyses used SAS version 9.4 (SAS Institute).

3.4 Results

TGD ED Cohort

Sociodemographic/clinical characteristics

Comparing the TGD ED cohort (n=728) with the general population of ED users (n=581,708), the TGD ED cohort was younger and lived more in urban areas and areas of low neighborhood income and dependency; and high residential instability, material deprivation, and ethnic concentration (**Table 4**). The TGD ED cohort was more likely to be diagnosed with a mood disorder, psychotic disorder, personality disorder, and deliberate self-harm. They had much greater prior psychiatric service use than the general population of ED users, including more prior hospitalizations, ED visits, outpatient visits, and deliberate self-harm.

Post-discharge follow-up

TGD individuals had greater outpatient mental health-related physician follow-up in the 7 (26.5% versus 19.5%, $p < 0.001$) and 30 days (55.4% versus 37.7%, $p < 0.001$)

after discharge from the ED, compared to the reference group (**Table 5**). TGD individuals also were more likely to have a post-discharge mental health-related visit with a psychiatrist in the 7 (13.1% versus 6.4%, $p<0.001$) and 30 days (33.0% versus 15.0%, $p<0.001$) after discharge from the ED, with a family physician in the 30 days (34.1% versus 27.9%, $p=0.001$) after discharge, and with two or more types of physicians in the 7 (2.9% versus 1.1%, $p=0.003$) and 30 days (12.5% versus 5.5%, $p<0.001$) after discharge.

After adjusting for sociodemographic and clinical factors, TGD individuals had greater adjusted odds of having an outpatient mental health-related physician visit within 30 days (OR 1.21, 95% CI 1.03 to 1.42) after ED discharge (**Table 6**). While the unadjusted odds ratios were significantly increased for almost all secondary outcomes, only the adjusted odds of post-discharge follow-up with a psychiatrist within 30 days was significantly elevated (1.28, 95% CI 1.07 to 1.52).

When assessing the outcomes broken down by the three most common diagnostic categories in the ED cohort (**Table 7**), TGD individuals with mood disorder diagnoses had greater unadjusted odds of post-discharge follow-up within 30 days with any physician type (1.47, 95% CI 1.08 to 1.99) and with psychiatry (1.71, 95% CI 1.29 to 2.28). TGD individuals with anxiety and related disorders had greater unadjusted odds of any post-discharge follow-up within 7 (1.47, 95% CI 1.12 to 1.91) and 30 days (1.80, 95% CI 1.42 to 2.29), and follow-up within 30 days with psychiatry (3.12, 95% CI 2.42 to 4.03). TGD individuals diagnosed with a substance-related disorder had greater post-discharge follow-up within 30 days with any physician type (2.07, 95% CI 1.37 to 3.12), with psychiatry (3.60, 95% CI 2.11 to 6.16), and with primary care (1.67, 95% CI 1.07 to 2.60). After adjusting for sociodemographic and clinical factors, TGD individuals with anxiety and related disorders still had greater adjusted odds of having a psychiatrist visit within 30 days (1.63, 95% CI 1.23 to 2.15) of ED discharge.

TGD Hospitalization Cohort

Sociodemographic/clinical characteristics

Comparing the TGD hospitalization cohort (n=454) with the general population of hospitalized individuals (n=217,507), the TGD hospitalization cohort was younger and less rural (**Table 4**). They were more likely to be in the lowest quintile for neighborhood income and dependency and the highest quintile for residential instability and ethnic concentration. The TGD hospitalization cohort was more likely to be diagnosed with a mood or personality disorder, and less likely a psychotic or substance-related disorder. The TGD hospitalization cohort had much greater prior psychiatric service use than the general population of hospitalized individuals, including more prior hospitalizations, ED visits, outpatient visits, and deliberate self-harm.

Post-discharge follow-up

TGD individuals had greater follow-up rates with psychiatry in the 7 (14.5% versus 10.3%, p=0.01) and 30 days (36.6% versus 31.7%, p=0.03) after discharge from a psychiatric hospitalization, compared to the reference group (**Table 5**). There were no statistically significant differences in post-discharge rates with the other outcomes.

After adjusting for sociodemographic and clinical factors, TGD individuals had reduced adjusted odds of having an outpatient mental health-related physician visit within 30 days (OR 0.81, 95% CI 0.66 to 0.99) after hospitalization (**Table 6**).

When assessing the outcomes broken down by the three most common diagnostic categories in the hospitalization cohort (**Table 7**), TGD individuals with mood disorder diagnoses had lower unadjusted odds of post-discharge follow-up with a family physician within 30 days (0.71, 95% CI 0.52 to 0.97). There were no other statistically significant differences in outcomes in the unadjusted or adjusted odds

ratios in the groups diagnosed with mood disorders, anxiety and related disorders, or schizophrenia and psychotic disorders.

3.5 Discussion

In this population-based study, over a quarter of the TGD individuals who visited the ED for a psychiatric reason received a physician follow-up within one week of discharge and over half received follow-up within one month of discharge. One-third of the TGD individuals had a follow-up with a psychiatrist within one month, which is double the rate for the comparison group. Regression adjustment for multiple demographic and clinical factors allowed for a rigorous assessment of the independent effect of TGD identity. Even after adjusting for known contributors to differences in post-discharge follow-up, TGD individuals were still more likely to have an outpatient physician visit, and specifically a psychiatrist visit, within a month of discharge from the ED. In contrast, TGD individuals were less likely to receive outpatient physician care in the month following a psychiatric hospitalization.

There has been a focus on equity in access to post-ED care (29–32), but this is the first study to examine post-ED outpatient mental health physician visits in a TGD population. A previous population-based study in Ontario found that only 40.2% of individuals had a follow-up mental health physician visit within 14 days of discharge from the ED (29). A similar minority (37.7%) of the comparison cohort in this study had a post-ED physician follow-up within one month, while over half (55.4%) of the TGD cohort did. Only 6.4% and 15.0% of the comparison cohort in this study had a post-ED psychiatrist visit within 7 and 30 days respectively, which is consistent with the 9.4% of individuals with a post-ED psychiatrist visit within 14 days of discharge in a previous study (29). This highlights the significance of TGD individuals being more than twice as likely to have had a post-ED psychiatrist follow-up. This increased post-ED follow-up persisted even after adjustment, suggesting there is increased need for specialist services for TGD patients. As substance-related disorders and anxiety and related disorders generally have lower

post-ED follow-up rates than other diagnoses in the general population (30), this may have made the corresponding increased post-ED follow-up rates more pronounced for the TGD cohort. This increased follow-up indicates greater complexity and severity of mental health needs facing TGD individuals; likely related to greater rates of comorbidity, suicidality, and experiences of trauma, marginalization, and oppression (3). However, the increased psychiatric follow-up may also partially reflect pathologization of TGD identities leading to greater clinician referrals to specialist care (33).

Physician follow-up after a psychiatric hospitalization is known to differ by diagnosis (34,35), geography (35), trauma history (34), racialization (36), among other factors. This is the first study to our knowledge that demonstrates that TGD individuals have reduced access to post-hospitalization mental healthcare. This is concerning as this is a group experiencing greater rates of marginalization and prior psychiatric service utilization suggesting increased illness severity and complexity. The healthcare system is a cisnormative system, meaning that many of its structures and policies operate under the assumption that everyone identifies as the gender they were assigned at birth, with a resulting lack of institutional policies to support TGD people in the inpatient setting, which often leads to experiences of discrimination and poor treatment (such as misgendering, invasive and inappropriate questions about gender identity and medical transition, etc.) (37). This may also have led to disengagement with the healthcare system following discharge. It is notable that TGD individuals with a primary diagnosis of mood disorders had reduced mental health follow-up with a family physician in the month after discharge, especially as this represented 40.1% of the TGD cohort. TGD individuals have an estimated multi-fold increase in depression (3,5,6) and a ten-fold increase in suicide attempts compared to the general population (3,7,38). Family physicians play a key role in treating depression as they are often the first point of contact with the healthcare system (39) and can provide gender-affirming care that reduces depression and suicidality (40,41). It may be that the hospitalization identified complex care needs requiring specialist care over primary care, but there was no corresponding access to this care post-discharge.

It is important to consider the difference in outcomes between the ED and hospitalization cohorts. If the higher post-ED follow-up rate reflects greater need for care among TGD patients, the lower post-hospitalization follow-up rate is a particularly concerning health inequity. Institutional and individual factors may contribute to this discrepancy. Providers may be offering or arranging lower rates of post-discharge follow-up following hospitalization for TGD patients. This may be related to a lack of services perceived to meet the needs of TGD patients. It may also be that the inpatient environment is experienced as distressing, such that even though similar post-discharge care is offered, TGD individuals are less likely to attend. Previous studies have highlighted the lack of guidelines and policy for inclusive care of TGD patients in the inpatient mental health setting (37). As TGD people are more likely to avoid ED care due to valid concerns and prior experiences of discrimination and stigma (24), it may also be that TGD people presenting to the ED more likely present involuntarily, leading to involuntary hospitalizations perceived as less useful, thus impacting subsequent help-seeking (42). Qualitative research centering the lived experience of TGD people with a history of acute mental healthcare utilization can clarify contributing factors to the difference in post-discharge outcomes, which may be an important health inequity to target through further research and policy.

3.5.1 Strengths and Limitations

A strength of this study is the use of adjustment for sociodemographic and clinical factors known to affect post-discharge care access to isolate the unique contribution of TGD identity on post-discharge care. The large population-based cohorts allowed for adequate power to adjust for these multiple factors. The comparison cohorts are inclusive of nearly every psychiatric hospitalization and ED visit within the study time period in Ontario, increasing validity and reliability of outcome measures. Gender identities of the TGD cohort were based on individual self-identification, which leads to a more representative cohort than using medical transition-based definitions in other studies (8,9). The outcome of physician visits is reliably

captured by physician billing data and is a measure of mental healthcare access less prone to measurement bias than self-report. The health administrative data included measures of marginalization that were important to adjust for given the theory of minority stress being on the causal pathway leading TGD people to have potentially different health outcomes compared to cisgender people (43).

Differentiating between the different types of post-discharge outpatient mental health physician care allowed for greater clarity around patterns of care access. Similarly, as clinical diagnoses are known to impact post-discharge follow-up rates, examining outcomes by diagnostic category provided more granular information on the impact of TGD identity on post-discharge care.

Limitations include that this cohort is representative of TGD individuals who have a valid OHIP card; have had a mental health hospitalization or ED visit; and have accessed care at clinics in larger cities. This may limit generalizability of findings. Selection bias may be present as the TGD cohort individuals were assessed at an outpatient clinic, increasing likelihood of post-discharge follow-up as they have engaged in healthcare. This was addressed by adjusting for previous mental healthcare utilization. The comparison cohort likely includes unidentified TGD individuals, but this would have low impact due to the low prevalence of TGD people in the general population (4), and this misclassification would bias results towards the null. This study was likely underpowered to fully detect differences broken down by diagnostic categories. Outcomes also do not capture non-physician mental healthcare. There is no direct measure of need for post-discharge follow-up, so the differences in post-discharge follow-up could be explained by differing need for follow-up between the groups, but a higher rate of post-ED follow-up for TGD individuals suggests greater need (or greater propensity) for follow-up after ED visits, which contrasts with lower rates following hospitalization. Additionally, there is a standard of care suggesting post-discharge follow-up should occur regardless (20).

3.6 Conclusion

This study found that transgender and gender diverse (TGD) individuals had increased outpatient mental health physician follow-up after discharge from ED but reduced follow-up after hospitalization. This apparent paradox warrants further examination as it may have implications for improving policy and care to better address the healthcare needs of TGD people. Qualitative research may be well positioned to centre lived experience to explore potential reasons for this discrepancy.

3.7 References

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Table 4. Demographic and clinical characteristics of TGD and comparison cohorts, by discharge category.

(i.)	TGD ED Cohort (n=728)		Unmatched Comparison Cohort (n=581,708)		p-value
	n	%	n	%	
Age at presentation (mean±SD)	28.8±11.7		38.3±18.1		p<0.001*
Rural residence:					p<0.001*
Rural (<10,000 population)	20	2.7	83,604	14.4	
Urban (≥ 10,000 population)	704	96.7	496,440	85.3	
Neighbourhood income quintile:					p<0.001*
Q1 (poorest)	266	36.5	160,320	27.6	
Q2	139	19.1	123,313	21.2	
Q3	110	15.1	108,753	18.7	
Q4	105	14.4	97,229	16.7	
Q5 (wealthiest)	103	14.1	88,884	15.3	
ON-Marg Dependency quintile:					p<0.001*
Q1 (least dependent)	216	29.7	135,070	23.2	
Q2	167	22.9	113,131	19.4	
Q3	137	18.8	103,316	17.8	
Q4	94	12.9	102,665	17.6	
Q5 (most dependent)	106	14.6	116,735	20.1	
ON-Marg Residential Instability quintile:					p<0.001*
Q1 (least unstable)	70	9.6	86,013	14.8	
Q2	61	8.4	91,172	15.7	
Q3	110	15.1	101,314	17.4	
Q4	138	19.0	122,734	21.1	
Q5 (most unstable)	341	46.8	169,684	29.2	

ON-Marg Material Deprivation quintile:					p=0.05*
Q1 (least deprived)	108	14.8	89,744	15.4	
Q2	113	15.5	98,194	16.9	
Q3	119	16.3	105,155	18.1	
Q4	141	19.4	117,440	20.2	
Q5 (most deprived)	239	32.8	160,384	27.6	
ON-Marg Ethnic Concentration quintile:					p<0.001*
Q1 (lowest ethnic concentration)	77	10.6	112,499	19.3	
Q2	92	12.6	109,298	18.8	
Q3	145	19.9	106,611	18.3	
Q4	196	26.9	114,077	19.6	
Q5 (highest ethnic concentration)	210	28.8	128,432	22.1	
Primary diagnosis at discharge:					
Mood disorders	191	26.2	90,528	15.6	p<0.001*
Anxiety, trauma/stressor, and OCD-related disorders	278	38.2	267,868	46.0	
Schizophrenia and psychotic disorders	36	4.9	19,874	3.4	
Substance-related disorders	98	13.5	145,610	25.0	
Personality disorders	26	3.6	4,013	0.7	
Deliberate self-harm	54	7.4	30,053	5.2	
Other mental health diagnoses	45	6.2	23,762	4.1	
Prior MH hospitalizations in last two years:					
Any	156	21.4	47,178	8.1	p<0.001*
Mean±SD	0.4±1.1		0.1±0.6		p<0.001*
Prior MH ED visits in last two years:					
Any	116	15.9	57,306	9.9	p<0.001*

Mean±SD	0.3±1.4		0.2±0.9		p=0.001*
Prior MH outpatient visits in last two years:					
Any	605	83.1	333,198	57.3	p<0.001*
Mean±SD	9.1±12.7		4.9±11.8		p<0.001*
Prior non-fatal self-harm in last two years:					
Any	53	7.3	13,216	2.3	p<0.001*
Mean±SD	0.1±0.6		0.0±0.3		p<0.001*
(ii.)	TGD Hospitalization Cohort (n=454)		Unmatched Comparison Cohort (n=217,507)		
	n	%	n	%	
Age at presentation (mean±SD)	28.3±11.9		40.9±18.5		p<0.001*
Rural residence:					p<0.001*
Rural (<10,000 population)	17	3.7	26,927	12.4	
Urban (≥ 10,000 population)	435	95.8	190,075	87.4	
Neighbourhood income quintile:					p=0.002*
Q1 (poorest)	163	35.9	62,642	28.8	
Q2	108	23.8	46,543	21.4	
Q3	71	15.6	39,429	18.1	
Q4	52	11.5	35,325	16.2	
Q5 (wealthiest)	57	12.6	32,509	14.9	
ON-Marg Dependency quintile:					p<0.001*
Q1 (least dependent)	137	30.2	48,244	22.2	
Q2	98	21.6	42,602	19.6	
Q3	95	20.9	39,060	18.0	
Q4	52	11.5	38,522	17.7	
Q5 (most dependent)	66	14.5	45,620	21.0	

ON-Marg Residential Instability quintile:					p<0.001*
Q1 (least unstable)	47	10.4	30,277	13.9	
Q2	38	8.4	33,062	15.2	
Q3	60	13.2	36,933	17.0	
Q4	97	21.4	45,864	21.1	
Q5 (most unstable)	206	45.4	67,912	31.2	
ON-Marg Material Deprivation quintile:					p=0.34
Q1 (least deprived)	70	15.4	32,255	14.8	
Q2	64	14.1	35,500	16.3	
Q3	71	15.6	38,705	17.8	
Q4	96	21.1	44,368	20.4	
Q5 (most deprived)	147	32.4	63,220	29.1	
ON-Marg Ethnic Concentration quintile:					p<0.001*
Q1 (lowest ethnic concentration)	42	9.3	41,010	18.9	
Q2	60	13.2	41,801	19.2	
Q3	79	17.4	40,709	18.7	
Q4	125	27.5	42,364	19.5	
Q5 (highest ethnic concentration)	142	31.3	48,164	22.1	
Primary diagnosis at discharge:					
Mood disorders	182	40.1	77,346	35.6	p<0.001*
Anxiety, trauma/stressor, and OCD-related disorders	63	13.9	29,779	13.7	
Schizophrenia and psychotic disorders	60	13.2	35,968	16.5	
Substance-related disorders	54	11.9	45,363	20.9	
Personality disorders	24	5.3	3,889	1.8	
Deliberate self-harm	23	5.1	12,962	6.0	

Other mental health diagnoses	48	10.6	12,200	5.6	
Prior MH hospitalizations in last two years:					
Any	74	16.3	26,009	12.0	p=0.004*
Mean±SD	0.3±1.0		0.2±0.7		p=0.02*
Prior MH ED visits in last two years:					
Any	214	47.1	71,871	33.0	p<0.001*
Mean±SD	1.1±2.2		0.7±2.3		p<0.001*
Prior MH outpatient visits in last two years:					
Any	406	89.4	165,400	76.0	p<0.001*
Mean±SD	10.7±13.0		8.5±15.0		p<0.001*
Prior non-fatal self-harm in last two years:					
Any	37	8.1	12,379	5.7	p=0.02
Mean±SD	0.1±0.5		0.1±0.4		p=0.05*

Note: Demographic and clinical characteristics above were for the TGD and comparison cohorts discharged from (i.) a mental health-related ED visit and (ii.) a psychiatric hospitalization. P-values compared to TGD cohort (* denotes statistical significance at $\alpha=0.05$). TGD = transgender and gender diverse. ED = emergency department. ON-Marg = Ontario Marginalization Index. MH = mental health. SD = standard deviation.

Table 5. Number of TGD individuals with a mental health-related physician follow-up within 7 and 30 days of discharge from (i.) mental health-related ED visits or (ii.) psychiatric hospitalization, compared with the general population.

(i.)	TGD ED Cohort (n=728)		Unmatched Comparison Cohort (n=581,708)		p-value
	n	%	n	%	
Primary Outcomes					
Any follow-up visit within 7 days	193	26.5	113,375	19.5	p<0.001*
Any follow-up visit within 30 days	403	55.4	219,479	37.7	p<0.001*
Secondary Outcomes					
Any psych visit within 7 days	95	13.1	37,228	6.4	p<0.001*
Any psych visit within 30 days	240	33.0	87,250	15.0	p<0.001*
Any MH GP visit within 7 days	115	15.8	81,434	14.0	p=0.18
Any MH GP visit within 30 days	248	34.1	162,480	27.9	p=0.001*
Any MH peds visit within 30 days	7	1.0	2,057	0.4	p=0.09
2+ MH MD visit within 7 days	21	2.9	6,107	1.1	p=0.003*
2+ MH MD visit within 30 days	91	12.5	32,199	5.5	p<0.001*
(ii.)	TGD Hospitalization Cohort (n=454)		Unmatched Comparison Cohort (n=217,507)		p-value
	n	%	n	%	
Primary Outcomes					
Any follow-up visit within 7 days	120	26.4	54,829	25.2	p=0.55
Any follow-up visit within 30 days	268	59.0	123,831	56.9	p=0.37
Secondary Outcomes					
Any psych visit within 7 days	66	14.5	22,341	10.3	p=0.01*
Any psych visit within 30 days	166	36.6	68,958	31.7	p=0.03*
Any MH GP visit within 7 days	61	13.4	35,355	16.3	p=0.08
Any MH GP visit within 30 days	156	34.4	77,913	35.8	p=0.52

Any MH peds visit within 30 days	7	1.5	1,261	0.6	p=0.10
2+ MH MD visit within 7 days	9	2.0	3,394	1.6	p=0.52
2+ MH MD visit within 30 days	61	13.4	24,237	11.1	p=0.15

Note: * denotes statistical significance at $\alpha=0.05$. TGD = transgender and gender diverse. ED = emergency department. Psych = psychiatrist. MH = mental health. GP = general practitioner or family physician. Peds = pediatrician. MD = physician.

Table 6. Unadjusted and adjusted odds ratios (ORs) of having a mental health-related physician follow-up within 7 and 30 days of discharge from (i.) mental health-related ED visits or (ii.) psychiatric hospitalization in TGD individuals, compared with the general population.

(i.)	TGD ED vs. Comparison ED Cohort			
	Unadjusted Odds Ratio (95% CI)	p-value	Adjusted Odds Ratio (95% CI)	p-value
Primary Outcomes				
Any follow-up visit within 7 days	1.46* (1.23 - 1.72)	p<0.001	0.95 (0.79 - 1.13)	p=0.53
Any follow-up visit within 30 days	2.01* (1.74 - 2.33)	p<0.001	1.21* (1.03 - 1.42)	p=0.02
Secondary Outcomes				
Any psych visit within 7 days	2.19* (1.77 - 2.72)	p<0.001	1.01 (0.80 - 1.27)	p=0.94
Any psych visit within 30 days	2.76* (2.36 - 3.22)	p<0.001	1.28* (1.07 - 1.52)	p=0.007
Any MH GP visit within 7 days	1.12 (0.91 - 1.37)	p=0.29	0.93 (0.76 - 1.15)	p=0.51
Any MH GP visit within 30 days	1.30* (1.12 - 1.52)	p<0.001	1.05 (0.89 - 1.23)	p=0.59
Any MH peds visit within 30 days	2.75* (1.30 - 5.79)	p=0.008	0.99 (0.46 - 2.13)	p=0.99
2+ MH MD visit within 7 days	2.80* (1.81 - 4.32)	p<0.001	1.45 (0.93 - 2.26)	p=0.10
2+ MH MD visit within 30 days	2.38* (1.90 - 2.97)	p<0.001	1.25 (0.99 - 1.57)	p=0.07
(ii.)				
	TGD Hospitalization vs. Comparison Hospitalization Cohort			
	Unadjusted Odds Ratio (95% CI)	p-value	Adjusted Odds Ratio (95% CI)	p-value
Primary Outcomes				
Any follow-up visit within 7 days	1.06 (0.86 - 1.31)	p=0.57	0.82 (0.66 - 1.02)	p=0.08

Any follow-up visit within 30 days	1.08 (0.89 - 1.30)	p=0.44	0.81* (0.66 - 0.99)	p=0.04
Secondary Outcomes				
Any psych visit within 7 days	1.47* (1.13 - 1.91)	p=0.004	0.90 (0.69 - 1.19)	p=0.47
Any psych visit within 30 days	1.23* (1.01 - 1.49)	p=0.04	0.82 (0.67 - 1.01)	p=0.06
Any MH GP visit within 7 days	0.81 (0.62 - 1.06)	p=0.12	0.79 (0.60 - 1.04)	p=0.09
Any MH GP visit within 30 days	0.93 (0.77 - 1.13)	p=0.47	0.93 (0.76 - 1.13)	p=0.47
Any MH peds visit within 30 days	2.70* (1.28 - 5.70)	p=0.009	1.11 (0.51 - 2.43)	p=0.79
2+ MH MD visit within 7 days	1.28 (0.66 - 2.48)	p=0.47	0.85 (0.44 - 1.66)	p=0.64
2+ MH MD visit within 30 days	1.22 (0.93 - 1.60)	p=0.15	0.95 (0.72 - 1.26)	p=0.73

Note: Logistic models adjusted for age, LHIN, rurality of residence, neighbourhood income quintile, Ontario Marginalization Index (ON-Marg) quintiles, psychiatric diagnosis, any previous MH hospitalizations, any previous MH-related ED visits, number of previous MH outpatient visits, and any previous non-fatal deliberate self-harm. 95% CI = 95% confidence interval. * denotes statistical significance at $\alpha=0.05$. TGD = transgender and gender diverse. ED = emergency department. Psych = psychiatrist. MH = mental health. GP = general practitioner or family physician. Peds = pediatrician. MD = physician.

Table 7. Unadjusted and adjusted odds ratios (ORs) of having a mental health-related physician follow-up within 7 and 30 days of discharge from (i.) mental health-related ED visits or (ii.) psychiatric hospitalization in TGD individuals, compared with the general population, in the three most common diagnostic categories in each cohort.

(i.)	TGD ED vs. Comparison ED Cohort					
	(a) Mood disorders		(b) Anxiety and related disorders		(c) Substance-related disorders	
	Unadjusted Odds Ratio (95% CI, p-value)	Adjusted Odds Ratio (95% CI, p-value)	Unadjusted Odds Ratio (95% CI, p-value)	Adjusted Odds Ratio (95% CI, p-value)	Unadjusted Odds Ratio (95% CI, p-value)	Adjusted Odds Ratio (95% CI, p-value)
Primary Outcomes						
Any follow-up visit within 7 days	1.06 (0.78-1.44, p=0.70)	0.81 (0.59-1.11, p=0.19)	1.47* (1.12-1.91, p=0.005)	1.08 (0.82-1.41, p=0.60)	1.83* (1.10-3.06, p=0.02)	1.23 (0.71-2.15, p=0.46)
Any follow-up visit within 30 days	1.47* (1.08-1.99, p=0.01)	1.04 (0.75-1.44, p=0.81)	1.80* (1.42-2.29, p<0.001)	1.21 (0.94-1.57, p=0.14)	2.07* (1.37-3.12, p<0.001)	1.35 (0.84-2.16, p=0.22)
Secondary Outcomes						
Any psych visit within 30 days	1.71* (1.29-2.28, p<0.001)	1.06 (0.78-1.44, p=0.70)	3.12* (2.42-4.03, p<0.001)	1.63* (1.23-2.15, p<0.001)	3.60* (2.11-6.16, p<0.001)	1.72 (0.97-3.07, p=0.07)
Any MH GP visit within 30 days	1.09 (0.81-1.46, p=0.57)	1.08 (0.81-1.46, p=0.59)	1.17 (0.91-1.50, p=0.22)	0.99 (0.77-1.28, p=0.96)	1.67* (1.07-2.60, p=0.02)	1.22 (0.75-2.00, p=0.43)
(ii.)						
TGD Hospitalization vs. Comparison Hospitalization Cohort						
(a) Mood disorders		(b) Anxiety and related disorders		(c) Schizophrenia and psychotic disorders		
Unadjusted Odds Ratio (95% CI, p-value)	Adjusted Odds Ratio (95% CI, p-value)	Unadjusted Odds Ratio (95% CI, p-value)	Adjusted Odds Ratio (95% CI, p-value)	Unadjusted Odds Ratio (95% CI, p-value)	Adjusted Odds Ratio (95% CI, p-value)	Adjusted Odds Ratio (95% CI, p-value)
Primary Outcomes						
Any follow-up visit within 7 days	0.96 (0.69-1.33, p=0.80)	0.81 (0.58-1.14, p=0.22)	1.60 (0.94-2.71, p=0.08)	1.28 (0.74-2.21, p=0.38)	1.13 (0.63-2.04, p=0.68)	0.84 (0.46-1.54, p=0.58)

Any follow-up visit within 30 days	0.90 (0.67-1.22, p=0.51)	0.79 (0.57-1.09, p=0.15)	1.29 (0.77-2.15, p=0.33)	1.03 (0.60-1.80, p=0.91)	1.10 (0.65-1.86, p=0.71)	0.82 (0.47-1.42, p=0.47)
Secondary Outcomes						
Any psych visit within 30 days	1.07 (0.80-1.44, p=0.64)	0.85 (0.63-1.17, p=0.32)	1.34 (0.79-2.26, p=0.28)	0.83 (0.48-1.46, p=0.53)	1.17 (0.70-1.95, p=0.56)	0.84 (0.49-1.42, p=0.51)
Any MH GP visit within 30 days	0.71* (0.52-0.97, p=0.03)	0.77 (0.56-1.06, p=0.11)	1.16 (0.70-1.93, p=0.57)	1.25 (0.74-2.11, p=0.41)	1.23 (0.71-2.13, p=0.46)	1.18 (0.68-2.07, p=0.56)

Note: Logistic models adjusted for age, LHIN, rurality of residence, neighbourhood income quintile, Ontario Marginalization Index (ON-Marg) quintiles, psychiatric diagnosis, any previous MH hospitalizations, any previous MH-related ED visits, number of previous MH outpatient visits, and any previous non-fatal deliberate self-harm. 95% CI = 95% confidence interval. * denotes statistical significance at $\alpha=0.05$. TGD = transgender and gender diverse. ED = emergency department. Psych = psychiatrist. MH = mental health. GP = general practitioner or family physician.

Chapter 4

4 “The less time I spend in a hospital, the more likely I am to go back”: Transgender and gender diverse people’s experiences of acute and post-discharge mental healthcare

4.1 Abstract

Background: Transgender (trans) and gender diverse (TGD) people experience significant oppression, with resulting mental health disparities and greater need for acute mental healthcare, i.e., mental health hospitalizations and emergency department (ED) visits. Early post-discharge care can reduce negative health outcomes following acute care presentations. The aim of this study was to conduct a qualitative study to explain prior quantitative findings from a study utilizing health administrative data to examine acute and post-discharge mental healthcare outcomes among TGD individuals.

Methods: Prior quantitative results guided the qualitative study design and data generation plan, including design of the semi-structured interview guide and the purposive sampling strategy. TGD people living in Toronto, Ontario, who have experienced acute mental healthcare (n = 15) were recruited. In-depth individual interviews were conducted, transcribed, and analyzed using constructivist grounded theory. Quantitative and qualitative results were integrated and presented together.

Results: Participants described minority stress experiences (social situations that cause stress for minoritized people related to their minoritized identity) in their life leading to mental health symptoms and care needs, which were inadequately addressed by traditional outpatient mental healthcare, i.e., medical care provided without staying in a hospital. This led to increasing distress, with acute care being increasingly one of few pathways to address care needs. Their experience of acute

care was impacted by the degree of autonomy, safety, and usefulness they attributed to their hospital visit. These experiences led participants to three pathways post-discharge: 1) engaging in post-discharge care within the formal mental health system, 2) preferring community care outside of biomedical models, and/or 3) avoiding the mental health system altogether. Participants who chose to avoid traditional mental healthcare did so related to traumatic (including transphobic) experiences in hospital and having autonomy in help-seeking taken away. ED visits were more likely to be experienced as more helpful and less traumatic compared to hospitalizations. Even when participants found hospitalization helpful, the hospital experience was described as depleting energy and resources such that they needed time away from the system after. Contrary to the formal mental health system, community care was often described as offering holistic and integrated care, prioritizing autonomy, and addressing social determinants of health and connection to community. These experiences explain the discrepancy between post-ED and post-hospitalization access to care in the prior quantitative study.

Discussion: Improving acute and post-discharge care with and for TGD people requires understanding of minority stress experiences that impact TGD people's engagement with and trust in the mental health system. To better serve TGD people's mental health needs, mental healthcare needs to be more integrated, address social determinants of health, support neurodivergence, and be competent in intersectionality and trauma-informed care. Hospital staff and policies need to prioritize autonomy and address systemic transphobia to support access to care. Integrating TGD-specific community organizations into acute mental health services may help address the needs of TGD individuals more holistically.

Keywords: Transgender health, psychiatric hospitalization, acute mental healthcare, post-discharge care, constructivist grounded theory, mixed methods research

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4.2 Introduction

Transgender (trans) and gender diverse (TGD) individuals are people whose gender identity differs from their sex assigned at birth, and can include gender identities outside of the gender binary (1). TGD people are estimated to be at least 0.5% of the population (2). They experience high rates of mental illness, such as over 60% having active depressive symptoms cross-sectionally (3,4) and 43% having attempted suicide in their lifetime in one study of 433 TGD Ontarians (5). The minority stress model explains that such disproportionate rates of mental illness and suicidality are not because of an individual's gender identity, but rather due to experiences of marginalization and oppression the individuals face in response to their gender identity; including frequent experiences of transphobia, violence, unemployment, and homelessness (2,6).

Higher rates of mental illness in TGD populations correspond with greater need for mental health services, including acute mental healthcare, defined as psychiatric emergency department (ED) visits and hospitalizations (7,8). Multiple qualitative studies have confirmed and explored the significant barriers to accessing mental healthcare that TGD people face (9–13). A review of qualitative studies focusing on mental health needs of TGD individuals found that common barriers to care include a lack of inclusive and appropriate services, a fear of discrimination and refusal of care, a lack of knowledgeable and non-judgmental providers, and factors related to social determinants of health and marginalization that make accessing care very challenging (14). Even when TGD people are able to access acute mental healthcare, hospital settings lack inclusive and affirming policies for TGD people (15,16), which leads to low perceived usefulness of hospital-based care (17).

Some studies have highlighted how qualitative research with TGD individuals can center lived experience and inform how to improve mental healthcare for this population (9,11–13,15,18,19). One qualitative study focused on TGD teenagers' experiences of mental health hospitalization (18) and another focused on TGD adults' experiences of emergency care but not emergency mental healthcare specifically (19). None of the qualitative studies focused on lived experiences of TGD

adults accessing acute mental healthcare, which is an important treatment option for mental health symptoms of higher severity and complexity, with or without safety concerns. No studies have focused on the Canadian context either, which is a different healthcare system than the US and other countries. Since TGD individuals face much higher rates of mental illness and suicidality, and have required more mental health services, the experience of acute mental healthcare is important to understand. There is valid fear of discrimination in acute care settings that can impact TGD people's decision to access care (20). Aspects of acute care, such as having to replace gender affirming clothing with a hospital gown, can also cause fear and avoidance of care (13). These aspects are important to elicit and explore, and can be explored more in-depth through qualitative methodology.

The time following discharge from a hospitalization or ED visit is known to be high risk for negative health outcomes, including suicide and readmission (21,22). There is some evidence that early and active follow-up after discharge can reduce these risks and improve health outcomes, including mortality (23,24). However, post-discharge access to care for TGD people is understudied. Many TGD people avoid healthcare due to experiences and fears of discrimination (25). This may translate to avoidance of post-discharge care or seeking of care outside of biomedical healthcare models. Qualitative studies have focused on barriers for TGD people to access traditional models of healthcare (14,26,27), but none have focused on their post-discharge mental health journey specifically.

Mixed methods research involves integrating quantitative and qualitative methods in a research study (28). In biomedical and health services research, where quantitative research has dominated, there is increasing recognition of the value of qualitative research, and mixed methods research in particular (29–33). The potential benefits of mixed methods research in health-related research are multifold, including more comprehensively understanding a topic through different perspectives, using one methodology to generate hypotheses or assessment tools to test with another methodology, and using qualitative research to center the lived experience of patients and explain quantitative results (29–33). Qualitative research

can help researchers explore and understand in more depth the findings from health administrative data. In equity-oriented research, the centering of lived experience to clarify quantitative findings is particularly important (30).

This qualitative study was designed as part of a mixed methods study to explain a previous quantitative study using health administrative data. The focus of the qualitative study is on the experiences of TGD people accessing acute and post-discharge mental healthcare in Ontario.

4.3 Methodology

Overall Mixed Methods Study Design

The overarching thesis study was a sequential explanatory mixed methods study that involved collecting quantitative data first and explaining the quantitative results with in-depth qualitative data (see Chapter 1 Introduction, Figure 2, p. 21) (28). The quantitative study found that post-discharge access to outpatient mental health physician care was increased after an ED visit but reduced after a psychiatric hospitalization for TGD individuals in Ontario. The quantitative results guided the refinement of the qualitative study design and the data generation plan, including sensitizing concepts used for interviews and the purposive sampling strategy. The interview guide probed for participant life events and experiences before, during, and after being in hospital for their mental healthcare needs. Interview guide questions focused on participant experiences of care in the hospital and after discharge to explain the previous quantitative results. Sociodemographic and clinical factors found to be associated with the need for acute mental healthcare presentations in the quantitative study informed the list of sensitizing concepts in the qualitative study (34), including experiences of socioeconomic marginalization and the impact of social determinants of health and minority stress (35). We also directly presented summaries of the quantitative findings to the participants by incorporating them in interview guide questions, which allowed for participants to contribute to co-construction of explanations for these findings and reflect on any

resonance of these findings to their own lived experience. Quantitative results also informed purposive sampling as we aimed to include a sample of participants in the qualitative study that was broadly representative of the quantitative cohorts. A participant sample matrix was used to monitor for participant characteristics including age, psychiatric diagnoses, and type of acute mental healthcare utilization for this purpose (36). The qualitative study also compensated for a weakness of the quantitative study by allowing for purposive sampling of TGD people with diverse racial identities, exploring how racialization – a key factor not measured in the data used for the quantitative study (37,38) – can affect acute and post-discharge mental healthcare among TGD individuals. After the qualitative data were analyzed, the results were interpreted and integrated together with the quantitative results for enhanced understanding.

Paradigmatic & Theoretical Foundations

Qualitative methodology is rooted in the researchers' ontology and epistemology (39). This study was grounded in a relativist ontology, which is the belief in multiple valid interpretations of reality and that reality is dynamic and socially co-constructed by individuals (39–41). Social location and positionality affect social processes and co-construct social realities (42). The epistemology guiding this study is interpretivist, which is the belief that knowledge on social realities is created through human interactions in a specific context; and specifically, that knowledge is co-constructed by the researcher(s) and the participant(s) through the research process (39,40). Social phenomena are dependent on the meanings and interpretations that people assign to aspects of the social world (39,40,43). Therefore, social realities are shaped by interactions between individuals and the shifting interpretations and meanings that people assign to aspects of the social world (39,40,43). Knowledge is co-created between the participants and researchers, and the knowledge needs to be situated within our social locations and the greater geopolitical, cultural, and historical context (39,40,42,43).

Our onto-epistemological paradigm impacted our methodology. Grounded theory (44,45) was chosen as a process to develop a substantive theory from the qualitative data that could explain the quantitative findings. However, to align with our onto-epistemological paradigm, the specific methodology in this study had to be constructivist grounded theory (cGT) (45,46). Grounded theory has roots in symbolic interactionism, where “interaction between people is viewed as symbolic because the interactive processes use the symbols of language, words and interpretation” (p. 664) (41). Those symbols interacting co-construct realities and knowledge. Charmaz describes cGT and symbolic interactionism as a “theory-methods package” (p. 20) (47). A grounded theory approach seeks to develop a substantive theory by understanding how meaning is created around a social process (41,45).

Reflexivity Statement

The first author (JL) was the interviewer and primary coder for this study as this is his PhD thesis study. As described in more detail in **Chapter 1** (see **Section 1.6** on Reflexivity, pp. 35–37), he is a queer East Asian person and a psychiatrist in Toronto. He has an interest in quantitative and qualitative research, and particularly in the potential for mixed methods research for health services research. His clinical and academic work is rooted in understandings of intersectionality (48) and the minority stress model (49). As both a researcher and a physician, his goal is to leverage scientific knowledge to inform evidence-based care and policy changes that reduce health inequities, especially for 2SLGBTQIA+ (Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, Asexual, and other gender and sexual minority identities) communities. Given that our positionalities as researchers drive and guide our work (42,50–53), as it has in this study, reflexivity and transparency around our social locations and their impacts on our research are crucial.

Qualitative Study Overview

Our research question aimed to develop a substantive theory to understand TGD people's acute psychiatric care experiences and post-discharge mental health journeys in hopes of having implications for improving the design of mental health service delivery with and for TGD people. This led us to ask the following research question: ***How do transgender and gender diverse (TGD) people living in Toronto (Ontario, Canada) with a history of mental health hospitalization(s) and/or emergency department (ED) visit(s) understand and experience their acute mental healthcare visits, and journeys after discharge?*** Our study examined how experiences both within and outside of the healthcare system impacted TGD people's mental health journeys. Following symbolic interactionism in cGT (47), we explored how and what symbolic meaning is attributed to social interactions before, during, and after a TGD person's mental health hospitalization or ED visit to shape their mental health journeys and experiences.

Charmaz's cGT offered explicit guidance on how to proceed from the initial research question to theory building and beyond (47). Intensive individual semi-structured qualitative interviews are common in the tradition of cGT and this was used to explore participants' interpretations of their experiences and meanings related to the research question (47). It is a method that operationalized our interpretivist epistemology as the semi-structured nature of the questions allowed the interviewer to pursue new avenues of knowledge during the interview. The methodology explicitly recognizes the co-construction of knowledge between participant and researcher by emphasizing that the interview is an interaction of symbols (via language and non-verbal behaviours) where the researcher's experiences and positionality, the context the interview occurs in, and the dynamic between the researcher and participant, will shape the knowledge that is generated during the interview (47).

Findings from the quantitative study shaped the development of the interview guide, which clarified specific interests for the study and facilitated interviews to be "in a smoother, less confrontational way" (p.64) (47). Charmaz offers specific

guidance on designing the interview guide for multiple purposes, including starting with background questions to generate knowledge needed to explore the substantive topic, reflecting on the assumptions that underlie questions and to what extent participants may share those assumptions, considering different intermediate questions that get at the substantive topic in different ways, and closing with ending questions that foster elaboration but also an end to the interview on a positive note (pp. 62 – 68) (47). The interview guide allowed the interviewer to actively listen and follow the participant's lead while knowing that they can refer to the guide as an aid to generate further data on the substantive topic if needed. Consistent with cGT, the interview guide was updated during the data generation and analysis process, as new relevant concepts and topics emerged.

In the context of the ongoing COVID-19 pandemic and changing restrictions, the default option was to conduct the interviews virtually. In-person interviews were available if preferred, but no participants opted for this option. Only individuals living in the Greater Toronto Area (GTA) were interviewed for both feasibility and to facilitate understanding of experiences that share a broad geopolitical context, recognizing that many different cultures and contexts exist within this large area.

Participants, Sampling, & Recruitment

Self-identified TGD individuals living in the GTA with a history of mental health hospitalization(s) and/or ED visit(s) in Ontario since January 2012 were recruited from hospitals, shelters, community centres, clinics, post-secondary institutions, other health care and community organizations, and through social media.

Recruitment purposively occurred both in and out of health care institutions to elicit a diversity of perspectives, including those who may have had neutral or negative experiences of the healthcare system. We used maximum variation sampling (36) to maximize diversity of demographic factors including age, gender identity, and ethno-racial identity. This was meant to include heterogeneous and diverse experiences of the phenomena (36) to support the process of theoretical sampling (47). Sample size for the study was guided by theoretical sampling in accordance

with cGT methodology (47). This is consistent with guidance around determining sample size using the concept of information power, which suggests that sample size in qualitative studies is determined by study aim, sample specificity, use of theory, quality of dialogue, and the analysis strategy (54).

Study inclusion criteria included individuals who: (a) Identify as TGD, (b) Are comfortable conducting an interview in English, (c) Are at least 18 years old, and (d) Had at least one mental health hospitalization or mental health-related ED visit since age 18 and since January 2012. Exclusion criteria included individuals experiencing any of the following at the time of the interview: (a) Manic symptoms, (b) Active substance intoxication or withdrawal, and (c) Significant cognitive impairment affecting ability to consent to study participation.

Informed consent was obtained prior to all interviews. The study protocol was approved by the CAMH Research Ethics Board (REB # 132/2021).

Data Generation & Analysis

Each participant underwent a semi-structured qualitative interview in English, between 53 and 116 minutes in duration. Each participant also completed a brief structured demographic interview. Participants were compensated for their time. Semi-structured interviews were conducted using the interview guide, allowing for open-ended questions and pursuit of new and emerging topics (47). A methodological journal was kept (47) from before the first interview to the writing up of the study results. The methodological journal is a key strategy for data generation and analysis, as through writing in the journal the researcher reflects on the process of the study, documents how their positionality may impact the research process and data generated, clarifies the research question further, and considers adjustments to the methodology and methods (47). Methodological journaling also occurred after interviews to record reflections that guided analysis.

Interviews were audio taped and transcribed by a professional transcriber with experience working with qualitative data on mental health. Data were entered into NVivo 12 to assist in the data organization and analysis process. The analyst initially read through each transcript without coding to begin immersing in the data, followed by open coding with the use of gerunds for coding as encouraged by Charmaz, and analytic memos written throughout the coding process (47). As part of the constant comparative method, this was followed by focused coding, where the more significant and frequent codes were used, and then moving recursively and iteratively towards categorizing and theory building (47). Consistent with cGT, coding was an on-going process during the data generation period. Analytic memos were written iteratively to reflect on salient codes, compare within and across transcripts, build relationships across codes to develop them into larger themes, and capture major issues relevant to each code. Each transcript was coded twice to ensure earlier transcripts are examined for codes and themes that developed through the process of data analysis. As codes and themes were generated it drove theoretical sampling and led to changes in the interview guide to flesh out as well as to challenge/confirm these themes. Research team members met regularly to discuss codes and larger themes. Data generation ended when no relevant new codes, themes, or categories were generated, and the identified themes adequately captured and categorized the phenomena, relationships between concepts, and complexity of experiences. This is also known as data saturation (47).

We recruited six individuals who identify as TGD, who are also clinicians and/or researchers with experience and expertise in trans health, to provide feedback on the qualitative data analysis to improve scientific rigour and enhance credibility. Individual meetings were conducted with each advisor once for 60 to 120 minutes. The theoretical model and illustrative quotes were shared with the advisors beforehand and during the meetings to elicit feedback that was iteratively incorporated into the final model. Honoraria were provided.

4.4 Results

4.4.1 Participant Characteristics

There were fifteen TGD participants in this study. In terms of sociodemographic characteristics (**Table 8**), their mean age was 30.9 (ranging from age 21 to 59). Approximately half of the participants were nonbinary, with six participants (40%) identifying as transfemme or as trans women. Half were white, with one-third Asian, and two Indigenous participants. Most (60%) were not in a current romantic relationship, and none had children. Most lived alone or with partner(s) and/or roommate(s) in a place they rent or own, though three individuals (20%) were living in supported or community housing. Forty percent of participants completed college/university while another forty percent completed some college/university. Most (60%) were currently receiving government assistance.

Clinically (**Table 8**), six participants (40%) reported having a chronic physical health condition, including fibromyalgia, chronic fatigue syndrome, migraines, obstructive sleep apnea, dysautonomia, Ehlers-Danlos syndrome, psoriasis, Hashimoto's thyroiditis, polycystic ovary syndrome, irritable bowel syndrome, and bladder pain syndrome. Participants reported having an average of four psychiatric diagnoses, with mood disorders and anxiety disorders each being diagnosed in two-thirds of the participants. Neurodevelopmental disorders and post-traumatic stress disorder (PTSD) diagnoses were each reported by nine participants (60%). Seven people (47%) had been diagnosed with borderline personality disorder (BPD). Participants had a lifetime mean number of 5.3 mental health ED visits and 5.9 psychiatric hospitalizations. In terms of formal mental health supports, all participants had a family doctor; and most had a therapist (53%), case worker (60%), and support from a community organization (73%). One-third reported having a psychiatrist.

4.4.2 The Model of Acute and Post-Discharge Care Experiences

Participants described experiences before, during, and after their hospital visit that influenced their mental health journeys (**Figure 4**). Participants described minority stress experiences throughout their lives that led to mental health symptoms. These minority stress experiences were related to developmental trauma, neurodivergence, physical disability, and marginalization. The accrual of mental health symptoms and distress led to a desire to seek care, but participants found it difficult to navigate access to care through the formal mental health system, and those who could access outpatient mental healthcare found it fragmented and inadequate for addressing their needs. The inability to access the care they needed led to mounting distress, which culminated in the hospital as one of few remaining pathways to potentially reduce their distress and improve their symptoms. Their experience of the hospital was impacted by their perceived agency in presenting to the hospital, and by their perception of how safe and useful the hospital visit was for them. These experiences would influence participants' subsequent decision to engage in post-discharge care in the formal mental health system, prefer care in community organizations outside of the biomedical model, or avoid the mental health system altogether.

4.4.2.1 Minority Stress Experiences

Participants described minority stress experiences, which are social situations that cause stress for minoritized people related to their minoritized identity (49), in multiple domains throughout their life and upbringing. These domains included developmental trauma during childhood, lack of recognition and support for neurodivergence, challenges related to physical symptoms and disability, and social marginalization in housing, education/employment, and practical/financial areas. These recurring and varied experiences of discrimination and invalidation were clearly described as being connected to mental health symptoms and the need for mental healthcare for the participants.

A. Developmental Trauma

Multiple participants discussed how interpersonal trauma early in their life disrupted their development of trust and secure attachment with caregivers (55), which shifted their sense of safety in the world, and contributed significantly to their mental health symptoms and distress.

Participant 3 described how coming out to their parent and having an unsupportive response led them to experiencing panic attacks and trauma-related symptoms, and the response from their parent triggered a re-experiencing of previous trauma:

“I had come out as queer to my mom recently, who's like kind of my main - like, my parents split up when I was really little, so she was the main person in my family that I needed to come out to, and it really didn't go well. And it was just really traumatic for me. And I started having uncontrollable panic attacks and I started having PTSD symptoms that were also related to other things when I was younger, like there's some emotional and physical abuse from when I was younger. And that event kind of triggered that.”

They later experienced another mental health crisis when they were trying to set boundaries around their relationship with the same parent, but despite wanting to set that interpersonal boundary for themselves, they still felt guilty about it because this was their parent:

“My second Emerg visit was also very related. It was like I was feeling so guilty about choosing not to have contact with my mom who was being homophobic and transphobic. I was feeling like so guilty about that choice that I was incredibly suicidal.”

Participant 6 similarly described a negative response after coming out to her family, and this led her to losing her housing and financial stability, as she was kicked out of her home in Canada. She then decided to move to another country with plans to join the military there so she would have more financial stability, but the plan to join the

military did not work out as planned and her family there was also not accepting of her gender identity, which worsened her distress:

"[My family in Southeast Asia] certainly weren't remotely accepting of, say, me, having found out I was trans, et cetera, even if I wasn't medically transitioning, and I was there for military service. But even outside of that I'd guess I'd say that, hmm, the best way to say it would be they kind of saw me as trash and, honestly, I was only there out of necessity and figuring that as soon as I got into the military or something, I wouldn't have to deal with them anymore. But I guess I'd say it was - long story short, it was miserable. And financially, basically, the biggest part of why I had left to [Name of Southeast Asian country] in the first place was that financially, I hadn't been doing so hot in Canada, because when my dad basically forced me to move out, due to finding out I was trans..."

Participant 9 also linked childhood trauma and lacking support for his identity to his mental health challenges and housing instability, which he described as being a reality for many other queer youth as well:

"I have mental health issues because, you know, I had an abusive family environment. So, going and living with my parents to save money for an apartment is not an option. I just have to leave and deal with whatever gets thrown at me. I mean, people in low income already have worse mental health issues. Add trans on top of that, it's not looking good for us. ...that's one of the reasons that [name of youth homeless organization] is so good about their trans care is because I think they found that, like, 40 to 60% of the youth that come in are queer because they either get disowned or they have to leave. So...if [you're] having to be kicked out or leave home for any reason, it's probably already contributing to mental health issues. Having it be because of part of your identity makes that a whole lot worse."

Participant 11 described experiencing multiple forms of trauma in her life, including being sent to an all-boys religious school as a transfeminine nonbinary person

growing up, before there was even language available for her to name and understand her gender identity:

“I obviously have always been nonbinary and that didn't even exist when I was a kid, or teenager. It didn't really exist until 5 years ago, it seems like. So, I didn't really know what to do with that. I always - that definitely impacted my mental health. My parents sent me to an all-boys school, kind of like St. Michael's but kind of more religious, because you could do that in [another Canadian province], that's where I'm from. And that really fucked me up in ways that I probably just can't even ever unpack or measure, but I'm trying to be happy with who I am now.”

Participant 13 summarized the impact of trauma related to living life as a trans person, and being invalidated throughout their life, from childhood to adulthood, as forming a lifetime of traumas that would undoubtedly impact anyone's mental health over time:

“A lot of trans folks have been through a lot of trauma to survive, and also choose to, like, live your true life, like as your true self, is really, really hard to do. And I think whether you count it as trauma or not, I think a lot of people who have grown up in environments where their experience of gender wasn't, you know - like, you experienced gender dysphoria but you couldn't put your finger on it. You, like, didn't get supports you needed when you were younger, that sort of stuff. You maybe overcompensated to try and fit in, that sort of stuff. That's a lifetime of, like, traumas - microtraumas in itself, and then you experience, in this coming out phase, you experience people being ignorant. You experience marginalization from doctors, you know?”

B. Neurodivergence

Nine participants talked about the impact of neurodivergence, including autism and/or ADHD, on their mental health. Several participants had not been diagnosed but felt strongly that they were neurodivergent. Neurodivergent participants

directly linked growing up and living in a neurotypical world as a neurodivergent child as causing mental health symptoms.

Participant 11 directly linked her mental health challenges to lacking support and accommodations for being autistic in childhood, which was worsened by her experiences of her family stigmatizing and invalidating her experiences:

“I didn't have a very good, stable mental health from my upbringing, or support for being autistic - like, no one brought me in for a screening, because they didn't want an autistic kid and stuff like that. Or my mom took me to a therapist who told me that I was valid and that my mom was the one who was basically crazy, and that's where I told my mom to back off, and then we never went again. So, that was - I was always a depressed and struggling kid. I struggled a lot with school. The older I got, the more that was dumped on me, because no one ever helped me learn in my own way. I never got any accessibility or whatever.”

She described how her experiences of invalidation around her neurodivergence were not only limited to her family of origin, but that even after she had been diagnosed with autism, *“my new doctor is the one who doesn't think I'm autistic because I talk too good, even though I'm diagnosed by someone way more specialized than him”*. She described how *“being autistic is just really hard”*, and how it has always made it difficult for her to make friends growing up, or even form *“good connections with people”* in general.

Participant 10 also connected their mental health symptoms with undiagnosed and unaccommodated autism:

“So, I've always had mental health struggles. But they were because I was growing up undiagnosed autistic. I'm diagnosed now. So, it's really great. But like, yeah, I had anxiety growing up, and I got depressed in high school. And I kinda stayed depressed for a pretty long time.”

They talked about how an autism diagnosis was empowering for them, because they had grown up believing they were “*just weird, and socially incompetent and lazy*”. They found that an autism diagnosis allowed them to stop the negative self-talk and help them accept themselves more.

Participant 4 described how harmful it is to make autistic people live in an allistic (non-autistic) society without appropriate accommodations and supports. They also discussed how mental health stigma still prevents many people from being assessed and supported for autism, perhaps even more so outside of the North American context:

“I resonate a lot with what they say about - like, you know - it will always be harmful to try to, like, forcibly assimilate an autistic person to a neurotypical or allistic society... for example, if an autistic child is having issues with the texture of the insides of shirts or whatever, why do they have to wear their shirts - like, they can wear their shirts inside out if they want, like why is that such a huge deal, you know? It's like - I feel like especially as an autistic person myself, I'm very aware of - it's just an intrinsic thing to me to have function over form. Like, there doesn't even need to be form at all, it just needs to be function. ...I just feel like there needs to be a lot of - like, you know, again, it's another major systemic overhaul to how people see - you know, obviously, I think it still stems from, like, the huge stigma around mental health still, like to this day, of course. And you know, even as we live in North America, there are a lot of other places in the world that still see it very differently.”

Some participants reported how even when they had a diagnosis that affirmed their neurodivergence, their neurodivergence still underlies and perpetuates mental health symptoms, and sometimes can even interfere with their ability to benefit from standard treatments. Participant 3 reported how their ADHD not only underlies their anxiety and depressive symptoms, but these symptoms then impact their ability to achieve their educational and financial goals or engage in self-care, which cyclically worsens their stress, which feeds back into worsening their mood and anxiety:

“...my ADHD is a really huge thing, like that makes a lot of things really hard for me. And it affects also, like, my anxiety and depressive symptoms because I'm not able to be on meds because of side effects and behavioural things for ADHD haven't really helped and I have pretty severe symptoms. So, that's a thing that really affects everything. And it has really impacted my ability to finish my program at school, which is really hard because that's an important goal for me. So, that's kind of an ongoing struggle. Keeping my space clean is an ongoing struggle. I forget things a lot, like there are just a lot of cognitive difficulties that I have and then that affects my emotional health. Financial stressors are an ongoing thing, that's a chronic stressor that makes me really anxious, and sometimes feeds into my depressive symptoms.”

Participant 14 described how even when he received helpful treatment for borderline personality disorder (BPD), and his mental health overall had significantly improved, his main residual mental health challenges came from undertreated ADHD. He described how ADHD symptoms lead him to not sleeping enough, which makes him feel irritable. He reports that he stays up related to his ADHD symptoms, *“thinking of things that I want to do or finish. So, I'll be planning in my head, or there's something I needed to do, but I forgot to do, so I'm like, oh, I should go do that now. And it's like 1:00 AM.”*

C. Physical Symptoms & Disability

As described above, six participants (40%) in this study reported having a chronic physical health condition. Several of the diagnoses lack significant research and understanding in current medicine, which led to the experience of invalidation from healthcare providers, among others, for some participants.

Participant 3 described how their cardiologist was not familiar with dysautonomia, so their concerns were dismissed, which led them to feeling acutely suicidal:

“I have dysautonomia, but before that was diagnosed - like, it can be quite debilitating. I don't know how much you know about it, but involves some

cardiac symptoms like tachycardia and stuff. And so, I went to a cardiologist - I got referred to a cardiologist, but she didn't know anything about dysautonomia, and she told me that I was just out of shape. And that made me feel so hopeless that I was, like, incredibly suicidal and it was, like, really difficult for me to decide to get help because I had been dealing with, like, all of these chronic health issues by myself, like during the pandemic..."

Participant 4 described how they struggled with multiple related physical health conditions, including fibromyalgia and chronic fatigue syndrome, and how the lack of definitive testing to confirm some of the diagnoses contributed to their minimizing of their own symptoms and distress:

"I have fibromyalgia and chronic fatigue syndrome. So, like, you see me in bed but, like, most days I kind of just try to - like, I kind of try to just power through it. It's like the same with autism, it's kind of like - yes, I've seen the relevant professionals, however I still don't really believe that this is something that I have. I think it's probably the - I could say it's, like, the way I was raised or because of, you know, how strong the grip of, sort of, like, Chinese cultural conditioning has on me, where it's like, oh, you have ghosts in your blood, you're not actually sick or whatever, You just - yeah, I don't know. There's a lot of denial around that. And I guess feeling imposter syndrome too, because I'm just like, oh, but other people have real problems. So, I just consider, you know, my mom will always tell you - like, if you ask her, she'll be like, oh, yeah, my child has always been super sickly, and has a very weak constitution, you know? As they would describe it in Mandarin. Like, my extended relatives would all agree that ever since I was very little, I would - you know, I have a very weak constitution. Yeah. So, obviously, along with the fibromyalgia CFS, they kinda look like a whole - there's a lot of sort of concurrent illnesses that come with it. Not necessarily illnesses but conditions, like IBS, like psoriasis, like bladder pain syndrome. Yeah, just stuff sort of - like all related to that. And it's also, like, kind of a - pardon my French, kind of a bitch of a disorder to be diagnosed with because there's no definitive tests. Like, you can go get your bloodwork done, and they'll just be like, oh, you have a low lymphocyte count, or oh, you're

anemic, or something. And you take supplements for it. And then, like, you know, it goes away, but your symptoms are still there.”

Participant 5 also reported having chronic fatigue and chronic pain, among other chronic physical symptoms, which severely limits their quality of life and their ability to find stable employment and financial stability:

“I feel like shit, like 90% of the time. On most days. I’m very nauseous, and my stomach doesn’t feel well, and I just feel totally run down. So, that very, very drastically reduces my quality of life and I don’t know what’s up with that. I also - like, I also can’t stand for - like, I can’t work like a full-time job where I have to stand for 8 hours a day, because I’ll just be totally wiped out the next day. And so, that makes finding employment for me very difficult because I don’t have a ton of experience, and I don’t have education yet. And so, trying to be more independent in my finances and/or not become unable to pay basic life costs is very difficult because I don’t have access to jobs where I won’t be really hurting my body.”

Participant 13 also experienced chronic pain and chronic fatigue, which they connected to their mental health. They also connected these physical symptoms to minority stress, trauma, and “windy life trajectories” that TGD people are more likely to experience:

“I think another piece, honestly, is that because trans people have, sort of, like, more windy life trajectories, you know, don’t necessarily finish school on time. Like, you have been through stuff. Like, it means that it is harder to find employment, especially safe employment. And you know, there’s also correlation of, like, if you experience trauma, or minority stress, you could say too, you’re going to be more likely to experience chronic illness and, you know, chronic pain and all that stuff.”

Several participants described physical health symptoms and challenges as being one part of a series of life stressors and events that built upon each other and culminated in a mental health crisis leading to the need for acute mental healthcare.

Physical health challenges were often an underlying stressor that, when combined with other stressors, led to intolerable distress and an inability to cope. Participant 1 described such a set of challenging life circumstances that led to presenting to the ED:

“I had a series of three miscarriages. Two typical miscarriages and one ectopic. The ectopic required chemo. So, because it was in my tube and they caught it early, that meant four months of being essentially, like my whole body being toxic. And then I had a whole bunch of just different events that just felt like it was never ending, of, like, job loss, out of nowhere, without cause. You know, and chronic pain, and you know, losing a friend and then my cat died, and then about a week after my cat had died and a week before that, I had lost a job... my financial situation wasn't great, and... I found out that my husband had been having an affair for almost a year. Job loss, cat died, then the affair. I tried to hold it together for about a week, and just kept discovering more and more lies. And so...I went to the [hospital] Emergency Department and I was there on an involuntary hold for two weeks.”

D. Marginalization

Consistent with the minority stress theory (49), the TGD participants in this study described recurrent experiences of transphobia and discrimination related to their gender identity, which was linked with social marginalization impacting their housing, employment/education, and financial stability; all of which contributed significantly to their distress and increasing mental health challenges.

As described above, several participants discussed how they, and TGD youth in general, lost housing and financial stability at a young age related to their family of origin not supporting their gender identity. Participant 3 directly connected their mental health symptoms, including suicidality, and times of crisis to their experiences of poverty and housing insecurity:

“I’ve had a lot of different life stressors that have contributed [to being in hospital for mental health]... But like, struggling with poverty, like I’m on ODSP at the moment and I’ve struggled with poverty my whole adult life for various reasons. Like, housing insecurity. One of the times that I almost followed through with suicide, like I was homeless.”

In addition to financial barriers to housing stability, TGD participants also described transphobia preventing access to stable housing. Participant 7 reflected on the connection between identifying as TGD and experiencing housing instability related to transphobia and cisnormativity, particularly around the judgment of whether a trans person may “pass” as a binary gender:

“I’ve met quite a few trans folks who have, like, when I was homeless as well, who struggled, and I think it’s more, like, just living in prejudiced society sometimes too, like, you know - and I feel like it’s really the folks that aren’t - like they can’t pass, I feel like they get the really shit end of the stick because of closeminded landlords and people, like they see somebody - let’s say someone’s going male to female and they’re not passing and then, you know, people get all really weird with their prejudice, I don’t really know how to verbalize it because I don’t look at trans people in that way. I just see beautiful people, you know?”

Repeatedly, participants in this study connected social marginalization to mental health symptoms and the increasing need for acute care. Participant 9 explained how experiencing financial precarity and homelessness connected to depression and hopelessness for him, feeling that he could not get the supports he needed to be able to get out of a challenging social situation:

“I mean, depression is hopelessness, right? So, when you are, you know, kind of living in a system that was designed to go against you, it doesn’t help alleviate the hopelessness and just kind of contributes to it. Like, leading up to me being homeless and being in more precarious housing, I had gone into a lot of debt trying to keep up my rent before I eventually became homeless. So, hopelessness

definitely stacks up on you, for sure. And then getting out of homelessness, without the right supports, it can feel like an impossible battle.”

Participant 2 similarly described how financial insecurity weighed her down, formed a background of underlying distress and struggle, and reduced her capacity for self-care and mental wellness, leading to suicidality and the need for emergency care:

“The moments that I have sought out emergency care have always been in moments of financial precarity. And that's not because you can pay to not be suicidal. It's just that if you're already struggling to make ends meet and weighed down by that, everything else becomes so much harder. And if you don't have - if you're working 14 hours a day, you don't have time to keep yourself alive. Either you're going to die, or at some point, someone else is going to have to do it for you.”

Participant 14 described why housing stability is so important. Having experienced trauma and a lack of safety in his life, having a home where he felt safe and secure, in control, and with people he trusts allowed him to focus on other priorities in his life, including imagining his future, beyond just trying to survive:

“So, because of all that happening and not having a stable place to live, it was, like, constantly... like, I was constantly daydreaming about the future so that I could just, like, have a second to think about what I wanted to do with my life. And it's affected me because now my environment's safe. Now I'm not worried - like, at the shelter someone stole all my food. Like, having a stable house where it's with people I trust, I'm like, yeah, nothing of mine is going to get stolen. Like, you can see, I have so many insurances now - I mean, my door locks, my partner is a great person to be around. So, like, it's overall a positive environment. And that sort of changes my outlook and my ability to focus on other things that I want to do.”

Participant 6 described how a mental health crisis was precipitated by the Winter holiday season, when the community organizations she depended on for food and

other financial and practical supports were closed, and this led her to physically starving, which led to a mental health crisis:

“...it was the holiday season. A lot of programs that I was going to, including some stuff where I was trying to return to school et cetera, kind of were down. And I guess I'd say it was just a down period of my life at the moment, and between that and bad budgeting and just falling into a reclusion, I guess I'd say - well, for starters, I maybe kind of started starving of a sort. Like, how do I put it? I guess I'd say from there things spiraled down to, hmm - financially I wasn't doing well as well, which was what I mentioned of the poor budgeting. And I guess I'd say maybe I was kind of - how do I put it? I guess basically I was kind of planning to either off or injure myself, and I ended up instead calling a suicidal hotline. And yeah, so I wound up hospitalizing.”

Participants described how financial and housing instability were related to employment discrimination and not being able to secure stable employment. Participant 15 is a 59-year-old trans woman who described how she was working in an industry prior to transitioning that she could no longer work in after she transitioned because of transphobia. Though the social and medical transition were affirming for her, she lamented how she was no longer able to financially support herself because she was not able to work in the field that she has trained and worked in for many years prior. She expressed feeling guilty all the time related to having to rely on others for support. She wishes for more employment supports for TGD people, as she described attending job fairs for TGD people, but not finding the support she needed:

“...when all of my life I've easily supported myself, never had any problems at all. I don't know. And now coming out of my transition, there's very few - there are a couple though, there are a couple of job fairs for trans people, but they're - well, not recently because of the pandemic, but at 519 and places like that. But I mean, I've seen them - I've gone into them before the pandemic, but I wasn't really ready to look for a job at that time. But I went into them. And they were really - like, the jobs that I'm talking about here, FreshCo, you know, in the

kitchen making salad dressing for \$15 an hour, you know, cafeteria people - you know, serving jobs, there weren't any good jobs. And I think it's all about support, we just need more support."

Again and again, TGD participants described how discrimination and marginalization related to their gender identity impacted their financial wellness, housing stability, and employment opportunities from a young age. These recurrent experiences made participants feel that society was not interested or able to support them, leading to hopelessness that they could improve their lives, which worsened their mental health and eventually led to crisis. Participant 3 connected all the minority stresses described above and in previous sections, linking them to each other and describing how they intersect and interact, and led them to feeling overwhelmed, suicidal, and in crisis. They described how these interconnecting minority stresses led to a complex and overwhelming knot that felt out of their control and impossible to untangle:

"...most of the times when I've been extremely suicidal, it's like when I get to a point that I feel like things can't get better because it's just too much, like it's too overwhelming and I feel like everything is against me. And then a lot of times when I feel like that, like I'm really hard on myself. I feel like I internalize it a lot. And then I start to also hate myself. So, it's like, all of these things kind of coming together in this big pool of overwhelm. And it just becomes too much. Like, it just feels like too many things being outside of my control. And I feel like, particularly, disability affects everything. Like, being neurodivergent and having experiences of chronic illness and disability in various ways, like that majorly impacts my financial situation, because if you're on ODSP, you're basically forced to live in poverty. And then ableism in academia and in employment spaces, that also impacts my state of mind and my finances, and then housing stuff - like I feel like a lot of these oppressions, like ableism and homophobia, like they feed so much into just my stability or lack of stability in terms of, like, the housing that I've been able to access. Like, I don't have family support, I can't ask my mom for support. And everything just affects everything

else. It's hard to even know where to begin to untangle it."

4.4.2.2 *Waiting for & Navigating Care*

Numerous participants could not access the care they needed despite their increasing distress and burden of mental health symptoms. Some participants did not know how to access care or were waiting for care but experienced barriers to accessing the care they needed. While other participants were able to access some form of outpatient care in the formal mental health system, they found the care to be fragmented and at times providing the wrong diagnosis and/or treatment. Overall, participants wanted and tried to access the care they needed but were met with multiple barriers along the way.

A. *Waiting for Care*

Participant 8 described how the mental health system in Ontario is limited in the mental healthcare that is covered by provincial health coverage. They articulated how the current system makes mental healthcare so difficult to access that many people must wait until they have more severe or acute symptoms before being offered treatment and support that they can afford:

"I'd say essentially that there isn't adequate proactive help available for people such as me, who do battle depression, that a lot of help is kind of contingent on being able to get to the Emergency Department in a hospital. For instance, our province does not cover any sort of counselling or psychotherapy for people with depression, outside of, you know, if it's psychiatric care or if you're being seen in an emergency setting. So, from a patient's perspective, if the only way I can get help is by going to the Emergency Department and getting help is something that is more severe, then I'm kind of incentivized by the system to have a more severe outcome before help is made available to me."

Participant 9 echoed these challenges in being able to access mental healthcare prior to experiencing a crisis:

“I think - well, the only reason that I am currently seeing a therapist now, that I'm not able to see my last therapist, is because I am paying for it because I have health benefit coverage at my current job... the waiting list at - it's so hard to find therapists that you can just see and not pay for. I know that there is walk-in counselling and stuff like that. But it's definitely not the same as seeing the same person on a weekly basis. But yeah, accessing that is very difficult still, even.”

Participant 11 noted that while she does have access to a psychiatrist, what she could not find access to was a regular therapist, who she sees as having a different role in her care:

“Also lack of access to my therapist, because I now have to pay out of pocket and they're too expensive, and I haven't seen them since May, and I've been getting worse since then. That's a huge problem too. I can see a psychiatrist but, like, they can't - like, it's an entirely different job, and no one seems to really care about the importance that my therapist had in my life for 5 years.”

Regular therapists were described as particularly important for some participants who described having limited social supports otherwise, and who felt that a therapist understood them in a way that other providers did not. These barriers to care disproportionately impact TGD people, as the multiple minority stressors they experience often limit their financial capacity to afford therapy privately or have a private health insurance plan through their employment that could cover private therapy. As participant 8 noted, these systemic pressures lead to many TGD participants feeling that they are unable to access help until their mental health challenges become an emergency.

B. Navigating Access to Outpatient Care

Even when participants were able to access outpatient care prior to presenting for hospital-based care in the ED, they noted how the care felt fragmented. Participant 11 expressed her experience of the mental healthcare system:

"...that's why I want my therapist back, is they know me as a whole person, and are trained to see me as a whole person. And every other aspect of medical care, I think that you guys, I think the medical institution thinks that it's being efficient by highly specializing everybody. But instead, you just wind up with people who can only have one piece of the puzzle, and you get bounced around, and it takes forever to figure out if someone even understands you, or if they're even - they might not even know that they're incompetent in this area. Like, this doctor thinks he knows about autism and he's completely incompetent because he has a basic misunderstanding, which is that they're all Dustin Hoffman in Rain man, like a 30, 40-year-old misconception. Like, there's no one who - the underlying philosophy is so fucked that, like, nobody - there doesn't seem to be any chance of me being recognized as queer and autistic and provided medical care at the same time. I have to give up, usually two out of those three things. With my therapist I give up one, I don't get medical care. Frankly, I'm fine with that, because what they do is so much better. And when I receive medical care, I have to give up my autistic identity or my gender identity or both, every time..."

Participant 1 also commented on this fragmentation in the healthcare system:

"They are limited. And I think some of that is specialization. So, if they are, like the difference between a psychiatrist and a psychologist and a social worker and a - you know, they're so vast. And because of that, despite the plan to, like, make integrated health care - that's not true, you know? That's not really true. My psychiatrist doesn't really think about how my hormones interact with my mental health, because that's not what they're specialized in. You need to go to, you know, an endocrinologist for that. And that's been my experience over the last year anyway, you know? With health care in general."

Congruent with the notion that providers only understood one piece of the puzzle, participants also described how they have been misdiagnosed even when they were able to access mental healthcare. Most participants in this study had more than one psychiatric diagnosis. Participant 13 noted how they received multiple diagnoses over time, but the diagnostic label they felt was most appropriate in understanding their mental health challenges for them was the one that recognized their experience of complex trauma:

“I’ve been diagnosed with a lot of different things over the years. Yeah, which is difficult. There is a level of dissociation going on, and there’s some bipolarity in there. I’ve been diagnosed with BPD before, and different anxiety disorders. ...I also got the complex PTSD one when I was at [name of hospital]. Because I guess they use that diagnosis - diagnostic label. I feel like that actually encompasses things pretty well because it is slightly different from the BPD; it acknowledges complex trauma. It also, kind of, signals, sort of, the dissociative aspect of things. So, that one kind of resonates with me.”

As noted in the previous section, nine participants reported being neurodivergent, which they often felt was an important part of understanding their mental health challenges and what supports they needed, but many had difficulties navigating outpatient access to a diagnostic assessment. Participant 12 described how lifechanging an autism diagnosis was for her, because it helped her explain her behaviours and challenges to herself and to her parents, including her pattern of needing to go to the hospital for care:

“I tend to hyperfocus on one thing, and then keep going until I burn myself out. And I have meltdowns, and I go to hospital, feel weak after meltdown... Even though I should have stopped at that moment. And a few days in hospital, I’m feeling alright afterwards. So, that [diagnosis] explains everything, kinda.”

Even though an autism diagnosis would have helped her understand her recurrent mental health crises and potentially access support much earlier to address these concerns, no previous providers had recommended or arranged an assessment for

autism for her despite multiple previous contacts with the mental health system. She only learned about autism spectrum disorder and considered getting assessed because of social media: *“It’s funny because I watch Tik-Tok and a lot of autism videos pop up, and it sounds like me, so I got it tested, just in case. Apparently, that’s the case, with my mental health. It kinda explains a lot.”* Participant 12 noted that she was able to access an assessment for autism quite quickly because she paid privately for the assessment, but she explained that others may have difficulty accessing autism assessments because of the cost, the wait times, and *“not knowing that you may be autistic”*.

Beyond the long waitlists for OHIP-covered (i.e., covered by provincial health insurance) assessments and the prohibitive cost of private assessments for autism, which other participants mentioned as well, Participant 8 added that neurodevelopmental disorders, which include autism spectrum disorder (ASD) and ADHD, usually require collateral information from sources other than the patient to help make the diagnosis:

“I’d been trying to see if I qualify for a diagnosis of autism spectrum disorder. And there’s a whole can of worms with the way that neurodevelopmental disorders are diagnosed today. ... it relies a lot on observations of the patient’s behaviour. And because it relies so much on observations, it is very heavy on what the physician sees, thinks, and also on other third-party accounts of people who are not the patient. So, in my case, I’d been told that the only likely way I will ever get a diagnosis is if my parents or somebody who was involved in my upbringing is involved directly, which - I’m not in touch with my parents, I have no intention of, you know, establishing contact with them for various reasons. So, that makes it so that the most likely way that I could ever be diagnosed for this, ever receive a diagnosis is now inaccessible to me. But also, it just brings up, again, this trust deficit issue, of - it’s almost as if the system assumes that a patient’s own interpretation of their behaviour is going to be more flawed than another person’s interpretation of their behaviour.”

As described in the previous section, many TGD participants described developmental trauma related to their family of origin, so having to rely on those same people to be able to complete an assessment for a diagnostic condition that can provide supports and treatment that they need can cause significant distress. Giving power to others to be able to affirm their neurodivergence, which for many neurodivergent people is a part of their identity, can be reminiscent of previous trauma they had experienced, particularly related to how their experience of themselves and their gender identity were considered less valid than other people's conception of them. As participant 8 explains, this great difficulty in accessing assessments for neurodevelopmental conditions also perpetuates a "trust deficit" in care providers and the mental health system, especially as this process can recreate previous experiences of invalidation and trauma.

Of course, not receiving the appropriate diagnoses was associated with not receiving the appropriate treatments for several participants who were able to access prior mental healthcare. Participant 7 described how they were misdiagnosed with a primary psychotic disorder (schizophrenia), and they received multiple medication trials that did not adequately address the underlying causes, which were related to substance use and experiences of trauma:

"...before it was just antipsychotics and lithium and mood balancers, and then benzos. And then it was like I would be on it for two weeks and then they would change it and then add something else, and like, that I was schizophrenic, even though I wasn't schizophrenic, it was drugs. And they couldn't tell the difference between me being on drugs and my actual disorders I had."

It was not until years later that they were diagnosed with complex post-traumatic stress disorder and received treatment and support that they felt truly addressed their underlying care needs.

These experiences of multiple barriers to care, fragmentation of care, and care that did not address their needs increased distress over time and led to presenting to the hospital ED as one of few remaining pathways to try to reduce their distress and

address their mounting mental health concerns.

C. Connecting to Community Organizations

Several participants described connecting to community organizations for support prior to presenting to the hospital for their mental health. Participant 12 described how community organizations helped her complete paperwork for her legal name change, organized walking groups to help build community, and connected her with TGD community members who taught her how to do her make up. She felt that all of this improved her mental health as she received needed support that affirmed her gender and helped her feel *“a sense of belonging”*. She opined that this transition support and advocacy is more helpful earlier in someone’s gender transition, because *“a lot of people resent you in the beginning”*. However, despite how helpful community organizations were, she described significant remaining mental health challenges that were unaddressed.

Participant 6 described moving from another province to Toronto specifically to connect to community organizations for support. She was kicked out of her family home when she came out to her parents, leaving her with housing instability and limited financial resources. After she arrived in Toronto, a 2SLGBTQIA+ youth organization was *“one of the first places that I went to”* because she wanted to transition and *“I knew or suspected that I was going to be homeless”*. Through that organization, she connected to counselling, housing, case management, and other practical supports that improved her mental health significantly. However, despite these important supports, she still had significant distress and unmet mental health need. In fact, she later presented to the ED with acute suicidality when the community organizations she had been relying on for support closed over the Winter holidays.

While for many participants, connection to community resources and care was beneficial and crucial, it was also insufficient for addressing the participants’

significant mental health challenges.

4.4.2.3 Presenting to Hospital

All the participants described how they eventually ended up presenting to a hospital ED.

A. Agency & Support in Going to Hospital

Key elements that impacted their experience of the hospital visit and their subsequent mental health journeys after discharge was their sense of agency in choosing to access acute care, and the support they received in making that decision.

Participant 3 succinctly described how their first presentation to ED was involuntary, and how that led to fear of going back to the ED after discharge:

“The first time that I went to Emerg was actually not like voluntary, it was like somebody called 911 because they thought I was in danger, and then I had a really terrible Emerg experience. So, after that, I was very scared to go back.”

This was in significant contrast to a subsequent ED experience where they chose to present for acute care, encouraged and supported by their chosen family and friends:

“I think I do have a pretty strong sense of when I'm in crisis, of being able to kind of look at it from the outside and recognize that, like, I almost can't trust myself right now and I need to get help. So, that's part of it. And then another part of it has been, like, I have had people who I can reach out to. Like, my chosen family and my friends have been there for me so much, like I've had friends come with me to Emerg. I've had text conversations where, like, one of my friends was encouraging me, like yes, I think you need help right now, you're in crisis, so that's been really huge. And it's been just kind of, I think, a combination of, like, that sort of self-insight and, like, the amazing people that I have in my life.”

Participant 5 discussed how they were struggling with their mental health related to dropping out of university, feeling isolated, and residing with people who were difficult to live with at the time, resulting in them feeling stressed and stuck in their living situation. Their mental health symptoms were worsening quickly, and they expressed suicidality to friends who they were also having an interpersonal conflict with during that period, leading them to being brought to hospital involuntarily by police, which they described as a distressing experience:

“I ended up running into - there's a forest nearby, and so I ended up running into the forest and there's all of these cops coming through the woods, and they've got dogs and stuff. And one of them finds me, and they bring me out of the woods, and you know, I don't know - I know that it would have been much worse if I wasn't white, so there's that. But at the same time, it was a terrible experience.”

This experience led to their subsequent avoidance of future contact with the formal mental health system, particularly refusing to return to an acute care setting, as they described distrusting the care they would receive there and wanting to avoid the high level of distress that they had experienced.

Participant 7 also linked their experience of the hospital as unsafe to how they were brought to hospital, which often involved police apprehension. They also described experiencing racism as an Indigenous person related to these apprehensions:

“I felt like [the hospital] was a very unsafe place. Especially when the police would bring me in. Because I think most of my apprehensions were through the police, and the police would drag me in by my arms and, like, yell at me or sometimes when they apprehended me they would mock me and make fun of me, and they even took my journal one time and tore pages out of it, and they're just like, I just said, is this about her smoking meth, and then ripping pages out of it in front of me ...and bringing me in, and then just saying that, like, I'm freaking out for no reason, and they would believe police over me, and I'd try to tell them, and then getting strapped down and - like, injected with the needles...”

I think that was the most traumatizing part, was being strapped down and sedated and not even getting - like, being treated like a human, essentially, but more being treated like a problem. ...and I used to feel abandoned - like whenever I was picked up, or in the ambulance I always knew I was getting locked up, you know, I didn't feel safe, very safe at all. I didn't know if I would be assaulted by police or not, and also sometimes I would have police be racist to me before bringing me in, like accusing me of being drunk when I wasn't drunk and stuff like that."

Several participants described the experience of being brought in by police or otherwise involuntarily to hospital as impacting the rest of their hospital experience as also feeling more coercive and less helpful. Participant 7 described how their apprehensions by police led them to feeling invalidated by clinicians who seemed to side with the polices' perspectives instead of theirs. The lack of agency in being brought to hospital was also associated with feeling that the entire experience was carceral and harmful, as they felt that they were dehumanized and that they were treated as a problem to be managed rather than a human being needing care.

Participant 9 described how he had presented to the ED once, not out of his own volition, but because his employer was concerned:

"...there was one night where I just was, like, very - I wasn't doing well. ...I missed a day of work. So, I just didn't show up. ...it's a very, very unusual thing for me to do. ...And so, I went in for my shift the next day. And they were like, we have to write you up for just not showing up. And then they just got me to fill out a form, which just kind of they made seem like a thing that they were, like, this is a formality, this is just going in a file... I didn't think anyone would read it necessarily, too closely, they just needed me to sign it. And I put down, like, as the reason I didn't come in was that I was suicidal. ... I handed it back to them and went down to keep doing my shift, and they pulled me out of work and got me to talk to the manager. ...he was, like...I think you should go to the [name of hospital] ER, just to make sure you're alright and stuff, because this was yesterday that this happened. And he's like, you know, don't worry about your

shift, you'll get paid for your shift and all that, but we just want to make sure you're alright. So, that's why I ended up going."

He was discharged from the ED after the ED assessment, and did not receive follow-up care, largely related to him not being interested in engaging with care at the time. This is an example of a different type of lack of agency in presenting to the ED, without police involvement, but how this still led to the acute care experience to be perceived as not useful. He did not present to the ED with a care or treatment goal in mind outside of being able to return to work afterwards.

In contrast, participant 12 described how she was experiencing a crisis and wanted to go to the hospital, but felt that she was lost and unable to find her way to the hospital, so she contacted the police to bring her to the hospital:

"I decided to go to hospital, but I took the wrong bus and got lost in the city. And I just got off the bus and told the driver to call the police to pick me up, because I am not able to go to the hospital at that point."

This is an example of how police involvement was experienced as helpful because she had agency in choosing to contact them for support. She subsequently described that hospitalization experience as useful for her.

B. Acute Hospital Experiences

Once participants were at the hospital ED, they described further experiences that impacted their perception of whether that hospital visit was safe and useful, which determined how they engaged with or did not engage with the mental health system after discharge. Participant 2 described presenting to the ED in the context of having self-harmed, seeking help and support, but she felt dehumanized in the ED:

"I sat there for...maybe an hour? But it felt a lot longer. And I was still very much in the throes of my episode. So, I was occasionally [actively self-harming]. The door to the room was always open, and it had a direct line from me to the security desk. And the security personnel and the nurses were all just gathered

around there, chatting and laughing. And they just sort of seemed to, like, not register me at all. And so, I went on self-harming there for about that 45 minutes, on and off. ... And like, in full view of the nurses. ...And no one ever came over to try and stop me, or check in, or see if I needed to be restrained or even just be talked to.”

She reported later being discharged from the ED without any further follow-up care offered. She did not find the setting helpful or safe, and it directly led her to avoiding the ED in the future even when she was experiencing acute mental health distress: “...my then-boyfriend, now best friend would always be, like, do you want to go to Emerg? And I’m like, God! You know I don’t want to go to Emerg! Like, this is bad. This really sucks, you know I don’t want to go to Emerg! [laughing]” While this experience would likely have been distressing for many people, including many cisgender people, the TGD participants in this study repeatedly described how these dehumanizing and invalidating experiences reinforce beliefs they already had that they cannot trust systems and society to care for them or support them, which comes from their lived experiences of developmental trauma, societal transphobia, and social marginalization throughout their lives.

Multiple participants described how the ED and inpatient settings took away their agency and autonomy, and did not consider how to be inclusive of their care needs. Some providers also did not seem to have the competency to provide affirming care for TGD people, and some providers were experienced as outright transphobic. Participant 5 described one of their ED experiences: “...one of the doctors, when I was in the Emergency area was, like, so you think you’re a girl? And I was like, okay, I don’t want to talk to you.” They later requested their chart notes for an ODSP application and they discovered that that the physicians had used the wrong pronouns for them throughout the notes, placed them in a men’s inpatient unit despite their request to be in a women’s unit, and documented that “*the patient believes he is a girl*”. This experience made them feel unable to trust clinicians, particularly in the hospital setting, because they have valid fear that “*I have to deal with, like, you know, doctors potentially discriminating against me because I’m transgender and doing - like, actively doing things that will make my mental health worse.*”

Participant 5 also described how the inpatient unit had other policies that took away agency and worsened their mental health. They discussed how *“I can't dress in a way that doesn't make me feel like shit about myself”*, which they explained further:

“...when I was in the psych ward, I don't know if this has changed, but I had to wear, you know, just the same hospital scrubs that everyone else was wearing. ...And I don't really know how to put it. It's like I can't express my personality through my clothing. I don't get to choose what I want to wear. I have to wear a hospital gown because I'm in the psych ward, because I just tried to kill myself, and it's like, my individuality is being taken away. And also, it's a constant reminder of wearing a gown and why I'm there.”

They later added that hospital gowns induced gender dysphoria for them as well. Participant 3 also described how having to wear hospital gowns made them uncomfortable because gowns remind them of dresses, and *“I had kind of a moment of panic where I was like, ugh, am I going to have to wear this thing that reminds me of being forced into dresses as a child?”* They also explained how policies that prevented access to tools for self-expression – such as razors, scissors, and hair dye – on the inpatient unit affected their mental health. They described how self-expression is particularly important for TGD people, especially around being able to present themselves in a way that is affirming of their gender:

“...there are certain things that are important to me about maintaining my physical appearance as a trans person. Like, for me, my hair - like, being able to be short is important to me. ...like the one admission...I was already thinking about how my hair was gonna grow out and how that was going to feel shitty. My nails were starting to grow long. It's just - they're things that are important to me for, like, gender, body reasons. And I think that's true for a lot of people. And I get that there are safety issues... But there should be opportunities for us to be able to access those things in a safe way because if you're forcing someone into a position where they're now experiencing body dysphoria on top of everything else, it's not going to make it easier for them to get better. ...I know this might sound really silly to some people but, like, even hair dye. My hair is

blue or green most of the time. It's important to me as a queer person! Like, I get that there are people that would think that this is ridiculous, but to me, like, being able to feel good in my body is - it's not something that I always feel, you know? Like, just naturally. And like, being able to do things that give me gender euphoria is important to me ...it's actually legitimately very important to my identity. So, yeah, I think there need to be considerations for that."

Several participants also described how the policy of not being able to contact friends and only being able to contact biological family members while hospitalized was experienced as particularly harmful. Multiple participants discussed how their biological family members were often invalidating of their gender identity and contributed to their experiences of trauma, so policies that required or prioritized contact with biological family members can be distressing. TGD participants also described the concept of chosen family, which is important to many TGD and queer people, but hospital policies often do not prioritize or even allow contact with chosen family for clinical care or social support purposes while admitted. Participant 5 noted how they felt further isolated in the inpatient setting related to such a policy:

"And once again, it's like I feel super isolated when I'm in a psych ward and I know that the rationale for that is, like, oh, well if you go online, then you'll see something that will make you upset or something like that. Or like, you know, you can't talk to your friends because what if there's - what if it's your friends that are making you feel upset? Or at least I don't know if those are the rationales at every hospital but those were the rationales given to me. I basically just keep to myself whenever I'm in there and I don't have contact with anyone on the outside except for my family who, like, my relationship with them is better now, but back then, it's like the only people I can talk to are the people in my life that are actively hurting me on a daily basis."

Several participants also discussed having to advocate for themselves and others around gender-affirming care in the hospital. Participant 1 described how they often overheard nurses use the wrong pronouns for them despite informing them

repeatedly of their pronouns. For them, this misgendering was in the larger context of feeling that some hospital staff were not reading their charts or providing quality care for them overall. They noted multiple institutional policies that could be improved around gender-affirming care, such as the hospital wristband indicating someone's gender identity rather than their sex, and encouraging patients to write their pronouns on their hospital room door.

Participant 3 suggested to the inpatient unit staff that clients in group therapy sessions on the unit could have the option of introducing their pronouns with their name, but they described receiving “significant pushback” from the hospital staff against this suggestion. They also met with the inpatient unit manager to discuss improving gender-affirming care on the unit, but they did not feel that the manager was receptive to their concerns:

“...she got really defensive with me. Like, when I - I had my points, I was like, these are some things I think that need to change, and she was like, well, the staff do do training on queer issues, and got really defensive. And I was like, do you really think this is good allyship right now? Because this is not. And that was another experience that really made me think about - like, the staff can't just have training on queer identity. It needs to be training also on, like, anti-oppression more generally, and allyship, and how to listen to marginalized people. Like, it needs to explicitly talk about intersectionality, intersections of queerness and disability, queerness and race. Like, because it's really clear that whatever training they had was very basic and didn't actually talk about how to enact anti-oppression, or strive towards anti-oppression, or how to listen, or like be a good ally. So, there's a lot of defensiveness. And that just really sucked.”

Participant 13 also described some challenges during their psychiatric hospitalizations. They reported that clinicians “asked a lot of questions about trans stuff” that were not necessarily relevant to their care. They also described an experience of not being prescribed a medication that was gender-affirming for them even though they were prescribed and taking this medication at home:

"I'm on a medication, finasteride and it, like, prevents hair loss and it's used as an adjunct for testosterone therapy. In the community a lot of people believe it also softens some of the effects of testosterone, so your hair might come in softer or stuff like that. And so, for me, that's a medication that is, like, gender affirming and important to me. And they decided that it wasn't important. And didn't prescribe it. And so, during my stay, I wasn't able to get that medication. And it's not like it's a rare medication, like they could have easily got it within, like, a day, you know? ...it just kind of showed me that the inconvenience of, like, providing care that's important to me, like, outweighed what would feel good to me. And there just wasn't an effort to understand why it mattered to me."

Participant 4 was recurrently hospitalized involuntarily from a young age, and they explained how a lack of agency was pervasive in their life, and how these multiple involuntary hospitalizations in "the incarceration model-based psychiatric system" perpetuated this harmful lack of agency for them:

"I feel like a recurrent theme in my life is lack of agency for myself. And I feel like...you have no agency in a psych ward... you don't get to keep any of your own stuff. Sometimes, if you're good, they'll let you have your clothes back. But even then, they don't give you a change of clothes at all. They're just like, oh, well, if nobody comes to visit you, then you're just gonna have to stink in the same underwear for the next however long. Like, they don't let you do laundry. I'm like, I could totally do my own laundry. ... They're like, no, you're not allowed to use the machines. ...I try to offer things for me to do that I know will make me feel better, and they're like, no, you're not allowed to do that. ...I'm like, well, can one of the security guys come on a walk with me outside because I wanna get some fresh air? There's no open windows, obviously, in the wards. ...They're just like, no, you can't do that. And I'm like, getting green space was one of the first things they recommend in mental health... I'm a prisoner here. They're like, no! You're not a prisoner. You have an illness, which is why you must be contained. ...And I'm like, so I'm not allowed to help myself? And they're just like, no, no. You are, but you need to help yourself in the way that

we let you help yourself, right? So, I just don't think the system is set up to help people help themselves."

Participant 15 described feeling unsafe in the ED when she saw the security guards who escorted her into another room, which may have perpetuated the feeling of a carceral system that other participants described in the acute care setting as well:

"...they reminded me of the, you know, the mental - the crazy house orderlies gone bad, you know? ...they pat your body down for weapons, I guess? You know, make sure that you're not going to kill people, I guess. But the way that they come in the room...it's like, oh my god, it's these two big guys, eh? They don't tell you... I went to the lady, nice lady, treats me very nice, transgender female pronouns and everything... And then these two big guys come in, she didn't say, oh there's going to be two big guys coming in to pat you down. ...I had to go with them, like they escort me down this thing and into another room. What happens when you get to the other room? ...That freaked me right out. I won't go back there. ...I don't see what it's going to do for me, they're going to put me on the same drugs that my doctor has me on already, right? They didn't talk to me; I didn't get a session with a doctor."

Her experience highlights how the perceived safety and usefulness of acute care both impact whether a participant decides to return to that setting for care in the future.

Participant 8 contrasted emergency care for mental health to that for physical health. They described that procedures can be helpful in an emergency setting for physical health issues such as a broken bone or an abscess, but they did not believe that such a quick fix for their urgent mental health concerns exist. They found that their acute mental health presentation simply worsened their situation:

"I was, like, right back to where I was before being in the hospital, except now I had the added trauma of that hospital visit with the wait time, and all the intrusive questioning, and having to air your dirty laundry in front of a bunch of health care professionals who you don't know, and that I've never met

before. Like, all of these things are traumatic, and I understand that, you know, sometimes you, sort of, need to, you know, deepen the wound before you can debride it, before you can clean it. And so, a certain amount of trauma might be beneficial in the long run. But it certainly doesn't seem like that was the case, or it could be the case in a mental health situation. Like, you know, the best that they could possibly do in that situation is just keep me in the hospital longer, give me more sedatives, that sort of thing, none of that would be helpful either. And even they know it."

Participant 11 shared her experience in the ED, where she was going to be taken to a secure waiting area that felt unsafe to her, so she advocated for herself and took back agency and autonomy in deciding how to access the care that she needed:

"...after my initial assessment, they were gonna send me into, like, whatever that back area of Emerg is... it's so carceral the way they have it set up, it's like they have this nice, friendly Emerg waiting room, and then this huge locking door that says, like, high AWOL risk on it. And I'm like, okay, so that's the next step for me, if I'm too honest with you guys, that's where I get sent. ...I'm sitting right beside [the locking door] the whole time, trying not to panic when I'm already experiencing mental distress. And so, yeah, she said, we're going to take you back there, and I was like, no... they're not enforcing masks back there... they weren't confronting those people because they're fucking scary, and because they could hurt a small trans person like me, and they wanted to take my backpack and my shit and my weed, and I'm like no... And so, I basically started getting cagey with them... I started shouting that I would rather leave than do that, and then they were like, okay, fine, you can wait out here."

She was offered treatment and follow-up care, and discharged from the ED. She described subsequently choosing to engage further in outpatient mental healthcare after this experience, which supports the importance of agency in accessing acute care that many of the participants articulated.

Though multiple participants described the hospital experience as difficult and distressing at times, some of the participants described the hospital experience as beneficial. Several participants described feeling the benefit of being able to take a break in hospital, receive support, and not be exposed to the life stressors they were experiencing outside of the hospital for a little while. As participant 6 described, the hospital “...wasn't overly stressful. ...There was food. There wasn't much to do. But it was kind of, life was on pause.”

Participant 1 described knowing that there were still life stressors outside of the hospital, but they appreciated the break in hospital:

“Well, I have to say that all of the problems that I went into the hospital with are the same problems that I left with. And there was a huge part of me that would have preferred to stay in hospital. It's like, three square meals a day, a ton of people who were a ton of fun, laughing at dark humour, and being able to help other people. And having my own space, that was put together for me, and really regimented timelines, like all of my meds were free. Like, why would I want to leave when all of my problems are on the outside?”

Participants described different factors that contributed to their sense of whether the hospital visit was safe and useful. Many participants described feeling less safe in the hospital related to policies and experiences that were not gender-affirming, and experiences that took away agency and were experienced as carceral. Many participants also felt that the hospital visit was not particularly useful for them, with several people expressing the limits of short-term acute care on improving mental health conditions long-term. Nonetheless, some participants did find the hospital visit useful, especially when they had a greater sense of agency and control in how their care was provided. Several participants also found the hospital visit useful for taking a break from life stressors even though they knew the break was temporary. Most participants were offered outpatient follow-up care after discharge, but whether they engaged in this care depended on their experiences both in hospital and preceding it.

4.4.2.4 Post-Discharge Journeys

Participants described experiences before, leading up to, and during the hospital visits impacting their mental health journeys after discharge. The three post-discharge pathways that participants described were: 1) choosing to engage in post-discharge outpatient care in the formal mental healthcare system, 2) preferring care in community organizations, and 3) avoiding the mental health system altogether. It is important to note that these were not mutually exclusive pathways, but rather three distinct narratives that emerged from participant experiences. Some participants did largely describe adhering to one of these pathways as reflective of their mental health journeys, while others described one of these pathways being predominant or choosing a different pathway after a subsequent hospital visit that was felt to be safer and more useful.

A. Engaging in Post-Discharge Outpatient Care in the Biomedical System

Several participants described that the acute hospital presentation was helpful for them for a variety of reasons, including some receiving a diagnosis that was validating and some being connected to helpful post-discharge follow-up care in the formal mental healthcare system.

Participant 14 described how during a hospital visit, a psychiatrist diagnosed him with borderline personality disorder (BPD), and was supportive and direct in explaining the diagnosis and treatment recommendations. This led him to realizing what he has been struggling with and it led him to connect to treatment that was ultimately quite helpful for him:

“She said, I can tell that you're really smart, and basically, like, in more professional way, you need to get your shit together. [laughing] So, I think it was just helpful - like, she basically was, like, yeah, BPD is what you're struggling with. And once I was able to, like, look up the information and relate it to, sort of, my behaviour, and then have the tools to sort of work on that, my life started changing, it was really cool.”

Several participants described how presenting to the hospital led to quicker access to outpatient mental healthcare after discharge, which led to treatment changes and connection to further resources that were helpful. Participant 2 described how she was connected to an urgent psychiatric care clinic soon after discharge, which helped her adjust her psychiatric medications. She was given agency and several options in managing her medications. She discussed how these medication changes combined with progressing along her transition journey improved her mental health synergistically:

“I made it through the next few days. I started back on my sertraline, and going back on it wasn't super fun, side effect-wise. But at least it felt like it was in service of something now. ...the outpatient clinic, they - oh, what they suggested was, I'd been taking my sertraline at night because that was when I could most easily remember to take a medication. ...Switching to the morning made a big difference. Immediately my sleep started getting better, and I had more energy through the day. And that was from the suggestion of the outpatient clinic of, like, try this, see then if you want to adjust the medications, there's a couple others here, here's what we recommend trying out now in place of - here's the list of replacements for the sertraline. Here's the list of replacements for the Wellbutrin. We can wean you off the sertraline if you want, but try it at this new time and see how it goes for you. And immediately that was a pretty big fix. Between that and just, like, the transition evolution that, like, it was taking less energy to present female now. I was having to do less work in voice training, which would put me in a bad headspace. It all just started to chill out.”

Participant 10 also described being connected to an urgent mental healthcare clinic after discharge from the hospital. They were prescribed a medication from the ED, and provided post-discharge follow-up through an outpatient urgent care clinic that followed them and adjusted their medications. They described finding the medications helpful:

“I'm on sertraline and Abilify. The sertraline helps me with my depression and my Abilify helps me with, like, being more emotionally stable and less

emotionally reactive and less - like, you know, I can regulate my emotions better because I'm a very emotional person, I get overwhelmed. ...I feel like without my medication I'd be a total mess."

The urgent care clinic also referred them for an autism assessment, which they requested. They were initially hesitant to involve their parents in the assessment, but since the assessment required an informant, they did eventually ask their mom to participate. They were ultimately diagnosed with autism spectrum disorder (ASD), which they described as very affirming and helpful for them.

Participant 11 was also discharged from the ED to an outpatient urgent care clinic, which she found helpful: *"...the [urgent care clinic] has helped with medication, which has been great. And helped me - everything positive has come from the [urgent care clinic], just medication support and setting me up with Ontario Works has been more important than anything else..."* However, she also described some challenges with the urgent care clinic, including multiple medication trials that were largely unhelpful and/or caused intolerable side effects, and not receiving a diagnosis that resonated with her symptoms and challenges until later visits at the clinic. She felt that the misdiagnosis was also related to being misgendered at the clinic, and related to the diagnosis of borderline personality disorder (BPD) being a gendered diagnosis:

"I wasn't diagnosed borderline personality disorder - they gave me Complex PTSD which apparently is not even a diagnosis. ...it wasn't until I started asking for women doctors only at [name of hospital] that as soon as the first female psychiatrist came in, she looked at my chart and said, have you ever heard of borderline personality disorder? And I was like, yes, I know that I have it, I googled the 9 top symptoms of it every few weeks and go, I have this, why don't I have a diagnosis? And I ask and no one will give it to me. And she was like, yeah, no, you have it. Again, she did say something about men can have it, too, and I'm like, no, I'm not a man though, like that's a big part of this, is that they keep mistaking me for a man, and then not diagnosing BPD because it's a gendered diagnosis. ...if I was a cis woman, I would have got BPD 5 or 10 years

ago, in undergrad probably. But instead, I kept getting social anxiety and everything, and then I got autism, which is valid, but does not tell the whole story. And nobody wanted to give me BPD until I saw a female doctor and explained my gender, and then she recommended me for the DBT support group.”

While the participants each described different coping skills and treatments that helped them improve their mental health, four participants specifically named dialectical behavioural therapy (DBT) as being particularly helpful and lifechanging for them in improving their mental health. They connected to this outpatient treatment through their acute care presentations. The participants described how clinicians in the acute care setting explained DBT to them and helped them connect to DBT resources after discharge.

Participant 7 described experiencing a complex and severe prolonged traumatic experience, which led to a mental health crisis and presenting to the ED. They were diagnosed with borderline personality disorder (BPD) and complex post-traumatic stress disorder (CPTSD). They described how this ED visit was a much better experience than previous ED visits, because they were there voluntarily and there was no police involvement in their mental health crisis. In the ED, the clinician validated their experiences and helped facilitate connection to an outpatient DBT program:

“And then I explained all of that to them, and the guy at the Emergency, he’s like, mmm, you sound like you’re having a normal reaction to the level of abuse you were experiencing. Like, I don’t think being an inpatient would be helpful and he said that I don’t think you need drugs. And then he gave me the little thing for the DBT program for BPD specifically. ...I would say the DBT is, like, really what changed my life.”

Participant 3 reflected on how them being an inpatient was helpful in facilitating access to DBT after discharge, and how impactful the DBT program has been for them:

“I think the biggest thing for me was, like, being able to get into the outpatient program that, like, it was the intensive DBT program, I actually just finished it in June. And that made a big difference for me. Like, I found it super helpful. It was like trauma and DBT therapy, combined. And it was through the [outpatient] clinic. And it really helped me, and I know that I got into that program a lot faster because I was inpatient, like kind of twice in a row, like I was inpatient in January-February and then April-May. And so, I got in a little bit more quickly. And that program helped me a lot. Like there are things that I would change and tweak about it, but it definitely helped, and DBT has been hugely helpful for me.”

Participant 14 described some of the ways that DBT has helped him continue to manage his daily mental health challenges:

“Just being able to learn how to express myself without attacking somebody else. Learning how to be assertive without having all the emotional intensity behind it. That was really helpful. And I liked it because it aligned more with how I saw myself... I was actually being the person that I saw myself as. Like, a person that’s able to calmly speak to people when I’m mad, or like, get my point across without being, like, malicious.”

Through his ED visit, participant 14 was connected to an 8-month long mental health treatment program through the hospital that he found quite helpful. He found the structure, connecting with peers, and his individual counsellor through the outpatient mental health program particularly helpful. He also commented on the length of the program being an important aspect of why the treatment was effective for him, as *“I found before when the programs were too short, it was helpful but then I’d have to re-enroll myself, so too much time would pass. And I think just the consistency and the length really helped.”* DBT programs are usually multiple months in length and quite structured, and both of those elements were described as important for other participants as well in explaining why the treatment was particularly effective in improving their mental health long-term.

Participant 15 described how the structure, self-care, and other skills from DBT have helped her manage her substance use challenges:

“I’ve got the [DBT] diary card, and I come back, like right away. Where it used to be, when I was doing my - anything, alcohol, or anything, it would take me weeks and weeks to come back. And now, it’s like if I do fall off the wagon or anything, I just, like, wake up and boom, I’m back on my schedule, I know exactly what I have to do. You know, I eat properly - I used to be, like - I’d just go off the tracks all over the place. It’s like I would lose everything. So, I’d be eating terribly, spending terribly, just all of these other things would come with it. DBT has helped. Plus, I meditate now. ...And when I last talked to [name of outpatient addictions clinic physician] he said I’d done a lot of good over the last couple of years, he said, you’ve gone a long way from, you know, from trying to kill myself to, you know, being transitioned and I don’t know, he made me look at it like I was actually doing something about it.”

Participant 15 was also connected to an outpatient addictions clinic through acute care, through which she was connected to a case manager, stable housing at a group home, medication management, and a free smoking cessation program; all of which she found quite beneficial.

Participant 3 reflected on how DBT skills even helped them validate and balance their perspectives and expectations of the mental health system broadly. They described experiencing both traumatic and helpful experiences in the mental health system, and how DBT provided some skills that helped them hold both of those types of experiences as valid and true at the same time, such that they feel comfortable still presenting to the ED if needed in the future, despite having had traumatic experiences in the acute care setting:

“I think that I’ve kind of come to a place of more acceptance in a way, about what the system is and what it is not because, like, my experiences in the system have ranged from really traumatic to really helpful. And everything in between. I think DBT has helped with this a little bit, that I’m able to, like, accept both of

those things as true. And to not accept in the way of, like, I don't think the system needs to change, because I do think it does in many ways. But like, kind of accept that, like, this is the way that it is right now, and all of my experiences have been valid and if I need to access the system for whatever reason, if I need to go to Emerg for safety, I'm still gonna prioritize my safety over everything else. So, yeah, I feel like the more experience I have with the system, the more trauma I have and the more good experiences I have because both of those things always manage to happen. So, it's just kind of - yeah, that's just where I'm at with it."

B. Preferring Community Care

Contrary to experiences in the biomedical system, participants described care in community organizations as being integrated and holistic, centering agency, and connecting them to peers with lived experience for support. Participant 4 experienced multiple involuntary hospitalizations and found the formal mental health system carceral. They much preferred care through community organizations, which prioritized their agency, depathologized mental healthcare, and connected them to peers with shared lived experience. Participants described appreciating peers with dual lived experience of being 2SLGBTQIA+ and having had mental health challenges. All of this was described as significant improvements over the biomedical system by participant 4:

"[Name of community organization] has been pretty great. ...basically, they have a lot of these sort of outpatient - not really outpatient, it's not medicalized at all - they have these community programs...like ...cooking class... yoga... a fitness class. ...it's very relaxed, it's like a community centre almost, but for people who have experienced... mental illness and related marginalizing - mostly medical experiences. ...it's not specifically for people with mental illness, you don't need a diagnosis... Like, they also offer case management. ... They have groups, like 8-week or 12-week DBT, CBT groups. ...they have this drop-in that's for queer-identified folks specifically that I used to go to all the time...and it would be a bunch of queer folks of all ages, just coming together - well, they

usually have a set topic or activity... I feel like stuff like that, that is very much community focused or centered on... the individual being respected. And all the people who run the groups are typically peer support workers. So, they know what it's like. So, when you talk about, say, getting tased by the police, at least one of them will have that experience as well. So, like they definitely know what it means to live, you know, as a marginalized individual. And yeah, so I just think that...model...would be more helpful."

Participant 13 also described the value of peer workers with lived experience of being in the mental health system: *"I really value the experiences of other people that have, you know, gone through mental health journeys and navigated these systems. There's a bit of camaraderie in that."*

Participant 14 clarified why having many queer and nonbinary workers at a substance use support program for 2SLGBTQIA+ youth in the community made a big difference for him. He described the experience of peers providing services as better understanding his lived experience and minimizing a power differential that is often prevalent in the traditional biomedical system:

"I think also a lot of their workers are queer and non-binary. And they really, like, enforce it - that was helpful for me. Just like anything queer oriented I find so helpful because the people are just different. ...Like, a lot more patient. A lot more patient, willing to empathize and, like, put themselves in the other person's shoes. ... And just I find that people act more like themselves - like, they joke around more, and I find that in an environment that's more heteronormative, everything is more professional. Yeah. Professional. People don't joke around as much, I think, out of fear of being called unprofessional, and I found that in queer spaces, people are just, like, yeah, I don't know. I had a weird experience and then blah blah blah. ... and then they'll just talk to each other like they're peers."

Many participants in the study also highlighted the importance of TGD community organizations in supporting TGD people in navigating their gender transition.

Participant 12 discussed how community organization staff helped her change her legal name to her chosen name as part of her transition. She also discussed how community members she connected to through a community organization taught her how to do her make up and gave her a sense of belonging. She remarked that, *“Especially at the beginning of somebody's gender journey, it could be harder to find the sense of community and belonging.”*

Participant 9 described how being with other TGD community members he connected with through a community organization allowed him to relax and not constantly fear being judged by others:

“...it's being able to go into a space and, you know, participate in even their hobby or activity groups without having all of these things that if you were to do that anywhere else, there'd be worries that you're constantly thinking about in the back of your mind. ...there was a trans group at [2SLGBTQIA+ community centre] before, that they would just meet up and play sports with. And I think that's great because whenever I did sports at summer camp or whatever, you're so self-conscious about the way your chest moves, right? Like, when you run, so that's a big source of anxiety and being around other trans people alleviates that a lot. The support groups that they have as well...I went to their FTM support group... was helpful because you'd meet up, you'd talk to other trans guys about issues, they would share resources that they have or stuff like that. And then afterwards, they would usually all go and, you know, grab a bite at a coffee shop or something. And there would be, like, you know, social interaction and friendships being built outside of the community centre. I participated with [a 2SLGBTQIA+ choir], as a trans person, like voice is a big thing. So, being in a queer supportive singing group is huge. I also went to...a bottom surgery support group, which I learned a lot through, because they had people go that had already gotten their bottom surgery as well, so they were, like, here are things that you don't think about... It's just building a community, which I think is great to be a part of.”

Participants described how community health organizations geared towards 2SLGBTQIA+ individuals often offer free or low-cost holistic care that is superior in multiple ways over the traditional healthcare system, but there is less government and other funding going to support this care. Participant 11 described her frustration with the system:

“There's other places that aren't run by the government - my tax paying dollars don't go to these community organizations that treat me well. ... [2SLGBTQIA+ community health organization] is offering monkeypox vaccinations, and now they're also offering physiotherapy and acupuncture and stuff - like, again, a lot of queer people hold their trauma in their body, like I have a very bad erector muscles in my neck and stuff and bad posture from crumpling up, like I'm being attacked all the time, and offering just the same thing that middle class people get from their insurance plans, from their bullshit jobs, like we should have access to that as much as anyone else, that kind of stuff is supplied on the fringes by places that barely have enough money to do it, and where people work, you know, as volunteers sometimes. But those are the most effective places, I think, if you ask around.”

She described how TGD people often experience chronic minority stress that leads to greater physical and mental healthcare needs, but the same minority stress also frequently prevents TGD people from having private health coverage such as through employment to afford the care they need. These community organizations fill the gaps in the care system for many TGD people, but are considered outside of the mainstream or traditional healthcare system in terms of funding and resources, which is reminiscent of the marginalization by mainstream society that many TGD participants described experiencing as individuals.

Multiple participants described how community organizations addressed social determinants of health, such as housing, employment, and financial and practical supports; which were important needs believed to be underlying much of their mental health challenges. These important factors were often not addressed adequately by formal mental healthcare. Participant 6 had experienced suicidality

and a mental health crisis related to community organizations closing over the Winter holiday season, as they were providing her with food and practical supports such that she was starving when they were not available over the holidays. She described these community organizations as “major supports” in her life, connecting her to a case worker and the housing program she was living with at the time of the interview. The case worker there was also helpful for practical and financial supports: *“they had been helpful in getting me to go to the food bank, for instance. Or helping me figure out my finances, some life planning stuff. Kind of helping be a support to me reconnecting, say, with a dentist, et cetera.”*

Participant 14 also described how a community organization for 2SLGBTQIA+ youth was helpful as they offered case management, housing supports, and practical supports such as helping apply for ODSP for increased financial support, and providing grocery nights for those who need groceries. Participant 14 described how addressing basic needs facilitates access to greater mental and overall wellness:

“I think that getting your basic needs met is the foundation of most people's issues. So, that sort of helps people get their needs met, and then they can focus on what else they need to do. ...the reason I couldn't even focus on school or my career or my interests is because I was, like, emotionally distraught... everything that we need, like sleep, food, social connection, that all contributes to our ability to have quality of life. So, if any one of those are lacking drastically, I think it's just really difficult to even think outside of the perspective. Because maybe someone's stuck in pessimistic thoughts, but it's really hard to not think that when they're constantly starving.”

Many participants described connection to TGD community as being considered essential and central in their mental health journeys. Participant 1 experienced significant challenges connecting to post-discharge outpatient mental healthcare in the biomedical system. They described how and why they preferred turning to their community instead for support:

"I had a pretty good realization recently, and it was post-hospitalization, which is this idea that I've been, like, waiting my entire life for someone to swing in and save me, you know? To love me unconditionally and save me. And unfortunately, it is not a romantic or sexual partner. It's never gonna be them. But it is these communities, you know? From the moment I walked into an AA meeting, they loved me unconditionally, and then they saved me. From the moment that I found, you know, more queer spaces with other non-binary people, when I identify as non-binary, there's no - nobody bats an eye. They're just like, of course! You're one of us! Come on in! And so, they love me unconditionally. And given the chance, they want to save me too, right? It's that reminder that I do have these spaces and communities, the people that visited me, the people that dropped off snacks, the people who did those things, are parts of these circles of community that I have around me."

Participants in this study also described how in the context of their recurrent traumatic and invalidating life experiences by people who did not understand them, connecting to TGD and queer community allowed them to feel safe, seen, and valued; which has made the biggest impact on improving their mental health. As participant 3 explained:

"...mostly just my relationships, like they're everything to me. Like, my friends and my community, my chosen family, are everything to me. And being able to, like, grow through difficult things with those people has been, like, I feel like, has just made me a lot kinder to myself, which really reduces my suicidal thoughts. That's been the biggest thing for me, like feeling like I'm loved as I am. And like, loved and accepted, and like I'm not bad or broken or disposable or any of the other things that I've been made to feel at various times. Like, that's just been the thing that's ultimately saved my life. So, yeah, community is everything."

C. Avoiding the System

Several participants described how their hospital experience was so negative for them that they actively avoided the possibility of returning to hospital. Participant 5 explained how they would minimize their distress and suicidality even when talking with a therapist, for fear of being brought back to hospital, reflecting the broken trust with the mental health system and the critical importance of having agency in how care was accessed:

"I generally don't really seek help if I'm in crisis. ...the reason I don't seek help is because of that experience [of hospitalization]. I feel very scared that if I go to another psych ward, I'm going to have the same experience where I'm being misgendered and disrespected... Put in gender separated lodging with someone that I'm not comfortable sharing a space with, based on gender and my own fears and traumas. Simply because, you know, the staff has decided based on my sex assignment and/or the way I look that that's where I should be, regardless of what I say. I also feel like I have no privacy when I'm in a psych ward, and so that really weighs on me. ...If I'm talking to a therapist, I always - like, even if I'm an active risk I say, nope, I'm good. I'm fine. Or like, oh, the thoughts are just passive, or the classic, I don't have a plan when I do have a plan, because I don't want to experience that again, because if I experience that again at a psych ward, as soon as I get out, I'm going to kill myself. ...Because, you know, it's somewhere that I'm forcibly being brought to for my help...and, like, fundamental aspects of my being are being disrespected on a daily basis. That's enough to...you know, make anyone question their faith in society. And other people."

Their hospital experience was so traumatizing for them that they described not only questioning the helpfulness and safety of the mental health system, but it led to a questioning of even their faith in society broadly. Participant 4 explained how a lack of agency has been a pervasive experience in their life, and this was re-experienced repeatedly in the acute hospital setting, which is why they actively avoided returning to the hospital. They added that the hospital visits have also been of no

significant benefit for them, not addressing root causes or systemic issues leading to their mental health concerns, which is consistent with how assessments of the usefulness of the hospital experience impacted the subsequent engagement with the system with other participants as well:

"...the first thing that I feel when I get discharged is an overwhelming sense of relief that I'm not going to have cameras on me like 25/8. ...I don't think psychiatric hospitalization is, as it currently stands... the answer to much more complex issues... complex systematic issues... I think you need to understand that psychiatry - like, it's because the people, the policy makers are never the ones who have the experiences. ...and those that have the lived experience will never become the policy maker... I definitely do not feel that hospitalization is conducive to - it's kind of like, oh great, another trauma to add to the compartmentalization bin, kind of thing. Like, I really don't need all this unnecessary, extra, trying to, like, force meds or IV into you and, you know, solitary confinement, like this and that, I really don't need you to strip away all of - you know they strip search you too, sometimes? ...if I have another crisis, I wish I could have a medical bracelet saying...do not call 911..."

Participant 13 experienced their gender-affirming medication withheld from them while they were hospitalized. At discharge, they also described how their inpatient care team did not help them switch their testosterone from an injection to a transdermal formulation, which they felt may have improved their mental health as well, despite their request to their care team. These experiences led them to fearing that in future they would have to choose between gender-affirming care and mental healthcare, and it influenced them away from seeking mental healthcare:

"I guess there's an element of fear that my mental health stuff will be a reason to gatekeep things like surgery for me when, in fact, surgery is a thing that would, you know, make my life a whole lot better, and I'd feel a lot better, generally - I'd feel more comfortable in my own skin and feel safer to be embodied and I don't think a lot of doctors really get that. Like, I definitely think that you need to be able to have basic self-care to be able to recover from

surgery and stuff like that. But besides that, it's like, it's lifesaving surgery. I don't know. So, yeah...I guess I have a bit of fear about, like, I don't know, seeking help when the fact of me seeking help might be a reason to withhold it from me."

Participant 8 echoed the sentiment that their acute care experience taught them that there is not much the current mental health system can do to support them and provide care in the way that they need. They described turning to peers for advice to navigate what works for their health because many in the community have found that traditional medical models are not working for them. They have instead had to rely on their own research and on recommendations from peers who are not healthcare professionals:

"When the system doesn't work, then you have to find what does work... over the top research that I had to do in areas that a lay person should never have to do any research, and a lot of my peers have done the same thing in their own capacity. And so, we've kind of built an informal knowledge sharing system... So, you know, why do we even bother with science and with evidence then, if it doesn't work for people like me?"

They summarized the following lesson they learned from their mental health journey:

"I've learned to not rely on the system much. It's not going to be there for me when I need it. ...It sounds tough, but I'm not saying it from a standpoint of, like, a defeatist attitude or being, you know, woe is me. I'm saying it very factually, like it's fine, you know, I've learned my lesson now. And the lesson is don't trust the doctors. Don't trust the system."

Importantly, those who avoided the system and/or opted for care through community organizations without care through the traditional mental health system after hospital discharge described significant residual mental health symptoms and challenges that they wanted to improve. However, the need for more mental health care and supports was outweighed by fatigue in trying to navigate the system, and

distrust that the formal mental health system can actually address their needs.

4.4.3 Explaining the Quantitative Findings

The qualitative study described above was designed based on the findings of the prior quantitative study with the goal of explaining those findings as part of a sequential explanatory mixed methods study (28). The model and theory presented above around TGD participants' lived experiences of acute and post-discharge mental healthcare were then developed using constructivist grounded theory methodology (47). Though the qualitative study has been conducted and presented above largely as an independent study, the mixed methods study is not complete until the qualitative data are integrated back with the quantitative data: a key component of mixed methods research (28). In particular, an important final step in mixed methods research is presenting the quantitative and qualitative data together to demonstrate the unique value of deciding to mix the methods in the first place, as opposed to conducting the studies separately or using only one set of methods (56,57). Here we turn our attention to this step.

Exploring Sociodemographic & Clinical Factors

In the quantitative study using health administrative data, key findings related to the sociodemographic characteristics of the TGD individuals who had a mental health ED visit or hospitalization included a greater association with indicators of socioeconomic marginalization in this group compared to the general population. TGD individuals were also more likely to have presented for an acute mental healthcare presentation with a mood or personality disorder diagnosis than population-based comparators.

The qualitative model described in the last section (**Figure 4**) offers explanations that clarify the association between these sociodemographic and clinic factors and TGD people's presentations to the acute care setting. TGD individuals were more likely to live in areas of low neighbourhood income, high residential instability, and

high material deprivation. Residential instability refers to high rates of family or housing instability while material deprivation measures indicators of poverty and difficulty accessing basic material needs (58). These quantitative findings suggest that TGD people were more likely to be marginalized related to important social determinants of health (59), and that this marginalization was associated with their need for acute mental healthcare (35). The qualitative model constructed a narrative of lived experiences that allows us to understand why this association exists.

Many TGD participants described experiencing developmental trauma and rejection from their family of origin, leading to several participants losing financial support and housing stability at a young age. Recurrent societal transphobia led to further marginalization in housing and employment. A lack of support around neurodivergence and physical disabilities also disproportionately impacted many of the participants, which increased the associated financial burden many participants faced and made finding stable employment even more difficult. These multiple and multiplying effects of minority stress led to experiences of poverty, homelessness, and inability to meet basic material needs; which were directly linked to causing worsening mental health symptoms and increasing need for acute mental healthcare (described above). Participant 3 explained how their mental health has significantly improved, but one of the main sources of their residual mental health challenges relates to experiencing poverty, which creates a background of stress and makes it difficult to meet basic needs, including paying for medications:

“I would say poverty is just an ongoing stressor, it's one of the hugest things that affects my mental health. Like, I get \$1169 per month from ODSP, and my rent is \$950. And then, you know, I have my phone bill, which is an essential thing. My WIFI, which is essential. Some of my meds aren't covered. So, like, at the end of the day, I really don't have any money and that's just extremely, extremely difficult.”

TGD participants described how these compounding challenges feel overwhelming and insurmountable, leading to feeling hopeless and believing that systems and

individuals in society are not interested or able to support them. Participant 3 explained how poverty led to experiencing housing instability, which was directly linked to their acute mental health concerns:

“...it can feel really hopeless because it's hard to see any way out. ...the time that I came closest to actually following through with a suicide attempt was right after becoming homeless and having nowhere to go.”

The qualitative model and the lived experiences of the participants paint a clear picture of the life histories and mental health journeys that can often tie TGD people's experiences of daily discrimination and marginalization to the need for acute mental healthcare.

The qualitative model was also helpful in explaining the increased likelihood of TGD individuals presenting to acute mental healthcare with a primary diagnosis of a mood disorder or a personality disorder compared to the population-based comparison groups. Participants connected the daily transphobia they faced to a greater likelihood of struggling with depression as TGD people. As participant 10 explained:

“Of course, there's this overlap between depression and transgender identities, and I feel like that's partly because of the stigma. ...if you were to get stigmatized for who you are, for being trans and experiencing hardships because of your trans identity, it will make it easier for you to get depressed.”

As already described above, this transphobia and discrimination lead to marginalization impacting social determinants of health, which are significant stressors that increase the likelihood of developing depression. Participant 9 clearly explained this connection, especially how these struggles can compound and lead to an overwhelming sense of hopelessness:

“I mean, depression is hopelessness, right? So, when you are, you know, kind of living in a system that was designed to go against you, it doesn't help alleviate the hopelessness and just kind of contributes to it. Like, leading up to me being

homeless and being in more precarious housing, I had gone into a lot of debt trying to keep up my rent before I eventually became homeless. So, hopelessness definitely stacks up on you, for sure. And then getting out of homelessness, without the right supports, it can feel like an impossible battle.”

Multiple participants described how personality disorders, particularly borderline personality disorder (BPD), are commonly and disproportionately diagnosed in TGD individuals, as they understood from both their own lived experiences and community knowledge. Participants reflected on and hypothesized around this increased likelihood of being diagnosed with a personality disorder based on their lived experience. Several participants believed that BPD is overdiagnosed because of stigma towards TGD people, and because symptoms of BPD, such as emotional dysregulation, can be present in other mental health conditions that disproportionately impact TGD people, including post-traumatic stress disorder (PTSD) and autism spectrum disorder (ASD). Participant 1 explained how they feel that BPD can resemble PTSD, and TGD people are more likely to experience trauma than cisgender people in general, which can lead to this misdiagnosis in TGD people:

“I think that lots of people have BPD traits in moments of crisis. So, being diagnosed BPD because you're receiving care in a moment of crisis is not actually the right diagnosis necessarily, right? The overlap between PTSD and BPD is massive. And particularly for, like, the trans community, I would wager that more of them probably have PTSD than have BPD. And it's like a misdiagnosis that happens a lot.”

Participant 10 theorized how autistic people can present with behaviours that resemble BPD symptoms, and how autistic people can also benefit from dialectical behavioural therapy (DBT), which is a treatment for BPD:

“I feel like the emotional dysregulation, the social aspects of BPD, like not having great social skills, benefiting from more structured communication skills, like communication being taught to you in a very structured way, and

DBT is also very structured. And also, the emotional dysregulation part. And having intense relationships, I feel like that's very autistic."

As the qualitative model highlights, participants described multiple and recurrent sources of invalidation throughout their lives as TGD people, which several participants hypothesized as another reason for increased BPD diagnoses in TGD individuals. This differs from the previous explanation offered in that this is not a misdiagnosis of BPD, but a rationale for the increased prevalence of valid BPD diagnoses in TGD populations. Participant 14 explained this relationship further:

"I know that with studies with BPD, it's often stemmed from childhood or possibly genetics, but I think it's definitely, like, early, formative experiences that sort of contribute to that. And then if someone's struggling with trans issues, you know, the world at large is invalidating, then it can probably play a role in exacerbating those symptoms."

Table 9 integrates the quantitative findings with illustrative qualitative quotes that explain those findings in a joint display.

Explaining Differences in Post-Discharge Outcomes

The qualitative model (**Figure 4**) and participants' lived experiences also offered explanations to understand the post-discharge outcomes in the previous quantitative study. Using health administrative data, we had found that TGD individuals had increased follow-up with a physician for mental healthcare in the 30 days following discharge from the ED (adjusted OR=1.21; 95% CI 1.03-1.42) but reduced 30-day follow-up post-hospitalization (adjusted OR=0.81; 95% CI 0.66-0.99) after adjusting for covariates. This discrepancy was difficult to understand or further explore using quantitative data, so we turned to qualitative data to explain these results.

Several qualitative themes emerged to understand the increased outpatient mental health physician follow-up rate following discharge from the ED for TGD people

compared to the population-based comparison cohort. Participants in the qualitative study described how they perceived more agency in choosing how their care was provided in the ED setting, as they were offered treatment and were not kept in hospital involuntarily. Participant 11 described having to actively advocate for herself to access care in the way that she wanted to, by telling the ED staff that she would rather leave without being assessed rather than be put in the secure waiting area where her belongings would be taken from her and she would be in a locked unit. After the ED staff respected her choice to wait for an assessment in the non-secure waiting area, she did find the ED visit helpful for her, and she chose to connect to post-discharge mental healthcare at the same hospital soon afterwards:

“I actually got help in Emerg, and I had choice and agency, and I could leave - and when I got cagey about giving up my stuff and would rather leave...that was an important moment because a lot of patients don't have that empowerment. ...showing that I had the power to leave completely changed their demeanour. And then they let me stay, and they gave me Seroquel and they were very compassionate... psychiatrists don't want their patients to be aware that they have so much power in the relationship. And that they should have more empowerment. The Emergency at least gave me, and I can imagine, gave others, a degree of empowerment, and actual support, like medication to take home with you, that helped right away, like Seroquel did.”

Participant 11 goes on to explain another reason why TGD individuals may have had increased post-ED follow-up. As the qualitative model highlights, the participants in this study described how they had increasing need to access mental healthcare but they had many barriers to accessing the care they needed. Thus, participants described presenting to the ED with more acute and severe mental health symptoms, which may be related to TGD people requiring greater post-ED follow-up for having a higher need for care on average when they present to the ED compared to cisgender people. Participant 11 added that TGD people tend to have less available funds and private health insurance to cover the costs of private mental healthcare, related to minority stress as previously described, so TGD people may

also have greater reliance on the public healthcare system for mental health treatment, which may in part explain the increased post-ED follow-up rate:

“The Emergency at least gave me...a follow-up, like access to a psychiatrist, which is really what most people are going to the Emerg for. Yeah, it makes sense that I think non-binary people probably are more ready to admit that there's a problem, or are in more dire straits and have less options, and also can't afford private - like these other people might go to private therapists after, and we can't afford that. And that's probably what drives us to the [urgent care clinic] afterwards.”

This is relevant to understanding the quantitative results as the post-discharge follow-up only measures physician-based mental health visits in Ontario, so private mental healthcare, such as with a psychologist, would not be captured in the post-discharge follow-up rates.

Finally, in understanding greater post-ED follow-up rates in TGD individuals compared to the general population, participants also suggested that perhaps a significant number of TGD patients are not having their care needs adequately addressed in the ED and/or their symptoms and safety concerns are at such a high level that they are needing a mental health visit soon after discharge. As participant 3 explained:

“...there have been times including in my own experiences, my friends' experiences, where, like, we get discharged from Emerg where maybe we shouldn't have been, so I think that could partially explain the follow up there, because you end up in crisis again, because you shouldn't have been sent home from Emerg.”

These explanations for increased post-ED care further highlight the apparent paradox of TGD individuals having reduced post-discharge follow-up mental healthcare after a psychiatric hospitalization. However, this paradox was explained using qualitative data and analysis.

Many participants explained that the acute care setting was experienced as traumatic and transphobic, with regular misgendering and rigid policies and practices that were experienced as invalidating, re-traumatizing, and carceral (as described above). This is in particular contrast to the agency in the ED that was described by several participants, in part because those who were hospitalized were, by definition, more likely to have experienced a longer involuntary period of detention in the hospital, which led several participants to avoid subsequent care after discharge. This was described by participant 5:

“I generally don't really seek help if I'm in crisis. ...the reason I don't seek help is because of that experience [of hospitalization]. I feel very scared that if I go to another psych ward, I'm going to have the same experience where I'm being misgendered and disrespected... if I experience that again at a psych ward, as soon as I get out, I'm going to kill myself.”

An important corollary is that several of the participants who felt that the hospital experience was harmful and thus avoided returning to biomedical models of care described opting for care through community organizations after discharge instead. This is of particular relevance in understanding the quantitative data, because again, care provided through community organizations would not be captured by the health administrative data unless it was provided by a physician, which is unlikely.

Another explanation offered by participants for the reduced post-hospitalization follow-up was that even if TGD patients were open to returning to outpatient mental healthcare in the public system after discharge, many TGD people may have felt exhausted by the hospitalization, as several participants described having to regularly advocate for themselves in hospital to be gendered correctly and be offered gender-affirming care. Participants also described the emotional and psychological burden of having to self-monitor their gender expression constantly while in hospital as they are regularly around other people and want to avoid being misgendered. As participant 2 described, even if a TGD person was open to receiving support through biomedical models of care after discharge, they would need to take

a break from the system before reconnecting to care, because of the energy and other resources they had to expend while they were in hospital:

“The less time I spend in a hospital, the more likely I am to go back because I haven't used up my expense of patience with the medical system, and energy for presenting and dealing with bureaucracy. Like, there's only so much of that one can deal with in a month. If you're gonna be hospitalized, that's gonna use up your supply for a couple months, at least.”

This insight is helpful in explaining the findings because the post-discharge follow-up rate measured in the health administrative data was within a month of discharge, so it may take longer than a month for some TGD patients to follow up with outpatient mental healthcare after discharge compared to cisgender patients.

One final explanation for why TGD patients may have had decreased post-discharge follow-up is that it is difficult to take the needed time to follow up with outpatient mental healthcare when TGD people have competing priorities to meet their other needs. As the qualitative model highlights, many participants were already having challenges related to precarious employment and financial stability prior to their hospitalization, which is what contributed to their need for acute mental healthcare in the first place. However, attending an outpatient mental health physician appointment often requires taking time out of the workday and may require waiting for up to a few hours for the appointment. Participant 2 described how she believes that for many TGD people, including herself, the longer she spends in hospital for a hospitalization, the greater impact it would have on her work and therefore her financial stability, so after discharge from a hospitalization she would need to shift her focus to prioritizing her job and meeting her other vital basic needs:

“If I had gone in for that inpatient treatment program, I think I would have counted that as my self-care for the year, and that would have been all that the health care system saw of me for a while because...I then need to be at my job every single day so they don't fire me. I don't have time to take off for a doctor's

visit, to worry about adjusting medications, that's going to have to wait for a longer time."

Taken together, it is understandable why post-ED follow-up rates and post-hospitalization follow-up rates differed significantly for TGD people. As a group, TGD people present to the ED with greater mental health symptom acuity and severity, related to marginalization and social determinants of health challenges. If they were discharged from the ED, they were more likely to have experienced more agency in their care experience, which may have then fostered greater trust in the system to encourage them to continue to engage in outpatient mental healthcare after discharge. This engagement in follow-up care is also influenced by TGD patients tending to have less options for accessing care outside of the public system, and by the greater acuity and complexity of mental health needs presenting for care.

In contrast, TGD patients who were hospitalized were much more likely to have been involuntarily kept in hospital. The longer someone stayed in hospital, the more draining it was as they face repeated minority stress in the hospital, and they also have to regularly monitor their gender expression and self-advocate for access to gender-affirming care. For many TGD people, these experiences are negative and impact their desire and ability to follow up with the same model of care in the outpatient setting after discharge. Staying in hospital for days or weeks (or longer) likely also impacted their employment security and financial stability such that many TGD individuals would then have to prioritize addressing their other basic needs after discharge, which would reduce their ability to follow up with outpatient care.

Table 10 presents qualitative data, including themes and illustrative quotes, in conjunction with the quantitative results that they explain.

4.5 Discussion

4.5.1 Summary of Findings

The TGD participants in this study narrated a model that demonstrated how life and care experiences impacted their journey into and out of the acute hospital setting. They described minority stress experiences throughout their lives, which contributed to the development of mental health symptoms they struggled with. Experiences of developmental trauma and rejection from their family of origin, lack of recognition and supports for neurodivergence and physical disability, and marginalization related to their gender identity intertwined with transphobia and led to invalidating and harmful experiences in multiple domains of their life. Housing instability, secondary to both family rejection and societal marginalization, was described as particularly linked to worse mental health. Their mental health symptoms and distress worsened as they tried to access care and stable housing but were found waiting and unable to access what they needed. This mounting distress led to presenting to the ED as one of increasingly few doors to potentially address this distress. Their experience of acute mental healthcare was impacted by the agency and support they had in presenting for care, and their perception of how safe and useful the care presentation was. The acute hospital setting and policies were described as lacking in gender-affirming care and autonomy, which recreated an invalidating and transphobic environment for many TGD participants. Some of the participants did find acute care helpful as a break from the stress of the outside world, a pathway to clarify and affirm any mental health diagnoses, and connect to more resources and supports after discharge.

Their experience of the acute hospital presentation influenced which of the pathways they preferred after discharge. Some felt able to trust the formal mental health system to provide ongoing care such that they continued to engage in outpatient care after discharge, and several participants found that urgent outpatient clinics, medication changes, and connection to more treatment and supports (including psychotherapy, particularly dialectical behavioural therapy) improved their mental health and symptoms in the long-term. Some participants

much preferred eschewing the formal mental health system in favour of engaging with care through community organizations after discharge instead. They clearly outlined the superior aspects of community care over the biomedical model for them; including connection to community, addressing social determinants of health, prioritizing agency, taking a depathologizing and destigmatizing lens to mental health, and being peer-led. All of these factors are particularly important for TGD people who have often experienced invalidation and lack of autonomy (sometimes from a young age), who have experienced pathologization of their identities, who have mistrust in the formal system due to systemic and institutional transphobia, who repeatedly describe the importance of connecting to community especially when many feel isolated, and whose main drivers of mental distress often stem from challenges in social determinants of health. Unfortunately, for some participants, the acute care experience was experienced as so traumatic and harmful that it led to increasing distress and avoidance of the system altogether, due to a “trust deficit” in the system’s ability to provide care for them, as well as valid fear of being involuntarily hospitalized again in a setting they experienced as carceral and without benefit.

The qualitative theory that was co-constructed by the narratives and lived experiences of the participants also offered explanations for the quantitative results from the previous study as part of a sequential explanatory mixed methods project. Their experiences explained the quantitative findings that TGD individuals who had an acute mental healthcare presentation were more likely to have experienced marginalization including living in areas of greater residential instability, material deprivation, and low income. This corresponds to how the participants described minority stressors throughout their lives, including societal transphobia and marginalization, compounded to cause housing instability, poverty, and inability to meet basic material needs that were directly linked to their increasing distress and acute mental healthcare needs. It is relevant that even though six participants completed some college/university, six other participants had a college/university degree, and one participant completed some graduate training; nine participants

were on government assistance at the time of the interview and two participants were working full-time.

The participants also offered explanations for the increased diagnoses of mood disorders and personality disorders in TGD populations found in the prior quantitative study. Not only does living with regular discrimination and social determinants of health challenges lead to poor mental health outcomes; furthermore, participants made clear the relationship between chronic struggles with minority stress and invalidation, and experiencing society and institutions as broadly unable and unwilling to offer support and care that adequately addresses their needs. Several participants described “living in a system that was designed to go against you”, which can lead to a sense of feeling overwhelmed and hopeless, which was commonly associated with depression. The participants shared their detailed narratives that clearly illustrate how chronic marginalization can explain the high rates of depression in TGD populations (60–62). Relatedly, participants discussed how chronic regular invalidation and discrimination experienced by TGD individuals sometimes from a young age can lead to presenting to the hospital with symptoms of borderline personality disorder (BPD). Some also hypothesized that symptoms of personality disorders, such as emotional dysregulation and interpersonal challenges, can be related to other diagnoses and experiences that are more common in TGD people than cisgender people, such as neurodivergence (including ADHD and autism) and complex trauma. Centering lived experiences and community knowledge in this study allowed for explanations of this association between BPD and TGD people that are depathologizing while also triangulating well with existing hypotheses of this relationship (63). It is of note that several participants specifically spontaneously named dialectical behavioural therapy (DBT) as a key treatment that significantly improved their mental health, which is relevant because DBT is a first-line treatment for BPD symptoms (63).

Finally, the qualitative model also explained multiple contributors to the difference in post-discharge outcomes for TGD individuals between those who presented to the ED only for acute mental healthcare versus those who were discharged after a psychiatric hospitalization. Agency was an important differentiator between ED

visits and hospitalizations as participants described being hospitalized often meant being in a setting involuntarily for an extended period of time. This was a setting that some participants described as carceral and with rigid policies and sometimes staff that were not gender-affirming and at times actively transphobic. Even if the hospitalization was experienced as more helpful, participants described the need to advocate for themselves and regularly monitor their gender expression while in hospital, such that they needed a break from the health system afterwards.

Participants also reported how having more precarious employment and financial instability as TGD people meant that they would have to focus on meeting their other basic needs after spending days or weeks in the hospital focusing on their health. As the qualitative model theorized, many TGD patients may eschew the formal system and opt for follow-up with community organizations after hospitalization, which would also partially explain the reduced post-discharge mental health physician follow-up rate compared to the general population.

In contrast, those who were discharged from the ED described having more agency in their experiences as they were not kept involuntarily in hospital. This agency and autonomy contributed to greater trust in the system, which encouraged TGD individuals to return for outpatient care. In addition, as the qualitative model highlighted, TGD people often face greater complexity and acuity of mental health symptoms related to social determinants of health and other challenges, such that there may be a greater need for follow-up after discharge. Some participants discussed minimizing their mental health symptoms to clinicians to retain more autonomy in their care, so that may have also contributed to some TGD individuals being discharged from ED with greater care needs that required sooner follow-up. Furthermore, TGD people may have less options for addressing their care needs outside of the public health system, related to social determinants of health challenges, which may further contribute to greater follow-up with outpatient care after ED discharge compared to cisgender patients.

4.5.2 Strengths and Limitations

This study centered the lived experiences of TGD people to co-construct a theory that was able to explain previous quantitative results using health administrative data. There is scant literature on specifically mixing health administrative data and qualitative research for health services research (29–33), so this study offers an example of the potential of mixed methods research to leverage both the ability of health administrative data to highlight inequities in health outcomes using population-based data and the power of qualitative data in centering lived experiences of marginalized communities to understand these inequities in-depth. The qualitative findings were able to explain the quantitative results beyond the limits of the health administrative data alone. This study also explored the life histories of the participants to understand how lived experiences, long before presenting for acute care, have impacts on their experiences leading up to and during the acute care visit, as well as on their mental health journeys after. This interview approach allowed for an in-depth understanding of how the acute care experience can be disproportionately traumatizing for TGD people as it can recreate transphobic and invalidating environments they have regularly experienced outside of the hospital. Presenting the health administrative data with the qualitative findings in joint displays also highlights the power of mixed methods research to examine a research problem more fully, holistically, and synergistically (28).

By exploring and documenting in-depth the acute care experiences of TGD people, this study is able to offer evidence that can be leveraged to improve care and policy in acute psychiatric settings to make them more affirming and inclusive. This is the first qualitative study exploring post-discharge mental health journeys of TGD people, and the findings identify potential targets of intervention to consider for clinicians and policymakers interested in increasing support for TGD people along their mental health trajectories. Having advisors who are part of the TGD community and who are experts in TGD health was of immense value in this study to support triangulation and the scientific rigour of the analysis. The feedback and expertise of the advisors also helped to better position and frame the findings for greater clinical and research relevance.

A limitation in this study is that none of the participants identified as Black. While the study reached data saturation despite this limitation, and the qualitative data adequately captured and explored the phenomenon under study, a future study may want to specifically examine the experiences of racialized TGD people in navigating acute and post-discharge mental healthcare. The participants in this study were also relatively young and there were fewer older participants, so there may be limitations to the transferability of the findings for older TGD people with acute mental healthcare experiences. We wanted the qualitative sample to reflect the demographics of the TGD cohorts in the prior quantitative study in order to best position this study to be able to explain the quantitative findings, so the younger ages of our participants correspond with the younger ages of the TGD cohorts in the quantitative study (35). Furthermore, there is evidence that there are more people in Ontario identifying as TGD who are below the age of 35 than above (87), so our sample also reflects the demographics of the broader community. No participants in the study reported having a diagnosis of a psychotic disorder or a substance use disorder, which limits transferability of these findings to TGD patients with these diagnoses. However, there was intentionality in enriching the qualitative sample with participants who are well positioned to help explain the quantitative findings, and we had found through the health administrative data that there were increased diagnoses of depression and personality disorders in the TGD cohorts, with corresponding reductions in substance use and psychotic disorders as the primary diagnosis for presenting to acute care (35). In addition, many participants described struggling with substance use during their interviews even though no one reported being diagnosed with a substance use disorder, so this may reflect low mental health literacy in the general population around substance use disorders existing as diagnoses or being diagnosed separately from other psychiatric diagnoses. There is also limited transferability of the findings outside of the Ontario context, because there can be significant differences in the laws, policies, and clinical care practices that shape hospital-based care and mental healthcare in different contexts. However, many of the experiences described by the participants, including minority stress experiences, transphobia in healthcare settings, and barriers to accessing care have been well documented in multiple settings globally; suggesting that at least

some of the themes and experiences shared by the participants would resonate across contexts.

Another important limitation in this study is that TGD community members were not fully involved throughout the study from study design through to analysis. The extent of community involvement was limited in the study due to it being a PhD thesis study. We sought out TGD advisors to improve the scientific rigour and engagement with community during the analysis process. The advisors were also invited to be co-authors in future publications related to this study in recognition of the value of their contributions. A final consideration around methodological limitations is that there was only one primary coder in this study. Again, this was influenced by the study being a PhD thesis study. However, multiple methods were used to ensure credibility of the findings and scientific rigour; including ensuring data saturation was reached through a rigorous analysis process consistent with constructivist grounded theory (47), having multiple discussions throughout the study including throughout analysis with senior author (JZ) who also reviewed full transcripts and coding, incorporating feedback from discussions with multiple TGD advisors, and triangulating the qualitative data with the health administrative data and existing literature.

4.5.3 Research & Clinical Implications

This study highlighted several unique and intersecting experiences that contribute to mental health symptoms and distress in TGD people. Many studies have confirmed that marginalization and transphobia affecting the social determinants of health of TGD people have obvious and predictable detrimental impact on the mental health of TGD people (2,64). An ethnographic study of TGD people in the USA highlighted the ways in which social determinants of health struggles were interrelated, with housing instability linked to trauma, interpersonal rejection, poor access to health care, poverty, lack of educational and employment opportunities, and other social determinants of health challenges (64). The authors described how housing instability led to mental health distress, which could result in coping

through substance use and sexual risk-taking, leading to further financial instability, precarious employment, and other social challenges in a cyclical manner (64). In the context of significant interpersonal rejection and isolation, institutions (including housing resources) that are gender-affirming and the presence of chosen family for support become particularly important for improving mental health (64). The same dynamics described in this aforementioned study were borne out in our qualitative study. TGD participants described how developmental trauma and interpersonal rejection from their family of origin led to housing instability and poverty, which was perpetuated by further marginalization and lack of employment opportunities related to their TGD identity. This study furthers the previous research by connecting these interrelated experiences of social determinants of health challenges, including barriers to accessing needed mental healthcare, directly to an eventual need for acute mental healthcare for many TGD people.

Our study goes further to clarify other minority stress factors that disproportionately affect TGD people and contribute to their need for acute mental healthcare, including chronic physical health conditions and neurodivergence. Many studies have consistently found that TGD people globally carry a greater burden of chronic physical health conditions than cisgender people, including higher rates of asthma, chronic obstructive pulmonary disease (COPD), diabetes, polycystic ovary syndrome (PCOS), chronic liver and kidney disease, arthritis, and fibromyalgia (65–70). TGD individuals are also more likely to have more than one chronic physical health condition concurrently (70). Forty percent of the participants in our study reported having a chronic physical health condition, with several reporting multiple conditions simultaneously, which is particularly noteworthy given how young the participants were on average. A significant number of physical conditions described both in the literature and in our study are inflammatory-related and suggest that inflammatory processes related to experiencing chronic minority stress, trauma, and discrimination may play an important role in driving chronic disease (65,68). Other factors described in the literature, including exogenous sex hormone use, HIV disproportionately affecting TGD people, and chronic experiences of gender incongruence or dysphoria may also contribute to poor physical health outcomes

(e.g., cardiovascular disease) (65,69). Our study extends this discourse by illustrating how the physical health conditions disproportionately affecting TGD people, many of which are still inadequately understood and lack definitive testing, can lead to invalidation from clinicians and others that compounds the invalidation many already feel related to their gender identity. TGD people with chronic physical conditions may also have greater care and support needs that worsen existing social determinants of health challenges, thus intimately intersecting with existing forms of minority stress and contributing to increasing distress and a potential need for acute mental healthcare. In these ways, our study highlights how chronic physical health symptoms have direct and significant impact on TGD people's acute and chronic mental health challenges and needs.

The association between neurodivergence, particularly autism and ADHD, and gender diversity is well-documented (71–74). Regarding the association between autism and gender diversity, this co-occurrence is commonly proposed to be related, at least in part, to many autistic people inherently questioning and challenging social norms, and experiencing less pressure to conform to and perform stereotypes of gender (73). It is important to highlight that few studies focusing on the overlap of neurodivergence and gender diversity have centered neurodivergent TGD people's lived experiences or engaged them in research design or authorship (74). This enables a cisgenderist-ableist lens and discourse that pathologizes both gender diversity and neurodivergence, and puts up compounding barriers to accessing needed care and supports, including gender-affirming care, in part by perpetuating the notion that gender diversity is a “symptom” of neurodivergence and therefore questioning the validity of neurodivergent TGD people's self-identified gender identity (74–76). Many people experience gender identity, neurodivergence, and disability each as part of their identity (75–77). When an individual embodies all of those identities, the challenges they face in terms of discrimination and lack of supports related to each of those domains can converge and multiply (75–77). This experience can feel overwhelming and magnify distress, which, in turn, likely explains the greater need for acute mental health services and the adverse experiences of these services (68). Relatedly, a prior qualitative study of

autistic TGD adults highlighted the multiple ways that the respondents experienced the world as not being set up in the right way for them (76). However, the participants highlighted the important ways in which they challenged the oppressive systems, including through claiming space and creating affirming community, and being selective in who to disclose which parts of their identities to (76). All of the above resonates with the multiple TGD participants in our study who reported being neurodivergent, as they felt doubly invalidated on a daily basis and unable to access holistic care that considered their entire being. Previous literature described how often few biological family members support both gender diversity and neurodiversity, and can also miss and minimize neurodivergent behaviours (74,76), which supports the participants in our study desiring access to clinical assessments for ADHD and autism that do not require or as heavily prioritize collateral information from biological family to make the diagnoses. Further resonating with previous literature (75–77), the neurodivergent TGD participants in our study also called for mental healthcare providers who are competent in both neurodiversity and gender diversity and the intersectionality between them, who offer support that helps them navigate the barriers to accessing care for both, who challenge pathologization and opt for a more strengths-based approach to their care, and who recognize the importance of connection to community for them. Our study highlighted how the lack of neurodiversity-affirming care intersected with their other minority stress challenges and furthered their experience of the mental health system as fragmented and unable to address their needs.

Many TGD people avoid the ED due to fears based on past experiences of discrimination in the ED and other healthcare settings (20,78). In the OutLook Study of TGD participants' experiences in EDs, greater experiences of transphobia were predictably associated with greater ED avoidance, while having social support reliably decreased the likelihood of ED avoidance (78). This resonated with our study findings that prior negative experiences in the ED led some participants to avoid returning, while having people in their life who supported and encouraged them to access care led several participants to feel more comfortable and able to present to the ED. This is particularly important in the context of the high rate of

TGD people describing experiences of significant isolation and limited social support secondary to chronic minority stress. Helping TGD people connect to community and supports as part of routine clinical care can have knock-on effects towards improving access to healthcare more broadly as well. A recent scoping review on the experiences of TGD patients in emergency psychiatric settings confirmed that there are currently no known qualitative studies of TGD patient experiences in this area (16). Our study is not only the first qualitative study to our knowledge that focuses on TGD people's experiences of the psychiatric ED setting, but we clarified how experiences and perceptions of agency, safety, and usefulness related to the ED presentation influence subsequent engagement with mental healthcare.

There have similarly been limited qualitative studies on TGD peoples' experiences of psychiatric hospitalization. One qualitative study focused on TGD youth (age 13–17) in an inpatient psychiatric hospital setting (18). A recent scoping review on TGD inpatient mental healthcare (15) found seven articles and confirmed that no qualitative studies, to our knowledge, have focused on TGD adults. It was thus crucial to explore in-depth the lived experiences of TGD adults in inpatient psychiatric care to understand how current inpatient settings impact them, and how institutions and policies could improve. The participants in our study described multiple ways in which TGD inpatients experience a lack of gender-affirming care, from individual clinicians repeatedly misgendering them or asking invasive questions about their gender that were not relevant clinically, to structural issues such as having rigid policies around not being able to contact chosen family or not being able to have room assignments based on gender rather than assigned sex at birth. While the ED setting can also feel carceral and lack agency, participants described how the inpatient setting can be much worse because of the longer time spent in the setting and the greater likelihood of being kept there involuntarily. Participants described how they had to advocate for themselves to receive gender-affirming care – such as the use of their pronouns, being provided with hospital clothing that is affirming, and being able to access their gender-affirming medication – because existing hospital policies were not created with TGD people in mind. Furthermore, participants explained how the acute care setting can often feel

carceral and lack agency for cisgender people as well, but TGD people have experienced recurrent trauma and other minority stress in their life that render the lack of agency and the carceral experience of the inpatient setting that much more distressing and invalidating, especially when it recreates transphobic experiences previously endured outside of the hospital setting.

The lived experiences of the participants offer important considerations in terms of policy and care implications for acute mental healthcare. While autonomy is an important medical ethical principle for all patients, agency is a particularly key priority for TGD patients in the acute psychiatric care setting. This resonates with a previous cross-sectional study of TGD individuals who were hospitalized for suicidality, which found that perceived usefulness of hospital-based care was low overall, but greater trust in mental healthcare providers and being hospitalized voluntarily (rather than involuntarily) were associated with higher perceived helpfulness of the care received during the hospitalization (17). Trust in mental healthcare providers and the system more broadly is often limited to start, not only because TGD people commonly have a history of trauma and minority stress, but also because the mental health system has pathologized TGD identities and prevented access to gender-affirming care historically (79). Prioritizing agency for TGD patients in how care is offered and accessed can help build trust in the healthcare system over time.

The TGD participants' lived experiences also lend themselves to other institutional and policy recommendations that can improve TGD patients' sense of safety in the acute mental healthcare setting. The aforementioned scoping review on TGD patients' experiences of emergency psychiatric care reported on care considerations based on previous studies, and the recommendations included the use of affirming and inclusive language; cultural humility and reflective practice for clinicians to identify biases; and structural and policy changes such as the need for confidential spaces for TGD patients in the ED setting, allowing for chosen support people to be present if the patient wants, and having TGD-specific resources and clinical champions available for patients as needed (16). These recommendations align with

the experiences described by our participants, particularly the need to allow for chosen family and chosen support people to be included in their care if desired, in the context of many TGD people having experienced harm with their biological family related to their gender. Similarly, the scoping review on inpatient psychiatric care for TGD people highlighted six themes to consider for improving policies to better address the care needs of TGD patients in inpatient settings, which included: using chosen name and pronouns, communicating among providers (including through proper documentation), training in TGD healthcare, addressing personal bias among providers, creating formal policies that are inclusive and affirming, and housing segregation by gender rather than sex (15). Again, these recommendations are also supported by the lived experiences of the participants in this study, and our findings also illustrate the serious potential consequences of not addressing these concerns. Participant 5 specifically explained how being put in a men's inpatient unit rather than a women's unit, which they had requested, contributed significantly to their mistrust of the mental health system such that they avoided the system after discharge. A failure to improve affirming and inclusive care in the hospital setting is likely to perpetuate avoidance of needed care and a sense for many TGD people that the system is not designed to care for them.

There has been a focus on equity in access to mental healthcare after discharge from acute psychiatric care (80–86). Our prior quantitative study was the first using health administrative data to study post-discharge access to physician-based mental healthcare for TGD patients. Our study found that TGD individuals were more likely to have an outpatient mental health physician visit within a month of discharge from the ED, but less likely to receive outpatient physician care in the month following a psychiatric hospitalization compared to non-TGD individuals. This discrepancy in post-discharge outcomes was important to further understand because if the higher post-ED follow-up rate reflects greater need for care for TGD patients, the lower post-hospitalization rate is a particularly concerning health inequity in that the greater need for follow-up among TGD patients is not being met. However, while this inequitable outcome was quantified in the first study, reasons for the discrepancy in follow-up after ED versus hospitalization visits were unknown and

unattainable using only quantitative methods. For this purpose, we turned to the current qualitative study to explain those findings. Sequential explanatory mixed methods research is a specific study design meant for a qualitative study to explain prior quantitative findings (28), which this study was able to do by centering the lived experiences of TGD people. The participants co-constructed a coherent theory that tied their life narratives and experiences from before, leading up to, and during the acute care visit(s) that shaped their decision and behaviour around engaging in mental healthcare after discharge. They also offered multiple explanations for the discrepancy between post-ED and post-hospitalization outcomes based on lived experience and community knowledge, which were roundly clarifying. They highlighted the importance of having agency in their acute care experience, how that is particularly crucial for TGD people in the context of a lifetime of invalidating experiences that have led to understandable mistrust of the system, and how that impacted their post-discharge mental health journeys. The participants also described the ways in which being hospitalized was exhausting and traumatic, such that the longer they spent in hospital, the more time they potentially needed away from the hospital after discharge. They clearly explained the deficits of the biomedical model for TGD people, and why many might opt for community-based care because it uniquely addresses many of their needs (including connection to community and addressing social determinants of health) that biomedical models are not well-equipped to address. This study demonstrates the importance and potential of centering lived experiences of marginalized communities to truly understand health inequities that impact them in health services research.

4.6 References

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Table 8. Participant sociodemographic and clinical characteristics (n=15).

		Number of participants (%)
Age		Mean 30.9 (Range 21-59)
Gender Identity	Nonbinary	7 (47)
	Transfemme or trans woman	6 (40)
	Trans man	2 (13)
Self-Reported Race	Asian (East, Southeast, South Asian)	5 (33)
	Indigenous	2 (13)
	White	8 (53)
Romantic Relationship Status	In a relationship, married	1 (7)
	In a relationship, not married	5 (33)
	Not in a relationship	9 (60)
Children	No children currently	15 (100)
Current Housing Situation	Living alone, rent or own	5 (33)
	Living with partner(s) and/or roommate(s), rent or own	6 (40)
	Living with family of origin	1 (7)
	Living in supported or community housing	3 (20)
Highest Education Level	Completed high school	2 (13)
	Some college/university	6 (40)
	Completed college/university	6 (40)
	Some graduate school	1 (7)
Current Financial Support	Government assistance	9 (60)
(can choose more than one)	Savings	2 (13)
	Loved ones	5 (33)
	Part-time work	6 (40)

	Full-time work	2 (13)
Chronic Physical Health Condition(s)	(Reported conditions include fibromyalgia, chronic fatigue syndrome, Ehlers-Danlos syndrome, Hashimoto's thyroiditis, polycystic ovary syndrome, obstructive sleep apnea, dysautonomia, irritable bowel syndrome, psoriasis, bladder pain syndrome, migraines)	6 (40)
Number of Psychiatric Diagnoses (per individual)		Mean 3.9 (Range 1-7)
Psychiatric Diagnoses (can report more than one)	Mood disorders (Major depressive disorder, Bipolar I disorder)	10 (67)
	Anxiety disorders (Generalized anxiety disorder, Social anxiety disorder, Panic disorder)	10 (67)
	Post-traumatic stress disorder, Dissociative disorders	9 (60)
	Neurodevelopmental disorders (Autism spectrum disorder, ADHD, Specific learning disorder)	9 (60)
	Personality disorders (Borderline personality disorder, Schizotypal personality disorder)	7 (47)
	OCD and related disorders (Obsessive compulsive disorder, Body dysmorphic disorder)	2 (13)
Number of Mental Health ED Visits (lifetime)		Mean 5.3 (Range 0-20)
Number of Psychiatric Hospitalizations (lifetime)		Mean 5.9 (Range 0-20)
Current Mental Health Supports	Family doctor	15 (100)
	Psychiatrist	5 (33)
	Therapist or counsellor	8 (53)

	Case worker	9 (60)
	Community Organization	11 (73)
	Faith-based organization	2 (13)

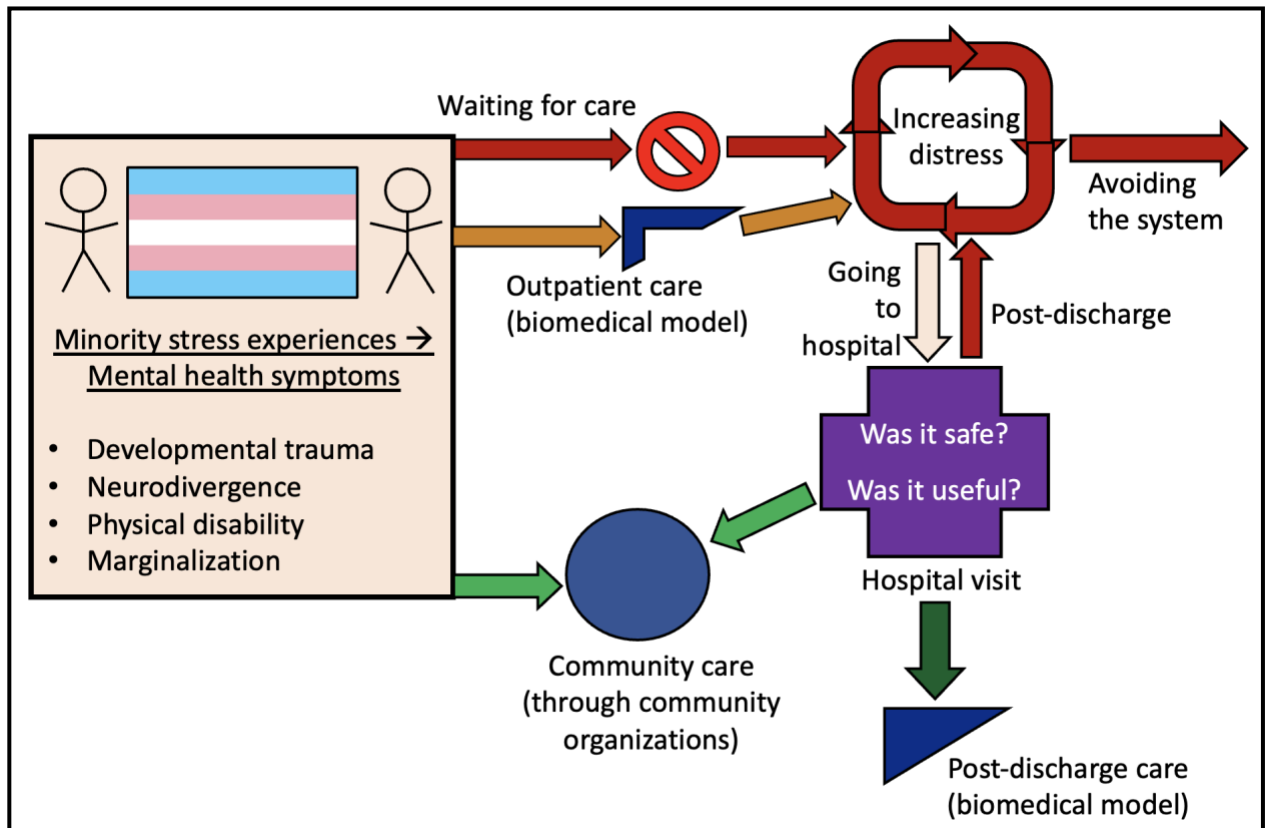


Figure 4. The model of acute and post-discharge mental healthcare experiences and pathways.

Table 9. Quotes illustrating key sociodemographic and clinical characteristic differences in the TGD individuals presenting for acute mental healthcare compared to the matched comparison sample.

<u>Sociodemographic / Clinical Characteristic</u>	<u>TGD ED Sample vs. Matched Comparison Sample</u>	<u>TGD Hospitalization Sample vs. Matched Comparison Sample</u>	<u>Illustrative Quotes</u>
Lowest neighbourhood income quintile	36.5% vs. 26.6%	35.9% vs. 26.6%	<i>"I would say poverty is just an ongoing stressor, it's one of the hugest things that affects my mental health. Like, I get \$1169 per month from ODSP, and my rent is \$950. And then, you know, I have my phone bill, which is an essential thing. My WIFI, which is essential. Some of my meds aren't covered. So, like, at the end of the day, I really don't have any money and that's just extremely, extremely difficult."</i>
Highest residential instability quintile	46.8% vs. 37.6%	45.4% vs. 34.7%	<i>"...it can feel really hopeless because it's hard to see any way out. ...the time that I came closest to actually following through with a suicide attempt was right after becoming homeless and having nowhere to go."</i>
Highest material deprivation quintile	32.8% vs. 25.9%	32.4% vs. 25.6%	<i>"...it was the holiday season. A lot of programs that I was going to...kind of were down. ...it was just a down period of my life...I maybe kind of started starving of a sort. ...financially I wasn't doing well as well, which was what I mentioned of the poor budgeting. ...I guess basically I was kind of planning to either off or injure myself, and I ended up instead calling a suicidal hotline. And yeah, so I wound up hospitalizing."</i>
Mood disorder diagnoses	26.2% vs. 19.4%	40.1% vs. 34.6%	<i>"Of course, there's this overlap between depression and transgender identities, and I feel like that's partly because of the stigma. ...if you were to get stigmatized for who you are, for being trans and experiencing hardships because of your trans identity, it will make it easier for you to get depressed."</i>
			<i>"I mean, depression is hopelessness, right? So, when you are, you know,</i>

			<i>kind of living in a system that was designed to go against you, it doesn't help alleviate the hopelessness and just kind of contributes to it. Like, leading up to me being homeless and being in more precarious housing, I had gone into a lot of debt trying to keep up my rent before I eventually became homeless. So, hopelessness definitely stacks up on you, for sure. And then getting out of homelessness, without the right supports, it can feel like an impossible battle."</i>
Personality disorder diagnoses	3.6% vs. 1.4%	5.3% vs. 2.3%	<i>"I know that with studies with BPD, it's often stemmed from childhood or possibly genetics, but I think it's definitely, like, early, formative experiences that sort of contribute to that. And then if someone's struggling with trans issues, you know, the world at large is invalidating, then it can probably play a role in exacerbating those symptoms."</i>
			<i>"I mean, BPD is known to be highly related to trauma, like it's basically just CPTSD except call it a personality disorder so they can victim blame us because there's a whole gendered bullshit thing around it. So, I did not word that eloquently, but you know what I'm saying."</i>

Table 10. Quotes illustrating qualitative themes explaining the difference in the adjusted odds of having a mental health-related physician follow-up within 30 days of discharge from a mental health-related ED visit vs. a psychiatric hospitalization in TGD individuals, compared with the general population.

<u>Cohort</u>	<u>Adjusted Odds Ratio</u> (95% CI, p-value)	<u>Qualitative Theme</u>	<u>Illustrative Quote</u>
TGD ED Cohort – Any follow-up visits within 30 days	1.21 (1.03 – 1.42, p=0.02)	Care needs not addressed by ED visit	<i>“...there have been times including in my own experiences, my friends' experiences, where, like, we get discharged from Emerg where maybe we shouldn't have been, so I think that could partially explain the follow up there, because you end up in crisis again, because you shouldn't have been sent home from Emerg.”</i>
		Having agency in the ED	<i>“I actually got help in Emerg, and I had choice and agency, and I could leave - and when I got cagey about giving up my stuff and would rather leave...that was an important moment because a lot of patients don't have that empowerment. ...showing that I had the power to leave completely changed their demeanour. And then they let me stay, and they gave me Seroquel and they were very compassionate... psychiatrists don't want their patients to be aware that they have so much power in the relationship. And that they should have more empowerment. The Emergency at least gave me, and I can imagine, gave others, a degree of empowerment, and actual support, like medication to take home with you, that helped right away, like Seroquel did.”</i>
		Greater need for care not otherwise met for TGD people	<i>“...promising a follow-up, like access to a psychiatrist, which is really what most people are going to the Emerg for. Yeah, it makes sense that I think non-binary people probably are more ready to admit that there's a problem, or are in more dire straits and have less options, and also can't afford private - like these other people might go to private therapists after, and we can't afford that. And that's probably what drives us to the [urgent care clinic] afterwards.”</i>

TGD Hospitalization Cohort – Any follow-up visits within 30 days	0.81 (0.66 – 0.99, p=0.04)	Facing transphobia and trauma in hospital leading to avoiding care post-discharge	<i>“I generally don't really seek help if I'm in crisis. ...the reason I don't seek help is because of that experience [of hospitalization]. I feel very scared that if I go to another psych ward, I'm going to have the same experience where I'm being misgendered and disrespected... if I experience that again at a psych ward, as soon as I get out, I'm going to kill myself.”</i>
		Being exhausted by the hospitalization	<i>“The less time I spend in a hospital, the more likely I am to go back because I haven't used up my expense of patience with the medical system, and energy for presenting and dealing with bureaucracy. Like, there's only so much of that one can deal with in a month. If you're gonna be hospitalized, that's gonna use up your supply for a couple months, at least.”</i>
		Needing to prioritize other needs	<i>“If I had gone in for that inpatient treatment program, I think I would have counted that as my self-care for the year, and that would have been all that the health care system saw of me for a while because...I then need to be at my job every single day so they don't fire me. I don't have time to take off for a doctor's visit, to worry about adjusting medications, that's going to have to wait for a longer time.”</i>

Chapter 5

5 Discussion

5.1 Dissertation Overview

My doctoral research examined the acute and post-discharge mental healthcare experiences of TGD people in Ontario using a sequential explanatory mixed methods study integrating health administrative data and qualitative data. Prior studies have demonstrated the strength of health administrative data in being able to identify access to care issues and health inequities experienced by different populations and communities, particularly around access to outpatient mental healthcare after discharge from an emergency department (ED) visit or hospitalization for a mental health reason (1–7). Early post-discharge follow-up is a quality-of-care indicator (8,9) because it has been shown to reduce the risk of adverse outcomes after discharge, including readmissions, suicidality, and even mortality (10–12). However, health administrative data have not been used to examine these outcomes for TGD populations. This was my rationale for initially selecting this as a topic of study, as I suspected there may be access to care inequities for TGD individuals because TGD people have experienced, and have valid fears of, discrimination in healthcare settings, which have led to ED avoidance and mistrust of healthcare providers and systems more broadly (13–15). I was also curious about factors associated with the need for acute mental healthcare for TGD patients, as that may lead to identification of targets for clinical intervention.

As I reflected further on the primary research questions, I realized that while health administrative data could identify *what* patterns and inequities exist for TGD acute psychiatric care users in Ontario, these data alone could do little to explain *why* these patterns and differences exist, and not from the lived experience perspective. It was for this reason that I decided to add a qualitative study to explain the quantitative results and turn my thesis project into a sequential explanatory mixed

methods research study (16). It was also more consistent with my values as a researcher to integrate qualitative research to ground the quantitative data in lived experience, so that the voices of the people being affected by the research are highlighted to effect change. The extant literature did not provide much guidance on mixing health administrative and qualitative data, so I was also interested in pursuing this study design to learn more about the potential for this type of work in health services research. Much of my reflexivity centered around the research paradigm that would guide this mixed methods study (16). Ultimately, this study's paradigm is most aligned with a combination of transformative-emancipation and pragmatism (16). Transformative-emancipation underlies my axiology as a researcher and the study's overall goals of improving mental healthcare with and for TGD people by highlighting inequities they face and centering their lived experiences (17). Simultaneously, the approach of mixing the methods involves a pragmatic approach that focuses on shared meaning-making between the qualitative and quantitative methods to practically address the research problem of what inequities exist in access to mental healthcare for TGD people and what factors explain and contribute to these differences (16–18).

The dissertation was divided into three core chapters that described the two quantitative studies using health administrative data followed by the qualitative study designed to explain the quantitative results. Chapter 2 outlined the findings from the first quantitative study, which used matching (on age, region of residence, and prior mental healthcare utilization) of the TGD ED and hospitalization samples with comparison samples to isolate the unique contribution of TGD status on factors associated with acute mental healthcare presentations. Compared to the unmatched comparison groups presenting for acute mental healthcare, TGD individuals in our sample were younger, more likely to experience marginalization, had different diagnostic patterns for their acute mental healthcare presentation, and had more prior mental healthcare utilization (as an outpatient, in the ED, and for hospitalization). Even after matching, TGD individuals were still more likely to live in lower-income neighbourhoods and areas of greater residential instability and material deprivation. TGD individuals were more likely to be diagnosed with a mood

disorder and twice as likely to be diagnosed with a personality disorder during their acute mental healthcare presentation. TGD individuals in the ED sample were also more likely to have presented to acute care for self-harm even after other mental healthcare use differences disappeared with matching.

Chapter 3 outlined the second quantitative study using the same health administrative data to assess early post-discharge outcomes for TGD cohorts and comparison cohorts after acute psychiatric presentations in Ontario. The study adjusted for known contributors to differences in post-discharge follow-up to again isolate the independent effect of TGD identity on post-discharge outcomes. In this population-based study, over a quarter of the TGD individuals who attended the ED for a psychiatric reason received a physician follow-up within one week of discharge and over half received follow-up within one month of discharge. One-third of the TGD individuals had a follow-up with a psychiatrist within one month, which was double the rate for the comparison group. Even after adjusting for covariates, TGD individuals were still more likely to have an outpatient physician visit, and specifically a psychiatrist visit, within a month of discharge from the ED. In contrast, TGD individuals were less likely to receive outpatient physician care in the month following a psychiatric hospitalization.

The quantitative findings from Chapters 2 and 3 shaped the subsequent qualitative study's study design, interview guide, and recruitment (Chapter 4). The aim of the qualitative study was to explain these prior quantitative findings. Charmaz's constructivist grounded theory was used for this study (19), which is a methodology grounded in symbolic interactionism, a theory positing that social reality and knowledge are co-constructed by individuals engaging in an interactive process of using symbols of language, words, and interpretations (20). The TGD participants in the qualitative study narrated a theory of how earlier life and care experiences impacted their journey to and out of the acute hospital setting. They described minority stress experiences throughout their lives, which contributed to the mental health symptoms they struggled with. Experiences of developmental trauma and rejection from their family of origin, lack of recognition and supports for neurodivergence and physical disability, and marginalization related to transphobia

intertwined with their gender identity and led to invalidating and harmful experiences in multiple domains of their life. Their mental health symptoms and distress worsened as they tried to access care but were found waiting and unable to access the right care that they needed. This mounting distress led to presenting to the ED as one of increasingly few doors to potentially relieve this distress. Their experience of acute mental healthcare was impacted by the agency and support they had in presenting for care, and their perception of how safe and useful the acute care presentation was. The acute hospital setting and policies were described as lacking in gender-affirming care and autonomy, which recreated an invalidating and transphobic environment for many TGD participants. Some of the participants did find acute care helpful as a break from the stress of the outside world, a pathway to clarify and affirm any mental health diagnoses, and connect to more resources and supports after discharge.

The qualitative study participants' experiences of the acute hospital presentation influenced which of the pathways they preferred after discharge. Some felt able to trust the formal mental health system to provide ongoing care such that they continued to engage in outpatient care after discharge, and several participants found that urgent outpatient clinics, medication changes, and connection to more treatment and supports improved their mental health and symptoms in the long-term. Some participants much preferred eschewing the formal mental health system in favour of engaging with care through community organizations after discharge instead. Unfortunately, for some participants, the acute care experience was experienced as so traumatic and harmful that it led to increasing distress and avoiding the system altogether, due to a "trust deficit" in the system's ability to provide care for them, as well as valid fear of being involuntarily hospitalized again in a setting they experienced as carceral and without benefit.

The qualitative theory that was co-constructed by the narratives and lived experiences of the participants explains the quantitative results from the previous studies. Their experiences explained the quantitative findings that TGD individuals who had an acute mental healthcare presentation were more likely to have experienced marginalization including living in areas of greater residential

instability, material deprivation, and low income. This corresponds to how the participants described minority stressors throughout their lives, including societal transphobia and marginalization, compounded to cause housing instability, poverty, and inability to meet basic material needs that were directly linked to their increasing distress and acute mental healthcare needs. The participants also offered multiple explanations for the increased diagnoses of mood disorders and personality disorders in TGD populations found in the prior quantitative study.

Finally, the qualitative model also explained multiple contributors to the difference in post-discharge outcomes for TGD individuals between those who presented to the ED only for acute mental healthcare versus those who were discharged after a psychiatric hospitalization. Agency was an important differentiator between ED visits and hospitalizations as participants described being hospitalized often meant being in a setting involuntarily for an extended period of time. This was a setting that some participants described as carceral and with rigid policies and sometimes staff that were not gender-affirming and at times actively transphobic. Even if the hospitalization was experienced as more helpful, participants described the need to advocate for themselves and regularly monitor their gender expression while in hospital, such that they needed a break from the health system afterwards. Participants also reported how having more precarious employment and financial instability as TGD people meant that they would have to focus on meeting their other basic needs after spending days or weeks in the hospital focusing on their health. As the qualitative model theorized, many TGD patients may eschew the formal system and opt for follow-up with community organizations after hospitalization, which would also partially explain the reduced post-discharge mental health physician follow-up rate compared to the general population.

In contrast, those who were discharged from the ED described having more agency in their experiences as they were not kept involuntarily in hospital. This agency and autonomy contributed to greater trust in the system, which encouraged TGD individuals to return for outpatient care. In addition, as the qualitative model highlighted, TGD people often face greater complexity and acuity of mental health symptoms related to social determinants of health and other challenges, such that

there may be a greater need for follow-up after discharge. Some participants discussed minimizing their mental health symptoms to clinicians to retain more autonomy in their care, so that may have also contributed to some TGD individuals being discharged from ED with greater care needs that required sooner follow-up. Furthermore, TGD people may have less options for addressing their care needs outside of the public health system, related to social determinants of health challenges, which may further contribute to greater follow-up with outpatient care after ED discharge compared to cisgender patients.

The three core chapters addressed the study's research questions comprehensively. Chapter 2 outlined the sociodemographic and clinical factors associated with presentations to acute mental healthcare for TGD individuals in Ontario while Chapter 3 followed the same TGD individuals in the month after their discharge from hospital to assess for differences in post-discharge access to physician-based mental healthcare compared to the general population of acute care users. The subsequent qualitative study (Chapter 4), designed using the quantitative findings, was then able to provide significant context and explain the quantitative findings using in-depth qualitative data and a co-constructed theory grounded in the data. Together, these chapters meaningfully and significantly contribute to the literature around access to acute and post-discharge mental healthcare for TGD people. They used health administrative data and rigorous quantitative methodology to clearly isolate factors and outcomes related to acute and post-discharge mental healthcare that are uniquely associated with TGD identity. These findings could then be explored in-depth with the qualitative study that was designed to explain the quantitative findings. I co-constructed a theory with participants and study advisors through the rigorous analysis process that fully explained the quantitative findings and offered mechanisms and pathways linking prior life experiences, including minority stress, to later need for acute mental healthcare and how it all impacts post-discharge access to care. In addition, this dissertation demonstrates the powerful potential of integrating health administrative and qualitative data for the purpose of health services research with marginalized populations. The three studies offer methodological and theoretical considerations for designing and

conducting such a mixed methods study. In the following sections, I reflect on the importance of reflexivity, the contributions of this dissertation, implications for policy and practice, and study limitations. I conclude with some final remarks.

5.2 How Reflexivity Informed the Study

Before discussing potential academic contributions offered by this thesis project, I will share more details of how reflexivity crucially informed and impacted this study throughout.

The data generation process brings up challenges researchers face when navigating ethics and power relations related to the research process (21). In being invited into the lives of participants, it was important to conduct research sensitively and mindfully, which aligns with good quality research in general but also the transformative-emancipatory mixed methods research paradigm in particular (17). For example, one of the participants in the qualitative study repeatedly redirected and declined to discuss the details of their lived experiences in and out of the hospital, opting instead to respond to interview questions in a more vague and general way. While I as the interviewer tried to be transparent in explaining the goals of the research and the overall aim of qualitative research in eliciting the details of lived experience, when they continued to be hesitant about sharing details of their personal experience, it felt important to honour that choice, especially when they alluded to their experiences of the mental health system as limiting their agency and autonomy. It was important to me to not recreate that experience for them in the research process.

Related to the concept of reciprocity in the research process (21), it was also important to ensure that participants were compensated for their time and their generous sharing of lived experience and expertise. Several participants requested a gift card for groceries rather than the standard Starbucks or Amazon gift card, and this was difficult to acquire due to logistical and administrative reasons, but ultimately it was important to honour those requests, especially when our

quantitative study found that TGD Ontarians requiring acute mental healthcare are also more likely to have greater difficulty attaining their basic material needs (22). It was important to me that our research practice and process aligned with our underlying research values and ethics.

How results are interpreted is particularly important in health equity-oriented research. Our quantitative study found that TGD Ontarians were more likely to be diagnosed with a personality disorder than the general population (22), which can contribute to pathologizing of TGD identities if the finding is not properly contextualized (23). Thus, it was important to be clear in our discussion in Chapter 2 that personality disorder diagnoses are susceptible to healthcare provider bias (24,25); TGD people have a greater likelihood of being diagnosed with a psychiatric diagnosis as mental health assessments are often still required to access medical transition (23); and TGD individuals live in a society that is regularly invalidating of their gender, which can lead to personality disorder symptoms (26,27). Clinicians may also more readily misdiagnose personality disorders in the ED setting, where patients presenting with acute distress are assessed cross-sectionally (28). In alignment with a transformative-emancipatory research paradigm, the appropriate framing of results is crucial in research meant to give voice and advocate with community rather than potentially perpetuate longstanding harm. Data do not speak for themselves and are not inherently neutral but require the researcher to interpret in a way that is clear about the perspective being taken, and consistent with the values and rigour stemming from the researcher's scientific paradigm (29).

It is consistent with the emancipatory-transformative research paradigm to center lived experience in understanding the data. It also makes intuitive sense that individuals with lived experience of the phenomena under study would have unique access to insights that would offer explanatory models for better understanding quantitative data. In the example of explaining the increased diagnoses of personality disorders, it was particularly important to co-construct the meaning of the quantitative findings with the qualitative study participants, to interpret the finding holistically and minimize the risk of pathologization. Presenting some of the quantitative findings directly to the qualitative study participants and seeking their

reflections and lived experience expertise was a method aiming to further minimize the distance and power differential between academia and community. Instead of presenting specific statistics, the interview questions for the participants translated the results from the health administrative data into layperson language to improve accessibility of the research findings. In addition, related to centering community voices and minimizing distance between research and community, it was important to seek out the expertise and feedback of trans health clinicians and researchers who also identify as TGD to ensure resonance of findings with community lived experience and also optimally position the results to provide evidence for future potential practice and policy changes to improve the lives of TGD people in the mental health system.

5.3 Research Contributions

This mixed methods research study offers multiple contributions to the extant literature on acute and post-discharge mental healthcare for TGD people. The first quantitative study (Chapter 2) provides evidence for acute mental healthcare utilization being associated with increased measures of marginalization for TGD people. Our study echoes previous United States findings of TGD psychiatric inpatients being more likely in the lowest neighbourhood income quintile (30), and extends that same finding to TGD individuals presenting to the ED for mental healthcare. Our study clarifies that residential instability and material deprivation are disproportionately affecting TGD individuals presenting for acute psychiatric care. Residential instability refers to high rates of family or housing instability while material deprivation measures indicators of poverty and difficulty accessing basic material needs (31). These findings being persistent after matching add strength to the possibility that experiences of marginalization are an important contributor to acute mental healthcare utilization for TGD individuals. This is consistent with evidence that high mental illness rates for TGD people are associated with elevated rates of homelessness, unemployment, and poverty (32–36).

The strength of the qualitative study (Chapter 4) was in clearly illustrating the potential mechanisms and pathways that can lead TGD people from experiencing marginalization to requiring acute mental healthcare. Participants in the qualitative study co-constructed a theory for this relationship, highlighting specifically how the minority stress from developmental trauma, lack of recognition and supports for neurodivergence, physical symptoms and disability, and social determinants of health challenges related to and intersecting with transphobia all contribute to worsening mental health distress. These compounding challenges lead to overwhelming symptoms, combined with an inability to access appropriate mental healthcare in a system not designed for them, led to worsening distress. This eventually led to the ED being one of a dwindling set of options for them to access needed care. However, when the participants did present to the ED, many of them encountered a system they experienced as harmful, unsafe, carceral, and limiting their agency further. For many, the acute psychiatric care system recreated trauma and oppression they experienced in society, and this further damaged their trust in the system, to the point where some no longer trusted the system to care for them at all. Others did find the system helpful and safe enough that they engaged in post-discharge care in the formal system, while still others opted for care through community organizations they experienced as more holistic and integrated, peer-led, destigmatizing, and centering their agency. A strength of the qualitative study was therefore in co-constructing these clear pathways tying these different factors together and explaining the quantitative findings from the previous studies, highlighting several areas for potential intervention to improve care with and for TGD people.

The qualitative study (Chapter 4) further highlighted in detail several unique and intersecting experiences that contribute to mental health symptoms and distress in TGD people. Many studies have confirmed that marginalization and transphobia affecting the social determinants of health of TGD people have obvious and predictable detrimental impact on the mental health of TGD people (37,38). An ethnographic study of TGD people in the United States highlighted the ways in which social determinants of health struggles were interrelated, with housing

instability linked to trauma, interpersonal rejection, poverty, lack of educational and employment opportunities, poor access to healthcare, and other social determinants of health challenges (38). The authors described how housing instability led to mental health distress, which could result in coping through substance use and sexual risk-taking, leading to further financial instability, precarious employment, and other social challenges in a cyclical manner (38). In the context of significant interpersonal rejection and isolation, institutions (including housing resources) that are gender-affirming and the presence of chosen family for support become particularly important for improving mental health (38). The same dynamics described in this aforementioned study were borne out in our qualitative study. TGD participants described how developmental trauma and interpersonal rejection from their family of origin led to housing instability and poverty, which were perpetuated by further marginalization and lack of employment opportunities related to their TGD identity. This study furthers the previous research by connecting these interrelated experiences of social determinants of health challenges, including barriers to accessing needed mental healthcare in the outpatient setting, directly to an eventual need for acute mental healthcare for many TGD people.

Our study goes further to clarify in detail other minority stress factors that disproportionately affect TGD people and contribute to their need for acute mental healthcare, including chronic physical health conditions and neurodivergence. Many studies have consistently found that TGD people globally carry a greater burden of chronic physical health conditions than cisgender people (39–44). TGD individuals are also more likely to have more than one chronic physical health condition concurrently (44). Forty percent of the participants in our study reported having a chronic physical health condition, with several reporting multiple conditions simultaneously, which is particularly noteworthy given how young the participants were on average. A significant number of physical conditions described both in the literature and in our study are inflammation-mediated and suggest that inflammatory processes related to experiencing chronic minority stress, trauma, and discrimination may play an important role in driving chronic disease (e.g., cardiovascular disease) (39,42). Our study extends this discourse by illustrating

how the physical health conditions disproportionately affecting TGD people, many of which are still inadequately understood and lack definitive testing, can lead to invalidation from clinicians and others that compounds the invalidation many already feel related to their gender identity. TGD people with chronic physical conditions may also have greater care and support needs that worsen existing social determinants of health challenges, thus intimately intersecting with existing forms of minority stress and contributing to increasing distress and a potential need for acute mental healthcare. In these ways, our study highlights how chronic physical health symptoms have direct and significant impact on TGD people's acute and chronic mental health challenges and needs.

The association between neurodivergence, particularly autism and ADHD, and gender diversity is well-documented (45–48). Regarding the association between autism and gender diversity, this co-occurrence is commonly proposed to be related, at least in part, to many autistic people inherently questioning and challenging social norms, and experiencing less pressure to conform to and perform stereotypes of gender (47). It is important to highlight that few studies focusing on the overlap of neurodivergence and gender diversity have centered neurodivergent TGD people's lived experiences or engaged them in research design or authorship (48). This enables a cisgenderist-ableist lens (i.e., ideology that produces discrimination against gender diverse and disabled people) and discourse that pathologizes both gender diversity and neurodivergence (49). This cisgenderist-ableist system puts up compounding barriers to accessing needed care and supports for neurodivergent TGD people (48–50). In particular, they have increased difficulty accessing gender-affirming care, in part because the cisgenderist-ableist lens perpetuates the notion that gender diversity is a “symptom” of neurodivergence and therefore questions the validity of neurodivergent TGD people's self-identified gender identity (48–50).

The different diagnostic patterns in the TGD cohorts described in Chapter 2 are consistent with the two- to five-fold higher prevalence of depression in TGD individuals compared to comparison individuals (30,32,51–53). While there are also increased rates of anxiety and trauma-related disorder diagnoses in TGD individuals

described in the literature (30,32,53,54), this was not reflected in our results. This may be related to the cohorts of TGD individuals in our study all being connected with healthcare as opposed to those who are most marginalized and likely not connected with care, who may have different diagnostic patterns. It is also possible that many TGD individuals had diagnoses of anxiety and trauma-related disorders, but they were not the primary reason for the acute care presentation. The multi-fold increase in personality disorders found in the TGD samples in this study may be partially explained by the minority stress theory (26,55). One prominent theory of BPD (i.e., the biosocial theory) posits its development in individuals living in emotionally invalidating environments (26). A society that subscribes to a rigid sex-gender binary (56) where TGD individuals are regularly misgendered can be construed as an environment that is constantly emotionally invalidating. However, diagnosis of borderline personality disorder is also prone to healthcare provider bias (24,25) and this may have impacted our results. Furthermore, TGD people are frequently pathologized and those seeking medical transition are required to have a mental health assessment, both of which can lead to psychiatric diagnoses (23).

The qualitative study participants in Chapter 4 offered further explanations for the increased diagnoses of mood disorders and personality disorders in TGD populations found in the prior quantitative study. Not only does living with regular discrimination and social determinants of health challenges lead to poor mental health outcomes; furthermore, participants made clear the relationship between chronic struggles with minority stress and invalidation, and experiencing society and institutions as broadly unable and unwilling to offer support and care that adequately addresses their needs. Several participants described “living in a system that was designed to go against you”, which can lead to a sense of feeling overwhelmed and hopeless, which was commonly associated with depression for the participants. The participants shared their detailed narratives that clearly illustrate how chronic marginalization can explain the high rates of depression in TGD populations (32,51,52).

Relatedly, participants discussed how chronic regular invalidation and discrimination experienced by TGD individuals sometimes from a young age can

lead to presenting to the hospital with symptoms of BPD. Some also hypothesized that symptoms of personality disorders, such as emotional dysregulation and interpersonal challenges, can be related to other diagnoses and experiences that are more common in TGD people than cisgender people, such as neurodivergence (including ADHD and autism) and complex trauma. Centering lived experiences and community knowledge in this study allowed for explanations of this association between BPD and TGD people that are depathologizing while also triangulating well with existing hypotheses of this relationship (27). It is of note that several participants specifically spontaneously named dialectical behavioural therapy (DBT) as a key treatment that significantly improved their mental health long-term, which is relevant because DBT is a first-line treatment for BPD symptoms (27).

The second quantitative paper (Chapter 3) offers insights into TGD patients' access to mental healthcare in the month after discharge from acute mental healthcare, which is a quality-of-care standard (8,9). There has been a focus on equity in access to post-ED care (1–4), but this is the first study to examine post-ED outpatient mental health physician visits in a TGD population. A previous population-based study in Ontario found that only 40.2% of individuals had a follow-up mental health physician visit within 14 days of discharge from the ED (1). A similar minority (37.7%) of the comparison cohort in this study (Chapter 3) had a post-ED physician follow-up within one month, while over half (55.4%) of the TGD cohort did. Only 6.4% and 15.0% of the comparison cohort in this study had a post-ED psychiatrist visit within 7 and 30 days respectively, which is consistent with the 9.4% of individuals with a post-ED psychiatrist visit within 14 days of discharge in a previous study (1). This highlights the significance of TGD individuals being more than twice as likely to have had a post-ED psychiatrist follow-up. This increased post-ED follow-up persisted even after adjustment, suggesting there is increased need for specialist services for TGD patients. As substance-related disorders and anxiety and related disorders generally have lower post-ED follow-up rates than other diagnoses in the general population (2), this may have made the corresponding increased post-ED follow-up rates more pronounced for the TGD cohort. This increased follow-up indicates greater complexity and severity of mental

health needs facing TGD individuals; likely related to greater rates of comorbidity, suicidality, and experiences of trauma, marginalization, and oppression (32). However, the increased psychiatric follow-up may also partially reflect pathologization of TGD identities leading to greater clinician referrals to specialist care (23).

Moving to post-hospitalization mental healthcare, physician follow-up after a psychiatric hospitalization is known to differ by diagnosis (5,6), geography (6), trauma history (5), racialization (7), and other factors. The study from Chapter 3 of this thesis project is the first study to our knowledge that demonstrates that TGD individuals have reduced access to post-hospitalization mental healthcare. This is concerning as this is a group experiencing greater rates of marginalization and prior psychiatric service utilization suggesting increased illness severity and complexity. The healthcare system is a cisnormative system, meaning that it operates under the assumption that everyone identifies as the gender they were assigned at birth, with a lack of institutional policies to support TGD people in the inpatient setting, which can lead to experiences of discrimination and poor treatment (57). This may have led to disengagement with the system following discharge.

It is important to consider the difference in post-discharge outcomes between the ED and hospitalization cohorts detailed in Chapter 3. If the higher post-ED follow-up rate reflects greater need for care for TGD patients, the lower post-hospitalization rate is a particularly concerning health inequity. Institutional and individual factors may contribute to this discrepancy. Providers may be offering or arranging lower rates of post-discharge follow-up following hospitalization for TGD patients. This may be related to a lack of services perceived to meet the needs of TGD patients. It may also be that the inpatient environment is experienced as distressing, such that even though similar post-discharge care is offered, TGD individuals are less likely to attend. Previous studies have highlighted the lack of guidelines and policy for inclusive care of TGD patients in the inpatient mental health setting (57). As TGD people are more likely to avoid ED care due to valid concerns of discrimination (13,15), it may also be that TGD people presenting to the ED more likely present involuntarily, leading to involuntary hospitalizations perceived as less useful, thus

impacting subsequent help-seeking (58). Since these are only hypotheses that could not be fully explored using health administrative data alone, I conducted a qualitative research study (i.e., Chapter 4) centering the lived experience of TGD people with a history of acute mental healthcare utilization to clarify contributing factors and reasons that would explain the difference in post-discharge outcomes.

Many TGD people avoid the ED due to fears and past experiences of discrimination in the ED setting (13,15,59). In the OutLook Study of TGD participants' experiences in EDs, greater experiences of transphobia were predictably associated with greater ED avoidance, while having social support reliably decreased the likelihood of ED avoidance (59). This resonated with our qualitative study findings (Chapter 4) that prior negative experiences in the ED led some participants to avoid returning, while having people in their life who supported and encouraged them to access care led several participants to feel more comfortable and able to present to the ED. This is particularly important in the context of many TGD people describing experiencing significant isolation and limited social support secondary to chronic minority stress, so helping TGD people connect to community and supports as part of routine clinical care can have knock-on effects towards improving access to healthcare more broadly as well. A recent scoping review on the experiences of TGD patients in emergency psychiatric settings confirmed that there are currently no known qualitative studies of TGD patient experiences in this area (60). Our study is not only the first qualitative study to our knowledge that focuses on TGD people's experiences of the psychiatric ED setting, but we clarified how experiences and perceptions of agency, safety, and usefulness related to the ED presentation influence subsequent engagement with mental healthcare.

There have similarly been limited qualitative studies on TGD peoples' experiences of psychiatric hospitalization. One qualitative study focused on TGD youth (age 13–17) in an inpatient psychiatric hospital setting (61). A recent scoping review on TGD inpatient mental healthcare (57) found seven articles and confirmed that no qualitative studies, to our knowledge, have focused on TGD adults. It was thus crucial to explore in-depth the lived experiences of TGD adults in inpatient psychiatric care to understand how current inpatient settings impact them, and how

institutions and policies could improve. The participants in our study described multiple ways in which TGD inpatients experience a lack of gender-affirming care, from individual clinicians repeatedly misgendering them or asking invasive questions about their gender that were not relevant clinically, to structural issues such as having rigid policies around not being able to contact chosen family or not being able to have room assignments based on gender rather than assigned sex at birth. While the ED setting can also feel carceral and lack agency, participants described how the inpatient setting can be much worse because of the longer time spent in the setting and the greater likelihood of being kept there involuntarily. Participants described how they had to advocate for themselves to receive gender-affirming care – such as the use of their pronouns, being provided with hospital clothing that is affirming, and being able to access their gender-affirming medication – because existing hospital policies were not created with TGD people in mind. Furthermore, participants explained how the acute care setting can often feel carceral and lack agency for cisgender people as well, but TGD people have experienced recurrent trauma and other minority stress in their life that render the lack of agency and the carceral experience of the inpatient setting that much more distressing and invalidating, especially when it recreates transphobic experiences previously endured outside of the hospital setting.

5.4 Methodological & Theoretical Contributions

A strength of the first study of this thesis project (Chapter 2) is the use of two comparison samples – one unmatched and one matched on key characteristics. This allowed for an understanding of the ways TGD individuals differ from general populations who access acute mental healthcare and the unique contributions of TGD status on sociodemographic and clinical factors associated with acute mental healthcare presentation. The large sample of TGD individuals also allowed for adequate power to examine for differences in multiple characteristics associated with psychiatric hospitalizations and ED visits for this population. In total, the unmatched samples are inclusive of nearly every psychiatric hospitalization and ED

visit within the study time period in Ontario. Unlike previous studies that have relied on diagnostic and medical transition-based definitions to identify TGD individuals (62,63), this study used self-reported gender identities to identify individuals, which is more representative of the overall TGD population.

This thesis project also offers a case example of a mixed methods study integrating health administrative and qualitative data to understand the health experiences and needs of a marginalized population. One of the unique aspects of incorporating health administrative data in this way is that health administrative data are often anonymized such that individuals cannot be identified to recruit for the subsequent qualitative study as can be part of other sequential explanatory mixed methods studies (16). This may be a common limitation of such studies. In our study, the quantitative study included large samples of TGD individuals and general population individuals who experienced an acute mental healthcare presentation, and the findings were felt to be largely representative of TGD individuals living in those three cities who have accessed acute mental healthcare as well as outpatient clinical care prior to those acute presentations (22). When designing the qualitative study, we deliberately chose one of the three cities (Toronto) that matched the quantitative study, and we purposively recruited for a participant sample that paralleled the quantitative study in demographics (age, diagnoses). We believe that this improved the qualitative study's explanatory power. While it was not possible for our study, other researchers using health administrative data in mixed methods studies can consider linking data for individuals from specific clinics or other health institutions where they have access to a list of potential participants to recruit for a qualitative study. This would increase the likelihood of the qualitative study participants being from the same cohort as the quantitative study.

The quantitative study guided the purposive sampling strategy in the qualitative study, as the quantitative study highlighted differences that we wanted to explain with the qualitative study. In this way, methods were integrated through *building* from one method to the next (64). We created a recruitment rubric to keep track of participant characteristics we decided to prioritize (65). Since we wanted to explain

the discrepancy observed between post-ED and post-hospitalization follow-up outcomes, we ensured that the participant sample included experiences of psychiatric hospitalizations and ED visits so these experiences could be compared. Since there was evidence from the quantitative data that some TGD people avoided care after their acute care visit and therefore may not be in clinical care currently, it was important to recruit from non-clinical settings (e.g., shelters, community centres) to elicit a diversity of lived experiences around this phenomenon. Since the quantitative TGD cohort skewed young, but included individuals of different ages, we ensured that the qualitative sample roughly matched the quantitative cohorts in terms of age representation. We also kept track of the number and categories of diagnoses (similar to the categories used in the quantitative study) reported by the participants, to ensure a diversity of diagnoses to be able to explain differences in the quantitative data.

Qualitative data also allowed for exploration of important sociodemographic factors that could impact healthcare outcomes but could not be explored using the quantitative data alone (44,66,67). We strived for participant diversity in gender identity (i.e., transmasculine, transfeminine, and nonbinary representation) and racialization, so those factors were also prioritized during recruitment. Diversity in TGD identities is important because transmasculine, transfeminine, and nonbinary lived experiences can be quite different from each other categorically (e.g., the experience of transmisogyny (68)). Racialization was prioritized because of extant literature to suggest that BIPOC experiences are intersectional with gender identity and can be quite different from white trans experiences (69).

From a practical perspective, it was important to make decisions around feasibility of a mixed methods study in a PhD thesis. It was helpful to be clear with the rationale for pursuing a mixed methods study. The qualitative study was added with the specific aim to explain the quantitative findings, so those quantitative findings could be included in the semi-structured interview guide directly, and their meaning co-constructed with participants from the community. The clarity in using the qualitative analysis to triangulate to the quantitative data also allowed for the study

to be narrow and focused in the research questions, which contributed to feasibility and the ability to have a smaller sample size to still be able to address the research question comprehensively, consistent with the concept of information power in determining sample size in qualitative research (70). Importantly, my reflexivity and positionality contributed significantly to decisions in this study, as my values of wanting to build evidence through research to improve care with and for TGD Ontarians combined with my aim of centering the voices of those with lived experience meant that adding a qualitative study was crucial rather than simply supplemental. Reflexivity also clarified my positionality as a researcher, guiding my use of minority stress theory as an important guiding theory in this study, and locating myself in the research to remind myself of how my social location impacts the questions I ask, my power relations with my participants, how I conduct the research, and how I interpret the findings (71).

Theory played important roles throughout the mixed methods study (16). The minority stress theory clarified what research questions to ask and how to ask them, including important measures to collect (e.g., the Ontario Marginalization Index measures) and how to understand the relationships and findings that emerged ((22) and see DAG in Introduction Chapter 1, **Figure 3**, p. 29). The minority stress theory also guided the qualitative study from the study design and the interview guide questions to the codes that were generated and how to frame and present the combined findings of the study (16).

Clarifying my mixed methods study research paradigm was foundational in executing the study from beginning to end. Pragmatism being a guiding paradigm is relevant in a study that is ultimately outcome-oriented in its aim to understand specific health inequities facing TGD Ontarians in a more holistic way in order to point to potential clinical, research, and policy implications and actions (16–18). Pragmatism as a paradigm was evident in our attempts to maximize the similarities between the quantitative and qualitative studies, and in the presenting of the quantitative findings to the qualitative study participants with the aim of shared

meaning-making and communication between the two studies (17). In contrast, a dialectical perspective would have been less focused on solving the social problem of inequities in access to mental healthcare for TGD Ontarians, and may instead have focused more on highlighting the contradictions and dialogue between the postpositivist paradigm of the quantitative study and the constructivist paradigm of the qualitative study (16–18). Our study may then have deliberately compared the quantitative study's limited measure of mental healthcare through physician visits only in contrast to the qualitative study where participants embraced multi-faceted definitions of care and often eschewed formal mental healthcare in favour of care through community, with one participant clearly explaining that community, rather than formal mental healthcare, has "*been the thing that's ultimately saved my life*". A dialectical perspective on our study may also have highlighted the increased diagnoses of personality disorders and mood disorders in the quantitative study in contrast with participants in the qualitative study questioning and deconstructing the limits of diagnostic categories in an oppressive, neurotypical world. A dialectical perspective would put the different paradigms in conversation with each other but would have been less coherently focused on addressing the same research problem.

Relatedly, the use of pragmatism was driven also by the transformative-emancipation paradigm being a strong influence in this study, as the explicit goal of collaborating with marginalized communities to center their voices and advocate for change led me to wanting the quantitative and qualitative components of the study to build on each other to understand and address the same research problem of inequities in care (17). I also decided to invite experts in trans health who also identify as TGD to help guide the analysis to maximize the study's potential to reflect community lived experiences and be used for improving care for TGD individuals. Clarifying the mixed methods research paradigm in this study was thus of foundational importance in grounding a complex study for a junior researcher.

As health administrative data are increasingly used to assess for and highlight issues of inequity around health outcomes and access (7,44,72,73), and there is increasing recognition of the value of qualitative research, and mixed methods research in

particular, in understanding health inequities (74–78); this thesis project offers an example and guidance on methodological considerations in an explanatory sequential mixed methods study meant to explore the health needs and experiences of a marginalized population. This project argues for the importance of paradigmatic considerations in guiding this type of mixed methods research from beginning to end, and also demonstrates the impact of the researcher’s paradigm and positionality on each aspect of the study. We also offer practical guidance around conducting such a study, including specific elements of data collection and analysis, as well as the thought processes and rationale around how decisions were made. This work contributes to the limited literature on how to conduct a mixed methods study using health administrative data when working with a marginalized population, especially when considering the feasibility of such a study in the confines of a PhD program.

5.5 Implications for Policy and Practice

The three studies of this mixed methods thesis project combined offer multiple considerations for clinical care and policy moving forward. Chapter 2 findings highlight the increased diagnoses of mood disorders in TGD individuals presenting for acute psychiatric care. Meanwhile, the qualitative study (Chapter 4) participants described experiences of depression being related to minority stress and inability to access care. It is also notable that in the study from Chapter 3, the second quantitative study, TGD individuals with a primary diagnosis of mood disorders had reduced mental health follow-up with a family physician in the month after discharge, especially as this represented 40.1% of the TGD cohort. TGD individuals have an estimated multi-fold increase in depression (32,51,52) and a ten-fold increase in suicide attempts compared to the general population (32,79,80). Family physicians can play a key role in treating depression as they are often the first point of contact with the healthcare system (81) and can provide gender-affirming care that reduces depression and suicidality (82,83). Perhaps these findings from our study provide evidence to support the integration of greater mental health training in trans health education for primary care providers (84,85). This may also partially

address the significant unmet healthcare need reported by TGD Ontarians (86). Family physicians may be particularly well-positioned to address mental health needs in the context of our qualitative study finding that physical disability and symptoms can contribute significantly to mental health distress. It may thus be helpful to incorporate education around the greater burden of chronic physical health conditions that TGD people experience as part of integrated trans health education (39–44). Trans mental health training for primary care providers may also want to have a focus on addressing social determinants of health, connection to community, and maximizing agency as key factors for improving TGD patients' mental health long-term. This training for primary care providers is especially important given evidence that many TGD Ontarians have not felt comfortable to share their health needs fully with their primary care providers (14,15,87).

As some of our qualitative study participants described (in Chapter 4), many people experience gender identity, disability, and neurodivergence each as part of their identity. When an individual embodies all of those identities, the challenges they face in terms of discrimination and lack of supports related to each of those domains can converge and multiply (49,50,88). This experience can feel overwhelming and magnify distress, which, in turn, likely explains the greater need for acute mental health services and the adverse experiences of these services (42). Relatedly, a prior qualitative study of autistic TGD adults highlighted the multiple ways that the respondents experienced the world as not being set up in the right way for them (50). However, the participants highlighted the ways in which they challenged the oppressive systems, including through claiming space and creating affirming community, and being selective in who to disclose which parts of their identities to (50). All of the above resonates with the multiple TGD participants in our qualitative study who reported being neurodivergent, as they felt doubly invalidated on a daily basis and unable to access holistic care that considered their entire being. Previous literature with neurodivergent TGD participants reported some familial support for either gender identity or neurodivergence but rarely both; and how biological family members can miss and minimize neurodivergent behaviours (48,50). This aligns with the participants in our study desiring access to clinical assessments for

ADHD and autism that do not require or as heavily prioritize collateral information from biological family to make the diagnoses. Further resonating with previous literature (49,50,88), the neurodivergent TGD participants in our study also called for mental healthcare providers who are competent in both neurodiversity and gender diversity and the intersectionality between them, who offer support that helps them navigate the barriers to accessing care for both, who challenge pathologization and opt for a more strengths-based approach to their care, and who recognize the importance of connection to community for them. Our study highlighted how the lack of neurodiversity-affirming care intersected with their other minority stress challenges and furthered their experience of the mental health system as fragmented and unable to address their needs.

The qualitative study participants' experiences (Chapter 4) support several recommendations from previous studies on how to improve gender-affirming care in the acute psychiatric setting (57,60). Our post-discharge findings from Chapter 3, when integrated with qualitative findings from Chapter 4, suggest that addressing these practice and policy concerns are needed to reduce the experiences of harm and the inequities around access to post-discharge care for TGD patients.

A previous article suggested that having clinical champions knowledgeable about TGD health identified and available to support other clinicians and patients could be helpful to improve the experience of TGD patients (60). Perhaps there is a role for a team of providers available in the acute hospital setting who are experts in TGD health, which other hospital teams can consult to offer a more holistic and integrated assessment and care recommendations for TGD patients who present for care, similar to the role of a consultation-liaison psychiatrist in acute care settings (89). This team would address stigma and discrimination in the acute hospital setting by partnering with staff in the ED and inpatient units to provide education, implement and evaluate practice and policy changes, and offer consultation on gender-affirming care for specific patients. The goal of such a team would not be to further fragment care by subspecializing TGD health expertise. Instead, such a clinical service is meant to recognize the current lack of gender-affirming care knowledge and practice in hospital settings, and thus it would aim to target this gap

by building competence and capacity in providing gender-affirming care with clinicians in their specific settings all across the hospital. Any such program should be developed and evaluated through mixed methods research with TGD patient engagement throughout to facilitate iterative improvements and share any learnings with other providers and institutions.

Previous studies have also recommended hospital policy changes that can improve care for TGD patients, including improving communication systems (such as electronic medical records) to facilitate documentation and communication of chosen name and pronouns for patients, ensuring confidential spaces for TGD patients to provide history in the acute care setting, allowing for chosen family and support people to be present to support them, creating TGD-specific resources and clinical expertise available for further support as needed, and ensuring housing assignments by gender rather than sex (15,57,60,87). Based on our study, other important considerations for improving care from a policy perspective include facilitating access to gender-affirming gear to support gender expression, including clothing, binders, gaffs, hair dye, razors, make-up, etc. Future research could use qualitative methodology to understand potential barriers and facilitators of some of the above suggested changes, particularly from the perspectives of clinicians and policy makers, including potential concerns related to safety in the acute care setting such as with access to razors. Exploring their perspectives can illuminate the perceived barriers to the above recommendations to facilitate change.

Our study findings also lend evidence to support potential mental healthcare interventions that could prevent the need for acute care for TGD people and also improve the quality of care post-discharge even when acute care is still required. As social determinants of health challenges are main drivers of mental illness in TGD people (from the results of Chapters 2 and 4), addressing social determinants of health as a primary treatment goal may be particularly helpful in improving their mental health. Housing First is a model that provides rent supplements for people with mental health and substance use challenges who are experiencing homelessness to access housing in the community and recovery-oriented supports that are uncoupled from the housing support (90). This model centers consumer

choice and harm reduction, supporting clients to access as much or as little clinical care and supports as desired (90). A randomized controlled trial to assess the effectiveness of Housing First in helping frequent ED users with a mental illness achieve housing stability, improve mental health and functioning, and reduce ED use found that the program was indeed able to stably house frequent ED users, reduce their ED use and substance use issues, and improve mental health symptoms and functioning in the community (90). As the name implies, this Housing First intervention aims to treat housing stability as a primary treatment goal to improve mental health of participants separate from whether they choose to access clinical care at all, centering their agency and their social determinants of health (90). This model is an example of potential programs that can be developed and evaluated to target the social determinants of health needs that TGD people with acute mental health challenges often have. A mixed methods evaluation of an LGBTQ2S population-based housing program found that participants living with this housing program reported improvements in mental health related to feeling more stable and independent, having opportunities to connect with community, getting support to access medical transition, and being able to live as their true authentic selves (91). This is an example of the potential for focusing on addressing more upstream social determinants of health as a primary clinical focus to improve overall mental health and quality of life. However, the same study noted that youth in the LGBTQ2S housing program still reported unmet mental health needs (91), which is consistent with several participants in our qualitative study describing that despite opting for care in community organizations over the traditional mental health system, they had residual unmet mental health needs.

Connecting to care in community organizations was described repeatedly as preferable by multiple participants in the qualitative study (Chapter 4), as they outlined the superior aspects of community care over the biomedical model; including access to peer-led services and supports, much more agency in how to access care, a depathologizing model of mental healthcare, opportunities to connect to community, and practical and other supports that address their social determinants of health needs. A previous ethnographic study outlined how TGD

people preferred peer support over traditional mental health services, and found that engagement with peer support and TGD community improved the mental health and well-being of TGD people in part because it normalized TGD identities and experiences, helped develop a social support network that was often more helpful and knowledgeable than professional mental healthcare providers, and empowered TGD people to both receive support and support others (92). This resonates with many of our participants' reports that community care was often experienced as safer and more useful than traditional mental healthcare. However, as services in community organizations alone may not fully address the mental health needs of TGD people (91), perhaps embedding elements of traditional mental healthcare into community organizations can foster greater engagement, uptake, and trust with marginalized communities including TGD communities (93). Providing more traditional mental healthcare in community organizations may facilitate access to care earlier and prevent the need for acute care later on, while also collaborating with community organizations to offer care that is experienced as more holistic and less fragmented.

5.6 Future Directions

Our mixed methods study found that TGD individuals who use acute mental healthcare are more likely to follow up with mental healthcare after discharge from the ED but less likely to follow up after hospitalization. One explanation from the qualitative study is that the TGD hospitalization cohort was more likely to have been involuntarily hospitalized, taking away their sense of agency and keeping them in a setting that many found transphobic and unhelpful. These findings create a hypothesis that can be further explored using health administrative data.

A future sequential explanatory mixed methods study could compare the relative rates of involuntary psychiatric hospitalization between TGD and non-TGD individuals in Ontario using health administrative data. TGD and non-TGD individuals can then also be stratified by voluntary versus involuntary hospitalizations, assessing for the length of stay in hospital and the psychiatric

symptom severity at discharge to use quantitative data to test our qualitative theory. These factors can then be examined as potential predictors of post-discharge follow-up at 1, 3, 6, and 12 months using multivariable logistic regression analyses. The quantitative results would guide the subsequent qualitative study design, which could include interviews of TGD patients during psychiatric hospitalization and again three months after discharge to understand their lived experiences and explain the quantitative findings using constructive grounded theory. The qualitative study could probe in more detail for factors that impact perceived safety, usefulness, and agency surrounding the hospitalization; which were major themes found to impact post-discharge follow-up in this thesis study. In this way, qualitative research is used to create theories to explain quantitative outcomes, and then quantitative data are used to test the qualitative framework in specific ways in an iterative manner that leverages the strengths of each methodology to generate new knowledge for evidence-based care (16).

Historically, clinical training in TGD health has been inadequate to provide healthcare providers with confidence and competence in gender-affirming care (85,87). Our study highlighted several topic areas that should be included in future TGD health training for mental health clinicians and staff. Clinicians and staff can benefit from more training around cultural humility, reflective practice to identify personal biases, and using gender-affirming language including chosen name and pronouns (57,60,87). Other important training areas include the impact of minority stress on TGD people and how that leads to mental health symptoms and distress, how to provide trauma-informed care that incorporates intersectionality and affirms other aspects of patients' identities including neurodivergence and disability, and resources to connect TGD patients to community and support their social determinants of health. Future research can use a mixed methods program evaluation approach (16,94) to iteratively develop, evaluate, and improve training for acute psychiatric care providers in TGD mental health. This educational program should involve co-design with both TGD community members and acute care clinicians for improved uptake and impact. Outcomes for care providers should be measured longitudinally, as program evaluations for TGD health training often focus

on short-term impacts that may have limited benefit for patients long-term (85). The mixed methods evaluation should also examine the impact of the program on direct TGD patient experiences and outcomes, as that is the ultimate goal of the program. These outcome data can then be integrated with qualitative data from participating clinicians and TGD patients to examine the mechanisms of change and the barriers to that change so that the program could be iteratively improved and evaluated further in a cyclical manner (16). The Project Extension for Community Healthcare Outcomes (ECHO) program is an example of a model that aims to increase health system capacity to manage the care of patients with certain medical needs/conditions within their communities through education, mentorship, information, and support for community healthcare providers on specific medical topics (95). Project ECHO has been shown to improve outcomes at the patient level, at the practice level, and in objective clinical measures (95).

Finally, I would like to revisit the Chapter 2 finding of increased diagnoses of personality disorders in the TGD cohorts who received acute psychiatric care. Several participants in the qualitative study (Chapter 4) later spontaneously and specifically named dialectical behavioural therapy (DBT) as an important treatment that significantly improved their mental health long-term. This is important to highlight because DBT is a primary treatment for borderline personality disorder (BPD) symptoms (27). Our qualitative study results resonate with prior assertions that BPD symptoms can be more prevalent in TGD people due to chronic experiences of invalidation and minority stress regardless of whether they meet diagnostic criteria for BPD (27,96). There is also the potential for complex trauma and neurodivergence to produce similar symptoms and behaviours (e.g., emotional dysregulation, interpersonal conflict, deliberate self-harm, suicidal behaviours) that could benefit from DBT (i.e., mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation skills), as described by our participants in the qualitative study. DBT can be particularly beneficial for TGD people because a central tenet of this therapy modality is embracing the dialectic of acceptance and change, which can be applied to TGD people around accepting that they live in a world where discrimination and oppression exist while recognizing that they can

make changes in their life to create a life worth living regardless (27,96). DBT skills may be beneficial to TGD individuals independent of a diagnosis of BPD. It would be of value for clinicians to consider working with 2SLGBTQIA+ community organizations to build greater capacity for DBT to be offered in these settings to reduce the barriers to access that currently exist.

Clinicians have previously offered some recommendations on how DBT can be adapted to better suit the needs of TGD clients; including by incorporating minority stress, using a strengths-based approach that fortifies resilience, and engaging in advocacy and consultation to the environment (27,96). It would be helpful to further develop and manualize DBT adapted for TGD people's mental health needs, and evaluate this treatment such that it can be improved and disseminated. Future research can pursue a mixed methods evaluation of such a DBT program (97) using validated measures to monitor symptoms and behaviours before and after the intervention, and then use qualitative methodology to explain the quantitative data and improve the clinical intervention. A previous Cognitive Behavioural Therapy (CBT)-informed group intervention tailored for sexual and gender minorities was similarly developed and evaluated (98). Since there is significant overlap between gender diversity and neurodivergence, future research can also use mixed methods to develop and evaluate DBT programs adapted for neurodivergent TGD people. A recent article by clinicians and researchers describe how DBT skills can be useful for autistic people to address emotional and sensory challenges, recommending modifications to adapt DBT for autistic people including visuals, graphics, and a gaming format that target individual personal interests (99).

5.7 Study Limitations

In reviewing the mixed methods research study's strengths and potential contributions to research and practice, it is also important to discuss several limitations of this study.

Health administrative data may not capture important variables for equity-oriented research as the data are not captured prospectively for research purposes or

specific research questions (66). Health administrative data in Ontario are currently not able to readily identify TGD people. To overcome this limitation, one of my thesis committee members had previously identified TGD people through linking data obtained from four outpatient 2SLGBTQIA+ specialty health clinics with the capacity to systematically identify TGD people in their clinic electronic medical records in three cities (Thunder Bay, Ottawa, Toronto) across Ontario to existing health administrative databases (44). However, we were not able to identify all TGD people based on this process in this study, and the findings may not generalize to TGD people living in other areas of Ontario, particularly in smaller cities and rural areas. It was also not possible to analyze the data by gender identity because one of the four clinics did not capture the specific gender identity of the clients presenting to the clinic. Future studies could benefit from linking data from other settings and in more cities and towns throughout Ontario, ideally including linkage through community organizations and other non-clinical settings to be able to include individuals who may have low contact with clinical care. The Canadian Institute for Health Information (CIHI) provides guidance on and recommends documenting self-identified gender in health and other administrative sources as an important measure for reporting health inequities (100).

In the TGD samples in the health administrative data, some of the sociodemographic and prior mental healthcare utilization differences may reflect the specific TGD sample (44) and may not be specific to those with acute psychiatric care utilization. TGD samples are also representative of TGD individuals who have a valid OHIP card; have had a mental health hospitalization or ED visit; and have accessed care at clinics in larger cities. This may limit generalizability of findings. In the first study (Chapter 2), we addressed these limitations through matching to isolate the unique contribution of TGD status on acute mental healthcare utilization. However, matching likely did not remove all variation in mental illness severity between TGD and comparison groups, which may have also impacted results. Since TGD status was based on self-report, some individuals may not have disclosed their identity and thus would have been excluded from the TGD samples. The comparison samples will include TGD individuals who were not identified to form the TGD samples. However,

this would have low impact due to the low prevalence of TGD people in the general population (101), so the vast majority of the comparison samples are likely to consist of cisgender individuals (30,63). Also, this kind of misclassification would bias results towards the null since it would make the two groups more alike.

In the quantitative studies, consistent with prior research (102), if an individual presented again for acute psychiatric care within 30 days of the initial discharge, the index date was reset to the discharge date of the second acute care visit to allow for a sufficient window for physician follow-up to be observed. However, individuals with a third discharge date within 30 days after a second discharge date were excluded because this is a comparatively small number of patients (1.5%) with likely significantly different clinical needs and characteristics than the general population of acute care users (102).

In the second study on post-discharge outcomes (Chapter 3), limitations include that selection bias may be present as the TGD cohort individuals were assessed at an outpatient clinic, increasing likelihood of post-discharge follow-up as they have engaged in healthcare. This was addressed by adjusting for previous mental healthcare utilization. This study was likely underpowered to fully detect differences broken down by diagnostic categories, so future studies may wish to identify more TGD individuals through data linkages with more healthcare institutions in more regions of Ontario. Outcomes also do not capture non-physician mental healthcare, which is an important limitation in interpreting the quantitative findings. This was addressed in part through a subsequent qualitative study that explored TGD patients' access of non-physician mental healthcare after discharge and how that may have impacted post-discharge quantitative findings.

There is no direct measure of need for post-discharge follow-up, so the differences in post-discharge follow-up between the cohorts could be explained by differing need for follow-up between the cohorts, but a higher rate of post-ED follow-up for TGD individuals suggests greater need (or greater propensity) for follow-up after ED visits, which contrasts with lower rates following hospitalization. Additionally,

there is a standard of care suggesting post-discharge follow-up should occur regardless (8).

Race and ethnicity data are often not captured in health administrative databases (66), which similarly limits the ability for these data to examine important dimensions of health equity that different groups face. There are multiple calls for more inclusive variables to be captured in health administrative data; including gender identity, sexual orientation, and race and ethnicity (44,67,103). In the meantime, there have been innovative though still limited methods to address these challenges, such as using a validated surnames algorithm to identify Chinese and South Asian individuals in health administrative data in Ontario (7). At ICES, which is the institution where the health administrative data in the quantitative studies were hosted and analyzed, there has been increasing recognition of the importance of collecting and reporting on race-based data responsibly and engaging with community respectfully to do so (104).

Relatedly, a limitation in the qualitative study is that none of the participants identified as Black. While the study reached data saturation despite this limitation, and the qualitative data adequately captured and explored the phenomenon under study, a future study may want to specifically examine the experiences of racialized TGD people in navigating acute and post-discharge mental healthcare. Though it was not used as a guiding theory in this study, the use of intersectionality to identify how intersecting systems of oppression (e.g., racism, transphobia, classism, sanism, etc.) may operate in and around the healthcare system to impact TGD people's access to mental healthcare may be of interest in future research (105).

The TGD participants in the qualitative study were also relatively young and there were fewer older participants, so there may be limitations to the transferability of the findings for older TGD people with acute mental healthcare experiences. We wanted the qualitative sample to reflect the demographics of the TGD cohorts in the prior quantitative studies in order to best position this study to be able to explain the quantitative findings, so the younger ages of our participants correspond with the younger ages of the TGD cohorts in the quantitative study (22). Furthermore,

there is evidence that there are more people in Ontario identifying as TGD who are below the age of 35 than above (101), so our sample also reflects the demographics of the broader community.

Our exclusion criteria for the qualitative study included excluding individuals experiencing active manic symptoms, acute substance intoxication or withdrawal, or significant cognitive impairment affecting their ability to consent to the study participation. These exclusion criteria were meant to exclude those with difficulty demonstrating informed consent to participate in the study. These experiences also increase the likelihood of having interview responses that are tangential or difficult to understand. People who have bipolar disorder or substance use disorders could still participate in the study; they just could not participate when acutely manic or intoxicated/in withdrawal. In fact, one participant reported having a diagnosis of bipolar disorder.

No participants in the study reported having a diagnosis of a psychotic disorder or a substance use disorder, which limits transferability of these findings to TGD patients with these diagnoses. However, there was intentionality in enriching the qualitative sample with participants who are well positioned to help explain the quantitative findings, and we had found through the health administrative data that there were increased diagnoses of depression and personality disorders in the TGD cohorts, with corresponding reductions in substance use and psychotic disorders as the primary diagnosis for presenting to acute care (22). In addition, many participants described struggling with substance use during their interviews even though no one reported being diagnosed with a substance use disorder, so this may reflect low mental health literacy in the general population around substance use disorders existing as diagnoses or being diagnosed separately from other psychiatric diagnoses.

There is also limited transferability of the findings outside of the Ontario context, because there can be significant differences in the laws, policies, and clinical care practices that shape hospital-based care and mental healthcare in different contexts. However, many of the experiences described by the participants, including minority

stress experiences, transphobia in healthcare settings, and barriers to accessing care have been well documented in multiple settings globally; suggesting that at least some of the themes and experiences shared by the participants would resonate across contexts.

Another important limitation in this study is that the TGD advisors were not fully involved throughout the study from study design through to analysis. The extent of community involvement was limited in the study due to it being a PhD thesis study. I sought out TGD advisors to improve the scientific rigour and engagement with community during the analysis process. The advisors were also invited to be co-authors in future publications related to this study in recognition of the value of their contributions.

A final consideration around methodological limitations is that there was only one primary coder in the qualitative study. Again, this was influenced by the study being a PhD thesis study. However, multiple methods were used to ensure credibility of the findings and scientific rigour; including ensuring data saturation was reached through a rigorous analysis process consistent with constructivist grounded theory (19), having multiple discussions throughout the study including throughout analysis with a thesis committee member with extensive qualitative research experience who also reviewed full transcripts and coding, incorporating feedback from discussions with multiple TGD advisors, and triangulating the qualitative data with the health administrative data and existing literature.

5.8 Conclusion

This dissertation examined the acute and post-discharge mental healthcare experiences of TGD individuals using both health administrative data and qualitative research in a sequential explanatory mixed methods study (16). Early post-discharge mental healthcare access for TGD patients is a health access and equity issue, and had not been examined using health administrative data previously (1–7). Qualitative studies of TGD adults' experiences of acute and post-

discharge mental healthcare had also not been previously examined (57,60). Our quantitative findings shone a spotlight on unique factors associated with TGD individuals' need for acute psychiatric care, particularly factors related to experiences of marginalization and diagnostic differences (22). The quantitative post-discharge outcomes also highlighted the discrepancy in access to mental healthcare for TGD individuals following an ED visit versus a psychiatric hospitalization. The use of population-based health administrative data and rigorous quantitative methodology allowed for the isolation of the contribution of TGD identity on acute and post-discharge mental healthcare outcomes with high validity and reliability.

The apparent paradox in the quantitative post-discharge outcomes (i.e., the differences between post-ED and post-hospitalization follow-up) showcased the power of mixed methods research, qualitative research, and centering lived experience in explaining the quantitative results beyond the limits of the health administrative data alone. The rigorous qualitative research process facilitated a detailed co-constructed model of TGD patients' experiences before, during, and after acute psychiatric care. This theoretical model not only offered explanations for all of the quantitative findings, but it also provided narratives and pathways to understand in-depth how early life experiences, minority stress, marginalization, psychiatric diagnoses, and mental healthcare utilization were all linked together. The qualitative results demonstrated the immense value of lived experience and in-depth qualitative methodology in answering the *why* questions around health inequities that quantitative methodologies alone struggle to answer (74–78).

The qualitative findings also offered multiple evidence-based avenues to address inequities in mental healthcare affecting TGD Ontarians. While the quantitative data highlighted differences in diagnoses, experiences of marginalization, and post-discharge access to mental healthcare; they did not point readily to tangible next steps of action towards addressing these inequities. In contrast, analysis of the qualitative data highlighted *how* TGD people's care needs were not adequately addressed in and out of hospital. The qualitative study participants identified multiple layers of needed changes to improve care in the system, including

prioritizing autonomy and agency in the mental healthcare system, addressing of social determinants of mental health, offering connection to community, and providing support in navigating a complex system. Data analysis centered the lived experiences of TGD participants in the mental healthcare system to highlight tangible data that institutions, healthcare providers, and policymakers can use to improve care with and for TGD patients moving forward.

This dissertation also offered methodological considerations for other researchers wanting to integrate health administrative data and qualitative data in a sequential explanatory mixed methods research study for health services research. The researcher's paradigm and values, the importance of reflexivity, the use of theory, and the intentional mixing of the quantitative and qualitative studies guided the mixed methods study from beginning to end. Integrating the two types of data leveraged the strengths of each, and helped compensate for the limitations of each, to examine the research problem from different perspectives, resulting in a complementary and more holistic understanding of the acute and post-discharge experiences of TGD people. Perhaps most importantly, this thesis project demonstrates the importance and the power of centering lived experiences of marginalized communities to truly understand health inequities that impact them in healthcare research. It is not only possible, but an imperative, to ensure that community voices are not marginalized in the very research that is meant to understand and address the health inequities they face.

5.9 References

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