Dr. iur. Jovan Kojičić

Illusory System

Human Rights and Mental Health

LGBTIQ socijalni centar

Ministarstvo ljudskih i manjinskih prava

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i manjinskih prava

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LGBTIQ Social Centre
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Human Rights and Mental Health

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Foreword

The book before you was created as a response to the clear and chronic need of the LGBTI community in Montenegro for scientifically based and clearly understandable resources in the field of protecting our mental health. Through the realised research and multi-layered intersectional analysis, *Illusory System: Human Rights and Mental Health*, authored by Dr. iur. Jovan Kojičić, is exactly that key resource which the LGBTI community in Montenegro lacks.

In addition to presenting real problems, which were pointed out by LGBTI people themselves, this book also draws numerous parallels with the context in other countries around the world, where similar processes have been taking place for decades and where there are systems that protect the welfare of marginalised social groups more than that is the case in Montenegro.

The path that led to the creation of this publication was long and challenging, but its importance is even greater so. It can and should serve as a guide to all institutions of the system on how to approach concrete and effective reforms, with the aim of creating a mental health protection system for LGBTI persons, which practically does not exist in our country, that is, it relies on the work of civil society organisations.

Without deep-rooted reform processes, which penetrate much deeper than the field of mental health—they must include the education system, the entire public health, the judiciary, the security sector, and others—we cannot talk about essential improvement for LGBTI people, but also for all citizens of Montenegro. This book is a guide to that.

John M. Barac
Editor

Introduction

The book in front of you provides an overview of the literature on the mental health of LGBTIQ persons and defines key deficiencies and differences in Montenegro. It analyses the collected data of the Montenegrin LGBTIQ community on access to mental health, points to unrealised mechanisms of human rights policy and health policy, and related policies. It points to the causes of inequality and the continuous (decade-long) failure of the authorities to intervene and solve people's health problems, which seriously violates their human rights.

The mental health of the LGBTIQ community is just one of a series of shortcomings on the standards, measures, and governance of health authorities and competent authorities for human and minority rights, as well as other authorities—to take reasonable and effective actions and intervene in solving the problems of citizens. The shortcomings of cross-sectoral disconnection and the related negative impacts are visible. They are unfair and socially harmful. Although this is an important area of consideration, it was beyond the focus of the present study. All of this complicates the assessment of serious systemic obstacles and possibilities for intervention regarding real problems. In this regard, further research is necessary.

To illustrate, the physical health of a nation cannot be viewed outside the context of mental health (about the common good) and vice versa. That would be one segment of the indicator of the level of entanglement. However, solutions require a synergy of different policies, indicators, and levels of intervention. For example, the physical health area of cardiovascular disease, stroke or lung cancer must share impacts on mental health. These are serious health sector problems that burden the entire population. However, public policies do not offer reasonable and meaningful answers and solutions for this. As a result, there is the creation of systemic obstacles in the provision of health services for all, and the effects of minority stress on LGBTIQ persons are particularly strong.

As key recommendations in the study, I emphasise the necessity of reforms in the approach and creation of public policies (health, human rights, environmental, social and others; Recommendation 1 and 2). It is important that this be done with *true* respect for the Government's methodology. For decades, this was not the case. If it were otherwise, the mental health of the LGBTIQ community and access to health would long ago have been the subject of serious analysis and attention, and psycho-social support programmes would not have remained without support. The problems lie in the redistribution of resources and the lack of respect for the reasons for which the administration exists. And those are the citizens. In our discussion it is the LGBTIQ community. This fact alone makes it clear that definitions and values have been neglected. And betrayed. The general impression in the community is that decades of practice in the creation of public policies are more like a matrix of copying arbitrary measures, rather than focusing on real reasons and problems. That is why it can be said that instead of public policies, we have '*public policies for the sake of policies*'. The result is negative.

Dr. iur. Jovan Kojičić
The Author

About the Author

Jovan Kojičić is a law professor. He is a visiting professor at the Centre for Medical Law at the Faculty of Law of the University of Göttingen and the Jean Monet Chair for European Politics at the University of Passau, FR Germany. He is a scholar of the Williams Institute at the University of California School of Law (UCLA), in the United States of America. His research in health and health policy is supported by the German Academic Exchange Service (DAAD, 2023).

Kojičić received his Doctorate of Law at the European University Viadrina in Germany (2001-2005). During his doctoral studies, he was awarded a prestigious scholarship from the German Academic Exchange Service (DAAD). He completed his postdoctoral studies at Lund University in Sweden, on the topic of the relationship between law and social changes, with a profile at the intersection of law and social sciences and with an emphasis on policy development, distributive justice, institutional reforms, and practice (2008-2010). He worked as an international consultant at the UCLA School of Law – Williams Institute in Los Angeles, California, United States of America, and as a researcher and development expert at *Egale Canada Human Rights Trust*, in Canada. He was a visiting assistant professor at the Department of European, International Public and Public Law at the Faculty of Law of the University of Leipzig, FR Germany (DAAD, 2008).

Since 2006, he has been involved in the project “Justice in the Balkans: Equality for Sexual Minorities”, which has grown into an international movement of renowned professors, lawyers, public figures, and representatives of civil organisations. Dr. Kojičić is a member of the DAAD Alumni Club Montenegro, the European Commission for Sexual Orientation Law (ECSOL) for Montenegro, and the main organiser of the international conference “Justice in the Balkans”. He is the author of numerous scientific articles, books, book chapters, and theses in his area of expertise.

Summary of the Intersectional Analysis

30 key arguments about the minimum possible standard of health

1. An Exhausting Experience

The struggle of the Montenegrin LGBTIQ community with anxiety and depression is exhausting enough that its members feel that they need to distance themselves from their own potential, dignity, and personal well-being. Health authorities and those responsible for human and minority rights fundamentally do not think about the community. The expected respect does not exist. There are no appropriate and methodologically sound policies for progress to happen at all. The constant adaptation of the community to social and cultural heteronormative pressures and expectations are widespread and chronic and have become the norm. Harmful effects on health are multiple and multidimensional.

2. Unscrupulous Opportunism

The absence of methodology invalidated values and made real health problems invisible. It is assumed that they were concealed because they were not unknown. It was not in the interest of the authorities to show the problems, because a bunch of problems would indicate bad governance and the dysfunctionality of the system. Montenegrin citizens measure the achieved results by hundreds of lost years of life expectancy. Avoiding solving problems for the sake of preserving one's own political privileges and political and personal comfort was determined by unscrupulous opportunism in governance. It is associated with authoritarian rule and the dominance of political power.

3. The Logic of One Party

The problems are rooted in social norms and are reinforced by decades of systemic anomalies that were created by the authoritarianism of government, the dominance of power and interest (political) games. The so-called “conveyor belts” were in the function of control, including social processes. This prolonged the agony and seriously slowed down the long-awaited social changes. Decades of governance façade shaped the cosmetic variants of public policies in the long term. This is recognised in the difference between political fraud and good (proclaimed) governance. In combination with numerous other limitations, but also due to persistence in creating anomalies, a bad reputation has been created in the international community about the system and governance.

4. Systemic Limitations

Socio-economic determinants of health are not considered, and there is no institutional and political design to accompany them. Constitutional guarantees and laws have not been a benchmark for exercising and enjoying rights for decades. Possibilities for action are limited, and every activity is “beyond belonging” to the definition that is (are) being pursued and without the possibility of communication and action. The created system has deprived itself of the original governance function. It did not represent a logically organised and non-contradictory set of legal definitions (expectations) that should all be mutually exclusive,

depend on each other and guarantee adopted values, respect for human rights and human dignity. In the absence of the former, expectations are betrayed, and social reproduction itself is flawed. The result is negative.

5. Social Consequences

All together determined the relevance and character of the society, but also the systemic inability to respond to the challenges of European integrations. Dysfunction exists at all levels. Regulations do not monitor and/or develop mechanisms to provide a systemic response to expected requests. As a result, weak institutions were created, which is conditioned by numerous inconsistencies and contradictions. At the same time, intelligentsia and young people, as well as medical doctors, were leaving the country. According to the philosophical narrative, these were systemic anomalies for which analytical objectivity in intelligence was not the goal, nor were they necessary for the (so) created system.

6. Community as a Screen for the World

In the processes of Euro-Atlantic integration, the LGBTIQ community was used as a cover. This became visible because it has been waiting for a full seven years (since 2016) for the government to implement the activities promised to reflect the actual contents of the law systemically at all levels of governance: in access to health, education, social services and services, employment, environmental policy, justice, and other. Therefore, it is more than obvious that in the integration processes it was important to satisfy the international community, and not the needs of LGBTIQ people. Observers and interested parties are misled, and the political fraud about the proclaimed values is covered up.

7. Politicisation of Inequality

The extensive review of evidence in this book indicates that public policies have ignored demands and know next to nothing about health inequalities for decades. Moreover, it can be said that health inequality is politicised. Various dimensions related to socio-economic and ethnic conditions, including sexual orientation and gender perspective have been excluded from governance models for decades. It has never been the goal of the authorities to inform themselves, to encourage research and improve public policies, but also to foresee effective public health interventions to help citizens face challenges and inequalities, especially vulnerable social groups.

8. Consequences of Cosmetic Policies

The problems of the absence of vision are significant and more serious. They are systemic, structural, and last for decades. They are additionally seasoned with façade models and unscrupulous opportunism. No one in the administration deals with it, to identify inherited anomalies. For example, to define widely recognised party recruitment, political servility and personnel incompetence against efficiency and expected development. That is why the expected processes are very slow, and the consequences of such policies are multiple and have various negative effects on the health and mental health of the nation.

9. Domination of Power

Minority stress theory recognises homonegativism as a root cause of health disparities for the LGBTIQ community. However, although the Montenegrin authorities have promised the international community changes in the approach to public policies, the authorities have been avoiding acknowledging health disparities for a whole decade, and other public policies continue to ignore all links about inequalities. This applies to all marginalised social groups.

For the sake of illustration, the Montenegrin authorities have decades of experience in avoiding establishing a registrar of persons with disabilities, which is essential for the enjoyment of their rights and access to health. These were measures that were written in the plans but were never implemented. That would be just one of the numerous arguments in defining the difference between political fraud and good (proclaimed) governance, in using LGBTIQ issues as a cover for Euro-Atlantic integrative processes and misleading the international and LGBTIQ community.

10. Corruption

The dominant majority of Montenegrin citizens perceive corruption as a “normal” pattern of behaviour. International reports and analyses of prestigious universities warn of a “trapped state”. For decades, health authorities have failed to be effective, optimise health and minimise the burden of disease, especially for vulnerable groups. This is also connected with a consistent, decade-long lack of funding for health and mental health research, as well as the development of various support programs.

11. Structural Defects

In this way, marginalised social groups are prevented from receiving adequate medical assistance. And that, structurally, which is reflected in economic and political pressures on social and institutional policies that limit opportunities for marginalized groups. And structurally, in institutional policies that, in decades of service, do not recognise the content of binding legal definitions and the consequences of which hinder the opportunities of marginalised groups in accessing health.

12. Absence of Value

The almost complete absence of values is also indicated by the attitudes of the Montenegrin LGBTIQ community in the study. The vast majority of the sample (88%) declared that in their experience the proclaimed values (about dignity, non-discrimination, institutional care, respect for diversity, etc.) are not inherent in the Montenegrin health system. They have never enjoyed them (58%), they don't know it exists at all (12%), or it happened very rarely (18%).

13. Structural Stigma

There is solid scientific evidence indicating that experiences of stigma and discrimination create health inequalities, but also higher rates of problems for people's physical and mental health. The Montenegrin environment is defined not only by the various stressors to which the community is exposed in an extremely homophobic environment, but also by the socio-economic status of the people—which, contrary to their obligations, the authorities for a whole decade do not recognise and avoid reflecting in (cosmetic) policies. For example, these are discrimination in the workplace (completely unexplored area), services (completely unexplored area), various events related to prejudice such as hate crimes or hate speech (significantly limited access to justice)[1], family rejection (absence of institutional care and closure of social support services), research on the community (complete absence of systemic care), environmental justice (decade-long continuous exceeding of permissible concentrations of harmful substances in the air), mental health (completely unexplored area), as well as numerous other examples... Additionally, this includes the so-called “unique stressors”, such as internalized homophobia and concealment of sexual or gender identity (dominant protective mechanisms of the Montenegrin community). Altogether, people

[1] Discrimination cases before the courts are not effective, there is only one verdict for a hate crime in ten years of administration, hate speech has increased in public space, on social networks, etc., and systemic responses are missing.

experience various forms of minority stress that have a negative impact on their physical and mental health.

14. Internalised Stigma

Also, there is strong scientific evidence that internalised homophobia has a greater impact on psychological distress for an individual than does perceived discrimination. This is precisely the most serious consequence of cosmetic policies for the LGBTIQ community, which is why it is still dominantly invisible. Significantly more than two-thirds of the Montenegrin LGBTIQ community in the study (78%) highlighted their own community affiliation as the main reason for dealing with stressful experiences. In the open question regarding psychological and emotional problems and pressures, more than half of the sample (56%) defined hatred and discriminatory attitudes as reasons for dealing with stress.

15. Consequences of One Logic

In the context of power, a heterosexual bias was created. This dominantly determined the intensity of internalised homophobia and conditioned the concealment of sexual or gender identity. Effective authority did not create the duties to be aspired to, so it was not effective. Legitimate authority created the only duty “to be respected”, regardless of the lack of solutions. Among other things, the authoritarianism of the government is also recognised in this. Decades of avoiding solving the problem cannot be justified and such governance was not justified. Moreover, it was not based on the expected moral values either, because the good health of the nation could not be the goal in such governance (i.e., the consequences of air pollution on the health of people in Pljevlja or Nikšić).

16. Chronic Stress

The continuous exposure of sexual minorities to social pressures and dominance of power has made minority stress considered widespread and chronic. However, for a decade, the authorities have avoided systematically responding to these challenges and empowering the LGBTIQ community. Although in the processes of NATO integration, in the context of the rule of law, they promised the international community a genuine commitment and implementation of the actual content of the proclaimed standards and legal definitions, the authorities never fulfilled the expectations. Therefore, Montenegrin society has never functioned as a resource for the LGBTIQ community. In such conditions, individuals cannot identify with society, nor feel belonging (to society). In this, the connection with society is lost, as well as with the governance system, which, by creating a façade, limited transformative processes, as well as benefits for the community.

17. Homophobic Environment

The effects of a homophobic environment are multiple on the mental health of the community, and with various negative effects. The vast majority of the Montenegrin LGBTIQ community (81%) declared that they had psychological and emotional problems due to environmental pressures and negative social attitudes. And that, 30% several times in their life, 34% several times a year, 9% several times a month, and 8% almost every day. The characteristics that describe their psychological and emotional reactions are: loneliness and listlessness (55%), outbursts of insecurity and strong fear (48%), unbearable fear of the unknown (35%), lack of sexual drive (31%), restlessness, confusion and anxiety , (29%), fatigue, exhaustion, lack of energy and sleep disturbances (28%), lack of joy in life (21%), intense sadness (19%), expressed sensitivity, vulnerability, irritability, desire and thinking about death (9%), self-pity (7%) and others (5%).

18. Pushing the Problem “Under the Carpet”

Mental health problems have been pushed “under the carpet” for decades. There is practically no one to help Montenegrin citizens. According to the number of suicides, Montenegro is at the top of the world rankings, and the authorities have been silent about it for a decade. The results of this study indicate a clear relationship between different types of minority stressors and suicidal thoughts and ideas among the LGBTIQ community and emphasise the importance of prevention measures. The vast majority of the sample of the Montenegrin LGBTIQ community in this study (73%) declared that they had suicidal thoughts or attempts as a reflection of psychological and emotional problems due to their sexual orientation and/or gender identity. Of that, 17% of the sample had it happen at least once in their life, 35% several times in their life, and even 21% several times a year.

19. Depression, Anxiety, and Stress Disorders

Depression, anxiety, and stress disorders are key mental health problems of the Montenegrin LGBTIQ community. More than half of the respondents (56%) stated that they have a diagnosed anxiety problem. Approximately half of the sample (48%) reported that they had depression, while 44% of the respondents declared that they had a stress disorder. Other diagnosed problems include sleep disorders (17%) and eating disorders (12%).

20. Distrust in Institutional Care

Homonegativism is deeply rooted in Montenegrin social, institutional, and medical structures and perpetuates fear and discrimination of the community. It is the root cause of pronounced health disparities. The problems are even more pronounced and complex because Montenegrin public policies have not recognised and considered these risks for a whole decade. It is also linked to a consistent, decades-long lack of funding for research into health, mental health, and the development of various support programmes. Heterosexual assumptions are dominant at the institutional level as well, and this is confirmed by the community's views of almost absolute distrust in public policies, the health system and institutional care.

21. Injustice

Equity as a real determinant of public policies and strategies for the Montenegrin LGBTIQ community does not exist at all. Social solidarity doesn’t exist as well. The dissatisfaction of the community is constant and is reinforced by emotional reasons due to decades of overall (bad) treatment of them by society. The authorities have never apologised to the LGBTIQ community for the prolonged persecution and suffering, for the unequal and unjust life and social circumstances in which they live, and for the limited social resources and chances to achieve freedom and enjoy equal rights. This is why the community's decade-long mistrust of institutional care is still strong, which seriously slows down the expected transformative processes. Consequently, in such conditions, social change is unattainable. The Montenegrin LGBTIQ community predominantly does not believe (80%) that public policies advocate health equity, social justice, and social cohesion, and they do not believe in the efficiency, accessibility and quality of health care for LGBTIQ people. Also, for the Montenegrin community in a huge sample (80%), public health institutions do not act proactively and do not provide adequate support to the community. For 70% of the Montenegrin LGBTIQ community, public policies are not connected and coordinated, and do not mediate in solving various health, social, environmental, educational, economic, and other problems.

22. Avoiding Discrimination

In such conditions of stigma and to avoid exposure to the expected homonegativity, the majority of the Montenegrin LGBTIQ community hides their sexual or gender identity. More than half of the sample in this study (57%) stated that very often in public places they prevent themselves from doing or saying certain things so that people do not think they belong to the LGBTIQ community. More than half of the respondents (52%) stated that they did not disclose their belonging to the LGBTIQ community in a conversation with a mental health expert, because they were afraid of the reaction (50%). Only 9% of the sample believes that they can freely discuss sexual orientation and/or gender identity with a health professional. Furthermore, 40% of those surveyed said that they would be able to talk freely only under the auspices of the programme of LGBTIQ organisations and if an expert was recommended by them. A little more than half of the sample (51%) does not have a positive opinion about it, and 21% of those surveyed would not be able to freely talk to an expert about their sexual orientation and/or gender identity. A significant number of the sample (30%) does not even dare to try such a thing.

23. Gender Perspective

Gender sensitivity is a key prerequisite for achieving quality health care, and this is not the case in the Montenegrin experience. Access to health and the services of the health system, the Montenegrin community assessed in absolute value (100%) that it was conceived on the basis that it is assumed that you are a heterosexual person. The vast majority of the Montenegrin LGBTIQ community (80%) believes that there are negative stereotypes of all kinds within the mental health system, that there is a lack of appropriate skills and knowledge about LGBTIQ health, that there is a lack of knowledge about specific topics and procedures that identify with the LGBTIQ community (homo/bi/ transphobia, driving, etc.), and declared that they do not believe that the Montenegrin health system in general assesses and takes care of the appropriate treatment of LGBTIQ persons.

24. Lack of an Inclusive Environment

The vast majority of the Montenegrin LGBTIQ population (70%) pointed out that they feel alienated and unaccepted in the Montenegrin health system, and they believe that there is a lack of culturally sensitive communication, the use of the desired name and the addressing of patients, especially trans persons. For more than half of the sample (60%), such a health system does not represent a welcoming and affirming environment for the LGBTIQ community, and there are no appropriate spaces or hospital units that would affirm people's identities (i.e., gender-neutral toilets, forms with inclusive language, etc.).

25. Lack of Inclusive Practices

Half of the Montenegrin LGBTIQ community (50%) in the study believes that the health system lacks a medical practice that would expand policies and statements on non-discrimination and include LGBTIQ identities. A significant part of the Montenegrin community (40%) recognizes access to hormonal and surgical treatment for trans people as insufficient, while the remaining 60% were not aware of the problem. Moreover, a fairly high percentage of respondents (30%) believe that in the Montenegrin health system, people can be influenced to change their sexual orientation (quite often 30%, very or quite rarely, 20%; don't know, 50%).

26. Division about the Expertise

Confidence in the knowledge of experts on LGBTIQ issues is divided. Half of the sample believes that they have no knowledge about it (no knowledge at all, 20.8%; almost no knowledge at all, 16.7%; to the greatest extent no knowledge, 12.5%), while the other half of the respondents think the opposite, of which all 33.3% of the sample believe that they have excellent or almost excellent knowledge.

27. Structural Discrimination

The analysis of constitutional guarantees, legal solutions and public policies on health, respect for human rights and the principle of non-discrimination against a realistic perspective and practice in access to health, shows that marginalised social groups, including LGBTIQ persons, experience structural discrimination that negatively affects numerous aspects in their lives, outcomes, and overall well-being.

28. The Absurdity of Policy

Essential parameters on health inequalities are not defined and recognized in public policies at all. This reflects the absurdity of the human rights policy in access to health, but also the overall wrong redistribution of resources and their waste, including financial resources. In such circumstances, one cannot talk about effective measures and systemic preconditions for facing challenges, nor about institutional care for marginalised groups and the LGBTIQ community.

29. Ignoring the Facts

Altogether, the Montenegrin LGBTIQ community experiences various forms of minority stress that have a negative impact on their physical and mental health. In contrast, the experiences of marginalisation and multiple marginalisation of LGBTIQ persons have not existed in public policies for decades. Institutional capacity to mitigate the adverse effects of stress is negligible. Thus, the key conditions of support were lost. The vast majority of the Montenegrin LGBTIQ community in this study does not believe (90%) that public policies are based on real data, needs and health assessments of LGBTIQ persons; They do not believe that public policies are focused on health inequalities, that they are predictable and designed to improve human rights, and they do not believe in institutional care in combating poverty and efforts to improve the socio-economic status of the community. Also, the vast majority of the sample (80%) does not believe in the effectiveness and predictability of public policies, especially regarding mental health care, HIV treatment and the provision of necessary support to transgender people.

30. The Minimum Possible Standard of Health

The arguments presented here (from 1—30) provide a brief overview of the intersectional analysis from this research, and in the rest of this book provide detailed and reference explanations in relation to all thematic areas. All arguments point to non-compliance with binding legal definitions, as well as the content of proclaimed standards and methodology. They unequivocally indicate the real experience of the Montenegrin LGBTIQ community in access to health, which can only be measured as the minimum possible standard of health. Also, they are all examples of non-implementation of the UN Agenda 2030 and the goals of sustainable development. In the interpretation of the right to health, Montenegrin public policies do not recognise the required characteristics:

- **They do not define** social determinants,
- **They do not consider** socio-economic status,
- **They do not recognise** minority stress and different stressors,
- **They do not consider** the gender perspective of health,
- **They do not establish** a relationship between these experiences and the right to health, and
- **They do not monitor** the risks that condition health inequalities.

Therefore, there is no doubt that a broad national effort is necessary to encourage and fund the necessary research and raise people's awareness of real health problems, including the LGBTIQ community, and to develop public health interventions, prevention strategies and establish methodologically based public policies that will recognise and admit the real facts.

The Author

A Study on Mental Health

Method

General Aim and Objectives of the Study

The general goal of the research was to investigate the experiences and analyse the needs and state of mental health of LGBTIQ persons in Montenegro. The approach used is a research design, and the research instrument was completed electronically.

The objectives of the study were to…

> • Identify positive and negative experiences in accessing and using mental health services for LGBTIQ people.
> • Identify barriers and opportunities in accessing mental health for LGBTIQ people and define gaps in services.
> • Identifies good practice in addressing the mental health and well-being of LGBTIQ people.
> • Provide recommendations on mental health needs and practice, public health policy and research.

Participation and Sampling Criteria

People who identify themselves as LGBTIQ, are 18 years old and older and live in Montenegro took part in the research. The study sample included all persons who met the inclusion criteria and agreed to participate. Respondents were provided with information about the research and confidentiality and anonymity. Answers were anonymous, and privacy was guaranteed. The intention was to achieve a higher participation rate.

A total of 100 questionnaires were returned. The representativeness of the sample is difficult to assess because there are no national data on LGBTIQ identity. There are no estimates on the percentage representation of LGBTIQ persons among the population. According to MONSTAT data, the total number of inhabitants of Montenegro according to the last census from 2011 was 620,029 (Monstat, 2011).

Survey Design

The author designed the survey in cooperation with the research advisory group of the LGBTIQ Social Centre. The survey consisted of 35 questions that were obtained from several previously developed instruments. The survey primarily consisted of closed questions, grouped into different thematic chapters, namely: Demographics and other characteristics, Intersectional analysis, Access to health, and Health as a human right. In the survey there were also three open questions. One related to suggestions for improving mental health services and any additional comments, and two open questions related to psychological or emotional problems, pressures, and negative social attitudes of the environment and/or

acceptance of one's own sexual orientation, i.e., how the behaviour works in real life situations.

Testing

The content and validity of the survey were tested in a pilot survey with three respondents. Respondents were recruited from the LGBTIQ Social Centre in Podgorica, and all respondents met the criteria for participation. To improve it, each respondent was asked to fill out a survey and provide suggestions. Feedback from respondents was generally positive, describing the survey as useful, meaningful, and appropriate for the community. Several suggestions were made to change the wording of the questions in the interest of easier filling. The feedback was taken, and the final survey was created.

Recruitment and Data Collection

The survey instrument was developed for online completion. A recruitment strategy was employed to promote the survey and increase the number of people who might hear about the research. The project holder, LGBTIQ Social Centre, sent e-messages to the members of the organisation with a request to forward information about the study and a link to the survey. LGBT Forum Progres and LGBTIQ Social Centre highlighted the details of the research and the link to the survey on their social networks.

Demographics and Other Characteristics

A total of 100 questionnaires were collected until the closing date of the survey in mid-June 2023. The research lasted 2 months. There were no surveys that were removed from the dataset due to non-eligibility or incomplete questionnaires. Therefore, a total of 100 surveys were included in the analysis. No one in the sample was over 65 years old. The age of the respondents was grouped by age, namely: 56-65 years (4%), 46-55 years (10%), 36-45 years (30%), and 56% were 18-35 years old. In relation to the biological characteristics assigned at birth, 63% of the respondents declared that they are male, 27% female, 1% intersex, while 9% of the respondents did not want to declare themselves. Regarding their own experience, 48% of respondents perceive themselves as a homosexual man (gay), 20% as a homosexual woman (lesbian), 22% perceive themselves as a bisexual person, 1% as an asexual person, and 9% declared themselves as “other”. 49% of respondents defined their gender identity as a man, 21% as a woman, 11% as a trans woman, 1% as a trans man, and 18% as queer.

The largest number of respondents, 64%, stated that they live in the central region (Cetinje, Podgorica, Danilovgrad, Nikšić and surroundings), 22% stated that they live in the Northern region (Kolašin, Mojkovac, Žabljak, Plužine, Plav, Andrijevica, Berane , Rožaje , Bijelo Polje, Pljevlja and surroundings), while 14% of the respondents were from the Southern region (Ulcinj, Bar, Budva, Kotor, Tivat, Herceg Novi and surroundings). More than 70% of the sample (72%) worked—40% in line with their education, and 32% outside their vocational training and occupation. Among those surveyed, 19% were unemployed, and the rest were students (9%). More than 50% of the sample has completed a higher level of education, of which 13% have a master's degree or doctorate, and 40% completed a college or university. 37% of those surveyed completed high school, and 10% completed elementary school or lower.

Regarding partner status and relationship, only 1% of respondents live in a registered partnership, while 24% lived as a couple in a joint household. More than 40% of the sample lived in a state of existential threat. Almost 30% of those surveyed declared that they live

without monthly income (28%), while the remaining 15% had incomes from 451 to 650 euros. Approximately 40% of the respondents lived in a joint household with their parents, of which 28% in a joint household owned by their parents, and 11% in a joint rented household. 42% of the respondents lived in a rented household themselves.

Advantages and Limitations

The study presents the opinions of LGBTIQ persons who participated in the survey and had the opportunity to share their experiences about real life in the community, about the right to health and mental health services in Montenegro. The findings are based on a practical sample of LGBTIQ people, which is the only possible one. The sample size is conditioned by specific social circumstances and serious systemic limitations for LGBTIQ people, including limitations regarding the possibility of statistical testing. It is not possible to determine and test a nationally representative sample. It is possible that the study did not sufficiently represent LGBTIQ people in a regional context, or those living in rural areas. The sample does not even define LGBTIQ persons who are being treated in psychiatric and medical institutions. Also, the sample does not represent marginalised groups such as persons with disabilities, the Roma and Egyptian population, ethnic affiliation, but neither narrowly specific groups of trans persons nor elderly persons from the LGBTIQ population.

An Aspiration or Just a Narrative

Standards in Books

Montenegrin public policies are based on international standards. These are the main characteristics that the Montenegrin authorities attribute to themselves. International applause is arranged according to a similar principle. All standards have been (re)written and "implementation" is expected. However, writing about written standards is not the same as processes and managing public policies. For example, after the implementation of the mental health plans (Master plan 2015-2020) and the human rights policy (LGBTIQ policy, 2019-2023), it was necessary to check whether what was intended was done, i.e., what were the specific goals of the nation's mental health from 2018 to date, and that they have really been achieved.

> • What are the specific goals that have been achieved for LGBTIQ people to meet the (pre)scribed standards?
> • Did health and other LGBTIQ human rights policy plans respond to mental health needs and address the specific (imagined) goal that was designed to address the specific problem?
> • Which benchmarks should be continued according to such (achieved) plans to benefit more from (public) policies?
> • What are the (real) experiences of (pre)lived by LGBTIQ people and what has been learned from (public) policies?
> • Can we (really) measure and apply what has been achieved for future actions?

Values

The goals and meaning of the values of the Conference on Primary Health Care in Alma Ata (International Conference on Primary Health Care, 1978), as well as the goals of the World Health Organization on health for all in the 21st century, have been completely (over)taken into Montenegrin public policies, health plans, and guidelines of human rights policy. In the introductory approaches of all plans, in the sections where the standards are (re)written, the prevailing views are that health, even in Montenegro, only partially depends on the availability of health services—and that it relates to other sectoral policies and services, including human rights policy. The Constitution of Montenegro and international treaties also define the right to health as such. The problem is that (pre)scribed and (re)written does not live in practice.

Health as a Human Right

The World Health Organization's document "Health for All in the 21st Century" (WHO, 1997) updated and reaffirmed the Alma-Ata principles. The issue of equity has become central to global health policy. After 45 years since the Alma Ata Declaration, which became the official primary health care policy, Montenegrin citizens should understand health as a **human right** based on their participation and principles of equality, on social determinants and social justice. All together conditions a complex process that is determined by context, culture, politics, economy, and social problems (Rifkin, 2018).

Health for All

Is the right to health really a human right in Montenegrin practice? The World Health Organization's document "Health for All" marked a transformation in global health policy. Health implies community action, intersectoral cooperation and a broader perspective of respect for the concept of social justice (Bassett, 2006: 2089). Such a holistic approach was a response to profound changes in the global world, and the proposed transformation was a challenge to real problems and threats that needed to be prevented (Antezana, Chollat-Traquet & Yach, 1998: 3). Health has emphasized the role of specific values to achieve a **sustainable** improvement in the quality of life for all, and the marked values are...

> • The enjoyment of the highest attainable standard of health as a human right.
> • Strengthening ethics in health policy.
> • Development and strengthening of research and service provision.
> • Health equity as a catalyst for public policies and strategies, including a gender perspective, and with an emphasis on solidarity as a value principle in relation to all. (Antezana, Chollat-Traquet & Yach, 1998: 3).

Illusory System

After 45 years of transformation of the Montenegrin health sector, the study before you is analysing the values and benefits that members of the LGBTIQ community enjoy in the decades-long efforts of the health authorities and human rights authorities to ensure the implementation of the adopted standards. In this regard, especially...

> • Achieving the highest attainable standard of mental health.
> • Implementation of ethics in health policy.
> • Development of research and services.
> • Equity, as an essential determinant of public policies and strategies, including a gender perspective, and with an emphasis on solidarity.

Invisible Community

The processes of Euro-Atlantic integrations caused the civil rights of LGBTIQ persons to be the subject of intensified political and social discussions. However, that was not enough. Politicians remained at the level of myths about LGBTIQ persons, and compromise solutions became the rule (Kojičić, 2022: 27-29). This has led to stagnation and neglect of real community problems in accessing health, employment, justice, and other resources. Satisfying the universal rights and needs of LGBTIQ people have been failed. Social conditions and inequalities have prolonged the agony and limited the conditions for LGBTIQ people to develop according to personal autonomy, potential, dignity, and general well-being. The dominant number of the Montenegrin LGBTIQ community is still invisible.

A large number of the sample, **77%**, stated that they were **afraid** of being rejected and/or discriminated against if others found out about their sexual orientation and/or gender identity. The fear is predominantly caused by the hatred of others towards the LGBTIQ community (56%). Approximately half of the sample (47%) believes that finding out about their sexual orientation would affect their exposure to discrimination, and approximately the same number (46%) believe that this would destroy their own reputation. 38% of those surveyed believe that others finding out about their sexual orientation would cause them to lose their job and extended family, 37% believe that they would become less valuable in the eyes of others, and that others would distance themselves from them (31%). For quite many respondents (32%), fear of violence is the reason for their invisibility.

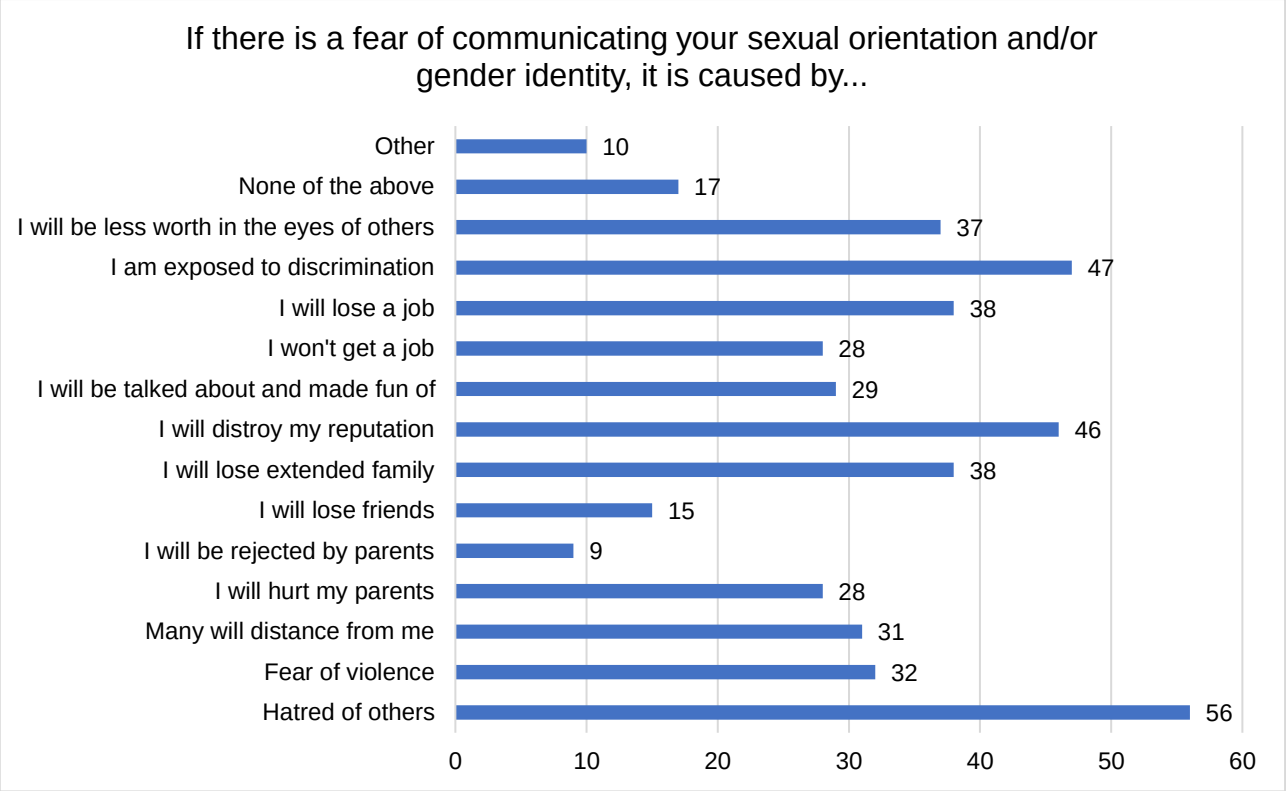

Figure 1 Respondents' answers regarding reasons for fear of communicating sexual orientation and/or gender identity

Authoritarianism

The authorities' authoritarianism and lack of understanding left serious consequences for poverty, inequality, and the overall quality of life of the Montenegrin LGBTIQ community (Kojičić, 2022: 7-15). For a decade, health plans have not recognised LGBTIQ people as a vulnerable social group. Therefore, real progress in access to health could not even happen. Here I am referring to systemic approaches that would reflect the concepts of health equity and reduce health inequalities. The absence of definitions and disregard for social determinants is key arguments. Second, the disconnection and inconsistency of public policies and intersectoral action (health, human rights, environmental, social policy, and others). Third, non-compliance with legal solutions and the Government's methodology, which require evidence, facts, development of research and services, but also cross-sectoral assessment and action. Instead of all that, *public policies* were created for *the sake of policies*. In real time, it also indicates the authoritarianism of the government, because it is self-sufficient and exists only for itself.

Exclusion

There are no inclusive policies that would develop the impact of diversity of sexual orientation and protect LGBTIQ persons in the workplace (Barac, 2023). Public policies in their own metaphor of the concept resemble a group of unrelated words on paper. They are not designed to be compliant, nor do they address deficiencies in access to health and quality of health care. They do not recognize minority stress, socioeconomic status, but also the shortcomings and differences in the status of the LGBTIQ community. Therefore, they do not meet the concept of inclusivity, which is directly related to mental health, sexual orientation and identity as important components of overall health and well-being (Dodge, Friedman & Schick 2016: 137; Feinstein 2016: 88; cf. Kojičić, 2022: 38).

Predatory Culture

Human rights policy did not adapt or change. There is nothing that resembles that the proclaimed standards are respected. There is still no political will for the administration to face the problems of the LGBTIQ community. For decades, there have been no statistical data on LGBTIQ people, generated by the state. Expected results on the development of research and services were neglected. Consequently, the predictability of public policies is not possible and does not exist.

Controlled Conditions

Social stigma, discrimination and homo/bi/trans phobia negatively affect the overall quality outcomes and lifestyles of LGBTIQ people, including employment, income, and access to health care (Jalali & Sauer, 2015: 418; Veltman & Chaimowitz, 2014). Instead of taking care of continuous expectations, to establish meaningful solutions and plans for action, the Montenegrin LGBTIQ community continues to face strong impacts of sexual structural stigma, discrimination, and inequality (Kojičić, 2022: 27-36). The results of discussions about the position of LGBTIQ persons in society are not measurable. Moreover, it can be said that they are controlled by the conditions of power and authority (governance). This is why change processes are slow, and results are insufficient, limited or even unattainable.

Magic (About the Rule of Law)

Nevertheless, in the façade form of such created authority there are magic words that “everything is done” for the LGBTIQ community. These words are really written when proposing public policies and plans. In practice, “doing everything” means having random support interventions. Maybe the magic will happen, but only after LGBTIQ organisations are no longer able to face the growing problems, i.e., when strong pressures from the international community appears. It most often happens when the inability of civil organisations to solve a pressing problem is so pronounced that the problems are insurmountable. That's when *the magic* appears, which presents itself as *care*, and *doing everything* in practice turns into *hope*. There is hope because it was thought that things have moved. However, over time it becomes apparent that it was just magic. That will determine *the deadlock*. Then there are new interventions and pressures from the international community... Opportunities are balanced, compromises are rare, and the LGBTIQ community is neglected and suffers. The most common excuses are that these are *demanding processes* and that the results are not possible *overnight*. After decades of commitment to LGBTIQ issues, it would still have to look different than it does today. ***If only*** the laws and methodology were respected, and work was done to create structural preconditions for the LGBTIQ community. Instead, at the core of understanding the concept of the rule of law, excuses persist. This 'only' is nothing but *par excellence* **a service conception** of a governance that ignored real definitions and values. In actual logic, these were mechanisms of control, dominance, and power (Kojičić, 2024).

Governance Façade

Strong pressures from the international community caused that in 2020 the Law on Life Partnership of Persons of the Same Sex was adopted (entered into force a year later). The law in question “behind the back” of the international community offered unfinished, balanced, and discriminatory solutions that have not been harmonised in the meantime. That is why the

LGBT Forum Progress filed a lawsuit against the state of Montenegro[2]. Although discrimination cases are **urgent** for action, even today, 15 months after the filing of the lawsuit, not a single hearing has been held. This suggests a predatory culture and controlled governance model for the LGBTIQ community. To clarify the mechanisms at play, I emphasise this oversimplified (effective) example of the efficiency of the principle of non-discrimination, which also determines the actual status of LGBTIQ persons in society. This is where **the façade is recognised**, in the difference between political fraud and good governance. This determines the relevance and implications of real LGBTIQ politics (as opposed to 'magic'), which is reflected in the avoidance of solving real problems.

Unscrupulous Opportunism

LGBTIQ policy exists institutionally on paper. It is motivated by good intentions about Euro-Atlantic integration. For this reason, among other things, in 2017, NATO and the EU rewarded Montenegro with membership and favourable EU integration processes. However, over time it became apparent that the authorities used the LGBTIQ community as a front. The system succumbed to the temptation and opted for cosmetic plans in the long run. Clearly, it was important to satisfy the international community, not the needs of LGBTIQ people. Everything looks nice on the outside, but inside it's ugly. For a long time, public policies did not change and adapt to the needs of the LGBTIQ community. The actual contents of rights in access to justice, health, education, social services and services, employment, environmental policy, and others are still missing. The governance façade exists in all areas. In this way, observers and interested parties are misled, and the political deception about the dominant heterosexual norms that should be preserved is covered up. This determines **unscrupulous opportunism**, which is reflected in avoiding solving problems for the sake of preserving "peace in the house" (widespread homonegativism) and preserving one's own political privileges and political convenience in this connection.

Background of Effects

This is how we come to understand the metaphor about the magic of the governance. The results are reflected in social injustice, structural stigma, heterosexism, discrimination, and violence against LGBTIQ people. Everything is combined with the subtle effects of the interpretation of adopted legal solutions, administrative (authoritative), social and cultural, which also explains **the subtle** background of the magic words "doing everything" for the LGBTIQ community. In real time, and this is confirmed by the views of the community in this study, the real effects of such efforts are significantly limited people's life chances, limited access to health and mental health, and limited overall well-being for LGBTIQ people.

[2] On June 7, 2022.

The highest attainable standard of health

Microaggression

Scientific studies indicate that LGBTIQ people face numerous challenges in accessing health care and experience higher rates and unique health disparities (Morris, Cooper, Ramesh et al., 2019; Graham, Berkowitz, Blum et al., 2019). LGBTIQ people are exposed to greater social and greater health inequalities, and this makes them at greater risk of illness and death (Jalali & Sauer, 2015: 417). These inequalities can also be conditioned by the prejudices of health workers (Morris, Cooper, Ramesh et al., 2019; Veltman & Chaimowitz, 2014). Unconsciously expressed prejudices of doctors and medical staff lead to the fact that LGBTIQ patients may have limited access to health services or lower quality health care. It affects the bad communication between doctor and patient and the existence of the so-called "microaggression", which reduces the optimal quality of health care and service (Morris, Cooper, Ramesh et al., 2019: 2). LGBTIQ people are more likely to delay or avoid necessary medical care, while perceived discrimination by medical facilities and complete denial of health care are common experiences for LGBTIQ patients (Morris, Cooper, Ramesh et al., 2019). All are factors that contribute to health inequalities (Morris, Cooper, Ramesh et al., 2019).

Distrust in the Health Care System

Due to the fear of discrimination, LGBTIQ patients often hide their identity (sexual orientation or gender identity) from healthcare providers (Jalali & Sauer, 2015: 417). In the context of Montenegrin conditions, the data in the study show that more than 2/3 of the respondents (69%) would not request specialist services and advisory support from mental health experts: Either they do not trust the public health system (37%), or they think that they are not would help (21%), or they do not want others to find out about their sexual orientation (11%). In terms of psychological support provided by LGBTIQ organizations, the situation is different. Approximately half of the respondents (48%) declared that they used specialist services and advisory support from their experts. Out of that, 38% of the respondents stated that they had the understanding and help of the doctor, of which a significant number of them (28%) concealed the real problem in the conversation with the doctor.

Unconscious Prejudices

Less time and limited approaches in processing information give way to stereotypes and unconscious prejudices of medical personnel (Morris, Cooper, Ramesh et al., 2019: 2). As much as one third of the Australian LGBTIQ community does not disclose their sexual orientation or gender identity when accessing health care. It is assumed that this comes from the fear of discrimination and worse health treatment (Ross & Setchell, 2019: 99). Lesbian, gay, and bisexual persons, and especially lesbian and bisexual women, have an increased risk of psychiatric morbidity, and it is assumed that this is conditioned by discrimination based on stigma (Gmelin, De Vries, Baams, et al., 2022).

> *Simple actions, such as poor eye contact, insufficient follow-up, or awkward body language, can easily be interpreted as discomfort or discrimination by providers (…)*

> *Many report bullying, verbal abuse, and denial of care (…) Transgender patients have reported clear experiences with discrimination, including gender insensitivity, expression of discomfort, denial of services, ... verbal and physical abuse and forced placement in psychiatric institutions. Reported negative experiences also include insensitivity to medical complaints, fixation and assumptions about gender identity, incorrect use of gender pronouns and inadequate education of doctors (Jalali & Sauer, 2015: 420).*

Effects of Minority Stress

The effects of minority stress can be multiple and have different effects on LGBTIQ people. For example, people from the Roma and Egyptian communities who belong to the LGBTIQ population experience stress related to both racism and heterosexism, so the risk of negative health outcomes for them is even greater. Intersectionality theory recognises the meaning and establishes a relationship between these experiences of multiple marginalisation and their relationship to health. The theory establishes a gender analysis of health and recognises how power relations affect these processes and gender inequality at different levels (Manandhar, Hawkes, Buse et. al., 2018: 644; cf. Kojičić & Krstić, 2020: 55), that is, how "overlapping and crossing" of social identities reflects on "oppression and domination" (Black, Guest, Bagnol et al., 2019: 111; cf. Kojičić & Krstić, 2020: 55).

Minority Stress Theory

Minority stress theory or minority stress recognises homonegativism as the root cause of health disparities for the LGBTIQ community (Layland, Maggs, Kipke et. al., 2022). The theory claims that a higher rate of community physical and mental health problems results from the experience of stigma and discrimination (Kamen, Palesh, Gerry et al., 2014). Such an environment is determined by socio-economic status, but also by various **stressors** to which LGBTIQ persons are exposed (Meyer & Frost 2013: 252; cf. Kojičić, 2022: 8). These can be, for example, discrimination in the workplace, or various events related to prejudices (family rejection, hate crimes, etc.), but also the so-called "unique stressors", internalised homophobia and concealment of sexual or gender identity (McConnell, Janulis, Phillips et al., 2018; Layland, Maggs, Kipke et. al., 2022). Altogether, LGBTIQ people experience various forms of minority stress that negatively affect their physical and mental health (Pachankis & Lick 2018: 479; McConnell, Janulis, Phillips et al., 2018; Frost, Lehavot, & Meyer, 2015). Frequent exposure of sexual minorities to dominant heterosexual norms makes minority stress considered widespread and chronic (Layland, Maggs, Kipke et. al., 2022). To illustrate, for a gay man who is poor, "stressors" are determined by his sexual orientation (versus the social environment), his poverty, but also the available resources to face such circumstances (for more see Kojičić, 2022: 8-9).

Resistance to Stress

Montenegrin health policy and human rights policy in the interpretation of the right to health do not recognise all these characteristics...

> • They do not define social determinants,
> • They do not consider the socio-economic status of LGBTIQ persons,
> • They do not recognize minority stress and different stressors,
> • They do not consider the gender perspective of health,
> • They do not establish a relationship between these experiences and the right to health, and

> • They do not monitor the risks that condition health inequalities.

Interpretation of the Law

The interpretation of the right to the highest attainable standard of health, in connection with Article 12 of the **International Covenant** on Economic, Social and Cultural Rights, points out that the right to health includes freedoms and rights (Paragraph 8, General Comment No. 14, UN Committee on Economic, Social and Cultural Rights). This concept should consider both the biological and socio-economic preconditions of the individual and the available resources of the state, and the right to health must be understood as the right to enjoy various benefits, goods, services, and conditions necessary to achieve the highest possible standard of health (Paragraph 9, General Comment No. 14: UN Committee on Economic, Social and Cultural Rights).

> • Freedoms include the right to control one's own health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, medical treatment without consent and experimentation.
> • In contrast, rights include the right to a health care system that provides people with equal opportunities to enjoy the highest possible level of health.
> (Paragraph 8, General Comment No. 14, UN Committee on Economic, Social and Cultural Rights).

Incompetence

For the Montenegrin health authorities, experiences of marginalisation and multiple marginalisation of LGBTIQ persons **do not exist**, and the abilities of public policies to mitigate the harmful effects of stress in dealing with sexual and structural stigma are negligible. Thus, **the key conditions** for the support of health institutions and authorities, which would have to recognise these reasons and intervene in the suppression of bad psychological outcomes (stress) and stigmatised experiences of the LGBTIQ community (stigma), have been **lost**. When asked how they evaluate access to health and services in public policies, the vast majority of respondents (**90%**) do not believe that public policies are based on real data, needs and assessments of the health of the LGBTIQ community, and that their voice is not heard at all. Of these, 80% do not believe in the real credibility of public policies at all, and 10% do not believe in it at all. The vast majority (**90%**) of those surveyed do not believe that public policies are focused on the health inequalities of LGBTIQ persons, that they are predictable and designed to improve their human rights (70% do not believe at all, and 20% do not believe it at all). The same ratio of mistrust of the sample (**90%**) in relation to institutional care in suppressing poverty and efforts to improve the socio-economic status of the LGBTIQ community (70% do not believe at all, and 20% rather do not believe in it).

Inefficiency

There is a huge negative perception of the sample (**80%**) regarding the effectiveness and predictability of public policies, especially regarding mental health care, HIV treatment and the provision of necessary support to transgender people (60% do not believe at all, and 20% do not believe it at all). Because they do not feel the good effects of public policies, the LGBTIQ community dominantly does not believe (**80%**) that policies advocate health equity, social justice and social cohesion (60% do not believe at all, while 20% do not believe it at all). The perception of the community is also dominant (**80%**) that they believe that public policies do not define and evaluate the efficiency, accessibility and quality of health care for LGBTIQ persons (50% do not believe at all, while 30% do not believe). Also, that public health institutions do not act proactively and do not provide adequate support to the community

(**80%** do not believe—50% do not believe at all, 30% rather do not believe). There are similar views that public policies are not connected and harmonized, and do not mediate in solving various health, social, environmental, educational, economic, and other problems of LGBTIQ persons (70 **%** do not believe, of which 60% do not believe at all, and 10% rather does not believe).

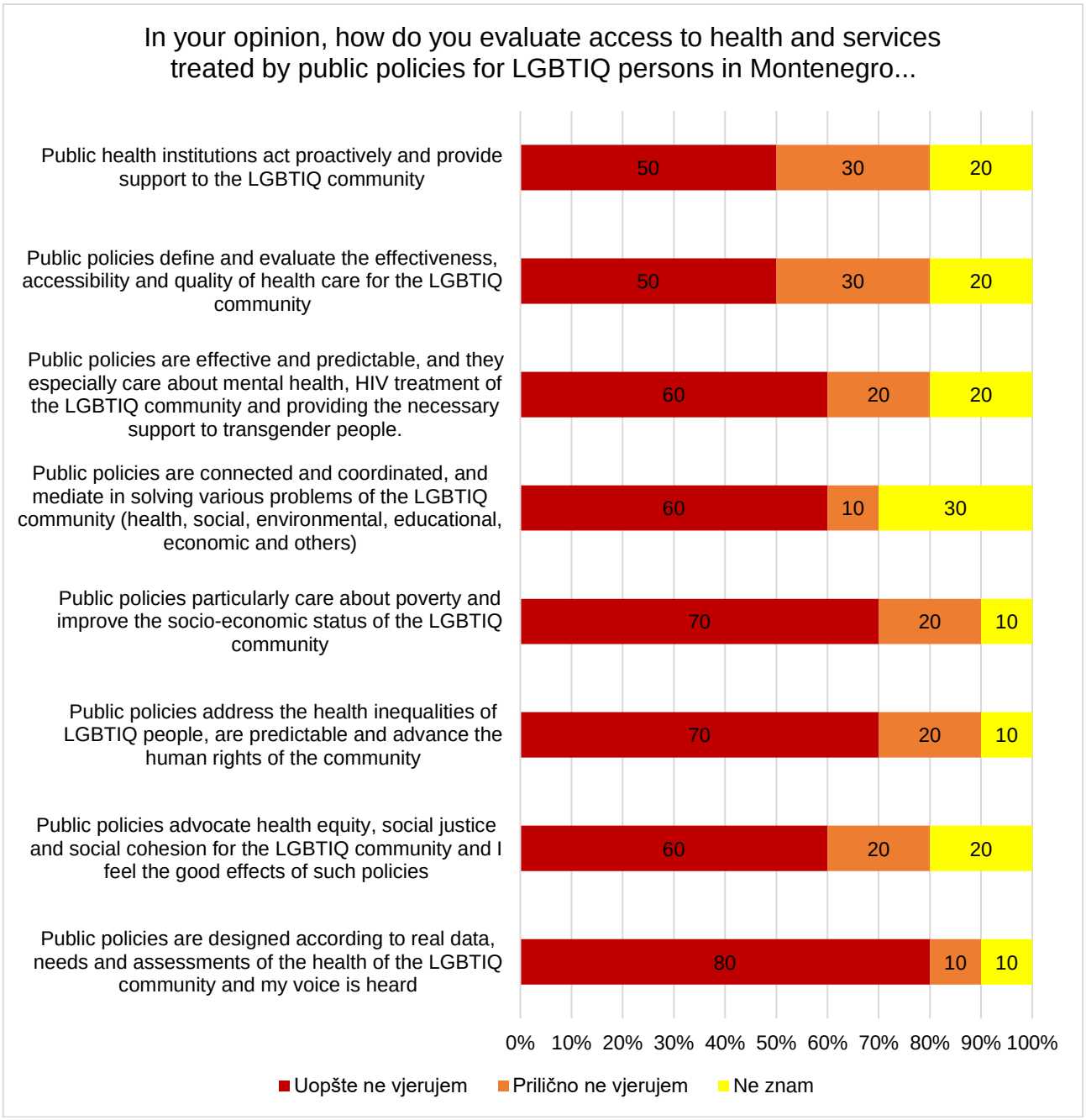

Figure 2 Respondents' views on public policies in the context of the LGBTIQ community

Neglect

The overall result in access to health for the LGBTIQ community is extremely negative. Among the respondents, the vast majority of the sample (43%) lives on the edge of existence. Out of that, 28% of respondents stated that they live without monthly income and live in a joint household owned by their parents. An additional 15% have a monthly income of € 451.00

to €650.00. According to Monstat data, the value of the minimum consumer basket for June 2023 was €818.20 (Monstat, 2023). Minimum expenses apply to food and soft drinks. An additional 11% of respondents stated that they live in a rented joint household with their parent(s).

Special Obligations

In connection with paragraphs 43 and 44, paragraph 19 on the interpretation of the right to the highest attainable standard of health and in connection with Article 12 of the International Covenant on Economic, Social and Cultural Rights, emphasises that states have a special obligation to provide access[3] to **health** and prevent any discrimination on internationally prohibited grounds in the provision of health services and care, especially with regard to "basic obligations" regarding the right to health. Basic obligations, among others, include:

> • Ensuring the right to access health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
> • Access to basic shelter, accommodation and sanitary conditions, as well as an adequate supply of safe drinking water;
> • Essential medicines, defined by the WHO Action Program for Essential Medicines;
> • Fair distribution of all health benefits, goods and services;
> • Education and access to information regarding the main health problems in the community, including methods of their prevention and control;
> • Appropriate training for health personnel, including health and human rights education.

Systemic Exclusion

On the example of persons in institutions for the execution of criminal sanctions or convicted persons, including the LGBTIQ community, public policies are not only disconnected but also ignore the expected outcomes. Seen through the prism of the UN Sustainable Development Goals, prejudice, stereotypes, violence, and discrimination are not harmless, especially for gender-sensitive groups (SDG 4, Quality education). However, there are no social services for post-criminal reception and monitoring, nor appropriate measures that provide support for cultural determinants appropriate to criminal-legal conditions according to gender and gender-sensitive social groups (SDG 5: Gender Equality; SDG 10: Reducing Inequality). Convicted persons have structural obstacles in employment, because the systems are not designed for them (SDG 8: Decent work and economic growth). They have limited access to social services and affordable housing projects and loans, which significantly differentiates them in treatment and directly leads to poverty (SDG 1: A world without hunger). Due to the existence of numerous institutional barriers and discrimination, convicted persons are systematically excluded from learning, education, career, and employment opportunities (Kojičić & Blažić, 2021: 11). All affect their physical and mental health (SDG 3: Good Health), economic growth and development (SDG 8: Decent Work and Economic Growth; SDG 9: Industry, Innovation, and Infrastructure), and point to social and institutional injustice (SDG 16: Peace, Justice and Strong Institutions) and lack of partnership (SDG 17: Partnering to the Goal).

[3] General comment no. 14, UN Committee on Economic, Social and Cultural Rights .

Absence of Vision

Problems related to the absence of vision are significant and more serious. They are systemic, structural, and last for decades. Additionally, they are seasoned with a governance façade and unscrupulous opportunism. That is why there are no solutions, and no one in the administration deals with it. If it were otherwise, even such non-standardised measures in the Strategy on the quality of life of LGBTIQ Persons from 2019 would have been implemented. This is not the case in the largest sample. It would be both a charming pictorial representation of the absence of vision, but also a cosmetic background of subtle magic words of “doing everything” (for the LGBTIQ community).

Minimal Standards

A large number of the sample of the LGBTIQ community in this study does not recognise the coherence and connection of public policies (see page 15). In short, that would be a display of demonstrated (non)compliance with binding legal definitions, standards, and methodology, but also examples of (non)implementation of the UN Agenda 2030 and sustainable development goals. Everything together determines the experience of the Montenegrin LGBTIQ community in access to health, which can be described as *the minimum possible standard of health*. If it were otherwise, the answers to the questions (see page 38) would determine the conditions for speaking about efficiency. **The absence of answers and the absence of methodology, which is the case at all levels of treatment of LGBTIQ persons, is new in a series of arguments that indicate that there is no vision, especially in health and human rights policy, which should provide clear guidelines for the position of marginalized social groups in improve society, including the LGBTIQ community.**

Exposure to Discrimination

Homophobic Environment

The latest report of the LGBTIQ Social Centre, from September 2023, on the attitudes of citizens regarding the presence of stereotypes, prejudices, and social acceptance of LGBTIQ persons in Montenegro (Kojičić & Barac, 2023), indicates that the vast majority of Montenegrin citizens agree in the attitude that homosexuality is not natural and normal (80%) and that it is a mental illness (80%). For the vast majority of citizens, homosexuality is a choice, not something people are born with (68%) and needs to be treated (65%). At the same time, more than half of the sample declared that homosexuality can be cured (52%), while the vast majority (44%) believe that homosexuality is dangerous for society. Significantly more than half of the sample of the general population indicates that LGBTIQ persons are dangerous for children (62%), and that they should not be allowed to adopt children (61%). Therefore, it is clear that the government's years-long failure to truly face the effects of homonegativism and stigma leaves multiple negative and multidimensional consequences for the LGBTIQ community, their safety and exposure to discrimination, and can have serious harmful implications for their physical and mental health. These implications are "non-existent" for the authorities (they have not been investigated), and public policies in all areas and at all levels do not take into account the actual content and interpretations of legal definitions.

Effects on Mental Health

CIP research in the United States indicates that LGBTIQ people, compared to those who are not, are **more often** exposed to discrimination in various life environments and situations, namely: in public spaces (28% vs. 17% for non-LGBTIQ), at school (19% vs. 9% for non-LGBTIQ), in the workplace (23% vs. 17% for non-LGBTIQ), in housing situations (13% vs. 5% for non-LGBTIQ). The indicators are even more pronounced for LGBTIQ persons of colour (in public spaces 32%, at school 22%, at the workplace 27%, in housing situations 15%) and LGBTIQ persons with disabilities (in public spaces 34%, at school 25%, in the workplace 27%, in housing situations 18%) (Medina & Mahowald, 2023). For transgender or non-binary people, the rates of discriminatory experiences are also extremely high (in public spaces 42%, workplace 31%) (Medina & Mahowald, 2023). Also, recent public debate in the US regarding state laws that limit LGBTIQ rights has made more than half of LGBTIQ adults and more than 8 (in 10) transgender or non-binary people feel less safe. It moderately or significantly affected their mental health (Medina & Mahowald, 2023). In communication and interaction with a mental health professional, approximately one (in three) LGBTIQ adults, four (in ten) LGBTIQ persons who are persons of colour and more than one (in two) transgender or non-binary persons reported at least one type of negative experiences or forms of bullying (Medina & Mahowald, 2023).

Multiple Effects

There is strong scientific evidence linking higher rates of psychiatric morbidity to the experience of individual-level stressors for LGBTIQ people. These are violence based on sexuality or internalized social stigma (Gmelin, De Vries, Baams, et al., 2022: 2320).

However, the effects of stress on mental health can be multiple and cause various negative effects. These are emotional dysregulation (poor ability to manage and control emotions, including sadness, anger, irritability, and frustration), interpersonal problems and mental processes and characteristics with an increased risk of psychopathology (Gmelin, De Vries, Baams, et al., 2022: 2320) . Additionally, LGBTIQ people are often dissatisfied with the health care they receive and have a heightened sense of awareness of discriminatory behaviour (Jalali & Sauer, 2015: 420).

Internalized Stigma

Compared to perceived discrimination, studies indicate that internalised homophobia has a greater impact on psychological stress for the individual. This is because internalised stigma is expressed in a social context and can affect an individual even when the person is alone in the space, without the influence of other prejudice factors or situations that are perceived as discriminatory behaviour (Doyle & Molix, 2015) . A person internalises homonegativism in such a way that he accepts and integrates social messages about the inferiority of sexual minorities as his personal value systems, which has negative effects on mental health (Layland, Maggs, Kipke et. al., 2022). Significantly more than **two-thirds** of the Montenegrin LGBTIQ community (**78**) highlighted their own belonging to the LGBTIQ community as the main reason for facing stressful experiences. In the open question regarding psychological and emotional problems and pressures, **more than half of** the sample (**56%**) defined hatred and discriminatory attitudes as reasons for facing stressful experiences. This points to an internalised stigma and an extremely homophobic environment for the Montenegrin LGBTIQ community.

Montenegrin Experience

The effects of the homophobic environment are multiple on the mental health of the Montenegrin LGBTIQ community, with various negative effects. First, **the vast majority** of the sample (**81%**) declared that they had psychological or emotional problems due to environmental pressures and negative social attitudes. And that, 30% several times in their life, 34% several times a year, 9% several times a month, and 8% almost every day. **The characteristics** that describe the psychological and emotional reactions in this regard are—loneliness and listlessness (55%), outbursts of insecurity and strong fear (48%), unbearable fear of the unknown (35%), lack of sexual drive (31%), restlessness, confusion and anxiety, (29%), fatigue, exhaustion, lack of energy and sleep disturbances (28%), lack of joy in life (21%), intense sadness (19%), marked sensitivity, vulnerability, irritability, desire and thinking about death (9%), self-pity (7%) and other (5%). 8% of respondents did not want to answer.

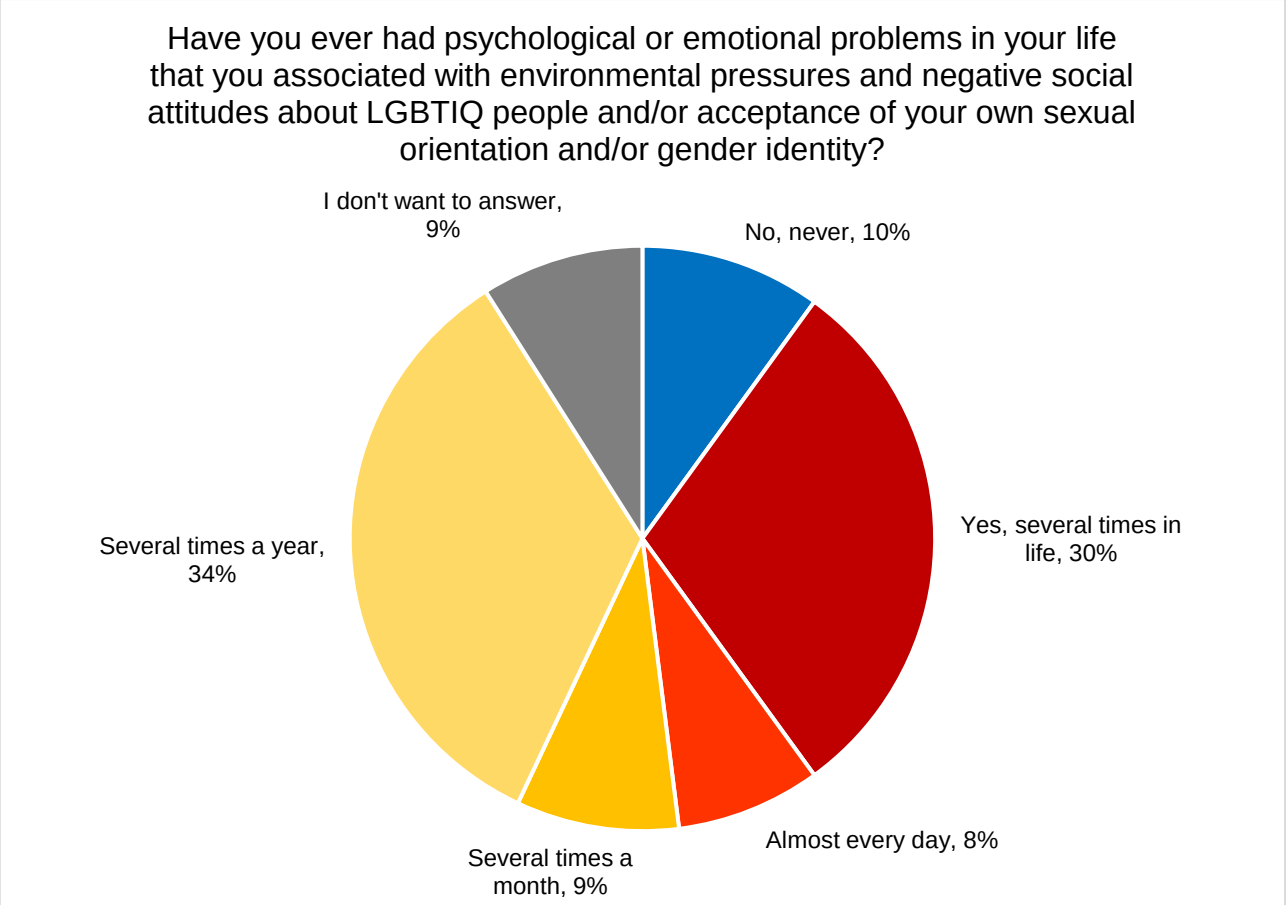

Figure 3 Answers of respondents in relation to experiences with psychological or emotional problems

School Environment

A large number of studies indicate that in schools and school environments where there are clubs such as gay-straight alliances or gender-sexuality alliances, which provide support to students with different sexual and gender identities, they represent a safer environment, have positive effects on mental health and influence to better school outcomes (Baams & Russell, 2021). In such conditions, there is a lower degree of suicidality, depression and substance use, a lower degree of absenteeism from school, a lower degree of bullying and violence, and academic achievement is higher (Baams & Russell, 2021: 212, 223). Professor at the Department of Pedagogy and Educational Sciences at the University of Groningen, in the Netherlands, Laura Baams and Professor of Child Development in the Department of Human Development and Family Sciences at the University of Texas, USA, Stephen Russell, in a March 2021 study, indicate that—compared to heterosexual and cisgender youth, youth from sexual and gender minorities have worse mental health and school outcomes, experience more victimization and report more substance use (Baams & Russell, 2021: 213). Their findings highlight positive effects for all students in schools where there are gender-sexual alliances, better mental health and better overall outcomes, including overall school functioning (Baams & Russell, 2021: 223).

Silence on Inclusion

However, in Montenegro, the school environment for the LGBTIQ population can be characterised more as a “loud silence” (about it), than that there are truly inclusive approaches (Kojičić, 2022: 10-11). In the absence of relevant research and data, it is

assumed that dominant social heterosexual and cisgender norms are present in schools. It is not talked about, which defines **the silence** about LGBTIQ identities in teaching. Moreover, the dominantly binary gender identities and heterosexual relations assumed in the manifestation of the behaviour of teaching staff and the reproduction of teaching plans become the **norm** that students adopt in school activities and interactions (Johnson, 2022; cf. Kojičić, 2022:11). This has negative implications for the mental health of LGBTIQ youth, affects their safety and complicates various risks... from bullying, violence, suicidal thoughts, depression, use of various substances, absenteeism, and poorer school outcomes.

Correlation and Interaction of Public Policies

This would be an example of the unbreakable connections and intertwining of different public policies, which **are not** connected and coordinated in the Montenegrin governance system. One cannot talk about concern for the mental health of the LGBTIQ community, and at the same time advocate “loud silence” about it in the school environment or in the workplace. Medical staff training programmes, even if they are the best, cannot provide adequate effects or bring about changes in such governance circumstances. First, the programmes are not standardised. They are not systemically based, because they are not **recognised** by the competent authorities, nor were they created by them. As such, they are not **compatible** with the system, and are not based on **evidence** that they include adequate guidelines and (systemically) affect stigma and specific health needs for the LGBTIQ community. Consequently, they cannot be compatible and linked with similar training of teaching staff or staff of the judicial or administrative branches of government, including the industrial sector. **If it were otherwise**, the health needs specific to LGBTIQ people would be expressed in all public policies and at all levels, which is not the case. In addition, the complete absence of the will of the authorities to face the real problems of the LGBTIQ community and investigate the systemic shortcomings especially complicates the processes and interactions and increases the suspicion of subtle mechanisms of governance façade. This probably has a negative impact on **the distrust** of the LGBTIQ community in the health system and the governance of public policies.

Heterosexual Assumptions

When asked how they evaluate access to health and services of health experts, staff and the overall health system, the entire surveyed Montenegrin LGBTIQ community, in a sample value of **100%**, answered that the Montenegrin health system is designed on the basis that it is assumed that you are a heterosexual person. The vast majority of the sample (**80%**) believes that there are negative **stereotypes** of all kinds within the mental health system, that there is a lack of appropriate skills and knowledge about LGBTIQ health, as well as knowledge about specific topics and procedures that identify with the LGBTIQ community (homo/bi/transphobia, coming out, etc.), and they declared that they do not believe that the Montenegrin health system in general assesses and takes care of the appropriate treatment of LGBTIQ persons.

Alienation and Non-Acceptance

For the vast majority of respondents (**70%**), there is a feeling of alienation and non-acceptance in such a health care system, and they believe that there is a lack of culturally sensitive communication, the use of the preferred name and the addressing of patients, especially trans persons. For more than half of the sample (**60%**), such a health system does not represent a welcoming and affirming environment for the LGBTIQ community, and there

are no appropriate spaces or hospital units that would affirm people's identities (i.e., gender-neutral toilets, forms with inclusive language and other).

Weak Non-Discrimination Practices

Half of the respondents (**50%**) believe that there is a lack of medical practice that would expand policies and statements on non-discrimination and include LGBTIQ identities. A significant part of the sample (**40%**) declared that access to hormonal and surgical treatment for trans people is insufficient, while the remaining 60% were not aware of the problem. Lack of access to hormonal and surgical treatment for transgender people can negatively affect their mental health (Veltman & Chaimowitz, 2014). This is contrary to the protocols and proclaimed standards for the care of transgender persons, to whom Montenegro guarantees access to health care. Moreover, a fairly high percentage of respondents (**30%**) believe that the Montenegrin health system can influence people to “change” their sexual orientation (quite often 30%, very or quite rarely, 20%; don't know, 50%).

Non-Recognition of Inequality

If there were no good efforts, initiatives and various programs of non-governmental organisations, the actual activities of the state regarding the human rights of the LGBTIQ community and their access to health would not have taken place. This is best seen through financial support (i.e., lack of support) in numerous measures in public policies. At the same time, the essential parameters of inequality have not been defined and recognized at all. So, they don't exist. This reflects the absurdity of the human rights policy in access to health, but also the wrong redistribution and waste of resources, including financial ones. In such circumstances, one cannot talk about effective measures and systemic preconditions to really ensure that the position of LGBTIQ persons in Montenegrin society is systematically improved.

Unique Challenges for Transgender and Non-Binary People

Although the sample in these studies does not represent a narrowly specific group of trans and nonbinary people, studies indicate that transgender and nonbinary people face **unique** challenges in accessing health care and services. Trans people experience greater discrimination and a high rate of social violence and exclusion, while trans men and non-binary people are often excluded and experience various inconveniences and discriminatory behaviour in the treatment and provision of health services and care (Medina-Martínez, Saus-Ortega, Sánchez-Lorente et al., 2021). A survey by the Centre for American Progress (CAP) found that 49% of transgender or nonbinary adults were concerned that they might be denied good health care if they disclosed their gender identity to a doctor or health care provider (Medina & Mahowald, 2023). As many as 30% of surveyed transgender or non-binary persons, that is, 34% of transgender or non-binary persons who are persons of colour, answered that they had to teach doctors or health personnel about these topics to receive appropriate care (Medina & Mahowald, 2023). Furthermore, 21% of respondents reported that health care providers intentionally misinterpreted gender or used the wrong name and were visibly uncomfortable with their actual or perceived gender identity (Medina & Mahowald, 2023). For 17% of surveyed health care providers used harsh and offensive language, 11% experienced unwanted physical contact (i.e., caressing or sexual assault), and in 9% of cases health care providers were physically rude or abusive (Medina & Mahowald, 2023).

Fear of Discrimination

In the case of physiotherapy, the first such study in Australia showed that, due to fear of discriminatory treatment, LGBTIQ people often withhold information that is important for medical treatment or avoid visits to physiotherapy (Ross & Setchell, 2019: 104). These include incorrect assumptions by physiotherapists, discomfort, explicit and implicit discrimination, and a lack of knowledge and understanding of physiotherapists about the specific health problems and health needs of the LGBTIQ community, including general parameters in access to health care (medicine and nursing, mental health and perinatal care) (Ross & Setchell, 2019). The study also showed that physiotherapists often they make wrong assumptions about the gender and sexuality of LGBTIQ persons, and that heterosexuality and gender normativity are woven into physiotherapy as an expected and general norm (Ross & Setchell, 2019: 103). The authors of the study, researchers at the Faculty of Health and Rehabilitation Sciences, at the University of Queensland, in Brisbane, Australia, Dr. Megan Ross and Dr. Jenny Setchell, indicate that unconscious heteronormative assumptions ... *unintentionally lead to feelings of invisibility for LGBTIQ people, and incorrect use of gender pronouns it can be distressing for transgender people and other non-binary gender people* (Ross & Setchell, 2019: 103). They recognise systematic solutions, such as the inclusion of LGBTIQ health in undergraduate and professional health training, as a way to improve health experiences, services and problem solving. This implies curricula that will be based on evidence and include adequate terminology, stigma and health needs that are specific to LGBTIQ people (Ross & Setchell, 2019: 104).

Unintentional Practice

Only 9% of the sample of the Montenegrin LGBTIQ community in the study believe that they can freely discuss sexual orientation and/or gender identity with a health professional. Moreover, 40% of those surveyed stated that they would be able to talk freely **only** under the auspices of the program of LGBTIQ organizations and if an expert was recommended by them. A little more than half of the sample (**51%**) does not have a positive opinion about it, and **21%** of those surveyed would not be able to talk freely with an expert about their sexual orientation and/or gender identity. A significant number of the sample (**30%**) does not even dare to try such a thing.

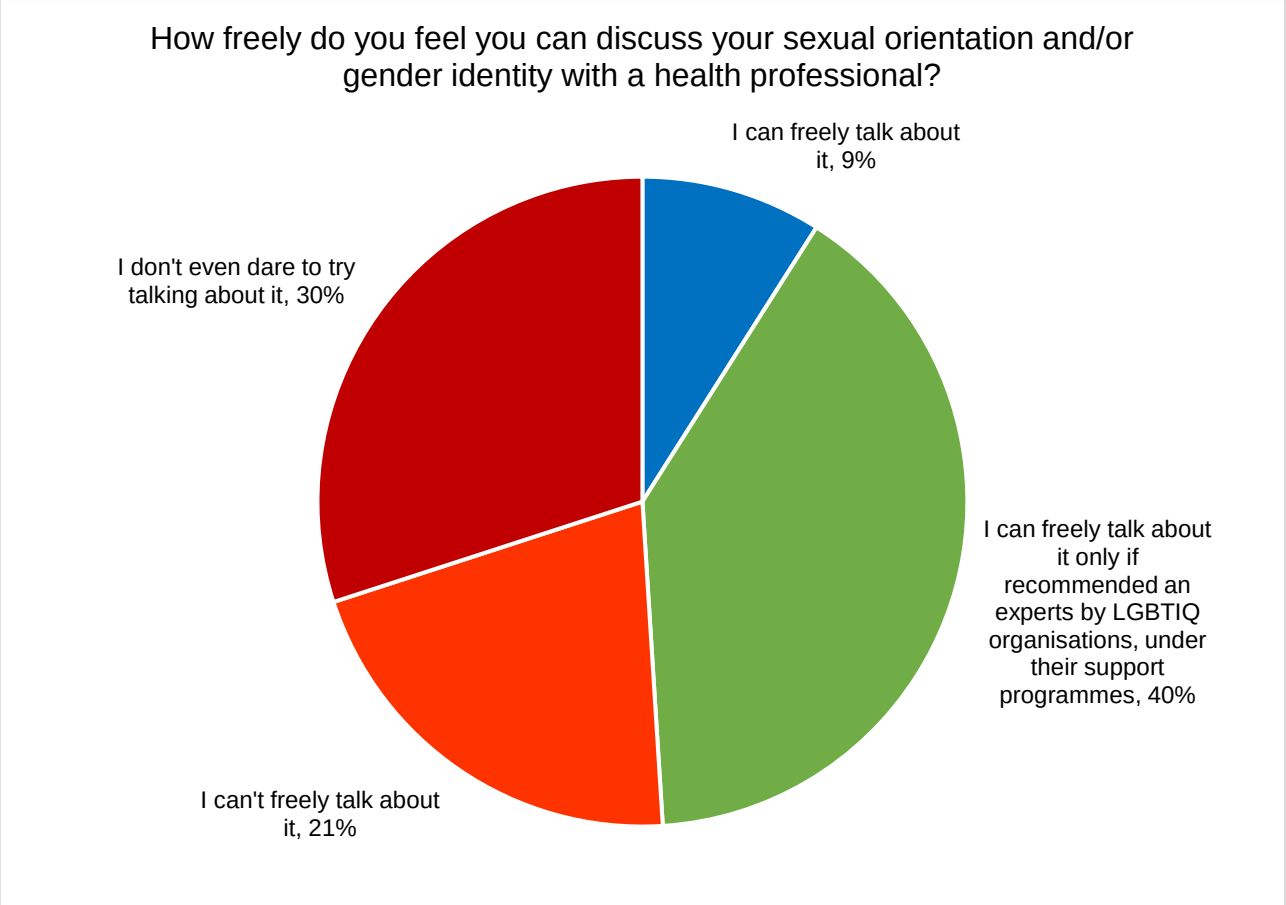

Figure 4 Attitudes of respondents in relation to the approach of health professionals

Structural Discrimination

If appropriate skills and knowledge on specific topics and procedures identified with the LGBTIQ community in access to health; If we measure the sense of belonging that LGBTIQ persons are accepted in the system, that culturally sensitive language is used, and that they are treated with dignity and addressed as patients; If a welcoming environment for LGBTIQ persons is affirmed and there is an active medical practice that promotes and disseminates policies and statements on non-discrimination, and includes LGBTIQ identities; If there is unhindered access to hormonal and/or surgical treatment for trans people; If there is knowledge about the disparities in the health care of the LGBTIQ community... **If we define it all** as values... Then it is clear that the Montenegrin health system is not based on values that respect different identities, nor on Constitutional and legal guarantees about non-discrimination and respect for human rights that (all) define it.

Key Arguments

For a whole decade back, in public policies, there are no measures on enumerated values—that they are reasonable, efficient and predictable. Health authorities have never acknowledged health disparities for LGBTIQ people, and public policies at all levels ignore the associated inequalities. These are the key arguments, and any further discussion on this topic would be deficient. Therefore, all that exists are measures that serve the constructed model of governance façade and flattering the international community, rather than real efforts to improve the position of the LGBTIQ community. The pages of this book provide many examples and arguments about structural and structural deficiencies. Social

determinants are not defined, and health disparities are not considered. The complete absence of proclaimed values is also confirmed by the views of the Montenegrin LGBTIQ community. **The vast majority** of the sample (**88%**) stated that in their experience these values are not inherent in the Montenegrin health system. They have never enjoyed them (**58%**), they don't know it exists at all (**12%**), or it happened very rarely (**18%**). In addition, the analysis of Constitutional guarantees, legal solutions and public policies on health, respect for human rights and the principle of non-discrimination *against* the realistic perspective and practice in access to health... shows that the Montenegrin LGBTIQ community, as well as other marginalised groups, experience **structural discrimination** that has a negative impact on numerous aspects in their lives, outcomes and overall well-being.

Inequalities and Barriers

Health Inequalities

Theory suggests that medical education and training on specific LGBTIQ health needs can improve the knowledge and skills of medical and health personnel and reduce stigma and discrimination of patients (Sekoni, Gale, Manga-Atangana et al., 2017; Jalali & Sauer, 2015: 417). Without adequate standards and a better understanding of the disparities and health risks of the LGBTIQ community, healthcare providers will not be able to respond to such a challenge—due to various negative effects, such as loss of trust and avoidance of access to (emergency) medical care (Jalali & Sauer, 2015: 417). Gender sensitivity is a key prerequisite for achieving quality health care (Cheng & Yang, 2015). However, after 45 years of the government's commitment to the Alma-Ata principles, health and access to health care and mental health is a systemically unregulated area for LGBTIQ people in Montenegro.

Systematic Search

A systematic search of the scientific literature of various databases and data points to the conclusion that a multidimensional approach (and with multiple methods), including formal education and educational strategies, contact with LGBTIQ individuals and interactive experiences with the community, best influence the improvement of LGBTIQ cultural competence in nursing education (Orgel, 2017). Also, teaching staff in educational institutions for medical education often do not know the appropriate terms and protocols necessary to provide quality health care to LGBTIQ patients, and there is a lack of mandatory teaching programs (Jones, 2021: 4). Scientific studies, Australian, European, and North American contexts, indicate:

→ Lack of information about the health of LGBTIQ persons,
→ Worse health outcomes compared to the general population,
→ Discrimination and direct denial of health care,
→ Negative attitudes towards the LGBTIQ community and fear of discrimination,
→ Low-quality care and behaviour of health personnel, and
→ Lack of trust and privacy in the provision of health services
(Banerjee, Walters, Staley et al., 2018; Sekoni, Gale, Manga-Atangana et al., 2017).

Depression, Anxiety, and Stress Disorders

Depression, anxiety, and stress disorders are **key** mental health problems of the Montenegrin LGBTIQ population. More than half of the respondents (**56%**) stated that they have a diagnosed anxiety problem. Approximately half of the sample (**48%**) reported that they had depression, while **44%** of the respondents declared that they had a stress disorder. Other diagnosed problems include sleep disorders (**17%**) and eating disorders (**12%**). **47% of respondents** stated that they received appropriate therapy and psychiatric drugs (various anxiolytics, antidepressants, and/or sedatives). Compared to the general population, LGBTIQ people otherwise have higher rates of mental health problems such as depression and anxiety (Medina-Martínez, Saus-Ortega, Sánchez-Lorente et al., 2021; Hafeez, Zeshan, Tahir et al., 2017). Scientific evidence suggests that higher risks are due to higher prevalence of certain behaviours associated with cancer risk. In lesbian and bisexual women, a higher risk

of breast cancer can be infertility and nulliparity (not giving birth), alcohol use, smoking, and obesity, while in gay men receptive anal intercourse increases the risk of anal cancer (Banerjee, Walters, Staley et al., 2018).

Greater Barriers to Access to Health

In the perspective of global indicators of different studies, compared to heterosexuals, LGBTIQ people experience greater obstacles in accessing health care, have worse mental and physical health, higher rates of depression, anxiety, suicide or suicide attempts, use and abuse of substances (Rice et al., 2021; Plöderl & Tremblay, 2015), a higher probability of suffering from cardiovascular diseases (Ross & Setchell, 2019; Rice et al., 2021), suffering from cancer, diabetes and disability (Ross & Setchell , 2019: 99), a higher probability and the rate of heart attack, hypertension, arthritis, gastrointestinal problems, liver disease, obesity, and stroke (Fredriksen-Goldsen et al., 2017; Blosnich et al., 2016; Case et al., 2004; Cochran & Mais, 2007; Fredriksen-Goldsen, Kim & Barkan, 2012). The probability of developing mood, anxiety and substance use disorders is at least 1.5 times higher among lesbian, gay, and bisexual people than in the general population, while the risk of receiving a diagnosis is twice as high for at least one of the mentioned disorders (Gmelin, De Vries, Baams, et al., 2022: 2319).

Associated Effects

Data from the National Longitudinal Study of Adolescent Health indicate that sexual minority youth tend to be isolated and excluded from social networks, which can increase the risk of depressive symptoms among men, while bisexual men, and women compared to heterosexuals showed a more pronounced tendency to depression (Hafeez, Zeshan, Tahir et al., 2017). It has also been established that bisexual people have a particularly high risk of negative mental health outcomes (Gmelin, De Vries, Baams, et al., 2022: 2319-2320). CAP research indicates that discrimination and disrespect by health care providers negatively impacted respondents seeking health care. Many delayed or did not attempt preventive examinations, three times more likely than non-LGBTIQ people (23% vs. 7%). Such negative rates are significantly higher among transgender people, where approximately half of the respondents (51%) answered that they delayed or did not even try to get the necessary medical care. Also, high negative rates are expressed among LGBTIQ persons who are members of racial minorities and LGBTIQ persons with disabilities (Medina & Mahowald, 2023).

Avoiding Discrimination

In order to avoid their own exposure to the expected homonegative stigma, the Montenegrin LGBTIQ community adopts protective strategies. Examples of behavioural protection are concealing sexual orientation or avoiding family and friends (Layland, Maggs, Kipke et. al., 2022). Such anticipation contributes to shame, emotional dysregulation, and social isolation, which adversely affects health (Layland, Maggs, Kipke et. al., 2022). A homophobic environment and social pressures condition various psychological and emotional reactions. Avoiding harassment and discriminatory treatment, as well as changing the way of behaviour is dominantly expressed in their attitudes. More **than half of** the sample (**57%**) in this study stated that very often in public places they prevent themselves from doing or saying certain things so that people would not think they belong to the LGBTIQ community.

Protective Strategies

More **than half of** the respondents (**52%**) in this study stated that[4] they did not reveal their belonging to the LGBTIQ community in a conversation with a mental health expert because they were **afraid of** the reaction (50%). Moreover, 43% of respondents (out of 52%) believe that it is necessary for a mental health professional to know their sexual orientation, but they do not trust that doctors will be of help to them (28%), that is, they would not benefit from it, because they would not be understood because (doctors) "*don't know anything about it"* (15%). In a conversation with an expert, approximately half of the respondents (48%) revealed their own sexual orientation. Of that number, 37.5% (18) stated that the reaction of mental health experts was negative, i.e., repulsive and hostile. Four respondents (8.3%) stated that the reaction was undefined, strange, mixed, vague, and distant, while more than half (54.2%) stated that the reaction was positive, supportive, and friendly. **Regarding the trust of** the LGBTIQ community in the knowledge of experts on LGBTIQ issues, sexual orientation and/or gender identity, the indicators are divided. Half of the sample believes that they have no knowledge about it (no knowledge at all, 20.8%; almost no knowledge at all, 16.7%; to the greatest extent no knowledge, 12.5%), while the other half of the sample thinks the opposite (they have satisfactory knowledge, 16.7%; they have almost excellent knowledge, 14.6%; they have excellent knowledge, 18.7%).

Disease Prevalence

Compared to heterosexual women, women who reported a lesbian sexual orientation have a higher prevalence of risk factors for breast cancer and high daily alcohol intake (Case et al., 2004), arthritis (Cochran & Mays, 2007; Fredriksen-Goldsen et al., 2017: 1334), diabetes, asthma, heart disease, high cholesterol (Blosnich et al., 2016), heart attack, stroke, a number of chronic conditions and poor general health (Fredriksen-Goldsen et al., 2017: 1334). Compared to heterosexual men, gay/bisexual men have higher blood pressure (Hatzenbuehler et al., 2013), angina pectoris, lower back or neck pain, cancer, and a weakened immune system (Fredriksen-Goldsen et al., 2017: 1334), hypertension (Everett & Mollborn, 2013; Wallace et al., 2011), diabetes, symptoms of psychological distress and physical disability (Wallace et al., 2011), and stroke (Blosnich et al., 2016). Men in same-sex partnerships are almost 4 times more likely to have a mood disorder than men in heterosexual partnerships (Blosnich et al., 2016). Gay and lesbian youth have an increased prevalence of abdominal pain (Roberts et al., 2013), and youth who face life situations where they are rejected by their family because of their sexual orientation or gender identity, compared to peers in the community who have not lived through such an experience are more than three times more likely to be suicidal (Veltman & Chaimowitz, 2014).

Psychological and Emotional Problems

Limited access for the LGBTIQ community to have clinically and culturally competent health personnel who will respect terminology, protocols, stigma, and health needs, including specific recommendations for providing quality care, contributes to health inequalities between heterosexual/cisgender and LGBTIQ people (Sekoni, Gale, Manga-Atangana et al., 2017). When asked if they ever had suicidal thoughts or attempts in their life as a reflection of psychological or emotional problems due to their sexual orientation and/or gender identity... The vast **majority** of the sample (**73%**) declared that this was the case. 17% of the sample faced it at least once in their life, 35% several times in their life, and even 21% several times a year.

[4] Family doctor, psychologist, psychiatrist, or medical staff.

Neglecting the Health of the Nation

The nation's mental health problems have been swept “under the carpet” for decades. There is practically no one to help Montenegrin citizens, and public policies do not reflect real problems. The results of this study show a clear connection between different types of minority stressors and suicidal thoughts and ideas within the Montenegrin LGBTIQ community and indicate the importance of **prevention measures** in health policy (which do not exist). Moreover, such measures were not proposed even in times of increased problems and pronounced social stress, such as the COVID-19 pandemic. In addition, major depressive episodes associated with major depressive disorders have a significant impact on suicide deaths (Turecki & Brent, 2016). However, the actual clinical relevance in Montenegro does not define the sensitivity of health personnel towards LGBTIQ patients, while knowledge and skills in the provision of culturally competent care is limited. All together are not factors in the prevention of health, and the systemic perspective of the problem is missing.

Socioeconomic Reasons

Compared to the general population, systematic scientific studies and meta-analytic research have established that there is an association between sexual orientation and an increased risk of self-harm, suicide attempts and suicide (Chum et al., 2023; Jadva et al., 2023; de Lange et al., 2022; Jonas et al., 2022; Williams et al., 2022; Adelson et al., 2021; McDermott et al., 2021; Pereira, 2021; Berona et al., 2020; Blosnich et al., 2017; Mereish et al., 2014; Haas et al., 2011). Montenegrin data show that around 130 people commit suicide each year (Injac-Stević et al., 2021). In addition to individual risk factors—distal or predisposing, cognitive styles or mediating effects, and proximal risk factors that are time-related and act as precipitants (Turecki & Brent, 2016), studies also define **social circumstances** that contribute to people's suicides. Most often, these are the reasons of the socio-economic background, such as unemployment, risks that come from unemployment (i.e., poor financial conditions), but also poor access to mental health services (Injac-Stević et al., 2021). However, the Centre for Investigative Journalism (CIN) doubts the reliability of Montenegrin data, because they differ from the data of the World Health Organization (CIN, 2022). Data from the World Health Organization indicate that according to the number of suicides per capita, Montenegro ranked 14th in the world in 2019, and had the highest suicide rate in the Region (16.2%)[5] (CIN, 2022). The latest national data are worse than for 2019, which is why CIN assumes that we are therefore even closer to the top of the world list (CIN, 2022).

Evidence

The extensive review of evidence in this book indicates that health authorities and human rights authorities, and related public policies, have ignored requests for decades and know next to nothing about the health inequalities of LGBTIQ people. If we take into account the data of the World Health Organization, that Montenegro ranks **fourth** in the world in terms of inflammatory/cardiac death, and that we are **eighth** in the world in terms of mortality from stroke and lung cancer (see page 38), then it is a neglect of the authorities that acknowledge health inequalities—to inform and explore the links of LGBTIQ people with heart disease, stroke and lung cancer, but also mental health and palliative care, is obvious. Therefore, although the authorities claim that they respect “methodology” in the creation of public policies, it was never their goal to inform themselves, to encourage research and improve public policies, but also to foresee public health interventions to help citizens, especially marginalised social groups. in dealing with inequalities. In this way, decades of governance

[5] Slovenia (14%), Croatia (11%), Serbia (7.9%), Macedonia (7.2%), Albania (3.7%).

and governance of the health sector **itself** has been an obstacle to the development of public health interventions that could tackle health inequalities. Moreover, practices are noticeable that it can be said that health inequality was **politicised**, due to which different dimensions—which are related to socio-economic and ethnic conditions, including sexual orientation and gender perspective—were excluded from the model, because it was necessary to hide the bad results (Kojičić, 2024). On the other hand, if it is true that the authorities "respected" the methodology, then the decade-long absence of the former would be convincing evidence of **deliberate** neglect of the (nation's) health. Therefore, there is no doubt that a broad national effort is necessary to encourage and fund the necessary research and raise people's awareness of real health problems, including the LGBTIQ community, and to develop public health interventions, prevention strategies and establish methodologically based public policies that will recognise and admit the real facts.

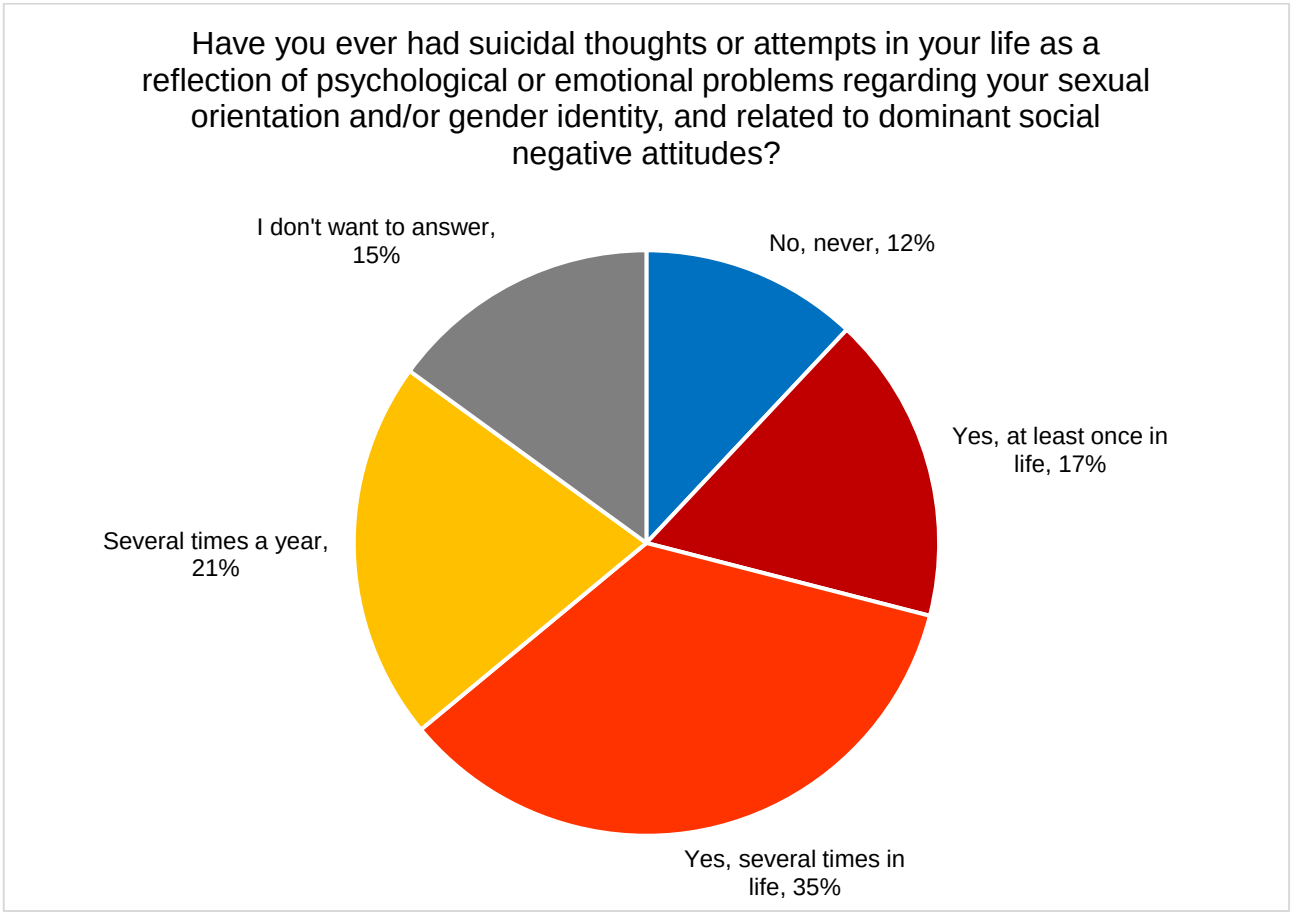

Figure 5 Answers of respondents in relation to the existence of suicidal ideas or attempts during life

Other Indicators

The prevalence of osteoporosis and cancer of the colon, liver, breast, ovaries, or cervix are higher in lesbians and bisexual women, while anal cancer, prostate, testicular, and colon cancer, eating disorders, and transmission rates of the human immunodeficiency virus (HIV), viral hepatitis and other sexually transmitted infections, are higher in gay and bisexual men (Medina-Martínez, Saus-Ortega, Sánchez-Lorente et al., 2021). Bisexual people are exposed to a disproportionate risk of intimate partner violence. Compared to the general population, LGBTIQ people also face a higher rate of anal cancer, asthma, obesity, substance abuse, including the use of tobacco, alcohol and other drugs, and suicidal behaviour (Medina-Martínez, Saus-Ortega, Sánchez-Lorente et al., 2021; Mattei, Russo, Addabbo et al., 2021;

Morris, Cooper, Ramesh et al., 2019). Gay men have also been found to have a higher rate of cancer diagnosis and worse outcomes after diagnosis (Kamen, Palesh, Gerry et al., 2014). Physical inactivity, substance use, and psychological stress are risk factors for poorer health outcomes (Kamen, Palesh, Gerry et al., 2014).

Access to PEP

The vast majority of the sample (**81%**) declared that they were not satisfied with the approach to PEP (post-exposure prophylaxis) and the way the therapy was organized. Of these, a number of respondents (**21%**) stated that they do not have access to PEP therapy in their place of residence, half of the respondents see access to PEP as an impossible mission (**50%**), while **10%** of respondents due to the required efficiency of drug use, on the one hand, and complicated procedures in accessing therapy on the other hand, did not think about it at all.

Access to PrEP

For **the vast majority** of respondents (**75%**), access to PrEP (pre-exposure prophylaxis) is limited. They don't use it; it doesn't officially exist as a prevention option and it can't be obtained in pharmacies. On the other hand, 20% of respondents declared that they take PrEP, but not regularly, and obtain it illegally.

Community as a Smokescreen for the World

Ignoring the Needs of the Community

All the above suggests **an absence of vision**. Despite numerous suggestions and studies, competent ministries, especially those of health and human and minority rights, for a whole decade have shown no willingness to integrate, structurally connect, and harmonize LGBTIQ issues, and foresee the consequences of real problems. To illustrate, in the midst of the COVID-19 pandemic, which has significantly worsened the situation and overall negative effects on the quality of life and health of the community—when the needs and demands for social services, psychological support, and legal and economic assistance have tripled, the Ministry of Human and Minority Rights showed no concern in distress. Due to lack of support, the LGBTIQ shelter was then closed (January 2022). The community never received a response to the request it made. And that is also a question of dignity, isn't it? A huge number of members of the LGBTIQ community were left without existential support and protection: physical, psychosocial, legal and any other (Kojičić, 2022: 46-47).

Dealing with Discrimination

In January 2023, the Centre for American Progress (CAP) published the Report on Discrimination and Barriers to the LGBTIQ Community.[6] The report indicated that the LGBTIQ community and other "sexually and gender diverse"[7] people experience both structural and interpersonal discrimination, with very negative effects on their lives and overall well-being (Medina & Mahowald, 2023). LGBTIQ people were more exposed to some kind of discriminatory behaviour compared to people who do not belong to the community. More than one (out of three) LGBTIQ adults reported experiencing discrimination compared to less than one (out of five) non-LGBTIQ adults (Medina & Mahowald, 2023). More than half of transgender or non-binary people, and two (out of three) intersex people, as well as almost half of people who are persons of colour and people with disabilities who belong to the LGBTIQ community have experienced some form of discrimination (Medina & Mahowald, 2023). Half of the LGBTIQ respondents reported some form of discrimination or harassment in the workplace, including dismissal from work (Medina & Mahowald, 2023). A dominant number, four (out of five) respondents among LGBTIQ adults responded that they had taken at least one action to avoid discrimination, including hiding a personal relationship… or avoiding doctor's offices or changing the way they dress. Due to disrespect or discrimination by service providers, more than one (in five) LGBTIQ adults, and more than one (in three)

[6] The report is a comprehensive, nationally representative survey of the lives, attitudes, and experiences of the LGBTIQ community in the United States. The research was designed in collaboration with the research centre at the University of Chicago (NORC) and covered a wide range of situations about the experiences of LGBTIQ people in the public and private spheres. This included physical and mental health, medical care, discrimination and education, a comparative analysis of survey response outcomes, as well as a review of research in relation to marked demographic differences among LGBTIQ communities.

[7] The term sexual and gender diverse is a US National Academies of Sciences, Engineering and Medicine term used to „describe individuals who identify as lesbian, gay, bisexual, transgender, queer, intersex, non-binary, or who exhibit attractions and behaviours that are not conforming to heterosexual or traditional gender norms." Also, this term is commonly used by the National Institutes of Health (Cited in the CAP Report, by Karolina Medina and Lindsay Mahowald) (Medina & Mahowald, 2023).

transgender or non-binary people, reported delaying or avoiding medical care (Medina & Mahowald, 2023).

Bad Reputation

Let's try to imagine similar comprehensive research and potential results in a homophobic environment such as the Montenegrin environment. This also explains why the authorities, in the decades of their own practices, **have failed** the community's expectations to provide systemic conditions for LGBTIQ issues to be treated with due methodological attention and the expected vision. Today, it is obvious that they were more dedicated to the challenges of governance façade and flattering the international community, than they showed **the structural** facilities to really care for the LGBTIQ community. In combination with numerous other defects and limitations of the system, but also due to persistence in governance façade, such behaviour significantly contributed to **a bad reputation** in the international community. This is demonstrated by numerous examples and arguments in this book.

Environmental (In)justice

States are obliged to refrain from denying or limiting equal treatment in access to health, including for prisoners or detainees, minorities, asylum seekers, and illegal immigrants. Moreover, the obligation to respect implies that the state is obliged to refrain from **illegal pollution** of air, water, and land (Paragraph 34, General Comment No. 14, in relation to Article 12 of the International Covenant on Economic, Social and Cultural Rights; UN Committee on Economic, Social and Cultural Rights). Contrary to the law, information from the Environmental Protection Agency indicates frequent non-compliance with obligations and legal content, while the effects of such governance have never been investigated. Moreover, they were not even recognised. Not a single word about it in health policy and human rights policy, but also related policies—that these are problems that need to be analysed and solved. The effects of such governance are multiple times harmful to the overall well-being of all citizens, especially marginalized social groups. In public policies, problems are still invisible, and for health authorities and the human rights system, the risks of danger to people's health are not relevant.

The Air that Kills

From 2010 to 2020, reports continuously warn of extremely high loads of suspended PM10 and PM2.5 particles in the air of Pljevlja—constant, multiple, and significantly **illegal** exceeding of almost all prescribed limit values (Agency 2020: 15 and 16; Agency 2019: 13, 15 and 17; Agency 2018: 28 and 29; Agency 2017: 25 and 38; Agency 2016: 23; Agency 2015: 20; Agency 2014: 21; Agency 2013:19-20; Agency 2012: 15; Agency 2011: 15). In the Report for 2021, the Agency found in Pljevlja **114 days** of exceeding the limit value of the average daily concentration for PM10 particles (Agency 2022: 5). Significant exceedances of sulphur(IV)oxide (SO2) values were recorded in 2020 and with higher amounts than in previous years (Agency 2021: 6). Extremely high concentrations of sulphur(IV)oxide (SO2) were also registered for the period 2015-2019 (Agency 2020: 15; Agency 2019: 11-12; Agency 2018: 27 and 40; Agency 2017: 24 and 38; Agency 2016: 22).

Disheartening Data

Data from the World Health Organization for Montenegro indicate that, measured **only** by the concentration of PM2.5 particles, 486 people die **prematurely each year** because of air pollution. On average, 229 die from ischemic heart disease, 175 from heart attack, 41 from cancer of the trachea, bronchi, and lungs, 31 from chronic obstructive pulmonary disease,

and 10 from lower respiratory tract infections (WHO, 2023).[8] A World Health Organization study on the impact of air pollution on health in Montenegro indicates that close to **6%** of all deaths in Podgorica, **12%** in Nikšić and **22%** in Pljevlja **can be** attributed to air pollution (Krzyzanowski, 2016: 16). However, this study was published in 2016 and is based on data from 2010-2012. Therefore, it is likely to be expected that the indicators and estimates will be much worse today. The latest estimates of the European Environment Agency (EEA) for Montenegro, from 2021, indicate that 919 people **prematurely** annually die **only** from exposure to PM2.5 particles (EEA, 2021)[9]. This is supported by the facts about the constant increase in the incidence of inflammatory/cardiac death, stroke, and lung cancer (Kojičić 2023: 17). The number of deaths is increasing compared to the number of births, and the number of citizens has decreased by 40,755 (Monstat, 2014: 38). The UN estimates that the number of Montenegrin citizens will decrease by over eight percent (589,000) by 2050 (UN, 2019, Table A.9: 31).

Structural Defects

These indicators suggest a **multi-decade** history of serious systemic deficiencies in governance methods, and the creation and implementation of public policies. They indicate non-compliance with obligations and legal content, constitutional guarantees, and standards of human rights. Therefore, one can freely talk about decades of arbitrary public policies, because as such they could not be methodologically based, and the harmful effects on physical and mental health are constantly increasing. For the sake of illustration, **there are no measures** in the health, environmental, social, and human rights policy to help citizens, especially marginalised social groups and the LGBTIQ community, to cope with the consequences and to ease harmful impacts, and to reduce pollution to acceptable levels. Furthermore, state data only reflect annual averages and do not reveal daily or maximum levels of pollution. It additionally casts a shadow over problems and deepens doubt about real effects and truth and makes the assessment of the social position of marginalized groups more complex.

Consequences of Cosmetic Approaches

There is no doubt that cosmetic variants of public policies have left negative implications on people's physical and mental health and prolonged agony, especially for marginalised social groups and the LGBTIQ community. Decades of the government's attitude towards the health of the nation meant that citizens probably lost hundreds of years of life expectancy. Among others, these are **supporting** arguments about the authoritarianism of the government and the dominance of power, but also the reasons that, in political, sociological and philosophical observations, indicate why in the past experience we have never had connected and coordinated public policies, and why the methodology was not respected—the problems are **thus** concealed , because it was not in the interest of the authorities to be visible. At the same time, the intelligentsia and the youth were leaving the country and were not desirable for such a value system (For more, see pages 39 and 40; Corruption and migration; System pressures and disruptions; Systemic consequences).

The COVID-19 Pandemic

The COVID-19 pandemic has had a strong negative impact on the mental health of marginalised social groups. Several studies in the United States have indicated a threefold

[8] World Health Organisation (2023). Global Health Observatory Data. Ambient air pollution: Burden of disease — Deaths. *World Health Organisation*.
[9] European Environment Agency (2021). Montenegro - Air pollution country fact sheet: Health impacts.

increase in the prevalence of depression among adults. Compared to the general population, the prevalence rate among people with disabilities in the first year of the pandemic was 68% higher (Brown & Ciciurkaite, 2022: 215). Studies also point to various discriminatory experiences that have had a continuous and devastating impact on the mental health of the LGBTIQ community. The COVID-19 pandemic has increased **structural gaps** in access to health for the LGBTIQ community (Sampogna, Ventriglio, Di Vincenzo et al., 2021). Growing stress, negative emotions, worries and feelings of uncertainty had an increased impact on their physical and mental health (Sampogna, Ventriglio, Di Vincenzo et al., 2021). High levels of stress and symptoms of depression were especially pronounced among young people, transgender, and gender diverse people (Kneale & Becares, 2020). During the COVID-19 pandemic in Montenegro, the LGBTIQ community's demand for social services, psychological, legal, and economic support **tripled** (EC Montenegro Report: 36; cf. Kojičić, 2022: 46). And just then, when the community's demands for support increased significantly, it happened that the state did not show the necessary care, and the LGBT Forum Progress' shelter was closed. What a coincidence?! This would be an example of how the work of an administrative body, the Ministry of Human and Minority Rights, which should take care of the human rights and dignity of citizens, including the LGBTIQ community, can by its own (in)action affect the mental health problems of a marginalised and discriminated groups.

Irresponsibility

Scientific research suggests that economic downturns and conditions **increase** discrimination against LGBTIQ people, while the COVID-19 recession may **affect** mental health issues in this population group (Mattei, Russo, Addabbo et al., 2021: 400). Emphasis is placed on strict monitoring of phenomena and the establishment of special policies with the aim of improving mental health and reducing social and health inequalities and discrimination. However, the health authorities and the Ministry of Human and Minority Rights not only did not monitor these phenomena and establish special policies for the improvement of mental health, but **significantly** did not implement the already adopted (regular) measures to improve the social position of the LGBTIQ community. Or maybe they followed these phenomena, but in a way that they did not support the voice of the community, and in the middle of the COVID-19 pandemic, they left the community without the necessary social, psychological, and legal assistance services that were used by hundreds of people. Moreover, even 630 days after the closure of the shelter and the confiscation of community support programs, the Ministry of Human and Minority Rights has not found a solution to the real problem. It has never responded to the community's request to aid in times of need.

Incentives of Oppression

In such circumstances, formulations, and values about the reduction of social and health inequalities and discrimination are more reminiscent of **science fiction** than of obligations that Montenegrin competent authorities actually make and respect. In addition to numerous structural obstacles and problems, the closure of necessary social, psychological, and legal assistance services is an example of how the authorities can influence the mental health problems of the community. In fact, how the (in)action of the authorities contributes to the strengthening of the influence of social oppression on the community and the weakening of the community. Moreover, such a relationship unequivocally suggests that the authorities in the Ministry of Human and Minority Rights do not understand (or will not understand) the **nature and human rights problems** of the LGBTIQ community, nor **the transformative** processes for long-awaited social changes.

Community Resilience

The literature makes a clear distinction between individual resilience and community resilience. Individual resilience refers to the ability of **an individual to overcome** problems and cope with stress, and community resilience is defined as **society's ability to empower** marginalised groups (McConnell, Janulis, Phillips et al., 2018: 6). Empowerment is achieved through the provision of material and non-material resources, to make it easier for vulnerable groups to cope with stress (McConnell, Janulis, Phillips et al., 2018: 6). For society to function as **a resource for the individual**, the resilience of the community must first be achieved, for individuals to identify, feel belonging and connect with society (McConnell, Janulis, Phillips et al., 2018: 6). In this way, conditions are created when individuals feel **the resilience of the community** in relation to real problems, which is a prerequisite for encouraging appropriate frameworks of action that will condition social changes. However, the nature and methods of decade-long governance, as well as practices regarding the creation of public policies, have made Montenegrin society function not as a resource for vulnerable social groups, which is why the processes of identification and connection of the LGBTIQ community with the competent authorities and society are very slow, difficult, and sporadic or non-existent. Therefore, it should not be surprising that the vast majority of the sample from this study declared that **they have almost no** trust in competent institutions and public policies (see pages 15 and 16).

Community Perception

When asked how they would describe the normal life of an LGBTIQ person in Montenegro, the complete sample (**100%**) of the surveyed persons from the LGBTIQ community stated that they think that Montenegrin citizens perceive LGBTIQ persons as sick and that they need to be treated. The vast majority of the sample (**90%**) declared that they believe that citizens think that homosexuality is unnatural and abnormal, that they treat them as if they are superior and better, that LGBTIQ identities are not accepted as normal and natural, and that people avoid them, they pity, gossip, name-call and insult (with the derogatory terms like “fag”, etc.) ... That citizens do not support and accept same-sex communities, and do not like to see same-sex people embraced in public, and LGBTIQ people are treated with less respect. Also, the vast majority of the sample (**80%**) believes that people do not enjoy the company of LGBTIQ people, that they tease them and make jokes about them, that they treat them as if they are afraid of them or morally disgust them, and they believe that it is very difficult that an LGBTIQ person is allowed to work with children. The vast majority of the sample (**70%**) also stated that LGBTIQ people are treated less kindly than others.

Domination of Power

Although the methodology requires the connection and coordination of Government policies, this has not happened in the practice of the administration so far. In contrast, every official announcement proclaims that everything was done “*in accordance”* with the methodology. **If it were otherwise**, the expectations are that the health authorities and those responsible for human and minority rights will respond...

(1) What are the state’s mental health support programmes for the LGBTIQ community?
(2) Additionally, in connection with point 1, what are the mental health support programmes, including the LGBTI community, in criminal law matters?

About that…

What is the degree of compatibility between such “methodologically” based programmes (in points 1 and 2) and what are the indicators—with health policy (for example, on the occasion of inflammatory/cardiac death, death from stroke or lung cancer)? What are the results of such selected “methodological” activities for the mental health of the LGBTIQ community, including human rights and criminal law matters?
What is the degree of compatibility between such “methodologically” based programmes (in points 1 and 2) and what are the indicators— with the educational and school environment, that is, rehabilitation programmes in criminal law matters? What are the results of such selected “methodological” activities for the mental health of the LGBTIQ community, including human rights and criminal law matters?
What is the degree of compatibility between such “methodologically” based programmes (in points 1 and 2) and what are the indicators—with the work environment and employment programmes? What are the results of such selected “methodological” activities for the mental health of the LGBTIQ community, including human rights and criminal law matters?
What is the degree of compatibility between such “methodologically” based programmes (in points 1 and 2) and what are the indicators—with social policy and socio-economic status? What are the results of such selected “methodological” activities for the mental health of the LGBTIQ community, including human rights and criminal law matters?
What is the degree of compatibility between such “methodologically” based programs (in points 1 and 2) and what are the indicators—with the environmental policy (for example, due to continuous exceedances and the presence of harmful substances in the air, in Pljevlja, and a significant increase in diseases with that related)? What are the results of such selected “methodological” activities for the mental health of the LGBTIQ community in Pljevlja and the northern region of Montenegro, including human rights and criminal law matters?
What is the degree of compatibility between such “methodologically” based programmes (in points 1 and 2) and what are the indicators—with demographic policy (for example, regarding the continuous growth of premature death of citizens in which tens of thousands of years of life are lost)? What are the results of such selected “methodological” activities for the mental health of the LGBTIQ community, including human rights and criminal law matters?

Actual Results

After 45 years of the transformation of the Montenegrin health sector and the government's commitment to the goals and values of Alma-Ata (WHO, 1978), whose principles are the key (written) pillars of Montenegrin health policy, the **measured results** of the achievement of the highest attainable standard of health, improvement of ethics, development research and service, and health equity are…

→ Share of direct payment of health services by citizens, the so-called “out-of-pocket spending” is 39.6 percent, three times higher than the average in the EU (Kojičić, 2021b: 28).
→ Inflammatory/cardiac deaths in Montenegro reached 311 or 4.72% of the total number of deaths. The age-adjusted death rate is 27.07 per 100,000 inhabitants, which ranks Montenegro 4th in the world.

→ Mortality from stroke in Montenegro reached 2,208 or 33.49% of the total number of deaths. The age-adjusted death rate is 184.75 per 100,000 inhabitants, which ranks Montenegro 8th in the world.
→ Mortality from lung cancer in Montenegro reached 340 or 5.16% of the total number of deaths. The age-adjusted death rate is 33.82 per 100,000 inhabitants, which also ranks Montenegro in 8th place in the world.

According to the adjusted rate per 100,000 inhabitants, 351.53 deaths were recorded from stroke alone, while 278.29 deaths were attributed to coronary, i.e., ischemic heart diseases (WHO, 2020)[10].

[10] World Health Organisation (2020). Global Health Estimates 2020: Deaths by Cause, Age, Sex, by Country and by Region, 2000-2019, *World Health Organisation*.

Conclusion

The struggle of the Montenegrin LGBTIQ community with anxiety and depression is exhausting enough that its members feel that they need to distance themselves from their own potential, dignity, and personal well-being. The administration, health authorities and those responsible for human and minority rights do not think any less of them. The expected respect does not exist. There are neither appropriate nor methodologically based policies to measure progress. Constant community adaptation to social and cultural heteronormative pressures and expectations has become the general norm—with potential multiple and multidimensional adverse health effects. The impacts are widespread and reach civil society. In the absence of adequate government resources, current research and advocacy is insufficient or limited by modest NGO resources. The effects of homonegative stigma are widespread and can adversely affect the physical and mental health of a community.

Systemic Problems

The problems are rooted in social norms and are conditioned **by systemic anomalies** that have been created and/or served for decades to control various processes and governance, including slow progress on LGBTIQ issues. At the same time, intelligentsia and young people were leaving the country, and analytical thinking and knowledge were not the values that were needed. The absence of methodology made the real problems of citizens, including marginalized social groups, invisible. It can be said that they were concealed because they were not unknown. Effective measures to solve the problem have not been proposed and do not exist. For example, regarding the impact of polluted air on people's health, or cardio-vascular diseases, or the mental health of the LGBTIQ community... **There are not even adequate descriptions** of the problems that are generated by the state. It was not a lack of initiative, vision, or knowledge, because everything was there. According to the philosophical narrative, these were systemic anomalies for which analytical **objectivity** in intelligence was not the goal, nor was it necessary for the (so) created system.

Corruption and Migrations

The British Westminster Foundation for Democracy reported in 2019 that their research shows that 70% of young people are considering leaving Montenegro, and 62% of the sample considered belonging to a **political** party crucial for career advancement (Radio Free Europe, 2019a). Research by the German Friedrich-Ebert Foundation indicated that corruption is the biggest **obstacle** in realizing the wishes of young people in the region (Radio Free Europe, 2019b). Their study on young people in Montenegro indicated that significantly **more than half of** young people (**62.91%**) fully believe in the existence of cases **of corruption** in education (Friedrich Ebert Stiftung, 2019: 56). Only 20.4% of the sample was satisfied or very satisfied with the state of democracy in Montenegro, while a **significant majority** (**44.6%**) was not. They were either somewhat satisfied (21.5%) or very unhappy and dissatisfied with the state of democracy (23.1%). Even 16.5% of the sample did not know how to answer the question, and 18.3% did not answer at all (Friedrich Ebert Stiftung, 2019: 40). However, significantly **more than two-thirds** of young people (**76.8%**) declared that they believe that

the differences between the incomes of the rich and the poor should be more uniform (Friedrich Ebert Stiftung, 2019: 40). This also suggests systemic anomalies and corruption.

System Pressures and Disturbances

The various pressures grew over time. In that **interaction**, between serious systemic disturbances and original demands for values, **the dominance of** (unjust) **power**, but also **corruption,** was established. The inability of the community to face real problems grew at the same time (Kojičić, 2024). All of these left numerous unexplored negative effects on the mental health of the nation, especially of marginalised social groups, but also caused **migration**, that a large number of people left the country, and a large number of medical doctors (Kojičić, 2021b: 48; Kojičić, 2024). In such a small and "poor" country, today in reality there is **a huge gap** between the (very) rich and the poor. According to the latest available data from the World Bank, more than 130,000 Montenegrin citizens lived below the poverty line in 2020 (World Bank, 2023). This number is even higher, because the amount shown in thousands is based on the national sample from 2011, when 620,029 people lived in Montenegro. Health inequalities **have been ignored** by health authorities and public policies at all levels for decades. Consequently, nobody in the system cares about it. Statistically speaking, slightly **more than a fifth of** Montenegrin citizens, including members of the LGBTIQ community, **do not have** institutional care in dealing with numerous obstacles in accessing physical and mental health.

Systemic Consequences

Dysfunction exists at all levels. Regulations **do not follow** and/or do not develop mechanisms to provide a systemic response to expected demands. Many regulations are created, proposed, and adopted without any order and systematic consideration and/or lucrative reasons. Instead of analytical objectivity and intelligence, "anomalies" were frequent. Moreover, the impression is that they were also desirable. This can be inferred from **the logic** of the system thus formed, which is reflected in **the dominance** of power (political formal control) and **interest** games of power (political informal control) (Kojičić, 2024). As a result, weak institutions were created, conditioned by numerous contradictions and inconsistencies in the system. Among other things, many regulations and acts are outdated but still valid. Intersectoral connection, coordination and action are almost non-existent. Socio-economic determinants of health are not considered, and there is no institutional and political design to follow them (Kojičić, 2024). Constitutional guarantees and laws are not a benchmark for realising and enjoying the right to health. This limits the possibilities for action, and every activity is "beyond belonging" to the definition it aspires to—and without the possibility of communication and action (Kojičić, 2024). The system that has been in place for decades has simultaneously **rendered** meaningless its own function of managing and coordinating (expected) processes (Kojičić, 2024). Therefore, the health care system does not represent a logically ordered and non-contradictory set of legal definitions (expectations) that should all be consistent with each other, depend on each other and guarantee the adopted values, respect for human rights and human dignity (Kojičić, 2024). In the absence of the former, **expectations are disappointed** and social reproduction itself is wrong (Kojičić, 2024).

Corruption in the Health Sector

The Centre for Monitoring and Research *CeMI* warns that corruption in the health system of Montenegro is a serious problem with negative consequences for "access, quality and fairness of health care" for LGBTIQ persons (CeMI, 2023). In short, this could be a description of the success of the governance of the health sector in (at least) the past decade. Also, this

suggests disturbances in the value system, which is inherited as such. All this does not last one, two or five years, so that the excuses that changes are not possible “overnight” are valid. This has been going on for decades and is caused by the way of governance, because the system did not work structurally and was not supportive in access to health and equity, including the creation and implementation of public policies (Kojičić, 2024).

Authoritarianism Without Justification

Political-philosophical considerations of systemic problems (and consequences) help us understand the discrepancy between effective and legitimate authority. From the examples shown, it is noticeable that **the effective** authority did not create the duties to which it is aimed, so it was not effective. For example, to create effective measures regarding the problem of air pollution and the consequences it has on people's health. In contrast, **legitimate** authority created a single duty “that it must be respected”, although there were no solutions. That is why he was authoritative, and was not justified (Kojičić, 2024). For decades, health authorities and governance have failed to be effective, optimise health and minimise the burden of disease, especially for vulnerable groups. The relationship between doctor and patient almost does not exist, primary health care has lost its function, and the required logic of the health system was not in focus (Kojičić, 2024). Therefore, it had to be respected even without the expected solutions. All this cannot be justified. Moreover, it influenced the overall behaviour in society and shaped its **character** to a significant extent. The dominant majority of Montenegrin citizens today perceive corruption as a “normal” pattern of behaviour (Kojičić, 2024), and international reports and academic analyses of prestigious universities warn of a **“captive state”** (Transparency International, 2020; Cooper-Millar, 2019).[11]

Isolation and Loneliness

Suicidal thoughts are **the most serious** consequence of heterosexism and sexual structural stigma on the mental health of the Montenegrin LGBTIQ community. In a dominant homophobic environment, this normalized the feeling of isolation and loneliness. The impression is that the processes are very complex, multidimensional, and multiple negative for the health outcomes of the LGBTIQ community, which requires further research in this area. Moreover, the impression is that they are **controlled** by the dominance of power and that it is prevented from talking about it. This was also shown in the way the necessary social and psychological support programs of the LGBTIQ Social Centre were closed. This can also be seen in the way the administration feels about its own work and the LGBTIQ community—which could result from homonegative cultural messages and social norms. At the same time, it supports the survival of internalised social stigma and deepens the risk factors for the development of psychological disorders of the LGBTIQ community. Altogether, it is reinforced by serious systemic anomalies and negative effects on the whole society.

Distrust in Institutional Care

Homo-negativism that is deeply rooted in social, institutional, and medical structures **perpetuates** community fear and discrimination. It is the main cause of pronounced health disparities, and Montenegrin public policies do not take this into account. This is also related to the consistent decade-long lack of funding for mental health research and the development of various support programs. In this way, LGBTIQ people are prevented from receiving adequate medical assistance. And that, **structurally**, in economic and political pressures on

[11] See the blog of the Centre for the Study of Corruption at the University of Sussex, in Great Britain, and under the auspices of the event "New actors and strategies for the fight against corruption and research on corruption in the Western Balkans" at the Harriman Institute, Columbia University in the United States of America (7-8 November 2019).

social and institutional policies that limit opportunities for LGBTIQ people. And **structurally**, in institutional policies that, in decades of service, do not recognize the content of binding legal definitions and the consequences of which hinder the opportunities of LGBTIQ people in accessing health. Therefore, it is not surprising that the community in a huge sample declared that they have no confidence at all in institutional care, the health system, and public policies.

Stigmatisation

Numerous studies indicate that the Montenegrin LGBTIQ community is faced with a high degree of discrimination and social distance. This marginalized group was dominantly recognized by society as “different” and labelled them negatively—as sick, mentally disturbed persons who need treatment (66%). Only 5.3% of the population has a positive attitude (Bešić 2020: 34 and 35, cf. Kojičić 2021a: 183). Society has attributed various stereotypes to the community and attached labels to them. Reasoning devalues, dehumanises, and discriminates against them. For example, the gender confusion stereotype, which emphasises that it is natural for all men to desire a female sexual partner and vice versa; That gay men are something deviant in relation to prescribed gender roles; That homosexuals are looking for students and that they are a danger to society; That homosexuality is dark, something equated with mental illness; That homosexuality is contrary to basic social values such as marriage and family (Lance, 1987; Kite & Whitley, 1996; Ronner, 2005; cf. Kojičić, 2014: 43-44). In the context of power, **heterosexual bias** was created, and this dominantly determined **the intensity** of internalised homophobia and conditioned **the concealment** of sexual or gender identity in the community.

Heterosexual Assumptions

Heterosexual assumptions are also dominant at the **institutional** level. This can be seen in the decade-long failure of the authorities to systematically create initiatives that will strengthen the community. There are no systemic solutions in the approach to health, which is explained in detail on the pages of this book. This is also confirmed by the views of the community, which in the dominant sample expressed an almost **absolute lack of trust** in public policies, the health system, and the institutions of the system. In such conditions of stigma, the majority of the Montenegrin LGBTIQ community decided to **conceal** their sexual or gender identity. These are their protective mechanisms, i.e., caution and precaution against serious social and institutional obstacles **to live freely** and exercise their rights. However, the risks and dangers for poor health outcomes are therefore even greater, as such interactions contribute to anxiety to a much greater degree. Institutional carelessness and ignoring affect the weakening of the community, which further limits access to various services. All together are significant risk factors, with possible adverse effects on physical and mental health. These would be the real outcomes of Montenegrin public policies. The result is negative.

Analysis and Synthesis of Results

Although research on sexual and gender minorities in this study found poor mental health outcomes and identified risk factors, the study's findings point to serious institutional gaps in understanding how these effects arise and how they should be addressed. The results identified five key themes:

(1) Marginalisation;
(2) Rejection, fear, isolation, and need for support;

(3) Depression, anxiety, and stress disorders;
(4) Public policies and the environment; and
(5) Affiliation.

The synthesis of findings provides clear guidelines for policy, future practice, and radical change, as well as future research in the field of mental health. Significantly **more than 2/3** of the sample (**82%**) stated that to improve mental health, it is most necessary to reduce hatred, violence and discrimination in society, and **more than 2/3** of the respondents (**72%**) expect more available support services and **professionals**. Approximately **half** of the sample (**48%**) recognises that respect and acceptance of the LGBTIQ community would be helpful in dealing with mental health challenges, while **a significant number** (**44%**) see the solution in system reforms, policy, and practice. Be that as it may, radical changes in the creation of future public policies, and the obligation of their mutual connection and coordination are **imperatives**. Otherwise, the effectiveness of public policies in reducing hatred, violence and discrimination cannot be expected. Without this, the scope of improving the mental health of LGBTIQ people will continue to be significantly limited. The findings from the research strictly point to the importance **of empowering** the LGBTIQ community, to facilitate coping with stigma, marginalization, isolation, and victimization. This is related to the necessity of further **research** in this area.

Recommendations

#1 Authorities need to learn to understand and manage their own actions

The LGBTIQ community has a heightened sense of awareness of discriminatory behaviour. This comes from fear of discrimination, worse systemic position, and worse overall treatment in society, including access to health. Normal living conditions and social opportunities for LGBTIQ people in Montenegro have been limited and unfair for decades. Community dissatisfaction with this is common. That is why it is important that the authorities learn to understand and manage their own actions. This is important so that in the future it would not happen that the authorities promote messages of homonegativity, instead of working on the empowerment of the LGBTIQ community. When this happens and they are understood, then there will be the necessary preconditions for them to start working on reducing (and correcting) their own **structural** pressures on social and institutional policies that limit opportunities for the LGBTIQ community—and reducing the serious **structural** flaws in public policies that do not recognise the contents of legal definition. Contrary to governance façade models, these are the only effective ways to start working on stopping the systemic consequences that hinder the opportunities of LGBTIQ people to access health. Heterosexism and sexual structural stigma, as well as the influence of dominant social heterosexual and cisgender norms, will be less pronounced in such an expected administration. This will have a positive impact on the mental health of the nation and the LGBTIQ community and will condition the release of the community from numerous pressures, but also their identification that the authorities treat them with respect and dignity, that they are valued equally as others, and that they are worthy of attention, cooperation and response administration.

#2 Authorities need to get closer and work closely with the community

The way to do this is to make the voice of the LGBTIQ community heard and respected. In order to be heard, it is necessary to break with the established practices of elected individuals in the administration independently coming up with solutions in public policies. This will represent an innovation in the functioning of the public administration, but it will also mark the long-awaited reforms that are essentially still not happening. For the voice of the community to be respected, the administration should get rid of the bad habits of manipulating the methodology and devote itself to respecting the prescribed rules. In all this, the authorities should work closely with the community and ensure that the **deliberation** processes take place in accordance with the real meaning of (that) term. It is also important that the authorities establish the expected intersectoral **synergy** and thematic **connection** of problems at all levels. This means that proposals are collected, analysed, valued, and evaluated based on facts and evidence. The mosaic of different ideas and needs would be methodologically analysed, valued, and classified according to key (previously defined) priorities, and everything would be grouped together into a (connected) whole system. In this way, governance would experience **administrative regeneration**, take on the original (methodological) design, and the original governance functions would be restored. Then one

could talk about public administration in the function of citizens, for whom it exists. In our discussion it is the LGBTIQ community.

#3 Governments need to acknowledge health disparities

Experiences of stigma are key drivers of sexual orientation-related health disparities, morbidity, and mortality. To solve the problems, it is important that the authorities **acknowledge, understand, and contextualize** such experiences. Therefore, the health authorities should formally recognize the LGBTIQ community as a population with pronounced health disparities and recognise that social stigma and discrimination are key obstacles to health equality for the Montenegrin LGBTIQ community. This recognition should be supported by the views of the entire Government administration, especially the competent departments for education and human and minority rights. Recognition should include a clear vision with a multidimensional approach (and with multiple methods) that will provide frameworks for establishing adequate standards and demonstrate that the authorities understand the disparities and health risks of the LGBTIQ community. Recognition of the gender perspective and sensitivity are key prerequisites in this. This should include formal education and educational strategies, professional health training, but also interactive cooperation and experiences with the LGBTIQ community. This is important for healthcare providers to be able to respond to the expected challenges.

#4 Governments should recognize cultural competence programmes

Authorities should formally recognise training programmes for mental health and LGBTIQ cultural competence. It is necessary to define the goals of LGBTIQ **cultural competence** and develop curricula into medical training programmes. Materials concerning patients of this marginalised social group should be explicitly included, and all relevant factors should be included in broad consultation with interested parties.[12] Goals, curricula and programmes should be connected and made **compatible** with other support programmes, in educational, social, and judicial topics and others, including criminal law. Therefore, everything should be connected and made compatible with cultural competency programmes in serving different populations, including the LGBTIQ community. In this regard, training **modules** should be developed, as well as other necessary **tools** such as campaigns, discussions, scholarship programmes and the like. Priority in training should be given to mental health students, relevant medical staff and other professionals involved in support services. In the public health system, everyone should be required to undergo cultural competency training. For all of this to happen and take on a systemic approach in solving the problem of access to health (and mental health), it is necessary for the health authorities, educational authorities and those responsible for human and minority rights to provide:

» Systemic **reform of the allocation of financial conditions** and provide continuous and stable financial support to medical education, continuing education programmes and thus developed models of training on LGBTIQ cultural competence, and

» **Financial grants** for mental health education and training support programmes for civil society institutions and organisations that demonstrate commitment to cultural competency priorities. These grants should be connected and compatible with previously defined and developed goals, priorities, and cultural competence curricula.

[12] Political organisations, administration, research and welfare centres, various national health services, consumer organizations and direct health service providers serving the LGBTIQ community.

#5 Eliminating health inequalities should become a real goal

Eliminating health inequalities based on sexual orientation or gender identity should become a real goal of public health in Montenegro. There is overwhelming evidence that, compared to the general population, LGBTIQ people experience minority stress and a greater burden of health risks, and numerous limitations in accessing health care. Exposure to stigma puts them at increased risk of institutional and interpersonal discrimination and marginalisation and increases their vulnerability to mental illness and psychological distress. In relation to all demographic categories, mental health outcomes for the LGBTIQ population are non-existent in Montenegro, as generated by the state. This means that the Montenegrin health authorities have not developed an understanding of LGBTIQ health, and the overall result of the health policy for the community is negative. Therefore, it is important that in the creation of public policies, these bad technical norms, and practices in (in)activity of the administration are replaced by measures and plans that will **show understanding and respect the actual interpretation** of the legal definitions of the right to health. To achieve this, and the proposed recommendations (from 1 to 5) work in synergy, it is necessary that the authorities...

» **Conduct research programmes** that will work to build a database (evidence) on LGBTIQ health issues. These programmes should be adapted to support research on similar topics that concern the general population. For the proposed programmes to make sense, it is important for the authorities to define which areas are of the highest priority and align them with the defined goals (see recommendations 2 to 4). This is important because the health of the LGBTIQ community in Montenegro is completely unresearched and covers numerous areas. In the absence of priorities, it could easily happen that the expected results are lost in the flurry of numerous arbitrary initiatives.

» **Data on sexual orientation and gender identity** should be collected in surveys that can provide information on different dimensions that affect the health of LGBTIQ people. These are health care and outcomes, education, human rights, employment, and social status, but also the social and economic circumstances of health. Competent Ministries and MONSTAT should coordinate synergy and connect activities on community data collection. Also, to provide stable financial support for conducting surveys, especially the Ministry of Health, the Ministry of Human and Minority Rights, the Ministry of Education and Science, the Ministry of Labor and Social Welfare, the Ministry of Youth and Sports, the Ministry of the Environment, and the Ministry of Finance. For other necessary surveys that prove to be relevant, the Ministry of Human and Minority Rights should make a proposal and propose new surveys for funding to the national government.

» To produce good effects regarding the expected transformative and social changes to suppress the dominant hatred and stigma, the authorities should **collect data continuously and in a double form**: with surveys at a certain moment, and especially through longitudinal studies that will follow the data collection over the years. All relevant evidence should be used by the authorities to propose effective (measures) and solutions for the problems of the LGBTIQ community in public policies, in all areas and at all levels, following the defined priorities (see recommendation 2).

» In collecting data to form a base of reliable evidence on the health status of LGBTIQ persons in Montenegro, the authorities should ensure that the data collected can be

used for research on the LGBTIQ community in general, but also for new research on the characteristics of LGBTIQ sub-populations and comparisons within (sub)populations. The authorities **should especially take care** that these surveys include different variables, such as victimisation, housing, environmental environment and conditions, family and registered partnership, ethnicity, socio-economic status, and **especially** to work on improving **demographic questionnaires** and in different national studies include variables related to measuring sexual orientation and gender identity. This would be very important to obtain reliable data on the health status of LGBTIQ persons.

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