



# Pathways to inclusion

Frameworks to include LGBTI people in mental health and suicide prevention services and organisations

Scoping Paper 2012

## Acknowledgements

The National LGBTI Health Alliance is the national peak health organisation for a range of organisations and individuals from across Australia that work in a range of ways to improve the health and well-being of lesbian, gay, bisexual, trans/transgender, intersex and other sexuality, sex and gender diverse (LGBTI) people and communities.

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The National LGBTI Health Alliance acknowledges the traditional owners of country throughout Australia, their diversity, histories and knowledge and their continuing connections to land and community. We respect all Australian Indigenous peoples, their cultures and elders of past, present and future generations. We strive to ensure that the Alliance is inclusive of Aboriginal and Torres Strait Islander LGBTI people and that their issues are taken into account in all areas of our work.

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### \*Terminology

The Alliance uses 'LGBTI' as an umbrella term to include lesbian, gay, bisexual, trans/transgender, intersex and other sexuality, sex and/or gender diverse people. Other groups and previous Alliance documents may use these and/or other initials in a different order. In discussing other documents we have aimed to accurately use the terms of those document. Sometimes the term diverse sexuality, sex and gender is used to be inclusive of all these people. The phrase diverse sexuality, sex or gender that is used in this document takes into account people who are not heterosexual

(sexuality), people who are intersex and do not identify as transgender (sex), and people who are transgender or genderqueer (gender).

## **Purpose and rationale**

The specific aim of this paper is to ensure that providers of mainstream mental health and suicide prevention organisations are better able to recognise, understand and meet the specific needs of LGBTI people. This framework is designed to be used by mainstream mental health services in Australia, both government and non-government, covering counselling, support, mental health and suicide prevention services, as well as government and private residential mental health services. The framework has been developed as part of the National LGBTI Health Alliance's MindOUT! Project. The overall aim of the Project is to build the capacity of both mainstream and LGBTI organisations to respond to the specific mental health, suicide and self harm prevention needs of LGBTI people.

In 2011 the National LGBTI Health Alliance (the Alliance) commissioned a study by Price Waterhouse Coopers (PwC) on the capacity of both LGBTI health organisations and mainstream mental health organisations to support people from these communities to recover from suicide ideation, self harm and suicide attempts, as well as depression and other mental health issues. PwC (2011a) found that there was a high perceived need for mental health services and programs that targeted and welcomed LGBTI people. Very few mainstream mental health services had LGBTI specific training, programs or policies. Very few LGBTI health organisations felt confident dealing with people who were suicidal, but were also not confident in referring these people to police or hospital emergency departments and ultimately to residential mental health services.

The PwC report identified a lack of awareness of mainstream health service providers in Australia about LGBTI issues in the 143 mainstream mental health and suicide prevention services that responded to the survey. 85% had an anti-discrimination policy with a positive statement of care, 56% had patient intake forms that include options inclusive of transgender, intersex and other gender diverse people and only 28% have had LGBTI awareness training for client-facing/direct-care staff and volunteers (PwCa 2011 p.7)

## **Method**

Existing guidelines for mental health services have been reviewed from Victoria and Queensland (Queensland Association of Healthy Communities 2008; Victorian Department of Health 2011; Victorian Government, Department of Health 2009) as well as the United States (Gay and Lesbian Medical Association nd; Joint Commission 2011), Scotland (NHS Scotland 2005), Ireland (NHS Ireland 2008), New Zealand (Birkenhead & Rands 2012a & 2012b), and the United Kingdom (UK) (NHS UK 2009). General practice guidelines from Australia have also been reviewed (McNair 2010; McNair & Hegarty 2010). Peer reviewed articles have also been accessed.

## LGBTI people and mental health status

Lesbian, gay, bisexual, transgender and intersex (LGBTI) people make up a significant proportion of the Australian population. There are even higher numbers of people who do not necessarily identify as LGBTI, but who report same sex attraction or experience. 8.6% of adult men and 15.1% of women report either same sex attraction or some sexual experience with the same sex (Smith et al 2003 p.138), up to 1:1,000 people may be transgender (Department of Health 2008) and up to 1:200 intersex (Blackless 2000; Lev 2004). LGBTI people are part of all population groups, including Australians living in rural and remote areas, indigenous communities, and in culturally and linguistically diverse populations. LGBTI people have demonstrated considerable resilience in looking after themselves and their communities despite adversity. Many LGBTI people lead healthy and fulfilling lives contributing to their families, local communities, workplaces and society as a whole. Nevertheless, the experience of dealing with marginalisation and stigmatisation often impacts on people's health including their mental health.

The Alliance has published an overview of issues called *LGBTI People Mental Health and Suicide Briefing Paper* (Rosenstreich 2011) where more information can be obtained. The Australian Research Centre in Sex, Health and Society have published *Private Lives: A Report on the Health and Wellbeing of Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Australians* (Pitts et al 2006) and *Private Lives 2: The Second National Survey of the Health and Wellbeing of Gay, Lesbian, Bisexual and Transgender (GLBT) Australians* (Leonard et al 2012). These sources have all found that there are high levels of psychosocial distress in LGBTI populations compared to heterosexual populations in Australia.

There are high rates of depression, suicide ideation, attempted suicide and self harm in LGBTI communities. Government data in Australia on completed suicides do not always reflect the statistics from other sources (SPA 2009). The sexuality, sex or gender identity of the person may not be known to families or officials at the time of death. Specific data on sexuality, sex and gender identity is not collected in population based research on suicide. Many young bisexual and gay people, and transgender people, have suicided while they were struggling with their identities and orientations, sometimes before coming out or telling other people (SPA 2009). SPA (2009 p.2) estimates the completed suicide rates for LGBTI people to be between 3.5 and 14 times higher than their non sexuality, sex or gender diverse peers. Official health statistics also have not often captured LGBTI identities or orientations, but the Alliance is working with the Department of Health and Ageing and other bodies to attempt to rectify this.

Many studies have identified the high risk of suicide and suicide attempts in LGBTI populations in Australian and elsewhere (Clark 2004; Hughes et al 2010; Pitts et al 2006; Scott et al 2004; SPA 2009). This population also has significantly higher rates of depression, suicide ideation, and self harm than the general population. *Private Lives* (Pitts et al 2006 p.10) found that 49% of LGBTI men and 45% of LGBTI women had experienced a major depressive episode, and 16% of all respondents had suicidal ideation in the two weeks prior to the survey. Suicide Prevention Australia (SPA 2009 p.3) estimates that 28% of lesbians have self harmed or attempted suicide compared to 8.3% of heterosexual women. The rates of suicide attempts are higher for bisexual women (Hughes et al 2010). 20.8% of gay men compared to 5.4% of heterosexual men have self harmed (SPA 2009 p.3).

29.4% of young bisexual men and 34.9% of young bisexual women have self harmed (SPA 2009 p.3). There is a high rate of self harm and suicide attempts in transgender communities, particularly gender mutilation, although more Australian research needs to be conducted (SPA 2009 p.3). Gay men have a higher risk of depression than heterosexual men (Körner et al 2011).

Intersex people who have suffered through non medically necessary surgery without their consent have reported living in silent despair (Diamond & Sigmundson nd). Research from Germany found that intersex people had similar levels of suicidality and self harm as women who had been traumatized as children (Schutzmann et al 2009). This appears to be due to the high levels of secrecy and shame surrounding intersex and non medically necessary surgical interventions which are often repeated throughout intersex people's childhoods.

LGBTI people who are also Aboriginal and Torres Strait Islander, from culturally and linguistically diverse backgrounds, and those in rural and remote areas have compounded risk factors for suicide and suicide ideation, although more research needs to be conducted in this area (Murray 2011: SPA 2009).

More research also needs to be conducted on the mental health needs of LGBTI people with disabilities. *The Count Me In Too* study (Browne 2008 p.80) of LGBTI people in the UK found that people with disabilities were over twice as likely as people without disabilities to have had serious thoughts of suicide.

LGBTI people from rural and remote areas are particularly isolated and vulnerable:

*"I tried to commit suicide a few times after leaving high school early due to bullying, while I was still living with my parents, on a farm in a small community. I was isolated physically and mentally, thinking I would never be able to leave my home or my community. They were no other GLBTIQ people to be seen or heard of near me, and my family believed at the time that being me being trans and attracted to same sex was just to get attention or part of my depression - not a reason for my depression but some sort of side effect and I'd get over it. The idea of being alone forever and never having the chance to live in the gender I wanted to made me feel like life wasn't worth living at all."*

(25-45, Transgender, Bisexual, VIC Metro, *beyondblue* 2011)

## **LGBTI experiences of mental health and telephone counselling services**

Lesbian, gay, bisexual, transgender and intersex (LGBTI) people suffer from discrimination and fear of discrimination from mainstream mental health services (Birkenhead & Rands 2012a) which may delay them seeking treatment until problems are acute (Pitts et al 2009). When LGBTI people do seek help from mainstream mental health services, they have often experienced discrimination (Israel et al 2011). In-patient acute psychiatric units present further problems for LGBTI people. Studies in New Zealand (Birkenhead & Rands 2012a) and Scotland (NHS Scotland 2005) have found

that LGBTI people fear for their safety in mental health facilities. A study in the United States found that violence was perpetuated against LGBTI people in residential mental health facilities (Lucksted 2004).

Some common themes emerged in the literature on LGBTI people's experience of mental health services:

- Fear for safety from staff or other consumers
- Fear of discrimination
- Actual discrimination
- The importance of early intervention
- The importance of affirmation of LGBTI identities or sexualities
- The need for consumer and ex-consumer input into the design, planning and assessment of services to ensure that services uphold their ideals of humane and equal treatment for all
- The need for protection from discrimination, hatred or violence (physical/emotional/etc)
- the importance of caring, warm interactions that affirm sexuality, sex and gender diversity

A fear for their safety from staff or other consumers, or fear of discrimination was expressed in many studies. This fear, as well as actual discrimination or a feeling that they were not being treated with respect, may be one of the reasons that LGBTI people have been reluctant to seek help from mainstream mental health services, their dissatisfaction with those services, or their dropping out or leaving programs early.

LGBTI people have often expressed dissatisfaction with, or fear of, mainstream mental health services. An Irish study (Gibbons, et al 2008:61,64,65) found that "LGB" people's experience with mental health providers was sometimes welcoming and sensitive, but that some interactions with psychiatrists were "cold," or the psychiatrist did not understand "LGB" issues. The clients that were dissatisfied with the issues tended not to tell the service providers that the service had not been satisfactory. A man struggling to come out after his marriage had broken up was hospitalized after attempting suicide. He reported speaking for several minutes with a psychiatrist who was dismissive of gay issues. This man was discharged from hospital with no further support or referrals, again attempted suicide, and again saw the same psychiatrist for a few minutes and was offered no further support or referrals. This man eventually found a private therapist who he found to be more supportive. Lesbians involved in this study had found that mental health professionals had "[p]athologized" their identity, for example, by claiming that their identity as a lesbian was a result of maternal abandonment.

Mainstream mental health services in the UK were found not to protect LGBTI clients from homophobia from other clients and service providers (Clark 2004). Staff had been judgmental or unaware of LGBTI specific needs, and may have discriminated against same sex partners in decision

making in favor of birth families (NHS UK 2009). The recent changes to NHS UK, with the appointment of Diversity Champions, the introduction of LGBTI sensitivity training and guidelines, and consultations with the LGBTI community have resulted in improvements to services (Springett et al 2009).

Involuntary admissions are also an issue. Involuntary admissions may be necessary for people who are at risk of harm to self or others. There is a need to develop strategies such as LGBTI targeted early interventions and sensitive crisis support to avoid involuntary admissions. This includes services for some people with an AIDS related illness, AIDS Dementia Complex (ADC), which can include symptoms such as “severe depression, personality changes, psychosis, and intense excitability (mania)” (Allard 2009 p.23). Sensitive treatment of LGBTI people during and after an involuntary admission would include ensuring that the patient's same sex partner is acknowledged as the patient's Primary Carer on admission, and the Mental Health Review Tribunal and treating teams including partners/friends in treatment planning.

A study of mental health consumers in the United States focused on helpful and unhelpful situations (Israel et al 2008b). Helpful situations were more likely to be found in private practice with social workers or psychologists, and included respectful, safe interactions that affirmed gender or sexual identity and maintained confidentiality. The mental health professional was perceived as caring or listening, and they did not press the consumer to talk about their sexuality, sex or gender identity where it was not relevant. Helpful situations were likely to result in increased self-esteem, positive experiences of therapy, and increased self-acceptance.

Unhelpful situations were more likely to be found with psychiatrists, and/or in the public system, and in inpatient situations. Consumers who identified unhelpful situations were likely to terminate therapy early or have other poor outcomes. Unhelpful situations included breaches of confidentiality, assumptions of heterosexuality, a feeling of not being safe, feeling disrespected or uncomfortable, non-affirming practices which deny sexuality, sex or gender identity, attempted conversion therapy, being discouraged from coming out, or not using transgendered people's preferred pronouns. Other unhelpful situations included over medication, sexual touching or talk, or focusing on sexual orientation inappropriately, for example a psychiatrist attributing a consumer's low sex drive to being female rather than as a side effect of the medication that he had prescribed. Other unhelpful situations included the consumer perceiving the therapist as cold, unfeeling, disrespectful, disengaged or uncaring, imposing their values and judgments on the consumer, and involuntary hospitalizations (Israel et al 2008b).

Research of LGBTI people in Australia found many who delayed seeking help, or who did not seek help at all, due to fear of discrimination (*beyondblue* 2011). In a study based in New Zealand, *Lets talk about sex* (Birkenhead & Rands 2012a) several health practitioners identified a reluctance or hesitancy for many mainstream health organisations to deliver services to transgender clients. Clients also reported that many mental health services were particularly unhelpful for transgender clients. An Australian and New Zealand Study (Pitts et al 2009) found that many transgendered people delayed seeking help from health services because of their experience of discrimination, or their fear of discrimination from services. *Tranznation: A Report on the Health and Wellbeing of Transgendered People* (Couch et al 2007) also identified issues for transgendered people accessing

mental health services in Australia and New Zealand. Approximately half had private health cover. Some transgendered study participants had found mental health and wider health services including private psychologists and psychiatrists to be supportive and accepting, with some practitioners knowledgeable about transgender issues. However, many participants reported experiencing hostility and a lack of respect.

Transgender people have had particular difficulties with accessing supportive mental health services. New Zealand research found that transgender people had some positive experiences with accessing mental health support, often from private providers, and some very negative experiences where their gender identity was not recognized by mental health or addiction services (Birkenhead & Rands 2012a). There were also many barriers to accessing services, such as compulsory assessment and counselling before a medical transition, but no publically funded counselling available if they did not meet the entry criteria for public mental health services.

An Australian transgender person described their experience of mental health services:

*"The depression I've experienced was directly related to being trans, specifically society's expectations of me.... Seeing health professionals in general is often a scary and intimidating experience for transfolk, I've learnt the hard way that being a medical professional doesn't make someone knowledgeable about trans issues and sadly with some finding out that I'm trans has removed the professional from their title with many inappropriate questions or clear discomfort, I've learnt to keep my guard up with them. Because of this, if I wanted to see some kind of mental health professional in the future I would only see one that had previous exposure to trans issues so I wouldn't have to educate them and wouldn't feel violated."*

(25-45, Transsexual, Queer, SA, Metro *beyondblue* 2011)

A study in the United States found that transgender people were particularly unhappy with Alcohol, Tobacco and Other Drug support services, and that they had lower levels of feelings of therapeutic support, ability to be honest and open about their issues, feelings of connection, and current abstinence compared to heterosexual or gay and lesbian cohorts. There were examples of inpatient rehabilitations that did not allow transgendered people to take hormones, dress in their preferred gender, and discriminated against them in other ways. Research has also found that staff in Alcohol, Tobacco and Other Drug treatment centres have felt uncomfortable dealing with transgender clients, and have felt alienated from them (Senreich 2011 p.296).

A lesbian living in rural Australia identified the issue of being pathologized for her sexuality when accessing a mental health service:

*"My long-ago therapist, ... said I was homosexual because I was attempting to get love from a woman... that I was denied as a child.... and to be mentally healthy, I would need to be with a man... (25-45, Female, Lesbian, NSW, Regional beyondblue 2011).*

LGBTI people living in rural and remote communities have difficulty in accessing support services. There are very few mental services available in rural and remote communities. Some have had unfortunate experiences of attempted conversion therapies with psychiatrists in rural Australia:

*"When I was 13 my mother sent me to a psychiatrist because I came out as gay.. she thought that it was a 'phase' and that putting enough pressure on me would change things. I found that even through a youth service, the staff didn't recognise how critical my depression and anxiety was.. and although they were always happy to listen, no one wanted to step in and really help me. The emotional and psychological abuse I was exposed to at the time was intense.. I expressed feelings of being suicidal.. but after every session I was piled back into the car with the person who was causing me harm....It's as if it's the 'untouched issue'... no one wants to talk about it - and if they do talk about it no one wants to step on anyone else's toes by acting on it." (18-24, Female, Lesbian, NSW, Rural, beyondblue 2011)*

People living on the outskirts of metropolitan areas have had difficulty accessing support. A person living in a suburban area had lost two friends to completed suicides in the last twelve months, both of whom had sought help from a GP:

*I have lost 2 friends ... to suicide in the last 12 months, both were from the western suburbs, both had sought assistance for their issues but their mainstream doctors did not have the necessary education in GLBTI mental health issues to assist (PwC 2011b).*

Some LGBTI people accessing mainstream telephone counselling and crisis lines in Australia have also reported negative experiences. One said that when they had called a service in a crisis "they had no idea what to say to me" (PwC 2011b). Another said:

*when you are at the end of your tether with no where to turn, and you call a service [...], and talk to someone who doesn't understand and just wants to refer you onto another service, it does little to quell the feelings of self harm you feel (PwC 2011b).*

There is anecdotal evidence that some LGBTI people have had positive experiences when accessing telephone crisis lines. The PwC research found mixed experiences in this. One LGBTI community member said, "it depends on the counselor you encounter" (PwC 2011b). Another said "they had no idea what to say to me" (PwC 2011b).

## Issues for consideration

1. consultation with LGBTI consumers
2. safety
3. staff training
4. screening for violence
5. comorbidity
6. religious-based services
7. confidentiality

### 1. Consultation

Services can tailor and assess their inclusive practices through consultation with both LGBTI community organisations, and LGBTI consumers and ex-consumers. LGBTI people who had been dissatisfied with the treatment that they had received from health services tended not to complain about that service, so those providers may not be aware that the service that they were providing was not satisfactory (Gibbons et al 2008). NHS Scotland recommends extensive consultations with targeted diversity groups of consumers and ex consumers of mental health services so that services can be tailored, and programs assessed. NHS Scotland also recommends that services consult with out workers and engage local LGBTI organisations to assist in identifying areas for positive change.

An Irish study (Gibbons et al 2008 p.79) of LGB consumer input had several suggestions for improving mental health services in Ireland. Their specific suggestions are:

- Stop pathologizing homosexuality
- Recognise minority stress and the impact that discrimination can have on mental health
- Have knowledge of and refer to outside supports, contacts, groups and organisations
- Do not ignore or minimize the importance of sexual orientation to mental health
- Do not presume that the mental ill-health of an "LGB" client is necessarily linked to their sexual identity
- Provide targeted and sensitive support and counselling.

## 2. Safety

The safety of LGBTI consumers residential care mental health services is an important issue. A report from the Victorian Department of Health (2011) as well as one from NSW Health (2005) identified a risk of sexual assault for women in residential mental health units, since offenders and alleged offenders are often placed with potential victims of assault. The reports both recommend the separation of clients based on gendered lines where practical or for new units. This raises the issue of placement of transgendered clients in separately gendered units, which Birkenhead and Rands (2012a) found to be problematic for transgendered consumers. For transgendered consumers, these placements need to be conducted according to the consumer's preference.

To address the issue of safety in residential care units training of staff is needed in identifying and observing at risk behavior, as well as increased surveillance in acute units.

A policy of zero tolerance of homophobia should also be introduced and swiftly enforced by senior management (Birkenhead & Rands 2012a). Services should make staff and patients aware of discrimination and disrespectful treatment, and to post grievance processes for consumers in high traffic areas (Joint Commission 2011).

The Victorian Department of Health (2011) report discusses the likelihood that LGBTI people have been subjected to homophobia and abuse, and recommends guidelines for the sensitive treatment of LGBTI people. A NSW Department of Health (2005) report also recognises that there may be same-sex violence but does not include specific recommendations to address this problem other than to state that staff should be made aware of this as a potential problem. There are however general recommendations for increasing the safety of potential female victims in mixed gendered wards in increased surveillance and monitoring of patients who had been identified as being likely to be vulnerable to sexual assault, and increased monitoring of those with a history of sexual assault or alleged sexual assault.

More research is needed on the risk of violence to LGBTI people in inpatient units, and on the experiences of LGBTI people in inpatient units in Australia.

## 3. Staff training

The importance of staff training to combat discrimination and to encourage best practice treatment of LGBTI people was highlighted in all the guidelines. Services may be unaware that consumers were LGBTI, since many people choose not to disclose their sexual orientation or gender identity because they do not feel safe in that service to do so (Birkenhead & Rands 2012a; NHS Scotland 2005).

The issue of making staff training mandatory rather than optional was also raised. Birkenhead and Rands (2012b p.10) claim that training should be mandatory for all staff, and that: “[t]raining and ongoing education in working effectively with Rainbow communities is considered a key cultural competency. This is reflected in organisational policy.” Mandatory training would be regular and ongoing, and be followed up with evaluations of its effectiveness. All clinicians needed to be able to work effectively with LGBTI clients. This would be evidenced by systems for consultation and supervision if clinical support workers have specific questions relating to their Rainbow client. If a clinician or support worker was identified as being unable to work safely with a Rainbow client, then clear policies and procedures were to be followed.

NHS Education for Scotland (NHS Scotland 2005 p.11) also recommends mandatory training for all health services staff. They recommend that training be extended throughout the healthcare sector and include trainers of health care staff, higher education lecturers, human resource trainers and practice educators.

Mandatory training is necessary because:

"Without comprehensive training for all, including medical staff and managers, participants felt that those who chose to opt out did not take the issues seriously and were belittling the call for training. While participants reported gaining understanding, they felt that a core change in the NHS could not happen without all staff engaged in training" (NHS Scotland 2005 p.11).

However, at this stage, the NHS in Scotland has not mandated LGBTI sensitivity training for all staff.

#### **4. Screening for violence**

An issue for consideration is the need for health service providers to screen for the possibility that clients have been subjected to same sex domestic violence (Siemieniuk et al 2010). The NHS UK (2009) guidelines argue that same-sex domestic violence can be as high as rates of mixed gender domestic violence, but that this tends to be overlooked in government, health and service policies and practices. Australian research found very high self reported rates of intimate partner violence in LGBTI communities (Pitts et al 2006). Sensitive questioning on the home environment may lead to disclosures of intimate partner violence, especially where trust and rapport have been established by the service provider, and confidentiality is assured.

Homophobic violence potentially has an impact on the mental health of LGBTI people. Birkenhead and Rands (2012b) as well as the NHS UK (2009) guidelines, recommend that health services ask specifically about experiences of violence in a sensitive manner. This is particularly important for LGBTI clients because of the high levels of violence that these communities tend to experience. Transgender men reported the highest rates of violence, but a large proportion of LGBTI people in an Australian survey reported having been subjected to homophobic violence, and to fear

homophobic violence. The rates were higher for those in rural areas compared to major metropolitan centres (Private Lives 2006).

Tactful screening for intimate partner violence or past history of homophobic violence may lead to good outcomes for LGBTI people.

## 5. Comorbidity

Another issue identified by Birkenhead & Rands (2012a) was that LGBTI communities have a high risk of alcohol and other drug dependency. *The 2010 National Drug Strategy Household Survey Report* (Australian Institute of Health and Welfare 2011) found a higher incidence of alcohol and other drug problems in "LGB" communities. The highest proportion of recent drug use across all subpopulations was for people who identified as homosexual/bisexual (35.7%) (Australian Institute of Health and Welfare 2011 p.92). Hughes et al (2010) found a link between sexual orientation, mental health and at risk drinking and substance use in women, with the highest rate for substance abuse among bisexual women compared to lesbian or heterosexual women. *Private Lives 2* (Leonard et al 2012) found a much higher incidence of recent drug use in LGBTI communities than the general population.

There is link between mental health problems and alcohol and other drug problems (NSW Health 2009). Some state government guidelines on co-morbidity treatment currently include some recommendations on sexual orientation and gender identity. For example, the *NSW Clinical Guidelines For the Care of Persons with Co-morbid Mental Illness and Substance Use Disorders in Acute Care Settings* (NSW Health 2009 p.49) advises that practitioners should enquire about consumer's sexual orientation and gender identification so that the increased risk of suicide can be monitored closely. The aim of this screening is to reduce stigma and encourage open dialogue and disclosure. Practitioners are also advised to ask about recent drug or alcohol use because it is an increased risk factor for people of diverse sexual orientation and gender identity.

Some services provide Alcohol, Tobacco and Other Drug services in the same facility as mental health services. Other facilities need to refer on. The ideal is an integrated model of care. Birkenhead and Rands (2012b) suggested that appropriate, targeted referrals be made for LGBTI clients, such as referrals to gay Narcotics Anonymous. Some services such as the Mater Hospital at Newcastle refer to AIDS Councils such as ACON at Newcastle which offers AOD and mental health counselling, but at this stage, many AIDS Councils are not funded to provide counselling services to the wider LGBTI community.

It may be difficult for services to access a list of local, targeted LGBTI specific or LGBTI friendly Alcohol, Tobacco, and Other Drug services. State based gay and lesbian information lines, and local transgender and intersex support groups, may be able to offer a predominantly volunteer based referral service. The Alliance is working with our Member Organisations and *beyondblue* to develop a national database of LGBTI counselling services.

High co-morbidity rates in LGBTI communities mean that screening for this is important in developing treatment plans.

## 6. Religious based services

Many mental health and suicide prevention services are offered by religious based non-government organisations (NGO's). Birkenhead and Rands (2012a) identified as an issue the religious and cultural identities of many people working in NGO community mental health services in New Zealand, and their reluctance to deal with LGBTI clients. NGO service providers had the "least experience working with (visible) Rainbow service users and presented with significant issues around workforce skill, often in relation to the service providers own cultural identity (including religion, ethnicity, and cultural practices)" (Birkenhead & Rands 2012a p.12). Staff who are deeply religious can sometimes express homophobic attitudes that are inappropriate or even hostile for LGBTI people.

NHS Scotland (2005) found in their study that a gay man reported being referred to pastoral care for alcohol and other drug counselling, and was told that homosexuality was a sin, and that he had to stay celibate if he wanted to recover from alcoholism.

An Administrator in a counselling service run on a religious campus was concerned because although an "LGBT" specific group was run by heterosexual counsellors who were perceived to be gay friendly, there were several staff members employed who held deep religious convictions against non heterosexuals. The Administrator believed that these staff members may have created an atmosphere of hostility that had turned away some "LGBT" clients (Israel et al 2011 p.152).

Mental health practitioners experienced in treating LGBTI clients identified several service issues that contributed to poor outcomes for clients. Homophobia of some staff in a service, a lack of any out LGBTI staff, or hierarchical staff relations were all identified as unhelpful factors in services (Israel et al 2008a).

In Australia, many of the community mental health programs are run by religious based NGO's. Some of these services such as UnitingCare welcome LGBTI clients, and some such as *Support After Suicide* run by Jesuit Social Services include some LGBTI examples, links or case studies on their websites. However, this is not widely known in LGBTI communities, who often perceive any faith based service to be potentially homophobic. Including an anti-discrimination statement that includes diverse sexuality, sex and gender on the website may reassure potential consumers. Specific targeting of LGBTI people on websites is another potential strategy.

The experience of some Scottish, United States and New Zealand mental health service consumers suggests that there may be some individual staff members in both religious based and government

based services who express homophobic attitudes or who do not provide an accepting and sensitive environment for LGBTI people.

A welcoming environment and accepting and sensitive service needs to be provided in order to attract and retain consumers, and to provide the best possible care. Homophobia, biphobia, intersex phobia and transphobia contribute to negative outcomes for LGBTI clients, or to LGBTI people not accessing services, or leaving services early.

Some LGBTI people experience strong conflicts with their religions. The American Psychological Association (2012) recommends that people experiencing conflict between their sexuality and their religion be referred to LGBTI religious support groups.

## 7. Confidentiality

Mental health practitioners experienced in working with LGBTI clients identified confidentiality as a serious issue affecting treatment. Overcrowded waiting rooms and a lack of sound proofing in treatment rooms were identified as factors that contributed to poor outcomes (Isreal et al 2008a). LGBTI clients of services based in the United States who found that when a breach of trust or confidentiality had occurred, poor outcomes resulted (Israel et al 2008b).

Confidentiality is a particularly pressing issue for transgendered consumers. Disclosure of transgendered status to relatives, friends, or other services could have serious implications (NHS Ireland 2008). Many LGBTI people fear to disclose their sexuality, sex or gender identity will lead to further discrimination from people or services accessing records. A third of the "LGB" people interviewed for a research study in Ireland avoided health services because of their fears that confidentiality would not be maintained. Concerns were expressed for the treatment of their partners, parents or children in small communities and rural communities should their sexual orientation be disclosed to a health care provider or hospital. Participants were also concerned about the location of some of the health services in very public spaces, so that their treatment there would become common knowledge (Gibbons et al 2008).

Staff working with LGBTI young people in Victoria expressed concerns that data collection could compromise their professional relationship. Young people had also expressed concerns that their sexual orientation or questioning may be recorded in their files, and had been upset after asking to view the file (Dyson et al 2003).

Individual consumers should be consulted about what information about their sexuality, sex or gender should be recorded in their files and case notes. Staff should discuss with consumers what level of confidentiality can be guaranteed.

## Responses

This section discusses three possible responses to the issues discussed above:

1. LGBTI Charter
2. Best practice example
3. Other Alliance activities

### 1. LGBTI Charter

An issue for inclusion in a framework for LGBTI inclusive mental health services is a publically available charter, position statement or policy that specifically states that the service is inclusive and supportive of LGBTI clients. An aged care service in Queensland that provides LGBTI specific services, Care Connect, has a specific, publically available charter outlining their commitment to providing a sensitive service.

An LGBTI charter could encompass other diversity needs. Many LGBTI people have multiple identities and cultural affiliations that may include culturally or linguistically diverse backgrounds, Aboriginal or Torres Strait Islander identities, or disabilities. Issues of access to health services for these communities are also important for LGBTI communities, since many people are discriminated against for a range of identities and reasons.

LGBTI charters are visible signs that an organisation is committed to inclusive practices, and they signal this to potential consumers and employees.

### 2. Best practice example

The rights of LGBTI people in mental health in patient units were also addressed by mental health service administrators in the United States (Israel et al 2011 p.152).

Administrators of mental health services in the United States recommended the following best practice points:

- **Respond sensitively to transgender consumers.** Use their preferred gender, inclusive language on forms, and in hospital and in patient settings, and assisting the consumer with grooming as appropriate for that gender.
- **Coordinate services within and outside the agency.** A best practice example was a lesbian support group co-sponsored by a public mental health agency and an "LGBT" agency. This support group was advertised through flyers and word of mouth, and enabled consumers to access mental health services in a supportive manner. Another best practice example of co-ordination of services was a multi-disciplinary treatment team that included the consumer's partner in consultation over treatment.
- **Connect with LGBTI individuals.** Several best practice examples ran "LGBT" specific support groups for consumers in conjunction with other agencies. Examples included youth residential settings, an "LGBT" seniors centre, a university counselling centre, and a hospital recovery unit.
- **Have visible, openly gay staff.** The presence of out staff reassured clients that the service was unlikely to discriminate against them, and was likely to be supportive and affirming of their sexuality, sex or gender identity.
- **Have senior staff openly supportive of "LGBT" staff and issues.** Having senior staff supportive of "LGBT" issues and actively intervening in the case of complaints against staff or interagency problems led to good outcomes for "LGBT" consumers. Supportive senior staff members could introduce agency wide training on treatment of transgendered consumers, or for individual staff (Israel et al 2011 p.152).

### 3. Other Alliance activities

#### LGBTI Champions

To support the development of LGBTI sensitive organisations and services, the Alliance is advocating for a senior member of each service to take on the role of LGBTI Champion. This model has been effective in engendering organisational change in many private and public organisations in the UK, Scotland and Ireland through the organisation Stonewall (2011). The NZ Guidelines (Birkenhead & Rands 2012b) also recommend that Diversity Champions be appointed in every health service. An Australian example where Diversity Champions have been employed very effectively is Youthlink in Western Australia. YouthLink provides specialist mental health counselling, consultation, training and community development. All clinical staff within YouthLink are encouraged to take on a specific

portfolio in addition to their clinical workload for example child protection, Aboriginal and Torres Strait Islanders, or Diverse Sexuality and Gender.

The Alliance is developing a Champions Policy Document. The Champions program is designed to assist organisations to implement specific LGBTI policies and practices, and to develop a more targeted and sensitive approach to LGBTI issues at both the individual staff member level, and the whole of the organisation level.

## **Cultural Competency Framework: Pathways to Include LGBTI People in Mental Health and Suicide Prevention Services and Organisations**

The Alliance is developing a Cultural Competency Framework designed to assist mainstream mental health and suicide prevention organisations and services to work towards inclusive and sensitive practice with LGBTI people. The Cultural Competency Framework is designed to ensure that the context of the therapy, the mental health organisation or telephone counselling organization or service, its policies, practices and other staff, and environment, are all conducive to promoting the wellbeing and recovery of LGBTI people who are at risk of suicide, or who are living with mental health issues.

The framework will address the need for changes in the knowledge, values and skills of organisations and staff to increase cultural competency.

Cultural competency refers to an ability to interact effectively with people of different cultures. Vital elements of cultural competence are awareness of one's own culture, beliefs and values; knowledge of different cultural practices and world views; valuing of cultural diversity, and skill in working across cultures. These elements are required across all levels of an organisation. Cultural competence requires the development of an understanding of LGBTI lived experience, histories, relationships, communities and cultures, and where an organisation has contact with consumers, sensitive treatment of LGBTI individuals.

## **Practice Wisdom Resources**

The Alliance, in collaboration with health professionals, is developing Practice Wisdom Resources for Australian mental health professionals for the counselling and therapy of LGBTI clients.

The Practice Wisdom resources, to be used in conjunction with the Cultural Competency Framework, will be designed to ensure that the actual therapy and counselling of LGBTI service recipients is sensitive and responsive to their needs.

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