

ASEXUAL BISEXUAL
QUEERTAKATAAPUI
FA'AFINE
TRANS/TRANSGENDER
RAINBOW LESBIAN
WHAKAWAHINE GAY

Improving mental health and addiction services for Rainbow Communities

Let's talk about sex... (sexuality and gender)

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Foreword

We have known for sometime that the experience of stigma for the Rainbow community has a specific and measureable impact in terms of the experience of mental health and addictions. The Rainbow community and Auckland District Health Board (ADHB) have largely overlooked this particular encounter with mental health and addictions until now.

Recognising the impact of both mental health and addiction problems on the community, ADHB initiated this project as a first step in understanding people's experience of using primary care, specialist, and community based mental health and addiction services. There were two further aspects to this project. The first was to explore options for enabling improvements in the responsiveness of services to the community, and the second was to look at ways to provide people support to make it easier to get the right service at the right time. Both of these options are being developed further.

This project was conceived of as being relatively small but through the expertise, commitment, and engagement provided by the two project consultants (Diana Rands and Anna Birkenhead) it has become something bigger, making an important and significant contribution to the literature on mental health and addiction and the Rainbow community. ADHB are delighted to have sponsored and supported this important piece of work and look forward to the next stage in its development.

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Together we can make a difference.

Nga mihi nui ki a koutou mo enei mahi
No reira
Naaku noa
Ko Anna Birkenhead raua Ko Diana Rands

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Glossary and Acronyms

Asexual:	A person with an absence of sexual attraction or desire.
Bisexual male:	A man who is sexually and emotionally attracted to both men and women.
Bisexual female:	A woman who is sexually and emotionally attracted to both men and women.
Cissexism:	The belief and treatment of trans/transgender people as inferior to cissexual (non-trans) people.
Coming out:	‘Coming out’ (of the closet) or being ‘out’ refers to disclosing one’s same-sex attraction or one’s non-conforming gender identity. Coming out relates to oneself, and with others; and is a complex process that is ongoing, especially in new situations.
Training:	Training in the issues of sexual orientation and gender identity to enable effective engagement and enhanced outcomes for people from the Rainbow community.
Fa’ afafine:	A Samoan term that literally means “like a woman”. Fa’ afafine is often used to refer to people born male who express feminine gender identities in a range of ways. It is sometimes used broadly across Pacific People.
Female:	The traditional definition of female was “an individual of the sex that bears young” or “that produces ova or eggs”. However, female can be defined by physical appearance, by chromosome constitution (XX), or by gender identification.
Gay:	Gay can refer to homosexual/same-sex attracted women and men, but is more often used in relation to males.
Gender queer:	Gender queer is a term some people use to describe themselves who do not conform to or agree with traditional gender norms and who express a gender identity that is neither completely male nor female. Some may identify as gender neutral or androgynous.
Gender identity:	Gender identity is an aspect of identity that can be understood as their psychological sex. It is an individual’s internal sense of being male or female or something other, or in between. It may or may not correspond to a person’s physical sex. A person’s sexual orientation cannot be assumed on the basis of their gender identity.
Heterosexual/straight:	A term used for people who are sexually attracted to the “opposite” sex only.
Heterosexism:	Heterosexism is a predisposition to considering heterosexuality as ‘normal’ which is biased against other forms of sexual orientation. This is not the same as homophobia, but is rather the discrimination against non-heterosexual people due to a cultural bias.

Heteronormative:	Heteronormativity is the cultural bias in favour of opposite-sex relationships of a sexual nature, and against same-sex relationships of a sexual nature. Because the former are viewed as normal and the latter are not, lesbian and gay relationships are subject to a heteronormative bias.
Homo/trans/bi-phobia:	A dislike of people who are homosexual, transgender or bisexual that may manifest as discrimination or violence.
Homonegative:	This term describes a negative attitude towards homosexuality, emotional, moral or intellectual disapproval.
Homonegative trauma:	Trauma experienced through homonegative negative attitudes or behaviors, such as violence, alienation from family and friends and discrimination.
Intersex:	The term 'intersex' covers a range of people born with a reproductive or sexual anatomy that doesn't conform with typical definitions of 'male' and 'female'.
Lesbian:	Lesbian is used exclusively in relation to homosexual/same-sex attracted women.
MSM:	The abbreviation MSM (men who have sex with men) is used to include both gay and bisexual men, and men who identify as heterosexual, or otherwise, but who at least occasionally engage in sexual activities with other men. This term was developed in response to HIV/AIDS education initiatives. It was discovered that many men who have sex with men do not identify with or respond affirmatively to health education which uses the term 'gay' or 'homosexual'.
Male:	The traditional definition of male was "an individual of the sex that produces sperm" (or some such). However, male can be defined by physical appearance, by chromosome constitution (XY), or by gender identification.
Non-heterosexual:	A broad term used to encompass anyone who does not identify as heterosexual e.g. gay, lesbian, queer, bisexual, takataapui etc.
Rainbow:	A generic term that incorporates all the people who do not identify as heterosexual or asexual, or do not fit standard gender identity norms; such as (but not limited to) gay, lesbian, bisexual, trans, intersex, takataapui, fa'afafine, queer, gender queer, fakaleiti (Tongan), Akava'ine (Cook Islands Maori), Fiafifine (Niuean), Vakasalewa (Fijian) et al.
Sexual orientation:	Sexual orientation denotes the direction of a person's sexuality relative to their own sex (i.e. homosexual, heterosexual or bisexual). It is usually classified according to the sex or gender of the people an individual finds sexually attractive. This can relate to psychological, behavioural or to an individual's social identity. Sexual orientation may be fluid, or change over time.
Stealth	A term used to describe some trans people who do not wish to disclose their trans status.
Takataapui:	The traditional meaning is 'intimated companion of the same sex'. Many Maori people have adopted this term as a cultural identity for being non-heterosexual or for having non-traditional gender identities.
Training:	Training in the issues of sexual orientation and gender identity to enable effective engagement and enhanced outcomes for people from the Rainbow community.

Trans/Transgender:	The term transgender is used by different groups in different ways, often seen as an ‘umbrella’ term for a variety of people who feel that the sex they were assigned at birth is a false or incomplete description of themselves. The adjective “trans” is an increasingly preferred general term, and has been used within this report. Trans can include a number of sub-categories including transsexuals, cross-dressers, genderqueer and consciously androgynous people. If a gender term is also used this refers to the person’s identity e.g. ‘trans man’ was born in a body defined as female but identifies as male (FtM) or conversely male to female (MtF). Trans/transgender people may or may not use some form of medical intervention to better align their physical sex with their gender identity, and may or may not have any interest in any procedure.
Transition/transitioning:	Steps taken by trans people to live in their gender identity. These often involve medical treatment to change one’s sex through hormone therapy and gender reassignment surgeries. The process of transition varies between individuals, with some trans people identifying a point where transition is complete (i.e. they may no longer identify as trans, but as male or female), while for others the process is continuous.
Transnegative:	This term describes a negative attitude towards transgender, emotional, moral or intellectual disapproval.
Queer:	A reclaimed word used in a positive sense by some to describe sexual orientation and/or gender identity or gender expression that does not conform to heteronormative expectations. Sometimes used as an ‘umbrella’ term for same-sex attraction and gender diversity. It is more commonly used among youth and in academic contexts. It is sometimes used to reject or express rejection of traditional gender categories and distinct sexual identities such as gay, lesbian, trans, queer, bisexual, takataapui.
Questioning:	Is a process of exploration by people who may be unsure, still exploring, and/or concerned about applying a social label such as a particular sexuality or gender identity to themselves for various reasons.
WSW:	The abbreviation WSW (women who have sex with women) is used to include both gay and bisexual women, and women who identify as heterosexual, or otherwise, but who at least occasionally engage in sexual activities with other women.
Whakawahine:	Maori trans woman.

Acronyms:

ADHB	Auckland District Health Board
CMHC	Community Mental Health Centre
CSW	Community Social Worker
PHO	Primary Health Organisation
PHMS	Public Mental Health Service
AOD	Alcohol and Other Drugs
P.C.	Primary Care
NGO	Non-Governmental Organisation
S.O.	Sexual Orientation
G.I.	Gender Identity
LGB	Lesbian, Gay, Bisexual
LGBT	Lesbian, Gay, Bisexual, Transgender
LGBTTF	Lesbian, Gay, Bisexual, Transgender, Takataapui, Fa’afafine
S.U.	Service User
S.P.	Service Provider

Executive Summary

(project goal, methodology, findings and recommendations)

The term Rainbow is being used in this report to represent sexual orientation and gender identity minorities. It is a word that invokes a sense of diversity, inclusiveness and hope for the future, and as such has been embraced by many in these communities.

Anecdotally the experience of many people from Rainbow communities involves harassment, bullying, and alienation from family and friends. Prevalence research reports significantly higher rates of mental health and addiction issues are experienced by this population when compared to the general population. This is attributed to the effects of marginalisation and stigmatisation. This population can therefore be seen as being at greater risk of developing mental health or addiction problems as well as having less protective factors to ameliorate against this elevated risk.

In spite of this, there is a lack of information, specialist training, service provision and support for Rainbow people in New Zealand. Very little is known about the experience of Rainbow people who access mental health and addiction services.

Auckland District Health Board (ADHB) funded this research-based project to provide detailed information about the experiences of Rainbow service users as they access mental health and addiction services in Central Auckland. A key part of the research was to specifically identify any barriers or obstacles Rainbow consumers may face when engaging in services; and to record their experience of the responses from the service providers to their sexual orientation and gender identity during their engagement. Gaps in services were to be identified as well as recommendations for future service development.

The overall aim of the project was to inform ways to improve the access to, and experience of, mental health and addiction services to the Rainbow Community in the ADHB catchment area.

Combinations of qualitative and quantitative research approaches were used, and included:

1. A national and international literature review of best practice in working with Rainbow people in mental health and addiction services.
2. Key informant interviews with 20 Rainbow individuals who had previously accessed mental health and addiction service(s) in Central Auckland.

3. Key informant interviews with 47 service providers (across a wide range of services within ADHB, PHO's and NGO's) currently working in mental health or addiction services in Central Auckland.
4. Surveying of 1160 current service users of public mental health services in Central Auckland.

The summary of findings from this project are:

- There are significant barriers and obstacles to effective services due to sexual orientation and gender identity issues not being identified and discussed (73% of all public mental health service users who responded to the anonymous survey have not had a discussion with their keyworker about their sexuality. This finding was consistent across key informant interviews with both Rainbow service users and service providers and is reflected in previous research in this area).
- Whilst there are a significant number of Rainbow service users, there is poor visibility of Rainbow service providers and service users. Most of the visible Rainbow service users had self identified, rather than been asked by the clinician/health professional. Increased visibility of Rainbow service users and providers would significantly improve access to services, and reduce stigma and/or discrimination (26% of all Central Auckland public mental health service (PMHS) service users who responded to the anonymous survey identified as being from the Rainbow community).
- Many service users have had homonegative or transnegative experiences, and/or experienced services as being heteronormative in their approach. Many had been discriminated against or experienced prejudice by service providers. Service users commonly reported fearing the response of the clinician if they came out; they often concealed their sexual orientation or gender identity, and/or felt ashamed or embarrassed. This creates a barrier to effective services.
- The experiences of service users varies considerably, and is often dependent on individual clinicians; though when the clinician or health professional was skilled, rainbow aware and sensitive, most service users found the experience positive, and were comfortable talking about their sexual orientation or gender identity when it was raised either by themselves or by the clinician. Nearly all service users indicated they would like to be asked directly about their sexual orientation or gender identity at the first assessment. Many service users interviewed would have liked the opportunity to talk about issues relating to sexual orientation or gender identity, but did not perceive an opportunity to do so.
- There are significant gaps in clinician/health professional skills, in terms of cultural competency in working with Rainbow service users. Many indicated they met the Rainbow service user's needs by being non-discriminatory and providing the 'same' services as they do to non-Rainbow service users. Many of the 'non-Rainbow' self-identifying service providers did not have a good understanding of the specific issues Rainbow people face (such as discrimination; heteronormativity; stigma; prejudice; homonegativity self harm/suicide; and significantly increased rates of mental health/addiction problems). Most of the clinicians who felt skilled and experienced working with Rainbow service users identified themselves as from the Rainbow community.
- Most (84%) clinicians/health professionals have not undertaken or provided training on sexual orientation and gender identity though nearly all would like to, or would be prepared to; with many indicating training in trans issues/awareness as their greatest need.

- Most service users would like the option of seeing a competent clinician/health professional from the Rainbow community as they would feel more comfortable and think a Rainbow clinician/health professional will have a better understanding of their needs; though skill of the clinician/health professional was also important.
- NGO providers had the least experience working with (visible) Rainbow services 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).
- There are gaps in mental health and addiction services to Rainbow communities, including identification of Rainbow service users, assessment of homonegative and transnegative trauma, Rainbow specific services/resources (within mainstream services) and peer support/advocacy.
- Trans-specific issues are poorly understood and trans-needs are poorly met with no clear pathway and significant barriers to accessing care.
- Organisational policies, procedures and pathways relating to meeting the needs of Rainbow consumers do not exist across services, beyond the standard health and disability standard 'non-discrimination' policy.

The recommendations are:

1. Improve Rainbow people's access to mental health and addiction services, through the implementation of best practice guidelines for working with Rainbow consumers for all services providing mental health and addiction services. Including:
 - Creating a welcoming environment where Rainbow service users are likely to feel welcome and that issues of sexual orientation and gender identity matter
 - Provide guidelines for how service providers initiate discussions with service users about sexual orientation and gender identity including assessment of homonegative and/or transnegative trauma
 - Training which supports staff to enact the above guidelines as part of normal clinical practice.
 - Policies and procedures that underpin Rainbow inclusive practice, including enacting of clinical and organisational guidelines.
2. Ongoing resourcing for external monitoring and auditing to ensure the implementation of best practice guidelines and provide avenues of support to key people/Rainbow champions within services.
3. All staff (including frontline staff and administrators) working in mental health or addiction services complete effective training provided by a quality recognised training provider. Specific trans issues/education are well addressed within this training. This training must support enactment of best practice guidelines.
4. Establishment and support of Rainbow specific resources including:
 - Rainbow support groups
 - Rainbow Peer support services or advocacy services
 - Option of access to a skilled Rainbow clinician/health professional as part of care/treatment as individuals needs indicate it. This option does not negate the need for all providers to be able to enact best practice guidelines.

- An online/web/accessible directory of Rainbow specific mental health/addictions services, including support services
 - Rainbow champions/advocates within each service, as part of a wider clinical role.
5. Inclusion of Rainbow cultural competency in Real Skills (contained within Challenging Stigma and Working with Communities modules).
 6. Specific organisational policies and procedures are implemented to ensure appropriate effective (and non-discriminatory) services are delivered to and received by all Rainbow service users, as part of best practice guidelines.
 7. Mandatory participation in training for all mainstream services, that includes follow-up evaluation to compare pre and post training audit measures. This training needs to be regular and ongoing to ensure continual improvement in engagement and treatment of all clients covered by DHB contracts (Rainbow and non-Rainbow). A recommendation of this report is to pilot a training programme across 2-3 mainstream services in the first instance with a view to implementing this across all services within a measurable timeframe.

Introduction

ADHB funding and planning are adopting an evidence based approach to the development and delivery of services. As part of this process, they are utilising a project based approach to planning and examining services across a spectrum or continuum of delivery.

Research suggests that discrimination has a negative impact on the mental health of Rainbow people. For lesbians, gay men and bisexual people, these higher prevalence rates of mental health problems are commonly theorised as being a consequence of living in homonegative societies (Bailey, 1999; Fergusson, Horwood, & Beautrais, 1999; Fergusson, Horwood, Ridder, & Beautrais, 2005; Meyer, 2003; Sandfort, de Graaf, Bijl, & Schnabel, 2001). In support of this hypothesis, there is a developing body of research showing that people who have experienced anti-homosexual violence, whether physical, sexual, or verbal, are at increased risk of mental health problems (D'Augelli, 2002; Herek, Gillis, & Cogan, 1999; Otis & Skinner, 1996; Rivers, 2001).

Many Rainbow people are reluctant to disclose their sexual orientation to their clinician or health professional because they fear discrimination or poor treatment. This has been found in studies in New Zealand (Semp, 2006) and overseas (Daley, 2010; Golding, 1997; Robertson, 1998).

There is less research about trans people's experience of mental illness. This suggests that trans people are more likely to have many of the risk factors identified above and experience high rates of discrimination (HRC, 2008).

There is little specific data collected on service user's sexual orientation (S.O.) or gender identity (G.I.), and little research in New Zealand on how mental health and addiction services are received by Rainbow peoples; including identification of specific barriers or obstacles they face when accessing those services.

Detailed information about specific barriers and/or obstacles is required to enable services to adjust their delivery of services as required to better meet the mental health and addiction needs of the Rainbow communities in New Zealand.

Background

Evidence from both international and New Zealand research is that non-heterosexual people have a higher prevalence of mental health difficulties such as self-harm, suicide, depression, mood disorder, anxiety disorder and addiction compared to heterosexuals (Finnegan & McNally, 2002, Hughes et.al. 2010 and Haas et.al 2010).

Rainbow people are over-represented in youth suicides in international studies (Sandfort et al., 2001; Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003) and in New Zealand (Fergusson et al., 1999). A New Zealand study (Fergusson et al., 1999) found that LGB youth were at increased risk of many serious mental health issues including major depression, generalised anxiety disorder, substance abuse and/or dependence, multiple disorders, suicidal ideation and suicide attempts. Fergusson, Horwood, Ridder, and Beautrais (2005) conducted a further stage in their longitudinal study and reported that young male adults “classified as predominantly homosexual had an overall rate of [mental health] problems that was over five times the rate for exclusively heterosexual males” (p. 977).

Furthermore, there is an expanding body of research suggesting that adults with same sex attraction are at increased risk of various mental health disorders (Gilman et al., 2001; King et al., 2008; Sandfort et al., 2001; Warner et al., 2004).

A recent national study of the alcohol use of 8,000 young women in Australia suggested that lesbian identified young women are twice as likely to be binge drinking and 3 times as likely to be drinking at risky levels compared to heterosexual women (Hughes, Szalacha, & McNair, 2010).

Meyer (2003) states this increased prevalence may be due to ongoing discrimination based on sexual orientation and sexual identities. Also, prejudice often leads to violence and this fear of violence may influence the prevalence of anxiety disorder the most (Martell, Botzer, Williams, & Yoshimoto, 2003). This stems from heteronormativity which is a belief that anything other than being heterosexual is abnormal (Finnegan & McNally, 2002).

In Aotearoa there remains evidence of differential general life outcomes for Rainbow people compared to heterosexual populations, including higher rates of physical and verbal

assault, bullying and victimisation, depression and social isolation, workplace discrimination and impediments to career progression (Associate Minister of Health, 2006). Further, the findings of a longitudinal study of a large birth cohort, was that at the age of 21 years, those who identified as LGB were six times more likely than those who identified as heterosexual to report one or more suicide attempts (Fergusson, Horwood & Beautrais, 1999). These findings are reflected in the New Zealand Suicide Prevention Strategy 2006-2016 which has identified both an increased risk for LGB young people and a lack of data to understand the extent of this risk and the factors that contribute to it (Associate Minister of Health, 2006).

In Aotearoa the Health Behaviours Survey data on drug use in 2003 and alcohol use in 2004 (Pega & Coupe, 2007) showed significantly higher use of alcohol, tobacco and illicit drugs among lesbian, gay and bisexual (LGB) populations compared to heterosexual ones. There is little equivalent research in New Zealand on the prevalence of mental health and addiction problems for transgendered people.

It is well known that trans people experience high levels of stigma, abuse and discrimination (HRC report 2008) that would place them at high risk for mental health and addiction problems. This stigma, abuse and discrimination and inadequate access to care can exacerbate mental health and addiction problems, particularly if combined with lack of family support.

Unlike sexual orientation, gender identity is still pathologised. It is classified as a disorder in the DSM (gender identity disorder) and as a disease in the International Classification of Diseases (transsexualism). This means trans people are required to access mental health services in order to transition, and 'prove' that their case is authentic, which puts them in a very vulnerable position. This vulnerability is exacerbated in New Zealand where there is fragmentation of available gender reassignment services, with many trans people experiencing difficulty accessing these services (HRC report 2008). The lack of knowledge of many health professionals on trans issues, including medical options, competency, and appropriate sensitivity (such as the use of correct personal pronouns), can negatively impact on the well-being of trans people (HRC report 2008).

International data on MtF sex workers; substance use and HIV risk behaviours (Clements et.al 1998, Reback and Lomnardi, 1999) and identifies higher rates of substance use when compared to the general population. These trends are seen in Auckland where young trans women are over-represented in homelessness, sex work and problematic AOD use (NZPC 2011). “

The New Zealand Human Rights Commission also highlighted the difficulty that many trans people have in accessing appropriate health care and hormones (HRC 2008). This can lead to obtaining hormones illegally with all the associated health risks.

Literature Review

Review of international best practice and evidence based models of service delivery for LGBT populations (further details including references are included in appendices):

The literature review compiled national and international literature of best practice guidelines in working with Rainbow Communities experiencing mental health and addiction services. The literature search included: published reports, government documents and 'grey literature' documents (such as academic theses and other unpublished reports), both internationally and from New Zealand, over the last decade. The literature was selected on the basis of:

- Relevance to the project
- Being practical and applicable to project
- Currency: within the last 10 years
- Similar environment to New Zealand i.e. English speaking country or with similar socio-cultural environment
- A variety of countries: Canada, USA, Germany, Australia, Scotland and New Zealand
- A variety of documents including books, journal articles, reports and thesis

Common themes from the literature:

International literature has identified that the stigma and discrimination Rainbow people face (i.e. transnegative/homonegative society) contributes to their over-representation in both mental health and addiction statistics. The literature also suggests most Rainbow people are either not seeking treatment for their mental health or addiction issues, or are invisible within those services.

A small number of Governmental departments internationally have responded by providing information and guidelines on how to: redress the heterosexism prevalent in health services, reduce the invisibility of Rainbow clients and improve services to Rainbow people.

Main issues identified by the literature were:

- Sexuality (including heterosexuality) is often not included in assessment and treatment planning in mental health treatment services
- Homosexuality and transgender identities are sometimes seen as not as healthy or as 'potentially pathological'
- Heteronormative language, environments, assessments and treatment plans
- A need for clinician competence of all staff in S.O. and G.I. (not just Rainbow staff)
- Lack of specific policies for both Rainbow clients and employees
- Lack of Rainbow affirmative treatment options
- Paucity of information and research on Transgender specific issues

Common elements for best practice guidelines from the literature:

1. Mental health and addiction services have an environment where Rainbow people feel comfortable talking about their sexual orientation or gender identity.

Evidenced by:

- Rainbow positive images, flyers, posters, Rainbow community groups brochures in waiting rooms
- Presence of service in Rainbow media e.g. advertising employment positions on GayNZ.com/Express
- Sexuality is recognised as an important aspect in the recovery journey
- All clinicians are comfortable and skilled in initiating and participating in discussions about sexual orientation and gender identity
- The work place is an inclusive and non-discriminatory place for Rainbow employees
- Rainbow staff are supported and encouraged to be visible and their experience acknowledged

2. Including sexual orientation and gender identity in the assessment process.

Evidenced by:

- All clinicians having attended appropriate training so they are practiced and comfortable using suitable language to discuss sexual orientation and gender identity
- Sexual orientation and gender identity is asked about as a routine part of assessments and discussed at clinical allocations
- The service has a clear treatment pathway for clients who identify as from the Rainbow communities questioning of sexual orientation or gender identity
- Giving trans people the option of identifying as male, female and/or trans

3. All clinicians are able to work effectively with Rainbow clients.

Evidenced by:

- There are systems for consultation and supervision if clinician/support workers have specific questions relating to their Rainbow clients

- There is a clear policy and procedure to follow if a clinician/support worker is identified as not being able to work safely with a Rainbow client
- Each service location has a specific role called 'Rainbow Advocate' or 'Diversity Champion' to support Rainbow best practice
- Supervisors receive ongoing training in Rainbow best practice
- Awareness of and referral to local Rainbow affirming community groups, and recognition of those that are not appropriate for Rainbow clients

4. Policies that underpin Rainbow inclusive practice.

Evidenced by:

- Specific non-discrimination policies that protect and include Rainbow people
- All relevant policies and procedures include references to sexual orientation and gender diversity. Included in this are employment, employee benefits, client treatment plans and pathways, confidentiality policies
- Sexual orientation and gender diversity is recognised in forms, data capture and other systems

5. Ongoing training on specific mental health needs and issues for Rainbow

Evidenced by:

- The service provides or accesses comprehensive ongoing training for all clinicians and support workers
- All new staff from all disciplines attend Rainbow affirmative training
- Service planning includes provision of this training

Project Strengths and Limitations

This research project has been highly successful in engaging Rainbow service users through the use of an anonymous survey, and key informant interviews. It has also been successful in engaging a wide variety of individuals/professionals who are providing services to Rainbow service users across a broad range of mental health and addiction services.

There has been a willingness to participate fully by nearly every individual encountered through the interviewing process, with most people, regardless of their experience or own identity, showing positivity and enthusiasm for the overall aims/goals of the project. These goals were to provide detailed information on the experiences of Rainbow service users when accessing services, including the identification of particular barriers or obstacles. This project has been successful in that goal.

In terms of service user key informant interviews, it needs to be noted that the many generous Rainbow service users who came forward and talked openly about their experiences whilst accessing services, did so with some degree of confidence or conviction. There will likely be many more Rainbow service users, or Rainbow individuals who did not access services because of fear, who were not able to come forward to tell their stories. This research is unable to represent those who did not come forward, and therefore the results may not fully represent the true degree of difficulties in accessing effective services.

For the service user anonymous survey, the data on discussing S.O. or G.I. was consistent across the three arms of the research, it must be noted that there may have been a greater impetus for Rainbow service users to return the survey.

The scope of this project did not specifically include Rainbow youth or Rainbow older adults (aged 65+) and it is anticipated that there will be specific mental health and addiction issues that need to be researched and/or addressed elsewhere that are not within this report.

Whilst the principle and associate researcher have worked extensively in the mental health and addiction services they are not experienced researchers. They have been generously supported and supervised by a number of experienced, skilled clinicians and researchers, including those in the steering group, who have ensured that effective research principles have been followed and recognised.

Methodology – Service User Anonymous Survey

Participants:

A combination of qualitative and quantitative approaches were used in the surveying of approximately 1160 people who represented all the current service users of two Central Auckland DHB community mental health centre's (CMHC). The two CMHC's were selected to ensure a representative sample size of the Central Auckland area. CHMC I is located central to the city, in an area considered to have a higher than average concentration (for NZ) of Rainbow people residing there. CHMC II is located outside the city centre in the suburbs, and covers a varied demographic area. A total of 106 replies were received, with 54 returns from CMHC I, and 52 returns from CMHC II. The overall return rate was 9.1%.

Procedure:

The two selected CMHC's were provided with pre-packed envelopes that contained the survey, an information sheet, and a return addressed freepost envelope. The information sheet contained the background and rationale for the project, an outline of the procedure and options for support if any issues arise for the participants. In section one, the survey asked participants to identify their sexuality and gender by ticking as many boxes as relevant. In section two, participants were asked to indicate if they had ever discussed their sexuality with their key worker and how this experience was for them (see appendix 3).

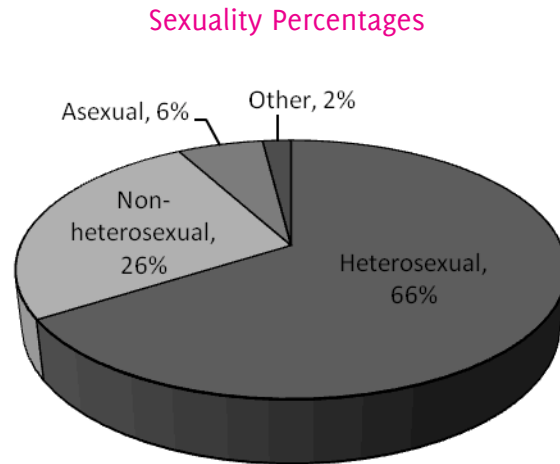
The pre-packed envelopes were labeled and posted by the CMHC staff to maintain privacy and confidentiality of the service users to the project team. The surveys were coded in two colours, one for each CMHC so data could be collectively and separately analysed.

Results

Sexuality

Two thirds of the total respondents identified as heterosexual. Just over a quarter identified as Rainbow, and a smaller group (6%) identified themselves as asexual or other (2%).

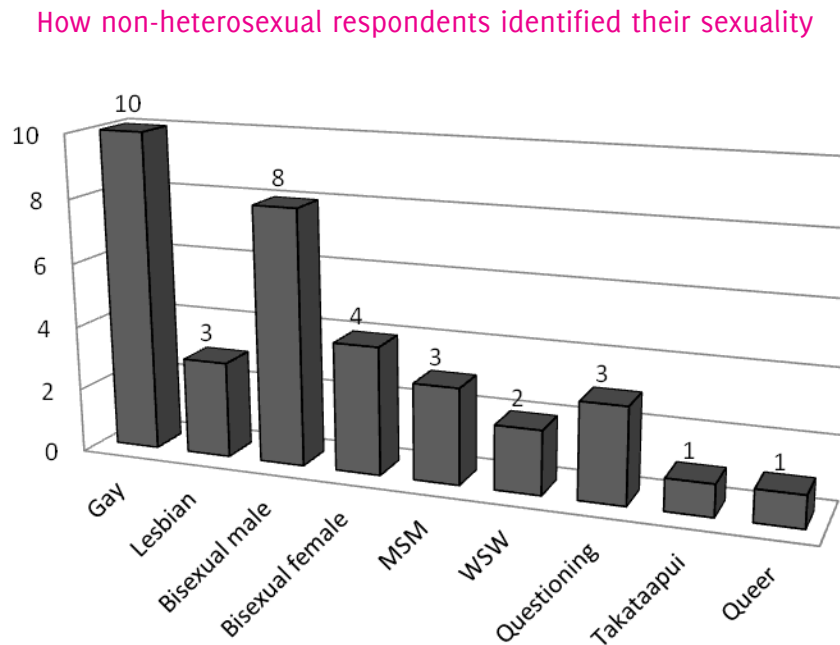
Figure 1



Identity of non-heterosexuals

The Rainbow group (26%) represented a variety of sexual orientation identities.

Figure 2

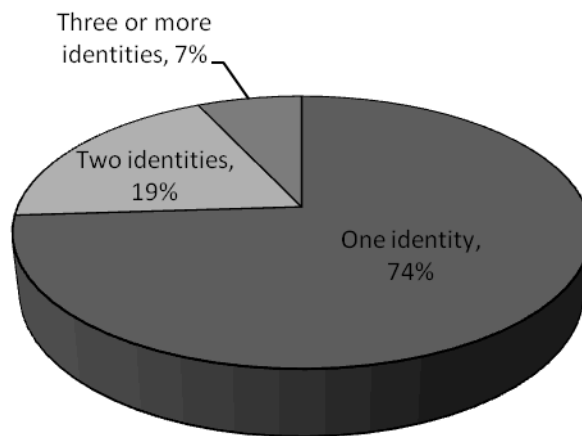


Note: Some have identified themselves as more than one

Of the Rainbow group, one quarter identified their sexuality in more than one way. For example, one respondent ticked lesbian, queer and WSW (women who have sex with women). NB non-heterosexual was one of the options to select for sexual orientation. Whilst Trans participants are included within the Rainbow group, they may identify their sexual orientation as either heterosexual or non-heterosexual, or other.

Figure 3

Number of ways Rainbow respondents identified their sexual orientation

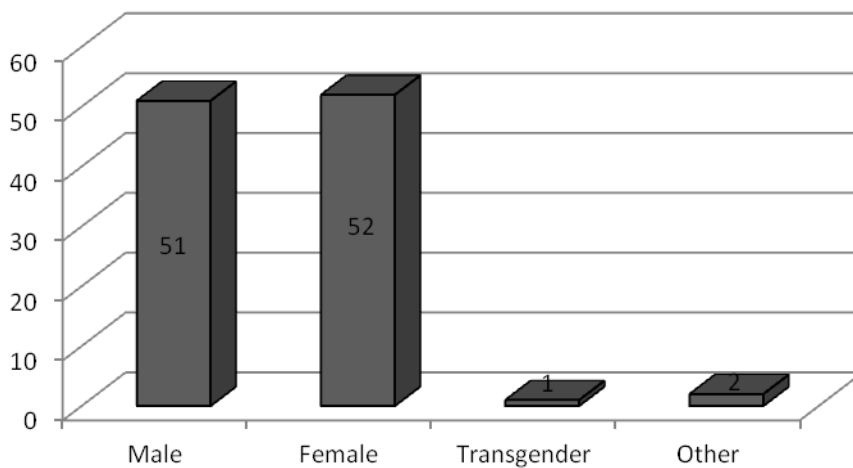


Gender identity

Whilst there was the option to select more than one identity, most of the respondents identified as either male or female, with two identifying as other, and one respondent identifying as transgender.

Figure 4

Gender identity

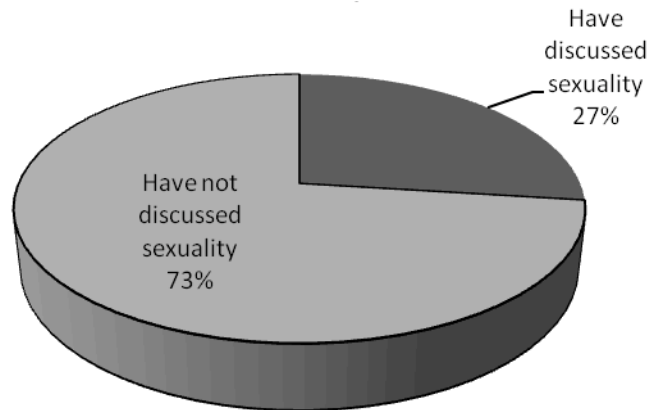


Discussion with keyworker

The large majority of all participants surveyed indicated they had never had a conversation about sexuality with their keyworker.

Figure 5

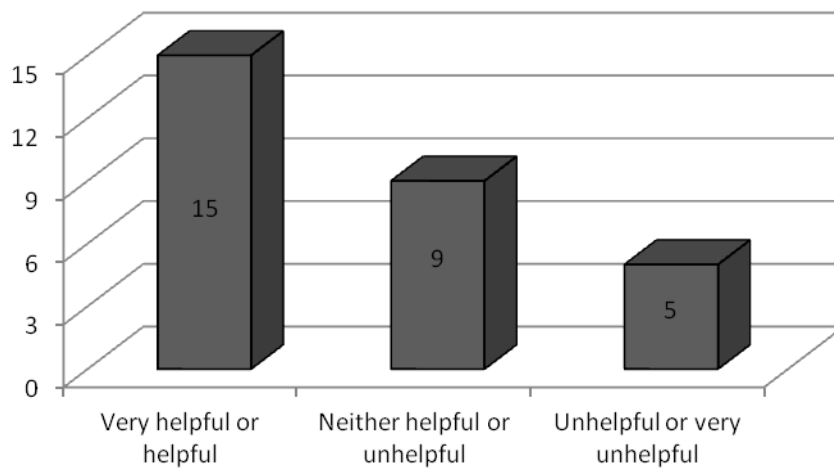
Discussion with keyworkers



About half of the respondents who had discussed sexuality with their key worker (15 out of 29) indicated that this had been a positive or helpful experience. 9 respondents indicated the discussion was neither helpful nor unhelpful and 5 respondents indicated it was unhelpful or very unhelpful. Some respondents did not rate what the experience was like.

Figure 6

Rating experience of discussing sexuality



The respondents who found the discussion neither helpful nor unhelpful tended to be those who indicated that their sexual orientation was not really that relevant to their mental health care or issues. This finding was evident across all sexual orientation identities (106 participants).

The 5 respondents who experienced the discussion about sexuality as unhelpful or very unhelpful gave a variety of reasons:

"Just didn't have much relevance" (female heterosexual)

"my keyworker said she was unable to talk about this and referred me to the sexual health clinic" [and it would have been better] "if she could have talked to me about my issues" (female heterosexual)

"Just pushed the issue aside like it did not matter as I question about male staff on the team, as I am not ready to work with males" (female rainbow)

"A non appeal kind of threatening to talk about etc. I thought I should never of told her. She downed me a little too much" (male rainbow)

3 out of 5 of the above respondents indicated this (unhelpful) discussion had made it hard to get the mental health support they needed.

Main themes

For the qualitative section of the survey, participants who had indicated they had previously discussed their sexuality with their keyworker responded to three questions about this discussion:

- Did the discussion make it harder to get the mental health support they needed?
- What could have made the discussion better?
- If it had not been helpful, why?

19 respondents added replies to some or all of the questions.

The main three themes identified from the response to this question were:

- The keyworker's lack of ability to facilitate appropriate discussion on sexuality was commented on by 9 respondents. This included level of comfort, skill, ability to engage in in-depth conversations and negative responses from the service provider.

Some responses were:

"My keyworker avoids talking about sex with me. I don't know why" (female rainbow service user)

"They just pushed the issues aside like it did not matter" (female rainbow service user)

"For her to agree with things I said. To make sure genders are OK, to ensure that talks like that stay in control" [This would have made the discussion better] (male rainbow service user)

"More in-depth discussion" [would have made the discussion better] (female service user who identified as asexual and heterosexual)

"My keyworker said she was unable to talk to me about this" (female heterosexual service user)

- Sexuality was not felt to be relevant or an issue by 8 respondents. Some of the responses indicated that they identified as asexual, or they felt comfortable about their sexuality (regardless of orientation), or felt their sexuality did not impact on or contribute to, their mental health issues or treatment.

"My being gay made no difference to my therapy/support" (female rainbow service user)

"My sexuality was already known by my keyworker, and was never an issue" (male rainbow service user)

- Talking about sexuality was helpful, supportive or positive was commented by 7 respondents.

"My therapist was compassionate, non-judgmental and very supportive" (female rainbow service user - Takataapui)

"My sexuality was already known, and getting the support was easy and happened very fast and efficiently" (male rainbow service user)

"Talk about it make things easy for the health support to identify the problem" (female rainbow service user)

Further comments of interest

One service user who had not been asked about her sexuality commented

"I have not discussed my sexuality as such with my keyworker, but I do admit there must be a lot of problems surrounding sex in mental health" (female asexual service user)

Another service user who had not been asked about his sexuality commented:

"This questionnaire is the first of its kind I have participated in. I strongly feel more questionnaires like this are needed" (male rainbow service user)

Summary of survey results

- About a quarter (26%) of all services users identified as from the Rainbow communities
- About two thirds of service users (66%) identified as heterosexual
- Rainbow service users identified in a variety of ways (e.g. MSM, WSM, gay)
- A quarter of Rainbow service users identified in more than one way (e.g. WSW and lesbian)
- The majority (73%) of all service users had never had a conversation about sexuality with their keyworker
- Rainbow service users were asked about their sexuality at a higher rate (42% versus 12%) than heterosexual service users
- Most service users who were asked about sexuality found it helpful or supportive
- Some service users reported that sexuality was not relevant to the mental health issues they were dealing with
- Many service users who commented about their discussion with their keyworker about sexuality (9 out of 29) felt their keyworker lacked the ability to facilitate an appropriate or positive discussion on sexuality

Methodology – service users interviews

Participants:

A qualitative approach was used through the use of semiformal, structured key informant interviews with 20 participants between May and July 2011.

Recruitment:

Advertisements seeking participants were placed in mainstream media, and LGBT/Rainbow media publications and websites; flyers were displayed in waiting rooms in a wide variety of mental health and addiction services within District Health Board (DHB) and Non-Governmental Organisations (NGO) settings. Advertisements were also published in local consumer network newsletters and publications.

Selection and criteria:

Interested participants contacted the researchers directly. Participants who met the research criteria were provided with an information sheet about the project and given time to consider whether to take part in the anonymous and voluntary interview. Participants had accessed and experienced mental health and/or addiction services within central Auckland within the last ten years, and were self identified as a member of the Rainbow community. Participants were offered a voucher to compensate them for their time/travel.

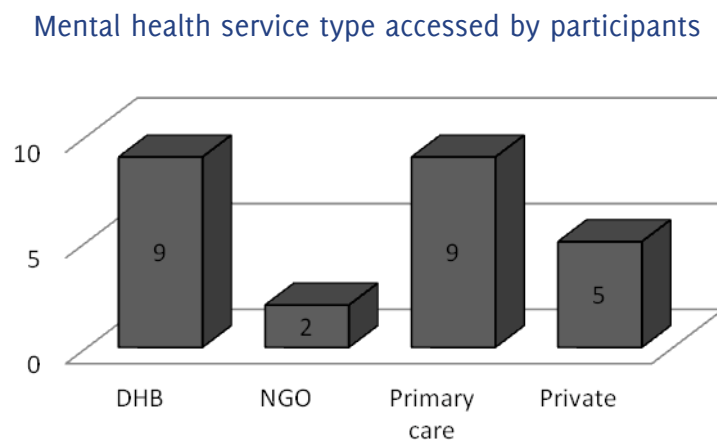
Demographics:

Participants were from the adult population (18 to 65 years) and all self identified themselves as from the Rainbow community. Identities included (but were not limited to) lesbian, gay, bisexual, transgender male, transgender female, takataapui, whakawahine, Rainbow and queer. One participant's interview was withdrawn from the study by the researchers, due to information provided which undermined the validity of the interview, leaving 19 interviews included in the results.

Service Engagement:

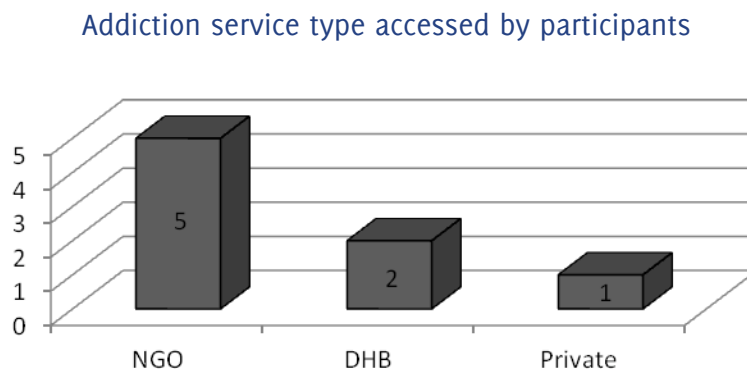
A large majority (84%) of service users who were interviewed, had accessed mental health services from DHB, NGO, primary care or private providers (including psychotherapists, psychologists, psychiatrists and counsellors). Nearly half (47%) of the interviewees had accessed DHB mental health services. Primary care services were also accessed for a mental health problem by nearly half (47%) of participants. A smaller percentage of service users had accessed mental health care through private services (26%) and NGO services (10%). Only one participant had accessed mental health services from primary care services alone.

Figure 7



There were fewer users of addiction services in the participant group (7 or 31%), and most had accessed NGO services (5 out of 7). DHB addiction services were accessed by 2 of the interviewees, 1 interviewee had accessed a private addiction service and 1 had accessed more than one type of addiction service. A small number (10%) of total participants had accessed addiction services alone; and no participants from this group reported accessing primary care services for an addiction problem or issue.

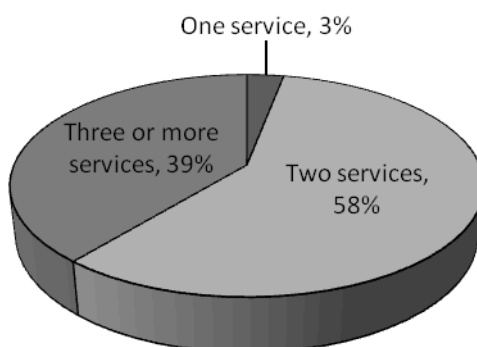
Figure 8



All but one of the participants had accessed a range of mental health or addiction treatment services across more than one service type (DHB, NGO, primary care or private). The majority of participants accessed two service types. Some of these participants who accessed more than one service type had also accessed multiple treatment services within one service type e.g. a service user will have used 3 different mental health DHB services, as well as a primary care provider.

Figure 9

Participants who accessed more than one type of service
(DHB, NGO, PHO, private)



Procedure:

Face to face interviews were held with 20 participants at a location of their choice within central Auckland. One interview was undertaken by phone as the participant was not residing in Auckland at the time of the interview.

An information sheet was provided to each participant with the exception of the phone interview (the sheet was read out in this instance). The consent process was discussed and a consent form was completed and signed by each participant. The key informant interview focused on experiences related: to sexual orientation; gender identity; particular pathways and barriers; and obstacles they may have faced when accessing mental health and addiction services, rather than their specific mental health or addiction problem(s). (See appendix 5.)

Comprehensive notes were taken by the researcher during the interview and direct quotes recorded. The large majority of notes were merged and formally recorded within 48 hours of the interview. The remaining small minority were entered within 7 days.

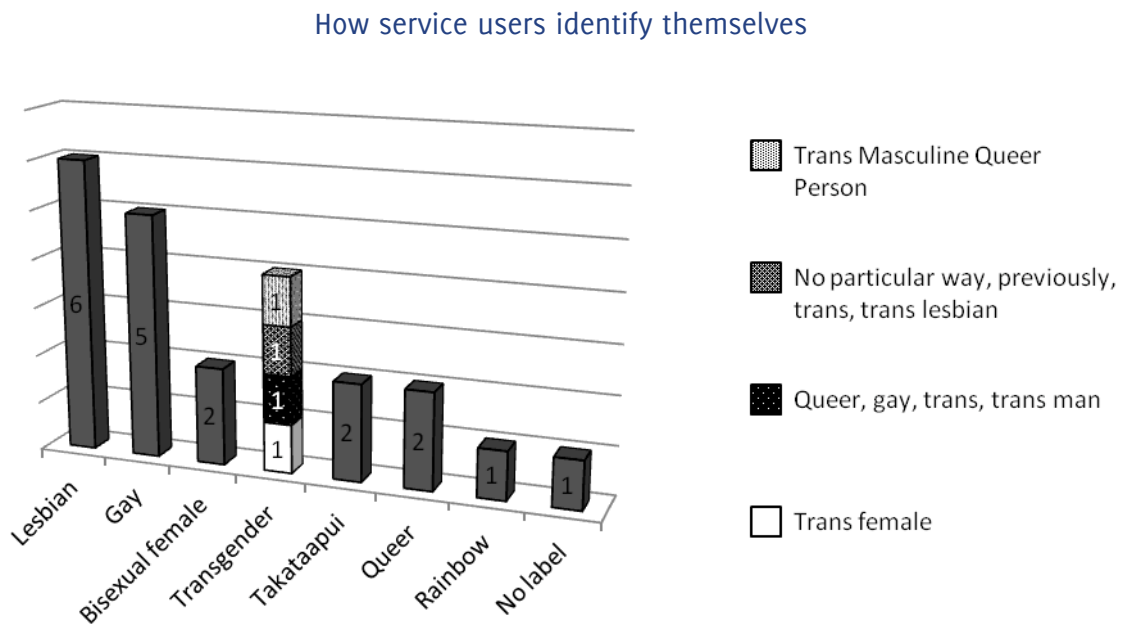
Results

A wide variety of services had been accessed by the participants between 2001 and 2011, with 14 participants accessing services at the time of the interview. A few of the participants had accessed services outside Central Auckland, or had accessed some services prior to 2001. This information was not captured, or included with the results.

Identity

Participants were asked how they identified their S.O. or G.I. for the purposes of the interview. Most participants identified in one way, e.g. queer or gay, but a small number identified in more than one way e.g. queer and trans. Out of 19 participants 11 different identities were named.

Figure 10

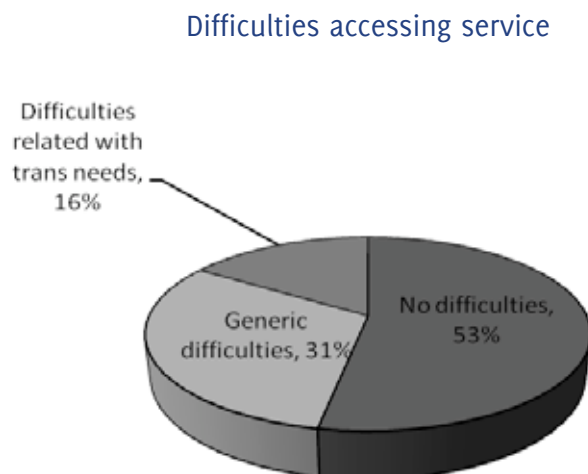


Access to services

- 10 of the participants reported having no difficulties accessing services (getting into services)
- 6 participants identified *generic difficulties in accessing services
- 3 out of the 4 trans participants experienced difficulties accessing services

*The generic difficulties participants encountered when accessing services were predominantly around the high entry level criteria and/or waiting times for public mental health services. These difficulties were not in themselves perceived by the participants as being specifically related to their sexuality or gender identity.

Figure 11



Of all the participants, trans people were the only group who reported specific difficulties related directly to sexual orientation or gender identity with the following comments made:

- A lack of clinicians or counsellors who are experienced in working with trans people on issues relating to gender identity or transition
- A lack of services available to assist trans people with specific transgender issues
- An unclear pathway for medical and surgical treatment for transition; with counselling and/or assessment being compulsory before treatment is provided
- No funding or financial support to trans people who do not meet the high entry criteria for public mental health services, and who are required to undertake counselling or assessment before treatment for transitioning is considered
- That being the only trans person visible within services is difficult

"Finding skilled and experience a counsellor is hard...there are financial difficulties in following the prescribed pathway. When you can find them, trans friendly counsellors are usually in private practice and this is generally unaffordable to trans people. It seems if you go to public services, you get a freak out person"
(trans male)

When participants were asked about barriers to accessing services, rather than difficulties accessing services, most participants (14 out of 19) indicated they did not feel their sexual orientation was a barrier to accessing services.

These comments represent the main themes from the feedback about this:

"It is easy to hide if you need to"

"It [sexual orientation] was on my GP referral, so they knew already"

"Sexuality was not relevant"

The 5 participants who reported feeling their sexual orientation or gender identity was a barrier to accessing services, gave the following reasons:

- Fearing the clinicians/health professionals response, or fearing rejection by the clinician
- Experiencing a negative response after disclosing sexuality or gender identity previously when accessing a mental health or addiction service
- Fear of distracting and negatively impacting on other service users in inpatient treatment by the service user being “out” (trans participant felt their identity made it difficult for others)
- Lack of a clear pathway for trans people
- Fear of pathologisation of gender diversity (gender identity disorder) and/or fear of being ‘forced’ into a specific pathway to access medical or surgical treatment for transition
- Lack of availability of skilled and experienced clinicians; especially clinicians who are experienced working specifically with trans people.

“My identity has made it hard for me to get the support I need because there is no clear pathway and a lack of experienced counsellors to help me with my issues” (trans male)

“It is very difficult to identify someone who is skilled and experienced in working with trans. There is no list or network of trans, or trans-friendly or LGB counsellors. Usually I end up having to educate them [the counsellor]. I would love it if I could find someone who I don't have to do that with” (trans male)

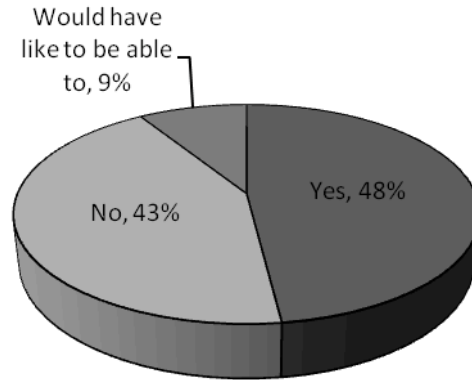
Visibility

Half of the participants felt they needed to conceal their S.O. or G.I. when accessing services at some point. 9 service users who accessed the Central Auckland mental health or addiction services in the last 10 years felt they needed to conceal their S.O. or G.I. when accessing one or more mental health or addiction service. 9 service users felt they did not need to conceal their S.O. or G.I., though one of this group stated they would “have liked to” conceal their gender identity. One participant stated their sexual orientation was already known by the service provider so the question was not relevant.

The stigma attached to being transgender was commented on by 2 of the 4 transgender participants who indicated they would have liked to have been able to conceal their gender identity if possible, when accessing certain mental health or addiction services. (Note: For some trans people who have transitioned and identify as male or female ‘being stealth’ (i.e. not disclosing that they are trans) is their preferred way. In this case they may not want their trans status to be recorded).

Figure 12

Did you feel you had to conceal your sexual orientation or gender identity?



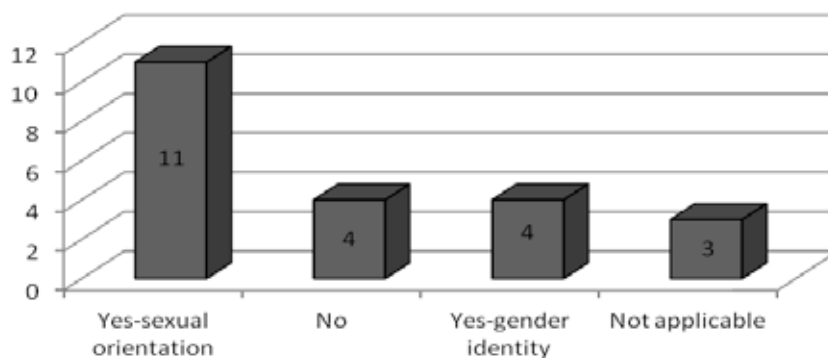
The most common reason participants concealed their sexual orientation or gender identity was because they feared the response of the clinician. This was often based on past negative responses and experiences, or they felt embarrassed.

"Yes, of course [I concealed my sexual orientation], because of self embarrassment, and fear of how other people may respond" (gay male)

Over half the participants had previously felt their sexual orientation or gender identity had been presumed at some point when accessing services (either correctly or incorrectly). 4 participants felt their identity had not been presumed, and 3 participants stated it was not applicable to them (e.g. one participant said they had been "out" immediately so there was no opportunity to make any assumptions). Whilst most participants indicated gender identity was not an issue for them, 4 participants commented that they felt their gender identity was assumed.

Figure 13

Did you perceive that your sexual orientation or gender identity was ever presumed?



"I was assumed to be straight everywhere, my GP and XXX [CMHC]" (gay male)

"I certainly felt that they assumed how I identify my gender. In terms of my sexuality, the psychiatrist assumed that I was bisexual as I saw him write that down" (queer female)

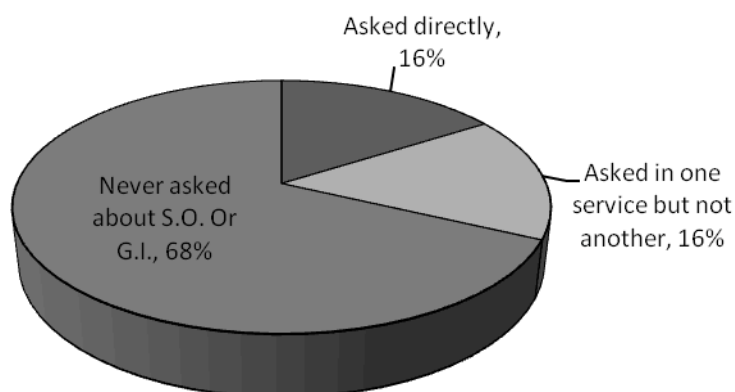
Talking about sexual orientation and gender identity

Most participants were not asked about their S.O. or G.I. when they accessed one or more Central Auckland mental health or addiction services; with 13 out of 19 participants never being asked in any service; 3 being asked in one service but not in another, and 3 being asked directly when accessing services.

"I would have liked to have been asked if I had a partner; this would have been an opportunity to open up another bridge" (lesbian woman)

Figure 14

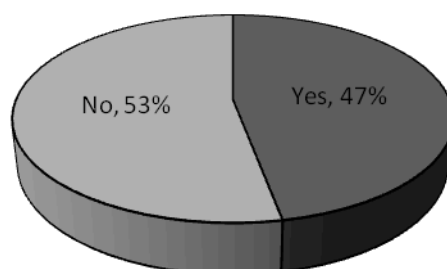
Were service users asked about their sexual orientation or gender identity?



Whilst most participants stated they were never asked about their S.O. or G.I. the majority also felt (10 out of 19) there were no opportunities to discuss S.O. or G.I. or possible issues in relation to this.

Figure 15

Were there any opportunities to talk about S.O. or G.I.?



"I have felt embarrassed and didn't feel I could talk to my case-manager - in fact it was never spoken about" (bisexual female)

"I felt I had to be really out right from the beginning. I created the opportunities [rather than staff asking her]. I was worried that I might be harassed otherwise" (trans woman)

"XXX was a straight woman, and at the first meeting she was obviously pregnant...I asked her what experience she had working with gay men or LGBT people. I don't think she had an understanding of what it is like to be gay bashed physically and mentally, so I didn't raise some of the core issues I had. She asked about family history, but not about sexual orientation" (gay male)

When participants were asked how they would like discussions around S.O. and G.I. to be held in the future, just over half (10 out of 19) commented they would like to be asked directly at the first face to face interview. 6 out of 19 mentioned that they would like services to create a safe and welcoming environment, so identity was easy to talk about, a further 6 comments were made about asking broad questions, such as asking about current issues, or partnerships, in a non-heteronormative way.

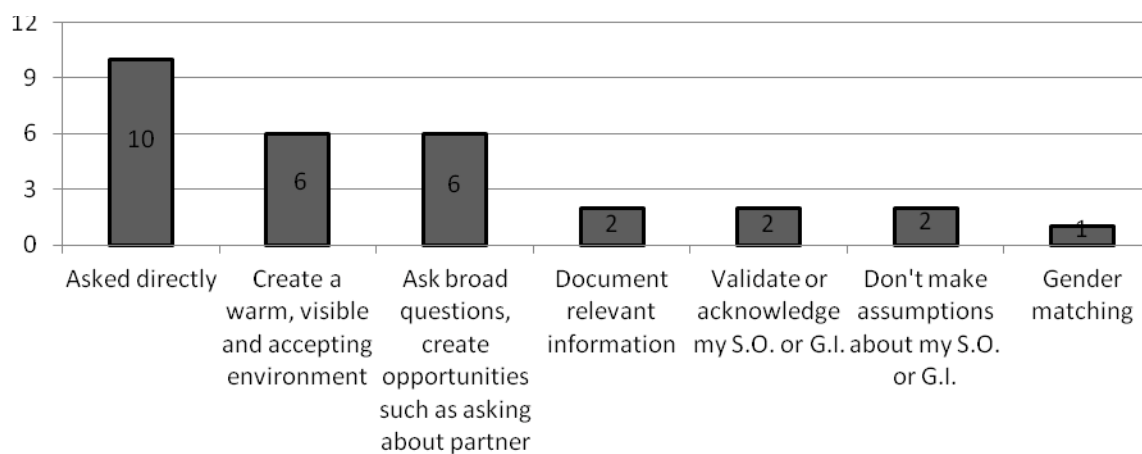
"One psychiatrist asked me as part of the assessment process about my past relationships and how I identify my sexual orientation. This felt comfortable. I liked that this was being asked in the context of the full assessment; if it is asked in a vacuum then I think it can be taken in a way that pathologises it" (lesbian woman)

"I would like to be asked about how I identify, directly, but not over the phone, [but] as part of the information they [CMHS] do at the beginning of an assessment" (gay male)

Suggestions were made about ensuring that language is non-heteronormative, inclusive of same sex relationships and diverse gender identities. None of the participants indicated they did not want to be asked about their S.O. or G.I.

Figure 16

Service users suggestions for asking about or addressing issues about S.O. or G.I.



In terms of the participants feeling comfortable talking about their sexuality and/or gender orientation, 12 out of 19 participants had experiences where they had felt comfortable talking about S.O. or G.I. when accessing one or more mental health or addiction services.

The common themes were:

- The participant felt confident or comfortable about their own identity and/or sexuality
- The participant's identity was not an issue relevant to the mental health or addiction problem/issue
- The participant felt supported by the clinician/counsellor when they disclosed their own sexual orientation or gender identity.

"The female psychiatrist I saw put me at ease and made me feel comfortable. She also asked me about my sexual orientation, and was inclusive of my female partner" (lesbian woman)

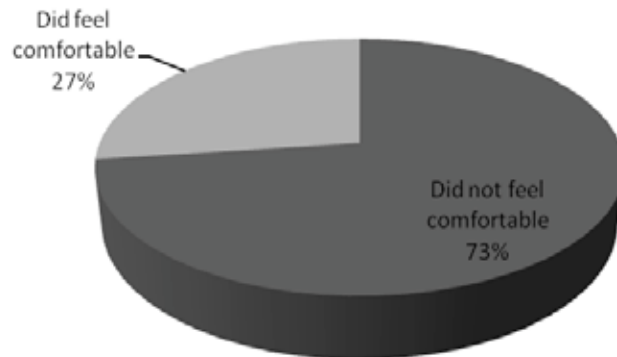
14 out of 19 participants, including some of those who had positive experiences in some services, felt uncomfortable talking about sexuality or gender when:

- Clinicians/health professionals did not ask about S.O. or G.I.
- Clinicians/health professionals responded inappropriately, or negatively when the service user identified their S.O. or G.I. ultimately creating a 'conversation stopper'
- 3 out of 4 trans participants felt uncomfortable in at least one service because of lack of skill or experience by the clinician/counsellor; with one participant reporting the counsellor "freaked out" when they disclosed their gender identity

Most of the participants had accessed more than one service therefore when they were asked if they felt comfortable talking about sexuality or gender identity, many answered both "yes" and "no", depending on the services.

Figure 17

Service users comfort discussing S.O. or G.I. when accessing one or more services



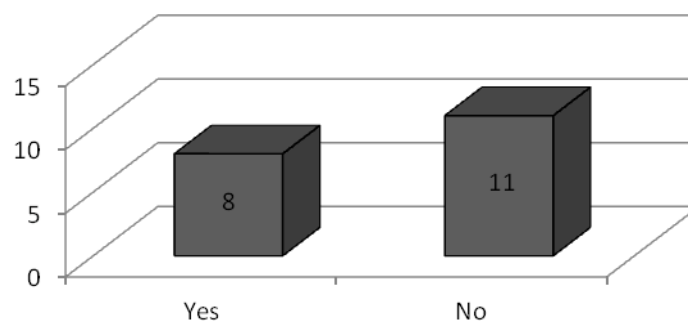
"I only felt comfortable raising my sexuality within a group setting; I would have liked to have talked about my sexuality with my counsellor" (lesbian woman)

"I did not feel comfortable talking about it, as the one time I raised it, I wish I hadn't as my counsellor asked me "well how do you identify?" after I responded she said "well being bisexual is freeing" and then it felt like it was a conversation stopper" (bisexual woman)

8 out of 19 of the participants said that they 'came-out' straight away when they first accessed a service. Many of this group stated the rationale for this was so that assumptions were not made about their identity.

Figure 18

Self identified at the beginning of contact with a service



3 of these 8 participants who self identified at the beginning of contact with services said they received a negative response after disclosing their identity. Participants commented:

"This was not the prime importance to the Doctor, or psychologist [being gay]... none of the staff would go near the issue" (gay male)

"Not when accessing XXX service. When I first went there I came out straight away, but they were not interested in that sort of thing. It was a total shut down" (gay male)

A few of these 8 participants commented on helpful or positive situations or responses by the clinician/health professional when talking about S.O. or G.I. These were:

- Knowing the health professional was gay themselves
- Being asked about sexual orientation or gender identity directly as part of the assessment process
- Other residents being 'out' or visible within services (made it easier to talk about S.O. or G.I.)

Most participants (16/19) indicated that they would like to, or thought it was important for them to see a Rainbow clinician. Of these 16 people 9 said they definitely would like to see one, 7 said that being a Rainbow clinician and being skilled was equally important, 5 said they would like the choice to see a Rainbow clinician and 2 thought it would be a "bonus".

Many participants commented that they felt a clinician from the Rainbow community themselves, was more likely to have an understanding of LGBT specific issues and be accepting. The service users also reported that they would feel much more comfortable and at ease.

"I would love that you know! Seeing an LGBT person would feel more comfortable, and would have a better understanding of the issues [being gay] and have a better awareness. Also, it would feel like an acknowledgement" (gay male)

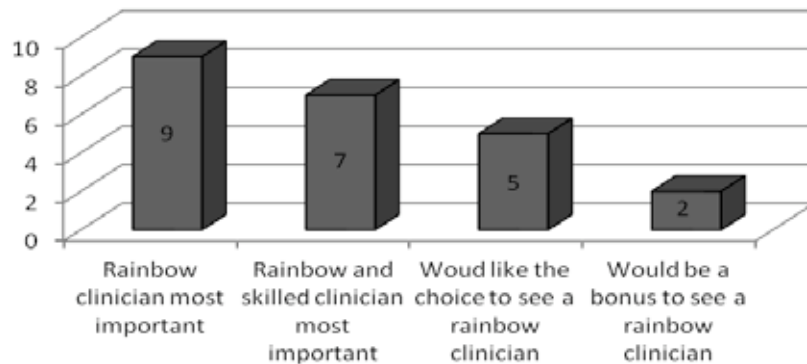
"Yes, I would want to know that they have some personal connection to what I am talking about. For example, knowing that they have experience working on the issues of gender and sexual diversity" (trans male)

"The last place I'd like to be is with someone who is homophobic, though if it wasn't an issue that I was gay, then I wouldn't need to see a Rainbow person" (lesbian female)

"Yes, but it depends on their approach. I would like it if they were skilled on those issues [sexuality]" (bisexual female)

Figure 19

Number of service users who would like to see a rainbow clinician



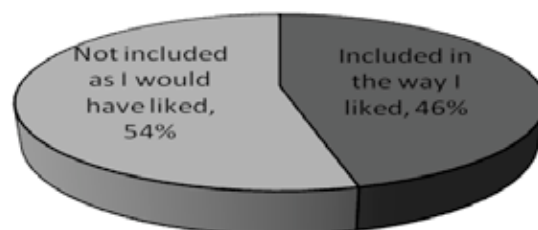
Whanau/family and partners

13 of the 19 participants felt the inclusion of whanau/family or partners was relevant to them. Over half of these 13 participants (7) felt the mental health or addiction service(s) did not acknowledge or include whanau/family or partners as they would have liked. Specific feedback relating to S.O. or G.I. from participants was:

- Participants felt there was a lower value placed on Rainbow relationships than the value placed on heterosexual service users' relationships
- The clinician/health professional struggled with the concept of a trans participant having a trans partner, and the concept that sexual orientation gender identity are different things.

Figure 20

Inclusion and acknowledgement of whanau, family and partners



"No, not at XXX service. My ex-partner of 19 years is my closest support and my immediate family; more so than my family of origin who I have been somewhat estranged from. I felt that the staff did not recognise him as that, and it felt that they put a lower value on the relationship because it was a gay relationship" (gay male)

6 out of the 13 participants felt that their whanau/family or partners were acknowledged and included, with 2 participants commenting on very positive outcomes as a result:

"We had some sessions with my family, and worked through some issues of how it was for me growing up trans. I am now reconnected with my family and have a relationship with them after about 16 years" [after being estranged] (trans woman)

"...we [same sex partner] were offered 1:1 session which we did. This had the effect that my partner then engaged with services herself" (lesbian woman)

Positive experiences when accessing mental health or addiction services in relation to S.O or G.I.

- 13 out of 19 participants commented that it had been positive when they felt accepted and comfortable or at ease when talking about their S.O. or G.I. with their clinician/health professional.

"At XXX, and with my psychotherapist, it felt perfectly normal to talk about it [being gay], and there was no sense of hesitation or surprise" (gay male)

- 6 participants commented that it was positive when there were 'out' or seemingly 'out' clinicians/health professionals being visible within a service.

"XXX was really positive, because he was really empathic and also gay himself..." (gay male)

"One assessment with a psychiatrist was really comfortable and easy. I think that she was also a lesbian" (lesbian woman)

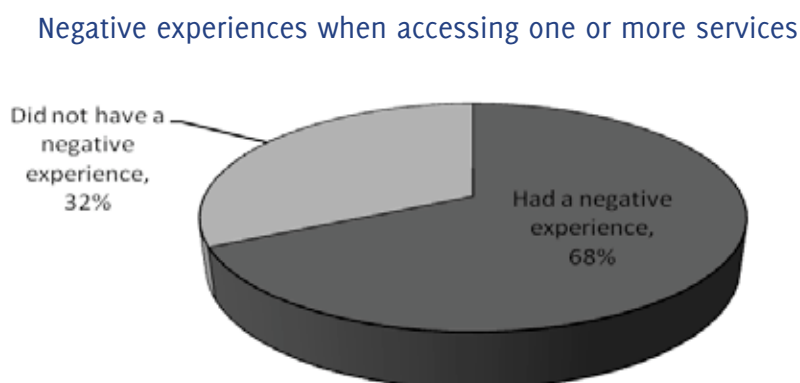
- Other positive experiences related to having specialist needs catered for e.g. connection to Rainbow community groups, private bathroom facilities for trans person.

"XXX CMHC were really positive and encouraging once it was out. They helped me practically and I felt really supported. Whilst my keyworker was not gay, he was really supportive and found out about community resources on my behalf and assisted me with re-engaging with the community" (gay male)

Negative experiences when accessing mental health and addiction services in relation to S.O. or G.I.

Most participants (13 out of 19) reported negative experiences in their interactions with clinicians/health professionals or services when previously accessing a mental health or addiction service.

Figure 21



The main theme for these experiences was that the clinician/health professional was unskilled and/or uncomfortable talking about S.O. or G.I. or the participant experienced a negative reaction(s) when they identified themselves as from the Rainbow community.

"The conversation with the psychiatrist was very uncomfortable, and he did not accept my explanation of my identity. He said that he thought I might be confused. He said that lots of young people have a time when they question their sexuality and lots of people end up straight, and that I might 'grow out of it' and even be married one day...the assessment process and comments about my sexual identity was negative overall, and yet another situation where I felt I had to challenge assumptions (queer female)"

"Not being asked about my sexuality [was negative]" (gay male)

"Feeling like I was not understood [by the staff], and feeling confused and ashamed of my emerging sexuality [was negative]" (bisexual female)

One third of participants (6) reported an unprofessional incident by the clinician/health professional. This included breaching service user confidentiality; leaving the room abruptly during an interview after the service user identified themselves as trans; not accepting a participants explanation of their Rainbow identity and enquiring about the service user's S.O. with another resident/consumer instead of the service user themselves.

The main theme participants commented on was that not having the opportunity to talk about their S.O. or G.I. (They were not asked; it was avoided; or they received a negative response), negatively impacted on their treatment/outcomes.

Recommendations for specific Rainbow services

When participants were asked what specific Rainbow services they would like to have available in the future, participants responded in a variety of ways. The main themes were:

- Specific Rainbow resources or networks/databases for professionals (8 participants)
- Rainbow peer support or advocacy for service users (7 participants)
- Specific Rainbow services (OUTLine (2), Youthline, pride centre, gay N.A.) and/or social groups (6 participants)

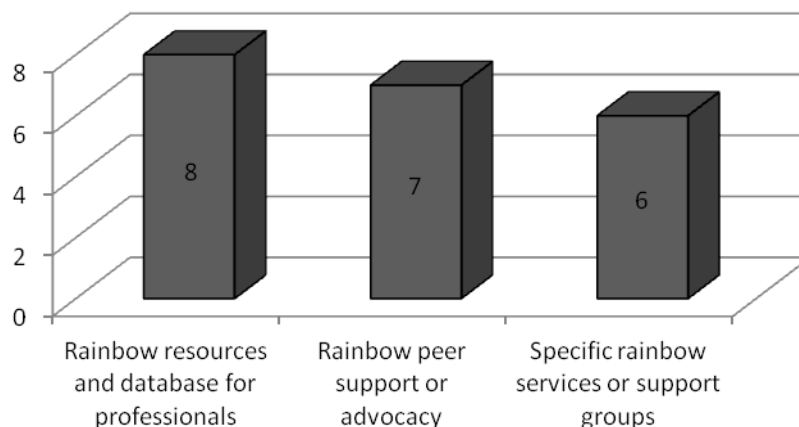
"To have an [Rainbow] advocacy service, and peer support; I think that would be absolutely brilliant"
(gay male)

"Having LGBT identified staff available. Having a national database of LGBT orientated services and the best places to go" (gay male)

"LGBT support groups and peer support. This would be an opportunity to get stronger as a group, and to re-integrate into the rest of the community stronger, and more confident" (bisexual female)

Figure 22

Main specific services participants would like in the future



Other suggestions included: specific trans support (funding, provider training, guidelines/pathway for transition); a Rainbow 'like minds like mine campaign' similar to the one provided by the Mental Health Foundation to counter stigma and discrimination; Rainbow visible professionals; and a Rainbow 'arm' to existing services.

Other issues

Some of the participants commented that they would have liked to have had an informed conversation about how medication can impact on sexual dysfunction.

Summary of interview results

- There were significant barriers and obstacles to effective services due to S.O. and G.I. not being discussed, and fear of how the clinician/health professional would respond to the participants identity
- Most participants were not asked about their S.O. and/or G.I. and they would like to have been (with a general preference for it being part of the standard assessment process)
- Half of the participants felt that they had to conceal their S.O. or G.I. when accessing one or more mental health or addiction services, usually due to their fear of the clinician/health professional's response.
- None of the participants indicated they did not want to be asked about their S.O. or G.I.
- Most participants had experienced negative events relating to their S.O. and G.I.
- Participant's perceptions of problems accessing services were more generic than related S.O. or G.I. The exception to this was the trans participants who had specific issues that presented significant barriers/obstacles when accessing services
- Most participants had accessed many services or varying types of services (e.g. NGO or DHB)
- Most participants felt 'invisible' in relation to their S.O. or G.I. at some stage of their contact with services, and/or assumptions were made about their S.O. or G.I.
- The participants used many different terms to identify their S.O. or G.I. and some participants used more than one way.
- Many participants had positive experiences with clinicians/health professionals in relation to their S.O. or G.I. and had at some stage felt accepted by one of their clinicians/health professionals
- Most participants found that clinicians/health professionals were often not sufficiently skilled or experienced in working with Rainbow specific issues.
- Most participants would like to have the option of seeing a Rainbow clinician/health professional (or at least a Rainbow competent clinician as one of the professionals involved in their care); and have Rainbow staff that are visible
- Trans participants indicated the need for a clear pathway to access treatment for counselling
- Many participants want access to peer support and Rainbow support groups in the future
- Participants suggested the development of resources and training for service providers and a database of services/counsellors for both service users and service providers
- Participants indicated they want clinicians/health professionals to be informed on Rainbow specific issues, and be comfortable and skilled in working with Rainbow service users, with essential skills for clinicians including being open and flexible

Methodology and results – service providers interviews

47 participants were interviewed in a qualitative approach consisting of semiformal, structured key informant interviews from March to June 2011.

A combination of self selection and recruitment of interviewees ensured that a wide range of clinicians, support workers, and managers participated. This approach enabled the researcher to interview service providers who came from both the Rainbow community and the non-Rainbow community, who have a varied range of skills and experience in working with Rainbow people.

Of those interviewed, 25 participants self identified as from the Rainbow community, 20 self identified as from the non-Rainbow community, and 2 did not identify as from either community. A small number of participants were identified by the researchers or steering group as having significant experience in working with Rainbow people, and were recruited by the researchers to take part in a voluntary capacity. The remainder of participants volunteered to participate after their line managers advised them about the project.

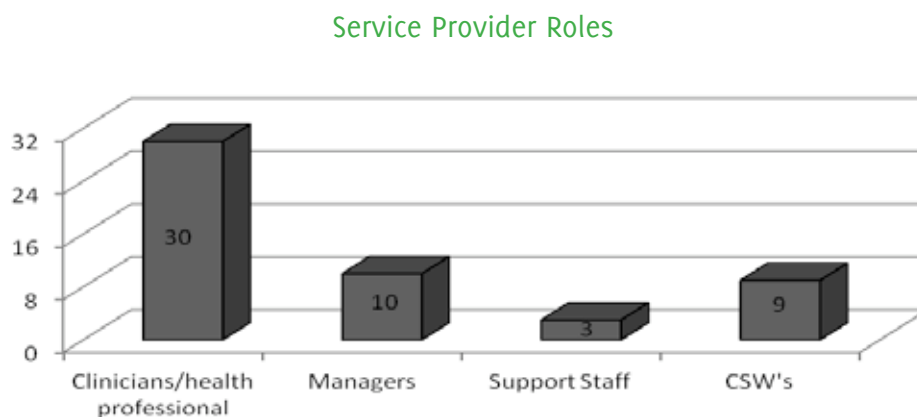
Participants mainly represented adult mainstream mental health and addiction services from DHB, NGO and primary care services, from a variety of settings that included inpatient, community and residential settings. There were an additional two participants involved with older adult services and one participant working in mainstream services with a youth focus (up to age 27).

All but one participant held roles solely within central Auckland (ADHB catchment area). One participant held two roles, one with primary care in central Auckland and one DHB role in the greater Auckland area.

The majority of interviewees came from clinical backgrounds currently working directly with service users. They represented a wide range of clinical and non-clinical staff. This group included nurses, psychiatrists, psychologists, psychotherapists, social workers, community support workers, managers (team managers, senior managers, practice manager and team coordinator) a nurse educator, residential support workers, a family advisor, practice managers, general practitioners, a mental health chaplain, cultural support workers, and AOD clinicians (including a same sex attraction youth AOD clinician, and LGBTTF designated clinician).

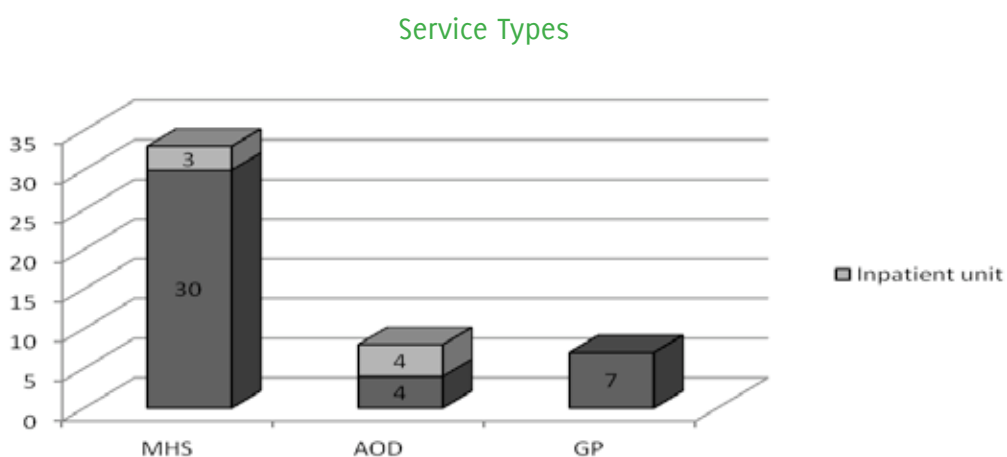
39 out of the 47 participants had clinical or support roles working directly with service users. 10 participants had management roles with 8 participants having management roles only (5 senior managers, 2 team managers and one practice manager), and one team coordinator and one team manager having both clinical roles and management roles.

Figure 23



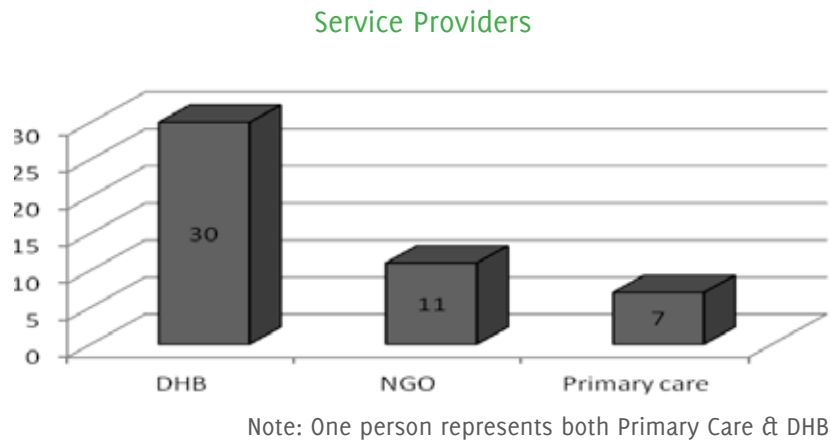
41 of the participants were employed within community mental health or addiction based services, with 7 participants employed in an inpatient setting (with one participant working in two service types).

Figure 24



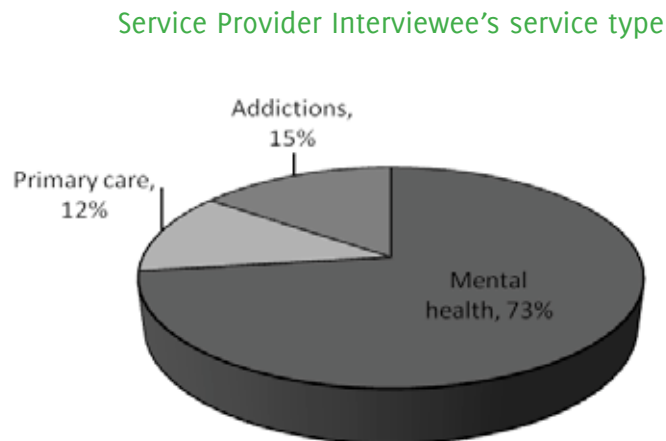
The majority (64%) of participants were employed by the DHB.

Figure 25



Most participants (73%) were employed in mental health services.

Figure 26



Primary care participants were all mostly from the central city area, and reported having a high number of Rainbow patients (Anecdotal evidence and evidence from the service user interviews suggest higher numbers of Rainbow people in the central city area). Attempts to interview GPs from outside the city area (who were likely to be less experienced working with Rainbow people) were unsuccessful.

In addition to the key informant interviews with DHB, NGO and primary care services, primary care services from the main central Auckland PHO's CEOs were contacted and asked to provide summarised information from their general practices. This information was to report on the current issues when working with LGBT people in terms of particular gaps; barriers or obstacles; care pathways; knowledge and skills and areas of strength and/or weakness when working with LGBT people.

Procedure:

Most participants were provided information by the researcher about the project via their manager prior to volunteering for the interview. All interviewees were given a verbal outline of the overall project goals at the beginning of the interview. Comprehensive notes were taken by the researcher during the interview, including direct quotes. The majority of interviews were typed up within two days, with the remaining small minority typed within one week.

Of the 47 interviews held, 33 were face to face interviews. In addition, 3 focus groups were held with a total of 8 participants (groups of 2; 4; 2), and 6 participants replied to the interview questions in writing. Meetings were arranged at a time and location to suit the interviewee. Focus group interviews were conducted by two researchers, with one researcher conducting the interview and one recording the meeting.

Results

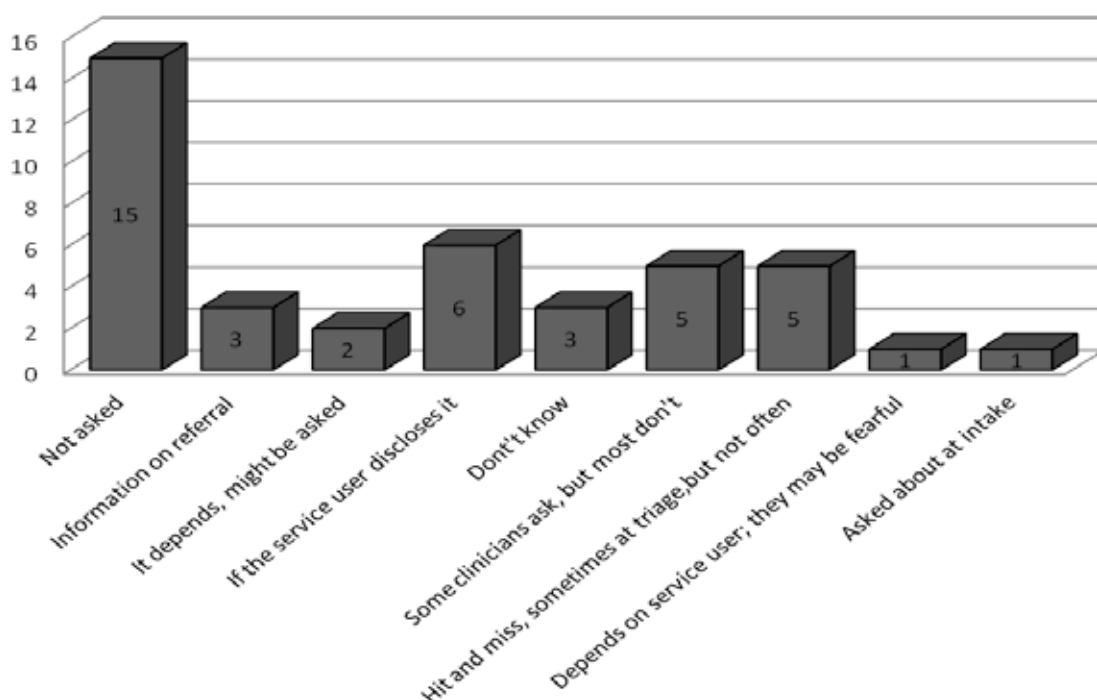
Visibility

Participants were asked a general question on how Rainbow service users are identified. Most of the 42 out of the 47 participants who responded answered on behalf of their team or colleagues (rather than their own practice):

- About half of those who answered stated they or their service did not ask service users about S.O or G.I.
- 6 participants said Rainbow service users are usually only identified if they self disclose
- 5 indicated that the process of identification was adhoc, and that it may be asked occasionally
- 5 participants stated that some individual clinicians/health professionals ask, but most do not.

Figure 27

How do service providers identify Rainbow service users?



"[There is] no specific tool or assessment process that identifies sexual orientation or gender identity and this process would differ between individual clinicians" (DHB clinician/health professional)

"...depends on the situation. There is no formal way of identifying an individual's sexual orientation or gender identity. Sometimes it is recorded in the clinical notes, but only if it is relevant" (PHO GP)

"If a young person rings, most clinicians ask how they identify, or if they have issues to do with sexual orientation, or if they would like to see a same-sex attraction worker" (DHB clinician/health professional)

In terms of how information about S.O. or G.I. is recorded or documented, nearly all participants indicated that it varied between clinicians/health professionals. If the information was recorded (and more often it was not), it could be in a variety of places such as clinical notes, core assessment form, risk plan, care plan, referral form, HCC, life plan, individualised plan, progress notes or daily notes.

A few clinicians from PHO and DHB services commented that they may not necessarily record this information if known with the rationale being that it was private information (private to the service user) or that the information could be accessed by a third party (e.g. insurers or employers) and result in discrimination.

"There is no way to record it by itself. It is recorded in consult notes, under say, next of kin. On our system we have categories for married, ethnicity, country of origin; but not sexuality" (PHO GP)

"Queer consumers are often unidentified. It's hit and miss and it varies between clinicians. It's hardly ever done [asked or recorded]" (DHB clinician/health professional)

"Hit and miss. Sometimes are identified on triage information; sometimes during the triage process if obvious" (DHB clinician/health professional)

"It depends on if the client is wanting to be identified as LGBT; they may be reticent because of fear of reactions from staff" (DHB clinician/health professional)

"In the clinical notes, or in a private note area if very relevant to medical care" (PHO GP)

Only one NGO service and one DHB service had a semi-formal or formal network of Rainbow clinicians:

- One NGO service has a single cultural group (which includes Rainbow) that meets irregularly but individual members are available to consult with at other times
- One DHB service has a regular Rainbow multi-disciplinary meeting which includes one clinician (not necessarily a Rainbow clinician) from each service

"Yes, each service has to identify one person who will be their Rainbow advocate. They do not have to be LGBTTF, but they must feel skilled and comfortable working with this population" (DHB clinician/health professional)

Most services do not offer the option of seeing a Rainbow clinician and none of participants were employed by services who routinely offer the choice to service users to see a Rainbow clinician/health professional (two services offer this in an adhoc way). There were barriers identified for matching of Rainbow service providers with Rainbow service users, with comments made by 4 participants:

- A fear of sexual accusation, or being at risk in some way if 'out' with service users in an inpatient setting (2)
- Possible attraction to the service provider (1)
- Unsure of employers support being 'out' with service users (1)
- Being part of a small Rainbow community e.g. running into each other socially (2)

Only 4 participants held a formal or mandated role in working with Rainbow consumers and/or providing training:

- Two individuals provided clinical services to Rainbow consumers and provided diversity training within a Rainbow specific role
- One held a specific liaison role as part of a wider clinical role,
- One provided training as part of their general clinical role.

3 individual services had a formal matching process for some of their Rainbow consumers:

- Two services had mandated roles (HIV liaison and addictions Rainbow service)
- One service was an inpatient addiction service where one clinician reported formal/semi-formal matching with Rainbow consumers

(These four clinicians/health professionals who worked in services who offered formal matching identified as from the Rainbow community themselves.)

14 out of 47 participants indicated that there was some sort of informal matching process at times (if requested or case by case), or that a Rainbow clinician/health professional was more likely to be allocated to (or self-select) a Rainbow service user, as they were seen by the team as having 'specialist' knowledge or having particular skills working with Rainbow service users. This informal matching was both overt and covert at times (depending on the clinician and team culture).

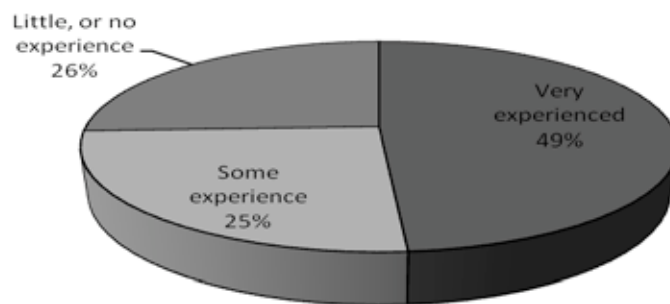
Most of the Rainbow service providers were 'out' with other staff members and a small number (3 out of 25 Rainbow service providers) were 'out' with both other staff members and with service users.

Service providers experience and competence working with Rainbow consumers

Participants across all service types (DHB, NGO and primary care) were asked how experienced they felt they were working with Rainbow consumers. Of the 39 clinician/health professionals who responded, 49% (19 participants) felt they were very experienced working with Rainbow service users, 26% (10 participants) felt that had some/moderate experience working with Rainbow service users and 26% felt they had very little or no experience working with Rainbow service users.

Figure 28

Individual service providers experience working with Rainbow consumers

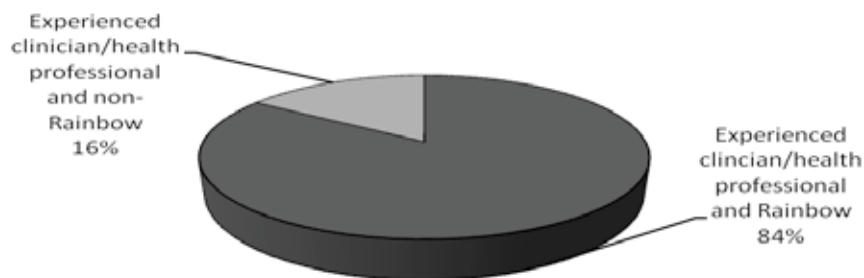


16 out of the 19 clinicians/health professionals (84%) from all service types, who felt they were very experienced working with Rainbow service users, identified as being from the Rainbow community themselves.

Of the 19 participants who felt they were very experienced working with Rainbow service users, 5 had specialist Rainbow roles working with Rainbow service users (HIV liaison, specific rainbow services within an addiction service), or were providing diversity training to staff as a part of their clinical role.

Figure 29

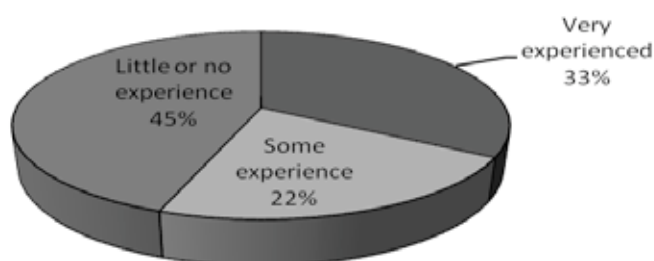
Experienced clinicians/health professionals own identity (Rainbow/non-Rainbow)



Subjective experience levels of the clinicians/health professionals varied across the service types, with NGO services having the least experience; with only 3 out of 9 NGO participants (33%) felt very experienced working with Rainbow service users. These 3 participants were all working in addiction services. 4 (45%) of NGO participants felt they had little or no experience working Rainbow service users. The remaining 2 (22%) had some experience.

Figure 30

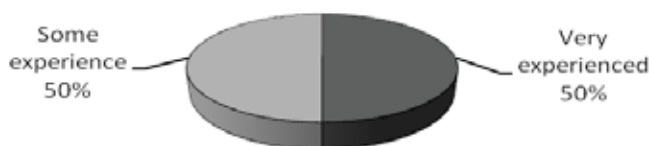
Individual experience working with Rainbow service users in NGO services



As stated earlier, those who participated from primary care were generally from the central city GP practices, and were likely to have a higher number of Rainbow services users than practices outside of the central city. None of these participants felt they had little or no experience working with Rainbow consumers.

Figure 31

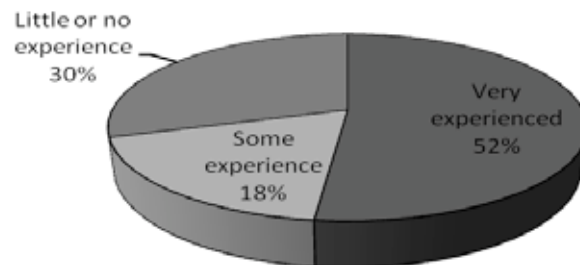
Individual experience working with Rainbow service users in primary care services



About half (52%) of clinicians/health professionals from DHB services felt they were very experienced working with Rainbow service users, 18% felt they had some experience and about a third (30%) of clinicians/health professionals felt they had little or no experience working with Rainbow service users.

Figure 32

Individual experience working with Rainbow service users in DHB services

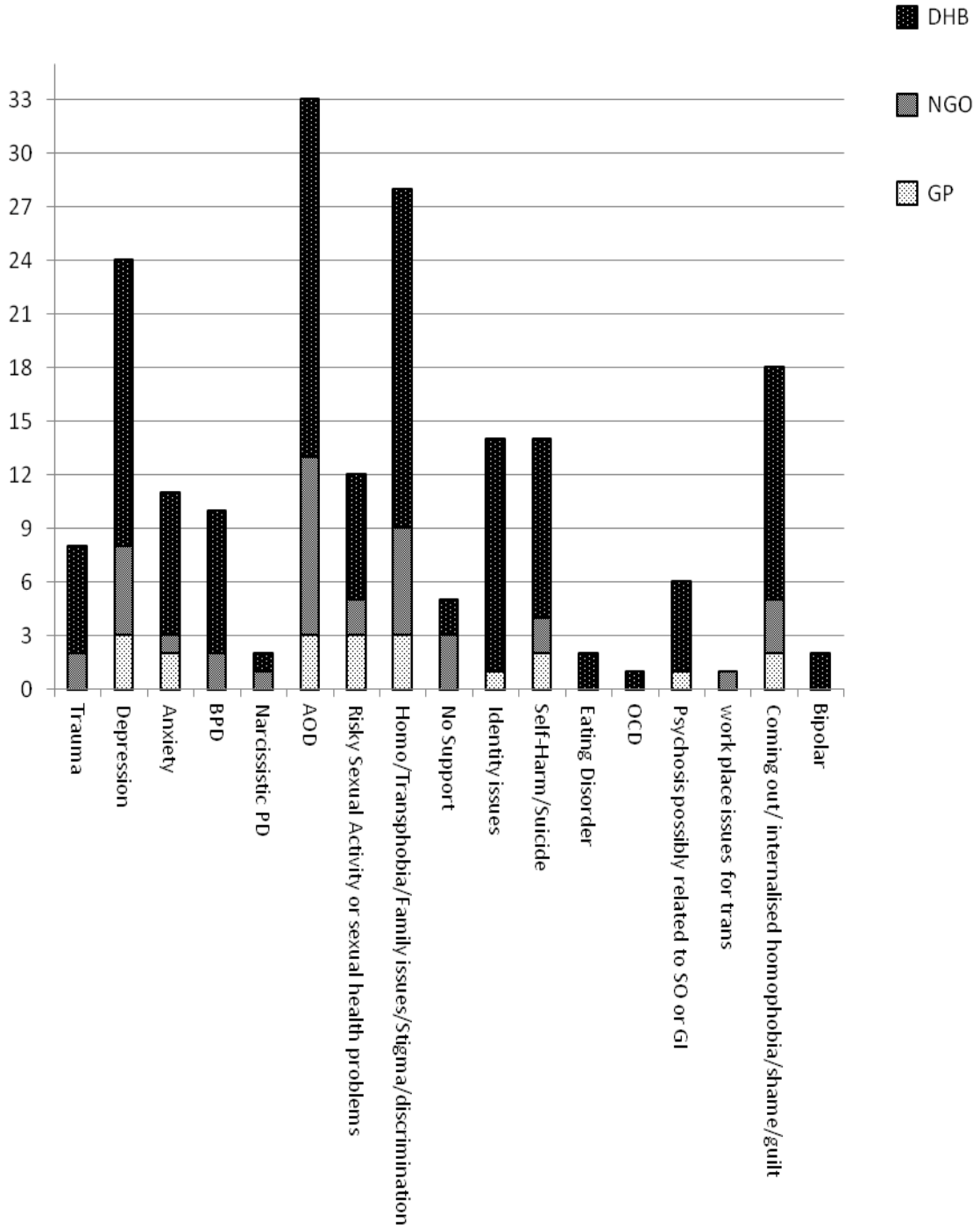


There were a number of differences in the responses from participants from the different service types when asked about their experience of common mental health and addiction related problems for the Rainbow community, with DHB participants listing more specific problems and/or issues than NGO or primary care participants. The most commonly identified problems or issues were:

- Addiction problems (33 participants)
- Homophobia, transphobia, family issues, stigma and/or discrimination (28 participants)
- Depression (24 participants)
- Coming out, internalised homophobia, shame and guilt (18 participants)
- Self harm/suicide (14 participants)
- Identity issues (14 participants)
- Risky sexual activity or sexual health problems (12 participants)
- Anxiety (11 participants)

Figure 33

Common mental health and addiction related problems for Rainbow communities reported by GP, NGO, and DHB participants



Access to effective and appropriate services

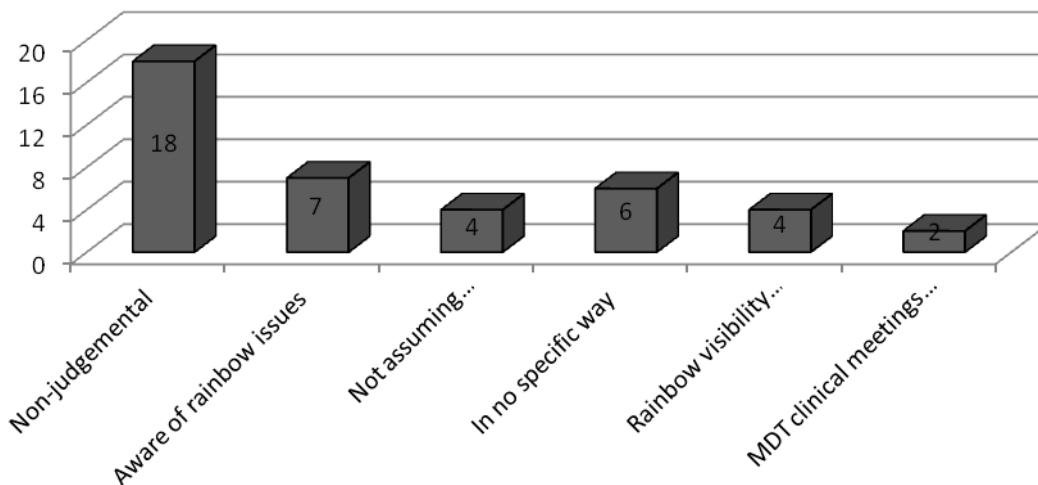
Participants were asked about how effective they felt their engagement with Rainbow consumers was. Of the 33 participants who answered, there were a variety of responses (as below), with the most common response (18 participants) being a generalised comment about having an open/non-discriminatory/non-judgmental/accepting/respectful approach.

- Non-judgmental/non-discriminatory/open/accepting/respectful (18)
- Aware of Rainbow issues, asking about S.O. or G.I., creating opportunities to talk (7)
- Not assuming heterosexuality (4)
- In no specific way, or in no way (6)
- Rainbow visibility, Rainbow posters and/or literature (4)
- MDT clinical meetings and/or supervision (2)

"[I am] very respectful, and everyone is treated equally... there is no favouritism" (NGO health professional)

Figure 34

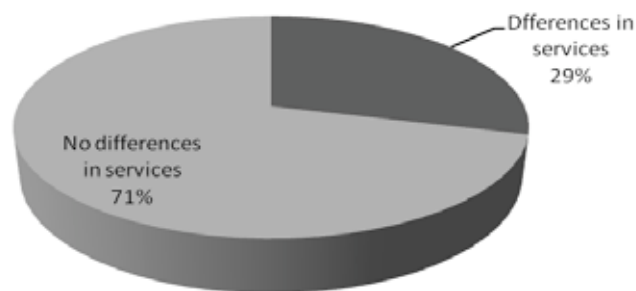
How participants described how their engagement with Rainbow service users is effective



71% of respondents (27 out of 38) felt there were very little or no differences in the services provided to Rainbow service users when compared to non-rainbow services users. 11 out of 38 felt there were some differences, with 5 participants commenting that Rainbow service users might be/would be 'matched' with Rainbow clinicians/health professionals.

Figure 35

Are there differences in services to Rainbow service users (compared with non-Rainbow)



Summary of comments made:

- More in-depth discussion may be provided as the issues are often more complex with Rainbow service users
- Rainbow service users may get a better service if matching (either S.O. or gender) occurs as the clinician/health professional may understand the issues better
- More 1:1 rather than just group is needed as the issues for Rainbow service users are often more complex
- Non-Rainbow clinicians/health professionals may be prejudiced
- Rainbow service user's needs may be less well met if the service user is not 'out' (i.e. not asked about S.O. or G.I.)
- Services would be poorer because of unskilled, untrained staff
- Some clinicians/health professionals are uncomfortable working with Rainbow consumers, or have a lack of awareness, and understanding; sometimes due to their own culture or religion
- Some clinicians/health professionals get anxious, especially working with trans

"There may be differences between clinicians, and it could be difficult if there are no LGBT staff, especially if prejudices exists (DHB clinician)"

When participants were asked how they supported their Rainbow service users, or how they met their needs, a range of responses were given by 43 individuals (see below). 23% responded by saying that they, or their team/organisation did not meet the needs of Rainbow service users.

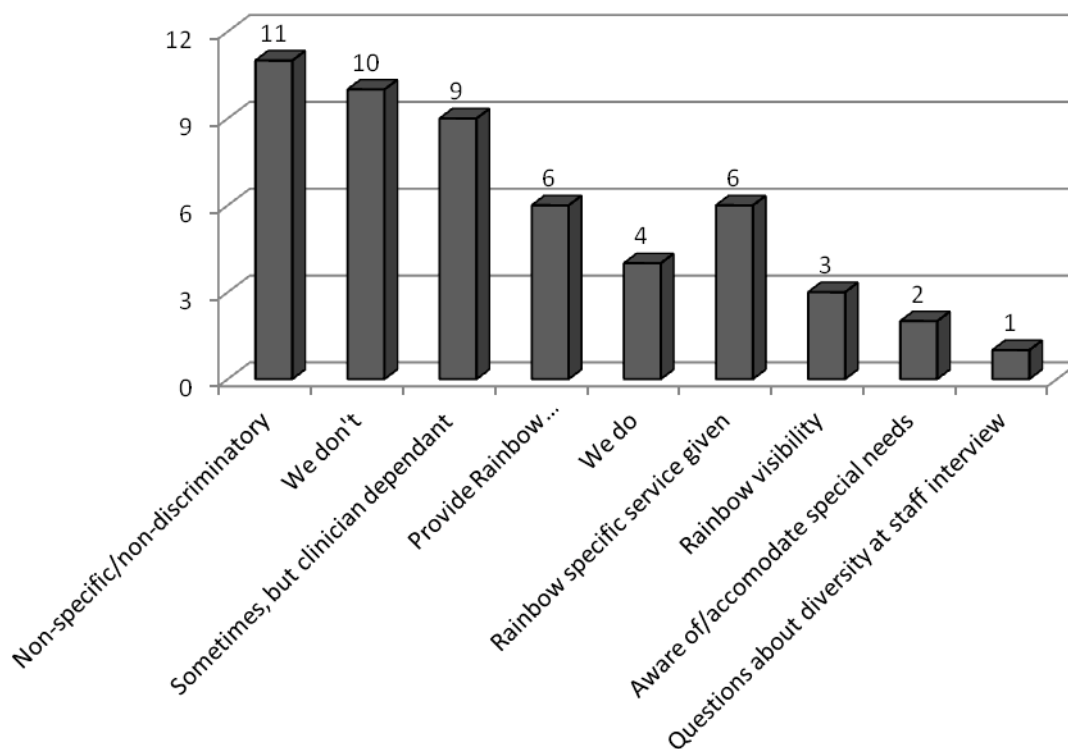
- A generalised comment made about the clinician/health professional or service being non-discriminatory, or meeting the needs of Rainbow consumers "like everyone else" (11)
- We don't (10)
- Sometimes we do, but it depends on the clinician (9)

- Providing Rainbow related literature, referrals and/or resources (6)
- We do (4)
- Rainbow specific services provided or assistance given accessing them e.g. transport to gay N.A. when in inpatient setting (6)
- Rainbow visibility e.g. posters on the wall, Rainbow staff visible (3)
- Aware of unique sensitivities or special needs and accommodate the same (2)
- Questions about diversity are asked at staff interviews (1)

"The staff that have an awareness of Rainbow issues would ask clients about their sexual orientation or gender identity as part of the assessment process...otherwise specific needs may go unmet" (DHB Rainbow clinician/health professional)

Figure 36

How clinicians/health professional support, or meet the needs of Rainbow service users



Participants were asked what they perceived the understanding of Rainbow issues was by other clinicians/health professionals in their team (Rainbow awareness; mental health and addictions issues).

51 comments were made by 44 participants, and were categorised as:

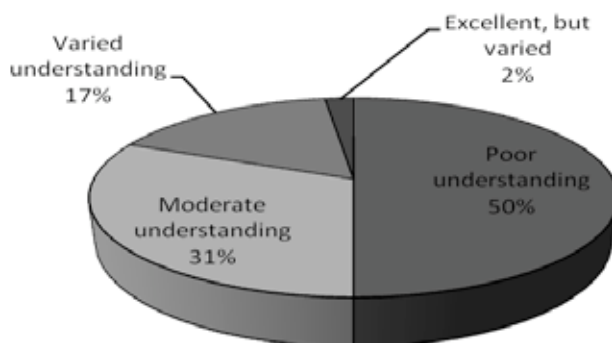
- A poor understanding (24)
- Moderate (15)
- Varied (8)
- Excellent but varied (1)

"Poor. Clinicians within the MDT are uncomfortable and unskilled working with LGBT individuals... Currently, there would be nobody on the team who would be culturally competent working with LGBT (DHB clinician/health professional)"

"I would say it [teams understanding] would be moderate, though would vary a lot between clinicians... issues around LGBT or sexuality are often hard to ask" (DHB manager)"

Figure 37

Individual service providers perception of their teams understanding of Rainbow specific mental health and addiction issues

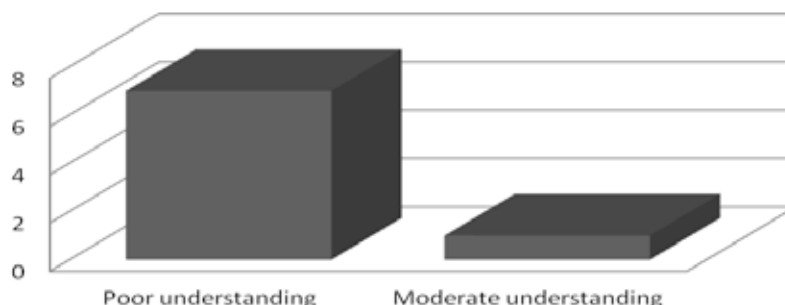


Of the 15 participants who indicated their team had a moderate understanding of Rainbow mental health and addiction issues, only 3 of these participants identified themselves earlier in the interview as being experienced in working with Rainbow consumers.

Of the NGO participants from mental health services, 7 out of 8 rated their teams understanding as poor; and 1 as moderate. None of the participants rated their teams understanding as excellent.

Figure 38

Individual NGO service providers from mental health services perception of their teams understanding of Rainbow specific mental health and addiction issues



"I'm not sure. We have some resources available at XXX and some LGBT staff. They [Rainbow service users] may have issues that are different from normal people" (NGO clinician/health professional)

(NB the use of the word "normal" in the above quote was used to describe heterosexual and/or non-trans people).

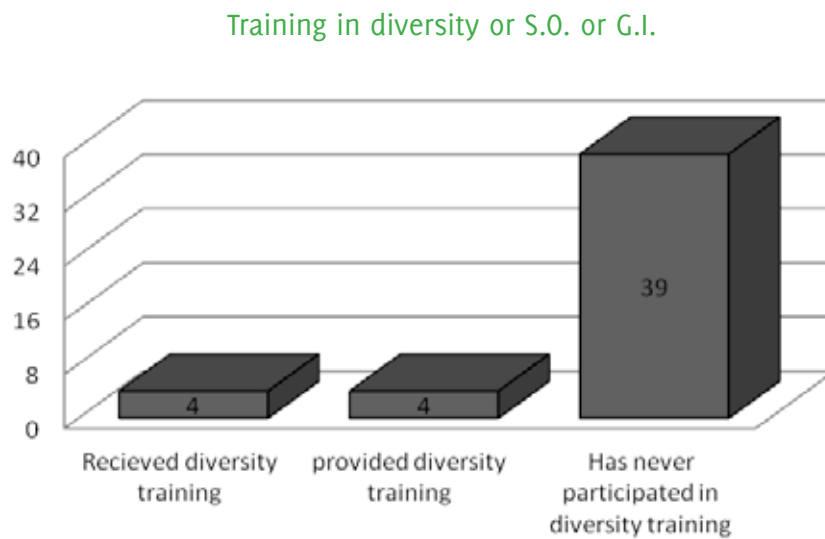
"Generally there is a very poor understanding of Rainbow issues. This is partly as 85% of support workers are not NZ born, so there can be considerable cultural differences. Also, many support workers are Christian and have a set view [negative] on homosexuality or gay lifestyle" (NGO manager)

In terms of formal training, 4 out of 47 participants had previously undertaken some sort of S.O. or G.I./diversity training, and a further 4 participants had provided some sort of diversity training. 39 participants (83%) had never participated in any diversity training.

Of the 4 participants who had previously provided training:

- 2 participants had delivered this as a brief (half a day or less) training as part of a wider DHB/NGO role
- One participant had delivered brief training, and one whole day training as part of their DHB clinical role
- One DHB participant provided 4 day training to volunteer telephone counsellors outside of their DHB role to a NGO Rainbow service.

Figure 39



46 out of 47 participants stated they would be prepared to undertake diversity training in the future. 1 participant stated neither yes nor no, as they did not consider it to be their training priority at that time. There were some additional specific comments made by participants:

- Short sessions as part of CME training would be good (GP continuous medical training)
- Training with a particular focus or interest on trans issues
- Some staff would be a higher priority for diversity training, such as CSW's; particularly those who have a strong cultural or religious belief
- Time constraints are difficult, and internet resources, such as e learning would be helpful
- Short sessions better

"Cultural and social sensitivity towards minority groups is essential in good practice. Some nurses appear to get anxious around trans care as they are worried about not getting "it right" or being "politically correct" and they don't check or don't ask (the individual). Usually when anxiety exists it indicates a lack of training, or training needed" (DHB clinician/health professional)

"LGBT cultural competency should be part of skills training" (NGO clinician/health professional)

Specific gaps and barriers

Most participants perceived barriers and/or gaps for Rainbow service users when accessing services. The majority of this group indicated that training of clinicians/health professionals is the greatest gap. A lack of specific services and systems or pathways for Rainbow service providers and/or service users was also a common gap that was identified. The greatest barrier to service users receiving effective services identified by participants was the fear of being judged or discriminated against by the clinician/health professional.

Gaps:

Main specific gaps identified by service providers by 41 participants were:

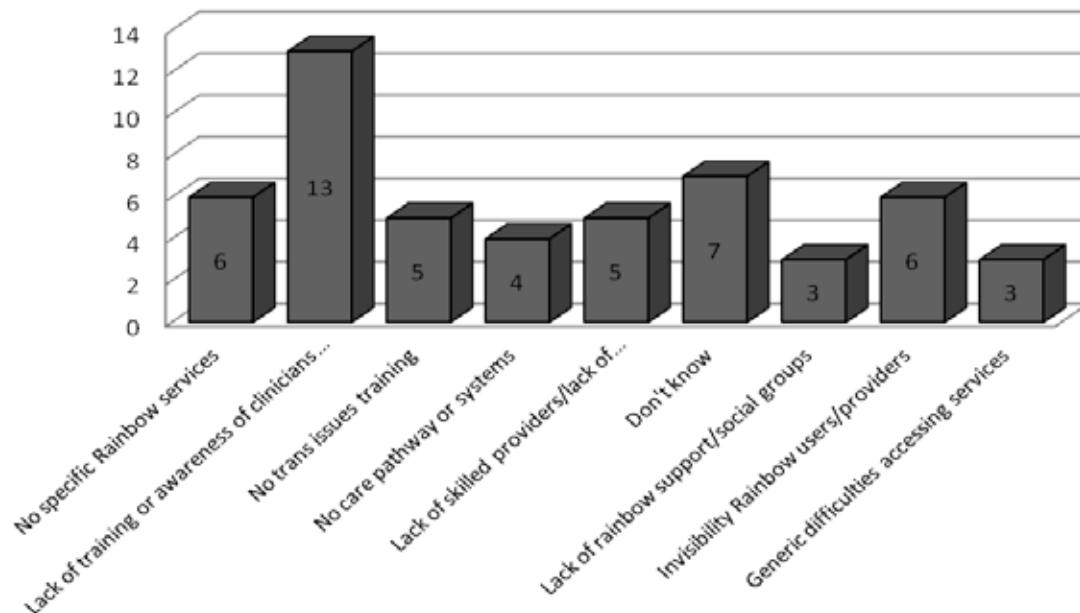
- A general lack of training in working with Rainbow service users, or lack of awareness or knowledge of specific Rainbow issues (13)
- No specific or targeted Rainbow clinical services and/or community Rainbow services to refer to (6)
- No training on trans specific issues or needs (5)
- No systems or care pathway for Rainbow service users (4)
- Lack of skilled service providers, or lack of engagement skills by service providers (5)
- Don't know (7)
- Lack of Rainbow support groups or social groups (3)
- Invisibility of Rainbow service providers and/or service users (6)
- Generic difficulties accessing services (3)
- Lack of acknowledgement of Rainbow identity and not asking about S.O. or G.I. (3)

Other comments included:

- short GP consult time;
- no clinical discussions of Rainbow issues;
- lack of awareness of Rainbow specific services that are available;
- lack of coordination between services;
- a need for de-homophobia training;
- fear of confidentiality being breached;
- lack of inclusion of whanau/family;
- a lack of invitation (to discuss S.O and G.I identity).

Figure 40

Gaps for Rainbow service users identified by clinicians/health professionals



"There are no systems, or sensitive assessments to identify trans...it's not on the radar and not discussed [at clinical staff meetings]" (GP/DHB clinician)

"All staff need training; specifically that challenges their own homophobia, attitudes and understanding on issues and experiences. Clinicians need to be comfortable about their own sexuality and have overcome their own prejudices and fears" (DHB clinician)

"There may be, but I don't know" (DHB professional in support role)

"None of our members have the special skills in working with Rainbow clients" (DHB clinician)

"LGBT is almost a taboo topic. We need a high profile poster campaign and encourage conversations about sexuality" (DHB clinicians/health professional)

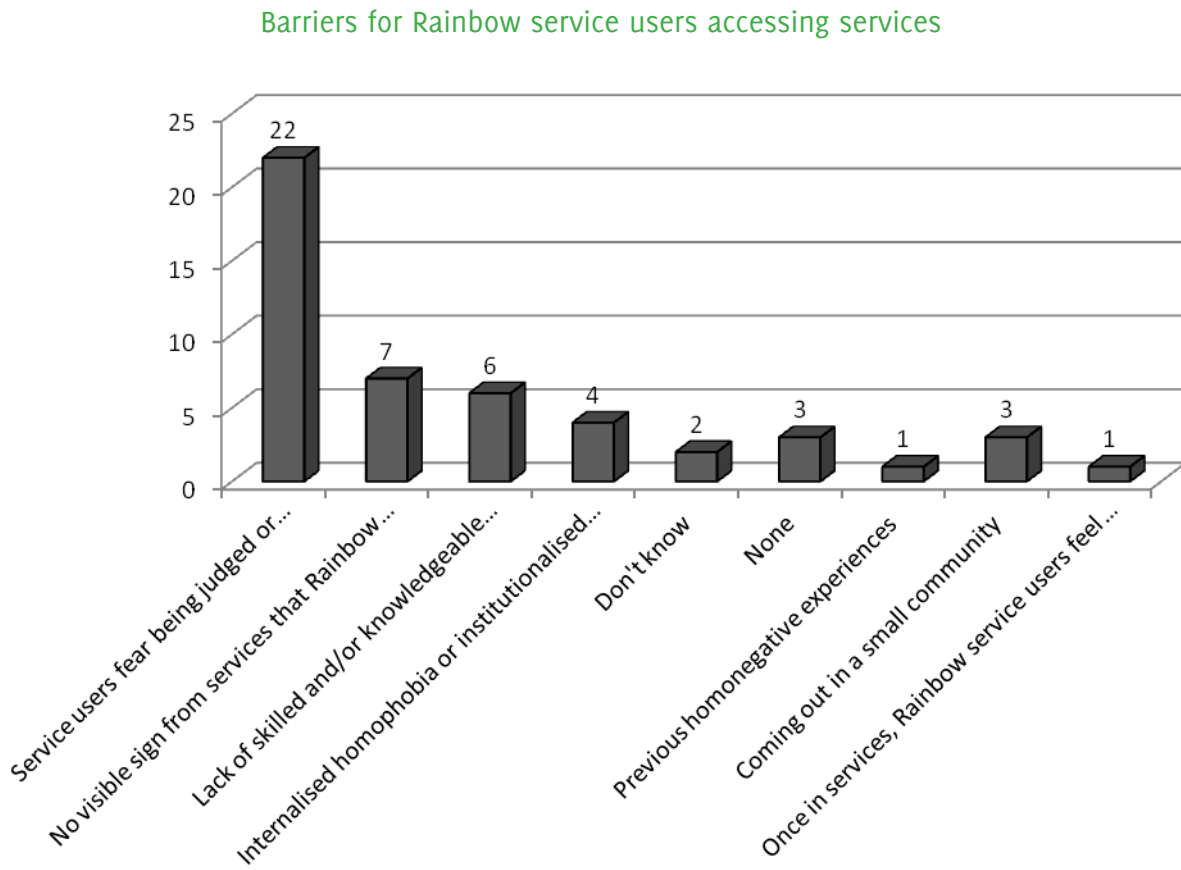
Barriers:

Specific barriers for accessing mental health or addiction services identified by service providers by 41 participants were:

- Service users fear being judged or discriminated against by the clinician/health professional (22)
- No visible sign from services that Rainbow service users are welcome (7)
- Lack of skilled and/or knowledgeable clinicians/health professionals (6)
- Internalised homophobia or institutionalised homophobia (4)
- Don't know (2)
- No barriers (3)
- Previous homonegative experiences (1)
- Coming out in a small community (3)
- Once in services, Rainbow service users feel comfortable (1)

At least 3 participants commented specifically about inpatient staff not understanding specific needs of Rainbow consumers, and in particular trans. An example was provided of a recent trans service user who experienced staff who were unsure how to provide basic care such as which gender wing they should be in and in provision of appropriate bathroom facilities.

Figure 41



"Yes, there is institutionalised homophobia and a lack of skills and knowledge by the clinician. LGBT people may fear this experience if they enter services and so may choose, and do choose not to [engage with, or enter services] because of it" (DHB clinician/health professional)

"Yes, [there are barriers] if the clinician is unable to address the core issues" (DHB clinician/health professional)

"Trans find it very difficult to come to the service. They have a fear of waiting rooms, accessing the toilets, and fear about how they will be received at the service. There needs to be more outreach clinicians so that we go to where they are already. There is a dire need for trans professionals!" (DHB clinician/health professional)

"Yes, a reluctance to engage for fear of discrimination because of their sexuality" (DHB clinician/health professional)

"Services need to make it inviting for LGBT" (DHB clinician/health professional)

"I think there is a fear of discrimination, or internalised homophobia... a fear of lack of confidentiality or family being contacted against their wishes" (DHB clinician/health professional)

"I think there are lots of barriers...there is stigma with mental illness, but a double stigma for LGBT" (DHB manager)

"Internalised homophobia, or fear around response [of the clinician]...we live in a homophobic society" (DHB clinician)

Culture

There were a number of themes relating to the culture of clinicians in mental health and addiction services that emerged from the interviews, with a number of service providers commenting on difficulties arising from the varying cultural and religious backgrounds of the people working in MHS.

Identifying as Takataapui or whakawahine was described by two Maori mental health service providers as "normal and integrated, and not a big issue", as well as shame and lack of awareness of Takataapui/Rainbow issues by staff being identified as another issue by another Maori service provider.

"That sexuality is not such a big issue; that being takataapui or LGBT is normal and integrated with the person" (DHB Maori mental health professional)

Issues identified by service providers for Pacific peoples related to:

- Shame and the inclusion/exclusion of extended family
- Fa'afafine have an accepted role in Pacific Island communities, but the wider Rainbow community did not necessarily, and many lesbian, gay, bisexual and some trans are invisible

"In terms of Pacific Island mental health issues, there are cultural issues relating to shame, that mean that LGBT people tend to hide their sexuality to the wider community. ... Being outwardly LGBT threatens the cohesion of P.I. society" (DHB/PHO Pacific Island clinician/health professional)

"There is respect for each individual and they have the choice to be who they are, but they are not seen as an individual by the Pacific Island community, as they are part of a wider family or community" (Pacific Island cultural support professional)

Shame and stigma was identified as an issue for Asian service users, with little visibility of Rainbow service users. Lack of specific skill and comfort when providing services to takataapui by team members, was also commented on by a clinician/health professional.

"Within Asian ethnicity, stigma in the cultural context and rejection by significant others associated with their sexual identity might present as a major barrier with seeking help; thus delayed treatment until [the] severity of mental health condition is built up to crisis intervention" (DHB Pacific Island clinician/health professional)

"...this is a sensitive subject to discuss. It is challenging to explore the sexuality of the service user. LGBT has not been openly accepted within the Asian community" (DHB Pacific Island cultural worker)

Many participants commented about the issue of religious beliefs or culture in terms of either the service provider and service user (or both), in that there may be personal issues/beliefs which affect the therapeutic relationship, or effective services. One participant described their own practice of exploring issues or possible "obstacles for a therapeutic alliance" that may interfere in the therapeutic relationship e.g. their own gender, belief system, political view or culture. The participant described seeing this as an important first step in establishing if cultural issues are a barrier for engagement

"Cultural and social sensitivity towards minority groups is essential in good practice" ... "[Explore] obstacles for a therapeutic alliance" (DHB clinician/health professional)

The importance of cultural competence working with Rainbow service users was raised by a few service providers and they suggested that training is needed to raise the awareness of different cultural perspectives.

"There are barriers from services; discrimination, uneducated staff, religious beliefs ...homophobia" (NGO manager)

"Some mental health workers struggle because of their own cultural belief systems and this may result in some clients disadvantaged" (DHB clinician/mental health professional)

"CSWs are often unaware of LGBT issues and have their own cultural differences that interfere with them being LGBT aware or LGBT culturally competent" (DHB clinicians/health professional)

"Half of the team would be aware [of Rainbow issues] the other half probably don't have a clue, nor really care. It would be outside their realm of experience...there is a high number of workers who are relatively new to NZ who are from a variety of ethnic and cultural backgrounds."

Primary care issues by PHO's

Summarised feedback on Rainbow specific care/services was received from 3 different PHO representatives. The current issues from these primary care providers when providing mental health or addiction services to the Rainbow communities were identified as:

- No specific pathways/best practice guidelines when working with Rainbow service users
- A lack of training for Primary Care providers on understanding the issues for the Rainbow community; and lack of awareness of specific Rainbow services
- Variable levels of understanding of the specific stresses and mental health challenges of Rainbow service users, and very limited knowledge and skills by primary care professionals, especially with trans men and women
- Visibility of (lack of) Rainbow service users in services; there are no systems for identifying them
- Possible prejudice towards Rainbow people in some individual primary care services due to low levels of awareness and/or religious or personal beliefs of service providers
- Lack of service providers to refer to who are known to be Rainbow themselves
- Lack of knowledge of community resources and supports for Rainbow people (including therapists experienced in working with Rainbow people). Limited funding
- Rainbow community service users who live in a high-needs community will be less likely to be referred to services (One practice stated their data shows practices in high-needs areas refer less to Primary Mental Health services)
- Short consultation time for assessment and intervention in primary care; restricted access to talking therapies, public mental health services etc.
- There are no specific mental health or AOD initiatives or services currently or historically, targeting the Rainbow communities

"Variable levels of understanding of the specific stresses and MH challenges of being LGBT. And probably variable levels of prejudice re: LGBT people in some primary care personnel..." (PHO representative)

The main barrier identified for Rainbow service users accessing primary care services is the fear of negative responses from the service provider. One representative commented that this could be related to the lack of visible, experienced staff within all PHO's.

The main areas of strength for primary care providers in regard to knowledge and skills when delivering mental health or AOD services to Rainbow consumers was identified as:

- Most primary care providers understand diversity
- Primary care providers are keen to do best for their patients
- One PHO has an established Primary Mental Health provider network
- One PHO funds City Mission to provide Primary Mental Health services, where there are high numbers of trans-gendered (MtF) patients
- One PHO representative commented that they are aware of a range of support organisations for the LGBT community, and therapists/ GP's/PN's who are seen by the LGBT community as "LGBT friendly"

Gaps, barriers, or obstacles Rainbow service users may face when accessing primary care were summarised as:

- Rainbow service users may be fragile and may feel that there is a risk in being 'out' as it may negatively affect the treatment relationship
- Lack of skilled and experienced staff in working with Rainbow communities, with service providers possibly not picking up on sensitive issues
- Self-stigma and a reluctance of Rainbow service users to disclose both sexual orientation and mental health issues
- Difficulties meeting moderate to severe needs which do not reach thresholds for access to DHB mental health services

Other comments or information provided:

"In this primary mental health programme we see a reasonable number of GLBT people, and I think [we] meet their needs pretty well, BUT particularly young GLBT people are recognised as having increased risks of mental health issues especially depression/anxiety/stress, and this added risk seems part of the issue of coming to terms with sexual orientation through late childhood/teens - so there does seem to be a need for strengthened specific MH promotion/prevention activities and programmes for this population" (PHO representative)

Other comments

Some participants contributed comments that did not relate to a particular question, but were relevant to the interview scope and not included elsewhere in the results. These summarised comments are below:

- Family inclusive practice (family of origin and family of choice) can be problematic, particularly if the service user is hidden, or in the closet
- Peer support (Rainbow peer support) along with Rainbow support groups would improve services/outcomes
- Rainbow champions/specialist should be in every service or connected to each service to have available as a resource/consult role
- Training in Rainbow awareness and other minority groups should be part of qualification level training, rather than the responsibility of individual service provider organisations
- Training of rest home staff is required as there are specific issues for older Rainbow service users not being addressed appropriately
- Access to trained and skilled therapists is very difficult in either the public or private sector

Summary of results from all key informant interviews with service providers

- About half of service providers felt that service users feared being judged or discriminated against, and this was a barrier to accessing effective services
- Many participants felt that Rainbow consumers feared the response of the clinician/health professional if they identified their S.O. or G.I. and that effective service provision to Rainbow communities is 'hit and miss' and dependent on individual clinicians skills/experience
- About half of participants felt their team had a poor understanding of Rainbow mental health and addiction issues, with the most of the remaining group indicating a moderate or variable understanding
- A number of gaps in providing effective services were identified, with the main themes being a general lack of awareness of Rainbow issues and a lack of training (Rainbow/diversity training)
- Nearly a quarter of service providers did not think that services met the specific needs of Rainbow service users
- A high number of service providers felt they met the needs of, or supported their Rainbow service users by being non-judgmental, non-discriminatory, open and accepting in their approach
- The large majority of participants perceived little or no differences to services to Rainbow services users. Positive differences identified by a few participants was more time spent on complex issues, and the negative differences being the lack of effective engagement meant their needs were less well met

- Half of the participants felt experienced working with Rainbow service users; with the large majority of these being service providers who identify as Rainbow themselves
- No-one from NGO mental health services felt very experienced working with Rainbow consumers, and rated their teams understanding/awareness of Rainbow issues as poor (7) or moderate (1); and issues around workforce skills were identified. Similarly other service types identified a training need for CSW's on Rainbow awareness
- The most common mental health and addictions issues/problems identified were addiction problems; homophobia/transphobia, family issues, discrimination; depression; problems with 'coming out'; self harm; identity issues; risky sexual activity or sexual health problems; and anxiety
- There are significant cultural issues for service providers and service users around their own cultural practices and religious beliefs
- About a third of service providers indicated that 'informal matching' of Rainbow service providers with Rainbow service users occurred/could occur in their service as required
- A small number of Rainbow specific roles exist, but these are mainly within addiction services
- Many participants indicated they would like trans awareness training, as they had limited understanding of trans and trans issues
- Most participants (83%) have never undertaken any diversity training; with all but one participant indicating they would be willing to take part in this training in the future.
- Very little training is available, and is generally provided by clinicians/health professionals in a short session (half day)

Key themes and findings

1. Visibility:

- i. Discussions about S.O. or G.I. are not being initiated or facilitated by most clinicians/ health professionals with all service users (Rainbow and non-Rainbow), and there is a lack of understanding of why this is important
- ii. Most Rainbow service users clearly indicated they would like to be asked about their S.O. or G.I. directly at the initial assessment. Not being asked directly was viewed as a barrier to effective services. This was evident in both the anonymous survey and service user key informant interviews
- iii. Service users identify their S.O. and/or G.I. in a multitude of different ways
- iv. There is a lack of visibility of Rainbow service users and Rainbow service providers with very few targeted services and/or mandated clinical or support roles working with Rainbow service users. This acts as a barrier to effective services
- v. There is a lack of visual invitation to Rainbow service users, both overt and covert, with very few visual cues that indicate Rainbow service users are welcome
- vi. Very few support groups or resources/peer support for Rainbow service users exist
- vii. Rainbow service users whanau/family are often not included adequately in care, and/or not equally recognised

2. Service users fear the response of the clinician/health professional or discrimination:

- i. Service users experience heteronormativity/heterosexism/cissexism within services. Assumptions about S.O. or G.I. are often expected and/or experienced, with many service users concealing their S.O. or G.I. because of this.
- ii. Many service users have had previous negative experiences when accessing mental health and addiction services, and service users fear a negative reaction, including discrimination and prejudice if they identify as from the Rainbow community (reported by both S.U and S.P).
- iii. Some service users experience internalised homo/bi/transphobia, such as shame or embarrassment, and this can contribute to their fear of talking with their clinician/health professional, as reported by both service users and providers

- iv. Discussion of sexuality or gender identity was reported as usually positive when the clinician is skilled, sensitive and aware of Rainbow specific issues
 - v. Many service users would like to either see a Rainbow clinician/health professional, or have the option of seeing a Rainbow clinician/health professional. The rationale for this being that the service provider is more likely to feel comfortable about their S.O. or G.I. and/or have a greater awareness and understanding of Rainbow issues, or less likely to have a negative experience if they see a Rainbow clinician/health professional
- 3. The experiences of service users varies considerably and is often dependent on individual clinicians:**
- i. Only a very small percentage of clinicians/health professionals have received diversity training and there is a significant lack of skill and awareness of many clinicians/health professionals across a broad range of services. Nearly half of service provider participants felt they met the needs of Rainbow service users by being non-discriminatory, non-judgmental and providing the same services as non-Rainbow service users
 - ii. Service users have often had both positive and negative experiences in relation to their S.O. or G.I. when accessing mental health and addiction services. These experiences tend to depend largely on the individual clinicians/health professionals skills or approach and are described by service users and service providers as ad hoc
 - iii. Most of the clinicians/health professionals who consider themselves as experienced as working with Rainbow service users, identify as Rainbow themselves
 - iv. There is a lack of training available. All but one clinician/health professional indicated they would either like to, or would be prepared to undertake training in the issues of sexual orientation and gender identity
- 4. Lack of formal pathways or policies to guide practice, and a lack of Rainbow specific resources:**
- i. None of the participants from the service provider groups worked within services which had a clear written pathway or guidelines in working effectively with Rainbow service users
 - ii. Very few specific Rainbow support groups, peer support and/or resources to both service users and service providers are available across all services
- 5. Trans people's mental health and addiction needs are particularly poorly catered for and/or understood.**
- i. Trans people face significant barriers, including unclear and inconsistent treatment pathways to effective services
 - ii. Many service providers are unaware, or unsure of how to provide basic care, such as the use of the correct pronoun, access to the correct gender group or facilities such as accommodation or bathrooms.
 - iii. Training in trans issues was requested by many service providers, as it was an area they felt least skilled in, and/or had limited knowledge or experience

Discussion

In spite of New Zealand Homosexual Law Reform in 1986 which decriminalised homosexuality, and amendments to the Human Rights Act in 1993 that made it unlawful to discriminate on the grounds of sexual orientation*, 18 years on there are still significant inequities, including discrimination for Rainbow people, as evidenced in this research. Much of this discrimination in mental health and addiction services is occurring through heteronormativity and the pathologisation of diverse gender identities. Clinicians and health professionals are generally failing to consider the importance of sexual orientation and gender identity issues for mental health. Further they are not supported in their professional training, or by the mental health services they work for, to address this important service issue.

(*Gender identity was not explicitly listed as a ground of unlawful discrimination in the Human Rights Act. The HRC and 2006 Crown Law office recommend that the Act be changed to include discrimination based on gender identity.)

Studies show that Rainbow populations, in addition to having the same basic health needs as the general population, experience health disparities related to S.O. and/or G.I. (Fergusson et.al. 1999, Hass 2010, Hughes et. al. 2010, Rossen, et.al. 2009, Mayock 2009) Many however avoid or delay care, or receive inappropriate, inferior or ineffective care because of real (or perceived) homo/trans/biphobia and discrimination by service providers or organisations.

Unless all service users are asked about their sexual orientation and/or gender identity by trained and skilled staff, there will continue to be a significant degree of invisibility of our Rainbow service users. This lack of identification and acknowledgement compromises treatment for Rainbow service users as it prevents some core mental health and addiction issues being identified and addressed. Having said this, it is vital that service providers understand that being stealth is very important for some trans people. This requires asking trans people how they identify (male, female, trans, and/or using a culturally specific term) and clarifying privacy concerns including any limitations on who can access those details.

Whilst there appears to be a slowly increasing visibility of Rainbow people in NZ, there is a continuation of poorer health outcomes compared with the general population, including significantly higher rates of self harm and suicide. Effective and appropriate mental health and addiction services are the right of all New Zealanders, including those from minority groups.

During the course of this research, a readiness and willingness to improve services to the Rainbow communities has been experienced by every person encountered. Many of these clinicians/health professionals simply did not fully understand the issues specifically related to Rainbow communities, such as stigma, discrimination and homonegative and/or transnegative experiences and therefore, do not understand that there are specific cultural accommodations that need to be made to ensure services are effective and respectful.

It is necessary now, to implement effective organisational policy and procedures for working with Rainbow service users, which include, (but are not limited to) mandatory core cultural competency training in working with Rainbow service users in mental health and addiction services for all staff, to affect the level of change required. This will help ensure that the specific mental health and addiction needs of all Rainbow service users are addressed and/or met, in the dignified and respectful way they deserve.

Conclusion

- There are significant barriers to accessing effective services; including a lack of clinician/health professional skill in identifying and providing care to Rainbow service users and fear of the clinician/health professional's response to service users with a Rainbow identity
- There are significant gaps in mental health and addiction services to Rainbow communities; resulting in unmet needs, including:
 - i. Rainbow specific services
 - ii. Peer support
 - iii. Training/cultural core competency training working with Rainbow communities
- Specific issues for trans and trans needs are particularly poorly met with no clear pathways and significant barriers to accessing care, including very little understanding or awareness of trans issues by service providers
- An increased visibility of Rainbow service users and providers would significantly improve access to services, and reduce stigma and/or discrimination
- Organisational policies, procedures and pathways are essential to ensure effective and appropriate services are implemented across all services

Recommendations

1. **Improve Rainbow people's access to mental health and addiction services, through the implementation of best practice guidelines for working with Rainbow consumers for all services providing mental health and addiction services. Including:**
 - Creating a welcoming environment
 - Best practice guidelines for providers on how to initiate and participate in discussions about S.O and G.I. with all service users. This needs to include how to assess homonegative trauma
 - Staff sensitivity and cultural competency training to support the best practice guidelines
 - Policies and procedures that underpin LGBT inclusive practice, including accurate recording of S.O. and G.I.
2. **Ongoing resourcing for external monitoring and auditing to ensure the implementation of best practice guidelines and provide avenues of support to key people/Rainbow champions within services.**
3. **All staff (including front line staff and administrators) working in mental health or addiction services complete effective sexual orientation and gender identity training provided by a quality recognised training provider. Specific trans issues/education are well addressed within this training.**
4. **Establishment and support of Rainbow specific resources including:**
 - Rainbow support groups
 - Rainbow Peer support services or advocacy services
 - Option of access to a skilled Rainbow clinician/health professional as part of care/treatment as individuals needs indicate it
 - An online/web/accessible directory of Rainbow specific mental health/addictions services, including support services

5. Inclusion of Rainbow cultural competency in Real Skills (contained within Challenging Stigma and Working with Communities modules).
6. Specific organisational policies and procedures are implemented to ensure appropriate effective (and non-discriminatory) services are delivered to and received by all Rainbow service users, as part of best practice guidelines.
7. Compulsory participation in training for all mainstream services, that includes follow-up evaluation to compare pre and post training audit measures. Training needs to be regular and ongoing to ensure continual improvement in engagement and treatment of all clients covered by DHB contracts, not just the straight ones. A recommendation of this report is to pilot a training programme across 2-3 mainstream services in the first instance with a view to implementing this across all services within a measurable timeframe.

References

- Associate Minister of Health. (2006) The New Zealand Suicide Prevention Strategy 2006–2016. Wellington: Ministry of Health.
- Avery, A., M., Hellman, R., E., & Sudderth, L., K. (2001) Satisfaction with mental health services among sexual minorities with major mental illness. *American Journal of Public Health*, 91(6), 990-991.
- Bailey, J. M. (1999). Homosexuality and mental illness. *Archives of General Psychiatry*, 56 (October), 883-884.
- Barbara, Angela M., Farzana Doctor, Gloria Chaim. (2007) Asking the right questions 2 Talking with clients about sexual orientation and gender identity in mental health, counselling and addiction settings. Centre for Addiction and Mental Health (CAMH) publication Canada.
- Beatty, R., L., Lewis, K., L. (2003) Substance Use Disorder and LGBT Communities Resource Links Vol. 2 (3)
- Centre for Substance Abuse Treatment. (2001) A provider's introduction to substance abuse treatment for lesbian, gay, bisexual and transgender individuals. Rockville, MD: United States Department of Health and Human Services
- Clark, M.,E., Landers, S, Linde, R, and Sperber, J. (2001) 'GLBT health access project: a state-funded effort to improve access to care. *American Journal of Public Health*, 91 (6): 895-896
- Clements-Nolle K, Marx R, Guzman R, & Katz M. (2001) HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health*, 91(6), 915-921
- Cornelson, B. M. (1998) Addressing the sexual health needs of gay and bisexual men in health care settings *The Canadian Journal of Human Sexuality*, Vol. 7(3)
- Crisp, C. (2006) The gay affirmative practice scale (GAP): A new measure for assessing cultural competence with gay and lesbian clients. *Social Work*, 51 (2), 115-126.

- Daley, A. (2010). Being recognized, accepted, and affirmed: Self-disclosure of lesbian/queer sexuality within psychiatric and mental health service settings. *Social Work in Mental Health*, 8(4), 336-355. doi:
- Fell, G. R. (2008) Challenging heteronormativity in psychological practice with lesbian, gay and bisexual clients *Gay and Lesbian Issues and Psychology Review*, Vol. 4, No. 2
- Fergusson, D. M., Horwood, L. J., & Beautrais, A. L. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry*, 56(October), 876-880.
- Fergusson, D. M., Horwood, L. J., Ridder, E. M., & Beautrais, A. L. (2005). Sexual orientation and mental health in a birth cohort of young adults. *Psychological Medicine*, 35, 971-981.
- Finnegan, D., G., & McNally, E., B. (2002). *Counselling lesbian, gay, bisexual, and transgender substance abusers: dual identities*. New York: Haworth Press
- Gay & Lesbian Medical Association (GLMA) (2006) *Guidelines for care of Lesbian, Gay, Bisexual, and Transgender Patients* San Francisco, California, USA.
- Gilman, S. E., Cochran, S., D., Mays, V. M., Hughes, M., Ostrow, D., & Kessler, R. C. (2001). Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the national comorbidity survey. *American Journal of Public Health*, 91(6), 933-939.
- GLBTI Retirement Association Inc. (GRAI) (2010) *Best Practice guidelines. Accommodating older gay, lesbian, bisexual, trans and intersex (GLBTI) people* Australia
- Golding, J. (1997). *Without prejudice: Mind lesbian, gay and bisexual mental health awareness research*. London: Mind Publications
- Haas, A. P., PhD, et. al. (2010): *Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations*, *Journal of Homosexuality*, 58:1, 10-51
- Harry Benjamin International Gender Dysphoria Association (2001) *The Standards of Care for Gender Identity Disorders, Sixth Version*. Dusseldorf: Symposion Publishing.
- Herek, G. M., Gillis, J., & Cogan, J. C. (1999). Psychological sequelae of hate-crime victimization among lesbian, gay, and bisexual adults. *Journal of Consulting & Clinical Psychology*, 67(6), 945-951.
- Hughes, T., Eliason, M.,(2002) *Substance Use and Abuse in Lesbian, Gay, Bisexual and Transgender Populations*. *The Journal of Primary Prevention*, 22(3), 263-298
- Hughes, T., Szalacha, L. A., & McNair, R. (2010). Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Social Science & Medicine*, 71(4), 824 – 831

Human Rights Commission. (2008). To Be Who I Am/Kia noho au ki toku ano ao, the final report of the Transgender Inquiry. Auckland: Human Rights Commission

Human Rights Commission (2010) Human Rights in New Zealand Nga Tika Tangata O Aotearoa

Human Rights Commission (2011) Trans People: Facts and information

King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, 8, 70. doi:

Liszez, A. M., Yarhouse, M. A. (2005) A Survey of Views of How to Assist With Coming Out as Gay, Changing Same-sex Behavior or Orientation, and Navigating Sexual Identity Confusion *Ethics & Behavior* 15(2), 159-170

Luckstead, A. (2004) Raising Issues: Lesbian, Gay, Bisexual & Transgender people receiving services in the public mental health system Centre for Mental Health Services Research, Department of Psychiatry, University of Maryland, Baltimore, USA

McFarlane, L. (1998) *Diagnosis: Homophobic: The experiences of lesbians, gay men and bisexuals in mental health services* London: PACE: The Project for Advice, Counselling and Education.

Martell, C.R., Botzer M., Williams, M., Yoshimoto, D. (2003) *A Literature Review & Resource Guide for Evidence Based Best and Promising Mental Health Practices: Gay, Lesbian, Transgender and Bisexual Individuals* The Washington Institute for Mental Illness Research and Training, Washington State University Spokane (205-224).

Mayock, P., Bryan, A., Carr, N., Kitching, K., (2009) *Supporting LGBT Lives: A study of the mental health and well-being of lesbian, gay, bisexual and transgendered people* Gay and Lesbian Equality Network (GLEN) and BeLonG To Youth Service, Ireland

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674-697.

Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing, (2009) *Well Proud A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services* Department of Health Victorian Government, Department of Health, Melbourne, Victoria

NHS Inclusion Project (2005) *Fair For All – The Wider Challenge Good Practice in the NHS Working for Lesbian, Gay, Bisexual and Transgender Health*, NHS Education Scotland

Otis, M. D., & Skinner, W. F. (1996). The prevalence of victimization and its effect on mental well-being among lesbian and gay people. *Journal of Homosexuality*, 30(3), 93-121.

- Pega, F., & Coupe, N. (2007). GLB People's Substance Use: Findings from the New Zealand Health Behaviours Surveys: 2003 Drug Use and 2004 Alcohol Use. New Zealand Public Health Association Conference. Auckland, New Zealand, July 4-6.
- Pega, F., & MacEwan, I. (2010) Takataapui, Lesbian, Gay and Bisexual Scoping Exercise. Report to the Alcohol Advisory Council of New Zealand.
- Pega, F., MacEwan, I. (2010) 'Making Visible' Improving services for sexual minority people in alcohol and other drug addiction prevention and treatment. Matua Raki – National Addiction Workforce Development Centre
- Reback, C. J. & Lombardi, E. L. (1999). HIV risk behaviors of male-to-female transgender participants in a community-based harm reduction program. *International Journal of Transgenderism*
- Rivers, I. (2001). The bullying of sexual minorities at school: Its nature and long-term correlates. *Educational & Child Psychology*, 18(1), 32-46.
- Robertson, A. (1998). The mental health experiences of gay men: A research study exploring gay men's health needs. *Journal of Psychiatric & Mental Health Nursing*, 5(1), 33-40.
- Rossen, F., Lucassen, M., Denny, S., & Robinson, E. (2009). Youth '07 The health and wellbeing of secondary school students in New Zealand: Results for young people attracted to the same or both sexes. Auckland: The University of Auckland 2010 Aug;71(4):824-31. Epub 2010 May 25.
- Sandfort, T. G. M., de Graaf, R., Bijl, R. V., & Schnabel, P. (2001). Same-sex sexual behaviour and psychiatric disorders: Findings from the Netherlands mental health survey and incidence study (NEMESIS). *Archives of General Psychiatry*, 58(Jan), 85-91.
- Semp, D. (2006). A public silence : discursive practices surrounding homosexuality in public mental health services in Aotearoa/New Zealand. PhD-Psychology, University of Auckland.
- Semp, D (2011). Questioning heteronormativity: using queer theory to inform research and practice within public mental health services *Psychology & Sexuality* Vol. 2, No. 1, 2011, 69-86
- Skegg, K., Nada-Raja, S., Dickson, N., Paul, C., & Williams, S. (2003). Sexual orientation and self-harm in men and women. *American Journal of Psychiatry*, 160(3), 541-546.
- The World Professional Association for Transgender Health (WPATH) (2011) Standards of Care for the Health of Transsexual and Transgender, and Gender Non-Conforming People, 7th Version
- Warner, J., McKeown, E., Griffin, M., Johnson, K., Ramsay, A., Cort, C., & King, M. (2004). Rates and predictors of mental illness in gay men, lesbians and bisexual men and women: Results from a survey based in England and Wales. *British Journal of Psychiatry*, 185(6), 479-485.
- Welch, S, Collings, S. C., & Howden-Chapman, P. (2000) Lesbians in New Zealand: Their mental health and satisfaction with mental health services. *Australian & New Zealand Journal of Psychiatry*, 34(2), 256-263

Appendices

Appendix 1

Barbara, Angela M., Farzana Doctor, Gloria Chaim. (2007) Asking the right questions 2 Talking with clients about sexual orientation and gender identity in mental health, counselling and addiction settings. Centre for Addiction and Mental Health (CAMH) publication Canada.

Summary

This manual is a revised edition of ARQ (Asking the Right Question) published in 2004 which came from a research project of the CAMH Rainbow Services. The expansion of this project included mental health issues and is known as ARQ2. The general finding of these two phases is that 'Substance use and mental health concerns may be related to sexual orientation and/or gender identity issues, particularly those issues in relation to societal oppression – to provide effective treatment, therapists and counsellors must know about these issues.'

The manual is designed to give therapists/counsellors the tools to create a LGBT friendly environment, in which LGBT people are comfortable identifying themselves. It is based on the ARQ2 guide, which has been developed to be used when completing a standard substance use, mental health or other service assessment. Background material is provided to help clinicians use the guide, and it contains a checklist on providing culturally competent treatment to LGBT people.

The manual is very practical and applicable. It relates to both substance use and mental health issues. The ARQ2 is very comprehensive, and although it may seem daunting for NZ counsellors, it would be worth investigating it further. It has been designed to educate clinicians while explaining the importance of each question and so it would relate well to a training package. The questions listed under the counsellor competences cover many issues that counsellors have.

The updated version is only 3 years old, it is practical and although it was written in Canada it has relevance to New Zealand.

Relevance to project – very relevant

Centre for Substance Abuse Treatment (2001) A provider's introduction to substance abuse treatment for lesbian, gay, bisexual and transgender individuals. Rockville, MD: United States Department of Health and Human Services

Summary

This comprehensive document was developed by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) Centre for Substance Abuse Treatment. The information is for both administrators and clinicians working in substance abuse treatment.

The document outlines appropriate diagnosis and treatment approaches for the development or enhancement of effective LGBT sensitive programmes. It is both a reference tool and a guide – with suggested interventions, treatment guidelines, case studies and organisational policies and procedures.

The Executive Summary gives an overview of what is covered in the document. This includes: prevalence rates of substance use and abuse in LGBT individuals, an introduction to terminology, homophobia and heterosexism – and how they contribute to substance abuse, cultural and legal issues, accessibility, treatment modalities, the coming out process, families and families of choice, clinical issues, related health issues, interpersonal violence, counsellor competence, administrative issues, training and education, and alliances and networks.

Section I – is an overview of the specific issues relating to LGBT communities.

Section II – is the clinician's guide, and includes chapters on clinical issues with lesbians, gay males, bisexuals, transgender clients and youth. It gives an introduction to strategies and methods for improving services to LGBT individuals and steps for starting LGBT sensitive programmes.

Section III – is the programme administrator's guide, and gives an overview of the issues that need to be addressed when developing a LGBT programme, or expanding a current service. It includes organisations missions, policies and procedures.

Although 'A Providers Introduction' is specifically designed for substance abuse treatment, the issues it covers and the policies and procedures it recommends apply equally to mental health services. There is of course specific information relating to mental health treatment that is missing. The quality of information is impressive, and the recommendations it advocates are thorough.

It is however an American publication and so does not include the New Zealand/Aotearoa context (e.g. it does not include Maori and Pacific perspectives) and it is 10 years old.

Relevance to project – relevant

Clark, ME, Landers, S, Linde, R, and Sperber, J (2001) 'GLBT health access project: a state-funded effort to improve access to care' *American Journal of Public Health*, 91 (6): 895-896

Summary

The Gay, Lesbian, Bisexual, and Transgender (GLBT) Health Access Project is a community-based effort first funded by the Massachusetts Department of Public Health (MDPH) in 1997. The project was designed to eliminate barriers to health care for the GLBT community, foster the development of culturally appropriate health promotion policies and health care services for GLBT people and their families. A health care curriculum was developed (the Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Client) and technical assistance was offered to health care providers implementing the standards which covered: personnel, clients' rights, intake and assessment, service delivery and planning confidentiality, community outreach and health promotion. Further information on the project is readily available on the website:

Although the project is not specifically focussed on mental health and AOD, the standards and indicators in the Community Standards of Practice are comprehensive and relevant, and would make a good start for an audit document.

Relevance to project – relevant

Crisp, C. (2006) The gay affirmative practice scale (GAP): A new measure for assessing cultural competence with gay and lesbian clients. *Social Work*, 51 (2), 115-126.

Summary

The Gay Affirmative Practice (GAP) scale is a 30 item scale designed to assess social workers beliefs and behaviors in practice with their gay and lesbian clients. It is designed for clinicians who want to improve their practice, by evaluating their attitudes and practice.

The GAP scale outlines a very useful range of questions covering attitudes and practice that can be included in best practice guidelines.

Relevance to project – limited

Finnegan, D., G., & McNally, E., B., (2002). *Counselling lesbian, gay, bisexual, and transgender substance abusers: dual identities*. New York: Haworth Press

Summary

The 2002 edition of 'Counselling lesbian, gay, bisexual and transgender substance abusers: dual identities', is a revised version of 'Dual Identities: Counselling Chemically Dependent Gay Men and Lesbians' published in 1987, by the same authors - Dana Finnegan PhD, and Emily McNally PhD.

The book is divided into three main parts:

1. The first 5 chapters give a basic understanding of the issues and problems specific to lesbian, gay, bisexual and transgendered people. They also examine how these issues relate to levels of substance use and abuse, and the treatment they receive. The chapters are: introductory material, background information, counsellor competence, societal prejudice and oppression and internalised homo/bi/transphobia.
2. Chapters 5 to 9 present information on direct treatment issues. These include: setting, policy and procedures, creating a safe treatment environment, gathering information, and some 'how to's' when asking about sexual orientation, gender identity, sexual behaviour, sexual abuse, learning the truth and the importance of asking. The following chapters touch on special issues in treatment and developing a positive lesbian, gay or bisexual identity.
3. The Appendix has a glossary of LGBT terms, an organisational audit called 'Evaluating Organisation Attitudes and Practices', LGBT resources and suggested readings.

Although this book is written specially for LGBT substance abusers the background information about the issues for LGBT individuals is relevant for mental health as well as addictions, as are the best practice guidelines.

This is an easy and practical book to read, and gives in-depth understanding to many issues facing counsellors who want to work in a culturally competent way with their LGBT clients. The organisation audit in the appendix could provide a good start to inform the projects audit, it is however very specific to systems found in the USA.

Relevance to Project – relevant (AOD), primarily on sexual orientation issues

Gay & Lesbian Medical Association (GLMA) (2006) Guidelines for care of Lesbian, Gay, Bisexual, and Transgender Patients San Francisco, California, USA.

Summary

These guidelines have been created to relate to medical practices in America (called primary care in NZ). Although it is not specifically focused on mental health and addictions, it does include many practical and applicable suggestions.

The first chapter focuses on creating a welcoming clinical environment for LGBT patients, and includes, creating a welcoming environment, guidelines for discussions, confidentiality, specific LGBT issues, language, staff sensitivity training and recommended questions for LGBT-sensitive intake forms.

The second two chapters focus on the specifics of caring for lesbian and bisexual women, gay and bisexual men. These chapters are mainly about important medical interventions specific to these people, and so have limited relevance to the project.

As noted above the first chapter provides practical and applicable ideas for best practice in all health settings – which include mental health and addictions.

Relevance to project - relevant, primarily on sexual orientation issues

Harry Benjamin International Gender Dysphoria Association (2001) The Standards of Care for Gender Identity Disorders, Sixth Version. Dusseldorf: Symposion Publishing.

Summary

When assessing someone who wishes to transition the nine tasks of the mental health professional identified in this publication are:

1. Accurately diagnose gender disorder
2. Accurately diagnose any co-morbid psychiatric conditions
3. Engage in psychotherapy
4. Ascertain eligibility and readiness for hormone and surgical therapy
5. Make formal recommendations to medical and surgical colleagues
6. Be a collegial member of a team of professionals
7. Educate family members, employers, and institutions
8. Be available for follow-up for patients.

Specific information regarding best practice for mental health professionals in the treatment of trans people is rare, and so this is an essential document to inform the project.

Relevance to project – relevant

(In September 2011 this document has been superseded by: The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual and Transgender, and Gender Non-Conforming People, 7th Version -please see below)

WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (September 2011)

Summary

This newly released document is an excellent resource which has a section specifically on mental health. This sections covers:

1. Competency of mental health professionals working with adults who present with Gender Dysphoria
2. Tasks of mental health professionals working with adults who present with Gender Dysphoria

3. Tasks related to assessment and referral
4. Tasks related to psychotherapy
5. Other tasks of the mental health professional
6. Culture and its ramifications for assessment and psychotherapy
7. Ethical guidelines related to mental health care
8. Issues of access to care

Relevance to project – very relevant

Luckstead, A., (2004) Raising Issues: Lesbian, Gay, Bisexual & Transgender people receiving services in the public mental health system Centre for Mental Health Services Research, Department of Psychiatry, University of Maryland, Baltimore, USA

Summary

This comprehensive and relatively recent document was commissioned by the Centre of Mental Health Services (CMHS) in Baltimore USA. The purpose of the report was to gather information from published and unpublished literature, service users, providers and community leaders – and pull it together into an accessible and practical report.

The brief for this report was almost identical to the one for the project. It is however reflecting on the systems in the USA, with quite different systems to that of Aotearoa. It does however contain many practical suggestions, and the tables could make an excellent starting point for developing resources for training, best practice guidelines and other resources e.g. page 93 'Concrete Service recommendations'.

Relevance – very relevant

Human Rights Commission. (2008). To Be Who I Am/Kia noho au ki toku ano ao, the final report of the Transgender Inquiry. Auckland: Human Rights Commission.

Summary

The terms of reference of the Inquiry was look into:(a) the nature and extent of discrimination experienced by transgender people (b) the accessibility of public health services to transgender people (incorporating the minimum core obligations of both the primary and secondary health services, including, but not limited to, gender reassignment services) (c) the barriers faced by transgender people when attempting to gain full legal recognition of their gender status.

As a recent New Zealand publication, this document is essential reading to inform the project. Particularly relevant chapters including those focused on discrimination (for the discussion about discrimination within the health sector), the right to health and the findings and recommendations. These included the need for information about DHB services available for trans people, and the development of clear treatment pathways for trans people. Subsequently CMDHB

has produced some good practice guidelines for health professionals providing services for trans people who choose to physically transition. This national resource was published online in August 2011, based on the 2001 international standards of care. The 2011 revised standards of care was published in September 2011 and therefore should be read in conjunction with the CMDHB document.

Relevance – very relevant

Martell, C.R., Botzer M., Williams, M., Yoshimoto, D., (2003) A Literature Review & Resource Guide for Evidence Based Best and Promising Mental Health Practices: Gay, Lesbian, Transgender and Bisexual Individuals The Washington Institute for Mental Illness Research and Training, Washington State University Spokane

Summary

The section on Gay, Lesbian, Transgender and Bisexual Individuals is part of the larger document which attempts to address the needs of populations that are particularly vulnerable and in need of evidence based best and promising mental health practices. This document gives an overview of specific therapies and approaches which have been found to be successful when working with LGBT people.

The specific approaches critiqued for LGBT people are:

LGBT-Affirmative/Feminist Therapies, Community Reinforcement Approach, Cognitive-Behaviour Therapy for Generalised Anxiety Disorder, Panic Control Treatment, Cognitive Behavioral Group Therapy for Social Phobia, Cognitive Therapy For Depression, Interpersonal Therapy for Depression, Brief Dynamic Psychotherapy for Depression, Group Counselling Theory, Ingersoll Gender Center, TalkSafe, Seeking Safety and other Resources on Transgender Issues.

Although the document mainly focuses on specific therapeutic modalities, and this is not the focus of the project, it provides some excellent general recommendations for working with LGBT people which can be incorporated in the best practice guidelines. It would also be an excellent resource to refer to.

Relevance to project – relevant

Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing, (2009) Well Proud A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services. Department of Health Victorian Government, Department of Health, Melbourne, Victoria.

Summary

This guide is aimed at supporting services to be more responsive to issues related to sexual

orientation, gender identity and intersex conditions. It is aimed at all health and human services, and has specific suggestions for working with gay and bisexual men, lesbian and bisexual women and sex and gender diverse people.

As a very recent (2009) Australian document, the evidence-based recommendations in this guide are very relevant to the project. The document does provide some specific guidelines for mental health and AOD services, but they are fairly limited when it comes to specific issues related to mental health and addiction services.

Relevance – very relevant

NHS Inclusion Project (2005) Fair For All – The Wider Challenge Good Practice in the NHS and Working for Lesbian, Gay, Bisexual and Transgender Health. NHS Education Scotland

Summary

This is the third major publication in the Inclusion, Lesbian, Gay, Bisexual and Transgender (LGBT) Project, which was set up in 2002 to promote the development of a mainstreamed approach to LGBT equality and diversity. It is informed by the first two projects.

This publication is the practical ‘how to’ guide and provides information, case studies and examples of good practice for LGBT people who have used the National Health Service (NHS) in Scotland. It is primarily aimed at people responsible for developing policy and planning. It is an interactive document which educates the reader, includes findings from the previous research (including case examples) and provides suggestions for further action.

This very comprehensive document provides relevant areas for consideration within the project. Of particular interest are the items contained in the ‘taking it forward checklist’ and ‘opportunities for further action’ found at the end of each chapter. These are listed together in the checklist at the back of the publication.

Although it is a Scottish publication and it has a very broad focus, the actions contained in the checklist made a great start for best practice guidelines.

Relevance – relevant

Pega, F., MacEwan, I. (2010) ‘Making Visible’ Improving services for sexual minority people in alcohol and other drug addiction prevention and treatment. Matua Raki – National Addiction Workforce Development Centre, New Zealand

Summary

This recently updated (2010) New Zealand booklet is designed to improve services for sexual minority people in alcohol and drug addiction prevention and treatment. It covers issues facing

sexual minority people, terms and concepts, AOD use, health promotion and treatment. It is an excellent resource for all AOD clinicians in New Zealand who want to provide high quality service to their sexual minority clients.

This booklet will be one of the key resources utilised in the project in relation to formulating best practice guidelines for working with sexual minorities within AOD services. Many of the core concepts can be used when considering Mental Health services as well. The one area that it does not cover is policy and management, as it is directed at individual clinicians.

Relevance – very relevant

Semp, D (2006) A Public Silence: A Report On Sexual Orientation And Public Mental Health Services in New Zealand. Psychology Department, University of Auckland

Summary

This report is a summary of the doctoral thesis: A Public Silence: Discursive practices surrounding homosexuality in public mental health services in Aotearoa/New Zealand. Its main focus is on MSM (men who have sex with men) with the research goals based around this population. In brief the research goals were to explore how MSM viewed their mental health problems, how the PMHS met their needs, if 'matching' gay and lesbian staff to MSM would improve mental health services to LGB clients and what changes may enhance PHMS for MSM.

The primary recommendation for improving services to MSM was that all staff ask all clients about homosexuality and homonegative trauma. This strategy was seen to address the invisibility of LGB people in PHMS and give relevance and importance to the harmful effect of heterosexism on mental health, legitimising the fact that this may be the source of a clients mental health issues.

This report is essential reading. It details relevant research, and gives many insights into the complexities for improving mental health services to MSM – including the experiences of LGB staff. In particular, Chapter 6 'Implications for Research, Policy and Practice' provides important considerations for creating best practice guidelines for working with LGBT in mental health and addiction services.

Relevance – very relevant

Semp, D. (2008). A public silence: The discursive construction of heteronormativity in public mental health services and the implication for clients. Gay & Lesbian Issues and Psychology Review, Vol. 4. No. 2 2008

Summary

This paper is an analysis of interviews with queer staff at a PMHS to determine how queer clients are identified within that service. Semp found that there are many barriers to talking about sexual

orientation in PHMS. Some of these are: discussing sexual orientation is seen as 'risky' with 'vulnerable' clients, it is not 'core business' and sexuality of any sort is rarely discussed, and so the practice is not fostered. The result is a silencing of queer clients, preventing clinicians giving them the support they need in their recovery.

Relevance – essential reading

Semp, D (2011). Questioning heteronormativity: using queer theory to inform research and practice within public mental health services *Psychology & Sexuality* Vol. 2, No. 1, 2011, 69-86

Summary

This article explores how a queer theoretical perspective can usefully inform research and clinical practice in ways that affirm queerness by questioning heteronormativity. It builds on the earlier work 'Public Silence' which found that when it came to Sexual Orientation and Public Mental Health Services (PHMS) heteronormative practices of clinicians limited conversations about homosexuality, with the resulting silencing of people who are non-heterosexual.

It advocates that "all (PHMS) staff are supported to enquire about sexuality with all clients as 'good practice' and a matter of course. This is a universalising strategy which directly challenges the assumption of heterosexuality and makes homosexuality relevant to all staff."(pg 80)

The concept of heteronormativity is essential when working with sexual orientation. It provides a framework to identify how non-heterosexual people are made invisible within the assumption of heterosexuality. Heteronormativity highlights the two defining differences for sexual orientation minorities when compared to other minorities.

The first is invisibility and the second is the widely held belief that homosexuality is less than, or even wrong, sick and/or immoral. These beliefs can be held by both heterosexual and non-heterosexual people.

There are suggestions on page 72 under 'Queer positioning: challenging heteronormativity in mental health research' on how to ask about sexual orientation in a way that does not reinforce oppressive practices e.g. "How do you describe or think of your sexuality or sexual orientation to yourself?"

The article also challenges the notion that the best people to work with same-sex attracted clients are always queer staff. This is seen as a minoritising approach and could lead to segregation. Rather than focusing on separate services, the article advocates for mainstream PHMS with all clinicians being able to meet the need of LGBT clients. The first step towards this is that as part of the initial assessment all clients are encouraged to talk about sexual orientation.

Relevance – essential reading

Appendix 2

Key informant interview questions on current LGBT/Rainbow service provision within central Auckland:

ADHB have funded a one year project to improve the treatment and pathways to the Rainbow* community in the mainstream mental health and addiction services. This includes the setting up of virtualised networks, development of best practice guidelines, and the facilitation of training health professionals in those services. This interview will help inform the project by helping us understand how services are currently delivered. Interviews with Tangata Whai Ora will also be held so we can understand their experiences as service users. Information obtained in the interviews will not be directly attributed to any particular individual, but names of those interviewed will be listed within the report.

*Rainbow communities includes gay, lesbian, bisexual, trans, takataapui, intersex, whakawahine, fa'afafine, queer and questioning.

Name of interviewee, service and date

Individual's skills and experience

1. Tell me about your position/role within your organisation?
2. What experience do you have in working with* Rainbow consumers of mental health and addiction services?
3. In your experience, what are some of the common mental health or addiction related issues/problems for the Rainbow community?

Training needs

4. What do you think the general understanding is of clinicians within your team, about LGBT/ rainbow specific mental health and addiction issues?
5. How skilled or competent do you feel in working with Rainbow clients and what training needs you might you have?
6. Are you aware of any training available, or undertaken any? Provided any?
7. Would you be prepared to participate in further training in the future?

Visibility, networks, and resources

8. Are you (or other staff within your team) identified as a clinician who can work effectively with consumers from the Rainbow community? (E.g. would a referral be forwarded to you/ other if a client presented with sexual orientation or gender identity related issues? Are you seen as having expertise working with Rainbow clients?)
9. Are you (or any other staff within your team) comfortable with being identified as a member of the Rainbow community, or as having particular experience/skills in working with this community? (If not, what are the issues or barriers?)
10. Do you have a specific role/mandated role within your team in working with Rainbow consumers? Or is there a specific Rainbow/LGBT orientated role within the team?
11. Are there any other people within this organisation that may identify as working well with the Rainbow community, or that may be prepared to be identified as from the Rainbow community? From other organisations that you know of? (so we can connect with them)
12. Is there a formal/semiformal network of LGBT/Rainbow clinicians within your service/ organisation? (social or professional)

Service pathway, assessment and documentation

13. How are consumers from the Rainbow community identified and how is this information recorded?
14. Are consumers offered an option of seeing Rainbow/Rainbow friendly clinician where available?
15. How are issues related to sexual orientation or gender identity recorded?
16. What differences if any, are there between the assessment and of services to the Rainbow community as compared to those from the non Rainbow communities?
17. How is your service's (or your own) assessment and engagement process effective and respectful to individuals from the Rainbow community?
18. How do you think your organisation meets the needs of, and/or supports your Rainbow consumers?

Gaps and barriers

19. Are you aware of any specific care pathways/best practice guidelines for Rainbow clients within your service? Or other?
20. Do you think there are any barriers for Rainbow consumers accessing mental health/ addiction services, and what are they?
21. What gaps do you think there are within your service in delivering mental health and addictions assessment and treatment to Rainbow clients?
22. Are you aware of any policies (local or organisation wide) within your service related to mental health or addiction services to LGBT or Rainbow communities?

Any other useful information?

Thank you!

Appendix 3

Brief questionnaire for PHOs on current LGBT/Rainbow service provision within central Auckland:

ADHB have funded a one year project to improve the treatment and pathways to the Rainbow community in the mainstream mental health and addiction services. This includes the setting up of virtualised networks, development of best practice guidelines, and the facilitation of training health professionals in those services. This questionnaire will help inform the project by helping us understand how services are currently delivered. Interviews with Tangata Whai Ora will also be held so we can understand their experiences as service users. Information obtained in the interviews will not be directly attributed to any particular individual, but names or organisations of those who responded will be listed within the report.

Please answer the questions below – you can continue over the page if you need to.

1. What are the current issues for primary care providers when providing mental health or AOD services to the LGBT communities?
2. What are the main areas of strength and weakness of individual primary care providers in regard to knowledge and skills when delivering mental health or AOD services to LGBT persons?
3. What gaps, barriers, or obstacles might LGBT people currently face when accessing primary care?
4. Do any specific care pathway, policy or best practice guidelines relating to LGBT care currently exist within any services your PHO provide? (if yes, please provide summary).
5. Are there any specific mental health or AOD initiatives or services currently (or historically) targeting the LGBT communities? (If yes, please provide summary).
6. Any other comments or information that may be useful:

Many thanks!

Please return this questionnaire to:

Anna Birkenhead – NZRCpN

Project coordinator Community Project Manager - Clinical

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Appendix 4

Questionnaire for Service Users

Section One:

How would you currently identify your sexuality? (please tick as many boxes as is relevant)

1. Asexual (no sexual attraction)
2. Bisexual male
3. Bisexual female
4. Fa' afafine
5. Gay
6. Heterosexual/straight
7. Lesbian
8. MSM (men who have sex with men)
9. Non-heterosexual
10. Takataapui
11. Queer
12. Questioning
13. WSW (women who have sex with women)
14. Other
please specify _____

How would you identify your gender? (please tick as many boxes as relevant)

1. Female
2. Male
3. Transgender
4. Transgender male to female
5. Transgender female to male
6. Whakawahine
7. Fa' afafine
8. Intersex
9. Gender queer
10. Other
please specify _____

Section Two:

Have you ever discussed your sexuality with your key worker or Doctor? Yes No

If you answered **yes**, please rate what this experience was like: (please circle one)

Very helpful helpful Neither helpful or unhelpful Not helpful Very unhelpful

If it was **not** helpful, why? _____

What would have made the discussion better? _____

Did this discussion make it hard to get the mental health support you needed? _____

Many thanks for your time and participation in this survey – your response is really valuable to us. The information received will be collected by the project manager at OUTLine and the results will be shared with services to help improve them.

Please post your questionnaire in the self addressed envelope addressed to Anna Birkenhead at OUTLine.

Appendix 5

Questions for service users – past and present experiences within MHS and addiction services

The purpose of this project is to improve mental health and addiction services and access to the Rainbow Communities. We are interested to find out about service users experiences, both positive and negative, in relation to how each person’s sexuality (and/or gender identity) and relationships are talked about, or included in the assessment and treatment processes. This will help us understand how services currently work, and to establish what we can do to enhance or improve them.

We appreciate that for some people it is not easy to talk about sexuality, so please, only answer the questions you are comfortable doing so.

1. For the purposes of this interview, are you comfortable to identify yourself as from the Rainbow Community or as heterosexual? How do you identify? (if comfortable doing so)
2. Are you currently using mental health or addiction services? If so which ones? (and for how long?)
3. Have you previously accessed mental health or addiction services? If so which ones?
4. Did you experience any difficulties in accessing services?
5. When accessing services, were there any opportunities to talk about possible issues relating to your sexual orientation and/or gender identity?
6. What is your perception about whether your sexuality or gender identity was ever assumed? (e.g. heterosexuality/non-trans)
7. When you were in contact with mental health services, or AOD services, did you feel comfortable talking about your sexual orientation and/or your gender identity? (which ones). Have you ever felt you had to conceal your sexual orientation? (or gender identity). If so, why do you think that was?
8. Were you ever asked about your sexual orientation or gender identity? Or if you had any issues relating to sexual orientation? (Which services?)
9. In regards to your sexuality or gender identity, what positive experiences have you had when accessing services?
10. In regards to your sexuality/ gender identity, what negative experiences have you had when accessing services?
11. If applicable, did the service acknowledge and/or include same sex partners or family/ whanau (either of origin or as identified) as you would have liked?
12. Did you ever feel that your own sexual orientation or gender identity was a barrier in any way in accessing services?
13. Can you think of any way mental health or AOD services could address or ask about this issue (sexuality/gender identity) better in the future? E.g. How would you like it to be?
14. What do you think the service should **not do** when comes to issues relating to sexual identity or gender orientation?
15. Do you think it would be important to be seen by a person who identified as from the Rainbow Community? (If so why?)
16. Are there any specific LGBT services you think would be most helpful?

Any other comments or concerns?

Thank you very much!

Many thanks to the service providers who contributed to this research:

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Rebecca Mac Cormack
Dr Susan Moller

Leigh Murray
Dr Carol Nicholson
Phil Nottingham
Dr Rebecca Potts
Wendy Semmons
David Semp
Barbara Stevens
Koringo Strickland
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