11 June 2012

Ms L Craze
Craze Lateral Solutions
10 Gunyah Pl
GLEN ALPINE NSW  2560

Dear Ms Craze

I am writing on behalf of the National LGBTI Health Alliance (the Alliance) in response to the *National Recovery-Oriented Mental Health Practice Framework 1st Consultation Draft Questions*. We appreciate the opportunity to provide further input.

The Alliance is the national peak health organisation for a range of organisations and individuals from across Australia that work together to improve the health and well-being of lesbian, gay, bisexual, trans/transgender, intersex and other sexuality, sex and gender diverse (LGBTI) people and communities. Formed in 2007, the Alliance includes the major providers of specialist community-based services for LGBTI people in Australia, with Members drawn from each State and Territory.

A key area of work for the Alliance is the improvement of mental health and suicide prevention outcomes in LGBTI populations. The Alliance has been funded by the Department of Health and Ageing for a two year project called MindOUT! which has a focus on working with mainstream mental health and suicide prevention organisations to assist them to be more responsive to the needs of LGBTI persons and communities. Therefore the Alliance is keen to ensure that mental health service initiatives such as the *National Recovery-Oriented Mental Health Practice Framework* recognises the specific issues of LGBTI persons who experience mental illness.

**Consultation Question**

In relation to each or any of the population groups discussed, are there any further issues or challenges that need to be addressed in ensuring the relevance of the recovery-oriented practice framework?

The particular issues and challenges that need to be addressed by the framework for diverse sexuality, sex and gender people is the need for LGBTI culturally competent complete care to be provided by mental health services. LGBTI people have often experienced discrimination from mainstream mental health services in Australia and overseas. The Alliance advocates that the *National Recovery-Oriented Mental Health Practice Framework* needs to take account of the lived experiences of LGBTI people. This lived experience often includes marginalisation, discrimination and stigma, which have a negative impact on the mental health of LGBTI people (Aguinaldo 2008; Hatzenbuehler 2010; Ross et al 2010). High rates of violence against people of diverse sexuality, sex and gender is also a major factor affecting their mental health (Meyer 2003; Scout 2005).
LGBTI people have often expressed dissatisfaction with, or fear of, mainstream mental health services. Despite the high need for services, they tend to underutilize services, or to not disclose their diverse sexuality, sex or gender to health services, which can lead to poor outcomes. An Irish study (Gibbons, et al 2008:61,64,65) found that LGBTI people’s experience with mental health providers was sometimes welcoming and sensitive, but that some interactions with psychiatrists were “cold,” or the psychiatrist did not understand LGBTI issues. The clients that were dissatisfied with the issues tended not to tell the service providers that the service had not been satisfactory. For example, a man struggling to come out after his marriage had broken up was hospitalized after attempting suicide. He reported speaking for several minutes with a psychiatrist who was dismissive of gay issues. This man was discharged from hospital with no further support or referrals, again attempted suicide, and again saw the same psychiatrist for a few minutes and was offered no further support or referrals. This man eventually found a private therapist who he found to be more supportive. Lesbians involved in this study had found that mental health professionals had “pathologized” their identity, for example, by claiming that their identity as a lesbian was a result of maternal abandonment.

Australian LGBTI consumers of mental health services who were consulted by the Alliance about the draft National Recovery Framework shared their experiences. Several reported that counsellors and doctors were discriminatory even when they thought that they were being supportive. For example, a doctor asserted that gay people did not have any heterosexual friends, and a psychiatrist assumed that all gay men would engage in illegal sexual activity.

Mainstream mental health services in the United Kingdom (UK) did not protect LGBTI clients from homophobia from other clients and service providers (Clarke 2004). Staff had been judgmental or unaware of LGBTI specific needs, and may have discriminated against same sex partners in decision making in favor of birth families (NHS UK 2009). The recent changes to NHS UK, with the appointment of Diversity Champions, the introduction of LGBTI sensitivity training and guidelines, and consultations with the LGBTI community may have resulted in improvements to these services (Springett et al 2009). Counsellors that advocate for LGBTI people, and are visibly supportive of LGBTI cultures are valued highly by LGBTI people (Israel et al 2008; Lev 2004). Services that are knowledgeable of LGBTI issues and provide appropriate referrals can assist people of diverse sexuality, sex and gender who have mental health and suicide prevention needs to recover (APA 2012; Israel 2008). Counselling and interactions that are affirming of diverse sex, sexuality and gender are highly valued by LGBTI people (Israel et al 2008). Warmth and engagement in the therapeutic relationship are also skills that are highly valued by LGBTI consumers of mental health services (Israel et al 2008).

Counsellors who assist in negotiating coming out issues in the workplace and building careers can also help consumers to build protective factors, since discrimination in the workforce for people who are visibly of diverse sexuality, sex or gender are likely to be discriminated against and to have poor career trajectories (APA 2012; Lev 2004). Many transgender people are likely to lose their jobs during transitions (Lev 2004). LGBTI people who also have needs for mental health support are likely to suffer “double” levels of discrimination in the workforce (UPenn Collaborative on Community Integration and National Alliance on Mental Illness 2009). Support such as career counselling, workplace identity management (APA 2012; Bockting, Knudson, Goldberg 2006), directions for LGBTI friendly careers and co-ordination between counselling and job placement services may assist LGBTI people in developing long term recovery support through supportive workplaces.

Counselling and advocacy for housing support may also be necessary for young LGBTI homeless people who are sometimes displaced from home after coming out to their families, and are at high risk of suicide (APA 2012). Sensitive and supportive interactions to rebuild relationships with families where possible is important for building protective factors for LGBTI young people (APA 2012).
Support and referrals for housing support and community organisations can assist LGBTI consumers to build protective factors. Counsellors that can assist LGBTI people of all ages to build families of choice as well as those that can assist in building relationships with family and friends can assist consumers to build protective factors and assist them in their long term recovery.

Possible responses:

- Seek input from consumers through an Advisory Board of consumers or consumers and staff. This can be LGBTI specific, or a general Board that includes LGBTI representation.
- Train staff in affirming LGBTI identities, building relationships with carers, building families of choice, and where possible and desired by the consumer, building relationships with biological families.
- Develop LGBTI resources for training and links for appropriate referrals.
- Change forms to include LGBTI specific questions and inclusive language on intake forms, incident reports and consumer and carer feedback forms.
- Implement a zero tolerance on homophobia/biphobia/transphobia/intersexphobia policy.

Question

What is your response to the suggested practice domains and key capabilities? Would you suggest any changes?

The Alliance agrees with the suggested Practice Domains, but would advocate for an additional criteria under “Promoting Citizenship and Connectedness,” “Working with Lesbian, Gay, Bisexual, Transgender, and Intersex People, Families of Choice, and Communities.”

Question

What should be the core principles, behaviours, attitudes, skills and knowledge for each capability?

<table>
<thead>
<tr>
<th>Practice Domain: Promoting citizenship and connectedness</th>
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<tbody>
<tr>
<td>Valuing the person and promoting citizenship</td>
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<tr>
<td>Core Principles</td>
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<tr>
<td>Key Capabilities Mental health practitioners</td>
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<tr>
<td>Behaviours eg</td>
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<tr>
<td>Attitudes eg</td>
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<td>Skills eg</td>
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<td>Knowledge eg</td>
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<tr>
<td>Good Practice</td>
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<tr>
<td>Working with Lesbian, Gay, Bisexual, Transgender and Intersex people, families of choice, and communities</td>
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<tr>
<td>Core Principles</td>
</tr>
<tr>
<td>1. Recognition and affirmation of sexuality, sex or gender diversity</td>
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</tbody>
</table>
2. Recognition of the negative impact of discrimination, stigma and phobia on a person's well-being.

3. Critical analysis of the dominant heterosexist and heteronormative\(^1\) cultural assumptions, beliefs and values.

4. A client-centred approach that takes into account the broader social determinants that impact on the well-being of LGBTI persons.

5. An LGBTI culturally competent and safe workforce that is knowledgeable and responsive to the lived experience of LGBTI persons, reflected in organisational policies.

6. Commitment to LGBTI cultural safety, reflected in organisational policies.

7. Safe and welcoming environment and services free from discrimination based on sexuality, sex or gender diversity.

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<thead>
<tr>
<th><strong>Key Capabilities</strong></th>
<th>Mental health practitioners</th>
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<tbody>
<tr>
<td><strong>Behaviours</strong></td>
<td>eg Sensitive, LGBTI culturally competent, building rapport, use gender-neutral and inclusive language, use transgendered people's preferred pronoun</td>
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<tr>
<td><strong>Attitudes</strong></td>
<td>eg Positive about LGBTI diversity</td>
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<tr>
<td><strong>Skills</strong></td>
<td>eg Ability to establish rapport and understand LGBTI people's lived experiences</td>
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<tr>
<td><strong>Knowledge</strong></td>
<td>eg Knowledge of LGBTI cultures, identities and jargon</td>
</tr>
<tr>
<td><strong>Good Practice</strong></td>
<td>Policies and forms include LGBTI sexuality, sex and gender diversity</td>
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| **Good Leadership**  | All Managers, including Senior and Middle Managers, actively promote zero tolerance of homophobia, biphobia, transphobia and intersexphobia, and implement and support a complaints mechanism on discrimination |

| **Supporting people’s social inclusion and community participation** |

| **Core Principles** | Recognition of LGBTI populations as high risk populations for organisational planning, outreach and service delivery |

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<tr>
<td><strong>Behaviours</strong></td>
<td>eg Promoting links with LGBTI community organisations and services, including promoting links between mainstream rural services and LGBTI urban organisations.</td>
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<tr>
<td><strong>Attitudes</strong></td>
<td>eg Promoting LGBTI inclusive practice</td>
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<tr>
<td><strong>Skills</strong></td>
<td>eg establishing links to LGBTI community organisations and practitioners, research into and provision of current resources</td>
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<tr>
<td><strong>Knowledge</strong></td>
<td>eg of local LGBTI community groups and organizations and LGBTI friendly practitioners, knowledge of LGBTI advocacy groups</td>
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<tr>
<td><strong>Good Practice</strong></td>
<td>Changing policies to reflect LGBTI people as high risk populations</td>
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\(^1\) Heteronormativity is the unquestioning assumption that all people fall into distinct and complementary genders (man and woman) corresponding to their sex assigned at birth and with ‘natural roles in life’; that heterosexuality is the only ‘normal’ sexual orientation; and that sexual and marital relations are only appropriate between a man and a woman. Consequently, a "heteronormative" view is one that involves alignment of biological sex, gender identity, sexuality and gender roles.
Changing forms to include LGBTI people
There are systems for monitoring the effectiveness of LGBTI inclusive policies, such as LGBTI specific questions on consumer and carer feedback forms, and incident reports

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<tr>
<td>The organisation’s website, if it has one, includes information showing that LGBTI people are welcome</td>
</tr>
<tr>
<td>Information on websites on suicide and mental health risks includes information targeted to LGBTI people</td>
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<tr>
<td>Training in LGBTI cultural competency is mandatory</td>
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Are you able to suggest any Examples of Good Leadership for any of the capabilities?

YouthLink (a mainstream youth mental health service) in Western Australia has an LGBTI Champion who supports policy changes and staff training to make the service culturally competent and inclusive for LGBTI people, and also provides updated appropriate referrals to LGBTI community organisations.

Are you able to suggest any examples of Good Practice for any of the capabilities?

Youthlink

- Maintain an obviously welcoming environment at YouthLink by displaying the rainbow flag at our entrance and on office doors, “Safe Space” posters, etc in our waiting room
- Have visible materials, artwork, magazines, safe sex info etc in the waiting room that is inclusive of LGBTI people
- Provide regular training within YouthLink on issues such as gender diversity, the transitioning process, LGB identity issues, relevant mental health research etc
- Provide training with external youth and mental health services on diverse sex, sexuality and gender and how to provide inclusive services
- Provides provides one to one consultation to staff in their clinical work with LGBTI clients through the LGBTI Champion
- Ensures that our assessment processes and interviews are LGBTI inclusive and friendly, for example, uses gender-neutral language when asking about relationships, directly asks about sexuality and gender during assessment, lets all clients know that sexuality and gender issues are some of the issues that we work with at YouthLink
- Advocates in the mental health and medical system for the need for knowledgeable services for trans people
- Development of an organisational policy on providing inclusive and knowledgeable services to LGBTI young people (still working on this at the moment)
- Developing a group therapy program for trans young people and their families
- Linkages and liaison with other LGBTI services such as the Freedom Centre

Question

How might the domains and capabilities ensure relevance, to diversity and, across the life span?

The capabilities of "staff training" and "staff knowledge" is relevant to diversity across the lifespan. Staff will need knowledge to understand that different cohorts and associates of LGBTI people have different needs and different life experiences. Ageing LGBTI people are less likely to be “out” to service providers, but may need their friendships and relationships treated with as much or more respect than that of their biological families, for example, an older woman not “out” to services may name a sister that she had
not seen for years as a carer rather than her partner that she lives with for consultation about treatment decisions. Younger people may have more need of developing relationships with biological families to build protective factors. Intersex people who have faced early surgery, secrecy and often repeated surgeries through their childhoods may need to be supported through their high risk of self harm and psychological distress (Schutzmann et al 2009), and they may need to be referred to a specific support group (Cameron & Kirkman 2009). Transgender people may need support to join transgender specific support groups, and to negotiate with medical services, partners, families, friends and workplaces about their transitions because there is a high risk of relationship and work breakdowns during this time (Lev 2004). Many people with non heterosexual experience may be reluctant to discuss this with service providers, but if approached tactfully and inclusively, engagement and discussion could assist people with challenging internalised homophobia or shame (Reeders 2010).

Staff need to be trained and knowledgeable about the different needs of LGBTI people across their lifespans. They also need to help build or support lasting relationships and friendships to assist people to become more independent of services, and to support them in recovery. Staff also need to support LGBTI consumers to access support from both mainstream and LGBTI community support groups and community organisations. Involvement in community can reduce isolation and provide protective factors to assist in recovery across their lifespan (Crisp & McCave 2007; Fenaughty & Harre 2003; Mental Health Commission of Canada 2009).

* Question

What suggestions do you have as to how the Commonwealth, state and territory governments, mental health services and people with lived experience and their families might collaborate to ensure practice and service development become more recovery-orientated?

- Implement a National LGBTI Cultural Competency Frameworks as well as the National Recovery Framework.
- Collaborate over consumer feedback
- Co-ordinate housing and employment support with mental health services.

* Question

What principles should guide mental health services in deciding how to measure their progress in increasing their recovery-orientation?

Principles

Measurements of consumer satisfaction with services are prioritised—including representation of LGBTI consumers and other diverse consumers—and/or focus groups conducted by people external to the organisation.
Indicators

- An Advisory Board has been created that includes representation of diversity, including LGBTI representation. The Board meets regularly and has identifiable goals, implementation plans and indicators.
- Mandatory staff training of existing staff as well as staff induction includes LGBTI cultural competency, appropriate referrals and LGBTI recovery goals such as mainstream and LGBTI community integration, career and housing support linkages if necessary, and information on building relationships with carers, partners and friends, building families of choice, and if the consumer wishes, building relationships with biological families.
- A designated person is responsible for collecting and acting on consumer feedback, including incident reports and consumer and carer feedback forms that have LGBTI inclusive questions, and is responsible for acting on complaints.
- LGBTI data is included in local and national accreditation and standards processes and key performance indicators.

Yours sincerely

Warren Talbot
GENERAL MANAGER
References


