LGBTI Cultural Competency Framework

Including LGBTI people in mental health and suicide prevention organisations
Acknowledgements

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

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* The Alliance acknowledges the traditional owners of country throughout Australia, their diversity, histories and knowledge and their continuing connections to land and community. We pay our respect to all Australian Indigenous peoples and their cultures, and to elders of past, present and future generations.

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1. Introduction: The Cultural Competency Framework

This document is designed to support mainstream mental health and suicide prevention services to better provide for lesbian, gay, bisexual, trans/transgender, intersex and other sexuality, sex and gender diverse (LGBTI) communities. The aim of the Framework is to ensure that these organisations are better able to recognise, understand and meet the specific needs of LGBTI people. Culturally appropriate and inclusive services lead to better health outcomes and greater satisfaction with health care for members of LGBTI communities. The Framework is designed to inform practice and policy in public, private and non-government organisations (NGO). This includes mental health and suicide prevention services, both residential and non-residential, drug and alcohol services, mainstream NGO and community based organisations (CBOs), outreach organisations and primary care.

The Alliance

The National LGBTI Health Alliance (the Alliance) identified the need for a Framework that addresses mental health issues and higher rates of suicidality within the community. The Framework addresses the particular needs of LGBTI people as a community.

Formed in 2007, the Alliance is one of the first organisations of its type in the world. Originating out of community based organisations with an HIV/Aids focus the Alliance is the national peak health organisation for LGBTI people and communities. The Alliance works to improve the health and wellbeing of LGBTI people by working collaboratively to advocate for greater recognition of LGBTI health needs as well as the provision of targeted program delivery and research. The main aims are to facilitate:

- a national agenda for LGBTI health and wellbeing
- a national voice on LGBTI health needs
- commitment to the support of LGBTI health
- access to national funding for LGBTI health projects
- the sharing of information and resources to build capacity in the LGBTI health sector
- the identification of social determinants that have health implications for LGBTI communities.

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 (DoHA) for a project called MindOUT!. The Framework is a MindOUT! project initiative undertaken by the Alliance.
2. What is Cultural Competency?

Cultural competency Frameworks are designed to help organisations and individuals provide services that are appropriate to those outside their usual frame of reference. Cultural competency is about understanding and learning to communicate with people from cultures other than our own. While many people within professional mental health and suicide prevention organisations may be aware of cultural competency they may not have considered LGBTI as a distinct cultural group with particular needs and experiences and many have not received cultural competency training. Under these circumstances staff may be uncertain how to react when a consumer reveals their diverse sexuality, sex or gender.3 4

Cultural competence with regard to LGBTI people and communities requires the development of an understanding of lived experience, histories, relationships and communities through:

- developing awareness of the practitioners own culture, beliefs and values
- knowledge of cultural practices and world views within the LGBTI community
- understanding and valuing cultural diversity within the LGBTI community
- acquiring skill in working with the LGBTI community as a cultural group.5

For mental health services this means providing specific standards and actions to increase the knowledge of LGBTI cultures, including skills and values such as accepted language and lifestyle choices.

Consumer consultations conducted by the Alliance have found common misconceptions and stereotypes about LGBTI cultures repeated by health care providers and counsellors in Australia:

- gay men do not have heterosexual friends
- all gay men are promiscuous
- being gay or lesbian is just a phase
- there is no such thing as bisexuality, you have to pick gay or heterosexual
- a lesbian was only a lesbian because she had been denied her mother’s love as a child
- all trans people are actually gay.

The Framework is designed to address the gap between providers and counsellors perceptions and the realities of LGBTI experience.
3. Why we need a Framework: health information

Historically mental health care has been low status and under-resourced (RANZCP, 2005) nonetheless with limited resources mainstream mental health and suicide prevention organisations have provided high quality suicide prevention and mental health services. The Alliance appreciates that implementing the Framework requires organisations to extend their limited resources. However, compelling evidence to support the need for culturally competent service provision exists. A useful summary of issues and statistics on why LGBTI people have significantly poorer mental health and higher rates of suicide than other Australians has been constructed by Rosenstreich (2013). While many factors that contribute to mental health are unique to individuals, a reduction in the rate of LGBTI suicide and suicide attempts requires strategies that promote socially inclusive and supportive environments. Furthermore, mental health and crisis intervention strategies need to be accessible and culturally specific to diverse sexuality, sex and gender. There are specific risk factors for poor mental health and suicidality within the LGBTI community. These include:

- stigma
- discrimination in all levels of society, including the workplace and education institutions
- fear of violence
- experience of violence
- heterosexist bullying
- family rejection
- rejection from friends
- internalised homophobia particularly from conflicts with family and religious upbringing
- homelessness from family rejection
- alcohol and substance misuse
- suicidality or completed suicides among friends.

The sections below outline evidence concerning specific risk factors for poor mental health and suicidality within the LGBTI population: Included in this section is a list covering a variety of issues and a discussion of two key issues in the literature, firstly, pathologisation and labelling and secondly, fear of discrimination and non-disclosure.

Evidence to support the need for a Cultural Competency Framework:

- LGBTI people have significantly poorer mental health and higher rates of suicide ideation than the general Australian population.¹ ¹
- There is no population based research on LGBTI completed suicides in Australia. A population based study from Norway found that men who had ever been in a registered same sex relationship were twice as likely to have completed suicide than those who had never been in a registered relationship with either sex and eight times more likely to have completed suicide than men who had ever been in a registered relationship with the opposite sex.¹²

¹ Royal Australian and New Zealand College of Psychiatrists
• Research including population based studies and twin studies from the United States, New Zealand and Europe have found that "LGB" people are three to six times more likely to attempt suicide than heterosexual people.13
• There are no population based studies comparing completed suicides of trans/transgender people with the general population, but research from comparable nations reveals that transgender people have higher rates of suicide attempts than LGB people. Between twenty five and thirty four percent of trans/transgender people have attempted suicide.14
• There has been little research conducted on intersex people and mental health, but an overseas study comparing the self-harm and suicide attempt rates of intersex people with other groups found that intersex people have self-harm, distress and suicide attempt rates comparable to women who have been severely traumatized as children.15
• The Australian Bureau of Statistics (ABS) found that "LGB" people in Australia have higher incidences of all types of mental illness compared to heterosexual people.16
• Australian studies have shown that trans/transgender people, and intersex people, suffer from high levels of distress and depression.17
• Research from the United States shows that there may be an increased risk of suicide attempt for "LGB" people who are also from culturally and linguistically diverse backgrounds. No equivalent Australian data exists.18
• LGBTI people often delay seeking healthcare, or experience dissatisfaction with their healthcare due to experiences of discrimination against themselves, their families or their friends.19 20 21
• Fear or awareness of violence. Not all LGBTI will have personally experienced violence as a result of stigma and discrimination,22 but there are higher levels of violence against LGBTI people than the general population, which is a significant risk factor in suicide, self-harm and poor mental health.23
• Young LGBTI people, homeless LGBTI people, and trans/transgender people have particularly high rates of violence against them.24
• Many "LGBTI" people have been rejected from their biological families. They may also have experienced discrimination and stigma. Lack of family support is a significant risk factor.25 26
• LGBTI people live with an awareness of stigma even when concealing their own identity from others or not directly experiencing it themselves.27
• People in the LGBTI community are more likely to experience the effects of others’ mental health status or suicidality including losing LGBTI friends, partners or acquaintances to suicide.28

Pathologisation and labelling

It is still common to pathologise people on the basis of their diverse sexuality, sex or gender identity.29 Being lesbian, gay or bisexual was widely considered to be a mental illness until the American Psychiatric Association (APA) abolished the pathologisation of people based on their sexual identity in 1973. The Australian Psychiatric Association released position papers calling for the decriminalization of homosexuality in 1972 with the removal of gay as a category of mental illness in 1973.30 However, the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association is still used by clinicians and psychiatrists in Australia today and the historical legacy of homosexuality as pathology still influences some mental health services.31 Recent examples of pathologising include telling a lesbian that she is only a lesbian because she is adopted and has maternal abandonment issues and a bisexual person being told while in a public
residential mental health facility that he “mistakenly believed that he was bisexual” as a result of schizophrenia or delusions. Many LGBTI people in Australia and overseas have also experienced direct or overt discrimination from mental health services. Direct discrimination includes telling the consumer that their diverse sexuality is “wrong”, and trying to use conversion therapy to “cure” that person of their diverse sexuality or gender.

Categories within the DSM still classify diverse sex or gender people as having a mental illness or disorder while intersex people are ascribed a Disorder of Sex Development. A Disorder of Sex Development diagnosis could lead to therapists or others supporting or attempts to impose gender norms, hormonal, or surgical interventions. Conversion or reparative therapy for perceived sexuality or gender abnormality has been shown to have very negative effects on the mental health of consumers. The policy of the Alliance is that sex and gender variations are part of a normal range of human experience and that LGBTI people have the same personal rights and responsibilities with regard to the delivery of health and social services as all Australians.

Trans/transgender people are required to have themselves diagnosed with Gender Identity Disorder in order to access surgical or hormonal interventions in Australia. This classification is heavily debated and contested by people in trans communities and associated with higher numbers of trans people accessing mental health services than other LGBTI people.

Direct discrimination against transgender people also includes not addressing them as their preferred gender, trying to force them to live as their non-preferred gender, or forcing intersex people to conform to gender norms. Direct discrimination has also includes requiring support or treatment groups to vote whether or not to accept an LGBTI member.

For intersex people, silence, or a refusal to talk about intersexuality can be a source of distress. Many intersex people live with silence around sex, gender and sexuality. Silence around intersex issues can cause difficulties in family relationships thus reducing the protective role of families. On the other hand being forced to conform to gender norms by family or society can also cause distress. Trauma as a result of medical, surgical, and psychological interventions are also an issue for intersex members of the LGBTI community.

Those who are rejected or experience discrimination and stigma at home have an increased risk of homelessness and significantly increased risk of suicide, self-harm, substance abuse and sexual victimization compared to their non-diverse sexuality, sex or gender counterparts. Counsellors working with families of youths to reduce discriminatory attitudes on the basis of diverse sexuality, sex and gender can build protective factors and reduce the risks of homelessness.

Experiences of violence are associated with an increased risk of suicide. The higher rates of violence against young people and trans people, of any age, make these groups particularly high risk for suicide attempt.

Fear of discrimination and non-disclosure

Over-representation of LGBTI people seeking mental health treatment is a global phenomenon. Evidence from Private Lives 2 (2012) the national survey of the health of LGBTI Australians suggests that many LGBTI people have delayed seeking treatment, or have not disclosed their diverse sexuality, sex or gender to their mental health provider. The LGBTI health statistics may
therefor under-represent the problem. Fear of discrimination is one of the reasons for delay in seeking help or non-disclosure. Bisexual people are less likely than gay or lesbian people to be out to their healthcare provider. Less than half of LGBTI identifying people are out to their health care provider in comparable countries. Many people claim that they do not disclose their diverse sexuality, sex or gender to mental health services for fear of being pathologised or discriminated against.

Some services may not be aware that they have LGBTI consumers, and do not provide space on forms to ask consumers about their diverse sexuality, sex or gender. Many organisations consider that they are good at providing for LGBTI consumers already because they treat everyone the same. In recent Australian research, the idea that treating everyone the same constitutes good practice, emerged as the biggest barrier to change within organisations.

In LGBTI research and consultations consumers have expressed a fear that a counsellor may:

- assume that a gay man's mental illness is a result of being gay
- assume that a lesbian's sexuality is a result of child sex abuse
- assume that a lesbian single mother with a mental illness is a bad mother
- discriminate against a lesbian who is suicidal after her lover of ten years has died of a heroin overdose
- share information about diverse sexuality, sex or gender with another health care worker who may then discriminate against them
- assume LGBTI consumers are second-class
- be "hopeless" and not understand intersex issues
- not understand polyamory
- try to categorise bisexual people as lesbian or gay
- assume all bisexual people are promiscuous or incapable of monogamy
- make negative comments about lesbians appearance and attractiveness
- be uncomfortable about discussing sexuality, sex and gender diversity
- be judgemental
- impose religious or spiritual beliefs
- suggest that a transman's desire to transition stems from patriarchal oppression.
- tell an LGBT person that all they need is to have sex or get married in their non-preferred gender to a person of the opposite gender
- tell a transgender person that they are wrong and not support the transition process
- reject of judge on the basis of LGBTI status
- pathologise an intersex person
- try to make an intersex person conform to gender norms.

There are a wide range of social and cultural factors that lead to the overrepresentation of LGBTI people in suicide, suicidality, self-harm and depression statistics. Changes in current practice have the potential to change these statistics significantly.
4. Current Practice

Most mainstream mental health and suicide prevention organisations already follow protocols preventing discrimination and maintaining patient confidentiality. However, these protocols often do not explicitly address the experiences of LGBTI people. Some practices, such as allowing consumers to vote on whether people of diverse sexuality, sex or gender should join the group, may seem to be inclusive, but may make the LGBTI person feel excluded and judged. Other practices, such as recording whether the person is LGBTI in their patient notes, also designed to be inclusive, will be undermined if the information is subsequently used by a staff member in a heterosexist or discriminatory manner. Most LGBTI consumers will not complain directly about discrimination, so organisations may not be aware that it is happening.

When the Alliance originally surveyed national mental health and suicide prevention services in 2011 only ‘18% stated their organisation currently included the LGBTI community specifically in their goals and/or strategic plan’. Lack of awareness of LGBTI consumers may be a contributing factor. It is likely that the lack of awareness is in part due to LGBTI people’s reluctance to come out to clinicians or stealth (when a person keeps their gender history or actual gender private). Fear that confidentiality will not be respected is cited as another reason to not reveal LGBTI status. People may also travel outside their geographical area to ensure confidentiality of service.

In Australia there are large differences in acceptance between remote, rural, regional and metropolitan areas, with societal acceptance of diverse sexuality, sex and gender more likely in certain parts of large metropolitan areas, such as Darlinghurst in Sydney. The repercussions of being outing as being LGBTI in a small rural community are enormous in terms of potential stigma, discrimination, rejection and violence. Some Australian consumers from rural areas have reported traveling many miles to find a service that was experienced with LGBTI consumers. Others have reported being forced to undertake reparative or conversion therapy. Another contributor to the low number of organisations with an LGBTI policy may be the idea that ‘we treat everyone the same’ is best practice and a lack of understanding of the ways in which this reinforces the status quo and acts as a barrier to change.

Good practice exists in some organisations. For example, in rural Australia transgender people have reported some good telehealth experiences. However, confidentiality, geography, negative attitudes and unintentionally alienating organisational practices mean that access to services for the rural LGBTI community is often problematic.

The facts presented in section 4 above clearly demonstrate that change is needed. Cultural competency is designed to facilitate understanding and inclusion building resilience and contributing toward protective factors for LGBTI people.
5. Community, resilience and protective factors

Resilience and protective factors that work to promote positive mental health outcomes can be developed and constructed. Resilience and protective factors include supportive workplaces, schools, families, friends, social groups, partners, inclusion in LGBTI communities, and mainstream social inclusion.  

LGBTI communities and friendship networks are very important for many people who identify as being of diverse sexuality, sex and gender.

"The role of the community as a critical societal support in the context of LGBT health may be a more significant factor for LGBT individuals and families than for others [...] The HIV/AIDS epidemic, the effects of social stigma, experiences of discrimination, and the tireless efforts of many to advance rights of LGBT persons has strengthened the sense of resilience and cohesiveness within the LGBT community."  

Referrals to LGBTI support groups, online resources and community groups can assist LGBTI people to find acceptance and support and to build families of choice that can provide ongoing support and assist in recovery. Many LGBTI people develop resilience living happy and fulfilling lives. Most (even if they choose not to be out) will be aware of LGBTI specific language, identities, values and beliefs.

Protective factors for LGBTI youth at school include the enforcement of diverse sexuality, sex and gender anti-bullying policies, a supportive counsellor, teacher or administrator, a caring adult, or a home environment that is supportive and affirming of diverse sexuality, sex or gender.

Protective factors for older gay men and lesbians of any age are same-sex partnerships. Respect for LGBTI cultures can be a significant protective factor. Inclusion of LGBTI individuals and visible respect for LGBTI cultures in the general community can build resilience and is key in enhancing people’s quality of life as they age.

Support for individuals from diverse sexuality, sex and gender cultures can come from:

- families
- partners
- workplaces
- schools
- religious groups
- social groups
- government agencies
- support and mental health services.

Support from these areas can protect LGBTI people from suicide, suicidality, self-harm, and depression.
6. Diversity within the Community

There is cultural diversity within LGBTI communities with some groups historically having more of a voice than others at certain times. Currently for example, bi-sexual people are less represented than other groups included under the LGBTI umbrella. It is important to consider more marginalised members of the community when developing strategies for inclusiveness. Aboriginal or Torres Strait Islander people, people from culturally and linguistically diverse (CALD) backgrounds or disabled people, may experience multiple layers of discrimination and have less opportunity to voice their particular concerns. They may face difficulties finding acceptance from within mainstream culture, their own cultures, and the LGBTI community.

There are many challenges for Aboriginal and Torres Strait Islander people who have diverse sexualities, sex or gender including challenges being accepted by their families and communities. However, it is important to note that a small number of remote traditional Aboriginal or Torres Strait Islander cultures, such as Tiwi Islanders, have traditionally included and supported people of diverse sex and genders such as Sistergirls and Brotherboys.

Many LGBT people from culturally and linguistically diverse backgrounds choose not to come out to their families due to fear of violence, discrimination or rejection. Concealing diverse sexuality, sex or gender can have a negative effect on people’s mental health and suicidality. Intersecting identities can also lead to compounded stigma and discrimination. Some people of diverse sexuality, sex or gender are rejected by mainstream cultures, their own cultures, as well as LGBT[I] cultures.

There are many variations between and within different culturally and linguistically diverse communities in their attitudes to diverse sexuality, sex and gender. Support from culturally and linguistically diverse communities for individuals of diverse sexuality can play an important role in developing protective factors.

LGBTI disabled people also face particular challenges including silence about and denial of their sexuality.

Community can provide protective factors and be a source of resilience. As mental health and suicide prevention programs become more inclusive of LGBTI people, difference and particular diversity related needs that exist within the community will become more apparent. The principles and practices outlined below are designed as a guide towards inclusive practice.
7. LGBTI Inclusive Principles and Practices

A variety of Frameworks and guidelines for "LGBT[I]" people or "sexual minority groups" are in use in comparable countries, including the United States\textsuperscript{87} the United Kingdom\textsuperscript{88} and New Zealand.\textsuperscript{89} The principles and practices outlined in this document build on existing Frameworks and draw from relevant Australian material.\textsuperscript{90} The seven principles are:

1. Recognition and affirmation of sexuality, sex or gender diversity.
2. Recognition of the negative impact of discrimination, stigma, homophobia and heterosexism on a person's well-being.
3. Critical analysis of the assumption that all consumers or staff are heterosexual and not diverse in terms of sex or gender.
4. Recognition of LGBTI populations as high risk of suicide populations for organisational planning, outreach and service delivery.
5. A client-centred approach that takes into account the broader social determinants that impact on the well-being of LGBTI persons.
6. A culturally competent and safe workforce that is knowledgeable and responsive to the lived experience of LGBTI persons.
7. Safe and welcoming environment and services free from discrimination based on sexuality, sex or gender diversity.

The LGBTI Inclusive Practice Standards (the Standards) outlined below are designed to operationalise the inclusive principles by enabling mental health, counselling or suicide prevention organisations to be more supportive, inclusive and welcoming.

These Standards are designed to work alongside the best practice guidelines and anti-discrimination policies already in place in many mental health, counselling and suicide prevention organisations providing specific recommendations for supporting LGBTI people as a distinct culture with specific needs.

National Practice Standards and definitions

The Standards included in the Framework are consistent with the National Standards for Mental Health Services.\textsuperscript{91} The National Standards for Mental Health Services were endorsed by the Australian Health Minister’s Conference and are designed to be used by Public, Private and Non-Government Organisation (NGO) mental health care services, including drug and alcohol services, community based mental health services and primary care.

The National Standards for Mental Health Services includes Diversity Responsiveness (Standard 4), which refers to the need to identify diverse groups of consumers and carers based on sexual orientation or gender.\textsuperscript{92} This includes recognition of diversity in planning, service implementation,
and staff training. It also requires services to implement non-discriminatory practices and to provide equitable access to services.

To supplement the National Standards, the Alliance proposes that the definition of gender be amended to include transgender, intersex and other sex and gender diverse people.

The Standards for the LGBTI community are outlined below. In addition to the Standards, in 2013 the Alliance will produce a cultural competency document including principles of good provision for the LGBTI community, guidelines for practice, and practical examples of how inclusive practice might be achieved.
8. The Standards

The standards cover 7 areas of service provision: access to services (inclusion), use of valid and reliable data, inclusion of the values of LGBTI communities, demonstrated cultural knowledge, appropriately trained staff, anti-discrimination, and the inclusion of carers outside of biological family.

Standard 1: Access to the Service

The Service or Organisation identifies that LGBTI people access services through inclusive language on forms such as intake forms, incident reports, complaints and feedback forms.

i. LGBTI people are identified through inclusive language on forms such as intake forms, incident reports, complaints and feedback forms (see Appendix 1 for an example).

ii. A designated person collects the information about LGBTI people's access to and satisfaction with that Service through information on complaints, feedback forms, incident reports, and intake forms, and reports on this.

iii. Staff establish rapport with consumers, and use inclusive language, such as "partner" instead of "husband or wife"

iv. Staff understand that disclosure of diverse sexuality, sex or gender is an individual choice, and that fear of discrimination and heterosexism will often discourage this disclosure.

v. As part of cultural competency, in collecting information about LGBTI people accessing services, staff explain confidentiality policies and ask consumers what information regarding sexuality, sex and gender that they want recorded on forms.

Standard 2: Reliable data

The Service or Organisation utilises available and reliable data on identified diverse groups to document and regularly review the needs of LGBTI communities and communicates this information to staff.

i. The Organisation recognises that LGBTI populations have a higher risk of depression, self-harm, suicide ideation and suicide attempts, and this is reflected in their organisational planning, outreach and service delivery.

ii. Where possible, the latest research on risk factors for LGBTI people is accessed by a designated person and incorporated into training and policies and in service strategy planning.

iii. LGBTI standards are developed and incorporated into existing policies.

iv. A designated person researches the needs of LGBTI communities and regularly reviews policies to reflect the changing needs of LGBTI consumers and carers.

v. Policies that are LGBTI inclusive are communicated to staff.

vi. Consultations with LGBTI consumers and the community are established, for example, through representation on Consumer Advisory Boards, or focus groups.
Standard 3: Values of LGBTI communities

Planning and service implementation ensures differences and values of the LGBTI community are recognised and incorporated as required.

i. If an organisation has a website, it displays affirmative statements or a charter welcoming LGBTI people.
ii. Stock images used in marketing and promotional materials include positive images of same sex couples and people of diverse sex and gender.
iii. Waiting rooms have a visible welcoming sign, such as a poster or sticker of a rainbow flag.
iv. If possible, services advertise in the LGBTI press or through LGBTI community organisations or websites.
v. Promotional material, websites and fact sheets on suicide and depression explicitly mention LGBTI populations as high risk groups, along with protective factors and support options.
vi. The Organisation considers the appointment of an LGBTI Champion.

Standard 4: Demonstrate knowledge

The Service or organisation has demonstrated knowledge of and engagement with other service providers or organisations with diverse sexuality, sex or gender expertise or has programs relevant to the diverse needs LGBTI communities.

i. A referral list for LGBTI organisations and groups is developed by a designated staff person, and kept up-to-date.
ii. Staff do not assume that because a person is LGBTI, they would prefer an LGBTI counsellor.
iii. The Organisation engages with an LGBTI community organisation, or another or service that is experienced at working with people of diverse sexuality, sex or gender.
iv. If possible, the Organisation has specific programs or support groups for LGBTI people.
v. All programs are inclusive, safe, and supportive for LGBTI people.

Standard 5: Staff training

Staff are trained to access information and resources to provide services that are appropriate to the diverse sexuality, sex and gender needs of its consumers.

i. All staff undergo mandatory training at induction and regularly thereafter on cultural competency with LGBTI people.
ii. All existing staff undergo mandatory training on cultural competency with LGBTI people.
iii. Staff allocate professional development time to increasing their knowledge about LGBTI people and their experiences and mental health issues through news, documentaries, reports, papers etc.
iv. There are clear policies to follow when a staff member is identified by senior staff members as unable to work effectively with LGBTI people.
v. Cultural competence with LGBTI consumers is built into performance reviews.
vi. Staff screen for co-morbidity problems, for example alcohol and drug misuse, which are high risk factors in LGBTI cultures.
vii. Staff screen for violence, since there is a high risk that LGBTI people have been subjected to violence.
viii. Staff are aware of the possibility of intimate partner violence in LGBTI relationships.
ix. Staff understand that LGBTI people who also have a disability, who are from a rural or remote area, who are Aboriginal or Torres Strait Islander, or from culturally and linguistically diverse backgrounds, may suffer from multiple levels of discrimination.

Standard 6: Address discrimination

The Service or Organisation addresses issues associated with prejudice, bias and discrimination on the basis of diverse sexuality, sex or gender in regards to its own staff to ensure non-discriminatory practices and equitable services.

i. A policy of zero tolerance on discrimination against staff, consumers or carers on the basis of diverse sexuality, sex or gender is implemented and visibly supported by senior and middle managers.
ii. A designated staff person monitors complaints and their actions.
iii. Posters advertising zero tolerance on disrespectful language, misgendering and heterosexism should be displayed in high traffic areas.

Standard 7: Carers

The Service or Organisation considers the needs of carers in relation to people of diverse sexuality, sex and gender

i. The consumer is asked whether their family of choice is more important that their family of origin in decision making.
ii. Partners or close friends are included in treatment discussions or groups.
iii. The needs and issues faced by parents and partners of LGBTI children and young people are considered in service delivery.
iv. A designated staff person collects information on LGBTI carer inclusion from consumer and carer feedback forms.
9. Conclusion

This LGBTI Cultural Competency Framework is a vital part of the process towards social inclusion and reducing the over-representation of LGBTI people in suicide, suicidality, self-harm and depression statistics. Cultural change within organisations is required if services are to better serve the needs of LGBTI communities. Currently the idea that treating everyone the same is best practice constitutes the biggest barrier to change. A ‘we treat everyone the same’ policy reinforces the current situation while the research shows that this approach is not enough. Instead, services that recognise individual circumstances, and also address the social and cultural determinants of LGBTI health are required. This will involve organisational change, but with appropriate training, should be achievable in an industry that works within tight fiscal frameworks.

LGBTI cultural competency policies which are upfront, explicit and implemented on an organisationally wide basis will enable organisations to build confidence and experience in welcoming and affirming LGBTI consumers. In doing this, we will improve the mental health of many LGBTI Australians and their families.
**Glossary**

**Bisexual person**: A person who identifies as being sexually and/or romantically attracted to both men and women.

**Cisgenderism**: The discriminatory view that people’s own understanding of their genders and how they label their genders and bodies are invalid or pathological if they were assigned a sex that is not typically associated with that gender.

**Coming out**: ‘Coming out’ (of the closest) or being ‘out’ refers to disclosing one’s same-gender attraction. Some people use this term to describe the experience of beginning to express a previously secret gender identity, such as when someone who was assigned as ‘male’ begins to live publicly as a woman. However, some people find the term ‘coming out’ inappropriate when applied to gender because unlike coming out about one’s sexual orientation, the gender affirmation process typically involves identifying as a woman or a man and not as ‘trans’. Being ‘outed’ is a process of someone else making an individual’s diverse sexuality, sex or gender known to a third party or organisation.

**Gay**: A man who identifies as being sexually and/or romantically attracted to other men, although the term is sometimes used in relation to lesbians.

**Gender identity**: Is peoples’ experience of their own gender or genders. This may or may not be congruent with their biological or assigned gender.

**Genderqueer**: Is a term some people use to describe their gender identity when it does not conform to or agree with traditional gender norms and who express a gender identity other than woman or man. Some may identify as gender neutral or androgynous.

**Heterosexism**: Is the cultural ideology that perpetuates sexual stigma. Sexual stigma is the shared knowledge that of society’s negative regard for any non-heterosexual behaviour, identity, relationship, or community.

**Heteronormative**: the unquestioning assumption that all people fall into one of two 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.

**Homophobia**: A term coined in the late 1960s to indicate dislike, hatred or irrational fear of people who are homosexual. Homophobia often also refers broadly to a dislike, hatred or fear of all LGBTI people. This term is often misused to describe heterosexism, sexual stigma and sexual prejudice.

**Intersex**: A term used to describe physical variations that are not strictly “female” or “male”.

**Lesbian**: A term used to describe being romantically and/or sexually attracted to other women. (Also see WSW).

**Misgendering**: A term for describing or addressing someone using language that does not match how that person identifies their own gender or body. Using inclusive language means not misgendering people.
**MSM:** MSM, or men who have sex with men, is a term that was adopted in response to HIV education and research, since many men who are sexually involved with other men do not identify as gay or bisexual.

**Polyamorous person:** A person whose affectional orientation is to seek or desire more than one concurrent romantic relationship, with the consent of all people involved. Polyamory is defined as the state or practice of having more than one open concurrent romantic relationship at a time.95, 96

**Same gender attracted:** A person who is attracted to a person of the same gender, but who does not necessarily identify with sexual orientation labels such as gay, lesbian or bisexual.

**Sexuality:** Sexuality encompasses sex, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.97

**Trans:** An umbrella term some people use to describe themselves when they were assigned a sex designation that is not typically associated with their gender identity. Some people who identify as trans do not wish to be referred to as transgender

**Transgender:** The term ‘trans’ means ‘across from’. In some societies, people choose their own gender when they come of age and more than two genders are recognised. These societies often use culturally specific terms instead of ‘trans’. In Australia, people are classified at birth as female or male. Female-classified children are raised as girls. Male-classified children are raised as boys. A female-classified person who identifies as a boy or man might describe himself as a trans man or simply as a man. Similarly, a woman classified as male might describe herself as a trans woman or simply as a woman. Some trans people identify trans as their gender. We use ‘trans’ in this document as a collective term to describe these diverse life experiences. It is generally considered rude to assume that someone identifies as ‘trans’ based on their history or to call someone ‘a trans’, ‘a transgender’ or ‘tranny’.

**WSW (women who have sex with women):** WSW is a term used for women who have sex with other women but do not identify with sexual orientation labels such as lesbian or bisexual.
Appendix 1 Inclusive admission forms, research and coding

Example of an inclusive intake admission form

This admission form can be modified to suit the needs of the Agency. Using this document as a starting point will provide some degree of consistency across state boundaries and across different types and sizes of organisations however, it is intended as a guide only and should be adapted to the specific needs of the organisation or Agency.

Intake Form

Please provide us with some details about yourself to help us ensure that the views provided represent a diverse range of people.

We recognise that many intersex people and trans people identify as simply women or men. The multiple question format of the gender questions will give you a chance to identify your experience, history or status even if you do not identify with identity labels.

Q1: How would you currently describe your gender?

Option 1:

“Please select all that apply”.

*Permit multiple item selections.*

☐ Woman  
☐ Man  
☐ Sistergirl  
☐ Genderqueer  
☐ No gender label  
☐ Other: (Please specify)

OR

Option 2:


Q2: During your lifetime, have you had an experience, history and/or status as…(Please select all the relevant boxes)

☐ Trans—i.e., your assigned sex at birth is not typically associated with your current gender
☐ Intersex—i.e., physical variations that are not strictly “female” or “male”
☐ Not having identity documents that listed your preferred sex (i.e., you wanted ‘M’ but had ‘F’)
☐ Neither of the above
☐ Prefer not to say

Q3. Do you think yourself as: “Please select all that apply”. Permit multiple item selections.

☐ Gay/homosexual
☐ Bisexual
☐ Heterosexual/straight
☐ Queer
☐ Pansexual
☐ Asexual
☐ No label
☐ Other (please specify):

Quantitative coding of demographic data on sex, sexuality and gender

‘Woman’ and ‘man’ can be treated as ‘either’ ‘or’ and ‘and-both’ variables. Some people may select both. (Creating separate variables for each category will also allow you to identify multiple response patterns for respondents (SPSS/SAS provides this option).

Focus groups

The Alliance recommends separate focus groups for each letter in L, G, B, T and I.

Some trans or intersex men identify as gay or bi, some trans or intersex women identify as lesbian or bi, and some trans or intersex people identify as straight. You may also wish to have a focus group for gender diverse people who do not identify as women or men, as they might otherwise be excluded.

Suggested wording: We are asking the following questions to give you the opportunity to let us know how we are doing on intersex inclusion and on trans inclusion, as well as to provide you with appropriate services that meet your needs. We recognise that many intersex and trans people identify as simply women or men. The multiple question format will give you a chance to identify your experience, history or status, if you wish to disclose—not just your identity.

Interviews should explicitly state the limits of anonymity/privacy of responses in each case.
Questions:

Q1: Which term(s) would YOU use to describe yourself? (Please check all that apply)

- Woman (of any gender history and/or experience)
- Man (of any gender history and/or experience)
- Not a woman or a man
- Trans/transgender person
- Other (please tell us more if you wish): [blank text box]
- Prefer not to say

Q2: Your experience, history and/OR status is as... (Please select all that apply)

- Intersex—i.e., physical variations that are not strictly “female” or “male”
- Trans—i.e., your assigned sex at birth is not typically associated with your current gender
- Neither of the above
- Prefer not to say
  (please tell us more if you wish):

If sexual orientation is included on forms, the following options are suggested:

(note this item collects sexual identity, not sexual behaviours)

- Heterosexual
- Gay
- Lesbian
- Bisexual
- Unsure
- Other (please specify below)
Endnotes:


Schutzmann (2009)


Pitts et al. (2006)


21 Leonard et al. (2012)


23 Haas et al. (2011)


26 Cochran et al. (2002)

Bockting et al. (2006)


27 American Psychological Association (2012)


PricewaterhouseCoopers. (2011b)


Gibbons et al. (2008)


Gibbons et al. (2008)

32 Gibbons et al. (2008) pp.65

33 Birkenhead & Rands (2012)


Gibbons et al.(2008)


PricewaterhouseCoopers (2011b)

34 beyondblue (2011)

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37 British Psychological Society (2012)

American Psychological Association (2012)


38 National LGBTI Health Alliance (2012, November) Diversity in Health. Improving the Health and Well-Being of Transgender, Intersex and Other Sex and Gender Diverse Australians.


40 Leonard et al. (2012) pp.43


42 Cochran et al. (2002)

Cochran et al. (2002)
44 Haas et al. (2011)
45 Maguen & Shiperd (2010)
46 Leonard et al. (2012)
47 Leonard et al. (2012)
48 Birkenhead & Rands (2012)
50 PricewaterhouseCoopers (2011)
51 Barrett & Stephens (2012)
52 Gibbons et al. (2008)
53 Gibbons et al. (2008)
54 Gibbons et al. (2008)
55 Rosenberg et al. (2005)
56 National LGBTI Health Alliance Consumer Consultation (2012)
57 PricewaterhouseCoopers (2011b)
59 Firestein (2007)
60 Firestein (2007)
61 beyondblue (2011)
62 PricewaterhouseCoopers (2011a) pp. 7
63 Gibbons et al. (2008)
64 PricewaterhouseCoopers (2011b)
PricewaterhouseCoopers (2011b)

Barrett & Stephens (2012)


American Psychological Association (2012)


Leonard et al. (2012)

The Joint Commission (2011)

Alderson et al. (2004)

American Psychological Association (2012)

British Psychological Society (2012)


Crisp & McCave (2007)


77 Cantor et al. (1999)


79 Crisp & McCave (2007)

Fenaughty (2003)


Liddle (2007)


84 American Psychological Association (2012)

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Maguen & Shipherd (2010)

Poljski (2011)

86 Poljski (2011)


90 Victorian Government (2009)


93 Birkenhead & Rands (2012)


96 Barker, Meg. (2004): This is My Partner, and this is My... Partner’s Partner: Constructing a Polyamorous Identity in a Monogamous World. International Journal of Constructivist Psychology. (18) pp.75-88.