Mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand:

Needs assessment report

Te Pou
o Te Whakaaro Nui
www.tepou.co.nz

Mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand:

Needs assessment report

Jeffery Adams
Pauline Dickinson
Lanuola Asiasiga

Published in May 2012 by Te Pou o Te Whakaaro Nui
The National Centre of Mental Health Research, Information and Workforce Development.
PO Box 108-244, Symonds Street, Auckland, New Zealand.

Web www.tepou.co.nz
Email info@tepou.co.nz

ISBN 978-1-877537-77-6


SHORE


Whariki

Acknowledgements

We thank all those who took part in this needs assessment research: gay, lesbian, bisexual, transgender and intersex (GLBTI) individuals who completed the online submission form, key informants who were interviewed, and service providers who detailed their GLBTI-related services.

We thank Dr Nigel George, Department of Psychology; The University of Auckland who peer reviewed the draft report.

We also thank research staff at Te Pou, for support and guidance over the course of the project.

Finally we thank colleagues at SHORE and Whariki Research Centre, in particular, Associate Professor Karen Witten (SHORE), Associate Professor Tim McCreanor (Whariki) and Associate Professor Helen Moewaka Barnes (Whariki), for their advice and support.

EXECUTIVE SUMMARY

Background

This report presents the findings of research on the mental health promotion and suicide prevention needs of gay, lesbian, bisexual, transgender and intersex (GLBTI) populations in New Zealand. The project was funded by Te Pou o Te Whakaaro Nui as part of the Ministry of Health's implementation of the New Zealand Suicide Prevention Action Plan 2008–2012. It was undertaken to provide the Ministry with information to develop an appropriate policy and funding framework.

The research is a needs assessment, which comprises:

- a review of the evidence (literature review)
- a description of existing services, including identification of any gaps (service stocktake)
- a description of key issues and gaps (stakeholder consultation: key informants and GLBTI individuals)
- conclusions in response to the findings.

Description of research

This research used an exploratory qualitative descriptive approach. It consisted of a literature review and stakeholder consultation. The consultation was designed to obtain a description of current mental health promotion and prevention services or programmes for some or all of the GLBTI populations, and to obtain the views of stakeholders on current service delivery and the issues facing the sector.

For the stakeholder consultation the following data collection methods were used: (1) an email survey of service providers (see service stocktake, Section 4); (2) interviews with key informants (see key issues and gaps, Section 5); and (3) an online submission form completed by GLBTI individuals (see key issues and gaps, Section 5).

Key findings

Literature review

Little is known about the effectiveness of mental health promotion initiatives specifically targeting GLBTI people. The evidence for effective mental health promotion in the general population is still emerging and while there is no consensus on what works best, it is recognised that protective and risk factors can be enhanced or reduced by interventions (Barry, Domitrovich, & Lara, 2005). Specifically, promising mental health promotion activities are those that:

- strengthen individuals' self-esteem, self-efficacy, life and coping skills, relationships and social connections
- strengthen organisations, to ensure environments are inclusive, safe, and supportive
- strengthen communities to increase social cohesion, social participation and inclusion
- strengthen whole societies through interventions designed to counter stigma and discrimination and reduce inequalities.

Such actions require a cross-government approach to enhancing mental, emotional and social wellbeing at a whole population level rather than focusing on preventing mental illness for individuals.

There is convincing international evidence that GLBT individuals experience higher levels of mental health distress than their heterosexual counterparts. In New Zealand there is robust evidence that non-heterosexual populations are more at risk of suicide and mental health problems than the heterosexual population (Fergusson, Horwood, & Beautrais, 1999; Fergusson, Horwood, Ridder, & Beautrais, 2005). Links between sexual orientation and self-harm, suicide ideation and attempted suicide have also been made (Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003).

It is readily acknowledged in the literature that the mental health of GLBT people is impacted by repeated exposure to a wide range of psychosocial stressors associated with anti-GLBT attitudes and behaviours, which include stigmatisation, discrimination and violence. Experiencing these stressors is associated with increased mental health distress and suicidality, and is often referred to as 'minority stress'.

Addressing the mental health promotion and prevention needs of GLBTI people requires both societal and individual approaches that are strengths- and assets-based, affirmative, inclusive, accessible and appropriate.

With regard to mental health service provision, health professionals need to be well-trained in relation to GLBTI issues and inequalities, as well as working in a non-judgemental, respectful and sensitive manner.

Service stocktake

Very few organisations were identified that provided specific services and programmes to some or all of the GLBTI populations. Such services are currently provided by five organisations: Auckland CADS (Community Alcohol and Drug Services), OUTLine NZ, NZ AIDS Foundation (NZAF), Rainbow Youth, and City Associates.

In addition, several mental health promotion resources focused on GLBTI populations were identified.

No GLBTI-focused mental health promotion initiatives funded by district health boards were identified. Another gap was the lack of GLBTI organisations who were actively involved in mental health promotion at a national level, either through service provision or advocacy for mainstream services to better meet the needs of GLBTI people.

Key issues and gaps

The analysis of issues and gaps identified by key informants and GLBTI respondents who completed the online submission form are presented as three themes – macro-social environment; social acceptance and connection; and services and support.

Macro-social environment

A key issue for informants and respondents was the negative impacts on the mental health of GLBTI people that arose from stigma and homophobia or trans-phobia. While some of the actions that lead to GLBTI people experiencing stigma and homophobia or trans-phobia were viewed as resulting from deliberate acts, these actions were also often reported as being less deliberate. Education and general public awareness campaigns were suggested as one way to address these problems and to raise understanding amongst mainstream society of GLBTI issues.

The informants and respondents also reported a need to de-stigmatise mental health issues – both within society as a whole and within the GLBTI community. Awareness campaigns were suggested as an appropriate way to address these issues.

The need for all health promotion activity to include the needs of GLBTI people was noted. Health promotion activities also need to reflect the diversity within the GLBTI population.

Social acceptance and connection

Informants and respondents identified poor social acceptance and connection as contributing to hostile conditions in which to achieve good mental health and wellbeing. Along with broader social acceptance, receiving support from friends and family, and ensuring support and safe environments for young people and older people were identified as important. The need for GLBTI people to address negative issues within their own communities, relating to supporting community members, was also discussed.

Services and support

Access to mental health services and the competency of mental health services were the two overarching issues for informants and respondents.

For all respondents who are currently accessing, or would like to access, mental health counselling and other services the most widely reported issue that hindered access to these services was cost. Several respondents reported that financial barriers meant they did not access services, even though they identified these as necessary for their mental health and overall wellbeing. In some instances this prolonged the distress being experienced.

The other main barrier was the lack of mental health services provided by the public health system, particularly for those with mild to moderate needs. Many respondents also reported a lack of knowledge about available services.

In relation to service competency, the chief issue identified was that all services should be provided in a culturally safe and appropriate way. For GLBTI people, culture may relate to issues associated with sexual or gender identity, or body diversity, as well as ethnic identity. Ensuring that mental health staff displayed appropriate attitudes, had the necessary skills and abilities to work with GLBTI people, and did not make assumptions about sexual and gender identity were identified as important. In addition, it was seen as essential that services were gay-friendly.

Conclusion

International and New Zealand research has clearly demonstrated GLBTI individuals experience higher levels of mental health distress than their heterosexual counterparts. This needs assessment confirmed that there is minimal policy specifically focused on mental health of GLBTI people. Very few mental health promotion or prevention services directed at GLBTI populations in New Zealand were identified. While the impact of current programmes and services could not be determined, several of the GLBTI-focused services appeared to be well-utilised. Government-funded mainstream mental health promotion and prevention services were reported as not responding appropriately to the needs of these groups.

The evidence review (Section 3) and key findings from the stakeholder consultation (Sections 4 and 5) can be used to inform enhanced GLBTI mental health promotion and services in New Zealand. It is important that the needs of each of the distinct GLBTI population groups are addressed.

These findings establish the need for appropriate mental health promotion and service provision to be available to GLBTI people; with appropriate engagement with GLBTI communities to assist in the development of effective health promotion and service delivery.

Building GLBTI national leadership capacity

A key finding of the research is that there is very limited leadership evident with respect to mental health issues for GLBTI. In addition, participants did not identify a GLBTI organisation that is suitably positioned, that could take a national leadership role. One idea to improve co-ordination and leadership in the health area (including mental health), which was raised at a community meeting organised by OUTLine NZ, was the establishment of a national health alliance which could represent GLBTI concerns and issues.

Reducing stigma

While some participants reported that social conditions for GLBTI people had improved in recent years, others noted that improvements varied for different GLBTI groups. The literature review clearly points out that the social environment (including actions such as , stigma, discrimination, rejection and violence directed towards GLBTI people) plays an important role in their mental health. It is imperative that initiatives aimed at reducing GLBTI people's exposure to such negative experiences and countering societal heterosexism are developed.

Enhancing young people's safety

A key issue for many participants was the need to ensure the safety of young people, particularly in schools. The wellbeing of GLBTI students must be fostered by ensuring teachers are trained (through pre-service and professional development) in suicide prevention, mental health promotion, preventing bullying, and challenging homophobia/transphobia. It is unclear whether the Health and Physical Education Curriculum is meeting the needs of young GLBTI people.

Funder obligations

Most respondents reported that mainstream health services should also be able to provide competent high quality services that are accessible and acceptable to GLBTI people. This suggests that agencies responsible for providing health services to their communities (as well as funding others to deliver services), need to prioritise resources for GLBTI mental health and provide both GLBTI-focused services and general services that are inclusive of GLBTI people and recognise any specific needs.

GBLTI components within existing mainstream mental health promotion programmes and suicide prevention services should be funded alongside GLBTI-focused mental health promotion programmes and suicide prevention services which promote community cohesiveness, provide support for young people coming out, and deliver information and support through helplines and websites and so forth. GLBTI access to mental health services could be improved by ensuring all agencies are inclusive of GBLTI clients, including re-allocating resources for this purpose.

Research and information needs

There is very little research information available in New Zealand about the epidemiology of mental health issues for GLBTI people, or in-depth understandings of their experiences. Particular gaps include research that addresses the needs and experiences of transgender and intersex people, and of older GLBTI people. Along with GLBTI-focused research initiatives, there remains a need for data to be routinely collected about sexual orientation in mainstream research.

Supporting practitioners through training and resources

Many participants talked about ensuring the competency of practitioners (for example general practitioners, school counsellors, counsellors, psychologists, psychiatrists) who provide mental health services. In particular, they identified that practitioners needed to have knowledge of GLBTI issues (both

mental health-related and wider issues), to deliver services in respectful ways and avoid making assumptions. Many participants considered that practitioners received inadequate training and education in GLBTI issues, both pre-service and in-service. A training programme is needed for professional bodies, and education and training providers, to enhance GLBTI-related training and education opportunities for practitioners.

Having services that were GLBTI-inclusive was identified by many participants as very important. As well as having well-trained staff, it was noted that organisations would require appropriate resources and other support.[1] It was also suggested that an audit system[2] be established to encourage services to review their policy, practices and procedures, make changes as necessary and maintain their inclusive practices.

[1] For examples of practice guidelines see: *Well proud: A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services* (GLBTI MAC, 2009), and *Best Practice Guidelines: Effective engagement and treatment with Rainbow Tangata Whai Ora/ service users of mental health and addictions services in Aotearoa*. (Birkinhead and Rands, Auckland District Health Board 2012).
[2] For an example of an audit see: *Sexual diversity health services audit* (Gay and Lesbian Victoria, 2007).

CONTENTS

List of tables

List of figures

1 Background

1.1 Background to research

This report presents the findings of research on the mental health promotion and prevention needs of gay, lesbian, bisexual, transgender and intersex (GLBTI) populations in New Zealand. The project was funded by Te Pou o Te Whakaaro Nui as part of the Ministry of Health's implementation of the New Zealand Suicide Prevention Action Plan 2008–2012. It was undertaken to provide the Ministry with information to develop a framework on policy and funding around these issues. The research is a needs assessment, which comprises:

- a review of the evidence (literature review)
- a description of existing services, including identification of gaps (service stocktake)
- a description of key issues and gaps (stakeholder consultation: key informants and GLBTI individuals).

1.2 Population groups and terminology

This research covers three distinct population groups, which can be categorised by sexual orientation (gay, lesbian and bisexual), gender identity (transgender) and body diversity (intersex). In this report we have followed common practice and used GLBTI as an acronym for gay, lesbian, bisexual, transgender and intersex. Where we have used material from other sources or quoted research participants we have used the acronym used in that source[3].

The definitions adopted in this research for transgender and intersex people are:

- trans – a person whose gender identity is different from their physical sex at birth
- intersex – a general term for a variety of conditions in which a person is born with reproductive or sexual anatomy that does not seem to fit the typical biological definitions of female or male (Human Rights Commission, 2008, pp.12-13).

Gender identity and its external expression vary greatly. Transgender people use a wide variety of terms to describe themselves, including culturally specific Māori or Pacific terms. Some, particularly those who have transitioned, prefer to be simply known as a man or a woman. One word cannot convey this complexity. However, for the purposes of this report, we have chosen to adopt the umbrella term used in the Human Rights Commission's (2008) transgender inquiry report, which was trans. Additionally, "intersex people describe their sexual and gender identities in varied ways" (Clarke, Ellis, Peel, & Riggs, 2010, p.263).

This diversity within and across GLBTI people highlights a range of distinct communities, rather than one coherent GLBTI community. We use the term GLBTI communities to signal the diversity and complexity within the population groups of interest. However, we also note that many of the research participants used GLBTI community to describe these same groups.

[3] In other sources the letters may be used in another order, and other letters may be added, e.g. Q for queer.

1.3 Approach to the research

In this section we describe key facets of our approach to the research (specifically, our understandings of mental health promotion and prevention and of GLBTI research), and outline the background of the key research team.

Mental health promotion

Mental health promotion often refers to positive mental health, rather than mental ill health, and positive mental health is the desired outcome of mental health promotion interventions (World Health Organization, 2005). Mental health promotion focuses on the whole population to enable and achieve positive mental health (Jané-Llopis, Barry, Hosman, & Patel, 2005). Often referred to as a multidisciplinary approach, mental health promotion aims to "enhance wellbeing and quality of life for individual, communities and society in general" (Jané-Llopis, et al., 2005, p.9), and initiatives are designed to reduce health inequalities in an empowering, collaborative and participatory manner. According to Joubert and Raeburn (1998), mental health promotion involves building individual resilience in the context of supportive environments.

Mental health promotion focuses on building individual strengths while seeking to address the broader determinants of health, which is in keeping with the fundamental principles of the Ottawa Charter[4] (World Health Organization, 1986). The determinants of mental health include social and environmental factors, such as income, social status, education, employment, housing and working conditions, and access to appropriate health care services, as well as actions by individuals, such as behaviours and lifestyles, coping skills and good interpersonal relationships (World Health Organization, 2010). Mental health promotion action involves: strengthening individuals (e.g. building life skills, coping strategies and self-esteem to increase emotional resilience); strengthening communities (e.g. increasing social connections, inclusion and participation, and improving environments); and removing structural barriers to mental health (e.g. reducing discrimination and inequalities).

Prevention in mental health

Prevention activities are primarily concerned with preventing mental illness and suicide, and the target population tends to be smaller and more sharply defined. Preventing mental health problems involves targeting risk factors and early signs of illness, as well as promoting activities that improve overall quality of life (World Health Organization, 2010). For example, mental health promotion aimed at increasing community wellbeing may also reduce mental health problems for individuals.

GLBTI research

In relation to mental health and GLBTI, our orientation draws on contemporary research and theorising in lesbian, gay, bisexual, trans, and queer (LGBTQ) (health) psychology (Clarke, et al., 2010; Peel & Thomson, 2009). These approaches recognise that disparities in (mental) health exist for such groups when compared with heterosexual populations, but also that the continued focus on individual deficit, as privileged in mainstream psychology and medicine, does not ensure full account is taken of all those aspects that continue to marginalise LGBTQ peoples (Flowers, 2009).

[4] Ottawa Charter principles: building healthy public policy, creating supportive environments, developing personal skills, strengthening community action, and re-orienting health services.

In this respect, wider issues, such as the heterosexism in society (and its institutions, such as health care), and the effect this has on the mental health of GLBTI people, are theorised as being much more important in understanding the mental health of this group than individual factors.

We also recognise that there has been limited policy attention directed at GLBTI people in New Zealand (Adams, 2010; Adams, Braun, & McCreanor, 2007, 2010; Pega, 2007; Pega, Gray, & Veale, 2010). This needs assessment research has the potential to inform policy development for GLBTI people.

Research team

SHORE researchers	Whariki researchers
Dr Jeffery Adams (JA) Dr Pauline Dickinson (PD) Dr Lanuola Asiasiga (LA)	Associate Professor Tim McCreanor (TM) Associate Professor Helen Moewaka Barnes (HMB)

This team has particular experience in research in relevant topic areas and with the relevant communities of interest, including:

- mental health promotion (PD, LA, TM, HMB)
- gay men (JA, LA, TM)
- lesbian women (LA)
- trans people (LA)
- Māori (TM, HMB)
- Pacific populations (LA).

The SHORE researchers were the main researchers on the project, and were involved in all aspects of the research, including recruitment, data collection, analysis, and reporting of research results. The Whariki researchers were available to guide the project in relation to appropriateness and responsiveness to Māori.

1.4 Research overview and outline of report

This report consists of six sections.

- Section 1 introduces the research and aims of the project.
- Section 2 describes the research methodology and methods.
- Section 3 provides a review of the existing literature relating to the mental health of GLBTI populations, including mental health promotion and prevention needs, and best practice principles.
- Section 4 reports on the service stocktake and identifies specific GLBTI-focused mental health services.
- Section 5 reports on the key issues and gaps identified by key informants and GLBTI individuals.

2 Description of research

2.1 Qualitative research

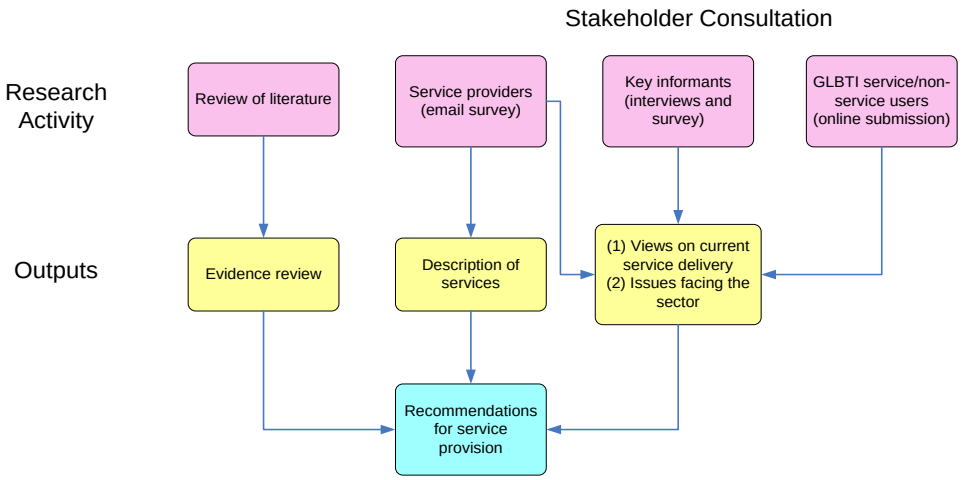
The methodology utilised in this research is an exploratory qualitative descriptive approach. This approach is useful to explore areas of interest where there is little theoretical or factual knowledge available (Tarzian & Cohen, 2006).

This research was conducted under the guidelines of Massey University's Northern Human Ethics Committee. Information sheets were provided to all participants, which outlined their rights and other practical details of taking part in the research.

2.2 Research design

The research consisted of a literature review and stakeholder consultation (see Figure 1). The consultation was designed to obtain a description of current mental health promotion and prevention services or programmes for some or all of the GLBTI populations, and to obtain the views of stakeholders on current service delivery and issues facing the sector. In addition, one researcher (JA) attended the Rainbow Health and Wellbeing Symposium[5], where he made a presentation about this research project and participated in many discussions about mental health issues for GLBTI people.

Figure 1: Research overview



[5] Organised by OUTLine NZ (12 to 14 November 2010), and funded by the Auckland District Health Board.

2.3 Data collection

Methodologically, for the stakeholder consultation three means of data collection were undertaken:

- email survey of service providers (service stocktake)
- interviews with key informants
- online submission form completed by GLBTI individuals.

Email survey

An email survey was circulated to all district health boards (DHBs) and all known providers of services to GLBTI populations. Responses to the survey were received from 13 of 21 DHBs (Northland, Waitemata, Auckland, Waikato, Bay of Plenty, Lakes, Whanganui, MidCentral, Capital and Coast, Hutt Valley, West Coast, South Canterbury, Southern).[6]

In addition, surveys[7] were sent to all GLBTI health and social service or support organisations that were listed online and in print directories.

Both these surveys sought information on any specific mental health promotion and prevention services or programmes provided for some or all of the GLBTI populations, in either mainstream or GLBTI settings. The results of this service stocktake are reported in Section 4.

Service providers were also invited to comment on broader issues in relation to mental health promotion and prevention services, and this data is included alongside the data from the key informant interviews and GLBTI submissions. These results are reported in Section 5.

Interviews with key informants

Seventeen key informants were interviewed by one of the research team, primarily by telephone, although some interviews were conducted face-to-face. A further two informants provided written responses to questions, but were not interviewed. Informants were typically people working in, or having some other interest in, one or more of the areas of GLBTI mental health. The interviewers used a semi-structured topic guide[8] to gather insights into the understandings of the field among these informants. The analysis of this data is reported in Section 5.

The key informants were identified through our knowledge of the field, through networking and in discussion with Te Pou, and through snowball sampling. A diverse range of informants was sought (refer Table 1 for the details of key informants).

[6] A negative response from a DHB does not mean that no programmes or services were provided, as in some instances the respondents advised they did not have a comprehensive knowledge of all services provided by the DHB. Also a non-response from a DHB does not mean no programmes or services were provided.
[7] See Appendix 1 for a list of the survey questions.
[8] See Appendix 2 for the topic guide.

Table 1: Key informant details

Ian McEwan	Independent social worker	Wellington
Barry Taylor	Wairarapa District Health Board	Masterton
Merryn Statham	SPINZ/Mental Health Foundation	
Diana Rands	Gay communities trainer/project worker, Community Alcohol and Drug Service	Auckland
Glenda Neilson	Counsellor	Auckland
Jack Byrne	Independent comment	Auckland
Hana Tatere	Transgender Rights, NZ Prostitutes Collective	Rotorua
Peri Te Wao	Founder of FtM Aotearoa	Wellington
Fuimaono Karl Pulotu-Endeman	Independent health consultant	Wellington
Mani Mitchell	Counsellor and trainer/educator	Wellington
Mathijs Lucassen	PhD candidate, University of Auckland	Auckland
Shona	Independent comment	Auckland
Vaughan Meneses	General manager, OUTLine	Auckland
Kay Jones	Independent comment	Wellington
Warren Lindberg	Ministry of Health	Auckland
Tom Hamilton	Executive director, Rainbow Youth	Auckland
Serafin Dillon	Therapist	Auckland
Calum Bennachie	NZ Prostitutes Collective	Wellington
Anonymous	Mental health professional	Auckland

Online submission form for GLBTI individuals

An online submission form[9] was developed (using Snap software) and used to gather the views of GLBTI individuals (mental health service users and non-users of services) about a range of issues related to mental health and wellbeing for the GLBTI people, including issues and gaps in current mental health service delivery. The analysis of this data is reported in Section 5.

The online submission process was promoted on gaynz.com, and sent directly by email to all GLBTI organisations that were identified. Several organisations promoted the submission process to their members and others via their mailing lists and websites. A total of 124 GLBTI individuals completed the online submission form (refer Table 2 for the details of participants).

Table 2: GLBTI respondents

Population group	n
Gay man	44
Bisexual man	2
Lesbian	28
Bisexual woman	13
Transgender	14
Other and mixed[10]	23
Total	124

Ethnicity	n
Pakeha/New Zealander	82
Māori	11
Pasifika	3
Asian/Indian	3
Other European	15
Other various	10
Total	124

Age	n
20 and under	9
21–30	30
31–40	22
41–50	29
51–60	25
61–70	5
71 and over	4
Total	124

Location (nearest city)	n
Auckland	37
Wellington	35
Dunedin	19
Christchurch	6
Hamilton	6
Tauranga	2
Whangarei	2
Paraparumu	2
Nelson	2
New Plymouth	2
Gisborne	1
Rotorua	1
Levin	1
Not stated	8
Total	124

Mental health service user	n
Yes – current or former	88
No	36
Total	124

[9] See Appendix 3 for a list of the submission questions.
[10] See Appendix 4 for a full breakdown of the other and mixed category.

2.4 Data management and analysis

All interviews with key informants were digitally recorded. Professionally employed transcribers were used to transcribe the recordings. Transcripts were returned to most of the informants for checking; two informants made minor changes to the transcripts.

Data was analysed using thematic analysis (Braun & Clarke, 2006). The basic tenet of this approach is the generation of themes: "Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail" (Braun & Clarke, 2006, p.79). An inductive approach was used, meaning the analysis was data driven, and not driven by a pre-existing coding frame, prior theoretical questions or commitments (Braun & Clarke, 2006). The focus of the analysis was on the semantic (explicit) level content of the data.

All researchers read the transcripts and the submission data independently, and undertook initial coding. Data from the key informants and GLBTI individuals was coded separately. The initial coding and provisional themes were reviewed and discussed by the researchers. Due to the congruence between coding and provisional themes developed from the key informant and GLBTI individuals' data sets, the two sources of data were combined at this point. The researchers undertook further refinement of the coding and analysis, until the salient patterns repeated across and within transcripts were identified and agreed on. Additional development of the themes was undertaken during the writing of the report.

Data extracts presented in this report have been slightly edited for ease of reading.

3 Literature review

3.1 Introduction

> *Historically, LGBTQ[11] people were considered mentally ill simply because they were not heterosexual or did not conform to gender norms (Clarke, et al., 2010, p.134).*

The state of research into mental health issues for GLBTI populations has been described in contrasting ways. Writing from a positivist or scientific framework, Kurtzman and Omoto (2006) note "the emergence of an impressive body of rigorous empirical knowledge" (p.3), while Clarke et al. (2010), with a more critical view of the field, highlight that "what is known about the mental health of LGBTQ people is limited, and mainly relies on a patchy collection of studies using self-report data from samples that largely comprise of white, middle-class, US lesbians and gay men" (pp.136-137). Such tensions underpin and inform this evidence review.

A feature of the published literature is a predominance of research about mental health in relation to sexual identities, rather than gender identities or body diversity. Therefore, research reports are mainly concerned with gay, lesbian and bisexual (in various combinations) issues, and less frequently report on gay, lesbian, bisexual and trans, or gay, lesbian, bisexual, trans and queer, issues, and almost never report on GLBTI. While we have located and reported on research relating specifically to trans people, this is somewhat limited. Published research on intersex people is even more limited.

Research investigating mental health issues for gay, lesbian and bisexual people is uneven in coverage – with mood disorders and alcohol use being the most dominant topics (Kurtzman & Omoto, 2006). Other topics that are increasingly being investigated include "eating disorders, body dysmorphic disorders, and conduct disorders, as well as the abuse of tobacco, methamphetamine, and injection drugs" (Kurtzman & Omoto, 2006, p.8).

Focus of this evidence review

This evidence review focuses on three aspects identified by our contract with Te Pou:

1. the mental health of GLBTI[12] populations
2. mental health prevention and promotion needs of GLBTI populations
3. best practice principles in mental health promotion and prevention service delivery for GLBTI populations.

3.2 Literature review methodology

Scope of the review

Published international reviews contained within relevant book chapters, reports and journal articles were included, along with published and unpublished primary reports and theses.

[11] In reporting the literature we have used the acronyms adopted by the study authors.
[12] Because of the lack of literature available about intersex people, in this review we use GLBT as the overall descriptor for the population of focus. I is used when we are referring to specific research about intersex people or are making a comment that specifically includes intersex.

Literature search strategy

Firstly, books and reports held by the research team that addressed the areas of interest were accessed. Secondly, a literature search was conducted to identify suitable reviews of the literature and all New Zealand-based research. The following databases were searched: SCOPUS, Medline, PsychInfo and CINAHL, using the terms and keywords gay/lesbian/bisexual/transgender/intersex/queer, in combination with mental health/psychology/psychological/psychiatry/psychiatric/alcohol/substance (ab)use/illicit drug(s)/mental health promotion/health service(s)/wellbeing. This literature was supplemented with research identified during the stakeholder consultation (key informant interviews and service provider surveys).

Considerations when reading this review

When interpreting this review the following considerations are necessary. The first relates to the different ways that the sexual orientation of non-heterosexual populations is measured in the research literature (Corboz, et al., 2008), as this is often done in diverse and imprecise ways (Cochran, 2001). We also know that identity and gender categories are fluid, e.g. trans may identify as heterosexual, or as lesbian, gay, bisexual or queer, or may refuse sexual categorisation, while intersex people also describe their sexual and gender identities in varied ways (Clarke, et al., 2010). The second issue relates to the inconsistent definitions of depression (and of other mental health issues) in the studies (Corboz, et al., 2008). A third consideration is that many "studies are underpowered, making it difficult to consistently detect differences" (Cochran, 2001, p.647) in mental health and mental illness between various population subgroups. Finally, there is limited New Zealand GLBTI mental health related research, with research focused on Māori and Pacific GLBTI people even more limited.

> Despite the many differences that separate them, LGB people share remarkably similar experiences related to prejudice, stigma, discrimination, rejection and violence directed towards them across cultures and locale…The social environment plays an important role in the health of LGBs. Prejudice affects the health of LGB people in many ways (Meyer, 2007, p.242).

Promoting and supporting mental wellbeing

Little is known about the effectiveness of mental health promotion initiatives specifically targeting GLBTI people. The evidence of effective mental health promotion in the general population is still emerging and while there is no consensus on what works best, there are recognised protective and risk factors that can be enhanced or reduced by interventions (Barry, et.al., 2005). Mental health promotion actions can include:

- strengthening individuals through interventions designed to increase social connections, build self-esteem and self-efficacy, life and coping skills, relationships and parenting skills;
- strengthening organisations to ensure inclusive, responsive, safe, supportive and sustainable environments for health, developing partnerships across sectors and implementing evidence-informed approaches to their work;
- strengthening communities to increase social participation, inclusion and cohesion, improve physical and social environments; implementing anti-bullying strategies in schools and workplaces, providing childcare and self-help networks, increasing citizenship and engagement and increasing awareness across sectors and communities of mental health and wellbeing issues;
- strengthening whole societies through a whole sector approach to reduce structural barriers to mental health through interventions designed to counter stigma and discrimination, reduce inequalities through facilitating access to education, employment, housing and support for more

vulnerable community members (ProMenPol Project European Commission, 2009; Keleher & Armstrong, 2005).

At a national policy level reducing inequalities, addressing the determinants of health and strengthening whanau ora are identified as a primary focus of mental health promotion action.

Mental wellbeing

Most of the published literature concerning the mental wellbeing of GLBT people has focused on mental health issues, negative events and stress. Although the current social and political environments continue to negatively impact on mental wellbeing, there is a small body of research suggesting that "aspects of a sexual minority identity may contribute to psychological health and wellbeing" (Riggle, Whitman, Olson, Rostosky, & Strong, 2008, p.210). Positive aspects identified in a study involving 203 gay men and 350 lesbians included: belonging to a community; creating families of choice; having strong connections with others; serving as positive role models; having personal insight and a sense of self; being authentic and honest; having empathy and compassion for others; promoting social justice and being active in advocating for gay and lesbian rights; and achieving more equality in relationships.

Only five per cent of participants reported there was nothing positive or negative about being a gay man or lesbian, and one per cent stated they did not believe there was anything positive about being a gay man or lesbian (Riggle, et al., 2008).

It is, however, readily acknowledged that the mental health of GLBT people is impacted by repeated exposure to a wide range of psychosocial stressors associated with anti-GLBT attitudes and behaviours, which include stigmatisation, discrimination and violence (Allen, 2010; Casey, 2009; Eady, Dobinson, & Ross, 2010; Willging, Salvador, & Kano, 2006). Experiencing these stressors is associated with increased mental health distress and suicidality (Friedman, 1999; Heubner, Rebchook, & Kegeles, 2004; Koh & Ross, 2006) and is often referred to as minority stress – the psychological stress derived from minority status and conditions within the social environment that may contribute to mental health problems (Allen, 2010; Brooks, 1981). According to Meyer (1995, p.38) "the concept is based on the premise that LGBT people, like members of other minority groups, are subjected to chronic stress related to their stigmatisation".

A cautionary note regarding the linking of mental health issues among GLB populations to their sexual orientation was provided by Volpp (2010): "remember that mental health issues in the heterosexual population are not attributed to the person's heterosexuality, even if the issues are manifested in sexual issues, feelings, or problematic behaviours. We should not a priori implicate someone's sexual orientation as the cause of these issues or problems" (p.46). Findings from a study conducted by Koh and Ross (2006) also suggested that sexual orientation, per se, does not result in mental health issues. Rather, various authors have suggested that the development of mental health issues appeared to be associated with experiencing social stress related to stigmatisation (Bos, van Balen, van den Boom, & Sandfort, 2004; Koh & Ross, 2006; Mays & Cochran, 2001).

There is a substantial body of evidence that has indicated higher rates of depression (Bakker, Sandfort, Vanwesenbeeck, van Lindert, & Westert, 2006; Cochran & Mays, 2000b; Cochran, Sullivan, & Mays, 2003; Kurtzman & Omoto, 2006; McNair, Kavanagh, Agius, & Tong, 2005; Tjepkema, 2008), anxiety (Bakker, et al., 2006; Johnson, Mimiaga, & Bradford, 2008; Tjepkema, 2008), and substance abuse (Burgard, Cochran, & Mays, 2005; Hatzenbuehler, Keyes, & Hasin, 2009; Jordan, 2000; Knox, Kippax, Crawford, Prestage, & Van de Ven, 1999; Pega, 2007; Trocki, Drabble, & Midanik, 2009) among GLBT people than in the general population.

There are also different patterns of the prevalence of mental health problems among lesbian, gay and bisexual people. For example, findings from a study conducted by Cochran and Mays (2009) indicated that, compared with heterosexual individuals, gay men and lesbians were significantly more likely to meet criteria for a major depression, generalised anxiety disorder and panic, but not for substance abuse-related problems. Bisexual individuals were also significantly more likely than heterosexuals to be diagnosed with major depression, generalised anxiety disorder, panic and alcohol dependency. In examining the mental health of bisexual individuals, Volpp (2010) stated: "if bisexuals are at higher risk than gays or lesbians for psychological and psychiatric distress, then lumping GLB together may artificially raise rates of mental disorders for gays and lesbians, in addition to hiding a population that may actually be in need of more study and clinical attention" (p.48).

A study conducted by Tjepkema (2008) included 346, 000 adults who self-identified as gay, lesbian or bisexual. Bisexual individuals reported more unmet mental health care needs than both heterosexual and gay or lesbian individuals. Bisexual men were more than twice as likely as heterosexual men to perceive their mental health as poor, and bisexual women were three times more likely than heterosexual women to experience poor mental health.

Much of the literature has suggested that these poor mental health outcomes may result from the social pressure and stress that bisexual individuals experience due to having a different sexual identity from the majority, as well as from not fitting into the traditionally accepted dichotomy of heterosexual or gay or lesbian identities (Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002).

Community surveys have indicated that lesbian women were three times as likely as women in the general community to experience poor mental health (McNair, et al., 2005; Meads, Buckley, & Sanderson, 2007). These authors also suggested that increased perceived stress, increased rates of lifetime abuse, and reduced social support play a role in contributing to mental health concerns.

GLB youth mental health research has indicated that this group have a similar risk as GLB adults for a variety of mental health and substance abuse problems (Crisp & McCave, 2007). Young people with emerging GLB identities face additional challenges (e.g. experiencing bullying, victimisation and isolation by peers), along with the multiple transitions and developmental changes associated with the period of adolescence (Bagley & D'Augelli, 2000). Higher rates of depression and suicidality among GLBT youth can be "typically understood in developmental terms, focusing on the problems of identity development during early adolescence (puberty)" (Nuttbrock, et al., 2010, p.21). GLBT youth have been found to experience elevated levels of emotional distress due to being verbally abused and physically beaten by family members, acquaintances, neighbours, strangers and police officers for not conforming to conventional gender role expectations. (Balsam, Beauchaine, Mickey, & Rothblum, 2005; D'Augelli, 2002; D'Augelli, Grossman, & Starks, 2006).

Older GLBT individuals have been referred to as an invisible population and there is limited research on the prevalence of mental illness and related treatment concerns for them (Shankle, Maxwell, Katzman, & Landers, 2003). Studies about gay, lesbian and bisexual older people have produced mixed results. One California study reported no significant differences in depression and social isolation among heterosexual and homosexual men and women (Dorfman, Walters, Burke, & Hardin, 1995). However, in contrast, another study explored mental health among 416 LGB adults aged 60 to 91 years old, and found male homosexuals and bisexuals to have significantly more internalised homophobia, alcohol abuse, and rates of suicidality related to their sexual orientation (D'Augelli, Grossman, Hershberger, & O'Connell, 2001). Research relating to older GLBTI and mental health is an undeveloped field in New Zealand.

There is a dearth of published research on the mental health of individuals with intersex conditions and the available literature provides mixed results. For example, Berebaum (2003) found no differences in mental health status between intersex and heterosexual individuals, whereas earlier research conducted by Coates and Spector Person (1985) showed children with intersex conditions presenting with separation

anxiety, depression, emotional and behavioural difficulties, learning difficulties and school refusal, and suicide attempts during adolescence. The most consistent evidence found is from a study of females with congenital adrenal hyperplasia, which reported that their mental health does not differ from those in a control group, even though they may have problems relating to body image and psychosexual function (Berenbaum, Korman Bryk, Duck, & Resnick, 2004).

Depression

Internationally, there is evidence that the prevalence of depression differs across dimensions of sexual orientation, and that patterns of risk differ for men and women, as well as for specific sexual minority groups.

Higher rates of depression in gay men have been reported in a number of studies (Cochran & Mays, 2000b; Cochran, et al., 2003). Another study found that gay men were between 4.5 and 7.6 times more likely to experience depression, compared to heterosexual men (Mills et al., 2004).

In their review, Corboz and colleagues (2008) noted that younger gay men appeared to be at "higher risk for 12-month prevalence of depression than their older counterparts" (p.36). However, there is limited literature relating to depression among different age groups within the gay population. Depression was also found to be the most prevalent presenting mental health concern among HIV-positive men who have sex with men (MSM) (93.6 per cent), with 21.4 per cent diagnosed with a major depressive disorder (Berg, Mimiaga, & Safren, 2004).

Lesbian and bisexual women are more likely than heterosexual women to have higher depression scores (McNair, et al., 2005). Likewise Tjepkema (2008) found mood disorders to be of higher prevalence for GLB , than heterosexual individuals, and particularly high among bisexual women. In this study, one in four GLB individuals reported at least one disability day in two weeks for mental and emotional reasons. A Dutch study, which included bisexual males (n=25), gay men (n=64), bisexual females (n=65) and lesbian women (n=79), also found that the number reporting an episode of at least two weeks' duration in the previous year of feeling very anxious or depressed was nearly three times higher than for heterosexual men and women (Bakker, et al., 2006). The same study reported no difference between heterosexual men and women and bisexual individuals.

Depression has consistently been found to be a major mental health issue for lesbians (Cochran & Mays, 1994; Cochran, et al., 2003; McNair, et al., 2005; Valanis et al., 2000). Higher rates of treatment of depression and of having made a suicide attempt have been reported among lesbians than among heterosexual women (Matthews, Hughes, Johnson, Razzano, & Cassidy, 2002). Another study found that lesbians were more likely to report depression and to use antidepressants than heterosexual women (Case et al., 2004). There is also some evidence suggesting that bisexual women report higher levels of depression, anxiety, suicidal ideation and self-harm, compared with both lesbians and heterosexual women (Jorm, et al., 2002; McNair, et al., 2005; Steele, Ross, Dobinson, Veldhuizen, & Tinmouth, 2009). New Zealand research findings from the Christchurch Health and Development Study (Fergusson, Horwood, Ridder, & Beautrais, 2005) also indicated higher rates of DSM-1V criteria for major depression (41.6 per cent) for lesbians, compared with heterosexual women (32.7 per cent).

Studies of transgender individuals presenting at gender clinics (Hepp, Kraemer, Schynder, Miller, & Delsignore, 2005) and community survey findings have observed levels of depressive disorders that are much higher than the general population (Clements-Nolle, Marx, Guzman, & Katz, 2001; Clements-Nolle, Marx, & Katz, 2006; Nuttbrock, et al., 2010; Nuttbrock, Rosenblum, & Blumenstein, 2002). The literature suggests that emotional distress in this population mainly reflects that transgender individuals live in an often hostile environment (Cole, Denny, Dyler, & Samons, 2000).

There is robust evidence that GLB youth experience higher rates of depression than heterosexual youth, which contribute to higher rates of suicide attempts and completions by GLB youth (Bos, Sandfort, de Bruyn, & Hakvoort, 2008; Galliher, Rostosky, & Hughes, 2004; Lemoire & Chen, 2005; Lipkin, 1999; Williams, Connolly, Debra Pepler, & Craig, 2005). In New Zealand, GLB youths were found to be at higher risk for major depression, generalised anxiety disorder and conduct disorders than were non-GLB youth (Fergusson, Horwood, & Beautrais, 1999; Fergusson, et al., 2005).

Lack of parental support has been identified as one factor that increases the risk of some mental health problems for GLB youth (Needham & Austin, 2010).

Anxiety

A number of studies have acknowledged that there is a higher prevalence of anxiety disorders for GLB people than for the heterosexual population (Bakker, et al., 2006; Tjepkema, 2008). Bakker and colleagues (2006) found experiencing an episode of feeling very anxious for at least two weeks in the previous year was nearly three times higher for gay and lesbian people than for heterosexual individuals. No difference was found between heterosexual and bisexual people. Anxiety has been associated with experiencing social stigma (Johnson, et al., 2008), and with lack of protective policies for LGB individuals (Hatzenbuehler, Keyes, & Hasin, 2009). Over half the lesbians in the Boston Lesbian Health Project 11 (49.5 per cent) reported a history of panic or anxiety attacks (Roberts, Grindel, Patsdaughter, Reardon, & Tarmina, 2004). Findings from a small New Zealand qualitative study involving gay Māori men indicated anxiety was associated with experiencing non-consensual sex (Aspin et al., 2009).

Suicide and self-harm

In a review of research on mental health issues for gay men and lesbians, Cochran (2001) found that, across studies, both groups were at a greater lifetime risk for major depression and suicide, especially during adolescence. Gay men were more at risk of suicide, whereas lesbians were more likely to report alcohol dependency. Other research has focused on suicide prevention and highlighted suicide risk factors that bisexual and gay male youth face, such as stressful life events, alcohol and drug use, the influence of which is mediated by personal resiliency factors (Fenaughty, 2000, 2004; Fenaughty & Harré, 2003).

Higher rates of suicide attempts and completions have been associated with higher rates of depression among GLB youth compared with heterosexual youth (Lemoire & Chen, 2005; Lipkin, 1999). Female youth with both-sex partners have been found to be at higher risk of suicidality than lesbian and heterosexual females (Udry & Chantala, 2002). Additionally, suicide rates have been found to be significantly higher among bisexual and lesbian youth than their heterosexual peers (Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Remafedi, French, Story, Resnick, & Blum, 1998). Berg and colleagues (2004) reported nearly one in six (16.1 per cent) of HIV-positive MSM experienced some form of suicidal ideation, with none reporting suicidal plans or means.

Coming out at a young age (early adolescence) has also been identified as a risk factor for attempted suicide among gay, lesbian and bisexual youths. Adolescents who come out at a younger age are likely to be more vulnerable to distress, due to difficulties with identity confusion, stigma, discrimination, bullying, and possible negative responses from family and peers, than are older adolescents who are likely to have more mature coping strategies (Hegna & Wichstrøm, 2007).

Lesbian and bisexual women have been found to experience higher rates of self-harm than heterosexual women. These women had "approximately twice the odds of feeling life was not worth living in the previous week (suicidality)" (McNair, et al., 2005, p.270). The authors stated that the reasons for high levels of suicidality were unclear. However, in other studies, sexuality-based discrimination appears to be associated with suicidality (Friedman, 1999; Millard, 1995; Remafedi, et al., 1998). A study conducted by

Warner and colleagues (2004) found more than half the bisexual women had considered suicide or attempted suicide. Rates were similar for lesbian women.

Findings from the Boston Lesbian Health Study 11 (Roberts, Reardon, et al., 2004) indicated that one-fifth (n=225, 19.5 per cent) of their lesbian sample reported having made a suicide attempt and, of these, almost two-thirds (n=146) reported their first suicide attempt occurring at age 18 or younger. Drug overdose was the most common method listed for attempted suicide (N=109, 48.9 per cent).

A study involving 181 transgender individuals found almost half (47 per cent) had considered or attempted suicide in the past three years (Bockting, Knudsen, & Goldberg, 2007). While little is known about the prevalence of self-harm among transgender individuals, therapists have reported seeing numerous clients seeking care for self-injurious behaviour (Gapka & Raj, 2004). Experiencing social stigma is also associated with suicidal behaviour among GLB people (Meyer, 2007).

It is only within the past 10 or so years that a link between sexuality and suicide has been acknowledged in New Zealand, when researchers with the Christchurch Health and Development Study[13] determined that non-heterosexual populations are an at-risk population for suicide and mental health problems (Fergusson, et al., 1999; Fergusson, et al., 2005). Predominantly homosexual males were found to have an overall rate of mental health problems over five times the rate for exclusively heterosexual males, including suicide attempts (28.6 per cent and 1.6 per cent respectively) and suicide ideation (71.4 per cent and 10.9 per cent) (Fergusson, et al., 2005). Findings from the Dunedin Multidisciplinary Health and Development Study[14] also confirmed a link between sexual orientation and self-harm, suicide ideation and attempted suicide (Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003).

Substance misuse

Another focus in the mental health literature has been substance misuse. Making use of unanalysed data collected in a nationwide Ministry of Health survey, Pega (2007) found that gay men had higher levels of alcohol and drug use than men in general. Recent reviews of the international and (limited) local literature in respect of alcohol use have been undertaken (Adams, 2010; Adams, McCreanor, & Braun, 2007; Pega, 2007; Pega & MacEwan, 2010b). In the context of research on gay men's health, alcohol (and other drug use) is often discussed in relation to its role in HIV infection, and is specifically linked to unsafe and risky sex – principally unprotected anal intercourse (McInnes, Hurley, Prestage, & Hendry, 2001; Slavin, 2001). Although it has been claimed that the "association between alcohol and unsafe sex among MSM is well-established in the literature" (Saxton, Dickson, & Hughes, 2006, p. 85), elsewhere it has been suggested that the relationship is not unequivocal (Adams, 2010). While numerous studies have reported an association between drinking and sexual risk behaviour in the general community (Maisto et al., 2004), the relationship between alcohol and unsafe sex has remained a contested and complex issue for gay men (Stall & Purcell, 2000; Stall & Hays, 2000).

Lesbians have been found to use alcohol and cigarettes at rates higher than the general population (Hatzenbuehler, et al., 2009; Meads, et al., 2007). Research has indicated that bisexual women have higher rates of substance abuse than lesbian and heterosexual women (Burgard, Cochran, & Mays, 2005).

There appears to be little understanding of why this population is more at risk of substance abuse than their heterosexual counterparts (Case, et al., 2004; Cochran, Keenan, Schober, & Mays, 2000; Cochran & Mays, 2000a; Gruskin, Hart, Gordon, & Ackerson, 2001; Hughes, Szalacha, & McNair, 2010; Valanis, et

[13] A longitudinal study, which has "followed the health, education, and life progress of a group of 1,265 children born in the Christchurch (New Zealand) urban region during mid 1977". (University of Otago, n.d., para. 1).
[14] This longitudinal study has followed 1037 babies born in Dunedin, New Zealand between 1 April 1972 and 31 March 1973 (University of Otago, 2005).

al., 2000). Explanations for increased heavy alcohol use and abuse in lesbians suggested by Hughes and Wilsnack (1997) are: lesbians are more likely to socialise in bars; they may be at risk of partner violence and have a past history of childhood sexual abuse, both of which are related to heavy drinking; stress related to discrimination; and being more likely to drink due to experiencing anxiety and depression.

Several studies have highlighted that lesbians are more likely to drink, and to drink more heavily, than heterosexual comparison groups (Case, et al., 2004; Cochran, et al., 2000; Gruskin, et al., 2001; Roberts, Reardon, et al., 2004; Valanis, et al., 2000).Findings from a study conducted in Boston (Roberts, Grindel, et al., 2004) indicated that 126 (11.1 per cent) of lesbian respondents reported having problem with alcoholism, and 121 (10.6 per cent) reported that they did not drink, but were in recovery from alcoholism. One-third of these (n=41) reported their problems with alcoholism began at the age of 18 years or under.

Research findings have indicated that GLB adolescents and young adults engage in more drug and alcohol use than their heterosexual peers (Jordan, 2000; Rosario, Hunter, & Gwadz, 1997; Rosario, Schrimshaw, & Hunter, 2006). Possible explanations for this higher drug and alcohol use again relate to minority stress factors (Jordan, 2000).

Some research on alcohol use by trans people has suggested alcohol abuse may be an issue for this group (Beatty, Madl-Young, & Bostwick, 1998; Lawrence, 2007; Lombardi & van Servellen, 2000). However, robust current evidence on this is scarce and a few older studies are often cited. For example, a study of intake records at the Gender Identity Project in New York noted that 27.1 per cent of trans people reported alcohol abuse (Valentine, 1998, in Beatty, et al., 1998). Possible explanations for the high prevalence of alcohol abuse by trans people may include the greater stigma, violence and marginalisation experienced by them (Hughes & Eliason, 2002).

Illicit drug use

Much of the research on illicit drug use has focused on gay men. In the US it has been reported that gay men are significantly higher users of marijuana than heterosexual men (Trocki, Drabble, & Midanik, 2009), while Australian research has reported that 53 per cent of gay and homosexually active men used drugs, compared with 17 per cent for the general population (Knox, Kippax, Crawford, Prestage, & Van de Ven, 1999). Pega's (2007) study found that those who identified as LGB "were more than twice as likely to have used marijuana over the last year as heterosexual survey respondents; nearly four times as likely to have used amphetamines on a regular basis in the previous 12 months; more than four times as likely to have used LSD over the last year; and more than three times as likely to have regularly used ecstasy over the previous year" (p.38). Berg and associates (2004) found more than half of their sample of HIV-positive MSM (58.9 per cent) reported a history of substance abuse problems in their lifetime, with 42.4 per cent using marijuana and 30.3 per cent using cocaine. Injecting drug use was not reported by any HIV-positive MSM.

Similar levels of drug use have been found among Auckland men who have sex with men: 57 per cent of respondents reported using a recreational drug over the past six months, with 27.8 per cent having frequently used at least one recreational drug (Saxton, et al., 2006). The positioning of drug use as normalised in gay culture is paralleled in Australian research, which has explored a normalised gay drug taking culture (see, for example, Dowsett, Keys, & Wain, 2005; Ireland et al., 1999; Slavin, 2004a, 2004b; Southgate & Hopwood, 2001).

Hughes and colleagues (2010) compared rates of substance use (alcohol, marijuana and other illicit drugs) and potential predictors of mental health distress, such as depression, anxiety, perceived stress, and lower levels of social support across sexual identity groups. Compared with exclusively heterosexual women,

sexual minority women reported significantly higher levels of substance use. Findings indicated stress was a significant predictor of substance use.

Research about drug use among trans women in the US reports that alcohol, cocaine and methamphetamines were the most commonly used drugs (Reback & Lombardi, 1999 in Lombardi & van Servellen, 2000).

However, these "traditional substances of abuse are not the only potential health risks faced by transgendered individuals. Injectable hormones and silicone can pose problems for transgendered individuals in much the same way steroid use can" (Lombardi & van Servellen, 2000, p.293). While hormones should be prescribed by a doctor, it is noted that for a variety of reasons (e.g. cost, healthcare practitioners not sensitive to needs) some trans people access hormones from underground sources.

Eating disorders and body image

One-fifth of the lesbians in the Boston Lesbian Health Project 11 reported they had an eating disorder, and almost twice as many reported that their problem was overeating, rather than anorexia or bulimia

(Roberts, Reardon, et al., 2004). These rates were consistent with rates of eating disorders reported in other studies (French, Story, Remafedi, Resnick, & Blum, 1996; Share & Mintz, 2002). In relation to gay men, studies have shown that they are more vulnerable to the development of body image concerns and eating disorders than their heterosexual counterparts (Boroughs & Thompson, 2002; Russell & Keel, 2002; Siever, 1994; Yelland & Tiggemann, 2003). Explanations for this vulnerability include the notion that "the gay ideal does involve being both thin and muscular, and that gay men actively engage in behaviours aimed at achieving this ideal" (Yelland & Tiggemann, 2003, p.114).

In summary, it is clear that GLBT individuals experience depression, anxiety, and suicidal behaviour at rates higher than heterosexual individuals, and studies have reported even higher rates for bisexual individuals. The most commonly reported explanations for health disparities among GLBT people are those related to social stress. Theorists suggesting that adverse social conditions and stigmatisation of their identity can lead to mental health distress in disadvantaged social groups (Mays & Cochran, 2001; Meyer, 2003). The literature has also suggested that bisexual individuals experience social pressure due to having a different sexual identity from the majority, as well as not fitting into the traditionally accepted dichotomy of heterosexual or gay/lesbian identities (Jorm, et al., 2002). Lack of protective policies has also been highlighted as impacting on the mental health of LGB people (Hatzenbuehler, et al., 2009).

3.3 Mental health promotion and prevention needs of GLBTI populations

While GLBTI individuals have the same basic mental health prevention and promotion needs as members of the general population, they also have additional unique issues that are related to social discrimination, personal and community social and behavioural risk factors, and certain unique medical conditions (Johnson, et al., 2008). In promoting and supporting the mental health of GLBTI individuals, the following needs have been identified in the literature and are discussed below: having a sense of belonging and connection; being supported with the coming out process; ensuring safe settings and environments; being able to access socially and culturally appropriate mental health services and support; and being able to interact with affirming and respectful mental health professionals who are educated about GLBTI communities (Corboz, et al., 2008; Rankine, 2008).

Sense of belonging and connection

Having strong connections with others is a critical protective factor for positive mental health (Eisenberg & Resnick, 2006). Strong social networks have been linked to enhanced meaning in life and physical health (Ebin & Van Wagenen, 2006).

Various authors have suggested that belonging to a community with the commonality of experiences of being LG, creating families of choice (current partners, former partners, friends – both from the LG community and supportive straight allies) provides support and acceptance, particularly if rejection by family members is experienced (Riggle, et al., 2008). Feeling supported by and connected to the general and GLB communities has been confirmed as a protective factor for better mental and emotional wellbeing outcomes, compared with those individuals who are not well connected with, or disconnected from, their community (McLaren, 2006; McLaren, Jude, & McLachlan, 2007, 2008). It has also been suggested that belonging to a community provides GLBT people with the solidarity and strength needed to cope with minority stress (Meyer, 2003). Being able to meet other gay people and access peer support groups has also been linked to the development of a sense of identity and acceptance of sexual identity (Casey, 2009).

Little is known about the epidemiology of GLBTI mental health issues among marginalised ethnic and cultural groups. The term "double jeopardy" has been used to describe the marginalisation that GL people experience within their ethnic and cultural communities, due to their GL identification and the stigma and exclusion experienced within these communities as a result of "white ethnocentricity" (Greene, 1997). These experiences can contribute to a lack of connection and belonging in either community, which is associated with feelings of isolation and increased mental health distress (Clarke, et al., 2010).

One area of research in New Zealand addressing ethnicity and sexuality has focused on takātapui tane[15]. Research amongst gay men has shown that Māori are less likely to be attached to the gay community than non-Māori men (Aspin et al., 1998) and that while sexual identity is important for Māori, "culture plays a more important role for Māori than it does for tauiwi[16] in both their decisions about their sexual identity and in the balance of their lives" (Henrickson, 2006, p.259). Findings such as these suggest that "takātapui men have a strong sense of not only their cultural identity but also of their sexual identity" (Aspin, 2005, p.9). In relation to health, a previous needs assessment highlighted that these men faced discrimination, and that both mainstream and Māori specific services were not meeting the health needs of Māori gay men. This was found to have a negative impact on their health and wellbeing (Herewini & Sheridan, 1994).

More recent research and theorising, however, has addressed the role of attachment to cultural identity, and shown that this can be protective against a range of health issues (Aspin, 2000, 2002; Aspin & Hutchings, 2007) and how "being Māori brings with it a range of factors that can be harnessed to shore up men's resilience" (Aspin, Reynolds, Lehavot, & Taiapa, 2009, p.45). As discussed above, these types of strong connections are likely to be protective factors for positive mental health.

[15] Takatāpui is widely used to refer to an intimate companion of the same sex, and can be used to describe Māori gay, lesbian, bisexual, and trans people (Human Rights Commission, 2008). Using takatāpui in conjunction with tāne "renders the phrase specific to men" (Fenaughty et al., 2006, p.15). Takatāpui incorporates sexual and cultural dimensions (Aspin & Hutchings, 2006) and means something more than the word 'gay' (Aspin, 2002; Herewini & Sheridan, 1994).

[16] A Māori term for non-Māori (McCreanor & Nairn, 2002).

Coming out

Coming out is a lifelong process due to the heteronormative nature of the society in which GLB individuals live (Rendle-Short, 2005; Valentine, 1998). It is a particularly challenging process for GLB young people who may not have family and community support to develop their social identity (D'Augelli, 2002). In recent New Zealand research, Rankine (2008) found that 107 of 134 (80 per cent) survey participants expressed their need for "coming out groups and services" (p.39). For youth, an important part of the coming out process was finding a social network of other GLB youth (Hegna & Wichstrøm, 2007).

Disclosing sexual identity may be a protective factor for mental health particularly if this is in the context of being connected to the GLB community (Oetjen & Rothblum, 2000). Eisenberg and Resnick (2006) suggested "improving the ability of parents and other influential adults to connect with and support adolescents grappling with issues of sexual identity may be a critical component of mental health promotion and protection for young people" (p.667).

Transitioning

Transitioning is the process of changing genders to match "an inner conviction of a gender identity which is at odds with the primary and secondary sexual characteristics of the body, the sexual hormones and the subsequent social role of the individual" (West, 2004, p.4). Before a trans person is able to be referred to appropriate secondary health services (e.g. a hormone specialist) a diagnosis of gender identity disorder[17] is usually required (Human Rights Commission, 2008). In New Zealand and internationally, some trans people reject the diagnoses in the Diagnostic Statistical Manual of Mental Disorders (DSM IV) and the implications of a mental illness (Human Rights Commission, 2008; Lawrence, 2007).

Transitioning is a challenging process, often involving high levels of stress (Human Rights Commission, 2008). This is not in itself evidence of mental illness. However, the "impact of gender identity disorder on mental health and emotional wellbeing is well recognised and people need access to therapeutic support" (Human Rights Commission, 2008, p.59). The process requires a clear holistic treatment pathway encompassing spiritual, social, physical and psychological dimensions of change (Human Rights Commission, 2008; West, 2004).

The experiences of trans people in New Zealand seeking services related to transitioning has been documented in the report of the inquiry into discrimination experienced by trans people (Human Rights Commission, 2008). The report concluded that there were access difficulties to both general health services and to the services required to transition.

Intersex issues

As noted, the literature on intersex and mental health issues is very sparse, with much of the literature focusing around issues related to surgery on infants (e.g. Australian Human Rights Commission, 2009; Human Rights Commission, 2008).

One issue raised at the New Zealand inquiry into discrimination experienced by trans people concerned the effect of discrimination on intersex people and their families (Human Rights Commission, 2008). This was often exacerbated by secrecy and shame. More support for parents and families was identified as needed, as was the need to be treated with dignity and respect when seeking medical support.

[17] Gender identity disorder is classified as a mental illness in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (American Psychiatric Association, 2000).

Safe social settings and environments

As with the general population, the social settings and environments, in which GLBTI people live their lives have the potential to promote, support and protect their mental, emotional and social wellbeing (Bos, et al., 2008; Joubert & Raeburn, 1998). These settings – schools, workplaces, families and communities – are amenable to change, and as such are appropriate targets for mental health promotion and prevention initiatives that address challenges related to sexual orientation, such as family conflict and rejection, discrimination, victimisation, bullying and violence (Eisenberg & Resnick, 2006).

For many young people, their GLBT identity development begins during their school years and, for some, at an early age (Nesmith, Burton, & Cosgrove, 1999).

A considerable body of research indicates that young GLBT people experience bullying, victimisation, and harassment in and around schools (Athanases & Larrabee, 2003; Lasser & Tharinger, 2003; Rossen, Lucassen, Denny, & Robinson, 2009; Szalacha, 2003; Warwick, Aggelton, & Douglas, 2001; Little, 2001). Particular difficulties for young trans people in New Zealand schools have been noted. In particular, "barriers to education and participation in school life in relation to the appropriate name on school records, school uniforms, participation in sports, and safety" (Human Rights Commission, 2008, p.29) have been reported. According to Bass and Kaufman (1996, p.216), "when schools are at their best, all students are treated with respect and are provided with a high quality education that will help them fulfil their potential and contribute to society... But because schools mirror the problems in larger society, this is not always the case".

Homophobia and heterosexism have been identified as particularly challenging for young GLBT people and influence their ability to be 'out' in the schools setting, mostly due to fear of rejection from peers (Little, 2001). School-based initiatives in the United States, located in California, Massachusetts and Washington, have broken important ground in reducing harassment and responding to the needs of GLBT youth, and the programmes are supported by ethical and legal provisions in relation to human rights (Henning-Stout, James, & Macintosh, 2000). New Zealand schools are also legally required to provide, under National Administration Guideline 5, a safe physical and emotional environment for students, and to comply in full with any legislation currently in force or that may be developed to ensure the safety of students and employees (Ministry of Education, 2010).

Evidence also suggests that bisexual individuals may experience less safety and support within their social settings than both heterosexuals and homosexuals, and this could be a contributing factor to poorer mental health outcomes reported in the literature (Jorm, et al., 2002; McNair, et al., 2005).

Access to mental health services and support

It is well documented that GLBTI people are an invisible minority in mental health service provision, and face structural, financial, personal and cultural barriers when attempting to access mental health services (Clover, 2006; Jillson, 2002). The literature reviewed signals an often torturous journey for GLBTI individuals in accessing appropriate mental health care.

One example of this journey is described by Eady and colleagues (2010) in relation to the experiences of bisexual individuals with mental health services in Ontario, Canada. Negative experiences included: providers who made negative judgements about individuals' bisexual identity or attractions; the dismissal of bisexuality, and practitioners referring to bisexuality as a transitional stage or not a valid sexual orientation; practitioners pathologising bisexuality and explicitly associating individuals' mental health concerns with their sexual identity; and practitioners asking intrusive or excessive questions about individuals' bisexual identity and sexual practices.

These negative encounters with mental health providers have led to some bisexual people ending their relationship with providers, as Eady and colleagues (2010) report, which could lead to mental health needs being unmet, relative to people with other sexual orientations. Positive experiences related to practitioners being open-minded, asking open-ended questions, and reacting in a neutral or positive way to disclosure of bisexual identity. Bisexual individuals reported positive experiences with providers who made the effort to educate themselves about bisexuality, outside of their time with their client.

GLBT population groups can experience health disparities relating to access and utilisation of health programmes and services (Johnson, et al., 2008). A study of 1,110 LGB people in Ireland reported key issues in mental health service provision that related to: exclusion of those with serious mental illness; sexuality not being addressed; lack of knowledge and poor attitudes of staff; peer intolerance; and lack of information about LGB community resources (Clover, 2006; Luckstead, 2004). Cost has also been identified as a factor that limits access to services.

Research on mental health service utilisation in Boston has documented a high rate of use by lesbians (Roberts, Grindel, Patsdaughter, DeMarco, & Tarmina, 2004). Several studies have reported significantly higher therapy use by lesbian than by heterosexual women (Cochran & Mays, 2000b; Matthews, et al., 2002). Another study found that 80 per cent of lesbian respondents had received therapy (Sorensen & Roberts, 1997). The majority of this sample reported positive experiences with therapists, with GLB therapists being rated more highly than heterosexual therapists. The health care experiences of LQ women have been described as exposing the "double bind" that they are confronted with as they enter a service. Do they remain silent or come out to service providers? (Daley, 2010). Van Dam and colleagues (2001, in Daley, 2010) reported that 36 per cent of lesbian women, compared to 2.7 per cent of heterosexual women, delayed care because of concerns about the responses of heath care providers to the disclosure of sexual identity. Developing a sense of identity, acceptance of sexual identity, and access to support groups, resources and opportunities to meet other GLBTI people have been identified as important mental health needs to be met (Casey, 2009).

Participants in Daley's (2010) Canadian study indicated that the negation and dismissal of LQ sexuality as an identity may compromise the recovery process, despite women's participation in mental health services; that non-disclosure may be implicated in a closing off or compartmentalisation of concerns by LQ women, and therefore may impact on women's relationships with service providers; and that self-disclosure broadens service providers understandings of potential sources of stress and support for LQ women (p.350). Lesbian women's concerns regarding disclosing sexual orientation to health care providers (Eliason & Schope, 2001), and perceptions that providers may not understand their needs (Austin & Irwin, 2010; Bonvicini & Perlin, 2002), have been attributed to delayed seeking of care.
Provider ignorance about transgender care, insensitivity to transgender needs and discrimination have also been identified as barriers to health care (Shipherd, Green, & Abramovitz, 2010).

Furthermore, issues unique to rural settings, such as geographical isolation, confidentiality concerns, affordability and barriers within heterosexually oriented services, have been identified as challenges to rural GLBTI people being able to access mental health services appropriate to their needs (Willging, et al., 2006).

Barriers to mental health services for New Zealand trans people, particularly in the context of transitioning or obtaining a diagnosis of gender identity disorder, have been identified (Human Rights Commission, 2008). For some trans with experiences of mental illness, their gender issues were dismissed as being a symptom of a mental health condition.

Others reported that access to a mental health professional, to undertake an assessment required so other services could be accessed, has been lengthy or refused, as the assessment service was not available in the public health system. This lack of service meant many trans people were required to privately fund their

own assessments. In a report on the health and wellbeing of trans people in New Zealand and Australia, the scarcity of health services for trans people in the public system and long waiting times were also noted (Couch et al., 2007). Around one quarter of the Australian respondents in this research had used private health insurance for a gender-related matter.

Interactions with GPs and mental health professionals

Although the literature often discusses the role of therapists and mental health professionals, there is much less discussion in relation to GLBTI people's use of doctors (GPs) for mental health issues. In New Zealand, it is likely that GPs provide the management of the mental health issues of a large proportion of GLBTI people. Referrals within the public mental health system are largely controlled by GPs, and are made only if the GP feels that specialist expertise is required and the individual "is in a really bad crisis" (Mental Health Commission, 2009, para. 1). Other access points to public mental health services are through hospital emergency departments, the police, or community-based mental health crisis or emergency teams (Mental Health Commission, 2009). Responsibility for managing mild to moderate mental health problems has traditionally rested within primary care, and the growing importance of this role is apparent[18]. Limited funding has been available over the last few years through primary health organisations (PHOs) for GPs to refer patients to primary mental health services which include low cost or free counselling for depression and other common mental health problems. In addition to these, are private psychiatric or psychological services.

The general literature on the role of GPs and healthcare provision for GLB people suggests some limitations in accessing GPs for mental healthcare services. New Zealand survey research of GLB people shows healthcare providers routinely assume their GLB patients are heterosexual (83.2 per cent – women; 65.8 per cent – men) and just over a third (39.5 per cent – women; 35.3 per cent – men) have not disclosed their sexuality to their health care providers (Neville & Henrickson, 2006). Many gay men do not disclose their sexuality or sexual practices to their doctors, which runs against best practice that a doctor needs to know the sexuality or at least sexual practice of patients in order to provide optimal care (Australian Medical Association, 2002; Baber & Dayan, 2006; Gee, 2006; Meckler, Elliott, Kanouse, Beals, & Schuster, 2006; Russell, 2004; Stone, 1997). While some gay men have reported they deliberately withhold disclosure of sexuality, others have reported "waiting for an opportunity to disclose their sexuality" (Adams, McCreanor, & Braun, 2008, p.17).

Saphira and Glover's (2001) New Zealand study explored how open or out lesbians were about their sexual orientation, in relation to sexual behaviour, self-assessed health status, relationships and use of health services. Findings indicated that lesbians who were not open to their doctors were more likely to delay seeking their help.

The authors suggested that "more education on gay and lesbian issues for all professionals may address these factors and may also decrease lesbians' anxiety around choosing professionals, making it easier for lesbians to come out" (Saphira & Glover, 2001, p.193).

Cochran (2001) argued that lesbians' need for therapy has been generated by social stigma and victimisation. The majority of lesbians in the Boston Lesbian Health Project 11 (Roberts, Reardon, et al., 2004) reported feeling more comfortable with female and especially lesbian therapists. One common question raised in the literature is whether therapists need to have an LGB identity to be effective with LGB clients. While some researchers have found LGB clients to have a preference for an LGB therapist (Kaufman et al., 1997; Liddle, 1997), other research indicates that a therapist does not have to be LGB to

[18] Mental Health and Addiction Service Workforce Review Working Group. July 2011. MH&A Workforce Service Review (Phase 1Report). Health Workforce New Zealand. Unpublished report.

be effective (Jones & Gabriel, 1999). Therapists who, regardless of their sexual orientation, held LGB affirming views, understood the LGB experience, disclosed experiences of working with the LGB community, normalised homosexuality, and allowed clients to explore their sexuality and relationships were rated as effective by LGB clients (Lebolt, 1999).

Attitudes and behaviours of a therapist who lacks awareness of LGB issues include: overemphasis on the individual's sexual identity; failure to recognise the individual may not be heterosexual; and use of heterocentric language. Clients who experienced this lack of awareness were more likely to terminate therapy (Burckell & Goldfried, 2006). Three essential therapist characteristics were identified in this research: LGB specific knowledge; LGB affirming practice; and the development of a therapeutic alliance, a relationship quality that is consistently rated as one of the most significant factors contributing to successful outcomes for clients (Martin, Garske, & Davis, 2000).

While some trans people in New Zealand reported positive experiences with healthcare professionals, many others have reported poor service (Human Rights Commission, 2008). Discrimination and marginalisation were reported as pervading the experiences of trans people, including reports of health professionals deliberately refusing to use the gender pronoun that the trans person had indicted was appropriate. Some trans people reported that they "were often afraid to seek medical help, even for minor matters" (Human Rights Commission, 2008, p.51). In other research, the "respondents' worst experiences of health services usually involved encounters where they were met with hostility and not treated respectfully" (Couch, et al., 2007, p.7).

3.4 Best practice principles in mental health promotion and prevention service delivery for GLBTI populations

Best practice can be thought of as incorporating action at structural (social) and individual levels.

Social-level best practice

The literature clearly identifies homophobia, transphobia and heterosexism as pervasive attitudes and behaviours impacting on the mental health of GLBTI individuals. Such attitudes point to a burden of poor mental health that could be preventable in their absence (Espelage, Aragon, Birkett, & Koenig, 2008; Harper & Schneider, 2003; Kelleher, 2009). According to Corboz and colleagues (2008), an effective response to addressing depression for non-heterosexual people would be to introduce initiatives that address homophobia and discrimination in the general community, and create a more level platform for heterosexual and non-heterosexual populations.

This raises the question of how, from a public health perspective, a more supportive social environment can be facilitated.

Ross and colleagues (2010), in relation to bisexual individuals, suggested that "sexual health education presenting bisexuality as a legitimate and healthy identity would both address the invisibility of bisexuality, public health agencies could include healthy images of bisexuality in antidiscrimination public education campaigns" (p.501).

Societal-level principles recommended in a systematic review conducted by McNair and Hegarty (2010) related to equity and human rights, the importance of antidiscrimination policy including sexual orientation, awareness of the LGB population, awareness of multiple minority status, and socioeconomic status and ethnicity.

Others have recommended the need for supportive policies that ensure education and advocacy at a number of levels to reduce prejudice and discrimination, including the need for policies that advocate for the development of safe and supportive workplaces and communities (Roberts, Reardon, et al., 2004).

One area that has been discussed in the New Zealand policy context is suicide and GLB. Fenaughty (2000) argued that, "L/B/G youth suicide prevention requires efforts to reduce risk and increase resiliency factors" (2000, p.ii, emphasis in original). The need for a government strategy to address GLB needs has also been acknowledged: "All of these considerations suggest the need for this strategy to recognise the increased risks faced by GLB young people and to devise policies addressed to meet the needs of this group" (Associate Minister of Health, 2006, p.22).

Individual-level best practice

McNair and Hegarty (2010) have identified individual-level best practice principles in mental health promotion and prevention service delivery for GLB people. These included: ensuring an inclusive service environment; respectful health professional–client communication (e.g. inclusive language, open questions, affirming attitude); special knowledge for cultural awareness (e.g. impact of discrimination on health, same sex relationships, referral agencies, networks); and education and training for all staff, including receptionists. Other best practice principles identified in the literature include: strengths and assets-based interventions (Gamache & Lazear, 2009; Riggle, et al., 2008); and affirmative practice (Crisp & McCave, 2007; Higgins & Allen, 2010; Riggle, et al., 2008). Best practice principles for working with GLB youth have also been given specific attention in the literature (Crisp & McCave, 2007). These principles are described more fully below.

An inclusive service environment

To create a welcoming and inclusive service environment, displays of media, brochures and non-discriminatory policy, which are inclusive of sexual orientation and gender identity or expression in a multi-cultural context, are recommended (Johnson, et al., 2008). In relation to health service provision, Irwin (2007) signalled the need for health professionals to be educated about sexual orientation and homophobia, as well as about embracing diversity and providing an open, respectful environment. The environment should reflect inclusive language and portray materials that encompass both identity issues and sexual behaviours. This could be achieved, for example, by mentioning the terms bisexual and bi-curious in discussion, as an alternative to gay or lesbian, and using the same labels in advertising and outreach. Another example would be having bisexual specific materials and having non-specific materials for those who may not identify as bisexual (Bonvicini & Perlin, 2002; Ebin & Van Wagenen, 2006).

Various authors have highlighted concerns in relation to meeting the general health care needs, including mental health, of an increasing older adult population, which inevitably includes an increase in numbers of LGBTI people requiring appropriate health care support (Neville & Alpass, 2006). For example, this is especially so for so called gay "baby boomers" who have increased risks for mental health distress, due to experiencing the loss of friends and social supports as a result of the AIDS epidemic (Jones, 2001). Findings from Neville and Hendrickson's (2010) New Zealand study indicated that LGB people reported a preference for a LGB-friendly retirement or residential care facility to ensure they received care that was "cognisant of their sexual orientation" (p.591).

An inclusive aged care environment for LGB will include nurses who are aware of the "sociocultural aspects of living life as an older LGB person" (p.592) to ensure that older LGB people experience safety and comfort in their interactions with staff.

Strengths and assets-based practice

Various researchers have cautioned that the deficit and problem-focused portrayal of GLBT people in the literature serves to pathologise sexual orientation and gender identity as causing negative outcomes (Bakker & Cavender, 2003; Harper & Schneider, 2003; Meyer, 2003).

Theoretical underpinnings of strengths and assets-based approaches are resiliency theory 19 (Masten & Powell, 2003), community-focused cultural competency 20 (Hernandez & Nesman, 2006), organisation-focused cultural competency 21 (Hernandez & Nesman, 2006), and rethinking interventions to incorporate both individual and community behaviour change expectations (Gamache & Lazear, 2009). Rather than exclusive GLBT services, Gamache and Lazear (2009) suggested that responsive, inclusionary asset-based approaches need to be infused into existing systems of care and professional training.

The literature calls for a raised awareness of GLBT issues among service providers and recommends ways of working with GLBTI that include: being a positive voice; helping GLBT people to effectively access and use their strengths; exploring positive attributes of functioning and coping; and helping GLBT people imagine and realise lives of meaning and connectedness (Kulkin, 2006; Riggle, et al., 2008). In addition, a strengths and assets-based way of working challenges a powerful discourse of neutrality or one-size-fits-all approach to service delivery.

Affirmative practice

In keeping with strengths and assets-based approaches, affirmative practice within services and therapeutic environments is considered a culturally sensitive model for working with GLB individuals (Davis, 1996 cited in Crisp & McCave, 2007; Langdridge, 2007; Riggle, et al., 2008). According to Landgridge (2007):

> *…gay affirmative therapy (GAT) has recently emerged in an attempt to rectify previously discriminatory psychotherapeutic practices with lesbians, bisexuals and gay men. GAT aims to achieve this by providing a framework for practice which is affirmative of lesbian, gay and bisexual identities (p.27).*

Affirmative practice positions GLB identities as equally positive experiences to heterosexual identity and adopts the following principles: considering the contexts and roles GLB people play in their environments; building on individual strengths; focusing on health, not pathology; examining homophobic influences; working to reduce feelings of stigma relating to difference; validating probable identities; recognising the reality of heterosexual oppression; and celebrating, advocating, validating and encouraging pride in identities (Crisp, 2006; Davis, 1996 cited in Crisp & McCave, 2007; Ritter & Terndrup, 2002).

Others have advocated for practitioners to work with GLB individuals to enable them to engage in creative and authentic living through assisting them to unpack their beliefs about gender and providing

[19] Resiliency theory supports an assets-based approach by: identifying qualities of individuals and support systems that can explain or predict success; describing the process of coping with stressful experiences; and creating experiences that assist with identity integration (Masten & Powell, 2003; Richardson, 2002).
[20] Community-focused cultural competency includes organisations and services working in partnership with the community to ensure that the services are compatible with the community they serve (Hernandez & Nesman, 2006).
[21] Organisation-focused cultural competency includes the way in which the service is accessible, available and used by the population served (Hernandez & Nesman, 2006).

them with the opportunity to see their gender as a positive aspect of themselves, which can assist them to contest negative messages (Riggle, et al., 2008).

Skills of affirmative, culturally competent practice with GLB youth identified by Crisp and McCave (2007) include: creating safe environments; assessing rather than assuming GLB sexual orientation; helping youth work through stages of the coming out process; determining how out a youth is and who supports their sexual orientation; treating the presenting challenge, not the youth's sexual orientation, and examining this in the context of their lives as both youth and GLB individuals; working with family members to accept GLB youth and working to address their feelings around sexuality; and referring youth to gay affirmative resources.

Inclusive language

The use of inclusive language is considered to be an important first step in building working relationships with GLB individuals seeking help from mental health services and professionals. Rather than asking "Are you married?", inclusive language, such as "Are you in a relationship right now?" is simple to use and can encourage a broader range of disclosures (Rosenberg, Rosenberg, Huygen, & Klein, 2005). Literature relating to youth suggests the use of appropriate language, such as gay, lesbian or bisexual, rather than homosexual, and gender neutral terms, such as partner, rather than boyfriend or girlfriend to avoid assuming heterosexuality (Crisp & McCave, 2007). These authors also suggest that practitioners need to be familiar with the terms that GLB youth use to describe their identity.

Health professionals' knowledge of GLBTI communities and resources

Health care professionals need specific teaching related to GLBTI issues and inequalities to ensure GLBTI individuals are treated with understanding, respect, sensitivity and confidentiality (Bonvicini & Perlin, 2002; Crisp & McCave, 2007). Clinical practice guidelines increasingly call for the inclusion of sexual orientation questions in all intake histories (Makadon, Mayer, Potter, & Goldhammer, 2008). Established guidelines for working with LGBT individuals note the need for therapists to interrogate their own LGBT feelings; not enter into therapeutic arrangements that imply that LGBTQ identities are pathological or undesirable; work to explore awareness of feelings, especially anger, amongst LGBTQ clients; encourage the development of an LGBTQ support network; support LGBTQ clients in engaging in consciousness-raising activities; encourage LGBTQ clients to develop their own value system, mindful of the risk of relying on society's systems for self-validation; work to lessen shame and guilt around LGBTQ thoughts and feelings; and use the weight of their authority to affirm LGBTQ thoughts and feelings (Langdridge, 2007).

While there is the conventional notion of matching queer staff with queer clients in public mental health services, Semp (2006) cautions that staff and clients are sometimes not able to disclose their homosexuality to each other, and that systematic and structural changes are needed to support staff to be able to routinely ask all clients about their sexuality.

In New Zealand, specific guidelines, in respect of counselling for alcohol and drug problems for GLB individuals, have been developed (Pega & MacEwan, 2010a). The guidelines include the following principles: accessing relevant knowledge for preventing and treating drug and alcohol problems; providing competent staff, some of whom would be of sexual minority status; exploring carefully and openly how sexual minority identity either positively or negatively impacts on the lives and drug and alcohol use of sexual minority individuals; assisting with the coming out process; and identifying support within families and social networks.

An implication for clinical practice and policy, highlighted by Steele and colleagues (2009) in relation to ensuring inclusive and appropriate health care for lesbian and bisexual women, is the need for GPs to

understand the relationship between discrimination and health status and health risk behaviours. Given that bisexual women have been identified as experiencing a high level of health challenges compared to others, it is important that interventions are inclusive of them.

Addressing sexual orientation

Important considerations when addressing sexual orientation include: not making an issue of sexual orientation when it is not relevant; not being afraid to deal with issues around sexual orientation when they were relevant (Liddle, 1996, in Eady et al., 2010); and having a good level of self-awareness and comfort with all sexualities (Casey, 2009).

In summary, the findings from this review highlight the significant role played by social and structural factors in determining the mental health of GLBTI people. There is convincing evidence that GLBT individuals experience higher levels of mental health distress than their heterosexual counterparts. Addressing the mental health promotion and prevention needs of GLBTI people requires both societal and individual approaches that are strengths- and assets-based, affirmative, inclusive, accessible and appropriate. With regard to mental health service provision, health professionals need to be well-trained in relation to GLBTI issues and inequalities, as well as working in a non-judgemental, respectful and sensitive manner.

4 Service stocktake

4.1 Introduction

This section reports on the results of the service stocktake. The purpose of the stocktake is to provide a description of services and programmes available to prevent mental illness, and promote mental health and wellbeing, for GLBTI populations in New Zealand. These include general mainstream services and programmes, as well as those initiatives that have GLBTI-specific services and programmes.

This recognises that general mainstream mental health services and programmes, even without a GLBTI focus, are likely to have some effect on the mental health and wellbeing for these populations. However, GLBTI-focused services and programmes are also likely to be required to address specific issues for these populations arising from sexual and gender minority status.

Data for the stocktake were obtained from key informant interviews, online submissions, existing documents and other discussions with people with knowledge of mental health promotion services. In addition an email survey, was sent to a senior staff member with responsibility for mental health services in each district health board. The survey was also emailed to all known mainstream and GLBTI community providers of health and social services to GLBTI populations.

4.2 Programmes and services

Approaches for addressing GLBTI mental health

To address mental health wellbeing of GLBTI people, discrimination against GLBTI people and the provision of general mainstream and GLBTI-focused health promotion and prevention services need to be considered.

GLBTI and discrimination/human rights

Substantial progress has been made in addressing discrimination against GLBTI people through legislative action (including the Homosexual Law Reform Act 1986, Human Rights Act 1993, Civil Union Act 2004). For example the Human Rights Act outlawed discrimination in the provision of services on the grounds of sexuality.

Despite these important reforms, community-based organisations continue to advocate for full equal rights for GLBTI people in two areas:

- Civil Unions/Marriage. While the Civil Union Act 2003 has provided a way to solemnise same-sex couples in a civil union, 'marriage' is not available to these couples.
- Adoption. Same sex couples are restricted from adopting.

In addition, others have advocated for gender identity to be added as prohibited ground of discrimination in the Human Rights Act to make it explicit the act covers trans people. The safety of youth, particularly in school settings, is also a recent area of concern for several GLBTI-based community organisations (see also, Riches, 2011).

Mental health promotion and suicide prevention services

There are several overarching policy and strategy documents to guide strengths-based mental health promotion and suicide prevention in New Zealand. These include:

- *The New Zealand Suicide Prevention Strategy* (Ministry of Health, 2006) – acknowledges issues relating to sexual orientation and in particular suggests the need for policies to address the needs of GLB young people.
- *The New Zealand Suicide Prevention Action Plan* (Ministry of Health, 2008) – includes population health approaches aimed at increasing public awareness of mental health and addiction problems, destigmatising mental illness and encouraging people to seek help.
- *Youth Health: A Guide to Action* (2002) – identifies specific health issues for GLBT young people and the need for schools to acknowledge and support their needs.
- *Te Tahuhu* - the current mental health policy (Ministry of Health, 2005) – emphasises the importance of promoting mental health at a population level and to ensure services are tailored to meet different needs.
- *Health Promoting Schools* (www.hps.org.nz) – the model focuses on holistic wellbeing/hauora and supportive environments for students and provides a framework through which issues of social justice, discrimination and sexual and gender diversity within the school community can be addressed.
- *Health and Physical Education in the New Zealand Curriculum* (Ministry of Education, 1999) – three of the four aims of this curriculum are directly related to the affirmation of a diversity of sexualities and gender identities. The descriptor for "relationships with other people" makes direct reference to sexual orientation "…students learn to evaluate the impact that social and cultural factors have on relationships, in particular the impacts of stereotyping and discrimination against individuals on the basis of their gender, ethnicity, age, economic background, sexual orientation, cultural beliefs or different abilities".
- *Youth Development Strategy Aotearoa* (2002) – this document identifies young lesbian, gay, bisexual and transgender people as a group with specific issues which include discrimination and harassment and access to support groups and programmes.
- *Professional Standards for Teachers* (1998) – requires that teachers act with respect towards all students by maintaining environments that enhance learning by recognising and catering for the learning needs of a diversity of students.
- School legislative documents – the *National Administration Guidelines* (1990) require schools to provide a safe physical and emotional environment for students.

Translating policies and strategies into programmes and services that may reach GLBTI people

General mental health services and programmes

The stocktake identified several general population level services and programmes provided to address mental health issues.

- *The National Depression Initiative* (NDI) (www.ndi.org.nz) aims to reduce the impact of depression on the lives of New Zealanders, by aiding early recognition, appropriate treatment, and recovery. Launched in 2006 it is a suicide prevention initiative, as well as seeking to improve the mental health and wellbeing of all New Zealanders. It comprises a multi-media campaign (fronted by ex-All Black John Kirwan) that aims to reduce the impact of depression through increasing understanding of symptoms, increasing awareness of effective interventions and where to seek help (www.depression.org.nz). Other intervention activities include a national helpline, youth support services delivered via text and the Lowdown website, an online self-management

programme (The Journal) with personalised back-up support, and web-based information services. Evaluation findings indicate the messages are far-reaching, with 90 percent recall by the total population and 96 per cent recall by Maori (Wyllie and Mackinlay, 2007). Little is known about the effectiveness of the campaign in relation to behaviour change, but tracking surveys have shown changes in knowledge and attitudes.

- *Like Minds, Like Mine* (www.likeminds.org.nz) is a national, publicly funded programme aimed at reducing the stigma and discrimination associated with mental illness, which has been in place for over a decade. This programme recognises that stigma and discrimination are major barriers to a person's recovery. The programme includes national advertising, education and training, working with the media and advising on policy initiatives. Regional providers undertake a wide variety of activities to address stigma and discrimination within their local community groups, marae, businesses and media. Evaluation of the programme shows that attitudes relating to campaign messages have improved (Wyllie, Cameron, & Howearth, 2008).
- Public health units (PHUs) around the country (except Auckland) are funded by the Ministry of Health to deliver mental health promotion services. These vary between PHUs, but include community development activities, input to school-based programmes such as Health Promoting Schools, some suicide prevention activities, and participation in Mental Health Awareness Week. Canterbury PHU responded to the earthquakes with 'mental health promotion messages'. Funding for mental health promotion activities delivered by PHUs is modest, on average less than one FTE per PHU.
- The Mental Health Foundation (MHF) (www.mentalhealth.org.nz) is funded by the Ministry of Health to provide mental health promotion activities for the northern region, a national mental health information service, and to organise Mental Health Awareness Week. The MHF also provides training, and advocates for policies and services that support people with experience of mental illness, and also their families/whanau and friends.
- *Mental Health 101* (www.mh101.co.nz) is a mental health literacy and learning programme developed to give people greater confidence to recognise, relate and respond to people experiencing mental illness. Workshops are available nationally, or can be requested by corporate and community groups.
- *Travellers* (http://travellers.org.nz/) is a programme for year 9 students in schools, developed and delivered by Skylight in partnership with the Injury Prevention Research Centre, The University of Auckland to build resilience and life skills.

GLBTI-focused mental health services

A number of social and other GLBTI organisations provide general support, social, advocacy and information services that are likely to contribute to the mental health and wellbeing of GLBTI people. Examples of organisations providing these services are: Body Positive, Women's Centre (Christchurch), Pink Health Otautahi, Step Ahead Trust – Rainbow Group, Wellington Gay Switchboard, GenderBridge, and Intersex NZ. A range of specific community-based after school and school-based youth support services has previously been identified (Metzger & Camburn, 2010; Riches, 2011).

However, those organisations which have services and programmes with a specific health promotion focus for some or all of the GLBTI populations are much more limited. Identified services are provided by: Auckland CADS (Community Alcohol and Drug Services), OUTLine NZ, NZ AIDS Foundation (NZAF), Rainbow Youth, and City Associates. In relation to mental health these services work mainly at a settings level (e.g., in schools) or at the personal level (e.g., counselling). Details of these services follow. In addition, GLBTI-focused mental health promotion resources were identified.

Name of service	Auckland CADS (Community Alcohol and Drug Services)
Location of service	Auckland
Coverage	Auckland region (Wellsford to Bombay)
Target population	LGBTTFI22 and same-sex attracted youth, and their family, whanau and significant others, with alcohol or other drug problems. LGBTTFI adults, and their family, whanau and significant others, with alcohol or other drug-related issues (includes individuals questioning sexuality or gender identity). Sex workers with alcohol or other drug problems, targeted through a sex workers' outreach clinic.
Funding sources for service	Waitemata District Health Board, Auckland District Health Board, Counties Manukau District Health Board.
Approach/philosophy of service (e.g., youth development, recovery model)	Harm reduction service for anyone wanting to solve an alcohol or drug related question, issue or problem. Recovery model. Diversity affirming.

Name of service	OUTLine NZ
Location of service	Ponsonby, Auckland
Coverage	National
Target population	"Rainbow Communities" (lesbian, gay, bisexual, trans, queer, questioning) and their families.
Funding sources for service	Various – mostly donations and philanthropic trusts. Auckland District Health Board (has funded community worker project).
Approach/philosophy of service	Personal advice and support – phone counselling, information services, advocacy, and face-to-face work. Community-based programmes – social, cultural and welfare.

Name of service	NZ AIDS Foundation (Positive Health Services)
Location of service	NZAF Burnett Centre (Auckland), NZAF Awhina Centre (Wellington) and NZAF South/Te Toka (Christchurch)
Coverage	Coverage is nationwide. As well as the centres listed above, NZAF Positive Health Services has a network of contracted counsellors and psychologists across the country.
Target population	NZAF Positive Health Services provides support to people infected with or affected by HIV in New Zealand. Because men-who-have-sex-with-men (MSM) are the group most at risk of new HIV infections within New Zealand, this group makes up the majority (76 per cent in 2009) of those seeking counselling and therapeutic services. As well as MSM, a smaller number of individuals from other rainbow communities seek the services of NZAF Positive Health Services (in 2009: 1 per cent transgender, 1 per cent lesbian and 2 per cent not identified). Note that mental health promotion and prevention may form a part of a counselling or therapeutic consultation with NZAF Positive Health Services, but not necessarily in every instance.
Funding sources for service	NZAF receives 92.25 per cent (2009/2010) of its funding from the Ministry of Health, which funds the therapeutic service. Other income sources include grants (3.65 per cent), PHARMAC (0.80 per cent), fundraising, events and sponsorship (1.57 per cent), donations and bequests (1.48 per cent), membership (0.03 per cent), interest (0.20 per cent) and consultancy (0.02 per cent).
Approach/philosophy of service (e.g., youth development, recovery model)	NZAF Positive Health Services employ a multidisciplinary approach when providing specific mental health promotion and prevention services. Models include (but are not limited to) harm reduction, alcohol and drug rehabilitation, and short-term cognitive behavioural therapy.

Name of service	Rainbow Youth Incorporated
Location of service	Auckland City
Coverage	Wellsford to Bombay
Target population	1) Youth (27 years old and under) who are questioning or identify as queer23 or transgender.

[22] Lesbian, gay, bisexual, transgender, takātapui, fa'afafine, intersex

	2) Schools and people who work with youth to improve awareness and diversity in all youth based environments (through an education package that outlines the differences between sexuality and gender). 3) Parents who are faced with the issues arising from youth questioning their sexuality or gender identity are supported.
Funding sources for service	Lotteries, COGS, ASB Community Trust and various trusts. Rainbow Youth has minimal untagged or philanthropic funding and no government funding.
Approach/philosophy of service (e.g., youth development, recovery model)	Rainbow Youth is a youth led and youth run organisation. The service focuses on 100% youth participation and have a peer to peer support model and recognises the Youth Development Strategy of Aotearoa and Youth Worker Guidelines of Aotearoa. The organisation affirms diversity.

Name of service	City Associates
Location of service	Wellington
Coverage	Regional
Target population	Youth with high-risk, complex problems, most of whom are same-sex attracted.
Funding sources	Variety of government, district health board and philanthropic sources.
Approach/philosophy of model)	Intensive individual and group-based treatment provided by multidisciplinary team using motivational approaches and peer-support.

GLBTI-FOCUSED MENTAL HEALTH RESOURCES

Name of resource	Curious website
Producer of resource	NZ AIDS Foundation and Rainbow Youth
Target audience	Young people
Availability of resource	Online – www.curious.org.nz

Name of resource	You, me, us. Our people, Our relationships (booklet and posters)
Producer of resource	OUTLine NZ and Rainbow Youth
Target audience	GLBTTFIAQQ24
Availability of resource	Hard copy from OUTLine and Rainbow youth, or available online – www.rainbowyouth.org.nz/healthyrelationships
Funding source	Ministry of Social Development

Name of resource	Safety in our schools
Producer of resource	Out There project (NZAF and Rainbow Youth)
Target audience	Board of Trustees and schools
Availability of resource	Online – www.spinz.org.nz/file/downloads/pdf/file_209.pdf

Name of resource	Making schools safe for people of every sexuality
Producer of resource	PPTA
Target audience	PPTA members and their school communities
Availability of resource	Online – http://www.ppta.org.nz/index.php/resources/publications/doc_details/273-making-schools-safe-for-people-of-every-sexuality

Name of resource	Social and ethical issues in sexuality (curriculum resource)
Producer of resource	PPTA and NZ Secondary Principals' Council
Target audience	PPTA members and their school communities
Availability of resource	Online – http://www.ppta.org.nz/index.php/resources/curriculum-support/curric-resources/doc_details/432-health-education-year-12-social-a-ethical-issues-in-sexuality

[23] Queer is a reclaimed word that represents sexuality and gender diversity. It is used by Rainbow Youth to encompass lesbian, gay, bisexual, transgender, intersex, fa'afafine, and takatāpui identities, as well as everyone in between and not sure. While the word is used by many people, it is not the preferred term for everybody.
[24] Gay, lesbian, bisexual, transgender, takatāpui, fa'afafine, intersex, asexual, queer, and questioning communities.

Name of resource	Trans people: Facts & information (fact sheets)
Producer of resource	Human Rights Commission
Target audience	School communities
Availability of resource	Online – http://www.hrc.co.nz/human-rights-environment/action-on-the-transgender-inquiry/resources/trans-people-facts-information/

Name of resource	pridenz.com
Producer of resource	pridenz.com
Target audience	Queer New Zealanders and those questioning their identity
Availability of resource	Online – www.pridenz.com/
Funding sources for resource	GABA Charitable Trust, Gareth Watkins Creative, Gay Line Wellington Trust, Hannah Ho, Mental Health Foundation of New Zealand, Roger Smith, Rule Foundation.

Name of resource	Sexuality, gender identity and depression fact sheet
Producer of resource	National Depression Initiative
Target audience	General
Availability of resource	Online www.depression.org.nz/content/waythrough/resources and www.thelowdown.co.nz/fact-sheets/

Name of resource	Column in express! (Addressing alcohol and drug issues, and related health matters)
Producer of resource	Diana Rands, CADS
Target audience	Rainbow community
Availability of resource	Nationwide (400 outlets) and by subscription

Name of resource	Gay men's mental health
Producer of resource	Chris Banks, Mental Health Foundation
Target audience	Gay men and others
Availability of resource	Newsletter (Summer 2009) and online www.mentalhealth.org.nz/newsletters/view/article/15/182/summer-2009/

Name of resource	Recommended reading on queer mental health
Producer of resource	Mental Health Foundation
Target audience	General
Availability of resource	Online www.mentalhealth.org.nz

Name of resource	Bipolar Bear Blog
Producer of resource	Chris Banks
Target audience	General
Availability of resource	Online http://bipolarbear.co.nz/

4.3 Gaps in service provision

It is unclear how effective general mainstream programmes are in promoting mental health and wellbeing for GLBTI populations. The stocktake identified a very limited number of services directly focused on preventing mental illness, and promoting mental health and wellbeing for GLBTI populations in New Zealand.

A chief gap was the lack of services, programmes or funding of GLBTI-focused mental health initiatives by public health units at district health boards. The exception to this was funding allocated by the Auckland District Health Board for a community project worker based at OUTLine. The view of several district health boards contacted was that mental health services are available to all, and there is no need for GLBTI-specific services or programmes. It should be noted that some mainstream health services appear to be providing services to GLBTI populations, but these were not identified through the survey

sent to district health boards, e.g. one informant noted that Kidz First Hospital run by Counties Manukau District Health Board provides support for young fa'afafine, fakaleti[25] and other trans youth, and that Auckland Sexual Health Service (Greenlane Clinical Centre) has provided counselling when trans people approach them to gain access to hormones.

Another gap was the lack of GLBTI organisations who were actively involved in mental health promotion on a national level, either through service provision or by advocating for mainstream services to meet the needs of GLBTI peoples. However, OUTLine is leading an Auckland-based community development initiative to address the health and wellbeing (including mental health) of the rainbow community (Meneses, 2010). In addition a GLBTI community-based organisation, Aotearoa Rainbow Alliance (ARA) (www.outlinenz.com/ara/), has recently been established to advocate for change for a better present and future and improve the health and wellbeing of rainbow communities.

In relation to services for trans and intersex people there is potential for two other projects to inform the development of new, and reorientation of current, services. Counties Manukau District Health Board was funded to manage a small national project looking at Gender Reassignment Health Services for Trans People in NZ to look at the full range of health services a trans person might need that are related to their transition (Human Rights Commission, n.d.). Consultation with intersex people is also underway that will look at the "human rights of intersex people, including information about historical and current medical practices" (Human Rights Commission, n.d., para. 4).

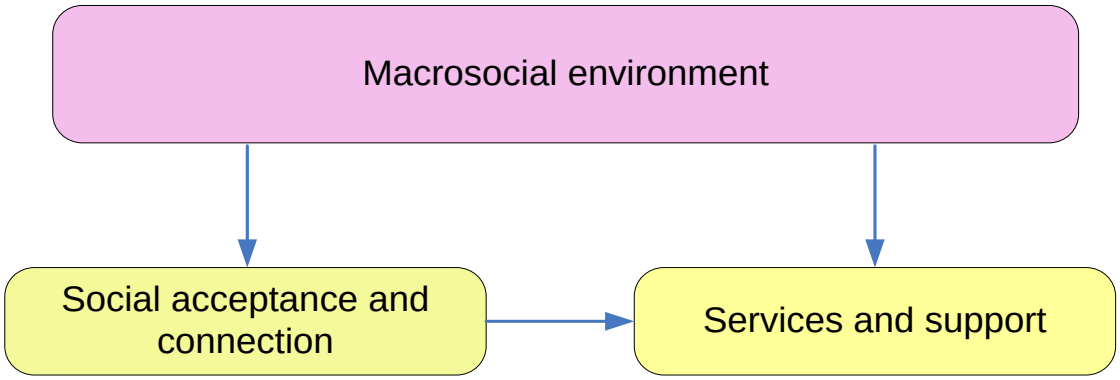
[25] Fa'afafine and fakaleiti are terms that Pasifika trans and "third sex" people may use to "describe themselves and which also have wider meanings that are best understood within their cultural context" (Human Rights Commission, 2008, p.13).

5 Key issues and gaps

5.1 Introduction

In this section, the themes related to key issues and gaps in mental health service provision raised by key informants and GLBTI individuals are reported on[26]. Three themes are identified – macro-social environment[27], social acceptance and connection, and services and support. The overarching theme of macro-social environment influences both the social acceptance and connection experienced by GLBTI individuals, and the provision of mental health services and other support (see Figure 2). The issues and gaps identified apply across GLBTI populations[28], but at times in uneven and in different ways.

Figure 2: Themes – key issues and gaps



5.2 Macro-social environment

Negative (and positive) attitudes towards GLBTI people need to be understood, as they contribute towards the environment within which GLBTI people form social connections and relationships. Such attitudes also influence the environment in which mental health promotion occurs and mental health services are provided.

Stigma and homophobia or transphobia

Stigma and homophobia or transphobia were identified as key issues in relation to mental health by most respondents. Many respondents reported experiencing prejudice, hostility and discrimination in public,

[26] In this analysis we refer to key informants as informants and GLBTI who completed the online submission as respondents. When we refer collectively to informants and respondents we use the term participants. Respondents are identified by the descriptor they chose to use e.g., gay man, trans, transsexual.

[27] A range of social factors lie beyond the individual, e.g. culture, mass media, political systems, which affect the health of the population and can be broadly thought of as macro-social determinants of health (Galea & Putnam, 2007).

[28] Although participants were encouraged and invited to provide information about one or more of the population groups, many of them spoke in general terms about GLBTI people. In instances where it is not clear whether a particular group is being referred to, we have assumed it related to GLBTI people as a whole.

social and clinical settings. The following examples illustrate fear within social settings and hostility within the hospital setting.

> *I currently don't feel comfortable expressing my sexuality for fear of retribution from drunks (particularly guys who would be willing to start fights) and discrimination from bouncers who prefer to have straight guys and girls in the bars and clubs, particularly single ones. (Gay man, bisexual man, 20 or younger)*

> *…I guess where I met hostility is within hospitals when I have been ill and doctors (not normally nurses) do not know how to cope with my partner being my partner or us being close or wanting information from them and sharing it with my partner. (Gay man, 61–70)*

However, while in many instances the negative feelings reported by respondents appeared to arise from deliberate acts or omissions, in other instances the actions were reported as less deliberate. In this account, for instance, the more subtle outcomes of heterosexism were noted.

> *I find the public domain challenging. The number of billboards and other public advertising appear heterocentric and directed at the rugby-moronic masses but the gay/lesbian scene is quite bi-phobic and presents its own challenges. (Bisexual man, 31–40)*

For many participants, issues of stigma, discrimination and lack of understanding were discussed as a whole-of-society issue, which needs to be addressed as an equity and human rights issue at a government level, rather than being focused on the individual. An ongoing issue for these participants was that, although GLBTI people are fully contributing members of society, their contribution is minimised and not recognised or acknowledged.

> *The health and wellbeing of LGBT people is directly related to our status in society. Prejudice and discrimination against us remains the last bastion of open bigotry. Until government undertakes a commitment that requires absolute equality (gay marriage, gay adoption, full funding for gay couples seeking fertility treatment not to mention a public apology for past and current policies and laws) we will continue to suffer for we will continue to be treated as second class citizens. Once we have full legal equality, we can work to obtain civil equality – promoting and accepting our orientation and relationships as equal to that of other groups within the greater community. (Lesbian, 31–40,).*

> *Firstly the government more powerfully acknowledging the importance of this issue. (Gay man, 41–50).*

> *No justice, not policed social rights, our government's use [of] the fairness notion as an equitable argument to persuade Joe average to think everything is OK…they are homophobic…We are not talking delayed rights we are denied all rights – we have all these new laws protecting us but we don't because those politically correct laws are never policed therefore denying us our rights. So my reply to that MP is scathing, give me access to what I require just like our heterosexual families provide to our heterosexual siblings who promise to provide grandchildren…and I have always promised to be a fully contributing member of society but still I am not wanted. (Gay man, 41–51)*

Informants who talked about trans issues, and trans individuals who responded to the online submission, reported a general lack of understanding of and prejudice against trans people by society as a whole.

> *Visibility is essential, trans people must be recognised as a viable part of society and therefore just like everyone else seen to be in posters, mentioned in fliers, part of depression awareness campaigns, part of 'its not okay' campaigns. Recognition and acceptance are two key factors for*

our community to grow and engage in the wider community as well as improve our health issues. Trans people suffer so much from low self worth, isolation, depression, anger, lack of trust, yet we are some of the most high achieving individuals…Not enough of the wider community engage in our community to really understand how much we achieve with no funding. (Trans, aged 31–40)

There is no public awareness or support of transgender issues. This means that the topic is shrouded in fear thanks to negative media portrayals being the only source of education, and ignorance even amongst queer circles…Transphobia is normal and rife and not frowned upon in the way that other prejudices are, and this stems from an overall hush and shame around the subject. (Trans, polysexual, aged 21–30)

Further evidence of a lack of understanding of and prejudice against trans can be found in the report from the Human Rights Commission's Transgender Inquiry (Human Rights Commission, 2008). The inquiry took place because of the level of marginalisation and stigmatisation of trans people.

Stigma also applied to intersex people and one informant suggested that the needs of intersex people are not visible and remain hidden, yet the little information that does exist suggests a growing need for mental health support. There is little support provided for parents with an intersex child.

Education and public campaigns were reported by many of the participants as an appropriate way to address the effects of social stigma and discrimination, and the lack of understanding amongst mainstream society of GLBTI people.

More education about the negative impact of the milieu we live in. For example, most people know that we have increased rates of mental ill-health, but make all sorts of assumptions about this – because we are weak or broken – education about the negative impact of homophobia on a national level would be good – through well thought out TV ads – perhaps the American ones that targeted "That's so Gay" – I think celebrities were used. (Gay man, 31–40)

Several gay men considered that greater visibility of gay people through positive images and messages would benefit the general public as well as the gay community, particularly younger gay men.

Maybe promotion activity aimed at the general public would help. If gay men, especially young gay men could see that being gay is good, can give you loving relationships and isn't just about fucking this would be good – reaching parents – finding ways to give help to them to adjust when a kid comes out. More visibility of gay people in general – on TV – just taking us out of the shadows more would really help. (Gay man, 41–50)

I'd be interested to see a promotion activity taking into account the range of ways people arrange their relationships…My impression of NZ promotion is that it assumes people are in monogamous relationships or no relationships. (Gay man, 41–50)

De-stigmatising mental health issues

As well as general initiatives aimed at greater acceptance of GLBTI people, a number of participants discussed the importance of initiatives to de-stigmatise mental health problems.

One informant discussed how GLBTI people with mental health issues can experience double stigma resulting from being a person with a minority sexual or gender identity and from having the mental health illness.

Stigma towards mental health issues was reported as both a concern at a general community level and as a specific concern within GLBTI communities. In most cases, participants reported that education-focused initiatives were required to raise awareness of mental health issues and where to access support.

> *Education within the LGBTI communities as well. There's quite a bit of stigma against people with mental health issues within LGBTI communities and that doesn't help those people who do have mental health issues. (Key informant)*

> *Awareness campaigns for those who are looking for help. These people are not always in the community, and so these activities need to target both inside and out. (Gay man, 51–60)*

> *People need to know more about mental health issues. We need programmes to help communities understand about concepts of mental illness, what can keep us healthy and what can make us unwell. GLBTI communities experience the pressure of discrimination and stigma which increases our risk. We do need a specific mental health awareness campaign for our communities covering issues like suicide, alcohol and drug use and relationships including those of complex family relationships and our children who may live across 2 homes or also be struggling with discrimination. (Key informant)*

> *I think a more open, honest, acceptance of mental health services would be beneficial – it should not be seen as a sign of weakness to accept help. These services can be very expensive, so when free services are offered, such as school or university counselling, a wide range of staff should be on offer – male and female, a wide range of ages, and people who specialise in certain areas, such as drugs and alcohol, sexual orientation, sexual abuse, etc. (Gay man, 20 or younger)*

Appropriate mental health promotion

There was considerable discussion about what constituted appropriate health promotion for GLBTI people. Several informants noted that all mainstream health promotion needs to be inclusive and include GLBTI people.

> *All promotional material needs to state GLBTI explicitly – otherwise it's invisible. (Lesbian, 41–50)*

In addition to this, participants also noted that health promotion needs to recognise the diversity within the GLBTI population.

> *Promotion material needs to go beyond stereotyped "cute gay guys" which tends to dominate a lot of queer-representative material (maybe influenced by AIDS-related resources). Women and non 'scene'/non-glam people remain relatively invisible in media, implicitly stigmatising range of sexualities. I think young people are a lot more resilient today, resisting narrow stereotyped labels – though it really helps if they can access a confidence-building school peer-support group. (Bisexual woman, 41–50)*

> *Advertising not only directed at the "normal, white, adult, upper class" culture but at varying socio-economic cultures and age group. (Lesbian, 51–60)*

The current campaign featuring former All Black John Kirwan29, 30 were discussed by a number of participants. Two positions with respect to the appropriateness of these were identified. The first group supported the campaign and highlighted the success in raising the issue of depression (and mental illness more generally).

> *I think there are some fabulous programmes in mental health now the depression initiative is you know the online thing we have got with John Kirwan as the front person is I think one of the best initiatives in the world. (Key informant)*
>
> *I think the John Kirwan campaign has been great. (Gay man, 41–50)*

However, others took an opposing view. While there was some recognition that there had been improvements in raising awareness of mental health issues, there was strong criticism about the campaign because of a front person that many GLBTI would not relate to. Many respondents suggested that this campaign could include other types of role models.

> *In general, I think that NZ has taken great strides forward in moving mental health issues out of the shadows and into the public consciousness, but John Kirwan does not represent all of us. (Gay man, 71+)*
>
> *We have a famous rugby player on TV and in the media promoting help for depression and yet we will never have the same commercial showing a full scene camp drag queen in a tutu saying its ok to seek help. (Gay man, 41–50)*
>
> *Probably need better role models for all GLBT members – probably in the public space rather than hidden within our own community. I am not actually aware of any services so an awareness raising campaign would be a good start. (Gay man, 51–60)*

5.3 Social acceptance and connection

General community acceptance

Participants discussed several issues related to social acceptance and connection. In general terms, participants identified that poor social acceptance and connection was likely to contribute to hostile conditions in which to achieve good mental health and wellbeing.

> *I think it is so important that people are not isolated and that feeling good about yourself and your sexual identity is a huge part of mental well-being, and emotional and social well-being. (Bisexual woman, 41–50)*

Participants talked of negative general community attitudes towards them, which resulted in their not being out in some situations, or feeling that they did not measure up, due to the heteronormative nature of society. For example:

> *I had to change my church when I came out. This was very difficult. (Gay man, 51–60)*

[29] These advertisements refer viewers to a website that "is part of a national public health campaign called the National Depression Initiative and has been created to reduce the impact of depression on the lives of New Zealanders, as well as being a component of the New Zealand Government's approach to suicide prevention" (Ministry of Health, 2009, para.1)

[30] During the data collection phase of this research, advertisements for this campaign were screened on television and were also placed on websites accessed by GLBTI people (gaynz.com and nzdating.com).

A gay relationship is seen as inferior to straight relationship. (Gay man, 41–50)

It is possible to feel very isolated from both typical heteronormative aspects of society and limited perceptions of queer society. (Trans, 61–70)

Family and friends

Support from (biological) family and friends was identified by many respondents as an important factor in maintaining their mental health and wellbeing. However, there were also a number of respondents who reported experiencing either a lack of friends, friends not being available when needed, or hiding their identity from family and friends, to the detriment of their health and wellbeing.

Well, although I maintain my wellbeing, barely any of them know that I am bisexual, therefore, that hidden part of my life for me is difficult to reveal to family and friends at this stage. (Bisexual man, 20 or younger)

A lack of support from (biological) family and the potential to lose friendships was reported as something that particularly impacted on trans people.

Total exclusion from my family, that is made worse when there are events such as Father's Day, Christmas, family members' birthdays etc. All of which I and many such as myself are excluded and from isolation by those very same family members. (Trans, 51–60)

For older, late transitioners, who for reasons of societal acceptance adopted the role model dictated by their physical representation for the bulk of their lives, there is a massive sacrifice for many in areas such as career, financial independence, family interactions and possible alienation. The friendships built over a lifetime can evaporate in an instance leaving people facing a critical stage in their lives vulnerable and without support. (Transexual, 51–60)

A few respondents discussed the interplay between cultural identity, sexual identity and family relationships. The view expressed was that cultural identity was more important than sexual identity.

For Samoans it is important as part of our own uniqueness is very much tie in with our cultural identity first and sexuality second. My own experience shows that for Palagi it is sexuality first and cultural second, if acknowledged at all. (Fa'afafine, 51–60)

There were a couple of reports of how negative mental health impacts could arise if there were tensions between an individual's cultural and sexual or gender identities. This was discussed in relation to family acceptance.

I think overall Māori have different values to non-Māori (e.g. Pākeha), in that I believe that one of the areas of biggest concern for mental and spiritual wellbeing for Māori is that it is evident that when Māori are not supported by their whanau for being trans, and this indicates that they are not supported by their hapu and iwi and the thought of not belonging and being dissociated from your people, your whenua, tipuna, tikanga is a huge blow to anyone's wellbeing. That they feel they have no mana and that they may feel spiritually affected by this does have an effect on them. Therefore there needs to be

access to the right Māori leaders or Māori experts of their iwi, to be able to connect and feel they belong. (Key informant)

A friend of mine who is Chinese…he does all the family things and then he goes out night clubbing with his gay mates and he drinks more and does more drugs and sometimes he has flareups but at the same time it is all squashed back down and part of that is the fact that there is this lack of ability to be open with his family in a way that they will accept. (Key informant)

Young people, bullying and schools

An area that concerned many participants was young people, especially those still at school for whom bullying was identified as a particular issue. Several respondents talked of the pervasiveness of bullying and lack of safety and understanding in schools.

Our young people are still being bullied and threatened about their sexuality. (Lesbian 31–40)

More attention given to bullying, prejudice. (Gay man, 51–60)

A lot of young transgendered youth, (I'll use the umbrella term as many will still be trying to sort out where they stand) will have suffered bullying and alienation in the school system and will therefore be academically disadvantaged, which in itself causes further alienation from society. (Transexual, 51–60)

The effects of bullying resulted in a gay young person being home schooled, rather than being subjected to ongoing severe intimidation and hostility. The parent had been unable to access appropriate support for him.

Kids are maturing at a younger age. I have a camp little 12 year old boy who is no doubt that he is gay. Rainbow Youth is not much use until he reaches 14 and he has had some pretty horrific instances of bullying at school. I now home school him but it would have been helpful to have had some sort of gay friendly counselling for him. (Key informant)

Many considered schools to be important settings for promotion and education to ensure enhanced understanding amongst teachers, students and parents about GLBT issues and concerns.

I think that targeting young people at an age where they are coming to terms with themselves would be of great benefit to everyone including parents. (Gay man, 61–70)

Perhaps also programmes for parents wanting to know how to deal with teenagers should be offered to the parents of high school age children and a section on rainbow issues included. If I had had parental support (as opposed to abuse!) around my sexuality, my teenage years would have been a lot easier. I think my mother had no idea how to cope as a solo parent and was too scared to ask for help but might have taken it if offered. (Bisexual woman, 21–30)

A goal often articulated was the provision of a safe school and the responsibility of the Ministry of Education to lead the achievement of this was clearly noted.

I think more needs to be done to make sure that the schools have to create safe environments for these young people and I think that the attitude from some of the schools is very much tough luck if you are GLBTI youth, you have to either fit in or you can go somewhere else, and they don't usually have that option and so at macro level I think that's what needs to be done in terms of making it compulsory for the schools to create that safe environment and I think some of them are un-motivated to do that. (Key informant)

I think across the GLBT spectrum there needs to be more promotion of support at High School level so that young people's mental health and wellbeing is not impacted negatively. It is just who we are. (Lesbian, 31–40)

And, and take on the Ministry of Education a little bit more. (Key informant)

There is a need for mandatory national school based support for young people considering their sexuality and gender. This would not necessarily just focused on same-sex attraction and transitioning – but would provide a forum for all young people to explore these developmental issues. (Key informant)

A number of respondents considered they would have experienced better mental, emotional and social wellbeing if they had experienced more supportive environments when they were younger. Instead many had struggled to access the support they needed and their journey to wellbeing was rather torturous.

I feel that a targeting of youth would be critical as I would have saved myself many years of doubts and uncertainty, not to mention illusions if it had been available at the time. (Gay man, 61–70)

I think if I had undergone counselling when I was younger I might never have had ended up becoming clinically unwell and needing the services of the mental health service. (Gay man, 41–50)

Schools were discussed as a key entry point where health promotion and antidiscrimination measures could be initiated and spread more widely. The flow on from this would be enhanced support for GLBTI in other areas of society such as families and communities.

The area of discrimination I think we can do most is in the education sector around schools. (Key informant)

I think there is no I mean it is interesting at schools communities and families and I think schools are probably going to be the most susceptible to change cause they are by and large state funded, it is going to be much more difficult to change communities and families but I think if you target one and we know that all have to be going to school then that is something that might work, this is certainly outside of how to make the changes is sort of outside. (Key informant)

The work of Rainbow Youth in providing positive (peer) support for young people was noted by some key informants and respondents.

There's Rainbow Youth, there are some very effective stuff being led by young people and we ought to be providing them with much more support, and they will lead the change and they will probably do it on a holistic approach. (Key informant)

Older adults

Some key informants discussed mental health issues for older adults. These informants talked about general mental health, wellbeing and social issues that older adults experience, but also specific issues that are more likely to be experienced by GLBTI older individuals. One area of concern was housing, particularly whether retirement living options were suitable for GLBTI. While these issues were noted as being present right now, they were also seen as an emerging issue due to the general ageing of the population.

> *How do people fit in when older…maintenance of identity in later life, different age cohort needs, lack of resources in rest homes and care facilities and lack of knowledge for these communities, grief from unacknowledged relationships, and HIV affected people? (Key informant)*

> *We have got GLBTI people who are in their later years, who have got mental health problems addiction problems. The addiction problems and just general ageing dementia related problems as well and it's looking at whether they should just be provided for within general services or whether there is a good reason for setting up something which is a different initiative that comes the community for them, I mean we haven't even got housing sorted for retirement, so there are huge general social and health issues for our older communities and within that needs to cover mental health and addiction as well. (Key informant)*

> *We are going to be faced with huge issues for older people in isolation as they retire and need care and they are just going to be put into generalist retirement homes or rest homes or nursing homes. We yet don't know how much that is going to impact on them, how much that kind of isolation is going to affect their mental health, all this is ahead of us but when we are not organised in a way to be able to address it, it seems to me. (Key informant)*

Gay, lesbian and transgender communities

While some participants reported positive aspects of the GLBTI communities, others identified challenges that were posed by the communities, which impacted on their lives and their mental health. For example, some of these related to attitudes within these communities, lack of social spaces and a lack of community cohesiveness:

> *I think the gay community has a culture where you only fit in if you are up to 40 years old, otherwise it's thought you pay for sex if you are over 45 years old. (Gay man, 61–70)*

> *Lack of available social opportunities to be in a gay man only setting. (Gay man, 41–50)*

> *I find the lack of a cohesive, local GLBTI community difficult. (Gay man, 41–50)*

Some participants discussed how the values of the GLBTI communities were problematic in that they were unhealthy and needing to be challenged. One particular area of concern was suicidal behaviour, and one informant reported that acceptance of suicide (as a way to cope with the negative impact of homophobia and other social pressures) was a prevalent discourse within some communities, which was alarming and needing to be addressed.

Promoting the mental wellbeing of the GLBTI communities – some of the values and accepted behaviours are very unhealthy. (Lesbian, 31–40)

I am extremely concerned by that as a key message in terms of understanding within our own community, that suicidal behaviour is part of the condition and its really you know that is something that I feel passionate about in terms of the over simplified way that suicidal behaviour is explained and understood can actually contribute to further suicidal behaviour…It is the underlying narrative that floats through so many of their interactions… it becomes almost 'fait accompli' that is something that disturbs me in the extreme. (Key informant)

One informant noted that the capacity of various parts of GLBTI communities varied, and that both the trans and intersex sectors had less capacity to offer support to their members.

I think one of the things about the transgender and intersex community is those communities and it is communities that is absolutely plural it is still very new and raw and lots of people are still in that journey of coming out and so you don't have a huge capacity of people who have got on with their lives and able to be support peer mentors. (Key informant)

One key informant reported that many intersex people have been "badly injured physiologically" and have grown up with "trauma related injuries" and so the idea of "a high functioning peer support group" was not possible.

The informant also noted that while there is pride in being part of the gay, lesbian and the emerging trans communities, that sort of pride does not exist in being intersex, often because of the secrecy, shame and fear associated with being intersex.

5.4 Services and support

In relation to services and support, two main areas were discussed by participants – access to services and the competency of service.

Access to services - cost

For all groups of respondents who are currently accessing or would like to access mental health services, the most widely reported issue that hindered access to these services was cost. Several respondents reported that financial barriers meant they did not access services, even though they identified these as necessary for their mental health and overall wellbeing and in some instances the delay in accessing services prolonged distress for the respondent. Cost issues, particularly in relation to counselling, were a common concern for people, especially for younger people and those not in the workforce or studying.

Fortunately my counselling is currently free but if it weren't and I had to pay the market rate of $100 per hour, it would be prohibitive for me. (Gay man, 41–50)

What recently prevented me from seeking help for six months was the lack of an affordable male counsellor in the city in which I was living, so this caused my distress/trauma to continue for much longer than it could/should have. (Gay man, 20 or younger)

Counselling was a really good part of my treatment. It helped to have someone to be accountable to and monitor my health.

However the downside is the price of the service. It was $100 a session, an amount I am unable to afford, and I am now going without it. (Bisexual woman, 21–30)

I need some counselling to deal with issues related to being a lesbian however, when I did seek counselling I had to pay for the services and the prices are ridiculous!!
If there is free counselling no-body disclosed that information. I called the hospital and they said I have to be a "patient" to attend any free counselling and I also talked to my GP and he had no idea I rang a few other public services and no one could help. (Lesbian, 21–30)

Several respondents had accessed free counselling through universities, which had enabled them to access the support they needed.

I have only used counselling at the University of Auckland. I love it because the counsellors are so understanding and supportive, it's free for me (if it wasn't, I wouldn't be able to go to counselling at all because my parents do not know I go and I can't afford to pay for normal counselling). (Lesbian, 20 or younger)

For trans people, access to services is often severely compromised because of the lack of access to publicly provided services and the need to access private services. The ongoing cost of treatment and the lack of appropriate support services for transgender people make the journey of transitioning more fraught than it should be and have significant impacts on mental health.

Transgender people find it hard to get good service without paying big money. (Trans, 71+)

I think the main problem is the services are hugely variable and in many cases unaffordable for lots of people. (Key informant)

Increasing the availability of free and cheaper counselling opportunities and providing this within the public health system were suggested as strategies to mitigate the financial burden on individuals.

Although counselling services are free to students not all GLBTI youth are studying. I feel that although there are free counselling services in place such as LifeLine, face-to-face counselling is often far more effective. Incorporating more counselling services into sexual health services and making them more approachable may be an effective way of allowing GLBTI youth to access free or cheap counselling, particularly concerning their sexuality. (Gay man, bisexual man, 20 or younger)

Cost is excessive for clinical psychology and simply isn't available within the public system – very poor given very good evidence for benefit. (Lesbian, 31-40)

Access to services – lack of services

A lack of available mental health services was a key issue reported by participants. There were many reports that publicly funded mental health services for the whole population were lacking, and that GLBTI-focused services were non-existent. Further, it was noted that those public mental health services that are available are focused on crisis-level needs and not for those with mild to moderate symptoms.

In terms of publicly funded services, I've received next to nothing. Sought help at age 17 was stuffed around by DHB (no disrespect to the individuals I dealt with but just no funding available for people in my situation – basically would have had to tell them I was suicidal in order to get any assistance). (Bisexual, gender confused, 21-30)

The gaps I think particularly are right across the queer identifying community is when a person is struggling with depression and anxiety but not in a life threatening way there is very little here in Wellington. You know I used to say there needed to be blood on the floor, well blood on the floor is not even enough now to get a person help from a service which means that we have large numbers of people not functioning well they might be on the sickness benefit or the invalids benefit and I just know if they got some simple quality help for the issue that could move out of that situation. (Key informant)

The current mental health service treatment is pretty much limited to: "You're mentally ill – here go home and take these pills." There doesn't seem to be much help given to help people find ways to live happy, productive and satisfying lives. (Gay man, 41–50)

A particular need that was identified was for mental health services for trans people when they were in the process of transitioning. One key informant likened physical transitioning to going through puberty again, and a time when there needed to be a lot of mental health support in place.

An adult transitioning is going through puberty again and two puberty cycles at the same time so that often is something that has a, a huge impact on mental health for a short period of time just you know hormonal stuff up and down. And also everyone around them is responding to that changing…the ability to have an integrated sense of self for me is a big part of wellbeing and…it's particularly hard for people to do that at the stage when they are transitioning. (Key informant)

An argument was made that the failure to address mental health issues for GLBTI early might lead to a disproportionate burden on health resources later on. This was discussed by one participant.

Mental health services should be offered as a prevention to breakdown and suicide rather than only being available when things are really really bad. It's no good waiting at the bottom of the cliff with an ambulance! (Bisexual woman, 21–30)

There was also some discussion about who most appropriately could provide GLBTI-focused services – voluntary services provided by GLBTI communities or professionally provided services. Several informants noted that the GLBT communities had attempted to provide services. However, the expectation that groups could provide high-quality and sustained mental health services was particularly unrealistic when community groups are not funded to do this.

We acknowledge that we have a community of responsibility and ability as a community to do something about it provided we get the adequate resourcing to do it. (Key informant)

There needs to be peer support for the transsexual community in mental health. Support groups such as the nationwide group Agender NZ, do as much as they can, but receive no govt funding and do not employ any full time staff. This means that volunteer help is limited as the people in these groups are busy trying to create a living and survive in this difficult world using the limited resources they have for themselves. (Transexual, 51–60)

There is also the issue of the quality of the service…while the efforts of volunteers are admirable and worthy of support in the end what you have to provide is a reliable service of unimpeachable quality that requires professional standards, professional training professional standards of delivery. (Key informant)

I think there are people within the communities who try to be supportive and they are trying to do a bit of outreach and they try to link up to the facilities that sort of are there. Some of them say they spend so much time trying to fundraise to keep the facilities going…and in a lot of ways it

shouldn't be the GLBTI community that have to do all the fundraising – if the government was actually funding the service. (Key informant)

Many participants noted that the most appropriate and valuable role GLBTI communities could play was in the provision of peer support and education sessions to a broader audience. Some considered that providing services to support young people would have longer-term mental health benefits.

I think it would be beneficial in general to have some form of GLBTI group (similar to Rainbow Youth sort of thing) in most towns. (Gay man, trans, 21–30)

If you can help ensure GLBTI people become mentally healthy in their teens then you may well help set them up for a mentally healthy life. For example, the Wellington Gay Welfare Group (WGWG) Inc runs a group called Schools Out, which is a support group for GLBTI youth particularly focused on helping kids fully come to terms with their sexuality while they are still at school…the Schools Out group seems to be having excellent results…however it is a charitable incorporated society run by volunteers that receives no government funding. (Gay man, 41–50)

Several participants highlighted the need for GLBTI communities to take a leadership role in advocating for the establishment of appropriate services, and ensuring that existing services and mental health professionals are providing a safe service.

Activities and social networking that are inclusive of all members of the GLBTI community and that are drug free and does not necessarily promote drinking. Information as to what is available and the raising of already practising professionals awareness of how they could or should be practicing. A manner in which to create safe practice and also encourage potential clients to feel safe when approaching a practitioner. (Lesbian, 21–30)

GLBTI communities should be proactive in helping to set up some of these services and to support more vulnerable members of our communities. We should try and avoid the patterns of general society in not valuing the very young or the very old. (Lesbian, 51–60)

Many of the respondents noted a lack of knowledge about the services that did exist – in part this may reflect that there are not a lot of services, but it also suggests that existing services are not widely known about. Knowing what services are available often relied on word-of-mouth and informal networks. This means people who are unconnected to GLBTI communities may have worse access than those that are connected. Having information about services more readily available was identified as being important.

Access and availability: more effective advertising of what is available through educational service providers. (Trans, 61–70)

A database of some sort online would be a great help! Listing doctors and/or clinics that are specifically GLBTI-friendly could take a lot of stress out of the process. (Gay man, trans, 21–30)

I think that this is one of the weaknesses of our current system is that is very hard for people to find services…so a lot of my private clients would find out about me through that service [gay telephone information service] and then probably the most powerful way is word of mouth. (Key informant)

Service competency – cultural appropriateness

A point raised was that all mental health services should be provided in a culturally appropriate way, and that this was applicable across all groups. One informant and one respondent discussed the notion of

cultural safety, which included both ethnicity and sexuality. These responses suggest that, for many GLBTI people, services are provided by organisations and services operating from different cultural perspectives, and by individuals who have different cultural characteristics. The aim of cultural safety, as expressed here, was to ensure that mainstream organisations provided services in appropriate ways, which recognised the diversity of clients.

> *I think the mental health services should be firstly be culturally safe for Maori, Pacific, Asians and other non-European so that they are able to access services without compromising their own cultural identity as the current services are European in nature and service delivery (despite the rhetoric of being otherwise). Once this is achieved than people are more likely to address sexuality identities as before mentioned. My own experience is that cultural safety is about a change in attitude displayed by behaviours by the service provider/worker that enables and empowers the service user to grow and achieve their goals. The hardest to be achieved has been cultural and then sexuality safety for service users. (Fa'afafine, 51–60)*

> *Health services that were set up by another group of people – different culture and…people with a different sexuality from my own…and it's really entering those services of people different culture, different sexuality… without me having to take on board the sexuality and the culture of that group in order for me to access those services. And that's the whole tenet of the cultural safety. Is actually entering a service that's been done by somebody else without cultural risk to your own, or your sexuality. (Key informant)*

While most of the discussion was about mainstream services being safe, one respondent's experience was that education about trans issues was needed by some Māori health providers and that this would help ensure non-judgemental services were provided.

> *I go to a Māori Health Provider and I find them very good…I've been helping educate them on transgender issues…like Māori health providers…having information sent to them about LGBTIs that they can know that when, when we do apply for services and that that it's treated in a you know, non-judgemental proper manner. (Key informant)*

Service competency – staff attitude

While some respondents reported good interactions with mental health practitioners, there were many reports from respondents who had encountered inappropriate attitudes by a range of staff in mental health and school settings.

> *School counsellors, very unsupportive and was very judgemental and dismissive of how I was feeling, this made me very reluctant to seek help later in my life. (Bisexual man, bisexual woman, trans, 21–30)*

> *I was asked sexual details of what I had done with women (which was nothing) and told I was not gay. I felt judged. Before rapport was built when I was gaining trust of a mental health worker they told me my problems were not bad, and I did not need them. No time was given to disclose the issues impacting me (I was suicidal). (Bisexual woman, 31–40)*

> *Counselling provided through universities...Every single counsellor contacted through these services consistently demeaned any form of non-monogamous, non-hetero sexual behaviour. Myself and partners were consistently told that our choice of sexual behaviour was mentally detrimental, based only on it's non-monogamous, non-hetero state. (Bisexual woman, 21–30)*

One of the key informants reported being contacted by parents with an intersex child who did not want their child to have the surgery as they wanted their child to be involved in the decision and they were told by the paediatric team "if your child grows up to be an axe murderer don't blame us".

A key concern expressed was that GLBTI people needed to feel confident that appropriate attitudes were evident in the staff they dealt with.

> *I feel that as a patient we need to feel confident that there is an understanding relating to gay issues and that you don't run into any of the prevailing assumptions that bedevil people in our community. (Gay man, 61–70)*

> *It should be clear that there are particular gay friendly people that can be contacted. (Gay man, 41–50)*

Service competency – skills and abilities of practitioners

Another area relating to individual practitioners was the competency of staff and their skills and abilities. Many respondents reported a lack of knowledge amongst staff about GLBTI specific issues.

> *My experience has been that most mental health specialists are ignorant of issues surrounding gender identity and abuse issues, and it comes down to the transgendered population to educate the specialists who are supposed to be the experts (rather than the other way around). (Trans, 51–60)*

> *GPs not always well-equipped to help. (Gay man, 51–60)*

> *I think all mental health practitioners who deal with queer people should be well-versed in queer issues (and this is the same for all 'sub-groups', such as people who deal with drug addicts, people who deal with depressed people, and so on) in order to avoid relying on stereotypes like, "He'll grow out of it; it's just a phase" or "How do you know if you're gay if you haven't had sex with a person of the same gender?" (Gay man, 20 or younger)*

Other respondents discussed aspects of mental health practitioners' ways of working that they experienced as inappropriate.

> *It was a counselling service and it wasn't very good because I found the practitioner leading and not always open to discussion about my sexuality, but more than happy to pick my already fragile family life to pieces. (Lesbian, 21–30)*

> *Psychiatrist – turned out he was just a GP with no mental health training.*
> *He was obnoxious, rude and unprofessional. He badgered me into talking about sexual abuse issues before I was ready and mis-medicated me resulting in hideous side-effects and health problems including going from 90kg to 45kg. (Gay man, 21–30)*

For many respondents, the lack of knowledge and skills amongst practitioners was viewed as resulting from a lack of training received by staff. Improving pre-service and in-service training about a range of issues related to GLBTI people was strongly advocated to rectify this.

Respondents for the most part talked about good intentions amongst staff to provide quality services. When poor services were provided by practitioners, this was usually explained as being due to inexperience or not being trained adequately, rather than deliberate acts or personal traits of the practitioner. A lack of training was noted by many participants as being a key issue.

I am not aware there are any programmes including in their training, how to work well with this population. Someone told me I don't know if it is true or not but doctors get two hours in their seven years of training and that is for working with lesbians and gay men that's not even include transgender or intersex. (Key informant)

And so you know, most training programmes don't, don't regularly include it. For instance the Clinical Psychology training programme at Auckland doesn't regularly include any training on sexual orientation. Occasionally they do but mostly they don't. (Key informant)

Increasing the quantity and quality of training for those delivering mental health services was very strongly advocated.

Training counsellors to know exactly how to deal with GLBTI patients in advance would be beneficial. (Gay man, bisexual man, 20 or younger)

Counsellors/therapists/mental health workers who are trained and sensitive to the issues we face – we are different from the general population. (Gay man, 41–50)

For those providing mental health and other services to trans people the need for training was even more strongly advocated and several trans respondents reported how they ended up training the service provider while at the same time paying the service provider for that service.

Better education of all health providers (GPs, psychiatrists, nurses, doctors) on the treatment and care of transgender people. Better support for transgender people in help services such as suicide prevention services. (Bisexual woman, trans, 31-40)

Mental health professions get no training on trans issues. They pick that up as they go along, maybe they educate themselves when their first trans client presents. At that stage, if the transperson is looking for answers the health professional can't supply them, or the transperson ends up educating that health professional themselves from the research they have already done. Either way, we end up paying for ineffective treatment to begin with. (Trans, 31–40)

Assumptions and issues of sexual identity and gender identity

A particular issue noted by respondents was the making of assumptions by practitioners. Many reported quite negative experiences with practitioners who made negative and usually incorrect assumptions about their sexual identity, typically assuming gay, lesbian and bisexual respondents were heterosexual.

The community mental health service in Tauranga is the worst service I've ever received. I saw a psychologist there who never asked about my sexual preferences, preferring to assume that I was straight, always referring to any potential partners as boyfriends. When I accessed my records he had made particular note that a male friend I had was gay, where the sexuality of all other friends wasn't mentioned. (Bisexual woman, 21–30)

A lot of mental health services aren't aware of mental health issues for LGBTT people, assume heterosexuality until you disabuse them, and don't make any effort to show (by posters or inclusive questions) that they're supportive of LGBTT people. (Lesbian, 51–60)

There were very few reports of respondents who wished that their sexual identity was not known. However, whilst participants often wished their identity was discussed in an appropriate way, a few discussed the dangers of linking sexual identity with the pathology of mental health.

Health practitioners that have the skills to inquire about my sexual identity in a way that is not confrontational and that they ask only if it is relevant to the overall service they are providing. However it is also nice that people do not make assumptions i.e. that they think I am straight when I am not. (Gay man, 41–50)

I had an emergency doctor who wouldn't listen when I said my sexuality had nothing to do with my depression, he seemed rather transfixed. I had a friend with me so between us we sorted him out. (Lesbian, 41–50)

We also need to make sure that people don't assume if you're GLBTI you must have problems, or that if you do have mental health issues that it's because of being GLBTI. Sexuality needs to be promoted as a normal part of life, which can sometimes complicate things in combination with other issues. (Lesbian, 21–30)

In respect of trans people, linking gender identity with mental health issues remains much more problematic, because of the need to have a mental health diagnosis to access more specialised treatment through secondary health services. Trans participants reported that to access certain services they needed to have a diagnosis of gender identity disorder.

Part of the process that people have to go through to be able to be legally recognised in the appropriate sex currently requires medical interventions and the process to be able to get medical interventions requires a DSM IV diagnosis of gender identity disorder. (Key informant)

One respondent pointed out that being gay, lesbian or bisexual stopped being classified as a mental illness in 1974, but this same de-classification had not been applied to trans people.

Being gay, lesbian or bisexual is no longer a mental illness in NZ since 1974 yet being transgendered is? So where are the support services/systems that should be in place for trans communities? (Trans, age 31–40)

A key informant commented that a pregnant woman gets access to services, but she is not diagnosed as sick, and transgender people are also not sick but require access to services.

Inclusive, gay friendly services

An area associated with appropriate staff attitudes and skills and abilities was the provision of mental health services that were inclusive.

Many respondents talked about services being gay friendly, and identified the ability to access staff who were gay friendly as being the most important component of that.

It should be clear that there are particular gay friendly people that can be contacted. (Gay man, 41–50)

A wide range of staff should be on offer – male and female – a wide range of ages, and people who specialise in certain areas such as drugs and alcohol, sexual orientation, sexual abuse. (Gay man, 20 or younger)

There was some discussion about the desirability of matching GLBT staff with GLBT clients or patients. There was limited support for the notion of matching on either the basis of sexuality or gender, but there were some instances where this was noted as being desirable.

I do not think it is always necessary to see a mental health professional who is of the same sexual orientation as his patient - i.e. a gay man seeing a gay man, a bisexual trans woman seeing a bisexual trans woman, but this might make some queer people more comfortable. (Gay man, 20 or younger)

Some of my counselling/mental health issues have been centred around my sexual orientation as a gay man, and I prefer to talk to a man about these things, although the sexual orientation of my male counsellor is irrelevant, so long as he is non-judgemental and factual when it comes to such matters. (Gay man, 20 or younger)

Overall, most respondents felt that having a choice available to clients or patients was the most appropriate practice.

I think that providing 'specialists in queer' as part of mental health facilities would be beneficial, for those who seek help for matters pertaining to their sexual orientation. (Gay man, 20 or younger)

Would be good if all mental health services had at least someone that was available to gay/lesbian that was gay/lesbian. This is no different from Māori working with Māori, women working with women, etc. (Lesbian, 41–50)

The workforce in the mental health and addiction services should employ GBLTI, takatāpui, fa'afafine etc. A good model is the NZ AIDS Foundation. (Fa'afafine, 51–60)

Knowing if there is a gay man or lesbian at a mental health team could be useful if you could then access that person. Maybe being allocated a support worker on the basis of sexuality could be helpful if that is what someone wanted. (Gay man, 41–50)

To enable this choice to happen it was recognised that staff would need to be supported in their work environments.

At senior levels promote appropriate client pathways for LGBTTF staff and clients. If staff are prejudiced / have strong religious views that are derogatory towards LGBTTF people do not allow them to work with people who are non-heterosexual. Having colleagues who are prejudiced (especially in a senior role) is bad enough, being a client who is mentally unwell goes against the concept of 'do no harm'. (Bisexual woman, 31–40)

A related area of discussion was whether services should be provided within mainstream settings or whether there should be GLBT-focused services.

There was limited support for GLBT specific services, but one argument made was that having such a service would ensure that there was resource focused to meet the needs of GLBT people, rather than their needs being side-lined, and that the services would be guaranteed to be gay friendly and gay focussed.

There might be a need for us to have a specific community based organisation that is separately funded to look out for the needs of people affected with mental health disorders in the community and the reason that you would want that to be separate is because what we would perceive potentially perceive happening is that resources get sidelined in minimising and resource go away, we actually, mental health can be a pretty labour intensive one. (Key informant)

You might not want to go to a potentially stigmatizing social service or whatever it is, if there is a doctor or whatever a counsellor and especially there are a whole lot of issues around like information and confidentiality. (Key informant)

However, overwhelmingly, informants discussed that mainstream services where likely to be the most appropriate option, both from a resource and logistical point of view, and also from a clinical point of view, so that GLBT people's needs were met as part of the wider organisational services.

> *Of course the debate is do you have specific targeted services like, or some of the things that have been tried to have been done in other places or you try to improve mainstream services that they have become more inclusive or more friendly, and often in countries with limited resources like in New Zealand it is usually the latter is going to be the best approach for a lot of ways. (Key informant)*

> *I mean it doesn't matter what the health issue is the specialist service won't meet everybody's needs because I mean the other problem to deal with is that New Zealand has this small population stretched out over a long thin country and apart from the big bit up this end it is very hard to make services widely available around the rest of the country. (Key informant)*

> *You could probably have a unit that was specifically dedicated to looking out for the needs of the Rainbow community so therefore you wouldn't have to actually reinvent an entire organisation you would just need a dedicated team that says OK this is where we are based, this is what we do, and we resource region wide and provide the same kind of services but in the right context for people within the Rainbow community. (Key informant)*

For several informants, the service provided by Community Alcohol and Drug Services (CADS) Auckland, where specific programmes for GLBTI people are located within a mainstream health setting, was viewed as a desirable model.

> *Well CADS is a good example it is mainstream organisation but it is got a specialist service attached. (Key informant)*

Many informants emphasised that these mainstream services should have the ability to deal with everyone, and that quality services did not depend solely on the individual providing services.

> *I think that normalised like differing sexualities then the services should be able to meet anyone's needs. (Key informant)*

> *Mental health service recognises cultural differences and responds non-judgementally in its delivery of treatment support on the basis of a consumer's age, gender, sexual orientation. (Key informant)*

5.5 Summary

Overall, participants reported that access to, and quality of, publicly funded mental health services was poor. Those respondents who reported good mental health service experiences most often reported accessing private services.

> *The best service was from a private therapist, who has vast amounts of experience with transgender people. (Bisexual woman, trans, 31–40)*

The key issues and gaps identified related to the macro-social environment, social acceptance and connection, and services and support. A key issue identified was the negative impacts on the mental health of GLBTI people that arose from stigma and homophobia or transphobia. While some of the actions that lead to GLBTI people experiencing stigma, homophobia and transphobia were viewed as resulting from deliberate acts, these actions were also often reported as being less deliberate. Education

and general public awareness campaigns were suggested as one way to address these issues, and to raise the understanding amongst mainstream society of GLBTI issues. A need to de-stigmatise mental health issues, both within society as a whole and within GLBTI communities, was identified. Awareness campaigns were also suggested as an appropriate way to address these issues. The desirability for all health promotion to be inclusive and to include the needs of all GLBTI population groups was noted, as was the need to recognise the diversity within the GLBTI population.

Poor social acceptance and connection were identified by informants and respondents as factors that would contribute to hostile conditions in which to achieve good mental health and wellbeing. Along with broader social acceptance, support from friends and family, and ensuring support and safe environments for young people and older people were identified as important. A need for GLBTI communities to address issues within themselves, relating to supporting community members, was also discussed.

Access to mental health services and the competency of mental health services were the two issues identified in relation to mental service delivery. For all respondents who are currently accessing or would like to access mental health services, the most widely reported issue that hindered access to these services was their cost. The other main barrier was the lack of publicly funded mental health services that are available, particularly for those with mild to moderate needs. Many respondents also reported a lack of knowledge about available services. In relation to service competency, the chief issue identified was that all services should be provided in a culturally safe and appropriate way.

Ensuring mental health staff displayed appropriate attitudes, had the necessary skills and abilities to work with GLBTI people, and did not make assumptions around sexual and gender identity, were identified as important. In addition, services that were gay friendly were viewed as essential.

Nonetheless there was optimism that change was possible, given commitment from individuals and organisations.

> *And yet ... there are some government departments that have come on board and just respond very appropriately… there can be real change happen it doesn't actually need to cost very much money or much effort from people that would make a huge difference to this population. (Key Informant)*

> *Things have got a lot better over the years. GPs, support organisations are all getting there with their knowledge and understanding of our community. (Gay man, 51–60)*

6 Conclusions

6.1 Introduction

While GLBTI individuals have the same basic mental health prevention and promotion needs as members of the general population, they also experience additional unique issues related to social discrimination, personal and community social and behavioural risk factors (Johnson, et al., 2008). A wide range of international research has clearly demonstrated GLBTI individuals experience higher levels of mental health distress than their heterosexual counterparts.

This needs assessment has confirmed there is minimal policy in relation to GLBTI mental health. Limited mental health promotion or prevention services directed at GLBTI populations in New Zealand were identified. While the review of existing services did not identify robust evidence or any evaluations of the impact of existing programmes and services on the mental health and wellbeing of GLBTI New Zealanders, several GLBTI-focused services (e.g., telephone helplines, counselling) appeared well utilised. There were many reports that government-funded mainstream mental health promotion and prevention services were not responding appropriately to the needs of these groups. These findings mirror other New Zealand studies, which have also reported limited service delivery and policy attention to the health needs of these groups (Adams, 2010; Adams, et al., 2007, 2010; Pega, 2007; Pega et al., 2010).

In this section, the evidence review (Section 2) and key findings from the stakeholder consultation (Sections 4 and 5) are drawn on to inform the enhancement of GLBTI mental health promotion and service delivery in New Zealand. These findings are consistent with those developed from a three-year US-based project addressing LGBT suicide and suicide risk (Haas et al., 2010).

6.2 Building national leadership capacity

A key finding of the research is that there is very limited leadership evident with respect to mental health issues for GLBTI people, either from within government agencies, or from GLBTI communities. The findings of this research indicate that the needs of GLBTI people are largely overlooked in mainstream policy and service delivery, and many participants suggested this neglect was an area of equity or human rights concern. One option would be to develop a relationship between key agencies at local, regional and national levels and stakeholders from GLBTI communities. Stakeholders suggested that a national health alliance body representing GLBTI concerns and issues could be established, to form collaborative partnerships with agencies and provide co-ordination and leadership.

Health promotion and mental health services need to be tailored to GLBTI people's needs. Best practice guidelines are needed for mental health services.

Involving GLBTI people would enable them to advocate for a strengths-based approach, which actively promotes mental, emotional and social wellbeing, while at the same time challenging pathologising mental health discourses. This would orient any initiatives towards the improvement of social and physical environments, rather than individualistic personal-change strategies (Albee & Fryer, 2003). Involvement of GLBTI people could also guard against mental health service development being removed from the influence of GLBTI people themselves. A related outcome is the potential to develop coalitions between GLBTI people and allies in health promotion, such as funders, service providers and researchers (Hart, 1997). The combination of such factors would enhance the possibility of a GLBTI-focused framework for health (Adams, et al., 2010).

Partnerships and collaboration have been identified as important strategies in other fields, such as with respect to TLGB people and alcohol (Pega & MacEwan, 2010b) and with respect to queer youth (Metzger & Camburn, 2010).

6.3 Reducing stigma and discrimination

Despite greater social and legal acceptance of homosexuality, sexual minorities are arguably one of the few remaining minority status groups where socially sanctioned bigotry is accepted, and at times encouraged, resulting in heterosexism and anti-gay prejudice in many social institutions (Fassinger, 2008). While some participants reported that social conditions for GLBTI had improved in recent years, others noted that this improvement varied across different GLBTI groups. For example, the Transgender Inquiry and the National Project on Gender Reassignment Health Services for Trans People were identified as indicators that improvements are needed in many areas, given that discrimination impacts severely on trans people's lives. In other areas community-based initiatives are advocating for legislative and other action to address issues of human rights inequalities (e.g., same-sex marriage, and adoption rights for same-sex couples).

The literature review clearly suggests that the social environment (including actions such as prejudice, stigma, discrimination, rejection and violence) plays an important role in the mental health of GLBTI people. For this reason, it is imperative that actions aimed at reducing GLBTI people's exposure to such negative experiences and countering societal heterosexism are developed. Many of the negative impacts on the mental health and wellbeing of respondents arose from environmental and social factors rather than personal factors. A number of respondents suggested social marketing and other activities that aimed to build supportive social environments through challenging homophobic, heterosexist and discriminatory views and behaviour were necessary. Such actions would need to be evidence-based, and international initiatives evaluated for suitability in the New Zealand context. Government involvement and action in these areas is consistent with international human rights principles and obligations such as the Yogyakarta Principles (International Commission of Jurists, 2007).

6.4 Enhancing young people's safety and wellbeing

The safety of youth, particularly in school settings, has been a recent area of concern for several GLBTI-based community organisations and was a concern for many participants. Despite the Minister of Education drawing attention to the legal requirement for schools to provide a safe physical and emotional environment for students and the provision of programmes to assist with this (Ministry of Education, 2011), there is no evidence that provides reassurance that schools are safe places for GLBTI. In fact this research indicates schools are not safe places for GLBTI.

Adequate support is required for young people through peer support, information resources, and counselling services, as well as supporting schools to address GLBTI pupils' safety. Addressing bullying in schools was identified as a key issue and has been a recent focus of the Ministry of Education. Many respondents identified Rainbow Youth as the key organisation working in this area and, given its recent investigations into exploring appropriate models of supporting young people on a national basis (Metzger & Camburn, 2010), collaboration between key agencies to enhance young people's safety would be appropriate.

It is important that teachers are trained (pre-service and professional development) in suicide prevention, mental health promotion, preventing bullying, and challenging homophobia/transphobia. As well, it is not clear whether the Health and Physical Education Curriculum is meeting the needs of young GLBTI people.

6.5 Funder obligations

The evidence review has demonstrated that GLBTI people experience higher levels of mental health distress than their heterosexual counterparts. In response to this, many participants discussed the need to address these unequal mental health outcomes. Most respondents also reported that mainstream health services should be providing for GLBTI people's mental health needs.

Agencies responsible for funding and delivery of mental health and mental health promotion services need to ensure that these services are responsive to and inclusive of GLBTI people and recognise their specific needs.

Agencies involved in mental health promotion could be strengthened through a focus on GLBTI needs in ways that promote community cohesiveness, provide support for young people coming out, and deliver information and support through helplines and websites. GLBTI access to mental health services needs to be improved by ensuring they are more inclusive of GBLTI clients, including re-allocating resources for this purpose.

6.6 Research and information needs

Without access to good data, it is difficult to assess the mental health of GLBTI people (Rhodes, McCoy, Hergenrather, Omli, & DuRant, 2010) and respond to their mental health needs. The lack of data about GLBTI people and mental health remains a problem internationally (Rhodes, et al., 2010). There is very little research information available in New Zealand about the epidemiology of mental health issues for GLBTI people, or in-depth understandings of their experiences.

Particular gaps include research that addresses the needs and experiences of trans and intersex people, and of older people. Other avenues of research could focus on mental health, not just on problems, and could, for example, focus on how GLBTI people maintain their psychological wellbeing (Clarke, et al., 2010). Along with GLBTI-focused research initiatives, there remains a need for routine data collection about sexual orientation in mainstream health research (Pega, et al., 2010).

Consideration should be given to the collection of data about sexual orientation in mainstream health surveys and health research projects. Evaluations of mental health promotion and prevention services should assess their effectiveness and appropriateness for GLBTI populations.

6.7 Supporting practitioners through training and resources

Many participants talked about ensuring the competency of practitioners (e.g. GPs, school counsellors, counsellors, psychologists, psychiatrists) who provide mental health services. In particular, they identified that practitioners needed to have knowledge of GLBTI issues (both mental health-related and wider issues), and that they needed to deliver services in respectful ways and avoid making assumptions. Many participants considered that practitioners received inadequate training and education in GLBTI issues, both pre-service and in-service.

This could be addressed through training programmes and resources for professional bodies, health services and education and training providers, to enhance practitioner understanding of GLBTI issues and improve engagement with GLBTI populations. This work would need to be undertaken collaboratively by GLBTI people and workforce development agencies.

Having services that were GLBTI inclusive was identified as a priority by many participants. As well as having well-trained staff, it was noted that organisations require appropriate resources and other support. Resources should be based on best practice principles (e.g. regarding affirmative practice and inclusive language)[31]. Others suggested that an audit system[32] should be established to encourage services to review their policies, practices and procedures, make changes as necessary and maintain their inclusive practices.

[31] For examples of practice guidelines see: *Well proud: A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services* (GLBTI MAC, 2009), and *Best Practice Guidelines: Effective*

Many participants talked about practitioner competency in the provision of mental health services. In particular, they identified the need for practitioners to have knowledge of GLBTI issues (both mental health-related and wider issues), so that assumptions were avoided and services were delivered in respectful ways.

In conclusion, the findings of this study reiterate the need to ensure that appropriate mental health promotion and service provision is available to GLBTI people; but appropriate engagement by GLBTI communities is also encouraged to assist in the development of effective health promotion resources and service delivery.

It is important to recognise the diversity across the GLBTI population groups. While some needs may be the same, others may be different between the groups. This means that sometimes needs can be addressed collectively, while at other times a focus on particular group might be required. In addition, the needs of varying ethnic groups within these populations and differing age groups, especially young people and older people, may need special attention.

engagement and treatment with Rainbow Tangata Whai Ora/ service users of mental health and addictions services in Aotearoa. (Birkinhead and Rands, Auckland District Health Board 2012).

[32] For an example of an audit see: *Sexual diversity health services audit* (Gay and Lesbian Victoria, 2007).

REFERENCES

Adams, J. (2010). *Gay men and health: A critical analysis* (Unpublished PhD thesis). University of Auckland, Auckland.

Adams, J., Braun, V., & McCreanor, T. (2007). Warning voices in a policy vacuum: Professional accounts of gay men's health in Aotearoa New Zealand. S*ocial Policy Journal of New Zealand, 30*, 199-215.

Adams, J., Braun, V., & McCreanor, T. (2010). A critical analysis of gay men's health policy documents. *Gay & Lesbian Issues and Psychology Review, 6*(1), 42-59.

Adams, J., Braun, V., and McCreanor, T. (2011). Gay men talking about health: Are sexuality and health interlinked? *American Journal of Men's Health.* doi: 10.1177/1557988311421980

Adams, J., McCreanor, T., & Braun, V. (2007). *Alcohol and gay men: Consumption, promotion and policy responses.* In V. Clarke & E. Peel (Eds.), Out in psychology: Lesbian, gay, bisexual, trans and queer perspectives (pp. 369-390). Chichester, UK: John Wiley & Sons.

Adams, J., McCreanor, T., & Braun, V. (2008). Doctoring New Zealand's gay men. *The New Zealand Medical Journal, 121*(1287), 11-20.

Allen, O. (2010). *Lesbian, gay & bisexual patients: The issues for general practice*. Retrieved from www.google.co.nz/#hl=en&source=hp&biw=1099&bih=507&q=Lesbian%2C+gay+%26+bisexual+patients%3A+the+issues+for+general+practice&aq=f&aqi=&aql=&oq=&gs_rfai=&fp=ddfe4f791a9fb663.

American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). Washington, DC: American Psychiatric Association.

Aspin, C. (2002). *I didn't have to go to a finishing school to learn how to be gay: Maori gay men's understandings of cultural and sexual identity.* In H. Worth, A. Paris & L. Allen (Eds.), The life of Brian: Masculinities, sexualities and health in New Zealand (pp. 91-103). Dunedin: University of Otago Press.

Aspin, C. (2005). *The place of takātapui identity within Māori society: Reinterpreting Maori sexuality within a contemporary context*. Paper presented at the Competing Diversities: Traditional Sexualities and Modern Western Sexual Identity Constructions Conference, Mexico City, Mexico.

Aspin, C., & Hutchings, J. (2006). Maori sexuality. In M. Mulholland (Ed.), *State of the Maori nation: Twenty-first-century issues in Aotearoa* (pp. 227-235). Auckland: Reed.

Aspin, C., Reid, A., Worth, H., Saxton, P., Hughes, A., Robinson, E., & Segedin, R. (1998). *Male call/waea mai, tane ma report no.3: Maori men who have sex with men*. Auckland: New Zealand AIDS Foundation.

Aspin, C., Reynolds, P., Lehavot, K., & Taiapa, J. (2009). An investigation of the phenomenon of non-consensual sex among Maori men who have sex with men. *Culture, Health & Sexuality, 11*(1), 35-49.

Associate Minister of Health. (2006). New Zealand suicide prevention strategy 2006–2016. Wellington: Ministry of Health.

Athanases, S. Z., & Larrabee, T. G. (2003). *Toward a consistent stance in teaching for equity: Learning to advocate for lesbian- and gay-identified youth.* Teaching and Teacher Education, 19(2), 237-261.

Austin, E., & Irwin, J. (2010). *Health behaviors and health care utilization of southern lesbians.* Women's Health Issues, 20(3), 178-184.

Australian Human Rights Commission. (2009). *Surgery on intersex infants and human rights*. Retrieved from www.hreoc.gov.au/genderdiversity/surgery_intersex_infants2009.html.

Bagley, C., & D'Augelli, A. (2000). Suicidal behaviour in gay, lesbian and bisexual youth: It's an international problem that is associated with homophobic legislation. *British Medical Journal, 320*(7250), 1617-1618.

Bakker, F., Sandfort, T., Vanwesenbeeck, I., van Lindert, H., & Westert, G. (2006). Do homosexual persons use health care services more frequently than heterosexual persons: Findings from a Dutch population survey. *Social Science and Medicine, 63*(8), 2022-2030.

Bakker, L. J., & Cavender, A. (2003). Promoting culturally competent care for gay youth. *Journal of School Nursing, 19*(2), 65-72.

Balsam, K., Beauchaine, T., Mickey, R., & Rothblum, E. (2005). Mental health of lesbian, gay, bisexual, and heterosexual siblings: Effects of gender, sexual orientation, and family. *Journal of Abnormal Psychology, 114*(3), 471-476.

Barry, M., Domitrovich, C., & Lara, M. (2005). The implementation of mental health promotion programmes. *Promotion and Education, 12*(2), 30-36.

Bass, E., & Kaufman, K. (1996). *Free your mind: The book for gay, lesbian and bisexual youth and their allies*. New York: Harper Collins.

Beatty, R. L., Madl-Young, R., & Bostwick, W. B. (1998). *Lesbian, gay, bisexual, and transgender substance abuse.* In I. H. Meyer & M. E. Northridge (Eds.), The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations (pp. 201-220). New York: Springer.

Berenbaum, S. A. (2003). Management of children with intersex conditions: Psychological and methodological perspectives. *Growth, Genetics & Hormones, 19*(1), 1-6.

Berenbaum, S. A., Korman Bryk, K., Duck, S. C., & Resnick, S. M. (2004). Psychological adjustment in children and adults with congenital adrenal hyperplasia. *The Journal of Pediatrics, 144*(6), 741-746.

Berg, M., Mimiaga, M., & Safren, S. (2004). Mental health concerns of HIV-infected gay and bisexual men seeking mental health services: An observational study. *AIDS Patient Care and STDs, 18*(11), 635-643.

Birkinhead, A., and Rands, D. (2012). *Best Practice Guidelines: Effective engagement and treatment with Rainbow Tangata Whai Ora/service users of mental heatlh and addictions services in Aotearoa.* Auckland District Health Board.

Bockting, W., Knudsen, G., & Goldberg, J. (2007). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism, 9*(3/4), 35-82.

Bonvicini, K. A., & Perlin, M. J. (2002). The same but different: Clinician-patient communication with gay and lesbian clients. *Patient Education and Counseling, 51*(2), 115-122.

Boroughs, M., & Thompson, J. K. (2002). Exercise status and sexual orientation as moderators of body image disturbance and eating disorders in males. *International Journal of Eating Disorders, 31*(3), 307-311.

Bos, H. M. W., Sandfort, T. G., de Bruyn, E. H., & Hakvoort, E. M. (2008). Same-sex attraction, social relationships, psychosocial functioning, and school performance in early adolescence. *Developmental Psychology, 44*(1), 59-68.

Bos, H. M. W., van Balen, F., van den Boom, D. D., & Sandfort, T. G. M. (2004). Minority experience of parenthood and child adjustment in lesbian families. *Journal of Reproductive and Infant Psychology, 22*(4), 291-304.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Brooks, V. R. (1981). *Minority stress and lesbian women*. Lexington, US: Lexington Books.

Burckell, L., & Goldfried, M. (2006). Therapist qualities preferred by sexual-minority individuals. *Psychotherapy, 43*(1), 32-49.

Burgard, S. A., Cochran, S. D., & Mays, V. M. (2005). Alcohol and tobacco use patterns among heterosexually and homosexually experienced Californian women. *Drug and Alcohol Dependence, 77*(1), 61-70.

Case, P., Austin, B., Hunter, D. J., Manson, J. E., Malspeis, S., Willett, W., & Spiegelman, D. (2004). Sexual orientation, health risk factors, and physical functioning in the Nurse's Health Study 11. *Journal of Women's Health, 13*(9), 1033-1047.

Casey, M. (2009). Addressing key theoretical approaches to gay male sexual identity: Issues and insights for practitioners of mental health. *Critical Public Health, 19*(3-4), 293-305.

Clarke, V., Ellis, S. J., Peel, E., & Riggs, D. W. (2010). *Lesbian, gay, bisexual, trans and queer psychology: An introduction*. Cambridge: Cambridge University Press.

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.

Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *Journal of Homosexuality, 51*(3), 53-69.

Clover, D. (2006). Overcoming barriers for older gay men in the use of health services: A qualitiative study of growing older, sexuality and health. *Health Education Journal, 65*(1), 41-52.

Coates, S., & Spector Person, E. (1985). Extreme boyhood femininity: Isolated behaviour or pervasive disorder? *Journal of the American Academy of Child and Adolescent Psychiatry, 24*(6), 702-709.

Cochran, S. D. (2001). Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter? *American Psychologist, 56*(11), 931-947.

Cochran, S. D., Keenan, C., Schober, C., & Mays, V. M. (2000). Estimates of alcohol use and clinical treatment needs among homosexually active men and women in the US population. *Journal of Consulting and Clinical Psychology, 68*(6), 1062-1071.

Cochran, S. D., & Mays, V. M. (1994). Depressive distress among homosexually active African American men and women. *American Journal of Psychiatry, 151*(4), 524-529.

Cochran, S. D., & Mays, V. M. (2000a). Lifetime prevalence of suicide symptoms and affective disorders among men reporting same-sex sexual parenters: Results from NHANES 111. *American Journal of Public Health, 90*(4), 573-578.

Cochran, S. D., & Mays, V. M. (2000b). Relation between psychiatric symptoms and behaviorally defined sexual orientation in a sample of the US population. *American Journal of Epidemiology, 151*(5), 516-523.

Cochran, S. D., & Mays, V. M. (2009). Burden of psychiatric morbidity among lesbian, gay, and bisexual individuals in the California Quality of Life Survey. *Journal of Abnormal Psychology, 118*(3), 647-658.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*(1), 53-61.

Cole, S. D., Denny, D., Dyler, E. A., & Samons, S. (2000). Issues of transgender. In I. Szuchman & F. Muscarella (Eds.), *Psychological perspectives on human sexuality* (pp. 80-101). New York: Wiley.

Corboz, J., Dowsett, G., Mitchell, A., Couch, M., Agious, P., & Pitts, M. (2008). *Feeling queer and blue: A review of the literature on depression and related issues among gay, lesbian, bisexual and other homosexually active people. A report from the Australian Research Centre in Sex, Health and Society*. Melbourne: La Trobe University, Australian Research Centre in Sex, Health and Society.

Couch, M., Pitts, M., Mulcare, H., Croy, S., Mitchell, A., & Patel, S. (2007). *Tranznation: A report on the health and wellbeing of transgendered people in Australia and New Zealand*. Melbourne: La Trobe University, Australian Research Centre in Sex, Health & Society.

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.

Crisp, C., & McCave, E. (2007). Gay affirmative practice: A model for social work practice with gay, lesbian, and bisexual youth. *Child and Adolescent Social Work Journal, 24*(4), 403-421.

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.

D'Augelli, A., Grossman, A. H., Hershberger, S. L., & O'Connell, T. S. (2001). Aspects of mental health among older lesbian, gay and bisexual adults. *Aging Mental Health, 5*(2), 149-158.

D'Augelli, A. R. (2002). Mental health problems among lesbian, gay, and bisexual young people ages 14 to 21. *Clinical Child Psychology and Psychiatry, 7*(3), 433-456.

D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2006). Childhood gender atypicality, victimisation, and PTSD among lesbian, gay, and bisexual youth. *Journal of Interpersonal Violence, 21*(11), 1462-1482.

Dorfman, R., Walters, K., Burke, P., & Hardin, L., Karanik, T., John Raphael, J., & Silverstein, E. (1995). Old, sad, and alone: The myth of the aging homosexual. *Journal of Gerontological Social Work, 24*(1&2), 29-44.

Dowsett, G. W., Keys, D., & Wain, D. (2005). Gay men don't get "messy": Injecting drug use and gay community. *Sexuality Research and Social Policy: Journal of NSRC, 2*(1), 22-36.

Eady, A., Dobinson, C., & Ross, L. (2010). Bisexual people's experiences with mental health services: A qualitative investigation. *Community Mental Health Journal*, DOI 10.1007/s10597-010-9329-x.

Ebin, J., & Van Wagenen, A. (2006). Developing successful sexual health and support services for bisexual people: Lessons learned from the BiHealth program. *Journal of Bisexuality, 6*(1/2), 165-189.

Eisenberg, M. E., & Resnick, M. (2006). Suicidality among gay, lesbian and bisexual youth: The role of protective factors *Journal of Adolescent Health, 39*(5), 662-668.

Eliason, M. J., & Schope, R. (2001). Does "Don't ask don't tell"apply to health care? Lesbian, gay, and bisexual people's disclosure to health care providers. *Journal of the Gay and Lesbian Medical Association*, 5(4), 125-134.

Espelage, D., Aragon, S., Birkett, M., & Koenig, B. (2008). Homophobic teasing, psychological outcomes, and sexual orientation among high school students: What influence do parents and schools have? *School Psychology Review, 37*(2), 202-216.

Fassinger, R. E. (2008). Workplace diversity and public policy: Challenges and opportunities for psychology. *American Psychologist*, 63(4), 252-268.

Fenaughty, J. (2000). *Life on the seesaw: An assessment of suicide risk and resiliency for bisexual and gay male youth in Aotearoa/New Zealand* (Unpublished master's thesis). University of Auckland, Auckland.

Fenaughty, J. (2004). The end of queer: Heteronormativity and suicide. In L. Alice & L. Star (Eds.), *Queer in Aotearoa New Zealand* (pp. 71-85). Palmerston North: Dunmore Press.

Fenaughty, J., Braun, V., Gavey, N., Aspin, C., Reynolds, P., & Schmidt, J. (2006). *Sexual coercion among gay and bisexual men in Aotearoa/New Zealand*. Auckland: Department of Psychology, University of Auckland.

Fenaughty, J., & Harré, N. (2003). Life on the seesaw: A qualitative study of suicide resiliency factors for young gay men. *Journal of Homosexuality, 45*(1), 1-22.

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*(10), 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*(7), 971-981.

Flowers, P. (2009). How does an emergent LGBTQ health psychology reconstruct its subject? *Feminism & Psychology, 19*(4), 555-560.

French, S., Story, M., Remafedi, G., Resnick, M., & Blum, R. W. (1996). Sexual orientation and prevalence of body dissatisfaction and eating disordered behaviors: A population-based study of adolescents. *International Journal of Eating Disorders, 19*(2), 119-126.

Friedman, R. C. (1999). Homosexuality, psychopathology and suicidality. *Archives of General Psychiatry, 56*(10), 887-888.

Galea, S., & Putnam, S. (2007). The role of macrosocial determinants in shaping the health of populations. In S. Galea (Ed.), *Macrosocial determinants of population health* (pp. 3-14). New York: Springer.

Galliher, R. V., Rostosky, S. S., & Hughes, H. K. (2004). School belonging, self-esteem, and depressive symptoms in young people: An examination of sex, sexual attraction status, and urbanicity. *Journal of Young People and Adolescence, 33*(3), 235-245.

Gamache, P., & Lazear, K. (2009). *Asset-based approaches for lesbian, gay, bisexual, transgender, questioning, intersex, and two-spirit (LGBTQI2-S): Youth and families systems of care*. Tampa: University of South Florida.

Gapka, S., & Raj, R. (2004). *Trans health project: A position paper and resolution adopted by the Ontario Public Health Association (OPHA)*. Retrieved from www.opha.on.ca/our_voice/ppres/papers/2003-06_pp.pdf.

Garofalo, R., Wolf, R. C., Wissow, L. S., Woods, E. R., & Goodman, E. (1999). Sexual orientation and risk of suicide attempts among a representative sample of youth. *Archives of Pediatrics and Adolescent Medicine, 153*(5), 487-493.

Gay and Lesbian Victoria. (2007). *Sexual diversity health services audit*. Retrieved from www.glhv.org.au/files/glhv_%20audit_2.pdf.

GLBTI MAC. (2009). *Well proud: A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services.* Melbourne: Department of Health.

Greene, B. (1997). Ethnic minority lesbians and gay men: Mental health and treatment issues. In B. Greene (Ed.), *Ethnic and cultural diversity among lesbians and gay men* (pp. 216-239). London: Sage.

Gruskin, E. P., Hart, S., Gordon, N., & Ackerson, L. (2001). Patterns of cigarette smoking and alcohol use among lesbians and bisexual women enrolled in a large health maintenance organisation. *American Journal of Public Health, 91*(6), 976-979.

Harper, G. W., & Schneider, M. (2003). Oppression and discrimination among lesbian, gay, bisexual, and transgendered people and communities: A challenge for community psychology. *American Journal of Community Psychology, 31*(3/4), 243-252.

Hart, G. (1997). 'Yes, but does it work?' Impediments to rigorous evaluations of gay men's health promotion. In L. Segal (Ed.), *New sexual agendas* (pp. 113-124). New York: New York University Press.

Hatzenbuehler, M., Keyes, K., & Hasin, D. (2009). State-level policies and psychiatric morbidity in lesbian, gay, and bisexual populations. *American Journal of Public Health, 99*(12), 2275-2281.

Hegna, K., & Wichstrøm, L. (2007). Suicide attempts among Norwegian gay, lesbian and bisexual youths: General and specific risk factors. *Acta Sociologica, 50*(1), 21-37.

Henning-Stout, M., James, S., & Macintosh, S. (2000). Reducing harassment of lesbian, gay, bisesexual, transgender, and questioning youth in schools. *School Psychology Review, 29*(2), 180-191.

Henrickson, M. (2006). Ko wai ratou? Managing multiple identities in lesbian, gay and bisexual New Zealand Maori. *New Zealand Sociology, 21*(2), 251-273.

Hepp, U., Kraemer, B., Schynder, U., Miller, N., & Delsignore, A. (2005). Psychiatric comorbidity in gender identity disorder. *Journal of Psychosomatic Research, 58*(3), 259-261.

Herewini, T., & Sheridan, R. H. (1994). *A report on the health needs of Maori gay men*. Wellington: Public Health Commission.

Hernandez, M., & Nesman, T. (2006). *Conceptual model for accessibility of mental health services to culturally/linguistically diverse populations.* Paper presented at the 19th Annual Research Conference: A System of Care for Children's Mental Health: Expanding the Research Base, Tampa, Florida.

Heubner, D. M., Rebchook, G. M., & Kegeles, S. M. (2004). Experiences of harassment, discrimination and physical violence among young gay and bisexual men. *America Journal of Public Health, 94*(7), 1200-1203.

Higgins, A., & Allen, O. (2010). *Gay, lesbian & bisexual people: A good practice guide for mental health nurses*. Dublin: The Irish Institute of Mental Health Nursing.

Hughes, T., Szalacha, L., & McNair, R. (2010). Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Social Science and Medicine, 71*(4), 824-831.

Hughes, T. L., & Eliason, M. J. (2002). Substance use and abuse in lesbian, gay, bisexual and transgender populations. *The Journal of Primary Prevention, 22*(3), 263-298.

Hughes, T. L., & Wilsnack, S. (1997). Use of alcohol among lesbians: Research and clinical implications. *American Journal of Orthopsychiatry, 61*(1), 20-36.

Human Rights Commission. (2008). *To be who I am / kia noho au ki toku ano ao*. Auckland: Human Rights Commission.

Human Rights Commission. (n.d.). *Health of trans people*. Retrieved from www.hrc.co.nz/human-rights-environment/action-on-the-transgender-inquiry/health-of-trans-people/.

International Commission of Jurists. (2007). *Yogyakarta principles – principles on the application of international human rights law in relation to sexual orientation and gender identity, March 2007*. Retrieved from www.unhcr.org/refworld/docid/48244e602.html.

Ireland, K., Southgate, E., Knox, S., Van de Ven, P., Howard, J., & Kippax, S. (1999). *Using and the 'scene': Patterns and contexts of drug use among Sydney gay men*. Sydney: National Centre in HIV Social Research, University of New South Wales.

Irwin, L. (2007). Homophobia and heterosexism: Implications for nursing and nursing practice. *Australian Journal of Advanced Nursing, 25*(1), 70-76.

Jané-Llopis, E., Barry, M., Hosman, C., & Patel, V. (2005). Mental health promotion works: A review. *Promotion and Education, 12*(Suppl. 2), 9-25.

Jillson, I. A. (2002). Opening closed doors: Improving access to quality health services for LGBT populations. *Clinical Research and Regulatory Affairs, 19*(2/3), 153-190.

Johnson, C., Mimiaga, M., & Bradford, J. (2008). Health care issues among lesbian, gay, bisexual, transgender and intersex (LGBTI) populations in the United States: Introduction. *Journal of Homosexuality, 54*(3), 213-224.

Jones, B. (2001). Is having the luck of growing old in the gay, lesbian, bisexual and transgender community good or bad luck? *Journal of Gay and Lesbian Social Services, 13*(4), 13-14.

Jones, M. A., & Gabriel, M. A. (1999). Utilisation of psychotherapy by lesbians, gay men, and bisexuals: Findings from a nationwide survey. *American Journal of Orthopsychiatry, 69*(2), 209-219.

Jordan, K. M. (2000). Substance abuse among gay, lesbian, bisexual, transgender and questioning adolescents. *School Psychology Review, 29*(2), 201-206.

Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A., & Christensen, H. (2002). Sexual orientation and mental health: Results from a community survey of young and middle-aged adults. *British Journal of Psychiatry, 180*(5), 423-427.

Joubert, N., & Raeburn, J. (1998). Mental health promotion: Problems and possibilities. *International Journal of Mental Health Promotion,* Inaugural Issue(September), 15-22.

Kaufman, J. S., Carlozzi, A. F., Boswell, D. L., Barnes, L. L. B., Wheeler-Scruggs, K., & Levy, P. A. (1997). Factors influencing therapist selection among gays, lesbians, and bisexuals. *Counselling Psychology Quarterly, 10*(3), 287-297.

Keleher, H., & Armstrong, R. (2005). *Evidence-based mental health promotion resource*. Melbourne: Department of Human Services and VicHealth.

Kelleher, C. (2009). Minority stress and health: Implications for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) young people. *Counselling Psychology Quarterly, 22*(4), 373-379.

Knox, S., Kippax, S., Crawford, J., Prestage, G., & Van de Ven, P. (1999). Non-prescription drug use by gay men in Sydney, Melbourne and Brisbane. *Drug and Alcohol Review, 18*(4), 425-433.

Koh, A., & Ross, L. (2006). Mental health issues: A comparison of lesbian, bisexual and heterosexual women. *Journal of Homosexuality, 51*(1), 33-57.

Kulkin, H. (2006). Factors enhancing adaptive coping and mental health in lesbian youth: A review of the literature. *Journal of Homosexuality, 50*(4), 97-111.

Kurtzman, H. S., & Omoto, A. (2006). Introduction: Current and future research on lesbian, gay, and bisexual people. In A. Omoto & H. S. Kurtzman (Eds.), *Sexual orientation and mental health* (pp. 3-9). Washington: American Psychological Association.

Langdridge, D. (2007). Gay affirmative therapy: A theoretical framework and defence. *Journal of Gay and Lesbian Psychotherapy, 11*(1), 27-43.

Lasser, J., & Tharinger, D. (2003). Visibility management in school and beyond: A qualitative study of gay, lesbian, bisexual youth. *Journal of Adolescence, 26*(2), 233-244.

Lawrence, A. A. (2007). Transgender health concerns. In I. Meyer & M. E. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations* (pp. 473-505). New York: Springer.

Lebolt, J. (1999). Gay affirmative psychotherapy: A phenomenological study. *Clinical Social Work, 27*(4), 355-370.

Lemoire, S. J., & Chen, C. P. (2005). Applying person-centred counseling to sexual minority adolescents. *Journal of Counseling and Development, 83*(2), 146-154.

Liddle, B. J. (1997). Gay and lesbian clients' selection of therapists and utilisation of therapy. *Psychotherapy, 34*(1), 11-18.

Lipkin, A. (1999). *Understanding homosexuality, changing schools: A text for teachers, counselors, and administrators*. Boulder: Westview Press.

Little, J. N. (2001). Embracing gay, lesbian, bisexual and transgendered youth in school-based settings. *Child & Youth Care Forum, 30*(2), 99-110.

Lombardi, E. L., & van Servellen, G. (2000). Building culturally sensitive substance use prevention and treatment programs for transgendered populations. *Journal of Substance Abuse Treatment, 19*(3), 291-296.

Luckstead, A. (2004). Lesbian, gay, bisexual, and transgender people receiving services in the public health system: Raising issues. *Journal of Gay & Lesbian Psychotherapy, 8*(3/4), 25-42.

Maisto, S. A., Carey, M. P., Carey, K. B., Gordon, C. M., Schum, J. L., & Lynch., K. G. (2004). The relationship between alcohol and individual differences variables on attitudes and behavioral skills relevant to sexual health among heterosexual young adult men. *Archives of Sexual Behavior, 33*(1), 571-584.

Makadon, H. J., Mayer, K. H., Potter, J., & Goldhammer, H. (2008). *Fenway guide to lesbian, gay, bisexual and transgender health*. Philadelphia: American College of Physicans.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*(3), 438-450.

Masten, A. S., & Powell, J. L. (2003). A resilience framework for research, policy and practice. In S. S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. 1-28). New York: Cambridge University Press.

Matthews, A. K., Hughes, T. L., Johnson, T., Razzano, L. A., & Cassidy, R. (2002). Prediction of depressive distress in a community sample of women: The role of sexual orientation. *American Journal of Public Health, 92*(7), 1131-1139.

Mays, V. M., & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay and bisexual adults in the United States. *Journal of Public Health, 91*(11), 1869-1876.

McCreanor, T., & Nairn, R. (2002). Tauiwi general practitioners' talk about Maori health: Interpretative repertoires. *The New Zealand Medical Journal, 115*(1167). Retrieved from www.nzma.org.nz/journal/115-1167/1272/.

McInnes, D., Hurley, M., Prestage, G., & Hendry, O. (2001). *Enacting sexual contexts: Negotiating the self, sex and risk in sex on premises venues*. Sydney: University of Western Sydney.

McLaren, S. (2006). The interrelations between sexual orientation, sense of belonging and dysphoria among Australian women. *Women and Health, 43*(3), 123-137.

McLaren, S., Jude, B., & McLachlan, A. (2008). Sense of belonging to the general and gay communities as predictors of depression among gay men. *International Journal of Men's Health, 7*(1), 90-99.

McLaren, S., Jude, B., & McLachlan, A. (2007). Sexual orientation, sense of belonging and depression in Australian men. *International Journal of Men's Health, 6*(3), 259-272.

McNair, R., & Hegarty, K. (2010). Guidelines for primary care of lesbian, gay, and bisexual people: A systematic review. *Annals of Family Medicine, 8*(6), 533-541.

McNair, R., Kavanagh, A., Agius, P., & Tong, B. (2005). The mental health status of young adult and mid-life non-heterosexual Australian women. *Australian and New Zealand Journal of Public Health, 29*(3), 265-271.

Meads, C., Buckley, E., & Sanderson, P. (2007). Ten years of lesbian health survey research in the UK West Midlands. *BMC Public Health, 7*(art. no. 251). doi:10.1186/1471-2458-1187-1251.

Meckler, G. D., Elliott, M. N., Kanouse, D. E., Beals, K. P., & Schuster, M. A. (2006). Nondisclosure of sexual orientation to a physician among a sample of gay, lesbian, and bisexual youth. Archives of Pediatrics & Adolescent Medicine, 160(12), 1248-1254.

Meneses, V. (2010). *Takataapui ora: Rainbow health & wellbeing. Framework for community based action*. Auckland: OUTLine NZ.

Mental Health Commission. (2009). *How to access mental health services?* Retrieved from www.mhc.govt.nz/Content/Mental-Health-Information/Accessing-Mental-Health-Services.htm.

Metzger, N., & Camburn, F. (2010). *Rainbow Youth national outreach scoping project*. Auckland: Point Research.

Meyer, I. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*(11), 38-56.

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

Meyer, I. H. (2007). Prejudice and stress as social stressors. In I. H. Meyer & M. E. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations* (pp. 242-267). New York: Springer.

Millard, J. (1995). Suicide and suicide attempts in the lesbian and gay community. *Australia and New Zealand Journal of Mental Health Nursing, 4*(4), 181-189.

Mills, T. C., Paul, J., Stall, R., Pollack, L., Canchola, J., Chang, J. M. S., Moskowitz, J. T., & Catania, J. A. (2004). Distress and depression in men who have sex with men: The urban men's health study. *American Journal of Psychiatry, 161*(2), 278-285.

Ministry of Education. (2010). Interim Professional Standards. Retrieved from http://www.minedu.govt.nz/NZEducation/EducationPolicies/Schools/SchoolOperations/EmploymentConditionsAndEvaluation/InterimProfessionalStandards/Revised_Professional_Standards_for_Secondary_and_Area_School_Principals.aspx

Ministry of Education. (2010). The National Administration Guidelines (NAGs). Retrieved from www.minedu.govt.nz/NZEducation/EducationPolicies/Schools/PolicyAndStrategy/PlanningReportingRelevantLegislationNEGSAndNAGS/TheNationalAdministrationGuidelinesNAGs.aspx#NAG4.

Ministry of Education. (2011). Safe physical and emotional environment for students. Retrieved from http://www.minedu.govt.nz/Boards/LegalObligations/SafeEnvironment.aspx.

Minister of Health. (2005). *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan*. Wellington: Ministry of Health.

Ministry of Health (2001). *Building on strengths: A guide for action. A new approach to promoting mental health in New Zealand/Aotearoa*. Wellington. Ministry of Health.

Ministry of Health. (2002). *Youth health: A guide to action*. Wellington: Ministry of Health.

Ministry of Health (2008). *New Zealand Suicide Prevention Action Plan 2008-2012: The evidence for action*. Wellington: Ministry of Health.

Ministry of Health. (2009). Depression – about us. Retrieved from www.depression.org.nz/content/about.

Needham, B., & Austin, E. (2010). Sexual orientation, parental support, and health during the transition to young adulthood. *Journal of Youth and Adolescence, 39*(10), 1189-1198.

Nesmith, A. A., Burton, D. L., & Cosgrove, T. J. (1999). Gay, lesbian, and bisexual youth and young adults: Social support in their own words. *Journal of Homosexuality, 37*(1), 95-108.

Neville, S., & Alpass, F. (2006). Older men and worries – the impact on well-being. *Vision. A Journal of Nursing, 14*(1), 4-7.

Neville, S., & Henrickson, M. (2006). Perceptions of lesbian, gay and bisexual people of primary healthcare services. *Journal of Advanced Nursing, 55*(4), 407-415.

Neville, S., & Henrickson, M. (2010). 'Lavender retirement': A questionnaire survey of lesbian, gay and bisexual people's accommodation plans for old age. *International Journal of Nursing Practice, 16*(6), 586-594.

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research, 47*(1), 12-23.

Nuttbrock, L., Rosenblum, A., & Blumenstein, R. (2002). Transgender identify affirmation and mental health. *International Journal of Transgenderism, 6*(2). Retrieved from www.iiav.nl/ezines/web/IJT/97-03/numbers/symposion/ijtvo06no04_03.htm.

Oetjen, H., & Rothblum, E. D. (2000). 'When lesbians aren't gay: Factors affecting depression among lesbians'. *Journal of Homosexuality, 39*(1), 49-73.

Peel, E., & Thomson, M. (2009). Lesbian, gay, bisexual, trans and queer health psychology: Historical development and future possibilities. *Feminism & Psychology, 19*(4), 427-436.

Pega, F. (2007). *Health policies for lesbian, gay, bisexual, transgender, and intersex people* (Unpublished master's thesis). Massey University, Palmerston North.

Pega, F., Gray, A., & Veale, J. (2010). Sexual orientation data in probability surveys: Improving data quality and estimating core population measures from existing New Zealand survey data, 2010/2. (Official Statistics Research Series, Vol 2010-2). *Statisphere - The official statistics forum*. Retrieved from www.statisphere.govt.nz.

Pega, F., & MacEwan, I. (2010a). *Making visible: Improving services for sexual minority people in alcohol and other drug addiction prevention and treatment*. Wellington: Matua Raki - National Addiction Workforce Development Centre.

Pega, F., & MacEwan, I. (2010b). *Takatapui, lesbian, gay, and bisexual scoping exercise*. Wellington: Alcohol Advisory Council of New Zealand.

ProMenPol Project European Commission. (2009). A manual for promoting mental health and wellbeing: The educational setting. Retrieved from www.mentalhealthpromotion.net.

Rankine, J. (2008). *Lesbian, gay, bisexual, takatapui, transgender community centre needs assessment*. Auckland: Words and Pictures.

Remafedi, G., French, S., Story, M., Resnick, M., & Blum, B. (1998). The relationship between suicide risk and sexual orientation: Results of a population based study. *American Journal of Public Health, 88*(1), 57-60.

Rendle-Short, J. (2005). 'I've got a paper-shuffler for a husband': Indexing sexuality on talk-back radio. *Discourse & Society, 16*(4), 561-578.

Rhodes, S. D., McCoy, T., Hergenrather, K. C., Omli, M. R., & DuRant, R. H. (2010). Exploring the health behavior disparities of gay men in the United States: Comparing gay male university students to their heterosexual peers. In S. R. Harper & I. Frank Harris (Eds.), *College men and masculinities: Theory, Research, and implications for practice* (pp. 370-382). San Francisco: Jossey-Bass.

Richardson, G. E. (2002). The metatheory of resilience and resiliency. *Journal of Clinical Psychology, 58*(3), 307-321.

Riches, M. (2011) How do we make it better? Mapping the steps towards a more supportive coming out environment for queer youth in Aotearoa New Zealand (unpublsihed paper) The University of Waikato, Hamilton.

Riggle, E., Whitman, J., Olson, A., Rostosky, S., & Strong, S. (2008). The positive aspects of being a lesbian or gay man *Professional Psychology: Research and Practice, 39*(2), 210-217.

Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York: The Guilford Press.

Roberts, S., Grindel, C., Patsdaughter, C., DeMarco, R., & Tarmina, M. (2004). Lesbian use and abuse of alcohol: Results of the Boston Lesbian Health Project II. *Substance Abuse, 25*(4), 1-9.

Roberts, S. J., Grindel, C. G., Patsdaughter, C., Reardon, K., & Tarmina, M. S. (2004). Mental health problems and use of services of lesbians: Results of the Boston Lesbian Health Project 11. *Journal of Gay and Lesbian Social Services, 17*(4), 1-14.

Rosario, M., Hunter, J., & Gwadz, M. (1997). Exploration of substance use among lesbian, gay, and bisexual youth: Prevalence and correlates. *Journal of Adolescent Research, 12*(4), 454-476.

Rosario, M., Schrimshaw, E., & Hunter, J. (2006). A model of sexual risk behaviors among young gay and bisexual men: Longitudinal associations of mental health, substance abuse, sexual abuse, and the coming-out process. *AIDS Education and Prevention, 18*(5), 444-460.

Rosenberg, S., Rosenberg, J., Huygen, C., & Klein, E. (2005). No need to hide: Out of the closet and mentally ill. *Best Practices in Mental Health: An International Journal, 1*(1), 72-85.

Ross, L., Dobinson, C., & Eady, A. (2010). Perceived determinants of mental health for bisexual people: A qualitative examination. *American Journal of Public Health, 100*(3), 496-512.

Rossen, F. V., Lucassen, M. F. G., 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 sex or both sexes*. Auckland: University of Auckland.

Russell, C. J., & Keel, P. K. (2002). Homosexuality as a specific risk factor for eating disorders in men. *Eating Disorders, 31*(3), 300-306.

Saphira, M., & Glover, M. (2001). The effects of coming out on relationships and health. *Journal of Lesbian Studies, 5*(1-2), 183-194.

Saxton, P., Dickson, N., & Hughes, A. (2006). *GAPSS 2006: Findings from the Gay Auckland Periodic Sex Survey*. Auckland: New Zealand AIDS Foundation.

Semp, D. (2006). *A public silence: Discursive practices surrounding homosexuality* (Unpublished PhD thesis). University of Auckland, Auckland.

Shankle, M. D., Maxwell, C. A., Katzman, E. S., & Landers, S. (2003). An invisible population: Older lesbian, gay, bisexual and transgender individuals. *Clinical Research and Regulatory Affairs, 20*(2), 159-182.

Share, T. L., & Mintz, L. B. (2002). Differences between lesbians and heterosexual women in disordered eating and related attitudes. *Journal of Homosexuality, 42*(4), 89-106.

Shipherd, J., Green, K., & Abramovitz, S. (2010). Transgender clients: Identifying and minimizing barriers to mental health treatment. *Journal of Gay and Lesbian Mental Health, 14*(2), 94-108.

Siever, M. D. (1994). Sexual orientation and gender as factors in socioculturaly acquired vulnerability to body dissatisfaction and eating disorders. *Journal of Consulting and Clinical Psychology, 62*(2), 251-260.

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.

Slavin, S. (2001). Recreational use of amyl nitrite. *Venereology, 14*(2), 81-82.

Slavin, S. (2004a). Crystal methamphetamine use among gay men in Sydney. *Contemporary Drug Problems, 31*(3), 425-465.

Slavin, S. (2004b). Drugs, space and sociality in a gay nightclub in Sydney. *Journal of Contemporary Ethnography, 33*(3), 265-295.

Sorensen, L., & Roberts, S. (1997). Lesbian uses of and satisfaction with mental health services: Results from Boston Lesbian Health Project. *Journal of Homosexuality, 33*(1), 35-49.

Southgate, E., & Hopwood, M. (2001). The role of folk pharmacology and lay experts in harm reduction: Sydney gay drug using networks. *International Journal of Drug Policy, 12*(4), 321-335.

Stall, R., & Purcell, D. W. (2000). Intertwining epidemics: A review of research on substance use among men who have sex with men and its connection to the AIDS epidemic. *AIDS and Behavior, 4*(2), 181-192.

Stall, R. D., & Hays, R. D. (2000). The gay '90s: A review of research in the 1990s on sexual behavior and HIV risk among men who have sex with men. *AIDS, 14*(Suppl. 3), S110-S114.

Steele, L. S., Ross, L. E., Dobinson, C., Veldhuizen, S., & Tinmouth, J. M. (2009). Women's sexual orientation and health: Results from a Canadian population-based survey. *Women and Health, 49*(5), 353-367.

Szalacha, L. A. (2003). Safer sexual diversity climates: Lessons learned from and evaluation of Massachusetts Safe Schools Program for gay and lesbian students. *American Journal of Education, 110*(1), 58-88.

Tarzian, A., & Cohen, M. (2006). Descriptive research. In J. Fitzpatrick & M. Wallace (Eds.), *Encyclopedia of nursing research* (2nd ed.) (pp. 143-144). New York: Springer.

Tjepkema, M. (2008). Health care use among gay, lesbian and bisexual Canadians. *Health Reports / Statistics Canada, Canadian Centre for Health Information, 19*(1), 53-64.

Trocki, K. F., Drabble, L. A., & Midanik, L. T. (2009). Tobacco, marijuana, and sensation seeking: Comparisons across gay, lesbian, bisexual, and heterosexual groups. *Psychology of Addictive Behaviors, 23*(4), 620-631.

Udry, J. R., & Chantala, K. (2002). Risk assessment of adolescents with same-sex relationships. *Journal of Adolescent Health, 31*(1), 84-92.

University of Otago. (2005). *Who we are*. Retrieved from http://dunedinstudy.otago.ac.nz/whoweare.html.

University of Otago. (n.d.). Christchurch Health and Development Study – Introduction. Retrieved from www.chmeds.ac.nz/research/chds/.

Valanis, B. G., Bowen, D. J., Bassford, T., Whitlock, E., Charney, P., & Carter, R. A. (2000). Sexual orientation and health: Comparisons in the women's health initiative example. *Archives of Family Medicine, 9*(9), 843-853.

Valentine, G. (1998). "Sticks and stones may break my bones": A personal geography of harassment. *Antipode, 30*(4), 305-332.

Volpp, S. Y. (2010). What About the "B" in LGB: Are bisexual women's mental health issues same or different? *Journal of Gay and Lesbian Mental Health, 14*(1), 41-45.

Warwick, I., Aggelton, P., & Douglas, N. (2001). Playing it safe: Addressing the emotional and physical health of lesbian and gay pupils in the UK. *Journal of Adolescence, 24*(1), 129-140.

West, P. (2004). *Report in the medical and related needs of transgender people in Brighton and Hove*. Brighton: Brighton and Hove City NHS Teaching Primary Care Trust.

Willging, C., Salvador, M., & Kano, M. (2006). Unequal treatment: Mental health care for sexual and gender minority groups in a rural state. *Psychiatric Services, 57*(6), 867-870.

Williams, T. J., Connolly, J., Debra Pepler, D., & Craig, W. (2005). Peer victimisation, social support, and psychosocial adjustment of sexual minority young people. *Journal of Young People and Adolescence, 34*(5), 471-482.

World Health Organization. (1986). *Ottawa Charter for health promotion, adopted at the First International Conference on Health Promotion: The move towards a new public health, 17-21 November, Ottawa, Canada*. Geneva: World Health Organization.

World Health Organization. (2005). *Promoting mental health: Concepts, emerging evidence, practice*. Geneva: World Health Organization.

World Health Organization. (2010). *Mental health: Strengthening our response*. Retrieved from www.who.int/mediacentre/factsheets/fs220/en/index.html.

Wyllie, A., Cameron, A., & Howearth, J. (2008). *Impacts of a national media campaign to counter stigma and discrimination associated with mental illness. Survey 9. Report for the Ministry of Health*. Auckland: Phoenix Research.

Wyllie, A., & Mackinlay, C. (2007). *Impacts of a national media campaign to counter stigma and discrimination associated with mental illness. Survey 8. Report for the Ministry of Health*. Auckland: Phoenix Research.Yelland, C., & Tiggemann, M. (2003). Muscularity and the gay ideal: Body dissatisfaction and disordered eating in homosexual men. *Eating Behaviors, 4*(2), 107-116.

Appendix 1: Service provider email survey

Mental health promotion and prevention services to GLBTI populations:

Service stocktake and provider consultation:

Name of organisation:

Key contact person:

Phone:

Email:

---

1. Do you provide any SPECIFIC mental health promotion and prevention services or programmes for some or all of GLBTI populations? (includes services in mainstream and GLBTI settings)

Yes – services are provided (provide details in Table below)
No – go to question 2

(expand table as needed and copy and paste table if you provide or fund more than one service)

Name of service	
Location of service	
Coverage (e.g., local, regional, national)	
Target population (G,L,B,T,I or same-sex attracted youth)	
Funding sources for service	
Approach/philosophy of service (e.g., youth development, recovery model)	
Are you able to provide any documents describing the service, or related research and evaluation reports	

2. Apart from any services you may provide are you aware of any other specific services or programmes provided for some or all of GLBTI?

(copy and paste table if needed)

Name of service	
Location of service	
Contact details if available	

OPTIONAL questions

3. What do you think is going well for existing mental health promotion and service delivery for GLBTI?

(please note if your comments are general, or specific to G, L, B, T, I, or same-sex attracted youth)

Expanding box for comments

4. What could be improved for existing mental health promotion and service delivery for GLBTI?

(please note if your comments are general, or specific to G, L, B, T, I, or same-sex attracted youth)

Expanding box for comments

5. Are any additional services, supports, promotion activity or anything else required to help improve the mental health and wellbeing of GLBT people?
(*please note if your comments are general, or specific to G, L, B, T, I, or same-sex attracted youth)*

Expanding box for comments

6. Are there any other comments you would like to make about mental health promotion and prevention services for GLBTI people?

Expanding box for comments

Appendix 2: Key informant topic guide

1. What is your interest / involvement in mental health services for GLBTI populations?
    - general GLBTI or identity specific
    - Paid – voluntary
    - Length of time involved in this field

2. If a service provider (interpreted broadly)
    - what services do you provide that you consider are related to mental health
    - is the service GLBTI specific or mainstream with a specific GLBTI component
    - location of services
    - coverage
    - target population
    - funding sources
    - approach/philosophy of service (eg youth development approach)
    - any research, evaluation or other documents you can provide

3. Apart from your own services, what other services are you aware of providing services to GLBTI
    - GLBTI specific or mainstream with a specific GLBTI component

4. Overall, how would you describe the state of play when it comes to mental health promotion and service delivery for specific/general GLBTI?
    - what is going well
    - what is not going well / what are the main issues for GLBTI
    - what are the gaps

5. Is anything required to improve existing mental health promotion and prevention services?
    - formal services and non-formal (eg community based development)

6. In addition to any improvements to current services, are any further services, supports, promotion activity or anything else required to help improve the mental health and wellbeing of GLBT people?
    - what is needed to make that happen (funding, policy etc)?
    - who is responsible for making things happen?

7. Are there any other comments you would like to make about mental health promotion and prevention services for GLBTI people

Appendix 3: GLBTI submission form questions

In addition to demographic questions [location, age, ethnicity, identity] the following questions were asked.

[All questions, except question 3, used an expanding box for respondents to type in comments.]

1. What kinds of things do you do to maintain your social and emotional wellbeing?
2. Thinking about the things that maintain your social and emotional wellbeing, what, if anything, makes it hard to access these things?
3. Have you used or are you using any services to help with any mental health issues. These services could be GLBTI focused or mainstream/general services? [Yes/No question, skip to question 6 if answer No]
4. Thinking about the BEST services you have received, could you tell us what kind of service it was, and why it was good?
5. Thinking about the WORST services you have received, could you tell us what kind of service it was, and why it was poor?
6. Whether or not you have used any services, do you think anything would help improve existing mental health services? (please describe, please also note if your comments are general, or specific to G,L,B,T,I, or same-sex attracted youth)
7. Do you think any further services, support, promotion activity or anything else are required to help improve the mental health and wellbeing of GLBTI people? (please describe, please also note if your comments are general, or specific to G,L,B,T,I, or same-sex attracted youth)
8. Are there any other comments you would like to make about mental health promotion and prevention services for GLBTI people? (please describe, please also note if your comments are general, or specific to G,L,B,T,I, or same-sex attracted youth)

Appendix 4: Profile of GLBTI respondents by population group

Gay man		44
Bisexual man		2
Lesbian		28
Bisexual woman		13
Transgender		14
Other and mixed:		
Queer	3	
Lesbian, trans	3	
Bisexual woman, trans	2	
Fa'afafine	1	
Bisexual man, bisexual woman, trans	1	
Lesbian, bisexual woman	1	
Gay man, bisexual man	1	
Lesbian, intersex	1	
Bisexual man, intersex	1	
Gay man, trans	1	
Trans (heterosexual female)	1	
Bisexual woman, asexual	1	
Poly-amorous, polysexual	1	
Bisexual, gender confused	1	
Lesbian, queer woman	1	
Trans, queer	1	
Trans, polysexual	1	
Other, not specified	1	
Total for other and mixed		23
Total		124

Te Pou
o Te Whakaaro Nui
www.tepou.co.nz