Social Work in Mental Health
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wsmh20

Toward Transformative Practice: Facilitating Access and Barrier-Free Services With LGBTTIQQ2SA Populations

Alexandra Lamoureux MSW, RSW[a] & Ameil J. Joseph MSW, RSW[b]

[a] Health Equity Coordinator, CMHA Toronto Branch, Toronto, Ontario, Canada

[b] PhD Candidate, School of Social Work, York University, Toronto, Ontario, Canada

Accepted author version posted online: 15 Jan 2014.Published online: 24 Apr 2014.

To cite this article: Alexandra Lamoureux MSW, RSW & Ameil J. Joseph MSW, RSW (2014) Toward Transformative Practice: Facilitating Access and Barrier-Free Services With LGBTTIQQ2SA Populations, Social Work in Mental Health, 12:3, 212-230, DOI: 10.1080/15332985.2013.875092

To link to this article: http://dx.doi.org/10.1080/15332985.2013.875092

Social Work in Mental Health, 12:212–230, 2014

ISSN: 1533-2985 print/1533-2993 online
DOI: 10.1080/15332985.2013.875092

Routledge
Taylor & Francis Group

Toward Transformative Practice: Facilitating Access and Barrier-Free Services With LGBTTIQQ2SA Populations

ALEXANDRA LAMOUREUX, MSW, RSW
Health Equity Coordinator, CMHA Toronto Branch, Toronto, Ontario, Canada

AMEIL J. JOSEPH, MSW, RSW
PhD Candidate, School of Social Work, York University, Toronto, Ontario, Canada

This article explores the process of critical reflection on the development and implementation of a strategy to provide more appropriate access and barrier-free services to lesbian, gay, bisexual, transsexual, transgender, intersex, queer, questioning, 2-Spirited, and allies (LGBTTIQQ2SA) populations at a community-based early psychosis intervention mental health program in Toronto. There is a long history of mental health assessment and diagnostic issues for LGBTTIQQ2SA populations that have been associated with the medicalizing of difference and the pathologization of gender and sexual orientation. The experiences of people of diverse gender identities, gender expressions, and sexual orientations have resulted in unique mental health service needs, requiring affirming and appropriate services that do not participate in the reproduction of Othering through labeling and stigmatization. The strong relationship between institutionalized oppression, school victimization, discrimination, LGBTTIQQ2SA-directed violence, and mental health issues highlight the complexities that demand critical reflection and reflexivity in order to transform mental health services beyond discursive or rhetorical changes. This article explores a summary of the findings and achievements in this journey toward

Address correspondence to Ameil J. Joseph, York University, 4700 Keele Street, Toronto, Ontario M3J 1P3, Canada. E-mail: ajjoseph@yorku.ca

transformation as well as lessons learned, recommendations for similar initiatives, and questions for future research and practice.

KEYWORDS early psychosis intervention, LGBT mental health, community mental health, anti-oppressive practice, health equity, clinical practice

INTRODUCTION

In order to provide equitable access and barrier-free mental health services, it is crucial that mainstream mental health service programs and providers consider the needs and perspectives of historically marginalized and underserviced groups. The acronym LGBTTIQQ2SA is used as an initialism of the terms lesbian, gay, bisexual, transsexual, transgender, intersex, queer, questioning, 2-spirited[1] and allies[2]. These terms are often lumped together to outline and bring visibility to marginalized communities of diverse sexual orientation, gender identity, and gender expression through their shared experiences of resilience, advocacy, oppression, and exclusion. Many people see many of these identities as fluid, and use of the longer acronym as a way to make more visible various communities. We want to also acknowledge that language is important in making organizations more inclusive. For clarity, we have opted to use the acronym LGBTQ throughout the rest of this article. This is consistent with the literature to refer to populations and communities that have been historically "Othered" by reason of gender identity, gender expression, sexual orientation, or for not conforming to the contours of the dominant heterosexual and cisgender societal norms.[3]

[1] As Jill Aaers describes, "the use of two-spirit by Aboriginal people to replace terms such as in LGBTQ has spread rapidly. Two-spirit has been 'deployed as a panhistorical as well as a pantribal term' (Roscoe, 1998. p. 111, cited in Alaers, 2010). Identifying oneself as two-spirit is in itself an act of decolonization, as individuals break free of essentialist and sometimes derogatory Euro-colonial terms such as berdache [sic], gay, lesbian, transgender, homosexual, or hermaphrodite. Further, acronyms such as LGBTQ create divisions between gender, sexual, cultural, spiritual, and other aspects of identity. It is understood by two-spirits that one's sexuality cannot be separated from their culture (Roscoe, 1998, cited in Alaers, 2010). Separation of various aspects of the self is not congruent with many First Nation beliefs where sexuality and life are seen as circular (Roscoe, 1998, cited in Alaers, 2010). 'Two-spirit' is inclusive of men, women and intersexual individuals. It facilitates Aboriginal people uniting in a way that is inclusive to various sexual orientations, including heterosexuality, while equally recognizing traditional Aboriginal cultural beliefs and identity" (Alaers, 2010, pp. 71–72.).

[2] See Barber (2009) and Bishop (2002) for discussions regarding becoming and ally. Within Ontario, EPI programs include family education and support. In the case of the MOD program that is the subject of this article, support is available to family members as defined by the service user, and as such, can include support around allyship.

[3] As Schilt and Westbrook describe, *"Cis* is the Latin prefix for 'on the same side.' It compliments *trans*, the prefix for 'across' or 'over.' 'Cisgender' replaces the terms 'nontransgender' or 'bio man/bio woman' to refer to individuals who have a match between the gender they were assigned at birth, their bodies, and their personal identity" (2009, p. 461).

In this article, we aim to share a critical reflection on our process of developing and implementing a strategy to provide more appropriate access and barrier-free services[4] to LGBTQ[5] populations at a community-based early psychosis intervention (EPI) mental health program in Toronto. We provide a brief review of relevant literature on the importance of attention to LGBTQ specific issues in early intervention and continue with a reflection on our process, challenges, and achievements as a team to provide some ideas for groups considering similar initiatives. We believe directed attention is required in this area as directed marginalization and exclusion have been and continue to be a concern. We also acknowledge it is important to have LGBTQ-specific health services, and at the same time, direct attention is required to better meet the needs of LGBTQ youth within mainstream mental health providers.

METHODOLOGY

This case study shares practice-based insights gained through a process of critical reflection and is systematically reviewed through an epistemological lens that appreciates all knowledge creation is mediated by power relations that are socially and historically constituted (Prasad, 2005). Also, this article's analysis shares with critical theory, a focus on research aimed at meeting the goals of human liberation and social justice as well as a commitment to confronting injustices and oppressive practices in contemporary society (Prasad, 2005).

This article also shares an understanding that the rational enlightenment-based assumptions of the biomedical model of psychiatry can be described as coming from a positivist epistemological approach. Using a positivistic, natural science approach to investigation of social phenomenon has been criticized for ignoring the contingency of empirical research and that generalizations based on limited observations are necessarily incomplete and therefore, highly fallible (Hawkesworth, 2006; Ingleby, 1981). Positivistic, empirical approaches also ignore power relations, ideological structures, and distort reality to maintain bifurcated conceptualization of the individual–society relationship (Prasad 2005; Strega, 2005; Wardell, & Fuhrman, 1981).

[4] The terms "accessibility" and "barrier-free" services in the article and title refers to current language in Ontario's *Early Psychosis Intervention Standards* and in Canada's national mental health strategy, *Changing Directions Changing Lives* (Mental Health Commission of Canada, 2012, pp. 10 & 11; Ontario Ministry of Health and Long Term Care, 2011, p. 30) .

[5] Because this article focuses on services for youth we believe it is important to make space for queer identities, which are particularly relevant for this age group. As a Kenta Asakura's 2010 study on Queer youth describes, "Queer Youth Space was found to provide sexual minority youth with protective attributes as such as (1) a sense of safety, (2) meaningful relationships with others, and (3) positive identity development" (p. 371).

Also, positivist scientists do not only attend to their empirical world; their examination of that world is framed by their intentions (Crouch, 1987; Prasad, 2005). The insights shared in this article value people's lived experiences as important sources of knowledge.

REVIEW OF LITERATURE

History of Pathologizing LGBTQ Communities

A long history of mental health assessment and diagnostic issues exists for LGBTQ populations. Although gender and sexual orientation have always varied throughout history (Alaers, 2010; Mussi, 2002, pp. 340–344; Talalay, 2008; Todd, 2005), the construct of "homosexuality" did not actually exist until the nineteenth century. Richard Freiherr von Krafft-Ebing wrote *Psychopathia Sexualis: eine Klinisch-Forensische Studie* [*Sexual Psychopathy: A Clinical-Forensic Study*] in 1886 and categorized homosexuality as a mental disorder (Hick, 2010). These ideas were advanced by Sigmund Freud when he wrote *Three Essays on the Theory of Sexuality* in 1905 (Hick, 2010).

The first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was published in 1952 and listed homosexuality under the category of "psychopathic personality with pathological sexuality." The second edition had homosexuality listed as a "sociopathic personality disturbance" (Marmor, 1980). These classifications pathologized specific sexual behaviors and resulted in people being hospitalized for "treatment" or receiving sometimes damaging medical and counseling services including aversion therapies, electroconvulsive therapy (ECT), and drug and hormone injections (LeVay, 1996). The gay liberation movement advocated and protested for the removal of homosexuality from the DSM beginning in the late 1960s until the diagnosis was officially removed in 1973 (Robertson, 2004).

Jack Drescher's work on transgender identities, Gender Identity Disorder, and the DSM overviews the historical medicalization of gender variance (2010). As Drescher describes,

> As in the case of homosexuality, the medical study of transgenderism began in the 19th century. Then, as now, a lack of distinction between homosexuality and transgender presentations was common. Krafft-Ebing (1886) weighed in on the side of transgenderism as psychopathology, documenting both cases of gender dysphoria and of gender variant individuals born to one sex yet living as members of the other. Hirschfeld (1923) is credited with being the first person to distinguish the desires of homosexuality (to have partners of the same-sex) from those of transsexualism (to live as the other sex). (2010, p. 111)

What began in the 19th century continues to this day, as transgender identities continue to be medicalized and pathologized as "mental disorders." The DSM has been recently revised to the 5th edition. "Members of the lesbian, gay, bisexual, and transgender (LGBT) community have expressed interest and concern regarding the future status of the diagnostic categories of Gender Identity Disorder (GID) of Adolescence and Adulthood and GID of Childhood (GIDC) in the DSM-5" (Drescher, 2010, p. 109).[6] Societal uncertainty and discomfort with gender and sexual orientation variance continues to perpetuate marginalizing and pathologizing ideas for those who do not fit into the dominant binaries of gender and sexual orientation (Drescher, 2010).[7] These historical contexts and considerations are crucial to any understanding of contemporary issues for mental health services and LGBT populations.

Mental Health Needs of LGBT Populations

According to Samuel, Rosenberg, Huygen, and Klein, (2005):

> Research suggests that the mental health needs of the lesbian, gay, bisexual, & transgendered (LGBT) population differ from those of heterosexual seriously mentally ill individuals. Unfortunately, the unique treatment needs of the LGBT population who suffer from serious mental illness are often overlooked, even though self-acceptance & support have been shown to go a long way in ameliorating the stresses & risks faced by LGBT persons. Despite these findings, mainstream clinics & hospitals seldom make a commitment to provide LGBT consumers with culturally competent & affirming treatment. (p. 72)[8]

As a 2008 study "Therapists' Helpful and Unhelpful Situations with LGBT Clients" suggests, clinical practitioners that are positive, knowledgeable, appropriate, and affirming of sexual orientation, gender identity and LGBTQ

[6] It is important to note that in contrast to the medical model, transgender identity is widely understood within LGBTQ communities as a self-applied term "meant to convey the sense that one could live nonpathologically in a social gender not typically associated with one's biological sex, as well as the sense that a single individual should be free to combine elements of different gender styles and presentations, or different sex/gender combinations" (Currah, Green and Stryker, 2008). Contemporary transgender communities have provided new understandings of trans experiences in which trans people are not mentally ill people, but rather emotionally healthy people whose gender expression does not happen to fit rigid societal expectations (Denny, 2002).

[7] It is important to note that many people are assumed to be gay, lesbian, bisexual, or queer because of their gender expression.

[8] We acknowledge that in the Samuel et al. quotation there appears to be a conflation of sexual orientation and gender identity, a tendency noted in our introduction. Specifically, the section that states, "the mental health needs of the lesbian, gay, bisexual, & transgendered (LGBT) population differ from those of heterosexual seriously mentally ill individuals" comments on a comparison among the LGBTQ population and heterosexual individuals but does not comment on a comparison among the LGBT population and the dominant gendered population.

issues are crucial to a helpful therapeutic relationship. (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008).

Although scholarship under the umbrella of LGBTQ identities has contributed to advancing practice, the conflation of sexual orientation and gender identity, and the tendency to focus on sexual orientation, have lead to ongoing exclusion of the realities and needs of transgender people (Benson, 2013). It is important to respond to this conflation and acknowledge that it "risks the perpetuation of ongoing trans exclusion in considerations of health services barriers and access, and associated initiatives that may inadvertently address LGB populations only" (Daley and MacDonnell, 2011, p. 7).

The *Journal of LGBT Health Research* suggests that compared to heterosexuals, LGBTQ individuals experienced higher levels of psychological distress, greater likelihood of having a diagnosis of depression or anxiety, greater perceived mental health needs, greater use of mental health services, more substance use (higher levels of binge drinking, greater likelihood of being a smoker and greater number of cigarettes smoked per day), and were more likely to report unmet mental health care needs (Burgess, Lee, Tran, & van Ryn, 2007). Lesbian, gay, bisexual, and transgender individuals were also more likely to report having experienced a major incident of discrimination over the past year than heterosexual individuals (Burgess et al., 2007). Correspondingly, racial and homophobic oppression (both incidental and internalized) increases the likelihood of depression (Kamilah, 2003). Allan Berube (2007) has shared a thorough discussion and analysis of how images of middle to upper class, White, males become dominant within common associations to the term "gay" and those identified as belonging to the "gay" community. This provocation often functions to oppress the diversity of gay identities while shoring up notions of Whiteness and wealth as worthy of recognition.

Although some academic literature exists on HIV/AIDS, violence, abuse and suicide among transgender populations, little is known about clinical needs or mental health functioning of this group (Shiperd, Green, & Abramovitz, 2010). A recent U.S. study, *Injustice at Every Turn*, found that transgender and gender non-conforming individuals face exceptionally high levels of systemic discrimination in all facets of life, and that this is particularly compounded by other forms of structural oppression such as racism (Grant et al., 2011). The study found that nearly half of Black transgender respondents (49%) reported having attempted suicide, compared to 41% for transgender people or all racial backgrounds, and 1.6% for the general U.S. population (Grant et al., 2011).

Bullying is also a major issue. Lesbian, gay, bisexual, and transgender-related school victimization is strongly linked to young adult mental health needs. High rates of LGBTQ school victimization have been associated with elevated levels of depression and suicidality (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011).

A study from a large, urban, community health center that serves the LGBTQ community reported findings that "support the notion that presenting problems and mental health concerns among gay and bisexual men are similar to those frequently reported by individuals in other mental health facilities, however, specific psychosocial stressors are unique to this population" (Berg, Mimiaga, & Safren, 2008, p. 293).

Suggestions From the Literature for Improving Services for LGBTQ Service Users

The use of critical reflection (an individual activity) and reflexivity (a collective activity) has been shown to provide insight into the experience of power and power relations within the interviewing process for lesbian and queer women in the psychiatric and mental health system (Daley, 2010b). Although some specialized services exist for the LGBTQ community in mental health, we need to expand access to services that are safe and welcoming. Practitioners can be allies by addressing sexual history, "being aware of gay-affirmative mental health services in their area, and advocating for services where none exist" (Barber, 2009, p. 133). Mental health organizations need to take on a greater role in the amelioration of prejudice against LGBTQ people through advocacy for social justice issues both domestically and around the world. (Dworkin & Yi, 2003). The LGBTQ community has demonstrated significant strengths, resiliency, capacity for resistance, creativity and transformative potential. These strengths should be acknowledged to allow space for both resiliency and vulnerability discourses to co-exist (Smith & Gray, 2009).

As Andrea Daley reminds us, there is a current and ongoing need for

> mental health organizations and service providers to create inviting relationships with lesbian/queer women that facilitate self-disclosure opportunities and foster recognition, acceptance, and affirmation of women's sexual identities. This is particularly urgent given the effects of stigma as a result of both a mental health diagnosis and a minority sexual identity are pervasive and often mean a loss of dignity as lesbian/queer women interact within psychiatric and mental health service settings. (Daley, 2010a, p. 353)

A study of "55 bisexual participants across the province of Ontario, Canada" found that 69% of participants reported mental health issues (p. 378). Also, the study described that participants found that when mental health service providers contributed to negative experiences when "expressing judgment, dismissing bisexuality, pathologizing bisexuality, and asking intrusive or excessive questions" (Eady, Dobinson, & Ross, 2011, p. 382). Mental health service providers contributed to positive experiences for bisexual participants

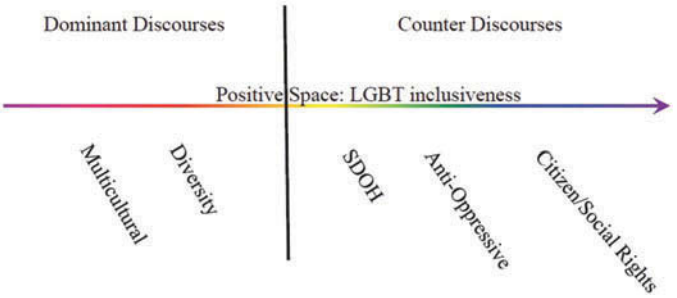

FIGURE 1 Dominant and counter discourses.

when they sought education, asked open-ended questions and maintained positive or neutral reactions to disclosure (Eady et al., 2011, p. 382).

A gender-based analysis has been shown to reveal a continuum of dominant and counter discourses on health services access and equity (Figure 1) and offers a framework to identify and redress organizational assumptions about, and ideological commitments to, sexual and gender diversity and health services access and equity (Daley & MacDonnell, 2011).
As Daley and MacDonnell (2011) describe,

> A continuum of five discourses that characterize the health services access and equity literature were identified including two dominant discourses: 1) multicultural discourse, and 2) diversity discourse; and three counter discourses: 3) social determinants of health (SDOH) discourse; 4) anti-oppression (AOP) discourse; and 5) citizen/ social rights discourse (Figure 1). Importantly, the term "continuum" reflects the fluidity, blending and complexity of language use in health services access and equity texts as it relates to any one identified discourse within the context of multiple audiences (e.g., health care service providers, service users/consumer groups, health authorities and policy decision-makers), organizational and political contexts (religious) and expectations (e.g., reducing health disparities, enhancing social equity). (p. 4)

In other words, this model offers a fluid, visual framework to describe the kinds of access and equity discourses present at programmatic and organizational levels, while specifically highlighting discourses that better lend themselves to inclusivity and accessible practice.

THE JOURNEY OF AN EARLY INTERVENTION TEAM IN TORONTO

The Early Psychosis Intervention (EPI) Team at the Canadian Mental Health Association's Toronto branch provides services to youth between the ages of

16 to 34 who may be experiencing and having difficulty with early symptoms of psychosis. The program has been operating in Toronto since 2005 and serves approximately 170 people each year. As the website describes,

> The program, which is recovery focused, works to promote early identification and treatment of psychosis. The program helps individuals achieve their goals at work, at school and within their social networks, thereby minimizing the impact of the psychosis. Services include assessment, the provision and coordination of treatment, education, case management, support and referrals to other services in the community by a multidisciplinary team including a psychiatrist, nurses, social workers and occupational therapists. The program, which has a specialization in psychosis and mood disorders, also works closely with individuals' families, providing them with education and supportive counseling. (Canadian Mental Health Association-Toronto Branch, 2013)

The eligibility criteria for the program include:

- Individuals between the ages of 16 and 34 who are experiencing their first episode of psychosis
- Individuals who have not yet received treatment for psychosis, or who have had less than one year of treatment for psychosis from other mental health services
- Services are available to residents of the City of Toronto living between Victoria Park Avenue and Islington Avenue, and Finch Avenue and Lake Ontario
- Services are offered in the community, in clients' homes, or in our offices (Canadian Mental Health Association-Toronto Branch, 2013).

A Learning Moment for the Program

In 2008, CMHA Toronto began to organizationally embed an ongoing commitment to issues of equity and diversity. The commitment encompassed changes at various levels of the organization (Table 1).

TABLE 1 Organizationally Embedded Commitment to Change

• A strategic direction "Equity and Diversity," instituted by the board of directors, • Establishment of a Equity & Diversity committee, • Hiring of a full-time manager of Equity and Diversity, • Revision of policies and procedures within the organization, • Implementation of a series of workshops and training opportunities for all employees on issues of equity and diversity, • Development of work-plans within every team directed toward improving access and equity by addressing issues of diversity at direct service levels.

Ongoing reporting and evaluation by the Equity & Diversity committee of both team-based work plans and broader organizational goals ensured feedback on progress and setbacks was received while employees were being trained and changes implemented.

As part of one of the EPI team's Equity and Diversity work-plans, regular reviews were conducted and presented at team meetings. During a team discussion in January 2011, a clinician on the team provided feedback from a recent outreach presentation with LGBTQ positive organizations in Toronto. The feedback received indicated that "CMHA Toronto is not known for its attention to sexual orientation and gender diversity or services for LGBTQ communities." This began a profound discussion on historically institutionalized processes of pathologization and exclusion within mental health systems and services for LGBTQ people. A team member who identified as a queer young person stated "I wouldn't come here if I needed help."

One of the team's clinicians discussed their[9] work with a service user who had experienced significant distress and joined the program for support. The clinician reported that many months after enrolling with the program, the service user disclosed that they were feeling overwhelmed by uncertainty, feelings of exclusion and guilt that they associated with their struggles with sexual identity and sexual orientation. The clinician reflected on their relationship with this person and acknowledged they had never discussed this in their work together. The clinician reflected on their own naivety, what had been missed and how this had impacted the service user, and the team reflected on broader programmatic and structural omissions and oversights. This raised some questions about heteronormativity and pathologizing difference. What were the assumptions being made by clinicians about sexual orientation and gender identity of our service users? Was space being created for youth in the EPI program to discuss these issues? How would our service users know that it was safe to do so? Further, was the program a safe space?

We considered if the team was asking the right questions, missing important information during the establishment of relationship during the intake process and in ongoing work with service users enrolled in the program. The team reflected on current experiences and reports from clients, agreed that a great deal of work was required for improvements and committed to making changes around accessibility and delivery of services for LGBTQ service users. Initially, ideas generated included:

- Connecting with the Rainbow Health Ontario (RHO)[10] for resources and training. (Rainbow Health Ontario, 2006)

[9] Used to maintain anonymity.

[10] "RHO is a province-wide program that works to improve the health and well-being of lesbian, gay, bisexual and trans people in Ontario through education, research, outreach and public policy. Our

- Focusing outreach on LGBTQ organizations and requesting consultation
- Making changes to the reception area (e.g., adding LGBTQ positive posters and literature)
- Forming a committee—to seek out training, resources and consultation

We added a regular agenda item to the team's administration meeting held every month to discuss issues, updates, and progress related to more effective training and inclusion of LGBTQ people. We continued to discuss these issues as a team, utilizing reflection and reflexivity. We received valuable feedback from each other in those conversations.

Responding Through Critical Reflection and Reflexivity

The team's work created a space for challenging our practices and beliefs in a supportive environment that was open to external input. The committee that formed to address LGBTQ issues and communities committed to:

- Understanding that accessibility around sexual orientation and gender identity is critical for programs serving young people.
- Recognizing that significant barriers exist for LGBTQ youth in accessing health services including: lack of acknowledgment and validation, negative responses, prejudice, and discrimination.
- Valuing diversity, equity and the importance of building capacity to ensure accessibility and appropriateness of services for LGBTQ youth.
- Applying critical reflection, AOP and making changes in our documentation, practices, and program structure.

The committee met monthly to engage with difficult questions through external consultation and reflection; we asked ourselves questions such as:

- What does it mean to be LGBTQ friendly and affirming?
- What factors make a service provider LGBTQ friendly and affirming?
- How can we evaluate where we are as a team in terms of accessibility and appropriateness of services for LGBTQ communities?
- What kinds of approaches, resources, tools can we use to bring us in the direction of being LGBT friendly and affirming?
- What are some of the cautions we want to guard against in doing this work?

mission is to improve access to services and to promote the health of Ontario's lesbian, gay, bisexual and trans communities" (RHO, 2006).

The team agreed to amend the Equity and Diversity Plan to include improved accessibility and appropriateness of services for LGBTQ clients. We recognized this would take ongoing effort over the long term. We discussed initial action items, including a revision of our intake assessment for aspects related to gender identity and sexual orientation that were not previously acknowledged. We also proposed organizing a training/development day for the team and compiling a list of local and regional community resources.

The team consulted with CMHA's Manager of Equity and Diversity who provided us with guidance, support, and examples of tools we could use to assess where we were as a team. She also provided some specific suggestions around training opportunities, resources, and consulting agencies,

- **Scheduling Training**: Rainbow Health Ontario, Opening Doors, Teens Educating and Confronting Homophobia (T.E.A.C.H) (Rainbow Health Ontario, 2006; Opening Doors, 2013; Planned Parenthood Toronto, 2010)
- **Resources:** "Asking the Right Questions 2" resource manual, handouts on LGBTQ issues and terms, videos and documentaries that helped to foster awareness around LGBTQ issues and mental health (Barbara, Chaim, & Doctor, 2007).
- **Consulting with other agencies who specialize in work with LGBT people:** 519 Community Health Centre, Sherbourne Health, Access Alliance, Griffin Centre

We planned and undertook a number of activities with the whole team in an effort to improve our capacity to serve LGBTQ clients.

Assessing our Training Needs

In order to assess our training needs we utilized "Beyond Tolerance," a survey that looks at attitudes and comfort levels with LGBTQ people. We compiled results as our pretest measure, and agreed to re-administer the survey after participating in some training and other learning activities. Responses ranged on a fairly wide spectrum. However, the majority of the team identified as very comfortable with LGBTQ people. After the survey process, the committee discussed the appropriateness of the tool for assessing "practice" as it is directed toward attitudes and beliefs. We recognized that although organizational changes and practice-based policy amendments might affect the way we deliver services, individual beliefs and attitudes represent a complex array of contributing factors that demand greater levels of advocacy and intervention than our committee originally set out to transform. As a team, we wanted to remain true to the core commitments we had made, such as inclusive practice and addressing institutional oppression. Given this, we added ongoing advocacy to change exclusive practices and

protocols within our EPI team, with hopes that this would lead to impacts at the organizational level as well.

However, we maintained our commitments as a team and added ongoing advocacy to change practices of EPI clinicians to our agenda.

Engaging With Literature and the Media

The EPI team had already begun a journal club at team meetings to discuss relevant academic literature and how it could inform our practice. We explored assumptions and implications of cultural competence versus AOP, and critical race theory[11] frameworks for our practice serving clients with diverse identities (Larson, 2008; Abrams & Moio, 2009). Drawing on previous discussion of AOP we also looked more specifically at the experiences of transgender people within the mental health system. We discussed the history of medical professionals as gatekeepers to "treatment," the pathologization of gender identity and sexual orientation and the importance of acknowledging how this history can affect trust and rapport building with health care providers when seeking assistance (Drescher, 2010; Kamens, 2011). The LGBTQ liberation movement also provided numerous examples of how people can organize, advocate and change systems and institutions (Drescher, 2010; Kamens, 2011).

The team also discussed how daily experiences of discrimination experienced in the LGBTQ communities can affect mental and emotional wellbeing. The *National Post* ran an advertisement from the Institute of Canadian Values (Sept 30, 2011), which not only opposed teaching kids about gender identity and sexual orientation, but also stated that such curriculum "confuses" children. These advertisements specifically targeted Toronto District School Board curriculum, which is considered to be quite progressive and comprehensive. A campaign emerged out of an immediate and fierce mobilization within Toronto's LGBTQ communities (Balinski, 2011, September 29). The *National Post* issued an apology shortly thereafter (September 30, 2011). Our team discussion led to a realization that there were wide-ranging perspectives among team members when addressing LGBTQ issues. Most team members expressed opposition to the advertisement, while

[11] "CRT belongs to the family of critical postmodern theory that 'attempt[s] to understand the oppressive aspects of society in order to generate societal and individual transformation' (Tierney, as cited in Solórzano & Bernal, 2001, p. 31, cited in Ortiz & Jani, 2010, p. 1761). It does not assume the existence of universal truths and rejects master narratives that attempt to encompass all phenomena or dictate the construction of lives. Instead, it is based on the following assumptions: race is a social construction, race permeates all aspects of social life, and race-based ideology is threaded throughout society. Proponents of CRT are also committed to social justice, locating the voice of the marginalized, and employing the concept of intersectionality" (Delgado & Stefancic, 2001; Solórzano & Yosso, 2001, cited in Ortiz & Jani, 2010, p. 176).

a few felt the inclusion of curriculum on gender identity for school-aged children was debatable. Through open dialogue, the team agreed that as health care professionals, we have a responsibility to be aware of and respond to blatant acts of discrimination such as those the advertisement discussed.

Making Changes

We used the manual "Asking the Right Questions 2 (ARQ2): Talking With Clients About Sexual Orientation And Gender Identity In Mental Health, Counselling And Addiction Settings" (Barbara et al., 2007) to guide our development of questions in our intake process. Our assessment now includes the following questions addressing gender identity and sexual orientation, as recommended in the ARQ2:

- How do you identify your gender identity?
- Any concerns related to gender identity?
- Are you currently dating, sexually active or in a relationship?
- How do you identify your sexual orientation?
- Any concerns related to sexual orientation?

Most questions are open-ended and allow service users to self-identify gender identity and sexual orientation. We brought these amendments to the team for discussion and feedback. The committee provided support and resources around how to ask questions and the importance of asking them in the first place.

A full-day training with The Opening Doors Project and T.E.A.C.H. was offered. The Opening Doors workshops aim to: "Strengthen mental health, anti-racism and anti-discrimination literacy in Ontario communities; foster the participation of new immigrants and refugees with mental health issues; cultivate more inclusive and welcoming environments for new immigrants and refugees who face mental health challenges" (Opening Doors, 2013).

T.E.A.C.H., a program of Planned Parenthood Toronto, "uses an anti-oppression approach to deliver high-quality anti-homophobia peer education activities in high schools and community settings across the City of Toronto. [. . .] T.E.A.C.H. workshops challenge negative assumptions about gays, lesbians, bisexuals, and transgender people and show how these assumptions can lead to homophobic violence and hate crimes" (Planned Parenthood Toronto, 2010).

As a result the team developed knowledge and skills around serving LGBTQ populations and learned about the importance of being honest and careful when offering LGBTQ friendly and affirming spaces to people before policies and practices are in place to deliver them effectively. The team's feedback indicated recognition that despite our reluctance to label ourselves

as "queer positive program," we must keep advocating, responding to feedback and working with partners to mobilize our efforts as a matter of equity and social justice.

After the training and discussions the team amended the orientation process for new staff members to include an overview of our LGBTQ strategy including our process to date, values and resource materials. We also amended our regular nursing assessments to include Part A of the *Asking the Right Questions 2* manual (Barbara et al., 2007). The questions in the revised nursing assessment form include: significant relationships, sexual orientation, gender identity, relationship between sexual orientation/gender identity and substance use and/or mental health concerns.

CONCLUSION AND IMPLICATIONS

The team has decided that going forward, clinicians that have knowledge and experience working with LGBTQ specific resources from an AOP perspective could act as a resource to new clinicians. Further, items on our work-plan include: a review of hiring practices to include interview questions relevant to work with LGBTQ people, ongoing education and training, developing formalized partnerships with other agencies, and continuing outreach to underserviced areas and populations.

A key feature of our reflective and reflexive processes, for those who wish to begin their own journey towards equitable access and services for LGBTQ people, is the recognition of what made all of our effort possible.

We identified the following necessary components for successful transformation from our process:

- Collaborative management style
- Collaborative team dynamics
- Strong team identity and communication
- Reflective practice, individual clinicians
- Reflexive practice, team
- Core group of staff with knowledge, training and commitment to AOP
- Connecting with other agency committees/work groups
- CMHA's equity and diversity initiative
- Connecting with other groups—Opening Doors and T.E.A.C.H.
- Access to literature

We have ongoing questions around the process of becoming LGBTQ friendly and affirming— most organizations that serve LGBTQ communities have this commitment at the center of their mission. In our case we are doing this in reverse. We need to continue to be diligent and responsive in our work going

forward and continue to foster a respect and value for building capacity in these areas. We have also learned through our process that continuing the exercise of critical reflection and reflexivity and the maintenance of a strong connection between values (AOP) that have driven and continue to drive this process and our practice is crucial to this work. Also, opening communication vertically and horizontally, increasing transparency, creating comfort, and space for learning so that the team can continue to grow are absolutely essential. It is important to adopt an open attitude. Everyone has their own process—and this applies to individuals, groups, and organizations. We have to permit space for change to occur. Set clear goals, such as team trainings, amending intake forms, integrating LGBTQ affirming practices into performance reviews, and monitor these goals regularly. Reach out to others when needed and most importantly be cautious about naming one's organization as LGBTQ positive when practices and protocols are contrary to this.

The further we engage with this work, the more we have been able to recognize how power, authority, labeling and stigmatization can be oppressive regardless of what the label itself is. Our program is committed to supporting recovery for people who struggle with mental health issues and this will continue to be our primary focus. We will need, going forward, to continue to recognize broader systemic issues of power, oppression and privilege, and the marginalization of those we encounter in our work, and to address the pathologization of difference as we continue to direct our attention, advocacy, and diligent action toward transformative practice.

ACKNOWLEDGMENT

An earlier version of this was presented at the *2012 Ontario Working Group on Early Psychosis Intervention Conference*, Sheraton Centre Hotel, Toronto, ON (March 22).

REFERENCES

Abrams, L.S., & Moio, J.A. (2009). Critical race theory and the cultural competence dilemma in social work education. *Journal of Social Work Education*, *45*(2), 245–261.

Alaers, J. (2010). Two-spirited people and social work practice: Exploring the history of Aboriginal gender and sexual diversity. *Critical Social Work*, *11*(1). Retrieved from http://www.uwindsor.ca/criticalsocialwork/two-spirited-people-and-social-work-practice-exploring-the-history-of-aboriginal-gender-and-sexual-d

Asakura, K. (2010). Queer youth space: A protective factor for sexual minority youth. *Smith College Studies in Social Work*, *80*, 361–376.

Baklinski, T. (2011, September 29). Ad counters Toronto school board pro-homosexual curriculum. Lifesitenews.com. Retrieved from http://www.lifesitenews.com/news/ad-counters-toronto-school-board-pro-homosexual-curriculum

Barbara, A.M., Chaim, G., & Doctor, F. (2007). Asking the right question 2: Talking with clients about sexual orientation and gender identity in mental health, counselling and addiction settings. Centre for Addiction and Mental Health. Retrieved from http://knowledgex.camh.net/amhspecialists/Screening_Assessment/assessment/ARQ2/Documents/arq2.pdf

Barber, M.E., (2009). Lesbian, gay, and bisexual people with severe mental illness. *Journal of Gay & Lesbian Mental Health*, *13*, 133–142.

Benson, K.E. (2013). Seeking support: Transgender client experiences with mental health services. *Journal of Feminist Family Therapy*, *25*(1), 17–40.

Berg, M.B., Mimiaga, M.J., & Safren, S.A. (2008). Mental health concerns of gay and bisexual men seeking mental health services. *Journal of Homosexuality*, *54*(3), 293–306.

Berube, A. (2007). How gay stays white and what kind of white it stays. In T. Das Gupta, C.E. James, R.C.A. Maaka, G. Galabuzi, & C. Andersen (Eds.). *Race and racialization* (pp. 363–372). Toronto, Canada: Canadian Scholar's Press.

Bishop, A. (2002). Step 5: Becoming an ally. In *Becoming an ally: Breaking the cycle of oppression in people* (pp. 109–124). Halifax, Nova Scotia: Fernwood.

Burgess, D., Lee, R., Tran, A., & van Ryn, M. (2007). Effects of perceived discrimination on mental health and mental health services utilization among gay, lesbian, bisexual and transgender persons. *Journal of LGBT Health Research*, *3*(4), 1–14.

Canadian Mental Health Association-Toronto Branch. (2013). Early Psychosis Intervention Program (MOD). Retrieved from http://toronto.cmha.ca/programs_services/early-psychosis-intervention-program-mod/

Crouch, C. (1987). Objectivity: A crutch and club for bureaucrats/subjectivity: A haven for lost souls. *The Sociological Quarterly*, *28*(1), 105–118.

Currah, P., Green, J., & Stryker, S. (2009). *The state of transgender rights in the United States of America*. San Francisco, CA: National Sexuality Resource Center.

Daley, A. (2010a). Being recognized, accepted, and affirmed: Self-disclosure of lesbian/queer sexuality within psychiatric and mental health service settings. *Social Work in Mental Health*, *8*, 336–355.

Daley, A. (2010b). Reflections on reflexivity and critical reflection as critical research practices. *Journal of Women and Social Work*, *25*(1), 68–82.

Daley, A.E., & MacDonnell, J.A. (2011). Gender, sexuality and the discursive representation of access and equity in health services literature: Implications for LGBT communities. *International Journal for Equity in Health*, *10*(40), 1–10.

Denny, D. (2002). A selective bibliography of transsexualism. *Journal of Gay & Lesbian Psychotheraphy*, *6*(2), 35–66.

Drescher, J. (2010). Conference proceeding "in or out?": A discussion about gender identity diagnoses and the DSM transsexualism, gender identity disorder and the DSM. *Journal of Gay & Lesbian Mental Health*, *14*, 109–122.

Dworkin, S.H., & Yi, H. (2003). LGBT identity, violence, and social Justice: The psychological is political. *International Journal for the Advancement of Counselling*, *25*(4), 269–279.

Eady, A.A., Dobinson, C.C., & Ross, L.E. (2011). Bisexual people's experiences with mental health services: A qualitative investigation. *Community Mental Health Journal*, *47*(4), 378–389.

Grant, J.M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., & Keisling, M. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Hawkesworth, M. (2006). Contending conceptions of science and politics. In D. Yanow & P. Schwartz-She (Eds.), *Interpretation and method: Empirical research methods and the interpretive turn* (pp. 27–48). New York: M.E. Sharpe.

Hick, S. (2010). *Social work in Canada: An introduction* (3rd edition). Toronto, Canada: Thomson Educational Publishing.

Ingleby, D. (1981). *Critical psychiatry: The politics of mental health*. London, England: Free Assocation Books.

Israel, T., Gorcheva, R., Walther, W.A., Sulzner, J. M., & Cohen, J. (2008). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. *Professional Psychology: Research and Practice*, *39*(3), 361–368.

Kamens, S.R. (2011). On the proposed sexual and gender identity diagnoses for DSM-5: History and controversies. *The Humanistic Psychologist*, *39*(1), 37–59.

Kamilah, M. (2003). The impact of racism and homophobia on depression. *Dissertation Abstracts International*, A: The Humanities and Social Sciences.

Larson, G. (2008). Anti-oppressive practice in mental health. *Journal of Progressive Human Services*, *19*(1), 39–54.

LeVay, S. (1996). *Queer science: The use and abuse of research in homosexuality*. Cambridge, MA: MIT Press.

Marmor, J. (1980). *Homosexual behavior: A modern reappraisal*. New York, NY: Basic Books.

Mental Health Commission of Canada. (2012). Changing directions, changing lives: The mental health strategy for Canada. Retrieved from www.mentalhealthcommission.ca

Mussi, M. (2002). Earliest Italy: An overview of the Italian Paleolithic and Mesolithic. Boston, MA: Kluwer Academic Publishers.

National Post. (2011, September 30). An apology from the National Post. Retrieved from http://news.nationalpost.com/2011/09/30/an-apology-from-the-national-post/

Ontario Ministry of Health and Long Term Care. (2011). Early psychosis intervention program standards. Retrieved from http://www.health.gov.on.ca/english/providers/pub/mental/epi_program_standards.pdf

Opening Doors Project. (2013). The Opening Doors Project. Canadian Mental Health Association-Toronto Branch. Retreived from http://toronto.cmha.ca/programs_services/the-opening-doors-project/

Ortiz, L., & Jani, J. (2010). Critical race theory: A transformational model for teaching diversity. *Journal of Social Work Education*, *46*(2), 175–193.

Planned Parenthood Toronto. (2010). Anti-Homophobia Leadership Training: T.E.A.C.H. Retrieved from http://www.ppt.on.ca/Anti-Homophobia_teach.asp

Prasad, P. (2005). Critical theory; Hegemony, knowledge production, and communicative action. In *Crafting qualitative research* (pp. 136–158). New York: M. E. Sharpe.

Rainbow Health Ontario. (2006). Rainbow Health Ontario. Retrieved from http://www.rainbowhealthnetwork.ca/node/20

Robertson, P.K. (2004). The historical effects of depathologizing homosexuality on the practice of counseling. *The Family Journal: Counseling and Therapy for Couples and Families*, *12*(2), 163–169.

Russell, S.T., Ryan, C., Toomey, R.B., Diaz, R.D., & Sanchez, J. (2011). Lesbian, gay, bisexual, and transgender adolescent school victimization: Implications for young adult health and adjustment. *Journal of School Health*, *81*(5), 223–230.

Samuel, R., Rosenberg, J., Huygen, C., & Klein, E. (2005). No need to hide: Out of the closet and mentally ill. *Best Practices in Mental Health*, *1*(A1), 72–85.

Schilt, K., & Westbrook, L. (2009). "Gender normals," transgender people, and the social maintenance of heterosexuality. *Gender & Society*, *23*(4), 440–464.

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

Smith, M.S., & Gray, S.W. (2009). The courage to challenge: A new measure of hardiness in LGBT adults. *Journal of Gay & Lesbian Social Services*, *21*, 73–89.

Strega, S. (2005). The view from the poststructural margins: Epistemology and methodology reconsidered. In L. Brown & S. Strega (Eds.), *Research as resistance: Critical, indigenous, and anti-oppressive approaches* (pp. 199–235). Toronto, Canada: Canadian Scholars' Press.

Talalay, L.E. (2008). The gendered sea: Iconography, gender, and Mediterranean prehistory. In E. Blake and A. B. Knapp (Eds.) *The archaeology of Mediterranean prehistory* (pp. 130–148). Oxford, UK: Blackwell Publishing.

Todd, S. (2005). Social work and sexual and gender diversity. In S. Hick (Ed.), *Social work in* Canada: *An introduction* (2nd ed.) (pp. 272–295). Toronto, Canada: Thompson Educational Publishing.

Wardell, M., & Fuhrman, E. (1981). Controversy and ideological hegemony in sociological theory. *The Sociological Quarterly*, *22*, 479–493.