
Community Generated Recommendations to Improve the Behavioral Health Services Provided to Lesbian, Gay, Bisexual, and Transgender Persons in Philadelphia

Department of Behavioral Health/Mental
Retardation Services

Letter to the Director

Dear Dr. Evans,

Thank you for the opportunity to initiate a community wide response to your desire for the Department of Behavioral Health/Mental Retardation Services (DBH/MRS) to better meet the behavioral health needs of Lesbian, Gay, Bisexual and Transgender (LGBT) people in Philadelphia.

We are proud that this document represents many hours of work on the part of volunteers consisting of consumers, advocates, and providers. Many of these people have expressed a deep desire to continue offering their time and efforts to assist the Department in implementing these recommendations. This effort has raised the level of expectation and excitement not only by LGBT behavioral health consumers but also in LGBT communities in general.

We are appreciative of the dedication and support of the many individuals who have given input into the creating of this document. It has been our pleasure to work with them.

We look forward to seeing how the DBH/MRS will respond to and implement these recommendations. We acknowledge that for this document to become a reality in addressing the health disparities of LGBT persons with behavioral health needs, it will require an ongoing effort on the part of the Department.

Sincerely,

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The State of Behavioral Health Services for Lesbian, Gay, Bisexual and Transgender Persons in Philadelphia

Department of Behavioral Health/Mental Retardation Services

Introduction

In the United States, as in many other parts of the world, lesbian, gay, bisexual, and transgender (LGBT) persons have experienced hatred, hostility, discrimination, and violence because of their sexual orientation and/or gender identity. The roots of this hostility are deeply embedded in our culture from many different influences throughout history and are maintained by several well-established institutions including government, religion, education, family, and economics. Until 1973, the field of psychiatry supported this hostility classifying homosexuality as a mental illness which led to many “clinical” practices which would be considered unethical today. At this time, there are still problems with the diagnostic criteria affecting transgender people.

Without belaboring this point, there is a stigma attached with self-identifying oneself as LGBT making it very difficult for many LGBT people to not only tell others about this part of themselves but also to accept it within themselves. For people with severe mental health problems and/or addiction to substances, this stigma is only compounded by the stigma attached to having a behavioral health problem. LGBT persons who identify with other minority groups that are stigmatized can experience further conflict.

As with many other minority groups, LGBT communities have a rich culture that comes with many strengths and resources. However, to enjoy these benefits, LGBT people first have to grapple with “coming out”. Coming out entails accepting one’s sexual orientation and/or gender identity as LGBT and telling significant others of one’s orientation and/or identity. Coming out only marks the beginning of a longer process of working through all the challenges that come with living a life of integrity in the face of adversity. Many LGBT persons seek support for this process through formal behavioral health treatment and/or informally in the way of friends and organizations tailored to address this need.

In Philadelphia, LGBT behavioral health consumers are echoing the same problems LGBT consumers face in other parts of the country. They are saying that many of the people who provide treatment for their behavioral health problems still place a stigma on LGBT persons and treat them in ways that make it a barrier to accessing and receiving appropriate treatment. Other staff may be more accepting but are not knowledgeable about LGBT issues, and hence, therapy time is wasted by not dealing appropriately with the core issues that the consumer presents. LGBT behavioral health consumers have reported that peers in treatment programs have also been a source of ridicule and harassment. Consumers say that providers do not address the sexuality of consumers in general much less than specifically the needs of LGBT consumers. They report that they feel unsafe to reveal or express their sexual orientation and/or gender identity in treatment, especially in inpatient and residential settings. Hence, sometimes LGBT consumers never work on the relationship, identity, and health issues that

contribute to their behavioral health problems. They report there are certain levels of care for which there are no LGBT-affirming resources, and also, providers in general do not know what treatment or community resources are available for referrals.

At this time, this information can only come through certain vocal individuals as very little local data is currently collected in a way that can inform the behavioral health system of these problems. Hence, up to this point, the system has been hampered in addressing these problems either as a system wide problem or with individual providers as a quality of care issue.

However, the times are changing. Philadelphia is fortunate to have a City government and Department of Behavioral Health/Mental Retardation Services (DBH/MRS) that is interested in addressing these long neglected problems. Reports of these problems trickled to the DBH/MRS through various testimonies given in public forums and were included as a need in the County plan for mental health to the State. As part of the DBH/MRS's goal to develop a recovery oriented system of care that eliminates health disparities, Dr. Arthur C. Evans, Director, asked his staff to begin an initiative to develop recommendations to guide the Department. Those recommendations are laid out in the following sections of this document.

This process began with the development of a working group (the Behavioral Health LGBT Initiative) made up of consumers, providers, advocates, and DBH/MRS staff to start discussing the behavioral health needs of LGBT communities. Common themes began to emerge, and these needs were put into the following categories: training, service, system, and data. The recommendations that were formulated for these categories represent many hours of work from people dedicated to the welfare of LGBT consumers.

To broaden the base of input from the community at large, a community forum was held for all those who would like to speak about behavioral health services to LGBT persons in Philadelphia. The event attracted approximately 100 participants; many of whom were consumers of behavioral health services. In Section 6 of this document, you will find a summary of the input from that evening. This input was invaluable to the process.

Additionally, an even broader list of community members and experts in the field who could not be included in the working group were asked to review and provide comments on the recommendations that were being formed. You will find their names in the list of persons who contributed to these recommendations. Many of their comments were worked into this document as well.

Special Note:

At this time, this report uses "LGBT" to identify the communities these recommendations are intended to effect. This is done to build off of the political momentum that has been previously developed in Philadelphia government using the acronym LGBT. However, there are two additional groups of people who are part of the minority. Both Questioning (Q) and Intersex (I) groups are included in these recommendations even if the initials designating these groups is not included in the acronym describing these communities. Questioning refers to those individuals who are not decided on a particular sexual orientation and/or gender identity either at this time or indefinitely. Intersex refers to those individuals who are born with genitalia and/or secondary sex characteristics that are not exclusively considered male or female. These recommendations are not meant to exclude these two groups of people. Future implementation of these recommendations should also include both questioning and intersex individuals.

Training Recommendations

1. All training provided concerning Lesbian, Gay, Bisexual and Transgender (LGBT) sensitivity and issues should be provided by trainers with significant expertise and/or have had significant experience in providing services to LGBT persons. Support in identifying qualified trainers should be extended by the Department of Behavioral Health/Mental Retardation Services (DBH/MRS) to its provider network.
2. Recovering LGBT consumers who have experienced significant behavioral health issues should be considered in the process of finding qualified trainers due to their personal experience and ability to convey real life expertise on LGBT issues. These consumers may need support from DBH/MRS to fill this role.
3. All service providers who have a contract and/or receive funding from the DBH/MRS will have mandatory cultural competency training that specifically includes sexual orientation and gender identity issues.
4. The DBH/MRS would develop a set of definitions for terms related to sexual orientation and gender identity to be used across the system.
5. Service providers who wish to be designated as “LGBT Affirming”* and work with LGBT communities must have **all staff** trained in the following areas**:
 - a. culturally appropriate language
 - b. understanding of sexual orientation and gender identity issues (special attention needs to made to ethnic and racial minorities within LGBT communities)
 - c. the coming out process
 - d. common lifestyle issues unique to LGBT persons
 - e. ethics and boundaries
 - f. confidentiality
 - g. creating a welcoming, safe, and supportive environment for LGBT people
6. In order to develop **clinical staff** who are competent to work with LGBT persons, LGBT Affirming providers will have designated clinical staff who will receive specific training in the following areas:
 - a. recognizing resiliency and strengths
 - b. tailoring interventions to the individual’s needs across the lifespan

- c. community and cultural based assets and resources
- d. common relationship issues unique to people who are LGBT
- e. substance abuse issues in LGBT communities
- f. physical health issues of concern to LGBT communities
- g. trauma (including sexual, physical, emotional, etc.)
- h. risk factors contributing to behavioral health needs specific to LGBT persons
- i. suicide prevention methods tailored to LGBT persons
- j. clinical linkages to other LGBT providers/programs and resources
- k. needs of culturally diverse LGBT persons such as racial and ethnic minorities, those having disabilities, and those with low income

Providers will keep records of staff trainings which would be monitored by the DBH/MRS to determine compliance with these requirements.

7. LGBT Affirming providers must train (according to the recommendations above) all staff who come in contact with consumers as well as administrators before the providers are determined to be LGBT Affirming. Training must be made available to all new staff as part of orientation.
8. Training at LGBT affirming providers around LGBT issues must be on-going as evidenced by
 - a. more experienced staff mentoring less experienced staff;
 - b. case conferences;
 - c. training topics; and,
 - d. refresher courses.
9. The DBH/MRS should make efforts to link with appropriate programs at local colleges and universities to include LGBT competency training. The purpose of this is to produce culturally competent new professionals in the future. The DBH/MRS should inform their provider network of these opportunities.
10. All providers in the system must have training policies which reflect these recommendations.
11. DBH/MRS would offer a centralized training track for all agencies that are working towards being considered LGBT Affirming.

* An LGBT Affirming provider is an entire agency or a specific program of an agency that has put in place significant practices (defined here) that ensure clinical and cultural expertise to all LGBT clients who approach that agency or program for behavioral health services. When this term applies only to a specific program within an agency, the parent agency as a whole does not meet the requirements for the designation.

** It has been noted by several LGBT consumers that revealing their identity as a person who is LGBT causes significant problems when accessing services and often hinders LGBT persons from seeking help. To help address this problem, all Crisis Response Centers (CRC's) must meet at a minimum the requirements for training in number 5 above. This does not mean that CRC's will be designated as LGBT Affirming unless they choose to meet the other requirements described in this document.

Service Recommendations

1. Services offered to LGBT clients require a holistic approach incorporating an understanding of the client's clinical needs as well as recognition of LGBT issues which may be raised by the individual.
2. Accessing Services – see ** note under Training Recommendations concerning CRC's.
3. The range of housing support services in the behavioral health system should meet the needs of LGBT consumers in residential settings. The policy that has been developed by Office of Supportive Housing (see attached) should be used in developing policies and procedures to meet these needs.
4. Comprehensive physical/behavioral health services for LGBT persons should be developed which address a variety of sub-clinical issues including, but not limited to
 - a. relationship counseling – inclusion of partners and family members as defined by the consumer;
 - b. addictive behavior (both substance addiction as well as other addictions, including crystal methamphetamine treatment), including prevention efforts;
 - c. domestic violence, including awareness/prevention; and,
 - d. trauma, including prevention.
5. Clinical services must be goal directed and include coordination of different needs (such as HIV, hormone, mental health, addictions, etc.), and must link with appropriate other services/systems as needed.
6. In addition to clinically trained staff, service providers and programs to be designated as LGBT Affirming need to actively develop peer specialists and volunteers who have achieved some success in their own recovery.
7. Service providers who wish to be considered "LGBT Affirming" must develop a welcoming, safe, and supportive environment for LGBT consumers and staff (examples follow).
 - a) Social interaction
 - i. Staff at all levels would interact with LGBT people in a respectful manner by affirming their sexual orientation and/or gender identity

- ii. Staff take personal responsibility to maintain a safe environment by supporting a policy of non-harassment and/or non-discrimination against LGBT consumers by either other staff or other consumers in the program
- b) Physical environment
 - i. Clearly post the City's Fair Practice Ordinance
 - ii. Physical symbols would be used to show any LGBT person who comes to that agency that the provider is friendly to LGBT people (examples: rainbow flag sticker near entrance, posters that affirm LGBT persons, etc.)
 - iii. LGBT specific publications would be kept in the waiting room
 - iv. Residential settings would make provisions for transgender persons to have privacy in bathing areas either by providing a specified bathroom or designated times
- c) Policies
 - i. All policies mentioning rights of persons in regards to race, religion, ethnicity, cultural background, etc. would include sexual orientation and gender identity
 - ii. A policy regarding a no tolerance stance on the part of the provider regarding harassment or discrimination against LGBT consumers or staff
 - iii. A policy regarding training requirements of staff would include training around LGBT issues as outlined in the Training Recommendations in Section 2
 - iv. A policy regarding the protection of information concerning sexual orientation and/or gender identity for both LGBT staff and consumers would be developed
 - v. A policy regarding appropriate dress and appearance that allows transgender persons to wear the clothing of their self-identified gender identity as long as it is compatible with the standards for other persons of that gender in the program
- d) Recruitment and Hiring of Staff
 - i. Actively recruit and hire LGBT staff persons and have documented the methods which are employed to seek LGBT workers

System Recommendations

1. The DBH/MRS needs to have a similar workgroup to the Behavioral Health LGBT Initiative to specifically address the service needs of LGBT youth. Recommendations or work developed by that group should coincide with the work that has been done by the Mayor's Blue Ribbon Commission. The workgroup should include LGBT youth as well as providers, advocates, and family members.
2. The DBH/MRS needs to actively recruit both LGBT persons in recovery as well as providers who serve LGBT persons for participation in all DBH/MRS initiatives.
3. The DBH/MRS would consider the development of an ongoing advisory committee to be a resource for the DBH/MRS (to give feedback on how well the Department is using these recommendations, how they are being implemented, and how it is affecting LGBT Consumers seeking BH services).
4. The Faith Based Initiative needs to actively engage faith based institutions that specifically work with LGBT persons.
5. Many members of the LGBT community do not affiliate with religious organizations. Alternate non-behavioral health organizations need to be engaged in a manner similar to the Faith Based Initiative. The goal of this engagement with these organizations would be to give them support and information about behavioral health concerns and assist them in linking LGBT persons to behavioral health services.
6. The Department of Behavioral Health needs to actively recruit peer specialists who are LGBT as part of their Peer Specialist initiative. The number of LGBT peer specialists should parallel the percentage of self-identified LGBT people in the general population of Philadelphia (at least 5% according to the Philadelphia LGBT Community Assessment which uses data from the Household Health Survey for Southeastern Pennsylvania).
7. As part of implementing an "LGBT Affirming" designation for providers, it is recommended that the Department begin this work by identifying and using a small number of providers as a pilot to implement recommendations found in this document. Feedback from providers will be essential in the development of best practices.

8. LGBT Affirming services should be developed for every level of care deemed necessary for a full continuum of care. This should include options for day programming and a full range of outpatient services, and peer run support services.
9. The DBH/MRS should develop specific service related standards for providers designated as LGBT Affirming.
10. DBH/MRS should update the appendices in the current Community Behavioral Health Provider Manual to include requirements for all providers in their treatment of LGBT persons as well as more specific requirements to obtain the LGBT Affirming designation.
11. DBH/MRS should provide capacity building for organizations to develop/continue to develop behavioral health services for LGBT communities.
12. DBH/MRS should actively recruit LGBT staff and service providers.
13. DBH/MRS should develop on their website a specific page that informs the community at large of the efforts of the DBH/MRS to meet the behavioral health needs of LGBT people in Philadelphia. This page should also contain a link to a list of resources for people who may be seeking behavioral health services from providers in the DBH/MRS network and specifically highlight those providers who have been designated as LGBT Affirming.
14. All LGBT consumers should receive educational/outreach materials regarding services and LGBT Affirming providers as well as other related resources in the community that are supports for behavioral health (e.g. peer support groups, etc.). There should be specific marketing beyond the website directed towards LGBT persons to inform them of available behavioral health services.
15. The DBH/MRS should request that the Consumer Satisfaction Team begin to make a specific effort to engage LGBT BH consumers as part of their satisfaction surveys and that the results of these surveys would be reported back to the DBH/MRS as indicators of how well the system is addressing the needs of LGBT consumers.
16. All materials that are targeted at reaching LGBT persons seeking behavioral health services should state clearly, "If you, or someone in your care, have any problems while seeking or receiving behavioral health services as a result of your/their identity as a lesbian, gay, bisexual, and/or transgender person, please contact our member services line at 1-888-545-2600, and our staff will assist you."
17. In an effort to support transparency and accountability, it is recommended that progress in fulfilling these recommendations would be reported to appropriate bodies and the community.

Data Recommendations

1. The DBH/MRS would develop a set of questions that can be asked by providers and DBH/MRS Member Services addressing both sexual orientation and gender identity.
 - a. All providers who receive DBH/MRS funding must ask these questions as part of their assessments/intakes/evaluations done with consumers and include the results in the write-up.
 - b. All data must be collected in a private space.
 - c. The collection of data should be balanced with an actual need related to receiving services.
 - d. All questions on any form that relates to sexual orientation and/or gender identity (either directly or indirectly) should be worded in a fashion that leaves room for a wide range of responses (not restricted to heterosexual categories or gender being limited only to male and female). For example: “relationship status” rather than “marital status” with more options than “married, single, or divorced”. The option of “other” is not acceptable.
2. Consult with experts in data collection for the LGBT populations and get their input for all data needs.
3. Develop a method to measure possible health disparities and connect that data with the DBH/MRS Health Disparities Workgroup.
4. Sexual orientation and gender identity data would be utilized in the quality assurance process.
5. The DBH/MRS would develop a set of definitions for terms related to sexual orientation and gender identity. These definitions would be distributed throughout the DBH/MRS and provider network as well as making them part of provider and system trainings. These definitions must be seen as standard for providers to use in explaining terms to consumers who may have questions.
6. It is recommended that a small number of providers pilot whatever data collecting is developed so that it can be modified to fit the needs of LGBT persons with behavioral health concerns before it is implemented throughout the system.
7. Sexual orientation and gender identity data will be gathered from consumers currently receiving services at the point of updating assessments/evaluations.

8. All data collected by behavioral health providers and the DBH/MRS concerning gender identity and sexual orientation must be handled with the same confidentiality standards applied to all other personal health information.

LGBT Community Forum

Summary

Unwelcome environment in behavioral health services for LGBT persons:

- Intake worker asking a lesbian woman (not knowing her sexual orientation), “Do you have a boyfriend?” instead could have asked, “Do you have a significant relationship with someone in your life?” showed that the place was not an accepting place for her to be out with her sexual orientation
- Consumers expressed a need to keep their sexual orientation a secret from staff and other consumers out of fear of either violence or harassment
- There were several comments about there being front line staff (ex: techs in inpatient units or rehabs) who have more contact with consumers who were either very homophobic and/or very religious believing that God had brought LGBT consumers to them so that they could preach to them and try to change them.
- Providers commented that front line staff (paraprofessionals) are often not given the same training and experiences that create sensitivity to LGBT people as the people with more advanced degrees – but the people with advanced degrees are not the staff who are most with the person in treatment – there was also concern that these paraprofessionals are then blamed when they act out of their lack of information and training – it was noted that those who get paid the least in providers often cause the most problems for LGBT people but regardless of pay, no LGBT person should be harassed in treatment.
- A comment was made that lesbians can come out during addictions treatment much more easily than gay men because it is somehow more acceptable to some people.
- A comment was made that just because a professional is LGBT that does not mean they are qualified or even without biases when working with other LGBT people and still need the training
- At CRC’s and ER’s, trans people are only treated as being trans instead of focusing on the issues that have brought them to treatment
- The system in general across the board is not asking during intakes, assessments, and evaluations about sexual orientation or gender identity much less recording or reporting this data

Suggestions for the system:

- All paperwork asking for gender or relationship status would have more options that just male or female
- A registered nurse in the audience commented that all the cultural competency training that she has attended has lacked any discussion about LGBT concerns or culture
- The same nurse relayed a story about a transgender male-to-female person who came to their floor and was immediately put on the male unit without even questioning if this was the right place for the patient
- There are no LGBT affirming detox/rehab resources in the City
- Need support for victims of sexual trauma as this is common for LGBT persons seeking behavioral health services

- There needs to be outreach to the LGBT community that there is a caring system that wants to meet their behavioral health needs – there also needs to be more education to the LGBT community about behavioral health issues and resources
- Providers need to be held accountable for not providing a welcoming environment
- The Department needs to do outreach and offer support to organizations that come in contact with LGBT people but don't have a behavioral health focus
- Programs need to be more client centered and focus on what the client wants
- Domestic violence is rarely addressed with LGBT consumers
- While appreciating the work of Mazzoni, there was concern that they are the only LGBT Health Center and LGBT specific provider in the network because it brings up issues of choice and confidentiality for the consumer out in the LGBT communities
- LGBT consumers need a safe way to tell someone who can do something to change the situation when they are being harassed, abused, or attacked during treatment
- One counselor of female to male trans men stated the men she works with have problems of being treated fairly when seeking crisis services
- Comment by a consumer that consumers themselves need to be more proactive in making things change
- The system needs to check into the United Way's funding of "at risk youth"
- There were several consumers and providers who voiced a concern that just because a provider claims to be "gay friendly" that does not mean they are competent to work with LGBT people.
- There is a strong need to start collecting data on LGBT people so that future planning and evaluation of the system can be done (this also affects the accountability and performance measuring of providers)

Quotes from Participants:

"Hello, I am a transwoman, a person in recovery, and I suffer from depression. Once, before I was a person in recovery I stayed in treatment for 93 days, when you were only supposed to stay for 27. I was going to places like Mirmont and Bowling Green and sleeping arrangements were difficult. Usually the bedrooms have two beds. The women did not feel comfortable with me; the men thought I wanted to have sex with them. I had no place to go. They sent me to a halfway house. I did not commit a crime; I was not coming from jail, prison or any criminal justice system. I was just a little different. I hope my story encourages others to share."

"I am a 42 year old gay man, in recovery, and newly diagnosed with HIV. I have been a mental health consumer a few times at a few facilities. I have experienced strong prejudice from staff. A lot of these people are of a strong religious position. MH/MR facilities are the only places I have felt the need to hide my orientation, for safety reasons, since my early 20's."

"There are many organizations who say that they are "Gay Friendly", but they do not address GLBT issues. There are no programs that are GLBT focused."

"I think we need to shift gears and not look at this as an expectation of being "LGBT Friendly"... I would like for us to push for "LGBT Competent"...LGBT Friendly usually is staff and an organization that will not allow hateful words or hateful actions, or can pronounce words appropriately. However this is not enough to provide good/quality services to the LGBT community. Clinicians need to know how this impacts you, as someone who is oppressed, depressed, and in need of treatment."

"I am in recovery and in an organization. I never had been given respect. Thank you for the respect that you are giving me here. I suffer from depression and HIV. I just found out and need info, I need to adapt, I need resources, and I am hoping I can get something from being here. I need info on MH and recovery."

“Hello, I am a registered nurse and would like to speak on the LGBT competent remarks...Throughout my associates, masters, nursing and schooling in general there was not one course on LGBT. There has been no training based LGBT for staff. Many people do not know what to do, many people do not know how to do it, and the education is not there.”

“I have been gay all of my life. I work in an outpatient program and I am in recovery. I have 13 years last month! I am here to say that therapists do not know what to do. AA, I go to AA, but am not an alcoholic, but I go anyway. We need to give resources to the community. I need someone that I can talk with who will understand and be competent.”

“I am going to share what I experienced my whole life as a gay man. I am open at work and am in recovery. I am a medical director of an organization and am part of the Philadelphia BH System. We need to get to the point where people identify that they do not know, what they don't know. We need people to say “I don't know”. We need to place an importance in this minority, like we would any other minority. We have an LGBT program starting and I would like to have help from the taskforce in getting it to the next level. “

“Hello I am a Clinical Social Worker. I would like to speak on re-traumatizing those who are publicly or personally identify as LGBT. Many people we serve are victims of violence, assault, and sexual crimes. As service providers we need to be comfortable with our organization, who we serve, and most importantly our own sexual identity to not re-traumatize those we serve. It is more than having trauma based services.”

“Myself and another woman were the only two on the unit. She was open and because of comments mentioned to her I thought it best to keep it a secret. Staff told her that if she did not change her ways that she will burn in hell. The stuff that staff and other clients said could make or break you when you are in treatment.”

“We should begin collecting, using, and sharing Data on LGBT. We need to know how to best serve. CBH Billing could easily identify LGBT thru a demographics screen.”

“There should be a crisis unit that you can go to that you do not have to be suicidal/homicidal or hallucinating. Where you need to go for medication or an overhaul.”

“Many LGBT providers need more quality training in BH issues. It would be more helpful to clients for providers to be more thorough in both LGBT and MH/SA issues.”

“I have had gay vs. non-gay providers. I feel like it is a waste of time with non-gay providers. I don't think I should have to spend my time in therapy teaching someone about being gay.”

Other comments:

- While some consumers voiced problems with very religious staff at providers, one consumer got up and spoke about the importance of his Christian faith to his recovery. This statement was met with agreement from several other participants.

Important Documents for Future Developments

Miscellaneous Attachments

- **Office of Supportive Housing: Sexual and Gender Minority Addendum, Shelter Standards**
- **Experiences of LGBT People with Serious Mental Illness: Raising Issues**
by Alicia Lucksted, PhD

Sexual and Gender Minority Addendum

Shelter Standards

DEFINITION

Sexual minority is a term used to refer to gay, lesbian, or bi-sexual identified people. Gender minorities may include individuals whose gender identity and/or gender expression may be different from their assigned gender at birth. For example, gender minority individuals may refer to themselves as transgender, trans-sexual, cross-dressing, or transvestite. Gender minorities may represent or express their gender identity through behavior, clothing, hairstyles, and voice or body characteristics.

GENERAL POLICY STATEMENT

The mission statement of OESS is to plan for and assist adult individuals and families in moving toward independent living and self-sufficiency, with the end goal of households thriving in safe and stable housing located in supportive communities. In addition, all individuals/families seeking services with OESS and contracted shelter service providers must be treated with dignity and respect. This includes lesbian, gay, bi-sexual and transgender individuals. OESS is committed to complying with the Philadelphia Fair Practice Ordinance as amended in 2002. OESS and providers are prohibited from discriminating against persons on the basis of their gender identity or sexual orientation, as well as race, color, religion, sex, disability, national origin, ancestry, or marital status and all other protected cases as stipulated in the Philadelphia Fair Practices Ordinance.

“It is expected that this policy will function as an addendum until the Shelter Standards are revised and the language provided in this document are incorporated.”

CLIENT RIGHTS AND RESPONSIBILITY

OESS and shelter service providers will enforce all dress codes fairly and equally for everyone. Clients will have the right to dress in accordance with the gender with which they self-identify.

OESS and Shelter Providers will support the decisions made by transgender clients to access services in the gender they identify as best preserving their safety. Clients should receive services/placement consistent with their self-identified gender.

STAFFING

OESS and shelter service providers, shelter and case management staff, will be trained on policy, procedures, sensitivity and overall client issues. “This training is mandatory.”

Sexual and Gender Minority Addendum

Shelter Standards

CONFIGURATION OF SHELTER SPACE

PRIVACY

Space permitting, OESS and all contracted service providers will maintain at least one private restroom and private shower facility for clients whose personal needs require a high level of privacy while bathing, toileting and dressing. If such space cannot be made available OESS and service providers will make every effort to accommodate this need. For example, developing bathroom usage schedules to accommodate privacy.

SAFETY

When placing clients and assigning them to a bed or room, within a shelter: Clients' perceptions of their safety must be taken into account. It is essential that placement and bed assignment decisions be made in the context of a conversation between client and intake worker or case manager both at OESS intake and at the placement site.

On case-by-case basis individuals, couples and families may be determined to be at serious risk of physical or psychological harm. To the extent possible it is expected that OESS/Provider staff will attempt to house the at-risk individual or family separately to provide adequate safety and security. Secure areas may include separate bedrooms, access to private bathroom facilities and recreational areas that are under staff supervision.

INTAKE AND ASSESSMENT

OESS and Shelter providers will create and maintain a welcoming environment in all OESS facilities and during the Intake and Assessment process. Ensure privacy and confidentiality and use sexuality inclusive language. Examples of sexuality inclusive language are: Replacing the use of the term "sex" with "gender; or asking the client, "How do you self-identify your gender."

OESS and contracted service providers will inform all incoming consumers of the shelter's non-discrimination and anti-harassment policy, including its protection of lesbian, gay, bisexual and transgender consumers.

OESS and shelter service providers will accept and support the client's self-identification of his/her gender irrespective of physical appearance, surgical status, or documentation of identity.

OESS and contracted service providers will consider placement by taking into account where the client will be safe, their preference as well as availability.

OESS will provide sexual and gender minority couples and families with children equal access to couples' shelters and family shelters respectively, subject to availability.

Sexual and Gender Minority Addendum

Shelter Standards

CASE MANAGEMENT AND SUPPORTIVE SERVICES

OESS and contracted service providers will conduct all case management interviews in a private area.

Service providers within the OESS and shelter service system will accept the client's self-identification of his/her gender irrespective of physical appearance, surgical status, or documentation of identity.

OESS and shelter service providers will support transgender clients in their self-identified gender in the delivery of case management and supportive services.

COMPLIANCE WITH CODES AND LAWS

OESS and shelter service providers will prominently display in all facilities including intake areas and shelters the Philadelphia Commission on Human Relations Anti-Discrimination posters as well as OESS produced posters regarding sexual and gender minorities.

(The language in this policy will be incorporated into the existing Shelter Standards and will be utilized until the standards have been revised and issued)

Experiences of LGBT People with Serious Mental Illnesses: Raising Issues

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This is a summary (Sept. 2000) of a much larger report, which is not yet available. Please feel free to contact me for additional information about the topics covered.

Please do feel free to copy and distribute this summary, as long as this title page and my contact information are included in any copies. Thanks!

A version of this summary was presented as part of a poster at the 1999 American Psychological Association convention, Boston, Massachusetts

Funding for this research project was provided by the Center for Mental Health Services, SAMHSA. The opinions expressed in this document reflect the personal opinions of the author and are not intended to represent the policies of the Center for Mental Health Services or other parts of the Federal Government.

τΔτ Project Overview τΔτ

In 1997 the federal Center for Mental Health Services asked that a monograph be written drawing together existing information on the experiences of lesbians, gay men, bisexual people and transgender people (LGBT) receiving mental health services in the public sector. Usually such “monographs” are academic literature reviews. In this case, however, there is very little literature to review. While there is a growing body of work in counseling & clinical psychology, social work, and psychiatry on psychotherapy with gay and lesbian clients (less re Bi and Trans people), it focuses on coming out issues, general problems in living, and the stresses of living as LGBT in a intolerant society. It does not address serious mental illnesses, services other than therapy (inpatient hospitalization, day or residential programs), or the public mental health system.

Therefore, this project combined the slim relevant professional literature with information from grass roots publications, recordings, and first-person accounts (published and unpublished) through extensive networking and conversations with Key Informants (mental health consumers, providers, advocates and other with particular knowledge in this area).

The resulting report raises issues and questions rather than giving answers. Its purpose is to assist LGBT mental health consumers in having their views and voices heard – by mental health workers, by LGBT communities, by psychiatric consumer/survivor groups, and by mental health systems. With it, I also hope to spark interest and concern so that next steps may be taken and problems addressed. Finally, I also hope this report can put interested people in touch with each other – feel free to share it!

This summary highlights main themes from the monograph with brief topic summaries and first-person quotations. However, it necessarily leaves out many important issues, points, and quotes included in the full monograph. If you want or need further details or the entire (100 pg) report, please get in touch!

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“In the mental health system, we had to be closeted about being a sexual minority. There was no place we could feel at home, not be guarded because of fear of ridicule and rejection, and fully share who we are.” (Holochuck, 1993. p. 17)

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τ **No one is addressing the concerns of LGBT people with serious mental illnesses.**

- Existing LGBT affirmative therapists / centers often cannot address serious mental illnesses.
- Staff at general mental health services often cannot address the needs of people with LGBT identities.
- LGBT communities are often afraid of mental illness and full of stereotypes, just like rest of society.
- Mental Health consumer self-help organizations are often afraid of LGBT issues and full of stereotypes, just like the rest of society.
- There is no research in this area, no health administration policy, and discrimination is legal in most places.

“Any knowledge you could put out through the report would help. There is a woeful lack of knowledge all over. Even places that are relatively gay friendly – even gay clinicians – don’t know much about treating gay patients [with serious mental illnesses]” (staff member)

“For individuals diagnosed with serious mental illness who are LGBT, homophobic attitudes among providers of mental health services, and mental health programs which are heterosexist, create barriers to recovery and detract from the effectiveness of treatment and support services. (Chassman, 1996, p. 1-2)

τ **Often, consumers’ emotional and sexual life in general is not addressed except as a problem.**

- Many day, residential, inpatient, etc programs see any sexuality / relationship as disturbed or disturbing,
- Most make no provisions for learning about or having healthy adult intimate relationships (sexual or not)
- Most seem to want to see consumers are having no sexuality, including heterosexuality, but LGBT identities/behavior are even more stigmatized

“At the state hospital outpatient clinic...the staff tend to deny the sexuality of all patients. There’s this sense of patients as children, who don’t have a sexuality, or that it wouldn’t be good for them to be sexual. Staff don’t seem to want to deal with it. For example, a community residence locally that has a rule that residents cannot have sex in the house, [but] they don’t really provide other guidelines or information, don’t really address sexuality. More it seems they just don’t want to know about it –so, not in the house.” (Consumer)

“When I tried to develop a safe-sex workshop for clients...it took me weeks to get the staff to OK it. They were afraid that it would be too “stimulating” for the clients, would turn into a sex orgy. In reality it is quite different.... Clients are just thankful that someone is addressing sexuality issues in a positive open way – or at all. I’ve noticed the clients often really get organized and ask really good questions.” (Psychiatrist)

τ Staff Homophobia and Ignorance is not addressed

- Consumers experience many mental health workers as fearful: don't understand, don't know about, don't like LGBT identities and so don't treat the people well, and don't want to deal with relevant issues.
- Many staff hold stereotypes that LGBT people are all HIV positive, sexual predators, hate men, are swishy, are butch, are confused, are sick. Subtle to blatant pathologization of LGBT identities is rampant.
- Knowledge of and respect for LGBT consumers is not covered in staff trainings or program policies.

“It took me a long time to build my life back up again after that [a disastrous phone call to family made at the insistence of her social worker]. I believe that the social worker did not really have any idea about the issues of a family totally disowning someone for being gay – how strong homophobia is, and that it is not going to be ‘cured’ by a phone call.” (Consumer)

“Some [staff] see something bad in the gay community and (1) stereotype us by assuming that we're all like that just because we're gay. Then (2) they don't even think about how many really bad problems are going on that impact the gay community and cause the things they're seeing – how homophobia, AIDS, problems with families, isolation, all that, effect people.” (Consumer)

τ Peer Intolerance is also an unaddressed problem

- LGBT consumers report frequent harassment and belittlement from clients attending the same programs.
- Consumer-run self-help groups are often unwelcoming to LGBT consumers
- LGBT communities may be especially reluctant to embrace LGBT consumers given the history of LGBT identities per se being considered mental illness.

“Patients in the system also panic – there is LOTS of homophobia and transphobia, and attacks and harassment. And the staff will usually ignore it, condone it by their inactivity.” (Consumer)

“At the other clinic its OK in group to bring up gay examples (like, “I wish had girlfriend”), but no one joins in the discussion except the therapist. No one else is out, straight members don't join in even though they have exact same issue...When I bring up gay things the conversation stops.”

τ Family Stress around being LGBT, a Consumer, and both, can be considerable

- People with serious mental illnesses often rely on family members – for direct help or in knowing they are there as resource of last resort for housing, money, emotional support. Many LGBT consumers cannot count on this, cannot go home, and so do not have this safety net. Or, they have it, but at a high price of active conflict, stress, and/or being closeted, isolated.

“I, for example, came out to my family 13 years ago and was immediately disowned. Despite efforts to contact them, cards and gifts sent, etc, I have never seen another single member of my family again, even though my sister, nieces and mother live only 35 miles away. I was told that I would be arrested for trespassing if I tried to visit them. Although extreme, this is not entirely atypical of the [LGBT] consumers' experience at the Alliance.” (Consumer, peer advocate)

“I am bisexual and...living with an abusive father (finances keep me at home) I cannot at least for now even hint of such a possibility to my immediate family. There's been enough trouble...I fear they would call me crazy, just for [being bisexual].” (Jim Haller, 1996, p. 1)

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These add up to many LGBT Consumers spending tremendous energy managing identity, self presentation, fear/anxiety, and the negative reactions of the very people from whom one would hope to get support: the MH system, peers, family. In addition to their other life challenges.

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τ **LGBT identities are still pathologized**

- **Some providers still see being LGBT as pathology. Some assume that LGBT orientation is not real -- a delusion, a symptom because the person has been diagnosed with a mental illness.**
- **Unfamiliarity and stereotypes lead some staff to interpret adaptive behavior as pathological. For example, self-protectiveness or anxiety about homophobia interpreted as paranoia.**

“The fundamental issue is still that it is NOT a pathology, and the mental health system still is not as accepting as it ought to be of this.” (Consumer advocate)

“It is especially poignant with older clients who have experienced lots of abuse in the mental health system in decades past. They are very very wary about the Mental Health system -- period, and about being out certainly. Usually they are not out at all on the unit, and are reluctant to talk about it openly. I think this is due to years of misuse at the hands of the mental health system. In our LGBT support group, elderly gay and lesbian clients have talked about receiving ECT and aversion therapy (electric shocks applied to their genitalia when they respond to same sex erotica). Those with chronic mental illnesses like schizophrenia, for example, talk about not being seen as cured or the exacerbation being seen as in remission because the client “still” maintained attractions to members of their own sex.” (Psychiatrist)

τ **Programs/systems have little information or resources about LGBT-affirmative community and MH services:**

- **If I go to the day program can I expect hostility if I’m out or outed?**
- **If I live there will staff or other residents harass me?**
- **Does anyone there know anything about LGBT issues?**
- **Isn’t the LGBT community part of the “community integration” I’m supposed to be striving for?**

“[Once] I and another staff-person did an in-service on GLB issues. People asked very basic questions and did not know of even the most common community resources we listed. (Staff)

“According to Diane Johnson, president of Lambda Human Service Professionals, acknowledging service recipients’ sexual orientation is critical to developing individual service and discharge plans which reflect the recipient’s goals and choice” (OMH News, 1994, in Chassman, 1996, p. 2).

“Here in San Francisco...we’re fortunate to have a pool of sensitive or at least interested practitioners to draw from in discharge planning and community services for people leaving [our unit]. Others might not elsewhere, and that would change things a lot. What services any hospital

or program can provide depend on the available professionals and the politics in the surrounding area. Politics and health care certainly intermix. (Clinician)

τ **Inpatient and Residential/Housing services may be especially high risk for LGBT consumers**

- **LGBT people treated with suspicion, assumed to be sexual predators toward same gender staff, patients (especially roommates), watched, behavior over-interpreted.**
- **High level of harassment, discrimination, even physical assault, and staff disregard or blaming the victim.**

“Within any residential system – psychiatric, shelters, domestic violence shelters -- it is gender binary: women, men. Which dorm? Which wing? Which bathroom? If you don’t fit easily the staff get very upset. Other clients too. And its very very frightening for the client – the level of alienation and hostility, and danger, they can be in.” (Consumer / provider)

One person related a time when he felt attracted to another man who slept nearby on the hospital ward. He asked the nurses if he could sleep in another area, and had to tell them the reason. He was given another place to sleep, but the next day everyone on the floor knew about the request. In fact, the story had grown as it was passed around so that some people thought he had been ‘caught’ in an intimate act with the man or had aggressively pursued him. He recalls that a doctor said to him, “scum like you should be locked up,” and was not interested in hearing his version.

“Just recently in our group a 23 year old Latina woman in chronic treatment, in a residential program, was outed by a person she thought was a friend, and who she had told she was a lesbian in confidence. The friend went to the whole house, and the woman was harassed a lot and was very upset. We spent most of the afternoon meeting of our group helping support her.” (LGBT consumer support group leader)

τ **Providers may exhibit superficial sensitivity, but with little depth**

- **Service providers who know a little about LGBT people may be prone to stereotyping and uncomfortable with their own discomfort.**
- **They may also tend to assume/insist being LGBT is “no big deal,” or may insist on it as a focus even if client says its not the problem.**
- **They may shy away, or pathologize, client needs or conversations that go deeper than their own**

“Mental health workers often put on how advanced, knowledgeable, OK they are with GLBT and HIV topics, but if you scratch the surface at all you find they don’t know much, they really aren’t comfortable with it, and they don’t want to deal with it – with others’ issues or their own. They’re just trying to appear sensitive without really being so.” (Consumer)

“I finally got a counselor, but she was the same way.... kind of pseudo-sensitive. She’d jump to conclusions and wouldn’t listen to my real point about things. For example, one time I brought up that things were so bad at home that I didn’t dare even bring home a [LGBT newspaper] She immediately jumped to “Yeah. I’d be ashamed too to be seen with those disgusting personal ads!” She totally missed my point, and [blamed] the gay community as disgusting. I even agree – I think the personal ads are rather filthy. In fact I usually take out that section ...and just take the paper itself. But my point in that example was that (even without the ads) I could not bring it in the house because of the terrible conflict it would create with my mom.” (Consumer)

τ **Rigid gender roles are common in mental health programs, and LGBT people are often pressured to conform to mental health providers' ideas of "women" or "men"**

“On the behavior mod ward they had this system where they gave us tokens for doing what they wanted, and took them away for being bad. You had to pay tokens for anything you wanted to do, even taking a bath. I remember I had this green plaid skirt and matching sweater I used to get tokens for wearing ‘cause they were trying to change me into their idea of a proper woman.” (Blackbridge & Gilhooly, 1985)

“When I was at [the] Hospital, I got in a lot of trouble and was considered seriously depressed because I refused to put on make-up or act in other ways they considered appropriate for females...I was openly gay at the time.” (Consumer)

“Shelters cannot deal with men who are at all effeminate – they get beaten up.” (Consumer)

τ **Mental health workers, including Gay and Lesbian ones, are often very ignorant and prejudiced about issues important to Bisexual and Transgender people**

“Any degree of fluidity re sexuality, which is certainly part of being transgender, makes therapists anxious, even panic. It brings up their own sexuality issues – am I woman or man enough? This panic is then defended against and projected as attack, even hate, toward the client. Gender identity questions, and transgender lead to this panic because gender is even more central to one’s core identity than sexual orientation.” (Consumer advocate)

“As I was going along, most often my therapists didn’t know anything about being transgender. I had to educate them. It really bothered me, and changed the whole therapy dynamic and takes away from the trust you feel, and the time spent on you, even though that’s why you are there.” (Consumer/provider)

Effects of These Issues

τ **Stress and energy taken from rehabilitation and learning**

τ **Frustration, anger, depression**

τ **Safety concerns**

τ **Absence of / Barriers to useful services**

τ **Fear, isolation when need community integration**

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τΔτ Expressly LGBT-affirmative Services τΔτ

In addition to individual mental health workers who are well informed and experienced in providing care to LGBT people with serious mental illnesses, there are several clinics in the U.S. that bring this competence to a programmatic level. The ones I have been in touch with are profiled in the monograph, as are the few consumer-run self-help and advocacy groups made up of LGBT people with serious mental illnesses.

Although the time and funding to do program evaluation/comparisons has not been available, people from both anecdotally say that receiving services in a well-informed, expressly LGBT-affirmative program does make a difference:

- τ **Clients feel more comfortable and safe, which facilitates trust in therapeutic relationships and openness on the client's part.**
- τ **Knowing one does not have to constantly worry about reactions and intolerance, nor constantly monitor one's self presentation seems to allow LGBT identities to be LESS of an issue, allowing clients to better concentrate on the mental health issues they are trying to address.**
- τ **Services are provided that better address the clients' real-life needs, are more tailored to the client's life, re discharge planning, aftercare, housing, community integration.**

“Usually in other places I’ve found that if a counselor is bad to talk to on one thing, doesn’t want to hear you out...then you don’t want to talk to them on other things. It effects trust, and can make it hard just to get yourself to go. Here people are more comfortable with each other, more knowledgeable about themselves and issues, more aware of social problems, and more involved with each other. They don’t take just a medical view [of] “medicate and go.”...So, I feel I can be more up-front regarding all the complex parts of homosexuality, and of HIV. Communication is more open – so that if there is some tension or problem it can be put on the table; communication is much less defensive. (Consumer)

“Instead of pretending [sexual activity on the unit, despite official prohibitions] doesn’t happen, [our unit] tries to address it openly. We encourage people to think about, talk about, and express sexual feelings in thoughtful, adult ways...To not enter into unhealthy relationships... To talk about sex. To masturbate if they want to.” (Inpatient psychiatrist)

“Posting information, posters, books, brochures on LGBT issues and organizations is part of creating an affirmative environment.”

“...There needs to be a way to make sure we have clinicians who can provide the services that are needed, including gay-affirmative MH services. Its not the sexual orientation of the trainees that matters, but their willingness to learn the information, and their interest in being educated and sensitive in this area.”