

visions

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LGBT

lesbian, gay, bisexual,
transgender

healing the
wounds
of prejudice

a great group
of women
talk about
coming out

safe spaces
in bc's interior



visions

Published quarterly, Visions is a nationally award-winning journal that provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. It creates a place where many perspectives on mental health and addictions issues can be heard. Visions is produced by the BC Partners for Mental Health and Addictions Information and funded by BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority.

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letter to the editor

As a recent convert to the medical marijuana cause, I was delighted to read an entire edition of *Visions* devoted to cannabis. On August 18, I finished my sixth and last round of intensive in-patient chemotherapy. I would never have made it to round two had I not been able to use cannabis to reverse my severe nausea, depression, anxiety and loss of appetite.

During my first round of chemotherapy, my oncologist insisted I use anti-nausea medications. I did as directed but found myself suffering for hours as I watched the clock and waited for my next round of pills. Three days later I was in rough shape and wasn't able to eat or drink much. My husband suggested I try medical marijuana. I hesitated. Though familiar with the idea of medical marijuana, I associated cannabis with go-nowhere headbanger types or giggling teens getting high behind the bleachers. I took only two puffs and, to my surprise, my nausea disappeared instantly. I fell asleep for an hour, and when I awoke I was able to drink an entire bottle of juice and eat crackers. From then on, I relied solely on medical marijuana products to get me through subsequent chemotherapy sessions. They controlled my nausea, reduced my mouth sores and helped me eat.

Cannabis also alleviated some of the anxiety and depression I experienced after each round. This was extremely important to me as I needed to be calm and positive for not only my sake but for the sake of both my 7-year-old and newborn. Cannabis was a big part of my surviving cancer. It is also a key factor in my children still having a mom to take care of them.

—Nicole Bodner, Comox, BC

editor's message

Welcome to the new *Visions*! Although the content and approach haven't changed, we hope the new layout will make *Visions* easier to read and enjoy. The redesign is part of an overall refresh of the look and feel of materials produced by the BC Partners for Mental Health and Addictions Information. You may have also noticed the new, green Heretohelp logo on the cover page. This new logo builds on the well-recognized work and promise of the Heretohelp.bc.ca website where *Visions* and other BC Partners products live.

Now, back to the current issue...

Someone once said there are two "s"s about our humanity that always seem to get lost in conversations about health: sexuality and spirituality. This *Visions* issue deals with some aspects of the former, specifically sexual orientation and its connection to mental health and substance use. It's a subject not talked about enough in mental health and addictions circles. LGBT refers to lesbian, gay, bisexual or transgendered individuals, although you'll see that there are several acronym variations in this issue. What do all these terms mean? Because language and history are so central to understanding this area, I really encourage you to read the glossary at the end of *Visions* before you read any articles.

Like our upcoming issue looking at immigrants and refugees, this issue also looks at culture, community and diversity. And it deals with issues of identity, disclosure, prejudice, and pathology—concepts all too familiar to those involved in mental health and/or addictions. Contributors to *Visions* are always special, eloquent and courageous, but especially so in this issue. They're also great champions in reminding us, with practical examples and passion, that we need to remember the needs of the whole person and the multiple layers each of us wear.

Sarah Hamid-Balma



Sarah is Visions Editor and Director of Public Education and Communications at the Canadian Mental Health Association's BC Division. She also has personal experience with mental illness

footnotes reminder

If you see a superscripted number in an article, that means there is a footnote attached to that point. In most cases, this is a bibliographic reference. For complete footnotes, see the online version of each article at www.heretohelp.bc.ca/publications/visions. If you don't have access to the internet, please contact us for the footnotes by phone, fax or mail using the contact information on page 2.

We Are Family

Guest Editor Sophia Kelly

Family are the first to notice. My first contact with the mental health system occurred one evening when a friend of my wife's and mine—we'll call her Linda—came over for dinner. Linda seemed a bit off. Anxious and awkward, she told us that people at her workplace were invading her mind to control and manipulate her and others using some kind of psychic broadcast.

Linda was reluctant to even make eye contact with us, for fear those conspiring against her would identify and attack us too. I have a fairly open mind, but all this seemed highly unlikely.

A few days later Linda and I went for a walk. During our walk it became very clear to me that she needed medical attention. I calmly told Linda that we were going to head to the hospital. Luckily, she didn't object.

At the hospital emergency I was torn between Linda's request that I not tell anyone about the conspiracy and the need to give the nurse information to show how unwell Linda was. And I just couldn't tell the nurse, in front of Linda, that I thought Linda was delusional.

Linda and I waited together in emergency until 7:30 the next morning. Linda became more and more disoriented and less responsive, and was unconscious when they finally moved her to a gurney in a hallway. I took some blankets and slept on the floor next to her. I stayed because I was afraid if I did not, she might not have anyone to advocate for her to get the help she needed. I left when she was admitted, still not able to tell the doctor privately the things Linda had told me.

The hospital kept Linda for a couple of days and then released her. We'd let our circle of friends, some of whom had been very worried about Linda's strange behaviour, know she'd been in the hospital, and two of them were checking on her.

A few days after Linda had been released, one of these friends called us to let us know that Linda had not been seen at all for days and was not answering her phone. My wife went by and found that Linda had also left her door unlocked and ajar. My wife called the hospitals, found Linda at one of them and went to see her right

Sophia is Manager of several projects for the BC Schizophrenia Society, and a consultant in private practice in areas including project management, health education and online outreach. She has designed and facilitates an online support group for LGBT persons supporting a loved one with a mental illness.



Although some of us are accepted by our biological families, many of us have difficult or distant relationships with our biological family because of prejudice. So, we create families with one another.

away. Linda had been found unconscious in a hotel room and brought in by the police.

Linda had been completely non-responsive for hours, but when she saw my wife, she beamed at her and began to speak. I think that response convinced the hospital staff that my wife and I were important to Linda and would be useful in her care. The psychiatrist interviewed us about Linda, who still wasn't talking much.

We visited with Linda while she was in the hospital and after, while she recovered. We informed her workplace, made sure her rent was paid and cleaned her place for her return.

During her year of break from work while she recovered, Linda came to events in the community we are part of, like the women's softball league games and dances. She stayed part of our community.

Linda is now back at work and has been doing well for a few years. With her input and permission, her family of friends have created a plan to make a more formal safety net for her if she gets ill again. A web of friends keep in touch, and if Linda falls out of contact, one of us will go by to make sure she's all right.

Families are the people who care

All the friends in my story above are lesbian, as am I. Our shared community is the lesbian community, part of the

larger LGBT community. Lesbian, gay, bisexual and transgendered (LGBT) people often form "families of choice." Linda is part of our chosen family.

There is a long tradition in LGBT communities of making our friends and partners into family. This comes out of supporting one another in the face of discrimination. Although some of us are accepted by our biological families, many of us have difficult or distant relationships with our biological family because of prejudice. So, we create families with one another.

These families of choice are every bit as supportive and loving as biological families. We care for our sick, support each other in times of loss, celebrate holidays together and mark each other's births, marriages and deaths. When we end a relationship, our ex-partners often continue to be key parts of our families. We have distinct cultures, communities and webs of supportive connections that sustain us. There is a long tradition of making our friends and partners into family in LGBT communities, which comes out of experiences of supporting one another in the face of discrimination.

Family are the people who care.

We all need to care

This year is the 40th anniversary of decriminalizing private gay sex in Canada.¹ Before 1969, a person found guilty of having consensual, private sex with someone of the same sex could be sent to prison indefinitely as a dangerous

sex offender.²⁻³ At the time, many people thought homosexuality was a mental illness. In 1973 the American Psychiatric Association (APA) publicly declared that homosexuality was not a sexual disorder.⁴⁻⁵ Yet, organizations acting from prejudice still promote "reparative therapy" to 'cure' people of homosexuality—a practice now opposed by the APA on the grounds that it has not been shown to work, and there are reports of it causing psychological harm.⁶⁻⁷

The stress of discrimination continues to have serious health effects on LGBT people, who are at an increased risk for all stress triggered problems. These include mental disorders and problem substance use.⁸ LGBT who people need to hide who they are generally have worse mental and physical health than those who can be open.⁹

I now work on projects for the BC Schizophrenia Society (BCSS), an organization that helps family members care for their loved ones with a mental illness. One of my projects is an online support group for LGBT persons supporting a loved one with a mental illness. BCSS staff have been very receptive to me and to the idea of supporting lesbian, gay, bisexual and transgendered families. My colleagues understand how being doubly discriminated against as both a LGBT person and someone with a mental illness makes it much harder to access services and get help. Creating overtly welcoming health services is extremely important.

LGBT people and their families of choice are extremely resilient. These family structures may be unfamiliar to many people. But we all need to understand that families of choice are just as important as biological families to the successful recovery of our members with health challenges.▼

Pathologizing Sexuality and Gender

A BRIEF HISTORY

Jacqueline Holler

What makes us desire partners of one sex or another? What makes us feel “male” or “female” inside? What is “normal” and what is not? What can be considered “pathological” (i.e., unhealthy or sick)? These questions have taken on great importance over the last hundred years as researchers and the general population wrestle with the diversity of sexual and gender expression.

Sexology in the 1800s

Until the late 1800s, Western society didn't even have words for “homosexuality” or “heterosexuality.” Before this time, laws and social norms banned sexual acts between people of the same sex. Behaviours such as wearing the clothes of the opposite sex were also forbidden. These acts were usually seen as the result of sin, rather than as an expression of an individual's personality. At the time, everyone ‘knew’ that God had ordained two sexes, each with distinct roles, and that these two sexes were to “cleave [cling] to one another,” not to members of their own sex.

By 1850, sexologists¹ and psychologists were beginning to study human sexual behaviour. They came up with the idea that some men and women were members of a “third sex.” This third sex engaged in same-sex sexual relations and displayed gender-variant behaviour (that is, behaviour that wasn't viewed as normal for their sex). By 1870, the term “homosexual” — considered to be morally neutral — had been coined to refer to those who had same-sex relations.²

At about the same time, the idea of sexual “inversion” was brought forward to explain both gender nonconformity and same-sex attraction.

The “inversion” scholars believed that homosexuality was an inborn tendency. They believed it resulted from changes to an individual's brain while still in the womb. They thought these changes made both the brain and the behaviour of “inverts” resemble those of the opposite sex. This idea that homosexuality was an inborn deviation from normal gender development was widely embraced. For example, women who fought for the right to vote were sometimes described as “mannish inverts” whose desire for masculine

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In the 1800s, Everyone ‘knew’ that God meant for people of these two sexes to cling to one another, not to members of their own sex.

rights went along with their presumed seduction of younger women.³

In the nineteenth century there was little awareness that sexual orientation (the sex a person is attracted to) and gender identity (the gender one feels oneself to be) are not necessarily linked. But today, for instance, we understand that a man who likes “feminine” things may be heterosexual, while a stereotypically masculine man may be gay.

At the beginning of the twentieth century, a new theory developed by Sigmund Freud rose to the fore. He acknowledged that sexuality was an important inborn drive, but saw both sexual orientation and gender identity as being shaped in early childhood. For Freud, no one was naturally homosexual or heterosexual.

Homosexuality: something to be ‘fixed’?

Some see Freud as the father of clinical ‘treatment’ of homosexuality, but Freud himself did not view homosexuality as a disease. He famously advised the anxious mother of a gay son that homosexuality “is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function.”⁴

Freud did believe that homosexuality resulted from a disruption of the “normal” pattern of child development. But since homosexuality wasn’t an illness in and of itself, there was no reason to ‘cure’ it. However, while Freud’s developmental theories were adopted in North America, his attitude toward homosexuality was abandoned.

Homosexuality was included, along with other sexual “disorders,” in the first Diagnostic and Statistical Manual of Mental

Disorders (DSM-I), published in 1952. The DSM, published by the American Psychiatric Association, is used worldwide to influence diagnostic, research and public policy decisions.

Psychologists began to advocate a simple cause for homosexuality: cold, domineering mothers and/or weak or absent fathers. Some professionals began to ‘treat’ the gay “illness,” often seeking to root out experiences once considered innocent or normal, such as youthful crushes on same-sex teachers.⁵

The history of how we frame sexuality and gender as “healthy,” “normal,” “natural” or “pathological” makes it clear that we have an incomplete understanding of this complex human experience.

Treatment approaches ranged from psychoanalytic “reparative” therapies, which aimed to repair these problems supposedly caused by poor relationships with parents in early childhood, to “aversion” therapies.⁶ In aversion therapy, for example, a patient might be shown pictures of same-sex people engaged in sexual activity. When the patient begins to show signs of arousal, he (or, less commonly, she) might receive a painful electric shock or be given a drug that makes him nauseous. This is meant to

“teach” the patient to associate homosexuality with unpleasantness or pain.

The effectiveness of all these therapies has been widely debated. Beginning in the 1960s, American psychiatrist Charles Socarides developed a psychoanalytic approach for which he claimed a cure rate of about 33%, though critics have disputed the permanence of such “cures.”⁷

Though the period between 1945 and 1970 was dominated by the idea that homosexuality was an illness, some contested the idea that same-sex attraction was abnormal. Alfred Kinsey’s research in 1948 suggested that many American men had had homosexual experiences and that a surprising number of men were consistently attracted to other men.⁸

In the 1960s, homosexual men and women began to engage in increasingly open advocacy, particularly after the Stonewall riots of 1969. The Stonewall riots took place in response to a police raid on a gay bar and were one of the first instances of gay resistance.⁹

Gay advocates saw psychiatrists as “gatekeepers” of societal norms regarding human behaviour. An “activist committee”¹⁰ lobbied to have homosexuality removed from the second edition of the DSM (i.e., the DSM-II). Activists and many professionals argued that to be regarded as a mental disorder, homosexuality should be reliably associated with mental illness or distress, neither of which was supported by data.

On December 15, 1973, the American Psychiatric Association, accepting this argument, declassified homosexuality as a mental disorder. The new DSM-III, published in 1980, contained a



compromise between opposing views of homosexuality as mental illness; the new text introduced “ego-dystonic homosexuality” (i.e., distress about being gay). When a revised edition of the DSM-III (DSM-III-R) was published in the late 1980s, even this diagnostic category was removed.

Being gay was no longer officially a sickness, but conversion therapies (attempts to “treat” or change homosexual orientation) have continued. In 1992, Socarides co-founded NARTH (National Association for Research and Homosexuality), which continues to advocate for voluntary treatment.^{7,11} Christian approaches to conversion also remain prevalent in the United States. These use counselling, prayer and other techniques to treat a condition many Christians deem sinful.¹²

Gender identity: controversy prevails

Today, most of the LGBT community regards the idea of treatment for homosexuals as an offensive relic of the homophobic past. However, the idea of conversion is alive and well in therapies to treat gender identity disorder (GID).

GID was introduced into the DSM-III (previous editions had included only transvestism, or cross-dressing). Its first criterion for diagnosis is a “strong and

persistent cross-gender identification.”¹³ (In other words, one’s gender identity differs from one’s anatomical sex.)

Activists have lobbied for the removal of GID from the DSM, most recently demonstrating at the April 2009 meeting of the American Psychiatric Association.¹⁴ However, some people within the transgender community fear that removing the disorder from the DSM might limit access to sex reassignment surgery and hormone therapy. For this and other reasons, the removal of GID from the DSM remains controversial.

Meanwhile, transgender and gender-variant children and youth remain targets for treatment. Efforts toward a ‘cure’ can be quite aggressive. The most common treatment for young people requires parents to police their children’s behaviour, attempting “to make the child comfortable with the sex he or she was born with.”¹⁵ For example, a young boy might be forbidden to play with girls or with so-called girls’ toys.

Often parents seek a cure because they fear their children will be hurt by others. For instance, one mother decided to seek treatment for her young son after two 10-year-old boys threw him off some playground equipment because he was playing

with a Barbie doll.¹⁵ In a world where transgender people—and people who are different—are targeted for violence, and where being “like a girl” is a source of shame for boys, we shouldn’t be surprised that parents seek to protect their children in this way.

There is, however, strong evidence that GID in children is not a mental disorder, and some scholars recommend removing this diagnostic category from the DSM.¹⁶ Scholars and LGBT activists argue that gender-variant children are as mentally healthy as anyone else—or would be if they weren’t persecuted by hostile bullies and well-meaning ‘treatments.’

History: a red flag on the side of caution

The history of how we frame sexuality and gender as “healthy,” “normal,” “natural” or “pathological” makes it clear that we have an incomplete understanding of this complex human experience. Our former simple idea—two sexes, with two distinct gender roles and a sexual orientation toward one another—has been complicated by research findings and social change. But this history of our evolving understanding should make us cautious about what we consider pathological—and about the ethics and consequences of ‘treatments.’^v

LGBT People and Mental Health

HEALING THE WOUNDS OF PREJUDICE

Al Zwiars, MSW, RSW

Imagine knowing at a young age that you are different. Imagine that you see your difference contrasted every day in the relationships you grow up around. Imagine that your peers hurl insults defining how you are different. Imagine that the social and cultural institutions inform you that your difference is not acceptable. Imagine that you long to be with others who are also different, but don't have a way to connect with them.

Al is a Registered Social Worker. He has worked with Vancouver Coastal Health as an addictions counsellor for the past decade, with a special focus on sexuality and gender identity. Al considers himself fortunate to be able to work within the LGBT community to nurture healing, understanding and growth.

For many lesbian, gay, bisexual and transgender (LGBT) people, this has been the reality of their childhood and development into adulthood. The lasting effects of experiences with such prejudice and discrimination are profound.

Discrimination breeds ill

Research shows that LGBT people have higher rates of mental health challenges than the general population.¹ LGBT people often struggle with depression, anxiety, trauma and self-acceptance as a result of facing ongoing discrimination over their lifetimes.²⁻³ LGBT youth are about three to four times as likely to attempt suicide as their peers.⁴⁻⁶

There is evidence that these higher rates of mental health challenges are due to heightened and long-term exposure of LGBT people to societal and institutional prejudice and discrimination.⁷ There are many similarities in the effects of discrimination and how people respond to and cope with stress directly related to prejudice. It's important to remember, however, that not all LGBT people have lived the same experiences, and that people respond to similar experiences in different ways. It's also important to note that issues of sexual orientation (lesbian, gay and bisexual) are very different from the issues of gender identity (transgender). Gender is about how we view and express ourselves, such as male, female or somewhere between, while sexual orientation is about who we are attracted to romantically and sexually.

LGBT people unquestionably experience long-term stress related to their sexual orientation or gender identity. They often internalize the negative messages about being different. These messages become beliefs that can fester and develop into two struggles: shame about who they are and what they feel, and guilt about what they do.⁸ Moreover, LGBT people witness physical assaults against others they identify with,⁹ which further threatens their sense of physical and emotional safety.



Experiences of verbal and physical abuse by peers based on sexual orientation and gender variation are almost universal for LGBT youth.¹⁰ In a 1998 study, LGBT students heard derogatory slurs, such as “faggot,” “dyke” and “queer,” an average of 26 times each day.¹¹ Some youth report that these behaviours occurred in the presence of school staff, who did nothing to challenge the discrimination.¹² These experiences lead to youth feeling unsafe in schools and result in higher rates of skipping school and dropping out.

Through repeated negative experiences as children and teens, LGBT people learn to anticipate and expect rejection and judgment from their families, peers and communities. These young people come to understand that they are different from what is considered normal. LGBT people are often met with rejection and violence within their own families. LGBT youth continue to be at greater risk of being kicked out of their homes or running away to the streets than their peers.¹³⁻¹⁴

Living with these various challenges to their emotional well-being can foster anxiety over rejection and abandonment. Withdrawing from a culture that threatens their safety and lives is viewed by some LGBT people as a safer option. However, isolation due to a lack of a supportive family or community of peers can compound struggles with depression.¹⁵

In the not-too-distant past, even the medical community added to the emotional and physical risks to LGBT people. Before 1973, homosexuality was labeled a mental disorder and many individuals experienced prejudice and judgment from those who were supposed to help. Debate continued in

the medical field through to 1987, when it was widely accepted that homosexuality was not a mental disorder.¹⁶ While the situation for LGBT folks has improved over the past few decades, many are still dealing with the effects of societal discrimination experienced during their lifetimes.

Through repeated negative experiences as children and teens, LGBT people learn to anticipate and expect rejection and judgment from their families, peers and communities.

Allies...just imagine!

Having support in life is immensely important to a person’s mental health and overall well-being. Ongoing movements within the LGBT communities have developed alternative means for people to connect, share and heal in meaningful ways.¹⁷ Individuals have become connected through other activities and venues, such as recreational groups, political action, and peer support and discussion groups.

Community developers and researchers are recognizing the connections between the prejudice experienced by LGBT people and discrimination based on gender, race or ethnicity. LGBT individuals are tackling isolation and prejudice by developing healthy alliances with their neighbours, friends

and families. Gay–straight alliances are being developed within school systems.

Anyone can be an ally and provide support and nurturance to their friends, family and community members.¹⁸ The importance of the role that allies play is acknowledged publicly, as proven by the fact that the group that consistently gets the loudest cheers at pride parades is PFLAG, the Parents and Friends of Lesbians And Gays.¹⁹

Allies move beyond pity and tolerance to lead by example. They understand that LGBT people have a right to be true to themselves in expressing their gender and sexual orientation, and in living full and proud lives as equals in society. Allies challenge discrimination against LGBT people and acknowledge the impact of historical prejudice upon mental health.

Change needs to continue to occur within society to challenge systemic oppression on all levels. It’s important for everyone to recognize the strength and courage required for LGBT people to stand up in the face of discrimination. It’s also important to acknowledge the enduring capacity for people to heal from the wounds of prejudice. Change is always possible.

Imagine knowing at a young age that you are different. Imagine you learn that being different is okay. Imagine that you feel safe and nurtured in your families, culture and society. Imagine that you develop a strong sense of connection to a diverse community. Imagine that you are taught to love what makes you different. Just imagine...▼

Same But Different

SUBSTANCE USE IN QUEER AND TRANS COMMUNITIES

Stacey Boon, ATDip, MC, CCC



Health professionals who work with lesbian, gay, bisexual and transgender (LGBT) clients suggest that LGBT people use more of all substances than the general population.^{1,2} And current research suggests that about 30% of the LGBT population abuse substances, while only about 12% of the rest of the population does.

Stacey is an alcohol and drug counsellor for Addiction Services, Vancouver Coastal Health, actively involved with Prism Alcohol and Drug Services. She provides group and one-to-one counselling, trains staff to work with sexual minority clients and participates on Prism's program planning and evaluation committees.

There is, however, no solid agreement on these statistics and trends. Very little research has been done on LGBT people and substance use. The existing research is full of problems with methods: notably, problems with definitions, study locations, community representation and assumptions made. Terms like "homosexual" and "substance abuse" are not easy to define in a standard way.^{1,3} For example, women tend to report more changes in their sexual orientation over their lifetimes.⁴ Black-or-white definitions ("gay" or "straight") of sexual orientation do not fit for many people.

Some earlier studies on alcohol and drug use took place in gay bars, so only gay men were included. This represents a very small slice of the LGBT community. However, findings from studies of gay men have been assumed to apply to everyone else in the community. As a result, there has been very little research about lesbian women. There is even less research about bisexual and transgender people, even though there are notable differences between these groups.^{1,3}

Basically, more research is needed to help us clearly understand substance use in the LGBT community.

What are some differences? (Service providers take note)

Despite a lack of research, there are some things we do know about working with LGBT clients. We know that being queer (LGB) or transgender does not cause someone to have problems with substances.⁵⁻⁶ In fact, people who are queer or trans use alcohol and drugs for the same reasons that other people do.

There are, however, some special issues to consider when working with this community. The stresses that LGBT people experience in society just due to homophobia and heterosexism may cause them to turn to substances to cope.^{1,2,7}

In addition to being more at risk for substance use problems because they have to deal with more stress, LGBT people are targeted by tobacco and alcohol advertisers.⁸ For example, as early as the 1950s, Smirnoff vodka slyly advertised their product as "mixed or

straight.”⁹ The president of an LGBT marketing firm stated that clever and subtle targeting of gays and lesbians is growing because sexual minorities are an attractive market. He calls them “attention-starved and very loyal,” and noted that gay men in particular tend to have high disposable incomes.⁹

There are fewer specialized services to help LGBT people. Although these clients can access general services, there may be barriers that prevent them from getting help.¹⁰ LGBT clients may have had bad experiences with health care in the past. They may also fear facing prejudice. And service providers may not be equipped to reduce common barriers or to address special issues.

Research tells us that many alcohol and drug treatment programs aren’t doing a good enough job of dealing with issues of sexuality and gender.² While LGBT clients may come into alcohol and drug treatment with the same issues as other people, they may also have some unique concerns. They may need to explore their feelings about their sexuality or gender, explore the effects of stigma, or deal with “coming out” issues (i.e., issues around disclosing their sexual orientation and/or gender identity).

LGBT clients may prefer to work with LGBT staff. At the very least, they should have access to competent and supportive “allies.” However, competent and trained allies or openly queer and transgender staff are not always available to these clients. Many treatment programs do not address issues around sexual or gender orientation in their programming.

At the same time, it’s important to be aware that not all queer or trans clients will want or need to focus on issues

stacey recommends

Alcohol and drug services specific to LGBT clients

Prism Alcohol and Drug Services, Vancouver Coastal Health: There are more than 20 queer and ally counsellors involved with Prism, and there are treatment and recovery groups for trans people, LGBT youth, older LGBT people, queer women, queer men—including VAMP (Vancouver Addictions Matrix Program): Queer Men’s Crystal Meth Treatment Program—and LBT women who smoke. For more information, visit www.vch.ca/EN/find_services/find_services/?amp;program_id=265.

Other alcohol and drug services

- **Pacifica Treatment Centre:** Has a long history of working with LGBT clients
- Agencies and programs that work with high-risk and queer or trans youth:
 - **Watari Youth, Community and Family Services:** www.watari.org/youth_services.html
 - **UNYA (Urban Native Youth Association):** www.unya.bc.ca/programs
 - **PLEA Community Services Society of BC:** www.plea.ca/addictions_treatment.htm
 - **Peak House:** www.peakhouse.ca/program_info.htm
 - **Family Services of Greater Vancouver:** www.fsgv.ca/programpages/youthservices/
 - **Boys and Girls Clubs of Greater Vancouver Odyssey II and Nexus programs:** www.bgc-gv.bc.ca/content.asp?L=E&DocID=4

related to their sexuality or gender.^{7,10} Staff must look to the clients to decide when these issues are key.

Queer and trans people may also use substances differently than others. Club drugs may be part of the party scene for both sexual minority men and women. Gay men may mix Viagra with “uppers” or stimulants like cocaine or methamphetamine. This can lead to very risky sexual behaviour because their sex drive is heightened and inhibitions are lowered. It’s important to be aware of any links between sex and drug use as there’s a potential relapse risk for clients.¹ Sex may trigger urges to use substances.

Finally, LGBT people may have different family types or circles of support.^{1,2} Their families may be “families of choice,” made up of close friends and ex-partners. Services providers should be open when asking about or including people the client identifies as a family member or support.

Wanted: more specialized services

At this point, most of British Columbia’s substance use treatment resources for LGBT people are located in Metro Vancouver (see sidebar). Hopefully, more addiction and other services just for LGBT people will be offered across the province in the future.▼

The Light: Hallucination or Spiritual Energy?

Alexander Singh, RSW*



I have a mental illness, I'm gay and I'm a person of colour, from a South Asian community. I belong to a cultural community where most people do not accept homosexuality and many people do not understand mental illness. But over the years I've found ways to overcome my challenges and focus on my strengths.

Alexander is currently working on his Master of Social Work. He has a Bachelor of Social Work with a first-class standing from the University of British Columbia.

*Pseudonym

Leaving home; encountering the "light"

I was a closeted young man. I was very sad about being gay—was suicidal throughout my teens. I felt like a sick person for having sexual thoughts about men. I didn't want to be different and was afraid of being rejected by my family—there's a lot of pressure in the South Asian community to get married and have children.

When I was 13, I secretly found my way to a psychiatrist, hoping to become straight. His approach was to support me in whatever I decided, and he did

walk me through the process of coming out as part of exploring my options.

When I was 18, I had a brief but positive relationship with a man. I knew then that I couldn't change my sexuality. But I wanted to escape to another country, where very few people knew me, to live a gay life. So in 1991, at 19, I went to live with my grandfather in Kent, England, to attend college.

I felt lonely and missed my family in Canada. Within a few months of arriving in Kent, my emotions started going up and down. I didn't feel like eating. I'd pace in circles around my room. I had so many ideas in my head that I began to write—about politics, the cure for AIDS and homosexuality, and things that increasingly made no sense. When I looked in the mirror I didn't recognize myself, I'd changed so much in just three weeks. I'd lost weight and my eyes wouldn't stay still.

A cousin who lived nearby visited and was shocked by my appearance. He took me to his house and tried to get me to eat and sleep. I couldn't eat or drink much, but I did lie down, cover myself with a blanket and fall asleep on his bed.

All of a sudden I was awake and felt a surge of energy come from within me. Then it felt like it was leaving me. The top part of my body lifted up, the blanket fell off my face and I saw this light right in front of me. It's hard to describe it, but it was magnificent. Then I got scared, so covered myself again with the blanket. And when I took another peek, the light was gone.

Coming home; struggling through my 20s

I didn't know what to make of the light and struggled until my 30s to understand what it was. I wasn't a spiritual person at the time it happened. I'd say I was open to the idea of a god, but didn't think about it much. I'd also say I related more to Christianity than my cultural religion because of the friends I hung out with. But somehow, through seeing the light, I had a sense of God wanting me to pursue work in the helping professions.

I returned to Canada and decided to study social work. However, I had some mental health ups and downs to contend with.

When I was in England, I did go to the hospital for help after seeing the light. There they thought I just needed food and sleep. I was prescribed medication that did help me eat and sleep—but it didn't help me mentally.

Back home, I started school, but ended up losing a whole year of college. I didn't always take my medication—I thought I'd had a spiritual experience in England rather than a hallucination, so didn't need treatment. As a result, I'd get sick again, sometimes having to go to the hospital to get treatment. It was in that period that I realized I had

a mental illness and that I'd had a first break of mania in Kent.

In this period, my mother asked me if I was gay. I lied and said I was bisexual.

Later, when I was at the University of British Columbia (UBC), I volunteered with a student gay and lesbian group. I wanted to make gay friends, and I wanted to make a difference in people's lives. We did presentations to the campus community on homophobia and other forms of discrimination. We also organized a fun-filled "coming out" week, when gay and lesbian students could feel good about themselves and come out of the closet if they wished to.

At home with the light

I've been diagnosed with schizophrenia, bipolar disorder and schizoaffective disorder. I've been on numerous medications and am currently working with my doctors to reduce side effects by taking the lowest dose possible.

I am creating a custom world around me that I can handle. I believe in a holistic approach to treatment, including medication, counselling, nutritious diet, exercise, socialization, support groups, family support, good sleep and low stress. I find swimming really helpful for the body, mind and spirit. I'm

currently involved with a social support organization for gay, lesbian, bisexual, transgendered and intersex South Asians and friends (see sidebar).

Support of family and friends is very important. The people close to you can monitor the signs and symptoms of your illness. Their support can help reduce stress, which can reduce relapse. My mother has always been supportive. My father, who I felt anger at for abandoning me when I was younger, is now in my life. He doesn't agree with my gay activism and lacks education on mental illness. He did attend one meeting with my psychiatrist, but believes I don't need medication. But I'm grateful that my father supports me the best he can.

The other healing thing I have is my light experience. I'm now convinced that seeing the light was a spiritual experience. It took a long time for me to accept that, because in North American society we're not socialized to acknowledge spirituality (which is different from religion). The Western world is based on science and facts. The medical model relies on this to determine treatment.

I believe it was a spiritual energy that everyone has within them; that God is within everyone and is everywhere. My doctors think it was a chemical imbalance in my brain, but I've never had any other visual or auditory hallucination, ever. And, really, all that matters is what I believe.

When I think about the light, it feels like God telling me it's okay to be gay. I think of the light every other night and it brings me peace.▼

sher vancouver — for LGBT south asians and friends

Sher Vancouver is a social support organization for lesbian, gay, bisexual, transgender and intersex South Asians and friends of all ethnicities and sexualities. Its goal is to reduce the alienation, isolation, loneliness, depression and suicidal ideation of people dealing with gender, sexuality and coming out issues. Services include peer support, information, referrals, social activities and outreach presentations. Visit www.shervancouver.com.

A Great Group of Women Talk About Coming Out

Amanda, Angelica, Christine, Mary, Omira
and group facilitators Sharalyn Jordan and Milica Radovanovik

Coming out is not just about telling others that we are lesbian, gay or any other sexual identity. It's an ongoing process of living our sexualities and bringing them out and into our families, faiths, workplaces and communities.

Qmunity offers a range of social support groups for LGBTQ people and allies.

Volunteer facilitators are members of the LGBTQ community, who have training in facilitation and peer counselling skills.

This past summer, a small group of women met weekly at Qmunity in Vancouver. The group became a safe, supportive place for the women to explore what coming out meant for them. Meeting with the others in the group helped the women feel less alone and fearful. It also helped to counteract shame and to see positive possibilities for living as queer, lesbian, gay, bisexual or transgender.

The guidelines we used for this group are simple:

- No sexual identity label is required. Stay in uncertainty for as long as you want. Try things on, then modify or throw them out as needed.
- Having no timeline is normal—what is normal, anyway? Respect your own pace.
- There is no pressure to come out in any particular way, just encouragement to take responsible, self-loving risks.
- Take a good look around. Understand that your struggle is part of something bigger.
- Know that fear is a sign that something important is going on.

Mary, 48

I had a wonderful relationship with a woman when I was 24. Looking back, it was the freest and most authentic expression of my sexuality I'd ever had until this past year. I was a missionary at the time and was filled with a lot of guilt and fear, so I suppressed that part of myself.

As I started to think about coming out, I asked myself, "What will God think of me if I have another relationship with a woman?" Great books and a wonderful friend who is a spiritual director helped me work through this question. I now feel confident about finding fulfillment in this way.



The coming out group was an important part of the process. We were all of different ages and backgrounds, and that only added to the richness. It was good to have a place where I could totally express what I was going through and feel supported and safe in doing so.

I feel like I'm on a journey and I'm not sure where I'll be going next. It's a good journey, though, and I'm finally true to myself. I'm enjoying the process of discovering more and more about myself and the LGBT community, as well as feeling free to question things I've always held as true.

Amanda, 30

At age 24, I got my first social label: DIVORCED. My second label (which can be directly linked to labels one and three), came just after: BIPOLAR. It wasn't long before the hat trick, label three: BANKRUPT.

Not yet 25 and I had lost more than some people do in a lifetime. After a good five years of therapy and healing progress, the waters had started to calm. Time had separated the relationships worth keeping from the ones I wouldn't miss. People's judgments dictated the quality of the relationships that survived. I accepted that. I was as close as I could get to being 'accepted' again.

At 29, I realized my newest label: GAY. I had come to the realization that I am a lesbian. Homosexual. A dyke. Whatever your label of choice. I didn't "turn into" or "decide to become" gay. I simply realized and accepted an aspect of myself that previously had been misrepresented.

I am not looking forward to the "coming out" process. Will it leave me vulnerable

once again and change relationships I worked so hard to salvage? I'm hoping for a smoother journey than I had when I was 24, but I won't know the full effects until long after I've tallied the initial losses and saves.

The coming out group was an important part of the process. It was good to have a place where I felt safe and could totally express what I was going through.

Sadly, I know I stand to lose the trust and respect of some people. I may lose some people from my life completely. But I know from experience that it will hurt less than the damage I stand to suffer by keeping it hidden. I'm making a big effort to stand solidly behind all the things that make me, ME. Take me or leave me, but I want the world to know who I am.

Christine, 24

Scared, alone and confused . . . this is what I felt when I realized at the age of 14 that I was bisexual. I grew up in a very small, closed-minded town and in a very homophobic family. I heard gay bashing and put-downs constantly. I was afraid to tell my friends. All I had was TV, movies and the computers at school to help me understand. I spent

every lunch hour looking stuff up on the Internet. Every night for a week I watched *Better Than Chocolate*, *Queer as Folk*, *The L Word* and gay-themed movies. They saved my life. I loved watching the life I wanted. I didn't feel so alone any more. It was my own fantasy world, an escape where I could be true to myself.

Three years later, I built up the courage to tell my two best friends. They supported me! Four years after that, my family found out. They reacted with denial and anger.

I moved to the big city, where there's a wonderful gay community, and became actively gay. I worked up the nerve to tell my mom that I had a date with a girl—and my mom flipped. But I'd had enough of their abuse. I felt that if they couldn't accept me for who I am, they couldn't be in my life, so I cut them out. I had no contact with my family for two months. It was very hard, because we had been very close.

My family are now back in my life, and we are slowly working on things. They are trying their best, which is all I can ask for.

Joining the women's a group really empowered me. It showed me, in real life, that I wasn't alone. When I told my mom about the group, she was very happy for me—a big step for her. Now I'm fully out to my family, with no abuse for the first time in my life. It's wonderful. I'm as strong and courageous as ever.

Last summer's Pride celebration was my first real Pride that wasn't on a television or movie screen. I waved that flag with pride—pride for who I am and pride for everyone like me.

Omira, 40

As a lesbian and a practising Muslim, it took me many years to stop debating (mainly with myself) whether or not having a same-sex partner was acceptable to God. I was afraid I was going against God's teachings and that I'd pay the price in this life or the hereafter. But it became clear to me that it was not my choice and that God had created me this way. Trying to live as a straight woman would be living a lie. And I don't believe God put me on this Earth to go through life pretending to be someone else.

The debate in my mind had ended, but the anxiety and shame still wouldn't go away. It wasn't good enough to have the support of just my lesbian friends, but I still wasn't out to my family and straight friends. I began to feel that the dragging weight of this secret would affect my mental, physical and emotional health in a serious way.

I've always believed that God knows what's in our hearts. People come and go, but God is always there. Yet it took me years to get to the point of actually connecting directly with the Creator about this issue.

There did come a day when, in great despair, I reached out to God for help. There's a special prayer one can do just before bedtime. You can pose any issue where guidance is needed—and I needed guidance about whether God accepts my being a lesbian. That very night I had a dream in which the message was clear. I got my answer, symbolically. Without a doubt, the message was, "IT'S OKAY."

I always felt it was my faith in God and my being gay that was causing my anxiety because I couldn't reconcile

the two. When I finally put my trust in God and asked for guidance, I felt the support and acceptance I'd been searching for all along. It was almost as if God spoke to me and said, "I was always here. What took you so long?"



Angelica, 30

A long time ago, a girl kissed me. We never labeled our relationship, but it was the first time I fell in love. I couldn't avoid smiling every time I saw her—and people started to talk. In a small town in Mexico, people's talk matters. Parents started telling my friends not to hang around with me and I ended up being quite isolated. The girl left me as well. The gossip reached my parents. I can still see the repulsion and disgust on my mother's face. My mother never hugged me again.

I wanted to 'belong' so badly that I became a secretly non-straight, publicly homophobic person. I learned to divide my life, and love became a private matter. I left my family about 10 years ago, as soon as I finished university, with my heart broken into a thousand pieces.

I got tired of running two shows. About two years ago, I started a painful process of putting myself in one piece.

My first and most difficult step was to tell my parents. It took me a year to write a letter, which I brought to them in person. They took about two minutes to read it—and then asked me to leave. But they called me on my next birthday. Since then, they've made an effort to get to know me.

The next step in my quest to put myself together was to get in contact with other women with my sexual orientation. I found the group at Qmunity for women coming out. I never planned to come out or make a bold public statement, but I knew I had to open my mind to embrace diversity and equality. By accepting diversity, I was going to accept that secret part of myself.

In one of the first sessions, the facilitator called herself "dyke," without remorse. I was shocked by how comfortable she was and by her sense of belonging, despite the heavy word. But I kept coming back to the group. It was less difficult each time I came through the door of the Qmunity office. And eventually, I was able to interact with other lesbians in my office and in public places.▼

Treatment Delayed Because I Was Gay?

Ross Taylor

In my 45 years of existence, sex between two men in Canada has gone from being a criminal offence and diagnosable mental illness to being an act that “consummates” a marriage recognized by society, government and some churches.

Despite these legal, medical and social advances, the reality is that being gay and having a mental illness can result in delayed or inappropriate treatment. My story is a case in point.

The ‘cookie cutter’ approach

I was a sad and lonely child and felt I didn’t fit in anywhere. I got lost in fantasy adventure books—read all of C.S. Lewis’s *Narnia* books—and spent a lot of time alone secretly pretending I was something special. As a teenager, I found I could escape my feelings by using drugs and alcohol and sleeping a lot. I was suicidal and socially isolated, and I smoked hash oil daily and abused alcohol.

The first person I ever told I was gay was my Presbyterian minister, in 1982 when I was 18. I’d become a born-again Christian and had stopped using drugs the year before. After my born-again experience, I developed excessive religious beliefs. I thought I knew when the world would end and believed God talked directly to me through “messages” from squirrels, music and other people.

My disclosure about being gay wasn’t driven by great angst about it. I was attending a 12-step addiction support group and telling the minister happened when I was working on step five, to have no secrets. Being gay was another one of my secrets.

I always knew I was gay and clearly recall a powerful moment of clarity in the kitchen when I was 17 years old. I felt strongly that it was okay to be gay. I’d discovered that C.S. Lewis was a Christian, and he wrote¹ that it would be a sin to have sex with another man, just as it would be for an unmarried person to have sex. But he also accepted the fact of homosexuality as having purpose, in God’s mysterious way.¹ So it was okay to be attracted to men, but not to have sex. In a way this was a relief. I didn’t feel pressured to conform and pursue girls. And I didn’t have to deal with all the teenage anxiety about things like body image,

Ross is a Resource Development Associate for Coast Mental Health Foundation.

In his work and volunteer activities, he strives to bring understanding about issues related to mental health, addiction and homelessness and the importance of psychosocial and peer supports. Ross does public presentations and can be reached at rosst@coastmentalhealth.com.



intimacy and whether other men were attracted to me.

My minister was very uncomfortable when I said I was gay. At first he avoided the topic, then said it was a teenage phase. But he did refer me to counselling, at a mainstream service agency.

I saw a psychologist, though really didn't know what I wanted out of the sessions. And later, in 1983, I went to a family doctor for counselling. The doctor was recommended by a gay man I had met in my addiction support group.

The psychologist and the doctor both wanted me to come out. They felt that my symptoms—which I now see as depression—were part of not living as an out gay man. These professionals assumed that because society didn't accept gay people, I also hated myself and this was responsible for my suffering. Additionally, I had dropped out of high school, so the psychologist put a lot of focus on getting me on track with my education.

Basically, they both used 'cookie cutter' approaches: that is, they came up with clear, concrete solutions to obvious problems. Neither treated me for depression. I never told them about my grandiose religious thoughts, but I certainly did talk about my sadness and crying, and my suicidal thoughts. Because they saw reasons for my mood struggles, they didn't see the depression as clinical.

I didn't come out then other than to helping professionals and a few gay people I'd met in peer support groups. Besides, through watching and reading religious TV and books, I believed that God could change my sexual orientation.

I don't need treatment for being gay

Throughout my life, I've had many diagnostic labels and have tried various medications. I have depression, mania and psychosis, and am in recovery for addiction. Anyone with these mental health challenges faces issues related to human interactions. But I don't need treatment for being gay.

It's important that we raise awareness about the way some mental health professionals interact with gay clients. It seems to me that straight people wouldn't be asked some of the questions I've been asked—or at least not immediately.

In one psychiatric assessment, I was asked about my medical health. I said, "I have mild asthma but I'm fine otherwise." Then I was explicitly asked if I had AIDS. Over the years I've found that for some mental health practitioners "gay = AIDS." This is, of course, illogical—worldwide, the vast majority of people with AIDS are heterosexual.

I later wondered out loud to the psych assessment therapist whether women over a certain age were asked if they had breast cancer after answering that they had mild asthma. She didn't respond.

On another occasion, I mentioned to a different psychiatrist that I'd met a guy I liked. The psychiatrist immediately began to lecture me about safe sex and HIV/AIDS. I was stunned. Wouldn't questions about relationship issues such as fear of intimacy have been more appropriate?

Afterwards I wondered if he'd have asked a straight person about sexually transmitted infections (STIs), of which AIDS is one. After all, STIs are not unique to homosexuals. To practise

safer sex a person needs to have enough self-esteem to negotiate safer sex. Anyone with depression, suicidal ideation and low self-esteem may find this more challenging—everyone—not just gay people. Certainly, improving my self-esteem and treating my depression has enhanced my ability to be assertive in all areas of my life.

At my next session, I asked the psychiatrist why he'd brought up AIDS/HIV and hadn't asked what thoughts I had about the man and how I felt. He said he'd just attended a conference and heard there'd been an increase in new HIV/AIDS infection rates, so it was top of mind for him. Still, I was disappointed that I'd received such treatment from my 'gay-friendly' psychiatrist.

Coming out is no 'cure' for mental illness

I now realize that believing it was possible to change my sexual orientation or to practise abstinence was unrealistic. Delusional beliefs in change and abstinence meant that I didn't have to worry about romantic love, intimacy or fear of rejection. The reality is, though, that no person can eliminate homosexual urges. One can function as a heterosexual or live a life of abstinence, but one's attraction to members of the same sex will remain.

When I was 27, I came out and later moved in with my boyfriend. I was still paranoid, delusional, depressed and dealing with addiction on and off. Coming out as a gay man was a good step, but it didn't cure my mental illness or my chemical dependence. I think that if I'd been straight, the mental health professionals may have addressed these illnesses specifically and sooner.▼

Reducing Barriers

MAKING SERVICES RELEVANT TO LGBT CLIENTS

Peter Toppings

I've been giving awareness training on lesbian, gay, bisexual and transgender (LGBT) communities for Education Outreach Services at Qmunity, BC's queer resource centre. I've led workshops for health care, social service and criminal justice workers, as well as students at colleges and universities.

The majority of service providers who attend my workshops are open and eager to learn, but often have very little knowledge or practical skills in working with LGBT clients. This is not surprising, because it's only recently that educational institutions began to introduce LGBT content into their programs and courses. Many professionals currently working in their chosen fields may not have had opportunities to receive training on LGBT communities.

This means that many mainstream organizations have limited capacity to provide culturally relevant services to LGBT clients—that is, services that acknowledge the lived experiences and cultural identities of LGBT people.

It's not unusual for agencies to rely on an LGBT staff person to be the service provider for LGBT clients. There are several drawbacks to this approach. The LGBT staff person may end up with an increased and unmanageable workload without being officially recognized or compensated by management for this unique skills set. If this LGBT staff person should leave, the organization is left with even less or no capacity to serve LGBT clients appropriately.

Another drawback is that LGBT communities can be small, and a client might know the service provider through

shared networks. In this case, a client may not be comfortable or trustful seeing someone they know and may have added concerns about confidentiality.

It's also important to note that not all LGBT clients will necessarily want an LGBT service provider. The client may identify first as a youth or a Filipino, for instance, and age-related or cultural issues may be more important to them at that moment than LGBT issues.

LGBT people, like other marginalized groups, often experience barriers in accessing mainstream organizations. Barriers for LGBT people can include homophobic and heterosexist attitudes among service providers and a

Peter is the former Program Manager for Education and Outreach Services at Qmunity, BC's queer resource centre. He has delivered numerous LGBT awareness workshops to service providers.



Service providers are open and eager to learn, but often have very little knowledge or practical skills in working with LGBT clients.

visions recommends

Safe Harbour: Respect for all

Safe Harbour is an initiative to celebrate diversity and create welcoming, inclusive communities. Through Safe Harbour, businesses, community organizations and entire municipalities agree to treat everyone equally, to help those in need of immediate assistance and to teach staff members about diversity, respect and inclusiveness.

There are Safe Harbour-certified businesses and organizations in 25 communities across BC. Find a directory of members on their website at www.safeharbour.ca, or look for signage on storefronts. Safe Harbour also operates in Alberta, Manitoba and Newfoundland.

Web: www.safeharbour.ca

Phone: 1-888-355-5560 (toll-free) or 604-718-2776 (Lower Mainland)

Facebook: Safe Harbour: Respect for All

Twitter: SafeHarbourCdn

In BC, Safe Harbour is implemented by AMSSA, the Affiliation of Multicultural Societies and Service Agencies of British Columbia. AMSSA also coordinates the national program.

general lack of knowledge and skills in working with LGBT clients. It's not a simple matter of physically entering a building, going to reception and requesting service. Accessing services is a complex interplay of many factors. These factors include age, race, culture, ability, socio-economic background, gender, gender identity, sexual orientation, past experiences accessing mainstream organizations and more.

The desire of service organizations and providers to provide optimal care should motivate them to remove as many as barriers as possible.

Providing LGBT culturally relevant services

At the agency level:

Service organizations can do the following to ensure culturally relevant services for LGBT people:

- **Adopt a policy on diversity.** In drafting this policy, avoid making general commitments to diversity.

It's important to name sexual orientation, gender identity and your commitment to LGBT communities (as well as other marginalized communities). Consider inviting an LGBT individual to sit on your organization's board or diversity committee.

- **Arrange for LGBT awareness training for staff and volunteers.** It's a good idea to make this training mandatory or to strongly encourage staff to attend. Sometimes staff who are uncomfortable with LGBT issues will avoid attending.
- **Reach out to LGBT communities.** Find creative and low-cost ways to let your local LGBT communities know your organization welcomes LGBT clients. For example, staff an information booth at local Pride celebrations and provide information on your services and programs.
- **Create a welcoming environment.** Look for ways to make your reception and counselling rooms

more welcoming. For instance, display posters and pamphlets that celebrate diversity, including LGBT communities.

At the service provider level:

Along with these organizational changes, service providers play a key role in creating safe and respectful environments for LGBT clients. It's important for service providers to:

- **Examine their own attitudes and beliefs about LGBT people.** If you find yourself uncomfortable at the idea of working with LGBT clients, ask yourself if this due to stereotypes and lack of information. Ask yourself what you need to do to become more comfortable.
- **Use inclusive, non-heterosexist language and practices.** Allow for the possibility that any of your clients could be LGBT. Ask questions rather than making assumptions. Use inclusive questions that are broad enough to embrace all kinds of people.
- **Respond appropriately when a client discloses.** When a client tells you that he/she is a member of the LGBT community, don't say that it's not important to know or that you treat everyone the same. The client has just shared something very personal with you. Quietly thank them for sharing and acknowledge that it can be hard to trust in someone new.
- **Be aware of concerns for confidentiality.** LGBT clients may be out to varying degrees in their personal lives and may have concerns about confidentiality. For example, a client may ask whether personal information goes into his/her file and who has access to the file.
- **Offer support and make referrals with sensitivity.** As much as possible, make referrals to other

service providers and organizations that also welcome LGBT clients.

LGBT awareness training is critical

Any organization committed to working with marginalized communities should consider training all staff and volunteers to work with LGBT communities.

Typically, an LGBT awareness workshop covers:

- language and terminology
- LGBT culture and history
- the impacts of homophobia, biphobia, transphobia and heterosexism
- barriers to accessing services, including practical suggestions for making services more accessible to LGBT clients

Training can be tailored to specific audiences. For example, a workshop for health care professionals would

likely include additional information on the specific health issues of LGBT people. For far too long, LGBT health has focused mainly on HIV/AIDS. As a result, significant health challenges such as substance use, mental health and cancers may have been overlooked.

Ideally, workshops are at least two to three hours long, though I have managed with less time. Longer workshops (e.g., full-day) allow for exercises in which participants are encouraged to examine their own attitudes and beliefs about LGBT communities. Having an ease and comfort with sexuality and

gender diversity within LGBT communities is fundamental to providing services that are culturally relevant. If a service provider is uncomfortable with LGBT people and communities, their LGBT clients will pick up on this.

Qmunity's Education Outreach Services typically provides LGBT awareness training to organizations in the Lower Mainland of BC. In the past, staff were able to provide training in different regions of the province, but unfortunately that project funding has ended. The training is free, though honoraria are appreciated.▼

related resource

For more information on Education Outreach Services, contact Qmunity reception at 604-684-5307. Read more about Qmunity on pages 30-31.



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It's All About 'Asking the Right Questions'

Marcia Gibson, BA, MEd

Asking the Right Questions 2 (ARQ2) is both a highly successful assessment tool and a one-day training session. The assessment tool provides clinicians with a helpful guide for beginning discussions on sexual orientation and gender identity.

Marcia is a Provincial Services Program Consultant with the Centre for Addiction and Mental Health (CAMH) in Toronto, Ontario. She currently leads the Asking the Right Questions 2 (ARQ2) provincial project and coordinates a number of other diversity and health care access initiatives.

The assessment tool provides clinicians with a helpful guide for beginning discussions on sexual orientation and gender identity. It's for use with clients in mental health, counselling and addiction settings.

ARQ2 was developed at the Centre for Addiction and Mental Health (CAMH) in Toronto. CAMH is Canada's largest mental health and addiction teaching hospital, fully affiliated with the University of Toronto. It's one of the world's leading research centres and has been recognized as a Pan American Health Organization and World Health Organization collaborating centre. CAMH combines clinical care, research, education, policy development, prevention and health promotion to transform

the lives of people affected by mental health and addiction issues.

The ARQ2 training provides service providers with an orientation to the assessment tool, focusing on:

- key definitions and concepts to do with lesbian, gay, bisexual, transgender, transsexual, two-spirit, intersex and queer (LGBTTTIQ) people.
- unique issues of concern to LGBTTTIQ people
- health impacts of heterosexism (the belief that opposite-sex relationships are superior) and genderism (the belief that one gender is better than others)
- ways that organizations can better meet the needs of these diverse communities



Intake: sexual orientation and gender identity are relevant

ARQ2 was initially created in 2001 by staff in CAMH's Rainbow Service, a specialized addiction program for LGBTTTIQ clients. Staff had recognized a need for a set of standardized questions to improve the CAMH Addictions Program's general intake and assessment process.

LGBTTTIQ clients were having difficulty accessing Rainbow Service. Clients told staff that they were never asked about their gender or sexual orientation during the assessment process. And they often felt unsure or unsafe about disclosing their sexual and gender identities. As a result, clients weren't referred to Rainbow Service and often experienced homophobia or felt alienated in addiction groups they did join.

To help fix this, Rainbow Service researched questions for clinicians to ask clients during the addiction assessment process. They developed a manual and a one-day training, Asking the Right Questions (ARQ), for CAMH assessment staff. The manual and training session were then modified to include mental health assessments, and the acronym ARQ2 was officially adopted.

Teaching ARQ2: increasing LGBTTTIQ awareness

The ARQ2 training was so popular that in 2004, CAMH established the ARQ2 Project as part of a five-year diversity priority plan. This plan aimed to promote the specialized ARQ2 training and to build capacity by training trainers located throughout Ontario. The project's effectiveness would also be evaluated.

Project results were very encouraging. Nine experts from around the province

the ARQ2 assessment manual*



The manual includes:

- an assessment guide on when and how to identify a client's sexual orientation and gender identity and asking about related concerns
- background information to help therapists, counsellors, nurses, doctors and other clinicians use the ARQ2 guide
- answers to questions from therapists and counsellors

- a list of resources
- a glossary to help therapists and counsellors become familiar with terms that may be used by LGBTTTIQ clients and communities

Sample questions from the assessment guide:

How would you identify your sexual orientation?

- straight/heterosexual lesbian/gay bisexual
- WSW (woman who has sex with women)
- MSM (man who has sex with men)
- transensual (person attracted to transsexual or transgendered people)
- queer polysexual two-spirit
- questioning asexual autosexual
- unsure other prefer not to answer

Do you have concerns related to your sexual orientation, or do you ever feel awkward about your sexual orientation?

- not at all a little somewhat
- a lot unsure prefer not to answer

"There is a broad spectrum of sexual orientations. One way to think about sexual orientation is as a fluid continuum that ranges from exclusive same-gender attraction to exclusive opposite-gender attraction, with many points in between.

"It is important to note that not everyone who identifies as the same sexual orientation will fit in the same place on the continuum. For example, one bisexual person may fit directly in the middle of the continuum, but another bisexual person may fit away from the middle and closer to one end of the continuum than to the other."

* Barbara, A.M., Doctor, F. & Chaim, G. (2007). *Asking the right questions 2: Talking with clients about sexual orientation and gender identity in mental health, counselling and addiction settings.* Toronto: Centre for Addiction and Mental Health.
www.camh.net/Publications/Resources_for_Professionals/ARQ2/arq2.pdf.

joined CAMH's four-member training team. These new trainers are members of, and knowledgeable about, their local LGBTTTIQ communities. They are also experienced in clinical group facilitation, training and/or other clinical work.

The 13 trainers paired up to facilitate 44 training sessions throughout Ontario. More than 1,200 participants were encouraged to increase their comfort, knowledge and skills in working with LGBTTTIQ clients. Participants included front-line workers in community service settings, hospital social workers, high school guidance counsellors and therapists in private practice.

As part of the ARQ2 evaluation plan, follow-up interviews were conducted with a random selection of participants who had agreed to be interviewed. The feedback was consistently positive. Three months after attending

One of the Niagara Health System participants... thanked me for holding the training and indicated that it had changed her practice. She was asking more in-depth questions and was getting much more detailed information from clients.

– Bonnie Polych, CAMH Program Consultant, Niagara Region

the training, a majority of the 30 participants surveyed were applying components of the training to their work. They felt that ARQ2 raised their awareness, made them more open and sensitive to the issues, and gave them a language with which to speak to clients. Moreover, participants felt that ARQ2 training should be standard for all front-line workers and expanded to all levels of organizations.

This success of ARQ2 is due, in large part, to the ARQ2 trainers. As engaging and knowledgeable facilitators, they bring a wealth of experience and passion to their work. They bring the training and manual to life!

The ARQ2 manual can be ordered from CAMH or downloaded free of charge from the CAMH website. For more information about this resource and the training, visit www.camh.net/Publications/Resources_for_Professionals/ARQ2.v

related resource

Centre for Addiction and Mental Health (CAMH) – Other LGBTTTIQ programs, initiatives and partnerships

CAMH offers and is involved with other programs and initiatives for the LGBTTTIQ community. In addition to [Rainbow Service](#) substance use and concurrent-disorder counselling, there is a [Gender Identity Clinic](#), a program for co-occurring substance use and mood concerns, a bisexuality and mental health partnership research project, and ongoing partnerships with the trans community. There is also an LGBTTTIQ e-mail listserv for employees, a Health Equity Office (formerly the Diversity Programs Office), and a strategy to promote a safe and inclusive workplace for staff and volunteers who identify as LGBTTTIQ.

For more information on any of these projects, visit www.camh.net/About_CAMH/Guide_to_CAMH/index.html.

Safe Spaces in BC's Interior

WORKING WITH LGBT YOUTH TO PROMOTE MENTAL HEALTH

Wendy Hulko, PhD, MSW; Kari Bepple; Jenny Turco, BSW; and Natalie Clark, MSW, RSW



We are service providers, researchers and educators who work with youth that identify as lesbian, gay, bisexual, transgender, two-spirit, intersex, queer or questioning (LGBT).^{*} The following quotes from LGBT youth in the Interior highlight some of what we see and hear on a regular basis.¹

"I'm living in [small city] right now and it's very redneck—people screaming at you, swearing, cussing, giving me the finger—that's normal."²

"I think Kamloops is better than [my hometown], but it's definitely harder in different ways, I think, than where we grew up. In [my hometown] we didn't know anyone else that was gay at all growing up and—well I had one gay friend, but that was it—and then Kamloops is better, but it takes a while to realize who, like where to go, where not to go."²

"Even phoning like Kids Help Phone ... I have had a few people hang up on me...You try to reach out to somebody. You are crying...I was almost ready to lose it and I was on the edge literally and she was like, "Oh, you're 21. I can't help you." And I am like, "What do I do, call the after-hours line?" So I call the after-hours line, and they are like, "It's after hours so leave a message and someone will get back to you in the morning as soon as possible...that's great for two in the morning when I am thinking...I want to go smash my car or jump off a bridge or something

Wendy is Assistant Professor of Social Work at Thompson Rivers University (TRU) and Coordinator of TRU's Aging and Health Research Centre. She teaches courses on sexual diversity and aging, and does research with equity-seeking groups (e.g., LGBT youth, First Nation Elders, older women).

Kari is Coordinator of Safe Spaces at Interior Community Services in Kamloops, where she brings her passion and creativity to supporting LGBT youth and their allies.

Jenny is a Population Health Facilitator with the Interior Health Authority. She focuses on injury prevention, with a particular interest in addressing suicide prevention among youth ages 10 to 24 years.

Natalie is a faculty member in the Human Service department at Thompson Rivers University and Director of TRU's Centre for Community-Based Youth Health Research. She is a researcher and practitioner in the area of youth health, with a particular focus on youth who are marginalized or have experienced trauma.

* Normally we would use the abbreviation LGBTTIQ to include all those identified, but shortened it to LGBT for this article.



Despite the trauma and isolation often faced by these youth, many show the ability to bounce back when given support, skills and relationships built through school, home and community settings.

'cause I feel like I don't even exist... There are no resources here or any kind of outreach for gay youth, or anything."³

"Safe Spaces is the only program that I know of, and it has actually been a life-saver. I hit rock bottom and mean literally rock bottom. I was into drugs and everything else, and actually this program saved my life. I lost my family and everything, but the way that I am looking at it now is, just 'cause they are blood, doesn't mean they are family. And I am starting to find out actually who my family is."³

LGBT services and initiatives

LGBT youth struggle to survive on a daily basis. For instance, lesbian, gay and bisexual youth in BC experience higher levels of rejection, violence and discrimination in their families, schools and communities than heterosexual youth.⁴ LGBT youth also experience the particular challenges of living in a small city or rural town where there may be few resources to help reduce stress and anxiety that often arises. Additionally, they may not have positive role models.

Despite the trauma and isolation often faced by these youth, many show the ability to bounce back when given support, skills and relationships built through school, home and community settings. Family and school

connectedness can help protect youth and lower risky behaviours.³

We will outline a few services and initiatives that are designed to promote mental health, reduce suicide and help LGBT youth in the BC Interior "bounce back."

Safe Spaces is the main support and outreach service for LGBT youth (ages 14 to 25) in the Central Interior. It's offered through Interior Community Services (ICS) and funded by the Ministry of Children and Family Development (MCFD), Child and Youth Mental Health (CYMH) branch. While Safe Spaces works mainly with youth from Kamloops, youth who live up to 300 kilometres away have accessed this program.

LGBT youth view this service as "life-saving."² Kari, the part-time coordinator, facilitates weekly peer support and networking meetings in Kamloops, offers one-to-one mentoring appointments (drop-in or pre-booked) and gives workshops and presentations (on, e.g., homophobia, transphobia and heterosexism; diversity; let's talk about sex...uality).

In 2008 alone, Kari gave 38 presentations in Kamloops and Chase to 625 youth, teachers and other adults attending community youth events. These events included, for example,

Aboriginal girls' groups, gay-straight alliances and the Peer Helping conference for elementary and high school students.

Also in 2008, Kari facilitated 43 group sessions, including a new transgender group, which started in response to requests from trans youth wanting a separate group that could offer more support and privacy. The transgender group continues to meet on an as-needed basis.

Safe Spaces is getting more and more requests from rural communities—such as Ashcroft, 100 Mile House, Williams Lake, Barriere, Clearwater and Chase—for workshops and help starting their own weekly group meetings. Occasionally, youth from rural communities up to an hour away find their way to Safe Spaces in Kamloops by taking the bus or catching a ride with someone. Kari recently travelled 580 kilometres round trip to give a 3.5-hour presentation to 32 service providers and a handful of youth in Williams Lake. On her next visit, Kari will help these service providers move forward with their plans for a Safe Spaces group in Williams Lake.

Challenges related to funding and staffing do exist in smaller cities and rural towns. However, we are aware of a few other support groups and

resource-sharing networks for LGBT youth in the Interior. For example, Outlet is a group that meets in several communities in the Kootenays, including Castlegar, Trail, Nelson and the Boundary region (see www.queerkootenays.com/resources.php). Unity LGBT2S is a group offered by the Kelowna Boys and Girls Club (contact club180@boysandgirlsclubs.ca or Jessica Henihan at 250-868-8541).

Interior Health (IH) also recognizes the need to support high-risk youth, in particular LGBT and Aboriginal youth. Due to high rates of suicide-related deaths and injuries for youth ages 15 to 24, IH created the position of population health facilitator. The focus of the facilitator (Jenny) is youth suicide prevention. Jenny works in partnership with communities, advocates and service providers across the health authority to promote the health and well-being of the entire youth population.

Additionally, Interior Health is looking at ways to support events such as a workshop on how to be inclusive of trans people. This event, sponsored by the Women's Health Research Network, will be held in Kamloops on March 18, 2010.

Creative collaborations: LGBT youth voices are heard

Lacking resources for Safe Spaces programs, those working with LGBT youth have developed collaborative approaches to supporting youth. They do this through research, networking, sharing resources and providing opportunities for LGBT youth to have their voices heard. For example, LGBT youth have spoken with Thompson Rivers University (TRU) Bachelor of Social Work and Master of Education students—to the benefit of both groups. These classroom visits were a result of collaboration between Kari and Wendy (TRU faculty). Also, with funding from the Child and Youth Health Research Network, Natalie (also TRU faculty) brought Reel Youth to do claymation workshops at Safe Spaces in Kamloops and with her Aboriginal girls' group in Chase.

LGBT youth from Kamloops and other communities in the Central Interior such as Merritt, Chase and Williams Lake have participated in research projects through Natalie and Wendy and their research centres at TRU. Projects focused on transitions, identity and community, and health and well-being.

Safe Spaces youth hosted a Café scientifique⁵, sponsored by the Canadian Institutes of Health Research, in May 2009 at their meeting location in downtown Kamloops. It was called "Being Queer Out Here: Improving Sexual Health and Building Community for Sexual Minority and Gender Variant Youth." The speakers included Kari, Wendy and Dr. Jean Shoveller of the University of British Columbia (UBC). Thirty-five youth and adults attended.

There are strong ties between Safe Spaces and groups that help with family and school connectedness. These include gay-straight alliances (GSAs) in the high schools (there are up to five groups in Kamloops each year), Parents and Friends of Lesbians and Gays (PFLAG), GALA Kamloops (Gay and Lesbian Association) and TRU Pride. Kari attends meetings of the local GSAs and TRU Pride as frequently as possible. She also provides support to parents of LGBT youth, upon request.

Toward positive self-identity

Our research-practice collaboration includes a lesbian woman, a bisexual/queer (bi-queer) woman and two straight allies, each of whom has a role to play in supporting LGBT youth. We do this by modelling positive self-identity and by accepting youth where they're at. We also advocate, not only for youth to find their voice, but for service providers to hear these youth and act on their stories of discrimination, rejection and violence. Our common goal is to make sure that LGBT youth live to become healthy adults who see themselves as positive role models and mentors for the next generation.▼

related resource

For more information about [Safe Spaces](#) and other ICS programs, call Kari at 250-371-3086 or e-mail sspaces@interiorcommunityservices.bc.ca. Contact Jenny at 250-851-7387 or jenny.turco@interiorhealth.ca to ask about IH's youth health promotion work. For [TRU's Aging and Health Research Centre](#), call 250-852-6393 or e-mail Wendy at whulko@tru.ca. Call 250-377-6248 or e-mail nclark@tru.ca for Natalie and the Centre for Community-Based Youth Health Research at TRU.

To watch the [LGBT youth claymation creations](#), visit www.youtube.com/user/ReelYouth#p/u/61/Hs5tpiSye3M for "Being Your Truth" and www.youtube.com/user/ReelYouth#p/u/62/-VQ0UCH2MyE for "One World One Love."

Qmunity—BC's Queer Resource Centre

Myer Leach



What word describes community?

Note: This is a screen shot from Qmunity.com's home page

Qmunity* has been serving lesbian-gay-bisexual-trans (LGBT)—or queer—folk and our allies for more than 30 years. Our programs and services help to enrich queer and other communities, advance the health and well-being of queer communities and build capacity (that is, help individuals develop their personal gifts and abilities to benefit the community).

Myer is the part-time Program Facilitator for Qmunity's Generations, which provides services for older and aging queers. An older queer himself, Myer has a background in social work and education.

* Prior to June 2009, Qmunity was known as The Centre.

We also advocate for justice, challenge stereotypes and affirm the worth of all people. The majority of our programs are focused on the Lower Mainland, since we are largely funded by the City of Vancouver and Vancouver Coastal Health. Requests, however, come from all over BC and Canada due to a growing need for queer resources. We do operate a province-wide peer support, information and referral phone line.

Our age-specific programs

Gab Youth provides a safe, drug-free environment for queer and questioning youth, 16 to 25 years of age. Gab

programs are facilitated by professional staff, though youth participate in program development.

Gab Youth provides information and referral services, one-to-one peer support, weekly drop-ins and leadership training. Volunteer opportunities for young people include providing peer support, joining the youth advisory committee and doing educational outreach through PrideSpeak workshops. PrideSpeaks are interactive anti-homophobia and anti-transphobia workshops for youth, usually given in school settings.

Fun social events include Frisbee on the Beach, arts and crafts sessions, movie nights, the annual Queer Prom and a host of other youth-suggested and staff-supervised events.

Generations is one of only two programs in Canada (the other is in Toronto) dedicated to serving older and aging queers and to bringing generations together. "Older" is roughly 45 years, but the determining factor has less to do with years of age than with personal issues such as changing perceptions of body image and employability. For example, gay men and transgender people may begin to grapple with these issues in their late 30s or early 40s, while lesbian women may begin facing similar questions around 55.

Support and discussion groups focus on, for example, life transitions, smoking cessation (Catching Our Breath) and chronic illness (Chronically Queer). Educational workshops cover

topics such as memory and aging, representation agreements, sexuality and aging, and relationships and aging.

In partnership with Vancouver Coastal Health, Generations runs a weekly group for older queers who are dealing with substance abuse. This is not a 12-step program. These “Golden Oldies” meet with a trained therapist every Wednesday at 4:00 p.m. for mutual support. (For more information or to register, call 604-714-3480.)

Social events include a queer-themed movie night for older queers (Fruity Flicks), a community kitchen for older queers, bi-monthly card games for queers “of a certain age,” an annual Honouring Our Elders Tea, a discussion group for gay men between the ages of 40 and 59 (Club 4050), a monthly excursion to a fine arts event in the city—and the list goes on!

Intergenerational activities are organized with Gab Youth and other departments. These include activities such as bowling, Queer Jeopardy, a monthly social for queer women of all ages and National Coming Out Day events.

Generations also offers workshops and lectures in colleges, universities and care facilities. Students, staff members and managers are trained in developing queer-friendly human resources and guidelines that affirm the human rights of all clients. Home support workers, social workers, medical personnel and other service providers are given tools to help make queers feel safe in these care environments.

We’ve also begun an exciting new project—Moving Images—to archive videotaped stories told by older queers (see sidebar). Moving Images promises to be a valuable resource for researchers and the community at large.

Support, referral and counselling services

Qmunity offers a free counselling service for people in our queer communities who otherwise might not have access to a therapeutic relationship, or who prefer to access these services in a queer setting. Therapists are master’s- or doctoral-level students under clinical supervision, who have special sensitivity to, and knowledge of, the queer community.

(For intake, call 604-684-5307, extension 100, and say you’d like to see a counsellor.)

A number of 12-step addictions programs and other support groups for LGBT people also regularly meet at Qmunity.

PRIDELINE provides telephone support to queers of all ages throughout BC. Trained volunteers listen with a welcoming, non-judgmental, affirming ear. They also give information and referrals to other queer, mental health and substance abuse resources. PRIDELINE is not a crisis line, but volunteers will give callers information about crisis resources if needed. Call 604-684-6869, or 1-800-566-1170 from anywhere in BC outside Metro Vancouver between 7:00 pm and 10:00 pm Monday through Friday.

Qmunity is located at Bute Street and Davie Street in Vancouver’s West End. For general information, call the reception desk at 604-684-5307. Visit online at www.qmunity.ca to find out more about our programs. You can also become a fan of Qmunity on Facebook or follow Qmunity on Twitter. 

related resource

Moving Images

Qmunity’s Generations initiated Moving Images to preserve the stories of older queers so they will be available for research, education and other purposes. Videos of older queers telling their stories are being archived and will be accessible online. Older queer volunteers, as well as some younger queer volunteers, have been trained to do the interviewing and videotaping.

Moving Images is being done in partnership with the [Queer History Project](#) of Out On Screen. Out On Screen is a non-profit organization that presents the Vancouver Queer Film Festival and the province-wide Out in Schools educational program (www.outonscreen.com). The Queer History Project explores Vancouver’s queer history online through text, photos, video, audio and other media.

Moving Images and the Queer History Project are important efforts to preserve the queer dimensions of Vancouver’s history. As these LGBT people age and die, our city and region could be deprived of a rich source of understanding who we are and the challenges our queer community has faced.

For more information contact Myer Leach at Qmunity, 604-684-8449 or myer.leach@qmunity.ca.

Transgender Health Program

Kailey Willetts

Vancouver Coastal Health launched the Transgender Health Program (THP) in 2003 to address the health needs of transgender people. Lukas Walther, coordinator of THP, describes the program as a key hub for information and resources for anyone dealing with gender issues in British Columbia, as well as for their care providers and family.

Kailey is a former Communications intern at the Canadian Mental Health Association, BC Division and an English Honours and Professional Writing student at the University of Victoria.

The program offers peer counselling, support, advocacy and educational workshops, and helps connect people with the right service provider for their needs.

Finding the right service provider

Transgender people often need help dealing with emotional stress. This is often the case because many face significant stigma and harassment due to discrimination or transphobia (fear of transgender people). Many trans people feel isolated and approximately 62% experience depression. Some have given up, and one study found that 32% of transsexual people had attempted suicide.¹ “Being transsexual can place enormous barriers on a person, affecting every step of their daily life.

Without sincere, caring support, it can easily become too much,” says Walther.

Finding a knowledgeable, “trans-positive” service provider—one who understands and supports the identity of transgender individuals—is extremely important in ensuring a transgender person receives proper care. Since transgender people often have depression or anxiety, a skilled practitioner is needed to identify what is and isn’t a gender issue. Trans people run the risk of receiving a diagnosis that doesn’t take personal history or feelings around their gender issues into account. But, according to Walther, depression and anxiety can often eventually melt away when a person’s gender issue needs are met.

Trans people need to be aware that just because a mental health care provider says they’re an LGBT (lesbian, gay, bisexual, transgender) health care provider, it doesn’t mean they have any experience with transgender issues. Their specialty could be lesbian relationships, for example. Walther says people may include the T in the abbreviation LGBT simply because it’s politically correct to include it. But it doesn’t necessarily mean that the practitioner is familiar with transgender-specific mental health concerns, though it may well indicate they are open to learning.



Unfortunately, there aren't enough practitioners who specialize in transgender issues. So, Walther says, he's "in a constant state of triaging." This means the program has to address critical situations first.

"Safety and access are the priorities," says Walther. If a client has multiple issues of concern (e.g., trauma, mental health, addiction, unstable housing, etc.), Walther refers the person to one of the few practitioners, GPs and/or service agencies that have experience with gender identity issues and whatever else the person may be dealing with. As well, the THP has a community counsellor on staff who works hand-in-hand with the service providers to ensure that all the client's needs are met.

The Transgender Health Program puts people into relevant, competent care. "It can be salvation when someone gets into the right hands."

Counselling and support services

The community counsellor is available to help trans people cope with "big feelings" to do with isolation and discrimination, and to provide information about gender transitioning (i.e., sex change). The counsellor offers one-to-one short-term counselling and facilitates regular peer-support groups.

THP peer support groups include groups for transgender and questioning youth, adults and trans-identified sex trade workers. "It can be really powerful to be in a peer group of any kind," says Walther.

The groups are confidential, and THP doesn't keep electronic records. There is no pressure to talk or even to stay the entire length of a meeting; trans-

transgender health program, vancouver coastal health

Services for transgender people and their loved ones

- help finding trans-positive general and specialty health care and social services
- information on options about gender transition
- information about best practices and standards of care,* as well as client/patient rights
- peer counselling and support relating to gender identity, gender expression and life stresses
- support and information for family members, partners, friends and other loved ones
- outreach to trans people working in the survival sex trade
- information about transgender community groups

Services for care providers

- training on transgender health and medical issues
- help in care planning for transgender clients and loved ones
- information about best practices and standards of care
- help with developing policies and procedures that are inclusive of transgender people
- information about transgender health research findings and what it means for practice
- joint program planning and research with non-profit community groups and government services

* Best practice guidelines and standards of care are available online at transhealth.vch.ca/resources/careguidelines.html.

Source: VCH Transgender Health Program: transhealth.vch.ca

identified people can come and simply listen for as long as they want. People are invited to meet with Walther or the facilitator beforehand, or to just drop in for the group. Parents and close friends are welcome to attend the youth group.

Education for service providers

The THP provides education for service providers to help them better serve and address the needs and concerns of transgender people.

THP staff work with organizations or individuals to create custom

workshops on a variety of topics that meet their needs. Topics can include how to work respectfully with people who experience differing degrees of gender distress and may have a range of gender-variant identities, barriers to service, safety issues of being visibly trans, an overview of the assessment processes for hormones and surgery, which transition services are funded and which aren't, psychosocial issues, concurrent disorder (i.e., mental health and addiction) issues, best care practices for both adults and adolescents, and more.

The THP also hosts a group of multi-disciplinary specialists who meet once a month to discuss current, complex case studies of people seeking hormone treatment. This is an opportunity for professional service providers to share expertise and to gain training and insight. Walther says that a social worker will likely know something about one part of a person's life, while their psychiatrist may have a much different perspective. Through hearing the perspectives of the different service providers, care providers are better able to identify their own "blind spots." "Together, what we get is a very well-rounded picture," Walther says.

Walther says it's difficult to find care providers who specialize in, or are interested in, transgender issues. So he invites care providers who are interested in learning more about serving the transgender population or interested in starting their own trans support or advocacy groups to contact the THP.

Walther can connect clinicians with other clinicians who work with transgender clients. "There are all sorts of ways of partnering up," he says.

Advocacy

The Transgender Health Program staff assist transgender people who are involved with the health, social service and/or school systems, according to the needs of the client. For example, staff can inform people about their legal rights within the health and social service systems. They can accompany people on visits to their service providers. They can also help resolve conflicts with service providers or help service providers understand transgender issues.



The THP does advocacy in the school system. THP staff help schools create trans-positive spaces and educate school staff. They also support and advocate for individual youths transitioning while they're in school.

Staff also advocate to various organizations and service providers for trans-positive and inclusive services, guidelines and policies. Walther says that the THP works with the provincial government in developing inclusive policies to enable service providers to address the needs of transgender people.

A unique resource

The THP is the only program of its kind. This province-wide program can support transgender people living outside the Lower Mainland by phone and by e-mail.

"People call the program from all over the province," Walther says. "Many GPs [general practitioners] are hesitant to start a patient on hormones, because they aren't trained in gender issues." If people can't find a local doctor to help them, their only option is to seek help in the Lower Mainland. If they do have a local doctor willing to help, the doctor can freely download current clinical guidelines from THP's website (see sidebar). GPs can always consult with THP's coordinator for ongoing assistance and guidance as needed.

All THP services are free, including the custom workshops and education services. All services are confidential; you don't have to give your legal name and you don't need a doctor's referral; just phone or e-mail THP directly.

For more information, contact THP coordinator Lukas Walther at 604-734-1514, extension 2, or at 1-866-999-1514 (toll-free in BC). You can also visit www.vch.ca/transhealth or e-mail lukas.walther@vch.ca.

Glossary

ALLIES: heterosexual people who support LGBT rights and gender equality.

BISEXUAL: someone who is sexually attracted to both men and women, though not necessarily equally.

COMING OUT: accepting your sexual orientation or gender identity and telling others.

FAMILY OF CHOICE: friends, partners and others who provide a sense of belonging.

GAY: describes someone who is primarily attracted to people of the same gender. It can refer to both men and women, though women may prefer “lesbian.”

GENDER: roles and behaviours that society attributes to men and women. For example, “masculine” and “feminine” describe gender traits. Gender attributes may be different in different societies or cultures.

GENDER IDENTITY: how you see your own gender. For example, masculine, feminine, transgender and two-spirit describe how you see your gender and may be different from your physical anatomy.

GENDER NON-CONFORMING: describes people who don't adhere to the gender expectations of their sex. They may or may not be LGBT or two-spirited.

HETEROSEXUAL: describes someone who is primarily attracted to people of the opposite gender.

HOMOSEXUAL: describes someone who is primarily attracted to people of the same gender.

IDENTITY: How you see yourself and think of yourself.

INTERSEX: A person with a mix of male and female sex features.

LESBIAN: describes women who are primarily attracted to other women or women who identify with the lesbian community.

LGBT: A common acronym for lesbian (L), gay (G), bisexual (B), transgender and transsexual (T) people, though the letters can be arranged in any order. The acronym may also be written to explicitly include two-spirit (often T, TS or 2), intersex (I), queer (Q) or questioning (Q or ?) people. For example, LGBTTTIQ stands for lesbian, gay, bisexual, transgender, transsexual, two-spirit, intersex and queer. If applicable, it can also include straight allies (A or SA).

QUEER: originally a hurtful term for LGBT people, but some have reclaimed it and use it proudly. Some transpeople identify as queer, but others do not.

SEX: the physical features that determine if you are biologically female, male or intersex.

SEXUAL IDENTITY: how you identify your own sexual orientation.

SEXUAL ORIENTATION: describes your attraction to other people. Examples of sexual orientation include homosexuality, bisexuality and heterosexuality.

TRANSGENDER: describes someone who feels like their sex is different from their physical sex features, whether or not they make changes to their physical bodies and identities. The term “transgender” can also include transsexual, transvestite, two-spirit and intersex people.

TRANSSEXUAL: describes someone who feels like their sex is different from their physical sex characteristics, and medically and legally changes their public identity to match their self-identity.

TWO-SPIRIT: describes Aboriginal or other indigenous people who have “two spirits” or multiple genders. For more on the history of two-spirited people, see dancingtoeaglespiritsociety.org/twospirit.php.

☰ These are basic definitions, meant to briefly orient readers to the terms.



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resources

Mental Matters

mentalmatters@yahoo.ca

Vancouver-based support group for LGBT people with mental health issues. The group meets on the first and third Monday of each month.

Prideline BC

1-800-566-1170 toll-free in BC

or **604-684-6869** in the Lower Mainland

Peer support, information and referrals for anyone in BC

Available Monday to Friday from 7:00 pm to 10:00 pm

PFLAG Canada

www.pflagcanada.ca

Facebook: PFLAG CANADA

Information and support for parents, families, friends, co-workers and others. PFLAG chapters are located across BC and Canada.

QMUNITY: BC's Queer Resource Centre

www.qmunity.ca or **604-684-5307**

Facebook and Twitter: Qmunity

Information, education, support groups, advocacy and referrals for lesbian, gay, transgender, bisexual and questioning youth, adults and older adults and allies

Reach Out: Support for people who care about someone with a mental illness

www.support.bcscs.org

Facebook: British Columbia Schizophrenia Society

Twitter: BCSchizophrenia

Online forum for caregivers, including a forum for LGBT partners and friends

 This list is not comprehensive and does not imply endorsement of resources. Additional resources are listed at the end of *Visions* articles.



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