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## Towards barrier-free counselling for sexual/gender minorities and sex workers in rural Tasmania

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### Abstract

**Aims:** This paper combines a service review and proposed research and, thus, has two aims: to present a model of successful service delivery regarding the development of barrier-free counselling and to present the design of in-progress doctoral research that has been informed by this clinician's practice. Sexual and gender minorities (SGMs) and sex workers (SWs) in rural or remote (R/R) Tasmania are the focus.

**Clinical practice approach:** Common barriers to accessing mental health services were identified in clinical practice through a service review that included observation and client consultation. Barriers were addressed and enablers enacted to support the biopsychosocial realities of marginalised people in R/R Tasmania. Support consists of inclusive, intersectional, sex-positive counselling; free/reduced-cost counselling; after-hours appointments; all-ages counselling; client-determined settings for service; and outreach support. Practice-based and anecdotal evidence suggested reductions in severity of mental ill health; alienation caused by stigma and minority stress; and likelihood of negative health indicators (excessive drug use, self-harm, suicide).

**Doctoral research methods:** The PhD, a nexus between practice and research, is occurring between March 2018 and March 2021. The research will follow a mixed-methods design that is commencing with systematic literature reviews on the barriers, uptakes, enablers of mental health and related services for SGMs and SWs. The focus will then narrow in on SGMs and SWs in R/R Tasmania, specifically, with an online survey and in-depth, one-on-one interviews. The publication of papers based on research findings as well as presentations to other counsellors and services will occur to promote barrier-reducing approaches to direct practice support.

**Relevance:** This approach will give marginalised people in R/R Tasmania a voice in the nature and direction of their mental-health care to improve outcomes and wellbeing. The research will generate vital data that is currently lacking on these populations in this region. It will also provide improvement opportunities for service providers and users alike through the development of health access standards.

**Conclusion:** Improving the mental health of SGMs and SWs in R/R Tasmania through access to barrier-free or barrier-reduced counselling has the potential to improve individual lives, lessen the

burden of negative and compounding health impacts, and provide these populations with the inalienable human rights that have been restricted or denied.

## Background

Poor mental health is the single largest contributor to disability worldwide and will continue to be the leading cause of disability in the coming decades.<sup>1,2</sup> This is particularly true in rural or remote (R/R) regions, where issues pertaining to isolation, discrimination, and access to services and treatment are more salient.<sup>3-5</sup> The lack of mental health services in rural areas is well known; so too is the negative impact of this gap on mental health outcomes.<sup>6</sup>

Tasmania, one of Australia's poorest states, has among the highest per capita on mental health with 85% of current funding allocated to public services.<sup>7</sup> Yet, despite this investment, mental health remains poor in rural areas. The Australian Health Care Reform Alliance has stated that government approaches to rural mental health care 'fall short of the changes we need.'<sup>8,9</sup> These shortcomings affect marginalised people most profoundly. Marginalised people are those who live on the fringes of society, who have significantly reduced access to resources and opportunity, and who face a mix of economic, social, and health disadvantage.<sup>10</sup>

Many compounding, negative health determinants and barriers to service that marginalised populations face have been observed during the course of this practitioner's counselling work in R/R Tasmania: poor socioeconomic position, low educational attainment rates, social exclusion, limited social capital, high unemployment, and low-or-no access to mental health services. Research and counselling observations indicate that sexual and gender minorities (SGMs) and sex workers (SWs) have extreme levels of general psychological distress and attempted or completed suicides as well as prevalence of self-harm.<sup>11-15</sup>

In Australia, same-sex attracted people are more than three times more likely to experience mental ill health than heterosexuals while lesbian, gay, bisexual, transgender, and intersex (LGBTI) people are considered to have the highest national suicide rates.<sup>12</sup> In SW populations worldwide, levels of depression and posttraumatic stress disorder range from 10-100%(16). This poor mental health is **not** due to the perceived burdens of sex work, but to the external, inherent risk, stigma, exclusion, and discrimination that SGMs and SWs face.<sup>12,17</sup>

While there is a lack of comprehensive data around estimations due to stigma, the fluidity of sexuality, legalities, and regional variations, the prevalence of same sex attracted and gender diverse people in Australia is <1%-15% and the percentage of SWs is <1%.<sup>18-20</sup> The range of Australians who practice bondage, discipline, sadomasochism, or dominance (BDSM)—another SGMs group—is between 2% and 62%.<sup>21</sup> Thus, SGMs and SWs constitute between >2% to 77% of the population.

## Clinical practice

As a counsellor in Tasmania with a sexual assault support service, then a gender, sexuality, and intersex status support and education service, and currently in private practice, the researcher has counselled hundreds of Tasmanians of all ages presenting with a range of mental health issues. What is abundantly clear from this counselling work is that when marginality and intersectionality are added to rurality, mental health can decline significantly. Practitioner observation and client reporting indicate that SGMs and SWs in R/R Tasmania face significant, compounding barriers to access.

These barriers are even more challenging for people who face marginalisation in multiple ways. SGMs and SWs under this practitioner’s care, for example, lack access to resources, finances, and social support and face personal and structural stigma and discrimination exposing them to intersecting marginalisation across multiple aspects of life.

Using practice-based evidence (PBE) and working from an intersectional framework that recognises the varying configurations of these interwoven, compounding oppressions, this practitioner sought to address and offset marginality based on gender, gender identity, age, sexual orientation, socioeconomic status, and sexuality. PBE does not have a formal, empirical research base; instead, it involves practitioner authority and expertise and the synthesis of patterns that emerge during service provision and from related academic studies.<sup>23</sup> PBE originates in community as it focuses on the successful attainment of client outcomes as determined by clients.<sup>22</sup> Informed consent was obtained from clients for their participation, which included discussions regarding their clinical outcomes—both those specific to this practitioner’s practice and those held previously. Dozens of academic studies were also read on the issues. The general patterns that emerged were: mental health care seeking or uptake; barriers or negative experiences with either formal (counselling services) or informal (family, society) entities; the impact of these barriers; and enablers to care specifically or to improved mental health generally. Enablers were positive experiences with formal or informal individuals or organisations.

When consulted on these general patterns, clients cited several factors that contributed to their mental ill-health. Those that could be addressed in practice are outlined here; others are included below as policy recommendations.

- **Social support and peer contact:** To address the lack of social support that many clients deemed difficult and which Boza and Nicholson dub the most significant predictor of mental ill health in trans and cis people alike<sup>24</sup>, peer support groups are offered periodically and several peer mentors have been identified to assist clients’ entry into the community.
- **Financial:** To address the financial barrier to care, counselling is offered at free or reduced-cost with the client determining what they can afford.
- **Stigma and discrimination:** To address some of the stigma that SGMs and SWs face, the counselling practice is not heterosexist; does not pathologise; uses appropriate pronouns and names; is sex positive; is kink-aware and kink-friendly; does not expect clients to teach practitioner; is accepting and non-judgemental; knows that sex work is work and has no interest in rescuing SWs; offers a safe space; believes clients; and honours the diversity of identities, practices, and experiences.
- **Lack of mental health services, including inclusive or outreach based:** In addition to the above methods of attempting to address the lack of services tailored for marginalised clientele, the barrier-free service offers after-hours appointments; counselling to people of all ages with any level of mental health issues to offset common service silos; and counselling in a setting of client’s choosing (office, park, telephone) with the counsellor travelling to them, if needed.

Preliminary evidence gathered through clinical observation and client consultation at this counsellor’s practice seem to suggest that barrier-reduced mental health support for marginalised populations can result in improvements in mental health. Examples of these supports include: undertaking college/university programs to offset low educational attainment rates and poor

socioeconomic positions as well as regular participation in informal social gatherings thereby overcoming barriers of social exclusion and reduced social capital.

Clients' self-reported mental health outcomes have also improved through a focus on eradicating social exclusion and increasing social capital through strategies of inclusion, diversity, network building, support, and acceptance. PBE and anecdotal evidence has also suggested reductions in the severity of mental ill health; the alienation caused by stigma and minority stress; and in the likelihood of negative health indicators (excessive drug use, self-harm, suicide), thus apparently reducing the need for medical intervention. To explore the trustworthiness of these claims and refine this service delivery model, this work has been parlayed into a PhD.

## Doctoral research methodology

The doctoral research will involve methodical data collection, including the gathering of lived-experience evidence from SGMs and SWs on mental health and related services using a descriptive phenomenological approach.<sup>25</sup> Uptakes, barriers, enablers, and their impacts on these populations' mental health will also be explored. This mixed-methods research design consists of three phases: systematic literature reviews; online questionnaire; and in-depth interviews.<sup>26,27</sup>

### Systematic literature reviews

Broad literature searches were conducted between August and October 2018. PubMed, CINAHL, and Scopus databases were searched for peer-reviewed material and google, government agencies and departments, intergovernmental organisations, and public health agencies' websites were searched for grey literature. Keywords searched for were: mental health, sexual and gender minority, marginalised/zed, access, LGBT/LGBTQ, intersex, uptake, barrier, sex work/er, prostitute, enabler, BDSM, gender identity, and sexual orientation. Peer-reviewed and grey literature evaluations have occurred.<sup>28-31</sup> Documents written before 2008, that did not stem from Organisation for Economic Cooperation and Development (OECD) countries, in a language other than English, or that pertained to people under 18 years of age were excluded.

Two systematic literature review papers—one on SGMs and the other on SWs—are currently underway. The original intent was to produce one review paper, however, to honour the diversity of the populations and reflect existing research, two papers are needed. The reviews for each review paper will address the following questions:

- What evidence is there regarding the mental health and access to related care among SGMs/SWs?
- What barriers influence SGMs/SWs access to mental health care?
- What enablers influence SGMs/SWs access to and experiences with mental health care?

### Online questionnaire

An online questionnaire will be developed from the literature reviews and in consultation with SGMs and SWs. The survey is intended to reach a convenience sample and build a basis for collecting descriptive, associative, analytical, and evaluative data.<sup>26,32</sup> Survey data will be analysed using descriptive and inferential statistics.

### **In-depth interviews**

In-depth, one-on-one interviews will be conducted throughout R/R Tasmania to gain a description of the phenomenon under study: personal experiences with mental health, including uptake, barriers, and enablers to service access. Adhering to descriptive phenomenology, the participants will determine the narrative and direction of the interviews; general, open-ended questions will be posed should participants request guidance.<sup>33</sup> Ideally, interviews will be conducted in-person, however, Skype or telephone interviews will also be made available to participants to accommodate rurality. Interviews will occur in a place, date, and time of the participants' choosing. They will be audio recorded, last 60-120 minutes, and be conversational in nature. If required, two interviews will be held.

### **Recruitment**

Recruitment for phases two and three will be conducted via direct verbal, email, telephone, or social media-based invitations and snowball sampling.<sup>26,32</sup> Participants who volunteer for the online survey will also be invited to participate in an interview. To optimise response rates, the study will be advertised in organisations and businesses likely to engage or have contact with participants.

### **Ethics**

Ethics approval for the doctoral research will be obtained from the Social Sciences Human Research Ethics Committee Tasmania, University of Tasmania, prior to the commencement of phases two and three.

### **Anticipated outcomes**

As the doctoral research is a work in progress, there is currently no data to present. However, the researcher will be mindful of obtaining a representative and ample sample size to reflect the breadth of realities and diversities of communities under investigation; limiting forced-choice questions in the online questionnaire; using inclusive, intersectional terminology so as not to deter participation; and including as many people from as many racial, educational, and socioeconomic backgrounds as possible in an attempt to be representational. The outcomes of the research will help to inform the design and delivery of R/R mental health services for SGMs and SWs as well as impact policy.

### **Reflexive statement**

As a cisgender, white, middle class, feminist woman who is an academic and a counsellor, the researcher acknowledges that despite every best effort to be intersectional, inclusive, and culturally sensitive, there are biases and limitations inherent in the counselling practice and doctoral research. Researchers and counsellors with other frameworks for practice and lived experience may have different approaches to this work and may derive alternative conclusions from the case notes and client consultations, literature reviews, and upcoming research. To address alternate approaches and interpretations, determine suitability and comprehension of questions and instructions, and to aid in determining gaps in survey questions, the online survey and in-depth interviews will be reviewed and pilot tested by SGMs and SWs, with the researcher incorporating suggested edits.<sup>26,32</sup>

The researcher's interest in this doctoral project stems from decades of working with and being part of queer, trans, and SW communities; from a glut of anecdotal accounts from SGMs and SWs about the public, familial, and systemic discrimination and abuse they encounter with shocking regularity; and from a personal commitment to striving for equal and equitable rights for all.

Attraction, identity, and behaviour intersect in a myriad of ways.<sup>18</sup> Much of existing research groups sexual and gender diverse people together, as this work has done. The combining of SGMs and SWs

in this work stems from Nussbaum's **capabilities approach**, which theorises that people who face personal and structural stigma and discrimination are banned from living a life that honours their chosen representations of bodily integrity, emotions, and affiliations.<sup>34</sup> This work attempts to honour the differences within these communities, while viewing the grouping as a starting point for future, more specific research.

It is the researcher's intent to add to sexual and gender minority and sex-worker-based academic inquiry and improve clinical practice in R/R areas; however, the researcher also struggles with having to ask direct practice clients to participate in academic research. While exploring the ethics of holding those dual roles in a small state with a small population, the researcher also sits with that discomfort, takes direction from participants, and practices critical assessment and reflection while seeking regular clinical and research supervision.

## Discussion

A service review combined with exigent patterns that emerged in practice provided an opportunity to not only improve service delivery, but also attempt to address presenting mental health issues. There is anecdotal evidence that the resulting counselling approach reduced some of the barriers that marginalised people in R/R Tasmania face when seeking support. By involving clients in the informal assessment and creation of inclusive approaches to care, the counsellor was able to challenge personal presumptions, empower the clients through honouring their agency and self-determination, and adhere to trauma-informed care by collaborating with clients, thereby affirming their strengths and resources.<sup>35</sup> A counselling practice served as the impetus for research into an under-explored and poorly addressed set of issues. There is much value in a nexus between practice and research, particularly given the potential for research to inform practice in R/R mental health service delivery.

Rural Tasmania has a paucity of mental health services tailored to work with SGMs and SWs. Despite the staggering rates of mental unwellness in remote areas of the state, there are no dedicated mental health services for these populations outside of Hobart. While Tasmania has the second highest percentage of mental-health-based general practitioner (GP) consultations, only 34% of GPs consider their practices adequate to manage mental health problems.<sup>7</sup>

Much of existing research and, indeed, healthcare, legal, and social systems pathologise SGMs and SWs. Some examples of pathologising uncovered during the preliminary systematic literature reviews include: mental and physical healthcare providers discriminatorily othering SGMs, causing harm in the form of ridicule, contempt or refusal of support<sup>36</sup>; treating same-sex attraction as something to be cured via conversion therapy<sup>37</sup>; clinicians serving as the gatekeepers to hormones or surgery of trans people<sup>36</sup>; and researchers assuming that a desire to earn money for drugs was the only motivating factor for entry into sex work.<sup>38</sup> Furthermore, the glut of research on sexually transmitted diseases (STDs) and infections among SGMs and SWs implies that non-heterosexuals, non-binary people, people who practice kink, and SWs are dirty or worthy of condemnation, when, in fact, STDs are incredibly common and are considered a worldwide epidemic among **all** people by the World Health Organization.<sup>39</sup>

To pathologise is to discriminate. To deny or offer subpar care to those who seek it based on personal prejudice and discrimination is unethical. It is hoped that the doctoral research will fill gaps in existing research including addressing the intersectionality of rurality and remoteness with barriers and how this impacts service delivery. It is also hoped that the outcomes will positively

impact service delivery and potentially, legislation, and reduce the minority stress that marginalised people face by providing access to safe, inclusive, and informed mental health support.

## Policy recommendations

With a view to improving the lives and mental health of SGMs and SWs in R/R Tasmania, the following policy recommendations are suggested:

### Decriminalise sex work

To ensure SWs are no longer vulnerable and isolated and gain police, legal, and medical support, legislation needs to be enacted that eradicates penalties that contribute to marginalisation.<sup>40,41</sup>

### Remove legal barriers to equality for people of diverse genders and sexualities in Tasmania

Currently, the Tasmanian *Births, Deaths and Marriages Registration Act 1999* discriminates against SGMs by requiring sexual reassignment surgery before they can change their sex. Surgery is not desired or possible for all who are transitioning, moreover, forcing a person to undergo surgery is inhumane. The Act demands that people be unmarried to register a change of sex. This means that married trans people have to divorce. The Act also requires people to identify as either male or female, an approach that is discriminatory against genderfluid, gender nonconforming, non-binary, agender, bigender, and polygender people. The Act must be updated to be inclusive, equitable, and non-prejudicial, which will have significant mental health benefits for those suffering under the weight of this discriminatory legislation.<sup>42</sup>

### Enforce the *Tasmanian Anti-Discrimination Act 1998*

The Tasmanian Anti-Discrimination Act 1998 'makes discrimination and certain other conduct (such as sexual harassment) unlawful. The Act also provides for the investigation and inquiry into complaints of discrimination and prohibited conduct'.<sup>43</sup> Yet, discrimination against SGMs and SWs flourishes unhindered.<sup>44</sup> Enforcing the Act would not only hold lawmakers and the public alike accountable for violations, but make positive strides toward addressing the mental health impacts of discrimination.

### Make SGM- and SW-affirmative training mandatory in all mental health and healthcare education

To counter the medical field's long history of pathologising; to prepare mental and physical health workers to work with these populations; and to undo the long-standing clinical ignorance and insensitivity to same sex attracted, intersex, gender diverse people, SWs, and practitioners of kink, all degrees, diplomas for all mental health and healthcare students must include in-depth and extensive instruction on SGMs and SWs.

## Conclusions

The mental health of SGMs and SWs in R/R Tasmania is arguably the worst in the nation. The outcomes of this study will be used to inform service provision, government policy, and identify gaps and solutions. This research will generate vital data that is currently lacking on these populations including an exploration of the implications for rurality and remoteness. It will also provide improvement opportunities for service providers and users alike through the development of health access standards. Finally, the research will honour the right to a minimum standard of health<sup>45</sup>, to which all Australians are entitled and give these marginalised populations a voice and an opportunity for support that they themselves dictate and direct.

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## Presenter

**Tamara Reynish's** extensive counselling experience includes working with marginalised populations in the areas of torture; trauma; sexual assault; domestic, family, and intimate partner violence; discrimination; and exclusion. Through a PhD at the University of Tasmania, Tamara is exploring the impact of stigma, disadvantage, and a lack social and legislative human functioning capabilities on the mental health of sex workers and people with great diversity of sex, sexual, and gender identities in rural or remote Tasmania.