AOTI

Association of Occupational Therapists of Ireland

LGBT+ Awareness and Good Practice Guidelines for Occupational Therapists

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Whilst every effort has been made by the LGBT+ Working Group to ensure the accuracy of the information and material contained in this document, errors or omissions may occur in the content. This guide represents the view of AOTI which was arrived at after careful consideration of the evidence available. Whilst we accept that some aspects of the guide may be difficult to implement initially due to a lack of resources, we believe that these guidelines represent good practice for occupational therapists. Therefore, where there are difficulties, these should be highlighted to management so that measures are taken to ensure implementation. This guide does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of individual clients in consultation with the client and/or guardian or carer.

Foreword

This Good Practice Guide was prepared by the LGBT+ Working Group on behalf of AOTI to promote the highest standards of practice when providing an Occupational Therapy service to clients who are lesbian, gay, bisexual or transgender. LGBT+ ("LGBT plus") is used in this guide to capture everything on the gender and sexuality spectrums that letters and words cannot yet describe.

The guide has three main objectives:

1. To clarify language, concepts and good practice principles to enable occupational therapists to provide an LGBT+ friendly and inclusive service.
2. To assist occupational therapists to understand how particular life experiences (such as discrimination and fear of coming out) can affect some LGBT+ people's physical and mental health, as well as their occupational engagement and social identities.
3. To describe specific Occupational Therapy practices which enable LGBT+ clients' occupation and social engagement, and support their full occupational identity.

Numerous LGBT+ good practice guides for health professionals have been published nationally and internationally. This AOTI guide builds on these and, in addition, provides occupation-specific information to assist occupational therapists to achieve good practice.

A client-centred Occupational Therapy approach with LGBT+ clients will primarily focus on the person's health condition or occupational difficulties, whilst recognising and responding to any LGBT+ related needs. It is hoped that this guide will assist all Occupational Therapy practitioners, managers, educators and researchers in this regard.

This guide should be read in conjunction with the AOTI Code of Ethics and Professional Conduct (AOTI, 2013) and the CORU Code of Professional Conduct and Ethics (CORU, 2014). These documents set out the expectation that all occupational therapists treat LGBT+ clients or patients with dignity and respect, and the expectation that all LGBT+ people are treated equally to individuals who are heterosexual or cisgender. They also place a professional obligation on all occupational therapists to practice in an LGBT+ inclusive, non-discriminatory manner.

A number of key publications were consulted by the LGBT+ Working Group in the creation of this guide. One document that requires particular mention is the World Professional Association for Transgender Health Standards of Care (WPATH, 2011). This is the international gold standard for transgender health care which AOTI endorses.

The publication of this good practice document contributes to the achievement of AOTI Strategy 2017 - 2022 where Strategic Intention 2 is to promote excellence in professional practice. AOTI would like to acknowledge and thank the members of the LGBT+ Working Group: Dr Mark Brown, Jane Freeman, Vanessa Jordan, Niall Kirrane and Odhrán Allen.

Mary McGrath
Chairperson AOTI

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Section 1

Introduction to LGBT+ Inclusive Practice

Introduction to LGBT+ Inclusive Practice

1.1 Knowledge is Key to Inclusive Practice

The purpose of this document is to provide occupational therapists with the knowledge that they need about Lesbian, Gay, Bisexual and Transgender (LGBT) people and their identities, and about the attitudes underpinning LGBT+ inclusive practice.

Occupational therapists need this knowledge so that they can provide an LGBT+ inclusive service, which is both an ethical and legal requirement in Ireland. The term LGBT+ ("LGBT plus") includes everything on the gender and sexuality spectrums that letters and words cannot yet describe.

This information has not been provided in many professional training programmes and the AOTI recognise the need to address this knowledge gap in our profession. This is reflective of the wider situation in society where LGBT+ people have faced much misunderstanding, bias and prejudice. A lot of this centres around the assumption or bias that people are, or should be, heterosexual, which is often referred to as heteronormativity. Related to this is the assumption or bias that people are, or should be, cisgender (not transgender), which is often referred to as cisnormativity.

Valuing LGBT+ inclusion is enshrined in the AOTI Code of Ethics which requires occupational therapists to respect the rights and dignity of all clients.

The focus of interest for Occupational Therapy practitioners, managers, educators and researchers is the relationship between a person's health and their occupational performance.

The Occupational Therapy profession espouses an ethos of client-centredness and holism, which requires the respectful inclusion of any LGBT+ related needs which impact on the health and occupations of LGBT+ clients. It is hoped that this guide will assist all Occupational Therapy practitioners, managers, educators, students and researchers in this regard.

1.2 Understanding Bias

Bias means one-sided thinking, lacking a neutral viewpoint, holding a partial perspective, or not having an open mind. Biases are often learned from our culture and become part of our belief system. The problem with biases is that we often do not know that we have them, but still operate from them. In professional practice, biases can impair our judgement and clinical reasoning. Biases can also affect our ability to use appropriate language, build a therapeutic relationship, and provide a client-centred service.

Bias towards LGBT+ people can arise from many sources, ranging from misunderstanding about their identities to outright prejudice towards LGBT+ people. Bias can also lead to homophobic, biphobic or transphobic attitudes and behaviours which are detrimental to, and incompatible with, good professional practice. Any homophobia, biphobia or transphobia, intended or unintended, is unacceptable and constitutes a breach of the AOTI Code of Ethics.

In being aware of our LGBT+ biases and overcoming them, we can ensure that we have the right attitude to practice in an inclusive way.

1.3 LGBT+ Pride and Resilience

The Pride movement evolved from a belief that diversity should be celebrated rather than oppressed. Pride remains an important part of the LGBT+ community today. Part of how the LGBT+ community has evolved is by focusing on how it can become resilient and thrive in the face of discrimination. Furthermore, research highlights the importance of healthcare providers supporting LGBT+ people in developing resilience (Mayock et al., 2009). Resilience can be defined as the ability to bounce back, recover or successfully adapt to life challenges.

When faced with life challenges, LGBT+ people are no different in the support they need. However, in order to provide assistance, therapists need to be sensitive to the lived experience of LGBT+ clients and approach their practice in an inclusive way.

Occupational therapists can facilitate LGBT+ clients to transform their lives by affirming the person's LGBT+ identity and supporting them to live the life they want to live. By being sensitive to the particular issues and life challenges they can face, LGBT+ clients can be facilitated to live their lives with pride and resilience.

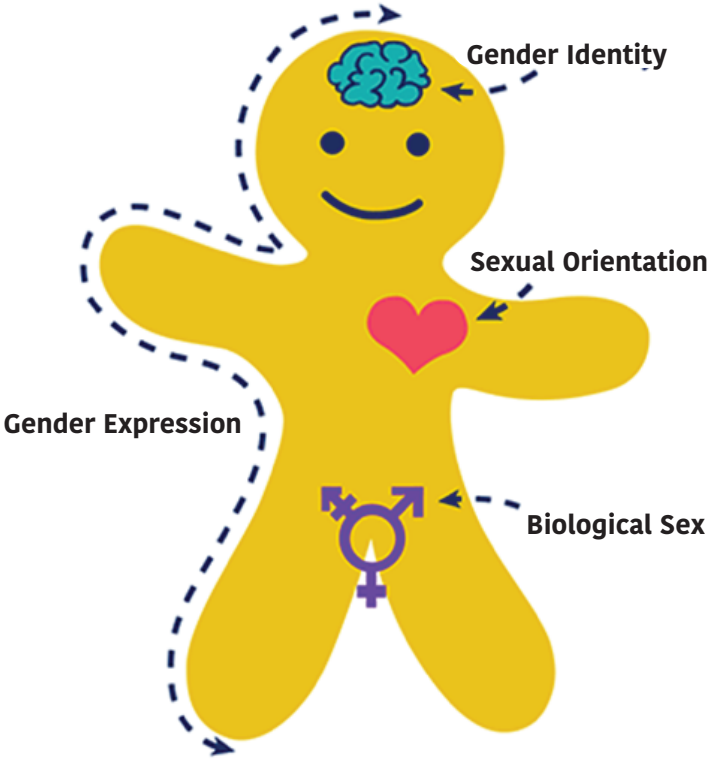
A key message in this good practice guide is that, with the right support, LGBT+ people, like all people, can thrive and flourish, and live satisfying and meaningful lives.

Section 2

LGBT+ People: Language and Concepts

LGBT+ People: Language and Concepts

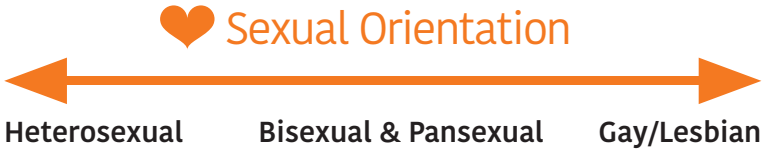
This section will focus on explaining the language and concepts that occupational therapists need to know in relation to LGBT+ people. Historically, lesbian, gay, bisexual, and transgender people have come together under the umbrella term LGBT, based on their shared experiences of being a minority because of their sexual orientation and their gender identity. The Genderbread Person below and the spectrums which follow illustrate what the key concepts mean (Killermann, 2012).



Genderbread person
(Killermann, 2012)

2.1 Sexual Orientation

Sexual orientation refers to an enduring pattern of emotional, romantic or sexual attraction to men, women, both or neither. This includes a wide range of attractions and terms, the most common being heterosexual, gay, lesbian and bisexual. People who do not experience attraction to any sex may identify as asexual.



(Killermann, 2012)

Sexual Orientation	
Heterosexual	Attracted to opposite sex
Gay & Lesbian	Attracted to same sex
Bisexual	Attracted to both sexes
Pansexual	Attracted to all sexes and gender identities
Asexual	No sexual attraction

A national study of youth mental health in Ireland, the My World Survey, found that 89% of young Irish adults aged between 17 and 25 years identified as heterosexual, 4% identified as gay or lesbian, 4% identified as bisexual, and 3% were unsure about their sexual orientation (Dooley & Fitzgerald, 2012; n=8,221). Based on this data, it is estimated that at least 1 in 10 Irish people identify as LGBT+. **This means that 1 in 10 people using Occupational Therapy services are likely to be LGBT+.**

There is no consensus among scientists as to how an individual develops their sexual orientation. While the percentages of the population who identify as heterosexual, lesbian, gay, bisexual, asexual and pansexual differ greatly, they are equally 'normal' sexual orientations. In a similar way, people who are left hand dominant are acknowledged to be a minority when compared to the right hand dominant majority, but are no longer seen as being in any way inferior or abnormal simply because they are a minority.

Many lesbian and gay people do not like the use of the term *homosexual* to describe their sexual orientation because of the association this word has with the historical criminalisation and pathologisation of homosexuality, and the continuing view by many religions that homosexuality is a sin. Use words like gay, lesbian and bisexual instead.

2.2 Heteronormativity

Heteronormativity is a bias that expresses heterosexuality as a given, and that it is the 'normal' and 'natural' expression of sexuality, instead of being one of many possibilities. Often expressed subtly, heterosexuality is widely 'accepted' as the default sexuality by print and electronic media, educators, law makers, and a range of attitudes prevalent in society in general.

Heteronormativity, however subtle, can have a negative effect on those who are not heterosexual. For example:

- A heteronormative assumption is that a boy will grow up and marry a woman.
- A heteronormative assumption is that a girl will grow up and marry a man.
- Heteronormative children's books only portray heterosexuality.
- Heteronormative TV shows only portray heterosexuality with the assumption that every character is heterosexual.

These assumptions can be hurtful because they are stigmatising and marginalising, making people who are not heterosexual feel like they are perceived as 'different' or 'unnatural'. While this is often unintended, the consequences are the same.

The concept of heteronormativity can exist on both a societal and individual level. On a societal level, heteronormativity takes the form of denying marriage equality and same-sex adoption (no longer the case in the Republic of Ireland). On an individual level, it can take the form of assuming that a woman is referring to a man, when she mentions a spouse or fiancé.

AOTI see lesbian, gay, bisexual, asexual and pansexual identities as part of the spectrum of normal human sexual orientation.

2.3 Gender Identity

Gender identity refers to whether one intrinsically feels male, female or something else, regardless of the sex assigned at birth. At birth we are assigned a biological sex of male or female. Gender identity is different from biological sex. Historically, society has assumed that biological sex and gender identity are the same and this was compounded by the term 'gender binary' which means seeing gender as only one of two options, i.e. male or female.

The majority of the population is cisgender which means that their gender identity is consistent with the sex that they were assigned at birth. Their birth certificate says male and they identify as a man. However, this isn't the case for everyone. Transgender people are those whose gender identity or gender expression differs from the sex assigned to them at birth, somewhat or completely. There is a diversity of gender identities contained within the term transgender and the table below explains some of these. This guide uses the term Trans to refer to transgender people and their identities.

Gender Identity*	
Cisgender / Cis	Gender identity is consistent with sex assigned at birth
Transgender / Trans	Gender identity is **inconsistent** with sex assigned at birth. Gender identity can be binary, non-binary, gender fluid or agender.
Binary	Gender identity is either male or female
Non-binary	Gender identity is both male and female or neither
Gender fluid	A gender identity that can vary at different times, or in response to different situations along a spectrum between male and female.
Agender / Non-gender	Does not identify as having a gender identity that can be categorised as man or woman, or identifies as not having a gender identity.

* These terms are offered to help you understand commonly used terms, but it is important to be guided by the client as to how they identify themselves. Be aware that terminology is continually evolving.

(Killermann, 2012)

The expression of gender identity through mannerisms, grooming, physical characteristics, social interaction and speech patterns is our gender expression (Higgins et al, 2016), i.e. how a person presents and communicates their gender to others.

(Killermann, 2012)

There can still be a social stigma attached to diverse gender expression. This can lead to experiences of discrimination and harassment.

There is a growing understanding in Irish society of the diverse ways that people can experience their gender, as we move away from the limiting stereotypes of how men/boys and women/girls should behave. Gender diversity embraces the spectrum of gender identities and gender expressions that exist, regardless of one's sexual orientation.

2.4 Intersex

Intersex is an umbrella term which refers to individuals who are born with sex characteristics (such as chromosomes, genitals, and/or hormonal structure) that do not belong strictly to male or female categories, or that belong to both at the same time.

(Killermann, 2012)

An intersex person may have elements of both male and female anatomy, have different internal organs than external organs, or have anatomy that is inconsistent with chromosomal sex. These variations may be identified:

- at birth (for example, where there is obviously ambiguous genitalia),
- at puberty (for example, when the person fails to develop certain expected secondary sex characteristics, or develops characteristics that were not expected),
- later in adulthood (for example, when fertility difficulties present),
- or a person may never be aware that they are intersex.

Most individuals who are intersex do not identify as transgender or do not consider themselves covered by the transgender umbrella. Depending on what is included as an intersex condition, the incidence is estimated to be between 1.7% and 4% of all births (Blackless et al., 2000).

2.5 Cisnormativity

Cisnormativity is the bias that all, or almost all, individuals are cisgender (i.e. a person's gender identity is aligned with the sex they were assigned at birth) and that this makes cisgender identities more normal and natural and, therefore, superior to trans identities or people. This bias stigmatises a trans person as being abnormal or unnatural. Although people who identify as transgender comprise a small percentage of the human population, many trans people and allies consider it to be offensive to presume that everyone is cisgender unless otherwise specified.

Some examples of cisnormativity are:

- The assumption that Male or Female on a form describes everyone,
- The assumption that men can't get pregnant (a trans man may be able to).

Although cisnormativity is rarely deliberate, it is almost always perceived as hurtful and offensive to the trans community. Cisnormativity contributes to the invisibility of trans and non-binary people. In its most pronounced form, cisnormativity can be a deliberate and calculated system of oppression, which includes institutionalised cissexism and transphobia.

2.6 Gender Dysphoria

Gender dysphoria refers to the discomfort and distress that a person experiences, caused by the mismatch between their intrinsic gender identity and the biological sex assigned to them at birth. The distress often centres on the fact that the person's body does not fit with their gender identity, and also that they are expected to adhere to the gender role of their biological sex. Gender dysphoria often becomes heightened with the onset of puberty because of the bodily changes that occur at this time.

Gender dysphoria is manifested in a variety of ways, including strong desires to be treated as the other gender or to be rid of one's sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender (American Psychiatric Association, 2013). Gender dysphoria can impair occupational performance and social functioning. It can often lead to clinically significant anxiety or depression, and consequently social withdrawal, self-harm and suicidality.

Gender dysphoria is a diagnosable condition, from which, with the appropriate treatment and support, a person can recover and live a more contented life. In Ireland, a diagnosis of gender dysphoria is currently required in order to access appropriate healthcare to support transitioning (hormones, surgery, etc.).

AOTI see transgender and non-binary identities as part of the spectrum of normal human gender identity, and part of the role of occupational therapists is to affirm and support trans individuals, whether or not they are experiencing gender dysphoria.

2.7 Transitioning

Some transgender people begin to live in the gender in which they identify, rather than the one assigned at birth. This is called transitioning and might include social, physical or legal changes such as coming out to family, friends, co-workers and others; changing one's appearance; changing one's name, pronoun and sex designation on their birth certificate and other legal documents (driving licence or passport); and medical intervention (for example, through hormones or surgery) (TENI, 2016).

Transitioning varies considerably depending on the individual's needs. A trans person may avail of one or more of the following during transitioning:

a. Support to help them change how they present or express their gender, including living in their preferred gender,
b. Hormone therapy to feminise or masculinise their body,
c. Surgical interventions to change their primary or secondary sex characteristics in line with their gender identity,
d. Psychosocial supports to manage the person's gender dysphoria, to deal with any co-occurring mental health difficulties (such as anxiety), and to address occupational performance and role changes and/or difficulties.

Transitioning leads to a reduction in feelings of dysphoria, in particular when the person's physical features begin to take on aspects of their identified gender. Early treatment helps young people enjoy better social integration, higher achievement, and they enter adult life without gender-nonconforming characteristics which can lead to harassment.

Notwithstanding the benefits that transitioning can bring, this is a challenging process. The key components in assisting transitioning in this phase are family and social supports, as well as having access to trans related healthcare.

2.8 Disclosure and Coming Out

It remains common in our culture for people to presume that others are heterosexual or cisgender, which means that LGBT+ people have to disclose their identity to correct this assumption. However, this assumption also leads to the phenomenon whereby LGBT+ children, adolescents and adults have to realise for themselves that they are not heterosexual or cisgender. For some people, the process of realising one's LGBT+ identity can be a difficult and painful one.

Disclosing one's LGBT+ identity is called "coming out" and this is an important part of LGBT+ people's lives. This is an ongoing process for many people. LGBT+ people may have to continuously disclose their identity when they meet new people. Some are "out" to everyone in their lives, while others are only out to selected people in their lives. For some people coming out is a positive experience, while for others it can be challenging.

In the LGBTIreland study, the most common age for Irish people to realise their LGBT+ identity was 12 years of age and the most common age to tell the very first person was 16 (Higgins et al., 2016). This study also identified that LGBT+ people aged 45 years or over had a nine year gap between realising they were LGBT+ and telling the very first person. However, for LGBT+ individuals who are currently 14 to 18 years of age, this gap has decreased, on average, to only one or two years. This indicates that Irish LGBT+ people are coming out at a much younger age. Interestingly, it is commonly reported that transgender children identify as transgender at an even earlier age than lesbian, gay and bisexual children identify themselves as LGB.

It is important to remember that LGBT+ people can come out at any and all stages of life - when they are teens, when they are seniors, when they are married, when they are single, when they have children, and when they don't. It is also important to be mindful that not everyone wants to or can come out, and therapists should avoid the assumption that coming out is always best for the client. Where the person's occupational performance is affected, the occupational therapist may have a role in supporting the coming out process. This is explored later in Alex's case scenario.

Section 3

Irish Research on the Lives of LGBT+ People

Irish Research on the Lives of LGBT+ People

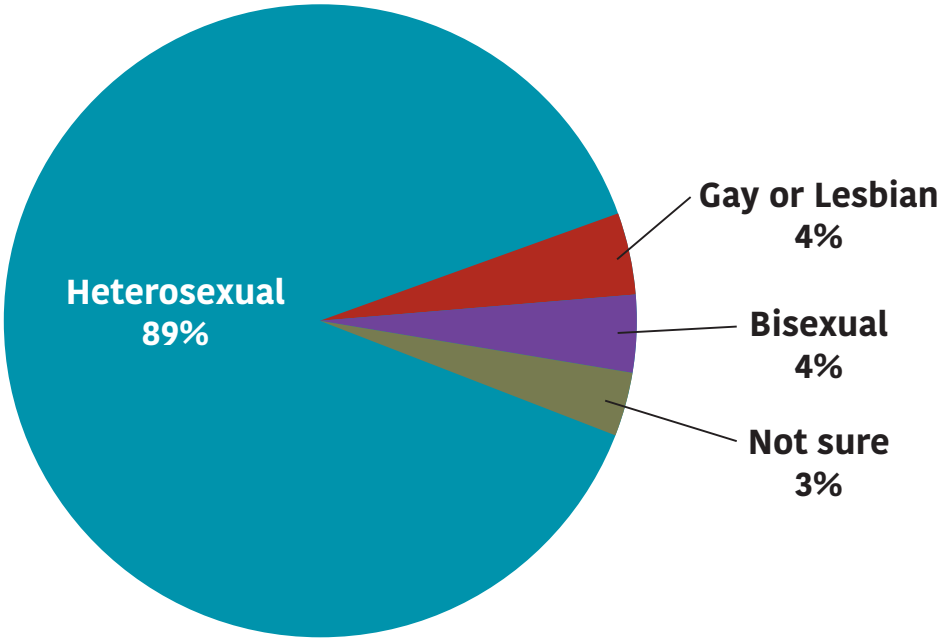
Recent years have seen some very valuable research done into the lives of LGBT+ people in Ireland. Consequently, we are witnessing a growing understanding of the needs of LGBT+ people, particularly in areas such as civil rights, healthcare, education and employment. Legislation, organisations and society are changing and developing to reflect this growing understanding, and changes in the approach to the delivery of health care to LGBT+ people is one example of this.

The growing body of Irish research gives new information, data and recommendations relevant to LGBT+ healthcare. In the Burning Issues 2 survey, which is the largest consultation with the LGBT+ community in Ireland to date, equality in health was identified as one of the most important issues for the LGBT+ community (Ó'hUltacháin, Mathews-McKay & Urain, 2016).

In this section, we examine some of the most recent Irish health studies, and present key findings on the lived experiences and healthcare needs of Irish LGBT+ people. This information is presented to underscore the importance of an evidence based approach to practice. Readers are encouraged to refer to these studies in their full format and to keep up to date with emerging evidence in relation to LGBT+ people.

3.1 My World Survey (Dooley and Fitzgerald, 2012)

The My World Survey was the first national study of youth mental health in Ireland with a representative sample of 14,306 participants between the ages of 12 and 25. While the primary focus of the research was mental health and wellbeing, participants aged between 17 and 25 were asked their sexual orientation (n=8,221). The study therefore gives the most reliable indication to date of the number of Irish people who identify as lesbian, gay or bisexual. While 89% identified as heterosexual, 8% identified as lesbian, gay or bisexual, and a further 3% were unsure of their sexual orientation. Within the 8% who identified as LGB, 4% identified as gay or lesbian, and a further 4% identified as bisexual. This is the most frequently cited study to support the figure that 1 in 10 people in Ireland identify as LGBT+.



The size of the transgender population in Ireland is unknown, but a recent report suggests the prevalence in Ireland is consistent with international estimates, which is that 1% of the population will experience some form of gender variance (for example, trans or non-binary). (Reed et al., 2009)

3.2 LGBTIreland (Higgins et al, 2016)

The LGBTIreland study was carried out prior to the Marriage Equality referendum in May 2015, and comprised two modules.

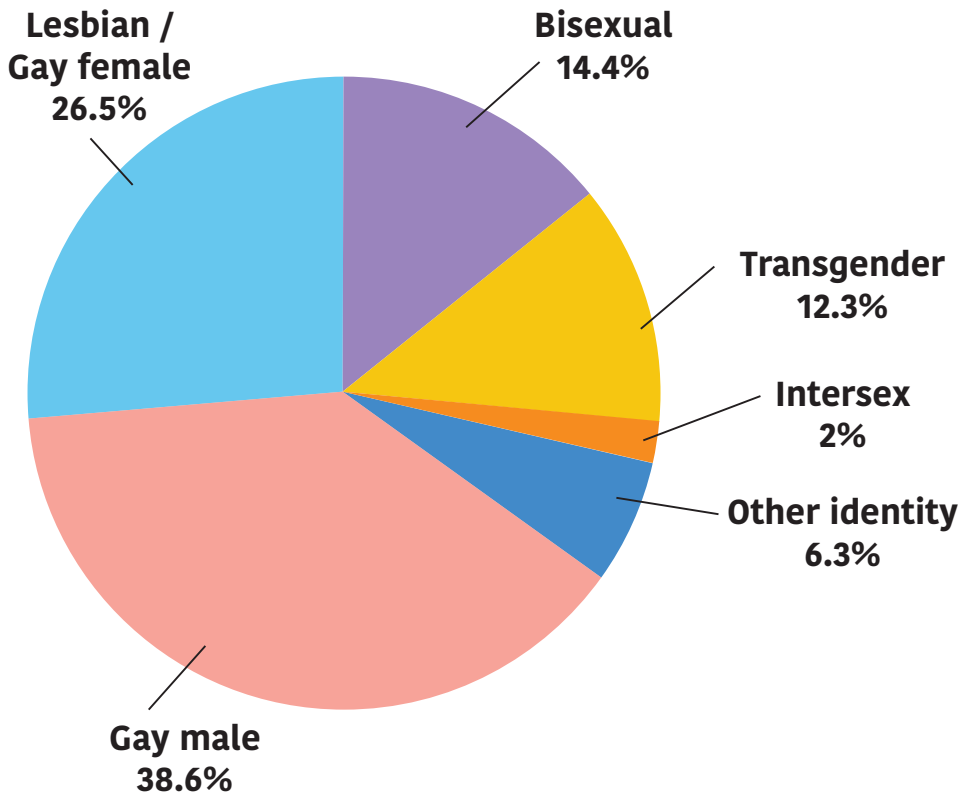
Module 1 was a national survey which explored the mental health and well-being experiences of LGBTI people aged 14 to 71 years in Ireland (n = 2,264). LGBTI is an abbreviation for Lesbian, Gay, Bisexual, Transgender, and Intersex.

Module 2 explored the attitudes of the general public (n = 1,008) towards LGBT people to gain a better understanding of how the social environment can shape the lives and wellbeing of LGBT people in Ireland. It did not explore attitudes to intersex people, as they noted that the general public's knowledge and understanding of intersex people was perceived to be too limited to ensure reliable responses.

Module 1 - Mental health and well-being of LGBTI people

Module 1 gathered data via an online survey from 2,264 LGBTI people living in the Republic of Ireland. It is the largest study of LGBTI mental health and wellbeing in Ireland to date. It is also the largest Irish study of transgender people to date, and the first study with a sample of intersex people. The age range of the 2,257 participants who provided their age was from 14 to 71 years. 1,064 participants were aged between 14 and 25 years, and 1,193 were aged 26 years and over.

The orientations and identities of the participants are shown in the pie chart below.



Well-being of LGBTI People

The LGBTIreland study found that although approximately 70% of the participants are experiencing positive well-being, a significant proportion of LGBTI people continue to experience victimisation and harassment in their day-to-day lives because of their LGBTI identity.

- 50% of students experienced LGBTI bullying
- 75% of all LGBTI participants had been verbally abused
- 1 in 5 had hurtful things written about their LGBTI identity on social media
- 1 in 3 had someone threaten to 'out' them against their will
- 1 in 3 had been threatened with physical violence
- 20% had been punched, hit or physically attacked in public
- 1 in 6 LGBTI people had experienced sexual violence

General Mental Health

- All participants in the LGBTIreland survey rated their levels of Stress, Anxiety and Depression using the DASS Scale (see table below).
- Intersex people had the highest scores for stress, anxiety and depression followed by transgender and bisexual people.
- Bisexual, trans and younger people were more likely to have self-harmed and more likely to have attempted suicide.

15% reported severe or extremely severe stress	**23%** reported severe or extremely severe \ anxiety	**20%** reported severe or extremely severe \ depression	**24%** had self-harmed	**60%** had seriously thought of ending their own life	**21%** had attempted suicide

Young People's Mental Health

While the LGBTIreland study found that the majority of the older participants aged 26 and over (n=1,193) were doing well, and reported good self-esteem, happiness and life satisfaction, the study found that a very significant number of those aged between 14 and 25 years (n=1,064) did not experience the same levels of positive mental health and wellness. Compared to the My World Survey (Dooley & Fitzgerald, 2012) of youth mental health in the general population, the young people in the LGBTIreland study had:

- 2 times the level of self-harm
- 3 times the level of attempted suicide
- 4 times the level of severe/extremely severe stress, anxiety and depression

The highest mental health risks were identified among teenaged participants (14 to 18 year olds). 69% of LGBTI teens had seriously thought of ending their life, compared to 50% of teens in the general population.

Recommendations to Improve Mental Health Services

Participants in the LGBTIreland study (n=2,264) made recommendations as to how mental health services could be improved for LGBTI users. It was felt that negative preconceptions of LGBTI identities held by some health professionals contributed to unfriendly service provision to LGBTI people. Their key recommendations were to:

- Move away from heteronormative and cisnormative assumptions.
- Adopt an open-minded, non-judgemental, positive approach to improve quality of service.
- Address potential barriers which would discourage future engagement with services, including unsatisfactory interactions with mental health professionals and homophobia.
- Include LGBTI people where appropriate in service literature and on the website in order to demonstrate an LGBTI friendly service.
- Display a positive signifier such as a rainbow sticker or flag or an LGBTI poster.

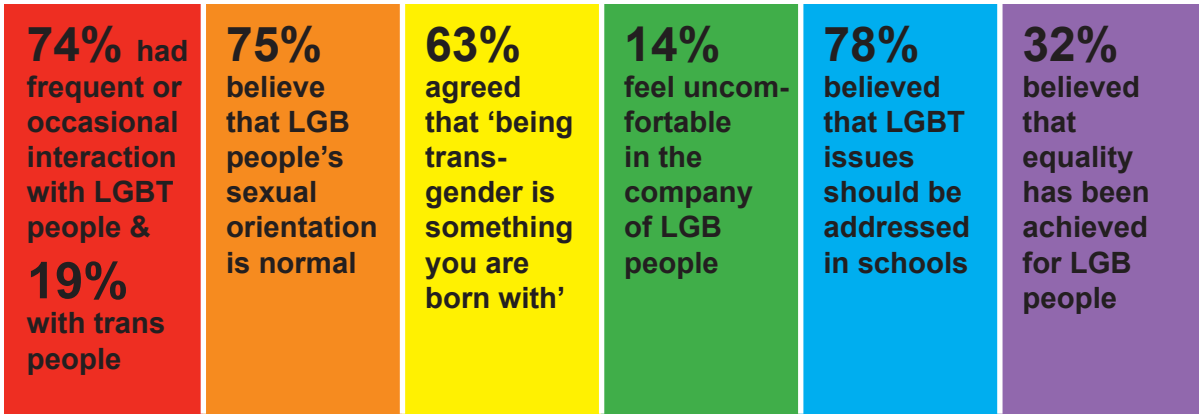
Module 2 - Public attitudes towards LGBT people

Module 2 of the LGBTIreland study explored the general public's attitudes towards LGBT people. The public's knowledge and understanding of intersex people was perceived to be too limited to ensure reliable responses, so they only explored attitudes towards LGBT people.

The questionnaire used for the telephone surveys incorporated 39 statements regarding attitudes towards LBGT people, using Likert scales of 1 to 5 (1 meaning 'disagree strongly' and 5 meaning 'agree strongly'). These statements explored:

- Frequency of interaction with LGBT people
- Belief system about being LGB
- Belief system about being transgender
- Comfort with contact or proximity
- Sexual expression or affection of LGB people
- Acceptance of discrimination against LGBT people

Key findings from Module 2 (N=1,008) are illustrated below. Interestingly, those who rarely or never interacted with LGBT people generally held less positive views towards LGBT people compared to those who frequently or occasionally interacted with LGBT people.



3.3 Speaking from the Margins (McNeil et al, 2013)

This report presents the findings of a study of the mental health and wellbeing of trans people in Ireland. The results from the 164 participants echo the findings in the UK Trans Mental Health Study 2012 (McNeil et al, 2012, n = 889). Speaking from the Margins also explored the barriers for participants in accessing appropriate health care, particularly in terms of mental health and transition services.

The study found that 44% of the participants reported having a disability or chronic health issue. The most common issue reported in the sample was poor mental health (32%). Depression, stress and anxiety were the most common mental health problems reported. 18% reported experiencing some form of neurodiversity such as Asperger's syndrome, or some form of intellectual or learning impairment. Other issues reported included hearing and visual impairments and mobility issues. 44% of participants in this study had not used Gender Identity Clinic (GIC) services.

Of those who had used a health service, participants reported a high level of negative experiences which they felt were due to their trans identity:

- 74% had at least one negative experience at a general health service
- 69% had at least one negative experience at a mental health service
- 60% had at least one negative experience at a GIC

The table below represents the most frequent negative experiences reported by participants in relation to mental health and general health care services.

Experiences of Negative Treatment included Health Care Professionals…
• Asking questions about trans people which made them feel like they were having to educate their healthcare professional • Telling the trans person that they didn't know enough about a particular type of trans-related care to provide it • Discouraging them from exploring their gender • Using the wrong pronoun or name by mistake • Telling the trans person they were not really trans • Thinking that the gender listed on patient's ID or forms was a mistake

3.4 Visible Lives Study (Higgins et al, 2011)

This was the first study of older LGBT people and their lives in Ireland. The study gathered survey data from 144 people and interview data from 36 people aged between 55 and 80 years old from across the Republic of Ireland. The research aimed to examine the specific issues faced by older LGBT people living in Ireland.

> "Older Irish LGBT people grew up in an environment where they were pathologised, criminalised, and faced stigmatisation, prejudice and exclusion. For many, this led to marginalisation from family and community, as well as discrimination in key areas of their lives, including in employment. As they enter the later years of their lives, older LGBT people are faced with a double invisibility both as older people and as LGBT people. Whilst some of the issues facing older LGBT people may be similar to those for all older people, there is a growing awareness of the need to identify the specific issues older LGBT people face."
>
> *(Visible Lives, 2011, Key Findings, p3)*

Key Findings:

Coming Out

Most participants went through the whole of their adolescence and early adulthood without disclosing their LGBT identity to anyone, and without contact with other LGBT people. Participants developed a range of strategies for concealing or hiding their identity including cautiousness, discretion, developing divided lives, self-exclusion from parts of their life, living a 'straight life' and emigration. 26% of participants are or have been married to a person of the opposite sex, and 1 in 3 are parents.

While 80% of participants said they are now very comfortable with their LGBT identity, 28% are not out to any of their neighbours, 10% are not out to any of their family and 7% have not told anyone that they are LGBT. The main reason for not coming out was fear of negative reactions and consequences.

Preparation for Ageing

A major concern for participants was that older age services will not recognise or respect their LGBT identity. Participants felt concerned that services might not protect their LGBT identity or respect their partners in decision-making, or might discriminate against them as LGBT people. Some would prefer to live in an exclusively LGBT retirement community or in an older age facility that is sensitive to and respectful of LGBT needs.

Relationship status, Living situation, and Community participation

Roughly equal proportions of the survey sample were either single (43.1%) or in a relationship (38.9%). The proportion of survey participants in this study who were single was much greater than the 15% reported for the entire over 55 year old population in Ireland in the 2006 Census.

Almost half of the survey participants (45.8%) reported living alone. Although not directly comparable, this high rate of solitary living contrasts sharply with the 29% of over 65 year old people who reported living alone in the 2006 Census.

Overall, almost two-thirds of the survey participants (64.1%; n = 82) in this study were involved in local mainstream community activities. About half of participants reported that they felt part of their local community (53.9%, n = 69).

Organised religion and the church have traditionally been a source of support and social engagement for older people in Ireland. The participants in the survey reported much higher rates of no religion (50.4%) when compared to just 2% of the whole population over 55 years of age in Ireland.

Experience of Health Services

Of the 134 Visible Lives survey participants to respond to the question on use of health services, most (89.6%; n = 120) were using some type of health service. Overall very small numbers of participants reporting using mental health (1.5%) or sexual health (9.0%) services.

Almost one in four survey participants (23.1%) in the study reported that they had received poor quality of treatment when using healthcare services in Ireland. Of those, almost 40% considered their negative experience to be related to being LGBT.

Violence and Abuse

Half of participants in this study reported being verbally insulted (47.3%) on the basis of their LGBT identity, and one out of five (19.1%) reported being punched or kicked because of their LGBT identity. 16% of participants had experienced domestic violence. 4 out of 5 people did not feel safe holding hands or showing affection with a partner in public. When compared to national studies into elder abuse and neglect, the rates of violence against LGBT elder people appear to be significantly higher.

Mental Health

One in three survey participants reported having a mental health problem at some point in their lives and 10% were currently taking prescribed medication for a mental health issue.

One in ten survey participants reported that, at some time in their lives, they had seriously thought about ending their life, and 4.5% reported that they had self-harmed in the past year.

Fourteen percent reported worrying about their alcohol consumption, and 17.2% drank five or more times a week. The qualitative findings suggest that participants used alcohol to help them cope with shyness around their sexual orientation or gender identity, to numb painful emotions and to give courage and boost confidence around coming out.

Section 4

LGBT+ Good Practice Guidelines

LGBT+ Good Practice Guidelines

These guidelines have been developed by AOTI to inform all occupational therapists as to how to provide an LGBT+ friendly and inclusive service. LGBT+ inclusive practice is required by law under the Equal Status Acts 2000-2015. Sexual orientation and gender identity are core parts of everyone's identity and are relevant to the person-centred practice of every occupational therapist. The aim of these guidelines is to reassure, encourage and educate occupational therapists to support good practice with LGBT+ clients.

- **Be Aware that 1 in 10 People Identify as LGBT+**
  You have LGBT+ service users and/or LGBT+ colleagues. While LGBT+ people may be using Occupational Therapy services for reasons unrelated to their identity, an inclusive approach is still required for good practice.

- **Consult the Evidence**
  It is important to have an evidence based approach to practice. Readers are encouraged to refer to the research and resources included in this document, and keep up to date with emerging evidence in relation to LGBT+ people.

- **Use Occupational Therapy Theory and Skills**
  Draw on your existing knowledge of Occupational Therapy theory to practice in an LGBT+ inclusive way. Use the core Occupational Therapy skills that you already have, rather than thinking that you need new skills.

- **Take a Client-Centred Approach**
  Good practice means taking a proactive, LGBT+ friendly approach. It is only the person's sexual orientation or gender identity that is different. Having an awareness of these differences means we can ensure a client-centred approach is taken with LGBT+ people.

- **Be Guided by the Client**
  Ensure you provide a safe space, respect confidentiality and take a professional approach with LGBT+ people. Be aware that although a client is out to you, they may not be out to other people.

- **Use the Correct Terminology**
  The correct terms to use when referring to LGBT+ clients are lesbian, gay, bisexual or transgender, or their preferred term for their sexual orientation or gender identity. If you are unsure, ask your client in a sensitive way.

- **Respect Preferred Name and Pronoun**
  If you have a transgender client, use the name and pronouns they would like you to use verbally, in writing and on their file. If you mis-name or mis-gender a client, simply acknowledge your mistake and apologise. Clients who identify as non-binary may prefer the use of the pronouns 'they' and 'their'.

Barriers to Being Inclusive:

- Believing “we don’t have LGBT+ service users”
- Presuming people are heterosexual or cisgender
- Lacking understanding of LGBT+ issues and language
- Not asking or not knowing how to ask about sexual orientation or gender identity
- Using the wrong name or pronouns when speaking to or about a trans person
- Being unwilling to engage with LGBT+ specific issues
- Communicating anti-LGBT+ bias to the person
- Not challenging bias towards LGBT+ people with colleagues or other service users

4.1 A Framework for LGBT+ Inclusive Occupational Therapy

The 4 Ps model is a framework for achieving a service that is inclusive of LGBT+ people and one that LGBT+ people experience as being helpful and supportive (Equality Authority (2002), cited in Crowley, 2015). This model has been promoted by LGBT+ organisations as a framework to assist services to become more LGBT+ friendly (GLEN, 2013). AOTI proposes this model as good practice for achieving inclusivity.

The 4 Ps model has four interlinked components which are key building blocks for LGBT+ inclusive practice. These are:

- **Public profile**
- **Policy and procedures**
- **Programmes**
- **Professional development**

By addressing all four areas of the 4 Ps model, the overall culture of the Occupational Therapy profession in Ireland can be transformed into a more LGBT+ inclusive one. Using the 4 Ps model can greatly enhance practice and ensure Occupational Therapy services are LGBT+ friendly for service users and their families, as well as for staff and volunteers.

To achieve an LGBT+ friendly service, it is recommended that the 4 Ps model is adopted by Occupational Therapy services throughout Ireland, and embraced by practitioners, managers, educators and researchers. In the following section, service means providing an Occupational Therapy service, managing an Occupational Therapy service, educating Occupational Therapy students, conducting research, or carrying out any other role in your capacity as an occupational therapist.

4.1.1 Public Profile

This refers to the message that the Occupational Therapy profession communicates publicly about lesbian, gay, bisexual and transgender people. It is vital that Occupational Therapy services clearly demonstrate that they are LGBT+ friendly. This will let prospective LGBT+ service users know that they are welcome and will receive the same high quality service as everyone else. It will also show that the service is aware that they have LGBT+ service users and demonstrates that they understand the types of issues LGBT+ people may experience.

Consider the following questions and possible solutions:

- What message does your service communicate about LGBT+ people?
  No message is a message!
- How would an LGBT+ person know your service is inclusive and that it's safe for them to disclose their identity?

  - Display an LGBT+ poster (e.g. for LGBT Helpline) or a rainbow sticker in a visible location.
  - Provide copies of LGBT+ publications and resources in Occupational Therapy and multidisciplinary spaces.
  - Clearly indicate on your website that your service is LGBT+ friendly.
  - Include imagery to reflect the diversity of gender and sexual orientation in any service publications or resources.
- How do you demonstrate that you are LGBT+ inclusive if you do not practice in a clinical environment?
  - Use a rainbow sticker on the front of your diary, or a rainbow key ring or badge on your bag when going on home visits.
- How do you demonstrate your understanding of the needs of LGBT+ people in your service?
  - Clarify and use the client's preferred name and pronouns.

4.1.2 Policy & Procedures

This refers to the service's policies and procedures that are relevant to LGBT+ service users and staff.

Consider the following questions:

- Does the service have an equality and diversity policy and, if so, does it make explicit reference to lesbian, gay, bisexual and transgender people?
- Does the service have LGBT+ inclusive policies and procedures to ensure compliance with legislative requirements (equal treatment and involvement of spouses, civil partners, or next-of-kin in care)?
- Is there a clear procedure for dealing with homophobic, biphobic and transphobic behaviour, comments or attitudes at all levels of the service?
- Is there a policy to ensure that transgender people are addressed according to the name and style of address that they choose, and for their records to reflect this?
- Are your forms and documentation LGBT+ inclusive? How do you record gender, sexual orientation and relationship status?
- Are these policies and procedures communicated to services users, staff, and volunteers and implemented throughout the service?
- Is there LGBT+ information in the staff induction guide?
- If the Occupational Therapy service is part of a larger service (for example, a day hospital or day care service) do all multi-disciplinary communications contain an equivalent Equal Treatment statement?

Under the Equal Status Acts 2000-2015, public and private services must ensure non-discrimination and equal access in the provision of their services. To demonstrate compliance with this legislation, it is good practice to have a written equality and diversity policy that outlines the nine grounds of the Acts, making explicit reference to LGBT+ people, sexual orientation, gender identity and gender expression. Adopting and implementing such policies and procedures communicates your service's commitment to valuing diversity and promoting equality for all service users.

4.1.3 Programmes

This refers to work being done by your service to address gaps identified in your public profile or your policy & procedures as well as other actions to enhance the LGBT+ friendliness of the service.

Consider the following questions:

- If LGBT+ people are underrepresented in your service user profile, what could you do to target your service at the LGBT+ population?
- Are there structures in place to ensure transgender people have a positive experience of using the service, and are there appropriate supports and referral pathways for transitioning in place?
- Would your LGBT+ service users benefit from a specific initiative to address their needs? Examples may include targeting mental health support for young LGBT+ people, structures to support trans people who are transitioning, responding to the needs of married people coming out, or supporting older isolated LGBT+ people due to having no contact with their family of origin.

4.1.4 Professional Development

This covers the work being done by the service to support Occupational Therapy staff to be LGBT+ friendly in their work.

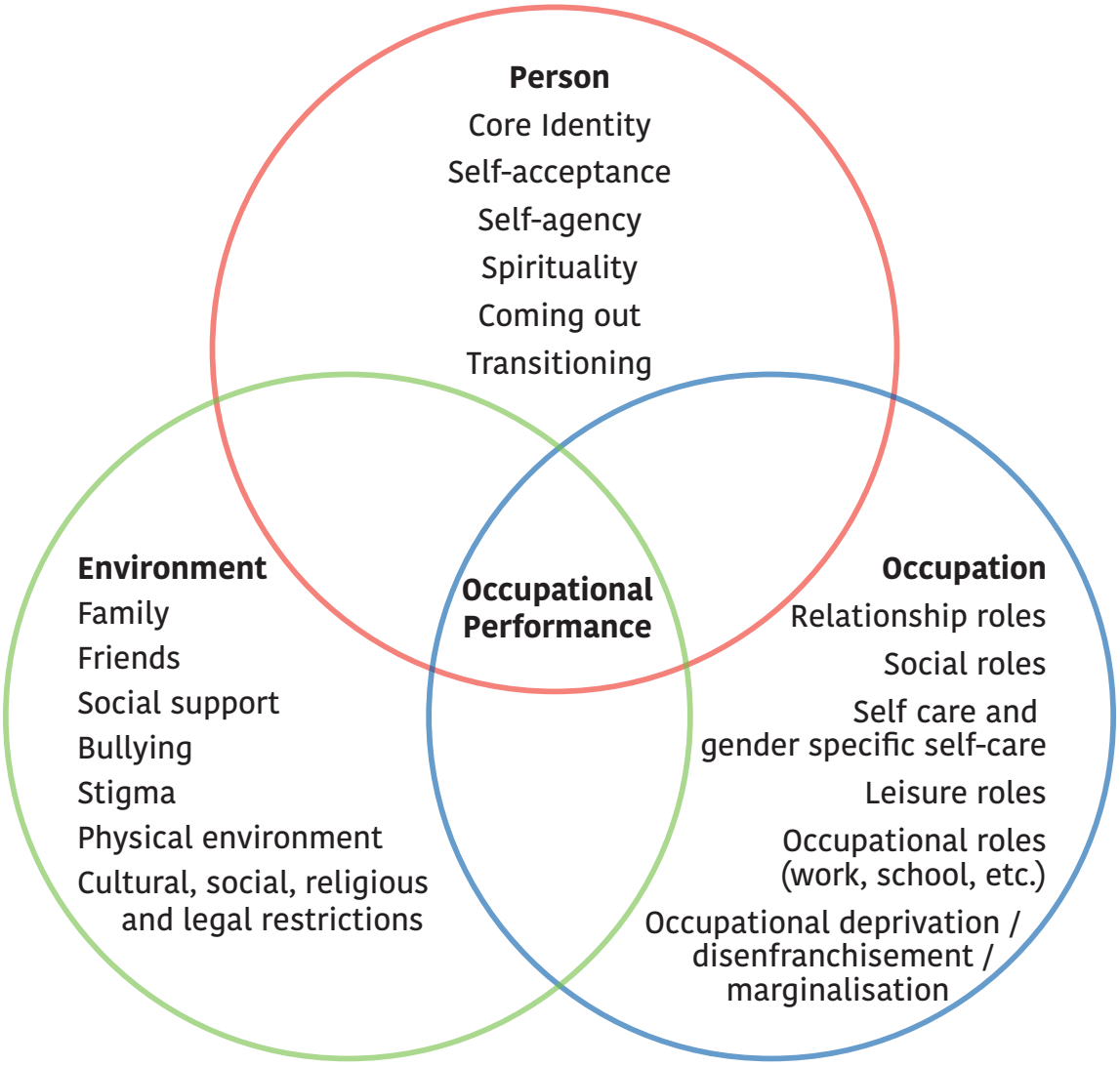
Consider the following questions:

- What can your service do to ensure staff understand LGBT+ issues and are aware of the needs that LGBT+ service users may have? For example, does a clinical audit need to be undertaken to determine their needs?
- What can the service do to ensure staff are comfortable using LGBT+ language and asking questions in a sensitive and appropriate manner?
- What resources can be put in place to support staff to be LGBT+ friendly and help them cater to the specific needs of LGBT+ people?
- Do you need to provide LGBT+ awareness training to staff? For example, including LGBT+ issues as part of CPD activities, in-services, team meetings, seminars, conferences and service publications.

4.2 Formulating the Occupational Therapy Role with LGBT+ Clients

Occupational therapists use different conceptual models and frameworks to guide their practice. Various models can be used to examine Occupational Therapy practice in relation to LGBT+ clients.

The Person Environment Occupation (PEO) model (Law et al., 1996) has been chosen as the basis for a simple and useful framework for examining the relationship between sexual orientation, gender identity and occupation, and for exploring the potential roles of occupational therapists in providing a service to LGBT+ clients. Occupational performance results from the dynamic relationship between people, the environments in which they live, work and play, and the occupations they engage in. Some examples of LGBT+ specific issues that are relevant to Occupational Therapy practice are shown below under the headings of person, environment and occupation.



Person:

The PEO model views each person as a unique being who assumes multiple roles and cannot be separated from contextual influences. The person brings to the context a set of attributes, skills, knowledge and experience. An individual's sexual orientation and gender identity forms a core part of their personhood, and directly links to their sense of self and personal identity. Each client's sexual orientation and gender identity is as unique and individual as the person themselves, and therefore this individuality should be acknowledged and respected by the therapist.

When considering the 'Person' related factors, a therapist should consider how the client views themselves, and how comfortable they are with their sexual orientation and/or gender identity. Literature indicates that LGBT+ individuals are more likely to have issues with self-esteem and self-acceptance (Downs, 2006). It is not uncommon for LGBT+ people to internalise negative messages received from their social environment, which can be detrimental to their sense of self and occupational identity. This is called *internalised homophobia, internalised biphobia, or internalised transphobia*. An example of this would be a young person feeling unhappy or distressed when they first discover their LGBT+ identity and feeling pressure not to be LGBT+.

A therapist should be aware of the personal challenges that the LGBT+ client may have had, due to their experience of belonging to a social minority. Minority stress is the extra stress which individuals from stigmatised social groups are exposed to, as a result of their social minority position (Meyer, 2003). LGBT+ individuals are more likely than their heterosexual peers to experience a mental health condition such as depression or anxiety because of minority stress (Meyer & Northridge, 2007). This is particularly the case for younger people, bisexual people, those questioning their sexual orientation or gender identity, and those who do not feel safe disclosing their identity to others (Higgins et al., 2011; Higgins et al., 2016).

Therapists should consider the unique life events and circumstances that relate to an LGBT+ person, such as their experiences of coming out to family and others, how they relate to the media's portrayal of LGBT+ people, and spiritual challenges they may face if they are attempting to reconcile their true identity with contradictory religious beliefs. These events can shape a client's personal expectations either positively or negatively.

Environment:

The PEO model places emphasis on the importance of a person's environments, and how they interact with them. Therapists working with LGBT+ clients should consider the various environments that their clients experience, and how their LGBT+ identity affects their interactions. For an LGBT+ person, particular experiences of their physical, social and cultural environment can have a negative effect on their occupational identity, occupational performance and wellbeing. These encounters can include stigma, discrimination, harassment, social exclusion and family rejection, and may cause minority stress.

Taking a wider perspective and understanding of your client, consider how LGBT+ people are regarded in the legal, political and cultural environment, both in their past and present contexts. Was homosexuality legal when they were growing up? Was same sex marriage legal? What rights do trans people have in society? Are there prominent LGBT+ role models? How are transgender people regarded in their culture?

Moving into the more immediate and personal environments of the client, consider how they are treated in their own social environments. Are they supported by their family and friends? Are they out and comfortable in their workplace? Are they engaged in their local community, LGBT+ or otherwise?

Occupation:

Participating in occupations can positively impact physical and mental health, and enhance quality of life (Clark et al., 2012). A person's sexual orientation and gender identity can have a significant influence on their occupations and roles, as well as their life decisions and goals. The occupations that a person chooses to engage in are often a reflection of their values, commitments, and interests, as well as the social context of their particular family, communities, and country. Consider the impact that a client's LGBT+ identity can have on all of their occupations, whether they are related to self-care, productivity or leisure.

While a client's LGBT+ identity may have no significant impact on their occupations, sometimes it can create barriers to occupational engagement. For example, many young LGBT+ people struggle in their student role and may miss school because of fear of coming out and bullying in school. Equally, transitioning can have a very significant impact on a trans person's life, requiring changes and transformations in life roles and occupations. Many trans people have difficulty securing employment and encounter challenges in the workplace when transitioning (McNeil et al., 2013).

A client-centred approach with LGBT+ clients will primarily focus on the person's occupational performance, while recognising and responding to any LGBT+ related needs. Consider if, and how, the person's identity is relevant to the Occupational Therapy process.

Section 5

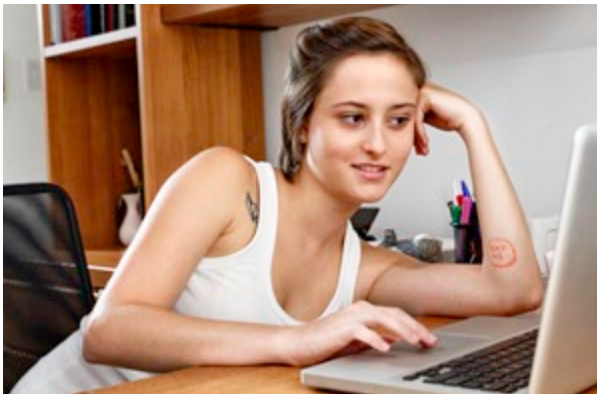
Case Scenarios

Case Scenarios

The following are some case examples to illustrate good Occupational Therapy practice in supporting LGBT+ people and ensuring inclusive practice. These scenarios are set in different areas of clinical practice where occupational therapists work, in order to demonstrate and explore a range of issues which may be pertinent for therapists working with LGBT+ people.

These cases are composite scenarios derived from the collective clinical experiences of the working group, and fictional names have been used.

- Declan Elderly gay man
- Alex Genderfluid person
- Tara Transgender teen
- Mary Bisexual married woman
- Niall Child in an LGBT+ family
- Claire Transgender woman



5.1 Declan - Elderly gay man

Declan was admitted via the emergency department with a urinary tract infection and delirium to the general ward of a community hospital. As Declan was over 70 years of age, his care was taken over by the geriatrician.

Paul, the occupational therapist on the multidisciplinary team, received a referral and having reviewed Declan's medical chart and nursing notes, he met with him. He quickly realised that Declan was unable to provide a history and was presenting as disoriented to time and place, but during this initial meeting, Declan kept asking for George. The medical chart noted that George was his next of kin and that they shared the same home, but their relationship was not included.

Paul telephoned George to obtain collateral information about Declan's baseline functional and cognitive level, and the home environment. Paul found out that Declan was relatively independent physically but that his cognitive function had deteriorated relatively quickly over the last year. George had been providing physical assistance and extensive prompting for Declan. He also found out that they had shared the same home for over 20 years. Paul clarified that they were in a partnership, although they did not have a legal partnership or marriage certificate. Paul asked George if the nature of their relationship could be added to complete Declan's records, and George was happy with this, so Paul arranged this with the ward clerk.

Understanding the legal requirement in Ireland to treat all patients the same regardless of sexual orientation, Paul undertook some preliminary research about the experiences of gay partners. He found the Visible Lives report (Higgins et al., 2011). This study identified that a large proportion of older LGBT+ individuals in Ireland share the same experiences of prejudice, harassment, and fear of physical and verbal abuse. He read that, as a consequence, LGBT+

seniors like George and Declan often remain 'invisible' to health care professionals until a crisis situation. Paul was surprised to note that nearly one quarter of LGBT+ seniors reported receiving poor quality treatment when they accessed healthcare. When Declan's delirium had resolved, Paul assessed his functional ability to do his personal activities of daily living. Paul found that Declan was managing well physically, but he required set up, verbal prompting and minimal assistance to complete dressing, toileting and feeding tasks.

Paul telephoned George to arrange to do a self-care session with him on the ward to observe how he usually assisted Declan. During the phone call, George spoke to Paul about living a hidden life with Declan, fearing the consequences of disclosure within their local community, and so had not availed of any external supports. George said he was physically and mentally exhausted. He expressed his fear, having experienced physical violence and ridicule as a gay man, of Declan being the victim of discrimination while in hospital. Paul was able to reassure George regarding Declan's care in the hospital and acknowledged that, as in their case, many LGBT+ couples do not have the level of community and family supports as heterosexual couples do. He encouraged George to consider availing of home care and community supports for Declan.

Paul shared George's concerns and information from the Visible Lives report at a weekly multidisciplinary team meeting and was, of course, assured that Declan would be treated in exactly the same manner as any heterosexual patient without discrimination.

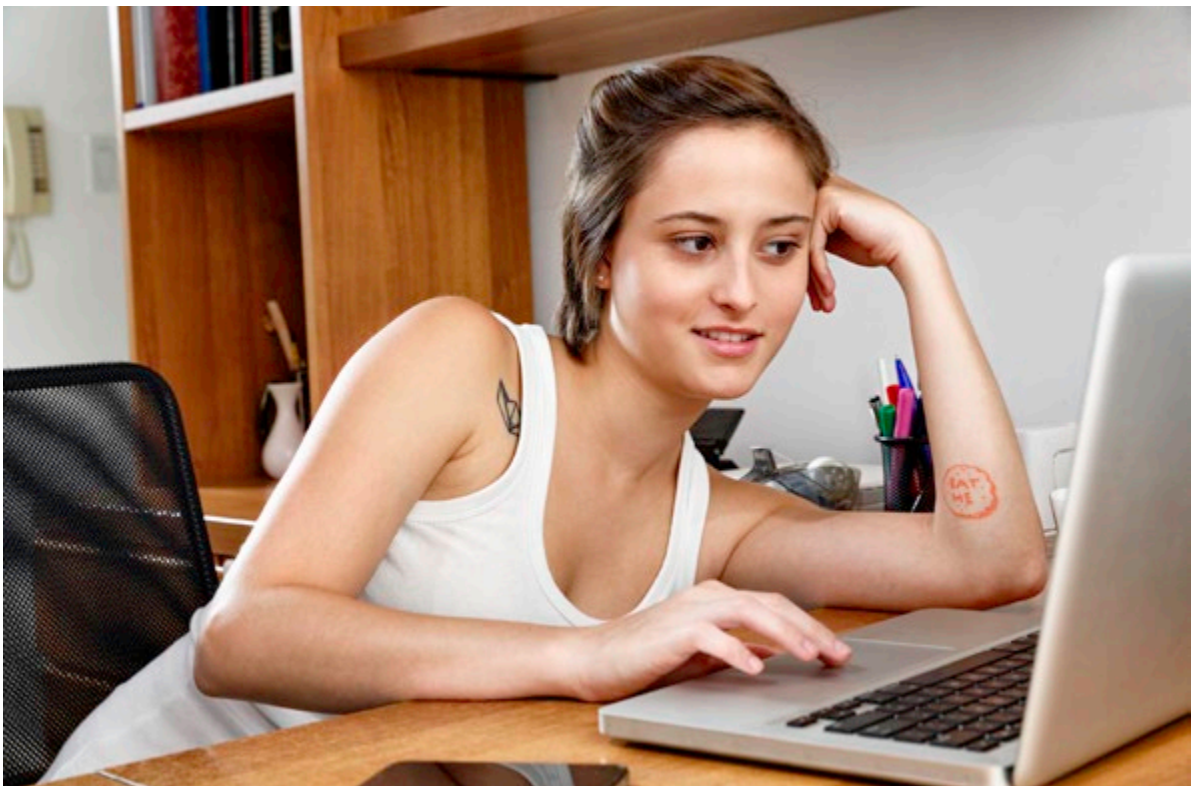
When Paul met George and Declan, the geriatrician had advised George that Declan had a diagnosis of dementia, so Paul was able to provide George with specific cognitive strategies to support someone with dementia, and provide him with some written information on relevant resources.

A care planning meeting was arranged with the team, with both Declan and George in attendance, to decide on an appropriate home care package and community supports for the couple. George was provided with information on the Age & Opportunity club and a local Carer's Support Group. Due to the concerns that George had raised and the level of carer stress, Paul recommended that Declan be followed up regularly in the geriatric out-patient clinic to ensure that the level of care and support remained sufficient to meet Declan's needs, to which the consultant agreed.

Declan - Key Learning: The occupational therapist ...

- Sought clarity where needed.
- Researched and built knowledge to allow greater understanding of the LGBT+ client.
- Provided reassurance to Declan and George.
- Communicated Declan and George's wishes to the MDT.
- Valued and recognised George as Declan's next of kin and partner.

5.2 Alex - Genderfluid person



Alex is a 21 year old university student, who identifies as gender fluid. Alex was assigned male gender at birth. However, having questioned their gender for many years, they were now taking their first steps in expressing their gender fluid identity.

Alex preferred the use of gender neutral pronouns ‘they’ and ‘their’. They also had a diagnosis of depression and anxiety, which they reported was intrinsically connected with the sense of dysphoria they had experienced throughout their life, living in a gender assigned to them that did not feel right. Alex was struggling to attend lectures and meet assignment deadlines, and was at risk of dropping out of college due to their mental health difficulties. They attended a community mental health service and had been referred to their team occupational therapist for vocational support.

The occupational therapist, Tom, carried out both informal and formal assessments with Alex, including the Occupational Self Assessment (Baron et al., 2006). Problem areas were identified, and, Tom and Alex prioritised these in accordance with the degree of importance or difficulty for Alex. The primary issues were:

- Taking care of myself
- Expressing myself to others
- Being involved as a student
- Doing activities that I like

Alex reported they identified as both male and female, and so would like to be able to express both of their gender identities freely. They reported they were slowly building their confidence in publicly presenting as female, and had tried this out in some of their larger lectures. They were concerned about negative reactions from others, particularly peers, and so didn’t feel

that they could do this as freely as they would have liked, particularly in their smaller lectures where it was more noticeable. As a result, Alex had missed a lot of lectures and was falling behind. On occasion, they had come into college presenting as female, however had then been too anxious to actually attend the scheduled lecture.

Alex was also an avid swimmer, and used to swim almost daily in their local gym. However, since they had started to express their gender fluidity, they had not been comfortable using either the male or the female changing rooms. Their anxiety levels about this were so high, that they had stopped engaging in their valued occupation of swimming.

Using the PEO model, Tom was able to demonstrate to Alex how their difficulties were interconnected. This enabled them to plan interventions which would help Alex achieve their most important goals of gender expression, self-care, and occupational participation.

Tom and Alex consulted the college's Gender Identity and Expression Policy and discussed it in detail. Tom supported Alex in contacting their college tutor, who was the designated college representative to support a student in transitioning, and a joint meeting was arranged. A course of action was decided upon with the tutor, in line with the college's policy, and it was agreed that Alex's tutor would inform relevant academic staff of Alex's gender fluidity, in a manner in which Alex was comfortable.

Tom made enquiries with the manager at Alex's local gym, and confirmed that gender neutral changing facilities were available. They made a joint visit to the gym, so Alex could familiarise themselves with these facilities and how they would access them. Together they set goals around a graded approach for Alex to return to their valued occupation of swimming.

Throughout their sessions, the importance of self-care occupations was explored with Alex. They reported that the occupations involved in expressing their female identity, such as putting on makeup and selecting what clothes to wear, were deeply comforting for them and had a positive influence on their mental health and wellbeing. The huge value of these occupations was explored with Alex and they were identified as wellness tools that could be incorporated into their daily routine in order to manage their depression and anxiety.

By using Occupational Therapy theory to conceptualise his client and the presenting issues, Tom was able to work in a client centred manner and support Alex to re-engage in their valued occupations, which were intrinsically linked with Alex's overall wellbeing.

Alex - Key Learning: The occupational therapist ...

- Used the PEO model to help identify how Alex's gender identity was impacting on their occupational performance.
- Respected Alex's preferred name and pronoun, and sought guidance from Alex on how to document this in their file.
- Found that a client centred approach enabled him to meet Alex's needs and realised that working with a genderfluid client was not a 'specialised area'.
- Sought out and followed the relevant policy which outlined the procedure to support the transitioning student.

5.3 Tara - Transgender teen

Tara is a secondary school student, preparing for her Junior Certificate. She was referred to a Primary Care occupational therapist by her mother due to concerns about Tara's handwriting and general difficulties in school.

Tara's occupational therapist, Niamh, started gathering some information by sending questionnaires to Tara's parents and school. The results of these were reviewed with Tara and her Mum at her initial Occupational Therapy appointment. Issues identified included low mood, poor concentration & attention, poor organisational skills, anxiety and poor sleep pattern. It was felt that Tara was underperforming at school and her poor handwriting continued to be an issue for concern.

Tara's Mum reported that in recent years Tara seemed to have difficulty making or keeping friends, and had become withdrawn, both at home and in school, and was not engaging with the school sports programme or other social activities.

While Tara's handwriting difficulties were initially highlighted as the primary concern, it became apparent to Niamh that these other reported issues required further attention. Niamh proceeded to assess Tara's motor and movement skills on a one-to-one basis, and both her fine and gross motor skills were within normal limits. Standard information and recommendations were given to Tara and her Mum around strategies to improve Tara's handwriting ability. Niamh chatted with Tara about school and the difficulties she was experiencing. Tara reported that she wasn't happy in school and didn't feel like she fitted in. It was an all-girls school, and she felt she would fit in better in the local mixed school, as she got on better with boys. She also mentioned she would love to be able to wear trousers instead of the skirt every day. Niamh had observed that Tara presented wearing gender neutral clothes, and her physical appearance was more typically masculine than feminine.

Niamh had made some other observations during her session with Tara: Tara's eye contact and non-verbal communication skills weren't very good. She had difficulty following some of the instructions in the tests and was easily distracted, and unduly bothered by the noise of the fax machine in the next room. In the context of Tara's other reported difficulties, Niamh was aware that this may have been suggestive of an Autistic Spectrum Disorder (ASD).

Niamh also considered Tara's gender neutral presentation and her difficulties integrating in her school. She felt that that Tara may have been questioning her gender or sexuality, and if so she would need support to explore this.

Niamh discussed her findings with Tara's Mum, who validated them, and said she was also concerned. She had assumed that a lot of it was just "normal teenage stuff" that Tara would eventually "grow out of". She agreed to Niamh making a referral to the team psychologist, giving full details of her findings and observations.

Tara was seen by the team psychologist, and Niamh subsequently learned that she had been formally diagnosed with Asperger's. In addition, it emerged that Tara had been self-harming for some time, and was in fact questioning her gender identity. Tara reported that a lot of the time she felt more like a boy and had been struggling to cope with those feelings.

Tara received further psychological support, and she and her family were also linked in with the Transgender Equality Network of Ireland (TENI), who provided emotional and practical support, and education and training to Tara's school. Their associated parents group, TransparenCI, were also able to provide invaluable information and support to Tara's parents and her family.

On reflection, Niamh noted to herself that even though Tara's gender identity was not the focus of her therapeutic intervention, her clinical awareness and reasoning had resulted in an important onward referral, which provided Tara with the appropriate supports she and her family required. Niamh was pleased that her intervention had contributed to a positive outcome for Tara.

Tara - Key Learning: The occupational therapist ...

- Reflected on the importance of observation skills and good communication in determining that there was more going on for Tara than handwriting problems.
- Worked in a holistic way which ensured a client centred outcome for Tara.
- Applied her knowledge of LGBT+ issues and ASD and used her clinical reasoning to make an appropriate onward referral.

5.4 Mary - Bisexual married woman

Mary is a 32 year old woman who was referred by her GP to the community mental health service as she had become depressed. Her GP was concerned as her low mood was affecting her work, interests, and her relationship with her husband.

After initial screening by the consultant psychiatrist, Mary was referred to the occupational therapist as she was finding it difficult to concentrate in work and was on sick leave. The consultant psychiatrist advised the occupational therapist, Julie, that Mary's low mood had been triggered because she was trying to come to terms with her sexual orientation, as she believed that she was bisexual not straight.

Before Julie arranged to meet Mary, she reviewed the AOTI LGBT+ Good Practice Guide to find out what the most common issues for bisexual people are. She gained an understanding of the importance of personal resilience for LGBT+ individuals. Julie realised that, as an occupational therapist, she was uniquely positioned to help Mary to develop sources of personal resilience by addressing the issues that are limiting her participation, and by promoting her engagement in daily activities.

When she looked at the report from the Burning Issues 2 survey for more information about bisexual adults, she found out that less than 20% of LGBT people "come out" over the age of 25 years old, and that only a quarter of bisexuals are out in their daily life, much less than their gay or lesbian counterparts (Ó'hUltacháin, Mathews-McKay & Urain, 2016, pp.27-28). Julie learned that there can be added difficulties for bisexual people in accessing a truly bi-inclusive support service, so she investigated which support groups and resources were the nearest available, should Mary be interested or benefit from these supports, and made contact with them to ensure that they were bi-inclusive.

Prior to Mary's first Occupational Therapy appointment, Julie made sure that the Rainbow poster was prominently displayed in the waiting area, to indicate that the service was LGBT+ inclusive.

During the initial interview with Mary, Julie created a positive, person-centred environment of mutual cooperation and trust. Mary told Julie that she identified as bisexual, and that she had developed an attraction to a female friend in recent months. She was concerned that her relationship with her husband would be affected if she told him that she was bisexual. This anxiety and uncertainty was negatively affecting her mood and her ability to engage in her daily activities. Mary said that her main concern was that she was currently on sick leave from work.

Julie responded with compassion acknowledging Mary's situation. She also acknowledged Mary's fears about the possible impact of telling her husband about her sexual orientation. This allowed Mary to realise just how stressful the last few months had been for her, and that being off work was a symptom of the stress of coming to terms with her sexual orientation.

To allow Mary to identify occupations that were most important and meaningful to her, Julie used a person-centred outcome measure. Having rated the list of everyday occupations, Mary then selected the areas of occupational performance that were causing her the most difficulty. These were Handling my responsibilities, Expressing myself to others, and Doing activities I like.

They both agreed that returning to work would help to improve Mary's mood and self-esteem. She also recognized that she needed to talk to her husband about her sexuality, but that she was not ready to do this yet. Julie reassured Mary that part of the Occupational Therapy role was to support Mary so that she could also achieve this goal when she was ready to do so.

Julie introduced the concept of resilience, and discussed how Mary could strengthen her personal sources of resilience by exploring her bisexual identity in a positive way, learning to increase her self-esteem, and develop positive coping strategies and positive environmental supports. She acknowledged the positive step Mary had already taken to explore her bisexual identity by contacting people in a reputable, online bisexual discussion group.

Julie made an appointment to meet Mary the following week to continue to explore ways of strengthening her resilience, and to set SMART goals to achieve her primary aim of returning to work.

Mary - Key Learning: The occupational therapist ...

- Realised the importance of therapeutic use of self to build rapport and trust with Mary, which enabled her to share her story.
- Consulted the AOTI LGBT+ Good Practice Guide.
- Used a Rainbow poster in the waiting area to indicate the service was LGBT+ friendly.
- Acknowledged Mary's fears and was then able to gain a better understanding of why she was struggling in her occupational roles.

5.5 Niall - Child in an LGBT+ family

Jane is an occupational therapist working in an early intervention service who recently received a referral to assess Niall, a 4 year old boy. When she called the family to schedule the first appointment she realised that Niall's parents were a lesbian couple.

She brought this up for discussion in supervision as she wasn't sure what to do as she had never worked with a 'gay family', as she put it. Her supervisor listened to her questions and concerns, and reassured her that this wasn't a specialist area and that essentially the process would be the same as with any other child or family.

Jane hadn't realised that one third of LGBT+ adults in Ireland are parents and that it wasn't uncommon to encounter gay and lesbian parents of children referred to the service. Her supervisor talked her through some of the tips in the AOTI LGBT+ Good Practice Guidelines, including making sure she used inclusive language, not using terms like 'the real mother' and not asking 'who is the father?' She also explained to Jane that while most children born into lesbian families are conceived from a known donor, she needed to be sensitive to the varying roles of donor dads. She advised her to read a guideline for healthcare professionals working with same-sex parented families (see the Appendices for Useful LGBT+ Publications for Healthcare Professionals).

In the subsequent supervision session, Jane spoke about her experience of meeting the family and concluded that "it was just like meeting any other family or assessing any other child really. In the end, my focus was on the difficulties Niall was having and how we could help him and his mums."

Niall - Key Learning: The occupational therapist ...

- Used supervision to seek guidance in an area she felt unfamiliar with.
- Learned that same sex headed families are essentially the same as all other families, and the same OT process was required to help Niall and his family with his difficulties.
- Found using the AOTI LGBT+ Good Practice Guidelines supported her learning.

5.6 Claire - Transgender woman

An occupational therapist is seeing a client for the first time and has noted from the referral that the person is transgender. After bringing the client to a private clinical area, she initiates the following conversation:

Siobhan: Hi Jason (name on referral), I'm Siobhan your occupational therapist. Your doctor referred you to me for a hand splint following your accident. Before we look at your hand, would you mind if I just clarified some details with you?

Jason: No problem.

Siobhan: I note from your file that you identify as transgender, but I can't find any further information on that. Is Jason your preferred name?

Jason: Well actually, thank you for asking, but I would like you to call me Claire.

Siobhan: Okay, I'm glad I asked. Would you like me to put Claire on your occupational therapy records?

Claire: That would be great if you could do that.

Siobhan: That's no problem. Would you like me to change your gender details on my file too?

Claire: Yes please. You can put me down as female.

Siobhan: Okay. That's done. So can I assume you use the female pronouns then?

Claire: Yes. I appreciate you checking that with me.

Siobhan: That's no problem Claire. Now just a few more details. Is it ok for me to use the name Claire when I write my report to the doctor, or when I send an appointment letter to your home?

Claire: Yeah. I didn't think of these things. You can use Claire when you write to me at home, but my doctor uses Jason. I wish he wouldn't. If you use Claire, put "Jason" in brackets, so he will know it's me, and maybe I can get it sorted with him properly when I see him next.

Siobhan: Super. I'm glad I clarified this at the start. Now, let's have a look at your hand…

Claire - Key Learning: The occupational therapist ...

- Asked rather than assumed Claire's preferred name and pronouns.
- Consulted with Claire about with whom and when her preferred name and pronouns can be used, for example, in a letter to her GP or her next appointment letter.
- Demonstrated how to take a sensitive approach to an initial meeting with a trans client.
- Considered gender designations on departmental documentation.

Section 6

Conclusion

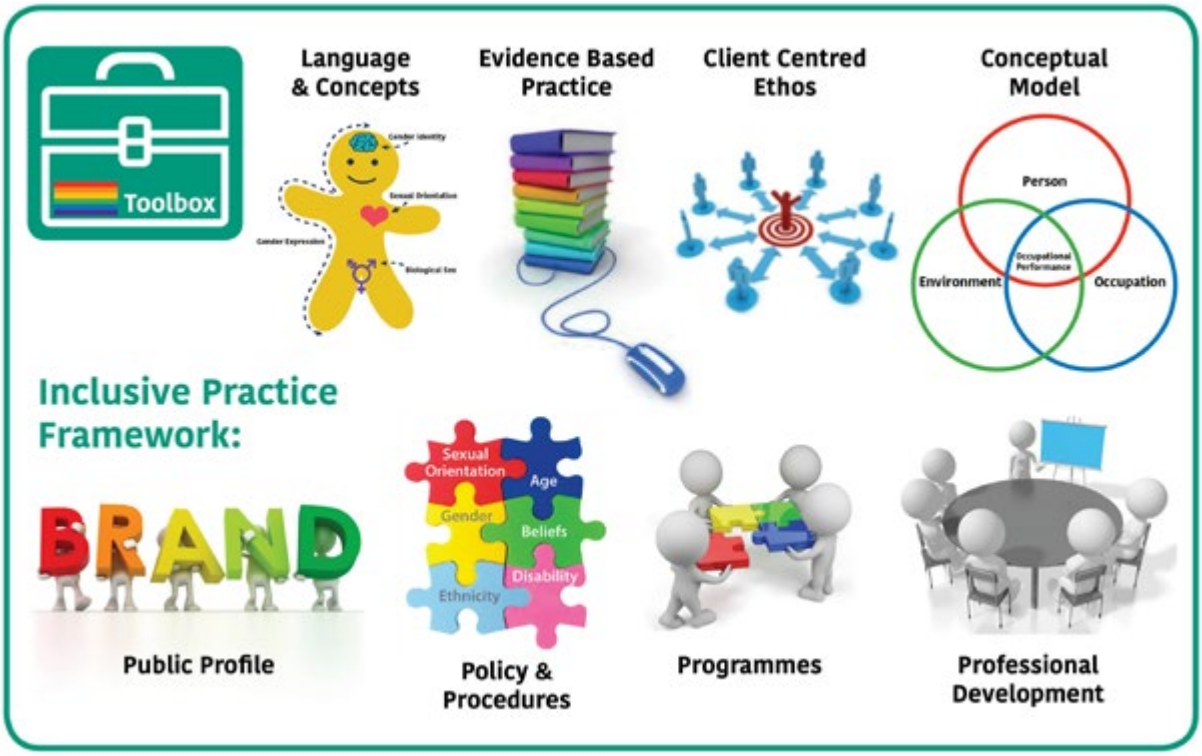
Conclusion

Occupational therapy theory emphasizes the link between the individual, their social and physical environment, their daily occupations and occupational performance. Gender identity and sexual orientation are central to every individual's core sense of self and how they connect with the world around them. The impact these elements of our identity have on our day-to-day functioning cannot be over-emphasized. Occupational therapists will become more skilful by taking these issues into account.

This Good Practice Guide demonstrates that LGBT+ individuals are part of our day-to-day service provision, whether or not we are aware of this fact. In Ireland, LGBT+ service users, especially the younger generation, no longer accept feeling stigmatised and now expect knowledge, equality and inclusion from their service providers. It is intended that this Good Practice Guide will empower occupational therapists to reflect on inclusivity in their own professional practice. It enables a deeper understanding of LGBT+ individuals and their needs, and it provides a framework for the development of LGBT+ inclusive Occupational Therapy.

It is important that all therapists have a good knowledge and understanding of the range of issues facing LGBT+ people. This document lays out this knowledge, so as to enable therapists to recognise and respond to any LGBT+ related needs that may emerge during the OT process.

The toolbox below provides a visual summary of the key points for therapists, managers, educators, students and researchers to achieve good practice when engaging with LGBT+ clients.



Furthermore, it is hoped that this Good Practice Guide will inspire occupational therapists and those with an interest in occupational justice to undertake further LGBT+ specific research to add to the evidence base and ultimately to progress social change in this area.

Given the client centred and holistic nature of their profession, occupational therapists have huge potential to be leaders within their own services and to become champions of LGBT+ inclusive practice. It is hoped that this Good Practice Guide can offer therapists the tools and inspiration to do so.

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Appendices

Glossary of Terms

Agender: A person who does not identify as having a gender identity that can be defined as male or female, or who identifies as having no gender identity.

Androgynous: A form of gender expression that typically features a combination of masculine and feminine traits.

Asexual: People who do not experience attraction to any sex.

Biphobia: A fear, dislike or hatred of bisexuality or people who are bisexual. Biphobia is a source of discrimination against bisexual people, and can lead to prejudice and violence.

Bisexual: A bisexual person is someone who is romantically, sexually and/or emotionally attracted to people of both sexes.

Cisgender: The term for a person whose gender identity matches the biological sex they were assigned at birth. This term is commonly abbreviated to 'cis' (pronounced /sis/).

Cisnormativity: The assumption that all, or almost all, individuals are cisgender.

Coming Out: This is the term used by lesbian, gay, bisexual, transgender and intersex people to describe their experience of discovery, self-acceptance, openness and honesty about their LGBT+ identity, and their decision to disclose this to others when and how they choose.

Conversion Therapy: (also known as reparative therapy) is based on the belief that sexual or gender variance can be "cured". It involves a range of unethical and discredited practices that falsely claim to change a person's sexual orientation or gender identity. It is not evidence based, or scientific, and research has shown it to be harmful. It is therefore rejected by mainstream medical and health practitioners.

Cross-dressing: To wear clothing typical of the opposite sex. Cross dressing can refer to a broad spectrum of experiences, and there are numerous motivations for cross-dressing, such as a need to express femininity/masculinity, artistic expression, performance (drag queen or king), or for erotic enjoyment.

FTM: Female to Male. See definition for Trans man.

Gay: A gay man is one who is romantically, sexually and/or emotionally attracted to men. Most gay men don't like to be referred to as 'homosexual' because of the negative historical associations with the word and because the word gay better reflects their identity.

Gender Expression: The external manifestation of a person's gender identity. Gender can be expressed through mannerisms, grooming, physical characteristics, social interactions and speech patterns.

Gender Fluid: This is a non-binary gender identity defining someone whose gender identity or expression shifts between male and female or falls somewhere along this spectrum.

Gender Identity: This refers to a person's deeply felt identification as male, female, or some other gender. This may or may not correspond to the sex they were assigned at birth.

Gender Identity Clinic: This is a specialist clinic providing holistic gender care, focusing on the biological/medical, psychological and social aspects of gender. The clinic is staffed by a multi-disciplinary clinical team, including psychologists, psychiatrists, endocrinologists, and speech and language therapists, who work collaboratively with the client and each other.

Gender-Nonconforming: When someone does not dress, behave, or otherwise "fit in" with gender expectations.

Gender Variant: People whose gender identity and/or gender expression is different from traditional or stereotypical expectations of how a man or woman "should" appear or behave.

Genderqueer: A person whose gender varies from the traditional "norm", or who feels their gender identity is neither male nor female, both male and female, or perhaps a different gender identity altogether. (see also "Queer")

Homophobia: This refers to fear of, or prejudice and discrimination against, lesbian and gay people. It is also the dislike of same-sex attraction and love, or the hatred of people who have those feelings.

Intersex: A general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male. Intersex has replaced the term 'Hermaphrodite' which is generally considered derogatory.

Lesbian: A lesbian woman is one who is romantically, sexually and/or emotionally attracted to women. Many lesbians prefer to be called lesbian rather than gay.

LGB: An acronym for 'Lesbian, Gay, Bisexual'.

LGBT: An acronym for 'Lesbian, Gay, Bisexual, Transgender'.

LGBTI: An acronym for 'Lesbian, Gay, Bisexual, Transgender, Intersex'.

MTF: Male to Female. See definition for Trans woman.

Non-binary: An umbrella term for gender identities that fall outside the gender binary of male or female. This includes people whose gender identity is neither exclusively male nor female, a combination of male and female, or between or beyond genders. Similar to the usage of transgender, people under the non-binary umbrella may describe themselves using one or more of a wide variety of terms.

Pansexual: a person who is attracted to all sexes and gender identities.

Queer: An umbrella term for a range of people who are not heterosexual and/or cisgender. Historically this has been used as a derogatory term. However, it has more recently been reclaimed by the LGBT+ community as a positive, affirming term.

Resilience: The ability to bounce back, recover or successfully adapt to life challenges.

Sex: The designation of a person at birth as male or female based on their anatomy (genitalia and/or reproductive organs, or biology), chromosomes and/or hormones.

Sexual Orientation: Refers to a person's physical, emotional or romantic attraction to another person. Three sexual orientations are commonly recognised – heterosexual, homosexual (gay and lesbian) and bisexual. Sexual orientation is distinct from sex, gender identity and gender expression.

Trans or Transgender: Refers to a person whose gender identity and/or gender expression differs from the sex assigned to them at birth. This is an umbrella term and can include diverse gender identities.

Trans Man: A person who was assigned female at birth but who identifies as male. He may live as male, make physical changes through hormones or surgery, or he may not make these changes.

Trans Woman: A person who was assigned male at birth but who identifies as female. She may live as female and/or make physical changes through hormones or surgery, or she may not make these changes.

Transition: The process through which some transgender people begin to live as the gender with which they identify. Transition can be social - such as coming out to family, friends, co-workers or others, and changing name and pronouns; it can be physical - such as changing one's appearance or the way one dresses; or it can be legal - changing one's name and/or sex designation on legal documents such as birth cert, passport, etc. It can also include medical intervention such as hormone treatment or surgery.

Transphobia: A fear, dislike or hatred of people who are trans, or who are perceived to challenge the traditional gender 'norms' of male or female. Transphobia can result in individual or institutional discrimination, prejudice and violence against trans or gender variant people.

Transsexual: An older term used to describe a transgender person (see above). While still used as an identity label by some, "transgender" has generally become the more accepted term.

Transvestite: A person who wears clothing, accessories, jewellery or make-up not traditionally or stereotypically associated with their assigned sex. This generally refers to a male to female transgender person who does not wish to transition or change their assigned sex but prefers to live 'dual role'.

LGBT+ Resources

BeLonG To is the national youth service for lesbian, gay, bisexual and transgender young people aged between 14 and 23 years. www.belongto.org

Bi+ Ireland aims to create a space where bi+ people can make friends, access peer support and reduce any isolation they may experience. They aim to increase the visibility and presence of bi+ people in Ireland and to create diverse, vibrant and welcoming communities. www.biireland.com

GenderEd website is an online education programme aimed at supporting adult family members of transgender young people (less than 18 years of age) in the Republic of Ireland. www.gendered.ie/home

LGBT Ireland helpline provides access to a network of trained volunteers who provide a non- judgemental, confidential, listening support and information service by phone, online or in a peer support group for LGBT people and their family and friends. www.lgbt.ie

National LGBT Federation (NXF) publishes Gay Community News and campaigns for equal rights for, and to combat discrimination against, LGBT people. www.nxf.ie

Transgender Equality Network of Ireland (TENI) is a non-profit organisation supporting the trans community in Ireland, seeking to improve the situation and advance the rights and equality of trans people, and provide resources and support to trans people and their families. www.teni.ie

Transgender Resources

Guidance for GPs, Other Clinicians and Health Professionals on the Care of Gender Variant People: Transgender Wellbeing and Healthcare.
NHS (National Health Service), 2008.
www.gires.org.uk

Heads Up: Trans guide to mental health and wellbeing.
TENI, 2016
www.transforminglives.ie/mental-health-guide/

Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (version 7)
WPATH, 2011
https://www.wpath.org/publications/soc

Useful LGBT+ Publications for Healthcare Professionals

Coping with the Death of Your Same-Sex Partner.
Irish Hospice Foundation & GLEN, 2010.
http://hospicefoundation.ie/wp-content/uploads/2012/07/Coping-with-the-Death-of-your-Same-Sex-Partner.pdf

Guidelines for Healthcare Professionals Working with Same-Sex Parented Families.
The Bouverie Centre, Australia, 2012.
https://www.bouverie.org.au/images/uploads/Bouverie_Centre_Guidelines_for_working_with_Same_Sex_Parented_Families.pdf

Lesbian, Gay, Bisexual and Transgender Service Users: Guidance for Staff Working in Mental Health Services.
GLEN, 2013.
www.mhcirl.ie/File/LGBT_SU_Guide_for_staff.pdf

Lesbian, Gay & Bisexual Patients: The Issues for Mental Health Practice.
College of Psychiatry of Ireland, GLEN & HSE, 2011.
www.irishpsychiatry.ie/wp-content/uploads/2016/12/Lesbian-Gay-Bisexual-Patients-The-Issues-for-Mental-Health-Practice-Full-doc.pdf

LGBT Health: Towards Meeting the Health Care Needs of Lesbian, Gay, Bisexual and Transgender People.
HSE, 2009.
www.hse.ie/eng/services/publications/topics/sexual/lgbt-health.pdf

LGBT+ Organisations and Services

BeLonGTo youth service
(ages 14 to 23)
info@belongto.org
www.belongto.org

Cork Gay Project, Cork
021 430 0430
www.gayprojectcork.com

Dublin Lesbian Line
01-8729911
www.dublinlesbianline.ie

Dundalk Outcomers
042-9329816
www.outcomers.org

Gay Community News,
Monthly LGBT+ magazine, which has a detailed list of social, cultural and sporting groups, organisations and online forums.
www.gcn.ie
.

Gay Men's Health Service
01-8734952
www.hse.ie/eng/services/list/5/sexhealth/gmhs/

Gender Identity Family Support Line
A volunteer-led listening and support service for families of trans and gender-nonconforming people in Ireland.
01-9073707
www.teni.ie

Greenbow Deaf LGBT+ Group
086-3671375
www.facebook.com/GBWDeafLGBT

Irish Trans Student Alliance
www.transstudentsalliance.ie/

LGBT Ireland
Helpline 1890-929539
www.lgbt.ie

LINC (Lesbians in Cork)
021-4808600
www.linc.ie

L.O.O.K. (Loving Our Out Kids)
Parent support group
087-2537699
www.lovingouroutkids.org

Outhouse Community Centre, Dublin
01-8734932
www.outhouse.ie

Parent Support in Cork
021-4304884
www.gayprojectcork.com/index.html

Transgender Equality Network Ireland
(TENI)
01-6334687
www.teni.ie

TransparenCI (parent & family support) & Transformers (peer support) groups
run in association with TENI.
www.teni.ie

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