Rainbow Youth Experiences of Mental Health Services in the Nelson/Tasman Region: A Mixed-Method Analysis

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Abstract

Rainbow young people (defined as 16–24-year-old people that hold diverse sexualities, genders, and sex characteristics) in Aotearoa New Zealand disproportionately experience higher rates of mental distress and adverse mental health outcomes compared to their cisgender and heterosexual counterparts. However, little is known about the experiences of rainbow young people who attempt to access mental health support in rural and semi-rural regions. To address this gap, I conducted a mixed-methods, community-based research project in the rural/semi-rural Nelson/Tasman region. My aim was to elucidate rainbow youth experiences of mental health support in this area and identify recommendations that would improve the provision of mental health care for rainbow youth in Aotearoa. I designed and distributed two online surveys to potential participants in the Nelson/Tasman region — one for health professionals working with young people (n = 44) and the other for rainbow young people who had sought mental health support (n = 81) — as well as conducted 10 semi-structured interviews with rainbow young people. Surveys and interviews assessed rainbow youth's experiences with mental health services, perceived and actual barriers to receiving care, and recommendations for improving the provision of mental health care to rainbow young people. Rainbow young people in Nelson/Tasman reported mixed experiences with mental health services; however, all participants experienced structural barriers to accessing appropriate support, such as lack of availability from health professionals, high cost for services, and fears about confidentiality and identity being misunderstood. Rainbow youth and health professionals made numerous recommendations to improve access and quality of mental health services for rainbow young people. Overall, my research demonstrates the structural barriers that exist for rainbow youth accessing mental health support, and highlights the need to develop rainbow cultural competency

among healthcare professionals working with young people in Aotearoa. Knowledge from this thesis can be used to improve the provision of healthcare for rainbow youth in the Nelson/Tasman region and beyond.

Keywords: Rainbow, youth, LGBTQ+, mixed-methods research, community-based, Aotearoa.

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A Note on Terminology

In this thesis, I use "rainbow" as an umbrella term, encompassing a range of identities and experiences, which include: diverse sexual orientations (attractions, behaviours, and identities) other than heterosexuality (e.g., gay, bisexual, lesbian, takatāpui, pansexual, queer, asexual), diverse gender identities or expressions (e.g., transgender, trans, takatāpui, whakawahine, tangata ira tane, fa'afafine, fa'afatama, genderqueer, fakaleiti, leiti, akava'ine, fakafifine, vakasalewa), and variations in sex characteristics (i.e., people born with intersex variations). Although the rainbow population is diverse and extensive, simply put, "rainbow" refers to people who either do not identify as heterosexual, have a gender identity that is not congruent with the sex they were assigned at birth, do not conform to typical gender norms, and/or were born with bodies that do not match common biological definitions of male or female. Other common words that describe this community include "queer" and "LGBTQ+".

I will use "rainbow," "queer," and "LGBTQ+" interchangeably throughout the study, except when the described study uses different language. For example, if a study investigated the experiences of people that identified as lesbian, gay, and bisexual (LGB), I would use the acronym LGB to accurately reflect the participant group.

To describe participants in this study that either provide or refer youth to mental health services, I use both "clinician" and "health professional".

Chapter 1: Introduction

Rainbow individuals around the world experience disproportionately high rates of mental distress compared to their cisgender and heterosexual peers (Almeida et al., 2009; Mays & Cochran, 2011; Russell et al., 2016). To begin to address this phenomenon in Aotearoa, the New Zealand government announced in 2021 that they were committing $4 million to mental health funding for young people in the rainbow community (Little, 2021). However, for this funding to reach the most vulnerable groups within the rainbow community, we need to understand better the barriers faced by rainbow youth living in rural areas of the country. For example, the Nelson/Tasman region hosted an anti-transgender conference in 2022 for healthcare professionals (Hubbard, 2022), highlighting the importance of considering the experiences of rainbow young people outside of urban centres. Research on minority groups within the rainbow community (e.g., those that live in rural locations, people of colour, rainbow people who also experience a disability, etc.) who access mental health support is minimal. The research that has been conducted indicates various minority groups within the rainbow community have elevated mental health challenges, such as gender minorities compared to sexual minorities, as well as those that live in socio-economic deprivation (Chiang et al., 2016; He Ara Oranga, 2018; Yarns et al., 2016) and are more likely to encounter barriers to accessing healthcare (O'Toole & Brown, 2002; Solway et al., 2010).

My research aimed to better understand the experiences of rainbow youth of mental health services in the rural/semi-rural region of Nelson/Tasman, investigate what barriers to receiving mental health support rainbow young people experienced in the Nelson/Tasman region, and explore recommendations from both rainbow young people and health professionals to improve the provision of mental health support for rainbow young people residing in the Nelson/Tasman region.

To answer my research aims, I used a mixed methods approach grounded in community-based research. I designed and distributed two online surveys – one for rainbow youth and one for clinicians/health professionals in the Nelson/Tasman region, and conducted 10 semi-structured interviews with rainbow young people. I believe it is critical to include youth perspectives as they are the experts of their own experiences and a key stakeholder. In this way, health care professionals can learn from the viewpoints of LGBTQ+ youth to improve care at the service level. The results can also benefit queer youth living in rural and semi-rural regions around New Zealand by expanding the understanding of barriers to mental health care that are specific in rural localities. Together, the data was used to assess rainbow youth engagement in health services, as well as the perceived barriers to accessing these services from the perspectives of both young people and health professionals.

In the following pages, I will review the relevant literature on rainbow youth mental health in rural/semi-rural regions (Chapter 2), describe my methodology (Chapter 3), review both quantitative and qualitative results (Chapter 4), and discuss my findings in light of the extant literature and present possible future directions for research, clinical practice, and health policy that would improve access to mental health care for rainbow young people in the Nelson/Tasman region (Chapter 5).

Chapter 2: Literature Review

My literature review begins with a broad exploration of existing research on the mental health and wellbeing of rainbow people and psychological frameworks used for understanding the mental distress of marginalised populations. My focus then narrows to international research on rainbow youth experiences of accessing mental health services. I also investigate the limited amount of research of clinician perceptions of working with rainbow people in mental health settings. I then discuss the Aotearoa New Zealand cultural context and rainbow mental health statistics nationally, followed by research specific to rainbow youth, and their experiences of accessing mental health services in Aotearoa. I also provide an overview of the national health system and the best practice guidelines that exist for working with rainbow people. This is to provide context for how the provision of mental health services is carried out for rainbow people in Aotearoa. I finish the literature review with research that explores barriers to accessing care in a rural context and a rationale for Nelson/Tasman as a case study for this research topic.

Mental Health and Wellbeing in Rainbow Communities

Compared to cisgender and heterosexual populations, rainbow people are a globally disadvantaged group (Adams et al., 2013; Almeida et al., 2009; Human Rights Commission, 2007). LGBTQ+ people are overrepresented in the experience of mental distress, with an increased prevalence of anxiety, depression, and both attempted and completed suicides (Adams et al., 2013). In a 2020 survey of over 40,000 American LGBTQ+ youth (Anderson, 2020), more than half of nonbinary and transgender respondents seriously considered attempting suicide in the previous 12 months (The Trevor Project, 2020.). Given this high mental health burden, it is unsurprising that rainbow youth report seeking support from mental health professionals at a higher rate compared to their heterosexual and cisgender peers (Benson, 2013; Clement et al., 2015;

Iacono, 2019; McNair & Bush, 2016). However, studies in the U.S. and New Zealand have found that rainbow youth report difficulties accessing mental health services (Fraser, 2020; Veale, et al., 2019; C. Wilson & Cariola, 2020).

Minority Stress Theory and Rainbow Mental Health

Minority stress describes ways in which mental distress can be created or exacerbated by factors outside of rainbow people's control, such as discrimination and violence, having to conceal sexual orientation or gender identity, internalising negative views (internalised homophobia), and constant vigilance due to fear of harm (Brooks, 1981; Meyer, 2003; Friedman et al., 2011). These societal stressors are unique to minority groups such as the rainbow community, are chronic, and occur through social institutions, structures, and processes. Psychologists commonly use minority stress theory to conceptualise how everyday societal issues cause health disparities amongst rainbow people (Brooks, 1981; Kelleher, 2009; Meyer, 1995, 2003). Anti-rainbow discrimination and social stigma can create stressful environments, e.g., bullying, verbal abuse, and even microaggressions, all of which increase the risk of developing mental distress (Brooks, 1981; Meyer, 1995, 2003).

Studies have linked anti-rainbow discrimination and harm to high rates of substance abuse, depression, attempted suicide, and other health-risk behaviours among those affected (Bontempo et al., 2002; Russell et al., 2016). Mediation analyses have further evidenced the relationship between experiences of discrimination based on LGBT identity and adverse health outcomes which is mediated by perceptions of having been treated poorly or discriminated against due to LGBT identity (Almeida et al., 2009; Toomey et al., 2010).

Minority stress exists within mental health institutions, further contributing to rainbow experiences of mental distress. Queer identities and behaviours, including gender identity and expression, have been historically pathologised by mental health professionals globally and even criminalised in numerous countries, including New Zealand (Dorey, 2006). Sixty-seven

countries currently criminalise consensual, private, same-sex sexual activity, with 11 of these countries still holding the death penalty for such activity and 14 countries criminalise transgender gender identity and expression (Human Dignity Trust, n.d.). Despite legal, political, and societal advances in the acceptance of LGBTQ+ people and their rights, some aspects of rainbow identity are still pathologised in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), such as gender dysphoria (American Psychiatric Association. & American Psychiatric Association. DSM-5 Task Force., 2013; Ault & Brzuzy, 2009). The pathologisation of gender identity contributes to barriers to quality mental health care for this vulnerable population (Fraser, 2020; Israel et al., 2008; Meyer, 2003).

Minority stress theory is well validated by empirical evidence and is recommended as a theoretical framework for affirmative-based interventions for LGBTQ+ people (Brooks, 1981; Meyer, 2003). However, as minority stress theory originally only focused on sexual orientation, it has been critiqued in recent years for not considering intersectionality and the institutionalised nature of stressors (e.g., assuming heterosexual or cisgendered identity, experienced by people with marginalised identities; Riggs & Treharne, 2017). Therefore, clinicians may unintentionally contribute to minority stress by perpetuating heteronormative and cisnormative practices, further contributing to experiences of mental distress in the very settings that are meant to alleviate it (Iacono, 2019).

Access and Experiences of Mental Health Services Internationally

Barriers to Accessing Services

Rainbow youth face additional, unique barriers to accessing mental health support as compared to both rainbow adults and their non-rainbow peers (He Ara Oranga, 2018; The Trevor Project, 2020; C. Wilson & Cariola, 2020; Zullo et al., 2021). LGBTQ+

people face similar barriers to care as non-LGBTQ+ people, including lack of transportation to attend sessions, financial barriers, and long waitlists as a result of shortages of mental health professionals (which is exacerbated in rural and semi-rural areas) (Andrade et al., 2014; McIntyre et al., 2012; Willging et al., 2006; Wilson et al., 2011). However, rainbow people also cite identity-specific barriers to accessing mental health care, the most common of which is fear of stigma and discrimination, which is compounded by a lack of mental health services explicitly advertising themselves rainbow affirming (M. E. Clark et al., 2001; Clement et al., 2015; Kitts, 2010; McIntyre et al., 2012; Mikalson et al., 2012; Safer et al., 2016; Thornicroft, 2017; Zullo et al., 2021)

Research indicates that rainbow people attempt to access mental health services more frequently than heterosexual and cisgender populations (Cochran et al., 2003; Rogers et al., 2003), likely as a result of their increased mental health burden. Brown et al. (2016) conducted a systematic review of barriers to accessing mental health care for LGBTQ+ young people.. The study found marginalisation, heteronormativity (heteronormativity and cisnormativity are insidious forms of discrimination, whereby a person's sexuality and gender are assumed as heterosexual and cisgendered (Schilt & Westbrook, 2009)), feeling unsafe in mental health units, shelters, or detox units, fear of being outed, harassment, and perception that treatment is insensitive to issues of transgender people as well as ineffective, were all significant barriers to accessing mental health support. Brown et al. (2016) reiterated that rainbow young people have unique needs which must be recognised to improve the access and quality of mental health care. These barriers are exemplified in the results of the 2020 The Trevor Project National Survey (2020), which surveyed 40,000 American LGBTQ+ youth aged between 13-24 about their mental health. Half of the survey respondents reported a desire for mental health support but were unable to receive it in the last year. Over 40% of respondents attributed this to concerns regarding parental consent (thus not having access to caregiver financial support for therapy); the

most significant barrier cited for receiving support was an inability to afford care, further evidencing general barriers being compounded by issues related to rainbow identity.

A group of researchers in the US conducted a qualitative study on barriers to care for suicidal LGBTQ youth (Zullo et al., 2021). LGBTQ+ youth service users raised concerns about limits to confidentiality as a barrier to care. Rainbow youth often didn't know what information would be shared regarding suicidal thoughts and LGBTQ identity, as disclosure of identity to parents or teachers was a concern (Zullo et al., 2021). Although informed consent covers limits to confidentiality (Parsonson, 2021), mental health professionals can take extra care to explain what type of statements would lead to recommendations for a higher level of care and provide a list of examples that would not require confidentiality to be broken – such as disclosure about questioning sexuality and gender identity (Zullo et al., 2021). This can contribute to fostering a positive therapeutic relationship and feelings of safety in disclosing personal information.

Positive Experiences

Rainbow people, including youth, report a mix of positive and negative experiences accessing mental health services (sometimes in the same encounter). Numerous factors contribute to a positive therapeutic experience, including therapeutic practices and techniques, and therapist qualities. Research with LGBTQ+ service users has evidenced gender-neutral language, asking open-ended questions, exploring identity in assessment, matching clients' language use, and wearing an indicator of LBGTQ+ support (e.g., pride flag, pronoun badge, rainbow lanyard etc.) as contributing factors to fostering safety and positive experiences in therapeutic spaces (Corliss et al., 2007; Zullo et al., 2021). Mental health professionals who were perceived as open-minded and non-judgmental were also viewed more favourably by rainbow clients (Corliss et al., 2007; Eady et al., 2011; M. K. Pitts et al., 2009). These actions and qualities helped rainbow

service users to feel affirmed in their identity and safe in therapeutic settings, thus enhancing the therapeutic relationship and reducing stigmatization and discrimination in therapeutic settings (Burckell & Goldfried, 2006; DeBord et al., 2017; Harper et al., 2013; Iacono, 2019; Israel, et al., 2008).

Recommendations have been made for fostering positive therapeutic experiences with rainbow clients (Zullo et al., 2021). Therapists can help create a safe therapy space by sharing pronouns and visibly displaying pride symbols, as well as by being educated on LGBTQ+ topics, vocabulary, and current events that might impact clients (Zullo et al., 2021). Considering the high rates of suicidality in rainbow populations (Cochran & Mays, 2000; King et al., 2008; & New Zealand Ministry of Health, 2019; Silenzio et al., 2009; Zullo et al., 2021), therapists should be extra mindful to give clients numerous opportunities to disclose information related to identity in a variety of ways (e.g., on intake forms, having intake questions related to sexuality and safety; Zullo et al., 2021). By allowing many opportunities to disclose information, therapists can help normalize LGBTQ+ identities throughout the therapeutic process. Although the research on positive therapeutic experiences for LGBTQ+ service users is limited, there are clear practices and techniques therapists can take to improve the provision of mental health care for rainbow people.

Negative Experiences

International research on the experiences of rainbow people who utilise mental health services is increasing (Bowers et al., 2010; Poteat et al., 2013; Simeonov et al., 2015; Sweeney et al., 2013). Despite accessing mental health support more frequently than heterosexual and cisgender individuals, sexual and gender minorities tend to be less satisfied with the support they receive (Avery et al., 2001; McNair & Bush, 2016; McNair, et al., 2011; Simeonov et al., 2015). Although instances of overt discrimination within mental health services have decreased over time, there are still numerous studies that cite cases of conversion therapy practices (Bartlett et

al., 2009; Haldeman, 1994; Israel et al., 2008; Liddle, 2000), refusal to use the client's correct pronouns (McCullough et al., 2017), and pathologising clients' sexual orientation (Ellis et al., 2015; M. K. Pitts et al., 2009; Whitehead et al., 2016).

As mentioned previously, heteronormativity and cisnormativity are insidious forms of discrimination, whereby a person's sexuality and gender are assumed as heterosexual and cisgendered (Schilt & Westbrook, 2009). Heteronormativity and cisnormativity are often unintentional, however, both are extremely prevalent, especially in clinical settings (Lefrançois, 2013; M. K. Pitts et al., 2009; Sump, 2011). Scholars have argued that all forms of heteronormativity and cisnormativity lower the quality of care for queer clients (Van Den Bergh & Crisp, 2004). It is not uncommon for clinicians to assume the gender and sexuality of the client (Lefrançois, 2013; Semp, 2008; Soinio et al., 2020), forcing the client to come out early in the therapeutic process if they are to correct the clinician. Some clinicians believe that labelling oneself as LGBTQ+ is unnecessary and that there are no meaningful differences between the experiences of queer individuals and heterosexuals (Whitehead, 2016). Thus LGBTQ+ clients are treated as heterosexual or cisgender, rendering the individual invisible and their unique needs and challenges dismissed (Greene, 2007; Hunter & Hickerson, 2003; Kidd et al., 2011). The opposite has been cited across many studies as well. Sexuality or gender can be overly focused upon or is attributed to the current distress, which may or may not be accurate for the client (Daly, 2019; Israel et al., 2008).

Transgender and nonbinary people are a particularly vulnerable subpopulation within the rainbow community and have reported concerning experiences within the context of mental health support, including verbal abuse by clinicians for gender identity-related issues (Ellis et al., 2015) and treating their gender identity as a symptom of mental illness (Ellis et al., 2015; Pitts et al., 2009). Not all discrimination experienced by

rainbow people accessing healthcare is overt or necessarily intentional. Lack of knowledge on rainbow-related issues (Knight et al., 2014; Longo, 2013), poor rainbow-related supervision (Murphy et al., 2002), assumptions about clients' identities (i.e., heteronormativity and cisnormativity) and minimisation of challenges relating to sexuality and/or gender identity (Anderson, 2020; Bauer et al., 2009; Fraser, 2020) all contribute to negative experiences of mental health support for rainbow individuals. Clinicians themselves have reported feeling underprepared to work with rainbow populations, which is exacerbated by a lack of rainbow competency training for medical professionals (Knight et al., 2014; Longo, 2013; Snelgrove et al., 2012) In particular, several studies have highlighted the negative impact on the client (e.g., feelings of frustration, alienation, and exhaustion (Evans & Barker, 2010; Nadal et al., 2011; Safer et al., 2016); and on the therapeutic relationship (e.g., diminished trust; (Israel et al., 2008; Sennott & Smith, 2011; Waltz Bauer, 2014)) when LGBTQ+ individuals are placed in the position of having to educate their mental health clinician (e.g., about pronouns) in order to receive the care they need (Bauer et al., 2009; Corliss et al., 2007; Evans & Barker, 2010). The therapeutic relationship can be negatively impacted when the client has to educate the provider and can cause feelings of frustration, alienation, and exhaustion for LGBTQ+ clients (Eady et al., 2011; Lucksted, 2004; McCullough et al., 2017).

Clinician Perceptions of Working with Rainbow People and Barriers to Care

Despite several studies on LGBTQ+ experiences of mental health support and LGBTQ+ people being more likely to seek therapy than heterosexual and cisgender individuals (Burckell & Goldfried, 2006), there is a dearth of research about mental health professionals' perceptions and experiences of working with rainbow people. Therapists who are LGBTQ+ themselves receive better feedback from rainbow clients on their care, but this does not guarantee that these providers are necessarily providing the best quality care (Alessi et al., 2015; DeBord et al., 2017; Hunter & Hickerson, 2003). Many studies have raised critical issues, including professional

training inadequacies, clinician-held biases, and systemic barriers to care (Case & Meier, 2014; Fraser, 2020; Fraser, et al., 2022; Harper et al., 2013; Lyons et al., 2010; McNair & Hegarty, 2010; Rutherford et al., 2012).

Despite numerous professional psychological international bodies issuing best-practice guidelines for working with rainbow people (Bouman, 2014; Coren et al., 2011; DeBord et al., 2017; Lev, 2004; Telfer et al., 2018), the lack of rainbow competency training for mental health service providers remains a widespread issue (Arora et al., 2016; Benson, 2013; Coren et al., 2011; Couch et al., 2007; Moleiro & Pinto, 2014; Harper et al., 2013; Israel et al., 2008; McNair & Hegarty, 2010; Mikalson et al., 2012; Owen-Pugh & Baines, 2014). For example, Owen-Pugh and Baines (2014) conducted a qualitative thematic analysis with sixteen novice counsellors in the UK about their clinical experiences of working with LGBT clients. All counsellors in the study reported feeling unprepared to work with LGBT clients following their professional training and described actively learning how to work with the population's unique needs (e.g.,), including learning how to confront heteronormative biases and overt anti-LGBTQ+ stigma. The study questioned the ethics of mental health training programmes neglecting to offer training on working with LGBTQ+ considering heterosexism is still endemic in society. Rainbow clients are often left responsible to provide education to their therapists. This finding echoes concerns LGBTQ+ clients have shared in accessing mental health support (Fraser, 2020). Likely due to the inadequacy of professional training in covering rainbow topics, many mental health professionals may be unaware of heterosexist and cisnormative biases which underpin most therapeutic models, theories of personality, and assessment and diagnostic techniques (Anderson, 2020; Ferlatte, 2015; Mustanski et al., 2010).

Longo (2013) investigated 86 clinicians' perceptions of the mental health of gay male-identifying clients and whether LGB competency and modern homophobia influenced these perceptions. Vignettes of gay and heterosexual clients with matching symptoms and presenting concerns were randomly (between subjects) assigned to clinicians. Results showed that the sexual orientation of the client significantly predicted the clinician's perceived level of mental health functioning for that client, such that gay clients were perceived as having worse mental health functioning than heterosexual clients with the exact same symptoms and presenting concerns. These results, along with more recent findings demonstrating a clinician bias towards diagnosing LGB clients with borderline personality disorder (Rodriguez-Seijas et al., 2021) highlight the impact of heterosexist and cisnormative biases on clinical assessment with rainbow populations, resulting in rainbow clients receiving less accurate assessments and care. This is an example of how minority stress exists within healthcare institutions.

Mental health professionals continue to lack knowledge about minority stress theory and the impacts of internalised homophobia on the mental health of queer clients (Alessi, 2014; Dickey et al., 2016; Mohr et al., 2009, 2013; Puckett & Levitt, 2015). Systemic changes need to occur to support the mental health of rainbow people. Scholars have suggested that increased funding for rainbow mental health services, education including rainbow competency training, and harm reduction initiatives that address bullying, harassment and discrimination could reduce stigma and prejudice toward rainbow people (Fraser, 2020).

Aotearoa Cultural Context

Rainbow Statistics

Although until 2023 the New Zealand Census did not ask direct questions about sexual orientation or gender identity, rainbow people make up an important portion of the New Zealand population. The most recent census modelling conducted by The New Zealand Household Economic Survey estimated an average of 4.2% across all ages, and over 8% of adults aged

between 18-29 identifying as LGBTQ+ (Olsen, 2022). There is no census data in New Zealand that estimates the percentage of rainbow young people below the age of 18.

Colonization and its Impact on Indigenous Models of Gender and Sexuality

New Zealand is a multicultural country in a bicultural framework between Māori and non-Māori (Sibley, 2004), with the first Europeans arriving in 1642, and New Zealand becoming a British colony in 1840 (History of New Zealand, n.d.). The Treaty of Waitangi is New Zealand's founding document and is an agreement between the British Crown and Māori which outlines three principles to ensure the rights and protection of Māori: partnership, protection, and participation (Treaty of Waitangi, 1840). All health practitioners practicing in Aotearoa are obligated to adhere to these principles. Despite the intentions of the Treaty of Waitangi, the negative impacts of colonization are extensive and ongoing. Māori disproportionately experience mental health inequities, and the rainbow community is no exception to this (Theodore et al., 2022).

Rainbow identities have always existed in Māori culture (Kerekere, 2017a, 2017b). Pre-colonisation, Māori people used the word takatāpui to describe people in same-sex relationships (Kerekere, 2017a, 2017b). Pre-colonisation, takatāpui people were accepted and celebrated in Māori society (Kerekere, 2017a, 2017b). Modern definitions of takatāpui incorporate Māori individuals who are diverse in sex, sexuality, and/or gender (Kerekere, 2017a, 2017b). When New Zealand was colonized, laws were put into place that criminalised same-sex relationships, and it wasn't until the 1970s that the modern gay and lesbian rights movement emerged in New Zealand (Dorey, 2006). Homosexuality was decriminalised in 1986 (Dorey, 2006), marriage equality was legalised in 2013 (Parliamentary Counsel Office, 2013), and in 2022 gay conversion therapy was banned (Parliamentary Counsel Office, 2022).

The field of psychology and associated mental health professions have historically pathologised rainbow identities (American Psychiatric Association, 1968), which has caused harm to rainbow people throughout generations in Aotearoa, especially to Māori who once celebrated Takatāpui identities. It is essential to acknowledge this harm, recognise the modern implications for Māori in particular, and actively work to support rainbow individuals, whānau, and communities in Aotearoa.

Rainbow Youth Mental Health in New Zealand

Mental Health Statistics of Rainbow Youth in Aotearoa

The mental health of rainbow populations in New Zealand mirrors concerns in research findings overseas (Chiang et al., 2016; He Ara Oranga, 2018; Mustanski et al., 2010; Russell et al., 2016; C. Wilson & Cariola, 2020; Zullo et al., 2021). Rainbow young people experience significantly higher rates of suicide compared with the rest of the Aotearoa population (T. Clark et al., 2013; & New Zealand Ministry of Health, 2019; Oakley-Browne et al., 2006). Longitudinal studies (both quantitative and qualitative) are scarce. However, New Zealand has two large-scale birth cohort studies: The Dunedin Multidisciplinary Study and the Christchurch Health and Development Study (Fergusson et al., 2005). Both studies found that rainbow-identifying young people up to 25 years of age experience increased rates (1.5 to 12 times higher) of depression, anxiety, alcohol and other drug dependence, and suicidality relative to their non-rainbow peers (Fergusson et al., 2005; Skegg et al., 2003). The Youth Wellbeing Study was conducted with 1799 Wellington secondary school students and found that LGB young people were five times more likely to engage in non-suicidal self-injury (NSSI) than their heterosexual peers (Fraser, et al., 2022). Rainbow young people continue to experience significantly higher levels of depressive symptoms, self-harm, and suicidality, compared to their heterosexual peers (Batejan et al., 2015; Hubbard, 2022; Nickels, 2014).

New Zealand-based research focused on transgender health has highlighted similar mental health disparities. Counting Ourselves (Veale et al., 2019) was the first nationally-based health survey for nonbinary and transgender people living in New Zealand, comprising 1,178 survey respondents. Survey results found that 71% of participants aged 15 and older reported high or very high psychological distress compared with only 8% of the general population in Aotearoa (He Ara Oranga, 2018). Counting Ourselves also found that 67% of participants had experienced discrimination at some point in their life, which is more than double the rate for the general population (Veale et al., 2019). Although causal relationships cannot be drawn, it is clear the trans community in Aotearoa continues to experience minority stress, which likely contributes to experiences of mental distress. Counting Ourselves launched their second national survey in 2022, with results due to be released in 2023. Unfortunately, no comparative studies have been conducted yet between trans and cisgender youth populations in Aotearoa. More research is needed that focuses specifically on transgender experiences of mental distress and accessing mental health services.

Due to the health disparities rainbow young people experience, there are a number of policies and recommendations in place to help improve mental health outcomes. The New Zealand Ministry of Health (2019) Suicide Prevention Strategy for 2019-2029 suggests that LGBTQ+ people be a priority population due to the significantly higher rate of suicide compared with the rest of the Aotearoa population (New Zealand Ministry of Health, 2019). Furthermore, a wide range of researchers, professionals, organisations, and groups, all of whom work in rainbow mental health and wellbeing across communities in Aotearoa, submitted a Mental Health and Addiction Inquiry to the New Zealand Government (He Ara Oranga, 2018). The submission calls on the New Zealand Government to prioritise the rainbow population in all national and regional

addiction and mental health policies. The submission reports that rainbow people have mixed experiences of mental health and addictions services in New Zealand and higher rates of mental distress and health issues than cis and heterosexual New Zealanders (He Ara Oranga, 2018). The report makes several recommendations for change, such as increasing funding for research and learning, increasing training and professional development for mental health professionals, developing streamlined appropriate referral pathways, and expanding community resources to include rainbow issues at all levels of policy, and service delivery (He Ara Oranga, 2018), all of which are discussed further in the literature review.

Access and Experiences of Services in New Zealand

Very little research exists investigating rainbow youth experiences accessing mental health services in New Zealand. The Youth 2012 survey (T. Clark et al., 2013) found that among high school students, 35.2% of gay or bisexual students and 39.2% of transgender students wanted to see a health professional in the past year but were unable to, compared to 17.6% of their peers. Despite the paucity of New Zealand-based research, there have been a few seminal studies that closely reflect international findings and describe the current understandings of LGBTQ+ youth experiences of accessing and utilising mental health services in Aotearoa. The limited research that does exist on rainbow service user experiences all identified common themes: rainbow people shared numerous barriers to accessing mental health services, and when they were able to access services, experiences were varied.

Barriers to Accessing Services

Youth experience numerous barriers to accessing mental health care in Aotearoa. Some of these barriers are applicable to all youth, while others are specific to those holding LGBTQ+ identities. Combined, they illustrate the very real challenges rainbow young people face in accessing appropriate mental health care.

Barriers to accessing mental health care in Aotearoa identified across studies broadly included systemic issues and circumstantial obstacles such as age, lack of transportation, and finances (Brown et al., 2016; Cupina, 2007; Fraser, 2020; Fraser, et al., 2022; He Ara Oranga, 2018; Tan et al., 2021; Theodore et al., 2022). In New Zealand, psychologists may work with a child under the age of 16 without parental consent if the young person is considered to have sufficient understanding to make their own informed decision (New Zealand Psychologists Board, 2017); however, many young people do not seek support due to perceived social stigma and lack of knowledge about rights to confidentiality (Radez et al., 2021). Those that do attempt to access support reported difficulties with referral pathways (e.g., unsure how to get referred to mental health services), long waiting times of six months to two years for public services (Arthur-Worsop, 2016; Broughton, 2016; He Ara Oranga, 2018), and difficulty meeting the criteria for publicly funded mental health support (Elliott, 2017). Young people that are able to access publicly funded mental health services face limited sessions which have been described as insufficient for providing adequate support (Elliott, 2017). Many young people would rather bypass the public system; however, young people tend to depend on their parents for financial support and transportation. This may limit their ability to access mental health care independently (Fraser, 2020; Out Loud Aotearoa, 2018).

In addition to the above common barriers, rainbow young people described challenges with accessing services related LGBTQ+ identity which echoed international findings (Fraser, 2020; Mays & Cochran, 2001; Zullo et al., 2021). Numerous studies have evidenced perceived stigmatization and discrimination for being a member of the rainbow community as a barrier to accessing care Fraser, 2020; Fraser et al., 2018, 2022; He Ara Oranga, 2018; Lucassen et al., 2015; Mariu et al., 2012). Rainbow young people

seeking mental health care have stated the importance of services being LGBTQIA+ friendly (Fraser, 2020; Out Loud Aotearoa, 2018). However, very few mental health services explicitly advertise themselves as such (Fraser, 2020), and those that reported high volumes of demand found it hard to meet (Kondou, 2017). Rainbow young people also reported a lack of clarity about their rights to confidentiality and worries about whether their rainbow identity and mental health difficulties would be disclosed to their parents/caregivers (Fraser, 2020). These concerns were even more relevant to under 16-year-olds; challenges associated with gender and sexuality can begin long before the age of 16 (Reitman et al., 2013), meaning young people that are not out to their parents or do not have parental support to access services may avoid getting support.

Positive and Negative Experiences with Services

Research suggests mental health providers can help foster more effective services which reduce alienation, distress, and trauma by being welcoming, safe, and respectful of rainbow individuals (Fraser, 2020; Fraser, et al., 2022; Zullo et al., 2021). Unfortunately, this does not guarantee a positive therapeutic experience. The majority of research conducted in Aotearoa with rainbow young people indicates dissatisfaction with mental health support (Fraser, 2020; Fraser et al., 2018; Fraser, et al., 2022; He Ara Oranga, 2018; Tan et al., 2021; C. Wilson & Cariola, 2020),

Out Loud's (2018) thematic analysis of experiences during service use conferred with Fraser's (2020) findings, equating identity with illness, a lack of strengths-based approach as well as holistic views on mental distress, and gatekeeping and inappropriate crisis response were echoed across participant responses. These negative experiences made participants feel like they had to find their own way and that services caused more harm than good. It wasn't all negative, however, with a minority of participants describing positive experiences with services. These experiences were characterised by feeling valued, accepted, and equipped with skills to cope effectively with the challenges they were experiencing. All the above studies were based in

major cities, and little is known about access to and experiences of mental health services for rainbow youth residing in rural locations. Systemic changes within the health system must increase access to mental health services for queer youth (K. Wilson, 2013).

Referral Pathways and Existing Rainbow Services

Currently there is no national strategy in place for a rainbow (including gender-affirming) referral pathway (He Ara Oranga, 2018; (Te Aka Whai Ora - Māori Health Authority, Te Whatu Ora - Health New Zealand, 2022). This is problematic as research shows that access to affirmative and timely mental health care reduces depression and suicidality in rainbow people (Birkenhead & Rands, 2012; Case & Meier, 2014; Lucassen et al., 2015). Aotearoa has a national health body, Te Whatu Ora/Health New Zealand, which oversees many public mental health services across the regions (Te Aka Whai Ora - Māori Health Authority, Te Whatu Ora - Health New Zealand, 2022). Te Whatu Ora is currently developing consistent referral pathways for mental health services. Very few rainbow-specific mental health services exist in Aotearoa. (Te Ngākau Kahukura, 2023).

To my knowledge, Outline, which primarily offers peer support over the phone, is the only service that provides free specialist mental health support for rainbow people (Outline, 2022), For gender-affirming care, PATHA provide the guidelines for best practice care in New Zealand (Oliphant et al., 2018). These guidelines recommend gender diverse individuals access hormones through general practitioners rather than endocrinologists (Oliphant et al., 2018), enabling quicker access to care. Numerous private practices specialise in rainbow mental health; however, as previously discussed, these services are often inaccessible for young people due to the high cost of services and at times, lack of parental support (Brown et al., 2016).

Despite the lack of a nationally consistent pathway, some regions have chosen to establish a pathway for gender-affirming healthcare, such as Auckland (Health Point, n.d.). Hopefully, this will lead the way for smaller regions to follow suit. Funding has increased for rainbow services - the government announced a $4.6 million funding package in 2021 for rainbow mental health, $3.2 million of which was awarded to two rainbow youth focused organisations (InsideOUT, 2021; RainbowYOUTH, 2021). An additional $600,000 was put aside for rainbow competency training for mental health and addiction professionals (Further $600k, 2021). The increase in funding and services is positive, and with better coordination through a referral pathway, rainbow young people will hopefully have easier and more timely access to rainbow-specific mental health services.

Despite the paucity of publicly funded rainbow-specific mental health care, there are numerous community-based organisations that provide peer support and other non-clinical services for rainbow young people (Te Ngākau Kahukura, 2023a; Te Ngākau Kahukura, 2023b). These community organisations can hold space for positive connections with other rainbow people, which has been demonstrated to support the well-being of LBGTQ+ identifying people (He Ara Oranga, 2018). There are also several national services that provide education and resources, as well as workplace training. RainbowYouth give specific support to resourcing schools, medical centres, hospitals, marae, and community centres with rainbow education materials in rural localities; InsideOUT helps support rainbow young people through schools and communities as well as government funding to provide rainbow competency trainings to healthcare providers; Gender Minorities Aotearoa and Intersex Trust Aotearoa both provide education, resources, and peer-support for gender and sex minorities.

Although it is heartening to see so many organisations dedicated to supporting LGBTQ+ people and youth, research indicates that rainbow young people rely heavily on the community for mental health support, shifting responsibility from mental health providers and specialists to

community organisations that lack funding and expertise (Fraser, 2020). The skill shortage of mental health providers, especially those with adequate rainbow competency training, is a critical issue for rainbow communities in Aotearoa (Deguara, 2019).

Barriers to Access in a Rural Context

Rainbow youth who live in rural locations are particularly underserved by mental health services in Aotearoa, which is concerning as they may be especially vulnerable to discrimination, stigmatisation, and experiencing mental distress (Edwards & Van Roekel, 2009; Whitehead et al., 2016; Willging et al., 2006a). One consequence of discrimination and marginalization in rural locations may be the migration of rainbow people to urban areas. Indeed, (Fraser, 2020) found that participants from small towns chose to relocate to larger cities for safety and acceptance reasons. Fraser (2020) suggested queer people, especially youth, residing in smaller towns and rural areas would be an important target for future research, as their mental health support needs and barriers to accessing appropriate support may be unique and varied compared to those living in cities. Importantly, no research has been conducted with clinicians working in rural New Zealand locations to assess their experiences working with LGBTQ+ youth and what support they might need to serve this community better. Research on queer youth residing in rural locations may aid the development of resources and training materials for mental health professionals working with this vulnerable population.

RainbowYOUTH launched a project titled Your Story Matters (2020) aimed at giving voice to rainbow youth living in rural locations, as smaller towns can be places where LGBTQ+ identities are silenced, ridiculed, or erased altogether. The project aimed to foster connections between LGBTQ+ youth and allies by sharing personal narratives of queer life in small towns with a larger audience and acknowledged the unique challenges queer youth living rurally face in Aotearoa. The stories are published on the

Rainbow Youth website (I'm Local Project, 2016), and the project is ongoing with an open invite for rainbow young people living rurally to share their own stories. Researchers can learn from this — several stories on this mention the challenges associated with living rurally as a rainbow person (e.g., bullying, lack of queer community and associated supports, etc.).

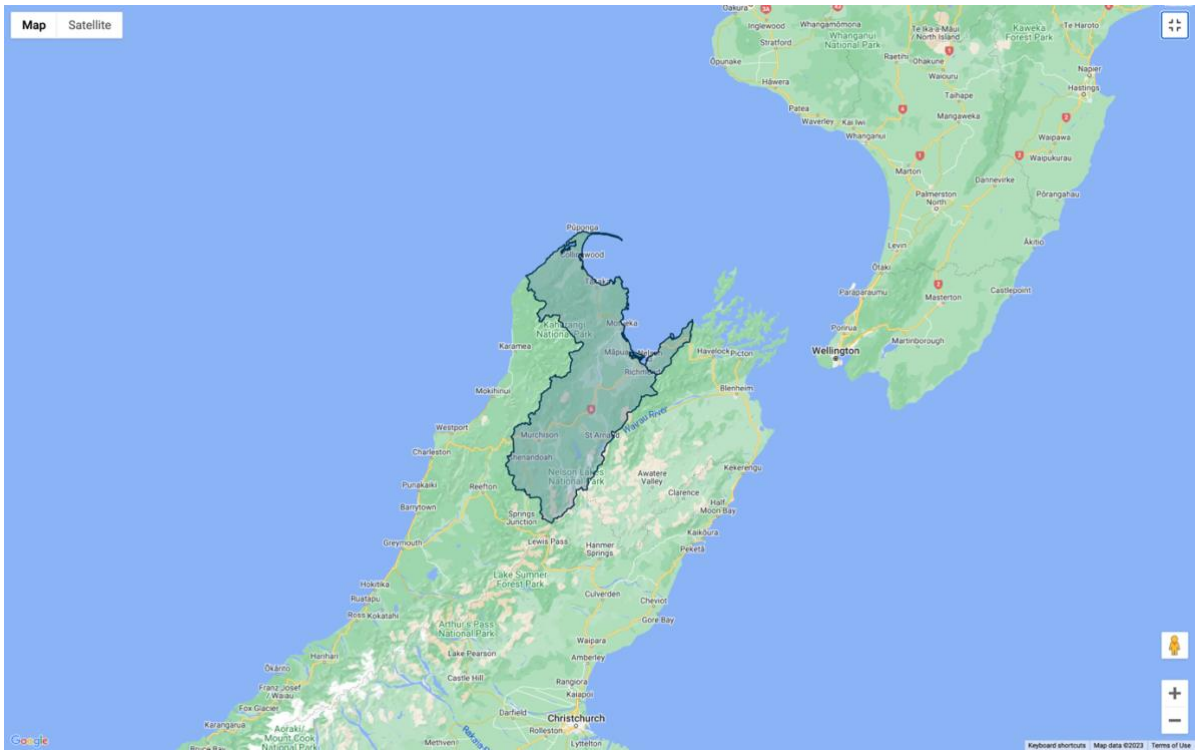
Nelson/Tasman as a Case Study

The Nelson/Tasman region stood out as an excellent location to conduct the study due to the rural positioning away from any major cities. As a member of the Nelson rainbow community myself, I was well positioned to conduct community-based research with the aim of producing results that could be applied to making practical changes to how rainbow youth mental health services are delivered in the region.

The Nelson/Tasman region is part of Te Tau Ihu or the top of the South Island of New Zealand. Nelson/Tasman has a combined resident population of 113,200 (Infometrics, 2023a) and is comprised of numerous rural communities and townships across a large geographic area (see Figure 1).

Figure 1

Recruitment Distribution Map



Note. Base image taken from Google Maps.

The Nelson/Tasman region has one main town (Nelson) with a population of 50,880 (Stats NZ Tatauranga Aotearoa, 2018). As of the 2020 census, 21.5% of the Nelson region population were aged between 15-24 years of age (Stats NZ Tatauranga Aotearoa, 2018). According to Statistics New Zealand (Stats NZ Tatauranga Aotearoa, 2021a), 3.2% of people in the Nelson/Tasman region identify as a gender, sex, or sexual minority. Statistics also indicate that young people (statistics are not gathered for people under 18) make up the largest proportion overall of rainbow people in Aotearoa, and thus likely in Nelson/Tasman as well (Stats NZ Tatauranga Aotearoa (2021a).

The Nelson/Tasman region has a poor record for providing rainbow-affirming mental health services for youth. The region received national attention for anti-rainbow

mental health services twice in 2022 alone (Dine, 2022; Hubbard, 2022). In June, a self-labelled counsellor who did not hold any professional registration was called out for refusing to stop providing so-called "conversion therapy" despite a national ban on the practice (Dine, 2022). Then, in August, an organisation called the Child and Adolescent Therapy Association, comprised of a handful of registered counsellors, ran a one-day conference titled, 'Children, Adolescents and Gender – Negative impacts of transgender ideology.' The conference featured talks such as "The Strange Rise of the T and the disappearing L — the history of transgenderism and its erasure of lesbians and gays." Despite media backlash (Hubbard, 2022) as well as repudiation from professional bodies like the New Zealand Association of Counsellors (New Zealand Association of Counsellors, 2022), the conference proceeded and recorded lectures were subsequently distributed throughout health professional networks (personal communication, October 20, 2022).

Given this troubling climate for rainbow youth, as well as the understudied challenges of providing services to rural rainbow young people, the Nelson/Tasman region is an important location for research that seeks to understand (and ultimately improve) mental health access for rainbow young people.

Research Problem

As described above, rainbow youth in Aotearoa are at greater risk of mental distress (e.g., depression, anxiety, substance abuse, NSSI and completed suicide) (Budge et al., 2013; Cochran & Mays, 2000; Mikalson et al., 2012; Nickels, 2014; C. Wilson & Cariola, 2020; Zullo et al., 2021) and seek mental health support more frequently than their heterosexual and cisgender peers (Benson, 2013; Berg et al., 2008; McNair & Bush, 2016). However, they experience numerous barriers to care (Gulliver et al., 2010; Hoffman et al., 2009; Macapagal et al., 2017; Mayer et al., 2008; McIntyre et al., 2012; McNair & Bush, 2016; Safer et al., 2016; Whitehead et al., 2016), and when they are able to access services, their experiences are often mixed

(Anderson, 2020; G. Fraser, 2020; Hiestand et al., 2008; Israel et al., 2008; Simeonov et al., 2015; Veale et al., 2017; Welch et al., 2000). No research has been conducted specifically on rainbow young people living in rural areas and their utilisation of mental health services, which means efforts to improve rainbow mental health care in these areas are not currently guided by research.

In this thesis, I used a mixed method approach (youth survey, clinician survey, interviews with youth) to examine rainbow young people's experiences of mental health support in a rural New Zealand community – specifically, the Nelson/Tasman region. This approach was selected in order to: 1) gain a larger snapshot of barriers to care both from the perspective of the clinician and the client via quantitative survey results, 2) explore and honour the unique experiences and identities of queer young people accessing mental health support in rural and semi-rural localities through semi-structured interviews, and 3) take an intersectional approach, which can better account for how different identities interact and thus influence mental health support experiences. Through this mixed approach, I hope that training and resources for mental health professionals can be more targeted, tailored, and specific to this vulnerable population's needs. I also want to allow space for my participants to share what they feel is essential and true to them, as their voices have largely been absent from the academic discourse on rainbow mental health in New Zealand thus far.

Research Aims and Questions

My research aims to investigate perceived and actual barriers to healthcare (mental health in particular) for rainbow youth outside of major cities, specifically within the Nelson/Tasman region. It is organized into three main aims with nine hypotheses.

Research Aim 1: Explore rainbow young people's experiences with health care providers in Nelson/Tasman.

1. What are rainbow young people's experiences with mental health providers (e.g., general practitioners, mental health professionals, youth workers, social workers etc.) in the Nelson/Tasman region?

Hypothesis 1 (H1): Based on the existing literature showing high levels of mental health support seeking from rainbow people, my hypothesis was that the majority of rainbow young people would have attempted to access support.

2. What level of quality and satisfaction do rainbow young people report when receiving mental health support?

Hypothesis 2 (H2): Based on existing literature evidencing mixed experiences with services and considering the recent anti-LGBTQ+ activity in Nelson/Tasman region, I hypothesized that rainbow young people would have poor satisfaction with mental health services.

3. What are clinicians' experiences with rainbow young people in the Nelson/Tasman region, and how do these experiences compare to those of rainbow young people in Nelson/Tasman?

Hypothesis 3 (H3): Based on international literature evidencing heteronormativity and cisnormativity in healthcare settings, as well as rainbow young people's reluctance to be out as LGBTQ+ in health settings, I hypothesized that clinicians would have some experience working with rainbow young people; however, they might initially be unaware of their rainbow identity.

4. What level of comfort and competence do clinicians hold when working with rainbow youth clinicians?

Hypothesis 4 (H4): I hypothesized clinicians would feel a lack of comfort and competency with this population based on the lack of available rainbow competency training in Aotearoa and based on international research evidencing health providers don't feel they get rainbow competency training across a broad range of professions.

Research Aim 2: Investigate what barriers to receiving mental health support rainbow young people experience in the Nelson/Tasman region.

5. What awareness of and access to specific providers that are rainbow-affirming do rainbow young people have in Nelson/Tasman?

Hypothesis 5 (H5): Although there is no existing literature, due to no current rainbow mental health referral pathway existing and no advertising for rainbow-affirming services, I hypothesized that rainbow young people would have little awareness of LGBTQ+ affirming services or providers in the Nelson/Tasman region. However, as I am a member of the rainbow community in Nelson, I do know that word-of-mouth is a common way to learn of affirming services or people, and so I hypothesized that if rainbow young people did know of providers, it would be through word-of-mouth.

6. What is rainbow youth awareness of and access to non-traditional sources of mental health support specific to the rainbow community (e.g., pride groups, LGBTQ+ friendly youth organisations) in Nelson/Tasman?

Hypothesis 6 (H6): I hypothesized that rainbow young people residing in more isolated locations within the Nelson/Tasman region (i.e., outside of Nelson) would have little to no access to non-traditional sources of mental health support, but those residing in or near Nelson would have some support through local pride groups.

7. What are the perceived and actual barriers for rainbow young people accessing healthcare in the Nelson/Tasman region?

Hypothesis 7 (H7): I hypothesized that rainbow young people would report numerous perceived and actual barriers to accessing mental health support, and that these barriers would be similar, however, actually experienced barriers might be slightly fewer due to difficulty with getting into services as noted by academic literature and government reporting in Aotearoa. Based on previous academic literature in Aotearoa

and abroad, I hypothesized perceived and actual barriers would include general barriers (e.g., long waiting lists, lack of available services, cost, transportation) and queer-specific barriers (e.g., fear of LGBTQ+ identity being misunderstood, lack of knowledge about confidentiality rights, lack of rainbow-specific services etc.).

8. What are the perceived barriers for rainbow young people accessing healthcare from the clinician's perspective?

Hypothesis 8 (H8): I hypothesized that perceived barriers for rainbow young people accessing healthcare from the clinician's perspective would be similar to those reported by rainbow young people.

Aim 3: Investigate recommendations from both rainbow young people and health professionals to improve the provision of mental health support for rainbow young people residing in the Nelson/Tasman region.

9. What recommendations do rainbow young people and clinicians must improve access to and quality of mental health services for rainbow young people in the Nelson/Tasman region?

Hypothesis 9 (H9): I hypothesized that both rainbow young people and clinicians would recommend increased resourcing for mental health services which would include funding and rainbow competency training. I also hypothesized that rainbow young people would want a dedicated rainbow youth mental health service to improve the provision of mental healthcare in the Nelson/Tasman region.

Chapter 3:Methodology

Research Design

Mixed methods research integrates quantitative and qualitative methods within a single project (Johnson & Onwuegbuzie, 2004). The goal of using mixed methods is to maximise the strengths of each research method and minimise the weaknesses (Creswell & Plano Clark, 2007). I quantitatively surveyed queer young people and clinicians residing in the Nelson/Tasman region to complement the qualitative research with generalisable findings that can be used to inform mental health care in Nelson/Tasman. The quantitative survey data provided a useful bigger picture of queer experiences of mental health services which could not be achieved by interviews alone. Qualitative research has been critiqued for its inability to generalise to a larger population and potential bias for the researcher (Carr, 1994). The qualitative interview data produced rich data which was nuanced and provided more depth than the surveys alone. Combined, they provided a more in-depth exploration of queer youth experiences of mental health services than either method could have on its own.

Both the quantitative and qualitative methodologies are grounded in community-based research. This is a collaborative approach to research that aims to directly benefit the community that is being studied (Israel et al., 2008). My research took place within the Nelson/Tasman community, and I spent a great deal of time working with the community on this project. I worked closely with my workplace, Whanake Youth, Q Youth (the local rainbow drop-in centre) as well as with numerous teams and individuals within Health New Zealand (Te Whatu Ora). I spoke to dozens of community organisations and met with most high school pride groups in the region.

Due to limitations of a masters' thesis (e.g., scope, timeframe), the project was ultimately research-led rather than properly community-partnered (Wallerstein & Duran,

2006), however, I hope the project embodied these values, nonetheless. I still wanted youth voices and perspectives to be front and centre in my research, so I included qualitative interviews with rainbow youth as stakeholders and experts in their own lived experiences.

The study design consisted of two short surveys — one for rainbow young people residing in Nelson/Tasman, and one for clinicians working with youth in Nelson/Tasman, and ten follow-up interviews with rainbow young people. The youth survey was based on Fraser's (2020) survey for rainbow young people as part of her dissertation, and the clinician survey was designed to mirror the youth survey so that a comparative analysis could be carried out between data sets. The follow-up interviews were also based on Fraser's (2020) interview guide and offered participants an opportunity to expand upon the survey questions. All interview participants first completed the survey.

Pre-Recruitment & Whakawhanaungatanga

This research project being community-based, whakawhanaungatanga was central to the recruitment process for both rainbow youth survey participants and clinician survey participants and provided a deep sense of joy for me as a queer researcher residing in the Nelson community. Whakawhanaungatanga (i.e., the process of building relationships and connections) helps to engage research participants and build trust, especially for Māori, who have historically been harmed by academic research (Forster, 2003). Prior to beginning recruitment, I focused on building relationships with key organisations in the Nelson/Tasman region that were youth-focused, rainbow health-focused, or both, including: Te Whatu Ora, Infant and Child Adolescent Mental Health Services, Inside Out, and Q Youth, and local iwi. This included letting them know the intentions of the research project and provided an opportunity to discuss the research design, aims, and field any questions or concerns prior to collecting data. Their feedback was incorporated into the final design of the surveys and interview questions.

Recruitment

Once ethical approval was gained, recruitment was carried out via email, social media, and in-person visits to organisations. All email and social media recruitment contained information sheets for both participant groups (rainbow young people and clinicians - see Appendix). Recruitment began on August 2, 2022 and finished on September 29, 2022. I emailed all major health organisations that worked with youth in the region, including Te Whatu Ora and Nelson Bays Primary Health, numerous smaller organisations, and large private practices such as The Nelson Clinic. Inside Out distributed research flyers to all public secondary schools in the Nelson/Tasman region. In total, I emailed roughly 40 organisations (see Appendix). In addition to emails, I recruited through social media — both my personal Facebook and Instagram, my Whanake Youth Instagram account, and through the Nelson and Motueka Community Groups, which have combined 40,000+ members.

Recruitment Strategy

To maximise participation, every email sent was personalised, and provided information sheets and flyers tailored to both participant types. Further, every email included an offer for me to come and speak with student groups (or staff groups) about the research. I received responses from most organisations emailed, including confirmation from the Chief Executive of Nelson Bays Primary Health and Te Whatu Ora (Health NZ Nelson/Marlborough) that they emailed my research participation request to their contacts including all local GP practices, mental health, and addiction services, ICAMHS, rural community health centres, and the Nelson Hospital. In addition, Dr. Gloria Fraser, advertised my research at the end of her three lectures hosted by Massey University.

I visited a mix of youth organisations and pride groups (such as Q Youth, high schools, and the Nelson Marlborough Institute of Technology), as well as health providers such as Te Whatu Ora and Nelson Bays Primary Health (See Appendix). I met with several pride groups including high school pride groups and youth centres, as well as with staff at these organisations. As a result of the community whakawhanaungatanga process, an article was published about my research in the local newspaper, which likely aided in recruitment as well (Chin, 2022). By the end of the recruitment phase, young people, schools, and other organisations were reaching out to me about this research, suggesting that my recruitment strategy was successful and that we reached saturation in our target community.

Community-based research can bring wider benefits to the community outside of the research project. Due to the whakawhanaungatanga process and building a relationship with Te Whatu Ora, I was invited to participate in an 'Unconference' aimed at establishing a transgender healthcare pathway for the Nelson/Tasman region with more than 80 local health professional attendees. I introduced my research and invited them to participate, with links to the flyers and information sheets provided to all attendees. As a result of the Unconference, a future collaboration with Te Whatu Ora was formed, and they requested to use the data to improve their services. This is further discussed in the ethical considerations.

In addition to recruiting via health and youth organisations, I spoke with several politicians, including Nelson City Councillors, Rachel Boyack (Labour MP for Nelson/Tasman), Jan Tinetti (Minister of Education), and Andrew Little (Minister of Health) about rainbow youth mental health needs in our region. Several rainbow youths attended the meeting and were able to share their experiences with mental health services. I requested they all share my research with their Nelson/Tasman contacts, to which they all agreed, and I feel confident that my research was thoroughly distributed throughout the Nelson/Tasman region.

Interview Participant Recruitment

As part of the youth survey, participants had the option to indicate whether they would be interested in completing a follow-up (45-60) minute interview to describe their experiences accessing mental health services in the region in more depth. I had aimed to interview 5-10 participants as that seemed feasible within the scope of the study. Seventeen participants requested to be interviewed, and of those, 10 interviews were completed (with the first people to confirm their availability for an interview selected as participants). Recruitment for interview participants was linked through the youth survey. Interviews were carried out over a three-week period — starting on August 18, 2022 and finishing on September 6, 2022. Of note, during the three-week period in which interviews were conducted, there was a flooding civil emergency in Nelson that displaced many families from their homes, closed roads and schools, and halted public transportation. Despite these significant barriers, I was able to conduct all 10 interviews in person.

Participants

Eligibility Criteria

The study had three participant pools: youth survey respondents, health professional survey respondents, and interview participants. The eligibility criteria for each participant pool are described below.

Youth participant eligibility criteria: aged between 16-24 years; identify as lesbian, gay, bisexual, transgender, queer, nonbinary, genderfluid, takatāpui, or otherwise stated within the rainbow community; currently live in the Nelson/Tasman region; have access to a mobile phone or computer to complete the survey on; have enough comprehension of the English language to complete the survey. I chose these criteria as I felt they were broad enough to enable a diverse range of rainbow young people to be

reached through the research project, but also ensured that participants would indeed have experience with accessing or attempting to access mental health support in the Nelson/Tasman region. My preference was to lower the age range to 14. However, this was not feasible to achieve due to the scope of the thesis and ethical requirements that under 16-year-olds have parental consent to participate in research. The age range of 16-24 is broadly considered as a 'youth' demographic in Aotearoa and abroad and thus was most appropriate considering the research topic and aims.

Young people that met the above criteria, completed the survey, and had either attempted to access or successfully accessed mental health support in the Nelson/Tasman region were eligible to complete a follow-up semi-structured interview. Due to the time constraints of the study, the first 10 eligible youth to respond to a scheduling email for the interviews were selected to complete this part of the study.

Clinician survey participant eligibility criteria: providing mental health services for youth (screening, assessment, treatment, e.g., psychologists, psychiatrists) or referring young people to mental health services (e.g., alternative education providers, GPs, youth workers; currently work in the Nelson/Tasman region. The above eligibility criteria were selected to ensure clinicians had experience working with young people (and thus rainbow young people) in the Nelson/Tasman region but were broad enough to encompass a wide range of clinicians from different professional health fields.

Sample Size Estimation

I aimed to collect 50 youth survey responses, 50 clinicians survey responses, and between 5-15 interviews with rainbow young people.

These estimates were calculated based on census data describing the Nelson/Tasman population. According to Stats NZ, Nelson/Tasman has a population of approx. 104,000 and

around 10.4% (*n* = ~10,816) of those are aged 15-24 years.[1] The latest Household Economic Survey found that 4.2% of NZ adults identify as LGBTQ+ (Stats NZ Tatauranga Aotearoa, 2021a). Since no estimates of rainbow prevalence among New Zealand youth exist, we used this adult rate (4.2%) to estimate that 454 of the 10,816 youth in the Nelson/Tasman region identify as rainbow (Olsen, 2022). Therefore, by sampling around 50 youth, we were sampling ~1 in 9 rainbow youth in the Nelson/Tasman region, which is a high sampling rate. Given that many rainbow people do not identify as such until adulthood, it is likely that fewer than 454 youth in the region identified as LGBTQ+ at the time of sampling. Thus, 1 in 9 was an underestimate of our sampling rate.

It was harder to know how many health professionals would meet the eligibility criteria in Nelson/Tasman as national or regional statistics are not collected on the number of health professionals who provide and/or refer youth to mental health services. However, given that we wanted to compare responses to similar questions between youth and health professionals, we aimed to recruit the same number of participants.

Youth Demographics

More than twice the anticipated number of youth participants began the youth survey (*N* = 125); 19 participants were excluded due to being under 16 years of age, and a further 12 were excluded because they lived outside of the Nelson/Tasman region. A further 13 participants were excluded due to predominately incomplete survey responses. This led to a final youth survey sample size of 81 (see *Figure 2* for a visual depiction of

[1] Data were not provided with enough specificity to allow us to calculate statistics for 16–24-year-olds specifically.

the distribution of survey participants across the Nelson/Tasman region). Participants had a mean age of 17.54 years (SD = 2.02), and the plurality lived in the city of Nelson (28.4%). Nearly half of the participants (48.5%) identified as non-binary, and 16% identified as polyamorous. Key characteristics included the above, as well as ethnicity and other identities to provide a more intersectional understanding of the sample. Additional demographic characteristics are described in Table 1. It is important to note that participants were able to self-describe their gender and sexuality in an open text box. Table 1 presents these self-described identities, which were wide-ranging.

Table 1

Demographic Characteristics of the Youth Survey Sample

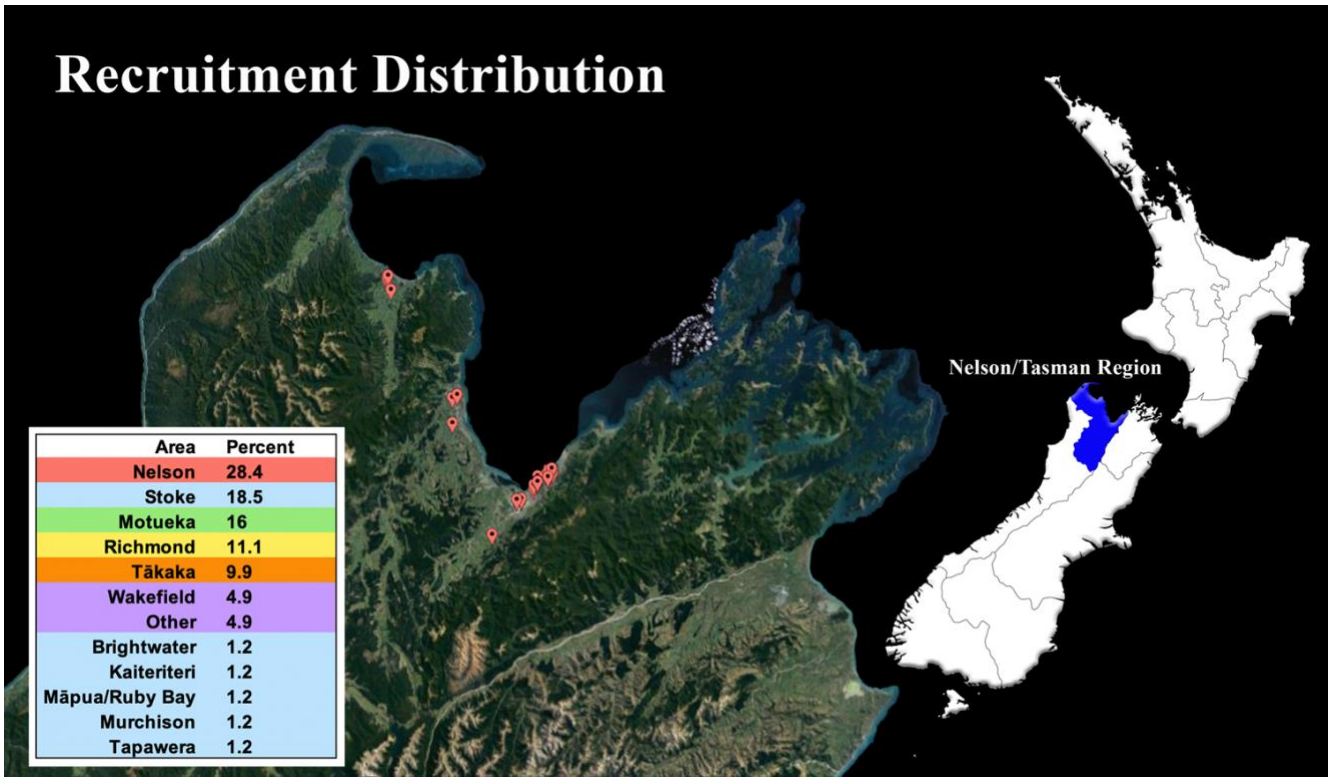
Demographic variable	%
Age	17.54 (2.02)
Region of Nelson/Tasman	
Brightwater	1.2%
Kaiteriteri	1.2%
Māpua/Ruby Bay	1.2%
Motueka	16.0%
Murchison	1.2%
Nelson	28.4%
Richmond	11.1%
Stoke	18.5%
Tākaka	9.9%
Tapawera	1.2%
Wakefield	4.9%
Other	4.9%
Sexual orientation	
Rainbow	97.1%
Androsexual	1.2%
Aromantic	3.7%
Asexual/Ace	6.2%
Bisexual	26.0%
Demisexual/Demiboy	2.5%
Gay	12.3%
Girls/non-binary	2.5%
Heterosexual	1.5%
Homosexual	1.2%
Lesbian	3.7%
Omnisexual	1.2%
Panromantic	1.2%
Pansexual	14.7%
Polyamorous	1.2%
Queer	11.0%
Unlabeled	4.9%
Unsure	4.9%
Other	1.2%

Variable	
Gender (cisgender vs transgender)	
Cisgender	32.4%
Agender	2.4%
Demi boy	1.2%
FTM trans man	8.4%
Gender fluid	6.0%
Gender queer	3.6%
non-binary	24.0%
MTF trans	1.2%
Woman lite	1.2%
Unsure	2.4%
Other	1.2%
Gender (binary vs nonbinary)	
Binary	41.2%
Nonbinary	48.5%
Neither	8.8%
Unsure	1.5%
Intersex	2.9%
Ethnicity	
British	7.4%
New Zealand Māori	13.6%
Pākehā	72.8%
Other	7.4%
Iwi	
Ngā Puhi	2.4%
Ngāi Tahu	1.2%
Ngāti Rakawa	1.2%
Te Arawa, Taranaki	1.2%
Te ātihaunui I a Pāpārangi	1.2%
Other identities	
Low socioeconomic status	9.8%
Neurodiverse	40.7%
Non-monogamous and/or polyamorous	16.0%
Physically disabled	6.1%
Religious	6.1%
Sex worker	2.5%
Other (listed at bottom of table)	2.5%

Note: M (SD). For region of Nelson/Tasman, “other” includes Māpua, Nelson South, Tāhunanui, and The Maitai. Other sexual orientations included, “gay/pan but not fully gay like I hate most men but sometimes I sleep with them as a form of self-harm and maybe like them a bit but couldn’t date one”. Other identities included: questioning and anxious; physically disabled/neurodiverse; religious; previously homeless and on the benefit. For gender, "other" includes: "a woman but only feminine in the same way Harry Styles is and occasionally wants to feel like a forest fairy but a boy forest fairy." Other ethnic identities include Scottish, Spanish, Scandinavian, Jewish, Israeli, Rotuman, South African. Other regions of Nelson/Tasman included: Māpua, Nelson South, Tāhunanui, The Maitai.

Figure 2

Distribution of Youth Participants Throughout the Nelson/Tasman Region



Note. Base image taken from Google Maps.

Clinician Participant Demographics

Sixty-two health professionals attempted to complete the survey (N = 62); 6 participants were excluded because they did not provide or refer to mental health services, and 4 were excluded because they did not work with youth. A further 8 were excluded for predominately incomplete survey responses. This led to a final clinician survey sample size of 44.

Participants ranged in profession, with the largest professional group being nurses (27.3%). Social workers were the next largest group at 13.6%, with general practitioners and psychologists following at 9.1% each. 50% of clinician survey respondents worked in either a general practice or youth organization setting (see Table 2). On average, respondents reported 10.9 client contact hours with young people per week.

Additional demographic characteristics of the sample are described in Table 2.[2]

Table 2

Demographic Characteristics of Health Professional Participants

Variable	%
n	44
Profession	
Not a health professional	6.8%
Counsellor	2.3%
Psychologist	9.1%
Therapist/Psychotherapist	2.3%
School counsellor	2.3%
Social worker	13.6%
General practitioner	9.1%
Other health professional	52.3%

[2] Age and ethnicity were not collected because they were not relevant or necessary to comparative data between youth and clinician participants. Additionally, I didn't want to discourage clinicians from responding by providing personal identifiable information. Furthermore, I recognized that clinicians tend to be short on time and I wanted to keep the survey as brief as possible to encourage completion of the survey.

Art therapist	2.3%
Crisis mental health nurse	4.7%
Kaupapa Māori whanau navigator	4.7%
Nurse	27.3%
Youth AOD clinician	2.3%
Youth worker	4.7%
Other medical doctor (youth nurse)	2.3%
Service provided	
Provide mental health services	63.6%
Refer mental health services	70.5%
Work schedule	
Full-time	56.8%
Part-time	43.2%
Workplace Setting	
General practice	25.0%
Private practice	9.1%
Hospital setting	2.3%
DHB	4.5%
Youth organisation	25%
Secondary school	20.5%
Te Piki Oranga	6.8%
Community centre	9.1%
Community-based health service	4.5%
ED	2.3%
Nelson Bays Primary Health	4.7%
Ministry of Education	2.3%
Animal assisted therapy NGO	2.3%
Te Whare Mahana (Dialectical Behaviour Therapy service)	2.3%
Sexual violence service	2.3%
Social service	2.3%

Interview Participant Demographics

The final interview sample (n = 10) was diverse. Participants' ages ranged from 16-21 (*M*=18). Participants endorsed a range of Rainbow sexual orientations, including queer (*n* = 4), gay (*n* = 2), bisexual/queer (*n* = 1), takatāpui/gay (*n* = 1), lesbian (*n* = 1), asexual (*n* = 1), and demiromantic/asexual (*n* = 1). At the time of data collection, participants described their gender as follows: trans-male (*n* = 4), trans (*n* = 1), cis female (*n* = 2), cis-male (*n* = 1), trans-masc/non-binary (*n* = 1), and non-binary (*n* = 1). Pronouns used were: he/him (*n* = 3), they/them and he/him (*n* = 3) they/them (*n* = 1), she/her *(n* = 2), and he/ze/it (*n* = 1).

Ethnic identities included Māori,[3] Pākehā, Polish, American, and Australians. Two participants were born overseas; however, all participants currently reside in the Nelson/Tasman region and have done so for at least the last 5 years. All participants had accessed mental health services in the Nelson/Tasman region, the majority (*n* = 8) through the public mental health system (ICAMHS). Only two participants' experiences accessing mental health support were primarily through private clinicians.

Other participant identities discussed in the interviews were: self-identified as autistic (*n* = 4), self-identified as likely autistic (*n* = 3), polyamorous (*n* = 6), disabled (*n* = 2), diagnosed with learning difficulties (dyslexia, ADHD, and dyscalculia) (*n* = 2), Catholic/Christian (*n* = 1), and one participant wanted it noted that they were formally a member of a religious cult which influenced their gender identity. Participant demographics are described further in Table 3.[4] The table was included to help readers to contextualise the participants when reading quotes throughout the qualitative results section.

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[3] I have chosen not to report specific iwi affiliations as this could compromise confidentiality of participants.

[4] I have chosen not to report specific disabilities in order to protect the confidentiality of participants.

Table 3

Demographic Characteristics of Interview Participants

Participant	Demographic Characteristics
1	16-year-old; cisgender female; lesbian; Pākeha; disabled; polyamorous
2	18-year-old; transgender (he/him they/them); Pākeha; queer; disabled; polyamorous
3	17-year-old; trans-male; Pākeha; gay; disabled; polyamorous
4	17-year-old; trans-male (they/them and he/him); Australian/Pākeha; queer; polyamorous
5	16-year-old trans-male (he/ze/it); American/Pākehā; gay; disabled; polyamorous
6	16-year-old trans-male (he/him); Pākeha; queer; disabled
7	20-year-old trans-masc/non-binary (they/them); Pākeha; queer
8	20-year-old cis male; Māori; takatāpui/gay
9	21-year-old cis female; Polish/Pākeha; demi-romantic/ace/asexual; Catholic/Christian
10	19-year-old non-binary (they/them); Pākeha; queer demi-bisexual; disabled; formerly a member of a religious cult

Note. These data were collected verbally through the whakawhanaungatanga process at the beginning of the interview.

Quantitative Methods

Measures

I created two measures for the quantitative portion of the research: a youth survey and a clinician survey (see Appendix).

Youth Survey

Background. The youth survey, adapted from Fraser & Bradley's (Fraser, et al., 2022) research exploring rainbow experiences of accessing mental health support in Aotearoa, collected information across five domains: demographics and eligibility, experience with mental health providers, mental health support from rainbow organisations, barriers to accessing mental health support, and recommendations for improving access to mental health services for LGBTQ+ youth in the Nelson/Tasman region.

Fraser & Bradley's (2020) survey included a section solely dedicated to transgender experiences of healthcare services but seeing as this was not the focus of my research, I removed this section from the survey. I also adapted the questions to be relevant only to experiences in the Nelson/Tasman region.

Final Survey. The final youth survey comprised 34 questions across five sections: (a) Demographics and eligibility, (b) Experience with mental health providers (c) Mental health support from rainbow organisations (d) Barriers to accessing mental health support, (e) Recommendations for improving access to MH services for LGBTQ+ youth in the Nelson/Tasman region. Each section is briefly described below, and full question details are provided in Appendix.

Demographics. Eight questions were asked to ensure participants met eligibility criteria, and to capture their gender, sexual orientation, ethnicity, other minority identities they identified with, and whether they identified as intersex. Participants that did not meet eligibility criteria were excluded from completing the survey. The demographics were collected to provide an

intersectional representation of the participants. Questions about sexual orientation, gender, intersex/variation of sex characteristics, and categories for other identities (e.g., neurodiverse, polyamorous, etc.) were taken from Fraser's (2020) survey.

Experience with Mental Health Providers. Five questions were asked about youths' prior experiences with mental health providers, including the number of providers seen, the settings in which they were seen, the type of providers they accessed, and the reasons for accessing support (Fraser, 2020). All these questions were selected all that apply. Three questions asked specifics about how helpful youth rated the clinicians they worked with, how comfortable they felt clinicians were working with youth in general, and how comfortable clinicians were working with queer young people specifically. These questions were based on a Likert-type scale of extremely uncomfortable (1) to extremely comfortable (5). Two open-ended questions asked if rainbow young people knew of any specific rainbow affirming clinicians in the Nelson/Tasman region and how they knew they were rainbow affirming. This section asked questions to help answer H1-H4 which were all focused on experiences of accessing mental health services from both a rainbow young person and clinician perspective. .

Mental Health Support from Non-clinical Settings. One "select all that apply" question asked if youth had received support for mental health from non-health sources (e.g., pride groups, general peer support groups, friends, partners, online platforms, whānau, etc.), and two questions asked youth if they had accessed support from rainbow community organisations in Nelson/Tasman from a list, and to describe in an open-ended response in what ways they had received support from these organisations. This section asked questions to help answer H5 and H6.

Barriers to accessing mental health support. Two questions asked youth to select barriers to accessing mental health support experienced from a list (with an option to write additional information) and rank barriers from least to most significant that they had experienced when attempting to access support. This was followed by one question asking youth to compare the health needs of LGBTQ+ youth to non-LGBTQ+ youth on a Likert-type scale (1= non-LGBTQ+ youth have much higher needs than LGBTQ+ youth; 5= LGBTQ+ youth have much higher needs than non-LGBTQ+ youth). Two questions then asked LGBTQ+ youth to list barriers they thought LGBTQ+ youth specifically face and to rank them from least to most significant. This section asked questions to help answer H7.

Recommendations for Improving Access to MH Services for LGBTQ+ Youth in the Nelson/Tasman Region. Three questions, two of which were open responses, asked youth what could be done to improve LGBTQ+ youth access to mental health support in Nelson/Tasman. One question listed options that youth could select as many as they felt would help. The suggestions listed were a result of previous research, both within Aotearoa and abroad of what barriers existed for rainbow youth attempting to access support (e.g., clear statements on mental health service website about what information will be kept confidential, more telehealth services, clear statements on websites about whether the service is LGBTW+ friendly/affirming, etc.). This section asked questions to help answer H9 .

Clinician Survey

Survey Background. To fully assess the accessibility of mental health services for Rainbow young people in the Nelson/Tasman region, I sought to include the perspectives of health providers in the area who work with this population (either directly or by referring Rainbow youth to mental health services. As Fraser (2020) did not survey mental health professionals, I was unable to use her survey as a template for this purpose. Instead, I designed the clinician survey to mirror questions in the youth survey to ensure a comparative analysis

regarding perceived barriers and accessibility of mental health services could be carried out between participant groups. Given that health professionals are incredibly busy (Campbell, 2017; Deguara, 2019; McAllen, 2017), their survey was designed to be shorter than the youth survey so as to limit the burden on professionals and maximize the potential number of responses.

Final Survey

The clinician survey consisted of 23 questions across 5 sections: (a) Demographics and eligibility, (b) Experience working with youth in general, (c) Experience working with LGBTQ+ youth, (d) Barriers to accessing mental health support, and (e) Recommendations for improving access to mental health services for LGBTQ+ youth in the Nelson/Tasman region. Full question details are provided in Appendix. The clinician survey asked questions to help answer H3, H4, and H8.

Demographics and Eligibility. Four questions were asked to ensure eligibility criteria were met (profession/job, work with young people aged 16-24 years old, provider or refer to mental health services, and do they currently practice in the Nelson/Tasman region — full or part-time).

Experience Working with Youth in General. Four questions asked health professional participants to indicate their professional work setting/s from a list (e.g., GP, schools, community-based health services, other etc.), open-response box of how many young people they work with regardless of frequency, how many contact hours they had with young people aged 16-24, and how comfortable they felt working with young people in general on a Likert-type scale (1= extremely uncomfortable and 5= extremely comfortable). The list of services was determined based on stakeholder mapping of available health services for young people in Nelson/Tasman. A further two questions were asked if the participant selected that they referred to mental health services. These

questions asked how frequently they referred (from a list of options) and an open-response box to list services they had referred young people to.

Experience Working with LGBTQ+ Youth. Six questions were asked in this section about whether they worked with LGBTQ+ youth clients that they knew of (open response), how many contact hours they had with LGBTQ+ youth clients, how comfortable they felt working with them (Likert-type scale question which mirrored the previous section), an open-ended description of what they felt contributed to their comfort levels, and finally how they thought the mental health needs of LGBTQ+ young people compared to non-LGBTQ+ young people (same format as the youth survey). The interview guide was designed to help me address hypotheses relating to youth responses (H1, H2, H4-H8).

Barriers to Accessing Mental Health Support. Four questions asked clinicians select barriers from a list and then rank them for both youth in general and LGBTQ+ youth. These questions mirrored the youth survey so that a comparative analysis could be carried out.

Recommendations for Improving Access to Mental Health Services for LGBTQ+ Youth in the Nelson/Tasman Region. Three questions, two of which were open responses, asked clinicians what could be done to improve LGBTQ+ youth access to mental health support in Nelson/Tasman. One question listed options that clinicians could select as many they felt would help. These questions mirrored the youth survey.

Qualitative Methods

Theoretical Framework

My theoretical framework for the qualitative interview portion of this study is underpinned by queer theory and utilises a combination of mixed methods and community-based research. This theoretical framework reflects my values as a researcher and my beliefs about the nature of knowledge (Lysaght, 2011). Fraser (2020) — whose work serves as a foundation for

the surveys in this thesis — also used this theoretical framework in their interviews with Rainbow people across Aotearoa.[5]

Queer theory originated in poststructuralism and came from the work of scholars such as Michel Foucault, Eve Kosofsky Sedgwick, and Judith Butler (Jagose, 1996). Though it covers a broad area of research, with no singular definition, queer theory generally assumes that knowledge and reality are produced from human experience, which is contextual and subjective (Gavey, 1989). There is no one version of reality; instead, queer theory recognises the importance of background, positioning, and values, which are all influenced by the researcher (Acker, 2001). Queer theory pays particular attention to the taken-for-granted assumptions about identity (Halperin, 2003) and approaches gender and sexuality as potentially fluid and nonbinary (Jagose, 1996). Queer theory recognises gender as something we 'do,' that is, an outward expression of our internal felt state, rather than something we 'are' (Fraser, 2020). Queer theory also challenges what is deemed as 'normal' and 'natural', thus actively working to dismantle heteronormative and cisnormative frameworks (Halperin, 2003). Queer theory embraces intersectional approaches to identity (Fotopoulou, 2012).

Queer theory allows me to work from a queer-affirmative perspective and is a powerful tool for challenging cis and heteronormative constructions of gender, sexuality, and sex characteristic diversity within my research. This theoretical underpinning is critical to understanding participants' experiences of mental health services in this study. Participants' experience of mental health services will be shaped not exclusively by their

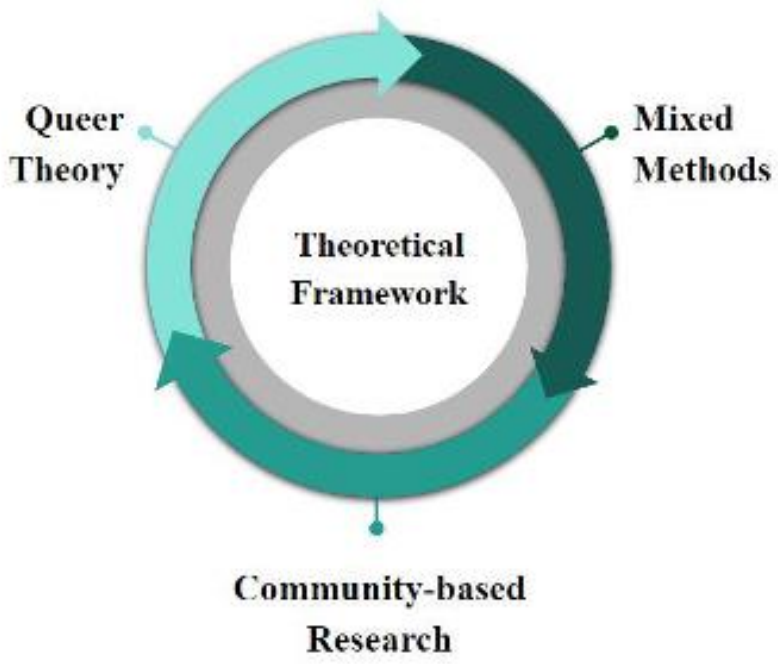
[5] I have spoken with Fraser & Bradley, who have expressed support for my project, and provided permission for the use of their materials.

sexuality and gender but also by their other subject positions and identities. In this way, there is no single experience of queerness or discrimination based on sexuality or gender.

Furthermore, queer theory is grounded in Postructuralist theory. I view truth and knowledge production as contextual, so I am not interested in 'proving' an ultimate truth. Ultimately, my research does not aim to define a singular queer youth experience, but instead acknowledge the intricacies of each unique experience within an intersectional perspective that healthcare providers can learn from to provide better services for all rainbow young people. For these reasons, I have chosen queer and poststructuralist theory as my theoretical framework for the qualitative analysis. Figure 3 depicts how queer theory, mixed methods, and community-based research combine to form the theoretical framework for this thesis.

Figure 3

Theoretical Framework for Current Study (Fraser, 2020)



Interview Materials

I chose to conduct semi-structured interviews (structured using an interview guide) in order allow consistency of topic coverage across all interviews while still allowing enough flexibility for young people to freely speak about their experiences and share what is important to them. The interview was based on Birkenhead and Rands' (2012) interview guide for rainbow service users' past and present experiences in New Zealand's mental health and addiction services and Fraser's (2020) adaptation of it in their project on rainbow experiences of mental health services in Aotearoa. I also chose to adapt Fraser's (2020) interview guide as it was compatible with the youth survey questions and thus helped me answer my hypotheses across the quantitative and qualitative data, as well as it being designed for the Aotearoa context, and validated by New Zealand-based research.

I adapted the interview guide (Fraser, 2020) to focus more specifically on the Nelson/Tasman community (for example, by asking about specific rainbow-affirming services and how they learned of them, as well as feedback on local community supports if they had accessed any) (see Appendix for the full interview guide). The interview guide is provided in full in the Appendix and is separated into seven sections: (a) brief introductions of myself, my thesis, and participants; (b) engagement with mental health support in the Nelson/Tasman region; (c) discussing sex, sexuality, and gender in health and mental health support services; (d) satisfaction with mental health support in the Nelson/Tasman region; (e) suggested improvements to mental health services; (f) feedback about the project; and (g) closing.

Procedure

Youth Survey

Participants self-selected to participate in the youth survey by following a link provided on recruitment materials that directed them to the information sheet for this study (which was hosted on Qualtrics). After reviewing the information sheet and study eligibility criteria, participants indicated their consent to participate by selecting yes or not following the question "Having read the information sheet above, do you consent to participate in this study?" prior to starting the survey. If participants selected "no" then the survey thanked them and ended. As described above, young people answered questions about their experiences accessing mental health services in the Nelson/Tasman region. This survey took approximately 10 minutes to complete, after which youth were offered the opportunity to participate in a semi-structured interview to discuss their experiences with health services as a rainbow young person in more depth. Those who indicated interest in the interview were asked to provide a contact email address. Regardless of their interest in the interview portion of the study, all participants were also offered the opportunity to enter a prize draw for one of four $40 vouchers to be used towards petrol, food, or at the Alphabet Club Bookstore — a queer kiwi-owned bookstore. Finally, participants were offered the opportunity to be sent a summary of the findings after the research project had finished as well as a full copy of the final report if they so wished.

Health Professional Survey

Health professionals who completed the survey went through the same information sheet and informed consent process via Qualtrics. During the 5-minute survey, health professionals answered questions about their experiences working with LGBTQ+ youth and referring them to mental health services in the Nelson/Tasman region. Upon completing the survey, they were offered the option to be sent a copy of Gloria Fraser's *Supporting Aotearoa's Rainbow People: A Practical Guide for Mental Health Professionals* as a thank you for participating in the research

as well as a summary of the findings. Finally, health professionals were also offered the opportunity to be notified of a seminar presenting the findings of this study once it was scheduled.

Youth Interviews

Interviews were conducted within one month of participants completing the online survey. Interviews were scheduled via email and took place in person at either the Whanake Youth office in Stoke, Nelson, or at Q Youth in Central Nelson. Interviews followed the semi-structured interview guide described above and were audio-recorded to allow for later transcription and analysis. I personally transcribed all interviews.

On the note of reflexivity, my analysis was reflexive and clarified my relationship to the research topic. I am not an objective, unbiased observer, and my own experiences and identities certainly shape my understanding, motivations, and investment in the research. I acknowledge at the outset that I currently work in a therapeutic context with LGBTQ+ youth. I was incredibly mindful of how I conducted the interviews to ensure my role as a researcher was at the forefront, as opposed to other roles I hold within the Nelson community (i.e., youth mental health clinician). Although the context of the interviews was not explicitly therapeutic, the process was arguably cathartic for some participants. The participants did share vulnerable experiences, and I worked to hold those experiences safely and with care whilst keeping the interviews focused on the broader research questions. Furthermore, I work in community mental health, and so I understand and see the tension between community and secondary services. I was very mindful of this potential bias during the interviews and throughout the data analysis process. I paid close attention to what the participants shared and did not ask leading questions or share my own views on the effectiveness of different models of mental health support. Finally, I am polyamorous and queer, and so I could empathise with

participants who described vulnerability in sharing these aspects of their identity in therapeutic contexts. I have personally felt this discomfort, and although I have had some extremely positive therapeutic experiences, they have not all been that way. I can understand how it must be hard for young people to advocate for themselves and be taken seriously by professionals when they hold minority identities which are counter to our cultural and societal norms. These reflections and findings are discussed in depth throughout the qualitative findings.

Ethics

The project proposal, submitted to the Massey Human Ethics Committee (Northern) for consideration and feedback, was approved (NOR 22/36) on 08 July 2022. The main ethical considerations were about how to maintain the confidentiality of participants in a small rural area as well as more specific concerns related to confidentiality around sexuality and gender identity, both of which are discussed in more detail below. In addition, there were several ethical considerations related to culture, harm to participants, harm to researcher, and storage and access of data.

Confidentiality

A number of measures were taken to ensure the confidentiality of participant data. Identifiable participant information (e.g., email address) were only recorded for the purposes of scheduling interviews, sending participant thank yous, and informing participants about the findings of the study/webinar. This identifiable information was kept separate from all other research data (e.g., survey responses, interview transcripts). Survey responses could not be linked to interview participant data. Breach of confidentiality is a risk when using web-based surveys. However, this risk was minimised in three ways: 1) the Qualtrics account was password-protected, 2) Qualtrics meets high standards for data security (SAS 70 Certification; meets HIPAA standards, and 3) the data was downloaded and removed from the server immediately after study completion.

Although there was great dismay expressed throughout the recruitment phase by youth aged 15 and younger that they could not participate, this decision was made in the interest of protecting vulnerable rainbow young people that might not be out to their whānau. Specifically, we did not want to risk confidentiality by under 16-year-olds needing to gain parental consent to participate in the research. This was a difficult decision, and future research should consider working with a lower age range with robust safety mechanisms in place to minimise any potential harm.

Surveys were presumably conducted on participants' personal devices at a time of their choosing to allow them to conduct study activities in private. Interviews were conducted in a private location (i.e., in offices with closed doors) to maximise participant privacy. Participants were reminded about steps the research team took to protect confidentiality and that they could refuse to answer any question at any time. Personal details shared in interviews that may have made the participant identifiable (as participants will resided in small towns where situational factors may make them identifiable) were discussed with the participant, and only included at the participant's request. No data which could compromise confidentiality were reported in a publicly available format (e.g., master's thesis document, conference slides, academic journal article).

Cultural Considerations

Cultural considerations were heavy on my mind throughout the research project, and I took extra care to consult with cultural advisors, including several Māori individuals, in the Nelson/Tasman community throughout the project. Although the research focus wasn't specific to Māori, it was important to me to include a strong cultural lens to the research and ensure I was following appropriate tikanga throughout the research process. For example, during all interviews, I took some time to build

rapport with participants by asking about all the different identities they held, I offered to perform a karakia, and started interviews with an offer of food and tea/coffee/hot chocolate. When interviewing Māori individuals, karakia, sharing of kai, and a greater emphasis on whakawhanaungatanga were all core components to the way we connected and related to each other. Colonisation and the harm psychologists have caused to Māori in the rainbow community were raised by participants during interviews, and I hope that my findings acknowledge these injustices and help make a small contribution toward decolonising the field.

Harm to Participants, Including Emotional Discomfort or Distress

Based on the survey and interview questions, we did not anticipate any harm to participants, including significant emotional discomfort or distress. However, as participants are diverse, some may experience emotional discomfort when recalling past experiences with mental health services. Participants were reminded of support services and resources in the information sheet, as well as prior to conducting interviews. Risks and benefits of the research were discussed with participants who consented to an interview before the interview began. At the beginning of each interview, I went over the information sheets with participants and re-stated the rights for participants to pause, stop, or cease participation at any stage. At no point did any participants appear upset during the interviews. In fact, all participants described the interview as a positive experience.

Harm to Researcher

As a queer person, I am close to the research topic. However, I regularly participate in private therapy and professional supervision, so I have excellent support structures to process discomfort. As I took a reflexive approach to the research project, I discussed aspects of the interview topics which had a personal impact on me with my research supervisor (e.g., interview participants sharing experiences of discrimination related to their polyamorous identity both in an out of therapeutic services), and that I would be mindful of how I reported on the data in the

findings. Overall, I found the research process to be deeply humbling, impactful, and positive. I felt privileged to have been trusted with the personal experiences and stories of the rainbow young people I interviewed.

Storage and Access of Data

Survey data from Qualtrics was stored securely with password protection only through the Massey Cloud system. All survey and interview data are stored on the encrypted Massey Cloud system, password-protected and only accessed by myself and my supervisor. Data will be kept for five years and then destroyed. Audio files of interviews were deleted once all interviews were transcribed. Interview consent forms were scanned and stored as PDFs and were stored separately to transcripts on Massey Sharepoint, which are only accessible by my supervisor and me. Interview transcripts were provided via email to participants that requested a copy; no participants requested edits to their interview transcript. I did not employ a transcriber, so transcripts were only viewed by myself and my supervisor. Any identifiable information was kept separate from the survey and interview data.

Unforeseen Ethical Considerations

Unforeseen ethical considerations arose during the research process. Due to the design of the research project (i.e., being community-based as well as regionally based), there was greater interest in the research than what I had anticipated. I had a high volume of requests for interview participation from young people (far beyond the 5-15 anticipated interviews), as well as clinicians reaching out and wanting to share their experiences in a verbal format (for which we had not planned). Given the scope of this master's thesis, as well as the activities that we had ethical approval for, we were unable to accommodate these requests. However, this response highlights for future researchers

the importance of including qualitative interview or focus group options when working in small communities.

Following the ‘Unconference’ set up for establishing a gender affirming healthcare pathway, Te Whatu Ora asked if we could collaborate on better understanding service-user experiences by offering to promote my surveys with a request to share the data as part of their own investigation of how to improve transgender healthcare pathways. Collaboration was discussed with myself, my supervisor, and Te Whatu Ora, but because ethical approval was sought only for this research, and participants had only consented to data collection and use in relation to this research project, as well as the scope of the thesis, it was decided instead that Te Whatu Ora would help distribute my recruitment materials for this research, and they would create their own survey for consumers. I reiterated that I would provide a summary of the findings to them after the thesis was completed, as well as present the findings to their staff. They asked and I agreed to let them use my survey questions.

Data Analysis

Survey Data

For quality assurance, we screened survey responses for bots and inconsistent responses to ensure high data quality and integrity. Similarly, we checked IP addresses to ensure each respondent was unique. We asked all participants two attention questions in the youth survey (e.g., “Please select ‘Strongly Agree’”) to ensure they were attentive in their responses. Attention questions have been used effectively to maintain data integrity in other psychological studies (Fraser, 2020; Lavrakas et al., 2019). We chose to use attention questions as we wanted to ensure participants were attending to the questions rather than just rushing through; 95.2% of responses were correct for the first attention question, and 93.4% were correct for the second question. We checked attention questions against responses to ensure the final dataset was genuine.

Data from both surveys underwent a cleaning process in which incomplete responses were removed from the datasets. Descriptive analyses (e.g., means, standard deviations) were then run on the survey variables of interest to summarise the responses of the youth and health professional participants. Independent-samples t-tests were used to compare youth and clinician participant groups perceptions of comparative mental health needs of rainbow youth to the general youth population, and comparative perceived clinician comfort in working with rainbow youth. Given the rural sample and the cross-sectional nature of the data, we did not recruit enough participants to run inferential statistics with appropriate power. However, as the research aims of this study are descriptive in nature, we do not view this lack of power as a limitation.

Interview Data

Reflexive thematic analysis (Braun & Clarke, 2006) was used to analyse the interview data. I aimed to acknowledge any biases I might hold that could impact the data analysis, based on my own lived experience. I choose to take a critical realist approach to the analysis, which "assumes an ultimate reality, but claims that the way reality is experienced and interpreted is shaped by culture, language and political interests" (Braun & Clarke, 2013, p.329). Braun and Clarke (2013) make a point that themes are not just summaries of data domains but instead represent patterns of shared meaning which are united by a core concept. Also, as I wanted the research to bring benefits directly back to those that participated (as well as the broader rainbow youth community in Nelson/Tasman), I felt a critical realist approach would make the findings more accessible and relatable for the participants compared to a more constructionist approach which focuses exclusively on discursive practices (Gubrium & Holstein, 2008). Queer theory was also used to analyse how normative understandings of gender, sexuality, and sex characteristic diversity may influence participant experiences.

I followed Braun and Clarke's (Braun & Clarke, n.d., 2013, 2013) approach to thematic analysis, which is broken down into six stages of data analysis: (a) Reflexivity and familiarisation with the data; (b) Coding, which takes place in several stages to summarise the data into smaller chunks; (c) Generating themes, which begins to move into analysis; (d) Reviewing themes; (e) Mapping themes; (f) writing up the findings. The transcription of interviews functioned as the familiarisation stage with the data, as transcription occurred within 48 hours of conducting each interview. By the time all interviews were transcribed, I felt very familiar with the data. I then printed off each de-identified transcript and collated them all into a binder. I conducted an initial read through of all 130 pages of interview transcripts without carrying out any analysis. Any experiences of mental health services in other regions/countries that were discussed during interviews were not included in the data analysed. As part of taking a reflexive approach, I was mindful of my own biases and experiences as a queer person who has accessed mental health support in the Nelson/Tasman region and noted any emotional responses that occurred while reading through the material.

Next, I began the coding process, which consisted of writing down summaries of the data on post-it notes. I did this section by section (i.e., I completed the section on experiences of accessing care across all interviews before moving on to the next section of barriers to care). For qualitative quality assurance, Braun and Clarke's (2013) 15-point checklist for good thematic analysis was used. This addresses explicitly how transcription, coding, analysis and overall criteria for research projects and written report can lead to good thematic analysis.

In total, I generated 236 codes which were organised into 25 preliminary themes. I spent significant time refining the themes, both in conjunction with my supervisor, and by myself through a mapping process. Across the four sections of the interview questions (experiences accessing support; discussing sex, sexuality, and gender in mental health services; satisfaction with services; and recommended improvements) I identified seven core themes, and 23

subthemes. All themes fit under one meta-theme of safety for LGBTQ+ people accessing mental health services. I presented the preliminary findings to a postgraduate qualitative research group through Massey University to gain feedback on the thematic analysis portion of the research.[6] The themes identified are explored in the qualitative findings (see figure 4).

Figure 4

Thematic Map

[6] I was particularly concerned with the large number of themes; however, I was reassured that this is more common in applied research that draws from a critical realist theoretical framework (compared to a more constructionist framework which has a heavier emphasis on larger metatheoretical themes).

Chapter 4: Results

The results are presented in two sections: Quantitative and qualitative findings. Both sets of findings are presented in three sections of (1) experiences of accessing mental health services (H1-H4), (2) barriers to accessing mental health services (H5-H8), and (3) recommended improvements to accessing mental health services (H9). These sections mirror the research questions, which hopefully make it easier for the reader to engage with the findings.

Quantitative Findings

General Wellbeing

Important context for this discussion was to have a general understanding of the sample's general wellbeing. Youth participants were asked to rate their well-being across four domains which reflected the Te Whare Tapa Whā (Durie, 1994) model of well-being (see table 4). On average, participants rated their mental health in the low-to-average range (*M* = 2.34, *SD* =1.1), which was the lowest across all four domains. Social health yielded the highest average score (M=3.31, SD=1.1), indicating that participants felt most well in this domain.

Table 4

Te Whare Tapa Whā — Subjective Wellbeing

Variable	*M*	*SD*
Physical health	3.26	1.02
Mental health	2.34	1.10
Social health	3.31	1.11
Spiritual health	3.20	1.03

Note. n = 68 youth participants completed these questions.

To assess perceptions of rainbow youth mental health more broadly, both youth and clinicians were asked to compare the mental health needs of rainbow youth with those of the general youth population on a Likert-type scale (1= non-LGBTQ+ youth have much higher needs than LGBTQ+ youth; 5= LGBTQ+ youth having much higher needs than non-LGBTQ+ youth). There was no significance difference between youth (M = 3.90, SD = 1.00) and clinician ratings (M = 4.21, SD = 0.88) of the relative mental health needs of LGBTQ+ and non-LGTBQ+ youth in the Nelson/Tasman region, $t(98)$=-1.56, p=.06, Hedges' g = 0.32. Both participant groups rated LGBTQ+ youth as having somewhat higher needs than non-LGBTQ+ youth.

LGBTQ+ Youth Experiences with Mental Health Services in Nelson/Tasman Region (H1-H4)

Hypothesis 1: The majority of rainbow young people would have attempted to access support. Youth were asked questions about their engagement with mental health seeking services in the Nelson/Tasman region (see table 5). The majority (65%) of youth participants attempted to access mental health support and 56% were successful in doing so, while 27.3% wanted support but did not attempt to access support. School counsellors were the most commonly accessed mental health professional (50.6%), followed by counsellors (48%) and general practitioners (42%). Only 16% of participants accessed a psychologist, and 12% accessed a psychiatrist, perhaps reflecting the shortage of psychologists and psychiatrists available. Feelings of anxiety (61.7%) and depression (64.2%) were the most commonly cited reasons for seeking mental health support, followed by general life stress (44.4%) and trauma (39.5%).

Table 5

Descriptive Characteristics of Rainbow Youth Engagement with Mental Health Services

Variable	%
Have you ever considered reaching out for support for your mental health from a mental health professional? (*n* = 66)	
No	7.6%
Yes, and I did reach out	65.2%
Yes, but I didn't reach out	27.3%
Have you ever received support for your mental health from a mental health professional? (*n* = 67)	
No	21.0%
Yes	55.6%
I'm not sure	6.2%%
Types of mental health professionals you have received mental health support from (*n* = 50)	
Mental health professional (not sure of title)	16.0%
Counsellor	48.0%
Psychologist	16.0%
Psychiatrist	12.3%
Psychotherapist	19.8%
School counsellor	50.6%
Social worker	14.8%
GP/Doctor	42.0%
Other (Health Coach)	1.2%
Reason for accessing support (*n* = 50)	
Feeling down or depressed	64.2%
Feeling anxious or worried	61.7%
Trauma	39.5%
General life stress	44.4%
Relationships (with whānau, friends, partners, colleagues)	37.0%
Sexuality (exploring; issues relating to, etc.)	17.3%
Gender (exploring; issues relating to etc.)	23.5%
Being intersex	1.2%
Accessing gender-affirming healthcare	16.0%
Not listed, please explain (see note at bottom of table)	6.2%

Note: Other reasons provided for accessing mental health support included: almost overdosing, bullying, learning disability, autism diagnosis, attempted suicide, and self-harm.

Clinicians were asked how often and where they referred rainbow youth to mental health services (see table 6). The most frequently referred to service was ICAMHS, with 41.3% of respondents having referred youth to them, followed by other Te Whatu Ora services (29.9%) and community-based mental health services (27.6%).

Table 6

Clinician Referral Information

Variable	%
How often refer youth to services	
Several times a week	6.80%
Once a week	6.80%
A few times per month	22.70%
Once per month	4.50%
Every few months	15.90%
A few times per year	4.50%
Once a year	2.30%
Less than once per year	4.50%
Which services referred to	
CAMHS	41.30%
Nelson Bays Primary Health	13.80%
DHB services	29.90%
General practices (GP's)	16.10%
Community-based mental health services	27.60%
Private practice	11.50%
Oranga Tamariki	2.30%
ACC counsellors	2.30%
Te Piki Oranga	9.20%
School Counsellors	6.90%
Rainbow community groups	2.30%
Work with LGBTQ+ youth (to their knowledge)	
No	2.30%
Yes	90.70%
Not sure	7.00%

Note. N = 44

Hypothesis 2: Rainbow young people would have poor satisfaction with the services they received. Rainbow youth described clinicians overall to be unhelpful in supporting them with their mental health needs (see Table 7). Rainbow youth participants were asked to share their closing thoughts in an open-ended response. Many participants described negative experiences with ICAMHS, as well as mental health services in general, and called for clinicians to take rainbow youth seriously. Participants wanted rainbow mental health services to be advertised, and also wanted LGBTQ+ identifying mental health professionals. GP practices and schools were both explicitly mentioned as needing to improve their awareness and knowledge of rainbow identities and mental health needs so that they can be safer spaces for rainbow young people. This included signaling safety by having rainbow posters or symbols around schools and offices, as well as improving sex education and easier access to information about rainbow-specific issues. Rainbow youth shared wrote they keep their identities hidden as they are actively having to negotiate safety in health settings. Participants wanted clinicians to be aware of the "taxing effects of the struggles of queer youth and the impact it has on our mental and physical health". One participant wrote,

> "If every person I've ever talked to on the matter of mental health in NZ has told me they've had awful and often traumatic experiences with nearly every outlet there is, why has nothing been done to change that? It is important that LGBTQ+ youth feel they have options that support who love and who they are — counselling and other support services won't work unless they work for everyone."

These responses closely mirrored the qualitative findings (particularly with regard to the theme "*I can't get what I need*", which are explored later in this thesis.

Hypothesis 3: Clinicians would have some experience working with rainbow young people but may not know they were queer due to rainbow young people not being 'out' in

health settings. The majority (90.7%) of clinician respondents reported that they have worked with LGBTQ+ youth at some point in their career (see Table 6).

Hypothesis 4: Rainbow young people would perceive clinicians to have low competence and comfort levels in working with them due to a lack of rainbow competency training. Both youth and clinician participants were asked to assess clinician's perceived level of comfort in working with youth in general as well as LGBTQ+ youth specifically (see table 7). Youth and clinician ratings of clinician comfort with youth in general were significantly different. Specifically, youth rated clinician's comfort with working with young people in general (M = 3.24; SD = 0.96) significantly lower than clinicians rated themselves (M = 4.30; SD = 0.83), $t(99) = -5.80$, $p < .001$, Hedges' g= 1.16. Youth rated clinician's comfort with working with queer young people (M = 3.02; SD = 1.07) significantly lower than what clinicians rated themselves (M = 4.18; SD = 0.64), t(95) = *-6.09*, $p < .001$, Hedges' g = 1.26. There was a small but significant difference between youth rated clinician comfort with youth in general compared to LGBTQ+ youth, $t(57) = 2.09$, $p = .04$, Cohen's $d = .27$, such that youth perceived clinicians to be less comfortable with LGBTQ+ youth compared to youth in general.

Table 7

Comfort Working with LGBTQ+ Youth vs. General Youth Population

Variable	Youth	Clinician
Thinking about all the mental health professionals you have seen — overall, how helpful have they been in supporting your mental health?	2.71(1.08)	n/a
How comfortable do you feel the mental health professionals you have worked with are in working with young people in general?	3.24(0.96)	4.30(0.83)
How comfortable do you feel the mental health professionals you have worked with are in working with LGBTQ+ young people in particular?	3.02(1.07)	4.21(0.88)

Note: M(SD)

Barriers to accessing mental health services in the Nelson/Tasman region (H5-H8).

Hypothesis 5: Rainbow young people would have little awareness of LGBTQ+ affirming services or providers in the Nelson/Tasman region, however, if rainbow young people did know of providers, it would be through word-of-mouth. Youth participants identified a total of 17 unique clinicians and two organisations in the Nelson/Tasman region as LGBTQ+ affirming; only eight youth (or 9.8% of youth participants) indicated that they did not know of any specific LGBTQ+ affirming professionals in the Nelson/Tasman region.

Hypothesis 6: Rainbow young people residing in more isolated locations within the Nelson/Tasman region (i.e., outside of Nelson) would have little to no access to non-traditional sources of mental health support, but those residing in or near Nelson would have some support through local pride groups. Youth participants received support for their mental health in a variety of ways outside of mental health services, with 60.5% of respondents describing receiving support from friends, 30% receiving support from online platforms (Tumblr, Twitter etc.), and 28.4%receiving support from partners. Interestingly, 19.8% of respondents reported receiving support from rainbow community groups (see table 8). Given that youth rated their social health as their strongest area of wellbeing (see Table 8), it makes sense

that peer-support was the most common form of non-mental-health service support. However, the high rate of support from rainbow community organizations is surprising considering the relative paucity of such groups in the Nelson/Tasman region.

Table 8

Non-Mental Health Resources Accessed by Rainbow Youth

Variable	%
Online Platforms (Tumblr, Twitter, etc.)	30.9%
Rainbow community organisations	19.8%
Q Youth	16.0%
Rainbow specific peer support groups (e.g., QSAs)	13.6%
InsideOUT	6.2%
General peer support groups	11.1%
Friends	60.5%
Partners	23.5%
Whānau	28.4%
Religious leaders or youth groups	1.2%
Phone lines (e.g., Outline; Youthline)	12.3%
I did not receive support from any of these sources	3.7%
Something else (see bottom of table)	3.7%

Note: QSA = Queer Straight Alliance. Other sources of support reported included: twin sibling, online friends/overseas friends, youth worker.

Hypothesis 7 and 8: Rainbow young people would face numerous barriers (both general and specific to being queer) to receiving mental health support. Barriers from the clinician's perspective would be similar to those reported by rainbow young people. Both surveys asked participants about barriers to accessing mental health support — both for youth in general, and barriers for LGBTQ+ youth (see Table 9). I looked at both frequency of a given barrier being endorsed, as well as participants' rankings of whether the given barrier was the most important (i.e., #1)

barrier facing this group. LGBTQ+ youth respondents most frequently experienced lack of availability from the clinician (40.7%), closely followed by uncertainty of whether the healthcare professional was affirming (38.3%) and fear of LGBTQIA+ identity being misunderstood (38.3%). Cost of services was also experienced by a third (33.3%) of respondents and was ranked as the most significant barrier (11.1%). Furthermore, lack of clinician availability was ranked as the second most significant barrier (9.9%) followed by fear of not being taken seriously (7.4%). Clinicians also perceived lack of availability as the most significant barrier for youth in general, but also rated lack of knowledge about services, lack of relatability with the provider, and fear of not being taken seriously as commonly experienced barriers for youth in general.

When asked about barriers specific to LGBTQ+ youth, clinicians perceived fear of identity being misunderstood (68.2%), uncertainty about whether the clinician was LGBTQ+ affirming (63.6%), and lack of availability from the clinician (61.50%) as the most commonly experienced barriers. Clinicians also ranked lack of availability and uncertainty of whether the clinician was rainbow affirming or not as the two most significant barriers (13.6%), followed by confidentiality concerns (6.8%). Lack of telehealth services was ranked by all participant groups as the least significant barrier for both LGBTQ+ youth and youth in general. There were no significant differences between youth and clinician endorsement of barriers (*p*s > .05) apart from cost of services, $\chi^2(1) = 1.63$, $p = .26$, which clinicians endorsed more frequently (61.4%) than youth (33.3%). Only one clinician participant selected the response "I don't think LGBTQ+ youth face any barriers to accessing mental health services in the Nelson/Tasman region," suggesting that the vast majority of providers perceive at least some barriers to accessing mental health care as a young person in Nelson/Tasman.

Table 9

Barriers to Accessing Mental Health Services in The Nelson/Tasman Region

	LGBTQ+ Experienced Barriers	All Youth Perceived Barriers	Perceived Barriers for LGBTQ+ Youth	
Barrier	Youth	Clinician	Youth	Clinician
Cost of services				
Perceived/experienced this barrier	33.3%	61.4%	44.4%	34.1%
Ranked this barrier as #1 most significant	11.1%	2.3%	13.6%	4.5%
Lack of transportation				
Perceived/experienced this barrier	14.8%	61.4%	24.7%	47.7%
Ranked this barrier as #1 most significant	1.2%	0%	1.2%	0%
Confidentiality concerns				
Perceived/experienced this barrier	27.2%	50.0%	53.1%	56.8%
Ranked this barrier as #1 most significant	3.7%	2.3%	7.4%	6.8%
Scheduling problems				
Perceived/experienced this barrier	25.9%	54.5%	33.3%	38.6%
Ranked this barrier as #1 most significant	1.2%	0.0%	1.2%	0.0%
Lack of telehealth services				
Perceived this barrier	7.4%	20.5%	12.3%	20.5%
Ranked this barrier as #1 most significant	2.5%	0%	1.2%	0%
Lack of availability from mental health professionals				
Perceived this barrier	40.7%	75.0%	48.1%	61.5%
Ranked this barrier as #1 most significant	9.9%	34.1%	9.9%	13.6%
Unsure if LGBTQ+ affirming/friendly				
Perceived this barrier	38.3%	n/a	61.7%	63.6%
Ranked this barrier as #1 most significant	3.7%	n/a	14.8%	13.6%
Fear of LGBTQIA+ identity being misunderstood				
Perceived this barrier	38.3%	n/a	65.4%	68.2%
Ranked this barrier as #1 most significant	3.7%	n/a	8.6%	2.3%
Fear of not being taken seriously				
Perceived this barrier	42%	59.1%	n/a	59.1%
Ranked this barrier as #1 most significant	7.4%	11.4%	n/a	9.1%
Lack of knowledge about services/resources				
Perceived this barrier	28.4%	70.5%	n/a	59.1%
Ranked this barrier as #1 most significant	1.2%	9.1%	n/a	2.3%
Lack of relatability with the professional				
Perceived this barrier	28.4%	65.9%	n/a	56.0%
Ranked this barrier as #1 most significant	1.2%	4.5%	n/a	0%
Fear of being 'outed'				
Perceived this barrier	n/a	n/a	n/a	54.5%

Ranked this barrier as #1 most significant	n/a	n/a	n/a	2.3%
Not being 'out' yet				
Perceived this barrier	n/a	n/a	n/a	59.1%
Ranked this barrier as #1 most significant	n/a	n/a	n/a	4.5%
Something else – (see note)				
Perceived this barrier	14.8%	20.5%	7.4%	2.3%
Ranked this barrier as #1 most significant	7.4%	2.3%	1.2%	2.3%

Note: n/a = question was not asked for this group. Other barriers identified by clinicians included: the wrong use of pronouns. Other barriers identified by youth included: parental support/consent, social expectations of [assigned male at birth] LGBTQ+ youth, being turned away from services due to rainbow identity, and inability to schedule an appointment outside of school hours.

Recommended Improvements for LGBTQ+ Youth Accessing Mental Health Services in The Nelson/Tasman Region (H9).

Hypothesis 9: Both participant groups would suggest increased funding and services, training opportunities for clinicians, and the establishment of a rainbow specific service would improve the provision of mental health support for rainbow young people. Youth and health professional participants were asked to select options from a list that would improve access to mental health services for rainbow youth in the Nelson/Tasman region (see Table 10). The majority (54.3%) of youth indicated that reducing the cost of mental health services, providing more LGBTQ+ affirmative trainings for professionals (54.3%), including clear statements on websites about whether the clinician is LGBTQ+ affirming/friendly (53.1%) would improve rainbow youth's access to mental health services in the region. These recommendations were closely aligned with clinician responses: 38.5% endorsed reducing cost of services, 56.8% endorsed more rainbow competency trainings for clinicians, and an even larger percentage of clinicians compared to youth respondents (61.4%) recommended providers

put clear statements on their website to indicate that they are LGBTQ+ affirming. The potential improvement that received the lowest percentage of endorsements from both participant groups was increased access to telehealth services; significantly more clinicians (29.5%) endorsed this recommendation compared to youth respondents (12.3%), $\chi^2(1) = 5.618$, $p = .02$. Clinicians *(36.4%)* were also more likely to endorse increasing the number of available providers outside of the community compared to youth respondents (16%), $\chi^2(1) = 6.604$, $p = .01$.

Table 10

Frequency of Endorsement of Potential Strategies to Improve Rainbow Youth's Access to Mental Health Services in the Nelson/Tasman Region

Potential Strategies to Improve Healthcare Access	Youth	Clinician
Reducing cost of mental health services	54.3%	38.6%
Transportation vouchers	29.6%	40.9%
Clear confidentiality statements	38.3%	43.2%
More mental health providers to choose from	48.1%	61.4%
More scheduling options	35.8%	45.5%
More telehealth services	12.3%	29.5%
Clear statements on websites about whether the clinician is LGBTQ+ friendly/affirming	53.1%	61.4%
More providers that aren't in my community	16%	36.4%
More trainings for mental health providers on how to work in an affirming way with LGBTQ+ people	54.3%	56.8%

Note. $N_{Youth} = 81$; $N_{Clinicians} = 44$

Numerous clinicians wrote more needed to be done to improve mental health services for LGBTQ+ youth. One clinician wrote, “personal bias exists, and rainbow youth will pick up on it even if it isn’t explicitly stated,” which corresponds with the qualitative findings discussed in the next section. Clinicians felt services needed to be better resourced, advertised, and rainbow competency training was required.

Clinicians also acknowledged that there are transphobic views within the health sector in Nelson/Tasman, evidenced by the recent CATA conference, and that these were causing harm to rainbow young people. One participant drew a comparison to anti-abortion services — “Think that it is a bit like offering pregnancy services - in that an anti-abortion stance should be readily identifiable in practice information and advertising to avoid people presenting to clinics where their reality might be undermined.” Although this would raise many ethical issues, the clinician indicated they were aware that young people in mental health services are in a vulnerable position, and clinicians that hold negative views towards LGBTQ+ people exist and can result in a harmful experience for rainbow young people. Clinicians highlighted the lack of services and LGBTQ+ support groups in smaller isolated communities such as Tākaka. A rainbow identifying health professional wrote, “I don’t even have knowledge about specific LGBTQ+ services — how can we expect young people to navigate the health system?” They went on to call for greater rainbow visibility within health services for clinicians as well as the populations they serve.

Qualitative Findings — Analysis of Interviews About Accessing Mental Health Support

Although the interview schedule was organized in three sections (experiences accessing services; barriers to accessing services; recommended improvements) which followed the hypothesis outline as presented throughout this thesis thus far, this section diverges from the previous pattern of presenting findings in order of hypotheses. I wanted to honour the narratives of the young people I spoke with as much as possible, rather than neatly fitting their responses

into my research categories. The data does not neatly fit into H1-H9, but instead I have presented several overarching themes from the interview data that traverse multiple hypothesis categories. I hope this thematic analysis adds depth and nuance to the findings presented thus far, presenting a rich and in-depth picture of rainbow youths' experience accessing mental health services in the Nelson/Tasman region.

Here, I discuss three key themes I identified through the interview process which are woven together to provide recommendations for the provision of mental health support for rainbow youth residing in the Nelson/Tasman region. The thematic analysis maps across the interview sections: (1) Experiences accessing mental health support in the Nelson Tasman region, (2) Discussing sex, sexuality, and gender in mental health support services, (3) Satisfaction with mental health support services and (4) Improvements to mental health.

The first major theme ("*I can't get what I need*") spans across both experiences accessing mental health support. It is the narrative that weaves together the difficulties of accessing quality mental health support for rainbow youth living in a rural region. The second theme *("What's working well"*) captures the positive experiences rainbow youth are having with mental health services. Together, they form the basis for theme 3 ("*It's all about safety")* — recommended improvements for safe and effective mental health services.

I can't get what I need describes the difficulties of accessing care as a rainbow young person living in the Nelson/Tasman region: rural locations, a shortage of mental health professionals, long waitlists, inflexible scheduling, and a lack of funding for services. In essence, a mental health system in crisis. Participants also described equity issues when trying to access care — many could not afford to access private services, which offered more clinicians as well as access to clinicians with specialist knowledge in

rainbow issues, and participants described having to wait longer through the public health system to be placed with a clinician that had some knowledge of rainbow issues.

I can't get what I need also described poor service quality as defined by a lack of clinician competency in important domains (e.g., rainbow issues, cultural practices, intersectional concerns, minority stress-informed care), leaving rainbow youth to start the conversation about identity with their providers. Rainbow young people described feeling as though they had to be the expert in all things LGBTQ+ and to educate their mental health care provider in order to receive the care they needed.

Despite the overwhelmingly negative experiences which described rainbow youth's journeys to accessing mental health support, rainbow youth also had some distinctly positive experiences (captured in theme 2 "*What's working well*"). Participants identified a handful of "local gems" (clinicians who are providing excellent, affirming care to rainbow youth), a Māori mental health care model that is working well, as well as community resources that are helping to foster wellbeing amongst the rainbow community.

The final theme ("*It's all about safety")* captured rainbow youth participants' recommendations for ways to increase access to and improve mental health care for rainbow youth in the Nelson/Tasman region. Participants described wanting to feel and be safe when accessing mental health services, without needing to constantly assess and negotiate safety with their providers. Rainbow young people wanted timely access to safe mental health services and made three key recommendations to improve mental health care provision: improve access to care (LGBTQ+ specific reform, general improvements, and funding community services), increase LGBTQ+ training of providers, and increase cultural competency of providers.

The following sections describe these themes in greater detail.

Accessing Mental Health Services in the Nelson/Tasman Region

Theme One: "I Can't Get What I Need." The theme of "*I can't get what I need*" describes the difficulties rainbow young people face when trying to access quality mental health support in the Nelson/Tasman region. Three subthemes capture the overall difficulties: structural barriers, equity issues, and a lack of clinician competency. Together these experiences created a revolving door experience for rainbow-service users, with most participants describing cycling between (i) long waitlists, (ii) poor service quality, (iii) disengagement from services, and then (iv) mental health crisis prompting the cycle to repeat all over again.

Subtheme 1: Structural Barriers. Rainbow young people reported frequent attempts to access a wide variety of mental health services; however, they faced many barriers in doing so, such as challenges associated with living rurally, availability of healthcare professionals with adequate skills, and barriers to receiving gender-affirming healthcare.

Structural barriers which may exist across Aotearoa such as a lack of mental health professionals (Ardern, 2018; Cowlishaw, 2017; Cupina, 2007; Hutton, 2017) seemed to be exacerbated by living rurally. As one participant succinctly put it, "We just need more people." All eight participants that had attempted to access care through the youth public mental health system (ICAMHS)[7] described waiting eight months or more to have an initial assessment, with some reporting that they still have not managed to access services. When participants did finally access an initial assessment appointment,

[7] Infant, Child, and Adolescent Mental Health Services (ICAMHS) and CAMHS are used interchangeably throughout this section as they recently changed their named to include Infant, but most people still call it CAMHS.

they described another long waiting period to begin treatment. During this time, many participants described being assigned to a case manager (who monitors patients or coordinates services but does not provide mental health services directly) and being told they will need to wait an unknown amount of time to work with a psychologist or equivalent mental health professional. Participants identified that options in more rural areas were extremely limited, with one participant describing their difficulties in accessing appropriate support in a rural town:

> In Tākaka there are basically two people you could go to: the school counsellor, who sucked, or you could go to the one person who worked in Tākaka, who was nice, but wasn't very much help in the slightest…otherwise I would have to spend an extra $50 on gas just to get to the place [in Nelson] which is just another barrier for a cost because we've been on the benefit the whole time. So, between travel costs and just lack of resources, there's really nothing you can do. (Participant 5)

For context, Tākaka has a population of roughly 1,335 people according to the 2018 census (Stats NZ Tatauranga Aotearoa, 2018) and is approximately a 1.5-3-hour drive from central Nelson depending on where someone resides in the Golden Bay region. The quote highlights the layers of barriers rainbow young people face when trying to access quality care in rural areas. Another participant described how living rurally not only made it hard to access services, but also impacted on their mental health:

> I went to a counsellor temporarily. This was quite a while ago. I was struggling with school. I was struggling with making friends. Which being LGBTQ+ plays a part in this. Especially being in a rural area — it's very isolating. And she [the counsellor] did suggest, in fact, she heavily suggested, almost insisted, that I go to boarding school. Which was something that me and my parents were not willing

to do. And she insisted this for two sessions. I then stopped going to her. (Participant 10)

Although not explicitly stated, the participant's quote highlights how living rurally and being LGBTQ+ exacerbated their mental health challenges, in part due to isolation and lack of social acceptance. Additionally, when care was accessed, it wasn't responsive to the family's needs and the clinician may not have understood the implications of going to boarding school for a queer, rural young person (e.g., attachment to home, cost, and potentially lack of acceptance in relation to LGBTQ+ identity). The participant accessed counselling privately, bypassing the public system, and they had to drive an hour to see the counsellor. Once engaged in services, the participant felt that the counsellor did not truly listen to them and respect their wishes and so disengaged from services. Numerous participants listed transportation as a barrier to accessing care and did not have access to buses or other forms of transportation. This limitation meant participants had great difficulty in accessing care confidentially as they often needed support from their parents to get to appointments.

Most participants (n = 7) had never seen a psychologist or a psychiatrist through the public health system. Numerous participants described difficulties in accessing mental health professionals that had the appropriate skills to address their concerns.

> So, my last one was previously a counsellor so they did CBT with me, but they weren't in a counselling role so they couldn't go deep into therapy. It was kind of patch ups here and there… It wasn't reparative work… my current one has a background in social work so completely not a counsellor…. I've been waiting ages to see a psychologist. I was going to see someone privately but that is just way out of my price range. I'm on a benefit. I am on a waitlist —and I have been for six months. Probably even longer than that. Pretty much all this year I've been

> on a waitlist…like how do you go through four years of intense mental health care and never get real therapy? (Participant 2)

A lack of providers not only contributed to long waitlists and large gaps between assessment and intervention, but it also meant rainbow young people could not access professionals with the right qualifications for their needs. One participant described his difficulty in getting a diagnosis for attention-deficit hyperactivity disorder (ADHD) and autism spectrum disorder due to structural barriers of not being able to access a psychiatrist who is qualified to work with adolescents. Difficulty in accessing professionals that can diagnose (e.g., gender dysphoria, ADHD, learning disorder) is problematic as sometimes diagnosis is required to access other forms of healthcare, including medication, hormone treatments for gender-affirming healthcare, and support in school for learning difficulties.

Gender diverse young people experienced unique systemic challenges when accessing mental health support:

> Most [clinicians] have been good at calling me [chosen name] and CAMHS maybe after I came out. But there was always the issue of it not being legally changed, so on all my documents it was still my dead name, and the hospital had my dead name until it was legally changed, which sucks. They printed out a thing on what to do, my family what to do when I was in different scales of crisis, and literally on that it had my dead name on it because it came as a legal document, not a legal document but came from the system. And so that had my dead name on it and this is like going to send me into crisis rather than remove me from it. (Participant 3)

Even when clinicians are using the client's chosen name, there are still systemic barriers which can cause distress rather than easing it. One participant stated there were no clinical psychologists in the Nelson/Tasman region through the public health system that would assess

and diagnose gender dysphoria — the nearest one was in Blenheim (approximately two hours away by car). All trans and non-binary participants noted that access to gender affirming healthcare in the Nelson/Tasman region was incredibly limited, with some estimating a 2-3 year wait for access to hormone therapy. The delay for gender-affirming healthcare can be detrimental to mental health (Ellis et al., 2015; G. Fraser, 2020; G. Fraser et al., 2018; McNair et al., 2001; Safer et al., 2016) and contributes to a larger equity issue for rainbow young people accessing healthcare.

Two participants were able to access care privately and they reported fewer barriers, including access to professionals that held the appropriate qualifications for their needs and shorter waitlists. However, even when participants were able to seek private healthcare services and thus had some choice in who they worked with, the difficulty of identifying rainbow-friendly or - competent clinicians was an issue:

> Let's just say there was a practitioner… well they are always full! Even the normal, you know, just, like, counsellors. Even though there are a lot more of them than there are any other type of psychological assessment of any description — they are very hard to book into. I find that doctors don't know who specialises in what. They can look up who is in the area, and they can look at a vague description. But, you see, I was looking through the descriptions with my GP and it almost appears like the website they are on just has the same description of what they specialise in, copied and pasted into every single psychologist or counsellor or therapist. So I think there is either a glitch there or some admin person on the computer end is being a bit lazy… I'd be incredibly- I wouldn't say afraid to go to a psychologist, counsellor, or therapist… but I would be hesitant on the first session without knowing much about them… there is no therapist that seems to specialise in the region… I feel like LGBT people, especially from a young age,

> are more likely to need mental health support. The fact that there is not funding or support for it is quite devastating. (Participant 10)

Almost all participants (*n* = 9) identified word-of-mouth as the only way of knowing whether a mental health care professional was rainbow-affirming or not.

Structural barriers such as long wait times, difficulties getting to appointments, and a shortage of professionals with adequate skills to meet rainbow healthcare needs all contributed to dissatisfaction with services. Rainbow participants described cycles of engagement and disengagement with services which often resulted in rainbow youth's mental distress increasing until it reached crisis point. Ironically, participants commonly described the only way of getting in to see CAMHS is by being in crisis — otherwise participants felt they could not meet the criteria for receiving services.

> CAMHS is the main sort of mental health thing I've been involved with, and it took so fucking long. It took 8 months to even see them. Except when I was in crisis mode and they were like come in straight away, and then go home and do nothing. And that was that. I was 15ish — something like that when I first saw them. I saw them for six months and then was discharged and then saw them again for another six months in 2021, then was discharged and have been on the waiting list 8 months this year. (Participant 3)

The consequences for the participant were what is commonly described as the 'ambulance at the bottom of the cliff' phenomenon (Selwyn, 2022): a cycle of only addressing crises, rather than using evidence-based best practices models of care as an early intervention tool to create more sustainable and long-term change. The ambulance at the bottom of the cliff can end up putting more pressure on the public health system, as needs are rarely addressed in a meaningful way, leaving people to continually seek mental health support.

Numerous structural barriers, long waitlists through the public health system, a shortage of psychologists, and financial barriers all contribute to difficulties accessing appropriate care and resulted in a revolving door of service-use.

Subtheme 2: Equity Issues — "Being Queer Makes It Harder to Access Services." Participants highlighted several equity issues when discussing their experiences with accessing mental health services in Nelson/Tasman. These ranged from perceived longer waiting times in the public system due to case managers wanting to place them with a clinician that had rainbow knowledge or competency, to rainbow young people being unable to access healthcare which they perceived as being due to their rainbow identity. Participants also reported a hesitance to be open about their rainbow identities in mental health services due to fears of discrimination or being denied services.

> I concealed it for years and that's what I felt like I had to do. I just felt like I'm not going to get the support I need. I was an ally for years and I saw my friends not getting support. I thought, 'if I'm out, I'm not going to get support, so why should I come out?' (Participant 2)

Numerous participants that had been through ICAMHS reported that they had to wait longer to see a mental health professional that was knowledgeable about rainbow identities and issues. When asked if this was their preference, participants said they were not given the option (i.e., of seeing a less knowledgeable clinician sooner vs. waiting longer for a rainbow-aware clinician). Participants described constantly negotiating the risks of coming out in health settings due to the fear of being denied care based on having a rainbow identity

> [Referrers] throw in the ‘queer’ [in the referral to services] and make it impossible for people to access services…They assume everything that a rainbow person like me was going through, and it’s kind of just made it hard since they assumed they were like, ‘maybe you don’t need this. Maybe you need something different. You don’t need us, or you don’t qualify because you’re rainbow.’ I have been told that. (Participant 6)

Experiences of discrimination, whether perceived or actual, were widely reported as a barrier to accessing care. Most participants had either directly experienced discrimination or had friends in the rainbow community experience discrimination in healthcare services which contributed to rainbow people anticipating discrimination any time they accessed care. One participant said they were scared to go to crisis services in case providers made things worse by not being affirming. Only one participant reported they felt totally accepted in their rainbow identity by all mental health professionals; however, this participant still reported that not all mental health professionals with which they had engaged were educated on rainbow identities or issues.

Transgender and non-binary participants experienced unique equity issues when trying to access care. One participant wanted to change the sex on their birth certificate, but felt they couldn’t for fear of being denied funding for healthcare in regards to their endometriosis. Another participant discussed their difficulties in accessing healthcare services as trans person:

> I tried to get on the waitlist for a hysterectomy and my GP was like ‘it’s probably not going to happen’, and I was like well I want to see, I want to annoy the system. (Participant 4)

These quotes demonstrate systemic barriers which prevent equitable access to healthcare. Participants themselves are keenly aware of the systemic barriers and must negotiate the ways in which they resist and conform to get their needs met. They also highlight the intersection of

physical and mental health, which is not always recognised or understood by healthcare professionals operating in a Western clinical framework. Participants described many barriers to accessing care, however, when participants were able to access mental health services, satisfaction with services varied, with most participants reporting negative experiences, which was broadly defined by a lack of clinician competency.

***Subtheme 3: Lack of Clinician Competency*.** Participants reported mixed experiences with how their gender and sexuality were discussed and understood in mental health services, with many participants expressing dissatisfaction in this domain. Clinician lack of competency was reported by all participants. This included a lack of general knowledge about LGBTQ+ identities and experiences. Clinician silence about rainbow identities and topics was commonly reported; participants often had to start the conversation about gender and sexuality, and felt their gender and sexuality were often assumed to be cisgender and heterosexual. Participants also reported a lack of cultural competency which failed to take an intersectional perspective, including lack of knowledge about Māori perspectives of health. This left participants to have to constantly assess and negotiate their safety in mental health services.

Without exception, all participants reported having to educate their mental health professionals on LGBTQ+ issues, either because it was necessary to receive the care they needed, or because clinicians expected this of them. When I asked one participant if they ever had to educate their mental health professional on LGBTQ+ issues, they responded:

> Often, yes. So often. All of them except for the one for the autism assessment. He knew what was going on. Otherwise, every single one of them. Besides that, every single one of them I had to explain every single bit of myself. Not in a 'I'm telling you who I am way,' but in a 'you have no idea what I'm saying' way. (Participant 5)

Participants frequently described it as ‘annoying’ to have to be the expert and it took time away from addressing their challenges. This left participants to have to start the conversation. Some participants would ask outright whether the clinician was rainbow friendly or not, but others stated they were not as comfortable sharing their identity directly, or if they were still working it out themselves, were more cautious with how they came out in session.

Participants shared that clinicians would say they had experience with rainbow people, but they did not feel this was accurate. Many participants reported their clinician didn’t know that pronouns other than he/she were used. Other participants discussed how clinicians would want to learn more, but did this in inappropriate ways: “If you’re going to work with a trans kid, don’t ask them, ‘hey what’s in your pants?’” (Participant 2). The participant discussed how this type of questioning was a boundary violation. Despite participants describing clinicians as lacking in LGBTQ+ knowledge, most didn’t expect their mental health professional to be an expert, but instead they wanted them to have a basic level of knowledge. Some participants described effective and positive therapeutic experiences even though they reported the clinician had little to no LGBTQ+ knowledge.

One of the most common experiences described by participants was that their identity was assumed as cisgender/heterosexual/monogamous. Most clinicians did not ask about gender or sexual identity on intake forms or in assessments. When sexuality and gender was brought up, usually at the instigation of the participant, many participants felt their identity was subsequently dismissed or ignored. Participants themselves acknowledged that the language and terminology shift rapidly, and it can be hard to keep up to date, but to be silent on the topic was not an acceptable option.

It was important that clinicians had enough competency to ask about gender, sex, and sexuality in an appropriate way. Participants raised the point that clinicians shouldn’t force them to come out, but should instead give choices:

> They could ask if the person is comfortable with saying what they think their sexuality or gender is. And if they aren't comfortable. That's fine as well. Don't pressure it. It's good to just, perhaps, get to know your client a bit more in that area so you know what to do to help. Maybe do a little research if you don't entirely know what it is. You are giving them a choice and that is a lot of what therapy should be about. Letting them know that they have a choice in what they want to say. A lot of the time you don't feel like you have the power over anything. So, getting the idea that you can make a choice without consequences that are negative gives you a bit of power for yourself. (Participant 9)

The participant identified that having choices can be an empowering experience, and rainbow people have identified that they often aren't given choice in mental health settings.

I asked participants if they thought clinicians ever focused on their sex, sexuality, or gender identity and if it was an accurate reason for their mental health difficulties, and responses to this varied. Willingness to explore challenges associated with gender or sexuality the clinician depended on whether they were perceived to be affirming or not:

> I find it hard — sometimes it's not relevant and sometimes it is. For me, most of the time it is relevant for me because who I am as a person and how my gender affects me and how much my sexual orientation affects who I am as a person. So, it's challenging. Sometimes I don't want to talk about it because I know the person isn't affirming. And other times I am like yeah totally ok to talk about this. (Participant 2)

I then asked them if the professional indicated they were a safe person to discuss it with, they responded: "Then I'd be fine. Then it would be something I would be open to and if they were a safe person then honestly it would probably be healing for me."

It was important to recognise that each rainbow person is a unique individual with unique needs:

> I say something about autism that also applies to being queer in this moment. My issue doesn't stem from being autistic. It's the way people treat me for being autistic. My autism has nothing to do with my struggles. It is all the other people that refuse to treat me as a person because of it. (Participant 5)

The participant's quote highlights that sometimes rainbow (or other marginalized identities) is directly relevant to the young person's distress, and sometimes it isn't, but it is impossible to know if the clinician doesn't ask, and the silence contributes to rainbow young people not knowing if the clinician is a rainbow affirming person or not. If clinicians are educated and aware of rainbow identities, they can combat heteronormativity by offering young people the opportunity to share about the various identities they might hold. It is a simple, and yet, powerful step that can help improve mental health services for rainbow young people. The participant went on to describe how being respected helps the client to feel comfortable and not pressured. She also made the point that clinicians need to adjust their approach based on the individual as not all people will want the same approach

> They need to actually treat us like people. Just because we are under eighteen — I feel like they don't listen to anyone under thirty. Our age doesn't determine how much of a person we are. That isn't really a thing past the age of two. We need to be listened to, respected, and the struggles that we are going through need to be understood. We might not be paying taxes, but this is the only thing in our lives and if that's going wrong it's everything. (Participant 5)

The quote raises another important point — that rainbow participants often felt their rainbow identities weren't taken seriously due to their age. When participants felt respected for who they were, they had much more positive therapeutic experiences.

Most participants described minority stress and intersectionality when discussing their experiences, however, no participants used this particular language. The ways in which participants described their challenges from a sociocultural perspective, and how they impacted on their wellbeing was sophisticated, however, it was often inferred that this perspective was not often validated by clinicians.

> When I say that's one of the reasons I'm upset [identity related distress], they immediately jump to that and say 'oh, actually you're just confused, or this is the whole reason, you're just around too many queer people and they are influencing you and this is why you're sad. And I'm like, actually, I've always been queer and different, and having friends who are or aren't doesn't make a difference. I would be like this no matter what. (Participant 2)

A minority stress perspective is completely absent, and instead the individual's identity is focused on as the reason for difficulties, rather than larger societal factors. Queer peers are seen as part of the problem rather than as a protective factor (Russell & Fish, 2016). The participant makes it clear that their identity is not a choice, but who they are. All participants held multiple minority identities, and so it wasn't surprising that all participants felt clinicians they had worked with lacked an understanding of how intersectionality impacted on experiences of mental distress. One participant described some of the everyday challenges he experienced as a trans teenager and how those difficulties intersect with his mental distress:

> Every time a group of teenage boys cross me, I go into fight or flight mode. The last time a group of teenagers my aged, biked past me I was like, 'no, don't judge them because they are your age and boys.' And they ended up following me almost all the way home spitting at me and throwing rocks. (Participant 4)

These quotes depict the devastating challenges rainbow young people face in their everyday lives. It is understandable that such experiences would lead to feelings of anxiety and depression, and yet participants reported they often felt their mental distress was not conceptualised in an accurate or helpful way by many clinicians. Although sometimes youths' mental distress was related to their rainbow identity, often participants felt their mental health difficulties were misattributed to being caused by their rainbow identity. Some participants felt their mental health issues were unrelated to their gender or sexual identity and felt that this was not well understood by their mental health professional.

Numerous participants discussed clinician lack of knowledge about alternative relationship structures (forms of ethical-non-monogamy) in particular, and that they felt judged for being ethically non-monogamous even more than they did for being queer. In addition to reports of judgement and discrimination for participating in alternative relationship structures, many participants felt they experienced transphobia by their clinician. Trans participants that did not present as strictly 'feminine' or 'masculine' as aligned with their gender identity reported being judged by their mental health professionals as 'not being trans enough'. Trans identities are often subjected to binary gender norms, which pressures trans people to 'pass' by conforming to societal norms and expectations of binary gender presentations (Selwyn, 2022) For example, if a trans woman doesn't look 'feminine' enough, they can be judged as not being authentically trans.

One transgender male participant described his difficulty in accessing appropriate care which was intersectional and took into consideration the different challenges he faced:

> I saw her for six months and she was good for anxiety and got me on medication and that was about where she stopped being great. She was like, 'mmm, you can't have autism. Girls can't have autism.' And I was like 'check mate, I'm trans now!' And she was like, 'no, females can't have autism. You are doing well at

> school; you can't have ADHD'…And I was like, 'yeah, but I'm wanting to kill myself because I'm doing good in school because I have to try 20 times harder than neurotypical people.' (Participant 3)

This quote illustrates how clinician lack of competency in modern models of mental distress can impact on the wellbeing of queer youth. The participant was aware of the irony of the situation and laughed when they shared this information with me. Participants seemed to normalise negative experiences in regard to gender identity in mental health services — after all, gender diverse people experience stigmatisation and discrimination in their everyday lives.

Other gender-diverse participants shared clinicians undermined their gender-diverse identity by saying things like, "you're just a teenager, your brain is still developing" (participant 5). Participants were often left questioning their own identity, which they likened to gaslighting, and felt it was incredibly damaging and harmful when they were already feeling vulnerable. These responses effectively dismiss the participants' experiences as a gender-diverse human as authentic and real and is an example of how cis-normative beliefs, as well as psychological models of 'normative' development can influence the ways in which mental health professionals understand rainbow clients.

Participants that held a minority ethnic identity, which was also not a choice, also felt their experiences weren't understood through an intersectional lens.

> They should stop Christianising our history. Before colonisation, it wasn't just like we got up and we prayed to God and then we worked and then we went home. It wasn't like it is now with campfires instead of TVs. I think Māori history isn't taught well enough. We barely got it at school. And yet, one of those aspects

> of it that does get censored is the whole takatāpui thing. The fact that those gender identities and sexuality aspects existed before the arrival. (Participant 8)

Māori in particular felt the impacts of colonisation on takatāpui people were absent from clinician knowledge. One participant spoke about how pākehā models of mental distress are different from that of Māori and are therefore not as effective when working with Māori people. This included practices like clients being passed between numerous mental health professionals, sterile hospital-like clinic settings which were not suitable for whānau, an individual rather than whānau approach to treatment, and a lack of understanding about Māori culture and worldviews. Numerous participants discussed the importance of understanding how mental and physical health are inseparable, and that whānau also plays a large role in experiences of mental distress.

It was clear to me that understanding minority stress and taking an intersectional approach was far more important to participants than having an in-depth knowledge of every LGBTQ+ identity and term. Discussing sex, sexuality, and gender in mental health services can be an incredibly vulnerable experience — particularly for those who are experiencing distress and still working out their identity. When rainbow identity isn't held in a safe and supportive manner by clinicians, it can be a disempowering experience, leading rainbow young people to disengage from services without receiving the help they need.

Theme Two: Strength in Our Community. Despite experiences of mental health services being reported as predominately negative, rainbow young people did report some things that were working well. I identified three subthemes that captured positive experiences: local gems, and Māori models of healthcare, and community supports. There were several local clinicians that were mentioned by numerous participants who were rainbow competent and delivered excellent mental health care. Māori models of healthcare were reported as more effective in supporting mental health care than pākehā systems. Finally, rainbow young people discussed the importance of community supports, and how sometimes their mental wellbeing

was most supported by non-mental health professionals such as youth workers and teachers. Overall, when participants felt understood and affirmed by support people, they reported much more positive experiences, even if the clinician was not especially knowledgeable on LGBTQ+ issues. Ultimately, all three subthemes fit under the umbrella of the power of community in supporting the wellbeing of rainbow young people in Nelson/Tasman.

***Subtheme 1: Local Gems*.** Participants described a handful of clinicians in the Nelson/Tasman region that did an exceptional job of providing care. The professions ranged from school counsellors, counsellors, whānau navigators, psychiatrists, clinical psychologists, and pediatricians. It was heartening to hear positive experiences with a variety of mental health professionals across different organisations. Professionals were accessed both publicly and privately. Participants sought out particular clinicians they had learned of through word of mouth, however, this was not as possible with clinicians accessed through the public health system.

When I asked participants what made an experience positive with a mental health professional, several factors were discussed. Participants appreciated it when clinicians asked about pronouns, as well as when they used pronouns correctly in sessions. By asking about pronouns, it signaled safety to rainbow young people, and demonstrated that their identity wasn't just assumed or ignored. One example of this was:

> My GP had inquired about what I wanted to be referred to as. She made sure that my pronouns were correct in the system, which was not something I knew could be fixed. So, I was very happy that she actually offered that without me having to inquire. This was in regard to a mental health appointment to do with my depression. (Participant 10)

When identity was acknowledged in mental health settings, it allowed participants an opportunity to explore their identity in a safe space, as well as work through associated challenges (from a minority stress and intersectional lens). On some occasions, school counsellors went out of their way to advocate for the rainbow youth they worked with (with consent), which was greatly appreciated by those that were being bullied in relation to their rainbow identity. This type of advocacy may be unique to school settings, as clinicians in other settings may not be connected to the young person's life in any way except through sessions. Perhaps advocacy could be carried out within family settings, but this would need to be youth-led and carefully managed by the clinician. Although rainbow young people didn't expect mental health clinicians to be experts on rainbow topics, when they did work with professionals that had knowledge, most noted it was greatly appreciated and helpful in the therapeutic process.

I inquired with participants on what made any given experience a positive one. One participant described their experience getting an assessment with a pediatrician — which was funded through a social worker:

> He was extremely understanding and listened very intently, they felt very comfortable. He gave me all the paperwork and said, 'this is the thing that you need to get the diagnosis because otherwise it's clear that you are autistic, and you could get this diagnosis. You need this test, and it costs about this much money. Can you ask if you can get the funding for that? It's a very specific one — it's easy you can do it the same way you got this set up and if you aren't able to get funding for that then just let me know and I'll set you up through CAMHS, because upsettingly you are too old to go through [pediatrics]'. (Participant 5)

The notable qualities for the participant were that the practitioner was understanding, and he listened intently, as well as him feeling comfortable working with a rainbow person. These traits were commonly reported amongst participants as critical to receiving quality care. Being

understanding and listening well are not unique to working with rainbow people but are fundamental to working with any person in the field of mental health. There were times that rainbow young people described very positive therapeutic experiences, despite the practitioner lacking in rainbow-specific knowledge. Feedback from participants indicated that the most critical aspects to positive experiences with mental health services were basic therapeutic skills of being attentive, affirming, and really listening to the client. Rainbow young people just want to be seen, heard, and treated with respect.

More important than rainbow-specific knowledge was clinician ability to apply minority stress perspective and intersectionality to understanding rainbow young people's distress. If these perspectives are lacking, the clinician can be knowledgeable on rainbow issues and identities, and still not be effective. The quote also highlighted how important good communication is for rainbow young people. The clinician understood how to navigate the mental health system and was able to provide clear guidance. Participants often felt disappointed with the level of communication from clinicians, however, some participants did acknowledge systemic issues outside of the mental health professionals' control such as the shortage of mental health professionals resulting in high caseloads.

Gender-diverse participants discussed the importance of gender-affirming mental health support in particular:

> My ACC counsellor forgot that I was trans, because, I don't know, he just forgot. One time we were talking about names, and he was like, do you like your name? And I was like yeah, I kind of have to like it because I picked it. And he was like, what do you mean? And I just looked at him, and he was like, oh, that's right...Yeah, I love him. It's nice to pass — that he forgot that I was not born a guy. (Participant 3)

> First people, I've gone, wow! So good with non-monogamy; so good with transgender people….they were like, 'you don't have to have dysphoria to be trans' — and that was the first time I had heard that. And they were like, 'actually it's kind of a minority thing. Most trans people don't feel it to the extent that it's advertised that it's meant to'. So a lot of people have that thing of 'am I trans enough'? And actually, there is no definition of enough. We can be trans and have no dysphoria and be just as valid as a trans person with severe dysphoria. (Participant 2)

The participant went on to say:

> I'd say the positives outweigh the negatives because they're so great! That moment of gender euphoria…the gender dysphoria does not matter…Just making sure people know they are heard and seen. Seen is the big one. If a trans person feels seen their life is changed. They feel like I am seen by this person for who I am inside. That can change a young person's life. (Participant 2)

These quotes give voice to the power of affirmative care and gives some examples of what this can look like. In the first quote, despite the clinician's gender-affirmation being somewhat accidental, it highlights how important it is for gender-diverse young people to be affirmed. The second quote also highlights that it's not all about 'passing' and depicts a different way of being affirmed. The clinician was clearly knowledgeable about transgender identities and issues and was able to validate the participant's identity by challenging the concept of being 'trans enough'. Together these quotes illustrate how nuanced gender-affirming healthcare can be, and why it is helpful for clinicians to have understanding and knowledge of these identities so that they can best support each unique rainbow person they might work with. Good listening skills, non-judgmental understanding and rainbow competency form the foundation of affirmative mental health support for rainbow young people.

Subtheme 2: 'She was Like an Aunty'-- Māori Models of Health Work.

Numerous participants throughout the interviews touched on the importance of mental health clinicians understanding how physical, mental, and emotional health all can intersect. Te Whare Tapa Wha, and other Māori models of wellbeing inherently take this perspective, and can be utilised by clinicians for all clients, not just those that identify as Māori. Participants reported positive experiences with healthcare professionals that utilised culturally informed models of understanding mental distress, although these experiences were far and few between. Although I only interviewed one Māori participant, the discussion was rich, and so it felt appropriate to assign a subtheme to capture positive experiences associated with Māori models of healthcare. It also felt important to explore the findings as there is so little rainbow research in Aotearoa, and even less so that includes takatāpui voices. Finally, I want to reiterate that I am a pākehā researcher, and so I cannot truly know or understand how it is to grow up as takatāpui, however, I have valued Māori models of health for a long time, and possibly hold a bias towards them as more holistic for both pākehā and Māori alike.

During our interview, we discussed the participant's long history of engagement with mental health services. This started with CAMHS and included involvement with numerous mental health professionals. The participant discussed how his whānau did not like going to CAMHS and mentioned that the office was "weird". The CAMHS office is part of a medical compound across from the hospital. The door to the building is always locked and you have to be buzzed in. It is an outdated building which is very reminiscent of sterile hospital rooms. It is no surprise that the premise would feel culturally out of place. It is important to have spaces that are large enough to comfortably accommodate whānau when working with Māori (Elder, 2017), and I doubt this was a focus for the organisation 10 years ago when the participant was working with them. The participant

noted how he worked with at least 5 mental health professionals while he was with CAMHS, and that this did not work well for him.

In addition to CAMHS, the participant was sent to some sort of 'health' camp on the North Island, which he believed was for 'troubled' tamariki. He reported mixed feelings about the experience — that he had some positive memories with playing fun games, but this also was the first time he felt suicidal. He shared how difficult it was to be away from his whānau and whenua, contributing to feelings of isolation and loneliness. When I heard him speak to this experience and how it increased feelings of distress in him, it made sense to me that separation from whānau and land would exacerbate feelings of distress. This was many years ago, but it made me consider whether sending Māori tamariki away for mental health support is a culturally appropriate intervention. When the participant was in college, he became engaged with a local Māori healthcare service. This service was wrap-around and took a whānau first approach. The participant ended up working with one mental health professional over a number of years, and he described this as an incredibly positive and powerful experience. The clinician was the first person he came out to:

> I can't remember how it was…she wouldn't do this when she first met me. But she knew me for seven years, so we had that relationship where she was my aunty, and she was happy to tease me. She'd be like, oh there's some pretty girls on the beach today. And I was like, no, I don't even like girls. And she was like, oh ok. She wasn't like oh ok, but she was like, interested. It felt good to have some interest. Like oh, you actually want to talk about it, sort of thing…she was just accepting and supportive…she would be like, of course, that's fine, that's good. That's good that you're open with me now. It was a good release of finally telling someone. (Participant 8)

This quote demonstrates a few key findings — one is that the therapeutic relationship was the most important factor for the participant — he felt accepted, supported, and that she was like ‘an aunty’. I believe this would be perceived as crossing a boundary from a Western clinical perspective, however, it was indicative of an effective therapeutic relationship within a Māori context. It is possible the clinician assumed the rangatahi’s sexuality, as evidenced by the comment about girls, but it is also possible the clinician did not want to force him to come out, as implied by them saying “that’s good you’re open with me now” — possibly indicating they had an idea about this previously. Either way it is speculation as it is impossible to know what the clinician’s intention was, but his coming out was received with warmth, care, as well as interest, which made for a positive experience.

The participant felt all mental health practitioners needed to have basic knowledge of rainbow identities. He felt strongly that CAMHS lacked this competency, but actually all mental health services in the region needed to upskill. He expressed his frustration with the role colonisation has had on erasing takatāpui identities and shared he didn’t discover the term himself until recently. There is no doubt that being engaged with a culturally appropriate mental health service helped the participant process his rainbow identity in a safe and supportive way. We need culturally informed models of mental health support which are rainbow competent to provide quality care for Māori rainbow young people.

When the participant discussed positive experiences with mental health services, they existed within Te Ao Māori. Therapeutic approaches included whanaungatanga — building relationships as well as connections with the community and the Te Tao — the environment. He described learning traditional skills such as waka ama and making Māori musical instruments as part of the therapeutic interventions he experienced. These

experiences demonstrate how mental health care is not just individualised but takes places within a larger community context. Positive therapeutic experiences within the community were highlighted not just by this participant but was a larger theme which I identified across all participant interviews.

Subtheme 3: Community Supports. Although the interviews were focused on experiences accessing mental health services, when participants described their positive experiences, they often spoke about community supports from non-clinical services. These positive experiences existed within community organisations, sometimes at school, and were sometimes with mental health professionals (as described previously), but often they were with non-mental health staff such as youth workers, school-based nurses, and teachers.

Half of the interview participants were still engaged with education providers (predominately secondary school). Although school-based experiences for participants was often fraught, there were also stand-out positive experiences shared which participants reported as making a large positive impact in their lives.

> [It's] not exactly mental health support but I had a really good teacher last year. And yeah, I was emailing him a lot in lockdown. I was feeling really shit having to live at home — she's [mum] heavily transphobic and also racist. So that sort of annoys me. And I was doing really badly so I was emailing him a lot and he was giving me work that I would actually enjoy doing — extra biology stuff because I love biology. Yeah, he's an awesome teacher. (Participant 4)

By simply having one really positive relationship with a teacher that connected well and was a safe and affirming person, the young person was able to get support during a really difficult patch of mental distress. The teacher was not directly providing mental health care but their engagement and support through learning were enough at that particular time. Numerous young people also reported receiving mental health support through school-based nurses, despite

this not explicitly being their professional role. It should be noted that not all schools fund nursing positions, so this care isn't available for all school-aged rainbow young people in the Nelson/Tasman region. Finally, participants reported some positive experiences with school counsellors, which was incredibly helpful because they often were the most accessible mental health professional for school-aged young people.

Outside of school, rainbow young people described a variety of community-based services as particularly helpful and more accessible for mental health support. These included youth organisations that employed youth-workers such as Q Youth, Whanake Youth, the Independent Nursing Practice (INP), as well as community mental health services such as Lifelinc and other smaller locally based organisations. These organisations' services varied from providing peer-support and drop-in spaces that were safe for rainbow young people, to more clinical services such as free counselling, nursing, community support workers, mental health coaching, and mentorship. Community services came with the advantage of having some choice around whom they engaged with, enabling rainbow young people to find someone they connected well with.

Q Youth was the region's only dedicated rainbow youth service; however, their hours are extremely limited, and they are chronically underfunded. Some participants also reported that they didn't find the 'vibe' right for them, and that it only suited a niche group of rainbow young people. For those that did connect well with Q Youth, they shared that the centre was an incredibly positive space for them and helpful in supporting their wellbeing.

> I've been on this journey as a disabled queer person and there is a lot to be said for spaces that are accessible spaces, especially for people on the spectrum…Someone who struggles with communication, how are they going to find a space where they can learn these things? People who are non-verbal; and

> there are a lot of people on the spectrum at Q Youth, but I think there needs to be. The quiet space, that is such a great idea for people who get overstimulated or want a private conversation. Safe word, great idea, A topic can be completely dismissed if it needs to be. (Participant 2)

The participant described some of the aspects they found integral to Q Youth being a safe space for rainbow people on the spectrum: having a quiet room, as well as group rules for conversations so that they are appropriate and safe for all. The participant was referring to a friend of theirs in the quote who was borderline non-verbal, and cross-dressing. He speculated that his friend might have been transgender, and that Q Youth was one of the only places where his friend could be safe to explore his identity. The participant highlighted how there aren't many community spaces that are oriented towards young people on the spectrum, and that Q Youth was filling an important gap. Overall, participants described the youth workers at Q Youth as rainbow experts, incredibly supportive of not just rainbow identities but ethical non-monogamy as well as disability friendly and caring. Furthermore, many participants shared they had health professionals recommended to them by the staff at Q Youth, and that this was the only way they who to go to for quality rainbow affirming care.

Another integral community organisation for the rainbow community in Nelson/Tasman was the INP. The INP received glowing feedback from gender-diverse participants. INP is a collection of nurses who specialise in sexual health and provide gender-affirming healthcare. Participants described their staff as incredibly rainbow supportive, knowledgeable, and non-judgmental, especially regarding non-traditional relationship structures such as ethical non-monogamy. Participants noted that the organisation worked to build relationships with local schools so that young people were aware of their services. They also provided a list of gender-affirming counsellors and mental health professionals — which is the only organisation that I

have heard of in this region that formally does this. Participants reported that their services were either free or highly subsidised, reducing a financial barrier to care.

It was encouraging to hear participants share their stories of positive experiences with clinicians, community organisations, schools, and their peers. To me, it demonstrated how mental health support can come from a wide variety of people and places. Their stories reminded me of a whakatauki by Kingi Tāwhiao that speaks to the importance of community: “Ki te kotahi te kākaho, ka whati; ki te kāpuia, e kore e whati”: When we stand alone, we are vulnerable, but together we are unbreakable. Rainbow people found strength in their community, and every positive experience, whether it was with a particular person or a community organisation, formed a piece of the puzzle toward mental wellness.

Theme Three: It’s All About Safety—Recommended Improvements for Mental Health Services. The final portion of the interviews explored recommendations to improve mental health services for rainbow young people in the Nelson/Tasman region. I asked about: (a) how access to mental health services could be improved; (b) what mental health providers needed to know to work effectively with rainbow young people; (c) how clinicians could better address or ask about sex, sexuality, and gender in services; and (d) clinician characteristics that are important to the provision of safe and affirming rainbow mental health care (e.g., sharing a gender/sexual orientation identity with their clients). Recommended improvements were informed by participants’ experiences of mental health services, and so the subthemes overlap with those in Themes 1 and 2.

The core theme of this section was safety. Rainbow young people wanted to feel seen, valued, and to be respected—whether that be in mental health services or in the community. It was important to rainbow youth that clinicians explicitly signalled safety

(e.g., by including rainbow signs or flags in clinical spaces) so that they could feel open in sharing their identity and mental health challenges with clinicians. Participants felt strongly that all clinicians should be competent in working with rainbow people, and that this could be achieved with more clinician training on both working with rainbow people as well as general cultural competency in order to provide quality care. Finally, participants shared general improvements to increase access to quality care in the Nelson/Tasman region.

Subtheme One: How Do I Know It's Safe? Increasing Access to Mental Health Services. As discussed in the previous themes, participants described constantly assessing whether they were safe to be open about their rainbow identity and experiences in mental health services. Rainbow young people discussed ways in which clinicians could signal to clients that they were rainbow-affirming, helping participants to feel more relaxed and able to share honestly in order to get the care they needed. Some participants shared that having rainbow posters or flags up in offices helped signal safety prior to even engaging with the clinician individually. Participants also recommended that intake forms include inclusive gender options and pronouns so that participants could disclose this information prior to sessions if they felt comfortable doing so. One participant reported that a clinician shared their own pronouns with them; however, this was a stand-out experience, and the counsellor was nonbinary themselves. Many participants said clinicians should ask everyone about pronouns and to be 'straight up' as this would counter heteronormativity in mental health services. On the other hand, one participant was concerned about clinician safety if this became standard practice:

> I think it would be potentially good if providers just asked everyone. However, I realise this could create conflict between some patients and their medical providers which could case violence and escalation. They might feel threatened by questions like that. I'm not sure how big it is in the Nelson region, but I know nurses in particular suffer violence from patients on a decently regular basis. So, I

> understand any hesitancy to do so. But maybe with youth in particular, it would be more appropriate. Because there is less physical threat from a teenager (laughs) than a fully grown man. (Participant 10)

It was incredible to me that throughout the interviews, participants not only assessed their own individual safety, but also the safety of clinicians and clinical services more broadly. This evidenced how ingrained threats to safety are in rainbow young people's everyday lives, and highlights how challenging heteronormativity can be not only an uncomfortable experience, but also a dangerous one. It was evident throughout the interviews that rainbow young people often exist in "fight-or-flight" mode (i.e., the heightened stress response the nervous system has when a person feels threatened). Rainbow young people are constantly attuned to possible threats in the environment and prepared to seek safety. Clinicians must respond to this threat vigilance by pre-emptively creating explicitly rainbow affirming environments that can put their clients at ease from the first point of contact, including visits to their website or referral forms.

In addition to asking about pronouns and having visual rainbow symbols of safety in clinical settings, participants wanted clinicians to be willing to start conversations about rainbow topics, rather than relying on rainbow youth to do so. By starting these discussions, clinicians demonstrate that they are comfortable with rainbow topics and signal that these are safe topics to discuss.

> I think mostly just being straight up with the questions. So how do you identify? Like how you asked me in the beginning. Ask the questions, don't dance around the subject like it's taboo. It's not. (Participant 4)

I asked the participant what a clinician should do if they inadvertently ask about rainbow topics in an inappropriate way that upsets the youth. The participant recommended a simple apology to the client, in combination with professional development (e.g., researching new approaches) and

striving to do better next time. He emphasised the importance of being openly supportive and not questioning the young person's identity unless the young person is themselves exploring their identity.

On the other hand, participants acknowledged that there are some aspects of rainbow health care that requires specialist knowledge and which may be best delivered by a rainbow-specific service.

> I think for things like gender therapy there has to be. You can't just have a normal therapist who does gender therapy on the side. You have to be a specialist in that. And for trans-affirming care. You actually should have specialist training in that and there should be the ability to go, 'hey, here's a whole space where all these people can come and they know if they can come here they will be affirmed and cared for.' And it just, it kind of should be everywhere. We shouldn't have the need. But I think at this stage we do have the need. (Participant 2)

Some participants were highly supportive of the idea of a separate rainbow-specific service. They felt that rainbow identity was a specialist area, especially for gender-diverse people, and thus required a specialist service.

> I definitely think there should be a specialised area just for the LGB community. I know there would be people who would just be like, 'oh why do they get special treatment?' But it's a completely different matter. It's like you wouldn't get mad at a heart surgeon because they only do hearts and not bone fixing. (Participant 9)

Some participants pointed out that a separate service could increase access to care by prioritising rainbow mental health as well as making it easier for rainbow youth to find support due to being a separate service. However, participants were also cognizant of the potential risks:

> I think it would be easy to find if it was separate, but that is not necessarily the priority because if it's easy to find, but underfunded, then what is the point? So, I

> mean I'd be a bit on the fence about that I guess. I'd have to see the context around why they would be suggesting an individualised/separate service. (Participant 10)

The participant went on to discuss how political party changes impact funding of health services, and that rainbow services could be at risk of losing funding if the political agenda shifted. Yet another participant brought up the recent arson of the Tauranga rainbow youth centre (Rainbow Youth, 2022) and felt highly concerned that a separate service could be vulnerable to physical attacks, and then there would be no service at all. Participants were also concerned about privacy — that rainbow young people would be "outed" as rainbow by the very fact they were using that service, which could cause harm. Participants also worried that by having a separate service, other clinicians would not bother to increase their rainbow competency, and thus any rainbow people who did not seek care through the rainbow service (e.g., because they were not out or were still exploring their identity) would be disadvantaged. Another participant raised concerns that a separate service felt like rainbow people were being segregated, further ostracising them. Alternative solutions included putting queer navigators in services like ICAMHS, having group therapy options for rainbow young people, as well as having queer and gender diverse clinicians available. Nelson currently has a community organisation called Compass which provides peer advocacy support services (Compass, 2023). This service could incorporate rainbow navigators, or collaborate with mental health providers to embed this model within their services. Rainbow navigators could also advocate for rainbow therapy groups to be established across mental health providers, as well as establish a rainbow peer-support group for rainbow young people experiencing mental distress.

It was amazing to see the depth of consideration participants gave to the benefits and potential consequences of having a separate specialised service for rainbow youth. Again, the responses evidence how rainbow young people are constantly negotiating safety when accessing mental health services. I felt sad that rainbow youth were burdened with considering things like the arson of a rainbow mental health service and potential funding loss due to political shifts. Despite feedback being mixed about having a separate specialised service, all participants felt strongly that clinicians need to be rainbow competent in order to deliver quality mental health care.

Subtheme Two: "We Are Everywhere" — Increase Cultural Competency Training. All participants stated mental health staff, as well as support staff such as receptionists and other administration staff, needed more training in order to make meaningful change for rainbow young people accessing mental health services. Although this primarily focused on rainbow competency training, participants also called for a broader scope of cultural competency which covered an awareness of different identities, knowledge of rainbow history, current rainbow legislation and social issues.

The need for all clinicians to be culturally competent was illustrated when they were discussing how their school supports Māori students in the counselling department:

> They've [the school] got two Māori counsellors who come in a couple of days a week and they specialise in that sort of stuff. I think that's really cool and really important and would be cool if they had specific gender diverse queer counsellors who come in a couple of days a week seeing queer students. (Participant 4)

When I asked him if he wanted this to extend beyond the school environment, he was hesitant, and again reiterated that clinicians should be competent to work with rainbow people, *"because we are everywhere".*

Participants wanted their providers to have enough knowledge of rainbow identities to not have to educate them on the basics, but they also wanted them to be educated on intersectionality and minority stress, which wasn't explicitly to do with just rainbow identities:

> I think there should be much more training on LGBTQ+. It should be at least a week of training. At least a week solely focused in their training just on LGBTQ+ identities — trans identities, two spirit, takatāpui, and it has to be involved in culture as well. It has to be intersectional. And disabled people have a very different experience in queer identities than non-disabled people. (Participant 2)

When I asked another participant what mental health providers needed to know in order to work effectively with rainbow young people, they reiterated the importance of intersectionality, and specifically identified the link between rainbow identities and neurodiversity/neurodivergence: "I feel like it would also be very advantageous if they could be more educated on how those identities overlap with learning disabilities and autism and things like that" (Participant 10).

The participant identified that there is a substantial crossover between transgender identity and autistic traits, however this link is still being researched, and is outside the scope of this study (Kallitsounaki & Williams, 2022; Mazzoli et al., 2022; Strang et al., 2022). Although my quantitative results are not representative nationwide, only 32.4% of participants identified as cisgender, and 40.7% of participants identified as being neurodiverse. 7 out of 10 interview participants also identified as being neurodiverse and non-binary and/or transgender.

In addition to understanding the intersectionality, participants wanted clinicians to be up to date with current research, relevant policy, and have an understanding of LGBTQ+ history: "They need to be more educated on the history of oppression and

keeping up to date with recent news articles — people are still getting beaten up for being gay in the street" (Participant 4).

Although participants wanted clinicians to have an awareness of different identities and how they impact on lived experience, as well as knowledge about rainbow history and current legislation, they didn't expect them to be experts.

> You don't have to understand the deep intricacies of very single sexuality and gender and stuff, but as long as you get the gist of them, and the idea of a lot of young people may not know entirely what they are yet. So, it's good to not just assume. It's not good to pressure them into being one thing or the other. It's basically helping them but still allowing them to pick for themselves. And guiding them to find what makes them most comfortable. It's about respect. (Participant 9)

For most participants, it came back to the basics of clinical competency - being educated, open, inquiring, and respectful were key characteristics participants wanted in their mental health professionals.

Subtheme Three: General Improvements. Participants not only made several rainbow-specific recommendations, but they also had a number of recommendations for general improvements to mental health services. These included increasing the number of professionals, as well as funding for services, better advertising for services, more flexibility with appointments and scheduling, and funding community prevention and early intervention services — both in and outside of the clinical scope.

Participants were well aware of the pressures on the mental health system and that more funding and professionals were required.

> I mean obviously funding is an issue. It's always going to be an issue. But it would be a huge start to actually know who to go to and who to inquire with. And

> to work on the funding issue — to have the service provided. Yeah, that's the probably the biggest number one thing. Especially in my experience." (Participant 10)

Participants identified that funding was required to increase access to services. Most participants did not want to go through the public health system (CAMHS) because they felt it was not rainbow friendly, and the wait times were impossibly long, but they didn't feel that there were any other options. Another participant felt mental health services should be free of charge and that there should be a broader range of services beyond CAMHS:

> I think it should be advertised — well I think it should be free. I think all of it should be free like any other health service. It should be a household name. Most people know what CAMHS is. I think most people should know that CAMHS — if they were — then they have good rainbow support. Because that is the main provider for young people. It should be known that these specific people, organisations, have the training to deal with queer issues. (Participant 8)

Improvements to advertising for youth-specific mental health and wellbeing services would help rainbow young people get access in a timelier fashion. Furthermore, rainbow young people wanted more diversity in the mental health workforce, and wished they had an option to work with a rainbow clinician. A few participants aspired to become psychologists, which was heartening to see.

Many participants noted that getting to appointments could sometimes be hard, and that flexible scheduling with location, time, and having a tele-health option would help increase access to care — especially for those that lived in rural areas where there were no local mental health services. Flexible scheduling was also noted as being more culturally appropriate — clinicians should be able to take a whānau approach, and this

included coming to the whare (home) rather than expecting whānau to come to clinical offices. One participant mentioned how it can be greatly beneficial if a clinician is available to go for a walk outside as part of an appointment — bringing nature into the healing context. Flexibility was key for meeting young people, who often did not have access to transportation, where they were at.

Finally, participants did not want the power of community to be underestimated. Having peer-support, youth workers, youth dedicated spaces and organisations, and mentorship opportunities were all described as invaluable — especially in prevention and early intervention. Rainbow young people wanted to be connected with their community, and to feel safe and valued. Clinical services could include peer-support staff as well as mentors to help support young people, and hopefully prevent mental distress from hitting a crisis point.

Chapter 5: Discussion

To my knowledge, this was the most extensive investigation of rainbow young people's experiences with mental health services in the Nelson/Tasman region. I aimed to explore rainbow young people's experience with healthcare providers in Nelson/Tasman, investigate what barriers to receiving mental health support rainbow young people experienced in the Nelson/Tasman region, and investigate recommendations from both rainbow young people and health professionals to improve the provision of mental health support for rainbow young people residing in the Nelson/Tasman region. My findings indicated that rainbow youth want mental health services, but frequently have negative experiences with healthcare providers. Structural barriers made it exceedingly difficult for rainbow young people to access services. Improvements in training and resourcing are necessary to improve access to mental health care for rainbow rangatahi in the Nelson/Tasman region. My findings mirrored national and international research (Andrade et al., 2014; Poteat et al., 2013). Both rainbow youth and health professionals in Nelson/Tasman perceive LGBTQ+ youth mental health to be worse-off compared to cisgender and heterosexual populations, with minority stress contributing to experiences of mental distress. Below I discuss the quantitative and qualitative findings which mirrored each other closely; describe rainbow youth experiences with mental health services, level of quality and satisfaction; perceived and actual barriers to receiving care; and suggest improvements to accessing mental health support for rainbow young people in Nelson/Tasman.

Experiences with Mental Health Services (H1-H4)

LGBTQ+ youth experiences with mental health providers in the Nelson/Tasman were varied. I hypothesized that the majority of rainbow young people would attempt to access support (H1), and the findings supported this: 65.2% of participants had attempted

to access support from a wide variety of health professionals and 55.6% reported receiving support. Rainbow youth overwhelmingly self-reported poor mental health. Using Te Whare Tapa Wha as a measure of wellbeing, rainbow young people rated their mental health in the low to average range. Most survey participants cited depression, anxiety, trauma, and general life stress as reasons for seeking support from a mental health professional. These results indicate that there is no one single entry point to accessing mental health support for rainbow young people; school counsellors were most frequently accessed (50.6%) followed by counsellors and general practitioners. Interview participant results corresponded with survey results; rainbow young people most commonly reported accessing a school counsellor as a preliminary step, with most young people then being referred on to ICAMHS for more intensive care as youth participants reported school counsellors not equipped to meet their mental health needs. Furthermore, due to fears of their rainbow identity (as well as other minority identities) not being well understood or positively received, interview participants described feelings of anxiety about working with a mental health professional.

My findings confirmed H2; rainbow young people reported poor satisfaction with mental health services. Furthermore, I hypothesized (H3) that clinicians would have some experience working with rainbow young people. The majority of health professionals surveyed reported they had experience working with rainbow young people, which would indicate they were aware of at least some young people that held rainbow identities. I also hypothesized (H4) that clinicians would feel a lack of comfort and competency working with this population due to the lack of available rainbow competency training. As predicted, rainbow youth perceived clinicians to be less comfortable working with rainbow young people compared to cisgender and heterosexual youth. These ratings were significantly different to health professional's self-ratings (i.e., health professionals rated themselves as competent and comfortable working with rainbow young people), indicating a gap between rainbow youth and health professional perceptions. This

mismatch was at least partially explained by during interviews with youth in which they frequently reported a lack of understanding of minority stress and intersectionality from health professionals, and often felt their mental health challenges were misattributed to issues related to identity. These results are concerning as it may indicate that health professionals already feel competent in working with rainbow youth, and thus may not seek out rainbow competency training which could enhance their professional practice. Despite the rater discrepancy between perceived competency, health professionals surveyed did believe rainbow young people have higher mental health needs than their cisgender and heterosexual peers — although the reasons for this may be poorly understood or misattributed by health professionals.

Further to H2, both rainbow youth and clinician survey respondents reported that rainbow youth are overwhelmingly referred to ICAMHS; however, most youth participants reported negative experiences with the service, as well as general difficulties being able to successfully access the service. According to youth and health professional participants, there is no other service for rainbow youth experiencing moderate mental distress. This is concerning considering the difficulties with access and plethora of negative experiences reported. One health professional survey respondent stated, “I don’t even have knowledge about specific LGBTQ+ services – how can we expect young people to navigate the health system?” This statement highlights the need for clearer referral pathways and advertising of mental health services, especially those which are rainbow specific or friendly.

Numerous health professionals acknowledged the prevalence of transphobic views within the health sector in Nelson/Tasman. The anti-transgender CATA conference that occurred in Nelson in August 2022 was cited as deeply problematic and causing harm to rainbow young people. Some clinicians went so far to write in an open-response

text box that clinicians who hold anti LGBTQ+ personal views should state this on their website, so as to minimize the potential of working with rainbow young people and thus causing harm. The context of this comment was an acknowledgment that personal biases exist, and that they impact professional practice. Although it would be unethical by numerous accrediting bodies to make anti-LGBTQ+ statements (as this would constitute as discrimination), the comment highlights that discrimination does exist, and it can be impossible to know which practitioners are 'safe' to go work with for rainbow young people. Rainbow youth who were interviewed suggested some sort of 'rainbow tick' (Rainbow Tick, 2019) for clinicians that had completed rainbow competency training and were deemed safe practitioners. This suggestion is further explored in the recommended improvements section.

In a poignant closing statement on the youth survey, one participant summed up the challenges rainbow youth often face when accessing mental health support,

> If every person I've ever talked to on the matter of mental health in NZ has told me they've had awful and often traumatic experiences with nearly every outlet there is, why has nothing been done to change that? It is important that LGBTQ+ youth feel they have options that support who they love and who they are – counselling and other support services won't work unless they work for everyone.

Despite experiences with mental health services often being reported as negative, there were also experiences to celebrate. Rainbow youth that participated in the research often reported a sense of pride in their identity. Numerous rainbow young people, across the quantitative and qualitative data, reported Māori models of mental health support (e.g., Te Piki) were working well and this is examined further as a potential model of rainbow youth mental health support in the recommended improvements section.

Barriers to Receiving Support (H5-H8)

Broadly speaking, my results evidenced LGBTQ+ youth frequently attempted to access a wide range of mental health services; however, they faced numerous perceived and actual barriers to receiving support in the Nelson/Tasman region. I hypothesized (H5) that rainbow youth would have little knowledge about rainbow-affirming services, but what knowledge they did held would be from word of mouth. From a systemic perspective, both rainbow youth and clinicians reported a lack of knowledge about specific rainbow affirming providers. Seventeen clinicians and two organisations were specifically named as being LGBTQ+ affirming in the survey data. Eight survey respondents, and 8 of 10 interview participants stated they did not know any specific LGBTQ+ affirming professionals in the Nelson/Tasman region. Rainbow young people that knew of rainbow-affirming clinicians reported once it becomes well-known within the rainbow community that a specific provider is rainbow-friendly, they quickly get overwhelmed with self-referrals for services. Some rainbow young people are finding clinicians that are rainbow friendly and safe, but that these clinicians are often discovered through word-of-mouth within the rainbow community. As one interview participant pointed out, websites for mental health professionals tend to be very generic, and so it can be hard for rainbow young people to find out whether a clinician has experience and knowledge working with LGBTQ+ people.

I hypothesized (H6) that rainbow young people residing in more isolated locations within the Nelson/Tasman region would have little to no access to non-traditional sources of mental health support, but those in or near Nelson would have some support through local pride groups. Rainbow youth participants across the region reported positive experiences of accessing non-traditional sources of mental health support particular to the rainbow community, which was contrary to my hypothesis. The

majority (60.5%) of youth survey respondents reported receiving support from their friends, suggesting peer support is playing a significant role in bolstering mental health for rainbow young people. Nearly 20% of rainbow youth survey participants reported receiving support from a rainbow community group, which is surprising and impressive considering the relative lack of such groups within the Nelson/Tasman region and indicates and that our rainbow community in Nelson/Tasman is strong and resilient.[8]

Both clinicians and youth participants were asked to select from a list the barriers youth and rainbow youth face when attempting to access mental health services. I hypothesized (H7) that rainbow youth would face numerous barriers (general and queer specific) to receiving support. Although there were numerous barriers listed, the most commonly cited barriers by rainbow youth were lack of availability from healthcare professionals, and uncertainty of whether the professional was LGBTQ+ affirming or not and thus identity being misunderstood. These responses align with my hypothesis, and again evidence the shortage of mental health professionals in Aotearoa. Qualitative findings confirmed these barriers and added more nuanced perspectives (i.e., clinicians often neglected to take an intersectional and culturally informed approach to conceptualizing mental distress, which deterred rainbow young people from staying engaged with services). Fuelling the mental health crisis that currently exists within rainbow youth populations are long waitlists for services, which often results in mental distress increasing while waiting for support, thus rainbow young people end up engaging with ICAMHS once they are in crisis. However, due to a lack of rainbow competency from clinicians, rainbow young

[8] Most high schools in the Nelson/Tasman region have pride groups. In addition to this there is a Nelson Pride Facebook group which encompasses Tasman as well. Google search results indicated no other pride groups in the Nelson/Tasman region.

people end up feeling dissatisfied with services, and subsequently disengage, resulting in a revolving door experience of engagement with services.

Health professionals also acknowledged the lack of availability of healthcare professionals available given the demand for services; however, they indicated that the main barriers to accessing care for rainbow young people were rainbow-specific barriers — that is, fear of identity being misunderstood by providers, and uncertainty if the health professional is affirming or not, were rated as the two most significant barriers to accessing care. Interview participants reported frequent experiences of heteronormativity and cisnormativity in clinical services, with clinicians often being silent on rainbow identity. Silence on rainbow identities was prevalent throughout service engagement – from lack of gender options/pronouns on referral forms, to a lack of discussion about gender and sexuality in assessments, and thus assumed identity throughout the intervention. This placed rainbow young people in the position of having to start the conversation about identity, which required careful assessment of safety. Once rainbow identity had been disclosed, participants reported feeling their mental health difficulties were misattributed to being caused by their minority identity(ies), despite this often not being the case. Due to these experiences, rainbow young people, although often in serious need of mental health support, found it difficult to open up with healthcare professionals. This hindered the support process and contributed to a revolving-door engagement/disengagement cycle with mental health services. Only one youth participant (out of 81) selected the response that rainbow youth do not face any barriers to accessing mental health services in the Nelson/Tasman region, reflecting the widespread nature of these perceived/actual barriers to accessing mental health care as a rainbow young person in the region.

Overall, rainbow youth and health professional-reported barriers to access closely mirrored each other, with the only significant difference being cost of services. Clinicians

more frequently endorsed cost of services compared to youth. Surprisingly, lack of telehealth services and transportation were not ranked as significant barriers among youth survey participants, despite the Nelson/Tasman region being geographically spread out, as well as a shortage of mental health professionals in rural locations such as Tākakā and other small regional communities (Andrade et al., 2014; McIntyre et al., 2011; He Ara Oranga, 2018). However, youth interview participants that had grown up in more rural locations did discuss living rurally as being a barrier to accessing care, and that telehealth services and assistance with transportation would have been helpful for them, thus confirming that rainbow young people residing in rural locations experience unique barriers to care. Fortunately, both participants had supportive family members and were able to get assistance with transportation.

The qualitative findings specifically identified the shortage of clinical psychologists and psychiatrists as barriers to receiving care. Numerous participants wanted support for Attention-Deficit/Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder-related challenges; however, they could not receive support for these without accessing a clinical psychologist or psychiatrist. Although these were not difficulties explicitly related to rainbow identity, they impacted on overall experiences of mental distress and contributed to minority stress. Moreover, there is evidence in the literature that there is an overlap between gender diversity and autistic traits (Strang, 2022), as well as evidence in New Zealand that rainbow people are more likely to describe having disabilities (Olsen, 2022); therefore professional support for these concerns represents a vital part of healthcare for this population. Many participants were also seeking gender-affirming healthcare and had been turned down from assistance because they had not received a gender dysphoria diagnosis – and reportedly only one clinical psychologist (based in Blenheim which is outside of the Nelson/Tasman region) conducts these for young people residing in Nelson/Tasman Although gender dysphoria is not a requirement to receive gender-affirming healthcare (nor is it best practice) (*PATHA - Professional Association for Transgender*

Health Aotearoa - Guidelines for Gender Affirming Care, 2018), many GPs and other health professionals require this before offering gender-affirming healthcare to rainbow youth

Youth and clinician participants cited a variety of barriers to accessing mental health support in the Nelson/Tasman region. The barriers listed illuminate some of the challenges rainbow youth face when accessing, or attempting to access support, and have been used to help inform recommended improvements to accessing mental health services for rainbow young people in the Nelson/Tasman region in the next section.

Recommended Improvements (H9)

I hypothesized that both rainbow young people and clinicians would recommend increased resourcing for mental hleath services which would include funding and rainbow competency training. I also hypothesized that rainbow young people would want a dedicated rainbow youth mental health service to improve the provision of mental healthcare in the Nelson/Tasman region. Although some of the experiences rainbow people have had with accessing mental health support in this region are those depicted by difficulty and disappointment, it is my hope that this research highlights what is working well, and to promote practical solutions which could be implemented relatively quickly to alleviate the mental health disparities rainbow young people face in Nelson/Tasman and Aotearoa more broadly.

The majority of rainbow youth participants endorsed reducing the cost of services (54.3%), providing more LGBTQ+-affirming trainings for health professionals (54.3%), and clear rainbow affirming statements on health service websites (53.1%) as key recommended improvements for increasing access to mental health services. In addition to these recommendations, the majority of health professionals also suggested clear rainbow affirming statements (61.4%) and more rainbow competency training (56.8%),

but differed in that the majority also endorsed more mental health providers to choose from (61.4%). It appears from the results that rainbow youth prefer to work with local clinicians face-to-face, and clear confidentiality and rainbow-affirming statements on provider websites would help them to navigate the confidentiality and safety issues raised above while meeting this desire for in-person care. Subsidising the cost to see mental health clinicians would enable rainbow youth to access care privately, potentially lessening wait times and providing more clinicians for youth to choose from. However, this option may not be as quick to implement as it would require systemic changes (e.g public mental health services contracting private providers at times to increase capacity) and significant funding. Interestingly, Te Piki Oranga — the Māori mental health service in the area — contracts psychologists external to the organization to provide care, which reduces wait times and enables the whānau they work with to have more choice. Given the reported success of this model among participants who described using it, Te Piki Oranga's approach could be a model that Te Whatu Ora look at implementing for rainbow youth.

In general, Te Piki Oranga received very positive feedback in both the quantitative and qualitative data. Rainbow participants often held multiple minority identities, and so intersectional perspectives to understanding mental distress, including culturally informed models of care, were reported as more effective than more individualized conceptualisations of distress that follow a Western narrative. Te Whare Tapa Whā as a way to understand wellbeing was noted as being particularly helpful, especially for gender non-conforming participants, as distress with gender often existed within the physical realm more than the psychological realm. Māori organisations such as Te Piki Oranga were also more flexible in the ways they worked with rangatahi – they were able to work with the whole whānau as well as in the whare (home) instead of in a clinical setting. These culturally informed practices enable more flexibility to work with rainbow youth in a way that works for them, and ideally center intersectionality and minority stress at the core of formulation and intervention.

Just as clinicians have obligations to practice in culturally informed and safe ways, clinicians must effectively signal this, as well as increase their rainbow competency if they are to effectively meet the needs of rainbow young people. Even though interview participants did not expect their clinician to be an expert in all things rainbow, most participants reported that clinicians had very little knowledge or understanding of even the basics of LGBTQ+ identity and experiences (e.g., ABC). With regard to increasing rainbow competency among clinicians, rainbow youth who were interviewed suggested some sort of 'rainbow tick' for clinicians that had completed rainbow competency training and were deemed safe practitioners. Some participants had worked with local clinicians that had claimed they were an expert in rainbow mental health and thus rainbow-affirming but found them to be transphobic and harmful in their professional practice. This finding mirrors evidence from the literature that even clinicians who self-identify as rainbow are not always experts in all types of rainbow identities, for example rainbow clinicians that may still hold transphobic views and practices (Human Rights Commission, 2007; Thornicroft, 2017; Veale et al., 2017). Interview participants said it would be extremely helpful to have a list of rainbow-affirming clinicians, but that there would need to be some sort of vetting process they went through to ensure they had received training and were indeed competent and safe in this area. InsideOUT offers rainbow competency training for healthcare professionals (InsideOUT, 2021); however, it is up to organisations to reach out to them to organize the training and is voluntary for staff to participate in. As mentioned previously in the results section, some Te Whatu Ora staff in Nelson were undertaking this training, but the process was described as ad hoc, and thus missed many health professionals who would have greatly benefited. A coordinated and systemic approach to rainbow competency training for healthcare professionals would likely have extensive benefits for rainbow

youth in the Nelson/Tasman region. Furthermore, training institutions for the helping professions (social workers, psychologists, psychiatrists, psychotherapists, counsellors etc.) could include compulsory rainbow competency training as part of their clinical training programmes, thus equipping new clinicians with domain-specific LGBTQ+-affirming skills and knowledge prior to entering professional practice.

It was evident across all participant groups that community plays a crucial role for the wellbeing of rainbow young people. Rainbow participants described the immense impact of having supportive teachers, rainbow groups (both in and out of school), peer-support through organisations such as Q Youth, and from friends in general, on their mental wellbeing. Interview participants highlighted how these spaces can be crucial to prevention and early intervention, and yet funding is incredibly limited for community-based resources and support.

I hypothesized (H9) that rainbow young people would want a dedicated rainbow youth mental health service to improve the provision of mental healthcare in the Nelson/Tasman region. The findings demonstrated mixed feedback. Although participants felt rainbow people needed more timely access to quality services, the majority of participants wanted existing services to be improved so that they were safe spaces for rainbow people. Participants felt there could be unintended adverse consequences to developing a rainbow-only mental health service, such as confidentiality concerns (e.g., being outed for going to these services), vulnerability to funding cuts, and even hate crimes (e.g., the Tauranga rainbow youth centre was burnt down in a targeted arson (Bay of Plenty Times, 2022) and this was raised as a concern). More targeted research would need to occur before proceeding with a separate mental health service for rainbow people.

Although feedback was mixed about establishing a separate service, participants were vocal about services that do currently work. The Independent Nursing Practice (INP) based in Nelson was one such service that received overwhelmingly positive feedback. Although the

service is not mental health focused, participants that had used their services for gender affirming healthcare and sexual and reproductive health, reported knowledgeable and affirming health professionals, as well as visual signals of safety such as pride flags and LGBTQ+ information. The organization was also described by youth as respectful and skilled in working with young people, and young people who had utilized their services felt safe, validated, and trusted as experts of their own lived experience. It was heartening to hear of a service that felt safe for rainbow young people in Nelson/Tasman. Perhaps other health organisations in the region could connect with the INP to learn about what is working well and how they could implement similar strategies.

Some of the recommendations that youth and clinician participants made are already being implemented in the Nelson/Tasman region. Rainbow competency training is being offered to all government employed and contracted health services across Nelson/Tasman by InsideOUT (however, to my knowledge the reporting on the uptake of this service is absent), and a Youth Primary Mental Health and Addictions service for rangatahi experiencing mild to moderate distress is being developed for Nelson/Tasman that incorporates peer support and specific support for rainbow young people.[9] My hope is that individuals, organisations, and government agencies will continue to collaborate with rainbow young people on improving mental health services so that our rainbow people can thrive. Ki te Kotahi te kākaho, ka whati; ki te kāpuia, e kore e whati. If a reed stands alone, it can be broken; if it is in a group, it cannot.

[9] I am the newly hired coordinator for the new Youth Primary Mental Health and Addictions service across Te Tau Ihu (The Top of the South Island). This service is new to the region and is part of a national Te Whatu Ora contract, and is being delivered by Nelson Bays Primary Health and Health Action Trust which provides intentional peer support services.

Implications and Future Directions

This research presents novel insights into the challenges rainbow young people face when accessing mental health services in rural and semi-rural settings in Aotearoa. National and international research evidence the urgent need for improved access to quality mental health services for rainbow young people (Andrade et al., 2014; Fraser, 2020; Gulliver et al., 2010; Mental Health Foundation New Zealand et al., 2018; He Ara Oranga, 2018). The statistics representing rainbow youth mental health are deeply concerning, and the results of this study reflect the international findings: rainbow young people need better access to quality mental health services now. The research elucidates a number of barriers that exist for rainbow young people attempting to access services. Although an overhaul of the public mental health system will not occur overnight, more immediate changes can be implemented to improve rainbow youth's access to life-saving mental health services, such as better advertising of services and explicit statements on service websites that services are rainbow affirming and confidential. This research has implications for how clinicians, the health sector more broadly, and researchers can all contribute to improving the provision of mental health support for rainbow young people.

Clinicians can improve the quality of services they provide. Training programmes and continuing education efforts can teach clinicians to use an intersectional, minority stress perspective when conceptualising the mental distress of minority populations. Considering roughly half of the youth surveyed, as well as almost all interview participants, had worked with school counsellors. This would be a good starting point for implementing targeted rainbow competency training. This would help address mental distress while it is still in the mild to moderate range and reduce the volume of referrals to ICAMHS. Rainbow competency training should educate health professionals in how to adapt basic clinical skills of empathy, validation, and openness to be most effective with rainbow clients (e.g., validation for a nonbinary client

likely includes using their affirmed pronouns) so that rainbow clients can feel safe in session. Clinicians must be intentional and explicit with the use of rainbow affirmations if they are to help make rainbow people feel safe and valued within clinical services.

This research has several implications for the health sector. The results highlighted how community groups and supports are integral to the well-being of rainbow young people. Better resourcing for community-based services such as Q Youth would likely be greatly beneficial. The health sector would likely benefit from collaborating with community organisations, as well as with rainbow young people themselves as key stakeholders, to provide mental health services for LGBTQIA+ youth. Furthermore, the health sector can increase cultural competency by providing training for health providers both within Te Whatu Ora and across community-based mental health services. Additionally, as a sector, advertising of mental health services should include whether healthcare providers have completed rainbow competency training, and thus, are rainbow affirming. Finally, the results highlight the need for clear referral pathways for rainbow youth, which currently does not exist.

It would be heartening to see a working group established between Te Whatu Ora and Te Piki Oranga that included rainbow tāngata whaiora to establish a regionally based plan to tackle the rainbow youth mental health crisis, with measurable goals and markers of efficacy (e.g., reporting on the number of rainbow young people accessing services as well as service-user feedback via pre, during, and post measures of wellbeing) so that the learnings and successes can be shared to other regions in Aotearoa. The Nelson/Tasman region has the opportunity to be a leader in improving mental health outcomes for rainbow youth.

This study demonstrated it is feasible to conduct in-depth mixed method studies with rainbow populations in rural and semi-rural locations. As researchers, we have much

to learn from young people themselves about what is needed in healthcare. This research highlighted discrepancies between providers and clients between perceptions and reports. Future research might consider how inter-rater discrepancies (i.e., provider vs. youth clients) predicts service use outcomes, as well as how youth engage in services with specific clinicians. More research is needed with Māori and Pasifika rainbow rangatahi to understand their needs more specifically as they are underrepresented populations in research.

Strengths and Limitations

This novel community-based study has both strengths and limitations. A mixed-method project of this scope was ambitious for a master's thesis, and although the results present a much-needed contribution to this under-researched area, a larger project (e.g., doctoral dissertation) would have allowed more space for active collaboration with community stakeholders. There was more interest in interviews than I had anticipated, which signaled excellent engagement with what is typically a hard-to-reach group within the field of research. It was disappointing to not be able to offer more interviews, and thus a larger project would have allowed for a greater sample size. Furthermore, psychologists and psychiatrists were underrepresented in the survey sample, which is disappointing as much of the research and findings were targeted at these professions. It is challenging to engage health professionals as they already have high demands on their time and are often over-capacity, and so allowing for more time to intentionally connect with psychologists and psychiatrists during the recruitment phase in future studies would be beneficial. Of note, during recruitment for this study, Nelson was in a state of civil emergency due to extensive flooding, which almost certainly increased demands on health professionals' time and thus reduced the likelihood that they would participate in this study.

Future research would benefit from incorporating a more diverse sample in terms of age, ethnicity, and identities. This initial research project did not target any specific subset of the

rainbow population aside from youth residing in the Nelson/Tasman region between the ages of 16-24, due to concerns about feasibility. During the recruitment process, I spoke to numerous school-based rainbow groups, and there were many under 16-year-olds that wanted to participate in the research and have their experiences heard and represented. Future research should incorporate younger youth populations, potentially from 12 years onwards, as this group is rarely represented in the literature despite having important knowledge and experience to add to the conversation of rainbow mental health (especially given many mental health concerns and rainbow health disparities begin to emerge during this age/developmental period; Seager van Dyk, 2020). It would also be advantageous for future research to specifically focus on working with transgender and non-binary youth, as well as with takatāpui and Māori rainbow young people as both of these populations are under-represented in both the research and in the provision of healthcare. Given the aforementioned concerns about feasibility, my research did not focus explicitly on gender-affirming healthcare (e.g., access to hormone therapy), and this was another limitation of the project. Future research could be conducted within Te Piki Oranga and based within a Kaupapa Māori framework with Māori researchers, as the Te Piki Oranga model of care seems to be working well and could help improve care for pākehā and Māori rainbow young people alike.

The whanaungatanga process of this project was both a strength and a limitation. Through the whanaungatanga process, there were numerous health professionals that requested to be interviewed, but again, due to the scope of the project, this was not feasible. It is recommended that future research look at conducting qualitative interviews with clinicians, and to potentially hold focus group sessions which include both clinicians and rainbow youth to encourage collaboration between the two groups. Despite limitations of sample size and scope, the whanaungatanga process from conceptualization

of the project, through to recruitment and data collection was thorough and comprehensive for a project of this size – I met with members of over 40 organisations, and even these conversations alone helped to raise awareness of the needs of rainbow youth, and to form connections between others that could grow into meaningful pieces of work outside of the research project.

Finally, the research was specific to Nelson and Tasman, which was a strength as it was highly community-driven and feasible from a geographic perspective for a project this size. Nelson/Tasman has been the focus of anti-LGBTQ+ efforts in the past year. Although the data are specific to this area, the parallels between these data and other national and international studies (Fraser, 2020; Whitehead et al., 2016; Willging et al., 2006b) mean that it is likely these findings will be relevant to rainbow youth in other semi-rural/rural locations in New Zealand. That said, more work is needed to fully understand the unique challenges of rainbow youth in these regions.

Despite these limitations, this study was the first piece of research conducted with rainbow young people residing in rural and semi-rural locations in Aotearoa and provides a valuable contribution to research conducted by rainbow people and for rainbow people.

Chapter 6: Conclusions

Rainbow young people are a globally disadvantaged group that experience higher rates of mental distress compared to their cisgender and heterosexual peers (Benson, 2013). Aotearoa-based research shows that LGBTQ+ youth are no exception to the global trend (*Annual Update of Key Results 2020/21*, 2021; Better Understanding New Zealand's Rainbow Population, 2020; Fraser et al., 2022; He Ara Oranga, 2018; M. Pitts et al., 2009; Tan et al., 2021). In this thesis, I found that rainbow youth in the Nelson/Tasman region follow these global trends, rating their mental wellbeing as low to average. Like rainbow youth around the world, rainbow young people in the Nelson/Tasman region regularly seek support for the mental distress they experience, but frequently encounter numerous perceived and actual barriers to accessing support (e.g., long waitlists, cost of services, unsure of the clinician is LGBTQ+ affirming). These barriers were exacerbated by a shortage of mental health professionals, resulting in long wait-lists and poor service-user experiences. When it came to acknowledging young people's rainbow identities in clinical encounters, participants participants were often met with silence from their healthcare professionals, burdening youth with the responsibility of negotiating safety when 'coming out' in healthcare settings.

Rainbow youth had an impressive understanding of how minority stress contributed to experiences of mental distress, especially for those that held multiple minority identities. Yet, rainbow young people often felt understandings of minority stress and intersectionality were missing when working with mental health professionals. Rainbow young people ultimately wanted to be seen, understood, affirmed for who they were, and have their experiences validated – all of which are foundational skills every clinician should possess. Although experiences with healthcare services tended to be predominately negative, when clinicians did provide excellent, affirming care, rainbow

young people described vast positive benefits (e.g., feeling understood, valued, and strong sense of belonging and connection). Despite the numerous challenges rainbow youth faced in the Nelson/Tasman region, participants took pride in their identities; they knew who they were, had a strong sense of community, and were fearless in their advocacy for their rainbow peers. Rainbow youth in this study held strong friendships which helped to support their mental wellbeing. The resiliency and strengh among the rainbow youth community in Nelson and Tasman was inspirational, as well as the desire from healthcare professionals to improve the provision of healthcare for this vulnerable population. It was evident that there are local clinicians and organisations providing excellent care for rainbow young people, and this will only improve and expand in time. Both clinicians and rainbow youth had many excellent ideas of how to improve mental health services for rainbow young people, and steps are already being taken in our region to do so. Although we have a long way to go, the desire and willingness for change is present, and together, alongside our rainbow young people, we can create a brighter future with better health outcomes for our rainbow taonga.

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Appendix

A1 – Youth Participant Information Sheet

Rainbow Youth Experiences of Mental Health Support in the Nelson/Tasman Region

INFORMATION SHEET FOR YOUTH PARTICIPANTS

I appreciate your interest in this project. Please read through this information before deciding whether you would like to participate or not. If you choose to be a part of this project, thank you. If you decide not to take part, thank you for considering my request.

Who am I?

My name is Meagan Goodman. I am a Master of Arts Psychology student at Massey University (via distance learning), and I currently work in mental health services with young people. I live in Whakatu, Nelson, and I identify as queer, gender diverse, and consensually non-monogamous. My supervisor at Massey University is Dr. Ilana Seager van Dyk, who specialises in LGBTQIA+ youth mental health.

Why I am doing this research

This research is for my Master of Arts in Psychology thesis, which is part of my journey to becoming a registered psychologist. I am conducting this project because all young people deserve to have access to high quality, affirming mental health care. Unfortunately, we don't know much about Rainbow/LGBTQIA+ youth's experiences with these services in the Nelson/Tasman region, so we don't know what needs to be done to make access to these essential services better.

What is the aim of the project?

I want to understand the barriers LGBTQIA+ young people living in smaller towns face when trying to access mental health support. I also want to hear about what LGBTQIA+ young people want to see improved when it comes to supporting their mental health care needs. When the study is finished, I plan to share the results with health providers in the Nelson/Tasman region, so that they can learn how to better support Rainbow youth.

How can you help?

If you are aged between 16 and 24, live in the Nelson/Tasman region, AND identify as LGBTQIA+, queer, trans, nonbinary, questioning, takatāpui, or MVPFAFF, you may be eligible for this study. It has two parts:

1. ***Brief online survey:*** It will take approx. 10-15 minutes to complete a brief online survey about your experiences accessing mental health support in the Nelson/Tasman region. This could include working with a school counsellor, counsellor, psychologist, social worker, youth worker, mentor, psychiatrist, health

coach, therapist, etc., or things that have made it difficult for you to access this support.

2. ***Optional interview:*** If, after you have completed the brief survey, you want to discuss your experiences accessing (or difficulty accessing) mental health support in the Nelson/Tasman region in more depth, you can request to take part in a semi-structured interview (details below).

What would you need to do?

Here's what you need to know about the ***brief online survey***:

- It will take you approximately 10-15 minutes to complete.
- We will ask you some questions about yourself, including your age, gender, sexuality, and ethnicity.
- Then we will ask about anything that has made it difficult or prevented you from receiving mental health support. We will also ask about any ideas you may have about how access to support services can be improved for LGBTQIA+ youth.
- As a thank you for taking part in the survey, you will have the option to enter a prize draw to win one of four $30 vouchers towards food, petrol, or The Alphabet Book Club (a queer Kiwi-owned bookstore).

Here's what you need to know about the ***optional interview***:

- If you would like to volunteer to be interviewed, you can indicate this during the brief online survey.
- Volunteers will participate in a private one-on-one interview either by Zoom or at the Whanake Youth office in Stoke, Nelson.
- The discussion will take roughly an hour.
- I will record the interview and write it out later.
- I will ask questions about your experiences with mental health support using the attached *Interview Guide*. I will ask more specific questions in response to what you share with me, but the interview guide outlines the main topics. There are no right or wrong answers, and the interview is an opportunity for you to share your own experiences without any judgment.
- Participants are welcome to bring a support person, or whānau, along to the discussion, however, this is entirely up to you!
- Kai will be offered, and as a thank you for participating, you will receive a $20 voucher towards food, petrol, or The Alphabet Book Club (a queer Kiwi-owned bookstore).

What will your responses be used for?

The experiences you share will help us make recommendations to healthcare professionals in the Nelson/Tasman region about how to reduce barriers to accessing mental health care for LGBTQIA+ youth. This research will also be used in Meagan's thesis and may be shared with Rainbow community organisations, mental health professionals, and the academic community (e.g., in journal articles).

What will happen with the information you share with me?
This research is confidential, meaning I will not share your identity with anyone else. Any information that I collect that could identify you (such as the recordings of the interview and consent forms) will be kept securely on a Massey University Cloud server which is only accessible by myself and my research supervisor. If you share your contact details with us (e.g., for the prize draw or for the interview), these details will be kept entirely separate from your survey responses, and your identity will not be revealed in any reports, presentations, or other documentation. Any identifiable information will be destroyed after five years once the research finishes. De-identified data will be kept indefinitely and may be shared with other researchers on request.

What are your rights as a research participant if you participate in the survey?

- If you change your mind about participating, please do not submit the survey. Once the survey is completed and submitted, it will not be possible to withdraw your survey responses from the project because the survey is anonymous and we won't be able to identify which survey response is yours.
- Ask any questions about the study at any time .
- Be able to read any finished reports of this research by emailing me to request a copy. I also will provide a short summary of the findings for anyone that requests it.

What are your rights as a research participant if you participate in an interview?

- Stop participating at any time, and you do not have to give a reason for this
- Choose not to answer any question
- Withdraw from the study after participating by contacting me up to one month after your interview with me
- Ask any questions about the study at any time
- Read over, comment on, and edit the written transcript of your interview for one month after the interview is completed. This is to ensure you are happy with the content and have the opportunity to make edits within a time frame that still enables me to complete the research project.
- Be able to read any finished reports of this research by emailing me to request a copy. I also will provide a short summary of the findings for anyone that requests it.

What else do you need to know?
While I hope that participating in this project will be a positive experience, I realise that reflecting on past experiences or difficulties in accessing mental health services might be distressing. If these topics tend to be upsetting for you, while completing the survey, please consider having a support person in easy reach if you need them. This could be a friend, whānau member, or you could call OUTLine on 0800 688 5463 or another helpline. During the interview, I will check in with you from time to time to see if you need a break or want to stop. I will provide you with some details for places you can contact if, at a later point, you feel you need some support. In the unlikely event that a serious threat to life or health to yourself or someone else came up in our interview, then I would take steps to protect the person's safety (i.e. contacting police or a crisis mental health team). After the study is

finished, I will be offering a presentation of my findings via Zoom (approximately January 2023).

If you have any questions or problems, who can you contact?
If you have any questions now or in the future, you can contact Meagan at pride@massey.ac.nz, meg@whanake on Instagram, or you can contact Dr. Ilana Seager van Dyk (Research Supervisor and Senior Lecturer at Massey University) at i.seagervandyk@massey.ac.nz.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 22/36. If you have any concerns about the conduct of this research, please contact A/Prof Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz.

A2 – Youth Participant Flyer

A3 – Clinician Participant Information Sheet

Rainbow Youth Experiences of Mental Health Support in the Nelson/Tasman Region

INFORMATION SHEET FOR CLINICIAN PARTICIPANTS

I appreciate your interest in this project. Please read through this information before deciding whether you'd like to participate or not. If you choose to be a part of this project, thank you. If you decide not to take part, thank you for considering my request.

Who am I?

My name is Meagan Goodman. I am a Master of Arts Psychology student at Massey University (via distance learning), and I currently work in mental health services with young people. I live in Whakatu, Nelson, and I identify as queer and gender diverse. My supervisor at Massey University is Dr. Ilana Seager van Dyk, who specialises in LGBTQIA+ youth mental health.

Why I am doing this research

This research is for my Master of Arts in Psychology thesis, which is part of my journey to becoming a registered psychologist. I am conducting this project because all young people deserve to have access to high quality, affirming mental health care. Unfortunately, we don't know much about Rainbow/LGBTQIA+ youth's experiences with these services in the Nelson/Tasman region, so we don't know what needs to be done to improve access to these essential services.

What is the aim of the project?

I want to understand the barriers LGBTQIA+ young people living in smaller towns face when trying to access mental health support. I also want to hear about what LGBTQIA+ young people want to see improved when it comes to supporting their mental health care needs. When the study is finished, I plan to share the results with health providers in the Nelson/Tasman region, so that they can learn how to better support Rainbow youth.

How can you help?

If you are a youth worker or health professional that works with young people aged 16-24 in Nelson/Tasman, you may be eligible to complete a short online survey (approx. 5 minutes to complete) that asks about your experience working with young people and what barriers you believe young people (including LGBTQIA+ youth) experience when trying to access mental health support in the Nelson/Tasman region. The survey also asks about your thoughts for what can be done to increase access to mental health support for LGBTQIA+ young people in this region. As a thank you, you will be sent a printed copy of Gloria Fraser's *Supporting Aotearoa's Rainbow People: A Practical Guide for Mental Health Professionals* and/or a summary of the findings.

We also have a similar survey for LGBTQIA+ young people, so another way you could help is by sharing the research flyer with youth who might be interested. If you are interested in this, feel free to reach out using the contact information at the end of this sheet for copies of the youth flyer.

What will happen with the information you share with me?
This research is confidential, meaning I will not share your identity with anyone else. Any information that I collect that could identify you (such as your mailing address) will be kept securely on a Massey University Cloud server which is only accessible by myself and my research supervisor. If you share your contact details with us (e.g., mailing address), these details will be kept entirely separate from your survey responses, and your identity will not be revealed in any reports, presentations, or other documentation. Any identifiable information will be destroyed after five years once the research finishes. De-identified data will be kept indefinitely and may be shared with other researchers on request.

What are your rights as a research participant?
If you choose to participate in my project, you have the right to:

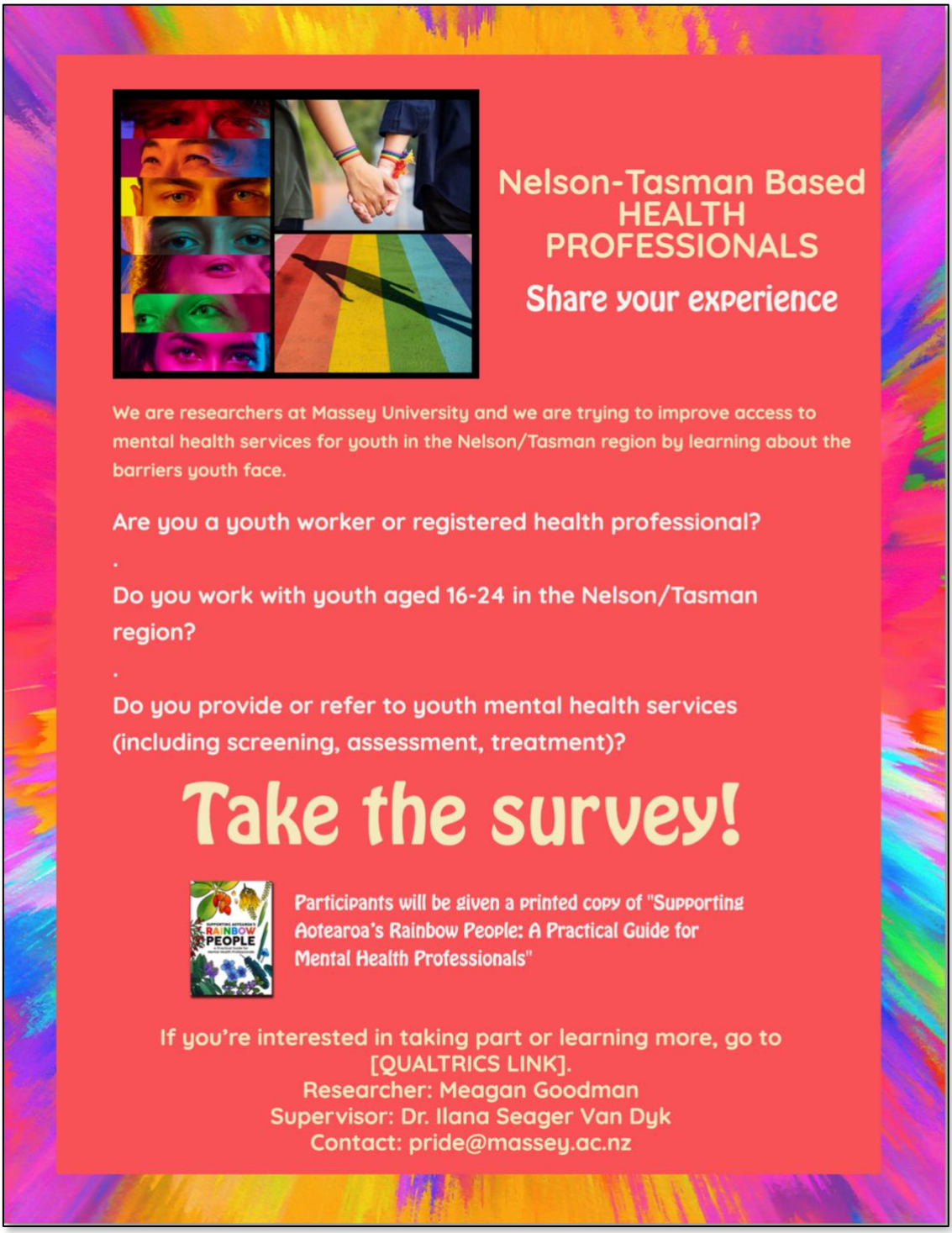
- Stop participating at any time, and you do not have to give a reason for this
- Choose not to answer any question
- Withdraw from the study after participating by contacting me up to one month after your last contact with me
- Ask any questions about the study at any time
- Be able to read any finished reports of this research by emailing me to request a copy. I also will provide a short summary of the findings for anyone that requests it.

What else do you need to know?
After the study is finished, I will be offering a presentation of my findings via Zoom for any health professional or youth workers living in the Nelson/Tasman region (approximately January 2023).

If you have any questions or problems, who can you contact?
If you have any questions now or in the future, you can contact me at pride@massey.ac.nz or you can contact Dr. Ilana Seager van Dyk (Research Supervisor and Senior Lecturer at Massey University) at i.seagervandyk@massey.ac.nz.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 22/36. If you have any concerns about the conduct of this research, please contact A/Prof Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz.

A4 – Clinician Participant Flyer



A5 - Organizations Emailed for Recruitment

Organizations Emailed

Note: Those that are highlighted I also visited for an in-person talk.

Addictions Services Newsletter (Te Whatu Ora)
Andrew Little – Minister of Health
Community-Led Development Network (DIA)
Fossil Creek
Habitat Health
Health Action Trust
Health Improvement Practitioners (Primary Health)
Inside Out
LifeMind Psychology
Ministry of Education Psychologists Nelson/Tasman
Motueka Community FB Pages (40k people between them)
Motueka High School
Motueka High School
Multicultural Nelson Tasman Youth
Nayland College
Nelson Bays Primary Health
Nelson City Council
Nelson City Council
Nelson Community FB Pages (40k people between them)
Nelson Family Medicine
Nelson Marlborough Institute of Technology
Nelson Pride
Nelson Tasman Youth Workers Collective
Nelson Tasman Youth Workers Collective
Nelson Training Centre
Nelson Training Centre
New Zealand Psychological Society Nelson Branch
Nikau Hauora Hub
On Track – Waimea College Alternative Education
Oranga Tamariki
Q Youth
Rachel Boyack – local Labour MP
RISE (Stopping Violence Services)
SASH (sexual Abuse Supportive Services)
Strengthening Families
Te Piki Oranga
Te Whare Mahana
The Nelson Clinic
Unconference – Te Whatu Ora and Community Members
Victory Community Centre
Whanake Youth
Whenua Iti Outdoors
Yellow Brick Road
Youth Habitat
Youth Nelson

A6 – Recruitment Email

EMAIL TO SCHOOLS/LGBTQ ORGANISATIONS

[MASSEY LETTERHEAD]

To Whom it May Concern,

My name is Meagan Goodman. I am a Master of Arts Psychology student at Massey University (via distance learning), being supervised by Dr. Ilana Seager van Dyk (senior lecturer). I currently work in mental health services with young people and live in Whakatu, Nelson. I am conducting a study on Rainbow young people's experiences of mental health support in the Nelson/Tasman region. I am recruiting participants who identify as LGBTQ+ and are aged between 16 and 24.

I was wondering if you would be willing to distribute the attached information sheet to your [students/youth clients]. If it would be helpful, I am also available to present the study to your school's QSA/Pride group.

Thank you in advance for your help. We hope that this project will help inform efforts to reduce barriers to mental health care for LGBTQIA+ youth in our region.

If you have any questions now or in the future, you can contact me at pride@massey.ac.nz or you can contact Dr. Ilana Seager van Dyk (Research Supervisor and Senior Lecturer at Massey University) at i.seagervandyk@massey.ac.nz.

Ngā mihi,
Meagan

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 22/36. If you have any concerns about the conduct of this research, please contact A/Prof Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz.

A7 – Youth Survey

Rainbow Youth Survey

{INSERT INFORMATION SHEET HERE}

Having read the information sheet above, do you consent to participate in this study (yes/no) – (survey will not be accessible unless the participant ticks 'yes)

Section 1: Demographics and Eligibility

1. What is your age in years
    a. [drop down box]
2. What area of Nelson/Tasman do you live in (e.g., ? (This will be kept confidential!)
    a. [alphabetical drop down list of all towns in Nelson/Tasman region]
    b. Other; please specify [open response]
    c. I don't live in the Nelson/Tasman region
3. What is your sexual orientation?
    a. [open response box]
4. What is your gender?
    a. [open response box]
5. Are you intersex/do you have a variation of sex characteristics?
    a. Yes, I am intersex/have a variation of sex characteristics
    b. No, I am not intersex/have a variation of sex characteristics
    c. I don't understand the question
6. When we describe who participated in our study, which of these *sexual orientation-related* categories would you like us to include you in?
    a. A Rainbow category (usually refers to people who identify as lesbian, gay, bisexual, pansexual, takatapui, or some other non-heterosexual sexual orientation)
    b. A heterosexual/straight category (usually refers to people who are attracted exclusively to others of a different gender)
    c. Neither cisgender nor transgender describe me because: _____
    d. Unsure because: _____
7. When we describe who participated in our study, which of these *gender-related* categories would you like us to include you in?
    a. A trans/transgender category (usually refers to people who were given a gender and/or sex label at birth that does not accurately represent them)
    b. A cisgender category (usually refers to people who are the same gender and/or sex they were assigned at birth)
    c. Neither cisgender nor transgender describe me because: _____
    d. Unsure because: _____
8. And which of these other *gender-related* categories would you like us to include you in?
    a. Binary (someone who identifies as completely a man/male or woman/female)
    b. Nonbinary (someone who has an identity other than completely woman/female or man/male)
    c. Neither binary nor nonbinary describe me because: _____
    d. Unsure because: _____

[IF PARTICIPANT DOES NOT MEET ELIGIBILITY CRITERIA AT THIS POINT, THE SURVEY WILL END AND PARTICIPANT WILL BE THANKED FOR THEIR TIME. OTHERWISE, THE SURVEY WILL CONTINUE]

Thank you for agreeing to take part! Before we get started, just a reminder that we will ask questions about your experiences of accessing mental health support. If that might bring up some stuff for you, consider filling out the survey with a support person, like a friend, sibling, parent, or other trusted adult.

If you need to, you can close this window and come back to the survey another time.

Okay, got it! ○

Throughout this survey we use a few different umbrella terms, including 'queer, trans, and intersex', 'rainbow', and 'sex, sexuality, and gender diverse'. We recognise not all of these terms work for everyone, so please let us know at the end of the survey if you use different words. As you fill out this survey, remember there are no right or wrong answers - we are interested in your thoughts and experiences.

What ethnic group or groups do you belong to? Tick all that apply state [open response box]

- ☐ New Zealand Māori
- ☐ Pākehā/New Zealand European
- ☐ Chinese
- ☐ Indian
- ☐ Samoan
- ☐ Tongan
- ☐ Cook Island
- ☐ Māori
- ☐ British
- ☐ Filipino/a/x
- ☐ Not listed, please

9. If you feel comfortable sharing, which iwi do you whakapapa to or affiliate with?
    a. [open response box]

We will ask you a lot about your experience as a rainbow young person today, but we know that this is only one aspect of the many important things there are to know about you. feel free to share as much of your experience as you would like.

10. Do any of these also describe you? Select all that apply

- ☐ Non-monogamous and/or polyamorous
- ☐ Physically disabled or impaired
- ☐ Neurodiverse
- ☐ Refugee migrant
- ☐ Migrant
- ☐ Sex worker
- ☐ Faith and/or religion (specify if you wish)
- ☐ Low socioeconomic status
- ☐ Homeless, or in unstable housing
- ☐ Not listed here, but I'd like you to know that...[open response box]

11. How would you describe your current health/wellbeing in each of the following areas?
    a. My physical health is...very poor/ poor /average /good /very good /not applicable
    b. My mental health is... very poor/ poor /average /good /very good /not applicable
    c. My social wellbeing is... very poor/ poor /average /good /very good /not applicable
    d. My spiritual wellbeing is... very poor/ poor /average /good /very good /not applicable

Section 2: Experience with Mental Health Providers

12. Have you ever considered reaching out for support for your mental health from a mental health professional?
    a. Yes, and I did reach out
    b. Yes, but I didn't reach out
    c. No

13. Have you ever received support for your mental health from a mental health professional?
    a. Yes
    b. No
    c. I'm not sure

[IF PARTICIPANT ANSWERS 'NO' TO BOTH Q15 & Q16, SKIP TO SECTION 3]

14. Which of the following types of mental health professionals have you received mental health support from? Select all that apply
    a. Mental health professional - not sure of their title
    b. Counsellor
    c. Psychologist
    d. Psychiatrist
    e. Therapist/Psychotherapist
    f. School counsellor
    g. Social worker
    h. GPs/Doctors
    i. Other mental health professional, please explain _____

15. For what reasons have you accessed support from mental health professionals? Select all that apply
    a. Feeling down or depressed
    b. Feeling anxious or worried
    c. Trauma
    d. General life stress
    e. Relationships (with whānau, friends, partners, colleagues)
    f. Sexuality (exploring sexuality, issues relating to sexuality, etc)
    g. Gender (exploring gender, issues relating to gender, etc)
    h. Being intersex/my variation of sex characteristics
    i. Accessing gender-affirming healthcare
    j. Not listed, please explain: _____

16. Thinking about all the mental health professionals you have seen - overall, how helpful have they been in supporting your mental health?
    a. Extremely unhelpful (1)
    b. Mostly unhelpful (2)
    c. Neither helpful nor unhelpful (3)
    d. Mostly helpful (4)
    e. Extremely helpful (5)

17. How comfortable do you feel the mental health professionals you have worked with are in working with young people in general?
    a. Extremely Uncomfortable (1)
    b. Uncomfortable (2)
    c. Neither Uncomfortable Nor Comfortable (3)
    d. Comfortable (4)
    e. Extremely Comfortable (5)

18. How comfortable do you feel the mental health professionals you have worked with are in working with LGBTQ+ young people in particular?
    a. Extremely Uncomfortable (1)
    b. Uncomfortable (2)
    c. Neither Uncomfortable Nor Comfortable (3)

d. Comfortable (4)
e. Extremely Comfortable (5)

19. Do you know of any specific mental health professionals in the Nelson/Tasman region that you think are LGBTQ+ affirming? If yes, please list. (reminder – this information is confidential!)
    a. [open response box]

20. How did you know those mental health care providers were LGBTQ+ affirming?
    a. [open response box]

Section 3: Mental Health Support from Rainbow Organisations

21. Apart from mental health professionals, have you received support for your mental health from any of the following? Select all that apply
    a. Rainbow community organisations e.g. Q Youth in Nelson, RainbowYOUTH, InsideOUT
    b. Rainbow-specific peer support groups (e.g. QSA/Pride groups based at school)
    c. General peer support groups
    d. Friends
    e. Partners
    f. Whānau/family
    g. Religious leaders or youth groups
    h. Phonelines, e.g. Youthline, OUTLine
    i. Online platforms, e.g. Tumblr, Twitter
    j. Something else, please explain: _____
    k. I did not receive support for my mental health from any of these sources.

[IF PARTICIPANT ENDORSED 24A OR 24B, SHOW Q25 AND Q26. OTHERWISE, SKIP TO NEXT SECTION]

22. If you feel comfortable, please share which rainbow community organisations you have received support from. Select all that apply
    a. Q Youth
    b. School Queer Straight Alliance/Pride group
    c. InsideOUT
    d. Rainbow Youth
    e. Other; please specify [open response]

23. In what ways have rainbow community organisations supported your mental health?
    a. [open response box

Section 4: Barriers to Accessing Mental Health Support

24. Which of the following barriers did **you** face when attempting to access mental health services in the Nelson/Tasman region? Select all that apply
    a. Cost of services
    b. Lack of transportation
    c. Confidentiality concerns (e.g. what if they see someone they know)
    d. Scheduling problems (e.g., no appointments in the afternoon/evening)
    e. Lack of telehealth services
    f. Lack of availability from mental health professionals (e.g., not taking new patients)
    g. Fear of not being taken seriously
    h. Lack of knowledge about services/resources
    i. Lack of relatability with the professional (e.g., age difference)
    j. Unsure if the health service is LGBTQ+ friendly/affirming
    k. Fear of LGBTQIA+ identity being misunderstood
    l. Something else, please describe: _____

25. Of the barriers you selected, please rank from most to least significant for you.
    a. [rank ordered list]

26. How do you think the mental health needs of LGBTQ+ youth compare to those of non-LGBTQ+ youth in the Nelson/Tasman region?
    a. non-LGBTQ youth have much higher needs than LGBTQ+ youth (1)
    b. non-LGBTQ youth have somewhat higher needs than LGBTQ+ youth (2)
    c. the mental health needs of LGBTQ+ and non-LGBTQ+ youth are the same (3)
    d. LGBTQ youth have somewhat higher needs than non-LGBTQ+ youth (4)
    e. LGBTQ youth have much higher needs than non-LGBTQ+ youth (5)

27. Which of the following barriers do you think **LGBTQ+ youth** face when attempting to access mental health services in the Nelson/Tasman region? Select all that apply
    a. Cost of services
    b. Lack of transportation
    c. Confidentiality concerns
    d. Scheduling problems (e.g., no appointments in the afternoon/evening)
    e. Lack of telehealth services
    f. Lack of availability from mental health professionals (e.g., not taking new patients)
    g. Unsure if the clinician is LGBTQ+ friendly/affirming
    h. Fear of LGBTQIA+ identity being misunderstood
    i. Something else, please describe: _____

28. Of the barriers you selected, please rank from most to least significant for **LGBTQ+ youth** in the Nelson/Tasman region.
    a. [rank ordered list]

Section 5: Recommendations for improving access to MH services for LGBTQ+ youth in the Nelson/Tasman region

29. What do you think could be done to improve LGBTQ+ youth's access to mental health care in the Nelson/Tasman region?
    a. [open response box]

30. Which of the following do you think would help improve LGBTQ+ young people's access to mental health services in your region?
    a. Reducing the cost of mental health services
    b. Transportation vouchers (e.g., free bus passes, free taxi vouchers)
    c. Clear statements on mental health service websites about what information will be kept confidential
    d. More mental health providers to choose from
    e. More scheduling options (e.g., appointments in the afternoon/evening)
    f. More telehealth services
    g. Clear statements on mental health service websites about whether the clinician is LGBTQ+ friendly/affirming
    h. More providers that aren't in my community
    i. More trainings for mental health providers on how to work in an affirming way with LGBTQ+ people

31. Anything else you'd like to say about mental health care for LGBTQ+ young people in Nelson/Tasman? Last chance!
    a. [open response box]

Closing

Thank you for your input and time on this survey!

32. As a thank you for your time and effort, would you like to be entered into a prize draw to win one of four $30 vouchers for either food, petrol, or The Alphabet Book Club (a queer kiwi bookstore)?
    a. Yes
    b. No

33. As described in the information sheet at the beginning of this survey, there is an optional second part to this study. Would you like to participate in an optional one on one follow-up interview with Meagan to discuss your experiences with mental health services in the Nelson/Tasman region in more depth?
    a. Yes
    b. No

Thank you for completing the survey. Please select the following:

- I would like to receive a copy of the final report: Yes/No
- I would like to receive a short summary of the findings: Yes/No

If you selected yes to any of the above, please provide your email address:_____)

A8 – Clinician Survey

Clinician Survey

{INSERT INFORMATION SHEET AND CONSENT FORM HERE}

Section 1: Demographics and Eligibility

1. What is your profession/job?
    a. Counsellor
    b. Psychologist
    c. Psychiatrist
    d. Therapist/Psychotherapist
    e. School counsellor
    f. Social worker
    g. General practitioner
    h. Other kind of medical doctor, please explain _____
    i. Other health professional, please explain _____
    j. I am not a health professional

2. Do you work with young people aged 16-24 years?
    a. Yes
    b. No

3. Do you provide mental health services to young people (including screening, assessment, and/or treatment) OR refer young people to mental health services (e.g., as a GP)? Select all that apply.
    a. Yes, I provide mental health services
    b. Yes, I refer to mental health services
    c. No

4. Do you currently practice in the Nelson/Tasman region?
    a. Yes, full-time
    b. Yes, part-time
    c. No

[IF PARTICIPANT DOES NOT MEET ELIGIBILITY CRITERIA AT THIS POINT, THE SURVEY WILL END AND PARTICIPANT WILL BE THANKED FOR THEIR TIME. OTHERWISE, THE SURVEY WILL CONTINUE]

Section 2: Experience Working With Youth in General
As a reminder, when referring to "young people" in this survey, we mean youth aged 16-24 years.

5. What setting do you work in in the Nelson/Tasman area? Please select all that apply from the following list.
    a. General Practice
    b. Private Practice

c. Hospital Setting
d. DHB service (please state)
e. Youth Organization
f. Secondary School
g. Oranga Tamariki
h. Te Piki Oranga
i. Mental Health Service (please state which one _____)
j. Community Centre
k. Community-Based Health Service
l. Faith-Based Community Service
m. My setting is not listed, please describe_____

6. Approximately how many youth clients aged 16-24 are you currently serving (regardless of frequency of visit)? (please make your best guess)
    a. [open response box]

7. Approximately how many client contact hours do you have with young people aged 16-24 in the Nelson/Tasman region each week on average?
    a. [open response box]

[IF PARTICIPANT ENDORSED Q3 B, SHOW Q8 & Q9. OTHERWISE, SKIP TO Q10]

8. You mentioned that you refer youth to mental health services. How often do you refer young people aged 16-24 to mental health services?
    a. Every day
    b. Several times per week
    c. Once a week
    d. A few times per month
    e. Once per month
    f. Once every few months
    g. A few times per year
    h. Once a year
    i. Less than once per year

9. Which mental health services have you referred young people in the Nelson region to? Please list:
    a. [open response box]

10. How comfortable do you feel working with young people in general?
    a. Extremely Uncomfortable (1)
    b. Uncomfortable (2)
    c. Neither Uncomfortable Nor Comfortable (3)
    d. Comfortable (4)
    e. Extremely Comfortable (5)

Section 3: Experience Working With LGBTQ+ Youth

As a reminder, when referring to "young people" in this survey, we mean youth aged 16-24 years.

11. In your practice in the Nelson/Tasman region, do you work with LGBTQ+ young people (as far as you know)?
    a. Yes
    b. No
    c. Not sure

[IF PARTICIPANT ENDORSES Q11A OR 11C, SHOW Q12 & Q13. OTHERWISE, SKIP TO Q14]

12. How many of your current youth clients identify as LGBTQ? (please make your best guess)
    a. [open response box]

13. Approximately how many client contact hours do you have with LGBTQ young people in the Nelson/Tasman region per year?
    a. [open response box]

14. How comfortable do you feel working with LGBTQ+ young people?
    a. Extremely Uncomfortable (1)
    b. Uncomfortable (2)
    c. Neither Uncomfortable Nor Comfortable (3)
    d. Comfortable (4)
    e. Extremely Comfortable (5)

15. In a few sentences, please describe what contributes to your level of comfort working with this population.
    a. [open response box]

16. How do you think the mental health needs of LGBTQ+ youth compare to those of non-LGBTQ+ youth in the Nelson/Tasman region?
    a. non-LGBTQ youth have much higher needs than LGBTQ+ youth (1)
    b. non-LGBTQ youth have somewhat higher needs than LGBTQ+ youth (2)
    c. the mental health needs of LGBTQ+ and non-LGBTQ+ youth are the same (3)
    d. LGBTQ youth have somewhat higher needs than non-LGBTQ+ youth (4)
    e. LGBTQ youth have much higher needs than non-LGBTQ+ youth (5)

Section 4: Barriers to Accessing Mental Health Support

As a reminder, when referring to "young people" in this survey, we mean youth aged 16-24 years.

17. Which of the following barriers do you think **young people in general** face when trying to access mental health services in the Nelson/Tasman region? Select all that apply

a. Cost of services
b. Lack of transportation
c. Confidentiality concerns (e.g. what if they see someone they know)
d. Scheduling problems (e.g., no appointments in the afternoon/evening)
e. Lack of telehealth services
f. Lack of availability from mental health professionals (e.g., not taking new patients)
g. Fear of not being taken seriously
h. Lack of knowledge about services/resources
i. Lack of relatability with the professional (e.g., age difference)
j. Something else, please describe: _____

18. Of the barriers you selected, please rank from most to least significant
    a. [rank ordered list]

19. Which of the following barriers do you think **LGBTQ+ youth in particular** face when attempting to access mental health services in the Nelson/Tasman region? Select all that apply
    a. Cost of services
    b. Lack of transportation
    c. Confidentiality concerns (e.g. what if they see someone they know)
    d. Scheduling problems (e.g., no appointments in the afternoon/evening)
    e. Lack of telehealth services
    f. Lack of availability from mental health professionals (e.g., not taking new patients)
    g. Fear of not being taken seriously
    h. Lack of knowledge about services/resources
    i. Lack of relatability with the professional (e.g., age difference)
    j. Unsure if the health service is LGBTQ+ friendly/affirming
    k. Fear of LGBTQIA+ identity being misunderstood
    l. Fear of being 'outed'
    m. Not being 'out' yet
    n. Something else, please describe: _____

20. Of the barriers you selected, please rank from most to least significant for LGBTQ+ youth in the Nelson/Tasman region.
    a. [rank ordered list]

Section 5: Recommendations for improving access to MH services for LGBTQ+ youth in the Nelson/Tasman region

21. What do you think could be done to improve LGBTQ+ young people's access to mental health care in the Nelson/Tasman region?
    a. [open response]

22. Which of the following do you think would help improve LGBTQ+ young people's access to mental health services in your region?
    a. Reducing the cost of mental health services
    b. Transportation vouchers (e.g., free bus passes, free taxi vouchers)
    c. Clear statements on mental health service websites about what information will be kept confidential
    d. More mental health providers to choose from
    e. More scheduling options (e.g., appointments in the afternoon/evening)
    f. More telehealth services
    g. Clear statements on mental health service websites about whether the clinician is LGBTQ+ friendly/affirming
    h. More providers from outside the local community (to protect client's privacy)
    i. More trainings for mental health providers on how to work in an affirming way with LGBTQ+ people

23. Is there anything else you would like to say about mental health care for LGBTQ+ young people in Nelson/Tasman?
    a. [open response box]

Closing

Thank you for your input and time on this survey!

24. As a thank you for your time and effort, would you like a free printed copy of Gloria Fraser & Bradley's *Supporting Aotearoa's rainbow people: A practical guide for mental health professionals*?
    a. Yes (please provide your name and full mailing address: _____)
    b. No

25. As described in the information sheet at the beginning of this survey, we plan to hold a seminar early next year to share the results of our study with the Nelson/Tasman community. Would you like to be notified about this seminar when it is scheduled?
    a. Yes (please provide your email address: _____)
    b. No

Thank you for completing the survey. Please fill out your mailing address and email if you would:

- I would like to receive a printed copy of Gloria Fraser's *Supporting Aotearoa's Rainbow People: A Practical Guide for Mental Health Professionals* (please provide mailing details below): Yes/No (if yes, please allow 12 weeks for the guide to arrive after you complete the survey)
- I would like to receive a copy of the final report (please provide email address below): Yes/No
- I would like to receive a short summary of the findings (please provide email address below): Yes/No

Mailing address (for receiving printed guide): _____

Email address (for receiving report/summary of findings): _____

A9 – Interview Guide

Rainbow Youth Experiences of Mental Health Support in the Nelson/Tasman Region

INTERVIEW GUIDE

Brief introduction – about me, the project, consent forms, confidentiality, pronouns
[REVIEW INFORMATION SHEET]

[OPEN WITH A KARAKIA, OFFER KAI]

Introduction

1. Please tell me a bit about yourself: Who are you? Where are you from?

Accessing mental health services in the Nelson/Tasman region.

2. Please describe your experiences accessing (or failing to access) mental health support (either in the past, or current) in the Nelson/Tasman region.

3. What made it harder to access mental health services in your region as an LGBTQ+ young person? What made it easier?

4. If you accessed services, which services did you access? How long were you engaged in those services?
    a. What was the profession of the person you talked to (e.g., psychologist, counselor)?

5. How were you referred to your mental health provider?
    a. If you chose the person or service (rather than being referred to them), what criteria did you use to select a provider?

6. How much was the provider's experience working with LGBTQ+ clients a factor in deciding which provider to work with?
    a. How did you find out whether a provider was affirming or not?

Discussing sex, sexuality, and gender in mental health support services

7. When accessing mental health services, how was sex, sexual orientation, or gender discussed?
    a. What do you think about being asked about your sex, sexual orientation or gender in an assessment?
    b. Did you ever feel that your gender or sexuality were assumed? How did you feel about this?

8. When you were in contact with mental health services, how did you feel talking about your sex, sexual orientation, sexual behaviours, and/or your gender?
    a. Have you ever felt you had to conceal your sexual orientation or gender? If yes, can you tell me a bit more about that? What were your reasons?

9. Have you ever had to educate your mental healthcare provider about issues important to you as an LGBTQIA+ person?

10. Has the provider ever been focused on your sexuality or gender identity as if this is the reason for your mental health difficulties?
    a. Did you feel that was accurate?

Satisfaction with mental health support services

11. What **positive** experiences have you had when accessing mental health support as an LGBTQIA+ person in the Nelson/Tasman region?
    a. Would you go back to the services in which you had these experiences? Why? Why not?

12. What **negative** experiences have you had when accessing mental health support as an LGBTQIA+ person in the Nelson/Tasman region?
    a. Would you go back to the services in which you had these experiences? Why? Why not?

Improvements to mental health services

13. How do you think access to mental health services could be improved for LGBTQIA+ young people living in the Nelson/Tasman region?

14. What do you think mental health providers need to know in order to work effectively with LGBTQIA+ young people?
    a. Is there anything specific about being a young person that identifies on the rainbow spectrum that clinicians should be aware of?

15. How could mental health providers better address or ask about sex, sexuality, and gender in the future?
    a. What would you like to see providers doing? Saying?

16. As an LGBTQIA+ person, what characteristics are important for you in a mental health provider?
    a. Is it important to be seen by a person who identifies as you identify, with regard to gender? Why? Why not?
    b. Is it important to be seen by a person who identifies as you identify, with regard to sexual orientation? Why? Why not?
    c. Do you think there should be separate or specialised services for LGBTQIA+ clients? Why or why not?

Feedback about the project

17. What drew you to participate in this study?

18. If you feel comfortable, could you share a bit about what it was like to participate in this interview?
    a. Is there anything I can improve on or change in future interviews?

Closing

19. Thank you – I am grateful for your time, knowledge, and perspective. I have covered everything I wanted to ask, but is there anything else I've missed that you feel is important to share?
    a. Anything I haven't asked about that you'd want to add?
    b. Do you have any questions for me?

[INTERVIEWER WILL CHECK PARTICIPANT'S PREFERRED VOUCHER TYPE & THEN END THE INTERVIEW]