Mental Health Professionals’ Gender-Sensitivity and Responsiveness to the Genderqueer population in Substance Use Disorder Treatment: A Systematic Review

A thesis submitted in fulfilment of the requirements for the degree of

MASTER OF ARTS IN COUNSELLING PSYCHOLOGY

of

RHODES UNIVERSITY

By

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March 2021

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PREFACE

The research project has been formatted in accordance with APA 7 guidelines (American Psychiatric Association, 2019). Noteworthy changes to APA 6 formatting include: several changed to how items should be recorded in the reference list, 2pt line spacing, page numbers in the top right-hand corner and left alignment of paragraphs (American Psychiatric Association, 2019). More information regarding the changes can be found at: https://apastyle.apa.org/instructional-aids/whats-new-7e-guide.pdf (American Psychiatric Association, 2019).

ABSTRACT

Background: The prevalence of Substance Use Disorders (SUDs) amongst the genderqueer population is a huge concern in the public mental health system. The genderqueer population‟s help-seeking barriers have been attributed to SUD treatment centre‟s questionable ability to be responsive to the unique mental health needs of genderqueer individuals.

Aim: The aim of this study is to conduct a systematic review on mental healthcare workers‟ responsiveness and gender-sensitivity towards the genderqueer population in SUD treatment centres.

Methods: Employing the Joanna Briggs Institute‟s (JBIs) systematic review method, 25 qualitative articles were included in this study. A thematic analysis was used to examine the data.

Results: The analysis revealed that SUD treatment centres are experienced as discriminatory and unreceptive by the genderqueer population due to several barriers. The barriers identified were structural, financial, personal, cultural and the use of a heterosexual framework to treat SUD which led to abuse, isolation, and stigma. Mental healthcare providers lack skills in working with genderqueer individuals as well as a lack of knowledge on genderqueer related needs. Lack of gender sensitivity affects genderqueer individuals in accessing SUD treatment centres and the progress they make. This magnified the need and importance of specialised gender-responsive and gender-sensitive training in working with genderqueer individuals. Twelve interventions to address the areas of difficulty were identified.

ACKNOWLEDGEMENTS

The process of compiling this systematic review research paper has been one that I have found to be challenging to me as a person and on my journey in pursuit of this qualification. I would sincerely like to thank four people who supported me during this phase of my academic endeavour. Firstly, I would like to thank my supervisor Dr Liezille Jacobs for her guidance, but most importantly for her patience with me. Her patience communicated an understanding that I sometimes did not have towards myself. Her words of encouragement during our supervision sessions would be motivating in instances where I felt stuck. I would also like to thank my research companion Adeline Duiker for our constant conversations on our research progress and time spent on weekends dedicated to doing our research. Thirdly, I thank Mr Sizwe Mkwanazi for being the third reader of my research paper and giving constructive feedback. Lastly, I appreciate the support and understanding shown by my family during this process.

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CHAPTER 1: INTRODUCTION

Context

In attempts to receive healthcare services, genderqueer individuals encounter several barriers that are structural, financial, personal, and cultural. They are particularly affected by stigma, harassment, and discrimination in the least (Sullivan et al., 2013). Jacobs (2019) argues that genderqueer individuals are at a higher risk for substance use disorders (SUDs) compared to cisgender individuals. The genderqueer population is also less likely to receive substance use related treatment because of the stigma from health professionals associated with discrimination against non-binary individuals (Green & Feinstein, 2012). Richards et al., (2016) reported that although there is an increasing number of genderqueer individuals seeking clinical services, mainstream healthcare appears to be unprepared for them. Reisner et al., (2016) also highlighted that the unique biological, behavioural, social, and structural contextual factors surrounding health risks and resiliencies for genderqueer people limits their equal access to healthcare within a public health framework. Moreover, there is an absence of clinical guidelines and treatment protocols for this group which means that there continues to be restricted access to SUD treatment centres (Litten et al., 2015). SUD treatment institutions should acknowledge how healthcare professionals can behave in a manner which is responsive to gender justice and gender equality issues. With that being said, very little is known about the challenges genderqueer individuals face in presenting for substance use treatment (Jacobs, 2019).

Basic Concepts

Given the ambiguous nature of the definitions of key terms, this research provides clear definitions of basic concepts referred to throughout the treatise. The following basic concepts will be used throughout this systematic review. They are defined to align with the context in which they are used in for the purpose of this systematic review.

Gender Identity

- An individual‟s gender is socially constructed for the most part, however, the early 1990s a shift in what gender is happened from an activist and academic stance. Gender identity has become more fluid and is performed, expressed, and experienced based on the internal psychological processes that shape one‟s personality (Butler, 2011).

Genderqueer

- The term genderqueer is open to many different interpretations, especially by trained mental health professionals. So, it comes as no surprise that various explanations exist. People who identify as being genderqueer deconstruct categories of femininity and masculinity and create room for their experiences to be accepted as valid and natural rather than deviant (Stone, 1991). In other words, to be genderqueer is to diversify gender, it is the exploration of gender as a continuum wherein different subjective gender performances, experiences, and expressions can combine to create potentially infinite genders, rather than a dichotomization of only masculinity and femininity (Butler, 2011).

Gender Sensitivity

- Health professional�'s ability to identify the complexities of different gender identities and take those differences into consideration in their actions and decision-making processes (Celik, 2009).

Gender Responsiveness

- Services that seek to not only understand the influences of gender, relationships, environment, access and quality of services, and so forth but to also properly respond to those influences (McKenna & Holtfreter, 2020). While gender sensitivity in this systematic review focuses on mental health practitioners, gender responsiveness focuses on how genderqueer individuals receive the services provided to them and consequently affecting their response to the SUD treatment.

Cisgender

- Cisgender identity matches one‟s sex assigned at birth (Aultman, 2014). Why not just say man or woman? The prefix *cis* was added as an antonym to *trans*gender which gave birth to the concepts cis-woman and cis-man in order to create an alliance with genders who are othered (Martin, 2005)

Access

- The process of acquiring adequate healthcare resources to preserve or advance one‟s health (Gulliford et al., 2001).

Mental Healthcare Worker

- A registered practitioner who evaluates behavioural, mental, emotional and cognitive processes using psychological methods and practices aimed at

aiding positive change, growth and development in an individuals‟ life (van Rensburg, 2013). In this thesis mental healthcare workers refer to psychologists, social workers and auxiliary social workers.

Substance Use Disorder (SUD)

- A disorder that is defined by a cluster of cognitive, behavioural, and physiological symptoms that are persistently observable in an individual using the substance despite significant substance-related difficulties. A diagnosis of the current DSM-5® SUD disorder requires at least two of 11 diagnostic criteria within the 12-month period (American Psychiatric Association, 2013).

SUD Treatment Centre

- An established or registered private or public organisation with the aim of the treatment and rehabilitation of people who use substances and are deemed as being dependent on substances (Government Gazette, 2009).

Healthcare System

- Organisations, institutions, and resources that produce actions whose primary purpose is to improve health (World Health Organisation, 2015). In South Africa the healthcare system is divided into public and private. Usually, public health clinics are the first point of entry into the South African health system.

In a further attempt at contextualising this study, it is important as a scholar in the discipline of psychology to demonstrate psychology‟s lack of response in giving genderqueer people adequate access to SUD treatment.

Psychology’s lack of response to the genderqueer population in SUD Treatment

Much of the literature on genderqueer individuals in relation to SUD treatment addressed the topic from the medical model"s point of view rather than from a biopsychosocial model. The difference between the two models is that the medical model believes that science and medicine interventions alone can cure diseases (www.cdhn.org). The biopsychosocial model on the other hand believes that a disease or disorder can be cured by understanding the individual"s biological, psychological, and social factors (www.cdhn.org). Finding literature taking a biopsychosocial approach where psychology is featured proved difficult, highlighting the importance of more research in the field of psychology. The importance of more research in the field of psychology dedicated at gaining more understanding on the topic and the role psychology can play was also amongst the noted gaps in academic literature. More psychological research is necessary because as Girouard et al., (2019) states that SUD commonly occurs in correlation with other mental health issues, polysubstance use disorders, and physical health problems. It is because of the above stated factors that integrated models of behavioural health and primary care services for genderqueer individuals within SUDs may offer many benefits. These benefits may include a reduction of the dual stigma on addiction and genderqueer minorities and focus on lessening the care disparities and the cultural barriers that exist between medical and mental health providers. Literature that focuses on the topic of genderqueer individuals and access to healthcare using the medical model appears to be abundant in comparison to one that takes the biopsychosocial model approach This suggests that although the theory of psychology shows that it is a discipline that contributes to the alleviation of the

prevalence of SUDs from a psychological stance, the medical model still dominates in SUD treatment centres.

The South African Community Epidemiology Network on Drug Use (SACENDU) established in 1996 by two institutions and funded by the World Health Organisation (WHO) is a network of researchers, practitioners and policy makers from all over South Africa (www.samrc.ac.za/intramural-research-units/atod-sacendu). The members of the organisation meet on a semester basis to provide quantitative and qualitative data on alcohol, tobacco and other drug (ATOD) use trends. The data is presented through presentations and discussions. The data provides information on many factors such as patterns of ATOD, risk factors, characteristics of vulnerable populations and so forth. As stated, out of all the factors of focus by SACENDU, characteristics of vulnerable populations are mentioned as an area of research. Two 2019 reports were released in April and in November of 2020 by SACENDU. In those two reports, there were no specific mentions of genderqueer individuals in the statistics sections. On the category of gender, only males and females were mentioned in the capturing of the statistics. This presents a disadvantage in shedding light in the number of genderqueer individuals accessing SUD treatment centres in the country. It also poses a question on the recognition of genderqueer individuals in SUD treatment centres and the catering of the unique needs that they present with. A resource such as SACENDU not recognising the other gender identities who also access centres targeted at the treatment of SUDs is concerning as it is a network meant to constantly provide data on substance use and the users.

A study by McCabe et al., (2009) reiterates the lack of recognition of genderqueer individuals in SUD treatment centres. The study states that population-based studies on substance use rarely ask about sexual orientation or gender identity (McCabe et

al., 2009). This is even after numerous studies have found that SUDs are more prevalent amongst the genderqueer population. This explains the lack of data speaking to this population‟s struggles to access SUD treatment as they are not properly identified and categorized in SUD studies. It appears that genderqueer and substance use is mostly presented to the public with the focus on stigma and discrimination against genderqueer individuals but not so much on the implications of those. A study by Howell and Couzyin (2015) is an example of the previous point brought forward. The study speaks of genderqueer individuals‟ difficulty in accessing treatment. It goes on to mention barriers that are personal and structural. These kinds of studies are crucial to the understanding of the barriers to treatment, but they fall short in zooming in on the experiences and narratives of the professionals. This short coming is undesired because not only does it not challenge healthcare providers to question themselves and their skills, it also presents either the genderqueer population or mental health practitioner as being at fault. It does not create a space that is neutral and open to solutions of a way forward.

An Overview of the Problem Statement

According to Green and Feinstein (2012), in comparison to the cisgender population, substance use and SUD remain extremely high amongst genderqueer individuals. Regardless of the high prevalence of substance use among genderqueer individuals, access to health and addiction services still present poorly with less than 10% of genderqueer individuals reporting access to SUD treatment programs worldwide (Card, 2019). This lack of access is attributed to several factors such as lack of availability of treatment programmes in certain settings such as rural areas. Non-acceptability of provided services that can be restrictive acts as another barrier suggesting that at times these treatment programs are not affordable to the general

population. Most critical factors are that treatment centres are experienced as non-approachable due to the bias against genderqueer individuals and the lack of considerations directed at different sexual orientations. Flentjie et al., (2015) echoes this by stating that genderqueer individuals are less likely to access substance use treatment because of the stigma and discrimination that comes with being a non-binary gender. As a result, the differences that exist in the delivery and access to services between genderqueer and heterosexuals individuals in the mainstream services of the healthcare system does not address the needs of the genderqueer population. According to Card (2019), genderqueer affirming programmes are advocated for and have shown to produce better outcomes.

Research Question

According to the JBI method, the Population, Phenomenon of Interest, and Context (PICo) framework assisted in formulating the review question.

Population:

Mental Healthcare Providers/Clinicians/Psychologists/Social Workers.

Phenomenon of Interest:

Experiences of genderqueer individuals.

Context:

Substance Use Disorder Treatment Centres.

Research question:

Based on the outcome of the above PICo framework, the following question was formulated for the systematic review:

How sensitive and responsive are mental health professionals to the genderqueer population in the treatment of SUDs?

Goals of the study

The main goals of this study are to build on the work of Jacobs (2019) in its efforts to engage with mental health practitioners and the concept of gender sensitivity and responsive specific to the genderqueer population in SUD treatment centres. It is also to find interventions that highlight the skills necessary for practitioners in SUD centres when working with the genderqueer population.

Underlying assumptions

Embarking on this research study, the underlying assumption is that there will be sufficient qualitative studies on substance use disorders and the treatment of them given their high prevalence in the healthcare system. Although there is an assumption of abundance of studies regarding SUDs, there is an assumption that there will be limited studies on SUDs and treatment in relation to genderqueer individuals.

Overview of the research methods

To conduct this research, I will be using the systematic review as a method. This type of method is suitable for this research because of its ability to study numerous qualitative studies on a topic. Because of this methodology‟s systematic way of gathering data, Population, Phenomenon of Interest, and Context (PICo) care setting framework will be used to guide the inclusion and exclusion criteria. The methodology of this research study will be divided into three sections namely; data collection, data analysis, and close with quality and rigour.

The data collection section will consist of three sub-sections namely, search strategy, data screening phases and the PRISMA Chart used to summarise the entire selection process into a chart. Following the first section will be the data analysis section which will work with the selected qualitative articles to identify dominant themes. In this section, Braun and Clarke (2006)‟s thematic analysis process will be used. To ensure unbiased representation of the results of this qualitative study research, I will use Four-Dimensions Criteria created by Forero et al., (2018).

Outline of the Thesis

Chapter 1 of this systematic review is the introduction chapter which serves the purpose of introducing the research topic. This chapter includes the explaining of basic concepts used, contextualising the importance of studying gender sensitivity and responsiveness in SUD treatment settings, psychology‟s lack of response to genderqueer individuals in SUD treatment centres, and the overview of the problem statement. The chapter further presents the research question, underlying assumptions, goals of the study, and gives an overview of the method used to conduct this research study. Chapter 2 follows with a literature review covering genderqueer individuals‟ access to private and public facilities, barriers (personal, financial, and structural), the exploration of the South African‟s Gender Policy Framework (GPF), gender sensitivity and responsiveness in SUD treatment centres, gender mainstreaming, and the summary section. Chapter 3 introduces and describes how queer theory underpins the systematic review in order to make sense of the data collected. It does so by talking through queer theory and the approach it is found under, the social justice approach.

Chapter 4 provides an in-depth description of the methodological procedures that were followed to conduct this systematic review. First, the research aims, and objectives are presented. The philosophical and methodological approaches and the methodological design are discussed thereafter. Then the procedure of selecting the studies for the systematic review is explained in detail. Attention is then paid to data analysis, as well as issues of ethicality related to this study. Interpretation of results is covered in chapter 5. In chapter 5, the focus is on the emergence of the themes and how they were picked. The last chapter focuses on the implications of the findings and the critical review of the results. The aim in this chapter is to tie the findings with the main aim of the study and to look at what the recommendations are based on the findings of this systematic review.

CHAPTER 2: LITERATURE REVIEW

Introduction

This treatise is about systematically reviewing literature on mental health workers" treatment of genderqueer individuals in SUD treatment centres. This chapter therefore presents literature to establish the gender-sensitivity (or lack) of mental health professionals towards the genderqueer population in SUD treatment centres. This section covers discussions on (1) Genderqueer individual"s access to public and private healthcare; (2) Personal, financial and structural barriers to accessing SUD treatment; (3) Government Policy on access of the genderqueer Population to SUD Treatment; (4) Gender-Sensitivity and Responsiveness in SUD treatment settings; and (5) Gender mainstreaming. The summary segment of this section summarises the discussions on the five points covered in this literature review chapter.

Genderqueer individuals' access to healthcare facilities

The genderqueer population is deemed susceptible to experiencing discrimination throughout their lifespan due to their gender expressions (Mckenzie, 2016). Kcomt et al., (2020) state that transgender individuals experience interpersonal and structural barriers to healthcare which contributes to them postponing or avoiding healthcare. The postponement and avoidance to healthcare can lead to negative physical and mental health outcomes. It would be easy for one to assume that access to healthcare in private settings would be more inclusive to different gender identities. Participants in the Lykens et al., (2018) study expressed facing challenges even in clinics which are known to specialize in gender-affirming healthcare. The challenges included being misunderstood by providers and a lack of sensitive care towards them as non-binary individuals. Genderqueer individuals expressed a lower satisfaction with healthcare because of being treated unfairly by healthcare providers

in healthcare settings (Mckenzie, 2016). Although literature on the topic supports the view of lack of competency from healthcare providers, Kilicaslan and Petrakis (2019) present a differing viewpoint that healthcare providers" lack of organisational support is also a contributing factor. They state that healthcare providers may have the desire to advocate for the rights of genderqueer individuals but may fear becoming targets of discrimination from other providers who feel differently about genderqueer individuals.

According to Mckenzie (2016) discrimination occurs in various contexts, including public and private businesses, healthcare settings, and within ones" own neighbourhood. In their 2020 study to examine avoidance of healthcare due to anticipated discrimination, Kcomt et al., (2020) identified living in poverty and not conforming visually in appearance as significant risk factors to discrimination in healthcare settings. On another study by Lykens et al., (2018) to examine the healthcare experiences of young adults who identify as genderqueer or nonbinary, four themes were identified giving summary of their experiences. The four themes were identified as; (1) providers failing to see beyond the binary of transgender, (2) lack of cultural competence in the provision of genderqueer care, (3) „„bending"" the trans label, and (4) falling short on services specific to transgender (Lykens et al., 2018, 192).

Both the above studies paint a clear picture on the topic. While accessing healthcare is an ordinary task with not a lot to think about for a cisgender individual, the same is not applicable to genderqueer individuals. Kcomt et al., (2020) highlighted that compared to the other gender identities; genderqueer people experience a higher occurrence of discrimination, which badly affects their health and well-being throughout the course of their lives. The discrimination ranges from being denied

access to healthcare to being abused physically, verbally and sexually in healthcare facilities. There appears to be failure in addressing homophobic behaviour in the healthcare system (Kilicaslan & Petrakis, 2019).

Personal, financial and structural barriers to access to SUD treatment

Williams and Fish (2020) state that roughly 20 million people in the United States meet the criteria for a substance use disorder, with the genderqueer population at an elevated risk. To explain the disparities seen in the number of genderqueer individuals struggling with SUDs compared to cisgender individuals, Williams and Fish (2020) use the minority stress theory. The theory identifies stigma, discrimination, homophobic and heterosexist social conditions as resulting in chronic stress and as a hindrance in sexual-related health inequalities (William & Fish, 2020; Meyer, 2003). These two factors prevent the genderqueer population from accessing quality healthcare services. William and Fish (2020) further highlight that the stigma and discrimination create a breathing ground for other mental and psychological disorders such as depression, anxiety, suicidal ideation and so forth. This is attributable to the lack of mental health care services tailored to the complex, unique experiences and needs this population present with. Alessi (2014) speaks of the little understanding of how minority stress should be addressed in healthcare institutions. The little understanding is observed judged against the empirical research which has repeatedly shown the negative mental health consequences of minority stress among genderqueer individuals.

According to a study by William and Fish (2020) conducted between January 2015 and December 2016, adequate access to mental health services that are sensitive to

the needs of the genderqueer population tend to show a reduction in mental health symptoms and the use of substances (William & Fish, 2020). The study obtained its data from three sources namely; the 2016 N-SSATS and the 2016 National Mental Health Services (N-MHSS) for information about treatment facilities and the Gallup Daily Tacking Survey (GDTS) for state-level genderqueer population density data (William & Fish, 2020). The N-SSATS and the N-MHSS yielded a sample of 13 044 facilities and the GDTS yielded a sample of 710 252 individuals. The results of the study clearly show that there is a correlation between a lack of mental health services and the development of SUD in the genderqueer population. This speaks to the section on this systematic review that talk about psychology‟s lack of response in SUD treatment on the genderqueer population. The literature on the mentioned section and William and Fish (2020) study suggests that the little role psychology appears to be playing in the lives of genderqueer individuals can very well be the huge contributing factor to the development of SUDs in the genderqueer population.

The study of William and Fish (2020) speak to the several potential financial challenges of accessing treatment faced by the general population but have severe outcomes to the genderqueer population. The financial challenges were dependant on the following:

Residential care

SUD treatment centres offering residential care were reported to be more likely to offer genderqueer specific programs than those that did not (William & Fish, 2020). In a study by Jacobs (2019), a participant reported that even in in-patient treatment centres there tends to be concerns around males and females being in one treatment facility because of safety reasons. This shows that although there is a

heteronormative approach in healthcare, even that approach has its own challenges outside of genderqueer related concerns.

Location of the facilities (in hospitals or external)

Facilities that were located within hospitals were less likely to offer inclusive genderqueer individuals compared to those located outside of hospital perimeters (William & Fish, 2020).

Private for profit facilities

The study revealed that genderqueer individuals who have financial means to access private facilities were more likely to be serviced in a manner that is inclusive (William & Fish, 2020).

Government funded or non-government funded

Compared to treatment facilities that received no funding from the government, treatment facilities receiving government funds were reported less likely to offer genderqueer specific programs (William & Fish, 2020). Mpanza and Govender (2017) bring forth that amongst other shortfalls within the healthcare system related to the treatment of SUDs, is the poor integration of substance abuse services in the daily running of the health facilities such as primary health care (PHC) facilities.

Sliding scale

Facilities offering their services on a sliding scale were more likely to offer genderqueer specific programs compared to facilities that offered free SUD treatment services (William & Fish, 2020).

The points identified by William and Fish (2020) show that financial means play a role in whether a genderqueer individual gets inclusive treatment or not. From the study, it was apparent that government related services were less likely to offer

inclusive orientated care for the genderqueer population. This is concerning as government facilities are open to the masses and financially disadvantaged individuals who cannot afford private facilities.

Williams and Fish (2020) also speak of additional structural barriers that are experienced by the genderqueer population in accessing SUD related programmes. He labels the structural barriers as costs, insurance coverage, stigma around mental health/substance use disorders, and availability of services. They highlight that in comparison to cisgender individuals, genderqueer individuals are more likely to reach out for treatment. A study mentioned in William and Fish (2020) that investigated perceptions of treatment amongst the genderqueer population who had been a part of a traditional substance use program expressed lower levels of satisfaction compared to cisgender individuals (William & Fish, 2020). Sexual orientation was perceived as the source of the negative experience for the genderqueer participants in SUD treatment programmes.

The article mentions two factors that act as structural barriers for genderqueer individuals accessing treatment. William and Fish (2020) identify these factors as service providers holding a negative attitude towards the genderqueer population and heteronormative practices that disregard the unique realities that come with this population. Through the article, it is revealed that research has consistently shown that service providers such as mental health care practitioners lack competency when working with the genderqueer population. This as a result pushes away genderqueer individual from seeking help. In those encounters with service providers, the interactions are experienced as non-affirming, lack of basic knowledge on genderqueer challenges, and prejudice. The above-mentioned results mostly resulting in genderqueer individuals not returning after the first session. Hence a

preference of approaching providers with a stated affirmative stance. William and Fish (2020) paint an adequate picture on the different factors acting as interferences in genderqueer individuals accessing healthcare. Their study is also able to speak about these different factors in association to the minority stress theory. But as Alessi (2014) argued, there is little understanding of how minority stress should be addressed in healthcare institutions. In his article, Alessi (2014) provides suggestions on how the minority stress theory can be incorporated into the treatment of genderqueer individuals. He proposes a two-part clinical assessment which presents an innovative approach to genderqueer healthcare practice. The first part examines the effects of stigma, homophobia, and sexual concealment. The second component to this assessment would be to examine the general psychological processes of the client such as emotional regulation, social, and cognitive processes.

Government Policy about Policy on Inclusion of the Queer Population in SUD Treatment

In 2009, the South African‟s National Policy Framework for Women‟s Empowerment and Gender Equality also referred to as the Gender Policy Framework (GPF) was released (van Rensburg, 2013). The framework outlined South Africa‟s vision pertaining to gender equality and for how this vision is intended to be realised (van Rensburg, 2013). The focus of the framework was to promote equality of opportunity and of treatment by employers and service providers. This was to be achieved by advocating for issues on gender to be on the centre of the transformation process rather than be an after-thought matter. According to the policy document, the framework was compiled to be used as a guideline to be integrated and used by the different sectors in line with their institutions‟ working models. Eleven guiding

principles were stated in the framework with a proposed movement geared towards ensuring a more effective structural arrangement.

The document touched on the history of South Africa in relation to gender, dating back to the Apartheid era. As a result, the South African government showed an interest coming up with gender sensitive national priorities with the commitment leading to: 1. an agreement to regional and international ways of promoting gender equality, 2. increased awareness of gender issues, and 3. an enhanced consideration when it comes to gender issues and their integration into government policies and programmes (van Rensburg, 2013).

One notable factor about the Gender Policy Framework was that although the emphasis of the crafting of the document was on ensuring gender equality, gender only referred to men and women, not other gender identities such as genderqueer individuals. The South African Gender Policy Framework document was crafted by the Department of Women which was mandated to implement gender mainstreaming (Tirivanhu & van Rensburg, 2017). The lack of consideration of genderqueer individuals in the document suggested that the concept of gender mainstreaming mostly likely did not encompass of other gender identities that did not fall within the binary spectrum.

The South African Government"s website has the 2009 version of the Gender Policy Framework, indicating that there have not been any changes to the policy since its release to the South African public in 2009. Research associated to the concept of GPF such as that of Ntakumba (2010) further verifies that the policy is still used in issues of equality, issues specific to men and women, not other gender identities.

It is understandable how the GPF has remained the same; the very idea of gender mainstreaming which largely guided the drafting of the policy also has not been challenged and changed. Looking at the aim and objectives of gender mainstreaming, changes in the concept would see change in policies such as the GPF and consequently changes in how institutions in South Africa manoeuvre working with other gender identities other than cisgender individuals. Ntakumba (2010) expressed the lack of monitoring measures in the implementation and execution of gender mainstreaming. This leading to a belief that having monitoring measures in place would activate and keep alive constant dialogues on the concept of gender in its broadness in South Africa.

Gender- Sensitivity and Responsiveness in SUD treatment settings

Substance use represents a huge problem in the public health domain worldwide and especially in South Africa (Sorsdahl et al., 2012). Although substance use represents a major public health concern, there are several studies that have shown that substance use disorders are highly stigmatised more than physical and mental disorders (Sorsdahl et al., 2012).

According to Sullivan et al., (2013), the significant barriers that are experienced in serving genderqueer individuals may include a lack of skills and knowledge regarding genderqueer health by treatment providers and a general lack of sensitivity, compassion and a lack of acceptance in treatment or in group settings where there are fixed ideas on what is considered to be an “appropriate gender”, in this case, cisgender being considered the appropriate gender (Veltman & Chaimowitz, 2014; White, 2012). The above statement is supported by literature which shows that programmes that are targeted at preventing substance use are usually specific to the majority cisgender population. It is therefore of great

importance to look at the different factors that are associated with the use of substances, factors which are exclusive to this population in order to come up with interventions that speak to their needs (Goldbach & Steiker, 2011).

Flentje et al., (2015) reiterated this importance by stating that it is uncertain whether treatment programmes and providers are sufficiently aware of the specific mental and physical needs of genderqueer individuals who come into their centres seeking treatment, an awareness that is fundamental in providing appropriate treatment services. This makes it vital to look at how they can access services such as SUD treatment but still be treated in a manner that acknowledges the differences that they bring into treatment. Differences in that they also present with eminent rates of comorbid diagnoses such as depression, anxiety, identity crisis, and so forth (Lipsky et al., 2012). Also, for health professionals to conduct themselves in a fashion that is sensitive to gender justice and gender equality issues in substance use disorder treatment facilities. They may experience multiple layers of discrimination that may potentially create multiple intersecting layers of stress. These potential sources of distress and conflict could present in limitless and multifaceted ways (Psychological Society of South Africa, 2017).

Using the Bronfenbrenner"s ecological theory, Goldbach and Steiker (2011) explain that besides the self, a young person also depends on the other significant people in their microsystem, which are their family members, friends, neighbours, and others for sustenance, security and for environment. They further explain that security for most of genderqueer youth is not usually found through their family relationships. One factor that could contribute to a young person abusing substances would be the lack of support from immediate family members and friends because of their sexual orientation and gender that is non-conforming. The lack of support could then result

in the individual developing a mental health condition like depression. The genderqueer youth experiences more challenges relating to belonging in the genderqueer community, exacerbating problems for their sexuality identity. Studies that have been conducted on substance use have often sought to determine the impact on secondary outcomes associated with substance use (Dowling-Guyer et al., 1994). Studies like that of Jacobs (2019) focusing on gender-sensitive training for mental health practitioners in substance use disorder treatment centres are important in that they shift the focus into an aspect of substance use treatment that in a country like South Africa that has not been explored, yet crucial in the responsiveness of genderqueer clients.

Gender Mainstreaming

In July 1997, the United Nations Economic and Social Council (ECOSOC) defined the concept of gender mainstreaming as a process which assesses the implications where women and men are concerned regarding any planned action, including legislation, policies or programmes, at any given time and level (UN Economic and Social Council, 1997). Gender mainstreaming is further defined by the United Nations Economic and Social Council ECOSOC as a strategy used to address concerns and experiences voiced out by men and women and integrating them to the design, implementation, monitoring and evaluation of policies and programmes in the different spheres that exist within the structures in societies. The main goal of gender mainstreaming is to ensure gender equality amongst men and women.

Just like any other mandate, gender mainstreaming was to be carried out with specific principles to serve as the foundation guiding the process. The following were some of the principles behind the implementation of gender mainstreaming set out in 1997 in Beijing (UN Economic and Social Council, 1997).

- Putting in place adequate mechanisms that can be used as a form of accountability in the monitoring of the progress of gender mainstreaming.
- The initial process of identifying presenting issues and problems should consist of clear ways of diagnosing gender differences and disparities.
- Assumptions that issues or problems are neutral from a gender-equality perspective should never be made.
- There should always be a process of gender analysis.
- There is a clear political and allocation of adequate resources such as necessary finances and human resources dedicated at gender mainstreaming to ensure that the concept is carried out in practice.
- Gender mainstreaming requires that efforts be made to broaden women's equitable participation at all levels of decision-making.

Tirivanhu and van Rensburg (2017) in a South African context, echoes that gender mainstreaming is a process that assesses the implications for men and women in any planned actions. It is further stated that gender mainstreaming aims at bringing transformation at a fundamental level by eliminating gender biases that exist and driving policies, programmes and project in a direction that allows for a contribution towards gender equality. Both the United Nations Economic and Social Council (ECOSOC) and Tirivanhu and van Rensburg (2017) definitions of gender mainstreaming highlight the focus being on men and women as the gender identities taken in consideration rather than the different gender identities that exist.

Summary

The literature review on the topic of healthcare providers working with the genderqueer population reveals a concerning reality around access, responsiveness,

and sensitivity in both the public and private healthcare sectors. The literature shows that genderqueer individuals experience stigma and discrimination in SUD treatment settings and in the healthcare system. The stigma and discrimination are explained as being visible from mental healthcare practitioners. Mental healthcare providers in these centres are described as lacking the skills and knowledge necessary when working with genderqueer individuals, and lacking sensitivity and compassion to the needs of genderqueer individuals in SUD treatment programmes. However, a different viewpoint suggests that there might be other factors other than the obvious acting as contributors to the problem. These factors are presented as a lack of institutional support and potential isolation of healthcare providers with the desire to advocate for the rights of genderqueer individuals. The second factor suggesting more focus on addressing the implications of minority stress theory in healthcare practice.

Although preferred compared to the public sector, literature suggests that even private healthcare facilities thought of as specialising in queer related needs, also show a lack of sensitivity to the specific needs of genderqueer individuals. The study by Kcomt et al., (2020) does support that there is a postponement and delay in accessing healthcare due to the stigma, discrimination and abuse genderqueer individuals are subjected to in the healthcare system. In South Africa, the GPF was crafted and released with the intention to advocate for issues around gender to form part of the transformation process. Although the policy document states that the GPF was crafted with the intentions of providing guidance that could be integrated by institutions at their own discretion, it lacked the inclusion of genderqueer individuals. This lack of inclusion of genderqueer individuals suggests an enormous impact on

the implementation and execution of gender mainstreaming in the country, affecting policies in facilities such SUD treatment centres that must provide services to the genderqueer population.

The issues highlighted by the literature review proved that the concept of gender mainstreaming is flawed as most of healthcare facilities are still designed and structured with the idea of cisgender individuals only in mind.

CHAPTER 3: THEORETICAL FRAMEWORK

Introduction

Grant and Osanloo (2014) define a theoretical framework as a blueprint that serves as a guide to be used to build and support a research study. They further explain that it provides a structure that enables a researcher to describe how they will philosophically, epistemologically, methodologically, and analytically approach the research study. With a theoretical framework serving as a blueprint in a research study, Grant and Osanloo (2014) caution that the task of selecting an appropriate theoretical framework is one that is necessary and crucial. The process of selecting a theoretical framework requires a clear understanding of the problem, purpose, significance and research questions (Grant & Osanloo, 2014).

The systematic review looks at mental health professionals" gender-sensitivity and responsiveness in SUD treatment centres. At the centre of this systematic review is the genderqueer population, hence queer theory is a fitting theoretical framework. Queer theory in simple terms is defined as a theory that focuses on the construction and categorization of gender and sexual identities and aim to challenge the formation of these categories in societies (April, 2019; Kirsch, 2013). It is because of the focus of the theory on gender, its construction and how that manifests in society that makes queer theory a suitable theoretical framework for the systematic review.

This chapter starts by defining queer theory and its emergence. It looks at Gender, the National Drug Master and Social Justice and the four principles of the social justice approach. Following the social justice and its principles section, the chapter

speaks on the rationale of this systematic review. The summary section consolidates the chapter.

Queer Theory

This systematic review draws on a social justice approach called the Queer Theory. Queer theory is a section of academic thought that focuses on how gender and sexual identity are constructed and categorized (April, 2009). Queer theory is defined as a body of work which aims to deconstruct the truths that have been put out leading in the distortion of queerness and reconstruct them into ones that coincide with reality (Franklin-Jeune, 2014). In her book *Gender Trouble*, Butler (1990) questions where the categories of gender come from and what makes them strong amongst societies. This theory speaks to the concept of queerness and advocates for an equal recognition of genderqueer individuals in different settings such as the healthcare systems. Using this theory allows for advocacy for the genderqueer population. The theory calls into question the authority of some of the principles indoctrinated by Western discourses influenced by Christian ideals with the main purpose of speaking on any matter related to queerness in a negative light (Franklin-Jeune, 2014). Mental health professionals‟ sensitivity towards genderqueer individuals is influenced by how they understand the concept of gender which is influenced by many factors, at the top, society‟s ideas. On the importance of queer theory, Kirsh (2013) give emphasis to the theory‟s ability to open new ways for societies to approach and treat the sexually diverse population as people who are also worthy of having their rights considered rather than being viewed as a population that is different from the general cultural theory in a negative light.

He explains the emergence of queer theory during the past decade as a representation of an enormous jump in our understanding of the genderqueer community. The theory challenges us to rethink what society has told us is normal and the power dynamics around gender, sexuality and sex. It encourages the challenging of the norms of the society with the aim to highlight that gender, sex and sexuality are socially constructed and constructed with the influence of heteronormative ideas. Heteronormativity referring to the advantaged position associated with heterosexuality based on the assumptions that there are only two gender identities which reflect a person‟s biological sex as assigned at birth. Heteronormativity assumes that only two opposite gender identities are acceptable, and the only ones that can be sexually attracted to each other (Psychological Society of South Africa, 2017).

As indicated above, queer theory draws on the social justice approach which consists of theories that are concerned with what is just for the society as a whole rather than what is just for one individual or a specific group (Capeheart & Milavonic, 2020). The basis of social justice is that there must be an understanding of the interactions that occur within and between several different people in a society. The pursuit of this kind of justice requires consideration and sensitivity of all the voices of those concerned which in this systematic review will be the Lesbian, Gay, Bisexual, Transgender, Queer, Intersex+ (LGBTQI+) population and mental health care workers.

Gender, the National Drug Master and Social Justice

On the 26th of June 2020, the 4th edition of the National Drug Master Plan 2019-2024 was released. The NDMP demonstrates the way the country is responding to the

challenge of substance abuse with the vision being to see a South Africa free of substance abuse (National Drug Master Plan 2019-2024). Although the NDMP acknowledges the noteworthy contribution that has been played by the various departments in the issue of substance use and abuse, it hopes for more. It provides a framework that stipulates what role each department ought to play in addressing substance use and abuse.

On their article, Howell and Couzyn (2015) give a critical review of the South African National Drug Master Plan 2013-2017. Howell and Couzyn (2015) explain that the plan presented seven key aims. Amongst those, it was 1, to reduce the bio-psycho-social economic impact of substance abuse and other related illnesses observed in the country"s population. 2, Create a platform where all South African"s residents would be able to work on their challenges related to substance abuse within their communities. These two aims would ideally speak to the biopsychosocial model, a model mentioned in the section that explored the lack of psychology in SUD treatment in relation to genderqueer individuals. This model would see to better implementation and execution of the aims of the plan. One critique that Howell and Couzyn (2015) had on the plan was that the relevant stakeholders working with SUDs are quick to point a finger at the user when there is no visible success in the plan. This questioned the stakeholder"s lack of accountability and how that affects individuals who struggle from SUDs.

Social Justice and its' Principles

According to Miller (1996), social justice in most writings of contemporary political philosophers is regarded as an aspect of distributive justice. In his book, Miller

(1996) defines distributive justice as meaning the fair distribution of benefits amongst members of different associations or groups.

In relation to this research, both definitions of social justice according to Capeheart & Milavonic (2020) and Miller (1996) mainly put an emphasis on access and treatment that is fair and accommodating of everyone irrespective of their gender identity. Both definitions emphasise the importance of this not only applying in SUD treatment centres, but also in the healthcare system.

Social justice comprises of four principles namely; equity, access, participation and rights. The Workforce Council, a non-profit organisation that was based in Australia viewed these principles of social justice as essential and connected to each other. The Workforce Council goes on to explain these principles as standing for the following:

Equity

This principle aims to ensure that resources that are available amongst people are fairly distributed with no other groups receiving more or less than the others.

In her article, Albertyn (2007) engages the idea that equality stated in the Constitution of this country has the potential to produce legal solutions and court decisions that may result in change that is transformative. She believes that this can be achieved through the concept of “substantive equality”. Substantive equality is defined as an approach that strives towards making sure that laws or policies do not reinforce the subordination of groups that are already at a disadvantage socially, politically and economically (Smith, 2014). This approach asks for an equal treatment of all individuals while recognising and being mindful of their differences.

The article speaks in an optimistic manner about substantive equality being able to address the numerous and diverse form of inequalities by stressing social and economic change. There is an acknowledgement in the strides that have been made over the years to ensure equality in a form of inclusion, but debates that the strides are not enough for transformative change. The emphasis is that although there is a broad reach in terms of people being protected by the constitution, there remain legal and social boundaries that are normative and sustain the traditional gendered ideas of society. These gendered ideas speaking to women, families, marriage and sexuality (Albertyn, 2007). The literature section did bring across that the different institutions use a heteronormative framework in their provision of services. The concept of equality in the legal system has broadened the perimeters of inclusion but has not been able to dismantle the underlying social framework that works against other groups (Albertyn, 2007). This is supported by the study Lykens et al., (2018) where the participants expressed facing challenges even in clinics which are known to specialize in gender-affirming healthcare. Even in facilities that claimed the affirmative and inclusive stance, challenges of being misunderstood by providers were voiced out questioning whether inclusion equates to true change.

Access

The principle of access aims to ensure that there is fair access to resources, goods and services to all people irrespective of factors such as age, race, gender, ethnicity, and so on. This principle is crucial and central to this systematic review because the research questions associate with the issue of access to SUD treatment centres for genderqueer individuals. How genderqueer individuals are treated in SUD treatment

centres and in the healthcare, system influences their decision whether to seek out treatment or decide against it.

As stated by Williams and Fish (2020) in the previous chapter that approximately 20 million people in the United States meet the criteria for a substance use disorder, with the genderqueer population at a higher risk. Litten et al., (2015) raised a point that there is an absence of guidelines and protocols in place for genderqueer individuals, meaning that limited access to SUD treatment centres prevail in relation to this population. Literature does give a clear indication that the genderqueer population does seek SUD treatment but are often discouraged by the experienced sigma, discrimination and various obstacles they face in their attempts. Richard et al., (2016) reported on the unpreparedness of mainstream healthcare services for genderqueer individuals. All these put out a compelling argument that there is complacency in institutions when it comes to creating an environment accommodative of genderqueer individuals and their unique needs. Richards et al., (2016) does suggest that the number of genderqueer individuals accessing healthcare is big enough to initiate conversations on implementing policies that address the accessing and utilization of SUD treatment centres by genderqueer individuals. Access to healthcare services, SUD treatment included is an apparent challenge for genderqueer individuals compared to cisgender individuals. In instances where services have been sought, access to quality treatment also poses a challenge. The issue of access appears to go beyond access to healthcare facilities but goes to access to adequate and satisfactory treatment.

Participation

The principle of participation is one that aims to enable people to participate and voice out their opinions in decisions that affect their lives and well-being. In this case of accessing SUD treatment centres, gender mainstreaming and policies such as the South African Gender Policy Framework, would see to an allowance of participation of genderqueer individuals. The failure to include the genderqueer population in such important documents and recognise their rights hinders this principle. Genderqueer individuals are not equipped to actively participate in issues pertaining to them. The principle of participation clearly states that it exists to enable people to voice out their opinions in decisions that affect their existence.

It seems that gender mainstreaming as a concept would need to be investigated from a social justice lens so there would be a consideration of enabling everyone to participate in the decisions of the country affecting all citizens. A hindrance in their ability to actively make use of healthcare facilities means less participation in the process of healthcare providers learning how to better their skills and ability for further use in working with genderqueer individuals.

Rights

This last principle of social justice theory aims to protect individuals in that they can access and engage with information on circumstances and decisions affecting them and the freedom to fight back on decisions that are unfair.

The Bill of Rights, sections number 9 and 10 under Chapter 2 of the South African Constitution highlights the right to equality and human dignity for all South African citizens. Point 3 of section number 9 speaks of how no individual in this country may be unfairly discriminated against either directly or indirectly on one or more grounds

including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth by the state (The Constitution of the Republic of South Africa, 1996). Point 4 of section number 9 further supports the above point by stating that no individual may be unfairly discriminated against directly or indirectly against anyone on one or more grounds in terms of subsection 3 and that measures such as enacting the National Legislation to see to the prohibition of unfair discrimination must be put into practice.

Although there are section numbers within the South African Constitution that allow for all individuals the right to freedom to issues pertaining to religion, beliefs, opinions, and so on, there are also section numbers such as section number 10 that states that everyone has inherent dignity and the right to have their dignity respected and protected (The Constitution of the Republic of South Africa, 1996). Some of the practitioners who were participants of the study (Jacobs, 2019) made a valid point that how they were brought up and their value systems only allowed them to socially construct gender as binary, and only accepting of that. The point is that there are major difficulties (biases) experienced by mental health practitioners in SUD treatment centres when having to work with people belonging to the genderqueer population. Irrespective, section number 10 does state that the extent to which the right to human dignity is protected is entirely and with no exceptions.

Jacobs (2019) identified a gap in gender-sensitive training amongst mental health practitioners who work in SUD treatment facilities. Gender binarism in substance use disorders, targeting treatment to a specific gender identity, and the need for gender-sensitivity training were the three predominant themes in a pilot study in the Eastern Cape by Jacobs, (2019). This study explored the training needs of mental health practitioners in gender-sensitive use disorders (SUDs) when working with the

genderqueer population. Analysis of themes showed the training needs for the practitioners in how to deal with their own biases and prejudices towards the genderqueer population. In a study done by Williams and Chapman (2011), fear of what the doctor would say or do was one of the reasons expressed by young people belonging to the genderqueer population as a barrier to accessing healthcare. The fear of the doctor‟s responsiveness to their non-conforming gender identities correlates with one of the themes in Jacobs (2019) study of the need for gender-sensitivity training. The results of the study also indicated that there was a need for training in how the practitioners working in SUD treatment centres would manage the integration of queer individuals into these centres that are predominantly structured for heterosexual individuals, heterosexual males specifically.

Rationale

Gender binarism in substance use disorders, targeting treatment to a specific gender identity, and the need for gender-sensitivity training were the three main predominant themes in a pilot study in the Eastern Cape conducted by Jacobs (2019). This study explored the training needs of mental health practitioners in gender-sensitive use disorders (SUDs) when working with the genderqueer population. Analysis of themes showed the training needs for the practitioners in how to deal with their own biases and prejudices towards the genderqueer population. In a study done by Williams and Chapman (2011), fear of what the doctor would say or do was one of the reasons expressed by young people belonging to the genderqueer population as a barrier to accessing healthcare. This fear in genderqueer people of what the doctor would say correlates with the one the themes in Jacobs (2019) of the need for gender-sensitivity training. The results of the study also indicated that there was a need for training in how the practitioners working in SUD treatment centres would manage the

integration of genderqueer individuals into these centres that are predominantly structured for heterosexual individuals, heterosexual males specifically.

Summary

The goal of this study is to explore the implications of mental health care workers‟ responsiveness and sensitivity when working with genderqueer individuals in SUD treatment centres. Queer theory as a body of work aimed at deconstructing biased viewpoints directed at minority groups such as the genderqueer population was suitable as a theoretical framework. Through the exploration of queer theory, the social justice approach and its four principles, it has become clear that the concept of gender mainstreaming does contribute to the disparities observable in the different spaces that genderqueer individuals experience stigma and discrimination from. Access presents as the main challenge, explained as a result of the absence of guidelines and protocols in place to prepare to the rising number of genderqueer individuals seeking treatment. Using queer theory as a framework, the social justice principles are impeded upon by the concepts and policies that are meant to ensure equality amongst all citizens. The Gender, National Drug Master Plan is a policy document meant to see to a South African free of substance use seem to fall short in accountability in seeing through the success of plans put in plan to combat substance use. This chapter makes it clear that substantive equality leading to transformative change will only be realised once concepts such as gender mainstreaming have been relooked and revised with all the different gender identities in mind.

CHAPTER 4: METHODOLOGY

Introduction

This research used systematic review as a methodology. A systematic review uses a clear algorithm, as opposed to a heuristic, to perform a search and critical evaluation of the literature (Crossan & Apaydin, 2010). This method of research is suitable for this study as it will allow for the synthesis of the investigation of qualitative studies on this topic. This will hopefully bring about more insight on the topic which can be applied to the South African context.

Qualitative research strives to learn about people"s experiences and understanding what is important for people (Silverman, 2020). Silverman (2020) mentions three aims of qualitative research, one being to understand the human experience. The focus on human experiences appears to be the main distinguishing factor compared to other types of research such as quantitative research which pursue objectivity and facts. Qualitative research is different from quantitative research in that it focuses on people"s subjective meanings (Silverman, 2020). Its" focus on people"s subjective meanings is what makes it the suitable methodological framework because it allows for the voices and experiences of mental health professionals and genderqueer individuals to be heard.

Philosophical Approach

Epistemology is the philosophy of knowledge. Using Judith Butler's (1990) critique of gender identity categories as a starting point, a queer epistemology explicitly opposes the gender categories of lesbian and gay studies and lesbian and gay identity politics. So, methodologically, approaches to the qualitative research subject of this treatise, epidemiologically, the assumption is that human beings are always and already embedded in a context/world of meaning. Therefore, to magnify the

mental health workers" treatment of genderqueer individuals, methodologically, queer theory interprets it rather than reduce it to a statistical relationship (Giorgi, 1970). Human beings are always interpreting the significance of their dealings with one another, even if pre-reflectively. Queer theory is therefore radically empirical in its insistence that the researcher takes up the attitude that the process of interpreting human experience includes all circumstantial and contextual evidence; unlike quantitative methods which leave out circumstances that might influence human behaviour (Giorgi, 1970).

Queer theory makes sense of the questioning of normality that is observed as being deeply engrained in our societies, making it a suitable theory to work with as a framework for this systematic review (Franklin-Jeune, 2014). Its suitability is also seen in its ability to put an emphasis on the importance of understanding minority groups such as genderqueer individuals. Highlighted in Kirsch (2013), the theory has opened new ways for us to approach and treat gender diverse people by hopefully being cognisant of the challenges they face because of their gender identities. These challenges are as a result of numerous factors ranging from lack of understanding of the genderqueer population to the acts that are fuelled by heteronormative ideologies in our societies. Queer theory pushes for an understanding on why there are differences that matter than others (Franklin-Jeune, 2014). The understanding of these differences permits for an in-depth understanding on the challenges that they come with as well as their implications. These challenges result in stigmatisation, discrimination, rejection from family, friends and community resulting in loneliness and isolation, which can be attributed to the development of many mental health disorders, substance use disorders being one of the predominant ones.

Queer Theory as a form of Post-modernism

The ideas of queer theory are highlighted in the postmodernism theory. The postmodernism theory came as a reaction to modernism. It strives to unearth the many forms of truth that have been presented and question the different methods used to attain them (Franklin-Jeune, 2014). By unearthing the many forms of truth, it disrupts the comfort that exists in the stagnant understanding of the world. An understanding that there are compartments in which people can be put in that are either normal or abnormal (Franklin-Jeune, 2014).

Franklin-Jeune (2014) talks of two ways in which postmodernism and queer theory go together, leading him to believe that queer theory is a form of postmodernism. He states that their ideas on published works question the normality of heterosexual in both biology and psychology, leading in the creation of terms used to normalise individuals whose identities fall out of binarism. The second point he makes is that their shared idea is seen in that both theories investigate and probe the “truths” that have been laid out by the Western achievements such as medicine in understanding homosexuality.

Methodological Approach

An understanding and acceptance of the self is one crucial element in the leading of a functional and meaningful life within a society (Seltezer, 2008). Seltzer (2008) sees self-acceptance as suggesting to a far more rounded affirmation of self, resulting in the acceptance of all the different aspects that make one. One advantage of self-acceptance realization is the ability and willingness to reveal oneself to the world without worrying about how one is to be perceived by others (Carson & Langer, 2006). Genderqueer has continuously been defined with negative connotations that

instil great fear amongst the population, leading in them hiding their sexuality in fear of the consequences upon revealing their true self (Franklin-Jeune, 2014). These consequences could vary from being excluded socially to as severe as being killed. The first edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-I) listed homosexuality as a “sociopathic personality disorder”, suggesting that with certain interventions it could be treated (Franklin-Jeune, 2014). Although there have been many and enormous changes in how homosexuality is viewed and understood, the problematizing and stigma of homosexuality is still the reality of genderqueer individuals (Franklin-Jeune, 2014). In relation to religion and the Western society, genderqueer individuals are viewed as an entity that is against the intended framework of humanity in which God created both the man and woman for a specific reason (Franklin-Jeune, 2014). Furthermore, in Christianity, queerness goes against what God wants and is therefore a sin committed. The idea of how sinners ought to be treated has ostracised genderqueer individuals making them feel as outsiders (Franklin-Jeune, 2014).

Although this systematic review mainly focuses on mental healthcare workers, it is imperative to understand the ontology of genderqueer individuals. Ontology refers to what is true and real and the nature of that reality (Hasa, 2016). It is an important aspect to understand as it acts as a vehicle into gaining full understanding of how their reality looks on a day to day basis. According to Franklin-Jeune (2014), there are dictionaries such as those of Merriam-Webster dictionary which provide ill definitions that insinuate queerness as being out of place. These definitions carry connotations of genderqueer being worthless, questionable, unconventional, homosexual, and so forth. The definitions give a clear picture of the reality of being a genderqueer individual. An understanding of this reality allows for an understanding

of why the treatment they receive from healthcare professionals in SUD treatment centres can affect their responsiveness. Literature consulted on genderqueer indicates that queerness comes with many trials that they have to navigate. According to Franklin-Jeune, (2014), the western discourse has influenced the public into thinking that there is a level of integrity that comes with heterosexuality that is threatened by the genderqueer population. This negative undertone has left genderqueer individuals with few options on embracing their true self, opting to hiding their identities even amongst those close to them. Matebeni et al., (2018) which is one of the very few writings on genderqueer in Africa states that there is an active and observed hostility towards gender-diverse and non-binary individuals in Africa.

Cama (2009) describes evidence-based design as a new strategy that has emerged for the design of healthcare facilities. This strategy presents with a shift that everyone involved in the design of healthcare facilities must be aware of strives to implement in their own practice model. Evidence-based healthcare is centred on arriving at the optimal decision regarding patients, decision supported by clinical knowledge, research evidence and patient values/preferences. The evidence component to this concept alludes to almost certainty of what the outcome will be because of the ability to predict it because of the evidence-based healthcare model.

Pearson (2011) acknowledges the other models such as The Ace Star Model of Knowledge Transformation, diffusion of innovation model, and so on that all attempt to speak to the different components that exist in evidence-based healthcare to aid understanding, analysis, improvement and/or the replacement of the process as it is currently conceived, purported and practiced. He however shows preference to the

JBI as he describes it as a model that is continuously developing and building on frameworks that over the years have evolved out of the construction of experience with evidence-based practice. In the JBI Model of Evidence-Based Healthcare, four major components of the evidence-based healthcare process are depicted as:

- Healthcare Evidence Generation
- Evidence Synthesis
- Evidence/Knowledge Transfer and
- Evidence Utilization.

Pearson and Jordan (2010) acknowledges the work that has been done internationally with regards to translational research advocating for an inclusive approach but point out that there are elements to the research yet to still be developed and implemented in many countries.

This research uses the JBI systematic review method. According to Peters et al., (2015), a JBI systematic review is a method of research that brings together literature on a particular research topic or intervention to answer questions of effectiveness, appropriateness, meaningfulness, and feasibility of healthcare practices and delivery. In agreeing with the above definition of a systemic review, Moola et al., (2015) defines it as a method that synthesizes an already existing data on a particular topic. It is different from a traditional literature review in that it goes beyond the subjective and narrative reporting characteristics by using procedures to thoroughly extract data from multiple studies that have been deemed as appropriate to be part of the review. Studies that are used in a systematic review are assessed for their quality (Moola et al., 2015). According to Crossan and Apaydin (2010), a systematic review is different from the predictable method of conducting research in

that it uses a clear and systematic process of gathering, extracting and evaluating data. A systematic review aims to provide a comprehensive and unbiased synthesized summary on a certain topic by looking at multiple individual studies in one research document.

This method of research is suitable for this study as it allows for a qualitative study on multiple literatures on this topic and will hopefully bring about more insight on the research topic. This review utilises the Joanna Briggs Institute systematic review method. The JBI"s systematic review method was chosen for this review because of the institute"s emphasis on developing evidence-based tools and resources such as systematic reviews that are concerned with improving health outcomes in communities globally by promoting and supporting the use of the best available evidence to inform decisions made at the point of care (Peters et al., 2015). The evidence gathered from such tools being used to provide impeccable quality, information that is reliable, pragmatic and useful where needed the most.

Methodological Design

This systematic review research uses qualitative data. Qualitative research strives to find out about people"s experiences and understanding what is important for people (Silverman, 2020). The qualitative data is obtained by usage of multiple qualitative articles on the research topic. This method of research is suitable for this study as it allowed for a qualitative study on multiple literatures on this topic. Hopefully this will bring more insight on the topic which can be applied to the South African context.

Inclusion Criteria

The Population, Phenomenon of Interest, and Context (PICo) care setting framework analysis process assisted in defining the inclusion and exclusion criteria.

The inclusion criteria look at mental healthcare workers as the type of population that is the main focus of this systematic review. It secondly focuses on studies that explore training needs of mental healthcare professionals" training needs. Lastly, the inclusion criteria look at studies at which the context focuses on SUD treatment centres, but also the healthcare system.

Type of Population

This review aims to understand if there is a relationship between the way mental care workers in SUD treatment centres interact with genderqueer individuals and their responsiveness to the treatment provided. Because the focus is on the professionals being the mental health care practitioners, they are the participants in this review.

Phenomenon of Interest

The phenomenon of interest for this review is to explore mental health practitioner"s training needs in gender-sensitive SUD counselling of genderqueer populations.

Context

Substance Use Disorder Treatment Centres and the healthcare system.

Exclusion Criteria

The exclusion criterion is on studies that were not included in the review. The exclusion criteria will focus on the language at which the studies have to be written in and the context that will be not be considered for the inclusion in the systematic review.

Type of Studies

With the guidance of the PICo framework, this review focuses on studies that explore the behaviours and attitudes of registered mental health professionals in SUD treatment centres and how those affect the responsiveness of genderqueer individuals to the treatment provided. To shed a light in how their behaviours and attitudes affect the responsiveness of the queer clients in SUD treatment centres, this also looks at studies that talk about the experiences of mental health care professionals and genderqueer individuals in SUD treatment centres. The review focuses on studies that have been conducted in countries belonging to the continents of North America and Africa. The emphasis on these two continents is because of the lack of research in Africa on working with genderqueer, especially in SUD treatment centre. North America on the other hand seems to be more engaged in research around genderqueer individuals. Studies considered for this review needed to have been conducted from the year 2005 going forward. Studies prior 2005 were not considered for this review.

Language

Studies in other languages other than English were not considered, unless translated to English.

Context

This review considered SUD treatment centres and the health care system when exploring the experiences of the genderqueer individuals when accessing health care. The healthcare system was looked into because of the broader understanding

that is needed in understanding how the system works because focusing on specific contexts within the system.

Data Collection

The following section of this chapter gives a detailed description on how the data that was collected. The section is categorised into three sub-sections namely; search strategy, data screening, and the PRISMA Chart summarising the whole selection process.

Search Strategy

The search strategy was carried out in a three-phase process;

Phase one: Keywords

1) ***The identification of initial key words***

Key Words / Databases	Clinicians' attitude towards queer individuals in SUD treatment centre	Genderqueer and Healthcare	Genderqueer in substance use treatment centres	Healthcare professionals and genderqueer	Genderqueer and Substance Use
Google scholar	X	X	X		
EBco-HOST		X		X	X
PsycINFO		X		X	X
MEDLINE		X		X	X
Web of Science		X		X	X
EMBASE		X		X	X

The same keywords were used to search all the search engines to allow for the maintenance of focus on the topic. On the Google Scholar search engine, an additional sentence was used to search for studies. This was done only in this specific search engine because it was the only one that allowed for the usage of a

longer search sentence, the other search engines required usage of shorter search terms.

Phase Two: Search Engines

This systematic review research paper made use of the following databases to source articles that were used to conduct the review. The databases are commonly used in the discipline of psychology and hold access to peer-reviewed and accredited journals.

Electronic bibliographic databases

Name of the Database	**Accessed**	**Not accessed**
Google scholar	X	
EBco-HOST	X	
PsycINFO	X	
MEDLINE	X	
Web of Science	X	
Cochrane Database of Systematic Reviews **The Cochrane Central Register of Controlled Trials** **Database of Abstracts of Reviews of Effects** **The Cochrane Central Register of Controlled Trials**		X *At the time of the commencement of the systematic review, the university"s library did not have access to these databases; as a result, it could not be utilized for this review.*
EMBASE	X	

Phase Three: Grey Literature

Grey literature was also explored for additional material for the review. Levin (2014) defines grey literature as any kind of material that has not been published in a traditional format. The material may not necessarily follow the academic use of words, lack bibliographic control meaning that it may make it hard to look up compared to traditional academic writing materials. Grey literature may include materials such as conference proceedings and posters, dissertations and theses, governments" reports and raw data, and so on. Much of grey literature is now available online, making it easily accessible to the public to utilise, especially in systemic reviews. Grey literature has been more specifically conceptualized in narrow and broad ways (Schöpfel, 2011). Grey literature was fitting for this review because it allowed for a broader exploration on the topic without being confined to the usage of academic materials only.

In exploring grey literature, the same keywords used in the search engines were used when searching for reading material relevant to the review.

Data Screening

Upon finishing the search of studies using the keywords in the search engines and grey literature, three screening phases followed.

Initial screening

The initial screening served as an exclusion process of studies that did not meet the inclusion criteria. Studies that had the following characteristics were excluded;

1. Studies conducted prior 2005

2. Studies that were conducted in countries that did not belong in North America or Africa.
3. Studies which did not make mention of mental health workers/healthcare providers.

Second screening phase

The second screening phase involved reading through the abstracts thoroughly. The abstract had to mention:

1. The experiences of genderqueer individuals in SUD treatment centres or in healthcare.
2. The interactions between mental health workers/healthcare providers and genderqueer individuals.
3. Proposed training and/or interventions targeted at mental health workers/healthcare providers.

Third screening phase

The final screening phase involved reading the full article to decide whether it did speak to the research question. A Microsoft Word document was created to document this screening phase. The crucial columns in this Word document were the ones that indicated whether an article met all the inclusion criteria after reading it or not. There was also a column that allowed for a reason/s to be stated as to why a specific article was not selected to form part of the articles selected to be in the review.

Analysis (PRISMA Chart)

The PRISMA Chart

PRISMA 2009 Flow Diagram (Diagram 1: Numerical Presentation of Results)

(Moher et al, PRISMA Group (2009).

Identification

Records identified through database searching **(n = 107)**

Additional records identified through other sources (Grey literature) **(n = 06)**

Screening

Records after duplicates removed **(n = 00)**

Eligibility

Records screened **(n = 113)**

Records excluded **(n = 74)**

Full-text articles assessed for eligibility **(n = 39)**

Full-text articles excluded, with reasons **(n = 14)**

- No suggested intervention/s = **04**
- Aimed at bringing awareness on the experiences of genderqueer = **03**
- An extended abstract of a project still in progress = **01**
- Genderqueer healthcare providers talking about own experiences working in health = **01**
- Focus more the medical side of the gender affirming procedure = **01**
- Articles used in the introduction and other chapters = **03**

Included

Studies included in qualitative synthesis **(n = 25)**

DATA ANALYSIS

The purpose of this study was to investigate the way mental health professionals in SUD treatment interact with genderqueer individuals and how those interactions affect their responsiveness to treatment. After having explored that, this study aimed at looking at training and interventions that mental health professionals need to be competent in when working with genderqueer individuals. In keeping with the queer theory, this thesis attempted to answer the main question; *how sensitive and responsive are mental health professionals to the queer population in the treatment of SUDs?*

According to Braun and Clarke (2006), in order to do a thematic analysis one needs to identify themes in what was collected throughout the data collection phase. The thematic analysis method is guided by six steps with the analysis beginning with familiarisation with the data, generating codes, searching for themes, reviewing the themes, defining and naming them, and then reproducing the report (Braun & Clarke, 2006). This method was chosen because of its ability to highlight the themes across all the data consulted.

Phase 1: Data Familiarisation

The first phase consisted of systematic reading of the selected articles. The reading of the articles was not only systematic, but also in-depth and engaged. Throughout the reading of the articles, special attention was paid to terms, concepts, and so forth that were repeated in the studies. This process allowed for a move to the next phase of the thematic analysis process.

Phase 2: Generation of Initial Codes

Initial codes were generated once familiar with the data. Initial codes are the features of the data that appear interesting and meaningful. These codes are more numerous and specific than themes but provide an indication of the context of the conversation. They were terms, concepts and keywords found in the articles. This process allowed for the grouping of information and finding of common links within the data (Braun & Clarke, 2006)

Phase 3: Searching and Reviewing of Themes

Themes refer to identifiable ideas that link to each other and they emerge from the collected data (Ibrahim, 2012). This step as proposed by Braun and Clarke (2006) was followed by reading the articles a few times to ensure that they indeed spoke of similar ideas. The process of searching for themes involved grouping key codes that held the same concepts and showed potential themes (Braun & Clarke, 2006).

Phase 4: Reviewing themes

Reviewing of the themes involves thoroughly reviewing the already identified themes to question whether to combine, refine, separate, or discard initial themes. Data within themes should have content that produces coherent meaningful understanding. This is usually done over two phases, where the themes need to be checked in relation to the coded extracts (phase 1), and then for the overall data set (phase 2).

Phase 5: Defining and Naming Themes

In the process of finalising the themes, there was an on-going thorough redefining of the emerging themes to ensure that there was no overlapping of themes which would produce two different themes talking about the same concepts. Themes were developed by grouping of the codes allowing for the development of themes (Braun & Clarke, 2006). Accessing healthcare, Interactions with Healthcare Professionals, and Substance Treatments Centers and genderqueer were the identified themes. These themes are accompanied by sub-themes which are more elaborated on the interpretations" chapter.

Phase 6: Producing the Thesis Findings

Producing the findings of the thesis involved giving a qualitative interpretation of the findings by discussing the themes and their sub-themes more and referring to the different studies. The discussion of the themes and sub-themes related to the research question of this research review. The results of the thesis relay the different interactions between genderqueer individuals and mental health workers validating the importance of such a review for the benefit of SUD treatment centres and also for the healthcare system.

Quality and Rigour

A paper by Forero et al., (2018) state that conventional terms such as internal validity, reliability, objectivity and external validity are used in quantitative research in relation to the quality and rigour of the research. In establishing quality and rigour in qualitative research, a strict criterion was created by Lincoln and Cuba, a criterion that looks at credibility, dependability, confirmability and transferability

(Forero, 2018). In the paper, the authors mention that they developed their own term called "the Four-Dimensions Criteria" (FDC) to give a name to the criteria initially created by Lincoln and Cuba. This thesis also subscribes to the term in recounting the criteria.

In their study, the Four-Dimensions Criteria (FDC) was explained as follows:

Credibility

The credibility of a study establishes confidence in that the results produced by the study are true, credible, and believable. Prolonged and varied engagement with each setting is one strategy mentioned in Forero et al., (2018) to ensure credibility. In this systematic review, the selected studies were engaged with in a thorough manner, therefore being confident that the results are true as there was a deeper understanding of the content of each study.

Dependability

A study"s dependability ensures that the findings of a qualitative study will be the same if the study were to be conducted again on the same group of people in the same context. Dependability speaks to ensuring that if another researcher were to conduct the same study on the same participants under the same context, they would get the same results as the initial ones. Rich description of the methods used in a study and the establishment of an audit trail are some of the strategies proposed to ensure dependability. This systematic review used a documented step by step process of collecting, screening and analysis of the data. The systematic review started by the identification of keywords that would be used to search for articles. The next step was to identify database search engines to be used in searching for the articles using the keywords already decided on. The screening process included

a three steps process to ensure that the chosen articles have gone through a thorough screening process. This process of exclusion and inclusion was documented and reasons were provided for the excluded articles. The process was then consolidated into a chart called the PRISMA Flow Chart. Another researcher following the exact steps would highly arrive at the same findings as the ones this study has arrived at.

Confirmability

The confidence that the results would be corroborated by other researchers reassures the study"s confirmability. The nature of the methods of a JBI systematic review which follow certain steps gives confidence that other researchers would confirm the findings of the study, especially if they also used this method and were guided by the exact inclusion and exclusion criteria.

Transferability

The degree in which the results can be generalized to other contexts other than the ones in the study confirms its transferability. In the exclusion criteria part of the methodology section, it was stated that only studies from countries in North America and Africa would be considered for this systematic review. The results of this systematic can be confidently transferred to countries found in North America as majority of the articles were from the continent. They would be transferable to countries in North America as they likely have similar contexts and settings.

Summary

The methodology chapter is divided into three sections namely, the philosophical approach, methodological approach and methodological design. The three sections

look at different components of the method employed in carrying out this systematic review. The philosophical approach section explored the Queer Theory as a framework for this systematic review.

The methodological design section of this research used the JBI‟s way of conducting a systematic review. The JBI method strives for an evidence-based healthcare approach which emphasizes that decisions around patients in any healthcare settings should be arrived at after the guidance of already trustworthy clinical knowledge, research evidence and so forth. Consulting and using already existing research allow for predictable outcomes which can be better managed. The last section of the methodology chapter spoke to the design of the acquiring, processing and producing data. PICo healthcare framework provided guidance in narrowing the selection of the studies to be a part of this systematic review. Studies that were included focused on mental healthcare workers as the population of interest, SUD treatment programs as interventions, SUD treatment centres as the context and gender sensitivity and responsiveness as an outcome of interest. This section also broke down the data collection process which started with the search strategy (keywords, search engines and consultation of grey literature). After the search strategy, data screening consisting of three screening phases followed. The last part of methodological design explained the six phases of data analysis starting from the first phase of data familiarization to the last phase of producing the thesis findings. The PRISMA Chart consolidated the results produced from data collection, screening, and analysis.

CHAPTER 5: INTERPRETATION OF THE FINDINGS

Introduction

The goals of this systematic review were threefold, with the main one being to build on the work of Jacobs (2019) in its efforts to engage with the concept of gender sensitivity and responsiveness specific to the genderqueer population in SUD treatment centres. The other goal was to highlight the consequences of not taking into consideration other gender identities in the conception and implementation of gender mainstreaming. The last goal was to find interventions that highlight the skills necessary for practitioners in SUD centres when working with the genderqueer population.

The systematic review method utilises clear procedures to perform a search and critical evaluation of the literature which was suitable for this task. It was suitable because in this case, it allowed for a critical study of multiple qualitative studies on the topic.

South Africa being a democratic country with equal rights set out for every citizen; a study like this one that highlights areas that impede on one of the minority groups‟ experiences of true freedom is vital. South Africa comes with a history of discrimination and oppression of other groups and recently the oppression and discrimination of vulnerable and minority groups (women, children, genderqueer individuals and so forth) being prevalent. The process of gender mainstreaming was intended to ensure fair treatment amongst gender identities, ensuring equality. Although gender mainstreaming was intended to correct the disparities seen between genders, it failed to be inclusive of all gender identities, creating a room for

gender discrimination against the genderqueer population. This lack of inclusivity is seen in a document as important as the South African Gender Policy Framework that is mandated to provide guidance to the state"s institutions such as those providing healthcare. Other than gaining an understanding of gender responsiveness and sensitivity, this systematic review is an advocate for transformative change that can only start through the revision of documents that hold power to inspire change.

The thematic analysis was used to analyse the data extracted from the 25 eligible articles used in this systematic review. This method was chosen for analysis because of its ability to highlight the themes in the data consulted. This method of analysis guided the writing up of the results of this systematic review. The findings are an elaboration of three themes and the subthemes identified. The findings also include a table of identified possible interventions to address the issue of gender sensitivity and responsiveness in SUD treatment facilities. Thematic analysis was also used in the identification of themes in the interventions. Lastly, the write up includes a critical review of the identified themes in the South African context.

Emergent Themes

This systematic review"s research question is*: how sensitive and responsive are mental health professionals to the queer population in the treatment of SUDs?*

The examination of 25 journal articles which were selected to be part of this systematic review shed light into various factors focusing on the relationship between genderqueer individuals, SUD treatment centres, and the healthcare system. Factors that were covered in the articles largely focused on accessing healthcare services within the healthcare system. Although some of these factors were not specific to the context of SUD treatment centres, they were applicable to

this review for two reasons; 1. Due to the lack of knowledge on the correct channels to follow to be admitted into a SUD treatment centre, individuals may approach other healthcare institutions such as local clinics, hospitals, and so on whereby they will be interacting with other healthcare providers in a position to refer them to SUD treatment centres. 2. SUD treatment centres form part of the healthcare system, therefore, the kind of treatment received in SUD treatment centres cannot be separated from the healthcare system.

Challenges and concerns expressed have the potential of negatively or positively affecting whether genderqueer individuals access SUD treatment centres and how they respond to SUD treatment programs. Findings of this chapter are broken down into two sections with section one discussing the three themes which consist of three of more sub-themes. Following the themes section, the different interventions proposed in the literature reviewed will be discussed and put in a table format.

Themes

Three predominant themes were identified through thematic analysis. These three themes are:

- Accessing healthcare,
- Interactions with healthcare professionals, and
- Substance Use Disorder Treatment Centres and the genderqueer population.

The themes highlight the responses of mental health providers which are mainly narrated by genderqueer individuals. Having to depend on the narratives of genderqueer individuals to understand the responses of mental health providers

highlights the inadequate amount of research conducted with mental health workers as the sole population of interest.

Accessing healthcare

An analysis of the themes that emerged showed that there is a need for training of practitioners in how to work around their own biases and prejudices towards the genderqueer population (Jacobs, 2019). This theme highlights the difficulties faced by genderqueer individuals in approaching and accessing healthcare. The focus being on issues within the healthcare system and the way it is presented to the external world and therefore perceived by genderqueer individuals. This perception therefore preventing or making it difficult for this population to approach healthcare institutions for services offered. The representation of healthcare facilities is constituted by health policies which are endorsed and carried out by healthcare providers who by their presence at healthcare institutions decree how healthcare facilities are used and perceived by the general population (Meer & Muller, 2017). Four sub themes under this theme emerged namely: acquiring health insurance, public and private sector, healthcare environment, and lack of trust and genderqueer staff representation.

Acquiring Health Insurance

Healthcare insurance presented as one of the reasons preventing genderqueer individuals from accessing healthcare institutions, especially SUD treatment centres that are rather expensive. The review revealed that genderqueer individuals found it challenging to acquire health insurance due to the discrimination posed against them for their gender identities and sexual orientations by health insurance providers. The following extract reiterates genderqueer individuals" inability to acquire health insurance in the same way heterosexual individuals are:

> *"Research shows that the LGBTQ population has difficulty accessing healthcare services, obtaining health insurance, and has lower rates of routine follow-up visits for chronic health monitoring and routine screenings"* (Mitchell et al., 2018, p.2).

Public and Private sectors

There is a discrepancy in the provision of healthcare services to genderqueer individuals in the public and private sectors. The private sector is experienced as more accommodating and better resourced allowing for more individualised, and a patient-centred approach that is inclusive of issues of gender and sexuality (Meer & Muller, 2017).

> *"The better-resourced care, including a more considered approach to issues of gender and sexuality"* (Meer & Muller, 2017, p.94).

A study by William and Fish (2020) supports this observation by stating that genderqueer individuals who have financial means to access private facilities were more likely to be serviced in a manner that is inclusive. However, the rates charged at private healthcare institutions tend to exclude individuals whose socio-economic status is low and do not permit for private healthcare. On the other hand, the public sector which is one that is open to the masses seeking health related services is perceived and experienced as unwelcoming due to factors attributed to lack of specialized training in genderqueer related health issues. Public health institutions are over-burdened resulting in healthcare providers who are overworked and unfriendly (Meer, & Muller, 2017). As stated by Klein (2008:11) cited in Meer & Muller (2017):

> *"Income is still intimately connected with gender and skin colour; the situation is especially difficult for persons who did not grow up categorized as white males – but private care is much too expensive even for many who have been categorised this way". (*Meer & Muller 2017, p.94)

Although both the public and private sectors in South Africa are governed by the same national policies which order the provision of healthcare, the Department of Health has not issued any guidelines on genderqueer-related health concerns (Meer & Muller, 2017, p.94).

Healthcare environment

Majority of genderqueer individuals included in the systematic review expressed experiencing the healthcare system from afar as heteronormative and unwelcoming to individuals outside of the gender-binary spectrum (Meer & Muller, 2017).

> *"Participants were keenly aware that the physical spaces of the healthcare facilities that they had visited overwhelmingly suggested that they were by and for heterosexual and gender-normative people"* (Meer & Muller, 2017, p. 95).

The heteronormative attitude is seen in the marketing of the healthcare services in the different forms such as campaigns, posters and pamphlets which only presented binary gender individuals.

> *“Further, whilst there was no explicit indication that genderqueer-specific healthcare concerns are addressed in the healthcare spaces visited by participants, there were no signs that the spaces even acknowledged the existence of queer bodies, identities or intimacies”* (Meer & Muller, 2017, p.95).

These marketing tools primarily addressed health and sexual needs of heterosexual individuals, excluding non-binary individuals. The presentations were experienced as lacking sexual diversity.

Lack of trust and genderqueer staff representation

The lack of trust towards the public healthcare system stems from various factors, with the lack of genderqueer healthcare providers as one of the reasons (Meer & Muller, 2017).

> *“Furthermore, the heteronormativity of the healthcare space is maintained by the casual visibility of normative bodies within it, and the complete invisibility of genderqueer service-users and staff”* (Meer & Muller, 2017, p.95).

Genderqueer individuals felt that there was nothing in healthcare institutions deliberately put in place to accommodate them and their needs. The discrimination and being misunderstood affects the levels of trust that genderqueer individuals have on healthcare institutions. The lack of genderqueer healthcare providers exacerbates the issue of trust. Having genderqueer individuals as part of the staff would make visits to these institutions more welcoming and inclusive.

The four subthemes under this theme of accessing healthcare speak to two principles (equity and access) of the social justice approach. As stated by The Workforce Council, the principle of access aims to ensure that there is fair access to resources, goods and services for all people. The principle of equity is there to compliment the principle of access in that it aims to ensure that upon having gained access to the resources, services, and so forth, they are available to everyone and distributed fairly. The four subthemes highlighted that within the healthcare system with which SUD treatment centres fall under, these two principles are highly infringed on. For an example, the inability to acquire health insurance as a genderqueer individual has an influence on the kind of facility a genderqueer individual can approach. The findings indicate that in comparison to public health facilities, private facilities offer better services which are considered somewhat inclusive by genderqueer individuals. For a genderqueer individual, an inability to acquire health insurance implies that the facilities that they can approach are restricted because of the lack of access to health insurance. An infringement on the principle of equity is also highlighted in the subthemes in how the healthcare environment and its healthcare providers are experienced by the genderqueer population. The findings reveal that genderqueer individuals are made to feel like the other because of the environment that screams heteronormativity, encroaching on fair distribution of services amongst everyone accessing the healthcare system.

Interactions with Healthcare Professionals

This theme focused on the experiences of genderqueer individuals in healthcare institutions and their interactions with healthcare providers. The above-mentioned theme (accessing healthcare) looked at healthcare from an external viewpoint and experiences of genderqueer individuals while this theme looks at genderqueer

individuals‟ experiences when they have managed to access healthcare and are faced with interacting with healthcare providers in order to make use of the services they require. Mitchell et al., (2018) states that on top of all the challenges that genderqueer individuals face whilst attempting to access healthcare, they are often faced with discrimination from healthcare providers which is due to the lack of cultural sensitivity.

> *"Additionally, once healthcare is sought, this population often faces discrimination due to a lack of cultural sensitivity from healthcare or staff members which can further exacerbate healthcare inequities and result in poor patient health outcomes"* (Mitchell et al., 2018, p.2).

The above excerpt directly links with gender social justice claims that basic human rights, such as access to healthcare is a barrier based on one‟s gender expression and performance (Butler, 1990).

Heterosexual Framework

Upon accessing healthcare institutions, genderqueer individuals find that the institutions use a heterosexual framework. The heterosexual framework is evident in the filling of intake forms and during history taking. Mitchel et al., (2018) emphasized how the experiences of genderqueer individuals in the healthcare system could be improved by providers taking the initiative to learn how to take a comprehensive health history addressing individuals‟ Sexual Orientations (SOs) and Gender Identities (GIs). Intake forms with SOGIs replace the traditional binary heterosexual normalising options that create the feeling of healthcare institutions subscribing to a heterosexual framework.

"Simple, yet powerful changes made within the healthcare environment can help patients feel more accepted and welcomed" (Mitchel et al., 2018, p.2).

The assumption of binarism during the history taking process often leads to non-binary individuals having to involuntarily disclose their gender identities and sexual orientations to provide clarity on some of their answers to questions asked by providers.

> *"The whole thing is not applying to you [a genderqueer woman]; because they are asking „how many men have you slept with in the past 5 weeks or the past 5 months?" And you are like „None". [The nurse says] „Then why are you here?" And now you have to disclose your [sexual orientation] status"* (Meer & Muller, 2017, p.96).

This speaks to the lack of cultural sensitivity amongst healthcare providers experienced as judgemental.

Lack of Knowledge

One consistent issue expressed by genderqueer individuals was the visible lack of knowledge of non-binary health needs and sex related topics. Genderqueer individuals often find themselves having to educate healthcare providers of their gender identities and sexual needs, especially transgender individuals. Whitman et al., (2020) speaks of the importance of healthcare providers being supported in gaining knowledge about the genderqueer population and their needs and more knowledge in providing respectful responsive care to this population. A lesbian

participant in the study of Meer and Muller (2017) reported being told by a healthcare provider that they did not need a certain type of services because they are lesbian.

Section number 10 of the Bill of Rights states that everyone has inherent dignity and the right to have their dignity respected and protected (The Constitution of the Republic of South Africa, 1996). The principle of rights of the social justice approach explained by The Workforce Council aims to protect individuals in that they can access and engage with information on circumstances and decisions affecting them and the freedom to fight back on decisions that are unfair (The Workforce Council). The two subthemes under the theme of genderqueer individuals having to interact with healthcare professionals shows that genderqueer individuals" rights to access healthcare is encroached on based of their sexual orientations and gender expressions.

Substance Use Treatment Centres and Queerness

The little research that has been conducted looking at provider"s capacities for working with genderqueer minority individuals paints an unattractive picture (Hardesty et al., 2012). The pilot study by Jacobs (2019) which explored the training needs of mental health practitioners in gender-sensitive use disorders (SUD) when working with the genderqueer population revealed these three themes; gender binarism in substance use disorder, targeting treatment to a specific gender identity, and the need for gender-sensitivity training. Sub-themes found under this theme in this review supports the three themes that were found in the pilot study by Jacobs (2019). These sub-themes are; abuse (physical and verbal), compartmentalisation of gender identities, allocation of sponsors, and isolation.

Abuse (Physical and Verbal)

Oberheim et al., (2016) speaks of three areas within SUD treatment centres that were found to not be helpful to the treatment of genderqueer individuals. A transgender protocol team in 1995 identified that genderqueer individuals are exposed to verbal and physical abuse from staff members and other clients. The verbal abuse came in a form of hurtful words and actions which shows lack of competencies from the healthcare providers as illustrated by the following quote:

> *"……. three areas within SUD treatment facilities that were not conducive to SUD treatment in transgender clients: (a) being the recipients of verbal and physical abuse by other clients and staff, (b) being required to solely wear clothes judged appropriate for their sex assigned at birth, and (c) being required to shower and sleep in areas judged to be appropriate for their sex assigned at birth". (*Oberheim et al., 2016, p.38).

The lack of skills amongst providers was also highlighted in their inability to safeguard genderqueer individuals from the abuse exerted by other clients in treatment programmes. Hardesty et al., (2012) pointed out how healthcare providers are not adequately equipped to work with genderqueer people which indicate that nearly half of the providers had negative and ambivalent attitudes towards genderqueer clients. They also exhibited lack of knowledge about legal and social issues related to the genderqueer population (Hardesty et al., 2012, p.100).

Compartmentalisation of gender identities

The other two areas that were identified by the Transgender Protocol Team were the requirements to solely wear clothes judged by the staff and to shower and sleep in

areas deemed as appropriate for sex assigned at birth. The providers put individuals into compartments that they find to make sense to them. In other words, whatever gender expression (also called gender presentation) the health care provider interpreted the genderqueer person to be (strictly male or female), the genderqueer person would be required to dress, and act in ways that affect how the health professionals view their gender. Someone who wears men‟s clothes and acts in a masculine way has a male gender expression. Queer theory provides tools for questioning concepts that are seen as truth in society. Such as what is natural, irrespective of whether they involve sexuality, gender or some other form of normality. The review also revealed a disregard amongst SUD workers of the individual‟s expression of discomfort with the pronouns used when addressing them.

One of the cases in the study of Oberheim et al., (2016) illustrated how genderqueer individuals are not granted the opportunity to choose for themselves therapy groups of their preference. They, however, are assigned to groups based on sex assigned at birth not the sex they present as or prefer.

Sponsors

In SUD treatment centres, genderqueer individual‟s preferences in terms of sponsors are often not taken into consideration when they are allocated sponsors.

> *"Therefore, counsellors-in-training should be prepared to help their clients articulate the gender of the sponsor that would be most appropriate for them and then to process this experience"* (Oberheim et al., 2016, p.41).

The allocation of sponsors is solely based on an individuals‟ sex assigned at birth rather than what the genderqueer individual preferred (Oberheim et al., 2016).

Isolation

As a result of feeling misunderstood, genderqueer individuals isolate themselves from the other patients in SUD treatment centres. This often results in genderqueer individuals opting to leave the programme before their treatment is finished. The following (Eliason & Hughes, 2004; Hughes, 2011) quote cited in Oberheim et al., (2016) state:

> *"As a result of unaddressed biases and ignorance toward transgender clients, SUD counsellors may unwittingly cause harm to clients rather than promote recovery" (*Oberheim et al., 2016, p.35).

Hardesty et al., (2012) suggested that there are no recent empirical studies to support ill treatment of genderqueer clients in treatment centres, there is reason to suspect that it is happening due to the lack of representation of the genderqueer population in SUD treatment.

> *"There is no reason to suspect that ill-equipped treatment facilities will lead to poorer treatment outcomes for SMs, yet no recent empirical studies have examined treatment outcomes for this group" (*Hardesty et al., 2012, p.100).

He built on this statement by referring to genderqueer individuals who were part of a study like this one which clearly illustrated that the client‟s queerness affected their ill treatment.

Interventions

The previous section focused on identifying themes that attempted to answer the research question of this review. This section of the chapter looks at the different interventions suggested in the systematic review as alternatives to be explored in addressing the training needs of mental health providers in SUD treatment centres. This section aims to address one of this research review‟s goals: to find interventions that highlight the skills necessary for practitioners in SUD centres when working the genderqueer population.

This section is divided into two parts. The first part is a table that lists the 12 interventions that were extracted from the studies in the review. The first part gives a summary of the themes extracted from the 12 interventions mentioned in the table. The identified themes are: 1. Terminology and pronouns, 2. Inclusive and Affirmative stance, 3. Cultural sensitivity, 4. Professional competencies and on-going discussions, and 5. Queer education in training curricula. The second part is a table that lists the 12 interventions that were extracted from the studies in the review.

Intake Form: Terminology and pronouns

A consistent issue raised by genderqueer individuals in the studies in this systematic review was having to teach providers who did not know much about genderqueer individual‟s health and vulnerabilities. Genderqueer individuals expressed feelings of being unwelcomed and discomfort when the incorrect pronouns were used. Providers‟ knowledge on genderqueer‟s needs is judged by the questions they ask and the language they use (Donatone & Rachlin, 2013). The intake form is usually the first form of contact between a provider and the genderqueer client. As a result, having an option in the intake form where a genderqueer individual can put a

preferred pronoun plays into the rapport building. The collection of Sexual Orientation and Gender Identity in the initial stages proves to be fruitful in the interactions going forward (Maragh-Bass et al., 2017).

Inclusive and Affirmative stance

Inclusive and affirmative settings were described as ideal in ensuring that genderqueer individuals feel welcomed in healthcare institutions. These conditions would be achieved by encouraging multiculturalism, gender-affirming language and open communication amongst healthcare providers and genderqueer individuals seeking healthcare services. Chazin and Klugman (2014) speak of the importance of adopting a stance of unconditional positive regard when working with genderqueer individuals. This stance is encouraged because of its emphasis on respect and allowing the client to be themselves without imposing one"s values and viewpoints on them. Chazin and Klugman (2014) further emphasize that cultivating an affirmative stance requires awareness of one"s own sexual orientation, one"s own internal assumptions and beliefs about sexual minorities and the ability to separate sexuality and mental disorders. Findings on a thesis by Forbes-Roberts (2018) explored patient satisfaction Transgender and Non-Binary identified healthcare users which revealed that healthcare settings that are inclusive lead to patients who are satisfied and therefore respond positively to treatment.

Cultural sensitivity

Self-reflection was encouraged as a critical component in the development of interventions that are specific to the attempts of creating a welcoming environment for genderqueer individuals. Self-reflection amongst healthcare professionals was encouraged as it is believed to allow for the identification of one"s own gender-identity, sexual orientation and biases (Troutman & Packer-Williams, 2014). The

findings in the articles reported that self-reflecting on the above-mentioned points assists in how the healthcare providers interact with a genderqueer individual.

Professional competencies and On-going discussions

Two studies (Eckstrand et al., 2014; Oswalt et al., 2016) each mentioned eight and six competencies respectively in the table above that counsellors should be competent in to affectively work with the genderqueer population. These competencies serve as a guideline of areas within training that still need to be looked at. On-going conversation between professionals and with professionals who have more experience working with genderqueer individuals.

Queer education in training curricula

Lack of content specific to genderqueer individuals and the different challenges they face, and their healthcare needs was expressed as the main problem leading to the underservicing of genderqueer individuals. Study by Troutman and Packer-Williams (2014) suggest specific training standards deemed as essential to addressing the challenges around counsellor‟s training/education related to genderqueer needs. Their suggestions advocated for the inclusion of the genderqueer population within the scope of multicultural counselling and training. This inclusion would interrupt the heterosexist scope that is dominant in the training of counsellors. It would allow for the confrontation of heterosexism and transphobia by encouraging a more affirmative language. This would be the first step that would potentially propel the advocacy even in communities.

Identified Interventions

INTERVENTIONS
1. **An Intake Form specific to genderqueer individuals' vulnerabilities;** (Donatone & Rachlin, 2013). • Terminology, Preferred Gender Pronoun, Patient Records, Diagnosis, Coming out, Transition Trajectory, etc.
2. 1-hour Online Assessment consisting of four categories addressing sexual and gender minority (SGM) health (Streed et al., 2019). • Terminology relevant to SGM individuals • Health disparities and preventive care issues affecting SGM individuals • Substance sexually transmitted illnesses affecting SGM populations • Common sexually transmitted illnesses affecting SGM populations
3. Counselling Competencies (Harper et al., 2013). • Human Growth • Social and Cultural Diversity • Helping Relationship • Group Work • Professional Orientation and Ethical Practice • Career and Lifestyle Development • Assessment • Research and Program Evaluation
4. Suggestions for Health Professionals (Oswalt et al., 2016). • Self-reflection on one"s identity • An increased knowledge and awareness of newer and revolving identities • Awareness of how health promotion for genderqueer individuals was portrayed • Awareness of the self-identified label chosen by genderqueer individuals • Understanding of the chosen pronouns • Self-identification and behaviour do not always align
5. **Strategies for tailoring interventions** (Chazin & Klugman, 2014). • Cultivation of affirmative stance • Addressing of institutional and systemic issues • Understanding of the identity formation trajectories • Examination of intersecting identities • Identification and clarification of dimensions of sexual identity and orientation • Helping of clients in reconciling sexuality with religious backgrounds and precepts • Confrontation of internalized homophobia • Handling of disclosures • Connecting of client to communities and resources
6. Measures that can be implemented (Kattari et al., 2020). • Support of staff in gaining knowledge about genderqueer individuals and providing respectful and responsive care • Increased provider exposure • Creation of platforms where genderqueer individuals can provide feedback to healthcare providers • Knowledgeable providers (Names and Pronouns) • Change in language to be more welcoming • On-going discussions
7. **Phobias, Attitudes, and Cultural Competence Assessment** (Logie et al., 2007). • The Queer Assessment Scale Survey Items - *Phobia Scale (13 questions)* - *Attitude Scale (9 questions)* - *Cultural Competencies (4 questions)*

8. Professional Competencies to improve healthcare (Troutman & Parker-Williams, 2014). • Clear and intentional inclusion of the genderqueer population within the scope of multicultural counselling • Confrontation of heterosexism and transphobia • Unpacking of heterosexual privilege • Taking a stance on the inclusion of competency training for counsellors working with genderqueer individuals • Integration of multicultural competency across curriculum • Formation of partnerships with diverse training sites • Collaboration with local community, genderqueer organizations and/or alliances • Engagement in multicultural counselling competence and skills training • Understanding of gender fluidity, multidimensionality, and intersectional • Interrupt the heterosexual status quo by being a genderqueer ally
9. Professional Competencies (Eckstrand et al., 2014). • Patient Care • Knowledge for Practice • Practice-Based Learning and Improvement • Interpersonal and Communication Skills • Professionalism • Systems-Based Practice • Interpersonal Collaboration • Personal and Professional Development
10. Competencies in SUD Centres (Oberheim et al., 2016). • Knowledge • Skills • Awareness
11. **Ten Tasks of the Mental Health Provider** (Lev, 2009). • Create a supportive environment and determine purpose of the visit • Assessment of gender identity concerns • Assessment of Mental Stability • Education regarding treatment options and advocating for support • Responsibility for Integrated services for family members • Determine eligibility and readiness for referral to medical treatment • Completion of psychosocial assessment • Documentation letter for hormone therapy or surgery • Provision of collaborative services
12. Working measures (Baldwin et al., 2018). • Language Use • Knowledge and experience • Treating identity disclosure as routine

Interventions in relation to the South African context

A qualitative study at Mkhanyakude District in the KwaZulu-Natal province on the experiences and challenges faced by mental health practitioners in delivering substance use services in rural areas revealed that a lack of resources poses a threat in the attempt to deliver the very much needed services (Mpanza & Govender, 2017). The study revealed that there is a poor resources allocation when it comes to

services directed at substance use and mental health, which in most cases go hand-in-hand. This lack of resources is seen in transports dedicated at substance use and mental health matters, and in building of facilities to attend to the two mentioned challenges. In the Mkhanyakude District, it was reported by the participants that there was neither public nor private SUD treatment centres. Keeping in mind the existence of such contexts in South Africa, these interventions would be difficult to implement. The difficulty would be a result of rural facilities aimed at alleviating substance use and its co-morbidities not being allocated the necessary resources to even attempt implementing some of these interventions proposed by this systematic review. Mpanza and Govender (2017) indicate that there is less focus on decentralised or community-based interventions, but rather on centralised and institutionalised SUD treatment centres. The less focus in decentralised or community-based interventions compromises the access to quality healthcare in rural areas, although 40% of the country"s population lives in rural areas. The interventions appear to require not only material resources, but effective human resources coupled with effective monitoring and evaluation channels from the relevant department which appears to lack in the country. The participants of the Mkhanyakude District study revealed the lack of proper evaluation and monitoring channels from the Department of Health results in treatment centres not having standard operating measures (Mpanza & Govender, 2017). It is suggested in the study that a lot still needs to be done before the proposed interventions could be implemented successfully in the South African healthcare system, especially SUD treatment centres. The interventions themselves would be applicable to any context that is favourable in that they have the correct resources, and monitoring and evaluation procedures.

Summary

The process of data analysis yielded results consisting of three main themes with sub-themes. These themes were namely: accessing healthcare, interactions with healthcare providers and substance use treatment centres and queerness. The first theme with four sub-themes revealed that lack of gender sensitivity can be overt in a manner that it makes it hard for genderqueer individuals to access SUD treatment centres in the healthcare system. Insurance, discrepancies in public and private healthcare, and lack of trust and genderqueer staff presentation were the sub-themes that arose. This theme highlighted the challenge that comes with acquiring insurance as a genderqueer individual, often leaving public health which is experienced as lack specialized training as an option. There concerns voiced out that the lack of genderqueer staff representation contributed to the lack of trust felt by genderqueer individuals in healthcare facilities.

The second theme spoke to the interactions that exist in healthcare facilities between healthcare providers and genderqueer individuals. This theme revealed that providers use a heterosexual framework when interacting with genderqueer individuals. This means that they make assumptions that all the individuals that they interact with are heterosexual which is mainly observed in the process of history taking. Lack of knowledge regarding genderqueer related needs was also highlighted. Genderqueer individuals reported finding themselves having to educate providers of the sexualities and needs.

The last theme spoke specifically to SUD treatment centres and queerness. Sub-themes in this theme revealed that genderqueer individuals in SUD treatment centres are exposed to physical and verbal abuse from providers and other individuals within the program. They also revealed that genderqueer individuals are

compartmentalised into categories that seem to be at the benefit of the providers in SUD treatment centres. The compartmentalisation often leads to genderqueer individuals being forced to work with sponsors that they are not comfortable with, leading to isolation.

The journal articles presented with 12 interventions geared towards improving interactions and working with genderqueer individuals. An analysis of the intervention produced five themes. These themes suggested that it is important to that the correct terminology and pronouns are used. It also suggested that an inclusive and affirmative stance is necessary. The interventions spoke of the importance of cultural sensitivity which can be achieved through on-going discussions on gendequeer related matters in the healthcare system. Lastly, the importance of genderqueer education being introduced to curricula was emphasized.

CHAPTER 6: IMPLICATIONS OF THE FINDINGS AND CRITICAL REVIEW OF THE RESEARCH

Implications of the Findings for Theory and Application

This systematic review has shown the lack of gender sensitivity and responsiveness to the genderqueer population in SUD treatment centres and in their programmes. The lack of sensitivity to the unique differences the genderqueer have in comparison to the heterosexual individuals is not only observed from other patients who are heterosexual, but it is also observed from the mental healthcare practitioners. With healthcare providers, the lack of sensitivity goes beyond the lack of specialized training. Therefore, was problematized in this thesis. Oberheim et al., (2016) speak of stigmatization and unaddressed biases and ignorance of genderqueer clients as other factors that influence the lack of sensitivity of providers.

In 2009 the GPF was released, outlining South Africa‟s vision pertaining to gender equality and for how this vision is intended to be realised. The document stated that its intentions were to provide guidelines that could be incorporated by the different institutions into their own values. The policy represents the country in terms of equality and gender related matters. One visible concern as a reader of the document was the lack of any mention of other gender identities that exist in South Africa such as the LGBTQI+ population. The policy stated that its focus was to promote the equality of opportunities and of better treatment by employers and service providers by advocating for issues on gender to form part of central discussions in this process of the country‟s transformation. The document appears to have been guided by the concept of gender mainstreaming as it was crafted and

mandated to implement gender mainstreaming in the country. The different structures within the country, healthcare and SUD centres in this case are meant to investigate the policy for guidance in gender related matters. Lack of mention of genderqueer individuals explain the themes revealed in the findings chapter and the finding of the pilot study by Jacobs (2019).

Queer theory and social justice advocate for the inclusion of marginal groups. The social justice approach utilizes four principles namely, equity, access, rights and participation as principles to guide the advocacy for marginal groups. While the GPF addresses equality amongst men and women, it does not recognise the other gender identities. If the GPF document was intended to be used as a guideline on gender issues, it provided no guidance on genderqueer matters. In a democratic country like South Africa, the document can be viewed as a tool that can be used to explain the lack of sensitivity on the genderqueer population. There are no guidelines in place that are explicitly inclusive of the genderqueer population and their needs which are different for heterosexual individuals. This exposes genderqueer individuals to inequality, lack of access to dignified healthcare, shuts them out from participating in important discussions and to having their rights infringed on. Queer theory magnifies the need to address this social injustice towards the genderqueer population.

On a local and international level, the concept of gender mainstreaming appears to need revisions that will be more inclusive of everyone regardless of whether they are binary or non-binary. The findings of this review show the important of theories such as queer theory in that they challenge people‟s ways of perceiving people and how those perceptions play out in practice. The theory is helpful in its ability to challenge

people‟s stagnant perceptions on gender, sexuality, and sex. Social justice theory advocates for people‟s rights.

Limitations and Recommendations for Future Research

Conducting this systematic review highlighted that there was an abundance of qualitative literature on genderqueer individuals in relation to SUD and how they experience healthcare. There was however very little to none research specific to healthcare workers, mental healthcare workers experiences of working with genderqueer individuals. There were no studies that told explicit experiences of healthcare workers in SUD treatment working with genderqueer individuals. The narratives on interactions with genderqueer individuals were raised when talking to genderqueer individuals. The studies focusing on genderqueer individuals made it clear that healthcare providers in general do need specialized training in working with genderqueer individuals and their needs. However, this investigation found this to be one-sided in that it did not hear the direct voice of the practitioners, indicating a need for more qualitative research specific to them and their experiences and their needs. A research study conducted using a systematic review is unable to tell the narratives of the healthcare and mental health providers because of its use of multiple already published works. Limited studies in academia result in limited work to cite in this systematic review.

Concluding Thoughts

This systematic review highlighted the gaps that exist in SUD treatment centres and in the healthcare system in relation to working with the genderqueer population. It is evident from the 25 qualitative studies selected to be part of this systematic review

that there needs to be specialized training specific to the health needs of genderqueer individuals.

Introduction of genderqueer education in all fields within health, challenging the heterosexual framework that exists within the healthcare system, cultural sensitivity, and more were all suggestions proposed by the studies to make healthcare services accessible to the genderqueer population. In a country like South Africa, a concept such as gender mainstreaming needs to be revisited with genderqueer in mind. The GPF revealed that queerness is a concept rarely engaged with in South Africa. The rarity was evident in the lack of mention of other gender identities other than cisgender individuals in the document that is intended to speak to the lack of equality amongst different gender expressions. Gender mainstreaming defined as a process that brings to the fore the challenges experienced by marginal groups and identities, is one process that has the power to challenge the biases and the turned blind eye seen in issues related to the genderqueer population. In the South African context, it would prove difficult to implement the suggested intervention as mentioned in Mpanza and Govender (2017) that there are no evaluations and monitoring procedures in relation to substance use and mental health services.

Word Count (*Abstract included*) **[20 340]**

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www.cdhn.org

APPENDIX 1 – PRISMA CHECKLIST

PRISMA 2009 Checklist

	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	X
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	X
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	X
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	X
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	X
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	X

Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	X
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	X
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	X
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	X
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	X

PRISMA 2009 Checklist

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	X

Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	X
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	X
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	X
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	X
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	X
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	X
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097.
doi:10.1371/journal.pmed1000097

For more information, visit: **www.prisma-statement.org**.

APPENDIX 2 – DATA EXTRACTION

Identification				Screening			Eligibility		Included		
Keyword search	Search Engine	Records identified through database searching	Additional Records identified through other sources	Records after duplicates removed	Records Screened	Records Excluded	Full text articles assessed for eligibility	Full text articles excluded with reasons	|Keyword search	Search Engine	Studies included in qualitative synthesis
Genderqueer and Healthcare	EBco-HOST	5	_	5	5	5	_	_	_	_	_
Genderqueer and Substance Use	EBco-HOST	1	_	1	1	1	_	_	_	_	_

Healthcare Professionals and Genderqueer	EBco-HOST	1	_	1	1	1	_	_	_	_	_
Clinicians' attitude towards queer individuals in SUD treatment centre	Google Scholar	27	5	32	32	17	15	4	Clinicians' attitude towards queer individuals in SUD treatment centre	Google Scholar	11
Genderqueer and Healthcare	Google Scholar	25	_	25	25	14	11	6	Genderqueer and Healthcare	Google Scholar	5
Genderqueer and Substance Use	Google Scholar	5	_	5	5	4	1	1	_	_	_

Healthcare Professionals and Genderqueer	Google Scholar	25	–	25	25	16	9	4	Healthcare Professionals and Genderqueer	Google Scholar	5
Genderqueer and Healthcare	MEDLINE	1	–	1	1	1	–	–	–	–	–
Genderqueer and Substance Use	MEDLINE	2	–	2	2	2	–	–	–	–	–
Healthcare Professionals and Genderqueer	MEDLINE	1	–	1	1	1	–	–	–	–	–
Genderqueer and Healthcare	PsycINFO	5	–	5	5	5	–	–	–	–	–

Genderqueer and Substance Use	PsycINFO	1	_	1	1	1	_	_	_	_	_
Healthcare Professionals and Genderqueer	PsycINFO	1	_	1	1	1	_	_	_	_	_
Genderqueer and/AND Healthcare	Web of Science	10	1	11	11	9	2	_	Genderqueer and/AND Healthcare	Web of Science	2
Genderqueer and/AND Substance Use	Web of Science	6	_	6	6	5	1	_	Genderqueer and/AND Substance Use	Web of Science	1
Healthcare Professionals and Genderqueer	Web of Science	2	_	2	2	2	_	_	_	_	_

APPENDIX 3 - ELIGIBILITY SPREADSHEET

EBco-HOST Database

1. **Genderqueer and Healthcare**

- None of the identified records were eligible for the eligibility screening phase

2. **Genderqueer and Substance Use**

- None of the identified records were eligible for the eligibility screening phase

3. **Healthcare Professionals and Genderqueer**

- None of the identified records were eligible for the eligibility screening phase

Google Scholar Database

1. Clinicians' attitude towards queer individuals in SUD treatment centre				
Title of the Article	**Author/s**	**Included**	**Excluded**	**Reason if excluded**
Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals	Harper, A., Finnerty, P., Martinez, M., Brace, A., et al	✓		
Clinical Considerations in Working with Clients in the Coming Out Process	Chazin, D. & Klugman, S.	✓		
Clinicia n competencies: Strengths and limitations for work with transgender and gender	Whitman, C.W., & Han, H	✓		

nonconforming (TGNC) clients				
Differences in Outcomes, Completion Rates, and Perceptions of Treatment Between White, Black, and Hispanic LGBT Clients in Substance Abuse Programs	Senreich, E.		✓	The article does not mention anything that can be used towards the training of professionals
Evaluating the Phobias, Attitudes, and Cultural Competence of Master of Social Work Students Toward the LGBT Populations	Logie, C., Bridge, T.J, & Bridge, P.D.	✓		
Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) Perceptions and Health Care Experiences	Gwendolyn P. Quinn, & K. Sutton, S.K.		✓	Focuses mainly on the experiences of the genderqueer community
LGBTQ Persons with Co-occurring	Penn, P.E. & Denali, B.M. et al.		✓	Focuses mainly on the

Conditions: Perspectives on Treatment				experiences of the genderqueer community
Moving Beyond CACREP Standards: Training Counselors to Work Competently with LGBT Clients	Troutman, O., & Packer-Williams, C.	✓		
Preparing social workers for practice with LGBT populations affected by substance use: perceptions from students, alumni, and service providers	Dentato, M.P., Kelly, B.L., Lloyd, M.R., & Busch, N.	✓		
Sexual and Gender Minority Health: What We Know and What Needs to Be Done	Mayer, K.H., Bradford, J. B., Makadon, H, J., Stall, R., et al.	✓		
Social and Health Service Use and Treatment Outcomes for Sexual	Hardesty, M., Cao, D., Shin, H., Andrews, C.M., & Marsh, J.	✓		

Minorities in a National Sample of Substance Abuse Treatment Programs				
Substance Use Disorder in the Context of LGBT Health: A Social Work Perspective	Silvestre, A., Beatty, R.L., & Friedman, M.R.		✓	Articles spoke only of the challenges, did not speak or suggest interventions
Substance Use Disorders (SUDs) in Transgender Communities: The Need for Trans-Competent SUD Counselors and Facilities	Oberheim, S.T., DePue, M, K., & Hagedorn, W.B.	✓		
The Effects of Honesty and Openness About Sexual Orientation on Gay and Bisexual Clients in Substance Abuse Programs	Senreich, E.	✓		
The Need for Specialized Programs	Mooney, E.E.	✓		

for LGBT Individuals in Substance Abuse Treatment				

TOTAL **11** **04**

2. **Genderqueer and Healthcare**				
	Author/s	**Included**	**Excluded**	**Reason if excluded**
Correlations between healthcare provider interactions and mental health among transgender and nonbinary adults	Kattari, S.K., Bakko, M., Hecht, H. K., & Kattari. L.	✓		
Health and identity-related interactions between	Baldwin, A., Dodge, B., Schick, V., Herbenick, D., Sanders, S.A., Dhoot,		✓	Article did not speak or suggest an intervention

lesbian, bisexual, queer and pansexual women and their healthcare providers	R. & Fortenberry, J.D.			
Healthcare Professionals Working with LGBTQ Patients	Mitchell, A., Somers, M., Bauder, A., & Lewis, D.	✓		
Intersecting Experiences of Healthcare Denials Among Transgender and Nonbinary Patients	Kattari, S.K., Bakko, M., Hecht, H.K. Kinney, M.K.		✓	The article did not speak or suggest an intervention
Is It Okay To Ask: Transgender Patient Perspectives on Sexual Orientation and Gender Identity Collection in Healthcare	Maragh-Bass, A.C., Torain, M., Adler, R., & Ranjit, A.	✓		

The Erasure of Sex and Gender Minorities in the Healthcare System	LeBreton, M.		✓	Case study that aimed more at bringing awareness on queer
Disclosing Sexual Orientation and Gender Identity in Healthcare Settings: Lessons for the Healthcare Providers and Policy Makers from LGBTQ Patients	Todic, J. & Brown, L.E.		✓	This was an extended abstract of a project that was in progress
Transgender and Genderqueer Individuals" Experiences with Health Care Providers: What"s Working, What"s Not, and Where Do We Go from Here?	Baldwin, A., Dodge, B., Schick, V. R., Light, B., & Schnarrs, P.W.	✓		

Exploring Patient Satisfaction among Transgender and NonBinary Identifed Healthcare Users: The Role of Microaggressions and Inclusive Healthcare Settings	Forbes-Roberts, S.	✓		
Standards of care: transgender/genderqueer clients' experiences with mental health workers	Swanson, H.G.		✓	The article was lengthy and would have been time consuming
Unanticipated: Healthcare Experiences Of Gender Nonbinary Patients And Suggestions For Inclusive	Mogul-Adlin, H.	✓		

Care				

TOTAL **09** **02**

3. **Genderqueer and Substance Use**				
Title of the Article	**Author/s**	**Included**	**Excluded**	**Reason if excluded**
Correlations between healthcare provider interactions and mental health among transgender and nonbinary adults.	Kattari, S.K., Bakko, M., Hecht, H. K., & Kattari. L.	✓		

TOTAL **01**

4. **Healthcare Professionals and Genderqueer**				
Title of the Article	**Author/s**	**Included**	**Excluded**	**Reason if excluded**
An Intake Template for Transgender, Transsexual, Genderqueer, Gender Nonconforming, and Gender Variant College Students Seeking Mental Health Services	Donatone, B., & Rachlin, R.	✓		
Beyond alphabet soup: Helping college health professionals understand sexual fluidity	Oswalt, S. B., Evans, S., & Drott, A.	✓		
Coping With Stress as an LGBTQ+ Health Care Professional	Eliason, M. J., Streed, C., & Henne, M.		✓	The focus of this study was on genderqueer

				healthcare professionals and their experiences working in healthcare
Genders and Individual Treatment Progress in (Non-)Binary Trans Individuals	AKoehler, A., Eyssel, J., & Nieder, T.O.		✓	The study focused on a more specific (medical) treatment of trans people -Gender affirming
Healthcare Professionals Working with LGBTQ Patients	Mitchell, A., Somers, M., Bauder, A., Lewis, D.		✓	Already chosen to be a part of the review
Knowledge, Beliefs, and Communication Behavior of Oncology Health-care Providers (HCPs)	Banerjee, S. C., Walters, C, B., Staley, J. M., Alexander, K., & Parker, P. A.	✓		

regarding Lesbian, Gay, Bisexual, and Transgender (LGBT) Patient Health care				
Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born With DSD	Eckstrand, K.L., Leibowitz, S., Potter, J. & Dreger, A.	✓		
The Ten Tasks of the Mental Health Provider: Recommendations for Revision of the World Professional Association for Transgender Health's Standards of Care	Lev, A.I.	✓		

Transgender and Genderqueer Individuals' Experiences with Health Care Providers: What's Working, What's Not, and Where Do We Go from Here?	Baldwin, A., Dodge, B., Schick, V. R., Light, B., & Schnarrs, P.W.		✓	Study already chosen to be a part of this review

TOTAL **05** **04**

MEDLINE Database

1. **Genderqueer and Healthcare**

- None of the identified records were eligible for the eligibility screening phase

2. **Genderqueer and Substance Use**

- None of the identified records were eligible for the eligibility screening phase

3. **Healthcare Professionals and Genderqueer**

- None of the identified records were eligible for the eligibility screening phase

PsycINFO Database

1. **Genderqueer and Healthcare**

- None of the identified records were eligible for the eligibility screening phase

2. **Genderqueer and Substance Use**

- None of the identified records were eligible for the eligibility screening phase

3. **Healthcare Professionals and Genderqueer**

- None of the identified records were eligible for the eligibility screening phase

Web of Science Database

1. Genderqueer and Healthcare				
Title of the Article	**Author/s**	**Included**	**Excluded**	**Reason if excluded**
“They treat us like we"re not there”: Queer bodies and the social production of healthcare spaces	Meer, T., & Muller, A.	✓		
Strategies for inclusion of lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) education throughout pharmacy school curricula	Llayton, C.K., & Caldas, L. M.	✓		

TOTAL **02**

2. Genderqueer and Substance Use

Title of the Article	**Author/s**	**Included**	**Excluded**	**Reason if excluded**
Assessment of Internal Medicine Resident Preparedness to Care for Lesbian, Gay, Bisexual, Transgender, and Queer/ Questioning Patients	Streed, C. G., Fedian, H. F., Bertram, A., & Sisson, S.D.	✓		

TOTAL **01**

3. Healthcare Professionals and Genderqueer

- None of the identified records were eligible for the eligibility screening phase

APPENDIX 4 – FINDINGS

Author	Title	Reference	Population	Phenomenon of Interest	Context
Baldwin, A., Dodge, B., Schick, V. R., Light, B., & Schnarrs, P.W.	Transgender and Genderqueer Individuals' Experiences with Health Care Providers: What's Working, What's Not, and Where Do We Go from Here?	Baldwin, A., Dodge, B., Schick, V. R., Light, B., & Schnarrs, P.W. (2018). Transgender and Genderqueer Individuals' Experiences with Health Care Providers: What's Working, What's Not, and Where Do We Go from Here?. *Journal of Health Care for the Poor and Underserved*, 29(4), 1300-1318, https:/doi.org/10.1353/hpu.2018.0097.	Healthcare providers.	I. Trans 101 when it comes to working with transgender individuals, and II. Inclusive Care.	Healthcare facilities
Banerjee, S. C., Walters, C, B., Staley, J. M., Alexander, K., & Parker, P. A.	Knowledge, Beliefs, and Communication Behavior of Oncology Health-care Providers (HCPs) regarding Lesbian, Gay, Bisexual, and Transgender (LGBT) Patient Health care.	Banerjee, S. C., Walters, C, B., Staley, J. M., Alexander, K., & Parker, P. A. (2018). Knowledge, Beliefs, and Communication Behavior of Oncology Healthcare Providers (HCPs) regarding Lesbian, Gay, Bisexual, and Transgender (LGBT) Patient Health care. *Journal of Health Communication*, 23(4_, 329-339, https://doi: 10.1080/10810730.2018.1443527.	Healthcare providers.	Knowledge, Beliefs, and Communication Behaviour of healthcare workers.	Healthcare facilities

Chazin, D. & Klugman, S.	Clinical Considerations in Working with Clients in the Coming Out Process.	Chazin, D. & Klugman, S. (2014). Clinical Considerations in Working with Clients in the Coming Out Process. Pragmatic Case Studies in Psychotherapy, 10(2), 132-146.	Counselors/ Psychotherapists.	I. Cultivating an affirmative stance, II. Addressing institutional and systematic issues, III. Understanding identity formation trajectories, IV, Examining intersecting identities, V. Identifying and clarifying dimensions of sexual identity and orientation, VII. Helping clients reconcile sexuality with religious backgrounds and precepts, VIII. Confronting internalized homophobia, IX. Handling disclosures,	Clinical setting

				and X. Connecting clients to communities and resources.	
Dentato, M.P., Kelly, B.L., Lloyd, M.R., & Busch, N.	Preparing social workers for practice with LGBT populations affected by substance use: perceptions from students, alumni, and service providers.	Dentato, M.P., Kelly, B.L., Lloyd, M.R., & Busch, N. (2018). Preparing social workers for practice with LGBT populations affected by substance use: perceptions from students, alumni, and service providers, *Social Work Education,* 37(3), 294-314, https://doi:10.1080/02615479.2017.1406467.	Substance abuse service providers and graduate social work students.	(Screening Brief Intervention and Referral to Treatment) SBIRT model.	School of Social Work
Donatone, B.. & Rachlin, R.	An Intake Template for Transgender, Transsexual, Genderqueer, Gender Nonconforming, and Gender Variant College Students Seeking Mental Health Services.	Donatone, B., & Rachlin, K. (2013). An Intake Template for Transgender, Transsexual, Genderqueer, Gender Nonconforming, and Gender Variant College Students Seeking Mental Health Services. *Journal of College Student Psychotherapy*, 27(3), 200-211, https://doi:10.1080/87568225.2013.798221.	Clinicians.	An intake template that can be used during an initial assessment.	College Counseling Centre

Eckstrand, K.L., Leibowitz, S., Potter, J. & Dreger, A.	Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born With DSD.	Eckstrand, K.L., Leibowitz, S., Potter, J. & Dreger, A. (2014). Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born With DSD (Chapter 3. Association of American Medical Colleges: Washington.	Healthcare providers	Eight Competency Domains.	Healthcare facilities
Forbes-Roberts, S.	Exploring Patient Satisfaction among Transgender and NonBinary Identified Healthcare Users: The Role of Microaggressions and Inclusive Healthcare Settings.	Forbes-Roberts, S. (2018). Exploring Patient Satisfaction among Transgender and NonBinary Identified Healthcare Users: The Role of Microaggressions and Inclusive Healthcare Settings. *Research paper*.	Healthcare providers	Inclusive Healthcare Settings.	Healthcare facilities
Hardesty, M., Cao, D., Shin, H., Andrews, C.M., & Marsh, J.	Social and Health Service Use and Treatment Outcomes for Sexual Minorities in a National Sample of Substance Abuse	Hardesty, M., Cao, D., Shin, H., Andrews, C.M., & Marsh, J. (2012). Social and Health Service Use and Treatment Outcomes for Sexual Minorities in a National Sample of Substance Abuse Treatment Programs. *Journal of Gay & Lesbian Social Services,* 24(2), 97-118, https://doi:	SUD treatment providers.	National Treatment Improvement Evaluation Study (NTIES).	SUD Treatment Programs

	Treatment Programs.	10.1080/10538720.2012.669669.			
Harper, A., Finnerty, P., Martinez, M., Brace, A., et al	Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals.	Harper, A., Finnerty, P., Martinez, M., Brace, A., et al. (2012). Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals. *Journal of LGBT Issues in Counseling,* 7(1), 2-43, https://doi: 10.1080/15538605.2013.755444.	Counselors, their trainers and supervisors.	I. Competencies for working with Lesbian, Gay, Bisexual, Queer, and Questioning Individuals III. Competencies for Working with Allies IV. Competencies for Working with Intersex Individuals.	Healthcare facilities
Kattari, S.K., Bakko, M., Hecht, H. K., & Kattari. L.	Correlations between healthcare provider interactions and mental health among transgender and nonbinary adults.	Kattari, S.K., Bakko, M., Hecht, H. K., & Kattari. L. (2020). Correlations between healthcare provider interactions and mental health among transgender and nonbinary adults. *SSM - Population Health*, https://doi.org/10.1016/j.ssmph.2019.100525.	Healthcare providers.	Improved Healthcare provider interactions/Affirming care.	Healthcare facilities

Lev, A.I.	The Ten Tasks of the Mental Health Provider: Recommendations for Revision of the World Professional Association for Transgender Health's Standards of Care.	Lev, A.I. (2009). The Ten Tasks of the Mental Health Provider: Recommendations for Revision of the World Professional Association for Transgender Health's Standardsof Care. *International Journal of Transgenderism,* 11(2), 74-99, https://doi:10.1080/15532730903008032.	Mental HealthCare Providers.	Standards of Care (SOC).	Mental Health Facility
Llayton, C.K., & Caldas, L. M.	Strategies for inclusion of lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) education throughout pharmacy school curricula.	Llayton, C.K., & Caldas, L. M. (2020). Strategies for inclusion of lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) education throughout pharmacy school curricula. *Pharmacy Practice*, 18(1), 1862, https://doi.org/10.18549/PharmPract.2020.1.1862.	Pharmacy students and graduates..	Five main strategies can be adopted to include LGBTQIA+ content in the curriculum: 1) integration into interprofessional courses, 2) didactic courses, 3) skillsbased laboratory courses, 4) elective courses, or 5) a combination of these	Healthcare facilities

				strategies for integration into multiple courses throughout the curriculum.	
Logie, C., Bridge, T.J, & Bridge, P.D.	Evaluating the Phobias, Attitudes, and Cultural Competence of Master of Social Work Students Toward the LGBT Populations.	Logie, C., Bridge, T.J, & Bridge, P.D. (2007). Evaluating the Phobias, Attitudes, and Cultural Competence of Master of Social Work Students Toward the LGBT Populations. *Journal of Homosexuality*, 53:4, 201-221, https://doi: 10.1080/00918360802103472.	Master of Social Work (MSW) students.	The LGBT Assessment Scale Survey Items.	Social Work Master's Programme
Maragh-Bass, A.C., Torain, M., Adler, R., & Ranjit, A.	Is It Okay To Ask: Transgender Patient Perspectives on Sexual Orientation and Gender Identity Collection in Healthcare.	Maragh-Bass, A.C., Torain, M., Adler, R., & Ranjit, A. (2017). Is It Okay To Ask: Transgender Patient Perspectives on Sexual Orientation and Gender Identity Collection in Healthcare. *Academic Emergency Medicine*, 24(6), 655-667, https://doi: 10.1111/acem.13182.	Healthcare providers.	Collection of Sexual Orientation (SO) and Gender Identity (GI).	Primary Care and Emergency Department setting
Mayer, K.H., Bradford, J.	Sexual and Gender Minority Health: What We Know and	Mayer, K.H., Bradford, J. B., Makadon, H, J., Stall, R., et al. (2008). Sexual and Gender Minority Health: What We	Service providers.	Training that is targeted at providers and other	Public and Clinical

B., Makadon, H, J., Stall, R., et al.	What Needs to Be Done.	Know and What Needs to Be Done. Framing Health Matters, 98(6), 989-995, https://doi:10.2105/AJPH.2007.127811.		staff to speak with patients and clients in a non-judgmental, gender-appropriate, and professional way.	health
Meer, T., & Muller, A.	"They treat us like we're not there": Queer bodies and the social production of healthcare spaces.	Meer, T., & Muller, A. (2017). "They treat us like we're not there": Queer bodies and the social production of healthcare spaces. *Health & Place,* 45, 92-98, https://dx.doi.org/10.1016/j,healthplace.2017.03.010.	Healthcare providers.	An inclusive space.	South African Healthcare facilities
Mitchell, A., Somers, M., Bauder, A., & Lewis, D.	Healthcare Professionals Working with LGBTQ Patients.	Mitchell, A., Somers, M., Bauder, A., & Lewis, D. (2018). Healthcare Professionals Working with LGBTQ Patients. *Journal of Advances in Medicine and Medical Research, 25(12): 1-5, https://doi: 10.9734/JAMMR/2018/40721.*	Healthcare providers.	I. Keeping up with the vocabulary used within the genderqueer population, II, Gather a complete client history, and III, Gaining competencies through education and training.	Professional Training

Mogul-Adlin, H.	Unanticipated: Healthcare Experiences Of Gender Nonbinary Patients And Suggestions For Inclusive Care.	Mogul-Adlin, H. (2015). "Unanticipated: Healthcare Experiences Of Gender Nonbinary Patients And Suggestions For Inclusive Care". *Public Health Theses*. 1197. htp://elischolar.library.yale.edu/ysphtdl/1197.	Healthcare providers.	Inclusive care	Healthcare facilities
Mooney, E. E.	The Need for Specialized Programs for LGBT Individuals in Substance Abuse Treatment.	Mooney, E. E. (2011). "The Need for Specialized Programs for LGBT Individuals in Substance Abuse Treatment". *Research Papers*. Paper 182.	SUD treatment providers.	I. Cultural Competence and Treatment, and II, LGBT-Specific Treatment Programs.	SUD Treatment Programs
Oberheim, S.T., DePue, M, K., & Hagedorn, W.B.	Substance Use Disorders (SUDs) in Transgender Communities: The Need for Trans-Competent SUD Counselors and Facilities.	Oberheim, S.T., DePue, M, K., & Hagedorn, W.B. (2017). Substance Use Disorders (SUDs) in Transgender Communities: The Need for Trans-Competent SUD Counselors and Facilities. *Journal of Addictions & Offender Counseling,* 38, https://doi: 10.1002/jaoc.12027.	SUD Counselors.	Accommodation allocated to transgender individuals and Trans-Competent SUD Counselors.	SUD Counseling
Oswalt, S. B., Evans, S., & Drott, A.	Beyond alphabet soup: Helping college health professionals understand sexual fluidity.	Oswalt, S. B., Evans, S., & Drott, A. (2016). Beyond alphabet soup: helping college health professionals understand sexual fluidity, *Journal of American College Health*, 64(6), 502-508, https://doi: 10.1080/07448481.2016.1170688.	College healthcare providers.	Strategies that can be incorporated.	College setting

Senreich, E.	The Effects of Honesty and Openness About Sexual Orientation on Gay and Bisexual Clients in Substance Abuse Programs.	Senreich, E. (2010) The Effects of Honesty and Openness About Sexual Orientation on Gay and Bisexual Clients in Substance Abuse Programs. *Journal of Homosexuality,* 57:3, 364-383, https://doi: 10.1080/00918360903542990.	SUD Counselors.	Creating a space where genderqueer clients can be open and honest about their sexuality.	Substance use programs
Streed, C. G., Fedian, H. F., Bertram, A., & Sisson, S.D.	Assessment of Internal Medicine Resident Preparedness to Care for Lesbian, Gay, Bisexual, Transgender, and Queer/ Questioning Patients.	Streed, C, G., Fedian, H. F., Bertram, A., Sisson, S.D. (2019). Assessment of Internal Medicine Resident Preparedness to Care for Lesbian, Gay, Bisexual, Transgender, and Queer/ Questioning Patients. *Society of General Internal Medicine,* 34(6), 393-8, https://doi: 10.1007/s11606-019-04855-5.	PGY1-3 residents at 120 internal medicine residency programs.	A 1-h online module addressing sexual and gender minority (SGM) health. The test evaluated each resident in four categories: (1) relevant terminology, (2) health disparities and preventive care issues, (3) unique substance use and mental health, and (4) common sexually transmitted illnesses.	Internal Medicine Residency programme

Troutman, O., & Packer-Williams, C.	Moving Beyond CACREP Standards: Training Counselors to Work Competently with LGBT Clients.	Troutman, O., & Packer-Williams, C. (2014). Moving Beyond CACREP Standards: Training Counselors to Work Competently with LGBT Clients. *The Journal of Counselor Preparation and Supervision,* 6(1), https://dx.doi.org/10.7729/61.1088.	Training Counsellors.	CACREP Standards of training Counsellors.	Counseling Training (Counselor Education)
Whitman, C.W., & Han, H	Clinician competencies: Strengths and limitations for work with transgender and gender nonconforming (TGNC) clients.	Whitman, C.W., & Han, H. (2016). Clinician competencies: Strengths and limitations for work with transgender and gender nonconforming (TGNC) clients. *International Journal of Transgenderism,* 18(2), 154-171, https://doi: 10.1080/15532739.2016.1249818.	Psychiatrists, psychiatry residents, clinical and counselling psychologists (PhD, PsyD), current doctoral students (in clinical or counselling psychology programs) providing therapy	I. Gender Identity Counselor Competency Scale (GICCS), II. TGNC Knowledge Assessment (KA), and IV, Social Desirability Questionnaire (SDQ).	Mental Health Facilities

			under supervision, licensed counselors (LPS, LMHC), and licensed clinical social workers.		