

Double Stigma: the needs and experiences of lesbian, gay & bisexual people with mental health issues living in Wales



O blaid gwell
iechyd meddwl
For better
mental health



Swansea University
Prifysgol Abertawe

A report for Stonewall Cymru and Mental Health Organisation Partners
Mind Cymru, Hafal and Journeys.

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Glossary of acronyms and abbreviations

| | |
|--------|--|
| BME | Black and minority ethnic |
| CAMHS | Child and Adolescent Mental Health Services |
| CBT | Cognitive Behavioural Therapy |
| CMHT | Community Mental Health Team |
| CPN | Community Psychiatric Nurse |
| CPS | Crown Prosecution Service |
| DoH | Department of Health |
| ECHR | Equality and Human Rights Commission |
| GIRES | Gender Identity Research and Education Society |
| HIW | Healthcare Inspectorate Wales |
| LGB | Lesbian, Gay, Bisexual |
| LGBT | Lesbian, Gay, Bisexual, Trans |
| NAW | National Assembly for Wales |
| NSF | National Services Framework |
| NSPCC | National Society for the Prevention of Cruelty to Children |
| ONS | Office for National Statistics |
| SEU | Social Exclusion Unit |
| SOGIAG | Sexual Orientation and Gender Advisory Group |
| RCN | Royal College of Nursing |
| RCP | Royal College of Psychiatrists |
| THT | Terrence Higgins Trust |
| WAG | Welsh Assembly Government |
| WAO | Wales Audit Office |

Part One: Background

Introduction

Stonewall Cymru was founded in 2003 with the aim of achieving legal equality and social justice for lesbian, gay and bisexual (LGB) people in Wales. It is an all Wales organisation that works individually and in partnership with agencies, organisations, statutory bodies and individuals inside and outside the LGB sector to:

- Promote the human rights and equal treatment of LGB people;
- Challenge discrimination against LGB people;
- Articulate the needs and interests of LGB people and represent these to the Welsh Assembly Government (WAG) and other appropriate bodies;
- Consolidate and develop the infrastructure with LGB communities across Wales to enable them to contribute to and have representation in policy developments.

Stonewall Cymru are currently working on six strategic areas, these consist of:

- Community engagement and participation
- Education
- Employment
- Fair Life chances
- Changing attitudes
- Community Safety

Stonewall Cymru currently employs 8 staff based in Cardiff and North Wales. More information may be found at:

Website: <http://www.stonewallcymru.org.uk/cymru/>

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Contact our Cardiff Office: Transport House, 1 Cathedral Road, Cardiff, CF11 9SB.

Or our North Wales Office: The Equality Centre, Bangor Road, Penmaenmawr, Conwy, LL34 6LF.

The purpose of the scoping exercise

Stonewall Cymru in partnership with Hafal, Mind Cymru and Journeys identified a need for an exploratory Wales- specific study to explore the needs and experiences of lesbian, gay and bisexual people who have experienced or have mental health issues. Funding was obtained from the Equalities and Human Rights Commission and researchers from Swansea University were commissioned to enable this preliminary piece of work. Stonewall Cymru and its partner mental health organisations anticipate this exploratory study will help shape policy and best practice. More specifically the objectives of the study are:

Objectives:

- To research the experiences and needs of LGB people with mental health issues living in Wales;
- To identify the key issues, concerns and aspirations of LGB people with mental health issues;
- Based on the findings, to provide recommendations to policy makers, organisations and practitioners around inclusion and good practice with LGB people with mental health issues.

Context

Definitions:

LGB people

Categorising people according to their sexual identity is an important consideration in research of this nature and there are a number of issues that may arise in terms of defining the parameters of sexual orientation. For example, defining sexual orientation on the basis of sexual experience fails to include people who may feel an attraction towards someone of the same sex but have not engaged in same sex activity. Furthermore, categorising people into distinct orientations of LGB risks compartmentalising sexuality and people who may deem their orientation to be fluid and multifaceted. Nevertheless, for the purpose of this study we needed an element of delineation in order to explore if there were particular issues facing lesbian, bisexual and gay men and women. A widely established definition of an LGB person is “one with an

orientation towards people of the same gender in sexual behaviour, affection, or attraction, and/ or self identity as gay/ lesbian/ or bisexual” (King and McKeown 2003:5).

Gender

This study targets people who self identify as LGB and is inclusive of individuals regardless of self-defined gender. We recognise there are some specific issues for people who identify as transgender and transsexual and have included these where appropriate in the review of research and the findings. We use the term ‘trans’ to include individuals who identify as transsexual or transgender, and the abbreviation LGBT to include trans people where appropriate in the text.

Mental health

Terminology and language around mental health is paramount if we are to avoid reinforcing stigma and stereotypes. However there is no agreed and shared language. In part, this reflects the differences of conceptual approach, models of care, intervention and practice that have been adopted over the years by different agencies and the professions within them. In this report we have used the term ‘mental health issue’ after consultation with the project reference group and mental health partner organisations. LGB individuals who self identify as having had or having mental health issues (including what Mind Cymru term mental distress) and regardless of the duration, or whether they sought help, or have been diagnosed with a long-term mental health condition such as anxiety, depression, schizophrenia, mania etc were invited to engage in the study.

Mental health issues in the general population of the UK and amongst LGB people

The prevalence of mental health issues in the general population is complex to evaluate, though several have done so (Singleton *et al.*2001¹; Goldberg and Goodyer 2005). The precise figures are contested due to definitional and methodological variation amongst such studies and Goldberg and Goodyer

¹ On behalf of the Office for National Statistics (ONS).

(2005) and Hatloy (2008)² provide a good discussion of this. Nevertheless with this in mind, a commonly held contention is that in the general population, one in four adults will “be affected by a mental disorder at some stage in their life” (World Health Organization 2001: 8). For LGB people, a substantial body of (predominantly USA based) population research suggests a greater prevalence of mental health issues (or psychiatric morbidity as it is commonly referred to). This is particularly noted in relation to anxiety, depression, and suicidal behaviour, and in relation to substance use, amongst LGB people compared to heterosexual people (King and McKeown 2003:552; Cochran *et al.* 2003). Whilst recent UK equality legislation³ and research alludes to more positive public acceptance of LGB people, the evidence also suggests a longevity of LGB marginalisation and discrimination that will take time to change at the personal, cultural and society level (for example, Robinson and Williams 2003, Williams and Robinson 2007⁴; Cowan 2007⁵; Hunt and Valentine 2008). Hence, whilst not necessarily always the case, the prevalence of mental health issues amongst the LGB population has generally been attributed to the adverse effects of societal discrimination, victimisation and intolerance of sexual orientation (Mays and Cochran 2001). Within the literature this is often referred to as ‘gay related stress’⁶(Rosario *et al.* 2002) or ‘minority stress’ (Meyer 1995; Mayock *et al.* 2009).

The evidence base, albeit blighted by definitional, methodological and outcome variations, paints a bleak picture of the susceptibility to mental health issues and substance use for LGB people⁷. An examination of the UK based literature suggests a small body of research on LGB people and mental health

² On behalf of mental health organisation Mind.

³ For example the Civil Partnership Act (2004), The Equality Act (Sexual Orientation) Regulations 2007.

⁴ Refer to Robinson and Williams 2003, Williams and Robinson 2007 for a Wales specific perspective.

⁵ Undertaken on behalf of Stonewall Cymru.

⁶ “Gay-related stress refers to the stigmatization of being, or being perceived to be, GLB (*sic*) in a society in which homosexuality is negatively sanctioned. Gay-related stress is multidimensional. i.e. it may arise through the experience of violence, verbal abuse, rejection, and other stressful life events perpetrated by other individuals against persons who are, or are perceived to be, GLB; or it may be internalised homophobia or discomfort around one’s sexual orientation” (Rosario *et al.* 2002: 967).

⁷ See for example, The National Institute for Mental Health in England (NIMHE)(2007), and King *et al.*(2008) for a systematic review of the literature, an overview of some of the key challenges to research with LGB populations particularly in relation to mental health and wellbeing, and an overview of key mental health outcomes of LGB people.

has emerged in recent years and is consistent with findings from the larger international pool of empirical work. For instance, reported as being the largest study of its type in Europe, King and McKeown (2003) undertook a controlled, cross sectional study⁸ of 656 gay men, 505 heterosexual men, 430 lesbians, 588 heterosexual women, 85 bisexual men and 113 bisexual women across England and Wales. The study aimed to compare the mental health, quality of life and experience of mental health services amongst LGB people and their heterosexual counterparts. King and McKeown (2003) found that lesbians and gay men reported more psychological distress than heterosexual women and men, despite similar levels of social support and quality of physical health. Bisexual men reported more psychological distress than gay men. King and McKeown (*ibid*) also suggest that lesbians and gay men were more likely to deliberately self-harm themselves and to use recreational drugs, though bisexual men were reported to be more likely than gay men to have recently used recreational drugs and lesbians were more likely to drink excessively than heterosexual women.

Meanwhile Hunt and Fish (2008) in their health survey of 6178 lesbian and bisexual women across England, Wales and Scotland⁹ found elevated levels of eating disorders, deliberate self harm and suicide attempts amongst lesbian and bisexual women compared to the general population. Browne and Lim's (2008a) mixed method study¹⁰ with a sample of 819 LGBT respondents provides further analysis of the nuances of mental wellbeing amongst different sexual, gender and other marginalised identities. For example, they found "bisexual, queer and those who identified as 'other' in terms of sexualities, trans people, BME [Black and minority ethnic] people, those with a low income, and those who feel isolated more likely than other LGBT people to report having experienced difficulties with their mental health in the past five

⁸ "A cross sectional study entails the collection of data on one or more cases and at a single point in time in order to collect a body of quantifiable data in connection with two or more variables, which are then examined to detect patterns of association" (Bryman 2004: 358).

⁹ Commissioned by Stonewall, Hunt and Fish surveyed 6178 women; 81% identified as lesbian and 16% as bisexual. The remainder did not specify. 85% of respondents lived in England, 9% in Scotland and 5% in Wales. Although not a control study, comparisons were made to the general population.

¹⁰ A mixed method study uses different methods of obtaining data, usually entailing quantitative and qualitative methods. In this study the researchers used a quantitative survey and qualitative focus groups.

years and trans people were significantly more likely than non-trans respondents to say they have had difficulties in the last five years with significant emotional distress, depression, anxiety, isolation, anger management, insomnia, fears/phobias, panic attacks, addictions/dependencies, and suicidal thoughts” (Browne and Lim 2008a: 8).

It is important to note that LGB people are heterogeneous, and that ‘minority stress’ and the aforementioned associated outcomes are not inevitable. LGB individuals have a diversity of social identities, experiences, subjectivities and, if facing adversity, a range of responses. Anderson (1998) in studying young LGB people’s resilient responses argues that the literature base is overly problem focused and neglects a more holistic and ecological approach to exploring adversity, risk and bolstering resources that young people may draw upon. There is a dearth of literature of this kind in the UK, though Scourfield *et al.* (2008) touch upon resilience in their qualitative study of young LGBT people’s experiences of distress. They found whilst self destructive behaviours were one strategy for responding to homophobia; there was also evidence of young people’s ambivalent and resilient responses. For example, ambivalence was demonstrated by young people in the study who articulated understandings of being ‘out and proud’ whilst simultaneously despising some aspects of gay culture and others derived strength from their endeavours to resist discrimination and / or actively sought ‘safe places and safe people’ (Scourfield *et al.* 2008: 332).

Our study, whilst recognising the heterogeneity of individual LGB people’s lives, focuses on LGB people who self identify as having had experience of, or who are currently experiencing mental health issues irrespective of the causal factors or extent of their psychological distress or condition. This study aims to explore the experiences, needs and aspirations of LGB people with mental health issues living in Wales.

LGB people with mental health issues: double stigma

People with mental health issues may experience discrimination and stigmatisation and several studies bear testament to this (see for example, Glendinning *et al.* 2002; Highland Users Group 2003; Department of Health (DoH) 2009a). According to the Social Exclusion Unit (SEU) (2004) stigma and discrimination are one of the main reasons why mental health issues too often lead to and reinforce social exclusion, stating:

“The prejudice and lack of understanding make it difficult for people to work, access health services, participate in their communities, and enjoy family life” (SEU 2004:24).

Furthermore, Fish (2008: online) points out that “health and social inequalities are rooted in relationships that are defined by race, class, age, disability, religion, gender and gender identity and single social categories, fail to encapsulate the range of experiences and social locations”. For LGB people, discrimination may be compounded because LGB people must confront the double stigma and prejudice based on their sexual orientation while also dealing with societal bias against mental health issues and distress. Those LGB individuals with other marginalised identities such as disability, people from BME backgrounds, trans people, older people etc. may experience multiple prejudice and stigma. Several UK based research reports provide evidence of discrimination stemming from mainstream society and from within the ‘LGB community’ and scene; from access to mainstream services such as mental health, disability organisations, healthcare and from LGBT specific services. For examples of these discussions, refer to The Equality Network and Disability Rights Commission (2006) on LGBT disabled people and community groups; Browne and Lim (2008b) on the experiences and needs of bisexual people; Whittle *et al.*(2007), and Browne and Lim (2008c) on trans people; and Fish (2007) on LGB people from BME backgrounds. (There is a plethora of literature that also suggests that people of BME backgrounds endure discrimination within access to and mis-diagnosis of mental illness¹¹).

¹¹ Refer to Hatloy (2006) for an overview and discussion of this literature.

Best practice¹²

Several authors have highlighted LGB (and in some cases T) people's experiences of discrimination when accessing mental health and other healthcare services (see for example, King and McKeown 2003; Cook *et al.* 2007; Hunt and Fish 2008). These studies, based on their findings, provide recommendations and a number of other authors and organisations provide guidelines for practitioners around good practice. For example, the Royal College of Nursing (RCN) and UNISON (2004), Barton (2005)¹³, and DoH (2009b) on best practice with LGB people who access mental health and health care services; Cree and O'Corra (2006)¹⁴ provide core training standards around LGB inclusive practice in healthcare; and Julie Fish on behalf of the DoH's Sexual Orientation and Gender Identity Equality Advisory Group (SOGIAG) provides a series of multiple strand briefings around best practice in health and social care with LGBT people from a diversity of backgrounds and multiple identities¹⁵. Finally, WAG (2008a) published a code of practice for mental health practitioners in Wales working within the parameters of the Mental Health Act (1983). The codes mainstream sexual orientation and gender identity as part of the wider discussion on equality and diversity.

The context of mental health provision in the UK

It should be noted that some of the dissatisfaction expressed by LGB people in access to mental health services can be attributed to the overall policy context and provision afforded mental health care in the UK. With devolution, mental health services and strategy differ across the four regions of the UK at inequitable pace (Royal College of Psychiatrists (RCP)(2006)). This is evidenced for example with Child and Adolescent Mental Health Services

¹² This section details best practice primarily with LGB people. Best practice with trans people is incorporated within these studies/ guidance to varying extents. For good practice literature specific to trans people refer to Whittle *et al.* (2007); DoH (2008); Gender Identity Research and Education Society (GIREs) (2008).

¹³ Commissioned by Stonewall Scotland and NHS Scotland and includes best practice with trans people.

¹⁴ Commissioned by the Department of Health and SOGIAG.

¹⁵ At the time of writing (2009) there are 13 briefings. These can be obtained via the following link: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078347

(CAMHS) wherein the RCP (2006) note particular issues in Wales include a lower number of adolescent inpatient beds per head of population compared to the rest of the UK. That said, since the establishment of devolved governance in Wales in 1999, a range of policy and strategy documents have outlined and set targets for the provision of mental health services in Wales. The following sections provide a brief overview of these in order to provide a background context for the current study.

Child and Adolescent Mental Health Services (CAMHS)¹⁶ in Wales

“Everybody’s Business” is a ten year strategy for CAMHS that was launched in 2001 (NAW 2001a). Signalled as the Assembly’s commitment to the United Nations Convention on the Rights of the Child (1989) and underpinned by the legislative framework of the Children Act (1989), the strategy aimed at establishing comprehensive, effective and high quality services across Wales and was underpinned by several key principles of service delivery. These were that services should be child centred, respectful and protecting, lawful, equitable and responsive, comprehensive and appropriate, integrated, competent and accountable, effective, efficient and targeted. Subsequently the Carlile report (2002) provided numerous recommendations for CAMHS, and the National Service Framework for Children, Young People and Maternity Services in Wales (Children’s NSF) followed in 2005 (see WAG 2005a). The Children’s NSF is a ten-year programme setting out eleven standards for health and social care that authorities must achieve by 2014. Chapter four of the NSF deals with mental health and prescribes twenty key actions.

A range of evidence illustrates the development of best practice and CAMHS provision in Wales. However, enduring concerns remain for inequitable and inconsistent service delivery across Wales and the impact on children and

¹⁶ “CAMHS is a term used to refer to all services that involve or affect the mental health of children and young people. However whilst some services that fall under the CAMHS umbrella are specialist in nature others do not specifically provide mental health services, nor are they aimed specifically at children and young people. Services include specialist inpatient and community services, social services, GP, voluntary and educational support services”, (Healthcare Inspectorate Wales (HIW) 2009: online).

young people's mental, emotional and physical wellbeing and rights (see Standing 2006; the RCP 2006; Webb 2006; the Office of the Children's Commissioner for Wales (2007); and NSPCC Wales 2007). In response to such concerns the Healthcare Inspectorate of Wales (HIW) and the Wales Audit Office (WAO) announced a joint review of CAMHS provision, the review is ongoing at the time of writing (July 2009) but it is anticipated that the findings and recommendations will point the way forward for the future of CAMHS strategy and service delivery.

Mental Health Policy and Provision for Adults of Working Age and Older Adults in Wales

In tandem with devolved government's strategic endeavours for mental health services for children and young people; mental health services for adults have evolved in similar fashion. In September 2001, and as reinforced in the National Assembly for Wales' (NAW) 'NHS Plan' (NAW 2001b: 26), the NAW (2001c) launched a strategy for mental health services for adults of working age. This set out aspirations for a modern, community focussed mental health service based on the principles of equity, empowerment, effectiveness and efficiency. The new strategy was seen as "highly significant given the Cinderella status from which mental health has suffered over many years" (Edwina Hart A.M. cited in NAW 2001c:1).

Subsequently the National Services Framework (NSF) for Adult Mental Health Services was devised as an implementation tool in order to set standards to improve quality, ensure equity of provision and produce a system of monitoring (see WAG 2002). In 2005 the NSF was reviewed by the WAO, and a revised NSF and Action Plan launched (see WAG 2005b), to meet structural changes in the commissioning, performance management, inspectorate arrangements and monitoring of services, and to reinforce WAG's strategic vision for public spending on services and health and social care¹⁷.

¹⁷ See strategy documents "Making the Connections" (WAG 2004) and "Designed for Life" (WAG 2005c) respectively.

In relation to mental health provision for older people, although “older people with mental health issues should receive services in line with the NSF for Adult Mental Health Services” (WAG 2006a:13); older people’s mental health and access to appropriate services was specifically and initially addressed within the Strategy for Older People in Wales (WAG 2003: 23) wherein it was seen as essential that a National Services Framework for Older People in Wales would have a priority around mental health provision and promotion. Subsequently in 2006, the NSF for older people included a standard that prescribed that:

“Older people who have a high risk of developing mental health needs have access to primary prevention and integrated services to ensure timely and appropriate assessment, diagnosis, treatment and support for them and their carers “ (WAG 2006a: 129).

In 2008, the older people strategy entered its second phase, wherein WAG reviewed the progress of the strategy and NSF and set out the strategic agenda for the period 2008 to 2013; mental health remains as a priority within this (see WAG 2008b).

All strategies relating to mental health provision for people in Wales are interlinked with legislation and other policy initiatives. For example “Making the Connections” (WAG 2004) is the government’s policy for public service reform, and “Fulfilled Lives, Supportive Communities” (WAG 2007a), sets out WAG’s intentions for the future of social care in Wales and identifies¹⁸ that social services play an important part in the provision of services and support for people experiencing mental health issues.

In 2007, with the coalition government’s joint manifesto, the provision of mental health services was given renewed priority (See WAG 2007b:10). Recent reviews of the mental health strategy and service provision (for example, the Burrows Greenwell Review 2007; Williams 2008) provide evidence of some good practices but equally illustrate the longevity and

¹⁸ Albeit briefly according to a range of respondents to the “Fulfilled Lives” consultation exercise (see WAG 2006b).

complexity of implementation of the mental health strategy across Wales and across policy strands.

Mental Health Provision: the future direction

As noted above, mental health services across Wales are undergoing a period of review and this coincides with (a) new proposed Legislative Competency Orders on mental health services¹⁹ and carers²⁰ and (b) a period of transition and restructuring of the NHS in Wales wherein seven integrated organisations are being established to replace the 22 Local Health Boards and 14 health Trusts of Wales. The new structure is expected to be operational by October 2009 (WAG 2008c) and WAG provide assurances that mental health services will be facilitated within these. In a written ministerial statement on the future of mental health services in Wales, Edwina Hart the Health and Social Services Minister declared:

“I have decided that mental health services will become a fundamental part of the new integrated local NHS bodies. However I am determined that the resources currently available for mental health services, at a minimum will be fully protected in the new organisations. I shall expect significant progress to be made to implement fully the NSF for mental health across Wales over the next 3 years.. I intend to ensure that mental health services are no longer a “Cinderella” service but have a strengthened presence within the new organisations.

....Whilst much has been achieved over the last 6 years since the original National Service Framework (NSF) for mental health was published there has to be an improvement in the access to and quality of the services available throughout Wales. No change is not an option and I will ensure that in the re-organised NHS mental health services have a very high priority” (WAG 2008d:2).

These are cautiously welcomed developments for mental health provision in Wales. With this policy context in mind, the current study on LGB people with mental health issues is timely in the sense that Stonewall Cymru and partner Mental Health Organisations Mind Cymru, Hafal and Journeys advocate that the findings and recommendations emanating from this report are, where

¹⁹ Click on this link to access the [Proposed National Assembly for Wales \(Legislative Competence\) \(No.6\) Order 2008](#), (relating to mental health services), 18 February 2008.

²⁰ Click on this link to access the [Proposed National Assembly for Wales \(Legislative Competence\) \(Social Welfare\) Order 2009](#), (relating to carers), 8 December 2008.

possible, integrated within equality strategies of future mental health policy and provision within the NHS, social care and other statutory services of Wales.

The following Chapter, Part Two details our method of gathering data along with some of the demographic details of the study's respondents and participants. Part Three is concerned with the findings of our study and entails some discussion of our findings in relation to the literature. Part Four concludes our findings and provides recommendations for further action.

Part Two: Methodology

Stonewall Cymru and its partner Mental Health organisations aimed to explore the needs and experiences of LGB people with mental health issues living in Wales. The project was funded by the Equalities and Human Rights Commission and had a relatively short timescale of August 2008 to March 2009, with field work commencing in early November 2008 and ending in Mid February 2009.

The project had a reference group made up of service users, members of the public, and representatives of mental health and LGB organisations. The reference group was invaluable in providing guidance around ethical issues, gate-keeping and access to participants, use of terminology, methodological and practical dilemmas and in deriving at what we consider to be pragmatic and achievable recommendations for further action.

Our study's design:

We used what is termed in the social sciences as a 'mixed method' cross sectional approach. This encompassed distributing an online questionnaire that was made up of a mixture of quantitative and qualitative questions; additionally we undertook five focus groups across Wales, and offered the option for participants to engage in individual interviews to gain qualitative data.

Sampling and distribution:

A prominent methodological dilemma of research with LGB people is the difficulty in obtaining a representative sample of LGB people (NIMHE 2007; King *et al.* 2008). This is due in part to the invisibility of the target group and is compounded by the absence of a baseline population figure with which to compare, such as that provided by the Census. Whilst the merits of including a category for sexual orientation has been a subject of consultation, for the time being, sexual orientation is not, and remains unlikely to be included in the Census in 2011 (NAW 2005; Office for National Statistics 2006). Survey

respondents, focus group participants and interviewees were self-selecting, therefore it is not possible to claim that our sample provides a 'representative slice' of LGB people with mental health issues living in Wales. However, we took active steps to engage with the target population and in order to access as many LGB people as possible we approached organisations that may come into contact with LGB individuals with experiences of mental health issues. The project partners, Journeys, Mind Cymru and Hafal, also advertised amongst their networks and projects. The distribution list consisted of Stonewall Cymru's database members, mental health organisations, LGB organisations, hospitals, universities, local authority health boards, county councils, the Samaritans, counselling services, GP surgeries, citizens advice, gay venues and community mental health teams (CMHTs).

Our Questionnaire:

The questionnaire was available online via a link on the Stonewall Cymru website from November 2008 to mid February 2009. Respondents had the opportunity to answer the survey in Welsh or English, on-line or in paper form. In total, 116 people completed the questionnaire, four of whom completed via post and one in the medium of Welsh. Our online survey was completed by people living across South & South East Wales (61%), South West and West Wales (22%), Mid Wales (5%) and North Wales (12%). The majority of respondents stated that they lived in a city, town or suburb (75%), and the remainder lived in rural areas and villages.

The questionnaire included questions around several themes. These aimed to capture demographics of respondents, their experiences of mental health issues and access to services, the perceived contributing factors to distress and mental health issues, details of individuals' level of inclusion and quality of life and their views on ways, if any, that the welfare of LGB people with mental health issues can be promoted and addressed. (See Appendix One for sample questionnaire).

Focus Groups/ Interviews:

We held focus groups in Cardiff (twice), Bangor, Aberystwyth, and Swansea. Twenty seven people engaged in qualitative focus groups and three took part in semi-structured individual interviews (several focus group participants/interviewees also completed the questionnaire). Based on themes set out in the questionnaire, focus groups and individual interviews provided opportunity for reflection, group discussion and further insight and subjective perspectives.

Data analysis

Questionnaires were analysed using SPSS statistical software. We predominantly subjected the data to descriptive statistical analysis, such as frequencies and percentages. In a few cases we carried out statistical tests to clarify if there were any statistically significant differences between different groups within the sample or to determine if different variables within the questionnaire were statistically significantly correlated.

Qualitative data from the focus groups, interviews and questionnaires were analysed using NVIVO software to aid the management of data. Data was interpreted thematically and where appropriate there was scope for quantification of some responses. We obtained a rich collection of personal views and experiences. However for practical reasons we have presented quotes that we feel best illustrate a point. In presenting quotes and to protect the anonymity of the study participants we have provided only a pseudonym and where necessary we have omitted other potentially identifying details such as organisational names and geographic areas.

Part Three: Findings

We present here the findings of our research. We divide these into four main sections. (1) demographical details of the questionnaire respondents and study participants; (2) About being LGB with experience of mental health issues and access to services; (3) LGB people's views on assumptions and contributing factors to mental health issues; (4) social inclusion and quality of life. The findings derive from both the survey and qualitative interviews and focus groups.

(1) Demographical details of study participants:

In asking respondents for some background information we utilised standardised categories to enable comparison with wider datasets such as national statistics etc. Doing so however requires respondents to place themselves into predefined boxes and some respondents provided feedback on the limitations of this. We have provided such comments here where appropriate to illustrate the complexity of self-identification and recognise that such categorisation may fail to adequately articulate the diversity of respondents.

Gender:

Almost equal numbers of men and women completed the survey with 50% defining as male, 46% defining as female, 3% defining as female and transsexual, and 1% as 'gender neutral'. The latter added:

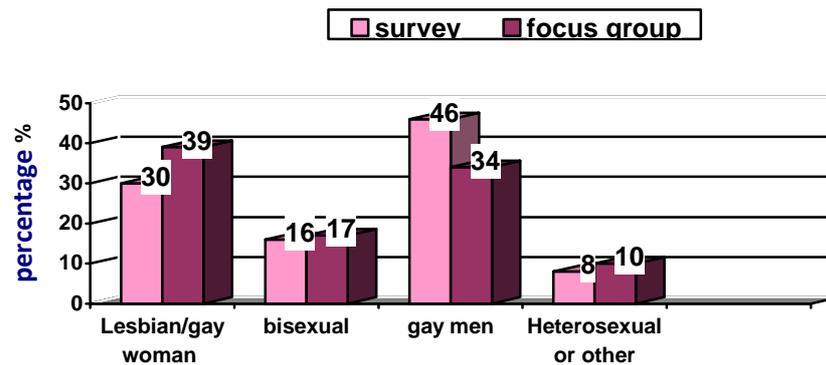
"In answer to your question about my gender, I'm female (i.e. my sex is female), but not being at all sexist, I am gender-neutral. I consider gender to be a sociological phenomenon, whereas sex is defined by one's biological make-up. I've been fighting gender-stereotyping just about all of my life, so find the application of the term 'gender' to define one's physical being is a misnomer!" *Louise*

In focus groups / interviews more women than men took part with 48% defined as female, 11% as female and trans, 38% as male, and one as 'gender neutral'.

Respondents' sexual identity:

Thirty percent (n= 35)²¹ of survey respondents identify as lesbian or gay women, 46% (n= 53) as gay men, 16% (n =19) as bisexual, and 8% (n=9) defined themselves as 'other' to include 'heterosexual', 'a person who has sex with members of the same sex', 'questioning', 'celibate' or 'pansexual'. In focus groups and interviews 39% (n= 12) were lesbian, 17% (n= 5) bisexual, 34% (n=10) gay and 10% (n=3) defined as 'other'.

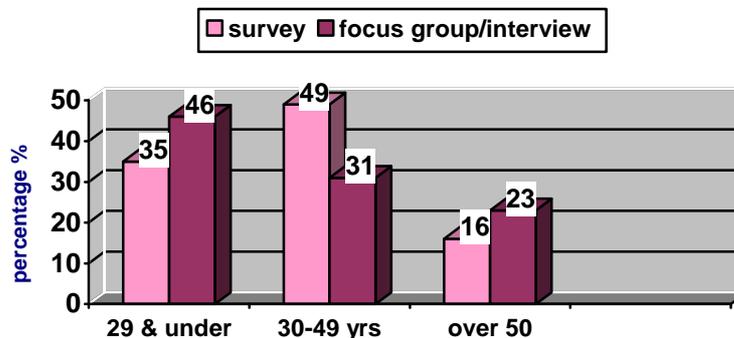
Table 1: Respondents' sexual identity



Age:

The youngest survey respondent was 15 and the oldest was 73. Thirty five percent were 29 and under; just under half were aged between 30- 49 (49%), and 16% were over 50. In focus groups/ interviews 46% were under 29 years, 31% were 30- 49 and 23% were over 50.

Table 2: Respondents' age



²¹ (n =) = the actual number of respondents.

Ethnicity and first language:

94.8% of survey respondents self defined as 'White'. Our sample is under-representative of the 2.1% Black and Minority Ethnic population of Wales in that only 0.9% of our sample declared as being of 'mixed' background. A further 1.6% preferred to define in terms of nationality as 'Welsh', 0.9% as 'British', and 1.8% as 'European'. One respondent added:

"I'd say I'm of North-West European origin, and, more specifically, British (going back for at least 4 generations). I prefer not to talk in terms of "black" or "white" as, despite the fact that they are politically-recognised terms, I find that they create false distinctions between us and exaggerate differences between people(s)."

Of the 116 respondents who informed us of their first language, 85% use English; 11.5% use Welsh as their first language; a further 3.5% use other languages.

Disability:

33% (n= 38) of survey respondents & 54% (n= 16) of focus group participants consider themselves to be disabled under the definition outlined in the Disability Discrimination Act (2005)²².

(2) About being LGB with experience of mental health issues

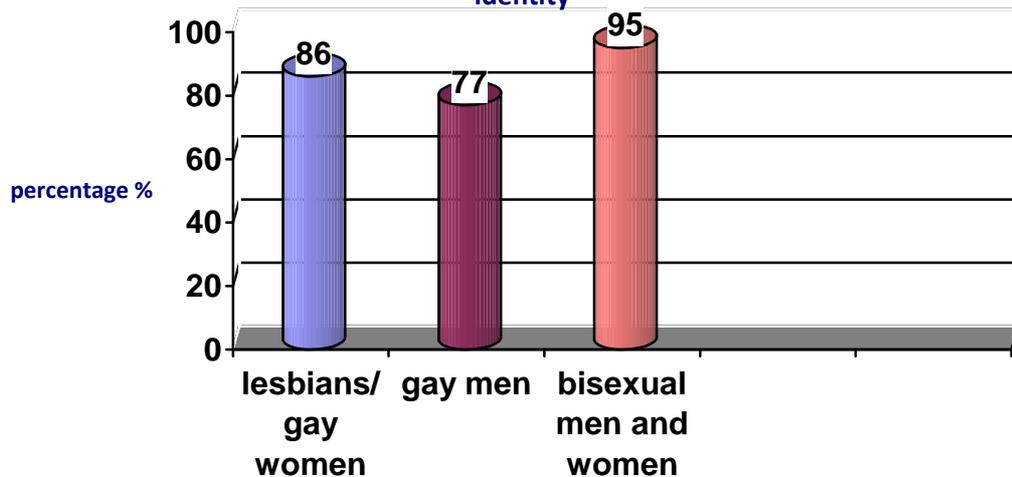
We wanted to find out about people's experiences of self-identifying as LGB and as having mental health issues. The survey asked respondents how they would describe their current mental health. Just over half of respondents (52%, n= 60) stated that they have 'fair', 'poor' or 'very poor' mental health. The remaining 48% (n=56) regarded themselves as having 'good', 'very good' or 'excellent' mental health now, but as having had mental health issues in the past.

²² Defined as 'disability is a physical or mental impairment, which has a substantial and long term adverse effect on a person's ability to carry out normal day to day activities'.

Access to mental health services:

In their study King and McKeown (2003) found that irrespective of their current mental health, gay men and lesbians were more likely than heterosexuals to have consulted a mental health professional. Within our sample it was not possible to make such comparisons, (given our study did not include a comparative sample of heterosexual men and women). However we found a high percentage of respondents (82%, n= 95) either currently access or have accessed mental health services, with just under half of these (44%, n= 42) declared as having accessed mental health services more or less continuously for several years. (It should be borne in mind that the study targets those identifying as having mental health issues hence the percentage may reflect this factor). We found almost equal numbers of men and women accessed or currently access services. That is of the 95 survey respondents 52% (n=46) defined as 'women' and 'women and trans', and 48% (n= 49) as 'men'. We found more bisexual men and women accessed services (95%, n=18 out of 19 bisexuals) compared to 86% of lesbian and gay women (n=30 out of 35); and 77% of gay men (n= 41 out of 53) and 67% of those who were undefined in their sexual identity (n=6 out of 9); though we suggest that this difference is not statistically significant²³.

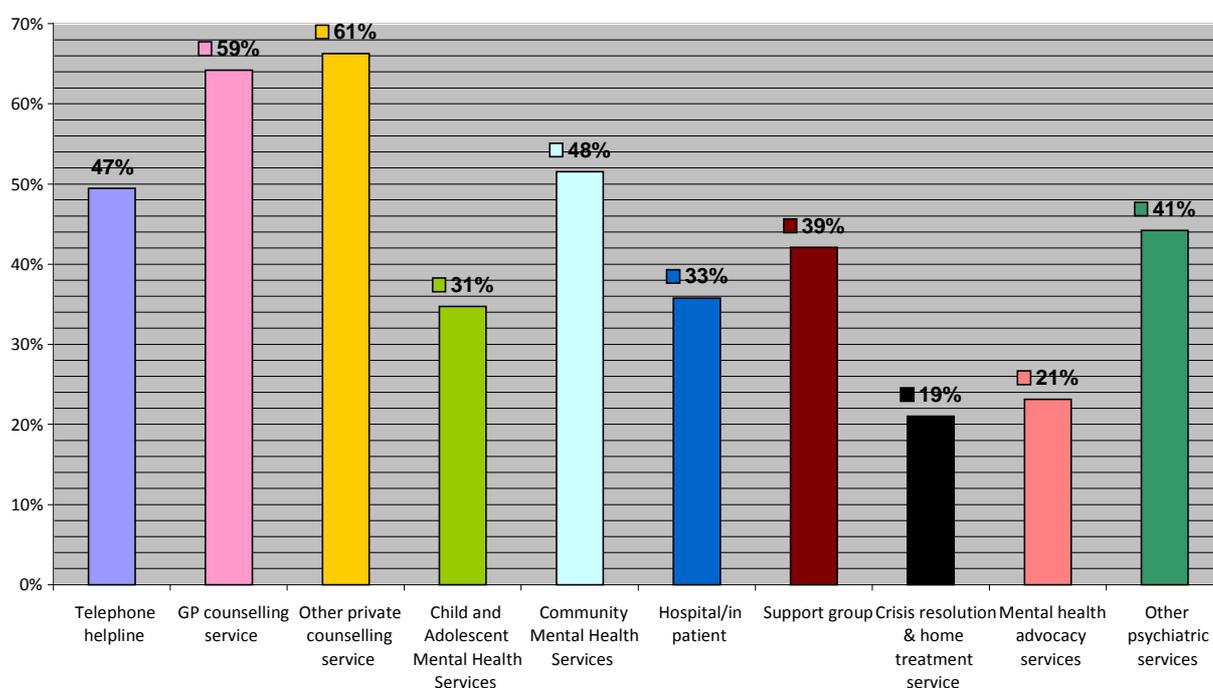
Table 3: LGB respondents who have accessed mental health services by sexual identity



²³ We undertook a Pearson's Chi Square Test to find out if the difference in those accessing services was likely true and not due to chance. We found that there was no statistically significant difference in those accessing services (value= 3.547; N= 109; $p = 1.70$).

The table below shows the range of mental health services that 95 respondents have accessed²⁴. The most accessed services were private counselling (61%, n= 64), followed closely by GP counselling (59% n=62). Just under half have accessed telephone helplines (47%, n=49), and support groups (39%, n= 41). Thirty one percent (n= 33) have accessed CAMHS, 48% (n=50) accessed a Community Mental Health Team (CMHT) and (19%, n=20) crisis resolution and home treatment services. Roughly one third have accessed hospital or been an inpatient (33%, n= 35). Forty one percent (n=43) have accessed other unspecified psychiatric services and (21%, n= 22) mental health advocacy services.

Table 4: Mental health services accessed by 95 survey respondents



Extent of Mental Health Service Provision:

The provision of mental health services in Wales is the responsibility of the Welsh Assembly Government and has been evolving in line with the National Assembly of Wales' CAMHS and Adult Mental Health strategies (see NAW 2001a; NAW 2001c, respectively). As noted elsewhere in this report, these

²⁴NB: of the 95 respondents who have accessed or access mental health services, 85% access(ed) more than one service.

strategies aim to provide sufficient services; however the evidence previously discussed illustrates a range of shortfalls in provision. Our study concurs with such findings in that although there were some positive aspects of service provision noted, it was the general consensus within focus groups and interviews that mental health services in Wales are under-resourced for the general population. One respondent pointed out:

“It’s a deeply over stretched service. It seems the problems of accessing resources are not just particular for gay people, but for all people in Wales.”
Deborah.

Many respondents expressed dissatisfaction at the extent of these services. Across all focus groups and interviews and based on data provided in the questionnaires, the main criticisms of existing services are:

Limitations in types of services on offer:

It appears common for people to be given access to medication and counselling when they first present to their GP with mental health issues. Some participants were of the view that drugs are being offered too readily as a solution by professionals rather than counselling and other therapeutic services.

“Problems are brushed under the carpet, and Prozac Smarties are just dished out. They dish them out with no help for years and years. I think I went for years without seeing anyone else other than my GP for mental health problems”.
Katie.

“It doesn’t seem to be taken seriously enough does it [*referring to mental health*]. My doctor’s good but I mean he’s given me medication but he hasn’t talked me through and said can you come back in a week or two weeks, there’s no monitoring and its such a big change for your body to take on these medications”. *Dean.*

Others saw that there is a blanket approach to dealing with mental health issues rather than devising individually tailored services. With many respondents (who could afford it), choosing to pay for private counselling and other mental health services. Within the survey 45 respondents who had accessed GP counselling had also paid for private counselling and overall as

illustrated in the table above, private counselling was the most accessed service. For example, one such respondent accessed Cognitive Behavioural Therapy privately and felt it was enormous benefit to him; “CBT is a life saver.”

Waiting lists:

Several respondents were unhappy with the length of time it took to access mental health provision:

“I got put on a waiting list for Anorexia in 2006 and I only just started getting treated last summer [2008]. It’s just long waiting lists. When I lived in [area] I was on a psychiatric waiting list for 3 years and it eventually just got completely cancelled.” *Cadan.*

Criteria for high demand services:

Some participants felt that the threshold for accessing mental health services was too high; “unless you are extremely distressed or are a real risk to yourself or others you will not be taken seriously by services”. Some participants were of the view that the demand for services left them without adequate support. For example, *Bethan* had been refused certain services by a psychiatric hospital on the grounds that she had received the services on previous occasions. She stated:

“If you break your leg they don’t say that you can’t get it plastered just because you’ve broken it before, so why should it be any different for your mental health and especially if the service is of benefit to me”. *Bethan*

A number of young people within local authority care and/or transitioning from CAMHS to adult mental health services were of the view that the level of support was insufficient, and in some cases, a child protection concern:

“It sounds really bad, I was in care and I was unhappy for a long time...and I said I was unhappy and I took an overdose and they moved me. They’ll start taking action when you start cutting yourself or doing things, it’s almost like you have to be really bad before they’ll do anything to help.” *Michael.*

“I’m under a mental health social worker but not an under 18s social worker any more..... They’re meant to come and see me once a week but they don’t. I think I’ve seen them twice in the 12 months I’ve lived there now. Child services are brilliant. But as soon as you’ve transferred they should have a 16- 25 service ‘cos that’s the most difficult.” *Lauren.*

“Currently they chuck young people in with adults within psychiatric units. Age-wise it can be quite a mix. I don’t think it works myself.” *Christian.*

Benefits of services:

Those that had received counselling or other more intensive support had mixed views on the benefit of such services. Our study found some good practice within mental health services. For example, CBT and Art therapy were heralded by some as useful and constructive forms of therapy, and for one young adult CAMHS provided extensive support:

“I ended up going to a specialist school for people with mental health issues, which was a really good service that I credit for giving me my confidence back. There’s a school there with specialist teachers with expertise in mental health. I was referred there by CAMHS. I Stayed there... they take people up to the age of 18 if they are staying on in school and they have support workers to help with moving on.” *Cathryn.*

Others were unhappy with the extent of support on offer:

“My counselling session is once every 3 months and that’s so hard for me because last time I saw her I was happy because it was a good day. But say the last 3 months have been terrible and the next time I see her I could be happy or unhappy, and she’s only gonna see me for that one hour on that one day .”*Shaun.*

“There’s no facility for women only spaces in hospitals. Wards are very mixed, you can be with people who are violent, and they are frightening places to be”.
Pamela

Rural areas and access to services:

Those in rural areas felt disadvantaged by transport routes and the concentration of specialist services in larger towns and cities, with some having to travel long distances to access services;

“There’s self-harm support groups but I don’t attend cos’ can’t get to them from where I live; there should be better transport links or help to get places.” *Sian.*

“There are limited mental health services in the area.” *Jodie*

“Too far away; nothing local for transgender young people.” *Ellen.*

Reasons for not accessing mental health services:

The reasons were varied for those survey respondents who did not approach mental health services (18%, n= 21). These included those who were fearful of their family finding out or those who wanted to hide their mental health issues from mental health services. Some did not realise the extent of their issues at the time or considered they could cope with these; others had support of family and friends. There were a number who thought the services on offer were limited or inaccessible; those who were fearful of being stigmatised as mentally ill and those who were fearful of prejudice from mental health services around sexual orientation:

“Given my role as Social Worker and the stigma of mental health in society.”
James.

“I had the support of my ex-partner, my current girlfriend and some very dear friends. Retrospectively perhaps I should have sought professional help to resolve the illness sooner, but I coped.” *Simone.*

“I didn't need other mental health services beyond counselling and medication for a while. However even if offered I would not want to go to other mental health services, as counsellors tend to me [*to be*] the most un-accepting of bisexuality, based on many interactions with mental health services when supporting friends and partners, and if I have had issues with counsellors then I don't want to imagine what other mental health service providers would say and have seen it too often.” *Melanie.*

People's experiences of mental health professionals:

'Being out' and working relationships-

Within the survey we asked if respondents were open about their sexual orientation when accessing mental health services. Of 98 survey respondents²⁵ who answered this question, just over two thirds were 'out' (n = 74). Comparing those who were out based on their sexuality, we found less bisexual men and women were out. i.e. 50% (n= 9 out of 18) of all bisexual respondents were out, compared to 79% (n=34 out of 43) gay men, 84% (n=26 out of 31) lesbians and gay women and 83% (n= 5 out of 6) of those who were undefined in their sexual identity. We undertook a statistical

²⁵ Note: There were 95 respondents who accessed mental health services and a further 3 respondents indicated that they had not accessed mental health services but had accessed a telephone helpline or other services.

test²⁶ and did not find a statistically significant difference based on sexual identity. Of those who did not declare their sexual orientation when accessing mental health services, the following table illustrates the rationale:

Table 5: Respondents' rationale for not being 'out'?

| | Frequency | Percent |
|--|-----------|---------|
| Didn't think it was relevant | 4 | 17 |
| Fearful of, or uncomfortable disclosing | 5 | 21 |
| Might be perceived as abnormal or the cause of mental health | 2 | 8 |
| I was still in the process of coming out | 6 | 25 |
| Other- including 'out to some but not others'; 'several of the above'; 'didn't make a point, but didn't hide it either'. | 7 | 29 |
| Total | 24 | 100 |

We asked those 74 that declared they were 'out' with any of the aforementioned services if they perceived this to have any effect on how they were treated, and if so how. In total we had 66 written responses detailing reactions that ranged from positive to worryingly homophobic. Additionally focus group participants and interviewees mirrored some of these responses. The following section will draw upon these 3 strands of data.

Positive experiences of being 'out' with mental health providers-

Sixty one percent (n=45) did not consider their being 'out' as having any relevance to the way in which they were treated and 21% (n=9) of this group were of the view that being 'out' enabled a more positive and inclusive experience of mental health services. In focus group discussions and interviews with 30 people, 20% (n=6) of participants explicitly highlighted good experiences of accessing mental health services.

²⁶ We carried out a Fisher's Exact Test and found no statistically significant difference (Value= 7.500, n= 98, p =.086).

“I was treated well - as I would expect of the general population.” *Cerys*.

“It helped because the professionals involved could be more specific in the support they gave me and there were no subliminal barriers to communication.” *Darren*.

“With CAMHS they were very understanding and dealt with the other problems not just focusing on my sexuality.” *Zoe*.

“With my first counsellor it had no effect. They accepted it as part of who I was and simply remembered to use the correct gendered pronouns for current partners, which encouraged me to keep seeing the same counsellor and was extremely positive.” *Claire*.

Respondents’ experiences of exclusionary and discriminatory mental health practitioners-

The Welsh Assembly Government (WAG) has recognised the need for non-discrimination and inclusive service delivery for LGB people (see for example the Welsh Health Circular 31 (WAG 2008d)). However the extent to which policy can be implemented is pivotal on frontline service providers and monitoring mechanisms.

Of the individuals who provided details of their experiences of practitioners and concerns around accessing mental health provision, we recognise that these incidents are anecdotal; and that as above pointed out there were 61% of survey respondents for whom being out with services made no difference to how they were treated. Nevertheless, for the remaining 39% (n=29) of survey respondents there were several main themes that emerged and indicate a pattern of potentially discriminatory practices. In all cases it is evident that the values, attitudes, knowledge and skills of individual workers influenced how they engage with people who identify as LGBT. Our focus groups and interviews²⁷, as well as other related research, mirror these concerns (See for example King and McKeown 2003; Cook *et al.* 2007; Hunt and Fish 2008).

²⁷ Whilst 20% of focus group participants and interviewees were explicit in their positive view of accessing mental health provision; it was not possible to quantify the exact numbers of those who had concerns around their treatment and experiences because of the nature of group discussion and participant’s comfort around discussing issues. Furthermore it was evident that not all participants who highlighted particular difficulties found their whole experience to be negative.

Values and attitudes-

A number of respondents reported feeling discriminated against by individual practitioners. This ranged from subtle forms to the more overtly intent homophobic, biphobic, and/or transphobic attitudes:

“I see a private counsellor whenever I feel the need, [it] helps that she is gay too. Years ago I saw a hospital psychologist; he was ok with my sexuality. Prior to this I had a session with the GPs counsellor and she seemed shocked and embarrassed with my sexuality.” *Emily.*

“I think my private counsellor has a conservative attitude to homosexuality which makes me feel uncomfortable disclosing information about myself. After coming out to her there has been an issue of confidentiality and she believes my private life to be a cause of my mental health problems.” *Glen*

“A senior nurse (female) who was my personal keyworker whilst an in-patient in NHS psychiatric hospital refused to continue to work with me when I was 'outed' by [*name*] in casual conversation. She was not questioned or challenged by any other staff & despite dealing with abuse issues I was assigned an inexperienced junior male keyworker without explanation or consultation regarding the staff change. The original key worker didn't speak to me again and wouldn't be in the same room as me.” *Sarah*

“I don't think it [*referring to being out*] had any affect at all except for Christian counselling as their view of it was wrong and I should pray for healing to become straight.” *Anna.*

“ First time I tried to get help from mental health services I ran into a GP who refused to refer me because he didn't like what transsexuals were and so refused to treat me. He also refuses to deal with anyone who is L, G or B as well and a lot of other stuff that he thought was morally wrong. So other professionals from outside of mental health will block access to mental health services because of their own values.” *Deborah.*

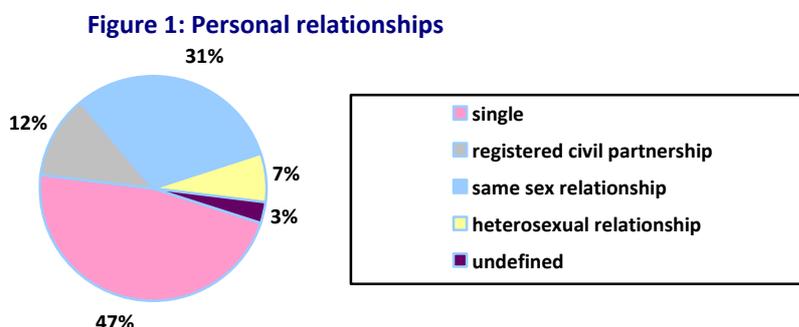
Knowledge and skills:

Subtle forms of discrimination and in some cases unintentional offence were often underpinned by heterosexism and practitioners' lack of awareness and knowledge around (a) LGBT issues and (b) an assumption made by mental health professionals that being LGB was the route cause of mental health issues.

Personal relationships-

Other research (e.g. Cooke *et al.* 2007; Hunt and Fish 2008) suggests that heterosexism is particularly notable in relation to the disregard with which

LGB people's family and partners are treated by service providers. The pie chart below demonstrates the diversity of personal relationships of the 116 respondents in our study.



When accessing mental health provision some respondents pointed out that their personal relationships and partners have either been trivialised by service providers or in some circumstances were viewed with suspicion:

“When I was with a female partner her position in my life wasn't taken as seriously as my male partner is taken now. We often felt tolerated by medical staff, where as my partner now is invited to be with me.” *Gemma*.

“The crisis team when I had a male doctor assess me refused to acknowledge my girlfriend even after I introduced her as my partner, kept calling her my friend, also asked if I had any real support of somebody who could stay with me overnight, when I said my girlfriend, he said ‘it's good your friend is willing to’, even though we already live together.” *Sian*.

“...It was suggested that I was an 'abuser' when I was [age] and had a relationship with a younger woman. Also that she might have been simply led by myself, although she was gay and I was bi.” *Catrin*.

Treatment Plans & misattributing being LGB as the root cause of mental health issues-

For some respondents who were open about their sexual orientation, there was a sense of not being treated and supported adequately because the practitioner was ill-equipped to address LGB issues.

“I was out with both my GP and my counsellor, however in both cases I was not confident about whether they actually understood my needs. I was treated with respect, but I feel that there needed to be more awareness for me to be able to feel comfortable”, *Lloyd*.

“My subsequent counsellors were not convinced that being bisexual was not an issue for me and did not affect my mental health. This made me reluctant to continue counselling at first and later on made me switch counsellors and eventually access peer support instead and stop going to counselling at all. They didn't understand and counsellors need to understand to be able to give appropriate support”, *Claire*.

“It would be of assistance if there was a mental health service solely for gay people available, instead of having to conform to a straight person's thought patterns and assessment.” *Cadan*.

A number of respondents reported an assumption made by mental health professionals that being LGB was the root cause of their mental health issue(s). This assumption has had consequences for some individuals in their treatment plans which were provided on this basis; apparently irrespective of the individual's own insight into their mental health and wellbeing:

“I've struggled with hereditary depression since I was 9, and I knew I was gay at age 12. For me, my sexuality was an area of relative clarity, certainty and confidence, and coming to terms with being gay was a limited (and now resolved) component of a long depressive history. However, very few service providers understand this.... I am always treated by the NHS as though it's not really possible to "get over" being gay, so if I think I'm fine with my sexuality I must be "repressing." I struggle to convey that my sexuality and my current relationship are in fact areas of real confidence and strength for me, and my depression is genuinely linked to factors unrelated to my relationship or my sexuality”, *Alison*.

“Homosexuality to the psychiatrist was seen as a reason for greater psychological disturbances. i.e. you're gay (even when i said bi) so you must have problems. Others [psychiatrists] were good however” *Rob*.

“ I've been in hospital since the age of 14- 15 and there were a few of us who came out at the same time. If sexuality was mentioned it was seen as a sickness. Being in hospital that young, I was a teenager with feelings coming up. I was put in hospital and told you're ill and it's taken a while to accept myself with labels being put on me.” *Nadine*.

Trans specific:

Those who identified as trans reported that issues around being trans were more prominent reasons for accessing mental health services than issues

around sexuality. However, two respondents were of the view that practitioners were unable to provide effective support:

“My psychiatrist, who isn't as open minded as my psychosexual counsellor, is simply overwhelmed by my abnormalness; non-op trans, queer pan, kinky switch, poly, slut, nymphomaniac (on top of everything else) so he doesn't get a chance to quibble about who I fuck and love.” *Ellen*.

“ I think my psychiatrist treats me more as a curiosity when it comes to my sex life. I seem to be hitting a wall with them just not understanding various issues I have with my sex life. So they're not providing support in that aspect which then complicates things.” *Suzanne*.

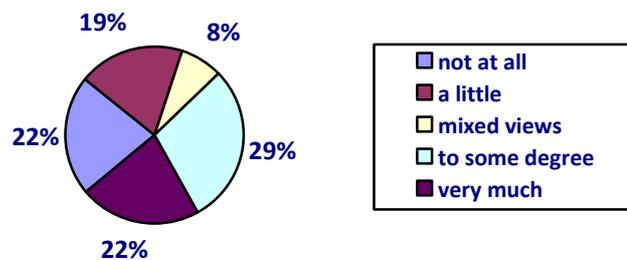
Advocacy and access

Of those who were 'out' about their sexual orientation and perceived that they were discriminated against in their treatment (i.e. n=29), 79% of these (n=23) indicated their experiences impacted or were likely to impact on their level of openness about their sexual orientation when accessing mental health services. Seventy six percent (n= 22) also indicated it impacted or was likely to impact on their willingness to access mental health services. Some respondents were unaware of how to complain, or said they would be cautious to complain if they were dissatisfied with the treatment they were receiving. Just under a quarter (21%, n=22) of the 95 respondents who have accessed mental health provision said they have also accessed mental health advocacy.

(3) LGB people’s views on assumptions and contributing factors to mental health issues

Given the underlying assumption made by some practitioners, as well as a vast literature base that contends that LGB people are ‘at elevated risk of experiencing mental distress’, we asked all survey respondents whether they thought there was any link between one’s sexual orientation and susceptibility to mental health issues. Twenty two percent (n= 26) thought ‘not at all’; 19% (n= 22) thought ‘a little’; 8% (n=9) had ‘mixed’ opinion and 51% (n= 59) thought to ‘some degree’ or very ‘much’.

Figure 2: respondents views on sexual orientation and susceptibility to mental health issues



Additionally within focus groups and interviews it was the consensus of all participants (n=30/ 100%) that there was a connection between the two. However, we cannot guarantee that group members would have been influenced by other group members’ views.

Respondents who perceived there to be no link between sexual identity and mental health issues.

Of the 22% of respondents who did not think there was any link, 12 respondents added comments. Some responses included:

“I don’t understand the connection if any exists.” *Adam.*

“ I suffered from the same symptoms before I even considered that I was gay, and I feel it is the life issues & day to day stresses, as well as any relationship that trigger anxiety/ depression etc.” *Hannah.*

“I think I would have had these problems whatever my sexuality.” *Janine.*

“I used to think it was the reason for my depression but it is not.... The depression was the reason I was depressed! I am on medication and have been well for 10 years....had a relapse when taken off medication.” *Geraint*.

‘Minority stress’ and mental health

For those who thought there was anything from “a little” to “very much” of a connection, we received 79 comments within the survey and held group discussions within focus groups it was the view of the vast majority that sexual orientation *per se* is not the cause of mental health issues. Rather, and as supported by the literature (for example Mays and Cochran 2001), respondents were of the view that the enduring pressures and experiences of discrimination from family, friends, services, and society more generally throughout the life course impact on one’s mental health and wellbeing. As noted earlier, Meyer (1995) conceptualises this as ‘minority stress’. One facet where this is particularly pivotal concerns ‘coming out’.

‘Coming out’ and mental distress

Within the literature there are several conceptual frameworks for exploring and explaining the ‘coming out’ process. In reviewing these, Rosario *et al.* (2001: 135) contends that ‘coming out’ entails four main dimensions: “1. Sexual identity, 2. involvement in LGB activities, 3. attitudes towards homosexuality (*sic*), and 4. disclosure of sexual identity to others.” The ‘coming out’ process is thought to be influenced by the interaction of strengths that may buffer individuals, and conversely, stressors that may be detrimental. For example, negotiating these four dimensions can lead to positive self esteem, self acceptance and identity; in some cases this was evident from our focus group discussions and survey responses. However for many respondents, ‘coming out’ and self acceptance was difficult and compounded by, and pivotal on the response of others:

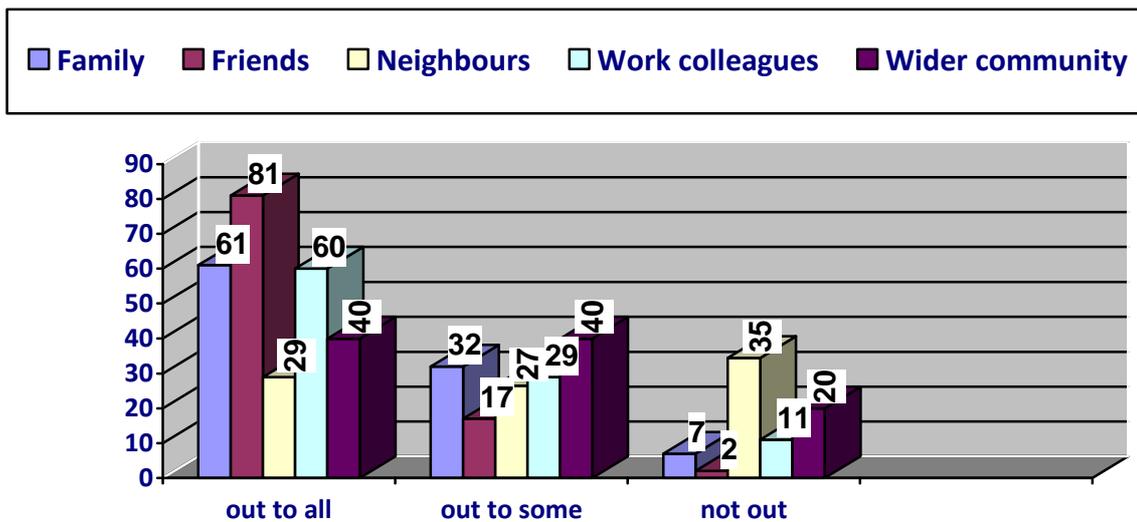
“Around coming out I had issues on the basis I’m transsexual. Initially I labelled myself as lesbian but people couldn’t get their head around how a transsexual could be a lesbian. ‘Cos if you’re a male to female transsexual and you still like women then obviously you’re a straight man who likes dressing up. So I started identifying as bisexual initially ‘cos that way people could accept me liking women without questioning too much because they also thought I was liking men, it was a very odd thing.” *Deborah*.

“I had a homophobic family and growing up in the valleys I wasn't able to accept myself let alone ‘come out’ .” *Shane*.

“I come from a traditional community and coming out meant that my homosexuality is viewed as a disease. My parents do not accept my homosexuality, and forbid me telling the rest of my family. this means I have to pretend that I am single to the rest of my family, lead to low self-esteem, and used to lead to depression.” *Angharad*.

Within our survey, we found more than half of respondents were completely ‘out’ about their sexual orientation to their family (61%, n= 71), and 81% (n= 94) completely out to friends. Of those in work, 11% (n= 12) were ‘not out’ to work colleagues and a further 29% (n= 30) were ‘out to some’. Roughly two thirds were ‘not out’ or ‘out to some’ neighbours (61%, n= 69), or wider community (60/%, n= 68).

Table 6: Respondents level of openness about sexual orientation in different social contexts



These statistics suggest that for a number of people being discreet or ‘closeted’ about one’s sexual orientation is a strategy for avoiding discrimination or unnecessary intrusion into their private lives. Within focus groups and interviews there was some debate over whether coming out is more difficult in the current climate or whether it was in earlier years. Some were of the view that in earlier years, for example the 1960s to the 1990s, LGB sexual orientation was deemed to be pathological and people endured hostility and stigma around AIDS and were made to feel abnormal:

"I was born in the 1960s and it was considered an abnormality. You get a perspective of yourself as a freak. I think there is a correlation between mental health or mental ill health and being in the closet. When things were really difficult for me, I'm talking about the 1970s, I was in teaching and I was trying to hide the fact that I was a lesbian. I think the more open and out you can be and if you can be yourself, I think that has got to be good for emotional and mental wellbeing, very much." *Geraldine.*

"I came out amidst the AIDS epidemic which was termed 'the gay plague'... so back in the wardrobe'." *Christian.*

"I grew up in a time and culture where homosexuality was not acceptable. I was in complete denial for most of my life, and lived in fear. As a child I experienced daily abuse and bullying at school because of my perceived sexuality. This and the lack of acceptance by my parents, and later church, made life very stressful, and unbearable." *Allun.*

Many respondents were of the view that their experiences of coming out were/are difficult regardless of the era. A further issue relates to age, and some were of the view that coming out and self questioning and acceptance typically occur as young people. This view is mirrored within the literature, particularly in relation to forging one's sexual identity (Rosario *et al.* 2001; Mayock *et al.* 2009). However for many, 'coming out' was perceived of as a process that is continuous over the life course and in different social contexts. Hinchcliff (2009)²⁸ asserts "a lot of LGBT people only self-identify later in life, having had a variety of relationships". In our study a small number of older adults informed us how they had suppressed their sexual orientation until later in life, with one respondent feeling the need for continued suppression for the sake of his family and "generational cultural expectations". The resulting enduring pressures around being 'in the closet' were deemed considerable and some individuals identified this as contributing to or causal to their mental health issues. For example:

"I felt that I was a failure at being a wife, a mother , a Christian.....I had a nervous breakdown and it was at that time that I started 'coming out'.....and started over again which was difficult. I've had suicidal tendencies and have received counselling and been on medication for several years." *Margaret.*

28 Commissioned by Age Concern Cymru and Help the Aged in Wales.

“There were times earlier in my life when my sexuality had a direct impact on my mental health - when I was not out with anyone it caused a huge amount of ill health. Now I am out it is much better.” *Bob*.

“Its hard to live with the denial about who you are inside and the worry of being found out.” *Nina*.

Within our study we found the level of support available to people in ‘coming out’ and accepting their sexual orientation (if indeed they felt the need to accept it), were pivotal to ‘working through’ and feeling less isolated. Mayock *et al.* (2009) suggest that social support is critical to LGBT people’s resilience and to the development of a positive LGBT identity. The absence of support for some respondents in our study served to exemplify this assertion:

“I knew I was different but didn’t know what it was. I was suicidal and reached a point and thought I either die tonight or get help.” *Paul*.

“I was in care all my life and when I came out at 16, the only people who were around me were like social workers and support workers, and I always say like that there’s no support for young people who are coming out. Like there is no advisors in that service who is there specifically supporting and is there for gay people, and this is a missed area.” *Shaun*.

“My family and community are very homophobic and my school don’t care to help me.” *Tanya*.

“When I realised, at the age of 19, I was also very lonely as a result of not confiding in anyone, I felt desperate.” *Simon*.

Research suggests that LGB young people may be particularly in need of support because they have less formal and informal support than do their heterosexual counterparts during the period of adolescence, which as Mayock *et al* (2009: 8) point out entails “the negotiation of early adulthood [and is] a critical time of social and emotional development”. For example young LGB people are more likely to lose important social relationships, including those with parents, when their sexual orientation is disclosed (Anderson 1998: 57). Recent UK based research provides some startling revelations concerning LGB young people’s experiences of victimisation and discrimination during

school (example, Hunt and Jensen 2008²⁹), and within our study there was some evidence of this amongst focus group participants. For example;

“I came out at school, but it was very homophobic. I guess people’s attitudes towards my sexuality did impact on my mental health a lot and some of my mental health issues have come from school and feeling isolated has impacted on my mental health.” *Carmen.*

“I also experienced homophobic bullying at secondary school. I was periodically ostracised by girls and sexually harassed by boys. This experience caused an eating disorder and depression for which I had to have a lot of counselling.” *Jonathon.*

This concurs with other established and international research which points to elevated levels of substance use and self-harm and suicidality amongst LGB young people, than among national samples, wherein it is hypothesised that ‘minority stress’ play a significant part in this (Mayock *et al.*2009; Rosario *et al.* 2009). Waldo *et al.* (1998) point out that unlike LGB adults, young LGB people are generally more isolated from members of their cultural group who might provide support for their LGB identities.

LGB Specific Support

Rossario *et al.* (2001:153) advocate the benefit of programs and environments in which young people “can become more accepting and knowledgeable about their sexual identity. Society also would benefit from such programs by ensuring that a subgroup of its youths had the opportunity to increase self-esteem and decrease distress”. Within our own study we found evidence of some notable support services such as the LGBT Helpline Wales available to people regardless of age and several LGBT youth groups scattered across Wales.

“I go to a queer youth group, and one of the workers there is a worker for [*name of LGBT organisation*] and she knew the system [referring to housing] and so she knew how to translate our needs. I was affected by homelessness at the time, it was a big help” *Anita*

“ [*name of youth service*] is 16 -25s. They’re flexible on this though. It’s a very good support network that [area] has. A very useful resource for young LGBT people”. *Susanne.*

²⁹ Commissioned on behalf of Stonewall.

For some though, rurality and transportation presented problems in accessing these. Furthermore in discussions it was highlighted by several participants that the age criteria for LGBT support groups is typically 16-25 years and essentially can exclude those who need the support beyond this.

Drug and Alcohol use, pressures around sexual orientation and mental health and wellbeing

In exploring drug and alcohol use we are not assuming that drug and alcohol use is problematic for LGB people; though the literature suggests that lesbians and gay men are more likely to use recreational drugs, and lesbians are more likely to drink excessively than heterosexual women (Cochran *et al* 2003; NIMHE 2007; King *et al* 2008). We wanted to explore the extent to which LGB people use recreational drugs and alcohol.

Recreational drug use

We found 19% (n=21 out of 111) respondents use recreational drugs and 86% (n= 18 of 21) were 'happy with the extent to which they use these'. In comparing drug use amongst lesbians, gay women and men, and bisexual men and women, we found 23.5% (n= 8 out of 34) lesbian/gay women; 18%(n= 8 of 50) gay men; 20% (n= 3 of 15) bisexual women, and 50% (n=2 of 4) bisexual men and 0% (n=0 of 8) respondents who were 'undefined' in their sexual identity use drugs. A statistical test showed that that these groups did not differ significantly in their use³⁰. 2 respondents that identified as lesbian/ gay women and 1 gay man accounted for the small number in the sample who declared as being unhappy with their drug use.

Alcohol use

Of 115 respondents who answered this question, Seventy five percent (n= 86) drink alcohol and 68.5% (n= 59 of 86) were 'happy with the extent to which they use these'. We found more gay men use alcohol (89%' n= 47 out of 53 gay men). This compares to 59% (n= 20 out of 34) lesbians/gay

³⁰ We undertook a Fishers Exact Test (Value =4.788, NS).

women, 67% (n= 10 out of 15) bisexual women, 100% (n= 4 of 4) bisexual men and 56% (n= 5 out of 9) respondents who were undefined in their sexual identity. This finding is statistically significant³¹. Of the 31.5% (n= 27) respondents that were unhappy or unsure about how they felt about their alcohol consumption, we found more lesbians/ gay women were unhappy/ unsure with 45% (n= 9 out of 20) lesbians/ gay women compared to 32% (15 of 47) gay men, 20% (2 of 10) bisexual women, 20% (1 of 5) of those who were undefined in their sexual identity and 0% (n=0 of 4) bisexual men. However a statistical test did not indicate significant between group differences³².

Minority stress and drug and alcohol use

We also wanted to gain respondents opinions on to what extent, if any, they thought pressures around sexual orientation have an impact on their use of recreational drugs or alcohol. We found 54.5% (n= 13 of 24) and 60% (n= 51 of 85) of respondents were of the view that there is no link between the use of substances or alcohol consumption and pressures around sexual orientation, respectively.

“ My sexuality has not made me drink any more or less than I would have done regardless”, *Timothy*.

“I don't think my sexuality (and the difficulties that's caused for me due to others having a problem with it) has had any influence on causing me to drink. I consume an average of only about 2 units of alcohol per week, anyway, (and have never drunk at higher levels than this), and I have never taken recreational drugs, apart from trying a little pot once or twice as a student. I've never smoked either”, *Rebecca*.

From those survey respondents and focus group participants who thought there may be anything from ‘a little’ to ‘very much’ of a link, there were two main themes. (1), respondents were of the view that drugs and alcohol were an endemic part of the ‘gay’ scene culture. (2), respondents perceived or experienced that drugs and/ or alcohol have been or are used by people as a

³¹ We undertook a Fisher's Exact Test and found (Value =13.547 Exact Sig. (2-Sided = 0.05). This tells us there is a 1 in 200 chance of this result being due to chance rather than an actual effect.

³² Again we found no statistically significant between group differences when undertaking a Fisher's Exact test (value = 7.221, NS).

form of self-medication for mental distress during difficult circumstances, and in relation to sexual orientation amongst other issues. For example:

“I believe recreational drug use is very common in LGBT culture. This culture inhabits the environments of night clubs and bars. There are few social opportunities for LGBT people outside of this environment. Thus drug and alcohol use are normalised to a large extent. Drugs and alcohol offer some escape from the pressure of modern living and also from the latent homophobia of wider society.” *Adam.*

“You’re like an alien in a world you don’t quite belong to. When you’re in a minority its difficult, it’s not awful but it’s difficult and you have to find ways to cope with that and sometimes its through drugs and alcohol.” *Jenny.*

“When I came out and everything went bad I turned to alcohol to block out what was going on and would get drunk as many times as I could get away with.” *Anna.*

It should be stressed that being LGB does not equate to homogeneity in recreational drug use or indeed that those who frequent the gay scene are necessarily engaged in any or greater usage of substances or alcohol.

(4) Social inclusion and quality of life

Whilst Stonewall Cymru's survey (Williams & Robinson 2007) provides a good overview of LGB people's engagement within their communities, we wanted to explore this further in relation to community engagement, social inclusion and quality of life for LGB people with mental health issues. As noted earlier, LGB people may endure stigma and prejudice based on their sexual orientation while also dealing with societal bias against mental health issues and distress. LGB individuals with other marginalised identities such as disability, BME backgrounds, trans people, older people etc. may experience multiple prejudice and stigma. The majority of focus group participants talked about the impact this has on their daily lives in terms of other people's treatment of them and their level of engagement within their local communities and LGB specific social groups and activities.

Such is the stigma around mental health issues, that within our survey we found less people were open about their mental health issues than were 'out' about their sexual orientation³³ with their family (29%, n=32) and friends (31%, n= 35), work colleagues (14%, n= 15), neighbours (9%, n= 10) and wider community (9%, n=10).

"I told my boss about my mental health issues and my boss said, 'don't tell anyone else 'cos you won't go any further in this company.'" *Paul.*

"...most friends and acquaintances of mine cover up that they have mental health issues and cover it up extensively because it is not acceptable in the community [referring to 'gay community']." *Tarra.*

"There is a lot of ignorance around LGB, mental health and disability." *Sue.*

"When I was in same sex relationships I felt very ashamed of having mental health problems and had some negative reactions from the friends I had at that time who did not understand..." *Tarra.*

Community engagement

Roughly two thirds (n= 80 of 116) respondents appear to engage in their communities to varying extents ranging from those who engage in only one activity to those who are more involved in community life with hobbies (38%,

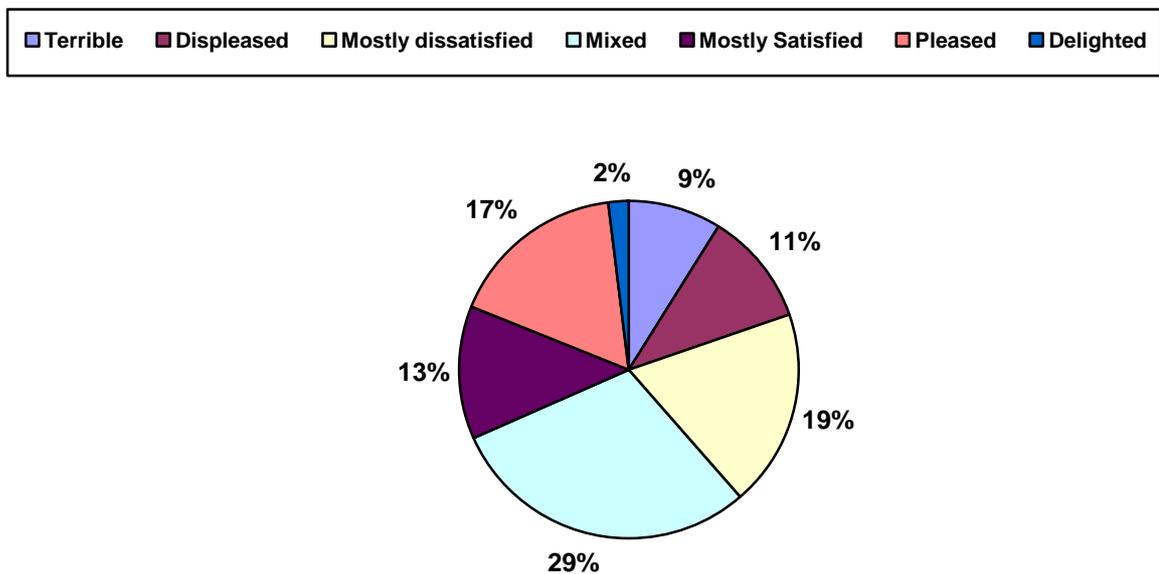
³³ Page 41 provides details relating to those that were out about their sexual orientation.

n= 44), voluntary work or political activity (33%,n=38), LGB&T specific groups (16%,n=19), church (7%,n=8) and support groups (6%,n=7)³⁴. Roughly one third of respondents (36%, n= 41) said they don't engage in any hobbies, community, social, voluntary or political activities within their local community on a regular basis.

Twelve percent (n= 14) of people said they never go out socially and 31% (n= 36) get out once a month. Conversely 41% (n= 48) go out at least once a week and a further 16% (n=18) of people go out once a fortnight.

We asked people to rank on a scale of 'terrible' to 'delighted' "how do you feel about the range of opportunities to be involved with community groups, clubs or organisations that are available in your area". Of 113 responses we found just under one third (n=36) were 'mostly satisfied' to 'delighted' with the range of opportunities to be involved in their communities and roughly two thirds (n=87) were 'mixed' in their views or mostly 'dissatisfied' to 'terrible'.

Figure 3: respondents perception of opportunities for community involvement.



³⁴ NB: respondents may engage in more than one activity.

We compared these responses to a random sample from the general population and found a significant difference in the level of satisfaction expressed, with those in the general population expressing more satisfaction with the range of opportunities available to them³⁵.

LGBT specific groups and ‘scene’

Of those who attend LGBT specific groups and/or those who frequent the ‘gay scene’, many found these beneficial and enjoyable. However for a proportion, these activities were ‘off limits’. In the previous section 2, we touched upon drug and alcohol use where a number of respondents made a link between drug/alcohol use and the ‘gay scene’. We found that a number of respondents recognised that drug and alcohol usage can be problematic for them and in some cases exacerbate existing mental health issues. For some the pressures to ‘fit in’ on the scene went hand in hand with drug/alcohol use or meant that the scene was off limits and an undesirable source of socialising. From these respondents and focus group and interview participants there was a call for alternatives to drug and alcohol social activities.

Several respondents, in particular those with enduring mental health issues, physical disabilities, bisexual men and women or people who identified as trans, the ‘gay scene’ was viewed as unwelcoming and unsupportive of diversity and difference and a festering pot of ‘internal prejudice’ and discrimination; to some extent the same accusation was levelled at other LGBT specific informal activities:

“Being bi if you’re in a straight relationship it means you can’t access services and activities; there is a fear of discrimination. LGBT services are not inclusive to bisexuals.” *Julie*.

“Anyone that deviates from the norm will not fit in. The scene is heavily stereotyped and you have to act a certain way to fit in. There is no acceptance of mental health at all.” *Phillip*.

³⁵ An independent samples t-test was conducted to compare the extent of involvement in community groups, clubs and organisation scores for the general population (N= 252) and our sample (N=116). There was a significant difference in scores for the general population ($M = 4.78$, $SD = 1.36$) and our sample [$M = 4.86$, $SD = 1.54$; $t(330) = 5.6$, $p = 0.000$]. The magnitude of differences in the means was moderate (eta squared = .07).

“There have been issues with the attitude of some lesbian and gay (but never bisexual) people over my right to exist.” *Helen.*

“ Most LGB support services are not particularly welcoming of bisexual people or tell us we need to make our minds up and that will solve our mental distress, and straight support services don't understand bisexuality either, so I've had to rely on friends rather than accessing support groups and services.” *Claire.*

There was a request from these respondents and participants of focus groups for greater understanding and acceptance from the 'gay community' and for LGBT services, activities and venues to be truly inclusive and not tokenistic.

Overall Levels of satisfaction with areas where people live

62% (n= 71) of respondents were 'mostly satisfied', 'pleased' or 'delighted' with the area where they lived. Of the remaining 38% (n= 45) who felt anything from “mixed” to “terrible” about where they lived, there appeared singular and cumulative factors ranging from not being happy with the local amenities and geography of where people lived; lack of services and LGBT specific services and activities, feelings of isolation, and what was described by several as 'narrow mindedness'. 39% (n=18) of these cited solely not feeling safe or able to be openly LGBT within the community because of actual or feared homophobia and violence.

“Not very good for young people here. It's very homophobic. I don't go out anywhere in case I get beat up.” *Lauren.*

“It's a pleasant place, but as for being accepting of difference, homophobia is often experienced.” *Jacquie.*

Hate crime

We asked how many respondents had been the victim of a hate crime and found just under a quarter had (n= 28). Of these, 25 people further elaborated on the context of these incidents. 3 were transphobic (this accounts for the experiences of the 3 out of 4 respondents who identified as trans); 14 were because of sexual orientation; 1 perceived to have been targeted because of their mental health issues and sexual orientation; 4 stated because of fear or ignorance of difference, and a further 3 were not explicit in the underlying premise of the incidents they experienced. There were also several

respondents in focus groups that reported having been the victim of a hate crime. According to the Crown Prosecution Service (CPS) (2008:32), in 50% of convictions for homophobic and transphobic hate crime, offences were against the person, 6% were criminal damage and 34% were public order offences. Men comprised 87% of defendants whose principal offence was 'against the person'. In our study we collected basic details of the nature of offences and found these ranged from verbal abuse and criminal damage, to the more severe including physical and sexual violence.

"I live on an estate where it's not good to be gay. This puts pressure on mental health and relationships. They threatened to come and brick our windows all the time, we were spat at on the street, the names we were called was no-one's business. There is no tolerance for gay people whatsoever." *Katie*.

"I had to leave [area] to be who I wanted to be. The first place I lived in was fine for about 2 years until they realised I was gay; thereafter I received death threats and my property was vandalised." *Ali*.

39% (n=11) of these respondents reported incidents to the police and just over half were satisfied with the way in which they were supported and the incident dealt with.

"They set fire to my flat when I was in it; it was terrifying that. The police didn't respond appropriately; I still see some of the people when I'm on the bus", *Mark*.

"I have reported trans and homophobic hate crime to the Minority Support Unit and they have been excellent in their response" *Deborah*.

Non- reporting

From the survey and focus group discussions it appears that reasons for non reporting range from either an unawareness that homophobia was a criminal offence and regarded as a hate crime under the Criminal Justice Act and Criminal Justice and Immigration Act (2008)³⁶; a perception that incidents

³⁶ The Criminal Justice Act 2003 introduced tougher sentences for offences motivated by hatred of the victim's sexual orientation. In addition, the Criminal Justice and Immigration Act 2008 received Royal Assent on 8 May 2008. Section 74 and Schedule 16 of the Act make amendments to the Public Order Act 1986 to create new offences of stirring up hatred on the grounds of sexual orientation. The offences deal with conduct – namely words or behaviour – or material which is threatening in nature

would not be taken seriously; a mistrust of the police to address the issue professionally and adequately; fear of reprisal from the perpetrator(s) and reluctance to report because of past experience or anecdotal evidence from peers that the police and criminal justice system fail to prosecute offenders or provide them with lesser convictions. That said, figures released by the CPS (2008:3) claim convictions for homophobic and transphobic hate crime in England and Wales have risen from 71% of cases in 2005- 2006 to 78% of cases in 2007- 2008. Furthermore, survey respondents and participants in focus groups recognised that the extent to which incidents are addressed is dependent upon a number of factors. This includes a reliance on witness cooperation, the availability of evidence, the police response and criminal justice proceedings³⁷.

In recent years proactive measures from Stonewall Cymru, the 4 police forces of Wales, the Criminal Justice system, Safer Wales, local authorities, members of the public and victims of hate crime have led to improvements in reporting and prosecution of homophobic hate crime in Wales (See Porter 2007³⁸). Some respondents were of the view that the police forces have made improvements around enabling reporting through for example police and community liaison meetings and the South Wales Police Minority Support Unit reporting line was seen as a good practice example. Several in the reporting of hate crime incidents had experienced positive interactions with the police, however on the basis of our findings further improvements are needed to address reporting, victim support and prosecution.

Overall perception of the extent to which people are included in society.

Finally, we asked survey respondents, “Overall, how do you feel about the extent to which you are included in society?” We found 44% (n= 51) were ‘mostly satisfied’ to ‘delighted’; 33% (n=38) were ‘mixed’ in their view, and

and which is intended to stir up hatred against a group of people who are defined by their sexual orientation, CPS (2008: 26).

³⁷ The CPS (2007) (2008) also provide information relating to factors that determine conviction rates.

³⁸ Written on behalf of Stonewall Cymru.

33% (n=26) were 'less than satisfied' to 'terrible'. When compared to a random sample of the general population, our sample showed a statistically significant difference in the levels of satisfaction expressed; with our sample on average feeling less included than the general population³⁹. This reinforces our other findings in relation to our respondents' experiences of exclusion in a range of contexts and the impact this has on mental health and wellbeing.

The remainder of the report concludes our findings and provides recommendations for further action.

³⁹ An independent samples t-test was conducted to compare the extent of inclusion in society scores for the general population (N= 252) and our sample (N=116). There was a significant difference in scores for the general population (M= 4.97, SD= 1.19) and our sample population [M= 4.22, SD= 1.52; $t(182)= 4.7, p= 0.000$]. The magnitude of difference in the means was moderate (eta squared= .06).

Part Four: Conclusion and Recommendations

In this final part we bring together the main findings and make recommendations for further action and consideration. These recommendations derive from our findings and have been guided by a reference group made up of representatives from LGB and mental health organisations, service user groups linked with the research project and members of the public. Importantly, recommendations are based on what respondents told us they thought was needed to help improve their quality of life and mental health and wellbeing. It should be pointed out however, that change requires more than a commitment to working towards recommendations from specific agencies and government departments. It requires attitudinal change and a cultural shift in how LGB people and people with mental health issues are viewed and included within society and in the communities in which they live. Our research has shown the detrimental impact on mental health stemming from society's lack of awareness and prejudicial attitudes around mental health issues and around people who identify as lesbian, gay, or bisexual.

We consider the recommendations to be practical and achievable with the recognition and commitment of those whom we address them to: Welsh Ministers responsible for equality and mental health in their portfolios to those responsible within local government, and mental health, health, social work and social care, housing, youth, criminal justice, and education service providers within the statutory, voluntary and private sectors.

Mental Health provision:

A high percentage of our sample has accessed mental health services (82%). Our study found some good practice within mental health services. For example, CBT was heralded by some as a useful and constructive form of therapy. On the other hand, a number of respondents were critical of the extent and scope of provision particularly in relation to waiting lists, criteria for high demand services, perceived benefits of services, and limitations of

service provision in rural areas of Wales. Evidence illustrates that these criticisms are endemic of the mental health service in Wales and are issues that all people may face irrespective of sexual orientation. Mental health, other healthcare, social work and social care, housing, police and other public services are legally obliged to be inclusive and non-discriminatory in their treatment and support of LGB people under the anti-discrimination goods and services legislation (Sexual Orientation Regulations 2007). Just over half (61%) of survey respondents reported that their experiences with mental health services were not detrimentally impacted because of sexual orientation, and/or that if they were out about this then the treatment was not any different and in 21% of cases was heralded a positive and inclusive service. However, of the 18% (n=21) of respondents who didn't access mental health services, we found fear of prejudice from mental health services around sexual orientation to be a factor that can and should be addressed in order to break down barriers. In order to promote inclusion of LGB people and access to sufficient and appropriate mental health services in Wales we therefore **recommend:**

- ✓ The Welsh Assembly Government to recognise and provide adequate funding and scope of mental health provision in Wales for children and adults based on need (irrespective of sexual orientation).
- ✓ Monitoring mechanisms should be in place to evaluate the extent of inclusion of LGB people within services.

Promoting good practice with LGB people with mental health issues:

Twenty two percent of survey respondents were of the view that there is no link between one's sexual orientation and susceptibility to experiencing mental health issues. Of the remaining 78% it was the general consensus that mental health issues may present because of enduring pressures and discrimination from family, friends, colleagues, services and society more generally throughout the life course. This concurs with the evidence base (and can be found earlier in the report).

39% of respondents in our survey talked of prejudice and assumption from mental health professionals ranging from the more subtle and usually heterosexist assumptions around relationships to the more overtly intentional homophobic, biphobic and transphobic reactions. In all cases it is evident that the values, attitudes, skills and knowledge of the individual practitioner influenced how they engaged with LGBT people. The implications of this are that LGBT people feel that their relationships are not taken seriously, treatment plans may be provided that are inappropriate or inadequate and LGBT people may not feel comfortable to access the services on offer. In order to raise awareness of LGBT people, and promote inclusive practice we therefore **recommend**:

- ✓ LGB specific and mental health specific training and awareness raising should form a compulsory element of key professional qualification for relevant professions such as health workers, social work and social care, education, youth work, housing, criminal justice and the police.
- ✓ In order to address the specific needs and Issues of LGB people the Welsh Assembly Government should provide funding for LGB trained counsellors and LGB specific counselling services across Wales.

Support around 'coming out' and other LGB specific matters

'Coming out' is a process that is ongoing over the life course and in different social contexts; our study found that 'coming out' can promote positive self esteem and confidence in one's sexual identity. However many respondents in our survey we found experienced considerable difficulties around 'coming out'. The response from family, friends, wider society and service providers has impacted on mental health and wellbeing. Furthermore, LGB individuals who are disabled, from BME backgrounds, living in poverty, trans, deaf, experiencing mental health issues etc. may experience further marginalisation and stigma. Change is needed at all levels of society. However our findings suggest that support groups and helplines (especially important for those in rural areas and without access to support groups) are particularly useful and valued. We are mindful of the need for support for all LGB people around 'coming out' and recommend:

- ✓ The Welsh Assembly government to recognise the emotional and mental health support needs of LGB people 'coming out', experiencing discrimination, or requiring practical advice around access to services etc (irrespective of age).
- ✓ There should be provision of funding for LGB specific telephone helplines and an online website that can promote networking, support and advocacy for LGB people with mental health issues. This would be particularly useful for people unable (or unwilling) to access formal services, for example, people living in rural areas, those without transport, or with barriers due to mental health issues, disability, or caring responsibilities.
- ✓ Publicity and information leaflets around 'coming out' should be developed with specific issues in mind. That is, whilst there will be common issues for individuals, specific information should be provided to those who identify as lesbian, gay, bisexual and at different life stages (e.g. young people and older adults).

Young People

From our study and other research evidence we know that LGB young people in particular are at risk of social exclusion and may experience bullying and victimisation in school and other youth and care services. Young people may be less likely to have established LGB support mechanisms and lack of support can be attributed to risk of social isolation, and mental health issues including deliberate self harm and suicide. Furthermore a number of young people experiencing mental health issues have reported not having a sufficient level of care or mental health support and in a few cases a failure of protection from significant harm. In order to provide crucial and appropriate support we **recommend:**

- ✓ In order to support and provide advocacy for young LGB people in local authority care, Local Safeguarding Children Boards and Local Authority Looked After Children Services should ensure policies and staff awareness raising address mental health issues and the support needs of young LGB people in care, and provide confidential referral routes to support and advocacy.
- ✓ The Welsh Assembly Government to recognise that LGB young people are vulnerable and to fund the development and capacity of LGB youth

groups by all 22 local authorities across Wales. This would ensure qualified & regulated youth workers & peer support for the 'coming out' process, particularly for those in areas outside of the main towns and cities.

Drug and Alcohol use and health promotion

The literature contends that LGB people are more likely to use substances and alcohol than the general population. Within our study this was refuted by 54.5% and 60% of survey respondents who thought that there is no link between being LGB and taking alcohol or drugs respectively. The remainder suggested that alcohol/and or drugs (a) were an endemic aspect of the social gay 'scene, or (b) may have been used as self medication and /or to cope with societal pressures around coming out and identifying as LGB, amongst other issues. Fourteen percent of people who use recreational drugs and 31.5% of those who use alcohol recognise that they are less than happy with their usage and in some cases believe their use exacerbates existing mental health issues. Refraining from drinking or taking drugs, or choosing not to frequent and socialise on the scene was viewed as leading to social isolation. For some the pressures to 'fit in' on the scene went hand in hand with drug/alcohol use or meant that the scene was off limits and an undesirable source of socialising. From these people there was a call for alternative to drug and alcohol social activities. In order to promote mental health and support those for whom substances and alcohol are problematic we therefore **recommend**:

- ✓ Health promotion services should target and fund services that promote the mental health and wellbeing of LGB people, including harm reduction strategies on drug and alcohol use and promotional materials at key venues.

Hate Crime:

Just under a quarter of respondents (n=28) experienced what they perceived to be homophobic, biphobic or transphobic hate crime. Of 39% who reported incidents to the police there were mixed views on the response received. Just over half were explicit in their satisfaction with the way in which the incident was dealt with. Whilst some respondents were of the view that reporting

routes and awareness raising around hate crime and LGB rights in this regard, we found that for a number of respondents there was reluctance to report hate crime incidents. Whilst steps have been taken in Wales to increase the level of reporting of crime and to build links between ‘the LGB community’ with community liaison officers, we further **recommend**:

- ✓ All agencies within the Criminal Justice System across Wales should take proactive measures to tackle homophobic hate crime and increase people’s confidence to report homophobic hate crime through consistent and clear promotion of reporting routes, resources to promote publicity material, more joined up working between police & the Criminal Prosecution Service to tackle homophobic hate crime and an all Wales joint strategy to tackle homophobic hate crime spanning the 4 police forces.

Bisexual specific:

Many bisexual respondents and focus group participants/ interviewees highlighted the detrimental impact of prejudice stemming from ‘mainstream’ society and the ‘gay community’ in relation to their sexual orientation. This was seen as excluding respondents from both ‘mainstream’ social activities and the ‘gay scene’, or activities and support services that aim to be LGBT inclusive. Our recommendations above are inclusive of bisexual people but additionally, based on our findings and the input of bisexual respondents concerning possible improvements, we **recommend**:

- ✓ Awareness raising and training around the specifics of bisexual people’s experiences and needs.
- ✓ LGBT organisations to consider the establishment of Bi specific support networks.

Trans Specific:

Our study and indeed our recommendations are aimed at individuals who identify as LGB with mental health issues irrespective of self defined gender. In our study several respondents identified as ‘female and trans’ or trans. Though we stress that people who identify as trans are not homogenous, we

found that trans people with mental health issues suffer considerable social exclusion, discrimination, stigma, and victimisation. This can be from all sectors of society including 'the LGB community' with which they are often co-located in service provision and social activities (whether they wish to be or not). Trans people appear to be poorly catered for in Wales in terms of gender dysphoria services, although we cautiously welcome Health Commission Wales' (HCW) recent change of policy in April 2009 in relation to criteria for gender reassignment services⁴⁰. Respondents talked of a lack of capacity for the limited trans specific services and support groups. Our recommendations above are inclusive of LGB people irrespective of self defined gender but additionally we **recommend**:

- ✓ Awareness raising and training around the specifics of trans people's experiences and needs.
- ✓ LGBT organisations and the Welsh Assembly Government in collaboration with trans people to consider the funding and establishment of trans specific support networks such as youth groups and peer support across Wales.
- ✓ Research is needed into the specific needs and experiences of trans people living in Wales; irrespective of sexual orientation. Such research may identify further areas of policy and service development for the support, inclusion and health and wellbeing of trans people in Wales.

Further research:

Our study was exploratory and highlighted a need for further research around mental health and wellbeing of people who identify as LGB. We further **recommend**:

- ✓ Research could usefully be undertaken in relation to suicide, self harm and LGB people living in Wales;
- ✓ Research to be undertaken in relation to drug and alcohol use and LGB people living in Wales;

⁴⁰ Amongst other clinical criteria, HCW previously required that referrals for gender reassignment were "in exceptional circumstances". The recent announcement removes 'exceptionality' amongst its criteria for treatment.

- ✓ Research is needed that is ecological in its approach to examining stressors and risks and the psychosocial sources of resilience that bolster LGB people in their mediation of these throughout their everyday lives;
- ✓ A needs analysis to be undertaken with professionals across Wales to identify training needs around working with people who identify as LGB with mental health issues.
- ✓ Research that focuses on social inclusion and community engagement and work that promotes inclusion and diversity.

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Appendix One- questionnaire

Part One - About you

If you do not wish to answer a question leave it blank and move on to the next one.

1. How old are you?

1.2. What is your gender?

- Female
- Male
- Transgender or transsexual
- Undefined

1.3. What are the first 4 digits of your postcode?

1.4. Are you currently?

- Single
- Registered civil partnership
- Same-sex relationship
- Heterosexual relationship
- Other (please explain)

1.5. What is your first language?

- Welsh
- English
- British Sign Language
- Other (please explain)

1.6 What is your ethnic background?

- White
- Asian or Asian British
- Black or Black British
- Chinese
- Mixed
- Other, please explain

1.7. Do you consider yourself to be disabled? 'Disability is a physical or mental impairment, which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities' - Disability Discrimination Act 2005 definition.

Yes

No

Rather not say

1.8. Which of these qualifications do you have? (please tick all that apply)

- 1 or more GCSEs (any grade)
- 1 or more AS levels
- GNVQ
- Other qualification (City and Guilds, RSA)
- Undergraduate degree
- Postgraduate degree
- Doctorate
- No formal qualifications

1.9. Which of the following best describes you? (please tick all that apply)

- Full-time work
- Part-time work
- Training scheme
- Unemployed and looking for work
- At school or in full-time education
- Unable to work due to long-term sickness or disability
- Looking after your home/family
- Retired
- Other, please explain

Part Two - LGB and mental health

If you do not wish to answer a question leave it blank and move on to the next one

2.1 How would you describe your sexual orientation?

- Lesbian
- Gay woman
- Gay man
- Bisexual
- Person who has sex with members of the same sex
- Heterosexual or straight
- Questioning
- Other (please explain)

2.2 How 'out' are you with the following: (By 'out' we mean that you are open about your sexual orientation / sexuality to others). (please tick one for each)

| | Not out | Out to some | Out to all |
|--|--------------------------|--------------------------|--------------------------|
| Family | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Friends | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Work colleagues | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neighbours | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Wider community | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental health service providers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other service providers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2.3. In general, how is your mental health right now?

- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor

If you answered 'fair', 'poor' or 'very poor' please skip the next question & go to question 2.5.

2.4. If you have good, very good or excellent mental health now, have you had mental health issues in the past?

Yes No*

*This survey is for people who have either had, or currently have mental health issues. Thank you for your time.

2.5. Have you accessed mental health/ psychiatric community or inpatient services in relation to your mental health?

Yes No skip the next 5 questions & go to question 2.12

2.6. If yes, for how many years have you accessed these services?

2.7. If you have been in more or less continuous contact with mental health services over a period of several years – tick this box.

2.8. And which services did, or do you currently, access? Of these services, how often did, or do you intend to, use them?

| | 1-2 times | 3-5 times | 6-10 times | 10 or more | Don't know |
|---|-----------|-----------|------------|------------|------------|
| Telephone helpline | | | | | |
| GP counselling service | | | | | |
| Other private counselling service | | | | | |
| Child and Adolescent Mental Health Services | | | | | |
| Community Mental Health Team Services | | | | | |
| Hospital/ in patient | | | | | |

| | | | | | |
|---|--|--|--|--|--|
| Support group | | | | | |
| Crisis resolution & home treatment service | | | | | |
| Mental health advocacy services | | | | | |
| Other psychiatric services | | | | | |

2.8. When accessing these services were you out about your sexual orientation?

No Yes - skip the next question & go to 2.10.

2.9. if 'no' what was your reason for not being out? (tick all that apply)

- Didn't think it was relevant
- Fearful of disclosing
- Might be perceived as abnormal or the cause of mental health issue
- I was still in the process of coming out

Other (please specify):

2.10. If you were 'out' with any of the above services, do you think that this had an affect on how you were treated? And if so, how? (In your answer please specify which services)

2.11. Have these experiences impacted, or are they likely to impact on your:

(a) Level of openness about your sexual orientation when accessing mental health services?

| | | | | |
|-----------|----------------|-------|----------|------------|
| Very Much | To some degree | Mixed | A little | Not at all |
|-----------|----------------|-------|----------|------------|

(b) Willingness to access services?

| | | | | |
|-----------|----------------|-------|----------|------------|
| Very Much | To some degree | Mixed | A little | Not at all |
|-----------|----------------|-------|----------|------------|

2.12. If you have not accessed mental health services, what are the reasons for this?

Now **goto** question **2.13**.

2.13. How 'out' are you about your mental health with the following:

(Please tick one for each)

| | Not out | Out to some | Out to all |
|---------------------------------|--------------------------|--------------------------|--------------------------|
| Family | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Friends | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Work colleagues | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neighbours | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Wider community | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental health Service providers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other service providers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2.14. Do you think that being LGB has had any effect on your mental health?

| | | | | |
|-----------|----------------|-------|----------|------------|
| Very Much | To some degree | Mixed | A little | Not at all |
|-----------|----------------|-------|----------|------------|

2.15. Please explain your answer.

2.16. Do you use:

Recreational drugs - Yes

No

Alcohol - Yes

No

2.17. Are you happy with the extent to which you use:

(If you don't use, leave blank)

Recreational drugs - Yes

No

don't know

Alcohol - Yes

No

don't know

2.18. To what extent, if any, do you think pressures around your sexuality have an impact on your use of :

Recreational drugs: (if you don't use drugs leave blank)

| | | | | |
|-----------|----------------|-------|----------|------------|
| Very Much | To some degree | Mixed | A little | Not at all |
|-----------|----------------|-------|----------|------------|

Alcohol: (if not don't use alcohol leave blank)

| | | | | |
|-----------|----------------|-------|----------|------------|
| Very Much | To some degree | Mixed | A little | Not at all |
| | | | | |

Part Three - Where you live and inclusion

If you do not wish to answer a question leave it blank and move on to the next one

3. Do you live:

- Alone
- With same sex partner
- With opposite sex partner
- With friends
- With strangers (house share)
- With parents

Other, please specify

3.2. What do you think of your current living arrangements?

| | | | | | | |
|----------|-------------|---------------------|-------|------------------|---------|-----------|
| Terrible | Dis-pleased | Mostly Dissatisfied | Mixed | Mostly Satisfied | Pleased | Delighted |
|----------|-------------|---------------------|-------|------------------|---------|-----------|

3.3. Please give reasons for your answer:

3.4. How would you describe the area where you live?

Rural Town Suburb
City Village

3.5. How do you feel about the area where you live?

| | | | | | | |
|----------|-----------------|------------------------|-------|---------------------|---------|-----------|
| Terrible | Dis- pleased | Mostly Dissatisfied | Mixed | Mostly Satisfied | Pleased | Delighted |
|----------|-----------------|------------------------|-------|---------------------|---------|-----------|

3.6. Please give reasons for your answer:

3.7. In the last year have you been the victim of a hate crime?

Hate crime is any criminal offence committed against a person or property that is motivated by an offender's hatred of someone because of their race, colour, ethnic origin, nationality, religion, gender or gender identity, sexual orientation and disability. *(Home Office online 2008)*

Yes No - skip the next 4 questions & **goto q. 312**

3.8. What do you think was the basis of this crime?

3.9. Did you report this to the police?

Yes No - skip the next 2 questions & **goto q. 3.12.**

3.10. If yes, were you satisfied with their response?

Yes No

3.11. Please give reasons for your answer?

3.12. What, if any, hobbies, community, social, voluntary or political activities do you engage in within your local community on a regular basis?

3.14. How do you feel about the range of opportunities for you to be involved within community groups, clubs or associations that are available in your area?

| | | | | | | |
|----------|-------------|---------------------|-------|------------------|---------|-----------|
| Terrible | Dis-pleased | Mostly Dissatisfied | Mixed | Mostly Satisfied | Pleased | Delighted |
|----------|-------------|---------------------|-------|------------------|---------|-----------|

3.15. How often do you go out socially?

Every day At least once a month
At least once a week Never
At least once a fortnight Don't know

3.16. Who do you usually spend most of your time with? (On a scale of 1- 5 please circle whom you spend time with. With “1” indicating “spend least time with”, “5” indicating spend most time with. (Do not circle any if you spend no time with).

| | Spend Least Time | | | | Spend Most Time |
|--|------------------|---|---|---|-----------------|
| Family | 1 | 2 | 3 | 4 | 5 |
| Friends | 1 | 2 | 3 | 4 | 5 |
| Neighbours | 1 | 2 | 3 | 4 | 5 |
| Paid personal assistant/ carer | 1 | 2 | 3 | 4 | 5 |
| Unpaid carer e.g. relative | 1 | 2 | 3 | 4 | 5 |
| Other: please specify: _____ | 1 | 2 | 3 | 4 | 5 |

3.17. Are there any LGB community groups, activities, clubs or gay scene near to, or where you live?

Yes No Don't know

3.18. To what extent do you feel able to engage in these LGB community groups and events? (Circle one)

Not at All A little mixed feelings To some degree Completely able to

1 **2** **3** **4** **5**

3.19. Can you tell us a bit more about the reasons for this?

3.20. Overall, how do you feel about the extent to which you are included in society?



Part Four – What do you think?

If you do not wish to answer a question leave it blank and move on to the next one

This final section asks you for your ideas on ways that the needs and welfare of LGB people with mental health issues can be promoted.

┌ ┌

Community Involvement & access to goods and services:

┌

4. If you have any views or face barriers to accessing local services, goods, leisure and other community groups in your area, in what ways (if any) could this change to include you/ support you?

Access to LGB events, social activities, scene etc. ┌ and LGB services.

4.2 If you have any views or face barriers to accessing LGB specific events, social activities or services in, or near to your area, in what ways (if any) could services and groups change to include you/ support you?

Access to mental health services: ⌈

4.2 If you have any views of the mental health services you access, or face barriers to accessing these, in what ways could services and groups change to include you/ support you?

Finally, is there anything else that you think we should know about your experiences of being LGB with mental health issues?

Thank you for your time in sharing your views and experiences!

Appendix Two:

Telephone Help lines & information

Mental health organisations

Mind Info Line: 0845 766 0163 www.mindcymru.org

Hafal: 01792 816 600 www.hafal.org

Journeys: 029 2069 2891 www.journeysonline.org.uk

LGB organisations

Stonewall Cymru Information Line: 08000 50 20 20

Stonewall Cymru: 02920 237744 www.stonewallcymru.org.uk

LGBT Cymru Helpline Free Phone: 0800 023 2201
contact@lgbtcymruhelpline.org.uk

LGB mental health groups

MindOut Cymru:

The all Wales lesbian, gay and bisexual mental health network for lesbians, gay men and bisexuals who either have or have had contact with mental health services through being service users or workers, paid or unpaid. Contacts:

Tel: 02920 - 39 51 23 email: mindoutcymru@org.uk